


A Review of Regional and National Human Rights Based HIV and AIDS Policies and Frameworks in Eastern and Southern Africa



UNDP-OHCHR Joint Initiative
for Eastern and Southern Africa

September 2006





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Commissioned by UNDP, Regional service Centre

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First published 2007-02-02

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Acknowledgement

This review has been prepared by Dr. Frans Viljoen and Susan Precious for the United Nations Development Programme-Regional Service Centre (UNDP) and the Office of the High Commissioner of Human Rights-Southern Africa Regional Office (OHCHR) as part of the OHCHR and UNDP joint initiative on human rights, gender and HIV and AIDS in Southern and Eastern Africa.

The authors are grateful to Karen Stefiszyn, Magnus Killander, Hye Young Lim, Soo Ryun Kwon, Matthew Splitek for researching individual sections of this report, Kristin Hughes for preparing appendices B, C, D, and E. and Nicolas Dasnois for assisting with translation of some French legislation.

The authors acknowledge the support of Shivaji Bhattacharya, Irene Akiy, Lopa Banerjee and Sihaka Tsemo.

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List of Abbreviations and Acronyms

AEC	African Economic Community
AIDS	Acquired Immune Deficiency Syndrome
APRM	African Peer Review Mechanism
ART	Antiretroviral treatment
ARV	Antiretroviral
AU	African Union
CAT	Convention Against Torture
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHR	Centre for Human Rights, University of Pretoria
CNLCSGE	National Commission to fight AIDS and other Endemic Diseases
CNLS	Comité National de Lutte contre le SIDA (National AIDS Committee)
COMESA	Common Market of Eastern and Southern Africa
CRC	Convention on the Rights of the Child
CSA	Centre for the Study of AIDS, University of Pretoria
CSOs	Community Service Organisations
EAC	East African Community
ECCAS	Economic Community of Central African States
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IEC	Information, Education, and Communication programme
IGAD	Intergovernmental Authority on Development
KNASP	Kenya National HIV/AIDS Strategic Plan
MCG	Monitoring and Coordination Group
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MPs	Members of Parliament
MSM	Men who have sex with men
NAC	National AIDS Council
NDI	National Democratic Institute for International Affairs
NEPAD	New Partnership for Africa's Development
OAU	Organisation of African Unity
OHCHR	UN Office of the High Commissioner for Human Rights
OVC	Orphans and vulnerable children
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
RECs	Regional Economic Communities
RIs	Regional Institutions
RSC	Regional Service Centre
SADC	Southern African Development Community
SADC PF	Southern African Development Community Parliamentary Forum
SARO	Southern African Regional Office
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Foreword



Twenty five years into the AIDS pandemic there is ample evidence that the inadequate realisation of human rights and gender equalities facilitate the spread of HIV and worsens the impact of AIDS. The protection of human rights, both of those vulnerable to infection and those already infected and affected, are

not only obligations of states but are critical to a successful response to HIV and AIDS. Supportive frameworks of policy and law are essential to effective HIV responses not only because of their moral rightness, but also because they promote positive public health results in addressing HIV.

This Study forms part of UNDP's work to promote HIV related human rights and gender equalities. It provides an inventory of policy documents, guidelines and legislation from 22 countries, several regional institutions and regional economic commissions in Southern and Eastern Africa, as well as a review of the application and implementation of these instruments. Further, it offers an evaluation of the extent to which these mechanisms are responsive to international standards on gender and human rights in the context of AIDS.

We hope that as part of scaling up the response to the epidemic, this study will serve as a useful benchmark for countries to assess their AIDS policies, laws and frameworks from the human rights and gender perspective. More importantly, we encourage all stakeholders to use the Review as a capacity development tool, and stimulate national and regional discussions on domestication of international and regional human rights and gender instruments, with a view to reducing vulnerabilities to HIV.

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Overview

HIV and AIDS presents a complicated socio-economic, development and human rights challenge. This is reflected in many of the declarations, commitments and guidelines issued by the United Nations, the African Union and the Southern African Development Community.

It is against that backdrop that this study examines the main AIDS and human rights policy documents, legislation and tools from 22 countries and from regional bodies and economic communities in Southern and Eastern Africa. The aim is to establish an inventory of existing instruments, to review their use and implementation, and to evaluate the extent to which they are responsive to international standards and gender concerns. In doing so, the study provides an overview of pertinent HIV and AIDS policies, laws and frameworks in these countries. This will hopefully serve as a basis for further, detailed country-specific research and for taking aboard some of the lessons and experiences from elsewhere.

The Southern African countries included in this study were: Angola, Botswana, Comoros, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Tanzania, South Africa, Swaziland, Zambia and Zimbabwe.

The East African countries included were: Burundi, Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan and Uganda.

In addition, the following regional economic communities and regional institutions were included: the African Union, the New Partnership for Africa's Development (NEPAD), the African Peer Review Mechanism (APRM), the regional African human rights instruments and human rights monitoring bodies, the Common Market for Eastern and Southern Africa (COMESA), the East African Community (EAC), the Economic Community of Central African States (ECCAS), the Intergovernmental Authority on Development (IGAD) and the Southern African Development Community (SADC).

A five-prong framework for analysis is used for each of the countries surveyed. Firstly, the HIV and AIDS policy and strategy framework of each country is examined. This includes national AIDS plans, national strategic frameworks as well as other sector-specific and subsidiary AIDS policies. Secondly, the study looks at the main bodies and institutions that are charged with, managing and supervising the respective national AIDS responses.

Thirdly, each country's national legislative framework is examined. This includes any legislation pertaining exclusively to AIDS, any constitutional provisions affording protection to People Living with HIV/AIDS (PLWHA), and any other general legislation that directly or indirectly affects the rights and lives of PLWHA. Bills and proposed legislation that have not yet taken effect are also included. The fourth section in each country analysis examines the national policies and legislative framework of each country against the UN Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS Revised International Guidelines on Human Rights and HIV/AIDS to determine the extent to which countries are adhering to international standards and are gender-responsive. The final section scans implementation and gaps by focusing on the ratification status of several international and regional treaties that are directly relevant to AIDS and human rights.

The research yielded several findings. At the regional level, the African Union (AU) has issued several important declarations relating to AIDS and human rights. Similarly, a commitment to place HIV and AIDS at the top of the agenda has been observed at the SADC Parliamentary Forum. However, three important challenges remain. Firstly, there is a need for greater coordination among the regional economic communities and regional institutions, in light of their overlapping memberships, mandates and objectives regarding HIV and AIDS. Secondly, the guidelines and policies at sub-regional level have not been widely adopted and are limited by their non-binding nature. Thirdly, self-review, monitoring and evaluation must be strengthened in order to secure greater implementation of international and regional human rights norms.

At the national level, there is a noticeable trend towards legislating in the AIDS and human rights realm. Approximately 80 per cent of legislative activity charted in this study has occurred since 2000, and numerous bills are currently making their way through the system. Eight broad categories of legislative activity were observed: (1) anti-discrimination and equality, (2) sexual offences, (3) property rights and inheritance, (4) customary practices, (5) domestic violence, (6) right to health care, (7) child rights and protection, and (8) protection of vulnerable groups.

Several other observations bear highlighting. Firstly, the majority of countries studied had some form of anti-discrimination legislation, but it was not always clear to what extent they would apply to PLWHA. In some cases, legislation explicitly covers HIV and AIDS, offering firm ground for legal recourse. In most cases, however, there is a more general prohibition of discrimination based upon a list of enumerated grounds of protection. Where such lists are “open”, it would fall to the courts to determine whether non-discrimination and equality protection should be expanded to PLWHA. But where the list is ‘closed’ and HIV or AIDS is not included, anti-discrimination protection for PLWHA would be much more tenuous. There is a need, therefore, for greater clarity concerning the scope of those anti-discrimination and equality provisions that do exist, and the extent to which they would apply on the horizontal plane (i.e. between non-state actors).

Secondly, the majority of legislative activity that has occurred has taken place in the realm of labour law and criminal law. More attention should be focused on expanding existing protections in the labour context to a much broader equality context. With respect to criminalisation, there has been insufficient investigation

into whether criminal sanctions adequately address the root causes of the spread of HIV. As well, too little is understood about the potential effect of criminalisation on groups such as women, who are already marginalised and stigmatised by the epidemic.

Thirdly, the three areas in which the least amount of legislative activity has taken place are: (1) property rights and inheritance, (2) harmful cultural practices, and (3) protection of vulnerable groups. These areas require immediate attention and legislative reform.

The study provides three broad recommendations for moving forward. Firstly, each country must conduct a comprehensive review of its legislation, and it should enact and reform legislation to fill gaps and correct inconsistencies in relation to AIDS and human rights. Secondly, regional economic communities and regional institutions must develop and approve model HIV and AIDS legislation to facilitate a comprehensive approach to HIV legislation and aid the push for harmonisation and domestication. Thirdly, parliamentary oversight, self-review, and monitoring and evaluation mechanisms must be strengthened to increase implementation at the national, regional and international levels.

I. Introduction



1. Introduction

A global epidemic

HIV has spread across the globe, infecting as many as 65 million people and AIDS has caused the deaths of some 25 million people in the past 25 years.¹

Sub-Saharan Africa is the region worst-affected by HIV and AIDS. Recent declines in HIV prevalence have occurred in Kenya and Zimbabwe,² and infection levels appear to have stabilised in several other countries – although often at very high levels, particularly in Southern Africa.³

The following table (based on data from the 2006 UNAIDS *Report on the Global AIDS Epidemic*) shows HIV prevalence for adults aged 15-49 years and for pregnant

women in the capitals of 22 countries in Southern and Eastern Africa.

AIDS as a development and human rights issue

The AIDS crisis constitutes a complicated development and human rights issue that requires sophisticated solutions across a range of sectors. As Mary Crewe has noted, “HIV and AIDS have brutally exposed all the fault lines of our society – poverty, gender inequality, violence, lack of access to education, health care and social service as well as the importance of employment and social security”.⁴ Jonathan Mann, one of the pioneers in linking human rights and health issues,⁵ remarked that “as the HIV epidemic matures and evolves within each community and country, it focuses inexorably on those groups that, before HIV/AIDS arrived, were already discriminated against, marginalised and stigmatised within

Country	Year	Prevalence for adults (15-49)	Year	Prevalence for pregnant women (15-24) in capital city
Angola	2005	3.7 [2.3-5.3%]	2004	2.8
Botswana	2005	24.1 [23.0-32.0%]	2005	33.5
Burundi	2005	3.3 [2.7-3.8%]	2004	8.6
Comoros	2005	> 0.1 [>0.2%]	-	-
Djibouti	2005	3.1 [0.8-6.9%]	-	-
Eritrea	2005	2.4 [1.3-3.9%]	-	-
Ethiopia	2005	0.9-3.5%	2003	11.5
Kenya	2005	6.1 [5.2-7.0%]	-	-
Lesotho	2005	23.2 [21.9-24.7%]	2005	27.3
Madagascar	2005	0.5 [0.2-1.2%]	-	-
Malawi	2005	14.1 [6.9-21.4%]	2001	15
Mauritius	2005	0.6 [0.3-1.8%]	-	-
Mozambique	2005	16.1 [12.5-20.0%]	2000	11.7
Namibia	2005	19.6 [8.6-31.7%]	2004	7.5
Somalia	2005	0.9 [0.5-1.6]	-	-
South Africa	2005	18.8 [16.8-20.7%]	2004	25.2
Sudan	2005	1.6 [0.8-2.7%]	-	-
Swaziland	2005	33.4 [21.2-45.3%]	2004	37.3
Tanzania	2005	6.5 [5.8-7.2%]	2000	7.5
Uganda	2005	6.7 [5.7-7.6%]	2005	5.2
Zambia	2005	17.0 [15.9-18.1%]	2004	20.7
Zimbabwe	2005	20.1 [13.3-27.6%]	2004	18.6

Information taken from the Global Report Annex 2: HIV and AIDS Estimates and Data 2005 and 2003. UNAIDS 2006 *Report on the Global AIDS Epidemic*.

1 UNAIDS, 2006 *Report on the Global AIDS Epidemic* p.4.

2 Note that declines in prevalence rates should not always be understood to be a positive development as it can sometimes reflect increased mortality. It is therefore critical to also monitor, as far as possible, incidence rates, that is, new infection cases.

3 UNAIDS, 2006 *Report on the Global AIDS Epidemic* p.8-9.

4 Statement made by Mary Crewe, Director of the Centre for the Study of AIDS at the University of Pretoria during her presentation “AIDS - democracy, development and human rights” given at the Stakeholder Consultation on Gender, Human Rights and HIV & AIDS: A UNDP-OHCHR Joint Initiative for Southern and Eastern Africa Rosebank Hotel, Johannesburg, 27-29 June 2006.

5 See eg J. Mann “Health and Human Rights: If not Now, When?” (1997) 2(1) *Health and Human Rights* 120. See also E. Cameron and Swanson “Public Health and Human Rights – The AIDS Crisis in South Africa” (1992) 8 *South African Journal on Human Rights* 200; M. Kirby “AIDS and the Law” (1993) 9 *South African Journal on Human Rights* 1; and E. Cameron “Human Rights, Racism and AIDS: The New Discrimination” (1993) 9 *South African Journal on Human Rights* 22.

each society".⁶ Christine Chinkin's statement that the "denial of human rights is both a cause and a consequence of being poor"⁷ is equally applicable in the context of HIV and AIDS. While human rights violations and falling human development indicators often reflect some of the consequences of the AIDS pandemic, they also rank among the key drivers of the epidemics that have spread so rapidly across the world.

While development and human rights were once seen as separate spheres, "rights-based development" is now regarded as part of a broader "human rights-based approach. Common to all such approaches is the notion that "the rights-based approach uses international human rights norms and treaties to hold governments accountable for their obligations".⁸ The rights-based approach also entails "making sure that citizens can hold governments accountable for their human rights obligations".⁹ Such a perspective moves development away from the discretionary or charitable realm and places it squarely within the rights realm. As Fareda Banda and others have pointed out, development and human rights ultimately are about securing freedoms.¹⁰

The HIV and AIDS context presents numerous examples where the spheres of development and human rights intersect.¹¹ Often, for example, the majority of health access points are located in urban centres, despite the fact that the majority of people may live in rural areas.¹² Ranged alongside the barrier posed by physical distance are out-of-pocket health care costs, institutional capacity constraints, human resource shortages, and an absence of effective new systems to manage funds, standardise work

methods and improve training strategies. In many Southern African countries, these hindrances stem from historical legacies and (sometimes ongoing) political and economic crises. The AIDS pandemic accentuates such health system fractures.¹³

In addition, the stigma and discrimination experienced by persons living with HIV/AIDS (PLWHA) take many forms¹⁴, and may prevent people from being tested for HIV. Lack of informed consent, proper pre- and post-testing counseling and violations of patients' right to confidentiality through non-consensual disclosure of their HIV status further discourages individuals from accessing testing and treatment services.¹⁵

Women, children and vulnerable groups such as men who have sex with men, injecting drug users, prisoners and sex workers often are even more susceptible to HIV infection because they are subjected to human rights violations or are unable to realise their rights.¹⁶

Women infected with HIV or vulnerable to infection do not slot into a single, uniform category of vulnerability or victimhood. Such uniformity would imply that women lack agency and power, which demonstrably is not the case.¹⁷ However, violence, poverty and inequality indisputably does increase women's vulnerability to HIV infection, as does the lack of adequate protection against such abuse and violation. Examples include a lack of anti-discrimination protection in the workplace, exposure to harmful cultural practices, lack of protection against domestic violence, restrictions on women's inheritance rights and on their ability to convey property freely.¹⁸ It is

6 J. Mann "Medicine and Public Health, Ethics and Human Rights" in *Health and Human Rights: A Reader* J. Mann et al, eds. (New York: Routledge, 1999) 439at 446.

7 C. Chinkin "The United Nations Decade for the Elimination of Poverty: What Role for International Law?" 54 *Current Legal Problems* (2001) at 556.

8 See *Ripple in still water: Reflection by activists on local- and national-level work on Economic, Social and Cultural Rights*, International Human Rights Internship Programme available at: <http://www1.umn.edu/humanrts/edumat/IHRIP/ripple/toc.html> (accessed 28 September 2006) Chapter 1.

9 *Realizing human rights for poor people: Strategies for achieving the international development targets* (DFID, 2000) 7, available at <http://www.dfid.gov.uk/pubs/files/tsphuman.pdf#search=%22realising%20human%20rights%20for%20poor%20people%22> (accessed 10 October 2006).

10 F. Banda *Women, Law and Human Rights* (Oxford: Hart Publishing: 2005) p.273-274. For more on poverty as a violation of human rights see C. Chinkin "The United Nations Decade for the Elimination of Poverty: What Role for International Law?" 54 *Current Legal Problems*, 553-589 (2001).

11 See generally, M. Heywood and D. Altman "Confronting AIDS: Human Rights, Law and Social Transformation" (2001) 5(1) *Health and Human Rights* 149.

12 For more on health care services for PLWHAs in rural and peri-urban communities in the South African context see J. Joni "Promoting the right to health care services for people living with HIV/AIDS in rural and peri-urban communities" *Righting Stigma* F.Viljoen, ed. (Pretoria: AIDS and Human Rights Research Unit University of Pretoria, 2005) p.132-149.

13 See M. O'Grady "The impoverishing pandemic: the impact of the HIV/AIDS crisis in Southern Africa on development" *From disaster to development: HIV and AIDS in Southern Africa* INTERFUND Development Update (December 2004) p.26.

14 See M. Maluwa, P. Aggleton and R. Parker "HIV- and AIDS-related Stigma, Discrimination, and Human Rights: A Critical Overview" (2003) 6(1) *Health and Human Rights* 1.

15 See N. Nongogo "HIV testing and voluntary counseling in the context of stigma" in *Righting Stigma* F.Viljoen, ed. (Pretoria: AIDS and Human Rights Research Unit University of Pretoria, 2005) p.94-114.

16 See eg F. Zuberi "If you (be)come HIV positive you will lose your human rights': HIV/AIDS stigma and human rights: A localized investigation of Hammanskraal communities – A report of the Tswelopele research project of the Centre for the Study of AIDS" in *Righting Stigma* F.Viljoen, ed. (Pretoria: AIDS and Human Rights Research Unit University of Pretoria, 2005) p.13.

17 For more on challenging stereotypes of women, vulnerability and HIV that ignore some women's agency see J. Berger "Re-sexualising the epidemic: desire, risk and HIV prevention" *From disaster to development: HIV and AIDS in Southern Africa* INTERFUND Development Update (December 2004) p.45-67.

18 See eg M. Pieterse "Beyond the reach of law: HIV, culture and customary law" (2000) *Journal of South African Law* 428; see also generally the work of Human Rights Watch, <http://www.hrw.org/women/aids.html> (accessed 10 October 2006).

vital to recognise the importance of such factors and the ways in which they interact with both development and human rights issues. Indeed, Amnesty International is among many organisations that views the AIDS pandemic as “a gendered health, development and human rights issue”.¹⁹

The law and human rights are therefore critical elements in the struggle to reverse the spread of HIV.²⁰ The AIDS crisis requires vigorous treatment roll-out and enhanced vaccine research, along with stepped-up prevention strategies, social campaigns, strengthened institutional capacities, increased human resources and much stronger political commitment. It also demands greater legislative protection in relation to gender equality and access to services.

It is important that development policies are implemented through a rights-based approach²¹ — that is to say, in line with human rights norms.²² Respect for human rights underpins a long-term and coordinated response. The temptation to sidestep human rights obligations when responding to development crises and public health emergencies (on the grounds that the emergency overrides the need to observe human rights) must be resisted. There is no evidence that human rights violations boost the AIDS response; on the contrary, they may fuel the crisis.

A meaningful human rights approach to HIV and AIDS requires both legislation and effective implementation – especially through court verdicts when disputes arise.²³ Numerous non-governmental organisations (NGOs), such as the Lawyers Collective (HIV/AIDS Unit) in India, the Treatment Action Campaign (TAC, based in South Africa) and the Canadian HIV/AIDS Legal Network, as well as international NGOs such as Human Rights Watch and Amnesty International, actively pursue a human rights-based approach to HIV and AIDS in their litigation and advocacy campaigns.

Internationally and regionally, HIV increasingly is being recognised as a development and human rights issue. At the 2001 Special Session of the UN General Assembly on

AIDS, 189 countries signed the *Declaration of Commitment on HIV/AIDS* in recognition that AIDS was a national and international development issue of the highest priority. In the same year, the Organization of African Unity (OAU) Assembly adopted the *Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases* (Abuja Declaration), which sought to make HIV and AIDS priorities in national development plans.²⁴ Member states also pledged to allocate 15% of their annual budgets to their health sectors.

In 2002, OHCHR and UNAIDS revised the 1996 *HIV/AIDS and Human Rights International Guidelines* to include an expanded Guideline 6 dealing with universal access to prevention, treatment, care and support.

In 2003, in the Maseru Declaration, SADC reaffirmed the commitments made in the Abuja Declaration, and emphasised the role of underlying social (especially gender) inequalities in the spread of HIV.²⁵ Among other things, the Maseru Declaration pledged to:

- Strengthen the capacities of women and children by providing health care services (including sexual and reproductive health services) that promote gender equality within culturally and gender-sensitive framework;²⁶
- Prevent and remove stigma, discrimination and denial, which continue to undermine HIV control efforts;²⁷
- Create and sustain an enabling environment conducive to gender balance, rapid and broad-based socio-economic development of the region and address major underlying factors that lead to the spread of HIV infection;²⁸ and
- Harmonise policies and strategies, and undertake joint programmes in the priority intervention areas, including prevention, treatment, care and support, nutrition and food security.²⁹

UN human rights treaties and other normative standards

Several international treaties, while not directly targeting HIV and AIDS, contain important commitments that deal

19 See Amnesty International. *Women, HIV/AIDS and human rights*. AI Index:ACT77/084/2004.

20 For more on this see Canadian HIV/AIDS Legal Network and the AIDS Law Project “Using Rights and the Law to Reduce Women’s Vulnerability to HIV/AIDS: a discussion paper” (October 2000).

21 P. Jones and K. Stokke “Introduction - Democratising Development: The Politics of Socio-Economic Rights” in *Democratising Development: The Politics of Socio-Economic Rights* eds. P. Jones and K. Stokke (Leiden: Martinus Nijhoff Publishers, 2005) p.9.

22 For more on the rights based approach to HIV/AIDS see C. Kisoona, M. Caesar & T. Jithoo “Whose Right?” *AIDS Review 2002* (Pretoria: Centre for the Study of AIDS, University of Pretoria).

23 See eg UNAIDS, *Courting Rights: Case Studies in Litigating the Human Rights of people Living with HIV* (Geneva: UNAIDS, 2006), published jointly with the Canadian HIV/AIDS Legal Network.

24 The Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases (April 2001) para 23.

25 The Maseru Declaration of SADC Heads of State on HIV/AIDS (4 July 2003).

26 The Maseru Declaration of SADC Heads of State on HIV/AIDS (4 July 2003) Article 1(f).

27 The Maseru Declaration of SADC Heads of State on HIV/AIDS (4 July 2003) Article 2(f).

28 The Maseru Declaration of SADC Heads of State on HIV/AIDS (4 July 2003) Article 3(a).

29 Maseru Declaration of SADC Heads of State on HIV/AIDS (4 July 2003) Article 3(b).

with states' legal responsibilities in the context of AIDS and human rights, and that touch on the lives of people living with HIV. These include:

- The Convention on the Elimination of all Forms of Discrimination,
- The International Covenant on Civil and Political Rights,
- The International Covenant on Economic, Social and Cultural Rights,
- The Convention on the Elimination of all Forms of Discrimination Against Women,
- The Convention on the Rights of the Child,
- The Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict,
- The Optional Protocol to the Convention on the Rights of the Child on the Sale of Children,
- The Convention Against Torture,
- The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.

All the States under discussion in this study belong to the UN and have ratified at least some of the major human rights instruments. (For a human rights treaty to become binding on a State, it must not only sign but also ratify that treaty. Signature merely indicates an intention to be bound in the future and does not entail binding obligations under international law to uphold all the provisions of a treaty.³⁰ Ratification is a formal action under international law that indicates consent on the part of the State to be bound by the treaty, and makes that State a "party" to a particular treaty. The principle of *pacta sunt servanda* determines that States are bound to respect treaties to which they explicitly consent.)

Since most of the major UN human rights treaties were adopted before the era of AIDS, none specifically refer to HIV or AIDS. Perusing documents such as the *International Covenant on Civil and Political Rights* (ICCPR), the *International Covenant on Economic, Social and Cultural Rights* (ICESCR), the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW), and the *Convention on the Rights of the Child* (CRC), it is obvious that many of their provisions nevertheless are very relevant to HIV and AIDS. Provisions dealing with equality, dignity, privacy, the prohibition of medical or scientific experimentation without free and informed

consent³¹ and the right to health, for example, directly affect the rights of persons living with HIV.³²

However, the potential applicability of provisions of these treaties remains unclear. Therefore, treaty monitoring bodies have supplemented the treaties with General Comments in which the effect of and relevance of the treaties for HIV and AIDS are spelled out.³³ Primary examples are General Comment 14 on the ICESCR (The right to the best attainable standard of health), General Comment 24 on CEDAW (Women and Health) and General Comment 3 on the CRC (HIV/AIDS and the rights of the child).

In General Comment 3 to the CRC, for example, the obligation of Governments to respect, protect and fulfil the rights of children is affirmed. States must, for example, "refrain from imposing mandatory" HIV testing on children (embodying the duty to *respect* their right to bodily integrity and privacy). States must also "ensure that children do not serve as research subjects until an intervention has already been thoroughly tested on adults" (illustrating the duty to *protect* children from exploitation during medical trials by pharmaceutical companies). Lastly, exemplifying their duty to *fulfil* a child's right to health, States must provide essential drugs to prevent transmission of HIV to children during birth. Through these General Comments, the extent of States' obligations under these treaties in the era of AIDS has been greatly clarified.

The major, tangible obligation of States under the above-mentioned treaties is to submit periodic State Reports. These are then examined by the treaty body which issues Concluding Observations. For example, after examining Botswana's report, the Convention on the Rights of the Child Committee concluded:³⁴ "In the light of General Comment No 3 [...] the Committee urges the State party to strengthen its efforts in combating the spread and effects of HIV/AIDS by, *inter alia*, training professionals, conducting education campaigns on prevention, improving the prevention of mother-to-child transmission programme, by providing free and universal antiretroviral medication and improving protection and support for AIDS orphans". In principle, these Concluding Observations³⁵ are not "binding determinations". Despite their lack of formal, legal force, the observations can be influential, depending on the State's concern for its

30 According to the 1969 Vienna Convention on the Law of Treaties, which sets out generally accepted rules for the interpretation of treaty obligations, signature of a treaty only requires a state to refrain from actions that will defeat the object and purpose of that treaty (art 18(a)).

31 See art 7 of the ICCPR.

32 See eg art 12 of the ICESCR.

33 These general comments are not binding in the same way as treaty provisions. To a great extent, their status depends on the competence provided for under the particular treaty to issue such comments. In so far as the comments are mandated and reflect an emerging jurisprudence, state parties negate them at the peril of moral sanctions.

34 CRC/C/15/Add.242, 3 November 2004, para 51.

35 See eg Tomuschat, C. (2003) *Human Rights Between Idealism and Realism* (Oxford: Oxford University Press) p. 154.

human rights record, and the interest of the media.³⁶

The extent to which States in the region have complied with their reporting obligations under the UN treaties is discouraging, with the exception of reporting under the CRC. This information is collated in Annexure D.

It is also important to note that international human rights treaties may serve as a forum for recourse if local (“national” or “domestic”) remedies have been exhausted. In all the UN treaties, States must make additional ratifications or “declarations” that accept the right of individuals to submit complaints against the State to the treaty body created under the relevant treaty. No individual complaints may be submitted under the ICCPR, unless a State has also ratified the First Optional Protocol to it. Similarly, States must formally accept the possibility of individual complaints under the Committee on the Elimination of Racial Discrimination (by making a declaration under article 14), the Convention Against Torture (by making a declaration under article 22) and by ratifying the Optional Protocol to CEDAW. No possibilities for accepting individual complaints exist under the ICESCR and CRC.

Some international human rights documents cannot be ratified, and are strictly declaratory. Although non-binding, such documents may carry significant persuasive force. An influential example of a non-binding commitment is the *International Guidelines on HIV/AIDS and Human Rights*³⁷, adopted in 1996 by a consultative meeting convened by UNAIDS and the Office of the High Commissioner for Human Rights. Although adopted by a limited group of 35 governmental, non-governmental and academic experts, these *Guidelines* have acquired strong persuasive weight as a benchmark for government action.³⁸

The *Guidelines* support a rights-based approach to HIV and AIDS and require the following:

- States should establish effective national institutions dealing with HIV and AIDS, such as inter-ministerial or parliamentary committees, and multisectoral advisory bodies, such as AIDS Councils;
- States should conduct comprehensive reviews of legislation, and adopt appropriate amendments and new legislation. In the realm of criminal law, States should ensure that criminal laws are not misused to target vulnerable groups;³⁹

- States are encouraged to enact or strengthen anti-discrimination laws and other laws protecting people with HIV, and to ensure the widespread availability of preventative measures and medication. Importantly, States need to go beyond legislating specifically for HIV and AIDS, by addressing underlying inequalities (especially those affecting women and children);
- States need to introduce monitoring and enforcement mechanisms to ensure that AIDS-related human rights and legal aid reaches persons in need.

In 1999, the Inter-Parliamentary Union and UNAIDS published a follow-up to the *Guidelines*, in the form of a *Handbook for Legislators on HIV/AIDS, Law and Human Rights*. The purpose of the *Handbook* is to “assist parliamentarians and other elected officials in promulgating and enacting effective legislation” in the AIDS response.⁴⁰ It contains several checklists against which compliance with the *Guidelines* can be measured. Unfortunately, the *Guidelines* lack mechanisms for monitoring or encouraging compliance by States.

One of the Millennium Development Goals (MDGs), adopted by the UN General Assembly in 2000, is to “to combat HIV/AIDS, Malaria and other diseases”.⁴¹ In 2001, the UN General Assembly Special Session (UNGASS) went further by adopting the *Declaration of Commitment on HIV/AIDS*, which provides for time-bound targets. Several such targets have been set: “By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups [...]”.⁴²

Although the primary responsibility to meet those targets rests with UN member States, the UN also provides support to the national implementation efforts of Governments. Thus UNAIDS has prepared and published an *Action Guide for United Nations Action Teams: Implementing the Declaration of Commitment on HIV/AIDS*. The document contains a checklist with questions concerning national compliance with the *Declaration of Commitment on HIV/AIDS* targets. In addition, core indicators have been identified.⁴³ For instance, countries have to adopt “laws and regulations that protect against discrimination of people living with HIV/AIDS” and “laws

36 Tomuschat at 154 – 155.

37 UN document E/CN.4/1997/37.

38 Two reasons in particular explain the high level of acceptance: The Guidelines were subsequently “welcomed” by the UN Commission on Human Rights (Resolution 1997/33), and were translated and widely disseminated.

39 *Guideline 4*.

40 *Handbook*, p.2.

41 Goal 6 of MDGs.

42 Para 58 of Declaration of Commitment on HIV/AIDS.

43 Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators.

and regulations that protect against discrimination groups of people identified as being especially vulnerable to HIV/AIDS”.

Regional treaties

Several regional treaties adopted under the auspices of the Organisation of African Unity (OAU) and its successor, the African Union (AU), are important in the context of AIDS and human rights:

- *The African Charter on Human and Peoples' Rights*,
- *The Protocol to the African Charter on the Rights of Women in Africa*,
- *The African Charter on the Rights and Welfare of the Child*.⁴⁴

With a few exceptions, these treaties have not been ratified, domesticated or implemented by the countries that signed them.

All the States under review in this study belong to the AU.

At the AU level, a distinction may be drawn between binding and non-binding regional human rights documents.

As regards binding standards, all the States under review are party to the *African Charter on Human and Peoples' Rights* (African Charter) and most are party to the *African Charter on the Rights and Welfare of the Child* (African Children's Charter). However, few are party to the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (Women's Protocol).

Adopted in 1981, the *African Charter* does not explicitly refer to HIV or AIDS. However, many of its provisions are relevant to HIV and AIDS. Those provisions include the rights to equality, dignity, security and health. The African Commission on Human and Peoples' Rights (African Commission) monitors compliance with the African Charter by examining reports which States themselves periodically submit. The Commission's amended guidelines on reporting now require States to report on issues concerning HIV and AIDS, and Commissioners consistently highlight this aspect when questioning State delegates. By ratifying or acceding to the African Charter, States also accept the rights of individuals to submit complaints to the African Commission. No communication concerning HIV and AIDS has yet been decided by the African Commission.

The *African Children's Charter*, adopted in 1990, also does not deal explicitly with HIV or AIDS. Despite this, numerous rights of children are relevant to HIV and AIDS. One example is the prohibition of child marriages.⁴⁵ Abolishing early marriage can reduce the vulnerability of the girl-child to infection by men who are older and therefore more likely to be HIV-infected. In its reporting guidelines, the African Children's Charter requires States to report on matters incidental to AIDS, such as health services and care for orphans, as well as on “HIV/AIDS orphans”.⁴⁶

The latest human rights instrument to be adopted under the auspices of the AU is the *Women's Protocol*. It not only refers to AIDS specifically, but also deals with numerous aspects that relate to women's status in the epidemic. State parties to the Protocol are required to guard the rights of women to “control their fertility”, “choose any method of contraception” and to “be protected against sexually transmitted infections, including HIV/AIDS”.⁴⁷ The Protocol entered into force in November 2005. By September 2006, 19 AU member states had become party to the Protocol.

Under these treaties, States incur an important reporting obligation. For details of the alarmingly low level of compliance with this obligation, see Annexure E.

AIDS and human rights legislation

Two important surveys have been conducted on AIDS and human rights legislation in the SADC region. In 2004, The Centre for Human Rights and the Centre for the Study of AIDS, both at the University of Pretoria, published eight country reports as part of their series *HIV/AIDS and Human Rights in SADC*.⁴⁸ In the same year, a survey conducted by the National Democratic Institute for International Affairs (NDI) and the Southern African Development Community Parliamentary Forum (SADC PF) made several important findings on HIV/AIDS in the region including:

- A lack of HIV- and AIDS-specific legislation;
- A lack of portfolio committees on HIV and AIDS;
- Incomplete implementation of national AIDS plans;
- Insufficient financial and human resources, weak health infrastructures, and poor coordination between governments, parliaments and civil society;
- Stigma, fear and discrimination remain major impediments to success of voluntary counselling and testing; and

44 State ratifications to all of these treaties for the 22 countries covered in this study can be found in Annexure A.

45 art 21(2) of the African Children's Charter.

46 See Guidelines VII and IX, reprinted in *African Human Rights Law Journal*, 2003, pp. 347 – 353.

47 art 1 of the Protocol on the Rights of Women.

48 This series is currently in the process of being updated and expanded.

The absence of mechanisms for monitoring AIDS programmes and expenditures.⁴⁹

On that basis, the National Democratic Institute for International Affairs (NDI) and SADC Parliamentary Forum recommended, among other things, the development of model HIV and AIDS legislation which all countries would adopt and implement at national level. However, funding constraints have stalled that initiative.

Meanwhile, some countries have pledged to address various concerns that have arisen in the AIDS, human rights and legal arena. Examples of such legislation include the criminalisation of wilful transmission of HIV, the prohibition of discrimination against people living with HIV (PLWHA) in the labour and employment context, gender equality legislation, the elimination of harmful cultural practices, protection for women and widows in the inheritance and property context, the criminalisation of marital rape, domestic violence legislation, the right to health care, protection of children and orphans and vulnerable children (OVC), and legislation dealing with vulnerable groups such as sex workers and injecting drug users.

Unfortunately, the harmonisation and application of these legislative efforts has been very weak.

2. The desk study

The main objective of this desk study is to:

Assess and analyse regional and national HIV and AIDS policies, strategies and frameworks in Southern and Eastern Africa. Review their application and implementation, as well as the extent to which existing policies, strategies and frameworks adhere to human rights principles and norms and are gender-responsive.

Methodology

In light of these objectives, the study researched the main AIDS and human rights policy documents, legislation, tools and methodologies from 22 countries and from several regional bodies. The following countries, listed within their geographical region, were included in the study:

Southern Africa

1. Angola
2. Botswana
3. Comoros

4. Lesotho
5. Madagascar
6. Malawi
7. Mauritius
8. Mozambique
9. Namibia
10. Tanzania
11. South Africa
12. Swaziland
13. Zambia
14. Zimbabwe

East Africa

15. Burundi
16. Djibouti
17. Ethiopia
18. Eritrea
19. Kenya
20. Somalia
21. Sudan
22. Uganda

In addition, this study examined the following Regional Economic Communities (RECs) and Regional Institutions (RIs):

1. The African Union (AU),
2. The New Partnership for Africa's Development (NEPAD),
3. The African Peer Review Mechanism (APRM),
4. The regional African human rights instruments and human rights monitoring bodies,
5. The Common Market for Eastern and Southern Africa (COMESA),
6. The East African Community (EAC),
7. The Economic Community of Central African States (ECCAS),
8. The Intergovernmental Authority on Development (IGAD),
9. The Southern African Development Community (SADC).

The framework for analysis for each of the countries was as follows:

1. Policy and strategy framework: The study researched national AIDS plans, national strategic frameworks, as well as other sector-specific and subsidiary AIDS policies.

2. Institutions: The study surveyed the main bodies and institutions charged with overseeing, managing,

⁴⁹ Survey of Legislative Efforts to Combat HIV/AIDS in Southern African Development Community (SADC) Region Report on the survey conducted by The National Democratic Institute for International Affairs (NDI) and The Southern African Development Community Parliamentary Forum (SADC PF) (November 2004).

supervising and decision-making with respect to the respective national responses on AIDS. This often included national AIDS coordinating authorities.

3. Legislative framework: For this component the study inquired whether each country had enacted legislation dedicated exclusively to HIV and AIDS. The study then analysed whether there were any constitutional provisions affording protection to PLWHA and whether there was any other general legislation that directly or indirectly affected the rights and lives of PLWHA. In doing so, the study included bills and proposed legislation that were being prepared and debated but had not yet taken effect.

4. Adherence of policies and laws to international standards and gender-responsiveness: The study examined the national policies and legislative framework against the Revised International Guidelines on HIV/AIDS and Human Rights to determine the extent to which countries were adhering to international standards and were gender-responsive.

5. Implementation and gaps: Here the study examined the ratification of several international and regional treaties that are directly relevant to AIDS and human rights.

Study limitations

This study is a starting point. It will provide countries with a baseline of their status with respect to HIV and AIDS laws, policies, frameworks and human rights instruments. It serves as a basis for domestication exercises and hopefully will enable countries to commission more detailed, country-specific research. The study will hopefully serve as a prelude to other efforts to bolster AIDS and human rights legal protection at national and regional levels.

To some extent, the study is also a work-in-progress. Time and resource constraints, linguistic obstacles and inaccessibility of source materials hindered efforts to provide a comprehensive inventory of the legal framework in all 22 countries under investigation. Those limitations were especially pronounced in a few countries, such as Burundi.

Moreover, the actual implementation of standards and the reasons for non-compliance could not always be ascertained. Even when legal frameworks do exist, factors such as a weak or dysfunctional judiciary, illiteracy, negative perceptions of the law, prohibitive legal cost and stigma may compromise the recourse to justice. There is a need for further research on those aspects.

II. The Study



1. The African Union

The African Union (AU) is committed to alleviating the AIDS pandemic and to the safeguarding the human rights of people living with HIV and AIDS (PLWHA). Although the AU Constitutive Act does not refer explicitly to HIV or AIDS, the following provisions do entail AIDS-related obligations:⁵⁰

Article 3: Objectives

[...]

(h) promote and protect human and peoples' rights in accordance with the African Charter on Human and Peoples' Rights and other relevant human rights instruments.

[...]

(n) work with relevant international partners in the eradication of preventable diseases and the promotion of good health on the continent.

Since its inception in 2001, the AU has explicitly declared its commitment to combating HIV/AIDS in numerous Declarations:

Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Disease (2001)

AIDS was seen to constitute a state of emergency and the AIDS response was to be placed at the forefront of respective national development plans. African Heads of State and Government also resolved to ensure equal rights for people living with HIV. The *Abuja Declaration* included a pledge to devote at least 15% of national annual budgets to the improvement of the health sector.

Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis, and Other Related Infectious Disease (2003)

The *Maputo Declaration* emerged from a special session to review and debate the status of HIV and AIDS, tuberculosis, malaria and other infectious disease in Africa at the Second Ordinary Session of the AU Assembly of Heads of State and Government. African leaders reaffirmed the commitments enshrined in the *Abuja Declaration*, and reiterated their commitment to intensify and consolidate their efforts.

The Solemn Declaration on Gender Equality (2004)

The attainment of gender equality in Africa can reduce the impact of AIDS on women and significantly alleviate the pandemic. Therefore, the *Solemn Declaration* ranked among the most significant commitments on HIV and AIDS made by African leaders. While all provisions were

indirectly related to the pandemic, African Heads of State and Government also agreed specifically to:⁵¹

accelerate the implementation of gender specific economic, social, and legal measures aimed at combating the HIV/AIDS pandemic and effectively implement both Abuja and Maputo Declarations on Malaria, HIV/AIDS, Tuberculosis and Other Infectious Disease. More specifically we will ensure that treatment and social services are available to women at the local level making it more responsive to the needs of families that are providing care; enact legislation to end discrimination against women living with HIV/AIDS and for the protection and care of people living against HIV/AIDS, particularly women; increase budgetary allocations in these sectors so as to alleviate women's burden of care;

[...]

establish AIDS Watch Africa as a unit within the Office of the Chairperson of the Commission who should render annual reports on the HIV/AIDS situation in the Continent during annual summits; and promote the local production of antiretroviral drugs in our countries.

Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care (2005)

African Ministers of Health committed themselves to the achievement of universal access to prevention, treatment and care by 2015 and requested the African Union Commission to produce a roadmap for sustainable universal access to prevention, treatment and care for the achievement of the UN millennium development goals. They also pledged to report on progress made.

A Special Summit of the AU on HIV/AIDS, Tuberculosis and Malaria was held in Abuja, Nigeria from 2 to 4 May 2006, which yielded the following documents:

Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (2006)

In the *Abuja Call*, African Heads of State and Government rededicated themselves and their countries to the twelve priorities of the *Abuja Plan of Action*: leadership at national, regional and continental levels; resource mobilisation; protection of human rights; poverty reduction, health and development; strengthening health systems; prevention, treatment, care and support; access to affordable medicines and technologies; research and development; implementation; partnerships; monitoring, evaluation and reporting.

Africa's Common Position to the UN General Assembly Special Session on HIV/AIDS (June 2006).

50 Constitutive Act of the African Union CAB/LEG/23.15 (May 26, 2001) (Constitutive Act), art 3.

51 Solemn Declaration on Gender Equality in Africa Assembly/AU/Decl.12 (III) Rev.1 (2004) (Solemn Declaration).

Africa's Common Position recognised opportunities for intensified action, outlined the guiding principles to which Africa would adhere, provided concrete targets to be met by 2010, requested the international community to reaffirm its commitment to strengthening the partnership with Africa for the fight against AIDS, and urged the donor community and health development partners to increase HIV- and AIDS-related allocations to African countries by replenishing the Global Fund Against HIV/AIDS, Tuberculosis and Malaria.

Draft continental Framework for harmonisation of approaches among member states and integration of policies on human rights and people infected and affected by HIV/AIDS in Africa (2006)

The *Draft Continental Framework* was the outcome of the *Continental Forum on Human Rights and People Infected and Affected by HIV/AIDS*. It emerged as a response to the prioritisation of the protection of human rights in the *Abuja Plan of Action*. The objectives of the framework included: awareness-raising on and reversal of the negative impact of AIDS on communities (especially vulnerable and marginalised groups); advocacy for the enactment or strengthening of legislation to protect PLWHA; addressing known cases of violations of human rights of PLWHA; and harmonising at regional and continental levels various human rights approaches aimed at protecting PLWHA. Annual reports are to be prepared at national level, and biennial reports are required at continental level. A mid-term review will be conducted after five years.

Nine organs of the African Union (AU)⁵² were tasked with implementing the objectives of the Constitutive Act, in line with its underlying principles. The Commission of the AU is the organ most relevant to the implementation of the above-mentioned commitments. One of the functions of the Commission is to implement decisions of other organs of the AU.⁵³ AIDS Watch Africa has been established in the office of the Commission to provide top-level leadership to the continental AIDS response. The Commission has been mandated to develop an implementation plan for *Africa's Common Position*, coordinate and monitor its execution, and submit annual reports to the AU Assembly.

The Pan-African Parliament (PAP), another organ of the AU, is also mandated to facilitate the effective implementation of the policies and objectives of the AU.⁵⁴ In this regard it could be involved in realising the above declarations and commitments, particularly through the subcommittee on health, labour, and social affairs. The PAP has held four sessions to date. Aside from a recommendation on AIDS, malaria and tuberculosis that emerged from the fourth session, its involvement in the continental response to AIDS is undefined.

The African Commission on Human and Peoples' Rights, the New Partnership for Africa's Development (NEPAD) and the African Peer Review Mechanism also have a role to play, as outlined elsewhere in this study.

Implementation of the *Abuja Declaration* and other commitments occurs in collaboration with, and is supported by WHO, UNAIDS, UNICEF, UNFPA, along with various other agencies and development partners. The implementation occurs within the framework of several global undertakings, including the *Millennium Development Goals* (MDGs) and the implementation of the *Declaration of Commitment on HIV/AIDS*.⁵⁵ Partnerships at local, national, continental and international levels are also an integral component of the implementation framework.

At the Special Summit (held in early May 2006), a progress report was presented on the implementation of the *Abuja Declaration*.⁵⁶ The report noted that approximately half of African countries had declared AIDS an emergency, almost all African countries had established national coordinating bodies⁵⁷, and one third of countries had allocated at least 10% of their national resources to health.⁵⁸

However, several gaps were also acknowledged. Coordination of regional and national partnerships was weak⁵⁹, few countries had adopted policies and legislation protecting PLWHA⁶⁰, and only 28% of the countries had put in place specific programmes targeting vulnerable groups.⁶¹ Monitoring and evaluation systems were deemed weak, and were being undermined by the cumbersome nature of the monitoring and evaluation framework for the *Abuja Declaration on HIV/AIDS and TB*.⁶²

52 n 50, art 5.

53 Statutes of the Commission of the African Union ASS/AU/2(I)-d (2002) art 3(2)(c).

54 Protocol to the Treaty Establishing the African Economic Community Relating to the Pan-African Parliament EAHG/3(V) (2001) (Pan-African Parliament Protocol), art 11.

55 Progress Report on the Implementation of the Plans of Action of the Abuja Declarations on Malaria (2000), HIV/AIDS and Tuberculosis (2001/1 to 2005) Sp/Ex.CL/ATM/6 (1), para 6.

56 As above.

57 As above, para 2(a).

58 As above.

59 As above, para 3.

60 As above. Figure 4 of the report indicates that 19 of 53 countries have applicable human rights legislation on HIV/AIDS.

61 As above, para 39.

62 As above.

The African Union has shown the collective political will to combat AIDS and to protect the rights of PLWHA. However, the realisation of its numerous commitments depends largely on the political will of its individual States, all of which are also confronted with many other competing priorities.

2. The New Partnership for Africa's Development (NEPAD)

The New Partnership for Africa's Development (NEPAD) was adopted in 2001. In its founding document, NEPAD identifies AIDS as one "the major impediments facing African development efforts".⁶³ However, the same document is surprisingly silent about how to approach HIV and AIDS.⁶⁴ Apart from the excerpt cited here, the few other references to HIV and AIDS regard the pandemic solely as a health issue and do not reflect its impact on development.⁶⁵ In paragraph 49, it is stated that "African leaders will take joint responsibility for" *inter alia* "[r]evitalising and extending the provision of education, technical training and health services, with high priority given to addressing the problem of HIV/AIDS, malaria and other communicable diseases".

Within NEPAD's sectoral priorities, health falls under the "human resource development initiative" along with poverty reduction, education and reversing the brain drain. One of the stated objectives is to "strengthen programmes for containing communicable diseases, so that they do not fall short of the scale required in order to reduce the burden of disease".⁶⁶ HIV and AIDS are mentioned only in the context of resource mobilisation.⁶⁷

According to paragraph 186, the programme on communicable diseases, including HIV and AIDS, is to be one of four fast-tracked NEPAD programmes.⁶⁸

The pandemic receives more attention in the NEPAD Health Strategy, which was adopted in 2003.⁶⁹ The goal of

the strategy is to "dramatically reduce the burden of disease, especially for the poorest people in Africa",⁷⁰ with one of the objectives to "scale up [...] disease control programmes".⁷¹ The strategy recognises AIDS as "an unprecedented challenge for Africa, reversing the gains made in life expectancy over the past half century"⁷² and "placing additional stress on an already overburdened health system".⁷³ The strategy notes the specific vulnerability of women and young people with regard to HIV and AIDS.⁷⁴

While recognising the many health problems facing the continent, the strategy states that the "immediate priority must be to reduce the burden of disease caused by AIDS and also by TB, malaria and childhood communicable diseases".⁷⁵ However, resources

*must not just go into disease specific programmes but also into securing the vehicle that needs to provide much of the specific prevention and care that has to be implemented - the health system.*⁷⁶

The specific target of the strategy with regard to HIV/AIDS is "[t]o halt and to begin to reverse the spread of HIV/AIDS by 2015"⁷⁷ as set out in the *UN Millennium Declaration*. It is further stated that:

*NEPAD envisages a massively scaled-up AIDS prevention effort incorporating education, access to condoms, voluntary counseling and testing, treatment for sexually transmitted infections (STIs) and prevention of mother-to-child transmission. Targeting of those at high risk, such as sex workers, migrant workers and youth must be stepped up and prioritised. Care includes home-based care and care of orphans, improvements in quality of life, treatment and prophylaxis of opportunistic infections and use of antiretrovirals. As with other diseases, effective care will require affordable drugs and strengthened health systems, including effective drug distribution, strengthened laboratory services and caring health staff. It also requires community action and empowered individuals and families.*⁷⁸

63 NEPAD para 125. See also NEPAD Health Strategy 12.

64 According to para 68 of NEPAD its goal is to achieve the "International Development Goals". The list of these goals enumerated in the paragraph glaringly omits the goal to halt and reverse the spread of HIV/AIDS by 2015 and to provide assistance to children orphaned by HIV/AIDS. Cf United Nations Millennium Declaration, A/res/55/2, para 19.

65 See also B Manby "The African Union, NEPAD, and Human Rights: The Missing Agenda" (2004) 26 *Human Rights Quarterly* 1017.

66 NEPAD para 123.

67 As above, para 124.

68 The other three being information and communications technology, debt reduction and market access.

69 Adopted by the First Conference of Health Ministers of the African Union, Tripoli, Libya, April 2003. See E Buch "General introduction to the NEPAD Health Strategy", September 2003.

70 NEPAD Health Strategy 14.

71 As above, 14.

72 As above, 4.

73 As above, 6.

74 As above, 5.

75 As above, 21.

76 As above, 25.

77 As above, 16.

78 As above, 21

Young people are deemed essential to successful HIV prevention, and should be involved in the design, implementation and evaluation of programmes affecting them.⁷⁹

The strategy sets out seven “strategic directions”:⁸⁰

- Strengthen commitment by, and the stewardship role of government,
- Build secure health systems and services,
- Strengthen programmes to reduce the burden of disease,
- Provide skilled care for pregnancy and childbirth,
- Enable individual action to improve health,
- Mobilise and effectively use sufficient sustainable resources,
- Strive for equity for the poor, the displaced and the marginalised.

The strategy's HIV- and AIDS-related programme of action is not very detailed and does not contain time-bound commitments:

- Enhance prevention-related HIV programmes, in particular peer education programmes for vulnerable groups and those targeting youth;
- Advocate for and support the provision of affordable antiretroviral therapy and treatment of opportunistic infections in persons living with HIV;
- Support the expansion of services for voluntary counselling and testing;
- Support the scaling-up of interventions for the prevention and treatment of Sexually Transmitted Infections.

NEPAD develops strategies and programmes, but it is not an implementation agency.⁸¹ The responsibility for monitoring implementation rests with individual Governments and with the NEPAD Secretariat. Independent reviews are undertaken in the context of the African Peer Review Mechanism (APRM).⁸² The Health Strategy also recognises the important role that regional economic communities can play in developing common legal frameworks and programmes.⁸³

The Report of the NEPAD Secretariat to the NEPAD

Heads of State and Government Implementation Committee meeting in Khartoum in January 2006 contains one paragraph on health, but provides no details about the impact of the Health Strategy:

*Countries have continued to use the AU/NEPAD Health Strategy in advancing their national health plans. Several projects (Annexure) have been implemented with the financial support of the African Development Bank. Support for the development of African health knowledge institutions and centres of excellence is on the increase. Health, in particular HIV and AIDS are being mainstreamed into NEPAD priority programs such as Agriculture, Education, ICT, and Science and Technology.*⁸⁴

3. The African Peer Review Mechanism (APRM)

In 2002, the AU Assembly adopted the *Declaration on Democracy, Political, Economic and Corporate Governance (Governance Declaration)*.⁸⁵ This Declaration forms the basis for the reviews undertaken voluntarily by African states under the auspices of the APRM.⁸⁶ The *Governance Declaration's* only reference to HIV and AIDS is an undertaking to “work towards the enhancement of our human resources through [...] education [...] and better health care, with priority attention to addressing HIV/AIDS and other pandemic diseases”.⁸⁷

A document entitled “Objectives, standards, criteria and indicators for the African Peer Review Mechanism” refers to the need to “[s]trengthen policies, delivery mechanisms and outcomes in key social development areas (including education and combating of HIV/AIDS and other communicable diseases)”.⁸⁸

The review process is based on a self-assessment by the country under review, which is complemented by a review report by an international panel and a national plan of action. Those documents are then discussed by the APRM Forum, which consists of the participating Heads of State and Government. As of May 2006, only Ghana's review had been finalised. South Africa began its self-assessment in 2005, with AIDS featuring prominently, particularly in civil society submissions to the process.

79 As above, 21

80 As above, 17.

81 As above, 26.

82 As above, 32.

83 As above, 18.

84 NEPAD/HSGIC/14-2006/PROGRESS REPORT, 22 January 2006, para 26.

85 AHG/235 (XXXVIII) Annex I.

86 Currently 25 states have signed up for reviews under the APRM.

87 Governance Declaration para 21.

88 paras 5.1 and 5.3.

4. The African regional human rights instruments and human rights monitoring bodies

The AU and its predecessor, the OAU, have adopted a number of conventions and protocols that deal with human rights, including the *African Charter on Human and Peoples' Rights (African Charter)*, adopted in 1981⁸⁹ and the *African Charter on the Rights and Welfare of the Child (African Children's Charter)*, adopted in 1990. The right to health is included in both those instruments. However, only the *Protocol on the Rights of Women (Protocol on Women)*, adopted in 2003) makes specific reference to HIV or AIDS. Article 14 of the *Protocol* deals with health and reproductive rights, and states that women have the right to be protected against "sexually transmitted infections, including HIV/AIDS" and

the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices.

The African Commission on Human and Peoples' Rights (African Commission), which monitors state implementation of the *African Charter and the Protocol on Women*, first elaborated on the issue of human rights in the context of AIDS in a 2001 resolution that called upon States

*to allocate national resources that reflect a determination to fight the spread of HIV/AIDS, ensure human rights protection of those living with HIV/AIDS against discrimination, provide support to families for the care of those dying of AIDS, devise public health care programmes of education and carry out public awareness especially in view of free and voluntary HIV testing, as well as appropriate medical interventions.*⁹⁰

In a 2004 resolution on the situation of women and children in Africa, the Commission appealed to Member States to implement programmes to combat AIDS. A review of the Commission's activity reports suggests that it has not vigorously engaged with the pandemic.

Some State reports have mentioned the pandemic. In its concluding observations on the periodic report of South Africa, adopted in December 2005, the African

Commission did not refer to HIV and AIDS in the "principal areas of concern" or "recommendations" sections. However, the Commission did mention that the South African delegation had pledged to provide it with additional information on law and policy relating to AIDS.⁹¹ No communications to the African Commission or the African Children's Committee, established to monitor compliance with the African Children's Charter, have dealt with HIV and AIDS.

5. African Regional Economic Communities

Numerous Regional Economic Communities (RECs) have been established in Africa, and in Southern and Eastern Africa. Under the Treaty establishing the African Economic Community (AEC), these entities form the building blocks of future economic integration on the continent. One of the main problems resulting from the multiplicity of RECs is overlapping membership, which tends to divide limited resources and duplicate efforts.

5.1 Common Market for Eastern and Southern Africa (COMESA)

The Treaty establishing a Common Market for Eastern and Southern Africa (COMESA) was adopted in 1993 and entered into force in 1994.⁹² Article 110(1)(a) of the Treaty states that "member states agree to undertake concerted measures to co-operate in health through the control of pandemics or epidemics".

In its Gender Policy, adopted in 2005, COMESA declares that AIDS and human rights should be mainstreamed in all its policies and programmes.⁹³

5.2 East African Community (EAC)

In the Treaty establishing the East African Community (EAC), adopted in 1999 and entered into force in 2000, the state parties undertake to take steps to prevent and control communicable diseases such as AIDS.⁹⁴

The EAC Development Strategy 2001-2005 only mentions HIV and AIDS in the context of establishing three regional working groups to deal with sexually transmitted diseases (including AIDS), communicable diseases and health research respectively.⁹⁵

89 Ratified by all the 53 member states of the AU.

90 Resolution on the HIV/AIDS pandemic / threat against human rights and humanity, para 2.

91 Thirty Eighth Ordinary Session, 21 November - 5 December 2005. Consideration of Reports submitted by State Parties under Article 62 of the African Charter on Human and Peoples' Rights Concluding observations and recommendations on the First Periodic Report of the Republic of South Africa, paras 22-23.

92 Member states: Angola, Burundi, Comoros, DRC, Djibouti, Egypt, Eritrea, Ethiopia, Kenya, Libya, Madagascar, Malawi, Mauritius, Rwanda, Seychelles, Sudan, Swaziland, Uganda, Zambia and Zimbabwe.

93 COMESA Gender Policy para 4.0(o).

94 art 118(a) of the EAC treaty. Member states: Kenya, Tanzania and Uganda.

95 The Second EAC Development Strategy 2001-2005, para 4.6.1.

An East African Integrated Diseases Surveillance Network (EIDSNet) was established in 2000 with the goal to

*reduce morbidity and mortality due to common communicable diseases in the East African Region through the establishment of a strong Network capable of generating useful epidemiological information for early warning of impending epidemics as well as supporting joint planning and implementation of disease control measures.*⁹⁶

5.3 Economic Community of Central African States (ECCAS)

The Treaty establishing the Economic Community of Central African States was adopted in 1983 and entered into force in 1985.⁹⁷ In article 60 it states that member states shall “initiate sub-regional cooperation in public health”.

In November 2003 the ECCAS Ministers of Health adopted a regional action plan against AIDS.⁹⁸

5.4 Intergovernmental Authority on Development (IGAD)

The Agreement Establishing the Inter-Governmental Authority on Development (IGAD) was adopted and entered into force in 1996.⁹⁹

In November 2003, IGAD launched a one-year “monitoring and evaluating programme” on HIV and AIDS in the member states with the objective to “address the HIV/AIDS pandemic and build the capacity of national HIV/AIDS monitoring and evaluation operations in countries of the sub-region”.¹⁰⁰

5.5 Southern African Development Community (SADC)

The *Treaty of the Southern African Development Community* was adopted in 1992 and entered into force in 1993.¹⁰¹ The *Treaty* was amended in 2001 and includes a commitment to “combat HIV/AIDS and other deadly or communicable diseases” as one of the objectives of the organisation.¹⁰²

SADC has been the most active of the RECs in responding to the AIDS pandemic.

The *SADC Protocol on Health* was adopted in 1999 and entered into force in August 2004. At the time of writing, nine of the 14 SADC Member States were party to the *Protocol*. According to article 10 of the *Protocol*, State parties shall harmonise HIV and AIDS policies, standardise surveillance systems and exchange information. State parties shall “endeavour to provide high-risk and trans-border populations with preventative and basic curative services for HIV/AIDS/STDs”.

In July 2003, the SADC Heads of State and Government meeting in Maseru adopted a *Declaration on HIV and AIDS and an HIV and AIDS Strategic Framework (2003-2007)*, which replaced an earlier framework (2000-2004).

The *Strategic Framework* set as its goal to

*decrease the number of individuals living with HIV and AIDS and families affected by the epidemic in the SADC region, so that HIV and AIDS is no longer a threat to public health and the socioeconomic development of Member States.*¹⁰³

The *Strategic Framework* was developed using the following guiding principles:

- Multi-sectoral approach
- Subsidiarity
- Prioritisation
- Gender mainstreaming
- Complementary to national initiatives
- Recognition of national, regional and global initiatives
- Human rights
- Participation

The Plan sets out several time-bound activities for directorates in a reorganised SADC Secretariat.¹⁰⁴ The SADC Secretariat has established an HIV and AIDS Unit within its Department of Strategic Planning, Gender and Policy Harmonisation. The mandate of the HIV and AIDS Unit is to “lead, coordinate and manage SADC’s response to the epidemic through the operationalisation of the HIV and AIDS Strategic Framework (2003-2007) and the

96 <http://www.eac.int/eidsnet/> (accessed 22 June 2006).

97 Member states: Angola, Burundi, Cameroon, Central African Republic, Chad, Congo, DRC, Equatorial Guinea, Gabon, Rwanda and Saõ Tomé and Príncipe.

98 Regional Action Plan Against AIDS.

99 Member states: Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan and Uganda.

100 “IGAD launches HIV/AIDS programme in member states”, AFP, 8 December 2003, <http://www.aegis.com/news/afp/2003/AF031266.html> (accessed 22 June 2006).

101 Member states: Angola, Botswana, DRC, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

102 art 5(1)(i) of the SADC Treaty.

103 SADC HIV and AIDS Strategic Framework and Programme of Action (2003-2007) 17.

104 As above, 20-32.

Maseru Declaration".¹⁰⁵ The Unit has four core staff members and additional project staff.¹⁰⁶ In November 2004 the Unit published a SADC HIV and AIDS Business Plan for 2005-2009.

The SADC Parliamentary Forum (SADC PF) has also been active with regards to HIV and AIDS. In 2004, it published a survey of legislative efforts to combat AIDS in the region.¹⁰⁷ The HIV and AIDS Unit of the SADC Secretariat and the SADC PF have produced information leaflets on the pandemic.

6. Angola

6.1 Policy and strategy framework

Angola's first national *HIV/AIDS and STI Strategic Plan*¹⁰⁸ dates to 1999, and was followed by a second strategy in 2003.¹⁰⁹ Prepared by various ministries, local and international NGOs, churches, and some Deputy Governors, donors and United Nations agencies, it aims to define the strategic direction of the Government of Angola's AIDS response. The *Strategic Plan* has a total budget of US\$160 million for the five-year period of 2003-2008, and centres on three objectives:¹¹⁰

1. Strengthen the capacity of the national response to fight the AIDS epidemic at various levels.
 - 1.1 Strengthen the National AIDS Control Commission (CNLS¹¹¹) and Provincial AIDS Control Commissions (CPLSs) to develop actions at the political level and to mobilise financial resources to combat the AIDS epidemic;
 - 1.2 Reinforce the National AIDS Programme (now the National Institute to fight HIV/AIDS) at the central and provincial level;
 - 1.3 Mobilise the Government and civil society to ensure greater integration of HIV and AIDS into their interventions;
 - 1.4 Reinforce the national system of haemotherapy and bio-safety;
 - 1.5 Strengthen the national network of HIV laboratories;
 - 1.6 Strengthen the national HIV epidemiological and

- behavioural surveillance system;
- 1.7 Establish a system of laws and norms related to HIV and AIDS and guarantee the respect of human rights of people infected with and affected by HIV and AIDS.
2. Reduce the spread of the HIV and other STIs.
 - 2.1 Promote change of behaviour, attitudes and risky practices among the sexually-active population aged 12-49 years;
 - 2.2 Reduce STIs.
3. Reduce the socio-economic impact of AIDS on the individual, family and community.
 - 3.1 Promote complete care for people living with HIV, including psychosocial support, medical treatment and medicines.

The *National Strategic Plan* was translated into Provincial and Ministerial Operational Plans. All 18 provinces and some ministries have prepared their own operations plans.¹¹²

The *National Plan for Reproductive Health 2002-2007*¹¹³ focuses on improving the health of women and men of reproductive age through quality services for prenatal care, birth assistance, family planning, STIs and HIV.¹¹⁴

UNAIDS has supported the development of national guidelines for HIV patient management.¹¹⁵

6.2 Institutions

The National Institute to Fight HIV/AIDS was created by an Executive Decree of the Council of Ministers¹¹⁶ as part of an effort to restructure and adapt the existing organisational state of the National AIDS Programme.

The National Commission to Fight AIDS and other Endemic Diseases (CNLCSEGE) was formed by Decree no/03 of 10 January 2003. It is coordinated by the President of the Republic and is composed of the following ministries: Health, Education, Culture, Assistance and Social Reintegration, Agriculture and Rural Development, Youth and Sport, Justice, National Defense,

105 SADC HIV and AIDS Business Plan (2004) 12.

106 As above.

107 Survey of legislative efforts to combat HIV/AIDS in the Southern Africa Development Community (SADC) region, Report on a survey conducted by the National Democratic Institute for International Affairs (NDI) and the Southern Africa Development Community Parliamentary Forum (SADC PF), November 2004.

108 Plano Estratégico Nacional Para Infecções de Transmissão Sexual, VIH e SIDA.

109 National HIV/AIDS and STI Strategic Plan 2003-2008.

110 As above, 62-85.

111 Comissão Nacional Luta Contra o SIDA.

112 UNGASS Report 2006 (December 2005).

113 Plano Estratégico Nacional de Saúde Reprodutiva 2002-2007.

114 C. Campher "Civil society response to HIV/AIDS in Angola" (2002) 5 *Interfund Development Update* 139.

115 <http://www.unaids.org/en/Coordination/Regions/default.asp> (accessed 23 June 2006).

116 n 112, 11.

Interior, Public Administration, Labour and Social Security, Territorial Administration, Information, and Planning.¹¹⁷

The CNLCSGE is assisted in its decision-making process by a Technical Committee which comprises the Deputy Ministers of the various Ministries belonging to the Commission.¹¹⁸ The CNLCSGE is represented at the provincial level by the Provincial Committees of the CNLSGE, which is composed of Provincial Directors from the above ministries and which is chaired by the Governor or Deputy Governor for Social Affairs. Most provinces have already formed their own provincial ministries.¹¹⁹

Angola's National AIDS Control Programme (*Programa Nacional de Luta Contra o SIDA*) was established in 1987 as part of the Ministry of Health, and serves as the national coordinating body in the fight against AIDS.¹²⁰

In April 2005, a National Monitoring and Evaluation Technical Working Group (GTMA) was created with the support of UNAIDS. It is mandated to support the CNLSGE and INLS in establishing a national monitoring and evaluation system as part of the "Three Ones" Strategy.¹²¹

6.3 Legislative framework

Law no 8/04 on the Human Immunodeficiency Virus-HIV and Acquired Immune Deficiency Syndrome-AIDS was approved in November 2004. A legal landmark in the strengthening of the national AIDS response, it clarified the duties of the State and other national institutions. It protects the rights of persons living with HIV, including the right to employment, free public health care, and confidentiality in the health care system.¹²²

In July 2004, the Council of Ministers approved *Decree 43/03, Regulations on HIV/AIDS, Employment, and Professional Training*¹²³, which expressly forbids HIV testing related to employment.

Part 2, article 18 of the Angolan *Constitution* ensures equality of all citizens. Part 2, article 20 states that the

State shall respect and protect the human person and human dignity.¹²⁴ Part 2, article 47 ensures that the State will promote the measures needed to ensure the rights of citizens to medical and health care.¹²⁵

Angola does not have any domestic violence legislation and does not prohibit marital rape.¹²⁶

6.4 Adherence to international standards and gender responsiveness

Angola has adopted a national framework for its response to AIDS in accordance with Guideline 1 of the International Guidelines on HIV/AIDS and Human Rights.

The progressive implementation of the "Three Ones" principles (with the establishment of the National AIDS Commission) and the approval of the *National Strategic Plan* (which has also been translated into Provincial Action Plans) show evidence of national commitment.¹²⁷

While the Government has sought to involve NGOs and civil society by inviting 44 NGOs to a national workshop in 2003, that trend has not endured. The Government is reportedly suspicious of the NGO sector and is generally reluctant to collaborate with civil society.¹²⁸ Angola will need to do more if it is to comply with Guideline 2's requirement for community consultation.

Guideline 5 requires States to enact or strengthen anti-discrimination legislation that can protect vulnerable groups. In its current form, legislation on HIV and AIDS does not adequately address gender-related issues or at-risk populations (such as men who have sex with men, commercial sex workers, injecting drug users or truckers).¹²⁹ Despite the law on employment and HIV, prepared by the Ministry of Public Administration, Labour and Social Security (MAPESS), some companies, mainly foreign, still require HIV tests as a hiring precondition.¹³⁰

Angola has not met the revised Guideline 6's requirement of universal access to treatment, care and support. Mechanisms for distributing antiretroviral drugs beyond the capital, Luanda, need to be implemented. Approximately 2,750 people were receiving antiretroviral

117 As above.

118 As above.

119 As above.

120 United States Agency for International Development Health Profile: Angola (December 2004).

121 n 112, 13.

122 n 120 above

123 n 112, 11.

124 Constitutional Law of the Republic of Angola, arts 18, 20.

125 As above, art 47.

126 See <http://hrw.org/english/docs/2005/01/13/angola9892.htm> (accessed 4 September 2006).

127 http://www.unaids.org/en/Regions_Countries/Countries/angola.asp (accessed 20 June 2006).

128 n 114, 141.

129 n 112, 12.

130 n 112, 12.

treatment in late 2006, but approximately 30 000 people were in need of the drugs.¹³¹

Guideline 8 requires the promotion of a supportive and enabling environment for women, children and other vulnerable groups. It has been reported that women and girls are exposed to widespread sexual and domestic violence in Angola, although the number of cases reported is very low.¹³² After the 27-year civil war, some 45 per cent of children younger than 4 years are believed to suffer from malnutrition, and that AIDS has become a leading health concern. Eleven per cent of children younger than 14 years have lost at least one parent.¹³³ Orphans and other vulnerable children are mentioned only under the responsibilities of implementing institutions.¹³⁴ Migration is mentioned in the *National Strategy*, but not prominently enough.¹³⁵

6.5 Implementation and gaps

Angola has not yet ratified the following international instruments:

- *Convention on the Elimination of Racial Discrimination*,
- *Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict*,
- *Convention against Torture*,
- *International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families*.

In addition, Angola has not ratified the *Protocol to the African Charter on the Rights of Women in Africa*.

7. Botswana

7.1 Policy and strategy framework

Botswana's *National Strategic Framework for HIV/AIDS* guides the country's AIDS response for the period 2003-2009. The *National Strategic Framework* emerged from significant consultation with civil society, communities and other stakeholders. The revisions move beyond a health response and place the AIDS epidemic within a broader development context that requires immediate attention.¹³⁶ The five, key goals are:

- (1) Prevention of HIV infection,
- (2) Provision of care and support,
- (3) Strengthened management of the national response to HIV and AIDS,
- (4) Psycho-social and economic impact mitigation, and
- (5) Provision of a strengthened legal and ethical environment.

A mid-term review of the *National Strategic Framework* was being conducted in late 2006 to ensure that the *Framework* was in line with the national development goals set out in *Vision 2016*. Among other things, the review examined stakeholder satisfaction and monitoring, evaluation and information management.¹³⁷

The *National Aids Policy* was first adopted in 1993 and revised in 1998.¹³⁸ The policy provides a guiding framework for a national multisectoral response. A *Draft National Policy on HIV/AIDS 2005* updates the National Policy, but it had not yet been adopted by late 2006.

The *HIV/AIDS Education Policy* of the Ministry of Education was drawn up with the aim of reducing the spread of HIV by making AIDS education compulsory at all levels of education.

In addition, Botswana has adopted several other HIV and AIDS interventions, including the Routine HIV Testing programme (2004), the National Voluntary Counseling Programme, the Prevention of Mother to Child Transmission of HIV Programme, the Sexually Transmitted Infections (STIs) Control Programme, the AIDS in the Workplace Prevention Programme, Life Skills-Based Education and condom distribution.¹³⁹

7.2 Institutions

The National AIDS Council (NAC) is chaired by the President of Botswana and is co-chaired by the Minister of Health. The National AIDS Council was established as a multisectoral body involving all sectors and ministries.

The National AIDS Co-ordinating Agency (NACA) oversees the implementation and coordination of AIDS programmes, and establishes the secretariat of the NAC. It is also responsible for monitoring and evaluation, as well as resource mobilisation.¹⁴⁰

131 n 120.

132 See Human Rights Watch Overview for Angola (2005) at <http://hrw.org/english/docs/2005/01/13/angola9892.htm> (accessed 4 September 2006).

133 UNICEF Humanitarian Action: Angola, Summary for 2006.

134 As above.

135 As above.

136 C. Stegling "Botswana's HIV/AIDS Programme" Interfund *Development Update*: From disaster to development? HIV and AIDS in Southern Africa p.231-232.

137 "Molomo enlists journalists" (22 May 2006) see http://www.gov.bw/cgi-bin/news.cgi?d=20060522&i=Molomo_enlists_journalists (accessed 21 June 2006).

138 See *Botswana National Policy on HIV/AIDS* (Revised Version), Gaborone, Ministry of Health, 1998.

139 National Multisectoral Strategic Framework on HIV/AIDS 2003-2007 p.17-22.

140 Republic of Botswana 2005 Progress Report of the National Response to the UNGASS Declaration of the Commitment on HIV/AIDS (2005) p.17.

In addition, district multisectoral AIDS committees have been set up in villages across the country. In recent years, these have been strengthened. All districts now have district AIDS co-ordinators.¹⁴¹

7.3 Legislative framework

Botswana's Constitution has anti-discrimination provisions but these do not refer specifically to HIV status, health or disability.¹⁴²

Two pieces of legislation specifically mention HIV or AIDS. The first is the *Medical Council (Professional Conduct) (Amendment) Regulations 77 of 1999*. The amendment stipulates that individuals taking care of, living with or coming into close contact with a patient shall be informed of their medical condition if the patient has a communicable disease or an infection that can be transmitted from person to person if the proper precautions are not taken. As a result, this legislation has introduced the notion of "shared confidentiality" in which medical practitioners can share an individual's HIV status with that person's family without the consent of the individual.¹⁴³ Some critics argue that this erodes patients' rights to confidentiality and privacy, and jeopardises their right to life, liberty and security of the person.¹⁴⁴

The *Penal Code (Amendment) Act 5 of 1998*¹⁴⁵ provides for compulsory HIV testing of all persons convicted of rape.¹⁴⁶ On receipt of the result, the court has the following sentencing powers:

- If the HIV test is negative, the minimum sentence is 10 years' imprisonment and the maximum sentence is life imprisonment. Where the rape is accompanied by violence resulting in injury to the victim, the minimum term is 15 years and the maximum is life imprisonment, with or without corporal punishment;
- If the HIV test is positive and it is proved that the accused had no prior knowledge of being HIV-positive, the minimum sentence is 15 years' imprisonment and the maximum is life imprisonment, with corporal punishment;

- If the HIV test is positive and on a balance of probabilities it is shown that the accused was aware of his HIV status, the minimum is 20 years' imprisonment and the maximum is life imprisonment, with corporal punishment.¹⁴⁷

In addition, Botswana's Penal Code prohibits acts deemed to be "against the order of nature", which has been interpreted to include anal or oral sex. The same legislation also prohibits sex work.¹⁴⁸

There is no domestic violence legislation, and marital rape is not prohibited.

7.4 Adherence to international standards and gender-responsiveness

In accordance with Guideline 1 of the Revised International Guidelines on HIV/AIDS and human rights, Botswana has a *National Strategic Framework on HIV/AIDS*.

The law in Botswana states that a woman gives her consent to sex upon marriage; marital rape is therefore not prohibited.¹⁴⁹ This and other similar laws require revision in light of Guideline 5's statement that States should strengthen anti-discrimination and other protective laws.

Botswana has actively sought to address Guideline 6's requirement of universal access to comprehensive prevention, treatment, care and support for all people living with HIV. Indeed, Botswana has been hailed for having adopted an aggressive approach for dealing with AIDS, backed by strong political will. Antiretroviral (ARV) treatment is available free of charge in the public health care system. Indeed, Botswana is only one of three countries in sub-Saharan Africa with ARV coverage reaching or exceeding 50 per cent.¹⁵⁰ The 2006 UNAIDS *Report on the Global AIDS Epidemic* estimated Botswana's estimated ARV coverage in 2005 at 85 per cent.¹⁵¹

The Prevention of Mother to Child Transmission (PMTCT) programme was the first of its kind in Africa and

141 C. Stęgling "Botswana's HIV/AIDS Programme" Interfund Development Update: From disaster to development? HIV and AIDS in Southern Africa p.231.

142 Republic of Botswana 2005 Progress Report of the National Response to the UNGASS Declaration of the Commitment on HIV/AIDS (2005) p.57.

143 M. Richter "The UNGASS Declaration of Commitment on HIV/AIDS: A review of legislation in six southern African countries" *Canadian HIV/AIDS Policy & Law Review* v.8 n.1 April 2003 p. 5.

144 A. Zuyderduin and I. Melville "Shared Confidentiality: An Ethical Dilemma in Botswana" (5 July 2000) Durban XIII AIDS Conference p. 1-2.

145 Act No. 5 of 1998.

146 See section 142 (3) Penal Code (2002 Rev.) as amended by section 3 Penal Code (Amendment) Act 1998.

147 *Ibid.* section 142 (1) (ii), (2) and (4). See also M. Richter, "The UNGASS Declaration of Commitment on HIV/AIDS: A review of legislation in six Southern African countries" (2003) 8 *Canadian HIV/AIDS Policy and Law Review*.

148 M. Richter, "The UNGASS Declaration of Commitment on HIV/AIDS: A review of legislation in six Southern African countries" (2003) 8 *Canadian HIV/AIDS Policy and Law Review* 5.

149 Republic of Botswana 2005 Progress Report of the National Response to the UNGASS Declaration of the Commitment on HIV/AIDS (2005) p.57.

150 The other two being Namibia and Uganda. See UNAIDS, 2006 Report on the Global AIDS Epidemic p.15.

151 UNAIDS, 2006 Report on the Global AIDS Epidemic, Annexure 3 p.558.

is now available in all districts in Botswana.¹⁵² After its April 1999 launch in the cities of Gaborone and Francistown, the programme was extended to the rest of the country within 18 months. Unfortunately despite access to ARVs, infant formula and clean water, stigma still acts as a significant obstacle in preventing PMTCT. For example, stigma was cited as the main reason why more than half the women participating in one study did not feed their babies infant formula.¹⁵³ (Many women apparently feared that doing so could have been interpreted as evidence that they themselves were infected with HIV.)

In 2000, voluntary counseling and testing centres (VCT, or “Tebelopele”) were established through a partnership between the Governments of Botswana and the USA (BOTUSA), and included collaboration between the Botswana Ministry of Health, Population Services International (PSI), the US Embassy Office of Defence Corporation and ACHAP.

After intense discussion, routine testing was introduced in 2003 as part of a bid to boost treatment uptake. One of the key points of debate was whether routine testing meant “routine offer of testing” or “opt-out testing” (where informed consent was not pivotal). The National AIDS Council recommended that informed consent be a prerequisite in all cases, but the extent to which this is heeded in practice is open to question.¹⁵⁴ In 2004, Botswana introduced a routine but not compulsory HIV testing policy, which makes HIV testing routine for the general public and pregnant women seeking health services in government health facilities.¹⁵⁵ Some authors have called for vigilance to ensure that human rights are observed in this opt-out routine testing programme.¹⁵⁶

Guideline 8 notes that states should promote a supportive and enabling environment for women, children and other vulnerable groups. However, in its latest UNGASS progress report, Botswana states that it has taken no policy or strategy for most-at-risk populations such as injecting drug users, men who have sex with men, sex workers, prison inmates, cross-border migrants and displaced peoples.¹⁵⁷

The Botswana Prison HIV Policy expressly prohibits the provision of condoms to prison inmates. The policy is defended on the basis that sodomy is a crime in Botswana.¹⁵⁸ This state of affairs runs counter to Guideline 4’s requirement that States should not misuse criminal laws targeting vulnerable groups. It is also at odds with Guideline 8’s requirement that a supportive and enabling environment must be created for vulnerable groups (including men who have sex with men).

In accordance with Guideline 11, Botswana’s National AIDS Coordinating Committee developed a *National Monitoring and Evaluation Plan 2003-2007*.¹⁵⁹ Botswana has also established the Botswana HIV/AIDS Response Information Management System (BHRIMS) which forms part of the country’s monitoring and evaluation response. Efforts to implement this response system have brought several challenges to the fore, notably institutional capacity and skills deficits.¹⁶⁰

7.5 Implementation and gaps

Botswana has not ratified the following international instruments:

- *International Covenant on Economic, Social and Cultural Rights*,
- *International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families*.

At the regional level, Botswana has not ratified the *Protocol to the African Charter on the Rights of Women in Africa*.

8. Burundi

8.1 Policy and strategy framework

A National Action Plan was drawn up in 2002 and covers 2002-2006. It includes five areas for intervention and 16 priority programmes. The five areas are prevention, medical and psycho-social care, socio-economic care, strengthening of institutional capacity, and response management and coordination.

152 C. Stegling “Botswana’s HIV/AIDS Programme” Interfund Development Update: From disaster to development? HIV and AIDS in Southern Africa p.235-6.

153 UNAIDS, 2006 Report on the Global AIDS Epidemic p.88.

154 C. Stegling “Botswana’s HIV/AIDS Programme” Interfund Development Update: From disaster to development? HIV and AIDS in Southern Africa p.233.

155 See *Guidelines for Routine HIV Testing*, Gaborone, Ministry of Health, 2004.

156 S.Weiser et al “Routine HIV Testing in Botswana: A Population-Based Study on Attitudes, Practices, and Human Rights Concerns” *PLoS Medicine* July 2006 v 3 Issue 7 p.1013.

157 Republic of Botswana 2005 Progress Report of the National Response to the UNGASS Declaration of the Commitment on HIV/AIDS (2005) p.48.

158 B.Odunsi “The Achilles Heel: Human Rights and Public Health Implications of restricting prisoners’ access to condoms and AIDS medication in Southern Africa” forthcoming p.19.

159 UNAIDS, 2006 Report on the Global AIDS Epidemic p.278.

160 National Multisectoral Strategic Framework on HIV/AIDS 2003-2007 p.35.

8.2 Institutions

Several AIDS institutions exist in Burundi which is one of the few African countries to have established a ministry that is responsible for AIDS control and which reports directly to the Office of the President. The ministry's functions include the coordination of international and national partners' activities. An Executive Secretariat answers to the Ministry and coordinates the programme.

The National AIDS Control Council (CNLS) was established in 2001. It is managed by a coordinating bureau consisting of the President of the Republic, the Vice-President of the Republic, and the Minister of the above-mentioned ministry (who coordinates the Council). A monitoring and evaluation arm has been created within the CNLS.

Each ministry contains a sectoral AIDS control unit which develops sectoral AIDS control plans.

8.3 Legislative framework

Article 19 of the *Constitution of Burundi* explicitly prohibits discrimination against PLWHA. Several other provisions also apply to PLWHA, notably articles 15 (arbitrary treatment), 17 (right to life, security of the person, and physical integrity) 25 (relative to the confidentiality of personal communications), 33 (concerning participation in public life), 35 (on child health and well-being), 41 (regarding the right to work), 42 (underlining the right to an appropriate salary) and 53 (on respect and tolerance).¹⁶¹

The *Law Establishing Legal Protection for People Infected with the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)* establishes legal protection for PLWHA.¹⁶² It addresses prevention by including institutional participation in the national fight against AIDS, and by promoting testing and medical research. It also tackles discrimination in the realm of public authorities, establishes guidelines regarding the disclosure of a person's HIV status, sets rules concerning access to education, sports and social facilities, and defines procedures in the employment and workplace context. The legislation establishes sanctions which, along with those in the *Penal Code*, apply to people who wilfully transmit HIV or violate law 1/018.¹⁶³

Article 6 of the law decree 1/037 of 7 July 1993 is also relevant since it prohibits discrimination in the workplace.¹⁶⁴

8.4 Adherence to international standards and gender-responsiveness

Guideline 1 of the Revised International Guidelines on HIV/AIDS and human rights require countries to establish an effective national framework for their AIDS response. Burundi has set up a *National Action Plan*. AIDS committees have been established at the provincial, communal, zonal and *collinaire* levels, forming a dense community network.

Guideline 2 requires States to ensure that community consultation occurs in all phases of HIV and AIDS policy design, programme implementation and evaluation. In Burundi, the *Alliance Burundaise contre le SIDA*, an umbrella organisation made up of 125 national members, is involved in the execution of many of the National Action Plan's programmes. The *Association Nationale des Séropositifs et Sideens du Burundi* provides care to over 3,000 people.¹⁶⁵

Implementation of Guideline 6's requirement of universal access to treatment, support and care along with access to widespread prevention programmes is hampered by the fact that numerous weaknesses, including limited access to ARVs, shortages of qualified health care professionals to manage opportunistic infections, and insufficient monitoring and evaluation (due to the complexity of the M&E framework). The effects of the armed conflict (such as population displacement, destruction of infrastructure, and economic and social difficulties) are undermining implementation.

8.5 Implementation and gaps

Burundi has not ratified the following international instruments:

- *The Convention on the Elimination of All Forms of Discrimination Against Women*,
- *The Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict*,
- *The Optional Protocol to the Convention on the Rights of the Child on the Sale of Children*,
- *The International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families*.

Regionally, Burundi has not ratified the *Protocol to the African Charter on the Rights of Women in Africa*.

161 See Constitution of Burundi at http://democratie.francophonie.org/article.php?id_article=368&id_rubrique=94

162 Law Decree 1/018 of 12 May 2005.

163 See *ITEKA Rapport 2005* and "Bulletin ITEKA n°77 September 2005". Both are obtainable at www.ligue-iteka.africa-web.org

164 See *Legislating against discrimination*, Nina Osin and Dina Porat

165 UNAIDS, 2006 Report on the Global AIDS Epidemic p.154.

9. Comoros

9.1 Policy and strategy framework

The Union of Comoros (Comoros) comprises four islands (Ndzuwani, Ngazidja, Maore and Mwali) located off the coast of Mozambique. The population is estimated to be approximately 790 000.¹⁶⁶ Unlike most Southern African countries, Comoros is considered a low-prevalence country, with adult HIV infection levels of less than one per cent.

The goal of Comoros' *National Strategic AIDS Plan 2005-2009 (Plan Strategique)* is to keep HIV prevalence under one per cent.¹⁶⁷ The National Strategic Plan is a multisectoral response to HIV/AIDS.

Comoros' AIDS response has two main components: a prevention-based program on "Information, Education and Communication on HIV/AIDS" (IEC) and condom distribution.¹⁶⁸

Comoros has policies dealing with sexual and reproductive health education for young people (2002) and PMTCT (2005). It also has a National Health Policy that guarantees equal access to preventative health care for men and women, and which devotes special attention to vulnerable groups.¹⁶⁹

9.2 Institutions

Comoros has established a national multisectoral HIV and AIDS coordinating body (*Comite National de Lutte contre le SIDA CNLS*).¹⁷⁰

9.3 Legislative framework

The Comoros *Constitution*, adopted on 23 December 2001¹⁷¹, proclaims equality for all persons irrespective of sex, origin, race, religion or belief, and asserts the right to health and education for all.¹⁷²

As each of the islands is considered sovereign and is equal in relation to one another and to the union as a whole, the island of Ngazidja also has its own constitution.¹⁷³ That document contains parallel provisions concerning anti-discrimination and the rights to health and education.¹⁷⁴

Comoros has no legislation specifically directed at anti-discrimination towards particular groups that are vulnerable to HIV-related discrimination.

9.4 Adherence to international standards and gender-responsiveness

In line with Guideline 1, Comoros has taken steps to bring itself in line with international standards for AIDS responses by enacting a national strategic plan, developing educational interventions, conducting a study on at-risk populations and by concentrating the majority of its efforts on prevention.

Comoros appears also to have heeded Guideline 8, which requires the establishment of a supportive and enabling environment for women, children and other vulnerable groups. Gender issues have been woven into aspects of its prevention efforts. Comoros has conducted AIDS-related knowledge and behaviour studies on sex workers.¹⁷⁵

9.5 Implementation and gaps

Comoros has not ratified the following international instruments:

- *International Covenant on Civil and Political Rights*,
- *International Covenant on Economic, Social and Cultural Rights*,
- *Convention on the Elimination of all Forms of Discrimination Against Women*,
- *Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict*,
- *Optional Protocol to the Convention on the Rights of the Child on the Sale of Children*,
- *Convention Against Torture*,
- *International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families*.

10. Djibouti

10.1 Policy and strategy framework

Djibouti's AIDS policy framework is set out in its *Cadre Strategique Intersectoriel de Lutte Contre le VIH/SIDA et les IST 2003-2007*¹⁷⁶ which guides the country's AIDS response.

166 UNAIDS Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Diseases: Comoros (2004) p. 3.

167 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS), Comoros country progress report (2005) p.11.

168 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS), Comoros country progress report (2005) p.18.

169 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS), Comoros country progress report (2005) p.20.

170 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS), Comoros country progress report (2005) p.18.

171 Constitution of the Comoros, adopted by referendum on 23 December 2001.

172 Constitution of the Comoros, adopted by referendum on 23 December 2001.

173 Constitution of the autonomous island of Ngazidja, adopted by referendum on 7 April 2002.

174 Constitution of the autonomous island of Ngazidja, arts 2 and 7.

175 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS), Comoros country progress report (2005) p.10.

176 Inter-sectoral Strategic Framework in the Fight Against HIV/AIDS and STIs (Ministry of Health).

10.2 Institutions

In a 2003 decree, the Government established an administrative structure to spearhead its AIDS response.¹⁷⁷ Heading the structure is an Inter-ministerial Committee Against AIDS, Malaria, and Tuberculosis.¹⁷⁸ The Committee meets at least once annually, is chaired by the prime minister, and is composed of ministers or deputy ministers from 13 administrative departments.¹⁷⁹

The Inter-ministerial Technical Committee Against AIDS, Malaria, and Tuberculosis applies decisions taken by the Inter-ministerial Committee. It also coordinates the implementation of national AIDS policy and oversees a number of regional health committees that handle AIDS policy at district level.¹⁸⁰ The Inter-ministerial Technical Committee is larger than the Inter-ministerial Committee, is composed of lower-ranking members, and meets at least once every three months.¹⁸¹

Day-to-day administration, planning and coordination of AIDS policy is handled by an Executive Secretariat Against AIDS, Malaria, and Tuberculosis.¹⁸² The body is directed by an executive secretary who is nominated by the Minister of Health and whose appointment is confirmed by Djibouti's Council of Ministers.¹⁸³

Djibouti's AIDS policies are carried out within National Vertical Programmes Against AIDS, Malaria, and Tuberculosis.¹⁸⁴ These Programmes operate under the auspices of the Ministry of Health, which nominates the coordinators for each of the programmes.¹⁸⁵

In addition to the Ministry of Health, more than ten other ministries have AIDS-related responsibilities, including the

Ministries of Justice, Finance, Youth and Sports, the Promotion of Women, Education, the Interior, Labour, Information, and Defence.¹⁸⁶

10.3 Legislative framework

The *Constitution of the Republic of Djibouti* obligates the State to respect and protect the sacredness of all human beings.¹⁸⁷ It deems all individuals to be equal before the law and to possess the rights of life, liberty, security and integrity of their persons.¹⁸⁸

Law 48 extends to citizens a general right to health and tasks the state with guaranteeing the realization of that right.¹⁸⁹ The same law provides children, mothers, the physically handicapped, victims of natural disasters, and vulnerable groups generally with a right to state health care assistance.¹⁹⁰

Law 173, which lays out a strategy to help integrate women into national development plans, includes a section on HIV and AIDS.¹⁹¹ Among other things, the law calls for the State to improve the quality and availability of data on HIV prevalence in women, to develop maternity services as part of the fight against mother-to-child transmission of HIV, and to combat rape and prostitution.¹⁹²

10.4 Adherence to international standards and gender-responsiveness

By developing the *Plan intersectoriel de lutte contre le Sida 2003-2007* and by creating an inter-ministerial AIDS administrative structure (with *Décret* no 2003-0049/PR/MEF/MS), Djibouti has made some progress

177 See Decree no. 2003-0049/PR/MEF/MS establishing an institutional framework in the fight against AIDS, Tuberculosis and Malaria, available at <http://www.presidence.dj/LES%20TEXTES/decr0049pr03.htm> (accessed 22 June 2006).

178 n 180 above, *Titre I*.

179 As above.

180 See n 180 above, *Titre II*.

181 As above.

182 See n 180 above, *Titre III*.

183 As above.

184 See n 180 above, *Titre IV*, Article 16.

185 See n 180 above, *Titre IV*, Article 17.

186 See WHO "Summary country profile for HIV/AIDS treatment scale-up: Djibouti" (2005) 2, available at www.who.int/3by5/support/june2005_dji.pdf (accessed 22 June 2006).

187 See the Constitution of the Republic of Djibouti, Article 10, available at <http://www.presidence.dj/constitution.htm> (accessed 22 June 2006): "Human presence is sacred. The State must respect and protect it."

188 See n 190 above, Article 10: "All human beings are equal before the law. Every person has the right to life, freedom, security and integrity of the person".

189 See Law no. 48/AN/99/4ème L establishing the Direction of Health Policy, Article 2, available at <http://www.presidence.dj/page392.html> (accessed 22 June 2006): "The State declares that everybody has the right to health. Guaranteeing this right is one of the essential duties of the State, which adheres to the principles and sets up the means that are necessary to perform this duty."

190 See n 192 above, Articles 4 and 5: "For parents, assisting children in their physical, intellectual and social development is a natural right and a responsibility which they exercise with the help of the State. This responsibility to assist also applies to mothers, disabled persons, most vulnerable persons and victims of natural disasters."

191 See Law no. 173/AN/02/4ème L Defining national policy in matters of including women in development, Title III, Health Goal 4, available at <http://www.presidence.dj/LES%20TEXTES/loi173an02.htm> (accessed 22 June 2006).

192 See n 194 above: "Improve the availability and quality of data on AIDS/STIs in general and especially in women and children to establish programmes appropriately tackling transmission. Consolidate the fight against mother-to-child vertical transmission through awareness and training staff in maternity services ... fight prostitution and the rape of women as a factor facilitating the transmission of the AIDS/STI epidemic."

toward meeting the requirements of Guideline 1 of the Revised International Guidelines on HIV/AIDS and Human Rights.¹⁹³

Law 173 suggests that Djibouti is taking steps to realise a gender-responsive AIDS policy that addresses Guideline 5 (which requires States to enact or strengthen anti-discrimination and other protective laws).¹⁹⁴

In 2005, the World Health Organization (WHO) noted that the “Government of Djibouti [was] strongly committed at the highest political levels to providing comprehensive care, including antiretroviral therapy, to people living with HIV/AIDS”.¹⁹⁵ The Government had recently announced “a decree to provide antiretroviral therapy free of charge to disadvantaged people”.¹⁹⁶ Djibouti would thus seem to be at least partially compliant with Guideline 6 of the “HIV/AIDS and human rights international guidelines”.¹⁹⁷ Nevertheless, WHO found that Djibouti faces a number of serious challenges in its fight against AIDS:

*Djibouti’s health system is weak. Health services need to be strengthened to provide a more vigorous response to the HIV/AIDS epidemic and to support scaling up antiretroviral therapy. The major constraints to scaling up antiretroviral therapy are the lack of human resources capacity and management skills. Drug procurement logistics systems are weak, and various parties run parallel procurement systems.*¹⁹⁸

10.5 Implementation and gaps

Djibouti has not ratified the following international instruments:

- *Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict,*
- *Optional Protocol to the Convention on the Rights of the Child on the Sale of Children,*
- *Convention Against Torture,*
- *International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families.*

Djibouti has not ratified the following AU instruments the *African Children’s Charter* and the *Protocol to the African Charter on the Rights of Women in Africa*.

11. Eritrea

11.1 Policy and strategy framework

Eritrea has a *National Strategic Plan on HIV/AIDS/STIs — 2003-2007 (National Strategic Plan)*.

The two priority populations in Eritrea’s AIDS response are young people and the military, with special attention focused on the latter.¹⁹⁹

The post-war climate poses a major challenge to implementing the *National Strategic Plan*: large numbers of people are internally displaced, and the country’s infrastructure and economy have been significantly weakened.

11.2 Institutions

The Ministry of Health and the National AIDS and Tuberculosis Control Division are the main implementing institutions of the *National Strategic Plan*, with significant support from international partners.

11.3 Legislative framework

Article 14 of the *Constitution of Eritrea* contains broad equality provisions that prohibit discrimination on a range of listed grounds, as well as on the basis of “any other improper factors”. The Democratic Principles in article 7 also state that “any act that violates the human rights of women or limits or otherwise thwarts their role and participation is prohibited”. Article 21 of the *Constitution* notes that every citizen has the right to equal access to publicly-funded social services and that the state shall endeavour to make available to all citizens health, education, cultural and other social services.²⁰⁰

11.4 Adherence to international standards and gender-responsiveness

As the *National Strategic Framework* was not available to this study, adherence to international standards and gender-responsiveness is difficult to access. However, UNAIDS observes that the framework is consistent with the *UNGASS Declaration of Commitment on HIV/AIDS*.²⁰¹

193 See OHCHR & UNAIDS “HIV/AIDS and human rights international guidelines” (1996) 11, available at http://data.unaids.org/publications/irc-pub02/jc520-humanrights_en.pdf (accessed 22 June 2006). See also sections 1 and 2 above for discussions of the “Inter-sectoral Plan to Fight HIV/AIDS 2003-2007” and of Djibouti’s institutional HIV/AIDS structure.

194 See section 3 above for discussion of Law 173.

195 n 189 above, 1.

196 As above.

197 See OHCHR & UNAIDS “HIV/AIDS and human rights international guidelines: Revised guideline 6” (2002) 14, available at <http://www.ohchr.org/english/about/publications/docs/g6.pdf> (accessed 22 June 2006).

198 n 189 above, 1.

199 UNDP Eritrea Accelerating Prevention Activities and Developing Care and Support Programmes in the Eritrean Defence Force (EDF) (February 2006) available at <http://www.er.undp.org/docs/hivfs.pdf> (accessed 21 June 2006).

200 Constitution of Eritrea adopted by the Constituent Assembly on 23 May 1997. The English translation can be found at *Human Rights Law in Africa* v.2 (Leiden/Boston: Martinus Nijhoff Publishers, 2004) p. 1066.

201 UNAIDS country profile for Eritrea available at www.unaids.org/en/Regions/Countries/Countries/Eritrea.asp

Eritrea probably has satisfied Guideline 1 of the Revised International Guidelines on HIV/AIDS by establishing a national framework for its response. Some observers consider Eritrea to be committed to meeting its country's health needs but point out that its efforts are retarded by financial, institutional and human resource constraints.²⁰²

Eritrea has given some regard to Guideline 2's requirement of community consultation. One component of the *National Strategic Framework* is a community-managed response, which has been implemented with some success. A rapid-response approach was used whereby specific 100-day goals were set, self-selected teams were assembled, and leadership and resource structures of support and accountability were established.²⁰³ For example, a goal was established to get at least 25 out of 100 commercial sex workers to practice safe sex in a particular district. After 100 days of activities, 76 percent of the commercial sex workers reported using female or male condoms.²⁰⁴

11.5 Implementation and gaps

Eritrea has not ratified the following international instruments:

- *The Convention against Torture,*
- *The International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families.*

Regionally, Eritrea has not ratified the *Protocol to the African Charter on the Rights of Women in Africa.*

12. Ethiopia

12.1 Policy and strategic framework

The *Strategic Framework for the National Response to HIV/AIDS (2001-2005)* updates the 1998 national policy on HIV and AIDS. Its objective is to guide the implementation of programmes aimed at preventing the spread of the disease, decreasing vulnerability, caring for PLWHA, and reducing the socio-economic consequences of the epidemic

A *Strategic plan for Intensifying Multisectoral HIV/AIDS Response (2004-2008)* also exists. Gender sensitivity

ranks among its guiding principles, along with multisectoralism, empowerment, involvement of PLWHA, and results-oriented interventions. The framework outlines six strategic areas: capacity-building, community mobilisation and empowerment, integration with health programmes, leadership and mainstreaming, coordination and networking, and targeted response.

Guidelines have been developed on VCT, PMTCT, home-based care and support, mainstreaming HIV and AIDS in government institutions, and antiretroviral therapy implementation. A framework for monitoring and evaluation has also been developed.²⁰⁵

12.2 Institutions

Established in 2002, the HIV/AIDS Prevention and Control Council (HAPCO) has a mandate to focus on coordination, resource mobilisation and multisectoral monitoring and evaluation. It is chaired by the President and oversees implementation of the *National Strategic Framework* with respect to information, education, prevention, HIV testing and screening and provision of medical care and psychosocial support to those affected by AIDS.

12.3 Legislation

No specific laws exist to protect PLWHA or vulnerable populations from discrimination.

The *Constitution* contains a general equality provision (in Article 25), but does not mention HIV status explicitly. The rights of women are addressed in Article 35 which addresses, among other things, harmful customs as well as inheritance and property transfer rights. Article 34 provides for marital, personal and family rights. Article 36 lays out the rights of children, and outlines special protection that should be accorded to orphans.²⁰⁶

Article 41 states that every Ethiopian has the right to equal access to publicly-funded social services and that the state is obligated to allocate ever-increasing resources to public health, education and social services.

Article 15 protects the right to life.

Ethiopia's labour and pension legislation has been amended to include benefits for PLWHA.²⁰⁷

202 <http://www.usaid.gov/er/health/health.htm> (accessed 21 June 2006).

203 *Findings Infobriefs* no 101 June 2004, World Bank.

204 As above.

205 Ethiopia UNGASS report 2006 available at http://data.unaids.org/pub/Report/2006/2006_country_progress_report_ethiopia_en.pdf

206 The Constitution of the Federal Democratic Republic of Ethiopia can be found at *Human Rights Law in Africa* v.2 (Leiden/Boston: Martinus Nijhoff Publishers, 2004) p. 1083 and 1088.

207 Ethiopian participants relayed this information at the UN Consultative Workshop 27-29 June 2006, Johannesburg South Africa see *Report Stakeholder Consultation on Gender, Human Rights and HIV & AIDS: A UNDP-OHCHR Joint Initiative for Southern and Eastern Africa* p.18

12.4 Adherence to international standards and gender-responsiveness

Adherence to international standards and gender-responsiveness is difficult to assess because the *National Strategic Framework* was not available to the study. However, Ethiopia has signed the *UNGASS Declaration of Commitment on HIV/AIDS* and did submit a progress report in 2006. The report noted that children orphaned by AIDS are sometimes expelled from their parental residences and that many of them live with poor relatives who are unable to provide for the children.²⁰⁸

The same progress report notes that a national partnership forum against AIDS has been formed to serve as a platform for all stakeholders. Registered members include a network of PLWHA, a coalition of women against AIDS, and representatives from higher education institutions. This has strengthened the overall coordination of the multisectoral response²⁰⁹ and probably brings Ethiopia at least partly in line with Guideline 2 of the Revised International Guidelines on HIV/AIDS and Human Rights (which requires community consultation).

In 2005, an initiative was launched for the provision of free ARVs²¹⁰, which moves Ethiopia toward meeting the requirement of universal treatment, care and support outlined in Guideline 6.

Guideline 8 requires the promotion of a supportive and enabling environment for women, children and other vulnerable groups. The high HIV infection levels found among female sex workers in some urban areas (as high as 73 percent)²¹¹ underline the urgent need for an effective prevention response for sex workers. Some civil society organisations (such as the Integrated Service for AIDS Prevention and Support Organisation) have taken up that challenge, but their activities need to be supported by stronger government commitment and action.²¹²

In 2003, the Ministry of Health launched a health extension programme whereby health extension workers are trained and assigned to health posts that provide rural households with AIDS outreach services. By January 2006, close to 10 000 health extension workers had been trained and deployed.²¹³ In addition, AIDS task forces and focal points have been set up in all federal government agencies and regional government bureaus. Their role is to promote workplace interventions and advocate for AIDS

mainstreaming.²¹⁴ These efforts represent a creative education and training programme in line with Guideline 9.

12.5 Implementation and gaps

Community mobilisation remains weak, as does the mainstreaming of AIDS in the regular activities of government.

Ethiopia has ratified many key international instruments, except for:

- *The Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict,*
- *The Optional Protocol to the Convention of the Rights of the Child on the Sale of Children,*
- *The International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families.*

Ethiopia has not ratified the *Protocol to the African Charter on the Rights of Women in Africa.*

13. Kenya

13.1 Policy and strategic framework

The *Kenya National HIV/AIDS Strategic Plan (KNASP)* was issued by the National AIDS Control Council in 2000. It outlines a multisectoral approach and an action framework for HIV and AIDS interventions. The Plan identifies three priority areas for action: prevention, improving the quality of life of PLWHA, and mitigating the socio-economic impact of AIDS.

HIV and AIDS has been integrated into the *Poverty Reduction Strategy Plan (PRSP)* (2002) and the *National Development Plan (2003-2007)*, both of which address the reduction of gender and income inequalities in the context of HIV and AIDS prevention, treatment and care.

The *National Condom Policy and Strategy (2001-2005)* was developed by the Ministry of Health in collaboration with the National Aids Control Council to improve access to quality, affordable condoms through an effective and responsive service delivery system.

A National HIV/AIDS Monitoring and Evaluation Framework also exists.

208 Ethiopia UNGASS report 2006 available at http://data.unaids.org/pub/Report/2006/2006_country_progress_report_ethiopia_en.pdf

209 As above.

210 As above.

211 UNAIDS, 2006 Report of the Global AIDS Epidemic p.107.

212 UNAIDS, 2006 Report on the Global Epidemic p.211.

213 As above.

214 As above.

13.2 Institutions

The National AIDS Control Council (NACC) is the national coordinating authority of the KNASP. It was established in 1999 as part of the Office of the President to provide leadership and to coordinate a multisectoral response to HIV and AIDS.

The NACC set up a Technical Sub-committee on Gender and HIV/AIDS (TSG) in 2001 to develop strategies for mainstreaming gender in the KNASP. It is responsible for identifying gender gaps in the KNASP, analysing gender issues arising from field research, formulating guidelines and creating a strategic framework through which gender concerns can be integrated into the analysis, formulation and monitoring of policies and programmes that relate to the five priority areas of the KNASP. A broad cross-section of organisations and sectors participate in the TSG.

Each priority area of the KNASP has a monitoring and coordination group (MCG) which includes broad membership of implementing agencies and partners.

13.3 Legislation

Section 82 of the current *Constitution* prohibits discrimination based upon "race, tribe, place of origin or residence or other local connexion, political opinions, colour, creed or sex whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description."²¹⁵ Despite the broad wording, the significant exceptions to that provision weaken protection against discrimination in the context of marriage, adoption, burial, devolution of property upon death, and more.²¹⁶

Notably, some proposed amendments to the *Constitution* extend the freedom from discrimination provision to include "health status" as a protected ground.²¹⁷ The restrictive provisions cited above have been replaced with a new "gender" provision which could afford women greater protection.²¹⁸ There are also specific provisions dealing with "youth" and "children".

Part VII of the *HIV/AIDS Prevention and Control Bill 2006*, which has been tabled with Parliament,²¹⁹ deals with discriminatory actions against PLWHA.²¹⁹ If the bill is passed, people who knowingly infect others with HIV will face jail terms of at least seven years and be liable for fines of up to \$6000 USD. The proposed law also bars mandatory HIV testing related to employment, marriage or admission to education institutions, but allows for testing of persons accused of sexual offences.²²⁰

The *Sexual Offences Bill* was signed into law in July 2006.²²¹ It seeks to address sexual violence against women, which is widespread, and declares the deliberate transmission of HIV to be a criminal offence which carries a prison term of at least 15 years.²²² The law also requires that rape survivors be provided with free medical care and counselling in public institutions.²²³

The *Children's Act 2002* guarantees free primary school education, and criminalises forced marriages and female genital cutting.²²⁴

The outlawing of homosexuality and sex work remains a barrier blocking the provision of effective prevention, treatment and care and support.

13.4 Adherence to international standards and gender-responsiveness

The *National Strategic Plans* multisectoral approach (with targeted interventions, recognition of the special needs of women and young people, engagement of PLWHA, empowerment of stakeholders, and evidence-based interventions) goes some way toward fulfilling Guidelines 1 and 2 of the Revised International Guidelines on HIV/AIDS and Human Rights.

Efforts to address sexual violence against women and reduce discrimination via the proposed *HIV/AIDS Prevention and Control Bill* are in line with Guideline 5's requirement that States enact or strengthen anti-discrimination and other protective laws. That noted, criminal laws targeting vulnerable groups such as men who have sex with men and sex workers are inconsistent with international human rights obligations and conflict with Guideline 4.

215 The Constitution of Kenya, 1969 (as Amended to 1997) Section 89.

216 The Constitution of Kenya, 1969 (as Amended to 1997) Section 89(4)(b).

217 The Proposed New Constitution of Kenya 2005, Section 37.

218 The Proposed New Constitution of Kenya 2005, Section 38.

219 <http://www.kanco.org/news.php?NoticeID=19> (Accessed 23 July 2006).

220 See http://www.plusnews.org/AIDSreport.asp?ReportID=6066&SelectRegion=Southern_Africa&SelectCountry=KENYA (accessed 23 July 2006).

221 <http://allafrica.com/stories/200607140858.html> (accessed 23 July 2006).

222 The Sexual Offences Bill (2006), section 27.

223 <http://allafrica.com/stories/200607140858.html> (accessed 23 July 2006).

224 Human Rights Watch, World Report 2003: Kenya.

There is some evidence of gender inequalities in the provision of AIDS care. Between 2002 and 2004, men were twice as likely to be admitted to hospitals as women, and women paid as much as 65% more per visit than did their male counterparts.²²⁵ This runs contrary to Guideline 6's requirement of universal access to prevention, treatment, care and support for all persons living with HIV.

Kenya has taken steps in line with Guideline 8's requirement to promote a supportive and enabling environment for women, children and other vulnerable groups. The KNASP addresses the issues of rape and sexual violence, and seeks to strengthen the capacity of the policing and health care systems to provide services to survivors of sexual violence, improve the provision of post-exposure prophylaxis services, and develop strategies to fight stigma associated with rape.

As regards an enabling environment for children, the elimination of primary school tuition fees in 2003 saw the number of young children enrolled in school rise by over one million.²²⁶

Outdated customary laws exacerbate the effects of HIV and AIDS on women and children. Although female genital mutilation is outlawed, it remains a widespread practice in parts of the country and involves a risk of HIV transmission when blades are shared.²²⁷ Women and children also continue to face discrimination in terms of inheritance and property rights. Often women do not hold actual rights to land when their husbands die and are only able to hold the property in trust on behalf of their children. The marginalised status of AIDS widows is aggravated by the fact that they are often accused of having infected their husbands, and are sometimes expelled from their homes as a result.²²⁸ The dispossession of orphans and vulnerable children of property is also widespread, with the girl-child worst-affected. Upon the death of her parents, she often assumes the role of her deceased mother, which can involve dropping out of school in order to work the family land and fulfil various household roles. Nevertheless, she lacks inheritance rights and, upon reaching adulthood, is often left with neither education nor property.²²⁹

Monitoring and coordination groups (MCGs) have been established for each of the three priority areas of the KNASP to monitor progress against the results framework in accordance with Guideline 11.

13.5 Implementation and gaps

Kenya has not ratified the *Optional Protocol to the Convention on the Rights of the Child on the sale of Children* or the *International Convention on the Protection of the Rights of Migrants Workers and Members of their Families*.

Kenya has also not ratified the *Protocol to the African Charter on the Rights of Women in Africa*.

14. Lesotho

14.1 Policy and strategy framework

The *Policy Framework on HIV/AIDS Prevention, Control and Management* (the *Policy Framework*), published in 2000, provides broad guidelines for containing the AIDS epidemic in Lesotho. The *Policy Framework* incorporates principles of human rights, including privacy and self-determination of all peoples, and the deep-rooted "cultural, social and religious world of the people of Lesotho".²³⁰ It regards the AIDS epidemic as a national emergency and stresses the importance of a co-ordinated and multisectoral approach.

The *Policy Framework* is divided into eight sections.²³¹ Sections three and four provide broad policy direction on various issues. General policy areas, which are dealt with in section three, include the incorporation of an Information, Education, Communication (IEC) programme in all sectors of society, VCT, shared confidentiality, comprehensive health care and social support, and human rights and anti-discrimination advocacy. Section three also sets out a co-ordinated institutional framework and establishes the Lesotho AIDS Programme Co-ordinating Authority (LAPCA), which was replaced by the National AIDS Secretariat and National AIDS Commission in 2005. Section four provides guidelines relating to HIV and insurance policy, international travel, the work place and the security forces. In addition, the *Policy Framework* makes specific provisions for vulnerable groups such as women, sex workers, prisoners, young people and men who have sex with men.

The *National AIDS Strategic Plan 2000/2001-2003/2004* (the *Strategic Plan*) sets out nine specific aims and nine broader objectives.²³² (Note that the *National AIDS Strategic Plan 2005-2008* was still in a draft form when this study was conducted.) A logistical framework defines nine

225 UNAIDS, 2006 Report on the Global Epidemic p.167.

226 UNAIDS, 2006 Report on the Global Epidemic p.185.

227 <http://www.womensnews.org/article.cfm/dyn/aid/2177> (accessed 23 July 2006).

228 S. Drimie, "The Impact of HIV/AIDS on Land: Case Studies from Kenya, Lesotho and South Africa: A Synthesis Report prepared for the Southern African Regional Office of the Food and Agricultural Organization of the United Nations (FAO) (August 2002) p.14.

229 S. Drimie, "The Impact of HIV/AIDS on Land: Case Studies from Kenya, Lesotho and South Africa: A Synthesis Report prepared for the Southern African Regional Office of the Food and Agricultural Organization of the United Nations (FAO) (August 2002) p.15.

230 Government of Lesotho, *Policy Framework on HIV/AIDS Prevention, Control and Management*, September (2000) 5.

231 The broad outline of the *Policy Framework* is following; 1.0 Introduction; 2.0 Goals and objectives; 3.0 General policies; 4.0 Specific policies; 5.0 Legal aspects; 6.0 Funding; 7.0; 8.0 Monitoring and evaluation Conclusion.

232 *National AIDS Strategic Plan 2000/2001-2003-2004* A three-year rolling plan for the national response to the HIV/AIDS epidemic in Lesotho (September 2000) 18.

key areas, including the effective co-ordination of a multisectoral National AIDS Programmes, resource mobilisation, strengthening IEC programmes, providing support to infected and affected persons, involvement of the young people in all AIDS programmes, reduction of STI and HIV prevalence, intensifying HIV surveillance and testing, and regular monitoring and evaluation of the NAP.

In addition to the main policy and strategic framework, Lesotho has produced several other policies and guidelines, including the:

- *Education Sector Strategic Plan*,
- *Five-year Strategic Plan for DOTs Expansion in Lesotho*,
- *Gender and Development Policy* (2003),
- *Guidelines to Prevent Mother-to-Child Transmission of HIV*,
- *Human Resources Development and Strategic Plan* (2005-2025),
- *Know Your Status (KYS) Campaign* (2003),
- *National Guideline on HIV Testing and Counseling* (2004),
- *National Policy on OVC and National Action Plan for OVC*, *National Youth Policy*.

Although the main focus of the five-year *Strategic Plan* is on TB treatment, it emphasises the importance of greater interaction between TB and AIDS management efforts.²³³

The *Guidelines to Prevent Mother-to-Child Transmission of HIV* provide detailed information on PMTCT, guidelines for medical practitioners on providing VCT to pregnant women, and on care for HIV-positive pregnant women, mothers and babies. The *Education Sector Strategic Plan* (final draft) is aimed at ensuring children's right to education is realized despite the AIDS epidemic. That plan sets out a detailed strategic framework to enhance access to education for orphans and vulnerable children, implement HIV and AIDS education, and support life-long learning.²³⁴ The Government of Lesotho launched the *Know Your Status* Campaign in 2003.²³⁵ The political commitment to the campaign was consolidated by the Prime Minister and other senior politicians who publicly testing for HIV in 2004.²³⁶ The Government plans to employ an additional 7,500 health care workers to carry out the nationwide door-to-door VCT exercise.²³⁷

14.2 Institutions

The main AIDS institutions in Lesotho are the National AIDS Commission (NAC), the National AIDS Secretariat

(NAS) and the Parliamentary AIDS Committee (PAC). The UN expanded theme group on HIV/AIDS (UN theme group) meets once a month to strengthen coordination among major stakeholders and donors. Various UN organisations, NGOs, foreign governments and departments of the Government of Lesotho, such as LAPCA participate in the UN theme group.

The National AIDS Commission (NAC) was established under the *National AIDS Commission Act 2005*. Responsible for coordinating and developing strategies to combat AIDS, its functions are specified in article 4 of the Act. The same Act also created the National AIDS Secretariat (NAS), which is responsible for the "administration and implementation of the strategies and policies of the Commission".²³⁸ Created under section 13 of the Act, the HIV/AIDS Forum is tasked with bringing together stakeholders and representatives from various sectors and organisations.

14.3 Legislative framework

Lesotho has no AIDS-specific legislation. However, the Lesotho Law Reform Commission is revising some laws that could have a bearing on the AIDS response. They include *The Sexual Offences Act of 2003*, *The Married Persons' Equality Bill* and *The Child Protection and Welfare Bill*.

14.4 Adherence to international standards and gender-responsiveness

The Government has made some effort to bring its AIDS response in line with international human rights principles and guidelines.

As required in Guideline 1 of the Revised International Guidelines on HIV/AIDS and Human Rights,²³⁹ the *Policy Framework* was devised to provide basic guidance to all stakeholders. The *Policy Framework's* strength is that it attempts to provide comprehensive protection to vulnerable groups. The *Policy Framework* is based on the principle of anti-discrimination, and HIV-positive persons are protected from discrimination in the insurance, employment, international travel and education realms. The *Framework* acknowledges the reality of sexual violence against women and advocates harsher rape laws.²⁴⁰ Importantly, it also recognises the high prevalence of violence against women in marriage, and supports the

233 Ministry of Health and Social Welfare and WHO, *Five-year Strategic Plan for DOTs Expansion in Lesotho*, (June 2003) 5.

234 Ministry of Education, *Education Sector Strategic Plan* (final draft) (October 2002).

235 *Status of the Lesotho National Response to the UNGASS Declaration of Commitment on HIV/AIDS* (January 2003-December 2005) 11.

236 As above 11.

237 As above 11; Although the door-to-door VCT programme should have started in 2006, its actual implementation of the programme is unclear.

Also see the (2006) 11/1 *HIV/AIDS Policy and Law Review*, Canadian HIV/AIDS Legal Network. available at:

<http://www.aidslaw.ca/maincontent/otherdocs/Newsletter.vol11no12006/intldev.htm> (accessed 15 June 2006).

238 *National AIDS Commission Act* (Act No 8 of 2005), sec 10.

239 Guideline 1 of the HIV/AIDS and human rights international guidelines requires the states to establish effective national HIV/AIDS framework.

240 The *Policy Framework* (n 227 above) section 4. 20.

establishment of laws and policies to help protect married persons against HIV and other sexually transmitted infections.²⁴¹

Guideline 5 requires States to enact or strengthen anti-discrimination and other protective laws. *The Sexual Offences Act of 2003* was developed in response to HIV transmission through sexual violence. The Act outlaws any sexual act in coercive circumstances. Importantly, marriage or any other relationship cannot be used as a defence against the charge of rape – a welcome development, given that studies indicate that over 70 percent of women respondents who have experienced forced sex reported their intimate partners as the perpetrators.²⁴² The Act also provides for mandatory HIV testing of persons charged with sexual offences. If the convicted person tests HIV-positive, but did not know or did not have reasonable ground to believe that he or she was infected, the sentence is less than ten years of imprisonment.²⁴³ However, if the person knew or had reasonable ground to believe he or she was HIV-positive, the offence can be punishable by death. The ambiguous wording of the Act is a concern. “Reasonable ground” is difficult to interpret with precision and could lead to selective prosecutions of individuals who “should have known” due to seemingly “immoral lifestyles”. As well, the harsh sentencing provision and the lack of mitigating considerations raises many human rights issues. They also run afoul of Guideline 4, which requires States to review and reform criminal laws to ensure that they are consistent with international human rights obligations and are not misused in the context of AIDS or targeted against vulnerable groups.

In other respects, Lesotho has sought to strengthen anti-discrimination laws that protect vulnerable groups pursuant to Guideline 5. Lesotho adopted a *Gender and Development Policy 2003*, which commits the Government to tackle gender inequalities.²⁴⁴ The enactment of the *Married Persons Equality Bill*, which enshrines equality

between men and women in marriage, could further strengthen the legal framework. Although debated for several years,²⁴⁵ the bill has not yet been adopted by Parliament.²⁴⁵

Lesotho's comprehensive *Policy Framework* and detailed *Strategic Plan* reflect efforts to comply with Guideline 6's requirement of universal care, treatment and support for all persons living with HIV. However, statistics from the Lesotho UNGASS Core Indicators Reporting are disappointing. Despite the impressive Guideline on PMTCT, only five percent of HIV-positive pregnant women were receiving a complete course of ARV prophylaxis to reduce the risk of MTCT²⁴⁶ and only 14 percent of PLWHA in need of ARV treatment were receiving it at the end of 2005.²⁴⁷ Furthermore, very few schools with teachers who had been trained in life-skills based AIDS education taught the curricula and most large enterprises or companies lacked HIV workplace policies or programmes.²⁴⁸ Despite the heavy emphasis on prevention, only 18 per cent of males and 26 per cent of females aged between 15-24 years could correctly identify ways to prevent the sexual transmission of HIV (which falls far short of the 90 per cent target for 2005).²⁴⁹

Lesotho's AIDS response is concentrated mainly in the prevention arena, which includes campaigns for behaviour change, awareness-raising and condom distribution.²⁵⁰ However, condoms are not always readily available and promotion messages often fail to address cultural barriers that hinder consistent condom use in long-term relationships.²⁵¹

The *Strategic Plan* is peculiarly silent on ARV roll-out programmes. Although the *Plan* aims to provide “100 percent coverage of graded PLWHA through support, counselling and care”,²⁵² it does not specify what is meant by support and care. Such ambiguity and apparent lack of commitment may partly account for the low numbers of people receiving ARV treatment.

241 As above section 4.21

242 The study, *Sexual violence against women in Lesotho* was conducted from February to July 2003 in collaboration between MEASURE Evaluation project (Tulane university), Sechaba Consultants (Lesotho) and CARE Lesotho.

243 D'Ambrose “Sexual Offences Act 2003 becomes law” (2003) 10/2 *Summary of events in Lesotho* available at: <http://www.trc.org.ls/events20.032.htm> (accessed 16 June 2006).

244 K Matashane-Marite, *Women's rights and participation- including women's access to land and inheritance, the role of lobbying and grassroots organisations*, delivered at the UN Division for the Advancement of Women expert group meeting enhancing participation of women in development through an enabling environment for achieving gender equality and the advancement of women, Bangkok, Thailand, 8-11 November 2005.

245 Representatives from the Lesotho team at the UN Joint Programme Consultative Workshop held in Johannesburg from 27-29 June 2006 highlighted this issue as one that they would like to move forward and pledged to push for a motion to be moved in Parliament to pass the Bill.

246 See, table 1- 2005/2006 Lesotho UNGASS Core Indicators Reporting, Status of the Lesotho national response to the UNGASS declaration of commitment on HIV/AIDS (January 2003- December 2005).

247 UNAIDS report on global AIDS epidemic, Lesotho country profile.

248 As above.

249 As above.

250 Speech of Ambassador Rapolaki in the panel discussion on the feminisation of HIV/AIDS: Lesotho's experience for the OIC international fifth annual African women's and children's health symposium, University of the District of Columbia, November 10-11, 2004.

251 US Government rapid appraisal for HIV/AIDS programme expansion, USAID and Centres for Disease Control and Prevention, Lesotho (September 5-13 2004).

252 Strategic Plan (n 229 above) 18.

Significantly, neither the *Policy Framework* nor the *Strategic Plan* address migrant workers and long-distance truck drivers. Six major towns of Lesotho are situated along border with South Africa²⁵³ and many Basotho work in South Africa, especially in the mining industry. Commercial sex work is rife at border crossings. It is vital that the HIV prevention strategy also target such areas with HIV education campaigns and condom distribution.

Under customary and common law, women are considered to be legal minors in Lesotho, a status that heightens their dependence on male family members. Women are prevented from entering into contracts, opening bank accounts or applying for passports without the consent of a male guardian. *The Land Registry Act of 1967* specifically prohibits registration of land in the name of married women, thus further limiting women's socio-economic rights.²⁵⁴ Inheritance laws and practices in Lesotho also prevent women or girls from inheriting property.

AIDS has exacerbated the vulnerability of women in this context.²⁵⁵ However, such discriminatory practices and laws cannot be challenged because there is no constitutional right to anti-discrimination currently. Article 26 of the *Constitution* deals with equality and justice, and encourages the Government to adopt policies that promote equality and anti-discrimination. However, it is only a "principle" of State policy and is not legally enforceable.²⁵⁶ Although the *Policy Framework* suggests an impressive commitment to various international human rights principles and gender sensitivity, fundamental changes in the *Constitution* and in social attitudes are needed to bring the country in line with Guideline 8's call for the creation of a supportive and enabling environment for women.

Attention to Guideline 8 is also important in the context of the recently developed *KYS Campaign*. Although the Campaign is based on international VCT guidelines, there is a danger that peer pressure and over-enthusiastic health workers might exert undue pressure on people to be tested. Considering that women are more vulnerable to HIV-related stigma, women who test HIV-positive may be exposed to domestic violence and social marginalisation.

14.5 Implementation and gaps

Lesotho is one of the few countries that has ratified

virtually all the key international and regional instruments that relate to AIDS and human rights, including:

- *The Convention on the Elimination of Racial Discrimination,*
- *The International Covenant on Civil and Political Rights,*
- *The International Covenant on Economic and Social Rights,*
- *The Convention on the Elimination of All Forms of Discrimination Against Women,*
- *Convention on the Rights of the Child,*
- *Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict,*
- *Optional Protocol to the Convention on the Rights of the Child on the Sale of Children,*
- *The Convention Against Torture,*
- *The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.*

At the regional level, Lesotho has ratified:

- *The African Charter on Human and Peoples' Rights,*
- *The Protocol to the African Charter on the Rights of Women in Africa,*
- *The African Charter on the Rights and Welfare of the Child.*

Against the background of such an exceptional ratification record, the challenge for Lesotho is to incorporate the content of those treaties more fully into domestic legislation, and for the judiciary to incorporate human rights more strongly in its work.²⁵⁷

15. Madagascar

15.1 Policy and strategy framework

Madagascar is a nation with a low HIV prevalence of less than one percent.

The *National Strategic Framework 2001-2006* was approved by the Government in December 2001 and adjusted two years later, in the wake of the country's first national seroprevalence survey. Madagascar's strategy focuses on behaviour change and prevention, treatment of STIs and AIDS, and AIDS education.²⁵⁸

253 USAIDS, *Lesotho and Swaziland: HIV/AIDS Risk Assessments at Cross-Boarder and Migrant Sites in Southern Africa* (2001).

254 As above 2.

255 S. Drimie, "The Impact of HIV/AIDS on Land: Case Studies from Kenya, Lesotho and South Africa: A Synthesis Report prepared for the Southern African Regional Office of the Food and Agricultural Organization of the United Nations (FAO) (August 2002) p.10.

256 Constitution of the Kingdom of Lesotho.

257 It should be noted that the representatives of the judiciary who attended the UN Joint Programme Workshop during 27-29 June 2006 in Johannesburg spoke about their eagerness and commitment to do just this but also highlighted the importance of civil society bringing key cases before the courts so that the judiciary has an opportunity to comment on these human rights and incorporate the instruments into their decisions.

258 http://www.synergyaids.com/Profiles_Web/Profiles_PDFs/MadagascarProfileFeb2005.pdf (accessed 14 June 2006).

Two other strategies help shape the country's overall AIDS response: the *Sectoral Strategy for Prevention of STIs and HIV/AIDS in the Structural Works Sector* (March 2003)²⁵⁹ and the *National Communications Strategy on STIs and HIV/AIDS* (2004-2006).²⁶⁰

15.2 Institutions

The president chairs the country's multisectoral HIV and AIDS body, the *Conseil National de Lutte contre le SIDA* (CNLS)²⁶¹, which is also the primary structure in the AIDS response. An Executive Secretariat provides technical and administrative support to the CNLS, while a Forum of Partners is charged with improving coordination, harmonisation and integration. The Multisectoral Technical Committee oversees the multisectoral dimensions of Madagascar's HIV and AIDS activities under the National Strategic Plan. There is also a Monitoring and Evaluation Unit within the Executive Secretariat.

15.3 Legislative framework

Article 8 of Madagascar's *Constitution* contains general anti-discrimination provisions, but lacks specific reference to HIV or AIDS. Article 19 recognises the right to protection of individuals' health, while Articles 23 and 24 provide for free public education for all and mandatory primary education.

There is a draft law on HIV and AIDS and the protection of the rights of PLWHA.²⁶² The bill covers stigmatisation and discrimination against PLWHA, particularly in the workplace, schools, clinics and hospitals.

In addition to general anti-discrimination and stigma provisions, the bill stipulates that:

- HIV testing is voluntary, anonymous and confidential;²⁶³
- Persons with HIV are entitled to care in the same manner as other patients;²⁶⁴
- ARV treatment is dispensed to PLHWA free of charge in public health facilities;²⁶⁵
- Production and importation of generic medication to treat AIDS is permitted;²⁶⁶
- HIV testing should be routinely offered to pregnant

women in antenatal care;²⁶⁷

- Special measures should be taken to guarantee satisfactory protection to vulnerable groups such as sex workers, youth, women and children, injecting drug users, men who have sex with men and mobile populations.²⁶⁸

The bill provides for fines to be levied against persons guilty of acts of stigma and discrimination, disclosure of HIV status without consent, or false advertising for medications, products or care relating to HIV and AIDS. It also stipulates imprisonment of between six months and 2 years, as well as fines (which are doubled if the perpetrator is a health care worker), for the wilful transmission of HIV.²⁶⁹ The bill has been accepted by Members of Parliament and is currently awaiting Senate approval.²⁷⁰

In addition, the *National Code on Public Health* prohibits all mandatory testing, presumably including HIV testing.²⁷¹

15.4 Adherence to international standards and gender-responsiveness

Madagascar has implemented a *National Strategic Framework* in conformity with Guideline 1 of the Revised International Guidelines on HIV/AIDS and Human Rights.

Despite its relatively low HIV prevalence, Madagascar has taken seriously its obligations under Guideline 6 to provide universal access to care, treatment and support for PLWHA. In 2005, Madagascar stepped up its PMTCT programme²⁷², but testing uptake has been very low, possibly due to severe stigmatisation.

The steps discussed above have moved Madagascar toward meeting the requirement of Guideline 5. However, the country has reported weak application of laws aimed at countering discrimination.²⁷³

15.5 Implementation and gaps

Madagascar has ratified a large number of international instruments that are relevant to HIV and AIDS. However,

259 Sectoral Strategy for the Prevention of and the Fight against STIs and HIV/AIDS in the Labour Sector Structure.

260 National Communication Strategy regarding STIs and HIV/AIDS (2004).

261 http://www.synergyaids.com/Profiles_Web/Profiles_PDFs/MadagascarProfileFeb2005.pdf (accessed 14 June 2006).

262 Bill on the Fight Against HIV/AIDS and Protecting the Rights of Persons Living with HIV/AIDS.

263 Article 5.

264 Article 12.

265 Article 14.

266 Article 15.

267 Article 20.

268 Article 26.

269 Article 63-66.

270 National Follow-Up Report on the Declaration of Commitment UNGASS:Madagascar p.69.

271 National Follow-Up Report on the Declaration of Commitment UNGASS:Madagascar p.70.

272 http://www.unicef.org/french/infobycountry/madagascar_29433.html (Accessed 21 June 2006).

273 National Follow-Up Report on the Declaration of Commitment UNGASS: Madagascar p.73.

the *International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families* still awaits its ratification.

At the regional level, Madagascar has not ratified the *Protocol to the African Charter on the Rights of Women in Africa*.

16. Malawi

Drafted by the National AIDS Commission in 2003, the *National AIDS Policy: A Call for Renewed Action 2003* (the *NAP*) is Malawi's chief HIV and AIDS policy document. The *NAP* identifies AIDS as a health, social, economic and development issue, and calls for a holistic and multisectoral approach based on human rights principles.

Divided into nine chapters²⁷⁴, the *NAP* provides comprehensive and detailed policy direction. Anti-discrimination and empowerment of PLWHA are two important themes in the *NAP*. Chapter 5 seeks to protect and empower vulnerable groups (including women and girls, orphans, widows and widowers, children and young people, the poor, people engaged in transactional sex, prisoners, mobile population and people engaged in same-sex relations). Importantly, the *NAP* assigns equal importance to prevention, treatment and care, and directs the Government to "progressively provide access to affordable, high quality ART and prophylaxis to prevent opportunistic infections".²⁷⁵ Furthermore, in its appendix (proposals for legislative reform), the *NAP* provides a detailed list of existing legislation that should be reviewed to provide better protection for PLWHA.

The *Malawi National HIV/AIDS Strategic Framework 2000-2004* (the *Malawi NSF*)²⁷⁶ sets out clear goals, objectives and strategies regarding the nine main areas of focus.²⁷⁷ It does not, however, address ARV treatment. The *Strategic Framework* is oriented around ten guiding principles, each of which provides a basis for policy formulation and programme design. The principles emphasise gender equality, anti-discrimination, the importance of legislative review, and urge all stake holders to collaborate in the fight against AIDS.

In addition to these two main policy and strategic frameworks, the Malawi National AIDS Commission and

other stakeholders have developed several other policy documents and guidelines which, indirectly or directly, relate to managing the epidemic and reducing its impact. These include:

- *A Plan for Scaling up Prevention to Mother to Child Transmission*,
- *Care and Support to OVC and Child Protection- 2006 Annual Workplan*,
- *Code of Conduct on HIV/AIDS and Workplace*,
- *Code of Ethics and Professional Conduct* (1990),
- *Education Sector Policy on HIV and AIDS* (Draft),
- *Guidelines for the Care of Orphans and Other Vulnerable Children* (2005),
- *HIV/AIDS Counselling and Testing: Guidelines for Malawi*,
- *HIV/AIDS Research Strategy for Malawi* (2005-2007),
- *National HIV/AIDS Monitoring and Evaluation Plan Conceptual Framework*,
- *National HIV/AIDS Monitoring and Evaluation Plan Operations Plans*,
- *National Plan of Action for OVC* (2005-2009),
- *National Policy on OVC* (2003),
- *Policy on HIV/AIDS in the Workplace* (Draft),
- *PMTCT of HIV in Malawi: Guidelines for Implementers* (2003),
- *Programme and National Plan of Action of Women, Girls and HIV/AIDS* (2005-2010),
- *Programme Document for Integrate Early Childhood Development (IECD) for Malawi* (2003),
- *Rules/Regulations for Children Homes/Orphanages* (2005),
- *Strategic Plan on Combating HIV/AIDS in the Education Sector in Malawi* (2005-2008),
- *Treatment of AIDS: Guidelines for the Use of ARV therapy in Malawi* (2003).

Under the *HIV/AIDS Counselling and Testing Guidelines*, anyone older than 16 years is considered competent to give full and informed consent for counselling and testing, as are young people aged 12-16 years who are married, pregnant or engaged in high-risk behaviour.²⁷⁸ The Government's efforts to provide care and protection to OVC are commendable. The *National Plan of Action for OVC* is especially important since it provides detailed activity plans with the overall goal to "build and strengthen family, community, and government capacities to scale up response for the survival, growth, protection and development of OVC by the end of 2009".²⁷⁹

274 The *National HIV/AIDS Policy: A call for renewed action 2003*, Chapter 1 Introduction; chapter 2 Strengthening and sustaining a comprehensive multisectoral response to HIV/AIDS; chapter 3 Promotion of HIV/AIDS prevention, treatment, care and support; chapter 4 Protection, participation and empowerment of people living with HIV/AIDS; chapter 5 Protection, participation and empowerment of vulnerable populations; chapter 6 Traditional and religious practices and services; chapter 7 Responding to HIV/AIDS in the workplace; chapter 8 Establishing and sustaining a national HIV/AIDS research agenda; chapter 9 Monitoring and Evaluation

275 Chapter 3.3.2 Policy Statement.

276 The National HIV/AIDS Action Framework 2005-2009 is in draft form.

277 *Malawi National HIV/AIDS Strategic Framework (2000-2004)* Culture, youth, social change, socio-economic status, despair and hopelessness, HIV/AIDS management, orphans, widows and widowers, prevention of HIV transmission, HIV/AIDS information, education and communication, and voluntary counselling and testing.

278 *HIV/AIDS Counselling and Testing: Guidelines for Malawi*, sec 2.9.

279 *National Plan of Action for OVC* (2005-2009) 39.

16.2 Institutions

The National AIDS Commission (NAC), which was established in 2001 under the Office of the President and Cabinet, is the overall coordinating authority of Malawi's AIDS response. The NAC comprises a board of 19 commissioners who represent traditional leaders, faith-based organisations, civil servants, NGOs and PLWHA. The body has a secretariat which is headed by an executive director.

The NAC's functions include facilitating policy development, guiding the *National HIV/AIDS Strategic Framework*, facilitating sectoral and local strategic planning, mobilising resources, building partnerships with regional and international linkages, overall monitoring and evaluation, and identifying research priorities.

The Parliamentary Committee on Health and Population (the Committee) is a standing committee which serves as the parliamentary oversight body for the health sector. In terms of section 164(2) of the *Standing Orders*, it is tasked with investigating and inquiring into matters related to health, studying programme and policy objectives of the Ministry of Health and other related structures, and reviewing relevant legislation and reporting to the National Assembly. It is also required to examine estimates of expenditure of relevant ministries and other public bodies, assess the impact of programmes, report to the National Assembly on its findings, and make pertinent recommendations. The Committee has created a sub-committee on AIDS.

16.3 Legal framework

Malawi does not have specific legislation on HIV and AIDS. However, the NAC, via the Malawi *NAP*, has proposed legal reforms to facilitate more effective implementation of HIV and AIDS policies. The proposed areas for legislative reform include the *Constitution*, labour-related legislation, criminal justice laws, public health laws, regulations affecting HIV- and AIDS-related goods and services, as well as laws concerning marriage, inheritance, children, orphans and the disabled.²⁸⁰

Section 20 of the *Constitution of Malawi* is a general equality provision which, it can be argued, applies to PLWHA since the wording "or other status" indicates

that the list of protected grounds from discrimination is not closed.

Several laws have been reviewed, although not all of them have been approved by Parliament:

The Deceased Estates (Will, Inheritance and Protection) Bill 2004 makes provision for the criminalisation of property-grabbing. Section 17 of the original Act is amended to protect the right to property of immediate family members. Section 17(b) reads "every spouse of the intestate shall be entitled to retain all the household belongings which belong to his or her households".²⁸¹

The Penal Code (Amended) Bill 2000 recommends in section 137(2) that the age of girls for consensual sex be raised from 13 to 16 years.²⁸² However, the recently revised *Constitution* allows girls older than 15 years to marry.²⁸³ In an attempt to introduce gender neutrality in sexual offences, the Law Commission recommends that section 137(A) criminalise "indecent practices between females" as well as between males.²⁸⁴

The revised *Children and Young Persons Act* codifies legal provisions related to child care and protection, which are located in several different laws. The inclusion of provisions related to residential placement and fostering could provide better protection to OVC.²⁸⁵

The Protection against (Prevention of) Domestic Violence Act was adopted by the Parliament in June 2006.²⁸⁶ The importance of this Act lies in its broad applicability. The Act covers spousal relationships as well as "relations between family members" and financially-dependent relations.²⁸⁷ The latter include spousal relations, child-parent relations and long-term (over 12 months) visiting relations.²⁸⁸ Furthermore, the Act interprets "domestic violence" to include "physical, sexual, emotional or psychological or financial abuse committed by a person against a spouse, child, any other person who is a member of the household, dependant or parent of a child of that household".²⁸⁹

16.4 Adherence to international guidelines and gender sensitivity

In line with Guideline 1 of the Revised International Guidelines on HIV/AIDS and Human Rights, Malawi has

280 The Malawi NAP, appendix (Proposals for legislative reform).

281 Law Commission Report on the Review of *Wills and Inheritance Act* (Zomba, Malawi) 9; also see 132 for new provisions relating to Intestacy.

282 Law Commission Report on Review of the *Penal Code* (Zomba, Malawi) 36.

283 The *Constitution of the Republic of Malawi* sec 22(8).

284 As above 36; also see section 156 of the *Penal Code*.

285 Children and Young Person's Act Cap 26:03.

286 Act no 5 of 2006.

287 *Protection Against (Prevention of) Domestic Violence Act* (Ac no 5 of 2006), see interpretation of terms.

288 As above, part 1 Preliminary, Interpretation.

289 Part 1 Preliminary, Interpretation, *Domestic Violence Bill*.

developed a national framework for its response to AIDS. Civil society groups have reported that framework was developed in a “very consultative” manner – which would fulfil Guideline 2’s requirements of community consultation.²⁹⁰

Malawi has initiated a number of legislative reviews to prohibit discrimination based on HIV status and to strengthen the protection of women.²⁹¹ By late 2006, these had not yet been adopted by Parliament, as required by Guidelines 4 and 5. In addition to section 20, which provides a general anti-discrimination and equality clause, section 24 of the *Constitution* is specifically devoted to women’s rights.²⁹² Section 24(2) renders invalid any law that discriminates against women on the basis of gender or marital status, and requires the State to pass legislation to eliminate discriminatory and harmful cultural practices and customs.²⁹³ Importantly, section 24(2)(a) specifically refers to “sexual abuse, harassment and violence”.²⁹⁴

The Domestic Violence Act, which provides a broad definition of “domestic violence”, marks an important step toward eliminating gender-based domestic violence. However, neither the *Penal Code* nor its revised version recognises marital rape. Also disappointing is the revised *Penal Code*’s criminalisation of same-sex sexual relationships, which are deemed punishable by up to 14 years in prison. This is likely to discourage men who have sex with men from accessing sexual health services.²⁹⁵ At the same time, the *NAP* identifies homosexuals as a vulnerable group and advocates non-discrimination, while the *Constitution* indirectly prohibits discrimination based on sexual orientation.²⁹⁶ There is a general sentiment among civil society that the legal protective framework for PLWHA in Malawi remains insufficient.²⁹⁷

Despite the recommendation of the NAC to increase the age of marriage consent to 16 years, the *Constitution*’s provisions are unclear. Under section 22(7) of the *Constitution*, persons older than 15 years may enter into marriage with the consent of their parents.²⁹⁸ At the same

time, the *Constitution* discourages but does not prohibit the marriage of a person younger than 15 years.²⁹⁹

Guideline 6 requires States to provide universal access to treatment, care and support. One of Malawi’s major achievements has been stabilising its national adult HIV prevalence at 14 per cent since 2001. However, the persistently higher HIV infection rates among women indicates gender inequalities continue to play a role in the epidemic.

Despite increased efforts to disseminate information relating to HIV and AIDS, only 25 per cent of females and 37 per cent of males aged 15-24 years could correctly identify ways of preventing HIV infection, and rejected key misconceptions.³⁰⁰

The Ministry of Education has developed a *Strategic Plan* (2005-2009) to combat HIV and AIDS in the education sector.³⁰¹ The *Plan* aims to develop and implement HIV and AIDS curricula for primary, secondary and tertiary institutions, as well as for teacher training colleges, and provide support and protection for educators living with HIV. It is an important development. However, greater effort should also go toward disseminating information to the large number of persons who do not participate in the formal education system. HIV and AIDS education should be boosted also in the transport sector.

There has been significant improvement in providing ARV treatment. In 2003, only 4 per cent of eligible HIV-positive patients were receiving ART, but by the end of 2005, 18 per cent of patients were on treatment.³⁰² Malawi has also made progress in paediatric HIV treatment, with 19 of its 61 sites providing ARV treatment to children (as of July 2005).³⁰³ However, the figure is lower than Malawi’s “three-by-five” goal of 23 per cent. Transport difficulties appear to be hampering treatment access in rural areas. In addition, food shortages are forcing some people to halt or interrupt their ARV treatment (the medication has to be taken with food).³⁰⁴ The proportion of HIV-positive

290 PANOS, “UNGASS Monitoring Civil Society Perspectives: Malawi” 2006 UNGASS Shadow Report p.2.

291 HIV and Human Rights, International guideline Access to Treatment, Care and Support

292 The *Constitution*, sec 20 and 24.

293 As above sec 24(2).

294 As above sec 24(2)(a).

295 UNAIDS, 2006 Report on the Global AIDS Epidemic p.112.

296 As above sec 20(1); Sec 20(1) prohibits discrimination on the grounds of “race, colour, sex, language, religion, political or other opinion, nationality, ethnics or social origin, disability, property, birth or other status.” The wording of “other status” could be interpreted to include sexual orientation.

297 PANOS, “UNGASS Monitoring Civil Society Perspectives: Malawi” 2006 UNGASS Shadow Report p.2.

298 As above sec 22(7).

299 As above sec 22(8); Section 22(8) reads “the State shall actually discourage marriage between persons where either of them is under the age of fifteen years.”

300 Department of Nutrition, HIV and AIDS, Office of the President and Cabinet, *Malawi HIV and AIDS Monitoring and Evaluation Report 2005: Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS)* 20-21.

301 Ministry of Education, *Combating HIV and AIDS in the Education Sector in Malawi, Strategic Plan 2005-2008*.

302 *Malawi HIV/AIDS Monitoring* (n 298 above) 24.

303 UNAIDS, 2006 Report on the Global AIDS Epidemic p.153.

304 PANOS, “UNGASS Monitoring Civil Society Perspectives: Malawi” 2006 UNGASS Shadow Report p.2.

pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT has increased, but the majority of HIV-positive women themselves do not have access to ARV treatment.³⁰⁵

Malawi, through the NAC, has developed impressive policy documents on prevention, treatment and care. The principle of anti-discrimination is strongly emphasised throughout those documents. The *Counseling and Testing Guidelines* acknowledge that “gender-related factors” put women at higher risk of HIV infection than men, and that women face greater difficulties when seeking and accessing HIV-related services.³⁰⁶ The *NAP* identifies women and girls as a “vulnerable population” and provides policy guidelines to ensure their “protection, participation and empowerment.”³⁰⁷ It also acknowledges that certain customary practices increase the risk of HIV infection and subject women to further vulnerability, and urges the elimination of such practices.³⁰⁸ Those stipulations are in line with Guideline 8, which requires States to provide a supportive environment for women, children and other vulnerable groups.

Nevertheless, stronger efforts are required to create a supportive and enabling environment for children. In particular, malnourishment in children who are HIV-positive must be addressed. A joint UNICEF and Action Against Hunger study conducted between May 2004 and March 2005 revealed that as many as 26 per cent of children admitted to Nutrition Rehabilitation Units were HIV-positive and that the figure ranged as high as 40 per cent in the most hunger-affected areas. Low HIV testing rates mean that the combination of malnourishment and HIV infection often goes undetected, thereby hampering treatment efforts.³⁰⁹

Infection rates are also high among men in prisons, where 25 per cent of deaths have been attributed to AIDS. Malawi's *NAP* expressly provides for prisoners' access to condoms. In reality, access is limited because prisoners are expected to pay for condoms and because the *Penal Code* criminalises same sex relations.³¹⁰ Among sex workers, HIV prevalence is estimated to reach as high as 70 per cent in some areas.³¹¹ This underlines the need to heed both Guideline 4's requirement of reviewing and reforming correctional systems, and Guideline 8's

requirement of creating a supportive environment for vulnerable groups such as sex workers.

16.5 Implementation and gaps

Malawi has not ratified the following international instruments:

- *The Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict*,
- *The Optional Protocol to the Convention on the Rights of the Child on the Sale of Children*,
- *The International Convention on the Protection of the Rights of Migrant Workers and Members of their Families*.

17. Mauritius

17.1 Policy and strategic framework

The *HIV/AIDS Strategic Five-Year Plan 2001-2005 (Strategic Plan)*³¹² was developed by the Ministry of Health and Quality of Life. The overall goal of the *Strategic Plan* is:³¹³

to prevent new infections and to continue caring and supporting people affected by HIV/AIDS in view to reduce morbidity and mortality associated with HIV infection and to minimise its psychological impact on individuals and the population at large.

The *National Strategic Plan 2006-2010* is currently in draft form.

Mauritius's other AIDS policy documents are the *Five-year HIV/AIDS Action Plan for Injecting Drug Users* (2003-2008) and the *Prevention of Mother to Child Transmission Plus Programme* (since 2001).

17.2 Institutions

Set up in 2001, the National Committee on HIV/AIDS (NAC) is the top multisectoral, inter-ministerial body providing policy guidance on HIV- and AIDS-related issues.³¹⁴

The Multisectoral Technical Advisory Committee (MTAC) consists of various stakeholders such as Ministries,

305 As above 17.

306 Ministry of Health, *HIV/AIDS Counselling and Testing: Guidelines for Malawi* (2004) 2.12.

307 The *NAP* (n 271 above) 15.

308 As above chapter 6 Traditional and Religious Practices and Services; also see chapter 5.4 Widows and Widowers.

309 http://www.unicef.org.uk/press/news_detail.asp?news_id=588 (accessed 24 July 2006).

310 B.Odunsi “The Achilles Heel: Human Rights and Public Health Implications of restricting prisoners' access to condoms and AIDS medication in Southern Africa” forthcoming p.19.

311 PANOS, “UNGASS Monitoring Civil Society Perspectives: Malawi” 2006 UNGASS Shadow Report p.2.

312 Statement by Permanent Representative of the Republic of Mauritius to the UN at the High Level Meeting and Comprehensive Review of the Progress Achieved in Realizing the Targets set out in the Declaration of Commitments on HIV/AIDS, NY (2 June 2006); also see Republic of Mauritius Progress Report 2005 on Declaration of Commitment of the UNGASS on HIV/AIDS 2001 (January 2006) 6-7.

313 Mauritius UNGASS Report 2006 7; No primary document was available on Internet.

314 As above, National Composite Policy Index Questionnaire 15.

NGOs, trade unions, employers' federations, private sector, civil society and UN agencies. Its role is to recommend action plans within the *Strategic Framework*. It also advises the NAC on all issues related to HIV and AIDS, and guides implementation.³¹⁵

17.3 Legal framework

Currently, Mauritius has no AIDS-specific legislation, although an *HIV/AIDS Preventive Measures Bill* is being finalised.³¹⁶

The Labour (Amendment) Act (Labour Act) does mention HIV status. It was enacted in 2004 to prohibit workplace harassment based on HIV status.³¹⁷ Section 3 of the *Labour Act* amends section 2 of the principal Act by adding:

“bullying” means any form of physical or psychological harassment; “harassment” means any unwanted conduct, verbal, non-verbal, visual, psychological or physical based on HIV status, domestic circumstances, sex, sexual orientation, race, colour, language, religion, political opinion or belief, national or social origin, association with a minority, birth or other status that have foreseen that a worker would be affected negatively in his dignity and include sexual harassment.

Several other laws have direct or indirect bearing on HIV prevention, treatment and care of PLWHA.

The *Constitution* prohibits discrimination based on race, caste, place of origin, political opinion, colour, creed or sex, but does not include health status. The right to health care or access to health care is not recognised in the *Constitution*.

The *Criminal Code Act 1838* does not recognise marital rape. Under the Act, sodomy³¹⁸ and “procuring, enticing and exploiting prostitute” is criminalised.³¹⁹ Under section 249 (4), the minimum age for consensual sex is 16 years and mutual consent is not a defence.³²⁰

The Protection from Domestic Violence (Amendment) Act 2004 amended section 2 of the principal Act to define “domestic violence” as:³²¹

- (a) wilfully causing or attempting to cause physical injury;
- (b) wilfully or knowingly placing or attempting to place

- the spouse or the other person in fear of injury to himself or to one of his children;
- (c) intimidation, harassment, ill-treatment, brutality or cruelty;
- (d) compelling the spouse or the other person by force or threat to engage in any conduct or act, sexual or otherwise, from which the spouse or the other person has the right to abstain;
- (e) confining or detaining the spouse of the other person against his will;
- (f) harming a child of the spouse;
- (g) causing or attempting to cause damage to the spouse's or the other person's property;
- (h) threatening to commit any act mentioned in paragraph (a) to (g)

The Sex Discrimination Act 2002 (Act 43 of 2002) prohibits discrimination on the grounds of sex, marital status, pregnancy or potential pregnancy with respect to employment, education, health care, accommodation, insurance and pension.³²²

17.4 Adherence to international standards and gender-responsiveness

Guideline 5 of the Revised International Guidelines on HIV/AIDS and Human Rights requires States to enact or strengthen anti-discrimination and other protective laws to protect vulnerable groups. Mauritius prohibits discrimination based on sex and the enactment of the *Protection from Domestic Violence (Amendment) Act* and the *Sex Discrimination Act* could provide stronger legal protection for women.

Guideline 6 requires universal access to treatment, care and support for all persons living with HIV. As part of the PMTCT Plus Project, implemented in 2000, 84 per cent of HIV-positive pregnant women have received a complete course of ARV prophylaxis. In addition, primary and pre-school teachers receive life skills-based AIDS education during their training and are required to teach similar curricula in schools. However, only eight percent of injecting drug users avoid using non-sterile injecting equipment and only four percent use condoms during sexual intercourse with sex workers.³²³

Recent UNAIDS statistics indicate that HIV prevalence is

315 As above.

316 Statement by Permanent Representative of the Republic of Mauritius to the UN at the High Level Meeting and Comprehensive Review of the Progress Achieved in Realizing the Targets set out in the Declaration of Commitments on HIV/AIDS, NY (2 June 2006); however the actual bill was no available on Internet.

317 The *Labour (Amendment) Act 2004* (Act 1/2004) available at: <http://www.gov.mu/portal/site/laboursite/menuitem.a6a9af165cce6fbb93347524e2b521ca/> (accessed on 21 June 2006).

318 Sec 250(1) of the *Criminal Code Act 1838* (Act 6/1838).

319 As above sec 253.

320 As above sec 249 (4).

321 The *Protection from Domestic Violence (Amendment) Act 2004* (Act 11/2004).

322 Information is available at: <http://www.gov.mu/portal/site/women-site/menuitem.8abf4dfaa942d54a3a5b31000b521ca/> (accessed 21 June 2006).

323 Progress Report 2005 (n 317 above) 12.

on the rise in Mauritius. In 2005, 921 HIV infections were diagnosed, almost half the 2,161 people infected with HIV since 1987.³²⁴ According to one study, Mauritius has the lowest media coverage of AIDS in the region. Such findings have sparked calls for a more intensive prevention programme that involves all sectors of society.³²⁵ Mauritius ought to pay greater attention to Guideline 9's requirement to promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatisation associated with HIV and AIDS.

The AIDS epidemic in Mauritius differs from that in most other SADC countries, with HIV transmission occurring mainly through the use of non-sterile drug injecting equipment. As the *Progress Report* points out, the last three years have seen a significant increase in drug injecting-related HIV transmission and a decrease in transmission attributable to unsafe sex.³²⁶ The fact that HIV infections are concentrated mainly among injecting drug users, sex workers and men who have sex with men³²⁷ increases the danger of stigmatisation and discrimination against PLWHA.

There has been recent community collaboration between UNAIDS and religious leaders of the Council of Religions. One outcome was a 2006-2007 Action Plan aimed at "forging compassion in the face of HIV/ AIDS suffering, and to create an environment where stigma and discrimination no longer flourish and where kindness is extended to marginalised groups in our society".³²⁸ This move is in line with Guideline 8, which requires States to create a supportive and enabling environment for vulnerable groups by addressing underlying prejudices and inequalities through community dialogue.

Since April 2002, ARV treatment has been provided free of cost to all AIDS patients. Free prophylactic treatment is available to medical and paramedical personnel accidentally exposed to HIV and to victims of sexual assault.

17.5 Implementation and gaps

Mauritius has not ratified the following international instruments:

- *The Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict,*
- *The Optional Protocol to the Convention on the Rights of the Child on the Sale of Children,*
- *The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.*

A the regional level, Mauritius has not ratified *the Protocol to the African Charter on the Rights of Women in Africa.*

18. Mozambique

18.1 Policy and strategy framework

Mozambique's AIDS response is guided by the *2005-2009 National Strategic Plan to Fight HIV/AIDS (Plano Estrategico Nacional de Combate ao HIV/SIDA)* which provides for a multisectoral response.

An operational plan outlining programme goals, budget lines and funding sources was developed in 2005.³²⁹ The Ministry of Health launched a second national AIDS strategic plan which covers the period 2004-2008.³³⁰

Mozambique has also integrated AIDS into other Government plans, including the 2005-2009 Plan, the *Second Action Plan for the Reduction of Absolute Poverty (2006-2009)* and the *2006 Economic and Social Plan.*³³¹

Other AIDS policies include:

- *Ministerial Diploma Nr. 183/A-2001,* which approves the norms of the Organisation of the National Health System for the Treatment of People Living with HIV, and the Guideline Principles for the Treatment of Sick People Infected with HIV, as well as the respective Technical Guides;
- *Decision that Authorises the Circulation in the Country of Antiretrovirals in the Therapeutic Schemes approved by Ministerial Diploma Nr. 183/A-2001;*
- *Guideline for the Prevention of HIV/AIDS Vertical Transmission,* December 2002, which provides for the routine testing of pregnant women to avoid HIV transmission from mother to child;³³²
- *National Action Plan for Orphans and Vulnerable Children (2005);*
- *National M&E Framework (revised during 2005).*

324 <http://un.intnet.mu/undp/html/mauritius/hiv%20more.htm> (accessed 24 July 2006).

325 The Southern African Media Action Plan on HIV and AIDS and Gender, "Mauritius HIV and AIDS and Gender Baseline Study" p.2.

326 As above 6.

327 As above 5, 8 and 9.

328 <http://un.intnet.mu/undp/html/mauritius/hiv%20more.htm> (accessed 24 July 2006).

329 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.14.

330 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.14.

331 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.14.

332 L. Amaral, *HIV/AIDS and Human Rights in Mozambique* (forthcoming).

There is also a draft *National Gender Policy and Implementation Strategy*.

18.2 Institutions

The National AIDS Council (*Conselho Nacional do Combate ao Sida*, CNCS) is the main body responsible for AIDS programmes and policies. It is chaired by the Prime Minister and comprises representatives from six ministerial offices and from civil society.

18.3 Legislative framework

While the new Mozambican *Constitution* (2005) does not specifically address HIV and AIDS, it does outline several important rights that apply to PLWHA.

Under article 89, all citizens have the right to medical and health care within the terms of the law. Article 95 provides that all disabled citizens have the right to assistance, although AIDS is not considered a disability in Mozambique and PLWHA only qualify for social assistance if they are employed and have contributed to the social security system.³³³ Article 45(e) states that everyone has a duty to defend and promote health.

According to article 47, children have the right to the protection and care required for their well-being. Article 88 makes education a right for all citizens.

Article 36 guarantees that men and women are equal before the law in all spheres, while article 35 states that:

*All citizens are equal before the law, and they shall enjoy the same rights, and shall be subject to the same duties regardless of colour, race, sex, ethnic origin, place of birth, religion, educational level, social position, the marital status of their parents, their profession or their political preference.*³³⁴

Article 40 states that everyone has the right to life and physical and moral integrity, while article 41 asserts the right to protect one's privacy. The *Constitution* further guarantees the rights of inheritance and freedom from expropriation, except by law and with fair compensation ("right of ownership") under articles 82 and 83.

An untitled piece of legislation (Act No. 5 of 2002) protects the workplace rights of PLWHA by prohibiting

pre-employment HIV testing. It also protects the confidentiality of individuals' HIV status in the workplace and addresses matters relating to medical assistance in the event of occupational exposure to HIV. The Act prohibits dismissal based upon HIV status and stipulates that employers must provide HIV education and advisory services to their employees.³³⁵

Mozambique has no law that provides broader anti-discrimination protection for people living with HIV. Civil society organizations have submitted such a bill to the national assembly for consideration.³³⁶

Prostitution is neither outlawed nor regulated, and sex workers can be charged for "vagrancy" or for performing "immoral acts" in public.³³⁷

18.4 Adherence to international standards and gender-responsiveness

Guideline 1 outlines that States should establish an effective national framework for their AIDS response, and Guideline 2 notes that States should ensure that community consultation occurs through all phases of HIV and AIDS policy design, programme implementation and evaluation. In its most recent UNGASS report, Mozambique observes that the *National Strategic Plan* for 2005-2009 was developed with the involvement of civil society and was endorsed by all stakeholders.³³⁸ Nevertheless, civil society participation remains very weak owing, among other things, to resource and capacity challenges.³³⁹

An advocacy mission in March 2005 revealed that the National AIDS Council had not met once in the preceding year. Following complaints, civil society now selects its own National AIDS Council representatives from an umbrella organisation (instead of having the Government appoint them). This appears to have prompted renewed commitment and action: the National AIDS Council now meets every six weeks.³⁴⁰

According to Guideline 5, States should enact or strengthen anti-discrimination and other protective laws. While Mozambique has addressed the issue of anti-discrimination within the workplace context, this has not been extended to broader human rights protection for PLWHA. Mozambique admits in its latest UNGASS progress report:

333 Centre for Human Rights and Centre for the Study of AIDS, *HIV/AIDS and Human Rights in Mozambique* (forthcoming).

334 Constitution Mozambique Article 35.

335 M. Richter "The UNGASS Declaration of Commitment on HIV/AIDS: A review of legislation in six southern African countries" *Canadian HIV/AIDS Policy & Law Review* v. 8 No. 1 April 2003 p. 5.

336 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.15.

337 Centre for Human Rights and Centre for the Study of AIDS, *HIV/AIDS and Human Rights in Mozambique* (forthcoming).

338 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.14.

339 <http://www.unaids.org/en/Regions/Countries/Countries/mozambique.asp> (accessed 25 June 2006).

340 UNAIDS, 2006 Report on the Global AIDS Epidemic p.267.

The promotion and protection of human rights and equal access to HIV/AIDS services for men and women and for vulnerable populations are clearly addressed in the national strategic plan. Nevertheless, the translation of these principles into legislation and actions remains limited.

While the development of workplace HIV policies in both the public and private sector has received attention and the numbers of employers who are developing such policies is on the rise, much remains to be done on that front.³⁴¹

Mozambique lacks legislation that specifically addresses domestic violence. Furthermore, the effect of article 1674 of the *Civil Code* is to subordinate women by restricting their ability to convey property and freely engage in commercial transactions.³⁴² Mozambique has drawn up a Gender Policy and Implementation Strategy but this is yet to be approved by the Government. A National Plan of Action on Violence Against Women has been developed.³⁴³

Guideline 6 requires universal access to treatment, care and support for all PLWHA. A major challenge in Mozambique is the lack of health coverage for the majority of the population. Geographical distance makes access to health services a comparative rarity. With nearly 70 per cent of Mozambicans living in rural areas³⁴⁴, there is an urgent need for more health facilities in rural areas. Also important is the inclusion of all stakeholders in the AIDS response, particularly traditional medicine practitioners (since the majority of the population uses their services).³⁴⁵ There is a need to expand treatment services in the major urban centres, as well.³⁴⁶ Human resource shortages in the public health sector also undermine care accessibility. Institutional capacity should be strengthened, and management of funds, social partnerships, standardisation of work methods and training strategies all need to be improved.³⁴⁷

Mozambique does not yet have a coordinated behaviour surveillance system. However, the Ministry of Health did conduct some behaviour surveillance research in 2000-2001. The results showed a minority adults (15-49 years)

could correctly identify the main ways of preventing the sexual transmission of HIV and rejected basic misconceptions about HIV.³⁴⁸ Knowledge and awareness was lowest in rural areas, which suggests that prevention strategies were not reaching into rural areas.³⁴⁹ While the percentage of young people using condoms increased from 1997 to 2003, a majority of sexually active persons still engage in unprotected sex.³⁵⁰ Closer adherence to Guideline 9's requirement that States promote wide and ongoing distribution of creative education, training and media programmes is needed. It has been suggested that HIV education campaigns should make greater use of radio as a medium for information dissemination, given the high levels of illiteracy that pertain in Mozambique.³⁵¹

18.5 Implementation and gaps

Mozambique has ratified a large number of the international and regional treaties that are relevant to AIDS and human rights. However, it has not yet ratified the following international instruments:

- *The International Convention on Economic, Cultural and Social Rights,*
- *The International Convention on the Protection of the rights of all Migrants Workers and Members of their Families.*

19. Namibia

19.1 Policy and strategy framework

The *National Strategic Plan on HIV/AIDS Mid Term Plan III (National Strategic Plan)* provides the framework for collaboration and guides the implementation processes for a multisectoral AIDS response in Namibia. The *National Strategic Plan* covers the period 2004-2009. The plan rests on five pillars:³⁵²

- An enabling environment: People infected with HIV and affected by AIDS should enjoy equal rights in a culture of acceptance, openness and acceptance;
- Prevention: Reduce new infections of HIV and other sexually transmitted infections;

341 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.17.

342 M. Richter "The UNGASS Declaration of Commitment on HIV/AIDS: A review of legislation in six southern African countries" *Canadian HIV/AIDS Policy & Law Review* v. 8 No. 1 April 2003 p. 5.

343 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.35.

344 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.33.

345 IDASA "An examination of the institutional arrangements established in Mozambique to address challenges of HIV/AIDS" extracts from draft reports (October 2003) p.5.

346 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.34.

347 IDASA "An examination of the institutional arrangements established in Mozambique to address challenges of HIV/AIDS" extracts from draft reports (October 2003) p.5.

348 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.23.

349 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.32.

350 Government of Mozambique: UNGASS Declaration of Commitment on HIV/AIDS Progress Report Reporting Period 2003-2005 Draft p.29.

351 IDASA "An examination of the institutional arrangements established in Mozambique to address challenges of HIV/AIDS" extracts from draft reports (October 2003) p.5.

352 Namibian National Strategic Plan on HIV/AIDS: Third Medium Term Plan (MTP III) 2004-2009, p.31.

- Access to treatment, care and support services: Ensure access to cost-effective and high-quality treatment, care and support services for all people living with, or affected by HIV/AIDS;
- Impact mitigation services: Strengthen and expand capacity for local responses to mitigate the socio-economic impacts of AIDS;
- Integrated and co-coordinated program management at all levels: Ensure effective management structures and systems, optimal capacity and skills, and high-quality program implementation at national, sectoral, regional and local levels.

In 2004, the Government established the National AIDS Coordination Programme, which is managed by the Directorate for Special Programmes (TB, Malaria and HIV/AIDS).³⁵³

Namibia is also finalising a National Policy on HIV and AIDS that will provide the overall framework for all other AIDS-related policies and guide the expanded national AIDS response.³⁵⁴ The guiding principles recognise AIDS as a development challenge which requires a response that promotes and protects human rights. They also position PLWHA at the centre of the response.³⁵⁵

The ministries of Basic Education, Sport and Culture, and Higher Education, Training and Employment Creation have prepared a draft *National Policy on HIV and AIDS for the Education Sector*.

In 2000, a *Charter of Rights on HIV/AIDS* was launched. It outlines guidelines on confidentiality and privacy for PLWHA.

Several other policies geared at specific interventions have been developed, including: PMTC, post-exposure prophylaxis, ARV treatment, home-based care, Nutrition, recruitment of community counsellors, guidelines for VCT, and rapid HIV testing. Additional policies deal with reporting, notification, confidentiality, surveillance and infant feeding, and ethical guidelines for clinical trials.³⁵⁶

Although not it does refer specifically to HIV and AIDS, the *National Policy for Reproductive Rights* of July 2001 recommends that people should not be denied services based on prejudice.³⁵⁷

19.2 Institutions

The National AIDS Committee (NAC) is responsible for policy decisions on matters related to HIV and AIDS.³⁵⁸

The NAC comprises 12 Cabinet Ministers, all 13 Regional Governors and the Permanent Secretary of the Ministry of Health and Social Services. The Ministry of Health and Social Services is the lead ministry in the AIDS response and the Minister chairs the NAC. Other officials from that ministry hold key positions in the coordination mechanism, while the Ministries of Education, Information and Broadcasting, and Defence also play important roles in the response.³⁵⁹

The National Multisectoral AIDS Coordination Committee (NAMACOC) coordinates the national multisectoral response.

The National AIDS Executive Committee (NAEC) implements decisions of the NAC and NAMACOC.

The Namibia Coordination Committee on HIV/AIDS, Tuberculosis and Malaria (NACCATUM) is the local Country Coordination Mechanism for Global Fund Programmes.³⁶⁰

The Namibia Network of AIDS Service Organisations (NANASO) was established to provide a network service to NGOs working in the HIV/AIDS arena and maximise their capacity to address the issues.

The Directorate for Special Programmes (TB, Malaria and HIV/AIDS) is responsible for guiding the development of sector-wide activity plans.³⁶¹

In July 2004, the Government also established the Namibia Business Coalition on HIV/AIDS with the goal of enhancing collaboration with the private sector.³⁶²

The Parliamentary Standing Committee on Human Resources, Social and Community Development is the parliamentary portfolio committee that conducts oversight of Government's AIDS activities. The *Standing Rules of Parliament* specifically task the committee to:

Facilitate the implementation of recommendations reached at international fora on HIV/AIDS prevention and care programmes, poverty reduction strategies and social development

353 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): Namibia Country Report, Ministry of Health and Social Services (2005) p.8.

354 National Policy on HIV/AIDS (19 January 2006).

355 National Policy on HIV/AIDS (19 January 2006) arts 1.5.1, 1.5.3-1.5.5.

356 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): Namibia Country Report, Ministry of Health and Social Services (2005) p.9.

357 Principle 3.2.e, Chapter three of the National Policy for Reproductive Health, 2001.

358 Medium Term Plan III p 12.

359 http://www.unaids.org/en/Regions_Countries/Countries/namibia.asp (accessed 14 June 2006).

360 http://www.unaids.org/en/Regions_Countries/Countries/namibia.asp (accessed 14 June 2006).

361 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): Namibia Country Report, Ministry of Health and Social Services (2005) p.8.

362 http://www.who.int/3by5/support/june2005_nam.pdf (accessed 14 June 2006).

programmes such as gender equality, children's rights and family values.³⁶³

19.3 Legislative framework

Chapter 3 of the Namibian *Constitution* ensures the protection of the fundamental rights and freedoms of all persons in Namibia. Articles 8, 10 and 13 of the *Constitution* are especially relevant to PLWHA. Article 8(1) states that "the dignity of all persons shall be inviolable". Article 10 ensures equality and freedom from discrimination, while Article 13 protects the fundamental right to privacy.

The Government has adopted the *National Code on HIV/AIDS and Employment* under the *Labour Act*. It prohibits discrimination based on an individual's HIV status and which aims to expand AIDS awareness and prevention in the workplace.³⁶⁴

Other national legislation that addresses issues relating to HIV and AIDS include:

The Combating of Domestic Violence Act 4 of 2003 lists offences that constitute domestic violence. Those offences include rape and the contravention of section 14 of the *Combating of Immoral Practices Amendment Act No. 7 of 2000*. The Act prohibits "sexual abuse" in domestic relationships (including undesired sexual conduct, which covers marital rape), as well as child abuse and incest.³⁶⁵

The Combating of Rape Act 8 of 2000 provides for harsher punishment of rapists who are infected with a serious sexually transmitted disease.³⁶⁶ It makes it an offence to coerce a person to have sexual intercourse with a third person. Article 2(3) makes marital rape an offence.

The Married Persons Equality Act 1 of 1996 abolishes the marital power of a husband over his wife and her property³⁶⁷, and provides for equal powers of spouses married in community of property.³⁶⁸

The Defence Act 1 of 2002 article 7(1)(c)(i)(ii)(iii) deals with the qualifications of Defence Force members and can

be interpreted to equate HIV-positive status with a disease status that prevents persons from enlisting in the Defence Force.³⁶⁹

The Labour Act 15 of 2004 states that a person must not discriminate in any employment practice, directly or indirectly, against any individual based on HIV status.³⁷⁰

The Children's Act 33 of 1960 prohibits any person or guardian or any person having the custody of a child from causing or allowing the seduction, abduction or prostitution of a child or the commission by that child of immoral acts.³⁷¹

While homosexuality is not illegal in Namibia, anal sex between men is outlawed. As a result, condoms are not distributed in Namibian prisons.³⁷²

19.4 Adherence to international standards and gender-responsiveness

In terms of legislation, Namibia has made progress in preventing discrimination against PLWHA in the workplace. It is also among the few countries to have prohibited marital rape. Namibia therefore appears to be heeding Article 5 of the Revised International Guidelines on HIV/AIDS and human rights, which recommends the strengthening of anti-discriminatory legislation. More can be done, though. In its latest UNGASS progress report, Namibia highlighted the need for a comprehensive review of its existing laws and policies as they relate to people living with HIV. It also pointed to the need to improve the technical capacities of lawmakers for drafting the necessary legal changes.³⁷³ By Namibia's own account, enforcement of existing policies, laws and regulations is mediocre.³⁷⁴ Namibia's biggest challenge arguably lies in implementing and enforcing its AIDS policies and legislation. Lack of resources, funds and human capacity pose significant hurdles.³⁷⁵

A literature review of existing policies, laws and strategic plans related to AIDS in Namibia, as well as pertinent international conventions signed by Namibia and national AIDS policies of other SADC countries was conducted as

363 Standing Rules and Orders of the Parliament of the Republic of Namibia, Section 51(1)(f).

364 http://www.who.int/3by5/support/june2005_nam.pdf (accessed 14 June 2006).

365 sec 2(1)(b) and 3(1).

366 art 3(1)(a)(ii)(dd) and art 3(b)(iii).

367 The Married Persons Equality Act 1 of 1996 sec 2(1)(b).

368 The Married Persons Equality Act 1 of 1996 sec 5.

369 See Haindongo *Nghidiphamba Nanditumbe v Minister of Defence* 1998 LC 24/98

370 art 2(f).

371 art 19(2).

372 "Namibia's prisons sit on AIDS 'time bomb'" Mail & Guardian online (4 January 2006).

373 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): Namibia Country Report, Ministry of Health and Social Services (2005) p.26-7.

374 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): Namibia Country Report, Ministry of Health and Social Services (2005) p.65.

375 "Lewis hails progress but underlines lack of capacity" (April 14, 2006) see <http://www.iohividaids.co.za/index.php?fArticleId=3203639> (accessed 20 June 2006).

part of preparations for the draft *National Policy on HIV/AIDS*.³⁷⁶ Indeed the language of that draft policy brings Namibia in line with many international standards and appears to be gender-responsive. In that sense, it can be said to be in accordance with Article 2 of the International Guidelines, which recommends community consultation for AIDS policy design.

Despite the positive signs of civil society consultation and participation, the AIDS and Rights Alliance for Southern Africa (ARASA) claims that the Namibian Government objected to its participation at the most recent UNGASS review in New York in May 2006.³⁷⁷

Guideline 7 requires the implementation and support of legal services for people living with HIV to be educated about their rights. Namibia's latest UNGASS progress report indicates a lack of legal aid systems for HIV casework, as well as a lack of state support to private sector law firms or university clinics that provide *pro bono* services to persons challenging, among other issues, discrimination on the basis of HIV status.³⁷⁸

Guideline 8 requires that States create an enabling and supportive environment for women, children and other vulnerable groups. A series of potentially harmful customary practices affecting women and children remain in practice in Namibia, however. These include property-grabbing, initiation ceremonies for children, arranged marriages between cousins, and lack of widow inheritance.³⁷⁹

Namibia's *Draft National Policy on HIV/AIDS* regards prisoners as vulnerable persons who should receive prevention, treatment and care services, including the provision of condoms, in line with the general population. However, the provision is in conflict with the fact that same-sex relations constitute a common law crime in Namibia.³⁸⁰

Guideline 11 requires States to ensure that monitoring and evaluation mechanisms are in place to guarantee the protection of HIV-related human rights. Namibia has made some progress in this respect, insofar as it has set up a Response Monitoring & Evaluation Subdivision of the Ministry of Health and Social Services Directorate of Special Programs. A monitoring and evaluation operational plan is being finalised. Nevertheless,

insufficient human resources, poor data gathering and lack of coordination have seriously hampered monitoring and evaluation efforts. Moreover, there are no AIDS-related indicators or benchmarks for compliance with human rights standards.³⁸¹

19.5 Implementation and gaps

Namibia has ratified most international conventions that relate to AIDS and human rights. It has not, however, ratified the *Convention on the Protection of the Rights of all Migrant Workers and Members of their Families*.

Namibia has ratified the key regional instruments relating to AIDS and human rights.

20. Somalia

20.1 Policy and strategic framework

The *Strategic Framework for HIV/AIDS Prevention and Control in Somalian Populations 2003-2008* is intended to provide a framework for "accelerated action toward control and prevention of the HIV/AIDS pandemic for local stakeholders in Somalia and their developmental partners".³⁸² Its current emphasis is on developing the basic systems and structures required to undertake a comprehensive, multisectoral response. This will entail developing human capacity, building technical and infrastructure capacity, and strengthening political commitment through advocacy and community mobilisation.

The broad objectives of the *Strategic Framework* are:³⁸³

- To reduce the incidence of HIV infection and STIs in adults and children through strengthened prevention;
- To empower individuals, families, and communities with knowledge and skills for AIDS prevention and community- and home-based care;
- To establish a programme management structure for the coordination, monitoring and evaluation of the AIDS and STI response;
- To ensure that Somalis living with HIV, and their families, are not subjected to discrimination;
- To ensure continuous support from both local and international communities in addressing the impact of AIDS.

376 National Policy on HIV/AIDS p.1.

377 See <http://www.arasa.info/index.php?page=news&article=14> (accessed 20 June 2006).

378 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): Namibia Country Report, Ministry of Health and Social Services (2005) p.64.

379 These comments were made by the Namibian team at the Joint UN Programme Consultative Workshop held in Johannesburg on 27-29 June 2006.

380 B.Odunsi "The Achilles Heel: Human Rights and Public Health Implications of restricting prisoners' access to condoms and AIDS medication in Southern Africa" forthcoming p.23.

381 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): Namibia Country Report, Ministry of Health and Social Services (2005) p.39, 58 and 64.

382 Strategic Framework for the Prevention and Control of HIV/AIDS and STIs within Somali Population 2003-2008 29.

383 As above.

To meet those objectives, the framework sets out the following priorities:³⁸⁴

- Strengthening advocacy, resource mobilisation, and policy formulation;
- Increasing awareness and community mobilisation;
- Increasing availability, quality and accessibility of safe services;
- Promoting comprehensive prevention and treatment;
- Mitigating the impact of the AIDS epidemic;
- Improving knowledge-based response management and implementation.

The *National Policy for HIV/AIDS and STI Prevention and Control* is currently in draft form, with International Cooperation for Development (an international NGO) and the WHO assisting in the drafting. The draft policy recommends voluntary testing and appropriate counseling, the development of comprehensive guidelines for VCT and for the progressive provision of ARV, and the development of a national plan for gradually realising universal access to treatment.³⁸⁵

In addition to the *Strategic Framework* and *National Policy*, the key strategy documents are:

- Three zonal *HIV/AIDS Action Plans 2004-2006*, one each for Somaliland, Puntland, and Central and Southern Somalia;
- *Somalia HIV/AIDS Prevention, Advocacy and Communication Framework*;
- *HIV/AIDS Capacity Assessment Report*;
- HIV/AIDS Advocacy and awareness raising: Facilitator's Guide and participants handouts;
- Stakeholder Inventory.

20.2 Institutions

Zonal coordination committees have been established in each of the country's three zones.³⁸⁶

In Somaliland, an HIV/AIDS and STI inter-ministerial steering committee, supported by a technical committee, is leading efforts to sensitise communities to the epidemic.³⁸⁷ The Presidency presides over the inter-ministerial steering committee, which comprises ministers of six key line ministries and is chaired by the Vice-President.³⁸⁸

In Puntland, an HIV/AIDS and STI control council has been established with a structure similar to that in Somaliland.³⁸⁹

The South Central AIDS Commission was established in March 2006.³⁹⁰ It is working with UNICEF to organise programs in 11 regions of central and south Somalia. The Minister of Health of the Transitional National Government (TNG) has signed on to the *Strategic Framework*. The zonal coordination committees for Central and Southern Somalia are divided into ten Regional Working Groups, which meet every three months to review implementation.

The HIV/AIDS Working Group of the Somalia Aid Coordinating Body (SACB) was formed in September 1999. It supports and implements advocacy, research and integration of AIDS activities in sectors such as education, and in social outreach programmes.³⁹¹ Members include UN agencies, international and local NGOs, local authorities and zonal coordination committees.³⁹²

Members of the three zonal coordination committees (Somaliland, Puntland, and South and Central) constitute a seven-member governing committee, the Somali AIDS Committee (SAC), with a UNAIDS technical advisor serving as the eighth member.³⁹³

The executive management of the AIDS response rests with a Technical Advisory Committee (TAC) that operates under the umbrella of the SACB. The TAC is comprised of a general committee and eight thematic task forces, with the SACB HIV/AIDS and FGM Forum acting as the Coordinating Committee for the TAC, which provides quarterly progress reports on the response.³⁹⁴ Membership of the TAC Coordinating Committee is open, but it has a core membership of key executing and implementing partners. The membership of the task forces varies depending on the thematic aspect of the response.

20.3 Legislative framework

Chapter 1, Part 2, article 17 of the Somaliland *Constitution* states that the Government "shall have the duty to meet the country's needs for equipment to combat communicable diseases, the provision of free medicine,

384 n 387 above, 30.

385 World Health Organization Summary Country Profile for HIV/AIDS Treatment Scale-Up 2005.

386 n 387 above, 23.

387 As above.

388 n 387 above, 48.

389 As above.

390 <http://www.medicalnewstoday.com/medicalnews.php?newsid=39687> (accessed 21 June 2006).

391 n 387, 24.

392 Support to a Coordinated HIV/AIDS Response for Somali Populations 6.

393 n 387, 46.

394 n 387, 47.

and the care of the public welfare” and “be responsible for the promotion and the extension of health care and private health centres”. Chapter 1, Part 2, article 8 provides for equality and freedom from discrimination.

Sections 2.5 to 2.7 of the Somali *Constitution* ensure equality and protection from discrimination.

The *Presidential Decree on HIV/AIDS* of July 2005 in Somaliland set up the National AIDS Commission.³⁹⁵

20.4 Adherence to international standards and gender-responsiveness

Guideline 1 of the Revised International Guidelines on HIV/AIDS and Human Rights requires that States establish an effective national framework for their AIDS response. The *Strategic Framework for the Prevention and Control of HIV/AIDS and STIs within Somali Populations 2003-2008* has been integrated into existing development plans such as the Consolidated Appeal Process, the United Nations Implementation Support Plan, the UN Transitional Plan and the Joint Needs Assessment process.³⁹⁶

The *Strategic Framework* includes the following sectors: health, education, civil society organisations, people living with HIV, religious leaders, and women. It recommends interventions such as VCT, STI prevention and treatment, blood safety, prevention of mother-to-child transmission and the integration of prevention into treatment, care, and support. The *Strategic Framework* and action plans have been used as tools to secure support from the Global Fund and DFID, as well as from UN agencies regular budgets.³⁹⁷

Unfortunately, many senior political leaders in Somalia appear disinterested in the AIDS response.³⁹⁸

Guideline 8 requires that States promote a supportive and enabling environment for women, children and other vulnerable groups. The Strategic Framework, however, does not focus on vulnerable groups and sectors such as labour, transport, military, women and girls, internally displaced persons, refugees and returnees. More needs to be done, too, in relation to AIDS impact mitigation, reducing gender inequalities, human rights and AIDS, uniformed services, reduction of income inequalities and the many vulnerability issues experienced by women and girls. Minimal information is available on condom promotion and distribution, and breastfeeding. The

Strategic Framework also does not address issues related to interventions for most-at-risk population groups.³⁹⁹

One of the biggest challenges is to build large-scale institutional and human resource capacity, and strengthen coordination mechanisms so that an integrated comprehensive response becomes feasible. Especially in the context of ongoing emergencies and humanitarian crises, the AIDS response must be tailored to the needs of those who are most at risk of HIV infection and most vulnerable to the epidemic's impact. In particular, the response must address the vulnerabilities of women and girls.⁴⁰⁰

20.5 Implementation and gaps

Somalia has not ratified the following international instruments:

- *The Convention on the Elimination of all Forms of Discrimination Against Women,*
- *The Convention on the Rights of the Child,*
- *The Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict,*
- *The Optional Protocol to the Convention on the Rights of the Child on the Sale of Children,*
- *The International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families.*

In addition, Somalia has not ratified the following regional instruments:

- *The Protocol to the African Charter on the Rights of Women in Africa,*
- *The African Charter on the Rights and Welfare of the Child.*

21. South Africa

21.1 Policy and strategy framework

The *HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 (Strategic Plan)* is a broad national strategy intended to guide the country's AIDS response. It reflects the reports of task teams appointed to review the *National AIDS Plan* for South Africa of 1994, along with the Department of Health *White Paper for the Transformation of the Health System* and the 1997 *Annual HIV/AIDS/STD Review*. The *Strategic Plan* is based on an integration of STD/HIV/AIDS

395 http://www.unicef.org/somalia/SOM_SomalilandAIDSSept1605.pdf (accessed 22 June 2006).

396 UNAIDS HIV Epidemic and its Response 2003-2005 p.19.

397 n 403, 20.

398 n 403, 19.

399 n 403, 37.

400 As above.

and TB care and responses. The main pillars of the response are (1) prevention, (2) treatment, care and support, (3) research and surveillance, and (4) legal and human rights.

In November 2003, the Cabinet approved the National Department of Health's *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa (Operational Plan)*, which was implemented the following April. The *Operational Plan* emerges from recommendations of the Report of the Joint Health and Treasury Task Team which had been mandated to examine treatment options to supplement comprehensive care for AIDS in the public sector. In terms of managing the AIDS epidemic, the *Strategic Priorities for the National Health System 2004-2009* emphasises the implementation of the *Operational Plan*, which includes the safe provision of antiretrovirals to patients who qualify for enrolment in the programme.

The following policy documents have been also adopted to regulate various areas related to HIV and AIDS:

- *Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV)*, Department of Health (1999),
- *National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions* (1999),
- *Ethical Considerations for HIV/AIDS Clinical and Epidemiological Research* (2000),
- *Guidelines on Voluntary Counseling and Rapid HIV Testing* (2000),
- *Recommendations for Managing HIV Infection in Children* (2000),
- *Guidelines for Good Clinical Practice in the Conduct of Trials in Human Participants in South Africa*, Department of Health (2001),
- *Policy Guideline for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault*, Department of Health (2003),
- *Policy Guideline and Recommendations for Feeding of Infants of HIV Positive Mothers*, Department of Health,
- *Prevention of Mother-to-Child HIV Transmission and Management of HIV Positive Pregnant Women*, Department of Health (2000),
- *Recommendations for the Prevention and Treatment of Opportunistic Infections and HIV Related Diseases in Adults*, Department of Health (2000),

- *Guidelines for Management of HIV-infected Children* (2005),
- *National Antiretroviral Treatment Guidelines* (2004),
- *HIV/AIDS and Sexually Transmitted Diseases in the Workplace*, Department of Health (2000),
- *National Guideline on Home-Based Care/Community-Based Care*, Department of Health (2001),
- *Code of Good Practice on Key Aspects of HIV and AIDS and Employment* (2000),
- *National Action Plan for Orphans and other Children made Vulnerable by HIV and AIDS 2006-2008*.

21.2 Institutions

The South African National AIDS Council (SANAC) is the highest body advising Government on matters relating to AIDS. Established in 2000 to mainstream a multisectoral approach to the epidemic⁴⁰¹, SANAC is chaired by the Deputy President and co-chaired by the Minister of Health. The Council is composed of 16 government representatives and 16 civil society representatives.⁴⁰²

SANAC's major functions include advising the Government on ANDS and STI policies, mobilising resources for the implementation of AIDS programmes, and monitoring the implementation of the *Strategic Plan* in all sectors of society. It is also tasked with advocating for the effective involvement of sectors and organisations in implementing programmes and strategies, and with recommending appropriate research.⁴⁰³

SANAC has been widely criticised for irregular meetings and insufficient civil society involvement.⁴⁰⁴ Many NGOs feel that it is structurally flawed, lacks transparency, accountability and independence, and is failing to serve as a national coordinating country mechanism.⁴⁰⁵

The Interdepartmental Committee on HIV/AIDS (IDC) was established in 1997. It is composed of the AIDS coordinators from various national government departments. As set out in the *Strategic Plan*, its mandate is to review government AIDS programmes, facilitate the development of AIDS workplace policies, ensure that all government departments allocate financial resources to the AIDS response, and develop minimum AIDS Programmes for all government departments.⁴⁰⁶

Provincial AIDS Councils are to drive the response at provincial level.⁴⁰⁷

401 South African National AIDS Council (SANAC) <http://www.info.gov.za/issues/hiv/sanac.htm>.

402 Republic of South Africa: Progress Report on Declaration of Commitment on HIV and AIDS prepared for UNGASS on HIV/AIDS (February 2006) p.11.

403 See the 2000-2005 HIV/AIDS/STD Strategic Plan for South Africa p.12.

404 ICASO, *Monitoring the Implementation of the UNGASS Declaration of Commitment Country Report South Africa* prepared by Shaun Mellors p.14.

405 A. Strode and K.B. Grant, eds. *Understanding the Institutional Dynamics of South Africa's Response to the HIV/AIDS Pandemic* (Pretoria: Institute for Democracy in South Africa, 2004) p.22-24.

406 <http://www.doh.gov.za/aids/docs/idc.html> (accessed 20 June 2006).

407 Republic of South Africa: Progress Report on Declaration of Commitment on HIV and AIDS prepared for UNGASS on HIV/AIDS (February 2006) p.11.

21.3 Legislative framework

The *Constitution* states in section 27(1)(a) that “[e]veryone has the right to have access to health care services, including reproductive health care”. According to section 27(2), “[t]he state must take reasonable legislative and other measures, within available resources, to achieve the progressive realisation of each of these rights”. Section 27(3) states that no-one can be denied emergency medical treatment. Section 28(1)(c) provides for “basic health care services” for children, while section 35(2)(e) provides for “adequate medical treatment” for detainees and prisoners at the State’s expense.

The Constitution also provides for the right to equality and anti-discrimination (Section 9), the right to human dignity (Section 10), the right to life (Section 11), the right to freedom and security of the person (Section 12), the right to privacy (Section 14), the right to adequate housing (Section 26), the right to sufficient food and water and social security (Section 27) and the right to education (Section 29).

The following legislation also regulates issues related to AIDS:

- Schedule 6 (a)(iv) of the *Criminal Procedure Second Amendment Act, Act 85 of 1997*, makes the granting of bail more difficult in instances where the suspected rapist is known to be HIV-positive;
- *The Criminal Law Amendment Act 105 of 1997* provides for life imprisonment of an HIV-positive first-time offender who is convicted of rape. A minimum sentence of ten years is provided for a first-time offender who is not HIV-positive. The Act does not require evidence of HIV transmission to support the imposition of a higher sentence;
- *The Medicines and Related Substances Control Amendment Act, Act 90 of 1997*, on the use of generic medicines;
- *The Employment Equity Act, Act 55 of 1998*, Sections 6, 7(1) and (2) and 50(4) of which deal specifically with HIV and AIDS in relation to employment;
- *The Labour Relations Act 66 of 1995* prohibits the dismissal of an employee on the basis of HIV and AIDS status. The Act does permit termination of services when a person is no longer able to work and proscribes that fair dismissal procedures must be followed. The Act does not apply to members of the South African Defence Force or the National Intelligence Agency;
- *The Occupational Health and Safety Act 85 of 1993* discusses the minimisation of occupational exposure to HIV and the administration of post-exposure prophylaxis;

- *The Basic Conditions of Employment Act 75 of 1997* covers minimum sick leave days;
- *The Promotion of Equality and Prevention of Unfair Discrimination Act, Act 4 of 2000* in which Sections 34(1) and (2) make direct reference to HIV and AIDS;
- *The Public Service Regulations Act of 2002*;
- *The National Health Act 61 of 2003* on rights of patients who use health care facilities;
- *The Medical Schemes Act 131 of 1998*;
- Commercial sex work is criminalised in South Africa in terms of the *Sexual Offences Act, Act 23 of 1957*;
- *The Domestic Violence Act No. 116 of 1998*.

The South African Law Commission investigated possible changes to the definition of the crime of rape, along with the possibility of requiring sexual offenders to undergo HIV tests if so requested by their victims and ordered by a Magistrate. Such changes have been incorporated into two separate bills tabled in Parliament: the *Sexual Offences Amendment Bill* and the *Compulsory HIV Testing of Alleged Sexual Offenders Bill*.

The new *Children’s Bill* also contains provisions that potentially relate to HIV and AIDS with respect to gender and young people. The Bill regulates cultural, religious and social practices that are potentially harmful to children. Forced marriage is considered a criminal offence and carries a prison sentence of up to 10 years. Forced genital mutilation and female circumcision are prohibited. Virginity testing is prohibited if the girl is under 16 years of age and can only be performed on girls older than 16 if they consent to the testing and if they have been properly counselled.

21.4 Adherence to international standards and gender-responsiveness

Guideline 1 of the of the Revised International Guidelines on HIV/AIDS and Human Rights requires States to establish an effective national framework for their response to AIDS. Such frameworks should enable coordinated, participatory, transparent and accountable approaches. While South Africa has designed a broad national HIV and AIDS strategy, the Government has been criticised for a lack of unconditional political commitment to the AIDS response and the often slow pace of implementation. A shadow UNGASS report prepared by the International Council of AIDS Service Organisations (ICASO) states that “the gap between what is said in official policy and what is happening in reality is continuing and concerning.”⁴⁰⁸ In addition, South Africa is not spending all of the funds allocated to AIDS programmes – mainly because of its “weak health-care system and insufficient government capacity to absorb funds”.⁴⁰⁹

408 ICASO, *Monitoring the Implementation of the UNGASS Declaration of Commitment Country Report South Africa* prepared by Shaun Mellors p.4.

409 UNAIDS, 2006 Report on the Global AIDS Epidemic p.251.

The most recent report prepared by the Government dealing with HIV/AIDS is the *2006 Progress Report on Declaration of Commitment on HIV and AIDS*.⁴¹⁰ Contrary to UNGASS policy and Guideline 2, the Government has been accused of failing to consult civil society for input into that report. Complaints about misinformation, along with the Government's attempt to exclude the Treatment Action Campaign and the AIDS Law Project from UNGASS, have underlined concerns that the Government has not sufficiently involved civil society in its AIDS response.⁴¹¹

Guideline 4 requires that States review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations. Nevertheless, the Department of Correctional Services has resisted providing antiretrovirals to prisoners. In June 2006, in a case brought by the AIDS Law Project on behalf of several prisoners, the Durban High Court ordered the Department to provide prisoners with antiretroviral treatment.⁴¹² The Government is reportedly appealing the verdict.

At the same time, South Africa shown progress in passing anti-discriminatory and protective laws in line with Guideline 5 – including the *Labour Relations Act*, the *Employment Equity Act*, and the *Promotion of Equality and Prevention of Unfair Discrimination Act*.

The Government of South Africa is party to the Agreement on Trade-Related Aspects of Intellectual Property Rights (the TRIPS Agreement). In 1997, Parliament passed the *Medicines and Related Substances Control Amendment Act*⁴¹³, the purpose of which was to ease access to cheaper medications in the public and private health sectors. The move was in line with Guideline 6's requirement that States enact legislation to ensure that safe and effective medication is available at affordable prices. South Africa has also made inroads in treatment access and now accounts for a significant proportion of ARV provision in sub-Saharan Africa.⁴¹⁴ Despite this, the large number of persons infected with HIV means that a relatively small share of persons in need of ARVs were receiving them in 2005.⁴¹⁵

Guideline 8 requires States to create a supportive and enabling environment for women, children and other

vulnerable groups. Meeting the needs of children infected, affected and/or orphaned by AIDS remains a challenge for South Africa. UNAIDS estimates that there were 1.2 million children orphaned by AIDS in South Africa at the end of 2005.⁴¹⁶

South Africa is yet to fulfil Guideline 11, which requires that States ensure monitoring and enforcement mechanisms are in place to help protect HIV-related human rights.

21.5 Implementation and gaps

South Africa has not ratified the following international instruments:

- *The International Covenant on Economic, Social and Cultural Rights*,
- *The Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict*,
- *The International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families*.

22. Sudan

22.1 Policy and strategy framework

The *National Strategic Plan for the Prevention and Control of HIV/AIDS in the Sudan* forms the cornerstone of Sudan's AIDS policy framework. The most recent *Strategic Plan* covers the period 2004-2009⁴¹⁷, while the previous version of the Plan covered the period 2003-2007.⁴¹⁸ The 2003-2007 *Strategic Plan* set out four general objectives:

1. Reduce HIV prevalence to less than one percent;
2. Reduce AIDS morbidity and mortality, and improve the quality of life of PLWHA;
3. Build the capacity of partners involved in the prevention and control of HIV and AIDS, and enable them to participate effectively in interventions;
4. Mobilise political community leaders and coordinate national (government and private sector) and international resources for prevention and control activities.⁴¹⁹

410 Republic of South Africa: *Progress Report on Declaration of Commitment on HIV and AIDS* prepared for the United Nations General Assembly Special Session on HIV and AIDS (February 2006).

411 See http://www.tac.org.za/newsletter/2006/ns30_03_2006.html#UNGASS. (accessed 25 June 2006).

412 *TAC and 15 others v. the Government of the Republic of South Africa and 5 others* Case No 4576/2006 Durban and Coast Local Division [unreported].

413 Act 90 of 1997.

414 UNAIDS, 2006 Report on the Global AIDS Epidemic p.17.

415 UNAIDS, 2006 Report on the Global AIDS Epidemic p.17

416 UNAIDS, 2006 Report on the Global AIDS Epidemic, p. 509.

417 See Sudanese National AIDS Programme (SNAP) & UNAIDS "HIV/AIDS integrated report: North Sudan, 2004-2005 (draft)" (2006) p.4, 21, 22, 27, 57 for references to the 2004-2009 plan.

418 SNAP "National strategic plan for the prevention and control of HIV/AIDS in the Sudan 2003-2007" (2003).

419 n 427 above, 9-10.

The 2003-2007 *Strategic Plan* also sets out 11 specific objectives in its budget section, and outlines the methods with which the Government intends to accomplish each objective as well as the funding allocated for each proposed activity. The 11 objectives are:

1. Raise AIDS awareness among the population,
2. Promote safe sexual practices,
3. Lobby for the policies needed to achieve the strategic plan's objectives,
4. Reduce STI rates,
5. Prevent transmission of HIV through blood transfusions,
6. Prevent mother-to-child transmission of HIV,
7. Establish VCT units,
8. Provide care for persons living with HIV,
9. Strengthen the managerial component of the Sudanese National AIDS Control Programme (SNAP),
10. Build capacity at lower governmental levels and decentralise authority and responsibility,
11. Strengthen Sudan's HIV surveillance system.⁴²⁰

The Sudanese National AIDS Programme's (SNAP) 2006 plan of action set out steps for implementing the *Strategic Plan* within a year.⁴²¹ The plan of action contains seven "expected results", as well as a range of activities aimed at realising those expectations. The "expected results" are:⁴²²

1. Stakeholder capacity for responding effectively to the AIDS epidemic will be improved at state and national levels;
2. The general population's awareness of AIDS will be increased, and positive behaviours will be promoted among vulnerable groups;
3. PMTCT services will be "provided to pregnant women in at least 10 states by the end of 2006";
4. 3,500 persons living with HIV will receive comprehensive care and support by the end of 2006;
5. VCT centres will be increased and the quality of service at those centres will be improved;
6. STI syndromic management coverage in health centres will be increased from 25% to 45% by the end of 2006⁴²³;

7. The national HIV monitoring and evaluation system will be "strengthened and expanded according to the second generation surveillance guidelines and the national protocols".

In 2005, SNAP developed a monitoring and evaluation framework and the draft of a treatment scale-up plan.⁴²⁴

The WHO's Eastern Mediterranean Regional Office website features a draft version of a treatment scale-up plan for Sudan, but it is unclear whether this is the same document which SNAP authored.⁴²⁵

22.2 Institutions

The Ministry of Health and SNAP jointly "coordinate and manage the overall HIV/AIDS programme".⁴²⁶ SNAP is responsible for developing the broad HIV and AIDS policy framework embodied in the strategic plan⁴²⁷, while the Ministry of Health "coordinates the legal and policy framework, programme evaluation" and "planning of human resources".⁴²⁸

The New Sudan National AIDS Council (NSNAC) was created in 2002 to guide the implementation of HIV and AIDS policy. The NSNAC guides advocacy, coordination, regulation and monitoring and evaluation of the policy.⁴²⁹

In a 2001 decree, the Minister of Health established "the National HIV/AIDS Prevention and Control Council and its implementing arm the National HIV/AIDS Executive Council".⁴³⁰ The Prevention and Control Council is responsible for creating and strengthening "partnerships for an expanded national response among all sectors" and for "mobilising resources for the implementation of" HIV and AIDS policy.⁴³¹ It is chaired by the Minister of Health and includes ministers "and other higher officials and representatives from government ministries and afflicted institutions", as well as from "leading National NGOs, religious bodies, and civil society".⁴³² The Executive Council's role is "technical and operational".⁴³³ It is composed of undersecretaries from a number of ministries, and is headed by the undersecretary for the Ministry of Health.⁴³⁴

420 n 427 above, 32-46.

421 SNAP "2006 plan of action" (2006).

422 As above.

423 The plan of action does not make clear whether the rates of coverage are meant to describe the fraction of health centres equipped to deliver services or the fraction of needy individuals who receive the services.

424 See n 426 above, 22.

425 "HIV/AIDS treatment scale-up plan for the Republic of Sudan, 2005-2009 (draft for discussion)" (2005), available at <http://www.emro.who.int/sudan/media/pdf/HivAids%20treatment%20scale%20up%20plan%20July05-Jun07.pdf> (accessed 22 June 2006).

426 WHO "Summary country profile for HIV/AIDS treatment scale-up: Sudan" (2005) 2.

427 See n 426 above, 21-22.

428 See n 426 above, 2.

429 UNICEF, Overview of the Health Situation in Southern Sudan 2002 by Dr. Michaleen Richer (2002) p.42.

430 n 426 above, 23.

431 As above.

432 As above.

433 As above.

434 As above.

The Strategic Plan specifies activities for seven government ministries, in addition to the Ministry of Health: the Ministries of Information, Guidance, the Interior, Defence, Welfare, Higher Education, and Youth and Sports.⁴³⁵

Sudan has also created a National Council on Communicable Diseases and Epidemic Control.⁴³⁶

22.3 Legislative framework

The *Constitution of the Republic of Sudan* establishes a number of rights relevant to persons living with HIV. Article 20 invests each person with the rights to life, freedom, security, and dignity.⁴³⁷ Articles 21, 23 and 29, respectively, create rights of equality, freedom of movement and privacy.⁴³⁸

SNAP “has drafted a special law on HIV/AIDS that encompasses legal and institutional reform to support” PLWHA.⁴³⁹ However, the draft is yet to be endorsed”.⁴⁴⁰

22.4 Adherence to international standards and gender-responsiveness

Sudan has moved toward bringing itself in line with Guideline 1 of the Revised International Guidelines on HIV/AIDS and human rights by forming both a national HIV/AIDS strategic plan and the institutional structure headed by SNAP.⁴⁴¹ However, resource and institutional gaps, along with capacity challenges, undermine the effectiveness of the framework. Thus, the SNAP and UNAIDS’ *HIV/AIDS integrated report: North Sudan, 2004-2005 (draft)* identifies nine major problems with Sudan’s AIDS response:

1. “Inadequate coordination among the stakeholders” in the planning and implementation of Sudan’s AIDS programmes;
2. Inadequate capacity within SNAP at both the state and federal levels;
3. Gaps in information-sharing, policy implementation and resource availability between federal and state organs;
4. Inadequate data for strategic planning;

5. Gaps in the collection, compilation and dissemination of “programmatic and financial data”;
6. A “lack of prioritising [in] the HIV/AIDS service delivery areas”;
7. A lack of a “comprehensive package of prevention and care services” for the populations most at risk of becoming infected with HIV;
8. A lack of a “comprehensive package for HIV/AIDS in emergency settings”;
9. A lack of “standardised guidelines, protocols [and] policies for all the HIV/AIDS service delivery areas”.⁴⁴²

The Government’s treatment scale-up draft plan may represent a step toward compliance with the revised Guideline 6.⁴⁴³ That said, WHO has noted a wide range of obstacles hampering Sudan’s attempt to deliver AIDS-related health care services to its citizens:

*In general, Sudan’s health system suffers from a weak infrastructure in terms of human resources, health service coverage and funds. There are major disparities in the distribution of services and resources between and within states, between rural and urban areas and in states affected by conflict. The availability and accessibility of treatment and care are poor. Major bottlenecks for scaling up treatment and care include stigma and discrimination, a lack of entry points and services for voluntary testing and counseling, weak health care services and lack of human capacity in the public system and civil society. Blood-banking facilities and regulations for blood testing do not exist in the south, which also suffers from a serious lack of health care personnel trained in antiretroviral therapy. The south is also experiencing a lack of access to key HIV/AIDS services including access to information, distribution of condoms, voluntary counseling and testing, preventing the mother-to-child transmission of HIV and care for people living with HIV/AIDS, including antiretroviral therapy. The previous delay in finalising the peace process and the conflict in Darfur are additional challenges to reaching those in need. With the signing of the peace agreement, up to an estimated 3.5 million refugees are expected to return to Sudan, resulting in an urgent need for prevention and care programmes specific to post-conflict situations. In particular, drug distribution mechanisms are needed to supply both remote areas and conflict areas.*⁴⁴⁴

435 n 427 above, 22, 23, 35, 36, 41.

436 As above.

437 The Constitution of the Republic of Sudan 1998, Part II, Chapter I, Article 20, available at <http://www.sudan.gov.sd/English/system%20of%20rule2.htm> (accessed 22 June 2006).

438 n 446 above, arts 21, 23, 29.

439 n 426 above, 25.

440 As above

441 See OHCHR & UNAIDS “HIV/AIDS and human rights international guidelines” (1996) 11. See also sections 1 and 2 above for discussion of Sudan’s national strategic plan and institutional HIV/AIDS structure.

442 n 426 above, 55-58.

443 See OHCHR & UNAIDS “HIV/AIDS and human rights international guidelines: Revised guideline 6” (2002) 14, available at <http://www.ohchr.org/english/about/publications/docs/g6.pdf> (accessed 22 June 2006). See also section 1 above for discussion of Sudan’s draft of a treatment scale-up plan.

444 n 435 above, 2.

22.5 Implementation and gaps

Sudan has not ratified the following international instruments relating to AIDS and human rights:

- *The Convention on the Elimination of All Forms of Discrimination Against Women*,
- *The Convention Against Torture*,
- *The Convention on the Protection of the Rights of All Migrant Workers and Members of their Families*.

At a regional level, Sudan has not ratified the *Protocol to the African Charter on the Rights of Women in Africa* and the *African Charter on the Rights and Welfare of the Child*.

23. Swaziland⁴⁴⁵

23.1 Policy and strategic framework

Swaziland's AIDS policy framework is laid out in the *National Multisectoral HIV and AIDS Policy (National Policy)*⁴⁴⁶, which lays out four broad goals:

- "Prevent the transmission of HIV";
- "Improve the provision and delivery of treatment, care and support to all those infected and affected by HIV and AIDS";
- "Mitigate the social and economic effects and impacts of the epidemic on Swazi society";
- "Create an enabling environment for the scaled-up and better-coordinated national response to the AIDS epidemic".⁴⁴⁷

The *National Policy* provides "the framework, direction and general principles for interventions" against AIDS.⁴⁴⁸ It includes policy statements intended to serve as binding guidelines on the Government and on "all other stakeholders and partners involved in [...] the national response".⁴⁴⁹

Swaziland's strategic framework is contained in its *Second National Multisectoral HIV and AIDS Strategic Plan 2006-2008 (the Strategic Plan)*.⁴⁵⁰ The *Strategic Plan* sets out the same four goals that guide national policy.⁴⁵¹ Each of the four goals is divided into more detailed objectives, and each objective in turn is linked to implementation strategies and indicators of success. A total of 70 specific objectives are listed in the *Strategic Plan*.⁴⁵²

The *Strategic Plan* refers to several additional policies and plans (some finalised, others still in preparation) relevant to the Government's AIDS response:

- The Government policy outline on economic empowerment and development commonly known as the *Smart Program on Economic Empowerment and Development (SPEED)*;
- A draft *National Policy on Children*, 2003;
- A draft *Decentralisation Policy*;
- *The National Development Strategy (NDS)*;
- A document titled *The Poverty Reduction Strategy and Action Plan, Health Sector Response to HIV/AIDS Plan in Swaziland 2003-2005*;
- *The National Population Policy*;
- A draft *Social Welfare Policy*;
- A draft policy titled *The Project Implementation Manual for Social Protection of Vulnerable Children Including Orphans*;
- *The National HIV/AIDS Communication Strategy for Swaziland 2004*;
- *The Public Sector HIV/AIDS Strategic Plan, 2006-2008: Policy Document on HIV/AIDS and STD Prevention and Control*.⁴⁵³

23.2 Institutions

The National Emergency Response Committee on HIV/AIDS (NERCHA) bears primary responsibility for Swaziland's HIV/AIDS policies and programmes. The Government of Swaziland "established NERCHA through an Act of Parliament to coordinate and facilitate the national multisectoral response to HIV and AIDS".⁴⁵⁴ NERCHA's mandate is broad and includes the responsibility to:

- Develop, implement and periodically to review the national strategic plan and national policy on HIV and AIDS;
- Develop and periodically review "sector HIV and AIDS policies, strategies and action plans";
- "Mobilise, receive, manage and allocate resources, from government and other sources";
- "Manage the HIV/AIDS Emergency Fund and any other fund that may be established by council";
- "Monitor and evaluate projects funded by council in the national response the epidemic";
- Develop "a national database of HIV and AIDS related

445 It should be noted that this section draws substantially on the Centre for Human Rights & Centre for the Study of AIDS' upcoming publication "HIV/AIDS and human rights in Swaziland".

446 See Government of the Kingdom of Swaziland "National multisectoral HIV and AIDS policy" (2006).

447 Government of the Kingdom of Swaziland "National multisectoral HIV and AIDS policy" (2006) p.3-4.

448 Government of the Kingdom of Swaziland "National multisectoral HIV and AIDS policy" (2006) p.iii.

449 Government of the Kingdom of Swaziland "National multisectoral HIV and AIDS policy" (2006) p.4.

450 See Government of the Kingdom of Swaziland "The second national multisectoral HIV and AIDS strategic plan 2006-2008" (2006).

451 See Government of the Kingdom of Swaziland "The second national multisectoral HIV and AIDS strategic plan 2006-2008" (2006) 19, 33, 44, 53.

452 See Government of the Kingdom of Swaziland "The second national multisectoral HIV and AIDS strategic plan 2006-2008" (2006) p.64.

453 See Government of the Kingdom of Swaziland "The second national multisectoral HIV and AIDS strategic plan 2006-2008" (2006) p.1.

454 n 455 above, 12. See also the NERCHA Act, No. 8 of 2003.

- policies and [to] facilitate policy dissemination”;
- Develop and periodically review “a database of responding organisations, institutions, departments and communities in the national response”;
 - “Facilitate information sharing on local and international best practices among all sectors of society”.⁴⁵⁵

NERCHA is the latest of several state institutions designed to manage Swaziland’s AIDS response. NERCHA superseded the Crisis Management and Technical Committee on HIV/AIDS, which was created in 1999 to assume leadership responsibilities from the Ministry of Health and Social Welfare and its National AIDS Prevention and Control Programme.⁴⁵⁶

23.3 Legal framework

Swaziland has no AIDS-specific legislation.

The national policy calls for AIDS-specific laws that address discrimination, sex crimes and wilful transmission of HIV.⁴⁵⁷ Versions of such laws have been drafted.

A draft *Public Health Bill* would criminalise the transmission of sexually transmitted diseases.⁴⁵⁸ However, the bill was “referred back for further stakeholder consultations” in 1999 and has yet to be enacted.⁴⁵⁹

A more recent draft *Sexual Offences and Domestic Violence Bill* would also expand Swaziland’s legal definition of rape to include rape within marriage, and would penalise any person who “intentionally fails to disclose [...] that he or she is infected by a life-threatening sexually transmissible infection in circumstances in which there is a significant risk of transmission”. It would also permit the death penalty for the crime of rape “where HIV/AIDS is an aggravating factor”.⁴⁶⁰

Chapter IV of the 2005 *Constitution of the Kingdom of Swaziland* guarantees the “fundamental human rights and

freedoms of the individual”.⁴⁶¹ A number of these rights potentially bear upon HIV and AIDS:

- A right to personal liberty: “A person shall not be deprived of personal liberty save as may be authorised by law” for any one of several enumerated purposes, including “the purpose of preventing the spread of an infectious or contagious disease”.⁴⁶²
- A right of detainees to medical treatment: “Where a person is arrested or detained [...] that person shall be allowed reasonable access to medical treatment.”⁴⁶³
- A right against inhuman or degrading treatment: “A person shall not be subjected to [...] inhuman or degrading treatment or punishment.”⁴⁶⁴
- A right to equality before the law: “All persons are equal before and under the law [...]. [A] person shall not be discriminated against on the grounds of gender [...] or disability.”⁴⁶⁵
- A right against arbitrary searches: “A person shall not be subjected [...] to the search of the person” except when “reasonably required in the interests of” fundamental social objectives such as the promotion of “public order, public morality [or] public health”.
- Rights of mothers and children to special protection: “Motherhood and childhood are entitled to special care and assistance by society and the State.”⁴⁶⁷
- Rights of the needy and elderly to special assistance: “Subject to the availability of resources, the Government shall provide facilities and opportunities necessary to enhance the welfare of the needy and the elderly.”⁴⁶⁸
- Rights of persons with disabilities: “Persons with disabilities have a right to respect and human dignity and the Government and society shall take appropriate measures to ensure that those persons realise their full mental and physical potential.”⁴⁶⁹ Furthermore, “Parliament shall enact laws for the protection of persons with disabilities so as to enable those persons to enjoy productive and fulfilling lives”.⁴⁷⁰

455 n 455 above, 12; NERCHA “Nercha Background” at <http://www.nercha.org.sz/bg.html?FrameLoad=100> (accessed 4 July 2006).

456 NERCHA “2003-2005 UNGASS indicators country report” (2005) 11 12, available at http://data.unaids.org/pub/Report/2006/2006_country_progress_report_swaziland_en.pdf (accessed 28 June 2006). See also n 441 above, 12, 15 for a brief history of Swaziland’s national response to HIV/AIDS.

457 n 455 above, 7, 9.

458 See Committee on the Rights of the Child “Consideration of reports submitted by state parties under article 44 of the Convention” (2006) secs 312-13, available at [http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/bcc378e5cb907f76c125718500470f31/\\$FILE/G0640511.pdf](http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/bcc378e5cb907f76c125718500470f31/$FILE/G0640511.pdf) (accessed 6 July 2006).

459 See n 467 above, 312.

460 Amnesty International “Memorandum to the Government of Swaziland on the Sexual Offences and Domestic Violence Bill” (2006) secs 3 7, available at <http://web.amnesty.org/library/Index/ENGAFR550032006?open&of=ENG-347> (accessed 13 July 2006).

461 The Constitution of the Kingdom of Swaziland (2005), sec 14(1).

462 The Constitution of the Kingdom of Swaziland (2005), secs 16(1), 16(1)(g).

463 The Constitution of the Kingdom of Swaziland (2005), sec 16(6).

464 The Constitution of the Kingdom of Swaziland (2005), sec 18(2).

465 The Constitution of the Kingdom of Swaziland (2005), sec 20(1)(2).

466 The Constitution of the Kingdom of Swaziland (2005), secs 22(1)(a), 22(2)(a).

467 The Constitution of the Kingdom of Swaziland (2005), sec 27(4).

468 The Constitution of the Kingdom of Swaziland (2005), sec 27(6).

469 The Constitution of the Kingdom of Swaziland (2005), sec 30(1).

470 The Constitution of the Kingdom of Swaziland (2005), sec 30(2).

New child legislation is being discussed and was to have been tabled by Parliament by the end of 2006 and put to a vote in 2007.

23.4 Adherence to international standards and gender-responsiveness

Having created NERCHA and formulated its national policy and strategic plan, Swaziland is at least partially in line with Guideline 1 of the revised HIV/AIDS and human rights international guidelines.⁴⁷¹

If passed, the draft *Sexual Offences and Domestic Violence Bills* criminalisation of marital rape would also help Swaziland comply with Guideline 4.⁴⁷² The bill's death-penalty provision, as well as its provision to criminalise the intentional failure to disclose a life-threatening STI, could cause Swaziland to run afoul of Guideline 4. The draft *Public Health Bills* provision to criminalise the wilful transmission of sexually transmitted diseases could cause similar problems with respect to Guidelines 3 and 4.⁴⁷³

Swaziland has done little to meet the requirements of Guideline 5, though the national policy's call for "[l]egislation ... to protect the rights of PLWHA including protection against any form of stigma and or discrimination"⁴⁷⁴ suggests an intention to rectify that shortcoming.⁴⁷⁴

Launched in 2003, the Government's free ARV programme is a step toward compliance with Guideline 6's requirement of universal access to treatment, care and support for all PLWHA.⁴⁷⁵ Unfortunately, Swaziland's performance against the 2003-2005 UNGASS indicators is poor. The country reduced MTCT by only one percent in 2004 and by two percent in 2005⁴⁷⁶, partly because of the limited number of PMTCT sites and human resource constraints. More encouraging is the relatively high rate of reported condom use during paid sex.⁴⁷⁷

ART treatment provision has improved. The number of

health facilities offering ARVs increased from three in 2003 to 17 in 2005. Consequently, the number of people receiving ARV treatment has risen, although it still falls short of the WHO "3 by 5" target of 13,000.

In terms of impact mitigation, school attendance for orphans appears to be lower than for non-orphans.⁴⁷⁸ However, Swaziland also boasts well-trained teachers who can provide life skills-based HIV education.⁴⁷⁹

Section 28 of the *Constitution* grants women the legal right to equality and requires that the State assist women in realising that right:

- (1) Women have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities;
- (2) Subject to the available of resources, the Government shall provide facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement.⁴⁸⁰

Currently, however, "[w]omen married in community of property legally hold a minority status" in Swaziland.⁴⁸¹ UNDP Swaziland reported in 2002 that it was planning, in collaboration with the Swaziland Government, to review three pieces of legislation (the *Marriage Act of 1964*, the *Administration of Estate Act of 1902* and the *Deeds Registry Act of 1968*) with a view to reforming the status of women in Swaziland.⁴⁸² By late 2006, the laws had not been amended. UNDP Swaziland also helped produce a draft national gender policy that addresses "legal and human rights", "health, reproductive rights and HIV/AIDS", and "gender-based violence".⁴⁸³ More effort is needed on these issues, given the widespread sexual aggression towards women revealed in studies.⁴⁸⁴

The Constitution proclaims that "a woman shall not be compelled to undergo or uphold any custom to which she is in conscience opposed".⁴⁸⁵ The draft *Sexual Offences and Domestic Violence Bill* would bolster this provision by

471 See OHCHR & UNAIDS "HIV/AIDS and human rights international guidelines" (1996) 11.

472 As above.

473 As above.

474 n 467 above, 9.

475 See NERCHA "2003-2005 UNGASS indicators country report" (2005) 20, available at http://data.unaids.org/pub/Report/2006/2006_country_progress_report_swaziland_en.pdf (accessed 28 June 2006); UNAIDS & WHO "Summary country profile for HIV/AIDS treatment scale-up: Swaziland" (2005) 2, available at http://www.who.int/3by5/support/june2005_swz.pdf (accessed 29 June 2006); OHCHR & UNAIDS "HIV/AIDS and human rights international guidelines: Revised guideline 6" (2002) 14, available at <http://www.ohchr.org/english/about/publications/docs/g6.pdf> (accessed 22 June 2006).

476 2003-2005 UNGASS Indicators Country Report, National Emergency Response Council on HIV/AIDS (December 2005) 7.

477 As above 15.

478 As above 20.

479 UNAIDS, 2006 Report on the Global AIDS Epidemic p.63.

480 Constitution, sec 28.

481 UNDP Swaziland "Gender" (2006) at <http://www.undp.org.sz/gender.htm> (accessed 13 July 2006).

482 UNDP Swaziland "Gender, human rights & law reform" (2002) at http://www.undp.org.sz/gender_hr_lw.html (accessed 13 July 2006).

483 UNDP Swaziland "National gender policy" (2006) at http://www.undp.org.sz/natl_gender_%20policy.htm (accessed 13 July 2006).

484 UNAIDS, 2006 Report on the Global AIDS Epidemic p.18.

485 Constitution, sec 28(3).

criminalising the non-consensual subjection of women to specific cultural practices.⁴⁸⁶ These developments go some way to addressing the spirit of Guideline 8's requirement to promote a supportive and enabling environment for women, children and other vulnerable groups. That said, current policies and strategic plans fail to target other vulnerable groups explicitly in the AIDS prevention, treatment and care programmes. The *Policy Document* and *NAP* do refer to orphans but fail to include other vulnerable groups (such as other vulnerable children, sex workers, mobile populations and men who have sex with men). A lack of participation in policy development at local level is also hindering implementation, as are infrastructure and human resources constraints, and various negative cultural norms and practices.⁴⁸⁷

23.5 Implementation and gaps

Swaziland has not ratified the following international instruments:

- *The Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict*,
- *The Optional Protocol to the Convention on the Rights of the Child on the Sale of Children*,
- *The International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families*.

Regionally, Swaziland has not ratified the *Protocol to the African Charter on the Rights of Women in Africa* or the *African Charter on the Rights and Welfare of the Child*.

24. Tanzania

24.1 Policy and strategy framework

The *National Multisectoral Strategic Framework (NMSF) on HIV/AIDS 2003-2007* governs the planning of AIDS programmes, projects and interventions in Tanzania, and outlines nine goals that are to be met by 2007:⁴⁸⁸

- (1) Reduce the spread of HIV;
- (2) Reduce HIV transmission to infants;
- (3) Political leaders consistently to provide high visibility to HIV and AIDS in their proceedings and public appearances;
- (4) Political leaders, public and private programmes, projects and interventions to address stigma and discrimination and promote respect for the human rights of PLWHA;

- (5) Fully integrate and prioritise HIV and AIDS into the National Poverty Reduction Strategy and Tanzania Assistance Strategy;
- (6) Reduce the prevalence of STIs in the population;
- (7) Increase knowledge of HIV transmission;
- (8) Increase the numbers of PLWHA who have access to a continuum of care and support;
- (9) Reduce the adverse effects of AIDS on orphans.

Indicators have been devised for each of the nine goals.

A *Health Sector HIV/AIDS Strategy for Tanzania* has also been drawn up.⁴⁸⁹

During November 2001, the *National Policy on HIV/AIDS* was elaborated and approved.⁴⁹⁰ It now constitutes the overall guiding framework for Tanzania's AIDS response.

Tanzania's *HIV/AIDS Care and Treatment Plan* was developed in 2003 and has four main aims:⁴⁹¹

- (1) Provide quality, continuing care and treatment to as many HIV-positive residents of Tanzania as possible, by building on the planning done by the Ministry of Health and the Tanzania Commission for AIDS;
- (2) Contribute to strengthening health care structures by increasing health care personnel, and expanding facilities, equipment and comprehensive training in the care and treatment of PLWHA;
- (3) Foster information, education and communication efforts that are focused on prevention, on increasing public understanding of care and treatment alternatives, and on reducing AIDS stigma;
- (4) Help strengthen social support for care and treatment of PLWHA, through home-based care, local support groups and treatment partners.

In addition, Tanzania has several, more specific policy interventions. They include the *National Policy on PMTCT* (2002), the *ART HIV/AIDS Policy* (2002), the *VCT HIV/AIDS Policy* (2002) and the *Nutrition and AIDS – National Health Policy* (1990 and revised annually).⁴⁹²

24.2 Institutions

The National AIDS Committee was formed in 1989, and the National Advisory Board on AIDS was set up a decade later.

486 See n 469 above, sec 10.

487 HSRC, *An audit of HIV/AIDS Policies: in Botswana, Lesotho, Mozambique, South Africa, Swaziland, and Zimbabwe* (2004) 40.

488 National Multisectoral Strategic Framework on HIV/AIDS 2003-2007 p.15-16.

489 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): United Republic of Tanzania (2005) p.13.

490 National Multisectoral Strategic Framework on HIV/AIDS 2003-2007 p.v.

491 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): United Republic of Tanzania (2005) p.14.

492 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): United Republic of Tanzania (2005) p.20.

Created in 2001, the Tanzania Commission for AIDS (TACAIDS)⁴⁹³ leads the multisectoral response from within the Prime Minister's Office.⁴⁹⁴ The TACAIDS is empowered to take the lead on all matters relating to HIV and AIDS policy formation, strategy and implementation.⁴⁹⁵ It is also responsible for managing the monitoring and evaluation of national multisectoral responses.⁴⁹⁶ It is currently developing a National HIV/AIDS Monitoring and Evaluation System to track progress against the *National Strategic Framework*.⁴⁹⁷

The Tanzania National Coordinating Mechanism was created in 2005. It combines the country coordinating mechanisms with financial coordinating mechanisms.⁴⁹⁸

A network of AIDS service organisations, TANASO, has been set up. People living with HIV are also forming a council.⁴⁹⁹ The HIV/AIDS Business Coalition – Tanzania (ABCT) was formed in 2005.

The National Coordinating Mechanism coordinates resources from the Global Fund, the World Bank, PEPFAR and others.

24.3 Legislative framework

Although Tanzania's *Constitution* does not refer specifically to HIV or AIDS, it contains several provisions that could apply to PLWHA.⁵⁰⁰ Section 12 states that all persons are born free and are equal, and adds that every person is entitled to recognition and respect of his or her dignity. Section 13 prohibits discrimination on the basis of "nationality, tribe, place of origin, political opinion, colour, religion or station in life". Section 14 states that all persons have the right to live and the right to protection of their lives by society in accordance with the law. Section 16 outlines the right to privacy. Under section 22, every person has the right to work and is entitled to equal opportunity to hold any office or discharge any function under the state authority.

The *Infectious Diseases Act Ch. 96 102 of 1963* requires that medical authorities be notified of listed medical conditions. Schedule G contains a list of infectious diseases (it was amended in 1986 and now also refers to AIDS). The Act contains potentially broad provisions

concerning the notification and restriction of movement of persons with infectious diseases.

24.4 Adherence to international standards and gender-responsiveness

Guideline 1 of the Revised International Guidelines on HIV/AIDS and human rights requires States to establish an effective national framework for their response to AIDS. Tanzania has established the *NMSF*, along with other, sector-specific strategies. The Government has shown political commitment by declaring the epidemic a national disaster.⁵⁰¹ However, community support must be strengthened in line with Guideline 2's requirement for community consultation at all phases of HIV policy design, implementation and evaluation.

Tanzania is not in compliance with Guideline 5, which requires States to enact or strengthen anti-discrimination and other protective laws. Indeed, the Government concedes in its *National Strategic Framework* that stigma and discrimination remain powerful barriers in dealing with the epidemic. Accordingly, national laws and regulations, particularly those relating to inheritance and to workplace discrimination need to be reviewed.⁵⁰²

Guideline 6 requires universal access to treatment, care and support for all PLWHA. As in many other southern African countries, Tanzania's health sector response is undermined by skills shortages in the health workforce and by weak information systems.⁵⁰³ Poverty also poses major challenges. HIV-positive mothers, for instance, lack viable alternatives to breast-feeding. Very few VCT services exist, especially in rural areas and people have to travel large distances to access them. Stigma and discrimination compound matters.⁵⁰⁴ On the positive side, the elimination of out-of-pocket fees for HIV testing has significantly increased the use of testing services.⁵⁰⁵

Tanzania needs to pay greater attention to Guideline 8's requirement that a supportive and enabling environment be created for women, children and other vulnerable groups. While the wording of the National Policy on HIV and AIDS is broad enough to support the provision of condoms in prisons, sodomy remains criminalised in Tanzania (thus hindering fulfilment of Guidelines 4 and 8).

493 Tanzania Commission for AIDS Act No. 22 of 2001.

494 National Multisectoral Strategic Framework on HIV/AIDS 2003-2007 p.v.

495 The functions and objectives of the TACAIDS are laid out in Tanzania Commission for AIDS Act No. 22 of 2001 s.5.

496 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): United Republic of Tanzania (2005) p.13.

497 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): United Republic of Tanzania (2005) p.18.

498 UNAIDS, 2006 Report on the Global AIDS Epidemic p.269.

499 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): United Republic of Tanzania (2005) p.9.

500 The Constitution of the United Republic of Tanzania of 1998.

501 This statement was made by President Mkapa in 1999 see National Multisectoral Strategic Framework on HIV/AIDS 2003-2007 p.1.

502 National Multisectoral Strategic Framework on HIV/AIDS 2003-2007 p.20.

503 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): United Republic of Tanzania (2005) p.16.

504 National Multisectoral Strategic Framework on HIV/AIDS 2003-2007 p.27.

505 UNAIDS, 2006 Report on the Global AIDS Epidemic p.130.

Young people's knowledge HIV and access to condoms is very low. School-based HIV education is limited by several factors, including parental resistance and a lack of capacity among teachers.⁵⁰⁶ Tanzania requires approximately 45,000 additional teachers to make up for losses caused by AIDS.⁵⁰⁷ Condom use is still rare, while risky sex appears to be relatively common, especially among men.⁵⁰⁸ All this points to the need for stronger education campaigns aimed specifically at young people, and for more innovative education, training and media programmes (as recommended by Guideline 9).

Tanzania has empowered the TACAIDS with monitoring and evaluation responsibilities, and is busy developing a national monitoring and evaluation system. Those moves should address Guideline 11's requirement that States put in place monitoring and enforcement mechanisms to protect HIV-related human rights. However, an initial review has shown that few agencies doing HIV and AIDS work in Tanzania use any form of monitoring and evaluation. Moreover, there is a marked lack of consistency with respect to the use of core HIV and AIDS indicators among those organisations that do have such systems.⁵⁰⁹

24.5 Implementation and gaps

Tanzania has not ratified the following international instruments:

- *The Convention Against Torture,*
- *The International Convention on the Protection of the Rights of Migrant Workers and Members of their Families.*

At the regional level, Tanzania has not ratified the *Protocol to the African Charter on the Rights of Women in Africa.*

25. Uganda

25.1 Policy and strategy framework

The *National Strategic Framework for HIV/AIDS Activities in Uganda 2000/1-2005/6 (National Strategic Framework)* guides sector-wide HIV and AIDS planning and implementation. Its emphasis is on collaboration and co-

ordination.⁵¹⁰ The *Framework* is aimed at linking the AIDS response to national development goals and action plans, promoting the involvement of stakeholders in HIV and AIDS interventions, establishing indicators, and providing a basis for costing and mobilising resources.⁵¹¹ Its principal goals are:⁵¹²

- Reduce HIV prevalence by 25 per cent by 2005/6,
- Mitigate health and socio-economic effects AIDS at individual, household and community levels,
- Strengthen national capacity to respond to the epidemic.

The *National Strategic Framework* complements the *Poverty Eradication and Action Plan (PEAP)*, the *Uganda Vision 2025*, and the *National Health Policy*.

The *PEAP* is the main medium-term guiding framework for the development activities of central and local government, while *Uganda Vision 2025* outlines long-term national goals.⁵¹³ Uganda regards the fight against AIDS as an integral part of its development efforts. The overall goal of the National Health Policy is to attain quality health care for all people.⁵¹⁴

Uganda also has national policies and guidelines for:

- HIV Voluntary Counselling and Testing with clear requirements for pre- and post-counseling as well as the need to obtain informed consent,⁵¹⁵
- PMTCT,⁵¹⁶
- ARV.⁵¹⁷

The *National AIDS Policy (NAP)* was revised in 2004/2005 and placed before the Cabinet for approval in October 2005. The *NAP* points out the need for various legislative measures, including the HIV and AIDS bill which is expected to follow once the revised *NAP* is approved.⁵¹⁸

25.2 Institutions

The Uganda AIDS Commission (UAC) was established by an Act of Parliament in 1992 and tasked with providing overall leadership in the coordination and management of an effective AIDS response. The UAC takes the lead in national priority-setting and policy-formulating processes.

506 National Multisectoral Strategic Framework on HIV/AIDS 2003-2007 p.30.

507 UNAIDS, 2006 Report on the Global AIDS Epidemic p.97.

508 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): United Republic of Tanzania (2005) p.15 and National Multisectoral Strategic Framework on HIV/AIDS 2003-2007 p.26.

509 Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS): United Republic of Tanzania (2005) p.18.

510 The National Strategic Framework for HIV/AIDS Activities in Uganda 2000/1-2005/6, 1.3.

511 As above, 1.4.

512 As above, 1.6.

513 As above, 1.5.1.

514 As above, 1.5.2.

515 Uganda National Policy Guidelines for HIV Voluntary Counselling and Testing, Ministry of Health (2003).

516 Policy for reduction of the Mother to Child HIV Transmission in Uganda, Ministry of Health (May 2003).

517 National Antiretroviral Treatment and Care Guidelines for Adults and Children, Ministry of Health (August 2003).

518 <http://www.aidsuganda.org/> (accessed 17 August 2006).

It is also involved in advocacy, resource mobilisation, information dissemination and partnership coordination.

25.3 Legislation

There is no specific legislation related to AIDS.

The *Constitution of the Republic of Uganda* does not specifically mention HIV or AIDS, but it does include a number of rights and entitlements that affect PLWHA.⁵¹⁹ Section 21 deals with equality and freedom from discrimination and includes “disability” as a protected category. Section 22 deals with the protection of the right to life, while section 30 protects the right to education. Section 33 deals with the rights of women and prohibits laws, cultures, customs or traditions that violate the dignity, welfare or interest of women or that undermine their status.⁵²⁰ Section 34 deals with the rights of children, while section 35 deals with the rights of persons with disabilities.

The *Domestic Relations Bill* has been before Parliament for over a decade but is yet to be passed into law. It is a potentially crucial piece of legislation since it addresses women’s property rights in marriage and their right to negotiate sex. It also sets the minimum age for marriage at 18 years, prohibits female genital mutilation, and criminalises widow inheritance and marital rape.⁵²¹ The Government is drafting a bill that addresses the wilful transmission of HIV.⁵²²

25.4 Adherence to international standards and gender-responsiveness

Guideline 1 of the Revised International Guidelines on HIV/AIDS and human rights requires States to establish an effective national framework for their response to HIV/AIDS; Uganda has established a *National Strategic Framework*.

Guideline 6 requires universal access to treatment, care and support of all persons living with HIV, as well as widespread availability of prevention measures and services. Uganda is hailed as one of the few countries to have achieved a decline in HIV infection rates, a feat many have attributed to strong political commitment paired with vigorous prevention efforts. In 2000, AIDS was

declared a development and security crisis.⁵²³

On the treatment front, Uganda is one of three countries in sub-Saharan Africa with antiretroviral coverage of 50 per cent or above.⁵²⁴ The WHO attributes at least some of this scale-up achievement to innovative treatment programmes. Shortages of health care workers prompted Uganda to adopt a simplified approach which entailed training nurses to perform some of the functions of doctors and training lay community workers to perform some of the functions of nurses. The responsibility for diagnosis and prescription remained with doctors, while some counseling tasks and the supervision of drug intake was delegated to other trained individuals.⁵²⁵

Some critics have accused the United States of forcing a policy shift in Uganda (based upon the USA’s status as an important funder of Uganda’s AIDS programmes) away from the ABC (Abstinence, Be faithful, Condomise) approach and focusing more on abstinence-based prevention strategies.⁵²⁶ Human Rights Watch has attributed a recent increase in HIV infection rates to this shift.⁵²⁷

In accordance with Guideline 11’s requirement for monitoring and enforcement mechanisms, Uganda established a National Monitoring and Evaluation Plan in 2003 (M&E Plan). The M&E Plan was developed with significant civil society input, and incorporates UNGASS indicators as well as national and local indicators.⁵²⁸

25.5 Implementation and gaps

Uganda is one of the few countries that has ratified all the international conventions and treaties that relate to AIDS and human rights. However, it has not ratified the *Protocol to the African Charter on the Rights of Women in Africa*.

26. Zambia

26.1 Policy and strategy framework

The guiding principles of the *National HIV/AIDS/STI/TB Policy 2005 (National Policy)* include a multisectoral approach, promotion and protection of human rights, gender equality, good governance, transparency and

519 The Constitution of the Republic of Uganda (22 September 1995).

520 The Constitution of the Republic of Uganda (22 September 1995) Section 33(6).

521 Human Rights Watch “Uganda Domestic Relations Bill would save lives” (May 31 2005) available at <http://hrw.org/english/docs/2005/05/31/uganda11051.htm>.

522 “Uganda HIV Bill in Offing” (4 August 2006) available at <http://allafrica.com/stories/200608070434.html> (accessed 17 August 2006).

523 <http://www.aidsuganda.org/> (accessed 27 June 2006).

524 See UNAIDS, 2006 Report on the Global AIDS Epidemic p.15.

525 WHO, “Uganda leads way in innovative HIV/AIDS treatment” (1 April 2005) see <http://www.who.int/bulletin/volumes/83/4/infocus0405/en/index.html> (accessed 17 August 2006).

526 <http://www.avert.org/aidsuganda.htm> (accessed 27 June 2006).

527 Human Rights News, “AIDS: Success in Fight Threatened by Rights Abuses” (17 July 2006) (accessed 17 August 2006).

528 <http://www.aidsuganda.org/> (accessed 17 August 2006).

accountability, and greater involvement of PLWHA.⁵²⁹ Chapter five of the *National Policy* expresses a commitment to incorporate international principles and urges the Government to domesticate international agreements, declarations and conventions on HIV and AIDS.⁵³⁰

The main policy area is divided into four sub-areas. Chapter six provides policy measures concerning prevention and control, as well as policy guidelines for strengthening HIV education, encouraging VCT, improving availability of condoms and other barrier methods, and preventing MTCT. Chapter seven deals with treatment, care and support measures, according each equal importance. The chapter identifies disabled persons, commercial sex workers, prisoners, refugees and long-distance truck drivers as most-at-risk and vulnerable groups, but fails to include women and girls in that category. Chapter eight sketches policy measures for institutional arrangements, while chapter nine specifies the responsibilities of each sector of Government in the AIDS response.

In May 2002, Zambia adopted the *National HIV/AIDS/STI/TB Intervention Strategic Plan 2002-2005* (NAISP), which set out eight objectives:⁵³¹

- Reduce HIV prevalence among 15-19 year-olds from 15 percent to 11 percent by 2005;
- Reduce MTCT from 39 percent to 28 percent by 2005;
- Ensure safe blood, blood products and body parts and infection control by 2005;
- Improve the quality of life of HIV-infected persons;
- Promote positive living and the prevention of opportunistic infections among HIV-positive persons;
- Improve care for orphans and other vulnerable children, as well as for other vulnerable groups such as refugees, prisoners and disabled;
- Improve the HIV information network and monitoring system;
- Achieve better coordination among all stakeholders.

The document provides clear guidelines on how to achieve those objectives.

In addition to these two main documents, several other important documents also guide the Zambia's AIDS response:

- *HIV/AIDS Education Strategic Plan* (2001-2005),

- *National Gender Policy* (2000),
- *National HIV/AIDS/STI/TB Monitoring and Evaluation Plan* (2002-2005),
- *National HIV/AIDS Communication Strategy* (2005),
- *Scaling-up Antiretroviral Treatment for HIV/AIDS in Zambia Implementation Plan* (2004-2005) (Scaling-up Plan),
- *Strategic Plan of Action for the National Gender Policy* (2003-2007).

The *Scaling-up Plan* is an ambitious strategy to provide universal access to treatment for all in need of such treatment. The aim was to provide antiretroviral treatment of 100 000 people by the end of 2005.

The *National Gender Policy* aims to achieve a sustainable development approach that is based on gender equality and that fully involves women in all its aspects. The *Strategic Plan of Action for the National Gender Policy* was adopted in March 2000 to facilitate implementation of the *National Gender Policy*. It provides detailed policy objectives and strategies for each of the Policy's 22 focus areas.

26.2 Institutions

The National HIV/AIDS/STI/TB Council (NAC) was established under the National HIV/AIDS/STI/TB Council Act in 2002. Its general role is "to coordinate and support the development, monitoring and evaluation of a multisectoral national response" to prevent the spread of HIV, STIs and TB.⁵³²

26.3 Legislative framework

Zambia has no legislation that deals specifically with HIV and AIDS. However, there are calls for creating laws that deal with the wilful transmission of HIV and that target individuals who deliberately withhold their HIV status from partners or spouses.⁵³³ The Law Commission is in the process of reviewing all relevant laws with a view to drafting comprehensive AIDS legislation.

Section 39 of the draft *Constitution* prohibits discrimination based on race, sex, pregnancy, health, marital, ethnic, tribe, social or economic status, origin, colour, age, disability, religion, conscience, believe, future, language or birth.⁵³⁴ Section 40 provides for equal treatment of men and women. Subsection 2 prohibits any law, culture, customs or traditions that undermines the dignity, welfare, interest or status of women or men.

529 Ministry of Health, *National HIV/AIDS/STI/TB Policy* 2005 16-17.

530 As above, chapter 5.1 Domestication of international declarations on HIV/AIDS.

531 See NAC *Joint Review of the NAISP and the Operation of the NAC* (2004) 13.

532 The *National HIV/AIDS/STI/TB Council Act* 2002 (No 10 of 2002), sec 4(1).

533 The *NAP* (2005) 23; also see the *National HIV/AIDS Communication Strategy* 7.

534 Draft Constitution of Zambia Cap 1.

Section 44 provides for equality in marriage, both during and at the dissolution of marriage. However, it does not provide a minimum age for marriage with parental consent and fails to include “sexual orientation” in its anti-discrimination clause.

Section 17 of the *Marriage Act*⁵³⁵ requires persons under 21 years of age, “not being a widower or widow”, to have the written consent of the guardian for marriage.⁵³⁶

Marital rape is not recognised under the *Penal Code Act*.⁵³⁷ Another weakness of the *Penal Code* is its lenient sentencing guidelines and wide provisions for defence in rape cases. For instance, section 137(2) prohibits consensual sex with a girl under 12 years old but accepts the defence that the accused had reasonable cause to believe, or had in fact believed that the girl was 12 years or older. Under section 155, same-sex sexual relationships are also criminalised.

Under section 5 of the *Intestate Succession Act*, a surviving spouse is entitled to 20 per cent of the estate. If more than one widow of the intestate survives, 20 per cent of the estate will be divided according to the duration of their respective marriages.⁵³⁸

The *Insurance Act* does not include anti-discrimination based on HIV status.⁵³⁹

Also relevant is the *Deceased Brother's Widows Marriage Act*, the *Immigration and Deportation Act*, the *Public Health Act Cap 295*, and the *Wills and Administration of Testate Estate Act*.

26.4 Adherence to international standards and gender-responsiveness

Guideline 1 of the Revised International Guidelines on HIV/AIDS and human rights requires States to establish an effective national framework for their response to AIDS. Zambia has adopted the *NAISP*, along with other pertinent national policies. The *National Policy* embraces the principles of anti-discrimination and tries to provide protection for various vulnerable groups. It also stresses the importance of a gender-sensitive approach and calls for stronger enforcement of existing legislation that deals with sexual offences and gender-based violence. Another positive development is the adoption of the *National Gender Policy* and its *Strategic Plan of Action*.

Guideline 5 requires States to enact or strengthen anti-discrimination and other protective laws. Currently, Zambia lacks legislation which specifically protects the rights of PLWHA. The legislative review process is slow and the existing legal framework fails to provide equal protection to women and girls, and other vulnerable groups. Although the draft *Constitution* provides equal rights to women in marriage, it is still in draft form and is yet to be adopted by Parliament. Moreover, the *Constitution* recognises the right to discriminate in succession and inheritance matters. The Justice for Widows and Orphans Project was set up to try and reconcile such contradictions between Zambia's international obligations and its domestic codes.⁵⁴⁰

Disappointingly, women and girls are not mentioned among the “high-risk and vulnerable groups” listed in the *National Policy*, nor do they feature as such in the *NAISP*. This absence runs counter to the National HIV/AIDS Communication Strategy which points out that the women's subordinate position in society puts them at greater risk of HIV infection.⁵⁴¹ It also conflicts with Guideline 8, which requires States to promote supportive and enabling environments for women, children and other vulnerable groups.

There are fears that the policy on shared confidentiality and the move towards criminalising the failure to disclose one's HIV status to a spouse or partner could have a prejudicial effect on women. The *National Policy* protects the right to privacy and confidentiality, but states that confidentiality does not apply to a “sexual partner or spouse [of the HIV-positive person] as doing otherwise would encourage wilful transmission”.⁵⁴² Section 5.8 of the *Policy* calls for legislation against individuals who “deliberately and knowingly withhold their HIV status from their partners or spouses”.⁵⁴³ Understandably, this is an attempt to prevent the wilful transmission of HIV. However, women are often afraid to reveal their HIV status to their partners for fear of the possible repercussions. Without effective legal protection for PLWHA and women, the principle of shared confidentiality and criminalisation of the failure to disclose might instead discourage persons, especially women, from learning their HIV status.

Guideline 6 requires universal access to treatment, case and support for all people living with HIV, as well as

535 *Marriage Act* Cap 50.

536 The *Marriage Act* Cap 50, part III When consent to marriage is necessary, sec 17.

537 *Penal Code* Cap 87.

538 *Intestate Succession Act* Cap 59.

539 *Insurance Act* Cap 392.

540 UNAIDS, 2006 Report on the Global Epidemic p.197-198.

541 The *National HIV/AIDS Communication Strategy 7*: According to the document, women in Zambia lack autonomy and are taught from early childhood to be obedient and submissive to males. In sexual relations, women are expected to please their partners even at the expense of their own well-being and health.

542 The *National Policy*, sec 2.8.2.

543 As above sec 5.8.

widespread access to prevention programmes. Zambia has made some strides in prevention, treatment and care programmes. The number of PMTCT sites doubled from 136 to 256 in 2005. In addition, 60 per cent of schools had teachers who taught life-skills-based HIV education. Meanwhile, the number of people accessing antiretroviral treatment has increased dramatically from 3,000 at the end of 2003 to 40 000 at the end of 2005. Zambia provides free antiretroviral treatment in public clinics.⁵⁴⁴ These are commendable achievements, especially considering the human capacity, infrastructure and financial resource shortages the country has to contend with.

Nevertheless, only 25 per cent of HIV-positive pregnant women received ARV treatment themselves, while only 20 per cent of people overall in need of ARVs were receiving them. In 2005, only 34 percent (males) and 31 per cent (females) of young people could correctly identify the main methods for preventing HIV transmission. Some 38 percent (males) and 26 per cent (female) of young people said they used a condom the last time they had sex with a casual partner. Women's lower levels of HIV knowledge and condom use reflects the kinds of gender imbalances that undermine Zambia's AIDS response.

Moreover, the most vulnerable populations (such as people in extreme poverty, rural women and street children) often lack access to formal education channels where most of the national HIV education effort is concentrated. The AIDS response needs to pay greater attention to informal education by mobilising community and religious leaders. There is a need, therefore, for creative education, training and media programmes, as recommended by Guideline 9.

Guideline 8 requires States to promote a supportive and enabling environment for women, children and other vulnerable groups. Despite this, the *NAISP* is almost silent on HIV education aimed at sex workers, migrant workers and transport workers. Studies show that in urban areas of Zambia, HIV infection levels among female sex workers are as high as 68%.⁵⁴⁵ Although NGOs have developed peer education manuals for sex workers, the nature of the Government's involvement in such projects is unclear. Prevention campaigns should also target border transit areas where sex work is widespread.

As elsewhere in the region, Zambia's *National Policy* highlights the vulnerability of prisoners and encourages the access to condoms in prison, but Zambian law prohibits condom distribution in prisons.⁵⁴⁶

Another major gap in the implementation plan relates to orphans and vulnerable children. The *NAISP* does not make specific provisions for financial and psychological support to orphans and vulnerable children, despite their large numbers in Zambia.⁵⁴⁷ The lack of political commitment and effective planning may have contributed to the fact that only 16 per cent of orphans and vulnerable children received free external support in 2005.

26.5 Implementation and gaps

Zambia has not ratified the following international instruments:

- *The Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict,*
- *The Optional Protocol to the Convention on the Rights of the Child on the sale of Children,*
- *The International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families.*

Regionally, Zambia has not ratified the *Protocol to the African Charter on the Rights of Women in Africa* and the *African Charter on the Rights and Welfare of the Child*.

27. Zimbabwe

27.1 Policy and strategic framework

The *National Policy on HIV/AIDS for Zimbabwe 1999* (National Policy) rests on eight fundamental principles which commit the country to prevention, care and impact mitigation based on principles of human rights (including anti-discrimination and gender equality).

The Policy is divided into nine thematic areas, each of which contains sub-themes that are guided by specific strategic principles. Under the theme of human rights, issues such as mandatory testing, discrimination, partner notification, surveillance and notification, wilful transmission of HIV, sex work, and prisoner's rights are discussed. The *National Policy* opposes mandatory testing, except in circumstances such as sexual offence cases. It endorses shared confidentiality and encourages partner notification. It also recognises that gender inequality may prevent women from disclosing their status, and calls for gender empowerment.⁵⁴⁸ Regarding the wilful transmission of HIV, Guideline 30 states that "wilful transmission of HIV in any setting should be considered a crime in the same sense as inflicting other life-threatening

544 UNAIDS, 2006 Report on the Global Epidemic p.155.

545 UNAIDS, 2006 Report on the Global AIDS Epidemic p.107.

546 B Odunsi, "The Achilles Heel: Human Rights and Public Health Implications of restricting prisoners' access to condoms and AIDS medication in Southern Africa" forthcoming p.28.

547 ILO, *HIV/AIDS and child labour in Zambia: A Rapid Assessment* no 5 (2002) 1-3.

548 *National Policy on HIV/AIDS for the Republic of Zimbabwe* (1999) chapters 6 and 7.

injuries to another".⁵⁴⁹ Sexual health and violence against women are dealt with under the theme of gender. Guiding principle 37 advocates gender sensitive HIV and STI programmes, while Guiding principle 38 calls for legislation to eliminate all forms of gender violence.⁵⁵⁰

The *National AIDS Council Strategic Plan 2005-2007* (NACSP) deals with 15 strategic issues, which group into four areas: prevention, care, impact mitigation, and the management and coordination of AIDS programmes. The strategic issues include:

- Prevention of HIV infections,
- Comprehensive care and treatment for the infected,
- Comprehensive community and home-based care for the infected,
- Mitigating the impact of AIDS,
- Advocacy enhancement,
- Operational research in HIV and AIDS programmes and documentation,
- Capacity building of stakeholders and partners,,
- Effective monitoring and evaluation of HIV and AIDS interventions,
- Operational policies, manuals and standards,
- Coordination and working relationships with stakeholders,
- Organisational structure efficiency and effectiveness,
- Human resources development initiatives,
- Communication for effectiveness,
- Development and enhancement of Information Technology.

On the prevention front, the *NACSP* focuses on behaviour change through education, development of Information, Education and Communication (IEC) materials and promotion of VCT and PMTCT services. It calls for harmonisation of legislation and policies on AIDS-related issues.

In addition to the main policy and strategy plan, several AIDS policies, guidelines and programmes have been drafted:

- *Community Home-Based Care Policy* (2001),
- *Ministry of Education, Sport and Culture Strategic Plan* (2002-2006),
- *National AIDS Council Strategic Operational Plan* (July –December 2005),
- *National Gender Policy for the Republic of Zimbabwe* (2000),
- *National Plan of Action for OVC* (Draft),
- *Patient's Charter* (non-binding),
- *Zimbabwe National Orphan Care Policy*.

The *Ministry of Education, Sport and Culture Strategic Plan* is meant to bring about effective HIV education in order to reduce HIV infection among the Ministry's personnel, students, pupils and young people, and to mitigate the epidemic's impact on them. The *National AIDS Council Strategic Operational Plan* (July-December 2005) is a six-month plan aimed at assisting effective implementation of the *NSP*.

27.2 Institutions

The National AIDS Council (NAC) was created to coordinate and facilitate a multisectoral response to the HIV and AIDS in Zimbabwe.⁵⁵¹ It is the main supervisory body that plans all aspects of the HIV and AIDS programme and oversees implementation. Its main function is to develop strategies to combat AIDS and mitigate the epidemic's impact. Its core areas of activity include:

- Policy and planning,
- Youth, gender and workplace intervention,
- Social support for orphans and PLWHA,
- Advocacy and communication
- Documentation and research,
- Finance,
- Administration,
- Internal auditing, and
- Monitoring and evaluation.

The Provincial AIDS Action Committee (PAAC) is committed to providing quality and effective leadership, guidance and support for a comprehensive and co-ordinated multisectoral response at the provincial level. It is also mandated to strengthen capacity for co-ordinating and facilitating local AIDS responses.

27.3 Legal framework

Several pieces of legislation include provisions that are relevant to PLWHA.

Section 23 of the *Constitution* prohibits discrimination based on race, tribe, place of origin, political opinions, colour, creed of gender. However, it does not refer to sexual orientation and health status.

Section 15 of *Sexual Offences Act* states that a person who knowingly and intentionally infects another person with HIV or does anything that is likely to infect another person is guilty of an offence and is liable to imprisonment of up to 20 years.⁵⁵² Section 17 provides for testing sexual offenders for HIV infection. However, section 17(4)

549 As above chapter 6.6.

550 As above chapter 7.

551 *National AIDS Council of Zimbabwe Act* (Act 16/1999) (Act 22/2001).

552 *Sexual Offences Act* Cap 9:21.

stipulates that the HIV test can only be conducted after the offender has been prosecuted. Section 8 recognises marital rape and criminalises non-consensual sexual intercourse regardless of the marital status of the parties.

In 1998, the Minister of Public Service Labour and Social Welfare enacted the *Statutory Instrument under the Labour Relations Act* to establish rights and responsibilities of both employers and employees in terms of prevention and management of HIV in the workplace. It requires that employers provide information and education on HIV. Under the *Statutory Instrument*, compulsory HIV testing and disclosure of HIV status is prohibited and HIV testing cannot be a precondition to the offer of employment.⁵⁵³

In late 2006, the *Prevention of Domestic Violence and Protection of Victims Bill* (2006) was before Parliament for debate.⁵⁵⁴

27.4 Adherence to international standards and gender-responsiveness

At a first glance, the *National Policy* is an impressive document. Its eight principles include the protection of human rights and the dignity of “all people irrespective of their HIV status”, and a commitment to gender sensitivity and gender equality. The inclusion of a specific gender provision is valuable. However, it is equally important to recognise that gender sensitivity should be incorporated into every aspect of the policy and legal framework. For instance, the *National Policy* provides strategies to assist and support overworked caregivers, but it does not mention the fact that the majority of caregivers are women. The strategy to assist caregivers should be formulated in ways that reflect the needs of female as well as male caregivers.

Partner notification (chapter 6.3) can affect women differently. Due to their use of antenatal services, women are more likely than men to discover their HIV status. Partner notification, which requires women to disclose their status to partners and spouses, may have a disadvantageous effect on women (who might experience serious repercussions). Certainly, partner notification is important, but it needs to occur in a legal and policy framework that protects HIV-positive women against abandonment and domestic violence. In addition, counselling components should address the predicaments women might anticipate.

Similar concerns can be raised in relation to the *Sexual Offences Act*. By recognising marital rape, the Act marks an important step towards gender equality in marriage. It also criminalises the deliberate transmission of HIV. However, the wording of section 15 may have a prejudicial effect on women. Close reading of the section reveals that it criminalises both the “wilful” transmission of HIV through rape or other sexual offences and “permitting a marital spouse to have sexual intercourse with him or her”. Considering that many women who know their status fail to disclose their status to their partners (usually for fear of violence, desertion, stigmatisation and discrimination), any ambiguity in the wording of the Act could lead to the penalisation of women.

Neither the *National Policy* nor the *NACSP* makes provision for the administration of post-exposure prophylaxis (PEP) to rape survivors or to people who are exposed to HIV as an occupational hazard. In terms of preventing HIV transmission, PEP could more effective than section 15 of the *Sexual Offences Act*.

The structure of the NAC reflects the importance of gender mainstreaming. The Board includes an Executive Director, a representative of the Traditional Medical Practitioners Council, a representative of the Law Society of Zimbabwe, and at least seven representatives from health care providers, women, young people, religious groups, industry, commerce, media, trade unions and PLWHA. However, home-based caregivers are not represented despite their vital role in the AIDS response.

Zimbabwe’s AIDS-related statistics indicate that the country still faces major implementation problems. In 2005, only about eight percent of PLWHA were receiving ARV treatment and only 4 percent of HIV-positive pregnant women received treatment to prevent MTCT. These figures are disappointingly low, given that the country is host to two local manufacturers of general antiretroviral drugs.⁵⁵⁵ The major obstacle to effective implementation of the national AIDS programme is a lack of infrastructure, scarce resources, and the wider context of economic and political instability in the country.

27.5 Implementation and gaps

Zimbabwe has not ratified the following international instruments:

553 Statutory Instrument (202 of 1998), Labour Relations (HIV/AIDS) Regulations 1998.

554 Muwanigwa, V. “Beyond legislation, saying no to domestic violence in Zimbabwe” (18 August 2006) available at http://www.agenda.org.za/index.php?option=com_content&task=view&id=1467&Itemid=147 (accessed 4 September).

555 As above.

- *The Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict,*
- *The Optional Protocol to the Convention on the Rights of the Child on the Sale of Children,*
- *The Convention Against Torture,*
- *The International Convention on the Protection of the*

Rights of all Migrant Workers and Members of their Families.

At the regional level, Zimbabwe has not ratified the *Protocol to the African Charter on the Rights of Women in Africa.*

III. Summary of findings, recommendations and way forward



1. Summary of findings

1.1 International, regional and sub-regional instruments and mechanisms

Regional Institutions and Regional Economic Commissions

The African Union (AU) has passed several declarations that indicate strong political will for combating AIDS. Most of these declarations highlight the epidemic's links to development, gender equality and human rights. However, monitoring of these undertakings is lacking.

Although 20 years-old, the African Commission, which is the main mechanism for human rights realisation on the continent, is yet to prioritise AIDS in its activities.

The African Peer Review Mechanism also has not been utilised to the full in relation to AIDS. However, one of the objectives of the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria (held in Abuja in 2006) was to “strengthen the African Peer Review Mechanism within the context of the New Partnership for Africa's development (NEPAD) for measuring progress towards achieving social development”.⁵⁵⁶

After being criticised for not addressing AIDS meaningfully, NEPAD created a Health Strategy which outlines important AIDS-related priorities and targets. However, the strategy contains no time-bound commitments and its implementation has not been closely monitored (a responsibility that rests with the NEPAD Secretariat).

Among the Regional Economic Communities (RECs), the Southern African Development Community (SADC) has been most active in addressing AIDS. One strength of its approach has been the appointment of permanent staff to work on AIDS-related matters in the region. The SADC PF has also made clear its desire to develop model HIV and AIDS legislation in conjunction with other regional partners – a move that followed on recommendations arising from the *Report on the survey of legislative efforts to combat HIV/AIDS in the SADC region*, conducted by the National Democratic Institute for International Affairs and the SADC PF.

Generally, there appears to be strong commitment to place AIDS at the top of agenda at the regional level. Also valuable has been the development of strategic objectives, priorities and guidance. However, three major weaknesses exist at the regional level.

Firstly, there is little coordination among the various RECs and RIs. In many cases, there is overlapping membership and, in the case of AIDS, overlapping objectives and mandates. This has led to a multitude of policies and guidelines without necessarily yielding any that are comprehensive in scope or application. As a result, some important AIDS and human rights issues are being neglected. An example is the limited attention devoted to vulnerable groups such as orphans and vulnerable children, sex workers, men who have sex with men, injecting drug users, refugees and displaced persons.

Secondly, at the sub-regional level, the adoption of guidelines and policies remains limited, and there is no evidence of their widespread implementation.

Thirdly, one of the reasons for the lack of implementation has been weak self-review (in the case of the African Peer Review Mechanism, for example) and weak monitoring and evaluation (in the case of the African Commission, for example).

Adoption and domestication of international and regional norms

This study has found that there are relatively strong ratification records of international and regional instruments. The status of ratification is set out in Annexures D and E (with respect to UN and AU instruments).

It is notable that the *Protocol to the African Charter on the Rights of Women in Africa* lacks universal acceptance, despite the instrument's importance in relation to women and AIDS.

Yet, for the most part these norms have not been adopted domestically in most Southern and Eastern African states.

Thus, there is a disjuncture between the powerful language and ideals expressed at both the international and regional levels, and commitments made at the national level to implement and adhere to those standards. The discrepancy is further illustrated by the reluctance of States to comply with their obligations to submit State reports under these treaties (as is shown in Annexures D and E).

1.2 National instruments and mechanisms

At the same time, there is a noticeable trend towards legislating in the AIDS and human rights realms at the national level. There has been impressive activity in recent years in moving bills and legislation toward adoption and, ultimately, implementation. Many states are drafting bills

⁵⁵⁶ See <http://www.africa-union.org/root/au/conferences/past/2006/may/summit/summit.htm> (accessed 4 September 2006).

that are expected to be move through the legislative processes in the next year or two. Based upon the research in this study, eight broad categories of legislative activity have been observed:⁵⁵⁷

1. Anti-discrimination and equality,
2. Sexual offences,
3. Property rights and inheritance,
4. Customary practices,
5. Domestic violence,
6. Right to health care,
7. Child rights and protection,
8. Protection of other vulnerable groups.

Anti-discrimination and equality

Each of the 22 countries studied has some form of anti-discrimination or equality protection. However, the extent to which such legislative protection extends to PLWHA is unclear in most cases.

Some countries have passed laws with broad protections that explicitly apply to PLWHA. This is the case with Burundi's *Constitution* and *Law 1/012*, and with Madagascar's draft law on the fight against AIDS and the protection of rights of PLWHA. Zambia's draft *Constitution* prohibits discrimination on the basis of health, while South Africa's *Promotion of Equality and Prevention of Unfair Discrimination Act* contains a "directive principle on HIV/AIDS, nationality, socio-economic status and family" which recommends that special consideration be given to the inclusion of HIV status as a prohibited ground under the Act.

Most countries' constitutions contain equality provisions. But when HIV, health or disability status is not explicitly mentioned, the possible inclusion of HIV status as grounds for protection depends on whether the list is closed or open. In countries with a closed list of protected grounds, PLWHA would have to locate themselves within existing categories (such as disability or, arguably, sex or gender) to gain protection. Other countries, though, have equality provisions with an open list of protected grounds. In those cases, the provision lists a series of specific grounds (such as sex, disability, religion etc.), along with "other status" (or similar language). In such cases, it is left to the courts to determine whether HIV status is an analogous ground of discrimination to those listed explicitly.

Aside from the general anti-discrimination and equality protection for PLWHA in the cases of Burundi, Madagascar, South Africa and Zambia, the bulk of equality legislation reform dealing with AIDS has been sector-specific and relates chiefly to labour and employment.

Angola, Burundi, Ethiopia, Kenya, Mauritius, Mozambique, Namibia, South Africa and Zimbabwe have all enacted laws (or draft laws) prohibiting discrimination against PLWHA in employment relationships. Such legislation generally prohibits mandatory HIV testing and, in some cases, also forbids disclosure of HIV status without consent.

Eritrea, Lesotho, Mauritius, Mozambique, Namibia and Zambia have also developed laws (or drafts) that specifically target and protect women's equality rights (with obvious relevance to AIDS, given women's heightened vulnerability to HIV infection).

Sexual offences

Ten of the 22 countries surveyed have enacted sexual offences legislation. Among them, Botswana, Kenya, Lesotho, Madagascar, South Africa, Swaziland and Zimbabwe all have legislation or bills dealing with the wilful transmission of HIV. These laws generally stipulate criminal sanctions in cases where an individual is aware of his or her status and intentionally transmits HIV to another person. Some of the laws also provide for compulsory testing of individuals accused of rape, and require harsher sentences for convicted rapists who test HIV-positive. South Africa's bill, for example, calls for a life sentence for a first-time rape offender who tests HIV-positive, while in Swaziland the death penalty is available in rape cases where HIV is an aggravating factor.

Property rights and inheritance

Six of the ten countries surveyed (Ethiopia, Malawi, Mozambique, Namibia, Uganda and Zambia) have enacted property rights or inheritance legislation that provides protection to PLWHA. Ethiopia and Mozambique provide for equal inheritance rights in their constitutions, while Malawi and Namibia have chosen to address the issues of "property-grabbing" and the marital power husbands have exercised in the property realm.

Customary practices

Only four of the 22 countries surveyed have legal provisions dealing with harmful customary practices or traditions. Ethiopia and Uganda's constitutions, along with Zambia's draft constitution, prohibit laws, cultures, customs or traditions that run contrary to the interests and dignity of women. Swaziland's new constitution states that women shall not be compelled to undergo or uphold any custom to which they are in conscience opposed.

Domestic violence

Nine of the 22 countries have some form of domestic

557 See Annexure C, where the legal responses in the 22 countries are tabulated according to these eight fields.

violence legislation (or bills) or sexual offences protection. Only five of them (Malawi, Mauritius, Namibia, South Africa and Zimbabwe) have legislation that deals specifically with domestic violence, while Swaziland and Uganda have domestic violence bills. Mauritius, Namibia and Zimbabwe have criminalised marital rape, with Swaziland and Uganda following suit if their respective bills are passed.

Right to health care

Twelve of the 22 countries surveyed have some form of right to health care. While Djibouti provides a general right to health, other countries assert less comprehensive protection. Eritrea states that the country “must endeavour to make health” and other public services available, Somalia provides for the “extension of health care and private health centres”, and South Africa has incorporated the notion of the “progressive realisation” of socio-economic rights, including health. South Africa and Swaziland also stipulate that detainees have the right to medical treatment.

Children's rights

Thirteen of the 22 countries protect some dimension of rights for children. Burundi, Comoros, Ethiopia, Mozambique, Swaziland and Uganda have included general protections of the rights of the child in their constitutions. Malawi's *Children and Young Persons Act* codifies childcare protection and pledges stronger protection for orphans and vulnerable children, while Burundi, Djibouti, Madagascar and South Africa have specifically addressed the right of children to health care.

Kenya, Madagascar, Mozambique, South Africa and Uganda protect the right to education, with Kenya and Madagascar also asserting children's right to free public education.

Some countries, including Malawi and South Africa (in the *Children's Bill*), have raised the minimum age for marriage or consensual sex, while Namibia's *Children's Act* prohibits persons from engaging in the seduction, abduction or prostitution of a child. Kenya's *Children's Act* and South Africa's *Children's Bill* criminalise female genital mutilation. South Africa has also tackled the issue of virginity testing by prohibiting the practice for girls younger than the age of consent and by allowing it for older girls only if they themselves have consented.

Vulnerable groups

Very few countries have laws that provide protection vulnerable groups, such as orphans and vulnerable

children, men who have sex with men, injecting drug users, sex workers, prisoners, refugees and displaced persons. Only four countries have legislation that potentially covers some of these groups. Djibouti has legislation providing a right to state assistance in matters of health for children, mothers, the physically handicapped, victims of natural disasters and vulnerable groups generally. Madagascar has a draft law on the fight against AIDS and the protection of the rights of PLWHA. South Africa and Swaziland grant detainees the right to health treatment, while the constitution of the latter also provides special protection to women and children.

Concluding observations

In conclusion, several observations can be made.

Firstly, virtually all the countries studied have some form of equality or anti-discrimination legislation that directly or indirectly affects PLWHA. The majority of these provisions are contained in national constitutions. When AIDS is specifically addressed, the provision is usually found in labour legislation. Since many of the constitutions were drafted after 1990, the absence of clear constitutional commitments to anti-discrimination on the basis of HIV status is disappointing. Indeed, only two countries have specific broad anti-discrimination or equality protection for PLWHA. Even when the constitutions contain a general anti-discrimination provision, the implications on the horizontal plane (affecting the relationships between non-state actors) usually is not spelt out. There is therefore a manifest need for anti-discrimination legislation that goes beyond the legally vague and open-ended commitments contained currently in constitutions.

Secondly, by far the most legislative activity directly addressing AIDS has occurred in the realm of criminal and labour legislation. The criminalisation of the wilful transmission of HIV and the prohibition of mandatory HIV testing in the workplace are the two most common legislative interventions affecting PLWHA. There is a noticeable trend toward criminalising and imposing harsh sentences on individuals who knowingly transmit HIV to others. This is evident in legislative amendments or review processes in nine of the 22 countries under review. An equal number of countries have legislation dealing with domestic violence, while five have sexual offences legislation or bills that mention HIV. The feasibility of this approach and its utility in addressing some of the root causes of the AIDS epidemics are questionable. In these cases, legislative intervention appears to have been directed at symbolic issues in order to assuage public outrage at isolated events, rather than at the real factors that drive the AIDS epidemics in the region. Further,

criminalisation of wilful transmission of HIV runs the risk of increasing stigma and discrimination and, in some cases, further marginalising and oppressing women.

Thirdly, and related to the previous observation, the areas in which the least AIDS-related legislative activity has occurred are property rights and inheritance (including “property-grabbing”), the prohibition of harmful cultural practices, and the protection of vulnerable groups. Interestingly, country representatives emphasised these as key areas requiring legislative reform when they met during the Consultative Workshop, held in June 2006.⁵⁵⁸ Also neglected is domestic violence, and in particular, the prohibition of marital rape.

Finally, although there have been some efforts to address AIDS and human rights, they have arrived late in the day. Southern and Eastern Africa is home to the biggest and most intense AIDS epidemics in the world. The policies and strategic plans adopted by most States are important, but they cannot fulfil the tasks of legislation. Only legislation creates enforceable rights, which form the basis of a rights-based approach. States have also put in place institutional mechanisms to oversee government policies, but their impact is often limited.

Although there is an emerging trend to address some of the root causes of the AIDS epidemics through legislation, those efforts are constrained by the protracted nature of law-making processes. The urgency of the situation requires that these processes be accelerated and that a comprehensive review of national legislation be conducted. This study has highlighted several significant steps taken by States in the surveyed regions, and these could serve as inspiration to others.

2. Recommendations and ways forward

The study has three main recommendations:

- (1) Each country studied must conduct a comprehensive review of its legislation, as well as enact and reform legislation to fill gaps and correct inconsistencies.
- (2) Regional Economic Communities and Regional Institutions must develop and approve model HIV and AIDS legislation to facilitate a comprehensive approach to HIV legislation and promote harmonisation and domestication.
- (3) Oversight, self-review, and monitoring and evaluation mechanisms must be strengthened to increase

national implementation at the national, regional and international levels.

2.1 Comprehensive legislation review at the country level

Each of the countries surveyed should conduct comprehensive reviews of their AIDS-related legislation. There are inconsistencies in some countries. For example, efforts have been made to address discrimination against PLWHA through labour legislation, but harmful cultural practices are not yet outlawed (which leaves women exposed to discrimination).

There are also gaps in legislation. Some countries have chosen to address only one or two areas that relate to AIDS and human rights, leaving other important matters untouched. Each country therefore needs to scrutinize its existing legislation in order to ascertain how various pieces of legislation interact. They should then engage in a process of legislative reform to remove inconsistencies and fill the gaps.

Specifically, it is recommended that States:

- Enact or strengthen equality legislation by providing specific and broad protection for PLWHA;
- Enact legislation that prohibits mandatory testing and that requires pre-and post-test counselling, confidentiality of medical information and prohibition of disclosure without consent;
- Enact legislation dealing with property rights and inheritance;
- Enact legislation dealing with harmful customs, laws and practices that oppress or cause bodily or mental harm to women;
- Enact legislation that protects orphans and vulnerable children and that provides for children's rights with respect to sexual abuse and education;
- Enact legislation protecting vulnerable groups, including men who have sex with men, injecting drug users, sex workers, prisoners, refugees and displaced persons;
- Enact legislation that provides equal access to prevention, treatment and care for all PLWHA;
- Enact domestic and sexual violence legislation, including provisions dealing with the prohibition of marital rape;
- Enact legislation concerning the regulation of HIV-related goods and services;
- Enact legislation dealing with HIV and AIDS prevention and care services in prisons;
- Enact legislation dealing with the rights of human participants in HIV and AIDS research;

558 *Report Stakeholder Consultation on Gender, Human Rights and HIV & AIDS: A UNDP-OHCHR Joint Initiative for Southern and Eastern Africa* Rosebank Hotel, Johannesburg, 27-29 June 2006 p.7, 18, 19, 20, 22, 24.

- Enact legislation regulating blood safety standards.

2.2 Development of model legislation by Regional Economic Communities and Regional Institutions

One way of addressing the lack of comprehensive legislation dealing with HIV and AIDS would be to task Regional Economic Communities (RECs) and Regional Institutions (RIs) with taking the lead in developing model legislation. By pooling the resources, knowledge and capabilities of States in the Southern and Eastern African region, comprehensive HIV and AIDS model legislation can be developed.

Model law has been developed successfully in other fields. The African Union, for example, developed the *Model Law on Rights of Local Communities, Farmers, Breeders and Access* (2000). The United Nations Commission on International Trade Law developed the *Model Law on International Commercial Arbitration* (1985).⁵⁵⁹ Recently, the Canadian HIV/AIDS Legal Network developed *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*.

The goal of such model legislation would be to have RECs and RIs pass the model legislation and then encourage each of the Member States to domesticate and implement the same piece of legislation nationally. The process can help States address all relevant areas requiring legislative reform.

Model legislation differs from treaties and declarations. A treaty is open for ratification, and its provisions acquire binding effect once a State ratifies it. A declaration, on the other hand, contains normative standards that may guide States. Those norms are not binding and are often vaguely formulated. A model law has features of both treaties and declarations. It therefore is not binding; its provisions serve as examples and inspiration to domestic law-makers. Domestic legislatures may adopt the model law in part or in its entirety, and they may adapt relevant

provisions to local circumstances. Model legislation is much more precise than both treaties and declarations, as it is framed in the legal language of law-makers rather than in the rhetorical discourse of lawmakers. Model legislation in a particular region, such as the SADC region, builds on existing best precedents, serves as guidance to legislators in the region and reinforces a common approach.

2.3 Strengthen oversight mechanisms, self-review and monitoring and evaluation

Ultimately, the impact of legislation the human rights approach depends on its implementation. Public interest litigation and monitoring and evaluation mechanisms are the main tools for ensuring implementation.

It is therefore recommended that States ensure that they enact and sharpen self-review, monitoring and evaluation, and oversight mechanisms.

It is recommended that self-review mechanisms such as the African Peer Review Mechanism be strengthened. Governments must prioritise the collection of HIV- and AIDS-related data, and they should increase consultation with civil society, community-based organisations and PLWHA to facilitate that process.

Research shows that the most useful HIV oversight bodies, such as parliamentary portfolio committees, tend to be dedicated AIDS committees.⁵⁶⁰ Uganda's Standing Committee on HIV/AIDS and Related Matters is one example.

It is recommended that the bodies responsible for oversight, along with other stakeholders, monitor Governments' HIV responses by using the indicators set out by UNAIDS in its "Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators" (July 2005).

559 Available at http://www.uncitral.org/uncitral/en/uncitral_texts/arbitration/1985Model_arbitration.html (accessed 4 September 2006).

560 HIV/AIDS Mainstreaming in the Gauteng Legislation, Final Report (6 February 2006) prepared by the AIDS and Human Rights Research Unit, Centre for Study of AIDS and Centre for Human Rights, University of Pretoria for the Gauteng Provincial Legislature p.66.

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Annexure A: Index of Laws, Policies and Guidelines

All the documents below are included on the CD Rom that forms part of this report.

East Africa

Burundi

- 2006 UNGASS country progress report

Djibouti

- Decret n 2003-0049
- La Constitution de la Republique de Djibouti
- Loi n 48
- Loi n 173

Ethiopia

- 2006 UNGASS country progress report

Kenya

- 2006 UNGASS country progress report
- Mainstreaming gender into the Kenya national HIV/AIDS strategic plan
- Kenya national HIV/AIDS strategic plan final report

Somalia

Central-South Somalia

- Central-South Somalia HIV/AIDS action plan budget
- Central-South Somalia process monitoring and evaluation logframe
- Central-South Somalia results monitoring framework
- HIV/AIDS action plan for Central-South Somalia
- Narrative report: HIV/AIDS action plan for central and southern Somalia

Puntland

- HIV/AIDS action plan for Puntland
- Narrative report: HIV/AIDS action plan for Puntland
- Puntland HIV/AIDS action plan budget
- Puntland process monitoring and evaluation logframe
- Results monitoring framework

Somalia National

- Budget for HIV/AIDS and STI at the strategic level
- HIV/AIDS capacity assessment report
- Somali HIV/AIDS prevention forum
- Somali HIV/AIDS prevention forum handouts
- Somalia HIV/AIDS prevention advocacy and communication framework

- Stakeholder inventory HIV/AIDS action plans
- Strategic framework for prevention and control of HIV/AIDS and STIs within Somali populations 2003-2008

Somaliland

- HIV/AIDS action plan for Somaliland
- Narrative report: HIV/AIDS action plan for Somaliland
- Results monitoring framework for Somaliland
- Somaliland HIV/AIDS action plan budget
- Somaliland process monitoring and evaluation logframe

Sudan

- Constitution of the Republic of Sudan 1998 Part II
- HIV/AIDS integrated report North Sudan, 2004-2005 (draft)
- HIV/AIDS treatment scale-up plan for the Republic of Sudan 2005-2009 (draft)
- National strategic plan for the prevention and control of HIV/AIDS in the Sudan 2003-2007
- Sudan national AIDS programme (SNAP) 2006 Plan of Action

Uganda

- National strategic framework

Southern Africa

Angola

- Decree no. 43/03
- Law no. 8/04
- National HIV/AIDS and STI strategic plan

Botswana

- Botswana national policy on HIV/AIDS
- National strategic framework for HIV/AIDS 2003-2009
- 2005 UNGASS country progress report

Comoros

- 2006 UNGASS country progress report
- HIV and AIDS Preventive Measures Bill

Lesotho

- Five year strategic plan for DOTS expansion
- Human resource development strategy 2025
- Lesotho national AIDS strategic plan

- Lesotho national AIDS policy
- Revised guidelines on PMTCT

Madagascar

- Madagascar strategic plan
- UNGASS progress report 2006

Malawi

- Prevention of Domestic Violence Bill (draft)
- National HIV/AIDS policy

Mauritius

- Child Protection (Amendment) Bill
- Protection from Domestic Violence (Amendment) Act

Mozambique

- Act No.5 of 2002
- Plano estratégico nacional 2005-2009
- Programme to control HIV
- Constitution of Mozambique 2004 (unofficial English translation)

Namibia

- 2006 UNGASS country progress report
- Combating of Domestic Violence Act
- Communal Land Reform Act
- Draft national HIV policy 19th Jan 2006
- Labour Act
- Married Persons Equality Act No. 1 of 1996
- Namibia HIV/AIDS Charter of Rights
- National strategic plan
- National policy on AIDS

South Africa

- 2006 country progress report
- HIV/AIDS strategic plan
- Ethical considerations for HIV/AIDS clinical and epidemiological research
- Guidelines for good practice in the conduct of clinical trials in human subjects in South Africa
- Learning through practice: Integrating HIV/AIDS into NGO programmes
- Managing HIV in the workplace: A guide for government departments
- National Health Act
- Notice no. 1926 of 1999
- Operational plan for comprehensive HIV and AIDS care, management and treatment
- Policy guideline and recommendation for feeding of infants of HIV-positive mothers
- Policy guideline for management of transmission of (HIV) and STIs in sexual assault
- Recommendations for the prevention and treatment of opportunistic and HIV-related diseases in adults

- Strategic priorities for the national health system 2004-2009
- Strategies to reduce mother-to-child HIV transmission during pregnancy and child birth
- Traditional Health Practitioners Act

Swaziland

- Policy document on HIV/AIDS and STI prevention and control
- National strategic plan for HIV/AIDS 2000-2005

Tanzania

- 2006 UNGASS country progress report
- Commission for AIDS Act
- Infectious Diseases Act
- National Policy on HIV/AIDS
- Tanzania national multisectoral strategic framework 2003-2007

Zambia

- HIV education strategic plan
- Marriage Act
- National gender policy strategic framework
- Strategic plan of action for the national gender policy 2003-2007
- Strategic framework

Zimbabwe

- Labour relations (HIV and AIDS) regulations 1998
- National AIDS Council Act
- National AIDS Council strategic plan 2005-2007
- National AIDS Council strategic operational plan July-December 2005
- National policy on HIV/AIDS
- Public Health Act
- Sexual Offences Act
- Ministry of Education strategic plan

Regional Institutions

ACHPR, etc.

- Protocol on the Rights of Women
- Resolution on the HIV/AIDS Pandemic
- Resolution on the Situation of Women and Children in Africa

African Union

- Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa
- Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases
- Draft Continental Framework for Harmonization of Approaches Among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa

- Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care
- Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Related Infectious Diseases
- Progress report on the implementation of the plans of action of the Abuja declarations on malaria (2000), HIV/AIDS and tuberculosis (2000/1 to 2005)
- Solemn Declaration on Gender Equality in Africa
- Africa's Common Position to the UN General Assembly Special Session on AIDS (June 2006)

COMESA

- Addis Ababa Declaration on the COMESA Gender Policy
- COMESA gender policy

EAC

- Development strategy

NEPAD

- Health strategy
- New Partnership for Africa's Development (NEPAD)

SADC

- HIV and AIDS business plan: Strategic 5-year business plan 2005-2009
- Declaration on HIV and AIDS
- Protocol on Health
- HIV and AIDS strategic framework and programme of action 2003-2007

Annexure B: Index of International and Regional Tools

Below are groupings of tools, including papers, policies, and guidelines. They focus on integrating gender and human rights in HIV/AIDS policy-making. Various UN bodies and other institutions created these tools aimed to inform governments and citizens of how to create new and reform existing policy, legislation, and program initiatives. All of the tools can be found on the CD Rom that is also part of this report. It should be noted that this list is indicative but not comprehensive.

UN General Tools

OHCHR & UNAIDS. HIV/AIDS and Human Rights International Guidelines (1998)

OHCHR & UNAIDS. Revised Guideline 6 of HIV/AIDS and Human Rights International Guidelines (August 2002)

UNAIDS Global Coalition on Women & AIDS. Keeping the Promise: An Agenda for Action on Women and HIV/AIDS (2006)

UNAIDS, UNDP, & World Bank. Mainstreaming HIV/AIDS in Sectors & Programmes: An Implementation Guide for National Response (September 2005)

UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS. Operational Guide on Gender and HIV/AIDS: A Rights-Based Approach (2005)

UNIFEM. Gender, HIV, and Human Rights: A Training Manual (2000)

UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS. HIV/AIDS and Gender: Fact Sheet Overview (2004)

UNAIDS, *Courting Rights: Case Studies in Litigating the Human Rights of people Living with HIV* (Geneva: UNAIDS, 2006), published jointly with the Canadian HIV/AIDS Legal Network

WHO Department of Gender & Women's Health. Integrating Gender into HIV/AIDS Programmes (2003)

Other General Tools

USAID, Gender & HIV/AIDS Task Force, & Interagency Gender Working Group (IGWG). How to Integrate Gender into HIV/AIDS Programs: Using Lessons Learned from USAID and Partner Organizations (May 2004)

Regional Tools

UNAIDS Global Coalition on Women & AIDS. Facing the Future Together: Report of the Secretary General's Taskforce on Women, Girls and HIV/AIDS in Southern Africa (July 2004)

UN Development Fund for Women (UNIFEM). Rapid Assessment for Persons Living with HIV/AIDS (May 2005)

Declarations

ActionAid International, African Women's Development Fund (AWDF), OSISA & UNIFEM. "The Johannesburg Position of HIV/AIDS and Women's and Girls' Rights in Africa" (April 2006)

Education-Focused Tools

UNDP HIV/AIDS Group & Bureau for Development Policy. Leadership Development Programme Implementation Guide (2005)

UNICEF. Girls, HIV/AIDS and Education (December 2004)

Health-Focused Tools

UNFPA & WHO. Sexual and Reproductive Health of Women Living with HIV/AIDS (2006)

UNAIDS/WHO. Ensuring Equitable Access to Antiretroviral Treatment for Women (2004)

WHO Department of Gender and Women's Health. Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers, and Outcomes (2004)

Labour-Focused Tools

ILO. An ILO Code of Practice on HIV/AIDS and the World of Work (2001)

Methodology-Focused Tools

UNAIDS & WHO. Guide for Sexually Transmitted Infections Surveillance (1999)

Refugee-Focused Tools

UNHCR. Refugees, HIV, and AIDS: Fighting HIV and AIDS Together with Refugees (2005)

Annexure C: Tables of Legislation and bills addressing HIV/Aids and Human Rights

Legislation Responding to HIV/AIDS: Part 1				
	Legislation			
Countries	Anti-discrimination, equality	Sexual offences	Property rights and inheritance	Customary practices
Angola	<ul style="list-style-type: none"> • Article 18 Constitution (general equality and anti-discrimination) • Law no 8/04 on HIV and AIDS (right to employment, free public health care and confidentiality in health care system) • Decree 43/03 Regulations on HIV/AIDS, Employment, and Professional Training (forbids HIV testing for employment) 			
Botswana	<ul style="list-style-type: none"> • Constitution (general anti-discrimination) 	<ul style="list-style-type: none"> • Penal Code (Amendment) Act 5 of 1998 (compulsory HIV test for persons convicted of rape and harsher sentences for convictions where HIV test is positive) 		
Burundi	<ul style="list-style-type: none"> • Article 19 Constitution (explicit anti-discrimination protection for PLWHA) • Article 6 Decree Law 1/037 (prohibits discrimination in workplace) • Law 1/018 of 12 May 2005 (specific legislation protecting PLWHAs) 			
Comoros	<ul style="list-style-type: none"> • Constitution (general equality) 			
Djibouti	<ul style="list-style-type: none"> • Article 10 Constitution (general equality) 	<ul style="list-style-type: none"> • Law 173 (strategy to integrate women into national development plans; calls for improved data on HIV prevalence in women, development of maternity services, and measures to fight rape and prostitution) 		
Eritrea	<ul style="list-style-type: none"> • Article 14 Constitution (general prohibition against discrimination) • Art 7 Constitution (protection specifically for women) 			
Ethiopia	<ul style="list-style-type: none"> • Article 25 (general equality provision) • Labour and Pension legislation (amended to include benefits for PLWHA) 	<ul style="list-style-type: none"> • Article 35 Constitution (equal rights of women for property and inheritance) 		<ul style="list-style-type: none"> • Article 35 Constitution (equal right of women in marriage, right of women to eliminate influences of harmful customs, prohibition of laws, customs, practices that oppress or cause bodily or mental harm to women)

Countries	Anti-discrimination, equality	Sexual offences	Property rights and inheritance	Customary practices
Kenya	<ul style="list-style-type: none"> Section 82 Constitution (general anti-discrimination) HIV/AIDS Prevention and Control Bill (2006) (bars mandatory HIV testing in employment, marriage, admission to education institutions) 	<ul style="list-style-type: none"> HIV/AIDS Prevention and Control Bill (2006) (7 year min sentence for willful transmission of HIV and fine; allows compulsory testing of those accused of sexual offences) Sexual Offences Law (renders deliberate transmission of HIV/AIDS a criminal offence; provides rape victims with free medical care and counselling) 		
Lesotho	<ul style="list-style-type: none"> The Married Persons' Equality Bill 	<ul style="list-style-type: none"> The Sexual Offences Act (2003) 		
Madagascar	<ul style="list-style-type: none"> Article 8 Constitution (general equality and anti-discrimination) 	<ul style="list-style-type: none"> Draft law on the fight against HIV/AIDS and the protection of rights of PLWHA (extensive rights protection) Draft law on the fight against HIV/AIDS and the protection of rights of PLWHA (provisions dealing with willful transmission of HIV and harsher sentencing provisions) 		
Malawi	<ul style="list-style-type: none"> Section 20 Constitution (general equality provision) 		<ul style="list-style-type: none"> Deceased Estates (Will, Inheritance and Protection) Bill (2004) (criminalises property grabbing) 	
Mauritius	<ul style="list-style-type: none"> Labour (Amendment) Act (2004) (prohibits harassment based on HIV status in workplace) Sex Discrimination Act (Act 43 of 2002) 			
Mozambique	<ul style="list-style-type: none"> Article 35 and 36 Constitution (general right to equality and women's equality) Act No. 5 (2002) (protects the rights of PLWHA in the workplace) 		<ul style="list-style-type: none"> Articles 82 and 83 Constitution (rights of inheritance and freedom from expropriation) 	
Namibia	<ul style="list-style-type: none"> Article 10 Constitution (general equality and anti-discrimination) Married Persons Equality Act (1996) (abolishes marital power husband would have over his wife and her property) Labour Act 15 of 2004 (no discrimination on basis of HIV status in employment) National Code on HIV/AIDS and Employment under the 	Labour Act	<ul style="list-style-type: none"> The Combating of Rape Act 8 (2000) Married Persons Equality Act (1996) (abolishes marital power husband would have over his wife and her property) 	
	Somalia	<ul style="list-style-type: none"> Article 8 Constitution (equality and anti-discrimination) 		
South Africa	<ul style="list-style-type: none"> Section 9 Constitution (general equality and anti-discrimination) Basic Conditions of Employment Act 75 (1997) (covers minimum sick leave days) Employment Equity Act, Act 55 (1998) (deals with HIV/AIDS in employment) 	<ul style="list-style-type: none"> Compulsory HIV Testing of Alleged Sexual Offenders Bill Criminal Law Amendment Act 105 (1997) (life imprisonment for an HIV-positive first offender convicted of rape) 		

Countries	Anti-discrimination, equality	Sexual offences	Property rights and inheritance	Customary practices
South Africa (contd.)	<ul style="list-style-type: none"> Labour Relations Act 66 (1995) (prohibits the dismissal of an employee on the basis of HIV and AIDS status except for members of the South African Defence Force or National Intelligence Agency) Occupational Health and Safety Act 85 (1993) (minimize occupational exposure to HIV, administration of post-exposure prophylaxis) Promotion of Equality and Prevention of Unfair Discrimination Act, Act 4 (2000) Sections 34(1) and (2) Public Service Regulations (2002) 	<ul style="list-style-type: none"> Schedule 6 (a)(iv) of Criminal Procedure Second Amendment Act, Act 85 (1997) (granting of bail more difficult for HIV positive suspected rapists) 		
Sudan	<ul style="list-style-type: none"> Articles 21 Constitution (general right to equality) Draft law on HIV/AIDS (legal and institutional reform to support persons living with HIV/AIDS) 			
Swaziland	<ul style="list-style-type: none"> Section 20 Constitution (general equality provision) 	<ul style="list-style-type: none"> Sexual Offences and Domestic Violence Bill (expand rape to marital rape, criminalises intentional failure to disclose HIV positive status, death penalty for rape where HIV/AIDS is aggravating factor) 		<ul style="list-style-type: none"> Section 28(3) Constitution (women shall not be compelled to undergo or uphold any custom to which they are in conscience opposed to)
Tanzania	<ul style="list-style-type: none"> Section 12 Constitution (general equality provision) 	<ul style="list-style-type: none"> Section 13 (general anti-discrimination provision) 	<ul style="list-style-type: none"> Section 22 Constitution (equal right to work, equal terms) 	
Uganda	<ul style="list-style-type: none"> Section 21 Constitution (general equality provision) 		<ul style="list-style-type: none"> The Domestic Relations Bill (before parliament for over a decade, but not yet passed; addresses women's property rights in marriage, women's right to negotiate sex on the grounds of health, sets the minimum age of marriage at eighteen, prohibits FGM, and criminalises widow inheritance and marital rape) 	<ul style="list-style-type: none"> Section 33 Constitution (prohibits laws, cultures, customs or traditions that are against the interests and dignity of women) The Domestic Relations Bill (addresses women's property rights in marriage, women's right to negotiate sex on the grounds of health, sets the minimum age of marriage at eighteen, prohibits FGM, and criminalises widow inheritance and marital rape)
Zambia	<ul style="list-style-type: none"> Section 39 Draft Constitution (prohibits discrimination on basis of "health") Section 40 Draft Constitution (equal treatment for men and women) Section 44 Draft Constitution (equality before, during and on dissolution of marriage) 		<ul style="list-style-type: none"> Intestate Succession Act (allows wife 20% of estate) 	<ul style="list-style-type: none"> Section 40 Draft Constitution (prohibits any law, culture, customs or traditions that undermines dignity, welfare of interest of women).
Zimbabwe	<ul style="list-style-type: none"> Section 23 Constitution (general anti-discrimination provision) Statutory Instrument under the Labour Relations Act (deals with HIV in workplace) 	<ul style="list-style-type: none"> Sexual Offences Act (willful transmission of HIV, testing for HIV of sexual offender if found guilty, criminalisation of marital rape) 		

Legislation Responding to HIV/AIDS: Part 2				
	Legislation			
Countries	Domestic violence	Right to health care	Children protection	Vulnerable groups
Angola		<ul style="list-style-type: none"> Part 2, Article 47 Constitution Law 8/04 on the Human Immunodeficiency Virus 		
Botswana				
Burundi			<ul style="list-style-type: none"> Article 35 Constitution (child health and well-being) 	
Comoros		<ul style="list-style-type: none"> Constitution 	<ul style="list-style-type: none"> Constitution 	
Djibouti		<ul style="list-style-type: none"> Law 48 (general right to health and proclaims the guarantee of this right to be an essential mission of the state) 	<ul style="list-style-type: none"> Law 48 (right to state assistance in matters of health for children, mothers, the physically handicapped, victims of natural disasters, and vulnerable groups generally) 	<ul style="list-style-type: none"> Law 48 (right to state assistance in matters of health for children, mothers, the physically handicapped, victims of natural disasters, and vulnerable groups generally)
Eritrea		<ul style="list-style-type: none"> Article 21 Constitution (equal access to publicly funded social services, and endeavour to make health, education, cultural and other services available) 		
Ethiopia	<ul style="list-style-type: none"> Article 35 Constitution (equal right of women in marriage, right of women to eliminate influences of harmful customs, prohibition of laws, customs, practices that oppress or cause bodily or mental harm to women) 	<ul style="list-style-type: none"> Article 41 Constitution (right to equal access to publicly funded social services, state must allocate increasing resources to public health, education and social services) 	<ul style="list-style-type: none"> Article 36 Constitution (rights of the child including special protection for orphans) 	
Kenya			<ul style="list-style-type: none"> The Children's Act 2002 (guarantees free primary school education; criminalizes forced marriages and female genital cutting) 	
Lesotho	<ul style="list-style-type: none"> The Sexual Offences Act of 2003 		The Child Protection and Welfare Bill	
Madagascar		<ul style="list-style-type: none"> Article 19 Constitution (protection of health) Draft law on the fight against HIV/AIDS and the protection of rights of PLWHA 	<ul style="list-style-type: none"> Article 23-24 Constitution (right to free public education) Draft law on the fight against HIV/AIDS and the protection of rights of PLWHA 	<ul style="list-style-type: none"> Draft law on the fight against HIV/AIDS and the protection of rights of PLWHA
Malawi	<ul style="list-style-type: none"> Protection against Domestic Violence Act 5 of 2006 (broad applicability not only to spouses but family members, long term visitors and others) 		<ul style="list-style-type: none"> Penal Code (Amendment) Bill 2000 (age of consensual sex for girls to be raised from 13 to 16) Children and Young Person's Act Cap 26:03 (codifies child care and protection, better protection for OVC) 	
Mauritius	<ul style="list-style-type: none"> Protection from Domestic Violence (Amendment) Act 2004 (prohibits marital rape, amongst other things) 	<ul style="list-style-type: none"> HIV and AIDS Preventive Measures Bill (disclosure, testing, counselling, needle exchange) 		

Countries	Domestic violence	Right to health care	Children protection	Vulnerable groups
Mozambique		<ul style="list-style-type: none"> Article 89 Constitution (right to medical and health care) Decision that authorises the circulation in the country of Antiretroviral in the therapeutic schemes approved by Ministerial Diploma Nr. 183/A-2001 	<ul style="list-style-type: none"> Article 47 Constitution (childrens' right to protection and care for their well-being) Article 88 Constitution (right to education) 	
Namibia	<ul style="list-style-type: none"> The Combating of Domestic Violence Act 4 (2003) (prohibits "sexual abuse" in domestic relationships including marital rape, child abuse, incest and abusive foster care arrangements) 		<ul style="list-style-type: none"> The Children's Act 33 (1960) (prohibits any person with custody of the child from causing or contributing to the seduction, abduction or prostituting of a child) 	
Somalia		<ul style="list-style-type: none"> Article 17 Constitution (country has duty to meet its needs for equipment to combat communicable diseases, provision of free medicine, care of public welfare, responsible for promotion and extension of health care and private health centres) 		
South Africa	<ul style="list-style-type: none"> Sexual Offences Amendment Bill Domestic Violence Act [No. 116 of 1998] 	<ul style="list-style-type: none"> Section 27 Constitution (right to access health care services, no one can be denied emergency medical treatment) Section 28 Constitution (basic health care services for children) Section 35 Constitution (adequate medical treatment for detainees and prisoners at state expense) 	<ul style="list-style-type: none"> Section 29 Constitution (right to education) Section 28 Constitution (basic health care services for children) Children's Bill (provisions touching on HIV/AIDS, gender and youth, prohibition of forced marriages below age of marriage, FGM and FGC prohibited, virginity testing below age of consent prohibited) Section 26 Constitution (right to adequate housing) Section 27 Constitution (right to sufficient food and water and social security) 	<ul style="list-style-type: none"> Section 35 Constitution (adequate medical treatment for detainees and prisoners at state expense)
Sudan				
Swaziland	<ul style="list-style-type: none"> Sexual Offences and Domestic Violence Bill (criminalises marital rape) 	<ul style="list-style-type: none"> Section 16 Constitution (right of detainees to medical treatment) 	<ul style="list-style-type: none"> Section 27 Constitution (special protection for women and children) 	<ul style="list-style-type: none"> Section 16 Constitution (right of detainees to medical treatment) Section 27 Constitution (special protection for women and children)
Tanzania				
Uganda	<ul style="list-style-type: none"> The Domestic Relations Bill (before parliament for over a decade, but not yet passed; addresses women's property rights in marriage, women's right to negotiate sex on the grounds of health, sets the minimum age of marriage at eighteen, prohibits FGM, and criminalises widow inheritance and marital rape) 		<ul style="list-style-type: none"> Section 30 Constitution (right to education) Section 34 Constitution (rights of children) 	
Zambia				
Zimbabwe	<ul style="list-style-type: none"> Sexual Offences Act (criminalisation of marital rape) The Prevention of Domestic Violence and Protection of Victims Bill (2006) 			

Annexure D: Status of Ratification & State Reporting under UN Treaties

International Convention on the Elimination of All Forms of Racial Discrimination (CERD)

Country	Date of Deposit	Number of state reports submitted (date of last examination)	Number of state reports overdue
Angola	-	-	-
Botswana	20/2/74	5(9/3/06)	0
Burundi	27/10/77	5(10/12/97)	4
Comoros	27/9/04	0	0
Eritrea	31/7/01	0	2
Ethiopia	23/6/76	6(10/12/97)	8
Kenya	13/9/01	0	2
Lesotho	4/11/71	5(24/1/01)	3
Madagascar	7/2/69	10(9/8/04)	1
Malawi	11/6/96	0	4
Mauritius	30/5/72	7(9/10/00)	3
Mozambique	18/4/83	1(23/7/93)	1
Namibia	11/11/82	3(6/11/96)	5
Somalia	26/8/75	2(15/8/95)	11
South Africa	10/12/98	1(-)	0
Sudan	21/3/77	4(12/6/01)	3
Swaziland	7/4/69	4(22/5/97)	5
Tanzania	27/10/72	5(18/8/05)	1
Uganda	21/11/80	2(25/3/03)	1
Zambia	4/2/72	4(16/8/05)	1
Zimbabwe	13/5/91	2(13/6/00)	3

International Covenant on Civil and Political Rights (ICCPR)

Country	Date of Deposit	Number of state reports submitted (date of last examination)	Number of state reports overdue
Angola	10/1/92	0	1
Botswana	8/9/00	0	1
Burundi	9/5/90	3(2/8/96)	1
Comoros	-	-	-
Eritrea	22/1/02	0	1
Ethiopia	11/6/93	0	3
Kenya	1/5/72	2(30/3/81)	3
Lesotho	9/9/92	1(4/12/00)	1
Madagascar	21/6/71	2(16/7/91)	4
Malawi	22/12/93	0	3
Mauritius	12/12/73	4(18/3/05)	2
Mozambique	21/7/93	0	3
Namibia	28/11/94	1(23/7/04)	0
Somalia	24/1/90	0	3
South Africa	10/12/98	0	2
Sudan	18/3/76	2(2/2/98)	1
Swaziland	26/3/04	0	1
Tanzania	11/6/76	3(11/12/98)	1
Uganda	21/6/95	1(31/3/04)	0
Zambia	10/4/84	2(20/6/96)	2
Zimbabwe	13/5/91	1(11/8/98)	1

International Covenant on Economic, Social and Cultural Rights (ICESCR)

Country	Date of Deposit	Number of state reports submitted (date of last examination)	Number of state reports overdue
Angola	10/1/92	0	2
Botswana	-	-	-
Burundi	9/5/90	0	3
Comoros	-	-	-
Eritrea	17/4/01	0	1
Ethiopia	11/6/93	0	2
Kenya	1/5/72	2(27/5/94)	0
Lesotho	9/9/92	0	2
Madagascar	22/9/71	3(15/4/86)	3
Malawi	22/12/93	0	2
Mauritius	12/12/73	1(30/11/95)	2
Mozambique	-	-	-
Namibia	28/11/94	0	2
Somalia	24/1/90	0	3
South Africa	-	-	-
Sudan	18/3/86	1(28/11/01)	1
Swaziland	26/3/04	0	0
Tanzania	11/6/76	1(16/04/81)	4
Uganda	21/1/87	0	4
Zambia	10/4/84	2(2/5/05)	0
Zimbabwe	13/5/91	1(6/6/97)	1

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

Country	Date of Deposit	Number of state reports submitted (date of last examination)	Number of state reports overdue
Angola	17/10/86	2(12/7/04)	0
Botswana	13/8/96	0	2
Burundi	-	-	-
Comoros	-	-	-
Eritrea	5/9/95	1(-)	1
Ethiopia	10/9/81	2(26/1/04)	1
Kenya	9/3/84	2(15/1/03)	1
Lesotho	22/8/95	0	3
Madagascar	17/3/89	1(19/1/94)	3
Malawi	12/3/87	2(25/1/90)	0
Mauritius	9/7/84	2(24/1/95)	0
Mozambique	16/4/97	0	3
Namibia	23/11/92	2(11/7/97)	0
Somalia	-	-	-
South Africa	15/12/95	1(29/6/98)	2
Sudan	-	-	-
Swaziland	26/3/04	0	1
Tanzania	20/8/85	2(1/7/98)	2
Uganda	22/7/85	2(9/8/02)	2
Zambia	21/6/85	2(4/6/02)	1
Zimbabwe	13/5/91	1(27/1/98)	3

Convention on the Rights of the Child (CRC)

Country	Date of Deposit	Number of state reports submitted (date of last examination)	Number of state reports overdue
Angola	5/12/90	1(27/9/04)	0
Botswana	14/3/95	1(16/9/04)	0
Burundi	19/10/90	1(26/9/00)	2
Comoros	22/6/93	1(5/6/01)	1
Eritrea	3/8/94	1(2/6/03)	1
Ethiopia	14/5/91	3(15/11/01)	0
Kenya	30/7/90	2(15/10/01)	1
Lesotho	10/3/92	1(1/2/01)	1
Madagascar	19/3/91	2(23/9/03)	0
Malawi	2/1/91	1(24/6/02)	2
Mauritius	26/7/90	2(19/1/06)	0
Mozambique	26/4/94	1(28/2/03)	2
Namibia	30/9/90	1(5/4/95)	2
Somalia	-	-	-
South Africa	16/6/95	1(19/5/00)	1
Sudan	3/8/90	2(27/9/02)	0
Swaziland	7/9/95	(-)	1
Tanzania	10/6/91	2(31/5/06)	0
Uganda	17/8/90	2(12/12/97)	0
Zambia	6/12/91	1(4/6/03)	1
Zimbabwe	11/9/90	(23/5/96)	2

AC Optional protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict (OP-CRC-AC)

Country	Date of Deposit	Number of state reports submitted (date of last examination)	Number of state reports overdue
Angola	-	-	-
Botswana	4/10/04	0	1
Burundi	-	-	-
Comoros	-	-	-
Eritrea	16/2/05	0	0
Ethiopia	-	-	-
Kenya	28/1/02	0	1
Lesotho	24/9/03	0	1
Madagascar	22/9/04	0	1
Malawi	-	-	-
Mauritius	-	-	-
Mozambique	19/10/04	0	1
Namibia	16/4/02	0	1
Somalia	-	-	-
South Africa	-	-	-
Sudan	26/7/05	0	1
Swaziland	-	-	-
Tanzania	11/11/04	0	1
Uganda	6/5/02	0	1
Zambia	-	-	-
Zimbabwe	-	-	-

Optional protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography (OP-CRC-SC)

Country	Date of Deposit	Number of state reports submitted (date of last examination)	Number of state reports overdue
Angola	24/3/05	0	0
Botswana	24/9/03	0	1
Burundi	-	-	-
Comoros	-	-	-
Eritrea	16/2/05	0	0
Ethiopia	-	-	-
Kenya	-	-	-
Lesotho	24/9/03	0	1
Madagascar	22/9/04	0	1
Malawi	-	-	-
Mauritius	-	-	-
Mozambique	6/3/03	0	1
Namibia	16/4/02	0	1
Somalia	-	-	-
South Africa	30/6/03	0	1
Sudan	2/11/04	1(-)	0
Swaziland	-	-	-
Tanzania	24/4/03	0	1
Uganda	30/11/01	0	1
Zambia	-	-	-
Zimbabwe	-	-	-

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)

Country	Date of Deposit	Number of state reports submitted (date of last examination)	Number of state reports overdue
Angola	-	-	-
Botswana	8/9/00	0	1
Burundi	18/2/93	1(-)	3
Comoros	-	-	-
Eritrea	-	-	-
Ethiopia	13/3/94	0	3
Kenya	21/2/97	0	2
Lesotho	12/11/01	0	1
Madagascar	13/12/05	?	?
Malawi	11/6/96	0	2
Mauritius	9/12/92	2(3/5/99)	1
Mozambique	14/9/99	0	2
Namibia	28/11/94	1(6/6/97)	2
Somalia	24/1/90	0	4
South Africa	10/12/98	1(-)	1
Sudan	-	-	-
Swaziland	26/3/04	0	1
Tanzania	-	-	-
Uganda	3/11/86	1(23/5/05)	4
Zambia	7/10/98	2(26/11/01)	0
Zimbabwe	-	-	-

International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW)

Country	Date of Deposit	Number of state reports submitted (date of last examination)	Number of state reports overdue
Angola	-		
Botswana	-		
Burundi	-		
Comoros	-		
Eritrea	-		
Ethiopia	-		
Kenya	-		
Lesotho	16/9/05	0	0
Madagascar	-		
Malawi	-		
Mauritius	-		
Mozambique	-		
Namibia	-		
Somalia	-		
South Africa	-		
Sudan	-		
Swaziland	-		
Tanzania	-		
Uganda	14/11/95	0	1
Zambia	-		
Zimbabwe	-		

Annexure E: Status of Ratification & State Reporting under AU Treaties

	African Charter on Human and Peoples' Rights	Protocol to the African Charter on the Rights of Women in Africa	African Charter on the Rights and Welfare of the Child	Number of state reports submitted and considered (date of last examination)	Number of state reports overdue*
Adopted	16/06/81	11/07/03	11/07/90		
Entered into force	21/10/86	25/11/05	29/11/99		
Angola	09/10/90		07/10/99	1(1998)	3
Botswana	22/07/86		10/07/01	0	9
Burundi	30/08/89		28/08/04	1(2000)	2
Comoros	18/07/86	16/04/04	16/04/04	0	9
Eritrea	15/03/99		25/01/00	0	3
Ethiopia	22/06/98		27/12/02	0	3
Kenya	10/02/92		10/08/00	0	6
Lesotho	27/02/92	05/11/04	29/10/99	1(2002)	2
Madagascar	19/03/92		24/06/05	0	6
Malawi	23/02/90	29/06/05	17/11/99	0	7
Mauritius	01/07/92		27/02/92	1(1996)	5
Mozambique	22/02/89	30/12/05	22/12/98	2(2001)	1
Namibia	16/09/92	26/08/04	26/08/04	2(2001)	1
Somalia	20/03/86			0	9
South Africa	09/07/96	14/01/05	21/01/00	2(2005)	1
Sudan	11/03/86			1(1997)	4
Swaziland	09/10/95			1(2000)	2
Tanzania	09/03/84		09/05/03	1(1992)	7
Uganda	27/05/86		21/10/94	1(2000)	8
Zambia	02/02/84			0	9
Zimbabwe	12/06/86		22/02/95	2(1997)	4

Dates indicate when instruments of ratification have been deposited.

* The number of state reports submitted and the number of state reports that are overdue is in reference to the African Charter on Human and Peoples' Rights.

*The table was compiled as at 1 August 2006 and its currency is dependent upon publicly available information.



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