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HIV, TB and Human Rights


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MODULE 3

Learner's Guide

ARASA
AIDS & Rights
Alliance
for Southern Africa

Guide to icons used in this manual

Throughout this manual you will find icons. Each relate to a different aspect of examples and activities for each topic.

Key Points:
the main facts and messages summarised, usually at the end of the unit

Definitions, Examples and Guidance

Case study:
This is an example of where the topic has been implemented

Resources and References:
Additional key resource materials are listed here

Self Reflection:
How does the topic relate to you or the situation in your country

Class Activity:
an opportunity to put your learning into practice

Read this:
a reference source is provided to provide more detail on the topic

Lunch Break

Tea Break

Suggested Materials

Suggested Time Allocated to Each Session

Stigma & Discrimination

Acronyms

ACHPR	African Commission on Human and Peoples' Rights
ACRWC	African Charter on the Rights and Welfare of the Child
AIDS	Acquired Immune Deficiency Syndrome
ARASA	AIDS and Rights Alliance for Southern Africa
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASWA	African Sex Workers Alliance
AU	African Union
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CND	Commission on Narcotic Drugs
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilites
CSC	Community Score Card
CSO	Civil Society Organisation
DNA	Deoxyribonucleic Acid
DR-TB	Drug-resistant TB
DRC	Democratic Republic of Congo
EAC	East African Community
EALA	East African Legislative Assembly
ECOSOC	United Nations Economic and Social Council
eMTCT	Elimination of Mother-to-Child Transmission
FGM	Female Genital Mutilation
FTA	Free Trade Agreements
FTM	Female-to-Male
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HRC	Human Rights Council
HRW	Human Rights Watch
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IP	Intellectual Property
IPRs	Intellectual Property Rights
ITPC	International Treatment Preparedness Coalition
KELIN	Kenya Legal & Ethical Issues Network on HIV and AIDS
LDAs	Least Developed Countries

LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MTF	Male-to-Female
MDR-TB	Multi-Drug Resistant Tuberculosis
MSF	Médicins Sans Frontières
MSM	Men Who Have Sex With Men
MTCT	Mother-to-Child Transmission
NAC	National AIDS Council
NGO	Non-Governmental Organisation
OHCHR	Office of the High Commissioner for Human Rights
OVC	Orphans and Vulnerable Children
PIHT	Provider-Initiated HIV Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-exposure Prophylaxis
PWUD	People Who Use Drugs
R&D	Research and Development
RNA	Ribonucleic Acid
SACHPR	African Commission on Human and Peoples' Rights
SADC	Southern African Development Community
SADC PF	Southern African Development Community Parliamentary Forum
SEA	Southern and East Africa
SOGI	Sexual Orientation and Gender Identity
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property
UDHR	Universal Declaration on Human Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCHR	United Nations Commission on Human Rights
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organisation
WTO	World Trade Organisation
WSW	Women Who Have Sex With Women
XDR-TB	Extensively-Drug Resistant Tuberculosis

Stigma and Discrimination

unit 1

1.1: Introduction to this Unit

This unit describes stigma and discrimination relating to HIV, people living with HIV and key populations in Southern and East Africa. It explains how to protect rights in the context of HIV and TB by strengthening laws and policies, access to justice and law enforcement, with examples from the region.

1.2: Unit Outcomes

At the end of this unit you should be able to:

- Define the right to equality and non-discrimination
- Describe stigma and discrimination against people living with HIV and key populations in the region
- Describe problems with access to justice and law enforcement in the region
- Explain how to protect equality rights and freedom from discrimination in relation to HIV & TB
- Share some examples of protective laws and policies to protect equality rights.

1.3: Stigma, Discrimination, Inequality and HIV

1.3.1 What is the right to equality and non-discrimination?

Article 26 of the *International Covenant on Civil and Political Rights* (ICCPR) says that all people have the right to equality before the law and to freedom from discrimination on any grounds like race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. This right is also protected in Article 2 of the *African Charter on Human and Peoples' Rights* as well as the national constitutions of countries in Southern and East Africa.

Discrimination takes place when people are treated differently, restricted, excluded or preferred simply because of a characteristic like their race or gender. The right to equality and freedom from discrimination protects people from this unfair treatment. It protects the right of all people to be treated as equals.

International, regional and national human rights instruments don't list HIV status (or grounds like sexual orientation) as a prohibited ground. But the right to equality and non-discrimination should be interpreted broadly. For example, the Commission on Human Rights has confirmed that 'other status' in non-discrimination provisions must be interpreted to include 'health status', including HIV or AIDS. The African Commission on Human and Peoples' Rights has also said that 'other status' can be interpreted widely to include grounds other than those listed.

This means that countries may not discriminate against people on the basis of various grounds, including amongst others, HIV or AIDS, sexual orientation, gender identity and disability.

Example 1: African Commission on Human and Peoples' Rights 2014 Resolution on SOGI Rights

In May 2014 the African Commission called for the protection of human rights, regardless of a person's real or perceived sexual orientation or gender identity (SOGI) in Resolution 275: Resolution on the Protection against Violence and other Human Rights Violations against Persons on the Basis of their Real or Imputed Sexual Orientation or Gender Identity.

Source: http://www.achpr.org/sessions/55th/resolutions/275/

1.3.2 Key issues for people living with HIV and key populations

Stigma and discrimination continues to affect people living with HIV and those affected by HIV as well as people with TB in Southern and East Africa. Findings of the Global Commission on HIV and the Law (GCHL) and the *People Living with HIV Stigma Index Studies*, undertaken by and for people living with HIV across many countries in the region, have strengthened existing information on stigma and discrimination. They show that stigma, discrimination and human rights violations take place in all spheres of life such as in families, communities, workplaces and in the health sector.

Major forms of stigma, discrimination and human rights violations reported by people living with HIV include:

- Stigma and discrimination amongst families and communities, such as gossip, verbal insults, threats or harassment, exclusion from social gatherings and even physical threats or abuse.

- HIV-related discrimination in the workplace such as being refused employment or losing employment as a result of HIV status as well as pre-employment HIV testing, particularly in the armed forces.

- HIV-related discrimination in the health care sector, particularly for women living with HIV and for key populations such as lesbian, gay, bisexual, transgender and intersex (LGBTI) populations and sex workers. Women living with HIV accessing sexual and reproductive health care report being advised not to have children, getting access to anti-retroviral treatment (ART) only on condition of using contraception, being coerced into methods of child birth and infant feeding and even forced or coerced sterilisation. Key populations such as men who have sex with men and sex workers report stigmatising attitudes, forced HIV testing, breaches of confidentiality, denial of access to health care services, travel restrictions and inadequate services to meet their health needs.

TB-related human rights violations include:

- Forced or coerced treatment
- Denial of access to services for people living with HIV, sex workers, transgender persons and other marginalised persons
- Denial of entry into a country on the basis of existing or previous TB infection.

Self-Reflection Exercise 1: Effect and Impact of Stigma

Think about all the examples of stigma and discrimination given in Section 1.3.2 and any other examples you may know of. Reflect on the effect and impact that stigma and discrimination has on affected people. For example:

- How do you think this impacts people living with HIV or TB?
- How do you think it impacts their feelings about themselves?
- How do you think it impacts their daily interactions with others?
- How do you think it impacts their ability to get support? To disclose their HIV status or TB status?
- How do you think it impacts their health?
- How do you think it impacts their ability to access health care services?

1.3.3 Examples from Southern and East Africa

Example 2: *People Living with HIV Stigma Index Studies*

"I went to pick up my appointment letter only to be told that I had to undergo a medical examination. I already knew my sero status which I told the Human Resource Officer. She could not believe me and therefore had to do the examination which confirmed to them my HIV-positive status. That marked the end of getting the job as they could not recruit me even though I had passed the interview."

Source: People living with HIV Stigma Index: Uganda

'My family members never wanted me to get married when I tested HIV-positive. My fellow support group members helped resolve the issue and the family members were sensitized and told that I had the right to marry"
People Living with HIV Stigma Index: Zambia

"I was badly beaten by my boyfriend. Saying that I slept with a person with AIDS, he beat me on the road, he hurt me in the head. I was admitted to hospital because he beat me with a stick."

People Living with HIV Stigma Index: Eastern Cape, South Africa

Example 3: GCHL Africa Regional Dialogue on HIV and the Law

"Women with HIV are not expected to fall pregnant. One day I could tell my doctor was angry. I had broken his trust when I said I was pregnant. He was disappointed. I had failed my doctor I felt irresponsible and guilty. He said I don't want you to go through this again so I was sterilised. I was the bad woman. I was HIV positive. I compromised my health. "

Civil society participant, Swaziland

"A lot of laws in Africa criminalise same sex activities. These laws were made by the British, although Malawi, Zimbabwe and Uganda have taken steps to strengthen penalties relating to these old crimes. Even where it is not criminalised there is homophobia. Sentences range from fines to death penalties. This makes men who have sex with men vulnerable to blackmail. Activists face arrest if they work with lesbians, gay and bisexual people, for example, in Malawi and Zimbabwe. There is a lack of programming for men who have sex with men in most of these countries. This group is now in hiding. It is very difficult to reach men who have sex with men with prevention messages and services. Studies in middle and low income countries show men who have sex with men are at high risk of HIV infection. Homophobia is being promoted by policy makers, the community and religious leaders.'

Civil society participant, Malawi

1.4: How do we Protect the Right to Equality & Non-discrimination?

1.4.1 International and regional guidance

Laws and policies should protect the equality rights of people living with HIV and key populations in the context of HIV and TB. ARASA partner countries in Southern and East Africa all have national constitutions that protect the right to equality and freedom from discrimination. However, these national constitutions do not specifically protect people against discrimination based on HIV, AIDS, TB or even 'health status'.

International and regional guidance recognise the need to specifically protect people from discrimination in law and policy.

Guidance: *International Guidelines on HIV/AIDS and Human Rights* (UNAIDS / OHCHR)

Guideline 5 says that 'states should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasise education and conciliation and provide for speedy and effective administrative and civil remedies.'

The 2006 *Abuja Call for Universal Access to HIV/AIDS, Tuberculosis and Malaria Services* by A United Africa by 2010 commits member states to:

- "Continue promoting an enabling policy, legal and social environment that promotes human rights particularly for women, youth and children and ensure the protection of people infected and affected by HIV and AIDS, TB and Malaria and to reduce vulnerability and marginalization including conflict-affected and displaced persons, refugees and returnees.
- Adapt national legislation to take cognizance of HIV and AIDS and TB issues, specifically discrimination and stigmatization and encourage Member States to ratify relevant International Conventions such as the Convention on Discrimination and Employment.
- Enact or repeal laws and policies related to gender and human rights in order to align them with AU frameworks including the Solemn Declaration on Gender Equality in Africa and the AU Protocol on Women."

1.4.2 Laws, policies and programmes to protect the right to equality for people living with HIV and key populations

There are a number of ways to protect the right to equality for people living with HIV and key populations in law, policy and programmes. Some examples include:

- Revising general anti-discrimination laws (such as inequality laws) to include specific protection for people living with HIV and other key populations
- Revising sector-specific laws (such as health laws, gender equality laws, and workplace laws) to include specific protection for people living with HIV and other key populations
- Enacting HIV specific laws that deal with various aspects of HIV and AIDS and which detail the right to equality and various other rights of people living with HIV and key populations
- Including principles of equality and non-discrimination in HIV and TB and related policies such as health policies, gender policies, children and youth policies
- Developing programmes, such as stigma and discrimination reduction programmes for communities, affected populations and specific sectors (such as the workplace and health care sector).

See Module 3: Unit 10 for more information on key human rights programmes for responding to HIV, TB and human rights issues.

Example 4: Anti-discrimination Laws and Policies

General anti-discrimination law: In Mauritius, a general anti-discrimination law, the Equal Opportunities Act of 2008, prohibits any form of discrimination, directly or indirectly, based on a number of grounds including physical state or sexual orientation.

Sector-specific law: In Kenya, the Employment Act protects employees' rights, including employees with HIV, to fair labour practices. Section 5 protects employees from unfair discrimination on the basis of HIV status and section 46 provides that HIV does not constitute a fair reason for a person's dismissal or for the imposition of a disciplinary penalty.

HIV-specific law: In Madagascar, the Madagascar Law 2005-040 on the Fight Against HIV/AIDS and the Protection of the Rights of People Living with HIV protects people from all forms of discrimination and stigmatisation based on a person's HIV status.

HIV policies: In Namibia, both the National Strategic Framework and the National Policy on HIV identify the need to protect the rights of and reduce stigma and discrimination for people living with HIV and various identified key populations.

In Tanzania, the National Multi-Sectoral Strategic Framework for HIV and AIDS and the National HIV Policy of 2001 recognise the importance of rights-based responses to HIV and AIDS.

Self-Reflection Exercise 2: What laws are best?

Some countries (like Angola, Kenya, Tanzania and Mauritius) have enacted HIV-specific laws to protect people living with HIV from discrimination. Other countries (like South Africa) have included HIV provisions in other laws (e.g. employment laws). Some other countries (like Malawi) have included protection of human rights for people living with HIV in policy.

What do you think is the best way to protect the rights of people living with HIV? What are the advantages of each approach? What are the disadvantages?

1.4.3 Access to Justice and Law Enforcement

People living with HIV and key populations also report access to justice and law enforcement as a problem. People report struggling to access justice for human rights violations even where protective laws exist. Women face particular challenges in implementing their rights both through law enforcement mechanisms and formal and customary courts and tribunals. Key populations such as sex workers, people who inject drugs and LGBTI persons also struggle to enforce their rights.

Women experience difficulties in accessing justice for gender based violence in every ARASA partner country. There is significant under-reporting of rape and domestic violence and police fail to adequately investigate complaints. Despite the increase in the number of ARASA partner countries who have adopted laws criminalising domestic violence and who have established specialized services in police stations for women and children (e.g. Lesotho, South Africa, Tanzania) many women are unable to access protection orders or have perpetrators arrested.

Given the links between gender based violence and HIV, these concerns are acute for women living with HIV.

Reasons include the following:

- Limited awareness and understanding of human rights broadly, and health, HIV and TB-related rights in particular, amongst all people, including people living with HIV and key populations as well as service providers
- Limited legal support services (e.g. legal aid or civil society organisations (CSOs) providing legal assistance
- Barriers to accessing courts due to the high costs of litigation, the limited access to legal representation and the distance to courts
- Limited understanding within, and access to, alternative dispute resolution mechanisms such as national human rights commissions and traditional mechanisms
- Law enforcement officers are not sensitised to the rights of people living with HIV and key populations. At times, law enforcement officers are themselves responsible for the human rights violations experienced by, for example, sex workers, which makes it especially difficult for sex workers to challenge human rights violations.

Example 5: GCHL Africa Regional Dialogue on HIV and the Law

"Where laws exist there is no implementation of the law. The law which is meant to protect people living with HIV means nothing if it is not enforced by the very people who are meant to help those living with this virus."

Civil society participant, South Africa.

"In Mozambique it is not very clear what is legal or illegal. Sometimes there is illegal detention and you are humiliated. I was detained when there was a summit in Mozambique. I spent 7 days in prison. I went to court and I asked if I could speak to my mother. The judge said 'Why are you here?' and I told him I was loitering, I need money for my child. The judge was humiliated; he told me to go home. We are used by the police, they take us to cemeteries and the beach to have sex without a condom. Sometimes we are beaten up by the police."

Sex worker civil society participant, Mozambique.

Countries in Southern and East Africa have begun to implement various programmes to strengthen access to justice and law enforcement, such as :

- Stigma and Discrimination Reduction Campaigns
- Know Your Rights Campaigns
- Training of service providers, like health care workers, on HIV and TB-related rights
- Training and sensitising of law enforcement officials on the rights of people living with HIV and key populations
- Programmes to reduce gender inequality, harmful gender norms and gender-based violence.

See Module 3: Unit 10 on key human rights programmes for more information.

1.4.4 Monitoring and Enforcement

With the Southern and East African region, access to justice remains weak. There are other mechanisms that can be used, in order to monitor the enforcement of laws. These include the use of Strategic litigation and National Human Rights Institutions.

Strategic litigation is an important component of legal strategies to make access to health care available, including ART, for people living with HIV and more recently, key populations in Africa and to challenge discrimination. High impact litigation has been undertaken in ARASA partner countries on the forced and coercive sterilization of women living with HIV (Kenya, Lesotho and Namibia) and to protect the rights to freedom of assembly and association for LGBTI people (Botswana) .

Case Study: KELIN (Kenya) challenges TB ruling

KELIN (Kenya) was also recently successful in challenging the practice of confining TB patients in prisons for purposes of treatment as being unlawful and unconstitutional. This type of litigation is however extremely expensive and time-consuming and many major donors are reluctant to fund it.

National Human Rights Institutions

Some SEA countries have established national Human Rights Institutions (NHRIs) which could serve as an additional or alternative mechanism for access to justice, and to monitor human rights including for abuses related to HIV and TB. These institutions could play a critical role in protecting and promoting human rights in the context of HIV and TB. It is unclear the extent to which these institutions are willing or able to investigate and/or adjudicate on HIV and TB-related abuses. From the ARASA 2016 HIV, TB and Human Rights Report, there is an indication that many of these institutions are plagued by a lack of funding and human resources, are not always independent of government and ineffective.

Table 1: Countries in SEA with "Free Legal Aids" and National Human Rights Institutions

COUNTRY	FREE LEGAL AID	INDEPENDENT NATIONAL HUMAN RIGHTS INSTITUTION
Angola	It appears legal aid is available in criminal cases	Several state institutions focus on human rights but no independent national human rights institution
Botswana	Yes	Ombudsman
Comoros	No	National Comission on Human Rights and Freedoms
DRC	Limited access to pro bono lawyers	National Comission on Human Rights (unclear whether it is functioning)
Kenya	Legal Aid Act, 2016 establishes a legal aid service for civil, criminal, constitutional and matters of public interest	National Commission for Human Rights
Lesotho	Yes	No
Madagascar	Yes	Commission Nationale des Droits de l'Homme de Madagascar
Malawi	Yes	Human Rights Commission
Mauritius	Yes	National Human Rights Commission
Mozambique	National Bar Association plans to expand services to indigent people. Legal aid is available for criminal trials, but there are insufficient numbers of public defenders	National Human Rights Commission of Mozambique
Namibia	Yes	Ombudsman
Seychelles	Yes	National Human Rights Commission
South Africa	Yes	South African Human Rights Commission
Swaziland	No	Commission on Human Rights and Public Administration
Tanzania	Yes	Commission for Human Rights and Good Governance
Uganda	Yes	Uganda Human Rights Commission
Zambia	Yes	Human Rights Commission
Zimbabwe	Yes	Human Rights Commission

Case Study: National Human Rights Institutions

In 2014, KELIN, UNAIDS, UNDP and the Kenya National Commission on Human Rights (KNCHR) organized a seminar for African NHRIs on HIV, Human Rights and the Law. The seminar was an opportunity for experience sharing between members of the National Human Rights Institutions from 11 countries across SEA on the legal and human rights issues raised by the HIV epidemic in Africa. Kenya remains the only ARASA partner country to have established an HIV-specific tribunal. The HIV and AIDS Tribunal can make a range of orders; it can enforce its own orders and its decisions can be executed by the High Court.

1.4.5 Examples from Southern and East Africa

Example 1: Assessment of the Kenya HIV and AIDS Tribunals

A 2014 assessment of the work of the tribunal was cautiously optimistic about the functioning of the tribunal. It suggests that while the tribunal got off to a slow start, it is now a relatively effective mechanism for the protection of the rights of people living with HIV. By the end of December 2014, the tribunal had handled 300 complaints, most dealing with employment related issues.

The tribunal also receives complaints related to discrimination in access to HIV-related services and gender-based complaints such as domestic violence and property grabbing. The complaints are overwhelmingly submitted by people living with HIV. The tribunal still faces challenges in effectiveness, including a lack of awareness about its existence and personnel and financial limitations. It continues to be an under-utilised justice mechanism.

1.5: Unit Summary

1. All people have the right to equality and non-discrimination.
2. This includes the right to non-discrimination on the basis of a person's health status, such as their HIV-positive status or TB status.
3. It also includes the right to non-discrimination on the basis of sexual orientation and gender identity.
4. Stigma and discrimination affects people living with HIV and those affected by HIV as well as people with TB in Southern and East Africa.
5. Stigma and discrimination includes verbal and physical abuse, discrimination in the workplace and discrimination in the health care sector.
6. Laws and policies should make special efforts to protect the rights of people living with HIV, TB and other key populations from discrimination.
7. Protective responses in law and policy can include:
    a. Strengthening anti-discrimination laws to protect the rights of people living with and affected by HIV and TB
    b. Strengthening sector specific laws (e.g workplace laws, children's laws and health laws) to protect the rights of affected populations
    c. Enacting specific laws (e.g an HIV-specific law) to protect the rights of affected populations
    d. Including rights protection in health, HIV, TB and related policies (e.g children's policies, gender policies, youth policies etc.)
8. Other human rights programmes that can help include:
    a. Stigma and Discrimination Reduction Campaigns
    b. Know Your Rights Campaigns
    c. Training of health care and other service providers
    d. Training of law makers and law enforcement officials
    e. Improving legal support services
    f. Programmes to reduce gender inequality, harmful gender norms and gender-based violence.

Summative Assessment

Complete the quiz to assess your knowledge of stigma and discrimination. Tick whether each of the following statements is true or false.

Question	True	False
International and regional human rights instruments specifically protect the right to non-discrimination on the basis of HIV status		
National constitutions specifically protect people with HIV from discrimination		
HIV status and TB status is protected in non-discrimination clauses under the term “other status”		
The Global Commission on HIV and the Law found that stigma and discrimination is limited.		
People still report being refused employment on the basis of their HIV status.		
Women and key populations experience less discrimination than others in accessing health care		
Treatment for TB is always voluntary		
People affected by HIV and TB need specific protection in law and policy		
The existing protections in law are helping to protect people from stigma and discrimination.		
Protecting the rights of people affected by HIV and TB is best done in policy, not law		
Affected populations are able to use the courts to enforce their rights		
People don’t know their rights		
Sex workers are able to lay charges for human rights violations at the police station		

1.6: Unit Outcomes Checklist

Use the checklist below to see whether you have met the outcomes that were set for this unit.

Outcome	Yes, I have met this outcome	No, I have not met this outcome	These are the things I still need to revise
Define the right to equality and non-discrimination			
Describe stigma and discrimination against people living with HIV and key populations in the region			
Describe problems with access to justice and law enforcement in the region			
Explain how to protect equality rights and freedom from discrimination in relation to HIV & TB			
Share some examples of protective laws and policies to protect equality rights			

1.7: Resources and References

1.7.1 Useful Websites

ARASA
www.arasa.info

International Centre for Research Centre on Women
http://www.icrw.org/what-we-do/hiv-aids/stigma-discrimination

TB Alert
http://www.tbalert.org/about-tb/global-tb-challenges/stigma-myths/

The People Living with HIV Stigma Index
http://www.stigmaindex.org/

1.7.2 Useful Resources

African Commission on Human and People's Rights Resolution on the Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity
http://www.achpr.org/sessions/55th/resolutions/275/

ARASA (2016) *Beyond rhetoric, civil society statement on strengthening linkages to address stigma and discrimination in sub-Saharan Africa*
http://www.arasa.info/files/7014/4979/2148/African_CSO_Stigma_and_Discrimination_Pre-conference_Outcome_Statement_9_December.pdf

Eba, PM (2015) *HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis* (2015) 15 African Human Rights Law Journal, 224-262

Global Commission on HIV and the Law (2011) *Report of the Africa Regional Dialogue of the Global Commission on HIV and the law*
www.hivlawcommission.org

Global Commission on HIV and the Law (2012) *Risks, Rights & Health*
www.hivlawcommission.org

UNAIDS (2012) *Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses*
http://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Programmes_en_May2012_0.pdf

UNAIDS (2014) *Reduction of HIV-related stigma and discrimination: Guidance Note*
http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_stigma_en.pdf

Women's Rights, Sexual and Reproductive Health and Rights and HIV

unit 2a

2.1: Introduction

2.1.1 Looking at HIV through a gender lens

Understanding gender, the differences that society ascribes to women and men and how they are expected to behave, is a crucial part of a rights-based and effective response to HIV. Some people confuse gender with women's rights, but it is a much broader construct than the biological differences between women and men. It is important to understand that gender is an inclusive term that includes men and lesbian, gay, bisexual, transgender and intersex (LGBTI) persons. Gender plays a critical role in the HIV epidemic and influences who is vulnerable to HIV transmission, who is likely to receive treatment and who provides care and support to people living with HIV. Below are some examples of this:

- Women and girls in Africa are disproportionately infected and affected by HIV and Southern and East Africa are the only regions where more women than men are living with HIV.[1] Their vulnerability to HIV is linked to their inequality in society.
- Even though women and girls are disproportionately vulnerable to HIV, there are also certain populations of men who are at higher risk of exposure. Gay men and men who have sex with men are at much higher risk of HIV exposure than the general population. There is little information about the vulnerability of lesbians, intersex, bisexual and transgender people, but research suggests that transgender people are at increasingly high risk of infection.
- Human rights abuses and violations significantly undermine the right to health of women and girls and LGBTI people and increase their vulnerability and risk of exposure to HIV, including by limiting access to sexual and reproductive health care such as HIV prevention, treatment, care and support.
- This module is intended to provide learners with information that will help them understand the gender dimensions of HIV that relate to women and girls, how human rights violations linked to gender and sex impact on the rights of women and girls and their ability to protect themselves from HIV and access health care. The module also provides information about sexual and reproductive health and rights (SRHR), how these rights are linked to women and girls' other human rights and how a SRHR approach to HIV can improve universal access.

There is another module that provides specific information on LGBTI populations and the impact of human rights violations on their vulnerability to HIV.

2.2: Unit outcomes

At the end of this unit, learner's should be able to:

- Understand and describe the differences between gender and sex and how they relate to HIV
- Understand and explain why women and girls are particularly vulnerable to HIV
- Know the definitions of sexual and reproductive health and rights and how they relate to HIV
- Participate in a discussion about why it is important to recognize and include gender in rights-based responses to HIV
- Understand the importance of including women at all stages of design, implementation, monitoring and evaluation
- Describe how to protect the rights to equality and non-discrimination for women.

[1] *All epidemiological data in this module is sourced from the UNAIDS (2014) The Gap Report available at http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf*

2.3: HIV, Gender Inequality, Gender-based Violence and Harmful Gender Norms

2.3.1 Sex and gender

Sex and gender are different, but related:

- **Sex describes the biological differences between men and women** e.g. women breastfeed babies.
- **Gender describes the differences between men and women that are created by society.** These change over time and there are differences between cultures. Gender determines what is expected from men and women and how they must behave.
- This has implications for the way that children are brought up and ultimately the roles that adults play in society:
    - Both women and men may work, but women still remain primarily responsible for caring for children and performing the other household tasks such as cooking and cleaning. Women are still paid less than men.
    - Women are denied their human rights in many places in the world – they are not able to make decisions about sex and reproduction, and they are subjected to different forms of violence (such as intimate partner violence, rape and sexual harassment).
    - Some countries impose restrictions on what women can wear or where they can travel.

Learning Activity 1: Sex or Gender

Think about various functions or conduct (e.g. pregnancy, knitting, fixing a motor vehicle) and whether these are associated with sex or gender.

2.3.2 HIV and women

UNAIDS provides data about HIV prevalence amongst women and girls in its annual global epidemic update. This information is updated annually and is available on the UNAIDS website: www.unaids.org

In 2015, there were 17.8 million women aged 15 years and older living with HIV; 80% living in sub-Saharan Africa. Women account for 56% of new HIV infections amongst adults in sub-Saharan Africa and Africa remains the only continent where more women than men are infected.

Table 1 shows the numbers of women and the number of adults living with HIV according to UNAIDS 2015 estimates.

Table 1: HIV infection amongst adults (15+), 2015

Country	Estimated number of women (15+) living with HIV	Estimated number of adults living with HIV
Angola	170 000	29 000
Botswana	190 000	340 000
Comoros	≤100	≤0.1
DRC	200 000	330 000
Kenya	830 000	1 400 000
Lesotho	170 000	290 000
Madagascar	19 000	44 000
Malawi	540 000	890 000
Mauritius	2 000	8 100
Mozambique	830 000	1 400 000
Namibia	120 000	200 000
Seychelles	No data	No data
South Africa	4 000 000	6 700 000
Swaziland	120 000	210 000
Tanzania	780 000	1 300 000
Uganda	790 000	1 400 000
Zambia	640 000	1 100 000
Zimbabwe	790 000	1 300 000

Case Study 1: Adolescent girls and HIV

Despite progress made to reduce the numbers of new HIV infections, adolescent girls remain particularly vulnerable to HIV and are at higher risk of HIV infection than boys.

UNAIDS provided the following data on girls in 2015:

- Adolescent girls and young women account for 25% of new HIV infections amongst adults
- 74% of new HIV infections amongst adolescents in Africa in 2013 occurred in girls
- HIV prevalence amongst adolescent girls in sub-Saharan Africa is 3 times higher than that of adolescent boys
- HIV is the leading cause of death of adolescents in Africa
- 15% of young women between 15 – 24 years in sub-Saharan Africa know their HIV status.

Source: UNAIDS and African Union (2015) Empowering Young Women and Adolescent Girls; UNAIDS (2016) AIDS By the Numbers

Table 2 shows the numbers of young men and women living with HIV and the disproportionate vulnerability of girls to HIV.

Table 2: HIV Prevalence amongst young women and men aged 15 to 24 years old

Country	Young women (15 – 24) prevalence	Young men (15 – 24) prevalence	New HIV infections amongst young women	New HIV infections amongst young men
Angola	1.2%	0.6%	5 500	3 000
Botswana	6.1%	3.5%	1 900	1 100
Comoros	Not available	Not available	Not available	Not available
DRC	Not available	Not available	Not available	Not available
Kenya	2.8%	1.7%	19 000	10 000
Lesotho	10.5%	5.8%	5 700	3 400
Madagascar	0.2%	0.2%	Not available	Not available
Malawi	3.8%	2.4%	6 700	4 000
Mauritius	0.2%	0.2%	Not available	Not available
Mozambique	6.1%	2.7%	25 000	15 000
Namibia	4.8%	2.7%	2 500	1 400
Seychelles	Not available	Not available	Not available	Not available
South Africa	13.1%	4%	90 000	36 000
Swaziland	12.4%	7.1%	2 700	1 700
Tanzania	2.2%	1.4%	12 000	6 800
Uganda	4.2%	2.4%	29 000	17 000
Zambia	4.5%	3.4%	8 700	7 000
Zimbabwe	6.6%	4.1%	15 000	8 700

2.3.3 Why are women and girls more at risk of HIV?

Women are more at risk of HIV because of their biological make-up, their unequal position in society and violations of their human rights.

- **Biological:** the vagina has a much larger surface area, compared to the penis, that can be exposed to HIV. Untreated sexually transmitted infections (STIs) or injuries to the vagina can also increase the risk of HIV for women.

- **Social:** women's unequal position in society is replicated in sexual relationships and many women cannot negotiate condom use or may experience sexual violence. Harmful practices like dry sex, child marriage, widow cleansing, female genital mutilation (FGM) and polygamy increases the risk of HIV. Married and co-habiting women may not be able to demand fidelity from their partners which can increase their risk of HIV.

- **Economic:** women in abusive relationships may not be able to leave violent partners because they are financially dependent on them and do not have other options. Women may engage in transactional or survival sex and may not be able to insist on condom use.

Learning Activity 2: Gender and Disclosure of HIV status

Men and women with HIV have different experiences when they disclose their HIV status. Discuss the differences and reasons for them.

2.3.4 International and regional human rights standards on women and HIV

Women, especially young women and girls, are at high risk of HIV infection in Africa. Many of the reasons for women's vulnerability relate to violations of their human rights. When women's rights are not protected, they are at higher risk of HIV infection.

There are two important human rights treaties that help to advance women's human rights and protect them from HIV infection if they are properly implemented:

- *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW): Women and girls are entitled to their full range of human rights on an equal basis with men. CEDAW promotes women's rights to equality, including in areas that are relevant to HIV e.g. it prohibits discrimination in all its forms against women, and it says specifically that there should be no discrimination in access to health care, including for mothers and pregnant women. It also has a specific focus on the needs of rural women and the problems that they face accessing health care.

- *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa:* The African Women's Protocol is the one of the few international treaties to specifically mention HIV. It says that women have a right to be protected from HIV transmission and to have information about their health status. It also says that countries must protect women from "unwanted or forced sex" which is one of the most important ways that women and girls are exposed to HIV.

- *The UNAIDS International Guidelines on HIV/AIDS and Human Rights* stress the link between HIV and women's rights. Protecting and promoting women's rights is seen as an important part of preventing the spread, and lessening the impact of HIV on women. The Guidelines recommend that states take measure to examine:

  - The role of women at home and in public life
  - The sexual and reproductive rights of women and men, including women's ability to negotiate safer sex and make reproductive choices
  - Increasing educational and economic opportunities for women
  - Sensitising service deliverers and improving health care and social support services for women.

See Module 1: Unit 4 on International and Regional Human Rights Commitments and Guidance for more information.

2.3.5 Links between gender inequality, harmful gender norms, gender based violence and HIV

Gender based violence is a form of gender discrimination and a violation of the rights of women and girls. There are high levels of violence against women and girls in Southern and East Africa. Although many countries have put laws and policies in place to protect women and girls from violence, many of these laws are not properly enforced and much more must be done so that they can live free from violence and protect themselves from HIV.

Case Study 2: Gender-based Violence

- 35% of women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence
- 30% of all women in a relationship have experienced physical and/or sexual violence by their intimate partner
- Women who have been physically or sexually abused by their partners are 1.5 times more likely to acquire HIV compared to women who have not experienced partner violence.

Source: WHO (2013) Global and Regional estimates of Violence Against Women: prevalence and health effects of intimate partner violence and non-partner sexual violence http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf

There are very strong links between HIV and sexual violence:.

Women and girls who have experienced sexual and domestic violence are more likely to have HIV, and women and girls living with HIV are also more likely to experience violence. Violence is also a barrier to women and girls accessing reproductive and sexual health services.

Definition: What are gender norms?

Gender norms refer to learned and evolving beliefs and customs in a society that define what is "socially acceptable" in terms of roles, behaviours and status for both men and women. In the context of the HIV epidemic, these gender norms strongly influence both men's and women's risk taking behaviour, expression of sexuality, and vulnerability to HIV infection and impact, including their ability to take up and use HIV prevention information and commodities, as well as HIV treatment, care and support.

Gender norms can also be the basis of discrimination and violence against men who have sex with men, lesbians and transgender people, placing them at higher risk of HIV infection and exacerbating the impact of HIV.

Gender norms dictate how women and girls must behave. Harmful gender norms such as female genital mutilation (FGM) and other cultural and religious practices expose women and girls to a higher risk of HIV and also limit their ability to access HIV prevention, treatment, care and support. These norms make it difficult for women and girls to make decisions about their lives or to seek redress if their rights have been violated.

Adolescent girls are particularly vulnerable to harmful gender norms like child marriage. Millions of girls in Africa are married before they reach the age of 18 and are forced to drop out of school. Child brides are forced to have sex and many become prematurely pregnant. They have no access to family planning or condoms and are vulnerable to HIV.

Many societies do not acknowledge that adolescent girls are sexually active and they cannot access information about sexuality, family planning and HIV prevention. Girls who do have sex, whether it is coercive or voluntary, are stigmatised and discriminated again, which further impedes their ability to access both information about sexual and reproductive health and services.

Example 1: Child marriage in Southern and East Africa

Setting a minimum age of marriage is a critical step to preventing child marriage. It helps send a clear message that children are not ready for marriage and they should be protected from the violence and sexual exploitation that frequently accompanies child marriage. The law should be accompanied by appropriate protection mechanisms. There has however been considerable global progress since the 2014 ARASA HIV and Human Rights Report in raising awareness about the abuses associated with child marriage and galvanizing support for efforts to end the practice.

In 2015, the international community adopted the Global Goals for Sustainable Development and included a goal to end child marriage by 2030. The UN Human Rights Council adopted a resolution on child marriage in July 2015 that recognizes child marriage as a human rights violation. Donor countries have begun to pledge specific funds to support child marriage eradication programmes and in 2015 both the Canadian and Dutch governments made funding available for civil society to work on child marriage.

There have been specific efforts to address the practice in Africa. The African Union (AU) launched a continental campaign in 2014 to end child marriage and Zambia, Mozambique, Tanzania and Uganda have recently developed national strategies to eradicate child marriage. In June 2016, AU member states adopted an African Common Position on Ending Child Marriage which includes establishing and enforcing laws that set 18 as the minimum marriage age. There has also been progress in the SADC region with the development of the SADC model law to end child marriage.

The law was developed by the SADC Parliamentary Form (SADC – PF) The African Union Campaign to End Child Marriage in Africa. The African Union launched a two year campaign to end child marriage on the continent in 2014 (the campaign was later extended to 2017).

The campaign seeks to accelerate change and encourages AU member states to raise awareness of the harms of child marriage and adopt strategies to prevent it and respond to the needs of girls at risk of child marriage and married girls. The campaign will focus on protecting girls' human rights and removing barriers to law enforcement.

The AU appointed a Special Rapporteur on Child Marriage and a Goodwill Ambassador for the AU Campaign to End Child Marriage to spearhead the campaign. The DRC, Madagascar, Uganda and Zimbabwe have launched the campaign in their countries. SADC Model Law to End Child Marriage and Protecting Children already in Marriage The drafting process started in 2015 and involved consultations with victims of child marriages, parliamentarians, civil society and national human rights commissions.

The model law makes the following recommendations:

- Laws prohibiting child marriage should be consistent with international human rights obligations and should protect children from discrimination and promote their human rights to education, health and to be free from all forms of violence
- Child marriage and betrothal should be legally prohibited
- Legislation should set the minimum age of marriage for boys and girls at 18
- Girls who become pregnant while at school must have the right to continue with their education
- Children, in line with their evolving capacities, should have the right to comprehensive, safe and quality sexual and reproductive health and rights
- Victims of child marriage, children in marriage and pregnant girls should have access to HIV counselling, testing, treatment and family planning and measures to prevent mother to child transmission of HIV
- Children have a right to birth registration
- All marriages should be registered
- Governments should put in place programmes to meet the needs of children in marriages, including economic empowerment
- Victims of child marriages should have access to legal aid and legal representation.

Source: ARASA 2016 HIV, TB and Human Rights Report in Southern and East Africa

2.3.6 Key issues for women and girls

- **Violence against women and girls (like rape and sexual abuse) is a crime and a human rights violation.** It makes women and girls vulnerable to HIV and it can also act as a barrier to accessing health services. For example women in abusive relationships may fear getting an HIV test because they are afraid of their partners.
- **In many countries marital rape is not a crime.** This makes it harder for married women, especially younger women and married girls, to protect themselves from HIV. It also means that they cannot seek redress when they are sexually assaulted by their husbands.
- **Women and girls often cannot access health care:** they may be poor, live too far away, or have too many household and childcare responsibilities and therefore may not get the information or care that they need to protect their health. Adolescent girls face particular challenges: health care workers may stigmatise them because they are sexually active and they may face violence and discrimination if they get pregnant outside of marriage.
- **Many girls are at risk of child marriage.** This practice affects nearly 100 million women and girls, many of whom live in Southern and East Africa. Child marriage increases girls' risk of HIV infection and also infringes on their rights to education and health and to live lives free of violence. Education has a protective effect and can reduce the risk of child marriage and adolescent pregnancy, but many girls are prevented from going to school and in some countries, pregnant girls are expelled or forced to drop out of school.
- **Few adolescents receive comprehensive sexuality education, including about HIV.** Access to information about sexuality, sexual and reproductive health and rights and family planning is an important component of protecting adolescents from HIV.
- **When women are denied economic rights, it is very hard for them to become independent.** This can stop a woman from ending a risky relationship (like an abusive marriage) or a risky work situation (like migrant work). Protecting women's economic rights (e.g. on divorce or death of a partner) and their workplace rights plays an important part in protecting women's health.

Self-Reflection Exercise 1: Impact of sexual violence

Women and girls experience high levels of sexual violence and many more live in fear of rape and assault. Think about how sexual violence and the fear of sexual violence impact on women and girls' daily lives. Identify some day to day activities that women and girls may choose not to do because they don't feel safe. Talk about how this differs from the choices that men and boys make about their lives.

2.4: How do you Protect Women's Human Rights?

2.4.1 Anti-discrimination measures

The best way to legally protect the rights to equality and non-discrimination for women is through laws and other measures that explicitly prohibit discrimination on the basis of sex, gender, pregnancy, sexual orientation and gender identity – these are called anti-discrimination measures. This means that governments should take steps to make sure that existing laws and policies do not discriminate against women and they should also enact laws that protect the rights of women. A good example of anti-discrimination laws are national constitutions that include provisions that prohibit discrimination against women.

Sometimes anti-discrimination measures do not just mean that women must be treated equally, they can also mean that laws and other measures must take into account the differences between women and men and make sure that women are not disadvantaged. An example of this type of anti-discrimination measure is a law that promotes a quota for women in education. This type of law recognizes that women have been historically excluded from education and promotes measures to change that.

Anti-discrimination measures can also recognize that women living with HIV have been particularly vulnerable to discrimination and can designate special measures such as protection from violence, to promote their human rights.

Example 3: Example: SADC Model Law on HIV in Southern Africa

The SADC Model Law contains a general anti-discrimination provision against people living with HIV and states that any direct or indirect discrimination on the grounds of HIV status or perceived HIV status is prohibited.

In addition, the Model Law has extensive provisions on women's equality. It states that women should have equal legal rights in all areas including marriage, divorce, inheritance, child custody, property and employment, and they should not be discriminated against on the ground of their sex, or their actual or perceived HIV status.

The Model Law also places obligations on governments to put in place policies and programmes that promote women's equality in the context of HIV.

2.4.2 Protection from violence

Protecting women and girls from violence is a critical part of protecting their human rights, as well as reducing their vulnerability to HIV. Countries in Southern and East Africa have made progress in enacting laws that protect women from domestic and sexual violence, but there are still gaps (e.g. the lack of recognition of marital rape) that must be addressed in order for women to have full protection.

Table 3: Laws on violence against women

Country	Marital rape is criminalised	Marital rape is not criminalised	Domestic violence laws
Angola	X		Domestic Violence Law 2011
Botswana		X	Domestic Violence Law 2008
Comoros	X		New law in 2014 strengthens protection for women against gender based violence
DRC		X	No domestic violence law
Kenya	Not clear – the penal code contains a marital rape exception, but the domestic violence law makes provision for "violence in marriage" to be prosecuted.		Protection Against Domestic Violence Act
Lesotho	X		Protection Against Domestic Violence Bill is still pending
Madagascar		X	Law 2000 - 12
Malawi		X	Protection Against (Prevention of) Domestic Violence
Mauritius		Not explicitly criminalised	Protection from Domestic Violence Act 1997
Mozambique	X		Law on Domestic Violence Perpetrated Against Women
Namibia	X		Combatting of Domestic Violence Act 2003
Seychelles	X		Family Violence (Protection Of Victims) Act 2000
South Africa	X		Domestic Violence Act 1998
Swaziland		X	
Tanzania	Criminalised in specific circumstances	No dedicated domestic violence laws, but aspects of domestic violence are criminalised in the Penal Code	
Uganda		X	Domestic Violence Act 2009
Zambia		X	Anti Gender Based Violence Act 2001
Zimbabwe	X		Domestic Violence Act 2007

In addition to laws, governments should provide supportive services for women and girls who have experienced violence, including access to shelters and post-rape health care, support for becoming economically independent and long term counselling, if needed. They should also put measures in place to protect and support children who have been exposed to violence in their homes.

2.4.3 Challenges to implementation

Enacting protective laws is only a first step to protecting rights – laws must also be properly enforced. There are serious challenges in implementing the anti-violence laws that have been passed and women and girls often cannot enforce their existing rights. Women and girls living with HIV may face particular challenges because they are highly stigmatised and afraid to disclose their HIV status.

Example 4: Reasons for lack of implementation of anti-violence laws

- **police officers and health care workers are inadequately trained on their legal obligations and do not always comply with various laws and policies**
- **social and cultural barriers prevent women from reporting sexual and domestic violence**
- **there are poor linkages between post-rape and HIV care, so women fall through the cracks.**

Source: Global Commission on HIV and the Law (2012) Risks, Rights & Health

In addition to the challenges described above, women and girls often do not know what their rights are, so it is important that governments put programmes in place to educate and inform women and girls about their rights and how and where to enforce them. Governments also need to educate men and boys about gender equality.

2.5: Sexual and Reproductive Health and Rights (SHHR)

Sexual and reproductive health are essential components of the right to health enshrined in the **Universal Declaration of Human Rights** and other international and regional human rights instruments.

Sexual and reproductive rights mean that all people have the right to a healthy, safe and consensual sex life, have access to information to inform their decision-making and services that keep them healthy. The sections below elaborate on what this means for women and girls, including those living with HIV.

2.5.1 What are reproductive health and rights? Why are they important to women and girls?

Reproductive rights are made up of a collection of human rights, including the rights to life, equality and non-discrimination, health, and the right to be free from violence. Almost all human rights are linked to reproductive rights.

They have two components: (1) access to reproductive healthcare and (2) the right to make decisions about sex and related issues, without discrimination, violence or force:

- **Reproductive health care:** this includes family planning and health services related to pregnancy, delivery and post-delivery. Women and men should also have access to prevention and treatment for sexually transmitted infections, including HIV and cervical cancer. Women and girls should have access to safe and legal abortions if they choose not to continue with the pregnancy. Everyone should be able to get information about their reproductive health status and available services, and adolescents should have access to comprehensive sexuality education. Women and men should be able to access these services without experiencing discrimination, coercion or violence.
- **Reproductive decision-making** means that everyone has the right to make decisions about when, how and with whom to have sex, when and whether they want to have children, and how many children they want to have and they should be able to make these decisions freely, without experiencing discrimination, violence or coercion.

Definition: WHO definition of reproductive health

The World Health Organisation (WHO) defines reproductive health as part of the right to health:

Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity; reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Without recognition and protection for reproductive rights, women and girls do not have control over their own bodies, but reproductive rights are also fundamental to protecting other human rights. Without protection for reproductive rights, women and girls are more vulnerable to violations of their other rights eg. pregnant adolescents are expelled from school, violating their right to education; women living with HIV are sterilised without their consent, violating their right to health care.

Many countries in Africa restrict access to abortion and do not provide meaningful access to contraception. Some women and girls are forced to have sex, or to have sex without condoms.

Women living with HIV experience violations of their reproductive rights both on the grounds of their HIV status and linked to their gender and sex: women who disclose their HIV status to their sexual partners often experience violence or they may not be able to access HIV testing and treatment for fear of their HIV status becoming known. Girls are forced into marriage and cannot negotiate safer sex and are at risk of HIV. These violations make them more vulnerable to HIV and undermine their access to reproductive health care.

See Module 2: Unit 1 - for more information on health rights

2.5.2 Sexual health and rights

Sexual rights are not yet recognized as part of international human rights law, but there is a growing consensus that people cannot have good reproductive and sexual health if their human rights, particularly the rights to equality and non-discrimination, privacy, health and education, reproductive rights and the right to be free from violence, cruel, inhuman and degrading treatment and torture, are not protected.

Example 5: Sexual rights include the rights:

- **To say "no" to sex**
- **To decide who to have sex with**
- **To decide what kind of sex to have**
- **To experience pleasure during sex**
- **Not to be married as a child or be forced into marriage as an adult**
- **To information and education about sexual health.**

Source: Engender (2006) Health, Sexual and Reproductive Rights of HIV-Positive Women and Adolescent Girls

Sexual health is different to reproductive health as it recognises that people have sex for pleasure, not just reproduction, and that they have health needs related to this sexual activity.

Definition: Elements of sexual health

- **A sexual life free from disease, injury, violence, disability, unnecessary pain or risk of death;**
- **A sexual life free from fear, shame, guilt, and false beliefs about sexuality;**
- **The capacity to enjoy and control one's own sexuality and reproduction.**

Source: International Women's Health Coalition

The CEDAW committee - set up to monitor how states comply with their obligations under the *Convention on the Elimination of All Forms of Discrimination Against Women* - says that women and girls have a right to sexual health information and services.

The SADC Model Law on HIV in Southern Africa also recognizes sexual rights and states that every person infected and affected by HIV should have the right to sexual and productive health rights. This includes that people living with HIV have the right to marry and have children.

Definition: WHO definition of sexual health and rights

The World Health Organisation has defined sexual health and rights as:

"a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."

2.5.3 What is a SRHR approach to HIV?

A SRHR approach to HIV means making sure that reproductive and sexual health services are integrated into HIV services and are offered without discrimination and coercion. This approach helps to respect and protect the rights of key groups and to provide a comprehensive package of health services. A SRHR approach is not just about the services that are offered to women and girls, but also about the way in which they are provided, the issues (including poverty, gender inequality, discrimination, violence) that are taken into account when providing the services, new ways of providing existing services and the attitude guiding the way in which these services are provided.

Example 6: An SRHR approach to women's health should include the following:

- **Access to services that are responsive to the sexual and reproductive health care needs of women and girls in all their diversities, free of coercion, discrimination, and violence, including access to youth-friendly services**
- **Access to cervical cancer prevention, screening, treatment, and palliative care**
- **Access to a full range of contraceptive options and attention to dual protection, free of coercion, discrimination, and violence**
- **Access to services to support safe conception, pregnancy, childbirth, and breastfeeding**
- **Access to emergency contraception and post-exposure prophylaxis**
- **Access to voluntary, safe, and comprehensive termination of pregnancy care and services.**

Source: HEARD (2011) From Talk to Action: Review of Women, Girls and Gender Equality in National Strategic Plans for HIV and AIDS in Southern and Eastern Africa: Policy Brief http://www.heard.org.za/gender/nsp

See Module 2: Unit 1 - for more information on health rights, including sexual and reproductive health.

2.5.4 Vulnerability and risk

Human rights protect the dignity of all people, regardless of their gender and sexuality. When human rights are not protected and when laws, policies and programmes undermine or abuse the rights of people living with HIV, they cannot achieve their full potential and it is more difficult to make choices that will lead to a healthy lifestyle. This can make certain groups of people more vulnerable to HIV.

Vulnerable groups are groups of people within the general population who are especially:

- at risk of getting infected with HIV
- most hard-hit once affected by HIV.

Violations of sexual and reproductive rights can make women and girls particularly vulnerable to HIV.

2.5.5 Key issues for women related to SRHR

- **Women living with HIV** often do not have access to accessible and appropriate information about contraception and pregnancy which makes it more difficult for them to make informed decisions about pregnancy. Women living with HIV have been sterilised without their consent or forced to have abortions, while others have not been able to access voluntary sterilisation and abortion services.

- **Pregnant women** are often tested for HIV without their consent and pregnant women with HIV are denied care or care is delayed when they are in labour. **Mothers with HIV** are not provided with accessible information about feeding options for their babies

- **Female migrants** are vulnerable to sexual abuse and exploitation and their undocumented status can make it difficult for them to access post-rape health care, including post-exposure prophylaxis (PEP) to reduce the risk of HIV transmission. It is also difficult for them to access HIV treatment, and if they are able to access treatment, many experience treatment disruptions because they may be detained or deported or because they are afraid to go to hospitals and clinics in case they are arrested.

- **Adolescent girls** are particularly vulnerable to violations of their reproductive rights: they are often coerced into sex and cannot negotiate safer sex. Reproductive health services may be inaccessible to them because of cost or because they are stigmatised and discriminated against by health care workers. Laws and policies governing access to key reproductive health services may prevent adolescent girls from accessing health care. For example policies that govern the age of consent to HIV testing may deny testing for adolescent girls unless they have parental consent. Contrarily, mandatory reporting laws and parental notification can also limit access to reproductive health care for adolescent girls who may fear their parents finding out that they are having sex.

See Module 2: Unit 3 on Treatment Literacy for more information on sexually transmitted infections and their treatment.

See Module 3: Unit 1 for more information on HIV-related stigma and discrimination.

2.6: Participation and Inclusion

Guidelines 1 and 2 of the International Guidelines on HIV/AIDS and Human Rights remind us of how important it is to create partners in the fight against HIV, not only with governments but with those outside of government, but also the private sector and communities. Guideline 2 focuses on how to create real working partnerships with communities.

Communities need to be included and supported by government in the response to HIV for a number of reasons:

- The community has vital knowledge and experience to contribute to the national response to HIV and AIDS.
- Communities are well placed to reach vulnerable populations within the community. They are either themselves affected by human rights challenges, or they deal directly with people who are.
- Communities need support (e.g. funds, capacity building) to help them to carry out their important work effectively.

Even when communities are consulted by government, women are often marginalised and not included in consultation processes. HIV activists have an important role to play in making sure that they advocate for meaningful inclusion of women.

This may pose the following challenges:

- Because of their unequal status, women may be uncomfortable participating in meetings and discussions. Their child care needs and domestic responsibilities may make it difficult for them to make the time to be involved in advocacy and human rights activism.
- Women in abusive relationships may find it difficult to leave their homes without the permission of their partners.
- Women from more marginalised groups such as undocumented migrants, sex workers and rural women, may require different strategies to enable them to engage.

Learning Activity 3: Brainstorming barriers to inclusion and participation

Make a list of all the reasons why women may not be able to participate in the following activities:

- An advocacy meeting with a government official
- A planning meeting at a non-governmental organisation (NGO) to discuss a campaign on HIV and human rights
- Attending a court case on violence against women
- Speaking at a public meeting on living with HIV.

Once you have made this list, develop strategies that could help to advance their ability to participate fully in each activity.

2.7: Unit Summary

1. Gender refers to the differences that society ascribes to women and men and how they are expected to behave. Understanding gender is a crucial part of a rights-based and effective response to HIV.

2. In Southern and East Africa, women and girls are disproportionately vulnerable to HIV and sub-Saharan Africa is the only region where more women than men are living with HIV.

3. Women and girls' unequal status increases their risk of exposure to HIV.

4. Gender-based violence is a serious concern in all Southern and East African countries and sexual violence puts women and girls at greater risk of HIV exposure.

5. Gender norms dictate how women and girls should behave. Harmful gender norms such as FGM and other cultural and religious practices expose women and girls to a higher risk of HIV and also limit their ability to access HIV prevention, treatment, care and support.

6. Progress has been made in enacting laws that protect women and girls from gender-based violence and to promote their right to equality, but there are serious challenges to implementing them.

7. Sexual and reproductive rights mean that all people have the right to a healthy, safe and consensual sex life, have access to information to inform their decision-making and services that keep them healthy. They are an essential part of the right to health.

8. Many women and girls cannot exercise their sexual and reproductive rights and do not have control over their bodies. Violations of sexual and reproductive rights make them more vulnerable to other human rights abuses.

9. Women living with HIV experience violations of their reproductive rights both on the grounds of their HIV status and linked to their gender and sex.

10. A sexual and reproductive rights approach to HIV means integrating reproductive and sexual health services into HIV services. It also means that all services are offered without discrimination and coercion and in a way that respects the human rights of women and girls.

11. Women and girls are often excluded from participating in decisions that affect their lives and more must be done to ensure their meaningful participation.

Summative Assessment

Complete the following quiz to assess your knowledge of human rights, gender and sexual and reproductive rights. Tick whether each of the following statements is true or false.

Question	True	False
Women and girls are not particularly vulnerable to HIV		
Human rights abuses can increase the vulnerability of women and girls to HIV		
Sexual and reproductive health and rights are important components of a rights-based response to HIV		
Gender based violence is a form of gender discrimination		
Women and girls can always participate in processes that affect their lives		

2.8: Unit Outcomes Checklist

Use the checklist below to see whether you have met the outcomes that were set for this unit.

Outcome	Yes, I have met this outcome	No, I have not met this outcome	These are the things I still need to revise
Explain the difference between sex and gender			
Describe a SRHR approach to HIV			
Participate in a discussion about why it is important to recognise and include gender in a rights-based approach to HIV			
Understand why the participation and inclusion of women and girls is important and describe barriers to their meaningful participation			
Describe the best ways to protect the rights of women and girls to equality and non-discrimination			

2.9: Resources and References

2.9.1 Useful Websites

Canadian HIV/AIDS Legal Network
http://www.aidslaw.ca/site/our-work/womens-rights/

Girls Not Brides
http://www.girlsnotbrides.org/

HEARD: Gender Equality and HIV Prevention Programme
http://www.heard.org.za/gender

International Centre for Research on Women
http://www.icrw.org/what-we-do/hiv-aids

UNDP, gender equality
http://www.undp.org/content/undp/en/home/ourwork/gender-equality/overview.html

UN Women
http://www.unwomen.org/en/what-we-do/hiv-and-aids

2.9.2 Useful Resources

Convention on the Elimination of All Forms of Discrimination Against Women
http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm

Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa
http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf

SADC Model Law on HIV/AIDS
http://www.sadcpf.org/SADC%20PF%20model%20law%20on%20HIV_position%20paper.pdf

UNAIDS and the African Union, Empower Young Women and Adolescent Girls: *Fast-Tracking the End of the AIDS Epidemic in Africa*
http://www.unaids.org/sites/default/files/media_asset/JC2746_en.pdf

Sexual Orientation and Gender Identity, Sexual and Reproductive Health and Rights and HIV

unit 2b

2.1: Introduction

Lesbian, gay, bisexual, transgender and intersex (LGBTI) people face severe human rights violations because of their sexual orientation, gender identity, HIV status, sex and gender. This unit provides learners with information to help them understand the human rights violations linked to sexual orientation and gender identity and how these violations impact on the ability of LGBTI individuals to protect themselves from HIV and those living with HIV to access adequate health care.

The human rights of LGBTI persons are often invisible or ignored in national responses to HIV:

- Gay men, men who have sex with men and transgender people may be at higher risk of HIV exposure than the general population, but often struggle to access condoms and water-based lubricant and information about HIV, sexually transmitted infections (STIs) and safer sex practices.
- There is inconsistent information about the vulnerability of lesbians, intersex, bisexual and transgender people to HIV, but some research suggests that transgender people are at increasingly high risk of HIV exposure because they are at high risk of sexual violence. Lesbians, gender non-conforming women and men also face high levels of sexual violence because of how they look or dress.
- Stigma and discrimination linked to HIV status and gender, sexual orientation and gender identity undermines LGBTI peoples' ability to access sexual and reproductive health care. Many LGBTI individuals do not access health care because they fear disclosure of their HIV status and/or their sexual orientation by health care workers. LGBTI persons cannot always access appropriate sexual and reproductive health services as health care providers may not be allowed to provide tailored services to criminalised groups or they may not have sufficient expertise and experience to provide the right services.
- Criminalisation of sexual orientation and gender identity help make these populations invisible to policy makers and programmers.

2.2: Unit Outcomes

At the end of this unit you should be able to:

- Understand and describe key concepts related to sexual orientation and gender identity
- Know the appropriate and rights-respecting terminology to use
- Understand and explain why LGBTI populations are particularly vulnerable to HIV
- Participate in a discussion about why it is important to recognise and include sexual orientation and gender identity in rights-based responses to HIV
- Understand why a sexual and reproductive health and rights approach to HIV protects and promotes the human rights of LGBTI persons
- Describe how to protect the human rights of LGBTI persons
- Understand the importance of including LGBTI populations at all stages of design, implementation, monitoring and evaluation of laws, policies and programmes that affect their rights.

2.3: Sexual Orientation and Gender Identity (SOGI)

2.3.1 Important definitions and terminology

Language is important. Words are often used to stigmatise and dehumanise LGBTI individuals and undermine their dignity. Human rights and HIV activists should not only be familiar with the meaning of key terms relating to sex, gender identity and sexual orientation, but they should also use the terminology that individuals prefer. Definitions and explanations of key terms appear throughout this module.

Definitions

Bisexual
A sexual orientation and identity. Bisexual people have a romantic and/or sexual attraction to people of the same and opposite gender. Not necessarily at the same time and not necessarily an equal amount of attraction for the same gender.

Gay
A sexual identity and orientation; a man attracted to other men, romantically and/or sexually.

Gender Identity
Refers to a person's innate, deeply felt psychological identification as a man, woman, or sometimes in between, which may or may not correspond to the person's body or sex assigned at birth. An internalized representation of gender roles and awareness from infancy which is reinforced during adolescence.

Gender non-conforming
A person who does not conform to the binary male-female categories that society prescribes; transgender people for example, are gender non-conforming, but others who are not transgender might be as well.

Heterosexual
A person attracted to people of the opposite gender, romantically and/or sexually, where the gender of the attracted person is the key to the attraction.

Homosexual
A person attracted to people of the same gender, romantically and/or sexually, where the gender of the attracted person is the key to the attraction.

Homophobic
Irrational fear of homosexual feelings, thoughts, behaviours, or people and an undervaluing of homosexual identities, resulting in prejudice, discrimination and bias against homosexual individuals.

Intersex
Being born with ambiguous sex characteristics (chromosomes, genitals and/or reproductive organs). Many variations exist; intersex is not one single category, but includes many different ways someone might defy the medical definitions of "male" and "female".

Lesbian
A sexual identity and orientation; a woman attracted to other women, romantically and/or sexually.

Men Who Have Sex With Men (MSM)
Sexual practice irrespective of sexual orientation or identity. An MSM can be hetero-, bi- or homosexual or transgender man. This term is more technical and is not necessarily an identity.

Sexual Orientation
Pattern of romantic and/or sexual attraction to a person of the opposite gender, same gender, or more than one gender.

Transgender Man
A transgender man or female-to-male (FTM) is assigned female at birth, but his gender identity is male.

Transphobia
Irrational fear of transgender feelings, thoughts, behaviours or people and an undervaluing of transgender identities, resulting in prejudice, discrimination and bias against transgender individuals. Where transphobia includes homophobia, we speak of homophobia and transphobia.

Transgender Woman
A transgender woman, or male-to-female (MTF) is assigned male at birth, but her gender identity is female.

Transgender
An umbrella term which is often used to describe people whose gender expression or gender identity differs from their biological sex or gender assigned at birth. The umbrella terms is used to describe a wide range of identities and experiences, including transsexuals, FTM persons, MTF persons, transvestites, cross-dressers, two-spirits, gender-queers and others.

Transsexual
This refers to people who wish to undergo hormone replacement therapy and/or gender affirming surgery to align their bodies to their gender identity.

Women Who Have Sex With Women (WSW)
A sexual practice irrespective of sexual orientation or identity. A WSW can be hetero-, bi- or homosexual or transgender woman. This term is more technical and is not necessarily an identity.

Source: ARASA (2015) Sexual Orientation, Gender Identity, HIV and Human Rights: An Advocacy Manual

2.3.2 SOGI and human rights

Evidence shows that people across Africa, including in Southern and East Africa, face discrimination, abuse and violence because of individual expression, who they love, have sex with and how they look. They face disproportionately high levels of violence, abuse and discrimination in laws, policies and practices that undermine their human rights, including their sexual and reproductive health and rights and that impede access to HIV-related prevention, treatment, care and support. Many countries in Southern and East Africa criminalise same sex sexual conduct reinforcing stigma and sanctioning discrimination. Even where same sex sexual conduct is not criminalised, LGBTI persons face social disapproval and stigma.

LGBTI persons living with HIV experience additional barriers when they try to access anti-retroviral treatment (ART) or seek information about safer sex practices. Gay men and men who have sex with men face double stigma on the grounds of their HIV status and sexual orientation, and may not disclose their sexual orientation to health care workers, leaving STIs undiagnosed and untreated. Many countries do not legally recognize transgender people and the lack of clarity about their legal status can make it difficult for them to access official documentation such as national identity documents which can undermine their access to health care.

2.3.3 Stigma and discrimination

LGBTI individuals face multiple and overlapping forms of stigma and discrimination, based on their sexual orientation, gender identity, gender, actual and perceived HIV status, socio-economic status and race, that impedes their ability to realise their human rights, including the right to access health care. The failure to access appropriate health care services timeously to prevent the risk of HIV transmission and to treat HIV makes LGBTI persons particularly vulnerable in the context of HIV. Campaigns about prevention do not specifically target LGBTI people, and do not contain relevant information about safer sex practices.

Case Study 1: Tanzania

LGBTI persons say they fear discriminatory treatment at the hands of health service providers because health care providers have limited understanding of sexual orientation, gender identity and transgender issues. This leads to prejudice, mistrust, discriminatory treatment, denial of health care and even abuse. LGBTI persons are also afraid that health care workers will 'out' them, disclosing information about their HIV status, sexual orientation or gender identity without their permission.

A Human Rights Watch (HRW) report documented the denial of health care, verbal abuse, harassment and violations of confidentiality of gay men and men who have sex with men transgender and intersex persons in Tanzania. For example, a transgender man described how health care workers refused to treat him for an STI at a government hospital.[1]

[1]*Human Rights Watch (2013) Treat Us Like Human Beings: Discrimination Against Sex Workers, Sexual and Gender Minorities and People Who Use Drugs. Available at http://www.hrw.org/reports/2013/06/18/treat-us-human-beings-0*

See Module 3: Unit 1 for more information on stigma and discrimination.

2.3.4 Criminalisation of same sex sexual conduct

Criminalising same sex sexual conduct is a violation of the right to equality and non-discrimination and reinforces stigma. Criminalisation of same sex sexual conduct, particularly between men, in Africa has a profoundly negative impact on the human rights of LGBTI persons, including undermining their right to health. It pushes vulnerable people away from important health services, including HIV testing, and information about their sexual and reproductive health needs. This in turn makes it difficult for health care providers to provide accessible, non-judgmental and effective access to HIV prevention, treatment, care and support. Some are concerned that it may be unlawful to provide health care to criminalised populations and governments do not make it clear that everyone is entitled to health care, regardless of whether they engage in behavior that is criminalised.

The 2009 and 2014 ARASA HIV and Human Rights reports found that nearly two-thirds of the fourteen Southern African Development Community (SADC) countries then surveyed had laws that criminalised consensual sex between men and some criminalised consensual sex between women. The 2016 report showed some positive changes, although the majority of countries from Southern and East Africa still have legislative measure that criminalises same sex sexual conduct for men and women and many governments promote homophobia and discrimination against people on the grounds of sexual orientation and gender identity.

Positive developments in Mozambique and Malawi

- **Mozambique:** the new Penal Code in Mozambique (Law 35/2014) decriminalised sex between men by repealing the old Penal Code. In May 2016, Seychelles also repealed provisions that criminalised sex between men.

- **Malawi:** in mid-2014 the Solicitor General of Malawi announced that the Law Commission was reviewing the constitutionality of Malawian anti-homosexuality laws. In 2015, the Minister of Justice confirmed the laws would not be enforced until the completion of the review.

Guideline 4 of the *UNAIDS HIV/AIDS and Human Rights International Guidelines* recommends that states should review laws that criminalise sodomy and other sexual acts between consenting adults, with a view to repealing them. At a minimum, criminal laws should not be allowed to impede the provision of HIV prevention, treatment and care services.

Table 1: Criminalisation of same sex sexual conduct

Country	Criminalise same sex conduct between men	Laws prohibiting discrimination
Angola		No
Botswana	Yes	Yes
Comoros	Yes	No
DRC	Can prosecute on the basis of indecent assault	No
Kenya	Yes	No
Lesotho	Yes	No
Madagascar	No	No
Malawi	Laws currently not being enforced pending review	No
Mauritius	Yes	No
Mozambique	No	Yes
Namibia	Yes	No
Seychelles	No	Yes
South Africa	No	Yes
Swaziland	Yes	No
Tanzania	Yes	No
Uganda	Yes	No
Zambia	Yes	No
Zimbabwe	Yes	No

2.3.5 HIV data and SOGI

There is not enough information about the prevalence of HIV amongst all LGBTI people. UNAIDS states that HIV prevalence is increasing amongst gay men and men who have sex with men. The *UNAIDS (2014) Gap Report* states that gay men and men who have sex with men are 19 times more likely to be living with HIV than the general population. At the moment, there is little global data about HIV prevalence amongst lesbians and women who have sex with women and amongst transgender people. However, there is some research that says that transgender women have even higher rates of HIV than gay men and men who have sex with men.

Learning Activity 1: Stigma and Discrimination against LGBTI populations

LGBTI people experience stigma and discrimination in many different settings, including in their homes, at school and in their communities. Think about the different types of stigma and discrimination and what drives stigma and discrimination against LGBTI people.

2.3.6 Human rights standards and SOGI

Human rights are based on the idea that every person is equal and entitled to be treated with dignity and respect regardless of their race, gender, age, disability, sexual orientation, gender identity or any other characteristic. This means that LGBTI persons have the same rights to equality, non-discrimination and other human rights as anyone else and countries should not pass laws that discriminate against LGBTI people.

Until very recently however, the UN and the African regional human rights systems failed to address the human rights of LGBTI persons and many countries argued that discrimination on the sexual orientation and gender identity did not fall under human rights law. There have been several important developments that contribute to recognition of the human rights of LGBTI persons and set out systems of protection for them:

- The Yogyakarta Principles were adopted in 2007 and underscore that the failure of governments to protect LGBTI persons results in the violation of their rights, including the rights to non-discrimination and recognition before the law.

- The 2008 UN General Assembly statement on sexual orientation, gender identity and human rights reaffirmed the right of every person to enjoy all human rights without distinction and the principle of non-discrimination, which applied equally to people regardless of their sexual orientation or gender identity. It condemned violations of human rights and fundamental freedoms based on sexual orientation or gender identity and urged member states to promote and protect the rights of all people regardless of sexual orientation and gender identity.

- 2011 and 2014 Human Rights Council (HRC) statement and resolutions: Eighty five countries adopted a joint statement in March 2011 - *Ending Acts of Violence and Related Human Rights Violations Based on Sexual Orientation and Gender Identity.* During the June 2011 session, the HRC passed a resolution on the violation of human rights based on gender identity and sexual orientation which was spearheaded by South Africa. This was the first resolution of the HRC on sexual orientation and gender identity and it was passed by 23 votes. The ground-breaking resolution expressed "grave concern at acts of violence and discrimination, in all regions of the world, committed against individuals because of their sexual orientation and gender identity" and called for a study by the High Commissioner for Human Rights to determine the extent of discrimination and violence against people on the basis of their sexual orientation and gender identity, and to identify ways in which international human rights law might be used to combat these.

  The report on discrimination and violence on the basis of sexual orientation and gender identity was published by the Office of the High Commissioner for Human Rights (OHCHR) in November 2011, and presented to the HRC in March 2012. The report found that "people experience violence and discrimination because of their sexual orientation or gender identity" in all regions of the world. The report found that governments and inter-governmental bodies often overlook violence and discrimination based on sexual orientation and gender identity and called for action, especially at the national level, to protect individuals from violence and discrimination. On September 26, 2014 the HRC passed another resolution to combat violence and discrimination based on sexual orientation. The resolution expressed grave concern regarding violence and discrimination and asked the High Commissioner for Human Rights to update the 2012 study, with a view to sharing good practices in overcoming discrimination and violence.

- **2014 African Commission on Human and Peoples' Rights (ACHPR) resolution:** The ACHPR adopted a landmark resolution on SOGI during its 55th session in May 2014. The resolution calls for the protection of human rights regardless of actual or perceived sexual orientation or gender identity and rejects discrimination on any ground.

2.3.7 Key issues

- LGBTI people often experience sexual violence because of their sexual orientation and gender identity. Lesbians have been targeted for punitive sexual violence, so-called "corrective" rape, and research shows that transgender persons are particularly vulnerable to rape and sexual assault. LGBTI persons experience violence at the hands of intimate partners, family members and their communities but also from officials such as police officers and health care workers. LGBTI adolescents are particularly at risk of violence.

- LGBTI people in some countries are subject to arbitrary arrest and detention and LGBTI organisations and human rights groups working on LGBTI issues have been harassed and threatened. Fear of arrest and harassment undermines efforts to provide LGBTI persons with information about safer sex and HIV prevention interventions. Arrest and detention can expose LGBTI persons to sexual violence and can interrupt treatment for LGBTI persons living with HIV or deny access to HIV testing and treatment.

- As already mentioned, the criminalisation of same sex sexual conduct is a violation of the right to equality and non-discrimination and makes it hard for LGBTI people to access health care and other services. Recently, some countries introduced laws that ban organisations from supporting and advocating for LGBTI people. These laws not only make it hard for LGBTI people to get health care and other services, they also reinforce stigma and discrimination.

- LGBTI people experience very high levels of stigma and discrimination in almost all aspects of their lives: LGBTI children and adolescents are expelled from schools or forced to drop out because of bullying and victimization on the grounds of their sexual orientation and gender identity, or that of their parents; lesbians lose custody of their children.

- Because of stigma and discrimination and failure by governments to prioritise their needs, many LGBTI people cannot access important HIV prevention and treatment services. Gay men and other MSM are not able to access water-based lubricant and condoms and proper information about how to have safer sex.

Examples of Stigma and Discrimination

Lilongwe, Malawi: One focus group participant in Lilongwe explained the discrimination and stigma lesbians and gender non-conforming individuals face in health facilities, often when exercising the right to gender expression. "When a tomboy goes to the clinic, the way he looks, everyone is looking…Is he a man? Woman? He has breasts. Then you get self stigma…They will say, why are you dressed like that, are you a woman or man? This is not our culture. In our culture we don't dress like that… Even if you wanted to go to the hospital the next day, I don't think you can go." - Interview with Mary, Lilongwe, Malawi, November 2015

Manzini, Swaziland: To avoid homophobia, transphobia and stigma against persons living with HIV amongst providers, LGBTI people may prefer not to get tested for HIV, since testing positive could subject them to additional marginalisation and discrimination. Some LGBTI persons who are HIV-positive even forgo lifesaving ARTs to avoid ill treatment in health facilities. "Because people are not treated well when they are [HIV]-positive they just go back, they stay back, they don't want to come back to the clinic, they don't want to because of the stigma that they know. So now you have to deal with stigma that I'm positive. And stigma that I'm gay. Which is too much for one to do. Double tragedies. So they stay home and deal with it at home until [they] die."5 - Focus Group Participant, Manzini, Swaziland February 2016.

Source: Identifying Injustice Report

2.4: Protecting the Human Rights of LGBTI People

United Nations human rights bodies have highlighted five key things that countries must do to prevent human rights violations against LGBTI persons:

- Protect them from violence that specifically targets them because they are LGBTI persons
- Prevent torture and cruel, inhuman and degrading treatment of LGBTI persons
- Prohibit discrimination based on sexual orientation and gender identity
- Protect freedom of expression, association and peaceful assembly for LGBTI people.

2.4.1 Anti-discrimination measures

The best way to legally protect the rights to equality and non-discrimination for LGBTI persons is through laws and other measures that explicitly prohibit discrimination on the basis of sex, gender, sexual orientation and gender identity - these are called anti-discrimination measures. Many countries have laws and policies that directly discriminate against LGBTI persons on the basis of their sexual orientation and gender identity. These laws include criminalising sex between consenting adults and criminalising

transgender people on the basis of their gender expression. Discriminatory laws reinforce stigma and discrimination and contribute to hate crimes, police abuse, torture and ill-treatment, family and community violence, and impede access to health and HIV services.

States should enact laws that actively promote the rights of LGBTI persons to equality and dignity. As a matter of urgency, countries should decriminalise all consensual, same sex sexual activity between adults.

Example: Protecting LGBTI individuals from discrimination

States should:

- **Prohibit all forms of discrimination on the grounds of sexual orientation and gender identity**
- **Ensure the legal recognition of the gender identity of transgender people**
- **Raise awareness of human rights violations against LGBTI persons and combat stigma through public education**
- **Ensure the full and meaningful participation of LGBTI people in all things that affect their lives.**

2.4.2 Protection from violence

LGBTI persons are vulnerable to many forms of violence, including sexual violence that places them at risk of HIV but are often unable to access legal protection. Laws criminalizing domestic violence may not recognise same sex relationships and therefore exclude victims of violence in same sex relationships from accessing protection orders and shelters. Sexual violence laws in some countries do not recognize male rape victims.

Stigma and discrimination may alienate LGBTI victims from the criminal justice system and many choose not to report violence to the police because they fear getting arrested themselves or that they will be treated badly by officials.

The Global Commission on HIV and the Law called for countries to end violence against key populations and ensure that the criminal justice system is able to adequately investigate and prosecute violence against LGBTI individuals.

LGBTI persons are also particularly vulnerable to violence and other abuses at the hands of law enforcement officials. It is important to educate and train law enforcement officials on the rights of LGBTI persons and ensure that they are held accountable for any abuse.

2.5: Sexual and Reproductive Health and Rights (SRHR)

Countries must protect the rights of LGBTI persons to the highest attainable standard of health. This means that LGBTI persons have the right to access sexual and reproductive health care without experiencing stigma, discrimination or violence.

See Module 3: Unit 2A on Women Rights, Sexual and Reproductive Health and Rights and HIV for more information on sexual and reproductive health and rights

See Module 2: Unit 1 for more information on health rights, including SRHR.

2.5.1 What is a SRHR approach to HIV and why is this important to LGBTI persons?

LGBTI persons are often unable to have safe and respectful sexual relationships because same sex relationships and/or sexual conduct is criminalised. They experience stigma and discrimination based on their sexual orientation and gender identity that negatively impact on their access to reproductive and sexual health services. The protection of their sexual and reproductive health and rights can help to improve their health and their ability to access health care and protect their human rights.

A SRHR approach to HIV means making sure that reproductive and sexual health services are integrated into HIV services and are offered without discrimination and coercion. This approach helps to respect and protect the rights of key groups, including LGBTI persons, and to provide a comprehensive package of health services. A SRHR approach is not just about the services that are offered to LGBTI persons, but also about the way in which they are provided, the issues that are taken into account (including poverty, stigma, gender inequality and discrimination and violence) when providing the services, new ways of providing existing services and the attitude guiding the way in which these services are provided.

2.5.2 Key issues for LGBTI persons related to SRHR

LGBTI individuals in Southern and East Africa (SEA) suffer discrimination in health care on the basis of their real or imputed sexual orientation, gender identity and gender expression. Health discrimination against LGBTI people comes in many forms including denials in access to health services, non-availability of targeted health programmes based on specific needs, and insensitive, degrading, and harmful treatment by health providers and workers. Some health violations may be less intentional, yet are nonetheless harmful, such as instances in which health providers ask LGBTI people invasive questions irrelevant to their health concerning their sexuality, gender identity and/or expression. Abuse and mistreatment in health facilities is a substantial barrier to accessing health services.

The UN Committee on the Elimination of Discrimination against Women has expressed concern about abuse and mistreatment by health providers against transgender, intersex, lesbian and bisexual women and called on the State to intensify efforts to “combat discrimination against women based on their sexual orientation and gender identity, including by launching a sensitization campaign aimed at the general public, as well as providing appropriate training to law enforcement officials and health services providers.”

Many individuals interviewed for ARASA's 2016 Identifying Injustice: Law and Policy on SOGI and HIV in Southern Africa report confirmed that due to verbal abuse, discrimination, and inappropriate treatment, many LGBTI people will not even seek emergency health services, let alone preventative or general health services.

One barrier to accessing sexual and reproductive health services for women who have sex with women (WSW) and trans-men in many countries in Southern Africa is the belief amongst providers and society that they are not at risk for HIV and STIs. Some health providers have minimised HIV risk to WSW and even discouraged HIV testing. Health providers have asked a number of WSW "how HIV contraction is possible for them," based on misconceptions about sexual practices and associated risks.

The belief that WSW are not at risk of HIV infection ignores the distinction between sexual identity and sexual behaviour - identifying as a lesbian does not mean an individual has never engaged in sex with men. Further, HIV can be transmitted during sex between women. While there is limited data available on risk of transmission, one study found that 21% of HIV positive lesbians surveyed in South Africa, Zimbabwe and Namibia acquired HIV from their female partners.

2.6: Participation and Inclusion

Guidelines 1 and 2 of the *UNAIDS International Guidelines on HIV/AIDS and Human Rights* remind us of how important it is to create partners in the fight against HIV, not only with governments but also the private sector and communities. Guideline 2 focuses on how to create real working partnerships with communities.

Communities need to be included and supported by government in the response to HIV for a number of reasons:

- The community has vital knowledge and experience to contribute to the national response to HIV and AIDS
- Communities are well placed to reach vulnerable populations within the community. They are either themselves affected by human rights challenges, or they deal directly with people who are.
- Communities need support (e.g. funds, capacity building) to help them to carry out their important work effectively.
- Even when communities are consulted by government, LGBTI persons are often invisible and marginalised and therefore not included in consultation processes. HIV activists have an important role to play in making sure that they advocate for meaningful inclusion of LGBTI individuals and groups.

This may pose challenges:

- Fears of stigma and discrimination may stop individuals from joining HIV organisations or participating in meetings.
- Because of their criminalised status, individuals may be afraid to participate openly in meetings and discussions that could expose them to arrest and prosecution.
- LGBTI individuals are highly stigmatised and some civil society groups and individuals may refuse to participate in meetings where LGBTI individuals or groups are present.

2.7: Unit Summary

1. HIV activists should be familiar with the meaning of key terms relating to sex, gender identity and sexual orientation and use the terminology that individuals prefer.

2. LGBTI persons face disproportionately high levels of violence, abuse and discrimination in laws, policies and practices that undermine their human rights, including their sexual and reproductive health and rights and impede access to HIV-related prevention, treatment, care and support.

3. Many countries in Southern and East Africa criminalise same-sex sexual conduct, reinforcing stigma and permitting discrimination.

4. Criminalising same-sex sexual conduct is a violation of the right to equality and non-discrimination and reinforces stigma.

5. LGBTI persons have the same rights to equality, non-discrimination and other human rights as anyone else and countries should not pass laws that discriminate against LGBTI people.

6. Laws should explicitly prohibit discrimination on the basis of sex, gender, sexual orientation and gender identity and prohibit violence against LGBTI persons.

7. LGBTI persons have the right to access sexual and reproductive health care without experiencing stigma, discrimination or violence.

Summative Assessment

Complete the following quiz to assess your knowledge of human rights, sexual orientation and gender identity. Tick whether each of the following statements is true or false.

Question	True	False
Human rights abuses can increase the vulnerability of LGBTI persons to HIV		
Countries do not need to protect the human rights of LGBTI people if they have criminalised sexual orientation and gender identity		
Health care workers cannot provide health care to LGBTI persons if it is a crime to be gay		
Stigma against LGBTI persons is driven by criminalisation and social disapproval		
LGBTI persons are marginalised and therefore cannot always participate meaningfully in processes that involve their lives		

2.8: Unit Outcomes Checklist

Use the checklist below to see whether you have met the outcomes that were set for this unit.

Outcome	Yes, I have met this outcome	No, I have not met this outcome	These are the things I still need to revise
Understand and explain key concepts of sexual orientation and gender identity			
Know the appropriate and rights-respecting terminology			
Understand and explain why human rights violations make LGBTI persons vulnerable to HIV			
Know why a sexual and reproductive rights approach protects and promotes the human rights of LGBTI persons			
Understand why the participation and inclusion of LGBTI persons is important and describe barriers to their meaningful participation			
Describe the best ways to protect the human rights of LGBTI persons			

2.9: Resources and References

2.9.1 Useful Websites

African Men for Sexual Health and Rights (AMSHeR)
http://www.amsher.org/

AIDS-Free World
http://www.aidsfreeworld.org/Our-Issues/Homophobia.aspx

Amnesty International
http://www.amnesty.org/en/sexual-orientation-and-gender-identity

Athena Network
http://www.athenanetwork.org/

GATE (Global Action for Trans* Equality)
http://transactivists.org/

Outright International (formerly International Gay and Lesbian Commission on Human Rights (IGL-HRC))
https://www.outrightinternational.org/

SafAIDS
http://www.safaids.net/category/thematic-focus-areas/lesbians-gays-bisexuals-transsexuals-and-inter-sex-lgbti

2.9.2 Useful Resources

Amnesty International (2013) *Making Love A Crime: Criminalization of same-sex conduct in Sub-Saharan Africa*
http://www.amnesty.org/en/documents/AFR01/001/2013/en/

ARASA (2015) *Sexual orientation, gender identity, HIV and human rights: an advocacy toolkit*
http://www.arasa.info/files/8414/3860/4501/ARASA_Toolkit_full_web.pdf

IGLHRC *Off the Map: How HIV/AIDS Programming is Failing Same-Sex Practising People in Africa*
http://www.iglhrc.org/sites/default/files/6-1.pdf

Criminalisation of HIV Transmission, Exposure and Non-disclosure

unit 3

3.1: Introduction

This unit provides information about the criminalisation of HIV transmission, exposure and non-disclosure, the negative impact it has on the human rights of people living with HIV and key populations and universal access to HIV prevention, treatment, care and support. The focus is on providing knowledge and skills so that learners can identify harmful HIV transmission, exposure and non-disclosure laws and advocate for laws that do not criminalise HIV transmission.

3.2: Unit Outcomes

By the end of this unit, learners should be able to:

- Understand what criminalisation of HIV transmission, exposure and non-disclosure is and the difference between transmission, exposure and non-disclosure
- Identify the links between human rights, universal access to HIV prevention, treatment, care and support, and the negative impact of criminalisation of HIV transmission, exposure and non-disclosure
- Understand the disproportionate impact of criminalisation on women and key populations
- Understand international and regional guidance on criminalisation of HIV transmission, exposure and non-disclosure and be aware of model laws and other instruments that can be used as advocacy tools to advocate against criminalisation
- Advocate for laws that do not criminalise HIV transmission, exposure and non-disclosure, respect the rights of people living with HIV and promote universal access, or for the repeal or amendment of laws that do criminalise HIV transmission, exposure and /or non-disclosure.

3.3: Criminalisation of HIV Transmission, Exposure and Non-disclosure

3.3.1 What is criminalisation of HIV transmission, exposure and non disclosure?

The criminalisation of HIV transmission, exposure and non-disclosure, which is often referred to as HIV criminalisation, is the unjust application of criminal law based solely on HIV status – either by enacting and applying HIV-specific criminal laws, or by applying general criminal laws exclusively or disproportionately against people with HIV.

In some countries existing criminal laws are used to prosecute people who transmit HIV or expose a person to HIV, in certain circumstances. For example in South Africa in 2013, an AIDS counsellor who knew himself to be living with HIV was prosecuted for attempted murder because he had sex with a person who was HIV negative without using any protective measures. He was convicted of attempted murder and sentenced to 6 years imprisonment. In this case the accused was not convicted of having in fact transmitted HIV to the complainant.

In other countries law makers believe that existing criminal laws are inadequate to address HIV. They create new HIV-specific laws that make it a crime to transmit HIV to another person. For example, in Tanzania the 2008 HIV and AIDS Prevention and Control Act makes it an offence for a person to intentionally infect another person with HIV and provides for a prison sentence of between 5 and 10 years should a person be convicted.

Many of these HIV-specific crimes go beyond the intentional transmission of HIV. For example, in Madagascar the 2005 HIV Law provides that "[i]n the event of transmission of HIV by recklessness, carelessness, inattentiveness, negligence or in violation of regulations, the offender shall be punished with imprisonment from 6 months to 2 years and a fine of from 100 000 ariary to 400 000 ariary".

Additionally, in some cases the provisions are very broad and vague, criminalising a wide range of potential acts. In Zimbabwe section 79 of the Criminal Law (Codification and Reform) Act of 2004 makes it a crime for anyone who realises "that there is a real risk or possibility" that he or she might have HIV to do "anything" that the person knows will involve "a real risk or possibility of infecting another person with HIV.

Guidance: Exposure and non-disclosure vs transmission

UNAIDS recommends that criminal law should only be used when HIV has been intentionally transmitted and not in cases where individuals have only been exposed to the virus or someone who not disclosed their HIV status to a sexual partner, but not actually transmitted HIV to the partner.

UNAIDS regards the use of criminal law in cases that only involve exposure or non-disclosure as overly broad and inappropriate. It recommends that where no actual transmission has taken place, criminal law should only be used in exceptional cases of exposure or non-disclosure.

There are two main reasons for this:

- **While it may be traumatic for a person to know that they have been exposed to HIV and therefore at risk of getting the virus, prosecuting and imprisoning people living with HIV for only exposing others to HIV is unfair, especially if they didn't intend to cause harm and did not actually cause any harm because HIV was not transmitted.**
- **Overly broad criminal laws have a negative impact on national HIV responses – they undermine efforts to encourage people to get tested and know their status, disclose their HIV status to their sexual partners and practise safer sex and seek health care and support.**

3.3.2 Why do countries criminalise HIV transmission, exposure and non disclosure?

Law makers who try to enact HIV-specific laws to criminalise HIV transmission are often driven by public pressure to be seen to be doing something about HIV in their country, without stopping to consider the effects of HIV criminalisation on the spread of HIV.

Criminalising HIV transmission is sometimes motivated by good intentions, including wanting to stop or slow down the spread of HIV and give justice to people in cases of deliberate transmission. Law makers may think that criminalising HIV transmission will act as a deterrent and discourage people from engaging in risky behaviour such as having unprotected sex or sharing needles. They may also believe that by imprisoning people living with HIV, they can remove them from society and protect others from the risk of transmission.

Law makers sometimes cite the rights and health of women and girls as an important reason to criminalise HIV transmission because women and girls are disproportionately vulnerable to HIV infection. In some countries, women's groups and organisations have supported the call to criminalise HIV transmission.

Self-Reflection Exercise 1: Is criminalisation of HIV transmission really a bad thing?

Criminalisation of HIV can be a very emotional issue for many people who believe in good faith that it is an important part of a response to HIV. It is important to reflect on your own beliefs about criminalisation.

- Do you think that people living with HIV are likely to deliberately infect others?
- Do you think that they should be prosecuted if they do infect others?
- Do you know what the laws of your country say about HIV transmission?

Case Studies: Prosecutions for HIV transmission /exposure in Southern and East Africa

- Botswana: in 2013, a Zimbabwean woman was charged with deliberate HIV transmission after she breastfed her neighbour's baby. A man was acquitted of the same offence (deliberate transmission) earlier in the same year.
- Uganda: in May 2014, a woman was convicted of criminal negligence and sentenced to three years imprisonment in a case stemming from allegations that she attempted to infect a child with HIV. She was accused of exposing the child to the virus by administering an injection with a needle that had been contaminated with her own blood.
- South Africa: 2013 saw the first successful prosecution of HIV exposure. The case was prosecuted under ordinary criminal law and the accused was convicted of attempted murder.
- Zimbabwe: there were two convictions of "deliberate" HIV transmission in 2012. Zimbabwe also convicted a woman of the same offence in 2008, for transmitting HIV to her husband.

Source: ARASA (2014) HIV and Human Rights in Southern and East Africa Report

3.3.3 ARASA countries and criminalisation

Table 1: Criminalisation in Southern and East Africa

Countries	HIV-specific offence	Prosecution	Conviction
Angola		2	Not able to ascertain
Botswana	Public Health Act 2013	2	1 acquittal 1 case pending
Comoros	X		
DRC	Law 08/11 Protection of People living with HIV and Those Affected		
Kenya	HIV Prevention and Control Act 2006		
Lesotho	X		
Madagascar	Law 2005 -04 Fight Against HIV and AIDS and Protection of People living with HIV		
Malawi	X		
Mauritius	X		
Mozambique	X		
Namibia	X		
Seychelles	X		
South Africa	X		1 conviction of attempted murder
Swaziland	X		
Tanzania	HIV and AIDS Prevention and Control Act 2008		
Uganda	HIV and AIDS Prevention and Control Act		1 conviction
Zambia	Penal code and Public Health Act refer to intentional / negligent transmission of a dangerous disease		
Zimbabwe	Criminal Law (Codification and Reform) Act 2004	3	3 convictions (2 pending appeal based on challenge of constitutionality of s79 of the Act)

3.3.4 What can be done if someone deliberately infects their sexual partner?

There can be situations when it is appropriate to use the criminal law to respond to HIV transmission. Prosecution of a person under criminal law is justified when someone deliberately transmits HIV to another person and therefore causes them harm.

Human rights experts argue that most countries already have criminal laws, such as the laws against assault with intent to cause grievous bodily harm, that can be used to deal with intentional transmission of HIV, and that as a result there is no need to create new laws to deal specifically with HIV.

Definition: What is intentional transmission?

This happens when a person:

- **knows his or her HIV-positive status**
- **sets out to transmit HIV to another person**
- **actually transmits HIV to that person**

3.3.5 Proof and scientific evidence

Human rights activists, many public health experts and UNAIDS strongly recommend that criminal cases only be brought for cases of intentional transmission and not for exposure or failure to disclose HIV status. A successful prosecution should provide appropriate evidence of all three elements.

The *UNAIDS 2013 Guidance on HIV Criminalisation*, referred to later in this unit, states that criminal law principles and elements that are applied to other criminal cases, should apply equally to cases involving HIV transmission. This means that there must be proof not only that the person has HIV, knew that they had HIV and that they wanted to cause harm by transmitting HIV to another person, but evidence to prove they actually did transmit the virus.

It is difficult in any criminal case to provide evidence of the mental state of an accused and what they intended. In HIV-related cases, it will not be enough to show that the accused knew that they had HIV, or had unprotected sex or shared a needle without disclosing their HIV status. It will be necessary to also show that they wanted to actually transmit HIV to the other person and cause them harm.

The UNAIDS 2013 guidance also recommends that criminal prosecutions be based on "the best available scientific and medical evidence relating to HIV". This means that cases must take into account the constantly evolving developments and standards in HIV treatment and care.

Proof that HIV was actually transmitted will require highly trained medical and scientific experts to provide expert evidence. These experts should be qualified and trained to accurately interpret the scientific evidence provided to a court and assess its limitations.

Guidance: Criminal law and medical confidentiality

Medical confidentiality is protected by law in many countries in Southern and East Africa. This means that health care workers are not allowed to disclose information about a patient's health status, including their HIV status, without their permission.

In criminal cases about HIV, the same laws about medical confidentiality should apply as they would in any other context. Where it is unlawful to give information about a patient's health status or HIV status, health care workers should not give information to the police and prosecutors, including copies of medical records, unless they have permission from a patient or there is a court order instructing them to do so.

The advances in HIV treatment have turned HIV into a chronic and treatable illness and this must be taken into account when using the criminal law. It is no longer appropriate to charge people with crimes such as murder, attempted murder, manslaughter or culpable homicide, assault with a deadly weapon or similar charges.

Guidance: When not to prosecute

The UNAIDS 2013 guidance states that prosecution should not take place if any of the following circumstances are present:

- **the person did not know he or she was HIV-positive**
- **the person did not understand how HIV is transmitted**
- **the person disclosed his or her HIV positive status to the person at risk (or honestly and reasonably believed the other person was aware of his or her status through some other means)**
- **the person did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences**
- **the person took reasonable measures to reduce the risk of HIV transmission, such as practicing safer sex through using a condom, or engaging in non-penetrative sex or oral sex**
- **the person agreed on a level of mutually acceptable risk with the other person**
- **the person believed that he or she could not transmit HIV given his or her effective treatment.**

3.3.6 Impact of Criminalisation

One of the major problems with laws that specifically criminalise HIV transmission is that provisions tend to be overly broad and extend liability beyond intentional (deliberate) conduct.

Examples: Overly broad criminalisation laws

- **A civil society participant from Kenya highlighted the false sense of security created by the law and their negative impact on HIV testing but also the complexitites of these laws, saying it "is difficult for the average person in the street to know what is criminalised".**

- **A Kenyan activist pointed to problematic laws that criminalise non-disclosure: "Two acts in Kenya, the Criminal Offences Act and the HIV Act are both so broad they criminalise conduct that would be regressive to prevention. Pregnant women are criminalised as they must disclose their HIV status immediately. The laws also cover breastfeeding by HIV positive mothers. There is no need for intention under these laws, you just need to have knowledge. If you don't tell your partners you are liable for conviction. Transmission of HIV is not required".**

Source: Africa Regional Dialogue of the Global Commission on HIV and the Law, 2011.

There is no evidence showing that criminalising HIV transmission changes the way that people behave and therefore protects others from HIV or slows down the spread of HIV. In fact, threatening people living with HIV with prosecution and imprisonment undermines treatment and prevention efforts and actually discourages people from being tested and seeking out treatment, because lack of knowledge of one's HIV status could be the best defence in a criminal case. There is evidence that criminalisation causes mistrust between people living with HIV and people at risk of HIV, and health care workers.

Criminalisation also promotes stigma and discrimination, including by creating misinformation and confusion about how HIV is spread. Although there are other sexually transmitted infections (STIs) that cause significant harm, there are no attempts to create new criminal laws to deal with them. Treating HIV as an exception sends a message that people living with HIV are potential criminals and should be treated as a threat to others.

See Module 3: Unit 1 for further information on HIV-related stigma and discrimination.

Criminalisation also creates a false sense of security – rather than encouraging everyone to know their HIV status and to disclose it to their sexual partners, criminalising HIV transmission places the main responsibility for transmission on people living with HIV. This may lead to people who do not have HIV or who do not know that they have HIV, not consistently practising safer sex.

Learning Activity 1: Impact of criminalisation

Brainstorm the impact of criminalisation on HIV prevention, treatment, care and support. Consider the following questions:

- Do you think that criminalising HIV transmission would have a negative or positive impact on access to HIV prevention, treatment, care and support?

Give reasons to support your answer.

3.3.7 Specific impact on women

Although criminalisation is often framed as a way to protect women and give them access to justice if their partner transmits HIV, they are more likely to be negatively impacted by it:

- Women are often blamed for transmitting HIV to their male partners. This is because they are more likely to know their HIV status first as a result of being tested during ante-natal care. This means that women are more likely to be prosecuted under HIV criminalisation laws.
- It is harder for women to insist on safer sex as it may suggest to their partners that they have HIV.
- Many women face violence and abandonment if they disclose their HIV status to their sexual partners.
- Women may be afraid to have an HIV test, seek out ante-natal care or HIV treatment if they are concerned that they might be arrested or imprisoned when their HIV status becomes known.
- Depending on how criminal laws are framed, pregnant or breastfeeding women with HIV may also be at risk of prosecution. Some criminal laws have been framed so broadly that women living with HIV who infect their children during pregnancy or breast-feeding could face criminal charges.

Example: The negative impact of criminalisation on women

- **A civil society participant from Kenya described the discriminatory impact of these laws on women: "Women are the first to know their HIV status through prevention of mother-to-child transmission services so they are the ones that would be charged. Women can't negotiate condom use due to negative cultural practices such as wife inheritance".**
- **A participant from the DRC explained the consequences of criminalisation: "Husbands reject their wives after they disclose. Some face violence and even the possibility of death. People living with HIV are ready to disclose voluntarily but if they are forced, this is wrong. The criminalisation of transmission is unacceptable"**

Source: The Africa Regional Dialogue of the Global Commission on HIV and the Law

See Module 3: Unit 2 - Women's Rights, Sexual and Reproductive Health and Rights for further information on women and HIV.

3.4: What is the Alternative to Criminalising?

Successful national HIV responses must focus on:

- Protecting the human rights of people living with HIV and key populations
- Investigating and removing legal barriers to HIV prevention, treatment, care and support
- Addressing the reasons why many people think that criminalisation will stop the spread of HIV.

Learning Activity 2: Alternatives to criminalisation

Read section 3.3.2 which provides possible reasons for lawmakers to criminalise HIV transmission. Add others reasons you may know of.

Make a list of human rights approaches that would be more helpful than criminalisation in preventing HIV transmission and ensuring that people living with HIV have access to prevention, treatment, care and support.

3.5: International and Regional Frameworks that do not Promote Criminalisation

There is now a wealth of guidance and good practices about how to create legal frameworks that advance prevention efforts, promote universal access and protect the human rights of people living with HIV and key populations. This section sets out some of the most important ones and provides information about key elements of a non-criminal response to HIV.

3.5.1 Model laws

SADC Model Law on HIV in Southern Africa 2008

The Southern African Development Community Parliamentary Forum (SADC PF) adopted a model law on HIV in December 2008. It does not criminalise HIV transmission, largely because of strong lobbying by ARASA and other non-govenrmental organisations (NGOs). The Model Law explicitly does not endorse coercive approaches to HIV.

Case Study: SADC Model Law on HIV in Southern Africa

Instead of criminalising HIV transmission, the Model Law on HIV promotes laws that respect, protect and promote the human rights of people living with HIV and key populations.

The Model Law on HIV promotes:

- Access to information about the nature, causes, modes of transmission, consequences and means of prevention and management of HIV. It recommends that governments make sure that the public has access to different sources of information about all these issues.
- Access to prevention - States should make information available about how people can protect themselves from HIV, and should also make sure that people have access to high quality male and female condoms.
- Non-discrimination and stigma – Governments must enact laws that challenge stigma and discrimination and provide information that addresses misinformation about HIV, people living with HIV and key populations. Laws should protect the rights of people infected and affected and outlaw any discrimination based on HIV status.

East African Community (EAC) HIV & AIDS Prevention and Management Act, 2012

The East African Legislative Assembly (EALA) passed a regional law on HIV in 2012. Similar to the SADC PF Model Law, the EAC HIV & AIDS Prevention and Management Act endorses a rights-based approach to HIV and rejects creating new criminal laws for HIV transmission.

3.5.2 Policy guidance

UNAIDS 2013 Guidance on Criminalisation

UNAIDS issued elaborate and updated policy guidance on criminalising HIV transmission in 2013. The guidance takes into account new developments in both criminal law and HIV-related treatment and prevention and sets out critical legal, scientific and medical considerations that countries should consider if they really want to give justice in truly blameworthy cases, but at the same time, protect the human rights of everyone involved and safeguard public health.

The guidance again confirms earlier recommendations that governments should not enact HIV-specific criminal laws and that only intentional transmission should be criminalised. It says that:

- Law makers must be guided by the best available scientific and medical evidence. This means that law makers need to familiarise themselves with the latest medical and scientific developments on HIV transmission, prevention and treatment, including the benefits of treatment and its impact on transmission, and ensure that any legal developments are based on the most up to date and reliable information. Law makers must seek expert advice from public health specialists and HIV

clinicians when they are thinking about using the criminal law as part of a national response to HIV.

- They should uphold the principles of fairness in how the law is applied. Lawmakers must make sure that the laws do not disproportionately target or affect particular groups of people. It is not appropriate to single out HIV from other sexually transmissible illnesses.

- Laws must protect the human rights of those who are involved in criminal cases.

Guidance: New scientific and medical developments and criminal law

The guidance sets out the latest medical and scientific facts and developments relating to HIV. These are relevant to the key issues that must be considered in criminal cases:

- **what level of harm, if any, has been caused to another person as a result of HIV non-disclosure, exposure and transmission**
- **whether the nature/level of risk of HIV transmission from particular sexual acts warrants criminal liability, for example HIV treatment is shown to reduce the infectivity of people living with HIV and therefore the risk of transmitting HIV to their sexual partners**
- **what elements should be recognised as defences to charges of HIV nondisclosure, exposure and transmission**
- **the merits and limitations of methods of proof used in the context of HIV non-disclosure, exposure.**

The guidance emphasises that effective HIV-treatment has extended the life expectancy of people living with HIV and reduced AIDS related deaths.

Source: UNAIDS (2013) Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission

International Guidelines on HIV/AIDS and Human Rights

The *UNAIDS 2006 International Guidelines* contain detailed guidance to states on human rights and HIV. Guideline 4 deals with criminalisation and recommends that criminal laws should not be created or amended to include specific offences on the intentional transmission of HIV, but that the existing criminal laws should be applied if needed. The Guidelines suggest that governments examine their existing criminal laws to make sure that they cannot be inappropriately used to target vulnerable groups.

Global Commission on HIV and the Law

The recommendations of the Global Commission also confirm that the criminal law should be used sparingly and only in cases of intentional transmission of HIV. They specifically mention not criminalising mother-to-child HIV transmission and recommend the immediate repeal of any laws that explicitly or effectively criminalise vertical transmission of HIV.

Guidance: Recommendations from the Global Commission

- **Countries must not enact laws that explicitly criminalise HIV transmission, HIV exposure or failure to disclose HIV status. Where such laws exist, they are counterproductive and must be repealed. The provisions of model codes that have been advanced to support the enactment of such provisions should be withdrawn and amended to conform to these recommendations.**
- **Law enforcement authorities must not prosecute people in cases of HIV non-disclosure or exposure where no intentional or malicious HIV transmission has been proven to take place. Involving criminal laws in cases of adult private consensual sexual activity is disproportionate and counterproductive to enhancing public health.**
- **Countries must amend or repeal any law that explicitly or effectively criminalises vertical transmission. While the process of review and repeal is under way, governments must place moratoria on enforcement of any such law.**
- **Countries may legitimately prosecute HIV transmission that was both actual and intentional, using general criminal law, but prosecutions should be pursued with care and require a high standard of evidence and proof.**
- **The convictions for those who have been successfully prosecuted for HIV-exposure, non-disclosure and transmission must be reviewed. Such convictions must be set aside or the accused immediately released from prison with pardons or similar actions to ensure that these charges do not remain on criminal or sex offender records.**

Source: Global Commission on HIV and the Law (2012) Risks, Rights & Health

Oslo Declaration on HIV Criminalisation

The Oslo Declaration on HIV Criminalisation, prepared by a high level group of civil society activists in February 2013, advocates for measures that "create an environment that enables people to seek testing, support and timely treatment, and to disclose their HIV status." It acknowledges that the criminal law has a limited role to play and emphasises a non-punitive and non-criminal HIV prevention approach.

Guidance: Factors that policy makers should consider when deciding whether to criminalise HIV transmission, non-disclosure and exposure

- **HIV epidemics are driven by undiagnosed HIV infections, not by people who know their HIV positive status. Unprotected sex includes risking many possible eventualities – positive and negative – including the risk of acquiring sexually transmitted infections such as HIV. Due to the high number of undiagnosed infections, relying on disclosure to protect oneself – and prosecuting people for non-disclosure – can and does lead to a false sense of security.**

- **HIV is just one of many sexually transmitted or communicable diseases that can cause long-term harm. Singling out HIV with specific laws or prosecutions further stigmatises people living with and affected by HIV. HIV-related stigma is the greatest barrier to testing, treatment uptake, disclosure and a country's success in "getting to zero new infections, AIDS-related deaths and zero discrimination".**

- **Criminal laws do not change behaviour rooted in complex social issues, especially behavior that is based on desire and impacted by HIV-related stigma. Such behaviour is changed by counselling and support for people living with HIV that aims to achieve health, dignity and empowerment.**

- **Neither the criminal justice system nor the media are currently well-equipped to deal with HIV-related criminal cases. Relevant authorities should ensure adequate HIV-related training for police, prosecutors, defence lawyers, judges, juries and the media.**

- **Once a person's HIV status has been involuntarily disclosed in the media, it will always be available through an internet search. People accused of HIV-related 'crimes' for which they are not (or should not be found) guilty have a right to privacy. There is no public health benefit in identifying such individuals in the media.**

3.6: Unit Summary

1. The criminalisation of HIV transmission, exposure and non-disclosure, referred to as HIV criminalisation, is the unjust application of criminal law based solely on HIV status.

2. This is done by either by enacting and applying HIV-specific criminal laws, or by applying general criminal laws exclusively or disproportionately against people with HIV.

3. UNAIDS recommends that criminal law should only be used when HIV has been intentionally transmitted and not in cases where individuals have only been exposed to the virus or someone has not disclosed their HIV status to a sexual partner, but not actually transmitted HIV.

4. There is no evidence that criminalising HIV transmission changes behaviour and protects others from HIV or slows down the spread of HIV.

5. Threatening people living with HIV with prosecution and imprisonment undermines treatment and prevention efforts and discourages people from being tested and seeking out treatment.

6. Women are more likely to be negatively impacted by criminalisation.

7. There is a wealth of international and regional guidance and good practices about how to create legal frameworks that advance prevention efforts, promote universal access and protect the human rights of people living with HIV and key populations.

Summative Assessment

Complete the following quiz to assess your knowledge of criminalisation of HIV transmission. Tick whether each of the following statements is true or false.

Question	True	False
Criminalising HIV transmission is an effective strategy to slow down the spread of HIV		
Existing criminal laws can respond to rare cases where people have deliberately transmitted HIV to their sexual partners		
Criminalising HIV transmission undermines human rights and universal access of people living with HIV and key populations		
Criminalising HIV transmission protects women		
Criminalising HIV transmission must be based on the most up to date and accurate scientific and medical information		
Countries should rather adopt laws that promote the human rights of people living with and affected by HIV as part of the national response to HIV.		

3.7: Unit Outcomes Checklist

Use the checklist below to see whether you have met the outcomes that were set for this unit.

Outcome	Yes, I have met this outcome	No, I have not met this outcome	These are the things I still need to revise
Define criminalisation of HIV transmission			
Understand the impact of criminalisation on the spread of HIV			
Understand how countries can respond to rare cases of deliberate transmission			
Participate in the debate on whether creating HIV-specific criminal laws helps to stop the spread of HIV			

3.8 Resources and References

3.8.1 Useful websites

Canadian HIV/AIDS Legal Network
http://www.aidslaw.ca/site/our-work/criminalization/

ARASA
http://www.arasa.info/advocacy/national-advocacy/decriminilisation-wilfull-transmission-hivaids/

Global Commission on HIV and the Law
http://www.hivlawcommission.org/

3.8.2 Useful resources

ARASA et al (2008) *10 Reasons to Oppose the Criminalisation of HIV Exposure or Transmission*
http://www.arasa.info/files/7913/7570/5795/10reasons_20081201-1.pdf

ARASA et al. *10 Reasons Why Criminalisation Harms Women*
http://www.arasa.info/files/7213/7513/9921/10_Reasons_Why_Criminalisation_Harms_Women2_0.pdf

Global Commission on HIV and the Law (2011) *Regional brief: Criminal law and HIV: Africa Regional Dialogue of the Global Commission on HIV and the Law*
http://www.hivlawcommission.org/index.php/regional-dialogues-main/africa?task=document.viewdoc&id=72

Global Commission on HIV and the Law (2011) *Factsheet on HIV and Criminal Law*
http://www.hivlawcommission.org/index.php/regional-dialogues-main/africa?task=document.viewdoc&id=36

Global Commission on HIV and the Law (2011) *Working paper, Criminalisation of HIV exposure and transmission: a global review*
http://www.hivlawcommission.org/index.php/working-papers?task=document.viewdoc&id=90

UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights*
http://www.ohchr.org/Documents/Issues/HIV/ConsolidatedGuidelinesHIV.pdf

Oslo Declaration on HIV Criminalisation
http://www.hivjustice.net/oslo/

SADC PF Model Law on HIV in Southern Africa, 2008
http://unpan1.un.org/intradoc/groups/public/documents/cpsi/unpan036509.pdf

UNAIDS (2013) *Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations*
http://www.unaids.org/en/resources/documents/2013/20130530_Guidance_Ending_Criminalisation

Sex Worker Rights

unit 4

4.1: Introduction

This unit provides information about the human rights of sex workers, the laws and policies on sex work, and how human rights violations, including violence and discrimination, contribute to making sex workers more vulnerable to HIV and undermine their access to prevention, treatment, care and support. The unit sets out what measures are needed to protect and promote the human rights of sex workers.

4.2: Outcomes of this Unit

By the end of this unit, learners should be able to:

- Understand the definition of sex work and be able to distinguish it from trafficking
- Identify how human rights violations and stigma increase sex workers' vulnerability to HIV and undermine universal access
- Understand the barriers to access to services and justice for sex workers
- Understand how to protect the rights of sex workers, reduce their risk of HIV transmission and improve universal access.

4.3: Sex Work, HIV and Human Rights

4.3.1. What is sex work?

Sex work is the selling of sexual services for money or goods between consenting adults. Sex work is very diverse and can happen in many different forms and in many different locations, ranging from street work, to in house work, massage parlours, through escort agencies, and so forth. Some sex workers work together with others, sometimes in business run by a third party, while others choose to work independently. While often sex workers are assumed to be cisgender women, this is far from true. While in absolute numbers, the majority of sex workers are cisgender women, there are large overlaps with men who have sex with men and transgender women as well; the marginalization – and thus the lack of economic opportunities – means that with e.g. transgender communities, sex work can be a lot more common.

4.3.2 Difference between sex work and trafficking

Sometimes policy makers, law enforcement officials and civil society conflate sex work and trafficking in the context of the sex industry, to the detriment of both adults who engage in sex work and children and adults who are trafficked into sexual exploitation. trafficking, including trafficking for the purpose of sexual exploitation, is a very serious human rights abuse, and these crimes can be prosecuted as a form of slavery. All counties have human rights obligations to take measures to prevent trafficking in humans.

The Palermo Protocol definition of trafficking

The Palermo Protocol (the UN convention that protects people from trafficking) sets out three conditions that must be met in order to decide whether a person has been trafficked:

- **the person must be transported, recruited, abducted by force, deception or coercion**
- **there must be payment of money to a person having control over the person being trafficked**
- **the purpose must be exploitation.**

If these conditions are not met, then the person has not been trafficked. They may be victims of other crimes or human rights abuses, but they cannot be said to be trafficked.

It is important to understand the differences between sex work and trafficking because they need different legal, policy and programmatic responses. Sex workers must be protected from violence, they are entitled to non-discriminatory access to health care and HIV prevention, and fair working conditions. People who are trafficked need immediate protection from exploitation and abuse, and may require access to witness protection programmes and long term psycho-social support. Trafficking, on the other hand, should be investigated as a crime and a human rights violation by law enforcement officials, regardless of which industry it happens in.

4.3.4 Sex work and human rights

Sex work is highly stigmatized and sex workers often experience human rights violations (see the next section for a fuller discussion of the types of abuses sex workers suffer) due the particular nature of their work. Many governments promote measures to eradicate sex work, rather than protect the human rights of sex workers. They see sex work as immoral or they assume that it is inherently exploitative, and they fail to acknowledge the agency of sex workers. These efforts to end sex work can often lead to more human rights violations, with sex workers having few opportunities to access their human rights.
It is important to remember:

- Sex workers are entitled to the same same human rights as everyone else
- Every person's human rights are guaranteed and protected in all the international instruments. Sex workers deserve the same standards of treatment due to all people, regardless of profession
- The rights to life, safety, free speech and access to information and to health and education, amongst others, are as important to sex workers as they are to anyone else
- Governments have a human rights obligation to protect sex workers from human rights violations and to make sure that when their rights are violated, they have access to justice.

4.3.5 Key issues for sex workers

The ARASA (2016) HIV and Human Rights in Southern and East Africa report states that all sex workers face exceptionally high levels of stigma, discrimination, violence, extortion, sexual abuse, and rape. The perpetrators of such violence can range from clients, intimate partners, to law enforcement officials. Such stigma and violence increases their vulnerability and marginalization and places them at increased risk of HIV.

Submissions, including by sex workers themselves, to the African Regional Dialogue of the Global Commission on HIV and the Law in 2011 showed that sex workers experience human rights violations that negatively impact on their access to HIV prevention, treatment, care and support:

- Violence

Sex workers are at a high risk of violence and they experience physical and sexual violence at the hands of the police, their clients, family and community members. Sex workers may be raped by clients or police

Examples of violence against sex workers from the Global Commission on HIV and the Law

South Africa: Violence against sex workers impacts on HIV prevention work. This happens at the hands of police who spray pepper spray into the sex worker's vagina if she doesn't give them oral sex. At border posts there are searches of sex workers vaginas by a police officer, without changing gloves, to check for money.

South Africa: The police really abuse workers: our clients tell us that they ask for bribes, they want sex.

officers, or forced to have sex without condoms, which increases their risk of HIV transmission. Regardless of gender, all sex workers can face such violence. Furthermore, when it comes to transgender sex workers, or male sex workers, it is important to understand that they do not just face violence due to being a sex worker, but also due to being transgender or MSM.

- Stigma and discrimination

Sex work is highly stigmatized in almost everywhere, including in countries where it is legal. Stigma and discrimination, or fear of both, pushes sex workers away from important and sometimes potentially life-saving HIV-related health services. Stigma and discrimination have a particularly negative impact on HIV prevention and sex workers struggle to get the right information about how to protect themselves from HIV transmission, and access to male and female condoms, lubricant and post-exposure prophylaxis (PEP). Many sex workers don't go to hospitals and clinics because they are afraid of being treated badly. Health service providers may discriminate against sex workers and humiliate and victimize them when they find out that they are involved in sex work.

Sex workers also experience stigma and discrimination when they try to access other services, including social housing and welfare benefits. Similarly to health care, many sex workers do not seek out available services because they fear that they will be treated badly when they do so. Children of sex workers are also vulnerable to stigma and may experience discrimination in access to education and health care.

Sex workers also experience stigma and discrimination by police officers and other officials. Some police officers do not believe that sex workers can be raped and refuse to accept and investigate crimes committed against sex workers. Police officers may threaten sex workers with arbitrary arrest and detention, or bribe them to have sex. Sex workers do not report these violations because they are afraid they will suffer even more abuse or be arrested and detained. Sex workers who are arrested and detained often experience interruption of their ART or cannot attend clinic or hospital appointments

Examples of stigma and discrimination against sex workers from the ARASA HIV and Human Rights in Southern and East Africa Report, 2014

Zambia: Sex workers are usually arrested for loitering. Arrests are fairly common and they just lock them up for the night

Mozambique: People think that if you have HIV, you must be a prostitute or you have misbehaved.

4.4: Criminalisation of sex work or aspects of sex work

Sex work, or aspects of sex work, is criminalised in 35 AU countries.

Sex work is criminalized in almost all East and Southern African countries, except Madagascar. Countries use many different laws to criminalise sex work and prosecute sex workers – some directly criminalise the selling or buying of sex, while others use laws that are not directly related to the selling and buying of sex, eg. laws that use concepts like 'public decency', and 'morality', to prohibit sex work. Some countries use laws that prohibit loitering and vagrancy; and zoning or health regulations, to prosecute sex workers. Some countries only criminalise the selling of sex, while others also criminalise clients who purchase sex and a wide range of other activities that may be associated with sex work eg. running a brothel and living off the earnings of prostitution. The many ways that governments use the law to criminalise aspects of sex work can be confusing and sex workers in some countries do not know what activities are illegal.

In instances where only clients are criminalized, this is sometimes erroneously presented as "partial decriminalization", however research has show that partial criminalization does not benefit sex workers. This model of partial criminalization is sometimes referred to as "the Nordic" model, as it originated there; however, it has not shown to reduce violence and stigma faced by sex workers.

Research shows that the criminalization of sex work or aspects of sex work deters sex workers from accessing health care, including HIV and TB prevention, treatment, support and care services. These laws also make it harder for sex workers to negotiate condom use with their clients, and they undermine the roll-out and rigorous assessment of HIV interventions for sex workers. Furthermore, they severely limit their access to justice when they face violence of any kind.

Examples of criminalization and how countries apply different laws to sex work

In Kenya, the implementation of vague loitering laws, that are open to interpretation by law enforcement, has presented barriers to the scale-up of targeted services for sex workers.

"In Mozambique it is not very clear what is legal or illegal. Sometimes there is illegal detention and you are humiliated. I was detained when there was a summit in Mozambique. I spent 7 days in prison ..... the judge said why are you here and I told him I was loitering, I need money for my child ,,,,, we are used by the police we go to cemeteries and beach and have sex without a condom. Sometimes we are beaten up by the police."

"The police in Botswana take condoms from sex workers as evidence.

4.5: Right to Health and Sex Work

The Universal Declaration of Human Rights states that "the highest attainable physical and mental health standards" are a basic human right. This applies to sex workers who have the right to comprehensive health care, including reproductive care.

3.5.1 Vulnerability of sex workers to HIV

Sex workers are a key population for HIV: they have multiple sexual partners and cannot always negotiate safer sex and the use of condoms, their criminalized status makes it harder for them to access HIV prevention services and they are vulnerable to sexual violence. Sex workers who are living with HIV need special support and they must be able to access HIV treatment and care on a non-discriminatory basis. Some sex workers, such as transgender sex workers, or sex workers who use drugs, are part of more than one "key population" and thus face the compounding issues of both.

There is not yet enough national research on HIV prevalence amongst sex workers and the majority of East and Southern Africa countries don't include information on sex workers in their National Commitments

and Policies Instrument (NCPI) reports. UNAIDS includes what available data they can access in their regular updates and they estimate that HIV prevalence amongst sex workers is about 12 times greater than the general population (2014 GAP report) and 17 of the top 18 countries where HIV prevalence among sex workers is more than 20% are in sub-Saharan Africa.

There is very strong evidence that shows that criminalizing sex work increases vulnerability to HIV, undermines sex workers' rights and their ability to access HIV related prevention, treatment and care.

Sex workers often do not disclose to health care workers and other service providers that they are sex workers because they are afraid of being arrested or treated badly. Many service providers do not cater to the specific needs of sex workers out of fear that if they do so, they will also be accused of acting unlawfully, or because they do not want to deal with sex workers. These barriers make it very difficult for sex workers to have information about their health, access available services or find the right services to meet their needs.

Many sex workers are afraid to carry condoms in case they get arrested and the condoms are used as evidence to prove they are sex workers. Ciminalisation makes it harder for sex workers to insist on or negotiate condom use with their clients. Sex Workers who are forced to have unprotected sex or are raped don't report these crimes to the policy because they fear that they might be arrested themselves due to being a sex worker. The criminalized nature of sex work also provided opportunities for abuse by police officer who use their "discretion" in arresting, detaining, and punishing sex workers.

Criminalisation of sex work also makes it hard for sex workers to organize themselves into trade unions or other organisations to lobby collectively to improve working conditions, to get the right health services and protect their human rights.

Examples of abuses of sex workers' right to health from the Global Commission on HIV and the Law

DRC: We have a right to health. We remain left out and neglected. We are exposed to things. We are dehumanised due to moral attitudes. Care-takers refuse to recognise our right to health. 374 sex workers are living with HIV with no access to care in the DRC. They are stigmatised. In 2008 the law changed giving free care to everyone but not to sex workers.

Zimbabwe: We are not human. If we can't organise then we can't get funding for service provisions by sex workers. In 2010 sex workers in Zimbabwe marched. We were asked to leave. We were denied our right to freedom of expression. We ask the question – why are sex workers not included in the NSP? We do not have data on the prevalence rate in sex workers. Sex workers are stopped from claiming their fundamental rights. There is no comprehensive approach when sex workers are left out of the NSP.

Namibia: Sex workers are so criminalised that they are denied ARVs due to stigma.

4.5.2 Insufficient programming to meet the needs of sex workers

While greater attention is being paid to sex workers in national AIDS responses, including increased spending on programming, most programmes across sub-Saharan Africa that target sex workers still have a limited scale, scope and coverage and sex workers are still not systematically included in national responses to HIV.

4.6: Barriers to Access to Justice for Sex Workers

Sex workers who experience sexual violence or other crimes struggle to access justice and must to overcome many barriers to get redress. The police or other members of the criminal justice sector such as magistrates and prosecutors are often themselves perpetrators of abuses against sex workers. Few are prosecuted and this creates a climate of impunity for crimes committed against sex workers by members of law enforcement agencies, which may fuel more abuse.

Officials have a high tolerance for abuse of sex workers by society and do not conduct proper investigations into allegations of abuse. Sex workers do not have much trust in the criminal justice system and may decide not to report crimes because they do not believe they will receive justice. Few sex workers know their rights or have access to lawyers and legal services to help them enforce their rights.

Stigma and discrimination also drive sex workers away from much needed legal services.

4.7: Protection of sex workers

4.7.1 Decriminalisation

UNAIDS strongly recommends that all governments work towards decriminalizing sex work in order to protect the human rights of sex workers, including their right to health, reduce violence and slow down the spread of HIV.

Full decriminalization of sex work allows sex workers to engage in sex work without being penalized, and helps to create a safer working environment and better access to HIV-related services. Many public health experts and human rights practitioners agree that decriminalizing sex work is the best way to protect the rights and health of sex workers and their clients.

A human rights and health imperative: decriminalizing sex work

The most important human rights voices in the world have called for sex work to be decriminalized.

The UN High Commissioner on Human Rights and UNAIDS recommended decriminalisation to uphold sex workers' human rights and health, as have the UN Special Rapporteur on Health and Human Rights, the Global Commission on HIV and the Law, and the UNDP.

4.7.2 Protection from stigma and discrimination

It isn't enough to decriminalize sex work – governments must also change laws and policiesthat discriminate against sex workers and develop new ones that protect them from discrimination and help to end stigma. These laws must explicitly acknowledge the human rights of sex workers and their rights to be protected from abuse. It is furthermore essential that these laws and policies are developed with meaningful involvement of sex workers, as they understand and know best how the daily reality of doing sex work.

Governments and civil society should also provide legal services to sex workers to help them enforce their rights and run awareness programmes so that they know what their rights are. Sex workers who experience violence must be able to access health care in the aftermath of rape and sexual assault and have shelters and other services if they need those.

It is also important to train officials, including the police and health care workers, about sex worker rights. Officials who violate the rights of sex workers must be held accountable for their actions. This will reduce impunity as well as stigma and discrimination.

See Module 3: Unit 3.1 - Stigma and discrimination

4.8: Partnerships and Inclusions

Even organisations that support the rights of sex workers sometimes fail to include them in various processes and sex workers' voices are frequently ignored and marginalized. A rights based approach to sex work and HIV means that sex workers are empowered not only to participate fully, but to lead in all aspects of policy and law formulation and programme design and implementation. Building the capacity of sex worker organisations and networks is a fundamental part of protecting and promoting their human rights.

Sex workers must be actively and meaningfully involved in all discussions about their lives and rights so that they can articulate what their needs and vulnerabilities are, rather than having others speak on their behalf. This means that human rights organisations must work in partnership with sex workers to remove barriers that they face, provide training for sex workers, ensure the sex worker groups and networks have access to adequate funds and acknowledge that without their full participation, it will not be possible to ensure universal access to HIV prevention, treatment, care and support for sex workers.

Human rights organisations must also help facilitate partnerships and dialogue with sex workers and health care workers, law enforcement, trade unions and others.

4.9 Unit Summary

1. Sex work is the voluntary exchange of sex for money or goods by consenting adults above the age of 18 years.

2. Trafficking is a crime and a human rights violations and takes place when a person has been transported by force or coercion to be exploited.

3. Sex workers face human rights violations because of their choice to practice sex work.

4. Sex workers are entitled to the same human rights as everyone else and their rights are protected in all the international instruments. Sex workers deserve the same standards for treatment of all people, regardless of profession.

5. Sex work, or aspects of sex work, is criminalised in 35 African Union (AU) Member States and the majority of countries in Southern and East Africa.

6. Criminalisation of sex work or aspects of sex work deters sex workers from accessing HIV and TB prevention, treatment, support and care services.

7. Few sex workers know their rights or have access to lawyers and legal services to help them enforce their rights.

8. UNAIDS strongly recommends that all governments work towards decriminalising sex work in order to protect the human rights of sex workers, reduce violence against them and slow down the spread of HIV.

Summative Assessment

Complete the following quiz to assess your knowledge of sex worker rights. Tick whether each of the following statements is true or false.

Question	True	False
Sex work is provision of sexual services for money or good between adults		
Sex work and trafficking are the same thing and need the same programmatic and legal responses		
If sex work is criminalized, health care workers do not have provide them with health services		
Sex workers are disproportionately vulnerable to human rights abuses and stigma		
Criminalising sex work increases sex workers' vulnerability to HIV transmission		
Criminalising sex work increases sex workers' vulnerability to HIV transmission		

4.10: Unit Outcomes Checklist

Use the checklist below to see whether you have met the outcomes that were set for this unit.

Outcome	Yes, I have met this outcome	No, I have not met this outcome	These are the things I still need to revise
Know the definition of sex work			
Understand the difference between sex work and trafficking			
Understand why sex workers are vulnerable to HIV transmission			
Understand how to protect the rights of sex workers			
Understand the impact of criminalizing sex work on access to HIV prevention, treatment, care and support			

4.11: Resources and References

4.11.1 Useful websites

Open Society
http://www.opensocietyfoundations.org/topics/sex-worker-rights

WHO
http://www.who.int/hiv/topics/sex_work/en/

4.11.2 Useful resources

10 Reasons to Decriminalise Sex Work
http://www.opensocietyfoundations.org/sites/default/files/10-reasons-decriminalize-sex-work-20150410_0.pdf

Global Commission on HIV and the Law: Working Paper: *Sex Work, HIV and the Law*
http://www.hivlawcommission.org/index.php/working-papers?task=document.viewdoc&id=99

Prevention and Treatment of HIV and other Sexually Transmitted Infections for Sex Workers in Low- and Middle-income Countries Recommendations for a public health approach
http://apps.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf

UNAIDS guidance note on HIV and Sex Work (amended 2012)
http://www.unaids.org/sites/default/files/media_asset/JC2306_UNAIDS-guidance-note-HIV-sex-work_en_0.pdf

People who use Drugs

4 hours

unit 5

5.1: Introduction to the uUnit

This unit looks at people who use drugs as a key population for HIV services. It describes the background to drug use and then focuses on why people who use drugs are vulnerable to HIV exposure. The international legal framework for regulating drugs is discussed and the negative implications that this often poses for HIV prevention programmes is set out. The unit concludes with recommendations for a new approach based on harm reduction principles.

5.2: Unit Outcomes

After finishing this unit you should be able to:

- Understand the global drug control system which is created through conventions and treaties
- Explain why people who use drugs are at greater risk of HIV exposure
- Know why criminalising drug use makes people more vulnerable to HIV exposure
- Set out the rights of people who use drugs
- Describe the steps that governments should take to ensure that harm reduction and other HIV prevention services can be provided to people who use drugs
- Be aware of recommendations for law reform in this area.

5.3: Background

5.3.1 What is a drug?

A drug is a medicine or substance which has a physiological effect on the body. There are both legal and illegal drugs. Legal drugs are drugs that are registered for use or for sale in a country by the national drug regulatory authority. Illegal drugs are drugs that are either not registered for use or for sale by the national drug regulatory authority or they are drugs that are expressly banned by legislation. For example, many countries have banned the use of drugs such as cocaine or crack.

5.3.2 How do drugs react within the body?

Recreational drugs (drugs that are used without a medical justification) generally fall into one of three categories according to the effect that they have on the body:

- Depressants slow down the functions of the central nervous system and make the user unaware of the environment that they are in. For example, alcohol can reduce a person's inhibitions and make them less afraid of socialising with others.
- Stimulants speed up the functioning of the central nervous system and make the user more aware of the environment. For example, caffeine is often used by students to keep themselves alert whilst studying for exams.
- Halucinogens distort the user's awareness and perceptions of the environment around them. For example, LSD can impact on a user's perception of time or create visual hallucinations.

Table 1: Examples of drugs which act as depressants, stimulants and hallucinogens

DEPRESSANTS	STIMULANTS	HALLUCINOGENS
Alcohol	Amphetamines	LSD
Benzodiazepines	MDMA	Mescaline
Opioid	Cocaine	PCP
Solvants	Nicotine	Ketamine
Barbiturates	Khat	Cannabis
	Caffeine	Mushrooms

5.3.3 Why do people inject drugs?

There are different ways of taking drugs in order to achieve the effects on the body which have been described above. These include swallowing tablets, smoking or sniffing the drug or injecting the drug. There are many reasons why some people choose to inject themselves with drugs and potentially place themselves at greater risk of HIV exposure. These may include the fact that lower costs are often associated with injectable drugs and that the body responds faster to injected drugs and the drug doesn't become diluted (e.g. lost in smoke.)

5.3.4 Why are recreational drugs criminalised?

The initial regulation of drugs flowed from two trade wars between Britain and China, commonly called the 'opium wars'. In the nineteenth century there was a great demand for Chinese products in Britain.

However, trade was difficult as the Chinese wanted to be paid in silver and Britain did not want to deplete its silver reserves. British merchants found a way around this by bringing in opium from India (a British colony at the time) and selling it for silver in China. They then used the silver to buy Chinese products. The opium wars were sparked by an attempt by China to stop illegal opium smuggling across its borders. This history is important as it shows that the regulation of the trade in opium, one of the first attempts to control drug use, was not initiated by concerns over the possible harmful effects of opium but rather about protecting different trade interests between two countries.

Since the opium wars, most drug control policies and laws have been grounded in ideological perspectives about creating a 'drug free society' through a) trying to stop the importing of drugs into a county and b) criminalising drug use. Experience from around the world demonstrates that this objective is unlikely to be ever be realised as virtually all known human societies have experienced and embraced drug use in some form. Furthermore, most countries allow the use of certain 'legal' recreational drugs such as alcohol or tobacco but prohibit others in a relatively arbitrary manner.

The international approach aims at eliminating rather than regulating drug use and focuses on the use of the criminal law to punish those involved in the production, distribution, sale or use of drugs. This is an approach which aims to stop the flow of drugs rather than addressing broader issues such as public health obligations on governments to reduce the harm faced by people who use drugs.

5.4: Why is Vulnerability to HIV a Key Issue for People who use Drugs?

People who use drugs are at high risk of HIV exposure as HIV can be transmitted through sharing unclean needles and other injecting drug equipment. People who use drugs may also engage in activities such as sex work in order to support their drug use. Research shows that many people using drugs are more likely to engage in behaviours that put them at risk of HIV exposure such as failing to use condoms and having multiple sexual partners. Given their high risk of HIV exposure, people who use drugs are recognised as a key population for HIV prevention and treatment services.

5.4.1 Why are people who inject drugs at particularly high risk of HIV exposure?

There are several reasons why people who inject drugs are at high risk of HIV exposure:

- **Sharing needles:** According to UNAIDS, between 5 to 10 % of new HIV infections worldwide result from sharing needles. The chance of HIV transmission through sharing needles is especially high until treatment is accessed.

- **Economic factors:** People who use drugs will often turn to cheaper ways of taking drugs such as sharing needles with others or doing sex work to pay for their drugs, both of which increase the risk of HIV exposure.

- **Gender specific factors:** Women who inject drugs may have a higher risk of HIV exposure due to pressure to share needles and engage in high-risk sexual activities or due to gender-based violence.

Case study: Recognising that people who use drugs are a key population

Seychelles conducted a review of its National Strategic Plan on HIV and AIDS, prior to the development of the new plan, and National Policy on HIV. The review noted the gaps and challenges within the legal and regulatory framework. It prioritised the need for a thorough review of all laws and policies impacting on affected populations in the context of HIV and AIDS, with a view to law review and reform, harmonisation of conflicting laws and policies and strengthening awareness of HIV and human rights and access to justice for human rights violations.

The new National Strategic Framework 2012 – 2016 has prioritised the needs of key populations. The new plan includes specific programmes for people who inject drugs, gay men men who have sex with men, sex workers, pregnant women and young people.

Source: ARASA (2014) HIV and Human Rights in Southern and East Africa

There are some people who use drugs who are particularly vulnerable. They include:

- Women who use drugs – women who use drugs face a double burden. Firstly, as women they are at greater risk of HIV exposure. Second, as drug users they often have to resort to sex work to support their drug use. Female drug users are particularly vulnerable to harassment and violence from the police. Some are forced to trade sex for their freedom as police officers threaten to arrest them unless they either pay them or perform sexual acts for them.

- Young people who use drugs – adolescents who use drugs are particularly vulnerable as their lack of maturity can lead to them falling into abusive and dependent relationships in order to secure access to drugs. Many also have to rely on sex work to support their drug habits. Young people who use drugs often leave home or are forced to leave home; being homeless can make them more likely to take risks and potentially put them at risk of HIV exposure.

- Sex workers – there is often an overlap between drug use and sex work. There is a greater risk of HIV infection if a person is a sex worker, transgender and using drugs.

5.5: The Use of the Law toRegulate and Control Illicit Drugs

5.5.1 The main conventions which currently guide national drug laws and policies

There are a number of international conventions that deal with drug policy and drug control. These create a framework of obligations that governments agree to follow at a national level.
The most important of these are:

- Single Convention on Narcotic Drugs of 1961 (as amended by the 1972 Protocol). This Convention aims to combat drug abuse by seeking to limit the possession, use, trade in, distribution, import, export, manufacture and production of drugs to circumstances in which they will be used for medical and scientific purposes only. It also aims to combats drug trafficking through international cooperation to deter and discourage drug traffickers.
- Convention on Psychotropic Substances of 1971. This convention places obligations on states to control psychotropic substances.
- The 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (137 parties). This is a convention that criminalises the illicit traffic in drugs.
- There are also a number of international programmes of action and special days which are used to try and ensure that the international community continues to try to ban drug abuse and the illicit trade in drugs. These include:
    - Global Program of Action: This is a programme of action that was first adopted by the United Nations in 1989. Its sets actions and targets for member states which aim at ending, amongst others, the illicit production, supply, and demand, trafficking and dissemination of drugs.
    - International Day against Drug Abuse and the Illicit trafficking in drugs: 26th June: Every year, this is a day in the United Nations calendar which is used to remind member states of the goal of a world in which there is no drug abuse.
    - African Union Plan of Action on Drug Control (2013 – 2017): This aims to address emerging issues relating to drug control in sub Saharan Africa. Its over-arching goal is to reduce drug use, illicit trafficking and other crimes.

5.5.2 The United Nations (UN) bodies responsible for overseeing the functioning of the international drug control system

There are a number of UN bodies that play various roles in enforcing the international law norms on controlling the production, distribution and use of drugs. These include:

- Economic and Social Council (ECOSOC): This is a UN body that has been created by the International Convention on Economic, Social and Cultural Rights. One of the programmes funded by the ECOSOC is the Office for Drug Control and Crime Prevention. This body co-ordinates the UN's work relating to drug control

- Commission on Narcotic Drugs (CND): This body acts as the over-arching regulator of the Office for Drug Control and Crime Prevention. It also ensures that countries comply with the various drug conventions.

- International Narcotics Control Board (INCB): This is the independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions.

World Health Organisation: The WHO also falls under the umbrella of ECOSOC. It acts as a health adviser to all of the UN bodies on drug control. It provides expert advice on certain drugs and how countries should respond to the public health needs associated with drug use.

5.6 Why do current dominant approaches to drug control infringe on the rights of people who use drugs?

In many countries, drug control efforts result in serious human rights abuses: torture and ill treatment by police, mass incarceration, extrajudicial killings, arbitrary detention, denial of essential medicines and basic health services. Drug control policies, and accompanying enforcement practices, often entrench and exacerbate systematic discrimination against people who use drugs, and impede access to harm reduction programmes.

Example: Direct and indirect discrimination and social stigma against drug users

People who use drugs face high levels of social stigma and discrimination. They are often rejected by their families and communities and are treated as criminals by service providers such as health care workers. This makes it very difficult to disclose that they are using drugs and access services as they may be afraid of the consequences that would flow from such am admission.

Some people who use drugs also face other forms of indirect discrimination. For example, if they have a criminal record for their drug use in many countries they will be unable to work. In South Africa, in the case of *Prince v President of the Cape Law Society and Others* 2002 (2) SA 794 (CC) the Constitutional Court had to decide whether the criminalisation of the use of cannabis violated the right to freedom of religion. In this case, Prince could not register as a candidate attorney with the law Society because he had previous criminal convictions for the use of cannabis. In this instance South Africa's drug control policies directly affected his ability to become a lawyer. The Constitutional Court found that the drug laws were a justifiable limitation on his rights to religious freedom because, amongst others, South Africa had committed itself to a number of international conventions in terms of which they had agreed to control the use of certain drugs.

Human rights abuses include the compulsory detention and treatment of people who use drugs. In some countries, either through the criminal law or other social systems, people who use drugs can be compelled against their will to be detained and subjected to treatment for their addiction.

Criminalising drug use also makes it difficult to provide public health services to this population as they do not want to be identified for fear of being prosecuted.

Key issues include:

- There may be legal obligations on health care workers to report illegal behaviour
- People who use drugs are often afraid of being identified as such and therefore do not trust health care workers
- Carrying sterile needles may be seen as evidence of drug use and people who use drugs are afraid of carrying extra needles in case they are stopped by the police
- Fear of being detected by the police results in people who use drugs injecting themselves with unsafe needles or not properly disposing old needles.

Case study: The impact of the criminalisation of drug use or equipment relating to drug use

Drug use is criminalised in Kenya, which is reported to create barriers to access to health care for people who inject drugs. Studies have shown high rates of HIV prevalence amongst people who inject drugs in both Nairobi and Mombasa. In Madagascar Law No 97-039 of 11/04/1997 criminalises the provision of any equipment that may facilitate the use of drugs. This provision creates a barrier to the provision of harm reduction services (such as needle-exchange programmes) for people who use drugs. Likewise, in South Africa there has been a failure to provide for harm reduction for people who inject drugs in contravention of the Prevention of and Treatment for Substance Abuse Act, 2008. There is also no policy on harm reduction, such as needle syringe exchange or opioid substitution therapy.

Source: ARASA (2014) HIV and Human Rights in Southern and East Africa

Learning Activity 1: The impact punitive drug laws have on HIV prevention and treatment programmes

An NGO is challenging the constitutionality of drug laws that prohibit people who use drugs from accessing harm reduction services. The application is being opposed by the Ministry of Justice.

Prepare arguments on behalf of both the NGO and the Ministry of Justice.

Local communities in drug-producing countries also face violations of their human rights as a result of campaigns to eradicate illicit crops, including environmental damage, displacement and damage to health from chemical spraying. These abuses are widespread and systematic in many regions of the world.

These abuses are cause for considerable concern in themselves, but they also impede an effective response to the HIV epidemic: by denying people who use drugs access to proven, effective HIV prevention, care, and treatment services and by contributing to at least one million people living with HIV going without adequate treatment.

5.7: The Rights of People who use Drugs

People who use drugs have the same fundamental human rights as anyone else, but they have very few legal rights relating to their drug use. Dealing in, using or being in possession of drugs is a criminal offence in most Southern and East African countries. In many countries in the region there is also strict enforcement of drug-related laws and offenders are frequently sent to jail for using, dealing in or being in procession of drugs. The fundamental human rights that people using drugs are entitled to include amongst others the right to:

- Equality and to not be unfairly discriminated against in terms of access to health and social services
- Decent work and not to be arbitrarily excluded from work opportunities simply because drug use is criminalised
- Privacy regarding their autonomous choices regarding their lifestyle
- Highest attainable standard of health care, which includes access to services such as anti-retroviral treatment (ART) and harm reduction programmes.

Case study: Mauritius

In Mauritius it is extremely difficult for people who use or used drugs to get employed as all job seekers have to produce a certificate of character which is issued by the police. This certificate states whether you have a criminal record or not. Given, that many people who use drugs have been convicted of the use or possession of drugs this excludes them from job applications.

Definition: What are harm reduction services?

Harm reduction refers to policies, programmes and practices which aim to reduce some of the harms related to the use of illegal drugs. Harm reduction does not aim at ending drug use; rather it tries to ensure that people who use drugs take steps to protect and promote safer drug-related behaviour. International agencies recommend that a comprehensive harm reduction package would include:

1. **Sterile Needle and Syringe programmes (NSP)**
2. **Opioid Substitution Therapy (OST) and other drug dependent treatments**
3. **Voluntary HIV Counselling and Testing (VCT)**
4. **Anti-Retroviral Therapy (ART)**
5. **Sexually Transmitted Infections (STI) prevention and treatment**
6 **Condom programming, including lubricants, for people who use drugs and their partners**
7. **Targeted Information, Education and Communication (IEC) for people who use drugs and their partners**
8. **Hepatitis diagnosis, treatment (Hepatitis A, B and C) and vaccination (Hepatitis A and B)**
9. **Tuberculosis (TB) prevention, diagnosis and treatment.**

Source: GCHL (2012) Risks, rights and health

Another key aspect of health care services that ought to be provided to people who use drugs is the treatment of hepatitis and in particular, hepatitis C.

Hepatitis C and people who use drugs

Globally, 90 % of hepatitis C infections are linked to injecting drug use. Hepatitis B and C can be transmitted through the sharing of needles and other equipment associated with drug use.

The Centres for Disease Control in the USA recommends that all people who inject drugs should be vaccinated against hepatitis A and B. Furthermore, treatment for hepatitis C and HIV should be intergraded into all drug programmes.

Finally, given the high risk of being exposed to HIV, it is critical that people who use drugs are targeted as a key population for receiving HIV testing and treatment services.

Learning Activity 2: The rights of people who use drugs

(a) What fundamental human rights are people who use drugs entitled to?

(b) Are there any situations in which these rights could be justifiably limited?

5.8: Access to Justice and Law Enforcement for People who use Drugs

Research has shown that it is not only laws that criminalise drug use and prevent harm reduction measures that increase the vulnerability of people who use drugs to HIV. It is also often the way drug laws are enforced that increase risks of HIV exposure. Key issues include:

- **Corruption amongst law enforcement officials** – corrupt police officers often require sex in return for not arresting or charging people who use drugs
- **Violence from law enforcement officials** – police officers who use violence against people who use drugs heighten their sense of vulnerability and fear. This can result in them engaging in unsafe behaviours such as shooting up very fast, dropping needles or sharing needles
- **Poor investigation techniques** – in some countries being in possession of more than one clean needle is regarded as evidence of drug taking, this then acts as a disincentive to people who use drugs carrying clean needles.

Generally, when people who use drugs do not have access to justice, this heightens their marginalisation from society and makes them vulnerable to abuse and exploitation.

5.8.1 Protective versus a punitive approach to drug use

There are a number of different ways in which law can be used to respond to drug use. On the one hand, laws can try and change drug-related behaviour by punishing people who use drugs and dealers. In terms of this approach, laws use the threat of imprisonment or even the death penalty to try and deter people from using or dealing in drugs. On the other hand, a protective legal approach tries to facilitate safer drug use behaviour through allowing people who use drugs to have access to a range of harm reduction services such as clean needles. Within a protective approach, the use of or sale of certain drugs may still be illegal but there will not be criminal penalties for using the harm reduction services.

Table 2: Protective vs punitive approach

	Types of laws that support this approach	Impact on HIV prevention and treatment
Punitive approach	• Laws prohibiting harm reduction programmes. • Law requiring that health care workers report drug users to the police. • Laws criminalising health workers who provide services to people who use drugs. • Criminalising drug possession and use.	• Very difficult to offer programmes to people who use drugs as many aspects of those programmes will be illegal. • Difficult for people who use drugs to come forward and access services as this may result in them being reported to the police • Information and media cannot be targeted to meet their needs
Protective approach	• Laws allow for harm reduction measures to be provided without the users facing criminal sanction. • Laws allowing opioid substitution therapy. • Decriminalising drug possession for personal use.	• Allows people who use drugs to come forward and access HIV prevention and treatment services. • Health care workers can provide services without fear of criminal charges. • Media can be developed specially targeting the needs of people who use drugs.

There are public health benefits to using the law to protect the health rights of people who use drugs.

Case study: Public health benefits of harm reduction programmes in Mauritius

There are positive signs of progress: in Mauritius in 2011, it was estimated that around 75% of people who inject drugs were being reached with harm-reduction services.

5.8.2 How can you protect the rights of people who use drugs?

The 2012 report of the *Global Commission on HIV and the Law, Risks, Rights and Health* recommends that countries take a protective approach to providing HIV prevention and care programmes to people who use drugs. The report found there were strong public health benefits to ensuring that people who use drugs are targeted by HIV programmes. It argues that countries that facilitate access to harm reduction have reduced HIV prevalence rates amongst people who use drugs, whilst the prevalence rate continues to grow in countries that do not offer services such as clean needles. The approach proposed by the Global Commission on HIV and the Law can only occur within a legal and law enforcement framework which facilitates access to harm reduction.

In light of this, they recommended that amongst others countries should:

- Reform their drug laws so that they do not prohibit harm reduction programmes for people who use drugs
- Take steps to introduce needle exchange programmes
- Decriminalise the possession of drugs for personal use.

The *UNAIDS (2014) Gap Report* recommends that states take the following actions to address the vulnerability of people who use drugs to possible HIV infection:
Transform punitive laws that criminalise the use of drugs: UNAIDS argues that there should be a continued movement away from criminalisation towards a humane and supportive approach to regulating drug use. This will enable governments to address the range of problems that are associated with controlling illegal drug activities and will facilitate the provision of services directly to people who use drugs. This approach will transform national strategies into the best public health outcomes.

Governments adopting this approach need to:

- Repeal all laws that criminalise drug use
- End arbitrary detention, so-called compulsory treatment, torture and other forms of ill-treatment of people who use drugs
- Increase access to justice for people who inject drugs whose rights have been violated
- Expand evidence-informed HIV services and programmes for people who use drugs. UNAIDS promotes an approach in which HIV services are:
- Integrated into programmes for people who use drugs. This enables people who use drugs to access what they need in a simple, coordinated and friendly fashion.
- Targeted at people who inject drugs who are living with HIV so they can be identified and can be referred to anti-retroviral programmes.
- There is monitoring and evaluation of services and report to the community of people who use drugs.
- Design, plan and implement as many services in cooperation with the community of people who inject drugs and as close as possible to where they are located.
- Improve programme monitoring with data collection that is disaggregated by sex and age
- Address institutionalised stigma and discrimination:
- Develop legal literacy and legal services that will empower people who inject drugs to challenge discrimination and abuse.
- Sensitise law enforcement and health-care personnel to reduce stigma, discrimination and abuse and enhance the quality of life of people who inject drugs and initiate surveys to monitor stigma and its effects.
- Expand social support to manage drug dependence.
- Foster leadership so that people who inject drugs can support their peers and be active in the HIV response in their communities.

Increase domestic funding for harm reduction programmes: It is recommended that states commit to fully funding evidence-informed programmes. To ensure that this is done in an accountable way there should be:

- Reporting on expenditures on HIV disaggregated by key populations.
- The strengthening of civil society engagement in the planning and roll-out of HIV services.
- The inclusion of people who inject drugs in national HIV plans and policies.

5.8.3 Laws, policies and programmes on drug use

There are very few examples of good practices on drug use in Southern and East Africa. Some countries are starting to recognise that people who use drugs are a key population and they are referred to in the national strategic plans.

Table 3: NSPs and People who use drugs in Southern and East Africa

Countries	HIV prevalence (%) as set out in garpr	Identified as key population in national response	Provision of prevention programmes in HIV responses
Angola	NDA	No	No
Botswana	NDA	No	No
Comoros	NDA	No	No
DRC	NDA	Yes	Yes
Kenya	18% (2010)	Yes	Yes
Lesotho	NDA	No	No
Madagascar	7.1% (2012)	Yes	Yes
Malawi	NDA	No	No
Mauritius	44.3% (2013)	Yes	Yes
Mozambique	NDA (study underway)	Yes	Unclear
Namibia	NDA	No	No
Seychelles	4% (2011)	Yes	Yes
South Africa	NDA	Yes	Yes
Swaziland	NDA	No	Yes
Tanzania	16% (2014)	Yes	Yes
Uganda	NDA	Yes	Yes
Zambia	NDA	No	No
Zimbabwe	NDA	No	No

Source: ARASA (2016) HIV, TB and Human Rights in Southern and East Africa

Mauritius is the only country that has taken legal steps to protect the rights of people who use drugs and ensure that they have access to harm reduction measures. However, Mozambique, South Africa and Tanzania, and the Seychelles have started to take steps towards this approach.

Case study: Best practice using the law to facilitate on harm reduction in Mauritius

The Mauritius HIV and AIDS Act 2006 contains a number of protections for people living with HIV. The Act provides for syringe and needle exchange programmes. People who use drugs and those who supply safe needles and syringes cannot be charged in terms of the criminal law.

Case study: Best practice using political commitment to facilitate harm reduction in Tanzania

A recent study in Dar es Salaam estimated HIV prevalence amongst people who inject drugs to be around 42%. Despite their high risk of HIV exposure, there is limited provision for harm reduction measures and rehabilitation of people who use drugs. The Tanzanian government has allowed Medicines du Monde to establish a needle exchange programme in Dar es Salaam and to train police officers about harm reduction. The government has also established two methadone clinics in Dar es Salaam.

Source: ARASA (2014) HIV and Human Rights in Southern and East Africa Report

Learning Activity 3: Developing a legal framework for addressing HIV prevention and treatment amongst people who use drugs

You have been appointed as a consultant to the National AIDS Council. You have been asked to develop a new draft policy on providing HIV prevention and treatment services to people who use drugs. Set out:

- Why people who use drugs are a key population in any response to the HIV epidemic?
- Should all drug use be decriminalised? Should the use of certain drugs remain criminalised? What should be the framework for drug control?
- Should harm reduction be offered? If yes, what services should form part of this package?
- What steps should be taken to ensure that people who use drugs are able to access HIV-related services?

5.8.4 Participation and inclusion

People who use drugs are a marginalised group in most Southern and East African countries because it is generally a criminal offence to use, possess or sell drugs. Given that people who use drugs are often excluded from mainstream organisations and opportunities to participate in civil society, their voices have often not been heard as part of community consultations. It is important that steps are taken to ensure that the views of people who use drugs are taken into account when designing policies and programmes that will affect them.

5.9 Unit summary

1. The current international approach to controlling drugs and creating a drug free world is based on a crime control model that heightens vulnerability to HIV.
2. Criminalising drug use acts as a disincentive for people who use drugs to access services, places inappropriate reporting obligations on health care workers and denies people who use drugs the opportunity of obtaining assistance from harm reduction programmes.
3. Various international institutions, including the Global Commission on HIV and the Law, UNDP and UNAIDS have made recommendations for law and policy reform that adopts a harm reduction approach to drug use.
4. Harm reduction refers to policies, programmes and practices which aim to reduce some of the harms related to the use of illegal drugs. Harm reduction does not aim to end drug use but tries to ensure that people who use drugs take steps to protect and promote safer drug-related behaviour.
5. There are very few examples of good practices on drug use in Southern and East Africa. Some countries are starting to recognise that people who use drugs are a key population and they are referred to in national strategic plans.

Summative Assessment

Complete the following quiz to assess your knowledge of cpeople who use drugs. Tick whether each of the following statements is true or false.

Question	True	False
Recreational drug use is not criminalised in most countries as long as people do it in private		
People who use injecting drugs are at higher risk of HIV infection because they may share needles		
People who use drugs are not entitled to human rights because they are breaking the law		
Harm reduction means stopping people from using drugs		
Criminalising drug use increases the vulnerability of people who use drugs to HIV transmission and undermines their access to HIV prevention, treatment, care and support		
Laws that protect the rights of people who use drugs can help protect them from HIV infection		

5.10: Unit Outcomes Checklist

Use the checklist below to see whether you have met the outcomes that were set for this unit.

Outcome	Yes, I have met this outcome	No, I have not met this outcome	These are the things I still need to revise
Understand the global drug control system which is created through conventions and treaties			
Explain to others why people who use drugs are at greater risk of HIV exposure			
Know why criminalising drug use makes people more vulnerable to HIV infection			
Set out the rights of people who use drugs			
Describe the steps that governments should take to ensure that harm reduction and other HIV prevention services can be provided to people who use drugs			
Be aware of recommendations for law reform in this area			

5.11 Resources and References

5.11.1 Useful websites

Canadian HIV/AIDS Legal Network
http://www.aidslaw.ca/site/our-work/drug-policy/?lang=en

Global Commission on Drugs
www.globalcommissionondrugs.org

Harm Reduction International
https://www.hri.global/?no-splash=true

Human Rights Watch
https://www.hrw.org/news/2009/04/10/drug-policy-and-human-rights

5.11.2 Useful resources

Global Commission on HIV and the Law Punitive Drug Use and the Risk Environment for Injecting Drug Users: Understanding the Connections
http://www.hivlawcommission.org/index.php/working-papers?task=document.viewdoc&id=98

Global Commission on HIV and the Law (2012) Risks, Rights and Health
http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf

Open Society Institution Protecting the Human Rights of Injection Drug Users: the impact of HIV and AIDS
https://www.opensocietyfoundations.org/sites/default/files/Human%2520Rights%2520IDUs%2520Web%2520%2528Feb%25202005%2529.pdf

UNAIDS Do No Harm: Health, human rights and people who use drugs
http://www.unaids.org/sites/default/files/media_asset/donoharm_en.pdf

Prisoners' Rights

unit 6

6.1: Introduction

This unit describes the health rights of prisoners in the context of HIV and TB in Southern and East Africa. It describes some of the key HIV, TB and human rights issues facing prisoners in the region. It explains how to protect rights in the context of HIV and TB by reviewing laws and policies and implementing programmes for prisons.

6.2: Unit Outcomes

At the end of this unit you should be able to:

- Define the health rights of prisoners
- Describe the sources for these rights in international and regional instruments, declarations and guidance documents
- Understand why prisoners' health and human rights are critical to effective responses to HIV and TB
- Describe the key HIV, TB and human rights issues facing prisoners in Southern and East Africa
- Explain how to protect the health rights of prisoners in law, policy and programmes
- Share some examples of protective laws, policies and programmes from Southern and East Africa.

6.3: HIV, TB and Prisoners' Rights

6.3.1 What are the health and human rights of prisoners?

It is important to understand that prisoners have human rights, even though they are jailed. Some of these rights may be limited because they are imprisoned – like the right to freedom of movement. But prisoners retain most of their basic human rights. These rights have been set out in a number of international and regional human rights instruments, statements and declarations over the years. They are also reflected in many of the national constitutions of countries in Southern and East Africa.

All prisoners have the following rights:

- The right to equality and non-discrimination
- The right to health
- The right to be protected from torture and from cruel, inhuman and degrading treatment or punishment
- The right to life.

Guidance: Every person has the right to health

The enjoyment of the highest attainable standard of physical and mental health is a basic human right accorded to all people, including prisoners.

In more recent years, there have also been declarations on the specific health and HIV-related rights of prisoners.

Guidance: The Standard Minimum Rules for the Treatment of Prisoners

The Standard Minimum Rules were approved by the United Nations in July 1957. Some of the fundamental principles are:

- **Prisons shall be well-ordered communities where there is no danger to life, health or personal integrity**
- **No discrimination shall be shown in the treatment of prisoners**
- **Prison conditions shall not impose a punishment additional to the deprivation of liberty caused by the imprisonment nor should they aggravate the suffering caused by the imprisonment**
- **Prison conditions should be compatible with human dignity and acceptable standards in the community.**

Table 1: International Statements and Declarations on the Rights of Prisoners

United Nations Standard Minimum Rules for the Treatment of Prisoners, 1955	The Standard Minimum Rules set out good practice for the treatment of prisoners including principles such as non-discrimination, adequate nutrition and accommodation that meets health requirements. They furthermore include detailed provision for health rights, to ensure that all prisoners have access to: • Medical examinations on admission into prison • Medical services working together with the country's public health services • Referrals to specialised institutions for those prisoners requiring specialised care • Pre- and post-natal care and treatment • The segregation of prisoners suspected of infectious or contagious conditions
United Nations Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, 1982	The principles of medical ethics relating to prisoners include, amongst others, the duty to provide prisoners with the same quality of health and treatment as all others and the duty to refrain from treating prisoners in a manner that constitutes cruel, inhuman or degrading treatment or punishment.
United Nations Basic Principles for the Treatment of Prisoners, 1990	The basic principles recognise that "except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the *Universal Declaration of Human Rights*…" The principles include, amongst others, the following with respect to prisoners: respect for their inherent dignity; non-discrimination; state responsibility for promoting their well-being and development and access to the health services available in the country without discrimination.
WHO Guidelines on HIV Infection and AIDS in Prisons, 1993	The Guidelines provide standards for HIV prevention, treatment, care and support in prisons. They include the following key principles, amongst others: • All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination • Compulsory HIV testing of prisoners should be prohibited; prisoners have a right to confidential, voluntary HIV testing and counselling • Prisoners have a right to confidentiality with regard to their HIV status • Prisoners should be provided with HIV prevention information and education and access to the means of prevention including, inter alia, condoms and harm reduction • Efforts should be made to prevent and treat TB infection in prisons

UNAIDS International Guidelines on HIV and Human Rights, 2006	Guideline 4 of the International Guidelines provides that "prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered."
WHO / UNAIDS Policy Brief: Reduction of HIV Transmission in Prisons, 2004	The Policy Brief recommends that prisons implement all the measures against HIV transmission which are carried out in the community outside prisons, including HIV education, testing and counselling performed on a voluntary basis, the distribution of clean needles, syringes and condoms, and drug-dependence treatment, including substitution treatment.

In fact, prisoners have a right to a standard of healthcare equivalent to that available outside of prisons and the state has an obligation not to harm prisoners. This means that prisoners should receive access to HIV and TB prevention, treatment, care and support services and should be protected from exposure to HIV and TB within the prison setting.

6.3.2 Why are these rights important?

States have committed to protecting the human rights of prisoners, including their health rights in international, regional and national human rights documents. Efforts to protect the human rights of prisoners recognise that prisoners retain their basic humanity and dignity.

In addition, protecting the health and human rights of prisoners is also critical to the national response to HIV and TB. Prisoners are a key population at higher risk of HIV exposure as well as TB exposure within prisons. They are also members of communities and most will return to those communities. Effective national responses to HIV and TB require a broad-based response that reaches all communities and particularly communities at higher risk of exposure. As a key population, prisoners require prioritisation in the national HIV and TB response; without reaching and prioritising key populations, the national response will not succeed in its efforts to eradicate HIV and TB.

Globally, including in Africa, HIV rates amongst prisoners are estimated to be at least twice and up to 50 times that amongst the general adult population. In recent years the estimated adult prevalence of HIV in African prisons has been between 6 and 50 times higher than outside prisons. While the exact HIV prevalence rates in most prisons in the Southern African Development Community (SADC) region are unknown, preliminary results of assessments done by a number of SADC Member States point to higher HIV rates inside prisons, especially among women prisoners.

HIV prevalence in prisons is due to various factors including unprotected sex, especially between men, sexual violence including rape of both men and women, tattooing with homemade and unsterile equipment, drug use and needle sharing.

In addition, prisoners are also at risk of TB and other opportunistic infections. Globally it is estimated that rates of TB infection are at least 100 times higher among prisoners than in the general population. Overcrowding, poor ventilation and poor nutrition in prisons spreads TB and other opportunistic infections, making HIV-positive individuals more susceptible to getting ill. Prevention, treatment and care for TB is very important for prisoners, especially those at higher risk of TB. Limited access to quality health care services for HIV and TB increases the risk for prisoners.

6.3.3 Key health and human rights issues for prisoners in the context of HIV and TB

Overcrowding in prisons

According to the SADC Minimum Standards in Prisons: "prisons in the region tend to be overcrowded, the average incarceration rate in the region is 157 per 100 000 inhabitants and prison occupancy rates average at 138%. Evidence shows that overpopulated prisons constitute high-risk environments for disease transmission and make it difficult to provide adequate health services. Overcrowding reduces the quantity and quality of ventilation, lighting and sanitation for prisoners. This is particularly important in the spread of airborne diseases such as TB."

International guidelines for addressing overcrowding have been considered by some SADC Member States and include measures such as the use of parole, amnesties, compassionate release and reduced sentencing or alternative sentencing provisions, that provide alternatives to imprisonment for those sentenced to less serious crimes.

Access to HIV Prevention, Treatment and Care Programmes in Prisons

There are a number of HIV prevention and treatment challenges in prisons, including the following:

- Limited awareness of HIV and TB amongst prisoners
- Fears of stigma, discrimination and breaches of confidentiality amongst prisoners
- Limited resources for implementation of HIV prevention programmes, including basic measures such as HIV testing and provision of condoms, as well as for access to anti-retroviral treatment (ART)
- A rapid turnover amongst the jail population combined with a lack of continuation of care and referral system linking prisoners (who may be on ART or TB treatment) to the public health care system when released from the prison environment
- Limited provision for nutritional support for prisoners, especially those who are on treatment or require special care
- Refusal to distribute condoms. Prison authorities argue that condom provision amounts to abetting a crime.
- Criminalisation of drug use has a similar effect: countries do not wish to provide harm reduction programmes, such as needle exchange programmes, in prisons.

Example: Criminalisation of access to condoms in prisons

Criminalisation of homosexuality STI cases in prisons have been documented in all SADC Member States, confirming that unprotected sex occurs inside prisons. Yet policy makers in most Member States continue to deny this reality. Most SADC Member States criminalise sex between men and lack provisions for supporting men who have sex with other men.

South Africa is the only country in the region with laws that protect men who have sex with men. Service providers report that criminalisation and broader social stigma regarding same-sex relationships makes it extremely difficult to openly provide support services. There is very little positive public awareness about these issues in most countries. Only Lesotho and South Africa currently make condoms available to prisoners (mainly to male prisoners)

This continues to be a core issue in debates about comprehensive health service provision in prison settings.

Source: Pg 12, Assessment Report on HIV and AIDS, Tuberculosis, Hepatitis B and C and STIs in Prisons.

Source: https://www.sadc.int/files/6314/1171/8815/Assessment_Report_on_HIV_and_AIDSTuberculosis_Hepatitis_B_and_C_andother_Sexually_Transmitted_Infectionsin_Prison_Settings_in_the_SADC.pdf

The criminalisation of consensual sex between persons of the same sex is inappropriately used as justification for the failure of governments to provide condoms and other protective barriers in prisons. These refusals underscore state homophobia, breach the governmental duty to provide inmates with access to preventative health measures, and ignores the issue of rape and coercive sex in prisons.

The lack of access to condoms and other protective barriers in prisons is a major obstacle in realising the right to health for all inmates in Southern Africa, who are key populations in terms of HIV risk. These refusals have a disproportionate impact on transwomen inmates who are frequently arrested for gender expression related offenses such as "cross-dressing" "public indecency" and "nuisance." Transwomen are often placed in male jail cells and are at high risk of sexual assault due to visibility and non-conforming gender identity

Mandatory HIV testing of prisoners on admission to prisons

Many prison laws, policies and regulations require prisoners to be medically examined on admission to prisons. However, in many countries this results in mandatory HIV testing of prisoners on admission.

Provision for the special needs of certain populations of prisoners

Within prisons, as with the general population outside of the prison setting, there are specific populations that may have special needs requiring targeted interventions and services. Vulnerable populations may include women, young people, lesbian, gay, bisexual, transgender and intersex (LGBTI) prisoners and non-national prisoners, amongst others. Many prisons policies and programmes fail to provide interventions for these specific populations. For example:

- In some countries, health services such as ART are not available to non-national prisoners
- Women, young people and LGBTI populations may be particularly vulnerable to sexual violence within prisons, yet prison services fail to provide protective measures or targeted health services to support those who've been assaulted
- There is limited access to targeted health services for vulnerable and key populations such as antenatal health care and PMTCT services for pregnant women and appropriate HIV information, education and prevention measures for LGBTI prisoners.

6.3.4 How do you protect prisoners' rights in the context of HIV and TB?

International and regional guidance on HIV and TB in prisons

International and regional guidance on HIV and TB in prisons suggests that an effective response should be protective, rights based and based on voluntary informed consent, rather than coercive and discriminatory approaches such as mandatory testing and isolation.

International guidance on HIV in prisons suggests the following rights-based responses:

- Protecting the rights of all prisoners to equality and non-discrimination on the basis of HIV status
- Prohibiting mandatory HIV testing and segregation of HIV-positive prisoners
- Providing HIV-related prevention, treatment, care and support
- Protecting prisoners from rape, sexual violence and coercion.

The Global Commission on HIV and the Law noted that necessary health care services should include condoms, comprehensive harm reduction services and voluntary treatment for drug dependence, regardless of criminal laws regarding sex between men and drug use.

At a regional level, the African Commission has articulated the need to ensure safe police custody and pre-trial detention in prisons across the continent. In addition, SADC and the East African Community (EAC) have developed HIV laws that protect prisoners' rights to prevention, treatment, care and support for HIV and TB as well as detailed minimum guidelines on the management of HIV in prisons.

The African Commission Resolution No 227 on the need to develop guidelines on conditions of police custody and pre-trial detention in Africa, 2012 noted with concern the abusive police and pre-trial detention practices in several Member States and called for the development of guidelines to strengthen the criminal justice system with regards to police custody and pre-trial detention. The *Guidelines on the Conditions of Arrest, Police Custody and Pre-Trial Detention in Africa* (the Luanda Guidelines) were adopted in 2014 and provide specific guidance on the rights of detained persons, such as the rights of persons on arrest, while in police custody and in pre-trial detention.

Guidance: Comprehensive care in prisons

UNODC recommends the following interventions as part of a comprehensive package for effective HIV and AIDS prevention, treatment, care and support in prisons:

- **Targeted or tailored information, education and communication (IEC)**
- **HIV testing and counselling (HTC)**
- **Needle and syringe programmes (NSP)**
- **Opioid substitution therapy (OST)**
- **Antiretroviral therapy (ART)**
- **STI prevention and treatment**
- **Condom programming and distribution**
- **Hepatitis diagnosis, treatment (for A, B and C) and vaccination (for A and B)**
- **TB prevention, diagnosis and treatment, and**
- **Provision of prevention of mother-to-child transmission (PMTCT) services.**

Guidance: Comprehensive care in prisons

Chapter IV of the Model Law protects prisoners' rights to:

- **Information and education about HIV and AIDS**
- **HIV prevention services (including condoms, water-based lubricants, clean injecting drug equipment)**
- **A prohibition on mandatory HIV testing**
- **Voluntary counselling and testing**
- **Health care services including ART and treatment for opportunistic infections**
- **Confidentiality**
- **A prohibition on isolation on the basis of actual or perceived HIV status**
- **Protection from violence**
- **Compassionate release on medical grounds.**

The EAC HIV and AIDS Prevention and Management Act 2012

The EAC law protects every prisoner's right to:

- **Protection from violence, including sexual violence**
- **Protection from compulsory HIV testing**
- **Voluntary HIV testing with informed consent and pre- and post-test counselling**
- **Information and education about HIV and AIDS**
- **Free health care services including ART and treatment for opportunistic infections**
- **Confidentiality**
- **A prohibition on isolation on the basis of actual or perceived HIV status.**

The SADC Minimum Standards for HIV and AIDS, TB, Hepatitis B and C, and Sexually Transmitted Infections Prevention, Treatment, Care and Support in Prisons in the SADC Region, 2009

The Minimum Standards establish regional standards of minimum requirements for effectively preventing, treating and controlling HIV and AIDS, TB, Hepatitis B and C, and STIs in prisons. They draw on international evidence-based standards adapted to the regional epidemiological, social and political conditions. They recommend that Member States adopt the following standards:

- An enabling legal and policy framework and a justice system that provides for HIV and TB services in prisons, supports access to health care services for all key populations, reduces prison time where appropriate and raises awareness about of the need for prisons' health policies and programmes
- Assessment of prisoners on admission to determine the prisoner's health status and to provide appropriate prevention, treatment, care and support services
- Provision of health services during prison term in order to prevent HIV and TB and provide treatment, care and support to those affected. This should include:
    - HIV testing and counselling, ART, needle and syringe programmes, and opioid substitution therapy for people who use drugs, post-exposure prophylaxis (PEP) for those who are sexually assaulted or exposed to contaminated body fluids, PMTCT services for all pregnant, HIV-positive female prisoners and detainees, condom programming; hepatitis B vaccination, male medical circumcision, STI diagnosis and control and preventive TB therapy
    - Education and information on non-discrimination on the basis of health status, sexual orientation or any other ground, and mechanisms for reporting stigma and discrimination
- Prison authorities must be trained to manage groups with special needs such as "circumstantial children", children in conflict with the law, women, prisoners with disabilities, non-national prisoners, prisoners who are lesbian, gay, bisexual or transgender and elderly persons
- Prisons must develop workplace programmes for prison staff, including wellness programmes and the provision of voluntary HIV testing and counselling services.

National laws, policies and programmes

At national level, countries are encouraged to develop HIV policies and programmes that reflect international, regional and national human rights principles and promote access to HIV and TB health services for all populations within prisons.

Case Study 1: Providing Legal aid for prisoners in Zambia

Zambian prisons are heavily congested: there are 17 000 prisoners, including awaiting trial detainees, in prisons that are designed to hold only 5000. As Godfrey Malembeka from PRISSCA, an NGO promoting the rights of prisoners, states, they are a "breeding ground for TB and other opportunistic infections."

PRISSCA, with funding from the Open Society Institute of Southern Africa (OSISA) has developed a programme in conjunction with three law firms to identify and take up cases that have been delayed in courts. The programme focuses on identifying cases involving petty offences and trying to get these through the courts, advocating non-custodial sentences with the aim of reducing overcrowding. Reducing overcrowding in turn promotes public health goals of reducing the spread of TB.

Case Study 2: Lesotho Prisons Policy

In Lesotho, the Correctional Services Policy and the new Strategic Plan on HIV and AIDS provide for the management of HIV in prisons, including for prevention, treatment and care. Notably, the policy provides for condom distribution in prisons, even though the law criminalises sex between men.

The role of the judiciary in promoting prisoners' rights

The courts have played an important role in protecting and promoting prisoners' rights to access HIV prevention, treatment, care and support services in the region. The courts have upheld various prisoners' rights and the duties of prison authorities in the context of HIV and TB including the following:

- **The rights of TB patients to be protected from unreasonable imprisonment:** In the Kenyan 2010 case of D.N. and Anor v Attorney-General, Petition No 3 of 2010, HC Eldoret, where the High Court found that the imprisonment of patients with TB, for defaulting on their treatment, was unconstitutional and contrary to the Public Health Act.

- **The duty upon prison authorities to manage the risk of TB infection in prisons:** In the South African case of *Dudley Lee v Minister for Correctional Services* [2012] ZACC 30, where the court found a connection between the prisoner's TB infection and the authorities' negligent failure to reduce the risk of TB contagion.

- **The right of prisoners with HIV to be entitled to release from prison on medical parole:** In the South African case of *Mazibuko v Minister of Correctional Services* [2007] JOL 18957 (T)

- **The right of prisoners to receive adequate medical treatment, which included ART and the duty upon prison authorities to provide access to such adequate medical treatment:** In the South African case of *EN and Others v South Africa 2006* (6) SA 53 (D) and *Van Biljon and Others v Minister of Correctional Services and Others* 1997 (4) SA 441 (C)

Case Study 3: The rights of non-citizen prisoners in Botswana

The Southern African Litigation Centre (SALC) and the Botswana Network on Ethics, Law and AIDS (BONELA) challenged the Botswana government's policy of refusing HIV treatment to non-citizen prisoners. In Botswana's prison service, non-citizen prisoners are entitled to treatment for opportunistic infections, such as TB, but are expected to pay for HIV treatment themselves, while citizens get free HIV treatment.

BONELA and two HIV-positive, non-citizen prisoners filed a challenge to the policy. On 22 August 2014, the High Court in Gaborone held that the denial of HIV treatment to foreign prisoners living with HIV violated their constitutional rights. The Attorney-General appealed the decision to the Court of Appeal.

The appeal was heard on 23 July 2015 before the Court of Appeal and on the 26 August 2015 the Court of Appeal dismissed the appeal, holding that the policy denying free HIV treatment to non-citizens was contrary to the Prisons Act and therefore unlawful. The Court ordered the government immediately to provide free testing, assessment and ART to all foreign prisoners to the same extent as citizen prisoners.

Self-Reflection Exercise 2: Prison Policy on HIV and TB

In your own country, is there a prison policy on HIV and TB? What does it provide for? What are the main gaps and challenges in the policy and its implementation? How could you advocate for stronger HIV and TB policies and programmes in the prisons? What have other countries in the region done to promote the rights of prisoners in the context of HIV and TB?

Other institutions, such as a national human rights commission or ombudsperson, are also able to protect and promote the rights of all people, including prisoners.

See Module 1: Unit 4 - International, Regional and National Commitments and Guidance for more information on enforcing international, regional and national human rights commitments.

6.5: Unit Summary

1. Prisoners still have basic human rights, even though they are jailed.
2. Prisoners have a right to a standard of health care equal to that outside of prison.
3. The health and human rights of prisoners are set out in a number of international and regional human rights instruments. They are also included in the national constitutions and laws of many countries.
4. International human rights commitments recognise the rights of prisoners to equality, dignity, protection from cruel, inhuman and degrading treatment or punishment and to health.
5. Prison conditions should protect the basic human rights of prisoners. They shouldn't be so bad that they create an additional punishment (e.g. poor health) on top of depriving a person of their right to liberty.
6. In the context of HIV and TB, this means that they have the right to be provided with services to prevent HIV and TB transmission and to treat HIV and TB.
7. Prisoners are part of and will generally return to the broader community. They are also a key population at higher risk of exposure to both HIV and TB. This means that national responses to HIV and TB, in order to be effective, must include and prioritise prisoners' health needs.
8. Prisoners are at high risk of HIV exposure because of unsafe sex, rape, tattooing, drug use and needle sharing.
9. Prisoners are also at risk of TB infection and illness because of overcrowding, poor ventilation and poor nutrition.
10. Although prisoners have a right to be protected from HIV and TB infection, they often don't receive the health care services they need.
11. Prevention, treatment, care and support for HIV and TB in prisons is limited in law and policy in countries in the region.
12. Criminal laws prohibiting sex between men and prohibiting drug use often act as barriers to providing condoms and harm reduction services for prisoners.
13. International and regional guidance recommend effective responses that should protect rights to equality, prohibit mandatory testing of prisoners and provide all necessary prevention, treatment, care and support services.

Summative Assessment

Complete the following quiz to assess your knowledge of prisoners' rights. Tick whether each of the following statements is true or false.

Question	True	False
Prisoners have basic human rights		
Prisoners have a limited right to health care in prisons		
Prisoners have the right to liberty		
Prisoners' rights are set out in international human rights instruments		
Prisoners are at low risk of HIV infection since sex is prohibited in prisons		
Prisoners are at high risk of TB infection		
Prison policies often refuse to supply condoms to prisoners		
Testing in prisons is always voluntary, based on informed consent		
Special needs prisoners include women, young people and non-national citizens		
Laws criminalising drug use block access to harm reduction services		
HIV and TB testing should be mandatory on entry to prisons		
Prisoners should receive clean needles for drug use		

6.6: Unit Outcomes Checklist

Use the checklist below to see whether you have met the outcomes that were set for this unit.

Outcome	Yes, I have met this outcome	No, I have not met this outcome	These are the things I still need to revise
Define prisoners' rights			
Define prisoners' rights to health care			
Identify the sources of prisoners' health and human rights			
Explain why protecting prisoners' health rights is important			
Explain why prisoners are at risk of HIV exposure			
Explain why prisoners are at risk for TB			
Describe some of the key issues and health and human rights violations prisoners experience			
Describe the role of the courts in the region in protecting prisoners' health rights			
Give examples of protective laws, policies and/or case law from Southern and East Africa			

6.7 Resources and References

6.7.1 Useful websites

ARASA
www.arasa.info

Global Commission on HIV and the Law
www.hivlawcommission.org

UNAIDS
www.unaids.org

UNODC
www.unodc.org

6.7.2 Useful resources

Council of Europe (1998) Recommendation No R (98) 7 of the Committee of Ministers to Members States Concerning the Ethical and Organisational Aspects of Health Care in Prisons

Council of Europe (2006) Recommendation Rec (2006) 2 of the Committee of Ministers to member States on the European Prison Rules

International Labour Organisation (2002) *Code of Practice on HIV/AIDS and the World of Work*

UNAIDS (1996) *Statement on HIV/AIDS in Prisons*

UNAIDS / WHO (2004) P*olicy Statement on HIV Testing*

United Nations Committee on Economic, Social, and Cultural Rights (2002) *Comment on the Right to the Highest Attainable Standard of Health.* Twenty-second session, Geneva, 2002.

World Medical Association (2000) *Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases*

WHO / Pompidou Group of the Council of Europe (2001) *Prison, Drugs and Society: A consensus Statement on Principles, Policies and Practices*

WHO (2003) *Moscow Declaration: Prison Health as part of Public Health*

WHO (2004) *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users: Evidence for action technical paper*

WHO / UNODC / UNAIDS (2004) *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*

People with Disabilities

unit 7

module 3 :

unit 7

7.1: Introduction

This unit describes the rights of people with disabilities, key health, HIV and TB rights for people with disabilities and how to create protective legal and policy environments for people with disabilities in the context of HIV and TB.

7.2: Unit Outcomes

At the end of this unit you should be able to:

- Define the rights of people with disabilities
- Describe the key issues for people with disabilities in relation to HIV and TB
- Explain an enabling legal, regulatory and policy framework to protect rights for people with disabilities in relation to HIV and AIDS
- Share examples of protective laws, policies and plans from Southern and East Africa.

7.3: People with Disabilities, HIV and TB

7.3.1 What are the rights of people with disabilities?

Definition: Persons with disabilities

Article 1 of the Convention on the Rights of Persons with Disabilities (CRPD) defines a person with a disability as follows:

"Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

The Convention does not refer specifically to HIV or AIDS in the definition of disability.

But, where people living with HIV (asymptomatic or symptomatic) have impairments which, in interaction with the environment, results in stigma, discrimination or other barriers to their participation, they can fall under the protection of the Convention.

States parties to the Convention have to ensure national laws comply with this understanding of disability. Some countries protect people living with HIV under their national disability laws. Others, like countries in Southern and East Africa, have made HIV-specific anti-discrimination laws.

These laws help people living with HIV fight discrimination in a number of areas, such as employment or education.

The CRPD affirms the right of all persons with disabilities to the full enjoyment of all their human rights and freedoms. It pays particular attention to the rights of women with disabilities and emphasises the need to integrate gender equality in all efforts to promote the rights of people with disabilities.

The CRPD does not specifically refer to HIV or AIDS. But many of the rights and key concepts within the CRPD are relevant for protecting people with disabilities from HIV and AIDS and protecting the health of people with disabilities living with HIV, such as the following:

- The right to equality and non-discrimination
- Protection from cruel, inhuman or degrading treatment or punishment
- Protection from exploitation, violence and abuse
- The right to privacy
- The right to enjoyment of the highest attainable standard of health.

Self-Reflection Exercise 1: HIV and Disability

There are some people who argue that people living with HIV, even when asymptomatic, should be thought of as a person with a disability. Other people living with HIV and people with disabilities do not agree with this.

Read through the definition of people with disabilities and ask yourself – do people living with HIV fall within the definition? What impairment do they have? What are the barriers they encounter? Why do you think some people would not want people living with HIV to be considered people with disabilities?

7.3.2 Key issues for people with disabilities in relation to HIV and TB

People with disabilities are at risk of HIV and TB exposure for a number of reasons:

- People with disabilities are a stigmatised, marginalised and vulnerable population. They often live in poverty and are unable to access basic rights such as education and health care. This marginalisation increases the risk of HIV and TB exposure for various reasons.
- People with disabilities may engage in behaviours that put them at risk of HIV exposure such as having unprotected sex or injecting drug use. This may be because they don't have access to appropriate HIV prevention information and services.
- People with disabilities and especially women and girls with disabilities are vulnerable to abuse, including sexual abuse and assault.
- People with disabilities find it hard to access health care services such as HIV prevention, treatment, care and support services that meet their needs. Also, they may get turned away from health care services because of the mistaken belief that they are not, or should not be sexually active.

Some of the key human rights issues for people with disabilities in the context of HIV and TB include the following:

- People with disabilities have limited access to appropriate health information, including sexual and reproductive health information.
- People with disabilities have limited access to health care services for the prevention, treatment, care and support of HIV and TB that are appropriate and accessible to them.
- People with disabilities experience stigma and discrimination from health care workers.
- People with disabilities are often subjected to mandatory testing and treatment since they are assumed to be incapable of giving their own voluntary and informed consent to, for example, HIV testing.
- People with disabilities experience breaches of their right to confidentiality in relation to their medical information, including HIV status.

7.3.3 How do you protect the rights of people with disabilities in the context of HIV and TB?

People with disabilities should be recognised as a vulnerable population in the context of HIV and TB who need to have their rights to equality, non-discrimination, protection from harm and universal access to HIV and TB health services, specifically protected.

For example:

- Countries should enact national disability laws that protect the rights of people with disabilities including in the context of health, HIV and TB. For example, laws should protect
    - The right to equality and non-discrimination
    - The right to voluntary treatment and testing with informed consent
    - The right to confidentiality
    - The right to health, including the right to sexual and reproductive health and rights.
- Countries with HIV-specific laws should ensure that these laws acknowledge people with disabilities as a vulnerable population and give them special protection.
- Countries should integrate people with disabilities into national strategic plans and programmes, to ensure that health programming for HIV and TB meets their specific needs. Health programming should include the following accessible and appropriate services, tailored to meet the needs of people with disabilities:
    - Information and education
    - HIV counselling and testing services
    - HIV and TB prevention, treatment, care and support services
    - Programmes to reduce stigma, discrimination and violence against people with disabilities
    - Training for health care workers on the rights of people with disabilities in the context of HIV and TB
    - Monitoring, evaluation and data collection on health care, HIV, TB amongst people with disabilities.

Guidance: EAC HIV and AIDS Prevention and Management Law 2012

Section 36

(1) Notwithstanding the generality of other provisions of this Act, the Government shall ensure that persons with disabilities living with or affected by HIV are protected from all forms of discrimination and are provided with appropriate support, care and treatment.

(2) The Minister, in consultation with relevant stakeholders shall develop and implement strategies, policies and programmes to promote and protect the health of persons with disabilities living with or affected by HIV including-

(a) increasing access by persons with disabilities to reproductive health information, programmes and services;

(b) recognizing the different types of disabilities and their different requirements as pertains to HIV related information, prevention, treatment, care and support services;

(c) adopting a framework, policies and strategies to support persons with disabilities to ensure respect for their human rights and access to quality HIV and AIDS information services, social protection and livelihood programmes;

(d) ensuring the active participation of persons with disabilities in the design, development, implementation and review of HIV and AIDS programmes and services;

(e) maintaining up to date gender and age disaggregated data on persons with disabilities in order to adequately plan for them; and

(f) putting in place measures that challenge negative concepts and attitudes about disability and working to eradicate the marginalization of persons with disabilities.

Case Study 1: Integrating disability into HIV policy and planning in South Africa

South Africa first included people with disabilities in the National AIDS Strategic Plan (NSP) in 2007– 2011. The 2000–2005 Plan acknowledged people with disabilities but was not explicit or clear. What promoted the recognition was a combination of leadership from champions within Government, the strong organisation of the disability sector and self-representation in the South African National AIDS Council.

Today, while South Africa's policy legislation and AIDS programming is highly inclusive of people with disabilities, the challenge is implementation, although real efforts in terms of access and participation are under way.

For example, disability issues are included in the South Africa HIV Treatment Guidelines in light of the increasing number of people with disabilities in need of HIV medical care. The Government has also undergone the process of accreditation of disability organisations to increase access to treatment.

Today counsellors with disabilities are placed in voluntary testing centres to counsel all clients and free HIV testing is encouraged at disability meetings. In order to improve access to information and services for those with hearing impairments, sign language interpreters are being trained in matters related to HIV in recognition of the real limitations of sign language to communicate key messages effectively. These trained sign interpreters are being assigned to HIV clinics in many urban areas.

In terms of advocacy and communication, disabilities and vulnerability to the impact of HIV are part of the broader media campaign in South Africa. The South African National AIDS Council also makes resources available to disability groups for ongoing HIV awareness through seminars, training, dialogue and "Indabas".

Monitoring and evaluation is still a major challenge. The Government of South Africa has set disability-specific targets within the broader AIDS monitoring and evaluation framework for the country. Data collected will be measured against pre-defined targets so that Government will not be in a position to ignore the evidence.

While this all seems like a lot, much still needs to be done. People living with HIV are not classified people with disabilities in South Africa. However, there is common ground when it comes to the stigma and discrimination faced by both groups, and in South Africa both people with disabilities and people living with HIV benefited from the disability grant, a social security cash transfer.

Unfortunately, the high numbers of people claiming the Disability Grant pushed the budgetary envelope to unaffordable heights resulting in people with disabilities lobbying for a "chronic illness grant" which would distinguish between people with pre-existing disabilities and people who also need chronic medical care.

Finally, HIV infection can cause temporary or permanent loss of function. This implies that the rehabilitation sector must be equipped to address not only pre-existing disabilities but also impairment related to HIV.

Source: UNAIDS (2009) Disability and HIV Policy Brief

7.4: Unit Summary

1. People with disabilities have the same rights as all others. They should be given the opportunity to enjoy their basic human rights and freedoms.

2. The rights of people with disabilities to equality, non-discrimination, privacy, protection from cruel, inhuman or degrading treatment of punishment and their right to health, in particular, help to protect them in relation to HIV and TB.

3. People with disabilities are at risk of exposure to HIV for various reasons.

4. People with disabilities find it hard to access appropriate health care services that meet their particular needs.

5. People with disabilities are treated with stigma and discrimination by health care workers who are sometimes ignorant of their sexual and reproductive health rights and their needs.

6. Disability laws, anti-discrimination laws and HIV-specific laws should include protection for the rights of people with disabilities in relation to HIV and TB.

7. National Strategic Plans on HIV and TB should recognise people with disabilities as a key population and should prioritise special programmes to address their needs.

Summative Assessment

Complete the following quiz to assess your knowledge of people with disabilities. Tick whether each of the following statements is true or false.

Question	True	False
People with disabilities have the same rights as other people		
The CRPD protects the rights of people with disabilities in relation to HIV		
People with disabilities are at low risk of exposure to HIV since they are generally not sexually active		
People with disabilities are at risk of sexual abuse		
Health care workers stigmatise people with disabilities who are sexually active		
People with disabilities can easily access appropriate HIV prevention information and services		
People with disabilities should be protected in law and policy		

7.5: Unit Outcomes Checklist

Use the checklist below to see whether you have met the outcomes that were set for this unit.

Outcome	Yes, I have met this outcome	No, I have not met this outcome	These are the things I still need to revise
Define people with disabilities			
Describe the rights of people with disabilities			
Explain key HIV, TB and human rights issues facing people with disabilities			
Explain how to protect health rights of people with disabilities in law and policy			
Give examples of protective laws and policies from Southern and East Africa			

7.6 Resources and References

7.6.1 Useful websites

Africa Disability Alliance
http://africadisabilityalliance.org/

African Disability Forum
http://www.internationaldisabilityalliance.org/african-disability-forum

Africa Disability Rights Yearbook
http://www.adry.up.ac.za/

HEARD
www.heard.org.za

Human Rights Watch
https://www.hrw.org/topic/disability-rights

Office of the High Commissioner on Human Rights
http://www.ohchr.org/EN/Issues/Disability/Pages/DisabilityIndex.aspx

OSISA
http://osisa.org/open-learning/law/regional/status-disability-rights-southern-africa

UNAIDS
www.unaids.org

7.6.2 Useful resources

Convention on the Rights of Persons with Disabilities
http://www.un.org/disabilities/convention/conventionfull.shtml

HEARD (2010) National Responses to Disability in East and Southern Africa
http://www.heard.org.za/wp-content/uploads/2015/07/National-response-to-disability-and-HIV-in-Eastern-and-Southern-Africa.pdf

VSO and LVCT A Handbook on Best Practices Regarding HIV and AIDS for People with Disabilities
http://www.miusa.org/sites/default/files/documents/resource/VSO%202010%20bestpractices_inclusion_hivaids-1.pdf

WHO, UNAIDS and OHCHR (2009) Disability and HIV Policy Brief
http://www.who.int/disabilities/jc1632_policy_brief_disability_en.pdf

Children's Rights

unit 8

8.1: Introduction

This unit focuses on the rights of children. It looks at what children's rights are, where they come from, who is bound to protect them and why they are important in the context of HIV and TB. It concludes by identifying some key advocacy issues.

8.2: Unit Outcomes

At the end of this unit you should be able to:

- Explain to others that children are entitled to most human rights
- Discuss how children's rights are special rights given to persons under the age of 18
- Understand why children's rights are important in the context of HIV and AIDS
- Know who is responsible for protecting children's rights
- Be aware of the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child
- Know what the UNAIDS HIV/AIDS and Human Rights International Guidelines say governments should do to protect the rights of children
- Be able to discuss some key laws and policies that affect access to HIV prevention and treatment services by children.

8.3 Children, the Law and HIV

8.3.1 What are children's rights?

Children like all other humans are protected by human rights. This means that they are protected by all the human rights described in the *Universal Declaration of Human Rights* (UDHR) except:

- Rights that they are expressly excluded from, such as the right to vote, which is only given to adults
- Rights that they may be justifiably excluded from enjoying because of their age and immaturity. For example, a child may be prohibited from buying pornography even though this limits their right to freedom of expression, as this is regarded as a justifiable limitation of the right.
- Children's rights are special rights that are given to all persons who are under the age of 18 years. In other words in addition to the basic human rights that children enjoy with adults they also have a set of special rights called children's rights. Anyone over the age of 18 is an adult and they are no longer entitled to this special legal protection.

Case Study 1: Children's rights in the Constitution of the Republic of Malawi

Article 23 of the Constitution of the Republic of Malawi provides that children (defined as persons below 16 years for the section) have the following rights:

1. All children, regardless of the circumstances of their birth, are entitled to equal treatment before the law.
2. All children shall have the right to a given name and a family name and the right to a nationality.
3. Children have the right to know, and to be raised by, their parents.
4. Children are entitled to be protected from economic exploitation or any treatment, work or punishment that is, or is likely to -
    a. be hazardous;
    b. interfere with their education; or
    c. be harmful to their health or to their physical, mental, spiritual or social development.

Children's rights are rights that both protect children from harm and ensure they can grow and develop to fulfil their true potential. Children are a vulnerable population because they are young and inexperienced. Child specific laws have been passed to ensure:

- An adult (normally either the parent or a legal guardian) is responsible for a child and provides day-to-day care and helps with making important decisions. These laws also deal with the procedures that must be followed when the adult responsible for the child is abusive or neglectful of the child. They also deals with what will happen when this adult dies or abandons the child.
- Children are protected from harm; for example, there are special laws setting out the age at which a child can consent to sex and get contraceptives.
- Children's physical and emotional needs are met by their parents or for example, through the payment of social grants to the care-givers of children
- The ability of older children to make some choices on their own autonomy, such as whether they wish to be adopted or not.

Table 1: Child Marriage in Southern and East Africa

Countries	MARRIED BY 15 (%)	MARRIED BY 18 (%)	INDEPENDENT MINIMUM MARRIAGE AGE
Angola	NDA	NDA	18
Botswana	NDA	NDA	21
Comoros	10%	32%	18
DRC	9%	39%	18 for men and 15 for girls
Kenya	6%	26%	18 for men and women
Lesotho	2%	19%	21
Madagascar	12%	41%	18 for men and women
Malawi	12%	50%	Girls and boys may marry at 15 with parental consent. New Marriage Bill will set the age at 18 for both, but will require a constitutional amendment to enforce
Mauritius	NDA	NDA	18
Mozambique	14%	48%	18, but 16 with parental consent
Namibia	2%	9%	18, but 16 with parental consent
Seychelles	NDA	NDA	18
South Africa	1%	6%	18
Swaziland	1%	7%	18 for men 16 for girls
Tanzania	7%	37%	18 for men, 15 for girls. Boys can marry at 14 with court permission; girls below 18 need parental consent.
Uganda	9%	42%	21 for men and women but some customary law allows marriage for girls when they reach puberty
Zambia	4%	31%	Constitutional Court recognised 18 as the minimum marriage age
Zimbabwe	NDA	No	No

Source: www.girlsnotbrides

Case Study 2: Protecting children by prohibiting child marriage

Child marriage affects many aspects of a young girls' health, including increasing their vulnerability to HIV exposure. A critical aspect of eradicating child marriage is developing and enforcing laws that set a minimum age of marriage of 18 years as this is the internationally accepted age of consent to marriage.

8.3.2 Key issues facing children in the context of HIV and TB

Globally, there are 3.4 million children living with HIV and about 16.6 million who have lost one or both parents to AIDS, millions more who have been affected by the epidemic in some way. The HIV epidemic affects children in many different ways. Children may be living with HIV and become ill or face discrimination. They may be touched by it through living in an affected household or when a parent or care-giver dies, resulting in them becoming homeless, having to drop out of school or even facing violence. Although fewer children are being born with HIV, adolescents are still at high risk of HIV exposure.

Children living with HIV have the right to the "highest attainable" standard of health and this should include access to ARVs. They are also entitled to be treated equally. Children affected by HIV have the right to be protected from abuse, discrimination, being forced into leaving school at a young age and having to do inappropriate work. All children have right to information on HIV, how to protect themselves from infection and how to access care.

Likewise, children's rights are important in the context of TB as almost half a million children are infected with TB every year and about 10 % of these children die annually. Just like adults with TB, they may face many rights violations including not being provided with adequate treatment and discrimination.

Learning Activity 1: Why are children's rights important in the context of HIV and TB?

Read each scenario and then answer the questions below it.

When I was at school, my school mates treated me badly because I had a rash on my skin. Everyone said that I had AIDS and no one wanted to play with me. So I decided not to go to school anymore. I stay at home and I don't have any friends. I don't feel like taking my medication anymore.

- What rights are being violated in this scenario?
- Who should assist the child by protecting their rights?

I am 17 years old and I am the head of my family. I have a sister who is 12 years old and a brother who is 5 years. I do not go to school anymore and I push trolleys at the supermarket. I earn a small amount each day but sometimes I get more at month end. My brother has HIV and is very sick. I cannot afford to buy him good food to eat. I worry all the time.

- What rights are being violated in this scenario?
- Who should assist the child by protecting their rights?

I am a nurse at a local clinic. I have been treating a 6 month olf baby for repeated infections. I am concerned that she is HIV positive. I have counselled her mother on the importance of having her baby tested for HIV but she says there is no need and her baby is fine. I feel very frustrated as I fear that the baby may die of HIV if it is not treated.

- What rights are being violated in this scenario?
- Who should assist the child by protecting their rights?

My mother is dead and my father left. I am 14 and I live with my aunt and uncle. They will not let me go to school and they make me work at the factory until 6pm every night. My uncle comes to my room at night and rapes me. He says that if I tell anyone, he will throw me out and I have nowhere to go. I think that I have something wrong as I have a discharge. I want to go to the clinic, but the sister there is a friend of my aunt.

- What rights are being violated in this scenario?
- Who should assist the child by protecting their rights?

8.3.3 Who is responsible for protecting and promoting the rights of children?

Parents or legal guardians are responsible for children. They must provide for their basic needs and protect their rights. Where parents or guardians cannot care for a child, the *Convention on the Rights of the Child* (CRC) says that there is an obligation on the state to assist, for example, if a parent is unemployed and doesn't have any money for food then the government should help by providing a social grant to the family. If a child does not have a parent or guardian there is an obligation on the state to assist in placing the child in alternative care.

8.4: How do you Protect the Rights of Children in the context of HIV?

There are many binding and non-binding international law documents that can be used to protect the rights of children affected by HIV. These include:

8.4.1 The Convention on the Rights of the Child

The CRC was adopted by the UN in 1989. It is regarded as a turning point in the struggle for children's rights as it was the first time that the international community recognised children needed a special convention. The CRC is important as it provides a universal set of standards against which we can measure and improve the treatment of children.

The CRC sets out the rights of children in 54 articles. It describes the basic human rights of children to survival, to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life.

The CRC is based on what are called the four pillars. These are the 4 most important principles relating to children's human rights, they are the right to:

- Non-discrimination and to be treated equally
- Have their best interests considered in all decisions affecting them
- Survival (food, clothing, shelter etc) and development (education)
- Participate in decisions that affect them.

Case study 3: Using the principles in the CRC to promote children's rights in domestic law

In the case of *Motlogelwa v Khan the High Court* in Botswana had to determine which parent should have custody of the children. In this case the court held that even though the CRC hd not been fully domesticated into Botswana law, given that Botswana was a party to the CRC, courts must consider its key principles such as the best interests of the child in any matter involving children.

Source: Motlogelwa v Khan 2006 2 BLR147 HC

The CRC does not specifically refer to HIV, AIDS or TB in any of its articles. However, the Committee on the Rights of the Child, a body set up to monitor the way in which states implement the CRC, has issued General Comment No. 3 which deals specifically with how governments should respond to HIV. This comment recommends that states undertake interventions in a number of key areas. In all of these areas they should ensure that there are programmes and services that meet the needs of children. These include:

- HIV prevention and education
- Treatment and care
- HIV testing and counselling.

The General Comment also identifies some children who are living in particularly vulnerable circumstances; these include orphans, the victims of sexual or economic circumstances, children facing violence or abuse and those who are dependent on substances. Governments must pay special attention to these groups and make sure that all policies and programmes address their special needs.

Learning Activity 2: The Convention on the Rights of the Child

Read a copy of the Convention on the Rights of the Child and answer the following questions:

1.Is there a right to equality in the CRC?

YES	NO

Would a child of 19 who heads up a child headed household be protected by the CRC?

YES	NO

Justify your answer:

2. Do children have the right to life?

YES	NO

3. Does the right to life mean that children may not be executed until they are 18?

4. Do AIDS orphans have the right to play?

YES	NO

5. Which article says that adults must do what is best for children?

6. What are the factors that we should take into account in deciding what is best for children?

7. Susan, is 8 she lives in country A. She was born in Country A but her father was a foreign national who only lived in Country A for a short time. Susan's mother is a citizen of Country A. Can Susan be considered a national of Country A?

YES	NO

8. What are children's socio-economic rights?

9. James is 16 and he does not want to go to school any more. He wants to join the army instead. His parents refuse to let him leave school. They say they will punish him if he drops out of school before he gets a school leaving certificate. Does James have a right to have his views on going to school taken into account?

10. Do adolescents have the right to keep their HIV status confidential and not tell their parents?

11. Do HIV positive children have the right to ARVs?

YES	NO

Justify your answer:

8.4.2 The African Charter on the Rights and Welfare of the Child

The *African Charter on the Rights and Welfare of the Child* (ACRWC) was adopted by the Organisation of African Unity in July 1990. It is important as it was the first regional treaty to describe the rights of the child and to set minimum standards on how governments could protect children. The ACRWC has 48 articles and is very similar to the CRC.

Some of the key children's rights in the ACRWC include articles:

- Prohibiting marriages involving children
- Prohibiting the use of children to beg
- Prohibiting the recruitment of children in armed conflicts
- Giving girls the right to go back to school after being pregnant
- Protecting pregnant women who are in prison and mothers of young children who are in prison.

The ACRWC does not specifically refer to HIV but its articles are broadly written and could be used to protect infected and affected children.

8.4.3 The International Guidelines on HIV/AIDS and Human Rights

Guideline 8 of the UNAIDS HIV/AIDS and Human Rights International Guidelines deals with children and other vulnerable populations. This Guideline say that:

> *States should, in collaboration with and through the community, promote a supportive and enabling environment for women, children and other vulner-able groups by addressing underlying prejudices and inequalities through community dialogue, spe¬cially designed social and health services and sup-port to community groups.*

The Guideline recommends that governments take steps to reduce the vulnerability of children to HIV and to address the impact it may have on them through amongst others:

(i) Supporting community organisations working with children
(ii) Providing HIV prevention, care and support to children
(iii) Ensuring that girl children have access to information and counselling on HIV prevention
(iv) Providing health information and sexual and reproductive services to all children
(v) Training health care workers on how to provide health services to children.

8.4.4 The Final Report of the Global Commission on HIV and the Law (2012)

The Global Commission on HIV and the Law was a body established by the United Nations Development Programme. In 2012 after considerable investigation and consultation across the world, it produced a report entitled *Risks, Rights and Health* which made recommendations on how governments should respond to the HIV epidemic.

In order to protect and promote children's rights it recommends that governments amongst others:

- Ensure that there is an accessible process for transferring guardianship so that orphans are not left without a legal guardian
- Introduce HIV-sensitive social protection systems
- Prohibit unfair discrimination against children living with HIV and children from affected families
- Protect children from losing their inheritance through property grabbing
- Ensure that children have a right to health education
- Reform laws relating to a child's sexual and reproductive rights to facilitate access to appropriate HIV prevention and care services.

8.5: Key Laws and Policies Providing Access to Services for Children in Southern and East Africa

8.5.1 Non-discrimination

Article 2 of the CRC provides that every child has the right to be free from discrimination on a number of different grounds including race, sex, language or "other status". It doesn't list HIV status as a ground of non-discrimination but the Committee on the Rights of the Child has interpreted the words "other status" to include the HIV status of a child or their parents.

In General Comment No. 3 issued in terms of the CRC it is recommended that countries adopt laws or policies, strategies and practices to address all forms of discrimination affected children including HIV-related stigma and unfair discrimination.

Case Study 4: Protective law in Burundi

Law 1/018 of 12 May 2005 on the Legal Protection of People Infected with HIV and of People Suffering from AIDS in Burundi provides in Article 32 that "children of infected persons, whether they themselves are infected or not, may not be denied admission or stay in public or private education centres, nor be the object of discrimination on any given pretext".

Case Study 5: Protective law in the Comoros

A new Bill called the Bill on the Rights of Persons Living with HIV and their Involvement in the Fight against AIDS, expressly protects children. It provides that children living with HIV and orphaned by AIDS have rights to, amongst others, privacy, health, education, awareness and access to information and protection against all forms of violence and abuse that could harm them.

Source: ARASA (2014) HIV and Human Rights in Southern and East Africa Report

8.5.2 HIV testing

General Comment No. 3 of the CRC recommends that governments recognise the evolving capacity of the child and ensure that they have access to voluntary, confidential HIV counselling and testing services.

Case Study 6: Draft law in Zanzibar facilitates access to HIV testing for adolescents

The HIV and AIDS Prevention and Management Bill (2011) in Zanzibar provides special protection for the rights of children and permits children above the age of 15 to undergo HIV testing without parental consent, providing they are mature enough to understand the consequences of their decision.

Source: ARASA (2014) HIV and Human Rights in Southern and East Africa Report

8.5.3 Access to prevention and treatment services

General Comment No. 3 of the CRC provides that children and adolescents have the right to access adequate information related to HIV prevention. This places an obligation on governments to create a legal and policy framework to ensure that this tales place and they ought to introduce youth programmes with both those in and out of school.

Case Study 7: Progressive education law in Kenya

The Kenyan HIV and AIDS Prevention and Control Act 14 of 2006 provides that the ministry responsible for education must provide information on the causes and modes of HIV transmission in "public and private schools at primary, secondary, and tertiary levels, including informal, non formal and indigenous learning systems".

A key issue for adolescents is ensuring that they have access to HIV prevention services such as condoms, HIV testing, treatment for sexually transmitted infections (STIs), access to male circumcision and anti-retroviral (ARV) treatment. A key barrier to youth accessing these services in many countries is the age at which they can consent independently to such services. Many countries in the region require children to be accompanied by their parents until they reach the age of 18; this discourages adolescents from using such services.

Table 2: Age of consent to various health interventions in selected Southern and East African countries

Country	Age of Consent	Age of Majority
Burundi	21	21
Botswana	No age of consent to medical treatment, but boys can consent to male circumcision at 16, and all children can consent to HIV testing at 16	18
Kenya	No age set in law, a minor may consent to HIV testing if they are married, pregnant or at high risk of HIV infection	18
Lesotho	12, contraceptives 12 for medical treatment and HIV testing	18
Mauritius	18, HIV testing permissible independently if the minor has understanding	18
Namibia	18	21
Seychelles	18	18
South Africa	12, contraceptives 12 for medical treatment and HIV testing	18
Tanzania	No age set in law	18
Zambia	21	Not defined
Zimbabwe	No age set in law	18

Source: UNICEF (2011) and Centre for Human Rights (2010)

The CRC provides in Article 24 that states should "recognize the right of the child to the enjoyment of the highest attainable standard of health". General Comment No.3 of the CRC provides further that this means that children have the right to consistent and equal access to HIV medication such as ARVs.

8.5.4 Confidentiality

Inappropriate disclosure of a child's HIV status could lead to discrimination and abuse. General Comment No. 3 of the CRC provides that every child that consents independently to an HIV test is entitled to confidentiality regarding their HIV status.

8.5.5 Orphans and vulnerable children

The African Committee of Experts on the Rights and Welfare of the Child, a body established by the African Charter on the Rights and Welfare of the Child, developed a Plan of Action on Orphans and Vulnerable Children (OVC). This emphasises the need for resource allocation to facilitate programmes to OVC. The Action Plan also highlights the importance of:

- Developing national strategies to enable OVCs to attain their full physical, mental, spiritual, moral and social development
- Meeting the special needs of OVCs by strengthening the capacity of care givers, providing OVCs with essential services, providing social protection and facilitating a supportive environment through child centred community development
- Poverty elimination
- Developing broad partnerships.

Case Study 8: Children's law in Malawi protects OVC

The Child Care, Justice and Protection Act has strengthened children's rights, and in particular the rights of orphaned and vulnerable children to care. However, it does not deal with children's health rights broadly or specifically in the context of HIV and AIDS.

Source: ARASA (2014) HIV and Human Rights in Southern and East Africa Report

8.6 Participation and Inclusion

One of the key pillars of the CRC is the principle of child participation. Article 12 of the CRC says that governments must ensure that a child: "who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child".

This article places an obligation on governments to encourage children to express their views, and have their views considered in accordance with their age and maturity. This principle applies equally to HIV related laws and policies that affect children. Mechanisms should be put in place so that children can be consulted on issues such as appropriate HIV prevention programmes.

8.7: Unit Summary

1. Children are entitled to most human rights and they also are protected by a special subset of rights called children's rights. Children's rights only protect people under the age of 18 years.
2. Without protection of the right to health, children living with HIV and TB may be denied treatment and support. Additionally, those affected by HIV and TB may be vulnerable to exploitation and abuse through the impact of illness on the family structure.
3. Athough the CRC and the ACRWC do not specifically refer to HIV, their provisions are broad enough to protect infected and affected children.
4. The *UNAIDS HIV/AIDS and Human Rights International Guidelines* require governments to take steps to support organisations working with children, facilitate access to HIV prevention and ensure all children have access to information and services to promote their sexual and reproductive health.

Summative Assessment

Complete the following quiz to assessment your knowledge of children's rights and HIV and TB. Tick whether each of the following statements is true or false

Question	True	False
The Convention on the Rights of the Child considers anyone under the age of 18 to be a child and therefore to have special protections		
It is appropriate to exclude children from some rights because of their age e.g. the right to vote		
If parents or guardians are not able to care for children, the state must take steps to help		
Children cannot consent to have an HIV test without the permission of their parents or guardians		
Children should be able to participate in decisions affecting their lives if they have the maturity to do so		

8.8: Unit Outcomes Checklist

Use the checklist below to see whether you have met the outcomes that were set for this unit.

Outcome	Yes, I have met this outcome	No, I have not met this outcome	These are the things I still need to revise
Aware that children are entitled to most human rights			
Able to discuss how children's rights are special rights given to persons under the age of 18			
Understand why children's rights are important in the context of HIV and AIDS			
Know who is responsible for protecting children's rights			
Be aware of the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child			
Know what the HIV/AIDS and Human Rights Guidelines say governments should do to protect the rights of children			
Be able to identify some key laws and policies affecting HIV prevention and treatment services for children			

8.9 Resources and References

8.9.1 Useful websites

Centre for Child Law, University of Pretoria, South Africa
http://www.centreforchildlaw.co.za/

Community Law Centre, University of the Western Cape, South Africa
http://www.communitylawcentre.org.za/children

Defence for Children International
http://www.defence-for-children.org

Save the Children USA
http://www.savethechildren.org

Save the Children UK
http://www.savethechildren.org.uk

UNICEF
http://www.unicef.org

8.9.2 Useful resources

African Charter on the Rights and the Welfare of the Child
http://www.au.int/en/sites/default/files/Charter_En_African_Charter_on_the_Rights_and_Wlefare_of_the_Child_AddisAbaba_July1990.pdf

Convention on the Rights of the Child
http://www.ohchr.org/en/professionalinterest/pages/crc.aspx

CRC, General Comment No.3 (2003): HIV/AIDS and the Rights of the child, Committee on the Rights of the Child
http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G03/408/16/PDF/G0340816.pdf?OpenElement

Global Commission on HIV and the Law (2011) Children and HIV: Using an evidence-based approach to identify legal strategies that protect and promote the rights of children infected and affected by HIV and AIDS: Working Paper
http://www.hivlawcommission.org/index.php/working-papers?task=document.viewdoc&id=88

Motlogelwa v Khan 2006 2 BLR147 HC

UNAIDS and UNOHCHR (2006) International Guidelines on HIV/AIDS and Human Rights
http://www.ohchr.org/Documents/Issues/HIV/ConsolidatedGuidelinesHIV.pdf

Workplace Rights

unit 9

9.1: Introduction

This section looks at HIV in the workplace. Southern and East African countries have made significant progress introducing (or interpreting existing) anti-discrimination laws and workplace HIV policies to protect the rights of workers with HIV. Despite this, many people living with HIV experience stigma, discrimination and other abuses in their workplaces. This module focuses on building the capacity of learners to recognise human rights violations against workers with HIV or perceived HIV and to advocate for workplace policies and anti-discrimination laws that promote their human rights.

9.2: Unit Outcomes

At the end of this unit you should be able to:

- Understand that people living with HIV experience human rights violations related to their HIV status or perceived HIV status in the workplace.
- Understand that migrant workers may be particularly vulnerable to HIV and struggle to access HIV prevention, treatment and care. Female migrants may face sexual violence and exploitation during their journey or when they arrive and require access to comprehensive post-rape care and HIV treatment, care and support.
- Understand that anti-discrimination laws and HIV workplace policies protect the right to work of people living with HIV and also protect them from stigma and discrimination.
- Identify the key elements of a rights-based approach to HIV workplace policies.

9.3: Workplace Law and HIV

9.3.1 Right to work, fair labour practices and HIV

The right to work is protected in various international and regional human rights instruments.

See Module 1: Unit 2 - Introduction to Human Rights for more information on human rights.

See Module 1:Unit 4 - International and Regional Human Rights Commitments and Guidance for more information on international and regional human rights instruments.

Every worker has the right to a safe workplace and that includes the right to be protected from getting infected with HIV at work.

HIV is recognized as a threat to the workplace as it often affects women and men during the prime of their working life, when they should be the most productive. In the early days of the epidemic when anti-retroviral treatment (ART) was not readily available or very expensive, especially in public health systems. HIV-related illnesses contributed to absenteeism and a loss of productivity. People were frightened about whether HIV could be transmitted in the workplace and employers introduced measures they thought could protect their businesses and other employees from HIV e.g. mandatory pre-employment HIV testing, excluding job applicants with HIV and forcing employees to disclose their HIV status.

Employees with HIV or those who were perceived to have HIV experienced stigma and discrimination and many were treated unfairly, missed out on opportunities for promotion and training or even lost their jobs. Reports of discrimination against employees with TB are also increasing in the region.

See Module 3: Unit 1 - Stigma and Discrimination, for more information on HIV-related discrimination.

As a result of civil society activism, significant progress has been made to protect the rights of workers with HIV in Southern and East Africa. Many countries have laws and policies that protect employees with HIV from discrimination and have introduced workplace programmes that challenge stigma.

Table 1: Country laws on HIV and the workplace

Country	
Angola	Law on HIV and AIDS, 2004 prohibits discrimination in the workplace
Botswana	Public Service Code of Conduct on HIV/AIDS and the Workplace, 2001 says that employers must create a non-discriminatory environment Public Service Act, 2008 prohibits unfair discrimination on the basis of health status Botswana National Code of Practice on HIV/AIDS and Employment discourages pre-employment HIV testing
Comoros	The draft Bill on Rights of Persons Living With HIV and their Involvement in the Struggle Against AIDS protects against discrimination on the grounds of HIV status, prohibits pre-employment HIV testing and dismissals on the grounds of HIV status.
DRC	HIV/AIDS Law 08/011 prohibits discrimination in the workplace and provides that HIV status or presumed status cannot be used to terminate or refuse someone employment; prohibits compulsory HIV testing and employers cannot disclose the HIV status of employees
Kenya	The Employment Act prohibits discrimination on the grounds of HIV and AIDS and HIV status cannot be a ground for dismissal. The Public Sector Workplace Policy on HIV and AIDS also prohibits HIV-related discrimination and states that HIV should be mainstreamed into the core activities of all public sector organisations.
Lesotho	The Public Service HIV and AIDS in the Workplace Policy prohibits unfair discrimination and mandatory testing. The Labour Code (Amendment) Act, 2006 prohibits unfair discrimination and mandatory HIV testing. It protects confidentiality of employees.
Madagascar	Law 2005–040 prohibits unfair discrimination and pre-employment testing. HIV status cannot be used to disqualify someone from employment
Malawi	Code of Conduct on HIV/AIDS and the Workplace prohibits discrimination against employees with HIV
Mauritius	HIV Act 2006 prohibits pre-employment testing
Mozambique	The Act on Defending the Rights and the Fight Against Stigmatisation and Discrimination of People living with HIV and AIDS, 2008 (as amended) prohibits discrimination in the workplace.
Namibia	The National Code on HIV/AIDS and Employment, 2000 prohibits unfair discrimination and pre-employment testing. Labour Act, 2008 lists HIV status as a prohibited ground of discrimination in access to or continued employment
Seychelles	The Employment Act and the National HIV/AIDS Workplace Policy protect against HIV-related discrimination

Country	
South Africa	Employment Equity Act, 1998 prohibits unfair discrimination on the grounds of HIV status. The Code of Good Practice of Key Aspects of HIV/AIDS and employment (attached to the Employment Equity Act) provides guidance on creating a non-discriminatory environment
Swaziland	Employment Act, 1980 (not HIV specific) but employers may not discriminate in any employment contract on various grounds
Tanzania	HIV and AIDS (Prevention and Control) Act, 2008 states that no-one can be denied an employment opportunity because of their HIV status and it prohibits mandatory testing. It also states that employers should establish workplace programmes.
Uganda	The Employment Act and the HIV Prevention and Control Act both prohibit discrimination on the grounds of HIV status.
Zambia	Employment Act Cap 268 and Industrial Relations Act Cap 269 (not HIV specific) but protects workers from discriminatory practices.
Zimbabwe	Regulations under the Labour Relations Act, part II, prohibit discrimination on HIV/AIDS in the workplace.

As ART became more accessible, people living with HIV are increasingly able to continue working and HIV can be treated as any other serious, chronic illness.

9.3.2 Key issues for workers with HIV

Despite the introduction of laws and workplace HIV policies by many countries, employees still experience abuses because of their HIV status or perceived status:

Stigma and discrimination

Many people living with HIV experience stigma and discrimination during the recruitment process, during their employment and when they are unfairly dismissed.

Examples of stigma and discrimination in the workplace

- **Pre-employment HIV testing (testing job applicants for HIV and refusing to hire those who test positive)**
- **Firing employees with HIV**
- **Denying benefits to employees with HIV**
- **Co-workers refusing to work with employees with HIV**
- **Breaches (breaking) of confidentiality**

Workers also report losing out on training and promotion opportunities, and being treated differently to colleagues.

Dismissal on the grounds of HIV status is one of the more common forms of discrimination and workers with HIV not only lose their jobs and their income, but may also lose access to health insurance, both of which could adversely affect their access to treatment.

Access to workplace benefits, including treatment

Many workers report discrimination in access to workplace benefits e.g. medical and life insurance. Employees living with HIV may be required to have an HIV test as a pre-condition for cover and employees with HIV may be excluded from certain benefits. A small, yet significant number of people living with HIV still report being denied access to health or life insurance. In Kenya, 5.5% of respondents in the *People Living with HIV Stigma Index* reported being denied access to medical or life insurance as a result of their HIV status, while in Uganda, 4.3% and Mauritius, 5% reported being denied access.

If workers are not able to access treatment, HIV can contribute to absenteeism, declining productivity and reinforce stigma and discrimination.

Migrant workers

Migrant workers face stigma and discrimination on the grounds of their undocumented or perceived undocumented status that negatively impacts on their access to HIV prevention, treatment, care and support. Migrant workers who are undocumented may not be legally entitled to access medical treatment, including HIV-related services, through public health systems or workplace programmes. They may experience treatment interruption if they are arrested, detained or deported, or it may be difficult because of language barriers and lack of money to access available care.

Undocumented workers may also experience violations of their labour rights which can contribute to their risk of HIV or undermine their access to treatment and care. Employers may not allow them time off to attend hospital or doctors' appointments, and they may not be able to take sick leave.

Female migrants are vulnerable to sexual violence and exploitation, and not be able to access post-rape care, including post-exposure prophylaxis (PEP) to reduce their risk of HIV. They may also not have access to health care.

Transportation workers, especially long-distance truck drivers are also at higher risk of HIV infection, as are migrant mine workers.

Learning Activity 1: Stigma and discrimination in the workplace

People living with HIV experience various forms of stigma and discrimination in the workplace based on their HIV status or perceived status.

Learners should think about their own experiences in the workplace and where workers with HIV may experience abuses and what the outcomes will be for workers.

Examples of workplace stigma and discrimination

The *Stigma Index* asks respondents to answer questions about their experiences of stigma and discrimination in the workplace. The results show that HIV-related stigma and discrimination are serious concerns in many East and Southern African countries

- **33% of respondents who were or had been employed reported having been refused a job as a result of their HIV status. *Stigma Index*, Mauritius, 2013**
- **33% of respondents who lost jobs cited their HIV status as the main reason or part of the reason for the loss. *Stigma Index*, South Africa (Eastern Cape Province, 2012)**
- **48% of respondents were denied employment or a work opportunity because of their HIV status. *Stigma Index*, Tanzania, 2013**
- **16.5% of respondents reported being refused a job or work opportunity in the previous 12 months because of their HIV status. *Stigma Index*, Zambia 2012**

Source: People Living with HIV Stigma Index Studies www.stigmaindex.org

9.4: How do you Protect Workers' Rights in the context of HIV?

Southern and East African countries have adopted different ways to promote the rights of employees with HIV to equality and non-discrimination and manage the impact of HIV on workplaces. These include:

- Developing workplace specific anti-discrimination laws that specifically prevent discrimination because of HIV or changing existing anti-discrimination laws to include HIV
- Promoting workplace laws, guidelines and policies that promote the principles of the *Greater Involvement of People Living with HIV* (GIPA) in all workplace responses
- Developing a national policy or employment code on managing HIV in the workplace.

9.4.1 Laws to promote equality and non-discrimination

Guidance: Guideline 5 of the *International Guidelines on HIV/AIDS and Human Rights*

Guideline 5 of the International Guidelines on HIV/AIDS and Human Rights recommends that States enact or strengthen anti-discrimination laws to protect vulnerable groups, people living with HIV and people with disabilities. The guideline has specific recommendations on HIV in the workplace and recommends that laws, policies and collective agreement should promote the following rights:

- **Employees should be free from HIV screening for employment, training and benefits**
- **Confidentiality regarding all medical information, including HIV status, should be guaranteed**
- **Employment security, including reasonable alternative working arrangements, until they are no longer able to work**
- **Defined safe practices for first aid and properly equipped first aid kits**
- **Protection for their social security and other benefits, including life insurance, pension, health insurance, termination and death benefits**
- **Adequate health care accessible in or near their workplaces**
- **Adequate supply of free condoms should be available**
- **Worker participation in decision-making on issues related to HIV**
- **Access to information and education programmes on HIV**
- **Protection from stigma and discrimination from colleagues, unions, employers and clients**
- **Inclusion in workers' compensation legislation for occupational transmission of HIV**

Source: UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights

Anti-discrimination laws and policies should not only specifically identify HIV status or perceived HIV status as a ground of discrimination, they must also specify what conduct is banned - such as mandatory HIV testing and screening, unlawful disclosure of HIV status, loss of benefits and dismissal on the grounds of HIV status - and mandate the development and implementation of HIV workplace policies.

The Southern African Development Community Parliamentary Forum (SADC PF) Model Law on HIV in Southern Africa, 2008 provides useful guidance for the development of workplace anti-discrimination laws. It explicitly prohibits any form of discrimination in the workplace against a person, his or her partner(s) or close relatives on the "sole account of his or her actual or perceived HIV status". It places an obligation on employers to bring disciplinary procedures against any employee who discriminates against another employee on the account of the latter's actual or perceived HIV status. The person who suffered the discrimination can sue the employee that discriminated against them.

SADC PF Model law on HIV in Southern Africa, 2008

The model law recommends that workplace anti-discrimination laws also address the following:

- Implementation of universal precautions to reduce the risk of HIV transmission in the workplace
- Free access to PEP and counselling if accidental exposure occurs
- HIV status cannot be used to refuse someone, their partners or close family members a job or terminate their employment. Fitness for work should be the relevant standard in all matters related to employment
- No HIV testing for the purposes of recruitment, promotion or any other reason
- No-one can disclose the HIV status of a job seeker, employee or co-worker
- There should be reasonable accommodation for employees with AIDS-related illnesses
- When employees with AIDS-related illness are no longer able to fulfil their duties on the account of poor health, they shall benefit from rights pertaining to employees affected by a long-term illness.

9.4.2 Workplace HIV Policies

Workplace policies are important tools to promote equality and non-discrimination for workers with HIV.

SADC Code on HIV/AIDS and Employment

One of the most important regional achievements on HIV has been the adoption of the SADC Code on HIV/AIDS and Employment in 1997. The Code is based on the principle that workers with HIV or AIDS should not be discriminated against and should be treated like any other worker with a health condition.

International Labour Organisation (ILO) Guidance

The ILO has issued policy guidance to help employers manage HIV in the workplace. In 2001, it issued its Code of Practice on HIV/AIDS and the world of work.

In 2010, the ILO adopted its first labour standard on HIV which is intended to build on the ILO Code of Practice. This recommendation protects all workers, including those who are in the informal economies, job applicants, people in training and those who have been laid off. It also protects soldiers and people in the armed forces.

Guidance: The SADC Code on HIV/AIDS and Employment

The SADC Code provides for:

- **Education, awareness and prevention**
- **No pre-employment HIV testing for job access**
- **No workplace testing or testing for training purposes**
- **Confidentiality**
- **No demotion or dismisssals for being HIV positive**
- **Occupational benefits (like medical aid)**
- **Management of occupational infection with HIV, including compensation**
- **Protection against victimisation**
- **Grievance handling**
- **Information**
- **Monitoring and review of HIV workplace policies and programmes.**

The Code has been very important for the region because it led to a number of countries (such as South Africa, Malawi, Mozambique, Zimbabwe and Namibia) developing their own national codes or HIV-specific legislation and it strengthened advocacy activities against pre-employment HIV testing which has been widely practiced within the region. As a result of this advocacy, many countries have stopped the practice of employment related HIV testing.

Guidance: Key principles of ILO Recommendation concerning HIV and AIDS and the world of work (No 200 of 2010)

- **The HIV response should contribute to human rights, fundamental freedoms and gender equality for all**
- **Non-discrimination and stigmatization of workers on the grounds of real or perceived HIV status**
- **Prevention of HIV transmission should be a fundamental priority**
- **Workplaces should facilitate access to prevention, treatment, care and support**
- **Prevention efforts should address the specific risks related to occupational transmission of HIV, TB and related diseases**
- **Employers should ensure confidentiality and privacy**
- **No mandatory HIV testing or screening for employment purposes**
- **The workplace response must be part of the national response to HIV.**

Learning Activity 2: Developing a workplace policy

Get copies of the SADC Code on HIV/AIDS and Employment and the latest ILO guidance. Once you have read the materials, set out the key elements of a workplace policy on HIV.

9.5: Unit Summary

1. The right to work is protected in various international and regional human rights instruments.

2. Every worker has a right to a safe workplace and that includes the right to be protected from HIV transmission in the workplace.

3. HIV is recognized as a threat to the workplace as it often affects women and men during the prime of their working life.

4. Employees with HIV or those who were perceived to have HIV experienced stigma and discrimination and many were treated unfairly, missed out on opportunities for promotion and training or even lost their jobs.

5. Many countries have laws and policies that protect employees with HIV from discrimination and have introduced workplace programmes that challenge stigma.

6. Workplace policies are important tools to promote equality and non-discrimination for workers with HIV.

Summative Assessment

Complete the following quiz to assess your knowledge of worker's rights. Tick whether the following statements are true or false.

Question	True	False
Employers can test employees to see whether they have HIV		
Anti-discrimination laws can be a good way to protect employees with HIV from discrimination		
Workers with HIV cannot work and can be fired		
Employees have to disclose their HIV status to their employers		

9.6: Unit Outcomes Checklist

Use the checklist below to see whether you have met the outcomes that were set for this unit.

Outcome	Yes, I have met this outcome	No, I have not met this outcome	These are the things I still need to revise
Understand why it is important to address HIV in the workplace			
Identify HIV-related stigma and discrimination in the workplace			
Identify the key elements of an HIV workplace policy			
Understand international and regional guidance on HIV in the workplace			
Be able to discuss the specific vulnerability of migrant workers			

9.7 Resources and References

9.7.1 Useful web sites

International Labour Organisation (ILO)
http://www.ilo.org/global/topics/hiv-aids/lang--en/index.htm

ILOAIDS
http://www.ilo.org/aids/Aboutus/lang--en/index.htm

Stigma Index studies
www.stigmaindex.org

SADC and HIV
http://www.sadc.int/issues/hiv-aids/

EAC
http://www.eac.int/health/index.php?option=com_content&id=141:hiv-and-aids&Itemid=160

9.7.2 Useful resources

ILO Code of Practice on HIV/AIDS and the world of work 2001
www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_113783.pdf

ILO Recommendation concerning HIV and AIDS in the World of Work No 200 of 2010
http://www.ilo.org/aids/Publications/WCMS_157866/lang--en/index.htm

SADC PF Model law on HIV in Southern Africa, 2008
http://www.justice.gov.za/vg/hiv/docs/2008_Model-Law-on-HIV-in-Southern-Africa.pdf

Key Human Rights Programmes

unit 10

10.1: Introduction

This unit describes seven key human rights programmes to respond to HIV and TB-related stigma and discrimination in Southern and East Africa. It explains how to protect rights in the context of HIV and TB by strengthening laws and policies, access to justice and enforcement, with examples from the region.

A lot of the information in this section is based on the AIDS Alliance (2013) *HIV and Human Rights Good Practice Guide*. Please refer to the Guide for additional information.

10.2: Unit Outcomes

At the end of this unit you should be able to:

- Name seven key human rights programmes for rights-based responses to health issues such as HIV and TB
- Understand why rights-based responses are important
- Describe each of the seven key human rights programmes and how we can use them
- Give concrete examples of each of the seven key human rights programmes.

10.3: What are Key Programmes for Rights-based Responses to HIV and TB?

10.3.1 What are key programmes for rights-based responses to HIV and TB

UNAIDS recommends that countries consider implementing specific rights-based programmes to protect rights and promote universal access to health care services in the context of HIV and TB.

It suggests seven key programmes to reduce stigma and discrimination and to strengthen access to justice in national responses to HIV and TB:

- Stigma and discrimination reduction programmes
- Legal support services
- Monitoring and Law Review and Reform
- Legal literacy e.g *Know your Rights*
- Sensitising law makers and law enforcement officials
- Training for health care workers
- Reducing gender inequality, harmful gender norms and gender-based violence.

10.3.2 Why do we need these programmes?

Human rights programmes are critical to promoting an enabling legal and regulatory environment for HIV and TB. Together, the programmes help to create:

- A protective legal and regulatory framework that protects the rights of people living with HIV and key populations in the context of HIV and TB
- Strengthened access to justice through creating increased awareness and sensitisation around human rights and gender equality and increased access to legal support services
- Sensitised law enforcement officials.

Table 1: Key Human Rights Programmes for HIV & TB Response

The programmes	How can you use them?
Stigma and discrimination reduction programmes	These programmes help to reduce actionable causes of stigma and discrimination. This empowers people affected by HIV and TB and creates a protective environment.
Legal literacy programmes	Legal literacy programmes teach people living with HIV and TB and key populations about laws, their rights and how to enforce them. This helps to strengthen access to justice.
Monitoring, law review and reform	Programmes to monitor, review and reform laws help to create a protective environment with laws and policies that support rather than block access to HIV, TB and health services.
Legal support services	These programmes facilitate access to justice and redress in cases of HIV and TB-related human rights violations.
Training for health care workers on human rights and medical ethics	Training programmes improve healthcare workers' understanding of their own and their patients' rights. This helps to reduce stigma and discrimination in the health sector and create a more protective environment for people living with HIV and key populations.
Sensitisation of lawmakers and law enforcement officials	These programmes sensitise lawmakers and law enforcers about how the law impacts on HIV and TB and about the rights of key populations. This helps to create an environment that protects rights as well as improves law enforcement for human rights violations.
Reducing gender inequality, harmful gender norms and gender-based violence	These programmes address gender inequality, harmful gender norms and gender-based violence as both causes and consequences of HIV infection. They help to create a more protective environment as well as to strengthen access to justice and improve law enforcement for gender equality.

Source: AIDS Alliance and ARASA (2013) HIV and Human Rights Good Practice Guide

10.4: Stigma and Discrimination Reduction Programmes

10.4.1 What are stigma and discrimination reduction programmes?

Stigma and discrimination reduction programmes are programmes aimed at reducing stigma and discrimination around HIV, AIDS, TB and affected populations.

These programmes specifically aim to reduce stigma and discrimination amongst individuals and communities. They work to address the causes of stigma and discrimination and to empower people living with HIV and other key populations.

10.4.2 Why are they important?

Stigma and discrimination violate the rights of people living with HIV and of key populations and are major barriers to universal access to prevention, treatment, care and support services.

Example: Why does stigma limit access to health care?

HIV-related stigma and discrimination distances people from important services and sources of care and support. They can't access information to help them reduce their risk. They may be afraid to have an HIV test or to disclose their HIV status to their sexual partners, families and friends. Stigma and discrimination can also undermine treatment where people hide or don't take their medicine in case it exposes their HIV status. This interrupts treatment and undermines health rights.

Stigma and discrimination reduction programmes work to address the root causes of stigma and discrimination – such as lack of understanding of how HIV is transmitted, prejudices and stereotypes and fear. These programmes work to change attitudes and actions towards people living with HIV and key populations. By reducing stigma and discrimination, affected populations are able to live with dignity. They are also more able to access important health care services that help them live better lives.

Self-Reflection Exercise 1: Responding to causes of stigma

Why do you think HIV is stigmatised in your country? Or alternatively, why do they think TB is stigmatised?

How could you respond to these causes in the way you develop a stigma and discrimination reduction campaign? What would you do to address these root causes of stigma and discrimination?

10.4.3 Key programmes and examples from Southern and East Africa

Examples of programmes include:

- Support groups of people living with HIV can share information and discuss fears with other community members
- TV and radio shows can include messages to reduce stigma and discrimination in relation to HIV and TB
- Community, religious and traditional leaders and celebrities can be asked to speak out against stigma and discrimination
- People living openly with HIV and representatives of key populations can take part in organisations, structures and processes to share the views of affected populations
- Stigma Index surveys can help to monitor acts of and reasons for stigma and discrimination.
- Stigma and discrimination reduction messages can be included in HIV and TB information and education programmes in hospitals, schools and workplaces.

Example: Stigma trainers' programme in Zambia

Alliance Zambia's Regional Stigma Training Programme integrates stigma and discrimination reduction within existing HIV programmes with different stakeholders. The team provides training, action planning and technical support for stigma reduction interventions across Africa.

This training addresses 3 main factors driving stigma and discrimination – a lack of awareness and understanding of stigma and discrimination; misguided fears of becoming infected with HIV and values and attitudes that link HIV with 'immoral' behaviour. Participatory exercises help trainees to identify, understand and change stigma and discrimination. For example a teacher in Zambia used his training to sensitise children at this school about HIV-related stigma and discrimination. The children encouraged a former learner to return to an accepting school community.

10.5: Legal Literacy

10.5.1 What are *Know Your Rights* campaigns?

Legal literacy programmes give information, education and training to people living with HIV and other key populations on human rights and laws relating to HIV and TB. Legal literacy helps us take action when our rights are violated because we know what our legal rights are.

10.5.2 Why are they important?

Information, education and awareness about human rights, health rights and the law helps to improve access to health care services. When people know their rights, it helps them to do things like avoid violence, negotiate safer sex, have an HIV status, disclose their HIV status or get treatment.

10.5.3 Key programmes and examples from Southern and East Africa

Legal literacy programmes can be included in other HIV, TB and health programmes. For example, Know Your Rights programmes can be dintroduced at hospitals and clinics while people are waiting to have an HIV test or get their medicine. They can also be stand-alone programmes to provide information about rights and law through, for example, the media, peer outreach or telephone hotlines. Some examples of programmes include:

- Awareness campaigns on human rights and law through TV, radio, print media and social media
- Community mobilisation and education workshops and training
- 'Edutainment' shows
- Training and awareness-raising through peer outreach
- Telephone hotlines and drop-in centres.

Example: Legal Advice Hotline

In South Africa, the South African National AIDS Council (SANAC) has developed a partnership with Legal Aid South Africa to develop a Legal Advice Helpline for people with HIV and TB. The Helpline will give people information about their rights. It will also help to refer them to legal support services to help them claim redress for human rights violations.

10.6: Law Review and Reform

10.6.1 What is monitoring and reviewing laws, regulations and policies?

Programmes to examine laws, regulations and policies that affect people living with HIV and key populations aim to create strong, supportive laws, regulations and policies. They help to:

- Collect information on the legal and regulatory framework
- Identify protective as well as discriminatory laws and policies
- Assess how these impact on HIV and on key populations
- Advocate for law review and reform to hold governments accountable for creating supportive laws and policies.

10.6.2 Why is it important?

Laws, regulations and policies can help us to protect our health. They can help to protect our rights to prevent us getting infected with HIV and TB and to get treatment, care and support. They can also help to reduce stigma and discrimination. Discriminatory and punitive laws, though, can block our access to health care services. They can increase stigma and discrimination and force key populations 'underground'.

10.6.3 Examples from Southern and East Africa

Many countries in Southern and East Africa have done audits or assessments of their laws, regulations and policies that impact on HIV, AIDS, TB and on affected key populations. These audits often include:

- A desk review of laws, regulations, policies and relevant research reports
- Informant interviews with key stakeholders and focus group discussions with key populations to understand how these laws are implemented and the impact of the laws, regulations and policies
- An analysis of the information
- An identification of protective laws and of punitive /discriminatory laws
- Recommendations for law and policy review and reform.

Case Study 1: Law Review and Reform in Mozambique

Mozambique developed an HIV law in 2009. The law had many protective provisions. But it also provided for the criminalisation of HIV transmission.

In 2013 a process started to review and reform the 2008 HIV law. The law was reviewed by civil society organisations working in partnership with UN agencies, parliamentarians and academics. The amended law was finally passed by Parliament to exclude the provision that criminalised HIV transmission.

10.7: Legal Support Services

10.7.1: What are legal support services?

Legal support services are services to help people to access justice when their rights have been violated. They help to make rights real by:

- Providing legal advice and assistance when rights are violated
- Helping people living with HIV and other key populations use redress mechanisms (like the courts or alternative dispute mechanisms) to enforce their rights
- Helping people living with HIV challenge violations of their rights by officials .

10.7.2: Why are they important?

Legal support services are a very important part of creating a protective legal and regulatory environment. Protective laws, regulations and policies are only effective if people living with HIV and other key populations know their rights and can claim them. Legal support services help by giving advice, referring people to complaints mechanisms and helping them use these complaints mechanisms.

10.7.3: Key programmes and examples from Southern and East Africa

Examples of legal support services include:

- Paralegal and human rights organisations that provide information, advice and referrals to people whose rights have been violated
- Networks of people living with HIV and key populations who have been trained to provide legal advice and referrals
- Legal aid clinics that provide legal advice and legal representation to help enforce claims in court
- Private lawyers providing pro bono legal support for HIV and TB-related complaints
- Alternative mechanisms, like human rights commissions and traditional courts, providing relief for human rights violations
- Organisations that take up strategic litigation in important cases relating to HIV and TB.

Self-Reflection Exercise 2: Accessing justice

One of the most common problems raised in many countries in southern and east Africa, is that people are not able to access justice when their rights are violated. They are not able to use the courts or other mechanisms available to seek redress.

Think about why people may be unable to access justice in your country. What are the possible reasons? How would you provide legal support services in a way that overcomes these obstacles?

10.8: Training Healthcare Workers and other Service Providers

10.8.1 What is training for health care workers?

Health care workers play an important role in helping affected populations to use health care services. Human rights training aims to train health care workers about the rights of patients in relation to HIV and TB. It helps to reduce stigmatising attitudes by giving health workers information, tools and skills to protect patient rights. It also aims to give health care workers information about their own rights as workers and as people also affected by HIV.

10.8.2 Why is it important?

All people have the right to health. However, people living with HIV and other key populations report many different violations of their rights in health care setting, such as:

- Being tested for HIV without giving voluntary and informed consent
- Breaches of their confidential HIV information
- Being denied access to health care services
- Being forced to take treatment for TB (especially MDR and XDR TB)
- Being forced or coerced into sterilisation (in the case of women with HIV) and
- Being humiliated by health care workers (especially in the case of sex workers and LGBTI populations).

Human rights training for health care workers reduces stigma and discrimination. It helps to create a supportive health environment where health care workers with HIV can continue to work and where key populations can feel safe and can access health care.

10.8.3 Key programmes and examples from Southern and East Africa

Programmes may include:

- Training for health care workers on HIV, TB and human rights
- Discussions between health care workers and people living with HIV and key populations to discuss the impact of discrimination on people's rights
- Training for health administrators on the rights of health care workers with HIV.

10.9: Sensitising law makers and law enforcement officials

10.9.1 What is sensitising law makers and law enforcement officials?

Lawmakers often fail to develop laws that protect human rights and law enforcement officials often don't implement laws in a way that protects rights.

Programmes to sensitise lawmakers and law enforcement officials helps to make sure that:

- Parliamentarians understand how law impacts on HIV and TB and make national laws that protect the rights of people
- Ministers and ministry officials understand why it's important to implement protective laws around health, people living with HIV and key populations
- Judges and prosecutors are sensitised to human rights, HIV, TB and health issues and are better able to enforce rights in the courts
- Law enforcement officials, such as the police and prosecutors, know their legal obligations, are sensitised to the rights and needs of key populations and have the skills to enforce protective laws.

10.9.2 Why is it important?

Many countries don't have strong protection in law – and even where they have protective laws, these laws are often not well implemented or enforced. The police may not enforce laws properly, or they may use laws to target and harass key populations like sex workers, people who use drugs and LGBTI populations. If lawmakers and law enforcers are sensitised to HIV, TB and human rights issues, and the impact of punitive laws and practices on affected populatoins, they can respond better.

10.9.3 Key programmes and examples from Southern and East Africa

Key programmes include:

- Programmes to sensitise lawmakers on the link between HIV, TB, law and human rights
- Presentations by people living with HIV and key populations to parliamentary committees to explain the impact of discriminatory and punitive laws on human rights and health care
- Programmes to sensitise police officers to improve law enforcement in relation to people living with HIV and key populations
- Training for prison staff on managing HIV in the prisons.

Case Study 2: Training prisons' officials from the region

Forty-three law enforcement officers from Kenya, Lesotho, Malawi, Swaziland, Tanzania & Zambia participated in a regional capacity building workshop on HIV and the law from the 17th -19th July 2013 in Nairobi. The workshop was organized by KELIN in partnership with United Nations Development Programme (UNDP).

During his opening remarks to participants, the UNDP-Kenya Deputy Country Director Alfredo Teixeira, said: "The report of the Global Commission on HIV and the law recommends engaging law enforcement officers in building an enabling environment through education and communication programmes. The engagement of law enforcement will foster trust and the rapport needed to deliver effective HIV prevention and care services to people living with HIV and key populations."

Topics of discussion included the status of the HIV epidemic in Eastern and Southern Africa, stigma and discrimination and its role in HIV prevention and treatment among law enforcement officers, HIV, human rights and the law, and the findings of the Global Commission on law and HIV as they relate to law enforcement officers.

In one of the workshop sessions, participants got insights into the personal life experiences of sex workers, MSM and people who use drugs -- and their expectations of law enforcement officers in creating and enabling legal environment to facilitate access to HIV prevention and treatment services for such key populations.

During group discussions, participants deliberated on potential entry points for legal & policy dialogue in their respective countries with regard to the topics of the workshop. At the end of it, participants developed country action plans that sought to take forward three key main issues:

- Strengthening HIV workplace programmes
- Creating and enabling legal environment to minimize human rights violations
- Policy and advocacy country actions.

For more information go to:
http://www.hivlawcommission.org/index.php/africa-follow-up-activities/203-law-enforcers-from-six-countries-commit-to-protect-rights-of-people-living-with-hiv

10.10: Reducing Gender Inequality, Harmful Gender Norms and Gender-based Violence

10.10.1 What are programmes to address gender inequality?

People all over the world face inequality, discrimination or violations of their human rights because of their sex, gender identity or sexual orientation. For example, women experience domestic and sexual violence at the hands of their partners. Transgender men and women may experience high levels of discrimination and violence, including sexual violence, from sexual partners, law enforcement officials and community members.

Programmes to address gender inequality, harmful gender norms and gender-based violence aim to increase protection of the rights of all people to gender equality, by:

- Raising awareness about different gender identities
- Raising awareness about the harmful effects of gender norms and gender-based violence
- Strengthening laws and policies, as well as their implementation and enforcement, to promote gender equality
- Training people on gender equality rights and how to enforce them.

10.10.2 Why are they important?

Gender inequality, harmful gender norms and gender-based violence make women, girls and key populations (e.g. LGBTI populations) vulnerable to HIV and TB infection. For instance, gender inequality makes it hard for women and girls to access information, make sexual and reproductive health decisions and access the services they need to prevent HIV infection. Harmful gender norms may allow, for example, for early marriages of young girls, exposing them to the risk of HIV infection. Gender-based violence, such as sexual violence, puts people at direct risk of possible HIV infection.

Programmes to reduce gender inequality, harmful gender norms and gender-based violence are critical to reducing the vulnerability of women, girls and other key populations (such as LGBTI populations).

10.10.3 Key programmes and examples from Southern and East Africa

Key programmes include:

- Information and education programmes with communities and service providers to reduce gender inequality, to raise awareness about different gender identities and to reduce gender-based violence
- Law review and reform to strengthen protection of the rights to gender equality and to be protected from gender-based violence
- Legal literacy to increase information and understanding of rights to gender equality amongst women, girls and key populations such as sex workers and LGBTI populations
- Legal support services for women, girls and LGBTI populations to challenge gender-based violence
- Programmes with traditional and religious leaders and communities to address harmful cultural norms that impact on women and girls
- Engagement and advocacy with lawmakers and policy makers on integrating gender equality into health, HIV and TB laws and policies.

Case Study 3: Access to justice for widows in Kenya: Using alternative dispute resolution to protect property rights

Many women in rural Kenya have lost partners to AIDS. According to customary traditions of some tribes, a female widow is 'inherited' by a male relative of the deceased – a brother, uncle or cousin. Originally, this tradition aimed to provide for and protect widows. However, it has been misinterpreted over time to oblige a widow to have sex with a male relative. Those who refuse to be 'inherited' are often evicted from their land and lose their property, they become 'disinherited' and homeless.

In response, KELIN developed a cultural structure project to support justice for women who have been disinherited. The project focuses on alternative forms of dispute resolution to promote access to justice. KELIN engages the elders of the Luo tribe, training them on human rights and supporting them to work with families to resolve disputes. Meetings with elders are held twice a month to support their work. Widows and orphans are supported to return to their original villages and homes, or to resettle elsewhere.

Learning Activity 1: Developing an understanding of key human rights programmes to protect rights of key populations

Read through the case study on the opposite page, which is the submission made by ASWA to the Africa Regional Dialogue on HIV and the Law in August 2011.

Consider how to develop and implement any one of the seven key human rights programmes to protect the rights of sex workers. Think about:

- The human rights programme to be developed and implemented, with detailed examples
- Why it is important
- How it will work to help to protect the rights of sex workers in this example.

Case Study 4: Submission to Africa Regional Dialogue on HIV and the Law, 2011 by African Sex Workers Alliance

A sex worker sexually assaulted by a client without a condom

The client invited her to a hotel, which she accepted. When they arrived, the client locked the doors of the hotel room forcing her to have sex without protection, claiming she was a prostitute and that she should serve the customers sexually. Later, the client called friends, and invited them to the hotel to do the same, and she could not defend herself.

The Mozambican Context Socio-cultural Factors

Mozambican society is very rigid with regard to gender roles. There is a common perception that women have specific roles in society – as mothers, housewives, partners - but not as sex workers. Therefore, it is common that sex workers are seen to be breaking the rules and as being immoral. Even the most progressive people and institutions, commonly stated: "The society in Mozambique is not ready to look at sex work as common work."

Machismo is one factor fuelling this reality, contributing to the vision of sex workers as "noncitizens" or "subhuman". There are many stories of sex workers driven from their homes by families or their neighbours. Moreover, there are incidents where they are mistreated and discriminated against in public. Often, their children are also marginalized in schools and in social life.

The media also feed this discriminatory view. When a sex worker courageously is interviewed in the newspaper or on television, it is likely that their opinions and statements are falsified or manipulated. Until today, there has not been a newspaper article or TV piece that presents sex work in a neutral way, without judgment and without discrimination. Moreover, perceptions of morality, as well as religious and political pressure are influential in the country. However, it is apparent that some people in big cities are beginning to change their opinion about sex workers and there are those who support the struggle for their rights.

Legislation

The Penal Code in Mozambique is not clear regarding the legal status of sex work. Although the Code was reviewed some years ago, still contains three articles that can be interpreted to condemn sex work – those which condemn "vices against nature". While these clauses now seem to generate fewer prosecutions or convictions, they are still present and pose a threat to the sex workers, by providing the police and other parties the opportunity to give legal effect to the disapproval of sex work. Also common are cases of sex workers subjected to arbitrary arrest by police.

The Law of Human Rights and the Fight against Stigma and Discrimination of People Living with HIV / AIDS in 2009, initially focused on defending human rights of people living with HIV, but its final version criminalizes the intentional transmission of HIV. Although it is almost impossible to be met, this law has been attempted as a legal argument by sex workers' customers who use the police to prosecute sex workers for deliberate transmission of HIV. Just like the Penal Code, the law increased the vulnerability of sex workers.

Policies
The recent National Strategic Plan for HIV and AIDS (2010-2014) indicates the need for development of prevention activities specific to sex workers and stimulates the increase of knowledge about this population. A professional commented: “The plan focuses strongly on human rights, and sex workers are often mentioned ...it is a very political document. Perhaps by becoming more liberal in the discourse became more marginalized in practice, written more for the donors as opposed to deal with the reality on the ground.”

Range of sex work
The vast majority of sex workers in Mozambique are women. There is anecdotal evidence suggesting the existence of transactional relationships between men, but they rarely declare themselves as sex workers. There are some transgender sex workers in Maputo, which seem to have an increased vulnerability to violence and police harassment.

Experiences with police
The quality of law enforcement has a significant impact on the day-to-day lives of sex workers. Violence against sex workers in the cities is high, possibly because of its greater visibility and an increase of reporting. Much of this violence comes from clients. Places where the police receive training on the human rights of sex workers (such as 100% Activity of Life Program, an HIV prevention program aimed at sex workers) are gradually experiencing improvements. The service to complaints of sex workers is less discriminatory. In Maputo, there is strong evidence that police behavior improved significantly. However, in Matola - the neighbouring city - the situation is very different, especially because the Municipal Police participates in policing the streets. “The staff of the chamber responsible for keeping the streets litter-free, consider sex workers like garbage that needs to be cleaned up in their city.” In Matola, complaints to police about sex clients are not taken seriously, and there are stories of physical violence by police against sex workers.

Emboldened by the lack of recognition or protection for sex workers in the law, many clients take advantage, offering them more money for unprotected sex, refusing to pay for what was contracted, and negotiating condom use to then break these agreements, as well as being violent. The sex workers are usually very poor and are sometimes accused of stealing clients’ property, which generates violence and increased the risk of injury. And as a way to escape jail, customers often bribe the police.

Experiences with social and health services
Sex workers usually have bad experiences with health services, with common delays in the treatment of previously diagnosed STIs, lack of professional confidentiality, discrimination and bad service by health providers. As a result, many avoid public health services and seek alternatives such as private medical treatment, traditional healers and self-medication, which can cause more damage to their health. The majority of sex workers are not able to share personal information with a doctor because of the lack of confidentiality in medical services. There are few social and health services specific to sex workers, or specialist clinics that meet their needs.

Barriers to freedom of association and expression
Organizations in Mozambique who wish to register officially as a NGOs need to ask permission from the Ministry of Justice and the Minister personally signs this

request. This is a difficult hurdle to overcome, at least “I am a sex worker living in the Nampula district of the Faina. I met a client who I lived with for five years and we had two children. After we parted and he took custody of my children and I lost the right to visit them because I am sex worker “

Recommendations

What sex workers want in Mozambique:

- End violence against sex workers
- Ensure equal rights for all, including gender equality
- Ensure access to education and training for sex workers
- End discrimination against sex workers
- Make sex work a recognized profession
- Facilitate the process of official registration of associations
- Repeal any provisions that may be used to condemn sex workers

10.11: Unit Summary

1. Rights-based responses to HIV aim to protect rights and provide universal access to health care services.

2. UNAIDS recommends seven key human rights programmes to strengthen national responses to HIV:
   a. Stigma and discrimination reduction campaigns
   b. Legal literacy campaigns
   c. Law review and reform
   d. Legal support services
   e. Training health care workers and other service providers
   f. Sensitising law makers and law enforcers
   g. Reducing gender inequality, harmful gender norms and gender-based violence

3. Human rights programmes aim to:
   a. Strengthen laws, regulations and policies for health
   b. Improve access to justice, and
   c. Improve law enforcement.

4. Stigma and discrimination reduction programmes are programmes aimed at reducing stigma and discrimination. They help to empower people affected by HIV and TB.

5. Legal literacy campaigns, or *Know Your Rights* campaigns, give information, education and training about HIV, TB, human rights and the law. They help people understand what their rights are and to know when these rights are being violated.

6. Law review and reform helps to relook at laws and policies to strengthen them. This helps to create protective laws that support, rather than block access to HIV, TB and health services.

7. Legal support services are services to help people to get justice when their rights are violated. They help people to enforce their rights through reaching agreements, going to court or using other dispute resolution mechanisms.

8. Training of health care workers gives information and education to health care workers on health rights in relation to HIV and TB – their rights, and the rights of their patients. This helps improve understanding and reduces stigma and discrimination against people with HIV and TB.

9. Sensitising lawmakers and law enforcement officials involves programmes to increase knowledge and understanding and change attitudes towards HIV, TB and the rights of affected populations. It targets parliamentarians, ministers and ministry officials, judges, police and prison warders. These programmes help create more protective laws and law enforcement.

10. Programmes to reduce gender inequality, harmful gender norms and gender-based violence include a broad range of efforts such as law review and reform, efforts to strengthen access to justice and to improve law enforcement. They aim to create gender equality to reduce vulnerability to HIV and TB.

Summative Assessment

Complete the following quiz to assess your knowledge of key human rights programmes. Tick whether the following statements are true or false.

Question	True	False
Rights-based responses aim to protect health and human rights		
UNAIDS recommends 5 key human rights programmes for HIV		
Stigma and discrimination reduction campaigns aim to train people on their rights		
Legal literacy programmes increase people's understanding of their health rights		
Law review and reform helps to sensitise police officers to the rights of affected populations		
Training of health care workers helps to protect patients' rights		
Sensitising lawmakers and law enforcers can help create better laws		
Gender equality campaigns help to protect the rights of LGBTI populations		
A telephone hotline is an example of a legal literacy campaign		
Community meetings can be useful in a stigma and discrimination reduction campaign		
Private lawyers can be asked to help improve legal support services for people living with HIV		
The courts are the only way to enforce rights		
Sensitising prison warders helps to create better laws		
TV and radio shows can help to reduce stigma and discrimination		

10.12: Unit Outcomes Checklist

Use the checklist below to see whether you have met the outcomes that were set for this unit.

Outcome	Yes, I have met this outcome	No, I have not met this outcome	These are the things I still need to revise
List seven key human rights programmes to create effective health responses			
Explain why these programmes are important			
Describe each of the seven key human rights programmes			
Explain how you can use these programmes to strengthen HIV and TB responses			
Give examples of each of the seven key human rights programmes			

10.13: Resources and References

10.13.1 Useful websites

ARASA
www.arasa.info

International HIV/AIDS Alliance
http://www.aidsalliance.org/

The Global Network of People Living with HIV
http://www.gnpplus.net/

The People Living with HIV Stigma Index
http://www.stigmaindex.org/

10.13.2 Useful resources

International HIV/AIDS Alliance and ARASA (2013) *Good practice guide: HIV and Human Rights*
http://www.aidsalliance.org/assets/000/000/926/Alliance_GPG-HIV_and_human_rights_original.pdf?1407762153

UNAIDS (2012) *Guidance note: Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses*
http://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Programmes_en_May2012_0.pdf