REPORT

HIV, the Law and Human Rights in the African Human Rights System: Key Challenges and Opportunities for Rights-Based Responses to HIV

Study for the African Commission on Human and Peoples’ Rights
EXECUTIVE SUMMARY

This report examines the extent to which the African human rights system addresses HIV human rights related violations. This question is posed against the background of discrimination and stigma, against people living with HIV, vulnerable and key populations at higher risk of HIV exposure in Africa. An examination of the African regional, sub-regional and national laws and institutions/mechanisms which are constitutive elements of the African human rights system and a desk review of literature reveals the followings:

Norms and Mechanisms on HIV and Human Rights at the Regional Level.


Normatively, all these documents clearly prohibit discrimination on all grounds including HIV, and provide for the right to equality before the law. They also provide for the right to health which include the right to health care services and access to medicine.

Besides these binding treaties, the African Union has also adopted numerous Declarations to address HIV and human rights issues. Therefore the regional norms are conducive to protection of HIV related human rights violations.

In terms of monitoring mechanisms, the regional treaties mentioned above have established monitoring bodies. The African Commission on Human Peoples’ Rights (the African Commission) and the African Court of Human and Peoples’ Rights (the African Court) are mandated to oversee the enforcement of the African Charter and the Maputo Protocol. So far, the African Commission has fully delivered its mandate and entrenched its operations to the benefit of all including those infected and affected by HIV. To this end, informed by its protective mandate, it relies on Resolutions, Principles and Guidelines, as well as General Comments to clarify the violation of the Charter, advance the rights of persons infected and affected by HIV, and key populations at higher risk and combat their stigmatisation. In addition, although it is yet to address a case on HIV, the African Commission relies on its Concluding Observations to State reports, the interpretation of existing laws, draws on international standards of human rights and relies on its Special Mechanisms, especially the HIV Committee to tackle the violation of HIV related rights. Similarly, the African Court is yet to deal with an HIV related matter. Nevertheless, it has the potential to make a significant difference in the lives of those infected and affected by HIV, especially if one taps into its advisory opinion mandate which empowers it to foster respect for human rights.

As for the African Children Charter, its normative protection of children’s rights including the right to health is not questionable. Its monitoring body is the African Committee of Experts on the Rights and Welfare of the Child (African Children’s Committee or (ACERWC)) which had issued two General Comments on the African Children Charter. Although these General Comments did not address HIV related concerns directly, they expended on the right to health which also covers those affected or infected with HIV and those at risk of infection. In addition
the ACERWC has been instrumental in dealing with HIV through its thematic issues while delivering its promotional mandate. Moreover, through its protective mandate, the ACERWC relies on country visits to expend on the right to health and health care services; use its Concluding Observations to deal with health issues embedded in HIV related matters. However, the ACERWC missed some good opportunities to stress the importance of human rights in the context of HIV. Firstly, although the mission reports conducted by the ACERWC have a section dedicated to the right to health, HIV was overlooked. Secondly, the ACERWC’s States Parties Reporting Guidelines do not compel States Parties to provide information related to the rights of children and adolescents to HIV-related healthcare, including health information.

Not only the African Youth Charter clearly provides for the right to health and prohibits discrimination, it also specifically calls on the States Parties to protect and fulfil HIV related rights. This instrument offers a strong normative protection of HIV related human rights. However, the institution in charge of monitoring compliance by States Parties is the African Union Commission which is neither a judicial body nor a quasi-judicial one. Therefore the good protection of HIV related rights by the African Youth Charter is watered down by a weak monitoring institution.

A similar explicit protection of HIV related rights is provided by the African Charter on Democracy, Elections and Governance. Nevertheless, the monitoring body is equally the weak African Union Commission that has to rely on the political will of States Parties. Although the African Union Commission is empowered to coordinate and evaluate the “implementation of the Charter with other key organs of the Union including the Pan-African Parliament, the Peace and Security Council, the African Human Rights Commission, the African Court of Justice and Human Rights, the Economic, Social and Cultural Council, the Regional Economic Communities and appropriate national- level structures” (article 45(c) of the Charter), it is quite difficult to see the exact role of these bodies and at what stage and how they can efficiently hold States accountable for the lack of implementation of the Charter on democracy in general and the violation of HIV related rights in particular.

Finally, the internally displaced Persons Convention prohibits discrimination and offers a very explicit protection of health including medical care, sexual and reproductive that can also cover those infected or affected by HIV. Nevertheless, its monitoring is left to the Conference of States Parties under the supervision of the African Union Commission. Although this seems to be the weakest monitoring institution for it all depends on the good will of States, the seed of hope can be found in article 14 (4) of the Convention which urges States Parties to report on steps taken to give effect to the Convention while reporting to the African Commission under article 62 of the African Charter, and under the African Peer Review Mechanism. Therefore, the only platform to hold States accountable is through the quasi-judicial process provided by the African Commission by its protective mandate.

Although the African regional treaties, declarations and institutional arrangements have the potential to address human rights in the context of HIV, they face some key challenges.

| Key challenges at the regional level |
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The limited accountability for and enforcement of commitments: This is more relevant for non-binding Declarations which have only a moral force. In addition, when the monitoring is vested in the African Union Commission, or to the Conference of States Parties, the latter are not likely to comply as the monitoring body is toothless.

The limited focus on HIV from all mechanisms: So far, besides the HIV Committee, no other body has addressed HIV-related issues. In this regard, the African Commission and African Court have yet to adjudicate on an HIV-related complaint.

Inaccessibility of the mechanisms: The regional mechanisms are inaccessible to civil society organisations and for people affected by HIV. To participate in the African Commission’s public session, civil society organisations must have observer status. In addition, the African Court does not permit individuals to approach the court unless their country has signed the declaration permitting such access.

Limited awareness of HIV and human rights issues: There is still a need to increase awareness of the rights of people living with HIV, vulnerable, and key populations in the context of HIV and AIDS, as protected by regional treaties. Thus, to date, the African Commission has not yet dealt with communications relating specifically to HIV.

Resource constraints: Finally, the special mechanisms are hampered in their work by resource constraints, limiting their ability to, for example, conduct missions and fact-finding visits.

Norms and Mechanisms on HIV and Human Rights at the Sub-regional Level

Although originally informed by the need to foster economic integration, African Regional Economic Communities (RECs) treaties have evolved to focus on human rights and have accordingly established mechanisms to that effect. In this vein, the East African Community (EAC) treaty obliges its States parties to harmonize national health policies and regulations and promote exchange of information on health issues for the interest of the sub-region. In this framework the EAC’s Legislative Assembly passed the EAC HIV and AIDS Prevention and Management Bill (EAC Bill) on 23 April 2012. The Bill has since been signed by all EAC Partner States and is an enforceable law. Non-binding instruments on the same issues provide persuasive HIV-related legal and policy norms. To enforce these instruments, there is the East African Court of Justice (EACJ) which receives direct complaints on human rights violations and may act as court of first instance, as it is not necessary to exhaust local remedies at the national level. Nevertheless, the EACJ missed the opportunity to deal with a HIV and human rights case brought by a group of civil society organisations in Uganda challenging the Anti-Homosexuality Act. The court refused to make pronouncement on the case on the ground that the matter had already been settled at the national court.

The Southern Africa Development Community (SADC) region adopted a Model Law on HIV/AIDS (SADC Model Law) in 2008. This law serves as a guide for legislators, policymakers and other stakeholders seeking to address the human rights response to HIV. It guarantees the respect for human rights principles, rejects coercive approaches, addresses the root causes of vulnerability to infection and ensures the protection of members of vulnerable and marginalised groups. It also emphasises the importance of information, education and communication in the HIV response. Legislatures can select and adapt provisions from the Model Law for their own particular national situation. However, the SADC Tribunal in charge of enforcement is no longer
effective as in its early days. It has been weakened since 2010 when Zimbabwe challenged its legitimacy after it was found guilty of human rights abused by the Tribunal. The Tribunal is no longer open to individual, but to States only, and this hinders the possibility to protect human rights and those related to HIV.

The Economic Community of West African States (ECOWAS) is in the process of considering a Minimum Legal Framework on HIV and AIDS for its Member States. Importantly, similar to the EACJ, the ECOWAS court of justice is open to individual as court of first instance and has a well-known reputation for protecting human rights. It is therefore hoped that in years to come it will offer remedies related to HIV and human rights issues.

The challenges at the sub-regional level are similar to those at the regional level, namely: The limited accountability for and enforcement of commitment, the limited use of existing mechanisms for HIV-related complaints, the inadequate focus on sensitive criminal law issues and the closure of the SADC tribunal to individuals among others.

**Norms and Mechanisms on HIV and Human Rights at the National Level**

In most African countries, human rights including those related to HIV are provided for by the Constitution which amongst other prohibits discrimination and guarantees the right to equality. They also adopt legislative and policy measures to deal with the right to health and address HIV related concerns. Although some policies and measures need to be updated or review for the sake to protect HIV related human rights, in general, national courts have developed a sound jurisprudence on the question. As for National human rights institutions (NHRIs) also mandated to protect human rights, besides South Africa and Malawi, other NHRIs have much more work to do in promoting HIV related rights. In addition, in many African countries, it is imperative to raise awareness of rights among affected populations, increase access to justice, repealing punitive and restrictive legal provisions and ensure that more accessible mechanisms, such as NHRIs are fully used to protect HIV related rights.

Even though African countries have made progress in dealing with HIV and Human Rights, some key issues remain problematic as they need to be further attended to.

**Key issues**

- Women and girls (the gender question);
- Harmful cultural practices and traditional beliefs in the context of HIV;
- Equality and non-discrimination (the issue of stigma);
- HIV testing;
- Criminalisation of HIV transmission;
- Key populations at risk of HIV;
- Intellectual property rights and access to HIV medicine in Africa; and
- The rights and welfare of the African child in the context of HIV and AIDS.
This report also records emerging trends in HIV and human rights in Africa

Emerging Trends

- **Human rights at the time of expanding HIV services**

As a result of the expansion of HIV prevention and treatment services, there has been good progress in the fight against HIV. However, further progress could be recorded if access to post-exposure prophylactics among others becomes available throughout the continent.

- **Implementation and enforcement of laws and policies relating to HIV**

Many African countries enacted human rights-respecting laws and policies relating to HIV. Further, they have guaranteed fundamental rights protecting people living with and affected by HIV from human rights violations. However, such laws and policies are often not adequately implemented or enforced; hence those living with HIV still suffer discrimination and stigma.

- **Civil society space and HIV**

In spite of the important role of the civil society organisations in addressing HIV, they face numerous restrictions including regulations to their establishment, operation and to the implementation of their mandates.

- **Funding crisis and its impact on human rights and the HIV response**

The international funding to governments and to civil society for HIV has been significantly decreasing in the last few years. This has had a negative impact on the human rights response to HIV in Africa.

- **Conflicts and HIV in Africa**

While armed conflict and post-conflict situations can increase the need for HIV prevention and treatment services as a result of the prevalence of sexual violence, it is challenging to provide these services given the instability wrought by war.

At the heart of this report was the need to examine whether the African human rights system addresses the questions of HIV and human rights. From the forgoing discussion, the continental human rights architecture has a huge potential to addresses HIV human rights related violations through its provision of the right to health, its prohibition of discrimination and prescription for equality, its courts and quasi-judicial bodies at the regional, sub-regional and national levels.

At the regional level, there is absolutely no question whether regional treaties for the protection of human rights in Africa reduces vulnerability and promotes human rights in the context of HIV. More importantly, these treaties have established institutions/mechanisms to ensure compliance by States Parties. At the centre of these mechanisms, the oldest institution is the African Commission that has relied on its protective and promotional mandate as well as Special Mechanisms to advance peoples’ rights including those related to HIV. In addition, although the African Court is yet to deal with a specific case on HIV and human rights, its advisory mandate provides a platform which can be useful in advancing the rights related to HIV. Furthermore, while the ACERWC still awaits its first case on children’s rights and HIV, it has also relied on its thematic issues, its promotional and protective mandates to explain the right to health and...
medical attention to cover children infected and affected by HIV. However, in its guidelines on state reporting, it missed the opportunity to oblige States to report specifically on what they do to give effect to the rights of children and adolescents with HIV-related healthcare needs including health information. Moreover, the African Union Commission is in charge of monitoring the African Youth Charter and to lead and coordinate the implementation of the African Charter on democracy by States Parties. Nevertheless, the success of the African Union Commission depends on the good will of States parties. Finally, the Conference of States parties which monitors the Internally displaced Persons Convention is the weakest link of the monitoring mechanisms for its extreme dependence on the political will of the States parties.

At the Sub-regional level, the RECs normative standards are conducive to the protection of HIV related human rights violations. Nevertheless, such protection face challenges such as the lack of individual access to court in SADC, limited use of existing mechanisms for HIV-related complaints in EAC and the inadequate focus on sensitive criminal law issues in general.

At the national level, laws and policies as well as courts and NHRIs are conducive to the protection of HIV related human rights. This report concludes that the African human rights system has a huge potential to address HIV and human rights. However, for the continental system to unleash its potential there is a need to improve and strengthen the monitoring mechanisms. To this end the following recommendations should be considered.

**Recommendations**

**Recommendations to the African Commission**

It is recommended that the African Commission continues to place the rights of People Living with HIV and those vulnerable to it on its agenda and ensure that all its bodies and mechanisms promote and protect these rights through:

i. The continued prioritisation of the rights of people living with HIV and those at risk, vulnerable to and affected by HIV, which should remain an Agenda item at all Ordinary Sessions of the African Commission.

ii. Ensuring that specific enquiries on the rights of people living with HIV and key populations are included in Article 62 reports, the investigations, fact-finding missions and reports of relevant Special Rapporteurs such as the Special Rapporteur on Prisons Conditions of Detention and Policing in Africa, the Special Rapporteur on Migrants, Asylum Seekers, Migrants and Internally Displaced Persons and the Special Rapporteur on the Rights of Women in Africa, and the work of relevant Committees and Working Groups such as the ACERWC, amongst others.

iii. Calling on Member States to include HIV-relevant information in their periodic reports and provide Member States guidelines on which HIV-specific information to include in national periodic reports. An initial list of the types of information that should be included is provided in Appendix 1.

It is recommended that the African Commission continues to encourage Member States to ensure that domestic legal frameworks protect the rights of People Living with HIV and those vulnerable to infection through:

iv. Encouraging Member States to conduct law and policy review and reform and adopt, implement and enforce rights-based laws, policies and plans in the context of HIV and AIDS, drawing on international and regional guidance on HIV law and human rights emanating from SADC, the EAC and ECOWAS.
It is recommended that the African Commission supports Member States in their efforts to enhance domestic legal systems through:

v. Developing policy and legal guidelines for Member States on particular legal and policy issues affecting the rights of people living with HIV and key populations, determined in conjunction with key stakeholders and the HIV Committee. This should include amongst others guidelines that specifically condemn the overly broad criminalisation of exposure to HIV in HIV specific laws or through amendments to existing criminal laws and the meaning of the right to health within the context of HIV.

vi. Developing the appropriate framework or guidelines to monitor the implementation of the Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV services (Resolution 260) at the national level.


viii. Issuing a statement on whether the phrase any status used in Article 2 of the African Charter includes discrimination on the basis of HIV and sexual orientation.

It is recommended that the African Commission ensures that access to justice for People Living with HIV and those vulnerable to infection are strengthened through:

ix. Making efforts to increase awareness of the mandate of the Commission and its Special Rapporteurs and Committees, to support submissions and communications from civil society organisations on the rights of people living with HIV and key populations.

x. Calling on Member States to conduct thorough investigations of violations of the rights of People living with HIV and key populations and hold perpetrators accountable.

Recommendations to the Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV

It is recommended that the African Commission ensures that access to justice for People Living with HIV and those vulnerable to infection are strengthened through:

1. Raising awareness of its work.
   It is recommended that the Committee continues to monitor the implementation of HIV-related resolutions issued by the African Commission such as the Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV services (Resolution 260) through:

   2. Undertaking further research and fact finding missions.
      It is recommended that the Committee supports efforts of Member States to improve their domestic legal frameworks; ability to respond to HIV through:

   3. Making recommendations to the Commission regarding the need for explicit reference to the need for access to condoms as part of basic sexual and reproductive health care services in the Guidelines on the Conditions of Arrest, Police Custody and Pre-Trial Detention in Africa, adopted by the African Commission in 2014.
4. Issuing recommendations on the need for prosecutorial guidelines to guide national prosecuting authorities using HIV-related criminal law provisions.

**Recommendations to the African Committee of Experts on the Rights and Welfare of the Child**

It is recommended that ACERWC continues to place the rights of children People Living with HIV and those vulnerable to infection on its agenda through:

1. Actively conducting investigations, monitoring key human rights violations and spearheading resolutions on the rights of children living with and affected by HIV.

2. Developing a General Comment focused on the rights of children living with and affected by HIV and the obligation of states to respect, protect and fulfil such rights. This should include reference to a child’s right to information and sexual and reproductive health services.

3. Requiring specific HIV-related information from Member States in the States Parties Reporting Guidelines.

It is recommended that the ACERWC continues to encourage Member States to ensure that domestic legal frameworks protect the rights of children living with HIV and those vulnerable to infection through:

4. Conducting the necessary law and policy review and reform and adopting, implementing and enforcing rights-based laws, policies and plans in the context of HIV and AIDS to ensure they are in compliance with the ACRWC.

5. Developing policy and legal guidelines for Member States on particular legal and policy issues affecting the rights of children living with and affected by HIV, determined in conjunction with key stakeholders.

It is recommended that the ACERWC ensures that access to justice for children living with HIV and those vulnerable to infection are strengthened through:

6. Making efforts to increase awareness of the mandate of the Committee, to support submissions and communications from civil society organisations on the rights of children living with and affected by HIV.

**Recommendations to the African Union**

It is recommended that the African Union takes steps to enhance the structures to enforce human rights through:

1. Continuing to encourage State Parties to the African Court Protocol to make Declarations accepting the jurisdiction of the Court, in order to broaden access for HIV-related complaints to be brought before the African Court.

2. Ensuring a strong focus on protection of the rights of people living with HIV and key populations in the development of the current strategic planning document entitled Catalytic Actions to end AIDS, TB and Malaria by 2030, to be considered at the AU 2016 Summit.
3. Strengthening the African Union Commission monitoring mechanism by linking it to the African Commission or the African Court which have expertise on human rights and the necessary authority to hold states accountable

**Recommendations for Member States**

- They should take appropriate steps to repeal laws that may further fuel discrimination in the context of HIV
- Should adopt laws and policies as well as develop guidelines on HIV and human rights with a view to addressing HIV related stigma
- Should take measures to audit relevant laws and policies that may have implications on the enjoyment of human rights in the context of HIV
- Should increase allocation to the health sector in general and HIV services in particular as agreed in the Abuja Declaration
- Should adopt integrated and holistic approach to HIV prevention by linking family planning services to HIV care and support programmes
### ACRONYMS

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<td>Africa Regional Intellectual Property Organisation</td>
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National strategic plans on HIV NSPs
Non-governmental organisations NGOs
Organisation of African Unity OAU
Orphan and vulnerable children OVC
People living with HIV PLHIV
Post-exposure prophylactics PEP

Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa the Maputo Protocol
Protocol to the African Charter on Human and Peoples’ Rights on the Establishment of an African Court on Human and Peoples’ Rights the Court Protocol

Provider-initiated testing and counselling PITC

Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV services Resolution 260
Resolution on Protection against Violence and Other Human Rights Violations against Persons on the Basis of their Real or Imputed Sexual Orientation or Gender Identity Resolution 275

The Roadmap: Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa AU Roadmap

SADC Model Law on HIV/AIDS HIV Model Law
Southern African Development Community SADC
Southern African Development Community Parliamentary Forum SADC PF

Transgender Education and Advocacy TEA

Tuberculosis TB
United Nations UN
United Nations Children’s Fund UNICEF
United Nations General Assembly Special Session UNGASS

Voluntary testing and counselling VCT
World Health Organisation WHO
World Trade Organisation WTO

Zambian AIDS Law Research and Advocacy Network ZARAN

1. INTRODUCTION
For more than three decades the international community has been working hard to address the scourge of the HIV pandemic which ravages the world and particularly Africa which is its epicentre. In 2015, there were an estimated 25.6 million people living with HIV in Africa, representing nearly 71% of the global total of 36.7 million.\(^1\) In that year alone, there were an estimated 1.4 million new HIV infections and some 800,000 deaths due to AIDS-related illnesses in Africa.\(^2\) Since the beginning of the HIV epidemic, the overwhelming majority of the 35 million AIDS-related deaths globally have occurred in Africa.\(^3\)

Although important progress has been made in the response to HIV in the region – with a decline in new HIV infections and significant increase in access to antiretroviral treatment – the epidemic remains the leading cause of death in sub-Saharan Africa.\(^4\) Moreover, serious social, legal and policy issues, such as stigma, discrimination, gender inequality and other negative norms and practices that affect people vulnerable to HIV and hinder access to HIV services, remain largely unchallenged.\(^5\)

In recognition of these challenges, the African Commission on Human and Peoples’ Rights (the African Commission) has adopted several resolutions to address the epidemic, including the following resolutions: ACHPR/Res.53 (XXIX) 01 on the HIV/AIDS Pandemic – Threat Against Human Rights and Humanity; ACHPR/Res.141 (XLIV) 08 on access to health and needed medicines in Africa; and ACHPR/Res. 260(LIV) 13 on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services.

Furthermore, in 2010 the African Commission adopted Resolution ACHPR / Res.163 (XLVII) 10 on the establishment of the Committee on the Protection of the Rights of People Living with HIV (PLHIV) and those at Risk, Vulnerable to and Affected by HIV (‘the HIV Committee’). The HIV Committee is mandated to:

- Seek, request, receive, analyse and respond to reliable information from credible sources, including individuals, community-based organisations, non-governmental organisations, specialised agencies, inter-governmental organisations, and State Parties, on the situation and rights of PLHIV and those at risk
- Undertake fact-finding missions, where necessary, to investigate, verify and make conclusions and recommendations regarding allegations of human rights violations
- Engage States Parties and non-state actors on their responsibilities to respect the rights of people living with HIV and those proven to be vulnerable to these infections
- Engage States Parties on their responsibilities to respect, protect and fulfil the rights of PLHIV and those at risk

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\(^2\) As above.
• Recommend concrete and effective strategies to better protect the rights of PLHIV and those at risk
• Integrate a gender perspective and give special attention to persons belonging to vulnerable groups, including women, children, sex workers, migrants, men who have sex with men, people who inject drugs and prisoners; and
• Report regularly to the African Commission.

It is against this backdrop that the African Commission during its 16th Extraordinary Session held in July 2014 in Kigali,(Resolution 290 on the Need to Conduct a Study on HIV, the Law and Human Rights) tasked the HIV Committee to conduct a study on “HIV, the Law and Human Rights in the African Human Rights System: Key Challenges and Opportunities for Rights-based Responses to HIV”. Nevertheless, due to resource constraint, the HIV Committee experienced some delay in finalising the studies. However, the African Commission adopted the Resolution 308 On The Extension Of The Deadline For The Study On HIV, The Law And Human Rights to give more time to the HIV Committee to conclude the study. The extension of the deadline demonstrates the importance of conducting a study that looks at the HIV response from law and human rights perspectives.

There is absolutely no doubt whether HIV is a human rights issue in Africa and globally. People living with HIV experience HIV-related stigma, discrimination, and violations of their rights every day in their families, communities, health care facilities, working environments, and schools. In addition, vulnerable and key populations such as women and girls, young people, persons with disabilities, migrants, sex workers, gay men and men who have sex with men, transgender people, and people who use drugs feel the impact of punitive and discriminatory laws, policies and practices that deny their rights and create barriers to their access to life-saving health care services. 6 Hence the need to rely on the human rights-based approach to protect the rights of PLHIV and key populations at higher risk of HIV exposure, to reduce stigma, discrimination, and human rights violations and to remove legal and policy barriers to universal access to HIV prevention, treatment, care and support. This approach is important because as correctly argued by the Global Commission “[t]he legal environment—laws, enforcement and justice systems—has immense potential to better the lives of HIV-positive people and to help turn the crisis around. International law and treaties that protect equality of access to health care and prohibit discrimination—including that based on health or legal status—underpin the salutary power of national laws”. 7 It is against this backdrop that this report focuses on the African human

7 About the Global Commission on HIV and the law, ‘Risk, Rights and Health’ (July 2012)
rights System to explore the extent to which this regional legal architecture addresses HIV/AIDS related human rights violations in Africa.

In this report, “the African human rights system” should be understood broadly. In other words, it includes “the regional” i.e. AU based system and “the sub-regional” and national laws with its case law and respective institutions at various levels. In effect, the AU human rights system is based on the Organisation of the African Unity (OAU) Charter of 1963, (now 2001 AU Constitutive Act), the 1969 OAU Convention Governing the Specific Aspects of Refugees in Africa, the 1981 African Charter on the Human and Peoples Rights (ACHPR or African Charter) and its 1998 Protocol to the ACHPR on the Establishment of an African Court on Human and Peoples’ Rights (Protocol on the African Human Rights Court); its 2003 Protocol to the ACHPR on the Rights of Women in Africa (Protocol on the Rights of Woman or Maputo Protocol), the 1990 African Charter on the Rights and Welfare of the Child (African’s Children Charter), the 2006 African Youth Charter, the 2007 African Charter on Democracy, Elections and Governance the 2008 Protocol on the Statute of the African Court of Justice and Human Rights, and finally the 2009 African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa. In addition, it also comprises sub-regional and national laws and mechanisms to give effect to human

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8 For more on this broad definition of the African human rights system, see F Vieljoen International Human Right Law in Africa (2012) 169 -170.
17 Adopted in 30 January 2007 in Addis Abeba and entered into force on 15 February 2012
18 Adopted in Sharm El-Sheikh, Egypt, on 1 July 2008; Ass/AU/Dec.196 (XI) DOC. ASSEMBLY/AU/13 (XI).
rights. Hence the report assesses how regional, sub-regional and national laws and institutions address human rights in the context of HIV.

Ultimately the report finds that the African human rights system has an immense potential for the protection of HIV related human rights as from the regional, sub-regional and national levels norms and mechanisms/institutions are well established for the protection of PLHIV and the vulnerable groups. Nevertheless, for the African human rights system to make a difference, it is important to move from normative protection to effective implementation, and for this to happen it is necessary to strengthen monitoring and enforcement institutions at the regional, sub-regional and national levels and make the more accessible to the grassroots.

This report is divided into seven sections. It begins with this introduction. Section 2 presents a synopsis of the HIV epidemic in Africa. Section 3 examines the African regional human rights system and HIV with special attention its norms and mechanisms. This section explores the extent to which legal and institutional arrangements at the regional and sub-regional level tackle HIV human rights related violations. Section 4 assesses the national legal and institutional responses to HIV and human rights, section 5 focuses on the key human rights concerns of PLVHI and the vulnerable groups and section 6 draws the associated trends. Finally section 7 presents the findings and recommendations. Some suggestions for inclusion of guidelines for state reporting on rights in the context of HIV, AIDS and TB; PLHIV and key populations at higher risk of HIV exposure can be found at Annex I.
12. THE HIV EPIDEMIC IN AFRICA

This section is divided into 3 parts. The first part reiterates that Africa is the epicentre of the HIV pandemic, examines the heterogeneity of the AIDS epidemic and response in Africa with attention to the diverse burden of the epidemic and patent of progress made. The second part focuses on population left behind and the third final part summarises the section.

2.1 Africa: The epicentre of the global AIDS epidemic

More than 30 years into the AIDS epidemic, Africa remains the region of the world most affected by HIV. As demonstrated at the introduction with statistics, to the dismay of the world, Africa has been associated with pain and related AIDS deaths\(^19\) and it would not be an exaggeration to claim that Africa has been ravaged by the epidemic.

The HIV epidemic is also contributing to high Tuberculosis (TB) incidence and deaths in Africa, as TB is the leading cause of mortality among PLHIV in the region.\(^20\) With 281 TB cases for every 100,000 people in 2014 – more than double the global average – the African region has the most severe TB burden relative to the population.\(^21\) More than 75% of all people with HIV-related tuberculosis live in just 10 countries, nine of them in sub-Saharan Africa. These include Ethiopia, Kenya, Mozambique, Nigeria, South Africa, the United Republic of Tanzania, Uganda, Zambia and Zimbabwe.\(^22\) More than two third (23 out of 30) of the countries with the highest TB burden are in Africa.\(^23\) Furthermore, 6 countries in Africa are among the 20 countries with the highest estimated numbers of incident multi-drug resistant TB, namely DRC, Ethiopia, Kenya, Mozambique, Nigeria, South Africa.\(^24\)

The impact of the HIV epidemic on families and communities is significant in the region. High HIV-related mortality among adults translates in high number of children orphaned by the epidemic. As of December 2012, an estimated 15 million children in sub-Saharan Africa –

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\(^24\) As above. Multi-drug resistant TB (MDR-TB) is defined as TB cases that are resistant to two of the following TB treatment, namely rifampicin and isoniazid.
85% of the global total – had lost one or both parents to AIDS. The AIDS epidemic also has important economic and social impacts. In the early 2000’s life expectancies in the countries most affected by HIV in Africa dropped significantly with up to 34 years decline in life expectancy in Botswana, for instance (see figure 1).

![Figure 1: Devastation from HIV/AIDS—life expectancy in Sub-Saharan Africa plummets](source: UNDP, Human Development report 2002, page 27)

The cost of caring for household members with AIDS-related illnesses is high and is compounded by the overall reduced family income because of the inability to work induced by AIDS-illness. While recent progress in access to HIV treatment on the continent have helped mitigate these impacts of the epidemic, the social and economic consequences of AIDS continue to be serious in communities where treatment coverage remains low.

2.2 The heterogeneity of the AIDS epidemic and response in Africa

2.2.1 Diverse burden of the HIV epidemic

The AIDS epidemic Africa is far from homogenous. Countries in Eastern and Southern Africa are generally more affected by HIV than those in West and Central Africa, and countries in North Africa are among those with the lowest HIV prevalence (see Table 1). All six countries in the world with HIV prevalence in the adult population above 15% (also referred to as hyperendemic countries) are in Southern Africa. With the exception of Equatorial Guinea, all countries in West and Central Africa have an HIV prevalence of less than 5% in the adult population aged 15-49 (see Table 1). With the exception of Djibouti, the HIV prevalence in all North African countries

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December 2016

is below 1% (see Table 1).

**Table 1: Estimated HIV prevalence (persons aged 15-49 years) in African countries in 2014**

<table>
<thead>
<tr>
<th>Sub-region</th>
<th>HIV prevalence below 1%</th>
<th>HIV prevalence between 1 and 5%</th>
<th>HIV prevalence between 5 and 10%</th>
<th>HIV prevalence above 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>North Africa</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Algeria</td>
<td>&lt;0.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Egypt</td>
<td>&lt;0.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morocco</td>
<td>0.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somalia</td>
<td>0.5%</td>
<td>Djibouti (1.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudan</td>
<td>0.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tunisia</td>
<td>&lt;0.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>West and Central Africa</strong></td>
<td></td>
<td></td>
<td></td>
<td>Equatorial Guinea (6.2%)</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>0.9%</td>
<td>Benin (1.1%), Burundi (1.1%),</td>
<td>Cameroon (4.8%), Cape Verde (1.1%), Central African Republic (4.3%), Chad (2.5%), Congo (2.8%), Côte d’Ivoire (3.5%), DRC (1%), Gabon (3.9%), Gambia (1.8%), Ghana (1.5%), Guinea (1.6%), Guinea Bissau (3.7%), Liberia (1.2%), Mali (1.4%), Nigeria (3.2%), Sierra Leone (1.4%), Togo (2.4%)</td>
<td></td>
</tr>
<tr>
<td>Mauritania</td>
<td>0.7%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Niger</td>
<td>0.5%</td>
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<td></td>
</tr>
<tr>
<td>Sao Tome and Principe</td>
<td>0.8%</td>
<td></td>
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<td></td>
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<tr>
<td>Senegal</td>
<td>0.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eastern and Southern Africa</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eritrea</td>
<td>0.7%</td>
<td>Angola (2.4), Ethiopia (1.2%),</td>
<td>Rwanda (2.8%), South Sudan (2.7%)</td>
<td>Kenya (5.3%), Malawi (10%), Uganda (7.3%), Tanzania (5.3%)</td>
</tr>
<tr>
<td>Madagascar</td>
<td>0.3%</td>
<td></td>
<td></td>
<td>Botswana (25.2%), Lesotho (23.4%), Mozambique (10.6%), Namibia (16%), South Africa (18.9%), Swaziland (27.7%), Zambia (12.4%), Zimbabwe (16.7%)</td>
</tr>
<tr>
<td>Mauritius</td>
<td>0.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Great differences in HIV prevalence and incidence also exist within countries. In Kenya, 65% of all new HIV infections in 2014 occurred in nine of the 47 counties (see Figure 2). Similar trends are reported across sub-Saharan Africa, with higher HIV prevalence and incidence being concentrated in some specific parts of the countries.

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2.2.2 Important but unequal progress

Significant progress has been made in recent years against HIV in sub-Saharan Africa. The number of people receiving antiretroviral therapy (ART) in the region increased from less than 100,000 in 2000 to 11.8 million in 2015. The expanded access to HIV treatment in the region is contributing to reducing AIDS-related deaths in sub-Saharan Africa which fell by 39% between 2005 and 2013. Countries that recorded the most significant reduction in AIDS-related deaths include Rwanda (76%), Eritrea (67%), Botswana (58%), Burkina Faso (58%), Ethiopia (63%), Kenya (60%), Zimbabwe (57%), Malawi (51%), South Africa (48%) and the United Republic of Tanzania (44%).

Coverage of programmes for the prevention of mother-to-child transmission (PMTCT) has increased drastically, particularly in Eastern and Southern Africa where 90% of pregnant women living with HIV were reported to receive effective antiretroviral medicines for PMTCT in 2015. Consequently, in some countries such as Botswana where PMTCT coverage is above 90%,
vertical HIV transmission rates have been reduced to below 5%.

In general, new HIV infections in sub-Saharan Africa have dropped from 2.3 million in 2000 to 1.4 million in 2014.

Key to these advances have been the commitment of governments, the critical role played by civil society including people living with HIV, the lowering costs of HIV treatment and the international funding for the response to the epidemic. However, recent data shows that donor governments’ spending on HIV has declined by more than $1 billion in 2015 (US$7.53 billion in 2015 compared to US$8.62 billion in 2014) – representing a 13% decline in a single year. This important decline marks the first reduction in donor funding for HIV in the past 5 years. It calls on governments in Africa to continue and step up their efforts to increase domestic funding to expand access to HIV prevention, treatment, care and support.

The advances in the response to HIV in Africa have been uneven with important difference between regions and countries in terms of access to ART and the reduction of new HIV infections. In general, countries in Eastern and Southern Africa are witnessing more robust progress in access to ART compared to countries in West and Central Africa. For instance, just 29% of adults living with HIV in West and Central Africa have access to ART compared to 53% in Eastern and Southern Africa. Only 20% of children below the age of 15 living with HIV in West and Central Africa were accessing ART in 2015 compared to some 63% in Eastern and Southern Africa.

According to a recent report by Médecins Sans Frontières, the lower access to HIV treatment in West and Central Africa is due to several factors, including high stigma and discrimination; weak health systems and inadequate service delivery models, limited role of civil society, low prioritisation of HIV and lack of political leadership, and delayed response to the needs of people living with HIV in the context of recurrent humanitarian crises in the region.

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36 As above.
North Africa is the only region in Africa where AIDS related deaths and new HIV infections are on the increase. Since 2010, new HIV infections among adults have increased by more than 40% in Egypt.\textsuperscript{39} Similarly, new HIV infections have increased in the same period in Somalia and Soudan.\textsuperscript{40} The limited access to antiretroviral treatment in the region translates in growing numbers of AIDS-related deaths with a 40% increase in AIDS-related deaths in Sudan between 2010 and 2015.\textsuperscript{41} All North African countries except Djibouti have experienced an increase in AIDS-related deaths since 2005.

\textbf{1.3. Populations left behind in the response to the HIV epidemic}

The impact of the HIV epidemic in Africa differs among populations. In sub-Saharan Africa, young women (aged 15-24) accounted for 25% of new HIV infections among adults and women accounted for 56% of new HIV infections among adults.\textsuperscript{42} There were approximately 4500 new HIV infections weekly among young women in the region, which is double the number among young men.\textsuperscript{43} Adolescent girls and young women are less able to negotiate condom use, have limited access to HIV testing, modern contraception and family planning. In Chad, Guinea, Mali, Mozambique and Niger, 1 in 10 girls has a child before the age of 15 years.\textsuperscript{44} Some 41% of girls in Western and Central Africa, and 34% of girls in Eastern and Southern Africa are married as children.\textsuperscript{45} Child marriage has been associated with higher exposure to intimate partner violence and commercial sexual exploitation. Women who are exposed to intimate partner violence are 50% more likely to acquire HIV than those who are not exposed.\textsuperscript{46} Women and young girls living with HIV in sub-Saharan Africa are also at increased risk of other sexually transmitted infections including the human papillomavirus (HPV) which causes diseases that range from benign lesions to invasive cancers. The prevalence rate of HPV among women living with HIV reaches as high as 80% in Zambia and 90–100% in Uganda.\textsuperscript{47}

In all sub-Saharan African countries – and regardless of the nature and level of the HIV epidemic – data shows that specific population groups, prisoners, sex workers, gay men and men who

\textsuperscript{39} UNAIDS \textit{Prevention gap report} (2016) 160.
\textsuperscript{40} As above, 222.
\textsuperscript{41} As above, 234
\textsuperscript{42} As above, 7.
\textsuperscript{43} As above, 100.
\textsuperscript{46} As above.
have sex with men and people who inject drugs are particularly impacted by the epidemic.\textsuperscript{48} These populations, also referred to as key populations,\textsuperscript{49} experience higher HIV prevalence and incidence and often have limited access to HIV prevention, treatment and care services.\textsuperscript{50} Even in high prevalence settings, HIV prevalence among members of key populations is higher than that of the general population. According to UNAIDS, 17 of the 18 countries where HIV prevalence among sex workers exceeds 20% are located in sub-Saharan Africa.\textsuperscript{51} No African countries report an HIV prevalence of less than 6% among sex workers.

HIV prevalence among men who have sex with men (MSM) in Western and Central Africa is over 18\% compared to less than 2\% in the general population.\textsuperscript{52} HIV prevalence among MSM in North Africa is also high at 13\% in Algeria, 10\% in Tunisia, and 5\% in Morocco. Even, in Eastern and Southern Africa, the region with the highest HIV prevalence in Africa, MSM face higher HIV burden. HIV prevalence among MSM is more than 15\% in Kenya and Mauritius and over 20\% in Tanzania.\textsuperscript{53}

Throughout Africa, HIV prevalence is higher among prisoners than in the general adult population. In Mauritania, in 2012 there was an estimated HIV prevalence of 24.8\% among prisoners, 40\% of whom inject drugs.\textsuperscript{54} In South Africa, HIV prevalence is 2.4 times higher among prisoners than in the general adult population.\textsuperscript{55} Prisons are often overcrowded due to inappropriate, ineffective, and excessive criminal laws. Overcrowding increases vulnerability to infections such as HIV, tuberculosis and hepatitis.\textsuperscript{56} Prisoners are also at risk of violence and denial or disruption in HIV prevention and treatment services, including access to harm reduction services.\textsuperscript{57} Available data on HIV among people who inject drugs in sub-Saharan Africa also point to particularly high HIV prevalence among these populations.\textsuperscript{58}

\textsuperscript{49} UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the main key population groups. These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere—they are key to the epidemic and key to the response. UNAIDS UNAIDS terminology guidelines 2015 (2015) 31, available at \url{http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf} (accessed on 28 December 2016).
\textsuperscript{50} As above, 45.
\textsuperscript{51} As above, 205.
\textsuperscript{52} As above, 46.
\textsuperscript{53} As above, 149.
\textsuperscript{54} As above, 150.
\textsuperscript{55} As above, 149.
\textsuperscript{57} UNAIDS The gap report (2014) 149-153.
\textsuperscript{58} As above29
High HIV prevalence among the populations most affected by HIV in Africa cannot be justified by biology or sexual practices. Gender inequalities, including gender-based violence, exacerbate women's and girls' physiological vulnerability to HIV and block their access to HIV services. Young people are denied the information and the freedom to make free and informed decisions about their sexual health, with most lacking the knowledge required to protect themselves from HIV.\textsuperscript{59} The impact of these barriers is strongest in high-prevalence settings, predominantly in Eastern and Southern Africa.

Similarly, stigma, discrimination, violence, negative gender and heteronormative constructs, as well as criminal laws against members of key populations particularly sex workers, people who inject drugs and MSM have been shown to increase their vulnerability to HIV and to limit their access to HIV services.\textsuperscript{60} For instance, harassment, violence (including by police) and denial of

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{59} UNAIDS, Prevention gap report (2016) 236.
\item \textsuperscript{60} WHO, Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations (2014) available at http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1 (accessed on 26 August 2016).
\end{itemize}
\end{footnotesize}
prevention services such as harm reduction programmes contribute to higher vulnerability to HIV among people who use drugs and their sexual partners.\textsuperscript{61} Similarly, MSM face serious barriers in accessing ART and other health care services due to discrimination in health care settings, abuse, fear of arrest and other negative consequences due to the criminalisation of same sex sexual relations.\textsuperscript{62} In Malawi, Botswana and Namibia, more than 80\% of MSM have not disclosed their same-sex sexual practices to a health practitioner. This situation has serious implications for providing information, protection and quality health care services for this population because

MSM have different HIV risks as compared to heterosexual men suggesting that the consistent association between discrimination events and [sexually transmitted infection] STI variables is reflective of the role of stigma in the general sexual health of MSM. Clinicians likely will not assess for anal [human papillomavirus] HPV infection, among other STIs, among men unless they are aware that these men are at specific risk for these infections.\textsuperscript{63}

2.3. \textit{Section conclusion}

This section shows that in spite of important progress in the HIV response in Africa, critical challenges remain for ensuring that all regions and populations benefit from the increase access to HIV treatment and reduce new HIV infection. Unequal progress within and between regions have led to a variety of HIV epidemics and their ensuing differentiated impacts on countries, locations and populations across Africa. Tailored responses are therefore needed to respond to the particular challenges facing specific populations and locations in the region.\textsuperscript{64} In particular, vulnerabilities and barriers – including in law, policy and practices – experienced by the populations most affected by the HIV epidemic in each national contexts must be identified and addressed. Effective measures are needed to respond to stigma and discrimination towards people living with, affected by and vulnerable to HIV.

3. OVERVIEW OF THE AFRICAN REGIONAL HUMAN RIGHTS SYSTEM AND HIV: NORMS AND MECHANISMS

\textsuperscript{62} WHO \textit{Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations} (2014).
Background

As indicated at the introduction, HIV is well recognised as a human rights issue in Africa and across the world. PLHIV and those affected by HIV are generally victim of stigma and discrimination in their daily lives and as such are not allowed to enjoy their rights to equality and dignity as on equal basis with others. Moreover, in addition, vulnerable and key populations identified earlier feel like if they were not humans as they suffer the effect of unjust laws policies and practices that keep them at the margin of the society to the extent that they cannot access basic rights including access to life-saving health care services, which are afforded to others. The key human rights issues experienced by people living with HIV (PLHIV) and key populations are discussed in further detail in Section 5 below.

National, regional, and international responses to HIV recognise the need to integrate rights-based approaches in order to protect the rights of PLHIV and key populations at higher risk of HIV exposure, to reduce stigma, discrimination, and human rights violations and to remove legal and policy barriers to universal access to HIV prevention, treatment, care and support. This understanding is reflected in various declarations, frameworks, and other non-binding documents, many of which are discussed in further detail in the sections below. Rights-based approaches to HIV demand respect for individual autonomy, elimination of barriers to services, participation and accountability. It is generally agreed that a rights-based approach to the HIV/AIDS will go a long way in not only improving the living conditions of those infected and affected by HIV, but will also help in curbing the further spread of the epidemic in the region. It will be recalled that in 2012 the Global Commission on HIV and Law released its report ‘HIV and the Law: Risks, Rights and health’ which addresses various human rights challenges in the content of HIV across the globe. While this report also features some of the challenges in Africa, it does not capture comprehensively the human rights situation in Africa. Hence, the need for this report which is intended to provide a much more detailed analysis on the human rights situation in the context of HIV in Africa. It is important to note that ‘The protection of human rights is essential to safeguard human dignity in the context of HIV and to ensure an effective, rights-based response to HIV and AIDS. An effective response requires the implementation of all human rights, civil and political, economic, social and cultural, and fundamental freedoms of all people, in accordance with existing international human rights standards.’

This section aims to establish the nature and extent of human rights protection for people affected by HIV through the African human rights system. It looks at the African Charter on Human and Peoples’ Rights and other key human rights treaties and the mechanisms established by these treaties, to determine the applicability of the treaties’ provisions for HIV and the findings and actions of its regional mechanisms in relation to HIV and human rights, to date. It seeks to discover what has been done, what has not been done and what is still possible.

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The relevant documents within the African human rights system are: The African Charter on Human and Peoples’ Rights (the African Charter), 1981; The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (the Maputo Protocol), 2003; The African Charter on the Rights and Welfare of the Child (the Children’s Charter), 1999; the African Youth Charter, the African Charter on Democracy, and the Internationally Displaced Persons Convention. This report will focus on these documents as the expressly provide for the right to health or HIV.

It is worth noting that the Maputo Protocol remains one of the most progressive and radical human rights instruments relating to the sexual and reproductive health and rights of women. It explicitly recognises women’s rights to be protected in the context of HIV. Its entry into force in November 2005 signifies a new dawn in the advancement of women’s rights in general and in the context of HIV in particular. In addition, the section draws inspiration from international human rights instruments and authoritative interpretations provided by treaty monitoring bodies. Within these treaties there are a number of provisions relevant to protecting rights in the context of HIV. These include the rights to life, dignity, privacy, non-discrimination, health, liberty and freedom from cruel inhuman and degrading treatment. More than 30 years into HIV/AIDS pandemic human rights violations have continued in nearly every facet of human endeavour, including housing, health care setting, workplace, community and family. The situation is more precarious for disadvantaged groups such as women, children, prisoners, person with disabilities and sexual minorities.

Regional human rights bodies such as the African Commission - responsible for monitoring the implementation of the African Charter and the Maputo Protocol - the Committee of Experts on the Rights and Welfare of the Child (ACERWC) - charged with monitoring the implementation of the Children’s Charter - can play an important role in addressing human rights issues relating to HIV. Through their promotional and protective mandate, these bodies can develop norms and standards as well as provide clarifications on issues relating to HIV and human rights.

### 3.1 Norms Related to HIV under the African Human Rights System

68 South Sudan is the only country to have not ratified the African Charter.

69 The following countries have signed but not ratified the Maputo Protocol: Algeria, Burundi, Central African Republic, Chad, Eritrea, Ethiopia, Madagascar, Mauritius, Niger, Sahrawi Arab Democratic Republic, Sao Tome and Principe, Sierra Leone, Somalia, South Sudan, and Sudan. The following countries have neither signed nor ratified the Maputo Protocol: Botswana, Egypt and Tunisia.

70 The following countries have signed but not ratified the Children’s Charter: Central African Republic, Djibouti, Guinea-Bissau, Liberia, Sahrawi Arab Democratic Republic, Somalia, Swaziland, Tunisia, and Zambia. The following countries have neither signed nor ratified the Children’s Charter: Democratic Republic of the Congo, Sao Tome and Principe, South Sudan, and Sudan.

71 37 African States are parties the to Youth Charter

72 21 African countries are parties to the African Charter on Democracy. They are: Benin, Burkina Faso, Cameroon, Chad, Ethiopia, Ghana, Guinea, Guinea-Bissau, Lesotho, Malawi, Mali, Mauritania, Niger, Nigeria, Rwanda, Sierra Leone, South Africa, Sudan, Togo and Zambia.

73 22 States have ratified the Kampala Convention: Angola, Benin, Burkina Faso, Central African Republic, Chad, Côte d’Ivoire, Gabon, Guinea-Bissau, Lesotho, Malawi, Mali, Niger, Nigeria, Rwanda, Sahrawi Arab Democratic Republic, Sierra Leone, Swaziland, The Gambia, Togo, Uganda, Zambia and Zimbabwe.

74 The African Commission is a quasi-judicial treaty body established under Article 30 of the African Charter. The African Charter was adopted in 1981 by member states of the Organisation of African Unity (OAU) which is now the African Union (AU). The African Commission is comprised of 11 members, holds two ordinary sessions and two extra-ordinary sessions per year, and has the mandate to protect and promote human and peoples’ rights in Africa.
The African Charter on Human and Peoples’ Rights, the Protocol on the Rights of Women, and the African Commission

The Organisation of African Unity (OAU), now the African Union (AU) adopted the African Charter in 1981 which then came into force on 21 October 1986. The African Charter protects a range of rights, including so-called ‘first generation’ civil and political rights as well as ‘second generation’ economic, social and cultural rights, and ‘third generation’ collective rights. The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (the Maputo Protocol) also protects and expands upon many of these rights.

In order to protect, promote, and interpret the provisions of the African Charter and the Maputo Protocol, Article 30 of the Charter established the African Commission. Thus, interpreting the human rights violations against people living with and affected by HIV outlined in this report, within the framework of the African Charter, would fall under the purview of the African Commission.

3.2 Providing Clarification on the African Charter and Maputo Protocol

Under its promotional mandate in article 45 of the African Charter, the African Commission is empowered to give clarity and provide interpretation of the relevant provisions of the Africa Charter. Subsequently, upon the entry into force of the Maputo Protocol the Commission is also charged with providing clarity to the provisions of the Protocol. The African Commission provides clarification to these instruments through the issuance of resolutions, general comments and guidelines. Over the years the African Commission has had the opportunity to provide guidance on issues relating to HIV in the region. For instance, the African Commission has adopted important resolutions to address the link between HIV and human rights in the region. Some of these include resolution on HIV pandemic as a threat against human rights and humanity, access to medicines in the context of HIV and forced or involuntary sterilisation of HIV positive women as a violation of human rights and violence against persons on the basis of real or imputed sexual orientation or identity.

In Resolution 141 on Access to Health and Needed Medicines in Africa, the Commission stated that a part of Article 16 is access to proper medication. The Resolution states that “access to medicines forms an indispensable part of the right to the highest attainable standard of health” and that, therefore, the right to health mandates that State promote “the realization of the right to medicines for all.” This right to access medications was also elaborated in the Principles and

75 The following countries have signed but not ratified the Maputo Protocol: Algeria, Burundi, Central African Republic, Chad, Eritrea, Ethiopia, Madagascar, Mauritius, Niger, Sahrawi Arab Democratic Republic, Sao Tome and Principe, Sierra Leone, Somalia, South Sudan, and Sudan. The following countries have neither signed nor ratified the Maputo Protocol: Botswana, Egypt and Tunisia.


Guidelines, which directs state parties to “adopt and implement policies that ensure that members of vulnerable and disadvantaged groups have access to medicines.” 81

In its Resolution 260 on Involuntary Sterilisation, the African Commission notes that forced sterilisation of HIV-positive women violates women’s rights to equality and non-discrimination, in addition to violating other fundamental rights guaranteed under the African Charter. 82 It condemns all forms of stigma and discrimination in terms of access to, and provision of, health services in the context of HIV and emphasises that all forms of involuntary sterilisation violate women’s rights to health.

Resolution 275 adopted in 2014, expresses the African Commission’s concern at the acts of violence, discrimination, and other human rights violations against persons on the basis of their real or perceived sexual orientation and/or gender identity. Resolution 275 confirmed that these acts violate the right to be free from discrimination and the right to equal protection of the law, amongst other things. While the Resolution does not mention HIV explicitly, this is relevant to HIV rights under the African system as the LGBT population is particularly prone to discrimination in education and healthcare which affects HIV outcomes.

In the context of education, the Commission issued Resolution 346 on the Right to Education in Africa which calls on states to “prohibit and prevent all forms of discrimination in education against children with HIV/AIDS based on their real or perceived status”. 83 These resolutions tend to draw the attention of states to important human rights issues in the context of HIV that warrant their urgent responses.

Also, the African Commission has issued important guidelines relevant to HIV and human rights in the region. For instance, the Guidelines on the Conditions of Arrest, Police Custody and Pre-Trial Detention in Africa, adopted by the African Commission in 2014, formulates standards, principles, and rules on which African Governments can frame their legislation. The Guidelines note that countries should ensure that measures seeking to protect vulnerable populations, including PLHIV, should not be discriminatory or applied in a discriminatory manner. 84

In the Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples’ Rights (Principles and Guidelines), the Commission also sets a target of 15% of state parties annual budgets to improve the health sector and mandates that “[a]n appropriate and adequate portion of this amount must be put at the disposal of the national authorities responsible for the fight against malaria, HIV/AIDS, tuberculosis and other related diseases.” 85 This 15% budgetary target was also set out in the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (Abuja Declaration). 86 The Commission has followed up on this budgetary requirement in several of

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85 As above, 25.
their concluding observations. The Principles and Guidelines also define people living with or affected by HIV/AIDS as a vulnerable group.\textsuperscript{87}

More recently, the African Commission has resorted to issuing General Comments to clarify the provisions of the African Charter and the Maputo Protocol. General Comments provide clarification on a specific right or provision of a treaty. They can advance thought about a difficult matter, encourage debate about a treaty, and spread and deepen its relevance to the human rights movement.\textsuperscript{88} General Comments have been used by UN treaty monitoring bodies to elaborate on states obligations in relation to a specific provision or right of a treaty. During its 52\textsuperscript{nd} Ordinary Session in Yamoussoukro, Cote d’Ivoire, the African Commission for the first time in its history adopted a general comment (herein after referred to as GC 1) to clarify article 14 (1) (d) and (e) of the Maputo Protocol.\textsuperscript{89} The African Commission explained the measures African governments must adopt to ensure the realisation of article 14 (1) (d) and (e) of the Maputo Protocol. These include creating an enabling environment that is respectful of women’s rights and ensuring access to sexual and reproductive health information and services as well as voluntary HIV counselling and testing. The Commission notes that the right to self-protection and the right to be protected are intrinsically linked to other women’s rights such as equality, non-discrimination, dignity, life and the right to be free from all forms of violence. Consistent with states’ obligations under international law, the GC obligates African governments to respect, protect and fulfil women’s rights in the context of HIV.

The second general comment (hereinafter referred to as GC 2) deals with the remaining provisions of article 14 and was adopted during the 56\textsuperscript{th} Ordinary Session in Luanda, Angola.\textsuperscript{90} The African Commission enjoins states to promote women’s rights to health care, including sexual and reproductive health services. It particularly enjoins states to ensure integration of family planning services with HIV prevention services. The Commission further enjoins states to take appropriate measures towards eliminating stigmatisation and discrimination in relation to sexual and reproductive health.\textsuperscript{91} This broadly covers HIV-related stigma and discrimination which often hinder women and girls from seeking information and services in health care institutions. More importantly, the Commission enjoins states to adopt legislative measures, administrative policies and procedures to ensure that ‘no woman is forced because of her HIV status, disability,

\textsuperscript{89} General Comments on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa adopted during the 52\textsuperscript{nd} Ordinary Session Yamoussoukro, Cote d’Ivoire 9-22 October 2012 available at http://www.achpr.org/news/2012/11/d65/ (accessed on 28 January 2016).
\textsuperscript{90} General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples’ Rights of the Rights of Women in Africa adopted during the 55\textsuperscript{th} Ordinary Session of the African Commission on Human and Peoples’ Rights held 28 April- 12 May 2014; for analysis of this general comment see Charles Ngwena, Eunice Brookman-Amissah & Patty Skuster Human Rights Advances in Women's Reproductive Health in Africa 129 International Journal of Gynecology & Obstetrics 184-187 (2015).
\textsuperscript{91} Para 44
ethnicity or any other situation, to use specific contraceptive methods or undergo sterilization or abortion'. 92

It should be noted that there are several rights within the African Charter and the Maputo Protocol that could be applied to strengthen states parties’ obligations regarding HIV, but have not yet been directly applied to the HIV context. This includes the right to life,93 the right to dignity,94 right to be free from cruel, inhuman and degrading treatment,95 and the right to liberty and to the security of person.96

The African Commission has stated that many of these rights should be interpreted broadly which makes their application to the HIV context much more likely. For example, the African Commission’s General Comment No. 3 expanding on the contents of the right to life explained that this right should be interpreted broadly to include a dignified life and economic rights. The General Comment notes that—

[[the right to life is aimed not only at securing the continuation of biological life, but of dignified life. The indivisibility of human rights further suggests that the protection of dignified life lies in securing not only the right to life as a civil and political right, but social, economic and cultural rights as well. The right to life should not be interpreted narrowly. In order to secure a dignified life for all, the right to life requires the realisation of all human rights recognised in the [African] Charter, including civil, political, economic, social and cultural rights and peoples’ rights.97

In addition, the GC 3 notes that the right to life includes the need for countries to “address more chronic yet pervasive threats to life, for example with respect to preventable maternal mortality, by establishing functioning health systems.”98 Therefore, the right to life is closely connected with access to health services presumably including prevention of and treatment for HIV. This is important in that it places obligation on states to prevent HIV-related deaths by ensuring universal access to life-saving medications. Failure by states to address barriers to life-saving medications in the context of HIV implicates the right to life.99

3.3 Jurisprudence of the Commission relating to HIV and Human Rights

The protective mandate of the African Commission, which relates to the communication procedure100 and state reporting process, 101 remains the strongest avenue to hold states accountable to their obligations to respect, protect and fulfil human rights in the

92 Para 47
93 Article 4 of the African Charter; Article 4 of the Maputo Protocol.
94 Article 5 of the African Charter; Article 3(1) of the Maputo Protocol.
95 Article 5 of the African Charter; Article 4 of the Maputo Protocol.
96 Article 6 of the African Charter; Article 4 of the Maputo Protocol.
98 As above, para. 3.
100 Articles 44-49 and 55-56 of the African Charter relate to communication by state and non-state actors respectively.
101 Article 62 of the African Charter and 26 of the Maputo Protocol requires states to submit periodic reports to the African Commission on measures they have taken to implement the provisions of these instruments.
context of HIV. While the African Commission is yet to address any communication specifically dealing with HIV, some of the provisions of the African Charter and the Maputo Protocol provide the Commission with the impetus to interpret them in the context of HIV. For instance, article 2 of the African Charter states that every individual shall be entitled to enjoy the rights and freedoms recognised and guaranteed in the charter without distinction of any kind on a number of specified grounds or any status. Also, article 1 of the Maputo Protocol defines discrimination against women broadly to include ‘any form of distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women…., in all spheres of life’. Article 2 of the Protocol further prohibits discriminatory practices against women.

Equality and non-discrimination are fundamental pillars of human rights recognised in virtually all human rights instruments. The right to equality and non-discrimination presupposes that all human beings must be treated in the same manner regardless of their social condition or health status. A distinction is often made between formal and substantive equality. While the former tends to treat all human beings equally without taking into consideration their socio-economic conditions, the latter tends to pay attention to peculiar circumstances of individuals, including their socioeconomic differences. A substantive equality approach to equality is crucial in the context of HIV in the sense that it recognises the disadvantaged position of certain groups including women, children, prisoners and sexual minorities and the need for their protection. The provision of the Maputo Protocol on non-discrimination accords with the notion of substantive equality.

The Commission has stated that Articles 2 and 3 are considered fundamental, linked to the enjoyment of other rights, and that they arguably protect people living with HIV to equality and to non-discrimination. There are also indications that the provisions protect other key populations on the basis of grounds such as disability, sexual orientation and/or gender identity. The African Commission has explained the importance and breadth of Articles 2 and 3 of the African Charter on various occasions and has noted its application to a range of persons. It has stated that “Article 2 lays down a principle that is essential to the spirit of the African Charter and is therefore necessary in eradicating discrimination in all its guises, while Article 3 is important because it guarantees fair and just treatment of individuals within a legal system of a given country. These provisions are non-derogable and therefore must be respected in all circumstances in order for anyone to enjoy all the other rights provided for under the African Charter.” In Legal Resources Foundation v Zambia the African Commission noted that “the right to equality is very important. It means that citizens should expect to be treated fairly and justly within the legal system and be assured of equal treatment before the law and equal enjoyment of the rights available to all other citizens. The right to equality is important for a second reason. Equality or the lack of it affects the capacity of one to enjoy many other rights.” In the 2005 recommendation, Good v Republic of Botswana, the African Commission described the importance and breadth of the principle of non-discrimination, which it said “guarantees that those in the same circumstances are dealt with equally in law and in practice.”

These interpretations are crucial in addressing HIV-related stigma and discrimination pervading in many African countries. In particular, they can serve as bulwark of protection for vulnerable and disadvantaged groups such as women, children, prisoners, person with disabilities and sexual minorities in the context of HIV.

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102 The Committee on CESCR in its General Comment 20 on non-discrimination in the enjoyment of socioeconomic rights has explained that the phrase ‘other status can be interpreted broadly to cover discrimination on the grounds of HIV and health status.
103 Communication 241/01, Purohit and Moore v The Gambia at para 49.
104 Communication 313/05, Kenneth Good v Republic of Botswana at para 218.
Furthermore, the Commission has had the opportunity to explain the scope and extent of article 16, which guarantees the right of every individual to enjoy the best attainable state of physical and mental health and places a duty on State Parties to take the necessary measures to protect the health of all peoples, particularly when they are sick. This provision derives inspiration from article 12 of the Covenant on Economic, Social and Cultural Rights which is regarded as the most authoritative provision on the right to health. The Committee on Covenant on Economic, Social and Cultural Rights (CESCR) has emphasized the need to ensure access to health care services for all paying attention to vulnerable and disadvantaged groups such as women, children and PLHIV. The Committee further notes that the essential elements of the right to health include availability, accessibility, acceptability and quality. The revised Guideline 6 of the International Guidelines on HIV and Human Rights reaffirm that access to HIV prevention, treatment, care and support constitutes an essential element of the right to health. It further urges states to take measures to ensure availability and accessibility of quality goods and services for HIV prevention, treatment, care and support.

Drawing inspiration from CESCR and the International Guidelines on HIV, the African Commission has provided some guidance on the nature and extent of the right to health, including reference to HIV and AIDS.

In *Purohit and Moore v The Gambia*, the African Commission held in relation to Article 16 that "[n] enjoyment of the human right to health as it is widely known is vital to all aspects of a person’s life and well-being, and is crucial to the realisation of all the other fundamental human rights and freedoms. This right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind." Although not HIV-specific, this is nevertheless relevant to situations of HIV-related discrimination in the health care setting. Even more explicitly, in the Pretoria Declaration on Economic, Social and Cultural Rights in Africa, the African Commission stated that “The right to health in article 16 of the Charter entails among other things the following: … f. Education, prevention and treatment of HIV/AIDS…”

The right to access medications is elaborated on in *Free Legal Assistance Group, Lawyers’ Committee for Human Rights, Union Interafrique des Droits de l’Homme, Les Témoins de Jehovah / DRC*. The Commission found that the Government of Zaire had violated Article 16 due to the lack of basic services in including a shortage of medication throughout the country.

The Commission has also affirmed the link between the right to health and other rights guaranteed under the African Charter. For instance, in *Social and Economic Rights Action Centre (SERAC) and Another v Nigeria*, the African Commission held that “exploitation of oil in a part of Nigeria by oil companies with no regard to the health and environmental consequences for local communities” constituted a violation of various rights provisions of the African Charter, including the right to life. Not only do states have the obligation to ensure the health of an individual, but the additional broad obligation to ensure that communities overall are healthy. This broad interpretation of the right to health to encompass the right to life is significant in holding African governments accountable to ensure the provision of life-saving medications in the context of HIV.

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105 Adopted at the Third International Consultation on HIV/AIDS and Human Rights held in Geneva from 25 to 26 July 2002.

106 *Purohit* (Communication 241/01, above), at para. 80.


109 As above, at para 47.

110 Communication 155/96, *Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v Nigeria* at para 2.
The African Commission also stated “the prohibition of torture, cruel, inhuman, or degrading treatment or punishment is to be interpreted as widely as possible to encompass the widest possible array of physical and mental abuses.”\(^{111}\) The African Commission emphasised in *Doebbler v Sudan* that Article 5 of the African Charter “prohibits not only cruel but also inhuman and degrading treatment. [It] includes not only actions which cause serious physical or psychological suffering, but which humiliate or force the individual against his will or conscience.”\(^{112}\) This interpretation could be applied to HIV context to prevent forced treatment and enforce the requirements for informed consent.

In *Democratic Republic of Congo v Burundi, Rwanda, Uganda* the Commission condemned sexual violence during conflict as a gross violation of human rights of women in general.\(^{113}\) The Commission noted that rape, among other acts of violence, violated the right to the integrity of one’s person.\(^{114}\) This was based on the complaints of the Democratic Republic of Congo (DRC) that Rwandan and Ugandan forces had been transmitting HIV among the DRC population through raping of local women,\(^{115}\) which Uganda denied. However, the African Commission did not specifically address the HIV allegation raised in this communication.

It is clear from these cases that the Commission is yet to specifically address violations of rights guaranteed in the African Charter and Maputo Protocol in the context of HIV. Given the Commission’s lack of experience in this regard, lessons can be drawn from other jurisdictions such as the European and Inter-American human rights systems. In *D v United Kingdom*, the European Court of Human Rights held that a deportation of an HIV positive person to a country where access to treatment could not be guaranteed would amount to a violation of the right to dignity under the European Convention.\(^{116}\) Also, in the case of *Odir Miranda et al v El Salvador*,\(^{117}\) the Inter-American Commission admitted the petition for the right to health, in the framework of article 26, but in the respective report on the merits, it considered that there was no violation of this right. The case involved 27 HIV positive persons who were denied access to medication that integrated the triple therapy necessary to prevent death and improve their quality of life. The Inter-American Commission ordered the government of El Salvador to adopt urgent precautionary measures for the victims in the case in order for them to obtain the relevant medical care and antiretroviral medications.\(^{118}\) This case is significant in the sense that it portrays how precautionary measures can be applied to good use in the context of HIV.

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\(^{111}\) Southern Africa Litigation Centre “SALC Litigation Manual Series: Equal Rights for All: Litigating Cases of HIV-related Discrimination” (September 2011), 44.

\(^{112}\) See also, Communication137/94-139/94-154/96-161/97, *International PEN, Constitutional Rights Project, Civil Liberties Organisation and Interights (on behalf of Ken Saro-Wiwa Jnr.) v Nigeria*.

\(^{113}\) Communication 227/99, *Democratic Republic of Congo / Burundi, Rwanda, Uganda* at para 80.

\(^{114}\) As above para 80.

\(^{115}\) As above at para. 5.

\(^{116}\) ECHR 2 May 1997 2/.


\(^{118}\) For a detailed analysis of this case see, Oscar Parra-Vera ‘The protection of the right to health through individual petitions before the inter-American system of human rights’ in E Durojaye (ed) *Litigating the right to health in Africa: Challenges and prospects* (2015) 243-274.
3.4 Ensuring Accountability through States Reporting

As part of its protective mandate, the African Commission examines states reports submitted under article 62 of the African Charter and 26 of the Maputo Protocol and provides responses in form of concluding observations.119 This process provides the Commission with the opportunity to assess states’ commitments to addressing issues relating to HIV and human rights within their jurisdictions. Through this process, the Commission can clarify if steps taken by a state to address the HIV pandemic are consistent with its obligations to realise human rights in general and the right to health in particular.

In some of its concluding observations to states, the Commission has drawn the attention of states to gaps in their efforts to address the HIV pandemic. For instance, in one of its concluding observations to the government of Sudan the Commission notes that while it is commendable that the government is making efforts to ensure access to medical services and social security to all, including vulnerable and marginalised groups, the report fails to provide detail information on access to life-saving medication for PLHIV in the country.120 In its response to the report of Gabon, the Commission recommended that the government should strengthen on-going HIV sensitisation programmes with particular focus on children and young people.121 With regard to one of its concluding observations to the report of Cameroon, the Commission urges the government to engage with relevant stakeholders with a view to ensuring the adoption of laws and policies to protect the rights of PLHIV.122 In its concluding observations to the government of Ethiopia, the Commission recommends the enactment of laws to address human rights violations experienced by PLHIV in the country.123 It further recommends to the government the need to develop programmes to prevent the incidence of mother-to-child transmission of HIV in the country. In its fifth periodic review of Uganda, the Commission recommended under its Non-Discrimination and Equality section that Uganda “[s]trengthen its legal framework for the protection of people living with HIV to discourage HIV-related human rights violations”.124 The Commission has made more novel recommendations, which include repealing Nigeria’s criminalisation of homosexuality law, which “has the potential to engender violence against persons on grounds of their actual or imputed sexual orientation, and also to drive this group of persons vulnerable to HIV/AIDS underground, thereby creating an environment which makes it impossible to effectively address

119 These provisions require states that have ratified the African Charter and the Maputo Protocol to submit periodic reports every two years
the HIV pandemic in the State”.

While concluding observations are not binding on states, they draw the attention of states to some issues that require further attention. Indeed, concluding observations may be likened to advisory opinions of courts on a specific human rights issue.

3.5 Special Mechanisms

Under Article 23 of the Rules of Procedures of the African Commission, special mechanisms are established to address various human rights violations and accord protection of rights in a number of thematic areas. Special mechanisms of the African Commission comprise Special Rapporteurs, Working Groups and a Committee. Currently, there are about 14 of such mechanisms. Some of the more relevant mechanisms include:

- The Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV (the HIV Committee);
- The Special Rapporteur on Prisons Conditions of Detention and Policing in Africa;
- The Special Rapporteur on Refugees, Asylum Seekers, Migrants and Internally Displaced Persons;
- The Special Rapporteur on Rights of Women;
- The Special Rapporteur on Freedom of Expression and Access to Information;
- Committee for the Prevention of Torture in Africa.

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128 The Special Rapporteur on Prisons Conditions of Detention and Policing in Africa (Special Rapporteur on Prisons) is one of the oldest mechanisms and was established under article 45 of the African Charter by the African Commission. The Special Rapporteur on Prisons is empowered to examine the situation of persons deprived of their liberty in countries which are a party to the African Charter. [http://www.achpr.org/mechanisms/prisons-and-conditions-of-detention/](http://www.achpr.org/mechanisms/prisons-and-conditions-of-detention/) (accessed 15 June 2016).


132 The Committee for the Prevention of Torture in Africa (Committee on Torture) was created in October 2002 by the African Commission. Its purpose is to raise awareness of the Guidelines and Measures for
• The Working Group on Economic, Social and Cultural Rights.\textsuperscript{133}

While all these mechanisms have important roles to play in addressing HIV in the region, the Committee on the Protection of the Rights of PLHIV and Those at Risk, Vulnerable to and Affected by HIV (HIV Committee) was specifically created to address this issue on behalf of the Commission. This section focuses on the work of the HIV Committee as well as that of the Special Rapporteurs on the Rights of Women in Africa in relation to protecting women and that of Prisons in Africa.

3.5.1 The Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV (the HIV Committee)

The Committee on the Protection of the Rights of PLHIV and Those at Risk, Vulnerable to and Affected by HIV is a special mechanisms overseen by the African Commission, specifically created to deal with the issues related to HIV on the Continent. It was established in May 2010 during the Commission’s 47th Ordinary Session by the passing of Resolution 163.\textsuperscript{134} The HIV Committee’s main purpose is to investigate human rights concerns affecting people living with HIV and those at risk, and to facilitate the implementation of measures throughout the AU Member States that will effectively protect their rights. The Committee was specifically created to address human rights violations in the context of HIV relating to key populations in the region.

**Mandate and Composition of the HIV Committee**

The mandate of the Committee on the Protection of the Rights of PLHIV and Those at Risk, Vulnerable to and Affected by HIV was originally authorised for two years, but it has been renewed by the Commission several times.\textsuperscript{135} The Commission appoints the Committee’s Chairperson, Members, and Expert Members either by a consensus or by a vote.\textsuperscript{136} Since its establishment the HIV Committee has had three working group members who are Commissioners of the African Commission, one of whom is appointed as Chairperson.

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The HIV Committee also has expert members who are not Commissioners. To be appointed as an Expert Member, candidates must be nationals of the AU Member States with expertise in protecting and promoting the rights of individuals living with HIV and those at risk, vulnerable to, and affected by HIV. When a position is available, the Committee accepts nominations from individuals, non-governmental organizations, Member States, National Human Rights Institutions, and other institutions. Currently there are six expert members of the HIV Committee from various backgrounds.

The Committee submits Intersession Activity Reports to the Commission each year, which outline the activities the Committee has undertaken. This information is included in the Commission’s Annual Activity Report which is submitted to the African Union Assembly.

Activities of the Committee

(i) Country visits
The HIV Committee undertakes a number of activities, including conducting visits to Member States to investigate and verify allegations of human rights violations. The Committee undertakes country visits to Member States, with their consent. During these visits (also known as missions), the Committee engages with government officials and civil society organizations, among others, to learn about the State’s laws and policies that protect the rights of persons living with HIV through prevention, care and support interventions, and treatment programs. The most recent country visit undertaken by the Committee was to the Republic of Côte d’Ivoire. After completion of a mission, the HIV Committee publishes a Mission Report which contains general recommendations to the State, and often include specific recommendations to the international community and civil society, among others.

(ii) Studying Human Rights Conditions
The Committee’s mandate also requires it to recommend concrete strategies to protect the rights of persons living with HIV and those at risk. To develop effective strategies, the Committee may conduct studies to better understand the human rights conditions and situations surrounding these persons.

(iii) Receiving and Disseminating Information
The HIV Committee also receives analyses and responds to reliable information from credible sources. Upon learning of alleged violations, the Committee may write letters to the relevant State and to other non-state actors involved, including corporations. These letters request information regarding what steps have been taken to remedy the alleged violations. On the basis of information received, the Committee may propose that the Commission take a certain action or decision, or it may raise awareness of an issue in a report, press release, or other activity.

The HIV Committee also obtains and disseminates and obtains information through promotional activities, such as panels, trainings for non-governmental organisations engaged in HIV-related

139 These are available at http://www.achpr.org/activity-reports/.
141 Rule 60 of the Commission’s Rules of Procedure.
issues, and roundtable meetings. The HIV Committee often coordinates these activities with other relevant Special Rapporteurs and Working Groups under the Commission or the United Nations.

There are other indications that the HIV Committee has ensured a strong focus on the rights of women living with HIV in carrying out its mandate. In March 2013, the HIV Committee and the Special Rapporteur on the Rights of Women in Africa convened a Regional Sensitisation Seminar on “Women and HIV in Africa: The African Commission’s Human Rights-Based Response.” The seminar aimed to promote the African Charter and the Maputo Protocol; raise awareness of the role of the African Commission’s subsidiary mechanisms in addressing human rights violations against PLHIV and women living with HIV; raise awareness of the impact of HIV and AIDS on the enjoyment and exercise of human rights and the particular vulnerability of women and to share experiences on providing legal assistance to women, and other vulnerable populations living with HIV. It was attended by members of the judiciary, lawyers, human rights activists, people working with PLHIV and women living with HIV.

In addition to the work of the HIV Committee, a number of Special Rapporteurs also assess how well countries are addressing HIV when conducting country-specific missions. The Special Rapporteur on the Rights of Women has often recognized the particular needs of women living with HIV, discrimination faced by women living with HIV, and the gendered aspect of HIV. The Declaration by the Special Rapporteur on International Women’s Day in 2009 was specifically focused on “Equal sharing of responsibilities between women and men, including providing care in the context of HIV/AIDS”. She noted that women “have limited and unequal access to care, anti-retroviral drugs and treatment. Moreover, they bear the greatest burden in terms of caring for and supporting PLHIV, including orphans and the affected. They are subjected to a very harsh form of stigmatization and discrimination, manifested through violence of all kinds particularly, expulsion from the home, deprivation of their rights to inheritance etc.”

In the Intercession Report of the Mechanism of the Special Rapporteur on the Rights of Women in Africa since its establishment, the Special Rapporteur noted the need for action by State Parties through “the enactment of legislation to protect women with HIV/AIDS from all forms of discrimination, and the establishment of mechanisms to ensure their full participation in the process of providing access to health care and antiretroviral treatment.”

In one the missions to assess the situation of prisons in the Cameroon, the Special Rapporteur on Prisons and Conditions of Detention in Africa looked at issues relevant to HIV, including how

145 Article 46 of the Charter which requires the African Commission to use “any appropriate method of investigation” is the legal basis for missions. Promotional missions are governed by the African Commission’s Guidelines for Missions and the Format for Pre-mission Reports. The African Commission also undertakes protective missions, which can be either onsite missions or fact-finding missions. Finally, Special Rapporteurs also undertake missions focusing on human rights violations within their mandates. African Commission “Missions Undertaken by the Commission” http://www.achpr.org/mission-reports/about/ (accessed 20 June 2016).
prevalent HIV was in prison. The Special Rapporteur expressed her concern at the failure of the government to provide her with information on the HIV prevalence rate in prison noting that it was not “the acceptable state of affairs given the potential threat posed by the pandemic”.

The Special Rapporteur recommended that Cameroon should initiate and intensify information and awareness raising sessions about HIV/AIDS for prisoners; encourage voluntary testing for HIV/AIDS; and strengthen structures for psychological care and counselling, particularly before and after testing for those who are found to be HIV/AIDS positive. The Special Rapporteur on Prisons and Conditions of Detention in Africa also looked at policies relating to the treatment of prisoners with HIV in its reports on prison conditions in Uganda and South Africa. Also, in 2001, the Special Rapporteur advised Namibia in response to their policy prohibiting HIV positive prisoners from working in the kitchen that “discrimination against people suffering from HIV/AIDS is not allowed.”


Another important document within the African human rights system is African the Children’s Charter, which came into force on 29th November 1999. It guarantees a range of rights for children, including those relevant to HIV. The Children’s Charter provides for the rights to non-discrimination (article 3); life (article 5); privacy (article 10); health (article 14); freedom from torture, cruel inhumane and degrading treatment (article 16); parental care (article 19; elimination of harmful practices (article 21); and protection from sexual exploitation (article 27).

The ACERWC draws its mandate from Articles 32-46 of the Children’s Charter. Similar to the African Commission the ACERWC possesses both promotional and protective mandate. However, the ACERWC has not addressed HIV specifically in its case law, guidelines, general comments, or mission reports.

Under its promotional mandate the ACERWC has so far adopted two general comments (GC). However, neither of these GCs deals directly with issues relating to HIV and human rights. The first GC deals with children of imprisoned parents under Article 30 of the African Children Charter. While it did not specifically address HIV and the specific vulnerabilities such children face with respect to HIV, there are several statements that could be used to apply to the HIV context. For example, the GC highlights Section 30.1 of the Children’s Charter which specifically states that States parties “shall undertake to provide special treatment to expectant mothers”.

The section could be applied to prevention of mother-to-child transmission of HIV requiring states to provide

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149 As above, 25.
153 As above, 6.
this specific treatment. Additionally, the GC speaks about a child’s “inherent” right to life and right to development which “entails a comprehensive process of realizing children’s rights in order to allow them grow up in a healthy and protected manner”. While there are no explicit mentions of HIV in the GC, these more general references to the rights of children to be healthy and have access to healthcare on a non-discriminatory basis could be easily applied to the HIV context in the future.

The second GC relates to birth registration under article 6 of the Charter and did not make any specific reference to HIV. The Committee adopted a broad interpretation of Article 6 of the Children’s Charter by noting that the rights to a name, to birth registration and to acquire a nationality cannot be fully implemented unless the cardinal principles of children’s rights are carefully observed. The implementation of those rights requires taking into account the best interests of the child, non-discrimination principles, his/her survival, development and protection as well as his/her participation. The implementation of Article 6 also depends on good understanding of the principle of interdependence and indivisibility of children’s rights in general and the interdependence and indivisibility of the three rights provided for under Article 6 in particular. This interpretation can be potentially applied to advance the right of children in the context of HIV. Given the serious impact of HIV on children and young people in the region, it is imperative the ACERWC considers adopting a general comment or resolution on this issue. The ACERWC can draw inspiration from its counterparts at the international level, which has directly addressed this issue.

There have been more informal ways that the ACEWRC has addressed HIV. In its 2002 inaugural meeting, one of the thematic issues they discussed was orphans affected and infected by HIV/AIDS. At its Second Session in February 2003, control of HIV/AIDS and other causes of ill health and death of Africa’s children were recognized as priorities for the Committee in the upcoming year. The Committee resolved to monitor and report on the impact of HIV/AIDS and monitor the relevant activities of governments. In another document produced by the ACERWC, its Report’s Committee at the Seventh Ordinary Session of the African Union in Libya, discussed the impact of HIV on children with special attention on how HIV affect their survival and health, as well as the problem of discrimination based on HIV status including neglect of HIV orphans by states. Finally, HIV is addressed tangentially through the ACERWC’s Day of the African Child (2015) which was titled “25 years after the Adoption of African Children’s Charter Accelerating our Collective Efforts”. In the Concept Note of the 25th Day of the African Child (DAC) 2015, the Committee noted that child marriage is caused by “[g]ender inequality due to entrenched societal differentiation between males and females”}

154 As above, 13.
155 General Comment on Article 6 (GC 2) deals with the issue of birth registration, name and nationality and prevention of statelessness.
156 As above para 13.
157 See Committee on the Rights on the Child General Comments No. 3 on HIV/AIDS and the rights of the child 17 March 2003; UN.Doc CRC/GC/2003/3; General Comment No. 4 on Adolescence health and development in the context of the convention on the rights of the child 1 July 2003; UN.Doc CRC/GC/2003/4;
160 As above.
including HIV status.\textsuperscript{163} Not only was HIV status a cause of child marriage, but also a result. The Committee stated that “[c]hild brides are prone to disabilities associated with early childbirth…including HIV.”\textsuperscript{164} While having not taken the formal steps such as conducting investigatory missions centered on HIV, the ACERWC has incorporated concerns about HIV into its work on other issues regularly.

Under its protective mandate the ACERWC through its jurisprudence, state reporting process and mission visits has touched on issues with implications for the HIV and the right of children.

For instance, in addressing children’s health in \textit{IHRDA and Open Society Justice Initiative (OSJI) (on behalf of children of Nubian descent in Kenya) v Kenya},\textsuperscript{165} the ACERWC noted that “[s]tatelessness is particularly devastating to children in the realisation of their socio-economic rights such as access to health care.”\textsuperscript{166} It further found that denial of basic medical services would violate the right to health.\textsuperscript{167} This interpretation establishes a state’s obligation to provide basic medical services to children, and therefore may be useful in the future to ensure access to HIV-related healthcare services for children.

In \textit{Michelo Hunsungule on behalf of children in Northern Uganda v The Government of Uganda},\textsuperscript{168} the ACERWC missed an opportunity to clarify states’ obligations in relation to the right to health and protection of the girl-child from sexual abuse during a conflict period. The Committee rejected the complaints of the applicants alleging that the respondent government failed to ensure the enjoyment of the right to health of children by not providing health care facilities and clinics and by not protecting female children from sexual abuse.

The ACERWC has also limitedly addressed HIV in its guidance on how countries should report on their compliance with the Children’s Charter. In the States Parties Reporting Guidelines, the ACERWC has indicated that countries should provide data on the death of children as a result of HIV, amongst other illnesses;\textsuperscript{169} measures taken to prevent transmission of HIV from mother to child; how many mothers were provided with Prevention-of-Mother-to-Child-Transmission (PMCT) services; and the percentage of children born with HIV.\textsuperscript{170} However, the Guidelines do not require countries to provide any information related to the rights of children and adolescents to HIV-related healthcare, including health information.

The ACERWC is also empowered, under Article 45 of the Charter, to resort to any appropriate method of investigation in respect of any issue covered by the Children’s Charter.\textsuperscript{171} However, though the mission reports thus far conducted by the ACERWC have a section dedicated to the

\textsuperscript{163} ACERWC “Concept Note of the 25\textsuperscript{th} Day of the African Child (DAC) 2015” (2015) \url{http://www.repssi.org/download/DAC%20CONCEPT%20NOTE%20CHILD%20MARRIAGE.pdf} at para 11.
\textsuperscript{164} As above para 14.
\textsuperscript{165} Communication 002/2009.
\textsuperscript{166} As above, at para 46.
\textsuperscript{167} As above, at para. 59.
\textsuperscript{168} Communication 2/2009, Hansungule and Others (on behalf of children in Northern Uganda) v Uganda, decided at the Committee’s 21st ordinary session, 15-19 April 2013.).
\textsuperscript{170} As above, at para 24(c) and 26(e)
right to health, HIV was not covered.\textsuperscript{172} This was missed opportunity to deal with HIV in the context of children’s rights.

Finally, the ACERWC issues concluding observations following the consideration of State Parties Reports. Concluding observations highlight any major issues of concern and makes recommendations to countries on the measures that can be implemented to complement the progress achieved and the challenges faced. The ACERWC has raised concerns regarding HIV in a number of concluding observations. For instance, in its Concluding Observations to Guinea, the Committee noted the high infant mortality due to HIV, and recommended “raising awareness on HIV”.\textsuperscript{173} It gave a similar recommendation to Sudan.\textsuperscript{174} However, it has also given much more specific and in-depth recommendations to countries. It recommended that Liberia “increase the comprehensive HIV information education campaign; make stronger its efforts to ensure proper coverage of HIV testing and ARVs provision by giving a particular attention to pregnant adolescents in rural areas and children born to mothers with HIV, and seek technical assistance from the concerned [i]nternational [o]rganizations and [civil society organisations]”.\textsuperscript{175} In its recommendations to Tanzania, the Committee recommended expanded their youth education on STIs to include ignored areas such as Mainland and Zanzibar and incorporate this type of education into primary school curriculums.\textsuperscript{176} They also recommended that South Africa step up its reproductive health education for school-aged children and work to better disseminate anti-retroviral medication.\textsuperscript{177} Despite, the ability to give recommendations, there is unfortunately no systemic way in which the ACERWC evaluates country reports to ensure compliance on HIV-related issues.

Ultimately, although the two GCs of the ACERWC did not address HIV related concerns directly, they expended on the right to health. In addition the Committee has been instrumental in dealing HIV through its thematic issues while delivering its promotional mandate. Moreover, through its protective mandate, the ACERWC relies on country visits to expend on the right to health and health care services; use its Concluding Observations to deal with health issues embedded in HIV related matters. However, the ACERWC missed some good opportunities to stress the importance of human rights in the context of HIV. Firstly, although the mission reports conducted


\textsuperscript{173} ACERWC “Concluding Observations: Guinea” \url{http://www.acerwc.org/download/concluding_observations_guinea/?wpdmdl=8745 (accessed 22 June 2016) at para 30}.


by the ACERWC have a section dedicated to the right to health, HIV was overlooked. Secondly, the ACERWC’s States Parties Reporting Guidelines does not does not compel States Parties to provide information related to the rights of children and adolescents to HIV-related healthcare, including health information.

3.7 African Court on Human and Peoples’ Rights

The African Court was to hear cases related to the Charter. It was established under the Protocol to the African Charter on Human and Peoples’ Rights on the Establishment of an African Court on Human and Peoples’ Rights (the Court Protocol).

Up to this point, the Court has been silent on the issue of HIV. However, this could be due to some of the strict procedural limitations the Court faces. The African Court’s jurisdiction is relatively limited as it only applies to States that have ratified the Court Protocol. Furthermore, the Court Protocol does not enable individuals from States and non-governmental organisations (NGOs) with observer status before the African Commission to access the Court directly, unless the respondent State has made a specific Declaration accepting the jurisdiction of the Court. As of November 2015, only seven of the twenty-nine States Parties to the Court Protocol had made the declaration recognising the competence of the Court to receive cases from NGOs and individuals.

Although the African Court has not yet received an HIV-related case, it could be a place where future jurisprudence regarding the rights of individuals with HIV could be developed. In particular, the advisory jurisdiction of the Court can be explored by civil society groups to require an authoritative interpretation of the human rights instruments related to HIV in the region. For instance, civil society groups may seek an advisory opinion of the Court on the nature and scope of Article 14 (1) (d) and (e) of the Maputo Protocol or even other relevant human rights instruments.

3.8 The African Youth Charter

To ensure the right to participation of the youth in the identification of the health needs and designing, the African Youth Charter is the legal framework for the protection of the rights of young people on the continent. This instrument is important for the protection of human rights related to HIV. Its article 2 is similar to article 2 of the African Charter, which prohibits discrimination on various grounds including “other status” which could include HIV. In addition the Youth Charter expressly protects the “right to enjoy physical, mental and spiritual health” (article 16(1)) and obliges state parties to ensure the availability of “equitable medical assistance and health care especially in rural and poor urban areas with an emphasis on the development of primary health care” (art 16 (2(a)). Moreover, States Parties are obliged programmes that meet those needs with a special focus to vulnerable and disadvantage youth, [such as those living with HIV for example] (article 16(2)(b)).

More importantly, the Youth Charter is very specific about HIV. Its urges State Parties to “institute programmes to address health pandemics in Africa such as HIV/AIDS, tuberculosis and malaria; to institute comprehensive programmes to prevent the transmission of sexually transmitted infections and HIV/AIDS by providing education, information, communication and awareness

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creation as well as making protective measures and reproductive health services available; to expand the availability and encourage the uptake of voluntary counselling and confidential testing for HIV/AIDS, to provide timely access to treatment for young people infected with HIV/AIDS including prevention of mother to child transmission, post rape prophylaxis, and antiretroviral therapy and creation of health services specific for young people; and finally to provide food security for people living with HIV/AIDS” (article 16(d) to 16(f)).

The African Youth Charter also obliges States to raise awareness on the dangers of drug and importantly to offer “rehabilitation for young people abusing drugs such that they can be re-integrated into social and economic life” (article 16 (2) (k) and (m)). This provision is significant for those at risk of HIV such as youth who inject drugs. In sum, the African Youth Charter is a strong normative protection against HIV related human rights violations.

As far as monitoring is concerned, article 28 of the African Youth Charter mandates the African Union Commission to monitor States’ compliance with the Charter. In this regard, the African Union Commission should rely on collaboration with governmental and non-governmental organisations and development partners to ascertain best practice and youth policy formulation and implementation (article 28 (a)). In addition it should ensure youth participation in various meetings and discussions and more importantly adopt measure to raise awareness of its activities especially in youth circles (article 28 (c)).

Unfortunately the African Union Commission is neither a judicial nor a quasi-judicial body, and as such, it is simply a political organ which efficiency depends on the political will of AU member States. Therefore the good protection of HIV related rights by the African Youth Charter is watered down by a weak monitoring institution.

3.9 The African Charter on Democracy, Elections and Governance

The African Charter on Democracy, Elections and Governance seeks to promote adherence to the universal values and principles of democracy and respect for human rights including those related to the HIV pandemic. In this regard, its article 8(1) prohibits all forms of discrimination including “any other form of intolerance” and States Parties are obliged to adopt measures to protect “the … marginalized and vulnerable social groups” (article 6(2)) including those who are stigmatised as those living with HIV.

More importantly, the right of those living with HIV is specifically catered for under article 27 (10) which compels States Parties to preventing “the spread and combating the impact of diseases such as Malaria, Tuberculosis, HIV/AIDS, Ebola fever, and Avian Flu” in order to foster political, economic and social governance.

Chapter 10 the African Charter on Democracy, Elections and Governance provides for mechanisms for application. These mechanisms come into play at three level: Firstly, at the national level where the political will is the key as one has to rely on the State’s commitment and good will to do the right thing (article 44 (1)).

Secondly, at the continental level, similar to the monitoring of the African Youth Charter, the key player is the African Union Commission mandated to “develop benchmarks for implementation of the commitments and principles of this Charter and evaluate compliance by State Parties [and] promote the creation of favourable conditions for democratic governance”
(article 44 A (2) (a and b). Furthermore, among others, the African Union Commission shall ensure that the Democracy and Electoral Assistance Unit and the Democracy and Electoral Assistance Fund offers the necessary assistance and resources to State Parties in support of electoral processes (art. 44 (2) (d)). The success of the African Commission will depend on States’ political will.

Thirdly, at the regional level, the African Union Commission shall take the lead in establishing a framework for cooperation with Regional Economic Communities on the implementation of the principles of the Charter. In this respect, it is mandated to encourage member state to comply with the Charter, and to designate focal points to achieve its objectives (article B (a and b)).

Importantly, under article 45 of the African Charter on Democracy, Elections and Governance, the African Union Commission shall not only be the coordination body in charge of implementing the Charter, it is also tasked to “coordinate evaluation on implementation of the Charter with other key organs of the Union including the Pan-African Parliament, the Peace and Security Council, the African Human Rights Commission, the African Court of Justice and Human Rights, the Economic, Social and Cultural Council, the Regional Economic Communities and appropriate national-level structures” (article 45(c)). Although this provision seems to associate quasi-judicial and judicial bodies to the monitoring process, it is quite difficult to see the exact role of these bodies and how they can efficiently hold States accountable for the lack of implementation of the Charter in general and the violation of HIV related rights in particular.

Ultimately, the African Union Commission is the regulatory body that spearheads the implementation of the African Charter on democracy. Nevertheless, this body is weak as its efficiency depends on states’ political will. Its weakness is aggravated by the fact that it lacks the authority of a court or quasi-judicial body

3.10 African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa

Also known as the Internally Displaced Persons in Africa Convention or the Kampala Convention, the Internally Displaced Persons in Africa Convention was adopted in Kampala, Uganda. Although this Convention does not mention HIV specifically, it prohibits discrimination in the protection of the right to health of internally displaced persons and recognises their right to equality (article 3 (1)). Amongst other, the Kampala Convention also obliges States Parties to “Provide internally displaced persons to the fullest extent practicable and without the least possible delay, with adequate humanitarian assistance, which shall include food, water, shelter, medical care and other health services, sanitation, education, and any other necessary social services, and where appropriate, extend such assistance to local and host communities” (article 9(2)(b)). Furthermore, the Convention also urges States to ensure that specific measures are taken to “protect and provide for the reproductive and sexual health of internally displaced women as well as appropriate psycho-social support for victims of sexual and other related abuses” (article 9 (2)(d)). The provision of medical care as well as all other services mentioned above to all internally displaced persons also benefit those with HIV and cover HIV human rights related violations.

The monitoring of the internationally displaced persons Convention is provided for by article 14 of the Convention. This article vests the responsibility to monitor and review the implementation
of the objectives of the Convention to a Conference of States Parties. In addition, States Parties shall improve “their capacity for cooperation and mutual support” through the Conference of States Parties (article 14(2) to be convened by regularly by the African Union (article 14 (3)).

The monitoring mechanism is left to the good will of States through a Conference of States parties. This seems to be weakest of all the monitoring mechanisms discussed so far. However, the seed of hope can be found in article 14 (4) which calls on States Parties to report on steps taken to give effect to the Convention while reporting to the African Commission under article 62 of the African Charter, and under the African Peer Review Mechanism. Therefore, the only platform to hold States accountable is through the quasi-judicial process provided by the African Commission through its protective mandate.

3.11. Section conclusion

In the final analysis, there is absolutely no question whether the regional architecture for the protection of human rights in Africa reduces vulnerability and promotes human rights in the context of HIV. The ACHPR, the Maputo Protocol, the African Children Charter, the African Youth Charter, the African Charter for democracy and the Kampala Convention which are all constitutive elements of the African human rights system expressly prohibit discrimination on all grounds. More importantly, the Maputo Protocol, the African Youth Charter, the African Charter for democracy and the Kampala Convention specifically refer to the need afford medicine to all, to protect and include those living with HIV in the society and avoid their marginalisation and stigmatisation.

Significantly, at the regional level, the African Human rights system has institutions/mechanisms to ensure compliance by States Parties. At the centre of these mechanisms, the oldest institution is the African Commission that has relied on its protective and promotional mandate as well as Special Mechanisms to advance peoples’ rights including those related to HIV. In addition, although the African Court is yet to deal with a specific case on HIV and human rights, its advisory mandate provides a platform which can be useful in advancing the rights related to HIV. Furthermore, while the ACERWC still awaits its first case on children’s rights and HIV, it has also relied on its thematic issues, its promotional and protective mandates to explain the right to health and medical attention to cover children infected and affected by HIV. However, in its guidelines on state reporting, it missed the opportunity to oblige state to report specifically on what they do to give effect to the rights of children and adolescents with HIV-related healthcare needs including health information.

Moreover, it was found that the African Union Commission is in charge of monitoring the African Youth Charter and to lead and coordinate the implementation of the of African Charter on Democracy by States Parties. Nevertheless, the success of the African Union Commission depends on the good will of States parties. Finally, it was found that the Conference of States parties which monitors the internationally displaced Persons Convention is the weakest link of the monitoring mechanisms for its extreme dependence on the political will of the States Parties. The following subsection provides detailed conclusions and key challenges at the regional level.

Conclusions and Key Challenges
December 2016

There are a number of opportunities presented by the African human rights system for protecting rights in the context of HIV. The treaties discussed above protect key rights relevant to HIV and AIDS. In addition, there are a number of regional mechanisms in Africa that are specifically mandated to protect and promote human rights relevant to people in the context of HIV such as the African Commission, the ACERWC the African Court,^{181} The African Union Commission and the African Union Conference of States parties. The HIV Committee has a specific mandate to address the rights of people living with and affected by HIV and other special mechanisms, such as the Special Rapporteurs, focus on populations that are vulnerable in the context of HIV such as prisoners and women. The mechanisms have broad mandates that include a range of possible actions, including fact-finding missions, giving decisions on communications, issuing resolutions and guidelines and convening meetings, amongst others. Additionally, some regional mechanisms have the power and procedures for hearing from civil society organisations. The African Commission, at its public session, hears and receives submissions from non-governmental organisations with observer status.^{182} Further, individuals and non-governmental organisations can file communications to the African Commission when there is a breach of rights under the African Charter against countries once domestic remedies have been exhausted.

The existing work of the regional mechanisms on HIV is useful. However, given the opportunities available within the African human rights system, there is significantly more to be done to ensure the rights of people living with HIV, vulnerable populations and key populations. Some of the key challenges currently facing the African system include:

**Challenge Limited focus on HIV from all mechanisms:** Thus far, very few regional mechanisms apart from the HIV Committee have addressed HIV-related issues. The African Commission and African Court have yet to adjudicate on an HIV-related complaint. There are a number of special mechanisms of the African Commission whose mandates are relevant to HIV but are not specifically mandated to address HIV. For example, the Working Group on the Rights of Older Persons and People with Disabilities is developing a Protocol on the Rights of People with Disabilities and Guidelines for State Parties on the implementation of the rights of people with disabilities; integrating HIV and human rights issues relevant to people with disabilities would be an effective way of infusing HIV into the work of this Group. The Special Rapporteur on Human Rights Defenders may need to respond to difficulties faced LGBTI organisations working on HIV and human rights issues. The HIV Committee has made efforts to link with some of the relevant Special Rapporteurs, particularly the Special Rapporteur on the Rights of Women, in its work. However, broadly speaking related mechanisms fail to regularly address HIV-related issues. This may be due to their lacking the necessary knowledge and expertise to address HIV-related issues and the lack of specific guidelines regarding how their mandate should address the problem of HIV and human rights in Africa.^{183} This limits the impact of the regional mechanisms on HIV and human rights related issues.^{184} There is need for the HIV Committee to reach out to other mechanisms such as Special Rapporteurs on Prisons and Human Rights Defenders and Working Groups on Indigenous Peoples and on Disabilities and Older persons.

Furthermore, there are a number of key HIV and human rights issues (set out in more detail in section 4, below) as well as critical, related rights contained within the African Charter, the Maputo Protocol and the Children’s Charter that have received limited, if any focus, in relation to HIV, such as the right to information – critical for young people’s access to sexual and

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^{181} So far not more than 20 states have ratified the Protocol establishing the Court.

^{182} The Commission deliberates on the submissions received during a private session. After that it passes resolutions that are followed through. However, not all submissions get resolutions as the commission decides which issues are most serious.


^{184} As above.
reproductive health information - and the right to work. An exposition of the right to health in the context of HIV would also be of particular importance in elucidating the sexual and reproductive health rights of vulnerable and key populations and for increasing access to treatment in the context of HIV. Sensitive issues such as the criminalisation of HIV transmission and exposure and the rights of key populations need to receive increased focus. The African Commission and its mechanisms have made efforts, in their work and country missions\(^{185}\) to focus on HIV and human rights issues affecting vulnerable and key populations such as women and prisoners. The African Commission has made several efforts to address the rights of women in the context of HIV and the impact of gender inequality, harmful gender norms, and gender-based violence. However, there is a need for a far stronger focus on key populations, including men who have sex with men and transgender persons, sex workers, people who use drugs, and indigenous populations in order for the HIV Committee to impact on some of the most critical legal and human rights barriers to fast-tracking the end to AIDS in Africa.

Additionally, where there is a normative focus on HIV as in the African Youth Charter, the African Charter on Democracy and the Kampala Convention, the monitoring institutions are weak for their allocation to the AU Commission and the Conference of States parties respectively. These institutions are not quasi-judicial or judicial bodies and as such have limited impact. It is therefore important to find ways to strengthen the monitoring mechanisms perhaps by linking them directly to the African Commission or/and the African court for a positive impact.

**Limited use of the full range of powers available to the HIV Committee:** The HIV Committee has a broad mandate that provides for, amongst other things, investigating information on the situation and rights of people living with HIV and affected populations; developing guidelines, undertaking fact-finding missions; engaging with stakeholders on rights-based responses to HIV and making recommendations. However, the HIV Committee has not made full use of its broad powers, in part due to some of the related challenges set out below such as limited awareness of the HIV Committee amongst civil society as well as resource constraints. It is critical that the HIV Committee makes greater use of its powers to, for example, conduct fact-finding missions, and make recommendations on HIV and human rights issues. This work is critical to mobilising accountability by States for rights-based responses to HIV. It is also critical for civil society groups to engage more with the Committee on issues relating to human rights violations in the context of HIV in the region. For instance, civil society groups can explore the urgent appeal powers of the Committee by bringing to its attention human rights violations relating to HIV.

**Limited awareness and visibility of the mechanisms:** Affected individuals and civil society organisations are unaware of the existence of the regional mechanisms. Publicly available information on the regional mechanisms and how to best approach them is not easily provided. For civil society organisations and people affected by HIV are unaware of the mandate of the regional mechanisms, the process for making a communication or otherwise interacting with the mechanisms and how to contact them.

\(^{185}\) E.g. The Promotion Mission to Sudan in 2015 focussed on human rights issues of particular concern for vulnerable populations such as women and children, elderly persons, persons with disabilities, individuals in detention and people living with HIV.
Although The HIV Committee has made efforts to interact with government institutions as well as civil society in country visits and in other forums, to enlighten civil society of its work and how civil society organisations can interact with itself and the African Commission. It has conducted training for members of civil society in order to promote greater involvement of civil society in the Commission’s mechanisms. It has also received petitions and communications from civil society in connection with human rights violations from time to time. However, broader awareness raising initiatives may be required over and above these ad hoc interactions during country visits.

Inaccessibility of the mechanisms: The regional mechanisms are inaccessible to civil society organisations and to people affected by HIV. To participate in the African Commission’s public session or lodge a complaint before the African Commission, civil society organisations must have observer status. This can be difficult to obtain and travel to public sessions is costly. Similarly, the African Court does not permit individuals to approach the court unless the country has signed the declaration permitting such access. To date, very few countries in Africa have signed the declaration meaning that people affected by HIV and civil society organisations have limited access to the African Court. Thus, it is unsurprising that the African Court has yet to issue any decision specifically relating to HIV.

Limited awareness of HIV and human rights issues: There is still a need to increase awareness of the rights of people living with HIV, vulnerable, and key populations in the context of HIV and AIDS, as protected by regional treaties. Thus, to date, the African Commission has not yet dealt with communications relating specifically to HIV.

Resource constraints: Finally, the special mechanisms are hampered in their work by resource constraints, limiting their ability to, for example, conduct missions and fact-finding visits. This limits their ability to establish a comprehensive approach to HIV and human rights issues, resulting in a tendency towards ad hoc responses where resources allow.

Other Regional and Sub-Regional Norms in the Context of HIV

186 E.g. The Committee met with representatives of civil society in Dakar, Senegal; Douala, Cameroon; Nairobi, Kenya and Cotonou, Benin in 2011. This included networks of people living with HIV and organisations of key populations, such as sex workers. Most recently the Committee went on a country visit to the Republic of Côte d’Ivoire and met with key ministerial officials dealing with HIV and human rights issues from the Ministries of Foreign Affairs, Human Rights and Public Freedoms Public Health and Hygiene, Justice, Women Empowerment, the Family and Child Protection, Employment and Social Protection, Youth Empowerment, Employment and Civic Service, and National Education. The delegation also met with parliamentarians, members of the Committee on General and Institutional Affairs and members of the Committee on Social and Cultural Affairs, as well as the National Human Rights Commission, UN agencies, other stakeholders responsible for implementing HIV programmes and civil society organisations, including people living with HIV such as women, young people, men who have sex with men and sex workers.

187 E.g. The Committee held a workshop on HIV, the Law and Human Rights in Africa at the International Conference on AIDS & STIs in Africa in Zimbabwe in December 2015. And coordinated a Meet the expert’s session on the role of the African Commission on Human and People’s Rights in advancing human rights in the context of HIV in Africa at the International Conference on AIDS & STIs in Africa in South Africa in December 2013.


189 E.g. The Committee received a complaint from the Human Rights Development Initiative in 2011 regarding violations of the rights of people living with HIV to confidentiality, in Tanzania.

190 The lack of understanding of the commission’s work makes some civil society organizations view attending sessions of the Commission an unnecessary expense.
In addition to the legal instruments within the African human rights system, there are a number of other regional laws and legal instruments that are relevant to HIV, many of which are listed below. These instruments commit countries to specific actions; provide HIV-related legal and policy norms; and acknowledge the impact of HIV on the region and in countries. Significantly, these legal instruments have included commitments and statements regarding HIV and human rights issues from the outset. Some of the more important and recent commitments to HIV, law and human rights issues are discussed in more detail, below.

- Tunis Declaration on AIDS and the Child in Africa (1994);
- Grand Bay (Mauritius) Declaration and Plan of Action (1999);
- Lomé Declaration on HIV/AIDS in Africa (2000);
- Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infectious Diseases (2001);
- Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Infectious Diseases (2003);
- Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care (2005);
- Continental Framework for Harmonisation of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa (2005);
- Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010 (2006);
- Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (2006);
- AU’s Common Position to the UN General Assembly Special Session on AIDS (2006);
- AU Roadmap on Shared Responsibility and Global Solidarity
- Southern Africa Development Community (SADC) Model Law on HIV/AIDS
- East African Community (EAC) HIV and AIDS Prevention and Management Bill
- Economic Community Of West African States (ECOWAS) Minimum Legal Framework for Rights-Based Responses to HIV

Regional Commitments

The importance of a rights-based response to HIV and the recognition of vulnerable populations in the context of HIV and AIDS has been a focus of regional and sub-regional declarations from the outset. Some of the earlier African Union (then OAU) Assembly of Heads of State and Government resolutions on the issue were the Resolution on the AIDS Epidemic in Africa: Progress Report and Guidelines for Action in 1993191 and the Tunis Declaration on AIDS and the Child in Africa which commits countries to “[e]laborate a ‘national policy framework’ to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues.”192

The Grand Bay Declaration (Grand Bay Mauritius, 16th April 1999) committed African governments to ensure the respect for the rights of people with disability and people living with HIV, in particular women and children, with a specific focus on sexual and reproductive rights and protection for those most affected by HIV from stigma and discrimination.193


In 2001, the OAU adopted the Abuja Declaration on HIV/AIDS, Tuberculosis and other related Infectious Diseases. The declaration included recognition of “stigma, silence, denial and discrimination against people living with HIV/AIDS (PLWA) increase the impact of the epidemic and constitute a major barrier to an effective response to it.” It also declared a state of emergency on the continent due to the AIDS crisis and endorsed the “African Consensus and Plan of Action: Leadership to overcome HIV/AIDS”. Additionally, as was briefly discussed above, State Parties pledged to allocate 15% of their national budgets to improvement of the health sector and that an “appropriate and adequate portion” would go specifically to fight HIV/AIDS, tuberculosis and other infectious diseases.

The AU has also recognized the gendered impact of HIV/AIDS. In its 2004 Solemn Declaration on Gender Equality in Africa, the AU stated it was “deeply concerned…about the status of women and the negative impacts on women of issues such the high incidence of HIV/AIDS among girls and women." Consequently, it agreed to “accelerate…the implementation of gender specific economic, social, and legal measures aimed at combating the HIV/AIDS pandemic and effectively implement both Abuja and Maputo Declarations on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Disease.” 

The Abuja Special Summit held in May 2006 adopted the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria (ATM) Services in Africa, subsequent to a review of the progress made in implementing (i) the Abuja Declaration and Plan of Action on Roll Back Malaria (RBM) of April 2000, and (ii) the Abuja Declaration and Plan of Action on HIV/ AIDS, TB and Other Infectious Diseases (ORsID) of 2001. In the 2006 Abuja Call, AU Member States committed to promote an enabling policy, legal and social environment to reduce vulnerability and promote human rights in the context of HIV, with a strong focus on vulnerable and key populations that include women, youth and children, conflict-affected and displaced persons, refugees and returnees. The Abuja Call also specifically noted the challenges included states’ “[f]ailure to take into account the link between HIV and AIDS and sexual and reproductive health” and “stigma, discrimination and gender inequity, which result in


inadequate application of the human rights of people infected or affected by HIV and AIDS and directly hampers their ability to access services”.

The subsequent Continental Framework for Harmonisation of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa adopted by the AU as well as the AU’s commitment in terms of the United Nations General Assembly Special Session (UNGASS) on AIDS in 2011 have strengthened Member States’ commitments to protect and promote human rights, eliminate gender inequalities, review inappropriate laws and address the specific needs of vulnerable populations.

More recently, the AU Roadmap on Shared Responsibility and Global Solidarity (AU Roadmap), adopted on 16 July 2012, has provided guidance on Africa’s commitment to and leadership on the AIDS response within Member States and has included a focus on promoting a strong ethical and legal framework for effective responses to HIV and AIDS. The AU Roadmap has 3 strategic pillars: (i) More diversified, balanced and sustainable financing models; (ii) Access to medicines - local production and regulatory harmonisation and (iii) Leadership, governance and oversight for sustainability. In terms of a focus on key human rights issues, the second pillar of the AU Roadmap includes a strong focus on using all measures, including flexibilities within international trade law and harmonisation of pharmaceutical regulation in Africa, to increase access to medicines. The third pillar on leadership, governance and oversight for sustainability includes a focus on investing in programmes that support people and communities to prevent HIV, HIV/TB co infection, TB and malaria, to know and claim their rights and to enable effective participation in planning and evaluating programmes. Reports by the African Union on the progress of Member States towards realising the goals of the Abuja Call and the AU Roadmap have recognised the failure to adequately monitor and hold states accountable for their commitments and have included a recognition of the need to strengthen legal and human rights responses, in particular for vulnerable and key populations.

The African Union is currently drafting a new strategic planning document entitled “Catalytic Actions to end AIDS, TB and Malaria by 2030”, which will be considered at the AU 2016 Summit. Some of the key actions include fast tracking access to medicines, diagnostics and harmonization of regulatory systems and the need to put in place an accountability framework and to develop indicators and a scorecard to monitor uptake and implementation of high level declarations at country level. This will help towards strengthening accountability for the commitments made by Member States.

Sub-regional commitments and mechanisms

The issues of HIV and human rights in the regional treaties discussed above are complemented at the sub-regional level by provisions in constitutive instruments of African Regional Economic Communities (RECs) and in other instruments adopted under the auspices of these RECs.

Although their primary objective is to foster economic integration, African RECs are also expanding their respective mandates to cover human rights in general and HIV related human rights in particular. Therefore, at the sub-regional level, binding instruments can commit countries to make changes to national laws and comply with them. The Partner States of the East African Community (EAC) are required, in accordance with Chapter 21, Article 118 of the Establishment of the EAC, to undertake, among other activities, the harmonization of national health policies and regulations and the promotion of exchange of information on health issues in order to achieve quality health within the EAC. It is within this framework that the EAC’s Legislative Assembly passed the EAC HIV and AIDS Prevention and Management Bill (EAC Bill) on 23 April 2012. The Bill has since been signed by all EAC Partner States and is an enforceable law. It seeks to protect the rights of people living with HIV and harmonize regional legislation and policy on the prevention and treatment of HIV.

Significantly, the EAC Bill does not criminalise the wilful transmission of HIV, unlike some of the laws in the individual member states of the EAC such as Burundi, Kenya, Tanzania and Uganda. It is also strong on the rights of women, “most at risk populations” and the rights of people with disabilities in the context of HIV and AIDS. The EAC Bill seeks to override “errors in current laws” in individual EAC member countries that have enacted HIV-specific criminal legislation. These individual EAC member countries are therefore pressed to amend the laws to reflect the spirit of the regional Bill.

Other instruments, while not binding, provide persuasive HIV-related legal and policy norms. In light of the gaps in HIV-related legislation and policy and the emergence of coercive HIV-related laws, including criminalisation of transmission, SADC Parliamentary Forum (PF) sought to adopt a Model Law on HIV/AIDS (SADC Model Law). The SADC Model Law, which was adopted in 2008, serves as a guide for legislators, policymakers and other stakeholders seeking to address the human rights response to HIV. The SADC Model Law guarantees the respect for human rights principles, rejects coercive approaches, addresses the root causes of vulnerability to infection and ensures the protection of members of vulnerable and marginalised groups. It furthermore emphasises the importance of information, education and communication in the HIV response. Legislatures can select and adapt provisions from the Model Law for their own particular national situation.

ECOWAS is in the process of considering a Minimum Legal Framework on HIV and AIDS for its Member States.

Conclusions and Key Challenges

There are a number of commitments to rights-based responses to HIV for people living with HIV and vulnerable populations at regional and sub-regional level. Key challenges with the responses to HIV and human rights at regional and sub-regional level include the following:

205 As above.
Limited accountability for and enforcement of commitments: There are limited mechanisms to enforce accountability for the commitments made at a regional and sub-regional level. While the AU has been consistent in its reporting on the progress made towards achievement of the Abuja Call and AU Roadmap, for instance, the AU itself acknowledges the limited reporting by Member States in terms of these commitments. In addition, while there are numerous rights-based and protective policies at sub-regional level, some of which are HIV-specific and others of which relate to the rights of vulnerable populations (e.g. women) and though these documents are helpful in guiding countries on a human rights-based HIV response, they rarely result in real action. Worse still, some states have not been faithful in meeting their reporting obligations under relevant human rights instruments in the region. This has made it difficult for the relevant treaty monitoring bodies to assess the level of commitments or progress made in realising human rights in general and in the context of HIV in particular. For instance, since the entry into force of the Maputo Protocol only five countries so far have submitted their reports in line with article 26.

In SADC, the SADC Tribunal, which was established to address violations of human rights in the region, among other things, has been ineffective for addressing human rights violations since 2010 when it was suspended after Zimbabwe challenged its legitimacy. In 2012, the SADC Heads of States chose to remove individual access to the SADC Tribunal, meaning that now only countries could bring cases against each other. Thus individuals whose human rights have been violated or organisations representing marginalised populations whose rights have been violated cannot access the SADC Tribunal.

Limited use of existing mechanisms for HIV-related complaints: In East Africa, the jurisdiction of the East African Court of Justice (EACJ) to hear human rights cases is unclear. Article 27 of the Treaty for the Establishment of the East African Community states that the EACJ “shall have such other original, appellate, human rights and other jurisdiction as will be determined by the Council at a suitable subsequent date. To this end, the Partner States shall conclude a protocol to operationalise the extended jurisdiction.” A protocol has yet to be adopted. Despite this, however, the EACJ has entertained various cases dealing with human rights issues. Importantly, for the individual access to the EACJ, the exhaustion of local remedies is not a prerequisite to take a case of human rights violation to court. This was the position of the EACJ in the Kenyan EALA Nominees case in which the Court held that the silence of the rule on local remedies rule was an indication that individuals of the Community have ‘the right of direct access to court’. This enables victim of human rights violations to approach the Court directly and this is important for the protection HIV related human rights violations as the victims can directly approach the court. As a matter of fact, the EACJ has had an opportunity to address a specific case that may have implications for HIV and human rights. The case was brought by a group of civil society organisations in Uganda challenging the Anti-Homosexuality Act. The court refused to make pronouncement on the case on the grounds that the matter had already

210 These include Nigeria, Malawi, Gabon, South Africa and Namibia.
212 See, for instance, Katabazi and 21 Others v Secretary General of the East African Community and Another (Ref. No. 1 of 2007) [2007] EACJ 3 (1 November 2007).
been settled at the national court. Given the implications of some of the provisions of the Ugandan law for HIV prevention programmes; it was a missed opportunity for the EACJ for failing to pronounce on this issue.

The ECOWAS Court of Justice, the judicial organ of the Economic Community of West African States (ECOWAS)\textsuperscript{216} charged with resolving dispute related to the Community’s treaties, protocols and conventions, has the competence to hear individual complaints of alleged human rights violations in any Member State,\textsuperscript{217} in terms of the provisions of the African Charter and there is no requirement that domestic remedies have been exhausted in bringing a complaint before the Court. For example, in \textit{Hadijatou Mani Koraou v The Republic of Niger}\textsuperscript{218} an individual woman was able to bring a complaint against Niger for violations of the African Charter related to slavery. The Court held that she was not required to exhaust local remedies first, Niger had not done enough to protect the plaintiff from slavery, and ordered that Niger pay her reparations in the amount of CFA 10,000,000. Not only was she able to get a ruling to vindicate her rights without exhausting local remedies, but also get compensation for her suffering. This example highlights just how useful bringing an HIV-related complaint to the ECOWAS Court could be in articulating rights related to the Charter, but also by providing monetary compensation to the individual. It is important that HIV-related complaints be brought before sub-regional mechanisms such as these, in order to increase understanding of and commitment to HIV and human rights issues at country, sub-regional and at regional level.

\textit{Inadequate focus on sensitive criminal law issues:} While regional and sub-regional commitments pledge to protect rights including those of vulnerable populations, there is a tendency towards silence on some of the more contentious issues such as the criminalisation of HIV transmission and the rights of key populations at higher risk, such as men who have sex with men, transgender people, sex workers and people who inject drugs. Both the EAC and the SADC PF HIV laws do not include provisions regarding the criminalisation of HIV transmission; however they fail to specifically condemn criminalisation. Similarly, they include fairly limited protection of the rights of key populations although they are stronger on the rights of vulnerable populations such as women and people with disabilities.

\textsuperscript{216} Created in terms of the Revised Treaty of the Economic Community of West African States, 1993.
\textsuperscript{217} In terms of the Supplementary Protocol A/SP.1/01/05 following the adoption of Protocol A/SP1/12/01 on Democracy and Good Governance.
\textsuperscript{218} (2008) AHRLR 182 (ECOWAS 2008).
4 NATIONAL HUMAN RIGHTS NORMS AND MECHANISMS RELEVANT TO HIV

In addition to the rights, mechanisms, and treaties at the regional and sub-regional levels, similar mechanisms and human rights relevant to the HIV response are provided for at national level. National responses to HIV have been far more comprehensive than that seen at regional and sub-regional levels and have included progressive judgements on a range of HIV-related issues (notwithstanding the inaccessibility of the courts in most African countries) as well as HIV-specific, anti-discrimination laws in 27 African countries, amongst other things.\(^{219}\)

4.1 National Human Rights Norms

African countries have guaranteed specific rights relevant to a human rights-based response to HIV in national laws. In particular, these rights are provided for in national constitutions and in statutes.\(^{220}\) In addition, at a policy and planning level, most countries have national strategic plans on HIV which seek to ensure a protective legal environment for HIV.

The relevant rights often provided in national constitutions are as follows:

- The right to equality, equal protection and non-discrimination;\(^{221}\)
- The right to health;\(^{222}\)
- The right to dignity and privacy;\(^{223}\)
- The right to liberty;\(^{224}\)
- The right to be free from torture and cruel, inhuman and degrading treatment;\(^{225}\)
- The right to information;\(^{226}\) and
- The right to life.\(^{227}\)

Additionally, a number of countries in Africa have enacted HIV-specific laws aimed at providing a protective legal environment to assist the HIV response. As of 31 July 2014, 27 sub-Saharan African countries had passed HIV-specific laws or introduced HIV-specific bills to address the legal issues raised by the HIV and AIDS epidemics.\(^{228}\) Many of the HIV-specific laws include protective provisions relating to non-discrimination in general or in specific areas, such as employment, health, housing and insurance.

However, the provision of rights in national constitutions and HIV-specific laws are inadequate to fully protect the human rights of people living with and affected by HIV,\(^{229}\) given that populations are not sufficiently aware of their rights and the laws are often poorly implemented and enforced.\(^{230}\)

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\(^{221}\) See e.g. Constitution of Ethiopia (1995), art 25.

\(^{222}\) See e.g. Constitution of Mozambique (2004), art 36

\(^{223}\) See e.g. Constitution of Namibia (1998), arts 8 and 13

\(^{224}\) See e.g. Constitution of the Republic of Ghana (1992), art. 14(1)

\(^{225}\) See e.g. Constitution of Kenya (2010), art. 25(a).

\(^{226}\) See e.g. Constitution of South Africa (1996), art. 32

\(^{227}\) See e.g. Constitution of the Federal Republic of Nigeria (1999), art. 33

\(^{228}\) Eba (2015).

\(^{229}\) As above

\(^{230}\) ARASA. HIV and Human Rights in Southern and East Africa (2014).
Further, many HIV-specific laws include punitive or restrictive provisions. The punitive and restrictive provisions include compulsory HIV testing, particularly for alleged sexual offenders, involuntary partner notification and criminalisation of HIV non-disclosure, exposure and transmission. Twenty-four countries in Africa, as of July 2014, provided punitive laws as part of HIV-specific laws.

In most instances, the restrictive provisions are overly broad and fail to take into account the evidence and recommendations on how best to legislate on HIV. Further, these restrictive provisions violate fundamental rights and exacerbate myths and prejudice about PLHIV, and thus fail to adequately address HIV.

At the policy and planning level, African states have developed strong national strategic plans that recognise rights-based responses to HIV and that include objectives aimed at creating an enabling legal and regulatory framework for the national response to HIV.

**4.2 National human rights mechanisms**

Most countries in Africa have operating judicial and quasi-judicial bodies tasked with interpreting, applying and enforcing national laws. These include courts, tribunals, and ombudsmen. In Africa, courts and tribunals have played a crucial role in ensuring a human rights-based response to HIV. National human rights institutions in Africa can also be effective in ensuring a human rights-based response to HIV, but thus far NHRIs have played a limited role in protecting the rights of people living with and affected by HIV.

The areas related to HIV where courts in Africa have been most active in upholding the rights of people living with and affected by HIV are HIV-related discrimination; access to HIV-related treatment; HIV prevention and care in prison; HIV and family law; HIV and confidentiality; HIV and testing; HIV and the law of delict (tort); HIV and criminal law; and HIV and freedom of expression.

With respect to access to treatment, the Constitutional Court of South Africa in *Minister of Health v Treatment Action Campaign* held that the state’s obligation to take reasonable steps to progressively realise the right to health required the government to develop and implement a comprehensive programme, including testing, counselling and providing antiretroviral treatment, to prevent mother-to-child transmission of HIV. In Kenya, the High Court struck down part of the *Anti-Counterfeit Act*, which effectively limited the ability of people living with HIV to

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232 As above.
233 As above.
235 UNDP (2008) IX.
236 See *Hoffmann v South African Airways* 2001(1) SA 1 (CC).
238 See *Mazibuko v Minister of Correctional Services and Others* 2007 JOL 18957 (2005).
240 See *NM and Others v Smith and Others* 2007 (5) SA 250 (CC).
241 See *Thebe v Mbewe t/a Checkpoint Laboratory Services* 2000 JOL 7142 (ZS).
242 See *Venter v Nel* 1997 (4) SA 1014 (SAHC D).
243 See *Republic v Cidreck* 1995 MLR 695 (High Court of Malawi 1994); *S v Marapo* 2002 (2) BLR 26 (2002).
244 See *De Vos v Talk Radio 702* [2006] JOL 16828 (BATSA).
245 2002 (5) SA 721 (CC).
access affordable generic HIV medication. In Nigeria, the High Court held that the denial of medical treatment to HIV-positive prisoners awaiting trial violated the prohibition of torture.

With respect to the rights of women, in Namibia, the Supreme Court of Appeal affirmed the coercive sterilisation of HIV-positive women at public hospitals finding that it violated the women’s fundamental rights. In Botswana, the Court of Appeal found that any customary law which discriminated against women solely on the basis of their gender would be unconstitutional. In Ghana, the High Court in Akrofi v Akrofi struck down the rule of male primogeniture noting that male-only inheritance has “out-lived its usefulness and is at present not in conformity with public policy.”

These and other important cases are discussed in further detail in section 4, below, looking at key HIV and human rights issues.

National human rights institutions (NHRIs) also are tasked with ensuring that international, regional and national human rights standards are upheld by the state. In particular, NHRIs submit regular reports to the African Commission on the country’s adherence to regional human rights standards, including the steps the state has taken to protect the rights of people living with and affected by HIV. At national level, NHRIs, through their promotional and protective mandate, are empowered to investigate and monitor human rights violations, including HIV-related human rights violations. For example, in Rwanda article 6(4) of the Law No. 19/2013 mandates the National Commission for Human Rights to ensure respect for the rights of the child, women, persons with disabilities, people living with HIV and AIDS, refugees, migrant workers and members of their families through oversight and monitoring activities of institutions and organs of the state.

In a few instances, NHRIs have supported human rights-based responses to HIV. For instance, in South Africa, the South African National Human Rights Commissions integrated HIV and AIDS into its strategic planning; in Uganda, the Human Rights Commission publicly criticized the Anti-Homosexuality Bill as unconstitutional including in relation to its impact on the health rights of all people in the context of HIV. The Malawi Human Rights Commission has embarked on sensitization seminars on sexual and reproductive health and rights, including issues on HIV/AIDS. However, to date generally NHRIs have not utilised their full capacity in ensuring an effective, rights-protective response to HIV.

4.3 Conclusions

African states have taken various steps to protect the rights of people living with HIV at national level, including through the development of anti-discrimination laws and policies and through judicial application of nationally-enshrined rights relevant to HIV and human rights. However, stigma and discrimination against people living with HIV continues at unacceptably high levels, for various reasons including weak implementation of laws and poor access to justice for affected populations. Affected populations struggle to access enforcement mechanisms such as the courts. The courts themselves are reliant on cases of alleged HIV-related human rights violations being brought before them and on the parties providing the necessary scientific, medical and legal information to enable sound judgements. Other, more accessible

248 Namibia v LM and Others Case No SA 49/2012 (3 November 2014).
mechanisms such as the NHRIs themselves have limited funding and their reliance on state funding may limit their independence.

Legislative responses to HIV have their own limits. Protection for key populations at higher risk of HIV exposure remains limited in law and policy. Punitive provisions within HIV laws themselves and beyond, in broader laws (e.g. laws that criminalise sex between men, sex work and injecting drug use) place key populations at higher risk, as is discussed in further detail in section 4, below.

Thus, though many tools are in place for a protective and enabling national legal environment to ensure an effective HIV response, much more needs to be done at national level, including raising awareness of rights among affected populations, increasing access to justice, repealing punitive and restrictive legal provisions and ensuring more accessible mechanisms, such as NHRIs are fully utilising their capacity.
5 KEY HUMAN RIGHTS ISSUES

This section will discuss key human rights issues and challenges related to HIV. It will provide an overview of each issue; discuss which key human rights are impacted; and how countries in Africa have sought to address these violations and protect those rights. The key issues are as follows:

- Women and girls;
- Harmful cultural practices and traditional beliefs in the context of HIV;
- Equality and non-discrimination;
- HIV testing;
- Criminalisation of HIV transmission;
- Key populations at risk of HIV;
- Intellectual property rights and access to HIV medicine in Africa; and
- The rights and welfare of the African child in the context of HIV and AIDS. Was this not cover earlier?

5.1 Women and girls

Laws, policies and practices that perpetuate gender inequality, harmful gender norms and gender-based violence undermine women and girls, keeping them in poverty, limiting their autonomy and decision-making power, including limiting their ability to access health care services.

Women are significantly more vulnerable to HIV in Africa. In Africa, women and girls account for 60% of the people living with HIV in the world. In sub-Saharan Africa infection rates for young women and girls are more than double those of young men and boys.

The increased vulnerability of women to HIV is due in part to entrenched gender inequality and discrimination; violence against women and restrictions on women’s sexual and reproductive rights.

This section will discuss each of these issues describing the issue with illustrative examples from Member States and highlighting the way in which these issues result in violation of key rights such as the right to equality and non-discrimination on the basis of sex, gender and/or marital status; the right to dignity, the right to be protected from cruel, inhuman or degrading treatment or punishment, the right to health, and the right to education.

5.1.1 Gender inequality in family and personal law

As set out above, article 2 of the Maputo Protocol requires countries to eliminate discrimination against women and to protect the rights of women and children. The Maputo Protocol also guarantees women the right to equality under Articles 8, 9, 12, 13, and 16.

Despite this, gender inequality is a major barrier to women’s development in Africa. A recent survey of 34 countries in Africa reveals that women continue to be more disadvantaged than men in their daily lives. Women lack access to the same levels of education, economic power and political leadership as men and report discrimination in the work place, courts and before traditional leaders. In personal and family law, gender inequality limits women’s rights to autonomy, equality in relationships, security of property ownership and financial control, in

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254 As above
256 As above.
contravention of international, regional and national protection of the right to gender equality. The protection of the rights of women to gender equality in their personal and family lives is complicated by the existence, in many countries across Africa, of inequitable customary and religious laws alongside protective statutory and constitutional laws. These customary and religious laws often deny women the right to make decisions relating to their lives and the lives of their children, their property and their health care and creating barriers to access to marital property. In Lesotho, Article 18(4)(c) of the Constitution arguably allows discrimination against women in terms of customary law. This continued inequality is significant in the context of HIV since it entrenches women’s dependency upon their partners and relatives, leaving them increasingly vulnerable to HIV infection and less able to care for and support themselves and their families. Research shows that gender inequality within a relationship increases a woman’s risk of HIV transmission by 13.9%.

There are countless examples of the impact of inequitable property and inheritance laws on the lives of women in Africa. For example, in Tanzania, under codified customary law, inheritance is patrilineal. In the event of a husband’s death, the brother or father of the deceased has the power to administer the estate. Women may only administer the estate if there is no living male relative. Furthermore, widows may not inherit from their husband’s estate. Customary law also prohibits women and daughters from inheriting clan land and grants them limited inheritance rights, since daughters are ranked lowest in terms of the customary law ranking system. In E.S. and Another v Tanzania, two women, E.S. and S.S. both married their respective husbands under customary law. During their marriages they jointly acquired property. E.S. and her husband acquired their house and S.S. and her husband acquired a car. Upon their husbands’ deaths, both women were denied any inheritance from their in-laws. Both E.S. and S.S. had to leave their homes at the behest of their respective brothers-in-law. They received no support from their late husband’s families. Both challenged these actions and the cases ended up before the Committee on the Elimination of Discrimination Against Women (CEDAW Committee), which found in favour of the women’s right to inherit. Such equity is critical to ensuring that women have control to mitigate their vulnerability to HIV.

Promising developments
In addition to the decision of the CEDAW Committee in E.S. and Another v Tanzania, a number of African courts have upheld the equality of women with respect to family and personal law. For instance, in 2013 the Court of Appeal of Botswana held that customary laws that discriminated against women solely on the basis of their gender would be unlawful and unconstitutional. The case challenged a Ngwaketse customary law which arguably denied women the ability to inherit the family home. In finding that women cannot be wholly exempted from inheriting the family home, the Court of Appeal noted that though the Constitution provides an exception for customary law, it was not an unlimited exception. The Court of Appeal reasoned that customary law could only be exempted from constitutional scrutiny if it is in the public interest and does not prejudice the rights and freedoms of others.

Alternative dispute mechanisms have also been used to ensure women equal access to inheritance. In Kenya, community leaders, with the support of a HIV law and human rights organisation, KELIN, are using traditional dispute resolution mechanisms to support women dispossessed of family property when their husbands die. According to some customary

257 Constitution of Lesotho (1993), art. 18(4)(c). See also Masupha v Senior Resident Magistrate of the Subordinate Court of Berea (Mr. Kolobe) and Others (CIV) 29/2013 (2014).
258 GCHL (2012).
261 As above.
262 Ramantele v Mmusi and Others CACGB-104-12 (2013).
263 As above.
traditions in Kenya, a female widow is “inherited” by a male relative of the deceased. Those who refuse to be inherited are often evicted from their land and lose their property. Others are dispossessed of property when a husband has died of AIDS. KELIN has worked with respected elders of the Luo tribe, supporting the elders to work with families to resolve disputes and to protect the property rights of widows to return to their original homes and villages or to resettle elsewhere. This model is premised on the view that customary law changes with society and can change to encompass gender equality. It has thus far been successful in ensuring widows are not dispossessed of their property.\textsuperscript{264}

Finally, promising legislative developments at regional level are seen in both the SADC PF’s Model Law on HIV and HIV Model Law) and the EAC’s HIV and AIDS Prevention and Management Act, 2012 (the EAC HIV Act). While national HIV laws are often criticised for their narrow focus on people living with HIV, The Model Law and the EAC HIV Act acknowledge the vulnerability of women to HIV and specifically recognise the importance of, and provide for gender equality and the rights of women living with HIV.

5.1.2 Violence against women
The African Charter and the Maputo Protocol clearly prohibit violence against women. The African Charter and Maputo Protocol guarantee women the right to dignity, freedom from cruel, inhuman and degrading treatment, right to health and right to security of person. Further, the Maputo Protocol requires countries to implement appropriate measures to protect women from violence.\textsuperscript{265}

Gender-based violence research confirms that sexual as well as intimate partner violence places women at increased risk of HIV infection.\textsuperscript{266} For example, a 2005 study found that men who were violent towards their partners were more likely to have multiple partners and HIV.\textsuperscript{267} Women from marginalised populations are at particular risk of violence.\textsuperscript{268} For example, research shows that sex workers are at high risk of sexual violence,\textsuperscript{269} as are women with disabilities.\textsuperscript{270} The rape of women in Africa places women at risk within their homes, their communities and within conflict zones where the rape of women and girl children is used as a weapon in war.\textsuperscript{271}

Despite this, women and girls across Africa continue to face high levels of violence, particularly rape and other forms of sexual violence. This is due in part to the fact that in many countries there are no laws protecting women from specific forms of gender-based violence. For example, in sub-Saharan Africa approximately 80 countries do not have legislation criminalising marital rape. Thus, a rape committed by a husband against his wife is not a criminal offence.\textsuperscript{272} Both Botswana and Tanzania have failed to make clear that marriage does not constitute indefinite consent to sex.\textsuperscript{273} A number of countries still have inadequate laws to protect women from domestic violence. For example, Swaziland, which has high levels of gender-based violence has no statutory protection against domestic violence.\textsuperscript{274}

\textsuperscript{264} Catherine Muyeka Mumma. \textit{Accessing Justice and Protecting the Rights of the Rights of the Vulnerable through Cultural Structures: A Tool on Working With Elders in Communities} (2010).
\textsuperscript{265} Maputo Protocol, art. 3(4).
\textsuperscript{267} GCHL (2012) 64.
\textsuperscript{269} GCHL (2012).
\textsuperscript{270} HEARD. \textit{National Response to Disability and HIV in Eastern and Southern Africa} (2009).
\textsuperscript{272} GCHL (2012) 64.
\textsuperscript{273} GCHL (2012) In 334.
\textsuperscript{274} As above
In other instances, where protective laws do exist, they are inadequately implemented and enforced. In Zimbabwe, the law criminalises marital rape, but requires the consent of the Attorney General for prosecution, resulting in few prosecutions for marital rape.275

Promising developments
There are promising initiatives aimed at addressing violence against women in Africa. A number of countries have enacted legislation aimed at addressing gender-based violence. For example, after decades of permitting marital rape, Namibia passed the Combating of Rape Act, No. 8 of 2000 which makes clear that marriage cannot constitute a defence to rape.276 Zimbabwe has under legislation created an Anti-Domestic Violence Council and counsellors to support the implementation of the Domestic Violence Act 14 of 2006 aimed at addressing domestic violence in Zimbabwe.277

Countries are including programmes to address gender-based violence in their National Strategic Plans on HIV and AIDS. For example, Mozambique’s National Strategic HIV and AIDS Response Plan 2010-2014 integrates the need to address gender-based violence within HIV programming.278 Similarly, Tanzania’s National Strategic Framework on HIV and AIDS provides for the sexual and reproductive health rights of women and girls including programmes aimed at addressing gender-based violence.279

5.1. 3 Sexual and reproductive health and rights of women living with HIV and AIDS
The African Charter and the Maputo Protocol directly and indirectly provide for the right to sexual and reproductive health. The African Charter and Maputo Protocol guarantees the right to dignity; the right to security of the person; the right to be free from cruel, inhuman and degrading treatment and torture; the right to be free from discrimination and equal protection in law. The Maputo Protocol further provides women the right to control one’s own fertility, the right to decide when and whether to have children, the right to contraception, and the right to information on family planning.

Research consistently shows a range of reported incidents indicating a trend towards discrimination and coercive practices in access to sexual and reproductive health services for women affected by HIV. For instance, women living with HIV report being advised not to have children, being forced to use contraception in order to obtain ART, and being coerced into a termination of pregnancy.280 For instance, in Rwanda 65% of men and 81% of women respondents report being advised not to have children; 17% of men and 12% of women report that ART was conditional on the use of contraception.281 In Mozambique 20.4% of the respondents reported that access to ART was conditional upon using contraceptives. In Uganda 26% of those responding to questions relating to sexual and reproductive health reported coercion in relation to birthing methods, 25% reported coercion in relation to infant feeding practices and 12% of women reported coercion in relation to termination of pregnancy.

In addition, women living with HIV are being subjected to coerced and forced sterilisation and have limited access to abortion. Women with HIV from Kenya, Malawi, Namibia, South Africa, 275 GCHL (2011).
276 See art 2(3).
277 See ss 15 and 16.
281 As above
Swaziland, Tanzania, Uganda and Zambia have reported being subjected to forced or coerced sterilisation. In these cases, women living with HIV have either been coerced into signing consent forms for sterilisation or have been unaware that they had been sterilised. The coercion has taken various forms, but includes requiring a pregnant woman to sign the consent form when she is in labour or on her way to the operating theatre. Thus far, countries have taken very little proactive action to address the issue. To the extent some action has been taken it has been due to the court orders.

The ability to access abortion is critical for women to enable them to have full control over their body and lives, including full control over how to best protect themselves against HIV. The importance of accessing abortion to women’s wellbeing has resulted in the African Commission launching a campaign to decriminalise abortion in Africa. The campaign seeks to bring attention to the impact of unsafe abortions on the lives and health of women in Africa and decriminalise abortion in Africa to ensure country compliance with African regional treaty obligations. In particular, article 14(2)(c) of the Maputo Protocol requires countries to “protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus”. Under the Maputo Protocol, countries are required to provide information on safe abortions and ensure the availability and accessibility of good quality and safe abortion services. Further, countries need to take appropriate measures to remove the obstacles to accessing safe abortions.

However, very few countries in Africa provide for at will abortion. Even in countries where specific exceptions are permitted for abortions, access to abortion is still limited.

Promising developments
A number of countries are addressing the coerced sterilisation of women living with HIV through the courts. For instance, the Supreme Court of Namibia found in Namibia v LM and Others that three women living with HIV had been forcibly sterilised in violation of their rights under Namibian law. The three women were the first women living with HIV in Africa to challenge in court their sterilisation. They further reflect a small percentage of the dozens of women living with HIV who have reported being sterilised in public hospitals. However, the Namibian government has thus far failed to address the systemic nature of the problem and has merely addressed the case of the three women who had raised the issue in court.

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283 See e.g. International Community of Women Living with HIV. The Forced and Coerced Sterilization of HIV Positive Women in Namibia (March 2009).
285 Id. para 61.
288 Case No SA 49/2012 (3 November 2014).
Similar cases challenging the coerced sterilisation of women living with HIV have been filed in Kenya.\(^{293}\)

In addition, in December 2015, the Sierra Leone parliament voted to legalise abortion. The bill still has not been signed by the President, however, the parliament’s actions are promising.\(^{294}\)

### 5.2 Harmful cultural practices and traditional beliefs in the context of HIV and AIDS

The Maputo Protocol under article 5 clearly requires countries to eliminate all harmful practices, “which negatively affect the human rights of women and which are contrary to recognised international standards”. States under the Maputo Protocol are required to create awareness of harmful practices, provide health and psycho-social support, amongst other things, to victims of harmful practices, legally prohibit female genital mutilation and protect women who are at risk of harmful practices. Further, depending on the particular harmful practice, a number of additional fundamental rights guaranteed under the African Charter and the Maputo Protocol can be at risk of violation. These include the right to dignity; right to be free from discrimination, torture, and cruel, inhuman and degrading treatment; right to security of the person; right to health; right to equality and right to property.

The African Commission’s Committee on the Protection of the Rights of PLHIV and Those at Risk, Vulnerable to and Affected by HIV (HIV Committee) has noted the disturbing feminisation of HIV in Africa, reporting that “[b]iological factors that make women and girls more vulnerable to HIV infection are exacerbated by socio-cultural and structural factors, such as poverty, harmful cultural practices, limited decision-making power, lack of control over financial resources, restricted mobility, violence, limited educational opportunities, and lack of quality sexual and reproductive health services.”\(^{295}\)

Harmful cultural practices, such as child marriage and female genital mutilation exacerbate the vulnerability of women and girls to HIV. Laws and policies often fail to outlaw these activities in Africa and many women report being unwilling to oppose them for religious or cultural reasons or simply feeling forced to abide by them for fear of recrimination.\(^{296}\) Both female genital mutilation and child marriage will be discussed in further detail below.

#### 5.2.1 Female genital mutilation

The Maputo Protocol under article 5(b) explicitly requires countries to “prohibit[], through legislative measures backed by sanctions, all forms of female genital mutilation”.

Female genital mutilation (FGM) can place girls at risk of HIV as it exposes them to blood and possibly to unsterilised equipment. In addition, FGM is a consequence of and further entrenches gender inequality and takes away women’s sexual agency, increasing women’s vulnerability to HIV.

At both international and regional levels, there has been a strong push towards ending the practice of FGM. In 2011, the African Union recognised that “female genital mutilation (FGM) is a gross violation of the fundamental human rights of women and girls, with serious repercussions on the lives of millions of people worldwide, especially women and girls in Africa.”\(^{297}\) This commitment at the regional and international levels has resulted in a decrease


\(^{294}\) Cassie Werber. *Sierra Leone’s President is Delaying a Crucial Decision that Would Save Thousands of Women’s Lives* (1 February 2016).


\(^{296}\) GCHL (2012).

in the prevalence of FGM and more men and women working to end the practice in communities.\textsuperscript{298} In Africa, over 20 countries have enacted laws prohibiting FGM.\textsuperscript{299}

However, despite these gains, the practice of female genital mutilation (FGM) continues across several countries in Africa, with the World Health Organisation (WHO) estimating that 3 million girls on the continent are at risk of FGM annually.\textsuperscript{300} Further, almost 30 countries in Africa have communities which still practice FGM.\textsuperscript{301} According to the WHO, the practice of FGM in these African countries is due to a range of factors, including social pressure to conform to societal norms, views about what is considered acceptable sexual behaviour for women and girls, and belief that it is required under the individual’s religion.\textsuperscript{302}

Changing laws does not necessarily result in changes to customary and religious practices. The GCHL notes that “where custom and tradition prevail, women do not feel the effects of progressive laws and judgements at the national level in their daily lives”.\textsuperscript{303} It recommends that “the enforcers of religious and customary laws must prohibit practices that increase HIV risk, such as widow inheritance, “widow cleansing” and female genital mutilation”.\textsuperscript{304} Also, reformed laws need to be supplemented with comprehensive education and awareness programmes, as recognised by the Maputo Protocol.

\textit{Promising developments}

As noted above, more than 20 countries in Africa have enacted laws prohibiting FGM. For instance, in the Gambia, the President in November 2015 indicated his support for outlawing the practice.\textsuperscript{305} Legislation to that effect is expected to be enacted. In Kenya, the Prohibition of Female Genital Mutilation Act, No. 32 of 2011 criminalises FGM. In 2015, Nigeria also prohibited FGM with the passing of the Violence Against Persons (Prohibition) Act 2015, which under section 6 also outlaws various forms of violence against persons. With respect to women, it outlaws harmful traditional practices and forms of violence against women such as harmful widowhood practices and forceful ejection from a home.\textsuperscript{306}

\subsection{5.2.2 Child marriages and early pregnancies}

Children’s rights are protected in international and regional law under the Convention on the Rights of the Child and the Children’s Charter. These two conventions protect a range of children’s rights, including amongst others: the right to have the best interests of the child as the paramount consideration in matters affecting the child; the rights to equality and protection from discrimination; the right to life; the right to dignity; the rights to education, social protection and health; the right to be protected from abuse, neglect and exploitation and the right to be protected from harmful cultural practices.

\begin{thebibliography}{99}
\bibitem{World Health Organization} World Health Organization. \textit{Female Genital Mutilation} (February 2016).
\bibitem{United Nations Population Fund} United Nations Population Fund. \textit{Female Genital Mutilation (FGM) Frequently Asked Questions} (December 2015). These countries are Benin, Burkina Faso, Central African Republic (1996, 2006); Chad (2003); Cote d'Ivoire (1998); Djibouti (1994, 2009); Egypt (2008); Eritrea, Ethiopia, the Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Mauritania, Niger, Nigeria, Senegal, South Africa, Sudan (state of South Kordofan and state of Gedaref), Tanzania, Togo, Uganda, Zambia.
\bibitem{World Health Organization} World Health Organization (February 2016).
\bibitem{World Health Organization} World Health Organization (February 2016).
\bibitem{GCHL} GCHL (2012) 68.
\bibitem{As above} As above.
\bibitem{K Jirsa} K Jirsa. \textit{Female Genital Mutilation Coming to an End in Gambia?} (December 4, 2015).
\bibitem{Violence Against Persons (Prohibition) Act 2015} Violence Against Persons (Prohibition) Act 2015, ss 9 (ejection of spouse) and 15 (harmful widowhood practices).
\end{thebibliography}
Article 6 of the Maputo Protocol provides for State Parties to ensure gender equality in marriage, which includes enacting appropriate laws to guarantee that “the minimum age of marriage for women shall be 18 years”.

Child marriage – that is, marriage where on party to the marriage is below the age of 18 years – violates a number of children’s rights protected in international, regional and national laws, such as a child’s right to equality and non-discrimination, dignity, the right to be subjected to cruel, inhuman and degrading treatment, the right to health and the right to education. Research by the Population Council has shown the causes of early marriage to be poverty and low educational attainment. It affects the child’s social networks, decision-making power and their ability to negotiate with partners and family. Amongst the various impacts on a young person’s development more broadly, child marriage also has long-term, life-threatening sexual and reproductive health consequences for children, especially girls, leading to maternal morbidity and mortality amongst young pregnant girls and placing the health and life of the children born to these young girls at significant risk. Studies indicate a close association between child marriage and early pregnancy as girls are pressured to prove fertility. Further, girls may not have access to contraceptive and other family planning services and thus are unable to control the timing of their pregnancies.

Sub-Saharan Africa has the highest prevalence of child marriage in the world. In at least 5 countries in SADC, almost 40% of children are married before they are 18 years old. The UN Special Rapporteur on Violence Against Women, Its Causes and Consequences highlighted the harmful effects of child marriage, reporting that “the majority of sexually active girls aged 15-19 in developing countries are married, and these married adolescents tend to have higher rates of HIV infection than their peers.” A study in Kenya and Zambia found that married girls in Kenya had a 50% higher likelihood than unmarried girls of becoming infected with HIV. In Zambia, the study found that married girls had a 59% higher likelihood than unmarried girls of acquiring HIV.

Laws in African Union Member States generally provide for a minimum age of marriage. However, there are various anomalies with these laws. In a number of countries, such as Botswana, Kenya, Namibia and Zimbabwe, the laws relating to the age of consent to marriage do not necessarily apply to customary or religious marriages. A number of countries provide for marriages below the age of 18 years with judicial or parental consent. For example in Lesotho, a girl of 16 years and a boy of 18 years may marry with parental consent; in addition children younger than these ages can marry with the written consent of the relevant Minister. Finally, a number of countries provide for differing ages of consent to marriage for males and females. Currently, the African Commission in conjunction with the ACERWC are working on a joint general comment that will address early/child marriage as a human rights challenge in Africa.

Promising developments

308 As above
310 As above .
313 As above .
314 As above .
315 As above .
In Zimbabwe, the Constitutional Court recently delivered a landmark ruling in the case of Mudzuru and Another v The Minister of Justice outlawing child marriage and declaring provisions in civil and customary laws allowing child marriage, to be unconstitutional. The applicants had challenged a provision of the Marriage Act that set the age of consent to marriage for girls at 16 (18 for boys) and provided for marriages for girls below the age of 16 with the written permission of the Minister of Justice. The Court found that the provision violated the purpose and spirit of the new Constitution and held that the minimum age of marriage should be 18 years.

Legislative reform is taking place in a number of countries. For example, in Tanzania, a recent Bill aims to set the minimum age of marriage at 18 years. Malawi recently passed the Marriage, Divorce and Family Relations Act 2015 which raises the minimum age of marriage to 18. However, it permits constitutionally-provided exceptions to the minimum age of marriage.

SADC passed a Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage. The law aims to act as a yardstick and advocacy tool, in order to support policy makers and legislative drafters to review and reform laws permitting child marriage. In addition, the African Commission in conjunction with the African Committee of Experts on the Rights and Welfare of the Child is preparing a joint General Comment on child marriage.

5.3 Equality and Non-Discrimination

The African Charter protects the rights to equality, non-discrimination and dignity of all persons.

The persistent stigma and discrimination against PLHIV, vulnerable and key populations at higher risk of HIV exposure are not only a violation of equality and dignity rights; they have been also identified as a major impediment to universal access to health care in Africa. Research has shown that stigma and discrimination make people afraid to seek HIV information and services to reduce their risk of infection and discourage people living with HIV from disclosing their status even to family members and sexual partners and undermines their ability and willingness to access and adhere to treatment.

The Global Commission on HIV and the Law’s (GCHL) Africa Regional Dialogue on HIV and the Law (GCHL’s Africa Regional Dialogue) found that “both stigma and discrimination are key characteristics of the epidemic in Africa” impacting on people in their families, communities, workplaces, health facilities and schools. The findings of People Living with HIV Stigma Index studies in countries across Africa bear striking consistencies across countries. A 2013

317 Legal Parliamentary Affairs, CCZ 12-15
320 Marriage, Divorce and Family Relations Act, 2015, s 14; Constitution of the Republic of Malawi (1994), s 22(7).
323 GCCHL (2011).
325 GCCHL (2011).
327 Studies are planned, underway or have been finalised in the following countries: Cameroon, Central African Republic, DRC, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mauritius, Mali,
review of studies conducted in East and Southern Africa found that common forms of discrimination against people living with HIV included marginalisation from families and communities; verbal harassment and even physical assault; violations within the workplace and coercive sexual and reproductive health care services, amongst others.\(^{328}\)

### Findings from the People Living with HIV Stigma Index Studies

There is a clear trend in all countries around community-based experiences of stigma and discrimination. Overwhelmingly, respondents experienced gossip as the major form of stigmatisation, with 75.5% of respondents in Zambia, 69% from Ethiopia and over half of those from Tanzania (Zanzibar) reporting that they believed that they had been gossiped about. In addition, respondents from all countries, when asked about their fears in relation to their HIV status, overwhelmingly expressed concern that they would be gossiped about: 65.4% of men and 68.4% of women in Ethiopia, 34.7% of men and 31% of women in Malawi, 61.4% of respondents in Kenya, 46.6% of men and 49.8% of women in Rwanda, 47.7% of respondents in Tanzania (Zanzibar), 35.3% of respondents in Swaziland, and 73% of men and 89.1% of women in Zambia. Exclusion from social gatherings and verbal insults, threats or harassment were also noted as significant experiences across countries.

HIV-related discrimination in the workplace is a key concern and respondents from Ethiopia, Malawi, Rwanda, Tanzania (Zanzibar) and Zambia revealed relatively high levels of perceived stigma in the workplace: 42.1% of respondents in Ethiopia reported having lost a job or another source of income with over 70% reporting that this was due *inter alia*, to their HIV status; in Rwanda 37.2% reported being refused an employment opportunity in the past 12 months because of their HIV status; and in Tanzania (Zanzibar), 26.8% of respondents reported that they had lost of job or a source of income.

While discrimination in health care settings was reportedly low, there were concerning reports of coercive practices in access to sexual and reproductive health care for people living with HIV, particularly pregnant women with HIV. In Ethiopia 36.5% of men and 43.9% of women were advised by a health care worker not to have children after an HIV diagnosis; and 12.2% of men and 14.4% of women reported that access to ART was conditional on use of contraception. In Malawi, 46.6% of those who responded to questions about sexual and reproductive health rights reported being advised not to have children since being diagnosed HIV positive, 11.5% reported being coerced into being sterilised and 14.5% and 16.3% reported being coerced into choice of methods of child birth and infant feeding options. In Rwanda, 65% of men and 81% of women who responded to further questions report being advised not to have children and 17% of men and 12% of women report that ART was conditional on use of contraception.

*Taken from UNAIDS. Stigma Index Review: East and Southern Africa (2013)*

Studies indicate that women with HIV may be more likely to experience discrimination than men living with HIV.\(^{329}\) They report stigmatisation, exclusion and harassment within their families and communities, churches and places of worship, workplaces, schools and health care facilities. They also experience physical and sexual abuse, being thrown out of their homes and communities, barred from seeing their children and being dispossessed of property,\(^{330}\) increasing their vulnerability. A 2011 study conducted using the People Living with HIV Stigma

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Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. See [www.stigmaindex.org](http://www.stigmaindex.org).

\(^{328}\) UNAIDS. *Stigma Index Review: East and Southern Africa* (updated draft, 2014).


Index in Algeria, Egypt, Lebanon, Libya, Morocco, Saudi Arabia, Sudan, Tunisia and Yemen showed the inhumane treatment of women living with HIV. This includes being forced to have sex (or to have sex without condoms) and being beaten daily by their husbands.

Although few countries in Africa impose HIV-related travel restrictions, there are countries that restrict stay and residence for migrant populations living with HIV as well as those that restrict access to health care in law or policy, for migrants and refugees. For instance, in the Seychelles, foreigners wishing to apply for a gainful occupation permit, residence permit and/or dependent’s permit require a medical fitness certificate which includes provision for HIV testing. Applicants testing HIV positive may be refused entry or asked to leave the country, reportedly on the basis of the health care costs of treating immigrants with HIV.

Stigma and discrimination against people with TB takes place in the workplace, health care facilities and within communities. Reports of discrimination in national TB policies and practices include immigration practices such as denying entry to those with previous or latent TB infection and deporting undocumented migrants with TB; mandatory treatment or confinement for drug-resistant TB and health workers denying equal access to TB clinics to PLHIV, sex workers, transgender people and other marginalised populations. In the workplace, employees may be retrenched due to repeated sick leave, unfairly dismissed, denied access to training and promotion and avoided for fear of contamination. Conditions in prison, including overcrowding, poor ventilation, poor nutrition and lengthy periods of detention, including pre-trial detention, place prisoners at high risk of TB infection.

The PLHIV Stigma Index studies furthermore highlight challenges with access to justice. They show that people who experience HIV-related discrimination often do not know their rights and where or how to seek legal redress for human rights violations. Affected populations told how stigma and discrimination blocked access to health services and access to justice for rights violations. Protective HIV laws are often narrow, failing to address the layers of discrimination people face based on HIV status and also age, gender, sexual orientation, disability or migrancy.

Promising Developments

There are some promising and positive examples in Africa of various measures to strengthen the rights of people living with HIV. These responses include anti-discrimination laws protecting the rights of PLHIV, programmes to understand, monitor and respond to stigma and discrimination; programmes to strengthen legal support services for PLHIV as well as litigation to challenge HIV- and TB-related discrimination.

Around 35 AU Member States report having laws to protect PLHIV HIV from discrimination, many of which are HIV-specific laws. Namibia has repealed its travel restrictions on PLHIV.

337 As above.
338 As above.
National strategic plans on HIV (NSPs) commit to rights-based response to HIV and 90% of countries report that their NSPs include stigma and discrimination reduction programmes and many include training for health workers.\footnote{341 Id.; UNAIDS. Desk Review of the National Strategic Plans of Countries in Eastern and Southern Africa (2011).}

A number of countries across Africa have conducted People Living with HIV Stigma Index studies.\footnote{342 For more information, see www.stigmaindex.org (last accessed 15 June 2016).} This has led to an increased understanding of HIV-related stigma and discrimination amongst governments as well as civil society organisations and networks of PLHIV, empowering PLHIV and supporting targeted, evidence-informed responses. In 2015, South Africa, a targeted stigma and discrimination reduction programme was developed in the Eastern Cape specifically to respond to the findings of the Stigma Index study in that region, and a Legal Advice Line was set up in a partnership between the National AIDS Council and Legal Aid South Africa to promote access to justice for people living with HIV and TB.\footnote{343 As above.}

Judicial recognition of the rights of PLHIV HIV continues to be confirmed in case law across the continent, with the judiciary in various countries ruling in favour of the rights of these people to equality and non-discrimination largely in the working environment,\footnote{344 See e.g. Banda v Lekha [2005] MWIRC 44 where the court held that the applicant’s unlawful dismissal on the basis of her HIV status violated her constitutional rights to equality and fair labour practices.} but also in the health care setting.\footnote{345 See e.g. Ahamefule v Imperial Medical Centre 2012 Suit No. ID/16272000 which found the denial of medical care to the plaintiff on the basis of her HIV status was a violation of the right to health guaranteed under article 16 of the ACHPR and national laws.}

In addition, there are also cases upholding the rights of patients with TB to equality, non-discrimination and protection. In the South African case of Dudley Lee v Minister of Correctional Services, the Constitutional Court of South Africa noted the state’s duty to provide prisoners with “conditions of detention that are consistent with human dignity” and held the state liable for damages resulting from the Applicant’s TB infection and illness, in “failing to maintain an adequate system for management of TB” in the prison.\footnote{346 [2012] ZACC 30.} In Ng’etich and Others v Attorney General and Others, the High Court in Kenya upheld the rights of TB patients to be protected from unreasonable imprisonment.\footnote{347 Petition No 329 of 2014 (24 March 2016).} The High Court found that the imprisonment of patients with TB, for defaulting on their treatment, was unconstitutional and contrary to the Public Health Act. In Zambia, Prison Care and Counselling Association, with funding from the Open Society Institute of Southern Africa has developed a programme in conjunction with three law firms to identify and take up cases involving petty offences and speeding up their progress through the courts, advocating non-custodial sentences with the aim of reducing overcrowding in prisons and promoting the health of prisoners.

### 5.4 HIV testing

Article 6 of the African Charter guarantees the right to liberty and to the security of person and the Maputo Protocol provides that every women is entitled to the integrity and security of her person. In addition, both the African Charter and the Maputo Protocol guarantee the rights to dignity, protection and cruel, inhuman and degrading treatment and to health. These rights are argued to protect the rights of all people from acts that violate the integrity of the person, such as mandatory HIV testing, and to ensure for all people the right to HIV testing only with voluntary and informed consent.\footnote{348 Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health A/64/272 (10 August 2009) para 19.}
Yet people affected by HIV still report instances of being tested for HIV without having provided voluntary and informed consent.\textsuperscript{349} In some countries in Africa, laws and policies result in coercive and even mandatory HIV testing.\textsuperscript{350} A recent study of all 26 HIV-specific laws in African countries found that, while all countries include provisions protecting the right to HIV testing with informed consent and confidentiality, most laws allow for exceptions or limitations which create the potential for human rights violations. These include provision for a health care provider to perform an HIV test without informed consent for purposes of treatment or care and provision for HIV testing in the context of personal relationships. For example, in Uganda informed consent for an HIV test can be dispensed with if a patient “unreasonably withholds” it. In Burkina Faso, HIV testing is used to settle matrimonial disputes.\textsuperscript{351} Additionally, over a third of these laws include provision for compulsory HIV testing in the event of an alleged sexual offence and another 10 countries provide for HIV testing if ordered by a court of law for judicial proceedings.\textsuperscript{351} These provisions arguably violate the rights to liberty and security of the person as well as the right to a fair trial; they provide little guidance as to the purpose, process and timeline for HIV testing; are often applied to those alleged, but not yet convicted of a sexual offence and are silent on the nature of the sexual offence to be applied to, opening the gateway for mandatory HIV testing for offences that carry little or no risk of HIV transmission.\textsuperscript{352}

The age of consent for HIV testing is a further issue. Setting an independent age for adolescents to access HIV testing without parental consent, can protect them from HIV and other sexually transmitted illnesses. However, in a number of countries in Africa, the age of consent to HIV testing is as high as 18 years old. For example, in the Democratic Republic of Congo (DRC) and Nigeria the age of consent for HIV testing is 18.\textsuperscript{353} Yet, in the DRC, as of 2011, women can consent to sex at 14 and in Nigeria, two studies found sexual debut to be significantly lower than 18.\textsuperscript{354} Age of consent issues are discussed further, below, in relation to human rights issues affecting children and young people.

Even where laws and policies provide for voluntary HIV testing with informed consent, in practice affected populations report unlawful testing. For instance, a South African study on pregnant women’s experience of provider-initiated testing during pregnancy, revealed that some women felt forced to test under threat of being denied services if they did not.\textsuperscript{355} This experience may be exacerbated with the recent impetus to significantly expand HIV testing services, including the implementation of provider-initiated testing and counselling (PITC) and home-based testing. A few countries in Africa, including Egypt, still require proof of HIV status for immigration purposes.\textsuperscript{356} Mandatory pre-marital testing occurs unabated in Nigeria, Burundi, DRC, Ghana, Kenya, Tanzania, and Uganda. In other instances, churches require engaged couples to present negative HIV test results prior to proceeding with marriage.\textsuperscript{357}

\textsuperscript{350}As above.
\textsuperscript{351}Eba (2015).
\textsuperscript{352}As above.
Breaches of the right to confidentiality are a further concern for those testing for HIV, with many HIV laws, policies and practices providing for disclosure of a person’s HIV status to health care workers, sexual partners and/or caregivers. In the aforementioned study of African HIV laws, nearly 21 of the 26 HIV laws were found to have provisions allowing for involuntary notification of a person’s HIV status to his or her partner.\textsuperscript{358} In 17 of these countries, this partner notification can be done at the discretion of a health care worker. Involuntary partner notification has the potential to infringe the rights of a PLHIV, if not carefully circumscribed in law and policy.\textsuperscript{359} The GCHL noted the potential impact uncircumscribed partner notification may have on women, who are generally more likely to be tested for HIV than men when accessing antenatal health care,\textsuperscript{360} yet only 4 countries provide for non-disclosure where there is fear of violence.

Evidence shows that violations of the rights to HIV testing only with informed consent and the right to confidentiality tend to discourage affected populations from accessing health care services.\textsuperscript{361}

**Promising developments**

The courts in Africa have been vigilant in striking down laws, policies or practices which permit mandatory or compulsory testing. In addition to the cases in Zambia, South Africa and Namibia, all which resulted in positive decisions, recently Malawi also found that subjecting sex workers to mandatory HIV testing violated their constitutional rights.\textsuperscript{362} In *S v Mwanza Police, Mwanza District Hospital, Ministries of Justice, Internal Affairs, Health, Attorney-General and Ex parte: HB, JM (o.b.o 9 others)*, the local police arrested a number of women during a sweep and forced them to undergo an HIV test while in custody. The women who were HIV positive were charged with spreading venereal disease prohibited under section 192 of the Penal Code. Eleven women challenged their subjection to a mandatory HIV test in the High Court. The High Court held that mandatory HIV testing violated the women’s constitutional rights to privacy, equality, dignity and freedom from cruel, inhuman and degrading treatment.\textsuperscript{363}

Legislatively, the SADC Model Law and EAC HIV and AIDS Prevention and Management Act, provide for disclosure of HIV status to a sexual partner at risk under defined circumstances, in accordance with international guidance.

### 5.5 Criminalisation of HIV transmission

The criminalisation of HIV transmission violates a number of fundamental rights guaranteed under the African Charter. In 2011, the GCHL Africa Regional Dialogue found a range of broad and ineffective laws specifically criminalising HIV transmission in Africa. Currently, over 25 countries in Africa have existing or draft laws criminalising HIV transmission. Many countries in West and Central Africa have broad criminalisation provisions based on a model law developed in Chad in 2004 referred to as the N’djamena Model Law.\textsuperscript{364}

These criminal law measures range from, but are not limited to, murder, manslaughter (culpable homicide), and assault to attempted murder.\textsuperscript{365} Often these laws include vague and ambiguous

\textsuperscript{358} Eba (2015).
\textsuperscript{359} As above.
\textsuperscript{360} GCHL. (2012).
\textsuperscript{361} As above.
\textsuperscript{362} See Kingaipe and Another v Attorney General 2009/HL/86 (27 May 2010); Nanditume v Minister of Defence NLLP 2002 (2) 242 NLC; C v Minister of Correctional Services [1997] JOL 407 (T).
\textsuperscript{363} Anneke Meerkotter and Ian Southey-Swartz, “Malawi High Court Rules That Mandatory HIV Testing is Unconstitutional” SALCBlog (20 May 2015).
\textsuperscript{365} Eba (2015).
provisions criminalising a range of acts that may expose a person to HIV, as well as intentional, reckless and negligent actions. For example, in Zimbabwe the law prohibits anyone who realises there is a possibility that he or she might be HIV positive from engaging in any activity that may possibly infect another person. This means that arguably anyone in Zimbabwe who has ever engaged in unprotected sexual activity more than once, regardless of whether they know their HIV status, is at risk of contravening the prohibition against deliberate transmission of HIV regardless of whether HIV was even transmitted. In Benin, the law does not require transmission of HIV to have taken place, as exposure to HIV is sufficient for prosecution. In Togo, the law prohibits people with HIV to engage in unprotected sex regardless of their partner’s HIV status and/or whether or not consent has been given. The law in Guinea criminalises exposing others to substances that could cause transmission of HIV, regardless of the consequences, and disregards circumstances, such as whether or not the defendant took precautions, knew their status and risk of transmission, disclosed their status, and whether or not the defendant had control over the sexual relationship.

In some countries, the laws criminalising HIV transmission potentially include mother-to-child transmission of HIV. For instance, Sierra Leone explicitly mentions pregnant mothers as a group required “to take all reasonable measures and precautions to prevent transmission”, which arguably violates the right to medical treatment with voluntary informed consent. Also what constitutes “reasonable measures and precautions” is not defined, so it is not clear whether or not an act such as breastfeeding, could be prosecuted under this clause.

UNAIDS has repeatedly warned against the serious human rights violations and public health concerns raised by criminalisation. UNAIDS guidance calls for the repeal of overly broad laws criminalising HIV transmission, recommending that criminal law only be applied to cases of intentional transmission – where a person knows his or her HIV-positive status, acts with the intention to transmit HIV and in fact transmits it – and that the judiciary are supported with guidance and up-to-date medical evidence to adjudicate such cases appropriately. The GCHL, in their review of the impact of criminalisation provisions, including in Africa, noted that “[s]uch laws do not increase safer sex practices. Instead, they discourage people from getting tested or treated, in fear or being prosecuted for passing HIV to lovers or children.”

Promising developments
In the DRC, the High Court addressed the case of Kalamu, a woman who was accused of deliberately transmitting HIV to a man. The High Court found that the woman did not violate article 45 of the HIV law which criminalises HIV transmission, as she had disclosed her HIV status to her partner and he chose not to use a condom after a few months.

In Kenya, the High Court in *Aids Law Project v Attorney General and Others* found that section 24 of the HIV and AIDS Prevention and Control Act which criminalised HIV exposure was vague and overbroad and thus violated the rights guaranteed under the Constitution, including the right to privacy.

The SADC Model Law deliberately excluded any provisions criminalising HIV transmission. In addition, recently, Mozambique has amended its HIV legislation, removing the criminalisation of HIV transmission. A number of other countries, including the DRC, Guinea, Senegal and Togo are reviewing their overly broad criminalisation provisions within HIV laws.

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366 See Criminal Law (Codification and Reform) Act, Ch 9:23, s 78.
368 GCHL (2012) at 8.
369 Case R.P 12.892 High Court (5 January 2015).
5.6 Key populations at higher risk of HIV exposure

The HIV epidemic continues to have a disproportionate impact on key populations at higher risk of HIV exposure. While each country should define its specific populations that are key to the epidemic and the response based on their epidemiological and social context, UNAIDS considers four main populations to be key populations - gay men and other men who have sex with men, sex workers and their clients, transgender people and people who inject drugs.

This subsection considers 6 populations key to the HIV epidemic and response in Africa: gay men and men who have sex with men, sex workers, people who inject drugs, transgender people, prisoners and people with disabilities. Women and girls, migrants and refugees are dealt with in other sections of the report.

Key populations, like all populations, are entitled to full protection of their rights, including their rights to equality, non-discrimination, dignity, freedom from cruel, inhuman and degrading treatment or punishment and the right to the highest attainable standard of health care. However, these populations often suffer from punitive laws or stigmatising policies, and they are amongst the most likely to be exposed to HIV. Stigma, discrimination and violence, coupled with punitive laws, create barriers to access to services for key populations.

Across Africa, key populations have received limited protective, rights-based responses at continental, regional and national level. National HIV laws tend to focus narrowly on the rights of PLHIV and national HIV responses fail to include the participation of and prioritise the needs of key populations in HIV-related law and human rights programmes. These laws, policies and practices not only violate rights to equality, dignity and protection from cruel, inhuman and degrading treatment or punishment, but also impact upon health rights. Fast-tracking the response to HIV requires creating an enabling, protective legal and regulatory environment in which key populations can ensure their rights are protected and can access targeted services.

5.6.1 Gay men and men who have sex with men

Globally, gay men and other MSM are 19 times more likely to be living with HIV than the general population. In 2012, the highest global median HIV prevalence rates amongst MSM were reported in Western and Central Africa (19%) and East and Southern Africa (15%). Notably, over 30 AU Member States criminalise same-sex relationships in some way, often with penalties of up to 14 years imprisonment, life imprisonment and even the death penalty for those convicted. These punitive legal environments, combined with stigma, discrimination and high levels of physical, psychological and sexual violence, often committed or condoned by law enforcement officials and national authorities against MSM as well as a lack of appropriate sexual health services, places gay men and MSM at high risk of HIV exposure.

Amnesty International reports that violations against gay men and MSM are increasingly visible on the continent and include rape, murder, harassment and violence, extortion and threats.

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379 As above.
380 UNAIDS (2014).
against individuals and the organisations that support them. Various acts of violence documented in 2013 range from arbitrary arrest, detention and torture through to rape and murder.

Paul Kasonkomona, a prominent human rights activist in Zambia, was arrested in 2013 when he appeared on TV calling for the decriminalisation of homosexual relationships as part of a national strategy to address HIV. He was charged with “soliciting for immoral purposes”. Following a lengthy trial, he was acquitted on these charges in February 2014. The government has appealed against the judgment and the case continues.

In 2013 the Director of Civil and National Registration, Ministry of Labour and Home Affairs refused to register the Botswana organisation Lesbians, Gays and Bisexuals of Botswana (LEGABIBO). Fortunately, the failure to register LEGABIBO was successfully challenged in court. In March 2014, the High Court of Botswana heard arguments in a case filed by 14 activists. Judgment was handed down in November 2014 finding that the failure to register LEGABIBO was unlawful and unconstitutional, violating the applicant’s right to freedom of expression, freedom of association and freedom of assembly.

Duduzile Thoko, a lesbian living in Thokoza, South Africa was raped and murdered in June 2013. Media reports indicate that her family and friends believe that she was attacked because she was living openly as a lesbian. Black lesbians, gender non-conforming women and transgender men are at high risk of violence and approximately 30 lesbians have been murdered in the past 15 years in South Africa. Few perpetrators have been brought to justice.

In Zimbabwe, the raids on the offices of Gays and Lesbians of Zimbabwe (GALZ), arrests, detention and assault while in detention of members as well as the charges against their chairperson are further examples of unlawful harassment of LGBT organisations in the region. In February, the Zimbabwean High Court held that GALZ was not a private voluntary organisation and therefore did not in fact require to be registered under the Private Voluntary Organisation Act. Prior to that the High Court had ordered the police to return all property seized during the police raid.


In recent years, a number of countries have introduced harsher laws and law enforcement to target sexual relationships between gay men and MSM and even to extend criminalisation to individuals and organisations perceived to support same-sex relationships.

“In Nigeria and Uganda, the adoption of new restrictive legislation is thought to have resulted in increased harassment and prosecution based on sexual orientation and gender identities. HIV outreach workers and services providers working with gay men and other MSM in these two countries have also reported heightened challenges in reaching this population. Some outreach organisations and health service providers have stopped or reduced the scope of their activities owing to the fear of harassment and prosecution...The passage of the Anti-Homosexuality Act in Uganda also triggered negative discussions in social media. The most worrisome signs included messages that advocated violence and that were highly discriminatory.”

UNAIDS Gap Report 2014

As a result, research shows that gay men and other MSM often have extremely limited access to HIV prevention services. It also appears that mainstream HIV programmes are not able to reach this population effectively and there is limited national spending on targeted services to meet their specific needs. \(^{383}\)

**Promising developments**

Current promising practices tend towards efforts to provide specialised prevention and treatment programmes for gay men and MSM, despite laws criminalising same-sex relationships within countries. Promising results have been seen with services that find ways to reach and target less visible populations (e.g. through digital mapping of populations and the provision of home-based testing and counselling services). \(^{384}\) Currently, there is inadequate data in many African countries to support such service provision and this information is critical to effective programming responses.

In other countries, efforts to work with the media, health care providers and law enforcement officials, to minimise stigmatisation, harassment and abuse of gay men, MSM and transgender people support increased access to services. In Malawi, a media engagement strategy developed by civil society organisations (CSOs) in partnership with the media has resulted in a Media Task Force on sexual minority rights and an Editor’s Forum on human rights to promote regular, sensitised columns on sexual minorities. \(^{385}\) However, long term efforts should still be directed towards decriminalisation of sex between men and support for organisations working with these populations, given the impact criminal laws have on access to services.

### 5.6.2 Transgender People

UNAIDS reports that transgender women are one of the populations most affected by HIV, being almost 50 times more likely to acquire HIV than other adults of reproductive age. \(^{386}\) In Africa, there is limited information on the impact of HIV on transgender women and men and for the most part, they are an “invisible” population in responses to the HIV epidemic.

Transgender people \(^{387}\) face a multitude of barriers to the full recognition of their rights through the operation of the law, policies as well as the actions of their families, communities, broader society, health care workers and other service providers and law enforcement officials. Transgender persons report being marginalised, abused and often rejected by their families and society from an early age, due to their expression of their gender identity. This is exacerbated by the failure of the law to recognise the rights of transgender persons to have their self-identified gender in personal documentation and non-official records. Their marginalisation and exclusion at these multiple levels impacts on their access to education, employment and access to basic services, including health care, ultimately also impacting on risk of HIV exposure as seen in studies in Kenya and South Africa. \(^{388}\) Research shows that the lifelong impact of this may often result in poverty, exclusion from society, homelessness and, in a significant proportion of people, selling sex in order to make a living. \(^{389}\)

Stigma and discrimination, often further fuelled by laws criminalising consensual same-sex acts in Africa, appears to lead to extreme violence against transgender people, with reports of high

\(^{383}\) As above .

\(^{384}\) As above .


\(^{387}\) Transgender is an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. UNAIDS. *UNAIDS Terminology Guidelines* (2015).


\(^{389}\) As above .
levels of physical violence (including murder, beatings, kidnappings), sexual violence (including rape and sexual assault), psychological abuse as well as hate crimes. A 2013 report notes that “[v]iolence directed against lesbian and transgender women is particularly vicious and brutal due to the multiple and intersecting layers of discrimination facing women in highly patriarchal African families and societies.” A CSO submission to the GCHL Africa Regional Dialogue noted that in Namibia, much of the violence towards sexual minorities is directed at transgender persons. In Cameroon in 2011, two transgender youths who identify as women were arrested, harassed and tortured in prison, tried and convicted of homosexuality, primarily based on evidence relating to the fact that they were wearing women’s clothing. The Trans Murder Monitoring Project reports 4 murders of transgender persons in South Africa.

**Promising developments**

There is significant work to be done to ensure protection of the rights to equality, dignity, freedom from cruel, inhuman and degrading treatment and health, amongst others, of transgender populations. A few countries are beginning to recognise the need to include transgender populations in their national HIV responses; however, for the most part they remain an ignored population: countries have a limited understanding of the HIV incidence and prevalence amongst transgender persons and of the key HIV-related human rights issues that act as barriers for transgender persons to access to health care services.

### 5.6.3 Sex Workers

Globally, HIV prevalence amongst sex workers is estimated to be 12 times higher than amongst the general population. In Nigeria and Ghana, HIV prevalence amongst sex workers is 8 times higher than amongst the rest of the population and a recent analysis in sub-Saharan Africa found pooled HIV prevalence of 36.9% among female sex workers.

Sex workers face exceptionally high levels of stigma, discrimination, violence, extortion, sexual abuse and rape in Africa from clients, intimate partners and law enforcement officials, placing them at increased risk of HIV. In Ethiopia and Kenya, a survey found that nearly 60% and 79% of female sex workers respectively reported violence relating to sex work. Sex workers also report stigmatising attitudes and high levels of discrimination in access to health care services, impacting on their willingness to access health care. Sex workers from Kenya, South Africa, Uganda and Zimbabwe reported how high levels of stigma dissuaded them from disclosing their occupation to health workers, hereby limiting their access to effective services, and impacted on their willingness to test for HIV.

Sex work, or aspects of sex work, is criminalised in approximately 35 AU Member States. The criminalisation of sex work is inextricably linked to the marginalisation of sex workers. The isolation of sex workers caused by stigma, discrimination and violence, in conjunction with a criminalised environment which tends to fail to punish and even condones these human rights violations and other related practices, exacerbates the barriers sex workers face in accessing legal support services and health care services. Submissions to the GCHL Africa Regional Dialogue from countries across Africa, including Botswana, DRC, Kenya, Mozambique, Namibia, South Africa and Zimbabwe, reported how other law enforcement practices such as

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390 AMSHeR and CAL (2013).
391 As above.
392 GCHL (2011).
393 AMSHeR and CAL (2013).
394 As above.
395 As above.
396 GCHL (2012); UNAIDS (2015).
398 UNAIDS. Making the Law Work for the HIV Response: A Snapshot of Selected Laws that Block or Support Access to HIV Prevention, Treatment, Care and Support (2010).
arbitrary detention and arrests based on condom possession deterred sex workers from accessing condoms and placed them at risk of HIV infection. The GCHL Africa Regional Dialogue found that criminalisation placed people at increased risk of violence and harassment from law enforcers and the public, driving key populations underground and deterring access to health care services. Conversely, a modelling study in Kenya found a reduction of around 25% in HIV infections when physical and sexual violence against sex workers is reduced.

**Promising practices**

Studies show the effectiveness of community-based programmes to provide health and legal support services to sex workers. Currently, many of the promising practices are carried out by CSOs. However, these programmes require an enabling environment, where sex workers are able to participate in, organise and lead responses without fear of violence, detention and discrimination – an environment in which authorities condemn violations against sex workers.

In Kenya, the training of local sex workers as paralegals helped to educate sex workers about their rights. In Uganda, legal support services for sex workers, including a hotline, legal services, documenting violations and training sex workers on their rights is working towards reducing violations against sex workers. Programmes to train Mozambican police and health care workers on the rights of sex workers and community mobilisation programmes with sex workers, using peer educators, have helped increase access to health care services.

There are furthermore countries that have recognised the importance of providing programmatic responses alongside ongoing work towards a longer-term goal of decriminalising sex work. In South Africa, the NSP includes the decriminalisation of sex work as an ongoing, long-term goal. Importantly, at a regional level, SADC’s HIV Cross-Border Initiative co-ordinates HIV prevention, treatment, care and support services for long-distance truck drivers, sex workers and border communities along major transport corridors in Southern Africa. The initiative recognises the impact of the legal and regulatory framework on access to services for its target populations. It includes a commitment to advocate for the review of laws and regulatory frameworks that criminalise sex work and the development of policy frameworks to increase access to services.

**5.6.4 People who inject drugs**

People who inject drugs are at extremely high risk of HIV exposure and HIV prevalence amongst people who inject drugs is estimated at around 28 times greater than amongst the general population. Recent studies show increasing injecting drug use in several countries, such as Kenya, Madagascar, Mozambique, the Seychelles, South Africa and Tanzania. A study in Zanzibar showed that HIV prevalence was 30% higher amongst people who inject drugs than amongst the general population. In Kenya, studies showed HIV prevalence of 18% among all people who inject drugs in Nairobi and Mombasa and other studies found prevalence of 7% and 5.8%, respectively, among people who inject drugs in Madagascar and the Seychelles in 2011. Research in Mauritius also indicates high rates of sex work amongst people who inject drugs.

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399 GCHL (2011).
404 UNAIDS (2015).
drugs and high rates of injecting drug use amongst sex worker respondents. Similarly a 2010 study in the Seychelles amongst sex workers found that all those interviewed in a Drug and Alcohol Council Survey were also injecting drug users.

The GCHL Africa Regional Dialogue found that criminalisation of drug use, fear of arrest, harassment and the imprisonment of people who use drugs, accompanied by widespread societal stigma, discourages access to health care services for people who use drugs and creates legal barriers to the provision of needle and syringe programmes and opioid substitution therapy. In Africa, individual drug possession and use is criminalised and highly stigmatised throughout the continent, with people who use drugs often facing discrimination at many levels. For example, the Mauritius People Living with HIV Stigma Index of 2013 shows the various layers of discrimination faced by people who use drugs as a result of their perceived or actual belonging to other key populations groups such as sex workers or people living with HIV. A survey in Seychelles found high levels of stigma and discrimination against people who inject drugs, with 68% of those surveyed reporting being refused a service in the preceding 12 months and just over 50% reporting having been arrested in the preceding 12 months. A survey in Mauritius found that almost all people who inject drugs said that they had been arrested in the previous 12 months and almost three quarters said that they had been refused services at some point; likewise 81% of people who inject drugs in Kenya have reportedly been incarcerated. Sixty-eight percent of countries in Southern and East Africa reportedly have laws that place barriers on providing harm reduction services such as clean needle exchange programmes. Participants in focus group discussions conducted during the 2013 legal environment assessment in the Seychelles complained of brutality and extortion at the hands of law enforcement officials and difficulties in accessing harm reduction services such as needle exchange programmes.

In addition to the barriers created by criminalisation and widespread societal discrimination, many countries in Africa fail to recognise people who inject drugs as a key population, have limited data on key populations within their countries and cities and fail to provide harm reduction programmes targeting their needs.

**Promising developments**

Mauritius is a positive example of a rights-based legal and programmatic response to managing HIV and injecting drug use. The HIV and AIDS Act No 31 of 2006 provides for people who use drugs to access a range of HIV prevention services, such as accessing clean needles without penalty, even though drug use is criminalised. This has facilitated a comprehensive programmatic response reaching large numbers of people who use drugs with methadone substitution therapy (including in prisons), needle exchange programmes, a harm reduction community service and a mobile caravan service for people who inject drugs and other key populations. An AIDS Project Management Group evaluation report showed an increase in the quality of life and a decrease in drug seeking behaviour amongst those accessing services.

HIV incidence amongst people who inject drugs has also been dramatically reduced since

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408 UNAIDS (2015).
410 GCHL (2011).
411 As above.
413 UNAIDS (2013).
414 GCHL (2011).
While countries with concentrated epidemics such as Seychelles and Mauritius have included programmatic responses for people who inject drugs within their NSPs for some time, rising HIV prevalence amongst people who inject drugs even in countries with generalised HIV epidemics, such as Kenya, Nigeria, South Africa and Tanzania, have required these countries to develop targeted responses.

5.6.5 Prisoners

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

Prison populations are estimated to be between 2 to 10 times at higher risk of HIV and TB infection than the general population. Whilst there is insufficient data on HIV and TB prevalence in prisons in African countries, the limited research shows a similar pattern. In South Africa, HIV prevalence amongst prisoners is 2.5 times higher than the general population. Studies in Zambia also show an HIV prevalence of nearly double that of the general adult population and TB incidence rates around 10 times higher than that outside prisons.

Many factors are considered to contribute to the high risk of HIV and TB exposure in prisons. A study carried out in Zambian prisons in 2010 is reflective of many of these problems across the continent. The study found conditions that violated the rights of prisoners to dignity, to be free from cruel, inhuman and degrading treatment or punishment and placed them at increased health risks: severe overcrowding (with prisons at 500 to 600% capacity); minimum ventilation; inadequate sanitation; poor nutrition; limited health care staff and services to prevent and treat HIV and TB and high levels of violence at the hands of warders and other prisoners. Various unsafe practices, such as unsafe sex and rape, drug use and needle sharing and tattooing with homemade and unsterile equipment place prisoners at risk of HIV.

Laws criminalising sex between men and drug use are furthermore held up by Member States as barriers to the provision of adequate HIV prevention services to prevent HIV transmission through sex between men and drug use. A 2009 study found that where same-sex conduct was criminalised, only one government distributed condoms to prisoners to prevent HIV transmission. Criminalisation of drug use creates similar barriers with countries failing to provide harm reduction services in prisons. In this way, criminal laws further exacerbate the risk of HIV exposure in prisons.

Promising developments

There is evidence of progressive prisons laws, policies, legal support services and jurisprudence to manage HIV and TB within prisons in Africa. For instance, the Department of Correctional Services in South Africa has an integrated HIV and TB policy providing for prevention and treatment of HIV and TB. In addition, it includes provision of condoms for

418 Prévention Information Lutte Contre le Sida “Evidence Base to Promote Drug Policy Reform in Mauritius” Presentation to ARASA Annual Partnership Forum (April 2015).
419 UNAIDS (2015).
420 As above.
422 As above.
423 GCHL (2012).
424 As above; GCHL (2011).
426 GCHL (2012).
prisoners.\textsuperscript{427} Similarly, in Lesotho the Ministry of Correctional Services provides access to condoms for prisoners despite the existence of laws criminalising sex between men.\textsuperscript{428} In Botswana, up until recently only prisoners who are resident in Botswana were provided with ART, treatment for opportunistic infections (including TB), CD4 count tests and viral load tests in terms of prison policy. However, in 2015, the Court of Appeal held that the policy was unlawful and ordered the Botswana government to immediately provide foreign prisoners access to the same HIV services as citizen prisoners.\textsuperscript{429} Similarly, in Nigeria, the High Court held that the denial of medical treatment to HIV-positive prisoners awaiting trial violated the prohibition of torture.\textsuperscript{430}

5.6.6 Persons with Disabilities

Article 1 of the Convention on the Rights of Persons with Disabilities defines people with disabilities as “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” In terms of this definition, there are more than 1 billion people living with disabilities across the world, the vast majority of whom live in low and middle-income countries.\textsuperscript{431}

The limited evidence available on people with disabilities and HIV suggests that they are at the same, if not higher risk of HIV exposure.\textsuperscript{432} A 2012 study in South Africa found HIV prevalence of 16.7% in people with disabilities.\textsuperscript{433}

Various reasons are cited for high HIV prevalence amongst people with disabilities including their marginalised and stigmatised status in society as a whole, poverty, limited access to health care services as well as violence and sexual abuse.\textsuperscript{434} Research shows that children and adults with disabilities are at a higher risk of violence, including intimate partner violence and sexual abuse, increasing their vulnerability and risk of HIV infection.\textsuperscript{435} Barriers to access to appropriate and accessible health care services include the attitudes of health care providers towards people with disabilities, particularly in relation to sexual and reproductive health care, the limited accessibility of services to people with disabilities as well as the limited provision for targeted services to meet their specific needs.\textsuperscript{436}

In addition to the risk of HIV exposure amongst people with disabilities, there is a growing understanding that conversely, people living with HIV are at risk of becoming either permanently or episodically disabled as a result of HIV-related illness.\textsuperscript{437} Yet despite the multi-layered needs of people with disabilities, national responses to HIV fail to effectively integrate the needs of people with disabilities,\textsuperscript{438} increasing the impact of HIV on their lives.

Promising developments

A number of countries in Africa have committed to the Convention on the Rights of Persons with Disabilities and have begun to develop protective, anti-discrimination laws to protect the rights

\textsuperscript{428} L Mathlo. \textit{Assessment of the Legal Environment for HIV and AIDS in Lesotho} (draft) (2015).
\textsuperscript{429} \textit{Attorney General and Others v Tapela and Another} Court of Appeal Civil Case No. CACGB-096-14 (2015).
\textsuperscript{431} UNAIDS (2015).
\textsuperscript{432} HEARD. \textit{National Response to Disability and HIV in Eastern and Southern Africa} (2009).
\textsuperscript{433} UNAIDS (2015).
\textsuperscript{435} UNAIDS (2015).
\textsuperscript{436} UNODHR, et al. (2009).
\textsuperscript{437} HEARD (2009).
\textsuperscript{438} As above.
of people with disabilities. More than half of the countries in East and Southern Africa have included disability related provisions in the national constitutions\(^\text{439}\) and the EAC includes strong protection for the rights of people with disabilities in the HIV and AIDS Prevention and Management Law.

### 5.6.7 Indigenous persons

The prevalence of HIV and specific vulnerabilities to the disease among indigenous populations in Africa is significantly unexplored. Data on HIV prevalence among indigenous populations is limited.\(^\text{440}\) The lack of information and data on the prevalence and impact of HIV among indigenous groups makes it difficult to assess their needs, identify obstacles to indigenous persons accessing HIV prevention and treatment services and developing programmes to tailored to the needs of the community.

However, what is known is that indigenous persons continue to have limited access to general health care services, and this would include HIV prevention and treatment services.\(^\text{441}\) This is due in large part to continued stigma and discrimination, poverty, distance from available medical facilities, and limited health care personnel speaking indigenous languages.\(^\text{442}\)

To fully address the HIV needs of indigenous populations, more evidence needs to be collected and used to develop policies and programmes targeting indigenous populations within countries.

**Promising developments**

The African Commission has established a Working Group on Indigenous Populations/Communities in Africa, which has the potential to conduct research on issues related to HIV in indigenous communities. Further, most African countries have affirmatively adopted the United Nations Declaration on the Rights of Indigenous Peoples.\(^\text{443}\)

There is limited progress at the national level with a few countries having adopted laws and policies seeking to address the rights of indigenous people. For instance, the Republic of Congo adopted a law which provides protection for the rights of indigenous peoples.\(^\text{444}\) The Central African Republic is the first country in Africa which has ratified the International Labour Organisation’s Indigenous and Tribal Peoples Convention, 1989 (No. 169) which outlines the rights of indigenous peoples.

### 5.7 Intellectual property rights and access to HIV medicine in Africa

Article 16 of the African Charter provides all people with the right to enjoy the best attainable state of physical and mental health and places an obligation upon Member States to “take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.” The African Commission has also read into Article 16 the obligation on the part of Member States to “take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realised in all its

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\(^{440}\) Interagency Coalition on AIDS and Development. *HIV/AIDS and Indigenous Populations in Canada and Sub-Saharan Africa* (July 2011).


aspects without discrimination of any kind.”

In addition, Article 14 of the Protocol on Women provides that states “shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.”

Providing access to affordable and high quality medicines for HIV and TB is a critical element of fulfilling the right to health and there is no doubt that Africa has achieved remarkable gains in increasing access to treatment in recent years. By June 2014, more than 10 million people living with HIV in Africa were on ART with the most rapid gains in access occurring in countries such as South Africa, Nigeria, Mozambique, Tanzania and Zimbabwe. Three of four people receiving HIV treatment live in sub-Saharan Africa. This has resulted in a dramatic increase in life expectancy and reductions in AIDS-related deaths by 39% in sub-Saharan Africa between 2005 and 2013. However, these gains still only represents 37% treatment coverage in this region. Three out of five people living with HIV – an estimated 67% of men and 57% of women - are still not accessing ART.

More pregnant women living with HIV are getting services with Botswana, Namibia, South Africa and Swaziland having reached 90% or more of pregnant women living with HIV with antiretrovirals (ARVs) to prevent vertical transmission of HIV in 2013. There were however declines of at least 10% in Chad, Ghana, Lesotho and Zambia from 2012 to 2013. In addition, there is a huge gap in paediatric HIV treatment with three out of four children living with HIV not accessing treatment.

The prices of first generation ARVs have been dramatically reduced over the past ten years, primarily due to increased marketplace competition from generic drugs. However, closing the gaps in access to treatment is a major challenge within the current climate of restrictive intellectual property laws that allow global pharmaceutical companies to control the price of drugs, an over-reliance on international funding for treatment in Africa, dwindling donor resources and a potential need for costly second generation treatment regimens to treat drug-resistant strains of HIV. The World Trade Organisation (WTO)’s 1994 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) sets unprecedented minimum standards for protecting and enforcing rights to intellectual property, requiring all WTO members to provide at least 20 years patent protection in all fields of technology, including pharmaceuticals. The TRIPS Agreement impacts severely on countries in Africa which currently import 98% of their supply of ARVs.

Despite the 2004 Doha Declaration on the TRIPS Agreement and Public Health (Doha Declaration), allowing for countries to apply “TRIPS flexibilities”, including the right to define standards of patentability and to issue compulsory licenses to increase treatment access, few African countries have used this opportunity to reform their intellectual property (IP) laws to make effective use of these flexibilities. Most African countries are members of the WTO and have intellectual property laws granting, amongst other things, patent protection on medicines. In some countries, such as Madagascar, Lesotho, Nigeria, Rwanda, Tanzania and Uganda, these legal frameworks pre-date the TRIPS Agreement and do not have any provisions which enable the state to access cheaper patented medicines. Other countries, such as Angola, Benin, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, Djibouti, Ethiopia, the Gambia, Guinea, Guinea Bissau, Lesotho, Malawi, Mali, Mauritius, Mozambique, Niger, Rwanda, Senegal, Sierra Leone, Sudan, Togo and Zambia are eligible to apply for a waiver.
regarding implementation of the TRIPS Agreement, but many do not take advantage of this flexibility.\textsuperscript{451} Patent protection is also strengthened by free trade agreements entered into by some countries as well as the enactment of stringent anti-counterfeiting laws that conflate generic medicines with substandard “counterfeit” medicines, further restricting access to cheaper generics. Similarly, while almost every African country has laws allowing for the issuing of compulsory licences for medicines, countries have not fully incorporated the “public health” grounds for issuing a compulsory licence for life-saving medicines set out in the Doha Declaration.\textsuperscript{452} Where countries do attempt to use intellectual property laws effectively, they are at times met by strong opposition from governments and pharmaceutical companies.\textsuperscript{453} The protection of intellectual property laws and the failure to reform or effectively use flexibilities within the intellectual property regime undermines equitable access to affordable medicines in Africa and places barriers on the ability of countries to fulfil their citizens’ health rights.\textsuperscript{454}

Additional complications within African countries include the lack of an adequate institutional framework to examine and register patents effectively, requiring countries to rely on regional organisations such as the Africa Regional Intellectual Property Organisation (ARIPO) and the Organisation Africaine de la Propriété Intellectuelle to review patent applications.\textsuperscript{455} Enabling, non-discriminatory legal and social environments are equally critical to ensuring continued access to life-saving treatment. The HIV “treatment cascade”, which is used to measure the number of PLHIV who are actually getting tested for HIV and going on to receive ARVs and achieve suppression of the virus in their bodies, indicates that even where affected populations do receive health services, there is a worrying drop off population reached at each stage of the testing, treatment and care continuum. With the current emphasis on scale-up of access to testing, treatment and care in order to fast-track the response to HIV towards reaching UNAIDS’ 90-90-90 targets by 2020 and ending AIDS by 2030, ensuring the creation of an enabling environment that promotes non-discriminatory access to treatment along a continuum of care for key populations will be critical.\textsuperscript{456} It is vital that fast-tracking responses to AIDS does not take place within the current context of high levels of stigma, discrimination and marginalisation of key populations. If so, there is a real danger of not “ending AIDS”, but rather allowing HIV and AIDS to continue to become a disease of only the poor and marginalised sectors of society.

\textit{Promising developments}

Recent years have seen a number of positive developments at both continental and regional level towards creating an enabling environment for local pharmaceutical production, for increased regulation and harmonisation of laws and policies governing medical products and for increased access to HIV and TB medicines. Examples of continental initiatives include the AU / NEPAD Agency’s African Medicines Regulatory Harmonisation Initiative, the development of a Model Law on Medical Product Regulation in Africa\textsuperscript{457} and the establishment of the Pharmaceutical Manufacturing Plan for Africa, to make use of the flexibilities within the TRIPS Agreement and the Doha Declaration and produce local generic medicines.\textsuperscript{458} SADC and the EAC have developed complementary pharmaceutical business plans in alignment with the continental plan.

\textsuperscript{451} As above.\textsuperscript{452} As above.\textsuperscript{453} As above.\textsuperscript{454} GCHL (2011).\textsuperscript{455} As above.\textsuperscript{456} UNAIDS (2015).\textsuperscript{457} Adopted by Ministers of Justice and Attorney Generals of the African Union in Addis Ababa (November 2015). The model law aims to support Member States and Regional Economic Communities to strengthen and harmonize the regulation of medical products.\textsuperscript{458} African Union. \textit{Pharmaceutical Manufacturing Plan for Africa} (2007).
At a national level, countries are continuing to engage in policy reforms to incorporate public health flexibilities. There are countries, such as Zimbabwe, Mozambique and Zambia, who have used their laws to issue compulsory licenses for medicines as well as countries who have adopted the principle of international exhaustion to permit parallel importation of medicines from anywhere in the world. Treatment activists in South Africa used competition law to reduce the price of first-generation ARVs in 2002, 2005 and 2007. Rwanda was the first developing country to make use of the WTO’s 30 August decision in 2007 by importing patented anti-retroviral generic medication from Canada.

The judiciary in Africa have also supported access to treatment over the years. Most recently, in the 2012 case of Ochieng and Others v Attorney General in Kenya, the High Court upheld an order declaring the Kenyan Anti-Counterfeit Act of 2008 to be unconstitutional. The petitioners argued that the provisions of the Anti-Counterfeit Act failed to exempt generic medicines from the definition of counterfeiting in section 2. The definition could be interpreted to include generic medicines, effectively prohibiting the importation of generic medicines into Kenya. The Court interpreted the right to health as placing an obligation upon the state to ensure people have access to the medicines they require to be healthy and noted that the right to access medicine has been recognised as an essential component of the right to health in other jurisdictions, including South Africa. The provisions of the Anti-Counterfeit Act were held to restrict access to affordable medicines and thus violated the right to life, human dignity and health, protected under the Kenyan constitution. The Court declared that “[t]here can be no room for ambiguity where the right to health and life of the petitioners and many other Kenyans who are affected by HIV/AIDS are at stake.”

However, at national level, it remains critical to ensure that countries avoid incorporating TRIPS-plus measures within national laws through free trade agreements or anti-counterfeiting measures.

5.8. The rights and welfare of the African child

The African Children Charter is the main instrument within the African human rights system for protecting the rights of children and adolescents under the age of 18 years in Africa. It sets out the various rights of children and state obligations to respect, protect, promote and fulfil these rights. To date, the African Children Charter has been signed by all AU Member States and ratified by all but Somalia and Zambia.

The African Children Charter protects a broad range of children’s civil, political, economic, social and cultural rights. Amongst others, it protects the rights to equality and non-discrimination, the right to privacy and the right to the best attainable standard of health.

Yet children and adolescents face various human rights violations in the context of HIV, creating barriers to their ability to protect themselves from HIV transmission or to access the necessary treatment, care and supported once infected or affected by HIV and AIDS. Despite significant progress in reaching young people with HIV prevention, treatment, care and support, young people remain highly vulnerable to HIV infection in Africa. In 2012, 2.5% of all people aged 15 to 24 in sub-Saharan Africa were living with HIV, with up to 20% of young people in Swaziland.
affected. Young women are still twice as likely as young men to be HIV-positive and generally, HIV awareness still remains low.\textsuperscript{466}

This section focuses on some of the key HIV-related laws, policies and practices that limit young people’s rights in the context of HIV: age of consent laws regulating the age at which young people may consent to sex, marriage and access to various health care services; HIV-related stigma and discrimination and the need to support orphaned and vulnerable children in the context of HIV and AIDS.

One of the greatest challenges affecting young people in Africa is their limited ability to access their right to high quality, confidential, youth friendly sexual and reproductive health information and services independently of their parents or guardians.\textsuperscript{467} This is compounded by contradictory laws, policies and attitudes about the competency of youth to make autonomous decisions in relation to sex, marriage and accessing medical treatment.\textsuperscript{468}

The age of consent to sex interrelates with the age of consent to marriage and the age of consent to access medical treatment / sexual and reproductive health care services, since young people who may lawfully consent to sex and to marriage are at risk of HIV exposure. They therefore need to also be able to lawfully and independently access the necessary sexual and reproductive health care services to prevent HIV transmission and to receive treatment, care and support.

Age of consent to sex varies widely amongst African countries and differs for boys and girls and/or on the basis of sexual orientation. It can range from as low as 12 years in Angola to 18 years in many other jurisdictions. However, in many African countries the age of consent to sex is not clearly and specifically provided for in law. Instead it is inferred from criminal laws regulating sexual offences. For example in Botswana the age of consent to sex is derived from the fact that the Penal Code criminalises unlawful and carnal knowledge of a person under the age of 16 years. Other countries, such as DRC, Malawi and Tanzania, have differing ages of consent to sex for boys and girls. There are also those countries, such as Cote d’Ivoire, where the age of consent to sex is not in alignment with the age of consent to access medical treatment, HIV testing and contraception.\textsuperscript{469} In effect, this means that children can lawfully have sex (or even marry) before the age at which they can get medical treatment without their parent’s consent or can receive comprehensive sexuality education. Many countries also fail to provide an age of consent for same-sex sexual activity, since it is criminalised. In the few countries that do provide for an age of consent, it may differ from that for heterosexual sex. For example in Cote d’Ivoire, the age of consent for heterosexual sex is 15 but is 18 for same-sex sex.\textsuperscript{470} Few African countries have laws that set an age at which children can consent independently to medical treatment, HIV testing or accessing contraceptives;\textsuperscript{471} there are also few laws that recognise the rights of young people to sexuality education.\textsuperscript{472}

The failure to provide clear and uniform laws and policies regarding the age at which young people can consent to sex (including same-sex sexual activity), marriage and sexual and reproductive health care services violates the health rights of young people, creating barriers to access to services.

\textsuperscript{466} As above .
\textsuperscript{468} GCHL (2012).
\textsuperscript{469} UNDP. Age of Consent Report (draft) (2016).
\textsuperscript{470} UNDP Age of Consent Report (draft) (2016).
\textsuperscript{471} As above . GCHL (2011).
\textsuperscript{472} GCHL (2012).
Children living with HIV furthermore experience stigma, discrimination and violations of their rights, including discrimination within communities and health care services (such as HIV testing without voluntary and informed consent as well as breaches of their rights to confidentiality) and within education.\textsuperscript{473}

According to the United Nations Children’s Fund (UNICEF), as of 2014 approximately 13.3 million children worldwide have lost one or both parents to AIDS; 11 million of these children live in sub-Saharan Africa.\textsuperscript{474} Orphaned and vulnerable children (OVC) are often absorbed into extended families who take on caregiving roles for these children. Others may head up youth-headed households, in institutions or on the streets where they are increasingly vulnerable to abuse, exploitation and, linked to this, risk of HIV exposure. Other children, while not orphaned, experience the multi-layered impact of HIV on their families and communities. They may live with chronically ill parents or adults and be required to work or put their education on hold (particularly in the case of girl children) as they take on household and caregiving responsibilities; their households may experience greater poverty because of the disease; and they may be subject to stigma and discrimination because of their association with a PLHIV. These children’s rights to equality and non-discrimination, dignity, health, education and their survival and development, more broadly, are jeopardised by their situation. These orphaned and vulnerable children are in need of alternative care, in the absence of parental care, as well as programming to ensure their access to rights to education, social support and health care, amongst other things.

For orphaned children, their recognition in law (i.e. through birth registration) and the legal recognition of the parental rights and responsibilities of their de facto caregivers may be critical to their access to healthcare, education and social support services. Yet in many countries, children remain unregistered at birth.\textsuperscript{475} Equally, the legal system fails to recognise the parental rights and responsibilities of informal caregivers in many countries. Additionally, orphaned children’s rights to family property may be violated where inheritance laws fail to protect children’s rights in favour of male relatives. For instance, in Kenya, where inheritance laws do not protect orphaned children, they are reported to be vulnerable to property grabbing.\textsuperscript{476}

\textit{Promising developments}

A number of African countries, such as Botswana, Kenya, Lesotho, Madagascar, Malawi, Mozambique, South Africa and Uganda, have developed new children’s laws based on the principles in the Convention on the Rights of the Child. These new laws are generally more responsive to the social context of children’s lives. In addition, a number of the HIV laws developed in 26 African countries contain protection for the rights of children affected by HIV and AIDS.\textsuperscript{477}

A number of countries have also specified the age at which children can consent to other sexual and reproductive health services such as HIV testing and accessing contraceptives. For example, in Lesotho the \textit{Children’s Protection and Welfare Act 2011} provides in section 240(2) that a child of 12 may consent independently to medical treatment if they are of ‘sufficient maturity and have the mental capacity to understand the benefits, risks, social and other implications of the treatment or operation’. Likewise in Senegal the \textit{Loi No 2010-03 Relative au VIH/SIDA} provides in Article 12 that a minor over the age of 15 may consent independently to HIV testing.

\textsuperscript{473} GCHL (2011).
\textsuperscript{474} UNICEF. \textit{A Growing Number of Countries are Developing National Action Plans for Orphans and Other Vulnerable Children} \url{http://data.unicef.org/hiv-aids/care-support.html} (last accessed 20 June 2016).
\textsuperscript{475} UNICEF. \textit{Strengthening Birth Registration in Africa} (undated); UNICEF. \textit{Birth Registration} (13 January 2014).
\textsuperscript{476} GCHL (2011); GCHL (2012).
\textsuperscript{477} GCHL (2011).
Some countries have introduced child-specific forms of social protection to support orphans and vulnerable children. For example, some countries have legislated broad socio-economic rights within children’s statutes, such as s 10(1) of the Lesotho Children’s Protection and Welfare Act 2011 which provides that a “child has a right to access education, preventive health services, adequate diet, clothing, shelter, medical attention, social services or any other service required for the child’s development”. Some countries have recognised the roles played by caregivers and granted them legal authority to protect and provide for the rights of children. Some countries have introduced child-specific forms of social protection to support orphans. Others provide a number of social services to all children. For example, Zimbabwe offers free health care to children under 5. Likewise, in Malawi there is free primary school education and grants for books and clothing. Finally, some countries provide cash grants to support children in need, such as the child support grant in South Africa which is paid to the primary caregivers of children.

5.9. Section conclusion

This section identified key human rights concerns and challenges related to HIV. This concerns revolved around the following:

- Women and girls;
- Harmful cultural practices and traditional beliefs in the context of HIV;
- Equality and non-discrimination;
- HIV testing;
- Criminalisation of HIV transmission;
- Key populations at risk of HIV;
- Intellectual property rights and access to HIV medicine in Africa; and
- The rights and welfare of the African child in the context of HIV and AIDS.

Although most African States are addressing these issues and that some of them have experienced some encouraging developments, in general much more need to done to ensure that these questions do not hinder the effective response to HIV and human rights on the continent.

6. EMERGING TRENDS

This section discusses five emerging trends, how these trends are affecting the HIV response in Africa and the challenges faced in implementing many of these trends. The five emerging trends that will be discussed are as follows:

- Human rights at the time of expanding HIV services;
- Implementation and enforcement of laws and policies relating to HIV;
- Shrinking civil society space and its impact on the HIV response, including challenges to meaningful involvement in government decisions;
- Funding crisis and its impact on human rights and the HIV response; and
- Conflicts and HIV in Africa.

6.1 Human rights at the time of expanding HIV services

Efforts to address HIV have made great strides in the last decade. Since 2001, new HIV infections have fallen by 38% and in the last decade deaths due to AIDS have fallen 35%.478 This progress is apparent in sub-Saharan Africa, where between 2005 and 2013, AIDS deaths declined by almost 40% and the rate of new infections fell by 33%.479

479 As above.
One of the key reasons for the progress in addressing HIV is the expansion of HIV prevention and treatment services. This includes the expansion of HIV testing services and the expansion of HIV treatment especially following medical evidence that early treatment can lower an individual’s viral load such that his infectiousness is greatly reduced.

Seeking to build on the progress in addressing HIV, UNAIDS is pushing to end AIDS by 2030. One of the key goals of this push is for 90% of all people to know their HIV status. For this, UNAIDS has acknowledged that “[t]esting initiatives will need to be more strategically focused to effectively reach those at greatest risk, and countries will need to use multiple strategies (such as community-based testing campaigns, provider-initiated testing and counselling and self-testing)”.

For a long time, voluntary testing and counselling (VCT) was solely recommended for HIV testing. This meant that individuals had to seek HIV testing of their own volition, the test itself and the results were to be confidential, and providers had to provide persons seeking an HIV test with pre- and post-test counselling. VCT was deemed necessary, in part, to ensure that individuals who did test positive for HIV were prepared for the diagnosis and thus able to take the necessary measure to protect themselves and others and to ensure the human rights of patients, specifically the right to informed consent and confidentiality.

However, in order to increase the rate of HIV testing, countries in Africa have implemented additionally types of testing, including PITC, community and home testing for HIV, routine HIV testing, couples' HIV testing, and mobile HIV testing.

As countries push to end HIV, these additional ways of testing for HIV are expected to be utilised to a greater extent, raising new human rights concerns, particularly as the expansion of HIV testing will be directed at key populations.

This report focuses on two HIV testing methods: PITC and home-based testing.

PITC is defined by the WHO and UNAIDS as “HIV testing and counselling which is recommended by health care providers to persons attending health care facilities as a standard component of medical care. The major purpose of such testing and counselling is to enable specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person’s HIV status.”

Further, PITC can be either opt-in or opt-out. Opt in requires “patients [to] affirmatively agree to the test being performed after pretest information has been received”. Opt out on the other hand requires “individuals [to] specifically decline the HIV test after receiving pretest information if they do not want the test to be performed.”

In 2007, the WHO and UNAIDS recommended the implementation of PITC, issuing guidance for countries considering provider-initiated testing. In its 2007 guidance, the WHO noted specifically for sub-Saharan Africa that according to surveys only a “median of just 12% of men and 10% of women had been tested for HIV and received the results”. Since that time, a number of countries in Africa have implemented PITC for specific populations, including

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482 UNAIDS (2014).
484 As above . at 14.
pregnant women. These include Botswana, Kenya, Malawi, South Africa and Uganda. In recent years, Uganda has sought to expand PITC to all individuals.

In the guidelines, the WHO and UNAIDS recommended the opt-out approach to PITC. Further, they recommend the following, among others:

- That it must be voluntary and confidential
- That informed consent must be obtained
- That adequate steps be taken to minimise negative consequences of HIV testing for vulnerable patients
- That adequate steps are taken to create and implement a supportive social and legal environment

Another avenue countries are considering to increase HIV testing is the use of home-based HIV testing. Countries in Africa have begun implementing home-based HIV testing especially in settings where VCT is not widely available. Home-based HIV testing includes going door-to-door offering HIV testing and counselling, visiting the homes of people at high risk of HIV, such as people whose partners are HIV positive and offering HIV testing and counselling services, and self-testing by individuals. South Africa is considering its use in schools. A number of countries in Africa have been implementing home-based HIV testing, including Kenya.

A scale up in testing can lead to negative outcomes if not appropriately devised. For example, the impact of many PITC programs in Africa has been that pregnant women are disproportionately subjected to HIV testing without any clear measures in place to ensure their safety and protection from family members, including spouses. For example, studies have shown a significant gender imbalance in HIV testing and access to treatment in Burkina Faso, Kenya, Malawi, and Uganda raising concerns that women will continue to be scapegoated for bring HIV into families.

In addition, as HIV testing increases the number of people needing HIV treatment will also increase and should be considered when scaling up HIV testing programmes.

Another area in which African countries are seeking to expand access to treatment is through access to post-exposure prophylactics (PEP). PEP can be used by an HIV negative person who has been exposed to potential HIV transmission. It has been used successfully in cases of rape and with sero-discordant couples.

However, despite the clear efficacy of its use, PEP is available in very few countries in Africa. The countries that do provide access to PEP include South Africa, Botswana, Zimbabwe, among others. Recently more countries are seeking to provide access to PEP. For example, Kenya’s Pharmacy and Poisons Board has recently approved the use of Truvada as PEP.

6.2 Implementation and enforcement of laws and policies relating to HIV

487 World Health Organization et al. (2012).
488 As above.
491 As above.
493 Wanjiru Mukoma “Approval of Truvada a Game Vhanger in Anti-HIV/Aids Effort” The East African (9 January 2016).
The legal environment, including the enactment and enforcement of laws, is a critical component in the HIV response. The GCHL has documented how an enabling legal environment, which respects human rights, can significantly help in addressing HIV.494

Many countries in Africa enacted human rights-respecting laws and policies relating to HIV. Further, many countries have guaranteed fundamental rights protecting people living with and affected by HIV from human rights violations. However, such laws and policies are often not adequately implemented or enforced.

One of the key legal protections guaranteed in most countries in Africa is the right to be free from discrimination on the basis of HIV status, gender, and marital status, among others. This protection is provided in constitutions, under specifically-enacted HIV laws and under national AIDS plans or strategies. Indeed, Article 22 of the Constitution of Burundi clearly prohibits any form of discrimination including on the ground of HIV.

In Kenya, the Constitution provides for the right to be free from discrimination on the basis of sex and health status, among others. Further, the HIV and AIDS Prevention and Control Act 14 of 2006 (HIV Act) specifically prohibits discrimination against persons on the basis of their HIV status.

In addition, international and regional treaties, including the African Charter and the International Covenant on Civil and Political Rights (ICCPR) prohibit any form of discrimination which includes a prohibition on discrimination on the basis of HIV status and sexual orientation.495

However, large number of people living with HIV in Africa continue to report experiences of discrimination and stigma as seen in the above discussion. Discrimination against people living with HIV includes discrimination in employment; discrimination in accessing health services; and discrimination against key populations, such as women and LGBT.

Implementation and enforcement of these laws and policies remains a significant obstacle to an effective HIV response throughout Africa. Failure to implement and enforce these laws, and many laws protecting the rights of people living with HIV, is due in part to people living with HIV not being aware of their rights and not having access to lawyers and legal services to seek to enforce law and key decision makers including legal professionals, health care workers and employers not understanding HIV.

To address these challenges, Kenya has created a HIV and AIDS Tribunal to specifically address issues and cases arising under its HIV Act. The Tribunal ensures that judges have specially informed regarding HIV and it is easier to access for potential applicants. The HIV and AIDS Tribunal has addressed hundreds of HIV cases to date.496 Most of the cases before the HIV and AIDS Tribunal fall into three categories: 1. workplace issues, including mandatory HIV testing and discrimination on the basis of an individual’s HIV status; 2. discrimination and abuse in health care settings and denial of services based on HIV status; and 3. issues involving domestic violence, property, and inheritance.497 The HIV and AIDS Tribunal has addressed some of the challenges of accessing justice for marginalised populations.498 However, a specific court just for cases arising under the HIV Act also has the potential to create the impression that HIV issues are significantly different than broader rights issues and need specific specialisation thereby limiting the mainstreaming of HIV.

494 GCHL (2012).
497 As above .
498 As above .
6.3 Civil society space and HIV

A vibrant and engaged civil society and community movement is critical to the AIDS response, and to ensuring that the realisation of the new post-2015 development agenda is grounded in human rights principles and leaves no one behind.

Yet, throughout the world, non-governmental organisations are facing restrictions to their establishment, operation and to the implementation of their mandates and activities. These legal, policy, regulatory and other restrictions directly infringe on several human rights, including the rights to freedom of association and assembly guaranteed under the African Charter on Human and Peoples’ Rights. They also have a negative impact on the HIV response.

In particular, countries restrict civil society in four primary ways: they restrict the ability of non-governmental organisations to register; they restrict the non-governmental organisation’s (NGO’s) operational activities; they place barriers on NGOs’ ability to communicate internally and externally; the place barriers on assembly and they place restrictions on funding.

A number of countries in Africa require NGOs to register with the government. Without such registration, they are not permitted to operate or receive funding. In Botswana, all NGOs are required to register in order to operate legally. In some countries, NGOs need to re-register after a relatively short period of time and may encounter limitations on registration if the founder or NGO is a non-national. In Ethiopia, for example, NGOs are required to re-register every 3 years. Finally, when registration is denied, there is little information or recourse apart from litigation to contest such a denial. In Kenya, the Transgender Education and Advocacy (TEA) had to litigate after the NGO Coordination Board failed to register the organisation. The High Court required the government to register the TEA.

Countries also have restricted the operational activities of NGOs, including by limiting the substantive operations of the NGO directly; requiring adherence to specific government development plans; and subjecting NGOs to governmental harassment due to the specific activities of the NGO. In Uganda, the Local Governments Act, 1997, gives local government bodies the power to monitor the activities of NGOs. In Ethiopia, NGOs receiving more than 10% of their funding from external donors are not permitted to work on issues related to human rights and democracy.

Countries also have limited NGOs’ ability to communicate internally and externally through harassment, denying visas for international allies; and restrictions on and monitoring of the use of means of communications, such as the internet. In Zimbabwe, the Gay and Lesbians of Zimbabwe’s offices are routinely raided by the government. Often government officials confiscate their computers and other publications, including personal information, during the office raids. This limits the ability of GALZ to effectively communicate with partners if they are concerned that such communication places their partners at risk of government harassment as

501 Charities and Societies Proclamation, No. 621/2009, art. 76
503 Charities and Societies Proclamation
December 2016

well. In Zambia, the government under Sata monitored the internet use of civil society activists and subjected them to regular harassment.505

Countries also restrict NGOs’ ability to assemble, including organising public marches. In Kenya, the Public Order Act requires NGOs and others to notify the police if they are planning a public gathering three days in advance. Though there is no explicit requirement that the police approve of the public gathering, they are able to deny NGOs the ability to proceed claiming it will breach the peace. They do not have to provide any evidence that the public gathering will breach the peace.

Finally, a number of countries in Africa do restrict NGOs’ funding including prohibiting specific types of funding; requiring government approval or compliance with onerous procedures for specific types of funding; and routing funding through the government. In Ethiopia, the recently-enacted Charities and Societies Proclamation 2009 prohibits any activity by an organisation which receives more than 10% of its funding from overseas.506

These restrictions have been shown to impact the HIV response. In particular, they limit the ability of organisations to advocate for a stronger legal environment for the HIV response and provide critical HIV-related services. Such restrictions also drive marginalised populations underground.

6.4 Funding crisis and its impact on human rights issues and civil society

The international funding to governments and to civil society for HIV has been significantly decreasing in the last few years.

However, many low- and middle- income countries remain heavily dependent upon international donors to finance their HIV response. In 2014, 44 countries had 75% or more of their HIV financing needs provided by external sources.507

The decrease in HIV funding has had a significant impact on the human rights response to HIV. In 2013, only $137 million was spent on the global human rights response to HIV accounting for just 0.13% of all HIV spending in low- and middle-income countries. As funding for HIV decreases, the funding for human rights-related HIV funding, which is already underfunded, is expected to further decrease. A 2015 UNAIDS study found that 59% of CSOs implementing human rights programmes reported decreases in funding.508

In Africa, the outlook for funding for organisations working on human rights programming is mixed depending on geography and type of human rights work the organisation. In middle income African countries, CSOs report significant decreases in funding for HIV and human rights work. However, CSOs in western and central Africa report, according to the 2015 UNAIDS study, that they expect an increase in funding for human rights and HIV.509 Further, organisations involved in legal services and service delivery and organizations working on broader issues, which include HIV, such as sexual and reproductive rights, were less likely to experience decreases in funding.


509 As above . 19.
The decrease in HIV funding has already led organisations to close in southern Africa, leaving a gap in services. For example, the Zambian AIDS Law Research and Advocacy Network (ZARAN) which had promoted the rights of people living with and affected by HIV closed in 2012 due to a lack of funding. ZARAN was one of the few organisations in Zambia which worked to address the legal environment for people living with HIV.

In light of the decrease in funding, NGOs have attempted to find alternative solutions. These include integrating HIV into broader health and other human rights issues and shifting geographical and/or methodological focus.\(^{510}\)

However such shifts can be positive but also come with potentially negative outcomes. Many organisations in Africa are considering integrating HIV into broader health and other human rights issues. The benefits to such an approach are that donors will be able to integrate HIV with other human rights issues, including sexual and reproductive health and rights; there will be better integration between grassroots mobilisation with government-funded primary care services; and lessons from the HIV movement can be learned and used for other issues. The risks to such integration are that HIV groups lose their sole focus on HIV thereby limiting their impact on the HIV epidemic; organisations take on issues and advocacy work for which they lack the necessary expertise; and the integration of HIV organisations into broader, existing movements of marginalised groups may be difficult and may shift priorities.

The stagnation/decrease in HIV funding is not only impacting CSOs and the human rights response, but also the ability of African governments to effectively address HIV.

As funding is decreasing, African governments are facing increasing pressure to cover the costs of the HIV response through country budgets. In response, The African Union emphasised the importance of sustainable financing in the Roadmap: Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa (AU Roadmap) and provides a clear roadmap for countries. The AU Roadmap recommends that countries do the following:

1. “[D]evelop country-specific financial sustainability plans with clear targets through a partnership approach, including with people living with HIV and affected populations;
2. Ensure development partners meet existing commitments and with long-term and predictable commitments that are aligned with Africa’s priorities; and
3. Identify and maximise opportunities to diversify funding sources in order to increase domestic resource allocation to AIDS, TB and malaria.”

Some countries in Africa have begun planning for the decrease in funding primarily by making certain aspects of the HIV response more efficient and increasing domestic spending on HIV. For example, Swaziland has saved millions of dollars by improving the antiretroviral drug tendering processes. They have done this through introducing “ceiling prices, supplier performance data and more reliable quantification methods”. This revised tender process resulted in an overall cost reduction of 27%.\(^{511}\)

In Namibia, the government has put in place measures to increase or sustain funding as external funding occurs. As a middle income country, Namibia has limited donor funding opportunities. In response, Namibia put out a Sustainable Financing Study in November 2011, which advocated for private sector contributions through workplace HIV education programmes; airline levies; raising the amount of public funds allocated to the HIV response; and using health insurance expenditures to increase access to health services.\(^{512}\)

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\(^{510}\) As above, 38.


\(^{512}\) As above, 27.
Though there has been some progress by governments in responding to the decrease in HIV funding, it continues to be a concern on the continent. This becomes even more concerning in light of the call to end AIDS by 2030 as HIV services are expanded and more individuals who need treatment are identified.

Countries may need assistance in implementing the recommendations from the AU Roadmap.

6.5. Conflicts and HIV in Africa

In 2001, the United Nations General Assembly Special Session passed a Declaration of Commitment on HIV/AIDS which aimed by 2003 to “develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognising that populations destabilised by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons, and in particular women and children, are at increased risk of exposure to HIV infection; and where appropriate, factor HIV/ AIDS components into international assistance programmes.”

Despite this, very little action has been taken to directly address HIV during conflict and post-conflict periods. This is of particular importance in Africa as the current ongoing conflicts raise issues not only with respect to ensuring that human rights standards are followed but also with respect to the provision of HIV prevention and treatment services.

There is conflicting information as to whether HIV transmission rates rise during armed conflict. One study claimed that women living in a refugee camp were six times more likely to acquire HIV than those who lived among the general population. However, other studies have shown that HIV prevalence rates are lower for countries in armed conflict than those of neighbouring countries who are not in conflict.

What is clear is that armed conflict and post-conflict periods raise distinct issues related to HIV prevention and treatment. During armed conflict HIV prevention and treatment services tend to be significantly reduced given the instability wrought by war. For example, in Cote d’Ivoire, areas of conflict reported at least a 75% reduction in healthcare staff. Without adequate healthcare staff, provision of HIV prevention and treatment services is greatly reduced.

However, armed conflict can increase the need for HIV prevention and treatment services. Armed conflict where sexual violence is highly prevalent appear to experience higher rates of HIV transmission. Unlike Sierra Leone and the South Sudan, the HIV prevalence rate in eastern DRC is high arguably due to the high levels of sexual violence in the region.

In response to the high levels of sexual violence in eastern DRC, mobile courts have been established to specifically try perpetrators of sexual violence. From 2009-2012, a mobile court in South Kivu heard 382 cases, resulting in 204 convictions for rape, 82 convictions for other offenses, and 67 acquittals. Such courts permit victims to attain some level of redress and hold perpetrators accountable for sexual violence.

514 As above, 326.
In addition, armed conflict destabilised people, removing them from their homes and from the regularity of their lives; in some cases, making them refugees and migrants. For people on HIV treatment or people seeking HIV prevention services, knowing where to access such services and having a regular supply of ARVs can be difficult in such circumstances. This can result in people living with HIV developing drug resistant HIV and people exposed to HIV not having the needed access to PEP when exposed to HIV.

This is particularly true for refugees and migrants who are more vulnerable to HIV. Refugees and migrants due to their socio-economic vulnerability among others are at heightened risk of sexual violence. In addition, due to the legal, administrative, cultural, and social factors, refugees and migrants may find it difficult to access health care services even when they are available.

In Botswana, the government introduced a policy denying non-citizens, including refugees and migrants, access to state-covered HIV treatment. However, the government revised this policy with respect to refugees and migrants after advocates raised concerns regarding the denial and the United Nations High Commissioner for Refugees offered to cover the extra costs. With respect to non-citizen prisoners, advocates had to litigate the policy to ensure that all prisoners who needed HIV treatment would receive it at no cost. The Court of Appeal of Botswana in 2015 held that non-citizen prisoners were entitled to HIV treatment at no cost. In reaching their decision, the Court noted that ensuring non-citizens, including refugees and migrants have access to treatment will reduce the likelihood of HIV transmission among others.\(^{518}\)

A key opportunity for addressing HIV is during the transition from armed conflict to post-conflict. As countries shift from armed conflict to post-conflict, new HIV risks can emerge. For example, following conflict, unemployment can rise as young men who were previously part of the military are no longer employed leading to a rise in crime. Further, domestic violence may increase as young men return to homes where women have been the primary caretaker of the family.

In addition, countries emerging from armed conflict often find it difficult to revive the necessary infrastructure needed to provide competent healthcare services.\(^{519}\) Populations emerging from conflict can also be more vulnerable to the new HIV risks as often, HIV prevention and treatment services and information tends to be unavailable during armed conflict and thus populations emerging from conflict do not have the necessary information regarding HIV to protect themselves from the virus and access treatment.

A few countries in Africa have attempted to address HIV during the aftermath of armed conflict. In the 1991 conflict between Ethiopia and Eritrea, Ethiopian military health authorities believed that the return of HIV-infected military personnel to their own communities increased HIV prevalence in Ethiopia. Thus, during the 1998-2001 war with Eritrea, Ethiopia embarked on an HIV prevention programme within the military, and following the conflict upon reintegration trained returning military personnel to educate their communities on HIV prevention and treatment.\(^{520}\) In a number of African countries, including Sierra Leone, Liberia, Niger, Sudan and Côte d’Ivoire, the provision of dedicated staff empowered to address HIV during the disarmament, demobilisation and reintegration process has been successful in addressing HIV during the transition.\(^{521}\)

\(^{518}\) Attorney General and Others v Tapela and Others CACGB-096-14 (26 August 2015).
\(^{520}\) As above
\(^{521}\) As above.
7. CONCLUSIONS AND RECOMMENDATIONS

This section is divided into two sub-sections: The first subsection provides conclusions and the second one offers recommendations.

7.1. Conclusions

The findings in this report indicate that people living with HIV and key populations at higher risk of HIV exposure experience violations of many of the basic human rights protected by the African Charter, the Maputo Protocol and the ACRWC.

**Human Rights Violations in the Context of HIV and AIDS**

Key affected human rights violations discussed in this report include violations of the rights to equality and non-discrimination; dignity; liberty and security of the person; protection from cruel, inhuman and degrading treatment or punishment and the right to health.

Stigma and discrimination continues to impact on the lives of people living with HIV as well as key affected populations such as women and girls, sexual minorities, sex workers, people with disabilities, prisoners and migrants. HIV-related stigma and discrimination is pervasive in the lives of affected populations - it takes place at the most private level, within people’s homes, families and communities as well as in public spheres of life such as in the health care setting and in the working environment. Stigma and discrimination takes various forms, including marginalisation and exclusion from family and community activities; denial of employment and access to services; verbal and physical abuse and violence; sexual abuse and assault and even murder. It is exacerbated by ineffectual laws attempting to criminalise HIV transmission, despite the fact that these laws have shown little impact on reducing the spread of HIV. It is also intertwined with stigma and discrimination on other levels, based on grounds such as a person's gender, gender identity, sexual orientation, age, disability and citizenship, amongst other things, increasing the impact on key populations. Stigma and discrimination is perpetrated by partners, family members, communities and vital service providers like health care workers, social support workers, educators and law enforcement officials. Significantly, it has an enormous impact on the lives of affected populations over and above the violation of equality rights; it robs people of their basic human dignity and makes affected populations unwilling and unable to access critical services, such as HIV-related prevention, treatment, care and support services, to protect themselves. Although 26 countries in Africa have enacted HIV-specific anti-discrimination laws to protect people from HIV-related discrimination, these laws are not well known, often narrowly drafted to protect only people living with HIV, insufficiently implemented and seldom enforced in countries where access to justice and law enforcement is already problematic.

Key populations are particularly affected by discriminatory laws, policies and practices. Gender inequality, harmful gender norms and gender-based violence place women and young girls at high risk of HIV exposure. Their inability to exercise control over basic aspects of their lives - such as their decision-making powers within their relationships, their ability to decide how and when they have sex, their ability to consent independently to sexual and reproductive health services, their lack of ownership of property and limited inheritance rights – means they have diminished autonomy, are increasingly reliant on male partners for their survival and are as a result vulnerable to exploitation, abuse and HIV exposure. Research has shown the links between gender-based violence and HIV – rape poses a direct risk of HIV transmission and equally, intimate partner violence is linked with higher HIV incidence rates amongst affected women. Finally, harmful gender norms such as widow inheritance, child marriage and female genital mutilation contribute towards further risk of HIV exposure.
HIV testing continues to be conducted without the voluntary and informed consent of individuals and people report disclosures of their confidential medical information to partners, spouses, health care workers and in the courts of law. Some of these human rights violations are sanctioned by law and policy in African Member States, where the law provides for instances of mandatory HIV testing and disclosures of HIV status. The recent push to expand testing services also raises concerns of potential human rights violations if the expansion of testing services are not carefully managed based on a human rights approach.

Many countries have laws that effectively criminalise key populations, such as gay men and men who have sex with men, transgender people, sex workers and people who inject drugs. These laws have been shown to fuel stigma, discrimination, harassment and acts of violence against key populations as well as to limit the ability of key populations to take action in law for acts of violence, exploitation and abuse. Critically, they also limit the willingness of states to provide health care services for these populations and limit the ability of populations to access appropriate services without fear or recrimination or abuse.

Laws and policies may also act as barriers to access to sexual and reproductive health care for adolescents. Across Africa, there are a myriad of conflicting laws and policies regarding when a child may lawfully and independently have sex, marry, consent to an HIV test, consent to medical treatment or access contraceptives. Different ages apply not only across but within countries. This creates confusion for all concerned - young people, their parents and guardians and service providers. Where laws conflict, untenable situations arise allowing, for instance, a young person to consent to sex or to marry, but not consent to his or her own medical treatment. These conflicting laws violate the rights of young people to sexual and reproductive health.

Intellectual property law also impacts on access to treatment for people living with HIV and TB. Strict application of intellectual property laws, without use of the flexibilities within these laws, means that countries in Africa fail to access cheaper medicines to meet their needs.

For some populations, such as prisoners, migrants, people with disabilities and transgender people, there is insufficient focus in national responses to HIV on their particular service needs. There is limited data on HIV incidence and prevalence in these populations; they receive inadequate focussed and targeted programmes, funding and monitoring and may be “ignored” in national laws, policies and programmes to respond to HIV and TB.

There are also a number of emerging issues which have the potential of violating fundamental human rights if not properly considered. These include the increased vulnerability to HIV and barriers to HIV prevention and treatment services during conflicts and post-conflict transitions; the impact on the HIV response of restrictions on civil society organisations and the decrease in funding for HIV, especially for HIV and human rights programming.

Application of human rights to HIV and AIDS
The analysis in this report notes that key rights within important regional treaties, such as the African Charter, Maputo Protocol and ACRWC, should be applicable to people living with HIV and key populations at higher risk of HIV exposure. There are a number of international as well as regional guidelines, declarations and plans that articulate the importance and application of key human rights principles in the context of HIV and AIDS.(It might be useful to mention some of these in the footnotes)
At national level, within countries, in particular the legislators and the courts have shown leadership in applying these rights in HIV-specific laws in 26 countries, as well as in national judicial decisions that uphold the rights of people living with HIV across Africa. To a lesser extent, national human rights institutions in some countries have also taken cognisance of the importance of investigating and responding to human rights violations in the context of HIV and AIDS.
Within the AU system, the establishment of the HIV Committee is an indication of the seriousness with which the AU views HIV-related human rights violations. The Resolution spearheaded by this Committee condemning the coerced sterilisation of HIV positive women in Africa – the Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services passed in 2013 by the African Commission and the Committee’s engagement on key issues within countries has helped to strengthen the rights of affected populations.

However, in order to cement the understanding of the importance of these rights across the various affected populations, there is a need for continued action by other relevant Committees as well as more specific jurisprudence on the application of key rights to the context of HIV and AIDS and to key populations at higher risk of HIV exposure, by the African Commission, African Court, the ACERWC, the African Union Commission and the Conference of States Parties.

7.2 Recommendations

7.2.1 Recommendations to the African Commission

It is recommended that the African Commission continue to place the rights of People Living with HIV and those vulnerable to it on its agenda and ensure that all of its bodies and mechanisms that protect and promote rights through:

i. The continued prioritisation of the rights of people living with HIV and those at risk, vulnerable to and affected by HIV, which should remain an Agenda item at all Ordinary Sessions of the African Commission.

ii. Ensuring that specific enquiries on the rights of people living with HIV and key populations are included in Article 62 reports, the investigations, fact-finding missions and reports of relevant Special Rapporteurs such as the Special Rapporteur on Prisons Conditions of Detention and Policing in Africa, the Special Rapporteur on Migrants, Asylum Seekers, Migrants and Internally Displaced Persons and the Special Rapporteur on the Rights of Women in Africa, and the work of relevant Committees and Working Groups such as the African Committee of Experts on Children’s Rights, amongst others.

iii. Calling on Member States to include HIV-relevant information in their periodic reports and provide Member States guidelines on what HIV-specific information to include in national periodic reports. An initial list of the types of information that should be included is provided in Appendix 1.

It is recommended that the African Commission continues to encourage Member States to ensure that domestic legal frameworks protect the rights of People Living with HIV and those vulnerable to infection through:

iv. Encouraging Member States to conduct law and policy review and reform and adopt, implement and enforce rights-based laws, policies and plans in the context of HIV and AIDS, drawing on international and regional guidance on HIV law and human rights emanating from SADC, the EAC and ECOWAS.

It is recommended that the African Commission support Member States in their efforts to enhance domestic legal systems through:

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v. Developing policy and legal guidelines for Member States on particular legal and policy issues affected the rights of people living with HIV and key populations, determined in conjunction with key stakeholders and the HIV Committee. This should include amongst others guidelines specifically condemning the overly broad criminalisation of exposure to HIV in HIV specific laws or through amendments to existing criminal laws and the meaning of the right to health within the context of HIV.

vi. Issuing a statement on whether the phrase any status used in Article 2 of the African Charter includes discrimination on the basis of HIV and sexual orientation.

It is recommended that the African Commission ensures that access to justice for People Living with HIV and those vulnerable to infection are strengthened through:

vii. Making efforts to increase awareness of the mandate of the Commission and its Special Rapporteurs and Committees, to support submissions and communications from civil society organisations on the rights of people living with HIV and key populations.

viii. Calling on Member States to conduct thorough investigations of violations of the rights of People living with HIV and key populations and hold perpetrators accountable.

7.2.2 Recommendations to the Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV

It is recommended that the African Commission ensures that access to justice for People Living with HIV and those vulnerable to infection are strengthened through:

i. Raising awareness of its work.

   It is recommended that the Committee continue to monitor the implementation of HIV-related resolutions issued by the African Commission such as the Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV services (Resolution 260) through:

   ii. Undertaking further research and fact finding missions.

   It is recommended that the Committee support efforts of Member States to improve their domestic legal frameworks; ability to respond to HIV through:

   iii. Making recommendations to the Commission regarding the need for explicit reference to the need for access to condoms as part of basic sexual and reproductive health care services in the Guidelines on the Conditions of Arrest, Police Custody and Pre-Trial Detention in Africa, adopted by the African Commission in 2014.

   iv. Issuing recommendations on the need for prosecutorial guidelines to guide national prosecuting authorities using HIV-related criminal law provisions.

7.2.3. Recommendations to the African Committee of Experts on the Rights and Welfare of the Child

   It is recommended that ACEWRC continue to place the rights of children People Living with HIV and those vulnerable to infection on its agenda through:

   i. Actively conducting investigations, monitoring key human rights violations and spearheading resolutions on the rights of children living with and affected by HIV.
ii. Developing a General Comment focused on the rights of children living with and affected by HIV and the obligation of states to respect, protect and fulfil such rights. This should include reference to a child’s right to information and sexual and reproductive health services.

iii. Requiring specific HIV-related information from Member States in the States Parties Reporting Guidelines.

It is recommended that the ACEWRC continues to encourage Member States to ensure that domestic legal frameworks protect the rights of children Living with HIV and those vulnerable to infection through:

iv. Conducting the necessary law and policy review and reform and adopting, implementing and enforcing rights-based laws, policies and plans in the context of HIV and AIDS to ensure they are in compliance with the ACRWC.

v. Developing policy and legal guidelines for Member States on particular legal and policy issues affected the rights of children living with and affected by HIV, determined in conjunction with key stakeholders.

It is recommended that the ACRWC ensures that access to justice for children Living with HIV and those vulnerable to infection are strengthened through:

vi. Making efforts to increase awareness of the mandate of the Committee, to support submissions and communications from civil society organisations on the rights of children living with and affected by HIV.

7.2.4 Recommendations to the African Union

It is recommended that the African Union take steps to enhance the structures to enforce human rights through:

i. Continuing to encourage State Parties to the African Court Protocol to make Declarations accepting the jurisdiction of the Court, in order to broaden access for HIV-related complaints to be brought before the African Court.

ii. Ensuring a strong focus on protection of the rights of people living with HIV and key populations in the development of the current strategic planning document entitled Catalytic Actions to end AIDS, TB and Malaria by 2030, to be considered at the AU 2016 Summit.

Other ideas I thought we should maybe think about which are a bit more specific include:

- Should develop the appropriate framework or guidelines to monitor the implementation of the Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV services (Resolution 260) at the national level.
7.2.5 Recommendations for Member States

- Should take appropriate steps to repeal laws that may further fuel discrimination in the context of HIV
- Should adopt laws and policies as well as develop guidelines on HIV and human rights with a view to addressing HIV-related stigma
- Should take measures to audit relevant laws and policies that may have implications of the enjoyment of human rights in the context of HIV
- Should increase allocation to the health sector in general and HIV services in particular as agreed in the Abuja Declaration
- Should adopt integrated and holistic approach to HIV prevention by linking family planning services to HIV care and support programmes
BIBLIOGRAPHY

Books, chapters in books and articles in academic journals


Mather, Colin D, Boerma Ties and Ma Fat Doris ‘Global and regional causes of death’ (2009) 92 British Medical Bulletin 27


Parra-Vera, Oscar ‘The protection of the right to health through individual petitions before the inter-American system of human rights’ in E Durojaye (ed) Litigating the right to health in Africa: Challenges and prospects (2015) 243-274
December 2016


**African Commission documents**


African Commission “275: Resolution on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity” (2014)


African Commission General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14.2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted during the 55th Ordinary Session of the African Commission on Human and Peoples’ Rights held 28 April- 12 May 2014


The Special Rapporteur on Prisons Conditions of Detention and Policing in Africa (Special Rapporteur on Prisons) is one of the oldest mechanisms and was established under article 45 of the African Charter by the African Commission. The Special Rapporteur on Prisons is empowered to examine the situation of persons deprived of their liberty in countries which are a party to the African Charter. [http://www.achpr.org/mechanisms/prisons-and-conditions-of-detention/](http://www.achpr.org/mechanisms/prisons-and-conditions-of-detention/) (accessed 15 June 2016).

The Special Rapporteur on Refugees carries out its mandate by seeking, receiving, examining and acting on the situation of refugees, asylum seekers, migrants and internally displaced persons. This is done through undertaking studies, research, fact-finding missions, assisting Member States of the African Union, cooperating and engaging in dialogue with relevant stakeholders, and raising awareness on the situation of its mandated population.


Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health A/64/272 (10 August 2009)


AFRICAN UNION DOCUMENTS


December 2016

Communication 241/01, Purohit and Moore v The Gambia.

Communication 313/05, Kenneth Good v Republic of Botswana where do you find it


Communication 155/96, Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v Nigeria


Communication 227/99, Democratic Republic of Congo / Burundi, Rwanda, Uganda.

CASE LAW AT THE SUB-REGIONAL LEVEL

East African Court of Justice

Anyang’ Nyongo and others v Attorney General of Kenya and Others, Reference No 1 of 2006, 27 November 2006


Katabazi and 21 Others v Secretary General of the East African Community and Another (Ref. No. 1 of 2007) [2007] EACJ 3 (1 November 2007)

CASE LAW AT THE REGIONAL LEVEL OUTSIDE AFRICA

D v United Kingdom, the European Court of Human Rights ECHR 2 May 1997 2/


AFRICAN COMMITTEE OF EXPERT ON THE RIGHTS OF THE CHILD (ACERWC) DOCUMENTS


Committee on the Rights on the Child General Comments No. 3 on HIV/AIDS and the rights of the child 17 March 2003;

African Committee of Experts on the Rights and Welfare of the Child (ACERWC)’s Communications


Documents at the National Level

Constitutions

Constitution of Lesotho (1993)
Constitution of Namibia (1998)
Constitution of South Africa (1996)

Case Law at the National Level

Botswana

Tapela and Another Court of Appeal Civil Case No. CACGB-096-14 (2015).

S v Marapo 2002 (2) BLR 26 (2002). (BwCA 2002)

Ramantele v Mmusi and Others CACGB-104-12 (2013)

Kenya

Ochieng and Others v Attorney General Petition 409 of 2009 (2012)

R v Non-Governmental Organisations Co-ordination Board and Another, Ex-Parte Transgender Education and Advocacy and Others JR Miscellaneous Application No. 308A of 2013 (23 July 2014).

Lesotho
December 2016

*Masupha v Senior Resident Magistrate of the Subordinate Court of Berea (Mr. Kolobe) and Others (CIV) 29/2013 (2014).*

**Malawi**

*Banda v Lekha [2005] MWIRC 44*  
*Republic v Cidreck 1995 MLR 695 (High Court of Malawi 1994).*

*Kingaize and Another v Attorney General 2009/HL/86 (27 May 2010)*

*Nanditume v Minister of Defence NLLP 2002 (2) 242 NLC*  
*C v Minister of Correctional Services [1997] JOL 407 (T)*

*S v Mwanza Police, Mwanza District Hospital, Ministries of Justice, Internal Affairs, Health, Attorney-General and Ex parte: HB, JM (o.b.o 9 others)*

**Ghana,**

The High Court in *Akrofi v Akrofi [1965] GLR*

**Namibia**

*Namibia v LM and Others Case No SA 49/2012 (3 November 2014).*

**Nigeria**

*Ahamefule v Imperial Medical Centre 2012 Suit No. ID/16272000*  
*Odafe and Others v Attorney-General and Others (2004) AHRLR 205 (2004).*

**South Africa**

*De Vos v Talk Radio 702 [2006] JOL 16828 (BATSA)*  
*Dudley Lee v Minister of Correctional Services, [2012] ZACC 30*  
*Hoffmann v South African Airways 2001(1) SA 1 (CC)*  
*Minister of Health and Others v Treatment Action Campaign and Others 2002 (5) SA 717 (CC)*  
*Mazibuko v Minister of Correctional Services and Others 2007 JOL 18957 (2005)*

*NM and Others v Smith and Others 2007 (5) SA 250 (CC)*  
*Venter v Nel 1997 (4) SA 1014 (SAHC D).*

**Tanzania**
December 2016


Zambia


Zimbabwe

Thebe v Mbewe t/a Checkpoint Laboratory Services 2000 JOL 7142 (ZS
Supreme Court
Mudzuru and Another v The Minister of Justice Legal Parliamentary Affairs, CCZ 12-15

OTHER DOCUMENTS


HEARD. *National Response to Disability and HIV in Eastern and Southern Africa* (2009)


Southern Africa Litigation Centre “SALC Litigation Manual Series: Equal Rights for All: Litigating Cases of HIV-related Discrimination” (September 2011),


UNAIDS National Commitments and Policies Instruments Reports available at www.unaids.org


UN Doc CRC/GC/2003/3; General Comment No. 4 on Adolescence health and development in the context of the convention on the rights of the child 1 July 2003; UN Doc CRC/GC/2003/4


Appendix 1

Suggestions for inclusion of guidelines for state reporting on rights in the context of HIV, AIDS and TB; PLHIV and key populations at higher risk of HIV exposure

1. **General description of socio-economic rights**: States to include information on HIV, AIDS and TB in their country and basic programmes and institutions to promote the right to health in the context of HIV and TB. Specific information should be provided for key populations, including gay men and other men who have sex with men, sex workers, transgender persons, people who use drugs, prisoners and young people.

2. **Specific questions relating to the right to work for people with HIV and TB**: States to include information on laws, regulations, agreements and court decisions protecting and promoting the rights of people living with HIV and TB to do the work of their choice, to be free from discrimination in access to work, to protection from arbitrary termination of employment; to safe and healthy working conditions that protect from the risk of HIV and TB infection; to equality of opportunity for promotion for people with HIV and TB.

3. **Specific questions relating to the right to social security for people with HIV and TB**: States to provide information on laws, regulations, agreements and court decisions relating to social assistance for PLHIV, people with TB and affected populations, including the provision of medical schemes, cash sickness benefits, family benefits for HIV and TB.

4. **Specific questions relating to the family for people with HIV and TB**: States to provide information on laws, regulations, agreements and court decisions (1) protecting the rights of PLHIV to marry and prohibiting pre-marriage HIV testing and (ii) prohibiting child marriage in order to protect the rights of adolescents from harmful norms that place them at risk of HIV exposure.

5. **Specific questions relating to maternity protection for women living with HIV**: States to promote information on laws, regulations, policies, programmes and court decisions promoting the health rights of pregnant women living with HIV and TB, including the right to access to sexual and reproductive health and rights without discrimination, the right to treatment for prevention of mother-to-child transmission and the right to be protected from coercive and forced treatment, such as forced and coerced sterilisation.

6. **Specific questions relating to the rights of children and young people**: States to provide specific information on laws, regulations, policies, programmes and court decisions protecting and promoting the rights of children and young people to HIV and TB health care services, including access to appropriate services without discrimination, age of consent laws facilitating access to sexual and reproductive health services for young people and special measures for the protection of the health rights of vulnerable children and adolescents including OVC and young key populations.

7. **Specific questions relating to the right to physical and mental health**: States to provide information on relevant laws, regulations, policies and programmes as well as relevant court decisions that promote and safeguard the rights of PLHIV and key populations to access HIV and TB health care services, including access to appropriate services without discrimination, age of consent laws facilitating access to sexual and reproductive health services for young people and special measures for the protection of the health rights of vulnerable children and adolescents including OVC and young key populations.