

# HIV, TB AND HUMAN RIGHTS IN SOUTHERN AND EAST AFRICA REPORT 2016



# ABBREVIATIONS

<b>ARASA</b>	AIDS and Rights Alliance for Southern Africa
<b>ART</b>	Antiretroviral Therapy
<b>ARV</b>	Antiretroviral medicine
<b>AU</b>	African Union
<b>CEDAW</b>	Convention for the Elimination of All Forms of Discrimination against Women
<b>CRC</b>	Convention on the Rights of the Child
<b>CSO</b>	Civil Society Organisation
<b>DHS</b>	Demographic and Health Survey
<b>DRC</b>	Democratic Republic of Congo
<b>EAC</b>	East African Community
<b>eMTCT</b>	Elimination of Mother to Child Transmission of HIV
<b>FDC</b>	Fixed Dose Combination
<b>FGM</b>	Female Genital Mutilation
<b>HBC</b>	High Burden Country – TB
<b>IDP</b>	Internally Displaced Persons
<b>IPR</b>	Intellectual Property Rights
<b>GARPR</b>	Global AIDS Response Progress Reports
<b>GBV</b>	Gender-Based Violence
<b>GCHL</b>	Global Commission on HIV and the Law
<b>GFATM</b>	Global Fund to fight AIDS, TB and Malaria
<b>ICCPR</b>	International Covenant on Civil and Political Rights
<b>ICESCR</b>	International Covenant on Economic Social and Cultural Rights
<b>LGBTI</b>	Lesbian, Gay, Bisexual, Transgender and Intersex Persons
<b>MDG</b>	Millennium Development Goals
<b>MDR-TB</b>	Multi-drug Resistant TB
<b>MMP</b>	Methadone Maintenance Programme
<b>MONUSCO</b>	United Nations Stabilization Mission in the Democratic Republic of Congo
<b>MSM</b>	Men who have sex with men
<b>NAC</b>	National AIDS Council
<b>NCPI</b>	National Commitments and Policies Instrument
<b>NGO</b>	Non-Governmental Organisation
<b>NSE</b>	Needle Syringe Exchange
<b>NSP</b>	National Strategic Plan on HIV and AIDS
<b>OST</b>	Opioid Substitution Therapy
<b>PEP</b>	Post-Exposure Prophylaxis

<b>PEPFAR</b>	President’s Emergency Plan for AIDS Relief
<b>PMCT</b>	Prevention of mother to child transmission
<b>PrEP</b>	Pre-exposure Prophylaxis
<b>RVLT</b>	Routine Viral Load Testing
<b>SADC</b>	Southern African Development Community
<b>SADC-PF</b>	Southern Africa Development Community Parliamentary Forum
<b>SEA</b>	Southern and East Africa
<b>STI</b>	Sexually Transmitted Infection
<b>TAC</b>	Treatment Action Campaign
<b>TB</b>	Tuberculosis
<b>TRIPS</b>	Trade-Related Aspects of Intellectual Property Rights
<b>TOT</b>	Training of Trainers
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Program on HIV/AIDS
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>UNHCR</b>	United Nations High Commission on Refugees
<b>UNICEF</b>	United Nations International Children’s Emergency Fund
<b>UNGASS</b>	United Nations General Assembly Special Session
<b>VSU</b>	Victim Support Units
<b>WHO</b>	World Health Organisation
<b>ARIPO</b>	African Regional Intellectual Property Organisation
<b>LDC</b>	Lest Developed Country
<b>COMESA</b>	Common Market for Eastern and Southern Africa
<b>TRIPs</b>	Trade-Related Aspects of Intellectual Property Rights
<b>WTO</b>	World Trade Organisation
<b>FTAs</b>	Free Trade Agreements
<b>IP</b>	Intellectual Property
<b>R&amp;D</b>	Research and Development
<b>NHRIs</b>	National Human Rights Institution
<b>NAC</b>	National AIDS Council
<b>IRP</b>	Intellectual Property Rights
<b>NSF</b>	National Strategic Framework
<b>BONELA</b>	Botswana Network on Ethics, Law & HIV/AIDS
<b>IDPS</b>	Internally Displaced Person
<b>UNHCR</b>	UN High Commission for Refugees



# CONTENTS

## 1. Introduction: About the Report |

- 1.1 Aim of the 2016 Report | 10
- 1.2 Background | 10
- 1.3 Overview | 10

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

- 2.1 HIV, AIDS and TB in Southern and East Africa | 12
- 2.2 HIV and Human Rights in Southern and East Africa: Achievements and Challenges | 18

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

- 3.1 Introduction | 26
- 3.2 Criminalisation of HIV-related conduct | 26
- 3.3 Sexual orientation and gender identity | 29
- 3.4 Sex Workers | 33
- 3.5 Gender inequalities and GBV: HIV and women | 36
- 3.6 Access to affordable medicines | 40
- 3.7 People who use drugs | 42
- 3.8 Prisoners | 44
- 3.9 Harnessing the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in SEA to promote Access to treatment/medicines | 47
- 3.10 Tuberculosis | 53

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

## 5. Country Snapshots |

- |              |     |
|--------------|-----|
| Angola       | 71  |
| Botswana     | 77  |
| Comoros      | 85  |
| DRC          | 91  |
| Kenya        | 99  |
| Lesotho      | 107 |
| Madagascar   | 117 |
| Malawi       | 125 |
| Mauritius    | 135 |
| Mozambique   | 143 |
| Namibia      | 151 |
| Seychelles   | 159 |
| South Africa | 167 |
| Swaziland    | 175 |
| Tanzania     | 183 |
| Uganda       | 191 |
| Zambia       | 201 |
| Zimbabwe     | 211 |

# KEY TO READING THIS REPORT

Throughout this report, you will see icons relating to key advocacy priorities that ARASA works on. Follow these icons and their corresponding colour if you are interested in one topic in particular.

**Criminalisation, with negative impacts for public health and human rights**



**Sex Worker Rights**



**Lesbian, Gay, Bisexual, Transgender & Intersex (LGBTI) Rights**



**Drug Policy Reform**



**Intellectual Property**



**Women's Rights**



**Human Rights**



**Law Enforcement**



**Tuberculosis (TB)**



# ABOUT THE AIDS AND RIGHTS ALLIANCE FOR SOUTHERN AFRICA (ARASA)

## Who are we?

Established in 2003, the AIDS and Rights Alliance for Southern Africa (ARASA) is a regional partnership of over 106 non-governmental organisations (NGOs) working together in 18 countries to promote a human rights approach to HIV, AIDS, Sexual and Reproductive Health and Rights (SRHR) and tuberculosis (TB) in Southern and East (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', Lesbian, Gay, Bisexual, Transgender and Intersex (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 (or indeed elsewhere).

## 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 HIV and AIDS, sexual and reproductive health (SRH) and TB 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 develops training resource materials related to HIV, SRH, TB and human rights programming.

**Advocacy and Lobbying:** ARASA strengthens and supports partner organisations to promote a human rights based response to HIV and AIDS, TB and SRH 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, SRH and TB and engage in effective advocacy initiatives on rights issues that are identified as relevant at both national and regional levels.

Central to all the programme areas is the recognition that the protection of human rights remains critical to a successful response to HIV, AIDS, SRH 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.

## For further information about ARASA please contact

Michaela Clayton (Director) or Lesley Odendal (Communications Lead)  
ARASA,  
PO Box 97100,  
Maerua, Windhoek, Namibia  
Tel: 264 61 300381 Fax: 264 61 227675  
Email: michaela@arasa.org.na / communications@arasa.info  
Website: www.arasa.info

## Acknowledgements

The support of the following donors for the work of ARASA and the production of this report is gratefully acknowledged:

- Embassy of the Kingdom of the Netherlands, Pretoria
- Robert Carr Civil Society Networks Fund
- SIDA
- NORAD
- Levi Strauss Foundation
- AIDS Fonds

ARASA is also grateful to Kitty Grant and Liesl Gertholtz for authoring this report and to Michaela Clayton, Felicita Hikuam, Lynette Mabote, HeJin Kim, Nthabiseng Mokoena and Lesley Odendal for editing the final version of the report. ARASA thanks Lisa Robertson for design and layout of this report and to Anthea Duce and Gerrit Giebel for additional layout support.





# SECTION 1 ABOUT THIS REPORT



## 1.1 AIM OF THE 2016 REPORT

The HIV, TB & Human Rights in Southern and East Africa 2016 report examines the legal and regulatory framework for responding to HIV, AIDS and TB 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, (LGBTI people, sex workers and people who use drugs), in context of HIV, AIDS and TB; and
- Populations are aware of their rights, are able to access justice and are able to enforce their rights in the context of HIV, AIDS and TB.

The 2016 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.

### The HIV, TB & Human Rights in Southern and East Africa 2016 report examines the legal and regulatory framework for responding to HIV and AIDS in countries in Southern and East Africa (SEA)



## 1.2 BACKGROUND

The AIDS and Rights Alliance for Southern Africa (ARASA) produced its first report on HIV and Human Rights in Southern Africa in 2006. This was followed by an update in 2009. In 2014 we reported for the first time on HIV and Human Rights in Southern and East Africa, expanding the reach of the report to Kenya and Uganda. These reports have been widely used as a resource for research and have been extensively quoted in publications on HIV, law and human 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 and TB incidence and prevalence.
- Section 3 sets out the progress made removing punitive laws that criminalise HIV-related conduct and key populations 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.

# SECTION 2 HIV, AIDS, TB & HUMAN RIGHTS IN SOUTHERN AND EASTERN AFRICA



2.1 HIV, AIDS AND TB IN SOUTHERN AFRICA

The 2016 UNAIDS Global AIDS Update highlights the “enormous gains” that have been made, particularly with regard to access to treatment: since 2014, the number of people living with HIV on ART has increased by about a third and by 2 million more than the 2015 target of 15 million on treatment, set in the 2011 Political Declaration. Approximately 17 million people globally living with HIV are receiving ART. Gains have also been made in reducing AIDS-related deaths which have decreased by 43% since 2003, and by 35% in Southern and East Africa (SEA). The number of people on treatment in the most affected region, namely SEA, has doubled since 2010: approximately 54% of people living with HIV who need ART are able to access it. <sup>2</sup>

HIV and TB by the numbers <sup>3</sup>

• 35% **decrease** in new HIV infections since 2000

• 58% **decrease** in new HIV infections amongst children since 2000

• 84% **increase** in access to ARVs since 2010

• 42% **decrease** in AIDS-related deaths since 2004

• 32% **decrease** in TB-related deaths amongst people living with HIV since 2004

• 77% of known TB patients with HIV started or continued ARVs by 2014

2015 marked the target year for the 2011 Political Declaration on HIV and AIDS which set out 10 ambitious targets. Table 1 sets out the progress made in reaching the agreed targets. <sup>4</sup>

Table 1: Targets from the Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS, 2011

TARGET	RESULT
Reduce sexual transmission of HIV	While gains in reducing new infections have been made, in 2015, the number of new infections amongst adults remained “static” at 1.9 million globally. The largest reduction in new adult infections took place in SEA with a 4% decline (nearly 40 000). <sup>5</sup>
Reduce transmission of HIV amongst people who inject drugs by 50%	There is no evidence to show there has been any decline in the numbers of new HIV infections amongst people who use drugs between 2010 and 2014; 140 000 people who inject drugs were newly infected with HIV in 2014. <sup>6</sup>
Eliminate new HIV infections amongst children and substantially reduce AIDS-related maternal deaths	New paediatric infections have halved in countries with 90% of the global new HIV infections in children.
Reach 15 million people living with HIV with ART by 2015	15.8 million people on treatment (the target was achieved 8 months before the deadline).
Close the global AIDS resource gap and reach annual global investment of \$22 – 24 billion in low- and middle-income countries	HIV funding rose by 11% between 2011 and 2014. Governments are increasing domestic funding for the AIDS response, but this investment does not always or adequately include increased investment in advocacy, human rights and programming for key populations.
Eliminate gender inequalities and gender-based abuse and violence and increase capacity of women and girls to protect themselves from HIV	No country has achieved full equality for women and girls. Gender inequality and violence continue to put women and girls at higher risk of HIV. In 2014, 56% of all new infections among 15 – 24 year olds were women and in the 15 – 19 year old group, 62% of new infections were amongst girls. AIDS is still the leading cause of death for women of reproductive age in Africa. 62% of new infections were amongst girls.
Eliminate stigma and discrimination against people living with and affected by HIV through the promotion of laws and policies that ensure the full realization of human rights and fundamental freedoms	There have been improvements in reducing discriminatory attitudes towards people living with HIV but there are still many countries who have not eliminated punitive and coercive laws that perpetuate stigma and discrimination. The recommendations by the Global Commission on HIV and the Law have encouraged progress.
Eliminate HIV-related restrictions on entry, stay and residence	Significant progress has been made eliminating HIV-related travel restrictions.
Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems	Growing numbers of countries report facility-level integration of HIV and sexual and reproductive health services, as well as extensive integration of HIV counselling and testing services with those for non-communicable diseases. Countries report integration between HIV and tuberculosis services.
Reduce TB-related deaths in people living with HIV by 50%	TB-related deaths reduced by 18% between 2010 and 2014.

The Secretary-General of the United Nations, in his report to the 2016 High Level Meeting on Ending AIDS, described the progress towards reaching the targets as “extraordinary” and the meeting of the treatment target as a “major global victory”.<sup>7</sup> But, he also pointed out that in some critical areas, only limited gains had been made: there were only “modest” improvements in reducing stigma and discrimination against people living with HIV and creating a more enabling environment; gender inequality, violence and abuse remain widespread and women and girls face discrimination and abuse that undermines their ability to protect themselves from HIV and access treatment, care and support.

There were only “modest” improvements in reducing stigma and discrimination against people living with HIV and creating a more enabling environment; gender inequality, violence and abuse remain widespread and women and girls face discrimination and abuse that undermines their ability to protect themselves from HIV and access treatment, care and support

He reinforced the continuing challenges: 22 million people living with HIV globally are not accessing life-saving treatment, with children especially lagging behind; over half of people living with HIV do not know their status, underscoring that late diagnosis is one of the most serious barriers to scaling up treatment; substantial numbers of people on ART struggle with adherence and do not achieve viral suppression.

The global progress and the continuing challenges are reflected in sub-Saharan Africa: there has been a 41% decrease in new HIV infections in the region since 2000 and 34% fewer AIDS-related deaths in the same period. This means that over 400 000 deaths were averted since 2000.<sup>8</sup>

Significant progress has been made in SEA countries in preventing new infections and scaling up access to treatment. The number of new HIV infections fell by just under a third between 2005 and 2013 and the scale of ART has contributed to a decline of 46% in AIDS deaths during the same period. South Africa still has the largest number of people with HIV on treatment, with 3.4 million people living with HIV able to receive it. Kenya has 900 000 people on treatment, giving it the second largest treatment programme in the world, and by the end of 2015, Botswana, Kenya, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe had all increased treatment access by at least 25% between 2010 and 2015.<sup>13</sup>

Table 2: Key HIV Epidemic Indicators for Southern and East Africa, 2014 <sup>9</sup>

People living with HIV	18.5 million
New HIV infections	1.1 million
New adult HIV infections	940 000
AIDS-related deaths	730 000
HIV prevalence (15 – 49 years)	7.4%
Children living with HIV	2 million
Children newly infected with HIV	120 000
Adults living with HIV	16.5 million
Women living with HIV	9.7 million
HIV prevalence amongst young women (15 – 24 years)	3.7%
HIV prevalence amongst young men (15 – 24 years)	1.8%
Adult ART coverage <sup>10</sup>	43%
Paediatric ART coverage <sup>11</sup>	27%
PMTCT coverage <sup>12</sup>	78%

There has been also a large scale up of Elimination of Mother to Child Transmission services: coverage reached 78% in 2013. Consequently new infections among children have fallen by 66% between 2005 and 2013. Despite this, SEA is still the worst affected region, accounting for almost half of the global burden of HIV.<sup>14</sup> Thirteen of the 35 countries that accounted for 90% of HIV infections globally in 2014 are in SEA.<sup>15</sup>

Table 3: Country snapshot: Key HIV estimate in ARASA partner countries in SEA <sup>16</sup>

COUNTRY	NUMBER OF PEOPLE LIVING WITH HIV	ADULT HIV PREVALENCE	NUMBER OF WOMEN LIVING WITH HIV	NUMBER OF CHILDREN LIVING WITH HIV	AIDS DEATHS
Angola	300 000	2.4%	160 000	32 000	12 000
Botswana	390 000	25.2%	380 000	16 000	5 100
Comoros	No data	No data	No data	No data	No data
Democratic Republic of the Congo	450 000	1%	230 000	59 000	24 000
Kenya	1.4 million	5.3%	700 000	160 000	33 000
Lesotho	310 000	23.4%	170 000	19 000	9 300
Madagascar	39 000	0.3%	16 000	4 500	3 200
Malawi	1.1 million	10%	560 000	130 000	33 000
Mauritius	8 300	0.9%	2 400	N/A	<500
Mozambique	1.5 million	10.6%	830 000	160 000	45 000
Namibia	260 000	16%	130 000	16 000	5 100
Seychelles	No data	No data	No data	No data	No data
South Africa	6.8 million	18.9%	3.9 million	340 000	140 000
Swaziland	210 000	27.7%	120 000	19 000	3 500
Tanzania	1.5 million	5.3%	800 000	N/A	46 000
Uganda	1.5 million	7.3%	770 000	150 000	33 000
Zambia	1.2 million	12.4%	540 000	100 000	19 000
Zimbabwe	1.6 million	16.7%	830 000	150 000	39 000

CHILDREN

The Global Plan towards the elimination of new HIV infections amongst children and keeping their mothers alive galvanized important advances in reducing the numbers of new HIV infections amongst children in the priority countries.<sup>17</sup>

**Quick facts: Global Plan towards the elimination of new HIV infections amongst children and keeping their mothers alive**

- It has been in operation since 2011 and prioritises 22 countries that account for the majority of pregnant women living with HIV who need access to eMTCT
- Its goals are to reduce the number of new infections amongst children by 90% (from the baseline in 2009) and the number of AIDS-related maternal deaths by 50%
- At the end of 2014, the Global Plan Countries had reduced new infections amongst children by 48%.<sup>18</sup>

South Africa reduced new infections amongst children by 76%. Tanzania (72%), Uganda and Mozambique (69% each), Namibia (64%) and Swaziland (63%) also made notable progress. Angola (25%), DRC (27%) and Kenya (29%) made the least progress amongst the priority countries.<sup>19</sup>

The gains in reducing the number of new HIV infections amongst children, access to treatment for adults and the scale up of eMTCT services have not been matched by similar progress in treatment access for children living with HIV. The increase in the number of children on ART during the first half of 2014 was only 3% compared to a 6% increase for adults.<sup>20</sup> Botswana and Namibia are providing treatment to more than half of the children living with HIV, followed by South Africa, with just under half of the children living with HIV receiving treatment.<sup>21</sup>

The gains in reducing the number of new HIV infections amongst children, access to treatment for adults and the scale up of eMTCT services have not been matched by similar progress in treatment access for children living with HIV.

There is a critical need to test, diagnose and treat children.<sup>22</sup> The lack of access to paediatric treatment is driven by various factors including a lack of paediatric formulations of ARVs, challenges in diagnosing infants, poor linkages to care and treatment for children and lack of qualified personnel trained to prescribe treatment for children.<sup>23</sup>

There are also significant challenges diagnosing TB in children and children who live in countries with a high burden of TB are less likely to be diagnosed.<sup>24</sup> The World Health Organisation (WHO) current estimates in 2015 are that 1 million children below the age of 15 years currently suffer from TB worldwide and more than 136 000 die each year.<sup>25</sup> This is the estimate for HIV negative children, as children who have TB and who are also HIV positive when they die are internationally classified as having died from HIV.

WOMEN AND ADOLESCENT GIRLS



Adolescent girls and young women below the age of 24 are particularly vulnerable to HIV, accounting for 20% of new infections amongst adults globally, despite being just 11% of the adult population.<sup>26</sup> There are 9.7 million women over the age of 15 living with HIV in SEA.<sup>27</sup> Gender disparities in HIV infection rates remain stark, with 5.6% of women between the ages of 15 and 49 years living with HIV in sub-Saharan Africa, compared to 3.9% of men. Around 25% of new infections are accounted for by adolescent girls and young women, and women account for 56% of new infections amongst adults.<sup>28</sup> AIDS is the leading cause of death for African adolescent girls.<sup>29</sup>

**Quick facts: women and girls <sup>30</sup>**

- 70% of women do not have basic awareness of HIV
- 46% of women (+15 years) are accessing ART
- In 2014, more than 5000 young women and girls acquired HIV, the majority of whom live in sub-Saharan Africa
- Of the approximately 1.8 million adolescent girls living with HIV in sub-Saharan Africa, less than one in five knew her HIV status

Women and girls frequently have little ability to protect themselves from HIV and there is a critical need to continue to scale up interventions that address gender inequality, harmful gender norms and gender-based violence. Women and girls must be able to access a full range of reproductive and sexual health care, including male and female condoms and PEP.

Women and girls frequently have little ability to protect themselves from HIV and there is a critical need to continue to scale up interventions that address gender inequality, harmful gender norms and gender-based violence.

Progress has been made in scaling up access to eMTCT services for pregnant women and girls living with HIV. In the first half of 2014, the number of pregnant women receiving ART rose by 13%, compared to 2013.<sup>31</sup>



KEY POPULATIONS

Key populations, including gay men and men who have sex with men, sex workers and people who use drugs have not benefitted equally from the gains in access to HIV prevention and treatment. While SEA countries have begun to implement and even scale up prevention and treatment efforts, stigma, discrimination and human rights abuses undermine the ability of key populations to protect themselves from HIV and access comprehensive treatment and care services. The 2016 AIDS Global Update states that 4% of new infections amongst adults occur amongst sex workers, 9% amongst clients of sex workers and sexual partners of other key populations, 6% amongst gay men and men who have sex with men and 2% amongst people who inject drugs.<sup>32</sup>



Key populations, including gay men and men who have sex with men, sex workers and people who use drugs have not benefitted equally from the gains in access to HIV prevention and treatment.

There continues to be a dearth of reliable data on HIV prevalence amongst key populations.<sup>33</sup>

- People who inject drugs: There is limited data on HIV prevalence amongst people who inject drugs, but UNAIDS indicates that 333 000 people who inject drugs are living with HIV in SEA.<sup>34</sup> Sub-Saharan Africa is an increasingly importance transit area for heroin smuggling and consequently for injecting drug use. Injecting drug use follows transport routes along Kenya, Madagascar, Mauritius, Mozambique, South Africa and Tanzania. In Kenya, HIV prevalence amongst people who inject drugs is 18%, compared to 5.6% in the general population. A survey in the DRC found HIV prevalence amongst injecting drug users of 13.3%. In Tanzania, HIV prevalence amongst people who inject drugs is four times the national rate, and as high as 62% amongst women who inject drugs.<sup>35</sup> TB is also more prevalent amongst people who use drugs.<sup>36</sup>
- Sex workers: HIV prevalence amongst sex workers continues to be much higher than prevalence amongst the general population and they face widespread human rights abuses and serious challenges to accessing health services. Globally, HIV prevalence among male sex workers is slightly higher than female sex workers.<sup>37</sup> Transgender sex workers face particularly high levels of abuse and discrimination; while prevalence surveys are not specific enough to extrapolate the prevalence rate among transgender women sex workers, globally it is estimated to be as high as 27%.<sup>38</sup>
- Transgender people: due to conflation with men who have sex with men there historically has been little clear information of HIV prevalence rates among transgender people; currently estimates globally are 19.2% among transgender women, with no estimates made in terms of transgender men. Figures from African countries are not available.<sup>39</sup>
- Gay men and men who have sex with men: globally, gay men and men who have sex with men are 19 times more likely to be living with HIV than the general population and very few have access to a basic package of HIV prevention services.<sup>40</sup> Emerging data suggests that young men who have sex with men may be at greater risk of HIV than older men who have sex with men or heterosexual men. Many are unaware that unprotected anal sex can transmit HIV.<sup>41</sup>

TUBERCULOSIS



Quick facts: TB and HIV <sup>42</sup>

- TB is one of the biggest killers of people living with HIV
- People living with HIV have an estimated 20 – 30 times greater risk of developing TB than people without HIV.
- 9.4 million people became ill with TB in 2009; of these, 3 million, including 1 million people living with HIV, were in Africa
- Nearly half a million people living with HIV died of TB in 2014. <sup>43</sup>



In 2014, Africa accounted for 28% of the world’s TB cases and Southern Africa has the highest TB burden globally as a result of poor access to TB prevention, care and treatment

In 2014, Africa accounted for 28% of the world’s TB cases and Southern Africa has the highest TB burden globally as a result of poor access to TB prevention, care and treatment. People living with HIV who develop TB have limited access to ART and in 2014, only one third of the 1.2 million people in Africa living with HIV and TB were accessing ART. South Africa has made gains in providing people living with HIV with isoniazid preventative therapy (IPT), but it does not appear that IPT is sufficiently accessible in the rest of SEA.<sup>44</sup>

Countries with the highest number of HIV associated TB deaths include Kenya, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe.<sup>45</sup> The WHO reports that the African TB effort is under-funded by 37%.<sup>46</sup>

GROUPS MOST AT RISK OF TB IN SOUTHERN AND EAST AFRICA

The TB epidemic amongst miners in Southern Africa has been well documented. The incidence of TB amongst miners in South Africa is estimated to be between 2500 – 3000 per 100 000 population, far above the WHO’s threshold for emergency which is 250 cases per 100 000. It is not only miners themselves that are affected, but also their families and communities around mines and those in labour sending countries. Providing treatment to all who need it is a significant challenge in Southern Africa.<sup>47</sup>



The incidence of TB amongst miners in South Africa is estimated to be between 2500 – 3000 per 100 000 population, far above the WHO’s threshold for emergency which is 250 cases per 100 00.

Health care workers are at particular risk of TB and DR-TB, with their annual risk of developing TB being three times higher than the general population. They are at higher risk of drug resistant tuberculosis (DR-TB) because of the delays in diagnosing it, less effective treatment and the longer periods of caring for people living with DR-TB.<sup>48</sup>

Prisons are a high risk environment for HIV transmission due to over-crowding, limited access to health care, drug use and unsafe injecting practices, sexual violence and unprotected sex and tattooing. In some detention settings, HIV prevalence amongst prisoners may be up to 50% higher than in the general population. There are large numbers of prisoners who use injecting drugs – it is estimated that between 56% and 90% of people who inject drugs will be imprisoned at some point.<sup>49</sup> Prisoners who inject drugs are at particularly high risk of TB.<sup>50</sup>

Migrants are also at high risk of TB and they face risk factors at all stages of the migration process, including over-crowding, poor living conditions, increased vulnerability to HIV, poor nutrition and lack of access to health care. They also face barriers to TB diagnosis and treatment because of their undocumented status, lack of awareness of their rights, including to health care and language barriers. Migrant workers may also find their access to health care linked to their employment contracts and insurance, while undocumented migrants fear deportation if they seek TB testing and treatment.<sup>51</sup>

2030 AND BEYOND

The UN High Level Meeting to End AIDS took place in New York in early June 2016. On 7 June 2016, the UN General Assembly adopted a new Political Declaration on HIV and AIDS to accelerate the fight against HIV and end the epidemic by 2030. The new Declaration reaffirms the central role of human rights in the struggle to end the epidemic and states that human rights should be mainstreamed into all HIV and AIDS policies and programmes.

Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030

The Declarations reaffirms the UNAIDS 90-90-90 targets and set the following targets for 2020:

- 30 million people accessing ART, with a special emphasis on providing 1.6 million children with ART by 2018
- Reduce the global number of new infections to below 500 000
- Reduce the global number of AIDS-related deaths to below 500 000
- Eliminate HIV-related stigma and discrimination
- Eliminate gender based violence and gender inequality
- Increase and fully fund the AIDS response and reach an overall investment in developing countries of \$26 billion per year
- Commit to measures to ensure access to safe, affordable and efficacious medicine, including generics
- Reduce TB-related deaths amongst people living with HIV by 75%
- Reduce new cases of chronic hepatitis B and C by 30% and have 5 million people receiving treatment for hepatitis B and 3 million for hepatitis C

While the bold goals in the new Declaration have been welcomed, it has been strongly criticized for the lack of recognition of those most at risk of HIV, including gay men who have sex with men, sex workers, people who inject drugs and transgender people.

While the bold goals in the new Declaration have been welcomed, it has been strongly criticized for the lack of recognition of those most at risk of HIV, including gay men who have sex with men, sex workers, people who inject drugs and transgender people. The Declaration calls for laws, policies and practices that enable access to services and help end stigma and discrimination, but does not explicitly call for the decriminalisation of consensual adult sex or drug use. A civil society declaration, endorsed by ARASA and ARASA mesbers, urged the UN and governments to endorse and follow ten steps to end the AIDS epidemic.<sup>52</sup>

10 Steps to end AIDS by 2030

- **Leave no-one behind:** acknowledge that key populations are most affected by HIV, but are also leading the response. Governments and civil society need to collect age and sex-disaggregated data and information about all groups, including those traditionally invisible to data collectors.
- **Protect and uphold human rights:** eliminate discriminatory laws, policies and practices that negatively affect people living with HIV, gay men and other men who have sex with men, sex workers, people who use drugs, transgender people, women and girls.
- **Decriminalise HIV transmission, exposure and non-disclosure**
- **Ensure treatment access now:** all people with HIV who need treatment should be able to access it. Access to treatment in developing countries should be consistent with the WHO Declaration on TRIPS and Public Health.
- **Revive the prevention revolution**
- **Achieve gender equality**
- **Recognise and respond to HIV amongst socially and politically marginalised groups:** these include young women and girls, gay men and men who have sex with men, sex workers, transgender women and people who inject drugs.
- **Fully finance a comprehensive HIV response**
- **Support community responses**
- **Implement strong accountability mechanisms to ensure that targets are met**

2.2 HIV, TB AND HUMAN RIGHTS IN SOUTHERN AND EAST AFRICA: ACHIEVEMENTS AND CHALLENGES

This section aims to give a broad overview of the human rights developments in SEA since the publication of the 2014 ARASA HIV and Human Rights report.<sup>53</sup> It also examines the continuing human rights challenges for SEA countries.

RESOURCES FOR HUMAN RIGHTS

HIV is one of the most stigmatized diseases in recent history. People living with HIV or perceived to be living with HIV have been subject to a vast range of human rights violations, including quarantine, mandatory HIV testing, violence and social exclusion. Human rights have therefore played a central role in the international and national responses to HIV. Civil society has been primarily responsible for advocating for the effective protection and promotion of human rights in AIDS and, more recently, TB responses and for the implementation of human rights programming. Many organisations have done this critical work on shoe string budgets and with minimal resources.

Quick facts: human rights achievements in the AIDS response<sup>54</sup>

- Made prevention and treatment affordable and accessible
- Protected the human rights of populations most affected by HIV
- Produced unprecedented global solidarity for people living with HIV

UNAIDS puts current global spending for human rights at approximately \$137 million, a very small fraction of the \$19.1 billion spent on the AIDS response in 2013 in low- and middle-income countries. As a result of its concerns about diminishing funding for civil society and community based organisations, UNAIDS commissioned research examining funding for human rights. 59% of the respondents reported a decrease in human rights funding, while only 17% reported an increase. Of particular concern is the finding that 58% reported a decrease in core funding, funds that often permitted them to undertake less popular or more controversial work.<sup>55</sup>

UNAIDS puts current global spending for human rights at approximately \$137 million, a very small fraction of the \$19.1 billion spent on the AIDS response in 2013 in low- and middle-income countries

Key findings of UNAIDS research into funding for human rights, 2015<sup>56</sup>

- The majority of respondents report that their funding has decreased.
- They anticipate that the decrease in funding will limit their ability to carry out HIV related human rights programming and will lead to organisational downsizing.
- Respondents anticipating the most severe decreases in funding for HIV related human rights programmes are in middle income countries.
- Respondents that anticipate less severe decreases in funding are in sub-Saharan Africa and carry out diversified programming, including service delivery.
- Although domestic funding grew in recent years, 70% of survey respondents do not access domestic funds. Respondents also reported that it seems unlikely that governments will provide funding for human rights work that may be seen to be challenging government policies.
- Respondents are accessing funds from bilateral donors, private philanthropic agencies and UN agencies.
- Although their work is on human rights and the law, only 51% of survey respondents report accessing funds from non HIV donors, such as those that focus on human rights, democracy and governance, and lesbian, gay, bisexual, transgender and intersex people.

Funding appears to have especially diminished over the past two years and many respondents believe this to be due to the global economic downturn, difficulty obtaining funding for human rights from international donors and a national context that is not always conducive to human rights. Organisations are actively fund raising more, primarily targeting international donors, but the UNAIDS report paints a picture of “a human rights response that is struggling and at risk in a shifting political and funding landscape.”<sup>57</sup>

HUMAN RIGHTS ABUSES, STIGMA AND DISCRIMINATION

In May 2016, the UN Secretary-General reinforced the central role of human rights in the AIDS response. He emphasized the importance of promoting gender equality and ensuring that the most affected people, including people living with HIV, young women and their sexual partners in sub-Saharan Africa, adolescents, gay men and men who have sex with men, sex workers and their clients, people who inject drugs, transgender people, prisoners, people with disabilities, migrants and refugees, have access to services.<sup>58</sup>

People living with HIV and/or TB and key populations continue to struggle against stigma and discrimination in SEA and progress for many has been inconsistent and uneven. The Stigma Index to measure and detect changing trends of HIV-related stigma and discrimination has continued to be used as a tool to advocate for change and the DRC, Kenya, Lesotho, Malawi, Mauritius, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe have all completed studies in stigma and discrimination.<sup>59</sup>



There is no evidence the **overly broad criminalisation of HIV exposure, non disclosure and transmission** in SEA led to an increase in arrests and prosecutions of people living with HIV since the 2014 ARASA report. As previous ARASA HIV and Human Rights reports have noted however, the mere existence of these laws and the continued failure to remove them from statute books stigmatises people living with HIV, undermines public health initiatives and infringes on their human rights.

SEA remains a largely hostile environment for gay men who have sex with men, sex workers, transgender people, and people who use drugs and they continue to experience widespread human rights violations. The criminalisation of sex work, drug use, and same sex practices, as well as the lack of legal recognition of gender identity, high levels of violence, discrimination and denial of health care experienced by these populations, undermine their human rights to health, equality and dignity. Service providers report that criminalisation of drug use is the most frequently reported barrier to HIV testing among people who use drugs. They also report that TB is more prevalent amongst people who use drugs than the general population.<sup>60</sup> Young men who have sex with men are more likely to experience homophobic bullying at home, in schools and communities. There has been some progress in eliminating punitive laws with both the Seychelles and Mozambique repealing provisions that criminalise sex between men.

The criminalisation of sex work, drug use, and same sex practices, as well as the lack of legal recognition of gender identity, high levels of violence, discrimination and denial of health care experienced by these populations, undermine their human rights to health, equality and dignity

Human Rights Watch and Amnesty International adopt policies on decriminalising sex work

Both organisations adopted policies in favour of the decriminalisation of consensual adult sex work (Human Rights Watch in 2012 and Amnesty in 2016). The policies affirm criminalisation of adult sex work is incompatible with human rights, makes sex workers less safe and exposes them to human rights violations. Amnesty calls for governments to protect sex workers from harm, coercion and exploitation; facilitate their participation in the development of laws that affect them, end discrimination in all forms and ensure access to education and employment for sex workers.

Despite some progress, **stigma and discrimination remain key concerns** for people living with HIV and TB and key populations. The country snapshots illustrate the many dimensions of stigma and discrimination and how these undermine access to health care and other services. Research illustrates the role that self-stigma plays in the lives of people living HIV: they experience shame and feelings of guilt and a lack of self-esteem which prevent them from engaging in relationships and/or having children. Women are especially vulnerable to stigma. For example, women who inject drugs face higher levels of stigma and discrimination than their male counterparts and experience higher rates of physical and sexual assault.<sup>61</sup> Discriminatory attitudes among health-care workers and within entire health systems push away people who use drugs from services. Gay men who have sex with men also experience high levels of stigma and young men who have sex with men are particularly vulnerable to stigmatizing conduct, including homophobic bullying. Young men who have sex with men are also at risk of self-stigma which is linked to HIV risk.<sup>62</sup> There is also increasing evidence of TB- related stigma, especially amongst already stigmatized groups.<sup>63</sup>



**Women and girls** are still at higher risk of HIV because of their unequal status and their vulnerability to sexual violence. Women living with HIV experience human rights abuses such as mandatory HIV testing and forced or coercive sterilization. Adolescent girls in Africa are at the highest risk of HIV and human rights violations such as coercive sex, child marriage and lack of access to sexuality education and reproductive health services contribute to their vulnerability. Women also bear the brunt of the TB epidemic and TB is one of the leading causes of death amongst women with HIV globally. As is the case with HIV, vulnerability to TB for women is related to their unequal status, especially their economic dependence on men: women struggle to access TB testing and treatment and often wait longer to seek treatment. Women with TB face violence, abandonment, divorce and separation from their children.<sup>64</sup>

Women living with HIV experience human rights abuses such as mandatory HIV testing and forced or coercive sterilisation

**People in prisons** are extremely vulnerable to HIV: they may share needles during injecting drug use; there is both consensual sex and sexual violence in prisons and prisoners may share instruments for tattooing. The prevalence of both consensual and non-consensual sex in prisons is difficult to quantify. Studies conducted in a large number of countries show prevalence estimates from 1-2% to 4 – 10%. There are high levels of drug use in prisons: United Nations Office on Drugs and Crime (UNODC) estimates that one in three people in prison have used drugs at least once while they were incarcerated. The criminalisation of sex between men and drug use is a barrier to harm reduction and few prisons in Africa provide condoms, lubricants, clean needles and tattooing paraphernalia.<sup>65</sup>

Remarkable progress has been made in **access to treatment**, but not all groups are able to benefit equally from the scale up of ART. There is limited data available on ART coverage among people living with HIV who inject drugs but that that is available suggests that uptake is much lower than among other people living with HIV. Among the countries that reported to UNODC in 2014, 22% described HIV treatment for people who inject drugs as unavailable or at low levels of coverage.<sup>66</sup> Trade and intellectual property laws and regulations keep prices high for first-, second- and third line antiretrovirals and other medication, making them inaccessible to the majority of people who need them now (or who will need them in future). In 2015, UNAIDS warned that continued dependency by many African countries on donor funding and imported medicines and diagnostic could significantly undermine the gains that had been made.<sup>67</sup>

In 2015, UNAIDS warned of continued dependency by many African countries on donor funding and imported medicines and diagnostic could significantly undermine the gains that had been made.



# END NOTES

<sup>2</sup> UNAIDS, *Global AIDS Update*, 2016, [http://www.unaids.org/sites/default/files/media\\_asset/global-AIDS-update-2016\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf) [accessed 12 June 2016]

<sup>3</sup> UNAIDS, *AIDS By The Numbers*, 2015, [http://www.unaids.org/sites/default/files/media\\_asset/AIDS\\_by\\_the\\_numbers\\_2015\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/AIDS_by_the_numbers_2015_en.pdf) [accessed 12 June 2016]

<sup>4</sup> UN General Assembly, *On the fast track to ending the AIDS epidemic, Report of the Secretary-General*, 1 April 2016 [http://sgreport.unaids.org/pdf/20160423\\_SGreport\\_HLM\\_en.pdf](http://sgreport.unaids.org/pdf/20160423_SGreport_HLM_en.pdf) [accessed 25 May 2016]

<sup>5</sup> Ibid., UNAIDS, *Global AIDS Update*, 2016

<sup>6</sup> UNAIDS, *Do No Harm: Health, Human Rights and People Who Use Drugs*, 2016, [http://www.unaids.org/sites/default/files/media\\_asset/donoharm\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/donoharm_en.pdf) [25 May 2016]

<sup>7</sup> UN General Assembly, *On the fast track to ending the AIDS epidemic, Report of the Secretary-General*

<sup>8</sup> Ibid., *AIDS By The Numbers*

<sup>9</sup> Ibid., HIV Epidemic Indicators for Eastern and Southern Africa 2014

<sup>10</sup> For 2013

<sup>11</sup> For 2013

<sup>12</sup> For 2013

<sup>13</sup> Ibid., UNAIDS, *Global AIDS Update*, 2016

<sup>14</sup> UNAIDS, *HIV Epidemic Indicators for Eastern and Southern Africa 2014*, [http://www.unaidsrsts.org/wp-content/uploads/2015/06/unaids\\_profile\\_Regional.pdf](http://www.unaidsrsts.org/wp-content/uploads/2015/06/unaids_profile_Regional.pdf) [accessed 24 May 2016]

<sup>15</sup> Angola, Botswana, DRC, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe

<sup>16</sup> Information extracted from UNAIDS country pages: <http://www.unaids.org/en/regionscountries/countries>

<sup>17</sup> Angola, Botswana, Burundi, Cameroon, Chad, Cote d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Uganda, Tanzania, Zambia, Zimbabwe

<sup>18</sup> UNAIDS, *2015 Progress Report on the Global Plan towards the elimination of new HIV infections amongst children and keeping their mothers alive*, [http://www.unaids.org/sites/default/files/media\\_asset/JC2774\\_2015ProgressReport\\_GlobalPlan\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf) [accessed 24 May 2016]

<sup>19</sup> Ibid., *2015 Progress Report on the Global Plan towards the elimination of new HIV infections amongst children and keeping their mothers alive*

<sup>20</sup> UNAIDS, *Fast Track: Ending the AIDS Epidemic by 2030*, [http://www.unaids.org/sites/default/files/media\\_asset/JC2686\\_WAD2014report\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf) [accessed 24 May 2016]

<sup>21</sup> Ibid., *2015 Progress Report on the Global Plan towards the elimination of new HIV infections amongst children and keeping their mothers alive*

<sup>22</sup> Ibid., *HIV Epidemic Indicators for Eastern and Southern Africa 2014*

<sup>23</sup> Ibid., *2015 Progress Report on the Global Plan towards the elimination of new HIV infections amongst children and keeping their mothers alive*

<sup>24</sup> World Health Organisation, *Global Tuberculosis Report 2015*

<sup>25</sup> Ibid. World Health Organisation, *Global Tuberculosis Report 2015*

<sup>26</sup> Ibid., UNAIDS, *Global AIDS Update*, 2016

<sup>27</sup> Ibid., *HIV Epidemic Indicators for Eastern and Southern Africa 2014*

<sup>28</sup> Ibid., UNAIDS, *Global AIDS Update*, 2016

<sup>29</sup> UNAIDS, *Women and adolescent girls on the fast track to ending the AIDS epidemic*, 23 May 2016, [http://www.unaids.org/sites/default/files/media\\_asset/2016WHA\\_Side%20event\\_brochure\\_NumPrint.pdf](http://www.unaids.org/sites/default/files/media_asset/2016WHA_Side%20event_brochure_NumPrint.pdf) [accessed 25 May 2016]

<sup>30</sup> UNAIDS, *Women and adolescent girls on the fast track to ending AIDS*, 23 May 2016 [http://www.unaids.org/sites/default/files/media\\_asset/2016WHA\\_Side%20event\\_brochure\\_NumPrint.pdf](http://www.unaids.org/sites/default/files/media_asset/2016WHA_Side%20event_brochure_NumPrint.pdf) [accessed 26 May 2016]

<sup>31</sup> Ibid., *2015 Progress Report on the Global Plan towards the elimination of new HIV infections amongst children and keeping their mothers alive*

<sup>32</sup> Ibid., UNAIDS, *Global AIDS Update*, 2016

<sup>33</sup> Ibid., *HIV Epidemic Indicators for Eastern and Southern Africa 2014*

<sup>34</sup> UNAIDS, *Do No Harm*, 2016, [http://www.unaids.org/sites/default/files/media\\_asset/Do\\_no\\_harm\\_slides.pdf](http://www.unaids.org/sites/default/files/media_asset/Do_no_harm_slides.pdf) [25 May 2016]

<sup>35</sup> Ibid.

<sup>36</sup> Ibid., *Do No Harm*

<sup>37</sup> The Lancet, *Facts about sex workers and the myths that help spread HIV*, <http://www.thelancet.com/infographics/HIV-and-sex-workers> [accessed 26 May 2016]

<sup>38</sup> The Lancet, *Facts about sex workers and the myths that help spread HIV*, <http://www.thelancet.com/infographics/HIV-and-sex-workers> [accessed 26 May 2016]

<sup>39</sup> The Lancet, *Facts about sex workers and the myths that help spread HIV*, <http://www.thelancet.com/infographics/HIV-and-sex-workers> [accessed 26 May 2016]

<sup>40</sup> UNAIDS, *The Gap Report*, 2014, [http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS\\_Gap\\_report\\_en.pdf](http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf) [accessed 26 May 2016]

<sup>41</sup> WHO, *Technical brief: HIV and young men who have sex with men*, 2015 [http://apps.who.int/iris/bitstream/10665/179867/1/WHO\\_HIV\\_2015.8\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/179867/1/WHO_HIV_2015.8_eng.pdf)

<sup>42</sup> UNAIDS, *Time to Act: Save a million lives by 2015*, [http://www.unaids.org/sites/default/files/media\\_asset/20110606\\_TB\\_HIV\\_Brochure\\_Singles\\_1.pdf](http://www.unaids.org/sites/default/files/media_asset/20110606_TB_HIV_Brochure_Singles_1.pdf) [accessed 25 May 2016]

<sup>43</sup> World Health Organisation, *Global Tuberculosis Report 2015*, [http://www.who.int/tb/publications/global\\_report/gtbr2015\\_executive\\_summary.pdf?ua=1](http://www.who.int/tb/publications/global_report/gtbr2015_executive_summary.pdf?ua=1) [accessed 24 May 2016]

<sup>44</sup> ARASA, *Close the Gap: TB and Human Rights, a guide for activists in Southern and East Africa*, [https://www.health-e.org.za/wp-content/uploads/2015/12/Activist\\_guide\\_final\\_double\\_spread.pdf](https://www.health-e.org.za/wp-content/uploads/2015/12/Activist_guide_final_double_spread.pdf) [accessed 24 June 2016]

<sup>45</sup> UNAIDS, *Time to Act: Save a million lives by 2015*

<sup>46</sup> ARASA, *Close the Gap: TB and Human Rights*

<sup>47</sup> Ibid.

<sup>48</sup> Ibid.

<sup>49</sup> Ibid., *The Gap Report*

<sup>50</sup> Ibid., *Do No Harm*

<sup>51</sup> ARASA, *Close the Gap*

<sup>52</sup> ICASO, *Civil Societies and Communities Declaration to end HIV: Human Rights Must Come First*, June 2016, <http://www.icaso.org/announcements/civil-society-and-communities-declaration-to-end-hiv-human-rights-must-come-first> [accessed 18 June 2016]

<sup>53</sup> [http://www.arasa.info/files/6714/0498/7909/ARASA\\_report2014\\_web\\_full.pdf](http://www.arasa.info/files/6714/0498/7909/ARASA_report2014_web_full.pdf)

<sup>54</sup> UNAIDS, *Sustaining the Human Rights Response to HIV*, 2015, [http://www.unaids.org/sites/default/files/media\\_asset/JC2769\\_humanrights\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2769_humanrights_en.pdf) [26 May 2016]

<sup>55</sup> Ibid.

<sup>56</sup> Ibid.

<sup>57</sup> Ibid., *Sustaining the Human Rights Response to HIV*

<sup>58</sup> Ibid., *On the fast track to ending the AIDS epidemic, Report of the Secretary-General*

<sup>59</sup> See: The People Living With HIV Stigma Index, <http://www.stigmaindex.org/>

<sup>60</sup> UNAIDS, *Do No Harm*, 2016, [http://www.unaids.org/sites/default/files/media\\_asset/Do\\_no\\_harm\\_slides.pdf](http://www.unaids.org/sites/default/files/media_asset/Do_no_harm_slides.pdf) [25 May 2016]

<sup>61</sup> Ibid., *Do No Harm*

<sup>62</sup> Ibid., *Technical brief: HIV and young men who have sex with men*

<sup>63</sup> ARASA, *Close the Gap: TB and Human Rights*, [http://www.arasa.info/files/3914/4922/6648/Activist\\_guide\\_final\\_double\\_spread.pdf](http://www.arasa.info/files/3914/4922/6648/Activist_guide_final_double_spread.pdf) [26 May 2016]


<sup>64</sup> ARASA, *Close the Gap: TB and Human Rights*

<sup>65</sup> Ibid., *Do No Harm*

<sup>66</sup> Ibid.

<sup>67</sup> UNAIDS, *HIV Treatment in Africa, a looming crisis*, 2015 [http://www.unaids.org/sites/default/files/media\\_asset/HIVtreatmentinAfrica\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/HIVtreatmentinAfrica_en.pdf) [accessed 26 May 2016]





## SECTION 3

# DEVELOPING LEGAL FRAMEWORKS TO PROTECT HUMAN RIGHTS IN THE CONTEXT OF HIV



3.1 INTRODUCTION

The 2014 ARASA HIV and Human Rights report found that some progress had been made in improving protective legal frameworks for people living with HIV, but expressed concerns that little progress had been made in developing laws that recognised the human rights of key populations, advanced their rights to access HIV prevention, treatment, care and support and protected them from violence, stigma and discrimination.

While there has been significant progress in recognising key populations, in particular gay men who have sex with men and sex workers, in national HIV responses, this progress has not been matched by protective laws and the high rates of HIV infection amongst these groups is a testament to the detrimental effects of criminalising consensual adult sex:



Almost every country under review for this report has identified gay men who have sex with men as a key population in their HIV programming. The majority are providing HIV prevention information and education to them. However, only Madagascar, Mozambique, Seychelles and South Africa do not criminalise sex between men. The DRC does not explicitly criminalise sex between men but uses indecency laws to prosecute them. Malawi recently announced a moratorium on prosecution of same-sex sexual practices while it reviews its laws in this regard. In the remaining countries under review, sex between men is illegal and gay men and men who have sex with men are subject to violence, discrimination and stigma, often at the hands of their own governments. The law not only criminalises their most intimate acts, but drives them away from needed health care and HIV prevention services and undermines their access to justice when they are abused and beaten. These laws are often enforced based on perceived sexual orientation and practices, resulting in transgender women being arrested and/or prosecuted for essentially heterosexual relationships.



Sex work is directly or indirectly criminalised in every country reviewed in this report, but every country has also recognised sex workers as a key population. Sex workers too describe grave violations of their human rights that expose them to HIV and undermine their access to sexual and reproductive health care. Sex workers are particularly vulnerable to abuse by law enforcement and have little or no redress when their rights are violated.



People who use drugs are also beginning to be recognised as a key population, but in every country under review, drug possession for personal use is criminalised and laws make it difficult to provide harm reduction and link people who use drugs to HIV prevention, treatment and care.

3.2 CRIMINALISATION OF HIV-RELATED CONDUCT



Criminalisation of HIV transmission, exposure and/or non-disclosure was identified as a key issue in the first ARASA human rights review ten years ago, with a large number of countries in SEA either having introduced specific legislation to criminalise HIV transmission, exposure and/or non-disclosure or indicating that existing legal provisions could be used to criminalise transmission and/or exposure.

In 2016, Africa leads the world with the most countries that have broad and/or vaguely worded laws criminalising various aspects of HIV transmission, although it is not the continent with the most HIV-related convictions. The Global Commission on HIV and the Law (GCHL) confirms with broadly worded statutes 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 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.<sup>68</sup>

**The Global Commission on HIV and the Law (GCHL) confirms with broadly worded statutes 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.”**

It also raised grave concerns about how continued criminalisation would reinforce stigma and undermine universal access to prevention, treatment, care and support. UNAIDS Guidance on ending overly broad criminalisation of HIV non-disclosure, exposure and transmission reiterates that there is no evidence that criminalising HIV non-disclosure, exposure or transmission is effective in addressing HIV and AIDS. 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.

It sets out key principles that should guide the use of the criminal law in dealing with harmful HIV-related behaviour and recommends that the use of criminal law in relation to HIV be guided by the best available scientific and medical evidence relating to HIV; uphold the principles of legal and judicial fairness (including key criminal law principles of legality, foreseeability, intent, causality, proportionality and proof) and protect the human rights of those involved in criminal law cases.<sup>69</sup>

Of the 27 countries in sub-Saharan Africa that have adopted HIV-specific laws, only 2 countries (Mauritius and Comoros) have not included a provision that criminalises HIV transmission. In addition, there are other countries (e.g. Zimbabwe) that criminalise transmission outside of HIV-specific laws – e.g. they have public health or penal code provisions criminalising HIV transmission, exposure and/or non-disclosure.

**Of the 27 countries in sub-Saharan Africa that have adopted HIV-specific laws, only 2 countries (Mauritius and Comoros) have not included a provision that criminalises HIV transmission.**

A recent review of HIV-specific laws in sub-Saharan Africa in terms of the UNAIDS guidance found that, of the countries covered in this review:

- Three countries (DRC, Madagascar and Tanzania) restrict criminalisation to cases involving actual transmission of HIV
- Two countries (Angola and Kenya) criminalise HIV non-disclosure
- Two countries (Kenya and Uganda) criminalise HIV exposure where transmission did not in fact take place
- Three countries (Angola, Kenya and Madagascar) allow for criminal liability on the basis of negligence or recklessness
- In six countries (Angola, DRC, Kenya, Madagascar, Tanzania and Uganda), the provisions could apply to vertical transmission of HIV from mother to child
- No countries exclude criminal liability in cases involving condom use
- No countries have provisions excluding criminal liability when a person has a low viral load or is on effective treatment
- One country (Kenya) allows for criminal liability only for people who are aware of their HIV status, and
- One country (Kenya) recognizes disclosure as a defence against criminal liability.<sup>70</sup>

Many of these provisions do not meet the standards set out in the UNAIDS guidance. Where countries allow for prosecution without an intention to transmit HIV or where in fact HIV has not been transmitted (in instances of non-disclosure or exposure), there are serious concerns about the fair application of the criminal law. Of particular concern is the failure to recognise protected sex or disclosure of HIV status as a defence to prosecution, since this is contrary to prevention messages for HIV. The fact that many provisions are so broad that they could be interpreted to prosecute mothers for transmitting HIV to their children may impact on women’s access to HIV services.

“Many ignore basic criminal law principles of legality, foreseeability, intent, causality, proportionality and proof that should serve as the basis for the definition of offences and the imposition of penalties. These criminal law provisions allow for the prosecution for acts that constitute no or very little risk of HIV infection; they fail to recognise condom use, low viral load and effective HIV treatment; and allow for the criminalisation of people who have taken steps to inform their sexual partners and obtain their consent prior to sex. Laws that allow for such use of the criminal law are overly broad, violate criminal law principles, trump human rights and are unfair. These provisions are often based on myths and misconceptions about HIV and its modes of transmission, and they risk undermining effective public health efforts that are based on the use of condoms and on encouraging disclosure. At a time when efforts are being made to end the AIDS epidemic in Africa and to globally focus on expanding access to HIV testing, these overly-broad criminal law provisions are likely to be counterproductive. The provisions will discourage people from coming forward for HIV testing and will negatively impact the patient-doctor relationship.”<sup>71</sup>

In addition to criminalisation provisions, six countries, Botswana, DRC, Lesotho, Namibia, South Africa and Zimbabwe, have laws requiring courts to impose harsher sentences on rapists living with HIV, while Botswana, Lesotho, Kenya and Uganda have laws providing for compulsory HIV testing of all sex offenders. Legislation in Angola, Mozambique, South Africa and Tanzania give the courts authority to order HIV testing in certain circumstances, including of alleged sex offenders.



**Very few laws have been repealed since 2009, as first recommended in the 2009 ARASA HIV and Human Rights report, but there have been some positive signs of reviewing criminalisation provisions in the DRC, Malawi and Mozambique.**



Very few laws have been repealed since 2009, as first recommended in the 2009 ARASA HIV and Human Rights report, but there have been some positive signs of reviewing criminalisation provisions in the DRC, Malawi and Mozambique. The current version of the Malawi draft HIV law no longer contains provisions on criminalisation.<sup>72</sup> The Mozambique HIV law 12/2009 was reviewed in 2013 and the criminalisation provision was removed. The DRC HIV Law 08/011 is due to come before Parliament, with a proposed repeal of criminalisation provisions.

In November 2015, the SADC Parliamentary Forum (SADC PF) unanimously adopted a motion on Criminalisation of HIV Transmission, Exposure and Non-Disclosure. The motion expresses concerns that specific laws criminalising HIV transmission, exposure and non-disclosure are harmful to successful HIV prevention and care and may infringe on human rights.

**SADC PF MOTION: HIV CRIMINALISATION**

- SADC Member States have an obligation to respect, protect, fulfil and promote human rights in all efforts to prevent and treat HIV;
- Parliamentarians have a critical role to play in enacting laws that support evidence- based HIV prevention and treatment interventions that conform with regional and international human rights frameworks;
- SADC Member States should consider rescinding and reviewing punitive laws specific to the prosecution of HIV transmission, exposure and non-disclosure.

However, alongside these positive developments, Botswana adopted a new Public Health Act in 2013 that contains “vague and overly broad”<sup>73</sup> provisions allowing for coercive public health responses, including isolation and detention, for HIV exposure. The Act also allows for forced HIV testing, mandatory disclosure of HIV status and limitations on the freedom of movement of people living with HIV.<sup>74</sup> The Uganda HIV and AIDS Prevention and Control Act was passed in 2014 and contains provisions criminalising HIV transmission and exposure. It also contains other problematic provisions such as mandatory HIV testing of pregnant women and their partners, victims of sexual offences and people convicted of a sexual offence, drug use and sex work; and the disclosure of HIV status without consent by medical practitioners.<sup>75</sup>

In Namibia, section 37 of the Public and Environmental Health Act, promulgated in May 2015 and which has yet to enter into force, has the potential to create an overly broad and vague criminal offence of HIV transmission, exposure and non-disclosure. This section provides that “A person who, knowing that he or she is infected with a sexually transmitted infection - (a) wilfully or negligently infects another person; or (b) wilfully or negligently permits or acts in a way likely to lead to the infection of another person”, commits an offence and is liable to a fine or to imprisonment. The Minister of Health has the discretion in terms of the Act to exclude HIV from the definition of sexually transmitted infections (STIs) but if this is not done, this section may be used to prosecute HIV transmission, exposure and non-disclosure.

**RECOMMENDATIONS**

**Civil society should:**

- Advocate for the removal of all HIV-specific laws that criminalize HIV transmission, exposure and non-disclosure.
- Provide legal advice and assistance to individuals who are prosecuted for HIV transmission, exposure and non-disclosure.
- Support and engage in strategic litigation to challenge overly broad, vague and inappropriate legislation.
- Strengthen the capacity of lawyers to undertake both criminal defence of people and strategic litigation.
- Work with parliamentarians to increase their understanding about the negative impact of HIV criminalisation on universal access to HIV prevention, treatment, care and support services.
- Work with public health specialists to ensure that the best available scientific evidence is accessible to criminal justice officials.

**Governments should:**

- Refrain from enacting new HIV-specific laws that criminalise HIV transmission and exposure and repeal any such laws currently in place.
- Use existing criminal laws to prosecute people in those exceptional cases where individuals intentionally transmit HIV to others with the express purpose of causing harm.
- Develop guidelines to support law enforcement agents, prosecutors and the judiciary to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered.

**3.3 SEXUAL ORIENTATION AND GENDER IDENTITY**



The 2009 and 2014 ARASA HIV and Human Rights reports found that nearly two-thirds of the 14 SADC countries then surveyed had laws that criminalised consensual sex between men and some criminalised consensual sex between women. This report demonstrates some positive change, although the majority of countries under review still have legislative measure that criminalises same sex sexual conduct for men and women and many governments promote homophobia and discrimination against people on the grounds of sexual orientation and gender identity.

**The 2009 and 2014 ARASA HIV and Human Rights reports found that nearly two-thirds of the 14 SADC countries then surveyed had laws that criminalised consensual sex between men and some criminalised consensual sex between women.**

The only countries that did not criminalise all same sex conduct in ARASA partner countries in 2009 were the DRC, Madagascar and South Africa. Men in the DRC may however be prosecuted under indecency laws, but so far, efforts to introduce legislation to criminalise same sex sexual conduct have been unsuccessful.<sup>76</sup> Very few countries have any laws that protect people from discrimination based on sexual orientation and gender identity.

In two significant developments, the new Penal Code in Mozambique (Law 35/2014) decriminalised sex between men by repealing the old Penal Code and in May 2016, Seychelles also repealed provisions that criminalised sex between men. There is also an indication that Malawi may move to decriminalise sex between men: in mid-2014 the Solicitor General of Malawi announced that the Law Commission was reviewing the constitutionality of Malawian anti-homosexuality laws. In 2015, the Minister of Justice confirmed the laws would not be enforced until the completion of the review.

In addition to the progress in Mozambique and Seychelles, there were other developments which may indicate a more positive trend.

Small steps: progress on LGBTI rights in Africa

- In May 2014, the African Commission on Human and People’s Rights adopted a landmark resolution on ending violence and other human rights violations against people on the basis of their sexual orientation or perceived orientation and gender identity. The resolution specifically condemned attacks by states that targeted people on the basis of their sexual orientation or gender identity.<sup>77</sup>
- The first openly gay association was formed in Angola in 2014.
- The Botswana Court of Appeal upheld a November 2014 ruling of the High Court that government refusal to register LEGABIBO (an LGBTI organization) was unconstitutional and ordered the Registrar of Societies to register LEGABIBO.<sup>78</sup>
- In April 2015, the Kenya High Court ruled the National Gay and Lesbian Human Rights Commission could register after the NGO Co-ordination Board rejected its application in 2013.<sup>79</sup>
- The African Commission on Human and People’s Rights, the Inter-American Commission on Human Rights and UN human rights mechanism held a joint dialogue on 3 November 2015 to discuss human rights violations against LGBTI people.<sup>80</sup>
- On 30 June 2016, the UN Human Rights Council adopted a third resolution on sexual orientation and gender identity. The resolution provides for the appointment of an independent expert on violence and discrimination based on sexual orientation and gender identity. The DRC and Kenya voted against the resolution and Botswana, Namibia and South Africa abstained from the vote.

It is too early to conclude whether these developments are indicative of a trend where more ARASA partner countries will begin to review or repeal anti-homosexuality laws.

Table 4: Criminalisation of men who have sex with men and supportive laws

COUNTRIES	CRIMINALISE SAME SEX CONDUCT BETWEEN MEN	LAWS PROMOTING PROHIBITING DISCRIMINATION
Angola	Yes	No
Botswana	Yes	Yes
Comoros	Yes	No
DRC	Can prosecute on the basis of indecent assault	No
Kenya	Yes	No
Lesotho	Yes	No
Madagascar	No	No
Malawi	Laws currently not being enforced pending review	No
Mauritius	Yes	No
Mozambique	No	Yes
Namibia	Yes	No
Seychelles	No	Yes
South Africa	No	Yes
Swaziland	Yes	No
Tanzania	Yes	No
Uganda	Yes	No
Zambia	Yes	No
Zimbabwe	Yes	No

The country snapshots show how homophobia, including by governments, violence and discrimination continue to shape the experiences of LGBTI people in ARASA partner countries, increasing their vulnerability to HIV and pushing them away from health and justice services.

Gay men are particularly vulnerable to violence and discrimination: in Angola, 25% of men who had sex with men in a Luanda study reported being physically coerced into sex and also experiencing other abuses.<sup>81</sup> A 2014 report by Human Rights Watch showed that LGBTI people engaged in sex work in Kenya were particularly vulnerable to sexual violence at the hands of law enforcement officials and others.<sup>82</sup> Gay men in Tanzania, Uganda and Mozambique report discrimination in access to health services, employment, housing and other services. The Centre for Human Rights and Rehabilitation (CHRR) and the Centre for Development of People (CEDEP) in Malawi documented 40 cases of abuses on the grounds of sexual orientation and gender identity, including stigma, harassment and violence.<sup>83</sup> In November 2015, the Justice and Legal Affairs Committee of the Kenyan Parliament rejected an attempt by the Republican Liberty Party to introduce a law prescribing stoning as a punishment for homosexuality.<sup>84</sup>

LGBTI people continue to be threatened with arrest and prosecution because of the criminalisation of various aspects of their relationships: information presented to the Kenyan National Assembly in 2014 showed that the police opened 595 cases of unnatural offences since 2010 and the LGBTI groups stated there have been 8 prosecutions of gay men between 2012 and 2014.<sup>85</sup> Despite the moratorium on enforcing anti-homosexuality laws in Malawi (see below), police arrested and charged two men in December 2014 and forced them to undergo medical examinations before releasing them on bail.<sup>86</sup>

It is also difficult for groups and organisations advocating for the rights of LGBTI people, including for access to HIV testing and treatment, to operate freely in several ARASA partner countries. In Kenya, Mozambique and Botswana, for example, LGBTI groups have had to challenge refusals to register their organisations in court.

Gay men are particularly vulnerable to violence and discrimination: in Angola, 25% of men who had sex with men in a Luanda study reported being physically coerced into sex and also experiencing other abuses

The 2014 ARASA HIV and Human Rights Report noted that some progress had been made identifying gay men and men who have sex with men as a key population in need of HIV-related services and support. This trend has continued and most governments are now attempting to collect more and improved data on HIV prevalence amongst gay men and men who have sex with men, include them in programming and provide them with more tailored information about HIV prevention. Of concern however is the continued failure of some countries to recognise and evaluate the impact of laws that criminalise or discriminate on the basis of sexual orientation and gender identity on an effective HIV response. Despite laws that criminalise sex between men, Kenya, Botswana, Tanzania, Zambia and Zimbabwe reported that there were no laws impacting on effective HIV prevention, treatment, care and support.<sup>87</sup>

LGBTI people continue to be threatened with arrest and prosecution because of the criminalisation of various aspects of their relationships

Table 5: Gay men who have sex with men and transgender people in the HIV response <sup>88</sup>

COUNTRIES	GAY MEN WHO HAVE SEX WITH MEN IDENTIFIED AS A KEY POPULATION FOR HIV PROGRAMMING	TRANSGENDER PEOPLE IDENTIFIED AS A KEY POPULATION FOR HIV PROGRAMMING	PREVENTION INFORMATION AND EDUCATION FOR GAY MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE	LAWS THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT TO GAY MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE
Angola (2012)	Yes	No	MSM – yes Transgender people – no	Information not provided
Botswana (2013)	Yes	Yes	MSM – yes Transgender people – no	Yes
Comoros (2014)	Yes	No	MSM – yes Transgender people – no	No
DRC (2014)	Yes	No	MSM – yes Transgender people – no	No
Kenya (2014)	Yes	No	MSM – yes Transgender people – no	No
Lesotho (2014)	Yes	Yes	MSM – yes Transgender people – no	Yes
Madagascar (2014)	Yes	No	MSM – yes Transgender people – no	No
Malawi (2014)	Yes	No	MSM – yes Transgender people – no	Yes
Mauritius (2012)	Yes	No	MSM – yes Transgender people – no	Yes
Mozambique (2012)	Yes	No	MSM – yes Transgender people – no	No
Namibia (2012)	Yes	No	MSM – yes Transgender people – no	No
Seychelles (2014)	Yes	No	MSM – yes Transgender people – no	Yes
South Africa (2012)	Yes	Yes	MSM – yes Transgender people – no	Yes
Swaziland (2014)	No	No	MSM – yes Transgender people – no	No
Tanzania (2014)	Yes	Yes	MSM – yes Transgender people – no	Yes
Uganda (2014)	Yes	No	MSM – yes Transgender people – no	No
Zambia (2014)	Yes	No	MSM – yes Transgender people – no	Yes
Zimbabwe (2014)	Yes	No	MSM – yes Transgender people – yes	Yes

Transgender people remain a neglected and often invisible population in the epidemic. Transgender women are disproportionately affected: a 2016 UN publication stated that they have “borne the epidemiological brunt of HIV disease.” <sup>89</sup> There is very little data on HIV infection amongst transgender women, and none regarding transgender men, but where it is available, it shows “disturbing levels” of HIV .<sup>90</sup> As the table above indicates, only Botswana, Lesotho, South Africa and Tanzania have identified transgender people as a key population and none are currently providing any prevention information and education for them.

Currently, South Africa remains the only country that provides for legal recognition of gender identity through the Alteration of Sex Descriptions Act 49 of 2003; no other country has specific legislation, however the Supreme Court in Kenya ruled in favour of a transgender woman, allowing her to change her name on her high school certificate and remove her gender marker. <sup>91</sup> On the opposite side of the equation, the new Marriages, Divorce and Family Relations Bill, 2015 in Malawi defines “sex” to be legally defined as one’s “sex assigned at birth”, essentially refusing any recognition of gender identity. <sup>92</sup>

RECOMMENDATIONS

Civil society should:

- Advocate for repeal of all laws that criminalise consensual adult same sex sexual conduct
- Advocate for the expansion of HIV programming that is acceptable and accessible to gay men and men who have sex with men, lesbians, transgender and intersex people and for the inclusion of gay men and men who have sex with men, lesbians, transgender and intersex people in the design, implementation and evaluation of such programming
- Advocate for the collection of adequate data on HIV prevalence amongst gay men and other men who have sex with men, lesbians, transgender and intersex people and factors that drive vulnerability to HIV
- Train health care providers on the human rights of LGBTI people, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly
- Work in partnership with LGBTI activists and organisations to design and implement advocacy strategies to promote the human rights of LGBTI people

Governments should:

- Immediately repeal all laws that criminalise consensual adult same sex sexual conduct
- Enact laws that explicitly protect people from violence and discrimination on the basis of sexual orientation and gender identity
- Expand HIV programming that is acceptable and accessible to gay men and other men who have sex with men, lesbians, transgender and intersex people and for the inclusion of gay men and other men who have sex with men, lesbians, transgender and intersex people in the design, implementation and evaluation of such programming
- Ensure the collection of adequate data on HIV prevalence amongst gay men and other men who have sex with men, lesbians, transgender and intersex people and factors that drive vulnerability to HIV
- Refrain from state sponsored or supported homophobia
- Provide legal recognition of gender identity, and allow for a process to change or eliminate a person’s gender markers from identity documents, certificates, etc. as well as provide for processes to change one’s name in accordance with one’s gender identity.

3.4 Sex Workers



Sex workers were identified as a key population in the first ARASA HIV & Human Rights Report ten years ago and continue to be prioritised as a key population at higher risk of HIV exposure. Globally, HIV prevalence amongst sex workers is estimated to be 12 times higher than amongst the general population and a recent analysis in sub-Saharan Africa found pooled HIV prevalence at 36.9% among female sex workers.<sup>93</sup>

Male, female and transgender sex workers face exceptionally high levels of stigma, discrimination, violence, extortion, sexual abuse and rape in SEA from clients, intimate partners and law enforcement officials, which increases their vulnerability and marginalisation and places them at increased risk of HIV. <sup>94</sup>

Transgender people remain a neglected and often invisible population in the epidemic. Transgender women are disproportionately affected: a 2016 UN publication stated that they have “borne the epidemiological brunt of HIV disease.”



**Male, female and transgender sex workers face exceptionally high levels of stigma, discrimination, violence, extortion, sexual abuse and rape in SEA from clients, intimate partners and law enforcement officials, which increases their vulnerability and marginalisation and places them at increased risk of HIV. <sup>94</sup>**

Sex workers also report stigmatising attitudes and high levels of discrimination in access to health care services, impacting on their willingness to access health care. In Malawi for example, a 2015 report by the Sexual Rights Initiative to the UN Human Rights Committee states that health care workers shout at sex workers in the presence of other patients, disclose their health conditions to third parties without their consent and publicly humiliate them. Sex workers from Kenya, South Africa, Uganda and Zimbabwe also reported how high levels of stigma dissuaded them from disclosing their occupation to health workers, limiting their access to effective services, and impacted on their willingness to test for HIV. <sup>95</sup>

In some countries, the possession of condoms is used as evidence of sex work by law enforcement officials, leading to arrest. <sup>96</sup> Criminalisation exacerbates stigma, discrimination and disempowerment of sex workers. Where sex work or aspects of sex work is criminalised, as is the case in all the countries under review, the high levels of stigma, discrimination and violence often go unreported and unmonitored. <sup>97</sup>

**In some countries, the possession of condoms is used as evidence of sex work by law enforcement officials, leading to arrest. Criminalisation exacerbates stigma, discrimination and disempowerment of sex workers marginalisation and places them at increased risk of HIV.**

There has been some scale up of programming for sex workers in countries in SEA. In October 2014, the Lesotho Planned Parenthood Association implemented a mobile clinic project for sex workers in various districts in Lesotho. These clinics provide HIV testing and counselling, family planning services, treatment of STIs, antenatal care and PMTCT services for pregnant women with HIV, ARV treatment, cancer screening and condom distribution. <sup>98</sup> South Africa has recently introduced a new plan to respond to HIV amongst sex workers.

**South Africa’s new strategy on sex work and HIV**

In March 2016, South Africa launched a National Sex Worker HIV Plan, 2016 – 2019. <sup>99</sup> The plan aims to provide equal access to health and legal services to sex workers, recognizing their disproportionate vulnerability to HIV, STIs, violence, TB and stigma and discrimination. The plan will include targeted services for sex workers, their clients, partners and families.

The plan will provide access to ART for all sex workers living with HIV and offer pre-exposure prophylaxis (PrEP) to sex workers who do not have HIV. The plan also emphasizes the need to include access to justice and protection services for sex workers, train health care workers and support service delivery to sex workers in various settings. <sup>100</sup>

However, many programmes are reported to be limited in scale, scope and coverage, while programmes for transgender and male sex workers are extremely limited. <sup>101</sup>

There has also been a significant increase in information provided by countries reporting to UNAIDS on sex workers and HIV amongst countries in SEA, with more data available in country progress reports than in previous years.

**Table 6: Sex work in SEA <sup>102</sup>**

COUNTRIES	HIV PREVALENCE (%) SEX WORKERS	CRIMINALISATION OF SEX WORK / ASPECTS OF SEX WORK	SEX WORKERS IDENTIFIED AS KEY POPULATION IN HIV PROGRAMMING	PREVENTION INFORMATION AND EDUCATION FOR SEX WORKERS
Angola	7.2% (2014)	Yes	Yes	Yes
Botswana	61.9% (2012)	Yes	Yes	Yes
Comoros	No data	Yes	Yes	No
DRC	6.9% (2014)	Yes	Yes	Yes
Kenya	29.3% (2010)	Yes	Yes	Yes
Lesotho	72%	Yes	Yes	Yes
Madagascar	1.3% (2012)	Yes	Yes	Yes
Malawi	29.9% (2014)	Yes	Yes	Yes
Mauritius	22.3% (2012)	Yes	Yes	Yes
Mozambique	30% (2013)	Yes	Yes	Yes
Namibia	20% (2015)	Yes	Yes	Yes
Seychelles	6% (2015)	Yes	Yes	Yes
South Africa	72% (2016)	Yes	Yes	Yes
Swaziland	70.3% (2011)	Yes	Yes	Yes
Tanzania	31.4% (2014)	Yes	Yes	Yes
Uganda	37% (2014)	Yes	Yes	Yes
Zambia	No data	Yes	Yes	Yes
Zimbabwe	58% (2015)	Yes	Yes	Yes

**RECOMMENDATIONS**

**Civil society should:**

- Advocate for the decriminalisation of adult consensual sex work, including the buying and selling of sex
- Provide access to legal services for sex workers whose rights have been violated to assist them to obtain access to justice
- Advocate for the expansion of HIV programming that is acceptable and accessible to sex workers and for the inclusion of sex workers in the design, implementation and evaluation of such programming
- Advocate for health services, including reproductive health care, to be available, accessible and acceptable to sex workers
- Train health care providers on the human rights of sex workers, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly
- Work in partnership with sex workers and sex worker-led organisations to design and implement advocacy strategies to promote the human rights of sex workers
- Train law enforcement officials to recognise and uphold the human rights of sex workers
- Advocate to hold law enforcement officials accountable if they violate the rights of sex workers

**Governments should:**

- Repeal all laws that criminalise consensual adult sex work, including the buying and selling of sex
- Expand HIV programming that is acceptable and accessible to sex workers and ensure the inclusion of sex workers in the design, implementation and evaluation of such programming

3.5 GENDER INEQUALITIES AND GBV: HIV, WOMEN AND GIRLS

“Everywhere, women and girls face discrimination and violence and, in some countries, harmful practices such as early and forced marriage and female genital mutilation.” <sup>103</sup>



In 2015, the year that marked the 20th anniversary of the landmark Beijing Declaration and Platform of Action, governments acknowledged that no country has yet achieved full equality for women and girls. At the UN Commission on the Status of Women in 2016, member states pledged to work towards full equality and empowerment of women and girls by 2030.

Women and girls remain disproportionately affected and infected by HIV and in sub-Saharan Africa they make up the majority of those who are infected.

VIOLENCE AGAINST WOMEN AND GIRLS

The global statistics in the 2014 ARASA HIV and Human Rights Report remain unchanged and violence against women and girls continues to be unacceptably pervasive. Over one third of women globally have experienced physical and/or sexual violence perpetrated by an intimate partner or a stranger. Women in domestic violent relationships are 1.5 times more likely to acquire HIV than women who have not experienced violence at the hands of an intimate partner. <sup>104</sup>

Where statistics are available, ARASA partner countries report high levels of violence against women: 23% of women in Angola experience physical or sexual violence; <sup>105</sup> Botswana indicates that around a third of women experience intimate partner violence and over two thirds of women have experienced some form of gender based violence (GBV) in their lifetime. <sup>106</sup> The Mozambique Demographic and Health Survey (DHS) shows that one-third of women experienced violence at some point since the age of 15 and 12% of women reported forced sex during their lifetime; <sup>107</sup> estimates from the Seychelles show levels as high as 50% of ever-married or partnered women aged 15–49 who have experienced physical or sexual violence from a male intimate partner in a 12 month period. In Tanzania, 45% of women experience physical or sexual violence during their lifetime <sup>108</sup> and in Uganda, 27% of women and girls between the ages of 15 and 49 had experienced domestic violence in the year prior to the survey and 56% of married women reported experiencing domestic violence during their marriage.

South Africa has the highest levels of violence against women amongst ARASA partner countries. The 2015 (SADC) Gender Protocol Gender Barometer found that as many as 77% of women in the Limpopo Province experienced GBV. <sup>109</sup> The South African Police Services reported there were 46 253 reported rapes in 2013/14. <sup>110</sup> The Medical Research Council has however estimated that only one in nine rapes are reported to the police.

Most of the ARASA partner countries now have legislation to protect women and girls from domestic and sexual violence. In 2014, Comoros adopted a new law to strengthen protections against and punishment for GBV, including criminalising marital rape. <sup>111</sup> The Protection against Domestic Violence Act in Kenya came into force in June 2015. <sup>112</sup>

Only Tanzania and the DRC do not have specific laws on domestic violence, while Lesotho and Swaziland have yet to finalise and enact pending legislation.

While all ARASA partner countries have laws that criminalise various forms of sexual violence, the criminalisation of marital rape is still a concern, with only Angola, Comoros, Lesotho, Mozambique, Namibia, South Africa, Uganda and Zimbabwe explicitly criminalising sexual violence in marriage.

Table 7: Laws on violence against women

COUNTRY	DOMESTIC VIOLENCE LAW	MARITAL RAPE CRIMINALISED	SEXUAL OFFENCES LAW
Angola	Law Against Domestic Violence, 2011	Yes	Yes
Botswana	Domestic Violence Act 2008	Not explicitly criminalised	Yes
Comoros	New law in 2014 strengthens protection for women against gender based violence	Yes	Yes
DRC	No	Not explicitly criminalised	Yes
Kenya	Yes	Not clear – the penal code contains a marital rape exception, but the domestic violence law makes provision for “violence in marriage” to be prosecuted.	Yes
Lesotho	Bill is still pending	Yes	Yes
Madagascar	No, but there are protective provisions in the penal code against physical abuse	Not explicitly criminalised	Yes

COUNTRY	DOMESTIC VIOLENCE LAW	MARITAL RAPE CRIMINALISED	SEXUAL OFFENCES LAW
Malawi	Prevention of Domestic Violence Act 2005	Not explicitly criminalised	Yes
Mauritius	Domestic Violence Act 1997	Not explicitly criminalised but pending legislation will do so when enacted	Yes
Mozambique	Law on Domestic Violence	Yes	Yes
Namibia	Combating of Domestic Violence Act 2003	Yes	Yes
Seychelles	Family Violence Act 2000	Yes	Yes

IMPLEMENTATION CHALLENGES

In many of the ARASA partner countries, strong legal frameworks are failing to deliver protection from GBV and access to justice and services for survivors. Challenges to implementation include a failure to finalise by-laws or regulations for the implementation of existing laws, as is the case with Angola <sup>113</sup> and limited capacity to investigate and prosecute perpetrators of violence against women. In Malawi, Victim Support Units have strengthened access to justice for some complainants, but others report the need for better training for staff in these units, including on human rights. Women in Namibia experience difficulties obtaining protection orders and there is limited capacity to prosecute rape, with many cases heard by traditional courts and authorities rather than criminal courts. <sup>114</sup> A 2014 study in Kenya estimates only 40% of rape cases are reported to the police and the rate of prosecution is low. Police also often fail to investigate domestic violence cases, regarding them as private matters. <sup>115</sup>

In addition to problems with investigation and prosecutions, victims also face barriers to accessing much needed services in the aftermath of rape and GBV: there is only one government funded shelter for victims of domestic violence in the capital of Lesotho, but the majority of victims are not aware of its existence. <sup>116</sup> There are too few shelters in the Comoros to accommodate the numbers of women who need protection. In Malawi, PEP is not easily accessible to rape survivors.

In many of the ARASA partner countries, strong legal frameworks are failing to deliver protection from gender based violence and access to justice and services for survivors.

ADOLESCENT GIRLS, HIV, CHILD AND EARLY MARRIAGE <sup>117</sup>

Despite impressive gains in reducing new infections amongst children, African girls and particularly adolescents, remain at extremely high risk of HIV. In 2014, 62% of new HIV infections amongst adolescents globally were amongst girls; in sub-Saharan Africa, this number jumps to 72%. Fewer than 20% know their HIV status.

In 2014, 62% of new HIV infections amongst adolescents globally are girls; in sub-Saharan Africa, this number jumps to 72%. Fewer than 20% know their HIV status.



In the ARASA partner countries where data is available, adolescent girls have consistently higher HIV prevalence and more girls are being newly infected, than boys. The disparities are particularly stark in some Southern African countries, where HIV prevalence amongst young women is nearly double that of young men: 6.1% of girls in Angola are infected, against 3.5% of boys; in Lesotho, the numbers are 10.5% and 5.8% respectively; 6.1% and 2.7% in Mozambique; in South Africa, 13.1% of young women are living with HIV and 4% of young men and in Swaziland, it is 12.4% and 7.1%.

Table 8: Women and girls living with HIV <sup>118</sup>

COUNTRY	YOUNG WOMEN (15 – 24) PREVALENCE	YOUNG MEN (15 – 24) PREVALENCE	NEW HIV INFECTIONS AMONGST YOUNG WOMEN	NEW HIV INFECTIONS AMONGST YOUNG MEN
Angola	1.2%	0.6%	5 500	3 000
Botswana	6.1%	3.5%	1 900	1 100
Comoros	Not available	Not available	Not available	Not available
DRC	Not available	Not available	Not available	Not available
Kenya	2.8%	1.7%	19 000	10 000
Lesotho	10.5%	5.8%	5 700	3 400
Madagascar	0.2%	0.2%	Not available	Not available
Malawi	3.8%	2.4%	6 700	4 000
Mauritius	0.2%	0.2%	Not available	Not available
Mozambique	6.1%	2.7%	25 000	15 000
Namibia	4.8%	2.7%	2 500	1 400
Seychelles	Not available	Not available	Not available	Not available
South Africa	13.1%	4%	90 000	36 000
Swaziland	12.4%	7.1%	2 700	1 700
Tanzania	2.2%	1.4%	12 000	6 800
Uganda	4.2%	2.4%	29 000	17 000
Zambia	4.5%	3.4%	8 700	7 000
Zimbabwe	6.6%	4.1%	15 000	8 700

Child marriage plays a critical role in driving HIV infections amongst girls in sub-Saharan Africa where 40% of girls are married before they reach 18. <sup>119</sup> Madagascar, Malawi, Mozambique and Zambia are amongst the 20 most affected countries for child marriage globally. Child marriage increases vulnerability to HIV by limiting girls’ access to education and increasing their risk of domestic violence. Girls often cannot negotiate when or how they have sex. <sup>120</sup> They also struggle to access information about sexuality and many child brides have no access to information about how to protect themselves from HIV. Their ability to access reproductive health care is limited.

Table 9: Child marriage in ARASA partner countries

COUNTRY	MARRIED BY 15 (%)	MARRIED BY 18 (%)	INDEPENDENT MINIMUM MARRIAGE AGE
Angola	Not available	Not available	18
Botswana	Not available	Not available	21
Comoros	10%	32%	18
DRC	9%	39%	18 for men and 15 for women
Kenya	6%	26%	18 for men and women
Lesotho	2%	19%	21
Madagascar	12%	41%	18 for boys and girls
Malawi	12%	50%	Girls and boys may marry at 15 with parental consent . New Marriage Bill will set the age at 18 for both, but will require a constitutional amendment to enforce
Mauritius	Not available	Not available	18
Mozambique	14%	48%	18, but 16 with parental consent
Namibia	2%	9%	18, but 16 with parental consent
Seychelles	Not available	Not available	18
South Africa	1%	6%	18
Swaziland	1%	7%	16 for girls; 18 for boys

COUNTRY	MARRIED BY 15 (%)	MARRIED BY 18 (%)	INDEPENDENT MINIMUM MARRIAGE AGE
Tanzania	7%	37%	15 for girls, 18 for boys, but can marry at 14 with court permission; girls below 18 need parental consent
Zambia	9%	42%	21 for boys and girls but some customary law allows marriage for girls when they reach puberty
Zimbabwe	4%	31%	Constitutional Court recognized 18 as the minimum marriage age

Setting a minimum age of marriage is a critical step to preventing child marriage. It helps send a clear message that children are not ready for marriage and they should be protected from the violence and sexual exploitation that frequently accompanies child marriage. The law should be accompanied by appropriate protection mechanisms.

There has however been considerable global progress since the 2014 ARASA HIV and Human Rights Report in raising awareness about the abuses associated with child marriage and galvanizing support for efforts to end the practice. In 2015, the international community adopted the Global Goals for Sustainable Development and included a goal to end child marriage by 2030. The UN Human Rights Council adopted a resolution on child marriage in July 2015 that recognizes child marriage as a human rights violation. Donor countries have begun to pledge specific funds to support child marriage eradication programmes and in 2015 both the Canadian and Dutch governments made funding available for civil society to work on child marriage.

**The African Union Campaign to End Child Marriage in Africa** <sup>121</sup>

The African Union launched a two year campaign to end child marriage on the continent in 2014 (the campaign was later extended to 2017). The campaign seeks to accelerate change and encourages AU member states to raise awareness of the harms of child marriage and adopt strategies to prevent it and respond to the needs of girls at risk of child marriage and married girls. The campaign will focus on protecting girls’ human rights and removing barriers to law enforcement.

The AU appointed a Special Rapporteur on Child Marriage and a Goodwill Ambassador for the AU Campaign to End Child Marriage to spearhead the campaign.

The DRC, Madagascar, Uganda and Zimbabwe have launched the campaign in their countries.

There have been specific efforts to address the practice in Africa. The African Union (AU) launched a continental campaign in 2014 to end child marriage and Zambia, Mozambique, Tanzania and Uganda have recently developed national strategies to eradicate child marriage. In June 2016, AU member states adopted an African Common Position on Ending Child Marriage which includes establishing and enforcing laws that set 18 as the minimum marriage age. There has also been progress in the SADC region with the development of the SADC model law to end child marriage. The law was developed by the SADC Parliamentary Forum (SADC – PF)

**SADC Model Law to End Child Marriage and Protecting Children already in Marriage**

The drafting process started in 2015 and involved consultations with victims of child marriages, parliamentarians, civil society and national human rights commissions. <sup>122</sup>

The model law makes the following recommendations:

- Laws prohibiting child marriage should be consistent with international human rights obligations and should protect children from discrimination and promote their human rights to education, health and to be free from all forms of violence
- Child marriage and betrothal should be legally prohibited
- Legislation should set the minimum age of marriage for boys and girls at 18
- Girls who become pregnant while at school must have the right to continue with their education
- Children, in line with their evolving capacities, should have the right to comprehensive, safe and quality sexual and reproductive health and rights
- Victims of child marriage, children in marriage and pregnant girls should have access to HIV counselling, testing, treatment and family planning and measures to prevent mother to child transmission of HIV
- Children have a right to birth registration
- All marriages should be registered
- Governments should put in place programmes to meet the needs of children in marriages, including economic empowerment
- Victims of child marriages should have access to legal aid and legal representation

RECOMMENDATIONS

Civil society should:

- Advocate for legislation that explicitly criminalises marital rape and the repeal of laws that permit marriage to be a defence to rape
- Advocate for legislation that sets a minimum marriage age of 18 for boys and girls in line with the SADC Model Law to End Child Marriage and Protecting Children already in Marriage
- Work in partnership with women’s organisations to design and implement advocacy strategies to promote the human rights of women and girls
- Train law enforcement officials to implement laws on violence against women and on investigating and prosecuting violence and providing appropriate support to victims
- Advocate for access to comprehensive post-rape care, including treatment for injuries, PEP, emergency contraception and treatment for STIs. Ensure that victims receive adequate and accessible information about the risks of HIV infection and how to avoid it
- Advocate for shelters and safe spaces for victims of domestic violence and child marriage and for girls at risk of child marriage
- Advocate for access to comprehensive, safe, quality and adolescent friendly reproductive and sexual health care for adolescents and train health care workers to provide appropriate and non-judgmental services to adolescents
- Develop campaigns to create awareness about the harms associated with child marriage and violence against women

Governments should:

- Urgently adopt a law that explicitly criminalises marital rape and repeal any laws that are inconsistent with this position
- Enact legislation or amend existing legislation to bring it in line with the SADC Model Law to End Child Marriage and Protecting Children already in Marriage

- Article 23 requires states to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood, and relationships, including in the areas of family planning, fertility, and family life.
- Article 25 requires that states ensure equal access to health services for persons with disabilities, with specific mention of sexual and reproduction health and population based public health programmes.

Almost all of the ARASA partner countries’ governments have ratified the Convention, with Angola ratifying in 2014 and Madagascar in 2015. Only Botswana and Comoros (who signed the Convention) have not yet ratified it. Despite the high level of ratification, few countries appear to have taken adequate steps to comply with its provisions.<sup>123</sup> Kenya, Malawi, Tanzania, Zambia and Zimbabwe all have legislation on disability that predates the Convention and it does not appear that they have undertaken a review to ensure that it is consistent with the Convention. Zambia enacted new legislation protecting the rights of persons with disabilities in 2012.

Few countries in Africa are collecting data on the HIV prevalence rates amongst people with disabilities. Global data is equally sparse, but available data suggests that people with disabilities have rates of HIV infection similar to, if not higher than the general population.<sup>124</sup> A 2014 analysis of data from Sub-Saharan African countries showed that people with disabilities are 1.3 times (1.48 for women) more at risk of contracting HIV than people without disabilities.<sup>125</sup>

People with disabilities are at risk of HIV for similar reasons to both the general population and key populations:

- Stigma and discrimination: people with disabilities are often marginalized and isolated from their communities and they are not able to access appropriate HIV-related information and services. People with disabilities who are also members of key populations such as gay men and men who have sex with men and sex workers, experience “compounded” stigma and discrimination.<sup>126</sup>
- Violence: women and girls with disabilities are at high risk of sexual violence, and those with intellectual impairments or living in residential facilities such as schools and hospitals, are at particularly high risk of being raped and sexually assaulted. Statistics suggest that people with disabilities are up to three times more likely to experience sexual violence than people without disabilities.<sup>127</sup>
- Access to appropriate and accessible HIV prevention, treatment and care and sexual and reproductive health care: many service providers assume that people with disabilities are not sexually active and fail to design and provide them with access to health and other services. Those that do seek health care related to their sexual and reproductive needs often face poorly trained or judgmental health care workers and health systems that cannot meet their needs.

People with disabilities left behind in the AIDS response in Zambia<sup>128</sup>

A 2014 report by Human Rights Watch showed that the nearly two million people with disabilities in Zambia faced major barriers to accessing HIV prevention, treatment and care. These include stigma and discrimination, lack of access to inclusive HIV prevention and testing and lack of appropriate support for adherence to ART.

The report highlighted the particular challenges faced by children with disabilities: they are often not able to attend school and therefore cannot access HIV prevention information, or if they were in school, they were excluded from HIV prevention information or could not get accessible materials.

The barriers that people with disabilities face in accessing health care has an impact on their ability to seek TB testing and treatment. They often require support from families and communities to obtain health care.

TB and people with disabilities

Research in Malawi shows that people with disabilities struggled to get access to accurate information about TB and treatment.<sup>123</sup> The majority of people interviewed for the study believed they had not been tested for TB, but some were not sure.

Approximately 10% of the world’s population, or around 650 million people, are living with a disability. There is increasing attention to the links between HIV and disability and the risks and vulnerabilities of people with disabilities

3.6 PEOPLE WITH DISABILITIES

Approximately 10% of the world’s population, or around 650 million people, are living with a disability. There is increasing attention to the links between HIV and disability and the risks and vulnerabilities of people with disabilities. The 2009 and 2014 ARASA HIV and Human Rights Reports did not focus on disability and HIV.

Convention on the Rights of People with Disabilities

Definition of disability

Article 1: Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Key provisions relevant to HIV and TB:

- Article 9 calls for accessibility, including access to medical facilities and to information.
- Article 16 requires states parties to take measures to protect persons with disabilities from violence and abuse, including gender-based violence and abuse.
- Article 22 asserts the equal rights of persons with disabilities to privacy, including privacy of personal health information.



RECOMMENDATIONS

Civil society should:

- Advocate for the provision of information about HIV and TB in accessible formats for persons with disabilities, including in braille and formats accessible to persons who are deaf or hearing impaired and those with intellectual impairments
- Advocate for the expansion of HIV programming that is acceptable and accessible to people with disabilities and for the inclusion of people with disabilities in the design, implementation and evaluation of such programming
- Advocate for legislation that is consistent with the Convention on the Rights of Persons with Disabilities
- Work in partnership with persons with disabilities and disability rights organisations to design and implement advocacy strategies to promote the human rights of human rights of persons with disabilities

Governments should:

- Review existing legislation to ensure that it is consistent with the provisions of the Convention and amend or repeal provisions that discrimination against persons with disabilities
- Expand HIV programming that is acceptable and accessible to people with disabilities and for the inclusion of people with disabilities in the design, implementation and evaluation of such programming
- Initiate the collection of data on HIV prevalence amongst persons with disabilities in order to inform programming for their needs

3.7 PEOPLE WHO USE DRUGS



Recent studies show increasing injecting drug use in several countries, such as Kenya, Madagascar, Mozambique, the Seychelles, South Africa and the United Republic of Tanzania. <sup>130</sup> However, countries in Southern and East Africa have been slow to identify people who use drugs as a key population at higher risk of HIV exposure within their national responses to HIV.

Existing evidence shows that in Africa, as in the rest of the world, people who inject drugs are at extremely high risk of HIV. <sup>131</sup> A Zanzibar study showed that HIV prevalence was 30% higher amongst people who inject drugs than amongst the general population. <sup>131</sup> In Kenya, studies showed HIV prevalence of 18% among all people who inject drugs in Nairobi and Mombasa. Other studies found prevalence of 7% and 5.8%, respectively, among people who inject drugs in Madagascar and the Seychelles in 2011. <sup>132</sup>

Recent studies show increasing injecting drug use in several countries, such as Kenya, Madagascar, Mozambique, the Seychelles, South Africa and the United Republic of Tanzania. However, countries in Southern and East Africa have been slow to identify people who use drugs as a key population at higher risk of HIV exposure within their national responses to HIV

In SEA, individual drug possession and use is criminalised and highly stigmatised , with people who use drugs often facing discrimination on many levels. <sup>134</sup> For example, the Mauritius People Living with HIV Stigma Index of 2013 shows the various layers of discrimination faced by people who use drugs – as a result of drug use and also as a result of their perceived or actual belonging to other key populations groups such as sex workers or people living with HIV.

A survey amongst people who inject drugs in Seychelles found reports of high levels of stigma, discrimination and harassment. 68% of respondents reported being refused a service in the preceding 12 months and just over 50% reported having been arrested in the preceding 12 months. <sup>135</sup> Focus group discussions during the Seychelles Legal Environment Assessment of 2013 found that people who inject drugs experienced brutality and extortion at the hands of law enforcement officials and difficulties in accessing harm reduction services such as needle exchange programmes. <sup>136</sup> A survey amongst people who inject drugs

in Mauritius found that all respondents said that they had been arrested in the previous 12 months and almost three quarters said that they had been refused services at some point. In Kenya, 81% of people who inject drugs have reportedly been incarcerated. <sup>137</sup>

The Global Commission on HIV and the Law Africa Regional Dialogue on HIV and the Law found that criminalisation of drug use, fear of arrest, harassment and the imprisonment of people who use drugs, accompanied by widespread societal stigma, discourages access to health care services for people who use drugs and creates legal barriers to the provision of needle and syringe programmes and opioid substitution therapy. <sup>138</sup>

In Mauritius, the HIV and AIDS Act No 31 of 2006 provides for people who use drugs to access a range of HIV prevention services, such as needle exchange programmes, even though drug use is criminalised. Mauritius has introduced a comprehensive HIV programmatic response to target people who use drugs over the years, reaching large numbers of people who use drugs with methadone substitution therapy (including in prisons), needle exchange programmes, a harm reduction community service and a mobile caravan service for people who inject drugs and other key populations. As a result, amongst other benefits, HIV incidence amongst people who inject drugs has been dramatically reduced since 2010. <sup>139</sup>

Several countries reported having laws that create barriers to providing harm reduction services such as clean needle exchange programmes. <sup>131</sup>

Several countries reported having laws that create barriers to providing harm reduction services such as clean needle exchange programmes. <sup>140</sup> In addition to the barriers created by criminalisation and widespread societal discrimination, only nine countries in SEA recognise people who use drugs as a key population, only four countries provide any harm reduction services (Mauritius, South Africa, Tanzania and Kenya) and only six countries included data on key populations within their country progress reports to UNAIDS. <sup>142</sup> In countries such as Seychelles and Mauritius with concentrated epidemics, responses have been in place for some time. However, a number of countries with generalised HIV epidemics (e.g. Kenya, Tanzania and South Africa) are now recognising the importance of responding to the needs of people who use drugs.

Table 10: HIV and people who use drugs

COUNTRIES	HIV PREVALENCE (%) AS SET OUT IN GARPR	IDENTIFIED AS KEY POPULATION IN NATIONAL RESPONSE	PROVISION OF PREVENTION PROGRAMMES IN HIV RESPONSES
Angola	NDA	No	No
Botswana	NDA	No	No
Comoros	NDA	No	No
DRC	NDA	Yes	Yes
Kenya	18% (2010)	Yes	Yes
Lesotho	NDA	No	No
Madagascar	7.1% (2012)	Yes	Yes
Malawi	NDA	No	No
Mauritius	44.3% (2013)	Yes	Yes
Mozambique	NDA (study underway)	Yes	Unclear
Namibia	NDA	No	No
Seychelles	4% (2011)	Yes	Yes
South Africa	NDA	Yes	Yes
Swaziland	NDA	No	Yes
Tanzania	16% (2014)	Yes	Yes
Uganda	NDA	Yes	Yes
Zambia	NDA	No	No
Zimbabwe	NDA	No	No

RECOMMENDATIONS

Civil society should:

- Advocate for the decriminalisation of possession of drugs for personal use and use of drugs and for comprehensive harm reduction programmes
- Provide access to legal services for people who use drugs whose rights have been violated to assist them to obtain access to justice
- Advocate for the expansion of HIV programming that is acceptable and accessible to people who use drugs and for the inclusion of people who use drugs in the design, implementation and evaluation of such programming
- Advocate for health services to be available, accessible and acceptable to people who use drugs
- Train health care providers on the human rights of people who use drugs, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly
- Work in partnership with people who use drugs and organisations who work to promote the rights of people who use drugs to design and implement advocacy strategies to promote the human rights of people who use drugs
- Train law enforcement officials to recognise and uphold the human rights of people who use drugs
- Advocate to hold law enforcement officials accountable if they violate the rights of people who use drugs.

Governments should:

- Decriminalise the possession of drugs for personal use and use of drugs
- Expand HIV programming that is acceptable and accessible to people who use drugs and for the inclusion of people who use drugs in the design, implementation and evaluation of such programming
- Develop evidence-based comprehensive harm reduction programmes for people who use drugs, including needle and syringe exchanges and opioid substitution therapy

3.8 PRISONERS

“Every year, 30 million people spend time in prisons or closed settings, and 10 million are incarcerated at any given point in time. Virtually all will return to their communities, many within a few months to a year. Health in prisons and other closed settings is thus closely connected to the health of the wider society.”<sup>143</sup>

“Every year, 30 million people spend time in prisons or closed settings, and 10 million are incarcerated at any given point in time. Virtually all will return to their communities, many within a few months to a year. Health in prisons and other closed settings is thus closely connected to the health of the wider society

Prisoners are at high risk of HIV and TB infection. Few ARASA partner countries are systematically collecting data on HIV and TB prevalence, but limited research suggests the risk for prisoners contracting HIV and TB may be as high as ten times the risk for the general population.<sup>144</sup>

HIV and TB in Zambian prisons<sup>145</sup>

A 2010 Human Rights Watch, ARASA and PRISCCA report showed that poor conditions and lack of access to medical care led to HIV and TB transmission in Zambian prisons. The report documented over-crowding, malnutrition, “grossly inadequate medical care” and sexual violence, all factors that contributed to an increased risk of HIV and TB. HIV prevalence amongst prisoners was measured at 27%.

The majority of ARASA partner countries report conditions in prisons that increase the risk of HIV and TB: there is severe over-crowding in prisons in Angola, Mozambique, South Africa, Tanzania, Uganda and Zambia, as high as 166%, in Angola.<sup>146</sup> In Angola, the DRC, Mozambique, Namibia, Tanzania, Uganda and Zambia, prisoners have limited access to health care, including for HIV and TB. Almost all prisons fail to provide adequate access to sanitation and food. The UN reported that 115 individuals in DRC prisons died in detention from starvation or illness nationwide between January and November 2015.<sup>147</sup>

Table 11: Prisoners and HIV

COUNTRIES	INCLUDED AS A KEY POPULATION	PROVISION OF INFORMATION AND EDUCATION ABOUT HIV FOR PRISONERS IN HIV RESPONSES
Angola	Yes	Yes
Botswana	Yes	Information not provided
Comoros	Yes	Yes
DRC	Yes	Yes
Kenya	Yes	Yes
Lesotho	Yes	Yes
Madagascar	Yes	Yes
Malawi	Yes	Yes
Mauritius	No	No
Mozambique	Yes	Yes
Namibia	Yes	Yes
Seychelles	Yes	Yes
South Africa	Yes	Yes
Tanzania	Yes	Yes
Uganda	Yes	Yes
Zambia	Yes	Yes
Zimbabwe	Yes	Yes

The majority of ARASA partner countries have identified prisoners as a key population in national HIV programming and indicate that they are providing HIV prevention related information to prisoners. Many report in the NCPI reports, from which the information is extracted, that this information includes information about condom usage.

There is a lack of adequate laws and policies protecting the right to health care, including access to HIV prevention and treatment, for prisoners

Despite this, there is a lack of adequate laws and policies protecting the right to health care, including access to HIV prevention and treatment, for prisoners. Laws criminalising sex between men present a significant barrier to prisoners obtaining access to condoms to protect themselves from HIV transmission. While there are few statistics on the rate of sexual violence and consensual sex between prisoners, anecdotal evidence and small scale research suggests that sex is widespread. In Botswana, Malawi, Mozambique, Namibia, Tanzania and Uganda, prisoners are not permitted to access condoms or lubricant because of the criminalisation of same sex sexual conduct. In Zambia, the Prisons Act classifies sodomy as a major criminal offence.<sup>149</sup>

A small number of ARASA partner countries do have progressive policies in place to support the human rights of prisoners to HIV prevention, treatment and care. Various countries provide prevention services to prisoners: in Lesotho, prevention services in prisons include HIV testing and counselling, access to condoms and peer support and education.<sup>150</sup> The Department of Correctional Services in South Africa provides access to HIV testing and a 2013 policy makes provision for the distribution of condoms and lubricant.

Prisoners with HIV also struggle to access HIV treatment and to remain compliant with treatment regimes. While 97% of prisoners living with HIV in South Africa are able to access treatment,<sup>151</sup> prisoners in other countries are not as fortunate. In Namibia, for example, health care for prisoners with HIV is limited and treatment interruptions are common when prisoners are transferred between facilities. Prisoners on ARVs complain of inadequate nutrition and difficulties with treatment adherence.<sup>152</sup> In Uganda, prisoners with HIV do not have adequate access to antiretroviral medication, especially in rural areas.<sup>153</sup>



**Access to treatment for non-citizen prisoners in Botswana** <sup>154</sup>

Botswana only provided prisoners who were citizens of Botswana with ART, CD4 counts and viral load tests <sup>155</sup> and non-citizen prisoners only had access to HIV tests and peer counselling. <sup>156</sup> However, the *Attorney General v Tapela* judgement of the Court of Appeal in 2015 found that the policy was contrary to the Prisons Act and unlawful, ordering government immediately to provide free testing, assessment and ART to all foreign prisoners to the same extent as citizen prisoners.

Of the six countries for which data is available (South Africa, Kenya, Malawi, Zambia, Tanzania and Uganda) none of these countries provide needle and syringe exchange programmes (NSE) or Opioid Substitution Therapy (OST) in prisons <sup>137</sup>.

**TUBERCULOSIS IN PRISONS**

Overcrowding and poor living conditions make many African prisons a breeding ground for TB. Prisoners struggle to access TB treatment and are often stigmatised. In Zambia, the TB epidemic in prisons is exacerbated by poor conditions in prison: TB isolation cells are in very poor condition and there is limited access to prison-based TB testing or treatment in prisons. <sup>158</sup> TB is a common complaint in Tanzanian prisons and in South Africa, prisons are considered to be a major source of TB and multi-drug resistant TB (MDR-TB). <sup>159</sup>

**RECOMMENDATIONS**

**Civil society should:**

- Develop and implement stigma reduction programmes in prisons
- Advocate for the decriminalisation of sex between men and for the repeal of laws and policies that undermine or prevent the distribution of condoms and lubricants in prisons
- Advocate for the development and implementation of policies for comprehensive HIV and TB prevention, treatment and care of prisoners based on the United Nations Office on Drugs and Crime UNODC recommended package of interventions:

1. Information, education and communication
2. Condom programmes
3. Prevention of sexual violence
4. Drug dependence treatment, including opioid substitution therapy
5. Needle and syringe programmes
6. Prevention of transmission through medical or dental services
7. Prevention of transmission through tattooing, piercing and other forms of skin penetration
8. Post-exposure prophylaxis
9. HIV testing and counselling
10. HIV treatment, care and support
11. Prevention, diagnosis and treatment of tuberculosis
12. Prevention of mother-to-child transmission of HIV
13. Prevention and treatment of sexually transmitted infections
14. Vaccination, diagnosis and treatment of viral hepatitis
15. Protecting staff from occupational hazards

- Train health care providers on the human rights of prisoners, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly
- Work in partnership with prisoners and ex-prisoners and organisations who work to promote their rights to design and implement advocacy strategies to promote the human rights of prisoners

**Governments should:**

- Repeal laws that undermine or prohibit the distribution of condoms and lubricants in prisons, including laws that criminalise sex between men
- Develop and implement policies for comprehensive HIV and TB prevention, treatment and care for prisoners based on the UNODC recommended package of interventions:
- Information, education and communication

- Condom programmes
- Prevention of sexual violence
- Drug dependence treatment, including opioid substitution therapy
- Needle and syringe programmes
- Prevention of transmission through medical or dental services
- Prevention of transmission through tattooing, piercing and other forms of skin penetration
- Post-exposure prophylaxis
- HIV testing and counselling
- HIV treatment, care and support
- Prevention, diagnosis and treatment of tuberculosis
- Prevention of mother-to-child transmission of HIV
- Prevention and treatment of sexually transmitted infections
- Vaccination, diagnosis and treatment of viral hepatitis
- Protecting staff from occupational hazards

**3.9 HARNESSING THE AGREEMENT ON TRADE-RELATED ASPECTS OF INTELLECTUAL PROPERTY RIGHTS (TRIPS) IN SEA TO PROMOTE ACCESS TO TREATMENT/MEDICINES**



One of the major successes of recent efforts to respond to HIV, as well as TB, in sub-Saharan Africa has been the increased access to medicine in the past five years. Antiretroviral treatment (ART) has resulted in significant reductions in AIDS-related deaths in SEA countries. It also reduces the risk that a person living with HIV will develop TB by 66% and lowers the risk of death amongst people co-infected with HIV and TB. In addition, evidence shows that ART also reduces the transmission of HIV to sexual partners. <sup>160</sup>

In 2014, UNAIDS reported that ART was available to almost 4 in 10 people living with HIV in sub-Saharan Africa. <sup>161</sup> Factors such as the increased investments in health systems, global resource mobilisation and development funding, bulk procurement and the availability of cheaper and effective generic medicines have all contributed towards these gains. <sup>162</sup> Within the African context, the HIV, TB, malaria and hepatitis B and C disease burdens are among the highest in the world, thus increasing the need for essential medicines for our populations. However, intellectual property rights continue to undermine access to diagnostics, medicines, and other devices for Africa and the rest of the developing world.

**Appreciating the linkages between intellectual property rights and access to essential medicines is critical. This is especially because intellectual property barriers to access to newer and affordable, quality, safe and efficacious HIV, TB and Hepatitis C medicines remains a crucial human rights issue that requires intensified advocacy in Southern and East Africa in the context of HIV and TB**

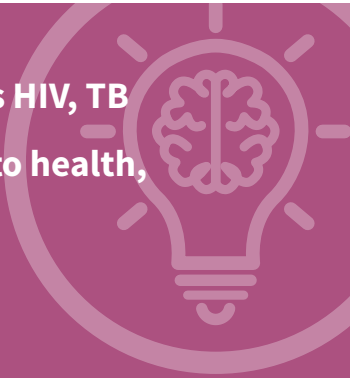
Appreciating the linkages between intellectual property rights and access to essential medicines is critical. This is especially because intellectual property barriers to access to newer and affordable, quality, safe and efficacious HIV, TB and Hepatitis C medicines remains a crucial human rights issue that requires intensified advocacy in Southern and East Africa in the context of HIV and TB. If treatment options for 2nd and 3rd line HIV, TB (including MDR and XDR-TB) are not improved <sup>163</sup> and treatment coverage is not expanded, there is a risk of rising AIDS-related deaths and HIV incidence and the development of drug-resistant strains of HIV and TB. <sup>164</sup>

Africa still imports the large majority of its medicines; this market is becoming increasingly monopolised with limited competition, limited investment in diseases such as TB that mainly affect lower income countries and overly high prices being charged for access to the existing medicines. A number of countries in SEA are still overly dependent upon donor resources for medicines.

However recent changes in global health and development means that many countries are moving from low-income to middle-income status (despite still having large numbers of people in their countries still living below the poverty line) leaving them ineligible for continued aid support from mechanisms such

as the Global Fund to Fights AIDS, TB and Malaria (GFATM) and the United States’ President’s Emergency Plan for AIDS Relief / Malaria Initiative (PEPFAR). This, combined with declining levels of development funding and the adoption of the Sustainable Development Goals (SDGs) will require increased efforts from countries to develop sustainable, national mechanisms to increase access to medicines – such as increasing access to cheaper medicines as well as strengthening local research and development (R&D) and local production of high quality, affordable and efficacious medicines.

**Access to newer and affordable, quality, safe and efficacious HIV, TB and Hepatitis C medicines forms part and parcel of the right to health, as guaranteed in a wide range of international, regional and domestic instruments**



The UN Commission on Human Rights has confirmed that access to essential medicines is a fundamental element of the right to health. Universal access to treatment care and support is a human rights issue. Access to treatment cannot be realised in practice in the absence of affordable or reasonably priced medicines. Access to newer and affordable, quality, safe and efficacious HIV, TB and Hepatitis C medicines forms part and parcel of the right to health, as guaranteed in a wide range of international, regional and domestic instruments. These include the International Convention on the Elimination of Racial Discrimination (ICERD, article 5), the International Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW, article 12), the Convention on the Rights of the Child (CRC, article 24) and the African Charter on Human and People’s Rights (Article 16).

This right is also recognised in numerous domestic Constitutions. As a duty bearer the state has an obligation to ensure to the maximum extent of its available resources that there is access to essential medicines and health care products.

Within SEA, the following table shows some of the countries that have the right to health enshrined in their national Constitutions.

<b>SWAZILAND, SECTION 27</b>	<ul style="list-style-type: none"><li>• The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to health.</li><li>• Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.</li><li>• A person shall not be denied emergency medical treatment.</li></ul>
<b>SOUTH AFRICA, SECTION 27</b>	<ul style="list-style-type: none"><li>• Everyone has the right to have access to health care services, including reproductive health care and no one may be refused emergency medical treatment.</li></ul>
<b>KENYA, SECTION 43</b>	<ul style="list-style-type: none"><li>• Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.</li><li>• A person shall not be denied emergency medical treatment.</li></ul>
<b>MALAWI, SECTION 13</b>	<ul style="list-style-type: none"><li>• The State shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation ... to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care.</li></ul>
<b>MALAWI, SECTION 30</b>	<ul style="list-style-type: none"><li>• Right to development- the state shall take measures for the realisation of the right, including equal opportunities for all in access to health services.</li></ul>
<b>MOZAMBIQUE, SECTION 116</b>	<ul style="list-style-type: none"><li>• The State shall promote the expansion of medical and health care and the equal access of all citizens to the enjoyment of this right.</li><li>• The State shall be responsible for promoting, supervising and controlling the production, the sale and the use of chemical, biological and pharmaceutical products and other forms of treatment and diagnosis, and the medical and health care activities run by collective and private entities shall be carried out in accordance with the law and be subject to the supervision of the State.</li></ul>

Creating an enabling legal and policy framework is one of a number of strategies to increase access to medicines in SEA. Except for South Sudan, all countries in SEA are members of the World Trade Organisation (WTO). They are generally obliged to comply with the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement. However, Least Developing Countries (LDCs) are exempted from applying some general provisions of the TRIPS until 2021 and medicines related provisions until 2023.

Intellectual property rights in general and patents in particular, are a tool that should ensure that the public benefits from human ingenuity. Intellectual property laws and trade rules set out by the WTO and in terms of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement have created barriers to access to affordable medicines in Africa. Intellectual property laws give market exclusivity (through e.g. patents) for those who develop medical products, allowing them to charge high prices, arguably on the basis of the investment in research and development made for their medical products. The strict protection and enforcement of Intellectual property rights has undermined access to medicines because they are tools that right holders use for extracting monopoly prices from the market. Monopoly prices tend to make medicines unaffordable and limit the ability of individuals, governments and private sector entities to develop and import inexpensive medicines.

In 2001, WTO members adopted the Doha Declaration on the TRIPS Agreement and Public Health, reiterating that least LDCs were able to use the “flexibilities” within TRIPS to increase access to affordable medicines – such as lower cost, generic medicines - for public health reasons. The Declaration recognised the gravity of public health problems affecting developing countries, especially HIV/AIDS, TB and Malaria and the “importance of creating a positive, mutually reinforcing link between the IP system and access to medicines.” The Doha Declaration made it clear that TRIPS does not and should not prevent members from taking measures to protect public health and that it should be interpreted in a manner supportive of public health.

**The Doha Declaration made it clear that TRIPS does not and should not prevent members from taking measures to protect public health and that it should be interpreted in a manner supportive of public health.**



Since that time, WTO members have adopted a number of additional, related decisions to implement the Declaration. However, SEA countries have diverse legal frameworks for intellectual property rights, many of which date back to colonial times and are not consistent with recent developments. While most African countries have incorporated intellectual property protection in their domestic laws, including harmonising their patent laws to protect patents on medicines, very few countries have become TRIPS compliant or have taken full advantage of TRIPS flexibilities to increase access to affordable medicines.<sup>165</sup>

In pursuant of the Doha agenda, numerous continental and regional strides have been made to increase access to medicines. These efforts have been aimed at ultimately building on the continent’s manufacturing capacity. Equally, they entrench strategies to fast track the domestication and implementation of the TRIPS-flexibilities.

**While most African countries have incorporated intellectual property protection in their domestic laws, including harmonising their patent laws to protect patents on medicines, very few countries have become TRIPS compliant or have taken full advantage of TRIPS flexibilities to increase access to affordable medicines**



In 2005, the AU Assembly through the adoption of Decision 55 (Abuja 2005) - made a clear commitment to promote access to medicines by encouraging the production of generic medicines. The decision also urged AU members to “take the lead in TRIPS negotiations and implementing measures identified for promoting access to affordable generic drugs.” Decision 55 was followed by the Gaborone Declaration on a Roadmap towards Universal Access to Prevention, Treatment and Care which was adopted by AU Ministers of Health in October 2005.




Pursuant to these obligations, the AU Commission has developed the Pharmaceutical Manufacturing Plan for Africa – ‘the Business Plan’. Among other things, the plan urges the AU Conference of Ministers of Health to “mandate a technical body to appoint all relevant expertise to study the detailed implications” of TRIPS and develop a suggested plan which should detail TRIPS-related legislative reforms.

These initiative, including the African Union Model Law on Medical Products Regulation <sup>166</sup> and correspondent EAC and recently updated SADC Pharmaceutical Business Plans (2016 – 2020) aim to maximise the local and regional regulation of medicines and the production of generic essential medicines, to strengthen the availability of affordable, quality, safe and efficacious medicines in the region.

Another commitment to remind States of their specific commitments and obligations pertaining to access to medicines, as well as the need for them to take concrete actions to promote the use of TRIPS flexibilities, was seen in 2008, through the African Commission for Human and Peoples Rights (ACHPR) and its adoption of Resolution 141 on Access to Health and Needed Medicines in Africa. <sup>167</sup>

The limited integration and use of TRIPS flexibilities within national laws and policies is a key issue in the successful implementation of continental and regional initiatives. Most countries in SEA have revised or are in the process of revising their Intellectual Property laws to incorporate TRIPS flexibilities. Within the SADC, these include Seychelles, Namibia and Botswana. Malawi and Zambia have draft laws, which purport to exclude pharmaceuticals from patentability until they graduate from Least Developed Countries (LDC) status. In east Africa, apart from Kenya, which is a developing country, Uganda, Rwanda, Burundi, and Tanzania are ranked as least developed countries. Rwanda and Burundi, have adopted laws that largely reflect the flexibilities availed to LDCs under the TRIPS agreement.



**The limited integration and use of TRIPS flexibilities within national laws and policies is a key issue in the successful implementation of continental and regional initiatives**

Even where countries have integrated flexibilities within their laws and policies, there is limited evidence of their use. This creates barriers to increased access to medicines in SEA. <sup>168</sup>

**A worrisome trend in the Common Market for Eastern and Southern Africa (COMESA) region has been the drive towards developing and adopting anti-counterfeiting legislation. Anti-counterfeiting laws are important in that they protect the public from harm. However, these laws may be problematic where they broadly define counterfeits and effectively equate generics to counterfeits**



Some of the major challenges identified in intellectual property laws in SEA include the following:

- There are flexibilities within TRIPs to ensure that only true inventions are patented. However, very few countries in SEA have a system of substantive patent examination. There are exceptions – such as Angola, DRC, Kenya, Madagascar – but many countries rely on regional organisations such as the African Regional Intellectual Property Organisation (ARIPO) to examine patent applications. This may limit opportunities to integrate flexibilities within national law. Also, very few countries (e.g. Malawi, Namibia, Zambia) exclude patents on new forms and uses of an existing medicine. Countries also do not make provision for pre- or post-opposition to patent applications.

- The inadequate utilisation of TRIPS flexibilities at domestic level (incl. compulsory licence, parallel importation, paragraph 6 system). Compulsory licences allow for the production of a patented medicine without the consent of the patent holder, for reasons such as high pricing, anti-competitive practices and emergency public health situations. For example, in the past, Mozambique, Zambia and Zimbabwe have issued compulsory licenses for anti-retrovirals. Although many countries are able to grant compulsory licenses for medicines on a number of grounds, countries have not fully amended their national laws to include the various public health grounds set out in the Doha Declaration for granting compulsory licenses.
- Proliferation of undeserving patents. There needs to be an assessment criteria for patentability in national legislation, capable of filtering out undeserving patents. For instance, South Africa has no patent examination system in place, thus leaving the country vulnerable to abusive patenting practices by pharmaceutical companies, and inflated medicine prices as a result. Brazil, for example, granted only 273 pharmaceutical patents during a five-year period (2003-2008), while South Africa granted 2,442 pharmaceutical patents in 2008 alone. <sup>169</sup>
- Governments entering into Free Trade Agreements (FTAs) that potentially hinder the use of flexibilities and access to medicines.
- Parallel importation allows countries to import medicines from countries where the prices are lower than that set in the country by the patent holder. Most SEA countries do not provide for parallel importation; only a few countries (e.g. Botswana, Mauritius, Namibia, South Africa and Zimbabwe) use this flexibility to allow for parallel importation of medicines.
- The “early working” exception allows a competitor to use a patented medical product before the expiry of its patent, in order to get regulatory approval of a generic. This helps generics to be available on the market as soon as a patent has expired on a patented medical product. However, few countries (e.g. Botswana, Namibia and Zambia) have provisions to allow for early working. A few countries do allow for exceptions to allow educational, research or experimental use on patented medicines.
- While the TRIPS Agreement protects test data used to develop medical products, the Agreement allows for this data to be used by national health authorities to register generic substitutes of medicines, if it is not disclosed to generic companies. However, very few countries in SEA provide measures for dealing with test data exclusivity.

**Use of competition provisions in South Africa**

Article 31(k) of the TRIPS Agreement allows the use of a patent without the consent of the patent holder to remedy “anti-competitive” practices. Although no compulsory license was issued, South African civil society organisations have used competition law to address excessive pricing of medicines in the past. In 2002, CSOs filed a complaint against 2 pharmaceutical companies before the Competition Commission arguing that the excessive prices of patented ARVs was an anti-competitive practice. The Commission recommended that a compulsory license be issued on the ARVs; however the companies entered into an agreement with generic producers to grant voluntary licenses for reduced royalties. In 2007 the Treatment Action Campaign brought a complaint against another pharmaceutical company for refusing to license its patent on an ARV on reasonable terms; a settlement was reached to grant multiple licenses to generic producers.

*Taken from GCHL (2011) Regional Issue Brief*

A worrisome trend in the COMESA region has been the drive towards developing and adopting anti-counterfeiting legislation. Anti-counterfeiting laws are important in that they protect the public from harm. However, these laws may be problematic where they broadly define counterfeits and effectively equate generics to counterfeits. A number of countries such as Kenya, Malawi, Uganda and Zambia are or have developed anti-counterfeiting laws to regulate and protect against substandard and fake medicines – however some of these laws are so broadly defined that they create barriers to legitimate generic medicines. <sup>170</sup>

**Examples of Positive Developments in countries in Southern and East Africa**

In Kenya, a broad definition of the understanding of counterfeit medicines in the Anti-Counterfeit Act of 2008 would have included generic medicines under the definition of counterfeit goods. The law was challenged and successfully overturned in Kenya’s Constitutional Court as infringing on the constitutional right to health.

The Lesotho Medicines and Medical Devices Bill, 2016 is currently in development and aims to incorporate TRIPS flexibilities into national law in Lesotho. <sup>171</sup>

At a global level, there is increased recognition that TRIPS has failed to encourage and reward research and development in medicines and products to meet the needs of the poor and for neglected diseases, such as TB. It is argued to be a need for a new intellectual property regime for pharmaceutical products that, for example, promotes open source discovery, places obligations upon inventors to increase transparency and investments in Research and Development (R&D), delinks R&D from pricing, incentivizes R&D in neglected diseases, pools intellectual property and generally meets the needs of international human rights and public health, while still safeguarding the rights of inventors.<sup>172</sup> The GCHL argues that until such time, WTO members should suspend the operation of TRIPS in relation to essential medicines and medical products for low and middle-income countries.<sup>173</sup>

In moving this agenda and debate forward, a global process led by the United Nations has taken place, to interrogate the inconsistencies inherent in TRIPS and access to essential medicines. In November 2015, the United Nations Secretary-General Ban Ki-moon convened a **High-Level Panel on Access to Medicines**. The objective of the High-Level Panel was “to review and assess proposals and recommend solutions for remedying the policy incoherence between the justifiable rights of inventors, international human rights law, trade rules and public health in the context of health technologies.” Contributions were received from over 200 stakeholders globally and two hearings were convened in South Africa and New York in March 2016. The report from the High-Level Panel on Access to Medicines, was received by the United Nations General Assembly in New York, in June 2016.

Another monumental development has been the adoption of the UN Human Rights Council landmark Resolution on “Access to medicines in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (the Resolution) at its 32nd Session, on the 30th of June 2016. The resolution articulates a right of access to medicines in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The resolution notes that;

- “actual or potential conflicts exist” between the WTO implementation of the agreement on (TRIPS) and the realization of economic, social and cultural rights in relation to restrictions on access to patented pharmaceuticals and the implications for the enjoyment of the right to health.
- It urges member states to make full use of TRIPS flexibilities.
- It further calls on the states to apply the principle of delinking medical research and development from the prices of medicines, diagnostics and vaccines.

The resolution above, as well as various regional and international tools, call on countries in SEA to take recommended steps to strengthen their existing intellectual property laws and policies to increase access to medicines, as set out below.


**Table 12: KEY Recommendations and Advocacy Entry Points for SEA:**

ENTRY-POINTS	KEY ADVOCACY ACTIONS
Poor health care delivery systems- health care crisis	<ul style="list-style-type: none"><li>• Conduct a situational analysis on healthcare</li><li>• Reports and briefings</li><li>• Networking and coalition building</li><li>• Campaigning</li><li>• Policy advocacy</li><li>• Use of media</li><li>• Running an active website</li></ul>
Inadequate domestication of TRIPS flexibilities:	<ul style="list-style-type: none"><li>• Conduct a TRIPS compliance analysis of the existing domestic legislation in order to determine the extent to which it incorporates TRIPS flexibilities.</li><li>• Determine the actual or potential impact of domestic law on access to medicines.</li><li>• Encourage the government to review and reform their IP legislations and to draft TRIPS compliant and IP friendly reforms in the laws and policies.</li><li>• Advocate for the inclusion of TRIPS flexibilities into national legislation.</li><li>• Engage policy makers and legislators to convince them on the necessity of the reforms.</li><li>• Build useful advocacy coalitions with communities, development partners, the media, the academia, CSOs and other relevant entities.</li></ul>
Inadequate utilization of TRIPS flexibilities at domestic level (compulsory licence, parallel importation, paragraph 6 system): Strengthen national intellectual property laws for increased access to medicines; by rejecting TRIPS-plus clauses	<ul style="list-style-type: none"><li>• Advocate to governments for the implementation of TRIPS flexibilities in national policies.</li><li>• Mount arguments in favour of the use of post-grant flexibilities including compulsory licensing – highlighting how the use of post-grant flexibilities can guarantee access to medicines and reduce national healthcare budgets.</li><li>• Mobilize public opinion, in favour of the use of flexibilities through media advocacy (using social networks, the media, demonstrations and other advocacy strategies).</li><li>• Harness domestic and international legal expertise to advance a persuasive argument in favour of compulsory licensing.</li><li>• Advocate to policy and decision makers, as well as legislators to support your cause.</li><li>• Mobilize the masses to put political pressure on the legislators and the executive.</li></ul>

ENTRY-POINTS	KEY ADVOCACY ACTIONS
Proliferation of undeserving patents	<ul style="list-style-type: none"><li>• Advocate for provisions which assesses the criteria for patentability in national legislation, to determine whether it is capable of filtering out undeserving patents.</li><li>• Pressurize governments to adopt appropriate criteria for patentability.</li><li>• Advocate for the introduction of procedures that filter out undeserving patents including.</li><li>• Patent examination systems.</li><li>• Where the systems exist, lobbying for their use and the enhancement of the capacity of patent examiners.</li><li>• Monitor the work of patents examiners to ensure that public health objectives guide their work by working with academic institutions and pro-bono lawyers.</li><li>• Advocate for the introduction of patent opposition systems (pre-grant and post-grant).</li><li>• Develop mechanisms for identifying undeserving patents- build coalitions and networks with other stakeholders engaged in similar initiatives.</li><li>• Where national legislation permits, make opposition submissions to the patent office to bring to its attention the existence of undeserving applications and patents.</li><li>• Build coalitions to expose and discredit undeserving applications in the media and other forums.</li><li>• Support patent opposition litigation.</li></ul>
Governments entering into FTAs that potential hinder the use of flexibilities and access to medicines.	<ul style="list-style-type: none"><li>• Critically assess FTAs in order to determine their potential impact on the use of flexibilities and access to generics.</li><li>• Disseminate the findings of the above assessment.</li><li>• Mobilize domestic and international coalitions to oppose retrogressive FTA provisions-through petitions and other means.</li><li>• Utilize the media to advance the FTA opposition agenda.</li><li>• Strengthen relationships with decision-makers within the Department of Trade and ensure that you have access to your country’s FTA negotiators to oppose TRIP-plus FTA clauses.</li><li>• Advocate to your parliament to provide the necessary oversight and to hold governments accountable to the electorate in relation to FTAs and EPAs.</li></ul>
TRIPS pharmaceutical waiver for LDCs extended to 2033	<ul style="list-style-type: none"><li>• Advocate to governments and policy makers to take advantage of the waiver to reform their domestic laws to cater for their local circumstances.</li></ul>
Inadequate R&D into diseases that predominantly affect poor people	<ul style="list-style-type: none"><li>• Advocate for more funding for R&amp;D for neglected diseases such as TB.</li><li>• Advocate for change in the way R&amp;D is incentivized.</li><li>• Use other laws, such as competition law, procurement law and medical regulations to increase access to safe, affordable medicines.</li></ul>


3.10

TUBERCULOSIS



The links between TB and human rights are increasingly being recognized at an international, regional and national level and that rights-based responses are critical to effectively managing the epidemic.

TB is a disease of poverty and inequality: people who cannot realise their human rights are often those most vulnerable to contracting TB and least able to access diagnostic, prevention and treatment services.<sup>174</sup> Populations at increased vulnerability for developing TB include people living in poverty, minorities, women, children, migrants, people living with HIV, prison populations, health care workers and homeless persons. Women bear the brunt of the TB epidemic and are more affected than men when they develop TB.



**TB is a disease of poverty and inequality: people who cannot realise their human rights are often those most vulnerable to contracting TB and least able to access diagnostic, prevention and treatment services.<sup>174</sup>**



There are various factors that increase vulnerability to TB. Poor living conditions, including over-crowding and lack of sanitation expose populations to the risk of TB. Limited access to education, nutrition, health services and facilities, employment and social security all play a role in increasing vulnerability to TB. Some groups may be more vulnerable due to their occupation (e.g. health care workers and miners).<sup>175</sup>

Access to TB diagnostics, treatment and care is also dependent upon income and where people live. The barriers created by IP rights, the funding and the limited investment into R&D on TB drugs – typically a disease of less developed countries – is a global human rights issue that requires urgent attention.

**Current responses to TB often fail to respect human rights and include criminalising patients with TB who fail or refuse to take their treatment, forcing them to have treatment or be hospitalized, isolating them and detaining them in prisons, and subjecting them to home arrests and travel restrictions.**



In similar ways to people living with HIV, people with TB are also subjected to violations of their human rights. Current responses to TB often fail to respect human rights and include criminalising patients with TB who fail or refuse to take their treatment, forcing them to have treatment or be hospitalized, isolating them and detaining them in prisons, and subjecting them to home arrests and travel restrictions. These responses fail to recognise and take into account why people may default on treatment. They also serve to increase stigma and discrimination around TB. Some of these measures may in fact increase health risks: many people are placed in facilities with sub-standard conditions, violating other human rights and, in the case of imprisonment, placing people with TB at increased risk and exposing other prisoners to the risk of TB infection. Measures such as involuntary isolation and involuntary detention should only be used as a measure of last resort, when voluntary, rights-based and community-based treatment models have not succeeded.

**Limiting people with TB’s human rights in the name of public health<sup>176</sup>**

Incarceration and other coercive TB measures unjustifiably interfere with patients’ human rights and dignity because:

- They neglect more effective, rights-respecting alternative models of treatment and care, such as the provision of community-based treatment, adherence support and in-patient or out-patient treatment options. These ambulatory and community-based models of care have shown to have successful health outcomes, especially in resource-constrained settings.
- There is strong evidence that rights-limiting measures increase vulnerability to TB by subjecting individuals to conditions that favor TB infection, transmission, illness and death
- They are generally considered by human rights experts to be “unnecessary from a scientific standpoint and dangerous from a programmatic perspective”

Criminalisation of TB status, involuntary treatment, involuntary isolation and involuntary detention are the four main areas where governments implement laws, policies and practices which undermine the health and other human rights of people affected by TB.

Countries have limited documented information on TB and human rights violations. However, there is an increasing awareness across countries in SEA of the importance of rights-based responses to TB and there are some examples of successful advocacy efforts. In Botswana, for example, in 2012, civil society advocated against proposed draconian provisions in the Public Health Bill to deal with communicable diseases. These included provisions allowing for the detention of a person in a health facility to prevent the spread of a disease and criminalising escape from detention. Some of the more restrictive provisions, such as notifying cases of TB to the police services, were removed from the Bill. However, many restrictive provisions remain in the Public Health Act, 2013. In Kenya, KELIN and other civil society partners advocated for the provision of TB treatment to a patient for XDR-TB at no cost, on the basis that the failure of the government to provide the treatment violated the patient’s constitutional right to health.

**Also in Kenya, the High Court declared in March 2016 that the practice of confining TB patients in prisons for purposes of treatment is unlawful and unconstitutional. Justice Mumbi Ngugi ruled that imprisonment of TB patients is unlawful, unconstitutional and a violation of their fundamental human rights to movement, dignity and security**



Also in Kenya, the High Court declared in March 2016 that the practice of confining TB patients in prisons for purposes of treatment is unlawful and unconstitutional. Justice Mumbi Ngugi ruled that imprisonment of TB patients is unlawful, unconstitutional and a violation of their fundamental human rights to movement, dignity and security. The court ordered an immediate stop to this practice. The court further directed the Cabinet Secretary for Health to develop a policy within 90 days, in consultation with the county governments, on the involuntary confinement of individuals with TB that is compliant with the Constitution. This policy has to incorporate principles from the WHO international guidance on the involuntary confinement of individuals with TB.<sup>177</sup>

In South Africa, a class action suit is being brought against 32 mines, on behalf of all miners who have silicosis and TB as a result of exposure to silica dust since 1965 as well as on behalf of the families of miners who have died of silicosis and TB. If successful, the outcome will have a significant impact on the responsibility of the mining sector to provide a work environment that protects miners from silicosis and TB and to compensate those affected.

**RECOMMENDATIONS**

**Civil society should:**

- Advocate for the reform of laws and policies that undermine effective TB responses, including those that encourage involuntary detention of patients.
- Train lawyers and other law enforcement officials on TB and human rights and encourage them to advocate for changes in law and policy
- Provide legal advice and representation to people with TB
- Train health care providers on the human rights of people with TB, including on non-discrimination, informed consent, confidentiality and the duty to treat people with TB fairly
- Undertake campaigns to promote human rights and TB treatment literacy

**Governments should:**

- Review laws to ensure that they do not discriminate against people with TB and undermine effective TB responses
- Repeal any laws and policies that unreasonably restrict the rights of people with TB

# END NOTES

<sup>68</sup> 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>, p.10

<sup>69</sup> UNAIDS, 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](http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/05/20130530_Guidance_Ending_Criminalisation.pdf), at p.2

<sup>70</sup> Eba, P. ‘HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis’ (2015) 15 African Human Rights Law Journal 224-262. Available at <http://dx.doi.org/10.17159/1996-2096/2015/v15n2a1>. Accessed on 1 July 2016

<sup>71</sup> Ibid

<sup>72</sup> Ibid

<sup>73</sup> Bernard 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>

<sup>74</sup> Ibid

<sup>75</sup> Ibid

<sup>76</sup> Human Rights First, The State of Human Rights for LGBT People in Africa, July 2014, <http://www.humanrightsfirst.org/sites/default/files/HRF-HRC-Africa-Report.pdf> accessed 23 April 2016

<sup>77</sup> African Commission on Human and People’s Rights, 275: Resolution on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity, May 2014, <http://www.achpr.org/sessions/55th/resolutions/275> [accessed 24 June 2016]

<sup>78</sup> AG Botswana v T Ramogge and others (Court of Appeal Civil Appeal No CACGB-128-14. Available at <http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2016/03/LEGBIBO-CoA-judgment.pdf>. Accessed on 1 July 2016

<sup>79</sup> Eric Gitari v Non- Governmental Organisations Co-ordination Board & 4 others [2015] eKLR. Available at <http://kenyalaw.org/caselaw/cases/view/108412/>. Accessed on 1 July 2016

<sup>80</sup> See: <http://hivhealthclearinghouse.unesco.org/library/documents/ending-violence-and-other-human-rights-violations-based-sexual-orientation-and>

<sup>81</sup> Ibid.

<sup>82</sup> Human Rights Watch, The Issue is Violence: Attacks on LGBT People on Kenya’s Coast, 28 September 2015, <https://www.hrw.org/report/2015/09/28/issue-violence/attacks-lgbt-people-kenyas-coast> [accessed 26 April 2016]

<sup>83</sup> US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015: Malawi, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 15 May 2016]

<sup>84</sup> Daily Nation, MPs throw out proposal to punish gays with death, 16 November 2015, <http://www.nation.co.ke/news/-MPs-throw-out-proposal-to-punish-gays-with-death/-/1056/2959152/-/12ay9ktz/-/index.html> [accessed 10 May 2016]

<sup>85</sup> US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015: Kenya, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 25 April 2016]

<sup>86</sup> US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015: Malawi, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 15 May 2016]

<sup>87</sup> 2014 NCPI reports. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2014countries>. Accessed on 1 July 2016

<sup>88</sup> The information in this table was compiled from the most recent NCPI reports. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2014countries>. Accessed on 1 July 2016

<sup>89</sup> UNDP and others, Implementing Comprehensive HIV and STI Programmes with Transgender People, [http://www.unaids.org/sites/default/files/media\\_asset/UNDP-et-al\\_2016\\_transgender\\_practical\\_guidance\\_collaborative\\_interventions\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/UNDP-et-al_2016_transgender_practical_guidance_collaborative_interventions_en.pdf) [accessed 29 May 2016]

<sup>90</sup> Ibid.

<sup>91</sup> Republic v Kenya National Examinations Council & another Ex-Parte Audrey Mbugua Ithibu [2014] eKLR

<sup>92</sup> Marriages, Divorce and Family Relations Bill, 2015.

<sup>93</sup> Ibid., Implementing Comprehensive HIV and STI Programmes with Transgender People,

<sup>94</sup> GCHL. Risks, Rights & Health. (2012); UNAIDS. The Gap Report. (2015).

<sup>95</sup> UNAIDS. The Gap Report. (2015).

<sup>96</sup> Ibid.

<sup>97</sup> Ibid.

<sup>98</sup> IPPF, Reaching Sex Workers Through Mobile Clinics in Lesotho, <http://www.ippfar.org/reaching-sex-workers-through-mobile-clinics-lesotho> [accessed 13 May 2016]

<sup>99</sup> AllAfrica, South Africa: Deputy President Cyril Ramaphosa – Launch of South African National Sex Worker HIV Plan, 11 March 2016, <http://allafrica.com/stories/201603142223.html> [accessed 21 May 2016]

<sup>100</sup> WHO, WHO congratulates South Africa on new strategy for sex workers, 15 March 2016, <http://www.who.int/hiv/mediacentre/news/southafrican-strategy-sex-workers/en/> [accessed 25 June 2016]

<sup>101</sup> Ibid.

<sup>102</sup> The information in this table was compiled from the most recent NCPI reports. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2014countries>. Accessed on 1 July 2016

<sup>103</sup> UN General Assembly, On the fast track to ending the AIDS epidemic, Report of the Secretary-General, 1 April 2016 [http://sgreport.unaids.org/pdf/20160423\\_SGREport\\_HLM\\_en.pdf](http://sgreport.unaids.org/pdf/20160423_SGREport_HLM_en.pdf) [accessed 25 May 2016]

<sup>104</sup> WHO 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](http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf)

<sup>105</sup> UNAIDS, Country progress report 2014, [http://www.unaids.org/sites/default/files/country/documents/AGO\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/AGO_narrative_report_2014.pdf)[accessed on 12 April 2016]

<sup>106</sup> Botswana GBV Indicator Study Research Report 2012, cited in Republic of Botswana , Progress Report of the National Response to the 2011 Declaration of Commitment on HIV and AIDS, 2014.[http://www.unaids.org/sites/default/files/country/documents/BWA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/BWA_narrative_report_2015.pdf) (Accessed 10 April 2016);

<sup>107</sup> <http://www.genderindex.org/country/mozambique> [Accessed 15 May 2016].

<sup>108</sup> US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015: Tanzania

<sup>109</sup> Gender Links, SADC Gender Protocol 2015 Barometer, South Africa, 28 August 2015, <http://genderlinks.org.za/programme-web-menu/publications/sadc-gender-protocol-2015-barometer-south-africa-2015-03-17/> [accessed 21 May 2016]

<sup>110</sup> Africa Check, South Africa’s official crime statistics 2013/14, <https://africacheck.org/factsheets/factsheet-south-africas-official-crime-statistics-for-201314/>[ accessed 21 May 2016]

<sup>111</sup> US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2015, Comoros, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 10 May 2016]

<sup>112</sup> Republic of Kenya, Protection Against Domestic Violence Act, 2015, [http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/ProtectionAgainstDomesticViolenceAct\\_2015.pdf](http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/ProtectionAgainstDomesticViolenceAct_2015.pdf) [accessed 25 April 2016]

<sup>113</sup> Human 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>

<sup>114</sup> Human Rights Committee, Concluding Observations on the second report of Namibia, 22 April 2016 <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/084/97/PDF/G1608497.pdf?OpenElement> [accessed 20 May 2016]

<sup>115</sup> US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015: Kenya, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 25 April 2016]

<sup>116</sup> US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015, Lesotho

<sup>117</sup> A marriage in which one spouse is younger than 18 years of age

<sup>118</sup> Information was extracted from the 2013 country HIV epidemic profiles: <http://www.unaidsrstes.org/countries/> [accessed 27 May 2016]

<sup>119</sup> Girls Not Brides: <http://www.girlsnotbrides.org/region/sub-saharan-africa/> [accessed 27 May 2016]

<sup>120</sup> Ibid., Women and Adolescent Girls on the fast track to ending the AIDS epidemic

<sup>121</sup> Girls Not Brides, African Union launches its first ever campaign to end child marriage, 29 May 2014, <http://www.girlsnotbrides.org/african-union-launches-first-ever-campaign-end-child-marriage/> [accessed 28 May 2016]

<sup>122</sup> The Herald, SADC drafters approve model law on eradicating child marriage, 25 March 2016, <http://www.herald.co.zw/sadc-drafters-approve-model-law-on-eradicating-child-marriage/> [accessed 28 May 2016]

<sup>123</sup> OSISA, Status of Disability Rights in Southern Africa, 2012, [http://www.osisa.org/sites/default/files/disability\\_open\\_learning\\_-\\_overview\\_final.pdf](http://www.osisa.org/sites/default/files/disability_open_learning_-_overview_final.pdf) [accessed 30 May 2016]

<sup>124</sup> UNAIDS and others, Disability and HIV Policy Brief, [http://www.who.int/disabilities/jc1632\\_policy\\_brief\\_disability\\_en.pdf](http://www.who.int/disabilities/jc1632_policy_brief_disability_en.pdf) [accessed 30 May 2016]

<sup>125</sup> IRIN, Heightened HIV Risk for People with Disabilities, 29 July 2014, <http://www.irinnews.org/report/100414/heightened-hiv-risk-people-disabilities> [accessed 30 May 2016]

<sup>126</sup> Ibid., Disability and HIV Policy Brief

<sup>127</sup> WHO/UNFPA, Promoting sexual and reproductive health for people with disabilities, 2009, [https://www.unfpa.org/sites/default/files/pub-pdf/srh\\_for\\_disabilities.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/srh_for_disabilities.pdf) [accessed 30 May 2016]

<sup>128</sup> Human Rights Watch, We are also dying of AIDS: Barriers to HIV services and treatment for persons with disabilities in Zambia, 15 July 2014, <https://www.hrw.org/news/2014/07/15/zambia-people-disabilities-left-behind-hiv-response> [accessed 30 May 2016]

<sup>129</sup> Grut, L and others, Access to Tuberculosis Services for Individuals with Disability in Rural Malawi, PLOS One 2015 10(4), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4382312/>

<sup>130</sup> UNAIDS. Getting to Zero: HIV in Eastern and Southern Africa. (2013).

<sup>131</sup> UNAIDS. The Gap Report. (2015).

<sup>132</sup> Dahoma et al., (2006) HIV and Substance Abuse: The Dual Epidemic Challenging Zanzibar, African Journal of Drug & Alcohol Studies, 5(2).

<sup>133</sup> UNAIDS. Getting to Zero: HIV in Eastern and Southern Africa. (2013).

<sup>134</sup> GCHL. Report of the Africa Regional Dialogue on HIV and the Law. (2011).

<sup>135</sup> Bibi et al (draft). Injection Drug Use in the Seychelles Integrated Biological and Behavioural Surveillance Study (2011) cited in Seychelles National AIDS Commission, UNDP and Ministry of Justice. Situation Analysis of Legal and Regulatory Aspects of HIV and AIDS in Seychelles. (2013).

<sup>136</sup> Seychelles National AIDS Commission, UNDP and Ministry of Justice. Situation Analysis of Legal and Regulatory Aspects of HIV and AIDS in Seychelles. (2013).

<sup>137</sup> UNAIDS. Getting to Zero: HIV in Eastern and Southern Africa. (2013).

<sup>138</sup> GCHL. Report of the Africa Regional Dialogue on HIV and the Law. (2011).

<sup>139</sup> PILS. “Evidence Base to Promote Drug Policy Reform in Mauritius”. Presentation to ARASA Annual Partnership Forum. (April 2015).

<sup>140</sup> GCHL. Report of the Africa Regional Dialogue on HIV and the Law. (2011).

<sup>141</sup> This relates to services provided by the public services and does not include services provided by NGOs. Global State of Harm Reduction Interactive e-tool. Harm Reduction International. Available at: <https://www.hri.global/sub-saharan-africa-harm-reduction-programmes>. Accessed on 1 July 2016

<sup>142</sup> INSERT REFS.

<sup>143</sup> UNAIDS, The Gap Report, [http://www.unaids.org/sites/default/files/media\\_asset/UNAIDS\\_Gap\\_report\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf) [accessed 30 May 2016]

<sup>144</sup> Ibid.

<sup>145</sup> Human Rights Watch, Prison Conditions Endanger Inmates, 27 April 2010, <https://www.hrw.org/news/2010/04/27/zambia-prison-conditions-endanger-inmates> [accessed 30 May 2016]

<sup>146</sup> World Prison Brief, Angola country page, <http://www.prisonstudies.org/country/angola> [accessed 12 April 2016]

<sup>147</sup> Ibid.

<sup>148</sup> The information in this table was compiled from the most recent NCPI reports.

<sup>149</sup> See submission by PRISCCA, Zambia, Africa Regional Dialogue on HIV and the Law , 4 August 2011

<sup>150</sup> Ibid., Global AIDS Response Progress Report, 2015

<sup>151</sup> Ibid., US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015: South Africa

<sup>152</sup> Ibid., Legal Environment Assessment of HIV and AIDS

<sup>153</sup> Department of State, Bureau of Democracy, Human Rights and Labour, Uganda



<sup>154</sup> Attorney General and others v Tapela and others Court of Appeal Civil Case No CACGB-096-14; High Court Case No. UAHGB-000066-15

<sup>155</sup> Global Commission on HIV and the Law. 2011. August 3 – 4. Pretoria, South Africa; GCHL Risks, Rights & Health at 134.

<sup>156</sup> US 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]

<sup>157</sup> Global State of Harm Reduction Interactive e-tool. Harm Reduction International. Available at: <https://www.hri.global/sub-saharan-africa-harm-reduction-programmes>. Accessed on 1 July 2016

<sup>158</sup> Submission by Prisons Care and Counselling Association, Zambia, Africa Regional Dialogue on HIV and the Law, 4 August 2011

<sup>159</sup> JOHNSTONE-ROBERTSON, Simon et al. Tuberculosis in a South African prison - a transmission modelling analysis. South African Medical Journal, [S.l.], v. 101, n. 11, p. 809-813, Nov. 2011. ISSN 2078-5135. Available at: <http://www.samj.org.za/index.php/samj/article/view/5043/3672>. Date accessed: 01 Jul. 2016. doi:10.7196/SAMJ.5043.

<sup>160</sup> UNAIDS (2014) The Gap Report.

<sup>161</sup> Ibid.

<sup>162</sup> SADC (2012) Pharmaceutical Patents, TRIPS Flexibilities and Access to Medicines in SADC

<sup>163</sup> G Brigden and K Athersuch, Medecins Sans Frontieres (2016) Submission to the High Level Panel on Access to Medicines

<sup>164</sup> UNAIDS (2015) HIV Treatment in Africa: A Looming Crisis: Issue Brief.

<sup>165</sup> GCHL (2011) Intellectual Property Rights and Access to Medicines: Regional Issue Brief

<sup>166</sup> African Union Model Law on Medical Products Regulation ([http://www.hst.org.za/sites/default/files/Model%20law%20Medical%20Products%20Regulation\\_English%20Version.pdf](http://www.hst.org.za/sites/default/files/Model%20law%20Medical%20Products%20Regulation_English%20Version.pdf)) . Accessed on 5th July 2016

<sup>167</sup> 44th Ordinary Session, 2008, Resolution 141 on Access to Health and Needed Medicines in Africa (<http://www.achpr.org/sessions/44th/resolutions/141/>). Accessed on 5th July 2016

<sup>168</sup> SADC (2012) Pharmaceutical Patents, TRIPS Flexibilities and Access to Medicines in SADC

<sup>169</sup> Treatment Action Campaign, Fix the Patent Laws campaign( <http://www.fixthepatentlaws.org/?p=69>). Accessed on 5th July 2016

<sup>170</sup> GCHL (2011) Intellectual Property Rights and Access to Medicines: Regional Issue Brief; SADC (2012) Pharmaceutical Patents, TRIPS Flexibilities and Access to Medicines in SADC

<sup>171</sup> N Sekokotoana, Attorney-General’s Chambers: Office of Parliamentary Counsel: Ministry of Law, Lesotho. (2016) Submission to High Level Panel on Access to Medicines

<sup>172</sup> GCHL (2012) Risks, Rights & Health. See also M Low, Treatment Action Campaign (2016) Submission to High Level Panel on Access to Medicines, Johannesburg; G Brigden and K Athersuch, Medecins Sans Frontieres (2016) Submission to High Level Panel on Access to Medicines, Johannesburg.


<sup>173</sup> GCHL (2012) Risks, Rights & Health.

<sup>174</sup> GFATM (2011) Global Fund Information Note: TB and Human Rights

<sup>175</sup> ARASA, Close the Gap: TB and Human Rights

<sup>176</sup> Ibid., ARASA, Close the Gap





## SECTION 4 ACCESS TO JUSTICE AND CHALLENGES IN IMPLEMENTING THE PROTECTIVE LEGAL FRAMEWORK



The 2014 ARASA HIV and Human Rights Report recommended that countries strengthen their efforts to advance access to justice for people living with HIV and prioritise the justice needs of key populations. The report recommended:

- Developing stigma and discrimination reduction programmes to reduce human rights abuses against people living with HIV and key populations
- Expanding access to information and education about rights and how to enforce them
- Increasing access to legal support services
- Educating key stakeholders such as health care workers, law enforcement officials and other service providers on the human rights of people living with HIV and key populations.

Some gains have been made in implementing the recommendations and there is increasing recognition, including by donors, that programmes to improve access to justice can have a positive impact on public health, and especially the health of marginalised and vulnerable populations. The country snapshots however indicate that lack of implementation of protective laws and lack of access to justice for abuses remain key challenges for people living with HIV, women and key populations. Information obtained from the Stigma Index reports from several countries shows relatively low levels of legal literacy, very few people living with HIV being willing or able to seek redress for abuses or having adequate knowledge about where to seek help.

4.1 LAW ENFORCEMENT



Civil courts do not provide consistent access to justice for people living with HIV, women and key populations and too few people are able to effectively use them to seek redress for rights violations. Courts in many SEA countries are physically inaccessible, especially to people living in rural areas, and infrastructure is often dilapidated and poorly maintained. Some are characterized by corruption and inefficiency and there are long delays in finalizing cases. Many courts have significant backlogs. There is also a critical lack of well trained and qualified legal and administrative personnel as illustrated in the albeit slightly dated (2011) table below.

Table 13: Lawyers in ARASA partner countries

COUNTRIES	POPULATION (MILLIONS)	POPULATION LIVING IN RURAL AREAS (%)	NUMBER OF LAWYERS
Angola	18	43	570
Botswana	2	40	465
Comoros	No data	No data	No data
DRC	64	66	6 000
Kenya	39	78	3 817
Lesotho	2	73	506
Madagascar	20	71	No data
Malawi	15	81	300
Mauritius	No data	No data	No data
Mozambique	22	63	779
Namibia	2	63	400
Seychelles	No data	No data	No data
South Africa	49	39	20 059
Tanzania	42	75	1 135
Uganda	32	87	2 000
Zambia	13	65	650
Zimbabwe	12	63	1 200

The 2014 ARASA HIV and Human Rights report identified the lack of legal aid as a key barrier to access to justice and Stigma Index reports show that the costs of legal advice and representation are prohibitive: in Uganda, 19.4% of respondents who had experienced a rights violation did not take action because of costs; nearly 10% of respondents from Kenya cited a similar concern. There does not appear to have been a significant increase in the provision of legal aid specifically to people living with HIV and TB and key populations and legal aid schemes in Africa generally focus on representation in criminal trials. Most ARASA partner countries do have some form of state funded legal aid, with only the Comoros and Swaziland not providing any free legal assistance. Kenya and Mozambique are working to establish legal aid services. Kenya adopted a Legal Aid Act in 2015, which was signed into law in 2016.

Legal aid services are significantly under-funded and frequently inadequate to meet the massive demand for services: the Legal Aid Bureau in Malawi does not have sufficient human, technical and financial resources and its services are not available in all areas; although the Legal Aid Act in Namibia establishes free legal aid for both civil and criminal cases, the majority of support is provided in criminal matters and it appears that legal aid does not play a significant role in civil cases where cases of HIV-related discrimination are more likely to be argued.

South Africa has established specialist courts to hear sexual offences cases and violations of the constitutional right to equality and non-discrimination. The Equality Courts are intended to provide access to justice to marginalized communities and are designed to be more accessible than other courts. The procedure has been simplified to avoid the need for legal representation and could potentially provide a useful mechanism for access to justice from complaints related to HIV and TB and for key populations. Unfortunately, the courts are under-utilised.

Strategic litigation is an important component of legal strategies to make access to health care available, including ART, for people living with HIV and more recently, key populations in Africa and to challenge discrimination. High impact litigation has been undertaken in ARASA partner countries on the forced and coercive sterilization of women living with HIV (Kenya, Lesotho and Namibia) and to protect the rights to freedom of assembly and association for LGBTI people (Botswana).

Strategic litigation is an important component of legal strategies to make access to health care available, including ART, for people living with HIV and more recently, key populations in Africa and to challenge discrimination. High impact litigation has been undertaken in ARASA partner countries on the forced and coercive sterilization of women living with HIV (Kenya, Lesotho and Namibia) and to protect the rights to freedom of assembly and association for LGBTI people (Botswana) . KELIN (Kenya) was also recently successful in challenging the practice of confining TB patients in prisons for purposes of treatment as being unlawful and unconstitutional.

This type of litigation is however extremely expensive and time-consuming and many major donors are reluctant to fund it.

Some SEA countries have established NHRIs which could serve as an additional or alternative mechanism for access to justice, including for abuses related to HIV and TB. These institutions could play a critical role in protecting and promoting human rights in the context of HIV and TB. It is unclear the extent to which these institutions are willing or able to investigate and/or adjudicate on HIV and TB-related abuses. The country snapshots indicate that many of these institutions are plagued by a lack of funding and human resources, are not always independent of government and ineffective.

Table 14: Access to justice: courts and other human rights institutions

COUNTRY	FREE LEGAL AID	INDEPENDENT NATIONAL HUMAN RIGHTS INSTITUTION
Angola	It appears legal aid is available in criminal cases	Several state institutions focus on human rights but no independent national human rights institution
Botswana	Yes	Ombudsman
Comoros	No	National Commission on Human Rights and Freedoms
DRC	Limited access to pro bono lawyers	National Commission on Human Rights (unclear whether it is functioning)
Kenya	Legal Aid Act, 2016 establishes a legal aid service for civil, criminal, constitutional and matters of public interest	
	National Commission for Human Rights	
Lesotho	Yes	No
Madagascar	Yes	Commission Nationale des Droits de l'Homme de Madagascar

COUNTRY	FREE LEGAL AID	INDEPENDENT NATIONAL HUMAN RIGHTS INSTITUTION
Malawi	Yes	Human Rights Commission
Mauritius	Yes	National Human Rights Commission
Mozambique	National Bar Association plans to expand services to indigent people	
Legal aid is available for criminal trials, but there are insufficient numbers of public defenders	National Human Rights Commission of Mozambique	
Namibia	Yes	Ombudsperson
Seychelles	Yes	National Human Rights Commission
Ombudsman		
South Africa	Yes	South African Human Rights Commission
Commission for Gender Equality		
Swaziland	No	Commission on Human Rights and Public Administration
Tanzania	Yes	Commission for Human Rights and Good Governance
Uganda	Yes	Uganda Human Rights Commission
Zambia	Yes	Human Rights Commission
Zimbabwe	Yes	Human Rights Commission

In 2014, KELIN, UNAIDS, UNDP and the Kenya National Commission on Human Rights (KNCHR) organized a seminar for African NHRIs on HIV, Human Rights and the Law. The seminar was an opportunity for experience sharing between members of the National Human Rights Institutions from 11 countries across SEA on the legal and human rights issues raised by the HIV epidemic in Africa.

Kenya remains the only ARASA partner country to have established an HIV-specific tribunal. 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.

**Assessment of the Kenya HIV and AIDS Tribunals**

A 2014 assessment of the work of the tribunal was cautiously optimistic about the functioning of the tribunal. It suggests that while the tribunal got off to a slow start, it is now a relatively effective mechanism for the protection of the rights of people living with HIV. By the end of December 2014, the tribunal had handled 300 complaints, most dealing with employment related issues. The tribunal also receives complaints related to discrimination in access to HIV-related services and gender-based complaints such as domestic violence and property grabbing. The complaints are overwhelmingly submitted by people living with HIV. The tribunal still faces challenges in effectiveness, including a lack of awareness about its existence and personnel and financial limitations. It continues to be an under-utilised justice mechanism.


ACCESS TO JUSTICE FOR KEY AND VULNERABLE POPULATIONS



Women experience difficulties in accessing justice for gender based violence in every ARASA partner country. There is significant under-reporting of rape and domestic violence and police fail to adequately investigate complaints. Despite the increase in the number of ARASA partner countries who have adopted laws criminalising domestic violence and who have established specialized services in police stations for women and children (e.g. Lesotho, South Africa, Tanzania) many women are unable to access protection orders or have perpetrators arrested. Given the links between gender based violence and HIV, these concerns are acute for women living with HIV.

Women experience difficulties in accessing justice for gender based violence in every ARASA partner country. There is significant under-reporting of rape and domestic violence and police fail to adequately investigate complaints.

Gay men who have sex with men, sex workers and injecting drug users also face additional barriers to justice because of criminal laws that push them away from health and justice services and increase their vulnerability to abuse and HIV infection. They are often abused by the very institutions that should protect them from violence and discrimination and investigate and prosecute their complaints.



The Namibia Legal Environment Assessment indicates that the Namibian Police fail to take complaints by and against LGBTI populations seriously and key populations faced many barriers to reporting crimes against them to the police, including corruption and harassment. Transgender people in Namibia face ridicule, sexual assault and rape and are not assisted by the police when reporting violations, despite their risk of HIV exposure. HRW reported in Kenya that criminalisation of same sex conduct made LGBT people extremely vulnerable to violence at the hands of ordinary citizens as well as police and other law enforcement officials.

Sex workers are particularly vulnerable to sexual violence at the hands of clients, law enforcement officials and partners. In the DRC, although sex work is not specifically criminalised, sex workers are highly stigmatized and experience physical and sexual assault perpetrated by the police and security forces. Stigma 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. Sex workers in Mauritius note being unable to report violations of their rights because of a general perception that due to the criminalised nature of their work they are not deserving of protection. It was reported in the South Africa parliament that there have been 16 assaults cases brought by sex workers against members of the police services between 2012 and 2015.

4.2 KNOW YOUR RIGHTS

The Stigma Index reports illustrate that many people living with HIV do not have access to adequate information about their rights or know about the laws and policies that protect them: in Uganda, only 41% were aware of the national HIV and AIDS policy; in Swaziland, nearly 60% of the respondents had not heard about the Act on HIV and AIDS , while in South Africa, less than a quarter of the respondents were aware of the AIDS Charter of Rights and Responsibilities. In Kenya, 44% of respondents in Kenya had heard of the HIV/AIDS Prevention and Control Act. Some countries appear to be making progress: in Malawi, 76% of respondents had heard of the national HIV and AIDS policy

Key populations in particular still struggle to access information about their rights and how to ensure that they are realised. Some ARASA partner countries are developing national awareness programmes for selected key populations: in 2015, the National Association of Angolan Disabled People started a national awareness raising programme on HIV, TB and STIs; the Tanzanian Ministry of Community Development, Gender and Children in partnership with civil society, initiated a campaign, the “Child Marriage-Free Zone” to end child marriage.

**RECOMMENDATIONS**

**Civil society should:**

- Advocate to expand access to legal services for people living with HIV and/or TB and key populations;
- Provide access to information about available legal services and how to access them;
- Train national NHRIs to protect and promote the human rights of people living with HIV and TB and key populations
- Conduct public awareness campaigns on human rights to include HIV and TB-related human rights concerns and undertake targeted campaigns to inform key populations about their human rights.

**Governments should:**

- Increase funding for legal aid services and expand access to available services
- Increase targeted legal support services for people living with HIV and TB and key populations and ensure that lawyers and paralegals have been appropriately trained to offer legal advice and representation to these groups



# END NOTES

- <sup>178</sup> Laura Goodwin and another, *What do we know about legal empowerment? Mapping the Evidence*, May 2014, <https://namati.org/wp-content/uploads/2014/05/Evidence-Review2.pdf> [accessed 6 June 2016]
- <sup>179</sup> UNDOC, *Access to Legal Aid in Criminal Justice Systems in Africa, Survey Report*, 2011, [https://www.unodc.org/pdf/criminal\\_justice/Survey\\_Report\\_on\\_Access\\_to\\_Legal\\_Aid\\_in\\_Africa.pdf](https://www.unodc.org/pdf/criminal_justice/Survey_Report_on_Access_to_Legal_Aid_in_Africa.pdf) [accessed 9 June 2016]
- <sup>180</sup> Uganda, *The People Living with HIV Stigma Index*, August 2013, <http://www.stigmaindex.org/sites/default/files/reports/Uganda%20People%20Living%20with%20HIV%20Stigma%20Index%20Report%2013%20-%20Final.pdf> [accessed 9 June 2016]
- <sup>181</sup> Kenya, *The People Living with HIV Stigma Index*, November 2011, <http://www.stigmaindex.org/sites/default/files/reports/Kenya%20People%20Living%20with%20HIV%20Stigma%20Index%20Report%202009.pdf> [accessed 9 June 2016]
- <sup>182</sup> Republic of Kenya, *The Legal Aid Bill 2015*, <http://www.jfjustice.net/downloads/1461658658.pdf> [accessed 9 June 2016]
- <sup>183</sup> Ibid., UNDOC, *Access to Legal Aid in Criminal Justice Systems in Africa, Survey Report*,
- <sup>184</sup> UN CEDAW Committee, *Concluding Observations on the seventh periodic report on Malawi*, 24 November 2015, [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/MWI/CO/7&Lang=En](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/MWI/CO/7&Lang=En) [accessed on 15 May 2015]
- <sup>185</sup> Open Society Foundations, *The Donor Landscape for Access to Justice and Health*, June 2014,
- <sup>186</sup> Government of the Republic of Namibia v L.M. and Others, [2014] NASC 19. Available at <https://www.escc-net.org/caselaw/2015/government-republic-namibia-v-lm-and-others-2014-nasc-19>. Accessed on 1 July 2016
- <sup>187</sup> AG Botswana v T Ramogge and others (Court of Appeal Civil Appeal No CACGB-128-14. Available at <http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2016/03/LEGBIBO-CoA-judgment.pdf>. Accessed on 1 July 2016
- <sup>188</sup> Daniel Ng'etich & 2 Others v. Attorney General & 3 Others, Petition No. 329 of 2014 [2016] eKLR. Available at <https://www.escc-net.org/caselaw/2016/daniel-ngetich-2-others-v-attorney-general-3-others-petition-no-329-2014-2016-eklr>. Accessed on 1 July 2016.
- <sup>189</sup> Open Society Foundations, *The Donor Landscape for Access to Justice and Health*, June 2014,
- <sup>190</sup> UNAIDS and another, *Handbook on HIV and Human Rights for National Human Rights Institutions*, 2007, [http://www.ohchr.org/Documents/Publications/HandbookHIV\\_NHRIsAug2007.pdf](http://www.ohchr.org/Documents/Publications/HandbookHIV_NHRIsAug2007.pdf) [accessed 9 June 2016]
- <sup>191</sup> KELIN and others, *Seminar for African National Human Rights Institutions on HIV, Human Rights and the Law*, November 2014, <http://kelinkkenya.org/wp-content/uploads/2010/10/Report-for-the-Seminar-for-African-National-Human-Rights-Institutions-on-HIV-Human-Rights-and-the-Law-NHRI.pdf> [accessed 9 June 2016]
- <sup>192</sup> Patrick Eba, *The HIV and AIDS Tribunal of Kenya: An effective mechanism for the enforcement of HIV-related human rights?* February 2016, HHR Journal <http://www.hhrjournal.org/2016/02/the-hiv-and-aids-tribunal-of-kenya-an-effective-mechanism-for-the-enforcement-of-hiv-related-human-rights/> [accessed 25 April 2016]
- <sup>193</sup> Kenya Ministry of Health, *Kenya AIDS Strategic Framework 2015/15 – 2018/19*
- <sup>194</sup> Ibid., Uganda, *The People Living with HIV Stigma Index*
- <sup>195</sup> Swaziland, *Stigma Index Report*, 2011, <http://www.stigmaindex.org/sites/default/files/reports/Swaziland%20People%20Living%20with%20HIV%20Stigma%20Index%20Report%20pdf.pdf> [accessed 9 June 2016]
- <sup>196</sup> South Africa, *The People Living with HIV Stigma Index Report*, 2012, <http://www.stigmaindex.org/sites/default/files/reports/South%20Africa%20People%20Living%20with%20HIV%20Stigma%20Index%20%20Report%202012.pdf> [accessed 9 June 2016]
- <sup>197</sup> Ibid., Kenya, *The People Living with HIV Stigma Index*
- <sup>198</sup> Malawi, *The People Living with HIV Stigma Index*, March 2012, [http://www.stigmaindex.org/sites/default/files/reports/Malawi\\_LowRes\\_ForWeb.pdf](http://www.stigmaindex.org/sites/default/files/reports/Malawi_LowRes_ForWeb.pdf)

## SECTION 5 COUNTRY SNAPSHOTS



<u>ANGOLA</u>	71
<u>BOTSWANA</u>	77
<u>COMOROS</u>	85
<u>DEMOCRATIC REPUBLIC OF CONGO</u>	91
<u>KENYA</u>	99
<u>LESOTHO</u>	107
<u>MADAGASCAR</u>	116
<u>MALAWI</u>	124
<u>MAURITIUS</u>	135
<u>MOZAMBIQUE</u>	143
<u>NAMIBIA</u>	151
<u>SEYCHELLES</u>	159
<u>SOUTH AFRICA</u>	167
<u>SWAZILAND</u>	175
<u>TANZANIA</u>	183
<u>UGANDA</u>	191
<u>ZAMBIA</u>	201
<u>ZIMBABWE</u>	211



# ANGOLA

## BACKGROUND

Angola has a smaller HIV epidemic than other Southern African countries. The 2014 HIV Country Progress Report to UNAIDS shows a prevalence rate amongst adults (aged 15 – 49 years) of 2.38% , but various donors, including PEPFAR, have expressed concerns about the lack of reliable HIV data, including amongst key populations. Angola is one of the few countries where the rate of new HIV infections has risen in the past decade.

Approximately 300 000 people are living with HIV, the majority of whom are women (160 000). HIV is primarily a heterosexual epidemic in Angola and the 4th National Strategic Plan (Pen IV) estimates that 86% of transmission is through heterosexual sex. The 2014 HIV Country Progress Report does reference transmission between gay men and men who have sex with men and through sex work and indicates that HIV prevalence amongst these populations is 8.2% and 7.2% respectively, significantly higher than the general population. These figures are however based on small surveys. The 2014 UNAIDS Angola HIV Epidemic Profile indicated that 8.7% of mineworkers were living with HIV, but this figure was extracted from a 2001 survey.

Angola has made some progress in initiating treatment for people living with HIV and HIV testing has doubled between 2011 and 2013. There is still an urgent need to scale up access, especially for children. The 2014 HIV Epidemic Profile indicates that adult treatment coverage increased from 16% in 2010 to 27% in 2013, while for children, it increased from 8% to 14%.



Angola was among the 22 priority countries identified by the UNAIDS 2009 Global Plan for the elimination of HIV infections amongst children and reducing deaths of mothers by 2015. In 2014, the government issued an Accelerated Response Strategy to speed up progress towards meeting the 2015 MDGs. Angola however only achieved a 25% decline in HIV amongst children. Despite a policy of providing treatment to pregnant women, only about half the number of women who need eMTCT services are receiving them: of the estimated 1,181,156 pregnant women in 2013, 41.6% were tested for HIV, and of those 11,372 pregnant women with HIV, 52% started treatment.

**TB is a major public health issue in Angola and Angola is classified by the World Health Organisation as a HBC for TB, HIV and multi-drug resistant TB (MDR-TB).**

TB is a major public health issue in Angola and Angola is classified by the WHO as a high burden country (HBC) for TB, HIV and multi-drug resistant TB (MDR-TB). 120 000 people are living with TB and HIV and 50% of TB patients know their HIV status. The number of deaths related to TB have increased over the last eight years, with 780 people dying in 2004 and 1380 in 2012.

The National Health Development Plan 2012 – 2025 sets out the government's plan to provide access to basic health care to all Angolans. The PEN IV focuses on increasing treatment coverage for pregnant women to 90%, for adults to 45% for adults and for children 80% by 2018.

## KEY HUMAN RIGHTS CONCERNS FOR 2016

- HIV-related stigma and discrimination
- Human rights abuses against key populations
- Gender based violence and gender inequality
- Access to treatment





CONSTITUTION

The Constitution of the Republic of Angola is the overarching law and includes provisions protecting human rights and dignity. Article 23 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. Health status is not specifically mentioned as a prohibited ground of discrimination, but people living with HIV and TB are entitled to the protections contained in the Constitution. The Constitution also provides for equality 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.

The Constitution explicitly protects children’s rights, including the right to non-discrimination against children with disabilities.

RATIFICATION OF INTERNATIONAL AND REGIONAL TREATIES

Angola signed and ratified the Convention on the Rights of People with Disabilities in 2014.

Angola has ratified:

- African Charter on Human and Peoples’ Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1992
- International Convention on Civil and Political Rights (ICCPR), 1966
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003

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 one of the earliest HIV-specific laws in Southern Africa, Law 8/04 on HIV and AIDS. 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. The 2004 law is however a mixed bag, providing some strong protections for people living with HIV from HIV-related discrimination, workplace protection for employees as well as laws protecting women from sexual violence, but it also contains some problematic provisions (set out below).

Sexual offences laws criminalise various forms of sexual violence. Marital rape is criminalised in the Penal Code . In 2011 a domestic violence law (Law 25 Against Domestic Violence) was enacted. The law defines domestic violence as 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 provides support services for people whose rights are violated, including psychological, social, medical and legal support.

Article 24 of the Family Code sets the minimum age of marriage at 18 years for boys and girls.

ACCESS TO JUSTICE AND LAW ENFORCEMENT

Access to justice for all human rights abuses is a challenge for Angolans and the justice system is often characterised by corruption and inefficiency. The justice system suffers from poor infrastructure and a lack of adequately trained and qualified personnel and cases take a long time to finalise.

There are several national institutions to protect human rights: the Parliamentary Commission on Human Rights, Petitions, Complaints and Citizens’ Suggestions consists of 22 members of Parliament and is mandated to accept complaints from members of the public about human rights abuses. The State Secretariat for Human Rights was established in 2010 to promote human rights. There is also a Justice Ombudsman with a human rights mandate. Human rights activists have raised concerns about the functioning of these institutions, especially their lack of independence and a lack of will to address human rights violations. Both the CEDAW Committee and the African Commission on Human and Peoples’ Rights recommended the creation of more independent human rights institutions.

In 2015, the National Association of Angolan Disabled People started a national awareness raising programme on HIV, TB and STIs. The programme is supported by the National Institute for the Fight against AIDS and aims to assist people with disabilities to reduce their risk of contracting HIV, STIs and TB.

GAPS AND CHALLENGES

PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

The Constitution does not address discrimination on the grounds of sexual orientation and gender identity and marriage is narrowly defined as occurring between men and women.



Law No 8/04 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. Section 15 makes the intentional as well as the negligent transmission of HIV a crime punishable in terms s353 and 368 of the Penal Code. It does not deal with the rights of key populations such as sex workers and gay men and men who have sex with men, amongst others. It does not provide for social assistance for those affected by HIV.

Same sex sexual conduct for men and women is criminalised in Angola. Other punitive provisions in the Penal Code (1886) and Draft Penal Code (2011) include the criminalisation of aspects of sex work, such as procuring and living off the earnings of sex work and prohibiting public acts of indecency, as well as highly punitive laws for people who inject drugs.

The law does not explicitly criminalise marital rape or prohibit sexual harassment. The domestic violence law has not been fully implemented as the necessary by-laws have not yet been written. Abortion is criminalised except in cases where the woman’s life is in danger. Polygamy is not explicitly prohibited in Angola. Despite the minimum marriage age, girls may marry “exceptionally” at the age of 15 and boys at 16, with the permission of their parents.

HUMAN RIGHTS CHALLENGES



**Stigma and discrimination** remain major challenges. Despite the 2004 HIV law, Angolans living with HIV face a spectrum of human rights abuses including workplace discrimination and lack of access to health care. Stigma and discrimination prevent Angolans from accessing HIV testing and treatment services. Key populations including gay men and men who have sex with men and sex workers also face stigma and discrimination that impact on their health seeking behaviour. The 2014 HIV Country Progress Report acknowledges the importance of combating stigma and discrimination and recommends a new survey to assess progress in combating stigma and discrimination .



**LGBTI:** The Angolan government is beginning to recognise the importance of including key populations in its national HIV response and has attempted to address stigma and discrimination against LGBTI individuals. The Angolan government has not been implicated in state sponsored homophobia as is the case with many other African countries. A 2011 survey conducted amongst men who have sex with men in Luanda indicated that 38% had been tested for HIV but also highlighted their heightened risk of infection. Study participants reported high levels of homophobic conduct, including being assaulted and verbally abused, and 25% reported being physically coerced into sex. In 2013, UNAIDS appointed an openly trans singer, Titica, as a goodwill ambassador and in 2014, the first openly gay association was formed.



**Women’s rights:** 23% of women report having experienced physical or sexual violence. Migrant women seem to be particularly vulnerable to violence but there is insufficient data on the numbers of cases and how they are investigated. The government does not collect data on victims of domestic violence or on police investigations and prosecutions of domestic violence. There is still an inadequate number of shelters to meet the needs of survivors of domestic violence. In January 2016, the Minister of Family and Women Promotion expressed concern about the large numbers of girls who were married before the age of 17, especially those married to partners who are 10 years or more older. Polygamy remains a concern, especially in rural areas.

**Prison conditions** in Angola continue to raise concerns and were described in the 2014 US State Department human rights report as “harsh and potentially life threatening.” Several prisons suffer from over-crowding, with a 2013 report putting overcrowding at 166%, and can generally only provide some access to medical care, sanitation, food and water. Children in detention are not always separated from adult prisoners. Although there are no statistics about the prevalence of TB in prisons, it is assumed that prisoners are at high risk of TB because of the over-crowding and poor hygiene and sanitation.

RECOMMENDATIONS

Civil society should:

- Advocate for the repeal of provisions criminalising HIV transmission in the HIV law of 2004.
- Advocate for better legal protection for key populations, including the decriminalisation of adult consensual same sex sexual conduct and sex work.
- Advocate for the enforcement of the domestic violence law and for its amendment to explicitly criminalise marital rape.
- Advocate for the enforcement of the minimum age of marriage and for the repeal of laws that permit parents to consent to the marriage of underage girls.
- Advocate for the decriminalisation of abortion.
- Advocate for programmes to strengthen access to justice for people living with HIV and/or TB and key populations.
- Train law enforcement officials, members of the judiciary and law makers on the human rights of people living with HIV and/or TB and key populations.
- Advocate for an anti-discrimination law that protects people living with HIV and/or TB and key populations.

The government should:

- Review the HIV law of 2004 to ensure that it is consistent with international human rights standards and urgently repeal provisions criminalising HIV transmission.
- Repeal all laws that criminalise adult consensual same sex sexual conduct and sex work.
- Enforce the domestic violence law and amend it to explicitly criminalise marital rape.
- Enforce the minimum age of marriage and repeal laws that permit parents to consent to the marriage of underage girls.
- Decriminalise abortion.
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, 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 and the judiciary.

END NOTES

<sup>1</sup> Angola, *Relatorio de Progresso de Reposta Global a SIDA (GARPR 2014)*, [http://www.unaids.org/sites/default/files/country/documents/AGO\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/AGO_narrative_report_2014.pdf) [accessed 7 May 2016]

<sup>2</sup> US Department of State, FY15 *Angola Country Operation Plan*, <http://www.pepfar.gov/documents/organization/250237.pdf> [accessed 10 May 2016]

<sup>3</sup> UNAIDS country data: <http://www.unaids.org/en/regionscountries/countries/angola/> [accessed on 10 April 2016]

<sup>4</sup> Ibid. Angola, *Relatorio de Progresso de Reposta Global a SIDA (GARPR 2014)*

<sup>5</sup> UNAIDS, *Angola HIV Epidemic Profile*, 2014 <http://www.unaidsrtesa.org/wp-content/uploads/2015/05/UNAids-Profile-Angola.pdf> accessed[8 May 2016]

<sup>6</sup> US Department of State, *Angola 2014 Country Operational Plan Executive Summary*, <http://www.pepfar.gov/countries/cop/240032.htm>[ accessed 10 May 2016]

<sup>7</sup> UNAIDS, *2015 Progress Report on the Global Plan towards the elimination of new infections amongst children and keeping their mothers alive*, [http://www.unaids.org/sites/default/files/media\\_asset/JC2774\\_2015ProgressReport\\_GlobalPlan\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf) [accessed 22 May 2016]

<sup>8</sup> Ibid., *Angola HIV Epidemic Profile*

<sup>9</sup> Ibid. US Department of State, *Angola 2014 Country Operational Plan Executive Summary*

<sup>10</sup> WHO, Use of high burden country lists for the post-2015 era, 2015, [http://www.who.int/tb/publications/global\\_report/high\\_tb\\_burden/countrylists2016-2020.pdf?ua=1](http://www.who.int/tb/publications/global_report/high_tb_burden/countrylists2016-2020.pdf?ua=1) [accessed 17 April 2016]

<sup>11</sup> WHO TB 2014 country profiles: <https://extranet.who.int/sree/Reports?op=Replet&loadingNo=3007&retry=true&> [accessed on 12 April 2016]

<sup>12</sup> TBFACTS.ORG, *TB and HIV Co-infection Statistics: Global, regional and Africa*, <http://www.tbfacts.org/tb-hiv-deat> [accessed 22 May 2016]

<sup>13</sup> Ibid., US Department of State, *Angola 2014 Country Operational Plan Executive Summary*

<sup>14</sup> OECD, Social Institutions and Gender Equality Index, Angola page, <http://www.genderindex.org/country/angola> [accessed on 12 April 2016]

<sup>15</sup> UNAIDS, *Angola National Commitments and Policies Instrument (NCPI) Report*, 2012. Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Angola%20NCPI%202012.pdf> [accessed 12 April 2016]

<sup>16</sup> Ibid.

<sup>17</sup> The Observatory for the Protection of Human Rights Defenders, Angola, *They Want to Keep Us Vulnerable*, March 2015, [https://www.fidh.org/IMG/pdf/angola\\_obs\\_eng\\_19\\_mars\\_2015\\_ok.pdf](https://www.fidh.org/IMG/pdf/angola_obs_eng_19_mars_2015_ok.pdf) [accessed 8 May 2016]

<sup>18</sup> Ibid.

<sup>19</sup> AllAfrica, “Vem Comigo” Project on Awareness About HIV/AIDS Danger, 26 March 2015, <http://allafrica.com/stories/201503270138.html> [accessed 8 May 2016]

<sup>20</sup> ARASA, *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, [http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/priorities/20100728\\_HR\\_Poster\\_en.pdf](http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/priorities/20100728_HR_Poster_en.pdf)

<sup>21</sup> Human 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>

<sup>22</sup> See: <http://www.girlsnotbrides.org/wp-content/uploads/2013/06/Minimum-age-of-marriage-in-Africa-June-2013.pdf>

<sup>23</sup> UNAIDS, *Country progress report 2014*, [http://www.unaids.org/sites/default/files/country/documents/AGO\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/AGO_narrative_report_2014.pdf)[accessed on 12 April 2016]

<sup>24</sup> US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2015

<sup>25</sup> Ibid.

<sup>26</sup> UNAIDS, *Country progress report 2014*, [http://www.unaids.org/sites/default/files/country/documents/AGO\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/AGO_narrative_report_2014.pdf)[accessed on 12 April 2016]

<sup>27</sup> Human Rights Committee, Concluding observations on the initial report of Angola, adopted March 2013, available at [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolNo=CCPR/C/AGO/CO/1&Lang=En](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolNo=CCPR/C/AGO/CO/1&Lang=En) [accessed 12 April 2016]

<sup>28</sup> ANGOP, Four of ten children from 12 to 17 years old get married, 22 January 2016, [http://www.portalangop.co.ao/angola/en\\_us/noticias/saude/2016/0/3/Four-out-ten-children-from-years-old-get-married,39f1cd4b-88f4-446a-92b4-04bf867b1edd.html](http://www.portalangop.co.ao/angola/en_us/noticias/saude/2016/0/3/Four-out-ten-children-from-years-old-get-married,39f1cd4b-88f4-446a-92b4-04bf867b1edd.html)[ accessed 12 April 2016]

<sup>29</sup> Committee on the Elimination of All Forms of Discrimination Against Women, Concluding Observations on the sixth periodic report of Angola, 2013, [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolNo=CEDAW/C/AGO/CO/6&Lang=En](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolNo=CEDAW/C/AGO/CO/6&Lang=En) [accessed 8 May 2016]

<sup>30</sup> US Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2015 World Prison Brief, Angola country page, <http://www.prisonstudies.org/country/angola> [accessed 12 April 2016]



# BOTSWANA

## BACKGROUND

According to UNAIDS, in 2014 there were 380 000 adults, that is 25.2 % of adults aged 15 to 49 years living with HIV, with more women affected than men (210 000 women have HIV compared to 170 000 men). There are 16 000 children below the age of 15 living with HIV, and 67 000 orphans.

Around 5 100 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 free ART and eMTCT programmes.

Although the ART program has done well since inception, there are concerns with loss to follow-up rates which have steadily increased among adults. The ART program data indicates that by the end of December 2014, there were 247,947 children and adults on ART, being 63.2% of total people living with HIV, which is lower than 69.9% recorded in 2013. Similarly, the eMTCT programme has done well in Botswana, although concerns have been raised regarding the drop in the percentage of HIV-positive pregnant women who received ART to reduce mother-to-child transmission, from 95.9% in 2013 to 90.8% in 2014.

Botswana has one of the world's highest burdens of TB per capita, with a notification rate of 470 per 100 000 population. There are around 7 900 people living with TB in Botswana; of these, around 61% with active TB are also living with HIV. TB remains the leading cause of death in people living with HIV, and is responsible for 13% of adult deaths and 40% of deaths among people living with HIV. Botswana has made great strides in TB management over the years. Data collection tools for integrated TB and HIV services have recently been revised, piloted and rolled out country wide; this will help improve monitoring and reporting of TB and HIV diagnosis, prevention and treatment.

Botswana has a generalised HIV epidemic which continues to be fuelled primarily by unsafe heterosexual sex with multiple partners, according to the 2014 Global AIDS Response Progress Report. Data collected during the Mapping, Size, Estimation & Behavioural and Biological Surveillance Survey of 2012 showed high HIV prevalence rates amongst key populations - HIV prevalence amongst sex workers was 61.9% and 13.1% amongst gay men and men who have sex with men. Botswana's 2013 Global AIDS Response Report mentions that the Size Estimation and Mapping Study Among Key Populations conducted in 2012 did not identify populations of people who inject drugs of any significance. However, the Ministry of Health did make a commitment to incorporate people who use drugs in the country's next HIV prevalence survey. At the time of developing this report, there was no available data on people who use drugs in Botswana.

Botswana's HIV and TB medicines are largely supported by public funds although international development partners also make a contribution. During the initial years of the HIV pandemic, part of the financing for the response was funded by external partners who included the Global Fund and PEPFAR. However, these external partners have pulled out, leaving a funding gap of \$73 million. This means that the country is effectively self-financing for all pharmaceuticals and reagents. Funding for TB activities was stated as \$17 million for the year 2014, the bulk of which was funded by the Botswana government.

Botswana's National Strategic Framework II (NSF II) for 2010 -2016 was revised in 2014 and extended to 2017. It 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, gay men and men who have sex with men, migrants and mobile populations, people with disabilities, adolescents and young men and women. The National AIDS Council (NAC) includes representation of civil society organisations and there is an HIV ethics, law and human rights office within the NAC.

## KEY HUMAN RIGHTS CONCERNS FOR 2016

- HIV-related stigma and discrimination
- Human rights abuses against key populations
- Gender based violence and gender inequality
- Access to health care for children and adolescents
- Access to ART for non-citizens of Botswana



## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### 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. These sections include protection for key human rights relevant to HIV such as the rights to non-discrimination, privacy, liberty, the rights to freedom of expression and association and the right not to be subjected to cruel, inhuman or degrading treatment or punishment.



## RATIFICATION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

Botswana has ratified many of the key international and regional human rights instruments, such as:

- African Charter on Human and Peoples’ Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- International Covenant on Civil and Political Rights (ICCPR), 1966

## NATIONAL LAWS, POLICIES AND RELATED CASE LAW

There is protection from discrimination in various statutes and within the common law. There is no comprehensive, rights-based HIV law in Botswana.

Since the Industrial Property Act (2010) and the Industrial Property Act Regulations, which came into effect in 2012, the country has domesticated the key TRIPS flexibilities including compulsory licensing, parallel importation, pre- and post-patent application challenges, patent examination and a list of exclusions from patentability. However, there are still inconsistent legal provisions, particularly the complete exclusion of intellectual property rights issues from the competition legislation resulting in the prospect of anti-competitive practices going unchecked in the medical drugs industry and services. Botswana has also legislated an unnecessary TRIPS-plus measure by criminalising patent infringements, which goes against accepted international practice and dissuades innovation and flexible procurement since the fear of criminal law is real in this case. The government is currently exploring ways of using TRIPS flexibilities as a strategy for enhancing access to cheaper medicines, with support from the United Nations Development Program (UNDP) and SARPAM. A 2013 national workshop on TRIPS and Access to Medicines set up a technical working group to look at implementing priority recommendations for increasing access to cheaper medicines through the use of TRIPS flexibilities.

In 2012 the Botswana Government started to explore ways of using TRIPS flexibilities as a strategy for enhancing access to cheaper medicines. With support from the United Nations Development Program (UNDP), the National AIDS Coordinating Agency (NACA) carried out an assessment on domesticating the public health provisions of the TRIPS Agreement. Later, SARPAM was incorporated as a technical partner in the project, and this resulted in the hosting of a national workshop on TRIPS and Access to Medicines from the 25th to the 27th March 2013. A number of recommendations were advanced during the workshop, and a technical working group, chaired by the Ministry of Health, was put in place to implement the recommendations.

The Code of Good Practice: HIV/AIDS and Employment, 2002 (attached to the Trade Disputes Act 15 of 2004) protects the rights of employees with HIV to non-discrimination, confidentiality, HIV testing only with voluntary and informed consent and to protection from unfair dismissals. There is additional protection from discrimination and unfair labour practices in other 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. The Employment Act (Amendment) 10 of 2010 section 23(d) prohibits dismissal based on “the employee’s race, tribe, place of origin, social origin, marital status, gender, sexual orientation, colour, creed, health status or disability”. Section 23 (e) provides more general protection against discrimination by including “any other reason which does not affect the employee’s ability to perform that employee’s duties under the contract of employment”.

These broad constitutional and labour rights have been used successfully by the courts in Botswana to protect people living with HIV from discrimination and from unlawful HIV testing in the workplace.

Children’s rights have been strengthened by the Children Act, 2009. The Act provides for, amongst other things, non-discrimination in the application of the provisions of the Act for children, the child’s right to participate in decisions that have a significant impact on him or her, where he or she is of an age, maturity and level of understanding to do so, protection of a child’s right to the highest attainable standard of health and medical care, protection of a child’s right to privacy, protection against sexual abuse and exploitation, protection against harmful cultural and practices including child marriage, protection against abduction and trafficking and care and support for orphans and vulnerable children. In this Act a child means anyone below the age of 18 years.

Women’s sexual and reproductive health and rights are protected by laws, policies and plans that, amongst other things, promote access to HIV-related prevention, treatment, care and support (including eMTCT services) and broader sexual and reproductive health care, to meet their needs. Access to abortion is available within the first 16 weeks of pregnancy, in terms of the Penal Code, in the event of a pregnancy as a result of rape, defilement or incest, or where there is a risk to the physical or mental health of the woman or the child.

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. A 2012 judgment of the High Court 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.

The Domestic Violence Act 10 of 2008 has also strengthened women’s protection from various forms of intimate partner violence, including physical, sexual, emotional and economic abuse or other forms of harassment and intimidation. However, the Act fails to explicitly criminalise marital rape.

Despite limited protection in Botswanan law, in March 2016 the Botswana Court of Appeal upheld the November 2014 ruling of the Botswana High Court, ruling that the government’s refusal to register LEGABIBO, an organization of LGBTI people, was unconstitutional. The Court of Appeal highlighted the potential role of LGBTI organizations in public health and HIV efforts and ordered the Registrar of Societies to register it. This was the first time a high court in Africa upheld freedom of assembly and association for LGBTI people.

## ACCESS TO JUSTICE AND LAW ENFORCEMENT

There are efforts 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 justice through the courts and the judiciary has extended rights protection to employees with HIV in the workplace in various judgments. However, this has been dependent on individual members of the judiciary and is not necessarily reflective of a coordinated and coherent government response. 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 CSOs.

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. CSOs 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. A recent Stigma Index survey conducted in Botswana found that less than a third of respondents living with HIV knew of an organisation that would help them if they experienced stigma and discrimination. A significant number, 87%, reported that they did not belong to a support group of people living with HIV.

Key populations report specific problems with law enforcement officials and with access to legal support services. For instance, sex workers report being unlawfully arrested and detained for longer periods than required by law on spurious charges. They report being prohibited from speaking, not being questioned and being unable to access legal support services.

Awareness and understanding of human rights and legal literacy is low across all levels of society including service providers who have limited capacity and skills to deal with human rights violations. However, there have been efforts to increase sensitisation of the media, law-makers, the judiciary and law enforcement officers on HIV, law and human rights issues. Efforts have been made to scale up stigma reduction initiatives for sex workers and for gay men and men who have sex with men at health care facilities, through partnerships between civil society organisations and the Ministry of Health.

## GAPS AND CHALLENGES

### PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

Botswana has not ratified the following:



- 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 Covenant on Economic, Social and Cultural Rights (ICESCR).

To date there has been limited HIV-related law review and reform despite ongoing legislative review processes in the country and a comprehensive stand-alone HIV law has not been developed. Major gaps and challenges in the legal and policy framework are the following:

- Botswana has a dual legal system and discriminatory customary laws entrench inequality, increasing women’s vulnerability to HIV. In 2011, submissions to the GCHL noted that the application of customary laws and practices that discriminated against women (such as customary laws of inheritance that only permit men to inherit) placed women at higher risk of HIV exposure. The real-life impact of the Mmusi judgement on improving women’s access to inheritance, at community level, remains to be seen.
- The recently enacted Public Health Act includes punitive provisions that allow for forced and mandatory HIV testing under certain circumstances, non-consensual disclosure of HIV status under certain circumstances, places obligations followed by severe restrictions, including isolation and detention, on a person living with HIV who is believed to have “knowingly or recklessly placed another person at risk of infection” and makes HIV a notifiable disease. The Act has been widely criticized since it has 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.
- There is 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.
- The Penal Code also requires a person convicted of rape to undergo an HIV test before sentencing and a rapist who knows that he has HIV is required to be sentenced to life imprisonment. 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) 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.
- 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.
- Chapter 8 of the Penal Code criminalises a wide range of acts associated with sex work including procurement, living off the earnings of sex work, brothel keeping, solicitation, idle or disorderly public conduct and 'rogue and vagabond' laws.

## HUMAN RIGHTS CHALLENGES



**Stigma and discrimination:** HIV-related stigma and discrimination remain a major constraint to universal access to HIV services for people living with HIV. The People Living with HIV Stigma Index Study of 2014 showed that people living with HIV experienced stigma and discrimination in their communities, workplaces and in the health care environment. Almost 40% of respondents reported being gossiped about, 21% reported verbal insults, abuse or threats and 10% reported physical abuse or threats. People living with HIV also had high levels of internal stigma, with 24% of respondents blaming themselves for their HIV infection.

Over 1 in 10 respondents said they had lost their job or other form of income during the past 12 months due to poor health and discrimination and 8% had been refused employment because of their HIV status. On the positive side, almost all respondents reported receiving access to health care services, voluntary HIV testing and counselling in the health sector and being able to disclose their HIV status to family, partners and health care workers. However, 98% of respondents reported being pressurised to disclose their HIV status. Of concern, 12% of respondents reported receiving advice from health care professionals not to have children, 22% of respondents said access to ART was made dependent on use of certain forms of contraception and 2% of respondents reported coercive sterilisation.

The Stigma Index also found that of those respondents who had experienced stigma or discrimination for reasons other than their HIV status, 44% were migrant workers and 19% were sexual minorities.

A recent study carried out in Botswana showed evidence of stigmatisation of those with drug-resistant TB at community level, but not within health care facilities. Some community members felt that those with drug-resistant TB should be restricted in their movements.



**Gender inequality and gender based violence:** Sexual and GBV is widespread, with a 2012 report indicating that around a third of women surveyed reported experiencing intimate partner violence in the preceding 12 months and over two thirds of women in Botswana have experienced some form of GBV in their lifetime. GBV and harmful practices such as widow cleansing place women at higher risk of exposure to HIV.

A 2014 Gender Assessment Report showed that women experience barriers to health care services including stigma and discrimination, GBV, harmful social norms and lack of access to resources. Law reform efforts and progressive case law have improved women's legal status. However, implementation of some of these reforms is inconsistent and sometimes weak. Also, it remains unclear whether the Domestic Act of 2008 criminalises marital rape.



**Criminalisation of same-sex sexual activity:** Sections 164, 165 and 167 of the Penal Code prohibit "unnatural offences" and "indecent practices." Section 164 on unnatural offences criminalises carnal knowledge against the order of nature. Such acts are punishable with up to seven years of prison. The Botswana Court of Appeal has defined "carnal knowledge against the order of nature" as anal sex and both parties committing such acts can be held criminally liable. Section 165 criminalises attempts to commit the same offences and is punishable with up to five years in prison. Section 167 criminalises "indecent practices between persons" which are defined as "acts of gross indecency" or procuring or attempting to procure another person to engage in "acts of gross indecency" whether they take place in public or private. Botswana Courts have provided little guidance on the application of Section 167. In *Kanane vs The State* 2003, the Court found that "[o]ral sexual stimulation of either a male or a female by either another male or female would no doubt be an example of gross indecency" under Section 167. Although the criminal laws are rarely enforced, the continued criminalisation impacts access to public services including health and police protection, in some cases resulting in denials.



**Criminalisation of sex work:** 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. 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.

**Health Rights of Vulnerable and Key Populations:** There is limited constitutional protection of socio-economic rights, including the right to health, and limited protection for the rights of non-citizens including migrants and refugees in Botswana. Additionally, health laws, policies and plans provide

inadequate protection for the health rights of vulnerable populations (such as women, children and migrants) and key populations at higher risk of HIV exposure such as sex workers, gay men and men who have sex with men, people who inject drugs and prisoners. People who inject drugs are not recognized as a key population in national HIV policies and plans.

**Access to treatment for non-citizens:** The national ART guidelines prescribe access of free ART to citizens only. 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.

**Children and adolescents:** 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. The Childrens Act does not include specific provisions for the health rights of children.

**Prisoners:** Prisoners are not able to access condoms for prevention of HIV transmission as a result of laws criminalising sex between men. In prisons, previously only prisoners who were residents of Botswana were provided with ART, CD4 counts and viral load tests and non-citizen prisoners only had access to HIV tests and peer counselling. However, the *Attorney General v Tapela* judgement of the Court of Appeal in 2015 found that the policy was contrary to the Prisons Act and unlawful, ordering government immediately to provide free testing, assessment and ART to all foreign prisoners to the same extent as citizen prisoners.

## RECOMMENDATIONS

### Civil society should:

- Advocate for laws and policies that are consistent with international human rights standards.
- Advocate for the repeal of laws that discriminate against people living with HIV and/TB and key populations.
- Raise awareness about the human rights of people living with HIV and/or TB and key populations and advocate for programmes to reduce stigma and discrimination.
- Advocate for programmes to strengthen access to justice for people living with HIV and/or TB and key populations.
- Train law enforcement officials on the human rights of people living with HIV and/or TB and key populations.

### The Botswana government should:

- Ratify the ICESCR, the CRPD and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
- Amend the Constitution to secure protection for socio-economic rights such as the right to health and to include an express prohibition on discrimination on the basis of HIV status, sexual orientation and gender identity and nationality.
- Amend the Children Act to include protection for the rights of children in the context of HIV and AIDS.
- Strengthen 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. Ensure the enforcement of existing protective laws and policies.
- Decriminalise consensual adult sex.
- Review and repeal provisions criminalising HIV exposure and/or transmission, such as those set out in the Penal Code and Public Health Act.
- Review and repeal provisions allowing for mandatory HIV testing, disclosure, isolation and detention of people living with HIV.
- Strengthen the legal and policy environment for women's rights in line with the 2014 Gender Assessment Report and strengthen national capacity to respond to gender inequality, harmful gender norms and gender-based violence. Explicitly criminalise marital rape.
- Strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes; 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; sensitisation of health care workers on the sexual and reproductive health and rights of women and other vulnerable and key populations; work with the judiciary and members of other alternative dispute resolution mechanisms as well as law enforcement officials.



# END NOTES

See [www.unaids.org/en/regionscountries/countries/botswana/](http://www.unaids.org/en/regionscountries/countries/botswana/) [Accessed 11 April 2016].

<sup>2</sup> Ibid.

<sup>3</sup> Republic of Botswana, *Progress Report of the National Response to the 2011 Declaration of Commitment on HIV and AIDS*, 2014. Available at [http://www.unaids.org/sites/default/files/country/documents/BWA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/BWA_narrative_report_2015.pdf) (Accessed 10 April 2016); see also <http://www.who.int/tb/country/data/profiles/en/> (Accessed 13 April 2016).

<sup>4</sup> Botswana Tuberculosis Analytical Summary. Available at [http://www.aho.afro.who.int/profiles\\_information/index.php/Botswana:Analytical\\_summary\\_-\\_Tuberculosis](http://www.aho.afro.who.int/profiles_information/index.php/Botswana:Analytical_summary_-_Tuberculosis) [Accessed 6 July 2016]

<sup>5</sup> Republic of Botswana, *Progress Report of the National Response to the 2011 Declaration of Commitment on HIV and AIDS*, 2014. Available at [http://www.unaids.org/sites/default/files/country/documents/BWA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/BWA_narrative_report_2015.pdf) (Accessed 10 April 2016); see also <http://www.who.int/tb/country/data/profiles/en/> (Accessed 13 April 2016).

<sup>6</sup> Ibid.

<sup>7</sup> [http://www.unaids.org/sites/default/files/country/documents/BWA\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/BWA_narrative_report_2014.pdf)

<sup>8</sup> Endeava, Health and Medicines Sector Market Assessment in Botswana, Lesotho, Namibia and South Africa, p19. Online at <http://www.sarpam.net/wp-content/uploads/images+docs/3-the-programme/g-market-innovations/supporting-documents/Health-Medicines-Sector-Market-Assessment.pdf>

Financing Country Profile. Available at [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBFinancingCountryProfile&ISO2=BW&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBFinancingCountryProfile&ISO2=BW&outtype=html) [Accessed 7 July 2016]

<sup>10</sup> UNAIDS, *Botswana Country Progress Report*, 2012

<sup>11</sup> Articles 3 and 15

<sup>12</sup> Article 9

<sup>13</sup> Article 5

<sup>14</sup> Articles 12 and 13

<sup>15</sup> Article 7

<sup>16</sup> Section 7.1.4

<sup>17</sup> <http://www.equinetafrica.org/sites/default/files/uploads/documents/Diss80TRIPSupdate2010.pdf>

<sup>18</sup>

<sup>19</sup> The Implementation of Trade Related Aspects of Intellectual Property Rights (TRIPS) Flexibilities in the National Intellectual Property Legislation for Strengthened Access to Medicines in Botswana (March 2013 Workshop Report). Available at <http://www.bw.undp.org/content/dam/botswana/docs/HIVAIDS/NACA%20MOH%20SARPAM%20UNDP%20Final%20TRIPS%20Workshop%20Report%20for%20printing%20-%2011th%20June%202013-1.pdf>

<sup>20</sup> Section 7(e), Public Service Act, 2008; see also Global Commission on HIV and the Law. Regional Dialogue Submissions (2011). Available at <http://www.hivlawcommission.org/index.php/regional-dialogues-main/africa/africa-regional-dialogue-report/download>. [Accessed 7 July 2016]

<sup>21</sup> Botswana Employment Amendment Act 10 of 2010, section 23 (d) (e)

<sup>22</sup> Section 7

<sup>23</sup> Section 8

<sup>24</sup> Section 15

<sup>25</sup> Section 23

<sup>26</sup> Section 25

<sup>27</sup> Section 62

<sup>28</sup> Part XVI

<sup>29</sup> Part XII and XIII

<sup>30</sup> Global 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. See for example the *Strategy and Programme of Action for Male Involvement in Sexual and Reproductive Health and Rights* 2007-2012

<sup>31</sup> Penal Code Cap 08:01, section 160 (2)

<sup>32</sup> Section 14

<sup>33</sup> Section 7

<sup>34</sup> Edith Mmusi and others v Molefi Ramantele and others, MAHLB 000836-10

<sup>35</sup> Cap 28:05

<sup>36</sup> Section 2 defines domestic violence broadly to include a variety of forms of abuse.

<sup>37</sup> See, for instance, *Diau v Botswana Building Society* (BBS) 2003 (2) BLR 409 (BwIC); *Jimson v Botswana Building Society* (2005) AHRLR 3 (BwIC 2003)

<sup>38</sup> UNAIDS, Botswana NCPI Report, 2012.

<sup>39</sup> Ibid.

<sup>40</sup> US Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Botswana* [accessed on 12 August 2012]

<sup>41</sup> BONEPWA+, NAC, Ministry of Health, UNAIDS and UNDP, *Botswana Stigma Index Survey Report*, 2014.

<sup>42</sup> Global 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

<sup>43</sup> Republic of Botswana, *Progress Report of the National Response to the 2011 Declaration of Commitment on HIV and AIDS*, 2014. Available at [http://www.unaids.org/sites/default/files/country/documents/BWA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/BWA_narrative_report_2015.pdf)

**82** *HIV, TB and Human Rights in Southern and East Africa Report 2016*

rative\_report\_2015.pdf (Accessed 10 April 2016)

<sup>44</sup> Global Commission on HIV and the Law, Regional Dialogue Submissions. Pretoria, 3 – 4 August 2011: Southern African Litigation Centre at p.297

<sup>45</sup> For 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.

<sup>46</sup> Sections 115 to 122 of the Public Health Act

<sup>47</sup> Section 116(1)(a) and (c)

<sup>48</sup> Section 116(9) and (10).

<sup>49</sup> HIV and AIDS are included in the Section 2 definition of a “notifiable disease”.

<sup>50</sup> Section 58(1) of the Public Health Act 2013.

<sup>51</sup> Section 184

<sup>52</sup> Penal Code (Amendment) Act 5 of 1998, s142

<sup>53</sup> AIDS 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

<sup>54</sup> Botswana Penal Code, Cap 08:01, 1964.

<sup>55</sup> Penal Code, s146

<sup>56</sup> Section 155 and 156

<sup>57</sup> Sections 157 and 168

<sup>58</sup> Section 155

<sup>59</sup> Section 179

<sup>60</sup> Section 182

<sup>61</sup> Ibid.

<sup>62</sup> BONEPWA+, NACA, Ministry of Health, UNAIDS and UNDP, *Botswana Stigma Index Study Report*, 2014.

<sup>63</sup> Ibid.

<sup>64</sup> ARASA, *Botswana National Tuberculosis Control Programme: Patient, Nurse and Community Member Experiences* (undated).

<sup>65</sup> Botswana GBV Indicator Study Research Report 2012, cited in Republic of Botswana , *Progress Report of the National Response to the 2011 Declaration of Commitment on HIV and AIDS*, 2014. Available at [http://www.unaids.org/sites/default/files/country/documents/BWA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/BWA_narrative_report_2015.pdf) (Accessed 10 April 2016);

<sup>66</sup> A practice in terms of which a widow must have sex with a male relative of her deceased husband

<sup>67</sup> Gender Assessment Report, 2014 cited in Republic of Botswana *Progress Report of the National Response to the 2011 Declaration of Commitment on HIV and AIDS*, 2014.

<sup>68</sup> Penal code, Chapter 8:01.

<sup>69</sup> Section 164 of the Penal Code

<sup>70</sup> Kanane v. State, 2003, p. 3.

<sup>71</sup> Penal Code, Chapter 8:01 section 164(a) and (c).

<sup>72</sup> Section 165 provides “Any person who attempts to commit any of the offences specified in section

164 is guilty of an offence and is liable to imprisonment for a term not exceeding five years.”

<sup>73</sup> Section 167 as amended provides “Any person who, whether in public or private, commits any act of gross indecency with another person, or procures another person to commit any act of gross indecency with him or her, or attempts to procure the commission of any such act by any person with himself or herself or with another person, whether in public or private, is guilty of an offence.”

<sup>74</sup> Penal Code, section 167.

<sup>75</sup> Kanane v the State 2003 (2) BCLR 67.

<sup>76</sup> Global Commission on HIV and the Law. *Regional Dialogue Submissions*. 2011. August 3 – 4. Botswana: Sisonke Botswana at 276; see also Republic of Botswana, Progress Report of the National Response to the 2011 Declaration of Commitment on HIV and AIDS, 2014. Available at [http://www.unaids.org/sites/default/files/country/documents/BWA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/BWA_narrative_report_2015.pdf) (Accessed 10 April 2016);

<sup>77</sup> Molathegi & 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

<sup>78</sup> UNAIDS, Botswana NCPI Report, 2012 although see the discussion regarding the March 2014 court case, above

<sup>79</sup> Global Commission on HIV and the Law. *Regional Dialogue Submissions*. 2011. August 3 – 4. Pretoria, South Botswana: Sisonke Botswana at 276

<sup>80</sup> GCHL, *Risks, Rights and Health*, 2012 at p. 141

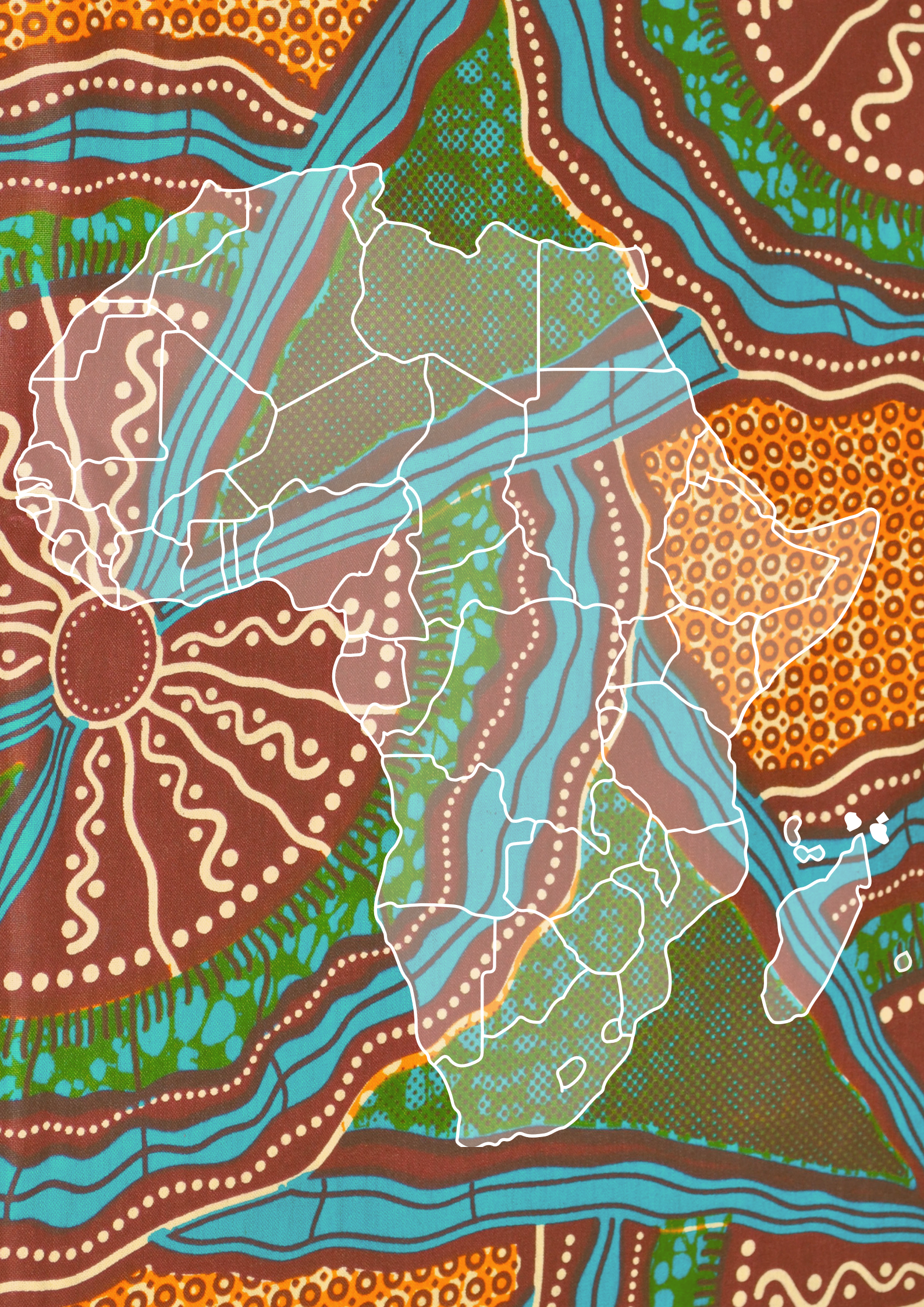
<sup>81</sup> Republic of Botswana, *Progress Report of the National Response to the 2011 Declaration of Commitment on HIV and AIDS*, 2014. Available at [http://www.unaids.org/sites/default/files/country/documents/BWA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/BWA_narrative_report_2015.pdf) (Accessed 10 April 2016)

<sup>82</sup> Global Commission on HIV and the Law. 2011. August 3 – 4. Pretoria, South Africa; GCHL *Risks, Rights & Health* at 134.

<sup>83</sup> US 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]

Attorney General and others v Tapela and others Court of Appeal Civil Case No CACGB-096-14; High Court Case No. UAHGB-000066-15





# COMOROS

## BACKGROUND

According to Comoros' 2015 Country Progress Report to UNAIDS<sup>1</sup>, the country continues to experience a small, low level HIV epidemic (HIV prevalence is 0.025%), with 197 people infected since 1988.



HIV prevalence amongst pregnant women attending ante-natal clinics has decreased since 2010 and eMTCT services are available in many health facilities. Since the introduction of ART in 2006, none of the children born to women living with HIV have been infected. Comoros has developed a strategic plan to eliminate mother to children transmission for 2014 – 2018 and a National HIV Strategic Plan (NSP) for 2015 – 2019.

**According to Comoros' 2015 Country Progress Report to UNAIDS, the country continues to experience a small, low level HIV epidemic (HIV prevalence is 0.025%), with 197 people infected since 1988.**

The NSP includes a focus on gay men and men who have sex with men, sex workers, prisoners and people with disabilities, but not people who use injecting drugs.<sup>2</sup> The 2015 HIV country report flags the lack of consistent data amongst key populations and the need for more research in particular on gay men and men who have sex with men and female sex workers. Although the national AIDS response prioritises prevention for key populations, monitoring surveys amongst sex workers and gay men and men who have sex with men conducted in 2012 did not record any HIV positive cases.<sup>3</sup>

Comoros has low levels of TB. The WHO 2014 country data indicates even people living with HIV are not particularly vulnerable to TB: only one patient with HIV was reported to co-infected with TB in 2014.<sup>4</sup>

## KEY HUMAN RIGHTS CONCERNS FOR 2016



- HIV-related stigma and discrimination
- Gender based violence and gender inequality
- Human rights abuses and lack of legal protection (including criminalisation) for key populations

## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### CONSTITUTION

The Constitution of Comoros, adopted on the 23 of December 2001, provides for “equality for all persons irrespective of sex, origin, race, religion and belief”.<sup>5</sup> The Constitution also provides a framework for the protection of children and health policies;<sup>6</sup> 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.<sup>7</sup>

### RATIFICATION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

Comoros has ratified:

- African Charter on Human and Peoples' Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003



NATIONAL LAWS AND POLICIES

There is no anti-discrimination legislation, but the constitutional protection applies to all people.<sup>8</sup>

Comoros adopted a new HIV-related law which came into force in June 2014. It affirms the right to freedom of movement for people living with HIV and bans restrictions on entry, stay and residence in the Comoros based on HIV status. It guarantees the right to HIV treatment for citizens and non-nationals and provides that people in prison have access to HIV prevention and treatment. Discrimination in employment, specifically dismissal from employment on the grounds of HIV status and mandatory pre-employment HIV testing, is prohibited.<sup>9</sup>

Comoros adopted a new HIV-related law which came into force in June 2014. It affirms the right to freedom of movement for people living with HIV and bans restrictions on entry, stay and residence in the Comoros based on HIV status

A new law adopted in 2014 strengthen protections against and punishment for GBV, including criminalising marital rape.<sup>10</sup> The Family Code, adopted by Parliament in 2006 recognises the central role of women.<sup>11</sup> Inheritance and property rights<sup>12</sup> do not generally discriminate against women and give men and women equal rights. In addition health policies ensure access to HIV prevention, treatment, care and support for women outside of the context of pregnancy and child birth,<sup>13</sup> 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 Comorian Family Code sets that minimum age of marriage at 18.

ACCESS TO JUSTICE AND LAW ENFORCEMENT

Comoros does not provide free legal representation and there is no free legal aid system, including for HIV-related complaints. There are significant delays in finalizing cases and reports of corruption in the justice system.<sup>14</sup>

The 2014 NCPI reports that there were no awareness raising or training programmes for people living with HIV or key populations or members of the justice system during the period under review.<sup>15</sup> It also reports that programmes are in place to reduce HIV-related stigma and discrimination: these target health care workers, the media and the workplace.<sup>16</sup>

Women experience particular challenges in enforcing their rights, although it has been reported that the police are efficient in enforcing laws on rape and domestic violence when reported. The police do not keep accurate data on the number of cases that are reported and many cases do not enter the justice system as families prefer to seek justice through traditional mechanisms or through negotiation.<sup>17</sup>

Legislation, establishing a National Commission on Human Rights and Freedoms, was adopted in 2012.<sup>18</sup> The Commission was officially inaugurated in October 2012 and consists of 15 members. There are no reports that the Commission has considered any human rights issues in relation to HIV.

There is also a General Office for Solidarity and Gender Advocacy that reports to the Vice President. It is responsible for promoting gender equality and combating extreme poverty amongst women. It does not have a national strategy or working programme, so it is not clear how effective it is.<sup>19</sup>

GAPS AND CHALLENGES

PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

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)

The 2014 NCPI report gives the Comoros a low score on its development of policies, laws and regulations to support human rights in relation to HIV.<sup>20</sup> The Constitution does not explicitly prohibit discrimination on the grounds of sexual orientation and gender identity.



Same sex sexual relationships and conduct are criminalised for men and women in the Comoros.<sup>21</sup> Sexual conduct between same sex couples are punishable by imprisonment and/or a fine. Sex work is also criminalised in the Comoros.<sup>22</sup> There is a dearth information about the number of people who use drugs or the number of people living with HIV who use drugs.

Same sex sexual relationships and conduct are criminalised for men and women in the Comoros. Sexual conduct between same sex couples are punishable by imprisonment and/or a fine.



HUMAN RIGHTS CHALLENGES

**Stigma and discrimination:** The 2014 HIV country progress report identified stigma and discrimination as major challenges for gay men and men who have sex with men and people living with HIV.

**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 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.<sup>23</sup>



**Women’s rights:** There are high levels of violence against women in the Comoros and concerns have been expressed at the number of cases that are not reported to the police. There are few shelters for women who need protection. Family law is regulated by civil, Islamic and customary laws and in 2012, the CEDAW committee expressed concerns that this system resulted in discrimination against women in matters related to marriage, divorce, maintenance and child custody. It also expressed concerns about the continued practice of polygamy.<sup>24</sup>

RECOMMENDATIONS

Civil society should:

- Advocate for and implement stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and GBV, legal literacy programmes, improved access to legal support services as well as training for law and policy makers and the judiciary.
- Support efforts to strengthen access to justice for people living with HIV and/or TB and key populations.
- Raise awareness about the human rights of women and children and support efforts to protect them from all forms of violence, including sexual violence.
- Advocate for the decriminalisation of possession of drugs for personal use and use of drugs and for comprehensive harm reduction programmes.

The Comoros government should:

- Decriminalise all consensual adult sex.
- Strengthen legal protections for women and enact laws that promote full equality for women in all areas of life.
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support services, training for law and policy makers and the judiciary.
- Decriminalise the possession of drugs for personal use and use of drugs.
- Strengthen the collection of data on how HIV affects key populations, including men who have sex with men, female sex workers and people who use drugs to inform HIV-related programming for these groups.

# END NOTES

- <sup>1</sup> Union of the Comoros, *National Report on the AIDS Response 2014*, [http://www.unaids.org/sites/default/files/country/documents/COM\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/COM_narrative_report_2015.pdf) [accessed 21 April 2016]
- <sup>2</sup> Union of the Comoros, *National Commitments and Policies Instrument 2014*, <http://www.unaids.org/sites/default/files/country/documents/Comoros%20the%29%20NCPI%202013.pdf> [accessed 10 May 2016]
- <sup>3</sup> Union of the Comoros, *National Report on the AIDS Response 2014*, [http://www.unaids.org/sites/default/files/country/documents/COM\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/COM_narrative_report_2015.pdf) [accessed 21 April 2016]
- <sup>4</sup> WHO, *TB country profiles, Comoros*, [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=KM&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=KM&LAN=EN&outtype=html) [accessed on 21 April 2016]
- <sup>5</sup> HIV, 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)
- <sup>6</sup> HIV, 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)
- <sup>7</sup> HIV, 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)
- <sup>8</sup> Viljoen, 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
- <sup>9</sup> UNAIDS, *New law in Comoros strengthens protection for people living with HIV*, 24 June 2014, <http://www.unaids.org/en/resources/presscentre/pressrelease-andstatementarchive/2014/july/20140724prcomoros> [accessed 21 April 2016]
- <sup>10</sup> US Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2015, Comoros*, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 10 May 2016]
- <sup>11</sup> Union 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](http://www.aidstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Comoros_2008-1012_French.pdf). at 18
- <sup>12</sup> HIV, 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)
- <sup>13</sup> Union of the Comoros, *National Composite Policy Index*. 2010. Available at [http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2010countries/comoros\\_2010\\_ncpi\\_fr.pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2010countries/comoros_2010_ncpi_fr.pdf). at 30
- <sup>14</sup> Ibid., US Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2015, Comoros*
- <sup>15</sup> Ibid., *National Commitments and Policies Instrument 2014*
- <sup>16</sup> Ibid.
- <sup>17</sup> Ibid., US Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2015, Comoros*
- <sup>18</sup> Office of the High Commissioner on Human Rights, <http://nhri.ohchr.org/EN/Contact/NHRIs/Pages/Africa.aspx>
- <sup>19</sup> UN Human Rights Council, *National Report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21, Comoros*, November 2013, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G13/185/29/PDF/G1318529.pdf?OpenElement> [accessed 10 May 2016]
- <sup>21</sup> Article 318 of the Penal Code
- <sup>21</sup> HIV, 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)
- <sup>23</sup> UNICEF: *Country Programme Document*. 2008- 2012. September 2007 [http://www.unicef.org/about/execboard/files/Comoros\\_final\\_approved\\_CPD.pdf](http://www.unicef.org/about/execboard/files/Comoros_final_approved_CPD.pdf). At 3
- <sup>24</sup> CEDAW, *Concluding observation on the initial to fourth periodic reports of Comoros*, October 2012, [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/COM/CO/1-4&Lang=En](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/COM/CO/1-4&Lang=En) [accessed 10 May 2016]



# DEMOCRATIC REPUBLIC OF CONGO

## BACKGROUND

UNAIDS estimates that approximately 450 000 people are living with HIV in the DRC.<sup>1</sup> This equates to a prevalence of 1% amongst adults between the ages of 15 and 49. Young people are at higher risk of HIV, with a prevalence of more than 1% and approximately 3 100 people between the ages of 15 and 24 are living with HIV. This may be suggestive of a growing HIV epidemic amongst this age group.<sup>2</sup>

The DRC has not made sufficient progress scaling up access to ART and in December 2013, only 17.1% of people living with HIV had access to treatment. Women fare better than men, with 20% of women living with HIV able to access treatment, compared to 13.1% of men. Only 7.3% of eligible children have access to treatment.<sup>3</sup>

The DRC is one of the 22 priority countries identified in the 2009 UNAIDS global plan to eliminate HIV infection in children and keep their mothers alive. The 2015 global progress report shows that the DRC has not met the established targets as only 47% of pregnant women with HIV receive ART to reduce the risk of vertical transmission and new infections amongst children have only been reduced by 27%.<sup>4</sup>

Sex workers have been identified as a key group in the National Strategic Plan 2014 – 2017 and the 2014 HIV Country Progress Report to UNAIDS states that HIV prevalence amongst sex workers is 6.9% nationally, with a prevalence of 3.4% amongst sex workers below the age of 25 and 9.6% amongst those older than 25 years. Men who have sex with men are also a key population and a survey of interventions conducted in five provinces shows that 7.7% of gay men and men above the age of 25 who have sex with men, and 22.9% of men below the age of 25 who have sex with men, are living with HIV. This data is however based on small surveys and may not be nationally applicable. People who use drugs are also identified as a key population in the NSP and small scale harm reduction interventions are in place in some states.<sup>5</sup>

**The DRC appears in all three of the WHO HBC lists for countries with a high burden of TB, a high burden of TB and HIV and a high burden of MDR-TB.<sup>7</sup>**

The DRC is considered to be a high burden TB country by the WHO, with approximately 400 000 people living with TB.<sup>6</sup> The DRC appears in all three of the WHO HBC lists for countries with a high burden of TB, a high burden of TB and HIV and a high burden of MDR-TB.<sup>7</sup> 14% of patients with TB are co-infected with HIV and 18% of patients living with HIV and TB are receiving treatment for both diseases.<sup>8</sup> There has been a slight reduction in TB related deaths from 6 700 in 2004 to 6 300 in 2012.<sup>9</sup>

## KEY HUMAN RIGHTS CONCERNS FOR 2016

- Gender inequality and gender based violence, including sexual violence in conflict
- Abuses against children, including child marriage
- HIV-related stigma and discrimination
- Human rights abuses against key populations
- Human rights abuses against internally displaced persons (IDPS) and refugees





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. There is constitutional protection for women’s rights. <sup>9</sup> The constitution does not explicitly prohibit discrimination on the grounds of sexual orientation and gender identity and prohibits same sex marriage.

RATIFICATION OF INTERNATIONAL AND REGIONAL TREATIES

The DRC has ratified:

- African Charter on Human and Peoples’ Rights, 1981
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1976
- International Convention on Civil and Political Rights (ICCPR), 1966
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003
- Convention on the Rights of Persons with Disabilities, 2006

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. It sets out rights of people living with HIV to equality, to marry and have children,<sup>12</sup> to reproductive health care, <sup>13</sup> to non-discrimination on the basis of HIV and AIDS including in public and private health care and to access to education. The HIV law also contains specific protection for the rights of employees with HIV and the rights of prisoners with HIV.<sup>17</sup> Protection of patients’ rights includes provision for HIV testing only with voluntary consent and counselling,<sup>18</sup> the right to confidentiality,<sup>19</sup> and protection of a child’s right to confidentiality.<sup>20</sup> However, civil society organisations report that people living with HIV do not fully benefit from these protections as the HIV and AIDS Law is not being adequately implemented.<sup>21</sup>

The Penal Code criminalises rape and Law 06/018 of 20 July 2006 amended and supplemented the Penal Code to strengthen protection for women from violence, including defining rape to include sexual slavery, sexual mutilation and forced pregnancy.<sup>22</sup> There is no law specifically addressing domestic violence and marital rape is not criminalised.

Law 09/001 of 10 January 2009 on Child Protection prescribes penalties for child trafficking. It also prohibits child marriage (marriage below 18 years of age).<sup>23</sup>

Congolese employment law includes reasonable accommodation for employees who can still work but who may have special needs. Law No. 015/2002 on the Code of Labour of 16 October 2002 does not specifically mention HIV, but could be used to argue for protection for people living with HIV.<sup>24</sup> Congolese law does not criminalise same sex sexual conduct or sex work (as long as it takes place between consenting adults).<sup>25</sup>

ACCESS TO JUSTICE AND LAW ENFORCEMENT

There is generally limited implementation of laws and access to justice and enforcement in both the conflict and non-conflict areas of the DRC. The state of the justice system in the DRC has been described as “alarming” and is characterised by “dilapidated infrastructure”, limited resources, untrained staff, low salaries and corruption. <sup>26</sup>

The law of 12 March 2013 created a human rights commission and members of the National Commission on Human Rights were sworn in in July 2013. <sup>27</sup> Although it is has been difficult to ascertain how well or even whether the Commission is functioning, it began to draft regulations on its operation in November 2013.

In 2016, a joint campaign called “Know Your Rights” was launched in the North Kivu Provincial capital of Goma by UNAIDS and the United Nations Stabilization Mission in the Democratic Republic of Congo (MONUSCO) to sensitise people about HIV and AIDS-related stigma and discrimination and how to enforce their rights. <sup>28</sup>

Problems with access to justice for people living with HIV include the following:

- Poor implementation of protective laws – a 2013 legal environment assessment that included a review of the 2008 HIV law indicated that little, if any, enforcement has taken place.
- High levels of stigma, including self-stigma, prevent access to justice.
- People living with HIV and key populations have limited awareness of the law and their rights and there are limited information, education and communication related interventions on HIV, law and human rights.
- Service providers (such as health care workers, welfare workers, police and even judges, activists and lawyers) have limited understanding of HIV, law and human rights issues .
- There is also insufficient information regarding and access to legal support services – there are few pro bono legal services available. The judicial system is expensive to access and has lengthy and cumbersome procedures. Most people are not aware of other services (e.g. mediation) outside of the courts.
- There is limited political commitment to HIV and human rights and inadequate oversight by parliamentarians.<sup>30</sup>

There has been some effort to increase access to justice for people affected by sexual violence in conflict. For example, a system of mobile clinics, supported by the UN and civil society, has been developed to provide legal representation, information and support to survivors of sexual violence in conflict. In 2014, they provided direct legal presentation to 750 victims. <sup>30</sup>

In the same year, courts convicted 27 people for rape, including a high ranking officer who was convicted of crimes against humanity, including 200 cases of rape and sexual slavery. Despite this progress, access to justice for victims of sexual violence remains a significant challenge as many survivors do not lay charges against perpetrators because they do not have the resources to do so, they lack confidence in the criminal justice system and they fear stigma from families and communities.

GAPS AND CHALLENGES

PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

The DRC has not ratified the African Charter on the Rights and Welfare of the Child.



The 2008 HIV law 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. It mandates disclosure of HIV status to a partner ‘promptly’ and, where he/she has failed to do so, for a doctor to disclose a patient’s HIV status. The provision does not emphasise psychosocial support to people living with HIV to support them to disclose, nor is there any consideration for women who report experiencing abuse, discrimination, abandonment and even violence when disclosing their results. <sup>33</sup> 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.

Article 174 in Law No. 06/018 of 20 July 2006, which increased protection against sexual violence, criminalises “willful transmission of incurable sexually transmitted infections” which would include HIV, and provides for a punishment of life imprisonment or a fine. <sup>34</sup> Likewise, Article 177 of 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.

Laws, policies, plans and programmes need to ensure the state’s obligation to provide HIV-related services is clear and enforceable across all sectors. Current laws and policies prohibit children below 18 years from accessing condoms – this creates a barrier to HIV prevention for young people. Similarly, an order dating back to the colonial system prohibits the distribution of condoms in prisons.

Despite the constitutional provisions prohibiting discrimination on the grounds of sex, women, including married women, are subject to various forms of legal discrimination and gaps exist in a range of laws and their implementation and enforcement that affect: 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. <sup>35</sup>

The 1987 Family Code recognises equality between spouses, but requires that wives obey their husbands. Women are prohibited from engaging in various legal transactions without the permission of their husbands, eg. purchasing or selling land, opening bank accounts or applying for a passport. There is an ongoing review of the 1987 Family Code, but it remains unclear when this process will be finalised. It is also concerning that the current draft of the new family code includes discriminatory provisions. The current minimum age of marriage for girls is 15 (and 18 for boys). Women also continue to experience discrimination in inheritance: where husbands die intestate, customary laws and practices allow children to take precedence and widows cannot inherit property.



Although assault is a crime, domestic violence by a spouse is not specifically mentioned in any laws and marital rape is not criminalised. Adultery is criminalised for men and women, although only women are subject to imprisonment if they are found guilty. While selling sex is not criminalised directly, the Penal Code criminalises aspects of sex work, including running a brothel. Drug trafficking and cultivation and possession during wartime is a capital crime in the DRC <sup>35</sup>, although no executions have been carried out since 2003. <sup>38</sup>

HUMAN RIGHTS CHALLENGES



**Women’s rights:** Women in the DRC face high levels of gender inequality, some permitted by law as described above, and sexual violence <sup>39</sup>, including conflict-related sexual violence placing them at higher risk of HIV and increasingly vulnerable to the impact of HIV. They have inequitable access to property and inheritance, <sup>40</sup> limiting their economic power. Harmful practices such as FGM, traditional tattoos and widow inheritance also place women at risk. <sup>41</sup> Women have limited information and decision-making power in relation to and access to sexual and reproductive health care services, <sup>42</sup> often requiring their husbands’ permission to access services, including contraception. Health services are not gender-sensitive. Additionally, women with HIV appear to be more stigmatised than men with HIV; <sup>44</sup> as they have reported being thrown out of their homes, divorced and abandoned due to their actual or perceived HIV status. <sup>45</sup>

**Children’s rights:** Children are vulnerable for various reasons: sexual abuse of children is a concern and places children, especially girls, at higher risk of HIV exposure. Children cannot independently access health care services, and require a parent to consent to services on their behalf, limiting access to HIV prevention services. Additionally, children with HIV experience discrimination within their communities and are deprived of inheritance rights. <sup>46</sup>

Children living in conflict-affected provinces remain at risk of forcible recruitment as child soldiers and girls are at risk of sexual abuse. <sup>47</sup> A UN Security Council report on conflict-related sexual violence in 2014 confirmed 332 cases of conflict-related sexual violence perpetrated against girls and two against boys. The report stated that the actual numbers were higher, but most cases were unreported. There were also reports that child soldiers, particularly girls, faced sexual exploitation. By June 2015, 108 children had been abducted by various armed groups. <sup>48</sup> Children affected by conflict are at high risk of HIV and face many barriers to accessing HIV-related treatment, care and support.

With a minimum marriage age of 15 for girls, they are at high risk of child marriage and 37% of girls in the DRC are married before their 18th birthday. <sup>49</sup> Child marriage exposes girls to HIV and other STIs and many do not have access to health care.

**Prisoners’ rights:** Prison conditions continue to pose serious threats to the health and life of prisoners. These include widespread violence (especially rape of both men and women), “food shortages; and inadequate potable water, sanitation, ventilation, temperature control, lighting, and medical care.” <sup>50</sup> Juvenile prisoners are frequently held with adults. The UN reported that 115 individuals died in detention from starvation or illness nationwide between January and November 2015. <sup>51</sup>

**HIV-related stigma:** People living with HIV continue to face high levels of stigma. The 2014 UNAIDS HIV country progress report for DRC provides information on research conducted in 2012 amongst four target groups (street children, miners, truckers and sex workers) about their attitudes towards people living with HIV. Truckers and sex workers had largely positive attitudes towards people living with HIV, with 72.2% of sex workers indicating they had a close relative or friend infected or who had died of AIDS-related causes. Street children and miners were less positive towards people living with HIV, despite miners indicating that many miners were living with HIV. <sup>52</sup>



**Rights of sex workers:** Sex work is not directly criminalised in the DRC, but sex workers are highly stigmatised. Sex workers experience human rights violations including stigma, discrimination, violence and sexual assault. Physical and sexual assault and other forms of abuse against sex workers, perpetrated by the police and security forces, has also been reported. 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 prosecution. <sup>53</sup> As a result, sex workers struggle to access justice as well as HIV and AIDS prevention, treatment and car services.



**Rights of LGBTI:** LGBTI people in the DRC also face high levels of discrimination and abuse. <sup>54</sup> While homosexuality is not specifically criminalised, there is no legal recognition of adult consensual same sex relationships, and gay men and men who have sex with men may be prosecuted under public indecency laws. Homosexuality is highly stigmatised and gay men and men who have sex with men are targets of harassment, including by state security forces. <sup>55</sup> The US State Department Human Rights report for 2015 includes information about a man, perceived to be gay because of how he dressed, who was arrested and had to pay 5 000 Conglese francs to be released, even though he was never charged with any crime. Efforts to introduce legislation to criminalise same sex sexual conduct have so far been unsuccessful. <sup>56</sup>

**Refugees and internally displaced persons:** As of 31 October 2015, the UN High Commission for Refugees (UNHCR) reported that there were 246,313 refugees from seven adjacent countries in the DRC, with the highest number of refugees being from Rwanda. Between mid-April and November 2015, 18,382 new arrivals from Burundi were registered as refugees. <sup>57</sup> UNHCR also reported that there are approximately 1.5 million IDPs in the DRC. <sup>58</sup> Displaced women and children are at risk of sexual exploitation and violence and they have limited access to health services, including HIV and TB prevention, treatment and care. There is also emerging documentation that suggests that men and boys are also targeted for conflict-related sexual violence and at increased risk of HIV.

**Access to treatment:** There is poor access to HIV-related health services, including treatment. People living with HIV are forced to travel long 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 do not have adequate medical equipment to work with. <sup>59</sup>

RECOMMENDATIONS

Civil society should:

- Advocate for laws that protect the human rights of people living with HIV and/or TB and key populations.
- 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, including prison personnel.
- Raise awareness about harmful practices that increase the risk of HIV for women and girls.
- Work with parliamentarians to strengthen their capacity on HIV, TB and human rights and to understand the negative impact of laws that undermine the human rights of people living with HIV and/or TB and key populations.
- Train health care providers on the human rights of people living with HIV and/or TB and key populations, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly.
- Advocate for access to comprehensive post-rape care for all survivors, including treatment for injuries, PEP, emergency contraception and treatment for STIs.
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights.
- Advocate for the decriminalization of possession of drugs for personal use and use of drugs and for comprehensive harm reduction programmes.
- Advocate for the expansion of HIV programming that is acceptable and accessible to people who use drugs and for the inclusion of people who use drugs in the design, implementation and evaluation of such programming.

The Congolese government should:

- Ratify the African Charter on the Rights and Welfare of the Child.
- Decriminalise all consensual adult sex.
- Review and repeal provisions of the HIV law that criminalise HIV transmission and permit disclosure of HIV status without consent.
- Review and repeal laws that discriminate against women and explicitly criminalise marital rape.
- Adopt an anti-discrimination law that protects and promotes the rights of key populations.
- Develop and implement an HIV policy for prisons, including distribution of condoms.
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, 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 and the judiciary.
- Decriminalise the possession of drugs for personal use and use of drugs.

# END NOTES

<sup>1</sup> UNAIDS, *Democratic Republic of Congo*, <http://www.unaids.org/en/regionscountries/countries/democraticrepublicofthecongo/> [accessed 21 April 2016]

<sup>2</sup> UNAIDS, *Country progress report*, 2014 [http://www.unaids.org/sites/default/files/country/documents//COD\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents//COD_narrative_report_2014.pdf) [accessed 21 April 2016]

<sup>3</sup> Ibid.

<sup>4</sup> UNAIDS, *2015 Progress Report on the Global Plan towards the elimination of new infections amongst children and keeping their mothers alive*, [http://www.unaids.org/sites/default/files/media\\_asset/JC2774\\_2015ProgressReport\\_GlobalPlan\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf) [accessed 22 May 2016]

<sup>5</sup> Ibid.

<sup>6</sup> WHO, *Global Tuberculosis Report 2015*, [http://www.who.int/tb/publications/global\\_report/gtbr15\\_annex02.pdf?ua=1](http://www.who.int/tb/publications/global_report/gtbr15_annex02.pdf?ua=1) [accessed 21 April 2016]

<sup>7</sup> Ibid.

<sup>8</sup> UNAIDS, *Country progress report*

<sup>9</sup> TBFACTS.ORG, *TB and HIV Co-infection Statistics: Global, regional and Africa*, <http://www.tbfacts.org/tb-hiv-deat> [accessed 22 May 2016]

<sup>10</sup> Preamble, Articles 5, 14 and 15

<sup>11</sup> Article 7

<sup>12</sup> Article 8

<sup>13</sup> Article 9

<sup>14</sup> Article 10

<sup>15</sup> Article 16

<sup>16</sup> Articles 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

<sup>17</sup> Articles 28 to 30 protects the rights of prisoners to health care and protection from compulsory HIV testing

<sup>18</sup> Article 36

<sup>19</sup> Article 39

<sup>20</sup> Article 17

<sup>21</sup> UNDP, *Revue de Cadre Juridique Congolais de Il Riposte au VIH et SIDA*, October 2013, <http://www.hivlawcommission.org/index.php/elibrary?task=document.viewdoc&id=200> [accessed 24 April 2016]

<sup>22</sup> Submissions to the *Africa Regional Dialogue on HIV and the Law*, 4 August, 2011: ANAMED, DRC

<sup>23</sup> <http://www.girlsnotbrides.org/wp-content/uploads/2013/06/Minimum-age-of-marriage-in-Africa-June-2013.pdf>

<sup>24</sup> UNDP, *Revue de Cadre Juridique Congolais de Il Riposte au VIH et SIDA*

<sup>25</sup> Ibid.

<sup>26</sup> Ibid.

<sup>27</sup> US Bureau of Democracy, Labor and Human Rights, *Country Reports on Human Rights Practices for 2015: Democratic Republic of Congo*, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 21 April 2016]

<sup>28</sup> ReliefWeb, *Promoting HIV testing in rural Democratic Republic of Congo*, 29 February 2016, <http://reliefweb.int/report/democratic-republic-congo/promoting-hiv-testing-rural-democratic-republic-congo-drc> [accessed 23 April 2016]

<sup>29</sup> UNDP, *Revue de Cadre Juridique Congolais de la Riposte au VIH et SIDA*

<sup>30</sup> UNAIDS, *DRC NCPI Report*, 2010

<sup>31</sup> OHCHR, *Legal clinics bring justice and rehabilitation to victims of sexual violence in DR Congo*, 25 November 2015, <http://www.ohchr.org/EN/NewsEvents/Pages/AccessJusticeInDRC.aspx> [accessed 22 April 2016]

<sup>32</sup> US Bureau of Democracy, Labor and Human Rights, *Country Reports on Human Rights Practices for 2015: Democratic Republic of Congo*

<sup>33</sup> Submission by ASADHO, DRC, *Africa Regional Dialogue on HIV and the Law*, 4 August, 2011

<sup>34</sup> ANAMED, DRC, *Africa Regional Dialogue on HIV and the Law*, 4 August, 2011

<sup>35</sup> Submission by ASADHO, DRC, *Africa Regional Dialogue on HIV and the Law*, 4 August, 2011

<sup>36</sup> Ibid.

<sup>37</sup> DRC Military Penal Code, Law No. 024/2002, Nov. 18, 2002.

<sup>38</sup> Cornell University, *Death Penalty Worldwide*, <http://www.deathpenaltyworldwide.org/country-search-post.cfm?country=Democratic+Republic+of+the+Congo#f15-3> accessed 24 April 2016

<sup>39</sup> Submissions to the *Africa Regional Dialogue on HIV and the Law*, 4 August, 2011: ASADHO, DRC; Okapi pour les Droits de l'Homme (OKDH), DRC,

<sup>40</sup> Submissions to the GCHL African Regional Dialogue, Pretoria, 4 August, 2011: Southern African Litigation Centre

<sup>41</sup> Submissions to the *Africa Regional Dialogue on HIV and the Law*, 4 August, 2011: OKDH, DRC,

<sup>42</sup> Submissions to the *Africa Regional Dialogue on HIV and the Law*, 4 August, 2011: Réseau des PVV en RDC (UCOP+), DRC

<sup>43</sup> Submissions to the *Africa Regional Dialogue on HIV and the Law*, 4 August, 2011: Southern African Litigation Centre.

<sup>44</sup> Submissions to the *Africa Regional Dialogue on HIV and the Law*, 4 August, 2011: UCOP+.

<sup>45</sup> Submissions 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.

<sup>46</sup> Submissions 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

<sup>47</sup> US 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)

<sup>48</sup> US Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Democratic Republic of Congo*, 2015 available at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> accessed on 24 Aril 2016

<sup>49</sup> Girls Not Brides, DRC country page, <http://www.girlsnotbrides.org/child-marriage/democratic-republic-of-the-congo/> accessed 23 April 2016

<sup>50</sup> US Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Democratic Republic of Congo*, 2015

<sup>51</sup> Ibid.

<sup>52</sup> UNAIDS, *Country progress report*, 2014 [http://www.unaids.org/sites/default/files/country/documents//COD\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents//COD_narrative_report_2014.pdf) accessed 24 April 2016

<sup>53</sup> This was recently reinforced by the findings of risk-mapping pilot studies in South Kivu

<sup>54</sup> Submission to the GCHL *African Regional Dialogue*, Pretoria, 3-4 August , 2011: Southern African Litigation Centre

<sup>55</sup> US 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]

<sup>56</sup> Human Rights First, *The State of Human Rights for LGBT People in Africa*, July 2014, <http://www.humanrightsfirst.org/sites/default/files/HRF-HRC-Africa-Report.pdf> accessed 23 April 2016

<sup>57</sup> US Department of State, Bureau of Democracy, Human Rights and Labour, *Country Reports on Human Rights Practices 2012, Democratic Republic of Congo*, 2015

<sup>58</sup> UNHCR, 2015 Country Operations Profile, *Democratic Republic of Congo*, <http://www.unhcr.org/pages/49e45c366.html> accessed 24 April 2016

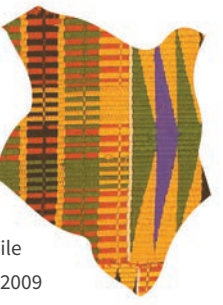
<sup>59</sup> Submissions to the *Africa Regional Dialogue on HIV and the Law*, 4 August, 2011: Association Africaine de Défense es Droits de l'Homme, ASADHO.



# KENYA

## BACKGROUND

Kenya has both a generalized and concentrated HIV epidemic, with an adult prevalence rate of 5.3%. Women remain disproportionately infected, accounting for approximately 700 000 (57%) of people living with HIV. Young women between the ages of 15 and 24 are particularly vulnerable to HIV infection. While research shows information about HIV prevention is generally low amongst youth in Kenya, young men have higher levels of knowledge about HIV prevention than their female peers.<sup>1</sup>



Kenya has shown a steady decrease in HIV prevalence amongst the general population, from a peak of 10.5% in 1995-6, to 6.7% in 2003. The 2014 HIV country progress report states that the decline from 1995 – 2003 was largely due to large numbers of AIDS related deaths, while the stabilization of the epidemic over the past decade is due to the scale up of ART. AIDS-related deaths have also declined, from 85 000 in 2009 to 58 000 in 2013.<sup>1</sup>

Kenya has scaled up adult ART programmes significantly over the past five years and is currently meeting 80% of the need. In December 2013, around 656 000 people were receiving treatment. While paediatric treatment programmes have also been scaled up, from 17.5% of eligible children receiving treatment in 2009, to 43.3% on treatment in 2013, children with HIV are still lagging behind.<sup>3</sup> Kenya was one of the 22 priority countries identified in the UNAIDS 2009 global plan to reduce the number of HIV infections amongst children and keep their mothers alive. By 2015, Kenya had only managed to reduce new infections amongst children by 29%. It has done better in providing pregnant women with HIV with access to ART to reduce vertical transmission, with 67% of women accessing PMTCT services in 2015.<sup>4</sup>

The 2014 HIV country progress report identifies men who have sex with men, female sex workers and their partners and people who use drugs as key populations. The most recent available data on HIV prevalence amongst these populations dates from 2010, but is valuable in indicating prevalence and the disproportionate vulnerability of these groups: 18.3% amongst injecting drug users, 18.2% amongst men who have sex with men and 29.3% amongst sex workers. Of concern is that while epidemic amongst the general population appears to be stabilizing, there is still an elevated epidemic amongst key populations.<sup>5</sup>

In 2014, Kenya adopted a new AIDS Strategic Framework(KASF) for 2015/16 – 2018/19.<sup>6</sup> It promotes a rights-based approach to access to services for people living with HIV and key populations and sets a goal of reducing stigma and discrimination by 50%. The KASF identifies priority populations (men who sex with men, female sex workers and people who inject drugs) who contribute disproportionately to new HIV infections and vulnerable populations (young girls and women; people in prisons and other closed settings; fishing communities, truck drivers, street children, migrant populations and mobile populations and people living with HIV, especially pregnant women and children).<sup>7</sup> The WHO classifies Kenya as a high burden country for TB because it has high numbers of people with TB, people with TB and HIV and people with multi-drug resistant TB (MDR-TB).<sup>8</sup> Approximately 110 000 people are living with TB. Kenya has made good progress in linking patients with TB to HIV testing and treatment. In 2012, 94% of patients with TB were tested for HIV and 82.8% of those who tested positive received treatment for HIV and TB. Kenya has experienced difficulties in providing the necessary treatment for multiple-drug resistant (MDR-TB) to all of the people requiring it. It is estimated that less than 50% of those needing this treatment are receiving it.

Kenya launched a National TB, Leprosy and Lung Disease Strategic Plan (2015 – 2018) in March 2015. The plan refers to human rights and recognizes the need to protect the rights of people with TB.<sup>9</sup>

## KEY HUMAN RIGHTS CONCERNS FOR 2016

- HIV-related stigma and discrimination
- Gender based violence and inequality
- Human rights abuses against key populations
- Refugees
- Persons with disabilities



## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### CONSTITUTION

Chapter 4 of the Constitution of Kenya 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.”

*HIV, TB and Human Rights in Southern and East Africa Report 2016*



The Bill of Rights protects a range of rights that are important for people living with HIV and TB, and key populations such as the rights to freedom and security of the person, privacy, marry and found a family, freedom of expression, property, access to information, freedom of movement and residence, work and fair labour practices and economic and social rights, including the right to “the highest attainable standard of health, which includes the right to health care services, including reproductive health care”.<sup>11</sup> Section 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 recognises international treaties, to which Kenya is a signatory, as valid sources of law.

RATIFICATION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

Kenya has ratified:

- African Charter on Human and Peoples’ Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003
- Convention on the Rights of Persons with Disabilities, 2006
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1992
- International Convention on Civil and Political Rights (ICCPR), 1966

NATIONAL LAWS AND POLICIES

In 2006, Kenya enacted the HIV and AIDS Prevention and Control Act. The law promotes equality and non-discrimination in employment, education, travel and choice of lodging; non-discrimination in the workplace; ethics in research and HIV testing only with voluntary and informed consent and confidentiality. It prohibits mandatory HIV testing (including for employment, marriage, education, travel or health insurance) and promotes measures to educate and treat affected persons. Section 25 created an HIV and AIDS Tribunal to hear HIV-related complaints, the only one of its kind in the world.

The Health Bill<sup>12</sup> has not yet been passed although it has been debated by both houses of Parliament. The Bill has protective provisions that promote the right to health and will benefit people living with HIV and/or TB and key populations, including recognition of the health needs of vulnerable groups,<sup>13</sup> the provision of health services with informed consent,<sup>14</sup> and medical confidentiality.<sup>15</sup> The bill also provides for the establishment of complaints procedures in health facilities so that patients can file complaints<sup>16</sup> about their treatment. It is not clear when the bill will become law.

Other important laws strengthen protection for affected populations:

- Various laws protect women and men from harmful gender norms, gender-based and sexual violence and exploitation. The Sexual Offences Act 2006 prohibits sexual violence (including rape and sexual assault) against men and women as well as 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 female genital mutilation (FGM). The Protection Against Domestic Violence Act,<sup>17</sup> which has a broad definition of domestic violence that includes harmful practices such as child marriage, FGM, forced marriage and virginity testing<sup>18</sup> came into force in June 2015.
- The Marriage Act of 2014 and Matrimonial Property Act reinforce equality rights in marriage and on divorce, including ownership and division 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 polygamous marriage). The Act provides safeguards to protect the property rights of a first wife in a polygamous union and sets the minimum age of marriage at 18 years for all marriages and for both boys and girls.
- The Reproductive Health Care Bill<sup>19</sup> was debated by the Senate in July 2015 but has not yet been adopted as it is considered controversial because of its focus on adolescent sexual and reproductive health. Amongst others, the bill protects the right to confidentiality for reproductive health information,<sup>20</sup> does not require parental consent for adolescents to access reproductive health services,<sup>21</sup> and provides for the establishment of a Reproductive and Child Health Tribunal to hear complaints relating to breaches of the bill. The bill also provides for free ante-natal and delivery services for pregnant women and provides for access to HIV testing and treatment in line with the HIV and AIDS Control Act.<sup>22</sup> The Bill confirms that abortion is only available in very limited circumstances where the life or health of the women is in danger.<sup>23</sup> It is not clear when and in what format the bill will become law.
- The Children’s Act of 2001 protects the rights of children and prohibits discrimination on any ground including sex, religion, creed, custom, language and other status among others. The Act also confirms that all children have the right to education and to be protected from harmful cultural practices such as FGM.
- The Employment Act protects the rights of employees with HIV to fair labour practices. Section 5 protects employees from discrimination on the grounds of HIV status and section 46 states 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.<sup>24</sup> 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 antiretroviral treatment and the availability of affordable ART under the Industrial Property Act. A judicial review of the constitutionality of sections 2, 32 and 34 of Kenya’s Anti-Counterfeit Act 2008<sup>25</sup> found that these sections, which were broad enough to outlaw the production of generic ART drugs, were unconstitutional and in conflict with the right to life, dignity, and health.

ACCESS TO JUSTICE AND LAW ENFORCEMENT

A 2014 study estimates that only 40% of rape cases are reported to the police and the rate of prosecution is low. Police also often fail to investigate domestic violence cases, regarding them as private matters.<sup>26</sup>

Civil society undertakes various initiatives to increase awareness and understanding of HIV- and TB-related human rights and gender equality amongst communities, law and policy-makers, lawyers, the judiciary and law enforcers in an effort to increase access to justice. Civil society groups such as KELIN provide access to legal advice as well as representation and have embraced an emerging focus on the rights of people with TB. Since 2014, KELIN has been supporting two clients who were arrested and detained for defaulting on their TB treatment. KELIN launched a case in the High Court to challenge section 27 of the Public Health Act (see below), which allows isolation and incarceration of people with TB.<sup>27</sup> On 24 March 2016, a landmark judgment was delivered confirming that the practice of confining TB patients in prisons for purposes of treatment is unlawful and unconstitutional.<sup>28</sup>

There are a number of institutions in Kenya that can investigate and adjudicate human rights violations. They include an 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. Recent research conducted into the functioning of the tribunal suggests that while it got off to a slow start, it is now a relatively effective mechanism for the protection of the rights of people living with HIV. By the end of December 2014, the tribunal had handled 300 complaints, most dealing with employment related issues. The tribunal also receives complaints related to discrimination in access to HIV-related services and gender-related complaints in regards to domestic violence and property grabbing.<sup>29</sup> The tribunal still faces challenges in effectiveness, including a lack of awareness about its existence as well as human and financial resource limitations.<sup>30</sup>

GAPS AND CHALLENGES

PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS



While the HIV and AIDS Prevention and Control Act, 2006 contains protective provisions, it also contains various gaps and challenges. For example, it does not specifically address the HIV-related needs of 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 Act also criminalises the intentional transmission of HIV in Section 24. Although the High Court declared this section unconstitutional in March 2015<sup>31</sup>, stating that it was “vague and over-broad” and lacked certainty, deliberate HIV transmission continues to the criminalised in the Sexual Offences Act of 2006.

Section 27 of the Public Health Act allows a medical officer to isolate and detain any person who has been exposed to an infectious disease.<sup>32</sup> This provision has been used to detain people living with TB.

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 penalties of up to 14 years imprisonment. The Constitution also prohibits same sex marriage by providing that every adult has the right to marry “a person of the opposite sex.”<sup>34</sup>

The Penal Code does not specifically criminalise sex work, but criminalises aspects of sex work including living off the earnings of prostitution and soliciting for “immoral purposes”. In addition, there are a range of municipal by-laws including provisions, which criminalise loitering and indecent exposure<sup>35</sup>, which vary according to location and are used by council officers and police to arrest and harass sex workers. It is also illegal to use any premises for the purposes of prostitution.<sup>36</sup>

Drug use, possession and cultivation is criminalised in Kenya. Of particular concern are provisions which criminalise possession of any “utensil for use in connection with the smoking, inhaling or sniffing or otherwise using”<sup>37</sup> drugs. These provisions effectively criminalise harm reduction interventions such as



needle exchanges and clean syringe programmes and KELIN reports that police have used them to bring charges against individuals providing harm reduction services.<sup>38</sup>

The Constitution states that life begins at conception and bans abortion, except in cases where there is a need for emergency treatment or the life or health of the woman is in danger.<sup>39</sup>

It is not clear whether marital rape is criminalised: there is a marital rape exception in section 43(5) the Penal Code, but the 2015 Domestic Violence Act does include “violence in marriage”.

## HUMAN RIGHTS CHALLENGES



**Stigma and discrimination:** The 2014 HIV country progress report confirms that stigma and discrimination remain major challenges to the uptake of HIV-related services.<sup>41</sup> The 2011 People Living with HIV Stigma Index study found that HIV-related stigma was prevalent and people living with HIV reported that they experienced stigma and discrimination most frequently within family and community settings, at the workplace and in the health sector, including HIV testing and disclosure without consent and denial of health care services. The Stigma Index found that 56% of respondents reported verbal abuse or harassment in these settings and 38% reporting physical abuse as a result of their HIV status.<sup>42</sup> Discrimination in access to insurance and mortgages was also reported,<sup>43</sup> as well as discrimination in schools and prisons.



**Women’s and girls’ rights:** Women account for the majority of adults living with HIV in Kenya. Factors increasing women’s vulnerability and risk of HIV 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 young males. 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.

Kenya experiences high levels of violence against women, children and young people, both girls and boys. The KASF reports that 33% of girls and 17% of boys are raped before they reach 18 years of age, while 22% of girls between the ages of 15 and 19 say that their first sexual experience was coerced. A significant number of girls in Kenya marry before they reach 18. The “Girls Not Brides” campaign indicates that 26% of Kenyan girls under the age of 18 are married, with prevalence varying across regions.<sup>44</sup> Young married girls are at high risk of HIV with a study showing that 33% of married girls were living with HIV compared to only 22% of unmarried girls.<sup>45</sup>

Discrimination in access to sexual and reproductive health care services is a concern, with reports of women experiencing HIV testing without consent as well as reports of coerced sterilisation when accessing antenatal services, for purposes of prevention of mother-to-child transmission programmes, as well as reports of coerced sterilisation.<sup>46</sup> KELIN filed two cases of forced and coercive sterilization of women living with HIV without their consent in December 2014. The cases were not concluded at the time of writing.<sup>47</sup>



**Rights of sex workers:** Sex workers in Kenya carry a disproportionately high burden of HIV, with rates of infection estimated at more than five times the rate in the general population. They are highly stigmatized and report various human rights violations from clients and law enforcement officers including harassment, physical and sexual violence, including being forced to have unprotected sex.<sup>48</sup> The 2014 HIV country progress report showed that outreach to sex workers remains a concern, with only 68% of female sex workers being tested for HIV and knowing their status.<sup>49</sup> The Kenyan Human Rights Commission, sex workers activists and their allies are calling for the decriminalisation of sex work and all consensual sex between adults.



**Rights of men who have sex with men:** Men who have sex with men in Kenya are highly stigmatised and experience widespread violence and abuse of their rights. Information presented to the National Assembly in March 2014 indicated that the police opened files on 595 cases of unnatural offences since 2010. A report by the Gay and Lesbian Coalition of Kenya and the National Gay and Lesbian Human Rights Commission stated that there have been 8 prosecutions of men who have sex with men between 2012 and 2014 on indecency charges.<sup>51</sup> LGBTI groups also experienced discrimination and some have been refused registration by the Non-Governmental Organisations Co-ordination Board (NGOCB). In April 2015, the Kenya High Court ruled that members of the National Gay and Lesbian Human Rights Commission could formally register the organisation after the NGOCB rejected its application in 2013.<sup>51</sup>

In 2015, Human Rights Watch reported that criminalisation of same sex conduct made LGBT people in Kenya extremely vulnerable to violence at the hands of ordinary citizens as well as police and other law enforcement officials. The report indicated that LGBT people engaged in sex work were particularly vulnerable and suffered “rape and other abuses at the hands of clients, police and county government law enforcement officials”.<sup>52</sup> In November 2015, the Justice and Legal Affairs Committee of Parliament rejected an attempt by the Republican Liberty Party to introduce a law prescribing stoning as a punishment for homosexuality.<sup>53</sup>

In June 2016, the Kenyan High Court ruled that forced anal examinations and forced HIV and Hepatitis B testing of men suspected of homosexual conduct, was constitutional. The case was brought by two men who were forced to undergo forced testing at the Mombasa Madaraka Hospital in February 2015.<sup>53</sup>



**Rights of people who use drugs:** People who use drugs in Kenya are “marginalized, stigmatized and criminalised, with increasing vulnerability to HIV and decreasing access to essential health services.”<sup>55</sup> A significant number (18.3%) of people who inject drugs in Kenya are living with HIV.<sup>56</sup>

Kenya has made progress in recognizing that people who use drugs are particularly vulnerable to HIV and in 2011, the Kenyan National AIDS Council introduced a harm reduction strategy. The 2015 – 2020 AIDS Strategic Framework also promotes the comprehensive harm reduction package recommended by UNDOC, UNAIDS and the WHO<sup>57</sup>. However, the 2014 HIV country progress report indicated that these programmes currently only serve the needs of 15% of the total number of people who need access to them.<sup>58</sup> Despite this, police continue to arrest people who use drugs or people in possession of drug paraphernalia.<sup>59</sup>

**Prisoners’ rights:** Over-crowding, poor hygiene and sanitation, inadequate food and access to health care, particularly for prisoners with HIV and/or TB, are major problems in Kenya’s prisons.<sup>60</sup> Female prisoners and juveniles are not always separated from male prisoners and sexual abuse is common.

**Refugees:** Kenya is host to over 500 000 refugees.<sup>61</sup> Refugees include long term refugees from Somalia and more recently displaced South Sudanese and Ethiopians. Sexual violence, including rape, FGM and forced marriage, has been documented in the Dadaab and Kakuma refugee camps.<sup>62</sup> Refugees who are victims of sexual violence have limited access to health care and justice and complaints are often resolved through traditional and customary justice mechanisms.<sup>63</sup>

**People with disabilities:** in 2014, the Kenya National Human Rights Council estimated that there were 7 million people with disabilities in Kenya. People with disabilities face significant stigma and discrimination and 17% have experienced physical violence. They also face barriers to accessing health care, including HIV testing and contraception.<sup>54</sup>

## RECOMMENDATIONS

### Civil society should:

- 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.
- Train service providers including health care providers and law enforcement officials on the human rights of people living with HIV and/or TB and key populations, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly
- Advocate for access to comprehensive post-rape care for all survivors, including refugee and internally displaced women, including treatment for injuries, PEP, emergency contraception and treatment for sexually transmitted infections.
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights.
- Advocate for meaningful access to health care, including reproductive health care, for persons with disabilities.
- Advocate for laws that protect and protect the human rights of people living with HIV and/TB and key populations.
- Advocate for the decriminalisation of possession of drugs for personal use and for comprehensive harm reduction programmes.

### The Kenyan government should:

- Decriminalise all adult consensual sex.
- Review and repeal laws criminalising HIV transmission.
- Strengthen anti-discrimination protection for people living with HIV and/or TB and key populations and ensure that laws promote human rights.
- Repeal laws and policies that prohibit the distribution of condoms in prisons.
- Explicitly criminalise marital rape.
- Decriminalise abortion.
- Develop and implement laws that protect the human rights of people with TB and repeal any laws and policies that allow for isolation or forcible detention of people with TB.
- Review and repeal laws that criminalise possession of drugs for personal use and develop a harm reduction policy for people who use drugs.
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support serices, training for law and policy makers and the judiciary.

# END NOTES

<sup>1</sup> UNAIDS, *Kenya AIDS Response Progress Report*, March 2014, [http://www.unaids.org/sites/default/files/country/documents/KEN\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/KEN_narrative_report_2014.pdf) [accessed 25 April 2016]

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> UNAIDS, *2015 Progress Report on the Global Plan towards the elimination of new infections amongst children and keeping their mothers alive*, [http://www.unaids.org/sites/default/files/media\\_asset/JC2774\\_2015ProgressReport\\_GlobalPlan\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf) [accessed 22 May 2016]

<sup>5</sup> Ibid., *Kenya AIDS Response Progress Report*

<sup>6</sup> Kenya Ministry of Health, *Kenya AIDS Strategic Framework 2015/15 – 2018/19*, [http://www.nacc.or.ke/images/KASF\\_F\\_web.compressed.pdf](http://www.nacc.or.ke/images/KASF_F_web.compressed.pdf) [accessed 29 April 2016]

<sup>7</sup> Ibid.

<sup>8</sup> WHO, *Global Tuberculosis Report 2015*, [http://www.who.int/tb/publications/global\\_report/en/](http://www.who.int/tb/publications/global_report/en/) [accessed 25 April 2016]

<sup>9</sup> See: KELIN: <http://www.kelinkenya.org/situation-analysis/hiv-and-tb/> [accessed 25 April 2016]

<sup>10</sup> Kenya, *Constitution of Kenya, 2010*, <https://www.kenyaembassy.com/pdfs/the%20constitution%20of%20kenya.pdf> [accessed 30 April 2016]

<sup>11</sup> Ibid. section 43

<sup>12</sup> Kenya, *Health Bill*, 2015, <http://kenyalaw.org/kl/fileadmin/pdfdownloads/bills/2015/HealthBill2015.pdf> [accessed 29 April 2016]

<sup>13</sup> Ibid. section 4

<sup>14</sup> Ibid. section 9

<sup>15</sup> Ibid. section 11

<sup>16</sup> Ibid. section 14

<sup>17</sup> Republic of Kenya, *Protection Against Domestic Violence Act*, 2015, [http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/ProtectionAgainstDomesticViolenceAct\\_2015.pdf](http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/ProtectionAgainstDomesticViolenceAct_2015.pdf) [accessed 25 April 2016]

<sup>18</sup> Ibid. section 3

<sup>19</sup> Kenya, *Reproductive Health Care Bill*, 2014, [http://kenyalaw.org/kl/fileadmin/pdfdownloads/bills/2014/ReproductiveHealthCareBill2014\\_\\_1\\_.pdf](http://kenyalaw.org/kl/fileadmin/pdfdownloads/bills/2014/ReproductiveHealthCareBill2014__1_.pdf) [accessed 29 April 2016]

<sup>20</sup> Ibid. section 27

<sup>21</sup> Ibid. section 33(2)

<sup>22</sup> Ibid. section 41

<sup>23</sup> Ibid. section 19

<sup>24</sup> See, 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

<sup>25</sup> *Patricia Asero Ichieng and Ors v Attorney General*, Petition No 409 of 2009

<sup>26</sup> US Bureau of Democracy, Labor and Human Rights, *Country Reports on Human Rights Practices for 2015: Kenya*, <http://www.state.gov/j/drl/rls/hrrpt/human-rightsreport/index.htm#wrapper> [accessed 25 April 2016]

<sup>27</sup> DN and others v The Hon Attorney General and Others, Petition 329 2014, KELIN, <http://www.kelinkenya.org/thematic-area/persons-experiencing-health-related-human-rights-violations-have-access-to-justice-4/> [accessed 27 April 2016]

<sup>28</sup> KELIN: <http://www.kelinkenya.org/case-tracker/> [accessed 27 April 2016]

<sup>29</sup> Patrick Eba, *The HIV and AIDS Tribunal of Kenya: An effective mechanism for the enforcement of HIV-related human rights?* February 2016, HHR Journal <http://www.hhrjournal.org/2016/02/the-hiv-and-aids-tribunal-of-kenya-an-effective-mechanism-for-the-enforcement-of-hiv-related-human-rights/> [accessed 25 April 2016]

<sup>30</sup> Kenya Ministry of Health, *Kenya AIDS Strategic Framework 2015/15 – 2018/19*

<sup>31</sup> Standard Digital, *Court nullifies section outlawing reckless spread of HIV*, 24 March 2015, <http://www.standardmedia.co.ke/article/2000155804/court-nullifies-section-outlawing-reckless-spread-of-hiv> [accessed 10 May 2016]

<sup>32</sup> Kenya, *Public Health Act*, 1986 (revised 2012) <http://www.kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/PublicHealthActCap242.pdf> [accessed 27 April 2016]

<sup>33</sup> Ibid. section 45

<sup>34</sup> Kelin, *Punitive Laws Affecting Sex Workers*, 2016, <http://www.kelinkenya.org/wp-content/uploads/2016/03/PUNITIVE-LAWS-AFFECTING-SEX-WORKERS.pdf> [accessed 25 April 2016]

<sup>35</sup> Ibid.

<sup>36</sup> Sexual and reproductive rights database, <http://sexualrightsdatabase.org/#countries/374/Kenya> [accessed 10 May 2016]

<sup>37</sup> Kenya, *Narcotic Drugs and Pyschotropic Substances Act*,

<sup>38</sup> KELIN, *Punitive Laws Against Persons who use Drugs*, 2016, [http://www.kelinkenya.org/wp-content/uploads/2016/03/Punitive-Laws-affecting-persons-who-](http://www.kelinkenya.org/wp-content/uploads/2016/03/Punitive-Laws-affecting-persons-who-use-drugs.pdf)

[use-drugs.pdf](#) [accessed 25 April 2016]

<sup>39</sup> Ibid. section 26

<sup>40</sup> Ibid., Sexual and reproductive rights database

<sup>41</sup> UNAIDS, *Kenya AIDS Response Progress Report*, March 2014

<sup>42</sup> NEPHAK, *The People living with HIV Stigma Index: Kenya, Nairobi*, 2011 <http://www.stigmaindex.org/sites/default/files/reports/Kenya%20People%20Living%20with%20HIV%20Stigma%20Index%20Report%202009.pdf>

<sup>43</sup> KELIN, UNAIDS, AIDS Law Project, NEPHAK, UNDP, UN Women, UNFPA, Ministry of Health, Kenya, National Symposium of HIV, Law and Human Rights: Respect, Protect and Fulfill Human Rights, Nairobi, October 2012

<sup>44</sup> Girls Not Brides, *Child Marriage Across the World: Kenya*, <http://www.girlsnotbrides.org/child-marriage/kenya/> [accessed 29 April 2016]

<sup>45</sup> Ibid.

<sup>46</sup> NEPHAK *The PLHIV Stigma Index Study: Kenya*, Nairobi, 2011; KELIN and others *National Symposium on HIV, Law and Human Rights*, Nairobi, October 2012

<sup>47</sup> KELIN, <http://www.kelinkenya.org/thematic-area/persons-experiencing-health-related-human-rights-violations-have-access-to-justice/> [accessed 27 April 2016]

<sup>48</sup> GCHL *Report of the Africa Regional Dialogue of the Global Commission on HIV and the Law*, Pretoria, 4 August 2011

<sup>49</sup> UNAIDS, *Kenya AIDS Response Progress Report*, March 2014

<sup>50</sup> US Bureau of Democracy, Labor and Human Rights, *Country Reports on Human Rights Practices for 2015: Kenya*, <http://www.state.gov/j/drl/rls/hrrpt/human-rightsreport/index.htm#wrapper> [accessed 25 April 2016]

<sup>51</sup> Human Rights Watch, *Kenya: High Court Orders LGBT Group Registration*, 28 April 2015, <https://www.hrw.org/news/2015/04/28/kenya-high-court-orders-lgbt-group-registration> [accessed 10 May 2016]

<sup>52</sup> Human Rights Watch, *The Issue is Violence: Attacks on LGBT People on Kenya's Coast*, 28 September 2015, <https://www.hrw.org/report/2015/09/28/issue-violence/attacks-lgbt-people-kenyas-coast> [accessed 26 April 2016]

<sup>53</sup> Daily Nation, *MPs throw out proposal to punish gays with death*, 16 November 2015, <http://www.nation.co.ke/news/-MPs-throw-out-proposal-to-punish-gays-with-death/-/1056/2959152/-/12ay9ktz/-/index.html> [accessed 10 May 2016]

<sup>54</sup> Human Rights Watch, *Kenya: Court Upholds Forced Anal Exam*, 16 June 2016, <https://www.hrw.org/news/2016/06/16/kenya-court-upholds-forced-anal-exams> [accessed 26 June 2016]

<sup>55</sup> KELIN, *Punitive Laws Against Persons who use Drugs*, 2016

<sup>56</sup> UNAIDS, *Do No Harm*, 2016, [http://www.unaids.org/sites/default/files/media\\_asset/Do\\_no\\_harm\\_slides.pdf](http://www.unaids.org/sites/default/files/media_asset/Do_no_harm_slides.pdf) [25 May 2016]

<sup>57</sup> Ibid.

<sup>58</sup> UNAIDS, *Kenya AIDS Response Progress Report*, March 2014

<sup>59</sup> Ibid., *Do No Harm*

<sup>60</sup> US Bureau of Democracy, Labor and Human Rights, *Country Reports on Human Rights Practices for 2015: Kenya*

<sup>61</sup> UNHCR, *2015 country operations profile – Kenya*, <http://www.unhcr.org/cgi-bin/tehis/vtx/page?page=49e483a16&submit=GO> [accessed 29 April 2016]

<sup>62</sup> US Bureau of Democracy, Labor and Human Rights, *Country Reports on Human Rights Practices for 2015: Kenya*,

<sup>63</sup> Ibid.

<sup>64</sup> Ibid.



# LESOTHO



## BACKGROUND

Lesotho has the second highest HIV prevalence rate in the world, with an adult prevalence rate of 23%.<sup>1</sup> It has a generalised epidemic, with more women (190 000) than men living with HIV. Data from the 2009 Lesotho Health and Demographic Survey shows HIV prevalence amongst women to be 27% compared to 18% amongst men.<sup>2</sup> There are 36 000 children below the age of 14 living with HIV.<sup>3</sup>

In Lesotho, HIV is transmitted primarily through heterosexual sex which accounts for 80% of transmission.<sup>4</sup> There are significantly high rates of HIV infection amongst key populations: a 2015 study found that 31.1% of 318 men who sex with men tested in Maseru were living with HIV, while 35.4% of 211 tested in Maputsoe were living with HIV.<sup>5</sup> Of the 410 female sex workers tested in Maseru, 73.3% were living with HIV along with 70.4% of the 334 tested in Maputsoe.<sup>6</sup> The 2015 HIV country progress report states that HIV prevalence is estimated to be 31% amongst prisoners and 43% amongst migrant workers (estimated to be approximately 50 000).<sup>7</sup> Although adult HIV incidence has declined by 29% between 2001 and 2014, Lesotho did not meet its 2015 target of reducing HIV incidence by 50%.<sup>8</sup>

**Lesotho did not meet its 2015 treatment target of 85% antiretroviral treatment (ART) coverage, with just over a third of adults and only 30% of children who required treatment receiving it by the end of 2014.**

Lesotho did not meet its 2015 treatment target of 85% ART coverage, with just over a third of adults and only 30% of children who required treatment receiving it by the end of 2014. Approximately 295 000 adults and 19 000 children were in urgent need of ART by the end of 2014. Vertical transmission has increased from 3.5% in 2012 to 5.8% in 2014 as eMTCT coverage declined from 2012 when 89% of pregnant women with HIV received ART to reduce the risk of transmission to their babies, to 72% in 2014. Factors undermining access to treatment include not meeting the 2014 target of having 240 facilities providing treatment (there were only 217); inadequate space and staffing and unreliable operating hours.

Lesotho was one of the 22 priority countries identified by the 2009 UNAIDS plan to reduce HIV infections amongst children and keep their mothers alive. The 2015 global progress report indicates that Lesotho has reduced new HIV infections amongst children by 42%.<sup>9</sup>

Although there has been improvement in expanding coverage of HIV testing, testing has been impacted by stock-outs of HIV testing kits due to inadequate procurement systems and lack of staff.<sup>10</sup>

Lesotho is considered a HBC for TB<sup>11</sup> and TB detection and treatment has been identified as a health sector priority in the National Health Sector Strategic Plan.<sup>12</sup> Prisoners and migrant mine workers are particularly vulnerable to TB. The 2015 HIV country progress report indicates that the numbers of TB patients who were tested for HIV increased from 82% in 2011 to 93% in 2014. Of the TB patients tested for HIV, 74% tested positive.<sup>13</sup> Lesotho failed to meet its TB treatment target of 85%, with the failure attributed to patient deaths, treatment default, inadequate evaluation of cases and transfers.

Lesotho has a national HIV and AIDS National Strategic Plan (NSP) that ends in 2016. The plan identified the need to address sexual and gender based violence, social norms and cultural practices that fuel the spread of HIV and promote HIV prevention in the workplace and amongst sex workers, men who have sex with men, prisoners and their partners. Human rights, gender and cultural sensitivity and the principle of greater involvement of people living with HIV and AIDS (GIPA) are all part of the guiding principles for the plan.<sup>14</sup> The National Health Sector Plan also identifies HIV as a priority.

Although there is no data on HIV prevalence amongst people who use drugs, the National HIV Prevention Strategy (2011/12-2015/16) highlights the need for innovation to address dynamics and factors that contribute to HIV incidence or affect at risk populations such as “sex workers, clients of sex workers, substance abuse-using populations, herd boys, prisoners, people with disabilities, single, separated, or divorced adults, OVC, men and women who work away from home, MSMs who have sex with men and their male and female partners.”<sup>15</sup> There is no domestic policy to support the provision of harm reduction services in Lesotho.

HIV and TB treatment in Lesotho is heavily dependent on external funding, with the PEPFAR for AIDS Relief (PEPFAR) being a major contributor towards the provision of ART.<sup>16</sup> Lesotho has not made use of the flexibilities provided for in the TRIPS; for essential medicines that are no longer patent protected, Lesotho relies on generic manufacturers based in India and, to some extent, China and other countries in Southern Africa.<sup>17</sup>

## KEY HUMAN RIGHTS CONCERNS FOR 2016



- HIV-related stigma and discrimination
- GBV and inequality
- Abuses against key populations
- Migrants
- Children

## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### CONSTITUTION

Lesotho’s Constitution protects the human rights and freedoms of all people and prohibits discrimination on “any ground whatsoever” which should include health status, HIV or AIDS, sexual orientation and gender identity. Article 4 provides that every person is entitled to fundamental rights and freedoms including the right to life, personal liberty, freedom of movement and residence, freedom from inhumane treatment, the right to private and family life, freedom from discrimination and equality before the law and the equal protection of the law, whatever their race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

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.

Article 33 commits Lesotho to design policies to facilitate training of people with disabilities and their admission into employment.

### RATIFICATION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

Lesotho has ratified:

- African Charter on Human and Peoples’ Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Rights of Persons with Disabilities, 2006
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1992
- International Convention on Civil and Political Rights (ICCPR), 1966
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003

### NATIONAL LAWS AND POLICIES

Lesotho does not have an HIV-specific law<sup>19</sup> but does have a number of protective laws for vulnerable and key populations, including the following:

- The Lesotho Children’s Protection and Welfare Act, 2011 has strengthened protection of the rights of children, including the right 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 for children living with HIV. The Education Act, 2010 makes primary education free and compulsory.<sup>20</sup>
- Women’s equality rights within marriage were strengthened in the Legal Capacity of Married Persons Act 9, 2006. However, the law is not adequately implemented.<sup>21</sup> Inheritance may still be regulated through customary laws with customary inheritance rights only applying to men. In addition to discriminatory inheritance laws, there are other customary practices, such as forced elopement, which discriminate against women and increase their risk of HIV.
- The Sexual Offences Act of 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 STI.<sup>22</sup> Sexual harassment is also criminalised.

- The Children’s Welfare and Protection Act, 2011 and the Anti-Trafficking in Persons Act, 2010 protect children and women from exploitation and trafficking.<sup>23</sup> There is a National Action Plan for Women, Girls and HIV and AIDS (2012-2016) and a National Anti-Trafficking in Persons Strategic Framework and Action Plan (2014 – 2016). The NSP provides PEP for survivors of sexual violence.<sup>24</sup>

- The Lesotho Correctional Services’ HIV Policy and the Strategic Plan on HIV and AIDS provides for the management of HIV prevention, treatment and care in prisons. 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,<sup>25</sup> prohibits compelling an employee to disclose his or her HIV status or that of any other person<sup>26</sup> and prohibits discrimination against an employee on the basis of his or her HIV status.<sup>27</sup>

- Currently no domestic policy supports provision of harm reduction services in Lesotho, as data is scarce and prevalence studies are required.

Lesotho’s Intellectual property regime is regulated by the Industrial Property Order 1989 (Order No. 5 of 1989, as last amended by Act No. 4 of 1997).<sup>28</sup> It covers the Patents, Trade Marks, Industrial Designs and Utility Model and is administered by the Registrar General in the Ministry of Law and Constitutional Affairs. As a LDC, Lesotho does not yet have an obligation to adhere to TRIPS (exempted until 1 July 2033). Despite this, Lesotho has granted a few patents for pharmaceutical products. The granting of patents is blocking the opportunity to import, produce and use generic versions of the products on which patents are applied in Lesotho.

### ACCESS TO JUSTICE AND LAW ENFORCEMENT

There are still very few responsive and effective mechanisms to address discrimination in Lesotho and the justice system is the primary avenue for redress. The justice system in Lesotho is beset by severe problems and the government has conceded that access to justice is a challenge.

A 2013 report by Open Society Initiative of Southern Africa (OSISA) described the justice system in Lesotho as characterised by under-performance and a severe backlog of cases. Lesotho also suffers from a shortage of lawyers and other legal practitioners while the majority of those available in the country are concentrated in urban areas. As a result, people living in rural areas have limited access to legal advice and representation. The costs of legal representation also prevent many from accessing justice. The lack of HIV-specific legislation makes legal action more difficult as a recourse for HIV-related rights violations.<sup>29</sup> The OSISA report observes that women face additional barriers to accessing justice<sup>30</sup> as the justice system is not equipped to prosecute sexual offences and there are no specialized sexual offences courts. This undermines the willingness of women and girls to report sexual abuse. There are special children’s courts and Child and Gender Protection Units are tasked with addressing discrimination against children.<sup>31</sup>

There have been several initiatives to raise awareness about GBV by Women and Law in Southern Africa and the Federation of Women Lawyers Lesotho. These have included training workshops to change public perceptions of violence against women and children and campaigns, including radio programmes, to educate women about their rights.

The Legal Aid Department of the Ministry of Justice provides free legal representation for indigent people, as do some NGOs. The Legal Aid Department is however not able to meet the demand for legal aid.

The Lesotho Network of People Living with HIV and AIDS Stigma Index shows that about one in ten people living with HIV have had their rights violated in some way, including being forced to submit to a medical procedure.<sup>34</sup> The majority of people who experienced rights abuses sought legal redress and 19% reported that nothing had happened or the matter was not dealt with. The report also indicates that more than half of the respondents had heard of the Declaration of Commitment on HIV/AIDS and 30% of them were aware of laws in Lesotho that contained provisions protecting the rights of people living with HIV.

In November 2014, the Minister of Law and Constitutional Affairs introduced a bill in parliament to establish a national human rights commission. The bill has not yet been passed into law.<sup>35</sup>

## GAPS AND CHALLENGES

### PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

The draft HIV Bill has not yet been finalised or promulgated.

There are also a number of punitive and/or discriminatory laws that create barriers to access to health care services, as well as other gaps within law and policy:<sup>36</sup>



- 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.”<sup>37</sup> 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.<sup>38</sup> The anti-sodomy laws have however not been enforced for cases of consensual adult same sex sex. Sex between women is not criminalised. There is no legal recognition of the rights of transgender people as persons within the law.<sup>40</sup>
- Various aspects of sex work are criminalised in the Penal Code, including procurement,<sup>41</sup> solicitation,<sup>42</sup> living off the earnings of prostitution<sup>43</sup> and committing indecent acts in public.<sup>44</sup> Sex workers may not establish and legally register sex worker organisations for advocacy and health support.<sup>45</sup>
- 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.<sup>46</sup> In addition, Section 30 of the Sexual Offences Act 2003 provides for mandatory HIV testing in cases of unlawful sexual acts with the results of the test to be used for purposes of sentencing.<sup>47</sup> A person convicted of sexual assault who commits the assault with the knowledge or reasonable suspicion that he has HIV can be sentenced to death. Lesotho has however effectively abolished the death penalty and the last execution was carried out in 1995.<sup>48</sup>
- Many laws and practices 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.<sup>49</sup> Domestic violence is not recognised as a criminal offence and the Domestic Violence Bill has still not been passed into law. 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 with parental consent (it is 18 for boys) and there is no minimum age of marriage for customary unions. Abortion is only allowed in Lesotho to save a woman's life.
- Despite labour protection, herd boys / child shepherds work outside of the traditional ‘labour’ environment and are not protected by laws or policies.<sup>50</sup>
- Pre-employment HIV testing of applicants to the armed forces is not prohibited by the Labour Code.<sup>51</sup>

## HUMAN RIGHTS CHALLENGES



**Stigma and discrimination:** The Lesotho Network of People Living with HIV and AIDS Stigma Index, published in 2014, concluded that the levels of stigma and discrimination against people living with HIV in Lesotho are widespread, with gossip, verbal and physical abuse and social exclusion being the main forms of stigma.<sup>52</sup>

Internalised stigma is also a significant concern: 25% of the respondents were ashamed to be living with HIV and 20% felt guilty about it. The report finds that self-stigma resulted in people living with HIV making difficult decisions about intimate aspects of their lives, including avoiding having children, engaging in sexual intimacy or getting married.



**Rights of LGBTI:** There are high levels of stigma and discrimination against men who have sex with men as well as lesbian, gay, bisexual and transgender people who experience high levels of violence and a lack of access to health care.<sup>57</sup> Men who have sex with men in both Maseru and Maputsoe reported being subject to stigma and human rights abuses: 22.3% in Maseru and 8.5% in Maputsoe were forced to have sex against their will at least once.<sup>60</sup> A large number reported being verbally harassed (40.3% and 40.6%), blackmailed (20.4% and 16.5%), or experiencing physical aggression (28.9% and 12.7%). Some also reported being afraid to access healthcare because of their sexual behavior and/or identity (17.3% in Maseru and 3.8% in Maputsoe)<sup>59</sup>.



**Rights of sex workers:** Sex workers in Lesotho have extremely high levels of HIV prevalence. Female sex workers surveyed in both Maseru and Maputsoe reported being subjected to discrimination and harassment, with 27.2% of respondents in Maseru having faced discrimination by family members and 42.0% having been forced to have sex against their will at least once.<sup>58</sup> They are also vulnerable to physical and sexual abuse at the hands of the police and clients.<sup>61</sup> Harassment and intimidation by police was experienced by 57.6% of respondents in Maseru.<sup>62</sup> Many respondents reported being verbally harassed (49.5% in Maseru and 36.6% in Maputsoe), blackmailed (24.9% and 34.0%), or experiencing physical aggression (58.5% in Maseru and 22.5% in Maputsoe)<sup>63</sup>. They also face stigma and discrimination, particularly in access to health care. 20.3% of participants surveyed in Maseru and 7.8% in Maputsoe reported they were afraid to access healthcare services.<sup>64</sup> Those who access health care services often face untrained health care workers who discriminate against them and undermine their access to HIV prevention, testing and treatment.<sup>65</sup> Since 2014, the Lesotho Planned Parenthood Association has implemented a mobile clinic project for sex workers in various districts in Lesotho. These clinics provide HIV testing and counselling, family planning services, treatment of STIs, antenatal care and eMTCT services for pregnant women with HIV, ARV treatment, cancer screening and condom distribution.<sup>66</sup>

**Prisoner’s rights:** Nearly one in three prisoners in Lesotho is living with HIV. The Lesotho correctional services provide access to HIV and TB treatment for inmates and refer prisoners who are discharged to local health facilities. Prevention services in prisons include HIV testing and counselling, access to condoms and peer support and education.<sup>67</sup>

**Children’s rights:** There are estimated to be over 200,000 orphaned and vulnerable children in Lesotho, of which around 67% are children orphaned by AIDS and who need assistance with their basic needs for food, clothing and assistance with school fees. They also need protection of their rights to birth registration, property and inheritance.<sup>68</sup> A large number of adolescents and young people are out of school.<sup>69</sup> Herd boys / child shepherds are particularly vulnerable because of their isolated working conditions, limited access to education and services as well as a high risk of HIV exposure.<sup>70</sup>

**Migrant workers:** Migrant miners who travel between Lesotho and South Africa are at high risk of TB and HIV. The 2015 HIV country progress report expresses concerns about the lack of continuum of care for migrant mine workers who do not always receive HIV and TB treatment irrespective of the country they are in.

**Access to medicines:** Access to newer TB and HIV medicines is particularly difficult in Lesotho, due to the fact that India, since becoming fully TRIPS-compliant in 2005, can no longer automatically make or export these pharmaceutical products. In the near future, generic versions of newly patented products will be needed in Lesotho. Lesotho needs to strengthen its commitments to taking steps towards the incorporation of TRIPS flexibilities in national legislation.

**Approximately 43% of those who had experienced stigma and discrimination because of their HV status experienced the loss of a job or a source of income; 15% were refused employment and 5% changed residence or were not allowed to privately rent somewhere to live.**

Approximately 43% of those who had experienced stigma and discrimination because of their HV status experienced the loss of a job or a source of income; 15% were refused employment and 5% changed residence or were not allowed to privately rent somewhere to live. A small but significant number, 6%, reported being denied access to health care in the 12 months preceding the survey.



**Women’s rights:** Rape and domestic violence are under-reported in Lesotho but are believed to be widespread. There is only one government funded shelter for victims of domestic violence in Maseru, but the majority of victims are not aware of its existence.<sup>53</sup> Research on forced sterilisation of women with HIV conducted in several districts found that 24 of 73 women interviewed had been sterilised without their consent.<sup>54</sup>

Women in Lesotho are still not accorded equality in laws and practice.<sup>55</sup> They have inequitable access to property and inheritance, and property grabbing remains a serious issue. Child marriage is also a significant concern, with nearly one in five girls married before they reach the age of 18.<sup>56</sup>

RECOMMENDATIONS

Civil society should:

- Advocate for laws that promote the human rights of people living with HIV and/or TB and key populations.
- Advocate for repeal of all laws that criminalise adult consensual sex.
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights.
- 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, including prison personnel.
- Train health care providers on the human rights of people living with HIV and/or TB and key populations, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly.
- Advocate for the repeal of all laws that discriminate against women.
- Advocate for an increase in the minimum marriage age to 18 for boys and girls and repeal laws that permit parents to consent to the marriage of underage girls.
- Advocate for the decriminalisation of possession of drugs for personal use and use of drugs and for comprehensive harm reduction programmes.

The Lesotho government should:

- Immediately re-establish the National AIDS Council.
- Review and repeal laws that criminalise HIV transmission and discrimination against people living with HIV.
- Strengthen anti-discrimination protection for people living with HIV and TB and key populations.
- Review and repeal laws that discriminate against women.
- Enact the Domestic Violence Bill and explicitly criminalise marital rape.
- Increase the minimum marriage age to 18 for boys and girls and repeal laws that permit parents to consent to the marriage of underage girls.
- Decriminalise all adult consensual sex.
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, 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 and the judiciary.
- Decriminalise the possession of drugs for personal use and use of drugs.
- Expedite measures to review and reform the Patent Law to incorporate the TRIPS flexibilities and maximize their use in order to improve access to essential medicines.

END NOTES

<sup>1</sup> UNAIDS, *Lesotho HIV Epidemic Profile*, 2014, <http://www.unaidsrstes.org/wp-content/uploads/2015/05/UNAids-Profile-Lesotho.pdf> [accessed 12 May 2016]

<sup>2</sup> UNAIDS, *Global AIDS Response Progress Report*, 2015, [http://www.unaids.org/sites/default/files/country/documents/LSO\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/LSO_narrative_report_2015.pdf) [accessed 16 May] 2016

<sup>3</sup> Ibid. *Lesotho HIV Epidemic Profile*

<sup>4</sup> Ibid. *Global AIDS Response Progress Report*, 2015

<sup>5</sup> Sweitzer S, Rolfe J, Ketende S, Grosso A, and Baral S. Examining Factors Associated with HIV-Related Risk Behaviors, HIV Prevalence, and Population Size Estimates of Two Key Populations—Men who have Sex with Men (MSM) and Female Sex Workers (FSW)—in Lesotho. January 2015. Baltimore: USAID.

<sup>6</sup> Ibid.

<sup>7</sup> UNAIDS, *Global AIDS Response Progress Report*, 2015, [http://www.unaids.org/sites/default/files/country/documents/LSO\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/LSO_narrative_report_2015.pdf) [accessed 16 May] 2016

<sup>8</sup> Ibid.

<sup>9</sup> UNAIDS, *2015 Progress Report on the Global Plan towards the elimination of new infections amongst children and keeping their mothers alive*, [http://www.unaids.org/sites/default/files/media\\_asset/JC2774\\_2015ProgressReport\\_GlobalPlan\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf) [accessed 22 May 2016]

<sup>10</sup> Ibid., *Global AIDS Response Progress Report*, 2015

<sup>11</sup> WHO, *Global Tuberculosis Report 2015*, [http://www.who.int/tb/publications/global\\_report/en/](http://www.who.int/tb/publications/global_report/en/) [accessed 25 April 2016]

<sup>12</sup> Lesotho, *Health Sector Strategic Plan 2012/13 – 2016/17*, April 2013 [http://www.nationalplanningcycles.org/sites/default/files/country\\_docs/Lesotho/19\\_04\\_2013\\_lesotho\\_hssp.pdf](http://www.nationalplanningcycles.org/sites/default/files/country_docs/Lesotho/19_04_2013_lesotho_hssp.pdf) [accessed 13 May 2016]

<sup>13</sup> Ibid., *Global AIDS Response Progress Report*, 2015

<sup>14</sup> Lesotho, *National HIV and AIDS Strategic Plan 2011/12 – 2015/16*, [http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/iiep\\_lesothodraftstrategicplan.pdf](http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/iiep_lesothodraftstrategicplan.pdf) [accessed 13 May 2016]

<sup>15</sup> Government of Lesotho, National HIV Prevention Strategy for a Multi-sectoral Response to the HIV Epidemic in Lesotho (2011/12-2015/16)

<sup>16</sup> <http://www.pepfar.gov/countries/lesotho/> [Accessed 6 July 2016]

<sup>17</sup> Available at <http://www.ls.undp.org/content/lesotho/en/home/presscenter/articles/2014/08/13/promoting-trade-and-intellectual-property-rights-trips-flexibilities-to-enhance-access-to-medicines-in-lesotho.html>

<sup>18</sup> Ibid. *Global AIDS Response Progress Report*, 2015

<sup>19</sup> An HIV and AIDS Bill was drafted a number of years ago, but has never been finalized.

<sup>20</sup> UNAIDS, *Lesotho NCPI Report*, 2012.

<sup>21</sup> AIDS 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

<sup>22</sup> International, 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

<sup>23</sup> UNAIDS, *Lesotho Country Progress Report*, 2012.

<sup>24</sup> Gertholtz, 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

<sup>25</sup> Section 235 C

<sup>26</sup> Section 235 D

<sup>27</sup> Section 235 E

<sup>28</sup> Industrial Property Order 1989 Available at <http://www.wipo.int/wipolex/en/details.jsp?id=5874> [Accessed 6 July 2016]

<sup>29</sup> UNAIDS, *Lesotho NCPI Report*, 2012.

<sup>30</sup> OSISA, *Lesotho: Justice Sector and the Rule of Law*, March 2013, [http://www.osisa.org/sites/default/files/afrimap\\_lesotho\\_justice.pdf](http://www.osisa.org/sites/default/files/afrimap_lesotho_justice.pdf)

<sup>31</sup> UNAIDS, , *Lesotho NCPI Report*, 2014, <http://www.unaids.org/sites/default/files/country/documents/Lesotho%20NCPI%202013.pdf> [accessed 13 May 2016]

<sup>32</sup> Ibid.

<sup>33</sup> Ibid.

<sup>34</sup> The Lesotho Network of People Living with HIV and AIDS, *The People Living with HIV Stigma Index, Lesotho 2014*, <http://www.stigmaindex.org/sites/default/files/reports/Lesotho%20Stigma%20Index%20draft%20report%206-%20L.pdf>

<sup>35</sup> US Bureau of Democracy, Labor and Human Rights, *Country Reports on Human Rights Practices for 2015, Lesotho* <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 13 May 2016]

<sup>36</sup> UNAIDS, *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, [http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/priorities/20100728\\_HR\\_Poster\\_en.pdf](http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/priorities/20100728_HR_Poster_en.pdf)



<sup>37</sup> Amnesty International, *Making Love A Crime: Criminalisation of Same-Sex Conduct in Sub-Saharan Africa*, April 2013 [http://www.amnestyusa.org/sites/default/files/making\\_love\\_a\\_crime\\_-\\_africa\\_lgbti\\_report\\_emb\\_6.24.13\\_0.pdf](http://www.amnestyusa.org/sites/default/files/making_love_a_crime_-_africa_lgbti_report_emb_6.24.13_0.pdf)

<sup>38</sup> Schedule 1 Part II

<sup>39</sup> Mail and Guardian, *We are Here: Basotho March for LGBTI Rights*, 21 May 2015, <http://voicesofafrica.co.za/basotho-march-lgbti-rights/> [accessed 13 May 2016]

<sup>40</sup> Global 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

<sup>41</sup> Section 55(2)

<sup>42</sup> Section 55(3)

<sup>43</sup> Section 55(4)

<sup>44</sup> Section 56

<sup>45</sup> Ibid.

<sup>46</sup> Section 30 (1) of the Sexual Offences Act of 2003

<sup>47</sup> Section 30 (3) and (4) of the Sexual Offences Act

<sup>48</sup> Cornell Law School, *Death Penalty Worldwide*, <http://www.deathpenaltyworldwide.org/country-search-post.cfm?country=Lesotho#f4-3> [accessed 13 May 2016]

<sup>49</sup> Submissions 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

<sup>50</sup> UNAIDS, *Lesotho NCPI Report*, 2012.

<sup>51</sup> Ibid.

<sup>52</sup> The Lesotho Network of People Living with HIV and AIDS, *The People Living with HIV Stigma Index, Lesotho 2014*, <http://www.stigmaindex.org/sites/default/files/reports/Lesotho%20Stigma%20Index%20draft%20report%206-%20L...pdf> [accessed 13 May 2016]

<sup>53</sup> US Bureau of Democracy, Labor and Human Rights, *Country Reports on Human Rights Practices for 2015*, Lesotho

<sup>54</sup> Ibid.

<sup>55</sup> Ibid.

<sup>56</sup> Girls Not Brides, *Child Marriage Across the World: Lesotho*, <http://www.girlsnotbrides.org/child-marriage/lesotho/> [accessed 13 May 2016]

<sup>57</sup> Huffpost Queer Voices, *A Movement that Matters: Trans Rights in Lesotho*, 2 February 2016, [http://www.huffingtonpost.com/randal-mason/a-movement-that-matters-t\\_b\\_6177810.html](http://www.huffingtonpost.com/randal-mason/a-movement-that-matters-t_b_6177810.html) [accessed 13 May 2016]

<sup>58</sup> Sweitzer S, Rolfe J, Ketende S, Grosso A, and Baral S. Examining Factors Associated with HIV-Related Risk Behaviors,HIV Prevalence, and Population Size Estimatesof Two Key Populations—Men who have Sex with Men (MSM) and Female Sex Workers (FSW)—in Lesotho. January 2015.Baltimore: USAID.

<sup>59</sup> Ibid.

<sup>60</sup> Sweitzer S, Rolfe J, Ketende S, Grosso A, and Baral S. Examining Factors Associated with HIV-Related Risk Behaviors,HIV Prevalence, and Population Size Estimatesof Two Key Populations—Men who have Sex with Men (MSM) and Female Sex Workers (FSW)—in Lesotho. January 2015.Baltimore: USAID.

<sup>61</sup> UNAIDS, *Lesotho NCPI Report*, 2014

<sup>62</sup> Sweitzer S, Rolfe J, Ketende S, Grosso A, and Baral S. Examining Factors Associated with HIV-Related Risk Behaviors,HIV Prevalence, and Population Size Estimatesof Two Key Populations—Men who have Sex with Men (MSM) and Female Sex Workers (FSW)—in Lesotho. January 2015.Baltimore: USAID.

<sup>63</sup> Ibid.

<sup>64</sup> Ibid.

<sup>65</sup> The Lancet, *Lives on the Line: sex work in sub-Saharan Africa*, <http://www.hivsharespace.net/system/files/Lancet%202015%20burden%20Sex%20work%20in%20SSA.pdf>

<sup>66</sup> IPPF, *Reaching Sex Workers Through Mobile Clinics in Lesotho*, <http://www.ippfar.org/reaching-sex-workers-through-mobile-clinics-lesotho> [accessed 13 May 2016]

<sup>67</sup> Ibid., *Global AIDS Response Progress Report*, 2015

<sup>68</sup> Ibid.

<sup>69</sup> Ibid.

<sup>70</sup> UNAIDS, *Lesotho Country Progress Report*, 2012.





# BACKGROUND MADAGASCAR

According to UNAIDS, in 2014 less than 1% of the population - 35 000 people aged 15 years and over - were living with HIV in Madagascar. Unlike most other countries in the SADC, women are less affected by HIV than men with 16 000 women aged 15 years and over living with HIV compared to 19 000 of their male peers. In 2014, there were also an estimated 4 500 children aged 0 to 14 years living with HIV and around 3 200 AIDS-related deaths. <sup>1</sup>

Madagascar is said to have a concentrated HIV epidemic. In 2012, a study found that 14.8% of gay men and men who have sex with men were living with HIV, 7.1% of people who inject drugs were living with HIV and 1.3% of sex workers were living with HIV. <sup>2</sup>

Key populations in Madagascar include people living with HIV, gay men and men who have sex with men, migrant and mobile populations, orphans and other vulnerable children, people who inject drugs, prisoners, sex workers, women and girls, young people, TB patients, patients with STIs and pregnant women. <sup>3</sup> Girls under 18 years of age living in areas frequented by tourists are also considered to be at particularly high risk of HIV exposure. <sup>4</sup>

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 (due to labour mobility), tourism as well as the presence of traditional rites and customs. <sup>5</sup>

The number of people on ART increased from 519 in 2013 to 744 in 2014; this is an increase of over 40%. However this increase still did not contribute enough to meet the treatment goals set for 2014. <sup>6</sup>

Madagascar has a high TB incidence and prevalence rate, with 96 000 people diagnosed with TB in Madagascar. <sup>7</sup> Around 1% of these are people are also living with HIV. <sup>8</sup> In 2014, 98 people on ART also began treatment for TB. The number of people living with HIV and on treatment in whom active TB was detected increased to 8.2% in 2014.

Madagascar's NSP for 2013-2017 envisions Madagascar as a country with zero new HIV infections, zero AIDS-related deaths and zero discrimination. The NSP is based on principles of human rights and gender equality. It aims to reduce new HIV infections by 50%, reduce the transmission of HIV from mother to child to less than 5% and increase the survival rates of people living with HIV by 95%, 12 months after initiation on ART. There is a strong focus on reaching key populations such as sex workers, gay men and men who have sex with men, people who inject drugs and prisoners, as well as children and marginalised young people.

## KEY HUMAN RIGHTS CONCERNS FOR 2016

- HIV-related stigma and discrimination
- Human rights abuses against key populations
- Gender inequality and gender based violence
- The rights of children in the context of HIV and TB



## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### 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. <sup>9</sup> It enshrines equality between men and women. <sup>10</sup> It protects the right of every person to dignity and privacy. <sup>11</sup> In addition, it provides for a range of socio-economic rights including the individual's right to the protection of his or her health <sup>12</sup> and the right to free public education. <sup>13</sup>

### RATIFICATION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

Madagascar ratified the Convention on the Rights of Persons with Disabilities in June 2015. In addition, Madagascar has ratified:

- African Charter on Human and Peoples' Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990



- Convention on the Rights of the Child (CRC), 1989
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1971
- International Convention on Civil and Political Rights (ICCPR), 1966

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 includes:

- 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 rights and fundamental freedoms in accordance with international human rights instruments.<sup>14</sup>
- Provisions for free, voluntary, anonymous and confidential HIV testing, with informed consent.<sup>15</sup>
- Provisions for voluntary HIV testing for pregnant women during antenatal consultations.<sup>16</sup>
- Protection from discrimination in terms of access to life or health insurance.<sup>17</sup>
- 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.<sup>18</sup>
- Protection from discrimination or stigmatisation in the workplace including pre-employment HIV testing,<sup>20</sup> being refused employment or the termination of employment on the basis of HIV status.<sup>21</sup>
- Protection from discrimination, isolation and compulsory HIV testing within prisons.<sup>22</sup>
- Protection from discrimination and from breaches of the right to confidentiality within the health care sector.<sup>23</sup>

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<sup>24</sup> and for condoms to be made available in highly frequented places and to be freely distributed in prisons.<sup>25</sup>

A Decree of 2006-092 on the enforcement of the Law 2005-040 set down 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.<sup>26</sup>

All national policies and strategies were reviewed by the Law and HIV Commission to ensure they were non-discriminatory and the national HIV policy, updated in 2010, explicitly includes respect for human rights.<sup>27</sup>

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.<sup>28</sup> 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.<sup>29</sup>

The Family Code in Madagascar was amended in 2007 to increase the minimum legal age of marriage to 18 for both men and women.<sup>30</sup>

Women are protected from domestic violence (narrowly defined as physical abuse) by article 321 and from sexual violence by article 332 of the Penal Code (as amended by Act 2000-021 of 30/11/2000, which strengthened protection against GBV).<sup>31</sup> The Penal Code severely punishes rape, attempted rape, indecent assault<sup>32</sup> and incest,<sup>33</sup> but does not explicitly criminalise marital rape.

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.<sup>34</sup> In practice, however, it remains important to pass down the father’s name and estate through male heirs and the law allows heirs to agree that male heirs will receive the land while female heirs receive their share in other assets.<sup>35</sup>

ACCESS TO JUSTICE AND LAW ENFORCEMENT

Madagascar has a legal aid system as well as private sector law firms to provide legal support services to people living with HIV. However, 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, CSOs as well as key individuals within state institutions. For instance:

- There has been some work carried out by various government ministries, CSOs and other stakeholders to create awareness and sensitise employers, the media, health care workers, members of the judiciary and tourists on HIV, law and human rights issues.<sup>36</sup>
- The HIV law has been distributed to parliamentarians, the Ministry of Justice and the Ministry of the Interior. Training on the HIV Law has also taken place for HIV focal point persons in various sectors and for human rights commissioners. However, many challenges remain including a lack of knowledge about rights.<sup>37</sup> Access to justice as a recourse for HIV-related human rights infringements is also weak, despite various initiatives to increase access to justice and the inclusion of penalties for discrimination within the HIV law. In particular, the following issues have been raised as challenges in relation to access to justice and law enforcement:
- 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.<sup>38</sup>

GAPS AND CHALLENGES

PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

Madagascar has signed but has not ratified the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003.

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 HIV-related services.

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.<sup>39</sup> This provision creates a barrier to the provision of harm reduction services (such as needle exchange programmes) for people who inject drugs.<sup>40</sup>

Homosexuality is not explicitly criminalised, but the Penal Code criminalises same-sex sexual activity where participants are below the age of 21.<sup>41</sup> Procuring sex, living off the earnings of sex work, brothel keeping and solicitation are criminalised in terms of the Penal Code.<sup>42</sup>

The Family Law of Madagascar raised the minimum age for marriage from 14 years for girls and 17 for boys, to 18 years for all children. However, the President of the Court may authorize a marriage upon the request of the child’s parents or guardian and the consent of the child.<sup>43</sup>

HUMAN RIGHTS CHALLENGES

**Stigma and discrimination:** HIV-related stigma and discrimination is a priority human rights issue in Madagascar, with people experiencing discrimination in various sectors, including in the workplace and the health care sector (including testing without consent, breaches of confidentiality and a denial of care). People avoid HIV testing services, for fear of testing HIV-positive.<sup>44</sup> SISAL, 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 coercive sterilisation from women living with HIV.<sup>45</sup>

**Rights of key populations:** Gay men and 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.

**Prisoner’s rights:** A report on human rights in Madagascar described prison conditions as “harsh and life-threatening”.<sup>46</sup> Prisons are severely over-crowded at almost twice official capacity<sup>47</sup> and malnutrition as well as a lack of hygiene make prisoners vulnerable to disease.<sup>48</sup> Given that TB is endemic in Madagascar, prison conditions make prisoners extremely vulnerable to TB infection.



**Rights of women and girl children:** Gender inequality, harmful gender norms and GBV are concerns in Madagascar. While women enjoy the same legal status as men, they experience discrimination in employment and in inheritance. Widows without children are less entitled to inheritance than a deceased’s husband’s surviving family. Early and forced marriage are of particular concern for girl children.<sup>49</sup> Intimate partner violence is widespread in Madagascar.



RECOMMENDATIONS

Civil society should:

- Advocate for laws that promote the human rights of people living with HIV and/or TB and key populations.
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights.
- Raise awareness about stigma and discrimination against people living with HIV and/or TB.
- Train law enforcement officials on the human rights of key populations.
- Advocate for the decriminalisation of possession of drugs for personal use and use of and for comprehensive harm reduction programmes.
- Support ongoing efforts to strengthen access to justice, especially for vulnerable and key populations through various interventions including stigma and discrimination reduction programmes; 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, including prison personnel.

The Madagascar government should:

- Ratify the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa.
- Review and repeal the provisions of the HIV law that criminalise HIV transmission.
- Decriminalise all consensual adult sex and review laws to ensure that the age of consent to all consensual sex is equal for heterosexual and homosexual sex.
- Review and repeal laws that criminalise the possession of drugs for personal use and the use of drugs and institute harm reduction for people who use drugs.
- Develop and implement a policy on TB in prisons.
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support services, training for law and policy makers and the judiciary.

END NOTES

<sup>1</sup> <http://www.unaids.org/en/regionscountries/countries/madagascar/> [Accessed 10 May 2016]

<sup>2</sup> ESNB 2012, as cited in UNAIDS, *Madagascar Country Progress Report*, 2015. Available at [http://www.unaids.org/sites/default/files/country/documents/MDG\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/MDG_narrative_report_2015.pdf) [Accessed 10 May 2016]

<sup>3</sup> UNAIDS, *Madagascar NCPI Report*, 2013. Available at <http://www.unaids.org/en/regionscountries/countries/madagascar/> [Accessed 12 May 2016].

<sup>4</sup> Correspondence from SISAL, August 2012.

<sup>5</sup> UNAIDS, *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/aid](http://www.worldbank.org/aid)s [Accessed 27 July 2012]

<sup>6</sup> UNAIDS, *Madagascar Country Progress Report*, 2015. Available at [http://www.unaids.org/sites/default/files/country/documents/MDG\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/MDG_narrative_report_2015.pdf) [Accessed 10 May 2016].

<sup>7</sup> Rapport DLIS/MSP 2014 as cited in , as cited in UNAIDS, *Madagascar Country Progress Report*, 2015. Available at [http://www.unaids.org/sites/default/files/country/documents/MDG\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/MDG_narrative_report_2015.pdf) [Accessed 10 May 2016].

<sup>8</sup> Ibid.

<sup>9</sup> Article 8

<sup>10</sup> Articles 8, 21, 27 and 28.

<sup>11</sup> Article 13

<sup>12</sup> Article 19

<sup>13</sup> Articles 23 and 24

<sup>14</sup> Articles 1 and 2

<sup>15</sup> Articles 5 and 7

<sup>16</sup> Article 20

<sup>17</sup> Article 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

<sup>18</sup> Article 36

<sup>19</sup> Article 44

<sup>20</sup> Article 11

<sup>21</sup> Article 46

<sup>22</sup> Article 59

<sup>23</sup> Articles 62 and 63

<sup>24</sup> Article 26

<sup>25</sup> Article 25.

<sup>26</sup> UNAIDS, *Madagascar NCPI Report*, 2012.

<sup>27</sup> UNAIDS, *Madagascar NCPI Report*, 2013.

<sup>28</sup> UNAIDS, *Madagascar NCPI Report*, 2012.

<sup>29</sup> Ibid.

<sup>30</sup> <http://www.genderindex.org/country/madagascar> [Accessed 13 May 2016]

<sup>31</sup> Ibid.

<sup>32</sup> Article 331

<sup>33</sup> Article 333

<sup>34</sup> Article 16

<sup>35</sup> <http://www.genderindex.org/country/madagascar> [Accessed 13 May 2016]

<sup>36</sup> UNAIDS, *Madagascar NCPI Report*, 2013.

<sup>37</sup> Correspondence, SISAL, August 2012; UNAIDS, *Madagascar NCPI Report*, 2012

<sup>38</sup> Ibid.

<sup>39</sup> Article 105

<sup>40</sup> UNAIDS, *Madagascar NCPI Report*, 2012. Available at <http://www.unaids.org/en/dataanalysis/knownyourresponse/ncpi/2012countries/Madagascar%20NCPI%202012.pdf>

<sup>41</sup> <http://www.genderindex.org/country/madagascar> [Accessed 13 May 2016]

<sup>42</sup> Sections 334, 335 and 336 of the Penal Code

<sup>43</sup> <http://www.genderindex.org/country/madagascar> [Accessed 13 May 2016]

<sup>44</sup> Submissions to the GCHL *Africa Regional Dialogue*, Pretoria 3-4 August 2011: Madagascar Independent submission at 42; correspondence from SISAL, August



2012

<sup>45</sup> Correspondence from SISAL, August 2012

<sup>46</sup> 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 22 September 2013]; See also updated report at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [Accessed 13 May 2016]

<sup>47</sup> <http://www.prisonstudies.org/country/madagascar> [Accessed 13 May 2016]

<sup>48</sup> Correspondence, SISAL, August 2012

<sup>49</sup> <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [Accessed 13 May 2016]

<sup>50</sup> <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [Acce



# MALAWI

## BACKGROUND

The last nationally representative HIV survey in Malawi was conducted in 2010. Since then, there has been no more recent research to estimate HIV prevalence. Based on previous survey data, Malawi has a generalised HIV epidemic. HIV prevalence among persons aged 15 to 49 years has been declining steadily from 16.4% in 1999 to 11.8% in 2004 and then 10.6% in 2010.<sup>1</sup> The 2014 Malawi HIV Epidemic Profile estimated that 1 000 000 people were living with HIV, with a 10.3% prevalence amongst adults between the ages of 15 – 49. There were 48 000 AIDS deaths in 2013, a reduction from 61 000 in 2010.<sup>2</sup>



The 2013 Modes of Transmission Study showed that married or co-habiting couples accounted for 67% of all new HIV infections. The study also estimated high levels of HIV amongst men who have sex with men, female sex workers and their partners and clients.

In 2014, Malawi conducted a national study to estimate HIV prevalence and risky behaviour amongst groups who face a disproportionate HIV burden including female sex workers, female border traders, long distance truck drivers, police officers, estate workers, teachers and fishermen. Although prevalence within each of these groups is higher than in the general population, it appears to have declined significantly in female sex workers, male teachers, police officers and fishermen. There was also a smaller decrease amongst male estate workers and female border traders. Prevalence remained the same amongst female teachers, male vendors and female estate workers. There was a marked increase in HIV prevalence amongst truck drivers and a marked gender difference, with women having a higher prevalence than men.<sup>4</sup> No data is available in regards to HIV prevalence among transgender people in Malawi.

Malawi implemented new clinical guidelines for the management of HIV in children and adults in April 2014.<sup>5</sup> Following these changes, the estimated number of children and adults in need of ART increased from 681 000 to nearly 800 000. By the end of December 2014, 533 027 people were on ART, an increase of 13% from 472,865 on ART by the end of December 2013.<sup>6</sup> Although this represents 67% of those needing ART, based on the new treatment guidelines, it is well below the 85% Universal Access target.<sup>7</sup> The introduction of Option B+ for pregnant women has increased the number of pregnant women receiving ART.

Malawi has developed a new National HIV and AIDS Strategic Plan (NSP) for 2015 – 2020. The NSP identifies the protection and promotion of human rights and gender equality as key guiding principles.<sup>8</sup> It recognizes the need to provide targeted interventions to key populations, which include female sex workers and their clients, men who have sex with men, fishermen, estate workers, discordant couples, family members of people living with HIV, young women, children and prisoners.<sup>9</sup> Transgender persons are mentioned as distinct from gay men and facing inequalities, but the plan does not recognise them as a key population and does not include specific interventions for this group.<sup>10</sup>

Malawi has recently developed an HIV Prevention Strategy for 2015 – 2020. The Prevention Strategy targets key populations including men who have sex with men, female sex workers and girls and young women and promotes a rights and gender based approach to implementing prevention, including addressing stigma and discrimination.<sup>11</sup>

Malawi is considered to be a high burden country for TB and HIV. Approximately 56 000 people are living with TB and HIV.<sup>12</sup> The 2015 Malawi AIDS Response Progress report estimated that 90% of the HIV/TB coinfected patients were receiving both TB and HIV treatment and 91% of TB patients were tested for HIV. Clinical screening for TB was conducted on 96% of pre-ART patients or patients already on treatment. Concerns have however been expressed about the poor sensitivity of the clinical assessment or diagnostic tools available in health facilities and that overstretched health care workers were not strictly adhering to TB screening guidelines when following up patients living with HIV.<sup>13</sup> The WHO estimates approximately 78% of TB cases are being diagnosed in Malawi.<sup>14</sup>

## KEY HUMAN RIGHTS CONCERNS IN 2016

- HIV-related stigma and discrimination
- Gender based violence and gender inequality
- Human rights abuses against key population
- Workplace abuses
- Children
- People with disabilities





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 protects a number of human rights that are important in the context of HIV, AIDS and TB such as the rights to equality and nondiscrimination,<sup>15</sup> privacy,<sup>16</sup> liberty and security,<sup>17</sup> life,<sup>18</sup> work,<sup>19</sup> freedom of<sup>15</sup> expression and information,<sup>20</sup> women’s rights,<sup>21</sup> children’s rights<sup>22</sup> and the rights of people with disabilities.<sup>23</sup> The right to health is not specifically included in the Constitution but it is a Principle of National Policy<sup>24</sup> and is also included in the right to development<sup>25</sup> which enjoins the state to take measures to promote development, including equality of access to health care.

Section 22(6) sets 18 as the minimum marriage age and section 22(4) prohibits forced marriage.

RATIFICATION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

Malawi has ratified:

- African Charter on Human and Peoples’ Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Rights of Persons with Disabilities, 2006
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1993
- International Convention on Civil and Political Rights (ICCPR), 1966
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003

NATIONAL LAWS AND POLICIES

There are various laws that protect people living with HIV and/or TB and other key populations from discrimination, exposure to HIV and from the impact of HIV and AIDS. Malawi undertook an assessment of the legal and regulatory environment for HIV and AIDS in 2012. The report concludes that while there are various health and other laws and policies that promote health rights, there are challenges to implementation, including a lack of financial and human resources.<sup>26</sup>

- 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 or TB.
- 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 Prevention of Domestic Violence Act, 2005 increased protection for women from domestic violence in all relationships, including from sexual abuse within their domestic relationships (although it fails to explicitly criminalise marital rape). The Penal Code criminalises sexual offences including rape,<sup>27</sup> defilement<sup>28</sup> and incest. The Penal Code also sets the age of consent to sex at 16 and sets a mandatory life sentence for the rape of an underage girl.<sup>29</sup> The Marriage, Divorce and Family Relations Act was passed in February 2015. The act recognizes different forms of marriage: civil marriage, customary and religious marriages and marriage by cohabitation<sup>30</sup> and gives equal rights to men and women in all matters related to marriage and divorce.<sup>31</sup>
- Malawi enacted a Trafficking in Persons Act in 2015. The law imposes a sentence of 14 years on anyone who trafficks an adult and 21 years for trafficking children.<sup>22</sup> The act makes provision for the protection of victims of trafficking and their access to services.
- The Deceased Estate (Wills and Inheritance) Act 2011 criminalises property grabbing and provides improved inheritance rights for women upon death of a spouse. The Gender Equality Act was also passed into law in February 2013. The 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 passed in April 2012. Although it makes no specific mention of HIV and AIDS, it does increase protection for the rights of people with disabilities. The act took effect in 2013, but the government has not developed regulations or an implementation plan.<sup>33</sup>

ACCESS TO JUSTICE AND LAW ENFORCEMENT

The 2012 legal and regulatory environment report stated that access to justice and law enforcement for human rights violations is limited.<sup>34</sup> Legal aid services are under-resourced and unable to meet the massive demand. The CEDAW Committee, in its 2015 review of Malawi, noted that insufficient human, technical and financial resources have been allocated to the Legal Aid Bureau and its services were not available in all areas.<sup>35</sup> Private lawyers are beyond the reach of most people.

The courts are also inaccessible due to high costs, distances to courts (which operate in a few urban areas) and the time delays involved in litigation. Women and children face particular challenges in enforcing their rights. The CEDAW Committee expressed concerns that women face multiple barriers in access to justice, including their lack of legal literacy, especially in rural areas. The Children’s Rights International Network released a report in<sup>36</sup> late 2015 that documented barriers to access to justice for children, stating that children in Malawi face significant challenges when their rights are violated.<sup>37</sup>

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. 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.

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. The CEDAW Committee was concerned that customary judicial mechanism are not gendersensitive and continue to apply discriminatory provisions.<sup>38</sup>

The Malawi Human Rights Commission is overstretched. The UN Human Rights Committee, in its 2014 review of Malawi, indicated that although the Commission is supposed to implement the Gender Equality Act, it lacks the resources to do so. The Committee also expressed concern about the reluctance of the Commission to engage in issues related to the rights of LGBTI persons.<sup>39</sup>

Due to the continuing criminalisation of same sex practices, there is limited access to justice for LGBTI persons. However, in 2015 Malawi adopted a recommendation from the UN Human Rights Committee to “take effective measures to protect lesbian, gay, bisexual and intersex persons from violence and prosecute the perpetrators of violent attacks and access to nondiscriminatory health services”<sup>40</sup>

GAPS AND CHALLENGES

PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

The legal and regulatory environment report concluded that many laws predate the HIV epidemic and do not specifically deal with the inequality and human rights abuses associated with HIV. There are coercive and punitive laws on the books that create barriers to the national response to HIV and AIDS.<sup>41</sup> The 2014 NCPI report states that there are current proposals to amend the Penal Code in relation to antisodomy laws and ongoing reviews of the Public Health and HIV draft bill.<sup>42</sup> It is not clear when these will be finalised.

The Constitution defines marriage as only between men and women.<sup>43</sup> It sets a minimum marriage age of 18, but allows exceptions for children between the ages of 15 and 18 with parental consent or the permission of a guardian.<sup>44</sup> The new Marriage Act has removed the exception but a constitutional amendment is required to enforce the prohibition on marriages where either spouse is below the age of 18.<sup>45</sup> Furthermore, the new Marriage Act defines sex as the one assigned at birth, essentially undermining the right to a gender identity.<sup>46</sup>

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). Punitive provisions included disclosure of HIV status by health care workers, compulsory HIV testing of specified populations (e.g. sexual offenders, pregnant women, sex workers, partners in polygamous unions), 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 vulnerable populations and key populations. 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 human rights standards. A revised Bill which excludes provisions for mandatory testing and criminalisation was drafted but has not yet been enacted.

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 <sup>47</sup> 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 Code 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.

It is not clear whether marital rape is criminalised. Although the Penal Code criminalises rape, rape is defined ‘outside’ of marriage and consent to sex is considered to be implied upon marriage. The Penal Code does not criminalise all forms of sexual violence against boys. <sup>47</sup>

The Penal Code criminalises sex between men<sup>49</sup> and sex between women.<sup>50</sup> Consensual same sex relationships are punishable by up to 14 years imprisonment. In 2014, the Solicitor General told the UN Human Rights Commission that the Law Commission was reviewing the constitutionality of antigay laws and would suspend enforcement until the review was complete. <sup>51</sup> On 18 December 2015, the Minister of Justice again confirmed the antigay provisions of the Penal Code would not be enforced, pending the finalization of the review. <sup>52</sup> Malawi rejected recommendations from a number of states to decriminalise consensual sexual conduct between adults of the same sex at the 2015 UPR session <sup>53</sup>. The 2015 Marriage Act discriminates against same sex couples by limiting marriage to persons of the opposite sex. It also reinforces the prohibition against unnatural offences in the Penal Code by listing a conviction for such an offence as evidence of irretrievable breakdown of marriage. <sup>54</sup>

While the Penal Code does not explicitly criminalise the selling of sex, it criminalises various aspects of sex work;<sup>55</sup> and ‘nuisance’ laws,<sup>56</sup> such as ‘rogue’ and ‘vagabond’ laws are also used against sex workers, despite a court ruling in the case of Bridget Kaseka et al v Rep<sup>57</sup> 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 people with specified infections, sex workers and men who have sex with men who are not citizens of Malawi. <sup>58</sup>

HUMAN RIGHTS CHALLENGES



**Stigma and discrimination:** People living with HIV are stigmatised and discriminated against in their communities, families and homes. In 2015, a popular entertainer, Jakuda Maxwell, known as the Serious Man, released a song mocking people living with HIV. The song was played on radio stations and in public venues.<sup>59</sup> A study published in 2014 investigated stigma and discrimination against people living with HIV receiving home base care. The results showed that all the participants faced stigma and discrimination on the grounds of their HIV status and that distant relatives, followed by friends and church members were the main source. Many participants felt they were stigmatized because HIV is associated with sex work and promiscuity. People with TB are also stigmatized and are reluctant to <sup>60</sup> seek treatment. <sup>61</sup>



**Women’s rights:** Women experience gender inequality in their relationships and are subjected to harmful 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 and postexposure prophylaxis (PEP) is not easily accessible to rape survivors.<sup>62</sup> The UN Human Rights Committee expressed concern about the lack of official data on the extent or violence against women and the number of prosecutions. <sup>63</sup>

**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. There is a high prevalence of sexual abuse of children and the 2014 Violence Against Children Survey, Malawi’s first nationally representative study on violence against children, found that 2 out of every 3 Malawians experienced violence in childhood, and 1 in every 5 girls were sexually abused before they reached 18. Malawi has very high rates of child marriage and is ranked 9th out of 20 global hotspots for child marriage.<sup>65</sup> Approximately 50% of girls are married before they reach the age of 18,<sup>64</sup> and 12% are married before the age of 15.<sup>66</sup> Child marriage exposes girls to adverse health consequences, including HIV. Efforts are being made to eradicate the practice, including by passing the 2015 Marriage Act which sets a minimum marriage of 18 for girls and boys.<sup>67</sup>



**Rights of LGBTI persons :** LGBTI people experience high levels of stigma and discrimination in all aspects of life including within their families, communities and in public. Despite the moratorium on enforcing the antigay laws, the police arrested and charged two men under the antisodomy laws in December 2014. They were forced to undergo medical examinations and then released on bail. The Minister of Justice later dropped the charges against them, citing the moratorium. Two other men, charged under the same laws in May 2014, remained free on bail. The Centre for Human Rights and Rehabilitation and the Centre for Development of People documented 40 cases of abuses on the grounds of sexual orientation and gender identity, including stigma, harassment and violence. <sup>68</sup>

Additionally, other criminal laws, including the following sections of the penal code are often used to harass and arrest LGBTI people; often on the basis of gender expression: section 168 (“common nuisance”), section 180 (“idle and disorderly persons”), and section 181 (“conduct likely to cause a breach of the peace”). One trans woman reported that she was arrested for “impersonating a woman”. While there are few actual prosecutions, these laws are used often to harass, blackmail, and illegally detain LGBTI persons.<sup>69</sup>

There is no legal recognition of gender identity in Malawi; furthermore, the definition of “sex” as one’s “sex assigned at birth” in the new Marriage Act of 2015 was specifically included to address the issue of the capacity to marry by transgender persons.<sup>70</sup> This definition is a clear dismissal of any legal recognition of gender identity, for both transgender and intersex persons.



**Rights of sex workers:** Sex workers experience violations of their right to health: health care workers fail to respect their confidentiality and sometimes deny health services to sex workers. A 2015 report by the Sexual Rights Initiative to the UN Human Rights Committee states that health care workers shout at sex workers in the presence of other patients, disclose their health conditions to third parties without their consent and publicly humiliate them. Pregnant sex workers with HIV face barriers to accessing eMTCT programmes which require that pregnant women bring their spouses with to their first ante-natal visit. Sex workers also face discrimination at the hands of landlords.<sup>71</sup> Human rights violations faced by sex workers are often linked to other violations. In 2009 seventeen sex workers were detained, forcibly tested for HIV and eleven prosecuted under section 192 of the penal code (spreading venereal diseases), which is often used to criminalise HIV transmission or non-disclosure. In 2015, the Blantyre High Court awarded damages to the eleven sex workers, citing that their the lack of proper procedure, including forced HIV testing to gather evidence.<sup>72</sup>

**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 they have HIV. Some employers are still requiring HIV tests as part of pre-employment medical screening.<sup>73</sup>

**Prisons:** The laws criminalising same sex sexual conduct prevent the distribution of condoms in prisons and the lack of confidentiality means that prisoners with HIV and/or TB are highly stigmatised. It appears that prisoners who are suspected of having TB may be quarantined from other prisoners. The Malawi Prisons Services does not isolate prisoners with TB who are on treatment.<sup>74</sup>



RECOMMENDATIONS

Civil society should:

- Advocate for laws that promote the human rights of people living with HIV and/or TB and key populations
- Advocate for repeal of all laws that criminalise adult consensual sex
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights
- Raise awareness about stigma and discrimination against people living with HIV and/or TB and key populations
- Advocate for access to comprehensive post-rape care for all survivors, including treatment for injuries, PEP, emergency contraception and treatment for STIs.
- Train health care providers on the human rights of people living with HIV and/or TB and key populations, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly
- Advocate for the decriminalisation of possession of drugs for personal use and use of drugs and for comprehensive harm reduction programmes
- 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, including prison personnel
- Train health care providers on the human rights of people living with HIV and/or TB and key populations, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly

The Malawi government should:

- Finalise and enact the draft HIV law and ensure that it protects the human rights of people living with HIV and key populations and does not contain coercive or discriminatory provisions
- Enact the National HIV and AIDS Workplace Policy to strengthen protection for employees living with HIV
- Decriminalise all consensual adult sex
- Amend the constitution to include a minimum marriage age of 18 for boys and girls and repeal any provisions that permit parents to consent to the marriage of underage girls
- Provide for legal recognition of gender identity
- Decriminalise the possession of drugs for personal use and use of drugs
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support services, training for law and policy makers and the judiciary

END NOTES

<sup>1</sup> UNAIDS, *Malawi AIDS Response Progress Report 2015*, [http://www.unaids.org/sites/default/files/country/documents/MWI\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/MWI_narrative_report_2015.pdf) [accessed on 15 May 2016]

<sup>2</sup> UNAIDS, *2014 Malawi HIV Epidemic Profile*, <http://www.unaidsrstes.org/wpcontent/uploads/2015/05/UNAidsProfileMalawi.pdf> [accessed 15 May 2016]

<sup>3</sup> Ibid., *Malawi AIDS Response Progress Report 2015*

<sup>4</sup> Ibid., *Malawi AIDS Response Progress Report 2015*

<sup>5</sup> UNAIDS, *Malawi AIDS Response Progress Report 2015*, [http://www.unaids.org/sites/default/files/country/documents/MWI\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/MWI_narrative_report_2015.pdf) [accessed on 15 May 2016]

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

<sup>8</sup> Government of Malawi , National Strategic Plan for HIV and AIDS 2015 – 2020, <file:///C:/Users/gernthl/Downloads/national%20hiv%20and%20aids%20%20strategic%20plan%20%2020152020.pdf> [accessed 15 May 2016]

<sup>9</sup> Ibid., National Strategic Plan for HIV and AIDS 2015 – 2020

<sup>10</sup> Government of Malawi, National Strategic Plan for HIV and AIDS 2015 – 2020

<sup>11</sup> Ibid., *Malawi AIDS Response Progress Report 2015*

<sup>12</sup> WHO, *Global Tuberculosis Report 2015* , [http://www.who.int/tb/publications/global\\_report/en/](http://www.who.int/tb/publications/global_report/en/) [accessed 25 April 2016]

<sup>13</sup> Ibid., *Malawi AIDS Response Progress Report 2015*

<sup>14</sup> USAID, *Malawi Tuberculosis Factsheet*, <https://www.usaid.gov/malawi/factsheets/usaidsmalawituberculosisfactsheet201213> [accessed 15 May 2016]

<sup>15</sup> Section 20

<sup>16</sup> Section 21(1)

<sup>17</sup> Sections 18 and 19

<sup>18</sup> Section 16

<sup>19</sup> Section 31

<sup>20</sup> Sections 34, 35 and 27

<sup>21</sup> Section 24

<sup>22</sup> Section 23

<sup>23</sup> Section 20

<sup>24</sup> Section 13 enjoins the State to provide adequate health care for all people

<sup>25</sup> Section 30

<sup>26</sup> UNDP and the Government of Malawi, *Assessment of the Legal and Regulatory Environment for HIV and AIDS in Malawi 2012*, <http://www.hivlawcommission.org/index.php/implementationofreport/legalenvironmentassessments>

<sup>27</sup> Section 132

<sup>28</sup> Section 137

<sup>29</sup> Section 138(2)

<sup>30</sup> Section 12

<sup>31</sup> Sections 2 and 48

<sup>32</sup> Section 14

<sup>33</sup> US Bureau of Democracy, Labor and Human Rights, *Country Reports on Human Rights Practices for 2015: Malawi*, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 15 May 2016]

<sup>34</sup> Ibid.,

<sup>35</sup> UN CEDAW Committee, *Concluding Observations on the seventh periodic report on Malawi*, 24 November 2015, [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/MWI/CO/7&Lang=En](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/MWI/CO/7&Lang=En) [accessed on 15 May 2015]

<sup>36</sup> Ibid., *Concluding Observations on the seventh periodic report on Malawi*

<sup>37</sup> Malawi 24, *Malawi amongst worst countries for children's access to justice*, 15 February 2016, <http://malawi24.com/2016/02/15/malawiamongworstcountriesforchildrensaccesstojustice/> [accessed 16 May 2016]

<sup>38</sup> Ibid., *Assessment of the Legal and Regulatory Environment for HIV and AIDS in Malawi 2012*

resources

<sup>39</sup> US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015: Malawi, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 15 May 2016]

<sup>34</sup> Ibid.,

<sup>35</sup> UN CEDAW Committee, *Concluding Observations on the seventh periodic report on Malawi*, 24 November 2015, [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/MWI/CO/7&Lang=En](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/MWI/CO/7&Lang=En) [accessed on 15 May 2015]

<sup>36</sup> Ibid., *Concluding Observations on the seventh periodic report on Malawi*

<sup>37</sup> Malawi 24, *Malawi amongst worst countries for children's access to justice*, 15 February 2016, <http://malawi24.com/2016/02/15/malawiamongworstcountriesforchildrensaccesstojustice/> [accessed 16 May 2016]

<sup>46</sup> Ibid., *Assessment of the Legal and Regulatory Environment for HIV and AIDS in Malawi 2012*

resources

<sup>47</sup> Section 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.”

<sup>48</sup> Ibid., *Concluding Observations on the initial periodic report on Malawi*

<sup>49</sup> Section 153

<sup>50</sup> Section 137A, Sections 153 and 156

<sup>51</sup> Human Rights First, *The State of Human Rights for LGBT People in Africa*, July 2014, <http://www.humanrightsfirst.org/sites/default/files/HRFHRAfricaReport.pdf> [accessed 15 May 2016]

<sup>52</sup> Human Rights Watch, *Moratorium on AntiGay Arrests Reaffirmed*, 21 December 2015, <https://www.hrw.org/news/2015/12/21/malawimoratoriumantigayarrestsreaffirme> [accessed 15 May 2016]

<sup>53</sup> Malawi Responses to Recommendations and Voluntary Pledges, Second Review, Session 22, 5 July 2015, paras. 113.13113.27.

<sup>54</sup> Ibid., Human Rights Watch, *New Marriage Law Can Change Lives*

<sup>55</sup> Sections 145 to 147 criminalise procuring women, solicitation, living off the earnings of prostitution

<sup>56</sup> Section 180 of the Penal Code criminalises ‘idle and disorderly conduct’ and section 183 criminalises offences likely to cause a breach of the peace

<sup>57</sup> Criminal Appeal No 2, 1999

<sup>58</sup> Section 4

<sup>59</sup> Key Correspondents, *Malawian Song Fuels HIV Stigma*, <http://www.keycorrespondents.org/2015/09/02/malawiansongfuelshivstigma/> [accessed 15 May 2016]

<sup>60</sup> World Journal of AIDS, *Stigma and Discrimination Against People Living with HIV and AIDS in Malawi*, June 2014, [http://file.scirp.org/pdf/WJA\\_2014061014014762.pdf](http://file.scirp.org/pdf/WJA_2014061014014762.pdf)

<sup>61</sup> TB Online, *Malawi's CCM adds new TB voices ahead of integrated concept note development*, 19 February 2014, <http://www.tbonline.info/posts/2014/2/19/malawisccmaddsnewtbvoicesaheadintegratedco/> [accessed 15 May 2016]

<sup>62</sup> ARASA, CEDEP, CHRR, *Malawi HIV/AIDS, TB and Human Rights Country Program Best Practices*, [http://www.arasa.info/files/7314/2408/4052/BEST\\_PRACTICES\\_BOOKLET.pdf](http://www.arasa.info/files/7314/2408/4052/BEST_PRACTICES_BOOKLET.pdf) accessed 16 May 2016





# MAURITIUS

## BACKGROUND

According to UNAIDS, as of 2014 there are 8 100 adults aged 15 – 49 years living with HIV in Mauritius – just under 1% of adults aged 15 - 49 years. Similar to Madagascar, less women than men are infected, with 2 400 women aged 15 and up living with HIV.<sup>1</sup> The Republic of Mauritius reports approximately 953 deaths due to HIV and AIDS since 1987.<sup>2</sup> UNAIDS does not have accurate statistics for the number of children living with HIV or number of orphans due to AIDS.<sup>3</sup> The Hepatitis C burden is more significant and is driven mainly by injecting drug use. A 2011 study estimated the number of people who inject drugs at 9,500 of which 97.3% were HCV-positive.<sup>4</sup>

Mauritius has a concentrated HIV epidemic with a low prevalence of HIV amongst the general population and high prevalence amongst key populations and in particular amongst people who inject drugs, who were found to have an HIV prevalence of 44.3% in a 2013 study.<sup>5</sup> Other key populations include sex workers and gay men and men who have sex with men. Female sex workers have the second highest HIV prevalence, currently estimated at 22.3% in terms of a 2012 study, followed by men who have sex with men with an estimated HIV prevalence of 20.0% in 2012.<sup>6</sup> It is important to note that many sex workers also inject drugs.<sup>7</sup> A Mapping Survey carried out in 2014 has, for the first time, identified Mauritius' transgender population, which will support better programming for transgender persons in Mauritius. Of the average 2400 prisoners, approximately 500 are living with HIV, many of whom are people who inject drugs. Young people are also recognised as a key population in Mauritius.<sup>8</sup>

As at December 2014, around 4085 people living with HIV were registered with ART services, although there are major challenges with adherence to treatment and follow-up, argued to be due to lack of faith in ART, HIV related stigma and discrimination and the perceived marginalisation of key populations within the health care setting.<sup>9</sup>

The expansion of harm reduction services has decreased HIV incidence amongst people who inject drugs. In 2005, 92% of new HIV infections were amongst people who inject drugs. Following the introduction of harm reduction strategies in 2006 (needle exchange programmes and methadone substitution therapy), this dropped to 68% in 2011, 38.8% in 2013 and 31.1% in 2014. Needle exchange programmes are reported to now cover the entire island, with 49 distribution sites and there are 18 dispensing sites for methadone substitution therapy.<sup>10</sup>

The Republic of Mauritius is a low TB burden country with the WHO estimating that there were around 440 people with TB in 2014.<sup>11</sup> The Republic of Mauritius reports that there are an annual number of 100-120 cases of TB. All newly diagnosed cases of TB are tested for HIV; people living with HIV are also screened for TB if they have symptoms. All persons co-infected with TB and HIV cases are given ART.<sup>12</sup>

The prevalence of non-communicable diseases in Mauritius is also a pointer to the need for a sustained supply of medicines for patients. Cirrhosis, probably linked to hepatitis infection and alcoholism is at 3.7%.

The National Strategic Framework (NSF) on HIV and AIDS 2013- 2016 guides the national response to HIV. The NSF is based on principles of human rights, gender equality and equal opportunities and the 3 main objectives of the NSF include (i) reduced HIV transmission, (ii) reduced morbidity and mortality of people living with HIV and (iii) reduced stigma and discrimination related to HIV. While people who inject drugs are at highest risk, the NSF also identifies a number of other vulnerable and key populations including sex workers, men who have sex with men, seafarers, migrant workers, street children, prisoners, women and young girls and young people.

### KEY HUMAN RIGHTS CONCERNS IN 2016

- HIV-related stigma and discrimination
- Human rights abuses against key populations
- Workplace discrimination
- Children's rights in the context of HIV and TB
- The rights of migrants
- The rights of people who use drugs





PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

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.

RATIFICATION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

- African Charter on Human and Peoples’ Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Rights of Persons with Disabilities, 2010
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- International Convention on Civil and Political Rights (ICCPR), 2005

NATIONAL LAWS AND POLICIES

Mauritius has a number of protections for human rights, including provisions specifically relating to HIV and AIDS, in its national legal framework. The Mauritius HIV and AIDS Act 2006 protects the rights of people living with HIV. Also, although there is no specific recognition of key populations, there is provision for syringe and needle exchange programmes. Additionally, the Act is one of the few in the region that does not criminalise HIV transmission.

Key protections include:

- A prohibition against mandatory HIV testing – 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 circumstances<sup>13</sup>
- Protection of the right to confidentiality, with disclosure of HIV status only permitted under exceptional circumstances<sup>14</sup>
- Provision for access to non-discriminatory HIV related treatment, care and support<sup>15</sup>
- Provision for syringe and needle exchange programmes and exemption from prosecution under the Dangerous Drugs Act if in possession of a syringe or needle in compliance with with Act<sup>16</sup>

The Civil Status Act and immigrant 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.<sup>17</sup>

The Equal Opportunities Act of 2008, reviewed in 2012, 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.

The Employment Rights Act 31, 2008 prohibits screening for HIV for purposes of employment<sup>18</sup> and prohibits harassment in the workplace based on a person’s HIV status or sexual orientation.<sup>19</sup> The National Policy on HIV/AIDS at the workplace, 2013 is based on the ILO Recommendation 200 of 2010 on HIV/AIDS and the World of Work and protects employees from stigma and discrimination in the working environment.

There are various protections in law for women’s equality rights 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.<sup>20</sup>

Women and girls 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 Act, 1997 (as amended). The amendments of 2004 and 2007 have provided better protection for women from domestic violence and has strengthened enforcement mechanisms such as protection orders, occupancy orders and tenancy orders and provision of legal aid for women. Section 249 of the Criminal Code of Mauritius criminalises rape, but there is no specific prohibition on 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.<sup>21</sup>

The Criminal Code Amendment Act was passed in 2012 allowing women to access an abortion in special circumstances, including (i) where necessary to prevent injury to the pregnant person, (ii) where there is substantial risk that the pregnancy will result in severe abnormality of the foetus, or (iii) where the pregnancy has not exceeded fourteen weeks and is the result of rape or intercourse with a female under the age of 16.<sup>22</sup>

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.<sup>23</sup> 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.

Intellectual property rights are dealt with by the Patents, Industrial Designs and Trademarks Act No. 25 of 2002.<sup>24</sup> Mauritius has developed an Intellectual Property Development Plan for the country with assistance from the World Intellectual Property Organisation. The plan is mostly focused on the use of intellectual property rights for economic development, and does not mention the use of TRIPS flexibilities at all. Medicines procurement is by way of public tender, published on the official website, followed by adjudication of bids by a committee.<sup>25</sup> A bi-annual audit of all procurement processes is carried out and the report goes to Parliament. An analysis of the tenders awarded reveals that the medicines procured from European suppliers are more expensive than those procured from India.<sup>26</sup>

Mauritius does not have a medicines regulatory authority that assesses the quality of medicines submitted for registration; this work is done by a Pharmacy Board. This Board is made up of doctors and pharmacists and a representative from the Ministry of Trade.<sup>27</sup> However, the country is in the process of constructing a pharmacy laboratory that will have the capacity to analyse medicine quality.

ACCESS TO JUSTICE AND LAW ENFORCEMENT

Mauritius has an Ombudsperson for children and strong CSOs, including HIV-specific human rights organisations. PILS and other civil society organisations undertake various programmes to strengthen access to justice including a National Candlelit Memorial, monitoring of all forms of HIV-related stigma and discrimination and providing legal support services for people affected by HIV and AIDS. There are also programmes to reduce HIVrelated 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.<sup>28</sup> The People Living with HIV Stigma Index study showed that, compared with other countries in the region, people living with HIV in Mauritius have a relatively strong awareness of the HIV law and their rights.<sup>29</sup>

The National Women’s Council is undertaking an island-wide campaign on the dissemination of information on gender equality and gender issues. There are also programmes targeting men and young boys to sensitise them on gender equality and challenging patriarchal attitudes and stereotypes.<sup>30</sup>

Despite strengths within the legal framework, access to justice and law enforcement remains problematic, particularly for key populations.<sup>31</sup> There is a need for greater awareness about human rights, law and HIV with people living with HIV and other key populations and 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.<sup>32</sup>

The establishment of the Equal Opportunities Commission and Equal Opportunities Tribunal, in terms of the Equal Opportunity Act, may strengthen access to justice. 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.

GAPS AND CHALLENGES

PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

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, 2003.

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,<sup>34</sup> who received counselling for such testing.<sup>35</sup> In these cases the decision to consent to any disclosures of the child’s HIV status lies with the legal administrator or guardian.<sup>36</sup> This is inconsistent with sexual offence laws that set the legal age for consent to sex at 16 years.<sup>37</sup> In addition, children under 18 years of age cannot access harm reduction programmes even with the consent of an adult.<sup>38</sup>



Sex work is criminalised in Mauritius in terms of the Penal Code, 1930 (as amended).<sup>39</sup> People involved in sex work are prosecuted for 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 charged<sup>40</sup> and being in possession of condoms may be used by law enforcement officials as evidence of the offence.<sup>41</sup>

Section 21 of the Dangerous Drugs Act, 2000 makes the possession of drugs a crime and section 30 creates a range of drug dealing offences. Other provisions in the Dangerous Drugs Act relating to drug dealing create barriers to the provision of harm reductions services. For example, the Dangerous Drugs Act prohibits the possession of dangerous drugs, illegal drug trafficking and illegal drug consumption.

Section 250 of the Mauritius Criminal Code of 1838 states that, “any person who is guilty of the crime of sodomy shall be liable to penal servitude for a term not exceeding 5 years.” Homosexuality is not specifically mentioned in the legislation, and sodomy is criminalised in both homosexual and heterosexual sexual practices. In 2012 it was reported that most sodomy cases that reach the courts involve heterosexual people, especially in divorce cases.<sup>42</sup>

HUMAN RIGHTS CHALLENGES



**Stigma and discrimination:** HIV-related stigma and discrimination remains high in Mauritius, despite protective laws.<sup>43</sup> Discussions with CSOs and the recent People Living with HIV Stigma Index Study show that people living with HIV, especially people with HIV who use drugs, complain of stigma and discrimination, particularly 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.<sup>44</sup> The most recent BSS reported that 10.3% of people had discriminatory attitudes towards people living with HIV.<sup>45</sup> Discrimination against LGBTI populations was also reported to be a matter of concern.<sup>46</sup>

**Workplace rights:** Employees living with HIV are discriminated against in the work place. 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.<sup>47</sup>



**Rights of sex workers:** Sex workers report many experiences of stigma and discrimination including verbal and physical abuse from the general public, assault, sexual violence, 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.<sup>48</sup>



**Rights of people who use drugs:** The criminalisation of drug use exacerbates stigma, discrimination and violence against people who use drugs and creates barriers to access to health care services.<sup>49</sup> Needle exchange programmes conflict with the law since possession of needles for purposes of injecting drug use is illegal. The Dangerous Drugs Act is a barrier to access to both harm reduction and HIV related health care services.<sup>50</sup> The provision in the HIV and AIDS Act, 2006 for needle exchange programmes is in conflict with the provisions of the Dangerous Drugs Act and effective implementation ultimately requires harmonization of the two pieces of legislation. 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.

**Children’s rights:** There are 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.<sup>51</sup>



**LGBTI people:** 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<sup>52</sup> and set an equal age limit of 16 years for sexual acts. The Bill has however not yet been adopted and in 2013 the government announced that it would amend the Criminal Code instead.<sup>53</sup> These criminal laws pose barriers to the provision of and the access to health services for gay men and men who have sex with men and transgender people.<sup>54</sup> Currently there is no specific legislation that deals with the legal recognition of gender identity in Mauritius.

**Migrant and Mobile Populations:** HIV positive migrant workers are not allowed to work legally in Mauritius.<sup>55</sup> 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.<sup>56</sup>

RECOMMENDATIONS

Civil society should:

- Train health care providers on the human rights of people living with HIV and/or TB and key populations, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly.
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights.
- Increase awareness on HIV, the law and human rights for the general public, employers, government officials and service providers.
- Train members of key populations and organisations that work with key populations on HIV and human rights.
- Disseminate information about the provisions of the HIV and AIDS Act.

The Mauritian government should:

- Ratify the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003.
- Review and harmonise the provisions of the Dangerous Drugs Act and the HIV and AIDS Act to ensure that a comprehensive, rights based approach to drug use and HIV, including decriminalisation of possession for personal use and needle exchange programmes, are legal.
- Decriminalise drug use.
- Enact the Sexual Offences Bill and/or amend the Criminal Code; decriminalise all consensual adult sex, including sex work.
- Reduce employment-related discrimination by, amongst others, removing discrimination against migrant workers with HIV and against people who use drugs and strengthening enforcement of the rights of employees with HIV.
- Create an accessible police complaints system to deal with complaints of misconduct and abuse by law enforcement officials.
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support services, training for law and policy makers and the judiciary.
- Review the Patents, Industrial Designs and Trademarks Act No. 25 of 2002 in order to fully incorporate TRIPS flexibilities.

# END NOTES

<sup>1</sup> <http://www.unaids.org/en/regionscountries/countries/mauritius/> [Accessed 14 May 2016].

<sup>2</sup> UNAIDS *Mauritius Country Progress Report 2015*; Available at [http://www.unaids.org/sites/default/files/country/documents/MUS\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/MUS_narrative_report_2015.pdf) [Accessed 14 May 2016].

<sup>3</sup> <http://www.unaids.org/en/regionscountries/countries/mauritius/> [Accessed 14 May 2016].

<sup>4</sup> <http://www.ncbi.nlm.nih.gov/pubmed/21700442>

<sup>5</sup> IBBS, 2013 cited in UNAIDS *Mauritius Country Progress Report 2015*.

<sup>6</sup> IBBS FSW, 2012, cited in UNAIDS *Mauritius Country Progress Report 2015*.

<sup>7</sup> Submission by Chrysalide, *Mauritius, Africa Regional Dialogue on HIV and the Law*, Pretoria, 3-4 August, 2011

<sup>8</sup> UNAIDS *Mauritius Country Progress Report 2015*; Available at [http://www.unaids.org/sites/default/files/country/documents/MUS\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/MUS_narrative_report_2015.pdf) [Accessed 14 May 2016].

<sup>9</sup> Ibid.

<sup>10</sup> UNAIDS *Mauritius Country Progress Report 2015*; Available at [http://www.unaids.org/sites/default/files/country/documents/MUS\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/MUS_narrative_report_2015.pdf) [Accessed 14 May 2016].

<sup>11</sup> [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCCountryProfile&lISO2=MU&LAN=EN&outype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCCountryProfile&lISO2=MU&LAN=EN&outype=html) [Accessed 14 May 2016].

<sup>12</sup> Ibid.

<sup>13</sup> Sections 6 and 7

<sup>14</sup> Section 13

<sup>15</sup> Section 12

<sup>16</sup> Sections 14-16

<sup>17</sup> UNAIDS, *Mauritius NCPI Report*, 2012

<sup>18</sup> UNAIDS, *Mauritius NCPI Report*, 2010 Available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Mauritius%20NCPI%2012.pdf>

<sup>19</sup> KeyInformantInterview,NicolasRitter,PILS,24 August2012

<sup>20</sup> <http://www.genderindex.org/country/mauritius> [Accessed 14 May 2016].

<sup>21</sup> Afrol News, *Battle over Sexual Offence Bill in Mauritius*, 3 May 2016, <http://afrol.com/articles/25317> [accessed 25 June 2016]

<sup>22</sup> Ibid.

<sup>23</sup> *Mauritius NCPI Report*, 2010.

<sup>24</sup> Patents, Industrial Designs and Trademarks Act 2002. Available at <http://www.wipo.int/wipolex/en/details.jsp?id=7269>

<sup>25</sup> Per Sarita Bollel and her team

<sup>26</sup> <http://publicprocurement.govmu.org/pages/awards.aspx>

<sup>27</sup> Per Preetam Radha, Ministry of Trade

<sup>28</sup> UNAIDS, *Mauritius NCPI Report*, 2012.

<sup>29</sup> National AIDS Secretariat, *People living with HIV Stigma Index Report*, Mauritius, 2013.

<sup>30</sup> <http://www.genderindex.org/country/mauritius> [Accessed 14 May 2016].

<sup>31</sup> Submission by Chrysalide, Mauritius, *Africa Regional Dialogue on HIV and the Law*, 4 August, 2011

<sup>32</sup> Submission by Chrysalide, Mauritius, *African Regional Dialogue*, Pretoria, 4 August, 2011

<sup>33</sup> UNAIDS, *Mauritius NCPI Report*, 2012

<sup>34</sup> Section 7

<sup>35</sup> Section 11

<sup>36</sup> Section 13(4)

<sup>37</sup> Key Informant Interview, Nicolas Ritter, PILS, 24 August 2012

<sup>38</sup> Ibid. This is currently being challenged by PILS

<sup>39</sup> *Mauritius NCPI Report*, 2012

<sup>40</sup> Submission by Chrysalide, Mauritius, *African Regional Dialogue*, Pretoria, 3-4 August, 2011 41 UNAIDS, Mauritius NCPI Report, 2012

<sup>41</sup> UNAIDS, *Mauritius NCPI Report*, 2012

<sup>42</sup> U.S. Department of State, Country Reports on Human Rights Practices for 2012: Mauritius, 2012, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm?year=2012&dliid=204146>

<sup>43</sup> National AIDS Secretariat, *People living with HIV Stigma Index Report*, Mauritius, 2013

<sup>44</sup> Ibid.

<sup>45</sup> UNAIDS *Mauritius Country Progress Report 2015*; Available at [http://www.unaids.org/sites/default/files/country/documents/MUS\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/MUS_narrative_report_2015.pdf) [Accessed 14 May 2016].

<sup>46</sup> <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [Accessed 14 May 2016].

<sup>47</sup> Key Informant Interview, Nicolas Ritter, PILS, 24 August 2012

<sup>48</sup> Submission by Chrysalide, Mauritius, *Africa Regional Dialogue on HIV and the Law*, Pretoria, 3-4 August, 2011

<sup>49</sup> GCHL, *Risks, Rights & Health*, 2012

<sup>50</sup> Ibid.

<sup>51</sup> Key Informant Interview, Nicolas Ritter, PILS, 24 August 2012

<sup>52</sup> Amnesty International, *Making Love a Crime; Criminalisation of Same-Sex Conduct in Sub-Saharan Africa*, 2013, p.17

<sup>53</sup> ILGA, *State Sponsored Homophobia*, 2015.

<sup>54</sup> Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 24 August 2012

<sup>55</sup> UNAIDS, *Mauritius NCPI Report*, 2010

<sup>56</sup> Key Informant Interview, Nicolas Ritter, PILS, 24 August 2012





# MOZAMBIQUE

## BACKGROUND

Mozambique is one of the 10 most HIV-affected countries in the world. <sup>1</sup> In 2014, according to UNAIDS there were 1.4 million adults aged 15 – 49 years living with HIV, that is 10.6% of adults aged 15 – 49 years. Women are more affected than men: in that year there were 830 000 women living with HIV aged 15 and older in Mozambique. There were 160 000 children aged 0 to 14 years living with HIV, and 610 000 children below the age of 18 years were orphaned due to AIDS. There were 45 000 deaths due to AIDS. <sup>2</sup>

Mozambique has a generalised HIV epidemic fuelled largely by unsafe heterosexual sex with multiple partners. Still, the Mozambique NSP recognises that there are a number of especially vulnerable and key populations at higher risk of HIV exposure within the country, including gay men and men who have sex with men, although no mention is made of women who have sex with women, bisexual, transgender or intersex persons. <sup>3</sup> A survey published in 2013 found over 30% HIV prevalence amongst sex workers and 8.2% amongst gay men and men who have sex with men in Maputo. There is no information available on prevalence amongst transgender people. People who inject drugs have been identified in the Mozambique NSP as a key population yet there are currently no health or prevention services specifically for people who inject drugs in the country and data in the country is not readily available. The first ever bio-behavioural survey in Mozambique found people who inject drugs to be at high risk of HIV exposure because of unsafe injection practices and high-risk sexual behaviors. In the data collected from two sites in the country, the prevalence of HIV was associated with long term injection, needle sharing and heroin consumption. A study amongst mineworkers found that around 1 in 5 mineworkers has HIV and around 1 in 20 mineworkers have had TB in their lives. A 2012 Integrated Biological and Behavioural Survey <sup>4</sup> conducted amongst truck drivers found HIV prevalence rates of around 15.4% amongst truck drivers <sup>5</sup> and a study amongst prisoners in that same year found that 24% of prisoners were living with HIV. <sup>6</sup>

Access to ART has increased substantially in Mozambique in the past few years with almost half a million people accessing ART in 2013. This is almost double the amount of adults and children accessing ART than in 2011 and 200 000 more people than in 2012. There are now 59% of those in need accessing ART. However, children's access to ART is still a challenge. <sup>7</sup>

There are around 150 000 people with TB in Mozambique and over 50% of TB patients are also HIV-positive. <sup>8</sup> There has been a significant increase in TB screening, with 85% of all people diagnosed with HIV in 2013 also being screened for TB. The number of HIV-positive people on isoniazid preventive treatment (IPT) reached nearly 50 000 in 2013. <sup>9</sup> In the period 2012 to 2013, around 95% of TB cases were also tested for HIV.

Mozambique receives its HIV and TB medicines from India and China, because of weak manufacturing capacity. The country continuously faces stock-outs of medicines due to various issues, including procurement, drug level management and an insufficient and heavily donor reliant health budget. The country has used the flexibilities provided for in the TRIPS. In March 2004, Mozambique granted a compulsory licence for the local manufacture of a first-line triple-combination ARV. But the viability of this was short lived due to high temperatures in the country, slow procurement of medicines by other SADC countries (who opted to received donor funded drugs from countries such as India) and a lack of pharmacovigilance in the manufacturing of these medicines.

Mozambique recently adopted its fourth NSP on HIV (PEN IV) which covers the period 2015 – 2019. PEN IV has set several targets for 2019: reducing HIV through sexual transmission by 30%, the rate of mother to child transmission to below 5% by 2019 and AIDS-related deaths by 40%. PEN IV has identified priority populations, which include both key and vulnerable populations. Key populations are sex workers, men who have sex with men, people who inject drugs and prisoners and vulnerable groups include people living with HIV, young women between the ages of 15 and 24, mobile and migrant workers, girls between the ages of 10 and 14 and orphans and vulnerable children. <sup>10</sup>

## KEY HUMAN RIGHTS CONCERNS IN 2016

- HIV-related stigma and discrimination
- Gender based violence and gender inequality
- Human rights abuses against key populations
- Protection for migrant and mobile populations

## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### 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 education <sup>11</sup> and the right to health. <sup>12</sup> 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.

## RATIFICATION OF INTERNATIONAL AND REGIONAL TREATIES

Mozambique has ratified:

- African Charter on Human and Peoples’ Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Rights of Persons with Disabilities, 2006
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- International Convention on Civil and Political Rights (ICCPR), 1966
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003

## 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, 2008. It contains a number of protections for affected people:

- It prohibits any form of discrimination against people living with HIV
- It provides for HIV testing 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
- Minors can 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 minors can 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.

The HIV law was revised in 2013 to consolidate protective HIV-related provisions within one law and to promote protection for the rights of key populations. The review removed punitive provisions such as those criminalising HIV transmission.

The Labour Act protects all employees from discrimination in terms of employment, training, promotion and career progression. <sup>13</sup> In addition, Act 5/2002 (5 February 2002) provides for non-discrimination against employees with HIV within the formal sector, and prohibits HIV testing without consent. It also prohibits dismissal of an employee on the grounds of HIV status. It protects the rights to confidentiality, to equal opportunity in employment, education, and promotion, and to compensation and appropriate medical treatment in the event of occupational infection with HIV. <sup>14</sup> The Act was reviewed and strengthened in 2013. Workplace HIV policies and programmes are led by the NAC and the Association of Entrepreneurs Against HIV and AIDS, Tuberculosis and Malaria (ECOSIDA).

Women’s equality rights are protected in the Constitution. <sup>15</sup> There are a number of laws that protect women from inequality, harmful norms and GBV including the following:

- The Family Law of 2004 protects the property rights of women in customary marriages. Article 30 establishes a minimum age of marriage of 18 years for men and women, although marriage can be authorised from 16 years of age in the event of pregnancy or with parental consent. <sup>16</sup>
- Articles 66 and 2133 of the Civil Code give women equal rights to inheritance; <sup>17</sup> however customary rules often mean that men regulate women’s access to land. <sup>18</sup>
- The Law on Domestic Violence improves protection for women against various forms of domestic violence. <sup>19</sup>
- The new Penal Code (Law 35/2014) which came into force in 2015 has removed provisions allowing rapists to marry their victims, prohibited marital rape and decriminalised abortion. <sup>20</sup> The revised Penal Code now permits abortion up to the 12th week of a pregnancy; in extraordinary circumstances (including threats to the mother’s life and rape), termination is permitted up to the 16th week and in cases of foetal anomaly, up to the 24th week.

Sex between men has been decriminalised by the new Penal Code, Law 35/2014 which has repealed the old Portuguese colonial laws, including those relating to “acts against nature.” <sup>21</sup>

Mozambique’s patent laws will now be regulated by the new Mozambique Industry Property Code, approved by the Council of Ministers of Mozambique on 31 December 2015 and which was intended to come into force in March 2016, although is currently still pending operation. <sup>22</sup> This Code will repeal Decree no. 4/2006 of 12 April. It provides stronger intellectual property protections which protect access to medicines by controlling the proliferation of patents. <sup>23</sup>

A recently developed Law on the Promotion and Protection of the Rights of People with Disabilities aims to domesticate the provisions of the Convention on the Rights of Persons with Disabilities (CRPD).

The Law on Promotion and Protection of the Rights of the Child (Law 7/2008) attempts to domesticate the provisions of the CRC and protect children’s rights. The Act contains provisions to protect children from abuse, including sexual exploitation and abuse.

## ACCESS TO JUSTICE AND LAW ENFORCEMENT

CSOs have 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. <sup>24</sup> There has also been more recent dissemination of the laws by the Ministry of Justice, NAC, ECOSIDA and CSOs by training, seminars, debates, theatre and community radio. <sup>25</sup> 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.

There is limited protection in law for the rights of key populations, and more importantly, even where protections exist, key populations still need more information and education on their rights and the laws need to be popularised and disseminated. <sup>26</sup> This is exacerbated by the fact that 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. <sup>27</sup> 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. <sup>28</sup>

## GAPS AND CHALLENGES

### PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

Mozambique has not yet ratified the International Convention on Economic, Social and Cultural Rights 1966.

Sex work is criminalised in Mozambique and the Penal Code criminalises drug use, even though the National Strategic Plan accepts people who inject drugs as a key population.

### HUMAN RIGHTS CHALLENGES

**Stigma and discrimination:** HIV-related stigma and discrimination impedes the national response to HIV in Mozambique, resulting in barriers to access to HIV-related health care services. <sup>29</sup> People living with HIV report discriminatory treatment when accessing HIV testing and counselling. <sup>30</sup> A Stigma Index survey was completed by the National Network of People living with HIV/AIDS (RENSIDA) in 2012. The report 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.” <sup>31</sup>

Stigma and discrimination occurs despite protection of the rights of people living with HIV in the HIV Act 12/2009. Challenges in the implementation and enforcement of the Act have been identified as the major stumbling block, with calls for the enactment of regulations to implement the provisions of the Act. <sup>32</sup>

**Women’s rights:** Despite protections in law, gender inequality, harmful gender norms and GBV 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 ongoing high levels of GBV and discrimination against women.

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. <sup>33</sup>



Gender-based violence is a key concern for women, with recent statistics provided by the Demographic and Health Survey showing that one-third of all women had experienced violence at some point since the age of 15 and 12% of women reporting forced sex during their lifetime. <sup>34</sup>

Women 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. <sup>35</sup>



**Sex workers:** The criminalisation of sex work leads to various forms of discrimination against sex workers. <sup>36</sup> 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. <sup>37</sup> They also experience violence from law enforcement officials and discrimination within the health care sector. <sup>38</sup>



**LGBTI people:** The new Penal Code (Law 35/2014) decriminalized sex between men. Mozambique’s Labour Law 23/2007 specifically prohibits discrimination based on sexual orientation. <sup>39</sup> However, under Article 7 of the Family Law of Mozambique, same-sex marriage is not allowed. <sup>40</sup> LGBTI people have reported various forms of discrimination <sup>41</sup> and have been denied the right to form support organisations with legal status, despite constitutional protection of the right of association. <sup>42</sup> Mozambique specifically rejected recommendations at the 2011 Universal Periodic Review session to register an LGBTI organisation. <sup>43</sup> 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). <sup>44</sup> Currently there is no legal recognition of gender identity, nor is gender or sex defined specifically to be “assigned at birth”.



**People who inject drugs:** While there is limited information in Mozambique on HIV and people who inject drugs, the preliminary results from the bio-behavioural survey <sup>45</sup> recommend the need for harm reduction interventions and specific prevention, care and treatment programmes to prevent the further spread of HIV amongst people who inject drugs and their sexual partners. Broadly speaking, the lack of legal protection for key populations and punitive laws and policies against these persons pose a major barrier in access to services.

**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). Currently there is no legal recognition of gender identity, nor is gender or sex defined specifically to be “assigned at birth”.**

**Prisoners:** Mozambique’s prisons are severely over-crowded and prisoners face potentially life threatening conditions, including a lack of access to health care and inadequate conditions. Malaria, TB, cholera and HIV are “commonplace among prisoners in nearly all prisons”. <sup>46</sup> There is no access to condoms in prisons for inmates, which the government has acknowledged is a barrier to preventing HIV. <sup>47</sup>

**Migrant and mobile populations:** Migrant mine workers are at risk of HIV and TB exposure. Migrant mine workers face barriers in adhering to their treatment for both HIV and TB, since treatment regimens are not harmonised between South Africa and Mozambique and patients who migrate or return are often not able to continue their HIV or TB treatment. In addition, workplace HIV programmes are often poorly implemented which means that people living with HIV are often denied access to HIV services during working hours. Many workers are unaware of the protections and rights afforded to them under the HIV legislation, particularly foreign workers who are unfamiliar with the Mozambican labour laws. <sup>48</sup>

RECOMMENDATIONS

Civil society should:

- Work to provide more information about human rights violations against people living with HIV and key populations
- Conduct programmes to improve gender equality, including raising awareness, peer education of men and women and economic empowerment of women
- Raise awareness about the decriminalisation of sex between men and conduct programmes to reduce stigma and discrimination against gay men and men who have sex with men
- Train health care providers on the human rights of people living with HIV and/or TB and key populations, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights

The government should:

- Ratify the International Covenant on Economic, Social and Cultural Rights 1966
- Review the law to strengthen anti-discrimination protection for key populations
- Review and repeal laws that discriminate against women
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support services, training for law and policy makers and the judiciary
- Decriminalise the possession of drugs for personal use and the use of drugs and promote harm reductions services for people who use drugs

# END NOTES

<sup>1</sup> UNAIDS *Mozambique Global AIDS Response Progress Report 2014*, Available at [http://www.unaids.org/sites/default/files/country/documents/MOZ\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/MOZ_narrative_report_2014.pdf) [Accessed 15 May 2016].

<sup>2</sup> <http://www.unaids.org/en/regionscountries/countries/mozambique/> [Accessed 15 May 2016]<http://www.unaids.org/en/regionscountries/countries/mozambique/> [Accessed 15 May 2016].

<sup>3</sup> Republic of Mozambique, *National Strategic HIV and AIDS Response Plan (2010-2014)*, at 5.

<sup>4</sup> Draft document, High prevalence of HIV, HBV and HCV among people who injected drugs: Results of the first bio-behavioral survey in Mozambique. [Unpublished report as of 7 July 2016]

<sup>5</sup> Findings from various IBBS 2011-2012, cited in UNAIDS *Mozambique Global AIDS Response Progress Report 2014*, Available at [http://www.unaids.org/sites/default/files/country/documents/MOZ\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/MOZ_narrative_report_2014.pdf) [Accessed 15 May 2016].

<sup>6</sup> Ibid.

<sup>7</sup> UNAIDS *Mozambique Global AIDS Response Progress Report 2014* Available at [http://www.unaids.org/sites/default/files/country/documents/MOZ\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/MOZ_narrative_report_2014.pdf) [Accessed 15 May 2016].

<sup>8</sup> [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=MZ&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=MZ&LAN=EN&outtype=html) [Accessed 15 May 2016].

<sup>9</sup> Ibid.

<sup>10</sup> Republic of Mozambique, *Resposta Global a SIDA, Relatorio do Progresso, 2016*, [http://www.unaids.org/sites/default/files/country/documents/MOZ\\_narrative\\_report\\_2016.pdf](http://www.unaids.org/sites/default/files/country/documents/MOZ_narrative_report_2016.pdf) [accessed 25 June 2016]

<sup>11</sup> Article 88(1)

<sup>12</sup> Article 89

<sup>13</sup> Article 42

<sup>14</sup> AIDS and Human Rights Research Unit, *Human Rights Protected?*, 2007.

<sup>15</sup> Article 36

<sup>16</sup> <http://www.genderindex.org/country/mozambique> [Accessed 15 May 2016].

<sup>17</sup> Ibid.

<sup>18</sup> <http://www.genderindex.org/country/mozambique> [Accessed 15 May 2016].

<sup>19</sup> <http://www.genderindex.org/country/mozambique> [Accessed 15 May 2016].

<sup>20</sup> Available at [http://dspace.col.org/bitstream/handle/11599/916/2015\\_MacDonaldE\\_et al\\_Gender-Profile-Mozambique.pdf?sequence=3&isAllowed=y](http://dspace.col.org/bitstream/handle/11599/916/2015_MacDonaldE_et al_Gender-Profile-Mozambique.pdf?sequence=3&isAllowed=y) [Accessed 6 July 2016]

<sup>21</sup> <http://mgafrica.com/article/2015-06-29-mozambique-decriminalises-homosexuality-abortion-is-it-now-one-of-the-most-liberal-african-countries> [Accessed 15 May 2016].

<sup>22</sup> <http://www.spoor.com/en/News/new-industrial-property-code-in-mozambique/>

<sup>23</sup> Ibid.

<sup>24</sup> UNAIDS, *Mozambique NCPI Report*, 2012; AIDS and Human Rights Research Unit, *Human Rights Protected?*, 2007.

<sup>25</sup> UNAIDS, *Mozambique NCPI Report*, 2013. Available at <http://www.unaids.org/sites/default/files/country/documents/Mozambique%20NCPI%202013.pdf> [Accessed 15 May 2016].

<sup>26</sup> UNAIDS, *Mozambique NCPI Report*, 2013 Available at [http://www.unaids.org/sites/default/files/country/documents/MOZ\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/MOZ_narrative_report_2014.pdf) [Accessed 15 May 2016].

<sup>27</sup> 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

<sup>28</sup> AIDS Alliance, Desk Review of the NSPs of Countries in ESA, 2011

<sup>29</sup> Submission by MONASO, *African Regional Dialogue on HIV and the Law*, 3-4 August 2011

<sup>30</sup> Submission by LAMBDA, *African Regional Dialogue on HIV and the Law*, 3-4 August 2011 at 425

<sup>31</sup> Information taken from <http://www.stigmaindex.org/454/press-releases/in-mozambique-plhiv-are-helping-themselves-2012.html> [accessed on 20 August 2013]

<sup>32</sup> UNAIDS, *Mozambique Country Progress Report 2014* Available at [http://www.unaids.org/sites/default/files/country/documents/MOZ\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/MOZ_narrative_report_2014.pdf) [Accessed 15 May 2016].

<sup>33</sup> See: <http://www.girlsnotbrides.org/where-does-it-happen>

<sup>34</sup> <http://www.genderindex.org/country/mozambique> [Accessed 15 May 2016].

<sup>35</sup> <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> (accessed 12 August 2013)

<sup>36</sup> Submission by ASWA, *Africa Regional Dialogue on HIV and the Law*, 3-4 August 2011

<sup>37</sup> Ibid.

<sup>38</sup> Ibid.

<sup>39</sup> Labour Law of Mozambique, No. 23/2007, arts. 4, 5 and 108, available at [http://www.tipmoz.com/library/resources/tipmoz\\_media/labour\\_law\\_23-2007\\_1533E71.pdf](http://www.tipmoz.com/library/resources/tipmoz_media/labour_law_23-2007_1533E71.pdf)

<sup>40</sup> Lei da Família, Lei No. 10/2004, 25 de Agosto, art. 7, available at [http://www.rjcplp.org/sections/informacao/anexos/legislacao-mocambique9630/outra-legislacao1180/lei-da-familia/downloadFile/file/Lei\\_Familia\\_Lei-10\\_2004.pdf?nocache=1366126250.19](http://www.rjcplp.org/sections/informacao/anexos/legislacao-mocambique9630/outra-legislacao1180/lei-da-familia/downloadFile/file/Lei_Familia_Lei-10_2004.pdf?nocache=1366126250.19).

<sup>41</sup> <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> (accessed 12 August 2013)

<sup>42</sup> Article 52

<sup>43</sup> Report of the Working Group on the Universal Periodic Review for Mozambique, A/HRC/17/16, 28 March 2011, para. 91(4), (6) and (8).

<sup>44</sup> Submission by LAMBDA, *Africa Regional Dialogue on HIV and the Law*, 3-4 August 2011

<sup>45</sup> Draft document, High prevalence of HIV, HBV and HCV among people who injected drugs: Results of the first bio-behavioral survey in Mozambique. [Unpublished report as of 7 July 2016]

<sup>46</sup> <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [Accessed 15 May 2016].

<sup>47</sup> UNAIDS, *Global AIDS Response Progress Report*, 2014 at p27.

<sup>48</sup> UNAIDS, *Mozambique NCPI Report*, 2013.



# NAMIBIA

## BACKGROUND

HIV prevalence amongst adults living with HIV in Namibia is estimated to be 16%. New HIV infections have remained stable between 2010 and 2014 at approximately 11 000 per year. Namibia has a high prevalence, high incidence, mature and generalised epidemic with the majority of transmission occurring through unprotected heterosexual sex and mother-to-child transmission. Women are disproportionately infected with prevalence rates highest amongst women between the ages of 40 – 44 years (30.6%) and women between the ages of 35 – 39 years (30.3%). 5100 people died of AIDS in 2014.<sup>1</sup> There are 23 000 children living with HIV.<sup>2</sup>

There is no systematic data collected on HIV prevalence amongst key populations, defined in the National Strategic Framework for the HIV and AIDS Response (NSF) as men who have sex with men, sex workers and their clients, migrant populations, prisoners and people who inject drugs. A limited study in 2008 found a prevalence of 12.8% amongst men who have sex with men.<sup>3</sup> A 2007/2008 study amongst sex workers in Katutura showed a 70% prevalence rate.<sup>4</sup> The Society for Family Health obtained data from routine programme reporting which showed that HIV prevalence rates among key populations in 2015 stand at 24% for men who have sex with men and 20% for sex workers. It is estimated that 13.2% of prisoners are living with HIV.<sup>5</sup>

Namibia has made progress on expanding access to treatment and the 2015 HIV country progress report describes the ART programme as the “flagship” of Namibia’s AIDS response. It reached its 2010 Universal Access target in 2009 and almost doubled the number of people on ART between 2010 to 2014.<sup>6</sup> Despite this, ART coverage amongst adults is 52% and 45% amongst children. eMTCT coverage is 84% and it has reduced HIV transmission between mother to child to 4%.<sup>7</sup> Uptake of voluntary testing and counselling remains a challenge and is relatively low at 56%.<sup>8</sup>

The NSF for 2010/11 – 2015/16 was reviewed in 2013 and extended to 2017. The guiding principles of the NSF include human rights, gender equality and promoting the meaningful involvement of people living with HIV.<sup>9</sup> It identifies most at risk groups as mobile and migrant populations, men who have sex with men, the security forces, prisoners, and injecting drug users. The NSF recognized the lack of systematic data collection on these groups and the impact the lack of information has on programming.<sup>10</sup>

Namibia is classified as a HBC for TB, with approximately 15 000 infections.<sup>11</sup> According to the 2011 national guidelines on the management of TB, Namibia has one of the highest case notifications rates of TB in the world and TB is the biggest killer of people living with HIV.<sup>12</sup> The 2015 HIV country progress report identifies TB/HIV co-infection as a “major public health problem”, including because of the increasing numbers of cases of multi- and extensively-resistant TB. By the end of 2012, 89% of TB patients had been tested for HIV and knew their status.<sup>13</sup>

## KEY HUMAN RIGHTS CONCERNS IN 2016

- HIV-related stigma and discrimination
- GBV and gender inequality
- Human rights abuses against key populations



## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### 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 for all people on the grounds of sex, race, colour, ethnic origin, religion and creed and social or economic status.<sup>14</sup> It also provides for the rights to respect for human dignity<sup>15</sup> and the privacy of all people.<sup>16</sup> 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.

Although HIV is not specifically listed as a ground of discrimination, case law dictates that the constitution be interpreted broadly and expansively to include protection of fundamental rights, including any unjustifiable limitation on the grounds of HIV and TB status.<sup>17</sup>



RATIFICATION OF INTERNATIONAL AND REGIONAL TREATIES

Namibia has ratified:

- African Charter on Human and Peoples’ Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Rights of Persons with Disabilities, 2006
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- International Convention on Economic, Social and Cultural Rights (ICESCR)
- International Convention on Civil and Political Rights (ICCPR), 1966
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003

NATIONAL LAWS AND POLICIES

There is no HIV-specific law in the Namibia but there are a number of protective laws, regulations and policies that seek to prevent discrimination against people living with HIV and TB and facilitate access to prevention, treatment, care and support:

- The National Policy on HIV/AIDS, 2007 includes a rights-based response to HIV.<sup>18</sup>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. It provides for confidential HIV testing and states that HIV status should not be disclosed to a third party without consent. The Namibia HIV Testing and Counselling Guidelines, 2010, provide additional guidance on HIV testing and reinforce confidential HIV testing with informed consent and pre- and post-test counselling. The policy also states that prisoners and awaiting trial detainees should have access to the same HIV services and support as the general population and prison officials should protect the medical confidentiality of inmates.<sup>19</sup>
- The National Guidelines for the Management of Tuberculosis, 2011, do not specifically mention human rights, but they adopt a patient centred approach and are protective of patients’ rights, stating that treatment should be provided in a manner that is convenient for the patient, the patient should be “well informed’ about the treatment and have access to support.<sup>20</sup>
- A new Public and Environmental Health Act was promulgated in May 2015 and repeals the 1919 Public Health Act. The Act has not yet come into effect<sup>21</sup>.
- Namibia has incorporated the TRIPS flexibilities into the Industrial Property Act 2014 to address the potential restricted access to essential drugs. The law has not yet come into force, but Article 144 of the Constitution confirms that international agreement form part of Namibian law.<sup>22</sup>
- The Namibia Labour Act 15 of 2004 prohibits HIV-related discrimination in the workplace. No person may discriminate in any employment practice, directly or indirectly against any individual, including on the grounds of HIV status.<sup>23</sup> 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.<sup>24</sup> In *Nanditume v Minister of Defence*<sup>25</sup> 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 equality rights in marriage and 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 divorce 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. Same sex sexual conduct between women is not criminalised.
- Laws that protect women from GBV include the Combating of Rape Act 8 of 2000, which criminalises various forms of sexual assault, including marital rape<sup>26</sup> and provides for harsher sentences for rapists infected with a serious STI; 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.<sup>27</sup>
- In the 2012 case of *LM, MI, NI v The Government of the Republic of Namibia* Case No I 1603/2008<sup>28</sup>the court had to determine whether adequate informed consent was given by 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 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 sterilisation had been unfairly discriminatory and taken place as a result of the women’s HIV status.
- The Child Care and Protection Act 3 of 2015 has been finalised but is not yet in force. It sets the age of majority at 18 and lists the Age of Majority Act (which sets the age of majority at 21) to be repealed. Section 220 states a child of 14 years old can consent to medical treatment if, in the opinion of a medical practitioner, they have the maturity to understand the “benefits, risks, social and other implications” of the treatment. The act specifically gives

children above the age of 14 the power to consent to an HIV test on their own The minimum age of marriage for boys and girls is 18 and the age of consent to sex is 16.<sup>29</sup>

- 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.<sup>30</sup> Although not it does 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.<sup>31</sup> 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.

ACCESS TO JUSTICE AND LAW ENFORCEMENT

Namibia has a strong legal and policy framework to protect the rights of people living with HIV and TB, many laws and policies are however not adequately implemented and enforced. Vulnerable and key populations are not adequately protected in law and policy and experience particular difficulties accessing justice.<sup>32</sup>

The Legal Aid Act 29 of 1990 establishes free legal aid in both civil and criminal cases for people who cannot afford to employ legal practitioners to assist them. According to the Director of Legal Aid, the majority of support is provided in criminal matters and it appears that legal aid does not play a significant role in civil cases where cases of HIV-related discrimination are more likely to be argued.<sup>33</sup>

Research cited in the Legal Environment Assessment indicates that the Namibian Police fail to take complaints by and against LGBTI populations seriously. Focus group discussions state that key populations faced many barriers to reporting crimes against them to the police, including corruption and harassment.<sup>34</sup>

Women report that it is difficult to obtain a protection order in terms of the Combatting of Domestic Violence Act and the prosecution of perpetrators of domestic violence.<sup>35</sup> There is limited capacity to prosecute rape and many cases are heard by traditional courts and authorities rather than criminal courts. Traditional courts can only award compensation to rape complainants, and cannot hold the perpetrators criminally liable. There are currently 15 Gender-based Violence Protection Units trained to assist victims of sexual violence.<sup>36</sup>

The Office of the Ombudsman has a human rights mandate and can investigate human rights violations, but it is under-resourced.<sup>37</sup>

GAPS AND CHALLENGES

PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS



There are various gaps and challenges in the Namibian legal framework that undermine the human rights of people living with HIV and TB and key populations. The Constitution only permits marriage between men and women. The New Public Health Act has several provisions which may be interpreted and enforced in ways that undermine the rights of people living with HIV and TB:

- Section 6 allows the Minister of Health to classify diseases as notifiable infectious diseases or notifiable vaccine preventable infectious diseases. These classifications have consequences for patients, including making it mandatory for a person who suspects that they may have a notifiable infectious disease to ascertain their status.<sup>38</sup> If HIV and TB are classified as notifiable infectious diseases, it would be compulsory for people to undergo HIV and TB testing.
- Section 7(3) requires reporting by various institutions to local authorities the particulars of patients and their symptoms where there is reason to suspect that they are suffering from a notifiable infectious disease.
- In terms of section 18(1), a person suffering from a notifiable infectious disease may not use public transport.
- Section 11 allows for the isolation of people with a notifiable infectious disease if in the opinion of the head of health services, that person is not being accommodated or treated in a way that minimizes the risk that the disease will spread. This provision could have negative implications for people living with HIV and TB.
- Section 4 regulates STIs and section 34, which has far reaching consequences, applies to all STIs unless the Minister of Health specifies otherwise. A medical practitioner treating a patient for an STI must advise the patient not to marry until the infection is cured or no longer infectious.<sup>39</sup> This provision will pose severe limitations on the rights of people living with HIV to marry and found a family if it is applied to them. A person suspected of having an STI can be asked to prove that they have an STI and are undergoing treatment.<sup>40</sup>
- Section 37 provides that “A person who, knowing that he or she is infected with a sexually transmitted infection - (a) wilfully or negligently infects another person; or (b) wilfully or negligently permits or acts in a way likely to lead to the infection of another person”, commits an offence and is liable to a fine not or to imprisonment. This section could be used to criminalise HIV transmission.



**Sodomy is a schedule 1 crime in terms of the Criminal Procedure Act, although there are very few charges and prosecutions. These provisions criminalise men who have sex with men and also poses a barrier to the distribution of condoms in prisons**



Sodomy is a schedule 1 crime in terms of the Criminal Procedure Act, although there are very few charges and prosecutions. These provisions criminalise men who have sex with men and also poses a barrier to the distribution of condoms in prisons. Any non-citizen convicted of sodomy in Namibia or elsewhere is considered to be a prohibited immigrant in terms of the Immigration Control Act.



Although the buying and selling of sex is not illegal in Namibia, the Combating of Immoral Practices Act, 21 of 1980, criminalises activities associated with sex work, including:

- Keeping of a brothel (section 2) ;
- 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 an 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).

In Windhoek, the municipality also uses regulations and by-laws against sex workers, including those dealing with loitering in a way that obstructs traffic or the movement of people in public places, loitering within 1000 meters of schools, hospitals, churches or institutions that care for the aged or people with disabilities. It is also unlawful to solicit for prostitution in public.

The Defence Act 1 of 2002 sets out the qualifications of Defence Force members. It requires that everyone who wishes to serve in the defence force undergo a prescribed medical examination and establish that they do not have any disease or ailment that will impair their ability to undergo training or perform their duties. The NDF relies on this provision to exclude recruits with HIV, as does the Police Force.

The Combating of Rape Act contains a list of circumstances for the highest minimum sentences for a conviction of rape. One of these is knowingly spreading HIV. The Abuse of Dependence-Producing Substances and Rehabilitation Centres Act 41 of 1971 criminalises the possession of drugs and dealing in them.

**HUMAN RIGHTS CHALLENGES**

**Stigma and discrimination:** The UN Human Rights Committee noted that there is ongoing discrimination against LGBTI populations and people living with HIV.



**Women’s rights:** Women and girls in Namibia are at high risk of GBV, including sexual violence. Approximately one third of women experience violence at the hands of an intimate partner. Research cited in the Legal Environment Assessment shows that pre-adolescent and adolescent girls are at increased risk of HIV infection because of the high incidence of coerced sex amongst these age groups.

There are high numbers of customary marriages that are not registered, which deprive women of their rights to inheritance and land ownership and encourage polygamy and increase vulnerability to HIV. There are also reports of forced marriage of children and widow inheritance.



**LGBTI people:** LGBTI populations 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 their community, or to seek health care and other services. Transgender people face ridicule, sexual assault and rape and are not assisted by the police when reporting violations, despite their risk of HIV exposure. There are reports of torture and ill-treatment of LGBTI people in police cells and detention facilities.



**Sex workers:** Sex workers are stigmatised and marginalised and vulnerable to violence, exploitation and abuse. There are reports that the police regularly detain and rape sex workers.

**Prisons:** A study by the University of Wyoming and AIDS Law Unit of the Legal Assistance Centre in Namibian correctional facilities confirms that sex take place between male inmates, both consensually or coercively. Rape also occurs in the correctional facilities.

There are limited programs to prevent HIV transmission in prisons and the government refuses to distribute condoms to prisoners. Health care for prisoners with HIV is limited and treatment interruptions are common when inmates are transferred between facilities. Inmates on ART complain of inadequate nutrition and difficulties with treatment adherence. There is no provision for needle exchange or safe tattooing.<sup>57</sup>

**There are limited programs to prevent HIV transmission in prisons and the government refuses to distribute condoms to prisoners. Health care for prisoners with HIV is limited and treatment interruptions are common when inmates are transferred between facilities. Inmates on ART complain of inadequate nutrition and difficulties with treatment adherence**

**RECOMMENDATIONS**

**Civil society should:**

- Work to strengthen access to justice by training law enforcement officials on the human rights of people living with HIV and/or TB and key populations
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights
- Increase awareness on HIV, the law and human rights for the general public, government officials and service providers
- Train members of key populations and organisations that work with key populations on HIV and human rights

**The government should:**

- Decriminalise all consensual adult sex
- Remove discriminatory criteria for entry into the NDF and ensure that recruits with HIV who meet the fitness criteria are not excluded from entry
- Review and repeal provisions in the Public Health Act that undermine the human rights of people living with HIV and TB, including provisions that criminalise the willful or negligent transmission of STIs
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, 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 and the judiciary
- Decriminalise the possession and use of drugs for personal use

# END NOTES

<sup>1</sup> UNAIDS, *The Namibia AIDS Response Progress Report 2015*, [http://www.unaids.org/sites/default/files/country/documents/NAM\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/NAM_narrative_report_2015.pdf) [accessed 16 May 2016]

<sup>2</sup> UNAIDS, *Namibia HIV Epidemic Profile 2014*, <http://www.unaidsrstes.org/wp-content/uploads/2015/05/UNAids-Profile-Namibia.pdf-20-Feb.pdf> [accessed 17 May 2016]

<sup>3</sup> Ibid., *The Namibia AIDS Response Progress Report 2015*

<sup>4</sup> Ibid., *Namibia HIV Epidemic Profile 2014*

<sup>5</sup> ARASA and LEA, *Legal Environment Assessment of HIV and AIDS*, unpublished

<sup>6</sup> Ibid., *The Namibia AIDS Response Progress Report 2015*

<sup>7</sup> Ibid., *Namibia HIV Epidemic Profile 2014*

<sup>8</sup> Ibid.,

<sup>9</sup> Republic of Namibia, *National Strategic Framework for HIV and AIDS Response in Namibia 2010/11 – 2015/16*, [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/legaldocument/wcms\\_301802.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_301802.pdf) [accessed 17 May 2016]

<sup>10</sup> Ibid., *The Namibia AIDS Response Progress Report 2015*

<sup>11</sup> WHO, *Global Tuberculosis Report 2015*, [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=NA&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=NA&LAN=EN&outtype=html) [accessed 17 May 2016]

<sup>12</sup> Republic of Namibia, *National Guidelines for the Management of Tuberculosis, 2011* [http://www.who.int/hiv/pub/guidelines/namibia\\_tb.pdf](http://www.who.int/hiv/pub/guidelines/namibia_tb.pdf) [accessed 20 May 2016]

<sup>13</sup> Ibid., *The Namibia AIDS Response Progress Report 2015*

<sup>14</sup> Article 10

<sup>15</sup> Article 8

<sup>16</sup> Article 13(1)

<sup>17</sup> Ibid., *Legal Environment Assessment of HIV and AIDS*

<sup>18</sup> UNAIDS, *Namibia NCPI Report, 2012*

<sup>19</sup> Ibid., *Legal Environment Assessment of HIV and AIDS*

<sup>20</sup> Ibid., *National Guidelines for the Management of Tuberculosis*

<sup>21</sup> Ibid., *Legal Environment Assessment of HIV and AIDS*

<sup>22</sup> Ibid., *Legal Environment Assessment of HIV and AIDS*

<sup>23</sup> Article 5(2)(f)

<sup>24</sup> UNAIDS, *Namibia NCPI Report, 2012*

<sup>25</sup> (2002) AHRLR 119 (NaLC 2002)

<sup>26</sup> Article 2(3)

<sup>27</sup> Godwin, 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*

<sup>28</sup> Section 221

<sup>29</sup> Section 14 of the Combating Immoral Practices Act 1980

<sup>30</sup> Ibid., S, *A Review of Regional and National Human Rights Based HIV and AIDS Policies and Frameworks in ESA*

<sup>31</sup> Ibid.

<sup>32</sup> UNAIDS, *Namibia NCPI Report, 2012*; Republic of Namibia, *Ministry of Health and Social Services, Global AIDS Response Country Progress Report, 2012*.

<sup>33</sup> Ibid., *Legal Environment Assessment of HIV and AIDS*

<sup>34</sup> Ibid., *Legal Environment Assessment of HIV and AIDS*

<sup>35</sup> Human Rights Committee, *Concluding Observations on the second report of Namibia*, 22 April 2016 <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/084/97/PDF/G1608497.pdf?OpenElement> [accessed 20 May 2016]

<sup>36</sup> US Bureau of Democracy, *Labor and Human Rights, Country Reports on Human Rights Practices for 2015: Namibia*, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 20 May 2016]

<sup>37</sup> Ibid., *Concluding Observations on the second report of Namibia*

<sup>38</sup> Section 5(2)(b)

<sup>39</sup> Section 35 (1)©

<sup>40</sup> Section 36

<sup>41</sup> Ibid., *Legal Environment Assessment of HIV and AIDS*

<sup>42</sup> In 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.

<sup>43</sup> In 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).

<sup>44</sup> Ibid., *Legal Environment Assessment of HIV and AIDS*

<sup>45</sup> Article 7(1)(c)(i)(ii)(iii)

<sup>46</sup> 57 Ibid., *Legal Environment Assessment of HIV and AIDS*

<sup>47</sup> Ibid.

<sup>48</sup> Ibid.

<sup>49</sup> Ibid., *Legal Environment Assessment of HIV and AIDS*

<sup>50</sup> Ibid., *Concluding Observations on the second report of Namibia*

<sup>51</sup> Baral, 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](http://www.plosone.org). at p.4 – 7

<sup>52</sup> Ibid.

<sup>53</sup> Ibid., *Concluding Observations on the second report of Namibia*

<sup>54</sup> Ibid.

<sup>55</sup> Ibid., *Legal Environment Assessment of HIV and AIDS*

<sup>56</sup> US Bureau of Democracy, *Labor and Human Rights, Country Reports on Human Rights Practices for 2015: Namibia*, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 20 May 2016]

<sup>57</sup> Ibid., *Legal Environment Assessment of HIV and AIDS*





# SEYCHELLES

## BACKGROUND

Seychelles has a concentrated HIV epidemic, with a low HIV prevalence (less than 1%) in the general population and higher prevalence in key populations. A survey conducted in 2011 showed a prevalence rate of 14% amongst gay men and men who have sex with men and people who inject drugs. In 2014, the country experienced the highest number of new cases of HIV infection since 1987 with an increase in 2013.<sup>1</sup>

There are currently 441 people living with HIV, 56% of which are male and 44% female. Seychelles reports that the main probable mode of transmission is heterosexual sex in 57% of cases, injecting drug use in 31% of cases and 10% as a result of sex between men (in comparison with 2011, where the mode of HIV transmission was reported to be 86% heterosexual sex and 14% sex between men).<sup>2</sup>

In a survey amongst sex workers in Victoria in 2014, HIV prevalence was found to be 6% and prevalence of Hepatitis C was at 87.5%.

A cumulative of 486 cases of Hepatitis C were reported between 2002 and 2014. Of these, 56 were HIV and Hepatitis C co-infection. In 2014, there were 93 new cases of Hepatitis C.

A cumulative of 591 TB cases have been reported between 1979 and 2014; of these, 31 cases of HIV & TB co-infection were reported between 2000 and 2014. In 2014 there were 7 reported newly confirmed TB cases, a reduction of 69% in new cases compared to 23 cases in 2013. There have been no reports of MDR or XDR TB to date in Seychelles.<sup>3</sup>

At the end of 2014, 231 adults and children were on antiretroviral treatment. However, 2014 also saw the highest number of deaths from AIDS since 1993 (19 deaths) despite increased access to treatment, with possible contributing factors being loss to follow up of diagnosed patients and the late presentation - 42% of those who died from AIDS related complications were newly diagnosed HIV cases who were in the late stage of AIDS.<sup>4</sup> In the recent legal environmental assessment (LEA), people living with HIV reported the need for improved access to counselling and psychological support as well as improved access to viral load and CD4 cell count testing.<sup>5</sup>

The National Strategic Framework (NSF) 2012-2016 has four priority areas for action including Prevention and Behaviour Change, Treatment and Care, Impact Mitigation and Human Rights Protection. It includes objectives to review and strengthen laws to reduce stigma and discrimination for people affected by HIV and especially for key populations. The NSF notes the failure to sufficiently prioritise key populations at higher risk of HIV exposure in previous plans. It commits to prioritising these groups during the upcoming period through the consolidation of existing HIV prevention programmes and the targeting of vulnerable populations and key populations such as men who have sex with men, people who inject drugs, sex workers, prisoners, migrants and young people, in prevention and behaviour change programmes.

## KEY HUMAN RIGHTS CONCERNS IN 2016

- HIV-related stigma and discrimination
- Human rights abuses against key populations
- Gender based violence and gender inequality
- The rights of children in the context of HIV and TB



## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### CONSTITUTION

The Constitution of the Republic of Seychelles is the supreme law in Seychelles. It recognises the inherent dignity and the equal and inalienable rights of all members of the human family as the foundation for freedom, justice, welfare, fraternity, peace and unity. It further reaffirms that these rights include the rights to life, liberty and the pursuit of happiness free from all types of discrimination.<sup>6</sup>

The Constitution also guarantees the right to equal protection of the law of all its citizens and to freedom from discrimination. Article 27(1) states that “Every person has a right to equal protection of the law including the enjoyment of rights set out in this Charter without discrimination on any ground except as is necessary in a democratic state.” The wording of the Seychellois Article 27 does not specifically refer to categories of people, such as people living with HIV, but to persons in general. However, it does provide protection from discrimination on “any ground” which may be argued to cover grounds such as “health status” or “HIV status”.



Article 16 guarantees the right to dignity, article 18 guarantees the right to liberty and security of the person and article 20 guarantees the right to privacy. Article 32 guarantees the right to family life and is guaranteed for all persons, which would include people living with HIV.

Article 29 guarantees the right to access to health care and the enjoyment of the highest attainable standard of physical and mental health for all its citizens, obliging the State to achieve the progressive realization of this right including through the provision of free primary health care, the management of diseases and the reduction of infant mortality.

Article 31 specifically 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.”

**RATIFICATION OF INTERNATIONAL AND REGIONAL TREATIES**

The Seychelles has ratified:

- African Charter on Human and Peoples’ Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- Convention on the Rights of People with Disabilities, 2006
- International Convention on Economic, Social and Cultural Rights (ICESCR)
- International Convention on Civil and Political Rights (ICCPR), 1966
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003

**NATIONAL LAWS AND POLICIES**

Seychelles does not have an HIV-specific law. However, the legal and policy framework includes specific protection for people affected by HIV and AIDS in the workplace.

The articulation of human rights principles in relation to health, HIV and TB is not set out in the new Public Health Act 2015. Instead, it is found in Seychellois health strategies, policies and plans, which reflect recognition of health, including sexual and reproductive health, as a human right and a commitment to protecting human rights in the provision and enjoyment of health.

There are policies in place to provide HIV-related prevention, treatment, care and support programmes, including targeted services for key populations. <sup>7</sup> The National Policy on the Prevention and Control of HIV and AIDS and STIs 2012 includes core values of respect for, protection and fulfilment of human rights and is aligned to international and national human rights instruments. The policy and NSF clearly provide for the rights of affected populations to HIV prevention, treatment, care and support services (including people who inject drugs, gay men and men who have sex with men, sex workers, prisoners, migrants and young people) without discrimination.

In the workplace, section 46A(1) of the Employment Act, 1995 specifically provides for non-discrimination in employment on the basis of HIV status. It states that “Where an employer makes an employment decision against a worker on the grounds of the worker’s age, gender, race, colour, nationality, language, religion, disability, HIV status, sexual orientation or political, trade union or other association, the worker may make a complaint to the Chief Executive stating all the relevant particulars.” The HIV/AIDS Workplace Policy, 2007 was reviewed in 2014 and updated in line with international best practice and is being finalised for approval by Cabinet. <sup>8</sup>



Women are protected from inequality, harmful norms and gender-based violence (GBV) in law and in policy. There is an Action Plan dealing with gender-based violence and the National Gender Policy of 2012 shows a strong commitment to achieving gender equality, eradicating poverty amongst women and achieving long-term social change. Girls are protected from early marriage and the minimum age of marriage is 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. <sup>9</sup> Up until this year, Article 151 of the Penal Code criminalised sex between men. In 2011 the Seychelles government committed to repealing all provisions that criminalized consensual sex between men <sup>10</sup> and in May 2016, Seychelles repealed the criminalization of sex between men. <sup>11</sup>

**ACCESS TO JUSTICE AND LAW ENFORCEMENT**

According to civil society and country reports to UNAIDS, there are various programmes, including national media campaigns, to raise awareness of 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. <sup>12</sup> There are reports that the National Human Rights Commission is perceived to be too closely aligned to government and is therefore rarely used. <sup>13</sup>

However, programmes and services do not reach everyone who needs them, 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. <sup>14</sup> Focus group discussions with selected vulnerable groups and key populations showed that people were not aware of their rights and some, such as migrant workers and prisoners, felt unable to use mechanisms because of their vulnerable positions in society. <sup>15</sup>

**GAPS AND CHALLENGES**

**PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS**

Although there are protective provisions in Seychellois law and policy, many laws pre-date and do not specifically deal with HIV and AIDS or the various inequalities and human rights abuses experienced by people living with HIV and other key populations. <sup>16</sup>

There is limited provision in law for individual health rights such as the right to HIV testing with voluntary and informed consent and the right to confidentiality. These issues are dealt with in policy but not in health law. <sup>17</sup>

The Public Health Act 2015 came into force in February 2016. As was the case in the previous Public Health Act, it contains a number of punitive provisions regarding the isolation, quarantine and detention of persons with infectious diseases. Infectious diseases are defined as diseases caused by a living organism or pathogen and any disease listed in the First Schedule – both STIs and TB are included in the First Schedule. While it appears that these provisions are not applied to persons on the basis of HIV status, there is a danger of them being used to perpetrate violations of the rights of people living with HIV and of people with TB.

The Public Health (TB) Regulations enacted in terms of the previous Act allow persons with TB to be detained in a hospital or sanatorium for the purposes of treatment, with or without their consent, until such time as they are medically certified as able to be discharged without danger to public health. Any attempts to escape amount to an offence.

Likewise, there are similarly coercive provisions for treatment and rehabilitation of people who use drugs under the Misuse of Drugs Act, 1995 as amended by Act 4 of 2012, where admission to treatment for drug addiction may be voluntary or the person may be committed to such treatment. Section 6 of the Misuse of Drugs Act criminalises a range of drug-related offences including the possession and use of drugs. In addition, the Act makes the provision of needle exchange programmes and substitution therapy programmes unlawful.

The Patents Act dates back to 1901 and is outdated in terms of global intellectual property standards. While it contains some patent flexibilities, such as provisions for compulsory licensing, it does not yet maximise mechanisms that can be used to source the most affordable treatment for HIV and its co-infections. Seychelles is in the process of acceding to the WTO and is, as a result, revising its entire patent legislation to comply with the WTO Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). This presents both an opportunity and a threat for access to essential medicines – the threat being that Seychelles may adopt TRIPS-plus measures that provide for greater intellectual property protection, restricting access to affordable medicines. However, there is an opportunity for Seychelles to take full advantage of public health flexibilities contained within the TRIPS Agreement to balance intellectual property protection with public health needs.

The Penal Code criminalises various aspects of sex work, including the buying and solicitation of sex, owning a brothel and living off the earnings of sex work. It also includes various offences relating to being an “idle and disorderly” person which are used to harass and arrest sex workers. <sup>18</sup>

Civil law provides that a child below 18 years of age requires the consent of a parent or guardian to consent to medical treatment. This means that in law, young people below 18 may not consent independently to an HIV test or to treatment for HIV – although a young person aged 15 and older can consent to sex. However, there is a policy that makes provision for access to, for example, contraception at a younger age, despite the laws. <sup>19</sup>

The Immigration Act requires 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.



The National Policy of HIV and AIDS in the Workplaces, 2007 specifically states that there shall be no screening solely for the purposes of exclusion from employment or work processes. However, there are reports that the armed forces continue to undertake HIV testing for recruitment purposes and for in-service staff, who are required to undertake testing prior to going on missions and upon their return.<sup>20</sup>

HUMAN RIGHTS CHALLENGES



**Stigma and discrimination:** A review of the 2005-2009 National Strategic Plan and Knowledges, Attitudes and Practices study conducted in 2013 confirms that stigma and discrimination continue to affect people living with HIV and create barriers to their access to HIV treatment, care and support.<sup>21</sup> The review 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. HIV testing centres are said to be ill-equipped to handle confidential counselling and testing, and populations at higher risk of HIV exposure report being asked about their HIV status and treated with indignity.<sup>22</sup> The 2013 Legal Environment Assessment found that patients reported discriminatory behavior at the hands of health workers and that HIV-related stigma and discrimination exacerbated the negative impact of HIV.

Stigma and discrimination against sex workers and people who use drugs and on the basis of sexual orientation hinders access by members of these groups to HIV prevention and treatment services.<sup>23</sup> Other specific acts of discrimination found by the LEA include HIV testing and discrimination in access to loans and insurance, in terms of the policies of some financial institutions and insurance companies which require HIV testing



**Key populations:** As a result of criminalisation, there are limited programmatic interventions for people who use drugs and they report stigma, discrimination, arrest and violations of their rights.<sup>24</sup> People who use drugs in Seychelles experience high levels of stigma and discrimination. 68% of people who use drugs reported being refused a service in the preceding 12 months because of their injection drug use.<sup>25</sup> Just over 50% of people who use drugs also reported being arrested in the preceding twelve months.<sup>26</sup> CSOs report difficulties in accessing sex workers to provide services and there are also reports of harassment of sex workers by law enforcement officials.<sup>27</sup>

**Children’s Rights:** 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. Research shows that the requirement of parental consent to HIV testing and treatment and medical care acts as a barrier to access to sexual and reproductive health care services for young people. There is a policy that makes provision for access to, for example, contraception at a younger age, despite the laws.<sup>28</sup>



**Women’s rights:** Despite protective laws, gender-based violence remains an issue of concern in Seychelles. Estimates suggest that 50% of women aged 15-49 who have ever been married or partnered have experienced physical or sexual violence from a male intimate partner in a 12 month period. The enforcement of protective legislation and the implementation of national gender plans remains a challenge.<sup>29</sup>

RECOMMENDATIONS

Civil society should:

- Advocate for and implement stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support services as well as training for law and policy makers and the judiciary
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights
- Train health care providers on the human rights of people living with HIV and/or TB and key populations, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly
- Raise public awareness and disseminate information about the decriminalisation of sex between men in an effort to reduce stigma
- Advocate for access to HIV treatment, care and support for key populations
- Address challenges with age of consent laws for children and adolescents younger than 18 years
- Advocate for the decriminalisation of possession of drugs for personal use and use of drugs and for comprehensive harm reduction programmes

The government should:

- Decriminalise all adult consensual sex
- Review and repeal all laws that undermine children’s rights to access health care
- Enact a comprehensive health law that promote the human rights of patients, including patients living with HIV and/or TB and protect the right to HIV testing with voluntary and informed consent and confidentiality
- Decriminalise drug possession for personal use
- Repeal immigration laws that require HIV testing for non-citizens who wish to marry a Seychellois
- Strengthen protection from gender based violence
- Repeal laws and policies that permit employment HIV testing, including in the armed forces
- Review and repeal provisions in the Public Health Act that undermine the human rights of people living with HIV and/or TB, including compulsory isolation, detention and hospitalisation
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support services, training for law and policy makers and the judiciary



People who use drugs in Seychelles experience high levels of stigma and discrimination. 68% of people who use drugs reported being refused a service in the preceding 12 months because of their injection drug use.

# END NOTES

<sup>1</sup> UNAIDS, *Seychelles Country Progress Report*, 2015

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> Ministry of Health et al, *Situation Analysis of Legal and Regulatory Framework for HIV and AIDS in Seychelles*, 2013

<sup>6</sup> Preamble.

<sup>7</sup> Ministry of Health et al, *Situation Analysis of Legal and Regulatory Framework for HIV and AIDS in Seychelles*, 2013

<sup>8</sup> UNAIDS, *Seychelles Country Progress Report*, 2015

<sup>9</sup> Key Informant Interview, Justin Freminot, HASO, 27 August 2012

<sup>10</sup> Amnesty International, *Making Love a Crime: Criminalisation of Same-Sex Conduct in Sub Saharan Africa*, 2013 at p17.

<sup>11</sup> Seychelles News Agency, *Seychelles parliament passes bill to decriminalize sodomy*, [http://m.seychellesnewsagency.com/view\\_news.php?id=5198](http://m.seychellesnewsagency.com/view_news.php?id=5198) (accessed 5 July 2016)

<sup>12</sup> UNAIDS, *Country Progress Report*, 2012; UNAIDS, *Seychelles NCPI Report*, 2015 Available at <http://www.unaids.org/sites/default/files/country/documents/Seychelles%20NCPI%202013.pdf> [Accessed 16 May 2016]; Key Informant Interview, Justin Freminot, HASO, 27 August 2012

<sup>13</sup> <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper> [accessed on 18 September 2013]

<sup>14</sup> Ministry of Health et al, *Situation Analysis of Legal and Regulatory Framework for HIV and AIDS in Seychelles*, 2013

<sup>15</sup> Ibid.

<sup>16</sup> Ministry of Health et al, *Situation Analysis of Legal and Regulatory Framework for HIV and AIDS in Seychelles*, 2013

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup> Ibid.

<sup>21</sup> Republic of Seychelles, National AIDS Council (2011) *Evaluation Report of the HIV and AIDS National Strategic Plan 2005-2009 and Roadmap for the National Strategic Plan 2012-2016*

<sup>22</sup> Key Informant Interview, Justin Freminot, HASO, Seychelles, 27 August 2012

<sup>23</sup> Ministry of Health et al, *Situation Analysis of Legal and Regulatory Framework for HIV and AIDS in Seychelles*, 2013

<sup>24</sup> Ibid.

<sup>25</sup> UNAIDS, *Country Progress Report*, 2015

<sup>26</sup> Ibid.

<sup>27</sup> Ministry of Health et al, *Situation Analysis of Legal and Regulatory Framework for HIV and AIDS in Seychelles*, 2013

<sup>28</sup> Ibid.

<sup>29</sup> Ibid. See also UNAIDS *Seychelles Country Progress Report*, 2015



# SOUTH AFRICA

## BACKGROUND

In 2013, there were 6.3 million people living with HIV and a national HIV prevalence of 19.1%. There were 5.9 million adults living with HIV, of which 3.5 million are women. The HIV prevalence amongst young women between the ages of 15 and 24 was significantly higher than their male counterparts, at 13.1% compared to 4%. HIV-related deaths declined from 410 000 in 2010 to 200 000 in 2013.<sup>1</sup>

At the time of writing, South Africa had not published its 2015 Country Progress Report to UNAIDS and information on the country's response to HIV was extracted from its 2012 report and the UNAIDS 2014 HIV Epidemic Profile.

HIV in South Africa is a predominantly heterosexual epidemic. Mother-to-child transmission is the main infection route for children.<sup>2</sup> Young women between the ages of 15 and 24 are disproportionately vulnerable to HIV and account for 25% of new HIV infections annually.<sup>3</sup> According to the National Strategic Plan (NSP), the drivers of the epidemic are intergenerational sex, multiple concurrent partners, low condom use, excessive use of alcohol and low rates of male circumcision. Key populations are at particularly high risk for HIV transmission (key populations as defined in the NSP are set out below). Data released in March 2016 on HIV prevalence amongst sex female workers was as high as 72% in some urban settings.<sup>4</sup> There are no statistics for HIV prevalence among transgender people.

South Africa has the largest HIV treatment plan in the world and has made significant progress expanding access to ART: in 2010, 729 312 adults living with HIV were receiving treatment; by June 2014, the number had increased to 2 593 630. ART coverage was 42% for adults and 44% for children in 2013. There is data that shows that some key populations face barriers in accessing HIV treatment: the uptake of ART by female sex workers known to be living with HIV is lower than the national average.<sup>5</sup>

South Africa was one of the 22 priority countries identified in 2009 by UNAIDS to reduce HIV infection amongst children and keep their mothers alive. In the 2015 progress report, South Africa showed significant progress, reducing new infections amongst children by 76% and providing ART to 90% of pregnant women living with HIV.<sup>6</sup>

**South Africa has the largest HIV treatment plan in the world and has made significant progress expanding access to ART: in 2010, 729 312 adults living with HIV were receiving treatment; by June 2014, the number had increased to 2 593 630**

The NSP for 2012-2016 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. It identifies key and vulnerable populations as 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.

In March 2016, South Africa launched a National Sex Worker HIV Plan, 2016 – 2019.<sup>7</sup> The plan aims to provide equal access to health and legal services to sex workers, recognizing their disproportionate vulnerability to HIV, STIs, violence, TB and stigma and discrimination. The plan will include targeted services for sex workers, their clients, partners and families.

South Africa is a HBC for TB, HIV and TB and MDR-TB and has one of the highest burdens of TB globally. The WHO estimates approximately 380 000 people are living with TB and HIV.<sup>8</sup> TB in South Africa has increased to more than 400% over the past 15 years<sup>9</sup> and is the one of leading causes of death. In 2014, 12% of men and 10% of women died from TB.<sup>10</sup> TB is also the biggest killer of South African youth, with 14% of all people between the ages of 15 and 34 who died in 2013, dying of TB.<sup>11</sup> Gold mineworkers in South Africa have particularly high rates of TB, with an estimated incidence of 2500 – 3000 per 100 000, well above the WHO's threshold for emergencies, which is 250 per 100 000.<sup>12</sup>



## In March 2016, South Africa launched a National Sex Worker HIV Plan, 2016 – 2019.

**The plan aims to provide equal access to health and legal services to sex workers, recognizing their disproportionate vulnerability to HIV, STIs, violence, TB and stigma and discrimination. The plan will include targeted services for sex workers, their clients, partners and families**

Key populations for TB are identified by the NSP as 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.<sup>13</sup>

## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### CONSTITUTION

The Constitution of the Republic of South Africa, 2006 protects the values of dignity, freedom, and equality for all. The Constitution has a well-developed equality provision<sup>14</sup> that outlaws unfair discrimination on a number of grounds, including sexual orientation and disability, but does not specifically include HIV status. Section 27 provides that everyone has a right to access health care services, including reproductive health.

While the constitution does not mention gender identity, courts have interpreted the bill of rights to provide protection based on gender identity.<sup>15</sup>

### RATIFICATION OF INTERNATIONAL AND REGIONAL TREATIES

South Africa ratified the International Convention on Economic, Social and Cultural Rights (ICESCR) in January 2015

South Africa has also ratified:

- African Charter on Human and Peoples' Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Rights of People with Disabilities, 2006
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- International Convention on Civil and Political Rights (ICCPR), 1966
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003

### NATIONAL LAWS AND POLICIES

South Africa has a well-developed legal framework that protects and promotes human rights and protects individuals from unfair discrimination in access to education, employment, correctional facilities and in health care. Some laws specifically include provisions for vulnerable and key populations, including women and girls, young people, LGBTI populations, sex workers, prisoners and migrant populations.

The Promotion of Equality and Prevention of Unfair Discrimination Act, 2000 elaborates on the constitutional guarantee of 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.<sup>16</sup> The act also provides for the establishment of equality courts.

The Labour Relations Act 1995 protects all employees from discrimination. The Employment Equity Act 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.



There are a range of laws that protect women from unfair discrimination and GBV, and promote their sexual and reproductive rights: the Domestic Violence Act 1998 recognizes a broad range of relationships, including same sex relationships, and protects individuals from physical, sexual, psychological and economic abuse. Marital rape is criminalized. The Criminal Law (Sexual Offences and Related Matters) Act 2007 has a gender neutral definition of sexual violence and equalizes the age of consent for both hetero- and homosexual sex to 16. It also makes provision for access to services for survivors of sexual violence, including PEP. The Recognition of Customary Marriage Act 1998 provides legal recognition for customary marriages and protects the property rights of women married in terms of customary law, including those in polygamous marriages. In May 2014, 100 imams were accredited as marriage officers to pave the way for the recognition of Muslim marriages.<sup>17</sup> The Choice on Termination of Pregnancy Act 1996 provides women with the right to terminate their pregnancies based on choice. Pregnant minors do not need the consent of their parents or guardians to terminate their pregnancies.<sup>18</sup>

The Prevention and Combating of Trafficking in Persons Act 2013 aims to prevent trafficking and provide protection and services to victims of trafficking.

The Children's Act 2010 provides comprehensive protection for 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).

South Africa has accelerated registration for MDR-TB drugs and has been commended for introducing new TB drugs by introducing bolder policies and making new and repurposed drugs available through Compassionate Use or patient names basis mechanisms.<sup>19</sup>

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. In 2013, the Department of Health adopted guidelines for the management of TB, HIV and STIs in Correctional Centres. The policy recognises the rights of prisoners to receive health care, including access to HIV and TB prevention and provides for access to HIV and TB testing and treatment.<sup>20</sup>

## 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. The Legal Aid South Africa Act, 2014, sets out the government's obligation to provide legal aid and advice, provide free legal representation to those who cannot afford it and educate and inform the public about their rights and obligations under the Constitution.<sup>21</sup> In addition, various international and local donors fund advice officers and paralegals to help promote access to justice, including in rural areas, prisons and to key populations.

There are various specialised courts: the Department of Justice operates 36 dedicated sexual offences courts throughout the country.<sup>22</sup> The Equality Act obliges the government to establish special Equality Courts to hear cases on unfair discrimination, hate speech and harassment. These courts are supposed to provide access to justice to marginalised communities and are designed to be more accessible than other courts. The procedure has been simplified to avoid the need for legal representation. Unfortunately, it appears that the courts are under-utilised.

Other mechanisms in place to ensure the implementation of laws include the South African 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 National Health Research Ethics Council with the authority to grant or deny permission to carry out research on human subjects.<sup>23</sup>

There is inadequate provision for monitoring and documenting HIV and TB-related human rights violations. While individual councils and commissions work on HIV- and TB-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, and to HIV and AIDS.<sup>24</sup>



GAPS AND CHALLENGES

PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS



Gaps and challenges within the South African legal framework include:

- Sex work is criminalised by the Sexual Offences Act 1957 and the Criminal Law (Sexual Offences and Related Matters) Amendment Act 2007. The South African Law Commission's Project 107 has been reviewing the legal position of sex work in South Africa for over a decade. The Sex Workers Education and Advocacy Taskteam (SWEAT) estimates that there are approximately 182 000 sex workers in South Africa.<sup>25</sup>
- The Criminal Law (Sexual Offences and Related Matters) Amendment Act 2007 provides for mandatory HIV testing for alleged perpetrators of sexual violence.<sup>26</sup> In addition, perpetrators with HIV and who were aware of their HIV status at the time of the offence, face a minimum life sentence unless substantial and compelling circumstances exist to justify a lesser sentence.
- The Prevention of and Treatment for Substance Abuse Act 2008 does not provide for harm reduction for people who inject drugs such as NSE and opioid substitution therapy OST programmes.
- The Recognition of Customary Marriages Act 1998 recognizes and legalises polygamy.

HUMAN RIGHTS CHALLENGES

While South Africa has developed a strong legal and policy framework recognizing the human rights of people living with HIV, TB and key populations, it still faces significant human rights challenges.



**Stigma and discrimination:** The 2015 Stigma Index summary report showed South Africa has made good progress in dealing with HIV-related stigma. Despite this, stigma affects approximately one third of people living with HIV. People living with HIV reported being excluded from social gatherings and family activities and being gossiped about, with many believing this was because of their HIV status. Just under half of the participants reported feelings of shame, guilt and low self-esteem related to their HIV status.

Participants in the Stigma Index also reported TB related stigma: over a third of respondents disclosed they had been verbally abused on the grounds of their TB status and 41% reported being gossiped about.<sup>27</sup>



**Women's rights:** South Africa has high levels of sexual and physical violence against women and girls. The 2015 Southern African Development Community (SADC) Gender Protocol Gender Barometer found that as many as 77% of women in the Limpopo Province had experienced some form of GBV.<sup>28</sup> The South African Police Services reported that there were 46 253 rapes reported in 2013/14.<sup>29</sup> The Medical Research Council has however estimated that only one in nine rapes are reported to the police. The National Prosecuting Authority operates 53 rape centres (called TCCs) at hospitals to facilitate comprehensive care and support to rape survivors, including the provision of PEP. Some survivors have reported sub-standard care from health care workers.

**Children:** Violence, including sexual violence, against children is widespread.<sup>30</sup> There is widespread sexual violence against schools girls by teachers and educators, resulting in unwanted pregnancies, HIV and other STIs and girls having to drop out of education.<sup>31</sup> Girls also face harmful practices such as ukuthwala, the forced, arranged marriages of girls in various provinces of South Africa. The 2013 trafficking act prohibits ukuthwala and the first conviction for ukuthwala was recorded in February 2014.<sup>32</sup>



**Sex workers:** Sex workers are stigmatised and marginalised and vulnerable to violence, exploitation and abuse. This creates barriers to access to health care services. The criminalisation of sex work makes sex workers particularly vulnerable to abuse and sexual violence at the hands of police. It was reported in the South Africa parliament that there have been 16 assaults cases brought by sex workers against members of the police services between 2012 and 2015. The 2016 national sex worker HIV plan makes provision for HIV testing for sex workers. Those who test positive will be offered access to ART, while those who are negative will be offered pre-exposure prophylaxis (PrEP) in combination with other prevention services.<sup>33</sup>



**LGBTI people:** The rights of LGBTI people are strongly entrenched in the legal framework in South Africa; the country is the only one in Africa that provides constitutional protection from discrimination. Same sex couples enjoy the right to marry<sup>34</sup> and adopt<sup>35</sup>, while there is legal recognition for gender identity. The reality remains, however, that the positive legal environment has not translated to an enabling social environment. "Corrective" rape of lesbian women and transgender men in townships remains a serious issue.<sup>36</sup> Violence in schools faced by LGBTI learners is a also serious issue. Another study found that between 10-20% of gay men in Johannesburg and Cape Town and 35% of gay men in KwaZulu-Natal and Eastern Cape had experienced sexual violence at some point in their life.<sup>37</sup> The Department of Justice and Constitutional Development has been working on a draft hate crimes bill since 2013.<sup>38</sup>

Legal recognition of gender identity takes place through the Alteration of Sex Description Act 49 of 2003. This act stipulates that people can change the gender markers on their identity documents upon undergoing medical treatment that alters either their primary or secondary sex characteristics; essentially this means that surgery is not required to legally change gender identity. While the law is relatively progressive compared to other legislation in the region, it has not been well implemented, with some transgender people who apply for a change of gender markers reporting that their applications have been denied because they did not yet have "the surgery". The lack of implementation has led to the denial of health care in some cases. Furthermore, there have been cases of forced divorce where applicants were married under the older Marriage Act 25 of 1961.<sup>39</sup>

The pervasive violence, discrimination and stigma faced by LGBTI people in South Africa – despite legal protection – has led to issues of access to health care, and contributes severely to vulnerability to HIV infection.



**People who use drugs:** 14% of people who inject drugs are living with HIV.<sup>40</sup> People who use drugs in South Africa experience human rights abuses that impact on their ability to access health care. A report released in 2016 documented 246 human rights violations against people use drugs in three cities over a three month period. The violations included assaults, confiscation of medication and detention without cause.<sup>41</sup> Awareness about harm reduction amongst police officers is low.<sup>42</sup>

**Prisoners:** South Africa faces significant over-crowding in its prisons. The 2014-15 Department of Correctional Services' annual report states correctional facilities were 32% above capacity. Overcrowding and poor living conditions have made prisons a breeding ground for TB and NGOs consider prisons a major source of MDR-TB. The Department of Correctional Services is providing access to HIV testing and 97% of prisoners living with HIV are able to access treatment. NGOs express concerns about inadequate follow up for prisoners with HIV when they are released from prison.<sup>43</sup> The 2013 policy makes provision for the distribution of condoms and lubricant in prisons

**Migrants:** South Africa has extremely large numbers of undocumented migrants, asylum seekers and refugees within its borders. In 2014, the South African Human Rights Commission released a report on health care at the Lindela Repatriation Centre, the country's largest detention centre. The report showed a lack of TB testing capacity and limited availability of condoms.<sup>44</sup>

South Africa recognises "a group of persons of a particular gender" and sexual orientation as "social groups" qualifying for asylum under the Refugees Act 130 of 1998. South Africa has reportedly admitted LGBTI asylum seekers from Angola, Malawi, Uganda, Tanzania, Burundi, DRC, Nigeria, Cameroon, Ethiopia, Zambia and Zimbabwe.<sup>45</sup> However, currently the immigration system is overwhelmed, creating a backlog in decisions, providing uncertainty for LGBTI asylum seekers in South Africa.<sup>46</sup>

RECOMMENDATIONS

Civil society should:

- Work to strengthen access to justice for key populations by training law enforcement officials on the human rights of people living with HIV and/or TB and key populations
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights

The government should:

- Review and evaluate laws relating to the possession of drugs and drug paraphernalia to ensure that it is possible to provide harm reduction services to people who use drugs
- Review and repeal laws that allow for mandatory HIV testing
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support services, training for law and policy makers and the judiciary
- Urgently address the pervasive violence faced by the LGBTI community

# END NOTES

<sup>1</sup> UNAIDS, *South Africa HIV Epidemic Profile 2014*, <http://www.unaidsrstes.org/wp-content/uploads/2015/05/UNAids-Profile-South-Africa.pdf-18-Feb.pdf> [accessed 20 May 2016]

<sup>2</sup> UNAIDS, *Country Progress Report*, 2012. Available at <http://www.unaids.org/en/regionscountries/countries/southafrica/>

<sup>3</sup> Ibid., UNAIDS, *South Africa HIV Epidemic Profile 2014*

<sup>4</sup> UNAIDS, *UNAIDS welcomes South Africa's groundbreaking National Sex Worker HIV Plan*, 11 March 2016, [http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/march/20160311\\_ZA\\_NSWHP](http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/march/20160311_ZA_NSWHP) [accessed 21 May 2016]

<sup>5</sup> Ibid., *UNAIDS welcomes South Africa's groundbreaking National Sex Worker HIV Plan*

<sup>6</sup> UNAIDS, *2015 Progress Report on the Global Plan towards the elimination of new infections amongst children and keeping their mothers alive*, [http://www.unaids.org/sites/default/files/media\\_asset/JC2774\\_2015ProgressReport\\_GlobalPlan\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf) [accessed 22 May 2016]

<sup>7</sup> AllAfrica, *South Africa: Deputy President Cyril Ramaphosa – Launch of South African National Sex Worker HIV Plan*, 11 March 2016, <http://allafrica.com/stories/201603142223.html> [accessed 21 May 2016]

<sup>8</sup> WHO, *Global Tuberculosis Report 2015*, [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=ZA&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=ZA&LAN=EN&outtype=html) [accessed 20 May 2016]

<sup>9</sup> Ibid., *Country Progress Report*

<sup>10</sup> VOA, *TB is Number One Killer in South Africa*, 21 March 2014 <http://www.voanews.com/content/tb-is-number-one-killer-in-south-africa/1876553.html> [accessed 20 May 2016]

<sup>11</sup> Health e-News, *TB, HIV killing country's youth*, 30 June 2015, <https://www.health-e.org.za/2015/06/30/tb-hv-killing-countrys-youth/> [accessed 21 May 2016]

<sup>12</sup> ARASA, *Close the gap: TB and human rights*, [https://www.health-e.org.za/wp-content/uploads/2015/12/Activist\\_guide\\_final\\_double\\_spread.pdf](https://www.health-e.org.za/wp-content/uploads/2015/12/Activist_guide_final_double_spread.pdf)

<sup>13</sup> Ibid., *Country Progress Report*

<sup>14</sup> Section 9

<sup>15</sup> QUINTON ATKINS vs DATACENTRIX (PTY) LTD. Labour Court of South Africa. 2009

<sup>16</sup> See, for instance, *Hoffman v SAA* (CCT 17/00) [2000] ZACC 17

<sup>17</sup> South Africa Info, *Full legal status of Muslim marriages in South Africa*, 2 May 2014, <http://www.southafrica.info/services/rights/muslim-020514.htm#Vz-JxvkrLIU> [accessed 20 May 2016]

<sup>18</sup> Section 5

<sup>19</sup> MSF, *Out of Step 2015: TB policies in 24 countries*, [https://www.health-e.org.za/wp-content/uploads/2016/01/report\\_out\\_of\\_step\\_2015\\_11\\_pdf\\_with\\_interactive\\_links.pdf](https://www.health-e.org.za/wp-content/uploads/2016/01/report_out_of_step_2015_11_pdf_with_interactive_links.pdf) [accessed 21 May 2016]

<sup>20</sup> Government of South Africa, *Guidelines for the Management of Tuberculosis, Human Immunodeficiency Virus and Sexually Transmitted Infections in Correctional Centres*, 2013, <http://www.section27.org.za/wp-content/uploads/2013/05/Guidelines-for-the-management-of-Tuberculosis-Human-Immunodeficiency-Virus-and-Sexually-Transmitted-Infections-in-Correctional-Centres-2013.pdf> [accessed 21 May 2016]

<sup>21</sup> Section 3

<sup>22</sup> US Bureau of Democracy, *Labor and Human Rights, Country Reports on Human Rights Practices for 2015: South Africa*, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper> [accessed 20 May 2016]

<sup>23</sup> UNAIDS, *Global AIDS Response Country Progress Report*, 2012

<sup>24</sup> Ibid., *Global AIDS Response Country Progress Report*, 2012

<sup>25</sup> SWEAT, <http://www.sweat.org.za/sexworkiswork/#> [accessed 21 May 2016]

<sup>26</sup> Section 32

<sup>27</sup> South African National AIDS Council, *The People Living with HIV Stigma Index, South Africa 2015*, <http://www.stigmaindex.org/sites/default/files/reports/Summary-Booklet-on-Stigma-Index-Survey%20South%20Africa.pdf> [accessed 20 May 2016]

<sup>28</sup> Gender Links, *SADC Gender Protocol 2015 Barometer, South Africa*, 28 August 2015, <http://genderlinks.org.za/programme-web-menu/publications/sadc-gender-protocol-2015-barometer-south-africa-2015-03-17/> [accessed 21 May 2016]

<sup>29</sup> Africa Check, *South Africa's official crime statistics 2013/14*, <https://africacheck.org/factsheets/factsheet-south-africas-official-crime-statistics-for-201314/> [accessed 21 May 2016]

<sup>30</sup> Ibid., US Bureau of Democracy, *Labor and Human Rights, Country Reports on Human Rights Practices for 2015: South Africa*

<sup>31</sup> Centre for Applied Legal Studies and others, *Sexual Violence by Educators in South African Schools: Gaps in Accountability*, May 2014, <https://www.wits.ac.za/media/news-migration/files/Sexual%20violence%20by%20educators%20in%20South%20African%20schools%20%20gaps%20in%20accountability%20%20CALS%20May%2014%20.pdf>

<sup>32</sup> Ibid., US Bureau of Democracy, *Labor and Human Rights, Country Reports on Human Rights Practices for 2015: South Africa*

<sup>33</sup> National Assembly, *Question 2967 14 August 2015*, 36/1/4/1/201500263

<sup>34</sup> Civil Union Act 17 of 2006

<sup>35</sup> Du Toit and Another v Minister of Welfare and Population Development and Others, <http://www.saflii.org/za/cases/ZACC/2002/20.html>.

<sup>36</sup> ‘We’ll Show You You’re a Woman’: Violence and Discrimination Against Black Lesbians and Transgender Men. Human Rights Watch, 2011

<sup>37</sup> University of California, San Francisco (2015), Report of the South Africa men-who-have-sex-with-men, Data Triangulation Project. San Francisco: UCSF.Global Health Sciences, at xiv.

<sup>38</sup> Address by the Deputy Minister of Justice and Constitutional Development, Annual General

Meeting of the Hate Crimes Working Group, Scalabrini Centre, Cape Town, 11 February 2015.

<sup>39</sup> Alteration of Sex Description Act 49 of 2003: Briefing paper. Gender DynamiX & Legal Resource Centre. [2014]

<sup>40</sup> UNAIDS, *Do No Harm*, 2016, [http://www.unaids.org/sites/default/files/media\\_asset/Do\\_no\\_harm\\_slides.pdf](http://www.unaids.org/sites/default/files/media_asset/Do_no_harm_slides.pdf) [25 May 2016]

<sup>41</sup> TB/HIV Care Association, *246 human rights abuses against people who use drugs reported over 3 months*, 3 February 2016, [http://www.tbhivcare.org/?page=news\\_archive&id=2016](http://www.tbhivcare.org/?page=news_archive&id=2016) [accessed 21 May 2016]

<sup>42</sup> Ibid., *Do No Harm*

<sup>43</sup> Ibid., US Bureau of Democracy, *Labor and Human Rights, Country Reports on Human Rights Practices for 2015: South Africa*

<sup>44</sup> Ibid., US Bureau of Democracy, *Labor and Human Rights, Country Reports on Human Rights Practices for 2015: South Africa*

<sup>45</sup> Moodly, University of Cape Town, *Receiving LGBTI Refugees in South Africa: Towards a Culture of Human Rights*, Paper 5 of 2012, at 6.

<sup>46</sup> United Nations High Commissioner for Refugees, *Global Appeal 2015*, <http://www.unhcr.org/5461e604b.html>.





# SWAZILAND

## BACKGROUND

Swaziland currently has the highest HIV prevalence in the world. According to UNAIDS, around 27.7% (200 000) of adults aged 15-49 years in Swaziland are living with HIV, with significantly more women infected than men (120 000 women living with HIV). There are currently around 3 500 deaths from AIDS each year. There are 19 000 children below the age of 15 living with HIV and 56 000 orphans.<sup>1</sup>



Though HIV incidence has decreased since 2011, it is still high. Heterosexual sex remains the main mode of transmission, accounting for the vast majority of new HIV infections. Risk factors include but are not limited to, multiple and concurrent sexual partnerships; early sexual debut; intergenerational sex; transactional sex, gender inequalities and gender based violence, stigma and discrimination, low and inconsistent condom use and low uptake of male circumcision.<sup>2</sup>

A study in 2011 showed high prevalence amongst key populations - HIV prevalence amongst sex workers was incredibly high at 70.3%. Although there is limited information on HIV prevalence amongst gay men and men who have sex with men, a 2011 behavioural surveillance survey found a 17.7% HIV prevalence, with marked age variations in prevalence, from 4% prevalence in the 16 – 20 years age group to as high as 53% in the 30-40 year age group.<sup>3</sup> The Behavioural and Biological Surveillance Survey reported a prevalence of 30.4% among mobile populations increasing to 50.3% amongst factory workers. In a 2010 study conducted in the country's correctional facilities the prevalence was found to be higher than in the general population, at 34.8%.<sup>4</sup> There is no information on HIV prevalence amongst people who inject drugs.

In Swaziland, government finances and procures all ARVs and TB drugs. By December 2013, around 100 000 of the 122 000 people in need of treatment (82%) were receiving ART and 9 500 of the 11 000 HIV positive pregnant women (84%) were receiving ART to reduce vertical transmission of HIV.

Swaziland also has the highest TB rate in the world. There are around 7 700 people living with TB, a prevalence rate of 605 cases per 100 000 people and around 73% of TB patients are also living with HIV, according to WHO.<sup>5</sup> In 2012 Botswana reported that 90% of TB patients were tested for HIV and 73% of TB patients received treatment for both HIV and TB.<sup>6</sup>

The new Extended National Strategic Framework 2014-218 focuses on high impact interventions and targeting of populations and areas where most of the new infections are coming from. Protecting human rights and reducing stigma and discrimination is a critical focus of the national response to HIV.

## KEY HUMAN RIGHTS CONCERNS IN 2016



- HIV-related stigma and discrimination
- Gender based violence and gender inequality
- Human rights abuses against key populations

## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### CONSTITUTION

Part III of the National Constitution, 2005 contains a Bill of Rights. It includes specific protection for a number of rights that are relevant to HIV and TB including the rights to equality and protection from discrimination and inhuman and degrading treatment, along with liberty, life, health, freedom of expression, assembly and movement, respect for the rights of the family, women, children, workers and persons with disabilities. The Constitution obliges the state to take practical measures to ensure the provision of basic health care services to the population.

Section 28 guarantees women's right to equality and places a duty upon the state to support women's realisation 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. 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."<sup>7</sup> 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.<sup>8</sup>

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.



## RATIFICATION OF INTERNATIONAL AND REGIONAL TREATIES

Swaziland has ratified:

- Convention on the Rights of the Child (CRC), 1989
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- Convention on the Rights of people with disabilities, 2006
- International Convention on Economic, Social and Cultural Rights (ICESCR), 2004
- International Convention on Civil and Political Rights (ICCPR), 1966
- African Charter on Human and Peoples’ Rights, 1981
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003

## NATIONAL LAWS AND POLICIES

There is no HIV-specific law. The existing Public Health Act 5 of 1969 contains limited provision for health rights and includes coercive provisions relating to HIV and AIDS, although these provisions have not been applied to HIV or AIDS in Swaziland. The Act will be replaced by the Public Health Bill, 2013, when enacted, which provides for the regulation of health care services, including for the manufacture, procurement, monitoring and control of all medicines. Part 6 of the Bill provides specifically for health responses to STIs and requires health practitioners to treat STIs, which would include HIV and AIDS.

The National Multi-Sectoral HIV and AIDS Policy 2006 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.<sup>9</sup> 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.

The Ministry of Health and Social Welfare’s HIV Testing and Counselling National Guidelines of 2006 provide for HIV testing and counselling in Swaziland. Chapter 7 of the Guidelines recognises the right of all patients to information, education, privacy, non-discrimination and equality, the right to marry and the right to the highest attainable standard of health. HIV testing must be voluntary with clients and patients making an informed decision about accepting an HIV test and being given the right to refuse testing. A child of 12 years or above can give full informed consent to an HIV test and the consent of a parent or guardian is required for children below the age of 12 years. The Guidelines also protect the right to confidentiality and provide that disclosure should only be with a patient’s consent, and to a child if he or she has sufficient maturity, or to a parent or guardian.

In the health sector, a number of 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 Elimination of Mother to Child Transmission of HIV 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 Guidelines, 2010 to bring the guidelines in line with World Health Organization recommendation of early enrolment into care.<sup>10</sup>

A review of intellectual property laws has taken place to strengthen access to treatment for HIV and AIDS.

Women and girls are protected from sexual abuse by the Girls and Women Protection Act. The 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. The Gender Policy, 2010 provides a clear commitment to strengthening gender equality in Swaziland and to redressing gender inequality and improving the living conditions of women and men. The Deputy Prime Minister’s office has a Gender and Family Affairs Unit tasked with co-ordinating responses to addressing gender issues. The National Violence Surveillance System aims to strengthen systems and structures to address gender issues.<sup>11</sup>

The case of *Mary-Joyce Doo Aphane and Registrar of Deeds, Minister of Justice and Constitutional Affairs and Attorney General*<sup>12</sup> resulted in the amendment of the Deeds Registry Act by Parliament to remove the property-related discrimination against women. Section 16(3) provides that where spouses are married in community, neither spouse can deal with property alone, unless he or she has the consent of the other spouse.

Swaziland has an Employment Act Cap 268 and Industrial Relations Act Cap 269 to protect workers against discriminatory practices. The Employment Act was 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.<sup>13</sup> Although the provisions are not HIV specific, they do contain anti-discrimination protection that should protect the rights of people living with HIV. Part X makes provision for the protection of women, children and young persons in the workplace. In addition, Part 1.6 of the Code of Good Practice: HIV/AIDS in Employment provides for eliminating discrimination in the workplace based on HIV status and also promoting a non – discriminatory workplace in which people living with HIV are able to be open about their status without fear of stigma or rejection. 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. Part IV, section 23(1) (a) of the Act furthermore defines a child who has been abused as a child in need of care and protection. The Act requires any member of the community to report suspected abuse of a child in section 36(1).<sup>14</sup> Part X of the Act also prohibits the sale, harbouring or abduction of children.

## 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 are not fully established.<sup>15</sup> The Human Rights Commission is reported to be weak and under-funded and enabling legislation has not yet been enacted which also hampers the functioning of the Commission.<sup>16</sup>

There are 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. CSOs such as Women and Law in Southern Africa, SWAPOL and the Swaziland National Network of People Living with HIV or AIDS (SWANEPPHA), amongst others, support rights protection for women and for people living with HIV. However, there is no legal aid system and a bill establishing one has yet to be passed into law.<sup>17</sup> University based centres and private sector law firms to provide free or reduced-cost legal services to people living with HIV, but this is insufficient to meet the needs.

The lack of HIV-specific protection in law also means there is no clear guidance on the rights of people in the context of HIV and AIDS. The Stigma Index Study found that many people are unaware of their rights and how to access and use enforcement mechanisms. Likewise, many service providers are not fully sensitised on HIV-related human rights issues.<sup>18</sup> 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 generally slow and inadequately resourced.<sup>19</sup>

## GAPS AND CHALLENGES

### PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

Swaziland has signed but not yet ratified the African Charter on the Rights and Welfare of the Child, 1990.

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. Swazi inheritance law prevents a woman from inheriting anything from their deceased husband’s estate in their own right. Rural women only have access to land through a husband if they are married, or through a male relative if they are single.<sup>20</sup> There is currently a review of inheritance law in terms of the Administration of Estates Bill, 2009.<sup>21</sup> Laws such as the Marriage Act, 1964 perpetuate gender inequality, allowing girls to marry at 16 years of age. The draft Marriage Bill which addresses inequality in marriage has not yet been passed into law.

Sex work is criminalised in Swaziland under the Crimes Act No 61 of 1889 in a very broad provision that fails to define “immoral acts”. Sections 32 to 40 of the Act also make it a criminal offence to keep a brothel. Section 13 of the proposed Sexual Offences and Domestic Violence Bill of 2009 furthermore criminalises “commercial sexual exploitation.” 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 if this defense is raised.<sup>22</sup>

Swazi common law criminalises sodomy.

The Opium and Habit Forming Drugs Act of 1922 regulates habit forming drugs in Swaziland. Section 7 of the Act prohibits drug taking, including the use of drug equipment for taking drugs, as well as the keeping of premises for drug taking. It is unclear to what extent these provisions will act as barriers to harm reduction services for people who inject drugs (such as needle exchange programmes) in Swaziland.





**Stigma and discrimination:** The Stigma Index Study conducted by the 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 of all sexes, ages and locations and contributing to self-stigma.

Stigma and discrimination occur at the family and community levels where people affected by HIV report being physically assaulted, gossiped about, verbally insulted, harassed, threatened and excluded from their families and social gatherings. People living with HIV experience discrimination in the workplace and there are 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 of HIV status.<sup>23</sup>



**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 laws 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 and early marriage, as well as GBV place women at higher risk of HIV.<sup>24</sup> GBV is a critical concern in Swaziland. The Sexual Offences and Domestic Violence Bill, 2010 fails to specifically criminalise marital rape. It was passed by Parliament but lapsed because it did not have royal assent.<sup>25</sup> It is not clear when the bill will be passed into law.

Women with HIV report discriminatory treatment including forced or coerced sterilization.



**Sex workers:** Sex workers face violence and abuse and do not report violations for fear of arrest.<sup>26</sup> During focus group discussions carried out in Swaziland, they reported being physically, sexually, verbally, emotionally and economically abused by law enforcement agents, clients and family members.



**Gay men and men who have sex with men:** LGBTI populations are not specifically protected from discrimination on the basis of sexual orientation and gender identity in Swaziland. Gay men and men who have sex with men experience high levels of stigma, discrimination and human rights violations in the country. They also report difficulties in accessing targeted health services, including HIV prevention services, as a result of the criminalisation of their sexual relationships.



**People who inject drugs:** There is very limited data on people who inject drugs in Swaziland. The new national strategic plan identifies various target populations for interventions, which include “key populations and vulnerable groups” such as people who inject drugs. However, it is unclear to what extent HIV-related health service programming in fact takes place for people who inject drugs.

RECOMMENDATIONS

Civil society should:

- Support and undertake awareness programmes to reduce stigma and discrimination
- Undertake programmes to increase legal literacy amongst people living with HIV and key populations
- Develop mechanisms including in health settings to monitor and document HIV-related human rights violations
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights
- Train health care providers on the human rights of people living with HIV and/or TB and key populations, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly

The government should:

- Ratify the African Charter on the Rights and Welfare of the Child, 1990
- Decriminalise all consensual adult sex
- Review and repeal all laws that discriminate against women, including their access to and ownership of land and their lack of equality under customary personal status laws; enact laws that give women full equality in all aspects of their lives; increase protection for women from discriminatory treatment in access to their sexual and reproductive health and rights, GBV and harmful gender norms
- Introduce enabling legislation for the Human Rights Commission
- Revise the Domestic Violence and Sexual Offences Bill to explicitly criminalise marital rape
- Strengthen policies and programming for people who inject drugs
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support services, training for law and policy makers and the judiciary

The King of Swaziland should:

- Urgently assent to the Domestic Violence and Sexual Offences Bill

# END NOTES

<sup>1</sup> Available at <http://www.unaids.org/en/regionscountries/countries/swaziland/> [Accessed 22 May 2016]

<sup>2</sup> UNAIDS *Swaziland Country Progress Report 2014*, Available at [http://www.unaids.org/sites/default/files/country/documents/SWZ\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/SWZ_narrative_report_2014.pdf) [Accessed 22 May 2016].

<sup>3</sup> BSS MARPS, cited in UNAIDS *Swaziland Country Progress Report 2014* Available at [http://www.unaids.org/sites/default/files/country/documents/SWZ\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/SWZ_narrative_report_2014.pdf) [Accessed 22 May 2016].

<sup>4</sup> Dlamini, P et al., 2010.

<sup>5</sup> [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&lSO2=SZ&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&lSO2=SZ&LAN=EN&outtype=html) [Accessed 23 May 2016].

<sup>6</sup> Ministry of Health Annual TB Report 2012, cited in UNAIDS *Swaziland Country 2014*.

<sup>7</sup> Section 28(3)

<sup>8</sup> Section 34(1)

<sup>9</sup> ARASA, *HIV & Human Rights in Southern Africa*, 2009 at p36; AIDS and Human Rights Research Unit, *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS and the Law*, 2007 at p306

<sup>10</sup> Ibid.

<sup>11</sup> UNAIDS, *Swaziland Country Progress Report 2014*, Available at [http://www.unaids.org/sites/default/files/country/documents/SWZ\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/SWZ_narrative_report_2014.pdf) [Accessed 23 May 2016].

<sup>12</sup> Civil Case No. 383/2009

<sup>13</sup> Article 29

<sup>14</sup> ARASA, *HIV & Human Rights in Southern Africa*, 2009

<sup>15</sup> UNAIDS, Swaziland NCPI Report 2013.

<sup>16</sup> Committee on the Elimination of Discrimination Against Women, *Concluding Observations on the combined initial and second periodic of Swaziland*, 24 July 2014, <http://www.ohchr.org/EN/Countries/AfricaRegion/Pages/SZIndex.aspx> [accessed 26 June 2016]

<sup>17</sup> Ibid., *Concluding Observations on the combined initial and second periodic of Swaziland*

<sup>18</sup> SWANNEPHA, *Stigma Index Report: Swaziland*, 2011. Available at [www.stigmaindex.org](http://www.stigmaindex.org) [Accessed 27 July 2012]

<sup>19</sup> UNAIDS, *Country Progress Report*, 2010 at p20

<sup>20</sup> 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 p118

<sup>21</sup> UNAIDS, *Country Progress Report*, 2010

<sup>22</sup> GCHL, *Risks, Rights & Health*, 2012 at p38

<sup>23</sup> Swaziland Network of People living with HIV/AIDS, *People Living with HIV Stigma Index Report: Swaziland*, 2011. Available at [www.stigmaindex.org](http://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

<sup>24</sup> UNAIDS, *Country Situation Analysis*, 2012. Available at [http://www.unaids.org/ctrysa/AFRSWZ\\_en.pdf](http://www.unaids.org/ctrysa/AFRSWZ_en.pdf) [Accessed 26 September 2012]; National Multi-Sectoral Framework on HIV and AIDS 2009-2014

<sup>25</sup> Ibid., *Concluding Observations on the combined initial and second periodic of Swaziland*

<sup>27</sup> UNAIDS, *Swaziland NCPI Report*, 2012.





# TANZANIA

## BACKGROUND

The 2014 HIV country progress report states the Tanzania mainland continues to experience a mature, generalized HIV epidemic while the epidemic in Zanzibar is a concentrated one. Data from the report shows that as of December 2013, 1,411,829 people were living with HIV and 79,338 were newly infected during 2013. HIV prevalence has declined since 2003 amongst adults between the ages of 15 – 49, from 7% to 5.3% in 2013, with a more significant decline amongst men.<sup>1</sup>



The HIV epidemic in Tanzania is still predominantly a heterosexual epidemic, although mother to child transmission accounts for 18% of new infections. Women are disproportionately infected and the Tanzania HIV and Malaria Indicator Survey (2011) shows that women aged 23 – 24 were more than three times more likely to be living with HIV. Risk factors for transmission include low educational level, multiple and concurrent sexual relationships, early sexual debut, transactional and cross generational sexual relationships, low and inconsistent condom use, low levels of male circumcision, low levels of HIV testing and disclosure, low transmission, gender inequality, sexual violence, substance abuse and STIs.<sup>2</sup>

There have been a number of studies that address key populations and the 2014 HIV country progress report states that prevalence amongst key populations may be high and cites available data for people who inject drugs (16%), men who have sex with men (22.2%) and female sex workers (31.4%). These figures are not nationally representative, and while they are high, they also show a decline in HIV infection when compared to earlier estimates. Based on few available studies from mainland Tanzania and Zanzibar, the HIV prevalence among people who use drugs decreased from 50% to 15.5% by 2013. This decline was also noted among men who have sex with men with a decrease from 41% to 22.2%.<sup>3</sup>

In 2013, 78 843 people died of AIDS related causes. The number of people receiving ART increased since 2010 and by December 2013, a total of 1,366,402 were enrolled in care and treatment centers, 512,555 people living with HIV were receiving ART of whom 8% were children.<sup>4</sup>

According to the WHO, Tanzania is considered to be a HBC for TB and HIV<sup>5</sup>. 91% of TB patients know their HIV status and 35% of people with TB are also living with HIV.<sup>6</sup> The 2014 TB country data also states that 54% of people living with HIV and TB are receiving treatment for both diseases.<sup>7</sup> Data from the Tanzania National TB and Leprosy programme paints a similar picture, indicating that of the 63,892 TB cases notified, 52,499 (82%) were counselled and tested for HIV. Among those tested, 20,269 (39%) were co-infected with HIV.

The country recently developed its third National Multi-sectoral Strategic Framework (NMSF III) covering the period 2013/2014-2017/2018<sup>8</sup>. The NMSF III promotes human rights and gender equality and includes a focus on reviewing and improving the legal, policy and social environment to encourage access for under-served and key populations.

## KEY HUMAN RIGHTS CONCERNS FOR 2016

- HIV-related stigma and discrimination
- Gender inequality and gender based violence
- Abuses against key populations



## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### CONSTITUTION

Tanzania has a pluralistic legal system where statutory, Islamic, Hindu and customary laws operate simultaneously. The Constitution of the Republic of Tanzania, 1977 recognises that all people are equal before the law and prohibits discrimination on the grounds of nationality, tribe, place of origin, political opinion, colour, religion, sex or station in life.<sup>9</sup> There is no reference to sexual orientation or gender identity in the constitution.

In 2011, then President Kikwete announced a constitutional review, the first since 1977, and appointed a Constitutional Review Commission (CRC) to collect public submissions. In December 2013, after it was adopted by a Constituent Assembly, the CRC presented a second draft of the new constitution to President Kikwete. Tanzanians were due to vote on the new constitution in a referendum in April 2015. The referendum was however postponed because of delays in registering voters and a new date for the referendum has not been announced.

The draft constitution did not explicitly include references to HIV and TB, but prohibited discrimination on a range of grounds and placed explicit obligations on the government to protect human rights.<sup>10</sup>

RATIFICATION OF INTERNATIONAL AND REGIONAL TREATIES

Tanzania has ratified:

- African Charter on Human and Peoples’ Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- Convention on the Rights of People with Disabilities, 2006
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1966
- International Convention on Civil and Political Rights (ICCPR), 1966
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003

NATIONAL LAWS AND POLICIES

Customary and Islamic laws also apply in Tanzania: customary laws should only be applied when they do not conflict with statutory laws, including the constitution, and Islamic law is applicable to communities that generally follow Islamic law in matters of personal status and inheritance.<sup>11</sup>

The National HIV Policy of 2001 recognises the importance of rights-based responses to HIV and AIDS. It protects the right to voluntary HIV testing with informed consent and provides for access to HIV-related prevention, treatment, care and support services. It 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.

The Tanzania Commission for AIDS adopted a Comprehensive National Multi-sectoral HIV and AIDS Stigma and Discrimination Reduction Strategy in December 2013.<sup>12</sup> The strategy was developed to assist all stakeholders to effectively address HIV-related stigma and discrimination.

The Ministry of Health and Social Welfare adopted national policy guidelines for collaborative TB and HIV activities in 2008.<sup>13</sup> The policy commits the government to tackle the overlapping epidemics of HIV and TB and to strengthen collaboration between national responses to HIV and TB. The policy does not explicitly mention human rights, but does recognise the need for strong stigma mitigation programmes and promotes the involvements of patients with HIV and TB in the design, implementation and evaluation of collaborative HIV and TB activities.

The Ministry also provided guidance to health care workers about the need for and importance of a patient centred approach to TB and TB treatment in 2005.<sup>14</sup> The Ministry developed national guidelines for the treatment of children with TB. These guidelines recognise the existence of TB-related stigma and how it can undermine diagnosis and treatment.<sup>15</sup>

The HIV and AIDS Prevention and Control Act, 2008 specifically protects people from HIV-related human rights violations. There are problematic aspects of this law which are discussed below.

Employees with HIV are protected from HIV-related discrimination by 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.<sup>16</sup>

Women are protected in law in various ways:



- The Land Act, 2002<sup>17</sup> provides for 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) 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 marry with parental consent), provides limited protection against marital rape, recognises sexual harassment as a punishable offence and includes protection of children by their guardians.
- The Penal Code (as amended by Section 5 of SOSPA)<sup>18</sup> 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.<sup>19</sup> 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 (FGM).
- The Anti-Trafficking in Persons Act, 2008 protects people from human trafficking

Zanziba

In 2013, the Zanzibar Parliament adopted an act for the prevention and management of HIV and AIDS and the promotion of human rights of people living with HIV and AIDS.<sup>20</sup> The act is still awaiting the signature of the President.

The law prohibits HIV-related discrimination (direct or indirect), including on the grounds of perceived status. It sets out specific protections against HIV-related discrimination in employment and educational settings and in connection with freedom of movement. It prohibits compulsory HIV testing and provides for confidential HIV testing, informed consent and prohibits unlawful disclosure of HIV status (with some exceptions). It provides special protection for the rights of children and permits children above the age of 16 to undergo HIV testing without parental consent, providing they are mature enough to understand the consequences of their decision. The act also contains specific protections for women and people with disabilities living with HIV.

ACCESS TO JUSTICE AND LAW ENFORCEMENT

There is still a limited understanding of the human rights of people living with HIV and TB and key populations. There is no right to legal assistance in Tanzania and free legal assistance is usually provided by a small number of non-governmental organisations. The Tanzanian government has no legal assistance scheme and does not provide financial support to those organizations providing this service.<sup>21</sup> Vulnerable populations like women report being unable to use the system to access justice for human rights violations<sup>22</sup> and to enforce laws. In addition, the Basic Rights and Duties Enforceability Act enforces some, but not all constitutional rights.<sup>23</sup> There are 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. In April 2016, the World Bank announced that it was providing a \$65 million credit to Tanzania to improve access to legal services.<sup>24</sup>

The 2013 Stigma Index showed low levels of awareness about laws and policies that protect the rights of people living with HIV, with women living in rural areas having especially low levels of knowledge and information. The Stigma Index also reported that a relatively small number of respondents had had their rights abused, but raised concerns about the lack of legal redress for these abuses. It emphasized the importance of interventions to increase literacy about human rights amongst people living with HIV and to ensure they know which institutions should protect their human rights and how to access them. The Stigma Index recommended regular training on the human rights of people living with HIV for health care workers, social workers, law enforcers, the police, prosecutors and judiciary.<sup>25</sup>

As part of efforts to address gender based violence, the police maintain 417 gender and children desks in police stations throughout the country to support victims and address crimes against women and children.<sup>26</sup>

In August 2014, the Ministry of Community Development, Gender and Children in partnership with civil society, initiated a campaign, the “Child Marriage-Free Zone” to end child marriage. The campaign will review discriminatory laws and assess measures needed to prevent child marriage.

GAPS AND CHALLENGES

PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

Although the HIV and AIDS Prevention and Control Act contains protections against HIV-related discrimination, it also has provisions that undermine human rights:

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 and fail to protect key groups against human rights abuses that increase their vulnerability to HIV and TB.

- The act criminalises willful transmission of HIV and provides that whoever intentionally transmits HIV to another person commits an offence. The negative impact of this provision on the response to HIV was noted in a number of 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.<sup>27</sup>



- The act does not protect women from abuse on disclosure of their HIV status to their spouse.<sup>28</sup>

Tanzania has particularly strict laws on homosexuality. The Sexual Offences Special Provisions Act explicitly criminalise sexual conduct between men. Section 154 criminalises “carnal knowledge of any person against the order of nature” and any person who permits another male to have carnal knowledge of him or her against the order of nature. Section 157 criminalises indecent acts between men, whether in public or private. The Tanzania Penal Code contains various provisions that are used to criminalise same sex sexual conduct between men. Consensual carnal knowledge against the order of nature is punishable by a minimum of 30 years imprisonment and a maximum of life imprisonment.<sup>29</sup>

The Zanzibar Penal Code contains similar provisions and also criminalises sex between women, although sentences are less harsh (14 years for men and 5 years for women). Zanzibar also criminalises anyone who purports to enter into a marriage or lives with someone of the same sex.<sup>30</sup> Sex work is illegal in Tanzania and Zanzibar. The Penal Code<sup>31</sup> in Tanzania criminalises loitering or soliciting in public places for the “purposes of prostitution”. Zanzibar Penal Code explicitly criminalises selling sex.<sup>32</sup>

Drug use is criminalised in Tanzania and Zanzibar.

### HUMAN RIGHTS CHALLENGES

**Stigma and discrimination:** The National Council of People Living with HIV (NACOPHA) published the results of the stigma index in December 2013.<sup>33</sup> The report shows high levels of stigma and discrimination, especially gossip, social exclusion and verbal insults. Stigma is largely driven by inadequate knowledge about how HIV is transmitted, fears about ill-health associated with HIV and moral judgement.

People living with HIV who participated in the Stigma Index also reported high levels of internal stigma and shame: they blamed themselves for being infected and avoided sexual relationships, decided not to have children, avoid social gatherings, and were afraid of being gossiped about.<sup>34</sup>

**Women’s rights:** There are gaps in the legal and policy framework for gender equality that increase women’s vulnerability to HIV:



- There are challenges with implementation of the laws protecting women from GBV.<sup>35</sup> In addition, there is no specific law on domestic violence, although the Marriage Act prohibits corporal punishment of a spouse, and marital rape is not fully criminalized as the Sexual Offences Special Provision Act only criminalises marital rape where spouses are legally separated.
- Despite the 1995 National Land Policy explicitly giving women the right to own land, customary and religious laws and practices continue to discriminate against women, particularly in relationship to inheritance and family land. Various judgements have declared aspects of customary laws to be discriminatory, but many women are still deprived of their right to inherit property or may only inherit the use or a small share of the estate, with male heirs given preference. The 2014 draft of the constitution proposed amendments to give women equality in inheritance and ownership of land.
- The Marriage Act permits polygamous marriages
- Despite the banning of FGM for girls below the age of 18, it remains common in the northern and central areas of the country and prosecutions of those who cut girls are rare.
- Tanzania has high levels of child marriage: two out of five girls are married before they reach 18, especially in rural areas where girls as young as 11 are married.<sup>36</sup> The minimum marriage age is 18 for boys and 15 for girls (as per the Marriage Age of 1971), but girls younger than 15 may marry with parental consent or the permission of a court.

According to the 2010 Demographic and Health Survey, 45% of women experience physical or sexual violence during their lifetime. The Legal and Human Rights Centre released a report stating that there were 2 878 reported cases of rape and 3 633 reported cases of other forms of abuse against women and children between January and June 2014.<sup>37</sup> Sexual violence is highly stigmatized in Tanzania and many victims do not report violence. There are low rates of prosecution for sexual violence.



**Rights of people inject use drugs:** 15.5% of people who inject drugs in Tanzania are living with HIV.<sup>38</sup> Although drug use is criminalized in Tanzania, the government appears to have recognized the importance of a harm reduction approach. Several small scale harm reduction interventions have been implemented in Tanzania and Zamzibar eg. syringe distribution (2000 people who use injecting drugs) and bleach kits for decontamination (6000 kits), with the intention to scale these up. The 2014 HIV country progress report shows that the government has begun to collect data on indicators related to the reduction of HIV infection amongst people who inject drugs.

**Prison conditions** are described as “harsh and life threatening. Inadequate food, overcrowding, poor sanitation, and insufficient medical care are pervasive”.<sup>39</sup> Government officials have reported deaths due to AIDS in prisons and common medical complaints include HIV, TB, malaria and diseases related to poor sanitation.



**Sex workers:** Sex workers, especially female sex workers, are at high risk of HIV in Tanzania. Zanzibar reports high levels of sex tourism. Female sex workers are vulnerable to arrest, detention and harassment at the hands of the police.<sup>40</sup> In March 2016, there were media reports that police had begun to crack down on the clients of sex workers who now also faced arrest.<sup>41</sup> As is the case with injecting drug users, the 2014 HIV country progress report contains data on HIV and sex workers.



**LGBTI people:** LGBTI people face high levels of stigma and discrimination in their access to housing, health care and employment. Homophobia in health care facilities pushes gay men away from services, including access to HIV testing and prevention. LGBT Voice reports that challenges vary “from everyday personal hardships to high-level factors such as hostility from civil society organizations, religious bodies, government and law enforcement.”<sup>42</sup> Research conducted by LGBT Voice shows that LGBT people who face stigma and discrimination, including violence at the hands of family members and pressure to marry, are more likely to engage in high risk sexual behavior.<sup>43</sup>

The US State Department 2015 human rights report indicates that no government effort has been made to combat stigma on the basis of sexual orientation and gender identity<sup>44</sup> and some government officials themselves display high levels of homophobia.

#### Recommendations

##### Civil society should:

- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights
- Advocate for laws that promote the human rights of people living with HIV and/or TB and key populations
- Raise awareness about stigma and discrimination against people living with HIV and/or TB
- Advocate for access to comprehensive post-rape care for all survivors, including treatment for injuries, PEP, emergency contraception and treatment for sexually transmitted infections.

##### The Tanzanian government should:

- Decriminalise all consensual adult sex
- Review the HIV and AIDS Control Act and repeal provisions that undermine the human rights of people living with HIV, including provisions that criminalise HIV transmission
- Review the Law of Marriages Act to set the minimum marriage age for boys and girls at 18 and repeal any laws that permit parents to consent to the marriage of underage girls
- Explicitly criminalise marital rape in all circumstances
- Review laws to ensure that they promote gender equality and repeal laws that discriminate against women, including in access to and ownership of property
- Enforce the ban on FGM
- Decriminalise drug use
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and GBVv, legal literacy programmes, improved access to legal support services, training for law and policy makers and the judiciary

# END NOTES

- <sup>1</sup> UNAIDS, *Global AIDS Response Country Progress Report, United Republic of Tanzania*, March 2014 [http://www.unaids.org/sites/default/files/country/documents/TZA\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/TZA_narrative_report_2014.pdf) [accessed on 12 April 2016]
- <sup>2</sup> Ibid.
- <sup>3</sup> Ibid.
- <sup>4</sup> Ibid.
- <sup>5</sup> WHO, *Use of high burden country lists for the post-2015 era*, 2015, [http://www.who.int/tb/publications/global\\_report/high\\_tb\\_burdencountryists2016-2020.pdf?ua=1](http://www.who.int/tb/publications/global_report/high_tb_burdencountryists2016-2020.pdf?ua=1) [accessed 17 April 2016]
- <sup>6</sup> WHO, TB country profiles, Tanzania, [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=TZ&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=TZ&LAN=EN&outtype=html) [accessed 12 April 2016]
- <sup>7</sup> UNAIDS, *Global AIDS Response Country Progress Report*
- <sup>8</sup> Tanzania, *Third National Multi-sectoral Strategic Framework for HIV and AIDS (2013/14 – 2017/18)*, <http://tacaids.go.tz/tacaids/en> [accessed on 16 April 2016]
- <sup>9</sup> Government of Tanzania, *The Constitution of the United Republic of Tanzania*, 1977, <http://www.judiciary.go.tz/downloads/constitution.pdf> [accessed 16 April 2016]
- <sup>10</sup> Proposed draft Constitution of Tanzania, September 2014, [http://www.constitutionnet.org/files/the\\_proposed\\_constitution\\_of\\_tanzania\\_sept\\_2014.pdf](http://www.constitutionnet.org/files/the_proposed_constitution_of_tanzania_sept_2014.pdf) [accessed 16 April 2016]
- <sup>11</sup> See: NYU, Guide to the Tanzania Legal System and Legal Research, <http://www.nyulawglobal.org/globalex/Tanzania1.html> [accessed 16 April 2016]
- <sup>12</sup> Tanzania Commission for AIDS, *Comprehensive National Multi-sectoral HIV and AIDS Stigma and Discrimination Reduction Strategy 2013 – 2017*, [http://www.healthpolicyinitiative.com/Publications/Documents/1536\\_1\\_SD\\_Strategy\\_booklet\\_TACAIDS.pdf](http://www.healthpolicyinitiative.com/Publications/Documents/1536_1_SD_Strategy_booklet_TACAIDS.pdf) [accessed 16 April 2016]
- <sup>13</sup> Government of Tanzania, National Policy Guidelines for Collaborative TB/HIV Activities, 2008, [http://ihi.eprints.org/1937/1/Tanzania\\_TB-HIV\\_POLICY19\\_Oct\\_post\\_Peacock.doc-Printed.pdf](http://ihi.eprints.org/1937/1/Tanzania_TB-HIV_POLICY19_Oct_post_Peacock.doc-Printed.pdf) [accessed 17 April 2016]
- <sup>14</sup> Government of Tanzania, How to Provide Patient Centred TB Treatment, a guide for health workers, 2005, [http://ntlp.go.tz/index.php?option=com\\_phocadownload&view=category&id=6:manual-and-guidelines&Itemid=139](http://ntlp.go.tz/index.php?option=com_phocadownload&view=category&id=6:manual-and-guidelines&Itemid=139) [accessed 17 April 2016]
- <sup>15</sup> Government of Tanzania, National Guidelines for the Management of TB in Children, 2012, [http://ntlp.go.tz/index.php?option=com\\_phocadownload&view=category&id=6:manual-and-guidelines&Itemid=139](http://ntlp.go.tz/index.php?option=com_phocadownload&view=category&id=6:manual-and-guidelines&Itemid=139) accessed 16 April 2016
- <sup>16</sup> UNAIDS, NCPI Report, 2012.
- <sup>17</sup> Cap 113 R.E.
- <sup>18</sup> Cap 4 of Revised Edition of the Laws of Tanzania, 2002
- <sup>19</sup> Section 130
- <sup>20</sup> Tanzania, An Act to Provide for the Prevention and Management of HIV and AIDS in Zanzibar, for the Protection and Promotion of the Human Rights of Persons Living with or Affected by HIV and AIDS and for Related Matters, September 2013, [http://www.zanzibarassembly.go.tz/bills/2013/abill\\_zanzibar3.pdf](http://www.zanzibarassembly.go.tz/bills/2013/abill_zanzibar3.pdf) [accessed 16 April 2016]
- <sup>21</sup> Submission by Legal Aid Clinic, Tanzania, Africa Regional Dialogue on HIV and the Law, 4 August 2011.
- <sup>22</sup> Submission by Tanzania Network of Women Living with HIV or AIDS, Tanzania, Africa Regional Dialogue on HIV and the Law, 4 August 2011
- <sup>23</sup> Submission by EALCO Advocates Company Ltd, Tanzania, Africa Regional Dialogue on HIV and the Law, 4 August 2011
- <sup>24</sup> AllAfrica, Tanzania U.S. \$65 Million Set for Tanzania Justice Project, 11 April 2016, <http://allafrica.com/stories/201604121256.html> [accessed 16 April 2016]
- <sup>25</sup> NACOPHA, The People Living with HIV Stigma Index Report, December 2013, <http://www.stigmaindex.org/sites/default/files/reports/Tanzania%20STIGMA%20INDEX%20REPORT%20-%20Final%20Report%20pdf.pdf>
- <sup>26</sup> US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015
- <sup>27</sup> Submission by Legal Aid Clinic, Tanzania; EALCO Advocates Company Ltd, Tanzania, Africa Regional Dialogue on HIV and the Law, 4 August 2011
- <sup>28</sup> Submission to African Regional Dialogue, Pretoria, 3-4 August 2011; available at [www.hivlawcommission.org](http://www.hivlawcommission.org)
- <sup>29</sup> Human Rights Watch, Treat Us Like Human Beings: Discrimination Against Sex Workers, Sexual and Gender Minorities, and People Who Use Drugs in Tanzania, 18 June 2013, <https://www.hrw.org/report/2013/06/18/treat-us-human-beings/discrimination-against-sex-workers-sexual-and-gender#44aa12> [accessed 30 April 2016]
- <sup>30</sup> Ibid.
- <sup>31</sup> Art. 176
- <sup>32</sup> Section 140
- <sup>33</sup> NACOPHA, The People Living with HIV Stigma Index Report
- <sup>34</sup> Ibid.
- <sup>35</sup> US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015: Tanzania, <http://www.state.gov/j/drl/rls/hrrpt/>

[humanrightsreport/index.htm#wrapper](http://www.state.gov/j/drl/rls/hrrpt/) [accessed 16 April 2016]

<sup>36</sup> Girls Not Brides, Country page, Tanzania, <http://www.girlsnotbrides.org/child-marriage/tanzania/> [accessed 16 April 2016]

<sup>37</sup> US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015: Tanzania

<sup>38</sup> UNAIDS, Do No Harm, 2016, [http://www.unaids.org/sites/default/files/media\\_asset/Do\\_no\\_harm\\_slides.pdf](http://www.unaids.org/sites/default/files/media_asset/Do_no_harm_slides.pdf) [25 May 2016]

<sup>39</sup> Ibid., Country Reports on Human Rights Practices for 2015: Tanzania

<sup>40</sup> See for example, BBC, Tanzania arrests 500 ‘sex workers’ <http://www.bbc.com/news/world-africa-35815997> [accessed 16 April 2016]

<sup>41</sup> DW, Tanzania police begin crackdown on men who pay for sex, <http://www.dw.com/en/tanzania-police-begin-crackdown-on-men-who-pay-for-sex/a-19117155> accessed 30 April 2016

<sup>42</sup> LGBT Voices, Tanzania, <http://lgbtvoicetz.org/the-real-situation-of-lesbian-gay-bisexual-and-transgender-individuals-and-activists-in-tanzania/> [accessed 1 May 2016]

<sup>43</sup> Ibid.

<sup>44</sup> US Bureau of Democracy, Labor and Human Rights, Country Reports on Human Rights Practices for 2015



# UGANDA

## BACKGROUND

In Uganda, the national HIV prevalence rate was 7.3 percent in 2014, a rise from 6.4 percent over the past five years. According to the 2014 UNAIDS Country Progress Report, 1.3 million people (aged 15 and up) were living with HIV, of which 770 000 were women, in Uganda. This accounts for 7.3% of the adult population (aged 15 to 49 years). Within the same year, it is estimated that there were 150 000 children living with HIV. The reports also notes that there were 33 000 AIDS related deaths.<sup>1</sup>



Uganda has a predominantly heterosexual epidemic with factors such as unprotected sex with multiple sexual partners acting as the main drivers of the epidemic. However, there is a high proportion of new infections amongst key populations. Recent studies indicate HIV prevalence is highest, at 15 – 40%, amongst fishing communities and 37% amongst sex workers. However, the government acknowledges the need for greater information on HIV incidence and prevalence amongst key populations.

**There is a high proportion of new infections amongst key populations. Recent studies indicate HIV prevalence is highest, at 15 – 40%, amongst fishing communities and 37% amongst sex workers. However, the government acknowledges the need for greater information on HIV incidence and prevalence amongst key populations.<sup>2</sup>**

Other key populations identified in Uganda are gay men and men who have sex with men, migrant and mobile populations, young people, orphans and vulnerable children, people with disabilities, prisoners, women, married couples and exposed infants.<sup>3</sup>

### *The Global*



The State of Harm report in 2014 estimated that HIV prevalence among people who inject drugs is 16.7% in Uganda; the government has pledged to prioritise innovative approaches to help this population.<sup>4</sup> In recent years the Ugandan government has displayed hesitancy in providing substantial financing for health services specifically for people who inject drugs. An earlier analysis from the World Bank suggests that access to antiretroviral treatment among people who inject drugs lag far behind other people living with HIV, especially so in low-income countries such as Uganda.<sup>5</sup>

Uganda's scale up of antiretroviral treatment (ART) resulted in an increase in the number of people on ART from around 570 000 in 2013 to 750 000 in 2014 and a dramatic reduction in AIDS-related deaths. Treatment coverage for children is still behind target, at 31% of those in need.<sup>6</sup>

According to WHO, there are 60 000 people living with TB in Uganda; around 159 cases per 100 000 people. Around 45% of people with TB are also living with HIV.<sup>7</sup> By the end of 2014, over 80% of the patients co-infected with TB and HIV were treated with both ART and TB drugs. In total 8250 patients co-infected with TB and HIV were on ARV and TB treatment.

According to the Medicines Index in Uganda (National Drug Authority), 80% of medicines in Uganda are imported from countries like India, China, Germany and Switzerland with only 20% produced by local industries for the local population. While Uganda has progressive intellectual property laws, implementation of these remains weak, thus affecting the country's access to essential and affordable HIV and TB medicines.

The new HIV Strategic Plan of 2015/16 - 2019/2020 is aligned to the fast-tracking approach and the global targets of 90-90-90. There is inclusion of principles such as non-discrimination in access to services; the greater involvement of people living with HIV, a rights-based responses to HIV and gender sensitivity. There is also a strong focus on delivery of services to key populations, such as sex workers.



## KEY HUMAN RIGHTS CONCERNS IN 2016

- HIV-related stigma and discrimination
- Gender based violence and gender inequality
- Human rights abuses against key populations



## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### CONSTITUTION

The Constitution of the Republic of Uganda, 1995 does not explicitly mention HIV and AIDS, despite the country recognising the gravity of the epidemic a decade before the Constitution was adopted.<sup>8</sup> Article 21 provides for equality before the law and 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 also 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.

### RATIFICATION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

Uganda has ratified:

- African Charter on Human and Peoples’ Rights, 1981
- Convention on the Rights of the Child (CRC), 1989
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979
- Convention on the Rights of People with Disabilities, 2006
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1987
- International Convention on Civil and Political Rights (ICCPR), 1966
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003
- African Charter on the Rights and Welfare of the Child, 1990

### NATIONAL LAWS AND POLICIES

Uganda passed the HIV Prevention and Control Act in 2014. The Act contains a number of protective anti-discrimination provisions - it prohibits discrimination on the basis of HIV status in the workplace,<sup>9</sup> schools,<sup>10</sup> health institutions<sup>11</sup> and in access to credit and insurance.<sup>12</sup> It also prohibits restrictions of travel and habitation.<sup>13</sup> It provides for voluntary HIV testing and counselling.<sup>14</sup>

The Equal Opportunities Act, 2007 and the Employment Act, 2006 provide some protection for employees living with HIV. 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 should include HIV and AIDS). The Employment Act explicitly prohibits discrimination on the grounds of HIV or AIDS. The Act also prohibits sexual harassment in the workplace.

The HIV and AIDS Prevention and Control Act 2014 contains detailed provisions for the protection of employees in the working environment. This includes provisions for access to post-exposure prophylaxis (PEP) and for compensation in the case of occupational transmission of HIV.

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 Public Health Act Cap 281 does not specifically mention HIV, but has provisions on infectious diseases. There are a range of protective health policies:

- 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 Testing<sup>15</sup> provide that consent should be acquired for HIV testing, regardless of the reason for testing. It provides further that testing should be accompanied by a comprehensive package of supportive services, including counselling, treatment, support and care. The guidelines contain special provisions for the testing of children, emphasising the best interests of the child and their human rights.
- These guidelines were amended and integrated into the National Policy Guidelines for HIV Testing<sup>16</sup> in 2005. The policy includes voluntary HIV testing and counselling, but also provides guidance on routine testing and home-based counselling and testing.
- The Antiretroviral Treatment Policy 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 antiretrovirals (ARV), 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 Mother-to-Child HIV Transmission 2003 includes provisions on treatment, voluntary HIV testing and counselling, breastfeeding and sexually transmitted infection (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 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.

Domestic violence was criminalised in 2010 when the Domestic Violence Act was signed into law. The definition of domestic violence includes physical, sexual, emotion, verbal, psychological and economic violence and establishes a system of protection orders for women in domestic violent relationships. Rape is criminalised under the Penal Code and the Code prescribes the death penalty for anyone convicted of rape.<sup>18</sup>

Abortion is illegal in Uganda. The Penal Code of 1950, Article 141 on “Attempts to procure abortion” states:

Any person who, with intent to procure the miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means, commits a felony and is liable to imprisonment for fourteen years.<sup>19</sup>

Article 142 lays out a punishment of seven years for an attempt to procure a miscarriage. The Penal Code only provides that an abortion may be performed to save the life of a pregnant woman. This though is in contradiction of the Constitution, which criminalises the “killing of the unborn child” in any other circumstances.

Female Genital Mutilation (FGM) was outlawed in 2010, through the promulgation of the Prohibition of Femial Genital Mutilation Act, 2010.<sup>20</sup> However, implementation of these laws remains limited. Some significant pre-existing difficulties preventing access to justice for women victims of violence have not been addressed, such as the costs associated with the complaint process.<sup>21</sup>

Other national laws that prohibit discrimination are the Police Act and the Children Act.

Uganda passed an Industrial Property Act in 2014 which incorporates a number of public health sensitive TRIPS flexibilities to improve access to medicines in Uganda.

### ACCESS TO JUSTICE AND LAW ENFORCEMENT

There are various mechanisms for accessing justice and enforcing rights in Uganda, including legal aid services, private law firms, university law clinics, the police and the judiciary.

The Uganda Human Rights 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. However, the Commission is reported to have inadequate resources to investigate all complaints received.<sup>22</sup> The Commission did intervene in the case of the teacher who was dismissed when she disclosed her HIV status.

Uganda has various programmes to increase awareness and understanding of rights in the context of HIV. These include 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 for law enforcement on HIV and human rights.

The most recent National Commitments and Policies Instruments (NCPI) report to UNAIDS again acknowledges the limited implementation and enforcement of protective non-discrimination laws, policies and plans.<sup>23</sup> Research conducted for this report confirms that access to justice remains a major challenge for HIV-related human rights violations.

### GAPS AND CHALLENGES

#### PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

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”.

The HIV Prevention and Control Act provides for compulsory HIV testing and disclosure in certain instances, as well as criminalisation of HIV transmission. Section 11(1) of the Act allows for HIV testing without informed consent, by a health care worker, if the patient “unreasonably withholds” it. Compulsory testing is



mandated of any person convicted of a drug abuse or in possession of drug paraphernalia; apprehended for a sexual offence or convicted of sex work.<sup>24</sup> Article 13 of the Act furthermore allows for compulsory HIV testing when ordered by a court of law. Article 18(2)(e) of the Act allows for notification of a person's HIV status to a partner by a health care worker where there's a risk of HIV infection.

The Act also places an obligation on every person to take reasonable steps and precautions to protect him or herself and others from HIV transmission. Failure to comply with these provisions constitutes a criminal offence. 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.<sup>25</sup>

While gender equality is guaranteed in the constitution, there are various laws and policies in place that discriminate against women, especially with regard to personal status. For instance, in 2014, an Anti-Pornography Bill, often referred to as the “mini-skirt bill” was passed. The law was criticised as infringing on women's rights and freedoms and bans “indecent” dressing including any skirt that falls above the knee and any form of dress that may “sexually excite.”<sup>26</sup> Customary laws and practices in Uganda tend to undermine women's equality, especially in relation to marriage, divorce, child custody and inheritance.<sup>27</sup>

The Penal Code prohibits sex between men. In addition, the Anti-Homosexuality Act was passed in 2014, with severe penalties for a range of offences relating to same-sex sexual activity, including life imprisonment as well as the introduction of new offences, such as offences relating to the promotion of homosexuality which had the potential to impact on the work of lesbian, gay bisexual, transgender and intersex (LGBTI) organisations. The law was later struck down by the Constitutional Court on technical grounds that it had passed through Parliament without a proper quorum. A new version of the bill is due to be passed by December 2016. The new draft continues to punish consenting sex between adult men.<sup>28</sup>

Sex work is illegal in Uganda. Access to HIV testing and treatment is unavailable for key populations such as sex workers because of societal attitudes and the criminalisation of sex work. In particular, stigma towards male sex workers who have sex with men is exacerbated owing to homophobia. Anecdotal evidence suggests that many sex workers consider social discrimination as a major barrier in their willingness or desire to test for HIV.<sup>29</sup> The Penal Code also criminalises being “idle and disorderly”, a provision that is often used to arrest sex workers.



## HUMAN RIGHTS CHALLENGES

**Stigma and Discrimination:** Uganda launched its first Stigma Index in October 2013 which surveyed over 1000 people living with HIV in 18 districts in Uganda. Nearly half the respondents stated 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”.<sup>30</sup> 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 study also showed high levels of discrimination in the workplace, with respondents reporting experiencing discrimination at the hands of co-workers 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.<sup>31</sup>

The Stigma Index concludes that stigma and discrimination are major barriers to HIV testing and disclosure of HIV status.

Uganda's 2014 Global AIDS Response Progress Report reported ongoing high levels of stigma and discrimination amongst people living with HIV and in the wider community as well as within institutional responses to people living with HIV. People living with HIV report exclusion from government economic empowering programs, denial of access to credit, denial of access to health insurance and loss of employment.<sup>32</sup>

Polygamy and widow inheritance are legal under customary and Islamic laws and practices such as widow inheritance and polygamy discriminate against women and increase their risk of HIV transmission. Female Genital Mutilation (FGM) is prohibited by law, but some groups continue to practice it.<sup>33</sup>

The current minimum age of marriage is 18, but 40% of girls are married before they reach 18, higher than the continental average (34%).<sup>34</sup> A 2004/2005 study found that married women were five times more likely to be infected with HIV than women who were never married.<sup>35</sup> Birth registration also remains a challenge: only 29% of rural births and 38% of urban births are registered.<sup>36</sup> The lack of registration weakens efforts to eradicate child marriage.

Gender Based Violence (GBV) is a significant problem in Uganda and includes reports of 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 domestic violence during their marriage. Women and girls who have experienced sexual violence often face stigma from their families and communities,<sup>37</sup> and rape and other forms of sexual violence remain seriously underreported.<sup>38</sup> 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.

Although rape is criminalised, laws are “inconsistently”<sup>39</sup> 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.<sup>40</sup> 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.<sup>41</sup> Marital rape was not criminalised in the Domestic Violence Act, but the draft Marriage and Divorce Bill and the Sexual Offences Amendment Bill would criminalise it, if passed.<sup>42</sup>

In addition to gender based violence, women also face widespread discrimination, especially in rural areas.

When the Anti Homosexuality Bill became law, LGBTI populations reported an increase in rights abuses, including arbitrary arrests, police abuse and extortion, loss of employment and eviction. Many fled the country.<sup>45</sup> Activists also reported the deliberate outing of gay men in the media leading to their loss of employment, assaults and verbal abuse.<sup>46</sup>



**Sex workers:** 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. Sex workers lack information concerning where to go for treatment of HIV and other sexually transmitted infections (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.<sup>47</sup>

**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. Civil society organisations (CSOs) 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.<sup>48</sup>



**People who inject drugs:** The Narcotics Act criminalises drug use and creates barriers to access to services for people who inject drugs.<sup>49</sup> For people who inject drugs, both political and cultural conditions need to be redressed, starting with transforming punitive laws that criminalise the use of drugs. Improving access to antiretroviral treatment among people who inject drugs and who are living with HIV and ending the criminalisation of drug use will help increase access to health care and also improve societal attitudes towards people who use drugs in Uganda.<sup>50</sup>

**LGBTI populations experience high levels of stigma and violations of their human rights at the hands of government and individuals. They 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”,<sup>43</sup> and “LGBTI people generally experience harassment, discrimination, intimidation and are denied access to health services”.<sup>44</sup>**

Recommendations

Civil society should:

- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights
- Advocate for laws that promote the human rights of people living with HIV and/or TB and key populations
- Raise awareness about stigma and discrimination against people living with HIV and/or TB
- Advocate for government to stop attempts to further criminalise homosexuality and impose severe penalties on individuals and LGBTI groups
- Work to strengthen access to justice for key populations by training law enforcement officials on the human rights of people living with HIV and/or TB and key populations

The Ugandan government should:

- Decriminalise all adult consensual sex
- Review and repeal laws criminalising HIV transmission
- Strengthen anti-discrimination protection for people living with HIV and/or TB and key populations and ensure that laws promote human rights
- Repeal laws and policies that prohibit the distribution of condoms in prisons
- Explicitly criminalise marital rape
- Decriminalise abortion
- Develop and implement laws that protect the human rights of people with TB and repeal any laws and policies that allow for isolation or forcible detention of people with TB
- Review and repeal laws that criminalise possession of drugs for personal use and develop a harm reduction policy for people who use drugs.
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support serices, training for law and policy makers and the judiciary.

END NOTES

1 Available at <http://www.unaids.org/en/regionscountries/countries/uganda/> [Accessed 23 May 2016].

2 UNAIDS Uganda Country Progress Report 2014 Available at [http://www.unaids.org/sites/default/files/country/documents/UGA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/UGA_narrative_report_2015.pdf) [Accessed 23 May 2016].

3 UNAIDS, NCPI Report 2013 Available at <http://www.unaids.org/sites/default/files/country/documents/Uganda%20NCPI%202013.pdf> [Accessed 24 May 2016].

4 IHRA (2014) The Global State of Harm Reduction 2014. Available at [http://www.unaids.org/sites/default/files/country/documents/UGA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/UGA_narrative_report_2015.pdf)

5 UNAIDS (2014) The Gap Report. Available at [http://www.unaids.org/sites/default/files/media\\_asset/UNAIDS\\_Gap\\_report\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf)

6 UNAIDS Uganda Country Progress Report 2014 Available at [http://www.unaids.org/sites/default/files/country/documents/UGA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/UGA_narrative_report_2015.pdf) [Accessed 23 May 2016].

7 Available at [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryPro-file&ISO2=UG&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryPro-file&ISO2=UG&LAN=EN&outtype=html) [Accessed 23 May 2016].

8 Mukasa, Stella and others, HIV/AIDS, Human Rights and Legal Services in Uganda: A Country Assessment, 2008, p.24

9 Article 32

10 Article 33

11 Article 37

12 Article36

13 Article 34

14 Article 10.

15 Developed in 2003

16 2003

17 Uganda Domestic Violence Act, No. 17 of 2010. Available at [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/legaldocument/wcms\\_172625.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_172625.pdf)

18 Social Institutions and Gender Index, Uganda country page, <http://www.genderindex.org/country/uganda> [accessed 26 June 2016]

19 The Penal Code Act. Chapter 120. [http://www.wipo.int/wipolex/en/text.jsp?file\\_id=170005](http://www.wipo.int/wipolex/en/text.jsp?file_id=170005) (WIPO Lex)

20 The Prohibition of Female Genital Mutilation Act 5 of 201. Available at [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/legaldocument/wcms\\_172631.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_172631.pdf) [Accessed on 6 July 2016]

21 Women’s rights in Uganda: gaps between policy and practice. Available at <https://www.fidh.org/IMG/pdf/uganda582afinal.pdf> [Accessed 6 July 2016]

22 Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Uganda

23 UNAIDS, National Commitments and Policies Instruments 2013 Available at <http://www.unaids.org/sites/default/files/country/documents/Uganda%20NCPI%202013.pdf> [Accessed 24 May 2016].

24 Article 12.

25 Article 40

26 Ibid., Social Institutions and Gender Index, Uganda country page

27 Women’s rights in Uganda: gaps between policy and practice

28 <https://www.fidh.org/IMG/pdf/uganda582afinal.pdf>

29 Huffington Post, Uganda’s new anti-gay law to pass by Christmas, say lawmakers, 2 February 2016, [http://www.huffingtonpost.com/2014/11/21/uganda-new-anti-gay-law\\_n\\_6198070.html](http://www.huffingtonpost.com/2014/11/21/uganda-new-anti-gay-law_n_6198070.html) [accessed 26 June 2016]

30 <http://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/uganda>

31 All Africa, Uganda: People with HIV Reveal Rampart Stigma in New Study, 6 November 2013 available at <http://allafrica.com/stories/201311071365.html>

32 Ibid.

33 UNAIDS, Uganda Country Progress Report 2014 Available at [http://www.unaids.org/sites/default/files/country/documents/UGA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/UGA_narrative_report_2015.pdf) [Accessed 23 May 2016].

34 Ibid

35 See: Girls Not Brides: <http://www.girlsnotbrides.org/child-marriage/uganda/>

36 USAID, Addressing Early Marriage in Uganda, 2009, p v

37 Ibid

38 Mukasa, Stella and others, HIV/AIDS, Human Rights and Legal Services in Uganda: A Country Assessment, 2008, p.25

39 Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices 2012, Uganda,



40 Department of State, Bureau of Democracy, Human Rights and Labour, Uganda

41 Ibid.

42 Ibid

43 Social Institutions and Gender Index, Uganda country page

44 Mukasa, Stella and others, HIV/AIDS, Human Rights and Legal Services in Uganda: A Country Assessment, 2008, p.24

45 Department of State, Bureau of Democracy, Human Rights and Labour, Uganda

46 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>

47 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>

48 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](http://www.hivlawcommission.org)

49 Department of State, Bureau of Democracy, Human Rights and Labour, Uganda

50 UNAIDS, Uganda NCPI Report 2013

51 Ministry of Health (2014) ‘HIV and AIDS Uganda Country Progress Report; 2013’. Available at [http://www.unaids.org/sites/default/files/country/documents/UGA\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/UGA_narrative_report_2014.pdf)



# ZAMBIA

## BACKGROUND

The HIV epidemic in Zambia has now become a generalised and mature epidemic. According to UNAIDS, in 2014 there were 1 million adults in Zambia living with HIV – 12.4% of adults aged 15 to 49 years. The majority of these people were women (540 000 women were living with HIV). There were around 19 000 deaths from AIDS. There were 100 000 children living with HIV and 380 000 orphans as a direct result of AIDS.<sup>1</sup>

One in every eight people in the country are living with HIV, and life expectancy is just 58.1 years.<sup>2</sup> There are variances in the provinces with the urban provinces of Lusaka and Copperbelt having the highest prevalence (16.3% and 18.2% respectively).

Zambia's national response has not systematically collected data, or monitored the impact of HIV and AIDS on key affected populations. Despite this, the country does recognise that certain groups of people, specifically sex workers, gay men and men who have sex with men, prisoners and mobile populations are more vulnerable to HIV in the country. Same sex sex is illegal in Zambia.<sup>3</sup> For this reason alongside many others, data on Zambian gay men and men who have sex with men is almost non-existent, with little knowledge of the HIV epidemic amongst this population. The number of sex workers in Zambia is disputed, as is the HIV prevalence among this population, with studies reporting vastly different statistics. One study in 2012 records 7-11% of all new HIV infections in the country among sex workers, their clients and clients' partners.<sup>4</sup> There is no available data on people who use drugs in Zambia, while various anecdotal reports speak to the penal sanctions being imposed on people who are suspected to use certain drugs.

According to the GARPR of Zambia in 2014, two large-scale studies are being undertaken in 2015 to determine the extent, impact, HIV prevalence and distribution of these key affected populations. It notes that the results from these studies are expected in 2016.<sup>5</sup>

HIV prevalence amongst prisoners, when last measured, was nearly double that of the general adult population. The HIV epidemic in Zambia's prisons is compounded by a concurrent TB epidemic with previous estimates of TB prevalence amongst prisoners to be at 15 to 20%.<sup>6</sup> According to the NGO Prisons Care and Counseling Association (PRISCCA), the country's 90 prisons had a capacity of 8,250 inmates but held approximately 18,500 persons. Approximately 3% of prisoners were women and 3% were juveniles.<sup>7</sup>

The total number of people living with HIV continues to rise due to both new infections and the fact that increased access to ART allows a larger number of people living with HIV to live longer.

The Revised Zambia National HIV & AIDS Strategic Framework 2014-2016 identifies the following key factors as impacting on HIV transmission: early sexual debut, multiple and concurrent partnerships, low and inconsistent use of condoms, low levels of male circumcision, knowledge of HIV, marriage patterns and polygamy, cultural norms, age-disparate relationships, transactional and commercial sex, sexual and physical violence, alcohol use, mobility and labour migration, HIV prevention and care in children and STIs.

Adult HIV prevalence peaked in the 1990s and recent trends indicate achievements in a continuous drop in HIV prevalence.<sup>8</sup> In 2014 approximately 68 000 of the 75 500 pregnant women living with HIV received ART to prevent vertical transmission of HIV. The rates of HIV transmission from mother to child have dropped from 24% in 2009 to less than 9% in 2014.<sup>9</sup> There has been an increase in the uptake of HCT and a significant increase in voluntary medical male circumcision results. Annual AIDS related mortality has dropped from approximately 58 000 in 2000 to 19 000 in 2014 with increasing access to ART.

In February 2014, Zambia started implementing the 2013 Zambia Consolidated Guidelines for Treatment and Prevention, based on the WHO 2013 Treatment Guidelines. With the introduction of Treatment as Prevention for selected sub-populations such as TB/HIV co-infected patients and discordant couples, significant further gains are expected in lowering HIV incidence.<sup>10</sup> The improvement of Zambia's national policies to scale-up access to treatment continue to be threatened by access to essential HIV and TB medicines.

There are 69 000 people with TB in Zambia according to WHO 2014 statistics; 436 cases per 100 000 people. 61% of TB patients are living with HIV.<sup>11</sup> Zambia's most recent GARPR indicated no data on the percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV;<sup>12</sup> however WHO reports that 73% of TB patients known to be HIV-positive are receiving ART.<sup>13</sup>

The national strategic plan recognises the importance of gender equality and empowerment as well as strengthened laws, legal policies and practices, as critical enablers for effective implementation of programmes.





## KEY HUMAN RIGHTS CONCERNS IN 2016



- HIV-related stigma and discrimination
- Gender based violence and inequality
- Abuses against key populations
- The rights of migrants in the context of HIV and TB
- The rights of children in the context of HIV and TB

## PROTECTIVE LEGAL FRAMEWORK FOR HIV, AIDS AND TB

### CONSTITUTION

Zambia is a constitutional democracy and the Constitution is the supreme law. The Constitution of Zambia Act, 1996<sup>14</sup> includes a bill of rights.

The Constitution 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.”<sup>15</sup> Protection from discrimination does not apply to some laws however, including those related to adoption, marriage, divorce, burial, devolution of property on death or other matters of personal law and particularly customary laws.

Although there is no 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. 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 was unconstitutional.

Proposed amendments to the Bill of Rights will strengthen protection for people living with HIV and members of key populations. Proposals include 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, strengthened protection for women and children’s rights and protection of the rights of marginalised groups and minority groups. In 2016 the Constitution Amendment Bill, which included various non-contentious provisions and excluded the proposed changes to the Bill of Rights, was passed. The proposed changes to the Bill of Rights are to go to referendum in August 2016.<sup>16</sup>

### RATIFICATION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

Zambia has ratified:

- African Charter on Human and Peoples’ Rights, 1981
- Convention on the Rights of the Child CRC, 1989
- Convention on the Elimination of All Forms of Discrimination Against Women CEDAW, 1979
- Convention on the Rights of Persons with Disabilities, 2006
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1966
- International Convention on Civil and Political Rights (ICCPR), 1966
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003

### NATIONAL LAWS AND POLICIES

Zambia does not have a comprehensive HIV-specific law and there is limited provision for HIV in other laws and policies.

The Employment Act<sup>17</sup> provides for access to health care for employees and it, along with the Industrial and Labour Relations Act<sup>18</sup> prohibits discrimination within the working environment. The Industrial and Labour Relations Act prohibits dismissal 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.<sup>19</sup> The Citizens Empowerment Act, 2006, which aims to support economic empowerment, specifically prohibits discrimination on the grounds of HIV in companies defined as citizen empowered companies.

The Gender Based Violence Act was passed in 2011. It prohibits gender based violence GBV which is defined to include physical, sexual, economic and psychological violence.<sup>20</sup> This Act should strengthen existing protections such as the Penal Code prohibition against rape,<sup>21</sup> defilement of girls below 16 years of age<sup>22</sup> and incest<sup>23</sup> as well as the Amendment to the Penal Code of 2005 that prohibits the sexual harassment of children.<sup>24</sup>

The Disabilities Act, 1996 and Citizens Economic Empowerment Act, 2006 protects the rights of people with disabilities to equality and non-discrimination. The Public Health Act makes limited provision for HIV although it does provide for HIV to be notifiable in terms of the Public Health Act<sup>25</sup> (Infectious Diseases Regulations).

Zambia’s patents are legislated by the Patent Act, Cap 400 of 1957. Zambia has a WTO compliant framework and as a least developed country is eligible to apply for a waiver regarding implementation of TRIPS in respect of pharmaceutical products; however they have not taken full 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.<sup>26</sup> This process appears to still be on-going.

### ACCESS TO JUSTICE AND LAW ENFORCEMENT

There are independent national institutions for the promotion and protection of human rights such as the police, victim support units, courts, labour bodies, the Zambia Human Rights Commission and other human rights structures, although funding, relevance and credibility of the Commission remains an issue. In addition there are legal support services, including private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV and legal aid systems for HIV and AIDS casework. There are also programmes to train members of the judiciary (including those serving on labour courts and employment tribunals) on HIV and AIDS and human rights issues.

In addition, there are also programmes to educate, raise awareness among people living with HIV concerning their rights and those designed to change societal attitudes of stigmatisation associated with HIV and AIDS to understanding and acceptance.<sup>27</sup>

Civil society organisations have undertaken various initiatives including implementing programmes to reduce stigma and discrimination and working with traditional leaders to reduce GBV and harmful gender norms such as sexual cleansing involving women and children.<sup>28</sup> However, the Stigma Index study indicated that of those who reported that their rights had been abused and had sought legal redress, over half reported that nothing had happened.<sup>29</sup>

## GAPS AND CHALLENGES

### PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS



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 examinations.<sup>30</sup>



**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 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’.

The Gender Based Violence Act, read with the Penal Code, may 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”.<sup>31</sup> 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.<sup>32</sup>



**Women's rights** are not adequately protected. While the Marriage Act provides non-discriminatory rules for property division between husband and wife for civil law marriages, the majority of Zambian women are married in terms of customary law which does not recognise gender equality in access to property.<sup>33</sup> 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 home steads. Customary law is protected by the Constitution and also excluded from the application of the discrimination clause. The Gender Based Violence law does not criminalise marital rape and neither does the Penal Code.

**The Penal Code classifies same sex relationships as unnatural offences and criminalises them. 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.**

The Penal Code<sup>34</sup> classifies same sex relationships as unnatural offences and criminalises them. 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.

Soliciting and living off the earnings of sex work is criminalised for men and women by the Penal Code.<sup>35</sup>

Section 19 of the Prisons Act<sup>36</sup> classifies committing sodomy as a major prison offence<sup>37</sup> and prevents the distribution of condoms in prisons.

Zambia has signed but not ratified the African Charter on the Rights and Welfare of the Child, 1990

## HUMAN RIGHTS CHALLENGES



**Stigma and discrimination:** HIV-related stigma and discrimination appears to be reducing and there are more people living openly with HIV, but it is still a matter of concern for affected populations within their families, communities and other sectors.<sup>38</sup> The Stigma Index conducted by NZP+ and GNP+ found evidence of various forms of discrimination including exclusion from places of worship, homes, work places, households, health care facilities; discrimination in access to work and services such as health, education and insurance; forced medical procedures; testing for HIV without voluntary, informed consent or counselling, detention, isolation and quarantine and coerced termination of pregnancy.

More recently, the UNAIDS Country Progress Report 2015 cited a survey that found that 18.7% of women and 27.2% of men aged 15-49 years had accepting attitudes towards people living with HIV.<sup>39</sup>



**Women's rights:** Women with HIV report high levels of stigma and discrimination within their families and communities including being forced from their family homes.<sup>40</sup> They also report discriminatory treatment within the health care sector, including reports of coerced terminations of pregnancy and coerced sterilisation.<sup>41</sup>

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.<sup>42</sup> 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 (including land) are considered to belong to the deceased’s family. 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.<sup>43</sup>

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.<sup>44</sup>

High levels of violence against women and girls continue to be an issue of concern.<sup>45</sup> 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 prohibit women from negotiating safe sex and places women at higher risk of HIV exposure.<sup>46</sup> 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 infections and psychological trauma.<sup>47</sup> Zambia also has one of the highest child marriage rates in the world with 42% of women aged 20 to 24 years married by the age of 18 years.<sup>48</sup>

**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 prohibit women from negotiating safe sex and place women at higher risk of HIV exposure.**



**LGBTI people:** Gay men and men who have sex with men are arrested and charged under the Penal Code, but the charges are usually dropped or the parties are fined and released, due to a lack of evidence and publicity.<sup>49</sup> Criminalisation leads to widespread stigma and discrimination against gay men and men who have sex with men, including denial of access to appropriate services by health care providers.<sup>50</sup> 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 challenged the constitutionality of the arrest and in May 2015, the Zambian High Court upheld his acquittal.<sup>51</sup>



**Sex workers:** Even though sex work itself is not criminalised, sex workers are often arrested on charges of loitering.<sup>52</sup> Sex workers report experiencing abuses of their rights;<sup>53</sup> however, due to the high levels of stigma and discrimination very few are willing to report violations to the authorities.<sup>54</sup>

**Prisoners:** Prisoners are subjected to severe overcrowding, poor ventilation, inadequate sanitation and nutrition, physical abuse, and negligible health services when they become ill. HIV and TB prevalence is exceptionally high. Health services are still inadequate and condom distribution is prohibited. The devastating effect of the HIV epidemic in Zambia’s prisons is compounded by a concurrent TB epidemic. TB isolation cells are in very poor condition and there is limited access to prison-based TB testing or treatment in prisons.<sup>55</sup> 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.<sup>56</sup>

**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**



**People who inject drugs:** 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.<sup>57</sup>



**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’.<sup>58</sup>

**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.<sup>59</sup> 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.<sup>60</sup>

**Workplace rights:** 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 service of at least six months duration, to ascertain the fitness of the employee to undertake work. Although the Act does not mention HIV, it is used as a justification for HIV testing by some institutions. In particular, HIV testing and refusal to employ applicants to the armed forces by the Zambia Defence Force is recognized as a key human rights issue.<sup>61</sup>

RECOMMENDATIONS

Civil society should:

- Advocate for the rights of people with disabilities to have access to accessible and effective health care, including reproductive and sexual health care
- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights
- Advocate for laws that promote the human rights of people living with HIV and/or TB and key populations
- Work to strengthen access to justice for key populations by training law enforcement officials on the human rights of people living with HIV and/or TB and key populations
- Raise awareness about discrimination against women’s sexual and reproductive health and rights, gender inequality, gender based violence and harmful gender based norms in the context of HIV and AIDS

The Zambian government should:

- Ratify the African Charter on the Rights and Welfare of the Child
- Decriminalise all consensual adult sex
- Decriminalise the possession of drugs for personal use and amend drug laws to allow for harm reduction programmes and opioid substitution therapy
- Review the Public Health Act and other laws to ensure that they do not discriminate against people living with HIV and/or TB, including by subjecting them to mandatory HIV testing
- Criminalise marital rape
- Review all laws to ensure that they do not discriminate against women and repeal discriminatory provisions, including in the Intestate Succession Law; protect girl children from early marriage
- Amend the Constitution to ensure that customary laws are subject to its equality provision
- Amend the Prisons Act to allow for the distribution of condoms in prisons and strengthen protection from HIV and TB within prisons
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support services, training for law and policy makers and the judiciary

END NOTES

<sup>1</sup> Available at <http://www.unaids.org/en/regionscountries/countries/zambia/> [Accessed 24 May 2016]

<sup>2</sup> UNAIDS, *The Gap Report*, 2014. Available at <http://www.unaids.org/en/resources/campaigns/2014/2014gapreport/gapreport> [ Accessed 6 July 2016]

<sup>3</sup> Available at <http://ilga.org/what-we-do/state-sponsored-homophobia-report/> [Accessed 6 July 2016]

<sup>4</sup> Gouws, E. & Cuchi, P. ‘Focusing the HIV response through estimating the major modes of HIV transmission: a multi-country analysis’ *Sexually Transmitted Infections* 88(2), 2012: i76-i85

<sup>5</sup> UNAIDS, *Country Progress Report 2015* Available at [http://www.unaids.org/sites/default/files/country/documents/ZMB\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/ZMB_narrative_report_2015.pdf) [Accessed 27 May 2016]

<sup>6</sup> Submission by PCCA, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>7</sup> <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper>

<sup>8</sup> UNAIDS, *Country Progress Report, 2012* Available at [http://www.unaids.org/sites/default/files/country/documents/ZMB\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/ZMB_narrative_report_2015.pdf) [Accessed 24 May 2016]

<sup>9</sup> Ibid.

<sup>10</sup> Ibid.

<sup>11</sup> [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=ZM&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=ZM&LAN=EN&outtype=html) [Accessed 27 May 2016].

<sup>12</sup> UNAIDS, *Country Progress Report 2015* [http://www.unaids.org/sites/default/files/country/documents/ZMB\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/ZMB_narrative_report_2015.pdf) [Accessed 27 May 2016]

<sup>13</sup> [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=ZM&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=ZM&LAN=EN&outtype=html) [Accessed 27 May 2016].

<sup>14</sup> Cap 1

<sup>15</sup> Article 23

<sup>16</sup> <http://www.constitutionnet.org/news/2016-constitution-zambia-elusive-search-people-driven-process> [Accessed 28 May 2016].

<sup>17</sup> Cap 268

<sup>18</sup> Cap 276

<sup>19</sup> AIDS and Human Rights Research Unit, *Human Rights Protected?* 2007

<sup>20</sup> UNAIDS, *Country Progress Report, 2012*

<sup>21</sup> Section 132

<sup>22</sup> Section 138

<sup>23</sup> Section 159

<sup>24</sup> AIDS and Human Rights Research Unit, *Human Rights Protected?*, 2007

<sup>25</sup> Cap 295

<sup>26</sup> See: <http://allafrica.com/stories/201002110309.html>

<sup>27</sup> UNAIDS, *NCPI Report 2012*; <http://www.unaids.org/sites/default/files/country/documents/Zambia%20NCPI%202013.pdf> [Accessed 28 May 2016].

<sup>28</sup> Submissions by MYDJCC, Zambia and World Vision Zambia, *African Regional Dialogue on HIV and the Law*, Pretoria, 4 August 2011

<sup>29</sup> NZP +, GNP+, *The People Living with HIV Stigma Index: Zambia*, 2011

<sup>30</sup> AIDS and Human Rights Research Unit, *Human Rights Protected?*, 2007

<sup>31</sup> UNAIDS, *Country Progress Report 2012*, 2012

<sup>32</sup> Key Informant Interview, Malala Mwendela, ZARAN, 6 September 2012

<sup>33</sup> GCHL, *Regional Issue Brief: Women, HIV and the Law*, 2011. Available at [www.hivlawcommission.org](http://www.hivlawcommission.org)

<sup>34</sup> Cap 87

<sup>35</sup> Sections 146, 147

<sup>36</sup> Cap 97

<sup>37</sup> Submission by PRISCCA, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>38</sup> Key Informant Interview, Malala Mwendela, ZARAN, 6 September 2012

<sup>39</sup> [http://www.unaids.org/sites/default/files/country/documents/ZMB\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/ZMB_narrative_report_2015.pdf) [accessed 24 May 2016]

<sup>40</sup> Submission by Individual, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>41</sup> NZP +, GNP+, *The People Living with HIV Stigma Index: Zambia*, 2011; see also HRI, 2009 cited in GCHL, *Regional Issue Brief: Women, HIV and the Law*, 2011

<sup>42</sup> McPherson 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.docs](https://www.lawutoronto.ca/documents/ihrp/HIV_mcpherson.docs).

<sup>43</sup> Submission by WLSA, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>44</sup> Key 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](http://www.hivlawcommission.org)

<sup>45</sup> AIDS and Human Rights Research Unit, *Human Rights Protected?*, 2007

<sup>46</sup> Centre for the Study of AIDS and Centre for Human Rights, University of Pretoria, *HIV/AIDS and Human Rights in Zambia*, 2004

<sup>47</sup> Submission by World Vision Zambia, Keembe Area Development Programme, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>48</sup> <http://www.girlsnotbrides.org/child-marriage/zambia/> [Accessed 28 May 2016].

<sup>49</sup> Submission by PRISCCA, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>50</sup> Key informant interview, Malala Mwendela, ZARAN, 6 September 2012

<sup>51</sup> Human Rights Watch, *Africa Rulings Move LGBT Rights Forward*, May 2015. Available at <https://www.hrw.org/news/2015/08/05/africa-rulings-move-lgbt-rights-forward> [accessed 26 June 2016]

<sup>52</sup> Key Informant Interview, Malala Mwendela, ZARAN, 6 September 2012

<sup>53</sup> Key informant interview, Malala Mwendela, ZARAN, 6 September 2012

<sup>54</sup> Submission by Treatment Advocacy and Literacy Campaign, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>55</sup> Submission by Prisons Care and Counselling Association, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>56</sup> Human 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>

<sup>57</sup> UNAIDS, *Country Progress Report 2012*, 2012; see also Key Informant Interview, Malala Mwendela, ZARAN, 6 September 2012

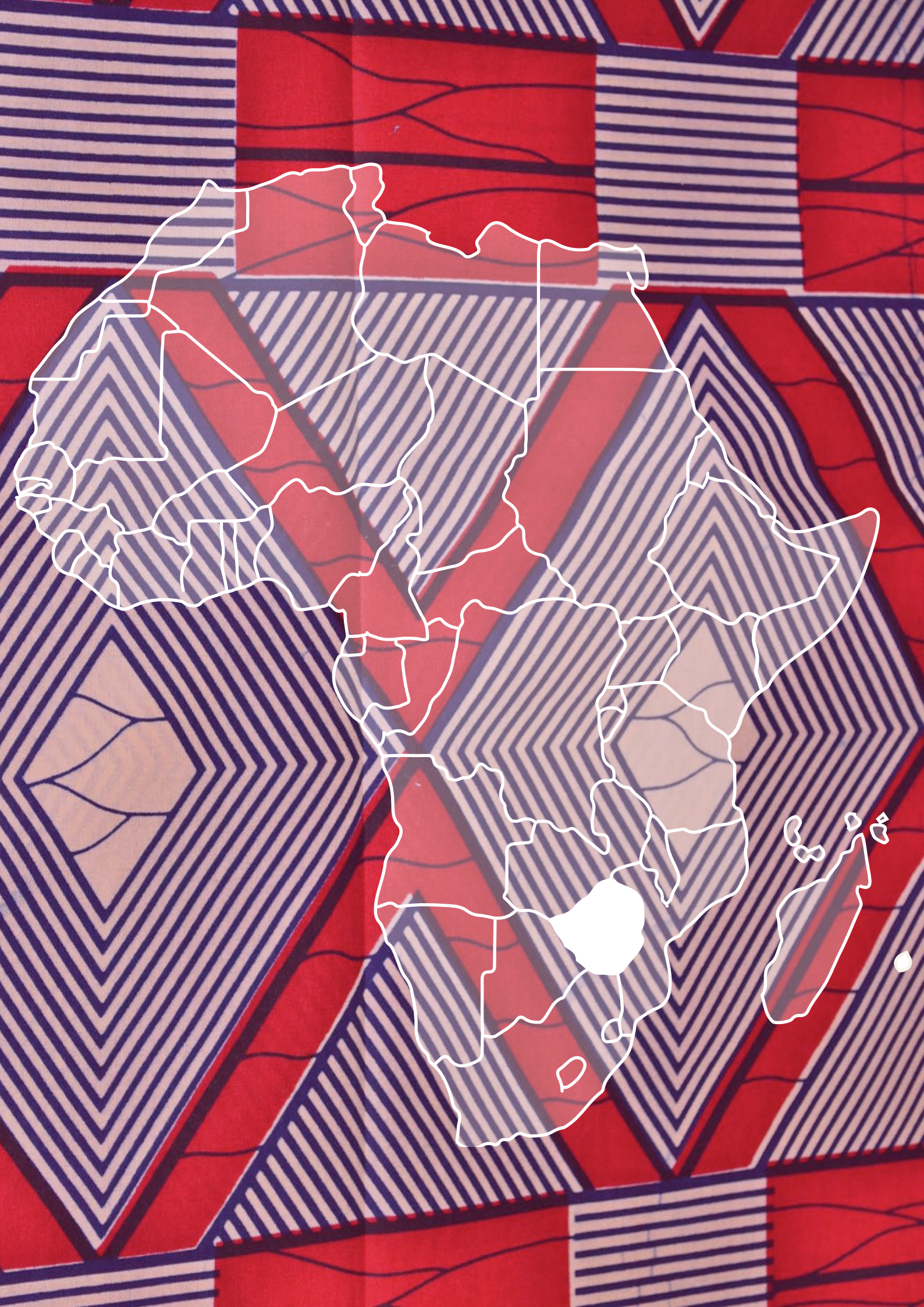
<sup>58</sup> Submission by Zambia Disability HIV/AIDS Human Rights Programme, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>59</sup> See: <http://www.girlsnotbrides.org/where-does-it-happen>

<sup>60</sup> AIDS and Human Rights Research Unit, *Human Rights Protected?*, 2007

<sup>61</sup> Centre for the Study of AIDS and the Centre for Human Rights, University of Pretoria, *HIV/AIDS and Human Rights in Zambia*, 2004





# ZIMBABWE

## BACKGROUND

Zimbabwe reports that the HIV epidemic in the country remains generalised, feminised and homogenous and continues to decline in new infection rates, prevalence and AIDS related mortality.<sup>1</sup> The national response is guided by the new National Strategic Plan 2015-2018. The epidemic is mostly heterosexual, although key populations are noted to be at higher risk of HIV transmission. According to UNAIDS, 16.7% (1.4 million) of adults aged 15-49 years in Zimbabwe are living with HIV, the majority of whom are women (830 000/1.4 million women are living with HIV). There are 150 000 children aged 0 to 14 years living with HIV and 570 000 orphans.<sup>2</sup>



However, there are now growing epidemics among key populations who are at higher risk of HIV.<sup>3</sup> National data on these populations is sparse, with data collection and reporting not featuring in national documents. A recent study based on data collected from 18 sites across the country shows HIV prevalence of 58% amongst sex workers.<sup>4</sup> Homosexual acts are illegal in Zimbabwe for gay men and men who have sex with men but legal for women who have sex with women. No national statistics are available for the number of gay men and men who have sex with men who are living with HIV, as a consequence of the punitive law.<sup>5</sup>

Migration is also noted as a factor increasing the risk of HIV transmission. Research furthermore shows that there are localised areas of high HIV transmission including border districts, growth points, small scale mining areas, fishing camps and commercial farming settlements.<sup>6</sup> Zimbabwe's prison population is also another source of increased risk of HIV/TB infection rates. Available data suggest that in Zimbabwe HIV prevalence in prison is higher than in society overall. There were approximately 18 900 prisoners, including approximately 600 women and 50 juveniles, spread across 46 main prisons and 26 satellite prisons.<sup>7</sup> According to a 2013 assessment undertaken by the SADC Secretariat, HIV estimates in Zimbabwe's prisons are at 14.2% and TB infection rates in prisons are 431 per 100 000.<sup>8</sup>



**Zimbabwe continues** to experience a major HIV driven TB epidemic. There are 42 000 people living with TB in 2014, and 68% of TB patients are also living with HIV.<sup>9</sup> According to the World Health Organisation, in 2014 75% of TB patients with HIV are receiving ART. The Global TB report puts the total number of TB notifications in 2013 at 35,278, and MDR-TB cases at 520, of which 351 of the MDR-TB cases are on treatment. The country sits on the 17th position of the 22 high-burden countries.

Zimbabwe's ART services have increased steadily from 2004 to 2013 by up to five times, with treatment sites increasing from 530 in 2010, to 1459 sites in 2014. Coverage of ART has increased from 5% of those in need in 2004, to 77% in 2014. In addition, there have been significant reductions in transmission of HIV from mother to child in recent years. In 2013, 82% of HIV-positive pregnant women accessed ART to prevent vertical transmission of HIV.

Zimbabwe requires access to newer and safer medicines for HIV and TB. There are a number of procurement mechanisms for medicines and other pharmaceutical commodities for HIV and TB in Zimbabwe. The PEPFAR programme supports the Ministry of Health in both HIV and TB interventions through the procurement of medicines, among other things.<sup>10</sup> Procurement for HIV and TB medicines and other commodities is done by PEPFAR itself based on quantities received from the Ministry of Health. Similarly, the Global Fund supports the ministry in both HIV and TB and procurement of medicines is mainly done through the UNICEF Copenhagen office.<sup>11</sup> Similarly, the Principal Recipient receives the quantities from the ministry and uses the UNICEF procurement mechanism to source the medicines. The Government also does its own procurement using funds from the National AIDS Trust Fund<sup>12</sup> through NatPharm, a pharmaceutical company wholly owned by the Government.<sup>13</sup>

Information on procurement of medicines in Zimbabwe is not public and is only available on application to the Ministry of Health. This lack of information makes it impossible to ascertain whether the prices being paid for the medicines are in line with the HAI or SARPAM indexes. Details of medicines procured through Global Fund grants are available on the Internet<sup>14</sup> and via Country Coordinating Mechanisms. However, both the Global Fund and PEPFAR do not apply TRIPS flexibilities in the procurement of medicines.

## KEY HUMAN RIGHTS CONCERNS IN 2016

- HIV-related stigma and discrimination
- Gender based violence and inequality
- Human rights abuses against key populations
- The rights of children in the context of HIV and TB
- Intellectual Property as a barrier to Access to Medicines





## BACKGROUND

## CONSTITUTION

**CONSTITUTION** Representative HIV survey in Malawi was conducted in 2010. Since then, there has been no more recent research to estimate HIV prevalence. Based on previous survey data, Malawi has a generalised HIV epidemic. HIV prevalence among persons aged 15 to 49 years has declined from 16.4% in 1999 to 11.3% in 2009, and to 8.6% in 2010.<sup>1</sup> The 2014 Malawi HIV Epidemics Profile estimated that, custom or conduct in 2005-2006, people were living with HIV will be 10.3% due to the extent of the fact it is below the target of 15-19%. There are 48 000 AIDS deaths explicitly promoted by law between from 61 000 in 2010<sup>2</sup> 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. The 2012 Modes of Transmission Study showed that HIV risk behaviours are predominantly coded for 57% prohibited HIV violations. This situation has created high levels of HIV as the right to have gay, lesbian and transgender persons work security and partners and abuse and cruel, inhuman and degrading treatment.

While the Malaysian constitution does not explicitly prohibit HIV, TB, or prescriptive and discriminatory laws on a number of additional rights and is not prohibitive of HIV, AIDS, or TB. In these subgroups, freight transporters, vendors, and small traders, regardless of their medical conditions, police officers, health care workers, and the people with the most HIV/AIDS prevalence within each of these groups is higher than in the general population, it appears to have declined significantly in female sex workers, male teachers, police officers and fishermen. There was also a smaller decrease amongst male estate workers and female border traders. Prevalence remained the same amongst female

## RATIFICATION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

**RATIFICATION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS**

Zimbabwe has ratified:

Malawi implemented new clinical guidelines for the management of HIV in children and adults in April 2014.<sup>5</sup> Following these changes, the estimated number of children and adults in need of ART rose from 1 581 000 to nearly 800 000. By the end of December 2014, 533 027 people were on ART, an increase of 13% from 472 866 on ART by the Rights to Life and Wellbeing of the Child (RLWC) in 2013. This represents 67% of those needing ART, based on the new treatment guidelines, it is well below the 85% target of the Rights to Life and Wellbeing of the Child (RLWC) target of 1 000 000. For pregnant women, the number of pregnant women receiving ART has increased since the introduction of the option B+ for pregnant women has increased the number of pregnant women receiving ART.

- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979

Malawi has developed the Rights of People Living With HIV Strategy II Plan (NSP) for 2015 – 2020. The NSP identifies the protection and promotion of human rights and gender equality as key guiding principles. It Socialized Culture Rights (SCSR) gendered interventions to key populations, which include female sex workers and their international counterparts on their political rights to CPR, 196 discordant couples, family members of people living with HIV, young women, children and adolescents. Transgender people are mentioned as people's rights and the rights of women in the plan, but the plan does not recognise them as a key population and does not include specific interventions for this group.<sup>10</sup>

## NATIONAL LAWS AND POLICIES

## NATIONAL LAWS AND POLICIES

It is worth noting that Zimbabwe has been one of the few countries in SEA to maximise the use of the TRIPs flexibilities to manufacture ARVs. 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 antiretroviral 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 ARVs.<sup>18</sup> In 2002, the Zimbabwe Government issued a compulsory licence allowing Varichem Pharmaceuticals (Pvt) Ltd to manufacture generic ARVs, and the company went on to manufacture a total of 9 single and fixed-dose formulations.<sup>19</sup> The company manufactured ARVs for the public and private sector in Zimbabwe, and also exported to other countries in the SADC region. Most of the first-line ARVs in the public health facilities in Zimbabwe during the 2000s were procured from Varichem Pharmaceuticals (Pvt) Ltd.

Zimbabwe has developed a national Intellectual Property Policy with technical and financial assistance from the World Intellectual Property Organisation.

The policy states that the health sector “shall [p]romote access to medicines at affordable costs, by exploiting the TRIPs flexibilities.” However, there are no specifics as to how this will be done.

The Labour Relations Act protects the rights of all employees to non-discrimination, including on the basis of HIV status.<sup>20</sup> HIV regulations were 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, prohibit mandatory HIV testing for purposes of employment, and protect the right to confidentiality and unfair dismissals.<sup>21</sup>

Various laws have been reviewed over the years to improve women's and girls' rights and protections, such as the Legal Age of Majority Act, 1982 that made all Zimbabweans, regardless of sex, majors upon turning 18 years and the Administration of Estates Amendment Act, 1997 which gave inheritance rights to women, including women in unregistered customary law marriages. The courts have also found in favour of the equality rights of women. The Constitution has been the biggest protector of women's rights in Zimbabwe, and in protecting girl children against forced and early marriages.

In 2016, Zimbabwe's Constitutional Court declared child marriage unconstitutional and set the minimum marriage age at 18 years for boys and girls. This followed the notable October 2014 case of two courageous former child brides, Ruvimbo Tsopodzi and Loveness Mudzura, now aged 19 and 20 respectively, who sued the Zimbabwe government over its failure to curb child marriage.<sup>22</sup> Since the judgement, the government has committed to developing laws criminalising the payment of lobola (bride wealth) for girls under age 18 years.<sup>23</sup>

Zimbabwe is making strides in ensuring the full adoption and implementation of the SADC Model Law to End Child Marriage in Southern Africa, which was developed by the SADC-PF in 2015.

Girls are protected from gender-based violence in the Criminal Procedure and Evidence Amendment Act, 1997 which punishes sexual abuse of minors and establishes Victim Friendly Courts to support sexually abused minors to testify against their perpetrators. The Sexual Offences Act, 2000 protects women from sexual violence including marital rape<sup>24</sup> and the Domestic Violence Act, 2007 criminalises all forms of psychological, emotional, economic, physical and sexual violence. More recently, the Gender Violence Act, 2011 provides for the punishment of all perpetrators of violence against women, including for marital rape.<sup>25</sup> In 2012, the Judicial Service Commission established the Multi-Sectoral Protocol on Sexual Abuse to improve the government's response to child and adult sexual abuse and GBV.

In its 2012 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.<sup>26</sup>

## 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. It has a number of national institutions for the promotion and protection of human rights over and above the police and the judiciary. It has a Public Service Commission and an Ombudsman to monitor the actions of the public service. It also has 'victim-friendly courts' and 'victim friendly units' under the police. The Human Rights Commission is "severely under-funded and largely a symbolic institution" that is reportedly unable to fulfill its mandate.<sup>27</sup>

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.<sup>28</sup>

It is worth noting that Zimbabwe has been one of the few countries in SEA to maximise the use of the TRIPs flexibilities to manufacture ARVs. 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 antiretroviral 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.



Human rights activists have indicated that human rights violations continue in Zimbabwe and that the enactment of a new Constitution has failed to improve Human Rights protection more broadly, since provisions are not adequately implemented.



However, human rights activists have indicated that human rights violations continue in Zimbabwe and that the enactment of a new Constitution has failed to improve human rights protection more broadly, since provisions are not adequately implemented.<sup>29</sup> 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

PUNITIVE LAWS AND LAWS THAT DO NOT SUPPORT HUMAN RIGHTS

The Criminal Law (Codification and Reform Act), section 79 criminalises the wilful transmission of HIV including 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.”

In the case *S v ST* [2010 case] 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.<sup>30</sup>

In June 2016, the Constitutional Court dismissed two people’s applications challenging their conviction of willfully infecting their partners with HIV. Their argument was that Section 79 of the Code violated their rights of protection of the law, as provided for under Section 18 of Zimbabwe’s previous Constitution. Their application was dismissed with costs.<sup>31</sup>

The Sexual Offences Act 8, 2001 also imposes a penalty of 20 years for persons convicted of raping and exposing the rape survivor to HIV. Section 16 states that where a person is convicted of rape, sodomy or having sex with a person with an intellectual disability and it is proved that at the time of the offence the convicted person was living with HIV, whether or not the convicted person was aware of the HIV infection, the person shall be sentenced to imprisonment not exceeding twenty years. Section 17 allows the court to order the testing of a sexual offender for HIV. Blood for HIV testing is taken from the accused and if 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.<sup>32</sup>

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.

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 willfully 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. 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; he was sentenced to 15 years.

**214** *HIV, TB and Human Rights in Southern and East Africa Report 2016*

Zimbabwean law recognises two forms of marriage - monogamous marriages and potentially polygamous customary law marriages. 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. While on paper even women in unregistered customary law marriages have the right to inherit, according

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.”

The Miscellaneous Offences Act does not criminalise sex work; however it makes loitering for the purposes of prostitution in a public place an offence.<sup>35</sup> 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 fraternising 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.<sup>36</sup>



HUMAN RIGHTS CHALLENGES

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.

**Stigma and discrimination:** There is ongoing stigma and discrimination against people living with HIV, including within families and communities and the health sector.



**Women’s rights:** Women’s vulnerability to HIV is exacerbated by gender inequality, a number of harmful gender norms as well as GBV in Zimbabwe. Despite the gains in legal equality, women continue to experience high levels of inequality in society, particularly in rural areas. Inequality is pervasive in customary laws and practices and women are treated as minors with limited rights to own and inherit property. Women do not have equitable access to property and inheritance or adequate access to sexual and reproductive health services.<sup>37</sup>

Harmful gender norms that place women at higher risk of HIV exposure include early marriage, FGM, wife inheritance and polygamy, amongst others.<sup>38</sup>



**LGBTI people:** The criminalisation of sex between men creates a barrier to access to services for LGBTI populations, preventing them from accessing preventive services, information, treatment, care and support, despite their high risk of HIV exposure.<sup>39</sup>

LGBTI organisation, 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 have emanated from the highest levels of government. 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.<sup>40</sup>



**Sex workers:** Sex workers report gross human rights violations, documented and confirmed in research by the African Sex Workers’ Alliance (ASWA) in 2010.<sup>41</sup> They are highly stigmatised 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.<sup>42</sup> Male sex workers are doubly vulnerable because of the 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.<sup>43</sup> They are unable to disclose their health needs for fear of arrest. This in turn impacts on their ability to seek and access treatment

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.

**Children’s rights:** Adolescents below 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 Child Adoption Act, 2006 allows for HIV testing of children up for adoption.

RECOMMENDATIONS

Civil society should:

- Work in partnership with members of key populations and organisations led by key populations to design and implement advocacy strategies to promote their human rights
- Advocate for laws that promote the human rights of people living with HIV and/or TB and key populations
- Work to strengthen access to justice for key populations by training law enforcement officials on the human rights of people living with HIV and/or TB and key populations
- Raise awareness about gender based violence and harmful gender norms and the links with HIV
- Train health care providers on the human rights of people living with HIV and/or TB and key populations, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly

The Zimbabwean government should:

- Review and repeal all laws criminalising HIV transmission, including the Criminal Law Act and the Sexual Offences Act
- Decriminalise all consensual adult sex
- Review all laws to ensure that they do not discriminate against women and repeal all discriminatory provision; enact laws that promote women’s rights to equality, including those in customary marriages
- Decriminalise the possession of drugs for personal use and use of drugs and review and amend drug laws to permit harm reduction programmes
- Review all laws to ensure they are consistent with the court judgement on child marriage and repeal any provisions that permit marriage of persons below the age of 18 and that permit marriage of underage girls with parental consent
- Review laws that undermine children’s access to HIV testing and treatment, including the requirement that parents consent to HIV testing
- Strengthen access to justice, especially for key populations through various interventions, including stigma and discrimination reduction programmes, programmes to reduce gender inequality, harmful gender norms and gender based violence, legal literacy programmes, improved access to legal support services, training for law and policy makers and the judiciary.

END NOTES

<sup>1</sup> Available at [http://www.unaids.org/sites/default/files/country/documents/ZWE\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/ZWE_narrative_report_2015.pdf) [Accessed 6 July 2016]

<sup>2</sup> Available at <http://www.unaids.org/en/regionscountries/countries/zimbabwe/> [Accessed 25 May 2016].

<sup>3</sup> Zimbabwe National Statistics Agency (2012) ‘Zimbabwe Demographic and Health Survey 2010-11’. Available at <http://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zimbabwe>

<sup>4</sup> UNAIDS, *Zimbabwe Country Progress Report 2015* Available at [http://www.unaids.org/sites/default/files/country/documents/ZWE\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/ZWE_narrative_report_2015.pdf) [Accessed 25 May 2016].

<sup>5</sup> ILGA, State-sponsored homophobia 2014, 2014. Available at [http://old.ilga.org/Statehomophobia/ILGA\\_SSHR\\_2014\\_Eng.pdf](http://old.ilga.org/Statehomophobia/ILGA_SSHR_2014_Eng.pdf)

<sup>6</sup> Ibid.

<sup>7</sup> <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper>

<sup>8</sup> Available at [https://www.sadc.int/files/6314/1171/8815/Assessment\\_Report\\_on\\_HIV\\_and\\_AIDSTuberculosis\\_Hepatitis\\_B\\_and\\_C\\_andother\\_Sexually\\_Transmitted\\_Infectionsin\\_Prison\\_Settings\\_in\\_the\\_SADC.pdf](https://www.sadc.int/files/6314/1171/8815/Assessment_Report_on_HIV_and_AIDSTuberculosis_Hepatitis_B_and_C_andother_Sexually_Transmitted_Infectionsin_Prison_Settings_in_the_SADC.pdf) [Accessed 6 July 2016]

<sup>9</sup> [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=ZW&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=ZW&LAN=EN&outtype=html) [Accessed 25 May 2016.]

<sup>10</sup> <http://www.pepfar.gov/documents/organization/212165.pdf>

<sup>11</sup> Per Eric Chiro, Essential Drugs Specialist, UNICEF Zimbabwe, and Sifiso Moyo, Procurement and Supply Manager, UNDP Zimbabwe

<sup>12</sup> National AIDS Council of Zimbabwe Act (Chapter 15:14)

<sup>13</sup> Per Flora Sifeku, NatPharm Director

<sup>14</sup> <http://pqr.theglobalfund.org/Screens/PQRLogin.aspx?Lang=en-GB>

<sup>15</sup> Article 56.

<sup>16</sup> Article 57

<sup>17</sup> Article 76

<sup>18</sup> Zimbabwe Patents Act (Chapter 26:03, as amended up to Act No. 14/2002). Available at <http://www.wipo.int/wipolex/en/details.jsp?id=8942> [Accessed on 6 July 2016]

<sup>19</sup> Patrick L. Osewe *et al*, *Improving Access to HIV/AIDS Medicines in Africa: Trade-Related Aspects of Intellectual Property Rights Flexibilities*, 2008

<sup>20</sup> Section 6(1), Labour Relations Amendment At 17, 2002

<sup>21</sup> AIDS and Human Rights Research Unit, *Human Rights Protected?*, 2007

<sup>22</sup> Human Rights Watch, *Ending Child Marriages in Zimbabwe* Available at <https://www.hrw.org/news/2016/03/31/dispatches-ending-child-marriage-zimbabwe> [Accessed 6 July 2016]

<sup>23</sup> <https://www.hrw.org/news/2016/03/31/dispatches-ending-child-marriage-zimbabwe> [Accessed 26 May 2016].

<sup>24</sup> Section 8(1)

<sup>25</sup> UNAIDS, NCPI Report, 2012 and *Country Progress Report*, 2012 available at <http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Zimbabwe%20NCPI%202012.pdf>

<sup>26</sup> UNAIDS, *Country Progress Report*, 2012.

<sup>27</sup> Department 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]

<sup>28</sup> AIDS and Human Rights Research Unit, *Human rights Protected?*, 2007

<sup>29</sup> Human Rights Watch, *World Report: Zimbabwe 2013* Available at <http://www.hrw.org/world-report/2014/country-chapters/zimbabwe?page=2>

<sup>30</sup> Submission to *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>31</sup> <http://www.newsdezimbabwe.co.uk/2016/06/concourt-rules-on-wilful-hiv-infections.html>

<sup>32</sup> AIDS and Human Rights Research Unit, *Human Rights Protected?* 2007

<sup>33</sup> Submission by WLSA, Zimbabwe, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011. Available at [www.hivlawcommission.org](http://www.hivlawcommission.org)

<sup>34</sup> Article 26

<sup>35</sup> Section 4

<sup>36</sup> AIDS and Human Rights Research Unit, *Human Rights Protected?* 2007; UNAIDS, NCPI Report, 2012

<sup>37</sup> Submission by Southern African Litigation Centre, South Africa, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011. Available at [www.hivlawcommission.org](http://www.hivlawcommission.org)

<sup>38</sup> AIDS and Human Rights Research Unit, University of Pretoria, *Human Rights Protected?*, 2007

<sup>39</sup> UNAIDS, *NCPI Report* 2012; see also Sexual Rights Centre, Zimbabwe; *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>40</sup> Submissions 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](http://www.hivlawcommission.org)

<sup>41</sup> Submission by ASWA, *Africa Regional Dialogue on HIV and the Law*, 4th August 2011. Available at XXX

<sup>42</sup> Submission by ASWA; Female Sex Worker Network of Zimbabwe, Zimbabwe, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011

<sup>43</sup> Ibid. 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



