

## Chapter 8

# HIV and AIDS

## 8.1 ISSUE ANALYSIS

### 8.1.1 HIV, AIDS and human rights

HIV, or Human Immunodeficiency Virus, 'targets the immune system and weakens people's defence system against infections and some types of cancer'.<sup>i</sup> It affects the CD4 cells, making the body less resistant to infections and other diseases.<sup>ii</sup> When the number of CD4 cells is low, a person has Acquired Immunodeficiency Syndrome (AIDS).<sup>iii</sup> There is no cure for HIV infection, but antiretroviral therapy (ART) has proved successful in controlling the virus and helping prevent transmission.<sup>iv</sup> The HIV virus is spread through certain body fluids such as blood, breast milk, semen and vaginal secretions. It is not transmitted by kissing, hugging, shaking hands or sharing personal objects, food or water.<sup>v</sup> In the 1980s, HIV was seen as confined to MSM, sex workers and intravenous drug users, with few women affected by the epidemic. In 2003, a significant milestone was reached when for the first time it was reported that half of the people living with HIV (PLWHIV) were women.<sup>vi</sup>

HIV has been a global concern for more than 80 years<sup>vii</sup> but it was only in the late 1980s that it started to be addressed from a human rights perspective. This happened at the first International Consultation on AIDS and Human Rights in 1989, which was followed by a series of consultations resulting in the 2006 International Guidelines on HIV/AIDS and Human Rights.<sup>1</sup> It was then recognised that the full realisation of human rights and fundamental freedoms for all was essential in the response to global AIDS.<sup>2</sup> This entailed looking at fundamental human rights such as the rights to health, non-discrimination, equality, participation, dignity and access to justice. Given the disproportionate impact of HIV on women and girls, the human rights of women and girls are at the heart of the fight against HIV and AIDS.

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1 The Second International Consultation on HIV/AIDS and Human Rights took place in 1996 and the Third in 2002. Since then, various international forums have taken place at which states have made major commitments to HIV prevention treatment and care and recognising the relationship between HIV and fundamental human rights. These include the 2005 World Summit Outcome, the political declaration of the 2006 High Level Meeting on AIDS and various African Summits on HIV (2001, 2015). See the 2006 International Guidelines on HIV/AIDS and Human Rights: <http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf>

2 In 2015, the UN Human Rights Council reaffirmed such recognition in its Resolution 30/8.

### 8.1.2 HIV prevalence and new infections: regional trends

HIV and AIDS continue to be a major public health issue in Africa, where there are 25.6 million PLWHIV out of the 36.7 million worldwide.<sup>viii</sup> The majority of these live in Eastern and Southern Africa (ESA), where there were 19.4 million PLWHIV in 2016, 59% of them adult women (see Table 8.1). In Western and Central Africa, 52% of the 6.1 million PLWHIV are women. Notably, this region has a relatively high burden of HIV: 'While it contains 7% of the world's population, the region is home to 17% of the world's people living with HIV and accounts for 30% of the world's AIDS-related deaths.'<sup>ix</sup> HIV prevalence in the Middle East and North Africa (MENA) region is much lower, at 230,000.<sup>3 x</sup> In 2017, the 15 countries with the highest HIV prevalence in the world were in Africa. Swaziland (27.2%), Lesotho (25.0%), Botswana (21.9%), South Africa (18.9%) and Namibia (13.8%) featured as the top five.<sup>xi</sup>

Table 8.1. Number of people living with HIV in 2016<sup>xii</sup>

	HIV prevalence (all ages)	Female adults (15+)	Male adults (15+)	Female adolescents (15-19)	Male adolescents (15-19)	Children (0-14)
Eastern and Southern Africa	19.4 million	10.9 million	7.2 million	740,000	530,000	1.3 million
West and Central Africa	6.1 million	3.2 million	2.4 million	260,000	200,000	550,000
Middle East and North Africa	230,000	82,000	140,000	5,200	4,500	9,300
Total	25.7 million	14.9 million	9.7 million	1.0 million	0.7 million	1.9 million
Percentage		58%	37.7%	3.9%	2.7%	7.4%

There has been a positive trend in the **reduction of new infections** globally in the past six years. In Sub-Saharan Africa, new infections declined by 41% between 2000 and 2014.<sup>xiii</sup> New infections tend to concentrate in specific countries in the different African regions. In ESA, a third of all new infections in 2016 were in one country: South Africa (see Figure 8.1). Another 50% of new infections occurred in Kenya, Malawi, Mozambique, Tanzania, Uganda, Zambia and Zimbabwe. Figure 8.2 shows that, in Western and Central Africa, Nigeria is the country with the highest HIV prevalence—and this is considerably higher than in other countries in the region.<sup>xiv</sup>

Figure 8.3 shows how, although Mozambique, Uganda and Zimbabwe are among the countries with the highest numbers of HIV new infections by 2016, from 2010 to 2016 the numbers in these countries declined considerably. Eritrea, Ethiopia and Madagascar, on the other hand, show an increase between 2010 and 2016. In the case of Western and Central Africa, Figure 8.4 shows that Burundi, Guinea-Bissau and Senegal have seen the most significant declines in new infections. In Congo, Ghana and Liberia, new infections increased more than 15% between 2010 and 2016. In many of the countries with high rates of new HIV infections, these are declining, for instance in Cameroon, DRC and Nigeria (slight decline) and Côte d'Ivoire (stronger decline).<sup>4,xv</sup>

Figure 8.1. Distribution of new HIV infections by country, ESA, 2016

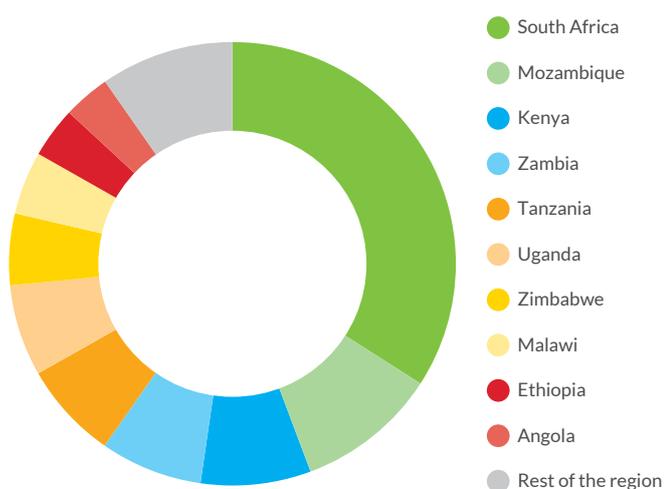
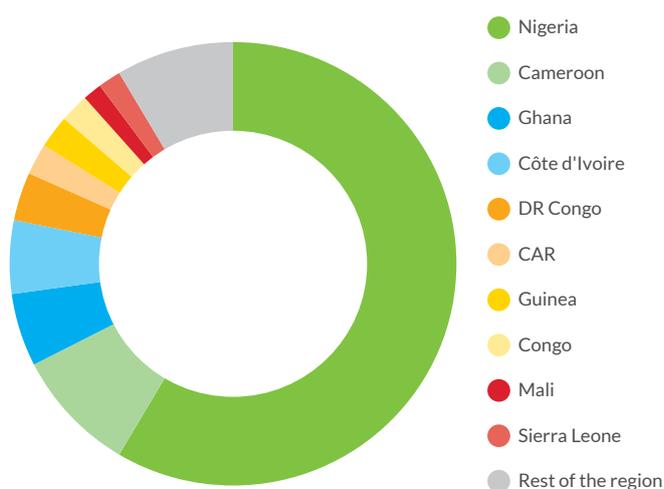


Figure 8.2. Distribution of new HIV infections by country, WCA, 2016



3 No sex-disaggregated information is provided for the MENA region.

4 All figures are estimates from UNAIDS. (2017). 'Ending AIDS: Progress towards the 90-90-90 Targets'.

Figure 8.3. Change in new HIV infections by country, ESA, 2010–16 (%)

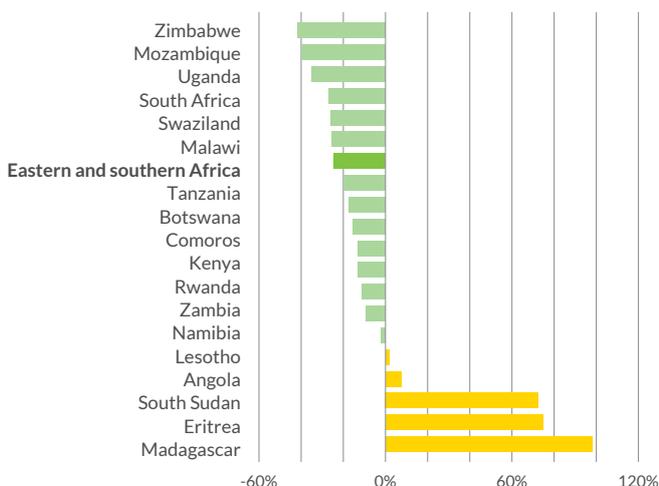
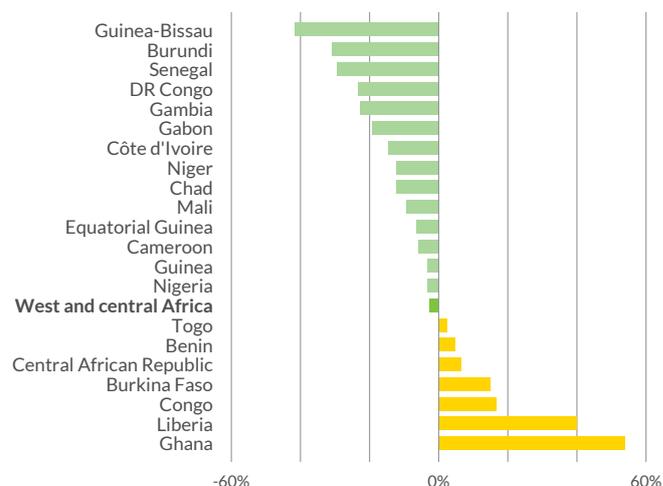


Figure 8.4. Change in new HIV infections by country, WCA, 2010–16 (%)

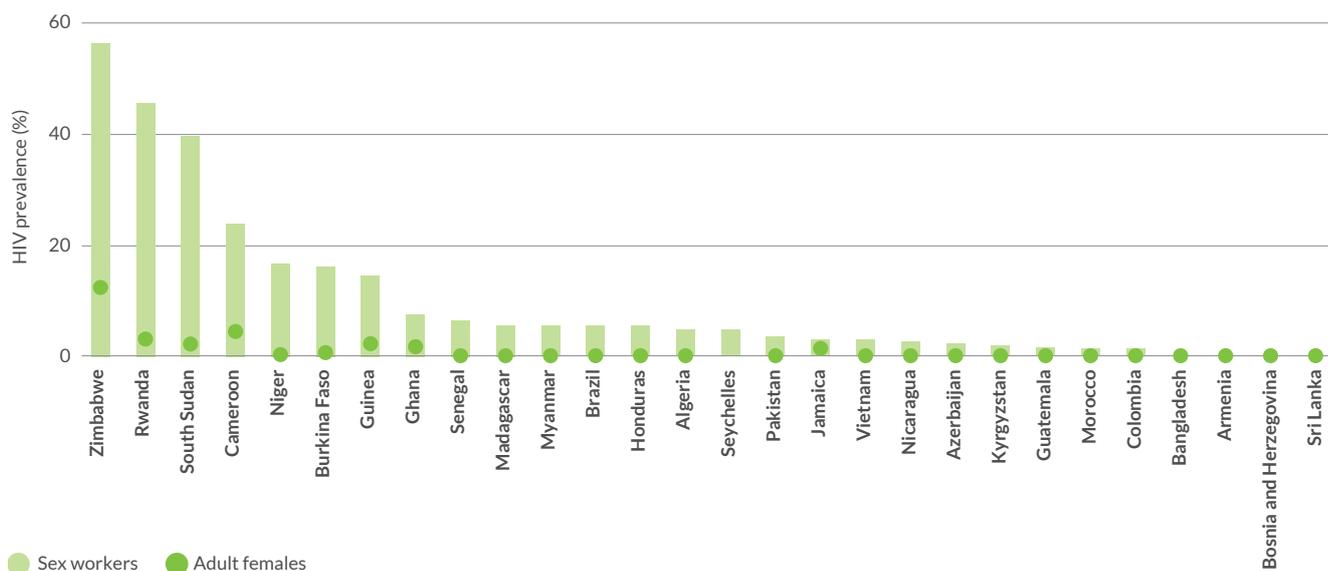


### 8.1.3 The disproportionate effect of HIV and AIDS on women and girls

HIV and AIDS affect women disproportionately. Young women aged 15–24 years in Sub-Saharan Africa are 2.5 times more likely to be infected than men.<sup>xvi</sup> Prevalence rates among women in ESA range from 14.5% in East Africa to 38.7% in Lusaka (Zambia) and 39.5% in Durban, South Africa.<sup>xvii</sup> By 2017, 56% of new infections among adults (15 years and older) in Sub-Saharan Africa were of women. Among young women between the ages of 15 and 24 years, the proportion of new infections is higher, at 67%.<sup>xviii</sup> In the MENA region, women accounted for 38% of newly infected adults, while young women aged 15–24 made up 48% of new infections.<sup>xix</sup> For the continent as a whole, AIDS-related illnesses are the second leading cause of death for young women aged 15–24.<sup>xx</sup>

Among women, female sex workers are particularly vulnerable to HIV, and are 13.5 times more likely to be living with HIV than other women.<sup>xxi</sup> An estimate of fifteen percent of HIV in the general female adult population is attributable to (unsafe) female sex work.<sup>xxii</sup> By 2013, it was estimated that, of the 106,000 deaths from HIV as a result of female sex work globally, 98,000 had occurred in Sub-Saharan Africa.<sup>xxiii</sup> Figure 8.5 shows prevalence of HIV among female sex workers and the adult female population, and points to the higher vulnerability of sex workers to HIV. All ten countries with the highest HIV prevalence among sex workers, in 2016 are on the African continent: Burkina Faso, Cameroon, Ghana, Guinea, Madagascar, Niger, Rwanda, Senegal, South Sudan and Zimbabwe (see Figure 8.5).<sup>xxiv</sup>

Figure 8.5. HIV prevalence among female sex workers compared with the adult female population<sup>xxv</sup>



HIV and AIDS affect women and girls disproportionately in terms of higher susceptibility to becoming infected with HIV when exposed. The risk of women acquiring HIV through heterosexual vaginal sex is higher than that of men, partly because of biological factors. Women's specific physiological and hormonal characteristics make them more likely to contract HIV than men.<sup>xxvi</sup> Social factors and in particular gendered unequal power relations play a major role in this as well.<sup>xxvii</sup> These include the limited access of women and girls to SRH services, and in particular information about HIV and AIDS and SRHR in particular (see also Chapter 7). This is also affected by access to education: women who lack formal education are less likely to receive information on SRHR and HIV prevention and are more likely to fall into misconceptions and believe in myths.<sup>xxviii</sup> Girls who are not at school are also to be more exposed to FGM and child marriage, which in turn increase the risk of HIV.

Gender unequal power relations between intimate partners or spouses are a critical factor, and can limit women and girls' abilities to protect themselves and negotiate safe sex. The economic dependency of women and girls on male partners can further reinforce constraints to women and girls protecting themselves against HIV infection. Women and girls' lack of property rights, and related lack of economic resources and low economic status, contributes to HIV infections, as they are associated with earlier sexual experience, lower condom use, having multiple sexual partners and the increased likelihood of transactional sex or physically forced sex.<sup>xxix</sup> A study conducted in South Africa and Uganda found that securing property rights had the potential to mitigate the consequences of HIV and AIDS, as it allows women to protect themselves from the virus, conduct testing and seek counselling and treatment.<sup>xxx</sup>

GVAW and harmful practices also increase women and girls' exposure to and risk of acquiring HIV and AIDS. In South Africa and Uganda, 'Adolescent girls who had been subjected to violence from a partner or who are in relationships with low levels of equality are at an increased likelihood of acquiring HIV.'<sup>xxxi</sup> GVAW has been proved to have a direct relationship with the risk of HIV infection, and can, for instance, be a strong limitation in terms of women's power to negotiate condom use, increasing their exposure to HIV.<sup>xxxii, xxxiii</sup> Furthermore, rape and forced sexual intercourse often result in injuries to women's vaginal tissue, which further increases the risk of HIV entering the bloodstream.<sup>xxxiv</sup> Harmful practices such as FGM, child marriage, virginity testing, widow inheritance and cleansing rituals are also a contributing factor to HIV.<sup>xxxv</sup> In the case of child marriage, (forced) intercourse with often older men, who may have had previous sexual partners, increases the risk of girls and young women contracting HIV. Moreover, South African women who have their 'sexual debut' before the age of 15 years are more likely to be HIV positive. Widow inheritance puts widows at risk of being infected by the male relative who 'inherits' her. Cleansing rituals, whereby a widow has to have sex with a man identified by the elders in the community, to 'clean' her from the burial ceremony of her late husband, increases the likelihood of her being exposed to HIV.<sup>xxxvi</sup>

HIV and AIDS also affect women and girls disproportionately because of the stigma and discrimination associated with HIV infection, and the effects this has on women and girls' lives. Stigma and discrimination persist in Africa and often affect women in particular.<sup>xxxvii</sup> Women living with HIV experience multiple types of discriminations on account of their HIV or health status. They face discrimination in their families and communities, such as being banned from community activities or cooking, but also in institutional settings, with women fired from their jobs and girls denied their right to attend school. It can also lead to the denial of treatment, or the opposite—that is, forced sterilization.<sup>xxxviii, xxxix</sup> Social perceptions that link HIV and promiscuity, such as in Zimbabwe, make people believe HIV-infected people are responsible for their disease and therefore 'don't deserve help'.<sup>xl</sup> In some cultures, as with the Ndaou people in Zimbabwe, women are blamed for their husband's disease or death and accused of witchcraft. This leaves them ostracised and they may be sent away, losing their land and property.<sup>xli</sup> Specific **vulnerable groups** are more susceptible to discrimination based on their HIV and health status. This in particular concerns female sex workers, women refugees and migrants, women from ethnic minorities, women with disabilities and young women. Their vulnerable condition and position often prevents them from accessing information, prevention and care services.<sup>xlii</sup> In ESA, sex workers are criminalised and are highly stigmatised, which limits their access to prevention, treatment, care and support.

Stigma and discrimination can be both a cause and a consequence of HIV infection, as can GVAW, poor educational attainment and women's lack of economic independence. Women are reported to suffer violence at the hands of their partners after disclosing their HIV status to them.<sup>xliii</sup> Women and girls living with HIV often drop out of school, and this further limits their potential to be economically independent. Women and girls also tend to carry the responsibility for caring for relatives with HIV and AIDS, which in turn can affect their school enrolment and attainment.<sup>xliv</sup> HIV stigma has reportedly led to loss of jobs, income or opportunities to work, for both women and men.<sup>xlv</sup> Women's property rights can become more fragile, as well as more valuable, for women and girls living with HIV, as well as women who give care and women widows. In Kenya, Malawi, Uganda and Zambia, it has been observed that 'HIV-related stigma and discrimination increases the likelihood of "property-grabbing" for affected widows.' In addition, stigma works as a deterrent to reporting or claiming property and inheritance rights violations, as evidenced in Cameroon, Ghana, Kenya, Mali, Nigeria, Rwanda, Tanzania, Uganda and Zimbabwe.<sup>xlvi</sup>

### 8.1.4 Testing and knowing one's status

Testing for HIV is essential to prevention as well as treatment, care and support services. An HIV test is the only way to know whether you have HIV. At the individual level, testing and counselling is key to protect oneself and one's partners, to access ART and to obtain care and support, as well as to reduce the risk of transmitting HIV to unborn babies. At the community level, denial, stigma and discrimination can be reduced and knowledge of HIV status can contribute to collective responsibility, care and action.

In 2014, the International AIDS Conference established the so-called 90-90-90 target for PLWHIV: 90% of people know their status, 90% of people who know their status are on treatment and 90% of people on treatment are virally suppressed.<sup>5</sup> These targets reflect an important shift in the approach to HIV treatment, away from a focus only on the number of people accessing ART and towards maximising viral suppression in PLWHIV.<sup>xlvii</sup>

90%

people know their status

90%

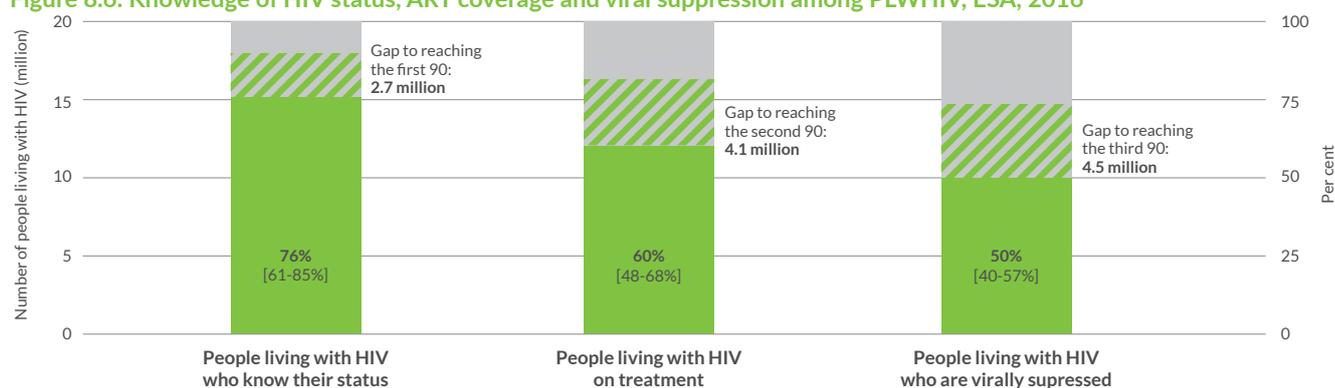
people who know their status are on treatment

90%

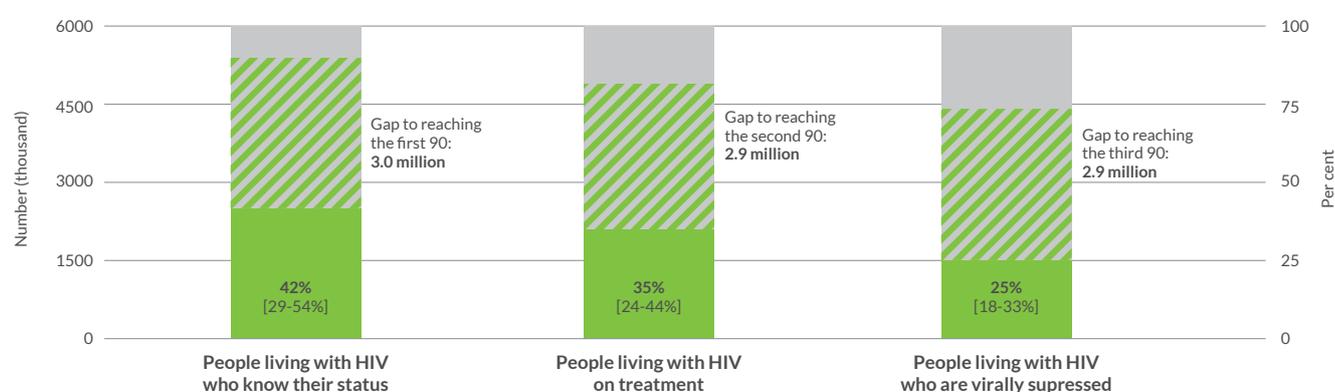
people on treatment are virally suppressed

In the past decade, a significant increase in the level of testing has been achieved, which has resulted in two-thirds of all PLWHIV knowing their status.<sup>xlviii</sup> In ESA, over three out of four PLWHIV know their status, and this proportion (of 79%) for the period 2012–16 is nearly twice that in 2007–11. Moreover, nearly four in five who know their HIV status are on treatment, and 83% of people on treatment are virally suppressed (see Figure 8.6). In Western and Central Africa the figures are lower, but there was a fourfold increase between 2007–11 and 2012–16. By 2016, 42% of PLWHIV knew their status, out of whom 83% were on treatment, of whom 73% were virally suppressed (see Figure 8.7). Coverage of HIV testing and treatment in Western and Central Africa is below the global average. Meanwhile, for the African region as a whole, the gap to breach to reach the 90-90-90 targets remains large. Despite the increases seen in access to testing and services and in people knowing their status and receiving treatment, many PLWHIV are still unaware of their HIV status.<sup>xlix</sup>

**Figure 8.6. Knowledge of HIV status, ART coverage and viral suppression among PLWHIV, ESA, 2016<sup>i</sup>**



**Figure 8.7. Knowledge of HIV status, ART coverage and viral suppression among PLWHIV, WCA, 2016**



<sup>5</sup> Virally suppression is when ART 'reduces a person's viral load (HIV RNA) to an undetectable level. Viral suppression does not mean a person is cured; HIV still remains in the body. If ART is discontinued, the person's viral load will likely return to a detectable level': <https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/1650/viral-suppression>

The gaps in the 90-90-90 continuum are often greater for men, young people and key populations.<sup>6</sup> Their access to testing is often lower, they are less likely to be linked to treatment and they have low viral suppression levels. Stigma and discrimination are among the factors that affect access to and levels of testing. This affects women in specific ways. Gender norms for married women, related to supposed purity and the sanctity of marriage, can prevent women from seeking testing or treatment. GVAW can stop women disclosing their status to their partner or seeking testing, counselling and even treatment out of fear of intimate partner violence.<sup>ii</sup>

Young people may face specific challenges, especially when they lack access to comprehensive information and sexual education, or when consent laws affect the ability of SRH health care. Apart from having limited information on provision of adolescent SRH services, adolescents and young people may also lack comprehensive knowledge and understanding of SRH issues, such as on how to prevent transmission of HIV. While there is a trend among both young women and young men of increasing knowledge on HIV prevention, general knowledge levels regarding HIV and AIDS remain low.<sup>iii</sup> Countries where young women and men aged 15–24 appear to have the least knowledge on prevention of HIV transmission and AIDS include Chad (11.2% of women, 15.4% of men), Eritrea (12.8% of women), Niger (13% of women, 24.8% of men), Congo (14.4% of women, 27.6% of men) and Côte d'Ivoire (15.7% of women, 24.6% of men).<sup>7, iii</sup>

Disclosure and forced testing are critical concerns in HIV testing. Knowing one's HIV status is a right recognised by various human rights treaties, including the Maputo Protocol (see Section 7.2 for more detail). The voluntary nature of testing is key, and WHO and UNAIDS do not support mandatory or compulsory testing of individuals on public health grounds. 'HIV testing, no matter how it is delivered, must always respect personal choice and adhere to ethical and human rights principles. Public health strategies and human rights promotion are mutually reinforcing.'<sup>iv</sup> As a right, it cannot be forced, and should involve the right to decline testing.<sup>iv</sup> Mandatory testing has the risk of further marginalising people infected with HIV. The 'five Cs' are key to voluntary HIV testing: **consent, confidentiality, counselling, correct results and connections**. A distinction needs to be made between voluntary counselling and testing (VCT), provider-initiated testing and counselling (PITC) and mandatory or forced testing (see Box 8.1).<sup>lv</sup>

#### Box 8.1. HIV testing models

**Voluntary counselling and testing (VCT)** is client-initiated and refers to individuals actively seeking HIV testing and counselling services because they wish to learn about their status.<sup>lvii</sup>

**Provider-initiated testing and counselling (PITC)** is HIV testing and counselling that is recommended by health care providers to persons attending health care facilities as a standard component of medical care, and with the purpose of enabling clinical decisions to be made and/or the provision of specific medical services. PITC needs to have an 'opt-out', as patients have the right to decline the recommendation of HIV testing and counselling if they do not wish the testing to be performed.<sup>lviii</sup>

**Mandatory or forced testing** concerns compulsory testing of individuals without their informed consent. Mandatory testing has been reported in the context of visa applications, pre-employment screening, scholarships or fellowship applications, insurance purposes or bank loans, as well as for sex workers, or for military personnel.<sup>lix</sup> HIV testing can also be mandatory for pregnant women, and there are also trends of mandatory pre-marital testing (of both women and men), enacted in laws (DRC, Ethiopia) or by churches (Burundi, DRC, Ghana, Kenya, Nigeria, Tanzania and Uganda).<sup>lx</sup>

Confidentiality and consent are of pivotal importance not only with respect to testing itself but also in relation to **disclosure** of results and decisions on medical treatment following the test result.<sup>lxi</sup> Fear of discrimination or stigma makes women reticent to seek testing, treatment and care and even prevent them from disclosing their status to their partners.<sup>lxii</sup> A study conducted in rural Zimbabwe found that 'Doctors are asked not to write the true diagnoses on the chart or the death certificates this causes problems for families and impacts on insurance.'<sup>lxiii</sup> A number of countries in Western and Central Africa demand disclosure for PLWHIV to their partners.<sup>lxiv</sup> (Section 8.3 looks at discriminatory laws in national legal and policy frameworks—i.e., laws that require mandatory testing of pregnant women, force disclosure of a person's HIV status or criminalise HIV transmission.)

6 Key populations include sex workers, people who inject drugs, gay men and other MSM, transgender people, clients of sex workers and other sexual partners of key populations.

7 Based on data from most recent national DHS, ranging from 2009 to 2016.

**Forced and coerced sterilisation** based on stigma and discrimination has been identified as a serious threat to PLWHIV, and generates fear and thus affects testing and access to care and treatment. Forced sterilisation of HIV women has been reported in various countries.<sup>lxv</sup> In Kenya, Namibia, South Africa and Uganda, for example, these practices are embedded in pervasive beliefs that these women 'should not reproduce', and in fact take place despite legal prohibitions.<sup>lxvi</sup> The 2014 South Africa HIV Stigma Index revealed that '7% of respondents reported that they were forced to be sterilized. In addition, 37% of the respondents said that access to ARV [antiretroviral] treatment was conditional on use of contraceptives'.<sup>lxvii</sup> In 2015, the International Community of Women living with HIV Eastern Africa (ICWEA) in Uganda found that '20 of the 72 women interviewed who had been sterilized, were either forced or coerced to undergo sterilization, while 3 were forced to abort'.<sup>lxviii</sup> In Namibia, a 2008 study observed that 40 women out of 230 women living with HIV (17%) stated that they had been coerced or forced into sterilisation.<sup>lxix</sup> In Kenya, a 2012 report by the African Gender and Media Initiative (GEM) documented the stories of 40 HIV-positive women claiming to have been forcibly sterilised. At the end of 2017, the High Court heard two cases of five HIV-positive women who were subject to coerced sterilisation.<sup>lxx</sup> In 2012, a landmark decision by Namibia's Supreme Court ruled in favour of three HIV mothers who had been coerced into signing sterilisation consent forms (see also Section 8.2, or Case studies 32 and 33 in Section 8.4).<sup>lxxi</sup> Twelve women living with HIV in South Africa also planned to take the government to court for being sterilised against their will.<sup>lxxii</sup>

### 8.1.5 Access to and use of treatment

Access to and use of ART is critical to the reduction of AIDS-related deaths. Scale-up of ART has surpassed expectations, with the greatest advances made in the world's most affected region, ESA (see Table 8.2).

**Table 8.2. PLWHIV on ARV treatment in 2010 and 2015**<sup>lxxiii</sup>

Regions	PLWHIV on ART 2010	PLWHIV on ART 2015
Eastern and Southern Africa	4,087,500	10,252,400
Western and Central Africa	905,700	1,830,700
Middle East and North Africa	13,600	38,200

Africa is one of the regions where the success of ART has been particularly outstanding. In ESA countries like Botswana, Kenya and Namibia, the number of AIDS-related deaths has declined by over 50% since 2005 as a result of ART. Botswana is the country with the highest coverage of ART (over 95%) and South Africa has the largest number of people on ART (2,150,880) (see Table 8.3).<sup>lxxiv</sup> In South Africa, for example, the number of AIDS-related deaths has reduced significantly since 2007 thanks to the roll-out of ART, from 325,241 deaths in 2006 to 150,759 in 2016. Treatment coverage is overall higher among women than among men living with HIV, with 59% of women covered and 44% of men covered in the ESA region, and 34% and 21% in Western and Central Africa (see Table 8.4).<sup>lxxv</sup> Despite these advances, there are still gaps in many countries, with ART continuing to be expensive and hard to access.

**Table 8.3. Access to ARV treatment and coverage in ESA in 2012**<sup>lxxvi</sup>

Countries	Estimated number of people needing ART	Estimated coverage (%)	Reported number of people on ART
Botswana	210,000	≥ 95	204,298
Namibia	13,000	90	116,687
South Africa	26,000,000	83	2,150,880
Swaziland	110,000	82	87,534
Zambia	590,000	81	480,925
Zimbabwe	720,000	79	565,675
Kenya	830,000	73	604,027
Malawi	580,000	70	404,905
Tanzania	710,000	61	432,293
Lesotho	170,000	56	92,747
Uganda	-	64	313,117
Mozambique	690,000	45	308,577
Angola	120,000	36	42,607
DRC	220,000	29	64,219

Note: Data not available for Comoros, Madagascar and Seychelles

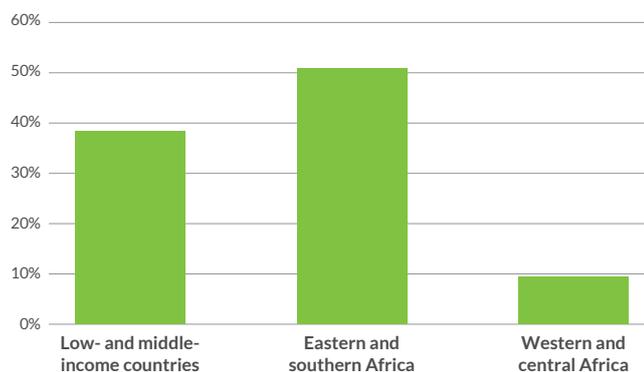
**Table 8.4. Regional AIDS-related deaths and treatment coverage**<sup>boxvii</sup>

Regions	AIDS-related deaths	Total number of PLWHIV accessing ART	% of all PLWHIV accessing ART	Treatment coverage among women living with HIV	Treatment coverage among men living with HIV
Eastern and Southern Africa	420,000	11.7 million	60%	59%	44%
Western and Central Africa	310,000	2.1 million	35%	34%	21%
Middle East and North Africa	11,000	54 400	24%	-	-

The use of **pre-exposure prophylaxis (PrEP)**<sup>8</sup> is highly recommended to prevent HIV infection. There have been several successful trials in Africa, Asia and Europe and, since September 2015, WHO has recommended PrEP as part of comprehensive prevention. South Africa and Zimbabwe have implemented this complementary method with promising results.<sup>boxviii</sup> PrEPWATCH estimates a current PrEP user rate of 1,500–2,000 in Zimbabwe and 4,000–5,000 in South Africa.<sup>boxix</sup> Other prevention methods apart from PrEP and the female and male condom are voluntary medical male circumcision (VMMC) and post-exposure prophylaxis (PEP).<sup>9</sup>

### 8.1.6 Mother-to-child transmission

Mother-to-child transmission (MTCT) is the transmission of HIV from a mother to her child during pregnancy, labour, delivery or breast-feeding. MTCT is also referred to as 'vertical transmission' and is the cause of the majority of new HIV infections in children. MTCT is measured by the estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months. To calculate this, the estimated number of children newly infected with HIV as a result of MTCT among children born to HIV-positive women in the previous 12 months is divided by the estimated number of HIV-positive women who delivered in the previous 12 months. In 2013, ESA had the highest rates of children born to HIV-positive women testing positive for HIV within two months of birth; MTCT was lower in Western and Central Africa (see Figure 8.8).

**Figure 8.8. Children born to HIV-positive women tested for HIV within two months of birth, by region (%)**<sup>boxxii</sup>

Without intervention, the transmission rates range from 15% to 45%. Effective interventions during pregnancy, labour, delivery and breast-feeding can reduce this to below 5%.<sup>boxxi</sup> Treatment consists of ART for the mother, a short course of ARV drugs for the baby and appropriate breast-feeding practices. Without treatment, about a third of children living with HIV die by their first birthday and half by their second.<sup>boxxii</sup> It is also important for HIV-negative pregnant women to remain negative; owing to their pregnancy, HIV-negative women are at a higher risk of acquiring HIV and transmission is increased as the viral load is high after being newly exposed.<sup>boxxiii</sup>

HIV-positive pregnant women can be exposed to discriminatory practices, such as receiving inaccurate information or inappropriate treatment. Failure to provide care during labour and forced or coerced sterilisation are also

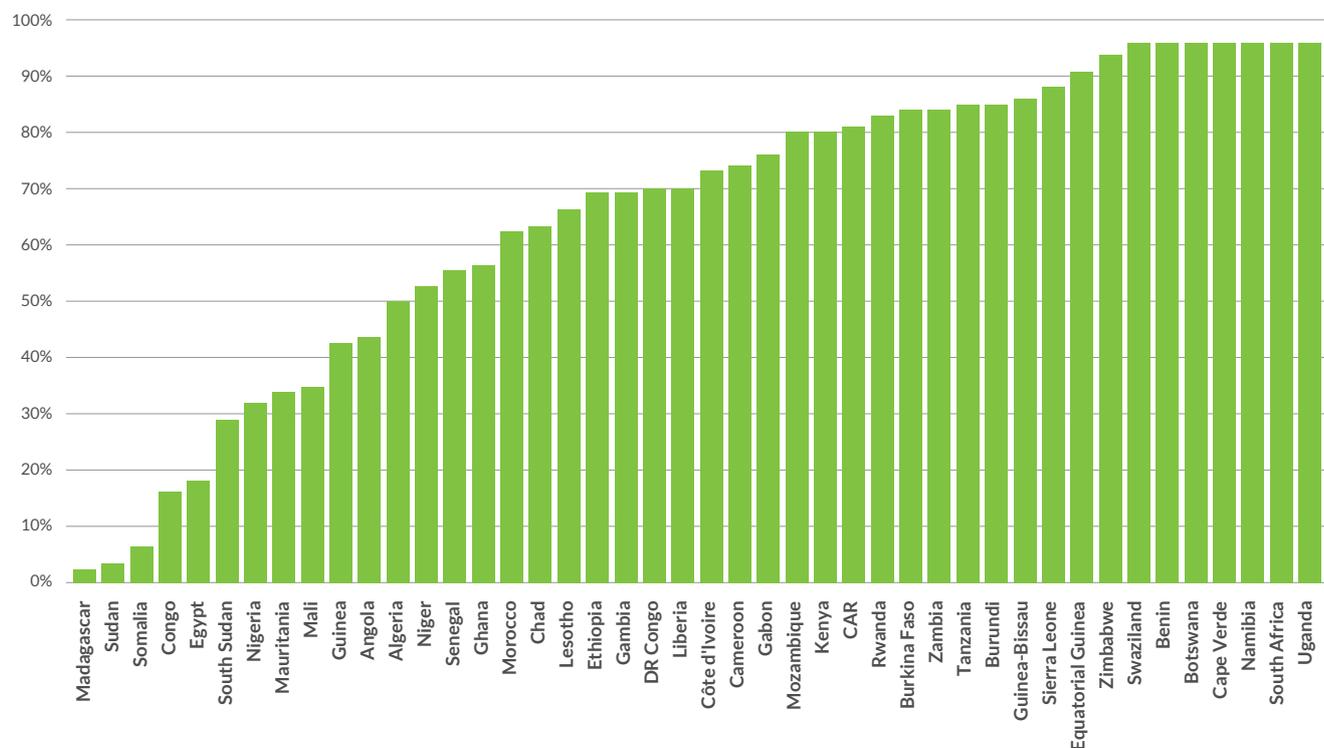
important concerns. In fact, 'Women who have faced HIV-related stigma and discrimination are less likely to access pre- and post-natal treatment and care.'<sup>boxxiv</sup> These practices are detrimental to women's health as well as to efforts to eliminate MTCT.

<sup>8</sup> These are medicines that should be taken daily in order to prevent the virus from establishing a permanent infection. It is provided to people who do not have HIV but who are exposed to substantial risk of infection.

<sup>9</sup> For more on these methods please refer to WHO HIV/AIDS Fact Sheet: [www.who.int/mediacentre/factsheets/fs360/en/](http://www.who.int/mediacentre/factsheets/fs360/en/)

Impressive progress has been reported in 21 countries<sup>10</sup> in which 88% of pregnant women living with HIV reside, under the Free Stay Free AIDS Free Framework to end AIDS among children, adolescents and young women by 2020.<sup>11</sup> In 2016, several of these countries reduced MTCT to under 5%. Five African countries have achieved 95% coverage of ARV treatment: Botswana, Namibia, South Africa, Swaziland and Uganda. This is also reflected in Figure 8.9 which gives an overview of national data on coverage of pregnant women who receive ARV for pMTCT across Africa (see Figure 8.9).<sup>bxxxv</sup>

**Figure 8.9. Pregnant women living with HIV receiving ARV medicines\* to prevent MTCT (%)**<sup>bxxxvi</sup>



Note: \* Either prophylaxis or lifelong therapy.

<sup>10</sup> These 21 countries are Angola, Botswana, Burundi, Cameroon, Chad, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, United Republic of Tanzania, Uganda, Zambia, Zimbabwe

<sup>11</sup> This is an initiative of UNAIDS and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) with other partners, and is a super-fast-track framework for ending AIDS in children, adolescents and young women by 2020. <https://free.unaids.org/>

## 8.2 CONTINENTAL AND REGIONAL POLICY FRAMEWORKS

HIV and AIDS is addressed in the Constitutive Act of the AU (2000), where ‘the eradication of preventable diseases and the promotion of good health on the continent’ is explicitly stated as an objective (Obj. n). In 2004, the Solemn Declaration on Gender Equality in Africa underlined the gender-specific nature of the HIV pandemic, calling for accelerated ‘implementation of *gender specific* economic, social and legal measures aimed at combating the HIV/AIDS pandemic’ (Agreement 1, emphasis ours). It continues by stating that ‘Treatment and social services are available to women at the local level’, in such a way that they are responsive to the needs of families providing care. In addition, it calls to ‘enact legislation to end discrimination against women living with HIV/AIDS and for the protection and care for people living with HIV/AIDS, particularly women’. Finally, it calls to ensure ‘budgetary allocations in these sectors so as to alleviate women’s burden of care’. AIDS Watch Africa (AWA) is established as a unit within the Office of the Chairperson of the AUC, to publish annual reports on the HIV and AIDS situation on the continent and to ‘promote the local production of anti-retroviral drugs in our countries’ (Agreement 10).<sup>12</sup>

### 8.2.1 The Maputo Protocol and General Comment No. 1

The Maputo Protocol speaks to HIV and AIDS and women’s rights under Article 14 on Health and Reproductive Rights. The Maputo Protocol is the first internationally legally binding instrument that specifically deals with HIV and AIDS. Art. 14 asserts the need to protect and respect ‘the right to health of women, including sexual and reproductive health’.

#### Maputo Protocol – Art. 14.1 (d) and (e) and Art. 14.2

##### Article 14.1

(d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS

(e) the right to be informed of 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 recognized standards.

##### Article 14.2

(a) States Parties shall take all appropriate measures to provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas.

In 2012, the ACHPR adopted **General Comment No. 1 on Art. 14.1 (d) and (e)**, in order to guide full implementation of these Maputo Protocol provisions, which were considered to be framed in relatively open-ended and broad terms. The General Comment provides interpretative guidance on these provisions by articulating ‘the specific measures to be taken by States Parties in order to fulfill their obligations’. It also provides more detail on international standards and best practices for the effective implementation of the provisions of Art. 14.1 (d) and (e). The guidance provided is considered relevant not only in the context of the risk of non-compliance by state parties but also because of the risk of women’s human rights being violated through inaction and ignorance. The General Comment articulates two aspects: the normative content of the article in the Maputo Protocol and then the obligations of state parties in relation to those.

General Comment No. 1 underlines the importance of recognising and addressing the intersections between women’s human rights and HIV. It also underlines that women’s right to the highest attainable standard of health includes SRHR, and that women are unable to enjoy these rights in the context of high HIV prevalence and significant risk of exposure to and transmission of HIV. Moreover, women living with HIV have limited or no access to these rights, owing to HIV-related discrimination, stigma, prejudices and harmful customary practices. The General Comment therefore stresses that Art. 14.1 (d) and (e) ‘should not be read or understood in isolation from other provisions in the Protocol dealing with the intersecting aspects of women’s human rights, such as gender inequality, gender-based violence, harmful customary practices, and access to socio-economic rights’ (Introduction). Whereas General Comment No. 1 focuses on HIV and AIDS, in light of the disproportionate effect of HIV and AIDS on women’s health in Africa, it reasserts that Art. 14.1 (d) and (e) also applies to STIs.

<sup>12</sup> AWA was created at the Abuja 2001 Special Summit, and is an entity of the AU with the specific mandate to lead advocacy, accountability and resource mobilisation efforts to advance a robust African response to end AIDS, tuberculosis and malaria by 2030. Its work is grounded in the AU Heads of State and Governments’ political commitments to prioritise AIDS, tuberculosis and Malaria (Abuja Declarations) and the broader health and development agenda. [www.aidswatchafrica.net/index.php](http://www.aidswatchafrica.net/index.php)

## 8.2.2 The right to self-protection and to be protected from HIV and STIs

Art. 14.1 (d) provides for women and girls' right to self-protection and to be protected from HIV and STIs. General Comment No. 1 interprets this to refer to 'states' overall obligation to create an enabling, supportive, legal and social environment that empowers women to be in a position to fully and freely realise their right to self-protection and to be protected' (para. 10).

The right to self-protected and be protected 'includes the right to access information, education and sexual and reproductive health services'. It is also 'intrinsicly linked to the right to equality and non-discrimination, life, dignity, health, self-determination, privacy and the right to be free from all forms of violence' (para. 11). General Comment No. 1 recognises that discrimination occurs in multiple forms and this prevents women and girls from realising their right to be self-protected and to be protected from HIV and STIs.

The right to self-protection and to be protected from HIV and STIs translates into several specific obligations for state parties. This first entails the obligation to guarantee *access to information and education* on sex, sexuality, HIV and sexual and reproductive rights. This information should cover HIV risk and transmission, prevention, testing, treatment, care and support and women's SRHR. It should be evidence-, facts- and rights-based, non-judgemental and understandable in content and language, and also address and deconstruct taboos, misconceptions and gender stereotypes. Chapter 7 discussed the features of comprehensive sexuality education (CSE) in more detail (in Section 7.2.2) –also in the context of the ESA Commitment, which has a strong reduction, and eventually elimination, in HIV prevalence among adolescents and youth as one of its key targets for 2020 (Case study 21 in Chapter 7).

Second, the right translates into access to *SRH services* (see also Chapter 7). General Comment No. 1 articulates a concern about limitations on and insufficient access to women's SRH services. It emphasises that these should be available to *all* women, and that this should not be based on a discriminatory assessment of risk (para. 30). In this context, women and girls' access to SRH services cannot be denied based on conscientious objection (para. 31).

Third, the enabling *legal and policy framework* should allow for women and girls 'to control their sexual and reproductive choices' and as such to strengthen their control over HIV prevention and protection choices (para. 33). This requires a non-discriminatory framework, as articulated in Art. 2 of the Maputo Protocol. This calls in particular for anti-discrimination legislation in relation to HIV and other STIs, and specifically to address related discrimination, stigma, prejudices and practices that heighten women's risk to HIV and related rights violations. Discrimination is noted to be based on various grounds, such as 'race, sex, sexuality, sexual orientation, age, pregnancy, marital status, HIV status, social and economic status, disability, harmful customary practices and/or religion' (para. 4). In cases where discriminatory laws and policies exist, states must take immediate action to remove these legal and policy barriers. Non-discrimination based on HIV is reiterated in General Comment No. 2 (discussed in Chapter 7, Section 7.2.3), which explicitly requires that HIV *testing* not be used as a condition for accessing contraception and safe abortion services. Moreover, it also mandates that positive test *results* 'must not serve as pretexts of the use of coercive practices or the suspension of service provision' (para. 59 of General Comment No. 2).

## 8.2.3 The right to be informed on one's health status and the health status of one's partner

The second specific article on HIV and STIs provides for the right to be **informed on one's health status**<sup>13</sup> and the health status of one's partner. This right, provided for in Art. 14.1 (e), encompasses a number of elements. First, it concerns the rights of women to 'access adequate, reliable, non-discriminatory and comprehensive information about their health'. This includes procedures, methods and technologies to determine one's health status, such as HIV testing, CD4 count, viral load, tuberculosis and cervical cancer screening (para. 13).<sup>14</sup> Second, the right to be informed also encompasses counselling, both pre-test (so decisions on testing can be based on informed consent) and post-test (e.g. on preventive measures or available treatment) (para. 14). Again, the applicability of these rights to all women is stressed in General Comment No. 1; this means irrespective of their marital status, and including young and adolescent women, women living with HIV, migrant and refugee women, indigenous women, detained women and women with physical and mental disabilities (para. 15).

<sup>13</sup> Health status 'refers to the complete state of a person's physical, mental and social well-being and not merely the absence of disease or infirmity' (General Comment No. 1, para. 12).

<sup>14</sup> New methods and technologies for protecting against HIV infection that are currently being tested in clinical trials include HIV vaccines and the vaginal ring for HIV prevention.

The right to be informed on the **health status of one's partner** is stressed as vital for women to make informed decisions about their health, and can help avoid transmission of HIV and other STIs. General Comment No. 1 pays specific attention to the normative content of this right. It emphasises that informed consent is key in obtaining information on a partner's health status, and that such information cannot be obtained with coercion and should be aimed primarily at preventing harm to one's health. This calls for caution, especially when 'revealing of a partner's health status may result in negative consequences such as harassment, abandonment and violence' (paras 16 and 17). General Comment No. 1 further articulates that 'Information about a partner's health status may be obtained through **notification** by a third party (usually a health worker) or **disclosure**<sup>15</sup> (e.g. by the person him/herself)' (para. 18). Disclosure can be implicit.

General Comment No. 1 articulates a set of principles to guide health care workers in deciding whether to inform a patient's sexual partners of his or her HIV positive status (see Box 8.2). It is emphasised that, 'While disclosure should be encouraged, there should be no requirement to reveal one's HIV status or other information related to one's health status' (para. 19). Health workers should be authorised, without being obliged to decide on informing a patient's sexual partners, taking into account the nature of the situation and according to ethical considerations.

#### Box 8.2. Principles and guidelines for revealing of a person's health status by a third party (General Comment No. 1)

The revealing of a person's health status by a third party outside the ambit of the below-mentioned guidelines is unlawful and may lead to penal sanctions.

1. The HIV-positive person has been thoroughly counselled.
2. Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes.
3. The HIV-positive person has refused to notify, or consent to the notification of, his/her partner(s).
4. A real risk of HIV transmission to the partner(s) exists.
5. The HIV-positive person is given reasonable advance notice.
6. The identity of the person is not revealed to the partner(s), if practicable, otherwise identity is revealed.
7. Follow-up is provided to ensure support to those involved, as necessary.
8. The person providing HIV treatment, care or counselling services has ensured that the person living with HIV is not at risk of physical violence resulting from the notification.

The right to be informed of one's health status and on the health status of one's partner translates into a set of obligations for states.

### 8.2.4 Obligations of states

When discussing both the right to self-protection and to be protected (Art. 14.1 d), and the right to be informed on one's health status and on the health status of one's partners (Art. 14.1 e), the specific obligations of states are addressed. This sub-section summarises these together with several overarching specific obligations, related to removing barriers, providing financial resources and setting up mechanisms for redress in case of violations (see Table 8.5). In addition to these specific obligations, General Comment No. 1 articulates *general* state obligations; these concern four sets of obligations on state parties—namely to respect, protect, promote and fulfil.

- To **respect**—requires states to refrain from interfering directly or indirectly with rights to self-protection, to be protected and to be informed on one's health status and the health status of one's partner.
- To **protect**—requires states to take measures that prevent third parties from interfering with these rights.
- To **promote**—requires states to create the legal, social and economic conditions that enable women to exercise their rights in relation to SRH.<sup>16</sup>
- To **fulfil**—requires states adopt all the necessary measures, including allocation of adequate resources, for the full realisation of these rights.

<sup>15</sup> 'Disclosure of one's health status is not always explicit. It may take various forms, including coded and implicit actions, by the person concerned. Coded or implicit actions may include disclosure that allows for the communication of a person's health status in a manner other than direct verbal dialogue. States must ensure that all forms of disclosure are recognized' (General Comment No. 1, para. 18)

<sup>16</sup> This involves engaging in sensitisation activities, community mobilisation and training of health care workers, religious, traditional and political leaders on the importance of the right to protection and to be informed on one's health status and the health status of one's partner.

**Table 8.5. Specific state obligations on Art. 14.1 (d) and (e), on women and girls' human right and HIV and AIDS**

General Comment No. 1 provides the interpretative guidance on the obligations of states on women and girls' human rights and HIV and AIDS, as reflected in Art. 14.1 (d) and (e).

Regarding Maputo Protocol Art. 14.1 (d)	
<b>Access to information and education</b>	<p>Guarantee information and education on sex, sexuality, HIV and sexual and reproductive rights to women, in particular adolescents and youths (evidence-, facts- and rights-based, non-judgemental and understandable; deconstructing taboos, misconceptions and gender stereotypes).</p> <p>Provide education programmes and access to information concerning HIV, including through sex education and public awareness campaigns,<sup>16</sup> on available health services responsible to <i>all</i> women's realities.<sup>17</sup> Include in curricula of educational institutions as well as in education that reaches women and girls in informal school systems, including faith-based schools.</p> <p>Provide appropriate pre-service and on-going in-service training to health providers and educators on health and human rights.</p>
<b>Access to SRH services</b>	<p>Ensure comprehensive, integrated, rights-based, women-centred and youth-friendly services that are free of coercion, discrimination and violence.</p> <p>Address limitations on and insufficient access to SRH services, especially HIV prevention and treatment. Guarantee available, accessible, affordable, comprehensive and quality women-centred HIV prevention methods (including female condoms, microbicides, prevention of MTCT (PMTCT) and PEP <i>to all women not based on a discriminatory assessment of risk</i>).</p> <p>Ensure health workers are not allowed, on the basis of religion or conscience, to deny access to SRH services.</p> <p>Integrate women-centred prevention methods in other services and promote access to such methods, including through planning, funding and distribution of new methods.</p>
<b>Enabling legal and policy framework</b>	<p>Create an enabling supportive, legal and social environment to allow women to control their sexual and reproductive choices, and thus to strengthen control over HIV prevention and protection choices.</p> <p>Ensure implementation of laws and policies through accountability mechanisms, implementing guidelines, a monitoring and evaluation framework and the provision of timely and effective redress mechanisms.</p> <p>Enact laws and policies to ensure women's access to health and legal services. Remove discriminatory legal and policy barriers. In particular, enact anti-discrimination legislation to address HIV and other STIs and related discrimination, stigma, prejudices and practices that perpetuate and heighten women's risk to HIV and related rights abuses.</p>
Regarding Maputo Protocol Art. 14.1 (e)	
<b>Access to information and education</b>	<p>Ensure access to information and education as highlighted above.</p> <p>Public health legislation should ensure pre- and post-test counselling is provided in all cases.</p> <p>Ensure information on one's health status held by authorities is subject to strict rules of data protection and confidentiality.</p>
<b>SRH procedures, technologies and services</b>	<p>Guarantee the availability, accessibility and affordability of comprehensive and quality procedures, evidence-based technologies and services for the medical monitoring of one's SRH, appropriate to the specific needs and contexts of women (including HIV testing, CD4 count, viral load, tuberculosis and cervical cancer screening)</p> <p>Provide training for health workers on, among others, non-discrimination, confidentiality, respect for dignity, autonomy and informed consent in the context of SRH services for women.</p> <p>Ensure testing is not used as a condition for access to other health services (including treatment, contraception, abortion, medical examination, ante- and post-natal services or any other reproductive health care). Also, positive test results should not be a basis for coercive practices, or the withholding of services.</p> <p>Ensure policies and programmes are sensitive to the needs of all women, and include youth-friendly services.</p> <p>Ensure procedures, technologies and services comply with ethical standards and are confidential, voluntary and obtained with informed consent.</p> <p>Create safe, enabling and positive conditions for informed disclosure and lawful notification on one's health status and the health status of one's partner</p>
Regarding both Arts 14.1 (d) and (e)	
<b>Barriers to SRHR</b>	<p>Take all appropriate measures to eliminate all barriers to women and girls' enjoyment of SRH.</p> <p>Take specific efforts to address gender disparities, harmful and traditional practices, patriarchal attitudes, discriminatory laws and policies.<sup>18</sup></p> <p>Take all appropriate measures to eliminate economic and geographic barriers of women in accessing health services and bring services closer to communities, especially to women in rural communities.</p>
<b>Provision of financial resources</b>	<p>Fund and empower public health authorities to provide a comprehensive range of services for the prevention and treatment of every person's SRH.<sup>19</sup></p>
<b>Redress for SRH violations</b>	<p>Ensure the availability and accessibility of redress and referral mechanisms such as legal and medical services in cases of violations of women sexual and reproductive rights, including non-discrimination, confidentiality, respect of autonomy and informed consent.</p> <p>Submit timely periodic reports on measures taken to implement the African Women's Rights Protocol in line with Art 26(1).<sup>20</sup></p>

<sup>17</sup> Information including HIV risk and transmission, prevention, testing, treatment, care and support and SRHR of women.

<sup>18</sup> All women, including young and adolescent women, older women, rural women, women who engage in sex work, women who use drugs, women living with HIV, migrant and refugee women, indigenous women, detained women and women with physical and mental disabilities (para. 15, General Comment No. 1).

## 8.3 NATIONAL LEGAL AND POLICY FRAMEWORKS

This section looks at the legal and policy frameworks at the national level regarding women's rights and HIV and AIDS. It tracks a selected number of legal and policy indicators at the national level to see the extent to which the Maputo Protocol provisions are being domesticated and implemented. These legal and policy indicators are complemented with a narrative analysis on the legal, policy and institutional changes in the countries. In the next and final section of this chapter, case studies shed light on strategies of change towards domestication and the realisation of women and girls' rights.

This section takes into account five legal and policy indicators on women and girls' rights and HIV and AIDS; these are presented in Table 8.6. Three indicators are of a legal nature and the other two are policy indicators. The first legal indicator concerns whether non-discrimination on the basis of HIV is guaranteed in the law. The second looks at the legal provisions regarding HIV testing and counselling. The scoring for this indicator can be that the legal provisions specify that testing is (a) voluntary or (b) mandatory. A third option here is that there are no legal provisions or guarantees regarding HIV testing; a fourth score is 'missing', for those countries where data such legal provisions could not be found.

The third legal indicator concerns the criminalisation of the wilful transmission of HIV. This captures whether a law to this extent is in place or not; such provisions can be in a penal code, sexual offences act, HIV policy or specific legislation. The indicator looks at the wilful transmission of HIV. Unlike all other indicators in this report, it is coded in yellow and blue, rather than red and green. This is to illustrate that criminalisation of wilful transmission is contested, and that, in theory, such legal provisions can both enhance and constrain women and girls' rights. Women and girls can be exposed to wilful transmission of HIV and suffer grievous bodily harm. But they can also be disproportionately and unrightly accused of wilfully transmitting HIV, and this can further marginalise minority groups, including sex workers. Yet the criminalisation can be counterproductive from a public health perspective, and can constitute a legal discriminatory barrier for women and girls living with HIV and AIDS.

The next two indicators are policy indicators. The fourth concerns whether there is a government programme providing access to ART. The fifth looks at the presence of government programming regarding MTCT. These indicators both look at whether or not such a policy and programmatic response is in place; the indicators themselves do not track the effectiveness of such programmes, or how many women and girls are reached by and benefit from these.

This section discusses trends, gaps and contestations on these five legal and policy indicators. This starts with a brief overview of these indicators for the African continent as a whole, and the main differences between regions. This is then followed by a more detailed discussion of countries, clustered in the five regions: Western, Eastern, Central, Southern and Northern.

**Table 8.6. HIV and AIDS: legal and policy indicators**

Name/description of indicator	Codes	Explanation of the indicator codes
Indicator 1 – Non-discriminatory legislation based on HIV	Yes	Legislation on non-discrimination on basis of HIV is in place
	No	Legislation on non-discrimination on basis of HIV does not exist
	M	Missing data: no data found on whether this legislation exists or not
Indicator 2 – Voluntary testing guaranteed	VOL	a. HIV testing and counselling is voluntary, or provider-initiated with an opt-out b. Footnote added in case voluntary testing is guaranteed, and there is an exception allowing for forced testing of people being tried for sexual offences
	MAN	There is a regulation that indicates HIV testing is mandatory for specific groups or circumstances, or that there are exceptions to voluntary testing (i.e. pregnant women, pre-marital testing)
	ABS	There is no regulation regarding HIV testing and counselling
	M	Missing data: no data found on whether regulations exist regarding HIV testing and counselling
Indicator 3 – Criminalisation of wilful transmission of HIV	Yes	There is legislation that criminalises wilful transmission of HIV
	No	There is no legislation that criminalises wilful transmission of HIV
	M	Missing data: no data found on whether this legislation exists or not
Indicator 4 – Programmatic response to access ART	Yes	A government programmatic response to access ART is in place (can be a pilot)
	No	There is no government response to access ART
	M	Missing data: no data found on presence of government programmatic responses on access to ART
Indicator 5 – Programmatic response on MTCT	Yes	A government programme is in place on MTCT
	No	There is no government programme on MTCT
	M	Missing data: no data found on presence of government programmatic responses on MTCT

<sup>19</sup> In line with Arts 2 and 5 of the Protocol.

<sup>20</sup> In line with Art. 26(2) of the Protocol and para. 7 of the MPoA.

<sup>21</sup> In line with Art. 26(1) of the Protocol.

Table 8.7 presents an overview of legal and policy frameworks regarding women and girls' rights and HIV and AIDS. (For an explanation of the regional units used here, see Section 1.6.3 in Chapter 1.) Please note that the total for the continent has been recalculated, as some countries are included in more than one region.<sup>22</sup> The main trends are that the majority of countries (35) have legislation in place that ensures non-discrimination on the basis of HIV status. Sixteen countries lack such legislation, mostly in Eastern Africa (the Horn), Northern and Central Africa. For four, this could not be established (missing data). Most countries also have provisions regarding HIV testing, and the majority (39) have legal regulations ensuring voluntary testing. For 10 countries, it could not be established whether they have policy or legal regulations that ensure voluntary testing (missing data).<sup>23</sup> In a notable minority of countries, HIV testing is mandatory for specific groups (Togo, for sex workers; Burundi and Uganda, for pregnant women; Angola and Chad, for medical procedures). In Eritrea, regulations ensuring voluntary HIV testing are absent.

The vast majority of countries have a programmatic response to access ART in place, and also have a programmatic response on MTCT of HIV. The only exceptions to this are Comoros (missing data regarding MTCT response), The Gambia (missing data on an ART programmatic response), Equatorial Guinea (missing data on both an ART and a MTCT programmatic response) and Tunisia (lacking a programmatic response on MTCT).

A key trend on the continent has been the criminalisation of the wilful transmission of HIV. More than six out of ten countries in Africa have adopted such legislation, and some others are considering doing so. This trend has raised controversy in the different regions, as these laws tend to further stigmatise people living with HIV and AIDS and certain sexual conducts, and also violate the right to dignity and privacy. Criminalisation of non-disclosure, exposure and transmission of HIV as well as of sexual and HIV-related conduct pose a threat to VCT and access to information, education and SRH services for people living with or at risk of HIV. As such, this type of legislation can be counterproductive from a public health perspective. The significance of these laws needs to be considered in the broader legal and policy frameworks regarding HIV and AIDS. When comparing trends in legal reform on non-discrimination and voluntary testing on the one hand, and criminalisation of wilful transmission of HIV on the other (see also comparison of Maps 6 and 7 in Chapter 2, Section 2.6.3), half of the 35 countries that criminalise wilful transmission of HIV also have legislation in place to ensure non-discrimination and voluntary testing. For the other half, these legal guarantees are not present: nine countries that criminalise wilful transmission of HIV lack guarantees for voluntary testing, three lack legislation on non-discrimination on the basis of HIV and five lack both. This means their legal frameworks lean more towards criminalisation than protecting and promoting the rights of women and girls living with HIV and AIDS.

Another set of laws that function as legal discriminatory barriers to accessing SRH services, including HIV testing and treatment, are those that criminalise and outlaw same-sex sexual acts. Three out of ten African countries criminalise and outlaw same-sex sexual acts;<sup>24</sup> in three countries same-sex sexual acts are punishable by death (Mauritania, Nigeria and Sudan). Twenty-one countries do not criminalise same-sex sexual acts; these include both countries that do not have a legal provision on the topic and countries that once had but have now removed a provision that criminalised same-sex acts.<sup>25</sup> South Africa is the only country that has legalised same-sex partnership and marriage. Mauritius' criminalisation of same-sex sexual acts is contradicted by the recognition of the right to non-discrimination based on sexual orientation.<sup>26, 27</sup> Stigmatisation and discriminatory attitudes and practices towards sexual orientation and gender diversity exist in virtually all African countries.

<sup>22</sup> A few countries are part of more than one of the regions used as analytical units here. For the continent 'total', these countries should be counted only once. (Angola and DRC are in both the Central and the Southern regional units, Rwanda and Burundi are in both Eastern and Central Africa and Tanzania is in both Eastern and Southern Africa).

<sup>23</sup> Algeria, Cape Verde, Equatorial Guinea, Gabon, Guinea, Guinea-Bissau, Mali, Mauritania, Niger and Western Sahara.

<sup>24</sup> In Western Africa: The Gambia, Ghana, Guinea, Liberia, Nigeria, Senegal, Sierra Leone and Togo. In Eastern Africa: Burundi, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, Sudan, Tanzania and Uganda. In Central Africa: Angola, Burundi and Cameroon. In Southern Africa: Angola, Botswana, Malawi, Mauritius, Namibia, Swaziland, Tanzania, Zambia and Zimbabwe. In Northern Africa: Algeria, Libya, Mauritania, Morocco and Tunisia.

<sup>25</sup> These 21 countries are all countries not listed in the previous footnote, minus South Africa, which has legalised same-sex partnership and marriage.

<sup>26</sup> Which is recognised in Mauritius' Equal Opportunities Act of 2008 and the Code of Ethics for Public Officers.

<sup>27</sup> Based on Carroll, A. and Mendos, L.R. (2017). 'State Sponsored Homophobia: A World Survey of Sexual Orientation Laws: Criminalisation, Protection and Recognition'. Geneva: ILGA.

Table 8.7. Continental and regional overview of legal and policy indicators, HIV and AIDS

HIV and AIDS	INDICATORS															
	Non-discrimination legislation based on HIV			Policy and/or legal regulations regarding voluntary HIV testing				Criminalisation of wilful transmission of HIV			Programmatic responses to access to ART			Programmatic response to MTCT		
	Y	N	M	VOL	MAN	ABS	M	Y	N	M	Y	N	M	Y	N	M
Western (15)	12	2	1	9	1	0	5	11	4	0	14	0	1	15	0	0
Central (11)	6	3	2	6	3	0	2	10	1	0	10	0	1	10	0	1
Eastern (11)	5	6	0	8	2	1	0	8	3	0	11	0	0	11	0	0
Southern (16)	15	1	0	15	1	0	0	10	6	0	16	0	0	15	0	1
Northern (7)	1	5	1	4	0	0	3	1	2	4	6	0	1	5	1	1
Total (55) <sup>27</sup>	35	16	4	39	5	1	10	35	16	4	52	0	3	51	1	3

<sup>28</sup> Excluding regional duplicates.

### 8.3.1 Western region

#### Trends, gaps and contestations

The national legal and policy frameworks in the Western region appear to be relatively strong regarding women and girls' rights and HIV and AIDS. Few countries have a mixed picture (Cape Verde, The Gambia, Guinea and Togo). Seven of the fifteen countries score positively on non-discrimination legislation, voluntary testing, programmatic responses to ART and MTCT. Two-thirds of the countries in the region have adopted laws that criminalise wilful transmission of HIV.

**Table 8.8. Key legal and policy indicators in Western Africa, HIV and AIDS**

Country	INDICATORS				
	Non-discrimination legislation based on HIV	Policy and/or legal regulations regarding voluntary HIV testing	Criminalisation of wilful transmission on HIV	Programmatic responses to access ART	Programmatic responses on MTCT
Benin	Yes	VOL	Yes	Yes	Yes
Burkina Faso	Yes	VOL <sup>29</sup>	Yes	Yes	Yes
Cape Verde	No	-	Yes	Yes	Yes
Côte d'Ivoire	Yes	VOL	No	Yes	Yes
The Gambia	-	VOL	No	-	Yes
Ghana	Yes	VOL <sup>29</sup>	No <sup>30</sup>	Yes	Yes
Guinea	No	-	Yes	Yes	Yes
Guinea-Bissau	Yes	-	Yes	Yes	Yes
Liberia	Yes	VOL	Yes	Yes	Yes
Mali	Yes	-	Yes	Yes	Yes
Nigeria	Yes	VOL	No <sup>31</sup>	Yes	Yes
Niger	Yes	-	Yes	Yes	Yes
Senegal	Yes <sup>32</sup>	VOL	Yes	Yes	Yes
Sierra Leone	Yes	VOL	Yes	Yes	Yes
Togo	Yes	MAN <sup>33</sup>	Yes	Yes	Yes

#### Trends in legal, policy and institutional reform

**Constitutional provisions:** None of the countries in Western Africa have constitutional provisions explicitly with respect to the rights of PLWHIV. The Constitution of Cape Verde expands on the right to health by specifying that it shall be achieved through an adequate network of health services and the gradual creation of economic, social and cultural conditions necessary to guarantee the improvement of quality of life of the populations.

**Statutory law regarding HIV and AIDS:** Benin, Burkina Faso, Côte d'Ivoire, Ghana, Guinea-Bissau, Liberia, Mali, Nigeria, Niger, Senegal, Sierra Leone and Togo have all adopted HIV-specific laws that include provisions on *non-discrimination based on HIV*.<sup>30,31</sup> These laws cover the right of women with HIV to marry and have a family, and address discrimination and stigma linked to PLWHIV. They also address MTCT and access to and use of ART. Under the 2011 National HIV and AIDS Commission Act, the government of Sierra Leone pledges to take steps to ensure not only access to health care but also medicines at affordable prices for PLWHIV and those exposed to the risk of HIV infections. The legislation adopted in Benin and Nigeria is noteworthy as it places a specific emphasis on the rights of PLWHIV. The 2014 Nigerian Anti-Discrimination Act aims to eliminate all forms of discrimination based on HIV status, as well as giving effect to human rights guaranteed in Chapter 4 of the 1999 Constitution of the Federal Republic of Nigeria, but also recognises obligations under international and regional human rights and other instruments. Similarly, in Benin, Act No. 2005-31 of 10 April 2006 on the prevention, treatment and control of HIV and AIDS states that any person living with HIV shall enjoy without any discrimination his or her civil, political and social (housing, education, employment, health, social protection, etc.) rights.

<sup>29</sup> According to WHO, testing in Burkina Faso is voluntary and confidential and is mostly carried out by community-based organisations.

<sup>30</sup> According to Ghana's National HIV AIDS and STI Policy (2013), mandatory testing is required of persons charged with rape, defilement and incest.

<sup>31</sup> Although Ghana has not adopted legislation specifically on wilful transmission of HIV, it may be prosecuted under the Criminal Offences Act of 1960 and the Domestic Violence Act of 2007.

<sup>32</sup> According to AIDSmap.com, although there is no national HIV-specific law, the states of Enugu and Lagos passed HIV-specific laws that include provisions for prosecuting 'wilful' HIV transmission in 2005 and 2007, respectively. There are no reports of prosecutions. A draft national HIV-specific law focusing on human rights, with no criminalisation provisions, is proposed.

<sup>33</sup> Law 2010-03 of 9 April 2010, Art. 24, addresses discrimination against PLWHIV in the context of employment.

<sup>34</sup> Sex workers are subject to mandatory and periodic testing for HIV and STIs under Art. 50 of Law 2005-012.

With respect to laws that prohibit *wilful transmission of HIV*, 11 out of 15 countries in Western Africa have enacted such laws, based on the N'Djamena model law, developed in 2004 in N'Djamena by Action for West Africa Region-HIV & AIDS, in short (AWARE-HIV & AIDS).<sup>lxxxviii</sup> Côte d'Ivoire and The Gambia are currently discussing proposals on HIV-specific criminal laws. While Nigeria does not have national legislation that prohibits wilful transmission, two states—Enugu and Lagos—have passed HIV-specific laws criminalising 'wilful' HIV transmission. In Ghana, wilful transmission of HIV may be prosecuted under the Criminal Offences Act (1960) and the Domestic Violence Act (2007).

In nine of the countries in the Western Africa region, *HIV testing* is voluntary as stated in adopted legislation and/or policies. However, there are exceptions made, and in some cases and/or for certain groups testing is mandatory. In Togo, it is compulsory for sex workers to undergo periodic testing for HIV and STIs, under Article 50 of Law 2005-012.<sup>lxxxix</sup> Additionally, legislation in Côte d'Ivoire and Senegal places age restrictions with respect to access to HIV testing. For example, for persons under 16 in Côte d'Ivoire and persons under 15 in Senegal, the consent of parents or legal representative is required for an HIV test. Under Ghana's National HIV AIDS and STI Policy (2013), mandatory testing is required of persons charged with rape, defilement and incest.

**Policy and institutional reforms:** All the countries in the Western Africa region have developed policies and strategic plans on HIV and AIDS. The areas covered in the policies reviewed include addressing discrimination and stigma linked to PLWHIV, investment in HIV and AIDS research, PMTCT and access to ART. Liberia has an HIV/AIDS Policy that focuses specially on the education sector (2010). Notably, Guinea has a National Strategy Framework on HIV & AIDS for 2008–17 that includes effective means of addressing the concerns of women and girls. Guinea-Bissau specifically recognises women as a priority group in its National Strategic Plan on HIV & AIDS 2007–11.

Almost all countries in West Africa have put in place a *national body* that focuses exclusively on HIV and AIDS, with the exception of Benin. Cape Verde, Liberia, Nigeria and Sierra Leone all have adopted a multi-sectoral approach in their policy and/or institutional reform. For example, in Sierra Leone, the National HIV & AIDS Secretariat is responsible for coordinating a multi-sectoral team to reduce the spread of HIV and AIDS and mitigate its impact. This commitment is also reflected in the country's National Strategic Plan on HIV & AIDS 2016–20.

All countries in Western Africa have adopted *programmatic responses to access to ART*. In most cases, this is done in connection to preventing MTCT, such as in Nigeria. In Liberia, as part of the National HIV and AIDS Strategic Plan 2015–20, HIV-positive mothers are to be placed on a lifelong ART.

In addition, all countries in Western Africa have adopted programmes specifically addressing *PMTCT*. The Gambia is one of the few countries to have adopted a specific strategic plan focusing on the elimination of mother-to-child transmission (eMTCT). For example, the Gambia's National Strategic Plan for eMTCT – HIV 2013–15 proposes to prioritise elimination activities in areas with high unmet needs, with innovative interventions such as the PMTCT fast track and mother support groups introduced and re-introduced, respectively. In Liberia, the eMTCT initiative is part of the National HIV and AIDS Strategic Plan 2015–20.

## Key gaps and contestations

With respect to HIV and AIDS and women's rights, the **absence of legislation on non-discrimination based on HIV** in six of the fifteen countries is a first critical gap, as these countries do not have legal protection for PLWHIV. A human rights-based approach would strengthen their protection. A second legal gap is that **voluntary HIV testing and counselling is not guaranteed** in six of the fifteen countries, with one country explicitly demanding mandatory testing for sex workers. A third legal gap related to HIV testing is that **age restrictions** are placed on HIV testing in two countries, and that young people can access these services only with third party consent. A fourth and related concern is that HIV test results of a minor can be **disclosed**: in Côte d'Ivoire it is not illegal for a doctor to share the status of a minor with his/her parents or legal representative, under Art. 15 of Law No. 2014-430. Guinea-Bissau also allows results to be shared with parents of a minor, a guardian in the case of orphans or persons deemed incapable or a judicial authority having legally asked for the test. A fifth critical issue are the many countries that have adopted, or are considering adopting, laws that **criminalise wilful transmission of HIV**. The effects of such laws on women and girls' rights merit specific attention and need to be investigated.

Another sixth gap and contestation relates to the **criminalisation of same-sex sexual acts and relations**. In Western Africa, same-sex sexual acts are legal in only half of the countries: Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Guinea-Bissau, Mali and Niger. In these countries, the Penal/Criminal Code does not specify provisions outlawing same-sex sexual relations. The Gambia, Guinea, Liberia, Nigeria and Senegal criminalise same-sex sexual activity between both men and women whereas in Ghana, Sierra Leone and Togo this law applies to men specifically. In Nigeria, same-sex sexual acts are **punishable by death** codified under *Sharia* law. The death penalty is implemented provincially in 12 Nigerian states. Besides, Nigeria's same-sex marriage (prohibition) act specifically prohibits 'registration of gay clubs, societies and organisations, their sustenance, processions and meetings'. In addition, a person can be sentenced to 10 year in prison if he or she 'registers, operates or participates in gay clubs, societies organization or "supports" the activities of such organisations'. This complicates work of NGOs on SOGIE issues and hampers the provision of essential health services for LGBT, including HIV and AIDS services.<sup>xc</sup>

**Table 8.9. Countries that do and do not criminalise same-sex sexual acts, Western Africa**

Countries that criminalise same-sex sexual acts	Countries that do not criminalise same-sex sexual acts
The Gambia	Benin
Ghana	Burkina Faso
Guinea	Cape Verde
Liberia	Côte d'Ivoire
Nigeria*	Guinea-Bissau
Senegal	Mali
Sierra Leone	Niger
Togo	

\* same-sex sexual acts are punishable by death

With respect to policy and institutional reform, a seventh gap is that one in three countries do not have a programmatic response to **access ART**. Although all countries in the region address MTCT, there is an urgent need for policies/laws that would take into account the **specific need of women and girls living with HIV and AIDS** as well as their rights. Moreover, countries would gain from policies and programmes that include eMTCT strategies and providing continual access to treatment and care. A final gap is that there are few policy, programme and institutional mechanisms specially addressing the needs of **youth and adolescents with respect to HIV and AIDS**. Some countries have adopted multi-sectoral approaches at either policy or institutional level, thus it may be that the concerns of these groups are addressed.

### 8.3.2 Eastern region

#### Trends, gaps and contestations

The majority of countries in the Eastern region show a strong profile on four key indicators regarding women's rights and HIV and AIDS. Djibouti, Kenya and Tanzania all score positively on non-discrimination provisions on HIV, on guarantees for voluntary HIV testing and on programmatic responses to access ART and also MTCT. Burundi, Ethiopia, Rwanda, Somalia, South Sudan, Sudan and Uganda have three positive scores on these indicators. Eritrea stands out with positive scores on the policy indicators (access to ART and MTCT) but no legal provisions guaranteeing non-discrimination on the basis of HIV or VCT. Two-thirds of the countries in the region have adopted legislation that criminalises wilful transmission of HIV.

The EAC HIV Prevention and Management Act 2012 has been operational since December 2014 (see also Case study 28 in Section 8.4). Given the Constitution of the Community at the time, this happened following signature of the said Act 2014 by the then Tanzanian Head of State President Jakaya Kikwete.<sup>35</sup> South Sudan only recently joined the community and thus is yet to sign this Act.

**Table 8.10. Key legal and policy indicators in Eastern Africa, HIV and AIDS**

Country	INDICATORS				
	Non-discrimination legislation based on HIV	Policy and/or legal regulations regarding voluntary HIV testing	Criminalisation of wilful transmission on HIV	Programmatic responses to access ART	Programmatic responses on MTCT
Burundi	Yes <sup>35</sup>	MAN <sup>36</sup>	Yes	Yes	Yes
Djibouti	Yes	VOL	Yes	Yes	Yes
Ethiopia	No	VOL <sup>37</sup>	No	Yes	Yes
Eritrea	No	ABS	Yes	Yes	Yes
Kenya	Yes <sup>38</sup>	VOL <sup>39</sup>	Yes	Yes	Yes
Rwanda	No	VOL <sup>40</sup>	Yes	Yes	Yes
Somalia	No	VOL <sup>41</sup>	No	Yes	Yes
South Sudan	No	VOL	Yes	Yes	Yes
Sudan	No	VOL <sup>42</sup>	No	Yes	Yes
Tanzania	Yes	VOL <sup>43</sup>	Yes	Yes	Yes
Uganda	Yes	MAN	Yes	Yes	Yes

<sup>35</sup> In line with the EAC's regulations, an Act of the Community obtains this status once all member states have signed it.

<sup>36</sup> In addition to legislation on the legal protection of persons living with HIV, non-discrimination on the basis of HIV and AIDS status is also explicitly prohibited in the Constitution of Burundi in its non-discrimination clause in Art. 22.

<sup>37</sup> The prohibition of mandatory testing is too narrowly drafted such that mandatory testing is expressly prohibited only if it is carried out to allow or for continued stay in social or professional venues or activities.

<sup>38</sup> Under the PMTCT guidelines, testing of pregnant women is carried out under the provider initiated 'opt-out' HIV testing approach—that is, all pregnant women are provided with the test unless they expressly decline it.

<sup>39</sup> In addition to HIV-specific legislation, Kenya's Constitution prohibits discrimination on the basis of health status in its non-discrimination clause in Art. 27(4).

<sup>40</sup> Exception to prohibition of mandatory testing in the context of sexual offenders.

<sup>41</sup> The Reproductive Health Act provides for voluntary testing but mandatory testing may be required on request by competent organs in accordance with the law.

<sup>42</sup> PITC recommended under the National HIV Strategy 2014–19.

<sup>43</sup> PITC.

<sup>44</sup> Exception to prohibition of mandatory testing in the context of sexual offenders.

### *Trends in legal, policy and institutional reform*

**Constitutional provisions:** Out of all the states in the Eastern region, Burundi's Constitution is explicit with respect to the rights of persons living with HIV and AIDS. Art. 22 asserts that all citizens are equal before the law and that no Burundian citizen is to be the subject of discrimination on the basis of, among others, sex and/or HIV and AIDS status. Kenya has an implied provision as it prohibits discrimination on the basis of health status in Art. 27(4) of the Constitution. All countries in the region have provisions that can be utilised to advance the rights of girls and women living with HIV and AIDS. Generally, these focus on the principles of non-discrimination and equality before the law, the right to health, the right to inherent dignity and physical integrity and the right to privacy.

**Statutory law on HIV and AIDS and women's rights:** Only five of the twelve states have specific laws dedicated to the *rights of PLWHIV*: Burundi, Djibouti, Kenya, Tanzania and Uganda. These laws cover testing and disclosure, addressing discrimination and stigma linked to PWLHIV, PMTCT and access to and use of ART. In Kenya, these laws also grant access for HIV testing for adolescents who are below the age of consent (18) in specified circumstances. Six other states (Eritrea, Ethiopia, Rwanda, Somalia, South Sudan and Sudan) have laws that touch on the rights of PLWHIV in other rights areas—for instance labour/worker rights and rights related to GVAW. Art. 3(d) of Uganda's Prohibition of FGM Act also specifically states that aggravated FGM is considered to have taken place where HIV is transmitted as a result.

In eight of the twelve countries, HIV counselling and testing is voluntary. Burundi has a provision that prohibits mandatory testing but this has so many restrictions and exceptions that it effectively renders testing mandatory. Uganda's HIV Prevention and Control Act 2014 allows for mandatory testing of pregnant women living with HIV and AIDS. This infringes on the right to privacy in the 1995 Constitution and also goes against the EAC HIV and AIDS Prevention and Management Act. Eritrea lacks a provision or regulation on the character of HIV testing and counselling.

Two-thirds of the countries in the region have provisions that prohibit *wilful transmission of HIV and AIDS*. These are found either in HIV and AIDS legislation or in the penal code. Such legislation is not found in Ethiopia, Somalia and Sudan.

**Policy and institutional reform:** All states have a policy that directly focuses on and/or alludes to HIV and AIDS. This is in the context of national health policies and/or strategic plans or policies that are exclusively dedicated to the rights of PLWHIV (Burundi, Djibouti, Ethiopia, Kenya, Somalia, South Sudan, Sudan, Tanzania and Uganda). With the exception of Sudan, all these policies acknowledge that the HIV and AIDS pandemic disproportionately affects women, including girls and youth. The areas covered in said policies cover scaling-up efforts with regard to testing and disclosure, addressing discrimination and stigma linked to PWLHIV, PMTCT and access to and use of ART. Kenya has a policy to specifically address HIV and AIDS among adolescents (the Fast-Track Plan to End HIV and AIDS among Adolescents and Young People 2015). Notably, all the reviewed states have either policy or programmatic interventions on ART and MTCT.

In addition, all states have an *institutional mechanism/body* that exclusively addresses the rights of PLWHIV. From the desktop research conducted, with the exception of Kenya, whose National AIDS Control Council has a Committee on Gender to ensure the state's plans are responsive to gendered concerns arising out of HIV and AIDS, it was not possible to ascertain the extent to which these bodies have units that exclusively address the rights of girls and women living with HIV and AIDS.

## Key gaps and contestations

The key gaps in legal and policy reform regarding women and girls' rights and HIV and AIDS in the Eastern region are, first, the **absence of non-discrimination** provisions in six countries to protect women and girls living with HIV from stigma and discrimination. These countries are Ethiopia, Eritrea, Rwanda, Somalia, South Sudan and Sudan. A second gap relates to **the lack of legal guarantees for voluntary HIV testing and counselling**, in Eritrea, and **mandatory HIV testing** for pregnant women in Burundi and Uganda.

A third gap entails provisions that allow for **disclosure of HIV and AIDS status to third parties** in Burundi and Uganda. According to Art. 28 of Law Decree 1/018(2005) in Burundi, doctors are in a position to reveal the HIV status of a PLWHIV to their partner or spouse if they are unable to or do not want to. In Uganda according to Section 18 of the HIV Prevention and Control Act [2014], the disclosure is framed very broadly, as HIV test results may be disclosed to 'any other person with whom an HIV infected person is on close or continuous contact including a sexual partner'. These exceptions raise serious questions as to confidentiality and undermine the right of girls and women to make decisions concerning their own bodies, as articulated in the Maputo Protocol and the constitutions of these states.

A key contestation concerns the adoption of laws on **wilful transmission of HIV and AIDS**. Views on the meaning of such laws for women and girls' rights are diverse. Of the eight countries that criminalise wilful transmission of HIV, five lack legal provisions that strengthen a human rights perspective. Of these eight, Rwanda and South Sudan have mandatory testing provisions, Burundi and Uganda lack legislation ensuring non-discrimination and Eritrea lacks non-discrimination legislation on the basis of HIV, and also lacks guarantees for voluntary HIV testing.

Another contestation relates to the criminalisation of same-sex sexual acts. Djibouti and Rwanda are the only two countries in Eastern Africa where consensual same-sex sexual relations are not criminalised by provisions in the Penal Code. Contrastingly, Burundi, Eritrea, Somalia, South Sudan, Sudan and Uganda **criminalise same-sex sexual acts** between both men and women. In Kenya and Tanzania the criminalisation applies only to men. In Sudan, the death penalty can be applied to some consensual same-sex sexual acts codified under *Sharia* law and implemented countrywide, making it virtually impossible for NGOs to work on SOGIE issues in the country. To a lesser extent, SOGIE-based NGOs in Tanzania and Uganda face legal barriers, as there are laws prohibiting registration of NGOs whose activities are 'not for public interest' or 'contrary to national written law'.<sup>xci</sup>

**Table 8.11. Countries that do and do not criminalise same-sex sexual acts, Eastern Africa**

Countries that criminalise same-sex sexual acts	Countries that do not criminalise same-sex sexual acts
Burundi	Djibouti
Eritrea	Rwanda
Ethiopia	
Kenya	
Somalia	
South Sudan	
Sudan*	
Tanzania	
Uganda	

\* same-sex sexual acts are punishable by death

With respect to policy and institutional reform, an important gap is that, with the exception of Kenya, all states need to institute mechanisms that specifically address gendered concerns, with regard to the rights of girls and women living with HIV and AIDS. Moreover, when acknowledging the disproportionate effect of HIV and AIDS on women and girls, it is necessary for states to institute action plans that are solely dedicated to addressing issues that girls and young women face, beyond PMTCT. Such explicit attention to women and girls is missing in many health policies and even HIV and AIDS policies. Yet HIV and AIDS interacts with various other factors, such as sex, gender, socio-economic status, age, marital status and access to reproductive health care, which result in women and girls being more disparately infected and affected. Therefore, failing to consider these intersecting factors while addressing other health-related matters amounts to an ineffective HIV response that does not respond to women and girls' lived realities.

### 8.3.3 Central region

#### Trends, gaps and contestations

The national legal and policy frameworks of the countries in the Central region show similarities. CAR, Congo Republic and DRC have non-discrimination legislation on the basis of HIV, and regulations for voluntary testing in place, as well as programmatic responses to access ART and on MTCT. Angola, Burundi and Chad differ in their profile, given that HIV testing in these countries is/can be mandatory for certain groups. São Tomé and Príncipe provides for voluntary testing, but no data was found regarding non-discrimination provisions regarding HIV status. Cameroon, Gabon and Rwanda stand out for lacking legal provisions on non-discrimination on the basis of HIV. All countries, except São Tomé and Príncipe, have legislation that criminalises wilful transmission of HIV. Data on the legal and policy framework of Guinea Equatorial could not be obtained.

**Table 8.12. Key legal and policy indicators in Central Africa, HIV and AIDS**

Country	INDICATORS				
	Non-discrimination legislation based on HIV	Policy and/or legal regulations regarding voluntary HIV testing	Criminalisation of wilful transmission on HIV	Programmatic responses to access ART	Programmatic responses on MTCT
Angola	Yes	MAN <sup>44</sup>	Yes	Yes	Yes
Burundi	Yes <sup>45</sup>	MAN <sup>44</sup>	Yes	Yes	Yes
Cameroon	No <sup>47</sup>	VOL	Yes	Yes	Yes
CAR	Yes	VOL	Yes	Yes	Yes
Chad	Yes	MAN <sup>48</sup>	Yes	Yes	Yes
Congo Republic	Yes	VOL	Yes	Yes	Yes
DRC	Yes	VOL <sup>49</sup>	Yes	Yes	Yes
Equatorial Guinea <sup>50</sup>	-	-	Yes	-	-
Gabon	No <sup>51</sup>	-	Yes	Yes	Yes
Rwanda	No	VOL <sup>52</sup>	Yes	Yes	Yes
São Tomé and Príncipe	-	VOL	No <sup>53</sup>	Yes	Yes

#### Trends in legal, policy and institutional reform

**Constitutional provisions:** Except for Burundi, which prohibits discrimination on the basis of HIV and AIDS infection, none of the constitutions has provisions on non-discrimination based on health status. General provisions in articles on discrimination, however, such as 'discrimination established by... other similar reasons' (Equatorial Guinea) or 'discrimination on the basis of sex or any other form of discrimination' (Rwanda) could be understood to include health status.

Some states explicitly include the duty of states to provide support to health promotion and adequate and resourced health services (e.g. Angola, CAR, Congo Republic, Equatorial Guinea, Rwanda). No states have explicit provisions on HIV and AIDS or STIs (prevention, protection, services) in their constitutions. Nine out of eleven constitutions in the region mention the right to health and health care or other related health rights. The constitutions of DRC and São Tomé and Príncipe specifically address youth rights, including protection from ill health. The Constitution of Gabon mentions protection of the health of vulnerable groups such as children, mothers, disabled persons and the elderly.

<sup>45</sup> This is a mixture of the two, as Law 8/04 on HIV and AIDS (2004) provides that persons deprived of freedom must not be subjected to compulsory tests to detect HIV infection, except for those whose judicial process or medical condition so demands.

<sup>46</sup> In addition to in legislation on the legal protection of persons living with HIV, non-discrimination on the basis of HIV and AIDS status is explicitly prohibited in the Constitution of Burundi in its non-discrimination clause in Art. 22.

<sup>47</sup> The prohibition on mandatory testing is too narrowly drafted, such that mandatory testing is expressly prohibited only if it is carried out to allow or for continued stay in social or professional venues or activities.

<sup>48</sup> The Penal Code 2016 prohibits discrimination in public spaces and on the workforce on the basis of health status.

<sup>49</sup> Art 4. Has provisions allowing for compulsory HIV testing when ordered by a court.

<sup>50</sup> Loi no 08/011 du 14 juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées.

<sup>51</sup> Original documents for Guinea Equatorial were not found, therefore indicators could not be assessed.

<sup>52</sup> HIV legislation, including an article on discrimination and stigmatisation, was in the proposal stage in 2012.

<sup>53</sup> The Reproductive Health Act provides for voluntary testing but mandatory testing may be required on request by competent organs in accordance with the law.

<sup>54</sup> The Penal Code (Art. 182) aggravates punishment for sexual abuse when the perpetrator is a 'carrier of sexually transmitted disease, namely venereal or syphilitic disease' but does not address wilful transmission.

**Statutory law on HIV and AIDS:** Legal guarantees for PLWHIV are provided in HIV-specific laws or in reproductive health laws (e.g. Rwanda). Six out of eleven countries in the region have a HIV-specific law that includes rights to protection from *discrimination on the basis of HIV status* (Angola, Burundi, CAR, Chad, Congo Republic and DRC). In Cameroon, policies seem to compensate for the lack of a HIV-specific law: its National HIV and AIDS Strategy includes actions aimed at reducing stigmatisation and discrimination of PLWHIV or the requirement of voluntary testing. The Penal Code of Cameroon also criminalises discrimination on the basis of medical status in public spaces and on the workforce.

All (six) HIV-specific laws include articles on the *criminalisation of the wilful transmission of and exposure to HIV and AIDS*. Among francophone African countries, Congo Republic, in its specific HIV law, provides for most exceptions (seven in total) to criminal liability for wilful transmission.<sup>xcii</sup> Four countries that do not have a HIV-specific law refer to the penal code for criminalisation of transmission (Cameroon, Gabon, Rwanda, São Tomé and Príncipe).

Nine out of eleven countries have legal provisions regarding *HIV testing and counselling*, six of them on voluntary testing and three with circumstances under which mandatory testing is permitted. Rwanda has a Reproductive Health Act that includes articles on HIV and AIDS. It provides the right to voluntary testing for all and confidentiality of results; however, it also includes a provision that mandatory testing may be demanded on request by competent organs in accordance with the law. The HIV-specific laws of CAR, Chad and Congo Republic have provisions explicitly ensuring confidentiality and protection against *disclosure* of HIV test results. In Gabon and São Tomé and Príncipe, the penal codes provide for non-disclosure of medical information by professionals.

**Policy and institutional reforms:** An analysis of the available national HIV and AIDS strategic plans reveals that the extent to which women's rights are addressed varies. Congo Republic has a gender-disaggregated analysis of vulnerable groups and identifies a broad range of vulnerable women: female sex workers, girl-mothers, girls in secondary and tertiary schools, female entrepreneurs, widows and female heads of households, female employees in the public and private sector and indigenous women. The strategic plan also includes a gender and power analysis of vulnerabilities and social determinants of health.

Rwanda's National Strategic Plan on HIV/AIDS 2009–12 is an exception in that it prioritises monitoring and protection of seropositive women, women's access to justice and economic empowerment. Targets in the results framework are also sex-disaggregated. The strategic plan of São Tomé and Príncipe, by contrast, does not recognise women and adolescents as vulnerable groups and does not analyse the social determinants of health. Most other strategic plans mention vulnerable groups such as youth and adolescents, police officers, prisoners, mobile populations such as truck drivers and traders, pregnant women, indigenous people and orphans and vulnerable children, but often without addressing gender differences.

Over the past few years, Central Africa has received increased attention from the HIV and AIDS donor community because of the rise in new HIV infection and AIDS morbidity rates. Several initiatives have been launched to accelerate the HIV and AIDS response in the region. Cameroon and DRC were among 25 countries<sup>55</sup> with high numbers of new HIV infections in adolescents and adults that participated in the development of the Prevention 2020 Road Map, together with UNAIDS. This provides the basis for a country-led movement to scale up HIV prevention programmes. The countries seek to fast-track a comprehensive response to meet global and national targets and commitments to end AIDS<sup>56</sup> as a public health threat by 2030. The roadmap also emphasises the empowerment of adolescent girls, young women and key populations at risk so they can protect themselves and stay free of infection.<sup>xciii</sup>

Another fast-track initiative has been launched focused on engaging large cities in the fight against HIV and AIDS (see Box 8.3). In 2006, members of the Economic Community of Central Africa, with support from Germany, initiated the *Projet prévention du VIH/Sida en Afrique centrale* (Project for the Prevention of HIV/AIDS in Central Africa), which targets young people between 15 and 24 years old. More recently, the '*test and treat*' approach (reducing delays in starting ART by offering it as soon as people are diagnosed HIV-positive) has been adopted and is being implemented in Cameroon, CAR, DRC and Gabon.<sup>xciv</sup>

55 These countries are Angola, Brazil, Cameroon, China, Côte d'Ivoire, DRC, Ethiopia, Ghana, India, Indonesia, Kenya, Lesotho, Malawi, Mexico, Mozambique, Namibia, Nigeria, Pakistan, South Africa, Swaziland, Tanzania, Uganda, Ukraine, Zambia and Zimbabwe. See [www.unaids.org/sites/default/files/media\\_asset/hiv-prevention-2020-road-map\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf)

56 [www.fast-trackcities.org/about](http://www.fast-trackcities.org/about)

### Box 8.3. Fast-Track Cities Initiative in West and Central Africa

Mayors of several cities worldwide have signed the Declaration on Fast-Track Cities: Ending the AIDS Epidemic, under which they commit to accelerate and scale up their local AIDS responses. The initiative was launched on World AIDS Day 2014 in Paris. The initiative is meant to build on, strengthen and leverage existing HIV-specific and -related programmes and resources to 1) attain the 90-90-90 targets, 2) increase use of combination HIV prevention services and 3) reduce to zero the negative impact of stigma and discrimination. The initiators, in their Declaration, propose a human rights-based approach and access for all. Young women, female sex workers and transgender people are mentioned as key target groups. The initiative is a global partnership between the City of Paris, the International Association of Providers of AIDS Care, UNAIDS and UN-Habitat, in collaboration with local, national, regional and international partners and stakeholders.

As part of their commitment, Fast-Track Cities are expected to develop a city-specific action plan to achieve the objectives. Cities are encouraged to produce quarterly internal reports and make them available to local stakeholders, particularly affected communities. The initiative provides a city-specific web-based dashboard for each city to map eight simple HIV indicators that will allow them to report their progress and to allow civil society actors and stakeholders to monitor activities and achievements toward attaining the 90-90-90 and zero discrimination and stigma targets.

As of April 2016, 60 local governments have signed the declaration, of which 30 are located in Sub-Saharan Africa and 18 in West and Central Africa in particular (Abidjan, Accra, Atakpamé, Bamako, Bamenda, Bangui, Cotonou, Dakar, Djougou, Douala, Kinshasa, Lagos, Libreville, Lomé, Lubumbashi, Mbujimayi, Ouesso, Yaoundé).

### Key gaps and contestations

A first gap in the national legal and policy frameworks in the Central region are the countries that **lack legal provisions on non-discrimination on the basis of HIV**—notably Gabon and Rwanda—and lack of clarity on the presence of such provisions in Equatorial Guinea and **São Tomé and Príncipe**.

Second, there is weak translation of women and girls' human rights in legal, policy and institutional frameworks. Despite commitments of ministries of health to including human rights and gender perspectives in their strategic plans, these are rarely translated into specific actions. Although most HIV policies and strategic plans provide gender-disaggregated data that show higher HIV prevalence in women, they **rarely provide actions specifically targeting** women or underlying gender relations contributing to high prevalence (with the exception of Congo Republic and Rwanda).

A third weakness concerns the absence of, or the gender-blindness of, any approach to **youth or adolescent girls**. These groups are absent in some plans (e.g. Cameroon, Gabon). Where they are present, they are often not addressed in a gender-specific manner. In none of the plans that we had access to were adolescent girls (with high infection rates) recognised as a specific target group. This is a missed opportunity to design and deliver HIV services that meet their needs.

A fourth gap concerns the need for **parental consent** for HIV testing. Some countries provide an explicit age of consent for testing. CAR, Cameroon and DRC mention that consent is needed for minors under 18.<sup>57</sup> Congo and Rwanda have lowered the age of consent to, respectively, 16 and 15. The laws in Burundi, Chad, Equatorial Guinea, Gabon and São Tomé & Príncipe are silent on all aspects of HIV testing, counselling and treatment *for children, adolescents or minors*. The need for parental consent may constitute a barrier for adolescents getting tested. Adolescents who have parents who are reluctant to give their consent may remain undiagnosed and, if HIV-positive, may be deprived of appropriate care and treatment. Similarly, when policies are silent on the issue or unclear, health providers may be reluctant to provide HIV testing services to adolescents.<sup>57</sup>

**A fifth gap concerns mandatory HIV testing regulations in Angola, Burundi and Chad. A related contestation is the bias in HIV testing policies and programmes** towards pregnant women, or sex workers. Most policies emphasising counselling and testing for MTCT and testing for female sex workers. Also, ART is free for pregnant women in many countries. This emphasis means that women who are not pregnant or not sex workers are inadequately reached with HIV testing and counselling services. Similarly, men involvement programmes target married men, leaving out unmarried men.

57 Fox, K., Ferguson, J., Ajose, W. et al. (2013). 'Adolescent Consent to Testing: A Review of Current Policies and Issues in Sub-Saharan Africa'. In *HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV: Recommendations for a Public Health Approach and Considerations for Policy-Makers and Managers*. Geneva: WHO. Annex 15.

The weak translation of women and girls' human rights in policies is also visible in HIV testing strategies. There is a strong need for **HIV testing modalities that support women's rights**. With increased attention to new and rapid testing modalities, women's concerns may be overlooked. In most countries, HIV testing for pregnant women is offered in antenatal care clinics in the context of PMTCT. Although most policy and legal regulations in the region require voluntary testing, consent and counselling of pregnant women, not all facilities have the resources and skills to respect these rights. Also, as a result of gender norms, social distance and power dynamics between pregnant women and medical professionals, women may be unlikely to decline testing.<sup>xcvi</sup> Women may have reasons to opt out of HIV testing because of the risks of disclosing a positive status, such as violence or the fear of violence, stigma and abandonment by their partner; yet women may agree to testing for fear of being perceived as challenging medical authorities, as has been observed in Cameroon.<sup>xcvii</sup>

The risks around disclosure of HIV test results are rarely acknowledged in HIV and AIDS strategic plans. Few national HIV and AIDS strategies under review have taken into account providers' capacities to identify such risks and avoid coercive testing in PMTCT programmes. This gap may be exacerbated by initiatives to expand or accelerate testing, including through lay provider HIV testing, when such initiatives do not ensure consent, counselling and confidentiality. Provider-initiated testing has been launched in some countries in the region but is not yet being implemented.<sup>58</sup> Another critical contestation around HIV testing is that countries, for example DRC, may require HIV-positive serostatus **disclosure to sexual partners**, which can put women at risk.

A final contestation relates to **conflicting and contradictory legislation** regarding discrimination in relation to HIV. Some states have a strong commitment towards non-discrimination of PLWHIV, grounded in HIV-specific laws or other legislation and strategies. Yet they also have laws that criminalise, for instance, sex work or same-sex sexual acts. In Central Africa, Cameroon criminalises same-sex sexual acts between both men and women in its Penal Code, which states that same-sex sexual relations shall be punished with imprisonment from six months up to five years and a fine of FCFA 20,000 up to FCFA 200,00. Laws that criminalise same-sex sexual acts are also present in Angola and Burundi. There are no specific provisions that criminalise consensual same-sex relations in CAR, Chad, Congo Republic, Equatorial Guinea, Gabon and São Tomé and Príncipe. However, discriminatory environments with regard to sexual and gender diversity persist across these states. In Gabon, the level of reporting of incidents against LGBT persons is very low because of a highly discriminatory environment, while Equatorial Guinea reportedly continues to intimidate LGBT persons, and efforts meant to increase levels of acceptance of sexual and gender diversity have been rejected by the state.<sup>xcviii</sup> Conflicting and contradicting legislation creates a paradox between criminalisation of the acts or work of marginalised groups on the one hand, and non-discrimination commitments on the other. A potential effect is that coverage of HIV services for these groups is very low, as health professionals, for example, may be reluctant to implement appropriate policies.<sup>xcix</sup>

**Table 8.13. Countries that do and do not criminalise same-sex sexual acts, Central Africa**

Countries that criminalise same-sex sexual acts	Countries that do not criminalise same-sex sexual acts
Angola	CAR
Burundi	Chad
Cameroon	Congo
	DRC
	Equatorial Guinea
	Gabon
	Rwanda
	São Tomé and Príncipe

All countries in the region are directly or indirectly affected by **civil, political and armed violence and conflict**. The crisis in CAR has led to a deteriorating HIV situation, with disruptions to prevention and treatment services, loss to follow-up and high incidence of GVAW.<sup>c</sup> CAR has the highest HIV prevalence in the region but one of the lowest ART coverage rates in the world (18%). As a response to this in the context of the crisis, CAR has integrated the HIV response into humanitarian action plans and enacted a decree (2014) exempting patients from payment during the crisis. However, this free care policy is limited to certain patient groups (primarily women and children) and to NGO-supported health facilities.<sup>ci</sup>

<sup>58</sup> As of July 2017, the following countries from the region reported that lay provider HIV testing was not yet implemented: Burundi, Cameroon, CAR, Chad, Equatorial Guinea and Gabon. <http://www.who.int/hiv/pub/meetingreports/wca-hiv-testing-workshop/en/index2.html>

### 8.3.4 Southern region

#### *Trends, gaps and contestations*

The national legal and policy frameworks in the Southern region look very similar, with all countries having a programmatic response to access ART and regarding MTCT in place. However, missing data in Comoros means the latter is unclear for the country. Countries also have legal provisions on non-discrimination on the basis of HIV, except for Swaziland. Almost two-thirds of the countries have adopted legislation that criminalises transmission, exposure or non-disclosure of HIV. The *SADC HIV and AIDS Strategic Framework 2010-15* was developed to respond to the pandemic and guide country responses and initiatives. Taking note that SADC has the highest gender inequalities globally, it highlights patterns of male dominance in sexual decision-making, as well as high levels of sexual violence in many communities and cultural practices in some communities that are key drivers of HIV transmission. SADC through its Secretariat has emphasised development and harmonisation of policies and legislation in the region. While the Framework undertook to tackle areas of concern, such as the need to protect individuals and communities against HIV and AIDS-related stigma and discrimination; criminalisation of HIV transmission; and prevention, care and treatment for marginalised communities such as sex workers, prisoners, drug users and sexual minorities, these areas remain underdeveloped and contested in the region, owing to issues related to moral judgement or prejudice.

Through its Parliamentary Forum, SADC has promoted the domestication and monitoring of the *SADC Model Law on HIV*. This provides a framework to tackle stigma and discrimination in member states. It integrates issues of SRHR, protection against violence for women and girls, equality and non-discrimination and provides sanctions for breaches of confidentiality and unlawful disclosure. The 2017 Mahe Declaration, adopted at the Regional Women's Parliamentary Caucus of SADC-PF, also recognises unequal power relations between women and men and systemic gender-based discrimination, combined with lack of or inadequate SRHR and HIV and AIDS services, as key drivers of new HIV infections and unnecessary deaths in the region. The Mahe Declaration also points to harmful patriarchal norms and practices, and absence of an enabling legal and policy environment in member states, as preventing women and girls from exercising their rights and protecting themselves from HIV. Included within this is the need for other-party consent to access to HIV and SRH services and information, as well as practices of child marriage, marital rape and property-grabbing from widows, all of which remain legal and common practice in several countries. Other factors are inadequate health care infrastructure, lack of youth-friendly health services, poor linkages between HIV and SRHR and lack of birth control, family planning and MCH services. In addition, the *SADC Protocol on Health, HIV and AIDS Strategic Framework and Business Plan* sets out priority areas for action and key performance indicators in order to harmonise policies and strategies towards HIV elimination as member states strive to live up to their commitments.<sup>cii</sup>

Table 8.14. Key legal and policy indicators in Southern Africa, HIV and AIDS

Country	INDICATORS				
	Non-discrimination legislation based on HIV	Policy and/or legal regulations regarding voluntary HIV testing	Criminalisation of wilful transmission on HIV	Programmatic responses to access ART	Programmatic responses on MTCT
Angola	Yes	MAN <sup>59</sup>	Yes	Yes	Yes
Botswana	Yes	VOL <sup>59</sup>	Yes	Yes	Yes
Comoros	Yes	VOL	No	Yes	-
DRC	Yes	VOL <sup>60</sup>	Yes	Yes	Yes
Lesotho	Yes	VOL <sup>61</sup>	Yes <sup>62</sup>	Yes	Yes
Madagascar	Yes	VOL	Yes	Yes	Yes
Malawi	Yes	VOL <sup>63</sup>	Yes	Yes	Yes
Mauritius	Yes	VOL <sup>64</sup>	Yes	Yes	Yes
Mozambique	Yes	VOL	Yes	Yes	Yes
Namibia	Yes	VOL	No	Yes	Yes
Seychelles	Yes	VOL	No	Yes	Yes
South Africa	Yes	VOL	No	Yes	Yes
Swaziland	No	VOL <sup>65</sup>	No	Yes	Yes
Tanzania	Yes	VOL <sup>67</sup>	Yes	Yes	Yes
Zambia	Yes	VOL <sup>68</sup>	No	Yes	Yes
Zimbabwe	Yes	VOL <sup>69</sup>	Yes	Yes	Yes

59 This is a mixture of the two, as Law 8/04 on HIV and AIDS (2004) provides that persons deprived of freedom must not be subjected to compulsory tests to detect HIV infection, except for those whose judicial process or medical condition so demands.

60 The National HIV Policy 2012 provided that HIV testing was voluntary. However, it also provided that HIV testing prior to sentencing would be mandatory for all individuals convicted of a sexual crime. The Public Health Act 2013 requires mandatory testing in six circumstances.

61 Loi no 08/011 du 14 juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées.

62 The National HIV and AIDS Policy 2006 provided for voluntary testing. However, it also provided that government establish guidelines and legislation for mandatory disclosure of the client's positive HIV status to sexual partner/s. Anecdotal information suggests that, by 2008, compulsory testing of pregnant women was government policy. See HRW. (2008). 'A Testing Challenge: The Experience of Lesotho's Universal HIV Counseling and Testing Campaign'.

63 Penal Code also criminalises non-disclosure

64 Mandatory testing in certain instances, e.g. rape, is required.

65 The People Living with HIV Stigma Index: Mauritius Report 2013 indicates that in 2013 there were reported incidences of forced testing at the hands of institutions; it is not clear whether this was a practice or a policy issue.

66 In general, mandatory testing is not policy, but the HIV Testing and Counselling National Guidelines 2006 provide that it can be considered in special circumstances, e.g. for blood donation and for rape perpetrators, only with a court order and only disclosed to the magistrate or judge handling the case.

67 However, the Sexual Offences and Domestic Violence Bill contains provision for aggravated punishment for convicted rapists who are HIV-positive.

68 Exception to prohibition of mandatory testing in the context of sexual offenders.

69 The Zambia Consolidated Guidelines for Prevention and Treatment of HIV Infection 2018 provide for routine testing with opt-out considerations. Partner notification is voluntary.

70 In general, mandatory testing is not allowed, but the National Guidelines on HIV Testing 2005 provide that it can be considered in special circumstances, e.g. for blood donation and for rape perpetrators, only with a court order and only disclosed to the magistrate or judge handling the case.

### *Trends in legal, policy and institutional reform*

**Constitutional provisions on HIV and AIDS:** All countries in SADC have provisions on non-discrimination, which could be extrapolated to protect PLWHIV. Fourteen countries' constitutions provide for gender equality (Angola, Comoros, DRC, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe). No country's constitution forbids discrimination based on HIV or health status but the constitutions of Seychelles and South Africa forbid discrimination on any grounds. Six countries in SADC do not provide for the right to health specifically as an inherent right (Botswana, Lesotho, Mauritius, Namibia, Tanzania, Zimbabwe).

**Statutory law on HIV and AIDS:** Fifteen countries have laws on *non-discrimination against PLWHIV* (Angola, Botswana, Comoros, DRC, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia and Zimbabwe). Many of these laws focus on discrimination in the workplace. Despite this, in 2007, a nine-country study in the region on HIV and human rights found weaknesses in the response to HIV in terms of human rights.<sup>ciii</sup> Some countries have laws relating to health care standards and services (Botswana, Lesotho, Madagascar, Seychelles, South Africa and Zambia). In Comoros, laws also grant access for HIV testing for adolescents who are below the age of consent (18) in specified circumstances. All countries except, DRC have policies on voluntary testing. However, alongside such provisions, it is possible to find in the same policy provisions making exception to such voluntary testing. This is the case in countries like Botswana, Lesotho, Malawi, Mauritius, Zambia and Zimbabwe.

Nine countries in the region have adopted legislation that criminalises HIV non-disclosure, exposure and transmission: Angola, Botswana, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Zambia and Zimbabwe. More countries are considering this course of action. The criminalisation occurs through specific laws, penal codes and laws against wilful exposure and transmission of HIV and AIDS. Some crimes against sexual violence increase the punishment of offenders based on HIV status. This is the case for Lesotho's 2003 Sexual Offences Act and Namibia's Combating of Rape Act 2000.

**Policy and institutional reform on HIV and AIDS:** All countries in the region have developed diverse and multi-sectoral responses and frameworks; all have national policies on HIV and AIDS and national strategic plans.<sup>civ</sup> Country policy responses all over the region are *making the link between combating HIV and gender inequalities*. The Malawi National HIV and AIDS Strategic Plan 2011–16, extended to 2020, emphasises the need to address gender dimensions of the epidemic; eliminate discrimination and marginalisation; and involve those most at risk, particularly women and young people. The Swaziland HIV Policy 2012 identified gender inequalities and sexual violence as drivers of HIV, stating that many cultural norms and values shape negative gender relations that constrain women's autonomy. The Seychelles National Strategic Framework 2012–16 for HIV and AIDS and STIs took stock of women and men in vulnerable situations with special emphasis on GVAW, social and economic vulnerabilities and disadvantages and disenfranchised sub-groups.

The major area in which countries have targeted service delivery for women living with HIV is with regard to *PMTCT*. PMTCT programmes exist in all countries (although information for Comoros was not found) and provide much-needed services to enable women living with HIV to attain reproductive health services. Mauritius has achieved 97% coverage of PMTCT, for example. ART is also availed to pregnant women in all countries as part of PMTCT programmes, although not all women access these much-needed services. Countries are also moving towards e-MTCT programming, as is the case with Mauritius, South Africa and Zambia. In South Africa, ARV prices have been halved to increase affordability, while Botswana, South Africa and Zambia have either abolished or slashed the costs of user fees for HIV treatment in order to increase access to treatment. This is beneficial especially for indigent and vulnerable women.

It is notable that all SADC countries now offer *comprehensive treatment* including *PEP* to survivors of violence, and that some countries have integrated *PrEP* into their programmes (Botswana, Malawi, South Africa, Zambia and Zimbabwe) to provide for sex workers and partners in sero-discordant couples.<sup>cvi</sup> This is beneficial especially for vulnerable women. Despite this, not all women can obtain these services, given challenges in health care coverage, shortage of ART supplies and societal attitudes that stigmatise and marginalise women suffering from HIV or seeking related services.

## Key gaps and contestations

A first gap is the **absence of non-discrimination provisions** regarding HIV status in Swaziland. A second gap relates to **mandatory testing** laws in six countries in the region, as stated above. Even countries that have policies on VCT have enacted laws that **criminalise non-disclosure**, which raises the risk of the public avoiding voluntary testing, so they can later use the defence that they were unaware of their HIV status because they did not get tested for HIV.

A critical trend with regard to HIV testing and disclosure is that the traditional VCT model of addressing HIV from a preventive and treatment-based perspective is under threat. The trend towards increased **criminalisation of HIV non-disclosure, exposure and transmission** has raised controversy in the region. Such laws serve to further stigmatise PLWHIV and their sexuality as well as violating their rights to dignity and privacy, among others. Further, in cases where HIV status is a factor in elements of a criminal charge, conducting forced testing and disclosing results against the wishes of the accused person violates the right to privacy. This is a hotly contested area of rights as debates are polarised around victim rights *vis-à-vis* the rights of PLWHIV.

Another contestation relates to the **criminalisation of same-sex sexual acts**. Same-sex sexual acts are legal in DRC, Lesotho, Madagascar, Mozambique, Seychelles and South Africa. South Africa is the only African state to include a *provision prohibiting discrimination* based on sexual orientation in its constitution. It is also the only state in which partnership and marriage between same-sex couples is allowed, under the Civil Union Act of 2006. In Angola, Botswana, Comoros, Malawi and Zambia, same-sex sexual between both men and women are criminalised; in Mauritius, Namibia, Swaziland and Zimbabwe the law applies only to men. Criminalisation of same-sex sexual acts in Mauritius is contradicted by recognition of the right to non-discrimination on the basis of sexual orientation in the *Equal Opportunities Act* of 2008 and the *Code of Ethics for Public Officers*. Malawian NGOs focusing on SOGIE issues reported being challenged by backlash after raising SOGIE issues on a political level. The government has reportedly threatened to close CSOs working on these issues.<sup>cvi</sup>

**Table 8.15. Countries that do and do not criminalise same-sex sexual acts, Southern Africa**

Countries that criminalise same-sex sexual acts	Countries that do not criminalise same-sex sexual acts
Angola	DRC
Botswana	Lesotho
Malawi	Madagascar
Mauritius	Mozambique
Namibia	Seychelles
Swaziland	South Africa
Tanzania	
Zambia	
Zimbabwe	
Comoros	

### 8.3.5 Northern region

#### Trends, gaps and contestations

The countries in the Northern African region show fairly similar profiles regarding their HIV and AIDS legal and policy frameworks. Egypt, Libya and Morocco all have guarantees for voluntary HIV testing, and a programmatic response to access ART and MTCT, but lack legislation on non-discrimination on the basis of HIV. Algeria only has a programmatic response in place, for both ART and MTCT. Tunisia has guarantees for voluntary testing and a programmatic response on ART but lacks non-discrimination legislation and does not have a programmatic response on MTCT. Mauritania's legal and policy framework looks different, as the only country of this region with non-discrimination legislation on HIV and the only one that criminalises wilful transmission of HIV.

**Table 8.16. Key legal and policy indicators in Northern Africa, HIV and AIDS**

Country	INDICATORS				
	Non-discrimination legislation based on HIV	Policy and/or legal regulations regarding voluntary HIV testing	Criminalisation of wilful transmission on HIV	Programmatic responses to access to ART	Programmatic responses on MTCT
Algeria	No	-	-	Yes	Yes
Egypt	No	VOL	No	Yes	Yes
Libya	No	VOL <sup>70</sup>	- <sup>71</sup>	Yes	Yes
Mauritania	Yes <sup>72</sup>	-	Yes <sup>73</sup>	Yes	Yes
Morocco	No	VOL	-	Yes	Yes
Tunisia	No	VOL <sup>74</sup>	No	Yes	No
Western Sahara	-	-	-	-	-

#### Trends in legal, policy and institutional reform

**Constitutional provisions on HIV and AIDS:** None of the countries in the Northern region has constitutional provisions that directly and explicitly address HIV and AIDS. Most of the states reviewed have constitutional provisions that can be utilised to make the case for non-discrimination against PLWHIV as well as for access to HIV prevention and treatment programmes. For instance, the constitutions of Egypt, Libya, Morocco and Tunisia include the right to health. States reviewed also have guarantees of equality and non-discrimination on the basis of sex, gender or other reasons, which provides a basis for protection for PLWHIV. These states include Algeria, Libya, Egypt, Mauritania, Morocco and Tunisia.

**Statutory law on HIV and AIDS:** In Mauritania, the law on HIV and AIDS is related to the prevention, management and control of HIV and AIDS in general and against the stigmatisation of PLHIV. It also criminalises wilful transmission of HIV.

Four states have guarantees for voluntary HIV testing. Where states have an exception to *voluntary testing*, this is mostly the case for blood and organ donors (Libya, Morocco, Tunisia). In Libya, however, HIV testing is reported to be mandatory in practice, such as for pregnant women during pregnancy and before labour and for issuance of health certificates related to employment and marriage.<sup>cvi</sup>

**Policy and institutional reform:** All states have a policy that directly focuses on and/or alludes to HIV and AIDS. These are in the form of national strategies, action plans or guidelines to providers. With the exception of Mauritania, policies are exclusively dedicated to the rights of PLWHIV. In Mauritania, HIV is addressed in the context of the National Action Plan for Birth Spacing and covers reduction of maternal, child and adolescent mortality. National policies and strategies include reduction of HIV transmission, voluntary testing, ART and PMTCT. Notably, all the reviewed states have either policy or programmatic interventions on ART. In addition, others have interventions with regard to PMTCT (Algeria, Egypt, Mauritania and Morocco).

In its Strategic Plan, Morocco commits to reducing new infections among key and vulnerable populations.

<sup>71</sup> The 2010 HIV Voluntary Counselling and Testing Services: A Guideline for Service Providers requires mandatory testing only for blood transfusions. Despite the guidelines for voluntary testing, mandatory testing happens in practice. (GARPR. 2015. 'Country Progress Report-Libya'. June.)

<sup>72</sup> On 7 February 2000, six Bulgarians were tried in Tripoli on charges of deliberately infecting children with HIV. Under Art. 305 of the Penal Code, they were charged with causing an epidemic through spreading a harmful virus, leading to the death of persons.

<sup>73</sup> Law 042/2007 is related to the fight against HIV and AIDS in general and against the stigmatisation of PLHIV.

<sup>74</sup> A HIV-specific law was adopted in 2007 based on the AWARE-HIV and AIDS Model Law: <https://www.aidsmap.com/resources/law/Western-Africa/page/1444873/#Modellaw>

<sup>75</sup> The only exception for voluntary testing is for blood and organ donors.

In addition, some of the states reviewed have an institutional mechanism or body that exclusively or as part of its mandate addresses the rights of PLWHIV (Algeria, Mauritania, Morocco). With the exception of Algeria, it could not be ascertained whether these bodies specifically addressed the gendered concerns of women and girls living with HIV and AIDS. In Algeria, the Ministry of Religious Affairs has trained imams and murchidates on the principles of equality and justice and developed modules on Islam and women, Islam and HIV and AIDS and GVAW.<sup>cxviii</sup>

### Key gaps and contestations

A key gap and contestation around HIV and AIDS in the Northern region relates to **social stigma and discrimination**. At just 0.1%, the MENA region has among the lowest HIV prevalence rates in the world. Yet infections are on the rise, and deaths resulting from HIV are also steadily increasing.<sup>cxix</sup> Some of these new infections have a gendered angle, with women disproportionately affected. For instance, in Algeria, it is estimated that over half of new infections in 2014 were of women;<sup>cx</sup> their limited role in decision-making and control of resources is a risk factor here.<sup>76</sup> One of the reasons for this downward spiral is that the region is plagued by intense HIV-related stigma and discrimination. The continuous repression of the subject and discrimination against those living with HIV has now been linked with an alarming increase in the HIV spread in these countries, particularly in Egypt. On a positive note related to this challenge, in 2016 a court in Egypt issued a landmark ruling for the country and the region prohibiting HIV discrimination in the workplace.<sup>cxii</sup> Efforts such as this as well as institutional and social change could possibly alleviate stigma and discrimination.

Yet, even where these countries have set up treatment centres and offer free treatment, high stigmatisation prevents those infected from seeking **treatment**: less than a quarter of those infected are on treatment and almost half of those infected are not even aware of their status.<sup>cxiii</sup> Even where persons living with HIV are willing to seek treatment, they risk being **denied services**. The HIV Stigma Index reports that 'More than half of people living with HIV in Egypt have been denied treatment in healthcare facilities.'<sup>cxiii</sup> In Algeria, stigmatisation has also been noted as a major deterrent to addressing HIV: in a culture of silence, women tend to be blamed for spreading the virus, whereas they may be equally vulnerable to catching HIV from their husbands. Constitutional human rights guarantees and HIV policy measures are seemingly ineffective against the tide of stigma and discrimination of persons living with HIV in Northern Africa.

A next gap is the **inadequate protection of key populations**. Female sex workers in the MENA region are particularly vulnerable owing to the criminalisation of their behaviour and work, which contributes to strong sociocultural disapproval, combined with other gender issues that women in the region face. Little value is placed on their protection from HIV and they suffer hindered or low access to HIV prevention programmes.<sup>cxiv</sup> In Mauritania, there is a concern that vulnerable groups at risk of HIV and AIDS are discriminated against, which could **prevent them from accessing treatment**. This exclusion fuels their pre-existing vulnerability to infection. For instance, in Algeria, national incidence of HIV was rated at 0.1%, but with a prevalence of 10.25% among sex workers in 2016.

**Sexual minorities**, especially MSM, also face heightened stigma and hindered access to HIV prevention programmes. This is all the more significant as the increase in HIV prevalence in the region has been linked to increased prevalence among key populations, as reported in Egypt, Morocco and Tunisia.<sup>cxv</sup> In Morocco in particular, two-thirds of new infections have occurred among female sex workers, their clients, MSM and injecting drug users, or among the stable sexual partners of these populations.<sup>cxvi</sup> Algeria, Mauritania, Morocco, Libya and Tunisia **criminalise** same-sex sexual acts between both men and women. Mauritania has even codified the death penalty for same-sex sexual acts in *Sharia* law. It is, however, reportedly not implemented for same-sex sexual behaviours, with lesser penalties preferred. Egypt is the only North African state where same-sex sexual relations are not criminalised. Besides criminalisation of same-sex sexual relations in law, other restrictive laws on association and foundation of non-profit organisations are found across all North African states except Tunisia, making the registration and work of NGOs on SOGIE issues difficult or even impossible. Also, high levels of hostility towards LGBT persons persist, forcing individuals to flee, as is reported in Libya.<sup>cxvii</sup>

<sup>76</sup> Young persons require parental consent to seek SRH services (Executive Board of UNDP and UNFPA. 2006. DP/FPA/CPD/DZA/4).

Table 8.17. Countries that do and do not criminalise same-sex sexual acts, Northern Africa

Countries that criminalise same-sex sexual acts	Countries that do not criminalise same-sex sexual acts
Algeria	Egypt
Libya	
Mauritania*	
Morocco	
Tunisia	

\* same-sex sexual acts are punishable by death

The **conflict and post-conflict** environment in Libya has hampered the HIV response. While there was a focus on HIV prevention and treatment services in 2010, all plans for establishing VCT services, monitoring and evaluation systems and PMTCT halted with the breakout of conflict in 2011.<sup>cxviii</sup> Libya has a number of policies around HIV from a VCT perspective. However, the post-conflict situation has created several additional factors with the potential to fuel the epidemic. During the conflict, a nationwide stock-out of ARV drugs, infection control and blood safety systems occurred, alongside a rise in GVAW related to the conflict. In 2014, there was no national HIV strategy and HIV and AIDS responses were addressed within a health and disease framework with a focus on treatment.<sup>cxix</sup>

## 8.4 CASE STUDIES

The section presents six case studies on initiatives to realise the rights of women and girls with respect to HIV and AIDS. They range from local-level initiatives with groups of women and girls living with HIV and AIDS (WLHIV) (Case studies 30 and 31) to national litigation cases (Case studies 32 and 33) as well as regional and continental initiatives (Case studies 28 and 29). Together, the cases present a range of interventions that are each relevant for women and girls who are living with HIV and AIDS or vulnerable to infection: an enabling legal environment (Case study 28), prevention of vertical transmission (Case study 29), care and support (Case study 30), treatment (Case study 31) and access to justice (Case studies 32 and 33).

What the initiatives have in common is that they are built on in-depth knowledge of the lived realities and particular circumstances of WLHIV. **Knowledge, information and evidence** are the basis for further action and are generated either by (participatory) research by WLHIV themselves or by research institutes that investigate particular issues. For example, the two cases on forced sterilisation started off from a research report presenting figures on the prevalence of this phenomenon. Evidence has been used as a tool to communicate on controversial issues and to trigger a public debate on women and girls' rights.

Four case studies focus on enhancing women's **empowerment** and on access to justice for WLHIV. This is particularly meaningful given that, generally, WLHIV and their associations have insufficient opportunities for training and access to legal support. These cases also have in common that they try to challenge social norms and taboos relating to sexuality, HIV and AIDS and fertility that often create a culture of silence. Breaking this silence is important in many of the strategies documented in these case studies, and often requires the creation and nurturing of safe spaces where WLHIV can come together and share experiences and challenges. The initiatives also recognise that women and girls are different, have different needs and experience different levels of discrimination. The initiatives in Mali and Malawi provide space for sharing stories among women of different ages, localities and classes and prepare WLHIV to voice their concerns as a collective. The Malawian initiative takes an intersectional approach in that it emphasises the right to quality treatment for all women and girls and opposes the preferential treatment of pregnant women based on the bias in policies regarding women's reproductive role.

The cases of forced and coerced sterilisation illustrate the prevalence of abuse in health care against WLHIV in many countries. The use of **litigation** is a first step to address this but additional measures are needed; while these actions have created public awareness, and changes in professional codes of conduct and behaviour, they have not yet resulted in further legal or policy change to protect WLHIV from discrimination, violence and abuse. Most initiatives target either women or institutions (government, NGOs) but the Malawian case shows the importance of addressing the environment and the structural challenges WLHIV face. Through **strategic alliance-building** with different groups of WLHIV, faith-based organisations, CSOs and a range of other stakeholders, the initiatives have been able to promote a rights-based HIV and AIDS agenda, promoting attention for gender equality and women's SRHR beyond increased access to HIV treatment and care.

## Case study 28. East African Community HIV Prevention and Management Act

In 2012, the EAC Legislative Assembly passed the HIV and AIDS Prevention and Management Act ('the HIV Act'). This Act seeks to harmonise the response to and management of HIV in the East African region. The development and enactment of the Act entailed intensive collaboration between political, administrative and civil society actors, and involved comprehensive analysis.

As part of its legal framework, the EAC has in place an EAC HIV and AIDS Prevention and Management Act ('the HIV Act'). This was passed in 2012, and is a regional response in the management of HIV across the EAC countries. The Act serves to ensure a harmonised approach in the region by addressing gaps, discrepancies and inconsistencies that may be found in national approaches to preventing and managing HIV and AIDS.

The enactment of this regional law was the result of concerted efforts by the EAC, particularly its Secretariat, and civil society stakeholders. On the part of the EAC Secretariat, comprehensive analysis of the various pieces of HIV legislation in the region was undertaken in preparation for enactment and implementation of the Act. This strategy was innovative because consultations were undertaken simultaneously with the legislative process. This proved effective in that, by the time the HIV Act was ready and had been fully signed by the EAC countries, the issues that needed to be addressed had already been part of a discourse with governments at the national level. This eased implementation of the HIV Act itself. Moreover, there was also room for an assessment towards the end of the process; this was useful because the HIV Act took so long to become law that the assessment was able to ascertain that the Act was still in line with the situation on the ground. In this way, the resultant Act was responsive and up-to-date.

Advocacy of civil society actors significantly contributed to enactment of the HIV Act. The East African Civil Society Organisations Forum (EACSOFF) undertook an advocacy campaign, through its member organisation, the Eastern African National Network of AIDS Service Organisations (EANNASO). These civil society actors were part of the development of the draft Act, including consultations as well as other processes up until enactment. Their campaign relied on multiple approaches, and on close collaboration between EACSOFF/EANNASO and the EAC Secretariat. The campaign lobbied members of the East African Legislative Assembly (EALA), which eventually passed the Act. It identified champions within EALA and in governments, such as ministers, former ministers and ambassadors, to also advocate for enactment. In addition, civil society actors played a critical role in terms of sharing information with other organisations in the EAC.

The development and enactment of the EAC HIV Act demonstrate how policy-makers such as the EAC Secretariat and civil society actors can join forces. Both sets of actors were in a unique position to shape the legal and policy environment and, in turn, the rights culture among states to the benefit of rights-holders—that is, the citizens in those countries.

## Case study 29. Free To Shine campaign

The *Free to Shine* campaign is a recently launched advocacy campaign driven by African First Ladies and focused on eliminating MTCT of HIV. The campaign leverages the unique position of First Ladies, as mothers of the nation, *vis-à-vis* the general public in their countries, as well as high-level policy-makers and politicians at national, continental and international levels. The campaign aims to end childhood HIV and to keep mothers healthy.

Significant progress has been made towards the global commitment to end the AIDS epidemic by 2030.<sup>xxx</sup> In order to end AIDS in Africa, it is imperative to prioritise children and their mothers, as well as adolescent girls, to ensure these vulnerable groups also benefit from the progress achieved in the wider population.

Of the 2.1 million children living with HIV globally, the majority are in Africa, with 1.4 million of these children in Sub-Saharan Africa. In 2015, an estimated 110,000 children living in 21 Sub-Saharan Africa were newly infected with HIV.<sup>xxxi</sup> Most new cases of HIV in children under 15 years old are caused by MTCT.<sup>xxxii</sup> The majority of these infections occur during the breastfeeding period.

Young women of child-bearing age account for a quarter of all adults newly infected with HIV, placing themselves and their future offspring at risk. In 2015, there were 250,000 new infections in adolescents, and 160,000 of them were among adolescent girls (aged 10–19); three out of four of these occur in Sub-Saharan Africa.<sup>77</sup> Among young people aged 15–24, young women bear a disproportionate burden of new HIV infections, accounting for up to 66% in Sub-Saharan Africa. Yet only 15% of young women are aware of their HIV status. These young women hence lack critical access to counselling and testing services, as well as SRH services and HIV treatment and care.

African countries need to accelerate efforts to reduce new HIV infections among women of reproductive age. There is also a need for more concerted and systematic efforts to keep women in HIV care, and to enable good adherence to HIV treatment until the risk of HIV transmission to the baby ends fully. Similarly, early infant diagnosis (EID) needs to be scaled up to diagnose infants living with HIV and enrol them in treatment as soon as possible. While WHO recommends that all HIV-exposed infants are tested within two months of birth, only half had access to EID screening in 2015. Furthermore, almost 50% of infants who were tested for HIV never received the results.<sup>xxxiii</sup>

The *Free to Shine* campaign, recently launched by the Organisation of African First Ladies against HIV/AIDS (OAFLA) and the AU, responds to these gaps in the elimination of MTCT of HIV (eMTCT).<sup>xxxiv</sup> The advocacy campaign aims to reduce new infections among women of reproductive age and ensure no child has AIDS. Africa's First Ladies drive critically important changes in their respective countries in the area of HIV and AIDS, and women and girls' health more generally. First Ladies, as mothers of the nation, can positively influence citizens' behaviours through awareness-raising, in a way that crosses divides and touches all citizens. Similarly, they leverage their reputation, their visibility and their access to high-level political leaders to influence decision-makers at policy level.

The *Free To Shine* campaign contributes to ongoing efforts to end childhood AIDS in Africa by 2030 and keep mothers healthy. It intends to drive advocacy by the First Ladies and other stakeholders at national and regional levels on the targets and commitments adopted in key regional and global commitments and frameworks.<sup>78</sup> These targets and commitments include the 2016 UN Political Declaration on Ending AIDS, the Maputo Protocol, the Maputo Plan of Action, the UNAIDS 90-90-90 Targets and the *Start Free, Stay Free, AIDS Free* framework. In particular, the campaign will contribute to:

- Eliminating new HIV infections among children by reducing the number of children newly infected to less than 40,000 by 2018 and 20,000 by 2020;
- Reaching and sustaining 95% of pregnant women living with HIV with lifelong HIV treatment by 2018;
- Reducing the number of new HIV infections among adolescents and young women to less than 100,000 by 2020.

*Free To Shine* highlights the need to remove barriers that prevent women and mothers engaging with HIV and AIDS-related health services for themselves and their children. It seeks to raise awareness of the HIV epidemic in children and the need to prioritise children and mothers, to ensure that successes achieved in reducing infections are extended to this vulnerable group. Furthermore, the campaign intends to increase understanding on how to prevent HIV and AIDS in childhood by keeping mothers healthy, preventing MTCT and ensuring fast and effective identification and treatment of HIV-infected children. *Free to Shine* advocates for the mobilisation of resources and the prioritisation of the delivery of effective and sustainable HIV and AIDS health services that are accessible to all who need them.

77 Start Free Stay Free AIDS Free: A Super-Fast Track Framework for ending AIDS among Children, Adolescents and Young Women by 2020. <https://free.unaids.org/>

78 *Free To Shine* is widely supported by organisations that are leading the work to end AIDS, including UNAIDS, WHO, the Elizabeth Glaser Pediatric AIDS Foundation, UNICEF, Abbott, UNDP and AIDS Accountability International.

The key strategies for this campaign are as follows:

1. To promote advocacy for domestic and global resource mobilisation to strengthen paediatric AIDS programmes in Africa;
2. To build networks and support and maintain coordinated partnerships at all levels to strengthen paediatric AIDS programmes;
3. To sensitise AU governance structures such as the Permanent Representatives Council, the Executive Council and the Assembly, AU Organs (the Pan-African Parliament, New Partnership for Africa's Development and African Peer Review Mechanism) and Regional Economic Communities and Regional Health Organisations on key issues related to paediatric AIDS;
4. To leverage high-level international forums (such as UN General Assembly and its special sessions and the G7 and G20 summits) and high-level advocacy missions in global advocacy hubs to mobilise support for paediatric AIDS in Africa;
5. To raise awareness among general populations within and outside Africa through mass media, publications, websites, colloquiums and other means;
6. To leverage the assets and competencies of the private sector to mobilise resources and to design a digital campaign; and
7. To engage and empower WLHIV to be able to create networks of support for each other and to reach other women in their communities with support through pregnancy and breastfeeding.

### Case study 30. 'Gundo-So': The Bambara Chamber of Confidences—empowering women living with HIV regarding serostatus disclosure

**Gundo-So is an initiative to equip and empower women to cope with their serostatus by providing a safe space to share experiences. The strategy uses cultural norms of engagement and decision-making in groups whereby women define the rules and topics and manage their own discussion space. The initiative is implemented by an NGO with reputed experience and legitimacy.**

Mali has one of the lowest HIV prevalence rates in the West Africa region; however, new HIV infections have increased by 11% and AIDS-related deaths have decreased by 11% since 2010, according to UNAIDS.<sup>cxv</sup> Organisations such as the Association for Research, Communication and Home Support for People Living with HIV/AIDS (ARCAD-Sida) have been working alongside the government on prevention and the provision of treatment, care and support for PLWHIV.

ARCAD-Sida was created on 29 November 1994 by a group of doctors to provide medical and psychosocial support to AIDS patients. It is one of the leading and oldest associations fighting HIV and AIDS in Mali, working alongside the Malian government. It has established screening and treatment sites and provides psychosocial support to PLWHIV throughout the country. In 1996, it created the Centre for Listening, Care, Animation and Counselling to develop community-based care for people living with the disease virus.<sup>cxvi</sup>

Mali is a deeply patriarchal society, with the roles and responsibilities assigned to women largely confined to the domestic and reproductive sphere. Socio-cultural barriers constrain women's roles in broader society, and these constraints increase with HIV infection. Women living with HIV are particularly vulnerable to stigmatisation, divorce, repudiation, child deprivation and neglect in the country, especially as they are often economically and socially dependent on their husbands. In this context, to reveal or not their seropositive status becomes for them a vital stake. Fear of being stigmatised makes it even harder for most women to disclose their serostatus.<sup>cxvii</sup>

In 2010, ARCAD-Sida launched the Gundo-So project, as it was concerned with the specific issues that WLHIV faced. 'Gundo-So' is a name in Bambara, a national language in Mali: *gundo* means 'confidentiality' and *so* means 'room' or 'box'. The name refers to the meetings women were holding in their communities to discuss their HIV issues—that is, *chambres des confidences*, and the project was inspired to further support these. The women chose the name to adapt the programme to reflect their own realities.<sup>cxviii</sup>

Gundo-So seeks to better equip and empower women living with HIV regarding their serostatus disclosure management, thus contributing to improving their quality of life. The aim is to promote and encourage reflection and exchanges between women on the issue of serostatus and the weight of secrecy. The project provides women with a platform to discuss issues related to sexuality and other problems they encounter in their life as PLWHIV. Many women see it as providing a safe space to discuss and share fears and worries with other women in a similar situation.<sup>cxix</sup>

The project includes an assessment interview as well as 10 weekly meetings and an optional group session for participants. Many tools specific to Malian culture are used—pebbles to estimate the weight of secrecy, wooden sticks to weigh the pros and cons, etc. It has been deployed in six sites in Bamako and one site in the region of Kayes, in the west of the country. The goal is to generate a framework the women can own with a particular operating model, rules and sanctions. For example, if someone is late, they must tell a funny story for the group to forgive them.<sup>cxx</sup> During the different discussions, women choose a name for their group—for example 'the Village of Peace' (Hèrèbougou) or 'the Village of Happiness' (La-fiabougou)—and elect a 'village chief' (*dogoutigui*). Every woman chooses a nickname; this can be Benjamine (Laguarè) for the younger person in the group, or 'Tanty' for older women—a sign of respect in African culture.<sup>cxxi</sup> The names signify a hierarchy as well as a relationship of mutual support between women of different ages.

The project has had a positive impact on the lives of the women. They report feeling less burdened by secrecy and better able to plan and implement strategies to unveil or not their status according to different contexts. The project has allowed them to connect and exchange with other women and feel supported by them without being discriminated against. The project also appears to have had beneficial effects on treatment adherence and given women a greater sense of control over their lives.<sup>cxxii</sup> The following are testimonies from some of the women in the project (translated from French to English).<sup>cxxiii</sup>

'Before the project, I used to cry the whole time, and now this is no longer the case, because I have now people with whom I can say everything and without rejection' (WLHIV, widow, 45 years).

'The strength of the project is that we are with other women. We even have a tontine, we get together and we keep in touch although we are not in the same neighbourhood' (WLHIV, widow, 34 years).

'The thing that has struck me the most in the project is the fact of being able to interact with others without fear of being rejected or discriminated against' (WLHIV, married, 44 years).

### Case study 31. Social accountability in Malawi and women living with HIV: Our Bodies, Our Lives campaign for better ARVs in Malawi<sup>79</sup>

The 'Our Bodies, Our Lives' movement is an initiative focused on access to better-quality ARVs for women. The initiative has grown through and uses a combination of strategies, with movement building at the centre. These strategies have addressed intersecting inequalities (HIV status, pregnant women, poor women) in access to ARVs and used political momentum to amplify their concerns at multiple levels.

Since 2007, Just Associates (JASS) has supported WLHIV to strengthen their demand for social justice as a collective and to identify common objectives and priorities in order to achieve their goals. Of particular importance has been the movement-building strategy JASS uses, which supports the strengthening of women's voice, agency and collective power with a view to ensuring their demands are met and gains secured. One of the key features of this movement-building strategy is finding an entry point, an issue for WLHIV to cohere around; in this case, this happened around the inability to access quality HIV treatment as a result of gender inequalities, power and poverty.

The Our Bodies, Our Lives movement-building initiative enabled 1,200 WLHIV to address the 'structural drivers of discrimination, inequality and violence' with a view to imbuing women at an individual and collective level with voice and agency.<sup>80</sup> JASS together with women leaders took stock of the structural and intersecting barriers for WLHIV in realising access to services. They recognised that through reawakening women's power and agency, WLHIV could claim freedom from marginalisation and exclusion individually and as a social group, and accordingly demand access to social goods, services and resources.

Using the approach of dialogue, self-reflection and workshops, JASS conducted a needs assessment in three regions and nationally in Malawi, where WLHIV were encouraged to talk about their personal and daily realities. Conceptual tools for mapping and analysing power helped women make the link between incidents of inequality and discriminatory norms and institutions. They also assisted in identifying targets and spaces for change, such as village chiefs, committees and families, affecting WLHIV in the private and public sphere. These reflective processes allowed women to take stock of their personal and individual struggles and to collectively identify and analyse common barriers with a view to overcoming them, through story-telling, among other activities. Women, within a supportive environment, were encouraged to imagine and live new realities based on a rediscovery of the inherent power they possessed. The processes eventually enabled WLHIV to identify and overcome fear, shame and isolation, and helped build trust and community. They were also important for women to appreciate their power as reflected in their survival and coping strategies, and to use that power to solve problems and improve their lives together and in solidarity with others. The major challenges identified during the conversations related to discriminatory attitudes and behaviours contributing to the feminisation of HIV and AIDS, HIV-positive women's marginalisation within social justice movements and society at large and disconnects among various WLHIV based on age, location, class and sexuality.

Initially, 25 community-based WLHIV leaders were selected to serve as political facilitators to work with JASS to strengthen and support community-level organising. The JASS team visited these women leaders in their communities to discuss progress reached on priorities and action plans as agreed on during the workshops. JASS partnered with the Malawi Network of Religious Leaders Living with HIV/AIDS (MANERELA+), with its network of faith-based leaders and activists, given the centrality of religion in Malawi, and with the Coalition of Women Living with HIV/AIDS (COWLHA) to expand the constituency and organisational infrastructure and ensure ongoing training and outreach for the WLHIV.

In the course of the movement-building and community-based outreach, the WLHIV undertook participatory action research to build the evidence base for a concerted campaign to demand access to better quality ARVs. More than 60 activist leaders were trained on research design and interviewing skills and collaborated in creating survey tools. This resulted in 856 WLHIV from 13 districts in the North, Central and South regions being interviewed. This was followed by a National Dialogue on ART held in Lilongwe, where the Our Bodies, Our Lives campaign was launched, with duty-bearers and power-holders engaged to fulfil their roles towards WLHIV. Press briefings, feature articles in two national newspapers, daily news clips on national news as well as a 20-minute in-depth news special on national television were instrumental in generating broader interest, and as such in shifting hidden and invisible power.

<sup>79</sup> This case study write-up is based on two JASS publications, with the permission of JASS Malawi: Essof, S. and Khan, A. (2015). 'The Our Bodies, Our Lives Campaign for Better ARVs in Malawi: Enacting Social Accountability Through Women's Activism and Organising'; JASS. (2013). 'Making Change Happen: Power-Movements-Change: Malawi'.

<sup>80</sup> Essof, S. and Khan, A. (2015). 'The Our Bodies, Our Lives Campaign for Better ARVs in Malawi: Enacting Social Accountability Through Women's Activism and Organising'.

A total of 160 women from the 3 regions convened around the dialogue with key stakeholders and decision-makers, including the Malawi Human Rights Commission, the Malawi Health Equity Network and MANERELA+, to map out demands for quality ARVs. The women drafted a communiqué listing their demands to the minister of health (also the vice president of Malawi) and also participated in the March to SAVE Children and Their Mothers from HIV Infections, Stigma & Preventable Deaths. Key messages were sent out to President Joyce Banda and government officials on the devastating impact of Stavudine<sup>81</sup> on women's bodies, on stigma and discrimination against WLHIV and on the linkage between women's access to quality ARVs and their access to other critical resources, including fertiliser and savings loans, to promote healthy living.

The combination of strategies elicited results. In 2013, the government announced that it would accelerate its rollout plan, eliminating the phased approach that had previously made the less toxic ARV regimens available only to pregnant and breastfeeding women and those with higher viral loads. The announcement was a swift victory for WLHIV, although the challenges of sustained funding for and delivery of the new drug regimen to women persisted. After the campaign launch in September 2012, district focal points and campaign committees were established throughout the country in order to monitor rollout of Tenofovir-based ARV regimens and to help women deal with barriers to access. MANERELA+ makes routine visits to districts to collect data from activists and compare these with treatment data compiled by the Ministry of Health.

In August 2017, the campaign presence covered all 28 districts, and was 6,000 WLHIV-strong. Significantly, the campaign has evidenced a reversal of side-effects among women who have started the new drug regimen. Success has been registered in accelerated rollout of the WHO-recommended first-line ARV drug regimens to replace the lower-cost, more toxic alternatives women previously received, monitored by WLHIV. In villages where WLHIV are organising other WLHIV, there is 100% conversion to second-line regimens. There is also evidence of improved relations between WLHIV and health officers, leading to better access to multiple drug regimens, essential medicines and mobile health services. Women from the campaign work closely with district health centres, which see them as a resource. The campaign has also begun a rollout of women-centred treatment literacy, based on set treatment literacy modules developed specifically for this purpose. In addition, the campaign leaders have extended their advocacy efforts to Malawi's Global Fund Country Coordinating Mechanism around predictable funding for AIDS treatment and are extending their quest to broader goals, including increased access to livelihood support and the setting-up of savings clubs.

<sup>81</sup> Stavudine is an ARV medication that can have serious and life-threatening side-effects owing to its toxicity. WHO has recommended discontinuing and phasing out its use. [www.who.int/hiv/pub/guidelines/arv2013/arv2013supplement\\_to\\_chapter09.pdf](http://www.who.int/hiv/pub/guidelines/arv2013/arv2013supplement_to_chapter09.pdf)

## Case study 32. Namibian court rules against forced sterilisation of people living with HIV and AIDS

In 2014, the Supreme Court in Namibia issued a landmark ruling on the forced sterilisation of WLHIV, recognising the right to personality, to human dignity and to found a family. This led to a better respect of ethical procedures by health professionals in the case of sterilisation.

Three women living with HIV sued the government of Namibia, alleging that they had been sterilised without their informed consent. They asserted that this violated women's constitutional rights to life, liberty and human dignity and the right to found a family. In addition to arguing that their sterilisation was unlawful, the women contended that they had been discriminated against as a result of their HIV status, which amounted to a breach of their constitutional rights. At the heart of this case was the contention that the sterilisation procedures lacked the victims' consent—nor were they given information about the risks and consequences of such a procedure. The landmark Supreme Court ruling of 3 November 2014 agreed that the right to SRH for WLHIV in Namibia had been compromised through the practice of forced sterilisation.

In 2008, the Namibian Women's Health Network, a chapter of the International Community of Women Living with HIV (ICW), uncovered the alleged practice of hospitals forcefully sterilising HIV-positive women.<sup>xxxiv</sup> At an advocacy training event of the ICW, it emerged that at least three women present had been sterilised without prior informed consent.<sup>xxxv</sup> Women alleged various violations, including that they had been forcibly sterilised; others reportedly were shunning hospital services for fear of forced sterilisation and pressure to use injectable contraceptives.<sup>xxxvi</sup> One 26-year-old woman who had gone to give birth naturally but underwent a caesarean operation during labour was given forms to sign in that state, only to learn later when seeking contraception that she had been sterilised during the operation.

On following up on the claims, ICW noted a pattern of forced sterilisation confronting HIV-positive women who sought reproductive health services. Out of a sample of 230 women, at least 40 women claimed to have been forcibly sterilised. ICW referred 13 cases for litigation to the Legal Assistance Centre (LAC) and presented all 40 cases to the deputy minister of health and social services.<sup>xxxvii</sup>

LAC initiated summons proceedings for 18 cases separately and individually, all around the same time. The LAC lawyers and government attorneys agreed to proceed to trial with only three (the other cases had been instituted with the Court and were only stayed pending the outcome of the three cases). Since these were landmark cases, LAC sought to leave room to amend particulars of the other 15 cases in the event that the Court did not find merit in the 3 initial cases. Luckily this was not to be necessary for the remaining 15 cases; the pleadings required no changes.

In July 2012, the High Court of Namibia determined that all three women litigants were indeed sterilised without their informed consent in violation of the law. Although the judges rejected the discrimination claim, the ruling was nonetheless a major victory for the victims. When the government appealed the High Court's decision, the primary legal issue was whether the women had given their *informed* consent to be sterilised. In all three cases, the women signed consent forms while they were in labour, but argued that their signatures were coerced and that they were not provided adequate information to make an informed decision. The government argued that this was irrelevant, contending that the only question the High Court needed to consider was whether the women were aware that sterilisation leads to sterility.

In November 2014, the Supreme Court of Namibia upheld the ruling of the High Court against the forced sterilisation of three HIV-positive women in public hospitals in the case of *Namibia v LM and Others*.<sup>82</sup> This is the first ruling of its kind in Africa that addresses intersectional discrimination faced by women. However, the issue of whether they had been discriminated against on the basis of their HIV status was not resolved in the women's favour, although the Court noted that 'the tenor of the women's evidence strongly suggests that they believe that their HIV positive status was the primary reason for their sterilization'.

The Supreme Court referred to the Ethical Guidelines for Health Professionals published by the Health Professionals Council of Namibia, which state that 'everyone has the right to be given full information about the nature of his or her illnesses, diagnostic procedures, the proposed treatment and the costs involved'. The Court noted in its general remarks that 'Informed consent implies an understanding and appreciation of one's rights and the risks, consequences and available alternatives to the patient.' The judgement also stated that, in the context of a sterilisation, the woman must in fact be in a position to comprehend the nature and consequences of the operation to be performed on her, and obtaining the consent of a pregnant woman while she is in labour does not meet this threshold.

82 LM and Others v. the Government of the Republic of Namibia (I 1603/2008, I 3518/2008, I 3007/2008) [2012] NAHC 211 (30 July 2012). [www.saflii.org/na/cases/NAHC/2012/211.html](http://www.saflii.org/na/cases/NAHC/2012/211.html)

Changes in the practice of health professionals have emerged, with more caution taken to comply with proof of informed consent. After the case was determined, medical personnel in public hospitals have required women seeking sterilisation to provide police affidavits to that effect. However, activists are concerned that this shifts the burden to women seeking to realise their reproductive rights rather than the duty-bearers. Fear remains that, even after the Supreme Court judgement, the situation is not resolved for the majority of WLHIV in Namibia.<sup>cxviii</sup> This is particularly related to the failure of government to establish policies to ensure the practice will not be repeated for any women living with HIV.

The Abortion and Sterilisation Act is still silent on the need for informed consent for sterilisation procedures, and policy changes have not been evidenced to protect WLHIV from further violations of their reproductive rights. Despite this, the Supreme Court judgement (case law) changes the status quo and the Act should be read in conjunction with this decision. Notwithstanding the absence of policies, it will be against the law for any life-changing procedures to omit to follow the requirements as set out in the forced sterilisation cases because case law is law in Namibia. The Supreme Court's decision is binding and subject to adherence by all state health facilities.

### Case study 33. HIV-related forced sterilisation in Kenya

**This case led to increased attention to the abuse of WLHIV in health facilities. The initiators used evidence on forced and coerced sterilisation of WLHIV to mobilise public opinion and call health providers and the government to account in Court for discriminatory treatment and violation of the right to bodily autonomy and informed consent.**

In 2012, the African Gender and Media Initiative (GEM) published a report titled 'Robbed of Choice', which presented evidence on a continuing silent violation of rights against WLHIV. This involved forced or coerced sterilisation of 40 women living with HIV as well as women living with disabilities, particularly those from peri-urban settlements with little to no education.<sup>cxvix</sup> Forced and coerced sterilisation of women living with HIV has been documented in at least six countries in Africa: Kenya, Lesotho, Namibia, South Africa, Swaziland and Uganda. Among these states, Namibia remains the only one where litigation has successfully been advanced on the issue (see Case study 32).

In response to the report and inspired by the litigation case in Namibia, the Kenya Legal and Ethical Issues Network on HIV & AIDS (KELIN) developed a dual strategy that entailed both a legal and an advocacy response. The first response was to take legal action in order to secure justice for the aggrieved women. The second response involved advocacy towards raising awareness on forced sterilisation.

Kenya is the second country on the continent to have challenged the issue through court processes. This has been done through two sets of ongoing cases fronted by KELIN—namely, Petitions 605 and 606 of 2014,<sup>cxl</sup> against Médecins Sans Frontières, Marie Stopes International and the government through the Ministry of Health, for forced and coerced sterilisation of women living with HIV.<sup>83</sup> The cases demand accountability for the discriminatory treatment of women living with HIV between the years 2005 and 2010, when numerous women were forcibly sterilised. The cases advance Art. 14 of the Maputo Protocol, which provides for the right to bodily autonomy and to integrity, dignity, privacy, health and life. The cases further reinforce the norms and guidelines established by General Comment No. 2 of the ACHPR, which elaborates on SRHR.

Although these cases are still ongoing, they have involved unique strategies in that there have been several trainings undertaken in the country with the objective of creating awareness among women that forced sterilisation is a human rights violation and one for which duty-bearers must be held accountable. The trainings have also served as platforms for the identification of additional victims. The national and international media attention that the cases have received has led them to have a visible impact, including breaking the silence and stigma associated with infertility in an African setting, and thereafter many more claimants sharing their stories.

KELIN is hopeful that, beyond breaking the silence, the cases will be able to ensure the government and private health care facilities are held accountable for the violations. Moreover, this case will present an opportunity for the Court to interrogate the constitutional obligation of the state to provide the highest attainable standard of reproductive health based on both a national and an international obligation. The case will also present the court with an opportunity to address discrimination of women and the inter-sectionality of issues such as poverty, HIV and illiteracy. Finally, KELIN is hopeful that the cases will compel the Ministry of Health to issue a circular clarifying that it is not the policy of the state to sterilise women.

<sup>83</sup> The affidavits and responses by the government are available at [www.kelinkenya.org/wp-content/uploads/2017/12/PETITION-NO.-606-of-2014-.pdf](http://www.kelinkenya.org/wp-content/uploads/2017/12/PETITION-NO.-606-of-2014-.pdf)

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