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### Acronyms and Abbreviations

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<tr>
<td>ACHPR</td>
<td>African Commission on Human and Peoples’ Rights</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AMRH</td>
<td>African Medicines Regulatory Harmonisation Programme</td>
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<td>AU</td>
<td>African Union</td>
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<td>AUC</td>
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<td>ART</td>
<td>Anti-retroviral therapy</td>
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<td>ARV</td>
<td>Anti-retroviral medicine</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>DRC</td>
<td>Democratic Republic of Congo</td>
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<td>EAC</td>
<td>East African Community</td>
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<td>EALA</td>
<td>East African Legislative Assembly</td>
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<td>ECOWAS</td>
<td>Economic Community of West African States</td>
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<td>GBV</td>
<td>Gender-Based Violence</td>
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<td>GCHL</td>
<td>Global Commission on HIV and the Law</td>
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<td>GFATM</td>
<td>Global Fund to Fight against AIDS, Tuberculosis and Malaria</td>
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<td>GIMAC</td>
<td>Gender is my Agenda Campaign</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>LDC</td>
<td>Least Developed Country</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NEPAD</td>
<td>New Partnership for Africa’s Development</td>
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<td>NGO</td>
<td>Non-governmental organisation</td>
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<td>NSP</td>
<td>National Strategic Plan on HIV and AIDS</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PMPA</td>
<td>Pharmaceutical Manufacturing Plan for Africa</td>
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<td>REC</td>
<td>Regional Economic Community</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<td>SADC PF</td>
<td>Southern African Development Community Parliamentary Forum</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>TB</td>
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<td>TRIPS</td>
<td>Trade-Related Aspects of Intellectual Property Rights</td>
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<td>UN</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNGASS</td>
<td>United Nations General Assembly</td>
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<td>WAHO</td>
<td>West African Health Organisation</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Introduction

African leaders, supported by the African Union Commission (AUC) have delivered unprecedented achievements in addressing AIDS, Tuberculosis (TB) and Malaria since 2000. New HIV infections have diminished by 34% since 2001 and over 7 million Africans are receiving treatment. Almost 13 million Africans have been treated for TB since 2000 and there is a 33% reduction in the malaria burden with 1.1 million deaths averted since 2000.\(^1\)

However, the three diseases remain a serious threat to the people of the continent and to attaining Africa’s development goals. In 2012 there were an estimated 25.2 million people living with HIV and 70% of all new HIV infections came from Africa.\(^2\) Most (80%) of the 207 million malaria cases worldwide in 2012 were also in Africa, with a further 90% of deaths from malaria occurring in Africa.\(^3\) Of the 8.6 million people who developed TB in 2012, 27% were from Africa. HIV and TB co-infection are a priority concern with 75% of the estimated 1.1 million of all people with TB who are HIV-positive living in Africa.\(^4\)

In order to sustain African-owned health gains, the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Responses in Africa\(^5\) sets out practical solutions, under three action pillars, for enhancing responses to the three diseases in Africa by 2015. Responsibilities are shared between the AUC, New Partnership for Africa’s Development (NEPAD), Regional Economic Communities (RECs) and AU Member States with the technical support of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP), the World Health Organisation (WHO) and other UN partners. Action Pillar One of the Roadmap sets out priorities for diversified, balanced and sustainable financing models. Action Pillar Two outlines priority actions for accelerated access to affordable and quality assured medicines and health-related commodities. Action Pillar Three calls for enhanced leadership and governance, including through law and human rights programmes that enable communities to know and claim their rights and to participate effectively in national health responses.

This report, prepared with the support of UNDP and the Stop AIDS Alliance, provides AIDS Watch Africa (AWA) with updated information on Africa’s successes and remaining challenges in developing rights-based responses to AIDS, TB and malaria under Pillars Two and Three of the Roadmap, to support vulnerable individuals and communities to know and claim their rights to available, accessible, affordable and quality health care. Reflections on Africa’s achievements and challenges over recent years indicate that although great gains have been made towards understanding and committing to rights-based responses, in particular for HIV, including and addressing the rights of those most in need remains a challenge. Current momentum requires to be expanded, to prioritise the most marginalised and affected populations and to be monitored closely, in order to strengthen implementation of human rights and gender equality to address the needs of all affected populations in the future. As an advocacy platform for mobilizing leadership, resource mobilization and action and promoting accountability on AIDS, TB and Malaria, AWA’s review of progress is critical. The recommendations emanating from AWA will galvanize accelerated efforts to promoting human rights and gender equality for AIDS, TB and Malaria, supporting African countries to achieve the MDGs by 2015 and beyond.
Box 1. Legal and human rights-based commitments within AU Roadmap 2012

Pillar 2

“Governments should use policy levers to create an enabling environment and counter rules that hinder the development of local manufacturing or put local players at a disadvantage relative to their foreign competitors. Examples include eliminating import tariffs for Active Pharmaceutical Ingredients, eliminating export tariffs for finished products to regional countries, and providing targeted tax breaks for the industry.”

“A regional or full-continental African medicines regulatory agency could more efficiently take on centralized assessment of new medicines and inspection of manufacturing sites using a limited pool of regulatory expertise and a number of other specialized functions to complement and support African countries’ own drug regulatory agencies.

Under the aegis of the African Union, an African medicines regulatory agency would bring together regional initiatives and provide a single advocacy, regulatory and coordination platform for availability of quality-assured medicines, including antiretroviral drugs, on the African continent.”

“New rules set that seek TRIPS-plus provisions in the area of pharmaceutical patenting raise a number of challenges and should be resisted, while pursuing alternative mechanisms to foster innovation within the pharmaceutical sector in an affordable and sustainable manner. Extending the waiver to be TRIPS compliant for least developed countries beyond 2016 is currently under negotiation in the World Trade Organization. Countries should adopt a common voice to demand an extension to this transition period to allow for more time to create a sound and viable technological base in the pharmaceutical sector. In concert, legislative language could be amended to better facilitate actions that are needed to import generic drugs from existing suppliers (e.g. from China and India) so that there are no supply disruptions while Africa is building its manufacturing sector.”

Pillar 3

“[e]ffective HIV responses rest on the ability of individuals and communities and their systems, particularly those most vulnerable and affected by HIV to demand and access to effective preventive and health services. Programmes that empower affected communities to know and demand their rights are critical to the HIV response and need to be expanded significantly. Hence investments must be made in programmes to reduce HIV-related stigma and discrimination including roll-out of the People Living with HIV Stigma Index, provide legal aid and legal literacy, reform laws, train police on non-discrimination, engage parliamentarians and the judiciary on protective legal responses to HIV, reach out to vulnerable populations, address violence against women and train health care workers on non-discrimination, informed consent and confidentiality. Stronger and positive partnerships should be built with communities and civil society organisations, including people living with HIV, for a more transparent, accountable, rights-based and result-oriented response to HIV that addresses the protection and health needs of all those in need of services.

With regard to Tuberculosis control, empower people with TB, and communities through partnership should be strengthened through pursue advocacy, communication and social mobilization. In order to reduce stigma the efforts should be made to foster community participation in TB care, prevention and health promotion.”
Key Law & Human Rights Issues in relation to HIV, TB and Malaria

The AU has emphasised the critical role of protecting human rights in responses to AIDS, TB and Malaria in various platforms over the years.

In 2001, the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases\(^6\) recognised that stigma, silence, denial and discrimination increase the impact of the HIV epidemic and constitute major barriers to an effective response. It specifically noted the vulnerability of women and girls due to factors such as social and economic inequalities and traditionally accepted gender roles. In that same year, the African Commission on Human and Peoples’ Rights’ Resolution on HIV/AIDS Pandemic\(^7\) recognised HIV as a human rights issue, calling upon State Parties to the African Charter on Human and Peoples’ Rights\(^8\) (‘the African Charter’) to ensure human rights protection for those living with HIV against discrimination.

The 2006 Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, TB and Malaria Services in Africa\(^9\) (‘the Abuja Call’) recommitted Member States to promoting an enabling policy, legal and social environment to reduce vulnerability and promote human rights in the context of HIV, in particular for vulnerable and key populations including women, youth and children, conflict-affected and displaced persons, refugees and returnees. As an addendum, the AU also adopted the Continental Framework for Harmonization of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa.\(^10\) Furthermore, African states joined countries of the world, in terms of the United Nations General Assembly (UNGASS) Political Declaration on HIV and AIDS, 2011\(^11\) in committing to national HIV and AIDS strategies that promote and protect human rights, eliminate gender inequalities, review inappropriate laws and address the specific needs of vulnerable populations.

The Global Commission on HIV and the Law (GCHL), an independent body convened in 2010 by UNDP on behalf of UNAIDS, examined the impact of laws, policies and practices on HIV. It looked specifically at the criminalization of issues such as HIV transmission, drug use, sex work and same-sex sexual relations; issues of prisoners and migrants; the rights of women; children’s rights; and intellectual property laws for access to treatment. During 2011, the GCHL held 7 regional dialogues across the world, including in Cairo for the North Africa and Middle East region and in Johannesburg for sub-Saharan Africa.\(^12\) The GCHL report of July 2012 contains important findings and recommendations which if acted upon, can save lives and money, while playing a transformative role in the AIDS response. The report cited evidence indicating that law, enforcement and justice systems that protect equality of access to health care and prohibit discrimination, are able to better the lives of HIV-positive people and help turn the HIV epidemic around. It furthermore found that “punitive laws, policies and discriminatory practices such as brutal policing, denial of access to justice for people with and at risk of acquiring HIV are fuelling the epidemic.”\(^13\)

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) notes the various interactions between human rights, HIV and TB which fuel the spread of the diseases particularly amongst key populations such as “prisoners, migrants, men who have sex with men, transgender people, women and girls, youth, people with disabilities, sex workers and their clients, people who inject drugs, indigenous people, internally displaced people and others.”\(^14\) GFATM recognises that HIV, TB and malaria are linked to poverty and social inequality and vulnerable and marginalised populations with poor access to basic services are most affected. In the case of HIV, the GFATM also notes that for populations who face criminalisation, stigma and discrimination, lack of respect for human rights exacerbates the risk environment increasing the risk of HIV transmission, marginalising people living with and affected by the disease and making people less likely to access available prevention, testing, treatment, care and support services.\(^15\) The GFATM states that for these populations, “[t]heir access to relevant services is significantly lower than the rest of the population,
and thus dedicated efforts and strategic investments are required to expand coverage, equity and accessibility. They face frequent human rights violations, high barriers to services and limited recourse because of systematic disenfranchisement and social and economic marginalization and criminalization.”

Focus of this report
This report focuses on six priority law and human rights issues that must be addressed in Africa to support access HIV, TB and Malaria prevention and treatment for all vulnerable and affected populations:

- Stigma and Discrimination in the context of HIV, TB and Malaria;
- The Criminalisation of HIV Transmission;
- Gender Inequality, Harmful Gender Norms and Gender-Based Violence;
- Criminal Laws Affecting Key Populations at higher risk of HIV exposure;
- Young Peoples’ Sexual and Reproductive Health and Rights; and

Other challenging issues of concern, although not receiving specific focus in this report, include the health care rights of mobile, migrant and displaced populations, prisoners’ rights, children’s rights and the rights of people with disabilities.

The AUC Roadmap recognises that an effective, rights-based response requires AU Member States to not only create protective laws, regulatory systems and policies but also to strengthen access to justice and law enforcement, to enable affected populations to know and claim their rights to health care services for AIDS, TB and Malaria. UNAIDS has identified seven key law and human rights programmes relevant to an effective HIV response, all of which are also relevant in the context of TB and Malaria:

- Stigma and Discrimination Reduction Programmes
- Providing Legal Support Services
- Monitoring and Reforming Laws, Regulations and Policies
- Legal Literacy (“Know Your Rights”) campaigns
- Sensitization of Law Makers and Law Enforcement Agents
- Training for health care providers on Human Rights and Medical Ethics; and
- Programmes to reduce Gender Inequality, Harmful Gender Norms and Gender-Based Violence.

Given the extraordinary history of the AIDS response, the Roadmap treats AIDS as a “pathfinder” for responses to TB, Malaria and other diseases. In the case of law and human rights, this Report notes that to date, rights-based responses to the three diseases in Africa relate primarily to HIV and AIDS issues. However, there is a growing understanding of the interactions between TB, Malaria and human rights, which requires a more focussed response as increased attention is paid towards a post-2015 health goal.

Stigma and Discrimination
Stigma and discrimination are rife in many parts of the world and have been identified as a major impediment to universal access to health care in Africa. Some significant steps have been taken to show leadership towards and reduce HIV-related stigma and discrimination since 2012 at continental, regional and national level. Additionally, recent monitoring efforts have improved information on HIV-related stigma and discrimination, although information for TB, Malaria and human rights remains comparatively limited.

Malaria is not widely associated with systematic discrimination. However, the link between malaria and poverty, socio-economic equality and gender inequality is well understood. Reports of discrimination in national TB policies and practices include denying entry to those with previous or latent TB infection, deporting undocumented migrants with TB; mandatory treatment or confinement for drug-resistant TB and
health workers denying equal access to TB clinics to PLHIV, sex workers, transgender people and other marginalized populations.

The Global Commission’s Africa Regional Dialogue on HIV and the Law found that “both stigma and discrimination are key characteristics of the epidemic in Africa” impacting on people in their families, communities, workplaces, health facilities and schools. Findings of People Living with HIV (PLHIV) Stigma Index studies in countries across Africa found that discrimination against PLHIV included marginalisation from families and communities; verbal harassment, physical assault; loss of employment and coercive sexual and reproductive health care services. A third or more of the respondents in Kenya and Zambia said they that had been physically assaulted. Around 40% of respondents from Ethiopia, Malawi, Rwanda and Zambia reported having lost a job or another source of income, often as a result of both discrimination and poor health. In Ethiopia, Kenya, Malawi and Rwanda a third of more of the respondents reported being advised not to have children after being diagnosed HIV-positive. In Malawi, 11.5% of women who responded reported being coerced into sterilization and in Uganda 12% of female respondents reported coercion in relation to termination of pregnancy. Although few countries in Africa impose HIV-related travel restrictions, there are countries that restrict stay and residence for migrant populations living with HIV as well as those that restrict access to health care in law or policy, for migrants and refugees.

The PLHIV Stigma Index studies furthermore highlight challenges with access to justice. They show that people who experience HIV-related discrimination often do not know their rights and where or how to seek legal redress for human rights violations. Affected populations told how stigma and discrimination blocked access to health services and access to justice for rights violations. Protective HIV laws are often narrow, failing to address the layers of discrimination people face based on HIV status and also age, gender, sexual orientation, disability or migrancy.

Since 2012, the African Commission on Human and Peoples’ Rights (ACHPR) has renewed the mandate of the Committee on the Protection of the Rights of PLHIV and Those at Risk, Vulnerable to and Affected by HIV (‘PLHIV Committee’). The Committee called upon States Parties to the African Charter and African Women’s Protocol to adopt legal frameworks to protect the rights of women living with HIV, PLHIV and other vulnerable persons and to enhance access to HIV treatment, care and support in 2013. In that same year, the Pan-African Parliament committed to continue working with legislators to promote accountability, implementation of laws and resource mobilization for the HIV response.

The West African Health Organisation (WAHO) and the Economic Community of West Africa States (ECOWAS) is currently supporting the roll-out of 15 PLHIV Stigma Index across West Africa to better understand and respond to HIV-related discrimination. ECOWAS is finalising a Minimum Legal Framework for rights-based responses to HIV in member states. The East African Legislative Assembly (EALA) passed the East African Community (EAC) HIV and AIDS Prevention and Management Act in 2012, providing rights-based regional law for PLHIV, vulnerable populations such as women, children, people with disabilities, refugees and internally displaced persons as well as ‘most-at-risk populations’ for East Africa. The Act has since been assented to by 3 of the 5 Partner States, namely Burundi, Kenya and Uganda. The Southern African Development Community (SADC) is advocating for national legal and regulatory frameworks in SADC, based on the rights-based SADC Parliamentary Forum (PF) Model Law on HIV & AIDS for Southern Africa, 2008. With the support of UN partners and civil society organisations (CSOs), a number of regional workshops have been held to build capacity and sensitise law and policy decision makers, the judiciary as well as law enforcement agents to HIV, law and human rights.

At national level CSOs, including PLHIV networks, have played a critical role in advocating for and implementing human rights programmes for HIV and TB. In December 2012, almost 50 African countries
reported the full involvement of CSOs in developing their HIV strategies and participating in national AIDS structures. PLHIV Stigma Index studies, undertaken by PLHIV networks and partners, have been completed in over 15 countries in West, Central, East and Southern Africa and are underway in a number of other countries. Since 2012, countries such as Burkina Faso, Cameroon, DR Congo, Lesotho, Malawi, Nigeria and Swaziland have undertaken legal environment assessments with the support of UNDP, to analyse and strengthen enabling environments for HIV and AIDS. Around 35 AU Member States report having laws to protect people living with HIV from discrimination, many of which are HIV-specific laws. Namibia has repealed its travel restrictions on people living with HIV. National strategic plans on HIV (NSPs) commit to rights-based response to HIV, 90% of the NSPs include stigma and discrimination reduction programmes and many include training for health workers. Programmes to increase access to legal support services and those for key populations, however, need strengthening. Judicial recognition of the rights of people living with HIV continues to be confirmed in case law such as in the recent case of *LM & Others v Government of Namibia* 2012 which found in favour of 3 women living with HIV sterilised without their consent.

**Criminalisation of HIV Transmission**

The GCHL found that over 60 countries across the world make it a crime to expose another person to HIV or to transmit it, noting that “[s]uch laws do not increase safer sex practices. Instead, they discourage people from getting tested or treated, in fear or being prosecuted for passing HIV to lovers or children.” Significantly, a number of African Member States have shown a commitment towards reviewing and restricting, rather than strengthening punitive laws that criminalise HIV transmission in recent years; however new laws criminalising HIV transmission continue to be enacted in other countries.

In 2011, the GCHL Africa Regional Dialogue found a plethora of broad and ineffective laws specifically criminalising HIV transmission in Africa, many of which may disproportionately impact upon, rather than support women who may be first to learn their HIV status in a household. The GCHL and UNAIDS note the serious human rights and public health concerns raised by criminalisation, calling for the repeal of overly broad laws criminalising HIV transmission. UNAIDS recommends that criminal law only be applied to cases of intentional transmission – where a person knows his or her HIV-positive status, acts with the intention to transmit HIV and in fact transmits it – and recommends that the judiciary are supported with guidance and up-to-date medical evidence to adjudicate such cases appropriately.

Currently, around 25 countries in Africa have existing or draft laws criminalising HIV transmission with the most recent enactment taking place in May 2014. Many countries in West and Central Africa have broad criminalisation provisions based on the N’djamena Model Law. Laws may include vague and ambiguous provisions criminalising a range of acts that may expose a person to HIV (potentially including mother-to-child transmission of HIV in some cases), as well as intentional, reckless and negligent actions.

In recent years, there has been some progress towards reviewing, rather than strengthening, criminalisation of HIV provisions. At a sub-regional level, the 2012 EAC HIV and AIDS Prevention and Management Act follows the approach of the SADC PF *Model Law on HIV & AIDS in Southern Africa, 2008* in specifically excluding provisions criminalising HIV transmission. Countries across Africa have also taken steps to review criminalisation of HIV transmission provisions. The most recent draft HIV laws in Nigeria and Malawi now exclude the criminalisation of HIV transmission, and in 2014, parliamentarians in Mozambique and the DR Congo will consider revised provisions in their existing HIV laws to remove the criminalisation of HIV transmission. Other countries, such as Congo, Guinea, Senegal and Togo have recently reviewed their broad criminalisation provisions in line with UNAIDS guidance.
Gender Inequality, Harmful Gender Norms and Gender-Based Violence

To date, the global response to HIV and TB has failed to meet the specific needs of women and girls. HIV is the leading cause of death in women of reproductive age across the world and in Africa, women account for almost 60% of all people living with HIV. Sub-Saharan Africa is home to 92% of all pregnant women living with HIV and 3.1% of young women aged 15 to 24 are living with HIV, compared to 1.3% of young men. Around 20% more TB deaths in Africa occur among women than men. The ACHPR’s PLHIV Committee has noted the disturbing feminization of HIV in Africa, reporting that “[b]iological factors that make women and girls more vulnerable to HIV infection are exacerbated by socio-cultural and structural factors, such as poverty, harmful cultural practices, limited decision-making power, lack of control over financial resources, restricted mobility, violence, limited educational opportunities, and lack of quality sexual and reproductive health services.” Laws, policies and practices that perpetuate gender inequality, harmful gender norms and gender-based violence undermine women and girls, keeping them in poverty, limiting their autonomy and decision-making power, including their ability to access health care services.

A recent survey of 34 countries in Africa reveals that women continue to be more disadvantaged than men in their daily lives. Women lack access to the same levels of education, economic power and political leadership than men and report discrimination in the work place, courts and before traditional leaders. Laws regulating gender equality in Africa are complicated by plural and often conflicting legal systems and customary practices. The protection of gender equality in statutory and constitutional laws exists alongside inequitable customary and religious laws, attitudes and practices regulating private and family life, denying women rights to autonomy, equality in relationships, security of property ownership and financial control; this impacts on their power, control over household spending and health seeking behaviour more broadly. National HIV-specific anti-discrimination laws, where they exist, often fail to prioritise the needs of women as a vulnerable population.

In addition, laws and limited implementation and enforcement fail to adequately protect women from harmful gender norms and domestic and sexual violence. The UN Special Rapporteur on Violence Against Women highlighted health and demographic survey findings of the harmful effects of gender norms such as child marriage: “the majority of sexually active girls aged 15-19 in developing countries are married, and these married adolescents tend to have higher rates of HIV infection than their peers.” Research confirms that sexual as well as intimate partner violence places women at increased risk of HIV infection yet almost half of sub-Saharan African countries fail to criminalise marital rape. The rape of women in Africa places women at risk within their homes, their communities and within conflict zones where the rape of women and girl children is used as a weapon in war.

Studies indicate that women with HIV are more likely to experience discrimination than men living with HIV. They report stigmatisation, harassment, physical abuse, being thrown out of their homes and communities and being dispossessed of property, increasing their vulnerability. They also report discriminatory treatment from health workers when accessing sexual and reproductive health (SRH). For instance, women report being advised not to have children and being given anti-retroviral therapy (ART) on condition they use contraception. Women with HIV from Kenya, Malawi, Namibia, South Africa, Swaziland, Tanzania, Uganda and Zambia have reported forced or coerced sterilisation.

There are signs of progress in African countries in recognising women’s equality rights, protecting women from violence and harm and prohibiting HIV-related discrimination. At continental level, the African Commission’s PLHIV Committee has noted the HIV-related violations of women’s human rights guaranteed under the African Charter and African Women’s Protocol and in particular the violation of sexual and
reproductive health and rights (SRHR) as a result of stigmatization, breaches of confidentiality, forced abortion and even involuntary sterilization. In 2013, the PLHIV Committee and the Special Rapporteur on the Rights of Women in Africa held regional sensitisation seminars on women and HIV for legal, HIV and human rights institutions to promote rights-based responses to women and HIV.67 Their Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services68 was subsequently adopted by the Commission at its 55th Ordinary Session.69 The Gender is My Agenda Campaign (GIMAC) has continued to advocate for gender mainstreaming and equality of women in Africa, with a 2013 recommendation to Member States of the AU to “ensure women’s equal participation in all spheres of decision-making and the equitable distribution of resources in the post-2015 development framework”.70

At sub-regional level, laws such as the SADC PF Model Law on HIV & AIDS in Southern Africa and the more recent EAC HIV and AIDS Prevention and Management Act, 2012 include recognition of gender equality and the particular rights of women living with HIV.

A number of countries in Africa have enacted, strengthened or are considering draft laws prohibiting intimate partner and sexual violence. Twenty countries in Africa now criminalise marital rape. Nearly all sub-Saharan African countries include gender equality initiatives in their national HIV responses and around 30 countries address gender-based violence (GBV) in national HIV responses, although implementation is argued to be varied72 and GBV services are acknowledged to be inadequate.72 Notably, research shows the need to strengthen involvement of women, in all their diversity, in national HIV responses.73

Criminal Laws Affecting Key Populations

The HIV epidemic continues to have a profound effect on key populations at higher risk of HIV exposure such as sex workers, men who have sex with men (MSM), transgender people and people who inject drugs.74 Global HIV prevalence figures find female sex workers 13.5 times more likely to be living with HIV than other women. A recent analysis in sub-Saharan Africa found pooled HIV prevalence of 36.9% among female sex workers.75 In 2012, the highest global median HIV prevalence rates amongst MSM were reported in Western and Central Africa (19%) and East and Southern Africa (15%).76 People who inject drugs account for 5-10% of the world’s population of people living with HIV.77

Criminal laws have been shown to increase stigma, discrimination and violence against key populations across the world.78 Over 30 AU Member States criminalise same-sex relationships in some way, often with penalties of up to 14 years imprisonment.79 Some countries allow for life imprisonment and even the death penalty for those convicted.80 In addition, sex work, or aspects of sex work, is criminalised in 35 AU Member States.81 The GCHL Africa Regional Dialogue found that criminalisation placed people at increased risk of violence and harassment from law enforcers and the public, driving key populations underground and deterring access to health care services.82 Key populations such as sex workers, MSM and people who inject drugs are less likely to access appropriate health care services to meet their specific HIV prevention, treatment, care and support needs. National funding for targeted programmes is generally inadequate.83

For these marginalised, key populations, there have been limited protective, rights-based responses at continental, regional and national level. At regional level, there have been efforts to include the protection of all “most-at-risk” or marginalised populations, within law and policy, including in the EAC and SADC regional HIV laws. This level of protection has yet to be translated to national level HIV-specific laws which tend to focus narrowly on the rights of PLHIV. While a number of national HIV policies and NSPs are beginning to refer to and include sex workers and their clients as well as MSM, as key populations, a 2011 review of NSPs in Eastern and Southern Africa shows that generally, national HIV responses fail to include the participation of and prioritise the needs of key populations in HIV-related law and human rights
programmes. Progress towards protecting key population rights in HIV policies and plans also conflict with recent national-level calls for and the enactment of draconian laws as well as harsh law enforcement initiatives against same-sex individuals and support organisations in a number of countries across the continent. These laws and the accompanying show of force are exacerbating discrimination and violence against sexual minorities, driving them underground and limiting their access to health care services.

**Young People’s Access to Health including Sexual & Reproductive Health and Rights**

Sub-Saharan Africa has achieved a 42% reduction in HIV prevalence amongst young people (aged 15 to 24 years) since 2001. HIV awareness, knowledge of HIV prevention, condom use and access to HIV testing has increased and sex before 15 years of age is decreasing amongst young people. However, young people remain vulnerable to HIV infection. In 2012, 2.5% of all people aged 15 to 24 in sub-Saharan Africa were living with HIV, with up to 20% of young people in Swaziland affected. Young women are still twice as likely as young men to be HIV-positive and generally, HIV awareness still remains low. With TB, adolescents and adults still account for the largest share of the burden of TB disease worldwide.

One of the greatest challenges affecting young people in Africa is their limited ability to access their right to high quality, confidential, youth friendly sexual and reproductive health information and services independently of their parents or guardians. This is compounded by contradictory laws, policies and attitudes about the competency of youth to make autonomous decisions in relation to sex, marriage and accessing medical treatment. In a number of countries, children can lawfully have sex or even marry before the age at which they can get medical treatment without their parents’ consent, or can receive comprehensive sexuality education. Few African countries have laws that set an age at which children can consent independently to medical treatment, HIV testing or accessing contraceptives; there are also few laws that recognise the rights of young people to sexuality education.

Countries that have adopted new children’s laws based on the Convention on the Rights of the Child (CRC) and new HIV-specific laws often include provisions for young people’s rights to health information and services. For instance, in Kenya the HIV and AIDS Prevention and Control Act, 2006 gives young people the right to comprehensive sexuality education and the Children’s Act provides every child with the right to health and medical care. Some countries such as Nigeria, Senegal, South Africa, Swaziland and Lesotho have followed international as well as regional guidance (in the SADC PF and EAC HIV laws) in specifying a lower age at which children can consent independently to medical treatment, HIV testing or accessing contraceptives; in Lesotho, the Children’s Protection and Welfare Act, 2011 allows a child of 12 to consent independently to medical treatment if they are of “sufficient maturity and have the mental capacity to understand the benefits, risks, social and other implications of the treatment or operation” and in Senegal the 2010 HIV Law provides that a minor over the age of 15 may consent independently to HIV testing. However, these provisions often conflict with other existing national laws relating to the age of consent to sex (which ranges from 12 in Angola to 18 in Uganda), early marriage (at 14 in countries such as Tanzania) and the broader age of consent to medical treatment or age of majority, which is as high as 21 years in Zambia.

**An Enabling Legal Environment for Access to Affordable, Quality-Assured Treatment**

Intellectual property remains a critical factor affecting access to affordable and quality-assured medicines in Africa. An effective framework for medicines regulation is also vital to ensuring the fast, effective and safe introduction and monitoring of pharmaceutical products in the market. There continues to be positive continental and regional progress towards creating an enabling environment for local pharmaceutical production and for increased access to medicines; however further work and collaboration is required in order to make optimal use of the opportunities available to countries.
The AU / NEPAD Agency’s African Medicines Regulatory Harmonisation (AMRH) Programme aims for effective regulation and harmonization of medical products to increase access to affordable, safe, high quality and effective medical products for Africans. The Pharmaceutical Manufacturing Plan for Africa (PMPA) aims “to pursue, with the support of our partners, the local production of generic medicines on the continent and to making full use of the flexibilities within the Trade and Related Aspects of Intellectual Property Rights (TRIPS) and the DOHA Declaration on TRIPS and Public Health”. In collaboration with partners throughout 2013, including the Pan-African Parliament, this Programme developed a draft AU Model Law on Medical Products Regulation and Harmonisation, which is critical for the full implementation of the AU Roadmap. On 26-28 November 2013, the AUC PMPA Consortium convened a “Stakeholder Workshop on Identifying Key Policy Actions to Create an Enabling Environment for Pharmaceutical Production in Africa” in Abidjan. The meeting resulted in the formation of an Action Plan to promote an enabling legal and policy environment for local production of quality pharmaceuticals in Africa.

AU Member States continue to work towards creating a legislative environment that incorporates the full use of TRIPS flexibilities. AU Member States contributed to a debate at the World Trade Organisation’s TRIPS Council, which in June 2013 resulted in the Council agreeing to extend the deadline for Least Developed Countries (LDCs) to comply with the TRIPS Agreement until 1 July 2021. This outcome has the potential to support the promotion of medicines manufacturing hubs in African Least Developed Countries (LDCs), as well as supporting the acquisition of essential skills through technology transfer; however a number of LDCs are yet to make use of this opportunity.

At a national level, a number of countries continued to engage in policy reforms to incorporate public health flexibilities in 2013. Government and civil society actors in Botswana, Malawi, Swaziland and Zambia held workshops in 2013 to strengthen capacity to engage in law and policy reform by developing action plans for the incorporation or use of TRIPS flexibilities. Other AU Member countries took concrete steps to strengthen legislative environments to make use of TRIPS flexibilities in 2013. Uganda passed an Industrial Property Act in 2014 which incorporates a number of public health sensitive flexibilities. The need to avoid incorporation of TRIPS-plus measures which may constrain the availability of generic competition in health-related technologies, for instance through free trade agreements or anti-counterfeiting measures, remains important in Africa. The Kenyan government commenced a review process in 2013 of its anti-counterfeiting legislation to ensure its compliance with the Constitutionally-affirmed right to health, including to essential medicines. Civil society organisations in that country have been active to ensure this mandate is effectively fulfilled by the review process.
Recommendations / Way Forward

- **Continued prioritisation of rights-based responses to HIV, TB and Malaria in Law, Access to Justice and Law Enforcement for all affected populations:**
  - Advocate for increased awareness and understanding of, accountability to and monitoring of rights-based responses to HIV, TB and malaria in terms of commitments made by AU Member States.
  - Continue to expand and broaden efforts to develop and implement protective, anti-discrimination laws and policies, and
  - Strengthen the implementation of regional and national programmes to increase awareness of human rights and gender equality, reduce stigma, discrimination, human rights violations, harmful gender norms and gender-based violence, increase access to justice and improve law enforcement for PLHIV and all vulnerable and key populations at higher risk of HIV exposure.

- **Strengthened efforts to protect the rights of vulnerable and key populations at higher risk of HIV exposure:**
  - Develop measures to increase the participation of all affected populations in national, regional and continental responses to HIV, TB and Malaria with a particular emphasis on vulnerable populations such as women, youth, children, people with disabilities and mobile, migrant and displaced populations and key populations at higher risk of HIV exposure.
  - Review and repeal discriminatory, punitive or coercive responses, including criminal laws for HIV, people living with HIV and all vulnerable and key populations.
  - Prioritise efforts to recognise women’s rights to equality in law, policy and practice, strengthen women’s access to resources and services, including health services, address harmful gender norms and eradicate all forms of gender-based violence, and
  - Develop laws, policies and programmes to increase young people’s access to age appropriate health care, including sexual and reproductive health services.

- **Continue efforts to create an enabling legal and regulatory framework for access to medicines:**
  - Strengthen review of laws and measures to fully incorporate and when necessary, utilize all public health related TRIPS flexibilities and avoid limits on the use of public health related TRIPS flexibilities. In particular, African LDCs should take steps to take full advantage of the extension to become TRIPS compliant.
  - Continue developing a positive, public health driven agenda that focuses on safety, quality and efficacy of medicines and developing the capacity and competence of drug regulatory agencies.
  - Build on efforts towards increased and quality assured local manufacturing of pharmaceutical products, including through advancement of an enabling legal environment (especially for effective medicines regulation and for a flexible intellectual property framework) which encourages technology transfer. Opportunities for South-South cooperation in the field of local pharmaceutical manufacturing as well as opportunities for exporting to countries with insufficient or no manufacturing capacity need further exploration.

- **Prioritisation of human rights based responses to HIB, TB, Malaria and health, including the needs of vulnerable and key populations, post-2015:**
  - Ensure the recognition of human rights based responses to HIV, TB, malaria and health more broadly, prioritising the needs of marginalised populations, are central to the post-2015 development agenda.
## Annex 1: Status of HIV-related Laws in African Union Member States

<table>
<thead>
<tr>
<th>AU Member States</th>
<th>Protection of PLHIV from Discrimination</th>
<th>Criminalisation of HIV Transmission</th>
<th>Criminalisation of Same-Sex Relationships</th>
<th>Criminalisation of (aspects of) sex work</th>
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Sources: GNP+; UNAIDS; UNDP; ILGA
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Annex 3: End Notes


5 Developed by the AUC in response to AU Decision Assembly/AU/Dec.413 (XVIII) to develop “a roadmap of shared responsibility to draw on African efforts for a viable health funding with support of traditional and emerging partners to address AIDS dependency response.”


9 Sp/Assembly/AU/Atm/2 (I) Rev.3, Special Summit of African Union on HIV and AIDS, Tuberculosis and Malaria, Abuja, Nigeria, 2-4 May 2006.


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21 In Cameroon, Ethiopia, Democratic Republic of Congo (DRC), Gambia, Kenya, Malawi, Mauritius, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Sudan, Swaziland, Uganda, United Republic of Tanzania and Zambia; see also www.stigmaindex.org (Accessed 10th April 2014); see also UNAIDS (2013) Stigma Index Review: East and Southern Africa (draft).


23 Ibid.

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Article 12.