HIV/AIDS & Human Rights in Southern Africa

2009

About ARASA

Who are we?

Established in 2002, the AIDS and Rights Alliance for Southern Africa (ARASA) is a regional partnership of non-governmental organisations (NGOs) working together to promote a human rights approach to HIV/AIDS in Southern Africa. It is constituted in the form of a trust and all partner organisations are members of the trust. Three steering committees, comprising trust members, act as advisory boards for the three ARASA programme areas: training and awareness raising, regional treatment literacy and advocacy and lobbying.

What do we do?

- Advocacy and Lobbying;
- Training and Awareness Raising; and
- Capacity building for access to HIV/AIDS & TB treatment and prevention.

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

ARASA's central operational strategy is to utilise the ARASA partnership to build and strengthen the capacity of civil society, with a particular focus on organisations of people living with HIV and AIDS (PLHIV), to effectively advocate for a human rights approach to HIV/AIDS and TB in Southern Africa.

Vision

A Southern Africa in which human rights are at the centre of all responses to HIV/AIDS and TB and in which the rights of PLHIV are respected and protected and socio-economic rights – the denial of which fuels the epidemic – are respected, protected and fulfilled.

Mission

To promote a human rights approach to HIV/AIDS and TB in Southern Africa through capacity building and advocacy.

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Credits

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About the Report

Aim

The Report is a guide to HIV/AIDS and human rights in the Southern African region. It seeks to:

- Describe the extent to which SADC countries have used and implemented selected guidelines from the International Guidelines on HIV/AIDS and Human Rights
- Describe good legal, policy and human rights practices in relation to HIV and AIDS
- Outline key human rights challenges facing PLHIV in the SADC region.

Background

In 2006, on the tenth anniversary of the Joint United Nations Programme on HIV/AIDS (UNAIDS)' International Guidelines on HIV/AIDS and Human Rights, ARASA conducted research to evaluate the extent to which the International Guidelines were being used and implemented in the SADC region. That Report, referred to as the '2006 Report', examined SADC countries' response to HIV/AIDS in all key areas recommended by the International Guidelines, to determine the existence of:

- Structures and Partnerships to support a multi-sectoral response to the epidemic
- A Legal and Policy Framework to protect and promote the rights of people infected and affected by HIV/AIDS and
- An enabling environment for people vulnerable to HIV and AIDS.

This Report is an updated version of the 2006 Report. It explores the key human rights developments in the region since the publication of the last report in April of 2007. Key differences between this and the previous report are the following:

- The 2009 Report compares regional progress not only in terms of the International Guidelines on HIV/AIDS and Human Rights, but also in terms of the new Model Law on HIV/AIDS adopted by the SADC Plenary Assembly in November 2008.
- The 2009 Report has a narrower focus and deals with the two priority areas of concern for SADC countries highlighted in previous years, namely laws and policies that protect rights of PLHIV to equality and non-discrimination and those that promote access to health care.

Overview of the 2009 Report

The first chapter describes the context for the report, including the most current statistics on HIV prevalence in the region. It explains the human rights context and the gains that have been made in protecting the human rights of people infected and affected by

HIV/AIDS. It also contains a section on the International Guidelines on HIV/AIDS and Human Rights and the regional human rights response.

Chapter Two evaluates the steps taken to create a protective legal and policy framework on HIV, AIDS and human rights. It focuses on areas where the most legal reform has taken place, namely anti-discrimination laws and the criminal law. It also includes a section on enforcement measures. The chapter concludes with a discussion of the key human rights issues in the region.

Chapter Three reviews the progress made by states towards creating laws, policies and programmes to promote universal access to health care. It examines recent developments towards developing HIV-specific public health laws, regulating HIV testing, providing ARVs and programmes for the prevention of mother-to-child transmission (PMTCT). As with Chapter Two, this chapter also concludes with a discussion of the key human rights issues around access to health care.

The final chapter sets out a number of broad conclusions that can be made on the extent to which SADC countries are reforming laws, policies and practices as required by international and regional standards. It summarises the key changes that have taken place in the last two years and concludes with an advocacy agenda for the next two years.

Methodology

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

- Questionnaires were distributed to NGOs working on HIV as a human rights issue in the SADC region, as well as all ARASA partners in the region. In total 111 questionnaires were distributed (see Table 1, below). A shorter and slightly modified questionnaire was developed and submitted to the government department responsible for HIV and AIDS in each SADC country.
- Key Informant Interviews, based on the same questionnaire, were held with ARASA partners at the ARASA Partnership Forum on the 18 – 19 November 2008. In total 12 partners participated in the interviews.
- A desk review of all literature and other material on HIV and human rights in SADC was conducted. Information was accessed from the internet, journals, NGO publications and newspapers. A large body of information was obtained from the 2008 Country Reports on the National Response to the UNGASS Declaration of Commitment on HIV/AIDS.

Table 1: No of questionnaires sent and returned in SADC

COUNTRY	NO OF QUESTIONNAIRES RETURNED / NO OF QUESTIONNAIRES SENT OUT		
	NGOs	ARASA Partners	Government
ANGOLA	0/2	0/1	0/1
BOTSWANA	1/6	1/1	0/1
DRC	1/9	1/1	0/1
LESOTHO	0/9	1/1	0/1
MADAGASCAR	0/3	0/1	0/1
MALAWI	0/13	½	0/1
MAURITIUS	0/1	1/1	0/1
MOZAMBIQUE	0/6	1/1	0/1
NAMIBIA	0/5	1/1	0/1
SOUTH AFRICA	0/6	1/1	0/1
SWAZILAND	0/6	0/1	0/1
TANZANIA	1/12	½	0/1
ZAMBIA	0/18	2/2	0/1
ZIMBABWE	0/15	½	0/1S

Strengths and Limitations

The 2009 Report was able to obtain more detailed information than previously in some respects, due to three factors:

- The narrower focus of the research, focusing on key aspects of law and policy where SADC countries have been seen to respond
- The increasing availability of information on law and policy in Southern Africa over the internet and through research reports
- The face-to-face interviews with staff in ARASA partner organisations.

However, the research was limited by a number of factors including the following:

- Time Frames: The questionnaires were sent out between July and August 2008 when many NGOs were preparing for and attending the International AIDS Conference in Mexico. This may have accounted for the poor response rate.
- Resources: The funding available for the project was limited and did not allow for country visits to source primary documents or to verify information;

- Language barriers: The English-speaking researchers found it difficult to obtain information from the French and Portuguese speaking countries, despite the questionnaire having been translated.
- Poor responses from other NGOs and from government: The difficulties in identifying, contacting and getting responses from other NGOs (non-ARASA partners), coupled with the poor response from government limited the depth of the research. Future updates of the Manual may have to focus on obtaining this information from ARASA partners.

Contents

Chapter One: Background to HIV/AIDS in SADC

"No disease in history has prompted a comparable mobilization of political, financial and human resources and no development challenge has led to such strong leadership and ownership by the communities and countries most heavily affected"[1]

"Let us not equivocate: a tragedy of unprecedented proportions is unfolding in Africa. AIDS in Africa today is claiming more lives than the sum total of all wars, famines, floods and the ravages of deadly diseases such as malaria. It is devastating families and communities, overwhelming and depleting health care services and robbing schools of both students and teachers … AIDS is clearly a disaster, effectively wiping out the development gains of the past decades and sabotaging the future."[2]

1.1 The HIV/AIDS Epidemic in SADC[3]

Sub-Saharan Africa continues to bear the global burden of HIV infection and AIDS deaths. Of the people living with HIV throughout the world, 67% live in sub-Saharan Africa and in 2007, 75% of all AIDS-related deaths occurred here. Southern Africa is worst hit: in 2007, 22 million men, women and children were living with HIV and 1.9 million were newly infected. Over one third of all those living with HIV live in SADC countries and 38% of all AIDS related deaths took place there.

Seven SADC countries have national prevalence rates above 15%, namely Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

Table 2: HIV Prevalence Rates in SADC countries

COUNTRY	ADULT % 15-49 yrs	ADULT No. 15 yrs +	WOMEN No. 15 yrs +	ADULT & CHILDREN No.
ANGOLA	2.1	180 000	110 000	190 000
BOTSWANA	23.9	280 000	170 000	300 000
DRC				

[1] UNAIDS, *2008 Global AIDS Epidemic Update*, p 13
[2] Nelson Mandela, 13th International AIDS Conference, Durban, 2000.
[3] UNAIDS *2008 Report on the Global AIDS Epidemic*.

LESOTHO	23.2	260 000	150 000	270 000
MADAGASCAR	0.1	13 000	3 400	14 000
MALAWI	11.9	840 000	490 000	930 000
MAURITIUS	1.7	13 000	3 800	13 000
MOZAMBIQUE	12.5	1 400 000	810 000	1 500 000
NAMIBIA	15.3	180 000	110 000	200 000
S.AFRICA	18.1	5 400 000	3 200 000	5 700 000
SWAZILAND	26.1	170 000	100 000	190 000
TANZANIA	6.2	1 300 000	760 000	1 400 000
ZAMBIA	15.2	980 000	560 000	1 100 000
ZIMBABWE	15.3	1 200 000	680 000	1 300 000

Source: UNAIDS *2008 Report on the Global AIDS Epidemic*.

1.1.1 Children

Ninety percent of children who die of AIDS related causes die in sub-Saharan Africa and in 2007, 270 000 children below the age of 15 years died of AIDS-related illnesses. Child HIV infections appear to be levelling off in the region, a function of the apparent stabilising of HIV infection in women and the increasing coverage of programmes to prevent mother-to-child transmission of HIV (PMTCT) for pregnant women living with HIV.

1.1.2 Women

Women continue to be disproportionately infected and affected in sub-Saharan Africa. Nearly 60% of all people living with HIV in this region are women. Young women between the ages of 15 – 24 years are more likely to be infected than their male peers.

1.2 Human Rights within the SADC Region

Discussions and debates about human rights in SADC in the past year have been dominated and over-shadowed by the renewed conflict in the Democratic Republic of Congo (DRC) and the brutal regime of Robert Mugabe in Zimbabwe. In the DRC, thousands have been killed, many women have been raped and sexually assaulted and 1.2 million Congolese have been displaced in North and South Kivu. The atrocities of political repression, which include torture and kidnapping of human rights activists in Zimbabwe, have recently been eclipsed by the humanitarian catastrophe, with the complete breakdown of the health system, food

insecurity amongst the majority of both the rural and urban population and over 60 000 people infected by cholera.

Many other countries, despite being relatively stable democracies, are plagued by on-going and deep patterns of human rights abuses, including violence against women, homophobia and violations of the rights of prisoners and other vulnerable groups.

The many competing human rights issues in SADC have both created opportunities to raise and address HIV-related human rights abuses and obscured the violations that continue to hinder efforts to expand access to prevention, treatment, care and support.

1.3 HIV/AIDS as a Human Rights Issue

The right to affordable treatment for HIV has dominated the agenda of human rights activists in Southern Africa for the past decade. A combination of international mobilisation of human rights organisations and grass roots movements, strategic litigation and high level advocacy focussed the world's attention on the preventable HIV-related deaths of men, women and children in some of the poorest countries in the world. The revision of Guideline 6 of the UNAIDS International Guidelines on HIV/AIDS and Human Rights in 2002 reflected the acceptance of access to treatment as a fundamental human right and spurred on local, regional and international action to expand access to life saving treatment.

At the United Nations High Level Meeting on AIDS in 2006, the world committed itself to achieving universal access to prevention, treatment, care and support by 2010. In the 2008 report assessing progress, UN agencies noted that substantial progress has been made, including "unprecedented scale up of treatment".[4] In 2007, a million more people, the majority living in poor countries, were able to access treatment. Progress has also been made in expanding access to vertical prevention programmes. In 2004, only 10% of pregnant women in low- and middle-income countries received antiretroviral drugs to prevent vertical HIV transmission. In 2007, this number had jumped to 33%.

Some of the most dramatic progress has taken place in Southern Africa. SADC countries reported increases in the numbers of people receiving medication, with 9 countries[5] reporting an increase of 10% or more by December 2007.

An increasingly vibrant and powerful HIV and human rights movement in the region has continued to press national governments and SADC to ensure that human rights remain a central concern of national responses to HIV/AIDS. A review of the legislation and policy in all fourteen SADC countries during January 2009 shows that all of them either had a law or national policy prohibiting unfair discrimination against people living with HIV or AIDS. In order to assist SADC countries to continue to develop effective legal frameworks to address

[4] UNAIDS *2008 Report on the Global AIDS Epidemic*, p5.
[5] Angola, Democratic Republic of Congo, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Tanzania and Zambia.

HIV and AIDS, the Southern African Parliamentary Forum (SADC) produced a model law on HIV and AIDS in 2008. The model law explicitly promotes a human rights and gender sensitive approach to HIV-related legislation and aims to 'ensure that the human rights of those vulnerable to HIV and people living with or affected by HIV are respected, protected and realised in the response to AIDS.'[6]

There is still, however, a need to be vigilant against actual and potential erosions of the gains that have been made. During research for this report, ARASA partners were asked to identify the key human rights issues that were facing them in the region. Of the 13 countries which responded to this question[7], the most significant issue raised was the limited access to anti-retrovirals (ARVs), particularly in rural areas. Despite the progress made in scaling up access to treatment, only two countries[8] are providing treatment to more than 70% of those in need, while five[9] have not yet been able to ensure treatment access to one quarter of those who require it.

Another key issue raised by ARASA partners is the continued existence of discriminatory laws and practices in SADC countries that hamper efforts to respond to HIV and AIDS. Around 46 % of ARASA partners surveyed cited the lack of access to condoms in prisons as a key issue. Since many SADC countries still have laws criminalising same sex relationships, service providers are unable to reach this population with prevention, treatment, care and support services. A further 30% of those surveyed reported various other forms of discrimination as the most significant issue facing them, citing examples such as HIV testing for purposes of discrimination amongst the military, as well as discrimination against marginalised groups.

The marginalisation of migrants and displaced people has always been an issue in Southern Africa, where war, conflict and poverty have forced people from their homes and communities in various countries over the years. The vulnerability of displaced populations was increasingly apparent in 2008 with the displacement of over a million people in the DRC due to conflict, the ongoing numbers of Zimbabweans fleeing their country to escape violence, hunger and cholera and the waves of xenophobic violence in South Africa forcing around 100 000 immigrants from their homes into makeshift camps. As a result, access to health care for migrant and mobile populations is re-emerging as a key issue of concern in the region.

This report suggests that harmful HIV-related behaviour seems to be a major preoccupation for legislators in SADC and shows a continuing trend to address these concerns in ways that undermine the human rights of people living with HIV. While the SADC model legislation does not contain provisions criminalising the transmission of HIV, model laws recently

[6] Section 1 (b) of the SADC model law on HIV/AIDS.
[7] No information was received from Angola.
[8] Botswana and Namibia.
[9] Democratic Republic of Congo, Madagascar, Mauritius, Mozambique, Zimbabwe.

developed by West African legislators that contain over-broad criminalisation provisions may have influenced some legislators in the SADC region.

Increasing concerns about the scale of deaths from AIDS, the slow uptake of Voluntary Testing and Counselling (VCT), the late enrolment of many people living with HIV in treatment programmes and the urgent need to expand access to treatment continue to lead to calls to reassess testing models. Although the predominant model of HIV testing in the region is still VCT, almost all SADC governments have introduced some form of routine offers of testing to pregnant women. In addition, new HIV-related legislation enacted by Tanzania, the DRC and Mozambique does not unequivocally affirm the right to confidentiality of HIV status and the laws are particularly ambivalent on the issue of partner notification.

As the statistics show earlier in this chapter, women in the SADC region bear the brunt of the epidemic. Over 40% of the countries surveyed for this report regarded rape and domestic violence as significant problems. While some progress has been made in developing legislation to protect women from gender-based violence, several countries have not developed adequate legal responses to violence against women. Even where laws do exist, implementation is inadequate and services are not available to support the survivors of gender-based violence. For example, although nine SADC countries now offer post-exposure prophylaxis (PEP) to survivors of sexual assault, NGOs report that women are often unable to access these services within the prescribed 72 hour time period. Despite more women than men being able to access treatment in the region, it is of grave concern that only 12% of pregnant women enrolling in PMTCT programmes were assessed for access to anti-retrovirals for their own health.[10]

Table 3: Key human rights issues as identified by ARASA partners surveyed in 2008[11]

COUNTRY	TB	DISCRIMINATION	LIMITED LEGAL PROTECTION FOR GENDER VIOLENCE	CONDOMS IN PRISON	TESTING SOLDIERS	ACCESS TO ARVS	CRIMINAL LAW & HIV
Botswana	X	X					
DRC			X				
Lesotho		X			X	X	

[10] WHO, *Towards Universal Access. Scaling Up Priority HIV/AIDS Interventions in the Health Sector. Progress Report 2008,* p 94

[11] Other issues identified by ARASA partners included discriminatory inheritance laws, lack of access to ARVs for prisoners, weak counselling services, lack of legal representation for PLHIVs and limited laws that preclude men from being able to rape their wives.

Madagascar							
Malawi				X	X	X	X
Mauritius		X					
Mozambique			X	X		X	
Namibia				X	X	X	X
South Africa	X			X		X	
Swaziland							
Tanzania		X		X		X	
Zambia							
Zimbabwe				X		X	

1.4 The International Guidelines on HIV/AIDS and Human Rights

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

The key points set out in the guidelines are:

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

In 2002, Guideline 6 of the International Guidelines was revised. The new version makes it clear that governments are under a duty to develop a legal and policy framework that promotes access to antiretroviral treatment through the public health services.

1.5 SADC Responses to HIV/AIDS

The Southern African Development Community (SADC) consists of 15 countries:

Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Seychelles, Tanzania, Zambia, Zimbabwe.[12] All SADC countries are members of the African Union.

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

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

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

- The Code on HIV/AIDS & Employment (1997), which aims to consolidate national employment codes on HIV/AIDS-related issues and sensitise employers to these issues;
- The SADC Health Protocol (1999), which specifically deals with HIV, AIDS and STIs and aims to promote prevention and management policies that work towards an inter-sectoral response to the epidemic;
- The SADC Declaration on HIV/AIDS (July 2003), which shows a commitment to address the epidemic through multi-sectoral intervention. The updated SADC HIV/AIDS Strategic Framework and Programme of Action (2003 – 2007) was also adopted recently;
- The Declaration of HIV/AIDS (2003) issued by the Council of Ministers of SADC at Maseru, which promotes multi-sectoral strategies to respond to HIV/AIDS; and
- The Protocol on Gender and Development (2008), which commits states to expand access to prevention, treatment and support for women who are infected and affected by HIV. It explicitly calls on states to make post-exposure prophylaxis (PEP) available to women after sexual assault.

These documents are important as they set a principled human rights framework within which countries ought to respond. The SADC Code on HIV/AIDS & Employment has been one of the most influential documents on HIV/AIDS and human rights in the region, leading

[12] http://www.sadc/int, accessed 11 March 2008.

to extensive legislative and policy changes within SADC countries. It remains to be seen whether the SADC model law on HIV and AIDS will have a similar impact, in the years ahead.

Chapter Two: Creating a Protective Environment

2.1 Introduction

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

- Laws and policies protect people infected and affected by HIV from discrimination;
- Laws and policies protect vulnerable people, in order to reduce their risk of HIV infection and to ensure they are not unfairly targeted in the response to HIV and AIDS; and
- Laws and policies set standards of appropriate conduct and sanctions if these standards are not met.

To meet this commitment states need to audit or review existing legislation and policies to ensure that they comply with human rights principles and achieve public health objectives of effectively managing the epidemic. This chapter of the Report reviews the progress made by governments in the SADC region towards these twin goals. It focuses on three key areas in which the most legal and policy reform has taken place, namely:

- Anti-discrimination laws;
- Criminal laws; and
- Enforcement measures.

2.2 International Guidelines on HIV/AIDS and Human Rights

The Report focuses on three guidelines relevant to developing a legal and policy framework that protects people infected with and affected by HIV/AIDS and prevents inappropriate responses to the epidemic. The three relevant guidelines are:

GUIDELINE 4: CRIMINAL LAWS AND CORRECTIONAL SYSTEMS

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

GUIDELINE 5: ANTI-DISCRIMINATION AND PROTECTIVE LAWS

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

GUIDELINE 11: MONITORING AND ENFORCEMENT MECHANISMS

States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related

human rights, including those of people living with HIV/AIDS, their families and communities.

2.3 Progress in Implementation

In all 14 of the SADC countries surveyed, steps have been taken towards developing a legal or policy framework to respond to HIV and AIDS.

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

International and Regional Standards

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

In 2008 SADC adopted a model law on HIV/AIDS. It proposes that SADC countries adopt a comprehensive HIV and AIDS Act aiming at:

- Providing a legal framework for the review and reform of HIV-related legislation so as to ensure that it is in conformity with international human rights standards;
- Promoting effective prevention, treatment, care and research strategies in relation to HIV and AIDS;
- Ensuring that the human rights of People Living with HIV or AIDS (PLHIV) are protected; and
- Stimulating the adoption of special measures to protect HIV-affected vulnerable or marginalised groups.

Discussion of Findings

A January 2009 review of fourteen[13] SADC countries showed that all of them had undertaken some form of law or policy reform with regard to HIV and human rights. Over 40% of countries had developed dedicated HIV legislation. A further 35% had reformed existing or new laws by inserting references to "HIV", "HIV status" or "health status". However three countries had established human rights principles in national policies only. None of the SADC countries had used disability legislation to protect PLHIV.

[13] Seychelles was not reviewed.

Table 4: Law and policy reform models

DEDICATED HIV LEGISLATION	HIV INTEGRATED INTO NEW / EXISTING LAWS	HIV POLICY PROTECTS HUMAN RIGHTS	DISABILITY LAWS USED TO PROTECT PLHIV
Angola	Botswana	Malawi	
DRC	Lesotho	Swaziland	
Madagascar	Namibia	Zambia	
Mauritius	South Africa		
Mozambique	Zimbabwe		
Tanzania			

Dedicated HIV and AIDS Law: Where countries have developed dedicated HIV and AIDS legislation, the HIV and AIDS law generally deals with a wide range of issues, reflecting a multi-sectoral response to HIV. This approach is to be supported for various reasons:

- It recognises that HIV is not simply a health issue;
- It makes laws around HIV and AIDS easily accessible, even for non-lawyers;
- It can be a speedy means of law reform as it does not require the amendment or development of a plethora of different statutes; and
- It is in keeping with the SADC model law which incorporates a broad range of HIV-related provisions (ranging from the provision of health care services through to the rights of research participants) in one piece of legislation.

Examples of Multi-Sectoral HIV and AIDS public health laws

Angola has passed the Law on HIV and AIDS, No. 8/04 which deals with:

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

In Mozambique, the Act on Defending the Rights and the Fight against the Stigmatisation and Discrimination of People Living with HIV and AIDS (2008) deals with amongst others:

- Rights;
- Children Living with HIV or AIDS;
- Confidentiality;

- Drug dependant individuals;
- Discrimination and abuse;
- Education;
- HIV testing;
- Research;
- Employment;
- Harmful HIV-related behaviour (voluntary transmission of HIV); and
- Offences and penalties.

In Tanzania the HIV and AIDS (Prevention and Control) Act No. 28 of 2008 provides for:

- Public education;
- Testing and counselling;
- Confidentiality;
- Health and support services;
- Stigma and discrimination;
- Rights and obligations of PLHIV;
- Establishment of a Research Committee;
- Monitoring and evaluation; and
- Offences and penalties.

There may be disadvantages to developing dedicated HIV and AIDS legislation, particularly in instances where the legislation is driven by the Ministry of Health:

- Where the process does not significantly involve other role players and the law does not regulate non-health issues, a multi-sectoral response to HIV and AIDS may be undermined. There may also be resistance from other ministries who see obligations being placed on them in legislation which their department has not developed.
- Adopting dedicated HIV legislation based on a model law without consideration for the local context or needs may result in the inappropriate application of such laws.
- Where HIV laws do not deal with a wide range of issues or the underlying causes of the rapid spread of HIV (such as gender inequality), this may lead to gaps in the national response.

In Angola, the Law on HIV and AIDS, No. 8/04 does not deal with children's rights, social security or measures to protect women.

Likewise the Mauritian HIV and AIDS Preventative Measures Act (2006) has limitations in the sense that it only deals with HIV testing, confidentiality, the transmission of HIV and syringe and needle exchange programmes.

Integration of HIV into other law: Other SADC countries have adopted a gradual approach to creating a protective legal and policy framework. This system has the advantage of often

resulting in a truly multi-sectoral response to the epidemic, with a range of government ministries having to take responsibility for legislating to respond to HIV and AIDS. Law reform is then not spear-headed by, or seen as the sole responsibility of the Ministry of Health. It also helps to ensure that law and policy deals with broader socio-economic issues relating to HIV and AIDS. However, this approach may result in limited law reform. For example in two of the SADC countries[14] that have adopted this approach, the only area of law that has been reformed in the criminal law.

South Africa is the best SADC country example of how this strategy has resulted in reform in various pieces of legislation by the Ministries of Justice and Constitutional Development, Social Development, Health and Labour.

In South Africa, the Department of Social Development recently integrated HIV-related clauses into the reform of childcare legislation. The new Children's Act[15] has HIV-specific provisions and provisions dealing with the "health status" of children. Section 13 provides that every child (a person under the age of 18 years) has the right to privacy regarding their "health status". The Act also deals with a child's right to confidentiality regarding their HIV status. Section 133 says that no person may disclose the fact that a child is HIV positive without consent, except in certain defined circumstances.

Using disability law: None of the countries surveyed have used disability legislation as a means of protecting PLHIV. In many developed countries, such as the USA and Canada, courts have accepted that HIV is a disability[16] and thus protected by disability legislation. However, even in South Africa where the Constitution protects disabled persons against unfair discrimination,[17] the Constitutional Court avoided making a finding that HIV was a disability in *Hoffmann v SAA*.[18] It is unclear why SADC countries have not adopted this approach but several reasons are suggested:

- The general trend in the region is to move towards dedicated HIV legislation;
- There may be a general lack of disability legislation in the region, making express HIV protections more appropriate; and
- Legislators may want to avoid the designation of HIV as a disability.

[14] Botswana and Lesotho.
[15] Act No. 38 of 2005. It should be noted that this Act has not as yet been fully operationalised.
[16] *Bragdon v Abbott* (1998) 524 US 624 and *Quebec (Commission des droits de la personne et des droits de la jeunesse) v Montreal (City)* 2000 SCC 27.
[17] Section 9, Constitution of the Republic of South Africa Act (1996).
[18] CCT 17/00

In *Hoffmann v SAA* the Appellant argued that he had been unfairly discriminated against on the ground of disability, in that South African Airways had denied him employment as a cabin attendant solely because of his HIV status. The court found that the discrimination was unfair. However, it did not state whether the finding of unfair discrimination was made on the basis of disability or on the basis of his HIV status.[19]

In the Mauritian legislation, the HIV and AIDS Preventive Measures Act (2006) expressly excludes HIV from the ambit of the term disability:

"Any person who is HIV positive or has AIDS shall not be considered as having a disability or incapacity by virtue of any enactment"[20]

National Policies and Plans on HIV and AIDS: In Malawi, Namibia, Swaziland and Zambia human rights principles are established in national policies rather than laws (although a draft law has been prepared in Malawi which Parliament hopes to pass during 2009). All SADC countries surveyed[21] had developed national plans to address the HIV epidemic. Almost 80% of them included references to human rights in their national plans. Only two countries[22] appear to make no reference at all to human rights in their plans.

Table 5: Existence of a national plan that recognises human rights

COUNTRY	NATIONAL PLAN	INCLUDES HUMAN RIGHTS
Angola	National Strategy Plan on HIV/AIDS 2007 – 2010	No reference
Botswana	National Strategic Framework for HIV/AIDS 2003 – 2009	Yes. Specific focus on improving the legal and ethical environment
DRC	National HIV/AIDS Strategic Framework 1999 – 2008	Yes
Lesotho	National HIV and AIDS Strategic Plan 2006 – 2011	Yes
Madagascar	No information	No information
Malawi	HIV/AIDS Action Framework 2005 – 2009	Yes. Human Rights is one of the guiding principles
Mauritius	National Strategic Framework 2007 – 2011	Yes. Emphasis on combating stigma and discrimination
Mozambique	National Strategic Plan (PEN II) 2005 – 2009	Yes. Reference to protecting the rights of people living with HIV/AIDS

[19] *Ibid.*
[20] Section 3, HIV and AIDS Preventative Measures Act (2006).
[21] No information was obtained on Madagascar.
[22] Angola and Swaziland.

Namibia	Medium Term Plan III	Yes. Focus on reducing stigma and discrimination
South Africa	National Strategic Plan 2007 – 2011	Yes. Human Rights and Access to Justice are a priority area in the plan
Swaziland	National Strategic Plan 2006 – 2008	No reference but reference to human rights in other policies
Tanzania	National Multi-sectoral Framework on HIV/AIDS 2008 – 2010	Yes. Focus on most at risk populations
Zambia	National HIV and AIDS Strategic Framework 2006 – 2010	Yes.
Zimbabwe	Zimbabwe National HIV/AIDS Strategic Plan 2006 – 2010	Yes. Focuses on specific vulnerable groups, women, children and sex workers

The inclusion of human rights in national policies and plans appears to be an inadequate approach, since these do not create legal obligations, nor do they provide for redress if human rights are abused. It is heartening to see that both Mozambique and Tanzania have moved from a policy to a legal framework within the last two years.

In Botswana, there is no legislation that prohibits pre-employment HIV testing, although the National Code of Practice on HIV/AIDS and Employment discourages pre-employment HIV testing of employees. [23] In the *Botswana Building Society* (BBS) matter an employee who had been hired as a security assistant was requested to undergo an HIV test. After testing HIV positive he was dismissed. Included with the termination letter was a copy of the HIV test results.[24] The Court of Appeal found that pre-employment testing was not unlawful in Botswana as the National Policy had "never been translated into law and (has) no statutory authority".[25]

However in a more recent case, the Industrial Court found that an employer had acted unfairly in dismissing an employee who voluntarily disclosed his HIV status. The employee was awarded 6 months pay as compensation. It remains to be seen whether the Appeal Court will confirm this decision and whether future cases will extend similar protection to job applicants, in the absence of specific laws prohibiting pre-employment testing.[26]

Conclusions

- Law reform is required in order to respond to the epidemic appropriately.
- The adoption of HIV and AIDS public health legislation appears to be an effective and expedient legislative strategy for ensuring a wide range of protections for PLHIV.
- Integrating HIV-related provisions into a range of different laws is also a successful legislative strategy, reflecting a commitment to multi-sectoralism, but may slow down the law reform process.

[23] *Op cit* note 45.
[24] www.bonela.org, accessed on 1 October 2006.
[25] BONELA Press release, 10 February 2004. www.bonela.org, accessed 9 November 2006.
[26] BONELA Press release, 8 August 2008. www.bonela.org, accessed 11 March 2009.

- Where human rights principles are not enshrined in law, they provide limited (if any) protection.

Recommendations

- Advocate for all SADC countries to develop law reform programmes, based on the result of a legal audit that examines:
    - existing relevant laws;
    - the nature of their enforcement;
    - the impact of the laws on the national response to HIV and AIDS (in particular, the access and uptake of HIV services and commodities by women, PLHIV and populations at risk); and
    - the need for law reform.
- Advocate for Swaziland, Zambia, Botswana and Lesotho to develop HIV and AIDS legislation that involves all key sectors and deals with a wide range of issues.

Table 6: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report recognised that some progress had been made in terms of creating laws and policies to deal with HIV and AIDS.	The 2009 Report recognises that there has been HIV-related law reform in all 14 SADC countries surveyed. Four more countries have adopted dedicated HIV and AIDS public health law since the last report[27] and these laws tend to deal with a broad range of issues.[28]
Recommendations: HIV and AIDS Law	The 2006 Report recommended that SADC countries adopt an integrated model of law reform.	This Report recommends continued law reform in SADC countries based on legal audits. It does not recommend a particular model of law reform.
Recommendations: Disability Legislation	The 2006 Report recommended research into why disability legislation was not being used as a model of law reform in SADC.	Given that disability legislation is clearly not a preferred model of law reform in SADC, this issue has been shelved.

[27] The countries are the DRC, Mauritius, Mozambique and Tanzania.
[28] See, for example, the legislation in Mozambique and Tanzania.

2.3.2 Reform of Criminal laws

International and Regional Standards

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

It is heartening to note that the final version of the SADC model law does not contain provisions on criminalisation of HIV transmission, largely as a result of strong lobbying on behalf of ARASA and other non-governmental organisations (NGOs) in the region.

Discussion of Findings:

In a review of the legislation in fourteen SADC countries in January 2009, it was found that further law reform in the field of criminal justice had occurred. Over 40% of SADC countries now have special legislation providing for a new offence dealing with harmful HIV-related behaviour. Six countries have introduced legislation requiring courts to impose harsher sentences on HIV positive rapists[29] and two have introduced legislation providing for HIV testing of all sexual offenders.[30] Legislation in a further four countries gave the courts the authority to order HIV testing in certain circumstances.[31]

Table 7: Use of criminal law in responding to HIV in SADC countries

COUNTRY	NO HIV-SPECIFIC CRIME	HIV-SPECIFIC CRIME	HARSHER SENTENCE FOR HIV+ OFFENDER	COMPULSORY HIV TESTING OF SEXUAL OFFENDER
Angola		X	No information	A judge may order testing
Botswana	X		X	X
DRC		X	X	
Lesotho	X		X	X
Madagascar		X	No information	
Malawi	X	Proposed law before parliament		
Mauritius	X			
Mozambique		X		A judge may order

[29] No information was obtained on the position in Angola, Madagascar and Zambia.
[30] No information was obtained on HIV testing within the criminal justice system in Zambia.
[31] These countries are Angola, Mozambique and South Africa.

				testing
Namibia	X	Calls for new legislation	X	
South Africa	X	Calls for new legislation	X	A judge may order testing
Swaziland	X			
Tanzania		X		A judge may order testing
Zambia	X	Calls for new legislation	No information	No information
Zimbabwe		X	X	

An HIV-Specific Crime: Since the last report, new legislation criminalising the deliberate transmission of HIV has been introduced in the DRC, Mozambique and Tanzania. There also remain strong calls for the introduction of legislation to criminalise HIV in Malawi, Namibia, South Africa and Zambia.

The reasons behind this preferred response are unclear since:

- All SADC countries have existing, broad common law or penal code crimes which could be used to prosecute persons who deliberately infect others with HIV;
- The SADC model law does not provide for any criminal offences; and
- In the last 12 months there has been an increase in advocacy for a human rights response to harmful HIV-related behaviour which does not use the criminal law. Initiatives such as the '*10 reasons why the criminalisation of HIV exposure or transmission is bad public policy*' by ARASA and the Open Society Initiative use strong public health and human rights arguments to show the futility of a criminal law response to HIV.[32]

10 Reasons why the criminalisation of HIV exposure or transmission is bad public policy

1. Applying the criminal law to HIV exposure or transmission does nothing to reduce the spread of HIV.
2. Applying criminal law to HIV risk behaviour can actually undermine HIV prevention efforts, not least by deterring people from seeking HIV testing.
3. Applying criminal law to HIV transmission promotes fear and stigma.
4. Instead of providing justice to women, applying criminal law to HIV transmission endangers and further oppresses them.

[32] http://health.osf.lt/downloads/news/001_10%20Reasons_Criminalization_draft%20for%20discussion.doc, accessed 28 January 2009.

5. Laws criminalising HIV exposure and transmission are drafted too broadly and often punish behaviour that is not blameworthy.
6. No matter how they are drafted, laws criminalising HIV exposure and transmission are often applied unfairly, selectively and ineffectively.
7. There are better ways to punish behaviour that truly is blameworthy.
8. Laws criminalising HIV exposure and transmission sidestep the real challenges of HIV prevention.
9. Rather than introducing laws criminalising HIV exposure and transmission, legislators must reform laws that stand in the way of HIV prevention and treatment.
10. Responses to HIV should be based on human rights, including sexual rights.

The 2006 Report posited that legislatures may have created HIV-specific crimes in order to confirm or clarify the existing legal position (such as in the case of Mozambique, where the new law creates a defence that narrows the scope of legal liability), or as a result of political pressure.

Article 52 of the Act on Defending Rights and the Fight against the Stigmatisation and Discrimination of People Living with HIV and AIDS (2008) in Mozambique provides:

"(i) Any person who, knowing his/her positive serological state, transmits HIV to another person, shall be punished with a prison term higher than two and up to eight years.

(2) It is not voluntary transmission when the carrier of HIV did not violate the right to care, or there is no significant risk of infection."

There are a number of examples of poor drafting in the new offences created by SADC countries. In most instances the vagueness of the terminology and the breadth of the provisions violate fundamental rights of PLHIV. In three SADC countries the criminal law is so broadly drafted it includes a wide range of negligent acts.

In the Angolan law No 8/04 the intentional transmission of HIV is a crime and is punishable in terms of section 353 of the Penal Code. Additionally, a person who, through negligence, inconsideration or failure to observe regulations, infects another, may also be punished under section 368 of the Penal Code.

In Article 53 of the Mozambique Act on Defending the Rights and the Fight against the Stigmatisation and Discrimination of People Living with HIV and AIDS (2008) it states:

"Any person who being a healthcare staff or not, voluntarily transmits HIV to a group of individuals, by any means different to sexual transmission, shall be punished with eight to twelve years of major prison"

Sentencing Provisions for Sexual Offenders with HIV: Various SADC countries now have provisions for minimum sentences for sexual offenders who are HIV positive.

Table 8: HIV status as an aggravating factor in the sentencing of sexual offenders

COUNTRY	SENTENCE (UNAWARE OF HIV STATUS)	SENTENCE (AWARE OF HIV STATUS)
Botswana	15 years	Life imprisonment with corporal punishment
DRC	Not applicable	Life imprisonment
Lesotho	10 years (first offender) Life imprisonment (repeat offender)	Death penalty
Namibia	Not applicable	15 years for first offenders, 45 years for repeat offenders
South Africa	Not applicable	Life imprisonment
Zimbabwe	Not applicable	20 years

In the South African case of *Nyalungu v State* the accused conceded under cross examination that he was aware of his HIV status at the time of the sexual offence. The court used the HIV-related sentencing laws to sentence him to life imprisonment[33].

Of concern, however, is the move in some countries towards introducing harsher sentences even where an offender is unaware of HIV status, as well as introducing a civil law standard of proof for knowledge of HIV status within a criminal trial. This is problematic as the burden of proof in the civil law is a "balance of probabilities" whilst the criminal law has the more exacting standard of "beyond a reasonable doubt". The civil law standard means that the prosecutor would simply have to show that it is more probable that an accused was aware of his HIV status than not.

The Botswana Penal Code (Amendment) Act (1998) provides in section 142(4)(b) that:

"it must be proved that on a balance of probabilities such person was aware of being Human Immune-system positive".

In Botswana there have been a number of cases in which the courts have found the HIV sentencing provisions to be constitutional, but have also made attempts to clarify the specific obligations on the state to prove that the offender was HIV positive at the time of the offence. The courts refused to simply accept the results of an HIV test showing that the offender to be HIV positive at the time of conviction.

In the case of case of *Qam Nqubi v The State*[34], the court held the accused's HIV status could not be regarded as an aggravating factor. There was no proof that the offender was HIV positive at the time that the rape was committed and this was held to be a precondition for the sentence of 15 years imprisonment.

[33] 2005 JOL 13254 (T).
[34] Criminal Appeal 49/2000.

In the case of *Makuto v the State*[35] the court held that the enhanced penalties for sexual offenders who were HIV positive would only be constitutional if they required the state to demonstrate that the offender had HIV at the time of the rape; nevertheless the court held that the person did not need to be aware of their HIV status at the time of the rape for the provisions to come into effect.[36]

HIV Testing of Sexual Offenders: Botswana and Lesotho have introduced legislation requiring a person convicted of a sexual offence to be tested for HIV. In Botswana the testing is post conviction[37] whilst in Lesotho the Sexual Offences Act requires a person accused of a sexual offence to undergo an HIV test within one week of being charged. Test results are then disclosed to the accused and the complainant and are reviewed by the court upon conviction of the accused for sentencing purposes.[38] In both countries convicted persons are liable for increased sentences even if they were unaware of their HIV status.

This approach appears to be inappropriate since the results of the HIV test cannot establish:

- Whether the offender was aware of their HIV status at the time of the offence; or
- Whether the offender intended to expose the complainant to, or infect the complainant with HIV.

This means in essence that offenders get harsher sentences simply for being HIV positive.

In Angola, Mozambique, South Africa and Tanzania there is no blanket HIV testing of all sexual offenders. However a judge may, in certain circumstances, order an offender to be tested for HIV. This approach is more reasonable, as it allows a court to consider all the facts before it and order compulsory testing in appropriate circumstances. In South Africa, the Sexual Offences Act places strict limits on when a court may order HIV testing for the purpose of disclosure to the offender and the survivor. An application for testing can only be made if there is a possibility that the survivor was exposed to HIV and no more than 90 days have lapsed since the date of the alleged offence. However in Angola, Mozambique and Tanzania the legislation does not detail the circumstances in which a court is competent to order HIV testing of offenders, leaving the provision open to abuse.

In Angola Law 8/04 prohibits compulsory HIV testing, but allows it in terms of criminal procedure, where authorised by a competent judicial authority.

Article 40 of the Mozambique Act on Defending the Rights and the Fight against the Stigmatisation and Discrimination of People Living with HIV and AIDS (2008) provides:

"(2) Depending on the circumstances of the case the judge or the prosecutor may, *ex officio*, order that the person who committed the crime be tested post-exposure for the diagnostic testing of HIV infection".

[35] [2000] 2 BLR 130 (CA).
[36] *Ibid* at para's 18 – 19.
[37] Section 142 Penal Code (Amendment) Act No. 5 of 1998.
[38] Section 30, Act No. 3 of 2003.

In South Africa the Criminal Law (Sexual Offences and Related Matters) Amendment Act provides in s 33:

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

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

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

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

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

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

(i) making informed personal decisions; or

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

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

In Tanzania the HIV and AIDS (Prevention and Control) Act No. 28 of 2008 provides in section 15(4)(a) that a court may order the testing of an individual.

Conclusions

- Despite the recommendations in the International Guidelines on HIV/AIDS and Human Rights, countries continue to develop a range of criminal provisions to respond to HIV and AIDS. Close to 50% of SADC countries have introduced legislation which creates specific offences for the wilful transmission of HIV and provides for harsher sentences for sexual offenders who are HIV positive at the time of the offence and HIV testing of a sexual offender.
- Many of these new criminal laws are poorly drafted and couched in broad language, lowering the standards of proof and widening the net of liability in a way that is legally unacceptable.
- There is some indication in Botswana that the courts have chosen to narrow the scope of the criminal law provisions, where appropriate. They have however held that HIV testing of sexual offenders is constitutional.

Recommendations

- Advocate for the use of public health law to respond to deliberate harmful HIV-related behaviour, rather than criminal law.

- In countries where new criminal laws have recently been enacted, advocate for their repeal.
- Alternatively, advocate for measures to ensure the appropriate use of such laws. Thus advocate for the development of prosecutorial guidelines on the application of the criminal law to HIV to promote appropriate use and avoid the selective use of criminal laws against marginalised groups
- Advocate for the repeal of laws which require all sexual offenders to be tested for HIV. Advocate further for law reform so that such testing may only take place on the basis of a court order, in a way that protects the rights of all parties and that facilitates access to PEP or other significant health decisions for the survivor of a sexual offence.
- Undertake research into the use of existing criminal laws on HIV and AIDS in SADC to determine the intention of the legislator in creating the various laws, the extent to which the laws are used, the application of the laws in practice, whether they are in fact achieving their intended goals and judicial attitudes towards the laws.

Table 9: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report found that many SADC countries had introduced criminal law measures to deal with HIV and AIDS.	The 2009 Report recognises that there is a continuing trend to develop criminal law measures to respond to HIV, with a worrying trend towards broader laws. Three more countries have HIV-specific crimes, two more require HIV testing of a sexual offender and the DRC has now also introduced harsher sentences for sexual offenders with HIV.
Recommendations: Discouraging Criminal Laws	The 2006 Report recommended advocacy to discourage criminal law (as opposed to public health law) measures to deal with harmful HIV-related behaviour and inappropriate compulsory HIV testing of sexual offenders.	The 2009 Report recognises the need for ongoing advocacy. However given the continuing trend towards the use of the criminal law and the fact that most laws are recent, it recommends both advocating for their repeal and alternatively for the adoption of guidelines on the appropriate use of such law. In the case of HIV testing laws it advocates for law reform to ensure that such testing is authorised by a judge and aims to serve a legitimate purpose such as enabling survivors to access PEP. Finally, research into the

		background, use and effectiveness of these laws, in order to inform future advocacy campaigns is recommended.
Recommendations: Developing Prosecutorial Guidelines	The 2006 Report recommended the development of prosecutorial guidelines to ensure the appropriate use of laws requiring HIV testing of a sexual offender.	The 2009 Report confirms this recommendation, given the continuing trend to pass new criminal laws to respond to HIV.

2.3.3 Reform of Anti-Discrimination Measures

International and Regional Standards

Guideline 5 requires states to enact or strengthen anti-discrimination laws to protect people infected and affected by HIV. In the implementation discussion under Guideline 5 it is recommended that governments do this by developing or revising general anti-discrimination laws to cover PLHIV.[39]

Within SADC, the Abuja Declaration on HIV/AIDS (2001) commits African nations to taking priority actions to fight HIV, AIDS, TB and other related infections. It prioritises human rights and recognises that "stigma, silence, denial and discrimination against people living with HIV/AIDS increases the impact of the epidemic"[40]

The SADC model law provides in section 17(2) that any direct or indirect discrimination against people living with or affected by HIV, based on actual or perceived HIV status, is prohibited.

Discussion of Findings

A review of the legislation and policy in fourteen SADC countries during January 2009[41] shows that all countries have either a law or national policy prohibiting unfair discrimination against PLHIV. In 50 % of these countries this protection was found within the law. Six SADC countries had HIV-specific anti-discrimination legislation, while one country protected PLHIV from discrimination through general equality legislation. The remaining 50 % of SADC countries protected PLHIV from discrimination through provisions in national policy, rather than law.

[39] UNAIDS *HIV/AIDS and Human Rights: International Guidelines* (1996). www.unaids, accessed 2 February 2009.
[40] www.un.org , accessed 7 September 2006.
[41] Angola, Botswana, DRC, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

Table 10: Equality laws prohibiting unfair discrimination on the basis of HIV status

HIV SPECIFIC LAW	GENERAL EQUALITY LAW	POLICY ONLY
Angola	South Africa	Botswana
DRC		Lesotho
Madagascar		Malawi
Mauritius		Namibia
Mozambique		Swaziland
Tanzania		Zambia
		Zimbabwe

In the area of HIV/AIDS and employment, SADC countries have adopted a wide range of laws and policies to manage HIV/AIDS and human rights in the workplace. Fourteen SADC countries had taken steps to protect the rights of employees with HIV and all but one of these countries had taken these steps through enactment of laws. Only in Malawi is there no law – there is a code of good practice on HIV and AIDS in the working environment.

Table 11: Best Practices in Employment Laws and Codes

COUNTRY	LAW / CODE REGULATING HIV, AIDS AND EMPLOYMENT
Angola	Law on HIV and AIDS (2004) prohibits unfair discrimination in the workplace. Employers are under a duty to educate and train workers on HIV/AIDS. A violation of these provisions makes the employer liable for a fine, 50% of which is paid to the National Programme to fight AIDS. Further details are contained within Order No. 43/03 (July 2003), the Regulations of HIV/AIDS in Employment and Professional Training.
Botswana	Public Service Act (2008) (not yet in operation) prohibits unfair discrimination on the basis of health status. Section 7(e) states "In making decisions in respect of the appointment, or other matters affecting human resource management, every appointing authority and every supervising officer shall…not discriminate against any employee on the basis of sex, race, tribe, place of origin, national extraction, social origin, colour, creed, political opinion, marital status, *health status*, disability, pregnancy or any other ground…" This only applies to public servants. The Directorate of Public Service Management has also published the Public Service Code of Conduct on HIV/AIDS and the Workplace (2001). This Code: • Sets out the rights and responsibilities of employers and employees • Places an obligation on management to create a non-discriminatory environment The Botswana National Code of Practice on HIV/AIDS and Employment sets out standards

	for an appropriate response to HIV within the workplace. It discourages pre-employment HIV testing.
DRC	Article 20 of the HIV/AIDS Law 08/011 prohibits any kind of discrimination or stigmatisation in the workplace or during vocational trainings against a person because of his/her status or presumed status, or that of his/her relatives' or spouse. Article 21 holds that the real or presumed status of a person or his/her spouse or relatives is not an acceptable reason to refuse employment or career advancement or advantages. It is also not an acceptable reason to terminate an employment contract. Compulsory HIV testing is prohibited during pre-employment or during routine medical examinations for work in terms of Article 22. Furthermore, Article 26 provides that employers and others who have access to an employee's medical records must keep the employee's status confidential.
Lesotho	The Public Service has a Public Service HIV and AIDS in the Workplace Policy. This prohibits unfair discrimination and mandatory HIV testing. The Labour Code (Amendment) Act, No. 5 of 2006, prohibits pre-employment HIV testing and HIV testing during employment, ensures confidentiality and non-disclosure and prohibits discrimination in employment. The Labour Code only applies to private employers and parastatals and does not apply to civil servants
Madagascar	Law No.2005-040 prohibits unfair discrimination in the workplace (Title III, Chapter IV, article 44-55). Article 44 provides that discrimination against a person living with HIV in the workplace is prohibited and Article 45 places an obligation on the employer to ensure that measures are taken against occupational exposure in the workplace. Prospective employees shall not be subjected to mandatory HIV tests in terms of Article 47 and HIV status is not a reason for refusing to employ a person in terms of Article 46.
Malawi	The Code of Conduct on HIV/AIDS and the Workplace acts as a guide to employers, trade unions and employees.
Mauritius	The HIV Preventative Measures Act (2006) prohibits pre-employment HIV testing as a condition of employment. Testing may also not be done as a pre-condition for workplace training or promotion.
Mozambique	Law No.5/2002 protects employees against discrimination in the workplace. It does not specifically mention HIV but is broad enough to cover HIV. The Act on Defending the Rights and the Fight against the Stigmatisation and Discrimination of People Living with HIV and AIDS (2008) provides in Article 41 that "A worker or work applicant living with HIV or AIDS is protected against any kind of discrimination, in terms of the Labour Act". Article 42 sets out the following workers' rights: • Non-discrimination regarding labour, training, promotion and career progression rights • Equal opportunities • Leave to receive medical care as per existing labour legislation
Namibia	The National Code on HIV/AIDS and Employment (2000) was promulgated in terms of section 112 of the Labour Act. The Code prohibits pre-employment HIV testing and unfair discrimination.

	In the new Labour Act, promulgated in 2008, HIV is listed as a specific prohibited ground of discrimination in access to or continued employment.
South Africa	Unfair discrimination due to an employee or job applicant's "HIV status" is prohibited by section 6 of the Employment Equity Act (1998). HIV testing without Labour Court authorisation is prohibited by section 7 of the Act. A Code of Good Practice on Key Aspects of HIV/AIDS and Employment is attached to the Act. It aims at giving guidance on creating a non-discriminatory environment and managing the impact of HIV and AIDS on the workplace.
Swaziland	Section 29 of the Employment Act (1980) says that employers may not discriminate in any employment contract. HIV is not referred to but it could fall under "social status".
Tanzania	The HIV and AIDS (Prevention and Control) Act (2008) provides in section 9 that every employer shall establish and co-ordinate a workplace programme. Section 15(1) states that a person shall not be compelled to undergo HIV testing. Section 30(c) states that a person shall not deny any person any employment opportunity due to their HIV status.
Zambia	The Employment Act Cap 268 and Industrial Relations Act Cap 269 protect workers against discriminatory practices. They are not HIV specific.
Zimbabwe	The Labour Relations Act, Part II, protects employees against discrimination. Although this does not mention HIV, regulations issued under the Act (Statutory Instrument 202 of 1998) prohibit discrimination based on HIV or AIDS in the workplace.

HIV-Specific Anti-Discrimination Laws: As seen above, legal protection against unfair discrimination exists in Angola, the DRC, Madagascar, Mauritius, Mozambique, South Africa and Tanzania. In all the countries mentioned, except for South Africa, these provisions are contained within dedicated HIV-related legislation.

Good Practice: Anti-Discrimination Laws

Angola has passed the Law on HIV and AIDS, which provides expressly that PLHIV are entitled to be protected from discrimination. It also expressly protects soldiers from pre-employment HIV testing.[42]

In the DRC Article 10 of the HIV/AIDS Law 08/11 protects PLHIV from stigmatisation in the public and private health care systems.

In Mauritius the HIV and AIDS Preventative Measures Act (2006) contains a number of provisions outlawing discriminatory testing. Section 6 states:

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

South Africa has passed the Promotion of Equality and Prevention of Unfair Discrimination Act (2000). This Act outlaws unfair discrimination.[43] Section 1 of the Act defines unfair discrimination as being when something

[42] Article 5, *op cit* note 21.
[43] Section 6, Act No. 4 of 2000.

imposes a burden on someone or denies them an opportunity. For example, the Act says that it is unfair discrimination to prevent women from inheriting property as this places economic and social burdens on women. Although the Act does not list "HIV status" as one of the grounds on which a person cannot discriminate, its provisions are broad enough to include this kind of discrimination.

While the adoption of HIV-specific anti-discrimination law is a sign of great progress, various limits to this approach have been noted:

- NGOs report that, although there are some signs of decreased discrimination, it is still a major issue facing PLHIV. For example, it was stated that in Lesotho discrimination has become more insidious - once employers become aware of an employee's HIV status they find other ways to discriminate against them.[44]
- Dedicated HIV anti-discrimination laws tend to focus only on discrimination based on HIV status or perceived HIV status. This means the laws often fail to recognise that people vulnerable to HIV may also be marginalised for other reasons (for example, because of being in a same-sex relationship). Without broader equality laws these PLHIV continue to face discrimination.
- Many laws are not broad enough in their scope (for example, labour laws protecting job applicants from pre-employment HIV testing do not extend to the military) or are limited by 'claw-back' clauses.

The Mauritian HIV and AIDS Preventative Measures Act (2006) is an example of legislation which is not wholly protective. It does not specifically prohibit unfair discrimination on the basis of a person's HIV status. However, it does provide that it is an offence to treat any other person "unfairly, unjustly or less favourably" [45] or to treat them with "hatred, ridicule or contempt" because they are or are perceived to be infected with HIV. This indirectly prohibits the discriminatory use of HIV status against PLHIV. This section is limited by the 'claw-back' clause in section 6(2) that states that the above shall not prevent the use of HIV testing as a requirement during an application for immigration, citizenship, defence or public safety.

Some of the unresolved, on-going discrimination issues in the region include the continuing testing and exclusion of HIV positive soldiers from the military, the discrimination and marginalisation of persons in same-sex relationships and the lack of legal rights and the low social status of women in terms of the law.

Constitutional protection: In countries which do not have comprehensive HIV-related anti-discrimination measures, litigants would have to rely on the constitution for protection. Whilst none of the constitutions in the SADC region expressly refer to HIV, it has been argued that in most instances the equality clause would be broad enough to outlaw HIV-related discrimination.

[44] Personal communication, Alfred Thotolo, Adventist Development and Relief Agency, Lesotho, 19 November 2008.
[45] Section 18(3).

In the Botswana case of *Attorney General v Dow*[46] the general principles were established regarding unlisted grounds of discrimination in the Botswana Constitution:

"I do not think that the framers of the Constitution intended to declare in 1966 that all potentially vulnerable groups or classes who would be affected for all time by discriminatory treatment have been identified and mentioned in the definition in section 15(3). I do not think that they intended to declare that the categories mentioned in that definition were forever closed. In the nature of things, as far-sighted people trying to look into the future, they would have contemplated that with the passage of time not only the groups or classes which had voiced concern at the time of writing the Constitution but other groups or classes needing protection would arise. The categories might grow or change. In that sense, the classes or groups itemized in the definition would be and in my opinion, are by way of example of what the framers of the Constitution thought worth mentioning as potentially some of the most likely areas of possible discrimination"[47].

Based on this passage the court in *Makuta v the State* held that a physical disability such as HIV would be protected by the equality clause.[48]

HIV-related Anti-Discrimination Policy: In Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe express prohibitions on unfair discrimination against PLHIV are contained only within policies.

The Swaziland national policy states:

" the HIV status of a person shall not be used as a reason for denying access to services, including education, health care or employment" [49].

It does not refer to any enforcement mechanisms.

HIV-related Employment Law: There are now protective employment laws in all SADC countries except Malawi. However, in Botswana the law only applies to civil servants and in Swaziland and Zambia the law is not HIV specific, although it has been argued that it is broad enough to protect HIV positive workers. A key concern remains the exclusion of the military from these protections in all countries except Angola.

In Botswana, BONELA has been using a variety of advocacy strategies to pressure the government to develop an HIV-related employment law. In 2007 they co-ordinated a petition of 13 000 signatures that was handed to the Minister of Labour and Home Affairs.[50]

[46] [1992] BLR 119.
[47] *Ibid.*
[48] *Op cit* note 28 at para. 6
[49] Government of Swaziland National Multisectoral HIV and AIDS Policy (2006).
[50] BONELA *Annual Report*, 2007. www.bonela.org/publication/annual_reports.html , accessed 2 February 2009.

Conclusions

- Significant progress has been made in ensuring legal protection for PLHIV within SADC, with 50% of countries having laws specifically prohibiting discrimination on the basis of HIV and AIDS.
- In countries with legal protection, this has generally taken place through provisions in a dedicated HIV law. However, HIV-specific anti-discrimination laws are, at times, limited in their scope and reach.
- All countries have taken steps to protect the rights of employees with HIV and AIDS through legislation, policies or codes.
- Despite the existence of HIV-specific laws, discrimination against PLHIV continues. For example, discrimination against soldiers with HIV continues to be an issue in some countries.
- Additionally, without broader laws protecting the rights of all vulnerable and marginalised groups, vulnerability to HIV will continue.

Recommendations

- Advocate for HIV-specific anti-discrimination legislation in the remaining 7 SADC countries.
- Advocate for the development of broad-based equality protection for all persons vulnerable to HIV and AIDS on a range of grounds such as race, gender, sex, pregnancy, marital status, disability, sexual orientation, religion, culture, language and birth. This law reform could be integrated into new HIV legislation, or alternatively could be developed as separate general equality and non-discrimination legislation.
- Advocate for all SADC countries to adopt employment legislation that protects employees, including the armed forces, from pre-employment HIV testing and discrimination.

Table 12: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report found that very few countries had introduced specific legislation to outlaw HIV-related unfair discrimination and most countries simply dealt with this issue through policy documents, despite this being an ineffective approach. In the workplace, however, much progress had been made and this was leading to reduced discrimination.	The 2009 Report recognises that there is an increase in anti-discrimination laws to protect PLHIV in Botswana, DRC, Lesotho, Mauritius, Mozambique and Tanzania.
Recommendations: HIV-Specific Anti-Discrimination	The 2006 Report recommended advocacy for HIV-specific anti-	The 2009 Report recognises the need for ongoing advocacy for HIV-

Law	discrimination laws in all SADC countries.	specific anti-discrimination law that fully protect the rights of PLHIV, as well as broader anti-discrimination provisions or laws.
Recommendations: HIV-Specific Employment Laws	The 2006 Report recommended the development of employment laws protecting employees with HIV from discrimination and prohibiting pre-employment HIV testing.	The 2009 Report confirms the need for ongoing advocacy for HIV-specific employment laws that cover all sectors, in Swaziland, Zambia and Botswana.

2.3.4 Enforcement mechanisms

International and Regional Standards

Guideline 11 deals with monitoring and enforcement mechanisms. It provides that states should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV and AIDS, their families and communities.

The SADC model law recommends two options for enforcement. Firstly, countries may establish an HIV tribunal made up of three advocates, two medical practitioners and two persons living with HIV or AIDS. This tribunal shall hear any matter relating to any disputes which arise out of the relevant HIV/AIDS act. Alternatively countries may grant jurisdiction to any high court.

Discussion of Findings

As of January 2009, of the 6 SADC countries[51] who have adopted HIV-specific legislation only one had adopted a dedicated HIV dispute resolution process. All six, however, gave the courts the power to impose fines and five of the six countries included fines and imprisonment as a possible punishment for infringing the rights of PLHIV.

Table 13: Enforcement mechanisms in HIV laws

COUNTRY	FINES	IMPRISONMENT
Angola	X	
DRC	X	X

[51] These countries are Angola, the DRC, Madagascar, Mauritius, Mozambique and Tanzania.

Madagascar	X	X
Mauritius	X	X
Mozambique	X	X
Tanzania	X	X

Dispute Resolution Mechanisms: In five of the countries surveyed the ordinary courts were given jurisdiction to hear contraventions of the legislation. The advantage to this approach is that it does not stigmatise PLHIV by creating a separate dispute resolution mechanism for them. However it does require the judiciary to be aware of HIV-related issues, such as the need for *in camera* proceedings, or the use of the plaintiff's initials only in the case title to protect the confidentiality of the PLHIV.

Chapter VII of the Madagascan Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2005) provides fines for discrimination against a person living with HIV,[52] the unlawful disclosure of a patient's HIV status[53] as well as the publication of misleading advertisements for medications, care, treatment and HIV preventative medications.[54]

In Tanzania, a special HIV dispute resolution process has been created. In terms of section 51 of the HIV and AIDS (Prevention and Control) Act No. 28 of 2008 any complaint about a contravention of the act may be lodged in writing with:

- The secretary of the village;
- A police station;
- The owner, manager or person in charge of the health facility; or
- An employer.

The advantage of this approach is that it extends access to justice, as all of the persons given the power to hear disputes are easily accessible. Additionally, in theory, having a separate HIV-specific dispute resolution mechanism ideally means that those involved have specialised skills to deal with HIV and AIDS-related complaints. However, the Tanzanian law does not specify that persons tasked with hearing complaints in terms of the Act are required to have specific HIV-related skills, nor does it set out how they are to deal with an HIV-related complaint. Further advocacy will be required to ensure that regulations are issued to regulate HIV-related disputes.

[52] Article 64.
[53] Article 65
[54] Article 66

Creation of Offences: The countries with dedicated HIV legislation all have HIV-related offences for persons who do not comply with the Act. This creates speedy enforcement mechanisms for PLHIV and ensures that they do not need to use the civil law (which can be costly and slow) to enforce their rights.

The Mauritian HIV and AIDS Act (2006) provides that any person who contravenes sections 4(1), 6(1), 7(1), 13(2) (3) or (4) or 14(2) has committed an offence and shall on conviction be liable for a fine not exceeding 50 000 rupees and to imprisonment for a term not exceeding 12 months.[55] A person who fails to safely dispose of used needles also commits an offence and may be liable for a fine not exceeding 100 000 rupees and to imprisonment not exceeding 5 years.[56] The Act also provides that it is an offence to treat any other person "unfairly, unjustly or less favourably" or to treat them with "hatred, ridicule or contempt" because they are or are perceived to be infected with HIV.[57]

Conclusions

- Where SADC countries have adopted an HIV-specific law, they have also created offences for failure to abide by the laws.
- In most cases, these offences are to be dealt with by the ordinary enforcement mechanisms used for resolving all other legal disputes – that is, the courts.

Recommendations

- Advocate for all SADC countries to create HIV laws and corresponding offences, ideally in the form of an HIV-specific law.
- Advocate for existing enforcement mechanisms (e.g. the courts) to hear HIV-related disputes and for training on HIV and human rights for the judiciary and law enforcement officers, so as to increase capacity to hear HIV-related disputes and to enforce HIV-related laws.
- Alternatively, advocate for HIV-related dispute mechanisms with clear policies, processes and skilled staff.
- Provide and advocate for the provision of legal services to PLHIV and members of vulnerable and marginalised groups in the form of legal aid, strategic litigation and community dispute resolution.
- Run 'Know your rights campaigns' that empower those affected by HIV to know their rights in the context of the epidemic and to know how to enforce their rights.

[55] Section 18(1).
[56] Section 18(2).
[57] Section 18(3).

Table 14: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report was unable to find much information regarding enforcement of HIV-related disputes.	The 2009 Report recognises that there is an increase in HIV-related offences and enforcement mechanisms, with the increase in HIV-related legislation. Only one SADC country, however, has created an HIV-specific dispute resolution mechanism.
Recommendations: Advocate for creation of HIV-related offences.		The 2009 Report recommends advocacy for countries to create HIV laws and corresponding offences.
Recommendations: Dispute Resolution Mechanisms		The 2009 Report recommends the use of existing enforcement mechanisms to deal with HIV-related disputes, but recognises that this will require judicial officers to be skilled in HIV, AIDS and the law. Accordingly, it recommends training for the judiciary and law enforcement officers. Where HIV specific enforcement mechanisms are created, it recommends the development of clear policies, processes and skills. It further advocates for the provision of legal services for PLHIV and "know your rights" campaigns.

2.4 On-going Human Rights Issues

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

2.4.1 HIV Testing and Discrimination in the Military

International and Regional Standards

Guideline 5 of the International Guidelines provides, in the commentary to the guideline, that anti-discrimination legislation should prohibit mandatory HIV testing of vulnerable groups such as those working in the military.

The United Nations Security Council unanimously passed Resolution 1308 which requires states to develop long term plans for AIDS education and prevention, voluntary counselling and testing and appropriate treatment for uniformed personnel.[58] This Resolution needs to be read with the HIV Testing Policy for Uniformed Peacekeepers[59], which strongly supports a policy of Voluntary Confidential Counselling and Testing (VCT) and states that:

"The UN does not require that individuals at any time be tested for HIV in relation to deployment as peacekeepers."[60]

Discussion of Findings

A January 2009 review of the legislation, policies and practises in ten SADC countries[61] shows that these principles are not being followed in practice. In almost 90% of the countries surveyed, HIV testing was taking place in the military and in four of these countries this practice was legally permissible because soldiers were excluded from protective employment laws.

Table 15: HIV testing within the Military

COUNTRY	NO PROHIBITION OF HIV TESTING	PROHIBITION OF HIV TESTING	MILITARY EXCLUDED FROM PROHIBITION	MILITARY TESTED FOR HIV IN PRACTICE
Angola		X		
Botswana	X			X
DRC		X		X
Lesotho		X	X	X
Madagascar		X		No info available
Malawi	X			No info available
Mauritius		X		X
Mozambique		X		X
Namibia		X	X	X
South Africa		X	X	X
Swaziland	X			No info available
Tanzania		X		No info available

[58] UNAIDS *On the Front Line*, 2005.
[59] Issued by the Office of Mission Support, Department of Peacekeeping Operations, January 2004.
[60] *Ibid.*
[61] Angola, Botswana, DRC, Lesotho, Mauritius, Mozambique, Namibia, South Africa, Zambia and Zimbabwe.

Zambia	X			X
Zimbabwe		X	X	X

The 2006 Report provided two primary justifications advanced for continuing with HIV testing within the military:

- The military needs to exclude HIV positive persons in order to ensure that their capacity to respond to security threats is not compromised; and
- Soldiers with HIV cannot meet fitness requirements.

Internationally, however, it has been accepted that pre-employment HIV testing does not, in practice, reduce the impact of HIV on a workplace – this is best served by managing HIV and AIDS in the working environment.[62] For example, despite the exclusionary approach to managing HIV within the Zambian military, the military continue to lose a large number of personnel to AIDS-related illnesses.[63] Furthermore HIV testing is not a good indicator of physical fitness.[64]

Litigation against HIV-related discrimination in the Military:

In the case of *Haindongo Nghipohamba Nanditume v Minister of Defence*,[65] the Namibian Defence Force argued that they were required by section 65(2) of the Defence Act[66] to submit all recruits to a medical examination. However the court found that an HIV test on its own could not establish whether a recruit was physically fit. HIV testing could only assist in the assessment of physical fitness if it was accompanied by a CD4 cell count and a viral load test. In this particular case the medical officer had certified that Nanditume was physically fit for military duties despite HIV status. Given this situation, the court held that the actions of the Namibian Defence Force constituted unfair discrimination as Nanditume had been excluded from the Defence Force solely on the basis of his HIV status.

In a number of cases, successful litigation strategies have not resulted in changes to HIV testing policies. For example, in Namibia, in the case of *Haindongo Nghipohamba Nanditume v Minister of Defence*[67] the Labour Court found that Nanditume had been unfairly discriminated against on the basis of his HIV status.[68] However, shortly after this matter was decided in favour of the litigant, the legislature introduced the Labour Amendment Bill to exclude section 107 of the Labour Act from applying to the military. This

[62] South African Law Reform Commission *Second Interim Report on Aspects of the Law Relating to AIDS: Pre-Employment HIV Testing*, 1998.
[63] UN Integrated Regional Information Networks *Give peacekeepers Antiretrovirals, new study urges*, 4 October 2006. www.allafrica.com/stories/printable/200610040567.html
[64] *Haindongo Nghipohamba Nanditume v Minister of Defence,* Case no. LC 24/98 (Namibia).
[65] *Ibid.*
[66] Act No. 44 of 1957.
[67] LC 24/98.
[68] Mchombu C, *HIV/AIDS and Human Rights in Namibia*, Centre for the Study of AIDS and Centre for Human Rights, University of Pretoria, Tshwane, South Africa, 2004.

effectively meant that no further litigation challenging HIV testing in the military is possible, as soldiers are no longer protected by the Labour Act.

In South Africa the AIDS Law Project (ALP), in *South African Security Forces Union and Others v Surgeon General and Other*,[69] obtained an order of the Pretoria High Court that the South African National Defence Force (SANDF)'s HIV policy constituted unconstitutional discrimination against HIV positive recruits and SANDF members. In terms of the order, the SANDF was required to immediately employ one of the individual applicants, immediately reconsider another applicant for foreign deployment and/or promotion and develop a new health classification policy within 6 months. In December 2008 the ALP reported that although the SANDF had developed a new draft policy, it had failed to re-employ the one applicant. Furthermore the ALP has evidence of the SANDF continuing with its unconstitutional HIV testing policy.[70]

Conclusions

- HIV testing and discrimination in the military continues to be a widespread practice within the SADC region and anti-discrimination laws often do not extend protection to the armed forces.
- Successful litigation does not always result in changes to discriminatory policies within the armed forces.

Recommendations

- Intensify advocacy against HIV testing in the military except in the context of VCT.
- Advocate for laws protecting employees from discriminatory HIV testing to extend to armed forces.

Table 16: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report found widespread HIV testing and discrimination against soldiers with HIV within SADC. It further found that many anti-discrimination laws excluded the military from their scope.	The 2009 Report recognises this as an ongoing issue of concern, with similar findings as in 2006. Significantly, the South African High Court has also ruled against such testing during this period.
Recommendations: Advocate for non-discrimination in the military	The 2006 Report recommended advocacy for legal protection for soldiers with HIV	The 2009 Report recognises that litigation alone does not necessarily result in changes to discriminatory policies and reinforces the call for advocacy for

[69] Case number 18683/07.
[70] www.alp.org.za [Accessed: 6 February 2009].

		legal protection from discrimination for soldiers or military recruits with HIV. It suggests that advocacy for extending existing anti-discrimination laws to cover the military may be useful.

2.4.2 Criminalisation of same-sex relationships

International and Regional Standards

Guideline 5 of the International Guidelines provides, in the commentary to the guideline, that laws should be enacted to reduce human rights violations against men having sex with men.

Discussion of Findings

In a review of the legislation in 14 SADC countries it was found that almost two-thirds of countries had laws that criminalised sex between men. The remaining five countries either had laws which protected men who had sex with men from unfair discrimination or the laws were silent on this issue.

Table 17: Criminalisation of sex between men in SADC Countries

COUNTRY	NO CRIME	COMMON LAW OFFENCE	CRIME IN PENAL CODE
Angola			X
Botswana			X
DRC			X
Lesotho	X		
Madagascar	X		
Malawi			X
Mauritius	X		
Mozambique			X
Namibia		X	
South Africa	X		
Swaziland	X		
Zambia			X
Tanzania			X
Zimbabwe			X

A number of negative consequences flow from the criminalisation of same-sex relationships:

- Service providers report that it is extremely difficult to openly provide services for people in same-sex relationships.
- State media messages on HIV and AIDS ignore same-sex issues.
- In most of the countries surveyed, men who have sex with men are publicly persecuted.
- In a number of countries political leaders have suggested that same-sex relationships are not part of African culture, making those in same-sex relationships an invisible group in society.
- The criminalisation of sex between men enables governments to deny condoms to prisoners on the basis that the sexual acts are unlawful.

Conclusions

- People involved in same-sex relationships and men who have sex with men remain a highly vulnerable group in SADC.
- This vulnerability is heightened by the continued criminalisation of same-sex relationships.
- The criminalisation of sex between men continues to act as a barrier to HIV prevention programmes (e.g. condom distribution) in prisons.

Recommendations

- Advocate for decriminalisation of laws prohibiting same sex relations.
- Advocate for the provision of HIV and AIDS health care services that are acceptable and accessible to people involved in same sex relations.
- Advocate for condom distribution in prisons.
- Advocate for social research into same-sex relationships in African societies.

Table 18: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report found that most countries had laws that criminalised sex between men and that this negatively impacted on condom distribution in prisons.	The 2009 Report recognises this as an ongoing issue of concern, with the criminalisation of same-sex relations impacting on access to health care and leading to discrimination in SADC.
Recommendations: Advocate for Decriminalisation	The 2006 Report recommended advocacy to decriminalise sex between men.	The 2009 Report also recommends decriminalisation of all same-sex laws impacting upon access to health care. It further recommends steps to increase

		access to health care for those in same-sex relationships in all sectors.

2.4.3 Inadequate legal protection for women from gender-based violence

International and Regional Standards

Guideline 5 of the International Guidelines provides, in the commentary to the guideline, that customary laws that affect the status and treatment of various groups of society should be reviewed. It further recommends that laws should be introduced to reduce the vulnerability of women to HIV, including the review of marriage, property, employment and economic opportunity laws that discriminate against women. Laws should expressly protect women against sexual violence.

Discussion of Findings

In a January 2009 review of the laws protecting women against violence in eleven SADC countries,[71] research showed that around two-thirds of SADC countries have legislation that protects women against gender-based violence – over 64% of countries had new rape laws, or domestic violence laws, or both. Another 2 countries were in the process of reviewing existing laws and introducing reforms.

Table19: Extent to which laws protect women from abuse in SADC

COUNTRY	LAW REFORMS
Angola	No information
Botswana	Domestic Violence Act (but does not prohibit marital rape)
DRC	Law criminalising sexual and gender violence
Lesotho	Sexual Offences Act provides for free medical attention to survivors of rape Married Persons Equality Act ensures equality between husband and wife
Madagascar	National policy document on reproductive health refers to combating the abuse of women, including sexual and domestic violence against women.
Malawi	Proposed law reform to the Wills and Inheritance Act.
Mauritius	Sex Discrimination Act

[71] No information was obtained on the position in Angola, Mozambique and Tanzania.

Mozambique	No information
Namibia	Combating of Rape Act Combating of Domestic Violence Act Married Persons Equality Act
South Africa	Choice on Termination of Pregnancy Act Domestic Violence Act Employment Equity Act Promotion of Equality and Prevention of Unfair Discrimination Act Criminal Law, Sexual Offences and Related Matters Amendment Act
Swaziland	Sexual Offences and Domestic Violence Bill
Tanzania	No information
Zambia	Penal Code prohibits marital rape
Zimbabwe	Termination of Pregnancy Act Draft Domestic Violence Bill

However, research indicates that despite an increasingly protective legal framework, women are still highly vulnerable to gender-based violence. Reasons for this may include:

- New laws may not yet be fully implemented or enforced;
- State provided services may lack the attendant resources to implement the necessary services;
- The legislation may not be comprehensive;
- The legislation may not yet have resulted in changes to women's socio-economic position, as well as changes in societal attitudes towards women;
- Dualistic legal systems which recognise discriminatory cultural laws and practices continue to exist; and
- Awareness of legal rights is low.[72]

According to the UN Special Rapporteur on Violence Against Women, who visited DRC in July 2007:

"Sexual violence has been a defining feature of the Congolese armed conflicts. Extreme levels of sexual violence, perpetrated by non-State armed groups, State security forces and civilians persist in those areas of Eastern Congo that are still experiencing hostilities. However, sexual violence is not restricted to zones of

[72] Personal communication, Martha Olotu and Cartas Kapela, Children and Education in Society, Tanzania, 18 November 2008.

armed conflict; it is rampant in the whole country"

"The normalization and banalisation of war-related rape is adding to the inequality and oppression women endure in public and private. The rape crisis associated with war, therefore, cannot be addressed in isolation from gender-based discrimination and violence women encounter in "peace". The war has further reduced women to mere objects that can be raped, tortured and mutilated. Without fundamentally altering gender relations and supporting women's empowerment, high levels of rape will persist, even if stability, the rule of law and democratic, civilian control over the armed forces are established." [73]

Conclusions

- There is legislation in a number of SADC countries protecting women against gender-based violence
- However, NGOs in the region continue to report high levels of gender-based violence.

Recommendations

- Conduct research into use of existing laws on gender-based violence in SADC, to determine failings of law.
- Advocate for adequate services and resources to accompany new law reform.
- Advocate for laws promoting gender equality.
- Advocate for review of customary and other laws that discriminate against women.
- Put in place programmes to empower women to know and enforce their rights and to address harmful and inequitable gender norms

Table 20: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report found that customary laws that place women at risk of HIV infection continue to be one of the greatest obstacles to gender equality in SADC. Additionally, it noted a lack of legal protection for women from gender-based violence.	The 2009 Report recognises that an increasing number of SADC countries have introduced protective laws for women against gender-based violence. However, violence against women continues to be a major concern.
Recommendations: Advocate for law reform	The 2006 Report recommended advocacy for law reform of customary laws that discriminate against women, as well as for the creation of laws to protect women from violence.	The 2009 Report recognises the continued need for advocacy around customary laws. It further recognises the need for broader advocacy for gender equality, in order to impact upon gender-based

[73] http://www2.ohchr.org/english/bodies/hrcouncil/docs/7session/A.HRC.7.6.Add.4.doc [Accessed: 10 February 009].

		violence.
Recommendations: **Implementation Issues**		The 2009 Report further recognises that, despite an increasingly protective legal framework around gender-based violence, violence against women continues. It therefore recommends research into the use and limits of existing laws, as well as resources to support implementation of laws and programmes to increase women's awareness of rights.

Chapter Three: Promoting Access to Health Care

3.1 Introduction

Prevention, treatment, care and support mutually reinforce each other and must be integrated to form a comprehensive response to HIV.

- Comprehensive treatment, care and support includes antiretrovirals (ARVs) and other medicines, diagnostics and related technologies for the care of HIV and opportunistic infections, good nutrition, social, spiritual and psychological support and family, community and home-based care.
- Prevention includes condoms, lubricant, sterile injection equipment, ARVs to prevent mother-to-child transmission of HIV (PMTCT) and occupational and non-occupational exposure to HIV.
- Based on human rights principles, states must progressively realise universal access to these goods, services and information.

This chapter reviews the progress made by SADC states to meet their obligations to create laws, policies and programmes that promote universal access to prevention, treatment, care and support, as set out in the International Guidelines on HIV/AIDS and Human Rights.

3.2 International Guidelines on HIV/AIDS and Human Rights

Guidelines 3 and 6 regulate the development and implementation of prevention, treatment, care and support programmes.

GUIDELINE 3: PUBLIC HEALTH LEGISLATION

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

GUIDELINE 6: REGULATION OF GOODS, SERVICES AND INFORMATION

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

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

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

The Preamble to the Southern African Development Community Parliamentary Forum (SADC)'s model law on HIV and AIDS promotes a rights-based and gender sensitive approach to law. One of the objectives of the model law is to promote the implementation of effective prevention, treatment, care and research strategies and programmes.

This chapter of the Report focuses on four key aspects of prevention, treatment, care and support:

- Whether states have reformed public health laws in a manner consistent with human rights, with a particular focus on HIV testing and confidentiality laws;
- Whether states have enacted national plans that include human rights;
- Progress made in ensuring universal access to treatment; and
- Progress made in rolling out PMTCT programmes.

3.3 Progress in Implementation

3.3.1 Reform of Public Health Laws

3.3.1.1 HIV-Specific Public Health Laws

International and Regional Standards

Guideline 3 requires states to develop public health legislation that addresses HIV and AIDS and that is consistent with human rights.

The SADC Model Law requires states to introduce legislation which addresses the following public health issues: education and information services, PMTCT, HIV prevention, epidemiological surveillance, HIV testing and counselling, the rights of PLHIV, treatment, care and support, research and clinical trials.

Discussion of Findings

Of the fourteen SADC countries surveyed in January 2009, 50% had introduced HIV-specific public health legislation. A further 42.8 % had existing public health legislation that was broad enough to use within the context of HIV and AIDS.

Table 21: Use of public health legislation to deal with HIV in SADC countries

HIV-SPECIFIC PUBLIC HEALTH LAW	GENERAL PUBLIC HEALTH LAW
Angola	Botswana
DRC	Lesotho

Madagascar	Malawi
Mauritius	Swaziland
Mozambique	Zambia
South Africa	Zimbabwe
Tanzania	Namibia

Rights-Based Public Health Legislation: Since the 2006 Report the DRC, Mauritius, Mozambique and Tanzania have all passed new public health legislation that purport to be based on human rights principles. They all however, to a greater or lesser extent, contain provisions that are problematic and potentially violate human rights principles. NGOs' advocacy efforts to remove offending provisions do however appear to have had some success – for example, in Mauritius some of the more coercive elements of the original draft bill were removed (such as provisions relating to criminalisation and to needle exchange programmes).

Good Practice: Public Health Laws

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

"(a) Guaranteeing the protection and integral promotion of the health of all people …

(b) Establishing the rights and duties of people infected by HIV or sick with AIDS".

The Mozambican Act on Defending Rights and the Fight against the Stigmatisation and Discrimination of People Living with HIV and AIDS (2008), Article 1, aims:

"…..to establish the rights and duties of the person living with HIV or AIDS, as well as to ensure the promotion of the necessary measures for the prevention, protection and treatment of such individuals."

The HIV and AIDS (Prevention and Control) Act No.28 of 2008 of Tanzania provides in its preamble that the act is to provide for the "prevention, treatment, care support and control of HIV and AIDS".

Outdated Public Health Legislation: In 8 of the SADC countries[74] the public health legislation is outdated and does not provide any protection for PLHIV. In Botswana, Lesotho and Malawi, draft public health acts have been prepared or are in the process of being developed. However, of concern is the fact that in Botswana relevant NGOs have been specifically excluded from this process.

In Lesotho the Public Health Order 1970 is used primarily by health inspectors at municipal level. It defines "communicable diseases" as "any disease which can be communicated directly or indirectly by any person suffering therefrom to any other person".

[74] These countries are; Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

In Botswana the Public Health Act dates back to 1971[75].

In South Africa, there are still regulations that make HIV a communicable disease and that specify a number of coercive measures that may be taken against PLHIV, such as isolation and detention. Although the regulations have not been used against PLHIV, they remain in existence[76].

Public Health Law and Harmful HIV-Related Behaviour: This report shows that harmful HIV-related behaviour appears to be a major issue for legislators in SADC and many countries have responded with criminal law measures to deal with it.

In Angola, Madagascar, Mozambique and Tanzania, provision is made in the public health law to address harmful HIV-related behaviour. For example, in the Angolan legislation it provides that PLHIV are under a duty to:

- Practice their sexuality responsibly;
- Adopt habits that limit the possibility of infecting others;
- Use condoms; and
- Disclose their HIV status to sexual partners[77]

The use of public health law rather than criminal law to deal with harmful HIV-related behaviour is to be supported.

However, public health provisions to address harmful HIV-related behaviour must strive towards creating a balance between public health and human rights. In some instances the attempts to describe the obligations of PLHIV are too broadly drafted and undermine efforts to encourage disclosure. For example in Tanzania, the HIV and AIDS (Prevention and Control) Act (2008) provides that a person who becomes aware they are HIV positive shall "immediately" inform their sexual partner of this fact and alert them to the risk of HIV infection[78]. This type of mandatory approach does not recognise the complexity of disclosing a person's HIV status and the processes that may need to be followed in order to reach a stage of acceptance and disclosure. Furthermore it fails to recognise the gender implications of disclosure, as in many instances it is women who are informed of their HIV status through PMTCT programmes and who experience gender-based violence on disclosure.

[75] Personal communication with Oratile Moseki, BONELA, 18 November 2008.
[76] In South Africa the Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, GNR 2438 of 1987, published in the Government Gazette No. 11014 of 30 October 1987 provide for coercive steps to be taken against PLHIV.
[77] Article 14, Law on Human Immunodeficiency Virus and the Acquired Immune Deficiency Syndrome, Law No. 8/04.
[78] Section 21(1).

Conclusions

- Half of the SADC countries have adopted HIV-specific public health legislation and all but one of these laws explicitly include some protection of the rights of PLHIV. This shows a new trend towards developing laws to deal directly with HIV and AIDS.
- Much of this legislation however also contain provisions which undermine the human rights of PLHIV and which are likely to encourage practices that violate their rights.
- In countries where law reform has not taken place, the existing public health legislation appears to be inadequate to address HIV and AIDS issues.
- Recent public health laws also contain principles which place emphasis on the responsibilities of PLHIV to prevent harmful HIV-related behaviour, thus placing the focus for responsibility for prevention on PLHIV rather than on the need for everyone to assume responsibility for protecting themselves.

Recommendations

- Advocate for continued law reform to develop HIV-specific public health laws that adequately protect the rights of PLHIV in all SADC countries.
- Where laws that contain harmful provisions have already been adopted, advocacy to remove these provisions must be undertaken. Advocacy strategies may include litigation, where appropriate and public education to raise awareness of the impact of these provisions, both in terms of public health and the rights of individuals.
- Continue to encourage the use of public health law (as opposed to criminal law) to respond to harmful HIV-related behaviour.

Table 22: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report found that SADC countries had begun to develop HIV-specific public health laws. Many of the new laws were based on human rights principles, although often also included provisions to deal with harmful HIV-related behaviour.	The 2009 Report recognises that there has been further progress in developing HIV-related public health legislation ostensibly based on human rights principles within the region. This has resulted in new laws being passed in the DRC, Mauritius, Mozambique and Tanzania. However, despite their attempts to promote human rights, most still contain provisions that in fact undermine them. Advocacy should focus on law reform to delete harmful provisions. Law reform processes have been

		put in place in Botswana, Lesotho and Malawi. Advocacy should focus on ensuring that these laws do not contain provisions that undermine human rights.
Recommendations: Advocate for law reform	The 2006 Report recommended advocacy for the development of laws to promote a rights-based response to HIV and AIDS and for the use of public health law (as opposed to criminal law) to deal with harmful HIV-related behaviour.	The 2009 Report recognises the continued need for repeal of outdated laws and to advocate for HIV-specific public health laws in countries where this is needed.

3.3.1.2 HIV Testing

International and Regional Standards

Guideline 3 requires states to ensure that public health legislation is consistent with human rights. Commentary on the guideline refers specifically to HIV testing and recommends that HIV testing should only be conducted with the 'specific informed' consent of the individual tested. Exceptions to voluntary testing should only be permitted with judicial authorization.[79] The guidelines also recognise the gravity of having an HIV test and recommend that it should be accompanied by pre- and post-test counselling.

The SADC model law on HIV supports these recommendations, stating that HIV testing should be voluntary, anonymous and confidential.

Both the guidelines and the SADC model legislation recommend the regulation of HIV testing. The model law specifically recommends that all facilities providing HIV testing be required to register with relevant authorities. There is clear consensus internationally, regionally and locally about the urgent need to scale up access to HIV testing but the question of how to do this has been the subject of heated debate. As treatment has become more available in resource-constrained settings, some medical and public health officials have argued that the scale of the epidemic in high prevalence regions such as southern and eastern Africa requires a more aggressive response, in which certain human rights protections should be suspended or restricted for the benefit of the greater good. These officials have pitted a 'rights-based' approach against a 'public health' approach. However, good public health and human rights practices generally go hand-in-hand: The right to make a decision based on informed consent is not only protected by human rights law, but is also crucial from a public health perspective, as it enables people to act on the knowledge they

[79] UNAIDS *International Guidelines on HIV/AIDS and Human Rights* 2006 Consolidated Version. http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf accessed on 29 January 2009.

obtain through the test; confidentiality, another aspect of the right to health and privacy, is also crucial for maintaining public trust in the health care system[80].

The scale up of testing has proved challenging in many SADC countries and there remains a need to be vigilant that human rights protections are not lost or undermined in attempts to increase access.

Discussion of Findings

In a January 2009 review of the situation in 14 SADC countries, all of the countries surveyed had regulated the provision of HIV testing. Over 50% had done this through legislation and the remaining six countries had done so through HIV policies.

Table 23: Existence of testing policies in SADC

COUNTRY	HIV TESTING LAW	HIV TESTING POLICY	HIV TESTING CASES
Angola	X*		
Botswana		National HIV Testing Guidelines are still pending	X
DRC	X		
Lesotho		X	
Madagascar	X		
Malawi		X	
Mauritius	X		
Mozambique	X		
Namibia		X	X
South Africa	X	X	X
Tanzania	X		
Zambia		X	
Zimbabwe		X	

In the case of South Africa, there are no specific policies or laws that regulate HIV testing, but the Health Act (2003) contains provisions that regulate the provision of all medical procedures.

[80] ARASA & Human Rights Watch, *A Testing Challenge. The Experience of Lesotho's Universal HIV Counselling and Testing Campaign,* available at http://www.hrw.org/en/node/75974/section/1, accessed on 20 March 2009

The review further showed that over 85 % of SADC countries had laws or policies that promoted informed consent before HIV testing. Four countries had in fact passed laws containing specific provisions on HIV testing in the period following the last report.[81]

Table 24: Existence of VCT policies in SADC countries

COUNTRY	CONSTITUTIONAL PROTECTION FOR PRIVACY & FREEDOM	LAW / POLICY PROMOTING VCT	CASE LAW SUPPORTING VCT
Angola		X	
Botswana	X		X
DRC	X	X	
Lesotho	X	X	
Madagascar	X[82]	X	
Malawi	X	X	
Mauritius	X	X	
Mozambique	X	X	
Namibia	X	X	
South Africa	X	X	X
Swaziland	X		
Tanzania	X	X	
Zambia	X	X	
Zimbabwe	X	X	

Exceptions to VCT: Despite the laws and policies promoting VCT, there is an apparent move in the region towards the implementation of provider initiated testing and counselling programmes. This is in line with the WHO/UNAIDS Guidance on Provider Initiated HIV Testing and Counselling (2007),[83] which recommends that in generalized HIV epidemics, HIV testing and counselling should be recommended to all patients attending all health facilities, whether or not the patient has symptoms of HIV disease and regardless of the patient's reason for attending the health facility.

[81] DRC, Mauritius, Mozambique and Tanzania.
[82] In terms of Article 13 of the Madagascan constitution, no search may take place except in terms of law or a court order. It is not entirely clear whether this section applies to the person or only to property.
[83] http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf, accessed on 24 March 2009.

At least five SADC countries[84] currently use a provider initiated, opt-out HIV testing model to deliver HIV testing to pregnant women. For example, Zimbabwe's National Guidelines on Testing and Counselling promotes provider initiated, opt-out testing as part of an overall strategy to increase access to treatment for pregnant women, as does Swaziland.

Provider initiated, opt-out testing is also being provided in other health care settings not related to pregnancy, as is the case in Botswana. Opt-out provider initiated testing is currently used in all Botswana health facilities delivering HIV testing. While the provider initiated opt-out testing model provides for informed consent in theory, concerns have been expressed about whether patients are in fact able to offer informed consent in light of the lack of pre-test counselling. In many places, pre-test counselling is either not provided at all, is truncated into a pre-test information session, or is offered as part of a group information session. In addition to concerns about the potential lack of informed consent, opt-out testing also raises the possibility of coercive testing, as some patients may feel unable to decline an HIV test, should they not wish to be tested. Many may not be aware that they are entitled to refuse the test.

Lesotho has adopted another model of testing which also raises concerns about informed consent, confidentiality and the protection of other human rights. The Know Your Status campaign aims to offer an HIV test to everyone above the age of 12 years. The testing is intended to be voluntary and confidential and to be offered by trained community counsellors. The Lesotho government undertook to simultaneously expand access to treatment, care and support. Despite the stated commitment to human rights principles, ARASA and Human Rights Watch recently documented flaws in the model and in the process of testing, which may well undermine the human rights protections built into the campaign. Of particular concern was the lack of adequate training of community counsellors and consequently, their ability to deliver adequate pre-test counselling and to ensure that testing was conducted with informed consent. The report[85] also documented problems relating to confidentiality and the lack of clear linkages between testing and treatment.

Many SADC countries also recognise exceptions which permit some form of involuntary testing. For example, over 50% of countries allow HIV testing without consent on blood donations and tissue and organ donations. This is considered an appropriate method of testing blood and tissue. However, of deep concern is that a similar number of countries permit compulsory testing within the criminal justice system[86] and four countries[87] also allow health care workers some discretion in deciding whether to test patients involuntarily.

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[84] Botswana, Lesotho, Mauritius, Mozambique, Swaziland.

[85] *A Testing Challenge. The Experience of Lesotho's Universal HIV Counselling and Testing Campaign,* available at http://www.hrw.org/en/node/75974/section/1 accessed on 20 March 2009

[86] For more information on how HIV status influences sentencing, see Section 2.3.2 above.

[87] Angola, Malawi, Mozambique and Tanzania

Table 25: Exceptions to informed consent requirement in SADC countries

COUNTRY	TESTING BLOOD & OTHER DONATIONS	TESTING AT DISCRETION OF HCW	TESTING FOR CRIMINAL PROCEEDINGS	OTHER
Angola	X	X	X (Judge may order testing)	
Botswana*			X	
DRC*				
Lesotho*			X	
Madagascar	X			
Malawi		X		
Mauritius*	X			X
Mozambique	X	X	X (Judge may order testing)	
Namibia	X			
South Africa°	X		X (Judge may order testing)	X
Swaziland	X			
Tanzania	X	X	X (Judge may order testing)	X
Zambia*			No information	
Zimbabwe	X		X	

**No information was obtained for these countries.*

°*South Africa also does not have national testing guidelines but the Health Act regulates the provision of all medical services.*

The Tanzania Act promotes voluntary testing and contains a definition of informed consent which means the "voluntary agreement of a person to undergo or be subjected to a procedure based on full information, whether such agreement is written, conveyed verbally or indirectly expressed."[88]

Section 15(3) states that no-one may be compelled to have an HIV test, while section 15(7) makes it an offence for a health care worker to force someone to have an HIV test, or to test a person without their knowledge. The act also promotes the scaling up of VCT by placing an obligation on health facilities to offer voluntary HIV

[88] Section 3

testing and counselling to all pregnant women and their partners and to everyone who attends a health facility.

Testing without consent may however be conducted for sex offenders, where a court order permits testing and for an organ donor.

The Mozambique Act also prohibits any HIV testing for diagnosis that is carried out without informed consent.[89] The Act however also specifies that testing that is conducted because "the patient's clinical condition requires such a test exclusively for the treatment and care of the patient", may be conducted at the "consideration of the physician"[90]. The section suggests that doctors have a discretion to conduct HIV testing without consent, if, in their view, it is for the benefit of the patient.

Good Practice: the South African National Health Act

The Act states that a health service may not be provided to any patient without informed consent. The Act does make provision for circumstances when consent may be obtained from a third party, but these are limited. A health care worker may only administer a health service without consent where failure to do so may cause a serious risk to public health or to the health or life of the patient. The Act places an obligation on health care workers to take "all reasonable steps" to secure consent before administering any health service.

Conclusions

- Most SADC countries have developed laws and / or policies to regulate HIV testing in terms of which most testing should be conducted with voluntary, informed consent.
- However, in an attempt to make HIV testing more universally accessible, several countries in the region are placing great emphasis on the scale up of testing, potentially at the expense of human rights protections. Whilst it is desirable that more people have access to HIV testing services, there is a real risk that the requirement of informed consent may be compromised.
- Additionally, some HIV testing laws and policies are ambiguous and appear to allow for non-consensual HIV testing in certain circumstances.
- ARASA and Human Rights Watch documented a lack of linkages between HIV testing and treatment in Lesotho. Scale up of HIV testing must be accompanied by a simultaneous scale up of treatment and appropriate linkages between testing and treatment.
- The majority of SADC countries for which information is available, conduct HIV testing without consent on blood, organ and tissue products. This form of testing is appropriate and failure to obtain consent does not violate human rights.

Recommendations

- Continue to advocate for legal regulation of HIV testing with informed consent and pre- and post-test counselling.

[89] Article 25(1)(a)
[90] Ibid.

- Where provider initiated opt-out testing is provided, advocate for measures to limit human rights abuses, such as the provision of accessible information about the right to opt-out and adequate pre-test counselling to ensure that informed consent is obtained.
- Advocate for adequate training for health care workers and anyone who provides pre-test counselling and other HIV testing services. Ensure that training deals with informed consent, confidentiality and other human rights protections.
- Advocate to ensure that those delivering HIV testing are adequately supported and supervised and that effective mechanisms are put in place to ensure the quality of the service and to identify complaints and problems.
- Monitor the implementation of opt-out testing to ensure that the rights of those who are tested are not violated. Particular attention should be paid to the testing of pregnant women (who may be vulnerable to coercive testing) and their right not to be tested without their informed consent.
- Monitor implementation of all HIV testing to ensure that it is provided in a way that is consistent with human rights protections, accessible to vulnerable groups (such as women, children, migrant populations, people involved in same-sex relations) and facilitates access to treatment, care and support.
- Advocate for the establishment of accessible mechanisms for redress where testing is performed without informed consent or without respect for confidentiality.

Table 26: Comparing findings from 2006 – 2009

Conclusions	The 2006 Report found that HIV testing without consent continued to be a problem in the region, despite constitutional protection of the right to privacy and freedom of the person.	The 2009 Report recognises that there has been progress in developing protective HIV testing laws and policies that promote VCT. Tanzania, Mozambique and DRC have passed laws, Lesotho has developed a draft HIV law and Botswana has developed national guidelines on HIV testing. The 2009 Report notes the continued use of opt-out HIV testing models in PMTCT programmes and other HIV testing programmes in the region and noted concerns about the potential for human rights violations in this form of testing. The Report also noted the introduction of a universal community based testing model in Lesotho and noted flaws in the implementation of this model that could undermine human rights and

		public health.
Recommendations: Advocate for law reform	The 2006 Report recommended advocacy for the development of laws to eliminate discrimination associated with HIV testing, as well as constitutional litigation.	The 2009 Report recognises the continued need for advocacy to promote HIV testing only with informed consent. In particular, advocacy efforts should encourage Lesotho and Botswana to finalise their draft laws and policies to provide for informed consent.
Recommendations: Monitoring of Implementation		In light of the trend towards provider initiated testing and the introduction of universal testing programmes, the 2009 Report recommends the need for NGOs to monitor the appropriate implementation of policies. HIV testing should be accessible to all, including vulnerable groups and be implemented in a way that protects rights and promotes a continuum of care.

3.3.1.3 Confidentiality

International and Regional Standards

The commentary to Guideline 3 of the International Guidelines recommends that states ensure that strict rules govern the confidentiality of a patient's HIV status and specify those instances in which health care workers may inform sexual partners of a patient's HIV status.

The SADC Model Law similarly promotes confidentiality of HIV test results and HIV status. It states that HIV test results are confidential and should be communicated directly to the person concerned. The model law encourages disclosure to sexual parties and comprehensively defines the circumstances in which a third party, including a sexual partner, may be informed. Persons providing treatment, care and support may notify a third party if:

- The third party is at immediate risk of HIV transmission;
- The person with HIV fails to inform the third party of this risk, after receiving appropriate counselling; and

- The notifying party informs the person with HIV of the intention to notify the third party and also ensures that the person with HIV is not placed at risk of physical violence as a result of the disclosure[91].

Persons providing treatment, care and support may, in terms of the model law, also notify sexual partners where a person with HIV has died, or is unconscious and unlikely to regain consciousness or regain the ability to consent and there is a significant risk of HIV transmission.

In all circumstances, the notifying party has an obligation to provide follow-up care to both the person with HIV and the third party.

Discussion of Findings

The number of SADC countries that now explicitly protect the right to confidentiality has increased since 2006, with the DRC, Tanzania and Mozambique enacting legislation that at least partially protects confidentiality. A January 2009 review showed that around 60% of SADC countries had a constitutional right to privacy[92] and well over 80% of countries surveyed had a law or a policy on HIV and privacy.

Table 27: Confidentiality and disclosure laws and policies in SADC countries

COUNTRY	CONSTITUTION PROTECTS PRIVACY	LAW / POLICY ON CONFIDENTIALITY	PARTNER NOTIFICATION POLICY	REPORTS OF UNLAWFUL DISCLOSURE
Angola	No	X	Encourages voluntary disclosure, but allows disclosure without consent to protect the life of a third party	
Botswana	X	X	Policy of shared confidentiality with those who need to know	
DRC	X	X	Encourages voluntary disclosure but may disclose without consent	X
Lesotho*	X			
Madagascar		X	Encourages voluntary disclosure but may disclose without consent if there are "imperative and justifiable reasons related to the	

[91] The limitations on third party disclosure set out in the SADC model legislation are based on those contained in the International Guidelines.

[92] No information was obtained on Madagascar.

			health of the patient or the health of the community"	
Malawi	X	X	Beneficial disclosure to sexual partners allowed without consent after counselling	
Mauritius	No	X	X	X
Mozambique	X	X	May disclose to sexual partners without consent	
Namibia	X	X	Encouragement of voluntary disclosure. Health care worker may inform sexual partner in closely defined situations in line with International Guidelines	
South Africa	X	X	Encouragement of disclosure to sexual partners after counselling	
Swaziland	No	X	Encouragement of disclosure to sexual partners after counselling	
Tanzania	X	X	X	
Zambia	No			
Zimbabwe	No	X	Encouragement of voluntary disclosure	

°*No information available*

In the 2006 report, over half of the SADC countries surveyed regarded disclosure of HIV status without consent by health care workers as a problem. However, during research for this Report, only two countries identified it as a concern. While this suggests that the right to confidentiality has been strengthened, there remains a need to be vigilant, particular as the provisions of laws in some SADC countries regarding disclosure are broad.

Article 27 of the Mozambique legislation states that:

"A doctor performing the HIV serologic test, or any other healthcare professional aware of such testing, must not disclose the result to any other person beyond the tested individual or his/her spouse, or his/her parents or persons in charge of his/her education, in the case of a minor."

The act does not specify the circumstances under which disclosure to a spouse may take place and does not appear to explicitly require prior permission from the person who has been tested.

The Tanzania legislation has a similar provision (section 16 (2)(b)) which allows disclosure to a spouse or sexual partner without consent.

Conclusions

- There continues to be an increase in the number of countries that develop and promulgate laws and policies protecting the right to confidentiality.
- However, protection of the right to confidentiality is weak in a number of new HIV-specific laws.
- A number of new laws are making disclosure of HIV status mandatory by creating criminal offences for non-disclosure (even where steps have been taken to protect sexual partners).

Recommendations

- Advocate for laws and policies in line with the International Guidelines on HIV and Human Rights and the SADC model law that explicitly protect the right to confidentiality, that limit circumstances of disclosure without consent, that clearly specify circumstances in which disclosure is lawful (with an appropriate risk assessment process) and that create offences for breaches of confidentiality.
- Ensure that HCW are adequately trained about the rules and importance of confidentiality and the consequences of breaches.
- Advocate for the provision of accessible mechanisms for redress where rights to confidentiality are breached.

Table 28: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report found continued breaches of the right to confidentiality, despite constitutional protection for the right to privacy. Breaches of confidentiality acted as a barrier to access to health care services and led to potential violence against women with HIV.	The 2009 Report recognises that there has been progress in developing protective laws and policies on confidentiality. However, some contain weak protection and others provide for overly-broad circumstances in which disclosures may take place.
Recommendations: Advocate for law reform	The 2006 Report recommended advocacy for the development of laws to provide for confidentiality.	The 2009 Report recognises the continued need for advocacy to promote laws on confidentiality and disclosure in line with those set out in the SADC model law and the International Guidelines. The 2009 Report also recommends that health care workers receive training on the right to confidentiality and that mechanisms are created to address breaches of

		confidentiality.
Recommendations: Monitoring		The 2009 Report furthermore recommends monitoring of disclosure to 3rd parties in terms of the legal provisions in the DRC, Tanzania and Mozambique.

3.3.2 Regulation of HIV goods, services and information

International and Regional Standards

In 2002, Guideline 6 of the International Guidelines was amended to "reflect the human rights dimensions to HIV prevention, treatment, care and support"[93]. The Guideline creates detailed guidance on laws and policies required to provide widespread availability to all relevant health care services.

The commentary on Guideline 6 recommends that states "develop and implement national plans to progressively realise universal access to comprehensive treatment, care and support for all persons living with HIV"[94]. The Guidelines further emphasize the need for governments to act 'quickly and effectively' in this regard. Guideline 6 also recommends that states take positive steps to address factors that hinder access to treatment, especially for vulnerable groups such as rural populations, children, women as well as migrants, refugees and displaced populations, amongst others.

The SADC Model Law also contains provisions that address prevention, treatment, care and support and state that there is an obligation on the state to provide access to affordable, high quality antiretroviral therapy (ARV) to treat or prevent HIV and opportunistic infections. The model law recommends, amongst others, that:

- Post-exposure prophylaxis after rape and sexual assault be available to all rape survivors without delay;
- States provide access to HIV testing and PMTCT programmes to all pregnant women and that these programmes including psychosocial support, follow up services and nutritional support;
- States develop national plans for the realisation of universal access to treatment (and in particular, for access to treatment for children), care and support and ensure that people living with HIV and those who are part of vulnerable and marginalised groups are able to participate in the design and implementation of the plan;

[93] Page 4.
[94] Page 38.

- Children receive all protection that they are entitled to under the Convention of the Rights of the Child; and not be subjected to discrimination on the basis of their HIV status, or the HIV status of their caregiver; and
- Prisoners should not be subjected to compulsory HIV testing and should have access to information on prevention, treatment and care, as well as access to the means to prevent HIV transmission, including condoms, lubricant and clean injecting drug equipment.

The 2006 Report focused on findings in SADC relating to access to treatment (specifically, ARVs) and prevention programmes, due to the lack of detailed information regarding SADC laws and policies regulating HIV-related goods, services and information. Similarly, this Report looks at

- Whether states have developed national frameworks for universal access that include human rights;
- Whether progress has been made in increasing access to treatment; and
- Whether progress has been made in increasing access to prevention programmes.

3.2.2.1 Treatment: Access to antiretroviral therapy

Information available indicates that 11 SADC countries have national ARV policies and or plans in place to facilitate access to treatment. There was no information available for the remaining three countries.

Table 29: Right to health and antiretroviral access

COUNTRIES	CONSTITUTIONAL RIGHT TO HEALTH	NATIONAL ARV POLICY OR PLAN	ARV CRITERIA IN POLICY OR PLAN
Angola	X	No information	No information
Botswana	No clause	X	X
DRC	X	No information	No information
Lesotho	X	X	X
Madagascar	X	No information	No information
Malawi	X	X	X
Mauritius	No clause	X	No information
Mozambique	X	X	X
Namibia	Contained under 'Principles of State Policy' so not	X	X

	enforceable per se.		
South Africa	X	X	X
Swaziland	No clause	X	X
Tanzania	No information	X	No information
Zambia	No clause	X	X
Zimbabwe	No clause	X	No information

SADC countries have reported frequently dramatic increases in the numbers of people receiving medication, with 9 countries[95] reporting an increase of 10% or more by December 2007. The UNAIDS *2008 Report on the Global AIDS Epidemic* reports that "the number of people receiving antiretroviral drugs in low- and middle-income countries has increased 10-fold in only six years, reaching almost 3 million people by the end of 2007"'[96]. The report states that almost a million more people were receiving treatment at the end of 2007, than in 2006, with the greatest increases occurring in sub-Saharan Africa[97].

Table 30: Progress in increasing access to treatment

COUNTRY	NOs RECEIVING TREATMENT DEC 2005	NOs RECEIVING TREATMENT DEC 2007
Angola	2,500-3,500	11 549
Botswana	67,000-77,000	92 932
Democratic Republic of Congo	7,000-8,500	4 716
Lesotho	7,500-9,000	21 710
Madagascar[131A]	<200	138
Malawi	31,000-35,000	100 649
Mauritius	<200	1500
Mozambique	19,000-21,000	85 822
Namibia	27,000-31,000	52316

[95] Angola, Democratic Republic of Congo, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Tanzania and Zambia.
[96] UNAIDS *2008 Report on the Global AIDS Epidemic,* p 130. www.unaids.org, accessed 20 February 2009.
[97] WHO, UNAIDS and UNICEF 'Towards Universal Access: Scaling UP Priority HIV/AIDS Interventions in the Health Sector' *Progress Report 2008*, page 15.
[131A] UNAIDS estimates that by December 2005 there were 5,000 people requiring ARV treatment in Madagascar with 51 people actually receiving ARVs (treatment coverage1%).

South Africa	178,000-235,000	428 951
Swaziland	12,000-14,000	24 535
United Republic of Tanzania	20,000-23,000	135 696
Zambia	45,000-52,000	151 199
Zimbabwe	22,000-27,000	97 692

Source: WHO, *Progress on Global Access to HIV Antiretroviral Therapy – A report on "3 by 5" and Beyond*, 28 March 2006 and *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector: Progress Report, 2008*.

However, despite these increases, the overall picture remains bleak: only two SADC countries[98] are providing treatment to more than 70% of those in need, while 35%[99] have not yet been able to ensure treatment access to a quarter of all those who require it.

Table 31: Percentage of the treatment need that is being met

COUNTRY	ABOVE 75%	50 – 75%	BELOW 50%
Angola			25 %
Botswana	79 %		
DRC			17 %
Lesotho			26 %
Madagascar			4 %
Malawi			35 %
Mauritius			22 %
Mozambique			24 %
Namibia	88 %		
South Africa			28 %
Swaziland			42 %
Tanzania			31 %
Zambia			46 %
Zimbabwe			17 %

[98] Botswana and Namibia.
[99] Democratic Republic of Congo, Madagascar, Mauritius, Mozambique, Zimbabwe.

While access to treatment is improving overall, there are clearly barriers to access to treatment for vulnerable groups, including:

- Rural populations
- Children
- Mobile and migrant populations

In May 2008, South Africa experienced a wave of xenophobic violence, displacing around 100 000 people from their homes who were then forced to rely on civil society to provide for their basic needs, including health care. Conditions in many of the camps were appalling, with inadequate shelter, food and access to health care. These conditions clearly posed a threat to the health of the people living there, especially those living with HIV, some of whom were forced to interrupt their ARV treatment. In addition to the lack of facilities in the camps, displaced people also experienced difficulties in accessing health care at local clinics and hospitals. In a complaint made by civil society organisations to the United Nations High Commission on Refugees in October 2008, concerns were expressed about the treatment of displaced persons at clinics and other health facilities, citing examples of abuse of displaced people by health care workers and denial of treatment[100].

Migrant populations and foreigners in Botswana report limited, if any, access to health care services. The Botswana government is currently not providing antiretroviral medication to foreigners or refugees. Children of Botswanan men, born to unmarried foreign mothers are unable to access health care.

Similarly, Zimbabweans forced from their homes due to the political conflict, poverty and the health care crisis report difficulties accessing health care services.

Rural Populations: Access to health care for people living in rural areas has been a perennial problem. The UNAIDS *2008 Report on the Global AIDS Epidemic* identifies specific concerns about rural populations, indicating that most health care facilities providing ARV coverage are located in urban areas and therefore inaccessible to people living in rural areas. Research undertaken by the World Health Organisation in 2006 indicated that over 75% of doctors and 60% of nurses work in urban settings, leaving rural populations critically under-served.

In Angola**,** despite a significant increase in ARV coverage, civil society expressed grave concerns about access to treatment for rural areas. Many facilities offering treatment are located in provincial capital cities, leaving those living in rural areas with limited access. There are some provinces which have no health care facilities in rural areas that are able to provide ARVs. People have to travel long distances to get to facilities and there are long waits to see health care professionals[101].

Children: South Africa, Mozambique and Zimbabwe have all made significant progress in expanding access to treatment for children.

[100] Civil society complaint to the United Nations High Commissioner on Human Rights, calling for an investigation into to United Nations High Commission on Refugees, 13 October 2008, available at http://www.tac.org.za/community/files/file/xenophobia/complaint%20by%20WC%20CS%20re%20UNHCR%2013%20October%202008%20final%20vers.pdf, accessed on 16 March 2009

[101] Irin News, www.plusnew.org, accessed 16 March 2009.

Table 32: Progress in increasing access to treatment for children

COUNTRY	NOs RECEIVING TREATMENT DEC 2006	NOs RECEIVING TREATMENT DEC 2007
Angola		
Botswana		
DRC		
Lesotho		1 553
Madagascar		
Malawi	5 783	10 439
Mauritius		
Mozambique	3 443	6 320
Namibia		4 300
South Africa	23 369	32 080
Swaziland		
Tanzania	3 576	11 176
Zambia	7 200	11 602
Zimbabwe	4 3 64	10 000

Source: WHO, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector: progress report, 2008;* information also accessed from UNAIDS Country progress reports.

Lesotho developed a National Action Plan on Women, Girls and HIV/AIDS for 2007 – 2010. The plan promotes equitable access to treatment for women and girls.
Malawi has a range of policies and strategies that attempt to promote access to comprehensive treatment, care and support for children. These include the National Policy on Orphans and Other Vulnerable Children (2003), the draft National Community Home Based Care Guidelines (2005), the National Plan of Action on Orphans and Other Vulnerable Children (2004) and the Prevention of Mother to Child Transmission of HIV Strategy (2003). These policies prohibit discrimination against children in the provision of treatment, care and support and recognise that children encounter barriers in access to treatment.

Although progress has been made in scaling up treatment to children, with 198 000 children receiving ARVs at the end of 2007[102], the UNAIDS *2008 Report on the Global AIDS Epidemic* called for intensified action to expand access to treatment for children, recognising that children are significantly less likely to receive antiretroviral therapy.

[102] WHO, UNAIDS and UNICEF 'Towards Universal Access: Scaling UP Priority HIV/AIDS Interventions in the Health Sector' *Progress Report 2008*, p 98

In Angola, SCARJOV (a local NGO) has expressed concerns about the costs of children's medication. Paediatric formulations of ARVs are not always available and children have to make do with adult formulations on occasion.

Shortage of health care workers: The 2006 World Health Report found that there was a global shortage of 4.3 million doctors, nurses and midwives. Sub-Saharan Africa was critically under-resourced in this respect, needing at least a million more health care workers. The HIV epidemic has stretched already over-burdened health care systems and the lack of health care workers has a significant impact on the provision of antiretroviral treatment.

Table 33: Distribution of health care workers in SADC

COUNTRY	PHYSICIANS	DENSITY PER 1000	NURSES	DENSITY PER 1000	MIDWIVES	DENSITY PER 1000
Angola	881	0.08	13 135	1.15	492	0.04
Botswana	715	0.40	4 753	2.65		
DRC	5 827	0.11	28 789	0.53		
Lesotho	89	0.05	1 123	0.62		
Madagascar	5 201	0.29	5 661	0.32		
Malawi	266	0.02	7 264	0.59		
Mauritius	1 303	1.06	4 550	3.69	54	0.04
Mozambique	514	0.03	3 954	0.21	2 229	0.12
Namibia	598	0.3	6 145	3.06		
South Africa	34 829	0.77	184 459	4.08		
Swaziland	171	0.16	6 828	6.30		
Tanzania	822	0.02	13 292	0.37		
Zambia	1 264	0.12	19 014	1.74	2 996	0.27
Zimbabwe	2 086	0.16	9 357	0.72		

Source: WHO World Health Report, 2006

Lesotho has improved its ARV coverage but its progress is being hampered by huge shortages in healthcare personnel. There are just five doctors and 62 nurses per 100,000 inhabitants in Lesotho (neighbouring South Africa has 74 doctors and 393 nurses per 100,000 inhabitants). 13 Eighty per cent of doctors in Lesotho are visiting foreigners, mainly from other parts of Africa and awaiting certification to practice in South Africa. In its

2007-2008 annual report issued in February 2008, the MOHSW reported that only two of the 171 health centres in the country had the minimum staffing required.[103]

Conclusions

- Almost all SADC countries have developed national ARV plans.
- SADC states continue to make progress, with many more people accessing treatment than in 2006.
- However, targets for universal access to ARVs are still far from being met.
- Vulnerable populations (for example, rural populations, children and migrants) face difficulties accessing ARVs, even in countries where treatment access is improving.
- The lack of adequate and trained health care personnel is a key barrier to universal access to treatment, care and support.
- Distances to health facilities providing treatment are also impeding access to treatment, especially for rural populations.

Recommendations

- Continue to advocate for the roll-out of ARV programmes, with a particular focus on identifying barriers to accessing treatment and prioritising vulnerable populations with limited access to programmes.
- Advocate for policies that ensure that all procurement processes include specific provision for paediatric formulations of ARVs.
- Conduct further research to evaluate regulation and implementation of ARV programmes in Angola, DRC and Madagascar.
- Conduct further research to identify barriers to access for vulnerable populations (e.g. rural populations and children).
- Advocate for states to increase available resources to ensure adequate, skilled health care workers to manage ARV programmes.

Table 34: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report found that ARV targets were not being met and that access to ARVs was a key human rights issue in the region.	The 2009 Report recognises that there has been progress in access to ARVs, but that treatment targets are still unmet. In particular, it recognises that vulnerable groups (such as rural populations and

[103] MSF Activity Report 2007 at http://www.msf.org/source/actrep/2008/IAR-2008_complete.pdf accessed on 25 March 2009

		children) have limited access to ARVs.
Recommendations: Advocate for ARV rollout	The 2006 Report recommended advocacy for the roll-out of ARV programmes.	The 2009 Report recognises the continued need for advocacy around ARV roll-out, with a specific focus on vulnerable populations.
Recommendations: Advocate for Health Care Personnel		The 2009 Report furthermore recommends advocacy for increasing funding for adequate and skilled health care personnel.

3.2.2.2 Prevention

The SADC Model Law recommends the provision of comprehensive prevention services relating to HIV and AIDS. This report focuses on prevention programmes for pregnant women, children and prisoners.

Prevention of Mother to Child Transmission (PMTCT): All SADC countries now provide PMTCT programmes to prevent transmission of HIV from mother to child.

Table 35: HIV prevention programmes for women

COUNTRY	PMTCT IN 2006	PMTCT IN 2007
Angola		X
Botswana	X	X
DRC		X
Lesotho	X	X
Madagascar	X	X
Malawi	X	X
Mauritius	X	X
Mozambique	X	X
Namibia	X	X
South Africa	X	X
Swaziland	X	X
Tanzania		X

Zambia	X	X
Zimbabwe	X	X

Ideally, the World Health Organisation recommends that PMTCT programmes promote a comprehensive approach, including:

- Primary prevention of HIV;
- Prevention of unintended pregnancies amongst women;
- Prevention of HIV transmission from mother to child; and
- Provision of treatment, care and support for mothers with HIV, their children and families.

Good Practice: Ave Maria Maternity Hospital, Madagascar

The Counselling and Testing Centre at the Ave Maria Maternity Hospital in Antisrable is an example of a successful approach to mother to child prevention programmes. The centre has offered free, confidential and voluntary HIV testing to pregnant women since 2004 as part of a programme to address sexually transmitted illnesses in pregnant women. It has a dedicated team of health care workers, including a doctor, a co-ordinator, an adviser and two laboratory assistants.

Since its creation, the centre has tested more than 2600 people and it has developed a set of indicators to ensure that it maintains a high quality service. These include benchmarks on the number of women with sexually transmitted illnesses who undergo HIV testing, the number of women with sexual transmitted illnesses who bring their partners in for treatment and the number of women with sexually transmitted illnesses that discuss their illness with their partners.

There are also indicators to ensure the availability of laboratory services and a sufficient supply of drugs needed to treat all sexually transmitted infections.

Good Practice: PMTCT in Mozambique

In 2006 Mozambique integrated PMTCT programmes into existing maternal and child health services. The Ministry of Health introduced a range of new policies to support the programme. These have included provider initiated, opt-out testing in antenatal and maternal health settings, the introduction of combination therapy, conducting CD4 counts in ante natal and maternal health facilities (to reduce the number of facilities that women had to visit) and the introduction of support groups for pregnant women and mothers. In September 2007, a policy permitting maternal and child health nurses and health technicians to provide antiretroviral medication to pregnant women was introduced to further expand access.

Unfortunately, the existence of PMTCT programmes has not guaranteed universal access to all pregnant women with HIV. Only 60% of SADC countries are providing access to half the women who require access.

In 2007, 15% of all pregnant women with HIV in low- and middle-income countries lived in South Africa. Mozambique and Tanzania accounted for another 7% each, while Zambia and

Malawi each accounted for 5%.[104] In 2004, only 10% of all pregnant women received ARVs for PMTCT and the majority of these lived in developed countries. This number has increased significantly in 2007, with over one third of pregnant women living with HIV now able to access PMTCT services. The most dramatic increases took place in sub-Saharan Africa.[105] Despite this, access to PMTCT services remains inadequate in SADC, placing children at risk of HIV infection.

Table 36: Percentage of Pregnant Women with HIV accessing PMTCT

COUNTRY	PERCENTAGE IN 2007	MODE OF TESTING
Angola		
Botswana	89.9	Op out
DRC		
Lesotho	31.1	Opt out
Madagascar		
Malawi		
Mauritius	31.7	Opt out
Mozambique	29.8	Opt out
Namibia	49	
South Africa	66	VCT
Swaziland	52	Opt out
Tanzania	55	
Zambia	39.1	
Zimbabwe	67.4	

Although the information in Table 35 is incomplete, it does not suggest that opt-out testing for pregnant women is not necessarily associated with higher numbers of women accessing PMTCT. South Africa, which provides VCT, rather than opt out testing in the context of ante-natal care, reports that 66% of women are able to access PMTCT services, while Lesotho, which provides opt-out testing to pregnant women, only reports a figure of 31.1%.

[104] WHO, UNAIDS and UNICEF 'Towards Universal Access: Scaling UP Priority HIV/AIDS Interventions in the Health Sector' *Progress Report 2008*, p 80.
[105] WHO, UNAIDS and UNICEF 'Towards Universal Access: Scaling UP Priority HIV/AIDS Interventions in the Health Sector' *Progress Report 2008*, p 79

Concerns about the opt-out testing model have already been discussed in this chapter[106] and are particularly relevant for pregnant women. The inequality in the relationship between health care providers and patients may inhibit women from rejecting an HIV test when it is offered to them and the truncated form of pre-test counselling, which is a feature of provider initiated opt-out testing, undermines their ability to provide informed consent to the test. Research suggests that human rights violations in health care settings create significant barriers for women and impede access to services, including PMTCT services. Given the current low uptake of PMTCT programmes, there is a need to undertake more research to identify the barriers to access and strategies to remove them.

Prisoners: The criminalisation of sex between men continues to act as a barrier to providing HIV prevention programmes in prisons, with authorities refusing to provide condoms to inmates whilst men having sex with men remains illegal. Even where there is agreement on the distribution of condoms in prisons, in practice inmates are not able to access them easily.

Table 37: Access to Condoms within Prisons

COUNTRY	SEX BETWEEN MEN NOT UNLAWFUL	SEX BETWEEN MEN UNLAWFUL	CONDOM DISTRIBUTION IN PRISON
Angola	X		Yes
Botswana		X	No
DRC		X	No
Lesotho	X		No
Madagascar	X		Yes
Malawi		X	No
Mauritius	X		Yes, by NGOs
Mozambique		X	No
Namibia		X	No
South Africa	X		Yes
Swaziland	X		No information
Tanzania		X	No
Zambia		X	Yes, but not always available in practice

[106] See section 3.3.1.2, above.

Zimbabwe		X	Yes

Children: A January 2009 review of HIV testing policies in five SADC countries showed that in four of the countries surveyed, children under the age of 18 can access HIV testing in certain circumstances.[107]

Table 38: Laws relating to children and consent in SADC

COUNTRY	LAW PROVIDING CHILDREN WITH CAPACITY TO CONSENT	AGE OF CONSENT
Lesotho	X	12
Mauritius	X	Child must be of an age at which they demonstrate understanding of the nature of the test
Mozambique	X	16
South Africa	X	12 and must be able to understand the nature of the test
Tanzania		18

In a number of SADC countries that have adopted new HIV-related laws, children under the age of 18 are able to consent independently to HIV testing. However, difficulties remain, even where new HIV-related laws on capacity to consent have been developed:

- In some countries, older laws setting the age of consent at 18 years have not been specifically repealed by the new HIV-related legislation;
- In the DRC, the new law fails to provide an age of consent;
- In Tanzania, section 15(1) of the HIV and AIDS (Prevention and Control) Act (2008) provides for parental consent for HIV testing; and
- In Mauritius, the law provides that an adolescent may request an HIV test without the permission of a parent or legal guardian if the test is requested in writing and the medical practitioner assesses that he or she has the capacity to consent[108].

Requiring parental consent for HIV testing creates a number of barriers to adolescents accessing HIV prevention services, as many would not want their parents to know they were

[107] Information was only obtained on the situation in Lesotho, Mauritius, Mozambique, South Africa and Tanzania.
[108] Section 7(5) of the HIV and AIDS Act 31 of 2006

sexually active. Others may not have parents or legal guardians as they have been orphaned by the epidemic. Further barriers arise when services for youth are not "youth-friendly".

In Lesotho, the Know Your Status Campaign found that the HIV testing guidelines did not deal expressly with testing young adolescents. Counsellors were not trained on how to ensure that informed consent was appropriately obtained and that the special needs of children in post-test counselling were addressed.[109]

Conclusions

- All SADC countries have programmes in place to provide ARVs to pregnant women to reduce the risk of HIV transmission to infants.
- However, this has not translated into universal access for pregnant women with HIV.
- The provision of opt-out testing for pregnant women does not appear to be associated with higher numbers of pregnant women accessing HIV testing and PMTCT programmes.
- Prisoners in many SADC countries are denied access to condoms, due to the criminalisation of sex between men.
- Some SADC countries have passed new laws recognising the emerging autonomy of children and allowing them to consent independently to HIV testing without parental consent. However, there are difficulties with some of these laws.
- HIV testing services for children under the age of 18 years are not always "youth-friendly".

Recommendations

- Advocate for the continued expansion of PMTCT programmes, with a focus on identifying factors that act as barriers to access.
- Ensure that health care workers providing HIV-related services to pregnant women are adequately trained to protect the human rights of pregnant women, including informed consent and confidentiality during HIV testing.
- Monitor PMTCT programmes to identify human rights violations that may impede access to health care and HIV-related services.
- Advocate for decriminalisation of sex between men and for access to condoms in prisons.
- Advocate for continued law reform to provide for independent consent to HIV testing for children, as well as dedicated HIV testing and counselling guidelines for children.
- Undertake further research into children and the age of consent in SADC countries.

[109] ARASA and Human Rights Watch *A Testing Challenge: The experience of Lesotho's Universal HIV Counselling and Testing Campaign*, 2008.

Table 39: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report found that substantial work was needed to ensure that women and children benefited from prevention programmes.	The 2009 Report recognises that although some progress has been made in key areas, there are still ongoing difficulties. Access to PMTCT has expanded slower than access to treatment and although all SADC countries now have programmes, this has not necessarily translated into universal access for women. Condom distribution in prisons remains an issue of concern, as does access to appropriate HIV testing services for children.
Recommendations: Advocate for PMTCT rollout	The 2006 Report recommended advocacy for the roll-out of PMTCT programmes.	The 2009 Report recognises the continued need for advocacy around access to PMTCT. It recommends that advocacy be accompanied by monitoring and research to identify the nature, extent and barriers to access and to identify the impact of new opt-out HIV testing polices on pregnant women.
Recommendations: Advocacy for condoms in prisons	The 2006 Report advocated for decriminalisation of sex between men and condom distribution in prisons.	The 2009 Report recognises the need for continued advocacy in this regard.
Recommendations: Advocacy for children's law reform		The 2009 Report recommends advocacy for all SADC countries to lower the age of consent for children.

3.4 Ongoing Human Rights Issues

3.4.1 Access to VCT services and move towards routine testing

The slow uptake of HIV testing continues to pose challenges for the SADC region. In 2007, it was estimated that only 2 out of every 10 Africans knew their HIV status[110]. This means that large numbers of people living with HIV in the most affected region of the world are unaware of their status and will be unlikely to access treatment, care and support services when they need them most.

Table 40: Numbers of adults testing for HIV in the past 12 months

COUNTRY	% Men (15 – 49 yrs)	% Women (15 – 49 yrs)	% Adults (15 – 49 yrs)
Angola	4	7	5
Botswana			
DRC	4	4	4
Lesotho	5	6	6
Madagascar*	1	0	
Malawi°	11	11	
Mauritius°	2	2	
Mozambique	2	2	2
Namibia	18	29	23
South Africa°	90	90	90
Swaziland	9	22	16
Tanzania	36	36	
Zambia	12	19	15
Zimbabwe	7	7	7

Source: *2008 AIDS Epidemic Update*

* This is for the age group 15 – 24 years

° Methodology not harmonised with UNGASS 2008 reporting guidelines

The question about how to scale up HIV testing has been a vexed one and has been accompanied by debates about the continued value of the VCT model, often regarded as the

[110] See for example de Kock's presentation, 27 July 2007, IAS Conference, Sydney Australia. http://www.ias2007.org/PAG/ppt/TUSY201.ppt, accessed on 29 January 2009.

'gold standard' of HIV testing, since it unequivocally promotes informed consent and confidentiality of HIV test results, thereby reducing the risk of human rights violations associated with HIV testing. Provider initiated testing has frequently been raised as a strategy to deal with the slow uptake of VCT in various countries.

In May 2007, the World Health Organisation (WHO) issued updated guidance on HIV testing[111]. The guidance note re-affirms that all testing should be conducted voluntarily, with informed consent and explicitly rejects any form of mandatory testing. This approach is consistent with Guideline 3. The guidance note also supports the continued expansion of VCT services, but acknowledges the need for "additional, innovative and varied approaches"[112] and supports provider initiated, opt-out HIV testing. WHO recommends that health care workers offer HIV testing to:

- All adults and children who present to health facilities with symptoms that are suggestive of HIV infection;
- Infants born of mothers with HIV;
- Children presenting with suboptimal growth or malnutrition; and
- Men seeking circumcision as a prevention initiative.

The guidance also makes specific recommendations for countries with generalised epidemics[113]. Where an enabling environment and adequate resources are in place, WHO recommends that HIV testing is offered to all adults and adolescents in all health facilities. Where it is not possible to offer HIV testing to all patients, the guidance note recommends that the following services be prioritised:

- Medical in patient and out-patient clinics, including TB clinics;
- Antenatal, child birth and post-partum health services;
- Health services serving most at risk populations;
- Services for young children and adolescents;
- Surgical services; and
- Reproductive health services, including family planning.

While the research conducted for this report suggests that most SADC countries are still delivering HIV testing through VCT models, several SADC countries have incorporated opt-out testing into their programmes.

[111] WHO and UNAIDS *Guidance on Provider Initiated HIV Testing and Counselling in Health Facilities*, April 2007.
[112] Page 5.
[113] The guidance note defines a generalised epidemic as one where HIV is firmly established in the general population.

Table 41: Testing models in SADC

COUNTRY	HIV TESTING MODEL
Angola	Legislation provides for voluntary testing and forbids any form of compulsory testing. No information on other policies was available.
Botswana	Government introduced 'provider initiated / opt-out routine testing'. Although informed consent is therefore required, a truncated form of pre-test counselling is provided and patients may not be given adequate information to allow them to make an informed decision about HIV testing. The policy allows for patients to decline tests, but in practice many are not aware that they may opt-out, nor do they feel able to do so.
DRC	No information available, but legislation provides for VCT.
Lesotho	VCT is still available, but community based routine offer of HIV testing is being rolled out in the Know Your Status Campaign. Shortened pre-test counselling is provided and patients may not be in a position to give informed consent to the test. Patients may also not be able to decline a test, even though they may not wish to be tested.
Madagascar	Includes reference to routine testing in national policy on VCT.
Malawi	HIV testing policy based on principles of VCT. Routine anonymous surveillance testing conducted on pregnant women presenting at antenatal health care facilities. Routine mandatory testing of blood (and other organ) donations.
Mauritius	Routine offer of testing to pregnant women, with women able to decline the test. However, the draft HIV Prevention Measures Act requires VCT with informed consent and pre- and post-test counselling.
Mozambique	VCT is the predominant model, but the national HIV testing expansion strategy emphasises provider initiated testing.
Namibia	VCT is the predominant model, but the Ministry of Health and Social Services has introduced opt-out testing for pregnant women.
South Africa	HIV testing policy says patients must give informed consent for HIV testing and it must be accompanied by pre- and post-test counselling. Draft National Policy on Counselling and Testing for HIV[114] moves away from client initiated testing towards provider initiated offer to those using health care services. The Policy and Guidelines for the Implementation of the PMTCT Programme (2008) refers to routine voluntary testing and counselling which involves a routine offer of testing to all pregnant women. If the offer is accepted, women will then receive pre-test counselling.
Swaziland	Health provider initiated testing and counselling routinely offered.

[114] www.alp.org.za, last accessed on the 25 October 2006.

Tanzania	Health provider initiated testing and counselling is available in all public health facilities; VCT is also provided.
Zambia	HIV testing policy is based on informed consent and pre- and post-test counselling. The Guidelines on HIV/AIDS Counselling (2000) specifically states that compulsory and mandatory testing is a violation of human rights. However, the National AIDS Council has repeatedly called for routine provider initiated testing because of the low rate of testing.
Zimbabwe	Policy focuses on VCT but acknowledges the need for provider initiated testing. Pregnant women are routinely offered an HIV test, but may refuse the test. The Minister of Health has stated that mandatory testing is unconstitutional.

Whilst there is agreement on the need for HIV testing to be widely available to all who seek it, concerns have been expressed from a human rights perspective that the practical implementation of provider initiated opt-out testing carries a real risk of testing being conducted without informed consent. Not only does testing without informed consent violate human rights, including the right to health, the right to privacy and bodily integrity and autonomy[115]but it is also likely to dissuade people from accessing health services, thus constituting a barrier to accessing treatment.

Conclusions

- Access to HIV testing services remains crucial to efforts to curb the spread of HIV and to enable timeous access to health interventions.
- Access to testing has increased in the SADC region, but much still needs to be done to ensure universal access to testing.
- Many countries are developing policies which facilitate either provider initiated opt-out testing or the routine offer of testing, as a response to the low number of patients who initiate HIV testing.
- Organisations have emphasised the need for monitoring of the implementation of provider initiated testing services to ensure that human rights abuses do not occur.

Recommendations

- Advocate for continued expansion of HIV testing services.
- Monitor the provision of HIV testing, particularly provider initiated opt-out HIV testing, to ensure that it is consistent with human rights.

[115] For a fuller discussion on routine testing and human rights, see Rickard C 'Balancing Acts' *AIDS Review*, Centre for the Study of AIDS, 2008.

Table 42: Comparing findings from 2006 - 2009

Conclusions	The 2006 Report expressed concerns about the slow uptake of VCT services and the introduction of routine testing as a method to increase access to testing. The Report highlighted the factors, including distance and costs of transport that impacted on access to VCT.	The 2009 Report recognises that access to HIV testing continues to increase in SADC, but concerns remain about the relatively low numbers of people testing for HIV. There continues to be a move towards provider initiated HIV testing, particularly for pregnant women.
Recommendations: Advocate for VCT	The 2006 Report recommended advocacy for VCT.	Until further research is available on opt-out testing, the 2009 Report continues to advocate for VCT.
Recommendations: Monitor Implementation		In the light of the increased roll out of provider initiated HIV testing in the region, the 2009 Report recommends monitoring of the implementation of this form of testing, to determine the impact on human rights.

3.4.2 Lack of prevention programmes for women

Most SADC countries now have both PMTCT and PEP programmes for women and the number of countries with PEP programmes has increased significantly since 2006. However, this Report has shown the ways in which access to PMTCT is still limited. Information regarding access to PEP is not widely available. Given that gender discrimination remains a key concern in SADC (64% of SADC countries indicated that women's vulnerability was a key human rights concern), access to PEP is a priority concern.

Table 43: HIV prevention programmes for women

COUNTRY	PMTCT	PEP
Angola	X	No information
Botswana	X	X
DRC	X	X (MSF)
Lesotho	X	X

Madagascar	X	X
Malawi	X	X
Mauritius	X	X
Mozambique	X	X
Namibia	X	X
South Africa	X	X
Swaziland	X	X
Tanzania	X	X
Zambia	X	X
Zimbabwe	X	X

Table 44: Women's vulnerability

COUNTRY	LIMITED LAWS ON GENDER-BASED VIOLENCE	DISCRIMINATORY LAWS AND CUSTOMARY PRACTICES	WOMEN'S VULNERABILITY NOTED AS A KEY ISSUE
Angola			
Botswana	X	X	X
DRC		X	X
Lesotho			X
Madagascar			
Malawi			
Mauritius			
Mozambique	X		X
Namibia			X
South Africa			X
Swaziland	X	X	X
Tanzania	X		X
Zambia	X	X	X
Zimbabwe			

Conclusions

- All SADC countries now have PMTCT programmes and the number of PEP programmes has increased.
- Despite these efforts, relatively low numbers of women are accessing PMTCT. Insufficient information is available about the levels of access to PEP.
- Sexual violence against women and children is a key issue in SADC countries.

Recommendations

- Advocate for the continued expansion of appropriate PMTCT programmes, with a focus on identifying factors to enhance access / remove barriers to access.
- Advocate for holistic PMTCT programmes to address issues of equity, access, as well as treatment for pregnant women themselves and likewise for PEP programmes to be integrated into a holistic package of care for survivors of sexual assault.
- Special attention should be paid to improving overall access to antenatal clinics and labour wards.
- Monitor access to and implementation of PEP policies.
- Advocate for eradication of gender-based violence and discrimination against women and for laws to be put in place to address violence and women's inequality.

Table 45: Comparing findings 2006 - 2009

Conclusions	The 2006 Report expressed concerns about the limited availability of PMTCT and PEP programmes in SADC.	The 2009 Report recognises that both PMTCT programmes and PEP programmes are more widely available in SADC. However, women still have limited access to programmes.
Recommendations: Advocate for Improved Access	The 2006 Report recommended advocacy for PMTCT and PEP programmes in all SADC countries.	Given the existence of programmes, the 2009 Report recommendations focus on advocacy to ensure holistic services, as well as increased access to the existing services.
Recommendations: Monitor Implementation		Additionally, the 2009 Report recommends monitoring the implementation of programmes, to identify the extent to which women are accessing services and barriers to access.

Chapter Four: Conclusion

Following from the findings and recommendations made with regard to HIV, AIDS and human rights in the Report, this chapter suggests:

1. Broad conclusions and on-going challenges regarding HIV and human rights in SADC; and
2. Possible advocacy strategies for the years ahead.

4.1 Conclusions

4.1.1 Model of Law Reform

Conclusions

All SADC countries have begun a process of law reform to respond to HIV/AIDS as a human rights issue. In many countries, this has involved the adoption of an HIV-specific public health law to manage various aspects of HIV and AIDS, which also includes protection of the rights of PLHIV.

The HIV-specific nature of such legislation, however, means that the law may not reflect an appropriate, multi-sectoral response to HIV and AIDS based on the national context. It also means that anti-discrimination provisions do not extend to people vulnerable to HIV infection due to discrimination on the grounds of, for example, sex, gender, sexual orientation, origin.

In all SADC countries governments have begun a process of law and policy reform. They have used a range of different approaches to review, update and implement law and policy reform measures. Six countries have adopted dedicated HIV-related legislation, 5 have integrated HIV issues into other laws and 3 have set out HIV-related principles in policies.

A common approach in SADC countries is the adoption of dedicated HIV-related legislation that deals with a broad range of HIV-related issues and that also protects the rights of PLHIV and those affected by the epidemic. While there are limitations to this approach – it is often health-driven, limiting a multi-sectoral approach to the epidemic and HIV-specific laws often fail to deal with broader issues of inequality that increase vulnerability of people to HIV – it nevertheless appears to have resulted in quick law reform in SADC countries. Since most SADC countries do not have comprehensive equality and non-discrimination laws (as is the case in South Africa), the trend towards developing HIV-related laws that protect the rights of PLHIV may continue. In South Africa, the integrated approach to law reform, in terms of which various government ministries adopt HIV-related laws and policies in response to HIV

and AIDS, has worked well. Ongoing law reform in SADC countries should be based on a thorough audit of existing laws, their enforcement and their impact on HIV and AIDS.

Challenges

Some SADC countries have yet to develop legal (as opposed to policy) provisions to protect the rights of PLHIVs. Additionally, law reform needs to be based on the national context and to ensure protection of the rights of not only PLHIV, but all those vulnerable to HIV infection. This will require countries to include broad equality and anti-discrimination provisions within their HIV-related laws, or to develop general equality and anti-discrimination legislation, based on a legal audit.

Although HIV-specific laws adopted in the region ostensibly promote a human rights based response to HIV, many contain specific provisions, for example on testing and disclosure, which in fact undermine the rights of PLHIV.

4.1.2 Rights-Based Responses versus Coercive Responses

Conclusions

The majority of SADC countries include both protective and coercive HIV-related laws in their legal response.

The development of dedicated HIV-related legislation has led to the establishment of protective legal norms - for example, many new HIV and AIDS laws include equality and anti-discrimination provisions for PLHIV and set out protective laws for HIV testing and disclosure of HIV status. These new norms are a significant step towards creating a public health response based on human rights principles.

Having said that, however, many protective legal provisions are limited by 'claw-back' provisions (exceptions which allow limits to the rights). Also, many SADC countries have simultaneously introduced coercive criminal law responses to HIV and AIDS.

In the context of on-going policy debates regarding the lack of uptake of ARV treatment and continuing low levels of HIV testing, it is encouraging to see that many SADC countries have adopted new legislation protecting the rights of persons using health care services. Given the ongoing pressure from many public health advocates to revert to more traditional and coercive approaches, such as mandatory HIV testing, such legislation could form an important buffer against irrational HIV testing policies.

Of concern, however, is the fact that in a number of instances the new rights contained within public health legislation have been "clawed back" by provisions which undermine these rights. For example, in a number of countries the right to informed consent has been expressly limited where legal provisions allow for HIV testing without informed consent in certain circumstances. Additionally, some HIV testing policies and programmes within the region - such as provider initiated opt-out HIV testing – leave patients vulnerable to potential human rights abuses.

Many countries also include criminal sanctions in public health legislation and / or in criminal laws. For example, a number of SADC countries have criminal sanctions if PLHIV do not 'immediately' disclose their HIV status to others. Six SADC countries have created a new crime to deal with harmful HIV-related behaviour, despite active advocacy from NGOs. Furthermore, in a number of countries these new crimes have considerably widened the net of liability to include negligent acts and even 'inconsiderate' acts by PLHIV. These coercive provisions undermine social support programmes which aim to facilitate a process of disclosure. They also fail to recognise the real dangers PLHIV face of being evicted from homes, being rejected and being subjected to physical violence if they disclose their HIV status without support.

This research for this Report was conducted primarily through NGOs and limited responses were received from SADC governments. As a result, the Report is unable to establish whether governments are aware of and are using the UNAIDS International Guidelines on HIV/AIDS and Human Rights. Nevertheless, it is clear that not all governments are aware of the synergy between public health and human rights and many legislative responses appear to be based on responding to populist views rather than a commitment to human rights. Reforms to the criminal law continue to reflect the latter position.

Challenges

There is an ongoing need to ensure that human rights gains (for example, in relation to HIV testing and disclosures of HIV status) are not eroded. There is a particularly complex challenge in responding to what is clearly a strong pressure within SADC to develop criminal law responses to HIV, suggesting that there is a need for a greater understanding of the legislative responses. Given that many of these laws are newly enacted, advocating for their repeal may need to be supplemented with advocacy initiatives aimed at ensuring these laws (such as laws relating to HIV testing of a sexual offender and sentencing) are used in a way that is appropriate and that protects rights.

4.1.3 Access to Health Care

Conclusions

Progress is being made in developing laws, policies, programmes and plans to facilitate access to treatment (ARVs) and to prevention services for women (PMTCT). However, there are still large numbers of people who are not accessing available services.

Progress has been made towards the rolling out of treatment, care and support programmes in the SADC region. However it is of grave concern that only 14 % of SADC countries are reaching 70 % of those who need ARV treatment. Key barriers to increasing access to treatment include the lack of facilities in rural areas, legislation which prohibits children accessing care without parental involvement and the lack of health care workers in the region. Access to treatment for the increasing number of migrant and displaced populations in the region is re-emerging as a concern.

With respect to prevention programmes, the slow up-take of HIV testing continues. It is estimated that only 2 out of every 10 Africans are aware of their HIV status. A key issue in the region has been facilitating access to HIV prevention services for women. Given the disproportionate impact of HIV on women, it is of critical importance that every SADC country provides women with, at a minimum, access to PMTCT. Progress appears to be being made in this area. However women in rural areas continue to lack access to such services and NGOs still report that HIV testing is offered in a coercive manner in many PMTCT services. In 5 SADC countries the PMTCT programme is provided on the basis of provider initiated opt-out HIV testing. Since this practice may result in human rights abuses, its implementation needs careful monitoring.

Many more SADC countries are now also offering PEP programmes for survivors of sexual offences. However, limited information is available on their availability and usefulness and in particular on whether women are able to access these services within the minimum time frame required for efficacy.

Challenges

Challenges include eliminating barriers and increasing access to available health care services, ensuring that HIV testing facilitates protection of patients' rights and promotes access to health care; and increasing understanding of access to PEP.

4.1.4 Ongoing Discrimination and Human Rights Abuses

Conclusions

Despite an increasingly protective legal and policy framework in SADC, gaps in the framework result in continuing discrimination against PLHIV. In addition, developing a human rights response to HIV/AIDS within the SADC region is made complex by the large number of competing human rights concerns and continued state repression and undermining of human rights in some countries.

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

Furthermore, although many governments have adopted human rights protections for PLHIV, there are limited other legal protections and ongoing gaps in the legal and policy framework. The majority of countries criminalise same sex relationships, women remain second class citizens under customary law and migrants and displaced populations remain marginalised from communities and services.

An enabling environment is required within which unfair discrimination against all marginalised groups is eliminated, as this ongoing discrimination is one of the underlying drivers of the HIV epidemic. NGOs advocating for HIV as a human rights issue need to work towards placing such strategies within a broader context of advocacy for the legal protection of all human rights within the region.

Challenges

The challenge in this area is to move beyond a narrow focus on protecting the rights of PLHIV to a broader equality agenda. Challenges in this area are great, since they require getting political support for a broader law reform agenda. This requires strengthening existing rights and also reforming discriminatory laws, policies, practices and beliefs against marginalised groups in society in traditionally conservative areas of the law – such as military law, correctional systems law and sexual offences law.

4.1.5 Monitoring and Implementation

Conclusions

The SADC region is moving into a new phase in which legal and policy frameworks are largely in place and a greater focus must be placed on advocating for and monitoring the implementation of such reforms.

NGOs are to be commended for their unrelenting advocacy, which has resulted in extensive HIV-related legal and policy reforms within the region. Legislative frameworks are now in place in all but 3 SADC countries. However, much needs to be done to make these rights real to PLHIV and those affected by the epidemic. For example, at a policy level, access to PEP for the survivors of sexual violence is provided by nearly 65% of SADC. However many ARASA partners state that the drugs are routinely not offered to survivors as they are not available, or they are not dispensed within 72 hours and therefore serve little purpose.

Challenges

Challenges include mobilising resources to ensure that laws can be fully implemented; supporting state initiatives to facilitate implementation of new laws and policies and undertaking research on the extent to which and how effectively laws are being implemented.

4.1.6 Enforcement

Conclusions

Enforcement mechanisms are being strengthened as more SADC countries introduce dedicated HIV-related legislation. Most HIV and AIDS laws include offences for HIV-related disputes. In most cases, SADC countries refer HIV-related disputes to the existing dispute resolution mechanisms (such as the courts) within the country.

The ability to enforce rights and obligations is increasingly being made easier in the region as countries pass HIV-related legislation. This legislation generally creates corresponding offences relating to legal provisions. For example, provisions relating to HIV testing and disclosure would generally be complemented by provisions making it an offence to test a person for HIV without their consent, or to disclose their HIV status outside of the defined circumstances. This facilitates enforcement of the rights of PLHIV.

Challenges

Challenges include determining the efficacy of dispute resolution mechanisms (such as general mechanisms like the courts, or newly created HIV tribunals) to ensure that they are

accessible and are staffed by officials skilled and knowledgeable in issues around HIV, AIDS and the law.

4.1.7 Emerging Human Rights Issues

Conclusions

As the epidemic evolves, so do the human rights issues. Emerging issues in the years ahead determined by this Report include the rights of access to health care of vulnerable groups (such as children and marginalised populations), the rights of people with TB and rights issues around the development of new prevention interventions, such as circumcision and HIV vaccines.

4.2 Key changes between 2006 and 2009

In 2006, less than half of the SADC states had adopted appropriate HIV-related legal frameworks. In 2009 it appears that in most countries frameworks are now in place. There has also been a spate of legal reform, with four more countries having adopted dedicated HIV legislation ostensibly based on human rights principles. This indicates a continuing trend within the region towards HIV-specific public health legislation that includes protection of the rights of PLHIV. However, it must be noted that there has been limited change regarding the general right to equality with few, if any, non-HIV milestones having been reached in advocacy for general equality legislation.

Of importance has been the adoption of a regional standard describing the key human rights norms that ought to be contained within HIV and AIDS legislation. The adoption of the model law on HIV and AIDS in 2008 developed by the SADC Parliamentary Forum (SADC) has been a significant achievement, as it has set clear regional human rights norms on HIV-related issues. It also reflects a regional commitment to HIV as a human rights issue and may encourage SADC countries to continue developing law reform agendas, based on the recommended norms and standards and the needs of their own particular contexts.

One of the most significant HIV-related cases that came before the courts during this period was *South African Security Forces Union and Others v Surgeon General and Other.*[116] In this matter the AIDS Law Project managed to reach an 'out of court' agreement with the South African National Defence Force (SANDF) that their HIV policy constituted unconstitutional discrimination against HIV positive recruits and members. Furthermore, the SANDF agreed to review and replace this policy within 6 months. This agreement was made an order of the Pretoria High Court of South Africa. This case may be a significant turning point in the region, as it places other discriminatory HIV testing policies in the military under threat and open to constitutional challenge.

[116] Case number 18683/07.

Treatment, care and support programmes continue to grow within the region, with increasing state commitment towards ensuring access. In many countries, legal frameworks have been put in place to support the roll-out of such programmes in a way that is consistent with human rights principles. This progress has shifted the emphasis, in 2009, on the need to monitor implementation to promote access to available services.

Table 46: Comparing Findings 2006 - 2009

PROGRESS IN 2009	ONGOING ISSUES IN 2009	NEW ISSUES IN 2009
More countries have HIV laws and policies. Many have a dedicated HIV law that includes protection of certain rights of PLHIV.	Developing a human rights response is complicated by large number of competing human rights interests and state repression of rights in some countries.	New HIV and AIDS laws mean that there are increased opportunities for enforcement of rights.
SADC has adopted a model law on HIV and AIDS, showing a commitment to HIV and human rights law reform.	Many countries continue to adopt laws that limit the rights of PLHIV.	New HIV and AIDS laws mean that there is now a shifting need for monitoring the implementation of the legal framework.
More countries have laws and policies on key health care interventions and there is increased access to prevention and treatment.	Discrimination against PLHIV continues to be a major issue.	New emerging human rights issues include access to health care for vulnerable groups (women, children and migrants), the rights of people with TB and rights issues around new prevention technologies.

4.3 An advocacy agenda for 2009 and beyond

Twelve years after the development of the UNAIDS International Guidelines on HIV/AIDS and Human Rights, both new and old challenges exist to human rights-based responses to HIV. Many of these new challenges relate to the changing environment for HIV programming, such as new prevention technologies, proven treatments and cheaper drugs. Nevertheless, even the international benchmarks such as the International Guidelines may need re-assessment at regular intervals to ensure that they are still providing guidance on the key human rights issues.

Moving forward over the following two years, the Report recommends advocacy priorities as follows:

1. Enhancing the understanding of HIV as a human rights issue amongst law makers and getting their buy-in for an approach which is based on the common goals of both public health and human rights.
2. Law reform in all SADC countries, based on an audit of the legal response to HIV and AIDS within countries that examine existing relevant laws, as well as the nature of their enforcement and the need for law reform and the impact these laws have on the quality of the response to the epidemic, in particular the access and uptake of HIV services and commodities by women, people living with HIV and populations at risk; to be followed by reform of law and/or enforcement as necessary. Law reform programmes should advocate for broad-based, multi-sectoral reform of all issues raised by HIV and AIDS, with a particular focus on key issues listed in the Report.
3. Repeal of inappropriate criminal laws relating to HIV and AIDS, as well as research into and the adoption of a clear regional position (including guidelines) on the appropriate use of some of the existing criminal laws on HIV and AIDS.
4. The repeal of laws and policies allowing HIV testing and discrimination amongst the armed forces.
5. The adoption of a SADC Code on Equality and Non-Discrimination, including reference to the protection of the rights of PLHIV and people vulnerable to HIV and AIDS.
6. The provision of legal support for people living with HIV and members of vulnerable and marginalised groups (women, care-givers, survivors of sexual violence, orphans and vulnerable children, injecting drug users, sex workers, men who have sex with men) in the form of legal aid, strategic litigation and community dispute resolution including working with traditional leaders.
7. The implementation of "Know your rights" campaigns that empower those affected by HIV to know their rights in the context of the epidemic and draw them down into concrete demands in terms of gender equality, non-discrimination on basis of HIV and other social status, elimination of violence against women and protection of the rights of the child.
8. The provision of human rights training for key service providers that focuses on informed consent, confidentiality, non-discrimination and non-violence.
9. The implementation of stigma and discrimination reduction programmes which actively seek to reduce stigma and discrimination based on HIV and related social status.
10. The implementation of programmes that address the intersection between violence against women/girls and HIV.
11. The implementation of programmes to transform harmful and inequitable gender norms that increase vulnerability to infection and impact for men, women and young people.
12. The implementation of programmes to ensure the equal rights of women and girls in the context of marriage and family law and access to economic opportunities.

13. The development of a regional advocacy strategy on necessary measures required to create an enabling environment for accessing HIV prevention and treatment services for all, with a particular focus on marginalised groups. Legal and policy barriers to access may include laws criminalising same-sex relationships, laws restricting the health rights of migrants, laws promoting gender inequality and laws limiting the capacity of children.
14. Regional goals regarding access to health care services, including ARVs.
15. Monitoring of new public health laws and policies, including enforcement mechanisms, in the region.
16. Developing advocacy strategies for new and emerging issues, such as the rights of patients with TB, into existing HIV and human rights programmes.

Continued vigilance and advocacy is needed to ensure that the principles of a human rights-based response remain central to all strategies to combat and mitigate the impact of HIV and AIDS.