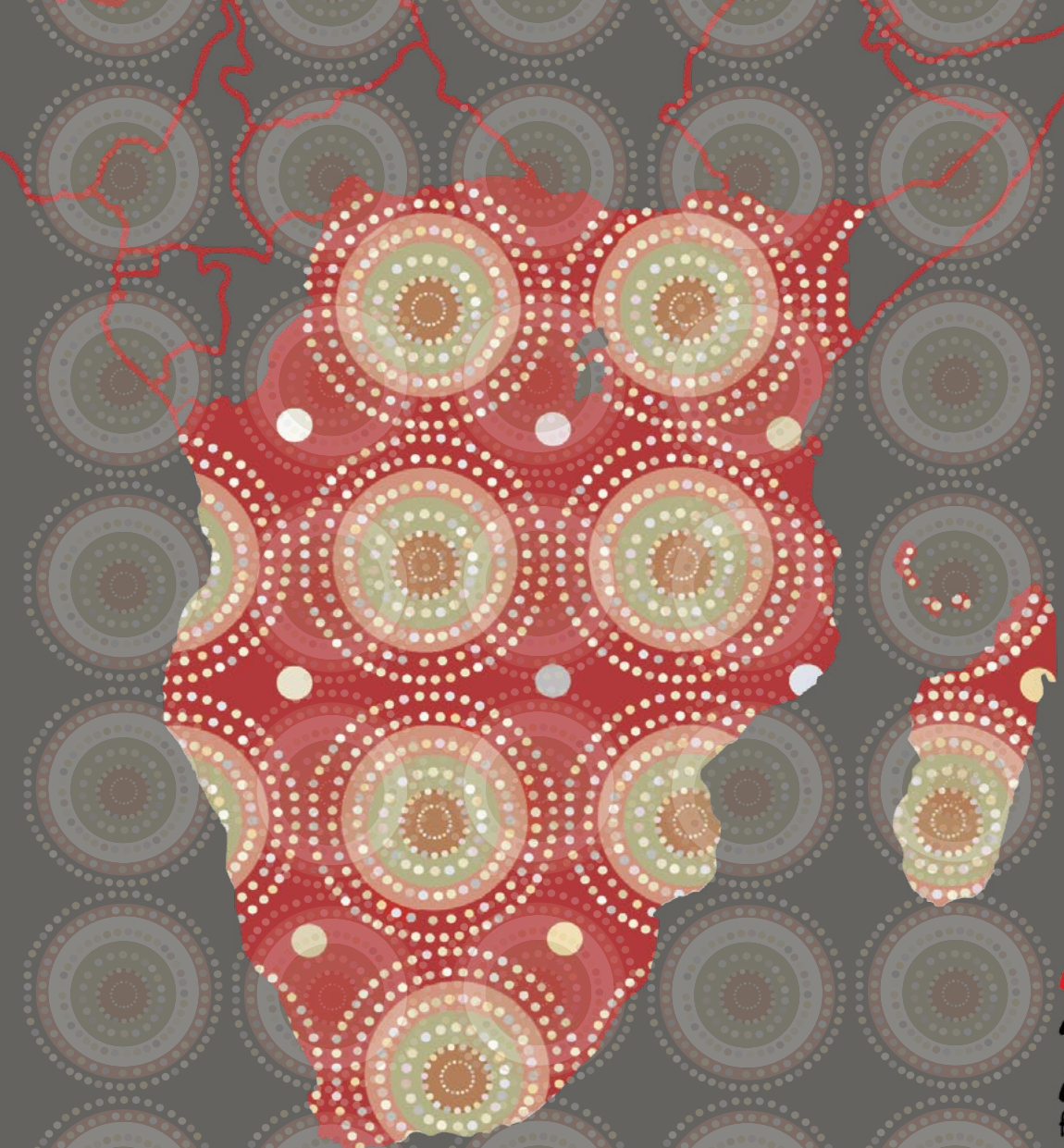
SEXUAL AND REPRODUCTIVE HEALTH, HIV, TB and HUMAN RIGHTS

in Southern and East Africa

2018/19



ARASA
AIDS & Rights Alliance for Southern Africa

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ABBREVIATIONS

ACHPR	African Commission for Human and Peoples' Rights
AGYW	Adolescent girls and young women
ARASA	AIDS and Rights Alliance for Southern Africa
ART	Antiretroviral therapy
ARV	Antiretroviral medicine
AU	African Union
CEDAW	Convention on the Elimination of All forms of Discrimination against Women
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
DRC	Democratic Republic of Congo
EAC	East African Community
eMTCT	Elimination of Mother to Child Transmission of HIV
FGM	Female Genital Mutilation
HBC	High Burden Country
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
IPR	Intellectual Property Rights
IPV	Intimate Partner Violence
GARPR	Global AIDS Response Progress Reports
GBV	Gender-Based Violence
GCHL	Global Commission on HIV and the Law
GFATM	Global Fund to fight AIDS, TB and Malaria
HCV	Hepatitis C
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex Persons
MDR-TB	Multidrug-Resistant TB
NGO	Non-Governmental Organisation
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-exposure Prophylaxis
REC	Regional Economic Commission
SADC	Southern African Development Community
SADC-PF	Southern Africa Development Community Parliamentary Forum
SALC	Southern African Litigation Centre
SDGs	Sustainable Development Goals
SEA	Southern and East Africa
SOGI	Sexual Orientation and Gender Identity
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
TPT	TB Preventive Therapy
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
UNHCR	United Nations High Commission on Refugees
UNICEF	United Nations International Children's Emergency Fund
UNGASS	United Nations General Assembly Special Session
US	United States
WHO	World Health Organization
XDR-TB	Extensively drug-resistant TB

KEY TO READING THIS REPORT

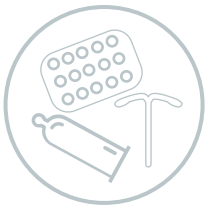
Throughout this report, you will see icons relating to key advocacy priorities that ARASA works on. Follow these icons and if you are interested in one topic in particular.

Advocacy

Cervical cancer

Child marriage

Condoms



Contraception

Criminalisation

Education

Finance

GBV

Girls

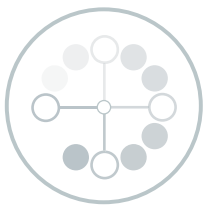
Human Rights

Hyperlink

Infrastructure

Intellectual Property

Key point



Key populations

Law

LGBTI

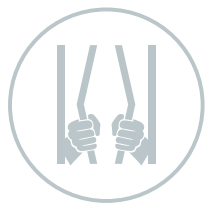
MSM

MTCT

Our work

PrEP

Prevention



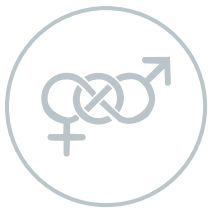
Prisoners

PWUD

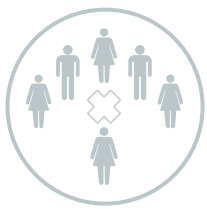
Rights

Safe abortion

Sex workers



SRHR



Stigma

TB

Treatment

VMMC

Women

Women and Girls

Women and HIV

ABOUT ARASA

The AIDS and Rights Alliance for Southern Africa (ARASA) was established in 2002 as a partnership of civil society organisations to galvanise a movement of progressive civil society actors to advance a human rights-based response to HIV in southern Africa. Over the past 16 years, the partnership has grown in size, diversity and geographic coverage, which has expanded to 18[1] countries in southern and east Africa (SEA).

ARASA seeks to contribute towards the creation of just, equal, productive and resilient societies in SEA, in which social justice and human dignity are at the centre of all development, policy and organising; and health and wellbeing are promoted for sustainable development. We envision an inclusive and diverse SEA, where the rights to bodily autonomy and integrity are respected and protected.

ARASA is the only partnership of its kind in this region and our partners are diverse in their scale, focus and expertise. They include networks of people living with HIV, key population groups, legal aid organisations, youth groups, women's organisations and AIDS service organisations.

Central to all ARASA's programme areas is the recognition that the protection of human rights remains critical to the successful realisation of sexual and reproductive health and rights (SRHR), including responses to HIV and its co-infections, in SEA. Punitive and discriminatory laws, policies and practices remain major obstacles to meeting the target of universal access to health care. Protection of human rights and gender equality promotes the health and development of all people, including vulnerable and key populations. The denial of human rights, such as the rights to non-discrimination, liberty and security of the person, education, health and social assistance increases vulnerability to poor sexual and reproductive health, HIV and TB infection and also increases the impact of poor health on the lives of those affected.

ARASA achieves these objectives through two synergistic programme pillars of Capacity Strengthening and Advocacy, implemented through a multi-dimensional, multi-level and multi-directional operational approach.

The ARASA partnership is supported by a team of 12 staff members which operates out of the head office in Windhoek, Namibia as well as remotely in South Africa and Uganda.

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ARASA
AIDS & Rights
Alliance
for Southern Africa

Uganda
DRC
Angola
Zambia
Zimbabwe
Namibia
Botswana
Lesotho
South Africa

ARASA works in 18 countries in Southern and East Africa

Kenya
Seychelles
Tanzania
Comores
Malawi
Mauritius
Madagascar
Mozambique
Swaziland

SECTION 1

ABOUT THIS REPORT

1.1 Background

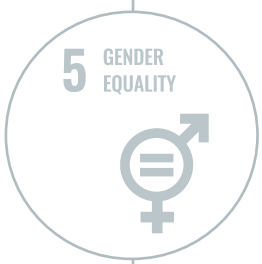
Since 2006, the AIDS and Rights Alliance for Southern Africa (ARASA) has produced a series of human rights reports examining countries' commitments and obligations to ensuring an enabling legal and policy framework in the response to HIV, tuberculosis (TB) and sexual and reproductive health (SRH). ARASA produced its first report on HIV and Human Rights in southern Africa in 2006, followed with an update in 2009, which documented the extent to which countries were promoting rights-based responses to HIV and TB.

Later, the 2014 report expanded its geographic focus to include information on the HIV, TB and human rights situations in Kenya and Uganda, increasing the number of countries covered in the report to 18 in southern and east Africa (SEA). The 2016 report covered 18 countries and included additional information on TB-related stigma, discrimination and punitive laws, access to HIV clinical management tools (including viral load testing) as part of the HIV treatment cascade, and intellectual property barriers to access to HIV, TB and Hepatitis C (HCV) medicines. The 2016 report also documented critical gaps in addressing the health needs of vulnerable and key populations, including lesbian, gay, bisexual, transgender and intersex (LGBTI) populations, people who use drugs, young people and people affected by TB.

This series of reports has been a significant resource over the last 12 years. The reports have been extensively quoted in publications on HIV, TB, law and human rights by numerous stakeholders and have been used by regional and country partners to assess the state of legal and human rights responses to HIV, TB and more recently, SRH in their countries and the region, and to prioritise areas for advocacy and action.

This series of reports has been a significant resource over the last 12 years.

The human rights reports examine countries' commitments and obligations to ensuring an enabling legal and policy framework in the response to HIV, tuberculosis (TB) and sexual and reproductive health (SRH).



1.2 Aim of the 2018/9 Report

The 2030 Agenda for Sustainable Development creates 17 indivisible goals (called the Sustainable Development Goals, the SDGs) and 169 targets, driven by the principle of "leaving no one behind", to ensure integrated efforts to achieve sustainable development across the world.

ARASA's work is guided by these interlinked SDGs, other international and regional frameworks and by the strengthened focus on addressing structural barriers to health, including SRH and HIV & TB prevention, inherent in the 17 SDGs. Recognising the intersectionality between poverty, human rights and gender equality, ARASA recognises that effective responses to SRH, including HIV, requires countries in SEA to strengthen the focus on protecting sexual and reproductive health and rights (SRHR) within a broader framework of integrated efforts to address a number of cross-cutting SDGs. Key to this is the protection of every person's rights to equality and to bodily autonomy and integrity, so that every person can control their own body, define their sexuality, choose their partner and receive high quality, confidential and voluntary health services without discrimination.

SDGs 3, 5 and 10 are inextricably linked with other goals, requiring efforts to address issues around human rights, gender equality and good governance in order to reduce sexual and reproductive health risks, including HIV and TB risks, for vulnerable and key populations, and to ensure the health and development of all people.

ARASA's work on sexual and reproductive health and rights reflects:

- The importance of promoting sexual and reproductive health and rights, including promoting respect for and protecting the rights to bodily autonomy and integrity in order to reduce inequality, including gender inequality, promote health, dignity and wellbeing.
- The need to promote social justice, Universal Health Coverage (UHC) and the achievement of the SDGs.
- The importance of addressing the structural and social barriers to achieving health goals (Goal 3) and reducing inequality (Goals 5 and 10), building on years of work around human rights-based responses to HIV to an expanded focus on SRHR more broadly.

- A continued strong focus on those populations in danger of being "left behind", including adolescent girls and young women (AGYW), young people and key populations such as LGBTI persons, people who use drugs, sex workers and prisoners.

- A strong focus on accountability to regional and international commitments and the need to set targets and indicators, based on the SDGs, and to ensure that reporting is done in terms of these commitments.

In light of countries' commitment to achieving the SDGs and ARASA's current strategic plan, this report examines the national legal frameworks for promoting an integrated, rights-based HIV and SRH response in countries in SEA. In particular, the report examines whether these legal frameworks:

- Protect and promote an integrated and rights-based HIV and SRH response;
- Protect people, particularly vulnerable and key populations, from HIV and its co-infections; and
- Ensure that vulnerable and key populations are aware of their SRHR and able to access justice for violations of their SRHR.

The report also identifies and analyses important national and regional developments towards building enabling legal, policy and regulatory frameworks.

Finally, this report highlights key achievements made towards ensuring an enabling legal framework and identifies existing gaps and challenges that need to be addressed for a rights-based, integrated SRH and HIV response. As a result, this report seeks to serve as an important resource for promoting accountability at national and regional level for reducing inequalities, including gender inequality, protecting the SRHR of all, and achieving the SDGs.

1.3 Overview

The report is organised as follows:

SECTION 2

Section 2 outlines countries' legal obligations and their other commitments to provide, protect and promote SRHR. It also provides recent statistics on specific SRH issues, including HIV and its co-infections, TB and HCV.

SECTION 3

Section 3 broadly examines the extent to which the region has addressed social and structural barriers to SRH created by discriminatory and punitive laws, policies, social norms and values and practices. It focuses on select, key issues including:

- access to contraception;
- access to comprehensive sexuality education (CSE);
- access to safe abortion;
- access to HIV, TB and HCV prevention, treatment and care;
- protection from and management of sexual and gender-based violence, as well as laws, policies and practices that create vulnerability to SRH risk and create barriers to access to healthcare for vulnerable and key populations such as laws criminalising HIV transmission;
- laws criminalising same-sex sex, sex work and drug use;
- age of consent laws barring young people from independent access to reproductive healthcare; and
- laws allowing for child marriage.

It identifies achievements, as well as major gaps in legal, regulatory and policy frameworks towards achieving SDGs 3, 5 and 10 in the context of SRHR.

SECTION 4

Section 4 looks at access to justice and the extent to which people know and are able to enforce their rights. It includes a strong focus on progress made in access to justice, including strengthened access to justice through the courts and strategic litigation in the region.

SECTION 2

SRH, HIV, TB AND HUMAN RIGHTS IN SOUTHERN AND EASTERN AFRICA

The aim of this section is to outline countries' legal obligations and their other commitments with respect to key SRH issues, including HIV and its co-infections, and also to provide an overview of global and regional statistics on key SRHR issues in SEA.

2.1 Introduction

In SEA, as with much of the world, people have insufficient access to comprehensive SRH services. While there have been significant gains in increasing access to treatment for HIV and TB, contraception and in certain SRHR issues, adolescent sexuality, access to SRHR for vulnerable and key populations, sexual and gender-based as well as intimate partner violence, access to safe abortion and appreciation of and protection of sexual orientation and gender identity (SOGI)- remain neglected.

Access to comprehensive sexual and reproductive health services and respect for SRHR is fundamental to promoting the health and welfare of all persons and to achieving universal health coverage and the SDGs. Progress in achieving SRHR goals and targets requires addressing laws, policies and practices – particularly gender inequality – that create barriers to the enjoyment of sexual and reproductive health and rights. It requires improving people's ability to make their own decisions about their SRH and their sexual and reproductive lives.[2]

Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction.

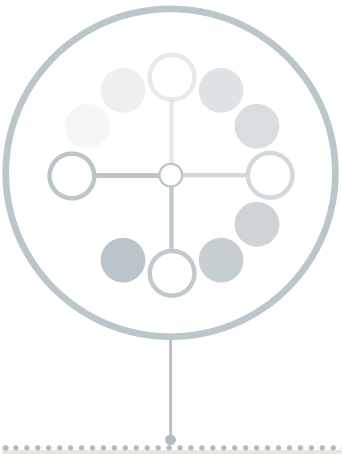
Integrated definition of sexual and reproductive health and rights

Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in promoting self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right.

Achieving sexual and reproductive health relies on realising sexual and reproductive health and rights which are based on the human rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when and whom to marry;
- decide whether, when and by what means to have a child or children, and how many children to have; and
- have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence.[3]

Vulnerable and key populations



Countries are obligated under international and regional law to provide, promote and protect SRHR, including prohibiting discrimination and removing structural barriers to SRHR. In addition, there is robust international agreement about the advantages of integrating SRH and HIV services:

SRH services can provide a platform for reaching especially women and children with HIV-related care, while HIV services provide an entry point for key SRH services such as contraception, antenatal care and cervical cancer screening.[4]

In addition to cross-cutting standards, the particular obligations and commitments of SEA countries on the following SRHR issues and to the following vulnerable and key populations are provided in the chart below:

- Access to contraception
- Comprehensive sexuality education
- Access to abortion and post-abortion care
- Access to HIV prevention and treatment services and for other sexually transmitted infections (STIs)
- Access to TB prevention and treatment services
- Access to sexual health services
- Access to services for reproductive cancers
- Age of consent to sex and marriage
- Prevention of and responses to gender-based violence
- Sex workers
- Criminalisation of HIV transmission, exposure and non-disclosure
- LGBTI people
- Criminalisation and punitive measures related to TB
- People who use drugs
- Intellectual property and access to medicines, including TRIPS.

The obligations and commitments have been drawn from the following international and regional laws and policies, international and regional guidance and goals, and recommendations from expert reports.

International and regional treaties and policies and related documents

- African Commission on Human and Peoples' Rights, 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, 2014.[5]
- African Commission on Human and Peoples' Rights, General Comment No. 1 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.[6]
- The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[7]
- Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030.[8]
- The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.[9]
- Southern African Development Community (SADC) Gender Protocol.[10]

International and regional guidance and goals

- → Fast Track Commitments to end AIDS by 2030.[11]
- → African Union (AU) 2063 Agenda.[12]
- → Common African Position on the World Drug Problem, 2016.[13]
- → International Conference on Population and Development Programme of Action.[14]
- → Maputo Plan of Action 2016-2030.[15]
- → The 2030 Agenda for Sustainable Development.[16]
- → SADC Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region.[17]
- → SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations, 2018.[18]

- → AU Catalytic Framework to end AIDS, TB and Malaria in Africa by 2030.[19]
- → UNAIDS Agenda for Zero Discrimination in Health-Care Settings.[20]
- → The African Committee of Experts on the Rights and Welfare of the Child Africa's Agenda for Children 2040.[21]
- → Organization of African Unity, Abuja Declaration on HIV/AIDS, TB and Other Related Infectious Diseases, 2001.[22]
- → World Health Organization (WHO) Africa Health Strategy: 2007 – 2015.[23]
- → Nairobi Strategy: A Human Rights-Based Approach to TB.[24]
- → Ten Commandments on MDR-TB.[25]
- → AU Gender Policy, 2009.[26]
- → Eastern and Southern African Commitment on Comprehensive Sexuality Education, 2015.[27]
- → AU Addis Ababa Declaration on Population and Development in Africa beyond 2014, 2013.[28]
- → SADC Framework for target setting for HIV Prevention in the SADC Region, 2017.
- → SADC SRHR Strategy and Scorecard (2019-2030), 2018[29]

Expert recommendations from the following reports:

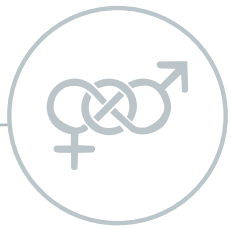
Accelerate progress - sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission[30]

Global Commission on HIV and the Law (GCHL), Risks, Rights and Health (Supplement)[31]

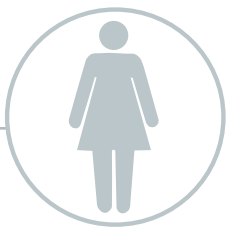
World Health Organization and the World Bank, Tracking Universal Health Coverage: 2017 Global Monitoring Report [32]

There are some clear cross-cutting standards outlined in international and regional law and policies, and by expert bodies, recommending that States:

Remove legal, regulatory and policy barriers limiting access to SRH commodities, programmes and services.[33]

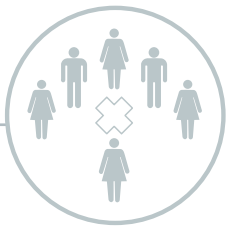


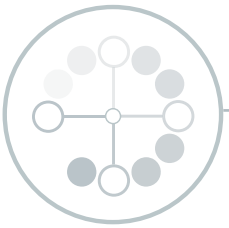
Imperatively take all necessary measures to remove socio-cultural structures and norms that promote and perpetuate gender-based inequality. This includes a review of cross-cutting forms of discrimination contained in laws, policies, plans, administrative procedures and the provision of resources, information and services concerning contraception/family planning and safe abortion, in the limited cases listed.[34] States Parties should pursue by all appropriate means and without delay a policy of eliminating discrimination against women. In particular, countries should ensure that national constitutions and other legislation embody the principle of the equality of men and women, including sanctions where appropriate, prohibiting all discrimination against women, to establish legal protection of the rights of women on an equal basis, to refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation, to take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise, to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women, and to repeal all national penal provisions which constitute discrimination against women.[35]



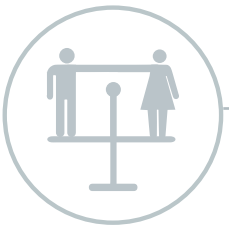
Ensure that the necessary legislative measures, administrative policies and procedures are taken to ensure that no woman is forced because of her HIV status, disability, ethnicity or any other situation, to use specific contraceptive methods or undergo sterilization or abortion.[36]

Enact anti-discrimination legislation to address HIV- and other sexually transmitted infections, related discrimination, stigma, prejudices and practices that perpetuate and heighten women's risk to HIV and related rights abuses.[37] Where discriminatory laws and policies exist, States must take immediate action to remove these legal and policy barriers that hinder women's access to sexual and reproductive health services.[38]



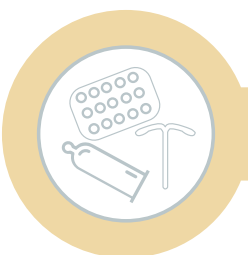


Address discrimination and violence affecting key and vulnerable populations.[39]



Implement national HIV strategies that empower people living with, at risk of, and affected by HIV, to know their rights and to access justice and legal services to prevent and challenge violations of human rights, including strategies and programmes aimed at sensitising law enforcement officials, members of the legislature and judiciary, training health care workers in non-discrimination, confidentiality and informed consent, supporting national human rights learning campaigns, as well as monitoring the impact of the legal environment on HIV prevention, treatment, care and support.[40]

In addition to the cross-cutting standards outlined above, standards for particular issues covered in this report are outlined below.



Access to contraception

Women have the right to access to contraception based on the right to control their fertility; to decide whether to have children, the number of children and the spacing of children; and to choose any method of contraception.[41] Thus, countries are obligated to ensure laws and policies provide for such access and redress measures are widely available when such access is not provided. Countries have the obligation to provide services that are comprehensive, integrated and rights-based. They must develop laws that are accompanied by administrative appeal and complaint mechanisms which allow women to fully exercise their rights so that they can clearly understand the procedures and reasons that led them to being denied family planning/contraception services and how to challenge such a decision, with a view to exercising the remedies provided within the timelines.[42]

Family planning / contraception services should include women's access to a variety of contraceptive methods, including short-term methods (hormonal contraceptives, male and female condoms, emergency contraception), long-term (implants, injections, IUDs, vaginal rings) and permanent ones (voluntary sterilization). Access to new technologies based on available evidence, when available, including, but not limited to, spermicidal microbicides, should also be included. Such services should be provided through both family planning/contraception programs and under post-abortion care.[43] Administrative

laws, policies and procedures of health systems and structures cannot restrict access to family planning/contraception on the basis of religious beliefs.[44] Further, countries cannot limit access to family planning/contraception services by health care providers for reasons of conscientious objection. While it is true that they may invoke conscientious objection to the direct provision of the required services, countries must ensure that the necessary infrastructure is set up to enable women to be knowledgeable and referred to other health care providers on time. In addition, countries must ensure that only the health personnel directly involved in the provision of contraception/family planning services enjoys the right to conscientious objection and that it is not so for the institutions. The right to conscientious objection cannot be invoked in the case of a woman whose health is in a serious risk, and whose condition requires emergency care or treatment.[45]

Countries must ensure that individuals have the necessary information on family planning.[46] The measures required of countries include: (a) training or upgrading healthcare providers and competent educators regarding complete information to provide to clients, including the causes of the failure of the practiced contraception method and the options that are available, if the said failure results in an unintended pregnancy; b) ensuring that available, accessible, acceptable and reliable information on contraceptive methods is provided, in printed form or by other means, such as the internet, radio and television, mobile phone applications, and other telephone assistance service; (c) enabling the structures of health facilities, institutions and teaching programmes, as well as civil society organisations which are duly competent, to provide the relevant population with necessary information and education on family planning/contraception; d) ensuring that information on family planning/contraception is provided to communities in accessible languages and in a form that is accessible to all women and girls, including those with disabilities.[47]

States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.[48]

Comprehensive sexuality education (CSE)

In addition to providing individuals with relevant health information, countries must ensure provision of comprehensive information and education on sex, sexuality, HIV, reproduction and sexual and reproductive rights. The content must be based on evidence, facts, and clinical findings, be rights-based, including promoting gender equality, be without judgement, be incremental, age and developmentally appropriate, curriculum-based, comprehensive and culturally relevant and context appropriate.[49] It should also be understandable in content and language. This information and education should

address all taboos and misconceptions relating to sexual and reproductive health issues, deconstruct men and women's roles in society, and challenge conventional notions of masculinity and femininity which perpetuate stereotypes harmful to women's health and well-being.[50]

The education must target children, adolescents and youth, both in and out of school with age-appropriate and culturally sensitive comprehensive sexuality education that involves parents and communities.[51]

Countries must ensure that educational institutions at primary, secondary and tertiary levels include sexual and reproductive rights issues in their school programs and take the necessary measures so those programs also reach women in private schools, including faith-based schools, as well as those out of school.[52]

Key factors for CSE: scientifically based; incremental; age and developmentally appropriate; curriculum-based; comprehensive; based on a human rights approach; based on gender equality; culturally relevant and context appropriate; transformative; able to develop life skills needed to support healthy choices.[53]

At a minimum, countries should review and revise Ministry of Education and other related policies to ensure the integration of SRH and HIV and the provision of CSE for children, adolescents and youth, including those who are not at school.[54]

Countries should ensure that the design and delivery of CSE and SRH programmes includes ample participation by communities and families and should initiate and scale up age-appropriate CSE during primary school education.[55]

Access to abortion and post-abortion care

Countries shall take all appropriate measures, including through legal and policy measures, to protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.[56] Evidence of prior psychiatric examination is not necessary to establish the risk to mental health.[57]

Countries are urged to adopt legal policies and frameworks so as to reduce cases of unsafe abortion, as well as to develop and implement national action plans in order to mitigate the prevalence of unintended pregnancies and unsafe abortions. The WHO reiterates that if States do not remove the legal and administrative barriers that impede women's access to safe abortion services, they cannot meet their international obligations to respect, protect, promote and implement the right to non-discrimination.[58]

Women must not be subjected to criminal proceedings and should not incur any legal sanctions for having benefited from health services that are reserved to them such as abortion and post-abortion care. Health personnel should not fear neither prosecution, nor disciplinary reprisal or others for providing these services, in the cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.[59]

Safe abortion services should include the methods recommended by WHO, and based on clinical findings, including procedures such as evacuation, dilation and intrauterine manual or electric suction, as well as the use of other efficient methods or medicines that might become available in the future. The equipment and medicines recommended by WHO should be included in the lists of national essential products and medicines. Techniques such as dilation and curettage should be replaced with safer methods.[60]

Countries should avoid all unnecessary or irrelevant restrictions on the profile of the service providers authorised to practice safe abortion and the requirements of multiple signatures or approval of committees, in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. In many African countries, there are not enough trained physicians available. Mid-level providers such as midwives and other health workers should be trained to provide safe abortion care. The training of health workers should include non-discrimination, confidentiality, respect for the autonomy and free and informed consent of women and girls.[61]

Access to HIV prevention and treatment services and for other STIs

Law and policies should provide for universal access to HIV treatment.[62] Countries should develop policies which address prevention of mother-to-child transmission and child survival using the 'double dividend' approach.[63]

Countries must guarantee available, accessible, affordable, comprehensive and quality women-centered HIV prevention methods, which include female condoms, microbicides, prevention of mother-to-child transmission, and post-exposure prophylaxis to all women and should not be based on a discriminatory assessment of risk.[64]

Countries should ensure that HIV testing is not used as a condition for accessing family planning/contraception and safe abortion services. When women reveal their HIV status, positive tests must not serve as pretexts to the use of coercive practices or the suspension of service provision.[65]

Countries should provide educational programmes and access to information concerning HIV, including through CSE, education and public awareness campaigns, on available health services responsive to all women's realities in all contexts. In addition,

countries should ensure that educational institutions (primary and secondary schools) include HIV and human rights issues in their curricula. These should include HIV risk and transmission, prevention, testing, treatment, care and support and SRHR of women. Countries must also ensure this education reaches women and girls in informal school systems including faith-based schools, as well as those out of school.[66]

Women should also have access to adequate, reliable, non-discriminatory and comprehensive information about their health. This involves access to procedures, technologies and services for the determination of their health status. In the context of HIV, this right includes, but is not limited to: access to HIV testing, CD4 count, viral-load, TB and cervical cancer screening. It also includes pre-test counselling which enables women to make a decision based on informed consent before taking the test, as well as post-test counselling services on preventative measures or available treatment depending on the outcome of the HIV test.[67]

In view of the serious nature of HIV testing and in order to maximise prevention and care, public health legislation should ensure that pre-and post-test counselling be provided in all cases. With the introduction of home-testing, States Parties should ensure quality control, and establish legal and support services for those who are the victims of misuse of such tests by others.[686970]

The 2040 Agenda aims to have children living with HIV identified and provided with anti-retroviral treatment and to ensure they are sustained on treatment to achieve viral load suppression.[71]

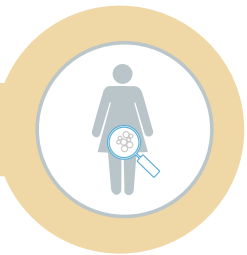
Countries should promote an enabling policy, legal and social environment to reduce vulnerability and promote human rights in the context of HIV, with a strong focus on vulnerable and key populations.[72]

Countries should adopt a public health approach that addresses the criminalization and punishment of drug possession and use and provides for prevention, treatment and support, including harm reduction services, including in prisons.[73]

Access to TB prevention and treatment services

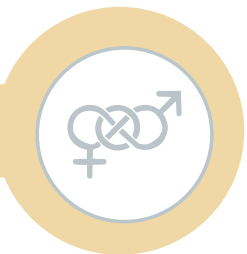
Countries should work with communities affected by TB to define its key populations, to plan and implement appropriate services and to measure progress towards reaching these populations. They should enhance the capacity of key stakeholders including the judiciary and legal community, policymakers, legislators, and healthcare workers' awareness on implementation of a human rights-based approach to TB.[74]

Access to TB prevention and treatment services



Countries are urged to address the rising burden of reproductive cancers, including breast, cervical and prostate cancers, by investing in prevention strategies including the human papillomavirus (HPV) vaccine and routine screening, early treatment at the primary care, and reliable referrals to higher levels of care.[75]

Access to sexual and reproductive health services



Countries shall take all appropriate measures to provide adequate, affordable and accessible sexual and reproductive health services, including information, education and communication programmes to women especially those in rural areas and should remove impediments to health services reserved for women, including ideology or belief-based barriers.[76]

Countries are required to ensure comprehensive, integrated, rights-based, women-centred and youth friendly services that are free of coercion, discrimination and violence; to develop a national public health plan with comprehensive sexual and reproductive health services, protocols, guidelines and standards that are consistent with current evidence-based standards; and remove administrative discriminatory laws, policies, procedures and practices so that women in all their diversity can claim their reproductive freedom and rights.[77]

Countries are obliged to guarantee the availability, accessibility and affordability of comprehensive and quality procedures, evidence-based technologies and services for the medical monitoring of one's sexual and reproductive health. These procedures, technologies and services should be evidence-based and should be appropriate to the specific needs and context of women.[78]

Countries should develop policies that support the provision of essential reproductive health commodities, age-appropriate services and information to adolescents and youth, especially sanitary pads and male and female condoms and contraceptives; review and revise or develop new policies that support access to integrated SRH and HIV services for key populations, especially adolescents, youth, migrant populations, LGBTI persons and people with disabilities; and develop or enact laws that ensure access to and utilisation of SRH and HIV services by key populations.[79]

Countries should urgently review - and where necessary amend - existing laws and policies on age of consent, to improve independent access to sexual and reproductive health services for adolescents and young people and also to protect children. Laws, policies and practices regulating access to services and in child protection must recognise the need for a balance between protection and autonomy and the evolving capacity of adolescents as they begin to make their own choices about their education and health needs.[80]

Gender-based violence

Countries shall adopt and implement appropriate measures to ensure the protection of women in all their diversity from all forms of violence, particularly sexual violence, take appropriate and effective measures to enact and enforce laws to prohibit all forms of violence against women, adopt such other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women, identify the causes and consequences of violence against women and take appropriate measures to prevent and eliminate such violence, actively promote peace education through curricula and social communication in order to eradicate elements in traditional and cultural beliefs, practices and stereotypes which legitimise and exacerbate the persistence and tolerance of violence against women, punish the perpetrators of violence against women and implement programmes for the rehabilitation of women victims, establish mechanisms and accessible services for effective information, rehabilitation and reparation for victims of violence against women, and provide adequate budgetary and other resources for the implementation and monitoring of actions aimed at preventing and eradicating violence against women.[81]

Countries should ensure that laws on gender-based violence provide for the comprehensive treatment, testing and care of survivors of sexual offences, which include emergency contraception; ready access to post-exposure prophylaxis at all health facilities to reduce the risk of contracting HIV; and preventing the onset of STIs. Countries shall ensure that cases of gender-based violence are conducted in a gender sensitive environment and establish special counselling services, legal and police units to provide dedicated and sensitive services to survivors of gender-based violence.[82]

Countries should eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking, and sexual and other types of exploitation.[83]

Age of consent to sex and marriage

Sex: Countries are required to provide a specific age of consent to sexual activities. Countries are required to ensure that specific legal provisions are provided for under domestic law that clearly set a minimum age for sexual consent. Further, the minimum age for sexual consent should be the same for males and females and that the minimum age should reflect the evolving capacity, age and maturity of the child.[84]

Marriage: Eighteen has been legally recognised under international treaties and bodies as the age when adolescents have the necessary maturity to be defined and treated as adults.[85] However, limited exceptions to 18 as the minimum age of marriage are permitted with three specific limitations: that the exceptions only apply to children 16 or older; that there be judicial consent for the marriage; and that there be no age distinction between females and males.

Criminalisation of HIV transmission, exposure and non-disclosure

Countries should repeal laws that criminalise HIV transmission, HIV exposure or failure to disclose HIV status.[86]

Countries should review convictions for HIV exposure, non-disclosure and transmission where scientific and medical facts[87] and general criminal law principles have not been applied. Such convictions should be set aside or the accused released from prison with pardons or similar actions in order to ensure that the charges do not remain on criminal or sex offender records.

In countries where HIV criminalisation laws still exist, courts must require proof, to the applicable criminal law standard, of intent to transmit HIV. The intent to transmit HIV cannot be presumed or derived solely from knowledge on the part of the accused of positive HIV status and/or non-disclosure of that status; from engaging in unprotected sex; by having a baby without taking steps to prevent mother-to-child transmission of HIV; or by sharing drug injection equipment.[88]

Criminalisation and punitive measures related to TB

Countries should repeal laws and end practices that criminalise patients with TB who fail or refuse to take their treatment, including through forcing them to have treatment or be hospitalized, isolating them and detaining them in prisons, and subjecting them to home arrests and travel restrictions.[89]

Sex workers

Countries should repeal laws that prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit sex work, such as laws against "immoral" earnings, "living off the earnings" of prostitution and brothel-keeping.

Countries should ensure that existing civil and administrative offences such as "loitering without purpose", "public nuisance", and "public morality" are not used to penalise sex workers and administrative laws such as "move on" powers are not used to harass sex workers.

Complementary legal measures must be taken to ensure safe working conditions for sex workers. Countries should take all measures to stop police harassment and violence against sex workers and prohibit the mandatory HIV and STI testing of sex workers.[90]

LGBT people

All laws criminalising consensual sex between adults of the same sex and/or laws that punish homosexual identity should be repealed.[91]

Countries should remove legal, regulatory and administrative barriers to the establishment, registration and operation of community organisations by or for gay men and other men who have sex with men, lesbian, bisexual, trans and intersex people. Countries should amend anti-discrimination laws expressly to prohibit discrimination based on sexual orientation and gender identity. They should promote effective measures to prevent violence against men who have sex with men.[92]

People who use drugs

Countries should decriminalise the possession of drugs for personal use, in recognition that the net impact of such sanctions is often harmful to society.

They should shut down all compulsory drug detention centres for people who use drugs and replace them with evidence-based, voluntary services for treating drug dependence. Countries should abolish national registries of drug users, mandatory and compulsory HIV testing and forced treatment for people who use drugs.[93]

Intellectual property and access to medicines, including TRIPS

Countries should utilize existing TRIPS flexibilities to ensure that infants, children and adolescents living with HIV have equal access to HIV diagnosis and age-appropriate treatment as adults. Countries should facilitate collaboration and sharing of technical expertise in pursuing the full use of TRIPS exceptions (for instance, by issuing compulsory licenses for antiretroviral medicines (ARVs) and medicines for co-infections such as HCV). Countries should proactively use other areas of law and policy such as competition law, price control policy and procurement law which can help increase access to pharmaceutical products.[94]

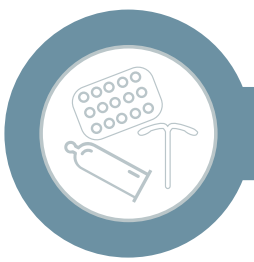
2.2 Data on sexual and reproductive health including HIV, TB and viral hepatitis.

This section presents global and SEA regional data on SRH. The issues covered are as follows:

- Access to contraception;
- Abortion;
- Reproductive cancers;
- Gender-based violence;
- STIs, including HIV and its co-infections TB and HCV.

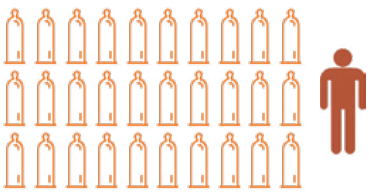
2.2.1 Sexual and reproductive health data and trends

There is insufficient consistent data available in SEA countries to provide a strong regional picture; however, the following data presents a regional overview of SRH issues in SEA.



2.2.1.1 Access to contraception

According to the Guttmacher-Lancet Commission 2018 report, the use of modern contraceptives has increased steadily since the 1980s in Africa, Asia, Latin America, the Caribbean and Europe. By 2015, more than half of all married (and in-union) women worldwide and in every major region were using a modern contraceptive method, except in Africa where that figure was 32%. According to 2017 estimates, 214 million women of reproductive age (13% of women aged 15–49 years) in developing regions have an unmet need for modern contraception.[95]

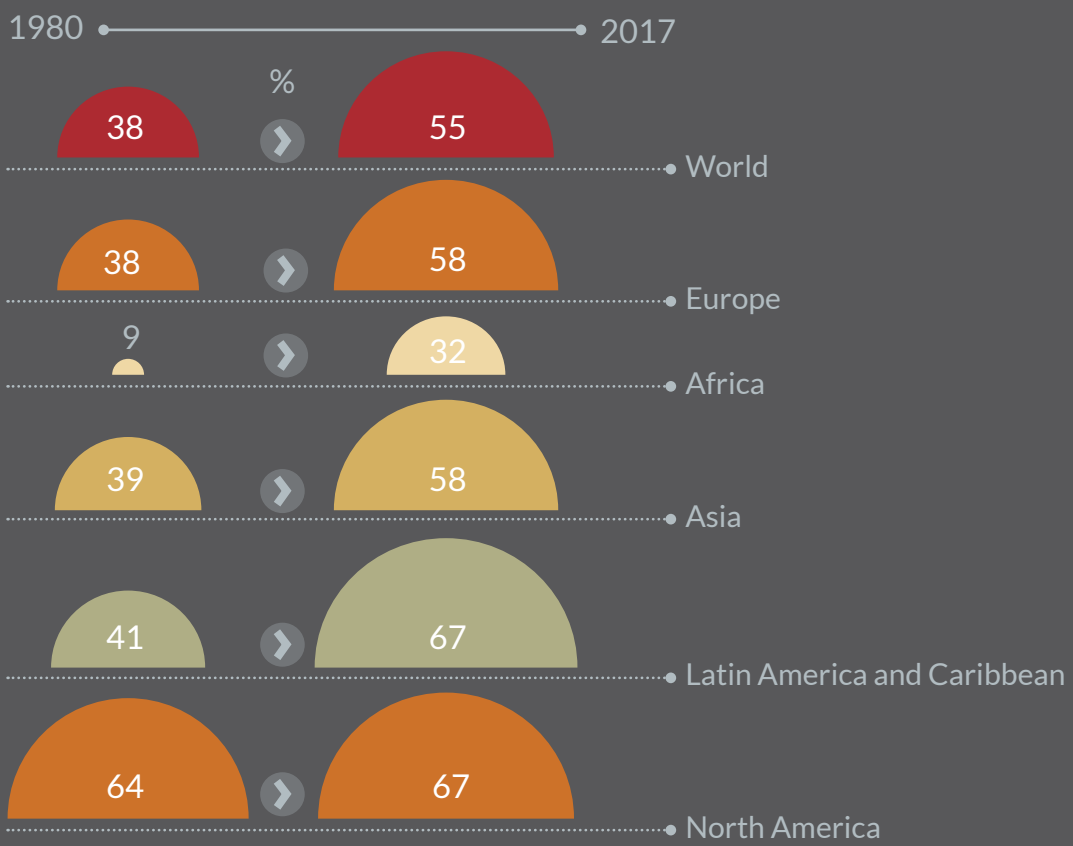


only **5** of the region's countries met the UNFPA regional benchmark of 30 male condoms distributed per man per year (2011–2014).

New estimates for all women of reproductive age show that about half of the 1.6 billion women of reproductive age who live in developing regions in 2017, want to avoid a pregnancy (either postpone or stop childbearing) and therefore need contraception. For example, the proportion of married or in-union women aged 15–49 years who wanted to avoid pregnancy in eastern Africa increased from 43% in 1990 to 65% in 2017. In Africa, just 53% of women who need modern contraception are using it; the poorest women tend to have the lowest access to modern contraception when needed.[96]

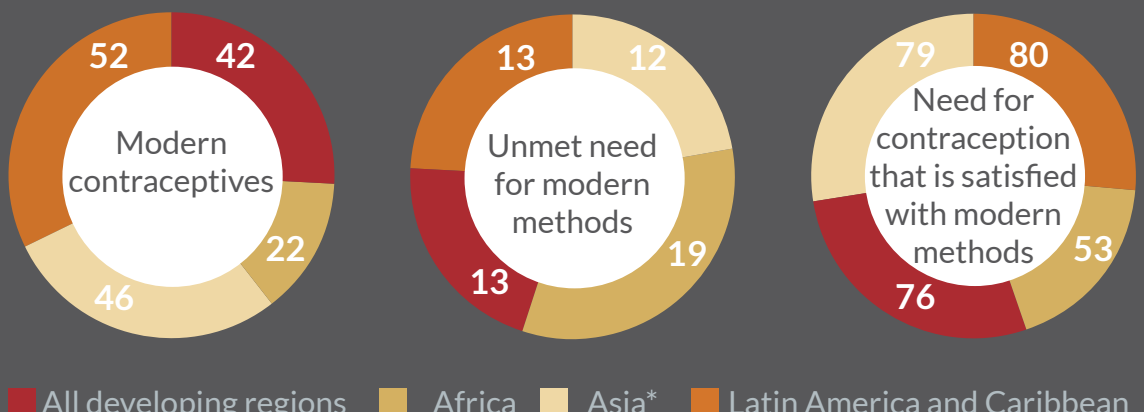
UNAIDS data[97] shows that overall levels of condom use remain low in sub-Saharan Africa. In 23 of 25 countries in sub-Saharan Africa with available data, condom use during last sexual act amongst men with multiple sexual partners was lower than 50%. In the SEA region, condom availability for men aged 15–64 years varied widely by country, with only 5 of the region's countries meeting the United Nations Population Fund (UNFPA) regional benchmark of 30 male condoms distributed per man per year (2011–2014).

Proportion of married or in-union women using modern contraception, 1980–2017



Data from UN Department of Economic and Social Affairs, Population Division, 2017.

Proportion of all women aged 15–49 years who use modern contraception, who have unmet need for modern methods, and who have a contraceptive need that is satisfied with use of modern methods, 2017



*Data from Darroch JE et al, 2017. *Includes eastern Asia (predominantly China) and Oceania*

Namibia had the highest level of availability of male condoms, with 54 available per man per year, followed by eSwatini (51), Botswana (50), Zimbabwe (33) and Lesotho (31); in Angola and South Sudan only 5 and 0.4 condoms per man per year were available, respectively.

Women in the region were even more underserved: female condoms accounted for a small fraction of the condoms procured in 2015. This lack of condom availability contributed to levels of condom use that were not high enough to significantly curtail rates of HIV, other STIs or unintended pregnancies.

Population-based surveys conducted between 2009 and 2015 indicate that condom use at last sex among adults aged 15–49 years who had sexual intercourse with more than one partner within the past 12 months was only 23% among men and 33% among women. There was substantial variation among countries, ranging from as low as 7% among men in Madagascar to 69% among women in Namibia and 83% among men in eSwatini.[98] The most recent data on use of HIV prevention for countries in SEA can be found in UNAIDS Data 2019.[99]

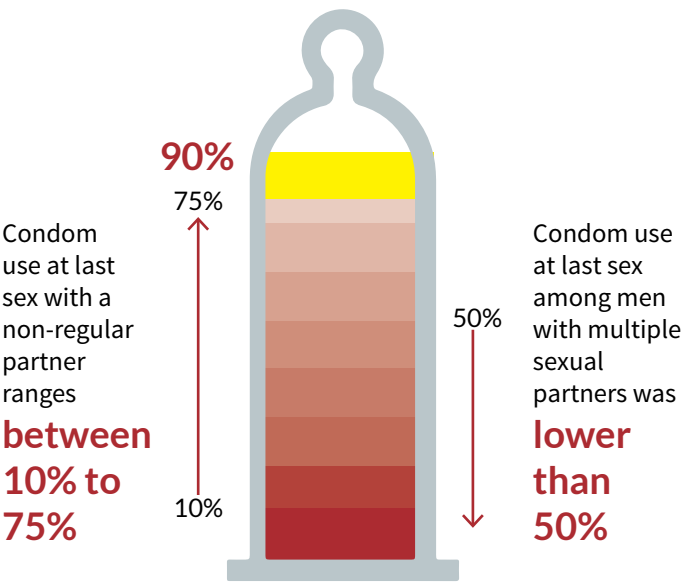
CONDOM USE IN THE REGION VARIES SUBSTANTIALLY

7%
of men in Madagascar

83%
of men in eSwatini

aged 15–49 years who had sexual intercourse with more than one partner within the past 12 months, between 2009 and 2015, used condoms

The condom gap: Condom use at last sex with a non-regular partner in sub-Saharan Africa ranges between 10% to 75%, but nowhere is yet at the required target of 90%. In 23 of 25 countries in sub-Saharan Africa with available data, condom use at last sex among men with multiple sexual partners was lower than 50%.



Source: ARASA Policy Brief 3, 2019

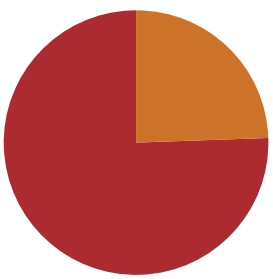
2.2.1.2 Abortion

Worldwide, 56 million induced abortions took place annually in 2010–14, which translates to an annual abortion rate of 35 abortions for every 1000 women aged 15–44 years.[100] The abortion rate has declined in developed regions as contraceptive use has become more common and the desire for smaller families is increasing. Still contraceptive access is poor, use is low and most developing countries have restrictive abortion laws making it far more likely that abortions in developing regions are illegal and unsafe than in developed regions.[101] In developing regions, 50% of abortions are unsafe, compared with 13% in the developed world.

In 2014, at least 9% of maternal deaths (or 16,000 deaths) in Africa were from unsafe abortion.

In 2012, nearly seven per 1,000 women of reproductive age in Africa were treated for complications from unsafe abortion - 1.6 million women. Africa is also the world region with the highest number of abortion-related deaths. In 2014, at least 9% of maternal deaths (or 16,000 deaths) in Africa were from unsafe abortion.[102]

While there is limited updated data on unsafe abortion in SEA countries, Abortion Worldwide 2017 indicates that the SEA region accounts for a large portion of unsafe abortions, estimating that only 23, 9% of all abortion in Eastern Africa during 2010–2014 were safe; 29, 2% were “less safe” and 46, 9% were “least safe”. In Southern Africa, 73, 5% were safe, 19, 4% less safe and only 7, 1% least safe.[103]

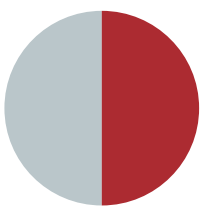


23.9% in Eastern Africa

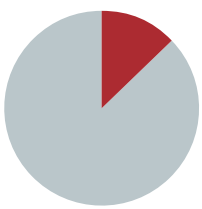
73.5% in Southern Africa

of all abortion between 2010 - 2014 considered to be safe

UNSAFE ABORTIONS



50%
in developing regions



13%
in the developed world

Examples: Unsafe abortions in SEA

Nearly half of pregnancies in **Malawi** are unintended and research conducted in 2015 showed that approximately 141 000 abortions took place in Malawi, the majority under unsafe and illegal conditions. It is estimated that between 6 – 18% of maternal deaths in Malawi are attributable to complications from unsafe abortion.[104] In addition, nearly one third of women were not able to obtain post abortion care despite it being provided free of charge at public health institutions.

Zimbabwe also has high levels of unsafe abortion, especially amongst adolescents who account for one in three abortion-related deaths. Complications from unsafe abortions contribute to 16% of maternal deaths in Zimbabwe.[105]

Although abortion is permitted in certain circumstances in **Zambia,** there are still high numbers of unsafe abortions and 13% of maternal deaths in 2014/15 were attributable to complications from unsafe abortions.[106] Women and girls in rural areas experience particular barriers to accessing legal abortion. Not all government facilities provide access and there is a lack of information about where and how to access a legal abortion. Abortion is highly stigmatized in Zambia.[107]

2.2.1.3 Gender-based violence

Sub-Saharan Africa, particularly southern and central African countries, was one of the regions with the highest prevalence of non-partner sexual violence

In the Guttmacher-Lancet Commission's 2018 report *Accelerate progress—sexual and reproductive health and rights for all*, gender-based violence is defined as an "act of violence that is inflicted upon an individual because of his or her gender or sexual orientation. Violence can take different forms: physical, sexual, or psychological, and it encompasses harmful practices, such as child marriage, sex trafficking, honour killings, sex-selective abortion, female genital mutilation, and sexual harassment and abuse."[108]

Worldwide, one in three women experiences intimate partner violence or non-partner sexual violence in her lifetime. However, the prevalence varies widely by country and region. According to WHO, women in southern and east Africa experience high levels of intimate partner violence; in east Africa, 38,8 % of women experience intimate partner violence.[109] In countries in SEA, prevalence is highest in Kenya, Tanzania, Uganda, Zambia and Zimbabwe.[110]

The prevalence of non-partner sexual violence varies widely; a 2014 study found that 7, 2% of women aged 15 or older globally reported non-partner sexual violence during their lifetimes. Sub-Saharan Africa, particularly southern and central African countries, was one of the regions with the highest prevalence of non-partner sexual violence.[111]

Examples: Gender-based violence in SEA countries

Information from 2012 in the **Comoros** and **Madagascar** show that 14% of women above the age of 15 had experienced physical violence[112] and 12% of women and girls aged 15 to 49 years reported physical or sexual violence from a partner.[113]

Survey results from 2015 on GBV in **Zimbabwe** found that 39% of women and 33% of men thought a husband was justified in beating his wife for at least one of the following reasons: burning the food, leaving the house without telling him, arguing with him, neglecting the children or refusing sex with him. GBV is closely linked to the inability to negotiate condom use, and greater vulnerability to HIV.[114] The Zimbabwe survey shows that 14% of women between the ages of 15 and 49 have experienced sexual violence during their lifetime and 6% of women who have ever been pregnant experienced violence during one of their pregnancies.[115]

In **Malawi**, 38% of women have experienced physical and/or sexual intimate partner violence in their lifetime and 24% have experienced physical and/or sexual intimate partner violence in the last 12 months.[116]

A South African survey provided new insights into GBV in **South Africa,** showing that 17% of young women aged 18 to 24 had experienced violence from a partner in the 12 months before the survey – 2.1% described this as often, and 8% as sometimes – compared to 16.7% among women 65 years old and older. Separated and divorced women were more likely to experience violence (40%), followed by those living together (31.1%). While there was no statistically significant difference between urban and rural areas, women in poorest households (24.4%) were more likely to experience physical violence compared to the top earning homes (13%).[117]

The **Uganda** Demographic Health Survey indicated that 22% of women between the ages of 15 and 49 have experienced sexual violence during their lifetime and 13% had experienced sexual violence in the preceding year. Younger women were less likely to report sexual violence.[118]

In 2016, the **Namibian** Police's GBV unit announced that 50 000 crimes related to GBV had been reported to the police over a three year period (2012 – 2015). These included assaults with the intention to cause grievous bodily harm, rape, attempted murder and murder.[119]

In 2017, the Zambia Police noted an increase in the number of GBV-related murders: the police recorded 55 murders related to GBV in 2017, as opposed 41 cases in 2016. They also noted that 82% of victims of assault involving actual bodily harm were female.[120]

There are clear links between HIV, SRHR and GBV: for instance, women in relationships where there is domestic violence are 1.5 times more likely to acquire HIV than women who have not experienced violence at the hands of an intimate partner.[121]

At least 200 million girls and women in 30 countries, primarily in Africa, the Middle East, and Asia, have been subjected to female genital mutilation (FGM).[122] The data on prevalence varies by study but according to UNICEF, Kenya has the highest FGM prevalence of countries in Southern and East Africa, with 21% of girls and women aged 15 to 49 years having undergone FGM; in Tanzania, 10% of girls and women aged 15 to 49 years have undergone FGM.[123]

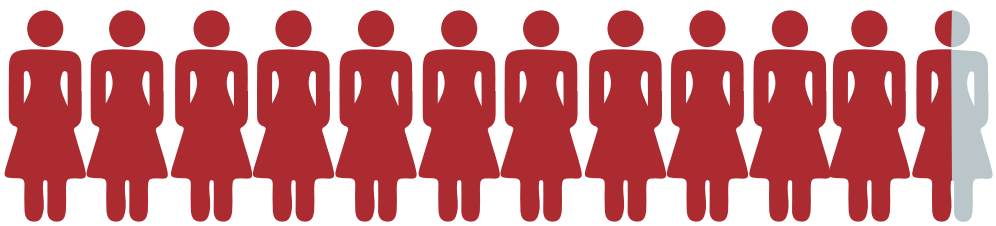
Despite worldwide efforts to end child marriage (before age 18 years), the practice remains common in developing regions, particularly in south Asia and sub-Saharan Africa. An estimated 7% of girls in developing regions marry before age 15 years, and 28% marry before age 18 years.[124]

United Nations International Children's Emergency Fund (UNICEF) estimates that sub-Saharan Africa is home to 115 million child brides. In 2018, close to 1 in 3 of the most recently married child brides globally were in sub-Saharan Africa, compared to 25 years ago when the proportion was 1 in 7.[125] In Eastern and Southern Africa, 9% of women aged 20 to 24 years were first married or entered into a union before age 15 and 34% before age 18.[126]

There are clear links between HIV, SRHR and GBV. In addition, early marriage is associated with early motherhood and a higher vulnerability to violence.

Early marriage is associated with early motherhood and a higher vulnerability to violence. Adolescent girls younger than age 15 had an estimated 77 000 births in developing regions in 2016; 58 percent of these took place in Africa.[127]

UNICEF ESTIMATES THAT SUB-SAHARAN AFRICA IS HOME TO



115 million
child brides

2.2.2 HIV, TB, hepatitis and STIs data

2.2.2.1 HIV and AIDS

UNAIDS Data 2019, shows that the number of AIDS-related deaths worldwide is the lowest this century, thanks to sustained access to antiretroviral therapy (ART). Three out of four people living with HIV now know their status—the first step to getting treatment. Southern and East Africa has seen rapid declines in new HIV infections and AIDS-related deaths in recent years. However, progress is fragile and it varies considerably within the region. Overall, the pace of progress is not matching the global 90-90-90 targets.

THE 90 – 90 – 90 TARGETS

These targets were launched in 2014 at the 20th International AIDS Conference in Melbourne and they have become a central pillar of the global response to ending AIDS. The targets are:

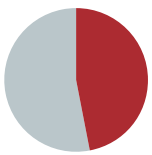
of people living with HIV

- **know their status**
- **who know their status are on treatment**
- **on treatment are virally suppressed**

Southern and East Africa remains the region most affected by the HIV epidemic, accounting for 47% of the world's HIV infections and 54% of people living with HIV globally. An estimated 800 000 people in SEA acquired HIV in 2018, and an estimated 310 000 people died of AIDS-related illness. Young women (15-24) accounted for 26% of new HIV infections, and an estimated one quarter of new infections were among key populations and their sexual partners.

A number of countries showed strong declines in new HIV infections between 2010 and 2018, such as Comoros, Rwanda, South Africa and Uganda but new infections increased in other countries such as Angola, Madagascar and South Sudan. This is despite the major progress in averting deaths from AIDS-related illness (with 44% fewer deaths in 2018 than in 2010) and preventing new HIV infections (with 28% fewer new infections in 2018 than in 2010), which has brought the incidence prevalence ratio of SEA from 6.5% in 2010 to 3.9% in 2018.[128]

SEA REMAINS REGION MOST AFFECTED BY THE HIV EPIDEMIC



47%
of global HIV infections

Global HIV trends in 2018

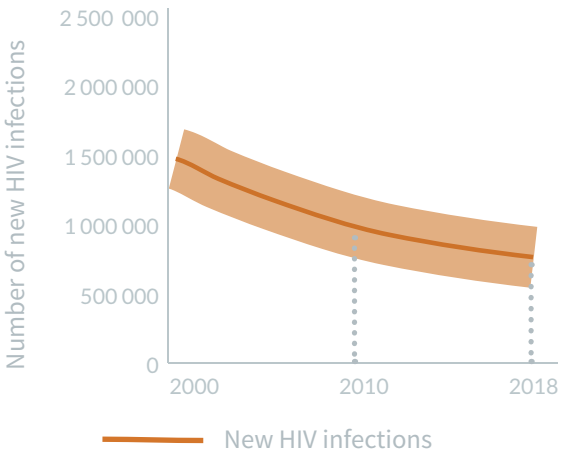
- 18% decrease in new HIV infections since 2010
- 34% decrease in AIDS-related deaths since 2010

Regional HIV trends in Southern and East Africa in 2018

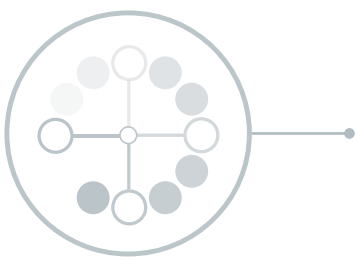
- 28% decrease in new HIV infections since 2010
- 44% decrease in AIDS-related deaths since 2010

Percentage change in new HIV infections since 2010

-28%



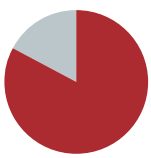
Source: UNAIDS 2019 estimates.



HIV prevalence is high among the regions' key populations, including gay men and other men who have sex with men, people who inject drugs, prisoners, sex workers and transgender people. Ten of the 19 countries in SEA with data reported since 2014 had an HIV prevalence in excess of 40% among sex workers, including an alarming 85% prevalence in Uganda. The most recent data on HIV prevalence amongst people who inject drugs exceeded 20% in half of the six reporting countries.[129] In 2015, an estimated 19.4% of people who inject drugs were living with HIV in South Africa.[130] In 2014, Tanzania estimated that around 35% of the 30 000 people who inject drugs in the country were living with HIV. [131]

According to the Kenyan AIDS Strategic Framework for 2015/6 – 2018/9, people who inject drugs account for almost 4% of all new HIV infections in Kenya.[132] A recent study in Maputo, Mozambique, showed that at least half of people who inject drugs are living with HIV. The sample also showed high levels of hepatitis B (32%) and hepatitis C (HCV) (44%).[133] Sub-Saharan Africa carries a substantial portion of the global burden of HCV.[134] Among gay men and other men who have sex with men, HIV prevalence was more than 30% in two of the 12 countries with data since 2014, and more than 12% in another five countries. Among 14 countries that reported data, median HIV prevalence amongst prisoners was 16.7% and among transgender people in Mauritius (the only country in the region to report epidemiological information on this key population) HIV prevalence was 28.4% in 2017.[135]

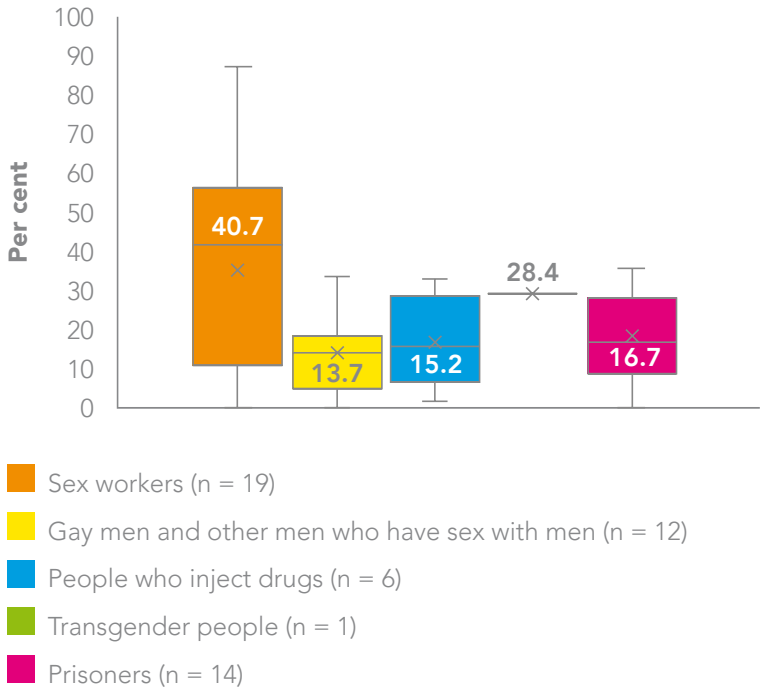
SINCE 2014, HIV PREVALENCE IS IN EXCESS OF



83%

among sex workers in Uganda

HIV PREVALENCE AMONG KEY POPILATIONS IN EASTERN AND SOUTHERN AFRICA, 2014-2018



Source: Global AIDS Monitoring, 2014-2018

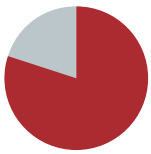
Globally, three quarters of people living with HIV know their status, with 79% accessing ART and 81% of people on treatment with suppressed viral loads as of 2017.[136] The 2017 UNAIDS progress report notes that a "major milestone" was reached when more than 50% of people living with HIV accessed ART.[137] The gains have been particularly striking in SEA, the region most affected by HIV.

The 90 – 90 – 90 Targets in SEA, 2018[138]

Progress towards achieving the 90:90:90 goals in SEA is varied. Botswana, eSwatini and Namibia have achieved the three 90s, while Rwanda has achieved the first two 90s and is closing in on the third. Despite this progress is slow. Knowledge of HIV status was below 25% in three countries and in eight countries no data on viral suppression were available.[139]

Clearly not everyone who needs access to HIV testing and treatment is able to obtain needed services. Data on access to treatment for key populations and their partners remains elusive, but they remain at higher risk of HIV infection.[140] Expanding access to HIV testing and treatment for adolescents and young people remains "unacceptably slow". Approximately 610 000 adolescents and young people were newly infected with HIV in 2016, of which 260 000 were adolescents (between the age of 15 – 19).[141] Adolescent girls and young women in SEA are disproportionately affected and young women (aged 15–24 years) accounted for 26% of new HIV infections in 2016 despite making up just 10% of the population.[142] The 2017 UNAIDS progress report raises concerns that too many young people are not aware of their HIV status.[143]

IN HIV TESTING FOR INFANTS, SOUTH AFRICA HAS ACHIEVED



80%

pediatric HIV testing

Although the number of new HIV infections amongst children is decreasing, they continue to lag behind adults in access to ART. In 2016, approximately 919 000 children out of 2.1 million children below the age of fourteen were accessing treatment. The number had increased to 947 000 by June 2017 and it was hoped that it would reach 1 million by the end of 2017. One hundred thousand children died of AIDS in 2016.[144]

Four SEA countries, Botswana (60%), ESwatini (64%), Kenya (65%) and Namibia (66%), have reached a 60% coverage for children.[145]

The WHO recommends that infants exposed to HIV are tested by 4 – 6 weeks, when breastfeeding ends and at any time when illness shows. Early testing allows for early diagnosis and referral to ART, but access to HIV testing for infants remains a challenge in many SEA countries. Only ESwatini (78%) and South Africa (80%) have made significant progress in expanding access to pediatric HIV testing. In addition to inadequate access to HIV testing, many SEA countries struggle to ensure that families and health care providers receive the HIV test results.[146]

WHO guidelines also recommend that children diagnosed with HIV are immediately started on ART.[147] The 2017 UNAIDS update indicated that there is an urgent need to scale up treatment for children and ensure that effective treatment regimes in optimal formulations are available.

100 000

children died of AIDS in 2016

2.2.2.2 Tuberculosis

With a worldwide 1.2 million estimated deaths among HIV-negative people in 2018, tuberculosis (TB) is one of the top 10 causes of death, and the leading cause from a single infectious agent (above HIV). According to WHO, there were an additional 251 000 deaths from TB among HIV-positive people in 2018.[148] Over 25% of TB deaths occurr in the African region.

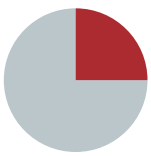
Drug-resistant TB continues to be a public health threat. In 2018, there were about half a million new cases of rifampicin-resistant TB (of which 78% had multi drug resistant TB). Diagnosing and treating drug resistant TB is a global challenge and in 2017 the WHO revised its guidelines for the treatment of drug resistant TB.[150]

On 26 September 2018, the United Nations (UN) held its first-ever high-level meeting on TB, elevating discussion about the status of the TB epidemic and how to end it to the level of heads of state and government. The outcome was a political declaration agreed by all UN Member States, in which existing commitments to the Sustainable Development Goals (SDGs) and WHO's End TB Strategy were reaffirmed, and new ones added. SDG Target 3.3 includes ending the TB epidemic by 2030. The End TB Strategy defines milestones (for 2020 and 2025) and targets (for 2030 and 2035) for reductions in TB cases and deaths. The targets for 2030 are a 90% reduction in the number of TB deaths and an 80% reduction in the TB incidence rate (new cases per 100 000 population per year) compared with levels in 2015. The milestones for 2020 are a 35% reduction in the number of TB deaths and a 20% reduction in the TB incidence rate. The strategy also includes a 2020 milestone that no TB patients and their households face catastrophic costs as a result of TB disease. **The political declaration included four new global targets:**

- treat 40 million people for TB disease in the 5-year period 2018–2022;
- reach at least 30 million people with TB preventive treatment for a latent TB infection in the 5-year period 2018–2022;
- mobilise at least US$ 13 billion annually for universal access to TB diagnosis, treatment and care by 2022; and
- mobilise at least US$ 2 billion annually for TB research.[151]

Currently, the world as a whole, most WHO regions and many high TB burden countries are not on track to reach the 2020 milestones of the End TB Strategy. Globally, the average rate of decline in the TB incidence rate was 1.6% per year in the period 2000–2018, and 2.0% between 2017 and 2018. The cumulative reduction between 2015 and 2018 was only 6.3%, considerably short of the End TB Strategy milestone of a 20% reduction between 2015 and 2020. The global reduction in the total number of TB deaths between 2015 and 2018 was 11%, also less than one third of the way towards the End TB Strategy milestone of a 35% reduction by 2020.

ACCORDING TO WHO, THE AFRICAN REGION ACCOUNTS FOR



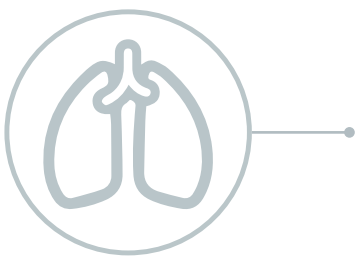
25%
of TB deaths

Drug-resistant TB continues to be a public health threat and in 2018, there were about half a million new cases of rifampicin-resistant TB

The good news is that incidence and deaths are falling relatively fast in the WHO African Region (4.1% and 5.6%, respectively, per year), with cumulative reductions of 12% for incidence and 16% for deaths between 2015 and 2018. Five high TB burden countries in SEA are on track to achieve the 2020 milestones: Kenya, Lesotho, South Africa, the United Republic of Tanzania and Zimbabwe.[152]

ESTIMATED EPIDEMIOLOGICAL BURDEN IN THE 10 SEA HIGH BURDEN TB COUNTRIES IN 2018[153]

	Total TB incidence (rate per 100 000 population)	HIV prevalence in incident TB (%)	MDR/RR TB incidence (rate per 100 000 population)	TB treatment coverage (%)
Angola	355	9.6	13	61
DRC	321	11	7.2	63
Kenya	292	27	4.5	63
Lesotho	611	65	38	55
Mozambique	551	36	28	57
Namibia	524	35	37	61
South Africa	520	59	19	76
Tanzania	253	28	3.3	53
Zambia	346	59	18	58
Zimbabwe	210	62	10	83



TB is a disease of poverty and inequality: people who cannot realise their human rights are often those most vulnerable to contracting TB and least able to access diagnostic, prevention and treatment services.[154] Populations at increased vulnerability for developing TB include people living in poverty, minorities, women, children, migrants, people living with HIV, prison populations, health care workers and homeless persons. There are various factors that increase vulnerability to TB. Poor living conditions, including over-crowding and lack of sanitation expose populations to the risk of TB. Limited access to education, nutrition, health services and facilities, employment and social security all play a role in increasing vulnerability to TB. Some groups may be more vulnerable due to their occupation (e.g. health care workers and miners).[155]

> The realization of human rights is challenged in the lives of many people living with and at risk of TB. People who live in conditions of overcrowding, inadequate ventilation and poor nutrition are vulnerable to the disease and likely also to be disadvantaged in not having sound information about TB or access to good-quality TB services. While TB services themselves may be free, such factors as transportation to services and attaining good nutrition to support good treatment outcomes may be impeded by poverty. TB incidence and prevalence reflect poverty and inequality from community to community, as well as globally. While TB-related mortality overall declined 40% from 1990 to 2015, over 95% of TB-related deaths are in low- and middle-income countries,6 with 86% of deaths in Africa and South and Southeast Asia. Sub-Saharan Africa, with only 11% of the world's population, accounts for about 26% of new TB cases and about three quarters of new cases of HIV-TB co-infection.
>
> The Global Fund, Tuberculosis, Gender and Human Rights, 2017.

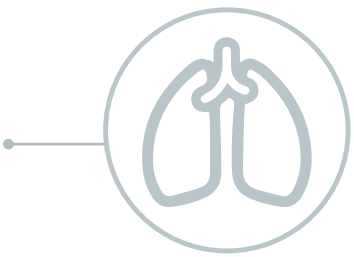
People living with HIV are 16-27 times more likely to develop TB than persons without. TB is the most common presenting illness among people living with HIV, including among those taking antiretroviral treatment, and it is the major cause of HIV-related deaths. Sub-Saharan Africa bears the brunt of the dual epidemic, accounting for approximately 86% of all deaths from HIV-associated TB in 2016.[156]

IN SOUTHERN AFRICA, THE PROPORTION OF TB CASES COINFECTED WITH HIV

50%
cases

The percentage of notified TB patients who had a documented HIV test result in 2018 was 64%, up from 60% in 2017. In the WHO African Region, where the burden of HIV-associated TB is highest, 87% of TB patients had a documented HIV test result. A total of 477 461 TB cases among HIV-positive people were reported, of which 86% were on antiretroviral therapy.

An estimated 8.6% (range, 7.4–10%) of the incident TB cases in 2018 were among people living with HIV. The proportion of TB cases coinfected with HIV was highest in countries in the WHO African Region, exceeding 50% in parts of southern Africa. The risk of developing TB in the 37 million people living with HIV was 19 (range, 15–22) times higher than the risk in the rest of the world population.[157]



Children can be at high risk of TB: they have vulnerable immune systems and even if they have been vaccinated, they may still become infected. Children below the age of 5 are most likely to contract TB at home from contact with family members. Children who come into contact with people with drug resistant TB are at high risk of developing drug resistant TB themselves. Poor children are more vulnerable to TB, including because they may be malnourished and/or often live in over-crowded conditions that are conducive to the spread of TB. However, despite this vulnerability, with children under

the age of 18 accounting for 10% of all new and relapse cases in Africa, children are often neglected in TB responses. [158] A child friendly TB formulation was only introduced to the market in 2015. Globally, TB treatment coverage (the number of people notified and treated divided by estimated incidence) was 69% (range, 63–77%) in 2018, up from 64% (range, 58–72%) in 2017 and 53% (range, 46–64%) in 2010.[159]

2.2.2.3 Hepatitis

IN AFRICA, CHRONIC VIRAL HEPATITIS AFFECTS

70 million
people

Viral hepatitis (especially types B and C) affects 325 million people globally and is 10 times larger than the global HIV epidemic. Every day, more than 3600 people die of viral hepatitis- related liver disease, liver failure and liver cancer. Chronic viral hepatitis is now the second biggest cause of death after TB. In Africa, chronic viral hepatitis affects over 70 million people (60 million with Hepatitis B and 10 million with Hepatitis C).[160] Various reports suggests that sub-Saharan Africa carries a substantial portion of the global hepatitis burden.

In May, 2016, WHO adopted a global hepatitis strategy with the goal of eliminating viral hepatitis as a public health threat by 2030. The targets to be achieved by 2030 are ambitious: a 90% reduction in new cases of chronic hepatitis B and C, and a 65% reduction in mortality due to HBV and HCV infection, both of which rely on 80% of treatment-eligible individuals with chronic HBV and HCV infections being treated globally.[161]

Recommended priority actions for the elimination of hepatitis B in sub-Saharan Africa[162]

- Prevention of mother-to-child transmission (MTCT)
- Mandatory antenatal hepatitis B surface antigen (HBsAg) screening: screening tests using available laboratory infrastructures—eg, ELISA-based serology or point-of-care tests
- Initiation of tenofovir 300 mg daily at 28–32 weeks of pregnancy if hepatitis B virus
- (HBV) DNA concentration is higher than 200 000 IU/mL to further reduce risk of perinatal transmission
- Real time quantitative PCR or in-house quantitative PCR to establish MTCT risk
- Hepatitis B e antigen (HBeAg) testing if quantitative HBV PCR not available
- If HBeAg and quantitative HBV PCR not available, treat pregnant women based on HBsAg positivity and refer for further assessment of whether antiviral therapy is needed after delivery
- Baby treated with HBV birth-dose vaccine within 24 h of birth
- Ensure full coverage of universal hepatitis B vaccination
- Identify high-risk groups, especially family members, household contacts, and sexual contacts for HBsAg screening, HBV vaccination, or linkage to care

- Use of affordable WHO prequalified point-of-care testing for HBV serology and HBV DNA concentration quantification to upscale identification of individuals infected with HBV
- Ensure that health-care workers are screened and vaccinated against HBV
- Establish pathways of linkage to care for individuals who are HBV monoinfected
- Ensure sustainable access to tenofovir for individuals who are HBV monoinfected

Unsafe health-care procedures and injecting drug use were the leading causes of new HCV infections, accounting for most of the 1.75 million new infections in 2015.[163] Global estimates also show that over half of all people who inject drugs are also living with HCV and a third of global deaths from HCV occur amongst people who inject drugs. Globally, around 2.9 million people with HIV are also infected with HCV. There is also some evidence to suggest that gay men and men who have sex with men who are living with HIV and use recreational drugs, are at higher risk of HCV.[164]

In countries in SEA, studies indicate that HCV seroprevalence data for people who inject drugs in Kenya is 51.4%, ranges between 24 to 77% in South Africa, in Tanzania it is 22.2% and in Mauritius, 97.3%. A seroprevalence study of gy men and men who have sex with men in Cape Town found HCV seroprevalence of 6%.[165]

2.2.2.4 STIs

Globally, more than 1 million curable STIs occur each day. According to WHO global estimates for 2016, there were roughly 376 million new infections of the four curable STIs – chlamydia, gonorrhoea, syphilis and trichomoniasis.

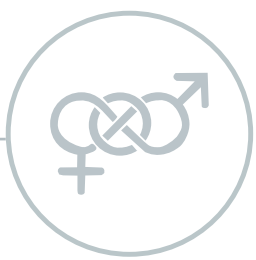
127 million
cases of Chlamydia

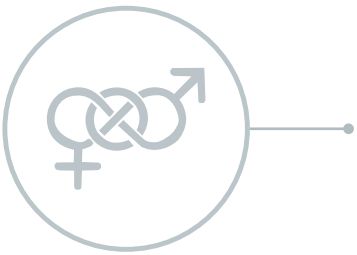
87 million
cases of Gonorrhoea

6 million
cases of Syphilis

156 million
cases of Trichomoniasis

GLOBAL ESTIMATES OF NEW CASES OF CURABLE STIs IN 2016





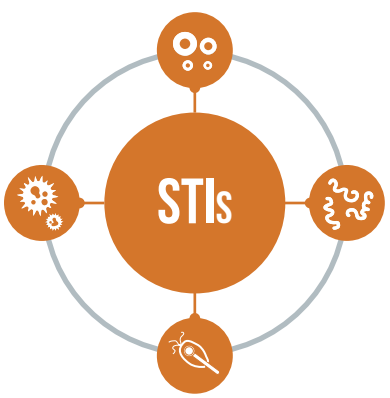
Left untreated, some STIs increase the risk of HIV transmission during unprotected sexual contact and lead to complications, such as pelvic inflammatory disease, infertility, ectopic pregnancy, miscarriage, fetal death and congenital infections. Estimated STI-related mortality includes 200 000 fetal and neonatal deaths each year due to syphilis in pregnancy and over 280 000 cervical cancer deaths each year due to human papillomavirus.[166]

The prevalence data on chlamydia, gonorrhoea, syphilis and trichomoniasis in countries of the SEA region is poor. However, various reports suggest a high level of STIs in Africa. WHO's 2018 report on global sexually transmitted infection surveillance estimates the prevalence of chlamydia, gonorrhoea, trichomoniasis and active syphilis in both African women and men aged 15–49 years to be among the highest in the world.[167]

ESTIMATED STI-RELATED MORTALITY INCLUDES

200 000
fetal and neonatal deaths each year due to syphilis in pregnancy

280 000
cervical cancer deaths each year due to human papillomavirus.



WHO ESTIMATES THE PREVALENCE OF STIs IN BOTH AFRICAN WOMEN AND MEN AGED 15–49 YEARS TO BE AMONG

the highest in the world

SECTION 3

LEGAL FRAMEWORKS TO PROTECT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS, INCLUDING HIV AND ITS CO-INFECTIONS, IN SOUTHERN AND EAST AFRICA

3.1 Introduction

Legal, regulatory and policy frameworks – including laws, regulations, policies and programmes - and access to justice can help to protect and promote sexual and reproductive health and rights. Conversely, stigma, discrimination, violence, bad laws and poor law enforcement can exacerbate the vulnerability of vulnerable and key populations, create barriers to their access to sexual and reproductive health information and services and increase the impact of poor sexual and reproductive health on their lives.

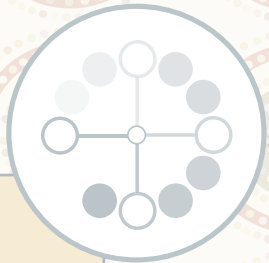
Stigma, discrimination, violence, bad laws and poor law enforcement can exacerbate the vulnerability of vulnerable and key populations

This section looks at countries in SEA to identify the extent to which their legal, policy and regulatory frameworks reduce inequalities and protect and promote sexual and reproductive health and rights, including the rights to bodily autonomy and integrity, equality – including gender equality - and social justice and remove human rights and gender-related barriers to universal access to health for all.

Firstly, it identifies vulnerable and key populations in the context of SRH, including HIV and its co-infections, TB and Hepatitis C and considers the legal, human rights and gender-related barriers these populations encounter in access to SRH care.

It notes the need for health laws, policies and programmes in SEA countries to protect and promote access to a comprehensive range of sexual and reproductive health information and services, including:

- access to contraception
- comprehensive sexuality education
- access to safe abortion and post-abortion care
- access to prevention and treatment for HIV and its co-infections (particularly TB and hepatitis C) and other STIs
- access to services for reproductive cancers
- services to prevent and address sexual and gender-based violence.



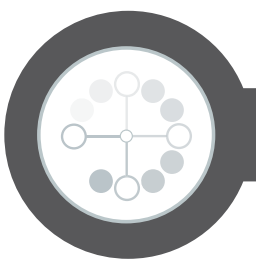
This section identifies vulnerable and key populations in the context of SRH, including HIV and its co-infections, TB and Hepatitis C and considers the legal, human rights and gender-related barriers these populations encounter in access to SRH care.

In the years ahead, it will be critical for ARASA and its partners to develop strong monitoring and accountability mechanisms to ensure that the relevant health laws and policies are in place, to provide a comprehensive response.

The report identifies select issues set out below and examines the extent to which health and other laws, policies and programmes address these broader human rights and gender-related barriers to SRH services to protect and promote the right to equality, rights to autonomy and bodily integrity and the health rights of vulnerable and key populations.

Specifically, it examines laws, policies and programmes to:

- protect vulnerable and key populations from stigma and discrimination, particularly in relation to HIV, TB and SOGI
- provide for age of consent for young people (including age of consent to treatment, sex and marriage)
- provide for criminalisation of HIV transmission, exposure and/or non-disclosure
- provide for punitive responses to TB treatment
- criminalise same-sex sex, sex work and drug use
- promote access to treatment, e.g. treatment for HIV, TB and viral hepatitis



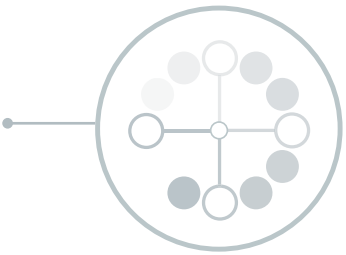
3.2 Vulnerable and Key Populations

ARASA's work in the region prioritises specific populations – those populations that are considered to be vulnerable and key populations in the context of SRHR, including HIV (and its coinfections) and other STIs.

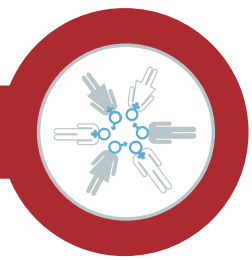
Vulnerable and key populations include populations that live in poverty without access to safe housing, water, sanitation and nutrition; those who are stigmatized, discriminated against, marginalized by society and even criminalized in law, policy and practice. These populations may struggle to fulfil their human rights, including their rights to access health and social services. They live in environments of inequality where they are unable to thrive, feel safe and actively participate in all aspects of society. Communicable diseases such as HIV, TB and malaria, and non-communicable diseases such as cancers, may disproportionately impact vulnerable and key populations.[168]

Section 2.2, above, showed the vulnerability of specific populations in terms of the incidence and prevalence of health issues and diseases. This section provides further detail on vulnerable and key populations in the context of SRHR in SEA countries and identifies some of the key factors impacting on their vulnerability, including laws, policies and practices that increase their vulnerability to ill health.

The key populations discussed below include LGBTI people, sex workers, people who use drugs and prisoners. In addition to these key populations, adolescents and young women and girls and women remain highly vulnerable to HIV and have high levels of unmet SRH needs.

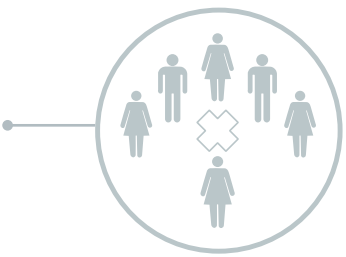


An introduction to the vulnerabilities experienced by these populations, in terms of stigma, discrimination and violence and SRHR risks, is set out below. A more detailed discussion of the criminal laws that impact on their health rights is set out in section 3.4; this includes an overview of laws criminalising HIV transmission, exposure and non-disclosure, criminal laws and law enforcement practices relating to sex work, people who use drugs and LGBTI people, laws and policies relating to the provision of condoms in prisons as well as laws and policies relating to adolescent sexual and reproductive health including access to services, contraceptives and CSE in schools.



3.2.1 LGBTI people

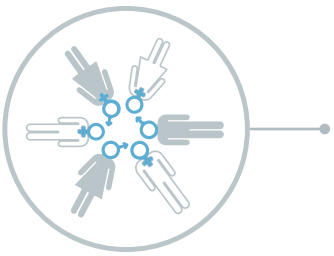
Available data shows that gay men and other men who have sex with men are at higher risk of HIV exposure in SEA, as shown in section 2.2, above. Research further shows how men who have sex with men and other LGBTI people in SEA face stigma, discrimination and violence in various aspects of their daily lives, creating barriers to their full participation in society, including in access to healthcare services. In addition, laws that criminalise consensual sex between adults of the same sex violate the rights of LGBTI people to equality, privacy and bodily autonomy, denying them the right to make choices regarding their sexual relationships. In 2019, the vast majority of countries in SEA criminalise same-sex sexual conduct for men and women, and a number of governments, political and religious leaders promote homophobia and discrimination against people on the grounds of SOGI.



In 2019, the vast majority of countries in SEA criminalise same-sex sexual conduct for men and women

Recent research finds that the continued criminalisation of consensual sex between persons of the same sex leads to victimisation and societal marginalisation of LGBTI people, by perpetuating stigma, violence, harassment, blackmail and discrimination by state and non-state actors.[169]

For instance, LGBTI people in southern Africa often report being arrested, detained, or harassed for offences such as “public indecency,” “nuisance,” “public disorder,” “loitering,” or other ill-defined criminal offences. Transwoman and other gender non-conforming individuals are especially vulnerable to arrest and they are often arrested for “cross-dressing” or “impersonation”. In many cases, it is clear that the individual is being targeted due to their real or perceived sexual orientation or gender identity, and there is no basis in law for an arrest or detention.[170]



Furthermore, criminal laws are perceived as justification - and even sanction, not only for unlawful arrest, but also for violence, abuse and discrimination against those who do not fit societal expectations of heterosexuality and cis normativity. A 2016 study into SOGI rights in Southern African countries[171] found that men, women and gender non-conforming individuals have been murdered, raped, beaten, assaulted, harassed, and targeted due to their real or imputed sexual orientation, gender identity and/or gender expression. Acts of violence were often committed by family members or others who perceived the individual's sexual orientation or gender identity as inconsistent with social or cultural expectations. This stigma and discrimination takes place in various societal spaces and, in most cases, research shows that crimes are not reported to law enforcement officials and go unpunished.

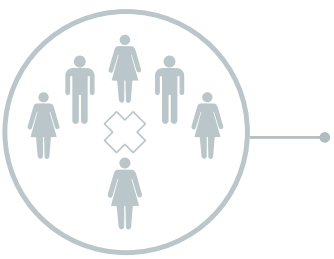
Acts of violence were often committed by family members or others who perceived the individual's sexual orientation or gender identity as inconsistent with social or cultural expectations

Young LGBTI people reported homophobia and/or transphobia amongst school administrators and teachers and limited access to remedies from bullying, harassment, discrimination and other rights violations.[172] A 2016 study by the Southern African Litigation Centre (SALC) found high levels of stigma and discrimination on the basis of SOGI in health care, including sub-standard and inadequate treatment, conditional access to treatment, denial of treatment, abusive language, physically and sexually abusive behavior as well as violations of the right to informed consent and confidentiality.[173]

Violence and human rights violations continue even in those countries that offer legal protection to the LGBTI community – ongoing violence against lesbian women in South Africa show that laws alone cannot end discrimination.[174]

Criminalisation is also used as a barrier to the supply of condoms in prisons,[175] including in almost all countries in SEA.

3.2.2 Sex Workers



Sex workers have been identified as a key population at high risk of HIV and other STIs, as set out in s2.2, above. The 2016 ARASA HIV, TB and Human Rights Report noted various violations of the rights of sex workers, including violations of their rights to equality, non-discrimination, bodily autonomy and integrity. Male, female and transgender sex workers faced high levels of stigma, discrimination, violence, extortion, sexual abuse and rape in SEA from clients, intimate partners and law enforcement officials, which increases their vulnerability and marginalisation and places them at increased risk of HIV. The report found that sex workers experienced particular challenges in accessing health care due to stigmatising attitudes from health care workers and discrimination in access to health care services, limiting their access to HIV prevention and treatment services and information.

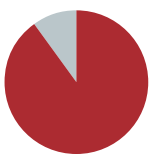
This research found that aspects of sex work are directly or indirectly criminalised in every ARASA partner country (dealt with in more detail in section 3.4, below). A 2018 report on HIV, the law and human rights in Africa also highlighted continued harassment by law enforcers, such as arbitrary detention and arrests based on condom possession, which further undermined HIV prevention efforts with sex workers.[176] Sex workers continue to experience violations of their human rights, increasing their vulnerability to HIV, with little access to justice, in countries in SEA.

Sex work, discrimination and violence

In **Zimbabwe**, law enforcement officers intimidate, arrest and harass sex workers. Findings on police harassment and abuse by the Centre for Sexual Health, HIV and AIDS Research in 2016 found 20% of female sex workers experienced violence from the police in the past year.[177] The possession of condoms is used as proof of sex work, with many sex workers reporting being arrested due to their work, or having their condoms confiscated.[178] This leads to increased vulnerability to HIV, due to their fear of arrest, inability to negotiate condom use and unwillingness to access health care services.[179]

Sex workers in **Zambia** report similar abuse at the hands of law enforcement officials. Recent research by SALC found that 91% of sex workers indicated they had a bad experience with the police and that they were often not treated well during arrest and detention. 90% reported that they have experienced violence from police or other men during their time as sex workers, 87% reported that the police have harassed them because they engage in sex work and 61% said they would be unwilling to lay a complaint against the police because they fear further abuse, that the complaint will not change anything, that the police think they are "above the law"; and because they are unfamiliar with all the complaints options available to them.[180] Sex workers also report high levels of stigma and discrimination within the health care sector, including denial of services, discriminatory treatment and abuse; similarly they feel unwilling or unable to challenge violations in the health care sector.[181]

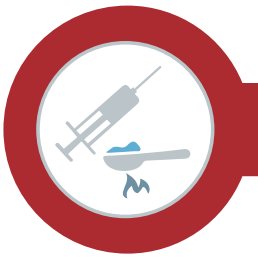
VIOLENCE AND ABUSE BY POLICE AND MEN IN ZAMBIA



90%

reported by sex workers

Sex workers in **Mozambique** are frequently unable to access justice for crimes committed against them, including when perpetrators are police officers. In a 2016 study, 27% of sex workers who participated in the research stated they had experienced discrimination on accessing police assistance. The same study showed that 23% of the sample had filed a police report and the majority were happy with the outcome, with about one quarter expressing dissatisfaction with the way their case was handled.[182]



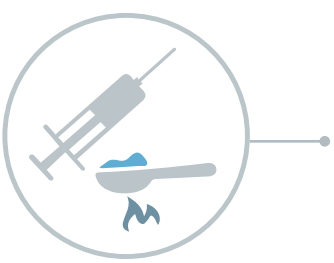
3.2.3 People who use drugs

There is very little reliable data from the region about the levels of HIV amongst people who use drugs;[183] however, the data available (see section 2.2, above) confirms the general global data, showing that people who inject drugs are a key population in the context of HIV, TB and viral hepatitis.

Countries in SEA have been slow to identify people who use drugs as a key population within their national responses to HIV

Despite this, countries in SEA have been slow to identify people who use drugs as a key population within their national responses to HIV and current national responses to prevent, diagnose and treat HCV infection remain inadequate, exacerbating the risk and impact of HCV on people who use drugs in SEA.

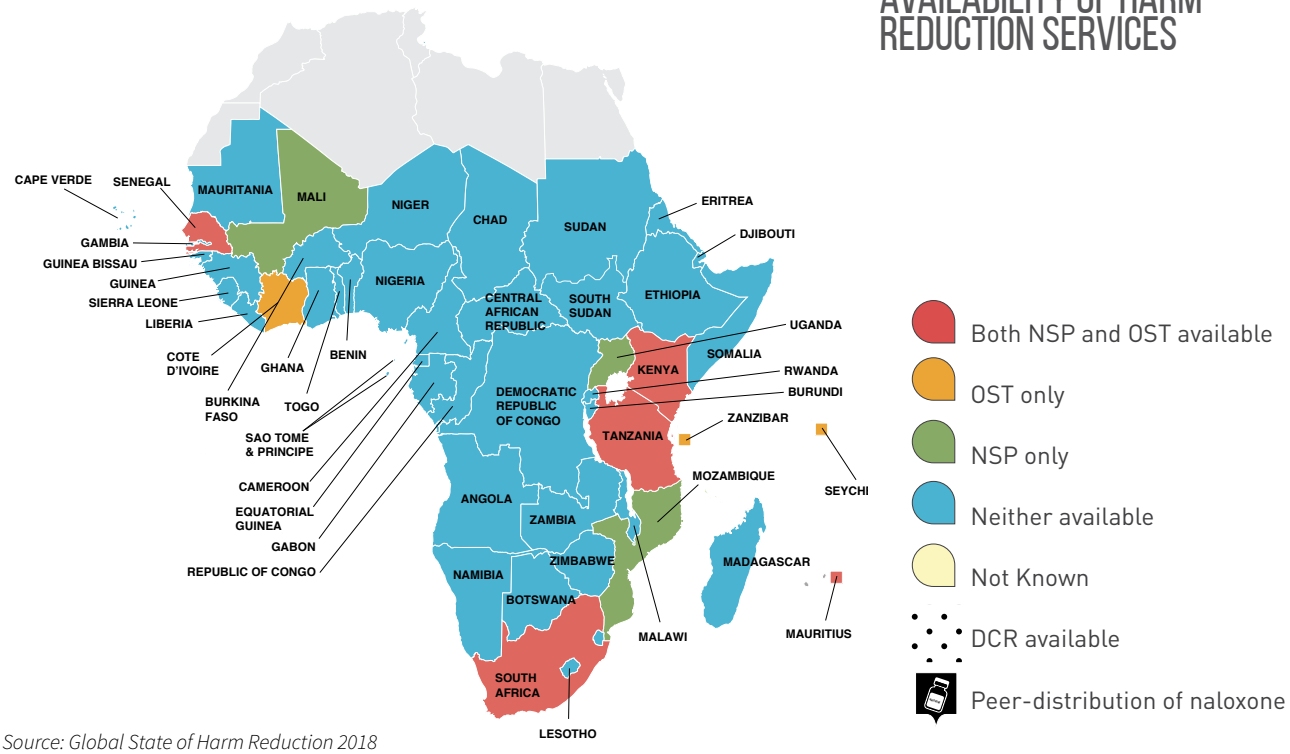
People who use drugs in SEA face various violations of their rights, including their rights to equality, non-discrimination, autonomy, integrity, health and access to justice. In SEA, individual drug possession and use is criminalised (discussed further in s3.4, below) and highly stigmatised, with people who use drugs often facing discrimination, violence and police abuse with limited access to justice for rights violations.[184] Recent research with people who use drugs in Malawi, Zimbabwe and South Africa documented rights violations, including that people who use drugs are routinely stopped and searched without cause; have ART and harm-reduction commodities (e.g. needles and syringes) confiscated; are detained and searched with excessive violence; beaten, threatened and intimidated; stripped naked and searched in public and detained until they experience withdrawal symptoms, in order to extract confessions. In South Africa, recent surveys found discrimination against people who use drugs in health care facilities, including degrading and humiliating treatment, sub-standard care and denial of care, including medication such as ARVs.[185]



Despite their proven benefits in terms of HIV and HCV prevention, countries in SEA have been slow to implement harm reduction programmes. There has however been programmatic scale up of harm reduction services in a select few countries.

Since 2016 needle and syringe programmes (NSPs) have been newly implemented in two countries 2016 –Uganda and Mozambique. There are four NSP sites in four cities in South Africa (Cape Town, Pretoria, Johannesburg and Port Elizabeth), an increase of one since 2016, with the City of Tshwane (Pretoria) planning to expand its services to eight locations in the future. In Kenya, NSPs have also increased, going from 13 to 19 since 2016. NSP sites in Mauritius, although still operational, remain restricted to a fixed quota of 30,000 needles per month.[51,64] The restriction, implemented by the government that came to power in 2014, inhibits service providers (who cannot respond to need) and is harmful, given the increasing number of people who inject drugs in the country. People under the age of 18 do not have access to harm reduction programmes and, with paraphernalia illegal under the Mauritius Dangerous Drugs Act, young and old

AVAILABILITY OF HARM REDUCTION SERVICES

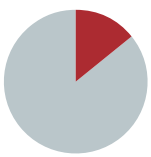


Source: Global State of Harm Reduction 2018

may be arrested for the simple possession of a syringe. In Kenya, although NSP services fail to reach everyone who needs them, approximately 135 needles per person who injects drugs per year are distributed, a substantial increase since 2015. Despite some increases in the region, coverage of existing NSP services remains disproportionately low compared to international targets. In Tanzania, NSP provision remains poor, and high risk behaviours such as needle sharing and the practice of flashblood have been reported, with an estimated 15.6% of people who inject drugs practising flashblood and 14.2% sharing a needle with another at last injection. NSP provision is currently unavailable in Zimbabwe. In all countries where NSP sites exist (Kenya, Mauritius, South Africa, Tanzania, Uganda and Mozambique), barriers to access remain, including social stigma, geographic coverage (often sites are restricted to urban areas with no mobile sites operational) and harassment/rights infringements by law enforcement, such as the confiscation of syringes/needles.[186]

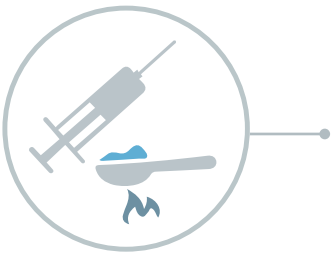
Opioid substitution therapy (OST) services are freely available for people who use/inject opioids in Kenya, Mauritius, Seychelles, South Africa, Tanzania and Uganda. Similarly to NSPs however, the majority of countries in the region have yet to introduce OST programmes. Barriers to accessing substitution treatment exist however. In South Africa a primary barrier is the cost of medication (with no generic products available), since the services are not subsidised. In Kenya, OST was introduced by non-private providers in December 2014; since then there has been a steady increase in provision and support for further roll-out of OST services with seven OST clinics now open. As at 2018 however they were reaching less than 10% of people who inject drugs in the country. Barriers to accessing substitution therapy in Kenya include lengthy distances for people to travel to receive daily dosages and limited uptake by people living with disabilities. In 2016, under the newly elected Mauritian government, OST distribution was moved from health facilities to police stations, with daily fixed times and reduced hours (from

AMONG PEOPLE WHO INJECT DRUGS IN TANZANIA



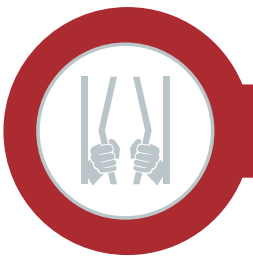
15,6%
practice flashblood

14,2%
share a needle with another at last injection



6.00 to 8.00 am) for people who use drugs to attend, with considerable negative impact on access to services. In the first half of 2018, distribution continued to be carried out at police stations and at the aforementioned fixed hours. However, in July 2018 the health minister of Mauritius announced that OST distribution would revert to primary healthcare settings with times of distribution to be reviewed.[187]

The GCHL Africa Regional Dialogue on HIV and the Law found that criminalisation of drug use, fear of arrest, harassment and the imprisonment of people who use drugs, accompanied by widespread societal stigma, discourages access to health care services for people who use drugs and creates legal barriers to the provision of needle and syringe programmes and opioid substitution therapy.[188] The GCHL *Risks, Rights & Health Supplement* in 2018 examined barriers to access to HCV treatment for people who use drugs and found that laws that criminalise drug use and prevent harm reduction interventions, combined with punitive health policies that require registries for people who inject drugs and exclude people who use drugs from accessing HCV treatment, as well as the high cost of HCV treatment, result in people who use drugs being unable to prevent or obtain effective treatment for HCV.



3.2.4 Prisoners

Prisoners are a key population in the context of HIV and TB: research to quantify the prevalence of infections, including HIV, Hepatitis C and TB, amongst people in prisons showed that overall, these are substantially higher than the general population. It is estimated that 3.8% of the global prison population are living with HIV and 2.8% have active TB.[189]

Research suggests the risk for prisoners contracting HIV and TB to be as high as ten times the risk for the general population

Although there is limited research in SEA, data available from select studies in SEA countries shows that prison inmates are at higher risk of HIV and TB (see section 2.2, above). Research suggests the risk for prisoners contracting HIV and TB to be as high as ten times the risk for the general population;[190] estimates have further suggested that across the region, the prevalence of HIV amongst prisoners is 15.6% and 5.3% for TB in SEA.[191]

OF THE GLOBAL PRISON POPULATION

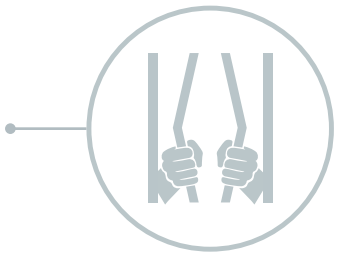
3,8%
are living with HIV

2,8%
have active TB

IN SOUTHERN AND EAST AFRICA

15,6%
are living with HIV

5,3%
have active TB



Overcrowding, poor sanitation, limited access to healthcare and the fact that a number of prisoners and detainees are also key populations for HIV – such as people who use drugs and sex workers – place prisoners at risk of HIV and TB.[192]

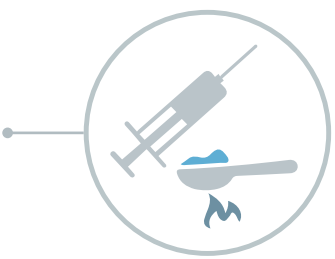
Example: Overcrowding in prisons

In **South Africa** in 2016, there were 119 134 beds for 161 984 inmates. While South African prisons have put strong HIV and TB screening, testing and treatment systems in place, concerns have been expressed that these will be undermined by the severe overcrowding in some prisons.[193] Uganda also has severely overcrowded prisons and estimates in 2017 suggest that Ugandan prisons are at 293% occupancy. The overcrowding has led to a serious public health crisis in prisons, including MDR-TB.[194]

Prisons in **Zimbabwe** are also overcrowded and unsanitary and prisoners lack access to nutrition, clean water and health care. Prisoners do not have access to condoms and lubricant. The Zimbabwe Human Rights Commission described the conditions in most of Zimbabwe's prisons as "dire.[195] The commission expressed concerns about food and medicine shortages.

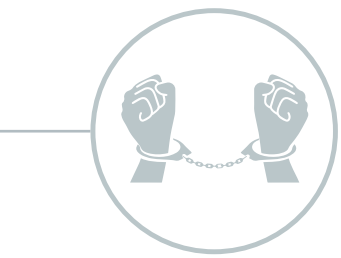
In 2018, **Uganda** and **Comoros**, along with **Zambia**, had amongst the most over-crowded prisons in the world.[196]

Laws and policies fail to adequately protect the right to health care, including access to HIV and TB prevention and treatment, for prisoners. For example, few prisons in SEA have established comprehensive treatment, care and support policies and programmes. The lack of financial and personnel resources and the fragmented care between prisons and when prisoners are released undermine access to health for prisoners living with HIV and/or TB. Where programmes do exist, they tend to be inadequate and do not cover all inmates.[197]



Furthermore, limited progress has been made in SEA to decriminalise laws prohibiting consensual sex between adult men; these laws present a significant barrier to prisoners obtaining access to condoms to protect themselves from HIV transmission. Similarly, laws criminalising the possession and use of drugs act as a barrier to the provision of harm reduction services for people who use drugs in prisons. These criminal laws are discussed in further detail in s3.4, below.

Same-sex sex laws bar the provisions of condoms in prisons:



In **Botswana**, **Malawi, Mozambique, Namibia**, **Tanzania** and **Uganda**, prisoners are not permitted to access condoms or lubricant because of the criminalisation of same-sex sexual conduct. In **Zambia**, the Prisons Act classifies sodomy as a major prison offence.[198]

3.2.5 Adolescent girls and young women

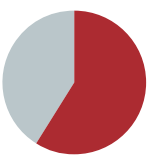
The data set out in s2.2, above, on various SRH issues shows that adolescent girls and young women are vulnerable to sexual and reproductive health risks, including HIV and other STIs, in SEA.

Women continue to account for a disproportionate percentage of new HIV infections among adults (aged 15 and older) in sub-Saharan Africa

For instance, women continue to account for a disproportionate percentage of new HIV infections among adults (aged 15 and older) in sub-Saharan Africa: they represented 59% of the 980 000 million new adult HIV infections in 2017.[199] Young women (age 15-24) in the region are especially at risk for new HIV infections. Of the total 290 000 new HIV infections in this age group, young women accounted for 200 000. Adolescent girls face other, particular SRH challenges: high levels of unintended and unwanted pregnancy, lack of access to contraception, CSE and abortion; sexual and gender-based violence and child marriage.

There are various reasons for the vulnerability of AGYW to HIV and other SRH risks. According to UNAIDS Data 2018 report, gender inequalities which result in limited autonomy and ability to insist on safer sex, harmful gender norms and gender-based violence, including high levels of sexual violence and coercion, combined with physiological factors, place women and girls in SEA at high risk of HIV infection. Laws, policies and practices that perpetuate inequality, discrimination and violence against adolescent girls and young women need to be addressed, in order to promote the health and wellbeing of AGYW.[200]

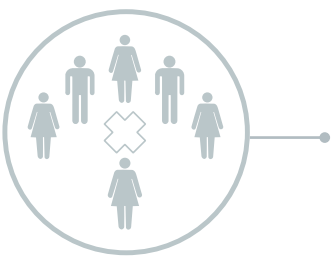
IN 2017, WOMEN REPRESENTED



59%

of the
980 000 million
new adult HIV infections

In addition, AGYW have limited access to appropriate SRH information and services for various reasons. Adolescent girls and young women frequently cannot access sexual and reproductive health information and services that are tailored to their needs and their access to HIV and SRH services is often compromised due to other factors, such as the fact that adolescent sexuality is deeply stigmatized. In addition, health laws and policies that deny independent access to sexual and reproductive healthcare services for young people, discussed in further detail in s3.4 below, create barriers to access to critical healthcare services for young people. In 10 countries in the region, laws and policies that require parental consent to access sexual and reproductive health services discourage adolescent girls from accessing the services they need to stay healthy.[201]



Stigma and discrimination is particularly problematic for AGYW living with HIV. Women living with HIV often experience discrimination, stigma and coercion when they try to access their SRHR, including breaches of their right to autonomy and privacy, delays or denial of SRH and HIV treatment and care and lack of access to information about their health.[202] Integrating HIV and SRH care can help women living with HIV make informed decisions about contraception, pregnancy, abortion and other aspects of SRHR.

3.2.6 Young people

Adolescents and young people in SEA are vulnerable to sexual and reproductive health risks and face barriers in trying to access their SRHR, including protecting themselves from HIV and other STIs, as seen in s2.2, above. Young key populations are significantly vulnerable to HIV. For example, young sex workers are more at risk of acquiring HIV than older sex workers, as they are least likely to know their status, have lower knowledge of HIV prevention, and are less likely to use condoms.[203]

Problematic or inadequate laws and policies pose significant barriers to adolescent access to SRH services. For instance, many countries lack legal and policy frameworks that explicitly promote the rights of young people to SRH. In addition, laws, policies and practices criminalise or highly stigmatise aspects of adolescent sexuality or actively undermine their access to HIV and SRH care. For instance, several countries do not have laws or policies that clarify the age at which adolescents can independently consent to medical treatment, including HIV and SRH services such as HIV testing and counselling, access to contraception and information about family planning and termination of pregnancy.

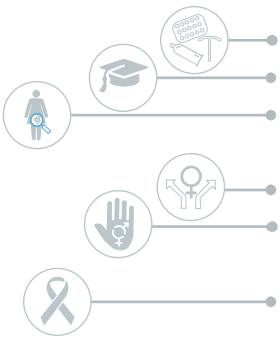
The lack of clarity leads to confusion for health care workers who do not know when they can provide medical treatment to adolescents without permission from their parents[204] and has a limiting effect on adolescents seeking essential HIV and SRH services. In addition, many SEA countries do not specify the age at which adolescents can consent to sex, inherently criminalising even consensual peer sex amongst adolescents and creating confusion for adolescents, parents and law enforcement officials about when they may lawfully engage in consensual sexual activity.

Other countries have discriminatory age limits, usually setting a higher age for girls or not specifying a minimum age for boys. These legal issues are discussed in further detail in s3.4, below.

Young sex workers are more at risk of acquiring HIV than older sex workers, as they are least likely to know their status, have lower knowledge of HIV prevention, and are less likely to use condoms

3.3 Health laws, policies, strategies and programmes in relation to specific sexual and reproductive health issues

Health and related laws, policies, strategies, plans and programmes need to provide for access to a comprehensive range of sexual and reproductive health information and services, including:



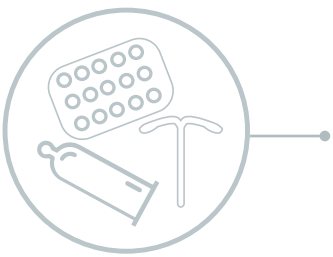
- Access to counselling and services for a range of modern contraceptives
- Comprehensive sexuality education
- Prevention, detection, and management of reproductive cancers, especially cervical cancer
- Safe abortion services and treatment of complications of unsafe abortion
- Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence
- Prevention and treatment of HIV and other STIs, as well as HIV co-infections such as TB and hepatitis C .

In the years ahead, ARASA and its partners will need to monitor the development of appropriate health and related laws, policies, strategies, plans and programmes to provide for the full range of SRH services set out below.

3.3.1. Access to Contraception

Access to modern contraceptives is critical to sexual and reproductive health and rights. It enables women and couples to plan pregnancies and prevent unintended pregnancies, births and abortions. Access to contraception allows persons to fulfil their right to choose when to have children and how many children to have. It also protects people from transmission of HIV and other STIs.

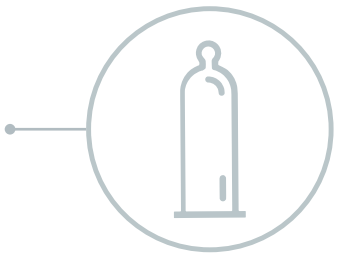
Health policies, plans and programmes in SEA need to specifically provide for adolescent girls and young women to independently access a range of modern contraceptive methods, without discrimination.



A particular challenge in accessing contraception in countries in SEA relates to laws and health policies specifying the age of consent for access to healthcare services. Since age of consent laws impact not only on access to contraceptives but also on a range of other SRH services, such as HIV testing and treatment, and are also interlinked with other age of consent laws that impact on young people's vulnerability to health risks (such as age of consent to sex and age of consent to marriage), age of consent laws are discussed in s3.4, with other legal issues, below.

3.3.2 Access to Comprehensive Sexuality Education

CSE is a key component of a holistic approach to adolescent sexual and reproductive health and rights, helping adolescents and young people to understand how to protect and promote their sexual health and wellbeing, prevent unintended pregnancies, STIs including HIV and reproductive health risks such as cervical cancer and get treatment and care for illnesses. Research on CSE and HIV, for instance, shows that CSE leads to improved knowledge, increased condom use, decreased multiple partners, better understanding of HIV prevention, and delays in initiating sex and better attitudes towards safer sex.[205] Health and education laws, policies, strategies and plans need to promote access to CSE for young people, including adolescents both in and out of school.

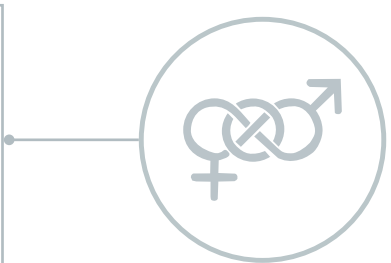


UNFPA (2017) recommends that countries ensure that their CSE is rights-based, includes accurate information and provides developmentally appropriate sexuality education[206] in line with international and regional commitments such as the International technical guidance on sexuality education and the Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa (ESA), (ESA Commitment).[207]

What is Comprehensive Sexuality Education (CSE)?

A rights-based approach to CSE seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality—physically and emotionally, individually and in relationships. It views sexuality holistically, as a part of young people's emotional and social development. It recognizes that information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values.

CSE covers a broad range of issues relating to the physical, biological, emotional and social aspects of sexuality. This approach recognizes and accepts all people as sexual beings and is concerned with more than just the prevention of disease or pregnancy. CSE programs should be adapted to the age and stage of development of the target group.[208]



CSE leads to improved knowledge, increased condom use, decreased multiple partners, better understanding of HIV prevention, delays in initiating sex and better attitudes towards safer sex.

Through the ESA commitments SEA countries[209] committed to scaling up CSE as part of their commitment to SRH and HIV prevention for adolescents and young people. They set a target that by 2020, 90% of teachers would be trained in CSE and that at least 90% of schools would have integrated CSE curricula.[210] In 2017, it was reported that this commitment has increased investment in CSE in the region with 2 300 teachers being trained on line and 42 000 receiving face to face training. Despite this progress, only 30% of girls and boys in Africa have comprehensive knowledge of HIV in the region.[211]

In addition to the training target, countries also made the following commitments:

- Reduce HIV infections amongst adolescents and young people aged 10-24. This includes reducing HIV infections by 75% and increasing knowledge of prevention to 95%.
- Promote gender equality and empowerment. This includes reducing the number of women childbearing by 75%; reducing the percentage of women who believe wife beating is justified; and reducing child marriage.
- Promote access to services among young people including HIV testing and antiretroviral therapy.
- Education institutions will have rules and guidelines for staff and students aimed at preventing school-related GBV.

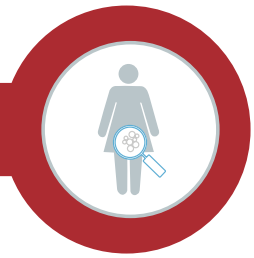
COMPREHENSIVE SEXUALITY EDUCATION IN SEA AS OF 2019

	Provision of CSE conduct
Angola	✓
Botswana	✓
Comoros	✗
DRC	✓
Kenya	✓
Lesotho	✓
Madagascar	In progress
Malawi	✓
Mauritius	✗
Mozambique	In progress
Namibia	✓
Seychelles	No information available
South Africa	In progress
ESwatini	✓
Tanzania	✓
Uganda	✓
Zambia	✗
Zimbabwe	✓

INCREASING ACCESS TO CSE IN SOUTHERN AND EAST AFRICA, 2014 - 2016[212]

134 teacher training colleges institutionalising CSE

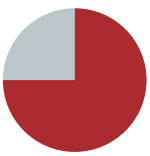
97 184 schools are implementing comprehensive CSE



3.3.3 Reproductive cancers, including cervical cancer

Cervical cancer is the most common cancer in women in sub-Saharan Africa, partly due to the high levels of HIV amongst women, and the leading cause of cancer deaths in Southern Africa, including in Madagascar, Mozambique, eSwatini and Zimbabwe. Cervical cancer is the second most common cause of cancer deaths amongst women in South Africa and Namibia. eSwatini is seeking to expand services to deal with increasing cases.[213] In Zimbabwe, it is estimated that nearly 75% of women with cervical cancer seek treatment too late because of limited screening, diagnosis and treatment services and stigma.

AMONG OTHER REASONS, STIGMA AROUND CERVICAL CANCER RESULTS IN



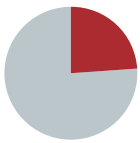
75%
of women seeking treatment too late

Cervical cancer, HPV and women and girls living with HIV

Cervical cancer is a preventable and treatable form of cancer if diagnosed early. The HPV vaccination, administered to adolescent girls before they become sexually active, is an essential component of prevention. Screening for cervical cancer is important for all women, but it is particularly important for women and girls living with HIV. Women and girls living with HIV are 4 – 5 times more likely than HIV-negative women and girls to get cervical cancer and cervical cancer has been recognised as an AIDS defining illness. Unfortunately, countries with high levels of HIV are often those with insufficient cervical cancer programming.

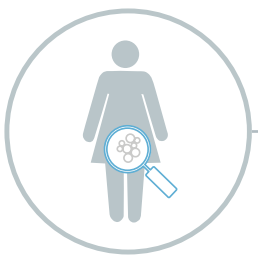
Access to cervical cancer prevention, screening and treatment are part of a comprehensive package of SRH care and the failure to provide them undermines the SRHR of women, including those living HIV.

IN 2013, CERVICAL CANCER SCREENING IN NAMIBIA REACHED



24%
of the female population

It is critical that SEA countries develop health policies, strategies and guidelines to address cervical cancer. Currently it is insufficiently addressed. For instance, a 2013 study showed that cervical cancer screening in Namibia only reached 24% of the female population, with more coverage in urban areas.[214] A 2012 report by Southern African Litigation Centre (SALC) on cervical cancer in Southern African concluded that very few SADC countries were effectively addressing cervical cancer, with few having comprehensive cervical cancer policies that ensure equal access to services in the public health system. While several countries in SEA have developed cervical cancer policies, the information in this report reinforces that more must be done to ensure that women, including women living with HIV, have timely access to prevention, screening and treatment.



Joint UN Programme on Cervical Cancer Prevention and Control

The Programme was launched in May 2016 and will support governments in developing and implementing functioning and sustainable high-quality national comprehensive cervical cancer control programmes that allow women to access services equitably. This is in line with the UNAIDS 2016–2021 Strategy, which emphasizes that prevention, treatment, care and support services should be integrated with services that address coinfections and comorbidities, and with SRH services.

Several countries have made progress introducing national HPV vaccination programmes. **Madagascar** began vaccinating girls with the HPV vaccine in a two-year pilot study in 2013.[215] **Zambia** also rolled out a national HPV vaccination programme in 2013. **South Africa** introduced a national HPV immunisation programme in 2014, targeting girls at the age of 9.[216]

In 2016, several SEA countries rolled out HPV programmes: Mauritius launched an HPV vaccination programme as part of its Expanded Programme of Immunization; Mozambique rolled out a national plan to provide the HPV vaccine to all 10 year old girls[217] and Namibia announced it would make the HPV vaccine available in the public sector and would target girls who were not yet sexually active. Previously the vaccine was only available through private practitioners.[218] The Swazi government also announced that it would roll out a national HPV vaccine programme in 2016.[219] The Seychelles introduced the HPV vaccination into its routine immunisation schedule in May 2014 and by 2016, it was reported that uptake of the vaccine was 86%.[220] Zimbabwe began a national HPV immunisation programme in 2018, aiming to immunise 800 000 girls.[221]

IN 2016, THE SEYCHELLES REPORTED AN UPTAKE OF THE HPV VACCINE WITH

86%
girls immunised

3.3.4 Access to safe abortion

Access to safe abortion, including post-abortion care, is a key component of women and girls' SRH and countries have binding human rights obligations to ensure that women can access safe abortions in accordance with their rights to health, equality and non-discrimination. Health policies, strategies and guidelines need to ensure non-discriminatory access to safe abortion and post-abortion care.

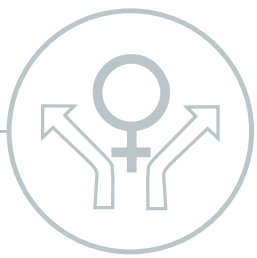
International and regional human rights standards on abortion

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) is currently the only human rights treaty to give women the right to access medical abortion. The treaty provides for limited circumstances where women are entitled to a legal abortion: where the pregnancy is the result of the sexual assault, rape or incest, or where the continued pregnancy would endanger the physical or mental health of the women or the life of the woman or foetus. All SADC countries that have ratified the Maputo Protocol have an obligation to decriminalise abortion and provide safe access in accordance with the Protocol.

In 2016, the African Commission on Human and Peoples' Rights and the Special Rapporteur on the Rights of Women in Africa launched a campaign to decriminalise abortion in Africa. The campaign aims to reduce the number of deaths related to unsafe abortions and to prevent women and girls from being criminally charged for having abortions.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) does not explicitly mention a right to abortion, but the CEDAW Committee has criticised restrictive abortion laws on the basis that these laws, particularly those that criminalise abortion in all circumstances, violate women's right to health. The CEDAW Committee continually encourages states to review punitive abortion laws.

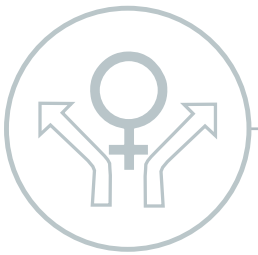
A 2015 study estimated that 93% of African women live in countries with restrictive abortion laws that allow legal abortions in very limited circumstances.[222] A 2012 Guttmacher study showed that abortions are increasingly concentrated in developing countries and correlate with poor access to contraception.[223] Improving access to contraception would therefore significantly reduce the number of unintended pregnancies and therefore abortions.



THE NUMBER OF AFRICAN WOMEN LIVING IN COUNTRIES WITH RESTRICTIVE ABORTION LAWS

93%
according to a 2015 study

Unsafe abortion has significant adverse health consequences for women and girls: the World Health Organisation (WHO) estimates that approximately 47,000 women die each year as a result of unsafe abortions, largely in countries with highly restrictive laws. Another 8 million women suffer serious and sometimes permanent injury as a result of complications from unsafe abortion.[224] In SEA, there are high levels of unsafe abortion and thousands of women experience adverse health consequences as a result of unsafe abortion, as set out in s2.2, above.



EVERY YEAR, COMPLICATIONS FROM UNSAFE ABORTION RESULT IN:

47,000 deaths due to unsafe procedures

8 million women suffering serious and permanent injury

ABORTION LAWS IN SEA AS OF 2019

	Abortion law
Angola	Abortion is permitted to save the life of the woman.[225]
Botswana	Abortion is permitted to preserve physical health, mental health, and in cases of rape, incest, and fetal impairment and to save the life of the pregnant women.[226]
Comoros	Access to abortion is restricted and only available to save the life of the woman or to preserve her health.227
DRC	Abortion is permitted to save the life of the woman.[228]
Kenya	The 1970 Penal Code criminalised abortion, but the 2010 Constitution makes some exceptions. Article 26(4), of the 2010 Constitution states that abortion is permitted when, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the woman is in danger, or if permitted by any other written law.[229] A 2019 decision by the High Court[230] held that the Ministry of Health's 2014 withdrawal of the "Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya", and its ban on abortion trainings for health care professionals, were unlawful. It also affirmed that abortion was permitted for victims of sexual violence.
Lesotho	There is no statutory law in Lesotho governing the performance of abortions. Instead, abortion is a matter of common law, which was patterned after Roman-Dutch common law. Under this law, abortion is prohibited except in cases of necessity. There is some disagreement, however, as to what constitutes a case of necessity.[231]
Madagascar	Abortion is criminalized except when it is the only way to save the life of the woman. Article 40 of Decree No 98-945 of 1998 on the Medical Professional Code of Ethics states that a therapeutic abortion can only be performed if three physicians, one of whom must be taken from a list of experts provided by the court, confirm that the life of the woman cannot be saved by any other means.[232] Both women and health care workers are subject to imprisonment in the case of unlawful abortion and health care workers can be suspended from practice for a period of five years to life.

Malawi	The Penal Code criminalises abortion unless it is performed to save the life of the pregnant woman. The Penal Code imposes a sentence of 14 years imprisonment on anyone who procures an abortion (this includes health care workers). Pregnant women who procure an abortion can be imprisoned for seven years and anyone who assists them can receive a sentence of three years. Although abortion is rarely prosecuted in Malawi, criminalisation has contributed to high levels of abortion-related stigma and confusion about when an abortion may be legally obtained.
Mauritius	Abortion was partially decriminalized in 2013 and is permitted to preserve the health of the woman, in cases of rape, incest or statutory rape or fetal abnormality.
Mozambique	Women can access legal abortions on request during the first 12 weeks of pregnancy. In cases of rape or incest, abortions will be legal during the first 16 weeks, and in cases of fetal anomaly, the first 24 weeks. Abortions must be performed at officially designated facilities by qualified practitioners.[233]
Namibia	While abortion is legal in Namibia under limited circumstances, the process to obtain a legal abortion is cumbersome: two doctors must certify that legal grounds exist, and if the application is based on mental health concerns, a psychiatrist must also certify that the grounds exist. A woman seeking an abortion on the grounds of rape must obtain a police report and obtain permission from a magistrate. Women who obtain illegal abortions may be imprisoned for up to five years. Health care providers may be imprisoned for up to three months. In addition to barriers to seeking legal abortion, women also struggle to obtain post-abortion care.[234]
Seychelles	Abortion has been partially decriminalised in the Seychelles since 1994. Women can terminate their pregnancies up to 12 weeks if the continued pregnancy put the health or life of the pregnant woman at risk or if there is a substantial risk that the child would be "seriously handicapped". Pregnancies that are the result of rape, incest or defilement can also be terminated or if the woman cannot care for the child because of mental incapacity.[235]
South Africa	The Choice on Termination of Pregnancy Act 1996 provides women with the right to terminate their pregnancies up to 12 weeks and then in limited circumstances beyond that time. Pregnant minors do not need the consent of their parents or guardians to terminate their pregnancies.[236]
eSwatini	Abortion is prohibited in all cases unless there is necessity. There is no guidance on what constitutes necessity for the purposes of obtaining a legal abortion.
Uganda	The Constitution bans the "killing of the unborn child" except as authorized by law. Abortion is criminalised in Uganda in terms of the Penal Code of 1950 except to preserve the life of the woman. Litigation has clarified that the provision should be interpreted to include preserving the mental health of the woman and the 2012 National Policy Guidelines set out additional circumstances where abortion may be legally performed. These contradictory laws and policies make it difficult for service providers and women to understand when abortion is legal.[237]
Tanzania	Abortion is permitted to save the life of the woman, to preserve physical health, and/or to preserve mental health.[238]
Zambia	The Termination of Pregnancy Act 1972 legalises abortion in certain circumstances, namely when the pregnancy poses a risk to the life of the woman, or to her physical or mental health or those of her existing children and where there is a substantial risk that the foetus would be "seriously handicapped". In addition, an amendment to the Penal Code in 2005 permits girls under 16 who have been raped to access legal abortion.
Zimbabwe	Abortion is partially decriminalised and the Termination of Pregnancy Act 29 of 1977 allows for abortions to save the life of the woman, preserve her physical health, where the pregnancy was the result of rape or incest or in cases of fetal impairment.

Only South Africa and Mozambique have decriminalised abortion in the first trimester of pregnancy and additionally permit pregnancies to be terminated under limited circumstances after the first trimester. All other countries permit abortions only under limited circumstances. Malawi has considered steps to liberalise its abortion laws: in 2016, the Ministry of Justice and Constitutional Affairs published a report of the Special Law Commission on the review of abortion laws and a draft law on the termination of pregnancy.[239] In 2017, the Madagascar National Assembly voted against an attempt to liberalise the abortion laws and two articles allowing for therapeutic abortion were deleted from a bill on family planning.[240]

Even in countries where abortion is partially decriminalised, women struggle to obtain accurate information about when it is legally available and many women are forced to resort to clandestine abortions.

Limited access to abortion in SEA countries

In **Mauritius**, despite the partial decriminalisation of abortion in 2013, many women are still unable to access safe and legal terminations of their pregnancies. In 2017, the UN Human Rights Committee expressed concern about the high number of women who were forced to endanger their lives by resorting to clandestine abortions.[241]

It is estimated that about 75% of abortions in the **Seychelles** are unsafe and take place in non-medical settings.[242]

Despite partial decriminalisation of abortion, **eSwatini** has high levels of unsafe and illegal abortion, especially amongst adolescent girls and young women; the government has yet to enact legislation or policy clarifying when and how legal abortions can be accessed.[243] In 2017, the UN Human Rights Committee expressed concern about the cumbersome procedures required to access legal abortion and the manner in which conscientious objection was blocking access for many women and girls in eSwatini.[244]

There is a widespread belief amongst health care workers and the general public that abortion is completely illegal in Uganda

Although abortion is legal in limited circumstances in Uganda, medical practitioners lack clarity on when they may legally perform abortions and many are reluctant to preform them because they fear legal consequences. There is a widespread belief amongst health care workers and the general public that abortion is completely illegal in Uganda. Many women also struggle to get access to contraception and there are instances where health care workers have required spousal consent before giving women access even though this is not required by law.[245]

3.3.5 Sexual and gender-based violence

Sexual and GBV continue unabated in SEA countries and continue to place women and girls at higher risk of HIV. 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.[246]

Africa has the highest reported rates of both physical and sexual violence against women of any region

The high levels of GBV in SEA persist despite most SEA countries having laws that criminalise various forms of GBV. Implementation of existing laws is reportedly weak, and violence and fear of violence undermines access to HIV prevention, treatment, care and support, as well as SRH care.

There also remain gaps in some laws – e.g. in relation to intimate partner violence and marital rape - in addition to these implementation challenges in many countries. Furthermore, few countries extend protection from domestic violence to same-sex couples.

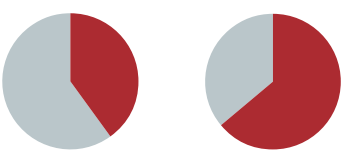
Examples in SEA: Gaps and challenges in laws protecting from gender-based violence

The current law in the **Seychelles** does not specifically criminalise acts of domestic violence. In 2013, the government reported during its statement to the UN Committee on the Elimination of All Forms of Discrimination against Women that it had developed a Domestic Violence Bill that explicitly criminalised domestic violence. It is not clear however when the new law will be enacted.

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

Only **Angola**, **Comoros, Lesotho**, **Mozambique**, **Namibia**, **Seychelles, South Africa** and **Zimbabwe** explicitly criminalising sexual violence in marriage. **Mauritius** confirmed in 2017 that it was possible to prosecute rape in marriage and in **Tanzania**, rape can only be prosecuted if the spouses are separated.

IN AFRICAN COUNTRIES, PHYSICAL VIOLENCE AFFECTS



40% - 64%
of women

3.3.6 Prevention and treatment of HIV and its co-infections TB and viral hepatitis, and other STIs

Various international and regional commitments commit SEA countries to taking steps to prevent new HIV and TB infections and to provide universal access to prevention services, including through addressing legal and policy barriers that block access to effective prevention. The 2017 *SADC Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual and Reproductive Health and Rights amongst Key Populations*, for example, confirms the high levels of both HIV prevalence and risk for key populations and the urgent need to address their access to HIV prevention. With respect to TB, the links between TB and human rights are increasingly being recognized at an international, regional and national level and rights-based responses are critical to effectively managing the epidemic.

The Global HIV Prevention Coalition, 2017

UNAIDS established the Global HIV Prevention Coalition[248] in 2017 to develop a roadmap to achieve the 2020 targets. The road map identifies four issues that need to be addressed to ensure progress on prevention: gaps in political leadership, legal and policy barriers, gaps in prevention financing, and a lack of systematic implementation of combination prevention programmes at scale.[249] The road map commits countries to take concrete steps to address the legal and policy barriers that undermine access to effective prevention, especially for most at risk and vulnerable populations. These include key populations and young people in and out of school.[250]

The links between TB and human rights are increasingly being recognized and rights-based responses are critical to effectively managing the epidemic

The enhanced focus on prevention has catalysed some progress in SEA countries, including those at higher risk of HIV exposure; however more needs to be done to ensure that people most at risk of HIV and TB are empowered to access HIV and TB prevention and treatment information and services. Access to TB diagnostics, treatment and care is also dependent upon income and where people live. The barriers created by intellectual property rights, the funding and the limited investment into research and development on improved TB drugs – typically a disease of less developed countries – is a global human rights issue that requires urgent attention.

Specifically for children, barriers to TB treatment for children are not particularly well understood, but a 2017 study identified several barriers that must be removed in order for children to benefit from TB treatment:

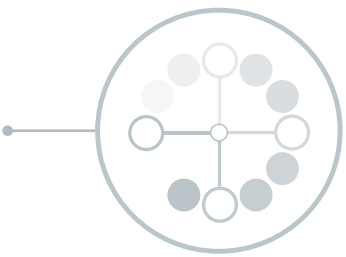
Costs: direct costs associated with treatment as well as indirect costs such as the cost related to caregiving undermine children's access to TB diagnosis and treatment. Catastrophic medical costs and poverty can delay and even prevent children from accessing treatment.

Infrastructure: Many children struggle to access TB treatment as a result of infrastructure barriers – these include distances to clinics, lack of laboratory services and delays in diagnosis and initiation of treatment. Health care workers are not always trained to diagnose and treat children with TB. Children living in rural areas experienced particular challenges.

Stigma and lack of information about TB and treatment is a significant barrier as parents and caregivers frequently do not have access to accessible information about the importance of timely and effective treatment.[251]

Prisoners are vulnerable to HIV and TB, due to prison conditions and a lack of access to health care services, including overcrowding and limited access to prevention methods, such as condoms, or harm reduction for people who use drugs. Laws criminalising key and vulnerable populations contribute to overcrowding in prisons.

A small number of countries where ARASA has partners do have progressive policies and programmes in place to support the human rights of prisoners to HIV prevention, treatment and care. However, the key messages on prisons from the second African Regional Dialogue noted the need for continuity of care for prisoners as they transition to the prison environment and once they leave the prison setting.



Laws criminalising key and vulnerable populations contribute to overcrowding in prisons

Laws and policies for HIV and TB prevention, treatment and care in prisons

In 2016, the **Uganda** Prisons Service begun implementing a project to scale up ART in prison settings. The prevalence of HIV was estimated to be 15% among prisoners and 12% among prison staff in 2015, compared to 7.3% in the general population. The programme shows positive preliminary results: the number of prisoners diagnosed with HIV increased during the first 9 months of 2017. The percentage of prisoners diagnosed with HIV who were newly enrolled in treatment increased from 59.8% in the first quarter of 2017 to 75.7% in the third quarter. In June 2017, among those enrolled on treatment who had viral load tests, 93% were virally suppressed.[253]

Both **South Africa** and **Malawi** have developed policies that address TB in prisons: South Africa has guidelines that outline a comprehensive package of TB and HIV prevention, treatment and care interventions for prisoners. Malawi has a policy on TB control in prisons and the NSP 2015 – 2020 articulates plans to align TB registration in the five largest prisons with the national TB programme and also includes plans to train prison officers on TB and HIV. In South Africa, 97% of prisoners living with HIV in South Africa are able to access treatment.[254]

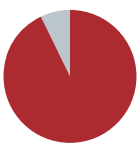
Zambia has made progress in prison-based HIV and TB care and treatment. The Zambia Correctional Service and the national TB programme worked with NGOs to improve HIV and TB detection among prisoners, prison staff, and the communities in and around six of the prisons with the heaviest TB burdens. They also reinvigorated efforts to institute routine TB screening at entry and train a cadre of prison peer educators in several facilities.[255]

However, prisoners in other countries are not as fortunate. Prisoners in **Zimbabwe** have access to only basic health care and are only tested for HIV if they request a test or a prison doctor requests one.[256]

IN UGANDA, AMONG THOSE ENROLLED ON TREATMENT WHO HAD VIRAL LOAD TESTS

93% were virally suppressed

AMONG PRISONERS LIVING WITH HIV IN SOUTH AFRICA



97% are able to access treatment

3.4 Other laws, regulations and polices impacting on access to sexual and reproductive healthcare information and services for vulnerable and key populations

There are various legal, policy, social, cultural, and other structural barriers that prevent vulnerable and key populations from accessing sexual and reproductive health care services in SEA. These include stigma and discrimination against people living with HIV, people with TB and key populations, laws addressing age of consent to SRH services, various criminal laws that act as barriers to access to sexual and reproductive health information and services more broadly for key populations such as people living with HIV, LGBTI people, people who use drugs and sex workers, and laws, policies and regulations which address intellectual property and access to essential medicines.

3.4.1 Stigma and discrimination against people living with HIV, TB and key populations

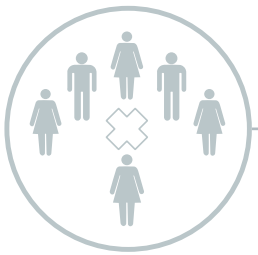
The People Living with HIV Stigma Index (SI) studies measure and detect HIV-related, and more recently TB-related stigma and discrimination against people living with HIV and people with TB. Botswana, the DRC, eSwatini, Kenya, Lesotho, Malawi, Mauritius, Mozambique, South Africa, Tanzania, Uganda, Zambia and Zimbabwe have all completed Stigma Index studies in stigma and discrimination, while Comoros is currently planning a study and a handful of countries have conducted or are planning follow up studies.[257]

The SI studies show that stigma and discrimination has not yet been eliminated and remain key concerns for people living with HIV and TB and for key populations. A review of the findings of the Stigma Index studies illustrate the many dimensions of stigma and discrimination and how these undermine access to health care and other services. Surveys indicate that discrimination in health-care settings still occurs, especially towards key populations. About one in three people living with HIV surveyed in Mauritius said they were denied health services because of their HIV status and that their HIV status had been disclosed without consent.

In Uganda, almost two thirds (64%) of surveyed people who inject drugs said they avoided health-care services for fear of discrimination or of being reported to law enforcement authorities.[258] In Botswana, Mozambique, Namibia, South Africa, and Zimbabwe, more than a third of sex workers felt discriminated against when they tried to access a health service. Sex workers were also refused medical assistance when health care workers found out that they do sex work.[259]

In Botswana, Mozambique, Namibia, South Africa, and Zimbabwe, more than a third of sex workers felt discriminated against when they tried to access a health service

The SI studies also illustrate the role that self-stigma plays in the lives of people living with HIV: they experience shame and feelings of guilt and a lack of self-esteem which prevent them from engaging in relationships and/or having children. Women are especially vulnerable to stigma in their relationships, communities and health care settings.[260] There is also increasing evidence of TB- related stigma, especially amongst already stigmatised groups.[261]

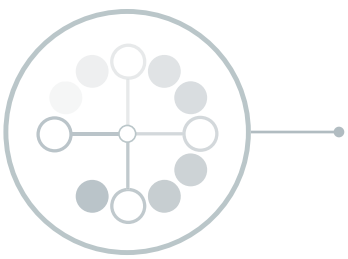


Example: HIV-related stigma and discrimination in Tanzania

The National Council of People Living with HIV (NACOPHA) Stigma Index study, 2013 showed high levels of stigma and discrimination against people living with HIV countrywide (39.4%) and particularly high levels in Dar es Salaam (49.7%). The most common forms of stigma and discrimination were gossip, social exclusion and verbal insults. Nearly one in three people in Dar Es Salaam experienced a loss of job or other source of income.

People living with HIV who participated in the Stigma Index also reported high levels of internal stigma and shame: they blamed themselves for being infected and avoided sexual relationships, decided not to have children, avoided social gatherings, and were afraid of being gossiped about.[262]

In 2017, the Legal and Human Rights Centre reported that HIV-related stigma and discrimination continued to be an issue on the streets, at work, at health facilities and at schools.[263]



Key populations also experience stigma and discrimination within their families and communities; this has been discussed in relation to each key population in s3.2, above. One study found that only 6% in Malawi of people would tolerate "homosexual neighbours"; 7% in Zambia; 10% in Zimbabwe; 12% in Madagascar; and 16% in Lesotho.[264] Young people, including young key populations, also report stigmatising attitudes and denial of appropriate sexual and reproductive health information services, creating further barriers to access to health care.

Discrimination in health care against women with HIV continues to be documented and acts as a major barrier to access to health care for key these populations.

% PEOPLE WHO WOULD TOLERATE "HOMOSEXUAL NEIGHBOURS" IN THE FOLLOWING COUNTRIES:

Discrimination against women with HIV in healthcare

SALC's study into discrimination in healthcare settings in Botswana, Malawi and Zambia[265] found various forms of discrimination against women with HIV in the healthcare setting, including treatment without proper informed consent, including failing to explain treatments and diagnoses; denial of treatment; aggressive attitudes and derogatory language; gossiping and unlawful disclosures of HIV status.

"Some HIV-positive expecting mothers are put on family planning without their full knowledge or consent. I have a deaf friend who was put on family planning without her full and informed consent." (Woman living with HIV respondent – Kabwe, Zambia)

"At Kasanda Clinic, they test you for HIV before providing family planning to you. Anyone who wants to receive family planning services has to test for HIV."
(Women living with HIV respondents – Kabwe, Zambia)

According to UNAIDS Data 2019 discriminatory attitudes are expressed by over 30% of people in Angola, over 25% in Uganda and over 20% in Mozambique.[266]

A number of countries in SEA have laws, policies and plans that provide for protection against HIV-related discrimination, including within healthcare settings and the working environment. However, it is clear that reducing stigma and discrimination requires efforts in addition to protective laws, including stigma and discrimination reduction programmes, efforts to train and sensitise healthcare workers as well as efforts to strengthen knowledge of rights and how to claim redress for rights violations.

In addition, laws criminalising HIV transmission, exposure and non-disclosure, which were identified as a key issue in the first ARASA human rights review of 2006, are arguably based on and contribute towards further HIV-related stigma and discrimination. Criminalisation is argued to reinforce stigma and undermine universal access to prevention, treatment, care and support for people living with HIV and people with TB. The issue of criminalisation of HIV transmission is dealt with in further detail, below.

Laws criminalising HIV transmission, exposure and non-disclosure, are arguably based on and contribute towards further HIV-related stigma and discrimination

Additionally, there are increasing reports of TB-related stigma and discrimination. The ARASA 2016 report[267] noted that countries have limited documented information on TB and human rights violations. However, some countries are beginning to investigate and document these reports, in order to build the evidence around stigma and discrimination against people with TB. Various efforts to document TB-related stigma and discrimination include, amongst others:

- Civil society efforts to document stigma, discrimination and human rights violations (e.g. through ARASA, KELIN and other partners in SEA countries)

- Efforts to conduct legal environment assessments for TB – either through stand-alone assessments conducted by governments with the support of the Stop TB Partnership, or integrated within HIV assessments conducted by governments in SEA with the support of UNDP, and
- Baseline assessments of human rights barriers to HIV and TB services, supported by the Global Fund to Fight AIDS, TB and Malaria (GFATM).

% DIAGNOSED WITH TB WHO REPORTED BEING TEASED, INSULTED OR SWORN AT

36%
of people

In South Africa, a GFATM-supported baseline assessment of human rights barriers to HIV and TB services found that stigma and discrimination against people with TB in communities and health care facilities, as well as self-stigma, is a serious challenge, leading to avoidance of and delay in seeking health care services, particularly with fears around breaches of confidentiality due to contract tracing and directly observed treatment (DOTs).[268] For those co-infected with HIV, the burden of stigma is compounded. The People Living with HIV Stigma Index survey found that over one-third (36%) of respondents with HIV and TB reported being teased, insulted or sworn at because of their TB status; 41% reported being gossiped about because of their TB status; and, 27% harboured personal feelings of uncleanliness or dirtiness in relation to their TB diagnosis.[269]

In Kenya, a 2017 Legal Environment Assessment for Tuberculosis found that TB-related stigma continues to prevail, and that there is limited guidance on addressing TB-related discrimination and violation of human rights at the facility and policy level. Empowerment and education of patients on rights and about TB is largely left to community based, civil society and partner organizations.[270]

3.4.2 Criminalisation of HIV transmission

In 2019, at least 29 sub-Saharan African countries have HIV criminalisation laws

Data from HIV Justice Worldwide and the HIV Justice Network, indicates that in 2019, a total of 75 countries across the world currently have such laws.[271] In 2019, at least 29 sub-Saharan African countries have HIV criminalisation laws. Prosecutions are known to have occurred (under HIV-specific laws and general criminal laws) in Botswana, Cameroon, Congo, Democratic Republic of Congo, Kenya, Lesotho, Malawi, Niger, Nigeria (Lagos State and Zamfara State), Somalia, South Africa, and Zimbabwe.[272] Of the countries in sub-Saharan Africa that have adopted HIV-specific laws, only 2 countries (Mauritius and Comoros) have not included a provision that criminalises HIV transmission. In addition, there are also countries (e.g. Zimbabwe) that criminalise HIV transmission outside of HIV-specific laws – e.g. they have public health or penal code provisions criminalising HIV transmission, exposure and/or non-disclosure.

UNAIDS' 2013 *Guidance on ending overly broad criminalisation of HIV non-disclosure, exposure and transmission* reiterates that there is no evidence that criminalising HIV non-disclosure, exposure or transmission is effective in addressing HIV and AIDS. The

guidance states that the overly broad application of the criminal law to non-disclosure, exposure and transmission of HIV causes significant human rights and public health concerns and urges countries to review provisions in light of the most recent, legal, medical and scientific evidence. It sets out key principles that should guide the use of the criminal law in dealing with harmful HIV-related behavior and recommends that the use of criminal law in relation to HIV should be guided by the best available scientific and medical evidence relating to HIV; and uphold the principles of legal and judicial fairness (including key criminal law principles of legality, foreseeability, intent, causality, proportionality and proof), and protect the human rights of those involved in criminal law cases.[273]

The GCHL confirmed, in 2012, that broadly worded statutes criminalising HIV transmission, exposure and non-disclosure are "inconsistent with international human rights law as they result in criminalisation of a wide range of negligent or reckless acts by persons who may even be unaware of their HIV status." The report concluded that many of these laws were poorly drafted and couched in broad language, lowering the standards of proof and widening the net of liability in a way that is legally unacceptable.[274]

The indiscriminate use of criminal law against people living with HIV is increasingly unjustifiable

The GCHL's 2018 *Risks, Rights & Health Supplement* includes updated recommendations on the criminalisation of HIV transmission, given the continued enactment and/or inappropriate use of criminal laws against people living with HIV and the slow pace of law reform, combined with recent advances in medical and scientific evidence on HIV transmission. Pre-exposure prophylaxis (PrEP), although not yet widely available, may be taken to prevent HIV transmission. More importantly, definitive studies show that ART, taken consistently, reduces a person's HIV viral load to undetectable levels and prevents HIV transmission. In light of these findings, the indiscriminate use of criminal law against people living with HIV becomes increasingly unjustifiable.

While many HIV-specific laws in the region, are termed "willful" or "**deliberate transmission**", the mental element of the offences often go further than punishing malicious and intentional conduct but include negligent conduct and even cases where the accused does not know their HIV-status or had no intention to transmit HIV. For example, section 79 of Zimbabwe's Criminal Law (Codification and Reform) Act [Chapter 9:23] is titled "deliberate transmission of HIV". The offence doesn't just criminalise people who know their HIV status and who act intentionally with the specific intent to transmit HIV.

Moreover, many of these offences do not require proof that actual transmission has occurred but would include possible exposure to HIV and/or someone not disclosing their HIV status. For example, section 26 of Kenya's Sexual Offences Act No 3 of 2006 criminalises conduct that the person knows or ought reasonably to know "**will infect**" another person with HIV or "**is likely to lead**" to their being infected. The offence has been applied against people living with HIV who are accused of conduct that scientifically has no risk of HIV transmission, such as in a case where a man living with HIV was charged with the offence after biting a police officer.

Of particular concern is the failure to recognise undetectable viral load, protected sex or disclosure of HIV status as a defence to prosecution

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

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

SADC PF Motion: HIV criminalisation

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

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

Very few laws have been repealed since 2009, as recommended in the 2009 ARASA HIV and Human Rights report,[275] but there has been some progress in the DRC, Malawi, Mozambique and Zimbabwe. The Mozambique HIV Law 12/2009 was reviewed in 2013 and the criminalization provision was removed. In 2018, following eight years of effective civil society lobbying, parliamentarians voted to amend Article 41 and abolish Article 45 removing the criminalisation provisions from the DRC HIV Law 08/011.

Malawi HIV and AIDS (Prevention and Management) Act 2017 excludes criminalisation of HIV transmission

Malawi's new HIV/AIDS (Prevention and Management) Act No. 12 of 2017, which came into force on 1 February 2018, removes all provisions to make HIV testing and treatment mandatory for select populations on a discriminatory basis, and provisions that criminalise HIV exposure and transmission that were included in the draft bill. Parliament's willingness to remove these provisions has been praised by CSOs and people living with HIV as a show of commitment to promoting a human rights-based response to HIV based on the best available scientific evidence, to realise the 90-90-90 targets to end AIDS.

In 2017 in the **Malawi** case of *EL v The Republic*,[276] the High Court upheld an appeal of a woman living with HIV against her conviction of a crime for breastfeeding her child. The Court found that the appellant did not have the requisite knowledge or belief that breastfeeding the child was likely to spread HIV.

In 2019, **Zimbabwe** tabled a Marriage Bill which proposes to repeal their HIV criminal law.[277]

However, alongside these positive developments, a number of countries in SEA have enacted broad laws criminalising HIV transmission. **Botswana** adopted a new Public Health Act in 2013 that contains "vague and overly broad"[278] provisions allowing for coercive public health responses, including isolation and detention, for HIV exposure. The Act also allows for forced HIV testing, mandatory disclosure of HIV status and limitations on the freedom of movement of people living with HIV.

The **Uganda** HIV and AIDS Prevention and Control Act was passed in 2014 and contains provisions criminalising HIV transmission and exposure. It also contains other problematic provisions such as mandatory HIV testing of pregnant women and their partners, victims of sexual offences and people convicted of a sexual offence, drug use and sex work; and the disclosure of HIV status without consent by medical practitioners.[280]

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

Zimbabwe's Public Health Bill 2017, includes punitive provisions for intentional transmission of a sexually transmitted infections and provides medical practitioners with a duty to report, in certain circumstances.[281]

3.4.3 Criminalisation and punitive responses to people with TB

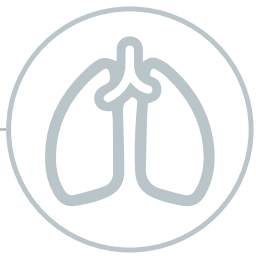
In similar ways to people living with HIV, people with TB are also subjected to violations of their human rights. Current responses to TB often fail to respect human rights and include criminalising patients with TB who fail or refuse to take their treatment, forcing them to take treatment or be hospitalised, isolating them and detaining them in prisons, and subjecting them to home arrests and travel restrictions. These responses fail to recognise and take into account why people may default on treatment. They also serve to increase stigma and discrimination around TB.

Some of these measures may in fact increase health risks: many people are placed in facilities with sub-standard conditions, violating other human rights and, in the case of imprisonment, placing people with TB at increased risk and exposing other prisoners to the risk of TB infection. Measures such as involuntary isolation and involuntary detention should only be used as a measure of last resort, when voluntary, rights-based and community-based treatment models have not succeeded.

Limiting people with TB's human rights in the name of public health [282]

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

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

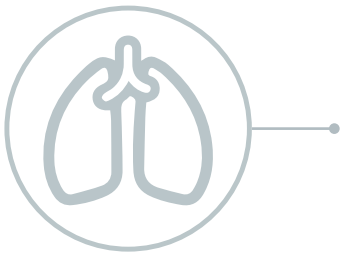


Criminalisation of TB status, involuntary treatment, involuntary isolation and involuntary detention are the four main areas where governments implement laws, policies and practices which undermine the health and other human rights of people affected by TB.

Existing laws which violate the human rights of people with TB

Zimbabwe's Public Health Bill 2017 includes provisions for the control of infectious diseases, including tuberculosis. It provides for the removal and detention of persons suffering from infectious diseases, in places of isolation, to guard against the spread of disease. Such persons can be detained until such time as the Director of Health Services or any medical practitioner is satisfied that the person is free from infection. It is important that isolation provisions such as these be accompanied by appropriate facilities as well as guidance on the implementation of isolation in a manner that respects the rights of TB patients.

South Africa's new Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions came into effect in June 2017. TB, including MDR-TB, is listed as a Schedule 2 notifiable condition, requiring full nominal reporting of TB and MDR-TB to provincial and national public health authorities. As a Schedule 2 notifiable condition, people with TB may be subjected to mandatory medical examinations and treatment or confinement in a medical facility, in exceptional conditions. The Regulations stipulate that these measures are only permissible as a last resort, in terms of a court order. The implementation of these regulations will require monitoring to ensure they do not unnecessarily violate the rights of people with TB.



There is an increasing awareness across countries in SEA of the importance of rights-based responses to TB and there are some examples of successful advocacy efforts. In Botswana, for example, in 2012, civil society advocated against proposed draconian provisions in the Public Health Bill to deal with communicable diseases. These included provisions allowing for the detention of a person in a health facility to prevent the spread of a disease and criminalising escape from detention. Some of the more restrictive provisions, such as notifying cases of TB to the police services, were removed from the Bill. However, many restrictive provisions remain in the Public Health Act, 2013.

In Kenya, KELIN and other civil society partners advocated for the provision of TB treatment to a patient for XDR-TB at no cost, on the basis that the failure of the government to provide the treatment violated the patient's constitutional right to health. Also, in Kenya, the High Court declared in March 2016 that the practice of confining TB patients in prisons for purposes of treatment is unlawful and unconstitutional. Justice Mumbi Ngugi ruled that imprisonment of TB patients is unlawful, unconstitutional and a violation of their fundamental human rights to movement, dignity and security. The Court ordered an immediate stop to this practice. The Court further directed the Cabinet Secretary for Health to develop a policy within 90 days, in consultation with the county governments, on the involuntary confinement of individuals with tuberculosis that is compliant with the Constitution. This policy has to incorporate principles from the World Health Organization's international guidance on the involuntary confinement of individuals with TB.[283]

On 26 July 2019, the Gauteng High Court in Johannesburg confirmed a historic R5-billion settlement in a class action case brought against mining companies on behalf of all miners with occupational silicosis and TB.[284] The plaintiffs argued that the defendants (over 30 gold mining companies, including African Rainbow Minerals, AngloGold Ashanti, Gold Fields and Harmony Gold companies), knew of the dangers posed to the miners by exposing them to silica dust and that defendants failed to take adequate measures to protect the workers from this exposure. The case had four classes of claimants: those who contracted silicosis or were exposed to silica dust; the dependents of deceased miners with silicosis; those who contracted tuberculosis; and the dependents of deceased miners that contracted tuberculosis while working at the mines. The case which was allowed to continue we a class action in 2016 and in 2019 a settlement which established a trust to pay miners, or the families of miners who have died of silicosis and TB was confirmed as a court order.

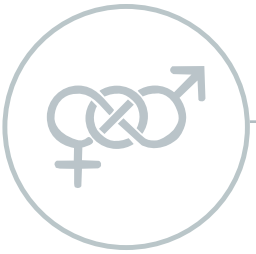
3.4.4 Age of consent

One of the key legal and policy barriers specifically limiting access to sexual and reproductive health information and services, such as modern contraception for AGYW and young people, relates to age of consent laws in countries in SEA.

For instance, laws that fail to set a clear age of consent or stipulate a minimum age of consent for independent access to healthcare services, such as HIV testing and contraception, deny minors the right to access contraception without the consent of a parent or guardian. According to UNFPA (2017),[285] the lack of legal and policy provisions for clear age of consent to issues such as contraception, sexual and reproductive health care and HIV testing can lead to confusion as to when young people can consent to receive health services, including medical treatment. This uncertainty creates a barrier to accessing sexual and reproductive health services and allows health-care providers to enforce their own belief systems regarding an appropriate age of consent.

The GHCL's 2018 *Risks, Rights & Health Supplement* notes that adolescent girls and young women are further behind in access to HIV-related and sexual and reproductive health care services and recommends that governments "adopt and enforce laws that protect and promote sexual and reproductive health and rights" and "remove legal barriers to accessing the full range of sexual and reproductive health services."[286]

More specifically, UNFPA (2017)[287] has recommended that countries in SEA should set the age of consent to access to healthcare services based on an adolescent's sufficient maturity to understand the risks, benefits and consequences of the treatment, and set the age of consent at 12 years for HIV testing, pre- and post-test counselling without parental consent. It also recommends that countries provide, in law, for health-care providers to respect the views and opinions of the adolescent or young person accessing a service and their right to confidentiality and should guide health-care providers on how they can assess this maturity. UNFPA further recommends that the age of consent to sex be harmonized for boys and girls and be aligned to the age of consent to access to contraception.[288]



Age of consent to access SRH services in SEA[289]

Democratic Republic of Congo (DRC), Mauritius, Seychelles, eSwatini and Tanzania require minors below the age of 18 years to have parental consent for access to sexual and reproductive health services. In Zambia and Zimbabwe, minors below 16 years of age require parental consent to access sexual and reproductive healthcare services.

However, some countries – such as South Africa and Lesotho - provide for young people to independently consent to access contraception, HIV testing, treatment and care from 12 years of age.

Some countries have taken steps to strengthen young people's access to SRH services in laws, policies and guidelines. In Namibia, Child Care and Protection Act 3 of 2015, which entered into force in Jan 2019 provides that a child may consent to a medical intervention (including HIV testing from 14 years.

The Zimbabwe National Guidelines on Clinical Adolescent and Youth Friendly Sexual and Reproductive Health Service Provision, 2016 are intended to facilitate access to youth friendly sexual and reproductive health services. The guidelines do not specify a minimum age at which adolescents can receive SRH services without parental consent but do expressly state that age should not be a barrier to receiving services. They specifically state that adolescents should be able to access contraception regardless of age or marital status.

In September 2017, the National AIDS Council of the DRC held consultations to discuss fast-tracking the DRC's prevention efforts. The consultation recommended passing a revised HIV law that would allow adolescents to access HIV prevention services.

The Zambian government developed a position paper on HIV prevention in 2017. The recommendations to scale up prevention include developing a policy for in and out of school youth that defines age specific services and clarifies the age of consent to SRH services, reviewing the legal framework to identify and address barriers to HIV prevention for key populations and increasing government's commitment to address legal barriers to providing condoms and lubricants to men who have sex with men and prisoners.

3.4.4.1 Age of consent to sex

Laws that criminalise consensual sex between young people exacerbate barriers to access to contraception and other sexual and reproductive health information and services, creating confusion for adolescents, parents, healthcare workers and law

enforcement officials about when they may lawfully engage in consensual sexual activity and how officials and service providers should respond to adolescent sexuality. In SEA, many countries criminalise underage sex between consenting adolescents and/or consensual same sex activity between adolescents. In addition, several countries have discriminatory age limits, usually setting a higher age for girls or not specifying a minimum age for boys.

A statutory age of consent to sex that takes into account the evolving capacity of adolescents and recognizes consensual adolescent sex can facilitate access to SRH services, including modern contraception, and complement HIV prevention messages.

AGE OF CONSENT TO SEX IN SEA[290]

	Legal age
Angola	16 for boys and 18 for girls.
Botswana	Sex with a girl under the age of 16 is criminalised; a minimum age is not specified for boys.
Comoros	The age of consent to sex is 13 for girls and not specified for boys.
DRC	14 for girls; 18 for boys.
Kenya	Age of consent to sex is 18 years.
Lesotho	Sexual acts with a child below the age of 16 are criminalized.
Madagascar	The age of consent to sex is 14 for girls and not defined for boys. Sex with a girl below the age of 14 is deemed to be an indecent assault and criminalised by the Penal Code.
Malawi	Sexual activity with a child below the age of 18 is criminalised.
Mauritius	The age of consent to sex is 16 for both boys and girls and sex with someone below that age is criminalised.
Mozambique	The age of consent to sex for boys is not defined while the Penal Code criminalises sex with a girl below the age of 18.
Namibia	The age of consent to sex is 14 for boys and girls, but there is a close in age exception of three years.
Seychelles	The age of consent to sex is 16 for boys and girls. There is no close in age exception[291] and a person above the age of 18 may be imprisoned for up to 14 years, while a person below the age of 18 is liable for up to 5 years imprisonment if they have sex with a person below the age of consent.[292]
South Africa	The Sexual Offences Act 2007 sets the age of consent to sex at 16 for boys and girls and criminalises consensual sex between adolescents between the ages of 12 and 16. A close in age defence is permitted for sexual violation but not for sexual penetration.
ESwatini	The Girls and Women Protection Act of 1920 sets the age of consent to sex at 16 for girls and the Sexual Offences and Domestic Violence Bill (yet to be enacted) sets it at 16 for both boys and girls.
Tanzania	18 for boys and 15 for girls.
Uganda	The age of consent to sex is 18 for boys and girls. The Penal Code criminalizes sex with a child under the age of 18.
Zambia	The age of consent to sex is 16 for girls and not specified for boys. Sex with a girl below the age of 16 is criminalized by the Penal Code.
Zimbabwe	The age of consent to sex is 16.

3.4.4.2 Laws regarding age of consent to marriage / child marriage

Complications from pregnancy and child birth are the leading cause of death for adolescent girls between the ages 15 and 19.[293] Ninety percent of adolescent pregnancies in the developing world occur within the context of child marriage, which remains a critical human rights concern for adolescent girls in SEA countries such as DRC, Kenya, Madagascar, Malawi, Mozambique, Tanzania and Uganda.[294] In 2017, UNICEF data showed that 38% of girls below the age of 18 in sub-Saharan Africa were married. Twelve percent of girls below the age of 15 were also married in that region.[295]

Child marriage in SEA

Mozambique (9), Malawi (11), Madagascar (13), Uganda (16) and the DRC (19) are amongst the twenty most affected countries, while the DRC, Uganda, Tanzania, Mozambique and Kenya are amongst the 20 countries with the highest absolute numbers of child brides.[296]

Child marriage also plays a critical role in driving HIV infections amongst girls in sub-Saharan Africa and has particularly harmful consequences for girls' education, as not all SEA countries have adopted and implemented laws and policies that protect the rights of pregnant adolescents and adolescent mothers to stay in school.

Example: Pregnancy and Access to Education

Lesotho and the DRC have adopted laws that allow girls to continue their education. Botswana, Kenya, Madagascar, Malawi, Mozambique, Namibia, South Africa, ESwatini, Zambia and Zimbabwe have policies that allow girls to re-enter schools under certain conditions.[297] Tanzania currently has an expulsion policy and does not allow pregnant girls to resume their education.[298]

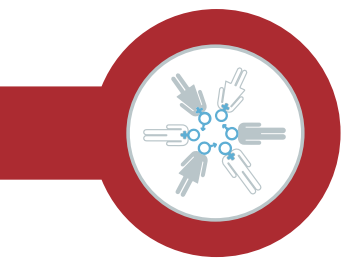
One of the key steps for governments to reduce child marriage is through setting a legal minimum age of marriage at 18 years of age for both boys and girls with no exceptions. However, very few countries in SEA have set a minimum age of marriage at 18 years with no exception.

The Southern African Development Community (SADC) Model Law on Eradicating Child Marriage, and Protecting Children Already in Marriage[299]

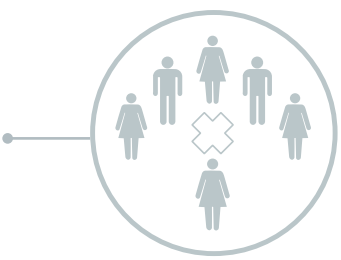
On June 3rd, 2016, The Southern African Development Community Parliamentary Forum (SADC-PF) adopted the Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage. The model law encourages member states to harmonise their national laws to prevent child marriages. The Model law has been used as an advocacy tool in Zambia, which has begun a review of its Marriage Act, with the aim of criminalizing child marriage. Malawi has also taken steps in eradicating child marriage by removing a provision in its Constitution that allowed children between the ages of 15 and 18 years to marry.

The 2014 and 2016 ARASA *HIV and Human Rights Reports* noted considerable progress in raising awareness about the abuses associated with child marriage and galvanizing support for efforts to end the practice. This progress has continued and in March 2018, UNICEF published new data that showed a significant drop in the global number of child marriages from 15 million new marriages every year to 12 million.[300] In 2015, the SDGs included targets to end child marriage by 2030.[301]

3.4.5 Criminalisation of same-sex sexual conduct



The 2016 ARASA HIV and Human Rights report found that although the majority of the countries surveyed still had laws that criminalised consensual sex between men and some criminalized consensual sex between women, positive changes could be seen, most notably the decriminalization of sex between men in Mozambique and the Seychelles. The report cautioned that it was too early to conclude whether these developments were indicative of a trend where more SEA countries would review or repeal anti-homosexuality laws.



Globally and within SEA, there has continued to be slow but important progress on LGBTI rights in terms of standard setting and awareness raising in regional and international human rights institutions. A 2016 UN report found that awareness about the widespread violence and discrimination targeted at LGBT people had grown and that over 100 countries, including some in SEA, had made commitments to addressing SOGI-related violence and discrimination.[302]

Recent, positive developments in SEA include:

- South Africa developed its first LGBTI HIV national plan and began a study on transgender health, including HIV.[303]
- In October 2017, a Botswana court ruled that a transgender man could have official documents that reflected his gender identity.[304]
- In March 2018, a Kenyan court ruled that forced anal examinations of people accused of having same sex sexual activity was unconstitutional.[305]
- In January 2019, Angola repealed the law criminalising same-sex sex and prohibited discrimination against people on the basis of their sexual orientation, with punishment of up to two years' imprisonment.[306]
- In June 2019, the Botswana High Court unanimously struck down penal laws criminalizing same-sex sexual conduct between consenting adults.[307]

The UN and SOGI

On 30 June 2016, the UN Human Rights Council adopted a third resolution on sexual orientation and gender identity.[308] The resolution provides for the appointment of an independent expert on violence and discrimination based on sexual orientation and gender identity. The DRC and Kenya voted against the resolution and Botswana, Namibia and South Africa abstained from the vote.

In October 2017, the Third Committee (the main body of the UN General Assembly dealing with human rights) received its first report from the UN Independent Expert on the protection from violence and discrimination based on sexual orientation and gender identity. The report called for immediate action to stop the "horrific violations" against LGBTI people. The Independent Expert called for all countries to repeal laws that criminalise same sex relationships.[309]

These positive trends are not universal in SEA and very few countries have any laws that protect people from discrimination and violence based on SOGI.

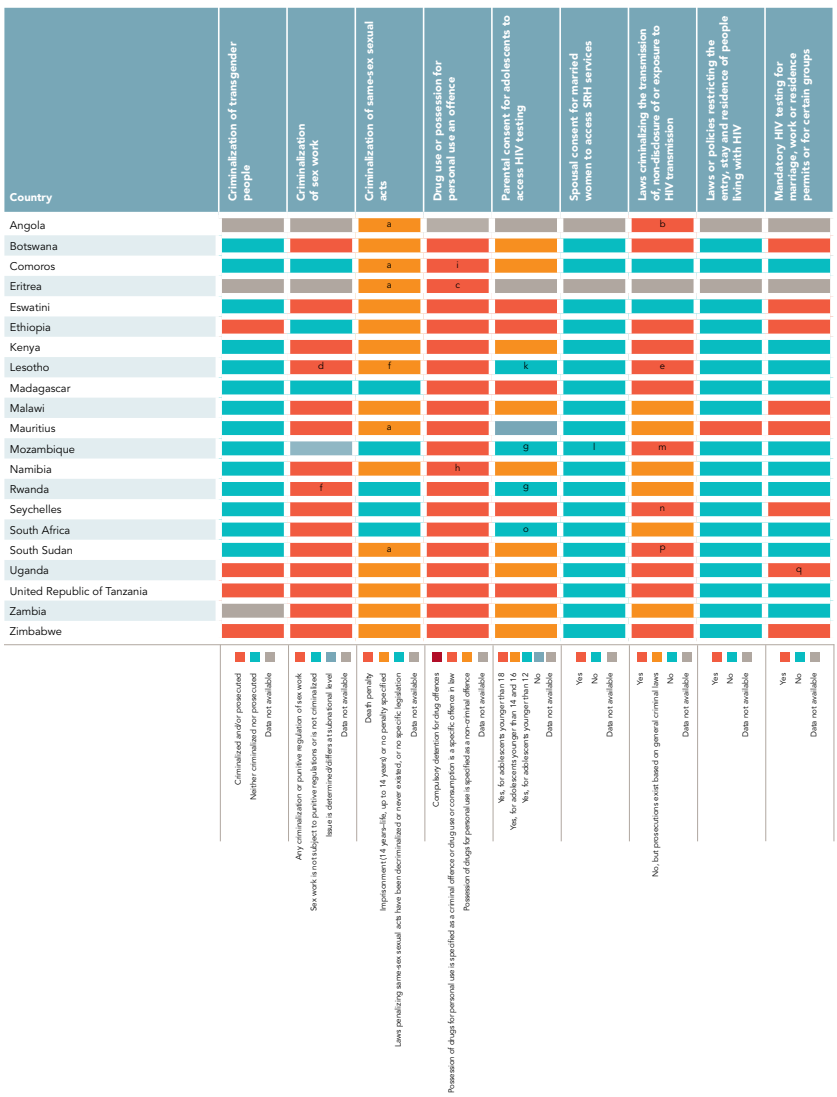
Ugandan LGBTI groups cancelled the annual Pride celebrations in Kampala and Jinja in 2017 after the government threatened to arrest the organisers and in December 2017, the government shut down the Queer Kampala International Film Festival. Ugandan police continue to conduct forced anal examinations of men and transgender women accused of consensual same sex conduct.[310] Despite the decriminalization of same sex in Mozambique in 2016, the country's only LGBTI organization, LAMBDA has struggled to obtain registration.[311] Groups and organisations advocating for the rights of LGBTI people, including for access to HIV testing and treatment, have experienced government opposition, making it difficult for them to operate freely in several ARASA partner countries. In May 2019, the High Court in Kenya upheld penal laws criminalising consensual sex between same-sex adults.[312]

Tanzania cracks down[313]

Since 2016, the government has intensified its repression not only of LGBTI men and women, but also of their supporters and advocates. In 2017, a young man was arrested for homosexuality based on pictures he posted on his Instagram account and subjected to an anal examination. The police also arrested parents of key population members attending a workshop and activists and lawyers attending a legal strategy meeting.

The closure of drop in centres and private clinics providing SRH services for key populations and the banning of distribution of water-based lubricant has undermined access to essential care and support for LGBTI people, including access to HIV testing. Organisations in Tanzania reported that the crackdown has resulted in gay men and other men who have sex with men losing access to their ART.

LAWS AND POLICIES SCORECARD



Note: Data on laws restricting the entry, stay and residence of people living with HIV are currently undergoing a global review that will involve country validation. An update is expected by the end of 2018.
Sources: National Commitment and Policy Instrument, 2017 and 2018; supplemented by additional sources where noted.

CRIMINALISATION OF MEN WHO HAVE SEX WITH MEN AND SUPPORTIVE LAWS

	Criminalise same sex conduct between men	Laws promoting/ prohibiting discrimination
Angola	✓	✗
Botswana	struck down by court 2019 ✗	✓
Comoros	✓	✗
DRC	Can prosecute on the basis of indecent assault	✗
Kenya	✓	✗
Lesotho	✓	✗
Madagascar	✗	✗
Malawi	Laws currently not being enforced pending review	✗
Mauritius	✓	✗
Mozambique	✗	✓
Namibia	✓	✗
Seychelles	✗	✓
South Africa	✗	✓
ESwatini	✓	✗
Tanzania	✓	✗
Uganda	✓	✗
Zambia	✓	✗
Zimbabwe	✓	✗

Transgender people remain a neglected and often invisible population in the epidemic. Transgender women are disproportionately affected: a 2016 UN publication stated that they have "borne the epidemiological brunt of HIV disease."[314] There is very little data on HIV infection amongst transgender women, but where it is available, it shows "disturbing levels" of HIV.[315] Only Botswana, Lesotho, South Africa and Tanzania have identified transgender people as a key population, although there is limited provision for appropriate healthcare services.

3.4.6 Criminalisation of aspects of sex work

The GCHL Supplementary Report found, based on a review of 27 countries, that "countries that have legalised some aspects of sex work have significantly lower HIV prevalence among sex workers," especially if such legalisation was properly enforced. Another study found that decriminalization of sex work would "avert 33 to 46 percent of HIV infections in the next decade" across all settings.[316]

As was the case at the time of the 2016 report, there has been progressive jurisprudence to protect sex workers from unlawful arrests and rights violations, despite the criminalisation of aspects of sex work. In Malawi, the Zomba High Court found in September 2016 that the arrest of sex workers charged with the offence of living on the earnings of prostitution, was unconstitutional and not based on evidence. The Court found that section 146 of the Malawi Penal Code did not criminalise sex work and was aimed at those who exploit them.[317]

Despite this, aspects of sex work continue to be criminalised in most countries in SEA. Though there are a handful of countries where sex work is not criminalised, activities associated with sex work, such as living on the earnings of sex work, are criminalised making it difficult for sex workers to engage in their work safely.[318] The criminalisation also hinders sex workers' access to health services and makes them vulnerable to violence. In Lesotho almost 10% of female sex workers reported having avoided health services in the past 12 months due to stigma and discrimination.[319]

3.4.7 Criminalisation of drug use

In 2011, several countries in SEA reported having laws that create barriers to providing harm reduction services, such as needle exchange programmes.[320] Little has been done to address these legal and policy barriers.

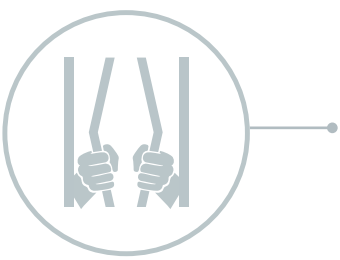
Harm reduction

Harm reduction is a public health philosophy and intervention that seeks to reduce the harms associated with drug use and ineffective drug policy.[321]

The WHO recommends a comprehensive package of health services for HIV prevention, treatment, care and support for people who use drugs.

These include:

- Needle and syringe programmes;
- Opioid substitution therapy;
- HIV counselling and testing;
- HIV treatment and care;
- Condom programmes;
- Behavioural interventions;
- Prevention and management of viral hepatitis, TB and mental health conditions;
- Sexual and reproductive health interventions; and
- Provision of naloxone and training on overdose prevention for the community of people who use drugs.[322]



In addition to the barriers created by criminalisation and widespread societal discrimination, many countries still fail to recognize people who inject drugs as a key population in their national responses to HIV. Only eight countries have HIV seroprevalence data available for people who inject drugs.[323] Key harm reduction interventions are not available in the majority of countries, and where available, coverage is insufficient and there are barriers, as described above, to accessing services. No prisoners in the region have access to harm reduction.[324] Concerns have also been expressed about the particular challenges women who use drugs experience accessing information and harm reduction. These is some evidence to show that women who inject drugs may experience worse health outcomes and face a higher risk of HIV.[325]

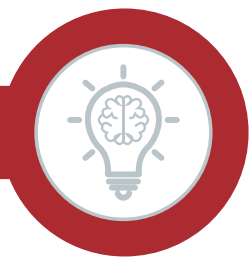
In December 2016, members of parliament from several East African countries, including Kenya, Tanzania and Uganda, attended a conference on harm reduction. They signed the Arusha Declaration that committed their countries to advocate for policies promoting access to health services for people who use drugs, to scale up services and to create an enabling environment for service delivery. It is hoped that the declaration will form the basis of a regional policy on harm reduction.[326]

The 2018 *Global State of Harm Reduction*[327] report noted that the global harm reduction response has stalled and that HIV and hepatitis C crises continue; it reinforced the urgent need for harm reduction implementation and scale-up. The 2019 Global State

of Harm Reduction Updates showed that since 2018, the total number of countries implementing needle and syringe programmes (NSP) has increased by just one, from 86 to 87 and no new countries have begun implementing opioid substitution therapy (OST) programmes since 2018.[328]

There are examples of efforts to provide an enabling legal and regulatory framework for drug use in SEA and access to harm reduction. Mauritius reviewed of its policy in July 2018 from prison-based services at restricted hours to allow for more access to services through primary health facilities.[329] In South Africa, the Departments of Health and Social Development have recognized harm reduction programmes as essential and although scale up has been slow, new sites have opened.[330] The Constitutional Court of South Africa in September 2018 held that the prohibition of the use and possession of cannabis by an adult for private, personal use was in violation of the right to privacy enshrined in the Constitution. The Court's decision is an important step towards the decriminalisation of drug use.[331]

3.4.9 IP laws, TRIPs and Access to Medicines



One of the major successes of efforts to expand access to ART and TB treatment in sub-Saharan Africa has been the increased access to drugs. However, access to safe, effective and affordable medicines remains a critical human rights issue in SEA as many countries import most of their medicines; this market is becoming increasingly monopolized with limited competition, limited investment in diseases such as TB that mainly affect lower income countries and overly high prices being charged for access to the existing medicines. A number of countries in SEA are still overly dependent upon donor resources for medicines.

The SDGs support access to affordable essential medicines: Goal 3 commits countries to ensure healthy lives and promote well-being, with one of the targets being to end the epidemics of AIDS, TB, malaria as well as combatting hepatitis. Goal 3 calls for the achievement of UHC and greater investment in developing medicines to combat communicable and non-communicable diseases. Ensuring access to affordable medicines is a critical component of achieving Goal 3 and both countries and pharmaceutical companies have human rights obligations in this regard.

A human rights-based approach to access to affordable medications

Key human rights principles of non-discrimination and equality; participation and inclusion; accountability; and the rule of law apply to access to medicines laws and policies. A rights-based approach pays special attention to vulnerable and marginalized groups, including people living with HIV and TB and people who cannot afford to pay for medicines.

In addition, states are obliged to respect, protect and fulfill the right to health, which includes an obligation to adopt legislative, administrative, and budgetary measures to facilitate access to medicines that are affordable, accessible, culturally acceptable, and of good quality. This obligation for a state to "use all available resources at its disposal" to satisfy its obligations with respect to health will often require a state to make full use of the TRIPS flexibilities available under international law.

Pharmaceutical companies also have a responsibility to respect human rights and governments and businesses must provide a remedy for business-related abuses. Within the Ruggie framework,[332] corporations have a duty to avoid causing or contributing to adverse human rights impacts through their activities, and they must address such impacts when they occur; and prevent or mitigate adverse human rights impacts that are directly linked to their operations, products, or services, even if they have not contributed to those impacts. Pharmaceutical firms have a responsibility to act with due diligence to avoid infringing on the right to health. These responsibilities come into stark relief when pharmaceutical firms prioritize the enforcement of their intellectual property rights at the expense of their right-to-health obligations.[333]

The World Trade Organisation (WTO) is made up of member countries and it negotiates agreements connected to world trade, covering goods, services and intellectual property. The agreements contain procedures for settling disputes between countries. Except for Comoros, all countries in SEA are members of the WTO.

The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) sets out minimum standards for the regulation of intellectual property by WTO member states. TRIPS gives market exclusivity (through e.g. patents) to companies who develop medical products, allowing them to charge high prices, arguably on the basis of their investment in research and development made for their medical products. TRIPS includes some safeguards to promote the right to health and also includes 'flexibilities' that enable member states to use their national intellectual property law, competition law, medical regulations and procurement laws to fulfil their human rights and public health obligations.[334]

Developing countries however became increasingly concerned, including because of the AIDS pandemic, that TRIPS was being interpreted too narrowly and creating barriers to affordable medicines, including in Africa. These concerns led to the adoption of the Doha Declaration in 2001.

The Doha Declaration and SEA

The Doha Declaration reiterates that the least developed countries can use the "flexibilities" within TRIPS to increase access to affordable medicines – such as lower cost, generic medicines - for public health reasons. Since 2001, WTO members have adopted a number of additional, related decisions to implement the Declaration.

In line with their human rights obligations, SEA governments must work towards creating an enabling legal and policy framework to increase access to medicines, including making use of TRIPS flexibilities. SEA countries have diverse legal frameworks for intellectual property rights, many of which date back to colonial times and are not consistent with recent developments. While most African countries have incorporated intellectual property protection in their domestic laws, including harmonising their patent laws to protect patents on medicines, very few countries are TRIPS compliant or have taken full advantage of TRIPS flexibilities to increase access to affordable medicines.[335]

In 2015, the UN Secretary General, in line with the 2030 Agenda and recommendations by the Global Commission on HIV and the Law, established a High-Level Panel on Innovation and Access to Health Technologies. In September 2016, the panel released a report[336] on access to medicines.

The report concluded:

- Many governments have not used TRIPS flexibilities for reasons ranging from capacity constraints to undue political and economic pressure from states and corporations. The use of TRIPS flexibilities may also be impeded by the proliferation of bilateral and regional free trade agreements containing TRIPS-plus provisions.

- Good governance, strong and accountability mechanisms and greater transparency are important components of the 2030 Agenda. The report identified the incoherence between human rights, trade, intellectual property and public health accountability mechanisms and a lack of transparency within these different but overlapping spheres.

The limited integration and use of TRIPS flexibilities within national laws and policies is a key issue in the successful implementation of continental and regional initiatives such as AU model law on medical regulation, and correspondent EAC and SADC Pharmaceutical Business Plans – which aim , amongst other things, to maximise the local and regional regulation of medicines and the production of generic essential medicines, to strengthen the availability of affordable, quality, safe and efficacious medicines in the region.

The recent Aidsfonds, ARASA and Southern African Programme on Access to Medicines and Diagnostics' 2019 report: *Breaking IP Barriers Creating Pathways to Medicine Access Progress Report 2012-2018* noted that significant strides have been made in the adoption of new and/ or in the revision of national IP and patent laws in SADC countries.[337] A number of countries, such as Malawi, Mauritius, Mozambique, Namibia, South Africa and Zimbabwe, have also drafted strengthened national IP policies, strategies and plans. There is also renewed political will within the SADC region by member states to move forward the implementation of the 2015 – 2019 SADC Pharmaceutical Business Plan. This progress will support SADC countries to harness the flexibilities within the TRIPS Agreement and the Doha Declaration to respond to HIV, TB and other health risks.

Progress in SADC in IP law and policy

As of 2012, at least four SADC countries have enacted new IP and/or patent laws, incorporating the TRIPS flexibilities, including the Republics of Botswana, Mozambique, Seychelles and Namibia. ESwatini and Zambia currently have pending regulations for their IP Acts to be enforced. Madagascar and Mauritius developed draft IP bills.

In addition:

- The Republic of Botswana enacted their Industrial Property Act (Act No. 8 of 2010) in 2012.
- Mozambique enacted the Industrial Property Code (Decree No. 47/2015) on 31 March 2016.
- Namibia promulgated the Industrial Property Act of 2012 on 1 August 2018 following the finalisation of the implementing regulations. This new Act repeals the Patents, Designs, Trade Marks and Copyright Act No. 9 of 1916 and Trade Marks in South West Africa (Act No. 48 of 1973).
- Seychelles enacted the Industrial Property Act (Act No. 7 of 2014) in March 2015 and also acceded to WTO and the TRIPS agreement within the same period. This IP Act contains all the relevant TRIPS flexibilities.
- Madagascar has a reformed Intellectual Property Bill No. 043/2017 which was announced on 27 October 2017. The Bill is still under review.
- In Mauritius, the Draft Industrial Property Bill was sent out for commentary early 2017.

However, in some countries, even where IP laws have been strengthened, implementing regulations have been slow to be developed; this has hampered the implementation of new legislation. For example, eSwatini's new Patent Act No 19 of 2018 is not yet in force, due to outstanding regulations; the patent regime continues to be governed by the Patents, Design and Trade Marks Act of 1936. It is important that advocacy for implementation of protective laws, policies, strategies and plans continues.

SECTION 4

ACCESS TO JUSTICE AND CHALLENGES IN IMPLEMENTING THE PROTECTIVE LEGAL FRAMEWORK

The 2016 ARASA HIV and Human Rights Report noted some progress in implementing the recommendations of the 2014 ARASA report on improving access to justice, particularly the increasing recognition, including by donors, that programmes to improve access to justice can have a positive impact on public health, and especially the health of marginalised and vulnerable populations.[338]

Despite this progress, access to justice for HIV-related abuses remains a key concern and this report shows that women, people living with HIV and key populations continue to face barriers to recourse and redress when their rights are violated. This report suggests that justice for violations of SRHR is similarly difficult.

This report shows that women, people living with HIV and key populations continue to face barriers to recourse and redress when their rights are violated

4.1 Access to justice for healthcare complaints

Women, including women living with HIV, people living with HIV and key populations frequently experience stigma, discrimination and other violations of their rights when they seek healthcare, which undermines their access to HIV prevention, treatment, care and support and SRH care and can have life threatening consequences. Few are able to access justice when their rights are violated.

A 2016 report[339] examined stigma and discrimination against women living with HIV, sex workers, people with disabilities and LGBTI persons in health facilities in Botswana, Malawi and Zambia. All of these groups experienced human rights abuses in accessing health care and few were able to access justice, either because they did not know where to report violations or because they did not have confidence in existing accountability mechanisms. Some feared victimisation from healthcare workers if it became known that they had reported misconduct. The criminalisation of sex work and same-sex sexual conduct created barriers for sex workers or men who have sex with men who were unwilling to complain, as did concerns that confidentiality about their health status or identity would be breached.

Access to justice for HIV-related abuses remains a key concern and this report shows that women, people living with HIV and key populations continue to face barriers to recourse and redress when their rights are violated.

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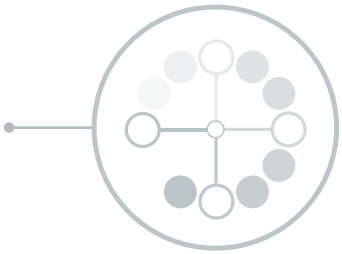
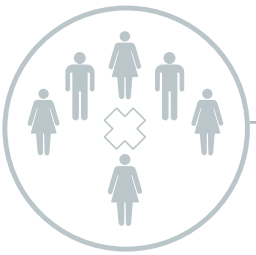
The report identified several key types of violations experienced by women living with HIV, sex workers, people with disabilities and LGBTI persons in health facilities in Botswana, Malawi and Zambia:



- Refusal to treat, including outright refusals to treat or refusal to provide certain types of care (e.g. contraception);
- Blaming sex workers and gay men for their health status;
- Lack of informed consent for treatment, especially for women living with HIV and people with disabilities;
- Lack of accommodation for people with disabilities (e.g. no sign language interpretation or physical assistance);
- Verbal abuse, particularly for gay men;
- Breaches of confidentiality;
- Physical abuse, especially of women with disabilities attempting to access SRH care;
- Lack of autonomy with regard to people with disabilities; and
- Sexual abuse by health care workers, particularly against sex workers.

Pregnant women are also vulnerable to violations when they seek health care. A Kenyan court found that the rights of a young pregnant woman had been violated when health care workers physically and verbally abused her and made her give birth on the floor.[340] The complainant was assisted by an NGO to bring the case as she had been unable to access justice through other means.

A 2017 report also examined legal and policy frameworks for adjudicating healthcare violations in Botswana, Malawi and Zambia. The report concluded that patients in all three countries had a legal right to access healthcare without discrimination and that healthcare workers were obliged to treat patients with due respect for their rights to dignity and non-discrimination.[341]



The Agenda for Zero Discrimination in Health Care[342]

UNAIDS and the WHO's Global Health Workforce Alliance launched the Agenda for Zero Discrimination in Health Care in 2016. The campaign aims to ensure that everyone receives the health care they need without discrimination.

The campaign has seven priorities:

- Remove legal and policy barriers that promote discrimination in health care.
- Set the standards for discrimination-free health care.
- Build and share the evidence base and best practices to eliminate discrimination in health-care settings.
- Empower clients and civil society to demand discrimination-free health care.
- Increase funding support for a discrimination-free health workforce.
- Secure the leadership of professional health-care associations in actions to shape a discrimination-free health workforce.
- Strengthen mechanisms and frameworks for monitoring, evaluation and accountability for discrimination-free health care.

A 2017 report on access to justice for healthcare violations shows that complaints mechanisms have a key role to play in expanding access to justice for key populations when it comes to violations that occur in health settings. Complaints mechanisms in hospitals and/or health ministries can provide more immediate and more accessible relief when patients experience poor treatment, stigma or discrimination.[343] As this report shows, access to justice through the formal justice system remains out of reach for many and these systems could represent an important expansion of mechanisms to obtain redress.

4.2 Access to justice through the courts

Courts do not provide consistent access to justice for people living with HIV, women and key populations and too few people are able to effectively use them to seek redress for rights violations. Members of vulnerable groups report significant barriers to accessing the formal justice system, including fear, lack of information about how courts work, high costs of litigation, lack of legal representation, delays and distance to courts.[344]

4.2.1 Strategic litigation

Despite this, there have been key high impact cases in several countries in which ARASA has partners, to advance the rights of women living with HIV, people living with TB and sex workers' rights, amongst other human rights issues. The positive results in these cases have contributed to better protections for people living with HIV, women and key populations and they demonstrate that strategic litigation continues to a key tool to protect and advance human rights in the context of HIV and TB. Strategic litigation can also be used to advance SRHR.

Examples of key cases between 2016 and 2018 in SEA

Malawi: *EL v The Republic*[345]

A young woman living with HIV accidentally fed another woman's child and was convicted of recklessly and negligently doing an act that was likely to spread a disease that is "dangerous to life", an offence under section 192 of the Penal Code. She appealed the conviction on the grounds that the provision was vague and over-broad and also led expert evidence to show that the risk of HIV transmission through breastfeeding was negligible when the woman was on ART.

The Court handed down judgment in January 2017 and found that the young woman did not have either the requisite knowledge or belief that breastfeeding was likely to spread HIV. The Court also affirmed that the criminal law should be protective, including protecting people living with HIV from the "unjust consequences of public panic." The Court also found that the prison sentence imposed on the woman was grossly excessive.[346]

Malawi: *Republic v Pempho Banda and Others*[347]

This case affirms that sex work is not criminalized in Malawi. The case involved the arrest of 16 sex workers who were charged and convicted of living off the earnings of prostitution. The conviction was overturned on appeal in 2016. The Court found that the section of the Penal Code was not intended to criminalise sex work, but rather to protect sex workers from exploitation.[348]

Botswana: *ND v Attorney General of Botswana and Others*[349]

In September 2017, the Court ordered the Registrar of National Registration to issue the applicant with a new identity document that reflected his male gender. The Court found that the non-recognition of gender identity exposed transgender people to harmful consequences and that the recognition of gender identity was a fundamental part of the right to dignity.[350]

Lesotho: *Mokhele and Others v Commander, Lesotho Defence Force and Others*[351]

Three female soldiers were discharged from the Lesotho Defence Force on the grounds they had contravened a Standing Order that prohibited female soldiers from becoming pregnant during the first five years of their service. The Court handed down judgement in February 2018 and found that both the dismissal and the Standing Order were unlawful and ordered all three women to be reinstated.[352]

Kenya: *COI and Another v Chief Magistrate Ukunda Law Courts and Others*[353]

In March 2018, the Court of Appeal ruled that forced anal examinations are unlawful.[354]

Botswana: *LM v Attorney General*[355]

In June 2019, a full bench of the High Court decriminalised same-sex sexual conduct between consenting adults. In a unanimous decision, the Court found that sections of the Penal Code prohibiting carnal knowledge of a person against the order of nature violated the rights to dignity, liberty, privacy and equality and were unconstitutional. The Court found that the criminalisation of gross indecency was unconstitutional to the extent that it applied to acts committed in private.

4.3 National human rights institutions

Many SEA countries have national human rights institutions (NHRIs) which could serve as an additional or alternative mechanism for access to justice, including for abuses related to HIV, SRH and TB. These institutions are well placed to deal with systemic human rights violations against people living with HIV, women and key populations and could make recommendations about law and policy change.[356]

4.3.1 NHRIs and SOGI

Since 2016, various NHRIs in partnership with the Network of African Human Rights Institutions and civil society, have strengthened their capacity to work on SOGI and human rights. Since 2016, ARASA in partnership with the Network has convened annual regional capacity strengthening meetings with NHRIs to discuss barriers to HIV services for key populations. The fora have provided a platform for NHRI representatives from different African countries to engage in evidence informed discussions on human rights, HIV, TB, SRHR and other pressing health and human rights issues in the region. The meetings not only assisted in strengthening the knowledge of the NHRI representatives on health and human rights but have also built bridges between NHRIs, people living with HIV and key populations in order to foster effective in-country partnerships and cooperation.

NATIONAL HUMAN RIGHTS INSTITUTIONS IN SEA

	Independent national human rights institution
Angola	Several state institutions focus on human rights but no independent national human rights institution
Botswana	Ombudsman
Comoros	National Commission on Human Rights and Freedoms
DRC	National Commission on Human Rights (unclear whether it is functioning)
Kenya	National Commission for Human Rights
Lesotho	No
Madagascar	Commission Nationale des Droits de l'Homme de Madagascar
Malawi	Human Rights Commission
Mauritius	National Human Rights Commission
Mozambique	National Human Rights Commission of Mozambique
Namibia	Ombudsperson
Seychelles	National Human Rights Commission Ombudsman
South Africa	South African Human Rights Commission Commission for Gender Equality
ESwatini	Commission on Human Rights and Public Administration
Tanzania	Commission for Human Rights and Good Governance
Uganda	Uganda Human Rights Commission
Zambia	Human Rights Commission
Zimbabwe	Human Rights Commission

Kenya,[357] Uganda,[358] Malawi,[359] and South Africa[360] all conducted in-country meetings and trainings to strengthen their capacity to deal with human rights in relation to SOGI.

4.4 Access to justice for key and vulnerable populations

Members of key and vulnerable populations experience particular barriers to accessing justice, including violence and harassment at the hands of law enforcement officials.

4.4.1 Gender-based violence

ARASA reports have consistently drawn the links between GBV and women and girls' vulnerability to HIV and their lack of access to justice. Although almost all ARASA partner countries have domestic and sexual violence laws, the 2016 HIV, TB and Human Rights Report highlighted that in many countries in SEA, the legal and policy environment did not deliver protection from GBV and access to justice and services for survivors. This report indicates that there are still significant hurdles that survivors must navigate in order to access the legal protections promised to them.

Some countries have taken steps to ensure better implementation of GBV laws:

In 2016, **Zambia** launched two fast track GBV courts to increase access to justice for survivors of GBV.[361] The courts include innovations such as one way glass windows to help minimise stress during trials, especially for child survivors of sexual violence.[362] Magistrates, prosecutors and police officers were specially trained prior to the opening of the courts.

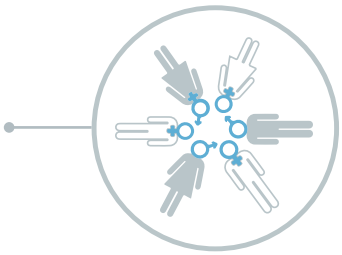
Mauritius reported during its periodic review before the UN Human Rights Committee in 2017 that legal advice, counselling and access to shelter were now more widely available to survivors of domestic violence. The National Coalition against Domestic Violence Committee has recommended the establishment of a domestic violence command centre to deal with all issues relating to domestic violence. Police officers are now duty bound to record all cases of domestic violence reported to them.[363]

The government in **Mozambique** has established victim service centres for survivors of GBV, generally staffed by female police officers and allowing for more privacy for victims reporting violence. In 2016, there were 22 stand-alone centres and a further 238 situated in police stations.[364]

Zimbabwe established Victim Friendly Units in the police services to respond to violence against women and children.

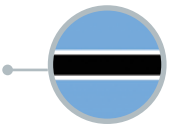
However, significant progress is still needed. Despite the presence of special Victim Friendly Units in Zimbabwe, domestic violence is under-reported, and prosecutions are rare.[365] Similarly in Namibia, there is limited capacity to investigate sexual violence and the prosecution rate is low. Although Namibia has established 15 Gender-Based Violence Protection Units trained to assist victims of sexual violence,[366] these units are understaffed.[367]

Child victims of violence face particular challenges in accessing justice. There are low reporting rates and delays in prosecutions for child victims in Malawi. The legal requirement that evidence of children had to be corroborated is a significant barrier to justice for child victims of sexual violence.[368]



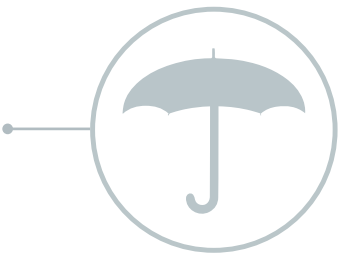
4.4.2 LGBT persons

The criminalisation of same-sex sexual conduct in many countries where ARASA has partners contributes to stigma and discrimination against LGBT persons which undermines both their access to HIV and SRH related services as well as their access to justice when they experience violations of their rights.



In **Botswana**, LGBT persons reported that they could not approach the police for assistance when they were victims of criminal behavior, including because they were afraid they themselves might be arrested and detained, concerns about breaches of confidentiality, family reprisals and other forms of victimization.[369] The attitude of the authorities and the police towards homosexuality in Zimbabwe makes LGBT people reluctant to make complaints against the police or to pursue cases of harassment.[370]

LGBT persons in **Namibia** face similar challenges. In 2017, the UN Committee against Torture expressed concern that LGBT people in detention suffered ill-treatment and that transgender women were placed in detention with men. The Committee also expressed concern about reported failures to investigate, prosecute and punish an array of serious crimes against LGBT persons.[371]



Research in several Southern African countries by ARASA shows that police often fail to investigate complaints by LGBT persons.[372]

4.4.3 Sex workers

The criminalisation of sex work in many SEA countries also has a chilling effect on access to justice for sex workers.

Law enforcement officers in **Zimbabwe**, rather than protecting the rights of sex workers, are frequently responsible for abuses against them. Findings on police harassment and abuse by the Centre for Sexual Health, HIV and AIDS Research in 2016 found 20% of female sex workers experienced violence from the police in the past year.[373]

Sex workers in **Zambia** also report high levels of harassment by law enforcement officials: 91% of sex workers surveyed indicated they had had a bad experience with the police, 87% reported that the police have harassed them because they engage in sex work and 61% said they would be unwilling to lay a complaint against the police because they fear further abuse, the complaint will not change anything, the police think they are “above the law”; and because they are unfamiliar with all the complaints options available to them.[374]

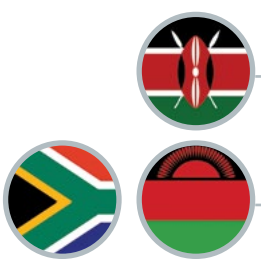
Research in Namibia shows that the key concerns for sex workers are HIV and sexual violence and abuse at the hands of clients and law enforcement officers. Sex workers also indicated that if they approached the police for help, they frequently encountered abuse from the police or were arrested.[375]

Sex workers in Mozambique are frequently unable to access justice for crimes committed against them, including when perpetrators are police officers. In a 2016 study, 27% of sex workers who participated in the research stated they had experienced discrimination accessing police assistance. The same study showed that only 23% of the sample had filed a police report and while the majority were happy with the outcome of their cases, about one quarter expressed dissatisfaction with the way their case was handled.[376]

4.5 Know Your Rights

Information about rights and how to enforce them remains a critical component of access to justice and training and awareness raising for people infected and affected by HIV and TB, along with service providers, on human rights, is crucial to ending stigma and discrimination. The 2017 UNAIDS progress report on achieving the 90 – 90 -90 targets showed that almost all of the reporting countries (110 out of 108) had training programmes for healthcare workers. However, in about half of the countries, these programmes were either small scale or isolated. In SEA, while 100% of countries reported that they had training for healthcare workers, only 56% reported that their training programmes were at scale nationally. With regards to training and awareness raising for people living with HIV about their rights, 94% of SEA countries reported that training existed, with 44% reporting these were at scale nationally.[377]

The 2016 report showed that key populations were frequently unable to access specific information about their rights and therefore less able assess whether their rights had been violated or know how to enforce them. Increasingly, civil society is targeting legal literacy programmes at key populations in order to provide them with information about international and local laws, how to protect their rights and how to seek redress when their rights are violated:



- In **Kenya**, groups are using social media to provide information about adolescents and SRHR and what their rights are.[378]
- Sex workers were provided with information about their legal rights and sex work in **Malawi**[379] and in **South Africa**, NGOs are providing legal services to assist sex workers in enforcing their rights.

end notes

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