



AFRICAN COMMISSION ON
HUMAN & PEOPLES' RIGHTS

HIV, THE LAW AND HUMAN RIGHTS IN THE AFRICAN HUMAN RIGHTS SYSTEM:

KEY CHALLENGES AND OPPORTUNITIES FOR RIGHTS-BASED RESPONSES



Report on the Study of the African Commission
on Human and Peoples' Rights



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on Human and Peoples' Rights**

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ABBREVIATIONS

ACERWC

African Committee of Experts on the Rights and Welfare of the Child

African Charter

African Charter on Human and Peoples' Rights

African Children's Charter

African Charter on the Rights and Welfare of the Child

African Commission

African Commission on Human and Peoples' Rights

African Court

African Court on Human and Peoples' Rights

CEDAW Committee

Committee on the Elimination of Discrimination against Women

Committee on ESCR

The Committee on Economic, Social and Cultural Rights

CRC

Convention on the Rights of the Child

Doha Declaration

Doha Declaration on the TRIPS Agreement and Public Health

EAC

East African Community

FGM

female genital mutilation

GALZ

Gays and Lesbians of Zimbabwe

HIV Committee

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

ICASA

International Conference on AIDS and STIs in Africa

ICCPR

International Covenant on Civil and Political Rights

ICESCR

International Covenant on Economic, Social and Cultural Rights

IP

intellectual property

LEGABIBO

The Lesbians, Gays and Bisexuals of Botswana

LGBTI

lesbian, gay, bisexual, transgender and intersex people

NSPs

national strategic plans on HIV

OAU

Organisation of African Unity

OHCHR

Office of the United Nations High Commissioner for Human Rights

PITC

provider-initiated testing and counselling

PMTCT

prevention of mother-to-child transmission

SADC

Southern African Development Community

STI

sexually transmitted infection

TAC

Treatment Action Campaign

TB

tuberculosis

TRIPS Agreement

Agreement on Trade-Related Aspects of Intellectual Property Rights

UN

United Nations

UNAIDS

Joint United Nations Programme on HIV/AIDS

UNGASS

United Nations General Assembly Special Session

UNICEF

United Nations Children's Fund

WHO

World Health Organization

WTO

World Trade Organization

ZARAN

Zambian AIDS Law Research and Advocacy Network

DEFINITION OF KEY CONCEPTS AND TERMS RELATING TO HIV¹

Acquired immunodeficiency syndrome (AIDS)

AIDS is a term that applies to the most advanced stages of HIV infection. It is defined by the occurrence of one or more of the HIV-related opportunistic infections or cancers.

AIDSinfo

AIDSinfo is a data visualization and dissemination tool intended to facilitate the use of AIDS-related data, both within individual countries and globally. AIDSinfo is populated with multi-sectoral HIV data from a range of sources, including Measure DHS, UNAIDS, UNICEF and WHO.

Antiretroviral medicines/antiretrovirals (ARVs)/antiretroviral therapy (ART)/ HIV treatment

Antiretroviral therapy is highly active in suppressing viral replication, reducing the amount of the virus in the blood to undetectable levels and slowing the progress of HIV disease. The usual antiretroviral therapy regimen combines three or more different medicines, such as two nucleoside reverse transcriptase inhibitors (NRTI) and a protease inhibitor, two nucleoside analogue reverse transcriptase inhibitors and a non-nucleoside reverse transcriptase inhibitor (NNRTI), or other combinations. More recently, entry inhibitors and integrase inhibitors have joined the range of treatment options. Suboptimal regimens are monotherapy and dual therapy.

Bisexual person

A bisexual person is defined as a person who is attracted to and/or has sex with both men and women, and who identifies with this as a cultural identity.

Epidemic

An epidemic refers to a disease condition affecting (or tending to affect) a disproportionately large number of individuals within a population, community or region at the same time. An epidemic may be restricted to one locale (an outbreak), or it may be more general (an

epidemic) or global (a pandemic). Common diseases that occur at a constant but relatively high rate in the population are said to be endemic.

Gay

The term “gay” can refer to same-sex sexual attraction, same-sex sexual behaviour and same-sex cultural identity.

Gender identity

Gender identity reflects a deeply felt and experienced sense of one's own gender. A person's gender identity typically corresponds with the sex assigned to them at birth.

Harm reduction

The term “harm reduction” refers to a comprehensive package of policies, programmes and approaches that seeks to reduce the harmful health, social and economic consequences associated with the use of psychoactive substances. The elements in the package are the following: needle-syringe programmes; opioid substitution therapy; HIV testing and counselling; HIV care and antiretroviral therapy for people who inject drugs; prevention of sexual transmission; outreach (which includes information, education and communication for people who inject drugs and their sexual partners); viral hepatitis diagnosis, treatment and vaccination (where applicable); and tuberculosis prevention, diagnosis and treatment.

Human immunodeficiency virus (HIV)

HIV infects cells of the immune system, destroying or impairing their function. Infection with the virus results in progressive deterioration of the immune system, leading to “immune deficiency.”

Homophobia and transphobia

Homophobia is an irrational fear, hatred or aversion towards lesbian, gay or bisexual people. Transphobia denotes an irrational fear, hatred or aversion towards transgender people.

¹ - These definitions were adapted from the following sources: Ending Violence and Other Human Rights Violations Based on Sexual Orientation and Gender Identity: A Joint Dialogue of the African Commission on Human and Peoples' Rights, Inter-American Commission on Human Rights and United Nations (Pretoria, South Africa: Pretoria University Law Press, 2016), <http://www.chrup.ac.za/index.php/>

[centre-news-a-events-2016/1617-african-commission-launches-joint-report-on-sexual-orientation-and-gender-identity-.html](http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf); and UNAIDS, UNAIDS Terminology Guidelines (Geneva: UNAIDS, 2015), http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf.

Intersex

An intersex person is born with sexual anatomy, reproductive organs, and/or chromosome patterns that do not fit the typical definition of male or female. This may be apparent at birth or become so later in life. An intersex person may identify as male, female, both or neither. Intersex status is not about sexual orientation or gender identity: intersex people experience the same range of sexual orientations and gender identities as non-intersex people. Intersex people suffer specific human rights violations based on their sexual characteristics.

Key populations

Gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs, and prisoners and other incarcerated people are considered the main key population groups. These populations often suffer from punitive laws or stigmatizing policies, and they are among those most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere—they are key to the epidemic and key to the response.

Lesbian

A lesbian is a woman attracted to other women. She may or may not be having sex with women, and a woman having sex with women may or may not be a lesbian. The term “women who have sex with women” should be used unless individuals or groups self-identify as lesbians.

LGBT

LGBT stands for the terms “lesbian, gay, bisexual and transgender.” While these terms have increasing global resonance, other terms may be used to describe people who are attracted to persons of the same sex and those who have non-binary gender identities. Some examples include hijra, meti, lala, skesana, motsoalle, mithli, kuchu, kawein, travesty, muxé, fa’afafine, fakaleiti, hamjensgara and Two-Spirit. In a human rights context, lesbian, gay, bisexual and transgender people face both common and distinct challenges.

Men who have sex with men

Men who have sex with men are males who have sex with males, regardless of whether or not they also have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but who have sex with other men.

Mother-to-child transmission (MTCT)

MTCT is the abbreviation for mother-to-child transmission. PMTCT, the abbreviation for prevention of mother-to-child transmission, refers to a four-prong strategy for stopping new HIV infections among children and keeping their mothers alive and families healthy. The four prongs are: helping reproductive-age women avoid HIV (Prong 1); reducing unmet need for family planning (Prong 2); providing antiretroviral medicine prophylaxis to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding (Prong 3); and providing care, treatment and support for mothers and their families (Prong 4).

Multidrug-resistant tuberculosis (MDR-TB)

MDR-TB is a specific form of drug-resistant tuberculosis, caused by a bacillus that is resistant to at least isoniazid and rifampicin, the two drugs that form the backbone of standard anti-tuberculosis treatment.

Opioid substitution treatment or therapy (OST)

Opioid substitution therapy is the recommended form of drug dependence treatment for people who are dependent on opioids. It has proved effective in the treatment of opioid dependence, in the prevention of HIV transmission and in the improvement of adherence to antiretroviral therapy. The most common drugs used in opioid substitution therapy are methadone and buprenorphine.

Opportunistic infection

Opportunistic infections are infections caused by various organisms, many of which usually do not cause disease in persons with healthy immune systems. Persons living with advanced HIV infection may have opportunistic infections of the lungs, brain, eyes and other organs. In many countries, tuberculosis is the leading HIV-related opportunistic infection.

Post-exposure prophylaxis (PEP)

Post-exposure prophylaxis refers to antiretroviral medicines that are taken after exposure (or possible exposure) to HIV. The exposure may be occupational (e.g. a needlestick injury) or non-occupational (e.g. condomless sex with a seropositive partner).

Pre-exposure prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) refers to antiretroviral medicines prescribed before exposure (or possible exposure) to HIV. Several studies have demonstrated that a daily oral dose of appropriate antiretroviral medicines is effective in both men and women for reducing the risk of acquiring HIV infection through sexual or injection transmission.

Prevalence

Usually given as a percentage, HIV prevalence quantifies the proportion of individuals in a population who are living with HIV at a specific point in time. HIV prevalence also can refer to the number of people living with HIV. UNAIDS normally reports HIV prevalence among people aged 15–49 years.

Sex worker

Sex workers include female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. It is important to note that sex work is consensual sex between adults, which takes many forms and varies between and within countries and communities. Sex work may vary in the degree to which it is more or less formal or organised. Since sex work is defined as the consensual sale of sex between adults,

children (people under 18 years) cannot be involved in sex work. Instead, children involved in sex work are considered to be victims of sexual exploitation.

Sexual orientation

Sexual orientation refers to a person's physical, romantic and/or emotional attraction to other people. Everyone has a sexual orientation, which is integral to a person's identity.

Stigma

Stigma is derived from a Greek word meaning a mark or stain, and it refers to beliefs and/or attitudes. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within particular cultures or settings and defined as discreditable or unworthy.

Transgender

Transgender (sometimes shortened to “trans”) is an umbrella term used to describe a wide range of identities—including transsexual people, cross-dressers (sometimes referred to as “transvestites”), people who identify as third gender, and others whose appearance and characteristics do not correspond with the sex they were assigned at birth or are considered to be gender atypical.

ACKNOWLEDGEMENTS

The development of this report was made possible by the engagement and technical and financial contributions of key partners of the African Commission on Human and Peoples' Rights (African Commission) and the Committee on the Protection of the Rights of People Living With HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV (HIV Committee): the Joint United Nations Programme on HIV/AIDS (UNAIDS), African Men for Sexual Health and Rights (AMSHeR) and the AIDS and Rights Alliance for Southern Africa (ARASA). We also acknowledge the support of the Southern African Litigation Centre (SALC) and the Eastern and Southern African Regional Think Tank on HIV, Health and Social Justice.

Expert members of the HIV Committee played key roles in coordinating the development and writing of this report with the support of consultants. The UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health provided written comments to an earlier draft of the study. Inputs were also received from the

United Nations Development Programme (UNDP).

The development of the report benefitted from the involvement and input of civil society organisations, particularly people living with, affected by and at risk of HIV from all regions of the continent. Their testimonies, experiences and perspectives were a reminder of the urgent need to advance rights-based responses to HIV in Africa. Finally, dialogues with HIV programme implementers, representatives of national AIDS bodies, medical experts, members of parliament and members of the judiciary brought deep insight and expertise that informed this report. The engagement of these representatives of all branches of governments from several African States is acknowledged. The African Commission is grateful to all these individuals and institutions for their diverse contributions, which made this report possible.



MESSAGE FROM THE UNAIDS EXECUTIVE DIRECTOR



The history and current reality of the HIV epidemic globally and in Africa illustrate the importance of the law and human rights in the context of global health.

A critical lesson from the past 35 years of the HIV response is that the protection of human rights—including for those most vulnerable to HIV, such as women and girls, young people, prisoners,

sex workers, transgender persons, gay men, men who have sex with men, and people who inject drugs—is essential for an effective response to HIV. A thriving civil society that is empowered to demand, support and monitor progress on HIV policies and programmes is a pre-condition to advances against the epidemic.

Rights-based approaches and community involvement have enabled great progress against the epidemic in the continent. Antiretroviral therapy, which was once declared impractical in Africa, was available to 13.8 million people on the continent in 2016. Significant reductions in deaths from AIDS-related illness were recorded in many countries in the region between 2005 and 2016. In certain countries, the coverage of services to prevent mother-to-child transmission of HIV is above 95%.

Despite these achievements, stigma, discrimination, gender inequality, violence and other human rights violations continue to make people vulnerable to the epidemic and hinder access to HIV services. AIDS activists and civil society organisations that were critical to successes to date are increasingly confronted by laws, policies and practices that create barriers to their registration, operations, activities and funding. These challenges occur at a time when African countries have committed to the bold visions of the Sustainable Development Goals, Agenda 2063, and of ending the AIDS epidemic as a public health threat by 2030. There is no better entity to address the legal, human rights and social justice challenges raised by the HIV epidemic than the African Commission on Human and Peoples' Rights, which has a broad mandate for the promotion and protection of human rights in Africa.

The present study is a significant contribution to efforts to advance rights-based responses to HIV in Africa and globally. UNAIDS is privileged to have contributed to this report, and we look forward to working with the African Commission, States, civil society and other partners to promote this study and support the implementation of its recommendations, which constitute a milestone in our efforts to end the AIDS epidemic as a public health threat by 2030 and to leave no one behind.

MICHEL SIDIBÉ



Executive Director, Joint United Nations Programme on
HIV/AIDS

Under-Secretary-General of the United Nations

FOREWORD FROM THE CHAIRPERSON OF THE AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS



Despite progress made through the mobilization of civil society organizations and the international community, the HIV epidemic on the continent is still a matter of concern. In many regions in Africa, people living with HIV—particularly those at risk—continue to face numerous obstacles in terms of testing

and access to prevention, treatment, care and other HIV-related services. Such obstacles include economic barriers, prejudice and stereotypes, gender inequalities, harmful socio-cultural practices and the persistence of stigma and discrimination in health facilities. The existence of punitive laws and restrictive policies and practices—along with the lack of a conducive legal environment for the effective protection of the rights of people living with HIV and those at risk in most African States—are some of the current challenges impeding the HIV response in the continent and affecting our efforts to reach the 90–90–90 targets.

In light of these considerations—and in recognition of the importance of ensuring a human rights perspective to the fight against the epidemic and to the management of its repercussions—the African Commission on Human and Peoples' Rights (the African Commission) deemed it necessary to undertake a study on HIV, the law and human rights.

By Resolution ACHPR/Res.290 (EXT.OS/XVI) 14—adopted at its 16th Extraordinary Session, held from 20 to 29 July 2014 in Kigali, Rwanda—the African Commission assigned the task of conducting this study to its Committee on the Protection of the Rights of People

Living with HIV (PLHIV) and those at Risk, Vulnerable to and Affected by HIV. The report, entitled *HIV, the Law and Human Rights in the African Human Rights System: Key Challenges and Opportunities for Rights-Based Responses to HIV*, was adopted by the African Commission at its 61st Ordinary Session, held from 1 to 15 November 2017 in Banjul, The Gambia.

On my behalf and on behalf of the African Commission, I would like to take this opportunity to thank all those who contributed to the realization of this study. We would especially like to extend our gratitude to the various partners who spared no effort in providing technical support to the Committee, particularly the Joint United Nations Programme on HIV/AIDS (UNAIDS), African Men for Sexual Health and Rights (AMSHeR), the AIDS and Rights Alliance for Southern Africa (ARASA) and the Southern Africa Litigation Centre (SALC).

This study, conducted in collaboration with State and non-State actors, presents the current situation of the HIV epidemic in Africa. It describes international, regional and national HIV-related norms and standards, as well as their interpretation and application by UN bodies, regional African mechanisms and national courts of law and other institutions. It contains a detailed analysis of key challenges and human rights violations affecting the HIV response in the continent. It also highlights best practices and other promising practices at the regional or national level in order to raise the awareness of States and other stakeholders on the need to integrate the human rights dimension as a key component in efforts to combat HIV. The study puts forward recommendations to the different stakeholders, including States Parties, for the effective protection of the rights of people living with HIV and those at risk. Attached to the report is a series of questions that could be used by States in the preparation of their periodic reports under Article 62 of the African

Charter on Human and Peoples' Rights to provide details on legislative and other measures they have adopted in combating HIV.

In this regard, the African Commission calls on all stakeholders—particularly States Parties—to take ownership of the conclusions of this study and to implement the recommendations therein to ensure that the human rights dimension is better integrated into their national policies, programmes, plans and strategies for an effective response to the epidemic. It further encourages national human rights institutions, civil society organizations and other development partners to disseminate and popularise the results of the study, thereby increasing awareness among States Parties of

the correlation between HIV and human rights for the effective promotion and protection of the rights of people living with HIV and those at risk.

Ending the AIDS epidemic as a public health threat is, now more than ever, our collective responsibility. Everyone should, in his or her own sphere of action and influence, fully and consciously play a role in promoting the effective implementation of the recommendations provided in this report to guarantee the promotion and protection of the rights of people living with HIV, those at risk and vulnerable to HIV.

HONOURABLE COMMISSIONER
SOYATA MAÏGA



Chairperson of the African Commission
on Human and Peoples' Rights

Chairperson of the Committee on the Protection of the
Rights of People Living With HIV and Those at Risk, Vul-
nerable to and Affected by HIV

EXECUTIVE SUMMARY

1. For more than three decades, the world has been battling the HIV pandemic, which is estimated to have claimed about 35 million lives globally. Africa is the region of the world most affected by the epidemic, with the great majority of deaths from AIDS-related illness and new HIV infections. Although important progress has been made in the response to HIV in the region—including a decline in new HIV infections and a significant increase in access to antiretroviral therapy—the epidemic remains a leading cause of death in sub-Saharan Africa.² Moreover, serious social, legal and policy challenges continue to impact the epidemic in a negative way. These challenges include stigma, discrimination, gender inequality and other negative norms and practices that affect people vulnerable to HIV and hinder their access to HIV services.¹
2. Across the continent, women, young people, sex workers, prisoners, people who inject drugs and gay men and other men who have sex with men are among the populations most affected by the epidemic. Factors and conditions that make people vulnerable to the epidemic often are linked to human rights violations and disabling legal and social environments. Laws, policies and practices have a direct impact on the effectiveness of country responses to the epidemic and the ability of affected individuals and communities to access HIV prevention, treatment and care services.
3. This report by the African Commission on Human and Peoples' Rights (African Commission) provides the first comprehensive analysis of the legal and human rights issues pertinent to HIV ever conducted by an organ of the African Union. This study was mandated by ACHPR/Res.290 (EXT. OS/XVI) 2014 (Resolution 290) on the Need to Conduct a Study on HIV, the Law and Human Rights, adopted by the African Commission in July 2014 in Kigali, Rwanda. It is intended to outline progress and challenges related to human rights in the response to HIV, and to share good practices and generate renewed action by States, civil society and other stakeholders to advance human rights as central to efforts to address HIV.
4. The report presents the current state of the HIV epidemic in Africa through a human rights and gender lens by showing the populations and locations most affected by HIV and those underserved by the response to the epidemic. It also describes the global, regional and national norms and standards relating to HIV and health, as well as their interpretation and application by African regional mechanisms, United Nations (UN) bodies and national courts and institutions. It further provides a detailed analysis of the key human rights challenges affecting the response to HIV on the continent, including the following:
 - › discrimination;
 - › inequality;
 - › coercive HIV testing;
 - › barriers to treatment access;
 - › violations of the human rights of women and girls;
 - › failure to uphold the human rights of children; and
 - › the criminalisation of people living with HIV and members of key populations (namely sex workers, transgender persons, gay men and other men who have sex with men, people who use drugs and prisoners).
5. This report not only outlines challenges and human rights violations; it also highlights good and promising practices at the regional or national levels that address these challenges. The report ends with conclusions and recommendations for advancing human rights and the response to HIV in Africa that are aimed at various stakeholders,

2 - WHO, Global Health Estimates 2015: Deaths by Cause, Age, Sex, by Country and by Region, 2000–2015 (Geneva: WHO, 2016).

including States, the African Commission, other African human rights bodies, national human rights institutions, civil society and donors. Below are the key findings from this study and the recommendations for strengthening human rights in the context of HIV in Africa.

KEY FINDINGS

Global and regional human rights frameworks contain solid foundations for the protection of human rights in relation to HIV

6. Most African States are Parties to numerous international and regional human rights treaties that guarantee critical protections in the context of HIV. At the global level, these include the following:

- › the International Covenant on Economic, Social and Cultural Rights;
- › the International Covenant on Civil and Political Rights;
- › the International Convention on the Elimination of All Forms of Racial Discrimination;
- › the Convention on the Elimination of All Forms of Discrimination against Women;
- › the Convention on the Rights of the Child;
- › the Convention on the Rights of Persons with Disabilities; and
- › the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

7. At the regional African level, key provisions in the African Charter on Human and Peoples' Rights (African Charter), the African Charter on the Rights and Welfare of the Child (African Children's Charter), and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) also are relevant to HIV.³ The Maputo Protocol includes explicit provisions addressing HIV under Article 14 on health and reproductive rights. People living with, vulnerable to or affected by HIV are entitled to all the human rights guaranteed in these global and regional treaties, which include (among others):

- › the right to non-discrimination, equal protection and equality before the law;
- › the right to life;

- › the right to the highest attainable standard of physical and mental health;
- › the right to liberty and security of person;
- › the right to dignity and integrity of the person;
- › the right to freedom of movement;
- › the right to seek and enjoy asylum;
- › the right to privacy;
- › the right to freedom of opinion and expression;
- › the right to freely receive and impart information;
- › the right to freedom of association;
- › the right to work;
- › the right to marry and to found a family;
- › the right to equal access to education;
- › the right to an adequate standard of living;
- › the right to food;
- › the right to adequate housing;
- › the right to social security, assistance and welfare;
- › the right to share in scientific advancement and its benefits;
- › the right to participate in public and cultural life; and
- › the right to be free from torture and cruel, inhuman or degrading treatment or punishment.

8. These protections have been elaborated upon and applied to HIV through global and regional commitments, guidelines and resolutions adopted by bodies such as the UN General Assembly, the African Union, the African Commission, the Intergovernmental Authority on Development (IGAD), the East African Community (EAC) and the Southern African Development Community (SADC). At the global level, the development of the International Guidelines on HIV/AIDS and Human Rights in 1996 and the adoption of several UN General Assembly political declarations on HIV and AIDS were important milestones in the recognition of HIV-related human rights. In Africa, the 2010 adoption of Resolution 163 on the Establishment of a Committee on the Protection of the Rights of People Living With HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV, which established the HIV Committee, was a critical breakthrough that localised HIV-related human rights within the work of the African

3 - See AIDS and Human Rights Research Unit, *Compendium of Key Documents Relating to Human Rights and HIV in Eastern and Southern Africa* (Pretoria, South Africa: Pretoria University Law Press, 2007).



Commission. At the global and regional levels, human rights protections also have been applied and interpreted through decisions on cases and through general comments on HIV-related issues. For example, at the global level, UN human rights bodies have addressed cases relating to HIV-related discrimination. In Africa, the African Commission's General Comments No. 1 on Article 14(1)(d) and (e) of the Maputo Protocol and No. 2 on Article 14(1)(a), (b), (c) and (f) and Article 14(2)(a) and (c) of the Maputo Protocol, directly relate to the protection of the rights of women in relation to HIV.

Good practices on the protection of HIV-related human rights across the continent must be expanded

9. In spite of the many human rights challenges and concerns facing the HIV response in Africa, critical progress and good practices have been documented across the continent. These include advances in the areas of legislation and policy at the national and regional levels, progressive rulings by courts and the implementation of rights-based

HIV programmes in several countries. These good practices are critical for guiding countries in the region on the best approaches to responding to the epidemic.

Legal and policy advances at the national, sub-regional and regional levels

Outlawing HIV-related discrimination

10. A significant number of African countries have taken legislative and policy steps to combat HIV-related discrimination. Some 35 African States have adopted laws to protect people living with HIV from discrimination, many of which are HIV-specific.⁴ In spite of their shortcomings, these laws prohibit discrimination in areas such as employment, housing, education and health care. In Kenya, the HIV and AIDS Prevention and Control Act, 2006, established an HIV and AIDS Tribunal to specifically address HIV-related discrimination cases (among others). The Tribunal is composed of legal experts, medical practitioners and people living with HIV. Since its inception,

⁴ - "2012 Progress Reports Submitted by Country," UNAIDS, accessed 15 June 2016, www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries.

the Tribunal has addressed several hundred cases relating to workplace issues—including mandatory HIV testing and discrimination on the basis of an individual's HIV status—as well as discrimination and abuse in health-care settings and denial of service based on HIV status.

Legislation to advance access to medicines

11. As part of efforts to increase access to medicines, a number of countries in Africa—including Mozambique, Rwanda, Zambia and Zimbabwe—have all used their laws to issue compulsory licenses for medicines. In 2008, Rwanda became the first country in the world to implement the World Trade Organization (WTO) Decision of the General Council of 30 August 2003, which permits someone other than the patent holder to manufacture a lower-cost version of a medicine for export to developing countries that do not themselves have the capacity to manufacture such products. The 2003 Decision requires that the developing country announce its intention to use this mechanism, and that it should further specify the expected quantity of drugs to be supplied and issue a compulsory license for them. In spite of these restrictions and challenges, the successful shipment of 7 million doses of generic antiretroviral medication from Canada to Rwanda demonstrates the possibility of implementing the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibility, provided that governments (both developed and developing) and international organisations (such as the WTO) effectively support such implementation.

Creating enabling legal and policy environments for the HIV response

12. Several countries have adopted protective laws and policies to advance the response to HIV. In Mauritius, for example, the HIV and AIDS Act No. 31 (2006) provides access to a range of HIV prevention services for people who use drugs; this includes the provision of clean needles without penalty, even though drug use is criminalised in the country. In Lesotho, the Children's Protection and Welfare Act, 2011, provides in Section 240(2) that a child of 12 years and over may consent

independently to medical treatment if they are of “sufficient maturity and have the mental capacity to understand the benefits, risks, social and other implications of the treatment or operation.” Similarly, Article 12 of Senegal's Loi n° 2010-03 du 9 avril 2010 relative au VIH/SIDA provides that a minor over the age of 15 years may independently consent to HIV testing.

13. At the sub-regional level, the Model Law on HIV in Southern Africa, adopted by the SADC Parliamentary Forum in 2008, provides rights-based and evidence-informed recommendations for legislating around HIV. Although it is a non-binding document, the Model Law has been used as a yardstick and advocacy tool for assessing and challenging national HIV laws. The East African Community HIV Prevention and Management Act, 2012, provides for binding provisions that create an enabling and protective legal framework for EAC countries.

14. At the regional level, the African Commission adopted in 2012 General Comment No. 1 on Article 14(1)(d) and (e) of the Maputo Protocol, and in 2014 General Comment No. 2 on Article 14(1)(a), (b), (c) and (f) and Article 14(2)(a) and (c) of the Maputo Protocol. Together these two General Comments elaborate on the protection of the human rights of women in the context of HIV in Africa. The African Commission also adopted ACHPR/Res.275 (LV) 14 (Resolution 275), which calls on States to end discrimination and other human rights violations based on sexual orientation and gender identity. Further, ACHPR/Res.376 (LX) 17 (Resolution 376), adopted by the African Commission in May 2017, expresses concerns about restrictions to civil society space and threats to human rights defenders working on the “right to health, the fight against HIV/AIDS, reproductive health, sexual orientation and gender” (among other issues). It calls on States to adopt specific legislative measures to recognise the status of human rights defenders and protect their rights. Finally, Resolution 260 on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services (Resolution 260),

adopted by the African Commission in 2013, calls on all countries to take measures to end and remedy involuntary and coerced sterilisation of women living with HIV.

Advancing HIV-related rights through the courts

15. Throughout the continent, courts have enabled critical advances in the protection of human rights in the context of HIV. Key judicial breakthroughs include the following.

Challenging discrimination based on HIV-related status

16. In *Hoffmann v. South African Airways*, the South African Constitutional Court held that the dismissal of an employee on grounds of HIV status violates the right to dignity and constitutes unfair discrimination.

Ending mandatory testing for sex workers

17. In *S v. Mwanza Police, Mwanza District Hospital, Ministries of Justice, Internal Affairs, Health, Attorney-General and Ex parte: HB, JM (o.b.o 9 others)*, the High Court of Malawi held that mandatory HIV testing violated a woman's constitutional rights to privacy, equality, dignity and freedom from cruel, inhuman and degrading treatment.

Ending overly broad HIV criminalisation

18. In Kenya, the High Court in *Aids Law Project v. Attorney General and Others* found that Section 24 of the HIV and AIDS Prevention and Control Act, 2006, which criminalised HIV non-disclosure and exposure, was vague and overbroad and thus violated the rights guaranteed under the Constitution, including the right to privacy.

Ending forced sterilisation of women living with HIV

19. The Supreme Court of Namibia found in *Namibia v. LM and Others* that the sterilisation without informed consent of three women living with HIV was a violation of their rights to physical integrity and to found a family—rights guaranteed to them under the Constitution. The court, however, dismissed their claim of discrimination on the basis of HIV status.

Programmes to advance human rights in the HIV response

20. Throughout the continent, countries have set up programmes to advance human rights and address barriers to HIV services, including for key populations. In Côte d'Ivoire, for instance, the Clinique Confiance, established in 1992, provides HIV and sexually transmitted infection (STI) prevention and treatment services for female and male sex workers. The tailored services for sex workers provided by Clinique Confiance has increased uptake of HIV and STI prevention and treatment services among sex workers in the areas covered. In Uganda, legal support services for sex workers—including a hotline, legal services, documentation of violations and training on rights for sex workers—are helping to reduce violations against that key population.

21. At the regional level, SADC's HIV Cross-Border Initiative co-ordinates HIV prevention, treatment, care and support services for long-distance truck drivers, sex workers and border communities along major transport corridors in southern Africa. It includes a commitment to advocate for the review of laws and regulatory frameworks that criminalise sex work and the development of policy frameworks to increase access to services.

22. Many of the advances in the HIV response in Africa have been made possible thanks to global solidarity and funding from bilateral and multilateral sources. As per the latest data available in 2017, 33 of the 89 low-income and middle-income countries globally had 75% or more of their HIV in-country expenditures provided by external sources. Despite this, overall external funding for the HIV response in low-income and middle-income countries is decreasing. While there are sub-regions in Africa where international financing is stable or continues to grow—such as East and South Africa—national financial commitments and actual in-country expenditures remain insufficient to fill the gap, particularly in West, central and North Africa. The flatlining or actual decrease in international funding for the HIV response—and the lack of an increase in domestic expenditures in many countries—poses a serious threat to the fight against the epidemic, especially for sustaining and expanding the protection of HIV-related human rights.

The engagement of the African regional human rights system remains limited in efforts to advance HIV-related human rights

23. In spite of recent progress, the role of the regional African human rights system in the response to HIV remains limited. The study has identified several challenges that must be addressed in order to ensure that regional mechanisms can fully contribute to efforts to advance human rights in relation to HIV. These challenges include the following:

Limited focus on HIV from most African human rights mechanisms

24. Besides the African Commission and its HIV Committee, other regional human rights bodies have thus far played little to no role in addressing the human rights issues raised by the most serious health epidemic on the continent. Bodies such as the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) could do more to address pertinent HIV-related human rights issues affecting children. A number of special mechanisms of the African Commission (e.g. special rapporteurs and working groups) could further articulate the HIV-related issues that are pertinent to their mandate. These include the following:

- › the Special Rapporteur on Prisons, Conditions of Detention and Policing in Africa;
- › the Special Rapporteur on Refugees, Asylum Seekers, Internally Displaced Persons and Migrants in Africa;
- › the Special Rapporteur on Rights of Women;
- › the Special Rapporteur on Freedom of Expression and Access to Information;
- › the Committee for the Prevention of Torture in Africa;
- › the Working Group on Economic, Social and Cultural Rights; and
- › the Working Group on Rights of Older Persons and People with Disabilities.

Limited accountability for, and enforcement of, regional commitments relating to HIV

25. There have been a plethora of resolutions, commitments and similar documents on HIV adopted at the regional and sub-regional levels. However, most of them have been symbolic and have lacked concrete measures for ensuring their

effective monitoring and implementation. As a result, human rights protections provided in these documents have not had much impact for the protection of people living, affected by or vulnerable to HIV.

Limited awareness and visibility of regional human rights mechanisms on HIV-related issues

26. Affected individuals and civil society organisations are generally unaware of the existence of regional human rights mechanisms. Publicly available information on regional mechanisms and how best to approach them is not easily accessible. Civil society organisations and people affected by HIV across the continent are generally unaware of the mandate of regional human rights mechanisms, the process for making a communication or otherwise interacting with the mechanisms, and how to contact them. Recent efforts by the HIV Committee to interact with government institutions and civil society through country visits and during regional and global HIV conferences are welcome, but they need to be expanded.

Inaccessibility of mechanisms

27. Regional mechanisms are inaccessible to civil society organisations and people affected by HIV. To meaningfully participate in the African Commission's public sessions, civil society organisations must have observer status. Only a handful of organisations working on HIV currently enjoy this status, and travel to the public sessions of the African Commission is costly. Similarly, the African Court on Human and People's Rights (the African Court) does not permit individuals to approach the Court unless the State related to the individual complaint has signed a declaration pursuant to Article 34(6) of the Protocol to the African Charter on Human and Peoples' Rights on the Establishment of the African Court on Human and Peoples' Rights that allows individuals and NGOs to bring matters directly to the Court. To date, only eight African Union Member States have signed this declaration, meaning that people affected by HIV and civil society organisations have limited access to the African Court.⁵ Thus, it is unsurprising that the Court has yet to issue any decisions specifically relating to HIV.

Resource constraints

- 28.** Regional human rights mechanisms—including the African Commission and, particularly, its HIV Committee—are hampered in their work by resource constraints. This limits their ability to conduct the promotional activities, missions and fact-finding visits expressed by their mandate.

HIV-related human rights violations represent a serious concern in Africa

- 29.** Across the continent, countries have introduced laws and taken other measures in response to HIV. In spite of these measures, HIV-related human rights violations continue to occur. These human rights violations impede programmes to address HIV by stifling health-seeking behaviours and limiting the abilities of stakeholders and service providers to act against the epidemic. Examples of human rights violations in the context of HIV include the following.

Inequality and discrimination against people living with HIV

- 30.** People living with HIV in Africa continue to experience high levels of discrimination and stigma because of their HIV status. Stigma and discrimination hinder efforts to end the HIV epidemic because they discourage people living with HIV from disclosing their status to family members and sexual partners. They also undermine the ability and willingness of people living with HIV to access and adhere to treatment.
- 31.** Stigma and discrimination have a profound effect on the ability of people living with HIV to enjoy their rights to work, health care, privacy, dignity and freedom of movement. Forms of discrimination and stigmatisation are similar across the continent and include marginalisation from families and communities, verbal harassment, physical assault, workplace discrimination, and coercive sexual and reproductive health-care services.
- 32.** In many countries where anti-discrimination laws exist to protect people living with HIV, their implementation and enforcement is often lacking. Key decision-makers—including legal

professionals, health-care workers and employers—do not always understand HIV or its relationship to the law, and they are therefore not able to uphold human rights. Similarly, people living with HIV are not always aware of their rights or they lack access to legal services, and these challenges—together with stigma and discrimination—combine to pose significant barriers to accessing legal services.

Compulsory and other forms of coercive HIV testing

- 33.** Mandatory and coerced testing and breaches of confidentiality have been reported across the continent. Countries such as Egypt and Mauritius still impose HIV testing for immigration purposes, and mandatory pre-marital HIV testing has been reported in several countries, including Burundi, Democratic Republic of the Congo, Ghana, Kenya, Nigeria, Tanzania and Uganda. Where same-sex sexual conduct is criminalised, cases of involuntary testing of men accused of engaging in consensual same-sex sexual acts have been documented. In efforts to expand access to HIV testing, countries have introduced testing modalities such as provider-initiated testing and counselling (PITC), community and home testing, routine testing, couples testing and mobile testing. While critical to expanding access to HIV testing, some of these approaches can have serious human rights implications, particularly in terms of confidentiality and informed consent. HIV testing also poses gender-related issues because women, particularly pregnant women, are disproportionately subjected to HIV testing without clear measures to ensure their safety and protection from abuse.

Challenges to access to treatment, including restrictive intellectual property regimes

- 34.** In spite of recent increases in access to antiretroviral therapy, a significant number of people living with HIV in Africa still lack access to life-saving medication. Article 16 of the African Charter places an obligation on Member States to “take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.”⁶ This includes non-discriminatory access to affordable life-saving treatments, such as antiretroviral medicines. The

protection of intellectual property (IP) rights—and the failure to reform or effectively use flexibilities within the IP regime—undermines access to affordable medicines in Africa: one in two people living with HIV are still not accessing antiretroviral therapy. In eastern and southern Africa, 67% [54–76%] of women and 51% [41–58%] of men were accessing antiretroviral therapy in 2016. In western and central Africa, 44% [32–56%] of women living with HIV and 25% [17–32%] of men living with HIV were accessing antiretroviral therapy in 2016.⁷

35. Countries face many barriers when trying to provide citizens with affordable drugs. The TRIPS Agreement limits the ability of countries to access affordable medicines: the flexibilities existing under TRIPS have proven too complex and restrictive for the great majority of African countries. In recent years, anti-counterfeiting laws have been shown to represent a threat to the ability of countries to manufacture or import generic medicines.

Overly broad criminalisation of HIV non-disclosure, exposure or transmission

36. More than 25 countries in Africa have adopted laws that explicitly allow for the criminalisation of HIV non-disclosure, exposure or transmission. This is problematic, because overly broad criminalisation of HIV non-disclosure, exposure or transmission raises both public health and human rights concerns. Rather than achieving justice or preventing HIV transmission, laws or prosecutions for HIV non-disclosure, exposure or transmission perpetuate stigma and discrimination against people living with HIV. They create barriers to accessing prevention, treatment and care services, and they expose already marginalised groups (such as sex workers and people who inject drugs) to further discrimination and persecution. These laws and prosecutions often relate to acts that represent no risk of HIV transmission, and they involve disproportionately high penalties. Furthermore, laws allowing for HIV criminalisation can be vague and ambiguous, and they pose a serious risk of unfair application and the miscarriage of justice.

Restrictions to civil society space in the context of HIV

37. A vibrant, well-funded, resourced and engaged civil society and community movement is critical to the response to the HIV epidemic. Civil society plays an important role in delivering testing and treatment services, educating communities on HIV and prevention, building the capacities and resilience of key populations, and advocating for law reform and increased government services.

38. Despite their importance, non-governmental organisations working on HIV or with key populations appear to be experiencing increased challenges, as governments restrict the activities of organisations seen to be supporting or promoting illegal or so-called immoral activities. Several organisations working on HIV have reported challenges while registering, operating or attempting to access funding. These challenges mainly target groups that conduct advocacy and human rights work on HIV and those that work with key populations, and they have been shown to impact the ability of these organisations to contribute fully to the HIV response. In particular, they limit the ability of organisations to raise funds or apply for grants, advocate for a stronger legal environment for the HIV response, and provide critical HIV-related services. Such restrictions also drive marginalised populations underground, inhibiting their ability to access testing and treatment and increasing their vulnerability to violence, abuse and HIV infection.

Conflict as a challenge for the HIV response

39. Armed conflict and post-conflict periods raise challenges for HIV prevention and treatment. During armed conflict, HIV prevention and treatment services tend to be significantly reduced because of the instability created by war. Armed conflicts also can increase the need for HIV prevention and treatment services, and they can increase the risk of sexual violence and abuse.

40. People displaced by conflict have reduced access to prevention and treatment services. Knowing where to access such services and having a regular supply

of antiretroviral medicines can be difficult in such circumstances. This can result in people living with HIV developing resistance to HIV medicines. Due to their socio-economic vulnerability and other factors, refugees and migrants also experience increased risks of acquiring HIV.

Challenges faced by women and girls

- 41.** Women are significantly more vulnerable to HIV than men in Africa, where women and girls accounted for 59% of people living with HIV in 2016.⁸ In sub-Saharan Africa, HIV prevalence among young women and girls is more than double what it is among young men and boys. Laws, policies and practices that perpetuate gender inequality, harmful gender norms and gender-based violence undermine the health of women and girls by keeping them in poverty and limiting their autonomy and decision-making power, including limiting their ability to access health-care services. In some settings, women who are subjected to intimate partner violence are on average 1.5 times more likely to acquire HIV.⁹

- 42.** Women living with HIV experience discrimination and coercive practices in relation to their sexual and reproductive health rights.¹⁰ Discriminatory treatment by health-service providers can deprive women living with HIV of their right to a family, breach their right to privacy, deny them potentially life-saving treatments or procedures and, in some cases, amount to torture. These practices include being advised not to have children, being forced to use contraception in order to obtain antiretroviral therapy and being coerced into terminating a pregnancy.

- 43.** Harmful cultural practices—such as wife inheritance, child marriage and female genital mutilation (FGM)—also could increase vulnerability to HIV among women and girls. Child marriage and FGM are still legal in a number of countries, and even where they are illegal, many women report being unable or unwilling to oppose them for religious or cultural reasons, or because they feel forced to abide by them out of fear of recrimination. A number of countries have



⁸ - UNAIDS 2017 estimates.

⁹ - World Health Organization et al., *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence* (Geneva: World Health Organization, 2013).

¹⁰ - Global Commission on HIV and the Law, *HIV and the Law* (New York: Global Commission on HIV and the Law, 2012), 64.

begun to outlaw both child marriage and FGM, but exceptions and loopholes continue to exist in relation to marriage. Changing laws also does not necessarily result in changes to customary and religious practices, particularly where custom and tradition tend to prevail over the law.

Challenges faced by children

44. Children and adolescents face various human rights challenges in the context of HIV. These include barriers to their ability to protect themselves from HIV transmission or to access the necessary treatment, care and support when they have acquired HIV or been affected by it. Child marriage and laws and policies that place restrictions on access to sexual and reproductive health services increase young people's vulnerability to HIV and limit their access to health and HIV services.

45. Children living with HIV often experience stigma, discrimination and violations of their rights, including discrimination within their communities and in their access to health-care services. Reports indicate that children are sometimes subjected to HIV testing without their voluntary and informed consent, or to having their rights to confidentiality breached by health professionals. Access to independent HIV testing, treatment and care for adolescents and young people is limited by laws and policy, including age of consent requirements that limit their access to services. For many children, access to HIV treatment and care is limited by social, medical, systemic and economic barriers, including the failure to implement appropriate systems and strategies for early diagnosis and treatment for children. Furthermore, lack of birth registration for children, particularly orphans and other vulnerable children, contributes to hindering their access to health and social services.

Challenges faced by persons with disabilities

46. Persons with disabilities are often marginalised and stigmatised in society. They experience high rates of violence, sexual abuse and poverty, and they face limited access to health-care services. These factors contribute to making them more vulnerable to HIV and to hindering their ability to access services when living with HIV.¹¹ The limited

research undertaken on HIV and disability in Africa suggests that persons with disabilities have a similar, if not higher, risk of acquiring HIV than the general population.

47. People living with HIV who have a disability face significant barriers to accessing health-care services. This includes negative attitudes among health-care providers towards persons with disabilities, particularly in relation to sexual and reproductive health care. There also is limited access to services for persons with disabilities, including actual services and educational materials and information. Services designed to meet their specific needs are also very limited.

Challenges faced by indigenous persons

48. The prevalence of HIV and specific risk factors among indigenous populations in Africa is significantly underexplored and the data are limited. Indigenous populations in Africa experience human rights violations that likely increase their vulnerability to HIV infection, including political and economic marginalisation, de facto discrimination of non-agricultural groups, loss of land and community, lack of access to health-care services (often due to geographic isolation) and poverty.

Challenges faced by migrants, refugees and displaced persons

49. Social, economic and political factors in both the country of origin and destination countries influence migrants' and refugees' risk of HIV infection. HIV prevalence can be higher among migrants, refugees and displaced persons, especially for those originating from regions and settings with high HIV prevalence in the general population. These populations may acquire HIV in their country or region of destination or while in transit and often face a specific vulnerability to HIV related to their status as migrants, refugees and displaced persons. Stigma, discrimination, violence, denial of health services and other human rights violations contribute to making these populations particularly vulnerable to HIV and limiting their access to HIV and other health services.

¹¹ - United Nations Office of the High Commissioner for Human Rights (OHCHR) et al., HIV/AIDS and Disability Policy Brief (OHCHR, 2009); Waimar Tun et al., "Limited Accessibility to HIV Services for Persons with Disabilities Living with HIV in Ghana,

Uganda and Zambia," *Journal of International Aids Society* 19, no. 5 (2016): 20829; and UNAIDS, *The Gap Report* (Geneva: UNAIDS, 2014).

Challenges faced by key populations in need of specific protection and access to HIV and health services

50. Key populations—who are already marginalised through other forms of stigma, inequality and discrimination—are disproportionately affected by HIV. Evidence from UNAIDS and the World Health Organization (WHO) shows that key populations in the context of HIV include gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners.¹² These populations face human rights violations as well as legal and social barriers that make them vulnerable to HIV and limit their access to health and HIV services.

Gay men and other men who have sex with men

51. In 2016, the highest global median HIV prevalence rates among gay men and other men who have sex with men were reported in western and central Africa (17%) and eastern and southern Africa (14%). Punitive legal environments—combined with stigma, discrimination and high levels of violence—place gay men and other men who have sex with men at high risk of HIV infection because they are driven underground due to fear of prosecution or other negative consequences. As a result, they do not receive appropriate health education and service provision, and they are reluctant to seek health-care services, testing and treatment. In recent years, a number of countries have introduced new laws that target these populations, in some cases extending criminalisation to individuals and organisations perceived to support same-sex sexual relationships. This is believed to have led to increased harassment and prosecution on the basis of sexual orientation and gender identity, and it has resulted in increased difficulties for health workers who are trying to reach this population. In most countries, national funding and spending to address the health and HIV needs of this population remain limited.

Transgender persons

52. Transgender persons are marginalised, abused and often rejected by their families and society. They experience discrimination, gender-based violence and abuse, and marginalisation and social exclusion, and in the face of such treatment, they

are less likely to seek out health care and testing. They also are vulnerable to HIV through sexual assault, and in many contexts, they are pushed into high-risk practices such as sex work. As a result, transgender people are one of the most vulnerable groups in relation to HIV, being 49 times more likely to be living with HIV than adults in the general population.¹³ Overall, there is limited information on the impact of HIV on transgender women and men in Africa; for the most part, they are an “invisible” population in responses to the HIV epidemic.

Sex workers

53. Globally, female sex workers are 10 times more likely to acquire HIV than adult women in the general population.¹⁴ In sub-Saharan Africa, HIV prevalence among female sex workers is roughly 26%. Sex workers in Africa face exceptionally high levels of stigma, discrimination, violence, extortion, sexual abuse and rape from clients, intimate partners and law enforcement officials; this, in turn, places them at increased risk of HIV.

54. Sex work (or aspects of sex work) is criminalised in a great majority of countries across Africa. Even in countries where sex work is not criminalised, law enforcement practices such as arbitrary detention and arrests based on condom possession deter sex workers from accessing condoms and place them at risk of HIV infection. Sex workers have also been charged with spreading STIs and forced to undergo mandatory HIV testing.

People who use drugs

55. HIV prevalence among people who use drugs in Africa is approximately 5% (based on nine countries reporting). While the number of people who use drugs in Africa is relatively small in comparison to other regions, this number is growing along with the HIV infection rate. Criminalisation of drug use, fear of arrest and harassment, the imprisonment of people who use drugs and widespread societal stigma all contribute to discourage access to health-care services among people who use drugs and to create legal barriers to the provision of needle-syringe programmes. These laws and practices have prevented most

¹² - These populations often suffer from punitive laws or stigmatizing policies, and they are among the people most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere: they are key to the epidemic and key to the response. See UNAIDS, UNAIDS Terminology Guidelines, 31; WHO, Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (Geneva: WHO, 2014).

¹³ - Stefan D. Baral et al., “Worldwide Burden of HIV in Transgender Women: A Systematic Review and Meta-Analysis,” *The Lancet Infectious Disease* 13, no. 3 (2013): 214–222.

¹⁴ - UNAIDS special analysis, 2016.

countries in Africa from establishing effective HIV prevention, treatment, care and support services for people who inject drugs (including harm reduction services, such as needle-syringe programmes and opioid substitution therapy).

Prisoners

56. Prison populations are estimated to be between two to 10 times more likely to contract HIV and tuberculosis (TB) than the general population. In 2016, the estimated median HIV prevalence among prison populations in East and southern Africa was 20%.

57. A number of factors contribute to the high risk of HIV exposure in prisons. Poor conditions—including severe overcrowding, minimum ventilation, inadequate sanitation, poor nutrition and high levels of sexual violence—play a part in high vulnerability to HIV and TB. Such conditions violate the rights of prisoners to dignity, health and to be free from cruel, inhumane and degrading treatment or punishment.

58. Prisons also are sites of unsafe practices that place prisoners at high risk of HIV, including unprotected sex, rape, drug use, multi-person use of injecting equipment and unsterile tattooing. Criminalisation of same-sex sexual relations and drug use continue to be used to prevent many countries from providing needed HIV services and commodities in prisons, including condoms, lubricants, clean needles and opioid substitution therapy.

RECOMMENDATIONS

59. To States

- › Take immediate steps to review and amend laws, policies and practices to ensure that they are in line with human rights norms and principles, and that they support effective HIV responses. In particular, steps should be taken to remove laws and other measures that allow for discrimination against and criminalisation of people living with HIV and members of key populations (including sex workers, people who inject drugs, gay men and other men who have sex with men, and transgender persons).

- › Adopt effective measures to prevent and redress human rights violations in the context of HIV, and refrain from discrimination, criminalization or other human rights violations against people living with HIV, key populations and other vulnerable groups.

- › Remove legal, policy, social and other barriers that limit the rights of women and girls to access HIV prevention, treatment, care and support services or those that make them more vulnerable to HIV.

- › Remove legal, policy, social and other barriers that limit access to HIV prevention, treatment, care and support services among children and young people or those that make them more vulnerable to HIV.

- › Remove punitive and restrictive laws, policies and practices that infringe upon the rights to freedom of association and assembly of organisations and human rights defenders working on health and HIV. Also remove the punitive and restrictive laws, policies and practices that stigmatise and discriminate against particular categories of human rights defenders on the basis of sex, health status, sexual orientation, gender identity and expression, or other status.

- › Maintain and expand dialogue and consultation with civil society organisations working on HIV and human rights, including those working with or for key populations.

- › Ensure that national mechanisms responsible for the response to HIV (including national AIDS commissions) apply rights-based responses and guarantee the meaningful participation of people living with HIV and key populations in the HIV response, as provided in the good practices identified in this report.

- › Take the necessary measures to increase their financial allocation to the health sector in general—and for HIV services in particular—as agreed in the Abuja Declaration on HIV/

AIDS, Tuberculosis and Other Related Infectious Diseases (Abuja Declaration).

- › Take the necessary measures to establish and expand programmes to reduce stigma and discrimination and to expand access to justice in the context of HIV and health. These measures should include the following:
 - » Programmes to reduce stigma and discrimination. These can include community interaction and focus group discussions involving people living with HIV and members of populations vulnerable to HIV infection, as well as the use of media, peer mobilization and support developed for and by people living with HIV to promote health, well-being and human rights.
 - » Programmes to ensure access to HIV-related legal services.
 - » Programmes on monitoring and reforming laws, regulations and policies relating to HIV.
 - » Legal literacy (“know your rights”) programmes.
 - » Sensitization of law-makers and law enforcement agents.
 - » Training for health-care providers on human rights and medical ethics related to HIV.
 - » Programmes to reduce discrimination against women in the context of HIV.

60. To the African Union and other regional and sub-regional bodies

- › Increase political and technical engagement in efforts to address the HIV epidemic in Africa, including the legal and policy challenges raised by HIV.
- › Encourage States to take appropriate measures to address laws, policies and practices that violate human rights and act as barriers to effective responses to HIV.
- › Ensure appropriate attention to HIV and human rights issues and challenges in the implementation of key regional and sub-regional priorities, agendas and frameworks, including Agenda 2063 of the African Union.

- › Create opportunities for dialogue between States, civil society and other key stakeholders on the challenges, good practices and progress related to the protection of human rights in the context of HIV.
- › Continue to provide space for all civil society organisations (including those representing key populations) to engage States and other stakeholders in the response to HIV at the regional and sub-regional levels, and to ensure their effective participation in regional policy development and decision-making processes.
- › Encourage and support full collaboration between States and national, regional and international human rights mechanisms, and support the independence of these mechanisms.

61. To the African Commission

- › Continue to raise awareness on the importance of promoting and protecting human rights in the context of HIV, including through country visits, fact-finding missions, urgent appeals and the work of subsidiary mechanisms.
- › Systematically monitor and denounce human rights violations that are committed in the context of HIV, including by publishing an annual update developed by the HIV Committee that examines the key human rights progress and challenges facing the HIV response in Africa.
- › Fully utilise the protective and promotional mandates to monitor State compliance with all relevant human rights norms and standards relevant to HIV, including through country visits, recommendations on State reports, fact-finding missions, urgent appeals and other means. In particular,
 - » call on Member States to address the questions provided in the Annex of this study when preparing their state reports under Article 62 reports; and
 - » ensure that the African Commission and its subsidiary mechanisms use the questions provided in the Annex of this study in their

country visits, consideration of state reports and fact-finding missions.

- › Encourage Member States to conduct law and policy review and reform, and to adopt, implement and enforce rights-based laws, policies and plans in the context of HIV and AIDS, drawing on international and regional guidance on HIV law and human rights.
- › Monitor and ensure the effective dissemination and implementation of HIV-related key resolutions, general comments and guidelines of the African Commission.
- › Develop guidelines and recommendations for Member States on particular legal and policy issues affecting the rights of people living with HIV and key populations. Among other issues, these guidelines should address criminal law and its impact on the HIV response.
- › Ensure that the HIV Committee has the necessary technical, human and financial resources to fully discharge its mandate as provided in Resolution 163 of the African Commission.
- › Ensure the effective dissemination and promotion of the present study and its recommendations, including through seminars, promotional visits and other appropriate means.
- › Continue and reinforce collaboration and dialogue with civil society, governments and relevant regional and global institutions working on HIV in order to discuss challenges, good practices, progress and effective accountability to advance human rights-based responses to HIV, including through the work of the HIV Committee.
- › Consider the extension of the mandate of the HIV Committee in the medium- to long-term to cover other critical health issues that are affecting the continent.

62.

To the ACERWC

- › Require specific information on children and HIV from Member States in the States Parties Reporting Guidelines.
- › Actively ensure the promotion and protection of the rights of the child in the context of HIV through its mandate, including country visits, reports and resolutions on the rights of the child.
- › Develop a general comment focused on the rights of the child in the context of HIV and the obligation of States to respect, protect and fulfil these rights. This should address access to HIV prevention, testing, treatment and care services for children, including access to sexual and reproductive health services.
- › Encourage Member States to ensure that domestic legal frameworks protect the rights of children living with HIV and those vulnerable to HIV infection.
- › Urge Member States to conduct the necessary law and policy review and reform, and to adopt, implement and enforce rights-based laws, policies and plans in the context of HIV and in accordance with the African Children's Charter.
- › Increase awareness of ACERWC's mandate among civil society and other organisations working on the rights of the child in the context of health and HIV.

63.

To national human rights institutions, gender commissions and similar bodies

- › Effectively use their promotion and/or protection mandates to hold States accountable for advancing human rights in the context of the HIV response.
- › Establish focal points on HIV and health within the institution or commission, and ensure they

are adequately resourced and actively engage all human rights issues affecting people living with HIV and members of key populations.

- › Work closely with and regularly engage national authorities and programmes (such as HIV and TB programmes) working on HIV, TB and other health issues, as well as civil society organisations (including those representing key populations) that are working on these issues.

64. To civil society organisations

- › Continue to engage national, regional and UN human rights mechanisms to prevent and respond to human rights violations in the context of HIV. In particular, prioritise engagement with the African Commission, its HIV Committee and other regional bodies on HIV and human rights.
- › Establish and reinforce regional partnerships and approaches to advance collaboration and intersectional approaches with the African Commission and African Union that build alliances with diverse civil society organisations working on areas such as women and young people, and with human rights defenders working on issues such as health, HIV, sexual orientation, gender identity and expression, civic space, and sexual and reproductive health and rights.
- › Develop innovative approaches to engage the general public, all branches of government and

other opinion leaders (including the media) on the critical human rights issues relating to the HIV epidemic.

65. To the media

- › Maintain and strengthen dialogue with people living with HIV and members of key populations. Support their efforts to advance human rights, the rule of law, social change and development in the context of the HIV response.
- › Refrain from inciting hatred against people living with HIV and members of key populations, and promote responsible reporting that advances rights-based and evidence-informed responses to HIV.

66. To religious and traditional leaders

- › Maintain and strengthen dialogue with people living with HIV and members of key populations. Support their efforts to advance human rights, the rule of law, social change and development in the context of the HIV response.
- › Refrain from inciting hatred against people living with HIV and members of key populations.
- › Encourage an inclusive, protective and humane attitude towards people living with HIV and vulnerable and key populations.

I. INTRODUCTION

GENERAL BACKGROUND

1. For more than three decades, the world has been battling the HIV pandemic, which is estimated to have claimed a total of 35 million lives globally, primarily in Africa. In 2016, there were an estimated 25.7 million [23.0–28.8 million] people living with HIV in Africa, representing nearly 70% of the global total of 36.7 million people living with HIV [30.8–42.9 million]. In 2016 alone, there were an estimated 1.2 million [990,000–1.4 million] new HIV infections and 730,000 [590,000–890,000] deaths due to AIDS-related illness in Africa.¹⁵

2. Although important progress has been made in the response to HIV in the region—including a decline in new HIV infections and a significant increase in access to antiretroviral therapy¹⁶—the epidemic remains the leading cause of death in sub-Saharan Africa.¹⁷ Moreover, serious social, legal and policy issues—such as stigma, discrimination, gender inequality and other negative norms and practices that affect people vulnerable to HIV and hinder access to HIV services—remain largely unchallenged.¹⁸

3. Very early in the HIV epidemic, it was recognised that the protection of human rights was essential to ensuring that those living with and affected by the epidemic would come forward to access HIV-related prevention, treatment and care services. It was also recognised that the protection, promotion and fulfilment of human rights for all was instrumental to addressing the factors that make specific populations—such as women, children, young people, sex workers, people who use drugs, prisoners, and gay men and other men who have sex with men—vulnerable to the epidemic. Contrary to restrictive measures generally used in the context of public health, the 41st World Health Assembly adopted Resolution WHA

41.24 in 1988, which called on States to protect people living with HIV against discrimination and other coercive measures.¹⁹ This pronouncement made by an international organisation under the impulsion of civil society organisations and people living with HIV set the tone for further articulation of the importance of human rights in HIV-related legal, policy and programmatic responses to the epidemic at the global, regional and national levels.

4. At the global level, human rights norms enshrined in the Universal Declaration on Human Rights and a number of human rights treaties have been interpreted to apply to HIV.²⁰ In particular, the norms in these treaties relating to non-discrimination, liberty, security, equality, health, education and free and fair trials have been explicitly interpreted to apply to HIV through general comments, concluding observations and findings in communications.²¹

5. In Africa, the great majority of legal and human rights developments relating to HIV have occurred at the national level.

► First, human rights norms have been invoked at the national level to ensure that people living with HIV are protected against discrimination, violence and coercion, including in accessing HIV services. This has taken the form of advocacy campaigns and court cases in response to discrimination in areas such as employment, housing and inheritance.²²

► Second, human rights norms have been used to claim HIV-related health services and entitlements, including access to evidence-informed HIV-related prevention and treatment services. This was illustrated by the Treatment Action Campaign's (TAC's) successful litigation against the South African Government to secure access to antiretroviral

¹⁵ - UNAIDS 2017 estimates.

¹⁶ - UNAIDS 2017 estimates.

¹⁷ - WHO, Global Health Estimates 2015.

¹⁸ - See Global Commission, HIV and the Law, 64; and Cynthia I. Grossman et al., "Global Action to Reduce HIV Stigma and Discrimination," *Journal of the International AIDS Society* 16, Suppl. 2 (2013): 18881.

¹⁹ - World Health Assembly, Res. WHA 41.24, AIDS: Avoidance of Discrimination in Relation to HIV-Infected People and People with AIDS (13 May 1988).

²⁰ - Examples of treaties include the following: the International Covenant on Civil and Political Rights (ICCPR), Art. 2; the International Covenant on Economic Social and Cultural Rights (ICESCR), Art. 2; the Convention on the Elimination of All Forms of

Discrimination Against Women (CEDAW); the Convention on the Rights of the Child (CRC), Art. 2(1); and subsequent human rights treaties, such as the Convention on the Rights of Persons with Disabilities.

²¹ - For example, please see: Committee on ESCR, General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights (Art. 2, para. 2 of the International Covenant on Economic, Social and Cultural Rights) (2009); and Committee on the Rights of the Child, General Comment No. 3 (2003): HIV/AIDS and the Rights of the Child (13–31 January 2003).

²² - Lawrence Gostin, *Global Health Law* (Harvard: Harvard UP, 2014).

²³ - Minister of Health and Others v. Treatment Action Campaign and Others (No. 2) (CCT8/02) [2002], ZACC 15.

therapy for the prevention of mother-to-child transmission (PMTCT).²³

- › Third, human rights norms and approaches have been used to demand specific actions to address factors such as vulnerability to HIV and barriers to HIV service access, including for specific groups (such as those identified as key populations). For example, in *Odafe and Others v. Attorney-General and Others*, the High Court of Nigeria relied on the African Charter in finding that the denial of access to HIV treatment for prisoners violated their rights to life and dignity.²⁴

6. At the regional level, the African Commission's first pronouncement on HIV was in 2001 with the adoption of Resolution ACHPR/Res.53 (XXIX) 01 on the HIV/AIDS Pandemic—Threat Against Human Rights and Humanity (Resolution 53). In this resolution, the African Commission “declare[d] that the HIV/AIDS pandemic is a human rights issue which is a threat against humanity.”²⁵ It subsequently called on African governments and State Parties to the Charter to allocate national resources that reflect a determination to fight the spread of HIV, ensure human rights protection against discrimination for those living with HIV, provide support to families for the care of those dying from AIDS-related illness, devise educational public health-care programmes, and carry out public awareness, especially in view of free and voluntary HIV testing and appropriate medical interventions.²⁶

7. Further to this resolution, the African Commission adopted Resolution ACHPR/Res.141 (XLIV) 08 on Access to Health and Needed Medicines in Africa (Resolution 141) and Resolution 260.²⁷ Through the work and reports of some of its subsidiary mechanisms—such as the Special Rapporteur on Prisons, Conditions of Detention and Policing in Africa (Special Rapporteur on Prisons), the Special Rapporteur on the Rights of Women in Africa and the Working Group on Economic, Social

and Cultural Rights—the African Commission has further addressed HIV-related issues.²⁸

8. However, the engagement of the African Commission has not been commensurate with the seriousness and diversity of human rights challenges faced in Africa due to the HIV epidemic. To provide a mechanism for intensifying its efforts to advance human rights in the response to HIV, the African Commission adopted Resolution 163 establishing the HIV Committee. The HIV Committee has been afforded a broad promotion and protection mandate that includes fact-finding missions on allegations of human rights violations, the publication of reports of key human rights issues relating to HIV and the production of recommendations to States to strengthen the respect, protection and fulfilment of the rights of people living with HIV and those at risk of (and affected by) the epidemic in Africa.

PROCESS AND METHODOLOGY OF THIS STUDY

9. At its 16th Extraordinary Session held in July 2014 in Kigali, Rwanda, the African Commission adopted Resolution 290 on the Need to Conduct a Study on HIV, the Law and Human Rights, which tasked the HIV Committee with conducting a study on “HIV, the Law and Human Rights in the African Human Rights System: Key Challenges and Opportunities for Rights-Based Responses to HIV. The resolution is based on the mandate of the HIV Committee to “recommend concrete and effective strategies to better protect the rights of people living with HIV and those at risk.”²⁹ Recognizing the various legal challenges involved in the HIV epidemic and the response in Africa, the resolution seeks to use the study to analyse “legislative/legal frameworks and human rights [with a focus] on best practices and opportunities for [strengthening] the promotion and protection of human rights” relating to HIV.³⁰ In line with the mandate of the HIV Committee, the study is expected to cover all people living with HIV and those at risk, vulnerable to and affected by

²⁴ - *Odafe and Others v. Attorney-General and Others* (2004), AHRLR 205 (NgHC 2004).

²⁵ - African Commission, Resolution 53 on the HIV/AIDS Pandemic—Threat Against Human Rights and Humanity, African Commission Res.53 (XXIX) (23rd April to 7th May 2001).

²⁶ - African Commission, Resolution 53 on the HIV/AIDS Pandemic.

²⁷ - See African Commission, Resolution 141 on Access to Health and Needed Medicines in Africa, African Commission Res.141 (XLIV) (2008); and African Commission,

Resolution 260 on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services, ACHPR/Res.260 (LIV) (2013).

²⁸ - Sabelo Gumedze, “HIV/AIDS and Human Rights: The Role of the African Commission on Human and Peoples' Rights,” *African Human Rights Law Journal* 2 (2004): 181.

²⁹ - African Commission, Resolution 290 on the Need to Conduct a Study on HIV, the Law and Human Rights, ACHPR/Res.290 (EXT.OS/XVI) (20–29 July 2014).

³⁰ - African Commission, Resolution 290 on the Need to Conduct a Study.



HIV, including “women, children, sex workers, migrants, men having sex with men, intravenous drugs users and prisoners.”³¹

10. The development of the report was effectively initiated in 2015 with the development of the terms of reference. In light of this delay, the African Commission adopted ACHPR/Res.308 (EXT.OS/ XVIII) 2015 on The Extension of the Deadline for the Study on HIV, the Law and Human Rights (Resolution 308), which prolonged the period for undertaking the report by one year.³² The process for developing this report was remarkable for the extensive consultations that it involved and the diversity of stakeholders engaged.

11. The terms of reference of the study were discussed and amended during a joint meeting between the HIV Committee and UNAIDS’ Eastern and Southern Africa Regional Think Tank on HIV, Health and Social Justice (the Think Tank) from 31 August to 1 September 2015, in Abidjan, Côte d’Ivoire. A revised version of the terms of

reference for the study was produced in October 2015. It served as a basis for a consultative session during the 18th International Conference on AIDS and STIs in Africa (ICASA), held in December 2015 in Harare, Zimbabwe. The consultative session was attended by members of the African Commission, expert members of the HIV Committee, representatives from national AIDS commissions, HIV programme implementers, civil society organisations, people living with HIV, human rights experts and representatives from key populations (including sex workers and men who have sex with men). Following the consultative session, a first draft of the report was developed and tabled for discussion and input from experts and stakeholders at a 23 July 2016 meeting during the 21st International AIDS Conference in Durban, South Africa. The meeting in Durban brought together HIV programme implementers, members of the judiciary, people living with HIV, women, young people, civil society organisations and the UN. It enabled a good representation of members of key populations to participate in

³¹ - African Commission, Resolution 163 on the Establishment of a Committee on the Protection of the Rights of People Living With HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV, African Commission Res.163 (2010).

³² - African Commission, Resolution 308 on the Extension of the Deadline for the Study on HIV, the Law and Human Rights, ACHPR/Res.308 (EXT.OS/XVIII) (2015).

the study review and deliberations, including sex workers, people who inject drugs, men who have sex with men and transgender persons.

- 12.** Further to the face-to-face consultative meetings, the draft of the study was posted online for public submissions for a period of two weeks. Comments were received from individuals, civil society organisations and international institutions with expertise on human rights, health and HIV. Through these consultations, meetings and submissions, the HIV Committee was able to engage and elicit the views of over 200 organisations and individuals working on HIV in Africa and around the world.
- 13.** This report is divided into six chapters and an annex:
 - › It begins with this introduction as Chapter I.
 - › Chapter II presents a synopsis of the HIV epidemic in Africa.

- › Chapter III provides an overview of global African regional human rights norms applicable to HIV.
- › Chapter IV examines the extent to which legal and institutional arrangements at the African regional and sub-regional levels address HIV-related human rights issues.
- › Chapter V focuses on the key human rights challenges impacting the HIV response in Africa. It also provides an overview of good practices on addressing these human rights challenges.
- › Chapter VI concludes the study with a summary of its key findings and recommendations.
- › The study is completed by an annex, which provides questions and elements to guide both State reporting under Article 62 of the African Charter and other interactions with States regarding HIV.

II. THE HIV EPIDEMIC IN AFRICA³³

1. More than 30 years into the AIDS epidemic, Africa remains the region of the world most affected by HIV.³⁴ The HIV epidemic is also contributing to high TB incidence and deaths in Africa: TB is the leading cause of mortality among people living with HIV in the region.³⁵ With 275 incident TB cases for every 100,000 people in 2015—almost double the global estimate—the African region has the most severe TB burden relative to population in the world. Half of the countries with the highest TB burden are in Africa, and nine countries—Angola, the Democratic Republic of the Congo, Ethiopia, Kenya, Mozambique, Nigeria, Somalia, South Africa and Zimbabwe—are among the 30 countries with the highest burden of multi-drug resistant TB. Countries in sub-Saharan Africa accounted for approximately 75% of all deaths from HIV-associated TB in 2015.³⁶

2. The impact of the HIV epidemic on families and communities is significant in the region. High HIV-related mortality among adults translates into a high number of children orphaned by the epidemic. In 2016, an estimated 13.7 million [11.4–16 million] children in sub-Saharan Africa—83% of the global total—had lost one or both parents to AIDS-related illness.³⁷ The epidemic also has had important economic and social impacts. The cost of caring for household members with AIDS-related illness is high, and it is compounded by the overall reduced family income that results because of the inability to work due to illness. While recent progress in access to HIV treatment on the continent has helped alleviate the impacts of the epidemic, its social and economic consequences continue to be serious in communities where treatment coverage remains low.

DIVERSE BURDEN OF THE HIV EPIDEMIC

3. The AIDS epidemic in Africa is far from homogenous. Countries in eastern and southern

Africa are generally more affected by HIV than those in West and central Africa, and countries in North Africa are among those with the lowest HIV prevalence (see Figure 1). All four countries in the world with HIV prevalence in the adult population above 15% (also referred to as “hyperendemic” countries) are in southern Africa. With the exception of Equatorial Guinea, all countries in West and central Africa have an HIV prevalence of less than 5% in the adult population aged 15–49 years (Figure 1).

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

IMPORTANT BUT UNEQUAL PROGRESS

5. Significant progress against HIV has been made in recent years in sub-Saharan Africa. The number of people receiving antiretroviral therapy in the region increased from fewer than 10,000 in 2000 to 13.8 million in 2016. The expanded access to HIV treatment in the region is contributing to reduced deaths from AIDS-related illness in sub-Saharan Africa, which fell by 53% between 2005 and 2016. Countries that recorded the most significant reductions in deaths from AIDS-related illness include Rwanda (78%), Ethiopia (76%), Burkina Faso (72%), Tanzania (72%), Kenya (71%), Zimbabwe (70%), Botswana (70%), Eritrea (69%), Zambia (67%) and Malawi (67%).⁴⁰

6. Coverage of programmes for PMTCT has increased drastically, particularly in eastern and southern Africa, where 89% of pregnant women living with HIV were reported to receive effective antiretroviral medicines for PMTCT in 2016. Consequently, in

33 - This chapter is adapted from Patrick Michael Eba, *Righting Laws: An Appraisal of Human Rights in the Context of HIV and Their Applicability to the Normative Content and Implementation of HIV-Specific Laws in sub-Saharan Africa* (PhD diss., University of KwaZulu-Natal, 2016).

34 - “Global Health Observatory (GHO) Data,” WHO, accessed 28 December 2016, <http://www.who.int/gho/hiv/en/>.

35 - WHO, *Global Tuberculosis Report, 2015* (Geneva: WHO, 2015), 8.

36 - WHO, *Global Tuberculosis Report, 2015*, 8.

37 - UNAIDS 2017 estimates.

40 - UNAIDS 2017 estimates.

FIGURE 1: ESTIMATED HIV PREVALENCE (PERSONS AGED 15-49 YEARS) IN AFRICAN COUNTRIES, 2016³⁸

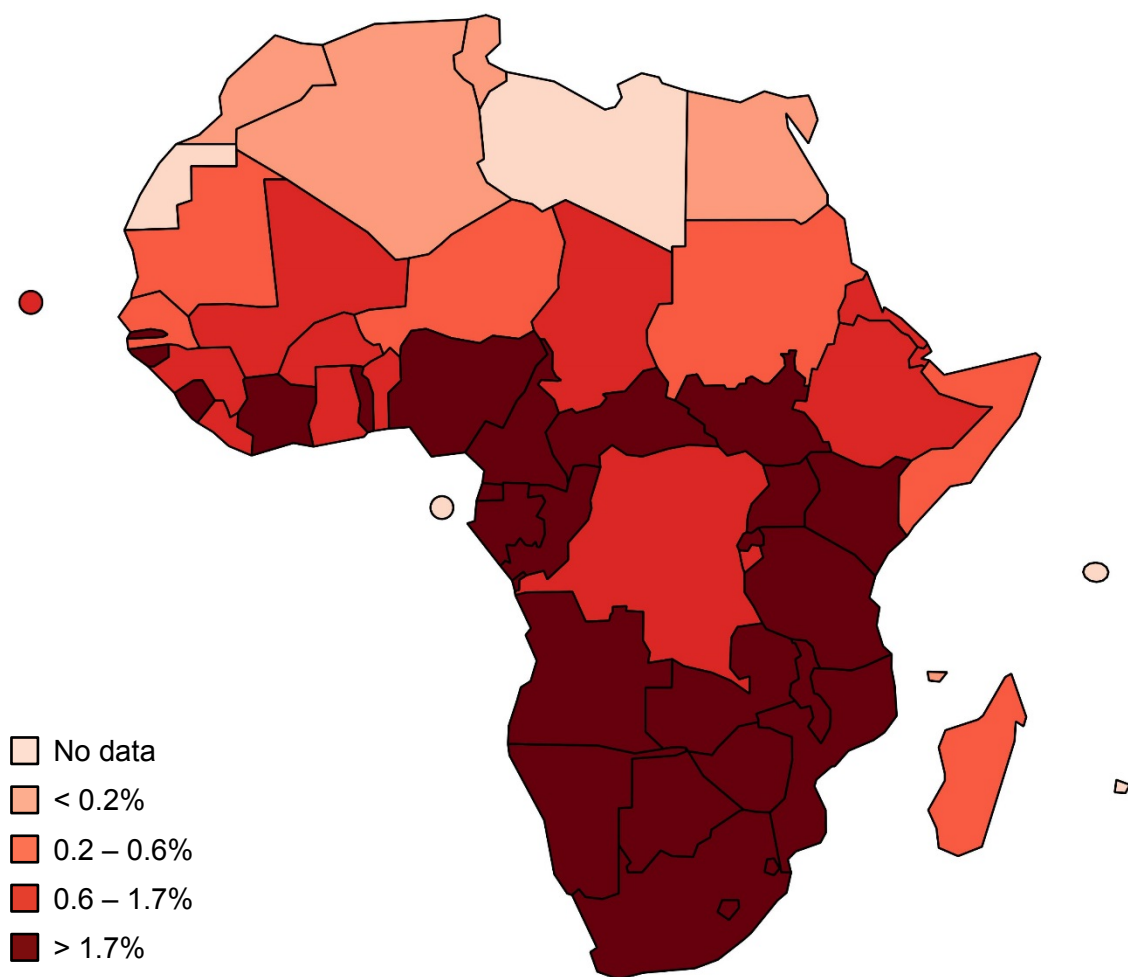
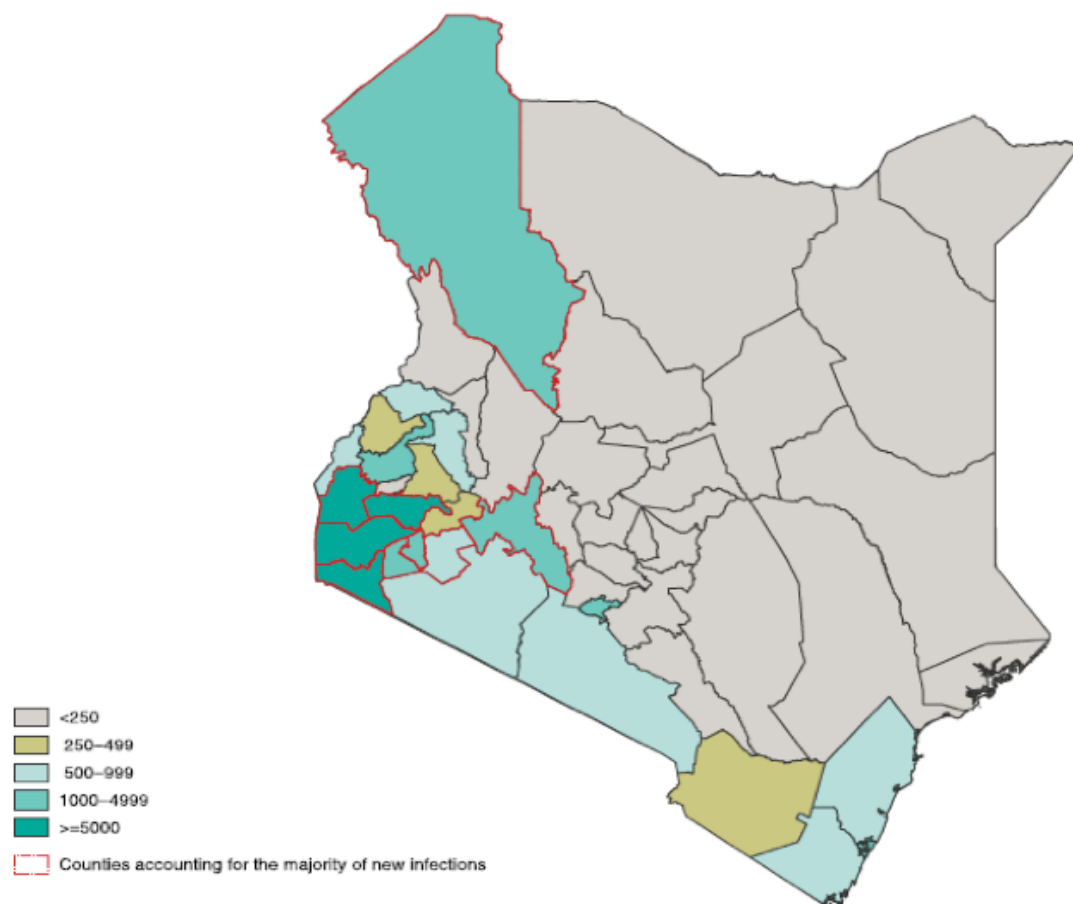


FIGURE 2: ESTIMATED NEW HIV INFECTIONS IN KENYA, 2014, BY COUNTY³⁹



³⁹ - UNAIDS, On the Fast-Track to End AIDS by 2030: Focus on Locations and Populations (Geneva: UNAIDS, 2015), 14.

some countries where PMTCT coverage is above 95%—such as Botswana, Namibia, South Africa and Uganda—vertical HIV transmission rates have been reduced to below 5%. In general, new HIV infections in eastern and southern Africa have dropped from 1.6 million [1.5–1.7 million] in 2000 to 790,000 [710,000–870,000] in 2016.⁴¹

7. The keys to these advances have been the commitment of governments, the critical role played by civil society (including people living with HIV), the reduced cost of HIV treatment and international funding for the response to the epidemic.⁴² Total resources available for in-country HIV responses in low-income and middle-income countries increased by 91% from 2006 to 2016. While international resources increased 65% in the same period, the trend has slowed: from 2010 to 2014, the international resources increased by 11%, but from 2010 to 2016, it increased by only 2%. Resource availability varies by region. In eastern and southern Africa, for instance, the international resource availability increased by 93% from 2006 to 2016 while the domestic resources increased by 130% over the same period. In West and central Africa, international resources increased by 60% and domestic resources by 77% for the same period, while in North Africa, international resources increased by 29% and domestic resources increased by 49%.

8. Resource availability in eastern and southern Africa mimics the global figures, showing a 1% decrease from international sources from 2015 to 2016 and a 6% increase from domestic resources over the same period.⁴³ This calls on governments in Africa to continue to step up their efforts to increase domestic funding to expand access to HIV prevention, treatment, care and support according to their financing capacity.

9. Advances in the response to HIV in Africa have been uneven, with significant differences between regions and countries in terms of access to antiretroviral therapy and reductions in new HIV infections. In general, countries in eastern and southern Africa are witnessing more robust progress in access to

antiretroviral therapy than countries in West and central Africa. In 2016, for instance, just 36% [25–46%] of adults living with HIV in West and central Africa were on antiretroviral therapy, compared to 61% [49–69%] in eastern and southern Africa. Only 22% [13–29%] of children below the age of 15 years living with HIV in West and central Africa were on antiretroviral therapy in 2016 compared to 51% [37–63%] in eastern and southern Africa.⁴⁴

10. According to a recent report by Médecins Sans Frontières, the lower access to HIV treatment in West and central Africa is due to a number of factors. These include high stigma and discrimination, weak health systems, inadequate service delivery models, the limited role of civil society, low prioritisation of HIV, lack of political leadership and the delayed response to the needs of people living with HIV in the context of recurrent humanitarian crises in the region.⁴⁵

11. North Africa is the only region in Africa where deaths from AIDS-related illness and new HIV infections are increasing. Since 2010, new HIV infections among adults have increased by 76% in Egypt. Similarly, new HIV infections have increased in Tunisia over the same period. The limited access to antiretroviral therapy in the region translates to growing numbers of deaths from AIDS-related illness, with increases in Tunisia and Egypt between 2010 and 2015.⁴⁶

POPULATIONS LEFT BEHIND IN THE RESPONSE TO THE HIV EPIDEMIC

12. The impact of the HIV epidemic in Africa differs among populations. In sub-Saharan Africa, young women (aged 15–24 years) accounted for 28% of new HIV infections among adults, and women aged 15 years and older accounted for 56% of new HIV infections among adults. There were approximately 5,500 new HIV infections weekly among young women in the region in 2016, double the number among young men.⁴⁷

13. Adolescent girls and young women are less able to negotiate condom use, and they have limited access

⁴¹ - UNAIDS 2017 estimates.

⁴² - UNAIDS, Update: How Africa Turned AIDS Around (Geneva: UNAIDS, 2013).

⁴³ - Jennifer Kates et al., Financing the Response to HIV in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2015 (Menlo Park, Ca: The Henry J Kaiser Family Foundation, 2016), 5.

⁴⁴ - UNAIDS 2017 estimates.

⁴⁵ - Médecins Sans Frontières, Out of Focus: How Millions of People in West and Central Africa are Being Left Out of the Global AIDS Response (Brussels: Médecins Sans Frontières, 2016).

⁴⁶ - UNAIDS 2017 estimates.

⁴⁷ - UNAIDS 2017 estimates.

to HIV testing, modern contraception and family planning. In Chad, Guinea, Mali, Mozambique and Niger, one in 10 girls has a child before the age of 15 years.⁴⁸ Some 41% of girls in western and central Africa—and 34% of girls in eastern and southern Africa—are married as children.⁴⁹ Child marriage has been associated with higher exposure to intimate partner violence and commercial sexual exploitation. Women who are exposed to intimate partner violence in some regions are 50% more likely to acquire HIV than those who are not exposed.⁵⁰ Women and young girls living with HIV in sub-Saharan Africa also are at increased risk of other STIs, including the human papillomavirus (HPV), which causes diseases that range from benign lesions to invasive cancers. The prevalence rate of HPV among women living with HIV is as high as 80% in Zambia and 90–100% in Uganda.⁵¹

14. Regardless of the nature and level of the HIV epidemic, data show that specific population groups in all sub-Saharan African countries—including prisoners, sex workers, gay men and other men who have sex with men, and people who inject drugs—are particularly impacted by the epidemic.⁵² Also referred to as “key populations,”⁵³ these groups experience higher HIV prevalence and incidence and often have limited access to HIV prevention, treatment and care services.⁵⁴ Even in high prevalence settings, HIV prevalence among members of key populations is often higher than it is among the remaining population. According to UNAIDS, all 12 countries where HIV prevalence among sex workers exceeds 20% are in sub-Saharan Africa.⁵⁵

15. HIV prevalence among men who have sex with men in western and central Africa is more than 14%, compared to less than 2% among the general population.⁵⁶ HIV prevalence among men who have sex with men in North Africa is also high at 9% in Tunisia and 6% in Morocco. Even in eastern and southern Africa, the region with the highest HIV prevalence in Africa, men who have sex with men face a higher HIV burden: HIV prevalence among men who have sex with men is over 33% in Lesotho, 17% in Malawi and Mauritius, and 18% in Tanzania.⁵⁷

16. Throughout Africa, HIV prevalence is higher among prisoners and other incarcerated people than it is among the general adult population. In 2016, for instance, there was an estimated HIV prevalence of 35% among prisoners in Swaziland. Similarly, HIV prevalence among prisoners in 2016 was 20% in Malawi and 27% in Zambia. In 2012, 40% of prisoners who were living with HIV in Mauritania had a history of injecting drugs.⁵⁸ In South Africa, HIV prevalence is 2.4 times higher among prisoners than it is among the general adult population.⁵⁹

17. Prisons often are overcrowded due to inappropriate, ineffective and excessive criminal laws. Overcrowding increases vulnerability to infections such as HIV, TB and hepatitis.⁶⁰ Prisoners also are at risk of violence and denial or disruption of HIV prevention and treatment, including access to harm reduction services.⁶¹ Available data on HIV among people who inject drugs in sub-Saharan Africa also point to particularly high HIV prevalence among these populations.⁶²

18. High HIV prevalence among all these populations most affected by HIV in Africa cannot be justified only by biology or sexual practices. Gender inequalities—including gender-based violence—exacerbate the physiological vulnerability of women and girls to HIV, and they block their access to HIV services. Young people are denied the information and freedom to make free and informed decisions about their sexual health, with most lacking the knowledge required to protect themselves from HIV.⁶⁴

19. Similarly, stigma and discrimination, violence, negative gender and heteronormative constructs, and criminal laws that affect members of key populations (particularly sex workers, people who inject drugs and gay men and other men who have sex with men) have been shown to increase vulnerability to HIV and limit access to HIV services.⁶⁵ For instance, harassment, violence (including by police) and the denial of prevention services (such as harm reduction programmes) contribute to a higher vulnerability to HIV

⁴⁸ - UNFPA, *Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy—The State of the World Populations* (New York: UNFPA, 2013), 5.

⁴⁹ - UNAIDS and the African Union, *Empower Young Women and Adolescent Girls: Fast-Tracking the End of the AIDS Epidemic in Africa* (Geneva: UNAIDS, 2015).

⁵⁰ - World Health Organization et al., *Global and Regional Estimates*.

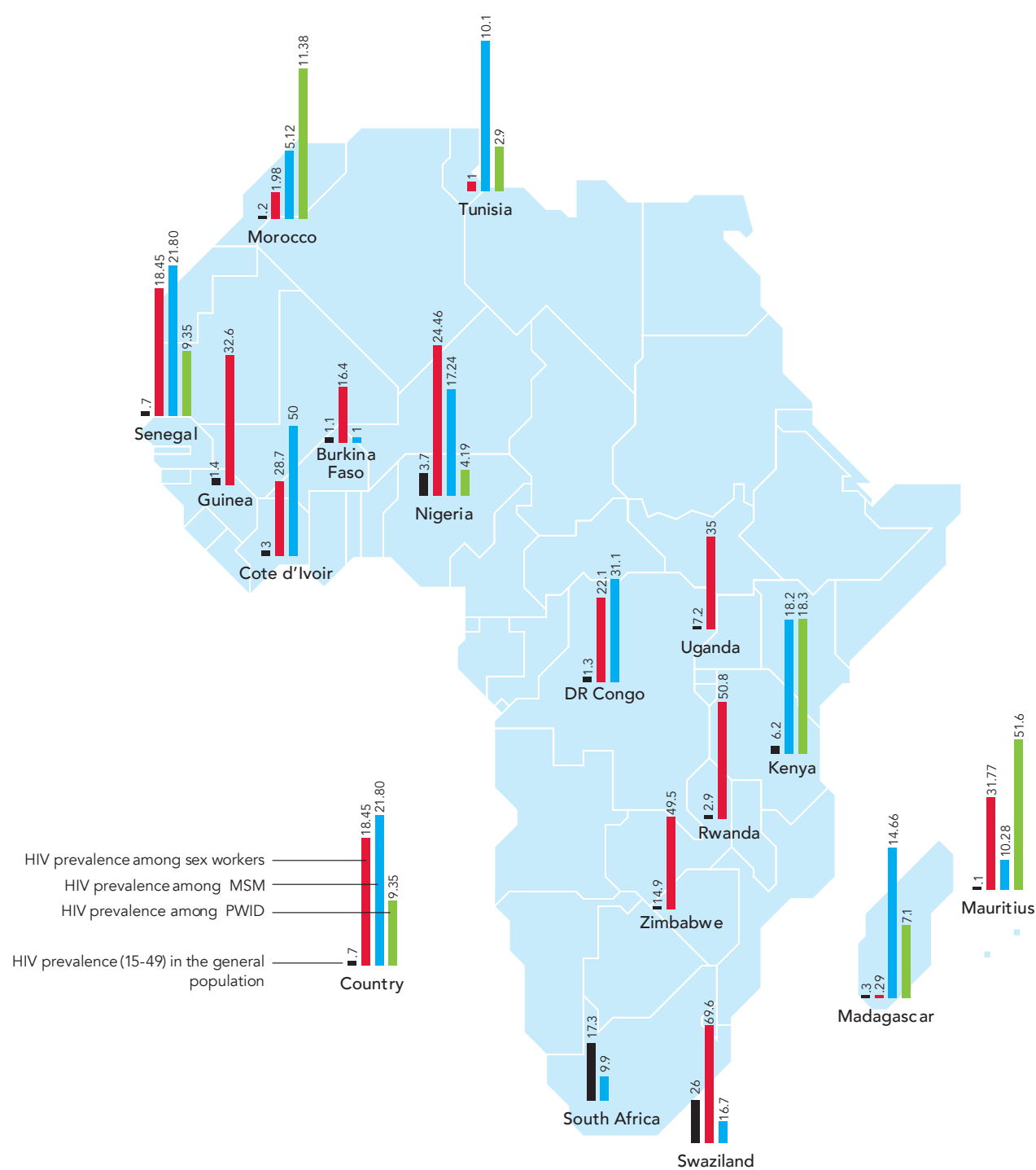
⁵¹ - UNAIDS, *HPV, HIV and Cervical Cancer: Leveraging Synergies to Save Women's Lives* (Geneva: UNAIDS, 2016), 11.

⁵² - UNAIDS, *The Gap Report*, 26–48.

⁵³ - Gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners and other incarcerated people are considered as the main key population groups. These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere—they are key to the epidemic and the response. UNAIDS, *UNAIDS Terminology Guidelines*, 31.

⁵⁴ - UNAIDS, *The Gap Report*.

⁵⁵ - UNAIDS, *The Gap Report*, 45.

FIGURE 3: HIV PREVALENCE IN ADULTS AND KEY POPULATIONS IN AFRICA, 2012⁶³

56 - UNAIDS, The Gap Report, 205.

57 - UNAIDS, The Gap Report, 46.

58 - UNAIDS, The Gap Report, 149.

59 - UNAIDS, The Gap Report, 150.

60 - Leonard S. Rubenstein et al., "HIV, Prisoners and Human Rights," Lancet 388, no. 10050 (2016): 1202-1214.

61 - UNAIDS, The Gap Report, 149-153.

62 - UNAIDS, The Gap Report, 29.

63 - UNAIDS, How Africa Turned AIDS Around, 9.

64 - UNAIDS, Ending AIDS: Progress towards the 90-90-90 Targets (Geneva: UNAIDS, 2017).

65 - WHO, Consolidated Guidelines on HIV Prevention.

among people who inject drugs and their sexual partners.⁶⁶ Similarly, men who have sex with men face serious barriers in accessing antiretroviral therapy and other health-care services due to discrimination in health-care settings, abuse, fear of arrest and other negative consequences that arise from the criminalisation of same-sex sexual relations.⁶⁷ In Botswana, Malawi and Namibia, more than 80% of men who have sex with men have not disclosed their same-sex sexual practices to a health practitioner.⁶⁸ This situation has serious implications for providing information, protection and quality health-care services for this population because men who have sex with men have different HIV risks than heterosexual men, which suggests that the consistent association between discrimination events and STI variables is reflective of the role of stigma in the general sexual health of men who have sex with men. For instance, clinicians likely will not assess for anal HPV infection or certain other STIs in men unless they are aware that these men are at specific risk for these infections.⁶⁹

CONCLUSION

20. This chapter shows that in spite of important progress that has been made in the HIV response in Africa, there are still critical challenges to our ability to ensure that all regions and populations benefit from increased access to HIV treatment and reduced new HIV infections. Unequal progress within and between regions has led to a variety of HIV epidemics and their ensuing differentiated impacts on countries, locations and populations across Africa. Tailored responses are therefore needed to focus on the particular challenges facing specific populations and locations in the region.⁷⁰ In particular, vulnerabilities and barriers—including in law, policy and practices—that are experienced by the populations most affected by the HIV epidemic in each national context must be identified and addressed. Effective measures are needed to respond to stigma and discrimination experienced by people living with, affected by and vulnerable to HIV.

⁶⁶ - Ralf Jürgens et al., "People Who Use Drugs, HIV, and Human Rights," *The Lancet* 376, no. 9739 (2010): 475–485.

⁶⁷ - WHO, Consolidated Guidelines on HIV Prevention.

⁶⁸ - H. Fay et al., "Stigma, Health Care Access, and HIV Knowledge Among Men Who Have Sex with Men in Malawi, Namibia, and Botswana," *AIDS Behaviour* 15, no. 6 (2011): 1088–1097.

⁶⁹ - H Fay et al., "Stigma, Health Care Access, and HIV Knowledge."

⁷⁰ - UNAIDS, *On the Fast-Track to End AIDS by 2030*, 14.

III. GLOBAL AND AFRICAN REGIONAL HUMAN RIGHTS NORMS RELATING TO HIV

1. Global and regional human rights instruments contain key human rights principles essential to effective responses to HIV. Global human rights instruments include the following:

- › the Universal Declaration of Human Rights;
- › the International Covenant on Economic, Social and Cultural Rights;
- › the International Covenant on Civil and Political Rights;
- › the International Convention on the Elimination of All Forms of Racial Discrimination;
- › the Convention on the Elimination of All Forms of Discrimination Against Women;

- › the Convention on the Rights of the Child;
- › the Convention on the Rights of Persons with Disabilities; and
- › the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

At the regional level, a number of key provisions in the African Charter, the African Children's Charter and the Maputo Protocol also are relevant to HIV.⁷¹ The Maputo Protocol includes explicit provisions addressing HIV under Article 14 on health and reproductive rights.⁷²



⁷¹ - AIDS and Human Rights Research Unit, Compendium of Key Documents.

⁷² - Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, CAB/LEG/66.6 (2000).

BOX: SELECTED AFRICAN REGIONAL AND SUB-REGIONAL INSTRUMENTS ON HIV

- › Grand Bay (Mauritius) Declaration and Plan of Action (1999)
- › Lomé Declaration on HIV/AIDS in Africa (2000)
- › Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infectious Diseases (2001)
- › Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Related Infectious Diseases (2003)
- › Gaborone Declaration on a Roadmap towards Universal Access to Prevention, Treatment and Care (2005)
- › Continental Framework for Harmonisation of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa (2005)
- › Brazzaville Commitment on Scaling Up towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010 (2006)
- › Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (2006)
- › Africa's Common Position to the UN General Assembly Special Session on HIV/AIDS (2006)
- › African Union Roadmap on Shared Responsibility and Global Solidarity (2012)
- › SADC Model Law on HIV/AIDS (2008)
- › East African Community HIV and AIDS Prevention and Management Act (2012)
- › Dakar Declaration on Key Populations in the Response to HIV and AIDS in ECOWAS Member States (2015)

⁷³ - UN General Assembly Special Session on HIV/AIDS, Res. S-26/2, Declaration of Commitment on HIV/AIDS (25-27 June 2001).

⁷⁴ - UN General Assembly, Res. S-60/262, Political Declaration on HIV/AIDS (15 June 2006); UN General Assembly, Res.65/277, Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (10 June 2011); and UN General Assembly, A-70/L.52, Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030 (8 June 2016).

⁷⁵ - For an overview of the resolutions on HIV of the Commission on Human Rights and the Human Rights Council, see "Publications and Documents on HIV and AIDS," United Nations Human Rights Office of the High Commissioner, accessed 26 August 2016, <http://www.ohchr.org/EN/Issues/HIV/Pages/Documents.aspx>.

⁷⁶ - UNAIDS et al., International Guidelines on HIV/AIDS and Human Rights, 2006: Consolidated Version (Geneva: UNAIDS, 2006), 10.

⁷⁷ - Following the elaboration of the International Guidelines in 1996, Guideline 6 on "Access to HIV-Related Prevention and Treatment Goods, Services and Information"

2. In addition to binding instruments, a number of resolutions and similar documents address human rights in the context of HIV. These include the 2011 Declaration of Commitments on HIV,⁷³ the UN High-Level Meetings on HIV in 2006, 2011 and 2016,⁷⁴ and the resolutions on HIV of the UN Commission on Human Rights (and later the UN Human Rights Council).⁷⁵ Numerous global guidelines and directives also have been adopted on HIV and human rights. Chief among these are the International Guidelines on HIV/AIDS and Human Rights.⁷⁶ These guidelines, published by UNAIDS and the Office of the High Commissioner on Human Rights (OHCHR), articulate human rights norms and principles that are applicable in the context of HIV, and that provide specific recommendations to countries for developing HIV-related laws, regulations, policies and programmes that comply with human rights.⁷⁷ In addition, the report of the Global Commission on HIV and the Law, which was convened by the United Nations Development Programme (UNDP) on behalf of the UNAIDS Joint Programme, articulates important human rights challenges that need to be addressed in the response to HIV.⁷⁸

3. At the regional level, several non-binding instruments on HIV have been adopted by the African Union, the African Commission, IGAD, the EAC and the SADC (see below).

4. The African Commission has recently adopted two general comments pertinent to HIV. The first, General Comments on Article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, was adopted in 2012. It highlights the measures that States should take to respect, protect, promote and fulfil women's rights to sexual and reproductive health, and it addresses women's rights in relation to HIV. The second, General Comment No. 2 on Article 14(1)(a), (b), (c) and (f) and Article 14(2) (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa was adopted in 2014, and it also specifically addresses the human rights of women living with HIV.⁷⁹

5. In general, human rights protections recognised under international and regional human rights norms are relevant to HIV, including the following:

- › the right to non-discrimination, equal protection and equality before the law;
- › the right to life;
- › the right to the highest attainable standard of physical and mental health;
- › the right to liberty and security of person;
- › the right to dignity and integrity of the person;
- › the right to freedom of movement;
- › the right to seek and enjoy asylum;
- › the right to privacy;
- › the right to freedom of opinion and expression;
- › the right to freely receive and impart information;
- › the right to freedom of association;
- › the right to work;
- › the right to marry and to found a family;
- › the right to equal access to education;
- › the right to an adequate standard of living;
- › the right to social security, assistance and welfare;
- › the right to share in scientific advancement and its benefits;
- › the right to participate in public and cultural life; and
- › the right to be free from torture and cruel, inhuman or degrading treatment or punishment.

6. Under human rights law, States should refrain from violating these human rights.⁸⁰ For instance, they should not adopt discriminatory measures against people living with HIV. Human rights norms also obligate States to take effective measures to prevent such abuses, including through legislative, policy and educational and informational means. In addition, States must ensure that accountability measures are in place to monitor and evaluate the effectiveness of preventative measures, and they must take steps to ensure the improvement of those measures. States also must ensure redress when violations occur.

7. The specific needs of persons living with HIV and other persons belonging to groups vulnerable

was revised during the Third International Consultation on HIV/AIDS and Human Rights convened by UNAIDS and OHCHR on 25–26 July 2002 in Geneva. See UNAIDS et al., International Guidelines, 11–12.

78 - "Background," Global Commission on HIV and the Law, accessed 13 June 2017, <http://www.hivlawcommission.org/index.php/about/overview>.

79 - See African Commission, General Comment on Article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in

Africa (2012); African Commission, General Comment No. 2 on Article 14(1)(a), (b), (c) and (f) and Article 14(2)(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa; and Charles G. Ngwenya et al., "Human Rights Advances in Women's Reproductive Health in Africa," *International Journal of Gynaecology & Obstetrics* 129 (2015): 184–187.

80 - See UNAIDS et al., International Guidelines, 11–12; and Frans Viljoen, *International Human Rights Law in Africa* (Oxford, UK: Oxford UP, 2012).

to HIV are better addressed by ensuring their meaningful participation in devising and implementing programs and services.⁸¹ This participatory process empowers individuals and civil society to assert their rights and report violations when they occur, and it enhances accountability for the implementation of laws and policies. International human rights bodies have increasingly addressed the rights of persons living with HIV and those most vulnerable to HIV, including in areas such as health care, employment, education and the context of freedom of expression.

8. In narrowly defined circumstances, States may impose restrictions on some rights that are provided under international and regional African human rights law, provided that these restrictions are necessary to achieve overriding goals, such as public health, the rights of others, morality, public order, the general welfare in a democratic society and national security.⁸² Public health, for instance, is often cited by States as a basis for restricting human rights in the context of HIV, but many such restrictions infringe on human rights. For example, the right to privacy is violated through mandatory testing and involuntary disclosure of people's HIV status, and the right to liberty of the person is violated when HIV is used to justify deprivation of liberty or segregation.⁸³

9. Below is a description of several key human rights norms that are pertinent to HIV, including (where possible) the interpretation of these norms in HIV-related matters by global and regional African human rights mechanisms. This chapter draws on global human rights norms for two reasons. First, African States have committed to global human rights treaties by ratifying them. Second, in terms of Article 61 of the African Charter, the provisions of global treaties and their authoritative interpretation—including by human rights bodies—constitute applicable sources of law in the African regional human rights system.⁸⁴

THE RIGHT TO HEALTH

10. The right to health is widely recognised in international and regional human rights instruments. It is protected under the following Articles:

- › Article 12 of the International Covenant on Economic, Social and Cultural Rights;
- › Articles 11 and 12 of the Convention on the Elimination of all Forms of Discrimination Against Women;
- › Article 24 of the Convention on the Rights of the Child;
- › Article 25 of the Convention on the Rights of Persons with Disabilities;
- › Article 16 of the African Charter;
- › Article 14 of the Maputo Protocol; and
- › Article 14 of the African Children's Charter.

UN human rights standards

11. The human right to health is recognised in several UN instruments. Article 25(1) of the Universal Declaration of Human Rights affirms that “everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.” Article 12(1) of the International Covenant on Economic, Social and Cultural Rights further recognises “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” The right to health is also recognised in Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in Articles 11(1)(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979, and in Article 24 of the Convention on the Rights of the Child of 1989 (among others).

12. The right to health is the short form for the right to the highest attainable standard of physical and mental health. This includes the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health. UN human rights bodies have stressed that persons living with HIV and those vulnerable to HIV must be guaranteed the right to health. In

⁸¹ - Odetoynbo Morolake et al., “Greater Involvement of People Living with HIV in Health Care,” *Journal of the International AIDS Society* 12, no. 1 (2009): 4.

⁸² - Viljoen, *International Human Rights Law*, 87 and 151.

⁸³ - For example, see *Z v. Finland* (1997), 25 EHRR 371; and *Enhorn v. Sweden* (2005), 41 EHRR 30.

⁸⁴ - See Article 61 of the African Charter.

particular, the Committee on Economic, Social and Cultural Rights (Committee on ESCR) emphasises in General Comment No. 14 on the Right to the Highest Attainable Standard of Physical and Mental Health, and later in its General Comment 22 on the Right to Sexual and Reproductive Health, the linkages that exist between the right to health and other human rights:

The right to health is closely related to and dependent upon the realization of other human rights . . . including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.⁸⁵

13. Also in General Comment No. 14, the Committee on ESCR describes the essential elements of the right to health as involving the availability, accessibility, acceptability and quality of health facilities, goods and services.⁸⁶ Applied to HIV, these elements relate to the following:

- › Availability: States must ensure that there are an adequate number of trained medical and professional personnel, functioning health-care facilities, services, goods and programs to serve the population. This includes essential drugs, as defined by the WHO Model List of Essential Medicines, which includes antiretroviral therapy for the treatment of HIV.
- › Accessibility: States must ensure that health facilities and services are accessible to all, especially the most marginalised. This includes people living with HIV. Facilities and services should be accessible both in law and in fact, without discrimination on any prohibited ground, including HIV status. There are various kinds of accessibility:
 - » Physical accessibility: facilities and services must be within safe and reasonable geographical reach for all sections of the

population, especially persons belonging to disadvantaged and marginalised groups. This includes adequate access to buildings for persons with disabilities.

- » Economic accessibility: facilities and services must be affordable for all through either publicly or privately provided services. Payment assistance must be based on the principle of equity to ensure that impoverished families and individuals do not bear a disproportionate burden of health costs. This includes affordable antiretroviral therapy.
- » Information accessibility: individuals and groups must be able to seek, receive and disseminate information and ideas concerning sexual and reproductive health issues generally, including information related to HIV and groups vulnerable to HIV, and for individuals to receive specific information on their health status. Information related to sexual and reproductive health—including information on HIV—must be accessible, evidence-based and not censored or withheld. Such information must be provided in a manner consistent with the needs of the individual and the community, taking into consideration, for example, age, gender, language ability, educational level, disability, sexual orientation and gender identity.
- › Acceptability: health facilities, services and goods must be culturally appropriate and consider the needs of minorities, indigenous populations, gender, sexual diversity and age groups. They also must be designed to respect medical ethics, such as confidentiality and informed consent, including in the context of HIV testing. However, this cannot be used to justify the refusal to provide tailored facilities, goods, information and services to specific groups.
- › Quality: health facilities, goods and services must be of good quality, evidence-based, scientifically and medically appropriate and up to date. This requires trained and skilled health-

⁸⁵ - Committee on ESCR, General Comment No. 14 on The Right to the Highest Attainable Standard of Health (2000). See also Committee on ESCR, General Comment No. 22 on The Right to Sexual and Reproductive Health (2016).

⁸⁶ - As above.

care personnel and scientifically approved and unexpired drugs and equipment. The failure or refusal to incorporate technological advances and innovations in the provision of sexual and reproductive health services, such as advances in the treatment of HIV and AIDS, jeopardises the quality of care.

- 14.** General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Standard of Health, adopted by the Committee on the Rights of the Child, has applied these norms to the right to health of adolescents.⁸⁷ General Comment No. 15 also stresses that States should provide health services that are sensitive to the needs and human rights of all adolescents.

African human rights standards

- 15.** In the African regional human rights system, Article 16 of the African Charter, Article 14 of the Maputo Protocol and Article 14 of the African Children's Charter all discuss the right to health. The African Commission has had the opportunity to elaborate on the scope and content of these provisions—including in relation to health and HIV—through general comments, resolutions, concluding observations, and case law.

General comments

- 16.** The first-ever general comment of the African Commission was adopted in 2012 in relation to Articles 14(1)(d) and (e) of the Maputo Protocol, which set forth the right of women to self-protection and to be protected from HIV infection, as well as their right to be informed of their HIV status and that of their partners, in accordance with international standards and practices.⁸⁸ In it, the African Commission outlines the measures that African States must adopt to ensure that the realisation of Article 14(1)(d) and (e) of the Maputo Protocol includes the following:

- › Information and education: States Parties should ensure that information and education, both in and out of schools, on sexual and reproductive rights (including HIV) is provided to women, particularly adolescents and young women. This requires States to ensure that content is

evidence-informed, fact- and rights-based, non-judgmental and understandable in content and language. It also stipulates that content should “address taboos and misconceptions relating to sexual and reproductive health issues, deconstruct men and women’s roles in society and challenge traditions notions of masculinity and femininity which perpetuate stereotypes harmful to women’s health and well-being.”⁸⁹

- › Access to sexual and reproductive health services: States Parties must guarantee available, accessible, affordable, comprehensive and quality HIV prevention and treatment procedures that are evidence-informed and women-centred—including female condoms, microbicides, PMTCT and post-exposure prophylaxis (PEP)—to all women independent of a discriminatory assessment of risk.⁹⁰
- › Enabling legal and policy framework: States Parties are obligated to create environments that allow women to control their sexual and reproductive choices, thus strengthening their control over HIV prevention and protection. A framework to create such an environment must include (1) anti-discrimination legislation that ensures women’s access to health services,⁹¹ (2) public health legislation that ensures the provision of pre-and post-test counselling in all cases,⁹² and (3) strict rules of data protection and confidentiality.⁹³
- › Accountability and redress: States Parties should ensure that laws and policies regarding women’s rights related to HIV are appropriately implemented and enforced.⁹⁴

- 17.** The second general comment adopted by the African Commission (General Comment No. 2) deals with the remaining provisions of Article 14 of the Maputo Protocol.⁹⁵ In it, the African Commission enjoins States to promote the right of women to health care, including sexual and reproductive health services. It particularly enjoins States to ensure integration of family planning services with HIV prevention services. The Commission further

⁸⁷ - UN Committee on the Rights of the Child, General Comment No. 15 on the Right of the Child to the Highest Attainable Standard of Health (Art. 24), Chapter IV, Section E (2013).

⁸⁸ - African Commission, General Comment on Article 14(1)(d) and (e).

⁸⁹ - African Commission, General Comment on Article 14(1)(d) and (e), paras. 27-28.

⁹⁰ - African Commission, General Comment on Article 14(1)(d) and (e), paras. 30 and 40.

⁹¹ - African Commission, General Comment on Article 14(1)(d) and (e), paras. 33 and 35.

⁹² - African Commission, General Comment on Article 14(1)(d) and (e), para. 38.

⁹³ - African Commission, General Comment on Article 14(1)(d) and (e), paras. 39 and 44.

⁹⁴ - African Commission, General Comment on Article 14(1)(d) and (e), para. 34.

⁹⁵ - African Commission, General Comment No. 2.

⁹⁶ - African Commission, General Comment No. 2, para. 44.

⁹⁷ - African Commission, General Comment No. 2, para. 47.

⁹⁸ - African Commission, Resolution 141 on Access to Health.

⁹⁹ - African Commission, Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples, para. 27.

urges States to take appropriate measures towards eliminating stigma and discrimination in relation to sexual and reproductive health.⁹⁶ This broadly covers HIV-related stigma and discrimination, which often hinder women and girls from seeking information and services in health-care institutions. More importantly, the Commission encourages States to adopt legislative measures and administrative policies and procedures to ensure that “no woman is forced because of her HIV status, disability, ethnicity or any other situation, to use specific contraceptive methods or undergo sterilization or abortion.”⁹⁷

Resolutions

- 18.** In Resolution 141, the African Commission stresses that “access to medicines forms an indispensable part of the right to the highest attainable standard of health.”⁹⁸ This right to access medications was also elaborated upon in the Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights (Principles and Guidelines), which directs State Parties to “adopt and implement policies that ensure that members of vulnerable and disadvantaged groups have access to medicines.”⁹⁹
- 19.** In the Principles and Guidelines, the African Commission also sets a target of 15% of the annual budgets of State Parties to improve the health sector, mandating that “an appropriate and adequate portion of this amount must be put at the disposal of the national authorities responsible for the fight against malaria, HIV/AIDS, tuberculosis and other related diseases.”¹⁰⁰ This 15% budgetary target was established in the Abuja Declaration.¹⁰¹ The African Commission has followed up on this budgetary requirement in several of their concluding observations. The Principles and Guidelines also define people living with or affected by HIV/AIDS as a vulnerable group.¹⁰²
- 20.** In Resolution 260, the African Commission notes that forced sterilisation of HIV-positive women violates their rights to equality and non-discrimination, and that it also violates other

fundamental rights guaranteed under the African Charter.¹⁰³ It condemns all forms of stigma and discrimination in terms of access to, and provision of, health services in the context of HIV, and it emphasises that all forms of involuntary sterilisation violate women's rights to health.

Concluding observations

- 21.** In some of its concluding observations, the African Commission has drawn the attention of States to gaps in their efforts to address the HIV pandemic. In its response to the report of Gabon, for instance, the African Commission recommends that the Government strengthen ongoing HIV sensitisation programmes, with a particular focus on children and young people.¹⁰⁴ In its concluding observations to the report on Cameroon, the African Commission urges the Government to engage with relevant stakeholders with a view to ensuring the adoption of laws and policies to protect the rights of people living with HIV.¹⁰⁵
- 22.** In one of its concluding observations to the Government of Sudan, the African Commission notes that while it is commendable that the Government is making efforts to ensure access to medical services and social security for everyone, including vulnerable and marginalised groups, the report fails to provide detailed information on access to life-saving medication for people living with HIV in the country.¹⁰⁶
- 23.** *Case law*
While the African Commission has not dealt directly with an HIV case, it has dealt with health-related issues in several communications.
- 24.** In *Purohit and Moore v. The Gambia*, the African Commission held in relation to Article 16 of the African Charter that

enjoyment of the human right to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realisation of all the other fundamental human rights and freedoms. This right includes the right to health facilities, access

http://www.achpr.org/files/instruments/economic-social-cultural/achpr_instr_guide_draft_esc_rights_eng.pdf.

¹⁰⁰ - African Commission, Principles and Guidelines, para. 67(g).

¹⁰¹ - Organization of African Unity, Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, OAU/SPS/ABUJA/3 (24-27 April 2001).

¹⁰² - African Commission, General Comment No. 3 on Article 4, para. 1(e).

¹⁰³ - African Commission, Resolution 260 on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services.

¹⁰⁴ - See African Commission, Concluding Observations and Recommendations on the Initial and Combined Report of the Gabonese Republic on the Implementation of the African Charter on Human and Peoples' Rights (1986-2012) (2014).

¹⁰⁵ - African Commission, Concluding Observations on the 3rd Periodic Report of the Republic of Cameroon (2014), para. XIV.

¹⁰⁶ - African Commission, Concluding Observations and Recommendations on the 4th and 5th Periodic Report of the Republic of Sudan (2012), para. 46.

to goods and services to be guaranteed to all without discrimination of any kind.¹⁰⁷

Although not HIV-specific, this is nevertheless relevant to situations of HIV-related discrimination in health-care settings. Even more explicitly, in the Pretoria Declaration on Economic, Social and Cultural Rights in Africa, the African Commission states that “the right to health in Article 16 of the Charter entails among other things the following . . . education, prevention and treatment of HIV/AIDS . . .”¹⁰⁸

25. The right to access medications is elaborated on in Free Legal Assistance Group, Lawyers’ Committee for Human Rights, Union Interafricaine des Droits de l’Homme, Les Témoins de Jehovah / DRC.¹⁰⁹ The African Commission found that the Government of Zaire had violated Article 16 due to the lack of basic services, including a shortage of medication throughout the country.¹¹⁰

26. The African Commission has also affirmed the link between the right to health and other rights

guaranteed under the African Charter. For instance, in Social and Economic Rights Action Centre (SERAC) and Another v. Nigeria, the African Commission held that “exploitation of oil in a part of Nigeria by oil companies with no regard to the health and environmental consequences for local communities” constituted a violation of various rights provisions of the African Charter, including the right to life.¹¹¹ Not only do States have the obligation to ensure the health of an individual, but they also have the additional broad obligation of ensuring that communities overall are healthy. This broader interpretation of the right to health encompassing the right to life is significant in holding African governments accountable to ensure the provision of life-saving medications in the context of HIV.

THE RIGHT TO BE FREE FROM DISCRIMINATION

27. Non-discrimination is a bedrock human rights principle found in international and regional human rights treaties (including those covered in



¹⁰⁷ - Communication 241/01, Purohit and Moore v. The Gambia, Sixteenth Annual Activity Report, para. 80.

¹⁰⁸ - Pretoria Declaration on Economic, Social and Cultural Rights in Africa (2004).

¹⁰⁹ - Communication 25/89-47/90-56/91-100/93, Committee for Human Rights, Union Interafricaine des Droits de l’Homme, Les Témoins de Jehovah/DRC (1996).

¹¹⁰ - Communication 25/89-47/90-56/91-100/93, Committee for Human Rights, Union Interafricaine des Droits de l’Homme, Les Témoins de Jehovah/DRC, para. 47.

¹¹¹ - Communication 155/96, Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v. Nigeria, para. 2.

¹¹² - UNAIDS, Reduction of HIV-Related Stigma and Discrimination (Geneva: UNAIDS, 2014). The People Living with HIV Stigma Index provides a tool that measures and detects changing trends in relation to stigma and discrimination experienced by people living with HIV. It aims to address stigma relating to HIV while also advocating on the key barriers and issues perpetuating stigma, which is a significant obstacle to

this document) and in national constitutions and other laws. The right to be free from discrimination must be protected regardless of resource and other constraints. This is critical to the realization of the right to health and other rights, including in the context of HIV. Under international and regional human rights law, not only must States refrain from discrimination on the basis of HIV or AIDS status, but they must also take effective measures to prevent this discrimination, including legislative, policy and educational measures to prohibit and counter stigma and discrimination related to HIV and AIDS. Addressing HIV-related stigma is important, as discrimination is often based on stigmatizing attitudes and prejudice about populations, behaviours, practices, sex, illness and death.¹¹²

UN human rights standards

28. While no UN treaty explicitly lists HIV status as a protected class for the purpose of discrimination, the general provisions on non-discrimination found in UN treaties have consistently and explicitly stated that health status, including HIV status, is a prohibited ground of discrimination. For example, the Committee on ESCR's General Comments Nos. 14, 20 and 22—on health, non-discrimination, and sexual and reproductive health, respectively—have noted over the past 15 years that discrimination is prohibited on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV and AIDS), sexual orientation and civil, political, social or other status.¹¹³ The Committee on the Rights of the Child, which monitors compliance with the Convention on the Rights of the Child, prohibits discrimination against children affected by HIV, including children who have been infected.¹¹⁴ The Committee on the Elimination of Discrimination against Women (CEDAW Committee) does the same with regards to women, calling on States to take measures to prohibit and prevent discrimination against women living with HIV.¹¹⁵ UN human rights bodies have recognised that discriminatory laws and practices can hamper the HIV response, such as when HIV status serves as the basis for differential treatment.¹¹⁶ They have

urged States to prohibit discrimination based on seropositive status, and to take steps to ensure that people living with HIV have non-discriminatory access to reproductive health services. States also have an obligation to take effective measures to counter stigma and discrimination related to the HIV epidemic.

29. States are obligated to ensure non-discrimination in access to health care and the underlying determinants of health. This is an immediate obligation for all States, regardless of resources, because “many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information.”¹¹⁷ Under international law, States must prohibit discrimination in access to health care and the underlying determinants of health, as well as the means and entitlements to their procurement. The Committee on ESCR also emphasises the need for equality of access to health care and health-care services.¹¹⁸ The prohibition on discrimination applies to people living with HIV and to groups that are particularly vulnerable to HIV, including young people, sex workers, gay men and other men who have sex with men and people who inject drugs.

African human rights standards

30. People living with HIV are entitled to equality and non-discrimination. The prohibition of discrimination is guaranteed under all main African human rights treaties. The African Commission has stated that Articles 2 and 3 of the African Charter, which relate to equality and non-discrimination, are considered fundamental and linked to the enjoyment of other rights.¹¹⁹ It notes that

Article 2 lays down a principle that is essential to the spirit of the African Charter and is therefore necessary in eradicating discrimination in all its guises, while Article 3 is important because it guarantees fair and just treatment of individuals within a legal system of a given country. . . . these provisions are non-derogable and therefore must be respected in all circumstances in order

HIV treatment, prevention, care and support. See <http://www.stigmaindex.org>.

¹¹³ - Committee on ESCR, General Comment No. 14 on the Right to the Highest Attainable Standard of Health, Art. 12 (11 August 2000).

¹¹⁴ - Committee on the Rights of Children, General Comment No. 3.

¹¹⁵ - CEDAW Committee, General Recommendation No. 15 on Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS) (1990); and CEDAW, General Recommendation No. 24 on Article 12 of the Convention (Women and Health) (1999).

¹¹⁶ - Committee on ESCR, General Comment No. 20, para. 33.

¹¹⁷ - Committee on ESCR, General Comment No. 20; and Committee on ESCR, General Comment No. 22.

¹¹⁸ - Committee on ESCR, General Comment No. 20; Committee on ESCR, General Comment No. 22; and Committee on ESCR, General Comment No. 14.

¹¹⁹ - Christof Heyns, “Civil and Political Rights in the African Charter,” in *The African Charter on Human and Peoples' Rights: The System in Practice, 1986-2000*, eds. M. Evans and R. Murray (Cambridge UP, 2002), 145-147.

for anyone to enjoy all the other rights provided for under the African Charter.¹²⁰

The African Commission has explained the importance and breadth of Articles 2 and 3 on various occasions, and it has noted their application to a range of persons.

General comments

- 31.** The first General Comment of the African Commission recognises HIV status as a prohibited grounds of discrimination:

According to the African Commission there are multiple forms of discrimination based on various grounds such as: race, sex, sexuality, sexual orientation, age, pregnancy, marital status, HIV status, social and economic status, disability, harmful customary practices and/or religion.¹²¹

- 32.** The African Commission recognises that vulnerable and disadvantaged groups face significant impediments to their enjoyment of economic, social and cultural rights—including their right to health—and that these groups include persons living with HIV and other persons vulnerable to HIV, including women, children, detainees, and lesbian, gay, bisexual, transgendered persons. Like the UN System, the African System also recognises intersectional or multiple bases of discrimination and recommends that States take steps to combat such discrimination.¹²²

- 33.** Most recently, the African Commission has issued a non-exhaustive list of grounds for discrimination in its General Comment No. 4 on the Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment. The list explicitly includes health status and other statuses of marginalised groups vulnerable to the HIV and AIDS, most notably because of sexual orientation and gender identity:

These include race, colour, ethnicity, age, religious belief or affiliation, political or other opinion, national or social origin, gender, sexual

orientation, gender identity, disability (including psychosocial and intellectual disability), health status, economic or indigenous status, reason for which one is detained (including accusations of political offences or terrorist acts), asylum-seekers, refugees or others under international protection, or any other status or adverse distinction, and including those marginalised or made susceptible on bases such as those above.¹²³

- 34.** General Comment 1 of the African Commission notes that the right to be informed of one's health status is applicable to all women, including women living with HIV and those vulnerable to HIV (such as young and adolescent women, women who engage in sex work, women who use drugs, migrant women, indigenous women, detained women, and women with physical and mental disabilities).¹²⁴ The General Comment further recognises that an

enabling legal and policy framework is intrinsically linked to women's rights to equality, non-discrimination, and self-protection. . . . States Parties have an obligation to create an enabling supportive, legal and social environment to allowing to control their sexual and reproductive choices and thus to strengthen control over HIV prevention and protection choices.¹²⁵

It also calls on State Parties to ensure that health workers are not allowed, on the basis of religion or conscience, to deny access to sexual and reproductive health services to women as highlighted in the document.¹²⁶

- 35.** In particular, the first General Comment calls on State Parties to enact anti-discrimination legislation to address discrimination, stigma, prejudices and practices related to HIV and other STIs that perpetuate and heighten risk to HIV and related rights abuses among women. Where discriminatory laws and policies exist, States must take immediate action to remove the legal and policy barriers that hinder access to sexual and reproductive health services for women.¹²⁷ For example, General Comment No. 2 notes that certain groups of women, such as women living

¹²⁰ - Communication 241/01, Purohit and Moore v. The Gambia, para. 49.

¹²¹ - African Commission, General Comment No. 1, para. 4.

¹²² - African Commission, Principles and Guidelines.

¹²³ - African Commission, General Comment No. 4 on the African Charter on Human and Peoples' Rights: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment, Art. 5, para. 20.

¹²⁴ - African Commission, General Comment No. 1, para. 15.

¹²⁵ - African Commission, General Comment No. 1, para. 33.

¹²⁶ - African Commission, General Comment No. 1, para. 31.

¹²⁷ - African Commission, General Comment No. 1, para. 35.

¹²⁸ - African Commission, General Comment No. 1, para. 47.

¹²⁹ - African Commission, General Comment No. 1, para. 24.

¹³⁰ - Lee, "African Commission Condemns Coerced Sterilisation."

¹³¹ - African Commission, Resolution 346 on the Right to Education in Africa, ACHPR/Res.346 (LVIII) (2016).

with HIV, may be subjected to coercive practices (including forced sterilization or abortion) because of their status, and it further calls on States to ensure that necessary laws and policies are in place to ensure that no woman is forced into such a procedure.¹²⁸ It also refers to State obligations to eliminate stereotypes that are harmful to women's health, including conventional notions of masculinity and femininity and the role of women in society.¹²⁹

Resolutions

36. The African Commission has found practices or acts against persons living with HIV or those belonging to groups vulnerable to HIV to be discriminatory. In Resolution 260, the African Commission notes that forced sterilisation of HIV-positive women violates women's rights to equality and non-discrimination, and that it violates other fundamental rights guaranteed under the African Charter.¹³⁰ It condemns all forms of stigma and discrimination in terms of access to, and the provision of, health services in the context of HIV, and it emphasises that all forms of involuntary sterilisation violate a woman's right to health. In relation to children, the African Commission issued Resolution ACHPR/Res.346 (LVIII) 2016 on the Right to Education in Africa (Resolution 346), which calls on States to "prohibit and prevent all forms of discrimination in education against children with HIV/AIDS based on their real or perceived status."¹³¹ These resolutions tend to draw the attention of States to important human rights issues in the context of HIV that warrant an urgent response.

37. The African Commission has also addressed the connection between violence and discrimination in Resolution 275. This Resolution expresses the African Commission's concern at acts of violence, discrimination and other human rights violations against persons on the basis of their real or perceived sexual orientation or gender identity. The Resolution confirms that such acts violate several rights, including the right to be free from discrimination and the right to equal protection of the law. While Resolution 275 does not mention

HIV explicitly, it is relevant to HIV rights under the African system because the lesbian, gay, bisexual, transsexual and intersex (LGBTI) population is particularly prone to discrimination in education and health care, both of which affect HIV outcomes.¹³²

38. In its Principles and Guidelines, the African Commission also recommends that States "review and reform public health legislation and criminal laws and correctional systems to ensure they adequately address the public health issues raised by epidemic, endemic, occupational and other diseases including in particular malaria and HIV/AIDS, and tuberculosis. . . ."¹³³ This includes the range of discriminatory criminal laws that directly and/or indirectly impact the HIV response.

Concluding observations

39. The African Commission has also made recommendations through its State reporting processes on State obligations to ensure the protection of persons living with HIV and those vulnerable to HIV and, further, to guarantee non-discrimination. In its fifth periodic review of Uganda, the African Commission recommends under its "Non-discrimination and Equality" section that Uganda "strengthen its legal framework for the protection of people living with HIV to discourage HIV-related human rights violations."¹³⁴ It calls on Nigeria to repeal a law criminalising homosexuality, noting that it "has the potential to engender violence against persons on grounds of their actual or imputed sexual orientation, and also to drive this group of persons vulnerable to HIV/AIDS underground, thereby creating an environment which makes it impossible to effectively address the HIV pandemic in the State."¹³⁵ It also recommends that Botswana reform a law that requires minors to be accompanied by their parents when getting tested for HIV.¹³⁶ With regard to one of its concluding observations on the report of Cameroon, the African Commission urges the Government to engage with relevant stakeholders with a view to ensuring the adoption of laws and policies that protect the rights of people living with HIV.¹³⁷

¹³² - African Commission, Resolution 275 on Protection against Violence and other Human Rights Violations against Persons on the Basis of their Real or Imputed Sexual Orientation or Gender Identity (2014).

¹³³ - African Commission, Principles and Guidelines.

¹³⁴ - African Commission, Concluding Observations and Recommendations on the 5th Periodic State Report of the Republic of Uganda (2010-2012) (2015), para. 14.

¹³⁵ - African Commission, Concluding Observations and Recommendations on the 5th

Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011-2014) (2015), para. 81.

¹³⁶ - African Commission, Concluding Observations and Recommendations on the Initial Periodic Report of the Republic of Botswana (2010), para. 68.

¹³⁷ - African Commission, Concluding Observations on the 3rd Periodic Report of the Republic of Cameroon, para. XIV.

Case law

- 40.** In *Legal Resources Foundation v. Zambia*, the African Commission noted that

the right to equality is very important. It means that citizens should expect to be treated fairly and justly within the legal system and be assured of equal treatment before the law and equal enjoyment of the rights available to all other citizens. The right to equality is important for a second reason. Equality or the lack of it affects the capacity of one to enjoy many other rights.¹³⁸

- 41.** In *Good v. Republic of Botswana*, the African Commission described the importance and breadth of the principle of non-discrimination, which it said “guarantees that those in the same circumstances are dealt with equally in law and in practice.”¹³⁹ This was in keeping with its decision on *Communication 245/02 Zimbabwe Human Rights NGO Forum v. Zimbabwe*, in which the African Commission observed that principles of equality and non-discrimination apply to all persons:

Together with equality before the law and equal protection of the law, the principle of non-discrimination provided under Article 2 of the Charter provides the foundation for the enjoyment of all human rights. . . . The aim of this principle is to ensure equality of treatment for individuals irrespective of nationality, sex, age or sexual orientation.¹⁴⁰

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

THE RIGHTS TO LIBERTY AND PRIVACY

- 43.** The rights to liberty and privacy include the protection of confidentiality, informed consent, autonomy and more. These rights are protected in regional and international human rights treaties, and they encompass decisional, physical and informational protections of privacy. In the context of health care, decisional privacy affirms the human right to make health care choices without the intervention of others, including family members or the State, and it supports autonomy. Physical privacy affirms the right of individuals to allow or deny providers the right to examine or treat them, ensuring that treatment requires informed consent. Informational privacy underpins the issues of confidentiality, which is the duty of health workers and others who handle private medical or health information about patients in a way that keeps it secret or private from others (except the patient). Protection of these rights is particularly important for patients seeking diagnosis and treatment of illnesses such as HIV because of associated sensitivities and stigma.

UN human rights standards

- 44.** The right to privacy includes the right of individuals to make informed decisions about their bodies and to be free from coercion, discrimination and violence.¹⁴¹ Interference with the exercise of sexual and reproductive autonomy also may reflect multiple forms of discrimination, violate numerous human rights, constitute forms of violence and even rise to the level of inhuman and degrading treatment, as is the case in the context of the forced sterilization of HIV-positive women.

Confidentiality

- 45.** In the context of health care (including HIV-related care), this right places an obligation on those who have access to personal information to ensure that such information is not shared with third parties, including the partners, family or friends of patients, without the full and informed consent of

¹³⁸ - Communication 211/98 *Legal Resources Foundation v. Zambia*, para. 63.

¹³⁹ - Communication 313/05, *Kenneth Good v. Republic of Botswana*, Twenty-eighth Activity Report, para. 218.

¹⁴⁰ - Communication 245/02, *Zimbabwe Human Rights NGO Forum v. Zimbabwe*, Twentieth Activity Report, para. 169.

¹⁴¹ - United Nations International Conference on Population and Development, Programme of Action (1994), para. 4.1; United Nations, Convention on the Rights of Persons with Disabilities, Arts. 3 and 25, A/RES/61/106; and CEDAW, General Recommendation No. 24 on Article 12 of the Convention (Women and Health) (1999), para. 31(e).

¹⁴² - CEDAW, General Recommendation No. 15; Committee on ESCR, General Comment No. 22; CEDAW, General Recommendation No. 24; and Committee on the Rights of

the Child, General Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health, Art. 24 (17 April 2013).

¹⁴³ - For example, UNAIDS and the UNDP issued a more detailed policy brief in 2008 that specifically outlined a number of recommendations regarding the use of both HIV-specific criminal laws and general laws by States to punish HIV exposure, non-disclosure and transmission. These included calling on States to “repeal HIV-specific criminal laws, laws directly mandating disclosure of HIV status, and other laws which are counterproductive to HIV prevention, treatment, care and support efforts, or which violate the human rights of people living with HIV and other vulnerable groups,” and to apply general criminal law “only to the intentional transmission of HIV, and audit the application of general criminal law to ensure it is not used inappropriately in the context of HIV.” UNAIDS, Policy Brief: Criminalization of HIV Transmission (Geneva: UNAIDS, 2008).

the patient. Women are particularly vulnerable to personal harm or discrimination from breaches in medical confidentiality, particularly when domestic violence, STIs (including HIV) or predisposition testing are involved. Under international human rights standards, States have an obligation to ensure legal and policy guarantees that protect confidentiality in HIV-related services.¹⁴²

- 46.** In terms of laws that mandate HIV status disclosure, UN human rights bodies and agencies have consistently condemned the criminalization of HIV.¹⁴³ In 2010, the UN Special Rapporteur on the Right to Health recognised that the criminalization of unintentional HIV transmission, exposure and non-disclosure is a violation of the right to health, calling on States

to immediately repeal laws criminalizing the unintentional transmission of or exposure to HIV, and to reconsider the use of specific laws criminalizing intentional transmission of HIV, as domestic laws of the majority of States already contain provisions which allow for prosecution of these exceptional cases.¹⁴⁴

Informed consent

- 47.** Informed consent to medical procedures is derived from the rights to privacy, liberty, security, dignity, health and protection against cruel, inhuman and degrading treatment that are provided under global and regional human rights law. In the context of HIV, informed consent to HIV testing and treatment involves two complementary elements: 1) access to information and knowledge, and 2) full agreement.¹⁴⁵ A person's informed consent to a medical procedure (such as HIV testing) therefore requires that the person be provided with full information and knowledge,¹⁴⁶ that they understand the information, and that they fully and freely agree to undergo the HIV test.¹⁴⁷ In order to fulfil this principle, States have an obligation to provide individuals with access to information and services that enable them to

exercise their autonomy. This includes providing counselling on the risks, benefits and alternatives to treatment that is understandable to the patient.¹⁴⁸

- 48.** The UN Special Rapporteur on Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health stresses that

informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to health-care providers. Its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being.¹⁴⁹

- 49.** States have an obligation to take measures to ensure that third parties (including health-care providers) do not interfere with the right to autonomy. States should also abolish laws, policies and practices that interfere with an individual's right to autonomous decision-making.¹⁵⁰

- 50.** UN human rights bodies have recognised that some groups are particularly vulnerable to violations of the right to informed consent. This includes persons living with and vulnerable to HIV (such as children, women, persons with disabilities, sex workers, transgender people, prisoners and persons who use drugs). States have an obligation to take particular measures to protect these vulnerable groups against violations of informed consent.¹⁵¹

- 51.** The Committee on the Rights of the Child, for example, has recognised that adolescents face formidable barriers in exercising their autonomy in the context of health care, and that this has a significant impact on their health and human rights. The Committee has recommended that States

review and consider allowing children to consent to certain medical treatments and interventions

¹⁴⁴ - United Nations General Assembly, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, A/HRC/14/20 (27 April 2010).

¹⁴⁵ - Kitty Grant et al., *Protecting Rights: Litigating Cases of HIV Testing and Confidentiality of Status* (SALC, 2012), 11.

¹⁴⁶ - HIV testing is recognised as a medical procedure. See *C v. Minister of Correctional Services*, 1996 (4) SA 292 (T).

¹⁴⁷ - The High Court of South Africa concluded that failure to provide pre-test counselling was an unlawful "deviation from the accepted norm of informed consent." See *C v. Minister of Correctional Services*.

¹⁴⁸ - CEDAW, General Recommendation No. 24; Committee on ESCR, General Comment No. 22.

¹⁴⁹ - UN General Assembly, Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, A/HRC/22/53, 2013.

¹⁵⁰ - CEDAW, General Recommendation No. 24.

¹⁵¹ - UN General Assembly, Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, A/HRC/22/53, 2013; CEDAW, General Recommendation No. 24; Committee on the Rights of Persons with Disabilities, General Comment No. 3 on Women and Girls with Disabilities (Art. 6) (2016); Committee on the Rights of Persons with Disabilities, General Comment No. 1 on Equal Recognition before the Law (Art. 12) (2014); and Committee on ESCR, General Comment No. 22.

without the permission of a parent, caregiver or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion.¹⁵²

African human rights standards

52. The African human rights system has addressed issues concerning confidentiality and informed consent explicitly in the context of HIV in two general comments.

53. According to the African Commission's General Comment No. 2 on the Maputo Protocol, States have an obligation to take measures to

prevent third parties from interfering with the enjoyment of women's sexual and reproductive rights. Particular attention must be given to prevention, as regards the interference of third parties concerning the rights of vulnerable groups such as adolescent girls, women with disabilities, women living with HIV and women in situations of conflict. The obligation entails the formulation of standards and guidelines containing the precision that the consent and involvement of third parties, including but not limited to, parents, guardians, spouses and partners, is not required when adult women and adolescent girls want to access family planning/contraception and safe abortion services in cases provided for in the Protocol.¹⁵³

54. The General Comment No. 1 states that the right to be informed on one's health status must not only encompass knowing one's HIV status, but that it should also include pre-test counselling (which enables women to make a decision based on informed consent before taking the test) and post-test counselling services (on preventative measures or available treatment, depending on the outcome of the HIV test).¹⁵⁴ In relation to the disclosure of a person's HIV status to partners, the General Comment clarifies that

information on a partner's health status must be obtained with informed consent in line

with international standards, without coercion, and should be primarily aimed at preventing harm to one's health. Caution should be exercised in relation to the conditions and environments under which the right to be informed on the health status of one's partner may be exercised, in particular, where the revealing of a partner's health status may result in negative consequences such as harassment, abandonment and violence.¹⁵⁵

It also notes that

while disclosure should be encouraged, there should be no requirement to reveal one's HIV status or other information related to one's health status. In the context of HIV, health-care workers should be authorised, without being obliged to, decide, depending on the nature of the case and according to ethical considerations, whether to inform a patient's sexual partners of his or her HIV-positive status.¹⁵⁶

55. The first General Comment also requires States to create an enabling legal and policy framework, including on counselling and confidentiality. States Parties have an obligation to create an enabling supportive, legal and social environment that allows women to control their sexual and reproductive choices and thus strengthen control over HIV prevention and protection choices. Such an environment includes public health legislation that ensures pre- and post-test counselling is provided in all cases.¹⁵⁷ States Parties also are obligated to ensure that strict rules for data protection and confidentiality apply, and that data are protected from unauthorised collection, use or disclosure. This includes creating "safe and enabling conditions through legal, policy, regulatory and programmatic measures that create positive conditions for informed disclosure and lawful notification of one's health status and the health status of one's partner."¹⁵⁸ In addition, General Comment No. 1 notes that States Parties should provide training for health-care workers on non-discrimination, confidentiality and respect for dignity, autonomy and informed

¹⁵² - UN Committee on the Rights of the Child, General Comment No. 15.

¹⁵³ - African Commission, General Comment No. 2, para. 42.

¹⁵⁴ - African Commission, General Comment No. 1, para. 14.

¹⁵⁵ - African Commission, General Comment No. 1, paras. 16 and 17.

¹⁵⁶ - African Commission, General Comment No. 1, para. 19.

¹⁵⁷ - African Commission, General Comment No. 1, para. 38.

¹⁵⁸ - African Commission, General Comment No. 1, paras. 45.

¹⁵⁹ - African Commission, General Comment No. 1, para. 41.

consent in the context of sexual and reproductive health services for women.¹⁵⁹

- 56.** Both General Comments No. 1 and No. 2 recommend that HIV testing should not be used as a condition for access to other health services, including treatment, contraception, abortion, medical examination, pre- and post-natal services or any other reproductive health care. Furthermore, positive test results should not be a basis or pretext for the use of coercive practices or the withholding of services.¹⁶⁰

THE RIGHT TO LIFE

- 57.** The right to life is guaranteed in virtually all major international and regional human rights instruments. Article 3 of the Universal Declaration of Human Rights guarantees the right to life for all persons. Similarly, Article 6 of the International Covenant on Civil and Political Rights provides that “every human being has the inherent for the

right to life,” that the right must be protected by law and that no one shall be arbitrarily deprived of their life. The right to life is interconnected with other rights and is one of the most important human rights guaranteed to all individuals. It is argued that the right to life has almost attained the status of *jus cogens* under international law.¹⁶¹

- 58.** In the context of HIV, the right to life implies that people living with HIV must not be denied access to information and services that are crucial to their health and well-being. For instance, denial of access to life-saving medications such as antiretroviral drugs will amount to the violation of the right to life. Equally, States are expected to ensure that hospitals and clinics are well-stocked with essential medicines needed to treat opportunistic infections for people living with HIV. More importantly, health-care providers must refrain from mistreating people living with HIV or engaging in any act that is prejudicial to their life and well-being.



¹⁶⁰ - African Commission, General Comment No. 1, para. 42; and African Commission, General Comment No. 2, para. 29.

¹⁶¹ - A.E. Yamin, “Not Just a Tragedy: Access to Medication as a Right under International Law,” *Boston University International Law Journal* 21 (2003): 330.

UN human rights standards

59. In its General Comment No. 6 on the Right to Life, the UN Human Rights Committee explains that the right to life should be broadly understood as intersecting with health issues such as maternal mortality and the treatment and prevention of diseases. The General Comment also mentions the need for States Parties to take all possible measures to eliminate epidemics.¹⁶²

In the Human Rights Committee's view, the right to life is not only the most fundamental of all human rights, but it is also non-derogable. In its concluding observations, the Human Rights Committee expresses concern about the availability of effective treatment for individuals at risk of or living with HIV and AIDS, and it urges States Parties to allow and facilitate access to adequate medical care, counselling and treatment (including antiretroviral therapy) as an obligation under the right to life.¹⁶³

60. The Committee on ESCR explains in its General Comments Nos. 14 and 22 that the violation of the right to health, including the right to sexual and reproductive health, is "indivisible from and interdependent with other human rights. It is intimately linked to civil and political rights underpinning the physical and mental integrity of individuals and their autonomy, such as the rights to life; liberty and security of person...."¹⁶⁴ The Committee identifies essential medication—including medicines and treatment for the prevention of STIs and HIV—as one of the minimum core contents of the right to health, and it indicates that States have an obligation to ensure their availability.

61. In its General Comment No. 35, the CEDAW Committee notes that the right of women to lead lives free from gender-based violence is indivisible from and interdependent with other human rights, including the right to life. It goes to indicate that health-care services should be responsive to trauma and include timely and comprehensive mental, sexual and reproductive health services, including PEP.¹⁶⁵

62.

In its General Comment No. 3 on HIV/AIDS and the Rights of the Child, the Committee on the Rights of the Child observes that the HIV epidemic not only affects the health and well-being of children, but that it also has implications for other rights, including their rights to life, survival and development. The Committee explicitly notes that the

State obligation to realize the right to life, survival and development also highlights the need to give careful attention to sexuality as well as to the behaviours and lifestyles of children, even if they do not conform with what society determines to be acceptable under prevailing cultural norms for a particular age group. In this regard, the female child is often subject to harmful traditional practices, such as early and/or forced marriage, which violate her rights and make her more vulnerable to HIV infection, including because such practices often interrupt access to education and information. Effective prevention programmes are only those that acknowledge the realities of the lives of adolescents, while addressing sexuality by ensuring equal access to appropriate information, life skills and to preventive measures.¹⁶⁶

63.

All of the above standards impose positive obligations on States to avoid unnecessary loss of lives, including by taking adequate measures to ensure that appropriate health-care services (including access to antiretroviral drugs) are provided. They coincide with the decisions of international tribunals such as the European Commission on Human Rights. In *Tavares v. France*, for example, the Commission held that the right to life guaranteed under the European Convention on Human Rights extends beyond a State's duty to abstain from intentional killing to also include taking necessary steps to protect the unintentional loss of life.¹⁶⁷

African human rights standards

64.

At the regional level, the right to life of all individuals is explicitly guaranteed under Article 4 of the African Charter, which provides that every human being shall be entitled to the respect for his

¹⁶² - UN GAOR Human Rights Committee, The Right to Life, 37th Session, Suppl. No 40.

¹⁶³ - See for instance, Human Rights Committee Concluding Observations: Uganda, 04/5/2004 UN Doc CCPR/CO/80/UGA; Human Rights Committee Concluding Observations: South Africa 27/4/2016 UN Doc CCPR/C/ZAF/CO/1; Human Rights Committee Concluding Observations: Kenya 31/8/2012 UN Doc CCPR/C/KEN/CO/3.

¹⁶⁴ - Committee on ESCR, The Right to Sexual and Reproductive Health, General Comment

22, UN Doc. CESCR/GC/22 (2016).

¹⁶⁵ - CEDAW Committee, General Recommendation 35 on Gender Based Violence against Women, General Recommendation 35, UN Doc. CEDAW/GC/35 (2017).

¹⁶⁶ - Children's Rights Committee, HIV/AIDS and the Rights of the Child, General Comment 3, UN Doc. CRC/GC/2003/3 (2003).

¹⁶⁷ - *Tavares v. France*, App No 16593/90 Euro. Comm. HR.

or her life and the integrity of his or her person. Article 5 of the African Children's Charter also declares that "every child has an inherent right to life. This right shall be protected by law." In language similar to that of the African Charter, Article 4 of the Maputo Protocol guarantees the right to life and security of all women. Given the high mortality rate associated with HIV in Africa, the right to life is one of the strongest rights to protect the right of persons living with, affected by or vulnerable to HIV in Africa.

General Comments

65. A number of the African Commission's general comments address the right to life. For instance, the African Commission's General Comment No. 3 is directly related to the right to life as provided under Article 4 of the Charter, Article 4 of the Maputo Protocol and Articles 5 and 30 of the African Children's Charter, all of which enshrine the right to life. Similarly, its General Comment on Articles 14 (1) (d) and (e) of the Maputo Protocol includes a recognition of the intrinsic link with the right to life.

66. General Comment No. 3 illustrates the connection between the right to life and other human rights, including the right to health, and it notes that the right to life should be interpreted broadly. It requires States to engage in preventive steps to respond to infectious diseases and other emergencies, and it indicates that the State has a positive duty to protect individuals and groups from real and immediate risks to their lives caused by the actions or inactions of third parties.¹⁶⁸

67. General Comment No. 3 also notes the responsibility of States to address more chronic yet pervasive threats to life (such as HIV and AIDS) by establishing functioning health systems and eliminating discriminatory laws and practices that affect the ability of individuals and groups to seek health care.¹⁶⁹ This General Comment also recognises that such an approach reflects the African Charter's ambition to ensure a better life for all people in Africa through its recognition of a wide range of rights, including economic, social and cultural rights.¹⁷⁰

68. Finally, General Comment No. 3 makes explicit the connection between State obligations to protect the right to life and those to ensure access to antiretroviral medicines. It notes that when the State deprives an individual of liberty, its control of the situation yields a heightened level of responsibility to protect the rights of that individual. This includes a "positive obligation to protect all detained persons from violence or from emergencies that threaten their lives, as well as to provide the necessary conditions of a dignified life, including the provision of adequate health care (including maternal health care and the provision of antiretroviral drugs)."¹⁷¹

Resolutions

69. In Resolution 53 on the HIV/AIDS Pandemic, the African Commission notes the high mortality associated with HIV in the region and the fact that the epidemic has become a threat to humanity. While affirming that the HIV pandemic has become a human rights challenge, Resolution 53 calls on African governments to take decisive measures towards addressing it. In particular, it calls on States to ensure the protection of human rights of those infected and affected and to provide "support to families for the care of those dying of AIDS, devise public health-care programmes of education and carry out public awareness especially in view of free and voluntary HIV testing, as well as appropriate medical interventions."¹⁷²

70. In Resolution 275, the African Commission notes the connection between violence, including sexual violence and violence based on sexual orientation and gender identity, and the right to life guaranteed in Article 4 of the Charter. In doing so, the African Commission calls on States to end such violence through laws prohibiting and punishing all forms of violence on the basis of imputed or real sexual orientation or gender identities, to pursue the proper investigation and prosecution of perpetrators, and to ensure judicial procedures that are responsive to the needs of victims.

71. The African Commission's Principles and Guidelines raises concerns about the negative

¹⁶⁸ - African Commission, General Comment No. 3 on Article 4 of the African Charter on Human and Peoples' Right: The Right to Life, paras. 3 and 41.

¹⁶⁹ - African Commission, General Comment No. 3 on Article 4, paras. 3 and 43.

¹⁷⁰ - African Commission, General Comment No. 3 on Article 4, para. 3.

¹⁷¹ - African Commission, General Comment No. 3 on Article 4, para. 36.

¹⁷² - Adopted during the 29th Ordinary Session in Tripoli, the Great Socialist Peoples' Libyan Arab Jamahiriya, from 23rd April to 7th May 2001.

impact of HIV and AIDS on the right to health and on other rights, including the right to life. It calls on States to ensure the availability of drugs and technologies at affordable prices for the treatment, care and prevention of HIV. It also calls for reform of public health and criminal laws to address public health issues raised by HIV, and to ensure and respect the rights of individuals infected and affected by HIV.¹⁷³

Concluding observations

- 72.** In a number of concluding observations to States, the African Commission has made the link between the right to health and the obligation to preserve the right to life. For instance, in its concluding observations to the report of Namibia, the Commission urges the Government to take concrete efforts with a view to reducing maternal and child mortality rates in the country.¹⁷⁴ The Commission expresses a similar concern on the report of Ethiopia when it raises the high maternal mortality rate in the country.¹⁷⁵ It also recommended that the Government of Ethiopia adopt appropriate measures to address this situation.

Case law

- 73.** The African Commission affirmed the interrelated nature of all human rights in *Social and Economic Rights Action Centre (SERAC) and Another v. Nigeria*, when it found that the Nigerian government was in violation of the rights to health, life, clean environment and other rights due to pollution caused by the activities of oil companies in Ogoniland.¹⁷⁶ Also, in *International Pen and others (on behalf of Ken Saro-Wiwa)*, the Commission reaffirmed the positive obligation imposed on States by the right to life under Article 4 of the African Charter:

The protection of the right to life in Article 4 also includes a duty for the State not to purposefully let a person die while in its custody. Here at least one of the victims' lives was seriously endangered by the denial of medication during detention. Thus, there are multiple violations of Article 4.¹⁷⁷

THE RIGHT TO BE FREE FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT

- 74.** The right to be free from torture and cruel, inhuman or degrading treatment is protected in many international and regional human rights treaties. It is closely connected to the right to informed decision-making and bodily autonomy, not only in the context of forced HIV testing, but also in the provision of family planning services to HIV-positive women.¹⁷⁸

UN human rights standards

- 75.** The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment defines torture as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person . . . [including] for any reason based on discrimination of any kind.”¹⁷⁹ Article 5 of the African Charter stipulates that every individual “shall have the right to the respect of the dignity inherent in a human being.” It also states that all forms of exploitation—particularly cruel, inhuman or degrading punishment and treatment—shall be prohibited.¹⁸⁰

- 76.** Similar to the African Charter, Article 4 of the Maputo Protocol addresses the rights to life, integrity, liberty and security of every woman.¹⁸¹ Article 4 sets out that “every woman shall be entitled to respect for her life and the integrity and security of her person. All forms of exploitation, cruel, inhuman or degrading punishment and treatment shall be prohibited.”¹⁸²

- 77.** The Committee against Torture, which monitors State compliance with the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, notes the enhanced risk of torture and ill-treatment in the context of reproductive health care in its General Comment No. 2:

Gender is a key factor. Being female intersects with other identifying characteristics or status of the person, such as race, nationality, . . .

¹⁷³ - African Commission, Principles and Guidelines.

¹⁷⁴ - African Commission, Concluding Observations and Recommendations on Sixth Periodic Reports of the Republic of Namibia on the Implementation of the African Charter on Human and Peoples' Rights (2011-2013), adopted during the 58th Ordinary Session, 6-20 April 2016 in Banjul, The Gambia.

¹⁷⁵ - Concluding Observations and Recommendations on the 5th and 6th Periodic Report of the Federal Democratic Republic of Ethiopia adopted during the 56th Ordinary Session of the African Commission 21 April to 7 May 2015.

¹⁷⁶ - See *Social and Economic Rights Action Centre (SERAC) and Another v. Nigeria*

(2001) AHRLR 60 (ACHPR 2001).

¹⁷⁷ - *International Pen and Others (On behalf of Ken Saro-Wiwa)* (2000) AHRLR 212 (ACHPR 1998).

¹⁷⁸ - Human Rights Council, Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1 February 2013).

¹⁷⁹ - UN General Assembly, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Art. 1 (10 December 1984).

¹⁸⁰ - African Charter on Human and Peoples' Rights, Art. 5.

¹⁸¹ - Protocol to the African Charter, Art. 4.

immigrant status etc. to determine the ways that women and girls are subject to or at risk of torture or ill-treatment and the consequences thereof. The contexts in which females are at risk include deprivation of liberty, [and] medical treatment, particularly involving reproductive decisions . . . (emphasis added).¹⁸³

78. The UN Special Rapporteur on Torture similarly states that “women seeking maternal health care face a high risk of ill-treatment, particularly before and after childbirth . . . Such mistreatment is often motivated by stereotypes regarding women’s childbearing roles and inflicts physical and psychological suffering that can amount to ill-treatment.”¹⁸⁴

79. International and regional human rights bodies have repeatedly affirmed that sterilisation without informed consent violates the right to be free from torture and cruel, inhuman or degrading treatment. These bodies include the African Commission,¹⁸⁵ the UN Committee against Torture,¹⁸⁶ and the UN Human Rights Committee.¹⁸⁷ For example, the UN Committee against Torture raised concern over the involuntary sterilisation of HIV-positive women in Kenya in its latest review of Kenya’s compliance with the Convention against Torture.¹⁸⁸

African human rights standards

80. In its recent General Comment No. 4, the African Commission refers to acts of sexual and gender-based violence that may amount to torture and other ill-treatment, including acts perpetrated against people living with HIV that also fuel the HIV epidemic.¹⁸⁹ The General Comment provides that

acts of sexual and gender-based violence, or the failure by States to prevent and respond to such acts, may amount to torture and other ill-treatment in violation of Article 5 of the African Charter. This General Comment specifically refers to those acts of sexual and gender-based violence that amount to a form of torture and other ill-treatment in view of the specific, traumatic and gendered impact of sexual violence on victims, including the individual, the family and the collective.¹⁹⁰

81. Such acts include physical and psychological acts committed against victims without their consent or under coercive circumstances, such as rape (including so-called corrective rape), domestic violence, verbal attacks and humiliation, forced marriage, isolation, dowry-related violence, trafficking for sexual exploitation, enforced prostitution, indecent assault, denial of reproductive rights (including forced or coerced pregnancy), abortion and sterilisation, forced nudity, mutilation of sexual organs, virginity tests, sexual slavery, sexual exploitation, sexual intimidation, abuse, assault or harassment, forced anal testing, or any form of sexual or gender-based violence of comparable gravity.¹⁹¹

FREEDOM OF EXPRESSION, ASSOCIATION AND ASSEMBLY

82. The rights to freedom of expression, association and assembly are closely linked rights protecting the ability of individuals and groups to organise, associate, and meet and express ideas around areas of interest and concern. These rights are protected under both international and regional treaties. Under international law, individuals and groups must be allowed to express views and opinions and disseminate information, even when such views are dissenting or held by a minority. They must be allowed to associate and assemble freely without interference or legal barriers, and they have the right to be protected from interference, intimidation or abuse by third parties when exercising such rights. These rights include the rights of marginalised groups to form civil society organisations, raise funds, provide services and participate in public and political discussions. They also include the rights of people living with HIV and others to assemble publicly for events and rallies, and for individuals (including adolescents) to receive and disseminate information relating to HIV or sexual and reproductive health.

UN human rights standards

83. Under international human rights law, everyone has the right to freedom of expression, association

¹⁸² - Protocol to the African Charter, Art. 4.

¹⁸³ - Committee Against Torture, General Comment No. 2: Implementation of Art. 2 by States Parties (23 Nov 2007), para. 22 (emphasis added).

¹⁸⁴ - Human Rights Council, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, para. 47.

¹⁸⁵ - African Commission, Resolution 260.

¹⁸⁶ - For example, see Committee Against Torture, Concluding Observations on the Second Periodic Report of Kenya, Adopted by the Committee at its Fiftieth Session (5–31 May 2013); Committee Against Torture, Concluding Observations of the Committee against Torture: Czech Republic (2012), para. 12; and Committee Against

Torture, Concluding Observations of the Committee against Torture: Slovakia (2009), para. 14.

¹⁸⁷ - Human Rights Commission, Concluding Observations of the Human Rights Committee: Czech Republic (2007), para. 9; Human Rights Commission, Concluding Observations of the Human Rights Committee: Slovakia (2003), para. 12.

¹⁸⁸ - Committee Against Torture, Concluding Observations on the Second Periodic Report of Kenya, para. 27.

¹⁸⁹ - African Commission, General Comment No. 4, para. 20.

¹⁹⁰ - African Commission, General Comment No. 4, para. 57.

¹⁹¹ - African Commission, General Comment No. 4, para. 58.

and assembly. No restrictions can be placed on these rights except as provided by law, and such restrictions may only be imposed in a democratic society where necessary for the protection of the rights and freedoms of others or the interests of national security, public order or public health and morals.¹⁹² Restrictions should not impinge upon the general democratic principles of pluralism, tolerance and broadmindedness.¹⁹³ These rights are to be enjoyed and protected without discrimination, including on grounds of sexual orientation and gender identity.¹⁹⁴

Freedom of expression and opinion

84. Freedom of opinion and expression is central to a functioning, free and democratic society, and it is necessary for the promotion and protection of all other human rights.¹⁹⁵ Individuals have the right to hold all forms of opinion, including political, scientific, historic, moral and religious opinions. Any harassment, arrest, detention, intimidation or stigmatization of people on the basis of their opinion is a breach of this right. The right to express oneself includes the right to receive and impart information and ideas of all kinds. Similarly, information about sexual health rights and HIV must be readily available to individuals, including adolescents. This availability is necessary for both prevention and treatment of the HIV epidemic.

85. State Parties have an obligation not only to refrain from preventing freedom of expression, but also to ensure that individuals are protected from attacks aimed at silencing people who are exercising free speech.¹⁹⁶ This is particularly the case where the topics of conversation are considered controversial in a particular context, or where groups experience stigma or discrimination. Individuals, including key populations, judges and lawyers and other community representatives and human rights defenders who speak out on human rights issues—such as the rights of sexual orientation and gender identity, sex workers and drug use—should be able to operate without fear of reprisal, either from the State or private individuals.¹⁹⁷

86. Any limitations must be necessary, proportionate and for a legitimate purpose; they should also apply to all persons equally. This means that in the area of HIV, limitations may not target key populations or limit speech around sexual orientation, gender identity, sex workers or people living with HIV.

Freedom of association

87. In the context of HIV, freedom of association is necessary to ensure that civil society organisations that work on HIV or with key populations can form and operate effectively. Civil society organisations perform an important role in implementing and supporting activities such as assisting people with HIV, promoting legal reform, combating discrimination and stigma, and preventing HIV transmission. Any restrictions on the freedom to associate must be necessary, proportionate and for a legitimate reason. Organisations working in the area of HIV through service delivery, education, legal reform, advocacy—or those working with key populations—must be allowed to register, fundraise and operate freely without interference or fear. Restrictions on the ability to form an association can have a significant effect on civil society organizations and, by extension, the HIV epidemic.

88. While States may make regulations for the registration and operation of associations, under international law, such regulations must be for the benefit of those associations rather than acting as a barrier to their operation. Registration procedures must be short, accessible and have strict time limits regarding responses; any delays may amount to interference with the exercise of the right to association.¹⁹⁸ Associations have the right to operate freely and be protected from undue interference, including acts of intimidation or violence, arbitrary arrests, media smear campaigns and threats.¹⁹⁹ As with individuals, associations should be able to express their views and advocate for changes to laws and the Constitution, even when such views represent the minority and may lead to tension.²⁰⁰ Unregistered associations also are protected by this right.²⁰¹

¹⁹² - UN General Assembly, International Covenant on Civil and Political Rights, Arts. 19, 21 and 22.

¹⁹³ - Human Rights Council, Report of the Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association, A/HRC/20/27 (2012), para. 17.

¹⁹⁴ - Human Rights Council, The Rights to Freedom of Peaceful Assembly and of Association, A/HRC/Res/20/27 (2012), para. 13.

¹⁹⁵ - Human Rights Committee, General Comment No. 34 on Freedoms of Opinion and Expression (Art. 19) (12 September 2011).

¹⁹⁶ - Human Rights Committee, General Comment No. 34.

¹⁹⁷ - Human Rights Committee, General Comment No. 34.

¹⁹⁸ - Human Rights Council, Report of the Special Rapporteur on the Rights to Freedom of

Peaceful Assembly and of Association, paras. 60 & 61.

¹⁹⁹ - Human Rights Council, Report of the Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association, para. 63.

²⁰⁰ - Human Rights Council, Report of the Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association.

²⁰¹ - Human Rights Council, Report of the Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association, para. 56.

²⁰² - Human Rights Council, Report of the Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association.

²⁰³ - As above.

²⁰⁴ - As above.

89. The freedom to associate means that such organisations must be able to work, to operate and to raise funds from domestic, foreign and international sources. Limitations on foreign funding have been held to violate the right to freedom of association.²⁰² For organisations working on HIV—where a significant amount of funding is from foreign sources—this is critical. Laws that limit the amount of foreign funding can limit an association's ability to operate, and they have led to the closure of many civil society organizations.²⁰³ Where countries require organisations to register, the process should be simple, accessible and voluntary, without fear of criminal sanctions.²⁰⁴

90. The right to freedom of association applies to all persons without discrimination, including people who normally experience discrimination or stigma because of sexual orientation or gender identity.²⁰⁵ Due to the stigma and discrimination surrounding both people living with HIV and key populations, associations connected with either HIV or certain key populations can experience a backlash. The Special Rapporteur on Freedom of Assembly and Association has specifically mentioned the rights of LGBTI organisations to be registered.²⁰⁶

Freedom of assembly

91. Connected closely to association and speech, everyone has the right to assemble in public and participate in peaceful assemblies. As with freedom of association, any restrictions should be minimal and should facilitate the holding of peaceful assemblies.²⁰⁷ Persons assembling should not require permission or an application; at most, governments may require prior notification in order to facilitate the assembly and protect public safety.²⁰⁸ Failure to notify the government in advance should not incur criminal or even civil penalties, nor should it result in the shutdown of otherwise peaceful assemblies.²⁰⁹

92. Organisations have a right to take part in the conduct of public affairs, including participating

in the State's decision-making processes by advocating for reform and commenting on government policies, actions and legislation.²¹⁰ People living with HIV, key populations and those working with people living with HIV all have the right to assemble in order to demonstrate, protest or hold a rally, procession or public event. Holding or espousing minority beliefs or views critical of the government cannot be a reason for disallowing or disrupting an assembly. Such assemblies are important for raising awareness of HIV, advocating for the protection of rights or influencing public policy. States also must ensure that participants in assemblies are protected from assault, violence and other violations by provocateurs or counter-demonstrators.²¹¹ This is particularly important given the stigma and discrimination faced by people living with HIV, especially those from marginalised key populations.

African human rights standards

93. Articles 9, 10 and 11 of the African Charter provide for the rights to freedom of expression, association and assembly.²¹² Any limitations imposed on these rights must be for a legitimate purpose and grounded in the rights of others and in collective security, morality and common interest; they also must be necessary and proportionate.²¹³ Both the African Commission and the African Court have upheld the rights of associations and individuals to speak out, associate and assemble, and they have condemned actions and restrictions that serve to violate these rights.

Freedom of expression and information

94. The African Commission recognises the freedom of expression and the right to information as cornerstones of democracy and as means of ensuring respect for all human rights and freedoms.²¹⁴ The African Commission has specifically declared that freedom of expression imposes an obligation on the State to promote diverse views through pluralistic access to the media, including by vulnerable and marginalised groups, and the availability and promotion of a

²⁰⁵ - UN General Assembly, Resolution on Human Rights, Sexual Orientation and Gender Identity, A/HRC/RES/17/19 (14 July 2011).

²⁰⁶ - Human Rights Council, Report of the Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association.

²⁰⁷ - As above.

²⁰⁸ - Human Rights Council, Report of the Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association; OSCE et al., Guidelines on Freedom of Peaceful Assembly, Second ed. (Poland: OSCE/ODIHR, 2010), para. 63; and Inter-American Commission on Human Rights, Report on the Situation of Human Rights Defenders in the Americas (Washington, DC: Organization of American States, 2006), para. 57.

²⁰⁹ - Human Rights Council, Report of the Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association.

²¹⁰ - As above.

²¹¹ - As above.

²¹² - African Charter, Arts. 9–11.

²¹³ - African Charter, Art. 27(2); Communication Nos. 105/93, 128/94, 130/94, 152/96, Media Rights Agenda and Others v. Nigeria, Twelfth Annual Activity Report, para. 68; Communication Nos. 140/94, 141/94 and 145/95, Constitutional Rights Project and Others v. Nigeria, Thirteenth Annual Activity Report, para. 41.

²¹⁴ - African Commission, Resolution on the Adoption of the Declaration of Principles on Freedom of Expression in Africa, ACHPR/Res.62(XXXII)02 (17–23 October 2002).

range of information and ideas to the public.²¹⁵ In an environment where individuals are targeted and stigmatised because of their sexual identity, gender orientation or HIV status, protection of the right to express oneself freely and speak about controversial or minority issues is key.

- 95.** Both the African Court and African Commission have heard cases on freedom of expression. They have held that States have an obligation to refrain from detaining journalists who are critical of the government.²¹⁶ They also have held that States have not only a positive obligation to protect individuals from attacks and reprisals by third parties when exercising freedom of expression, but that they are obligated to investigate any such reprisals or acts.²¹⁷

Freedom of association

- 96.** The African Charter and the African Children's Charter recognise the right of adults and children to associate freely. In 1992, the African Commission passed a resolution on the Right to Freedom of Association, stating that authorities should not override constitutional provisions or undermine fundamental rights.²¹⁸ When regulating freedom of association, States should not limit the exercise of that freedom, and any regulation should be consistent with the African Charter. The Kigali Declaration of 2003 also specifically recognises the important role of civil society organisations. In addition, Africa has a Charter on Democracy, Elections and Governance (2007) that imposes obligations on States to create conducive conditions for civil society organisations to exist and operate within the law. Under the Charter, State Parties commit to “fostering popular participation and partnership with civil society organisations” and “promoting partnerships and dialogue between governments, civil society and the private sector.”²¹⁹ Unfortunately, as of April 2017, only 10 States had signed and ratified the Charter, and none have done so since 2011.²²⁰

- 97.** The African Commission has upheld the rights of associations to operate without undue interference from the State.²²¹ According to the Commission,

there “must always be a general capacity for citizens to join, without State interference, in associations in order to attain various ends. . . . In regulating the use of this right, the competent authorities should not enact provisions which would limit the exercise of this freedom.”²²² States cannot interfere or act against members of an organization simply because they do not like the comments or views of the organization, or because the organisation is critical of the government.²²³ Membership of an association should not solely be considered as grounds for criminal charges.²²⁴

- 98.** The African Commission Study Group on Freedom of Association and Assembly in Africa has also published advice on registration and barriers for associations, stating that

States should not require associations to register in order to be allowed to exist and to operate freely. States' legitimate interest in security should not preclude the existence of informal associations, as effective measures to protect public safety may be taken via criminal statute without restricting the right to freedom of association.²²⁵

Freedom of assembly

- 99.** The African Charter and African Commission have likewise protected the right to freedom of assembly. Under African human rights mechanisms, States should not place unnecessary limitations or barriers on the right to assemble in public. Groups should not require authorisation to assemble peacefully, and notification procedures should be easy to use.²²⁶ Organisers should not be sanctioned because they failed to notify the authorities, nor should they be made liable for the unlawful conduct of others.²²⁷ There should be no blanket prohibitions on assembly, and any restrictions should be for a legitimate purpose with full reasons provided.²²⁸

THE RIGHT TO FREEDOM OF MOVEMENT

- 100.** The right to freedom of movement is protected by international and regional human rights law,

²¹⁵ - African Commission, Resolution on the Adoption of the Declaration of Principles on Freedom of Expression in Africa.

²¹⁶ - Lohé Issa Konaté v. The Republic of Burkina Faso, 4/2013 ACHR (2014); and Sir Dawda K. Jawara v. The Gambia, ACHR 147/95, 149/96 (2000).

²¹⁷ - Abdoulaye Nikiema v. The Republic of Burkina Faso, ACHR 13/2011 (2014).

²¹⁸ - African Commission, Resolution on the Right to Freedom of Association (2-9 March 1992).

²¹⁹ - African Charter on Democracy, Elections and Governance, Arts. 12, 27 and 28 (2007).

²²⁰ - “Ratification Table,” African Commission, accessed 12 April 2017, <http://www.achpr.org/instruments/charter-democracy/ratification>.

²²¹ - Civil Liberties Organization (in respect of the Nigerian Bar Association) v. Nigeria, Eighth Annual Activity Report.

²²² - Communication 101/93, Civil Liberties Organization (in respect of the Nigerian Bar Association) v. Nigeria, paras. 15-16.

²²³ - Communications 137/94, 139/94, 154/96 and 161/97, International Pen and Others v. Nigeria, Twelfth Annual Activity Report; Communication 205/97, Kazeem Aminu v. Nigeria, Thirteenth Annual Activity Report, paras. 22-23; Communication 225/98, Huri-Laws v. Nigeria, Fourteenth Annual Activity Report, paras. 47-49; and Communication 232/99, John D. Ouko v. Kenya, Fourteenth Annual Activity Report, paras. 29-30.

including the African Charter.²²⁹ This right to freedom of movement includes the right of persons living lawfully within a country to move freely within it and to choose their place of residence without coercion. It also includes the rights of nationals to exit and enter their country freely, including without any form of coercion or discrimination. Importantly, it also encompasses the right of non-nationals who are lawfully in the country to remain so unless expelled through legal processes that respect principles of access to justice.

- 101.** According to human rights and public health standards, there is no rationale for restricting freedom of movement on the basis of HIV status. Restrictions based solely on real or perceived HIV status, including HIV screening of travellers, are discriminatory and not justifiable as a public health concern. Some States may prohibit people living with HIV from long-term residency due to concerns about health care and other financial costs, but highlighting HIV status to determine residency is discriminatory. Economic considerations also should not play a role in the consideration of entry applications. Humanitarian factors should be the primary consideration, including family reunification and the need for protection.²³⁰

THE RIGHT TO MARRY AND TO FOUND A FAMILY

- 102.** Numerous international and regional human rights treaties guarantee the right to marry and to found a family, as well as the protection of the family.²³¹ The International Covenant on Civil and Political Rights states that “the right of men and women of marriageable age to marry and to found a family shall be recognized” and that “States Parties to the present Covenant shall take appropriate steps to ensure equality of rights and responsibilities of spouses as to marriage, during marriage and at its dissolution. . . . In the case of dissolution, provision shall be made for the necessary protection of any children.”²³²
- 103.** Various laws and/or practices in relation to people living with HIV infringe on this right. For example,

mandatory premarital testing as a precondition for the issuance of marriage licenses affects this right. Forced abortion and sterilization of HIV-positive women infringes on the right to found a family (in addition to many other rights). Informed decision-making—including in decisions related to reproduction and family formation—is a central aspect of the right to liberty and security and the right to privacy. Measures to ensure the equal rights of women within the family, which are explicitly protected by the African Charter, also are relevant in the HIV context because they are necessary for women to negotiate safe sex or to have the choice to leave a relationship.²³³

THE RIGHT TO ENJOY THE BENEFITS OF SCIENTIFIC PROGRESS AND ITS APPLICATIONS

- 104.** The right to enjoy the benefits of scientific progress is found in the International Covenant on Economic, Social and Cultural Rights.²³⁴ The right to enjoy the benefits of scientific progress in relation to medicine and health is closely related to the right to health and the right to quality health-care treatment. In the context of HIV, this right and its applications are important because of advances regarding testing and treatment.

- 105.** The Committee on ESCR General Comment No. 22 on the Right to Sexual and Reproductive Health notes the following:

Facilities, goods, information and services related to sexual and reproductive health must be of good quality, meaning that they are evidence-based and scientifically and medically appropriate and up-to-date. This requires trained and skilled health-care personnel and scientifically approved and unexpired drugs and equipment. The failure or refusal to incorporate technological advancements and innovations in the provision of sexual and reproductive health services, such as medication for abortion, assisted reproductive technologies and

²²⁴ - Communications 137/94, 139/94, 154/96 and 161/97, *International Pen and Others v. Nigeria*, paras. 107-110; Communications 54/91, 61/91, 98/93, 164-196/97 and 210/98, *Malawi African Association and Others v. Mauritania*, paras. 106-7.

²²⁵ - African Commission, Report of the Study Group on Freedom of Association and Assembly in Africa (2014).

²²⁶ - Communications 48/90, 50/91, 52/91 and 89/93, *Amnesty International and Others v. Sudan*, Thirteenth Annual Activity Report, paras. 81-82.

²²⁷ - Communications 54/91, 61/91, 98/93, 164-196/97 and 210/98, *Malawi African Association and Others v. Mauritania*, paras. 108-11; and Communications 137/94, 139/94, 154/96 and 161/97, *International Pen and Others v. Nigeria*, paras. 105-06.

²²⁸ - Communications 48/90, 50/91, 52/91 and 89/93, *Amnesty International and Others v. Sudan*, paras. 81-82; and *Malawi Law Society and Others v. President and Others*, AHRLR 110 (MwHC 2002), para. 30.

²²⁹ - African Charter, Art. 12.

²³⁰ - UNAIDS et al., *International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version*.

²³¹ - This is the case for instance of Art 18 of the African Charter.

²³² - United Nations, ICCPR, Art. 23.

²³³ - African Charter, Art. 18.

²³⁴ - United Nations, ICESCR, Art. 15.



advancements in the treatment of HIV and AIDS, jeopardizes the quality of care.²³⁵

- 106.** As with other rights, the right to benefit from scientific progress and its applications cannot be applied in a discriminatory fashion. The denial of affordable antiretroviral therapy to the public at large and specific marginalised populations (such as prisoners) violates numerous rights.²³⁶

THE RIGHT TO FOOD

- 107.** The right to food is recognised in Article 11 of the Universal Declaration of Human Rights. In its General Comment No. 14, the Committee on ESCR connected the right to health with adequate nutrition and food, identifying nutrition and food as core elements of the enjoyment of the right to health because access to adequate food and good nutrition is essential for healthy living. Furthermore, access to nutritious food is crucial in the context of HIV because malnutrition or hunger may worsen the health of people living with HIV.

- 108.** Article 11 of the International Covenant on Economic, Social and Cultural Rights recognises that every person has the right to an adequate standard of living for themselves or their families, including adequate food and the right to the continuous improvement of living conditions.²³⁷ In addition, it recognises “the fundamental right of everyone to be free from hunger.”²³⁸ It imposes obligations on States Parties to take necessary measures, including specific programmes, that are aimed at ensuring improved methods of production, conservation and distribution of food and those that ensure an equitable distribution of world food supplies in relation to need.²³⁹

- 109.** While the right to food is not explicitly recognised in the African Charter, the African Commission has noted that the right to food is “linked to the dignity of human beings and is therefore essential for the enjoyment and fulfilment of such other rights as health, education, work and political participation.”²⁴⁰ The African Commission has indicated that States Parties to the African

²³⁵ - CESCR, General Comment No. 22, para. 21.

²³⁶ - UNAIDS et al., International Guidelines, 10.

²³⁷ - CESCR, Art. 11 (1).

²³⁸ - CESCR, Art. 11 (2).

²³⁹ - CESCR, Art. 11 (2) (b).

²⁴⁰ - SERAC and Another v. Nigeria (2001) AHRLR 60 (ACHPR 2001), para. 65.

²⁴¹ - SERAC and Another v. Nigeria (2001), para. 66.

²⁴² - International Conference on Population and Development, para. 5.

²⁴³ - African Commission, Principles and Guidelines, para. 1v.

²⁴⁴ - African Commission, Resolution 374 on the Right to Food and Food Insecurity in Africa, ACHPR/Res.374 (LX) 2017, adopted in May 2017 in Niamey, Niger.

²⁴⁵ - African Commission, Resolution 374 on the Right to Food and Food Insecurity in Africa.

Charter can be in violation of the right to food when the Charter is read with other pertinent international human rights instruments.²⁴¹ The Commission's Principles and Guidelines notably provide that African countries should "promote food security and good nutritional practices as part of the response to HIV/AIDS, tuberculosis and other infectious diseases."²⁴² The Principles and Guidelines thus enjoin African countries to ensure that health policies and programmes address "issues related to food and nutrition."²⁴³

- 110.** During its 60th Ordinary Session, the African adopted Resolution 374 on the Right to Food and Food Security in Africa.²⁴⁴ This resolution recognises that the right to food is inherent in the Charter's protection of the rights to health and life, and it draws on existing standards, noting with concern the threats that food insecurity pose to the enjoyment of the right to food of millions of people in the region. It therefore urges African governments to adopt legislative, administrative and other necessary measures with a view to addressing the challenge of food insecurity and hunger in the region.²⁴⁵

THE RIGHT TO HOUSING

- 111.** The right to housing is often described as one of the most important human rights.²⁴⁶ Due to the inherently interrelated nature of human rights, a denial of the right to housing potentially also leads to a denial of an array of ancillary human rights, such as the right to water and sanitation, the right to food, the right to human dignity and equality, and even the right to work.²⁴⁷ Article 25 of the Universal Declaration of Human Rights guarantees the right of everyone to an adequate standard of living, which includes, inter alia, a right to food, clothing, housing, medical care and necessary social services.²⁴⁸ A similar provision is found in Article 11 of the International Covenant on Economic, Social and Cultural Rights, which recognises "the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and binds themselves to the continuous

improvement of living conditions."²⁴⁹ States are enjoined to take appropriate steps to ensure the realization of this right.

- 112.** In General Comment No. 4 on the Right to Adequate Housing and No. 7 on forced evictions, the Committee on ESCR clarified the nature and scope of State obligations regarding the right to housing. It explains that States have the obligation to respect, protect, promote and fulfil the right to adequate housing. This includes progressively realising the right to adequate housing and refraining from acts of forced evictions unless alternative accommodation has been provided.
- 113.** People living with HIV sometimes face discriminatory practices in relation to their right to housing. Reports show that people living with HIV have been denied access to housing or ejected from their accommodation based on HIV status. This further compounds human rights challenges encountered by persons living with, affected by or vulnerable to HIV.
- 114.** The African Charter does not contain an explicit right on housing, but the Principles and Guidelines adopts the same standards as the International Covenant on Economic, Social and Cultural Rights in its explanation of the nature of obligations imposed by the right to adequate housing on States Parties to the African Charter.²⁵⁰ It is further provided that States must prioritise the right to housing of vulnerable and marginalised groups, including people living with or affected by HIV.
- 115.** In some of its decisions, the African Commission has read into the African Charter an obligation on the part of the State to refrain from embarking on forced evictions or removal of groups of people from their community.²⁵¹ In *Social and Economic Rights Action Centre (SERAC) and Another v. Nigeria*, the African Commission noted that housing rights are protected under the African Charter through the combination of provisions protecting the right to property (Article 14), the right to enjoy the best attainable standard of

²⁴⁶ - South African Human Rights Commission, *The Right of Access to Adequate Housing*—Period: April 2000—March 2002, Chapter 2, https://www.sahrc.org.za/home/21/files/Reports/4th_esr_chap_2.pdf.

²⁴⁷ - Christopher Golay et al., *The Right to Housing—A Fundamental Right Affirmed By The United Nations And Recognised In Regional Treaties And Numerous National Constitutions*, <http://www.cetim.ch/legacy/en/documents/bro7-log-A4-an.pdf>.

²⁴⁸ - Universal Declaration of Human Rights, Art. 25 (1).

²⁴⁹ - ICESCR, Article 11 (1).

²⁵⁰ - African Commission, *Principles and Guidelines*, paras. 77-79.

²⁵¹ - *SERAC and Other v. Nigeria* (2001); see also, *Centre for Minority Rights Development (Kenya) and Minority Rights Group International on Behalf of Endorois Welfare Council v. Kenya* (2009) AHRLR 75 (ACHPR 2009).

mental and physical health (Article 16) and the protection accorded to the family (Article 18)²⁵²

CONCLUSION

116. The great majority of civil, political, economic, social and cultural rights provided under human rights law are relevant to the HIV epidemic. These rights have been interpreted at the global and regional levels to highlight critical principles

to guide governments on their duties to respect, protect, promote and fulfil human rights in the context of HIV. This information is contained in various documents, including general comments, resolutions, case law and concluding observations on State reports. Together, these global and regional documents represent a corpus of norms for ensuring a rights-based and effective response to HIV in Africa.

²⁵² - SERAC and Other v. Nigeria (2001).

²⁵³ - The African Commission is a quasi-judicial treaty body established under Article 30 of the African Charter. The African Charter was adopted in 1981 by Member States of

the Organisation of African Unity (OAU), which is now the African Union. The African Commission is comprised of 11 members, holds two ordinary sessions and two extraordinary sessions per year, and has the mandate to protect and promote human and peoples' rights in Africa.

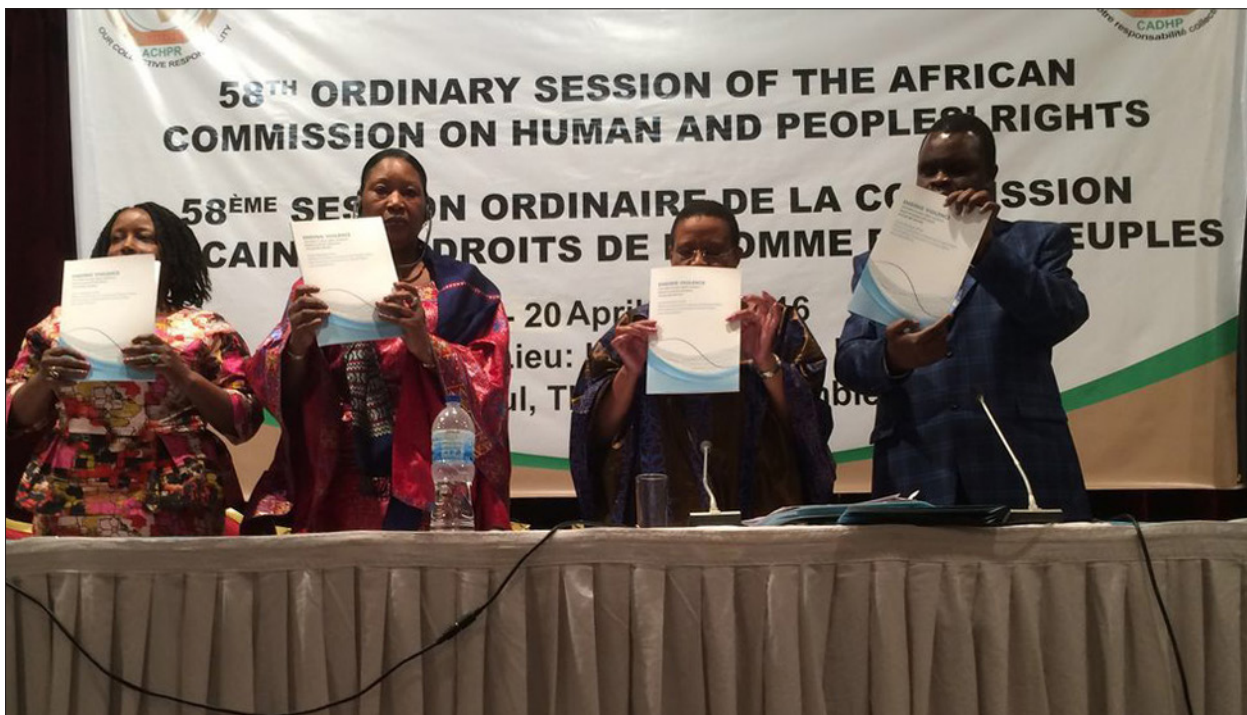
IV. THE PRACTICE OF THE AFRICAN REGIONAL HUMAN RIGHTS SYSTEM ON HIV

1. This chapter provides an overview of the work and engagement of African regional human rights mechanisms on HIV-related issues. It describes and assesses the nature and scope of the work of the regional mechanisms, with a focus on the African Commission²⁵³ (established under the African Charter) and ACERWC (established under the African Children's Charter).

THE AFRICAN COMMISSION AND THE HIV EPIDEMIC

2. Over the years, the African Commission has had the opportunity to address the HIV epidemic directly

and indirectly through its promotion and protection mandate, and through the work of several of its subsidiary mechanisms. This has involved the adoption of resolutions on specific issues relating to HIV and the issuance of general comments clarifying certain provisions of the African Charter and the Maputo Protocol. In several of its communications, the African Commission has also dealt with issues pertinent to HIV, and some of the subsidiary mechanisms established by the African Commission—such as the Special Rapporteur on the Rights of Women in Africa and the Special Rapporteur on Prisons—have also addressed HIV. The most important subsidiary mechanism



²⁵⁴ - African Commission, Resolution 53 on the HIV/AIDS Pandemic.

²⁵⁵ - African Commission, Resolution 141 on Access to Health.

²⁵⁶ - African Commission, Resolution 260 on Involuntary Sterilisation.

²⁵⁷ - African Commission, Resolution 275 on Protection against Violence.

²⁵⁸ - African Commission, Resolution 346 on the Right to Education in Africa.

²⁵⁹ - African Commission, Guidelines on the Conditions of Arrest, Police Custody and Pre-Trial Detention in Africa (2014), 23.

established by the African Commission in relation to the epidemic is the HIV Committee.

HIV-related resolutions of the African Commission

3. As described in Chapter III (“Global and African Regional Human Rights Norms Relating to HIV”), the African Commission has had the opportunity to provide guidance on issues related to HIV in the region. For instance, the African Commission has adopted important resolutions to address the link between HIV and human rights. Some of these resolutions include resolutions on the HIV pandemic as a threat to human rights and humanity,²⁵⁴ access to medicines in the context of HIV,²⁵⁵ forced or involuntary sterilisation of HIV-positive women as a violation of human rights,²⁵⁶ and violence against persons on the basis of real or imputed sexual orientation or identity.²⁵⁷

4. In the context of education, the Commission issued Resolution 346, which calls on States to “prohibit and prevent all forms of discrimination in education against children with HIV/AIDS based on their real or perceived status.”²⁵⁸ These resolutions tend to draw the attention of States to important human rights issues in the context of HIV that warrant their urgent response.

5. The African Commission also has issued important guidelines relevant to HIV and human rights in the region. For instance, the Guidelines on the Conditions of Arrest, Police Custody and Pre-Trial Detention in Africa, adopted in 2014, formulates standards, principles and rules that African governments can use to frame legislation. They note that countries should ensure that measures seeking to protect vulnerable populations, including people living with HIV, should not be discriminatory or applied in a discriminatory manner.²⁵⁹

6. More recently, the African Commission has issued three general comments (Nos. 1, 2 and 3) to clarify the provisions of the African Charter and the Maputo Protocol. As described in Chapter III, these general comments address non-discrimination, the protection of the sexual and reproductive health and rights of women,

the prohibition of forced sterilisation and the interconnection between rights. For example, General Comment No. 3 expands on the contents of the right to life by stressing that this right should be interpreted broadly to include a dignified life and economic rights. It notes that

the right to life is aimed not only at securing the continuation of biological life, but of dignified life. The indivisibility of human rights further suggests that the protection of dignified life lies in securing not only the right to life as a civil and political right, but social, economic and cultural rights as well. The right to life should not be interpreted narrowly. In order to secure a dignified life for all, the right to life requires the realisation of all human rights recognised in the [African] Charter, including civil, political, economic, social and cultural rights and peoples' rights.²⁶⁰

7. In addition, General Comment No. 3 notes that the right to life includes the need for countries to “address more chronic yet pervasive threats to life, for example with respect to preventable maternal mortality, by establishing functioning health systems.”²⁶¹ Therefore, the right to life is closely connected with access to health services, presumably including prevention of and treatment for HIV. This is important in that it places an obligation on States to prevent death from AIDS-related illness by ensuring universal access to life-saving medications. Failure by States to address barriers to life-saving medications in the context of HIV may infringe the right to life.²⁶²

Case law of the African Commission with relevance to HIV

8. The protective mandate of the African Commission—which relates to the communication procedure and State reporting process—remains the strongest avenue to hold States accountable to their obligations to respect, protect and fulfil human rights in relation to HIV.²⁶³ While the African Commission has yet to issue any communications specifically dealing with HIV, some of the provisions of the African Charter and the Maputo Protocol provide it with the impetus to interpret them in the context of HIV. For instance,

²⁶⁰ - African Commission, General Comment No. 3.

²⁶¹ - African Commission, General Comment No. 3, para. 3.

²⁶² - Alicia E. Yamin, “Not Just a Tragedy: Access to Medications as a Right under

International Law,” *Boston University International Law Journal* 21 (2003): 352–371.

²⁶³ - Articles 44–49, 55 and 56 of the African Charter relate to communication by State and non-State actors, respectively, Article 62 of the African Charter and Article 26

Article 2 of the African Charter states that every individual shall be entitled to enjoy the rights and freedoms recognised and guaranteed in the African Charter without distinction of any kind on a number of specified grounds or statuses.²⁶⁴ Further, Article 1 of the Maputo Protocol defines discrimination against women broadly to include “any form of distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women . . . in all spheres of life.” Article 2 of the Maputo Protocol further prohibits discriminatory practices against women.

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

10. The African Commission has stated that Articles 2 and 3 of the African Charter are considered fundamental, linked to the enjoyment of other rights, and that they arguably protect people living with HIV by affording them the rights to equality and non-discrimination. There also are indications that the provisions protect other key populations on other grounds, such as disability, sexual orientation and gender identity. The African Commission has explained the importance and breadth of Articles 2 and 3 of the African Charter on various occasions,

noting their application to a range of persons. It has stated that²⁶⁵

Article 2 lays down a principle that is essential to the spirit of the African Charter and is therefore necessary in eradicating discrimination in all its guises, while Article 3 is important because it guarantees fair and just treatment of individuals within a legal system of a given country. These provisions are non-derogable and therefore must be respected in all circumstances in order for anyone to enjoy all the other rights provided for under the African Charter.

11. In *Legal Resources Foundation v. Zambia*, the African Commission noted that

the right to equality is very important. It means that citizens should expect to be treated fairly and justly within the legal system and be assured of equal treatment before the law and equal enjoyment of the rights available to all other citizens. The right to equality is important for a second reason. Equality or the lack of it affects the capacity of one to enjoy many other rights.²⁶⁶

12. In *Good v. Republic of Botswana*, the African Commission described the importance and breadth of the principle of non-discrimination, which it said “guarantees that those in the same circumstances are dealt with equally in law and in practice.”²⁶⁷ This was in line with its decision on Communication 245/02, *Zimbabwe Human Rights NGO Forum v. Zimbabwe*, in which the African Commission observed that the principles of equality and non-discrimination apply to all persons.²⁶⁸

13. Furthermore, as described in Chapter III, the African Commission has had the opportunity to explain the scope and extent of Article 16, which guarantees the right of every individual to enjoy the best attainable state of physical and mental health and places a duty on State Parties to take the necessary measures to protect the health of all peoples, particularly when they are sick. In *Purohit and Moore v. The Gambia*, the African Commission stressed in to Article 16 that

of the Maputo Protocol require States to submit periodic reports to the African Commission on the measures they have taken to implement the provisions of these instruments.

²⁶⁴ - The Committee on ESCR in its General Comment No. 20 has explained that the phrase “other status” can be interpreted broadly to cover discrimination on the

grounds of HIV and health status.

²⁶⁵ - Communication 241/01, *Purohit and Moore v. The Gambia*, para. 49.

²⁶⁶ - Communication 211/98, para 63.

²⁶⁷ - Communication 313/05, *Kenneth Good v. Republic of Botswana*, para. 218.

²⁶⁸ - Communication 245/02, *Zimbabwe Human Rights NGO Forum v. Zimbabwe*, para. 169.

the “enjoyment of the human right to health . . . is crucial to the realisation of all the other fundamental human rights and freedoms.”²⁶⁹

14. The African Commission in *Doebbler v. Sudan* states that “the prohibition of torture, cruel, inhuman or degrading treatment or punishment is to be interpreted as widely as possible to encompass the widest possible array of physical and mental abuses.”²⁷⁰ In this decision, the African Commission emphasised that Article 5 of the African Charter prohibits not only actions that cause serious physical or psychological suffering, but also those that “humiliate or force the individual against his will or conscience.”²⁷¹ This interpretation could be applied to the HIV context to prevent forced treatment and enforce the requirements for informed consent.

15. In *Democratic Republic of Congo v. Burundi, Rwanda, Uganda*, the African Commission condemned sexual violence during conflict as a gross violation of the human rights of women.²⁷² The African Commission noted that rape and other acts of violence violated the right to the integrity of one’s person.²⁷³ This was based on the complaints of the Democratic Republic of Congo that Rwandan and Ugandan forces had been spreading HIV to the population of the Democratic Republic of Congo by raping local women, which Uganda denied.²⁷⁴ The African Commission did not specifically address the HIV allegation raised in this communication.

16. It is clear from these cases that the African Commission has yet to specifically apply to HIV the human rights protections provided under the African Charter. Lessons can be drawn in this regard from other jurisdictions, such as the European and Inter-American human rights systems, which have already adjudicated on HIV-related issues. In *D v. United Kingdom*, the European Court of

Human Rights held that the deportation of an HIV-positive person to a country where access to treatment could not be guaranteed would amount to a violation of the right to dignity under the European Convention.²⁷⁵ Further, in the case of *Odir Miranda et al v. El Salvador*—which involved 27 HIV-positive persons who were denied access to medication that integrated the triple therapy necessary to prevent death and improve their quality of life—the Inter-American Commission admitted the petition on the right to health, although it concluded that there was no violation of this right.²⁷⁶ It ordered the Government of El Salvador to adopt urgent precautionary measures for the victims in the case in order for them to obtain the relevant medical care and antiretroviral medications.²⁷⁷ This case is significant in the sense that it portrays how precautionary measures can be applied to good use in the context of HIV.

State reporting and HIV

17. As part of its protective mandate, the African Commission examines State reports submitted under Article 62 of the African Charter and Article 26 of the Maputo Protocol, providing responses in the form of concluding observations.²⁷⁸ This process provides the African Commission with the opportunity to assess the commitments that States have made to addressing issues relating to HIV and human rights within their jurisdictions. Through this process, the African Commission can clarify if steps taken by a State to address the HIV pandemic are consistent with its obligations to realise human rights in general, and the right to health in particular.

18. In some of its concluding observations to States, the African Commission has drawn the attention of States to gaps in their efforts to address the HIV pandemic. For instance, in one of its concluding observations to the Government of Sudan, the African Commission notes

²⁶⁹ - Communication 241/01, *Purohit and Moore v. The Gambia*, para. 80.

²⁷⁰ - Communication 236/2000, *Curtis Doebbler v. Sudan*, para. 37.

²⁷¹ - Communication 236/2000, *Curtis Doebbler v. Sudan*, para. 36.

²⁷² - Communication 227/99, *Democratic Republic of Congo/Burundi, Rwanda, Uganda*, para. 80.

²⁷³ - Communication 227/99, *Democratic Republic of Congo/Burundi, Rwanda, Uganda*, para. 80.

²⁷⁴ - Communication 227/99, *Democratic Republic of Congo/Burundi, Rwanda, Uganda*, para. 5.

²⁷⁵ - ECHR, *D v. UK*, 2 May 1997.

²⁷⁶ - *Jorge Odir Miranda Cortez et al. v. El Salvador*, Merits Report of 20 March 2009, IACHR Case 12,249 Report No. 27/09.

²⁷⁷ - For a detailed analysis of this case see, Oscar Parra-Vera, “The Protection of the Right to Health through Individual Petitions before the Inter-American System of Human Rights,” ed. Ebenezzer Durojaye, *Litigating the Right to Health in Africa: Challenges and*

Prospects (Farnham UK: Ashgate Publishing, 2015), 243–274.

²⁷⁸ - These provisions require States that have ratified the African Charter and the Maputo Protocol to submit periodic reports every two years.

²⁷⁹ - See African Commission, *Concluding Observations and Recommendations on the 4th and 5th Periodic Report of the Republic of Sudan*, para. 46.

²⁸⁰ - See African Commission, *Concluding Observations and Recommendations on the Initial and Combined Report of the Gabonese Republic*.

²⁸¹ - African Commission, *Concluding Observations on the 3rd Periodic Report of the Republic of Cameroon*, para. XIV.

²⁸² - African Commission, *Concluding Observations on the 3rd Periodic Report of the Republic of Cameroon*, paras. 84, 85 and Recommendation xxvii.

²⁸³ - African Commission, *Concluding Observations and Recommendations on the Initial, 1st, 2nd, 3rd and 4th Periodic Report of the Federal Democratic Republic of Ethiopia*, Adopted during the 47th Ordinary Session of the African Commission on Human and Peoples’ Rights, Held from 12–26 May, 2010, Banjul, The Gambia, para. 68.

that while efforts to ensure access to medical services and social security for all (including vulnerable and marginalised groups) have been commendable, the report fails to provide detailed information on access to life-saving medication for people living with HIV in the country.²⁷⁹ In its response to a report from Gabon, the African Commission recommends that the Government of Gabon strengthen ongoing HIV sensitisation programmes with a particular focus on children and young people.²⁸⁰ In one of its concluding observations to a report from Cameroon, the African Commission urges the Government to engage with relevant stakeholders with a view towards ensuring the adoption of laws and policies to protect the rights of people living with HIV.²⁸¹ It also expresses concern about the judicial harassment of human rights defenders working in the area of sexual orientation and the “discrimination, stigma and violation of the right to life and physical and mental integrity of individuals based on their sexual orientation.”²⁸² It goes on to urge the Government of Cameroon to take appropriate measures to ensure the safety and physical integrity of all persons, irrespective of their sexual orientation, and to maintain an atmosphere of tolerance towards sexual and gender minorities in the country.

19. In its concluding observations to the Government of Ethiopia, the African Commission recommends the enactment of laws to address human rights violations experienced by people living with HIV in the country.²⁸³ It further recommends that the Government develop programmes to prevent the incidence of mother-to-child transmission of HIV in the country. In its fifth periodic review of Uganda, the African Commission recommends that Uganda “review and revise the HIV and AIDS Prevention and Control Act (2014) . . . to ensure that it fully conforms with Uganda’s regional and international human rights obligations.”²⁸⁴

20. The African Commission has also called on Nigeria to repeal its law criminalising same-sex sexual relations because it has the potential to generate violence against persons on grounds of their actual or imputed sexual orientation. This law is also likely to drive underground this group of persons vulnerable to HIV, thereby creating an environment in which it is impossible to effectively address the HIV epidemic in the State.²⁸⁵ Further, the African Commission recommended that Botswana reform a law that requires minors to be accompanied by their parents when being tested for HIV.²⁸⁶

21. While concluding observations are not binding on States, they do draw their attention to issues that require further attention. Indeed, concluding observations may be likened to advisory opinions of courts on a specific human rights issue.²⁸⁷

HIV within subsidiary organs of the African Commission

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

- The HIV Committee;²⁸⁸
- The Special Rapporteur on Prisons;²⁸⁹
- Special Rapporteur on Refugees, Asylum Seekers, Internally Displaced Persons and Migrants in Africa;²⁹⁰
- The Special Rapporteur on Rights of Women;²⁹¹
- The Special Rapporteur on Freedom of Expression and Access to Information;

²⁸⁴ - African Commission, Concluding Observations and Recommendations on the 5th Periodic State Report of the Republic of Uganda, November 2015, para. 113.

²⁸⁵ - African Commission, Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria, para. 81.

²⁸⁶ - African Commission, Concluding Observations and Recommendations on the Initial Periodic Report of the Republic of Botswana, para. 68.

²⁸⁷ - Thomas Buergenthal et al., *International Human Rights in a Nutshell*, Second ed. (Minnesota: West Publishing, 1995), 46.

²⁸⁸ - The HIV Committee is the only special mechanism in the region that is specifically mandated to address HIV. In 2010, it was decided that the African Commission needed a specific mechanism for people living with, affected by and vulnerable to HIV. Therefore, the African Commission established the HIV Committee. It has a broad mandate on HIV-related human rights issues. For more information, see <http://www.achpr.org/mechanisms/hiv-aids/>.

²⁸⁹ - For more information, see <http://www.achpr.org/mechanisms/prisons-and-conditions->

[of-detention/](#) (accessed 15 June 2016).

²⁹⁰ - The Special Rapporteur on Refugees, Asylum Seekers, Internally Displaced Persons and Migrants in Africa carries out its mandate by seeking, receiving, examining and acting on the situation of refugees, asylum seekers, migrants and internally displaced persons. This is done through undertaking studies, research, fact-finding missions, assisting Member States of the African Union, cooperating and engaging in dialogue with relevant stakeholders, and raising awareness on the situation of its mandated population. For more information, see <http://www.achpr.org/mechanisms/refugees-and-internally-displaced-persons/>.

²⁹¹ - The Special Rapporteur on Rights of Women in Africa was established by the African Commission in 1999. For more information, see <http://www.achpr.org/mechanisms/rights-of-women/>.

- › Committee for the Prevention of Torture in Africa;²⁹²
- › The Working Group on Economic, Social and Cultural Rights;²⁹³
- › The Working Group on Rights of Older Persons and People with Disabilities.

23. These mechanisms have important roles to play in addressing HIV in the region. Some have already addressed the epidemic on several occasions. The Special Rapporteur on the Rights of Women in Africa has often recognised the particular needs of women living with HIV, the discrimination faced by women living with HIV and the gendered aspect of HIV. The Special Rapporteur's Declaration on the Occasion of International Women's Day in 2009 was specifically focused on "equal sharing of responsibilities between women and men, including providing care in the context of HIV/AIDS."²⁹⁴ She noted that women have limited and unequal access to care, antiretroviral medicines and treatment, and that they bear the greatest burden in terms of caring for and supporting people living with HIV, including orphans and the affected. They also are subjected to a very harsh form of stigma and discrimination, manifested through violence of all kinds, particularly expulsion from the home, deprivation of their rights to inheritance and more.²⁹⁵

24. In the Intercession Report of the Mechanism of the Special Rapporteur on the Rights of Women in Africa since its Establishment, the Special Rapporteur noted the need for action by State Parties through the enactment of legislation to protect women with HIV and AIDS from all forms of discrimination and through the establishment of mechanisms to ensure their full participation in the process of providing access to health care and antiretroviral therapy.²⁹⁶

25. An initiative for the protection of women human rights defenders is also worth mentioning.

Undertaken in 2015 by the African Commission's Special Rapporteur on Human Rights Defenders, the Study on the Situation of Women Human Rights Defenders calls on national human rights institutions to pay specific attention to female human rights defenders "working on issues and contexts of criminalised identities, such as the rights of sex workers, women living with HIV accused of deliberate transmission and sexual orientation and gender identity." The study further calls for the protection of female human rights defenders who are working on issues that are criminalised in their countries.²⁹⁷

26. Similarly, the Special Rapporteur on Prisons—one of the oldest mechanisms of the African Commission—has also addressed the HIV epidemic. For example, in a mission to assess the situation of prisons in Cameroon, the Special Rapporteur on Prisons addressed issues relevant to HIV, including the prevalence of HIV in prison. The Special Rapporteur expressed concern at the failure of the Government to provide her with information on the HIV prevalence rate in prisons, noting that it was not "the acceptable state of affairs given the potential threat posed by the pandemic."²⁹⁸ The Special Rapporteur recommended that Cameroon should initiate and intensify information and awareness-raising sessions about HIV for prisoners, encourage voluntary testing for HIV and strengthen structures for psychological care and counselling, particularly before and after testing for those found to be HIV-positive.²⁹⁹

27. The Special Rapporteur on Prisons also addressed policies related to the treatment of prisoners with HIV in reports on prison conditions in Uganda and South Africa.³⁰⁰ Further, in a 2001 response to a policy in Namibia that prohibited HIV-positive prisoners from working in the kitchen, the Special

²⁹² - The Committee for the Prevention of Torture in Africa (Committee on Torture) was created in October 2002 by the African Commission. Its purpose is to raise awareness of the Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa (the Robben Island Guidelines) and to facilitate the implementation of the Robben Island Guidelines throughout the African Union Member States. The Committee on Torture carries out its mandate by writing letters regarding alleged violations, developing strategies to promote the Robben Island Guidelines, analysing the domestic laws of States and their compliance with international standards, and conducting visits to Member States. For more information, see <http://www.achpr.org/mechanisms/cpta/>.

²⁹³ - The Working Group on Economic, Social and Cultural Rights is tasked with developing and proposing to the African Commission a draft set of Principles and Guidelines on Economic, Social and Cultural Rights, providing a draft of revised guidelines for State reporting, undertaking relevant studies and research, and making a progress report to the African Commission. For more information, see <http://www.achpr.org/mechanisms/escri/>.

²⁹⁴ - "Declaration by the Special Rapporteur on Women's Rights in Africa on the Occasion of the International Women's Day," African Commission, 8 March 2009, <http://www.achpr.org/press/2009/03/d15/>.

²⁹⁵ - "Declaration by the Special Rapporteur on Women's Rights in Africa on the Occasion of the International Women's Day," African Commission, 8 March 2009, <http://www.achpr.org/press/2009/03/d15/>.

²⁹⁶ - Soyata Maiga, Intercession Report of the Mechanism of the Special Rapporteur on the Rights of Women in Africa since its Establishment (Banjul: African Commission, 2012), <http://www.achpr.org/sessions/52nd/intercession-activity-reports/rights-of-women>.

²⁹⁷ - African Commission, Report of the Study on the Situation of Women Human Rights Defenders in Africa (Banjul: African Commission, 2015), para. 201, http://www.achpr.org/files/special-mechanisms/human-rights-defenders/report_of_the_study_on_the_situation_of_women_human_rights_defenders_in_africa.pdf.

²⁹⁸ - Vera Mlangazuwa Chirwa, Prisons in Cameroon: Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa (Banjul: African Commission, 2002), 21, http://www.achpr.org/files/sessions/37th/mission-reports/cameroon-prisons/misrep_specmec_priso_cameroon_2002_eng.pdf.

Rapporteur states that “discrimination against people suffering from HIV/AIDS is not allowed.”³⁰¹

The HIV Committee

28. In recognition of the specific and serious human rights challenges posed by the HIV epidemic in Africa, the African Commission established the HIV Committee in May 2010 through Resolution 163.³⁰²

Mandate and composition of the HIV Committee

29. The mandate of the HIV Committee was originally authorised for two years, but it has been renewed by the African Commission several times.³⁰³ The African Commission appoints the HIV Committee’s chairperson, members and expert members, either by consensus or by vote.³⁰⁴ Since its establishment, the HIV Committee has had three members who are Commissioners of the African Commission, one of whom has been appointed as Chairperson.

30. The HIV Committee also has expert members who are not Commissioners. To be appointed as an expert member, candidates must be nationals of an African Union Member State, and they must have expertise in protecting and promoting the rights of individuals living with HIV and those who are at risk, vulnerable to and affected by HIV. When a position is available, the Committee accepts nominations from individuals, non-governmental organizations, Member States, nation human rights institutions and other institutions.³⁰⁵ Currently there are six expert members on the HIV Committee from various backgrounds.

31. The HIV Committee submits intersession activity reports to the African Commission twice each year. These reports outline the activities that the HIV Committee has undertaken.³⁰⁶ This information is included in the African Commission’s activity reports, which are submitted to the African Union

Assembly twice every year during the summits of the African Union.

Activities of the HIV Committee

32. The HIV Committee undertakes a number of activities, including conducting visits to Member States (with their consent) to engage stakeholders on HIV-related human rights issues. During these visits (also known as “missions”), the HIV Committee engages with government officials and civil society organizations (among others) to learn about the State’s laws, policies, practices and programmes that relate to the human rights of persons living with HIV and other populations. For example, in 2016, the HIV Committee undertook a country visit to Côte d’Ivoire,³⁰⁷ and in 2017, the Committee completed a country visit to Namibia.³⁰⁸ After it completes a mission, the HIV Committee publishes a mission report that contains general recommendations to the State. Mission reports also often include specific recommendations to the international community, civil society and other stakeholders.³⁰⁹

33. The HIV Committee’s mandate also requires it to recommend concrete strategies to protect the rights of persons living with HIV, those at risk and those vulnerable to HIV. To develop effective strategies, the HIV Committee may conduct studies to better understand the human rights conditions and situations surrounding these persons.³¹⁰

34. The HIV Committee also receives analyses and responds to reliable information from credible sources on allegations of human rights violations. Upon learning of alleged violations, the HIV Committee may write letters to the relevant State and to non-State actors that are involved (including corporations). These letters request information about what steps have been taken to remedy the alleged violations. The HIV Committee may

²⁹⁹ - Chirwa, Prisons in Cameroon, 25.

³⁰⁰ - African Commission, Report on the Mission of the Special Rapporteur on Prison & Conditions of Detentions in Africa to Uganda (Banjul: African Commission, 2001), http://www.achpr.org/files/sessions/33rd/mission-reports/uganda/achpr33_misrep_specmec_priso_uganda_2001_eng.pdf; and Mission to the Republic of South Africa, Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa (2004), http://www.achpr.org/files/sessions/37th/mission-reports/prisons-2004/misrep_specmec_priso_southafrica_2004_eng.pdf.

³⁰¹ - Chirwa, Prisons in Cameroon, 25.

³⁰² - African Commission, Resolution 163 on the Establishment of a Committee on the Protection of the Rights of People Living With HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV.

³⁰³ - For example, see African Commission, Resolution 220 on the Extension of the Mandate of the Committee on the Protection of the Rights of People Living with HIV (PLWHIV), and Those at Risk, Vulnerable to and Affected by HIV in Africa (2 May 2012).

³⁰⁴ - African Commission, Rules of Procedure of the African Commission on Human and

Peoples’ Rights (Banjul: African Commission, 2010), Rule 23(2).

³⁰⁵ - For example, see African Commission, Call for Applications for the Nomination of Expert Members to Serve on the Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV (11 April 2014).

³⁰⁶ - These are available at <http://www.achpr.org/mechanisms/hiv-aids/>.

³⁰⁷ - “Press Release on the Visit of the Committee on the Protection of the Rights of People Living with HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV of the African Commission on Human and Peoples’ Rights to the Republic of Côte d’Ivoire,” African Commission, 30 May 2016, <http://www.achpr.org/press/2016/05/d302/>.

³⁰⁸ - “Press Release on the Country Visit to the Republic of Namibia,” African Commission, 24–29 April 2017, <http://www.achpr.org/press/2017/04/d352/>.

³⁰⁹ - African Commission, Rules of Procedure, Rule 60.

³¹⁰ - For example, see African Commission, Resolution 290 on the Need to Conduct a Study on HIV, the Law and Human Rights.

propose that the African Commission take a certain action or decision.

- 35.** The HIV Committee also obtains and disseminates information through promotional activities, such as panels, training for non-governmental organisations engaged in HIV-related issues and round-table meetings.³¹¹ The HIV Committee often coordinates these activities with other relevant special rapporteurs and working groups under the African Commission or the UN.

HIV-RELATED ISSUES AND OTHER AFRICAN REGIONAL HUMAN RIGHTS BODIES

ACERWC

- 36.** ACERWC draws its mandate from Articles 32 through 46 of the African Children's Charter. Similar to the African Commission, ACERWC possesses a mandate that is both promotional and protective, but it has not yet addressed HIV specifically in its case law, guidelines, general comments or mission reports.
- 37.** ACERWC has adopted two general comments, but neither has dealt directly with issues relating to HIV and human rights. General Comment No. 1 deals with children of imprisoned parents under Article 30 of the African Children's Charter. While it does not specifically address HIV and the specific vulnerabilities that such children face with respect to HIV, General Comment No. 1 does make several statements that could be applied to the context of HIV.³¹² For example, it highlights Article 30(1) of the African Children's Charter, which indicates that State Parties "shall undertake to provide special treatment to expectant mothers."³¹³ This section could be applied to PMTCT activities by requiring States to provide this specific treatment.
- 38.** Additionally, General Comment No. 1 speaks about a child's "inherent" right to life and right to development, which "entails a comprehensive process of realizing children's rights in order to

allow them grow up in a healthy and protected manner."³¹⁴ These more general references to the rights of children to be healthy and to access health care on a non-discriminatory basis could easily be applied to the HIV context in the future.

- 39.** Its General Comment No.2 on Article 6 of the African Children's Charter on the Right to a Name, Registration at Birth, and to Acquire a Nationality is the second general comment adopted by ACERWC.³¹⁵ It also does not make any specific reference to HIV. In General Comment No. 2, ACERWC adopts a broad interpretation of Article 6 of the African Children's Charter, noting that

the rights to a name, to birth registration and to acquire a nationality cannot be fully implemented unless the cardinal principles of children's rights are carefully observed. The implementation of those rights requires taking into account the best interests of the child, non-discrimination principles, his/her survival, development and protection as well as his/her participation. The implementation of Article 6 also depends on good understanding of the principle of interdependence and indivisibility of children's rights in general and the interdependence and indivisibility of the three rights provided for under Article 6 in particular.³¹⁶

- 40.** This interpretation can potentially be applied to advance the rights of children in the context of HIV. Given the serious impact of HIV on children and young people in the region, it is imperative that ACERWC consider adopting a general comment or resolution on this issue. In doing so, it can draw inspiration from its counterparts at the international level, which have directly addressed this issue.³¹⁷
- 41.** There are more informal ways that ACERWC has addressed HIV. In its 2002 inaugural meeting, one of the thematic issues discussed was orphans living with and infected by HIV.³¹⁸ At its

³¹¹ - For example, see Reine Alapini-Gansou, Intersession Report of the Committee on the Protection of the Rights of Persons Living with HIV/AIDS and Those at Risk, Intersession Activity Report, 50th Ordinary Session (Banjul: African Commission, 2011), http://www.achpr.org/files/sessions/50th/inter-act-reps/148/achpr50_specmec_hiv_aids_actrep_gansou_2011_eng.pdf.

³¹² - ACERWC, General Comment No. 1 (Article 30 of the African Charter on the Rights and Welfare of the Child) on Children of Incarcerated and Imprisoned Parents and Primary Caregivers (2013), <http://www.acerwc.org/?wpdmdl=8597>.

³¹³ - ACERWC, General Comment No. 1, para. 9.

³¹⁴ - ACERWC, General Comment No. 1, para. 25.

³¹⁵ - ACERWC, General Comment No. 2 on Article 6 of the African Children's Charter on the Right to a Name, Registration at Birth, and to Acquire a Nationality", 16 April 2014, ACERWC/GC/02 (2014)

³¹⁶ - As above, para. 13.

³¹⁷ - See UN Committee on the Rights of the Child, General Comments No. 3 on HIV/AIDS and the Rights of the Child, UN.Doc CRC/GC/2003/3 (17 March 2003); and UN Committee on the Rights of the Child, General Comment No. 4 on Adolescence Health and Development in the Context of the Convention on the Rights of the Child, UN.Doc CRC/GC/2003/4 (1 July 2003).

³¹⁸ - "African Committee of Experts on the Rights and Welfare of the Child," IHRDA, accessed 23 June 2016, <http://www.ihrda.org/515-2/>.

³¹⁹ - Amanda Lloyd, "Report of the Second Ordinary Session of the African Committee of Experts on the Rights and Welfare of the Child," African Human Rights Law Journal 2 (2003): 329.

³²⁰ - Lloyd, "Report," 329.

³²¹ - ACERWC, Concept Note of the 25th Day of the African Child (DAC), 2015 (Addis

second session in February 2003, the control of HIV and other causes of the ill health, as well as high mortality among children in Africa, were recognised as priorities.³¹⁹ ACERWC resolved to monitor and report on the impact of HIV and to monitor the relevant activities of governments on these issues.³²⁰

42. HIV is addressed in the Concept Note of the 25th Day of the African Child in 2015. In this document, ACERWC noted that child marriage is caused by “gender inequality due to entrenched societal differentiation between males and females,” including HIV status.³²¹ Not only was HIV status a cause of child marriage, but it was also a result, and ACERWC states that “child brides are prone to disabilities associated with early childbirth. . . . including HIV.”³²²

43. Under its protective mandate, ACERWC has touched on issues with implications for HIV and the rights of children through its jurisprudence, State reporting process and mission visits. For instance, in addressing children’s health in IHRDA and Open Society Justice Initiative (OSJI) (on behalf of children of Nubian descent in Kenya) v. Kenya,³²³ ACERWC noted that “statelessness is particularly devastating to children in the realisation of their socio-economic rights such as access to health care.”³²⁴ ACERWC further found in this case that denial of basic medical services would violate the right to health.³²⁵ This interpretation establishes a State’s obligation to provide basic medical services to children, and it therefore may be useful in the future to ensure access to HIV-related health-care services for children.

44. In *Michelo Hunsungule on behalf of children in Northern Uganda v. The Government of Uganda*, ACERWC missed an opportunity to clarify the obligations of States in relation to the right to health and protection of the girl child from sexual abuse during a conflict period.³²⁶ It rejected the complaints of the applicants, who alleged that

by not providing health-care facilities and clinics and by not protecting female children from sexual abuse, the respondent government failed to ensure that children enjoyed the right to health.

45. ACERWC has also addressed HIV in a limited way as part of its guidance on how countries should report on their compliance with the African Children’s Charter. In the States Parties Reporting Guidelines, ACERWC indicates that countries should provide data on the death of children from AIDS-related illness (in addition to other illnesses), measures taken to prevent transmission of HIV from mother-to-child, how many mothers were provided with PMCT services and the percentage of children born with HIV.³²⁷ The Guidelines, however, do not require countries to provide any information related to the rights of children and adolescents to HIV-related health care (including health information).

46. Under Article 45 of the African Children’s Charter, ACERWC also is empowered to resort to any appropriate method of investigation in relation to any issue covered by the African Children’s Charter.³²⁸ Although the mission reports thus far conducted by ACERWC have a section dedicated to the right to health, HIV was not covered.³²⁹ This was a missed opportunity to deal with HIV in the context of children’s rights.

47. Finally, ACERWC issues concluding observations following the consideration of State Parties reports. Concluding observations highlight any major issues of concern and make recommendations to countries on the measures that can be implemented to complement the progress achieved and the challenges faced. ACERWC has raised concerns regarding HIV in a number of concluding observations. For instance, in its concluding observations to Guinea, the Committee notes the high infant mortality due to HIV and recommends “raising awareness on HIV.”³³⁰ It gave a similar recommendation to Sudan.³³¹

Ababa: ACERWC, 2015), para. 11, <http://www.repssi.org/download/DAC%20CONCEPT%20NOTE%20CHILD%20MARRIAGE.pdf>.

³²² - ACERWC, Concept Note of the 25th Day of the African Child (DAC), para. 14.

³²³ - Decision No 002/Com/002/2009, IHRDA and Open Society Justice Initiative (OSJI) (on behalf of children of Nubian descent in Kenya) v. Kenya, 22 March 2011, para. 46.

³²⁴ - As above, para. 46.

³²⁵ - As above, para. 59.

³²⁶ - Communication 2/2009, Hunsungule and Others (on behalf of children in Northern Uganda) v. Uganda, Twenty-First Ordinary Session (15–19 April 2013).

³²⁷ - ACERWC, State Parties Reporting Guidelines (Addis Ababa: ACERWC, 2015), paras. 21(a), 24(c) and 26(e), <http://www.acerwc.org/?wpdmdl=8694> (accessed 19 June 2016).

³²⁸ - “African Committee of Experts on the Rights and Welfare of the Child,” IHRDA, accessed 17 January 2016, <http://www.ihrda.org/515-2/>.

³²⁹ - For example, see ACERWC, Report on the Advocacy Mission to Assess the Situation of Children in South Sudan (Addis Ababa: ACERWC, 2016), <http://www.acerwc.org/?wpdmdl=9490>; and ACERWC, Report of the ACERWC to Assess the Situation of Children Affected by the Conflict in the Central African Republic (Addis Ababa: ACERWC, 2014), <http://www.acerwc.org/?wpdmdl=9478>.

³³⁰ - ACERWC, Concluding Observations: African Committee of Experts on the Rights and Welfare of the Child to the Government of Guinea, para. 30, http://www.acerwc.org/download/concluding_observations_guinea/?wpdmdl=8745.

³³¹ - ACERWC, Recommendations of the African Committee of Experts on the Rights and Welfare of the Child to the Government of the Republic of Sudan on the Initial Report on Implementation of the African Charter on the Rights and Welfare of the Child (Addis Ababa: ACERWC, 2012), 4, http://www.acerwc.org/download/concluding_observations_sudan/?wpdmdl=8757.

48. ACERWC has also given much more specific and in-depth recommendations to countries. It recommends that Liberia

increase the comprehensive HIV information education campaign; make stronger its efforts to ensure proper coverage of HIV testing and antiretroviral medicines provision by giving a particular attention to pregnant adolescents in rural areas and children born to mothers with HIV, and seek technical assistance from the concerned international organizations and [civil society organisations].³³²

49. In its recommendations to Tanzania, ACERWC recommends that the country expand its youth education on STIs to incorporate this type of education into primary school curriculums.³³³ They also recommend that South Africa step up its reproductive health education for school-aged children and work to disseminate antiretroviral medicines more effectively.³³⁴ Despite the ability to give recommendations, there unfortunately is no system by which ACERWC evaluates country reports to ensure compliance on HIV-related issues.

The African Court

50. The African Court was established to hear cases related to the African Charter and the Maputo Protocol. It was established under the Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights (the Court Protocol).³³⁵
51. The African Court has been silent on the issue of HIV to date, but this could be due to some of the strict procedural limitations that it faces. The African Court's jurisdiction is relatively limited, as it only applies to States that have ratified the Court Protocol. Furthermore, the Court Protocol does not enable individuals or non-governmental organisations to access the African Court directly unless the respondent State has made a specific Declaration accepting the jurisdiction of the Court (Article 34(6) of the African Protocol). As of October 2017, only eight of the 30 States Parties to the Court Protocol had made the declaration

recognising the competence of the African Court to receive cases from individuals and non-governmental organisations.³³⁶

52. Although the African Court has not yet received an HIV-related case, it could be a place where future jurisprudence regarding the rights of individuals with HIV is developed. In particular, the advisory jurisdiction of the African Court can be explored by civil society organisations to request authoritative interpretation of the human rights instruments related to HIV in the region.³³⁷ However, in a May 2017 decision, the African Court held that only African non-governmental organisations that have observer status before—or a Memorandum of Understanding with—the African Union are entitled to bring a request for advisory opinion before it.³³⁸

CONCLUSION

53. The African regional human rights system includes institutions and mechanisms that can play a critical role in interpreting and applying human rights norms, and that can support accountability in the context of HIV. At the centre of these mechanisms is the African Commission, the oldest institution and one that has relied on its protective and promotional mandate and special mechanisms to advance the rights of people, including rights related to HIV. Although the African Court has yet to deal with a specific case on HIV and human rights, its advisory mandate provides a platform that can be useful for advancing the rights related to HIV. Furthermore, while ACERWC still awaits its first case on children's rights and HIV, it also has relied on its thematic issues and promotional and protective mandates to explain how the right to health and medical attention cover children living with and affected by HIV. In its guidelines on State reporting, however, ACERWC has missed the opportunity to oblige States to report specifically on what they do to give effect to the rights of children and adolescents with HIV-related health-care needs (including a need for health information).
54. In spite of these positive elements, much more needs to be done to ensure that the full potential of

332 - ACERWC, Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Liberia Report on the Status of the Implementation of the African Charter on the Rights and Welfare of the Child, 10, <http://www.acerwc.org/?wpdmdl=8747>.

333 - ACERWC, Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Republic of Tanzania Report on the Status [sic] of Implementation of the African Charter on the Rights and Welfare of the Child (Addis Ababa: ACERWC, 2010), 12-13, <http://www.acerwc.org/download/>

[concluding_observations_tanzania/?wpdmdl=8756](http://www.acerwc.org/download/concluding_observations_tanzania/?wpdmdl=8756).

334 - ACERWC, Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Republic of South Africa Initial Report on Implementation of the African Charter on the Rights and Welfare of the Child (Addis Ababa: ACERWC, 2014), para. 49, http://www.acerwc.org/download/concluding_observations_south_africa/?wpdmdl=8754 (accessed 22 June 2016).

335 - "Welcome to the African Court," African Court on Human and Peoples' Rights, accessed 19 June 2016, <http://www.african-court.org/>; and "African Court on Human and Peoples' Rights," accessed 19 June 2016, <http://www.african-court.org/>.

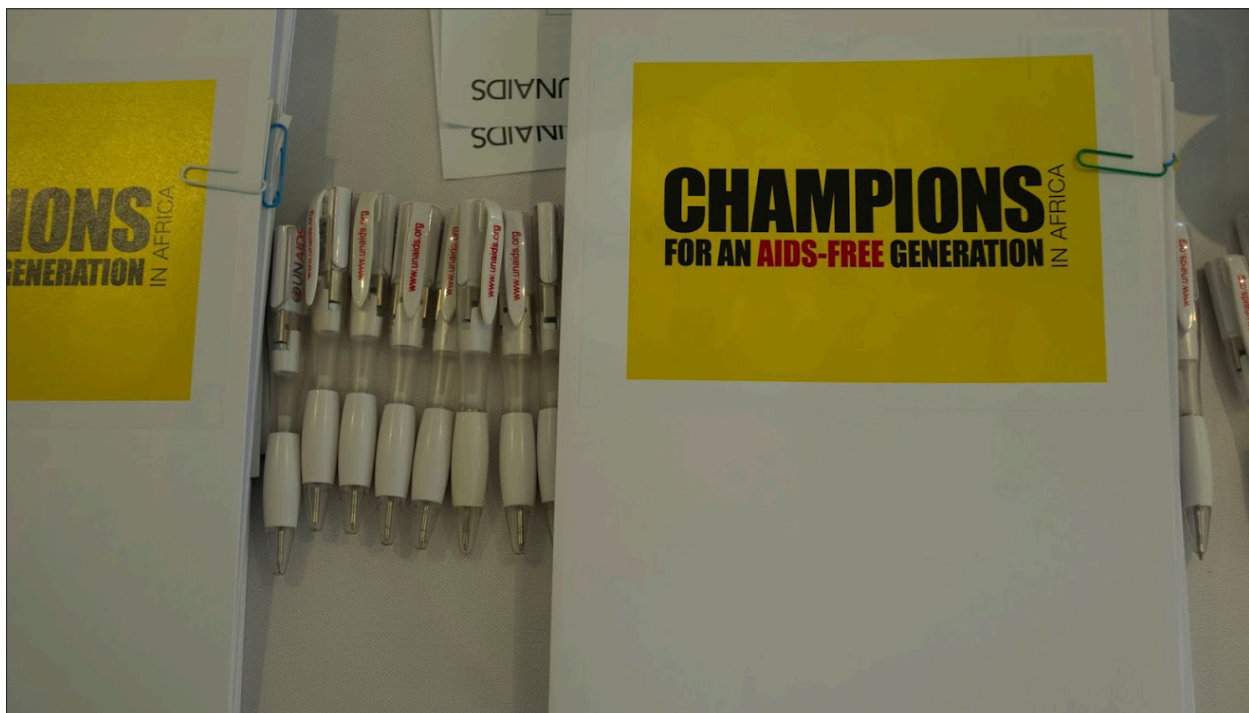
the regional human rights system is used to advance HIV-related human rights on the continent. Some of the key challenges currently facing the African system in relation to HIV include the following.

Limited focus on HIV from all mechanisms

55. Thus far, very few regional mechanisms (apart from the HIV Committee) have addressed HIV-related issues. The African Commission and the African Court have yet to adjudicate on an HIV-related complaint. There are a number of special mechanisms of the African Commission whose mandates are relevant to HIV, but that are not specifically mandated to address HIV. For example, the Working Group on the Rights of Older Persons and People with Disabilities is developing a Protocol on the Rights of People with Disabilities and Guidelines for State Parties on the implementation of the rights of persons with disabilities. Integrating HIV and human rights issues relevant to persons with disabilities into these documents would be an effective way of infusing HIV into the work of this Group.

56. The HIV Committee has made efforts to link with some of the relevant special rapporteurs in its work, particularly the Special Rapporteur on the Rights of Women in Africa. Broadly speaking, however, related mechanisms fail to regularly address HIV-related issues. This may be due to their lack of the necessary knowledge and expertise to address HIV-related issues and the lack of specific guidelines about how their mandate should address the problem of HIV and human rights in Africa.³³⁹ This, in turn, limits the impact of the regional mechanisms on HIV and human rights-related issues.³⁴⁰ There is a need for the HIV Committee to reach out to mechanisms such as the respective Special Rapporteurs on Prisons and Human Rights Defenders and the working groups on Indigenous Peoples/Communities and on Older Persons and People with Disabilities.

57. There are a number of key HIV and human rights issues (set out in more detail in Chapter V)—as well as critical related rights contained within the African Charter, the Maputo Protocol and the



Rights." African Commission, accessed 19 June 2016, <http://www.achpr.org/about/afchpr/>.

336 - The eight States are Benin, Burkina Faso, Côte d'Ivoire, Ghana, Malawi, Mali, Rwanda and Tanzania. See "Welcome to the African Court," African Court on Human and Peoples' Rights, accessed 19 June 2016, <http://www.african-court.org/>.

337 - See Article 4 of the African Protocol on the Establishment of the Court and Rule 68 of the Rules of Procedure of the African Court on Human and Peoples' Rights.

338 - See African Court, Request for advisory opinion by the Socio-Economic Rights and

Accountability Project (SERAP), No. 001/2013, Advisory Opinion, 26 May 2017.

339 - Gumedze, "HIV/AIDS and Human Rights," 190.

340 - As above.

African Children's Charter—that have received limited focus (if any) in relation to HIV. This includes the right to information, which is critical for young people's access to sexual and reproductive health information, and the right to work. An exposition of the right to health in the context of HIV would also be particularly important for elucidating the sexual and reproductive health rights of vulnerable and key populations and for increasing their access to HIV services. Issues—such as the criminalisation of HIV transmission and exposure and the rights of key populations—need to receive increased focus. The African Commission and its mechanisms have made efforts, both in their work and their country missions, to focus on HIV and human rights issues affecting vulnerable and key populations (such as women and prisoners).³⁴¹ The African Commission has made several efforts to address the rights of women in the context of HIV and the impact of gender inequality, harmful gender norms and gender-based violence. Despite this, there is a need for a far stronger focus on key populations—including gay men who have sex with men, transgender persons, sex workers, people who inject drugs and indigenous populations—in order for the HIV Committee to affect some of the most critical legal and human rights barriers to fast-tracking the end of AIDS in Africa.

Limited use of the full range of powers available to the HIV Committee

- 58.** The HIV Committee has a broad mandate that provides for (amongst other things), the following:
- › investigating information on the situation and rights of people living with HIV and affected populations;
 - › developing guidelines;
 - › undertaking fact-finding missions;
 - › engaging with stakeholders on rights-based responses to HIV; and
 - › making recommendations.

- 59.** However, the HIV Committee has not made full use of its broad powers, in part due to challenges such as resource constraints and limited awareness about the HIV Committee among civil society. It is critical that the HIV Committee makes greater

use of its powers, such as by conducting fact-finding missions or making recommendations on HIV and human rights issues. This work is critical to mobilising accountability for rights-based responses to HIV among States. It is also critical for civil society groups to engage more with the HIV Committee on issues relating to human rights violations in the context of HIV in the region. For instance, civil society groups can explore the urgent appeal powers of the HIV Committee by bringing human rights violations relating to HIV to its attention.

Limited awareness and visibility of the mechanisms

- 60.** Affected individuals and civil society organisations are often unaware of the existence of the regional mechanisms. Publicly available information on the regional mechanisms and how to best approach them is not easily available. Civil society organisations and people affected by HIV have limited information on the mandate of the regional mechanisms, the process for making a communication or otherwise interacting with the mechanisms, and how to contact them. Despite this, the HIV Committee has made efforts to interact with government institutions and civil society in country visits and through other forums.³⁴² For example, it has attempted to inform civil society about its work and how civil society organisations can interact with the HIV Committee and the African Commission, and it has conducted training for members of civil society in order to promote greater involvement of civil society in the African Commission's mechanisms.³⁴³ It has also received petitions and communications from civil society in connection with human rights violations.³⁴⁴ Despite these efforts, broader initiatives to raise awareness may be required over and above these ad hoc interactions during country visits.

Inaccessibility of the mechanisms

- 61.** The regional mechanisms are inaccessible to civil society organisations and people affected by HIV. To participate in the African Commission's public session or to lodge a complaint before the African Commission, civil society organisations must have observer status. This can be difficult to obtain

³⁴¹ - For example, the Promotion Mission to Sudan in 2015 focused on human rights issues of particular concern for vulnerable populations (such as women and children, elderly persons, persons with disabilities, individuals in detention and people living with HIV).

³⁴² - For example, the HIV Committee held a workshop on HIV, the law and human rights in Africa at the International Conference on AIDS and STIs in Africa in Zimbabwe in December 2015. It also coordinated a "Meet the Experts" session on the role of the African Commission in advancing human rights in the context of HIV in Africa at the International Conference on AIDS and STIs in Africa in South Africa in December 2013.

and travel to public sessions is costly.³⁴³ Similarly, the African Court does not permit individuals to approach the court on a matter against a State party unless that State has signed the declaration permitting such access. To date, very few countries in Africa have signed the declaration, meaning that people affected by HIV and civil society organisations have limited access to the African Court. Thus, it is unsurprising that the African Court has yet to issue any decision specifically relating to HIV.

Resource constraints

62. The African Commission and its special mechanisms are hampered by resource constraints that limit their ability to carry out their activities, such as conducting missions and fact-finding visits. This obstructs efforts to establish a comprehensive approach to HIV and human rights issues, resulting in a tendency towards ad hoc responses where resources allow.

³⁴³ - For example, the HIV Committee held a training session in Banjul in 2011 for members of non-governmental organisations from the sub-region. See Gansou, Intersession Report.

³⁴⁴ - For example, the HIV Committee received a complaint from the Human Rights Development Initiative in 2011 regarding violations of the rights to confidentiality of people living with HIV in Tanzania.

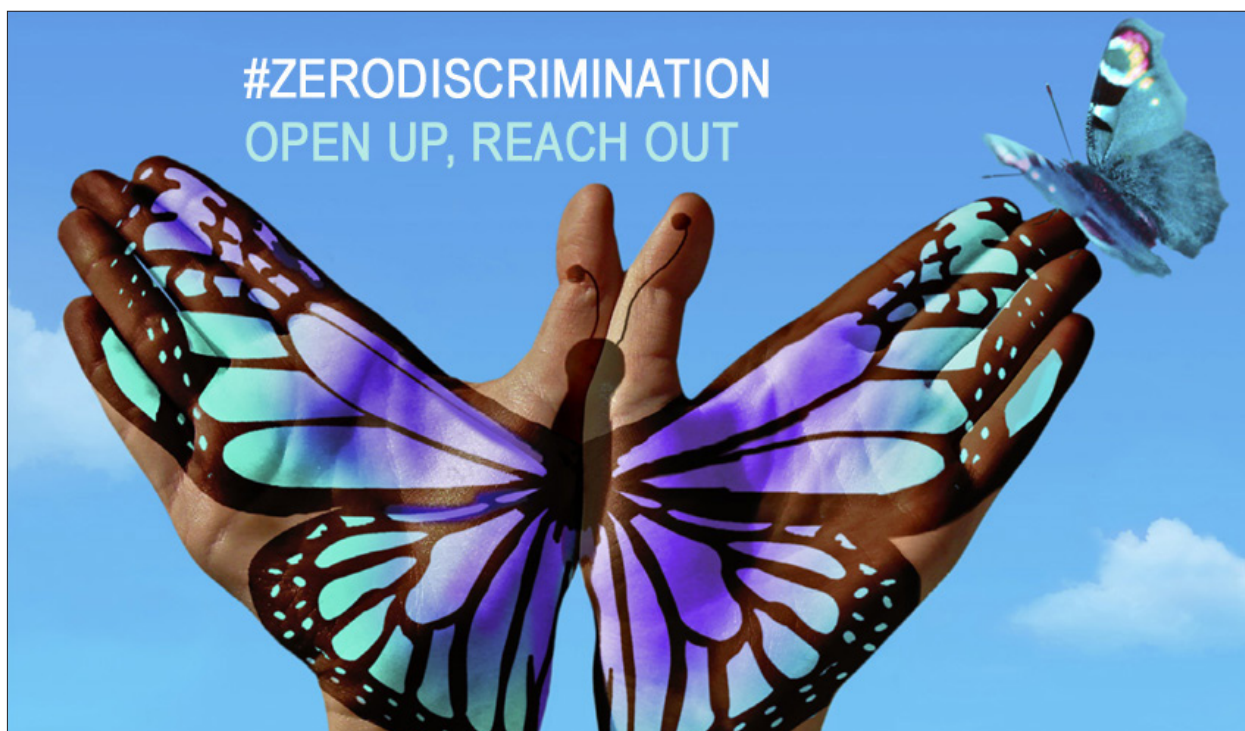
³⁴⁵ - The lack of understanding of the African Commission's work makes some civil society organizations view attending sessions of the African Commission an unnecessary expense.

V. KEY HUMAN RIGHTS CONCERNS AND GOOD PRACTICES IN THE HIV RESPONSE IN AFRICA

1. Across the continent, countries have introduced laws and taken other measures to respond to the legal challenges posed by the epidemic and to expand access to HIV prevention, treatment and care services. In spite of these efforts, human rights violations in relation to HIV continue to occur. This includes discrimination and inequality, coercive HIV testing, barriers to treatment access, violations of the human rights of women and girls, failure to uphold the human rights of children, and criminalisation of people living with HIV and members of key populations. These not only represent human rights violations: they are

impediments to efforts to end the AIDS epidemic in Africa, stifling health-seeking behaviours and limiting the ability of stakeholders and service providers to address the epidemic.

2. This chapter describes the key HIV-related human rights challenges on the continent—and the good practices and effective measures and approaches adopted to respond to them in some African countries. The aim of this chapter is not to provide an exhaustive description of all human rights challenges, but to highlight key issues and suggest actions that governments



can take to fulfil their human rights obligations related to HIV care and prevention.

INEQUALITY AND DISCRIMINATION AGAINST PEOPLE LIVING WITH HIV³⁴⁶

3. People living with HIV in Africa and globally continue to experience high levels of discrimination and stigma on the basis of their HIV status.³⁴⁷ This environment hinders efforts to end the HIV epidemic because it discourages people living with HIV from disclosing their status to family members and sexual partners, and it undermines their ability and willingness to access and adhere to treatment.³⁴⁸
4. Women report stigma, exclusion and harassment within their families, communities, workplaces, schools, health-care facilities, churches and other places of worship. They also suffer from physical

and sexual abuse, expulsion from their homes and communities, obstructions to seeing their children and dispossession of property—all of which increase their vulnerability.³⁴⁹ Individuals from key populations similarly are more vulnerable to human rights abuses because of the intersectionality between their HIV status and other forms of discrimination and stigmatisation.

5. People living with HIV who have TB face the stigma and discrimination of both illnesses. Stigma and discrimination targeting people with TB takes place in the workplace, health-care facilities and communities through travel restrictions and mandatory treatment (to name just a few violations).³⁵⁰ Health workers also have been known to deny equal access to TB clinics for people living with HIV, sex workers, transgender people and other marginalised populations.³⁵¹

EMPLOYMENT STIGMA AND DISCRIMINATION

In Ethiopia and Tanzania (Zanzibar), 42.1% and 26.8% of respondents, respectively, reported having lost a job or another source of income. In Ethiopia, more than 70% of those reported that this was due inter alia to their HIV status.

In Rwanda, 37.2% reported being refused an employment opportunity in the past 12 months because of their HIV status.

HEALTH STIGMA AND DISCRIMINATION

In Rwanda, 65% of men and 81% of women were advised not to have children by a medical practitioner upon HIV diagnosis. In Ethiopia, the same advice was given to 36.5% of men and 43.9% of women.

In Malawi, 46.6% of those who responded to questions about sexual and reproductive health rights reported being advised not to have children after being diagnosed with HIV. A further 11.5% reported being coerced into sterilisation, and 14.5% and 16.3% of those who responded reported being coerced into choice of methods of child birth and infant feeding options, respectively.

In Rwanda, 17% of men and 12% of women reported that antiretroviral therapy accessibility was conditional on use of contraception. In Ethiopia, this applied to 12.2% of men and 14.4% of women.

Source: The People Living with HIV Stigma Index: Country Analysis, 2016
<http://www.stigmaindex.org/country-analysis>

³⁴⁶ - This section focuses on discrimination and stigma on the basis of HIV status. For a discussion on how discrimination against particular populations can increase their vulnerability to HIV, see subsections below on each population.

³⁴⁷ - Global Commission, HIV and the Law, 10.

³⁴⁸ - UNAIDS, Reduction of HIV-Related Stigma.

³⁴⁹ - UNAIDS, Women Living with HIV Speak out Against Violence (Geneva: UNAIDS, 2015); and Global Commission on HIV and the Law, Report of the Africa Regional Dialogue of

the Global Commission on HIV and the Law (UNDP, 2011), https://hivlawcommission.org/wp-content/uploads/2017/06/AfricaRD_ReportEn.pdf.

³⁵⁰ - World Economic Forum, TB: Why You Should Not Discriminate, accessed 15 June 2016, http://www.justice.gov.za/vg/hiv/docs/tb/FactSheet_discrimination.pdf.

³⁵¹ - Global Fund to Fight AIDS, Tuberculosis and Malaria, Tuberculosis and Human Rights Information Note (2013), 2.

6. Stigma and discrimination have a profound effect on the ability of people living with HIV to enjoy their rights to work, health, privacy, dignity and freedom of movement. Negative social attitudes—including gossip about people living with HIV—remains high (see Figure 4). Forms of discrimination and stigma are similar across the continent, and they include marginalisation from families and communities, verbal harassment, physical assault, workplace discrimination and coercive sexual and reproductive health-care services.³⁵² A small number of countries also continue to impose travel restrictions on people living with HIV.³⁵³ Seychelles, for example, requires mandatory HIV testing for residence and work permits.³⁵⁴

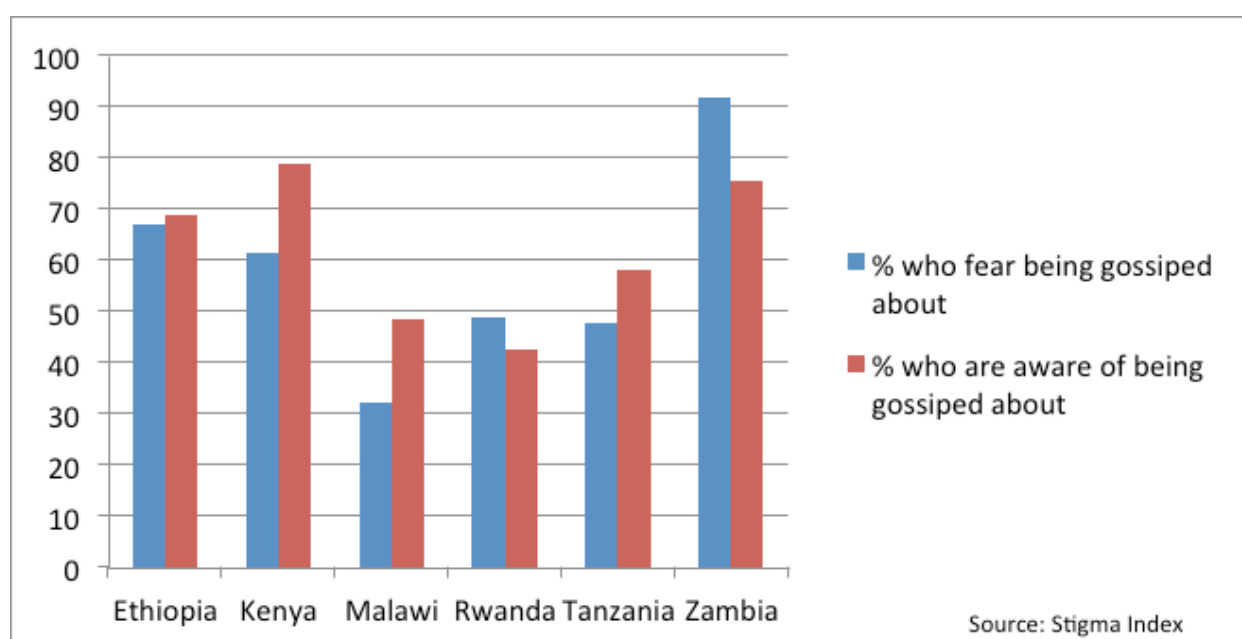
7. The majority of countries in Africa have constitutional or statutory protections against discrimination on the basis of gender, disability and marital status. An increasing number of countries are starting to introduce protections on the basis of HIV status.³⁵⁵ Unfortunately, these laws often are narrow in scope and fail to address the layers of discrimination people face due to HIV status.³⁵⁶

8. In many countries where these laws do exist, implementation and enforcement are often lacking. Key decision-makers (including legal professionals, health-care workers and employers) do not always understand HIV or its relationship to the law, and they are therefore not equipped to adequately uphold HIV-related human rights. People living with HIV also are not always aware of their rights, and they often lack access to legal services. This trifecta of stigma, insufficient information on rights and a general lack of resources poses significant barriers to accessing legal services.

Good practices

9. A significant number of African countries are taking steps to combat discrimination against people living with HIV. These include anti-discrimination laws that protect the rights of people living with HIV, programmes to strengthen legal support services for people living with HIV, support for litigation to challenge HIV- and TB-related discrimination, and programmes to understand, monitor and respond to stigma and discrimination.

FIGURE 4: GOSSIP AGAINST PEOPLE LIVING WITH HIV



352 - Exclusion from social gatherings and verbal insults, threats or harassment also were noted as significant experiences across countries. See "The People Living with HIV Stigma Index: Country Analysis," accessed 22 June 2017, <http://www.stigmaindex.org/country-analysis>.

353 - UNAIDS, *Welcome (Not)* (Geneva: UNAIDS, 2015).

354 - Ministry of Health Seychelles et al., *Situation Analysis of Legal and Regulatory Aspects of HIV and AIDS in Seychelles* (Ministry of Health Seychelles, 2013).

355 - For instance, see the Kenya HIV and AIDS Prevention and Control Act, 14 of 2006.

356 - Patrick Michael Eba, "HIV-Specific Legislation in Sub-Saharan Africa: A Comprehensive Human Rights Analysis," *African Human Rights Law Journal* 15, No. 2 (2015): 224.

357 - "Global AIDS Response Progress Reports," UNAIDS, accessed 15 June 2016, www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/.

358 - For more information, see "The People Living with HIV Stigma Index: Country Analysis," <http://www.stigmaindex.org/country-analysis>.

- 10.** Around 35 African States have laws to protect people living with HIV from discrimination, many of which are HIV-specific.³⁵⁷ A number of countries across Africa have conducted People Living with HIV Stigma Index studies and approximately 90% of countries report that their national strategic plans (NSPs) include stigma and discrimination reduction programmes. Many also include training for health workers.³⁵⁸
- 11.** Judicial recognition of the rights of people living with HIV continues to be affirmed in case law across the continent. The judiciary in various countries have been ruling in favour of the rights to equality and non-discrimination of people living with HIV. This has been largely in the working environment,³⁵⁹ with several also ruling in favour of these rights in health-care settings.³⁶⁰
- 12.** Countries also are looking for solutions outside of the traditional court arena. For example, Kenya has created an HIV and AIDS Tribunal to specifically address issues arising under its HIV and AIDS Prevention and Control Act. The Tribunal

is accessible to applicants, and judges working at the HIV and AIDS Tribunal are trained on HIV-related issues. The Tribunal has addressed hundreds of HIV cases to date, with most falling into one of three categories:

- › workplace issues, including mandatory HIV testing and discrimination on the basis of an individual's HIV status;
- › discrimination and abuse in health-care settings and the denial of services based on HIV status; and
- › issues involving domestic violence, property and inheritance.³⁶¹

COMPULSORY AND OTHER FORMS OF COERCIVE HIV TESTING

- 13.** Ensuring access to HIV testing that is confidential and only performed with free, prior and informed consent is integral to ending the epidemic. Globally, approximately 30% of all people living with HIV did not know their HIV status in 2016. Practices such as mandatory testing, breaches of confidentiality and requirements for parental



³⁵⁹ - For example, see *Banda v. Lekha*, [2005] MWIRC 44, where the court held that the applicant's unlawful dismissal on the basis of her HIV status violated her constitutional rights to equality and fair labour practices.

³⁶⁰ - For example, see *Georgina Ahamfule v. Imperial Medical Centre & Dr. Alex K. Molokwu*, Suit No. ID/1627/2000 (High Court of Lagos State) [2012], which found the denial of

medical care to the plaintiff on the basis of her HIV status was a violation of the right to health guaranteed under Article 16 of the African Charter and national laws.

³⁶¹ - Patrick Michael Eba, "The HIV and AIDS Tribunal of Kenya: An Effective Mechanism for the Enforcement of HIV-Related Human Rights?" *Health and Human Rights Journal* 18, no.1 (2016): 169-180.

consent discourage individuals from accessing HIV testing services, and they may also place individuals at risk of increased violence or discrimination. Testing that is not confidential, free or informed breaches the fundamental tenants of the right to health and the right to privacy.³⁶²

- 14.** Mandatory and coerced testing occurs across the continent, as do breaches of confidentiality.³⁶³ A review of HIV-specific laws adopted in 26 sub-Saharan African countries shows that they allow for broad exceptions to informed consent. Under these laws, health-care providers can perform HIV tests without informed consent for several purposes: for treatment or care, in the context of personal relationships and for alleged sexual offences or when ordered by the court for judicial proceedings.³⁶⁴ In some countries, mandatory HIV testing policies exist for employment in sectors such as law enforcement and the army. Mandatory pre-marital testing has been reported in countries such as Burundi, the Democratic Republic of the Congo, Ghana, Kenya, Nigeria, Tanzania and Uganda.³⁶⁵ In several countries where same-sex sexual conduct is criminalised, cases of involuntary testing of people accused of engaging in consensual same-sex sexual conduct have been reported.³⁶⁶

- 15.** Where laws provide for mandatory testing, particularly for sexual offences, they
- › violate the rights to liberty, security of the person and a fair trial;
 - › provide little guidance as to the purpose, process and timeline for HIV testing;
 - › are often applied to those alleged to have committed, but who have not yet been convicted of, a sexual offence; and
 - › are silent on the nature of the sexual offence to which a test can be applied, thus opening the gateway for mandatory HIV testing for offences that carry little or no risk of HIV transmission.³⁶⁷

- 16.** Laws, policies and practices in many countries

provide for disclosure of a person's HIV status to third parties, including to health-care workers, sexual partners or caregivers. Of 26 HIV laws reviewed, 21 were found to have provisions allowing for involuntarily notifying a partner of a person's HIV status. In 17 of those countries, partner notification can be done at the discretion of a health-care worker. As women are more likely to be tested than men due to their access to antenatal care, this has a disproportionate effect on women, but even so, only four countries provide for non-disclosure where there is a fear of violence.³⁶⁸ In particular, adolescents face significant barriers to confidential consensual testing, as medical procedures often requires a parent to consent and know the results when the individual being tested is under the age of 18 years. In contrast, the age of consent for sex can be as low as 14 years.³⁶⁹

- 17.** If it is not carefully circumscribed in law and policy, involuntary partner notification has the potential to infringe on the rights of a people living with HIV, including the rights to confidentiality, health and freedom from violence and discrimination.³⁷⁰ Failure to allow adolescents access to confidential testing can infringe on their rights to privacy and health (particularly sexual and reproductive health), as well as the right to make decisions in accordance with the developing maturity of the child.

- 18.** Even where laws and policies allow only voluntary confidential HIV testing with informed consent, implementation can still be an issue. Results can be disclosed to third parties and individuals can be coerced into being tested. For example, pregnant women in South Africa have reported being threatened with refusal of health services if they do not undergo an HIV test.³⁷¹

- 19.** Testing initiatives also are changing in response to the scale-up of testing and treatment.³⁷² It is becoming increasingly important to ensure that testing is performed in a manner that respects the

³⁶² - Fay et al., "Stigma, Health Care Access and HIV Knowledge," para. 119.

³⁶³ - ARASA, HIV and Human Rights in Southern and East Africa (ARASA, 2014); and Caitlin E. Kennedy, "Provider-Initiated HIV Testing and Counseling in Low- and Middle-Income Countries: A Systematic Review," *AIDS Behaviour* 17, No. 5 (2013): 10.

³⁶⁴ - For example, informed consent for an HIV test in Uganda can be dispensed with if a patient "unreasonably withholds" it. In Burkina Faso, HIV testing is used to settle matrimonial disputes. See Patrick Michael Eba, "HIV-Specific Legislation in Sub-Saharan Africa: A Comprehensive Human Rights Analysis," *African Human Rights Law Journal* 15, No. 2 (2015): 224.

³⁶⁵ - Open Society Institute, *Mandatory Premarital HIV Testing* (New York: Open Society Institute, 2010), 1.

³⁶⁶ - Human Rights Watch has documented involuntary HIV testing of men and transgender women accused of same-sex sexual relations in Egypt, Kenya and Uganda. Human Rights Watch, *Dignity Debased: Forced Anal Examinations in Homosexuality Prosecutions* (Human Rights Watch, 2016).

³⁶⁷ - Eba, "The HIV and AIDS Tribunal of Kenya."

³⁶⁸ - Eba, "The HIV and AIDS Tribunal of Kenya."

³⁶⁹ - In the Democratic Republic of Congo and Nigeria, the age of consent for HIV testing is 18 years of age, but the age of consent is significantly lower. WHO, HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV (Geneva: WHO, 2013), Annex 15; Olalekan A. Uthman, "Geographical Variations and Contextual Effects on Age of Initiation of Sexual Intercourse among Women in Nigeria: A Multilevel and Spatial Analysis," *International Journal of Health Geographics* 7 (2008): 27; and Miriam J. Temin et al., "Perceptions of Sexual Behavior and Knowledge about Sexually Transmitted Diseases among Adolescents in Benin City, Nigeria," *International Perspectives on Sexual and Reproductive Health* 25, No. 4 (1999): 18.

³⁷⁰ - Eba, "The HIV and AIDS Tribunal of Kenya."

³⁷¹ - Johanna Kehler et al., *Where are the Human Rights for Pregnant Women? Scale-Up of Provider-Initiated HIV Testing and Counselling of Pregnant Women: The South African Experience* (Cape Town: AIDS Legal Network, 2016), 6.

rights of privacy and health, especially as new forms of testing services expand. Traditionally, individuals had to seek out HIV testing of their own volition, the test and results were confidential, and providers had to supply pre- and post-test counselling to people seeking an HIV test.

- 20.** In order to increase the rate of HIV testing, some countries in Africa have implemented additional types of testing, including PITC,³⁷³ community and home testing,³⁷⁴ routine testing, couples testing and mobile testing. In contrast to voluntary testing and counselling, these approaches aim to integrate HIV testing into a standard element of medical care that can be opt-in or opt-out. They are often aimed at particular populations, such as pregnant women or sex workers.³⁷⁵ If improperly applied, these new approaches to HIV testing can have serious human rights implications, particularly in terms of confidentiality and informed consent. Issues of gender equality also are relevant because women, particularly pregnant women, are disproportionately subjected to HIV testing without clear measures to ensure their safety and protection from family members.³⁷⁶

Good practices

- 21.** Rights protected under the African Charter and Maputo Protocol—notably the rights to liberty, integrity and the security of person, dignity, health, fair trial, and protection from cruel, inhuman and degrading treatment—have been used in a number of cases to overturn practices and policies around HIV testing.³⁷⁷ In terms of disclosure, the SADC Model Law and EAC HIV and AIDS Prevention and Management Act tightly limit the situations in which a person's HIV status can be communicated to a sexual partner at risk of HIV infection in accordance with international guidance.
- 22.** In Zambia, the High Court found that mandatory HIV testing conducted in the Zambian Air Force

on two former employees without informed consent constituted a violation of the rights to privacy and to be free from inhuman and degrading treatment.³⁷⁸

- 23.** In *S v. Mwanza Police, Mwanza District Hospital, Ministries of Justice, Internal Affairs, Health, Attorney-General and Ex parte: HB, JM (o.b.o 9 others)*, sex workers in Malawi were arrested and forced to undergo HIV tests while in custody.³⁷⁹ Women who were HIV-positive were charged with spreading a venereal disease, which is prohibited under §192 of the Penal Code. Eleven women challenged being subjected to a mandatory HIV test in the High Court, which held that the mandatory tests violated their constitutional rights to privacy, equality, dignity and freedom from cruel, inhuman and degrading treatment.

CHALLENGES TO ACCESS TO TREATMENT, INCLUDING RESTRICTIVE INTELLECTUAL PROPERTY REGIMES

- 24.** Providing access to affordable, high-quality medicines for HIV and opportunistic infections such as TB is a critical element of fulfilling the right to health. While there has been remarkable progress made in increasing access to treatment in recent years, only some 53% [39–65%] of people living with HIV had access to treatment in 2016. One in two people living with HIV were still not accessing antiretroviral therapy. In East and southern Africa, 67% [54–76%] of adult women (aged 15 years and older) living with HIV and 51% [41–58%] of adult men (aged 15 years and older) living with HIV were accessing antiretroviral therapy in 2016. In western and central Africa, only 44% [32–56%] of adult women living with HIV and 25% [17–32%] of adult men living with HIV in the region were accessing antiretroviral therapy in 2016.³⁸⁰
- 25.** Article 16 of the African Charter places an obligation upon Member States to “take the necessary

³⁷² - UNAIDS, *Fast-Track: Ending the AIDS Epidemic by 2030* (Geneva: UNAIDS, 2014), 25.

³⁷³ - PITC is defined by the WHO and UNAIDS as “HIV testing and counselling which is recommended by health-care providers to persons attending health care facilities as a standard component of medical care. The major purpose of such testing and counselling is to enable specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person's HIV status.” See WHO et al., *Planning, Implementing and Monitoring Home-Based, HIV Testing and Counselling* (Geneva: WHO, 2012); and Kennedy et al., “Provider-Initiated HIV Testing and Counselling,” 1571.

³⁷⁴ - Home-based HIV testing includes going door-to-door offering HIV testing and counselling and visiting the homes of people at high risk of HIV (such as people whose partners are HIV-positive) to offer HIV testing and counselling services and self-testing. South Africa is considering its use in schools. See WHO et al., *Planning, Implementing, and Monitoring Home-Based, HIV Testing and Counselling*.

³⁷⁵ - Kennedy et al., “Provider-Initiated HIV Testing and Counselling,” 1571.

³⁷⁶ - Carla Makhoul Obermeyer et al., “HIV Testing and Care in Burkina Faso, Kenya, Malawi and Uganda: Ethics on the Ground,” *BMC International Health and Human Rights* 13, no. 6 (2016).

³⁷⁷ - Namibia, South Africa and Zambia have all had cases where mandatory or forced testing or breaches of confidentiality were found to be unconstitutional or a breach of human rights. See *Kingaibe and Another v. Attorney General*, 2009/HL/86 (27 May 2010); *Nanditume v. Minister of Defence, NLLP 2002 (2) 242 NLC*; and *C v. Minister of Correctional Services* [1997] JOL 407 (T).

³⁷⁸ - *Kingaibe and Another v. Attorney General*.

³⁷⁹ - Anneke Meerkötter and Ian Southey-Swartz, “Malawi High Court Rules That Mandatory HIV Testing is Unconstitutional,” 20 May 2015, <http://www.southernafricallitigationcentre.org/2015/05/20/malawi-high-court-rules-that-mandatory-hiv-testing-is-unconstitutional>.

³⁸⁰ - UNAIDS 2017 estimates.



measures to protect the health of their people and to ensure that they receive medical attention when they are sick” without discrimination.³⁸¹ This includes access to affordable life-saving treatments such as antiretroviral medicines. The right to equitable access to affordable medicines in Africa is undermined by the protection of IP laws and the failure to reform or effectively use flexibilities within the IP regime.³⁸²

26. The prices of first-generation antiretroviral medicines have been dramatically reduced over the past 10 years, primarily due to increased marketplace competition from generic drugs, but access to treatment is becoming more difficult.³⁸³ Demand for second-generation antiretroviral medicines is growing in the face of drug-resistant HIV. Property, trade and counterfeiting laws also render it difficult for countries to provide their citizens with cheaper generic treatments.
27. Countries face a number of barriers when trying to provide citizens with affordable drugs. The

WTO's TRIPS Agreement requires all WTO members to provide at least 20 years of patent protection on pharmaceuticals, restricting the ability of countries to use or import generic versions of medications instead of more expensive brand drugs. Anti-counterfeiting legislation also can limit the ability of countries to manufacture or import generic medicines.³⁸⁴

28. Under the TRIPS Agreement, governments can make exceptions for public health reasons. These exceptions include defining standards of patentability and issuing compulsory licenses to increase treatment access.³⁸⁵ However, few African countries have made use of these exceptions; either their laws predate the TRIPS Agreement or lack provisions to allow for the use of generics,³⁸⁶ or the provisions have not been utilised.³⁸⁷ Many African countries also lack adequate frameworks to examine and register patents effectively.³⁸⁸ Where countries do attempt to use IP laws effectively, they can be met by strong opposition from governments and pharmaceutical companies.³⁸⁹

381 - Communication 279/03-296/05, Sudan Human Rights Organisation and Centre on Housing Rights and Evictions (COHRE)/Sudan.

382 - Global Commission, HIV and the Law.

383 - Global Commission, HIV and the Law, 376.

384 - UNDP, Discussion Paper: Anti-Counterfeit Laws and Public Health: What to Look Out for, accessed 22 June 2017, <http://www.undp.org/content/dam/undp/library/hivaids/English/UNDP%20Discussion%20Paper%20-%20%28revised%29.pdf>.

385 - Trade-Related Aspects of Intellectual Property Rights, Annex IC of the Marrakesh Agreement Establishing the World Trade Organization, 15 April 1994. See also WTO,

Declaration on the TRIPS Agreement and Public Health (2004).

386 - For example, Lesotho, Madagascar, Nigeria, Rwanda, Tanzania and Uganda. See Global Commission on HIV and the Law, Regional Issues Brief: Intellectual Property Rights and Access to Medicines (2011).

387 - Angola, Benin, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, Djibouti, Ethiopia, the Gambia, Guinea, Guinea Bissau, Lesotho, Malawi, Mali, Mauritius, Mozambique, Niger, Rwanda, Senegal, Sierra Leone, Sudan, Togo and Zambia. See Global Commission, Regional Issues Brief.

388 - Global Commission, Regional Issues Brief.

Good practices

- 29.** The right to health has been successfully used in at least one case to defeat restrictions on the use of generic medicines. In the 2012 case of *Ochieng and Others v. Attorney General in Kenya*, the High Court upheld an order declaring the Kenyan Anti-Counterfeit Act, 2008, to be unconstitutional.³⁹⁰ The petitioners argued that the provisions of the Anti-Counterfeit Act failed to exempt generic medicines from the definition of counterfeiting in that legislation. The Court interpreted the right to health as placing an obligation upon the State to ensure people have access to the medicines they require to be healthy, noting that the right to access medicine has been recognised as an essential component of the right to health in other jurisdictions, including South Africa. The provisions of the Anti-Counterfeit Act were held to restrict access to affordable medicines and thus to violate the rights to life, human dignity and health protected under the Kenyan Constitution. The Court declared that “there can be no room for ambiguity where the right to health and life of the petitioners and many other Kenyans who are affected by HIV/AIDS are at stake.”³⁹¹
- 30.** Regional initiatives to reform laws in order to make greater use of the flexibilities in TRIPS and the Doha Declaration include the establishment of the Pharmaceutical Manufacturing Plan for Africa to produce local generic medicines.³⁹² Mozambique, Zambia and Zimbabwe have all used their laws to issue compulsory licenses for medicines, while other countries have adopted the principle of international exhaustion to permit parallel importation of generic medicines from anywhere in the world.³⁹³
- 31.** In 2008, Rwanda received 7 million doses of antiretroviral medicine from Canada through the use of flexibility under the WTO IP regime.³⁹⁴ In doing so, the Rwanda became the first country in the world to implement the WTO General Council Decision of 2003, which permits someone other than the patent holder to manufacture a lower-cost version of a medicine for export to developing countries that do not have the capacity

to manufacture such products themselves.³⁹⁵ The 2003 Decision requires that the developing country announce its intention to use this mechanism; it should then further specify the expected quantity of drugs to be supplied and issue a compulsory license for the drugs. In spite of these restrictions and challenges, the successful shipment of generic antiretroviral medication from Canada to Rwanda demonstrates the possibility of implementing the TRIPS flexibility provided that governments (both developed and developing) and international organisations such as the WTO effectively support such an implementation.³⁹⁶

- 32.** In their September 2016 report, the UN Secretary-General's High-Level Panel on Access to Medicines notes the barriers created by international trade agreements and the pressure on governments to refrain from using the TRIPS flexibilities. They call for a new deal to close the gaps between health innovation and access to medicines that would include greater transparency in costs related to medical developments and pricing.³⁹⁷

OVERLY BROAD CRIMINALISATION OF HIV NON-DISCLOSURE, EXPOSURE AND TRANSMISSION

- 33.** Overly broad criminalisation of HIV non-disclosure, exposure and transmission raises both public health and human rights concerns. There is no evidence that criminalisation deters people from engaging in behaviour that involves the risk of HIV infection. Rather, HIV criminalisation has a profoundly negative effect on HIV prevention and the lives of people living with HIV: it increases people's vulnerability to scapegoating, blame and marginalisation, and it undermines the relationship between health-care workers and their patients who are living with HIV. It also creates barriers to accessing prevention, treatment and care services and exposes already marginalised groups, such as people who inject drugs and sex workers, to further discrimination and persecution.³⁹⁸ More than 25 countries in sub-Saharan Africa have overly broad and/or vague HIV-specific criminal statutes.³⁹⁹

³⁸⁹ - Global Commission, Regional Issues Brief, 81.

³⁹⁰ - *PAO and Others v. Attorney General* [2012] eKLR.

³⁹¹ - *PAO and Others v. Attorney General* [2012] eKLR.

³⁹² - Pharmaceutical Manufacturing Plan for Africa (2007).

³⁹³ - Global Commission, HIV and the Law.

³⁹⁴ - Ashley Weber and Lisa Mills, “A One-Time-Only Combination: Emergency Medicine Exports under Canada's Access to Medicines Regime,” *Health and Human Rights* 12, no.1 (2010): 109-122.

³⁹⁵ - Weber and Mills, “A One-Time-Only Combination.”

³⁹⁶ - Weber and Mills, “A One-Time-Only Combination.”

³⁹⁷ - High-Level Panel on Access to Health Technologies, Report of the United Nations Secretary-General's High Level Panel on Access to Medicines (2016).

³⁹⁸ - UNAIDS, Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations (Geneva: UNAIDS, 2013). See also Global Commission, HIV and the Law, 8.

³⁹⁹ - Edwin J. Bernard and Sally Cameron, *Advancing HIV Justice 2: Building Momentum in Global Advocacy against HIV Criminalisation* (Brighton and Amsterdam: HIV Justice Network and Global Network of People Living with HIV, 2016), 13.

34. The fear, misconceptions and other concerns relating to the growing HIV epidemic have led to calls for legislators to adopt provisions to criminalise individuals who are perceived to place others at risk of HIV infection or to apply laws of a general nature to this context.⁴⁰⁰ Several sets of arguments often are highlighted to justify the calls for criminalising HIV non-disclosure, exposure and transmission.

- › First, the criminal law is considered to be a structural intervention that can contribute to reducing new HIV infections by deterring those who are considered to engage in behaviour that places others at risk of HIV infection.
- › Second, some proponents of the criminalisation of HIV non-disclosure, exposure and transmission argue that it is necessary to support and protect the “victims.” This includes women and girls who in many contexts are vulnerable to the risk of HIV infection due to unequal power relations, which particularly manifests in violence against women. This argument is commonly used in sub-Saharan Africa, where HIV prevalence among young women and adolescent girls is very high.
- › Third, criminalisation of HIV non-disclosure, exposure and transmission is considered to be an appropriate and valid State response to punish the so-called perpetrator for his or her “moral blameworthiness” and the “harm” that is caused to others, particularly in cases where HIV transmission occurs.

35. Contrarily to arguments from the proponents of HIV criminalisation, public health evidence and human rights principles call for caution. Over the years, human rights advocates and people living with HIV have challenged the criminalisation of HIV non-disclosure, exposure and transmission and the arguments used to justify it. They have shown that contrary to the arguments made by the proponents of criminalisation, such a stance does not support effective responses to HIV because there is no evidence that criminalisation deters people from engaging in behaviour that involves the risk of HIV infection. They have also

shown that HIV criminalisation does not protect women; rather, it exposes them to greater risks of prosecution because of the unequal social and economic power between women and men.

36. Existing laws and prosecutions for HIV non-disclosure, exposure and transmission in sub-Saharan Africa often are vague and overly broad in scope, which is contrary to key criminal law principles of legality, foreseeability, intent, causality, proportionality and proof. Laws and prosecutions that fail to consider those principles are unfair and may have far-reaching negative impacts on the human rights of people living with HIV.

37. For example, the law in Zimbabwe prohibits anyone who realises there is a possibility that he or she might be HIV-positive from engaging in any activity that may possibly infect another person. Interpreted broadly, anyone living with HIV in Zimbabwe who has engaged in unprotected sexual activity more than once, regardless of whether they know their HIV status, is at risk of contravening the prohibition against deliberate transmission of HIV, whether or not HIV was transmitted.⁴⁰¹ Similarly, exposing someone to HIV in Benin is sufficient for prosecution: the law does not require transmission of HIV to have taken place. In Togo, the law prohibits people with HIV from engaging in unprotected sex regardless of their partner's HIV status and/or whether consent has been given.

38. Overly broad criminalisation is likely to infringe upon the rights to liberty, security, health, privacy, access to justice and non-discrimination.⁴⁰² HIV criminalisation also involves a serious risk of selective prosecution. Studies conducted in various countries point out that specific vulnerable or marginalised populations are disproportionately impacted by these laws and prosecutions. This includes migrants, sex workers, people of minority ethnicity, prisoners and in some places, gay men and other men who have sex with men.

Good practices

39. UNAIDS and UNDP have called for the repeal of overly broad laws criminalising HIV non-disclosure,

⁴⁰⁰ - Global Network of People Living with HIV, The Global Criminalisation Scan Report 2010 (Amsterdam: GNP+, 2010).

⁴⁰¹ - See Zimbabwe Criminal Law (Codification and Reform) Act (2004), ch. 9:23, s. 78.

⁴⁰² - Edwin Cameron et al., “HIV is a Virus, Not a Crime: Criminal States and Criminal Prosecutions,” *Journal of the International AIDS Society* 11 (2008): 7.

⁴⁰³ - Global Commission, HIV and the Law; and UNAIDS, Ending Overly Broad Criminalisation of HIV Disclosure, Exposure and Transmission: Critical Science, Medical

and Legal Considerations (Geneva: UNAIDS, 2013).

⁴⁰⁴ - “Mozambique: Assembly Amends Legislation Defending HIV-Positive Citizens,” *All Africa*, 10 April 2014, <http://allafrica.com/stories/201404101657.html>.

⁴⁰⁵ - Eba, “HIV-Specific Legislation in Sub-Saharan Africa,” 224.

⁴⁰⁶ - Bernard and Cameron, *Advancing HIV Justice* 2, 13.

⁴⁰⁷ - *AIDS Law Project v. Attorney General and Others* [2015] eKLR.

⁴⁰⁸ - “Regional HIV Bill Passed without Criminalization Clause,” *IRIN*, 27 April 2012, <http://>

exposure or transmission. Instead, they recommend that criminal law only be applied to cases of intentional transmission, where a person knows his or her HIV-positive status, acts with the intention to transmit HIV and actually transmits it.⁴⁰³ Law reform on this issue is happening in a number of countries. Countries such as the Democratic Republic of the Congo, Guinea, Senegal and Togo have reformed their legislation to restrict the use of criminal law to cases of intentional transmission. Mozambique has amended its HIV legislation to remove the criminalisation of HIV transmission (among other changes).⁴⁰⁴ In 2011, Sierra Leone revised its Prevention and Control of HIV and AIDS Act, 2007, to end the criminalisation of mother-to-child transmission of HIV.⁴⁰⁵ Notably, countries such as Comoros, Mauritius and South Africa have rejected HIV criminalisation in legislation relating to HIV.⁴⁰⁶

40. In Kenya, the High Court in *Aids Law Project v. Attorney General and Others* found that Section 24 of the HIV and AIDS Prevention and Control Act—which criminalised HIV non-disclosure and exposure—was vague and overbroad and thus violated the rights guaranteed under the Constitution, including the right to privacy.⁴⁰⁷

41. The EAC HIV and AIDS Prevention and Management Act adopted on 23 April 2012, is an enforceable law signed by all EAC countries. It seeks to protect the rights of people living with HIV and harmonise regional legislation and policy on the prevention and treatment of HIV.⁴⁰⁸ Significantly, the EAC HIV and AIDS Prevention and Management Act does not criminalise HIV non-disclosure, exposure or transmission, unlike some of the laws in the individual Member States (namely Burundi, Kenya and Tanzania). Rather, the EAC Act focuses on the need for a human rights-based approach, the rejection of coercive approaches and the importance of addressing the root causes of vulnerability to HIV.

CIVIL SOCIETY SPACE AND HIV

42. A vibrant, well-funded, resourced and engaged civil society and community movement is critical

to the AIDS response. Civil society plays an important role in delivering testing and treatment services, educating communities on HIV and prevention, building the capacities and resilience of key populations, and advocating for law reform and increased government services.

43. Despite this, non-governmental organisations are facing increasing restrictions to the establishment, operation and implementation of their mandates.⁴⁰⁹ Governments are restricting the ability of non-governmental organisations to register and operate; they also are placing barriers on the ability of non-governmental organisations to communicate internally and externally and to assemble or raise funds. Such barriers and limitations can directly infringe on several human rights, including the rights to freedom of association and assembly that are guaranteed under the African Charter.⁴¹⁰ They also have a negative impact on the HIV response.

44. Some of the types of restrictions facing civil society include the following:

- Requirements to register with the government in order to operate or receive funding. This includes regular re-registration.⁴¹¹ Where registration is denied, reasons are not always provided. In some cases, the organisations that are denied registration have no access to judicial review.
- Limitations on the activities of civil society organizations, including forcing them to conform to government development plans or restricting them from working on human rights and democracy issues.⁴¹²
- Direct actions that hamper the ability of organisations to communicate and operate. This includes the harassment of non-governmental organisations, raids on their offices, the denial of visas for international allies and restrictions on (and monitoring of) means of communications.
- Restrictions on the ability to assemble or protest by requiring permits and permission for public assemblies.⁴¹³ These restrictions often involve

www.irinnews.org/report/95371/east-africa-regional-hiv-bill-passed-without-criminalization-clause; EAC Secretariat HIV and AIDS Unit and UNDP Regional Service Centre for Africa Addis Ababa (Ethiopia), Summary Report: A Comprehensive Analysis of the HIV and AIDS Legislation, Bills, Policies and Strategies in the East African Community (EAC, 2014), 5.

⁴⁰⁹ - "State of Civil Society Report 2015," Civicus, <http://www.civicus.org/index.php/socs2015>.

⁴¹⁰ - OHCHR, Civil Society Space and the United Nations Human Rights System: A Practical

Guide for Civil Society (Geneva: OHCHR, 2014).

⁴¹¹ - In Ethiopia, charities must re-register every three years. See Ethiopia, Proclamation No. 621/2009 of 2009, Charities and Societies Proclamation, Art. 76.

⁴¹² - In South Sudan for example, NGOs are limited to conducting humanitarian work.

⁴¹³ - For example, the Public Order Act Kenya (2003), Part III, requires notification of any public event or meeting.

broad police powers to prevent or shut down demonstrations.

- › Limits on fundraising, including prohibiting specific types of funding, requiring government approval or compliance with onerous procedures for specific types of funding, and routing funding through the government.

45. Organisations working on HIV or with key populations appear to be finding their work especially difficult because authorities restrict the activities of organisations they see as immoral or as supporting illegal activities. They experience challenges with registration, and the reasons for refusal, delay or denial of registration are not always clear. For example, the NGO Coordination Board in Kenya failed to register the group Transgender Education and Advocacy (TEA). The Board had delayed the registration, claiming that as one of the members of TEA was currently applying for a legal change of name and gender, the registration of the organization should wait until the legal change was made. The organization took the Board to court, where the Board was then ordered to register TEA.⁴¹⁴

46. In Zimbabwe, the offices of Gay and Lesbians of Zimbabwe's (GALZ) have been raided several times by police.⁴¹⁵ During these raids, police often confiscate GALZ's computers and other publications, including personal information. This limits the ability of GALZ to communicate effectively with partners if they are concerned that such communication places their partners at risk of government harassment. Similarly, HIV meetings organised for key populations in Nigeria and Tanzania are often raided by police, with those attending detained or harassed.⁴¹⁶

47. These restrictions have been shown to impact the HIV response. In particular, they limit the ability of organisations to raise funds, apply for grants, advocate for a stronger legal environment for the HIV response and provide critical HIV-related

services. Such restrictions also drive marginalised populations underground, inhibiting their ability to access testing and treatment, and increasing their vulnerability to violence, abuse, infection and, ultimately, death.

Good practices

48. A number of courts have upheld the right to freedom of association and overturned government decisions that limit the ability of organizations to function. In 2015, the High Court of Kenya held that a refusal to register an LGBTI organisation was unconstitutional.⁴¹⁷ The organisation had been refused registration on the basis that the phrase "gay and lesbian" appeared in the name of the organisation, and the penal code criminalises same-sex sexual conduct. The High Court held that the decision violated the constitutional right to freedom of association and that conceptions of morality cannot serve as a justification to limit fundamental rights.

49. The Court of Appeal in Botswana came to a similar decision in 2016 after the Government had refused to register an LGBTI organisation on the basis that its objectives were unlawful and that homosexual persons were not "persons," so they were not protected by fundamental rights. The Court held that refusal to register the organisation was a breach of the right to freedom of association.⁴¹⁸

50. In 2014, Côte d'Ivoire passed the Law on the Promotion and Protection of Human Rights Defenders. It is the first law in an African State that specifically ensures the protection of human rights defenders. The law came into force in February 2017.⁴¹⁹

51. The African Commission established the Study Group on Freedom of Association in 2009 to undertake a study on freedom of association and ensure that States take the study into account in their policies and laws.⁴²⁰ The study group also issued guidelines on freedom of association and assembly in Africa in 2017.⁴²¹ In May 2017, the

⁴¹⁴ - R v. Non-Governmental Organisations Co-Ordination Board and Another, Ex-Parte Transgender Education and Advocacy and Others, JR Miscellaneous Application No. 308A of 2013 (23 July 2014).

⁴¹⁵ - "Zimbabwe: End Attacks on LGBT People," Human Rights Watch, 27 August 2012, <https://www.hrw.org/news/2012/08/27/zimbabwe-end-attacks-lgbt-people>.

⁴¹⁶ - See Andrew Green, "In an Apparent Crackdown, Tanzania Government Raids NGO Meeting on Reproductive Rights," *devox*, 6 January 2017, <https://www.devox.com/news/in-an-apparent-crackdown-tanzania-government-raids-ngo-meeting-on-reproductive-rights-89394>; The Associated Press, "Police in Zanzibar Arrest 20 Over Homosexual

Activities," ABC News, 16 September 2017, <http://abcnews.go.com/amp/International/wireStory/police-zanzibar-arrest-20-homosexual-activities-49892622>; and "Mass Arrest of 40 Gay Men in Nigeria May Harm HIV Fight: Activist," Reuters, 31 July 2017, <https://www.reuters.com/article/us-nigeria-gay/mass-arrest-of-40-gay-men-in-nigeria-may-harm-hiv-fight-activist-idUSKBN1AG21W>.

⁴¹⁷ - *Eric Gitari v. Non-Governmental Organisations Co-Ordination Board & 4 Others* [2015] eKLR.

⁴¹⁸ - *Attorney General of Botswana v. Thuto Ramogae and 19 Others*, 2016, Civil Appeal No. CACGB-128-14.



African Commission adopted Resolution 376, which expresses concern about

new challenges, in particular the increased threats against defenders working on issues including the right to health, the fight against HIV/AIDS, reproductive health, sexual orientation and gender, extractive industries, promotion of democracy and peace, and women rights defenders irrespective of their area of activity.⁴²²

- 52.** Resolution 376 calls on African States to take measures to address the shrinking civil society space, including efforts to

adopt specific legislative measures to recognise the status of human rights defenders, and protect their rights and the rights of their colleagues and family members, including women human rights defenders and those working on issues such as extractive industries, health and HIV/

AIDS, reproductive health, sexual orientation and gender identity, promotion of peace and democracy, fight against terrorism and respect for human rights.⁴²³

CONFLICT AND HIV

- 53.** Armed conflict and post-conflict periods raise distinct issues related to HIV prevention and treatment. During armed conflict, HIV prevention and treatment services tend to be significantly reduced because of the instability wrought by war. For example, areas of conflict in Côte d'Ivoire reported at least a 75% reduction in health-care staff.⁴²⁴ Without adequate health-care staff, provision of HIV prevention and treatment services is greatly reduced. Armed conflict can also increase the need for flexible HIV prevention and treatment services.
- 54.** People displaced by conflict are at increased risk of not accessing prevention and treatment services.

⁴¹⁹ - "Côte d'Ivoire: La loi sur les défenseurs des droits de l'Homme enfin en vigueur," Organisation Mondiale Contre la Torture, 5 May 2017, <http://www.omct.org/fr/human-rights-defenders/urgent-interventions/cote-divoire/2017/05/d24327/>; and "Décret n° 2017-121 du 22 février portant modalité d'application de la loi n° 2014-388 du 20 juin 2014 portant promotion et protection des défenseurs des droits de l'homme," Ivorian Coalition of Human Rights Defenders, 5 May 2017, <http://ci-ddh.org/2017/05/decret-n2017-121-du-22-fevrier-portant-modalite-dapplication-de-la-loi-n2014-388-du-20-juin-2014-portant-promotion-et-protection-des-defenseurs-des-droits-de-lhomme/>.

⁴²⁰ - "Study Group on Freedom of Association," African Commission, accessed 27 March

2017, <http://www.achpr.org/mechanisms/study-group-freedom-of-association/>.

⁴²¹ - African Commission, Guidelines on Freedom of Association and Assembly in Africa, 2017.

⁴²² - "Study Group on Freedom of Association," African Commission, accessed 27 March 2017, <http://www.achpr.org/mechanisms/study-group-freedom-of-association/>.

⁴²³ - "Study Group on Freedom of Association," African Commission, accessed 27 March 2017, <http://www.achpr.org/mechanisms/study-group-freedom-of-association/>.

⁴²⁴ - Brent W. Hanson et al., "Refocusing and Prioritizing HIV Programmes in Conflict and Post-Conflict Settings: Funding Recommendations," AIDS 22, no. 2 (2008): 95.

Knowing where to access such services and having a regular supply of antiretroviral medicines can be difficult in such circumstances. This can result in people living with HIV developing drug-resistant HIV. Refugees, migrants and other groups that are vulnerable for socio-economic reasons are at heightened risk of sexual violence.

Good practices

55. A few countries in Africa have attempted to address HIV during and after armed conflict. In response to the high levels of sexual violence in the eastern regions of the Democratic Republic of the Congo, mobile courts were established specifically to try perpetrators of sexual violence. From 2009 to 2012, a mobile court in the province of South Kivu heard 382 cases; this resulted in 204 convictions for rape, 82 convictions for other offenses and 67 acquittals.⁴²⁵ Such courts permit victims to attain some level of redress and hold perpetrators accountable for sexual violence. Other countries—including Côte d'Ivoire, Liberia, Niger, Sierra Leone and Sudan—provide dedicated staff who are empowered to address HIV during the disarmament, demobilisation and reintegration process. This approach has been successful in addressing HIV during the transition to peace.⁴²⁶

THE FUNDING CRISIS AND ITS IMPACT ON HUMAN RIGHTS AND CIVIL SOCIETY

56. If Africa is to have any chance of reducing or ending the AIDS epidemic, greater resources are needed now. Many low-income and middle-income countries remain heavily dependent upon international donors to finance their HIV response. As per the latest data available in 2017, 33 low-income and middle-income countries had 75% or more of their HIV financing needs provided by external sources.⁴²⁷ Twenty-two of those countries were in sub-Saharan Africa.⁴²⁸ Despite this, civil society organizations surveyed in Africa and around the world feel that international HIV funding from governments and international donors is decreasing.

57. The flatlining of resource availability at the country level and the decrease of international HIV funding in selected countries affects many or all areas of HIV efforts, including human rights. In 2017, very few countries reported disaggregated data on stand-alone in-country expenditures on human rights. Among those that did, only US\$ 1.46 million was spent on specific stand-alone human rights activities in 10 low-income and middle-income countries.⁴²⁹ As funding for HIV decreases, human rights-related HIV funding, which is already underfunded, is expected to decrease further. A 2015 UNAIDS study found that 59% of civil society organizations implementing human rights programmes reported decreases in funding.⁴³⁰

58. The outlook for funding for organisations working on human rights programming in Africa is mixed. In middle-income African countries, civil society organizations report significant decreases in funding for HIV and human rights work. Civil society organizations in western and central Africa, however, report that they expect an increase in funding for human rights and HIV.⁴³¹

59. The stagnation or decrease in HIV funding is impacting civil society organizations, the human rights response and the ability of African governments to address HIV effectively. The decrease in HIV funding has already led organisations to close in southern Africa, leaving a gap in services.⁴³² Other non-governmental organizations have attempted to find alternative solutions, including integrating HIV into broader health and other human rights issues and shifting geographical and/or methodological focus.⁴³³ There are some benefits to such an approach:
- › donors will be able to integrate HIV with other human rights issues, including sexual and reproductive health and rights;
 - › there will be better integration between grassroots mobilisation and government-funded primary care services; and
 - › lessons from the HIV movement can be learned and used for other issues.

⁴²⁵ - Open Society Foundations, *Justice in DRC: Mobile Courts Combat Rape and Impunity in Eastern Congo* (Open Society Foundations, 2013).

⁴²⁶ - Open Society Foundations, *Justice in DRC*.

⁴²⁷ - According to UNAIDS, the latest available data of the external sources of funding from the recent four years are available for 88 low-income and middle-income countries.

⁴²⁸ - UNAIDS, *How AIDS Changed Everything: Fact Sheet* (Geneva: UNAIDS, 2016), <http://www.unaids.org/en/resources/fact-sheet>.

⁴²⁹ - Global AIDS Response Reporting Mechanism (GARPR) and Global AIDS Monitoring (GAM) country reports.

⁴³⁰ - GARPR and GAM reports.

⁴³¹ - UNAIDS, *Sustaining the Human Rights Response to HIV* (Geneva: UNAIDS, 2015), 19.

⁴³² - For example, the *Zambian AIDS Law Research and Advocacy Network (ZARAN)*, an organisation promoting the rights of people living with and affected by HIV, closed in 2012 due to a lack of funding. ZARAN was one of the few organisations in Zambia that worked to address the legal environment for people living with HIV.

⁴³³ - UNAIDS, *Sustaining the Human Rights Response*, 38.

⁴³⁴ - UNAIDS 2017 estimates.

60. The risks to such integration are that HIV groups lose their sole focus on HIV, thereby limiting their impact on the HIV epidemic. Similarly, organisations take on issues and advocacy work for which they lack the necessary expertise, and the integration of HIV organisations into broader existing movements of marginalised groups may be difficult and result in a shift in priorities.

WOMEN AND GIRLS

61. In 2016, young women accounted for 67% of new HIV infections among young people aged 15–24 years in sub-Saharan African, and women accounted for 56% of new HIV infections among adults.⁴³⁴ Overall, three in four new HIV infections among those aged 15 to 19 years in sub-Saharan Africa occurred in girls.⁴³⁵

62. The HIV Committee has noted the disturbing feminisation of HIV in Africa, reporting that

biological factors that make women and girls more vulnerable to HIV infection are exacerbated by socio-cultural and structural factors, such as poverty, harmful cultural practices, limited decision-making power, lack of control over financial resources, restricted mobility, violence, limited educational opportunities, and lack of quality sexual and reproductive health services.⁴³⁶

63. Across the continent, women continue to be more disadvantaged than men in their daily lives.⁴³⁷ They lack access to the same levels of education, economic power and political leadership as men, and they report discrimination in the workplace, in courts and in their communities.⁴³⁸

64. Women are not free to make decisions on issues that affect their lives, including in areas such as sexual and reproductive health decisions and access to medical care. Women living with HIV often experience high levels of human rights violations in health-care settings, including coercion, lack of privacy, disrespect, humiliation and denial of services.⁴³⁹

65. Laws, policies and practices that perpetuate gender inequality, harmful gender norms and gender-based violence undermine women and girls, keeping them in poverty and limiting their autonomy and decision-making power, including their ability to access health-care services. All these factors contribute to making women more vulnerable to HIV. Key issues relating to gender inequality and HIV are outlined below.

Gender inequality in family and personal law

66. In personal and family law, gender inequality limits women's rights to autonomy, equality in relationships, security of property ownership and financial control. Inequitable customary and religious laws often deny women the right to make decisions relating to their lives, the lives of their children, their property and their health care. They also create barriers to accessing marital property.⁴⁴⁰ Inequity in family and personal laws can mean women are denied the right to inherit property from their parents, their husband or their clan.

67. Gender inequality within a relationship increases a woman's risk of acquiring HIV because dependency on partners and relatives leaves them with few options for negotiating safe sex, ending a relationship or accessing health care (such as HIV testing and treatment).⁴⁴¹

Good practices

68. A number of African courts have upheld the equality of women with respect to family and personal law. In 2013, the Court of Appeal of Botswana held that customary laws that discriminated against women solely on the basis of their gender are unlawful and unconstitutional.⁴⁴² The case challenged a Ngwaketse customary law that arguably denied women the ability to inherit the family home. In finding that women cannot be wholly exempted from inheriting the family home, the Court of Appeal noted that although the Constitution provides an exception for customary law, the exemption only applies if it is in the public interest and does not prejudice the rights and freedoms of others.⁴⁴³ In Ghana, the High

⁴³⁵ - UNAIDS, *When Women Lead Change Happens: Women Advancing the End of AIDS* (Geneva: UNAIDS, 2017), 2.

⁴³⁶ - "Press Release on World AIDS Day," African Commission, 1 December 2013, <http://www.achpr.org/press/2015/12/d281/>.

⁴³⁷ - UNDP, *Africa Human Development Report 2016: Accelerating Gender Equality and Women's Empowerment in Africa* (New York: UNDP, 2016).

⁴³⁸ - UNDP, *Africa Human Development Report*.

⁴³⁹ - Johanna Kehler, "They Do Not Have That Right: Women's Experiences of Accessing Healthcare," (2015), 9.

⁴⁴⁰ - In Lesotho, for example, Article 18(4)(c) of the Constitution arguably allows discrimination against women in terms of customary law. See *Constitution of Lesotho* (1993), Art. 18(4)(c); and *Masupha v. Senior Resident Magistrate of the Subordinate Court of Berea (Mr. Kolobe) and Others (CIV)* 29/2013 (2014).

⁴⁴¹ - Global Commission, *HIV and the Law*.

⁴⁴² - *Ramantele v. Mmusi and Others*, CACGB-104-12 (2013).

⁴⁴³ - *Ramantele v. Mmusi and Others*.

Court in *Akrofi v. Akrofi* struck down the rule of male primogeniture, noting that male-only inheritance has “out-lived its usefulness and is at present not in conformity with public policy.”⁴⁴⁴

69. Alternative dispute mechanisms have also been used to ensure that women have equal access to inheritance. In Kenya, community leaders—with the support of the HIV law and human rights organisation, KELIN—are using traditional dispute resolution mechanisms to support women dispossessed of family property when their husbands die. KELIN has supported elders to work with families to resolve disputes and protect the property rights of widows to return to their original homes and villages or to resettle elsewhere. This model takes the view that customary law changes with society, and that it can change to encompass gender equality. Thus far, the model has been successful in ensuring that widows are not dispossessed of their property.⁴⁴⁵

Violence against women

70. Violence against women is closely correlated with HIV infection: in some settings, women who experience intimate partner violence are 50% more likely to acquire HIV than those who do not experience such violence.⁴⁴⁶ Violence—or the fear of violence—impedes the ability of women to insist on safer sex; it also affects their ability to use and benefit from HIV prevention, testing and treatment interventions and sexual and reproductive health services.⁴⁴⁷
71. Africa has the highest reported rates of both physical and sexual violence against women of any region. In more than half of African countries, over 40% of women experience some form of physical violence; that number increases to 64% in some countries.⁴⁴⁸
72. Women from marginalised populations, such as sex workers and women with disabilities, are at

particular risk of violence. Lesbian, bisexual and transgender women are particular targets of sexual violence. Perpetrators may be friends, family, acquaintances or occasionally complete strangers who are keen to establish the victim’s “proper femininity.”⁴⁴⁹

73. While general criminal laws should theoretically protect women from violence, they are often insufficient in practice. Laws specifically targeting gender-based violence are recommended, but many countries do not have laws protecting women from specific forms of gender-based violence. In 2016, some 14 countries in sub-Saharan Africa reported having legislation that specifically criminalised marital rape, while 29 reported having laws on domestic violence.⁴⁵⁰ Where protective laws do exist, they often are inadequately implemented and enforced, again because of factors such as gender stereotypes and inequalities, or barriers that exist within the legislation itself. For example, Zimbabwe criminalises marital rape, but the law requires the consent of the Attorney General for prosecution, which results in few prosecutions.⁴⁵¹

Good practices

74. The African Charter and the Maputo Protocol clearly prohibit violence against women. Resolution 275 explicitly recognises violence based on sexual orientation and gender identity as a violation of the right to be free from discrimination and the right to equal protection under the law.
75. A number of countries have enacted legislation addressing gender-based violence. Namibia has passed the Combating of Rape Act, No. 8 of 2000, which states marriage cannot constitute a defence to rape.⁴⁵² Zimbabwe’s Domestic Violence Act of 2006 calls for the creation of an Anti-Domestic Violence Council and counsellors to support the implementation of this Act.⁴⁵³ Countries such as Mozambique and Tanzania also are starting to include programmes to

⁴⁴⁴ - *Akrofi v. Akrofi* [1965] GLR 13, 16.

⁴⁴⁵ - Catherine M. Mumma, *Accessing Justice and Protecting the Rights of the Vulnerable through Cultural Structures: A Tool on Working with Elders in Communities* (KELIN, 2010).

⁴⁴⁶ - WHO et al., *Global and Regional Estimates*.

⁴⁴⁷ - Bedru Hussen Mohammed et al., “Intimate Partner Violence and Utilization of Maternal Health-Care Services in Addis Ababa, Ethiopia,” *BMC Health Services Research* 17, no. 1 (2017): 178; and Lauren Maxwell et al., “Estimating the Effect of Intimate Partner Violence on Women’s Use of Contraception: A Systematic Review and Meta-Analysis,” *PLoS One* 10, no. 2 (2015): e0118234.

⁴⁴⁸ - United Nations Department of Economic and Social Affairs, *The World’s Women: Trends and Statistics* (2015), 143.

⁴⁴⁹ - UN Women, *Ending Violence Against Women and Girls: Programming Essentials* (UN

Women, 2013); Global Commission on HIV and the Law; Health Economics and HIV/AIDS Research Division (HEARD), *National Response to Disability and HIV in Eastern and Southern Africa* (HEARD, 2010); and Human Rights Watch, “We’ll Show You You’re a Woman”: Violence and Discrimination against Black Lesbians and Transgender Men in South Africa (Human Rights Watch, 2011).

⁴⁵⁰ - UNAIDS 2017 National Commitments and Policies Instrument.

⁴⁵¹ - Global Commission, *HIV and the Law*.

⁴⁵² - Namibia Combating of Rape Act, No. 8 of 2000, Art. 2(3).

⁴⁵³ - Arts. 15 and 16 of Zimbabwe Domestic Violence Act 14 of 2006.

⁴⁵⁴ - Republic of Mozambique Council of Ministers, *National Strategic HIV and AIDS Response Plan, 2010–2014*, http://www.nationalplanningcycles.org/sites/default/files/country_docs/Mozambique/national_strategic_hiv_and_aids_response_plan_2010-2014.pdf; and ARASA, *HIV and Human Rights*, 125.

address gender-based violence in their NSPs on HIV and AIDS.⁴⁵⁴

Sexual and reproductive health and rights of women living with HIV

76. Women with HIV consistently experience discrimination and coercive practices in relation to their sexual and reproductive health rights. Discriminatory treatment by health-service providers can deprive them of their right to a family, breach their rights to privacy, deny them potentially life-saving treatments or procedures and, in some cases, amount to torture.

77. Discriminatory and coercive practices include being advised not to have children, being forced to use contraception in order to obtain antiretroviral therapy and being coerced into terminating pregnancy.⁴⁵⁵ Women with HIV from Kenya, Malawi, Namibia, South Africa, Swaziland, Tanzania, Uganda and Zambia have reported being subjected to forced or coerced sterilisation.⁴⁵⁶ As outlined above, pregnant women are often subject to mandatory testing, or their HIV status may be revealed to third parties (such as family and abusive partners) without their consent.

78. Very few countries provide abortion services on demand, and when they do, access is still limited.⁴⁵⁷ Women living with HIV may need abortion services for a variety of reasons. HIV-positive women experience higher rates of sexual assault, or they may be concerned about the health effects of seeing a pregnancy to term. Use of unsafe abortion services also may be more dangerous for women living with HIV, as they are more susceptible to infection and complications.⁴⁵⁸

Good practices

79. Women have successfully challenged violations of their rights in a number of national courts. The Supreme Court of Namibia found in *Namibia v. LM and Others* that the sterilisation

of three women living with HIV without their informed consent was a violation of their rights to physical integrity and to found a family, as was their right under the Constitution.⁴⁵⁹ However, it dismissed their claim of discrimination on the basis of HIV status. The Namibian Government has thus far failed to address the systemic nature of the problem, only addressing the case of the three women who had raised the issue in court.⁴⁶⁰ Similar cases challenging the coerced sterilisation of women living with HIV have been filed in Kenya.⁴⁶¹

80. A number of countries, including Sierra Leone, are moving towards the legalisation of abortion.⁴⁶² The importance of accessing abortion to the well-being of women has also resulted in the African Commission launching a campaign to decriminalise abortion in Africa.⁴⁶³ The campaign seeks to bring attention to the impact of unsafe abortions on the lives and health of women in Africa, and to decriminalise abortion in Africa to ensure country compliance with African regional treaty obligations.⁴⁶⁴

Harmful cultural practices and beliefs

81. Harmful cultural practices, such as child marriage and FGM, can significantly increase vulnerability to HIV among women and girls. Both FGM and child marriage are explicitly prohibited under African human rights instruments. The Maputo Protocol explicitly requires countries to “prohibit, through legislative measures backed by sanctions, all forms of female genital mutilation,” stating that the minimum age of marriage for women shall be 18 years. FGM can place girls at risk of HIV as it exposes them to blood and possibly to unsterilised equipment. There also is a higher prevalence of herpes among women who have undergone FGM, which again increases vulnerability to HIV.⁴⁶⁵ Communities in almost 30 countries in Africa continue to practice FGM, putting an estimated three million girls at risk of FGM annually.⁴⁶⁶

⁴⁵⁵ - UNAIDS, *Getting to Zero: HIV in Eastern and Southern Africa* (Geneva: UNAIDS, 2013).

⁴⁵⁶ - UNAIDS, *Getting to Zero: AIDS Legal Network et al., Ourselves. Their Bodies?* (2012); and Global Commission, *HIV and the Law*.

⁴⁵⁷ - Guttmacher Institute, *Abortion in Africa: Fact Sheet* (New York: Guttmacher, May 2016); and Wendell Roelf, “SA Teenagers Still Battle for Access to Abortion,” *Mail & Guardian*, 13 June 2006, <https://mg.co.za/article/2006-06-13-sa-teenagers-still-battle-for-access-to-abortion>.

⁴⁵⁸ - WHO et al., *Consolidated Guideline on Sexual and Reproductive Health and Rights of Women Living with HIV* (Geneva: WHO, 2017), 71.

⁴⁵⁹ - *Namibia v. LM & Others* (SA 49/2012) [2014] NASC 19.

⁴⁶⁰ - “Submission to the Committee on the Elimination of all Forms of Discrimination against Women Regarding the Government of Namibia,” SALC, 11 December 2014, <https://southernafricallitigationcentre.org/2014/12/11/salc-submission-to-cedaw-regarding-namibia/>.

⁴⁶¹ - Henry Kibira, “Kenya: Women Seek Justice Over Sterilisation,” *The Star*, 23 August 2012.

⁴⁶² - Cassie Werber, “Sierra Leone’s President is Delaying a Crucial Decision that Would Save Thousands of Women’s Lives,” *Quartz*, 1 February 2016.

⁴⁶³ - “Press Release: Launch of the Campaign for The Decriminalization of Abortion in Africa: Women and Girls in Africa are Counting on Us to Save their Lives!” African Commission, 18 January 2016, <http://www.achpr.org/press/2016/01/d287/>.

⁴⁶⁴ - “Press Release: Launch of the Campaign for The Decriminalization of Abortion in Africa,” African Commission, 18 January 2016, <http://www.achpr.org/press/2016/01/d287/>.

⁴⁶⁵ - OHCHR et al., “Eliminating Female Genital Mutilation: An Interagency Statement” (Geneva: WHO, 2008).

⁴⁶⁶ - WHO, *Female Genital Mutilation* (2016); and “Female Genital Mutilation (FGM) Frequently Asked Questions,” UNFPA, January 2017, <http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions>.

82. Child marriage has long-term, life-threatening sexual and reproductive health consequences for children (especially girls) that lead to maternal morbidity and mortality when pregnancy occurs at a young age.⁴⁶⁷ Girls who are married young have less access to contraceptive and other family planning services, and they thus are unable to control the timing of their pregnancies.⁴⁶⁸ They likely also are less able to negotiate safe sex. A study in Kenya and Zambia found that married girls aged 15–19 years were 75% more likely to have HIV than sexually active unmarried girls.⁴⁶⁹ Sub-Saharan Africa has the highest prevalence of child marriage in the world: in at least five countries in the SADC, almost 40% of children are married before they are 18 years of age.⁴⁷⁰

83. Child marriage and FGM are still legal in a number of countries, and even where they are illegal, many women report being unwilling to oppose them for religious or cultural reasons or because they feel forced to abide by them for fear of recrimination.⁴⁷¹ While a number of countries have begun to outlaw both child marriage and FGM,⁴⁷² exceptions and loopholes continue to exist in relation to marriage.⁴⁷³ But changing laws does not necessarily result in changes to customary and religious practices, particularly where custom and tradition tend to prevail over law.⁴⁷⁴

Good practices

84. At both international and regional levels, there has been a strong push towards ending harmful cultural practices. In 2011, the African Union recognised that FGM “is a gross violation of the fundamental human rights of women and girls, with serious repercussions on the lives of millions of people worldwide, especially women and girls in Africa.”⁴⁷⁵ In Africa, over 20 countries have enacted laws prohibiting FGM.⁴⁷⁶ Since criminalising FGM in 2011, Kenya has seen 71 cases of FGM taken to court, although as of 2014, only 16 had been convicted.⁴⁷⁷

85. In Zimbabwe, the Constitutional Court recently delivered a landmark ruling in the case of *Mudzuru and Another v. The Minister of Justice* outlawing child marriage and declaring provisions in civil and customary laws allowing child marriage to be unconstitutional. The Constitution specifically puts the age of marriage at 18 years.⁴⁷⁸

86. Recently, the African Commission—in conjunction with ACERWC—adopted a joint general comment addressing child marriage as a gross human rights violation in Africa.⁴⁷⁹ As mentioned above, a number of countries also have outlawed child marriage. The SADC passed a Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage that addresses the link between HIV and child marriage.⁴⁸⁰

CHILDREN AND ADOLESCENTS

87. Children and adolescents are impacted in various ways by the HIV epidemic. In 2016, 1.6% [1.4–1.8%] of young people aged 15 to 24 years in sub-Saharan Africa were living with HIV, with up to 10.7% [9.8–11.4%] of young people in Swaziland affected. An estimated 1.9 million [1.5–2.3 million] children under the age of 15 years were living with HIV, and only 42% [29–53%] of them had access to antiretroviral therapy in 2016.⁴⁸¹ Children and adolescents face various human rights violations in the context of HIV, creating barriers to their ability to protect themselves from HIV transmission or to access the necessary treatment, care and support once they have been infected with or affected by HIV and AIDS.⁴⁸²

88. In 2016, approximately 13.7 million [11.4–16 million] children in sub-Saharan Africa had lost one or both parents to AIDS-related illnesses.⁴⁸³ Orphaned children risk being in youth-headed households, in institutions or on the streets, where they are increasingly vulnerable to abuse, exploitation and to HIV. Other children, while

⁴⁶⁷ - WHO, *Early Marriages, Adolescent and Young Pregnancies* (Geneva: WHO, 2012), 3; Sanyukta Mathur et al., *Too Young to Wed: The Lives, Rights and Health of Young Married Girls* (International Center for Research on Women, 2003); and United Nations Children's Fund (UNICEF), *State of the World's Children 2009: Maternal and Newborn Health* (New York: UNICEF, 2008), 32.

⁴⁶⁸ - International Centre for Research on Women (ICRW), *New Insights on Preventing Child Marriage: A Global Analysis of Factors and Programs* (ICRW, 2007).

⁴⁶⁹ - ICRW, *New Insights on Preventing Child Marriage*, 7.

⁴⁷⁰ - UNICEF, *State of the World's Children 2015*, Table 9.

⁴⁷¹ - Global Commission, *HIV and the Law*.

⁴⁷² - For example, see Kate Lyons, “The Gambia Bans Female Genital Mutilation,” *The*

Guardian, 25 November 2015; Malawi, *Marriage, Divorce and Family Relations Act*, 2015, Sec. 14; and Constitution of the Republic of Malawi (1994) s22(7).

⁴⁷³ - For example, marriage laws may not always apply to customary or religious marriages, and children younger than 18 years may marry with parental consent.

⁴⁷⁴ - Global Commission, *HIV and the Law*, 68.

⁴⁷⁵ - African Union, *Decision on the Support of a Draft Resolution at the Sixty-Sixth Ordinary Session of the General Assembly of the United Nations to Ban Female Genital Mutilation in the World*, Doc. Assembly/AU/12(XVII) Add. 5 (2011).

⁴⁷⁶ - “Female Genital Mutilation (FGM) Frequently Asked Questions,” UNFPA, January 2017, <http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions>. The countries are Benin, Burkina Faso, Central African Republic (1996, 2006), Chad (2003), Côte d'Ivoire (1998), Djibouti (1994, 2009), Egypt (2008), Eritrea,



not orphaned, may live with chronically ill parents or adults and be required to work or put their education on hold in order to take on household and caregiving responsibilities; this is particularly the case for female children. Similarly, their households may experience greater poverty, and they may be subject to stigma and discrimination because of their association with a person living with HIV.

- 89.** For many children, access to HIV treatment and care is limited by medical, social, systemic and economic barriers, including the failure to implement appropriate systems and strategies for early diagnosis and treatment of children.⁴⁸⁴ Barriers begin with a lack of access to early testing of HIV-exposed infants, which is critical for the survival of HIV-positive children. Despite this, only 51% of children eligible for treatment actually start antiretroviral therapy.⁴⁸⁵ Children also suffer

from a lack of appropriate paediatric antiretroviral medicines, with the development of paediatric formulations of optimal new drugs lagging several years behind those for adults.⁴⁸⁶ Other barriers to initiating and maintaining children on treatment include the following:

- › difficulty identifying and testing children who were not tested as infants;
- › lack of trained personnel in clinics or at the community level to identify HIV-exposed children, link them to care and provide treatment adherence support; and
- › the lack of youth-friendly testing and counselling services.⁴⁸⁷

- 90.** Stigma and fear are barriers for both guardians bringing children to clinics for HIV testing and treatment and for children adhering to treatment. Further, treatment for children is difficult and their guardians frequently do not have the necessary

Ethiopia, the Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Mauritania, Niger, Nigeria, Senegal, South Africa, Sudan (States of South Kordofan and Gedaref), Tanzania, Togo, Uganda and Zambia.

⁴⁷⁷ - Zoe Flood and Wambua Kavila, "Kenyan Couple Deny Murder in FGM Case," *The Guardian*, 4 June 2014.

⁴⁷⁸ - *Mudzuru and Another v. The Minister of Justice* CCZ 12/2015.

⁴⁷⁹ - Adopted during the 60th Ordinary Session of the African Commission on Human and Peoples Rights held in Niamey, Niger, 8-22 May 2017.

⁴⁸⁰ - Adopted by SADC Parliamentary Forum at its 39th Plenary Assembly Session, Ezulwini, Swaziland.

⁴⁸¹ - UNAIDS, *Children and HIV: Fact Sheet* (Geneva: UNAIDS, 2016).

⁴⁸² - Global Commission, *HIV and the Law*.

⁴⁸³ - UNAIDS 2017 estimates.

⁴⁸⁴ - Elizabeth Glaser Paediatric AIDS Foundation, *Increasing Children's Access to HIV Treatment*, accessed 22 June 2017, http://www.ipu.org/PDF/publications/children_hiv_en.pdf.

⁴⁸⁵ - Martina Penazzato et al., "Optimizing Research to Speed Up Availability of Pediatric Antiretroviral Drugs and Formulations," *Clinical Infectious Diseases* 64 (2017): 1597-1603.

⁴⁸⁶ - Penazzato et al., "Optimizing Research."

⁴⁸⁷ - Elizabeth Glaser Pediatric AIDS Foundation, *Haba Na Haba, Technical Bulletin: Spotlight on ... Pediatric HIV Care and Treatment* (Washington DC: Elizabeth Glaser Pediatric AIDS Foundation, 2015), http://www.pedaids.org/page/-/uploads/resources/HNH_Tech%20bulletin%20June%202015%20RGB.pdf.

training and support to help care for children living with HIV.⁴⁸⁸

- 91.** Certain HIV-related laws and policies limit the ability of adolescents and young people to make informed decisions about health and relationships independent of their parents and guardians.⁴⁸⁹ There are often inconsistencies between the age of consent for marriage, sex and access to HIV testing, treatment and sexual health services. Few African countries have laws that set an age at which children can independently consent to medical treatment, HIV testing or accessing contraceptives.⁴⁹⁰ There also are few laws that recognise the rights of young people to sexuality education.⁴⁹¹ As a result, children are unable to safely access information, prevention, testing and treatment for HIV, even when they are willing to do so. Further, nine out of 17 reporting countries in eastern and southern Africa that responded to the National Commitments and Policy Instrument reported the existence of age restrictions for accessing condoms.⁴⁹² In western and central Africa, seven out of 16 reporting countries reported the existence of these restrictions.⁴⁹³

- 92.** For orphaned children, their recognition in law through birth registration and the legal recognition of the parental rights and responsibilities of their de facto caregivers may be critical to their access to health care, education and social support services. Yet in many countries, children remain unregistered at birth.⁴⁹⁴ Additionally, the rights of orphaned children to family property may be violated in instances where inheritance laws fail to protect their rights in favour of older male relatives.

- 93.** The African Children's Charter explicitly recognises that children separated from their parents are entitled to special protection and assistance. It further recognises the following:
- › a child's right to be registered at birth, to receive an education, and to be protected from economic exploitation, child abuse and torture; and
 - › the State's responsibility to ensure the survival,

protection and development of the child, and to assist persons responsible for children, including through the provision of material assistance such as nutrition, health, education, clothing and housing.⁴⁹⁵

Good practices

- 94.** A number of African countries—including Botswana, Kenya, Lesotho, Madagascar, Malawi, Mozambique, South Africa and Uganda—have developed new children's laws based on the principles in the Convention on the Rights of the Child. These new laws are generally more responsive to the social context of children's lives. A number of the HIV laws developed in 26 African countries contain protection for the rights of children affected by HIV and AIDS.⁴⁹⁶

- 95.** Other sexual and reproductive health services such as HIV testing and accessing contraceptives are important for adolescents. For example, Lesotho's Children's Protection and Welfare Act, 2011, provides in Section 240(2) that a child who is at least 12 years of age may independently consent to medical treatment if they are of "sufficient maturity and have the mental capacity to understand the benefits, risks, social and other implications of the treatment or operation." Likewise, Senegal's Loi n° 2010-03 Relative au VIH/SIDA provides in Article 12 that a minor over the age of 15 years may consent independently to HIV testing.

- 96.** In December 2013, ministers of education and health from 20 countries in eastern and southern Africa adopted the Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern African, which calls for "bold actions to ensure quality comprehensive sexuality education and youth-friendly sexual and reproductive health services in the ESA region."⁴⁹⁷ These actions include the "urgent review—and where necessary amend[ment]—[of] existing laws and policies on age of consent, child protection . .

⁴⁸⁸ - UNAIDS, Children and HIV: Fact Sheet.

⁴⁸⁹ - African Commission, General Comment No. 3; UNAIDS, Report of the Global AIDS Epidemic (Geneva: UNAIDS, 2015); and United Nations Committee on the Rights of the Child, General Comment No. 4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child (2003).

⁴⁹⁰ - Global Commission, HIV and the Law.

⁴⁹¹ - Patrick Michael Eba and Hye Young Lim, "Reviewing Independent Access to HIV Testing, Counselling and Treatment for Adolescents in HIV-Specific Laws in sub-Saharan Africa: Implications for the HIV Response," Journal of the International AIDS Society 20, no. 1 (2017): 21456; Global Commission, HIV and the Law.

⁴⁹² - UNAIDS 2017 National Commitments and Policy Instrument.

⁴⁹³ - UNAIDS 2017 National Commitments and Policy Instrument.

⁴⁹⁴ - UNICEF, Strengthening Birth Registration in Africa: Opportunities and Partnerships

Technical Paper, accessed 22 June 2017, https://www.unicef.org/esaro/Technical_paper_low_res_.pdf.

⁴⁹⁵ - See, among others, Arts 5, 14, 16 of the African Children's Charter.

⁴⁹⁶ - Global Commission, HIV and the Law.

⁴⁹⁷ - Young People Today, Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern African (2013), available at <http://www.unesco.org/fileadmin/MULTIMEDIA/HQ/HIV-AIDS/pdf/ESACCommitmentFINALAffirmedon7thDecember.pdf>.

⁴⁹⁸ - Young People Today, Ministerial Commitment, para. 3.2.

⁴⁹⁹ - Section 11(1) of the Children's Protection and Welfare Act, No 7 of 2011.

⁵⁰⁰ - Article 1 of the Convention on the Rights of Persons with Disabilities defines a person with a disability as having "long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective

. to improve independent access to sexual and reproductive health services for adolescents and young people.”⁴⁹⁸

- 97.** Finally, countries have introduced child-specific forms of social protection to support orphans and vulnerable children. For example, some countries have legislated broad socio-economic rights within children's statutes, such as Section 11(1) of the Lesotho Children's Protection and Welfare Act, 2011, which provides that a “child has a right to access education, preventive health services, adequate diet, clothing, shelter, medical attention, social services or any other service required for the child's development.”⁴⁹⁹

PERSONS WITH DISABILITIES

- 98.** There is limited evidence available on persons with disabilities and HIV.⁵⁰⁰ Their marginalised and stigmatised status in society, limited access to health-care services, and experiences of high rates of violence, sexual abuse and poverty render persons with disabilities more vulnerable to HIV and less likely to be able to access services when they are HIV-positive.⁵⁰¹ The limited research undertaken suggests that people with disabilities have a similar, if not higher, risk of contracting HIV than the general population.⁵⁰² For instance, a 2012 study in South Africa found an HIV prevalence rate of 16.7% among persons with disabilities, approximately the same as the general population.⁵⁰³
- 99.** People living with HIV who have a disability face significant barriers to accessing health-care services. These barriers include the attitudes of health-care providers towards persons with disabilities (particularly in relation to sexual and reproductive health care), the limited accessibility of services and educational materials for persons with disabilities (both physical accessibility and general availability), and the limited provision of services that are tailored to meet their specific needs.⁵⁰⁴
- 100.** People living with HIV are at risk of becoming either permanently or episodically disabled as

a result of HIV-related illness.⁵⁰⁵ Yet despite the multi-layered needs of persons with disabilities, national responses to HIV fail to recognise, reflect and integrate their specific needs, thus increasing the impact of HIV on their lives.⁵⁰⁶

Good practices

- 101.** The African Commission has adopted a draft protocol on the rights of persons with disabilities.⁵⁰⁷ The protocol does not specifically mention HIV, but it does call on States to ensure that all persons with disabilities have equal access to health services, including those for sexual and reproductive health. It also calls on States to prohibit discrimination by health-service providers.
- 102.** A number of countries in Africa have committed to the Convention on the Rights of Persons with Disabilities and have begun to develop protective, anti-discrimination laws to protect the rights of persons with disabilities. More than half of the countries in East and southern Africa have included disability-related provisions in their national constitutions, and the EAC includes strong protection for the rights of persons with disabilities in the HIV and AIDS Prevention and Management Law.⁵⁰⁸
- ## INDIGENOUS PERSONS
- 103.** The prevalence of HIV and specific risk factors among indigenous populations in Africa is significantly underexplored and data are limited.⁵⁰⁹ Indigenous populations in Africa experience particular human rights violations that increase their vulnerability to HIV infection, including political and economic marginalisation, de facto discrimination of non-agricultural groups, loss of land and community, lack of access to health care (often due to geographic isolation) and poverty.⁵¹⁰
- 104.** The health of indigenous persons, including in relation to HIV, is closely connected to other fundamental rights, such as loss of ancestral lands, cultural identity and traditional ways of life.⁵¹¹ To fully address the HIV needs of indigenous

participation in society on an equal basis with others.”

⁵⁰¹ - OHCHR et al., HIV/AIDS and Disability Policy Brief; Tun et al., “Limited Accessibility”; and UNAIDS, The Gap Report.

⁵⁰² - HEARD, National Response.

⁵⁰³ - UNAIDS, The Gap Report.

⁵⁰⁴ - OHCHR et al., HIV/AIDS and Disability Policy Brief.

⁵⁰⁵ - HEARD, National Response.

⁵⁰⁶ - HEARD, National Response.

⁵⁰⁷ - Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (2016).

⁵⁰⁸ - Liesl Gerntoltz et al., Disability Rights, HIV/AIDS in Eastern and Southern Africa (Durban: HEARD, 2010).

⁵⁰⁹ - Interagency Coalition on AIDS and Development (ICAD), HIV/AIDS and Indigenous Populations in Canada and Sub-Saharan Africa (Ottawa: Interagency Coalition on AIDS and Development, 2011).

⁵¹⁰ - African Commission, Report of the African Commission on Human and Peoples' Rights Working Group of Experts on Indigenous Populations/Communities (African Commission, 2005), 52; ICAD, HIV/AIDS and Indigenous Populations.

⁵¹¹ - Health Canada, HIV/AIDS and Indigenous Peoples: Final Report of the 5th International Policy Dialogue (Ottawa: Health Canada, 2009), 16.

populations, more evidence needs to be collected and used to develop policies and programmes that focus on the health and rights of indigenous populations within countries.

Good practices

105. Most African countries have affirmatively adopted the UN Declaration on the Rights of Indigenous Peoples.⁵¹² The African Commission has established the Working Group on Indigenous Populations/Communities in Africa, which has the potential to conduct research on issues related to HIV in indigenous communities.

106. Only a few countries have adopted laws and policies seeking to address the rights of indigenous people. In 2006, the Republic of the Congo adopted a law that provides protection for the rights of indigenous peoples.⁵¹³ The Central African Republic was the first country in Africa to ratify the International Labour Organisation's Indigenous and Tribal Peoples Convention, 1989 (No. 169), which outlines the rights of indigenous peoples. These are important legislative steps that should be accompanied by effective implementation, including measures to prevent and respond to health and HIV challenges facing indigenous populations.

MIGRANTS, REFUGEES AND INTERNALLY DISPLACED PERSONS

107. At the end of 2015, 65.3 million individuals were forcibly displaced worldwide, including 21.3 million refugees, 40.8 million internally displaced persons and 3.2 million asylum seekers.⁵¹⁴ In Africa, there were 4.4 million refugees in 2015. It is estimated that there are some 1 billion people who live outside of their original places of birth or residence, including both international and internal migrants.⁵¹⁵ Almost half of international migrants are women and girls, and in some countries, women now outnumber men among migrants.⁵¹⁶

108. Migration and displacement can place people on the move and those they leave behind in heightened

situations of vulnerability to HIV. Migrants, refugees and displaced persons may acquire HIV in their country of destination or while in transit; in fact, migration has been identified in certain regions, including southern Africa, as an independent risk factor for HIV. Whatever their diverse reasons for leaving, migrants, refugees and displaced persons often find themselves separated from their spouses, families and familiar social and cultural norms, and this situation increases their vulnerability. For example, they may face numerous barriers, including language, substandard living conditions, exploitative working conditions and lack of social protection (including health insurance). This in turn may lead them to engage in risky behavior, such as unsafe sex or drug use, or it may lead to experiences of sexual violence and other abuses, thus increasing risk of HIV. This vulnerability also affects those who do not migrate: for instance, women who stay behind when their spouses migrate may face ongoing economic challenges and food insecurity precipitated by the husband's or partner's migration, making them also vulnerable to increased risk of HIV.

109. The increased HIV risk and vulnerability is exacerbated by inadequate access to HIV prevention, treatment and care services. Migrants, refugees and displaced persons rarely have the same entitlements as citizens or locals to insurance schemes that make health care affordable; they also are more vulnerable to HIV stigma or to discrimination when they seek HIV-related information or support.⁵¹⁷ In particular, undocumented migrants face complex obstacles because they often lack complete access to health-care services or social protection, leaving them highly vulnerable to HIV.

110. Among the population of migrants, refugees or internally displaced persons, women and girls are particularly vulnerable to sexual exploitation, gender-based violence and HIV.⁵¹⁸ Sexual harassment, abuse and rape are experiences commonly reported by female migrants, refugees and internally displaced persons. In Kwa Zulu-

⁵¹² - "Press Release: General Assembly Adopts Declaration on Rights of Indigenous Peoples; 'Major Step Forward' Towards Human Rights for All, Says President," United Nations, 13 September 2007, <https://www.un.org/apps/news/story.asp?NewsID=23794#VV-YbOuGO9I>.

⁵¹³ - "New Law to Protect Rights of Indigenous Peoples," IRIN News, 7 January 2011, <http://www.irinnews.org/report/91564/congo-new-law-protect-rights-indigenous-peoples>.

⁵¹⁴ - UNHCR, Global Trend: Forced Displacement in 2015 (Geneva: UNHCR; 2016), <http://www.unhcr.org/576408cd7.pdf>.

⁵¹⁵ - UNAIDS, Gap Report, 157.

⁵¹⁶ - ILO, Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A

Framework for Action (Geneva: ILO; 2017).

⁵¹⁷ - UNAIDS, Gap Report, 157; John K. Anarfi, "Women's Migration, Livelihoods and HIV/AIDS in West Africa," in: Women Migrants and HIV/AIDS: An Anthropological Approach, Proceedings of the Round Table held on 20 November 2004 (Paris: UNESCO; 2005): 5-14.

⁵¹⁸ - ILO, Promoting a Rights-based Approach, 37.

⁵¹⁹ - UNAIDS, Gap Report, 159; T. Welz et al., "Continued Very High Prevalence of HIV Infection in Rural KwaZulu-Natal, South Africa: A Population-based Longitudinal Study, AIDS, 21m no. 11 (2007): 1467-1472.

⁵²⁰ - UNAIDS, Gap Report, 164.

Natal, South Africa, where migration is common, HIV prevalence among young migrant women aged 25–29 years was as high as 63%.⁵¹⁹

- 111.** Migrants, refugees and displaced persons often face conditions in their host country that make them vulnerable to HIV. Further violating their rights through compulsory testing and treating them as criminals with detention and deportation can be traumatic. This can be compounded by the stigma and financial consequences of being deported due to an HIV-positive status.

Good practices

- 112.** Some countries, such as Ethiopia and Kenya, have recognised the increased vulnerability to HIV of migrants and refugees, and they have used national AIDS strategies to address this. This includes programmes aimed at reaching mobile populations so that they receive effective HIV prevention, treatment, care and support services.⁵²⁰
- 113.** With the exception of Egypt and Mauritius, no country in Africa applies restrictions to the entry, stay and residence of persons living with HIV. In 2010, Namibia lifted its HIV-related travel restrictions, and several African countries—including Burkina Faso,⁵²¹ Congo,⁵²² Kenya⁵²³ and Uganda⁵²⁴—have explicitly stated in their national legislation that an HIV-positive status should not be a barrier to the entry, stay or residence of persons living with HIV. These provisions are in line with human rights standards and public health recommendations.

KEY POPULATIONS IN NEED OF SPECIFIC PROTECTION AND ACCESS TO HIV AND HEALTH SERVICES

- 114.** The HIV epidemic does not affect all persons equally. Key populations—already marginalised through other forms of stigma, inequality and discrimination—are disproportionately affected. UNAIDS and WHO have identified four main populations to be key populations: gay men and other men who have sex with men, sex workers,

transgender people and people who inject drugs.⁵²⁵ This report also covers prisoners as a key population as suggested by UNAIDS and WHO in their definition of key populations.⁵²⁶

- 115.** Like all populations, key populations are entitled to full protection of their rights, including the rights to equality, non-discrimination, the highest attainable standard of health care, dignity and freedom from cruel, inhuman and degrading treatment or punishment.⁵²⁷ These populations, however, often suffer from punitive laws or stigmatising policies that can increase their likelihood of exposure to HIV. That same stigma, discrimination and violence, coupled with punitive laws, also serves to create barriers to accessing services.⁵²⁸

- 116.** At most, key populations across Africa have received limited protective rights-based responses at the continental, regional and national levels. National HIV laws tend to focus narrowly on the rights of people living with HIV, and national HIV responses fail to include the participation of key populations or to prioritise their needs in HIV-related law and human rights programmes.⁵²⁹

Gay men and other men who have sex with men

- 117.** Globally, gay men and other men who have sex with men are 24 times more likely to acquire HIV than men in the general population.⁵³⁰ In 2012, some of the highest regional median HIV prevalence rates among men who have sex with men were reported in western and central Africa (14%) and eastern and southern Africa (17%). New infections also appear to be rising in several regions.⁵³¹

- 118.** Criminalisation, violence, discrimination and other human rights violations based on sexual orientation are contrary to international human rights law. They also have significant negative consequences on the HIV epidemic and public health, contributing to an environment of fear that drives LGBTI people away from HIV services. The possession of HIV and health commodities associated with or labelled for use by gay men and other men who have sex with men (such as

⁵²¹ - Article 19, Loi n° 030-2008/AN portant lutte contre le VIH/SIDA et protection des droits des personnes vivant avec le VIH/SIDA, 2008 of Burkina Faso.

⁵²² - Article 40, Loi n° 30-2011 du 3 juin 2011 portant lutte contre le VIH et le SIDA et protection des droits des personnes vivant avec le VIH, 2011 of Congo.

⁵²³ - Uganda, HIV Prevention and Control Act of 2014, Art. 34.

⁵²⁴ - Kenya, HIV and AIDS Prevention and Control Act, 14 of 2006, Section 33(2).

⁵²⁵ - WHO, Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (Geneva: WHO, 2014), http://apps.who.int/iris/bitstream/10665/128049/1/WHO_HIV_2014.8_eng.pdf; UNAIDS, UNAIDS Terminology

Guidelines, 2015.

⁵²⁶ - As above.

⁵²⁷ - UNAIDS, The Gap Report.

⁵²⁸ - UNAIDS, The Gap Report.

⁵²⁹ - UNAIDS, Desk Review of National Strategic Plans in East and Southern Africa (Geneva: UNAIDS, 2011).

⁵³⁰ - UNAIDS special analysis, 2016.

⁵³¹ - UNAIDS, The Gap Report, 203.

lubricants) has been used as evidence in criminal cases.⁵³² Fear of negative consequences can prevent uptake of health services and hinder gay men and other men who have sex with men from disclosing their sexual behaviour to health-care providers. In Botswana, Malawi and Namibia, more than 80% of gay men and other men who have sex with men have not disclosed their same-sex sexual practices to a health practitioner.⁵³³ Poor access to health-care services among gay men and other men who have sex with men translates into “underutilization of services, such as HIV voluntary counselling and testing, and ultimately to low self-awareness of HIV sero-status” among this key population.⁵³⁴

119. In Malawi, only 17% of men who have sex with men reported having been exposed to specific HIV prevention messaging for men who have sex with men, and only 35% had been tested for HIV.⁵³⁵ In Zambia, 73% of men who have sex with men had misinformation about HIV, thinking that anal sex was safer than vaginal sex.⁵³⁶ Lack of HIV prevention tools and messaging for gay men and other men who have sex with men compromises their ability to know and reduce the risk of HIV infection for themselves and their sexual partners. Similarly, treatment and care services to address the specific health needs of LGBTI people, including anorectal health services for gay men and other men who have sex with men, are often limited or not available in many health facilities.⁵³⁷

120. Rights violations against gay men and other men who have sex with men are increasingly reported on the continent. They include rape, murder, harassment, violence, extortion and threats against both individuals and the organisations that support them.⁵³⁸ Over 30 African States criminalise same-sex sexual relationships in some way, often with penalties for those convicted that range from imprisonment (for up to 14 years or life) to the death penalty.⁵³⁹

121. In Senegal, the 2008 arrest for “acts against nature” of nine HIV prevention and outreach personnel

working with gay men and other men who have sex with men negatively impacted HIV prevention efforts. According to a study conducted in Senegal following these arrests, all participants reported pervasive fear and hiding among men who have sex with men because of the arrests and subsequent publicity. Many service providers suspended HIV prevention work with gay men and other men who have sex with men out of fear for their own safety, while those who continued to provide services noticed a sharp decline in participation.⁵⁴⁰

122. In recent years, a number of countries have introduced new laws against these populations, in some cases extending criminalisation to individuals and organisations perceived to support same-sex sexual relationships. This is believed to have led to increased harassment and prosecution on the basis of sexual orientation and gender identity, and to increased difficulties in reaching this population for health workers, in part due to limited funding and national spending intended to meet their specific needs.⁵⁴¹ In Nigeria, for example, research has shown the negative impact that the passage of new legislation criminalising same-sex sexual conduct and related activities has had on access to HIV treatment and care, including higher numbers of gay men and other men who have sex with men reporting fear of seeking health-care services.⁵⁴² As part of a crackdown on same-sex sexual relations in 2016, Tanzania banned the import, sale and distribution of sexual lubricant, a commodity considered by health experts to be critical for preventing HIV during sex.⁵⁴³

Good practices

123. A number of countries, including Mozambique and South Africa, have removed laws criminalising same-sex sexual conduct. South Africa’s law was struck down by the Constitutional Court, which declared it a violation of equality rights and the rights to privacy, dignity and equal protection.⁵⁴⁴

124. In 2014, the Constitutional Court of Uganda overturned the Uganda Anti-Homosexuality

⁵³² - Global Commission, HIV and the Law, 47.

⁵³³ - Fay et al., “Stigma, Health Care Access, and HIV Knowledge.”

⁵³⁴ - Fay et al., “Stigma, Health Care Access, and HIV Knowledge.”

⁵³⁵ - Fay et al., “Stigma, Health Care Access, and HIV Knowledge.”

⁵³⁶ - Fay et al., “Stigma, Health Care Access, and HIV Knowledge.”

⁵³⁷ - Ross D. Cranston, “Anal Cancer Prevention: How We are Failing Men Who have Sex with Men,” *Sexually Transmitted Infections* 84 (2008): 417-419; and C. Williamson, “Providing Care to Transgender Persons: A Clinical Approach to Primary Care, Hormones, and HIV Management,” *Journal of the Association of Nurses in AIDS Care* 21, no. 3 (2010): 221-229.

⁵³⁸ - Amnesty International, *Making Love a Crime: Criminalisation of Same Sex Conduct in Sub-Saharan Africa* (London: Amnesty International, 2013), 9; and AMSHeR et al., *Violence Based on Perceived or Real Sexual Orientation and Gender Identity in*

Africa (2013).

⁵³⁹ - International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA), *Africa from a Gay and Lesbian Human Rights Perspective* (2013).

⁵⁴⁰ - Tonia Poteat et al., “HIV Risk among MSM in Senegal: A Qualitative Rapid Assessment of the Impact of Enforcing Laws that Criminalize Same Sex Practices,” *PLOS ONE* 6 (2011): 12.

⁵⁴¹ - UNAIDS, *The Gap Report*.

⁵⁴² - S. Schwartz et al., “The Immediate Effect of the Same-Sex Marriage Prohibition Act on Stigma, Discrimination, and Engagement on HIV Prevention and Treatment Services in Men Who have Sex with Men in Nigeria: Analysis of Prospective Data from the TRUST Cohort,” *The Lancet HIV* 2, no. 7 (2015): e299-e306.

⁵⁴³ - Agence France Presse (AFP), “Tanzania Bans Lube in Crackdown on Gays,” 23 July 2016, <http://www.news24.com/Africa/News/tanzania-bans-lube-in-crackdown-on-gays-20160722-26>.

Act, 2014. The claimants argued that proper procedures for its enactment had not been followed and that the Act breached the Constitutional rights of equality, non-discrimination and dignity. The Court found for the applicants on the basis of procedural issues and declined to explore the human rights arguments.⁵⁴⁵ The National Human Rights Commission of Uganda also had publically criticised the Anti-Homosexuality Act as unconstitutional, including providing comments about its effect on the right to health for all persons in the context of HIV.⁵⁴⁶

125. In 2013, Botswana's Director of Civil and National Registration refused to register the organisation Lesbians, Gays and Bisexuals of Botswana (LEGABIBO). Fourteen activists from LEGABIBO filed a complaint in the High Court in March 2014 alleging the refusal was unconstitutional. In November 2014, the court held that the failure to register LEGABIBO was unlawful and unconstitutional, violating the applicant's right to freedom of expression, association and assembly.⁵⁴⁷

126. Current promising practices tend towards harm reduction rather than law reform, including efforts to provide specialised prevention and treatment programmes for gay men and other men who have sex with men, despite laws that criminalise same-sex sexual relationships within countries. Promising results have been seen with services that find ways to reach less visible populations (e.g. through digital mapping of populations and the provision of home-based testing and counselling services).⁵⁴⁸

Transgender people

127. Transgender women are one of the most vulnerable groups in relation to HIV, being 49 times more likely to be living with HIV than other adults of reproductive age.⁵⁴⁹ In Africa, there is limited information on the impact of HIV on transgender women and men; for the most part, they are an invisible population in responses to the HIV epidemic.

128. Transgender persons are marginalised, abused and often rejected by their families and society from an early age. Discrimination, gender-based violence and abuse—as well as marginalisation and social exclusion—can damage their health and increase vulnerability to HIV. In the face of such treatment, transgender persons are less likely to seek out health care and testing, even though they are vulnerable to HIV through sexual assault and often are pushed into high-risk jobs, such as sex work.⁵⁵⁰

129. In 2011, two transgender youths in Cameroon who identify as women were arrested, harassed and tortured in prison before being tried and convicted of homosexuality, primarily based on evidence that they were wearing women's clothing.⁵⁵¹ In 2013, the Trans Murder Monitoring Project reported four murders and numerous instances of physical violence against transgender persons in South Africa.⁵⁵²

130. Research conducted in Cameroon, Egypt, Kenya, Tunisia, Uganda and Zambia shows that law enforcement officials work in tandem with medical personnel to subject transgender men and women arrested on homosexuality-related charges to forced anal examinations with the purported objective of finding so-called proof of homosexual conduct.⁵⁵³ This practice turns medical personnel into an arm of the State, implicating them in tests that have been described as a form of torture or cruel, inhuman and degrading treatment. This consequently widens the gap in trust between sexual and gender minorities and health-care providers.⁵⁵⁴ In its General Comment No. 4 on The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment, the African Commission explicitly lists forced anal and other testing as forms of sexual and gender-based violence that may amount to torture and ill-treatment under the African Charter.⁵⁵⁵

Good practices

131. Resolution 275 of the African Commission specifically condemns the increasing violence

⁵⁴⁴ - National Coalition for Gay and Lesbian Equality & Anor v. The Minister for Justice and Ors (1998) CCT 11/98.

⁵⁴⁵ - Oloka-Onyango & Nine Others v. Attorney General, No. 08 of 2014, UGCC 14 (1 August 2014).

⁵⁴⁶ - "Uganda: Anti-Homosexuality Law Will Come at a Serious Cost," Human Rights Watch, 19 February 2014, <https://www.hrw.org/news/2014/02/19/uganda-anti-homosexuality-law-will-come-serious-cost>.

⁵⁴⁷ - ARASA et al., Sexual Orientation, Gender Identity, HIV and Human Rights: An Advocacy Toolkit (2015).

⁵⁴⁸ - As above.

⁵⁴⁹ - Baral et al., "Worldwide Burden."

⁵⁵⁰ - "Transgender People and HIV and AIDS," AVERT, 9 May 2017, <https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/transgender>; Marion Stevens,

Transgender Access to Sexual Health Services in South Africa: Findings from a Key Informant Survey (Gender Dynamix and amfAR, 2012); and Kenya Human Rights Commission, The Outlawed Amongst Us: A Study of the LGBTI Community's Search for Equality and Non-Discrimination in Kenya (Nairobi: Kenya Human Rights Commission, 2011).

⁵⁵¹ - AMSHeR and CAL, Violence Based on Perceived or Real Sexual Orientation.

⁵⁵² - AMSHeR and CAL, Violence Based on Perceived or Real Sexual Orientation.

⁵⁵³ - Human Rights Watch, Dignity Debased.

⁵⁵⁴ - Human Rights Watch, Dignity Debased.

⁵⁵⁵ - General Comment No. 4 on the African Charter on Human and Peoples' Rights: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5), March 2017, para. 58.

and human rights violations of persons on the basis of their gender identity, including systemic attacks of State and non-State actors. It calls on States to end all violence and abuse, including by enacting and applying appropriate laws that punish all forms of violence and ensure proper investigation and prosecution.

- 132.** A few countries are beginning to recognise the need to include transgender populations in their national HIV responses. South Africa allows transgender persons to legally change their sexual identity.⁵⁵⁶ For the most part, however, transgender persons remain an ignored population: countries have a limited understanding of the HIV incidence and prevalence amongst transgender persons and of the key HIV-related human rights issues that act as barriers to their access to health-care services.

Sex workers

- 133.** Globally, female sex workers are estimated to be 10 times more likely to acquire HIV than women in the general population.⁵⁵⁷ In sub-Saharan Africa, HIV prevalence among female sex workers is around 27%.⁵⁵⁸ Prevalence of HIV among sex workers in East and southern Africa ranges from 10% in Eritrea to 72% in Lesotho. Across 12 western and central African countries, the pooled prevalence of HIV among sex workers is 14% [4–24%].⁵⁵⁹

- 134.** Female and male sex workers in Africa face exceptionally high levels of stigma, discrimination, violence, extortion, sexual abuse and rape from clients, intimate partners and law enforcement officials. This places them at increased risk of HIV.⁵⁶⁰ In Ethiopia and Kenya, a survey of female sex workers found that roughly 60% and 79%, respectively, reported violence relating to sex work; another study in Burkina Faso and Togo found that 23.9% and 57.9%, respectively, experienced violence and reported recent condomless vaginal intercourse.⁵⁶¹ Sex workers also report stigmatising attitudes and high levels of discrimination when accessing health-care services, which affects their willingness to access health care.⁵⁶²

- 135.** Sex work—or aspects of sex work—is criminalised in approximately 35 African Union Member States.⁵⁶³ Criminalisation places sex workers at increased risk of violence and harassment from law enforcers and the public, driving key populations underground and deterring access to health-care services.⁵⁶⁴ Law enforcement practices such as arbitrary detention and arrests based on condom possession deter sex workers from accessing condoms, placing them at risk of HIV infection. Sex workers also have been forced to undergo mandatory HIV testing and have been charged with spreading STIs.⁵⁶⁵ A study in Burkina Faso and Togo found that laws criminalising sex work acted as a barrier to participation in service design and use of health services for sex workers.⁵⁶⁶ Conversely, a modelling study in Kenya found a reduction in HIV infections of around 25% when physical and sexual violence against sex workers is reduced.⁵⁶⁷

Good practices

- 136.** In the case of *S v. Mwanza Police*, Mwanza District Hospital, the High Court of Malawi held that mandatory or forced testing of sex workers for HIV is a violation of their rights to privacy, equality, dignity and freedom from cruel, inhuman and degrading treatment.⁵⁶⁸
- 137.** The second Pan-African Conference on Prison and Penal Reform in Africa—held in 2002 in Ouagadougou, Burkina Faso, under the auspices of the African Commission—adopted the Ouagadougou Declaration and Plan of Action on Accelerating Prisons and Penal Reforms in Africa, which explicitly calls for the decriminalisation of sex work as a strategy for reducing prison populations by preventing people from coming into the prison system.⁵⁶⁹
- 138.** A number of countries have introduced programmes to increase access to justice among sex workers and to support their access to HIV prevention, treatment and care services. In Côte d'Ivoire, the Clinique Confiance, which was established in 1992, provides HIV and STI prevention and treatment services for female and male sex workers. The tailored services for

⁵⁵⁶ - See South Africa, Alteration of Sex Description and Sex Status Act, 49 of 2003.

⁵⁵⁷ - UNAIDS special analysis, 2016.

⁵⁵⁸ - AMShE and CAL, Violence Based on Perceived or Real Sexual Orientation.

⁵⁵⁹ - Sandra Duvall et al., "Assessment of Policy and Access to HIV Prevention, Care and Treatment Services for Men Who Have Sex With Men and for Sex Workers in Burkina Faso and Togo," *Journal of Acquired Immune Deficiency Syndromes* 68, no. 2 (2015): 189–97.

⁵⁶⁰ - Global Commission, HIV and the Law; and UNAIDS, The Gap Report.

⁵⁶¹ - Duvall et al., "Assessment of Policy."

⁵⁶² - Sex workers from Kenya, South Africa, Uganda and Zimbabwe reported that high levels of stigma dissuaded them from disclosing their occupation to health workers, limiting their access to effective services. It also impacted on their willingness to test for HIV. See UNAIDS, The Gap Report.

⁵⁶³ - UNAIDS, Making the Law Work for the HIV Response: A Snapshot of Selected Laws that Block or Support Access to HIV Prevention, Treatment, Care and Support (Geneva: UNAIDS, 2010).

⁵⁶⁴ - Global Commission, Report of the Africa Regional Dialogue.

⁵⁶⁵ - *S v. Mwanza Police*, Mwanza District Hospital, Ministries of Justice, Internal Affairs, Health, Attorney-General and Ex parte: HB, JM (o.b.o 9 others) (2015) Malawi.

⁵⁶⁶ - Duvall et al., "Assessment of Policy."

⁵⁶⁷ - Michelle R. Decker et al., "Estimating the Impact of Reducing Violence against Female Sex Workers on HIV Epidemics in Kenya and Ukraine: A Policy Modeling Exercise," *American Journal of Reproductive Immunology* 69, no. 1 (2013): 122–32.

⁵⁶⁸ - *S v. Mwanza Police*.

⁵⁶⁹ - Ouagadougou Declaration and Plan of Action on Accelerating Prisons and Penal

sex workers provided by Clinique Confiante has increased uptake of HIV and STI prevention and treatment services among sex workers in the areas covered. In Kenya, the training of local sex workers as paralegals helped to educate sex workers about their rights.⁵⁷⁰ In Uganda, legal support services for sex workers—including a hotline, legal services, documentation of violations and training on human rights for sex workers—is working towards reducing violations against that key population.

- 139.** At the regional level, SADC's HIV Cross-Border Initiative co-ordinates HIV prevention, treatment, care and support services for long-distance truck drivers, sex workers and border communities along major transport corridors in southern Africa. It includes a commitment to advocating for the review of laws and regulatory frameworks that criminalise sex work and the development of policy frameworks to increase access to services.

People who use drugs

- 140.** Globally, it is estimated that people who inject drugs are 24 times more likely to acquire HIV than adults in the general population.⁵⁷¹ Eleven sub-Saharan countries have reported recent data on prevalence among people who inject drugs that show a median HIV prevalence of 9% among three East and southern African countries, and 5% among seven West and central African countries.⁵⁷² While the number of people who use drugs in these areas is small in comparison to some other regions of the world, it is growing and the HIV infection rate is growing with it.⁵⁷³ A number of studies have revealed intersectionality between sex work and injecting drug use, placing individuals involved in both at an even higher risk of acquiring HIV.⁵⁷⁴
- 141.** Multi-person use of injecting equipment is the primary method of HIV transmission for people who use drugs. Despite this, 68% of countries in southern and eastern Africa reportedly have laws that establish barriers against the provision of harm reduction services (such as needle-syringe programmes).⁵⁷⁵ In addition, the criminalisation of drug use and the imprisonment of people who use drugs—combined

with widespread societal stigma and the fear of arrest and harassment—discourages access to health-care services and creates legal barriers to the provision of needle-syringe programmes.⁵⁷⁶ In Africa, individual drug possession and use is criminalised and highly stigmatised throughout the continent, with people who use drugs facing discrimination at many levels.⁵⁷⁷ A survey in Seychelles found high levels of stigma and discrimination against people who inject drugs, with 68% percent of those surveyed reporting being refused a service in the preceding 12 months; more than 50% reported having been arrested in the preceding 12 months.⁵⁷⁸

Good practices

- 142.** A human rights-based approach to drug use requires a move away from criminalisation towards harm reduction and support. The UN Committee on the Rights of the Child, the Committee on ESCR and the Special Rapporteur on the Right to Health have all endorsed a harm reduction approach, as has the Human Rights Council, UN General Assembly and the OHCHR.⁵⁷⁹ A number of countries in Africa are moving towards such an approach. Even though drug use is criminalised in Mauritius, the HIV and AIDS Act, 2006, enables people who use drugs to use a range of HIV prevention services, such as accessing clean needles, without penalty. An AIDS Project Management Group evaluation report showed an increase in the quality of life and a decrease in drug-seeking behaviour amongst those who do access services.⁵⁸⁰ HIV incidence amongst people who inject drugs has also been dramatically reduced since 2010.⁵⁸¹

Prisoners

- 143.** HIV and TB risk among prisoners is estimated to be two to 10 times higher than among the general population. While there is insufficient data on HIV and TB prevalence in prisons in African countries to allow any definitive conclusions, the limited research shows a similar pattern. HIV prevalence among prisoners in nine East and southern African countries ranged from 2.5% in Eritrea to 35% in Swaziland; among 13 West and central African countries, the range extended from 1.4% in Benin and Mali to 8.5% in Guinea.⁵⁸² Studies in Zambia

Reforms in Africa, <http://www.achpr.org/instruments/ouagadougou-planofaction/>.

⁵⁷⁰ - UNAIDS, The Gap Report.

⁵⁷¹ - UNAIDS special analysis, 2016.

⁵⁷² - UNAIDS estimates.

⁵⁷³ - UNAIDS, Getting to Zero.

⁵⁷⁴ - UNAIDS, The Gap Report; Ministry of Health Seychelles et al., Situation Analysis.

⁵⁷⁵ - Global Commission on HIV and the Law, Report of the Africa Regional Dialogue of the Global Commission on HIV and the Law (New York: UNDP, 2011), 39, https://hivlawcommission.org/wp-content/uploads/2017/06/AfricaRD_ReportEn.pdf.

⁵⁷⁶ - As above.

⁵⁷⁷ - As above.

⁵⁷⁸ - J Bibi et al., Injection Drug Use in the Seychelles Integrated Biological and Behavioural

Surveillance Study (2011), cited in Ministry of Health Seychelles et al., Situation Analysis of Legal and Regulatory Aspects of HIV and AIDS in Seychelles (Ministry of Health Seychelles, 2013).

⁵⁷⁹ - UNAIDS, Do No Harm: Health, Human Rights and People who use Drugs (Geneva: UNAIDS, 2016), 21.

⁵⁸⁰ - AIDS Project Management Group, The Right Service. At the Right Place, At The Right Time: An Evaluation of the National Harm Reduction Programme in Mauritius (Mauritius National AIDS Secretariat, 2011).

⁵⁸¹ - Prévention Information Lutte Contre le Sida, Evidence Base to Promote Drug Policy Reform in Mauritius: Presentation to ARASA Annual Partnership Forum (April 2015).

⁵⁸² - UNAIDS estimate.

show an HIV prevalence that is nearly double that of the general adult population.⁵⁸³

144. A combination of factors contributes to the high risk of HIV exposure in prisons. These factors range from laws, policies and policing practices that discriminatorily detain certain individuals from key populations to inhumane conditions and a failure to ensure the continuity of prevention, care and treatment, both when people are imprisoned and after they are released. A study of Zambian prisons in 2010 revealed severe overcrowding, minimum ventilation, inadequate sanitation, poor nutrition, limited health-care staff and services for HIV prevention and treatment, and high levels of violence.⁵⁸⁴ Prisons also are sites of unsafe practices such as unprotected sex, rape, drug use, multi-person use of injecting equipment and unsterile tattooing, all of which place prison populations at high risk for HIV.⁵⁸⁵

145. Such conditions violate the rights of prisoners to dignity, health and medical care, and to be free from cruel, inhuman and degrading treatment or punishment. Under human rights law, an individual's liberty can be restricted as a form of punishment for a criminal offence, but prisoners still retain their rights, including the rights to health and to be free from discrimination. Indeed, the very fact of their incarceration can mean that the State has a broader obligation to protect a prisoner's health than it does for someone who is not totally within the State's control, as outlined in the UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules).⁵⁸⁶

146. Criminalisation of certain practices, such as sex between men and drug use, means that policies can exacerbate risks for prisoners. Due to restrictive rules and policies, discrimination or resource constraints, prisons may fail to provide condoms, ensure access to needle-syringe programmes or provide voluntary HIV testing and treatment.⁵⁸⁷

Good practices

147. A number of courts have upheld the rights of prisoners to receive HIV treatment in prison.

In Nigeria, the High Court held that the denial of medical treatment for HIV-positive prisoners awaiting trial violated the prohibition of torture.⁵⁸⁸ In Botswana, failure to provide non-citizens with treatment and tests constituted a violation of human rights.⁵⁸⁹

148. A number of countries in Africa have now introduced progressive prison laws, policies, legal support services and jurisprudence to manage HIV and TB within prisons. For instance, the Department of Correctional Services in South Africa has an integrated HIV and TB policy that provides prisoners with condoms and prevention and treatment services for HIV and TB.⁵⁹⁰ Similarly, the Ministry of Correctional Services in Lesotho provides access to condoms for prisoners, despite the existence of laws criminalising sex between men.⁵⁹¹

CONCLUSION

149. The HIV response in Africa continues to face various legal and human rights challenges, including

- › HIV-related stigma and discrimination;
- › gender inequality and discrimination towards women;
- › failure to uphold the human rights of young people and children;
- › restrictive and criminal laws against people living with HIV and members of key populations; and
- › failure to address the HIV and health needs of other vulnerable populations (such as persons with disabilities and indigenous populations).

150. In spite of these challenges, civil society organisations, courts, governments and national and regional human rights institutions are championing and implementing reforms and good practices in many areas of laws, policies and programmes relating to HIV that are based on human rights. These good practices from across the continent demonstrate the feasibility and importance of creating an enabling legal environment to ensure that no one is left behind in the response to the HIV epidemic.

⁵⁸³ - Human Rights Watch et al., *Unjust and Unhealthy: HIV, TB and Abuse in Zambian Prisons* (New York: Human Rights Watch, 2010).

⁵⁸⁴ - Human Rights Watch et al., *Unjust and Unhealthy*.

⁵⁸⁵ - Human Rights Watch et al., *Unjust and Unhealthy*.

⁵⁸⁶ - OHCHR, *Standard Minimum Rules for the Treatment of Prisoners*, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx>.

⁵⁸⁷ - Leonard S Rubenstein et al., "HIV, Prisoners and Human Rights."

⁵⁸⁸ - *Odafe and Others v. Attorney-General and Others*.

⁵⁸⁹ - *Attorney General and Others v. Tapela and Another*, Court of Appeal Civil Case No. CACGB-096-14 (2015).

⁵⁹⁰ - Republic of South Africa Department of Health, *Guidelines for the Management of Tuberculosis, Human Immunodeficiency Virus and Sexually-Transmitted Infections in Correctional Facilities*, 2013 (Pretoria: Department of Health, 2013), 12.

⁵⁹¹ - Libakiso Mathlo, *Assessment of the Legal Environment for HIV and AIDS in Lesotho* (UNDP Lesotho, 2016).

VI. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

1. Addressing the HIV epidemic requires paying due regard to the legal and human rights factors that influence vulnerability to the epidemic and represent barriers to service access for those living with and affected by HIV. Across the continent, gay men and other men who have sex with men, women, young people, sex workers, prisoners and people who inject drugs are among the populations most affected by the epidemic. Factors and conditions that make people vulnerable to the epidemic often are linked to human rights and legal and social environments. Laws, policies and practices have a direct impact on the effectiveness

of national responses to the epidemic and the ability of affected individuals and communities to access HIV prevention, treatment and care services.

2. Human rights violations in the context of HIV take various forms and undermine the response to the epidemic. These human rights violations and challenges include inequality and discrimination towards people living with HIV, which has a profound effect on the ability of people living with HIV to enjoy their rights to work, health care, privacy, dignity and freedom of movement. In contexts where anti-discrimination laws exist, implementation and enforcement is often lacking. Together, insufficient information on rights and



legal services, stigma and a lack of resources pose significant barriers to accessing legal services.

3. Compulsory and other forms of coercive HIV testing violate the right to confidentiality. Overly broad criminalisation of HIV transmission, non-disclosure and exposure often involve vague and ambiguous provisions that punish a range of acts that may only pose a hypothetical risk to others.

4. Laws, policies and practices that perpetuate gender inequality, harmful gender norms and gender-based violence undermine women and girls, keeping them in poverty and limiting their autonomy and decision-making power (including their ability to access health-care services). Violence against women is closely correlated with HIV infection: sexual and intimate partner violence places women at increased risk of HIV infection, while men who are violent towards their partners are more likely to have multiple partners and HIV.

5. Children, persons with disabilities and indigenous populations face various human rights violations in the context of HIV. This, in turn, creates barriers to their ability to protect themselves from HIV transmission or to access the necessary treatment, care and support they require once they have been infected or affected by HIV. These barriers include legislation that limits access to HIV services for children and adolescents and that fails to address the specific needs and vulnerabilities of persons with disabilities and indigenous people.

6. Key populations—who are already marginalised through other forms of stigma, inequality and discrimination—are disproportionately affected by HIV. This includes gay men and other men who have sex with men, male and female sex workers and their clients, transgender people, prisoners and people who inject drugs. Members of these populations face legal and social barriers—including prosecutions, harassment and discrimination—that make them vulnerable to HIV and limit their access to health and HIV services.

7. Restrictions to the activities and work of civil society organisations, especially those working with key populations, are an increasing challenge. These organisations face barriers to registration, operation and access to domestic and international funding. The restrictions limit their ability to advocate for a stronger legal environment for the HIV response or to provide critical HIV-related services.

8. Armed conflict and post-conflict periods raise distinct issues related to HIV prevention and treatment. During armed conflict, HIV prevention and treatment services tend to be significantly reduced because of the instability wrought by war. Armed conflict also can increase the need for HIV prevention and treatment services: armed conflicts where sexual violence is more prevalent appear to experience higher rates of HIV transmission. People displaced by conflict also are at an increased risk of acquiring HIV and have greater difficulty accessing prevention and treatment services.

9. In spite of these challenges, national and regional human rights norms and frameworks have been applied to address HIV in many contexts. These include advances in the areas of legislation and policy, progressive rulings by courts and the implementation of rights-based HIV programmes in several countries. Legal and policy advances have involved outlawing HIV-related discrimination through national laws and regional legislation, such as the EAC HIV Prevention and Management Act of 2012.

10. Throughout the continent, courts have enabled critical advances in the protection of human rights in the context of HIV. These have involved decisions that challenge discrimination based on HIV-related status, end mandatory testing for sex workers, defeat overly broad HIV criminalisation, ensure access to HIV treatment for foreign inmates and end forced sterilisation of women living with HIV. Several countries have established programmes to advance human rights and address barriers to HIV services, including for key populations. These include programmes to train police, lawyers and the judiciary on human rights and HIV, as well as

programmes for access to justice for people living with HIV and members of key populations.

11. Many of the advances in the response to HIV in Africa have been made possible by global solidarity and funding from bilateral and multilateral sources. Yet HIV funding for civil society and governments is declining. Reductions in funding poses one of the greatest threats to the response to HIV, particularly for sustaining and expanding the protection of human rights.

12. The global and regional human rights frameworks contain solid foundations for expanding the protection of human rights in relation to HIV in Africa. States on the continent are Parties to numerous international and regional human rights treaties that guarantee critical protections in the context of HIV. These treaties provide for the protection of many human rights that are critical to HIV prevention, treatment, care and support for people living with, vulnerable to or affected by HIV. Notably, this includes the following rights (among others):

- › to non-discrimination;
- › to equal protection and equality before the law;
- › to life;
- › to the highest attainable standard of physical and mental health;
- › to liberty and security of person;
- › to freedom of movement;
- › to seek and enjoy asylum;
- › to privacy;
- › to work; and
- › to education.

13. The protections provided in treaties have been elaborated upon and applied to HIV through global and regional commitments, guidelines and resolutions adopted by bodies at various levels, including the UN General Assembly, the African Union, the African Commission, IGAD, EAC and SADC. In Africa, the African Commission's adoption of Resolution 163 in 2010, which established the HIV Committee, was a critical breakthrough that localised HIV-related human rights within the work of the African

Commission. Human rights protections have also been applied and interpreted through decisions on cases and general comments on HIV-related issues at the global and regional levels. In Africa, General Comments Nos. 1 and 2 of the African Commission on Article 14 of the Maputo Protocol directly relate to the protection of the rights of women in relation to HIV.

14. In spite of the importance and potential role of human rights norms and mechanisms in the response to HIV in Africa, the actual engagement of the regional African human rights system remains limited. This limited engagement by regional mechanisms is due to a number of factors, including lack of awareness of the mechanisms among civil society and community, and limited resources and focus by the regional human rights mechanisms on HIV.

RECOMMENDATIONS

15. To States

- › Take immediate steps to review and amend laws, policies and practices to ensure that they are in line with human rights norms and principles, and that they support effective HIV responses. In particular, steps should be taken to remove laws and other measures that allow for discrimination against and criminalisation of people living with HIV and members of key populations (including sex workers, people who inject drugs, gay men and other men who have sex with men, and transgender persons).
- › Adopt effective measures to prevent and redress human rights violations in the context of HIV, and refrain from discrimination, criminalization or other human rights violations against people living with HIV, key populations and other vulnerable groups.
- › Remove legal, policy, social and other barriers that limit the rights of women and girls to access HIV prevention, treatment, care and support services or those that make them more vulnerable to HIV.

- › Remove legal, policy, social and other barriers that limit access to HIV prevention, treatment, care and support services among children and young people or those that make them more vulnerable to HIV.
 - › Remove punitive and restrictive laws, policies and practices that infringe upon the rights to freedom of association and assembly of organisations and human rights defenders working on health and HIV. Also remove the punitive and restrictive laws, policies and practices that stigmatise and discriminate against particular categories of human rights defenders on the basis of sex, health status, sexual orientation, gender identity and expression, or other status.
 - › Maintain and expand dialogue and consultation with civil society organisations working on HIV and human rights, including those working with or for key populations.
 - › Ensure that national mechanisms responsible for the response to HIV (including national AIDS commissions) apply rights-based responses and guarantee the meaningful participation of people living with HIV and key populations in the HIV response, as provided in the good practices identified in this report.
 - › Take the necessary measures to increase their financial allocation to the health sector in general—and for HIV services in particular—as agreed in the Abuja Declaration.
 - › Take the necessary measures to establish and expand programmes to reduce stigma and discrimination and to expand access to justice in the context of HIV and health. These measures should include the following:
 - » Programmes to reduce stigma and discrimination. These can include community interaction and focus group discussions involving people living with HIV and members of populations vulnerable to HIV infection, as well as the use of media, peer mobilization and support developed for and by people living with HIV to promote health, well-being and human rights.
 - » Programmes to ensure access to HIV-related legal services.
 - » Programmes on monitoring and reforming laws, regulations and policies relating to HIV.
 - » Legal literacy (“know your rights”) programmes.
 - » Sensitization of law-makers and law enforcement agents.
 - » Training for health-care providers on human rights and medical ethics related to HIV.
 - » Programmes to reduce discrimination against women in the context of HIV.
- 16.** To the African Union and other regional and sub-regional bodies
- › Increase political and technical engagement in efforts to address the HIV epidemic in Africa, including the legal and policy challenges raised by HIV.
 - › Encourage States to take appropriate measures to address laws, policies and practices that violate human rights and act as barriers to effective responses to HIV.
 - › Ensure appropriate attention to HIV and human rights issues and challenges in the implementation of key regional and sub-regional priorities, agendas and frameworks, including Agenda 2063 of the African Union.
 - › Create opportunities for dialogue between States, civil society and other key stakeholders on the challenges, good practices and progress related to the protection of human rights in the context of HIV.
 - › Continue to provide space for all civil society organisations (including those representing

key populations) to engage States and other stakeholders in the response to HIV at the regional and sub-regional levels, and to ensure their effective participation in regional policy development and decision-making processes.

- › Encourage and support full collaboration between States and national, regional and international human rights mechanisms, and support the independence of these mechanisms.

17. To the African Commission

- › Continue to raise awareness on the importance of promoting and protecting human rights in the context of HIV, including through country visits, fact-finding missions, urgent appeals and the work of subsidiary mechanisms.
- › Systematically monitor and denounce human rights violations that are committed in the context of HIV, including by publishing an annual update developed by the HIV Committee that examines the key human rights progress and challenges facing the HIV response in Africa.
- › Fully utilise the protective and promotional mandates to monitor State compliance with all relevant human rights norms and standards relevant to HIV, including through country visits, recommendations on State reports, fact-finding missions, urgent appeals and other means. In particular,
 - » call on Members States to address the questions provided in the Annex of this study when preparing their state reports under Article 62 reports; and
 - » ensure that the African Commission and its subsidiary mechanisms use the questions provided in the Annex of this study in their country visits, consideration of State reports and fact-finding missions.
- › Encourage Member States to conduct law and policy review and reform, and to adopt, implement and enforce rights-based laws,

policies and plans in the context of HIV and AIDS, drawing on international and regional guidance on HIV law and human rights.

- › Monitor and ensure the effective dissemination and implementation of HIV-related key resolutions, general comments and guidelines of the African Commission.
- › Develop guidelines and recommendations for Member States on particular legal and policy issues affecting the rights of people living with HIV and key populations. Among other issues, these guidelines should address criminal law and its impact on the HIV response.
- › Ensure that the HIV Committee has the necessary technical, human and financial resources to fully discharge its mandate as provided in Resolution 163 of the African Commission.
- › Ensure the effective dissemination and promotion of the present study and its recommendations, including through seminars, promotional visits and other appropriate means.
- › Continue and reinforce collaboration and dialogue with civil society, governments and relevant regional and global institutions working on HIV in order to discuss challenges, good practices, progress and effective accountability to advance human rights-based responses to HIV, including through the work of the HIV Committee.
- › Consider the extension of the mandate of the HIV Committee in the medium- to long-term to cover other critical health issues that are affecting the continent.

18.

To the ACERWC

- › Require specific information on children and HIV from Member States in the States Parties Reporting Guidelines.
- › Actively ensure the promotion and protection of the rights of the child in the context of HIV through its mandate, including country visits, reports and resolutions on the rights of the child.

- › Develop a general comment focused on the rights of the child in the context of HIV and the obligation of States to respect, protect and fulfil these rights. This should address access to HIV prevention, testing, treatment and care services for children, including access to sexual and reproductive health services.
- › Encourage Member States to ensure that domestic legal frameworks protect the rights of children living with HIV and those vulnerable to HIV infection.
- › Urge Member States to conduct the necessary law and policy review and reform, and to adopt, implement and enforce rights-based laws, policies and plans in the context of HIV and in accordance with the African Children's Charter.
- › Increase awareness of ACERWC's mandate among civil society and other organisations working on the rights of the child in the context of health and HIV.

19. To national human rights institutions, gender commissions and similar bodies

- › Effectively use their promotion and/or protection mandates to hold States accountable for advancing human rights in the context of the HIV response.
- › Establish focal points on HIV and health within the institution or commission, and ensure they are adequately resourced and actively engage all human rights issues affecting people living with HIV and members of key populations.
- › Work closely with and regularly engage national authorities and programmes (such as HIV and TB programmes) working on HIV, TB and other health issues, as well as civil society organisations (including those representing key populations) that are working on these issues.

20. To civil society organisations

- › Continue to engage national, regional and UN human rights mechanisms to prevent and respond to human rights violations in

the context of HIV. In particular, prioritise engagement with the African Commission, its HIV Committee and other regional bodies on HIV and human rights.

- › Establish and reinforce regional partnerships and approaches to advance collaboration and intersectional approaches with the African Commission and African Union that build alliances with diverse civil society organisations working on areas such as women and young people, and with human rights defenders working on issues such as health, HIV, sexual orientation, gender identity and expression, civic space, and sexual and reproductive health and rights.
- › Develop innovative approaches to engage the general public, all branches of government and other opinion leaders (including the media) on the critical human rights issues relating to the HIV epidemic.

21. To the media

- › Maintain and strengthen dialogue with people living with HIV and members of key populations. Support their efforts to advance human rights, the rule of law, social change and development in the context of the HIV response.
- › Refrain from inciting hatred against people living with HIV and members of key populations, and promote responsible reporting that advances rights-based and evidence-informed responses to HIV.

22. To religious and traditional leaders

- › Maintain and strengthen dialogue with people living with HIV and members of key populations. Support their efforts to advance human rights, the rule of law, social change and development in the context of the HIV response.
- › Refrain from inciting hatred against people living with HIV and members of key populations.
- › Encourage an inclusive, protective and humane attitude towards people living with HIV and vulnerable and key populations.

ANNEX: INDICATIVE QUESTIONS AND ISSUES ON HIV FOR STATE PERIODIC REPORTING UNDER ARTICLE 62 OF THE AFRICAN CHARTER⁵⁹²

1. Data and information relating to the nature, scope and populations most affected by the HIV epidemic and TB. In particular, States should provide information on the following:
 - › Specific and disaggregated data on HIV and TB prevalence and incidence for children, women, young people and key populations (namely sex workers, gay men and other men who have sex with men, transgender persons, people who use drugs and prisoners).
 - › Information on the availability, accessibility, acceptability and quality of HIV prevention and testing commodities and programmes. This includes male and female condoms, lubricants, voluntary medical male circumcision, pre-exposure prophylaxis and harm reduction services for people who inject drugs.
 - › Specific and disaggregated data on access to and quality of HIV and TB treatment for children, women, young people and key populations (namely sex workers, gay men and other men who have sex with men, transgender persons, prisoners and people who use drugs).
2. Specific questions relating to the right to non-discrimination and equality provided under Articles 2 and 3 of the African Charter.
 - › Has the State enacted laws in all areas that protect people living with HIV against direct and indirect discrimination due to HIV status, including in employment, education, housing, social benefits and so on? If so, provide information on the progress and challenges relating to the implementation of these laws.
3. Specific questions relating to the rights to liberty and security provided under Article 6 of the African Charter.
 - › Has the State enacted laws or adopted other effective measures to address discrimination and stigma against key populations and other vulnerable populations in the context of HIV? If so, provide information on the progress and challenges relating to the implementation of these laws and measures.
 - › Has the State enacted laws, regulations and collective agreements to guarantee non-discrimination in the workplace? If so, provide information on the progress and challenges relating to the implementation of these laws, regulations and other measures.
 - › Has the State enacted laws to reduce human rights violations and inequality between men and women, particularly regarding sexual and reproductive rights, property, marital relations, economic opportunities and access to employment? If so, provide information on the progress and challenges relating to the implementation of these laws.
 - › What actions is the State taking to promote non-discrimination towards people living with HIV and key populations?

⁵⁹² - These questions are also pertinent for the use of the African Commission, its subsidiary bodies and other African regional human rights mechanisms in promotional visits, fact-finding missions and other interactions on HIV-related human rights issues with Members States.

- › Has the State enacted confidentiality or privacy laws to protect people living with HIV and key populations against abusive disclosure and other violations of privacy and confidentiality?
 - › If any of the above laws have been adopted, provide information on the progress and challenges relating to their implementation.
- 4.** Specific questions relating to the right to information provided under Article 9 of the African Charter.
- › What information programmes are in place to promote access to scientifically accurate information on HIV-related prevention, treatment and care for all?
 - › Do these programmes appropriately address the needs and realities of key populations, children, persons with disabilities and other vulnerable populations?
 - › Provide information on the progress and challenges relating to the implementation of the above programmes.
- 5.** Specific questions relating to the right to freedom of association (Article 10) and the right to freedom of assembly (Article 11) under the African Charter.
- › Are people living with HIV allowed to form associations and register them?
 - › Are key populations (such as gay men and other men who have sex with men, transgender persons, people who use drugs or sex workers) allowed to form associations and register as organisations?
 - › Are there any restrictions on the ability of organisations to register, operate or receive funding? If yes, please specify.
 - › Are there restrictions on the ability of people living with HIV and key populations to assemble? If so, please specify.
- 6.** Specific questions relating to the right to freedom of movement and residence provided under Article 12 of the African Charter.
- › Does the State apply any restrictions to the entry, stay or residence of people living with HIV based on their HIV status?
 - › Does the State apply any restrictions to the entry, stay or residence of members of key populations?
 - › If any of the above restrictions exist, what measures are being taken to remove them? Please specify.
- 7.** Specific questions relating to the right to work under Article 15 of the African Charter.
- › Does the State have laws, regulations and specific programmes to protect and promote the rights of people living with HIV to do the work of their choice and to be free from discrimination in access to work? If so, provide information on the progress and challenges relating to the implementation of these laws, regulations and programmes.
 - › Does the State protect people living with HIV from arbitrary termination of employment? If so, provide information on the nature and implementation of such protection.
 - › What measures are being taken by the State to create an enabling working environment in relation to HIV in accordance with Recommendation 200 of the International Labour Organization?
- 8.** Specific questions relating to the right to enjoy the best attainable state of physical and mental health under Article 16 of the African Charter.
- › Has the State taken measures to ensure the right of people living with HIV and key populations to non-discrimination in access to health services?
 - › What programmes and measures are in place to ensure access to HIV and TB prevention, treatment and care—as well as other health-care services—for people living with HIV?
 - › Has the State taken measures to increase access to affordable medicines, including through the use of the flexibilities under the TRIPS Agreement?

- › If any of the above measures have been adopted, provide information on the progress and challenges relating to their implementation.

9. Specific questions relating to the right to education under Article 17 of the African Charter.

- › Has the State taken measures to ensure the right of people living with HIV and key populations to non-discrimination in access to education? If so, provide details on these measures as well as the progress and challenges relating to their implementation.
- › What education programmes are in place to promote information on HIV-related prevention, treatment and care for all? Do these programmes appropriately focus on key populations, children, persons with disabilities and other vulnerable populations?

10. Specific measures relating to the right to the family under Article 18(1) of the African Charter.

- › Has the State enacted laws protecting the rights of people living with HIV to marry and form a family? If so, provide details on these laws and the progress and challenges relating to their implementation.
- › Has the State enacted laws prohibiting child marriage in order to protect the rights of adolescents from harmful norms that place them at risk of HIV exposure? If so, provide details on these laws as well as the progress and challenges relating to their implementation.

11. Specific questions relating to the elimination of discrimination against women under Article 18(3) of the African Charter and to the promotion and protection of the rights of women under the Maputo Protocol.

- › Has the State enacted laws, regulations or programmes protecting and promoting the rights of women and girls to HIV and other health-care services? If so, provide information on the progress and challenges relating to the implementation of these laws, regulations and programmes.

- › Has the State taken measures to guarantee access to appropriate health and HIV services for women and girls without discrimination? If so, provide information on the progress and challenges relating to the implementation of these measures.

- › Do health programmes address the specific health needs—including sexual and reproductive health needs—of women living with HIV? If so, provide information on the progress and challenges relating to the implementation of these programmes.

- › Has the State taken measures to promote the health rights of pregnant women living with HIV and TB, including the right to access sexual and reproductive health care without discrimination, and the right to access services for PMTCT? If so, provide information on the progress and challenges relating to the implementation of these measures.

- › Has the State enacted laws to protect women from coercive and forced treatment (such as forced and coerced sterilisation)? If so, provide information on the progress and challenges relating to the implementation of these laws.

12. Specific questions relating to the protection of children under Article 18(3) of the African Charter and the African Children's Charter.

- › Has the State enacted laws, regulations or programmes protecting and promoting the rights of children and young people to access HIV and other health-care services? If so, provide information on the progress and challenges relating to the implementation of these laws, regulations and programmes.

- › Has the State taken measures to guarantee access to appropriate services without discrimination? If so, provide information on the progress and challenges relating to the implementation of these measures.

- › Has the State enacted age of consent laws to facilitate access to sexual and reproductive health services for adolescents and young people? If so, provide information on the progress and challenges relating to the implementation of these laws.
- › Does the State have policies and programmes to ensure the protection of children and adolescents (including orphans and vulnerable children) and to support their access to HIV services? If so, provide information on the progress and challenges relating to the implementation of these policies and programmes.
- › Does the State have policies and programmes to ensure the protection of young key populations and to support their access to HIV services? If so, provide information on the progress and challenges relating to the implementation of these policies and programmes.

13.

Specific questions relating to the measures for the protection of older persons and persons with disabilities under Article 18(4) the African Charter.

- › Has the State adopted laws, regulations or programmes that protect and promote the rights of older persons and persons with disabilities to access HIV and other health-care services? If so, provide information on the progress and challenges relating to the implementation of these laws, regulations and programmes.
- › Has the State taken measures to guarantee that older persons and persons with disabilities can access appropriate services without discrimination? If so, provide information on the progress and challenges relating to the implementation of these measures.
- › Does the State have policies and programmes to protect and support access to HIV services for older persons and persons with disabilities? If so, provide information on the progress and challenges relating to the implementation of these policies and programmes.

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Report on the Study of the African Commission on Human and Peoples' Rights

AFRICAN UNION

الاتحاد الأفريقي

AFRICAN COMMISSION ON
HUMAN & PEOPLES' RIGHTS



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Commission Africaine des Droits de
l'Homme & des Peuples