ARASA TRAINING AND LEADERSHIP PROGRAMME, MODULE 4

SOCIAL AND STRUCTURAL BARRIERS TO THE REALISATION OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

EVERY BODY COUNTS

ARASA AIDS & Rights Alliance for Southern Africa

LEARNERS GUIDE

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Introduction

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

This module examines whether the legal, policy and regulatory frameworks in countries in Southern and East Africa (SEA) indeed protect and promote the realisation of sexual and reproductive health and rights for all or whether they create barriers to the realisation of sexual and reproductive health and rights, especially for vulnerable and key populations.

2

Unit outcomes

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

- Identify vulnerable and key populations in your country and explain why their sexual and reproductive health and rights are less likely to be realised
- Understand and articulate the particular social and structural barriers to the realisation of sexual and reproductive health and rights by each of these vulnerable and key populations
- Articulate the changes that need to be made to address these barriers.

3

Sexual and reproductive health and rights: A comprehensive definition

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

Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.[1]

Essential sexual and reproductive health services must meet public health and human rights standards, including the "Availability, Accessibility, Acceptability, and Quality" framework of the right to health. The services should include:

- accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
- information, counselling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers.[2]

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Vulnerable and key populations are less likely to realise their sexual and reproductive health and rights

Vulnerable and key populations include populations that live in poverty without access to safe housing, water, sanitation and nutrition; those who are stigmatized, discriminated against, marginalized by society and even criminalized in law, policy and practice. These populations may struggle to fulfil their human rights, including their rights to access health and social services. They live in environments of inequality where they are unable to thrive, feel safe and actively participate in all aspects of society. Communicable diseases such as HIV, TB and malaria, and non-communicable diseases such as cancers, may disproportionately impact vulnerable and key populations.[3] Key populations include LGBTI people, sex workers, people who use drugs and prisoners. In addition to these key populations, adolescents and young women and girls and women remain highly vulnerable to HIV and have high levels of unmet SRH needs.

1. Starrs A, Ezeh AC, Barker G, et al. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. Lancet. 2018; 391:2642–2692. doi: 10.1016/S0140-6736(18)30293-9
2. ibid
3. UNDP definition: see https://www.undp-capacitydevelopment-health.org/en/legal-and-policy/key-populations/

Around the world, survey results typically show that people who are less educated, live in rural areas, and poorer have greater unmet needs for sexual and reproductive health services than those who are more educated, live in urban areas, and better-off. Representative data on other marginalised people, such as sex workers, displaced people, refugees, and people who live in slums, are scarce because these groups are often not reached by household surveys.[4]

4.1 Access to Contraception

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

New estimates for 2019 show that sexual and reproductive health services fall well short of needs in lower- and middle-income countries globally. Approximately 218 million women of reproductive age (15–49) in these countries have an unmet need for modern contraception—that is, they want to avoid a pregnancy but are not using a modern method.[5]

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

4.2 Access to Comprehensive Sexuality Education (CSE)

CSE is a key component of a holistic approach to adolescent sexual and reproductive health and rights, helping adolescents and young people to understand how to protect and promote their sexual health and wellbeing, prevent unintended pregnancies, STIs including HIV and reproductive health risks such as cervical cancer and get treatment and care for illnesses. Research on CSE and HIV, for instance, shows that CSE leads to improved knowledge, increased condom use, decreased multiple partners, better understanding of HIV prevention, and delays in initiating sex and better attitudes towards safer sex.[6] Health and education laws, policies, strategies and plans need to promote access to CSE for young people, including adolescents both in and out of school.

UNFPA (2017) recommends that countries ensure that their CSE is rights-based, includes accurate information and provides developmentally appropriate sexuality education[7] in line with international and regional commitments such as the International technical guidance on sexuality education and the Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa (ESA), (ESA Commitment).[8]

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

CSE covers a broad range of issues relating to the physical, biological, emotional and social aspects of sexuality. This approach recognizes and accepts all people as sexual beings and is concerned with more than just the prevention of disease or pregnancy. CSE programs should be adapted to the age and stage of development of the target group. [9]

Through the ESA commitments SEA countries[10] committed to scaling up CSE as part of their commitment to SRH and HIV prevention for adolescents and young people. They set a target that by 2020, 90% of teachers would be trained in CSE and that at least 90% of schools would have integrated CSE curricula.[11] In 2017, it was reported that this commitment has increased investment in CSE in the region with 2 300 teachers being trained online and 42 000 receiving face to face training. Despite this progress, only 30% of girls and boys in Africa have comprehensive knowledge of HIV in the region.[12]

4. Starrs A, Ezeh AC, Barker G, et al. Op cit
5. Sully EA et al., Adding It Up: Investing in Sexual and Reproductive Health 2019, New York: Guttmacher Institute, 2020 – https://www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health-2019
6. UNFPA East and Southern Africa Region, How effective is comprehensive sexuality education in preventing HIV? 2016 – https://esaro.unfpa.org/en/publications/how-effective-comprehensive-sexuality-education-preventing-hiv
7. International technical guidance on sexuality education – https://www.unaids.org/sites/default/files/media_asset/ITGSE_en.pdf
8. ESA Commitment – http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/HIV-AIDS/pdf/ESACommitmentFINALAffirmedon7thDecember.pdf
9. Guttmacher Institute, Demystifying Data Toolkit, Comprehensive Sexuality Education, 2016 – https://www.guttmacher.org/report/demystifying-data-workshop-toolkit
10. Angola, Botswana, DRC, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, ESwatini, Tanzania, Uganda, Zambia and Zimbabwe endorsed this commitment.
11. ESA Commitment, see also How effective is comprehensive sexuality education in preventing HIV? – https://esaro.unfpa.org/en/publications/how-effective-comprehensive-sexuality-education-preventing-hiv
12. UNFPA, The Safeguard Young People Programme: Three Years On, 2017 – https://esaro.unfpa.org/en/publications/safeguard-young-people-programme-three-years

A range of issues,[13] common across sub-Saharan Africa (SSA) countries, has challenged CSE program implementation in the region. In most cases, sexuality education in SSA takes a biological approach. The focus tends to be on life skills and HIV and the frameworks tend to be fear based or negatively discussed. The focus on gender and human rights is weak, and key topic areas such as contraceptive methods, sexuality, and abortion are avoided. Emerging societal issues are not addressed, and on desire, pleasure, sexual diversity, and contraception, programs are silent. In Kenya, evidence reveals that only two percent of students have learned all the topics that constitute the CSE curriculum, although three in four teachers believed their teaching of CSE to have been comprehensive.

Sociocultural norms and values have been identified as the main barriers to effective implementation of CSE in SSA. Sociocultural norms are reinforced by laws and policies that consider information and activities such as condom demonstration and promotion of its usage as being contrary to the law, and by education-sector policies that primarily promote abstinence. In certain settings, teachers cannot provide information or promote practices considered taboo in their community. In such cases teachers avoid or skip culturally sensitive topics such as abortion, homosexuality, and masturbation; discuss them in negative light; or disseminate messages that contradict the tenets of CSE, especially with regard to gender norms and sexual harassment.

4.3 Reproductive cancers, including cervical cancer

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

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

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

Currently cervical cancer has been insufficiently addressed. For instance, a 2013 study showed that cervical cancer screening in Namibia only reached 24% of the female population, with more coverage in urban areas[14]. A 2012 report by Southern African Litigation Centre (SALC) on cervical cancer in Southern Africa[15] concluded that very few SADC countries were effectively addressing cervical cancer, with few having comprehensive cervical cancer policies that ensure equal access to services in the public health system.

Several countries have however made progress introducing national HPV vaccination programmes:

- Madagascar began vaccinating girls with the HPV vaccine in a two-year pilot study in 2013.[16]
- Zambia also rolled out a national HPV vaccination programme in 2013.
- South Africa introduced a national HPV immunisation programme in 2014, targeting girls at the age of 9.[17]
- Mauritius launched an HPV vaccination programme as part of its Expanded Programme of Immunization;
- Mozambique rolled out a national plan to provide the HPV vaccine to all 10-year-old girls
- Namibia announced it would make the HPV vaccine available in the public sector and would target girls who were not yet sexually active. Previously the vaccine was only available through private practitioners.[18]
- The eSwatini government also announced that it would roll out a national HPV vaccine programme in 2016.[19]
- The Seychelles introduced the HPV vaccination into its routine immunisation schedule in May 2014 and by 2016, it was reported that uptake of the vaccine was 86%. [20]
- Zimbabwe began a national HPV immunisation programme in 2018, aiming to immunise 800 000 girls.[21]

13. Frederick Murunga Wekesah, Vivian Nyakangi, Michael Onguss, Joan Njagi, and Martin Bangha. 2019. Comprehensive Sexuality Education in Sub-Saharan Africa. Nairobi, Kenya: African Population and Health Research Centre (APHRC).
14. Legal Assistance Centre, National Gender Analysis 2017, July 2017 – https://www.lac.org.na/projects/grap/Pdf/Namibia_Gender_Analysis_2017.pdf
15. https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/CERVICAL-CANCER-Report1.pdf
16. JSI, Introducing HPV vaccine in Madagascar – https://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=17263&lid=3
17. ICO/IARC Information Centre on HPV and Related Cancer, Human Papillomavirus and Related Diseases Report, South Africa, July 2017 http://www.hpvcentre.net/statistics/reports/ZAF.pdf
18. New Era, Health Ministry to roll out papilloma vaccine, 13 December 2016 – https://neweralive.na/posts/health-ministry-to-roll-out-papilloma-vaccine
19. UN Swaziland, Swaziland to introduce cervical cancer vaccine in 2017, 2016 – http://sz.one.un.org/content/unct/swaziland/en/home/news-centre/news/swaziland-to-introduce-cervical-cancer-vaccine-in-2017.html
20. WHO, HPV vaccine introduced into Seychelles routine immunization schedule – http://www.afro.who.int/news/hpv-vaccine-introduced-seychelles-routine-immunization-schedule
21. Guardian, Zimbabwe moves to protect women from spiralling cervical cancer rates, 4 May 2018 – https://www.theguardian.com/global-development/2018/may/04/zimbabwe-moves-to-protect-women-from-spiralling-cervical-cancer-rates

4.4 Access to safe abortion

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

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

Despite this, only 6 countries in southern Africa have abortion laws that meet or exceed the requirements laid down in the Maputo Protocol (Mozambique and South Africa permit abortion without restriction as to reason, and Botswana, Mauritius, Namibia and Seychelles permit abortion on the grounds set out in the Maputo Protocol. The remaining 9 countries do not permit abortion on all of the grounds set out in the Maputo Protocol. Whilst Zambia is amongst these, it does stand out as the only country in Southern Africa that permits abortion on the grounds of social or economic circumstances.

Countries	No restrictions	To save the life of the woman	On grounds of sexual violence	Foetal impairment	To protect the physical and mental health of the woman	Socio-economic circumstances	Maputo Protocol Compliant
Angola		X					
Botswana		X	X	X	X		X
DRC		X					
Lesotho		X					
Madagascar		X					
Malawi		X					
Mauritius		X	X	X	X		X
Mozambique	X (up to 12 weeks)		X (up to 16 weeks)	X (up to 24 weeks)			X
Namibia		X	X	X	X		X
Seychelles		X	X	X	X		X
South Africa	X						X
Swaziland		X					
Tanzania		X			X		
Zambia		X		X	X	X	X
Zimbabwe		X	X	X			

The safety of abortion depends largely on the extent to which it is legal. Where laws prohibit entirely or severely restrict the circumstances in which abortion is permissible, the general lack of formal abortion services, together with the desire to avoid judgment and arrest, drives women to seek clandestine abortion services, which are often unsafe. In addition, the gap between what the law says and what actually occurs in practice is often large. Unsafe abortions occur more often in countries with restrictive laws that prohibit the procedure or allow it in only in certain circumstances. More than 9 in 10 African women of reproductive age live in countries that prohibit abortion altogether or allow it only to save the life of the woman, preserve her physical or mental health, or in cases of rape, incest, or foetal abnormality.[22]

22. Guttmacher Institute, "Abortion in Africa," Fact Sheet, (March 2018), accessed at www.guttmacher.org/fact-sheet/abortion-africa

In some countries where abortion is legal, actual access to safe abortion services is limited by barriers other than the law, including lack of information about services that are theoretically accessible, long distances between facilities where safe abortion facilities are offered and high levels of conscientious objection on the part of medical personnel to providing safe abortions. While there is limited updated data on unsafe abortion in SEA countries, research indicates that the SEA region accounts for a large portion of unsafe abortions, estimating that only 23, 9% of all abortion in Eastern Africa during 2010–2014 were safe, whilst in Southern Africa, 73, 5% were safe.[23]

Unsafe abortion has significant adverse health consequences for women and girls: the World Health Organisation (WHO) estimates that approximately 47,000 women die each year as a result of unsafe abortions, largely in countries with highly restrictive laws. Another 8 million women suffer serious and sometimes permanent injury as a result of complications from unsafe abortion.[24] In SEA, there are high levels of unsafe abortion and thousands of women experience adverse health consequences as a result of unsafe abortion.

The consequences of unsafe abortion vary depending on the context and the environment, reflecting existing conditions of abortion provision, safety and legality. In countries where abortion is highly legally restricted, or where access to safe services is poor even though the law permits abortion under broad criteria, it is common to find that women who are financially better-off are able to obtain safe, clandestine abortion procedures because they can afford the services of a trained provider, while poorer women and other disadvantaged groups (such as adolescents and women in rural areas) will often go to providers who lack formal training, or attempt to induce the abortion themselves, resulting in health complications.[25]

Laws that criminalise abortion are thus a major barrier to the realisation of sexual and reproductive health and rights for all.

4.5 Sexual and gender-based violence

Sexual and GBV continue unabated in SEA countries and continue to place women and girls at higher risk of HIV. Africa has the highest reported rates of both physical and sexual violence against women of any region. In more than half of African countries, over 40% of women experience some form of physical violence; that number increases to 64% in some countries.[26]

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

In addition to the implementation challenges there are also remain gaps in some laws in that they do not cover intimate partner violence or marital rape. Furthermore, few countries extend protection from domestic violence to same-sex couples.

Tanzania and the DRC do not have specific laws on domestic violence, while Lesotho and ESwatini have yet to finalise and enact pending legislation. Only Angola, Comoros, Lesotho, Mozambique, Namibia, Seychelles, South Africa and Zimbabwe explicitly criminalise sexual violence in marriage. Mauritius confirmed in 2017 that it was possible to prosecute rape in marriage and in Tanzania, rape can only be prosecuted if the spouses are separated. New gender-based violence legislation in Namibia does not afford protection to same sex couples.[27]

4.6 Prevention and treatment of HIV and other STIs

Various international and regional commitments commit SEA countries to taking steps to prevent new HIV infections and to provide universal access to prevention services, including through addressing legal and policy barriers that block access to effective prevention. The 2017 ***SADC Regional Strategy for HIV and AIDS Prevention Treatment and Care and Sexual and Reproductive Health and Rights*** amongst Key Populations, for example, confirms the high levels of both HIV prevalence and risk for key populations and the urgent need to address their access to comprehensive HIV combination prevention, which include behavioural, bio medical and structural interventions.

23. Abortion Worldwide 2017: Uneven Progress and Unequal Access, Appendix, table 2, 2017 - https://www.guttmacher.org/report/abortion-worldwide-2017
24. WHO, Preventing Unsafe Abortion, 2019 – https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion
25. Singh S, Wulf D, Hussain R, Bankole A, Sedgh G: Abortion Worldwide: A Decade of Uneven Progress. Guttmacher Institute, New York, NY, USA (2009).
26. African Commission on Human and People's Rights and UNAIDS, HIV, the law and human rights in the African Human Rights System: key challenges and opportunities for rights-based responses, 2018 – https://www.unaids.org/en/resources/documents/2018/HIV_Law_AfricanHumanRightsSystem
27. https://www.namibian.com.na/208991/archive-read/Outrage-over-GBV-law-amendments-excluding-same-sex-couples

Behavioural interventions: Interventions that promote safe behaviour
Biomedical interventions: Interventions that use clinical and biomedical methods
Structural interventions: Interventions that promote an enabling environment

Biomedical

- condoms and lubricants
- treatment as prevetnion
- pre-exposure prophylaxis
- post-exposure prophylaxis
- voluntary medical male circumcision
- needle and syringe programmes

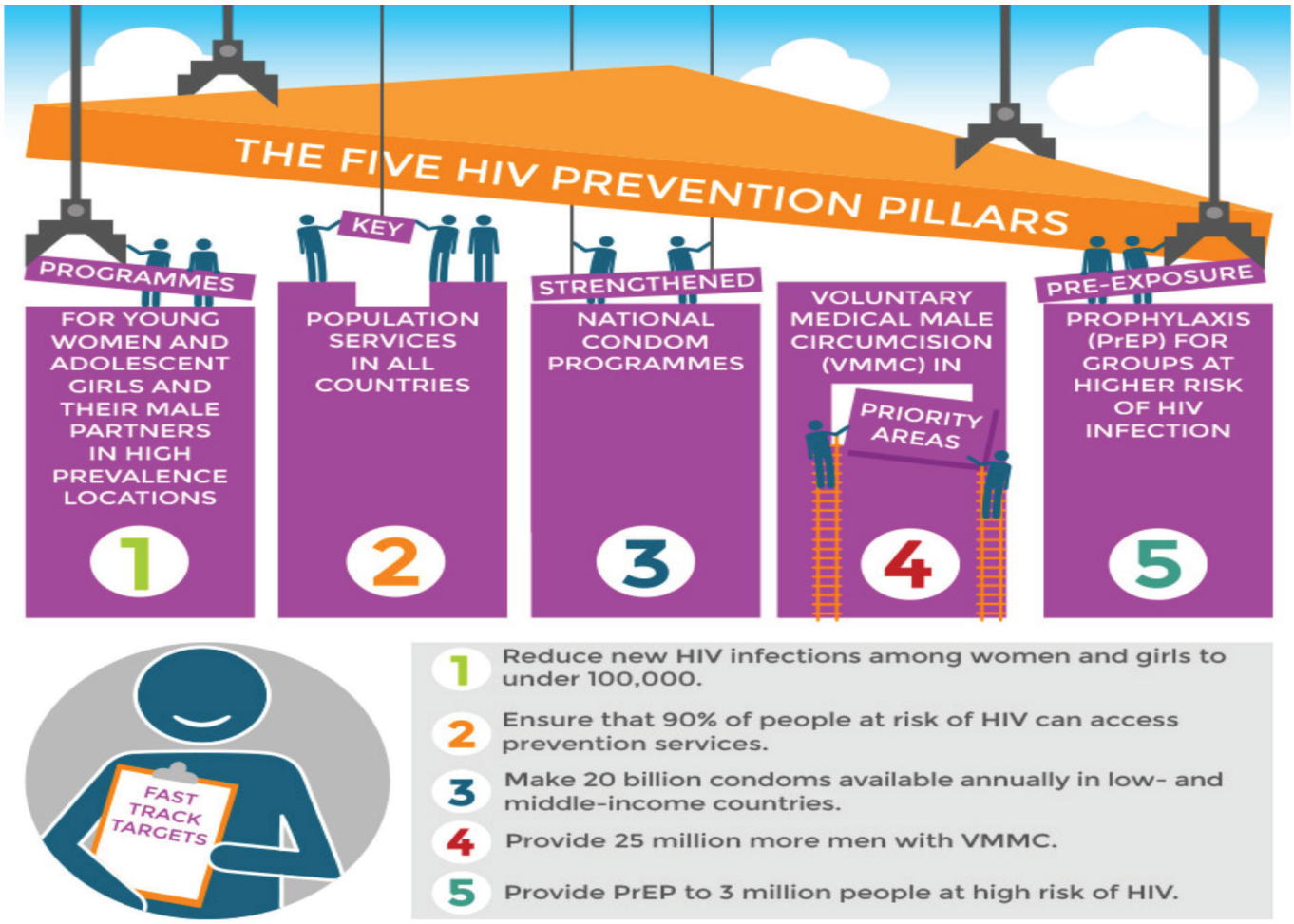
Behavioral

- risk reduction counselling
- comprehenisve sexuality education
- peer education programmes
- social marketing of condoms

Structural

- decriminalising sex work, same sex sex and drug use
- addressing gender inequality and violence
- laws to protect rights of PLHIV and key populations
- Stigma and discrimination reduction

UNAIDS established the Global HIV Prevention Coalition in 2017 to develop a roadmap to achieve the 2020 targets for prevention based on the five key prevention pillars.



28. Angola, Kenya, Lesotho, Mozambique, Malawi, Namibia, South Africa, ESwatini, Uganda, Tanzania, Zambia and Zimbabwe were founding members of the coalition.

The road map identifies four issues that need to be addressed to ensure progress on prevention: gaps in political leadership, legal and policy barriers, gaps in prevention financing, and a lack of systematic implementation of combination prevention programmes at scale.[29] The road map commits countries to take concrete steps to address the legal and policy barriers that undermine access to effective prevention, especially for most at risk and vulnerable populations. These include key populations and young people in and out of school. [30]

The enhanced focus on prevention has catalysed some progress in SEA countries, including for those at higher risk of HIV exposure; however more needs to be done to ensure that people most at risk of HIV are empowered to access HIV prevention and treatment information and services.

5

What are the social and structural barriers to the realisation of sexual and reproductive health and rights faced by the vulnerable and key populations?

5.1 Lesbian, gay, bisexual, transgender and intersex (LGBTI) people

LGBTI individuals face serious barriers in many countries to accessing sexual and reproductive health information and services, including pervasive stigma and discrimination, criminalisation of their sexualpractices, violence, and even fear for their lives.[31] When they do receive services, they might not disclose their sexual orientation, activities, or gender identity to their health providers, inhibiting their ability to receive the information and care they need. Additionally, the care they receive might be of poor quality because providers are judgmental or do not have sufficient knowledge about their specific needs. Many of their sexual and reproductive health needs are common to all adolescents and adults, but some are specific to their status. Their needs include contraceptive counselling and services; reproductive health screenings; access to safer sex technologies; counselling for STI risk prevention, STI treatment, pregnancy-related services, partner violence, and sexual violence; counselling on fertility options; and hormone therapy. [32]

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

29. UNAIDS, Implementation of the HIV Prevention 2020 Road Map, First Progress Report, March 2018 – https://www.unaids.org/sites/default/files/media_asset/jc2927_hiv-prevention-2020-road-map-first-progress-report_en.pdf
30. UNAIDS, HIV Prevention 2020 Road Map, accelerating HIV prevention to reduce new infections by 75%, 2017 – https://www.unaids.org/en/resources/documents/2017/hiv-prevention-2020-road-map
31. Starrs A, Ezeh AC, Barker G, et al. Op cit
32. Graham R, Berkowitz B, Blum R, et al. The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding. Washington, DC: The Institute of Medicine, 2011.

Country	Criminalise same sex sexual conduct between men	Criminalise same sex sexual conduct between women	Laws prohibiting discrimination and promoting equality
Angola	No	No	No
Botswana	No	No	Yes- on basis of sexual orientation
Comoros	Yes	Yes	No
DRC	No	No	No
Eswatini	Yes	No	No
Kenya	Yes	Yes	No
Lesotho	Yes	No	No
Madagascar	No	No	No
Malawi	Yes	No	No
Mauritius	Yes	No	No
Mozambique	No	No	Yes- on basis of sexual orientation
Namibia	Yes	No	No
Seychelles	Yes	No	Yes- on basis of sexual orientation
South Africa	No	No	Yes
Tanzania	Yes	No	No
Uganda	Yes	No	No
Zambia	Yes	No	No
Zimbabwe	Yes	No	No

On 30 June 2016, the UN Human Rights Council adopted a third resolution on sexual orientation and gender identity.[33] The resolution provided for the appointment of an independent expert on violence and discrimination based on sexual orientation and gender identity. The DRC and Kenya voted against the resolution and Botswana, Namibia and South Africa abstained from the vote.

In October 2017, the Third Committee (the main body of the UN General Assembly dealing with human rights) received its first report from the UN Independent Expert on the protection from violence and discrimination based on sexual orientation and gender identity. The report called for immediate action to stop the "horrific violations" against LGBTI people. The Independent Expert called for all countries to repeal laws that criminalise same sex relationships.[34]

Subsequent progress on LGBTI rights and the repeal of laws that criminalise same sex sex has been slow in SEA.

Recent, positive developments in SEA include:

- In 2015 Mozambique decriminalised sex between men in Mozambique 2015 and the Seychelles followed suit in 2016.
- In 2017 South Africa developed its first LGBTI HIV national plan and began a study on transgender health, including HIV.
- In October 2017, a Botswana court ruled that a transgender man could have official documents that reflected his gender identity.
- In March 2018, a Kenyan court ruled that forced anal examinations of people accused of having same sex sexual activity was unconstitutional.
- In January 2019, Angola repealed the law criminalising same-sex sex and prohibited discrimination against people on the basis of their sexual orientation, with punishment of up to two years' imprisonment.
- In June 2019, the Botswana High Court unanimously struck down penal laws criminalizing same-sex sexual conduct between consenting adults.[35]

These positive trends are not however universal in SEA and very few countries have any laws that protect people from discrimination and violence based on SOGI. Ugandan LGBTI groups cancelled the annual Pride celebrations in Kampala and Jinja in 2017 after the government threatened to arrest the organisers and in December 2017, the government shut down the Queer Kampala International

33. Protection against violence and discrimination based on sexual orientation and gender identity (adopted 30 June 2016) - A/HRC/ RES/32/2 – https://www.un.org/en/ga/search/view_doc.asp?symbol=A/HRC/RES/32/2
34. UN News, Action needed to stop violations of LGBT people's rights worldwide, expert tells UN, 27 October 2017 – https://news.un.org/en/story/2017/10/569492-action-needed-stop-violations-lgbt-peoples-rights-worldwide-expert-tells-un
35. LM vs. the Attorney General of Botswana – https://www.southernafricalitigationcentre.org/wp-content/uploads/2019/06/Botswana-decrim-judgment.pdf

Film Festival. Ugandan police continue to conduct forced anal examinations of men and transgender women accused of consensual same sex conduct.[36]

Despite the decriminalisation of same sex in Mozambique in 2016, the country's only LGBTI organization, LAMBDA has struggled to date to obtain registration. Groups and organisations advocating for the rights of LGBTI people, including for access to HIV testing and treatment, have experienced government opposition, making it difficult for them to operate freely in several SEA countries. In May 2019, the High Court in Kenya upheld penal laws criminalising consensual sex between same-sex adults.[37]

Tanzania cracks down[38]

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

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

Many transgender people feel let down by the health systems in their countries, whether these are private or public-health facilities. They face homophobic and transphobic attitudes from doctors and nurses who cannot understand their gender identity and who often do not have the knowledge and facilities to provide them with proper sexual and reproductive healthcare and advice. Many would rather avoid getting treatment than endure humiliation and invasion of their privacy.

Transgender people are vulnerable to HIV and AIDS, and yet they are often ignored in government programmes to combat the disease. In many countries, condoms, lubricants and other protection are not freely available. Access to gender reassignment surgery is practically impossible. Hormone treatment is also not widely available in Southern Africa.

Only Botswana, Lesotho, South Africa and Tanzania have identified transgender people as a key population, although there is limited provision for appropriate healthcare services.

Recent research finds that the continued criminalisation of consensual sex between persons of the same sex leads to victimisation and societal marginalisation of LGBTI people, by perpetuating stigma, violence, harassment, blackmail and discrimination by state and non-state actors.[39] For instance, LGBTI people in southern Africa often report being arrested, detained, or harassed for offences such as public indecency, nuisance, public disorder, loitering, or other ill-defined criminal offences. Transwomen and other gender nonconforming individuals are especially vulnerable to arrest and they are often arrested for cross-dressing or impersonation. In many cases, it is clear that the individual is being targeted due to their real or perceived sexual orientation or gender identity, and there is no basis in law for an arrest or detention.[40]

Furthermore, criminal laws are perceived as justification - and even sanction, not only for unlawful arrest, but also for violence, abuse and discrimination against those who do not fit societal expectations of heterosexuality and cis normativity. A 2016 study into SOGI rights in Southern African countries[41] found that men, women and gender nonconforming individuals have been murdered, raped, beaten, assaulted, harassed, and targeted due to their real or imputed sexual orientation, gender identity and/or gender expression. Acts of violence were often committed by family members or others who perceived the individual's sexual orientation or gender identity as inconsistent with social or cultural expectations. This stigma and discrimination takes place in various societal spaces and, in most cases, research shows that crimes are not reported to law enforcement officials and go unpunished.

36. Reid, G., After a Grim Year for LGBT Rights, The Way Forward, 2018 – https://www.hrw.org/news/2018/04/16/after-grim-year-lgbt-rights-way-forward
37. 312EG & 7 others v Attorney General; DKM & 9 others (Interested Parties); Katiba Institute & another (Amicus Curiae) – http://kenyalaw.org/caselaw/cases/view/173946/
38. 313Human Rights Watch, Human Rights Watch Country Profiles: Sexual Orientation and Gender Identity, 2018 – https://www.hrw.org/video-photos/interactive/2018/04/16/sexual-orientation-gender-identity-country-profiles
39. ARASA, Identifying Injustice: Law and Policy on Sexual Orientation, Gender Identity and HIV in Southern Africa, 2016 – https://hivlawcommission.org/wp-content/uploads/2017/06/ARASA_Toolkit_full_web.pdf see also SALC, The Law Needs to Change, We Want to be Free, 2018 – https://www.southernafricalitigationcentre.org/wp-content/uploads/2018/05/Botswana-rights-booklet.pdf
40. ibid
41. ARASA, Identifying Injustice: Law and Policy on Sexual Orientation, Gender Identity and HIV in Southern Africa, 2016 – https://hivlawcommission.org/wp-content/uploads/2017/06/ARASA_Toolkit_full_web.pdf

Young LGBTI people reported homophobia and/or transphobia amongst school administrators and teachers and limited access to remedies from bullying, harassment, discrimination and other rights violations.[42] A 2016 study by the Southern African Litigation Centre (SALC) found high levels of stigma and discrimination on the basis of SOGI in health care, including sub-standard and inadequate treatment, conditional access to treatment, denial of treatment, abusive language, physically and sexually abusive behaviour as well as violations of the right to informed consent and confidentiality.[43]

Violence and human rights violations continue even in those countries that offer legal protection to the LGBTI community – ongoing violence against lesbian women in South Africa show that laws alone cannot end discrimination. [44]

Criminalisation is also used as a barrier to the supply of condoms in prisons,[45] including in almost all countries in SEA.

5.2 Sex Workers

Sex workers have been identified as a key population at particular risk of HIV and other STIs. The 2016 ARASA HIV, TB and Human Rights Report[46] noted various violations of the rights of sex workers, including violations of their rights to equality non-discrimination, bodily autonomy and integrity. Male, female and transgender sex workers faced high levels of stigma, discrimination, violence, extortion, sexual abuse and rape in SEA from clients, intimate partners and law enforcement officials, which increases their vulnerability and marginalisation and places them at increased risk of HIV. The report found that sex workers experienced particular challenges in accessing health care due to stigmatising attitudes from health care workers and discrimination in access to sexual and reproductive health care services, limiting their access to HIV prevention and treatment services and information.

Aspects of sex work are directly or indirectly criminalised in the majority of countries in SEA. A 2018 report on HIV, the law and human rights in Africa also highlighted continued harassment by law enforcers, such as arbitrary detention and arrests based on condom possession, which further undermined HIV prevention efforts with sex workers.[47] Sex workers continue to experience violations of their human rights, increasing their vulnerability to HIV, with little access to justice, in countries in SEA.

The GCHL Supplementary Report[48] found, based on a review of 27 countries, that countries that have legalised some aspects of sex work have significantly lower HIV prevalence among sex workers, especially if such legalisation was properly enforced. Another study found that decriminalization of sex work would avert 33 to 46 percent of HIV infections in the next decade across all settings.[49]

There has been progressive jurisprudence to protect sex workers from unlawful arrests and rights violations, despite the criminalisation of aspects of sex work. In Malawi, the Zomba High Court found in September 2016 that the arrest of sex workers charged with the offence of living on the earnings of prostitution, was unconstitutional and not based on evidence. The Court found that section 146 of the Malawi Penal Code did not criminalise sex work and was aimed at those who exploit them.[50]

Despite this, aspects of sex work continue to be criminalised in most countries in SEA. Though there are a handful of countries where sex work is not criminalised, activities associated with sex work, such as living on the earnings of sex work, are criminalised making it difficult for sex workers to engage in their work safely.[51] The criminalisation also hinders sex workers' access to health services and makes them vulnerable to violence. In Lesotho almost 10% of female sex workers reported having avoided health services in the past 12 months due to stigma and discrimination.[52]

42. ibid
43. SALC, Accountability and redress for discrimination in healthcare in Botswana, Malawi and Zambia, 2016 – https://www.southernafricalitigationcentre.org/2016/09/28/research-report-accountability-and-redress-for-discrimination-in-healthcare-in-botswana-malawi-and-zambia/
44. ARASA, Identifying Injustice: Law and Policy on Sexual Orientation, Gender Identity and HIV in Southern Africa, 2016
45. ibid
46. https://hivlawcommission.org/wp-content/uploads/2017/07/ARASA_2016_Human_Rights_report.pdf
47. ibid
48. GCHL, Risks, Rights and Health: Supplement (July 2018) – https://hivlawcommission.org/supplement/
49. Kate Shannon, Steffanie A Strathdee ,Shira M et al., Global epidemiology of HIV among female sex workers: influence of structural determinants, The Lancet, Volume 385, Issue 9962, P55-71, January 03, 2015
50. https://www.southernafricalitigationcentre.org/2016/09/28/malawi-challenging-the-use-of-the-offence-of-living-on-the-earnings-of-prostitution/
51. https://www.unaids.org/en/resources/documents/2018/unaids-data-2018
52. ibid

Country [53]	Selling illegal	Soliciting illegal	Purchasing illegal	Organising illegal
Angola	Yes	Yes	No	Yes
Botswana	No	Yes	No	Yes
Comoros	Yes	Yes	Yes	Yes
DRC	No	Yes	No	Yes
Eswatini	No	Yes	No	Yes
Kenya	No	Yes	No	Yes
Lesotho	No	Yes	No	Yes
Madagascar	No	Yes	Yes	Yes
Malawi	No	Yes	No	Yes
Mauritius	No	Yes	No	Yes
Mozambique	No	No	No	Yes
Namibia	No	Yes	No	Yes
Seychelles	No	Yes	No	Yes
South Africa	Yes	Yes	Yes	Yes
Tanzania	No	Yes	No	Yes
Uganda	Yes	Yes	No	Yes
Zambia	No	Yes	No	Yes
Zimbabwe	No	Yes	No	Yes

Sex work, discrimination and violence

In Zimbabwe, law enforcement officers intimidate, arrest and harass sex workers. Findings on police harassment and abuse by the Centre for Sexual Health, HIV and AIDS Research in 2016 found 20% of female sex workers experienced violence from the police in the past year.[54] The possession of condoms is used as proof of sex work, with many sex workers reporting being arrested due to their work, or having their condoms confiscated.[55] This leads to increased vulnerability to HIV, due to their fear of arrest, inability to negotiate condom use and unwillingness to access health care services.[56]

Sex workers in Zambia report similar abuse at the hands of law enforcement officials. Research by SALC found that 91% of sex workers indicated they had a bad experience with the police and that they were often not treated well during arrest and detention. 90% reported that they have experienced violence from police or other men during their time as sex workers, 87% reported that the police have harassed them because they engage in sex work and 61% said they would be unwilling to lay a complaint against the police because they fear further abuse, that the complaint will not change anything, that the police think they are above the law; and because they are unfamiliar with all the complaints options available to them.[57] Sex workers also report high levels of stigma and discrimination within the health care sector, including denial of services, discriminatory treatment and abuse; similarly, they feel unwilling or unable to challenge violations in the health care sector.[58]

Sex workers in Mozambique are frequently unable to access justice for crimes committed against them, including when perpetrators are police officers. In a 2016 study, 27% of sex workers who participated in the research stated they had experienced discrimination on accessing police assistance. The same study showed that 23% of the sample had filed a police report and the majority were happy with the outcome, with about one quarter expressing dissatisfaction with the way their case was handled.[59]

53. See https://www.nswp.org/sex-work-laws-map/country-list
54. Busza, J et.al. Good news for sex workers in Zimbabwe, Journal of International AIDS Society, 20(1):21860, 2017 – https://www.researchgate.net/publication/317060446_Good_news_for_sex_workers_in_Zimbabwe_how_a_court_order_improved_safety_in_the_absence_of_decriminalization
55. Maseko, S and Ndlovo, S, Condoms as Evidence, 2012
56. Ibid. see also GCHL, Risks, Rights & Health, 2012 – https://hivlawcommission.org/wp-content/uploads/2017/06/FinalReport-RisksRightsHealth-EN.pdf
57. SALC, they should protect us because that it their job, 2016 – https://www.southernafricalitigationcentre.org/2016/09/24/salc-research-report-they-should-protect-us-because-that-is-their-job/
58. SALC, Accountability and redress for discrimination in access to health care in Botswana, Malawi and Zambia, 2016 – https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/Report-Accountability-and-Redress-for-Discrimination-in-Healthcare.pdf
59. Aidsfonds, Sex Work and Violence in Mozambique, 2016 – https://aidsfonds.org/resource/sex-work-and-violence-in-mozambique

5.3 People who use drugs

Most countries in sub-Saharan Africa have poor collection and availability of data on drug use and the health of people who use drugs, and harm reduction services for people who inject drugs are limited. Injecting drug use is reported in 38 of 49 countries in sub-Saharan Africa, and the number of people who inject drugs is estimated to be between 560,000 and 2.7 million, a range that demonstrates the paucity of data. Most people who report injecting drugs in sub-Saharan Africa are male, ranging from 66% in northern Nigeria to 93% in Nairobi, Kenya.[60]

Only a few countries in the region have implemented harm reduction programmes, particularly in the public sector. For example, needle and syringe programmes (NSPs) exist in six countries in SEA (Kenya, Mauritius, Mozambique, Tanzania, South Africa and Tanzania), while opioid agonist therapy (OAT) is available in six territories (Kenya, Mauritius, Seychelles, South Africa and Tanzania, as well as in Zanzibar).[61] Although regional data is limited, country surveys among people who inject drugs suggest high HIV prevalence. Overall, just under a third (30%) of people who inject drugs in the region are estimated to be living with HIV and the same population is estimated to have accounted for 2% of new HIV infections in the region in 2019.[62]

Seven countries across the region - Kenya, Mauritius, Mozambique, Seychelles, South Africa, Tanzania and Uganda - have incorporated harm reduction into their national HIV strategic plans. In addition to these ten countries, since 2018, the East African Community (EAC) with support from the Global Fund (through Principal Recipient Kenya AIDS NGO Consortium (KANCO) together with Sub-Recipients), has developed a regional policy for harm reduction.[63] This led to the development of the EAC Regional Policy on Prevention, Management, and Control of Alcohol, Drugs and Other Substance Use.[64] The African Union continues to demonstrate a strong commitment to addressing drug use in the region by facilitating the availability of a wide range of evidence-based treatment options, including OAT. For the first time, the new African Union Plan of Action on Drug Control and Crime Prevention for 2019-2023 calls for harm reduction services and alternatives to imprisonment to be made available. It includes a commitment to review and harmonise drug policies across the region and to the continuous support of international research and data collection processes.[65]

Among the estimated 15.6 million people who inject drugs worldwide, nearly one in five lives with HIV. Women make up one third of people who use drugs globally and one fifth of the global estimated number of people who inject drugs. Drug use is often seen as contrary to the socially normative roles of women as mothers, partners and caretakers, leaving women who use drugs facing greater stigma and experiencing a range of specific harms. [66]

A persistent gap in harm reduction programming in SEA is the lack of programmes designed to address the specific needs of women, taking into account the unique challenges they face. With the number of women who use drugs increasing across the region, they also face more serious consequences from co-infection with diseases such as HIV, hepatitis C and B and other sexually transmitted infections. In some cases, women who use drugs may also be members of other key populations. For example, an urban study in Kenya found that 48.7% of women who inject drugs in low-income urban settings engaged in sex work as their main source of income. [67]

People who use drugs in SEA face various violations of their rights, including their rights to equality, non-discrimination, autonomy, integrity, health and access to justice. Drug use is criminalised in most sub-Saharan African countries and highly stigmatised, with people who use drugs often facing discrimination, violence and police abuse with limited access to justice for rights violations.[68]

The GCHL Africa Regional Dialogue on HIV and the Law found that criminalisation of drug use, fear of arrest, harassment and the imprisonment of people who use drugs, accompanied by widespread societal stigma, discourages access to health care services for people who use drugs and creates legal barriers to the provision of needle and syringe programmes and opioid substitution therapy.[69]

60. Harm Reduction International, Global State of Harm Reduction 2020, https://www.hri.global/files/2021/03/09/Global_State_HRI_Sub-Saharan_Africa_FA_WEB_2.pdf
61. ibid
62. ibid
63. ibid
64. EAC-Regional-Policy-on-alcohol.pdf [Internet]. [cited 2020 Aug 2]. Available from – https://health.eac.int/publications/eac-regional-policy-on-alcohol-drugs-and-substance-abuse-2019#gsc.tab=0
65. Harm Reduction International op cit
66. Frontline AIDS, Advancing the Sexual and Reproductive Health and Rights of Women who use Drugs: A guide for programmes – https://frontlineaids.org/wp-content/uploads/2020/02/Guide-for-harm-reduction-programmes-FINAL-24Feb-WEB.pdf
67. Harm Reduction International op cit
68. 184IDPC, Drug policy in Africa: towards a human rights-based approach, April 2017 – http://fileserver.idpc.net/library/IDPC-advocacy-note_Human-rights-in-Africa.pdf
69. 188GCHL. Report of the Africa Regional Dialogue on HIV and the Law, 2011 – https://hivlawcommission.org/dialogues/africa/

The GCHL Risks, Rights & Health Supplement in 2018[70] examined barriers to access to HCV treatment for people who use drugs and found that laws that criminalise drug use and prevent harm reduction interventions, combined with punitive health policies that require registries for people who inject drugs and exclude people who use drugs from accessing HCV treatment, as well as the high cost of HCV treatment, result in people who use drugs being unable to prevent or obtain effective treatment for HCV.

The criminalisation of drug use is a critical barrier stopping women who use drugs from claiming and realising their SRHR. Punitive drugs policies underpin stigma, discrimination and violence faced by this group, and make reporting violence, or seeking tailored services almost impossible. There is thus a need to progressively expand access to an essential, integrated package of SRHR interventions, ensuring that the needs of women who use drugs in all their diversity are addressed. Harm reduction services can serve as an entry point to integrated SRHR services tailored for women who use drugs, provided by known, trusted providers, and to expanding referral systems.[71]

5.4 Prisoners

In Africa around 3.2% of the prison population is represented by women. People in prison are 5 times more likely to be living with HIV than adults in the general population. Moreover, women in prison have a higher HIV prevalence than men. The factors that lead to women becoming incarcerated are often also those that lead to their increased risk of acquiring HIV infection. Their situation in prison is exacerbated by stigma and discrimination, gender-based violence and inequality. Women have limited access to health care in prison settings and are less likely to receive treatment than men. This is even more the case in Africa, where the precarious and sometimes inhuman prison conditions, render the health-related interventions addressing women health particularly challenging. Their specific health care needs, such as sexual and reproductive health care, treatment of infectious diseases including STIs, as well as nutrition and hygiene requirements, are often neglected. The limited access for women (and their children) to ante- and postnatal care, labour and delivery services and antiretroviral therapy also leads to infants born in prisons being at high risk of contracting HIV. Women in prison should be able to access gender-responsive health care services which are equivalent and of the same quality as those available in the community.[72]

Laws and policies fail to adequately protect the right to health care, including access to HIV and TB prevention and treatment, for prisoners. For example, few prisons in SEA have established comprehensive treatment, care and support policies and programmes. The lack of financial and personnel resources and the fragmented care between prisons and when prisoners are released undermine access to health for prisoners living with HIV and/or TB. Where programmes do exist, they tend to be inadequate and do not cover all inmates.[73]

Furthermore, limited progress has been made in SEA to decriminalise laws prohibiting consensual sex between adult men; these laws present a significant barrier to prisoners obtaining access to condoms to protect themselves from HIV transmission. In Botswana, Malawi, Mozambique, Namibia, Tanzania and Uganda, prisoners are not permitted to access condoms or lubricant because of the criminalisation of same-sex sexual conduct. Similarly, laws criminalising the possession and use of drugs act as a barrier to the provision of harm reduction services for people who use drugs in prisons.

5.5 Adolescent girls and young women

Adolescent girls and young women (AGYW) are vulnerable to sexual and reproductive health risks, including HIV and other STIs, in SEA.

The incidence of HIV infections among adolescent girls and young women (aged 15 to 24 years) remains inordinately high: they are 2.5 times more likely than their male peers to acquire HIV infection and account for 26% of new infections in the region. Adolescent girls face other particular SRH challenges: high levels of unintended and unwanted pregnancy, lack of access to contraception, CSE and abortion; sexual and gender-based violence and child marriage. A comprehensive approach is required, including combination prevention programmes that take account of gender inequalities, improving girls' access to secondary education (which can have a protective effect against HIV), and increasing access to sexual and reproductive health services.[74]

70. https://hivlawcommission.org/supplement/
71. Frontline AIDS op cit
72. E Salah, Women's health in prisons in Africa: prevalence and challenges to address HIV among women in prison in Africa, European Journal of Public Health, Volume 30, Issue Supplement_5, September 2020, ckaa165.1367 – https://doi.org/10.1093/eurpub/ckaa165.1367
73. Telisinghe, Lilanganee et al, HIV and tuberculosis in prisons in sub-Saharan Africa, The Lancet, Volume 388, Issue 10050, 1215 – 1227, 2016 – https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)30578-5.pdf
74. UNAIDS, UNAIDS Global Data 2020 – https://www.unaids.org/en/resources/documents/2020/unaids-data

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

In addition, AGYW have limited access to appropriate SRH information and services for various reasons. Adolescent girls and young women frequently cannot access sexual and reproductive health information and services that are tailored to their needs and their access to HIV and SRH services is often compromised due to other factors, such as the fact that adolescent sexuality is deeply stigmatized. In addition, health laws and policies that deny independent access to sexual and reproductive healthcare services for young people create barriers to access to critical healthcare services for young people. The GHCL's 2018 Risks, Rights & Health Supplement notes that adolescent girls and young women are further behind in access to HIV-related and sexual and reproductive health care services and recommends that governments adopt and enforce laws that protect and promote sexual and reproductive health and rights and remove legal barriers to accessing the full range of sexual and reproductive health services.[75]

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

For instance, laws that fail to set a clear age of consent or stipulate a minimum age of consent for independent access to healthcare services, such as HIV testing and contraception, deny minors the right to access contraception without the consent of a parent or guardian. According to UNFPA (2017),[76] the lack of clear legal and policy provisions for the age of consent to issues such as contraception, sexual and reproductive health care and HIV testing can lead to confusion as to when young people can consent to receive health services, including medical treatment. This uncertainty creates a barrier to accessing sexual and reproductive health services and allows health-care providers to enforce their own belief systems regarding an appropriate age of consent.

UNFPA (2017)[77] has recommended that countries in SEA should set the age of consent to access to healthcare services based on an adolescent's sufficient maturity to understand the risks, benefits and consequences of the treatment, and set the age of consent at 12 years for HIV testing, and pre- and post-test counselling without parental consent. It also recommends that countries provide, in law, for health-care providers to respect the views and opinions of the adolescent or young person accessing a service and their right to confidentiality and should guide health-care providers on how they can assess this maturity. UNFPA further recommends that the age of consent to sex be harmonized for boys and girls and be aligned to the age of consent to access to contraception.[78]

Age of consent to access SRH services in SEA[79]

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

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

Some countries have taken steps to strengthen young people's access to SRH services in laws, policies and guidelines. In Namibia, the Child Care and Protection Act 3 of 2015, which entered into force in January 2019. provides that a child may consent to medical interventions, including HIV testing, from 14 years. The Zimbabwe National Guidelines on Clinical Adolescent and Youth Friendly Sexual and Reproductive Health Service Provision, 2016 are intended to facilitate access to youth friendly sexual and reproductive health services. The guidelines do not specify a minimum age at which adolescents can receive SRH services without parental consent but do expressly state that age should not be a barrier to receiving services. They specifically state that adolescents should be able to access contraception regardless of age or marital status.

75. GCHL, Risks, Rights and Health: Supplement (July 2018) op cit
76. UNFPA, Harmonizing the Legal Environment for Adolescent Sexual and Reproductive Health and Rights, A review of 23 countries in East and Southern Africa, 2017 – https://www.up.ac.za/media/shared/1/ZP_Files/unfpa-esaro-laws-and-policy-review-on-asrhr-2017.zp119762.pdf
77. ibid
78. ibid
79. UNAIDS, Implementation of the HIV Prevention 2020 Road Map, First Progress Report, March 2018 – https://www.unaids.org/sites/default/files/media_asset/jc2927_hiv-prevention-2020-road-map-first-progress-report_en.pdf

Laws that determine the age of consent to sex and criminalise consensual sex between young people exacerbate barriers to access to contraception and other sexual and reproductive health information and services, creating confusion for adolescents, parents, healthcare workers and law enforcement officials about when they may lawfully engage in consensual sexual activity and how officials and service providers should respond to adolescent sexuality.

In SEA, many countries criminalise underage sex between consenting adolescents and/ or consensual same sex activity between adolescents. In addition, several countries have discriminatory age limits, usually setting a higher age for girls or not specifying a minimum age for boys.

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

Country	Age of consent to sex
Angola	16 for boys and 18 for girls.
Botswana	Sex with a girl under the age of 16 is criminalised; a minimum age is not specified for boys.
Comoros	The age of consent to sex is 13 for girls and not specified for boys.
DRC	14 for girls; 18 for boys.
Kenya	Age of consent to sex is 18 years.
Lesotho	Sexual acts with a child below the age of 16 are criminalized.
Madagascar	The age of consent to sex is 14 for girls and not defined for boys. Sex with a girl below the age of 14 is deemed to be an indecent assault and criminalised by the Penal Code.
Malawi	Sexual activity with a child below the age of 18 is criminalised.
Mauritius	The age of consent to sex is 16 for both boys and girls and sex with someone below that age is criminalised.
Mozambique	The age of consent to sex for boys is not defined while the Penal Code criminalises sex with a girl below the age of 18.
Namibia	The age of consent to sex is 14 for boys and girls, but there is a close in age exception of three years.
Seychelles	The age of consent to sex is 16 for boys and girls. There is no close in age exception291 and a person above the age of 18 may be imprisoned for up to 14 years, while a person below the age of 18 is liable for up to 5 years imprisonment if they have sex with a person below the age of consent.
South Africa	The Sexual Offences Act 2007 sets the age of consent to sex at 16 for boys and girls and criminalises consensual sex between adolescents between the ages of 12 and 16. A close in age defence is permitted for sexual violation but not for sexual penetration.
Eswatini	The Girls and Women Protection Act of 1920 sets the age of consent to sex at 16 for girls and the Sexual Offences and Domestic Violence Bill (yet to be enacted) sets it at 16 for both boys and girls.
Tanzania	18 for boys and 15 for girls
Uganda	The age of consent to sex is 18 for boys and girls. The Penal Code criminalizes sex with a child under the age of 18.
Zambia	The age of consent to sex is 16 for girls and not specified for boys. Sex with a girl below the age of 16 is criminalized by the Penal Code.
Zimbabwe	The age of consent to sex is 16.

Laws that govern the age of marriage can also have a negative impact on the sexual and reproductive health and rights of adolescent girls. Complications from pregnancy and childbirth are the leading cause of death for adolescent girls between the ages 15 and 19.[80] Ninety percent of adolescent pregnancies in the developing world occur within the context of child marriage, which remains a critical human rights concern for adolescent girls in SEA countries such as DRC, Kenya, Madagascar, Malawi, Mozambique, Tanzania and Uganda.[81] In 2017, UNICEF data showed that 38% of girls below the age of 18 in sub-Saharan Africa were married, of which twelve percent of girls were below the age of 15. [82]

80. Girls Not Brides, https://www.girlsnotbrides.org/themes/health
81. Girls Not Brides, https://www.girlsnotbrides.org/where-does-it-happen/
82. ibid

Mozambique, Malawi, Madagascar, Uganda and the DRC are amongst the twenty most affected countries, while the DRC, Uganda, Tanzania, Mozambique and Kenya are amongst the 20 countries with the highest absolute numbers of child brides.[83] Child marriage also plays a critical role in driving HIV infections amongst girls in sub- Saharan Africa and has particularly harmful consequences for girls' education, as not all SEA countries have adopted and implemented laws and policies that protect the rights of pregnant adolescents and adolescent mothers to stay in school. Lesotho and the DRC have adopted laws that allow girls to continue their education. Botswana, Kenya, Madagascar, Malawi, Mozambique, Namibia, South Africa, ESwatini, Zambia and Zimbabwe have policies that allow girls to re-enter schools under certain conditions. Tanzania currently has an expulsion policy and does not allow pregnant girls to resume their education.[84]

One of the key steps for governments to reduce child marriage is through setting a legal minimum age of marriage at 18 years of age for both boys and girls with no exceptions. However, very few countries have done this. In an attempt to address this the Southern African Development Community Parliamentary Forum (SADC-PF) has adopted a (SADC) Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (2016).[85] The model law encourages member states to harmonise their national laws to prevent child marriages.

The 2014 and 2016 ARASA HIV and Human Rights Reports noted considerable progress in raising awareness about the abuses associated with child marriage and galvanizing support for efforts to end the practice. This progress has continued and in March 2018, UNICEF published new data that showed a significant drop in the global number of child marriages from 15 million new marriages every year to 12 million.[86]

6

Other laws, polices, social, cultural and other structural barriers to access to sexual and reproductive healthcare, information and services for vulnerable and key populations

In addition to those outlined above, there are various other legal, policy, social, cultural and structural barriers that prevent vulnerable and key populations from accessing sexual and reproductive health care services in SEA. These include stigma and discrimination against people living with HIV and key populations and laws that criminalise HIV transmission, exposure and non-disclosure.

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

The People Living with HIV Stigma Index (SI) studies measure and detect HIV-related stigma and discrimination against people living with HIV. Botswana, the DRC, eSwatini, Kenya, Lesotho, Malawi, Mauritius, Mozambique, South Africa, Tanzania, Uganda, Zambia and Zimbabwe have all completed Stigma Index studies.

These studies show that stigma and discrimination has not yet been eliminated and remain key concerns for people living with HIV and for key populations. A review of the findings of the Stigma Index studies illustrates the many dimensions of stigma and discrimination and how these undermine access to health care and other services.

83. ibid
84. Human Rights Watch, Leave No Girl Behind in Africa: discrimination in education against pregnant girls and adolescent mothers, 2018,
85. https://www.hrw.org/sites/default/files/report_pdf/au0618_web.pdf
86. https://www.girlsnotbrides.org/resource-centre/sadc-model-law-child-marriage/

Surveys indicate that discrimination in health-care settings still occurs, especially towards key populations. About one in three people living with HIV surveyed in Mauritius said they were denied health services because of their HIV status and that their HIV status had been disclosed without consent.

In Uganda, almost two thirds (64%) of surveyed people who inject drugs said they avoided health-care services for fear of discrimination or of being reported to law enforcement authorities.[87] In Botswana, Mozambique, Namibia, South Africa, and Zimbabwe, more than a third of sex workers felt discriminated against when they tried to access a health service. Sex workers were also refused medical assistance when health care workers found out that they do sex work.[88]

The National Council of People Living with HIV (NACOPHA) Stigma Index study, 2013 showed high levels of stigma and discrimination against people living with HIV countrywide (39.4%) and particularly high levels in Dar es Salaam (49.7%). The most common forms of stigma and ddiscrimination were gossip, social exclusion and verbal insults. Nearly one in three people in Dar Es Salaam experienced a loss of job or other source of income.[89]

People living with HIV who participated in the Stigma Index also reported high levels of internal stigma and shame: they blamed themselves for being infected and avoided sexual relationships, decided not to have children, avoided social gatherings, and were afraid of being gossiped about.[90] Women are especially vulnerable to stigma in their relationships, communities and health care settings.[91]

Key populations also experience stigma and discrimination within their families and communities. One study found that only 6% in Malawi of people would tolerate homosexual neighbours; 7% in Zambia; 10% in Zimbabwe; 12% in Madagascar; and 16% in Lesotho.[92] Young people, including young key populations, also report stigmatising attitudes and denial of appropriate sexual and reproductive health information services, creating further barriers to access to health care.

Discrimination in health care against women with HIV continues to be documented and acts as a major barrier to access to sexual and reproductive health services.

A study into discrimination in healthcare settings in Botswana, Malawi and Zambia[93] found various forms of discrimination against women with HIV in the healthcare setting, including treatment without proper informed consent, including failing to explain treatments and diagnoses; denial of treatment; aggressive attitudes and derogatory language; gossiping and unlawful disclosures of HIV status.

"Some HIV-positive expecting mothers are put on family planning without their full knowledge or consent. I have a deaf friend who was put on family planning without her full and informed consent."

(Woman living with HIV respondent – Kabwe, Zambia)

"At Kasanda Clinic, they test you for HIV before providing family planning to you. Anyone who wants to receive family planning services has to test for HIV."

(Women living with HIV respondents – Kabwe, Zambia)

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

87. 300Girls Not Brides, https://www.girlsnotbrides.org/articles/girls-not-brides-welcomes-historic-drop-in-global-number-of-child-marriages-but-warns-complacency-is-not-an-option/
88. UNAIDS Data 2018 – https://www.unaids.org/en/resources/documents/2018/unaids-data-2018
89. Aidsfonds Netherlands (2018), Sex work & violence in Southern Africa. A participatory research in Botswana, Mozambique, Namibia, South Africa and Zimbabwe, 2018 – http://www.sweat.org.za/wp-content/uploads/2019/09/Sex-work-and-violence-in-Southern-Africa-participatory-research-1-1.pdf
90. NACOPHA People Living with HIV Stigma Index Tanzania Country Assessment, 2013 - 2013 Available at https://www.medbox.org/document/the-people-living-with-hiv-stigma-index-report-tanzania#GO
91. ibid
92. UNAIDS Data 2018 op cit
93. Dulani B, Sambo G, Dionne KY. (2016) Good neighbours? African express high levels of tolerance for many, but not for all. Afrobarometer Dispatch No. 74. March 2016 – https://afrobarometer.org/publications/tolerance-in-africa
94. SALC, Accountability and redress for discrimination in healthcare in Botswana, Malawi and Zambia, 2016 – https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/Report-Accountability-and-Redress-for-Discrimination-in-Healthcare.pdf

6.2 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.

Laws criminalising HIV transmission, exposure and non-disclosure are rooted in and contribute towards HIV-related stigma and discrimination. They reinforce HIV-related stigma and as they create a fear of prosecution as a result of their health records being used against them, they also undermine universal access to prevention, treatment, care and support and other sexual and reproductive health services for people living with HIV.

Data from HIV Justice Worldwide and the HIV Justice Network, indicates that as of 2019 at least 29 sub-Saharan African countries have HIV criminalisation laws. Prosecutions are known to have occurred (under HIV-specific laws and general criminal laws) in Botswana, Cameroon, Congo, Democratic Republic of Congo, Kenya, Lesotho, Malawi, Niger, Nigeria (Lagos State and Zamfara State), Somalia, South Africa, and Zimbabwe. Of the countries in sub-Saharan Africa that have adopted HIV-specific laws, only 2 countries (Mauritius and Comoros) have not included a provision that criminalises HIV transmission. In addition, there are also countries (e.g., Zimbabwe) that criminalise HIV transmission outside of HIV-specific laws – e.g., they have public health or penal code provisions criminalising HIV transmission, exposure and/or non-disclosure.[94]

UNAIDS's 2013 ***Guidance on ending overly broad criminalisation of HIV non-disclosure, exposure and transmission*** reiterates that there is no evidence that criminalising HIV non-disclosure, exposure or transmission is effective in addressing HIV and AIDS. The guidance states that the overly broad application of the criminal law to non-disclosure, exposure and transmission of HIV causes significant human rights and public health concerns and urges countries to review provisions in light of the most recent, legal, medical and scientific evidence. It sets out key principles that should guide the use of the criminal law in dealing with harmful HIV-related behaviour and recommends that the use of criminal law in relation to HIV should be guided by the best available scientific and medical evidence relating to HIV; and uphold the principles of legal and judicial fairness (including key criminal law principles of legality, foreseeability, intent, causality, proportionality and proof), and protect the human rights of those involved in criminal law cases.[95]

The GCHL's 2018 Risks, Rights & Health Supplement includes updated recommendations on the criminalisation of HIV transmission, given the continued enactment and/or inappropriate use of criminal laws against people living with HIV and the slow pace of law reform, combined with recent advances in medical and scientific evidence on HIV transmission. Pre-exposure prophylaxis (PrEP) may be taken to prevent HIV transmission. More importantly, definitive studies show that ART, taken consistently, reduces a person's HIV viral load to undetectable levels and prevents HIV transmission. In light of these findings, the indiscriminate use of criminal law against people living with HIV becomes increasingly unjustifiable.[96]

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.

94. Sally Cameron and Edwin J Bernard on behalf of HIV Justice Worldwide and the HIV Justice Network (2019) Advancing HIV Justice 3: Growing the global movement against HIV criminalization, available at: http://www.hivjustice.net/advancing3/

95. UNAIDS, Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations, p.12, 2013 - p.12; available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/05/20130530_Guidance_Ending_Criminalisation.pdf

96. GCHL, Risks, Rights and Health: Supplement (July 2018) op cit

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".

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

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

SADC PF Motion: HIV criminalisation

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

There has been some progress in rescinding and reviewing punitive laws specific to the prosecution of HIV transmission, exposure and non-disclosure:

- The Mozambique HIV Law 12/2009 was reviewed in 2013 and the criminalization provision was removed.
- In 2018, following eight years of effective civil society lobbying, parliamentarians voted to amend Article 41 and abolish Article 45 removing the criminalisation provisions from the DRC HIV Law 08/011.
- The Malawi new HIV and AIDS (Prevention and Management) Act 2017 excludes criminalisation of HIV transmission.
- In 2017 in the Malawi case of EL v The Republic,276 the High Court upheld an appeal of a woman living with HIV against her conviction of a crime for breastfeeding her child. The Court found that the appellant did not have the requisite knowledge or belief that breastfeeding the child was likely to spread HIV.
- In 2019, Zimbabwe tabled a Marriage Bill which proposes to repeal the provision in the penal code that criminalises HIV transmission, exposure and non-disclosure.

7

Additional Readings and Resources

- Chimaraoke Izugbara, Seun Bakare, Meroji Sebany, Boniface Ushie, Frederick Wekesah & Joan Njagi (2020) Regional legal and policy instruments for addressing LGBT exclusion in Africa, Sexual and Reproductive Health Matters, 28:1, DOI: 10.1080/26410397.2019.1698905: https://www.tandfonline.com/doi/full/10.1080/26410397.2019.1698905
- Addressing inequalities and getting back on track to end AIDS by 2030: Report of the UN Secretary-General, March 2021: https://hlm2021aids.unaids.org/wp-content/uploads/2021/04/en-N2108064.pdf (En) and https://hlm2021aids.unaids.org/wp-content/uploads/2021/04/fr-N2108065.pdf (Fr)
- Sexual And Reproductive Health and Rights: An Essential Element of Universal Health Coverage, UNFPA: https://www.unfpa.org/sites/default/ les/pub-pdf/SRHR_an_essential_element_of_UHC_2020_online.pdf
- Legal Commitments for Sexual and Reproductive Health and Reproductive Rights for All, UNFPA: https://www.unfpa.org/sites/default/files/resource-pdf/19-321_UNFPA-SDG562-A4-Brochure-v3.7-2020-03-06-09491.pdf
- My Body Is My Own: State of the World population Report, 2021, UNFPA pages 85-107: https://www.unfpa.org/my-body-my-own-state-world-population-report-2021
- Advancing the Sexual and Reproductive Health and Rights of Women Who Use Drugs, Frontline AIDS, 2020: https://frontlineaids.org/wp-content/uploads/2020/02/Guide-for-harm-reduction-programmes-FINAL-24Feb-WEB.pdf
- Shapiro A., Duff P. (2021) Sexual and Reproductive Health and Rights Inequities Among Sex Workers Across the Life Course. In: Goldenberg S.M., Morgan Thomas R., Forbes A., Baral S. (eds) Sex Work, Health, and Human Rights. Springer, Cham. https://www.researchgate.net/publication/351166293_Sexual_and_Reproductive_Health_and_Rights_Inequities_Among_Sex_Workers_Across_the_Life_Course
- Ten Reasons to Oppose Criminalisation of HIV: https://www.opensocietyfoundations.org/publications/ten-reasons-oppose-criminalization-hiv-exposure-or-transmission#publications_download
- 10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women, Athena Network (2009): https://www.hivlawandpolicy.org/resources/10-reasons-why-criminalization-hiv-exposure-or-transmission-harms-women-athena-network

Videos

- Removing Legal and Structural Barriers to Ending AIDS by 2030: Lessons from the Global Commission on HIV and the Law: https://vimeo.com/566290740#
- Nothing about us, without us! HIV Justice Network: https://www.youtube.com/watch?v=YZXCzJ5Bz2k
- Women challenging HIV criminalisation in Africa, HIV Justice Network: https://www.youtube.com/watch?v=DGY5yej8Xlw