HIV/AIDS and Human Rights in SADC

An evaluation of the steps taken by countries within the South African Development Community (SADC) region to implement the *International Guidelines on HIV/AIDS and Human Rights*

Authors:

Ann Strode
Anneke Meerkotter
Michelle Lewis

Editors:

Brenda Grant
Kitty Grant
Michaela Clayton
Gregg Gonsalves
Angela Lee

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AIDS and Rights Alliance for Southern Africa
53 Mont Blanc Street
P O Box 97100
Windhoek
Namibia
Tel: +264 61 300381
Fax: +264 61 227675
Email: Michaela@arasa.org.na
Web: www.arasa.info

Chapter One: Introduction

> *"Realisation of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS drives an effective response."*[1]

2006 marks the tenth anniversary of the development of the *International Guidelines on HIV/AIDS and Human Rights.* To celebrate this occasion, the AIDS and Rights Alliance for Southern Africa *(*ARASA) has conducted research to evaluate the extent to which the *International Guidelines* have been used and implemented in the Southern African Development Community (SADC) region.

This report details the findings of that research. It focuses on the guidelines dealing with:

- Structures and partnerships to support a multi-sectoral response;
- A protective legal and policy framework;
- Access to treatment; and
- Access to legal services.

Funding permitting, ARASA hopes to repeat this survey on an annual basis to enable it to keep a close monitor of the state of HIV and human rights in the region.

[1] *Declaration of Commitment*, adopted at the United Nations General Assembly, Special Session on HIV/AIDS, June 2001.

1.1 Overview

The report is divided into six chapters. The first sets out the context for the report and describes the enormous burden that the SADC region bears with regard to the HIV/AIDS epidemic. It details the background to human rights within the region and HIV as a specific human rights issue. It describes the international law responses to HIV as a human rights issue through the development of the *International Guidelines on HIV/AIDS and Human Rights* and through regional SADC declarations. It concludes with information on the aims and objectives of this report, the methodology used to find the information, and its limitations.

The second chapter deals with the steps SADC countries have taken to show political commitment to HIV as a human rights issue and the structures that ought to be established to facilitate a multi-sectoral framework. Chapter Three evaluates the steps taken to create a protective legal and policy framework on HIV and human rights. Chapter Four looks at the prevention, treatment and care programmes.

Chapter Five, deals with access to legal services.

Chapter Six is the concluding chapter to this report. It discusses general themes and findings.

1.2 The HIV/AIDS Epidemic within SADC

Sub-Saharan Africa has just over 10% of the world's population, but it is home to more than 60% of all people living with HIV, a total of 25.8 million PLHAs. In 2005, an estimated 3.2 million people in the region became newly infected, while 2.4 million adults and children died of AIDS.[2] The SADC region is at the epicentre of the HIV epidemic within Sub-Saharan Africa. Five SADC countries have adult HIV prevalence figures of above 20% of the adult population.

The life expectancy in the region is low. The average life expectancy for men is between 36 to 47 years. It is marginally higher in countries like Madagascar and Mauritius, where it is between 55 to 69 years. The average life expectancy of women averages from 34 years in Zimbabwe to 55 years in Namibia. Again Madagascar and Mauritius have longer life expectancies at between 59 to 75 years.[3]

Table 1: HIV Prevalence Rates in SADC countries

COUNTRY	POP in 000's	ADULT % 15-49 yrs	ADULT N0S 15 YRS +	WOMEN NOS 15 YRS+	ADULT & CHILD NOS
ANGOLA	15 941	37%	280 000	170 000	320 000
BOTSWANA	1 765	24.1%	260 000	140 000	270 000
DRC	57 549	3.2%	890 000	61 000	1 000 000
LESOTHO	1 795	23.3%	250 000	150 000	270 000
MADAGASCAR	18 606	0.5%	47 000	13 000	49 000
MALAWI	12 884	14.1%	850 000	580 000	940 000
MAURITIUS	1 245	0.6%	4 100	Less 1 000	4 100
MOZAMBIQUE	19 792	16.1%	1 600 000	960 000	1 800 000
NAMIBIA	2 031	19.6%	210 000	130 000	230 000
S.AFRICA	47 432	18.8%	5 300 000	3 100 000	5 500 000
SWAZILAND	1 032	33.4%	210 000	120 000	220 000
TANZANIA	38 329	6.5%	1 300 000	718 000	1 400 000
ZAMBIA	11 668	17%	1 000 000	570 000	1 100 000
ZIMBABWE	13 010	20.1%	1 500 000	890 000	1 700 000

Source: UNAIDS *Report on the Global AIDS Epidemic 2006*[4]

[2] www.unaids.org
[3] UNAIDS Report on Global AIDS Epidemic 2006, www.unaids.org
[4] www.data.unaids.org

1.3 Human Rights within the SADC Region: The context

The legal protection of human rights within the SADC region is a current, emerging issue. Although all SADC countries are now democracies, many of them have recently emerged from long periods of war and internal strife. Almost all the countries have long legacies of poverty, colonialism and a lack of development. Some, like South Africa and Namibia, also have histories of extensive human rights abuses under apartheid. In this context, there are many competing human rights issues in the region ranging from women's rights to the continued existence of the death penalty.

The focus on HIV as an emerging human rights issue must be seen in this broader context. Given the devastating impact of the epidemic on the SADC region, HIV/AIDS is increasingly becoming a key human rights issue with civil, political and socio-economic rights implications.

1.4 HIV/AIDS as a Human Rights Issue

Early governmental responses to HIV were, in many instances, coercive. They included mandatory HIV testing, the placing of HIV positive persons in quarantine and forced disclosure of HIV status.[5]

This coercive approach to the epidemic was premised on outdated public health principles that required the "carriers" of this disease to be isolated and contained.[6] Accordingly, initial legal responses either targeted the behaviour that was seen to be escalating the epidemic (for example, sex between men), or the individuals who were viewed as being responsible for "spreading" HIV (for example (for example, men who had sex with men) using coercive public health measures such as quarantine. [7]

Furthermore, the active exclusion of people living with HIV or AIDS (PLHAs) from various spheres of life, such as the workplace, and even schools, was seen as a valid mechanism of keeping the community "AIDS free". For example, in South Africa in 1987 the Apartheid government amended the regulations under the *Aliens Control Act* to provide that anyone living with HIV or AIDS could be declared "prohibited persons". This gave immigration authorities the power to detain, deport or subject any person suspected to be infected with HIV to a compulsory medical examination.[8] These Regulations were used extensively to repatriate foreign mine workers back to their home countries, since HIV was seen as a disease emerging from other parts of Africa. The South African Minister of Foreign Affairs remarked some years later:

> *" … the terrorists are now coming to us with a weapon more terrible than Marxism: AIDS"*[9]

In this setting of widespread discrimination against PLHAs, a small but active HIV and human rights movement emerged. This international movement argued that our responses to the epidemic ought to be based on human rights.[10]

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[5] Cameron E "Human Rights, Racism and AIDS: The New Discrimination" (1993) *South African Journal of Human Rights*, Vol 9, Part 1.

[6] Buchanan D "Public Health, Criminal Law and the Rights of the Individual" in *African Network on Ethics, Law and HIV, Proceedings of the Inter-Country Consultation*, Dakar, Senegal, 27 June – 1 July 1994, United Nations Development Programme.

[7] Cameron E and Swanson E "Public Health and Human Rights – The AIDS Crisis in South Africa" (1992) South *African Journal of Human Rights.*

[8] These regulations were amended in 1991 by removing any reference to HIV or AIDS. Cameron E (note 5).

[9] Kirby M "AIDS and the Law" (1993) *South African Journal of Human Rights*, Vol 9, Part 1.

[10] Albertyn C and Heywood M *Human Rights and HIV/AIDS in the Commonwealth*, available from www.alp.org.za, last accessed on the 18 November 2006.

In Africa, this movement was led by the African Network on Ethics, Law and HIV. At its inaugural meeting in 1994, the seven countries represented all reported widespread human rights violations. For example, in Zambia, the exclusion of PLHAs from employment was a significant problem. In Ghana, it was reported that mandatory HIV testing was carried out on commercial sex workers. In Senegal, breaches of confidentiality were a major concern.[11] At its conclusion this meeting issued the *Dakar Declaration* containing ten rights-based principles including the principle of non-discrimination and the prohibition of mandatory testing.[12] Countries were urged to use these principles to guide all responses to HIV. Three years later, countries reported similar problems at a 1997 meeting of the Network. Almost all countries reported problems with pre-employment HIV testing, breaches of confidentiality and testing without informed consent.[13]

The *Dakar Declaration* made no mention of the right of access to treatment. In the context of no effective treatment for HIV, at this time the human rights abuses were largely civil and political in nature. They stemmed from unfair discrimination once a person's HIV status was known. Thus early legal and human rights concerns were on developing a protective framework against unfair discrimination, ensuring that testing was with informed consent and that confidentiality was maintained.

The situation in African countries echoed the problems in other countries worldwide, where PLHAs continued to experience ongoing human rights violations. Against this background, the United Nations Joint Programme on HIV/AIDS (UNAIDS), in conjunction with the United Nations Office of the High Commissioner for Human Rights, called together various experts to a consultation on HIV/AIDS and human rights. This consultation led to the development and issuing of the *International Guidelines on HIV and Human Rights*.[14]

In 2000, particularly after the XIII International AIDS Conference held in Durban, a major shift occurred in the human rights movement. The right to affordable treatment for HIV/AIDS became a major focus of the human rights agenda. This signalled a move towards a greater focus on socio-economic rights for PLHAs.[15] Access to treatment as a fundamental human rights issue has dominated the human rights agenda since this time. The treatment focus also resulted in a revision of Guideline 6 of the *International Guidelines on HIV/AIDS and Human Rights* in 2002 to reflect the acceptance of access to treatment as a fundamental human right.

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[11] African Network on Ethics, Law and HIV: *Proceedings of the Inter-country Consultation*, Dakar, Senegal, 27 June – 1 July 1994, United Nations Development Programme.
[12] *Ibid.*
[13] *Ibid.*
[14] UNAIDS and UN High Commissioner for Human Rights *HIV/AIDS and Human Rights: International Guidelines* (1996), available from www.unaids.
[15] *Op cit* note 10.

More recently, there has been another shift in the human rights movement. Increasing concerns about the scale of deaths from AIDS, the slow uptake of Voluntary Testing and Counselling (VCT) and the lack of PLHAs enrolling in the anti-retroviral (ARV) treatment programmes that are now available in some African countries has led to calls for routine HIV testing. While routine HIV testing has different meanings in different contexts, some forms of routine testing aim to limit the strict standards of informed consent, and to promote shared confidentiality.

This shift towards undermining many of the civil and political rights gains won during the first decade of the epidemic in order to facilitate access to socio-economic rights is of concern to many human rights activists. Whilst they recognise access to treatment as a key human rights issue, they caution against falling back into the earlier patronising responses that characterised the initial public health strategies towards HIV and AIDS.

This leaves us at a critical juncture in the human rights movement where there is a need for vigilance to protect human rights advances that have already been made, as well as a need to advance new frontiers within socio-economic rights.

1.5 The International Guidelines on HIV/AIDS and Human Rights

The culmination of the struggle for a response to HIV that was based on human rights was the issuing of the *International Guidelines on HIV/AIDS and Human Rights* in 1996 by UNAIDS and the Office of the High Commissioner for Human Rights.

The *International Guidelines* are the only international law document that describes in detail the responsibilities of governments towards creating a human rights-based response to HIV/AIDS. The *Guidelines* are made up of twelve guidance points and each one describes appropriate legislative and other responses that are required for an effective pubic health response to the epidemic.

The key points set out in the guidelines are:

- Guidance on how to improve the government's ability to co-ordinate a multi-sectoral response to HIV/AIDS - for example, by establishing an inclusive and participatory National AIDS Council;
- Guidance on law reform to promote a rights-based response to the HIV epidemic - for example, developing equality legislation to protect PLHAs from unfair discrimination;
- Guidance on law reform to support public health interventions - for example, introducing laws that support treatment programmes by allowing the importation of drugs; and
- Guidance on creating a supportive environment for groups that are vulnerable to HIV or affected by HIV – for example, law reform decriminalising homosexuality.

In 2002, Guideline 6 of the *International Guidelines* was revised. The new version makes it clear that governments are under a duty to ensure that there is access to ARV treatment through the public health services. This revision reflected the growing international acceptance that ARV treatment formed a key component of the right to the highest attainable standard of health, as described in the International Convention on Economic, Social and Cultural Rights.[16]

[16] *International Guidelines on HIV/AIDS and Human Rights* (2006) Consolidated Version, available www.ohchr.org, last accessed on 21 November 2006.

1.6 SADC Responses to HIV/AIDS

The Southern African Development Community (SADC) consists of 14 countries: Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe.[17] All SADC countries are members of the African Union.

Both the Organisation of African Unity (OAU) and the African Union (AU) have issued a number of statements and guidelines on HIV and human rights. These include:

- The *Grand Baie Declaration* (1999) which highlights the importance of dealing with human rights issues in Africa;
- The 2001 *Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases*, and the *Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*; and
- The *African Commission on Human and People's Rights Resolution on HIV/AIDS* (2001) that deals with the impact of HIV on the human rights of Africans.

SADC has also drafted a number of protocols and codes over the years such as:

- The *Code on HIV/AIDS & Employment* (1997) which aims to consolidate national employment codes on HIV/AIDS-related issues and sensitise employers to these issues;
- The *SADC Health Protocol* (1999) which specifically deals with HIV/AIDS and STIs, and aims to promote prevention and management policies that work towards an inter-sectoral response to the epidemic;
- The *SADC Declaration on HIV/AIDS* (July 2003) which shows a commitment to address the epidemic through multi-sectoral intervention. The updated SADC *HIV/AIDS Strategic Framework and Programme of Action* (2003 – 2007) was also adopted recently; and
- The *Declaration of HIV/AIDS* (2003) issued by the Council of Ministers of SADC at Maseru, which promotes multi-sectoral strategies to respond to HIV/AIDS.

Most of the OAU and SADC declarations are statements of intent. These are important as they set a principled human rights framework within which countries ought to respond. The SADC *Code on HIV/AIDS & Employment* appears to be one of the most influential documents on HIV/AIDS and human rights in the region, as it has lead to extensive legislative and policy changes within SADC countries.

[17] http://www.sadc/int, last accessed on the 20 November 2006.

1.7 This Report

This report is based on research into the state of HIV/AIDS and human rights in SADC countries.

It seeks to:

- Describe the extent to which SADC countries have used and implemented selected guidelines from the *International Guidelines on HIV/AIDS and Human Rights;*
- Detail (as far as possible) the nature and extent of human rights abuses that PLHAs continue to face in the SADC region;
- Describe good legal, policy and human rights practices in relation to HIV/AIDS; and
- Outline key HIV and human rights challenges that still exist in the region.

The report is based on information obtained through three different methodologies:

- Key informant questionnaires were distributed to non-governmental organisations (NGOs) working on HIV as a human rights issue in the SADC region;
- Telephonic and face-to-face interviews were held with ARASA partners; and
- A desk review of all literature and other material on the state of HIV and human rights in the SADC region was conducted. Information was accessed from the internet, journals, NGO publications and newspapers.

In total 67 questionnaires were distributed to NGOs within the various SADC countries. Questionnaires were distributed either electronically or by fax. Only NGOs working on HIV as a human rights issue, even if this was not their primary focus, were selected. Twenty completed questionnaires were returned or completed in person. This reflects a response rate of 29.8 %.

Table 2: Number of questionnaires distributed per SADC country

Country	No of Questionnaires Successfully Sent (1)	No of Questionnaires Unsuccessfully Sent (2)	No of Positive Responses (3)
ANGOLA	1	1	1
BOTSWANA	5	1	1
DRC	6	5	1
LESOTHO	3	4	1
MADAGASCAR	6	0	1
MALAWI	4	5	1
MAURITIUS	1	0	1
MOZAMBIQUE	4	9	2
NAMIBIA	4	0	3
SOUTH AFRICA	10	1	2
SWAZILAND	6	3	2
TANZANIA	7	5	2
ZAMBIA	5	1	1
ZIMBABWE	5	2	1

Finally, as far as possible the information obtained from the key informant questionnaires and the interviews was verified and supplemented by a desk review of all available material on HIV and human rights in the SADC region.

1.7.1 Key limitations of the research

This quality of the information in this report has been limited by a number of factors including:

(i) *Time frame:* This survey was conducted between September and November 2006. Given that only three months were available in which to conduct the research and to verify the information, it was extremely difficult to obtain detailed information in certain areas;

(ii) *Resources:* The funding available for the project was limited and therefore more detailed interviews or country visits could not be undertaken to verify information;

(iii) *Language barriers:* There was an enormous problem with the French and Portuguese speaking countries. The key informant questionnaires were translated into Portuguese in order to obtain responses from Angola and Mozambique. Only one response was received from French speaking Madagascar. We were unable to obtained additional information regarding policies or legislation in non-English speaking countries;

(iv) *Identifying and contacting NGOs*: Many of the contact details that we found on websites proved to be incorrect and accordingly our e-mails and faxes were not delivered. This limited the number of organisations that we could reach with our questionnaire; and

(v) *Broad approach taken in the questionnaire*. The questionnaire aimed at obtaining feedback on the steps taken by governments on three broad areas covered in the *International Guidelines on HIV/AIDS and*

Human Rights. This broad approach meant that respondents submitted vastly different responses, making inter-country comparisons difficult. It also meant that respondents did not always give sufficient detail in order for us to analyse areas of key concern. It may be more appropriate for future research to concentrate on issues of common concern (such as women's rights) and analyse these in more detail.

1.7.2 Acknowledgements

This report would not have been possible without the generous funding of SIDA and Irish Aid. The support of all ARASA partners and other NGOs, who allowed us to consistently badger them with "one just one more query" is also acknowledged. Finally, the advice and assistance provided by Michaela Clayton to the overall conceptualisation and writing of the report is acknowledged.

Chapter Two: Political Commitment and Multi-Sectoral Responses to HIV and AIDS

2.1 Introduction

A human rights based response to HIV and AIDS requires, among other things, that each country's government creates a framework that encourages and enables all sectors of society to respond in a coordinated and appropriate manner to the epidemic.

The *International Guidelines on HIV/AIDS and Human Rights* provide guidance on what countries should do to create this framework. They recommend that governments should ensure that the national HIV/AIDS response is based on:

- A national framework that co-ordinates and involves all sectors of government, as well as
- Support to, and consultation with civil society, so that they may also be involved in the national response to HIV and AIDS.

An effective national framework is an essential starting point for responding to HIV and AIDS, and a necessary basis for meeting other commitments set out in the *International Guidelines*. In order to ensure the successful involvement of all sectors, states need to begin by developing committed leadership and appropriate structures, building capacity, providing adequate resources and promoting participation.

This chapter of the report looks at the progress made by SADC countries towards developing a committed, multi-sectoral national response to HIV and AIDS. It focuses on the level of political commitment within countries to HIV and AIDS, the extent to which governments have created multi-sectoral structures and partnerships to respond to HIV and AIDS, and the involvement of PLHAs in the response.

2.2 HIV/AIDS and Human Rights Guidelines

There are two guidelines relevant to developing an effective multi-sectoral response to HIV and AIDS. They require states to establish a national framework for responding to HIV and AIDS across government. They further require states to support community involvement in the national response.

GUIDELINE 1: NATIONAL FRAMEWORK
States should establish an effective national framework for their response to HIV/AIDS which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and programme responsibilities across all branches of government.

GUIDELINE 2: SUPPORTING COMMUNITY PARTNERSHIP
States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design, programme implementation and evaluation and that community organisations are enabled to carry out their activities, including in the fields of ethics, law and human rights, effectively.

2.3 Progress in Implementation

Almost all SADC countries showed progress towards developing multi-sectoral national frameworks with varying levels of political commitment from all sectors towards HIV and AIDS.

2.3.1 Political Commitment to HIV/AIDS

Guideline 1 requires the development of leadership and dedication to HIV and human rights issues. At a regional level, political commitment towards HIV/AIDS and human rights issues has also been prioritised. The *Grand Baie Declaration* (2001) of the Organisation of African Unity highlights the importance of dealing with HIV and human rights issues in Africa. The African Commission on Human and People's Rights *Resolution on HIV/AIDS* made at the 29th Ordinary session (2001) also stresses the impact of HIV on the human rights of Africans.

Of the fourteen SADC countries reviewed[18] 92.9 % (n = 13) said that there was political commitment to HIV/AIDS.

[18] Angola, Botswana, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe.

Table 3: Political commitment to HIV/AIDS

Country	Political Commitment to HIV/AIDS
Angola	Yes
Botswana	Yes
DRC	No
Lesotho	Yes
Madagascar	Yes
Malawi	Yes
Mauritius	Yes
Mozambique	Yes
Namibia	Yes
South Africa	Yes
Swaziland	Yes
Tanzania	Yes
Zambia	Yes
Zimbabwe	Yes

In a review of eleven SADC countries[19] 54.5 % (n= 6) had demonstrated political commitment by allocating resources to HIV/AIDS. 63.6% (n = 7) had declared HIV a national disaster or had politicians who were open about their HIV status. 18.1 % (n = 2) had high profile political leaders heading up HIV/AIDS programmes.

Table 4: Nature of political commitment to HIV/AIDS

Country	Declaration of national state of emergency	HIV/AIDS programmes headed by key political figurehead	Openness by members of parliament	Resources allocated to HIV/AIDS
Angola	No information			
Botswana		X	X	X
DRC	No information			
Lesotho			X	X
Madagascar	Declared HIV/AIDS a "national priority"	X		X
Malawi			X	
Mauritius				X
Mozambique	No information			
Namibia				X
South Africa				X
Swaziland	X			
Tanzania	X			
Zambia	X		X	
Zimbabwe	X			

[19] Botswana, Lesotho, Madagascar, Malawi, Mauritius, Namibia, South Africa, Tanzania, Zambia and Zimbabwe.

In a review of all fourteen SADC countries, the most significant problem reported with political commitment was a lack of commitment to implementation, with 42.8 % (n = 6) countries identifying this as a key problem, 28.5 % (n = 4) saw the behaviour of parliamentarians as a key problem (for example, because of their own 'high risk' behaviour, their attitudes towards vulnerable groups such as gays and lesbians, or their AIDS denialism).

Table 5: Key problems with political commitment in SADC

Country	No commitment to implementation	Government not involved in service delivery	No resources	No policies	HIV programmes undermined by behaviour of leadership	No problems reported
Angola	X					
Botswana						X
DRC		X	X	X		
Lesotho						X
Madagascar						X
Malawi						X
Mauritius	X					
Mozambique	X					
Namibia					X	
South Africa	X				X	
Swaziland	X				X	
Tanzania	X					
Zambia						X
Zimbabwe					X	

The report made the following findings and recommendations with regard to political commitment to HIV/AIDS within SADC:

<u>Finding:</u> There is political commitment to HIV/AIDS within SADC; however it could not be established whether this always leads to effective or enhanced rights-based responses to HIV/AIDS.

<u>Recommendation</u>: Advocate for the adoption of a SADC strategic framework on HIV and human rights with concrete goals, activities and timelines to integrate human rights into the response to HIV/AIDS.

Informants reported evidence of political commitment in various forms, such as declaring HIV to be a national emergency, lifting the profile of HIV/AIDS programmes by making a key political figurehead, such as the president, the head of such programmes, openness and disclosure around HIV by politicians and allocating resources to HIV.

Good Practice: President heads HIV/AIDS Programme

In **Madagascar**, in spite of the low HIV prevalence rate – less than 1% - the government has created an HIV/AIDS prevention programme headed by the President. [20] In March 2006, the President and his wife set an example to the nation by both undergoing an HIV test and invited all Malagasy citizens to know their HIV status. The President stated, "AIDS is there! We must redouble vigilance… Testing is significant because it enables us to know''. [20A]

Although political commitment existed, it did not appear to always lead to the implementation of rights-based responses. For example, even though Swaziland, Tanzania, Zambia and Zimbabwe have declared HIV to be a national disaster or emergency, this has not led to them taking extensive steps to reform their legal and policy environment.

In Tanzania, the government commissioned the Tanzanian Lawyers Association to conduct research into the need for law reform to meet the challenges of HIV/AIDS in 2000. In 2004 they presented a report entitled *Review and Assessment of Laws Affecting HIV/AIDS in Tanzania*.[21] However to date it is unclear whether the Tanzanian government has implemented any of the recommendations made in the report, and numerous laws continue to discriminate against PLHAs. For example, the *Expulsion and Exclusion of Pupils from Schools Regulation* (2002)[22] allows the head of a school to refuse to admit or re-admit pupils with "undesirable physical health".[23]

Although there is political commitment to HIV/AIDS and this is demonstrated in various ways throughout the region, this report was unable to establish the extent or the impact that political commitment has on enhancing HIV and human rights programmes. Increased pressure and support needs to be directed towards political leaders to ensure an appropriate response.

<u>Finding:</u> Political commitment to HIV and AIDS is often undermined by the failure of leadership to respond appropriately to HIV and AIDS, either through their own actions and statements, or through their policy and programme implementation.

<u>Recommendation:</u> Advocacy for greater personal leadership by politicians who lead the response to HIV by demonstrating behaviour changes and commitment to human rights within their own lives, and through their policies and programmes.

[20] www.plusnews.org, last accessed on the 7 September 2006,
[20A] UNAIDS Madagascar's comments on original draft of this report, January 2007.
[21] *Op cit* note 1.
[22] Regulation No. 7.
[23] *Op cit* note 1.

The two primary problems noted by SADC countries were the lack of commitment to implementation and the lack of personal leadership by political figureheads.

In **Swaziland**, political leadership fails to set a good example and encourage behaviour change. Politicians are often involved in multiple relationships and practice polygamy.[24] King Mswati III has 13 wives.[25]

In **Namibia**, it was reported that there has been political commitment since 2000 but there are problems such as: " A history of verbal attacks on gays/lesbians."[26]

Good Practice: Malawian Parliamentarians promote openness and disclosure

In **Malawi**, the parliamentary speaker Sam Mpasu revealed that between 1996 and 2000, 28 members of parliament had died from AIDS. In 2002 cabinet minister Thengo Maloya indicated that he had personally lost 3 children to AIDS and that 100 important officials had died from AIDS in the previous 6 years. In 2004 then President Bakili Muluzi revealed that his brother had died of AIDS and urged Malawians to challenge stigma and discrimination.[27] Since then he has repeatedly urged Malawians to be open about HIV and to go for voluntary counselling and testing.[28] Like his predecessor, the current President Dr Mutharika, also tested for HIV and declared his HIV negative status. Women parliamentarians have also openly been tested for HIV and encouraged others to do so.[29]

[24] Key informant interview with Sibonelo Mdluli, Women and Law in Southern Africa Trust (WLSA), 26 October 2006.
[25] 'Church decries Swaziland's "tragedy beyond comprehension"' afrol News, 4 May 2006, article posted on http://www.afrol.com/articles/12163
[26] Anonymous respondent to the questionnaire, 11 October 2006.
[27] HIV& AIDS in Malawi, AVERT, http://www.avert.org/aids-malawi.htm, last accessed on the 18 October 2006.
[28] Strong efforts against AIDS in Malawi afrol News, 25 February 2006 http://www.afrol.com/articles/11380, last accessed on the 4 September 2006.
[29] Key informant interview, Lot Nyirenda, Social Scientist, Research for Equity and Community Health (REACH) Trust, Malawi, 3 November 2006.

2.3.2 Multi-sectoral response to HIV/AIDS

The *International Guidelines* require governments to create an effective multi-sectoral framework to co-ordinate the national response to HIV/AIDS. There is also a SADC health protocol and two SADC declarations on multi-sectoral approaches to HIV and AIDS. The *SADC Health Protocol* (1999) deals with HIV/AIDS and sexually transmitted infections (STIs) and aims at promoting prevention and management policies that are inter-sectoral in nature. Both the *SADC Declaration on HIV/AIDS* (July 2003) and the *Maseru Declaration* issued by the Council of SADC Ministers promote multi-sectoral strategies to respond to HIV/AIDS.

In a review of fourteen SADC countries,[30] 92.8 % (n – 13) reported the existence of a multi-sectoral body that co-ordinated the response to HIV/AIDS.

Table 6: Creating a Multi-Sectoral Framework to respond to HIV/AIDS

Country	Multi-Sectoral Structure	Title
Angola	Yes	National Institute Against AIDS
Botswana	Yes	National AIDS Council
DRC	No multi-sectoral body	
Lesotho	Yes	National AIDS Committee (has representation of cabinet ministers) Lesotho AIDS Programme Co-ordinating Authority) based in Prime Minister's Office Multi-Sectoral Taskforce on HIV/AIDS (includes representation from various sectors)
Madagascar	Yes	National AIDS Council
Malawi	Yes	Malawian National AIDS Commission
Mauritius	Yes	National AIDS Committee (headed by Prime Minister)
Mozambique	Yes	National AIDS Council (headed by Prime Minister)
Namibia	Yes	National Multi-Sectoral AIDS Coordinating Committee (with representation from cabinet ministers) National AIDS Executive Committee (implementation body)
South Africa	Yes	South African National AIDS Council

[30] Angola, Botswana, DRC, Lesotho, Madagascar, Malawi, Mauritius, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

		Inter-Ministerial Committee (with representation from cabinet ministers)
Swaziland	Yes	National Emergency Response Council on HIV and AIDS
Tanzania	Yes	Tanzanian Commission for HIV/AIDS
Zambia	Yes	National AIDS Council
Zimbabwe	Yes	National AIDS Council

This report makes the following findings and recommendations on multi-sectoral frameworks to guide SADC country responses to HIV/AIDS:

<u>Finding:</u> Although most SADC countries had multi-sectoral structures in place, this report was unable to establish the effectiveness of such structures in engaging a range of sectors in the national HIV/AIDS response.

<u>Recommendation:</u> Advocate for institutional appraisals of the effectiveness of national AIDS councils in driving a multi-sectoral human rights based response to HIV/AIDS.

This report found that many countries have adopted a multi-sectoral response to HIV, through, for example, involving a range of government departments in creating a protective legal and policy framework. However, it is unclear to what extent national AIDS councils are truly representative and have been involved in driving rights-based initiatives.

In a detailed institutional appraisal of the first term of office of the South African National AIDS Council, it was found that although 5 technical task teams were set up to assist the Council with its work, these teams were never fully operationalised. The Chairperson of the Law and Human Rights Task Team expressed his frustration that although a presentation to Council on key human rights issues was given in February 2001, no further feedback was received. As far as he is aware only one of the human rights issues, relating to insurance, was ever taken further.[31]

[31] Strode A and Barrett Grant C, *A South African Examination of the Institutional Arrangements established to address the Challenges of HIV/AIDS* (2003), Institute for Democracy, Pretoria, South Africa.

.2.3.3 The Greater Involvement of PLHAs in HIV/AIDS Principle (GIPA)

The *International Guidelines* require states to ensure community consultation in all phases of HIV/AIDS policy design and programme implementation.

In a review of thirteen SADC countries,[32] an overwhelming majority of 84.6 % (n = 11) reported that there was only a limited adherence to the GIPA principle.

Table 7: Adherence to GIPA Principle in SADC

Country	Full involvement of PLHAs	Limited involvement of PLHAs
Angola		X
Botswana	X	
DRC		X
Lesotho		X
Madagascar	X	
Malawi	No information	
Mauritius		X
Mozambique		X
Namibia		X
South Africa		X
Swaziland		X
Tanzania		X
Zambia		X
Zimbabwe		X

The report made the following findings and recommendations with regard to extent to which SADC countries are committed to implementing the GIPA principle:

<u>Finding:</u> Despite the existence of multi-sectoral structures within SADC countries, there is limited adherence to the GIPA principle.

<u>Recommendation:</u> Advocate for more effective involvement of PLHAs in multi-sectoral structures (such as National AIDS Councils) and in all phases of HIV and AIDS policy and programme design, implementation and evaluation.

There appeared to be a number of different reasons put forward for the limited involvement of PLHAs. This ranged from the situation in Mauritius where there are reportedly only two PLHAs who are open about their HIV status and available to participate in multi-sectoral structures,[33] to South Africa and Mozambique where due to state funding of PLHA groups, many were afraid to criticise government as they were afraid of losing their funding.[34]

[32] Angola, Botswana, DRC, Lesotho, Madagascar, Mauritius, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.
[33] Personal communication, Mr Nicolas Ritter, PILS, Mauritius, 3 November 2006.
[34] Key informant interview, Yvonne Spain, Children in Distress Network, 17 October 2006.

<u>Finding:</u> PLHAs appear to be sidelined in multi-sectoral structures and other consultations because of a perceived lack of capacity.

<u>Recommendation:</u> Advocate for funding towards capacity development for PLHAs to enable them to participate fully in structures and consultations with government.

Although it appears that in most instances PLHAs are represented on national AIDS councils, one country reported that they do not have many opportunities to participate as equal partners in such structures. This may well be the position in other countries as well.

In **Swaziland**, NGOs were outraged when the National Multi-sectoral HIV and AIDS Policy stated that GIPA was optional – PLHAs "shall, where relevant, be actively involved in the planning, development, implementation, monitoring and evaluation of HIV and AIDS-related plans and programmes."[35] SWANNEPHA (Swaziland National Network of People Living with HIV/AIDS) has not signed the policy because of this clause.[36] PLHAs and members of civil society report that they are brought into processes but they have to simply act as spectators because they are told that they should not participate or comment on issues because they are not the experts. [37]

[35] National Multi-sectoral HIV and AIDS Strategy, Government of the Kingdom of Swaziland, draft document November 2005.
[36] Key informant interview with Tembi Nkambule, SWANNEPHA, 26 October 2006.
[37] *Op cit* note 35.

2.4 Ongoing Human Rights Issues

The discussion above has indicated that although there is political commitment towards HIV and AIDS in a number of countries, this has not lead to effective rights-based responses or the effective involvement of PLHAs in multi-sectoral structures and other consultations regarding HIV/AIDS policies and programmes. There are a number of ongoing human rights issues of priority concern in the region, set out in more detail below.

2.4.1 Independence of multi-sectoral structures

In a number of countries, multi-sectoral structures are not independent of government, and their position within government ministries leads to politicisation of key issues. Additionally, some countries have repressive legislation that limits freedom of expression, preventing opponents from expressing criticism of the national response to HIV and AIDS. In other countries there is a climate of fear that prevents the full participation of all sectors in the national HIV/AIDS response. In these circumstances, multi-sectoral structures are prevented from functioning effectively.

Finding: A multi-sectoral response requires the full and equal participation of all sectors. Partnerships of this nature are only possible if all sectors are able to freely express their views on the national response to HIV.

Recommendation: Advocate for the strengthening of the independence of national AIDS councils by making them statutory bodies with defined powers and responsibilities, as well as defined representation from all relevant sectors.

In a number of countries it was reported that criticism of government policies was frowned upon, and that national AIDS councils were not fora at which frank discussions on the successes and failures of the national response to HIV could be discussed.

In **Zimbabwe** Human Rights Watch reported:

> "The government's inclusion of HIV/AIDS organisations and PLHAs in national HIV/AIDS strategies has done little to increase debate and activism on HIV/AIDS or to improve the rights of PLHAs. Human Rights Watch is concerned that a climate of fear exists in Zimbabwe that curtails people's ability to exercise their right to freedom of expression, association and assembly. PLHA and HIV/AIDS activists to whom Human Rights Watch researchers spoke reported problems expressing their concerns within the context of advocating for HIV/AIDS and human rights. The government was particularly hostile when they commented on the human rights ramifications of government policies on PLHAs, financial management or equitable distribution of resources to HIV/AIDS associations and NGOs"[38].

[38] Human Rights Watch, www.hrw.org

In **South Africa** in an institutional appraisal of the South African National AIDS Council, it was found that sectors do not participate fully within SANAC. Furthermore although there was a culture of decisions based only on consensus, NGOs reported that there was an unofficial sense that it would be inappropriate to criticize government policy within SANAC; thus participation took place within this culture of 'silence' and acquiescence.[39]

2.4.2 Sidelining of national AIDS councils from decision making processes

In a number of countries although multi-sectoral bodies exist, key decisions are not made at these forums.

<u>Finding:</u> National HIV/AIDS policies continue to be developed primarily by ministries of health. Legislation is also in many instances driven by health departments. National AIDS councils were not found to be playing a significant role in law reform.

<u>Recommendation:</u> Advocate for clear delineation of the policy and law reform role of national AIDS councils, ideally set out in statute (see Recommendation in 2.4.1 above)

Multi-sectoral structures could play an important role in identifying and lobbying for law reform. Given that these structures represent a wide range of different sectors, they are an ideal place to voice concerns regarding limitations within the current legal and policy framework.

In **South Africa**, Lawyers for Human Rights stated "The South Africa National AIDS Council has been in existence since 2000 but it still isn't functioning. It isn't advising cabinet on key decisions".[40]

2.4.3 Tokenistic use of PLHAs in law reform and policy-making

Many NGOs reported that PLHAs were either involved in a tokenistic manner or they were excluded from decision making processes.

<u>Finding:</u> Although PLHAs are represented on structures, their views are not fully reflected in the development of policies and programmes.

<u>Recommendation:</u> Advocate for the broader representation of PLHAs organisations on national AIDS councils. Advocate for the adoption of process policies within national AIDS councils that enable a range of views to be heard

[39] *Op cit* note 31.
[40] Key informant interview with Lawyers for Human Rights, 22 September 2006.

before decisions are made on the basis of consensus. Advocate for capacity building for PLHAs.

PLHAs are an important sector within our communities and they ought to be fully represented in national AIDS councils. However PLHAs ought to be involved as equals and not simply as a means of formalistically complying with the GIPA principle.

Civil society is represented in the **Zambian** National AIDS Council but the impact of their participation on decision-making is limited, and NGO report that participatory processes are often organised to simply rubberstamp decisions on government policy.[41] For example, only one PLHA organisation, NZP+, has been included on the National AIDS Council. The NZP+ is funded by government and has not attempted to get any mandate from other organisations.[42]

The **Tanzanian** National Network of People with HIV/AIDS complains that PLHAs are simply the recipient of services and are not involved in decision making.[43]

Human Rights Watch reports that there is only the superficial involvement of PLHAs in **Zimbabwe**:
"The government's inclusion of HIV/AIDS organisations and PLWHAs in national HIV/AIDS strategies has done little to increase debate and activism on HIV/AIDS or to improve the rights of PLWHA."[44]

In **Botswana** it was noted that PLWHA generally do not feel involved in decision making processes.[45]

The Mozambiquan Access to Treatment Movement reports that the GIPA principle is lacking in **Mozambique**:

"…. in most cases (PLHAs) are involved as tokens but not in decision making, since (they) cannot contribute (or) even address the concerns of PLHAs, since they are funded by the government."[46]

[41] Jones PS (2005) 'On a never-ending waiting list: Toward equitable access to anti-retroviral treatment? Experiences from Zambia' *Health and Human Rights Journal,* Volume 8 No 2, 77-102 at page 95. Key informant interview with Kaumba Mwondela, Zambia AIDS-law research and advocacy network (ZARAN), 26 October 2006.
[42] Key informant interview with Kaumba Mwondela, Zambia AIDS-law research and advocacy network (ZARAN), 26 October 2006.
[43] Key informant interview with Alex Margery, Tanzanian National Network of People with HIV/AIDS, 11 October 2006.
[44] *Op cit* note 38.
[45] with Nthabiseng Nkwe of Bonela, in Johannesburg, October 2006
[46] Key informant interview with Caesar Mufanequico, Mozambiquen Access to Treatment Movement, 26 October 2006.

2.5 Conclusions, Challenges and Recommendations

The Guidelines give very clear guidance on the steps that governments ought to take to establish a representative, inclusive and multi-sectoral framework to guide the national response to HIV/AIDS. This report shows that significant progress has been made in leadership's willingness to talk about HIV/AIDS, as well as in the establishment of a multi-sectoral framework (through the appointment of multi-sectoral structures). However, it appears that it many instances this has not resulted in the greater involvement of a range of other sectors in a rights-based response to HIV and AIDS.

Conclusion: There is political commitment to HIV/AIDS as a human rights issue within most SADC countries. However this has not necessarily lead to effective rights based responses within countries.

Most countries reported political commitment to HIV/AIDS as a human rights issue. However, human rights around HIV and AIDS were not necessarily reflected in policies and programmes, and implementation of adopted policies and programmes has been weak. This makes it appear that the political commitment to HIV/AIDS is often superficial.

Challenge: Developing a culture of political commitment to HIV as a human rights issue within a context of a lack of a general lack of respect for human rights.

A number of SADC countries are emerging from long periods of conflict; in others human rights have been undermined by repressive governments. In this context it is extremely challenging to obtain commitment to rights-based responses to HIV.

Challenge: Guiding political leadership towards a concrete, action-oriented response to HIV and AIDS.

Political leaders may well need concrete guidance, in the form of key goals, objectives and activities with dedicated time frames, to respond appropriately to HIV/AIDS as a human rights issue.

Recommendation: Identify, possibly through further research on successes and failures outside of Africa, ways to ensure that committed leadership begin to develop and implement rights-based policies and programmes on HIV/AIDS.

Although countries reported on a range of positive steps taken by politicians such as public disclosure of HIV status, more research is needed into possible advocacy and support to political leaders so that they may take concrete actions to reflect their commitment to responding to HIV in a holistic manner.

<u>Conclusion:</u> Multi-sectoral structures exist in most SADC countries but it was unclear whether true multi-sectoral responses existed.

In many instances although multi-sectoral bodies existed, NGOs reported that key sectors were excluded from participating; key decisions were not made at such forums and the multi-sectoral bodies lacked the capacity or resources required to effectively co-ordinate the national response.

<u>Challenge:</u> The full involvement of PLHAs in multi-sectoral structures remains a key challenge in SADC countries.

Most countries reported that PLHAs were not involved as equal partners in multi-sectoral bodies.

<u>Challenge:</u> The independence and effectiveness of multi-sectoral structures is at times questionable.

The creation of multi-sectoral structures headed by strong political figures has, in some instances, led to fear amongst non-governmental and community representatives of participating in a critical and challenging manner. This renders the work of these structures ineffective.

<u>Recommendation:</u> Advocate for independent multi-sectoral structures with a balance, in terms of membership, between government and other sectors. Advocate for the greater involvement of all sectors, but particularly PLHAs.

A careful balance ought to maintained between all the relevant sectors, with no one sector dominating the multi-sectoral structure. In practice, many multi-sectoral structures are dominated by government ministries and this has led to such bodies not being truly multi-sectoral and unable to take on key issues that challenge current government policy and strategy towards HIV and AIDS.

Chapter Three: Legal and Policy Framework

3.1 Introduction

Developing a protective legal and policy framework based on human rights principles requires a commitment to ensuring that:

- Laws and policies protect people infected and affected by HIV from discrimination;
- Laws and policies protect vulnerable people from the risk of HIV infection, create an effective framework for prevention and treatment responses to HIV; and
- Laws and policies set standards of appropriate conduct and sanctions if these standards are not met.

To meet this commitment, states need to audit or review existing legislation and policies to ensure that they comply with human rights principles and achieve public health objectives of effectively managing the epidemic. This chapter of the report reviews the progress made by governments in the SADC region towards these twin goals. It focuses on two areas where most legal review has taken place: criminal law and anti-discrimination measures.

3.2 HIV/AIDS and Human Rights Guidelines

There are four guidelines relevant to developing a protective legal and policy framework. They require states to review and develop law in four specific areas so as to ensure that the law protects the rights of persons infected and affected by HIV/AIDS. The four relevant guidelines are:

GUIDELINE 3: PUBLIC HEALTH LEGISLATION
States should review and reform public health legislation to ensure that they adequately address the public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.

GUIDELINE 4: CRIMINAL LAWS AND CORRECTIONAL SYSTEMS
States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted at vulnerable groups.

GUIDELINE 5: ANTI-DISCRIMINATION AND PROTECTIVE LAWS
States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality and ethics in research involving human subjects, emphasise education and conciliation and provide for speedy and effective administrative and civil remedies.

GUIDELINE 6: REGULATION OF GOODS, SERVICES AND INFORMATION
States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and safe and effective medication at an affordable price.

3.3 Progress in Implementation

In 13 out of the 14 SADC countries surveyed, all had either taken steps towards or were in the process of reviewing their legal and policy framework in order to reform this environment.[47]

3.3.1 Reform of Public Health Laws

Guideline 3 requires states to ensure that public health legislation does not inappropriately deal with HIV/AIDS and that its provisions are consistent with human rights.

Of the eight SADC countries surveyed,[48] 50.0 % (n = 4) had introduced HIV-specific public health legislation. However a further 50.0 % (n = 4) had existing or proposed public health legislation that was broad enough to use within the context of HIV/AIDS.

Table 8: Use of public health legislation to deal with HIV in SADC countries

No information	Public health legislation dealing directly with HIV	Non-HIV-specific public health legislation	No public health legislation
Lesotho	Angola	Botswana	DRC
	Mauritius (draft legislation) Madagascar	Malawi (proposed law reform) Madagascar (proposed law reform)	
Mozambique	South Africa	Zimbabwe	
Namibia			
Swaziland			
Tanzania			
Zambia			

This report makes the following findings and recommendations with regard to HIV/AIDS and public health legislation in SADC:

<u>Finding:</u> Recent HIV-related public health legislation adopted in some SADC countries appears to be based on human rights principles.
<u>Recommendation</u>: Advocate for HIV-specific public health legislation in other SADC countries

[47] Only the DRC has not taken any steps towards developing a protective legal framework. Obviously, the lack of progress in the DRC must be seen against the backdrop of its regional war between the Congolese government and Uganda and Rwanda-backed Congolese rebels since the late 1990s has which has left 2,3 million Congolese internally displaced and caused more than 412 000 Congolese refugees to flee to other countries. Although peace was officially declared two years ago, there have been several waves of violence in the Katanga Province. *CIA World Factbook*, https://cia.gov/cia/publications/factbook/geos/cg.html, last accessed on the 18 September 2006.

[48] Angola, Botswana, DRC, Madagascar, Mauritius, Malawi, South Africa and Zimbabwe.

The recent legislative developments in Angola and Mauritius seem to indicate a new trend in public health legislation that is firmly based on human rights principles.[49] Mauritius is also the only SADC country that has begun dealing with the transmission of HIV through intravenous drug use.

Best Practice: Public Health Laws

The **Angolan** *Law on HIV and AIDS*, Article 1 states that this law aims at

" (a) Guaranteeing the protection and integral promotion of the health of all people …
(b) Establishing the rights and duties of people infected by HIV or sick with AIDS"

In **Mauritius** the draft *HIV and AIDS Preventative Measures Bill* (2006) has a number of provisions outlawing discriminatory testing. Section 6 states:

"No person shall induce or cause another person to undergo an HIV test as a condition of employment or continued employment"

<u>Finding:</u> Recent HIV-related public health legislation has provisions dealing with harmful HIV-related behaviour
<u>Recommendation:</u> Encourage the use of public health law (as opposed to criminal law) to deal with harmful HIV-related behaviour

This report shows that harmful HIV-related behaviour appears to be a major issue for legislators in SADC, and many countries have responded with criminal law measures to deal with it (*See 3.3.2, below*).

In both Angola and Mauritius[50] provision is made in the public health law to deal with harmful HIV related behaviour. For example, in the Angolan legislation it provides that PLHAs are under a duty to:

- Practice their sexuality responsibly;
- Adopt habits that limit the possibility of infecting others;
- Use condoms; and
- Disclose their HIV status to sexual partners[51]

The use of public health law rather than criminal law to deal with harmful HIV-related behaviour is to be supported. However, public health provisions to deal with harmful HIV-related behaviour still need to strive towards creating a balance between public health and human rights.

[49] Law on Human Immunodeficiency Virus and the Acquired Immune Deficiency Syndrome, Law n.8/04 and the HIV and AIDS Preventative Measures Bill, 2006.
[50] *Ibid.*
[51] Article 14, Law on Human Immunodeficiency Virus and the Acquired Immune Deficiency Syndrome, Law n.8/04.

3.3.2 Reform of Criminal laws

Guideline 4 requires states to review and reform their criminal law so as to ensure that it is not inappropriately used in the context of HIV/AIDS and it does not target vulnerable groups.

In a review of the legislation in twelve SADC countries[52] it was found that considerable law reform had occurred. 33.3 % (n = 4) of the countries had introduced or were in the process of introducing law criminalising the wilful transmission of HIV. 50% (n= 6) had introduced harsher sentences for rapists who were found to have known their HIV status at the time of the rape. 41.7 % (n = 5) required rapists to be tested for HIV. However only 41.7 % (n = 5) had introduced or proposed a programme of providing post-exposure prophylaxis (PEP) to rape survivors.

Table 9: Use of criminal law in responding to HIV in SADC countries

Country	No special HIV crime	Special deliberate infection with HIV crime	Public health measures for harmful HIV related behaviour	Harsher sentences for HIV+ rapists	Compulsory testing of rapists	PEP programme
Angola			X			
Botswana	X		X	X	X	
DRC	No information					
Lesotho		X		X	X	X
Madagascar		X	X			Proposed in National Strategic Framework 2007-2012
Malawi	Proposed law reform of Penal Code but not HIV specific					
Mauritius			X			
Mozambique	X					
Namibia	X	Calls for new legislation		X		X
South Africa	X			X	X (draft bill)	X
Swaziland		X (draft bill)		X		X

[52] Angola, Botswana, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

Tanzania	No information					
Zambia	X	Calls for new legislation			X	
Zimbabwe		X		X	X	

This report makes the following findings and recommendations relating to criminal law and HIV/AIDS:

<u>Finding:</u> A number of countries have introduced new legislation creating specific offences regarding the wilful transmission of HIV, contrary to the guidance provided in the International Guidelines on HIV/AIDS and Human Rights. [53]

<u>Recommendation:</u> Discourage the use of criminal law and advocate for use of public health law to deal with harmful HIV-related behaviour. Undertake further research into the use of such legislation to deal with harmful HIV-related behaviour within the region.

New legislation has been introduced in Lesotho, Swaziland and Zimbabwe criminalising the wilful transmission of HIV. There are also calls for the criminalisation of HIV in Namibia and Zambia.

> In **South Africa**, the AIDS Law Project reports:
>
> "The *Criminal Laws (Sexual Offences and related Matters) Amendment Bill* (commonly called the *Sexual Offences Bill*) in South Africa has been debated since 1997, and various versions of the Bill have included sections that would make it a criminal offence to have unprotected sex when a person knows that s/he is HIV-positive. The August 2006 version of the Bill has fortunately excluded these proposed provisions, but it is necessary that civil society is vigilant so that these sections do not find their way into later versions of the Bill."[54]

It is uncertain why legislatures have elected to create new crimes to deal with harmful HIV-related behaviour given that in all SADC countries common law or penal code crimes exist which could be used to prosecute persons who deliberately infect others with HIV. It may be that legislatures wished either to confirm or clarify the existing legal position or they may have been under political pressure to create a 'new' offence. For example, in Lesotho, a new crime of wilful transmission of HIV has been created which is very broadly worded and extends liability to persons who fail to disclose their HIV status to their sexual partners.

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[53] UNAIDS "Criminal Law, Public Health and HIV Transmission: A Policy Options Paper" Prepared for UNAIDS by Richard Elliott, Canadian HIV/AIDS Legal Network, Montreal, Canada, 2002, UNAIDS/02.12E Available: http://data.unaids.org/Publications, last accessed on the 21 November 2006.

[54] Heywood M "Human rights and HIV/AIDS in South Africa – An Assessment" paper presented at ARASA Civil Society Conference, October 2006, Johannesburg, South Africa.

In **Lesotho**, the *Sexual Offences Act* (2003) criminalises wilful HIV transmission. It also criminalises consensual sex where one of the parties fails to disclose their HIV status.[55] It is not clear whether the use of safer sex techniques would be a defence in this instance.

In **Swaziland**, the draft *Sexual Offences and Domestic Violence Bill* initially contained provisions such as:

(i) The criminalisation of the wilful transmission of HIV
(ii) Presumptions that a person has transmitted HIV if his or her partner dies of HIV
(iii) The imposition of the death penalty for rape cases where the perpetrator had HIV[56]

Local and international NGOs such as Amnesty International and UNICEF intervened and managed to get some of these offensive sections removed from the Bill. Nevertheless, there are concerns that they may find their way back into the legislation.[57]

It is also unclear whether these statutory provisions are being used to deal with harmful HIV-related behavior. None of the countries surveyed reported any prosecutions of PLHAs charged with the crime of wilful transmission of HIV.

Finding: Some countries have developed new laws providing for harsher sentences for persons who commit the crime of rape whilst knowing they are living with HIV. However in practice such laws are difficult to apply.

Recommendation: Advocate for the development of prosecutorial guidelines on when and how to apply knowledge of HIV status as an aggravating factor in sentencing, to promote appropriate use and avoid misuse of laws.

The move towards developing legislation providing for harsher sentences for persons who commit rape whilst knowing they are HIV positive is to be supported, bearing in mind the difficulties of proving that a person knew his or her HIV status.

In the **Botswanan** case of case of *Qam Nqubi v The State*[58], the court held the accused's HIV status could not be regarded as an aggravating factor as there was no proof that the offender was HIV positive at the time that the rape was committed, which was a precondition for the imposition of the minimum of 15 years imprisonment.

Finding: An increasing number of countries have introduced law reform requiring the compulsory HIV testing of sexual offenders.

Recommendation: Discourage laws that require inappropriate compulsory HIV testing of sexual offenders.

An increasing number of countries have introduced legislation requiring a person convicted of a sexual offence to be tested for HIV. It appears that the purpose of

[55] 'New laws to strengthen HIV/AIDS action' http://www.africafiles.org/printableversion.asp?id4577, last accessed on the 14 September 2006.
[56] *Op* cit note 24.
[57] *Op* cit note 56.
[58] Criminal Appeal 49/2000.

HIV testing at this point (that is, after a person has been convicted of the crime) is to assist the court with determining an appropriate sentence. If this is correct it is cause for concern, as an HIV test undertaken on conviction cannot establish whether the offender was aware of their HIV status at the time of the rape, as was held in the *Qam Nqubi v The State*[59] case. Furthermore although superficially this may appear to be a reform that is aimed at assisting the survivors of sexual violence, knowledge of the offender's HIV status some months or years after the rape is of little value. Law or policy reform towards developing a package of services for the survivors of rape, such as immediate access to PEP, would be of far greater value.

It is only in South Africa that it appears that compulsory testing of sexual offenders is linked to providing the survivor of sexual violence with information to protect their health. HIV testing may however only be done by order of a magistrate, under certain conditions, in order to protect people accused of a sexual offence from arbitrary forced HIV testing.

The *Criminal Law (Sexual Offences and Related Matters) Amendment Bill* (B – 2006) provides in s 33:

"(1)*(a)* Within 60 days after the alleged commission of a sexual offence any victim or any interested person on behalf of a victim, may apply to a magistrate, in the prescribed form, for an order that—

(i) the alleged offender be tested for HIV and that the results thereof be disclosed to the victim or interested person, as the case may be, and to the alleged offender; or

(ii) the HIV test results in respect of the alleged offender, obtained on application by a police official as contemplated in section 37, be disclosed to the victim or interested person, as the case may be."

Section 37 of Bill describes the purpose of this compulsory testing as:

"The results of an HIV test may only be used in the following circumstances:

(a)To inform a victim or an interested person whether the alleged offender in the case in question is infected with HIV with the view to—

(i) making informed personal decisions; or

(ii) using them as evidence in any ensuing civil proceedings as a result of the sexual offence in question; or

(b*)* to enable an investigating officer to gather information with the view to using them as evidence in criminal proceedings."

<u>Finding:</u> Few countries have introduced PEP programmes for the survivors of rape.

<u>Recommendation:</u> Advocate for PEP programmes for rape survivors as part of a holistic package of services offered to the survivors of rape.

Only seven countries had programmes to provide PEP to the survivors of rape. Of these countries, only Lesotho and South Africa have created or are in the processes of ensuring that rape survivors have a legal right to PEP. Given the high levels of sexual violence in the region, the high prevalence of HIV and the

[59] *Op cit* note 58.

risks of exposure to HIV during a sexual assault, this is a matter of grave concern (see table 25 in 4.4.2 below).

3.3.3 Reform of Anti-Discrimination Measures

Guideline 5 requires states to enact or strengthen anti-discrimination laws to protect people infected and affected by HIV. In the implementation discussion under Guideline 5 it is recommended that governments do this by developing or revising general anti-discrimination laws to cover PLHAs.[60]

Within SADC, the *Abuja Declaration on HIV/AIDS* (2001) commits African nations to taking priority actions to fight HIV/AIDS, TB and other related infections. It prioritises human rights, and recognises that "stigma, silence, denial and discrimination against people living with HIV/AIDS increases the impact of the epidemic"[61]

A review of the legislation and policy in thirteen SADC countries[62] shows that 84.6 % (n = 11) had either a law or national policy prohibiting unfair discrimination against PLHAs. In 53.8 % (n = 7) of these countries this protection was found within policies. In only 30.8 % (n = 4) of these countries was there legal protection.

Table 10: General equality legislation prohibiting unfair discrimination on the basis of HIV status

No information obtained	No policy or law	HIV specific law	General equality law	Policy only
Lesotho	DRC	Angola	South Africa	Botswana
	Mozambique	Mauritius		Malawi
		Madagascar		Namibia
				Swaziland
				Tanzania
				Zambia
				Zimbabwe

In the area of HIV/AIDS and employment, however, SADC countries have adopted a wide range of laws and policies to manage HIV/AIDS and human rights in the workplace. Of the thirteen SADC countries reviewed[63] 69.2 % (n = 9) had laws (even if they were not HIV specific) which could be used to protect PLHAs from unfair discrimination in the workplace. In 38.5 % (n = 5) of the countries had adopted HIV specific codes of good practice for the workplace.

[60] *HIV/AIDS and Human Rights: International Guidelines* (1996) issued by the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, available from www.unaids.
[61] Available at www.un.org , last accessed on the 7 September 2006.
[62] Angola, Botswana, DRC, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.
[63] Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

Table 11: Best Practices in Employment Laws and Codes

Country	Law or code regulating HIV/AIDS and Employment
Angola	*Law on HIV and AIDS* (2004) prohibits unfair discrimination in the workplace; employers are under a duty to educate and train workers on HIV/AIDS. A violation of these provisions makes the employer liable for a fine of which 50 % is paid to the National Programme to fight AIDS. Further details are contained within *Order No. 43/03* (July 2003), the *Regulations of HIV/AIDS in Employment and Professional Training*
Botswana	Directorate of Public Service Management published the *Public Service Code of Conduct on HIV/AIDS and the Workplace* (2001). This Code: • Sets out the rights and responsibilities of employers and employees • Places an obligation on management to create a non-discriminatory environment *Botswana National Code of Practice on HIV/AIDS and Employment*. The Code is not legally enforceable but it sets out standards for an appropriate response to HIV within the workplace. It discourages pre-employment HIV testing
DRC	No legislation or policy
Lesotho	Public Service has a *Public Service HIV and AIDS in the Workplace Policy*. This prohibits unfair discrimination and mandatory HIV testing. A draft bill has been put before parliament, the *Legal Instrument on HIV/AIDS and Employment*. It requires employers to respond to HIV by, for example, developing an HIV policy. It also prohibits unfair discrimination
Madagascar	Law No.2005-040 prohibits unfair discrimination in the workplace see Title III, Chapter IV, article 44-55.
Malawi	The *Code of Conduct on HIV/AIDS and the Workplace* acts as a guide to employers, trade unions and employees
Mauritius	The draft *HIV Preventative Measures Bill* (2006) prohibits pre-employment HIV testing as a condition of employment. Testing may also not be done as a pre-condition for workplace training or promotion
Mozambique	*Law No.5/2002* protects employees against discrimination in the workplace. It doesn't specifically mention HIV but is broad enough to cover HIV
Namibia	*National Code on HIV/AIDS and Employment* (2000) was promulgated in terms of s 112 of the Labour Act. The Code prohibits pre-employment HIV testing and unfair discrimination. In the new Labour Act which will be promulgated in 2007, HIV is listed as a specific prohibited ground of discrimination in access to or continued employment.
South Africa	Unfair discrimination due to an employee or job applicant's "HIV status" is prohibited by s6 of the *Employment Equity Act* 1998). HIV testing without Labour Court authorisation is prohibited by s 7 of the Act. A *Code of Good Practice on Key Aspects of HIV/AIDS and Employment* is attached to the Act. It aims at giving guidance on creating a non-discriminatory environment and managing the impact of HIV/AIDS on the workplace
Swaziland	S 29 of the *Employment Act* of 1980 says that employers may not discriminate in any employment contract. HIV is not referred to but it could fall under "social status"
Tanzania	No information
Zambia	The *Employment Act* Cap 268 and *Industrial Relations Act* Cap 269 protects workers against discriminatory practices. It is not HIV specific
Zimbabwe	*Labour Relations Act*, Part II protects employees against discrimination. Although this does not mention HIV, regulations issued under the Act (*Statutory Instrument* 202 of 1998) prohibit discrimination based on HIV/AIDS in the workplace

Based on this information, this report makes the following findings and recommendations:

<u>Finding:</u> Very few countries have introduced specific legislation to outlaw HIV-related unfair discrimination, and most countries simply provide that unfair discrimination against PLHAs is prohibited in HIV-related policies. This appears to be ineffective as stigma and discrimination continue to be a significant barrier to the access of services and to enhancement of openness and disclosure.

<u>Recommendation</u>: Advocate for HIV-specific anti-discrimination legislation.

Only Angola and Mauritius (in the form of its draft legislation) have HIV specific legislation that outlaws discrimination. South Africa has specific equality legislation; however the legislation does not list "HIV status" as a prohibited ground on which no person may discriminate.[64]

Good Practice: Anti-Discrimination Laws

Angola has passed the *Law on HIV and AIDS,* which provides expressly that PLHAs are entitled to be protected from discrimination. It also expressly protects soldiers from pre-employment HIV testing[65]

South Africa has passed the *Promotion of Equality and Prevention of Unfair Discrimination Act* (2000). This Act outlaws unfair discrimination.[66] Section one of the Act defines unfair discrimination as being when something imposes a burden on someone or denies them an opportunity. For example, the Act says that it is unfair discrimination to prevent women from inheriting property as this places economic and social burdens on women. Although the Act does not list "HIV status" as one of the grounds on which a person cannot discriminate, its provisions are broad enough to include this kind of discrimination.

The Mauritian legislation in its current form is very limited. It essentially limits HIV testing to testing with a legitimate purpose but doesn't prohibit unfair discrimination as such.[67] This means that, for example, the Bill will not be able to be used to protect prisoners being unfairly discriminated against.

In **Mauritian** prisons it is reported that:
"Human rights are not respected in prisons. There is segregation of HIV prisoners in the 'new wing'. All HIV positive prisoners are taken there – tests are done without their consent or counselling. The families are not aware of their HIV status until they see that they have been transferred to new wing – thus breach of confidentiality. Treatment is generally worse in the new wing. They are not allowed to work in prison, even though they want to. ….. People on ARVs are stigmatised."[68]

[64] *Promotion of Equality and Prevention of Unfair Discrimination Act*, No. 4, 2000.
[65] Article 5, *Law on Human Immunodeficiency Virus and the Acquired Immune Deficiency Syndrome*, Law n.8/04.
[66] S 6, Act, No. 4, 2000.
[67] S 6, *HIV and AIDS Preventative Measures Bill*, 2006
[68] Key informant interview with Ms A D'Hoffman de Villliers, PILS, Mauritius, 19 October 2006.

Although most countries have national policies prohibiting unfair discrimination, this does not appear to have had a significant impact on the levels of stigma and discrimination in the region. Other than the DRC, all other countries reported varying levels of stigma and discrimination as human rights abuses.

PILS in Mauritius gave the following examples of wide-ranging discrimination in **Mauritius**:

"We have numerous reports of patients being refused treatment and admission at the public hospitals because they have HIV. For example, one case concerned a person in a private clinic that was tested without his knowledge or consent and upon found HIV positive was made to pay a huge fee for the linen and other material that had to be burned. A HIV positive female drug addict attending a rehabilitation centre was not allowed to have a tooth removed because of her serological status. A woman was dismissed from her new job because the co-workers had heard of her HIV status and refused to work with her. A PLWA was refused heart bypass surgery due to his HIV status"[69]

In a number of countries the discriminatory attitudes of health care workers continue to act as a barrier to PLHAs accessing services.

In **Swaziland**, it was reported that stigma and discrimination by health care workers are common and range from disclosure of HIV status without consent to ridicule and refusal of services.[70] Similar views were expressed from Tanzanian PLHAs who stated that "in many instances, health care workers stigmatise us and make us wait for up to 10 hours before we receive treatment."[71]

Stigma and discrimination are continuing to perpetuate a climate of fear, silence and denial.

In **Malawi**, the Centre for Human Rights and Rehabilitation reports "societal discrimination against persons living with HIV/AIDS is widespread and it inhibited access to treatment; many individuals prefer to keep silent about their health rather than to seek help and risk being ostracized."[72] They cite a press report on August 2003 which observed that "according to research by MANET, health workers around the country were demanding sexual, monetary and other favours from people living with AIDS to get proper treatment and care. This puts them at risk of transmission and re-infection. Medication is usually denied when patients are deemed as nearing death."[73]

A similar point regarding fear was articulately made in the *Hoffmann v South African Airways* case: "They (PLHAs) have been subjected to systemic disadvantage and discrimination. They have been stigmatised and marginalised … Society's response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received. People who are living with HIV/AIDS are one of the most vulnerable groups in our society."[74]

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[69] Key informant interview with Dhiren Mohar, PILS, Mauritius, 26 October 2006. This matter is currently before the courts.
[70] de Bruyn, M 'Reproductive rights for women affected by HIV/AIDS?' (2005) Ipas.
[71] *Op cit* note 43.
[72] *Malawi Human Rights Report* (2003-2004) Centre for Human Rights and Rehabilitation, available from www.chrr.org.mw, last accessed on the 21 November 2006.
[73] *Ibid*.
[74] 2001 (1) SA 1 (CC) at para. 28.

<u>Finding:</u> Most countries have taken steps to protect the rights of employees with HIV/AIDS through either legislation or codes. This has had a significant impact on reducing unfair discrimination in the workplace. In countries where no legal protection exists, discrimination continues unabated.

<u>Recommendation</u>: Advocate for all SADC countries to adopt legislation protecting HIV positive employees and prohibiting pre-employment HIV testing.

In **Mauritius**, PILS notes"
"Many people have lost their jobs – the discrimination is not openly on the basis of HIV status, the employer just says that they are not doing well or fires them for another reason. People also don't come forward to raise such abuses because of stigma"[75]

3.3.4 Reform of laws regulating access to affordable medication

Guideline 6 deals with the regulation of goods, services and information. In 2002, it was revised by the Office of the High Commissioner for Human Rights and UNAIDS. The new version makes it clear that governments are under a duty to ensure that there is access to ARV treatment through the public health services.

This revision reflects the growing international acceptance that ARV treatment forms a key component of the right to the highest attainable standard of health; a right contained both within the Universal Declaration of Human Rights and the International Convention on Economic, Social and Cultural Rights.[76]

<u>Finding:</u> This report was unable to find useful information regarding the regulation of affordable medication in SADC countries. Either this information is available, but not accessible to human rights advocates in the area, or alternatively very little has been done in this area of law reform

<u>Recommendation:</u> Conduct intensive research, as well as advocacy, around law reform regulating access to affordable medication

3.3.5 Models of HIV/AIDS Law and Policy Reform within SADC Countries

The *International Guidelines on HIV/AIDS and Human Rights* do not specify a particular law and policy reform model. Instead they focus on the steps that must be taken in certain areas of the law in order to ensure that the rights of persons infected and affected by HIV are protected.

A review of the fourteen SADC countries showed that in all these countries, except for the DRC, there had been some form of law or policy reform with

[75] *Op cit* note 69.
[76] *Op cit* note 16.

regard to HIV as a human rights issue. Most countries, 57.1 % (n = 8) had reformed existing or new laws by inserting references to "HIV", "HIV status" or "health status". A further 23 % (n = 3) of these countries had developed dedicated HIV legislation. Finally, a significant percentage of countries, 21.4 % (n = 3) had only established human rights principles in national policies.

Table 12: Law and policy reform models

Developed dedicated HIV legislation	Developed dedicated HIV public health legislation	Integrated HIV or general protections into new or existing laws	Used disability legislation to protect PLHAs	Developed HIV/AIDS policies on human rights	No law or policy reform
Angola	Mauritius (draft legislation)	Botswana		Malawi	DRC
Madagascar		Lesotho		Mozambique	
		Madagascar			
		Namibia		Tanzania	
		South Africa			
		Swaziland (draft legislation)			
		Zambia			
		Zimbabwe			

This report makes the following findings with regard to the process by which law reform takes place:

<u>Finding:</u> Integrated approaches to law reform appear more likely to involve a multi-sectoral response to HIV/AIDS

<u>Recommendation:</u> Advocate for integrated law reform approaches in SADC

Most SADC countries have adopted a gradual approach to creating a protective legal and policy framework. This has many advantages, particularly as it reflects a commitment to multi-sectoralism with a wide range of government ministries having to take responsibility for legislating to deal with HIV/AIDS. Law reform is then not spear-headed by, or seen as the sole responsibility of the ministry of health.

The impact of HIV/AIDS on children in Africa has been extensively documented.[77] In **Namibia** it is reported that there are currently 150 000 orphans.[78] This critical situation prompted the Namibian Ministry of Women's Affairs and Children's Welfare to develop new legislation on the status of children so as to ensure an appropriate response to the new social environment. The *Children's Status Bill*[79] was introduced and passed by Parliament in 2006[80]. Although the Act is not HIV specific, it deals with a range of social issues relating to the impact of HIV on children, including the death of a parent or care-giver. The Act now provides that where the sole custodian of a child dies, the surviving parent becomes the sole custodian.[81]

In **South Africa**, the Department of Social Development in South Africa also recently integrated specific HIV-related clauses into the reform of childcare legislation. The new *Children's Act*[82] has HIV specific provisions and provisions dealing with the "health status" of children. Section 13 provides every child (a person under the age of 18) has the right to privacy regarding their "health status". The Act also deals with a child's right to confidentiality regarding their HIV status. Section 133 says that no person may disclose the fact that a child is HIV positive without consent, except in certain defined circumstances.

<u>Finding:</u> Some countries have introduced dedicated HIV/AIDS legislation, although this legislation tends to be health-driven and does not cover a range of broader issues.

<u>Recommendation:</u> Advise caution with approaching HIV-related law reform by means of a single Act, for the reasons set out above. Dedicated HIV/AIDS legislation should be seen as part of a broader legislative agenda.

A limited number of SADC countries have introduced dedicated HIV/AIDS legislation. This type of legislation is very accessible and easy to find for non-lawyers. It can also be a speedy means of law reform as it does not require the amendment or development of a plethora of statutes.

[77] Hunter S, *Rethinking Development Paradigms in the Context of Extremely High Mortality in Sub-Saharan Africa*, Report prepared for UNICEF, August 1998, Daley S "Zambia, the Abandoned Generation" in the *New York Times*, Friday September 18, 1998.
[78] The Campaign towards Universal Access to HIV Prevention, Treatment, Care and Support: The Namibian Experience (May 2006), available from http://www.sadcpf.org, last accessed on the 18 September 2006.
[79] B. 23 – 2003.
[80] *Op cit* note 78.
[81] s 19, B. 23 – 2003.
[82] Act No. 38 of 2005, it should be noted that this Act has not as yet been operationalised.

Angola has passed the *Law on HIV and AIDS*[83], which deals with:

- The state's responsibilities;
- Coordination of the response to HIV/AIDS;
- The rights and duties of PLHAs, including the rights of prisoners and workers, the right to confidentiality and protection from HIV transmission;
- HIV information, education and research; and
- Prevention, control and treatment of HIV.

While the Act has a public health bias, it does try to deal with a range of issues. However, gaps include children's rights, social security provisions or measures to protect women. Accordingly, further law or policy reform will be required.

However, the difficulty with dedicated HIV legislation is that ministries of health generally drive it. It therefore does not significantly involve other role-players or regulate non-health issues. It also means that the legislative response remains health-focused and does not deal with some of the underlying cause of the rapid spread of HIV, such as gender inequality.

The **Mauritian** *HIV and AIDS Preventative Measures Bill* (2006) is a good example of public health legislation that deals with HIV/AIDS by simply regulating HIV testing, confidentiality, the transmission of HIV and syringe and needle exchange programmes. Resultantly, local NGOs have argued that the draft Bill ignores many key issues.[84]

<u>Finding:</u> The use of disability legislation to protect PLHAs is not used as a law reform approach in SADC countries.

<u>Recommendation:</u> Identify the reasons for the non-use of disability legislation to protect PLHAs in SADC, if considered to be a potentially useful mechanism for protection.

None of the countries surveyed had used disability legislation as a means of protecting PLHAs. Even in South Africa where the Constitution protects disabled persons against unfair discrimination[85] the Constitutional Court avoided making a finding that HIV was a disability in *Hoffmann v SAA*.[86]

In *Hoffmann v SAA* the Appellant argued that he had been unfairly discriminated against on the ground of disability, in that South African Airways had denied him employment as a cabin attendant solely because of his HIV status. The court found that the discrimination was unfair. However, it did not state whether the finding of unfair discrimination was made on the basis of disability or the ground of his HIV status.[87]

[83] Article 5, *Law on Human Immunodeficiency Virus and the Acquired Immune Deficiency Syndrome*, Law n.8/04.
[84] *Op cit* note 68.
[85] S 9, Constitution of the Republic of South Africa, 1996.
[86] *Op cit* note 74.
[87] *Ibid.*

In the draft Mauritian legislation, the *HIV and AIDS Preventive Measures Bill* expressly excludes HIV from the ambit of disability:

"Any person who is HIV positive or has AIDS shall not be considered as having a disability or incapacity by virtue of any enactment"[88]

Thus SADC countries appear to be approaching the protection of PLHAs against unfair discrimination in a different way to many developed countries such as the USA and Canada, where courts have accepted that HIV is a disability.[89] Although it could not be verified, this may be due to the general lack of disability legislation in the region making express HIV protections more appropriate. It may also be due to the seemingly common approach in the region of avoiding the designation of HIV as a disability.

Finding: Where human rights protections are not enshrined in law they provide limited, if any, protection.

Recommendation: Advocate that countries take human rights protections from HIV/AIDS policies, and enact as laws.

In Malawi, Mozambique and Tanzania human rights principles are established in national policies rather than laws. This appears to be an inadequate approach as policies do not create legal obligations and there is thus no redress if human rights are abused.

In **Zambia** the *Guidelines on HIV/AIDS Counselling* (2000) state that compulsory and mandatory HIV testing is a violation of human rights and shall only be allowed in exceptional circumstances.[90] The Guidelines also prohibit HIV testing and HIV-related discrimination or dismissals in the workplace.[91] Despite these Guidelines, during March 2002 the government introduced HIV testing for all its military recruits.[92] NGOs report that the parliamentary committee summoned the military to explain this, and they insisted that they no longer test recruits for HIV or exclude people on the basis of their HIV status.[93] However NGOs argue that the military are still continuing with this practice in contravention of the Guidelines.[94]

[88] S 3, HIV and AIDS Preventative Measures Bill, 2006.
[89] *Bragdon v Abbott* (1998) 524 US 624 and *Quebec (Commission des droits de la personne et des droits de la jeunesse) v Montreal (City)* 2000 SCC 27.
[90] *HIV/AIDS and human rights in Zambia* Centre for the Study of AIDS and the Centre for Human Rights, University of Pretoria, 2004, www.csa.org.za
[91] *Op cit* note 90.
[92] Noble R *HIV&AIDS in Zambia, prevention and care*, AVERT, http://www.avert.org/zambia-aids-prevention-care.htm, accessed 5 September 2006.
[93] *Op cit* note 41.
[94] *Ibid.*

In Botswana, there is no legislation which prohibits pre-employment HIV testing. However the *National Code of Practice on HIV/AIDS and the Employment* discourages pre-employment HIV testing of employees. [95] In the *Botswana Building Society* (BBS) matter an employee who had been hired as a security assistant was requested to undergo an HIV test. After testing HIV positive he was dismissed, included with the termination letter was a copy of the HIV test results.[96] The Court of Appeal found that pre-employment testing was not unlawful in Botswana as the National Policy had "never been translated into law and (has) no statutory authority".[97]

3.4 On-going Human Rights Issues

The discussion above has indicated that in a number of countries the legal framework is either not protective or there are gaps in it. There are a number of ongoing human rights issues of priority concern in the region, set out in more detail below.

3.4.1 HIV Testing and Discrimination in the Military

The discussion under Guideline 5 on anti-discrimination and protective laws provides that anti-discrimination legislation should prohibit HIV mandatory testing of vulnerable groups such as those working in the military.[98] Furthermore, the United Nations Security Council unanimously passed *Resolution 1308* which requires states to develop long term plans for AIDS education and prevention, voluntary counselling and testing, and appropriate treatment for uniformed personnel.[99] This Resolution needs to be read with the *HIV Testing Policy for Uniformed Peacekeepers*[100]*,* which strongly supports:

"*…. A policy of Voluntary Confidential Counselling and Testing. The UN does not require that individuals at any time be tested for HIV in relation to deployment as peacekeepers.*"[101]

A review of the legislation, policies and practises in nine SADC countries[102] shows that these principles are not being followed in practice.

Two thirds (n = 6) of the countries surveyed continue to use HIV testing as a means to keep HIV positive soldiers out of the military. It was reported that Lesotho also required HIV testing within its military but it could not be confirmed

[95] *Op cit* note 45.
[96] www.bonela.org, last accessed on 1 October 2006.
[97] Press release, BONELA, 10 February 2004, available from www.bonela.org, last accessed on the 9 November 2006.
[98] *Op cit* note 16.
[99] *On the Front Line* (2005) UNAIDS.
[100] Issued by the Office of Mission Support, Department of Peacekeeping Operations, January 2004.
[101] *Ibid* at point 4.
[102] Angola, Lesotho, Malawi, Mauritius, Namibia, South Africa, Swaziland, Tanzania and Zambia.

that HIV positive soldiers were being discriminated against. Only two countries, Malawi and Angola, were not using HIV testing to unfairly discriminate against soldiers.

In **Zambia** it is argued that PLHAs are being excluded from the military on the basis that they are not fit enough. [103] Likewise in **Swaziland**, recruits who test positive are not employed on the basis that they won't be able to do strenuous exercises.[104]

Furthermore 33.3 % (n = 3) of these countries specifically excluded soldiers from laws that protected other workers from unfair discrimination on the basis of their HIV status.

In **Mauritius**, **Namibia** and **South Africa** military personnel are excluded from legislative protections that protect other employees from unfair discrimination. For example, in Namibia, a *National Code on HIV/AIDS in Employment* was promulgated in terms of s 112 of the *Labour Act*. This Code prohibits pre-employment HIV testing and unfair discrimination due to an employee's HIV status.[105] However the *Labour Amendment Bill* (2000),exempts the defence force and police from s 107 of the Labour Act (the provision precluding unfair discrimination).[106] This means that military personnel do not have any express statutory protection against unfair discrimination due to their HIV status in either Namibia or Mauritius. In South Africa however there is the possibility of an action for unfair discrimination under the *Promotion of Equality and Prevention of Unfair Discrimination Act* and the AIDS Law Project is currently perusing this option.[107]

Although this could not be verified, it is also possible that pre- employment HIV testing is taking place in Botswana, the DRC and Mozambique as these countries have no specific legal prohibition against HIV testing for employees. Angola was the only country with express legislative protection for soldiers.[108]

[103] *Op cit* note 45.
[104] *Op* cit note 56.
[105] *The Campaign towards Universal Access to HIV Prevention, Treatment, Care and Support: The Namibian Experience* (May 2006), available from http://www.sadcpf.org, last accessed on the 18 September 2006.
[106] Mchombu C, *HIV/AIDS and Human Rights in Namibia* (2004) Centre for the Study of AIDS and Centre for Human Rights, University of Pretoria, Tshwane, South Africa.
[107] S 5, Act No. 4 of 2000 provides that the Act shall not have jurisdiction over matters falling under the *Employment Equity Act*, implying that persons excluded from the Act may proceed in terms of this one.
[108] Article 9, *Law on Human Immunodeficiency Virus and the Acquired Immune Deficiency Syndrome*, Law n.8/04.

Table 13: HIV testing within the Military

Country	Pre- or post-employment HIV testing not prohibited	Pre- or post-employment HIV testing is prohibited	Military excluded from ambit of protective employment legislation on HIV testing	HIV testing of military personnel takes place
Angola		X		Soldiers are expressly protected from the practice of pre-employment HIV testing
Botswana	X			No information
DRC	X			No information
Lesotho	X			Testing occurs but it could not be verified whether HIV positive soldiers are excluded from the military
Madagascar	No information	No information	No information	Testing occurs but on voluntary basis only. No information as to whether HIV positive soldiers are excluded.
Malawi	X			No testing takes place
Mauritius		X (Draft Bill)	X	Testing takes place
Mozambique	X			No information
Namibia		X	X	Testing takes place
South Africa		X	X	Testing takes place
Swaziland	X			Testing takes place
Tanzania	X			Testing takes place
Zimbabwe		X		No information
Zambia	X			Testing takes place

<u>Findings:</u> HIV testing and discrimination within the military is widespread within the SADC region, and anti-discrimination laws often do not extend to, and therefore protect those in the military.

<u>Recommendation:</u> Advocate for legal protection against unfair discrimination for soldiers.

It has been accepted internationally that pre-employment HIV testing cannot significantly reduce the impact of HIV on a workplace.[109] The continued practice of HIV testing within the military is therefore not only a human rights violation but also irrational. For example, despite this exclusionary approach to managing HIV within the Zambian military it has been reported that more personnel have been lost to AIDS-related illnesses than to military operations.[110]

Furthermore HIV testing is not a good indicator of physical fitness.

In the case of *Haindongo Nghipohamba Nanditume v Minister of Defence*,[111] the **Namibian** Defence Force argued that they were required by section 65(2) of the Defence Act[112] to submit all recruits to a medical examination. However the court found that an HIV test on its own could not establish whether a recruit was physically fit. HIV testing could only assist in the assessment of physical fitness if it was accompanied by a CD4 cell count and a viral load test. In this particular case the medical officer had certified that Nanditume was physically fit for military duties despite HIV status. Given this situation, the court held that the actions of the Namibian Defence Force constituted unfair discrimination as Nanditume had been excluded from the Defence Force solely on the basis of his HIV status.[113]

Finally, the management of HIV and AIDS in the military conflicts with the general approach adopted by national HIV/AIDS programmes to manage the epidemic.

"The **South African** National Defence Force employs over 100 000 people and allowing them to continue with unfair practise such as pre-employment HIV testing undermines national workplace strategies."[114]

[109] *Second Interim Report on Aspects of the Law Relating to AIDS: Pre-Employment HIV Testing*, South African Law Reform Commission, 1998.
[110] 'Give peacekeepers Antiretrovirals, new study urges' UN Integrated Regional Information Networks, 4 October 2006, http://allafrica.com/stories/printable/200610040567.html
[111] Case no. LC 24/98.
[112] Act No. 44 of 1957.
[113] *Op cit* note 111.
[114] *Op* cit note 54.

3.4.2 Criminalisation of same-sex relationships

The discussion under Guideline 5 on Anti-Discrimination measures provides that laws should be enacted to reduce human rights violations against men having sex with men.[115]

In a review of the legislation in eleven countries[116]it was found that in 72.7 % (n = 8) countries had laws that criminalised sex between men. In only 17.3 % (n = 3) of the countries surveyed were men who had sex with men protected.

In most of countries surveyed men who have sex with men are also publicly persecuted. For example, in Zimbabwe the government has spoken out strongly against gays and lesbians; this has been backed by strong homophobic statements from the President.

Table 14: Criminalisation of sex between men in SADC Countries

Country	No information	No crime	Common law offence	Crime under the Penal Code
Angola		X		
Botswana				X
DRC	X			
Lesotho	X			
Madagascar		X		
Malawi				X
Mauritius			X	
Mozambique				X
Namibia			X	
South Africa		X		
Swaziland			X	
Zambia				X
Tanzania	X			
Zimbabwe			X	

The criminalisation of sex between men in SADC countries negatively impacts on the availability of condoms in prisons. Although very limited information was available and accordingly we were only able to review access to condoms for prisoners in seven SADC countries,[117] of these countries only 57.1 % (n = 4) provided access to condoms. In 42.9 % (n = 3) of the countries surveyed did not provide condoms.

[115] *Op* cit note 16.
[116] Angola, Botswana, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.
[117] Angola, Botswana, Namibia, South Africa, Zambia and Zimbabwe.

Table 15: Access to Condoms within Prisons

Country	Sex between men not illegal	Sex between men is illegal	Condoms provided to prisoners
Angola	X		Condoms provided
Botswana		X	Condoms not provided
DRC	No information		No information
Lesotho	No information		No information
Madagascar	X		Condoms provided
Malawi		X	No information
Mauritius		X	No information
Mozambique		X	No information
Namibia		X	Condoms not provided
South Africa	X		Condoms are provided
Swaziland		X	No information
Tanzania	No information		No information
Zambia		X	Condoms not provided
Zimbabwe		X	Condoms are provided

Based on this information, this report makes the following findings and recommendations:

Finding: Men who have sex with men remain a highly vulnerable group to HIV in SADC countries. This vulnerability is heightened by the continued criminalisation of sex between men.

Recommendation: Advocate for decriminalisation of sex between men, and for HIV/AIDS programmes to target their specific needs.

Where sex between men is criminalised, it is extremely difficult to openly provide services to men engaging in sex with men. It also means that all state media messages on HIV/AIDS ignore this target group.

Finding: The criminalisation of sex between men continues to act as a barrier to providing HIV prevention programmes in prisons, with authorities refusing to provide condoms to inmates in affected countries.

Recommendation: See above. Further advocate for distribution of condoms in prisons.

The criminalisation of sex between men enables governments to deny condoms to prisoners on the basis that the sexual acts are unlawful. This policy has recently been criticised by the Botswana Prisoners' Commissioner who stated that the government's policy on sex between men ought to be reviewed in order to enable Botswana to make practical gains in the fight against HIV/AIDS. These

statements were supported by the Botswana Network on Ethics, Law and AIDS.[118] Zimbabwe is the only country where homosexuality is illegal and prisoners do have access to condoms.[119]

3.4.3 Women remain inadequately protected in most legal systems

The discussion under Guideline 5 on Anti-Discrimination measures provides that customary laws that affect the status and treatment of various groups of society should be reviewed. Furthermore laws should be introduced to reduce the vulnerability of women to HIV, including the review of marriage, property, employment and economic opportunity laws that discriminate against women. Laws should expressly protect women against sexual violence.[120]

In a review of the legal problems and responses in twelve SADC countries,[121] the review showed that in 58.3 % (n = 7) of the countries surveyed customary law unfairly discriminated against women. In 41.7 % (n = 5) of the countries rape and domestic violence was regarded as a significant problem for women. In 50.0 % (n = 6) of the countries law reform had taken place with regard to rape laws. In 58.3 % (n = 7) of the countries law reform dealing with domestic violence had occurred or was in the process of being developed.

Table 16: Extent to which laws protect women from abuse in SADC

Country	Human rights abuses against women	Law reforms
Angola	No information	No information
Botswana	No information	*Draft Domestic Violence Bill*
DRC	High levels of rape	Draft law criminalising sexual and gender violence (2005)
Lesotho	High levels of rape Customary laws discriminate against women, practices such as "property grabbing" are common	*Sexual Offences Bill* (2003) provides free medical attention to survivors of rape *Married Persons Equality Bill* ensures equality between husband and wife
Madagascar	No information	National policy document on reproductive health refers to combatting the abuse of women including sexual and domestic voiolence against women. On 17 July 1980, Madagascar signed the Convention on the Elimination of All Forms of Discrimination against Women.
Malawi	Customary law discriminates	Proposed law reform to the

[118] *Op* cit note 97.
[119] Key informant interview with Danmore Sithole, ZNNP+, 26 October 2006.
[120] *Op cit* note 16.
[121] DRC, Lesotho,Madagascar, Mauritius, Mozambique, Namibia, South Africa, Swaziland, pTanzania, Zambia and Zimbabwe.

	against women "Property grabbing" by relatives is common	*Wills and Inheritance Act*
Mauritius	Women are subordinate to men High levels of domestic violence	*Sex Discrimination Act* (2002)
Mozambique	Women are discriminated against by customary laws Wives require the assistance of their husbands in commercial transactions Domestic violence is not criminalised No access to PEP	No information
Namibia	Commercial sex work is still illegal	*Combating of Rape Act* (2003) *Combating of Domestic Violence Act* (2000) *Married Persons Equality Act* (1996)
South Africa	High levels of sexual and gender violence High levels of violence to women who disclose their HIV status Laws exist but are not implemented	*Choice on Termination of Pregnancy Act* (1996) *Domestic Violence Act* (1998) *Employment Equity Act* (1998) *Promotion of Equality and Prevention of Unfair Discrimination Act* (2000) *Sexual Offences Bill* (2006)
Swaziland	High levels of domestic violence Violence is linked to disclosure of HIV status Customary law is equal to civil law giving women limited legal protection Marital rape is not illegal	*Sexual Offences and Domestic Violence Bill*
Tanzania	Customary law discriminates against women, particularly in inheritance and after divorce High levels of domestic violence	No information
Zambia	Customary practices discriminate against women No access to PEP	*Penal Code* prohibits marital rape
Zimbabwe	Cultural practices discriminate against women No PEP Rape and sexual abuse are common	*Termination of Pregnancy Act* *Draft Domestic Violence Bill*

Based on this information, this report makes the following findings and recommendations:

<u>Findings:</u> Customary law practices that place women at risk of HIV infection continue to be one of the greatest obstacles for women in the SADC region.

<u>Recommendation:</u> Advocate for a SADC code of good practice on measures that ought to be taken to reform customary law provisions that discriminate against women.

It is of grave concern that in such a significant proportion of SADC countries customary law and practices continue not only to discriminate against women, but also to place them at increased risk of HIV infection.

In an audit of all laws and policies that affect women, the Tanzanian Women Lawyers Association noted that many women faced discrimination after divorce as under customary law they are not entitled to a share in their husband's property. Although the *Law of Marriages Act* (1971) supersedes the customary law provisions, they argue that many women living in rural areas do not receive maintenance from their former spouse after divorce. This is because many are unaware of their rights or have limited access to lawyers or courts.[122]

Furthermore the **Tanzanian** law relating to inheritance is very complex. It is governed by a pluralistic plethora of laws including the *Indian Succession Act*, the *Mohammedan Laws* and the customary laws of succession.[123] Native Tanzanians are presumed to be governed by the customary laws. The *Customary Law (Declaration Order)* provides that wives are not members of the family for land holding purposes and therefore they cannot inherit their husband's property. They recommend that the customary law provisions be repealed and be replaced with a uniform law governing inheritance. [124]

<u>Finding:</u> The lack of legislation protecting women from sexual and domestic violence continues to be a significant barrier to reducing the vulnerability of women to HIV infection.

<u>Recommendation:</u> Advocate for law reform throughout the SADC region to ensure that effective and efficient legal remedies exist for women who experience domestic and sexual violence.

Both the ongoing high levels of violence against women and the lack of protective legislation are of great concern. Added to this is the lack of services provided to the survivors of sexual assault. Only four of the countries surveyed were found to have programmes providing access to PEP after rape.

Although there seems to a regional move towards revising rape laws, very few countries have begun to introduce dedicated domestic violence legislation. For

[122] 2003, available from www.tawla.or.tz
[123] *Ibid.*
[124] *Ibid.*

example, neither Mozambique[125] nor Tanzania has dedicated legislation dealing with domestic violence. In Tanzania, women or children who are abused within the home have to use the *Penal Code*[126]as their only legal remedy.

[125] Louw L *HIV/AIDS and Human Rights in Mozambique* (2004), Centre for the Study of AIDS and the Centre for Human Rights, University of Pretoria.
[126] Cap. 16.

3.5 Conclusions, Challenges and Recommendations

This report is able to make the following concluding comments on the extent to which SADC countries have taken steps to create a legal and policy framework, based on human rights principles to respond to the HIV/AIDS epidemic.

3.5.1 Working towards a legal and policy framework for HIV/AIDS

Conclusion: All except one SADC country are in the process of taking steps towards developing a legal and policy framework to respond to HIV/AIDS.

In most SADC countries, governments have used a range of different approaches to review, update and implement law and policy reform measures. The most successful approach appears to be a gradual, piecemeal law reform programme by a range of government departments as this reflects a truly multi-sectoral approach.

Challenges: Turning policy into law and retaining commitment to human right. Key challenges exist in countries that have created a human rights framework only through policy documents. This approach has been shown to be ineffective in that it does not create any legal obligations on governments or other parties.

A further challenge is ensuring that governments remain committed to human rights principles and do not undermine litigation or advocacy successes. For example, in Namibia, in the case of *Haindongo Nghipohamba Nanditume v Minister of Defence*[127] the Labour Court found that Nanditume had been unfairly discriminated against on the basis of his HIV status.[128] However shortly after this matter was decided in favour of the litigant, the legislature introduced the *Labour Amendment Bill* to exclude section 107 of the *Labour Act* from applying to the military. This effectively meant that no further litigation challenging HIV testing in the military is possible, as soldiers are no longer protected by the *Labour Act*.

Recommendation: It is recommended that resources are committed to strengthening civil society responses in order to ensure that the commitment to human rights becomes a commitment to legal rights.

[127] Case no. LC 24/98.
[128] Mchombu C, *HIV/AIDS and Human Rights in Namibia* (2004) Centre for the Study of AIDS and Centre for Human Rights, University of Pretoria, Tshwane, South Africa.

This approach has been very successful in **South Africa**:

"In keeping with our new Constitution and the culture we have embraced after the end of apartheid, HIV prevention and treatment in South African AIDS has always been approached from a human rights perspective. Complex issues of HIV transmission, stigma, testing, disclosure, access to treatment have been debated and constructed overridingly in terms of human rights claims, entitlements and duties. It should be noted, however, that while on paper government policy and legislation has always shown a commitment to human rights, a number of progressive changes to South Africa's policy framework on HIV came about only as a result of litigation and pressure by civil society groups."[129]

Recommendation: It is recommended that advocacy be undertaken with SADC as a body to adopt a regional timeframe for a set of minimum law reforms within the region.

A key goal ought to be the conversion of a number of human rights principles currently contained within policies into relevant laws by 2010. Efforts should also be made to ensure that current gaps in legal frameworks are dealt with, such as the lack of legal protection for orphans and vulnerable children and the continued criminalisation of sex work and sex between men.

3.5.2 Reviewing criminal law and HIV/AIDS responses

Conclusion: Most law reforms have taken place within criminal codes.

The ease with which governments have introduced reforms within criminal law and their apparent reluctance to introduce reforms in other areas of the law is of concern. It appears to reflect an outdated approach to responding to HIV/AIDS as it is based largely on the coercive use of law against PLHAs.

Challenges: *Ensuring a rights-based approach to HIV/AIDS.*

Some of the law reforms undermine key human rights gains. For example, the move towards developing an HIV-specific crime for harmful HIV-related behaviour is contrary to the guidance given in the International Guidelines on HIV/AIDS and Human Rights. There is also an increasing focus on testing sexual offenders for HIV after conviction, even though this appears to be of little evidentiary value in proving that they were aware of their HIV status at the time of committing the crime. Finally, the continued use of the criminal law to criminalise men having sex with men is not only a human rights abuse, but a key challenge to ensuring that these men are able to access prevention and treatment services.

[129] *Op* cit note 54.

Recommendation: Review of criminal laws in line with the International Guidelines on HIV/AIDS and Human Rights.

Where criminal law is to be used as a coercive response to the HIV epidemic, it ought to be reformed. Where appropriate criminal law provisions are introduced, they ought to be supported by detailed guidelines for the judiciary to assist with their implementation. There also needs to be greater advocacy for the decriminalisation of sex between men in SADC countries.

3.5.3 Developing anti-discrimination laws to protect PLHAs

Conclusion: The area of greatest concern is the lack of anti-discrimination laws to expressly protect people infected or affected by HIV/AIDS.

Although most countries have national polices prohibiting unfair discrimination, most have not translated these into laws.

Challenges: The continued discrimination against HIV positive soldiers and the lack of protection for women under customary law.

Recommendation: Advocacy for a regional code and country-specific laws around HIV/AIDS and discrimination, with particular emphasis on vulnerable groups identified in the region.

It is recommended that advocacy be undertaken for the adoption of a SADC code prohibiting unfair discrimination against persons infected and affected by HIV. Furthermore advocacy should be undertaken within individual countries for the integration of this code into local law. Additionally, specific legal protections prohibiting unfair discrimination in the military ought to be adopted. Finally, urgent steps ought to be taken to reform discriminatory customary laws so as to ensure that women are treated equally in all legal systems.

From the above, we can see that SADC countries are beginning to create a protective legal and policy framework to respond to HIV/AIDS. However, greater advocacy and monitoring is required to ensure that reforms are in line with human rights principles.

Chapter Four: Prevention, Treatment and Care Programmes

4.1 Introduction

In September 2005, United Nations member states committed themselves to "developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it."[130] Similar commitments have been made on many other occasions, including in Guideline 6 of the *International Guidelines on HIV/AIDS and Human Rights*, yet universal access to treatment remains elusive.

Of the 13[131] SADC states for which information is available, only two countries, Botswana and Namibia, have achieved antiretroviral treatment coverage of more than 70 % of those who needed it by December 2005. The third highest treatment coverage is that of Swaziland which is at an appalling 31%. Three countries are providing treatment coverage between 20-30% (Zambia, South Africa and Malawi), whilst the remaining seven provide treatment to less than 15% of those who need it.

Table 17: Roll-out of ARVs in SADC countries

SADC countries	UNAIDS/WHO estimates		
	People receiving treatment in December 2005	People needing treatment in 2005	Treatment coverage
Angola	2,500-3,500	52,000	6%
Botswana	67,000-77,000	84,000	85%
Democratic Republic of Congo	7,000-8,500	209,000	4%
Lesotho	7,500-9,000	58,000	14%
Madagascar[131A]	<200	20,000	0%
Malawi	31,000-35,000	169,000	20%
Mauritius	<200	-	-
Mozambique	19,000-21,000	216,000	9%
Namibia	27,000-31,000	41,000	71%
South Africa	178,000-235,000	983,000	21%
Swaziland	12,000-14,000	42,000	31%
United Republic of Tanzania	20,000-23,000	315,000	7%
Zambia	45,000-52,000	183,000	27%
Zimbabwe	22,000-27,000	321,000	8%

Source: WHO, *Progress on Global Access to HIV Antiretroviral Therapy – A report on "3 by 5" and Beyond*, 28 March 2006

[130] Outcome document from the 2005 World Summit, 15 September 2005, www.avert.org/aidstarget.htm

[131] No information available for Mauritius.

[131A] UNAIDS estimates that by December 2005 there were 5,000 people requiring ARV treatment in Madagascar with 51 people actually receiving ART (treatment coverage1%)

The above table indicates the vast amount of work that remains to be done if the goal of universal access to treatment by 2010 is to be met. The lack of key prevention services in the SADC region will be dealt with later in the chapter.

This chapter first reviews the attempts by governments in SADC to implement the recommendations made in the *International Guidelines on HIV/AIDS and Human Rights as far as they will impact the provision of prevention, treatment and care*. It focuses on reviews and reforms made in terms of:

- Public health laws and policies (for example, laws and policies relating to HIV testing and confidentiality); and
- To a limited extent on the regulation of HIV-related regulate goods, services and information (such as laws and policies to ensure quality of condoms and registered medicines).

It also looks at whether SADC countries have used both domestic and international measures to achieve the recommendations, and the extent to which countries have prioritised vulnerable individuals and populations.

Due to the time constraints in the preparation of the report, this Chapter does not look at the steps states have taken to increase access to HIV-related goods, services and information for prevention, treatment, care and support.

4.2 International Guidelines on HIV/AIDS and Human Rights

Guideline 3 and revised Guideline 6 are relevant to countries when developing prevention, treatment and care programmes consistent with human rights.

GUIDELINE 3: PUBLIC HEALTH LEGISLATION

States should review and reform public health legislation to ensure that they adequately address the public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.

GUIDELINE 6: REGULATION OF GOODS, SERVICES AND INFORMATION

States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information and safe and effective medication at an affordable price.

State should take measures necessary to ensure for all persons, on a sustained and equal basis the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support including antiretroviral and other safe and effective medicines, diagnostics and related technologies for prevention, curative, palliative care of HIV/AIDS and related opportunistic infections and conditions.

States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

4.3 Progress in Implementation

The *Guidelines* have been divided into separate focus areas, discussed in more detail below. In general, SADC countries took more than five years to respond to the *International Guidelines* with the pace increasing dramatically in the last three years. The availability of antiretroviral treatment (ARVs) only became a possibility in most SADC countries after the price in medicines dropped and donor funding, in particular from the Global Fund, was made available for the purchase of antiretrovirals.

4.3.1 Reform of Public Health Laws

A number of countries have taken steps towards creating a protective legal and policy framework for public health interventions.

Voluntary HIV counselling and testing

Recommendations on the implementation of Guideline 3 state that public health laws should ensure that HIV testing is voluntary, with informed consent and pre- and post-test counselling where possible.

Of the 14 countries surveyed, 92,8 % (n =13) of countries have a clause in their constitution which prohibits the search of a person without his or her consent, although exceptions usually apply where a law or court order allows such search. While the right to privacy and freedom of person may be broadly protected in constitutions in the region, in many countries it is not clear how these general rights have been extended in real practice into the area of health, including confidentiality, informed consent and voluntariness of medical procedures, including VCT.

Little information was available regarding the existence of specific laws or policies that promoted VCT – evidence of such laws and policies were evident in only 35.7% (n = 5) of SADC countries. Case law that promotes the principles of voluntary testing, informed consent and counselling exists in South Africa and Botswana.

Table 18: Existence of VCT policies in SADC countries

SADC countries	Right to privacy and freedom of person protected in Constitution	Law and/or policy which promotes voluntary HIV testing, informed consent and counselling	Case law which promotes the principles of voluntary HIV testing, informed consent and counselling
Angola	No clause	None	None
Botswana	X		X
DRC	X		
Lesotho	X		
Madagascar	X[132]	X	
Malawi	X		
Mauritius	X	X[133]	
Mozambique	X		
Namibia	X	X	
South Africa	X	X	X
Swaziland	X		
Tanzania	X		
Zambia	X	X	
Zimbabwe	X		

This report makes the following findings and recommendations with regard to HIV testing and public health legislation in SADC:

<u>Finding:</u> HIV testing, without consent or knowledge, and the consequent potential for discrimination remains a problem.

<u>Recommendation:</u> States should implement law or policy to guide the practice of HIV testing and to prohibit discrimination.

Despite clear guidance on the importance of HIV testing, as well as constitutional protections for the right to privacy in SADC countries, unlawful HIV testing remains a problem. This suggests that constitutional protection alone is insufficient, and HIV-specific VCT laws and policies are required, in line with the recommendations made by the *International Guidelines.* Such guidelines need to be broad based so as to ensure that they deal with HIV testing in a variety of settings, including the workplace. For example, some countries reported that health care workers would disclose an employee's HIV test results to an employer at their request. Thus, although South Africa has labour laws that prohibit HIV testing of employees, ethical guidelines and health law that require informed consent for an HIV test and the maintenance of confidentiality are also

[132] In terms of Article 13 of the Madagascar constitution, no search may take place except in terms of law or a court order. It is not entirely clear whether this section applies to the person or only to property.
[133] The Proposed *HIV and AIDS Preventative Measures Bill* (2006) which provides for confidentiality is currently before Parliament.

needed. Domestic workers are still sent for HIV tests and the results disclosed to employers, without consent.

In **Mauritius**, HIV testing was often done without consent and linked to the denial of treatment. Patients undergoing surgery are compulsorily tested for HIV and if HIV positive they are denied the surgery. In some instances confidentiality is breached by doctors.[134]

<u>Finding:</u> The courts can serve as a useful tool to promote and protect human rights.

<u>Recommendation:</u> Challenge unlawful HIV testing through litigation, where possible, on the basis of the right to privacy and freedom of the person. Furthermore, use these constitutional rights to advocate for laws and policies to ensure HIV testing is voluntary, with informed consent and with pre- and post-test counselling.

The right to privacy in the Botswana constitution prohibits the unauthorized search of a person or her property. In a case against the *Botswana Building Society*[135] a woman was dismissed because she refused to undergo an HIV test. The court held that HIV testing without consent amounts to an infringement of the right to privacy unless such testing is reasonable and justifiable. This case establishes precedent for arguments against forced HIV testing and can be used by SADC countries with similar provisions in their constitutions.

Good Practice: Public Health Laws – VCT in South Africa

In the 1996 case of *C v Minister of Correctional Services*, C, along with other prisoners, were lined up and informed that a blood sample would be taken from them for HIV testing. The court had to determine whether C's informed consent had been obtained before the test. The court held that informed consent for an HIV test requires adequate pre-test counselling which includes providing the patient with information on the meaning of HIV infection; the manner in which HIV is transmitted; the nature of the test and the consent required; the social, psychological and legal implications of the test; and what was expected if the test result is positive. The patient had to be given time to consider the information before consenting to the test.

The Department of Health has since confirmed and elaborated on these guidelines in its *National Policy on Testing for HIV* (2000). These principles were affirmed in relation to all medical services in the National Health Act[136] which defines informed consent as:

- Consent for the provision of a specified health service
- Given by a person with legal capacity to consent
- Who has been adequately informed.

[134] Anyangwe C "formulation and implementation of a national human rights strategy for Mauritius" (2006) a report developed for the United Nations Development programme and the Office of the High Commission on Human Rights.

[135] Case no. 50/2003, available from <u>www.alp.org.za</u>. In this case, the court held that there was no factual unauthorised search of her person and consequent infringement of the right to privacy since she refused to undergo an HIV test.

[136] Act No. 61 of 2003

The Act also states that users have the right to be informed by a health care provider, in a language and manner that they understand, of the following:

- Their health status
- The range of diagnostic procedures and treatment options generally available to them
- The benefits, risks, costs and consequences of each option and
- The right to refuse health services and the implications of refusing.

The *National Health Act* provides much greater clarity to health care workers about what their duties are in relation to informed consent.

Right to confidentiality

Commentary on Guideline 3 suggests that states should also ensure that strict rules dictate confidentiality of a patient's HIV status and specify those instances in which health care workers may inform sexual partners of a patient's HIV status.

In 57.1% (n =8) of surveyed countries, the right to privacy is constitutionally protected. Furthermore, laws or policies which require that a patient's HIV status be kept confidential exist in 50.0% (n =7) of countries surveyed. However, despite this, breaches of confidentiality remain common. Of the 14 SADC countries, there are specific reports from 50.0% (n =7) of countries that disclosure, or perceptions of disclosure, of a patient's HIV status by health workers are common, and that such disclosures influence patients' access to prevention, treatment, care and support programmes. This figure is likely to be higher in reality.

Table 19: Existence of confidentiality and disclosure policies in SADC countries

SADC countries	Right to privacy protected in Constitution	Law and/or policy giving right to confidentiality	Policy on partner notification	Reports of disclosure of HIV status by health workers without consent
Angola	No			
Botswana	X	X	Policy of shared confidentiality with those who need to know	X
DRC	X			
Lesotho	X			X
Madagascar		X		
Malawi	X	X	Beneficial disclosure to sexual partners allowed without consent after	

			counselling	
Mauritius	No	X[137]		X
Mozambique	X			
Namibia	X	X	Encouragement of voluntary disclosure. Health care worker may inform sexual partner in closely defined situation in line with International Guidelines	X
South Africa	X	X	Encouragement of disclosure to sexual partners after counselling	X
Swaziland	No	X	Encouragement of disclosure to sexual partners after counselling	X
Tanzania	X			X
Zambia	No			X
Zimbabwe	No			

This report makes the following findings and recommendations with regard to confidentiality and HIV testing:

<u>Finding:</u> Despite constitutional and in many cases specific legal protection of the right to confidentiality, breaches of confidentiality continue. Fear of breaches of confidentiality, stigma and discrimination remains a barrier to accessing prevention, treatment, care and support programmes.

<u>Recommendation:</u> Advocate for the right to confidentiality to be entrenched in law or policies. Furthermore, advocate for clear remedies in cases where a breach does occur.

In SADC countries where the right to confidentiality is not specifically protected by law or policy, the enactment of confidentiality laws and policies may support respect for the rights of patients. In Zambia, NGOs have specifically advocated for legislation protecting confidentiality because health care workers have breached this ethical principal.[138] Until PLHAs are protected by an enabling legal and policy framework as a whole, many will still continue to fear breaches of confidentiality.

However, countries where the right to confidentiality is protected in law or policy continue also report unlawful disclosures of HIV status. This suggests that other

[137] The *Proposed HIV and AIDS Preventative Measures Bill* (2006), which provides for confidentiality, is currently before Parliament.
[138] Mazumara T "HIV & AIDS, Privacy and confidentiality of medical information" (September 2006) *ZARAN News*.

factors may contribute to the continued human rights abuses, such as the failures of monitoring and enforcement mechanisms to protect the rights of PLHAs. For instance, the Malawian National AIDS Policy states that the "government, through the National AIDS Commission, undertakes to establish mechanisms and services at family, community or national levels to protect those who choose to disclose their HIV serostatus, as well as their families and communities." This is useful since it places an obligation on government to protect people who choose to disclose their HIV status. The true test would be how such policies are put into practice in a manner that is in consultation with and to the benefit of PLHAs.

Good Practice: Public Health Laws – confidentiality of HIV test results

In **South Africa**, the common law right to privacy was applied in an appeal court case where a patient's HIV status was disclosed by his doctor.[139] The right to privacy was subsequently entrenched in the Constitution and supported through the introduction of various laws to specifically regulate circumstances when personal information may be disclosed. The *National Health Act* regulates access to health records held by clinics, hospitals and all other health facilities, and states that all information concerning a patient – including information relating to his or her health status, treatment or stay in a health facility – is confidential and should not be made available to third parties. This would include access to information about a patient's HIV status. In terms of the Act, health facilities are obliged to put in place control measures to prevent unauthorised access to records, and health care personnel have a legal duty to ensure that patients' personal information is kept confidential at all times. A patient must consent to the disclosure of such information in writing. The legal right to confidentiality is further reinforced by the health profession's ethical guidelines on confidentiality of medical information and HIV status.

Despite the existence of a legislative and policy environment which promotes the right to confidentiality, breaches still occur because of the public health system and professional bodies' failure to act against health care workers who breach confidentiality and patients' inability to access courts to enforce their right.

In a case pending before the Constitutional Court, three women have instituted an action for damages against a famous politician and the author and publisher of her biography in which the women's names and HIV status were disclosed. The women's lawyers argued that the common law and constitutional right to privacy imposes an obligation on the media and people who are similarly placed to consider the prevailing stigma and discrimination on the basis of a person's HIV status, and to take positive measures not to disclose someone's HIV status without his or her specific informed consent.[140]

<u>Finding:</u> The placement of HIV testing and HIV/AIDS-related services in special health establishments or special areas of existing health institutions can contribute to the disclosure of a patient's HIV status.
<u>Recommendation:</u> Advocate for HIV/AIDS related services to be integrated into general health services.

[139] *Jansen van Vuuren NNO v Kruger* 1993 (4) SA 842 (A).
[140] *NM, SM & LH v Charlene Smith, Patricia de Lille and New Africa Books (Pty) Ltd,* Constitutional Court, Case number 69/05.

HIV testing and counselling may occur in areas which are not fully enclosed or sound-proof or patients accessing services might be required to queue at specific places that are easily identifiable to others attending these institutions as queues for HIV/AIDS services. This may expose patients who are not ready to disclose their HIV status to situations of possible disclosure.

> "One woman's HIV status was revealed to her cousin whom the health worker met by chance in the street; another woman who went for STI treatment reported how the health worker herded all those who had come for treatment in front of all the other clinic clients ("STIs this way")." [**Swaziland**][141]

Finding: *All countries indicated that women hold an inferior position in society and are at risk of domestic violence and sexual abuse.*

Recommendation: *Any law or policy that specifies circumstances in which disclosure to sexual partners is permissible should take into consideration the vulnerability of women to abuse.*

The consequences of women disclosing their HIV status can be severe and this can influence women's decisions whether or not to disclose to their sexual partners.

Research conducted by the POLICY Project in Swaziland has revealed the extent to which women's minority status and risk of gender based violence before and after disclosure impact on their ability to access prevention, treatment care and support services.[142]

In addition, there are situations in which multiple partners might potentially be the source of HIV infection and make disclosure and couples counselling more complicated. There is a need for more research in this critical area.

Good Practice: National HIV/AIDS Policy in Malawi on partner disclosure

> **"3.2.2.5 Beneficial Disclosure**
> *3.2.2.5.1 Rationale*
> Refusal to notify sexual partners of one's positive serostatus can result in the onward transmission of HIV, therefore HIV post-test counselling programmes should involve strong professional efforts to encourage, persuade and support HIV-positive persons to notify their partners. In exceptional cases where a properly counselled HIV-positive person refuses to disclose his or her status to sexual partners, it is important that the health care provider be permitted to notify those partners without the consent of the source client.
> *3.2.2.5.2 Policy Statements*
> Government, through the National AIDS Council, undertakes to do the following:

[141] *Op cit* note 70.
[142] *Policy Reform to meet access-to-treatment goals: HIV-positive women's access to care, treatment and support in Swaziland*, (March 2006), POLICY Project, http://www.policyproject.com/pubs/generalreport/ACTS%20Final%20Report%205%2018%2006.pdf.

- "promote voluntary disclosure of his or her HIV serostatus by a PLWA to his or her sexual partner.
- ”ensure that voluntary disclosure of HIV status by the infected person to his or her sexual partner is explained and encouraged during counselling.
- ”ensure that professional and lay counsellors are trained on how to advise and assist PLWAs on how best to disclose their HIV serostatus to their partner.
- "develop appropriate and explicit guidelines outlining how, when and to whom beneficial disclosure by a health care worker may be made, in accordance with UNAIDS and the Office of the United Nations High Commissioner for Human Rights.”

4.3.2 Regulation of HIV-related goods, services and information

Guideline 6 stipulates that legislation which provides for the regulation of HIV-related goods, services and information should be enacted to ensure the availability of:

- Qualitative prevention measures and services;
- Adequate HIV prevention and care information; and
- Safe, effective and affordable medication.

The research was unable to determine the extent to which such legislation exists in SADC countries. This can be either because no such legislation exists, or because it is not widely known by NGOs, or simply due to need for more extensive research.

This report makes the following findings and recommendations with regard to the development of legislation to regulate HIV-related goods, services and information:

<u>Finding:</u> There is limited information readily available on the regulation of HIV-related goods, services and information. However, most countries have multi-sectoral HIV/AIDS structures (see Chapter 2 for more information) such as national AIDS commissions, as well as drug regulatory authorities.

<u>Recommendations:</u> Conduct further research to determine the nature and extent of legislation in SADC countries to regulate HIV-related goods, services and information. Advocate for national AIDS commissions to advise national drug regulatory authorities in SADC countries on key issues for regulating HIV-related goods, services and information.

Many of the antiretrovirals that are used in SADC countries would have gained FDA approval in the USA and/or be approved through national regulatory authorities, and would have been included in the World Health Organisation’s guidelines for the use of antiretroviral therapy or list of essential drugs and medicines. No information was available which enabled a comparison between

countries with regard to legislation enacted to regulate HIV-related goods, services and information.

<u>Finding:</u> In most instances, national drug regulatory authorities have a critical role to play in facilitating the import of medicines, including the registration of less costly generic equivalents of brand-name drugs, and they are also responsible for ensuring the safety and efficacy of medicines. This report was unable to establish whether national drug regulatory authorities are playing this critical role in HIV-that is, expediting registration of AIDS drugs. Including less costly generic versions, and guarding against formulations without proven safety or bioequivalence to brand-name versions.

<u>Recommendation:</u> Advocate for further research into the role national drug regulatory authorities are playing in terms of facilitating access to inexpensive, safe and efficacious AIDS drugs. Where such regulatory authorities are not fulfilling these responsibilities, advocate for the necessary legislative or policy changes to make this happen.

The procurement of antiretroviral treatment remains a problem, although few of the key informants interviewed were in a position to explain the difficulties faced by their government in this respect and the measures instituted to address these difficulties. Médecins Sans Frontières (MSF) notes that ARV procurement is often more difficult than procurement for other essential medicines.[143] In addition to dealing with cost issues, governments must also ensure stock management to avoid disruptions in treatment, quickly respond to new regimens, and develop quality reference standards to assess the quality of medicines.

Again, limited information was available on the legislative basis or policy framework for the regulation of the safety and efficacy of medicines in the region. In some countries where the regulation of medicines is well-established such as in South Africa, the relevant body, the Medicines Control Council is vastly under-resourced and is unable to deal timeously or efficiently with applications for the registration of new or essential medicines.[144]

4.3.3 Provision of Treatment programmes

Commentary on Guidelines 6 recommends that to ensure universal access to treatment programmes, States should:

- Develop national antiretroviral policies to progressively realise universal access;
- Set benchmarks and targets to ensure universal access;
- Facilitate the importation of cheaper medicines and diagnostics;

[143] *Surmounting challenges: Procurement of antiretroviral medicines in low and middle-income countries: The experience of MSF* (20 November 2003) http://www.accessmed-msf.org
[144] *Op* cit note 54.

- Ensure the quality, safety and efficacy of medicines and diagnostics;
- Ensure that medicines are supplied on a timely basis, in adequate quantities and with accurate information on its use; and
- Interpret international agreements in such a manner to fully utilise its safeguards and flexibilities.

Develop national antiretroviral policies

Of the 13[145] countries surveyed, 53.8% (n =7) have a clause in their constitution providing for the right to health. These provisions differ remarkably between countries, and the clauses usually have internal limitations. At the very least however, it is arguable that such provisions entitle citizens to policies that protect and promote their right to health. There are no constitutional provisions protecting the right to health care in 46.0% (n =6) of the countries surveyed but these countries do have national policies on antiretroviral treatment. Specific criteria is cited for accessing antiretrovirals in 7 countries, usually a CD4 count of under 200 or a clinical examination indicating that the patient is at WHO stage 3 or 4 of the illness.

Table 20: Right to health and antiretroviral access

SADC countries	Constitutional right to health	National antiretroviral policy	Specific criteria to qualify for antiretrovirals
Angola	X		
Botswana	No clause	X	
DRC	X	No	
Lesotho	X		X
Madagascar	X		
Malawi	X	X	X
Mauritius	No clause	X	
Mozambique	X	X	X
Namibia	No clause	X	X
South Africa	X	X	X
Swaziland	No clause	X	X
Tanzania	No information	X	
Zambia	No clause	X	X
Zimbabwe	No clause	X	

This report makes the following findings and recommendations with regard to the development of national antiretroviral policies to ensure universal access to treatment programmes:

<u>Finding:</u> The right to health care did not feature prominently as an issue in interviews and information obtained from respondents.
<u>Recommendation:</u> Conduct further research into the right to health clause in the constitutions of SADC countries, with the idea of a developing an advocacy tool for HIV/AIDS and human rights organisations.

[145] No information available for Tanzania.

The Treatment Action Campaign, an organisation campaigning for treatment access in South Africa, utilised the right to health care in the South African Constitution to campaign and litigate against the government's failure to implement a reasonable policy on providing PMTCT. The right was also extensively used in advocacy against the government's reluctance to provide antiretroviral treatment. It does not, however, appear as if any other countries which have a right to health care have utilised this right to advocate for the provision of prevention, treatment, care and support programmes. It must be noted that such action by the TAC was probably much easier in the context of a newly established discourse on rights in the South African constitution and the same discourse and human rights culture does not exist in many other countries.

Finding: This report indicates a gap between the existence of a national antiretroviral policy and the extent to which health workers, communities and organisations are aware of its contents and easily able to access the policy document.

Recommendation: Development and communication of a national antiretroviral policy should occur at community level, to determine criteria for access and mechanisms, to overcome any barriers to access, and at the health care worker level, to ensure consistent implementation of the policy.

The inaccessibility of policy documents was raised as a concern in Zambia and Zimbabwe where the policy was not widely communicated. It is also unclear whether there has been the same level of stakeholder involvement in the development of a national antiretroviral policy as there was in the development of HIV/AIDS strategic plans. Although the national antiretroviral policy might require more technical input, it remains essential that communities are involved in its development to ensure that the policy addresses the problems and challenges likely to be experienced at local level in implementing the policy.

Policies should ideally also be distributed in a plain language version at health establishments and in communities to ensure a culture of openness and to counter any myths, misconceptions and stereotypes about the provision of antiretroviral treatment.

Set benchmarks and targets

Countries should set benchmarks and targets for the provision of prevention, treatment, care and support services to ensure focused service delivery and to inform the community of the level of service that can be expected from government. Some countries have provided targets on the provision of antiretroviral treatment.

Table 21: Targets set on Antiretroviral treatment

SADC countries	Targets set on antiretroviral treatment
Angola	No information
Botswana	Increase access by 50% (Strategic Plan 2003-9)
DRC	No information
Lesotho	Don't have to travel more than 2km to get ARVs
Madagascar	400 on ARV treatment by end 2007, 2500 by end 2012
Malawi	126 ARV centres by end 2006
Mauritius	No information
Mozambique	No information
Namibia	30 000 on ARV treatment by 2007[146]
South Africa	No information
Swaziland	No information
Tanzania	50 000 on ARV treatment by end 2008
Zambia	No information
Zimbabwe	No information

This report makes the following findings and recommendations with regard to the development of targets and benchmarks to ensure universal access to treatment programmes:

Finding: Targets set around the 3 by 5 initiative were generally not met. However many governments have been forced into action by the existence of targets and access to antiretroviral treatment has subsequently improved.

Recommendation: Continue to advocate for setting benchmarks and targets for government, and monitor service delivery to ensure that quality service is not compromised in favour of quantity and vice versa.

It is not clear whether there is any community involvement in the development of benchmarks and targets. This is problematic since it can easily result in government, organisations or donors providing services which do not meet the needs of the communities they intend to serve.

Organisations from Swaziland and Zambia noted that the government's haste in meeting treatment targets often resulted in inadequate services. In Swaziland, many people were placed on antiretroviral treatment without adequate adherence counselling and have since defaulted on their treatment.

Utilising safeguards and flexibilities in international agreements

The commentary on revised Guideline 6 specifically states that:

"States should ensure that, in interpreting and implementing international agreements, domestic legislation incorporates to the fullest extent any safeguards and flexibilities therein that may be used to promote and ensure

[146] Daily Reports, Kaiser First Edition, 21 August 2006, available at www.kaisernetwork.org, last accessed on 5 September 2006.

access to HIV/AIDS prevention, treatment, care and support for all, including access to medicines, diagnostics and related technologies. States should make use of these safeguards to the extent necessary to satisfy their domestic and international obligations in relation to human rights. States should review their international agreements to ensure that these are consistent with treaties, legislation and policies designed to promote and protect all human rights and, where those agreements impede access to prevention, treatment, care and support, should amend them as necessary."

This recommendation was reaffirmed regionally by all states in the *Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious disease* (OAU, 2001) and the *Maseru Declaration* of SADC Heads of State on HIV/AIDS (2003).

Guideline 6 specifically refers to the World Trade Organisation (WTO) *Trade-Related Aspects of Intellectual Property Rights Agreement* (TRIPS), which sets out minimum guidelines for intellectual property protection that must be met by all WTO members by 2006. Among other things, TRIPS allows for patents on medicines for a minimum of 20 years, which grants a monopoly to patent holders in that period.

The price of some antiretroviral drugs remains high, especially for fixed dose combinations, second line treatment and paediatric formulations because they fall under patent protection and there is no generic competition which can drive the prices down.

In an antiretroviral programme in Khayelithsa, **South Africa** 10% of patients at 3 years and 16% at 4 years need to switch to second-line treatments which are 5 times more expensive than first-line antiretrovirals.[147]

The *Declaration on TRIPS and Public Health* at the Doha Ministerial Conference in 2001 affirmed WTO members' ability to interpret and implement the TRIPS agreement in a manner that supports public health and the promotion of access to medicines for all. The Declaration highlighted the following flexibilities in the TRIPS Agreement:

- Each member has the right to grant compulsory licenses and the freedom to determine the grounds on which such licences are granted – compulsory licences authorise a manufacturer to make, use and sell patented products without the permission of the patent holder.
- Each member has the right to determine what constitutes a national emergency, which would include HIV/AIDS and other public health crises
- Members are free to establish their own regime for the exhaustion of intellectual property rights without challenge

[147] *WHO sticks head in sand over high cost of newer AIDS drugs* 14 August 2006, http://www.accessmed-msf.org

- Least-developed country members (Angola, Lesotho, Malawi, Mozambique and Zambia) will not have to implement sections 5 and 7 of part III of the TRIPS agreement until 2016.

States can use the flexibilities to prevent pharmaceutical companies from pricing essential drugs out of reach for the majority of their citizens. MSF has expressed concern that the emergency restrictions suggest that a country 'would have to sit on its hands until a public health problem had reaches emergency proportions before taking action.'[148]

In terms of TRIPS, compulsory licences could only be issued for the domestic market. In 2003, the WTO General Council adopted a decision allowing member countries to export medicines produced under compulsory licences, but with specific criteria. This decision was made permanent in December 2005 but NGOs have criticised it as 'overly cumbersome and inefficient'. Between 2003 and 2005, no country has used this mechanism.[149]

Limited information is available about the progress made in countries in implementing the flexibilities in international agreements to ensure universal access to treatment for people living with HIV/AIDS. This is illustrated in the table below.

Table 22: Utilising TRIPS flexibilities or enforcing TRIPS?

SADC countries	Granted compulsory licences	Declared HIV a national emergency	Enforcement of intellectual property rights?
Angola	No information		
Botswana	No information		
DRC	No information		
Lesotho	No information		
Madagascar			Legislation allows for the import, export and sale of generic drugs to treat HIV/AIDS and its associated diseases. This includes the ingredients needed in the manufacture of the drugs.
Malawi			Patents exist on antiretrovirals but utilising flexibilities[150]

[148] 'Doha derailed: A progress report on TRIPS and access to medicines' MSF briefing for the 5th WTO Ministerial Conference, Cancun, 2003

[149] 'WTO approves TRIPS amendment on importing under compulsory licensing' HIV/AIDS Policy & Law Review, Volume 11 Number 1, April 2006.

[150] It is possible to buy a generic first-line antiretroviral combination in Malawi for US$288 ppy – Malawi does not have to enforce or grant pharmaceutical payments until 2016. 'Doha derailed: A progress report on TRIPS and access to medicines' MSF briefing for the 5th WTO Ministerial Conference, Cancun, 2003.

Mauritius	No information		
Mozambique	No information		
Namibia	No information		
South Africa	To local generic companies		Patents exist on antiretrovirals
Swaziland		X	
Tanzania		X	Legislation does not allow for the importation of generic drugs or local manufacture of patented drugs
Zambia	To local generic companies	X	Patents exist on antiretrovirals
Zimbabwe	To local generic companies		Patents exist on antiretrovirals

This report makes the following findings and recommendations with regard to the use of safeguards and flexibilities in international agreements to ensure universal access to prevention programmes:

Finding: Despite the availability of flexibilities in international agreements, albeit limited, states are reluctant to utilise these on public health grounds.

Recommendations: Advocate for SADC countries to coordinate efforts to find solutions to drug pricing and procurement problems, drawing on lessons from each other on utilising the safeguards and flexibilities available to them.

The South African and Zimbabwean governments have made attempts to utilise the flexibilities in the TRIPS agreement to counter the limitations placed on governments by patent protections in TRIPS. Local generic drug manufacturers in Zimbabwe are however hamstrung by the scarcity of foreign currency, which they need to import raw materials to make the antiretrovirals.[151]

In **South Africa**, the Medicines Control Act and Patents Act have been amended to reduce the price of essential medicines but this has not coincided with government willingness to utilise these provisions to reduce prices.

[151] IRIN newspapers www.newsplus.com

4.4 Ongoing Human Rights Issues

4.4.1 Access to VCT services and move towards routine testing

The slow uptake of VCT services continues to pose a serious concern in the SADC region.

Finding: Access to HIV testing services is crucial in efforts to curb the spread of the HIV epidemic and to enable timeous access to health interventions. Due to various constraints, HIV testing services have not been adequately utilised to achieve this purpose.

Recommendation: States should develop concrete plans to ensure the roll-out of VCT facilities.

Various factors influence access to VCT services; in particular, an inadequate number of VCT centres, distances from VCT centres and transport costs to access them, fear of stigma and discrimination from health care workers and the community on disclosure of results, cost of an HIV test, and staff shortages impacting on VCT facilities. Evidence from 7 SADC countries shows an inadequate number of VCT facilities and concomitant transport costs as a major factor inhibiting people from getting tested for HIV.

Table 23: Factors impacting on access to VCT services

SADC countries	Number of centres & transport costs	Fear of stigma & discrimination	Cost	Staff shortage
Angola	X Urban areas only		X	X
Botswana	No information			
DRC	X		X	
Lesotho	No information			
Madagascar	X			
Malawi	X	X		X
Mauritius		X		
Mozambique	X Urban areas only			
Namibia	X Has improved			
South Africa	No information			
Swaziland	X Isolated areas not reached	X		
Tanzania	No information			
Zambia	No information			
Zimbabwe	No information			

Finding: Many countries are developing policies which facilitate either routine testing or the routine offer of testing as a mechanism to deal with the low number of patients who initiate HIV testing. Organisations have emphasised the need for monitoring of routine testing to ensure that no human rights abuses occur.

<u>Recommendation:</u> As part of good patient management, health care workers should regularly offer patients the option of an HIV test. Clear policies should set out the criteria for such testing, which should include pre- and post-test counselling.

Routine testing has frequently been raised as a strategy to deal with the slow uptake of VCT in various countries. It is interesting to note that in the discussions about the promotion of routine testing, which would require additional government resources, the resource gaps which could improve access to VCT services are never discussed. Discussions on routine testing vary between the routine provision of HIV testing with the option to opt-out of such testing, and the routine offer of HIV testing with the decision being left to the patient.

In their policy statement on HIV testing issued in 2004, WHO and UNAIDS recommend the routine offer of HIV testing to pregnant women, people accessing STI services, and asymptomatic people where HIV is prevalent and antiretroviral treatment is available, which routine offer of HIV testing must be accompanied by pre-test counselling which ensures informed consent and knowledge of the right to refuse a test.[152] In November 2006, WHO and UNAIDS issued a draft guidance on provider-initiated HIV testing and counselling in health facilities for public comment. This draft guidance espouses an "opt-out" approach to provider-initiated HIV testing and counselling in heath facilities, including simplified pre-test information. With this approach, an HIV test is recommended as a standard part of medical care for all patients attending health facilities in generalized HIV epidemics, and in certain settings in concentrated and low-level epidemics. Individuals must specifically decline the HIV test if they do not want it to be performed.

Although there is consensus about the need for increased access to HIV testing, many human rights workers have expressed their concern about the fact that unless extreme care is taken about the manner in which provider initiated testing is implemented in practice, there is a real fear that informed consent in respect of testing may be compromised.

Table 24: Testing models

Country	Preferred HIV testing model
Botswana	Government introduced 'provider-initiated/opt-out routine testing'. Tested regardless of whether counselled – implication that many do not return for results.[153] Patients can decline but not aware can opt-out – expressed informed consent not required
Madagascar	Includes reference to routine testing in national policy on VCT
Malawi	HIV testing policy based on principles of VCT. Routinely test pregnant women and anonymous surveillance testing at ANCs and test blood/products for transfusion
Mauritius	Routine testing of pregnant women, blood donations, prisoners on

[152] WHO & UNAIDS, Policy Statement on HIV testing, 2004.
[153] *Op cit* note 45.

	arrival at prison, drug rehabilitation centres but draft HIV Prevention Measures Bill otherwise requires VCT with informed consent and pre- and post-test counselling
South Africa	HIV testing policy says patients must give informed consent for HIV testing and it must be accompanied by pre and post test counselling. No policy on routine testing except with pregnant women. Draft National Policy on Counselling and Testing for HIV[154] moves towards routine offer to health care clients, move away from client initiated testing
Swaziland	Health provider-initiated testing and counselling routinely offered
Zambia	HIV testing policy is based on informed consent, and pre- and post-test counselling – Guidelines on HIV/AIDS Counselling (2000) specifically states compulsory and mandatory testing is a violation of human rights. The National AIDS Council has repeatedly called for routine testing because of the low rate of testing.
Zimbabwe	Policy focuses on VCT. The only patients who are routinely tested for HIV are pregnant women. The Minister of Health has stated that routine testing is unconstitutional.

Lesotho opts for Universal Testing

In 2005 the Lesotho government announced that it will offer all citizens free HIV testing.[155] In terms of the 'Know your Status' campaign, launched on 1 December 2005, the government planned to give everyone over the age of 12 the option of HIV counseling and testing by the end of 2007.[156]

Preparation for the campaign required the involvement and preparation of communities, local health centres and volunteer health workers which was quite difficult in the light of severe health worker shortages and long distances.[157] The government has trained 720 volunteers to provide the service, but many do not have testing kits or funding for transport and stipends. [158] Much awareness has been done around the campaign to encourage testing. Once the campaign starts, people will receive information about stigma and HIV before the offer of a test is made. [159] Pre- and post-test counseling will depend on the uptake and the volunteers' discretion. Organisations have expressed concern the following concerns regarding universal testing:[160]

- that people will not receive enough information to assist them once they know their HIV status and
- that the tests will not be voluntary and that people might feel obliged to test because of the involvement of community leaders and chiefs. [161]

The current status of the campaign in unclear in terms of the progress made in meeting its two-year goals.

[154] www.alp.org.za, last accessed on the 25 October 2006.
[155] Article posted on http://news.bbc.co.uk/2/hi/africa/4480108.stm, 29 November 2005.
[156] 'Testing Campaign Struggles to Get Off the Ground' UN Integrated Regional Information Networks, 20 October 2006, http://allafrica.com/stories/printable/200610200742.html
[157] *Ibid.*
[158] *Ibid.*
[159] *Ibid.*
[160] *Ibid.*
[161] *Ibid.*

4.4.2 Lack of prevention programmes for women

Women are most affected by the HIV/AIDS epidemic, yet prevention programmes aimed at women are still lacking.

This report examined two key programmes that offer services to women, PMTCT and PEP, and could only establish the existence of PMTCT programmes in 10 SADC countries whilst antiretroviral post-exposure prophylaxis after rape was available at certain sites in 7 countries.

Table 25: HIV prevention programmes for women

SADC countries	PMTCT	PEP
Angola	None	
Botswana	X	X
DRC		X (MSF)
Lesotho	X	X
Madagascar	X	Provided for in the new National Strategic Framework 2007-2012
Malawi	X	X
Mauritius	X	
Mozambique	X	
Namibia	X	X
South Africa	X	X
Swaziland	X	X
Tanzania		
Zambia	X	
Zimbabwe	X	

This report makes the following findings and recommendations regarding HIV prevention programmes for women:

PMTCT

<u>Finding:</u> Much more work has to be done to ensure that more women and children benefit from PMTCT programmes. Equity in access and roll-out remains a problem, with PMTCT often only available at some health facilities, and little information available on where and how to access it.

<u>Recommendation</u>: Advocate for the roll-out of PMTCT programmes, with emphasis on identifying factors to promote as wide as possible access to such programmes. Special attention should be paid to improving overall access to antenatal clinics and labour wards. Any roll-out of PMTCT programmes should take place within the context of a reasonable plan which considers issues of access and equity. All pregnant women who are eligible for antiretroviral therapy for the purposes of their own treatment should have access to it.

A comparison between the women's willingness to participate in PMTCT programmes in Botswana, Malawi and South Africa indicate the extent to which

communities have to be involved in and educated about any new services offered in their area. Stigma attached to HIV in a community greatly influences the extent to which women are willing to participate in PMTCT programmes.

In **Botswana**, initial uptake of PMTCT was quite low, in Malawi it was only 2,7%. This is thought to be as a result of the stigma attached to HIV and the fact that many women to not deliver at facilities. Women do not always have control over getting pregnant and the negative attitudes towards HIV positive women appears to suggest that she is solely responsible for her predicament.[162] In contrast, in South Africa it has been estimated that 78.7% of pregnant HIV positive women received nevirapine to reduce the risk of PMTCT in public health facilities in 2004.[163]

In the case of *Minister of Health v Treatment Action Campaign*, the South African Constitutional Court considered the limited nature of the government's PMTCT programme. The court held that the PMTCT programme did not meet the Department's obligations under the right to access health care in the constitution in that it was rigid, inflexible and excluded key groups.[164]

Good Practice: National HIV/AIDS Policy on PMTCT in Malawi

3.2.4 Prevention of Mother-to-Child Transmission (PMTCT)
3.2.4.1 Rationale
HIV can be transmitted from a mother to her child during pregnancy, during delivery, and through breast milk. The desire of HIV-infected couples to have a child must therefore be balanced with the possibility of having an HIV-infected baby who has a high risk of dying in early childhood, after suffering extended periods of illness.
In addition, the death of a parent, especially the mother, drastically reduces the baby's chances of survival, regardless of the baby's HIV serostatus. It is important, therefore, that interventions address treatment for parents, in addition to PMTCT, so as to minimise orphanhood and improve the chances of child survival.
3.2.4.2 Policy Statements
Government, through the NAC, undertakes to do the following:

- promote VCT for couples planning to have a child, and early attendance at an antenatal clinic.
- ensure that HIV testing is done routinely for all pregnant women attending antenatal clinic unless they specifically choose not to be tested.
- ensure the availability of quality infrastructure, skilled staff and supplies for maternal and child health (MCH) care, and proper management of MCH services to increase women's access to PMTCT interventions.
- provide accurate and accessible information on PMTCT and infant feeding options to all pregnant women and their partners.
- provide access to affordable antiretroviral treatment (ART) to prevent HIV transmission from mother to child. PMTCT programmes shall also provide treatment, care and support for both parents.
- provide an enabling environment for women to participate in PMTCT or other preventive care or support programmes without the consent of their husbands, sexual partners or family.
- ensure baby-friendly hospital initiatives to support HIV-positive lactating mothers who choose to exclusively breastfeed for six months.

[162] Tangri K "Women's Reproductive Rights in the context of HIV and AIDS", *ALQ*, (2006).
[163] Republic of South Africa: progress Report on Declaration of Commitment on HIV and AIDS, February 2006, available from www.doh.gov.za, last accessed on the 16 September 2006.
[164] 2002 (5) SA 721 (CC).

- ensure that women who act as wet nurses are encouraged to undergo VCT prior to breastfeeding and are discouraged from breastfeeding if they are HIV-positive.

PEP

Finding: Sexual violence against women and children features prominently in almost all SADC countries, but PEP services are not widely available.

Recommendation: Advocate for prioritisation of improving reproductive health and rape services, and incorporation of PEP into these services. Clear protocols should be developed on PEP and communities should be informed where PEP can be accessed and the importance of accessing it within 72 hours.

All countries, except Madagascar, reported high levels of violence against women and girl children. The situation is particularly rife in conflict areas such as South Kivu where 25 000 rape cases were reported in 2005. MSF has noted that this number represents only a fraction of the women who have been raped and less than 20% of those who do seek care arrived within the 72 hours necessary to provide PEP.[165]

Despite this, PEP is not widely available or known and this report was unable to identify protocols on the provision of PEP after rape except in South Africa.[166] Specialist rape and reproductive health services for women are generally unavailable.[167]

4.6 Conclusions, Challenges and Recommendations

The Guidelines have clear recommendations on the actions governments must take in order to ensure access to holistic treatment for HIV/AIDS. However, the report shows that in this area there is still much that needs to be done.

Public Health Laws

Conclusion: Although most SADC countries have constitutional protection of the right to privacy and freedom and security, many still do not have clear laws and policies relating specifically to HIV testing and confidentiality.

Challenge: Dealing with ongoing fears of stigma and discrimination through creating protective legal frameworks and national programmes.

[165] "'Sexual terrorism' in South Kivu leaves HIV in its wake" article by UN integrated regional information networks, 22 October 2006, http://allafrica.com/stories/printabl/200610230073/html
[166] *Op cit* note 70.
[167] *Ibid.*

Challenge: Addressing stigma and discrimination more broadly as protective legal and policy frameworks on their own are insufficient to create an enabling environment.

Challenge: Dealing with disclosure to sexual partners, bearing in mind vulnerability of women, and their lack of legal protection in many parts of the SADC region.

Challenge: Implementing HIV testing services in a way that does not fuel stigma and discrimination, for example, ensuring that in resource constrained settings, there are facilities available that protect confidentiality.

Challenge: Scaling up HIV testing, through the routine offer of an HIV test, while nevertheless ensuring that pre-and post-test counselling and informed consent remain core elements of all HIV testing services.

The question of the nature of policies on routine HIV testing, or the routine offer of HIV testing, has been found to be a cross-cutting human rights issue in this report.

Recommendation: Advocate for SADC countries to adopt HIV-specific laws and policies on HIV testing and confidentiality. These ought to be accompanied by effective remedies to deal with human rights abuses. Popularise laws and policies to increase knowledge and understanding of rights.

Regulation of HIV-related goods, services and information

Conclusion: Limited information is available on the regulation of HIV-related goods, services and information within the SADC region.

This report was generally unable to establish if legislation existed across the entire region regulating the provision of HIV related goods and services.

Challenge: Making obtaining information on the regulation of HIV-related goods and services a key focus of future research.

Recommendation: Further research is required on the regulation of HIV-related goods and services.

Chapter Five: Legal Support Services

5.1 Introduction

Law reform alone cannot achieve the full realisation of human rights. It is imperative that individuals are able to use and enforce their rights. This requires:

- Accessible legal support services which provide assistance with resolving HIV-related legal disputes;
- Courts and a range of other mechanisms, such as human rights commissions, that can be used to assist to monitor and resolve HIV-related human rights abuses; and
- PLHAs who are aware of their legal rights and how to enforce them.

To meet these commitments, governments have to audit existing legal services, and human rights education programmes both within the state and NGOs sectors. Where gaps occur they need to ensure that resources and programmes are put in place to redress these issues. Governments also need to identify independent institutions that can effectively monitor human rights abuses and need to give such institutions a clear mandate to monitor HIV-related human rights abuses.

This chapter of the report reviews the steps that have been taken within the SADC region towards creating effective legal services that can provide remedial legal help, deliver human rights education and monitor human rights abuses.

5.2 HIV/AIDS and Human Rights Guidelines

There are three relevant guidelines. They require legal support services in the form of remedial legal help, legal and human rights education and the monitoring of abuses.

GUIDELINE 7: LEGAL SERVICES
States should implement and support legal support services that will educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

GUIDELINE 9: LEGAL AND HUMAN RIGHTS EDUCATION
States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance.

GUIDELINE 11: MONITORING AND ENFORCEMENT MECHANISMS
States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV/AIDS, their families and communities.

5.3 Progress in Implementation

Ten out of fourteen SADC countries had taken some steps towards creating legal services dealing with HIV/AIDS.

5.3.1 Access to legal services

Guideline 7 requires states to provide state support for legal aid services and private firms who undertake *pro bono* services for PLHAs. Legal services should also not be confined to courts but should include other institutions such as ministries of justice, ombudspersons, health complaints units and human rights commissions.

In a review of the legal services being provided in eleven SADC countries,[168] in only one country, Mozambique, were there neither NGO nor state-provided legal services to assist PLHAs. In 90.9 % (n = 10) of the countries reviewed there were NGO legal services available. In 54.5 % (n = 6) of the countries reviewed there were state provided legal services.

Table 33: Legal support services for PLHAS

Countries	Government legal support Services	NGO / other legal support services
Angola	None	NGOs, National Institute for the Fight Against AIDS
Botswana	Yes	NGO services, BONELA
DRC	None	NGOs
Lesotho	No information	No information
Madagascar	Yes	NGOs
Malawi	No information	No information
Mauritius	None	NGOs, PILS
Mozambique	None	None
Namibia	Yes	NGOs, Legal Assistance Unit has AIDS Law Unit
South Africa	Yes	NGOs
Swaziland	No information	No information
Tanzania	No information	NGOs
Zambia	Yes	NGOs, ZARAN
Zimbabwe	Yes	NGOs, ZLHR

Of the eleven countries reviewed[169] the most significant barrier to accessing legal services was a lack of resources, with 45.4 % (n = 5) of the countries identifying either costs or the funding of NGOs as a factor. Other barriers included stigma, 27.2 % (n = 3), a lack of information on rights and legal services, 27.2 % (n = 3) and the accessibility of services, 27.2 % (n = 3).

[168] Angola, Botswana, DRC, Madagascar, Mauritius, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe.
[169] Angola, Botswana, DRC, Madagascar, Mauritius, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe.

Table 34: Barriers to accessing legal support services

Country	*No info on service or rights*	*Services not capacitated*	*Cost*	*System is slow*	*Limited services*	*Inaccessible*	*Stigma*	*Parliament creates laws undermining cases*	*Lack of mechanisms*
Angola	*X*								
Botswana						X			
DRC							X		
Lesotho	No information								
Madagascar		X	X						
Malawi	No information								
Mauritius	X						X		
Mozambique									
Namibia								X	
South Africa	X		X			X			X
Swaziland									
Tanzania			X						
Zambia			X	X			X		
Zimbabwe			X		X	X			

Of the twelve SADC countries reviewed[170] 50.0 % (n = 6) reported that there had been no HIV-related litigation in their country. Of the countries in which there had been HIV-related litigation, 66.6 % (n = 4) had employment cases, 50.0 % (n = 3) had cases that dealt with criminal law issues (for example, HIV as a mitigating factor in criminal cases) and 33.3 % (n = 2) had cases dealing with access to treatment.

Table 35: HIV/AIDS litigation in SADC countries

Countries	No cases	Employment cases	Criminal cases / sentencing	Discrimination cases	Access to treatment cases	Cases involving children's rights
Angola	X					
Botswana		X	X			
DRC	X					
Lesotho	X					
Madagascar	X					
Malawi		X				
Mauritius					X	
Mozambique	No information					
Namibia		X				
South Africa		X	X	X	X	X
Swaziland			X			

[170] Angola, Botswana, DRC, Lesotho, Madagascar, Malawi, Mauritius, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

Tanzania	No information					
Zambia	X					
Zimbabwe	X					

This report makes the following findings and recommendations with regard to HIV/AIDS and legal services in SADC:

Finding: Legal support services are available in the region. These are most often provided by NGOs, despite their limited resources to do so. Details regarding the nature, extent and quality of such services could not be established.

Recommendation: Advocate for increased provision of state provided legal support services, as well as state support for other legal services in SADC countries, particularly in Mozambique. Advocate for state support for programmes to develop capacity of various role-players (such as law students, paralegals, legal and human rights NGOs) to deal with HIV-related disputes.

Many NGOs in the SADC region are providing legal support services despite difficulties, such as a lack of resources.

Good Practice: NGO Legal Support Services in Namibia

The Legal Assistance Unit, an NGO based in Windhoek, has an AIDS Law Unit that provides legal services to PLHAs.[171] The main objective of this project is to promote a human-rights based response to HIV/AIDS in Namibia. It focuses on:

- Civil and political human rights abuses due to HIV status, and
- The denial of socio-economic rights that increase vulnerability to HIV, and negatively impact on health.[172]

The AIDS Law Unit represented the Applicant in the *Handongo Nghipohamba Nanditume v Minister of Defence*[173] case. In this matter the Labour Court had to decide whether the refusal of the Namibia Defence Force to employ a recruit simply because he was HIV positive constituted unfair discrimination. The Court fond that Nanditume had been unfairly discriminated against and the defence force was ordered to allow him to apply for enlistment in the military following a medical examination to establish his fitness.[174]

[171] www.lac.org.na, last accessed on 3 November 2006.
[172] *Ibid*
[173] Case no. LC 24/98.
[174] *Op cit* note 128.

Good Practice: NGO Legal Support Services in South Africa

The AIDS Law Project is an NGO providing remedial legal services, education, advocacy and research services on HIV/AIDS and the law. The AIDS Law Project has been involved in two major Constitutional Court cases regarding HIV and human rights:

Hoffmann v SAA. In this case dealing with the lawfulness of pre-employment HIV testing, the Constitutional Court found that discrimination against PLHAs infringed section 9 of the Constitution (the equality clause). They ordered SAA to employ Hoffmann for the job that he had applied for and had been denied due to his HIV status.[175]

Minister of Health v Treatment Action Campaign: This Constitutional Court case concerned the limited nature of the government's prevention of mother-to-child transmission of HIV (PMTCT) programme. The court evaluated the government's PMTCT programme in the light of the rights of HIV positive women to access health care services in terms of section 27 of the Constitution. It held that the government's PMTCT policy and programme was unreasonable as it was rigid, inflexible and excluded key groups.[176]

<u>Finding:</u> Even where legal support services are available, there are often barriers to accessing them for PLHAs. The most significant of these barriers is the high cost of legal services and the lack of funding for NGOs.
<u>Recommendation:</u> Advocate for state support for a wide range of inexpensive legal support services, to increase availability and accessibility of services for PLHAs in SADC.

In most of the SADC countries reviewed, legal support services are being provided by NGOs working specifically on HIV and AIDS issues. However, in some countries, AIDS service organisations are linking with other human rights organisations that have the capacity to provide legal support to PLHAs. Therefore it appears that in many countries, there may well be a range of organisations (for example, children's rights organisations providing legal services) that have the potential to provide services to PLHAs if provided with the necessary capacity building.

In **Tanzania**, the Tanzanian Women Lawyer's Association (TAWLA) is working on a number of issues that relate to the vulnerability of women to HIV. For example, they have undertaken a review of laws entitled *Review of Gender Discriminative Laws in Tanzania*.[177] This Review identified the need for law reform in relation to domestic violence, as currently there is no dedicated legislation dealing with domestic violence. Women or children who are abused within the home have to use the *Penal Code*.[178] TAWLA has called for domestic violence legislation based on South Africa's *Domestic Violence Act,* to be developed.[179]

[175] 2001 (1) SA 1 (CC).
[176] 2002 (5) SA 721 (CC).
[177] *Op cit* note 122.
[178] Cap. 16.
[179] *Op cit* note 122.

Additionally, other non-HIV specific organisations and institutions could be supported to assist PLHAs. For example, all SADC countries have private law firms that could be supported and encouraged to provide *pro bono* legal services to PLHAs. A number of SADC countries also have other institutions such as ombudspersons and human rights commissions which could be supported to take a more active role in assisting PLHAs with resolving HIV-related disputes.

In **Mauritius** there are a number of institutions that are currently under-utilised by PLHAs. For example, there is a children's ombudsperson that is able to promote the rights and best interests of children in Mauritius.[180] The Ombudsperson has wide-ranging powers and functions, from advising the Minister on legislation, policies and practices, to investigating complaints on the violations of children's rights.[181] The Annual Report of the National Human Rights Commission has also recommended that a parliamentary sub-committee on human rights be established.[182] Although not HIV-specific this may be a forum at which HIV abuses could be tabled.

In Zambia, the Human Rights Commission has been established in terms of the *Human Rights Commission Act* (1996) to protect and promote human rights. The Commission has dealt with some HIV related discrimination cases.[183] However the Commission has very weak powers and can only make recommendations.[184]

Finding: The levels of HIV-related litigation remain low, even where legal support services are available.

Recommendation: Conduct further research into HIV-related litigation to determine the nature and extent of HIV-related litigation, in comparison to other human rights-related litigation, and the reasons for the low levels of enforcement of rights of PLHAs through the court systems.

Most of the HIV-related litigation in SADC has occurred in the field of employment law and criminal law. These are also the areas in which there has been the most law reform, which may well indicate that the law reform in these areas has created effective rights and remedies. If this is the case, it makes a persuasive case for the law reform recommended by the *International Guidelines on HIV/AIDS and Human Rights*.

However, due to the limitations of the research methodology (*See Chapter 1 for more details*), the report was unable to clarify some important questions around HIV-related litigation, such as:

- Whether HIV-related litigation occurs far less than other human rights-related litigation;

[180] S 5, *Ombudsperson for Children Act*, 2002, www.gov.mu, last accessed on 26 October 2006.
[181] *Ibid*.
[182] *Op* cit note 215.
[183] *HIV/AIDS and human rights in Zambia* Centre for the Study of AIDS and the Centre for Human Rights, University of Pretoria, 2004, www.csa.org.za.
[184] *Protectors or pretenders? Government Human Rights Commissions in Africa*, Human Rights Watch Report, (2001) Zambia.

- If so, why HIV-related litigation levels are low; and
- Whether law reform in certain areas has encouraged HIV-related litigation.

In **Botswana** it has been reported that legal services are inaccessible to PLHAs living in rural areas as there are great distances to travel.[185]

5.3.2 Awareness campaigns

Guideline 9 requires governments to ensure that ongoing education and training takes place in order to change the discriminatory attitudes associated with HIV/AIDS.

In a review of eight SADC countries,[186] 50.0 % (n = 4) of the governments were taking steps to raise awareness of the legal and human rights of PLHAs. However in 92.8 % (n = 13) of the SADC countries, NGOs were conducting HIV and human rights training. The research was unable to confirm any NGO activity relating to HIV and human rights in only one SADC country, Lesotho.

Table 36: Awareness & Training on HIV and human rights

	Government Awareness campaign	**NGO/Other awareness campaigns**
Angola	None	SCARJOV HIV & Human Rights awareness training since 2005
Botswana	None	BONELA runs a multitude of training campaigns
DRC	No information	PES supports many advocacy & training initiatives
Lesotho	No information	No information
Madagascar	Govt is actively responding to gaps in HIV/AIDS programme through BCC, radio / tv	ONUSIDA provides training and awareness campaigns
Malawi	National AIDS Commission developing road map policy including debates / radio / tv	NGOs / CBOs / FBOs have all been involved in training and awareness campaigns
Mauritius	None	ARASA provided first workshop in Mauritius. Smaller workshop later done by Human Rights Centre
Mozambique	No Information	Mozambique Access to Treatment Movement is running campaign on access to treatment
Namibia	No information	ALU runs a number of lobbying campaigns and conducts training on HIV and human rights

[185] *Op cit* note 45.
[186] Angola, Botswana, Madagascar, Malawi, Mauritius, South Africa, Swaziland and Zimbabwe.

South Africa	Human rights messages contained within national media strategies	Many HIV specific organisations like ALP, TAC and ALN
Swaziland	National media awareness campaign launched by NERCHA but was widely criticised	WILSA has Legal Rights Education and Training Programme
Tanzania	No information	Tanzanian Women Lawyers Association does legal literacy programmes
Zambia	No information	Treatment Advocacy and Literacy Campaign (TALC) is a 100 member organisation lobbying for access to treatment ZARAN programme also highlighted access to treatment issues
Zimbabwe	None	ZLHR and Zimbabwe Doctors for Human Rights have conducted workshop on HIV & Human Rights SAfAIDS has provided many training programmes and materials

Based on this information, this report makes the following findings and recommendations:

<u>Finding:</u> Generally, governments are not providing HIV and human rights training, education, and awareness raising activities. These awareness-raising activities are most often provided by NGOs.

<u>Recommendation:</u> Advocate for increased government commitment towards HIV/AIDS and human rights campaigns.

Given that NGOs report the lack of knowledge of legal rights as a key obstacle to PLHAs accessing legal services, human rights awareness, education and training is essential. Education around rights relating to HIV/AIDS not only increases knowledge and thus helps PLHAs to access rights but also contributes to destigmatising HIV and AIDS. The state can ensure that this takes place in various ways, such as integrating key human rights and legal messages into national media strategies.

Good Practice: HIV/AIDS and the Law Training

In 2005, the Zambia AIDS law Research and Advocacy Network (ZARAN) produced a video entitled the "Right to Life" which documented the problems experienced by people in the Southern province of **Zambia** in accessing treatment. The video was aired twice on national television. Shortly afterwards, access to antiretrovirals was provided free of charge in this province. The video was subsequently used as an advocacy tool to speak out about the challenges of accessing ARV treatment in rural areas.[187] ZARAN has also organised various workshops on HIV and Human Rights and how to mainstream human rights into HIV/AIDS programming.

[187] 'Lessons learning experience with Southern African AIDS Trust' by Paul Sichalwe, *ZARAN News*, July-September 2006 edition, page 5.

<u>Finding:</u> Despite human rights awareness, education and training, limited knowledge of rights as well as stigma and discrimination on the basis of HIV and AIDS continues.

<u>Recommendation:</u> Conduct further research into people's awareness, understanding and attitudes towards the rights of PLHAs.

Limited knowledge of the rights of PLHAs, as well as high levels of stigma and discrimination against PLHAs remain in SADC countries. This report was unable to determine the links between human rights-related awareness and education programmes, use of legal support services to monitor and enforce rights, and knowledge and attitudes towards the rights of PLHAs. This makes it difficult to answer important, often circuitous questions such as:

- Has awareness and education lead to increase knowledge and understanding of the rights of PLHAs?
- Has increased knowledge and understanding led to less stigma and discrimination against PLHAs?
- Has increased knowledge and understanding led to more use of existing legal support services?
- Has the lack of legal support services to monitor and enforce rights led to ongoing stigma and discrimination against PLHAs, despite awareness and education?
- Has the ongoing stigma and discrimination discouraged PLHAs from accessing existing legal support services?

5.3.3 Monitoring Human Rights Abuses

Guideline 11 requires states to ensure that there are mechanisms in place to monitor HIV-related human rights abuses.

Of the eight SADC countries reviewed,[188] 87.5 % (n = 7) had mechanisms that could be used to monitor human rights abuses. Of the possible monitoring mechanisms, 42.8 % (n = 3) of the countries were using human rights commissions, and 28,5 % (n = 2) of SADC countries were using NGO monitoring mechanisms.

[188] Angola, Botswana, Madagascar, Malawi, Mauritius, Mozambique, South Africa and Zimbabwe.

Table 37: Mechanisms to Monitor HIV-related human rights abuses in SADC

Country	No info	No mechanisms	NGO mechanisms	NAC	HRC	Ombudsperson	Other
Angola			X				
Botswana		X					
DRC	X						
Lesotho	X						
Madagascar							X
Malawi				X			
Mauritius					X	X	
Mozambique							X
Namibia			x			x	
South Africa			X		X		
Swaziland	X						
Tanzania	X						
Zambia			x				
Zimbabwe					X		

Based on this information, this report makes the following findings and recommendations:

<u>Finding:</u> There is a range of different mechanisms being used to monitor HIV-related human rights abuses within the SADC region. However, NGOs report that many of these mechanisms are ineffective.

<u>Recommendations:</u> Advocate for increased monitoring and reporting of HIV-related human rights abuses by a range of organisations.

A number of NGOs reported on the ineffectiveness of, or the lack of monitoring mechanisms. There is a range of organisations within countries that have the potential capacity to monitor HIV-related human rights, but it appears that underlying problems such as capacity and independence need to be addressed. Human rights commissions appear to be under-utilised as a form of monitoring, and should be capacitated and encouraged to monitor and report annually on compliance with the *International Guidelines on HIV/AIDS and Human Rights.*

In **Botswana**, BONELA reports that government approval in the form of a research permit is needed to monitor human rights abuses. Although BONELA and another NGO have requested permission to monitor human rights, to date they have not received permission. There is no other mechanism to monitor human rights abuses as there is no Human Rights Commission and the Office of the Ombudsman is limited in its scope of activities. [189]

In **Mauritius**, PILS reports:

"There is the inefficient human rights commission, the newly set up Human Rights Centre under the Ministry of Justice and a few NGOs such as Amnesty Mauritius, Right Now and Justice. So far successes in that field are meagre."[190] This view regarding the shortcomings of the National

[189] *Op cit* note 45.
[190] *Op cit* note 68.

Human Rights Commission is supported by the Human Rights Committee[191]. The Committee has criticised the *Human Rights Protection Act* (1998) for failing to comply with the Paris Principles, as it fails to guarantee the independence of the Commission and does not provide it with sufficient investigative powers.[192]A further problem with the Human Rights Commission is that it is only empowered to deal with complaints against public officers or officials employed by public bodies.[193] This means that private forms of discrimination or human rights abuses cannot be investigated by the Commission.

In **Mozambique** it was reported that there are mechanism to monitor human rights but they are not efficient and need improvement.[194]

In **South** Africa, Mark Heywood of the AIDS Law Project commented:
" …. although South Africa has a good legal framework, it is weakened by the lack of public education about human rights generally and specifically about HIV. There is no monitoring of levels of stigma or discrimination by government, NGOs or bodies such as the Human Rights Commission."[195]

Good Practice: Using alternative mechanisms to monitor and enforce rights

In **South Africa**, one of the most effective monitoring mechanisms appears to be the Joint Civil Society Monitoring Forum, which has been monitoring access to treatment. This Forum, established in June 2004, brings together over twenty organisations involved in health systems or NGO work.[196] The Forum aims to act as an early warning system for problems and to communicate successes, to ensure the Operational Plan[197] is speedily and successfully implemented, and to make recommendations for improved health delivery. It has a highly successful e-mail discussion group that is used to disseminate information and to debate key issues. It also has four meetings a year to discuss key advocacy issues. [198]

South African HIV-related legal support services, such as the AIDS Law Project, have also made use of enforcement mechanisms other than the courts when dealing with HIV-related disputes. For example, HIV-related disputes involving medical professionals are also referred to the councils regulating the profession. HIV-related labour disputes are referred to councils governing that sector of the labour market, where possible. The use of a range of enforcement mechanisms assists PLHAs by giving them a variety of possible remedies.

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[191] A monitoring an enforcement body established in terms of the International Convention on Civil and Political Rights.
[192] Concluding observations of the Human Rights Committee: Mauritius, 27 April 2005.
[193] National Human Rights Commission Act, 1998, available at www.gov.mu, last accessed on 26 October 2006.
[194] *Op cit* note 46.
[195] *Op cit* note 54.
[196] Hassan F "Strengthening civil society oversight of implementation of national and regional commitments and developing advocacy strategies" a paper presented at the Southern African Treatment Literacy and Advocacy Summit, 26 28 October 2006.
[197] South Africa's National ARV Treatment Plan.
[198] *Op cit* note 245.

5.4 On-going Human Rights Issues

The discussion above indicates that in a number of countries the remedial legal services, human rights education and monitoring mechanisms are failing to protect the rights of PLHAs. There are a number of on-going human rights issues in the region.

5.4.1 State restrictions on the right to freedom of expression

In a number of SADC countries human rights are under threat through state control of the media and information, as well as state control of funding for the work of NGOs. This limits the ability of NGOs to monitor and report actively on human rights and to distribute human rights based messages.

Finding: Anecdotal evidence suggests that SADC countries experience resistance in their efforts to monitor human rights relating to HIV and AIDS. The report had insufficient information to make a finding on the extent to which the right to freedom of expression is protected or infringed in the SADC region.

Recommendation: Regional advocacy is needed for the removal of repressive laws that limit the right to freedom of expression. More research needs to be undertaken into the impact that repressive media laws have on the rights of individuals to accurate information on HIV prevention, treatment and care.

In a number of countries the activities of NGOs are being limited by state actions that hamper their ability to undertake and promote HIV/AIDS programmes.

In **Botswana**, state approval is required to monitor and report on human rights abuses. BONELA and Ditshwanelo have requested permission to monitor human rights, but to date they have not heard from the government. There is no other mechanism to monitor human rights abuses at present.[199]

In **Zimbabwe**, it was reported that the police prohibited a rally by PLHAs commemorating World AIDS Day on the 1st of December 2005. This rally was an initiative of a variety of HIV/AIDS NGOs in Zimbabwe including, the Women and AIDS Support Network (WASN), Zimbabwe Lawyers for Human Rights, Zimbabwe Activists on HIV/AIDS (ZAHA) and the Zimbabwe National Network of People Living With HIV/AIDS (ZNNP+).[200]

[199] *Op cit* note 45.
[200] www.zlhr.co.zw, last accessed on 13 October 2006.

5.4.2 Stigma and discrimination against PLHAs

Ongoing stigma and discrimination were identified as key problems in SADC countries.

<u>Finding:</u> Stigma and discrimination against PLHAs continues, increasing the abuses of rights, as well as discouraging PLHAs from accessing legal support services.

<u>Recommendation:</u> Conduct and review existing research into stigma and discrimination in selected SADC countries to determine the links between the legal framework (including laws, policies and programmes, as well as legal support services) and stigma and discrimination, as well as the impact of a stigma and discrimination on PLHAs accessing legal support services.

It appears that the fear of stigma remains a significant obstacle to PLHAs. Government and NGOs offering legal support services need to find ways to address the fears of PLHAs, in order to encourage the use of existing services. A protective and supportive legal framework as a whole may finally work towards encouraging the use of services. However, awareness and education may also be useful in this respect, to advise PLHAs of their right to confidentiality from legal professionals and possible confidentiality with regard to their identity in court records.

In **Zambia** it was reported:

"There have been no court judgments on HIV/AIDS and some potential court cases have settled before the court date. People living with HIV/AIDS seldom access the legal system because of fear of stigma, the high cost of lawyers and the fact that the judicial system is too slow."[201]

In **Mauritius**, an NGO, PILS noted:

"The key problem facing vulnerable groups is the high level of stigma and discrimination. Very few PLHAs are open about their HIV status. Even when PLHAs do come forward for assistance and request help from an NGO such as PILS, they quickly disappear once they have been helped."[202]

Good Practice: Confidentiality protected in litigation

In **South Africa**, the AIDS Law Project successfully applied to have the litigants name kept confidential in *C v The Minister of Correctional Services*.[203] In this case a High Court judge allowed the media to report on the case, but he ordered them not to disclose the name of the plaintiff:

> *"There is no doubt that, whether a person is HIV positive or not, whether that person has AIDS or not, is in most circumstances a highly personal matter. Such a person should be*

[201] *Op* cit note 41.
[202] *Op cit* note 68.
[203] 1996 (4) SA 292 (T).

protected as far as is possible where the publication may impact upon his or her whole life. In referring to 'whole life' I include that person's position in the workplace and in the community in which he or she moves. It would seem that this is a case where, although the matter is apparently of great public concern, it may be published and reported without disclosure of the plaintiff's name.

The interest that the community at large has in knowing precisely what is happening in the courts of law will be achieved if this court sits with open doors but subject to the plaintiff's name not being published."

5.5 Conclusions, Challenges and Recommendations

The Guidelines have clear recommendations on the actions governments must take in order to implement an effective human rights response to HIV/AIDS. However, this report shows that in the area of legal support services, limited progress has been made. Even where there are legal support services, there appear to be numerous barriers to PLHAs accessing these services.

This report found it difficult to determine, without further in-depth analysis and research, clear links and reasons for some of the failings in this area. For example, the report clearly shows that there are limited legal support services as well as limited awareness, education and training on the rights of PLHAs. It also shows that stigma and discrimination continues, and HIV-related litigation is generally low, although higher in areas of the law where the most law reform has taken place. However, it is difficult to establish the relationships between these various trends, as they may often relate to the failings of a country to provide a protective legal framework as a whole, and not simply the failings of legal support services. For example, where anti-discrimination laws are weak, stigma and discrimination thrives and PLHAs are discouraged from using legal support services in any event.

It is clear that we need greater understanding of the failings in the use of existing legal support services. It is also clear that without all the elements of a protective legal framework in place, legal support services will not be used appropriately.

Conclusion: Governments have not provided adequate and accessible legal support services on HIV/AIDS and human rights issues

Most governments in SADC showed limited commitment to providing legal support services to assist PLHAs to access their rights. Nor do they provide adequate (if any) funding to NGOs to do this work. Despite this, various NGOs continue to provide valuable legal support services for PLHAs.

Challenge: Advocating for greater support from governments for legal services within the region within a context of limited, if any, state funding for public interest litigation.

In a number of countries there is limited state funding for legal aid and public interest litigation. In this context, creative strategies are required to increase support for public interest litigation. Most available services are currently being provided by NGOs, for whom funding is a serious concern.

Challenge: Obtaining support for further research and information on how to ensure effective legal support services that PLHAs are willing and able to access.

While the guidelines detail steps that governments can take to improve legal support services, at present, most legal support services are being provided by NGOs. There is therefore limited comparative information available on the best forms of legal support for PLHAs. There is also limited information on the reasons for the low levels of HIV-related litigation even from the existing services. Some informants cite fear of stigma and discrimination as a reason whilst others suggest that services are not accessible. However, the fact that HIV-related litigation has most often occurred in areas of the law where law reform has taken place suggests that there may well be a link between law reform and the use of legal support services. Further understanding and research will enable SADC countries to develop appropriate and effective legal support services.

<u>Recommendations:</u> Advocate for improved legal support services, based on the findings of further research into existing legal support services and HIV-related litigation.

<u>Conclusion:</u> Stigma and discrimination against PLHAs continues to be a major problem, acting as a barrier to accessing services.

High levels of stigma and discrimination within the SADC region has a double effect – it means that the rights of PLHAs continue to be abused, and it also results in many PLHAs being afraid of utilising legal services to redress those abuses. A major concern reported by NGOs appears to be the fear of PLHAs that their HIV status will become known within their community. This then acts as a social barrier to PLHAs using the law to resolve HIV-related disputes.

<u>Challenges:</u> Without all of the elements of an enabling environment in place, it will be difficult to reduce stigma and discrimination and thus facilitate access to legal services.

While the report recognises that there are steps that can be taken to improve PLHAs' access to legal support services, despite ongoing stigma and discrimination, the ultimate goal is to reduce stigma and discrimination itself. This will require that all elements of the *International Guidelines on HIV/AIDS and Human Rights* are in place, such as a protective legal framework to protect the rights of PLHAs and people vulnerable to HIV infection, accessible and effective legal support services to monitor and enforce the rights of PLHAs, and awareness and education to change the attitudes of the community towards the rights of PLHAs.

<u>Recommendation:</u> Advocate (possibly through the development of regional guidelines) for the media and for legal enforcement mechanisms to promote confidentiality and to protect PLHAs from stigma and discrimination during proceedings. Develop awareness and education on the guidelines for PLHAs.

<u>Conclusion:</u> There is still limited awareness of the rights of PLHAs, which may be why stigma and discrimination continues, and also why very few PLHAs use the courts to challenge human rights abuses.

Very little information and education on rights relating to HIV and AIDS is being provided by SADC governments. Where awareness and education is taking place, it is generally being done by NGOs. This means that PLHAs are often not aware of their rights, and stereotyped attitudes towards PLHAs persist.

<u>Challenge:</u> Given the vast need for awareness, education and training on human rights and HIV/AIDS, it may be difficult to address all needs.

This being so, SADC countries may need to focus on general awareness-raising and education, as well as targeted awareness and education for particularly vulnerable groups revealed by the report, such as men who have sex with men, prisoners and women.

<u>Challenge:</u> Integrating legal and human rights messages into national media strategies.

In most of the countries surveyed the state was using the national media to broadcast HIV prevention and care messages. However human rights messages were not a core part of these strategies. NGOs were the primary providers of human rights-related HIV awareness and education.

<u>Recommendation:</u> Advocate for government involvement in appropriate, targeted awareness, education and training aimed at increasing understanding of HIV/AIDS and human rights as well as promoting acceptance and non-discrimination through various means.

<u>Conclusion:</u> Various monitoring mechanisms are available within the region but they are ineffective, or alternatively are not being used to resolve HIV-related disputes.

A range of monitoring mechanisms exists within the region, but they are currently not effectively monitoring HIV-related human rights abuses. There is also not a consistent approach to monitoring HIV-related human rights abuses within the region, making comparisons between countries difficult.

<u>Challenge:</u> Ensuring that both NGO based and state funded institutions exist which can monitor HIV related human rights abuses.

<u>Challenge:</u> Developing human rights indicators that can be used to monitor human rights abuses.

<u>Recommendations:</u> Advocate for the capacity development of existing monitoring mechanisms (such as human rights NGOs, professional councils, human rights commissions) to monitor, report on, and, where it is within their mandate, resolve HIV-related human rights abuses.

Chapter Six: Conclusions

This report looks in detail at the steps taken by SADC countries in implementing a human rights framework to respond to HIV/AIDS with regard to:

- Developing political commitment and effective multi-sectoral structures;
- Creating a protecting legal and policy framework;
- The right to prevention and treatment programmes; and
- The provision of legal services to those infected and affected by the epidemic.

Key findings, challenges and recommendations are found within each chapter. The following broad conclusions can be made:

(i) It is clear that almost all SADC countries are committed, in principle, to responding to HIV and AIDS. However it is unclear if governments are committed to implementing a holistic, rights-based response to HIV and AIDS as set out in the International Guidelines on HIV/AIDS and Human Rights.

This research was conducted primarily by interviewing NGOs working within the SADC region. We were therefore unable to establish whether governments were aware of and were using the *Guidelines*. It was only in South Africa that direct reference was found to the *International Guidelines* in the reports of the South African Law Reform Commission's Project 85 on *Aspects of the Law Relating to AIDS*.[204] The recommendations made by the Law Reform Commission have been used by parliament to guide law reform around HIV and AIDS. So it is possible therefore to assume that the South African government is aware of the *Guidelines*. However no similar reference was found in any of the other literature to SADC governments using the *Guidelines*.

The views of governments on their awareness of and the usefulness of the *Guidelines* ought to be taken up in future reports.

(ii) Most countries in the SADC region have begun to implement key aspects of a human rights based response to HIV/AIDS by introducing legal and policy reforms and programmes based on human rights principles (such as the right to health care services, including ARV treatment.) However in a limited number of circumstances the criminal law is being used to respond to HIV in a coercive manner, thus undermining the principle of a human rights- based response.

[204] The five reports of this Commission can be viewed at www.doj.gov.za/salrc, last accessed on 19 November 2006.

Most countries have introduced some legal and policy reform relating to HIV and human rights. Most of these efforts have helped in creating a more protective legal environment for those infected and affected by HIVAIDS. All recent public health reforms were found to be consistent with human rights principles.

However, it appears in relation to reform of the criminal law that coercive responses based on "punishing" PLHAs for being infected with HIV are creeping onto the legislative reform agenda. This includes HIV testing of offenders convicted of sexual offences in circumstances where the public health or legal purpose of such testing is questionable.

NGOs need to continue to monitor reforms of the criminal law to ensure they do not undermine human rights based responses to the epidemic.

(iii) Developing a human rights response to HIV/AIDS within the SADC region is made complex by the large number of competing human rights concerns and in some instances, continued state repression and undermining of human rights.

In certain SADC countries, prevailing political and legal factors which undermine human rights generally, such as state restrictions of freedom of expression are also undermining the ability of government departments and NGOs to provide effective HIVAIDS programmes.

NGOs advocating for HIV as a human rights issue ought to work towards placing such strategies within a broader context of advocacy for the legal protection of all human rights within the region.

(iv) The mechanisms used to develop and implement human rights-based responses to HIV/AIDS, such as multi-sectoral frameworks, are in place in most SADC countries. However, it appears that in many instances, governments are paying lip service to key human rights principles such as transparency, consultation and inclusivity and are not meeting the needs of PLHAs for various reasons.

In most cases, governments are not fully committed to ensuring that a range of different sectors are involved in decision-making around HIV/AIDS. They also fail to fully involve PLHAs in decision-making.

Advocacy is needed to ensure that the framework for a human rights-based response is funded, accountable and representative.

(v) *Most legal services are provided by NGOs. The lack of funding limits their ability to extend and develop many human rights based programmes. A key gap is the lack of national structures to monitor HIV-related human rights abuses.*

The funding of NGOs remains a key human rights issue as in most instances they are driving human rights programmes and services. Without dedicated funding such programmes are not sustainable. Monitoring of HIV related human rights abuses ought to form part of national monitoring and reporting mechanisms.

Advocacy is needed for a change in the allocation of funding in HIV/AIDS programmes with greater weight needing to be placed on the funding of NGO-run human rights and legal services. Advocacy is also needed for human rights commissions to take on the monitoring of human rights abuses in the region.

(vi) It is not possible to establish whether the law and policy reforms are reducing HIV related human rights abuses in the region.

Given the nature of the questionnaire used, it was not possible to establish the effectiveness of the law and policy reforms. Further research is needed, particularly in the field of employment where much law reform has taken place, to establish if these recent reforms are reducing the human rights abuses against HIV positive employees and job applicants. The information reflected in this report indicates that legal prohibitions on pre-employment HIV testing have resulted in the halting of this practice. However, protections against unfair discrimination in the workplace have not prevented employees with HIV from being dismissed in both South Africa and Namibia[205], although it is possible that the number of such dismissals is lower.

More detailed research is required on the extent to which legal and policy reforms are creating a more enabling environment for PLHAs.

(vii) Most HIV and human rights reforms and the remedial legal services being offered in the SADC region have centred on civil and political rights issues. Most of the litigation in the region is also related to infringements of civil and political rights, such as the right to equality.

In some instances it appears that civil and political rights, such as the right to informed consent before HIV testing and confidentiality regarding HIV status, are protected in local laws. In most countries there is also protection in the field of employment against unfair discrimination, pre-employment HIV testing and occupational health and safety.

The protection of civil and political rights is an important step in creating a protective legal framework. However, an artificial separation between civil, political and socio-economic rights is inappropriate.

[205] *Op cit* note 54 and personal communication, personal communication, Amon Ngavetene, Legal Assistance Centre, Namibia, 21 November 2006.

There are also a number of civil and political rights which continue to be unprotected in many legal systems. For example, sex between men remains a criminal offence in many countries and the legal rights of women to equality are undermined by the continued recognition of discriminatory customary laws and practices.

Further activism is required for a human rights based response to HIV that is based on both civil, political and socio-economic rights. Activism is also required for the legal protection of vulnerable groups.

(viii) There are a number of emerging human rights issues relating to the civil and political rights of PLHAs. These relate to the undermining of civil and political rights by policy reforms aimed at enhancing access to HIV testing and treatment.

In recent months there has been considerable renewed debate on civil and political rights, and whether the focus on individual autonomy rights is undermining public health responses aimed at increasing the number of persons accessing health services, such as VCT and treatment. Mounting pressure to reduce the high rates of AIDS related deaths in the region is leading to pressure for a return to a more traditional public health approach, in which less focus is placed on individual choices.

This encroachment into the civil and political rights of PLHAs may be short sighted. It may be argued that this approach undermines a human rights based response by ignoring the vulnerability of certain groups to HIV. In many cases, there are complex reasons relating to stigma, discrimination and inequality that act as barriers to people coming for testing and treatment. Undermining individual rights in this context may heighten the vulnerability of such groups to HIV by further alienating them from health care services.

In this context NGOs need to continue to monitor the civil and political rights of PLHAs, to ensure that policies that introduce, for example, routine HIV testing, do not undermine individual rights but rather enhance opportunities for individuals to make informed choices regarding HIV testing and treatment.

(ix) The right to the highest attainable standard of health, including access to ARVs is currently one of the most significant human rights in the struggle against HIV. However SADC countries are currently failing to protect and promote this key socio-economic right in that fifty percent of SADC countries have ARV treatment coverage of less than 15%.[206]

In the post 2000 period, with ever increasing availability of cheaper and effective treatments for HIV, the right to treatment has become a key focus of the HIV and

[206] WHO Progress Report on Global Access to HIV Antiretroviral Treatment, March 2006.

human rights movement. The revision of the *International Guidelines* in 2001 to reflect this thinking was a key human rights victory. However this report has shown that this right is being undermined by the slow progress made by SADC governments in rolling out ARVs.

Greater advocacy is needed for treatment scale-up within the context of a human rights-based response. This requires the underlying factors hindering access to treatment, such as stigma and discrimination, to be addressed as a matter of urgency.

(x) Using socio-economic rights to promote access to a decent standard of living for PLHAs is an emerging issue. It appears that in many countries socio-economic rights, such as the right to health care services, are not protected in law. Accordingly rights are only founded in policies and are difficult to enforce.

The *International Guidelines* require governments to take a holistic approach to responding to HIV in a human rights-based manner. Governments need to address all aspects of the *Guidelines* as failure to do so undermines the entire response – for example, a failure to create effective law enforcement undermines protective laws. They also require a focus on civil, political and socio-economic rights. Given that socio-economic rights deal with many of the factors that are fuelling the epidemic such as poverty, a lack of access to health services, housing and education, it is imperative that a greater focus is placed on making such rights 'real' within the SADC region.

Continuing advocacy and litigation is required to ensure that socio-economic rights become part of domestic legal frameworks.

(xi) Stigma and discrimination against persons infected and affected by HIV remains one of the most significant cross-cutting human rights issues.

This report has found that stigma and discrimination remain a key obstacle to PLHAs accessing health and legal services. Stigma and discrimination continue to plague the response to HIV in many countries, and act as a social barrier to accessing available services. Despite the significant role that stigma and discrimination play in preventing effective responses to HIV, very few SADC countries have taken steps to create strong anti-discrimination laws to protect the rights of PLHAs.

Advocacy is required for the development of equality legislation protecting PLHAs in all SADC countries.

(xii) A number of human rights challenges continue to face SADC countries. These include; stigma and discrimination, limited access to health care

services, restrictions on the right to access to information, the lack of political leadership on HIV/AIDS, limited funding for human rights initiatives and the continued criminalisation of drug use and sex between men.

Ten years after the development of *International Guidelines on HIV/AIDS and Human Rights* both new and old challenges exist to human rights-based responses to HIV. Many of these new challenges relate to the changing environment for HIV programming, such as new prevention technologies, proven treatments and cheaper drugs.

Continued vigilance and advocacy is needed to ensure the principles of a human rights-based response remain central to all strategies to combat and mitigate the impact of HIV/AIDS. The *International Guidelines* ought to also be re-assessed at regular intervals to ensure that they are still providing guidance on the key human rights issues.