Righting laws: An appraisal of human rights in the context of HIV and their applicability to the normative content and implementation of HIV-specific laws in sub-Saharan Africa

By

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This Research Project is submitted in fulfilment of the regulations for the PhD Degree, College of Law and Management, School of Law, at the University of KwaZulu-Natal, Pietermaritzburg, South Africa.

Declaration by supervisor

As the candidate's supervisor I agree to the submission of this thesis.

Ann Elaine Strode

Signed:

Date: 07 March 2017

Declaration of originality

I, Patrick Michael EBA, declare that:

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(ii) This thesis has not been submitted for any degree or examination at any other university;

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Acknowledgements

'Dans mon pays, on remercie.'

René Char, "Qu'il vive ! ", Les Matinaux, 1950

Though not the easiest segment of this thesis, I must admit that writing this acknowledgement fills me with happiness for two reasons. First, as I pen these words, I am finally about to close three years of learning, hard work, doubts and also absences. Soon, my family will see more of me on weekends and during holidays. And, I will be fully with them; ending my half-presence of the past few years and its inherent sense of guilt. Second, I have here the opportunity to express my gratitude to all the persons whose support, generosity, ideas, understanding and prayers have made it possible for me to pursue and complete this PhD thesis.

I would like to start by thanking my father; an orphan son of farmers, with a staunch belief in education that continues to inspire me. It is his example that awakened me to a world of academic excellence. This thesis is as much his achievement as it is mine. I am grateful to my wife, Hye-Young, and my children – Paul-André, Hanl and Isl – for their understanding and support as I embarked on this not-so-wise idea of pursuing a full time doctoral degree while maintaining a rewarding but demanding job.

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This thesis is dedicated to the loving memory of my aunt, Eba Ama.

Acronyms

ACHPR	African Charter on Human and Peoples' Rights
ACRWC	African Charter on the Rights and Welfare of the Child
AHRLR	African Human Rights Law Reports
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
AWARE-HIV/AIDS	Action for the West African Region on HIV/AIDS
BCLR	Butterworths Constitutional Law Reports
BLR	Botswana Law Reports
BwCA	Botswanan Court of Appeal
CDC	Centers for Disease Control
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERPOD	Center for Studies and Research on Population for Development
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CRC	Convention on the Rights of the Child
DRC	Democratic Republic of Congo
EAC	East African Community
EALA	East African Legislative Assembly
EALS	East African Law Society
EANNASO	Eastern Africa National Networks of AIDS Service Organisations
ECHR	European Court of Human Rights
ECOWAS	Economic Community of West African States
eKLR	Electronic Kenya Law Reports
FAAPPD	Forum of African and Arab Parliamentarians for Population and Development
GC	General Comment
GIPA	Greater Involvement of People living with and affected by HIV/AIDS
HAART	Highly Active Antiretroviral Treatment

HAPCA	HIV and AIDS Prevention and Control Act (of Kenya)
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
IGAD	Inter-governmental Authority on Development
ILO	International Labour Organisation
IPU	Inter-Parliamentary Union
KANCO	Kenya AIDS NGOs Consortium
KELIN	Kenya Legal and Ethical Issues Network on HIV
LGBT	Lesbian, Gay, Bisexual and Transgender (persons)
MSM	Men who have sex with men
MWIRC	Malawi Industrial Relations Court
NACOPHA	National Council of People Living With HIV/AIDS (Tanzania)
NASC	Namibian Supreme Court
NEPHAK	National Empowerment Network of People living with HIV and AIDS in Kenya
NgHC	Nigerian High Court
NGO	Non-Governmental Organisation
NSWCCA	New South Wales Court of Criminal Appeal (Australia)
OHCHR	Office of the High Commissioner for Human Rights
OSIWA	Open Society Initiative for West Africa
PEP	Post-Exposure Prophylaxis
PITC	Provider-Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
RSA	Republic of South Africa
SADC	Southern African Development Community
SADC PF	Southern African Development Community Parliamentary Forum
SARS	Severe Acute Respiratory Syndrome
SCR	(Canadian) Supreme Court Reports

STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TB	Tuberculosis
UDHR	Universal Declaration on Human Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drug and Crime
US or USA	United States of America
VCT	Voluntary Counselling and Testing
WAHO	West African Health Organisation
WHO	World Health Organisation

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Hoffmann v South African Airways (CCT17/00) [2000] ZACC 17 81

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Note to the reader

This thesis is essentially composed of articles submitted to, or published in, different peer reviewed journals. As a result, the structure, formatting, editing and referencing style is different from one chapter to the other. Since each submitted or published article is a stand-alone document, acronyms and abbreviations are repeated, and cross-referencing of footnotes between chapters was not possible. The numbering of pages is done separately for each chapter. However, to facilitate the reading and examining of the thesis, consecutive chapter and page numbers have been added as superscript at the top of the pages.

Chapter One: Introduction – human rights in the context of HIV and their application to HIV-specific laws in sub-Saharan Africa

1.1 Overview

This thesis is a contribution to the literature on the role of the law and human rights in public health responses generally, and in the response to the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) epidemic in particular.[1] It uses human rights norms and frameworks to review how laws and policies influence vulnerability to HIV and barriers to effective HIV prevention, treatment and care. It also briefly reflects on the role of human rights in other public health challenges, such as the outbreak of Ebola in West Africa in 2014 - 2015.

This thesis offers the first comprehensive human rights analysis of the normative content and intrinsic implementation issues in 26 of the 27 HIV-specific laws adopted across sub-Saharan Africa in the past 15 years. It concludes with recommendations for improving lawmaking on HIV and other health-related issues.

This thesis is based on two interrelated premises:

1. Laws that ignore human rights norms and public health evidence contribute to increased vulnerability to HIV, and they often represent barriers to accessing HIV services, particularly for the populations that are most affected by the epidemic.

2. Human rights norms and sound public health evidence are critical to effective lawmaking in relation to HIV. This thesis argues that HIV-related laws that

[1] HIV refers to the virus that causes AIDS and AIDS describes a clinical syndrome. This thesis uses the term that is most specific and appropriate in each context in order to avoid confusion. In keeping with the UNAIDS terminology guidelines, this thesis will generally use the following expressions: 'people living with HIV', 'HIV prevalence', 'HIV epidemic', 'AIDS epidemic', 'HIV prevention', 'HIV testing and counselling', 'HIV-related disease', 'AIDS diagnosis', 'children orphaned by AIDS', 'AIDS response' and 'national AIDS programme'. In general, HIV will be the preferred term used in the thesis as it is more inclusive. For more information on the use of the terms 'HIV' and 'AIDS' and other HIV-related terminology, see UNAIDS *UNAIDS terminology guidelines* (2015) available at *http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf*, accessed on 5 March 2017.

ignore these human rights norms and the principles of sound HIV policy are likely to face challenges in their implementation.

This chapter presents the background to the thesis. It succinctly shows that, in spite of recent progress, the HIV epidemic remains a serious public health challenge, particularly in sub-Saharan Africa.

This chapter also discusses the role of the law and human rights norms in relation to HIV. It interrogates the pertinence and 'resilience' of human rights at a time of increased calls for accelerating biomedical responses to HIV that are centred on scaling up highly active anti-retroviral treatment (HAART). It also discusses the current contestation of the application of human rights to marginalised populations, and it describes the emergence of HIV-specific laws in sub-Saharan Africa and the criticisms that they have generated. Finally, this chapter outlines the objectives, research questions, premise, limitations and structure of the thesis.

1.2 HIV in sub-Saharan Africa: A serious epidemic in spite of recent progress

The HIV epidemic continues to represent a major public health challenge across sub-Saharan Africa. In 2015, there were an estimated 25.5 million people living with HIV in sub-Saharan Africa, which represents some 69.4% of the global total.[2] In that year alone, there were some 800 000 deaths due to AIDS-related illnesses in the region.[3] The HIV epidemic also is contributing to high tuberculosis (TB) incidence and deaths: TB is the leading cause of deaths among people living with HIV in the region.[4] Lastly, the impact of the HIV epidemic on families is significant. As of December 2012, an estimated 15 million children in sub-Saharan Africa had lost one or both parents to AIDS, which represents 85% of the global total.[5]

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[2] UNAIDS *AIDS by the number* (2016) 12-13 available at *http://www.unaids.org/sites/default/files/media_asset/AIDS-by-the-numbers-2016_en.pdf,* accessed on 26 August 2016.
[3] Ibid.
[4] WHO *Global tuberculosis report 2015* (2015) 8 available at *http://apps.who.int/iris/bitstream/10665/191102/1/9789241565059_eng.pdf*, accessed on 26 August 2016.
[5] UNICEF *Towards an AIDS-Free Generation. Children and AIDS: Sixth Stocktaking Report 2013* (2013) available at

The HIV epidemic in sub-Saharan Africa is far from homogenous. Countries in Eastern and Southern Africa are generally more affected by HIV than those in West and Central Africa (see Table 1). For instance, there are six countries in the world that have an HIV prevalence above 15% in the adult population (also referred to as 'hyperendemic countries'), and they are all in Southern Africa. With the exception of Equatorial Guinea, every country in West and Central Africa has an HIV prevalence in the adult population (aged 15 - 49) that is less than 5% (see Table 1).

Table 1. Estimated HIV prevalence (persons aged 15 - 49 years) in sub-Saharan African countries in 2014[6]

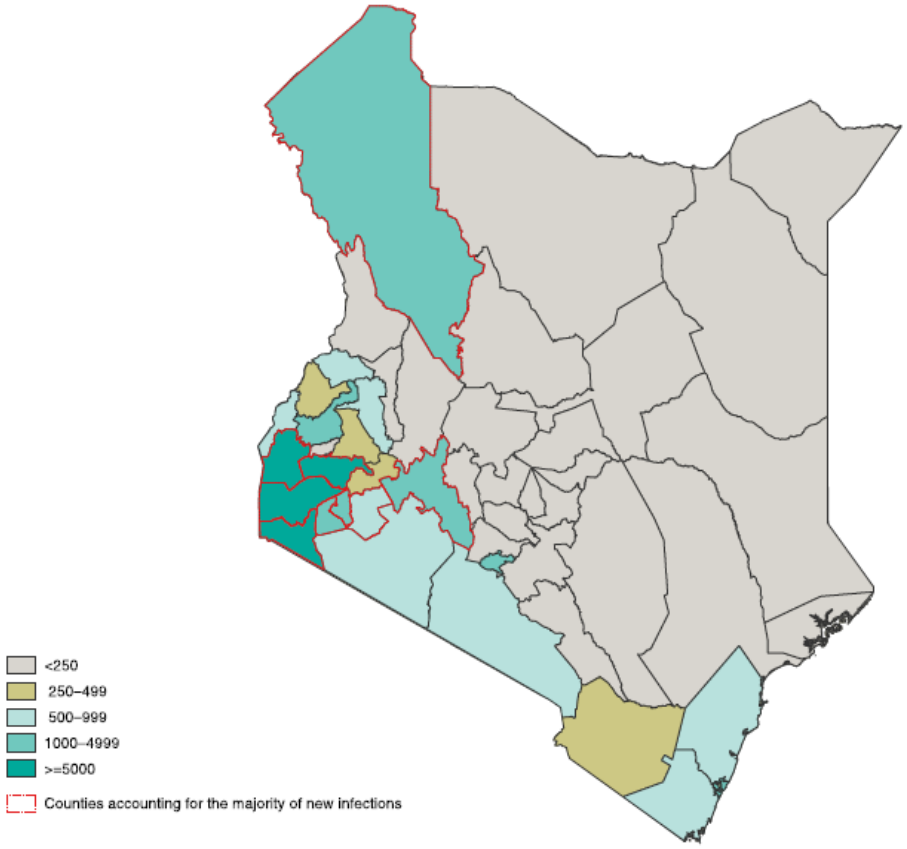
Sub-region	HIV prevalence below 1%	HIV prevalence between 1 and 5%	HIV prevalence between 5 and 10%	HIV prevalence above 10%
West and Central Africa	Burkina Faso (0.9%), Mauritania (0.7%), Niger (0.5%), São Tomé and Príncipe (0.8%), and Senegal (0.5%)	Benin (1.1%), Burundi (1.1%), Cameroon (4.8%), Cape Verde (1.1%), Central African Republic (4.3%), Chad (2.5%), Congo (2.8%), Côte d'Ivoire (3.5%), DRC (1%), Gabon (3.9%), Gambia (1.8%), Ghana (1.5%), Guinea (1.6%), Guinea-Bissau (3.7%), Liberia (1.2%), Mali (1.4%), Nigeria (3.2%), Sierra Leone (1.4%), and Togo (2.4%)	Equatorial Guinea (6.2%)	
Eastern and Southern Africa	Eritrea (0.7%), Madagascar (0.3%), Mauritius (0.9%)	Angola (2.4), Ethiopia (1.2%), Rwanda (2.8%), and South Sudan (2.7%)	Kenya (5.3%), Malawi (10%), Uganda (7.3%), and Tanzania (5.3%)	Botswana (25.2%), Lesotho (23.4%), Mozambique (10.6%), Namibia (16%), South Africa (18.9%), Swaziland (27.7%), Zambia (12.4%), and Zimbabwe (16.7%)

http://www.unaids.org/sites/default/files/media_asset/20131129_stocktaking_report_children_aids_en_0.pdf (accessed on 26 August 2016).

[6] UNAIDS *How AIDS changed everything. MDG 6: 15 years, 15 lessons of hope from the AIDS response* (2015) available at http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf, accessed on 26 August 2016.

Significant differences in HIV prevalence and incidence also exist within countries. In Kenya, 65% of all new HIV infections in 2014 occurred in nine of its 47 counties (see Figure 1). Similar trends are reported across sub-Saharan Africa, with higher HIV prevalence and incidence being concentrated in specific parts of the different countries.

Figure 1. Estimated new HIV infections in Kenya in 2014 by county[7]



Important progress against HIV in sub-Saharan Africa has been made in recent years. The number of people receiving anti-retroviral therapy (ART) in the region has increased, rising from fewer than 100 000 in 2000 to 11.8 million in 2015.[8] Coverage of programmes for the prevention of mother-to-child transmission (PMTCT) also has increased drastically, particularly in Eastern and Southern Africa, where 90% of pregnant women living with HIV in 2015 were reported to be receiving effective anti-

[7] UNAIDS *On the Fast-Track to end AIDS by 2030: Focus on locations and populations* (2015) 14 available at *http://www.unaids.org/sites/default/files/media_asset/WAD2015_report_en_part01.pdf*, accessed on 26 August 2016.
[8] UNAIDS (note 2 above; 13).

retroviral medicines (ARVs) for PMTCT.[9] Consequently, in some countries (such as Botswana, where PMTCT coverage is above 90%), vertical HIV transmission rates have been reduced to below 5%.[10] In general, new HIV infections in sub-Saharan Africa have dropped from 2.3 million in 2000 to 1.4 million in 2014.[11]

Notable differences in progress made against the HIV epidemic exist between countries. In general, countries in Eastern and Southern Africa are witnessing more robust progress in access to ART than are countries in West and Central Africa. For instance, just 29% of adults living with HIV in West and Central Africa have access to ART, compared to 53% in Eastern and Southern Africa. Only 20% of children under the age of 15 who are living with HIV in West and Central Africa were accessing ART in 2015, compared to some 63% of their peers in Eastern and Southern Africa.[12]

A recent report by Médecins Sans Frontières, a non-governmental organisation (NGO), blames the situation in West and Central Africa on several factors, including the following:

- high stigma and discrimination;
- weak health systems and inadequate service delivery models;
- limited roles for civil society;
- low prioritisation of HIV;
- lack of political leadership; and
- delayed responses to the needs of people living with HIV in the context of recurrent humanitarian crises in the region.[13]

Regardless of the nature and level of the HIV epidemic, data show that specific

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[9] UNAIDS *Prevention gap report* (2016) 236 available at *http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf*, accessed on 26 August 2016.
[10] UNAIDS *2015 Progress report on the global plan towards the elimination of new HIV infections among children and keeping their mothers alive* (2015) 9 available *http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf,* accessed on 26 August 2016.
[11] UNAIDS (note 6 above; 457).
[12] UNAIDS (note 2 above; 14).
[13] Médecins Sans Frontières *Out of focus: How millions of people in West and Central Africa are being left out of the Global AIDS Response* (2016) available at *http://www.msf.org/sites/msf.org/files/2016_04_hiv_report_eng.pdf*, accessed on 26 August 2016.

population groups in all sub-Saharan African countries are particularly affected by the epidemic, including women and girls, prisoners, gay men and men who have sex with men, transgender people, people who inject drugs and sex workers.[14] These populations, which include groups referred to as 'key populations,'[15] experience higher HIV prevalence and incidence, and they often have limited access to HIV prevention, treatment and care services.[16] Even in high-prevalence settings, HIV prevalence among members of key populations is higher than it is among the general population. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), 17 of the 18 countries where HIV prevalence among sex workers exceeds 20% are located in sub-Saharan Africa.[17] HIV prevalence among men who have sex with men in Western and Central Africa is over 18% (compared to less than 2% among the general population in the same area),[18] and available data on HIV among both prisoners and people who inject drugs point to particularly high HIV prevalence among these populations in sub-Saharan Africa.[19]

High HIV prevalence among key populations cannot be justified only by biology or sexual practices. Stigma, discrimination, violence, negative gender and heteronormative constructs, and criminal laws against members of key populations all have been shown to increase their vulnerability to HIV and limit their access to HIV services.[20] For instance, harassment, violence (including by police) and denial of prevention services (such as harm reduction programmes) contribute to higher

[14] UNAIDS *The gap report* (2014) 26-48 available at *http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf*, accessed on 26 August 2016.
[15] UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the main key population groups. These populations often face punitive and restrictive laws and practices, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response, meaning that they are key to the epidemic and the response to it. See UNAIDS (note 1 above).
[16] See UNAIDS (note 14 above).
[17] UNAIDS (note 14 above; 45).
[18] UNAIDS (note 14 above; 205).
[19] UNAIDS (note 14 above).
[20] WHO *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (2014) available at http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1, accessed on 26 August 2016.

vulnerability to HIV among people who use drugs and their sexual partners.[21] HIV-positive people who inject drugs experience barriers in accessing ART and other healthcare services due to discrimination in healthcare settings; they also face abuse, detention and denial of care.[22] Other members of key populations face similar vulnerabilities and barriers (see Chapter Three).

In light of those factors, effective responses to the HIV epidemic in sub-Saharan Africa should consider the nature of the respective epidemics and their different effects on countries, locations and populations. They then must develop tailored responses to respond to the particular challenges facing specific populations and locations.[23] In particular, vulnerabilities and barriers – including in law, policy, and practices – experienced by key populations in each context must be identified and addressed.

1.3 The law as a 'sword or shield' in relation to HIV[24]

From its inception, the HIV epidemic has generated fear, prejudice and stigma, and this has led to discrimination and other human rights violations against people living with, affected by, or perceived to be vulnerable to HIV.[25] Without seeking to excuse those acts, several reasons may explain the high level of stigma and discrimination associated with HIV.

First, because the early cases of what would later become known as AIDS were discovered among young gay men, the epidemic was initially associated with

[21] R Jurgens, J Csete, J Amon, S Baral & C Beyrer 'People who use drugs, HIV, and human rights' (2010) 376(9739) *Lancet* 475-485.
[22] Ibid.
[23] See UNAIDS (note 7 above).
[24] This expression is borrowed from E Cameron, *Using the law in the AIDS epidemic: sword or shield?* Birkbeck College, 28 June 2007.
[25] HIV is not the first or only health condition to generate fear, stigma and discrimination. Diseases such as leprosy, the bubonic plague, syphilis and, more recently, severe acute respiratory syndrome (SARS) or Ebola have often provided a context for social labelling, differentiation, and the expression of prejudice and blame. The emergence and spread of epidemics throughout history have generated blame and often violence towards 'others' who are identified on the grounds of their origin, race, social position and other perceptions of their difference. See, among others, C Quetel *History of syphilis* (1990); S Watts *Epidemics and history: Disease, power and imperialism* (1997); H Marais 'Buckling: The impact of AIDS in South Africa' (2005) *AIDS Review*; B Person *et al* 'Fear and stigma: The epidemic within the SARS outbreak' *Emerging Infectious Diseases*, 2004, 10(4), pp 358-363; M Davtyan, B Brown & MO Folayan 'Addressing Ebola-related stigma: Lessons learned from HIV/AIDS' (2014) 7 *Global Health Action* 26058.

homosexuality.[26] Later, sex workers and people who inject drugs also were associated with the epidemic. Before AIDS, these populations were already facing high levels of prejudice and marginalisation in many countries and communities, and this was only exacerbated in the context of the epidemic.[27] Although heterosexual populations constitute the great majority of people living with HIV today in sub-Saharan Africa, early (mis)representations of AIDS as a condition that affects gay men and other 'social deviants' continues to endure.

Second, the fact that sexual contact is the primary route of HIV transmission in Africa has played into cultural, social and religious taboos relating to sexuality. This has often led to people living with HIV being labelled as promiscuous.[28]

Third, fear and blame of HIV and people living with HIV is related to social constructs of death. Widely publicised images in the early years of the epidemic of the emaciated bodies of people at advanced stages of AIDS helped to shock the public and instil a fear of AIDS as a deadly condition that required decisive measures to protect the public.[29] While the increased availability and accessibility of HIV treatments has contributed to addressing some of that fear, perceptions of AIDS as a

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[26] It is widely considered that the first scientific account of AIDS occurred on 5 June 1981 when the United States Centers for Disease Control (CDC) published in its bulletin, *Mortality and Morbidity Weekly Report*, an article on '*Pneumocystis* pneumonia – Los Angeles'. See CDC, *Mortality and Morbidity Weekly Report*, 5 June 1981, 30(21) 1-3, available at *http://www.cdc.gov/mmwr/preview/mmwrhtml/june_5.htm*, (accessed 27 August 2016). The article revealed that between October 1980 and May 1981, five young men (aged 29 to 36 years), all sexually active gay men, were treated for pneumonia in three hospitals in Los Angeles, California. A month after the release of CDC's report, *The New York Times* published an article describing cases of Kaposi's Sarcoma in 41 gay men. See LK Altman 'Rare cancer seen in 41 homosexuals' The New York Times 3 July 1981 available at *http://www.nytimes.com/1981/07/03/us/rare-cancer-seen-in-41-homosexuals.html*, accessed on 27 August 2016. These early reports created the enduring link between AIDS and homosexuality. This association led to homophobic stereotyping and blaming as the sexual practices, lifestyle and behaviour of gay men became the centre of fantasies and myths. For a general description of early responses to the AIDS epidemic in the United States, see R Shilts *And the band played on: Politics, people and the AIDS epidemic* (1987); M Cochrane *When AIDS began: San Francisco and the making of an epidemic* (2004).

[27] P Aggleton, P Davies & G Hart *AIDS: Rights, risk, and reason* (1992); D Altman *AIDS in the mind of America* (1986); J Engel *The epidemic: A global history of AIDS* (2006).

[28] P Eba *Stigma(ta): Re-exploring HIV-related stigma* (2007).

[29] For a thorough discussion of the causes and mechanisms of HIV-related stigma, see, among others, A Malcolm, P Aggleton, M Bronfman, J Galvao, P Mane, J Verral 'HIV-related stigmatization and discrimination: Its form and context' (1998) 8(4) *Critical Public Health* 347-370; R Parker & P Aggleton 'HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action' (2003) 57 *Social Science and Medicine* 13-24; BC Link & J C Phelan 'Conceptualising stigma' (2001) 27 *Annual Review of Sociology* 363-385; GM Herek 'Thinking about AIDS and stigma: A psychologist's perspective' (2002) 30(4) *Journal of Law, Medicine & Ethics* 594-607.

deadly condition remain pervasive.[30]

Early fears of AIDS and prejudice towards people living with or vulnerable to HIV were translated into coercive responses by governments and authorities in many parts of the world.[31] These measures often were motivated by a traditional understanding of public health responses that sought to identify and control those perceived to be affected by or at risk of disease using both direct and indirect coercive measures.[32] In relation to HIV, *direct measures* were aimed at targeting known or presumed HIV-positive individuals through quarantine, isolation, travel restrictions or criminal prosecution. In 1991, for example, some 12 countries allowed placing people living with HIV under surveillance, and 17 more allowed for compulsory hospitalisation or isolation of people living with HIV.[33] Until 2008, some 59 countries, territories and areas had adopted measures restricting the entry, stay or residence of people living with HIV on the basis of their HIV status.[34] *Indirect measures* were aimed at enforcing measures (which were often pre-existing) that prohibited behaviours believed to lead to HIV transmission, including injecting drug use, sex work, or sodomy.[35]

As understanding of HIV and its modes of transmission grew, however, people living with HIV and their advocates started challenging coercive measures as violations of human rights. Leading global institutions also joined in calling for a transformation of the role of the law in relation to the AIDS epidemic. In 1988, Resolution WHA 41.24 of the 41st World Health Assembly called on states to protect people living with HIV

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[30] Eba (n 28 above).
[31] See, among others, K Tomasevski, S Gruskin, Z Lazzarini, A Hendriks 'AIDS and human rights' in J Mann, DJM Tarantola & TW Netter *AIDS in the world: A global report* (1992) 537-574; LO Gostin *The AIDS Pandemic: Complacency, injustice, and unfulfilled expectations* (2004); R Bayer & A Fairchild-Carrino 'AIDS and the limits of control: public health orders, quarantine, and recalcitrant behavior' (1993) 83(10) *American Journal of Public Health* October 1471-1476; ML Closen & ME Wojcik 'International health law, international travel restrictions, and the human rights of persons with AIDS and HIV' (1990) 1(2) *Touro Journal of Transnational Law* 285-305.
[32] E Cameron & E Swanson 'Public health and human rights – The AIDS crisis in South Africa' *South African* (1992) 8 *Journal of Human Rights* 201-202.
[33] Tomasevski, Gruskin, Lazzarini & Hendriks (note 31 above; 548).
[34] UNAIDS *Report of the International Task Team on HIV-related Travel Restrictions: findings and recommendations* (2008) 4 available at *http://www.unaids.org/sites/default/files/media_asset/jc1715_report_inter_task_team_hiv_en_0.pdf*, accessed on 27 August 2016.
[35] Cameron & Swanson (note 32 above).

against discrimination and other coercive measures.[36] In 1989, the United Nations (UN) Centre for Human Rights (the predecessor to the current Office of the High Commissioner for Human Rights or OHCHR) convened the First International Consultation on HIV/AIDS and Human Rights. The consultation stressed the importance of protecting human rights, both as an obligation of all states and as a public health necessity.[37] These calls for changes in the paradigm of the application of the law in relation to HIV – a change from coercion to protection – were summed up in an impassioned plea made to the UN General Assembly by Jonathan Mann,[38] the first director of the World Health Organisation's (WHO) Global Programme on AIDS:

> Fear and ignorance about AIDS continue to lead to tragedies: for individuals, families and entire societies. Unfortunately, as anxiety and fear cause some to blame others, AIDS has unveiled the dimly disguised prejudices about race, religion, social class, sex and nationality […] [T]hreatening infected persons with exclusion – or worse – will drive the problem 'underground', wreaking havoc with educational efforts and testing strategies. Therefore, how societies treat AIDS virus-infected people will not only test fundamental values, but will likely make the difference between success and failure of AIDS control strategies at the national level. To the extent that we exclude AIDS-infected persons from society, we endanger society, while to the extent that we maintain AIDS-infected persons within society, we protect society. This is the message of realism and of tolerance.[39]

At the core of Mann's perspective lie the following questions: what should be the response of society, and the law in particular, to the HIV epidemic? Should the law be, as is often the case in relation to public health, a sword that is used as a structural tool to constrain, ostracise or punish people living with HIV and those

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[36] World Health Assembly *AIDS: Avoidance of discrimination in relation to HIV-infected people and people with AIDS*, WHA 41.24, 13 May 1988 available at *http://apps.who.int/iris/bitstream/10665/164520/1/WHA41_R24_eng.pdf*, accessed on 28 August 2016.

[37] Centre for Human Rights & World Health Organisation Global Programme on AIDS *Report of an International Consultation on AIDS and Human Rights, Geneva, 26-28 July 1989* (1989).

[38] Jonathan Mann is considered by many as the first global public health leader to have articulated the importance of human rights in the context of HIV. For a presentation of Jonathan Mann's approach to HIV and human rights, see, among others, LO Gostin 'A Tribute to Jonathan Mann: Health and human rights in the AIDS pandemic' (1998) 26 *The Journal of Law, Medicine & Ethics* 256-258.

[39] J Mann 'Statement at an Informal Briefing on AIDS to the 42nd Session of the United Nations General Assembly' (1988) 151(1) *Journal of the Royal Statistical Society. Series A (Statistics in Society)* 134.

vulnerable to it? Should it be used to restrict the human rights of the minority (those living with HIV) for the protection of the majority, as it is generally the case in public health approaches? Or should the law be a shield that protects people living with or vulnerable to HIV against stigma, discrimination and other human rights violations, and that supports their access to HIV services?

The conception of the law as a shield and enabling framework for the HIV response was ultimately endorsed by the WHO Global Programme on AIDS and its successor, UNAIDS. This recognition of the enabling role of the law came from the realisation that traditional public health approaches that were centred on individual behaviour were not suited to respond to a socially complex epidemic like HIV. The enabling role of the law also was considered necessary to respond to the social factors that made people vulnerable to the epidemic. Furthermore, great doubts had been raised about the effectiveness of coercive measures (such as quarantine and isolation) in responses to the HIV epidemic.[40]

Michael Kirby – who was then a Justice of the High Court of Australia – referred to this paradigm shift from a reliance on coercion to the endorsement of protection as the first paradox of HIV:

> The first and central paradox of HIV/AIDS, in the first decade after it manifested itself, was the one that became best known and best understood. According to this AIDS paradox, the most effective means of preventing the spread of the virus, at that stage, was protection of the human rights of the people most at risk of acquiring the virus. This was a paradox because it was contrary to intuitive responses to the spread of a dangerous virus in society. Instinctively, in such a case, citizen and public health experts thought in terms of the public health paradigm. Citizens, moreover, thought of punishment. Their minds were in tune with the moralising and stigmatising response that those who had and spread the virus were unclean, immoral and dangerous to the community – people who needed to be controlled, checked and sanctioned.[41]

The recognition of the protective role of the law in the context of HIV did not come

[40] Kirby refers to these coercive legal measures as Highly Inefficient Laws or 'HIL' in reference and parallel to 'HIV'. M Kirby 'The new AIDS virus – ineffective and unjust laws' (1988) 1(3) *Journal of Acquired Immune Deficiency Syndromes* 304-312.
[41] M Kirby 'The never-ending paradoxes of HIV/AIDS and human rights' (2004) 2 *African Human Rights Law Journal* 167.

without tensions and oppositions, as opposing voices argued that this 'first HIV paradox' was contrary to effective public health approaches, thus making AIDS 'exceptional'.[42] These charges of exceptionalism did not hold sway as people living with HIV and human rights activists started to use international and national human rights norms and courts to address the legal issues raised by HIV in an effective way.[43]

1.4 Human rights norms and their application to HIV

Individuals are entitled to human rights by virtue of being human.[44] At the global level, human rights norms are enshrined in the Universal Declaration on Human Rights and in a number of human rights treaties, including the International Covenant on Civil and Political Rights (ICCPR),[45] the International Covenant on Economic Social and Cultural Rights (ICESCR),[46] the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC),[47] and other subsequent human rights treaties (such as the Convention on the Rights of Persons with Disabilities).[48] While none of these treaties explicitly address HIV, their provisions relating to non-discrimination, liberty, security,

[42] R Bayer 'Public health policy and the AIDS epidemic. An end to HIV exceptionalism?' (1991) 324(21) *New England Journal of Medicines* 1500-1504.
[43] 'HIV exceptionalism' or 'AIDS exceptionalism' was described by Bayer as efforts 'to sustain a set of policies treating HIV as fundamentally different from all other public health threats'. According to Bayer, the exceptionalist perspective was impressed during the 'first decade of the AIDS epidemic [by] an alliance of gay leaders, civil libertarians, physicians and public health officials'. He predicted that in the wake of the second decade of AIDS, 'HIV exceptionalism will be viewed as a relic of the epidemic's first years'. Bayer (note 42 above). For a discussion on HIV exceptionalism, see S Burris 'Public Health, 'AIDS exceptionalism' and the law' (1994) 27 *The John Marshall Law Review* 251-272.
[44] See, among others, F Viljoen *International human rights law in Africa* (2012); J Donnelly Universal human rights in theory and practice (2013); A Clapham *Human rights: A very short introduction* (2007); MJ Perry *The idea of human rights: Four inquiries* (1998); C Tomuschat *Human rights: Between idealism and realism* (2003).
[45] International Covenant on Civil and Political Rights (ICCPR), adopted on 16 December 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171. See article 2.
[46] *International Covenant on Economic, Social and Cultural Rights* (ICESCR), adopted on 16 December 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3. See article 2.
[47] Convention on the Rights of the Child, adopted on 20 November 1989, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989). See article 2(1).
[48] Convention on the Rights of Persons with Disabilities, adopted on 13 December 2006, G.A. Res. 61/106, Annex I, U.N. GAOR, 61st Sess., Supp. No. 49, at 65, U.N. Doc. A/61/49 (2006).

equality, health, education, and free and fair trial are pertinent to HIV.[49] Monitoring bodies established under these treaties have on several occasions affirmed relevant norms applicable to HIV in general comments and concluding observations.[50]

In Africa, regional human rights treaties also are relevant to HIV. A number of key provisions in the African Charter on Human and Peoples' Rights (African Charter),[51] the African Charter on the Rights and Welfare of the Child (ACRWC),[52] or the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) are relevant to HIV, including those relating to the following:

- non-discrimination,
- liberty and security,
- education,
- health,
- torture, and
- inhuman and degrading treatment.[53]

The Maputo Protocol even has specific provisions addressing HIV under its article 14 on health and reproductive rights.[54]

In addition to treaty norms, a multitude of global and national non-binding legal instruments that affirm the centrality of human rights in HIV responses also have been adopted. Chief among these are the *International guidelines on HIV/AIDS and human rights* (*International guidelines*), developed by the Second International Consultation on HIV/AIDS and Human Rights, which was convened by UNAIDS and

[49] PM Eba 'HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis' (2015) 15 *African Human Rights Law Journal* 227-228.
[50] See, for example, Committee on ESCR 'General Comment no 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)' 2 July 2009 E/C.12/GC/20; and Committee on the Rights of the Child 'General Comment No. 3 (2003): HIV/AIDS and the rights of the child' CRC/GC/2003/1.
[51] African Charter on Human and Peoples' Rights, adopted on 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5.
[52] African Charter on the Rights and Welfare of the Child, adopted on 11 July 1990, OAU Doc.CAB/LEG/24.9/49.
[53] See AIDS and Human Rights Research Unit *Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa* (2007)
[54] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted on 13 September 2000, CAB/LEG/66.6.

OHCHR in September 1996.[55] The *International guidelines* were drafted by a group of 35 experts from across the world, including government officials, people living with HIV, academics, human rights activists, and representatives of NGOs and UN bodies.[56] They provide a set of 12 action-oriented guidelines aimed at helping all countries develop appropriate laws, regulations, policies and programmes to comply with international human rights obligations applicable to HIV.[57] The *International guidelines* were endorsed in 1997 by the UN Commission on Human Rights (the predecessor of the Human Rights Council) as part of a report of the UN Secretary-General.[58]

In addition to the *International guidelines*, a number of resolutions provide specific standards for the protection of human rights in relation to HIV including:

- the resolutions adopted by the UN General Assembly Special Session on HIV in 2001;[59]
- the resolutions of the High-Level Meetings on HIV in 2006,[60] 2011[61] and 2016;[62] and
- the resolutions on HIV of the Commission on Human Rights and later the Human Rights Council.[63]

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[55] UNAIDS & OHCHR *International guidelines on HIV/AIDS and human rights, 2006 consolidated version* (2006). 10.
[56] Ibid.
[57] Following the elaboration of the *International guidelines* in 1996, Guideline 6 on HIV-related prevention and treatment goods, services and information was revised during the Third International Consultation on HIV/AIDS and Human Rights convened by OHCHR and UNAIDS on 25-26 July 2002 in Geneva. See UNAIDS & OHCHR (note 55 above; 11-12).
[58] The *International guidelines* were presented to the Commission on Human Rights as part of the report of the United Nations Secretary General in January 1997. At its 53rd session, the Commission on Human Rights '[w]elcome[ed] the report of the Secretary-General on the Second International Consultation on HIV/AIDS and Human Rights … including the Guidelines recommended by the expert participants' and invited 'all states to consider them'. Commission on Human Rights 'The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)' E/CN.4/RES/1997/33 11 Avril 1997 available at *http://ap.ohchr.org/documents/alldocs.aspx?doc_id=4480*, accessed on 26 August 2016.
[59] UN General Assembly Special Session on HIV/AIDS *Declaration of Commitment on HIV/AIDS* (A/RES/S-26/2) June 2001.
[60] UN General Assembly *Political Declaration on HIV/AIDS* (A/RES/60/262) 15 June 2006.
[61] UN General Assembly *Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS* (UN Doc A/RES/65/277) 10 June 2011.
[62] UN General Assembly *Political Declaration on HIV and AIDS: On the Fast-Track to accelerate the fight against HIV and to end the AIDS epidemic by 2030* (A/70/L.52) 8 June 2016.
[63] For an overview of the resolutions on HIV of the Commission on Human Rights and the Human Rights Council, see *http://www.ohchr.org/EN/Issues/HIV/Pages/Documents.aspx*, accessed 26 August 2016.

In Africa, several non-binding instruments in relation to HIV have been adopted by the African Union, the African Commission on Human and Peoples' Rights (African Commission), the Inter-governmental Authority on Development (IGAD), the East African Community (EAC), and the Southern African Development Community (SADC).[64]

Global and regional human rights norms relating to HIV have been used at the national level through three different streams. First, human rights have been invoked to ensure that people living with HIV are protected against discrimination, violence and coercion (including in accessing HIV services). This has taken the form of advocacy campaigns and court cases to respond to discrimination in areas such as employment, housing and inheritance.[65] Second, human rights norms have been used to claim HIV-related health services and entitlements, including access to evidence-informed HIV-related prevention and treatment services. This was illustrated by the Treatment Action Campaign's successful litigation against the South African government to secure access to ART for PMTCT.[66] Third, human rights norms and approaches have been used to demand specific actions to address factors such as vulnerability to HIV and barriers to HIV service access, including for specific groups (such as those identified as key populations). In 2015, for instance,

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[64] AIDS and Human Rights Research Unit (note 53 above). In particular, the African Commission on Human and Peoples' Rights has recently adopted two general comments that are pertinent to HIV. The first is General comment on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted in 2012. This General comment highlights the measures that states should take to respect, protect, promote and fulfil women's rights to sexual and reproductive health. This General comment addresses women's rights in relation to HIV. The second general comment adopted in 2014 relates to Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. This General comment also specifically addresses the human rights of women living with HIV. See African Commission on Human and Peoples' Rights, *General comment on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, adopted at the 52nd Ordinary Session, Yamoussoukro, Côte d'Ivoire, 9-22 October 2012 available at http://www.achpr.org/instruments/general-comments-rights-women/ (accessed on 25 February 2017); See African Commission on Human and Peoples' Rights, *General comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, adopted at the 55th Ordinary Session of the African Commission on Human and Peoples' Rights in 2014 available at http://www.achpr.org/instruments/general-comment-two-rights-women/ (accessed on 25 February 2017); C Ngwena, E Brookman-Amissah & P Skuster 'Human rights advances in women's reproductive health in Africa' (2015) 129 *International Journal of Gynaecology & Obstetrics* 184-187.

[65] Ibid.

[66] *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) (CCT8/02) [2002] ZACC 15.

Botswana's Court of Appeal held that denying HIV treatment to foreign prisoners living with HIV was unlawful, and it ordered the government to provide HIV-positive foreign prisoners with 'free testing and assessment and treatment with ARVs and HAART where appropriate' on the same basis as it did with citizen prisoners.[67]

Over the years, progress has been made in these three streams, and the commitment to non-discrimination based on HIV status – at least on a symbolic and rhetorical level – is now part of the discourse and policy on HIV in most countries in sub-Saharan Africa. For instance, a large number of HIV policies and strategic plans currently in place in sub-Saharan African countries refer to the importance of human rights in the context of HIV.[68]

HIV-related discrimination and other HIV-related human rights violations, however, remain pervasive across sub-Saharan Africa. People living with HIV continue to experience high levels of discrimination in their access to healthcare, employment, housing and insurance (among other services).[69] In Tanzania, for instance, 29.6% of people living with HIV were forced to change their place of residence or were unable to rent accommodation due to their HIV status.[70] In Ghana, 16.2% of people living with HIV reported having lost their jobs in the previous 12 months because of their HIV status.[71] In Congo, 15.3% of people living with HIV reported having been denied employment, and 6.3% of people living with HIV reported discrimination due to their HIV status when receiving healthcare services.[72] Involuntary sterilisation of women

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[67] *The Attorney General and Others v Dickson Tapela and Others*, Court of Appeal of Botswana, Case No CACGB-096-14, available at *http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2015/04/Court-of-Appeal-Judgment_Tapela_26-08-20151.pdf*, accessed on 27 August 2016.

[68] UNAIDS & International HIV/AIDS Alliance *Making it work: Lessons learnt from three regional workshops to integrate human rights into national HIV strategic plans* (2012); S Gruskin & D Tarantola 'Universal Access to HIV prevention, treatment and care: assessing the inclusion of human rights in international and national strategic plans' (2008) 22 (suppl 2) *AIDS* S123-S132.

[69] UNAIDS (note 14 above).

[70] National Council of People Living With HIV/AIDS Tanzania (NACOPHA) *The people living with HIV Stigma Index report Tanzania* (2013) 18 available at http://www.stigmaindex.org/sites/default/files/reports/Tanzania%20STIGMA%20INDEX%20REPORT%20-%20Final%20Report%20pdf.pdf, accessed on 27 August 2016.

[71] National Network of Persons Living with HIV in Ghana *Persons living with HIV Stigma Index Study Ghana* (2014) xii available at http://www.stigmaindex.org/sites/default/files/reports/GHANA%20Stigma%20Index%20report%202014.pdf, accessed 27 August 2016.

[72] Réseau National des Associations des Positifs du Congo *Index de stigmatisation et de discrimination envers les personnes vivant avec le VIH au Congo : rapport d'enquête* (2015) 27

living with HIV has been reported in various sub-Saharan African countries, including Kenya, Namibia and South Africa.[73] Other human rights violations that often are reported in the context of HIV include infringement of confidentiality, violation of informed consent, and violence and ill-treatment of people living with HIV or those vulnerable to (or affected by) HIV.[74]

1.5 Human rights and the HIV paradox: Current challenges

In addition to the existing HIV-related human rights challenges, two important trends are leading to increased questioning of rights-based approaches to the epidemic. First, human rights norms and approaches are being challenged in the context of efforts to scale up HIV services. Second, the application of human rights to specific populations at higher risk of HIV infection is being challenged in a general environment that is characterised by broader opposition to perceived attempts to 'impose concepts or notions pertaining to … private individual conduct'.[75]

1.5.1 HIV responses in a time of scale-up: The end of the HIV paradox?

The effectiveness of HAART in treating AIDS was demonstrated in the mid-1990s. HAART was then quickly adopted in developed countries and made available to people living with HIV in those countries. The cost of these medicines, however, was prohibitive, and fewer than 100 000 out of the millions of people living with HIV in

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available at http://www.stigmaindex.org/sites/default/files/reports/Rapport%20final-%20Index%20de%20Stigma%20au%20Congo.pdf, accessed on 26 August 2016.

[73] S Bi & T Klusty 'Forced sterilizations of HIV-positive women: A global ethics and policy failure' (2015) 17(10) *American Medical Association Journal of Ethics* 952-957; African Media and Gender Initiative *Robbed of choice: Forced and coerced sterilization experiences of women living with HIV in Kenya* (2012) available at *http://kelinkenya.org/wp-content/uploads/2010/10/Report-on-Robbed-Of-Choice-Forced-and-Coerced-Sterilization-Experiences-of-Women-Living-with-HIV-in-Kenya.pdf*, accessed on 26 August 2016.

[74] See, among others, AIDS and Rights Alliance for Southern Africa *HIV, TB and human rights in Eastern and Southern Africa*: *Report 2016* (2016) available at http://www.arasa.info/files/4514/6902/5171/ARASA_AnnualReport2016_-_for_web.pdf, accessed on 26 August 2016.

[75] See African Union, *Decision on the promotion of cooperation, dialogue and respect for diversity in the field of human rights*, Doc. Assembly/AU/17(XV) Add.9, Kampala Summit, 2010, available at *http://www.au.int/en/sites/default/files/decisions/9630-assembly_en_25_27_july_2010_bcp_assembly_of_the_african_union_fifteenth_ordinary_session.pdf*, accessed on 27 August 2016.

sub-Saharan Africa were receiving ART in 2000.[76]

This situation evolved with intense civil society advocacy and global pressure that led to reduced costs for ARVs; that same pressure also generated increased funding for the global response to AIDS with the establishment of the Global Fund to Fight AIDS, TB and Malaria (The Global Fund).[77] In this context, WHO and UNAIDS launched '3 by 5', an initiative to put 3 million people living with HIV in low- and middle-income countries on ART by 2005.[78] Increasing the number of people on ART required new efforts to identify people living with HIV through testing in order to provide them with treatment. As noted by the WHO Director General,

> lack of access to antiretroviral treatment is a global health emergency … To deliver antiretroviral treatment to the millions who need it, we must change the way we think and change the way we act.[79]

Some took this opportunity to call for more aggressive approaches to HIV testing, arguing that the prevailing testing model – which was essentially based on voluntary testing and counselling, where individuals came forward voluntarily to seek an HIV test – was not suited for the urgency of the HIV epidemic in sub-Saharan Africa. At the centre of these calls was a view that 'AIDS exceptionalism' – which was perceived to 'unduly' elevate individual rights in the context of a public health emergency such as HIV – was no longer warranted.[80] These views supported a return to traditional biomedical and public health approaches, thus turning away from the path set by Mann and others who advocated rights-based responses to HIV.

According to Bayer – who predicted the demise of 'AIDS exceptionalism' a decade earlier – the return to biomedical responses to HIV was inevitable.[81] He stressed that

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[76] UNAIDS (n 6 above).
[77] UNAIDS (n 6 above).
[78] WHO and UNAIDS *Treating 3 million by 2005: Making it happen. The WHO and UNAIDS global initiative to provide antiretroviral therapy to 3 million people with HIV/AIDS in developing countries by the end of 2005* (2003) available at *http://www.who.int/3by5/publications/documents/en/3by5StrategyMakingItHappen.pdf?ua*=1, accessed on 27 August 2016.
[79] Cited in WHO & UNAIDS (note 78 above; 1).
[80] For a critique of these calls, see F Viljoen & S Precious 'Human rights under threat in attempts to address HIV and AIDS' in F Viljoen & S Precious (eds) *Human rights under threat: four perspectives on HIV, AIDS, and the law in Southern Africa* (2007) 1-13.
[81] Bayer (note 42 above).

as scientific advances emerged and the effectiveness of treatment was established, public health officials regained confidence in asserting 'their professional dominance … and the relevance of their own professional traditions to the control of AIDS'.[82] This confidence manifested in increased calls to change HIV testing guidelines in order to introduce routine or other forms of 'simplified' testing that did not require 'cumbersome' consent and counselling procedures.[83] In sub-Saharan Africa, these calls for change further added that human rights considerations of confidentiality and consent were ill-suited for the magnitude and reality of the HIV epidemic in the region.[84] The most influential charge in favour of 'simplified' forms of HIV testing in sub-Saharan Africa came from Kevin de Cock, who later became the head of the WHO's HIV Department. In a joint publication, he called for routine HIV testing in order to allow medical practitioners to test any person they believed might be at risk of HIV. In support of this approach, de Cock and his co-authors noted that

> Human rights based approaches to HIV/AIDS prevention might have reduced the role of public health and social justice, which offer a more applied and practical framework for HIV/AIDS prevention and care in Africa's devastating epidemic.[85]

The debates on the return to traditional public health approaches in the context of HIV testing were translated in the 2007 WHO/UNAIDS *Guidance on provider-initiated HIV testing and counselling in health facilities*.[86] While endorsing new forms of HIV testing, including the routine offer of HIV testing, these guidelines seek to strike a balance with human rights by emphasising that

> at the same time as provider-initiated HIV testing and counselling is implemented, equal efforts must be made to ensure that a supportive social, policy and legal framework is in place to maximise positive outcomes and minimise potential harms to

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[82] Bayer (note 42 above; 1502).
[83] R Bayer & AL Fairchild 'Changing the Paradigm for HIV Testing – The end of exceptionalism' (2006) 355(7) *New England Journal of Medicine* 647-649.
[84] For a critique and discussion of these arguments, see M Crewe & F Viljoen Testing times, routine HIV testing: A challenge to human rights (Unpublished discussion paper prepared for the International HIV Testing Email Discussion Group, 2005); M Heywood 'The routine offer of HIV counseling and testing: A human right' (2005) 8(2) *Health and Human Rights Journal* 13-19.
[85] K de Cock, D Mbori-Ngacha & E Marum 'Shadow on the continent: public health and HIV/AIDS in Africa in the 21st century' (2002) 360 *Lancet* 67-72.
[86] WHO & UNAIDS *Guidance on provider-initiated HIV testing and counselling in health facilities* (2007) available at *http://www.who.int/hiv/pub/guidelines/9789241595568_en.pdf*, accessed on 27 August 2016.

> patients.[87]

They further note that

> implementation of provider-initiated HIV testing and counselling must include measures to prevent compulsory testing and unauthorised disclosure of HIV status, and potential negative outcomes of knowing one's HIV status. Potential negative outcomes include discriminatory attitudes of health care providers; financial burden associated with testing and/or unauthorised disclosure of an individual's HIV status resulting in discrimination or violence.[88]

In the end, the *Guidance on provider-initiated HIV testing and counselling in health facilities* was taken forward and implemented in the great majority of African countries.[89] As of 2010, some 42 African countries had adopted provider-initiated HIV testing and counselling.[90] As was expected, however, little attention has been devoted to creating enabling conditions for this form of routine HIV testing. As shown in a study of the routine offer of HIV testing in Botswana, important concerns relating to informed consent and confidentiality have emerged following the implementation of this approach to HIV testing.[91]

More recently, the demonstrated prevention benefits of ART have also translated into renewed calls for even more aggressive public health approaches involving earlier detection of HIV infection and the immediate treatment of people living with HIV.[92] These calls were endorsed in UNAIDS' 90-90-90 targets, which urge countries to ensure that 90% of those living with HIV know their HIV status, 90% of those who know their HIV status are on ART, and 90% of those on ART reach viral

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[87] WHO & UNAIDS (note 86 above; 32).
[88] WHO & UNAIDS (note 86 above; 30).
[89] R Baggaley, B Hensen, O Ajose, KL Grabbe, VJ Wong, A Schilsky, Y-R Lo, F Lule, R Granich & J Hargreaves 'From caution to urgency: the evolution of HIV testing and counselling in Africa' (2012) 90 *Bulletin of the World Health Organization* 652-658.
[90] Ibid.
[91] RA Kumar 'Ethical and human rights dimensions in prenatal HIV/AIDS testing: Botswana in global perspective' (2012) 5(1) *South African Journal of Bioethics and Law* 20-26.
[92] RM Granich, CF Gilks, C Dye, KM De Cock, BG Williams 'Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model' (2009) 373 *The Lancet* 48-57.

suppression, all by 2020.[93] While these targets are laudable for realising the right to health, they also raise key legal and human rights issues and challenges that require attention.[94] In particular, there is a fear that in 'desperate' efforts to reach targets, some countries will resort to coercive approaches or undermine human rights.[95]

In general, charges against human rights and rights-based approaches in relation to HIV are based on the view that current challenges in addressing the epidemic – including low HIV testing, limited access to treatment and unabated rates of new HIV infections – are due to the protection of human rights. These assumptions are in fact misguided and deceptive for at least three reasons. First, human rights approaches were central to the early successes in responding to the HIV epidemic, particularly in developed countries, where community-led responses enabled the rapid uptake of condoms and safer sex practices among gay men and other men who have sex with men, which resulted in a sharp decrease in new HIV infections.[96] Similarly, human rights norms, arguments and tools have played a significant role in advancing HIV responses, including through challenging government inaction, securing reductions in the price of ARVs, and demanding protection and access to HIV and health services for the populations most affected by the epidemic.[97]

Second, in most countries, human rights approaches have not been implemented in the response to HIV beyond rhetorical endorsements and patchwork pilot projects. Data from UNAIDS show that less than 1% of the $19 billion invested in HIV in 2014

[93] UNAIDS *90-90-90: An ambitious treatment target to help end the AIDS epidemic* (2014) available at *http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf*, accessed on 27 August 2016.
[94] D Barr, JJ Amon & M Clayton 'Articulating a rights-based approach to HIV treatment and prevention interventions' (2011) 9 *Current HIV Research* 396-404; S Gruskin, L Ferguson & DO Bogecho 'Beyond the numbers: using rights-based perspectives to enhance antiretroviral treatment scale-up' (2007) 21 (suppl 5) *AIDS* S13-S19.
[95] S Reenie & F Behets 'Desperately seeking targets: the ethics of routine HIV testing in low-income countries' (2006) 84(1) *Bulletin of the World Health Organization* 52-57; Barr, Amon & Clayton (note 94 above).
[96] HB Worth 'HIV does need a special response' (2005) 330 *British Medical Journal* 492.
[97] L London 'What is a human-rights based approach to health and does it matter?' (2008) 10(1) *Health and Human Rights* 65-80; M Heywood 'Debunking 'Conglomo-talk': A case study of the amicus curiae as an instrument for advocacy, investigation and mobilisation' (2001) 5(2) *Law, Democracy & Development* 133-162.

was related to human rights programmes.[98]

Third, human rights provided under global and regional treaties – as well as those in national constitutions – are binding on states, which must ensure that they respect, protect, promote and fulfil them, including in the measures and programmes that they put in place to respond to HIV and other health challenges.[99] While states may limit or diminish human rights in the case of public health emergencies or over-riding public health goals, these limitations should comply with human rights, and they must be in line with the conditions and circumstances provided under the *Siracusa principles on the limitation and derogation provisions in the International Covenant on Civil and Political Rights*.[100]

1.5.2 HIV, human rights and key populations: Contested ground

Evidence from across the world, including sub-Saharan Africa, shows high vulnerability to HIV and poor access to HIV services among key populations, particularly young women, men who have sex with men, prisoners, people who inject drugs and sex workers (see Section 1.2, above). States have therefore been called to give due consideration to the human rights of these populations and their access to HIV services. These calls are made against the background of criminal and other punitive laws in the great majority of African countries that target populations at higher risk of HIV infection, thus increasing their vulnerability to the epidemic. Some 36 countries in sub-Saharan Africa have laws criminalising same-sex sexual relations,[101] and all countries in the region have laws criminalising some aspects of sex work.[102] Possession of a small amount of drugs for personal use also is a

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[98] UNAIDS *Sustaining the human rights response to HIV: Funding landscape and community voices* (2015) available at *http://www.unaids.org/sites/default/files/media_asset/JC2769_humanrights_en.pdf*, accessed on 27 August 2016.

[99] London (note 97 above).

[100] United Nations, Economic and Social Council, Siracusa principles on the limitation and derogation provisions in the International Covenant on Civil and Political Rights, U.N. Doc. E/CN.4/1985/4, Annex (1985).

[101] International Lesbian, Gay, Bisexual, Trans and Intersex Association *State sponsored homophobia 2016. A world survey of sexual orientation laws: criminalisation, protection and recognition* (2016) 36 available at *http://ilga.org/downloads/02_ILGA_State_Sponsored_Homophobia_2016_ENG_WEB_150516.pdf*, accessed on 27 August 2016.

[102] UNAIDS *Making the law work for the HIV response: A snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support* (2010) available at

criminal offence in almost all sub-Saharan African countries.[103]

Across sub-Saharan Africa, there have been calls for human rights protection and access to health services for gay men and men who have sex with men, sex workers and people who inject drugs. Those calls, however, have been met with varied responses – including indifference, silence, rejection, contestation, violence, increased criminalisation and other forms of human rights violations – from both the public and the different political, health, social, and religious leaders and authorities.[104]

Contestations are not new in the context of a deeply political and socially-loaded epidemic such as HIV. The denialism that plagued the early years of the response to AIDS in South Africa,[105] as well as the decades-long opposition to condoms by religious institutions, illustrate some of the political debates that have surrounded the epidemic.[106] Current contestations relating to key populations in the response to HIV, however, involve a new element. They are taking place in a broader global context of the struggle for the recognition and protection of the human rights of several key populations, including lesbian, gay, bisexual and transgender (LGBT) people, people who inject drugs and sex workers.[107] While calls to protect sex workers and people who inject drugs as part of efforts to respond to HIV have intensified in the past few years, the struggle for the protection of LGBT people is arguably the one that best

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http://files.unaids.org/en/media/unaids/contentassets/documents/priorities/20100728_HR_Poster_en.pdf, accessed on 27 August 2016.

[103] Harm Reduction International *The global state of harm reduction 2014* (2014) available at https://www.hri.global/files/2015/02/16/GSHR2014.pdf, accessed on 27 August 2016.

[104] See, among others, Heinrich Boll Stiftung 'Struggle for equality: Sexual orientation, gender identity and human rights in Africa' (2010) 4(10) *Perspectives: Political analysis and commentary from Africa* available at https://www.boell.de/sites/default/files/perspectives_africa_4-2010_struggle_for_equality_lgbti_africa.pdf, accessed on 27 August 2016; R Thoreson & S Cook (eds) *Nowhere to turn: Blackmail and extortion of LGBT people in sub-Saharan Africa* (2011); M Epprecht 'Sexual minorities, human rights and public health strategies in Africa' (2012) 111(443) *African Affa*irs 223-243. In spite of these challenges, progress has also been made in the region in relation to the human rights of LGBT people including through national courts that have asserted the human rights of LGBT people. See Viljoen (note 44 above; 266-267).

[105] See AA Van Niekerk 'Moral and social complexities of AIDS in Africa' in AA van Niekerk & LM Kopelman (eds) *Ethics and AIDS in Africa: the challenge to our thinking* (2005) 58-59; Marais (note 25 above).

[106] AA van Niekerk & LM Kopelman (eds) Ethics and AIDS in Africa: the challenge to our thinking (2005); J Chan Politics in the Corridor of Dying: AIDS Activism and Global Health Governance (2015); P Piot *AIDS: Between science and politics* (2015).

[107] C Heyns 'The struggle approach to human rights' in A Soeteman (ed) *Pluralism and law* (2001) 171-190.

encapsulates the current challenges and opportunities – globally and in sub-Saharan Africa, in particular – that are associated with the protection of key populations.[108] For that reason, it will be used to illustrate and discuss the issues involved.

Over the past decade, the protection of the human rights of LGBT people, including their rights to access health and HIV services, has received great attention at the global, regional and national levels, including in sub-Saharan Africa. At the global level, important developments have taken place in the UN General Assembly and the UN Human Rights Council.[109] These advances also have unveiled the tensions relating to sexual orientation and gender identity, particularly within sub-Saharan African countries. In June 2011, for instance, the Human Rights Council adopted its first resolution on 'human rights, sexual orientation and gender identity';[110] a subsequent follow-up resolution on the issue was adopted in September 2014.[111] These resolutions were opposed by the great majority of sub-Saharan African countries that are members of the Human Rights Council.[112] Of the 13 African States that were members of the Human Rights Council, only two (Mauritius and South Africa) voted in favour of the 2011 resolution, and only one (South Africa) voted in

[108] Global Commission on HIV and the Law *HIV and the law: Risks, rights and health* (2012); MR Decker, A-L Crago, SKH Chu, SG Sherman, MS Seshu, K Buthelezi, M Dhaliwal & C Beyrer 'Human rights violations against sex workers: burden and effect on HIV' (2015) 385 *Lancet* 186-199; Jurgens, Csete, Amon, Baral & Beyrer (note 21 above).

[109] S Kara 'Norms, case law and practices relevant to sexual orientation, gender identity and intersex status in the United Nations system' in Centre for Human Rights *Ending violence and other human rights violations based on sexual orientation and gender identity: A joint dialogue of the African Commission on Human and Peoples' Rights, Inter-American Commission on Human Rights and United Nations* (2016) 64-78.

[110] Human Rights Council *Resolution 17/19 Human rights, sexual orientation and gender identity* (A/HRC/RES/17/19) 17 June 2011.

[111] Human Rights Council *Resolution 27/32 Human rights, sexual orientation and gender identity* (A/HRC/RES/27/32) 26 September 2014.

[112] Both resolutions called for reports by the High Commissioner for Human Rights that were considered by the Human Rights Council. Kara (note 109 above). In addition to the resolutions and reports by the High Commissioner for Human Rights on sexual orientation and gender identity, the Human Rights Council has also addressed the issues in the context of the Universal Periodic Review. Issues relating to discrimination and other human rights violations based on sexual orientation and gender identity have been raised in relation to many sub-Saharan African countries and specific recommendations made to these countries during the Universal Periodic Review process. In general, these recommendations were rejected by the countries concerned. However, as of October 2015, some 36 recommendations on sexual orientation and gender identity issued as part of the Universal Periodic Review have been accepted on areas such as investigating attacks and threats, protecting LGBT and intersex human rights defenders, and responding to violence and discrimination based on sexual orientation and gender identity. Kara (note 109 above; 77).

favour of the 2014 resolution.[113]

In 2016, the Human Rights Council adopted a resolution establishing an independent expert on protection against violence and discrimination based on sexual orientation and gender identity.[114] The adoption of this resolution illustrated the great global divide in relation to sexual orientation and gender identity: of the 13 African members of the Human Rights Council, none voted in favour of the resolution (nine states voted against it and four abstained).[115] Even South Africa, the only country in sub-Saharan Africa that explicitly recognises sexual orientation and gender identity in its Constitution as grounds for non-discrimination, abstained from the vote, allegedly in reaction to the methods and approaches of the sponsors of the resolution.[116]

Similarly, these contestations increasingly manifest within global negotiations of HIV-related technical and political agreements that address gay men, men who have sex with men and other key populations. This was notably the case in relation to the 2016 High-Level Meeting on AIDS and its ensuing Political Declaration on HIV and AIDS, which was 'dismissed' by several civil society organisations for allegedly failing to address the legal challenges faced by key populations.[117]

At the regional level in Africa, political and human rights bodies have also made pronouncements on sexual orientation and gender identity or have been called to do so. For instance, the African Union expressed concerns about the application of human rights in relation to sexual orientation and gender identity during its Kampala Summit in 2010. Without explicitly referring to sexual orientation or gender identity, the Summit adopted a decision that 'strongly' rejected

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[113] See Human Rights Council (notes 110 & 111 above)
[114] OHCHR 'Council establishes mandate on protection against violence and discrimination based on sexual orientation and gender identity' 30 June 2016 available at *http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20220*, accessed on 27 August 2016.
[115] Ibid.
[116] The explanation provided by the South African Ambassador before the vote noted that the draft resolution has created 'unnecessary divisiveness' and the approach to its adoption was 'arrogant'. As a result, South Africa did not support the resolution and abstained. OHCHR (note 114 above).
[117] See, for instance, Global Forum for MSM & HIV 'A High-Level failure for the United Nations on key populations' 8 June 2010 available at *http://msmgf.org/gay_men_transgender_people_and_sex_workers_express_outragemsmgf-expresses-outrage-unacceptably-weak-political-declaration-adopted-today-united-nations-high-level-meeting-ending-aids/#ixzz4IdO267wc,* accessed on 27 August 2016.

> any attempt to undermine the international human rights system by seeking to impose concepts or notions pertaining to social matters, including private individual conduct, that fall outside the internationally agreed human rights legal framework, taking into account that such attempts constitute an expression of disregard for the universality of human rights.[118]

In 2014, the African Commission on Human Rights adopted a resolution on ending violence, discrimination and other human rights violations based on sexual orientation and gender identity.[119] In a preceding resolution relating to the establishment of a committee on the protection of the rights of people living with HIV and those at risk, vulnerable to and affected by HIV, the African Commission also explicitly referred to men who have sex with men and other key populations as being covered under the mandate of this committee.[120] The protracted and challenging process relating to the granting of observer status to the Coalition of African Lesbians (an NGO) by the African Commission, however, illustrates the ongoing struggles for the protection of the human rights of LGBT people within the African regional human rights system.[121]

At the national level, developments and challenges also have been noted in relation to the human rights of LGBT people, with differences existing across countries in terms of the intensity, approaches and actors involved.[122] In spite of these differences, some elements are worth noting in terms of their relation to health and HIV.

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[118] African Union (note 75 above).
[119] African Commission on Human and Peoples' Rights *Resolution 275 on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity*, adopted at the 55th Ordinary Session of the African Commission on Human and Peoples' Rights in Luanda, Angola, 28 April - 12 May 2014.
[120] African Commission on Human and Peoples' Rights *Resolution 163 on the Establishment of a Committee on the protection of the rights of people living with HIV and those at risk, vulnerable to and affected by HIV*, 47th Ordinary Session, Banjul, The Gambia, 26 May 2010.
[121] For a discussion on the granting of observers status to the Coalition of African Lesbians, see Viljoen (note 44 above; 266-267). For a general description of the developments relating to sexual orientation and gender identity within the African human rights system, see F Viljoen 'Norms, case law and practices relevant to sexual orientation and gender identity in the African human rights system' in Centre for Human Rights (note 109 above; 29-42), and S Ndashe 'Seeking the protection of LGBTI rights at the African Commission on Human and Peoples' Rights' (2011) 15 *Feminist Africa* 17-37.
[122] See, among others, AM Ibrahim 'LGBT rights in Africa and the discursive role of international human rights law' (2015) 15 *African Human Rights Law Journal* 263-281; Heinrich Boll Stiftung (note 104 above); Thoreson & Cook (note 104 above); R Schafer & E Range *The political use of homophobia: Human rights and persecution of LGBTI activists in Africa* (2014) available at *http://library.fes.de/pdf-files/iez/10610.pdf*, accessed on 26 August 2016.

First, HIV stakeholders – including national AIDS commissions and ministries responsible for health in a number of countries – are engaging LGBT people and members of other key populations, and they are showing various degrees of support for the protection of LGBT people and their access to health services.[123] Some examples of this include the following:

- involving representatives of LGBT people and other key populations in national HIV bodies, such as the Country Coordinating Mechanisms, which were established under architecture for overseeing grants provided by the Global Fund;

- making explicit reference to the needs and concerns of these populations in national HIV documents; and

- establishing programmes in some countries to address the health and HIV needs of key populations.[124]

Policy and funding requirements from HIV donors and technical agencies – as well as the demands of civil society organisations representing gay men and men who have sex with men – are some of the reasons for these advances.[125]

Second, progress made in some sub-Saharan countries towards recognising, representing and protecting LGBT people and other key populations – as well as ensuring their access to HIV services – remains symbolic and fragile. Political, religious and moral motivations – combined with claims about the imposition of foreign sexual norms and behaviours – are still used to contest the application of human rights to these populations. They also are invoked to justify coercive

[123] Epprecht (note 104).
[124] A Kageni, L Mwangi, C Mugyenyi & K Macintyre *Representation and participation of key populations on Country Coordinating Mechanisms (CCMs) in six countries in Southern Africa: final report* (2015), available at *http://www.aidspan.org/publication/representation-and-participation-key-populations-country-coordinating-mechanisms-ccms*, accessed on 26 August 2016; African Men for Sexual health and Rights (AMSHeR), African Sex Worker Alliance (ASWA), GenderDynamiX and TransBantu Association Zambia *African key populations' engagement with global heath financing institutions: A rapid review* (2016); K Makofane, C Gueboguo , D Lyons & T Sandfort 'Men who have sex with men inadequately addressed in African AIDS national strategic plans' (2013) 8(2) *Global Public Health* 129-143; EJ Sanders, H Jaffe, H Musyoki, N Muraguri & SM Graham 'Kenyan MSM: no longer a hidden population' (2015) 29 (Suppl 3) *AIDS* S195-S199.
[125] Ibid.

approaches against them. This is illustrated throughout the region by multiple cases of discrimination, violence, harassment, healthcare service denial and other human rights violations towards LGBT people and other key populations.[126]

In Malawi, Nigeria and Uganda, the contestation of the human rights of LGBT people and its implications in relation to health and HIV are particularly illustrative of the challenges facing the HIV response. The arrest, prosecution and sentencing of a gay couple in Malawi in 2009 - 2010[127] – along the introduction of new legislation to increase penalties for same-sex sexual relations, criminalise support to LGBT people or individuals, or prohibit same-sex marriages in Nigeria and Uganda in 2014[128] – have placed HIV actors on the front line of justice demands for LGBT people. Civil society organisations working on the health and human rights of gay men and men who have sex with men in each of these three countries were at the forefront of the challenges against these laws and prosecutions.[129] Civil society used the language and evidence of HIV – particularly data and research on the negative health and HIV effects caused by criminalisation, detention and other punitive laws against men who have sex with men – to demand the release of those arrested and the removal of the new laws.[130] Other civil society organisations working on general advocacy for the human rights of LGBT people in these countries used similar HIV and health arguments.[131] Bilateral and multilateral donors involved in the HIV response, along

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[126] Ibid.

[127] L Price 'The treatment of homosexuality in the Malawian justice system: R v Steven Monjeza Soko and Tiwonge Chimbalanga Kachepa' (2010) 10 *African Human Rights Law Journal* 524-533.

[128] F Karimi & N Thompson 'Uganda's President Museveni signs controversial anti-gay bill into law' *CNN* 25 February 2014 available at *http://edition.cnn.com/2014/02/24/world/africa/uganda-anti-gay-bill/*, accessed on 27 August 2016; 'Nigeria anti-gay laws: Fears over new legislation' *BBC News* 14 January 2014, available at *http://www.bbc.com/news/world-africa-25728845*, accessed on 27 August 2016.

[129] See, for instance, G Mapondera & D Smith 'Human rights campaigners attack Malawi gay couple conviction' *The Guardian* 18 May 2010 available at *https://www.theguardian.com/world/2010/may/18/malawi-gay-couple-jailed,* accessed on 27 August 2016.

[130] SR Schwartz, RG Nowak, I Orazulike, B Keshinro, J Ake, S Kennedy, O Njoku, WA Blattner, ME Charurat & SD Baral 'The immediate effect of the Same-Sex Marriage Prohibition Act on stigma, discrimination, and engagement on HIV prevention and treatment services in men who have sex with men in Nigeria: analysis of prospective data from the TRUST cohort' (2015) 2(7) *Lancet HIV* e299-e306; P Semugoma, C Beyrer, S Baral 'Assessing the effects of anti-homosexuality legislation in Uganda on HIV prevention, treatment, and care services' (2012) 9(3) *SAHARA-J: Journal of Social Aspects of HIV/AIDS* 173-176.

[131] See, for instance, Amnesty International *'Rule by Law': Discriminatory legislation and legitimized abuses in Uganda* (2014) available at https://www.amnesty.org/en/documents/AFR59/006/2014/en/,

with global public health institutions such as UNAIDS, referred to those same arguments in their calls to free those arrested and to remove the new criminal laws.[132] The reliance on HIV evidence and the role played by HIV stakeholders in efforts to advance the protection of LGBT people and their access to HIV services are leading to accusations that the HIV response is being used to pursue a broader agenda for LGBT people and key populations.

The above developments and challenges illustrate the complex political, social and legal environments related to the human rights and health of key populations in sub-Saharan Africa. These challenges, together with intensifying calls for a return to biomedical responses to HIV, represent serious threats to the human rights-based approach to the epidemic. It should be a priority for HIV actors to understand and address these manifestations of the contestation of human rights in the context of HIV. Thus far, limited critical and strategic reflections have been undertaken by HIV actors, academics and researchers working on HIV in relation to these issues.[133] The 'legitimacy' and continued reliance on the language and tools of human rights in the response to HIV, however, will require responses to these threats: failure to do so might compromise the future of rights-based responses in relation to HIV – and to health more broadly.

1.6 HIV-specific laws and human rights

In all sub-Saharan African countries, there are several general laws that could be

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accessed on 28 August 2016; Human Rights Watch and Amnesty International 'Uganda: Anti-Homosexuality Act's heavy toll. Discriminatory law prompts arrests, attacks, evictions, flight' 14 may 2014 available at *https://www.hrw.org/news/2014/05/14/uganda-anti-homosexuality-acts-heavy-toll*, accessed on 28 August 2016.

[132] See, for instance, UNAIDS 'UNAIDS expresses serious concern over ruling in Malawi' 20 May 2010 available at *http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2010/may/20100520 psmalawi*, accessed on 28 August 2016; UNAIDS 'UNAIDS expresses concern over proposed 'Anti-Homosexuality Bill' in Uganda' 10 may 2011 available at *http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011/may/20110510psuganda*, accessed on 28 August 2016.

[133] While some research has been conducted in recent years on the challenges discussed above and their political implication for the HIV response, these studies do not appear to fully articulate or offer approaches for addressing the fundamental challenges to the response that these developments represent. D Altman & K Buse (eds) *Thinking politically about HIV* (2014); K Buse, C Dickinson & M Sidibé 'HIV: know your epidemic, act on its politics' (2008) 101(12) *Journal of the Royal Society of Medicine* 572-573.

interpreted and invoked to ensure the protection of people living with HIV and those vulnerable to HIV. These include constitutional provisions prohibiting discrimination on grounds of health or other statuses.[134] Similarly, employment legislation guaranteeing equality and fairness could be applied to HIV-related issues in the workplace.[135] Beyond these general laws, many countries in sub-Saharan Africa have adopted HIV-specific legislation to address the legal issues raised by the HIV epidemic.

1.6.1 The proliferation of HIV-specific laws

HIV-specific laws (also known as omnibus HIV legislation) are legislative provisions that regulate several aspects of HIV in a single document. They can include the following:

- HIV-related education and communication;
- HIV testing, prevention, treatment, care and support;
- HIV-related research; and
- non-discrimination based on HIV status.[136]

As of July 2014, some 27 countries in sub-Saharan Africa had adopted HIV-specific laws.[137]

Three inter-related factors seem to have generated the impetus for HIV-specific legislation in sub-Saharan Africa. First, the drive for legislation on HIV in Africa (and in other regions) originates from the broad recognition that the law – and legislation in particular – can play an important role in the response to HIV. The law is considered, in the context of HIV, to be a structural tool that can help shape individual attitudes and behaviour, thus orienting the manner in which states respond to the issues and challenges posed by the epidemic.[138]

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[134] AIDS and Human Rights Research Unit (note 53 above).
[135] Ibid.
[136] P Eba 'One size punishes all: A critical appraisal of the criminalisation of HIV transmission or exposure through HIV-specific laws in sub-Saharan Africa' (2008) *AIDS Legal Quarterly* 1.
[137] Eba (note 49 above).
[138] See J Hamblin 'The role of the law in HIV/AIDS policy' (1991) 5(Suppl 2) *AIDS* s239-s243.

Second, HIV-specific laws have the advantage of expediency. They offer the possibility of addressing several aspects of HIV in a single piece of legislation, as opposed to the challenges and delays inherent in drafting, introducing, debating and eventually voting upon multiple legislative texts that all deal with aspects of HIV.

Third, calls for a legal response to HIV found fertile ground in sub-Saharan Africa, the region of the world that is most affected by HIV. For policymakers in the region, adopting HIV-specific legislation served to 'illustrate' political and societal commitment to addressing the epidemic.[139] Though legislation, parliamentarians and other political leaders can show that they are 'doing something' against HIV. It is not surprising that sub-Saharan Africa has become the region of the world that is 'most legislated' in relation to HIV.[140]

In some countries – such as Botswana, Lesotho and South Africa – calls to legislate on HIV did not lead to the adoption of HIV-specific laws; rather, they have resulted in the reform of particular aspects of existing legislation to cover new issues raised by the HIV epidemic.[141] In South Africa, for instance, the Law Reform Commission conducted a series of analyses of national laws relevant to HIV that identified existing legislation that needed to be revised in order to better respond to HIV and protect human rights.[142]

The recourse to HIV-specific legislation in sub-Saharan Africa is a rather recent phenomenon. The first HIV-specific legislation on the continent was adopted in 2004 in Angola.[143] It was the 11 September 2004 adoption of the Model Law on HIV in West Africa, however, that transformed the legislative landscape on HIV in the region and, most specifically, in West and Central Africa.[144] This model law is generally

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[139] R Pearshouse 'Legislation contagion: The spread of problematic new HIV laws in Western Africa' (2007) 12 *HIV/AIDS Policy and Law Review* 1-12

[140] Ibid.

[141] Eba (note 49 above; 226).

[142] Under its project 85, the South African Law Reform Commission considered various legal issues relating to HIV, including discrimination in schools, the criminalisation of HIV exposure or transmission, and the compulsory HIV testing of alleged sexual offenders. The reports of the Commission are available at *http://www.justice.gov.za/salrc/dpapers.htm,* accessed on 28 August 2016.

[143] See Lei No 8/04 sobre o Virus da Immunodeficiência Humana (VIH) e a Sindroma de Immunodeficiência Adquirida (SIDA) of Angola.

[144] Eba (note 49 above).

known as the N'Djamena Model Law. Five years after the adoption of the N'Djamena Model Law, some 15 countries in West and Central Africa had adopted HIV-specific legislation broadly based on its provisions.[145] The model law also influenced the adoption of HIV-specific laws in other African sub-regions.[146] Serious concerns have been raised about the provisions of this model law and its embrace of coercive measures.[147]

In Southern Africa, the Parliamentary Forum of the Southern African Development Community (SADC PF) initiated a process in 2007 to develop model legislation on HIV for countries in the region.[148] The development of the model law involved members of parliament, civil society organisations, HIV experts, human rights advocates and members of the judiciary.[149] The final model legislation was adopted in November 2008 in Arusha, Tanzania, and it has since been heralded as a rights-based and evidence-informed instrument for legislating on HIV.[150] The model law is used by actors in the region as a yardstick to assess and orient the development of HIV-related legal and policy norms.[151]

In the EAC – an intergovernmental organisation comprised of Burundi, Kenya, Rwanda, South Sudan, Tanzania and Uganda – a regional legislation on HIV came into force in 2015.[152] The law was adopted by the East African Legislative Assembly (EALA) following a process that was initiated and supported by civil society organisations working on HIV in an attempt to respond to provisions of concern in their national HIV laws.[153] Under the EAC Treaty, laws passed by EALA and

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[145] Ibid.
[146] See D Grace *This is not a law: The transnational politics and protest of legislating an epidemic* (unpublished PhD Thesis), available at https://dspace.library.uvic.ca:8443/handle/1828/3944?show=full (accessed on 3 November 2013).
[147] Pearhouse (note 140 above); Grace (note 147 above); Eba (note 137 above).
[148] F Viljoen 'Model legislation and regional integration: Theory and practice of model legislation pertaining to HIV in the SADC' (2008) *De Jure* 383-398.
[149] R Johnson 'The Model law on HIV in Southern Africa: Third World approaches to international law insights into a human rights-based approach' (2009) 9(1) *African Human Rights Law Journal* 120-159.
[150] Ibid.
[151] Ibid.
[152] ICW Weekly Bulletin 'The East African Partner States Assent to the East Africa HIV and AIDS Prevention and Management Bill, 2012' 27 October 2015 available at http://www.iamicw.org/CampaignProcess.aspx?A=View&Data=UmSlGuoOqWuJHK8E06yawQ%3d%3d, accessed on 27 August 2016.
[153] EALA 'EALA passes regional Bill on HIV and AIDS' 23 April 2012, available at *http://www.eala.org/media/view/eala-passes-regional-bill-on-hiv-and-aids*, accessed 27 August 2016.

assented to by all heads of states of the community countries take precedence over national legislation in the same area.[154]

1.6.2 Human rights concerns in HIV-specific laws

In most countries where HIV-specific laws have been adopted, they often were intended to express a commitment to the protection of the rights of people living with HIV. This 'commitment' to human rights is generally proclaimed in HIV-specific laws. For instance, the preamble of the HIV law of Guinea Bissau states that its objective is to 'ensure that every person living with HIV or presumed to be living with HIV enjoys the full protection of his or her human rights and freedoms'.[155] Similar proclamations of intent can be found under section 3 of the HIV law of Kenya[156] and article 1 of the HIV law of Madagascar (among others).[157]

The normative content of HIV-specific legislation shows some attention to human rights and the protection of people living with HIV through provisions that prohibit HIV-related discrimination, affirm the right of people living with HIV to access health and other services, set principles and conditions on the right to confidentiality and autonomy, and spell out the nature and content of HIV prevention, treatment and care services to be provided in the country.[158]

A careful review of HIV-specific laws in sub-Saharan African countries, however, shows that they raise serious human rights concerns in many instances.[159] First, all HIV-specific laws adopted across sub-Saharan Africa contain provisions that restrict

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[154] Article 8(4) & (5) of the Treaty for the Establishment of the East African Community available at *http://www.eac.int/sites/default/files/docs/treaty_eac_amended-2006_1999.pdf,* accessed on 28 August 2016.

[155] See Loi n° 5/2007 du 10 septembre 2007 de la prévention, du traitement et du contrôle du VIH/sida de la Guinée Bissau (unofficial translation).

[156] HIV Prevention and Control Act of Kenya, No 14 of 2006.

[157] Loi No 2005-040 du 20 Février 2006 sur la lutte contre le VIH/SIDA et la protection des droits des personnes vivant avec le VIH/SIDA of Madagascar.

[158] Eba (note 49 above).

[159] For a discussion of the criticisms of HIV-specific laws in sub-Saharan Africa, see, among others, Pearshouse (note 140 above), R Pearshouse 'Legislation contagion: building resistance' (2008) 13(2/3) *HIV/AIDS Policy & Law Review* 1-11, Irinnews 'Africa: 'Terrifying' new HIV/AIDS laws could undermine AIDS fight' 7 August 2008 available at *http://www.irinnews.org/report/79680/africa-terrifying-new-hiv-aids-laws-could-undermine-aids-fight,* accessed on 28 August 2016; Irinnews 'West Africa: HIV law 'a double-edged sword''1 December 2008, available at *http://www.irinnews.org/report/81758/west-africa-hiv-law-a-double-edged-sword,* accessed on 28 August 2016.

the rights of people living with HIV or endorse some form of coercive measures in responding to the epidemic alongside their rights-proclaiming provisions.[160] For instance, this is the case for provisions that institute compulsory HIV testing, allow for denial of access to HIV education for adolescents, or introduce overly-broad criminalisation of HIV non-disclosure, exposure and transmission.[161] Second, the great majority of HIV-specific laws have failed to address the human rights challenges faced by members of key populations at higher risk of HIV infection, particularly men who have sex with men, sex workers and people who inject drugs.[162] Third, concerns have been raised about the process for adopting HIV-specific laws and the lack of (or minimal) consultation with HIV stakeholders, particularly civil society organisations, people living with HIV and members of key populations.[163] In some countries, intense advocacy on these concerns has led to the revision of some aspects of HIV-specific laws.[164]

Although more than half of the countries in sub-Saharan Africa have introduced HIV-specific laws, only limited academic research has been devoted to them. Existing studies on HIV-specific laws in sub-Saharan Africa can broadly be summarised into two categories. The first category relates to studies published in the wake of the adoption of HIV-specific laws based on the N'Djamena Model Law by several West African States.[165] The second category of research is comprised of a handful of studies that analyse some aspects of HIV-specific laws, particularly provisions criminalising HIV exposure and transmission.[166] In addition to these two main categories, there also are a small number of publications that address the process,

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[160] Ibid.
[161] P Sanon, S Kaboré, J Wilen, SJ Smith & J Galvão 'Advocating prevention over punishment: the risks of HIV criminalization in Burkina Faso' (2009) 17(34) *Reproductive Health Matters* 146-153; C Kazatchkine 'Criminalizing HIV transmission or exposure: the context of francophone West and Central Africa'(2010) 14(3) *HIV/AIDS Law and Policy Review* 1-11.
[162] Canadian HIV/AIDS Legal Network *A human rights analysis of the N'Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo* (2007) available at *http://sagecollection.ca/fr/system/files/ln_humanrtlegislnrvw_en_0.pdf*, accessed on 28 August 2016.
[163] Grace (note 147 above).
[164] This was the case in Guinea (2009), Togo (2010) and Sierra Leone (2011).
[165] See notably Pearshouse (note 140 above); Pearshouse (note 160 above); Canadian HIV/AIDS Legal Network (note 163 above).
[166] See, among others, D Grace 'Criminalizing HIV transmission using model law: troubling best practice standardizations in the global HIV/AIDS response' (2015) 25(4) *Critical Public Health* 441-454; Eba (note 137 above); Sanon (note 162 above); Kazatchkine (note 162 above).

nature and politics of the creation of HIV-specific legislation through the analysis of the model laws in West and Central Africa and in Southern Africa.[167] While important to understanding some of the questions around the process and content of HIV-specific laws, existing studies are not sufficient to provide a complete insight into the rationale for, and normative content of, these laws. The comprehensive analysis of the content of HIV-specific laws offered in this thesis is therefore needed to fully appreciate the strength of human rights protections and challenges in these laws.

1.6.3 The question of implementation and enforcement of HIV-specific laws

More than a decade after the first HIV-specific laws came into force, there has been very limited evidence about their effective implementation and enforcement. Qualitative studies conducted among people living with HIV in some of the countries that have adopted HIV-specific laws suggest that there have been challenges related to their implementation and enforcement.[168] Surveys also indicate that there is little knowledge of the laws among people living with HIV, even though they arguably are among the primary beneficiaries of HIV legislation.[169] In many cases, regulations, directives and other measures critical to ensuring the effective implementation of these laws have not been adopted.[170]

These challenges in the implementation of HIV-specific laws are both concerning and surprising. In fact, the importance of implementation was one of the main arguments – along with certainty and clarity – that motivated the adoption of these laws in the first place. It was argued that having HIV-specific laws would ensure that their norms were known and better implemented, and that such laws would facilitate and encourage monitoring (as opposed to the difficulties that would have been inherent in the implementation of multiple pieces of legislation relating to HIV).[171] Understanding the issues and challenges related to the implementation of HIV-specific laws is important because the mere adoption of HIV-specific laws – even

[167] See Grace (note 147 above); D Grace 'Legislative epidemics: The role of model law in the transnational trend to criminalise HIV transmission' (2013) 39(2) *Medical Humanities* 77-84; Viljoen (note 149 above); Johnson (note 150 above).
[168] PM Eba 'Towards smarter HIV laws: considerations for improving HIV-specific legislation in sub-Saharan Africa' (2016) 24 *Reproductive Health Matters* 178-184.
[169] Ibid.
[170] Ibid.
[171] Eba (note 137 above).

with the most protective provisions – is not sufficient to create the 'enabling environment' called for by the promoters of laws on HIV.[172]

This thesis notes that although they are related, the notions of implementation and enforcement have distinct meanings. *Implementation* is a broad term that refers to all the processes, actors, mechanisms and rules through which laws or policies are put into effect.[173] *Enforcement* is an element of implementation that refers to the methods (judicial or non-judicial) that are employed to ensure compliance with the law or policy.[174] This thesis mostly refers to implementation as the broader term and addresses enforcement only in instances when discussing issues pertinent to compliance with legal provisions. In particular, this thesis focuses on intrinsic factors that influence legislative implementation. These are factors that emerge directly from the provision of the law under consideration and are related to the quality of its normative content (see 1.7.3 for a discussion of intrinsic and extrinsic factors of legislative implementation).

1.7 Thesis objectives, research questions, premise, methodology, limitations and structure

1.7.1 Objectives

This thesis aims to contribute to the literature on the role of the law and human rights norms in the response to HIV in sub-Saharan Africa. It endeavours to do the following:

- To reflect on the application of human rights in relation to HIV during a time of increased calls for accelerating biomedical responses to HIV and contestation on the human rights of key populations.
- To apply this framework in prisons and the recent Ebola outbreak in West Africa.

[172] Eba (note 169 above).
[173] J-E Lane 'The concept of implementation' (1983) 86 *Statsvetenskaplig tidskrift* 17-40.
[174] GJ Stigler, G. J 'The optimum enforcement of laws' in GS Becker & WM Landes (eds) *Essays in the economics of crime and punishment* (1974) 55-67.

- To provide a comprehensive human rights analysis of the normative content of HIV-specific laws in sub-Saharan Africa and the intrinsic challenges affecting their implementation.
- To reflect on the role of civil society in the development and implementation of HIV-related laws.
- To make proposals for developing 'smarter' HIV-related legislation and creating legal environments that effectively advance the response to HIV.

Accordingly, the specific objectives of the thesis are as follows:

- To reflect on the role of the law and human rights in the response to HIV, as well as on recent challenges confronting rights-based responses to the epidemic.
- To use the normative framework, language and tools of human rights laws to analyse vulnerability to HIV and barriers to effective HIV prevention, treatment and care in prisons, as well as to critique responses to the outbreak of Ebola in West Africa in 2014 - 2015.
- To develop a theoretical framework for assessing and reviewing intrinsic challenges to HIV-related legislation, and to apply that framework to HIV-specific laws.
- To analyse and interrogate the effectiveness of the HIV Tribunal of Kenya as a mechanism for ensuring the implementation of HIV-related legislation and for protecting HIV-related human rights.
- To analyse and critique the role of civil society organisations in developing and challenging HIV-specific legislation.
- To contribute towards the development of considerations for improving the normative content and likelihood of effectively implementing HIV-related and other health-related legislation.

1.7.2 Research questions

The study investigates four key research questions.

1. How do human rights norms apply to and guide responses to vulnerability to HIV and barriers to accessing HIV services? This question is answered a) by describing and reflecting on the development and challenges of the HIV-related human rights framework (as was done in this chapter), and b) by using human rights norms, tools and approaches to discuss HIV in prisons and to critique coercive approaches to the outbreak of Ebola in West Africa.

2. To what extent do HIV-specific laws adopted in sub-Saharan Africa reflect human rights norms and best available public health recommendations on HIV? This question is addressed by providing a comprehensive analysis of the normative content of 26 of the 27 HIV-specific laws that have been adopted in sub-Saharan Africa as of July 2014.[175] Key provisions in these laws are assessed against rights-based and evidence-informed recommendations.

3. Does the process of developing HIV-specific laws and their normative provisions appropriately address intrinsic issues that influence the effective implementation of legislation? In other words, do the process and content of these laws reflect the principles and approaches of 'smarter' legislation? This research question is addressed by a) describing the notion and principles of 'smarter' legislation and systematically applying them to 26 HIV-specific laws in sub-Saharan Africa, and b) presenting and discussing the HIV Tribunal of Kenya as an example of a mechanism for implementing and enforcing HIV-related human rights.

4. What has been the role of civil society organisations in the development and implementation of HIV-specific laws in sub-Saharan Africa? This question is addressed by describing and reflecting on the role of civil society organisations in challenging the N'Djamena Model Law and in supporting the development and adoption of the East African Community HIV and AIDS Prevention and Management Act 2012.

[175] For this thesis, the author has set the date of 31 July 2014 as the cut-off date for including HIV specific laws in the analysis. However, for the article on independent access to HIV services for children (Chapter Six), an amended version of the HIV law of Mozambique (adopted in August 2014) was included. For more, see Chapter Two (on methodology).

It should be noted that the purpose and approach of this thesis is not to provide definitive or exhaustive responses to all four research questions. While it does respond to the second and third research questions by offering comprehensive analyses of 26 HIV-specific laws in sub-Saharan Africa, in relation to the first and fourth research questions, it provides critical contributions and reflections that highlight key human rights considerations and raises areas that may require further research.

1.7.3 Central premises of the thesis

This thesis is built on three central premises. First, it subscribes to the position that effective legislative responses to HIV are those that are based on human rights and grounded in sound public health evidence. Upholding HIV-related human rights norms advances the structural role of the law as a tool for addressing HIV vulnerability and for removing barriers to accessing HIV and health services. Equally, sound medical and public health evidence ensures the legitimacy and effectiveness of the legal measures in achieving their goals of supporting the response to HIV.

Second, this thesis is premised on the position that ensuring rights-based and evidence-informed HIV-related laws is critical to their effective implementation, because the normative content of laws directly impacts whether they are implemented and how that is done. This premise is informed by publications relating to policy and legislative implementation literature that link effective implementation to normative policy content.[176] The thesis also subscribes to the view that legislative implementation ultimately is influenced by two sets of distinct yet interrelated factors: intrinsic and extrinsic factors.[177] *Extrinsic* or socio-ecological factors involve a mix of social, political, economic, financial, administrative and other elements that are specific to a particular country or context, and that directly or indirectly influence

[176] See H Ingram & A Schneider 'Improving implementation through framing smarter statutes' (1990) 10(1) *Journal of Public Policy* 67-88.
[177] PA Sabatier & DA Mazmanian 'The conditions of effective implementation: A guide to accomplishing policy objectives' (1979) 5(4) *Policy Analysis* 481-504; PJ May & SC Winter 'Politicians, managers, and street-Level bureaucrats: Influences on policy implementation' (2009) 19(3) *Journal of Public Administration Research and Theory* 453-476; PD Jacobson & J Wasserman 'The implementation and enforcement of tobacco control laws: policy implications for activists and the industry' (1999) 24(3) *Journal of Health Politics, Policy and Law* 567–598.

whether legislation is implemented and how it is done.[178] These factors are generally not found in the law or policy itself, and they include issues such as the political system of the state (whether federal or unitary), the nature of legal or legislative tradition (common law or civil law), human and technical resources available for implementation (including the nature and strength of agencies tasked with implementation or courts responsible for enforcement), financial resources, and the general political situation in the country (including factors such as political or social unrest or conflict).[179] *Intrinsic* factors are those that emerge directly from the provisions of the law or policy under consideration.[180] Intrinsic factors that influence implementation and enforcement are those that relate to the quality of the normative content of the law.[181] While recognising that effective implementation in all contexts depends on a combination of these intrinsic and extrinsic factors, this study focuses on describing and addressing intrinsic factors.

Third, this thesis underscores that the application of human rights in relation to an epidemic such as AIDS – which has deep social, legal and moral implications – is an eminently political issue. Furthermore, legislating on such an issue highlights important differences when it comes to social values, protection, access to social goods and the reach of public control in relation to the epidemic. These differences, in turn, may resist public health evidence or human rights arguments. This thesis therefore calls for 'thinking more politically' about HIV, human rights and HIV-related legislation.[182] It highlights political considerations that may guide actors involved in supporting lawmaking or law reform in the context of HIV and similar public health challenges.

1.7.4 Overview of methodology

This study combines desk review and qualitative research. The desk study involved a comprehensive and systematic analysis of 26 of the 27 HIV-specific laws that have

[178] Ibid.
[179] Ibid.
[180] Ingram and Schneider (note 177 above).
[181] Ibid.
[182] Altman & Buse (note 134 above).

been adopted in sub-Saharan Africa as of July 2014. It also researched existing literature on human rights, as well as publications on lawmaking and implementation.

The qualitative research used in this study consists of a series of interviews with key informants conducted in Nairobi, Kenya, from 20 – 29 August 2014. The interviews focused on the development of Kenya's HIV Prevention and Control Act 2006 and on the composition and practice of the HIV Tribunal, which was established under this law. Chapter Two of the thesis provides a detailed description of the methodology.

1.7.5 Limitations

Three limitations of the study are worth noting. First, the study focuses solely on HIV-specific legislation and leaves out other legislation that may apply to HIV. A key reason for this focus on HIV-specific legislation is that these laws exist in a majority of countries in sub-Saharan Africa, but little is known of their full normative content and the issues that affect their implementation.

Second, this study's analysis of factors that affect implementation focuses only on intrinsic factors of legislation implementation. While acknowledging that the implementation and enforcement of legislation depends on both intrinsic and extrinsic factors, this study focuses primarily on the former. This is because extrinsic (or socio-ecological) factors do not offer themselves easily to analysis in the context of a predominantly desk-oriented study. These factors are context-driven and their influence on implementation varies across countries, making it difficult to extrapolate and draw conclusions about how a particular intrinsic issue may impact the implementation of legislation in different countries. In light of these complexities, this study did not focus on extrinsic factors, although the analysis of the HIV Tribunal of Kenya allowed for the review of some of the extrinsic determinants of legislative implementation and enforcement.

Finally, while 27 sub-Saharan African countries have adopted HIV-specific laws, the author was only able to conduct qualitative research in one country: Kenya. This country was selected for reasons related to its HIV tribunal, which is a mechanism for implementation and enforcement of HIV legislation.

1.7.6 Overview of the structure of the thesis

The thesis is based on eight articles that were published or submitted for publication in peer-reviewed journals by this author (alone or with others) over the last three years. These articles – together with the present introduction, the methodology and the conclusion – provide a cohesive discussion of human rights norms and frameworks relating to HIV, offer a comprehensive analysis of the normative content and intrinsic implementation issues in 26 of the 27 HIV-specific laws adopted in sub-Saharan Africa as of July 2014, and suggest approaches for creating more enabling legislative environments for the HIV response in the region.

The thesis is divided into four parts, which are preceded by an introduction (Chapter One) and a description of the methodology (Chapter Two).

Part One of the thesis is comprised of two articles: one relates to HIV, prisoners, and human rights (Chapter 3) and the other to Ebola and human rights in West Africa (Chapter 4).

Part Two relates to the application of human rights norms and evidence-informed public health recommendations to HIV-specific laws in sub-Saharan Africa. It includes two articles: a comprehensive human rights analysis of HIV-specific laws (Chapter Five) and a review of independent access to HIV testing, counselling and treatment for adolescents in HIV-specific laws (Chapter Six).

Part Three focuses on the considerations, mechanisms and challenges related to the implementation and enforcement of HIV-specific laws. It is comprised of three articles. The first article develops a framework for the effective implementation of HIV legislation and applies it to the laws in sub-Saharan Africa (Chapter Seven). The second article is an analysis of the HIV Tribunal of Kenya as a mechanism for supporting the implementation and enforcement of HIV legislation (Chapter Eight). The third article reflects on the role of civil society in supporting and challenging HIV-specific laws (Chapter Nine).

Part Four is the conclusion to the thesis. It is composed of two chapters. The first is a summary that draws on the preceding parts of the thesis to formulate concluding

remarks on the issues raised and to provide recommendations for amending and improving HIV-specific laws (Chapter Ten). The second is a note on those recommendations and reflections that closes the study with broader considerations for rights-based legal responses to HIV and other health challenges (Chapter 11).

1.8 Conclusion

Human rights norms and approaches provide a critical framework, language and tools for understanding and responding to vulnerability and barriers to services in the context of a socially, morally and politically-influenced health challenge such as HIV.

Over the years, there has been a growing consensus on the application of the law – particularly of human rights law – in responding to discrimination and supporting access to health and HIV services for people living with HIV. New calls for accelerated access to HIV services, however, involve the risk that some of these gains may be eroded in the pursuit of targets. Similarly, evidence of the increased vulnerability of key populations whose occupations, life choices or sexual practices are criminalised are confronting many sub-Saharan African countries and HIV actors with new challenges at a time when they are facing an environment of contestation and (over)politicisation of the human rights of LGBT people and other key populations.

Progress made in recognising the role of the law as a structural tool for addressing HIV has contributed to the adoption of HIV-specific laws in 27 sub-Saharan Africa countries as of July 2014. The content of these laws, however, reflects many of the challenges relating to the recognition and protection of HIV-related human rights in the region. The comprehensive analysis of the normative content – as well as the review of the intrinsic implementation challenges in these laws – offers the opportunity to identify both the strength of these laws and the areas that require reform for better implementation.

Chapter Two: Methodology

This chapter describes the desk study and qualitative research that form the basis of this thesis. It provides the rationale for the selection of these research methods and their application in the context of this study. This chapter also discusses the multidisciplinary analytical tools and frameworks that informed the review and analysis of the issues presented in the study, and it highlights both the ethical requirements that applied to the study and considerations relating to informed consent and confidentiality.

2.1 Desk research

This thesis is based primarily on desk research that involved two main components:

- The review of existing literature related to
    - HIV, human rights and the law,
    - policy implementation, and
    - HIV-related lawmaking.
- The identification and analysis of HIV-specific laws in sub-Saharan Africa.

2.1.1 Researching general literature on HIV, the law, human rights, legislation and policy implementation

Capturing the breadth of the substantive and multidisciplinary issues involved in this study required a broad literature search.[1] The desk research first sought to review the current status of the HIV epidemic and response in sub-Saharan Africa. Reports by global and regional institutions – such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organisation (WHO), the United Nations Children's Fund (UNICEF), the African Union and the Southern African Development Community (SADC) – about the state of the HIV epidemic in sub-Saharan Africa were

[1] AG Fink, *Conducting research literature review: From the internet to paper* (2009); M McConville & WH Chui (eds) *Research methods for law* (2007); TC Hutchinson & N Duncan 'Defining and describing what we do: doctrinal legal research (2012) 17(1) *Deakin Law Review* 83-119.

analysed with the aim of identifying key progress, gaps and challenges in the response. Similarly, public health evidence and recommendations for effective responses to HIV that are provided in guidelines produced by global and regional public health institutions also were reviewed.

Secondly the study involved researching the vast amount of available literature relating to HIV, the law and human rights.[2] This research focused on identifying key themes in the literature that relate to the role of the law and human rights in the context of HIV, and to health more generally. The desk research also involved the review of publications on human rights and HIV that address the thematic areas covered in the thesis, including HIV discrimination, HIV testing, employment, adolescents, prisoners and other key populations. Global and regional treaties, case-law, and guidelines and recommendations on HIV and human rights produced by organisations such as the Inter-Parliamentary Union (IPU), UNAIDS, the United Nations Development Programme (UNDP), and the International Labour Organisation (ILO) also were reviewed.

Finally, the desk review involved searching for publications relating to HIV-specific legislation in sub-Saharan African countries and other regions. Since a key aspect of the thesis relates to legislative and policy implementation, available literature relating to this area was reviewed for key notions and frameworks.

The above resources and materials on the legal, policy and human rights issues relating to HIV were identified by searching databases of legal journals (such as *Westlaw* and *HeinOnline*) through a combination of keyword search using 'HIV' combined with 'law', 'policy', 'legislation', 'human rights' and 'rights'.[3] In addition, Internet searches using Google and Google Scholar were conducted to identify additional publications and materials on these issues. References in the materials accessed also were reviewed to identify other relevant sources of information.

[2] Ibid.
[3] See Fink (note 1 above).

2.1.2 Researching HIV-specific laws in sub-Saharan Africa

Sub-Saharan Africa was selected as the geographic area for the research on HIV-specific legislation because it is the region most affected by HIV. It was thus anticipated that this region would be the one most likely to use legislation to respond to the legal, social and other challenges posed by HIV. Available research had already referred to sub-Saharan Africa as 'the region most legislated on HIV'.[4]

The desk research sought to identify all countries in sub-Saharan Africa that have adopted HIV-specific legislation. This first required a clear definition of HIV-specific laws. Using available descriptions and definitions of these laws in the literature, the research identified 27 HIV-specific laws that had been adopted in sub-Saharan Africa as of 31 July 2014. This date was used as a cut-off for the selection of laws to be included in the study in order to ensure consistency in the analysis of the legislation. Laws adopted after this cut-off date were not included in this study. The study does, however, include the revised version of the HIV law of Mozambique (which was amended in August 2014) in the discussion in Chapter Six on access to independent HIV services for adolescents. This revised law was included because it was available in 2016, when the article on adolescents and HIV that forms the basis of Chapter 6 was written and submitted. Furthermore, Mozambique's revised HIV law introduced important changes that needed to be discussed in this thesis.

The identification of HIV-specific laws in sub-Saharan African countries was done by searching peer-reviewed publications, reports and other materials relating to HIV and the law in sub-Saharan Africa for any indication of the existence of such laws in a particular country. In addition, a systematic Internet search using different combinations of the names of all sub-Saharan African countries and the words 'HIV laws' and 'HIV legislation' was used to retrieve information relating to the existence of HIV-specific legislation in specific countries.

[4] R Pearshouse 'Legislation contagion: The spread of problematic new HIV laws in Western Africa' (2007) 12 *HIV/AIDS Policy and Law Review* 1-12.

These general Internet searches also were completed by a search of existing databases of HIV-related laws and policies, such as *ILO/AIDS*,[5] *UNESCO HIV and health education clearinghouse*[6] and *AIDSPortal*,[7] as well as compendiums of HIV-related legal materials and publications relating to HIV laws and policies in Africa.[8] Where possible, official versions of the laws were secured through government gazettes, websites of national parliaments and other national and regional online repositories of laws (such as the Southern African Legal Information Institute).[9]

Through these methods, all HIV-specific laws in force in sub-Saharan Africa were secured except the HIV law of Equatorial Guinea.[10] All of the HIV-specific laws that were identified were then systematically analysed to ascertain whether or not their normative provisions addressed key thematic issues covered in this study, and if so, in what way. The key thematic issues (and the Chapter in which they are discussed) are as follows:

- HIV-related discrimination, rights violations in the workplace, HIV testing, and the criminalisation of HIV non-disclosure, exposure and transmission (Chapter Five);
- access to independent HIV services for adolescents (Chapter Six); and
- implementation issues (Chapters Seven and Ten).

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[5] ILO 'HIV legislation and policies' *http://www.ilo.org/aids/legislation/lang--en/index.htm*, accessed 7 September 2016.
[6] UNESCO 'HIV and health education clearinghouse' *http://hivhealthclearinghouse.unesco.org*, accessed 7 September 2016.
[7] 'AIDSPortal' *http://www.aidsportal.org/web/guest/home*, accessed 7 September 2016.
[8] See eg AIDS and Human Rights Research Unit (2007) *Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa*.
[9] 'Southern African Legal Information Institute' *http://www.saflii.org/*, accessed 7 September 2016.
[10] Research confirmed the existence of HIV-specific legislation in Equatorial Guinea. This law is referred to in several reports submitted by the Government of Equatorial Guinea. See, República de Guinea Ecuatorial Programa Nacional de Lucha Contra El Sida 'Declaración de compromiso sobre VIH/SIDA, UNGASS: Informe nacional sobre los progresos realizados en la aplicación del UNGASS' 2010 *http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/equatorialguinea_2010_country_progress_report_es.pdf*, accessed 25 October 2014. However, efforts to secure a copy of this legislation were not successful. As a result, the HIV Law of Equatorial Guinea is not included in this study.

The thesis then used approaches of doctrinal and non-doctrinal legal research to analyse the content and provisions of the laws.[11] *Doctrinal legal research* is defined as 'research which provides a systematic exposition of the rules governing a particular legal category, analyses the relationship between rules, explains areas of difficulty and, perhaps, predicts future developments'.[12] All other legal research is referred to as *non-doctrinal research,* including research relating to policy and law reform.[13]

The result of the analysis was systematically integrated in a comprehensive data extraction and coding tool developed to capture the situation of each country in relation to the thematic issues.[14] In general, a 'yes' or 'no' structure was used to distinguish between countries based on whether they addressed a specific issue. In some cases, the specific normative provision was analysed and its content included in a category depending on whether it appropriately addressed applicable human rights norms or public health recommendations. Tables summarising the findings from the application of the data extraction and coding tools are available in relevant chapters throughout the thesis.

2.2 Qualitative research

This study also involved qualitative research conducted in Nairobi, Kenya, from 20 to 29 August 2014. The findings of the qualitative research were used to supplement the information and materials relating to the analysis of the HIV Tribunal of Kenya (discussed in Chapter Eight).[15] Kenya was selected as the site for the qualitative study because its HIV legislation establishes the only HIV-specific tribunal in the world. The analysis of the HIV Tribunal of Kenya, its norms, practices and decisions was therefore

[11] Hutchinson & Duncan (n 1 above).
[12] See D Pearce, E Campbell & D Harding 'Australian law schools: A discipline assessment for the Commonwealth Tertiary Education Commission 1987' cited in Hutchinson & Duncan (n 1 above) 15.
[13] See Hutchinson & Duncan (n 1 above); I Dobinson & F Johns 'Qualitative legal research' in McConville & Chui (eds) (n 1 above) 16-45.
[14] J Fereday & E Muir-Cochrane 'Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development' (2006) 5 *International Journal of Qualitative Methods* 1-11.
[15] L Webley 'Qualitative approaches to empirical legal research' in P Cane & HM Kritzer (eds) *The Oxford handbook of empirical legal research* (2010) 926-950.

critical to understanding issues of implementation and enforcement of HIV-related rights.

The qualitative research consisted of semi-structured interviews conducted using an open-ended questionnaire (see Interview questionnaire in Annex 4). A total of 13 key informants from 10 institutions and organisations were interviewed as part of the research. Informants were selected for their involvement in the development of the HIV law of Kenya (which established the HIV Tribunal), their experience in engaging with the HIV Tribunal, or their general knowledge of the judicial system of Kenya. Informants were from the following institutions: the High Court, the HIV Tribunal, the National Human Rights Commission, and the Commission for the Implementation of the Constitution. Informants also included civil society actors (such as people living with HIV and lawyers), and staff members of UNAIDS and UNDP in Kenya. Additional information was sought through email exchanges and phone interviews with informants in September 2015.

2.3 Multidisciplinary framework of analysis

Although it is primarily based on legal and human rights analysis, this thesis also uses a multidisciplinary framework that integrates elements of public policy analysis and public health evidence and recommendations.[16]

Themes and frameworks of public policy analysis relating to 'smarter legislation' are used in the study to inform the assessment of the normative content and implementation issues of HIV-specific laws. The review and application to HIV-specific laws of key notions relating to policymaking and implementation is described in Chapters Seven and Ten.

The multidisciplinary approach in this study also relates to the use of public health recommendations as a framework for analysing national HIV legislation and policy. Public health recommendations and evidence are combined with human rights

[16] M Adams 'Doing what doesn't come naturally. On the distinctiveness of comparative law' in M Van Hoecke *Methodologies of legal research: Which kind of method for what kind of discipline?* (2011) 238.

principles and norms to assess the adequacy of the normative content and issues with implementation in HIV laws.

2.4 Ethical considerations, consent and confidentiality

The qualitative research conducted in Kenya received ethical approved on 7 August 2014 from the Humanities and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal ("Ethics Committee") in South Africa under the reference number HSS/0472/014D (see Annex 2).[17] As part of the ethical approval process, the study also was endorsed by a 'gate-keeper' institution as required by the rules of the Ethics Committee. In a letter dated 31 July 2014 (see Annex 3), the chairperson of the HIV Tribunal of Kenya welcomed the proposal for the research on the HIV Tribunal, noting that

> research of this nature is important to better understand current practices and challenges relating to the implementation and enforcement of HIV-specific legislation in sub-Saharan Africa. In particular, the focus of your study on the HIV Tribunal of Kenya would be helpful to the Tribunal as it works to ensure the effective enforcement of the HIV Prevention and Control Act, No 14 of 2006 of Kenya.[18]

Participants interviewed as part of the qualitative research were informed before the start of the interview that they could choose not to participate. The information sheet explaining the background of the research project and the nature of the interview was read to all participants, and they were asked to sign the consent form (see Annex 5). Only participants who agreed to be named in the research were referred to by name. All respondents also were informed of the ethical review process and were provided with the contact details of the Secretariat of the Ethics Committee and the contacts of my supervisor (Dr Ann Strode) for any questions pertaining to ethical issues relating to the

[17] For the description of ethical considerations in the context of qualitative research, see (among others), M Sanjari, F Bahramnezhad, FK Fomani, M Shoghi & MA Cheraghi 'Ethical challenges of researchers in qualitative studies: the necessity to develop a specific guideline' (2014) 7 *Journal of Medical Ethics and History of Medicine* 14; EJ Emanuel, D Wendler, J Killen & C Grady 'What makes clinical research in developing countries ethical? The benchmarks of ethical research' (2004) 189 *Journal of Infectious Diseases* 930-937. Key ethical considerations highlighted in these sources were duly taken into consideration when designing and conducting the qualitative research described in this study.

[18] J Arwa 'Letter of interest in research on the implementation and enforcement of HIV-specific legislation in sub-Saharan Africa', Ref. HAT/RES/1/Vol.I, 31 July 2014 (see Annexes).

study or interview (see Annex 5). Following the publication of the article on the HIV Tribunal of Kenya (Chapter Seven) in June 2016, it was sent by the author to each of the informants at the email address that they had provided during the qualitative research in Kenya.

PART ONE: **PUTTING HUMAN RIGHTS NORMS IN CONTEXT**

This part applies the general framework of human rights, described in the introduction of the thesis, to specific areas of HIV and health. It is composed of two chapters relating to HIV, prisoners, and human rights (Chapter Three), and Ebola and human rights in West Africa (Chapter Four).

Chapter Three uses the language, framework and approaches of rights to examine vulnerability to HIV among prisoners and the barriers to their access to HIV services. The chapter shows that marginalisation, discrimination and the unfair application of criminal law are among key reasons that contribute to make some populations particularly vulnerable to HIV, TB and hepatitis, and that expose them to the risk of over-incarceration. It also shows that punitive and discriminatory laws and practices often lead to sub-standard health and HIV care for prisoners or to denial of health care services to this population. The chapter offers a rights-based and evidence-informed framework for addressing human rights violations and improving HIV, TB and general health care services for prisoners during detention and after their release.

Chapter Four uses the human rights approach developed in the context of HIV to interrogate governments' responses to the Ebola outbreak in West Africa in 2014 - 2015. Drawing on the lessons of human rights protection and community involvement that lie at the core of effective responses to HIV, this chapter succinctly argues that rights-based responses were largely ignored in the response to Ebola. It shows that in the face of fear of public health emergencies, coercive and restrictive approaches continue to be used by governments.

Together, these chapters demonstrate the importance of human rights as a normative framework for understanding and addressing public health challenges.

Chapter Three

HIV and related infections in prisoners 4

HIV, prisoners, and human rights

Leonard S Rubenstein, Joseph J Amon, Megan McLemore, Patrick Eba, Kate Dolan, Rick Lines, Chris Beyrer

Worldwide, a disproportionate burden of HIV, tuberculosis, and hepatitis is present among current and former prisoners. This problem results from laws, policies, and policing practices that unjustly and discriminatorily detain individuals and fail to ensure continuity of prevention, care, and treatment upon detention, throughout imprisonment, and upon release. These government actions, and the failure to ensure humane prison conditions, constitute violations of human rights to be free of discrimination and cruel and inhuman treatment, to due process of law, and to health. Although interventions to prevent and treat HIV, tuberculosis, hepatitis, and drug dependence have proven successful in prisons and are required by international law, they commonly are not available. Prison health services are often not governed by ministries responsible for national public health programmes, and prison officials are often unwilling to implement effective prevention measures such as needle exchange, condom distribution, and opioid substitution therapy in custodial settings, often based on mistaken ideas about their incompatibility with prison security. In nearly all countries, prisoners face stigma and social marginalisation upon release and frequently are unable to access health and social support services. Reforms in criminal law, policing practices, and justice systems to reduce imprisonment, reforms in the organisation and management of prisons and their health services, and greater investment of resources are needed.

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This is the fourth in a **Series** of six papers on HIV and related infections in prisoners

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Introduction

The criminalisation of drug use and of some sexual behaviours, discrimination against racial and ethnic minorities, and lack of access to protections of due process for socioeconomically disadvantaged groups lead to unjust incarceration, increase the risk of HIV, tuberculosis, and hepatitis infection, and interrupt access to prevention and treatment. Both incarceration and the fear of arrest and harassment by police can prevent individuals from seeking or accessing prevention, harm reduction interventions, testing, and treatment. Consequently, in nearly every country in the world, criminalised populations and prisoners face higher burdens of HIV infection and lower levels of access to treatment than do non-incarcerated individuals.[1]

Prisoners are often held in overcrowded, unsanitary, stressful, and violent conditions, which are ripe for the spread of communicable diseases. Access to prevention and treatment programmes are often non-existent or severely underfunded. According to WHO, "Ill-health thrives in settings of poverty, conflict, discrimination and disinterest. Prison is an environment that concentrates precisely these issues."[2] Continuity of treatment during imprisonment and upon release is rare.

These practices violate human rights, which are founded on the dignity of all human beings. International and regional treaties, and many national constitutions and laws, mandate that governments respect, protect, and fulfil human rights, among them the rights to life and to the highest attainable standard of physical and mental health. Among other requirements of human rights law, countries are also obligated to respect bodily integrity and privacy, protect individuals from discrimination, guarantee due process of law in criminal justice, and refrain from cruel and inhuman treatment (table 1).

To realise the right to health, governments must eliminate barriers to prevention and treatment of ill health and the determinants of health and ensure the equitable provision of services sufficient to meet population needs.[4] In resource-limited settings countries can bring about the right to health progressively, but are required to draw on maximum available resources to

Key messages

- Criminalisation of drug use and sexual behaviour, discrimination against racial and ethnic minorities in policing and health services, and the lack of due process for socioeconomically disadvantaged groups lead to unjust incarceration, increase the risk of HIV, tuberculosis, and hepatitis C (HCV) infection, and interrupt access to prevention and treatment.
- Worldwide, incarcerated people endure pervasive violations of their human rights, including gross overcrowding, unsanitary conditions of living, and sexual and other forms of violence. These conditions and a lack of access to prevention interventions promote the transmission of HIV, tuberculosis, and HCV.
- Prisoners living with HIV, tuberculosis, or HCV are often subject to discrimination within prisons and to violations of rights of privacy and confidentiality, and lack access to appropriate medical care.
- Prevention and treatment of HIV, tuberculosis, and hepatitis in prisons are effective, but interventions such as the distribution of condoms and clean needles, voluntary HIV testing, and treatment are often impeded by inadequate resource commitments, discrimination, and restrictive prison rules or policies. Despite the high number of drug users in prisons, treatment for drug dependency is also often lacking.
- Linkages to medical care, housing, and social supports are inadequate for released prisoners.
- In the global response to HIV, tuberculosis, and hepatitis in prisons, the burden of disease can be reduced by law, policing, and criminal justice reforms that prevent unjust incarceration and extended pretrial detention. These steps can be combined with increased resources and political commitments to ensure adequate conditions of confinement and availability of medical care in prisons. Strong and effective linkages to care upon release are also urgently needed.

	Content	Key guidance	Example of jurisprudence
A right to medical care	Persons deprived of liberty have the right to access the health services available in the country without discrimination based on their legal situation	Mandela Rules (rules 24–35) UN principles of medical ethics (principle 1) European prison rules (article 40.3) European CPT standards Principles and best practices on the protection of persons deprived of liberty in the Americas (principle 10)	*Van Biljon and Others vs The Minister of Correctional Services* (Cape of Good Hope Provincial Division, South Africa, 1997): prisoners on ART at the time of incarceration have a right to continued medication *EN and Others vs The Government of the RSA and Others* (Durban and Local Coast Division, South Africa, 2006): prisoners have a right to ART *Odafe and Others vs Attorney-General and Others* (High Court of Nigeria, 2004): failure to provide HIV treatment violates African Charter on Human and Peoples' Rights
A right to timely medical attention	Individuals in detention have the right to access timely medical attention. Medical care for individuals deprived of liberty is only compliant with international law if it is available when needed	Mandela Rules (rules 24–35) Body of principles for the protection of all persons under any form of detention or imprisonment (principle 24) European CPT Principles and best practices on the protection of persons deprived of liberty in the Americas (principles 9, 10)	*Khudobin vs Russia* (ECHR, 2006): failure to provide timely medical assistance and independent examination of prisoner with mental illness and HIV amounts to degrading treatment
A right to preventive health	Individuals deprived of liberty must be provided with measures to prevent the transmission of disease	Mandela Rules (rules 24–35) UN rules for the protection of juveniles deprived of their liberty (paragraph 49) CPT standards (paragraphs 52–63)	*Concluding Observations on Moldova* (UN Human Rights Committee, 2002): failure to address rapid spread of disease could be violation of right to liberty and security of the person *Concluding Observations on Moldova* (UN Committee on Economic, Social and Cultural Rights, 2003): state must ensure availability of tuberculosis medicines and adequate sanitary conditions in prisons *Pantea vs Romania* (ECHR, 2005): authorities must take practical preventive measures to protect the physical integrity and the health of prisoners *Staykov vs Bulgaria* (ECHR, 2006): denial of prevention and treatment for tuberculosis amounts to inhuman and degrading treatment
A right to mental health care	Individuals deprived of liberty have a right to access psychiatric and mental health services. Given the unique vulnerability of persons with mental illness in detention, the State's positive obligations to ensure their humane treatment, and to protect their wellbeing, are heightened	Mandela Rules (rules 24–35) European prison rules (article 47) European CPT standards Principles and best practices on the protection of persons deprived of liberty in the Americas (principle 3)	*Sahadath vs Trinidad and Tobago* (UN Human Rights Committee, 2002): government has obligation to provide appropriate psychiatric care *Herczegfalvy vs Austria* (ECHR, 1992) and *Victor Rosario Congo v Ecuador* (Inter-American Court 1999): a prisoner's mental illness heightens government obligation to ensure prisoner wellbeing
A right to a professional standard of care	Individuals deprived of liberty have a right to a professional standard of heath service provided by qualified medical personnel	Mandela Rules (rules 24–35) European prison rules (article 41.1) UN principles of medical ethics (principle 1) European CPT standards Principles and best practices on the protection of persons deprived of liberty in the Americas (principle 10)	*Testa vs Croatia* (ECHR, 2007): lack of medical attention to chronic hepatitis C infection and inadequate prison conditions violates rights to dignity and to be free from humiliation
A right to informed consent and to refuse treatment	Individuals deprived of liberty have a right to consent and a right to refuse treatment. These rights are subject to some specific limitations, subject to due process of law	Mandela Rules (rule 32) UN body of principles for the protection of all persons under any form of detention or imprisonment (principle 25) UN rules for the protection of juveniles deprived of their liberty (paragraph 55) UN Committee on Economic, Social and Cultural Rights (general comment 14: right to be free from non-consensual medical treatment) CPT standards (paragraphs 46–49) Principles and best practices on the protection of persons deprived of liberty in the Americas (principle 10) European CPT standards	*C vs Minister of Correctional Services* (South Africa, 1996): HIV testing without consent is a violation of rights
A right to adequate living space	Persons deprived of liberty have the right to an amount of living space sufficient to safeguard their health	Mandela Rules (rules 12–17) European CPT standards Principles and best practices on the protection of persons deprived of liberty in the Americas (principle 12)	*Concluding Observations, Georgia* (UN Human Rights Committee, 1997): crowding increases spread of infectious disease and alarming mortality rate *Concluding Observations, Mongolia* (UN Human Rights Committee, 2000): lack of adequate spaces damages prisoners' health
A right to hygienic living conditions	The failure of the State to provide proper toilet or washing facilities, or clean living conditions, can contribute to a violation of international law	Mandela Rules (rules 12–17) European CPT standards (paragraph 53) Principles and best practices on the protection of persons deprived of liberty in the Americas (principle 12)	*Pedro Orlando Ubaque vs Director, National Model Prison* (Colombia, 1994): lack of sanitary and environmental conditions violates rights to health and life of prisoner with HIV *Malawi African Association and Others vs Mauritania* (African Commission on Human and Peoples Rights 2000): inadequate hygiene is a violation of prisoners' rights

(Table 1 continues on next page)

	Content	Key guidance	Example of jurisprudence
(Continued from previous page)			
A right to food and water	The failure to provide safe and adequate food and drinking water contributes to violations of international law in all human rights systems	Mandela Rules (rule 22) European CPT standards Principles and best practices on the protection of persons deprived of liberty in the Americas (principle 11)	*Malawi African Association and Others vs Mauritania* (African Commission on Human and Peoples Rights 2000): failure to provide sufficient food is a violation of right to health *Alver vs Estonia* (ECHR, 2005): prisoners have a right to food
Inadequate health care or denial of medical treatment as inhumane treatment or torture	In some circumstances, an inadequate level of health care or the denial of health care can lead to situations that are tantamount to inhuman and degrading treatment or torture	Mandela Rules (rules 32) CPT standards (paragraph 30)	*Khudobin vs Russia* (ECHR, 2006): absence of qualified and timely medical assistance and refusal to allow an independent medical examination created such a strong feeling of insecurity that, with inmate's physical suffering, amounts to degrading treatment *Odafe and Others vs Attorney-General and Others* (AHRLR 205 [NgHC 2004]): failure to provide treatment for HIV is a violation of rights

Adapted from Lines.[3] International legal sources for these rights are the International Covenant on Civil and Political Rights (articles 6, 7, 9, 10); International Covenant on Economic, Social and Cultural Rights (articles 11, 12); Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Convention on the Rights of the Child (articles 24 and 25); Geneva Conventions (especially conventions III, IV); European Convention of Human Rights (articles 2, 3); African Charter on Human and Peoples' Rights (articles 4, 16); American Convention on Human Rights (articles 4, 5); American Declaration on the Rights and Duties of Man; UN Committee on Economic, Social and Cultural Rights (general comment 14: the right to the highest attainable standard of health, E/C.12/2000/4 [2000]). ART=antiretroviral therapy. RSA=Republic of South Africa. CPT=European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. ECHR=European Court of Human Rights.

Table 1: **Key health rights of individuals deprived of liberty**

fulfil the right. They must also adhere to certain core obligations such as ensuring equal access to health services, especially for vulnerable and marginalised groups, and providing essential drugs.[4]

Human rights law recognises that punishment for a criminal offence can include restrictions on liberty, but that prisoners retain their human rights, including rights to health and to be free from discrimination and cruel or inhuman treatment (tables 1 and 2).[5] The UN Standard Minimum Rules for the Treatment of Prisoners, revised in 2015 as the Mandela Rules (panel 1),[6] apply and provide operational guidance for countries on the human rights of prisoners. They state that prisoners have a right to medical services to evaluate, promote, protect, and improve their physical and mental health, offered by sufficient well qualified medical personnel operating with clinical independence. In some circumstances, fulfilling this right might require health services of a broader scope than those available in the community.[7] Prisoners also have rights to sufficient living space, appropriate ventilation, lighting, heat, sanitation, clean water, adequate and nutritious food, and a clean environment, and to be protected against violence (table 1).[6] Their rights to confidentiality, informed consent, and access to records must be respected and fulfilled, and legal aid must be made available to them (table 1).[6] Governments are also responsible to link released prisoners with social and health services and to protect them from discrimination.[5,6]

These human rights of prisoners are affirmed, too, in regional treaties and standards and monitoring mechanisms promulgated by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT),[8] the Inter-American Commission on Human Rights,[9] and the African Commission on Human and Peoples' Rights.[10] (see table 1 for human rights instruments). Globally, 80 countries have joined the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which also sets standards and mandates the creation of national monitoring mechanisms for prisons.[11]

In this review, we examine the effects of criminal laws, law enforcement policies and practices, and justice systems on rights to prevention and treatment of HIV, tuberculosis, and hepatitis and on the imprisonment of people with or at risk of HIV. We also analyse governments' compliance with obligations to prevent and treat HIV and related health conditions during and after incarceration (see appendix for search strategy). We focus on facilities that hold individuals arrested for or convicted of crimes—police lock-ups, jails, and prisons. Because of the great variation in how these institutions are used in criminal justice systems, we use the word prisoners to refer to all people who are incarcerated in criminal cases, including those in pretrial detention. Significant human rights violations, including arbitrary detention, physical and sexual abuse, and the denial of prevention and treatment services, have also been reported in so-called rehabilitation or administrative detention centres for sex workers and drug users[1,12] (panel 2).

Punitive laws, discriminatory policing, and failed justice systems

According to WHO, between 40% and 50% of all new HIV infections among adults worldwide might occur in people from key populations and their immediate partners: men who have sex with men (MSM), sex workers, people who inject drugs, transgender people, and prisoners.[13] Racial and ethnic discrimination, low socioeconomic status, migrant status, mental illness, and housing instability can also, independently or with each other, increase the risk of detention and HIV infection.[14] Judicial systems often do not protect the

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See **Online** for appendix

	Rights-based guidance
Prevention of sexual transmission	Condoms and other safer sex materials must be made easily and discreetly available in a confidential and non-discriminatory manner
Prevention of injecting-related transmission	Needle and syringe programmes, including the provision of safer injecting supplies other than sterile syringes, must be made available in a confidential and non-discriminatory manner
Access to treatment	Evidence-based and voluntary drug dependence treatment (in particular opioid substitution therapy) must be made accessible to all persons in a non-discriminatory manner
HIV testing and counselling	Access to voluntary and confidential HIV testing and counselling must be made available to all who request it. No-one (detainee or staff member) should be tested without their informed consent. The confidentiality of test results must be ensured. HIV testing should never be a goal in itself, but instead a means to accessing HIV prevention, treatment, care, and support services
Medical care, treatment, and support	Detainees living with HIV must be ensured confidential and non-discriminatory access to timely and professional standards of HIV medical care, treatment, and support services; this must include provision of HIV antiretroviral therapy, proper diets, and access to pain management medications
Confidentiality	The confidentiality of a detainee's medical information must be ensured, and not shared without consent. Exceptional circumstances, when information must be shared without consent, must be defined in policy, and reflect the same legal and ethical principles as reflected outside of places of detention

Legal sources for these rights are UNODC, ILO, UNDP, WHO, UNAIDS—Policy brief: HIV prevention, treatment, and care in prisons and other closed settings: a comprehensive package of interventions, 2013; UNODC and WHO Europe—Good governance for prison health in the 21st century: a policy brief on the organisation of prison health, 2013; Principles and best practices on the protection of persons deprived of liberty in the Americas (resolution 1/08, March, 2008); Office of the UN High Commissioner for Human Rights, UNAIDS. International guidelines on HIV and human rights, 2006; UN Special Rapporteur on the Right to the Highest Attainable Standard of Health. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/65/255 2010); UN Special Rapporteur on Torture—Report of the Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment UN (A/HRC/22/53 2013); European CPT—CPT standards: substantive sections of the CPT's general reports (CPT/Inf/E [2002] 1, revised 2015); Principles and best practices on the protection of persons deprived of liberty in the Americas (resolution 1/08 2008); and African Commission on Human and Peoples' Rights—Guidelines on the conditions of arrest, police custody, and pretrial detention in Africa, 2015. UNODC=United Nations Office on Drugs and Crime. ILO=International Labour Organization. UNAIDS=Joint United Nations Programme on HIV/AIDS. CPT=Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

***Table 2*: Human rights-based, health-related guidance on HIV in prisons and other places of detention**

Panel 1: UN Mandela Rules

60 years ago, the UN adopted Standard Minimum Rules for the Treatment of Prisoners. Although not binding, they proved useful to prison administrators and monitoring bodies. But they were also a product of another era, a time when the human rights of prisoners were not widely recognised, and before the HIV/AIDS epidemic, the war on drugs, and the recognition of high prevalence of mental illness among prisoners. Bringing the rules up to date, however, was a major challenge, because many countries were reluctant to subject themselves to more stringent rules that could be used to hold them to account. Once the process of revision got underway, it took 5 years to reach fruition. The new rules, named the Mandela Rules, were finally adopted by the UN Commission on Crime Prevention and Criminal Justice in May, 2015, and approved by the UN General Assembly in December, 2015.

The new rules, though a product of negotiation and compromise, are nevertheless a milestone. They start from the premise (rule 1) that prisons must be managed in a manner to respect and protect the human rights and dignity of prisoners. Nigel Rodley, the former UN Special Rapporteur on Torture, wrote that they represent "a deontological reorientation of the philosophy of penal institutional management" (AR1). The rules view prisons as a place of preparation for reintegration into society and so, to the extent possible, they should minimise difference between life in prison and life in society (rule 5). Prisoners should be provided adequate food, sanitation, ventilation, and protected from violence, and not be subjected to discrimination. Prisons must be kept "scrupulously clean" (rule 17).

The Mandela Rules on health services are far reaching: prisoners "should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status" and be organised "in close relationship to general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence" (rule 24). A full range of evaluation, diagnostic, prevention, and treatment services, including mental health and drug-dependency treatment, must be in place to meet the health needs of prisoners, with records kept in a professionally appropriate manner. No clinical decision can be ignored or over-ruled by non-medical staff (rule 27). Finally, both medical ethics and the autonomy of patients must be respected, with protection of confidentiality and informed consent (rule 32).

See appendix for references. AR=appendix reference.

rights of people in these groups to be free from arbitrary arrest, to pretrial release and a speedy trial, and to fair and proportionate sentencing.

Key populations comprise a substantial percentage of all imprisoned individuals overall, and individually have a high lifetime risk of incarceration. According to United

Nations Office on Drugs and Crime (UNODC), 21% of sentenced individuals worldwide were convicted for drug offences in 2012,[15] more than 80% of them for drug use or possession; sentences are often long.[16] Mandatory sentences are common.[17] UNAIDS estimates that 56–90% of people who inject drugs are incarcerated at some stage in their lives.[18] Moreover, irrespective of the reason for incarceration, 10–48% of male inmates and 30–60% of female inmates are estimated to have used illicit drugs in the month before entering prison.[19] Though representing a smaller percentage of prison populations, sex workers are also at high risk of incarceration because more than 100 countries criminalise some or all aspects of sex work.[13] At least 75 countries make same-sex sexual activity a criminal offence.[20] Apart from laws targeted at key populations, at least 63 countries have adopted HIV-specific criminal laws and others have prosecuted people living with HIV under laws against sexual assault, attempted murder, and criminal negligence for spitting, hitting, or biting.[21]

In addition to criminal penalties, punitive law enforcement practices target key populations (even where sex work has been partly decriminalised or where homosexuality has been fully decriminalised) and also increase risk of HIV infection. These practices include sexual abuse and extortion of sex workers by the police, sometimes in exchange for their liberty.[22,23] In some places, possession of condoms is used as evidence for criminal prosecution of prostitution or homosexual sex.[24–26] These and related police practices also discourage people who use drugs, MSM, and sex workers from accessing health and harm reduction services, disrupt safe injection networks, discourage use of condoms, increase sharing of syringes, and interrupt attempts to obtain treatment and prevention services for HIV and hepatitis.[22,27–32]

Transgender people also often face high risks of HIV transmission and incarceration as a result of criminalisation, discrimination in health settings, punitive law enforcement, and social marginalisation. Laws against cross-dressing and homosexuality as well as discrimination result in high rates of unemployment and underemployment of transgender people and compel many of them to find work in the underground economy, including sex work.[33] Transgender women are subject to high levels of police abuse, including profiling as sex workers and sexual exploitation and physical and verbal abuse from guards and male inmates while in detention (panel 3).[34,35]

In many countries, the risk of arrest and incarceration increases substantially if one is a member of a racial, ethnic, or national minority, a migrant, a foreign national, or is from a low socioeconomic group.[16] Discriminatory law enforcement practices and subsequent incarceration are often part of systemic inequality and class disadvantage, paralleling disparities in health. In the USA, which has by far the highest number of prisoners in the world,[36] more than 60% of people incarcerated are racial and ethnic minorities and one in ten African American men in their 30s is in prison or jail.[37] Although white Americans commit more drug crimes than do racial minorities, two-thirds of people incarcerated for drug-related crimes are people of colour.[37] Because of racial disparities in HIV prevention and treatment, and discriminatory policing and justice system practices, African American male prisoners are five times as likely to have HIV as white male counterparts.[38] These high rates of imprisonment destabilise households, relationships, and communities, and exacerbate poverty and homelessness.[39] The USA is not alone in disparities in incarceration: Aboriginal, Indigenous people, ethnic minorities, and people who are religiously or culturally marginalised in many parts of the world, such as the Roma in Europe,[40] the Maori in New Zealand,[16] and Muslims and the Dalit in India,[41] are disproportionately incarcerated in those countries.

Once arrested, racial and ethnic minorities, key populations, and socially marginalised groups worldwide frequently face significant barriers to fairness in the criminal justice system. They often lack legal counsel, are not considered for pretrial release or alternatives to detention, or are denied release on inappropriate grounds, and do not receive a speedy trial.[42,43] Globally, 3 million people are in pretrial detention.[44] Long pretrial incarceration, lengthy sentences, lack of or ineffective parole and probation procedures, and failure to provide for compassionate release keep many people incarcerated

***Panel 2*: Arbitrary detention of patients with tuberculosis**

Individuals with tuberculosis, especially those with drug-resistant strains, can face a range of rights-limiting measures—from detention in a prison to forced admission in a hospital or home arrest for claimed non-adherence to treatment. Detention is usually initiated as a purported public health measure, but is often done under improper public health justifications (AR1).

In 1985, the UN Economic and Social Council adopted the Siracusa Principles (AR2) to set standards for the legitimacy of countries' limitations on civil and political rights in the name of public health or other social purposes. In conjunction with guidance by UN human rights bodies, these principles underscore that restrictions on human rights to advance public health must be non-discriminatory and strictly necessary to achieve pressing public or social need. They must also be proportionate to the aim, and also must be the least restrictive means required for achieving the purpose of the limitation. These principles of human rights are in harmony with WHO guidance, which emphasises the exceptional circumstances under which forcible detention of patients with tuberculosis can be considered appropriate (AR3).

The effect of detention of individuals with tuberculosis for non-adherence to treatment raises certain similarities to the criminalisation of HIV exposure, and concerns that such criminalisation could be expanded under treatment as prevention programmes that seek to immediately enrol all HIV-infected individuals in care. In both cases, use of the criminal law against people living with HIV or tuberculosis can jeopardise public health efforts to expand detection and ensure linkage to care, including among key populations and women.

See appendix for references. AR=appendix reference.

Panel 3: Abuse of African American transgender women in US prisons

Transgender individuals in the USA, especially those of colour, confront high rates of unemployment, homelessness, and marginalisation, which often force them to work in the underground economy, including commercial sex exchange. One in six transgender people reports a history of incarceration; and nearly half of African American transgender women have been incarcerated (AR1). Once incarcerated, 35% of transgender women experience sexual victimisation from other prisoners or from correctional staff (AR2). HIV prevalence among transgender women of colour in the USA has been found to be as high as 27% (AR3).

A personal testimony by Tela La'Raine Love:

"I am one of many African-American transgender women living in the Greater New Orleans area profiled and arrested for being in the right place at the wrong time, in the wrong body. I was arrested for the first time at 21 while trying to survive. In the past, police picked me up and threatened to take me in if I didn't perform oral sex on them, but this time I was taken to jail. It's like a stage set for depression and suicide.

I was probably infected with HIV because of unprotected sex, a product of fear and necessity. There are no condoms in jail, only plastic bread bags and some rubber gloves. In order to preserve my safety and dignity I always chose a man before he forced himself on me.

With little or no family support, during my first ten jailings I had to use my most valuable commodity at the time, my youthful body, to obtain necessities. I became a prison concubine to career criminals, many of who had been with every young trans-woman arrested on sex-work charges.

My last time in prison lasted 104 days. I had objects thrown in at me, was harassed for sexual favors, and was strip-searched by staff to look at my body. Staff allowed men with long sentences in maximum security threaten to get to me. I filed many complaints, but I was in the hole and guards paid no attention. The guards forced me to degrade myself just to have the bare necessities like a blanket to keep warm. 'Pop it off', I was told, 'or you gonna freeze tonight'. I had to flash private parts of my body to get a blanket.

During my incarcerations I witnessed innocence, vibrancy and youth snatched from countless transgender women of color, especially HIV positive women. At least eight of my friends probably became infected in jail. Once released, they had to engage in sex work outside to survive, just as in jail. None of them lived to the age of 35. I live with the trauma of this experience daily."

See appendix for references. AR=appendix reference.

for excessively long periods of time, increase risk of HIV infection, and pose barriers to accessing treatment.

Human rights and HIV within prisons

Prisoners with, or at risk of, HIV frequently endure pervasive human rights violations that affect all people incarcerated from time of arrest through completion of sentences. These violations include overcrowded and unhealthy conditions of confinement, sexual and other forms of violence, lack of adequate medical care, and absence of adequate planning for, and procedures and policies about, continuity of prevention, care, and treatment throughout all stages of the process, from arrest to release. They may also be subjected to abusive practices because of their HIV status, including discrimination, segregation, and denial of essential health interventions (table 3).

Overcrowding, unhealthy conditions, violence, and discrimination

Prison overcrowding is a systemic problem in more than half of countries globally: in 117 countries, prison occupancy is more than 100% of capacity, with 47 countries over 150% of capacity and 20 above 200% of capacity.[36] Overcrowding can force prisoners to sleep in shifts or on top of each other, reduce access to food, strain already substandard sanitation facilities, increase the spread of tuberculosis, encourage risky behaviour, exacerbate the suffering of individuals with mental illness, impede HIV prevention, increase risks of violence, and compromise the availability of medical care.[45–51] Among women, overcrowding exacerbates health risks associated with pregnancy and childbirth.[52–54] Sexual and other forms of violence, perpetuated by prison staff and other prisoners, is endemic in prisons, and contributes to HIV transmission, though rates are difficult to ascertain because of under-reporting.[52,55,56]

Although segregation of individuals with HIV in prisons has ended in many countries, it persists elsewhere. In some cases, on the basis of the false claim that it will protect HIV-positive people from violence, segregation is used as a purported means of protecting prisoners from violence.[48] Homophobia among staff and inmates can discourage HIV testing and treatment and lead to mistrust of medical staff.[31]

Denial of access to prevention and treatment

Prison health services in many countries are characterised by too few and poorly trained staff, inadequate health assessments on entry, poor record keeping, unavailability of prevention and treatment services, and breaches of confidentiality. Prison health services are often isolated from national AIDS and other disease programmes under the leadership of a country's ministry of health.[5] Negative attitudes by prison staff to key populations, stateless and poor people, minorities, and immigrants, who constitute a high percentage of the prison population in many countries, contribute to poor quality monitoring and treatment of HIV, tuberculosis, hepatitis, and drug dependency.[5,49,50,57,58]

UN agencies recommend 15 key prevention and treatment interventions for HIV in prisons, including prevention and treatment for HIV, drug dependence, tuberculosis, and hepatitis.[59] Unprotected sex and needle sharing are common in prisons, reinforcing the need for condom distribution, opioid substitution therapy, and needle exchange programmes as prevention strategies for both HIV and hepatitis.[31,57,59,60] In many countries, however, prevention interventions are either unavailable, sometimes as a matter of policy, or substantially compromised. Although some countries make condoms available to prisoners, accompanied by confidentiality protections,[56] others do not, citing security needs or prohibition of sex in prisons.[45,47,61] Prison guards can limit condom distribution to exercise power over inmates.[49]

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	Testimony of individuals before, during, and after detention
Before detention	
Discrimination against drug users	"They destroy all your day, all your program, your health…I said [to the police officer], 'You have taken me in 15 times you, yourself. You know who I am. You know there is no pending court decision or anything against me. Please let me go to do my surgery, I have an appointment with the doctor'. I said I have a problem, a serious one, and I showed it to them…He didn't even consider it. He told me sit where you are. And I missed my surgery." *Homeless drug user with hepatitis C and other health conditions, Greece* (AR1)
	"I've been stopped by the police. They ask me where I'm headed. Drug users are not considered people; they can do anything to you. They just classify people in their minds—drug users at the bottom…They believe drug users are always at fault. They judge you by your appearance. They make you show them your arms, and if they see needle marks, they demand money—you pay or you can be detained." *Drug user, Russia* (AR2)
	"I was caught by police in a roundup of drug users. They saw me with other users. They took me to the police station in the morning and by that evening I was in the drug center…I saw no lawyer, no judge." *Formerly detained male drug user, Vietnam* (AR3)
Discrimination against transwomen	"I was at [a bar] with a man and the cops asked only the transwomen to go outside and they searched us. If we had condoms we got arrested for attempted solicitation." *Transwoman, New Orleans, USA* (AR4)
LGBT/sexual violence	"One Sunday evening he called me over, handcuffed me, and told me that I was arrested for loitering. He drove me to a field, pulled my pants down, removed my handcuffs, put his gun to my head, and raped me. I grunted and screamed. When he was finished the police officer said, 'If you tell anyone, you're dead'." *MSM, Jamaica* (AR5)
Discrimination against LGBT individuals	"In December [2011], I was in a place where I look for clients. I met a client, but [it turned out] it was not a normal person, it was a police officer. We went to a guest house. The client said, 'Take off your clothes'. I took off my clothes and suddenly the man pointed a pistol at me. Suddenly the guy had a tape recorder and a video camera. He said 'You will be an example for others. I am from CID [Criminal Investigation Department] and I'm looking for people like you'. He took me to Central Police Station and put me in lock-up. The police there told me, 'Call your fellow gays. We are going to a bar'. They were asking for gays in general, not just sex workers. They were five police. They gave me their phone and said, 'Call your friends, tell them there is a party here, so there are a lot of drinks'. They were threatening to shoot me if I didn't call my friends. They had SMG [submachine] guns. They cocked the guns at me, saying, 'If you don't call your friends, we'll shoot you'." *MSM, Tanzania* (AR6)
Detention	
Access to care	"I started taking antiretroviral drugs before I was put into detox. Then when I was in [detox] I had to stop. I was really worried about my health but there was nothing I could do." *Formerly detained male drug user, China* (AR7)
Long-term pretrial detention of juvenile prisoners	"I am here on remand; I came in July 2007. I am done with my trial, just waiting for judgment…The trial didn't take too long, it is only the judgment that has taken long. It's been a year and four months since my trial ended. I've been back to court four times just for the judgment but it never comes." *Juvenile male prisoner, Zambia* (AR8)
Food/physical violence/torture	"They kept me in Buraiman Prison for 15 days. Sometimes they brought food but it was very little and people fought over it. There was no medical care. Sometimes they slapped us with belts." *Formerly detained male prisoner, Saudi Arabia* (AR9)
Legal representation	"I had no representation, I stood on my own behalf. It was my first time in a police station or in court. I was just speaking, and I was scared. So I didn't know what I was saying…As young people, it is very threatening to see the inside of the court. Even if you are not guilty, you end up pleading guilty." *Juvenile male prisoner, Zambia* (AR10)
Physical violence/torture	"If we opposed the staff they beat us with a one-meter, six-sided wooden truncheon. Detainees had the bones in their arms and legs broken. This was normal life inside." *Formerly detained male drug user, Vietnam* (AR11)
Access to care	"Lots of people inside drug detention centers have TB, and lots of people get TB while in detention. There is no treatment and everyone is all together all the time." *Formerly detained male drug user, China* (AR12)
	"I was kept in the HIV-positive ward [after I got my test result]. The people who were kept there went crazy. Many were serving long sentences, and they thought they would die there, so some of them did everything possible to die even sooner. There wasn't much difference in the treatment of HIV-positive prisoners compared to the rest. We didn't get better health care—we got some vitamins now and then, but they were past their expiration date. I wrote about this to the prison authorities because I knew that they had money that was supposed to be spent on AIDS in prisons. I complained over and over again about the food." *Former detainee, Russia* (AR13)
Physical abuse/ torture	"We were stripped naked, only in our underwear, forced to sleep directly on the tile floor. Early in the morning, we were ordered to crawl. We were kicked, beaten, trampled. If they held an iron bar, we got the iron bar. If they held a wooden bat, we got the wooden bat. If they held a wire cable, we got cabled. Shoes. Bare hands. They used everything." *Formerly detained male prisoner, Indonesia* (AR14)
Barred access to care	"The psychiatrist comes once a month. He was here two weeks ago, but I didn't get to see him. My family tried to get me my medication, but couldn't. In here, if you complain too much, they put you in solitary." *Male prisoner, Jordan* (AR15)

(Table 3 continues on next page)

	Testimony of individuals before, during, and after detention
(Continued from previous page)	
Sexual abuse	"The man who was interrogating me walked over and stood face-to-face with me, and he said, 'Little Tamara, here's when everything starts to change. Now we're going to give you love and affection…because here you're going to have many friends—they're lining up for you'… and they began to grope me all over. They lifted off my bra and I felt their hands all over my body. They touched my buttocks and insulted me saying, 'Now you're going to feel what's good. You're good, you damn whore'." *Formerly detained woman, Mexico* (AR16)
Physical violence/torture	"When I was in police custody, they beat me, a torture I have never experienced in my lifetime. They beat me, undressed me, whipped me. They put handcuffs on me so hard that the blood couldn't flow. They turned me upside down and hung me upside down, with a steel cord between my legs. They swung me and beat me. They saw I was crying and screaming and put a cloth in my mouth to suffocate me. I fainted—I couldn't handle the pain. They were abusing me with their language, calling me a prostitute. They put me somewhere where I couldn't talk to anyone. They were trying to get me to say something—I don't know. They were just torturing me for four days, beating me. After, there was lots of blood where I was beaten. My hands were green and swelling. They hit me on my ears and face with a metal band. There were scratches on my face. They said, 'you have to give us information about who had killed the person'. They tried to find out who had killed the person—I didn't know. The police are supposed to investigate a case, not to torture. After, they were scared to take me to a doctor because I still had injuries. They only took me after one month, when the swelling was down. When I went to the doctor, the police [officer] followed me into the doctor's room and listened to me. The police told the doctor that I was lying. 'Just a simple torture that she was given, not much', he said." *Formerly detained woman, Zambia* (AR17)
Lack of food	"If we get a sack of sorghum then we will eat it until it is finished. But after that we can wait for days before we get any more, just eating a bit of broth." *Male prisoner, South Sudan* (AR18)
Lack of food/ postnatal care	"My child is not considered for food—I give my share to the baby, beans and kapenta—we each eat once a day. I am not given any extra food, and no special diet for the child. I simply make some porridge for him out of my nshima. The baby has started losing weight and has resorted to breast milk because the maize meal is not appetizing." *Female prisoner, Zambia* (AR19)
Access to care	"It is not possible here to go to the doctor. At the moment we wake up, we go to the field, then we go to a different field. Even if you complain [that you are sick], the officers tell you that you still have to go." *Male prisoner, Zambia* (AR20)
Lack of ART medications	"I had VCT [voluntary counseling and testing for HIV]—they tested my blood again and told me I was HIV-positive. They told me my CD4 court was too high for ART. I wasn't given any HIV drugs to prevent transmission, only folic acid and vitamins." *Female prisoner, Zambia* (AR21)
Lack of clean water/physical violence	"There is no permanent water here. The kind of water we use is from the ponds we dig…When you're in the gardens, some people who are thirsty, if they come across stagnant water, kneel down and drink it. They drink it without the permission of the warden. But if you're found drinking like a cow, they beat you." *Male prisoner, Uganda* (AR22)
After release	
Discrimination	"I really can't go out in public anymore because if police are trying to fill their quota they will arrest me when they see me." *Formerly detained male drug user, China* (AR23)
Discrimination	"Employers tell me they can't hire me because the police will be on their backs. Ex-prisoners usually find work by opening up their own little shops or businesses. If they do anything big, however, they'll make problems for you. But I can't even start a little project because I have no money." *Male former prisoner, Tunisia* (AR24)

See appendix for references. AR=appendix reference. LGBT=lesbian, gay, bisexual, and transgender. MSM=man who has sex with men. ART=antiretroviral therapy.

***Table 3*: Prisoners' voices**

As of 2014, only 43 countries offer opioid substitution in at least one prison, about half the number that provides it in communities,[17,62] and rarely at adequate coverage.[31,63,64] Although needle and syringe exchange programmes have been widely adopted, only eight countries have implemented these programmes in prisons,[62] sometimes because officials do not want to be seen as encouraging unlawful drug use.[17] Women are more likely than men to have used illicit drugs before entering prisons, yet have less access to HIV prevention services.[57]

In the past decade, the availability of HIV testing in prisons has increased.[65] However, coercion, breaches of confidentiality and lack of protection from discrimination as a result of testing are commonly reported even in countries where national guidelines, along with UNAIDS and WHO, call for voluntary testing.[48,66–68] Therefore, prisoners often do not perceive opt-out testing to be voluntary.[69] Post-test counselling is often unavailable, as are linkages to care and treatment. In some prisons, individuals are not informed of their test results.[49,70]

Antiretroviral therapy (ART) for HIV is available to prisoners in just 43 countries as of 2012.[71] When ART is offered, ancillary services might be lacking. In the USA, a broad survey showed that over 90% of prisons and jails offered ART, but almost 25% did not test viral loads or CD4 cell counts, nor refer to HIV specialists or psychologists if indicated. Only half offered substance abuse counselling and support specific to HIV-positive inmates.[72] Even where ART is offered, it is sometimes compromised by poor nutrition, substandard prison conditions, and violence.[5,73,74]

Prisoners are also highly vulnerable to tuberculosis and hepatitis C virus (HCV) infection. Prison overcrowding

and inadequate ventilation can spread tuberculosis,[63,75,76] which is a leading cause of the death of inmates in many countries.[77] Yet worldwide only about 63 countries provide tuberculosis treatment for prisoners (Dolan K, unpublished). HCV prevalence in prisons globally is estimated to be more than 10% and is spread through sexual violence, tattooing, and drug injection.[1] Substantially higher prevalence is not uncommon (eg, 38% in central Asia and Italy,[78,79] and 17·4 % in the USA[80]). But screening and treatment for HCV is uncommon in prisons.[79–82]

Finally, medical care in prisons is compromised by structural factors that often compel prison health professionals to put the interests of prison administrators over their duty of loyalty to and respect for their patients. Conflicts arise, for example, in health professional participation in the discipline of prisoners and in rules for the presence of security officials in medical examinations and allowing them access to inmate medical records.[83–85] These conflicts can lead to compromised quality of health services and foster distrust by prisoners of medical staff, discouraging use of health services that are available.

Continuity of care upon release from prison

Linkage to care after release is rarely available or studied outside Europe and the USA. From published reports, various factors seem to contribute to positive outcomes for people living with HIV after release including access to HIV, substance use and mental health treatment, and social welfare support such as shelter, food, and livelihood. Yet most prisoners living with HIV are released without support to face pervasive and multidimensional forms of exclusion, stigma, and discrimination based on their incarceration history, HIV status, socioeconomic class, and race.[86]

The US Centers for Disease Control and Prevention recommends that discharge planning should include making an appointment with a community health-care provider, assisting with enrolment in social welfare or entitlement programmes for which released prisoners are eligible, and providing a supply of HIV medication and medical record.[66] But prisoners are either not linked to HIV, HCV, or drug treatment services upon release or are provided only some services; often they are deprived of information about them.[66,87]

The absence of adequate discharge planning and follow-through has profound and immediate health effects. A systematic review in the USA found that prisoners were likely to be lost to follow-up in post-incarceration linkage and retention in care. After release, ART use diminished from 51% to 29% and virological suppression dropped from 40% to 21%.[88] Hispanics and black people were less likely than non-Hispanic white people to acquire a prescription for ART after release.[89] Lack of follow-up for HCV treatment undermines the effectiveness of prison-provided care and contributes to spread of the disease in the community.[81,82]

Drug users have a severe risk of death from overdose after release from prison, especially in the first 2 weeks.[90] Results from a UK study showed that within the first week of discharge, drug users released from prison were 40·2 times more likely to die than individuals not formerly incarcerated.[91] Yet released prisoners are rarely able to access overdose prevention medications such as naloxone, methadone, or other treatment for substance dependence.

Fulfilment of the right of access to housing is an important determinant of access and retention in HIV care. Disparities in housing status contribute substantially to the gap in HIV treatment outcomes between homeless and non-homeless patients, including in achievement of virological suppression over time.[92] Homelessness among released prisoners is a significant barrier to retention in care[93] because it leads to social exclusion, difficulty accessing services, and lack of safe storage for HIV medications, thereby compromising adherence. More fundamentally, stigma and discriminatory housing laws and policies prevent former prisoners from finding stable housing[94] and from connecting with providers and social service agencies.

The way forward

The factors leading to the disproportionate incarceration of people with or at risk of HIV can be considered classic social determinants of ill health. More specifically, they are political determinants of health, subject to what one of us has identified as "political epidemiology", defined as exploring how laws, policies, and their enforcement affect health-related behaviours and outcomes and can point to key areas for reform.[95] For individuals whose identity or behaviours are criminalised, who are subjected to systematic discrimination, or who are currently or formerly detained, addressing political determinants is crucial to reducing incarceration and improving HIV and related outcomes.

Further research is needed to address the effects of social and political determinants on HIV outcomes and to support the development of appropriate legal, justice system, corrections, and public health reforms. There is evidence, though, that interventions that respect and fulfil human rights can reduce HIV incidence, enhance care, and improve retention for key populations and racial and ethnic minorities and other disadvantaged people in the cascade of care from diagnosis to viral suppression.

Evidence also exists that respecting human rights and engaging in good public health practice can reduce disproportionate incarceration of people with or at risk of HIV and related conditions. This human rights and public health approach includes ending the criminalisation of key populations; providing community-based drug treatment; ending the structural, social, ethnic, and racial disparities and violations of due process in law enforcement and criminal justice systems

that lead to overincarceration; ensuring fulfilment of prisoners' health and other rights within prisons; following UNAIDS guidelines for eliminating stigma and discrimination in the ability of people with HIV to access housing, treatment, jobs, and other resources;[96] and providing for a rigorous human rights monitoring programme in places of detention. Needed reforms can best succeed through ensuring the participation of groups most affected by the human rights violations.

Reform of criminal laws

Countries should repeal laws that criminalise behaviour, status, and identity and that lead both to the spread of HIV, tuberculosis, and hepatitis in communities and to the unjust imprisonment of many of the people most at risk of these diseases. Similarly, laws that criminalise sex work and same-sex behaviours should be repealed. Reforming laws to decriminalise drug use and personal possession can improve access to HIV prevention and treatment, reduce levels of incarceration, and lessen prison overcrowding. Various forms of decriminalisation have been undertaken in Europe and Latin America; Portugal's decriminalisation of individual use and possession of drugs, for example, led to decreases in HIV transmission from unsafe injection in addition to reducing arrests.[17] Decriminalisation of sex work can also be effective: according to one study it could avert 33–46% of HIV infections among sex workers and their clients over a 10 year period.[97] Decriminalisation of MSM and homosexual sex could reduce the vulnerability of lesbian, gay, bisexual, and transgender people to violence and enhance the ability of these groups to self-organise, work with law enforcement officials, maximise their protection and dignity, and help ensure equal access to health services and justice.

Reforms of law enforcement and the justice system

Reforms of law enforcement practices and the justice system can reduce both HIV transmission and incarceration. Good models exist to reduce HIV vulnerability among people who use drugs by engaging police in harm reduction approaches with them.[98–100] Arrest and prosecution of sex workers have been reduced by ending the use by police and prosecutors of condoms as evidence of prostitution.[24,101] Reforms to reduce disparities in law enforcement practices and to ensure a fairer justice system to reduce imprisonment overall can spare people with or at high risk of HIV the harms flowing from incarceration and can reduce overcrowding in prisons. Steps to reduce pretrial incarceration by ensuring quick case review, increasing use of release on personal recognisance, and adhering to human rights standards for the determination of whether to hold a person charged before trial (such as assuring presence in court), have been successfully undertaken in, for example, Argentina, Brazil, Costa Rica, and Russia.[42] In a pilot project in Nigeria, increasing access to legal counsel reduced the duration of pretrial detention by 72%.[42] In the absence of decriminalisation of sex work and drug use, justice reforms can include reducing lengths of prison sentences, adopting alternatives to prisons, and early release, such as have been undertaken in Finland, Kazakhstan, and Uruguay.[42]

As part of overall reform of the justice system, legal counsel and legal assistants can be available in communities to support access to justice for people with or at risk of HIV, including those released from incarceration, and to increase legal and health literacy. This intervention can improve uptake of health services, and provide additional entry points for outreach, testing, and treatment.

Addressing violence and rights violations in prisons and upon release

Prison violence, including rape and other forms of sexual violence against individuals in state custody, whether inflicted by staff or other inmates, can be reduced by rigorous data collection; analysis and reporting to understand the prevalence, causes, and dynamics of prison violence; adequate staffing and staff training; architectural interventions such as better lighting; redesigned prison management practices; documentation of incidents; and accountability for perpetrators.[56,102] Prison administrators and national officials can establish plans, with benchmarks, indicators, and regular reviews.[102] Other interventions to reduce violence include, but are not limited to, ensuring that prisoners have sufficient space to live; are provided with adequate food, nutrition, water, sanitation, and a hygienic and safe environment; are not subjected to torture or other forms of cruel, inhuman, or degrading treatment or punishment; and are not discriminated against or segregated on the basis of HIV status.[42,102] Prison disciplinary procedures can be accompanied by rigorous protections of due process, and guarantees against arbitrary or discriminatory punishment. In some countries, independent external monitors from national, regional, and international human rights bodies already have regular and complete access to detention facilities and individuals in detention, without prior notice. Such access can and should also be granted to non-governmental organisations involved in monitoring human rights and health conditions in prisons.

Comprehensive training to prison staff about the needs and rights of key populations, racial and ethnic minorities, migrants, poor people, foreigners, and women, as well as people with HIV generally, can help reverse discriminatory attitudes.[72] Furthermore, engaging key populations, racial minorities, women, and detained and formerly detained people to participate as peer supporters and to train law enforcement and health-care providers can bring their experiences to design effective strategies to reduce stigma and discrimination.

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Fulfilling the right to health in prisons

UNODC and WHO have urged that health services in prisons be organised under the leadership and authority of a country's ministry of health and national HIV/AIDS and tuberculosis programmes, whose expertise, independence from prison administration, and commitments to health can help ensure quality programmes.[5,85] Services should be at least equivalent to those in the larger community as measured by right-to-health standards of availability, accessibility, acceptability, and quality in staffing, equipment, supplies, and medication availability and services.[4,7] Referrals to community hospitals should be available where the prison cannot meet individual needs. Governments are responsible for assuring adequate resources to meet these requirements, and the international community can contribute resources to lower income countries through bilateral and multilateral mechanisms for global health funding.

Health services should include the full range of recognised prevention and treatment services for HIV, tuberculosis, hepatitis, drug dependence, and other health conditions. Experience has shown that prevention measures such as condom distribution and needle exchange programmes can be successfully implemented in prisons without causing security breaches or resulting in an increase in violence or other unlawful behaviour.[56,103] Opioid substitution therapy, ART, and tuberculosis treatment have all been successfully implemented in prisons,[76] reducing deaths among prisoners.[65,104] Despite the expense, screening and treatment for HCV is feasible and effective provided treatment is completed and there is continuity of care after release.[79–82] Providing health information to prisoners has been effective in engaging them in health promotion in prisons, especially if peer led.[76] Health administrators and staff can be trained in meeting the unique challenges of providing health care to prisoners and in addressing ethical concerns that arise in prison health practice, and given support in carrying out their responsibilities.[85]

Continuity of care upon discharge is essential for the effectiveness of HIV, tuberculosis, and hepatitis treatment, so discharge plans should include needed medicines, appointments for follow-up in the community, and copies of medical records. Linkage to social supports including housing should also be in place at the time of release.

Conclusion

Structural social, legal, and political injustices that lead to disproportionate risk of HIV and to incarceration can and must be addressed. The use of prison, and pretrial detention, in response to non-violent crimes must be reduced. People in prisons must have their human rights respected. Following the steps that we have outlined here can bring about both better health outcomes for these populations and advance human rights and dignity.

Contributors

LSR, JJA, and MM shared responsibility for literature search and developing initial drafts and writing the manuscript. KD contributed to the literature review. RL contributed tables on legal requirements. RL, LSR, JJA, MM, CB, and KD reviewed the initial draft and contributed content to it. LSR, JJA, MM, PE, RL, and KD participated in writing the second draft, which was reviewed by PE, KD, MM, RL, and CB. The third and final drafts were prepared by LSR and JJA with assistance from PE, MM, KD, and CB. All authors made substantial contributions to the design and approach, and approved the final paper. LSR had full access to the data for this paper and had final responsibility for submission for publication.

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We declare no competing interests.

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References

1 Dolan K, Wirtz AL, Babak M, et al. Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. *Lancet* 2016; published online July 14. http://dx.doi.org/10.1016/S0140-6736(16)30466-4.

2 Bone A, Aerts A, Grzemska M, et al. TB control in prisons: a manual for programme managers. Geneva: World Health Organization, 2000.

3 Lines R. The right to health of prisoners in international human rights law. *Int J Prison Health* 2008; **4:** 3–53

4 UN Committee on Economic Social and Cultural Rights. General comment no 14: The right to the highest attainable standard of health. UN Committee on Economic, Social and Cultural Rights, 2000.

5 UNODC, WHO Europe. Good governance for prison health in the 21st century. A policy brief on the organization of prison health. Copenhagen: World Health Organization, 2013.

6 UN Economic and Social Council Commission on Crime Prevention and Criminal Justice. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules). Vienna: UN Economic and Social Council Commission, 2015.

7 Lines R. From equivalence of standards to equivalence of objectives: the entitlement of prisoners to health care standards higher than those outside prisons. *Int J Prison Health* 2006; **2:** 269–80.

8 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. CPT standards: "Substantive" sections of the CPT's general reports. Strasbourg: Council of Europe, 2015.

9 Inter-American Commission on Human Rights. Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas, 2008. http://www.cidh.org/basicos/english/basic21.a.principles%20and%20best%20practices%20pdl.htm (accessed June 8, 2016).

10 African Commission on Human and Peoples' Rights. Guidelines on the conditions of arrest, police custody and pre-trial detention in Africa. Banjul: African Commission on Human and Peoples' Rights, 2015.

11 Office for the High Commissioner of Human Rights. Optional protocol to the convention against torture and other cruel, inhuman or degrading treatment or punishment. http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx (accessed June 8, 2016).

12 Jurgens R, Csete J, Amon J, Baral S, Beyrer C. People who use drugs, HIV, and human rights. *Lancet* 2010; **376:** 475–85.

13 WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization, 2014.
14 UNAIDS. 37th meeting of the Programme Coordinating Board. Agenda item 6 HIV in prisons and other closed settings. October, 2015. http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_PPT_15_21_UNODC.pdf (accessed June 8, 2016).
15 UN Commission on Crime Prevention and Criminal Justice. World crime trends and emerging issues and responses in the field of crime prevention and criminal justice, 2014. https://www.unodc.org/documents/data-and-analysis/statistics/crime/ECN.1520145_EN.pdf (accessed June 8, 2016).
16 Penal Reform International. Global prison trends 2015. London: Penal Reform International, 2015.
17 Csete J, Kamarulzaman A, Kazatchkine M, et al. Public health and international drug policy. *Lancet* 2016; **387:** 1427–80.
18 UNAIDS. The Gap Report 2014. Geneva: UNAIDS, 2014.
19 Dolan K, Moazen B, Noori A, Rahimzadeh S, Farzadfar F, Hariga F. People who inject drugs in prison: HIV prevalence, transmission and prevention. *Int J Drug Policy* 2015; **26** (suppl 1)**:** S12–15.
20 Carroll A, Itaborahy L. State sponsored homophobia 2015. A world survey of laws: criminalisation, protection, and recognition of same-sex love. Geneva: International Lesbian, Gay, Bisexual, Trans and Intersex Association, 2015.
21 Global Commission on HIV and the law. Regional Issue Brief: Laws and practices relating to criminalisation of people living with HIV and populations vulnerable to HIV. New York: UN Development Program, 2012.
22 Decker MR, Crago AL, Chu SK, et al. Human rights violations against sex workers: burden and effect on HIV. *Lancet* 2015; **385:** 186–99.
23 Hanssens C, Moodie-Mills AC, Ritchie AJ, Spade D, Vaid U. A roadmap for change: federal policy recommendations for addressing the criminalization of LGBT people and people living with HIV. New York: Center for Gender and Sexuality Law, Columbia Law School, 2014.
24 Wurth MH, Schleifer R, McLemore M, Todrys KW, Amon JJ. Condoms as evidence of prostitution in the United States and the criminalization of sex work. *J Int AIDS Soc* 2013; **16:** 18626.
25 Kyomya M, Todyrs KW, Amon JJ. Laws against sodomy and the HIV epidemic in African prisons. *Lancet* 2012; **380:** 310–12.
26 Open Society Foundations. Criminalizing condoms: How policing practices put sex workers and HIV services at risk in Kenya, Namibia, Russia, South Africa, the United States and Zimbabwe New York: Open Society Foundations, 2012.
27 Millett GA, Jeffries WL 4th, Peterson JL, et al. Common roots: a contextual review of HIV epidemics in black men who have sex with men across the African diaspora. *Lancet* 2012; **380:** 411–23.
28 Burris S, Strathdee SA. To serve and protect? Toward a better relationship between drug control policy and public health. *AIDS* 2006; **20:** 117–18.
29 Kalamar M, Maharaj P, Gresh A. HIV-prevention interventions targeting men having sex with men in Africa: field experiences from Cameroon. *Cult Health Sex* 2011; **13:** 1135–49.
30 Degenhardt L, Mathers B, Vickerman P, Rhodes T, Latkin C, Hickman M. Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed. *Lancet* 2010; **376:** 285–301.
31 Jurgens R, Nowak M, Day M. HIV and incarceration: prisons and detention. *J Int AIDS Soc* 2011; **14:** 26.
32 Strathdee SA, West BS, Reed E, Moazen B, Azim T, Dolan K. Substance use and HIV among female sex workers and female prisoners: risk environments and implications for prevention, treatment, and policies. *J Acquir Immune Defic Syndr* 2015; **69** (suppl 2)**:** S110–17.
33 Poteat T, Wirtz AL, Radix A, et al. HIV risk and preventive interventions in transgender women sex workers. *Lancet* 2015; **385:** 274–86.
34 Brennan J, Kuhns LM, Johnson AK, et al. Syndemic theory and HIV-related risk among young transgender women: the role of multiple, co-occurring health problems and social marginalization. *Am J Public Health* 2012; **102:** 1751–57.
35 Wilson E, Pant SB, Comfort M, Ekstrand M. Stigma and HIV risk among Metis in Nepal. *Cult Health Sex* 2011; **13:** 253–66.
36 Institute for Criminal Policy Research. World prison brief. Highest to lowest: prison population total. http://www.prisonstudies.org/highest-to-lowest/prison-population-total?field_region_taxonomy_tid=All (accessed Dec 21, 2015).
37 Sentencing Project. Racial disparity. http://www.sentencingproject.org/template/page.cfm?id=122 (accessed Dec 21, 2015).
38 Centers for Disease Control and Prevention. HIV among incarcerated populations. http://www.cdc.gov/hiv/group/correctional.html (accessed Jan 4, 2016).
39 Pew Charitable Trusts. Collateral Costs: Incarceration's effect on economic mobility, 2010. http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2010/collateralcosts1pdf.pdf (accessed June 8, 2016).
40 Amnesty International. We ask for justice: Europe's failure to protect Roma from racist violence. London: Amnesty International, 2014.
41 Ministry of Home Affairs, National Crime Records Bureau. Prison Statistics India 2012. New Dehli: Ministry of Home Affairs, 2013.
42 UNODC. Handbook on strategies to reduce overcrowding in prisons. New York: United Nations, 2013.
43 Open Society Foundations. Presumed guilty: the global overuse of pretrial detention. New York: Open Society Foundations, 2014.
44 Walmsley R. World pre-trial/remand imprisonment list. London: International Centre for Prison Studies, 2015.
45 Guin S. A qualitative exploration of HIV/AIDS health care services in Indian prisons. *J Correct Health Care* 2009; **15:** 179–89.
46 Todrys KW, Amon JJ. Criminal justice reform as HIV and TB prevention in African prisons. *PLoS Med* 2012; **9:** e1001215.
47 Kelly-Hanku A, Kawage T, Vallely A, Mek A, Mathers B. Sex, violence and HIV on the inside: cultures of violence, denial, gender inequality and homophobia negatively influence the health outcomes of those in closed settings. *Cult Health Sex* 2015; **17:** 990–1003.
48 Ammar D, Cordova A. HIV/AIDS in Lebanese prisons: challenges and proposed actions. *Int J Prison Health* 2014; **10:** 147–54.
49 Wilson D, Ford N, Ngammee V, Chua A, Kyaw MK. HIV prevention, care, and treatment in two prisons in Thailand. *PLoS Med* 2007; **4:** e204.
50 Todrys KW, Amon JJ, Malembeka G, Clayton M. Imprisoned and imperiled: access to HIV and TB prevention and treatment, and denial of human rights, in Zambian prisons. *J Int AIDS Soc* 2011; **14:** 8.
51 European Committee for the Prevention of Torture. Report to the Russian Government on the visit to the Russian Federation carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 21 May to 4 June 2012. Strasbourg: Council of Europe, 2013.
52 Todrys KW, Amon JJ. Health and human rights of women imprisoned in Zambia. *BMC Int Health Hum Rights* 2011; **11:** 8.
53 Moloney KP, van den Bergh BJ, Moller LF. Women in prison: the central issues of gender characteristics and trauma history. *Public Health* 2009; **123:** 426–30.
54 UNODC, WHO Europe. Women's health in prisons: correcting gender inequity in prisons. Copenhagen: World Health Organization, 2009.
55 Stemple L, Meyer IH. The sexual victimization of men in America: new data challenge old assumptions. *Am J Public Health* 2014; **104:** e19–26.
56 WHO, UNODC, UNAIDS. Interventions to address HIV in prisons: Prevention of sexual transmissions. Geneva: World Health Organization, 2007.
57 Gilbert L, Raj A, Hien D, Stockman J, Terlikbayeva A, Wyatt G. Targeting the SAVA (Substance Abuse, Violence, and AIDS) syndemic among women and girls: a global review of epidemiology and integrated interventions. *J Acquir Immune Defic Syndr* 2015; **69** (suppl 2)**:** S118–27.
58 Esposito M. "Double burden": a qualitative study of HIV positive prisoners in Italy. *Int J Prison Health* 2012; **8:** 35–44.
59 UNODC, ILO, UNDP, WHO, UNAIDS. Policy brief: HIV prevention, treatment, and care in prisons and other closed settings: a comprehensive package of interventions. Vienna: UNODC, 2013.
60 Rich JD, Beckwith CG, Macmadu A, et al. Clinical care of incarcerated people with HIV, viral hepatitis, or tuberculosis. *Lancet* 2016; published online July 14. http://dx.doi.org/10.1016/S0140-6736(16)30379-8
61 McLemore M. Access to condoms in U.S. prisons. *HIV AIDS Policy Law Rev* 2008; **13:** 20–24.

62 Harm Reduction International. The global state of harm reduction. London: Harm Reduction International, 2014.
63 The National Center for Addiction and Substance Abuse at Columbia University. Behind Bars II: Substance abuse and America's prison population. New York: The National Center for Addiction and Substance Abuse at Columbia University, 2010.
64 Larney S, Dolan K. A literature review of international implementation of opioid substitution treatment in prisons: equivalence of care? *Eur Addict Res* 2009; **15:** 107–12.
65 Milloy MJ, Montaner JS, Wood E. Incarceration of people living with HIV/AIDS: implications for treatment-as-prevention. *Curr HIV/AIDS Rep* 2014; **11:** 308–16.
66 Solomon L, Montague BT, Beckwith CG, et al. Survey finds that many prisons and jails have room to improve HIV testing and coordination of postrelease treatment. *Health Aff (Millwood)* 2014; **33:** 434–42.
67 WHO, UNAIDS. Guidance on provider-initiated HIV testing and counseling in health facilities. Geneva: World Health Organization, 2007.
68 UNODC, UNAIDS, WHO. Policy brief: HIV testing and counselling in prisons and other closed settings. Vienna: UNODC, 2009.
69 Rosen DL, Golin CE, Grodensky CA, et al. Opt-out HIV testing in prison: informed and voluntary? *AIDS Care* 2015; **27**(5): 545–54.
70 Rehman L, Gahagan J, DiCenso AM, Dias G. Harm reduction and women in the Canadian national prison system: policy or practice? *Women Health* 2004; **40:** 57–73.
71 Dolan K, Moazen B, Rahimzadeh S, et al. HIV prevention program in prison: a global systematic review of implementation. 20th International Conference on AIDS; Melbourne, Australia; July 20–25, 2014. TUPE111.
72 Belenko S, Dembo R, Copenhaver M, et al. HIV stigma in prisons and jails: results from a staff survey. *AIDS Behav* 2016; **20:** 71–84.
73 Shalihu N, Pretorius L, van Dyk A, Vander Stoep A, Hagopian A. Namibian prisoners describe barriers to HIV antiretroviral therapy adherence. *AIDS Care* 2014; **26:** 968–75.
74 Musumari PM, Feldman MD, Techasrivichien T, Wouters E, Ono-Kihara M, Kihara M. "If I have nothing to eat, I get angry and push the pills bottle away from me": A qualitative study of patient determinants of adherence to antiretroviral therapy in the Democratic Republic of Congo. *AIDS Care* 2013; **25:** 1271–77.
75 Aerts A, Hauer B, Wanlin M, Veen J. Tuberculosis and tuberculosis control in European prisons. *Int J Tuberc Lung Dis* 2006; **10:** 1215–23.
76 Møller L, Stöver H, Jürgens R, Gatherer A, Nikogosian H, eds. Health in prisons: a WHO guide to the essentials in prison health. Copenhagen: World Health Organization, 2007.
77 Dara M, Chorgoliani M, de Colomban P. TB prevention and control care in prisons. In: Enggist S, Møller L, Galea G, Udesen C, eds. Prisons and Health. Copenhagen: World Health Organization, 2014: 56–72.
78 Zampino R, Coppola N, Sagnelli C, Di Caprio G, Sagnelli E. Hepatitis C virus infection and prisoners: epidemiology, outcome and treatment. *World J Hepatol* 2015; **7:** 2323–30.
79 Iacomi F, Iannicelli G, Franceschini A, et al. HCV infected prisoners: should they be still considered a difficult to treat population? *BMC Infect Dis* 2013; **13:** 374.
80 Varan AK, Mercer DW, Stein MS, Spaulding AC. Hepatitis C seroprevalence among prison inmates since 2001: still high but declining. *Public Health Rep* 2014; **129:** 187–95.
81 He T, Li K, Roberts MS, et al. Prevention of hepatitis C by screening and treatment in U.S. prisons. *Ann Intern Med* 2016; **164:** 84–92.
82 Martin NK, Vickerman P, Goldberg D, Hickman M. HCV treatment as prevention in prison: key issues. *Hepatology* 2015; **61:** 402–03.
83 Council of Europe. Report to the Czech Government on the visit to the Czech Republic carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 1 to 10 April 2014. Strasbourg: Council of Europe, 2015. http://www.cpt.coe.int/documents/cze/2015-18-inf-eng.pdf (accessed June 8, 2016).
84 Council of Europe. Report to the Bulgarian Government on the visit to Bulgaria carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 13 to 20 February 2015. Strasbourg: Council of Europe, 2015. http://www.cpt.coe.int/documents/bgr/2015-36-inf-eng.pdf (accessed June 8, 2016).
85 Pont J, Stover H, Wolff H. Dual loyalty in prison health care. *Am J Public Health* 2012; **102:** 475–80.
86 Dennis AC, Barrington C, Hino S, Gould M, Wohl D, Golin CE. "You're in a world of chaos": experiences accessing HIV care and adhering to medications after incarceration. *J Assoc Nurses AIDS Care* 2015; **26:** 542–55.
87 Choi P, Kavasery R, Desai MM, Govindasamy S, Kamarulzaman A, Altice FL. Prevalence and correlates of community re-entry challenges faced by HIV-infected male prisoners in Malaysia. *Int J STD AIDS* 2010; **21:** 416–23.
88 Iroh PA, Mayo H, Nijhawan AE. The HIV care cascade before, during, and after incarceration: a systematic review and data synthesis. *Am J Public Health* 2015; **105:** e5–16.
89 Baillargeon J, Giordano TP, Rich JD, et al. Accessing antiretroviral therapy following release from prison. *JAMA* 2009; **301:** 848–57.
90 Binswanger IA, Nowels C, Corsi KF, et al. Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors. *Addict Sci Clin Pract* 2012; **7:** 3.
91 Leach D, Oliver P. Drug-related death following release from prison: a brief review of the literature with recommendations for practice. *Curr Drug Abuse Rev* 2011; **4:** 292–97.
92 Zelenev A, Marcus R, Kopelev A, et al. Patterns of homelessness and implications for HIV health after release from jail. *AIDS Behav* 2013; **17** (suppl 2)**:** S181–94.
93 Brinkley-Rubinstein L, Turner WL. Health impact of incarceration on HIV-positive African American males: a qualitative exploration. *AIDS Patient Care STDS* 2013; **27:** 450–58.
94 Brinkley-Rubinstein L. Understanding the effects of multiple stigmas among formerly incarcerated HIV-positive African American men. *AIDS Educ Prev* 2015; **27:** 167–79.
95 Amon JJ. The political epidemiology of HIV. *J Int AIDS Soc* 2014; **17:** 19327.
96 UNAIDS. Guidance note: Key programs to reduce stigma and discrimination and increase access to justice in national HIV responses. Geneva: UNAIDS, 2012.
97 Shannon K, Strathdee SA, Goldenberg SM, et al. Global epidemiology of HIV among female sex workers: influence of structural determinants. *Lancet* 2015; **385:** 55–71.
98 Beletsky L, Agrawal A, Moreau B, Kumar P, Weiss-Laxer N, Heimer R. Police training to align law enforcement and HIV prevention: preliminary evidence from the field. *Am J Public Health* 2011; **101:** 2012–15.
99 Erausquin JT, Reed E, Blankenship KM. Police-related experiences and HIV risk among female sex workers in Andhra Pradesh, India. *J Infect Dis* 2011; **204** (suppl 5)**:** S1223–28.
100 Meng J, Burris S. The role of the Chinese police in methadone maintenance therapy: a literature review. *Int J Drug Policy* 2013; **24:** e25–34.
101 Amon J, Wurth M, McLemore M. Evaluating human rights advocacy on criminal justice and sex work. *Health Hum Rights* 2015; **17:** E91–101.
102 Muntingh L. Reducing prison violence: implications from the literature for South Africa. University of the Western Cape, South Africa: Civil Society Prison Reform Initiative, 2009.
103 Jurgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting drug use in prisons. *Lancet Infect Dis* 2009; **9:** 57–66.
104 Maruschak M. HIV in prisons, 2001–2010. Washington, DC: US Department of Justice Bureau of Justice Statistics, 2015.

Ebola and human rights in west Africa

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The fear caused by the Ebola outbreak in west Africa, which is projected to infect some 20 000 people, is understandable.[1] However, the disproportionate measures recently adopted in some of the affected countries are a cause for concern. Some 25 years ago, Jonathan Mann, then Director of WHO's Global Programme on AIDS, warned world leaders alarmed at the relentless spread of HIV:

> "Fear and ignorance about AIDS continue to lead to tragedies: for individuals, families and entire societies... [T]hreatening infected persons with exclusion—or worse—will drive the problem 'underground', wreaking havoc with educational efforts and testing strategies. Therefore, how societies treat AIDS virus-infected people will not only test fundamental values, but will likely make the difference between success and failure of AIDS control strategies at the national level."[2]

Of course, Ebola is not AIDS. Yet two main points in Mann's warning should inform the response to the present outbreak of Ebola.

First, we must focus on what works for the prevention and treatment of Ebola and avoid disproportionate and coercive measures against communities and individuals affected by the virus. Isolation of individuals suspected or confirmed to be infected with Ebola, where necessary and least intrusive, for the purpose of observation, treatment, and avoiding onward transmission is in line with the principles of necessity and proportionality in limiting human rights provided under international law,[3] and reaffirmed in the International Health Regulations.[4] However, some measures adopted in Guinea, Liberia, and Sierra Leone, the three west African countries worst affected by Ebola, go beyond these principles. On Aug 1, 2014, these three countries announced the enforcement of a mass quarantine in vast forest areas around their common borders that are considered the epicentre of the outbreak.[5] The measure was implemented despite evidence that the virus had already passed outside of the quarantined zones.[6] A few days later, Liberian authorities imposed a 10-day quarantine over West Point, the country's largest slum, with soldiers enforcing the blockade of its some 75 000 inhabitants.[7] On Sept 6, Sierra Leone announced a nationwide mass quarantine between Sept 19 and Sept 21 to allow health workers to find hidden patients across the country.[8]

The unabated spread of Ebola in these countries, despite such coercive measures, suggests that they are not effective in responding to an outbreak that has already spread out of specific areas or population groups. Such measures, rather, violate the rights to liberty and security.[9] In some countries, restrictions to freedom of movement are leading to further human rights violations and humanitarian crises, since people in quarantined zones cannot always access food, health care, or other services.[10] Rightly, the African Union urged member states "to respect the principle of free movement, and to ensure that all restrictions are in line with recommendations from the relevant international organisations".[11]

Second, we must engage communities and build trust between those affected and health-care workers. The fact that people exposed to, or infected with, Ebola are reported to be hiding from health-care services indicates that suspicion and misinformation are rife in certain areas.[12] In some places, outreach efforts to engage community leaders and to educate the public about the disease remain insufficient.[13] Inhabitants of Nzérékoré, Guinea, recently attacked the local hospital to oppose the disinfection of the market area because they feared it was a plan to spread Ebola.[14] The deployment of military troops to enforce mass quarantine in such an environment of mistrust might reinforce defiance and further alienate people who must be engaged in the response to Ebola. In West Point, Liberia, an enforced

Associated Press

Residents of West Point, Liberia, wait in a holding area for a consignment of food on Aug 22, 2014

mass quarantine led to clashes between the army and population that left one child dead and several people injured.[15] According to Médecins Sans Frontières, "lockdowns and quarantine do not help control Ebola as they end up driving people underground and jeopardizing the trust between people and health providers".[16]

The Ebola outbreak in west Africa is too serious for needed resources to be used for the enforcement of disproportionate and counterproductive measures. The international community and WHO must call for evidence-informed responses that engage communities rather than alienate them. Admittedly, the global response to the present Ebola outbreak has been sluggish. Medical, logistical, material, human, and financial resources must be swiftly mobilised to combat this outbreak, and to support the countries affected in their efforts to build effective health systems after the emergency. Plans by the UN Secretary-General to convene a high-level event on Ebola during the 69th UN General Assembly are laudable. But these efforts should embrace the tested lessons of proportionality, trust-building, and respect for human rights from previous effective responses to infectious diseases.[17]

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1 WHO. Ebola response roadmap. Geneva: World Health Organization, 2014.
2 Mann J. Statement at an informal briefing on AIDS to the 42nd Session of the United Nations General Assembly. *J R Statist Soc A* 1988; **151:** 131–36.
3 UN Economic and Social Council, UN Commission on Human Rights. The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights. Sept 28, 1984. E/CN.4/1985/4. http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G84/182/73/PDF/G8418273.pdf?OpenElement (accessed Sept 16, 2014).
4 WHO. International Health Regulations (2005), second edition. Geneva: World Health Organization, 2008.
5 McNeil Jr DG. Using a tactic unseen in a century, countries cordon off Ebola-racked areas. *The New York Times*, Aug 12, 2014. http://www.nytimes.com/2014/08/13/science/using-a-tactic-unseen-in-a-century-countries-cordon-off-ebola-racked-areas.html (accessed Sept 17, 2014).
6 Nossiter A. Ebola reaches capital of Guinea, stirring fears. *The New York Times*, April 1, 2014. http://www.nytimes.com/2014/04/02/world/africa/ebola-reaches-guinean-capital-stirring-fears.html?_r=0 (accessed Sept 16, 2014).
7 Hildebrandt A. Ebola outbreak: why Liberia's quarantine in West Point slum will fail. *CBC News*, Aug 25, 2014. http://www.cbc.ca/news/world/ebola-outbreak-why-liberia-s-quarantine-in-west-point-slum-will-fail-1.2744292 (accessed Sept 12, 2014).
8 Nossiter A. Sierra Leone to impose 3-day Ebola quarantine. *The New York Times*, Sept 6, 2014. http://www.nytimes.com/2014/09/07/world/africa/sierra-leone-to-impose-widespread-ebola-quarantine.html (accessed Sept 12, 2014).
9 Human Rights Watch. West Africa: respect rights in Ebola response. *Human Rights Watch*, Sept 15, 2014. http://www.hrw.org/news/2014/09/15/west-africa-respect-rights-ebola-response (accessed Sept 16, 2014).
10 Nossiter A. At heart of Ebola outbreak, a village frozen by fear and death. *The New York Times*, Aug 11, 2014. http://www.nytimes.com/2014/08/12/world/africa/at-heart-of-ebola-outbreak-a-village-frozen-by-fear-and-death.html?_r=0 (accessed Sept 12, 2014).
11 African Union. African Union's Executive Council urges lifting of travel restrictions related to Ebola outbreak. Press release nº 211/2014. Sept 8, 2014. http://sa.au.int/en/sites/default/files/PR%20211-%20%20%20Ex%20Con%20on%20Ebola%20-%20Emengency%20Meeting%20-%208%20September%202014%20(2).pdf (accessed Sept 12, 2014).
12 Roy-Macauley C. Sierra Leone makes hiding Ebola patients illegal. *Associated Press*, Aug 23, 2014. http://www.aol.com/article/2014/08/23/sierra-leone-makes-hiding-ebola-patients-illegal/20951542/ (accessed Sept 16, 2014).
13 IRIN. Fear and ignorance aid spread of Ebola. *Irinnews*, June 11, 2014. http://www.irinnews.org/report/100195/fear-and-ignorance-aid-spread-of-ebola (accessed Sept 16, 2014).
14 Reuters. Guinean security forces break up riot in Ebola-racked south. *Reuters*, Aug 29, 2014. http://www.reuters.com/article/2014/08/29/us-health-ebola-guinea-idUSKBN0GT0ZM20140829 (accessed Sept 16, 2014).
15 Butty J. Liberia's West Point: life after Ebola quarantine. *Voice of America*, Sept 1, 2014. http://www.voanews.com/content/liberias-west-point-ebola-quarantine-lifted/2434374.html (accessed Sept 12, 2014).
16 Associated Press, Reuters. MSF: Sierra Leone lockdown will not stem Ebola spread. *Deutsche Welle,* Sept 7, 2014. http://www.dw.de/msf-sierra-leone-lockdown-will-not-stem-ebola-spread/a-17906558 (accessed Sept 12, 2014).
17 London L. What is a human-rights based approach to health and does it matter? *Health Hum Rights* 2008; **10:** 65–80.

PART TWO: **ASSESSING HUMAN RIGHTS IN THE CONTENT OF HIV-SPECIFIC LEGISLATION**

This part uses human rights norms and principles to assess the normative content of HIV-specific laws in sub-Saharan Africa. The assessment is based on existing global and regional human rights treaties as well as authoritative HIV-related human rights guidance issued by global and regional human rights bodies. The assessment of HIV-specific laws is also based on best available scientific evidence and recommendations relating to HIV developed by institutions such as UNAIDS and WHO. This part includes two chapters relating to a comprehensive human rights analysis of HIV-specific laws (Chapter Five) and independent access to HIV testing, counselling and treatment for adolescents in HIV-specific laws (Chapter Six).

Chapter Five offers a comprehensive human rights appraisal of the content of 26 of the 27 HIV-specific laws adopted in sub-Saharan Africa as of July 2014. It identifies key areas covered in these laws, namely HIV-related discrimination, rights violations in the workplace, HIV testing and the criminalisation of HIV non-disclosure, exposure and transmission. The chapter analyses the provisions of HIV-specific laws in relation to these areas and distinguishes between protective provisions in the laws (i.e. provisions that satisfy human rights standards and are based on best available scientific evidence on HIV), and restrictive and coercive provisions (i.e. provisions that ignore human rights principles and scientific evidence on HIV). In so doing, the chapter identifies areas in HIV-specific laws that require reform to ensure that they advance human rights and effective responses to HIV.

Chapter Six uses human rights norms and principles, together with public health recommendations from WHO to analyse the provisions of HIV-specific laws in sub-Saharan Africa on access to independent HIV testing, counselling and treatment for adolescents. It identifies the strength and the weaknesses in existing HIV-specific laws and suggests approaches for improving access to HIV services for adolescents including through law reform and other avenues.

Together, the two chapters in this part illustrate the importance of human rights norms and principles as frameworks for interrogating, identifying challenges, and offering responses to inadequate and restrictive HIV-related legal provisions.

Chapter Five

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HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis

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Summary

As at 31 July 2014, 27 sub-Saharan African countries had adopted HIV-specific legislation to address the legal issues raised by the HIV and AIDS epidemics. The article provides the first comprehensive analysis of key provisions in these HIV-specific laws. It shows that HIV-specific laws include both protective and punitive provisions. Protective provisions often covered in these laws relate to non-discrimination in general or in specific areas, such as employment, health, housing and insurance. However, these non-discrimination provisions are often not strong enough to fully protect the human rights of people living with HIV and those affected by the epidemic. Punitive or restrictive provisions appear to be a defining feature of HIV-specific laws, both in terms of the number of countries that have adopted them and with regard to the diversity of restrictive provisions provided in these laws. Restrictive provisions often covered in HIV-specific laws include compulsory HIV testing, particularly for alleged sexual offenders, involuntary partner notification and criminalisation of HIV non-disclosure, exposure and transmission. In the great majority of cases, these provisions are overly broad, they disregard best available recommendations for legislating on HIV, fail to pass the human rights test of necessity, proportionality and reasonableness, consecrate myths and prejudice about people living with HIV, and risk undermining effective

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responses to the HIV epidemic. While noting these gaps and concerns in HIV-specific laws, the article calls for ensuring the effective implementation and enforcement of their protective provisions, while devising strategies to address their restrictive stipulations.

Key words: *HIV and AIDS; HIV-specific laws; non-discrimination; criminalisation; non-disclosure; exposure; transmission; human rights norms; Africa*

1 Introduction

The human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) epidemics remain a serious public health challenge facing sub-Saharan Africa. In 2013, there were an estimated 24,7 million people living with HIV in sub-Saharan Africa, representing some 71 per cent of the global total.[1] In 2012, there were 1,2 million deaths due to AIDS-related illnesses in the region.[2] As of December 2012, an estimated 15 million children in sub-Saharan Africa had lost one or both parents to AIDS.[3] Although important progress has been made in the response to HIV in the region – with a decline in new HIV infections and a significant increase in access to anti-retroviral treatment – the epidemic remains a leading cause of death.[4] Moreover, serious social, legal and policy issues, such as stigma, discrimination, gender inequality and other negative norms and practices that make people vulnerable to HIV and hinder their access to HIV services, remain largely unchallenged.[5]

The law is considered a structural tool that can shape individual behaviour in the context of public health challenges such as HIV, and orient the manner in which states respond to these challenges.[6] Consequently, all sub-Saharan African countries[7] have adopted legislative, policy or other measures to respond to HIV. In their legal responses, many countries in the region (27 out of 45) have resorted to HIV-specific laws, as opposed to other forms of legislation (see annexure). Sometimes referred to as omnibus HIV legislation, HIV-specific laws are legislative texts that address, in a single document, several aspects of HIV, such as HIV-related education and

1 UNAIDS *The gap report* (2014) 26.

2 UNAIDS *Global Report. UNAIDS Report on the Global AIDS Epidemic* (2013) A43.

3 UNICEF *Towards an AIDS-Free Generation. Children and AIDS: Sixth Stocktaking Report 2013* (2013).

4 See UNAIDS *How AIDS changed everything. MDG 6: 15 years, 15 lessons of hope from the AIDS response* (2015).

5 See Global Commission on HIV and the Law *HIV and the law: Risks, rights and health* (2012); CI Grossman & AL Stangl (eds) 'Global action to reduce HIV stigma and discrimination' (2013) 16 *Journal of the International AIDS Society* 18881.

6 See, eg, J Hamblin 'The role of the law in HIV/AIDS policy' (1991) 5 *AIDS* s239-s243; L Gable et al 'A global assessment of the role of law in the HIV/AIDS pandemic' (2009) 123 *Public Health* 260-264.

communication, HIV testing, non-discrimination based on HIV status, HIV prevention, treatment, care and support and HIV-related research.[8] Many countries in sub-Saharan Africa have resorted to HIV-specific laws because these laws make it possible, through a single piece of legislation, to address several aspects of the response to HIV, as opposed to the challenges and delays inherent in the adoption of a multitude of legislative amendments dealing with different aspects of HIV.[9]

Before November 2005, only three countries in sub-Saharan Africa (Angola, Burundi and Equatorial Guinea) had adopted HIV-specific laws. The 2004 development of Model Legislation on HIV/AIDS for West and Central Africa (also known as the N'Djamena Model Law) transformed the legislative landscape on HIV in sub-Saharan Africa and, particularly, in West and Central Africa.[10] Four years later, some 13 West and Central African countries had adopted HIV-specific laws largely based on the N'Djamena Model Law.[11] Although presented as

7 This article uses the regional grouping of countries of the Joint United Nations Programme on HIV/AIDS (UNAIDS). Under UNAIDS's regional grouping of countries, there are 45 sub-Saharan African countries, namely, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, The Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, São Tomé and Príncipe, Senegal, Sierra Leone, South Africa, South Sudan, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

8 In a few cases, these laws also deal with the establishment of national mechanisms for responding to the HIV epidemic, such as national AIDS commissions. P Eba 'One size punishes all … A critical appraisal of the criminalisation of HIV transmission or exposure through HIV-specific laws in sub-Saharan Africa' (2008) *AIDS Legal Quarterly* 1.

9 Countries such as South Africa, Botswana and Namibia have addressed HIV issues in general legislation without adopting HIV-specific laws. In South Africa, the Law Reform Commission under its Project 85 conducted a thorough review of legal issues relating to HIV, including employment, discrimination in schools, the criminalisation of HIV exposure or transmission and compulsory HIV testing of alleged sexual offenders. The review identified various areas for law reform, through general laws, to better respond to HIV and to protect human rights. See 'South African Law Reform Commission: Reports' http://www.justice.gov.za/salrc/reports.htm (accessed 15 November 2014).

10 See AWARE-HIV/AIDS 'Regional workshop to adopt a model law for STI/HIV/AIDS for West and Central Africa: General report N'Djamena, 8-11 September 2014' (on file with author).

11 See R Pearshouse 'Legislation contagion: The spread of problematic new HIV laws in Western Africa' (2007) 12 *HIV/AIDS Policy and Law Review* 1-12.

12 As above; Canadian HIV/AIDS Legal Network 'A human rights analysis of the N'Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo' 2007 http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1530 (accessed 8 November 2014); 'Africa: "Terrifying" new HIV/AIDS laws could undermine AIDS fight' *Irinnews* 7 August 2008 http://www.irinnews.org/report/79680/africa-terrifying-new-hiv-aids-laws-could-undermine-aids-fight (accessed 8 November 2014); 'West Africa: HIV law "a double-edged sword"' *Irinnews* 1 December 2008 http://www.irinnews.org/report/81758/west-africa-hiv-law-a-double-edged-sword (accessed 8 November 2014); UNAIDS 'UNAIDS recommendations for alternative language to some problematic articles in the N'Djamena legislation on HIV (2004)' 2008

a model approach to legislating on HIV, it has been criticised for its embrace of coercive approaches that violate human rights and risk undermining the existing response to HIV.[12]

On 31 July 2014, Uganda became the twenty-seventh sub-Saharan African country to enact HIV-specific legislation following assent by the Head of State to the HV and AIDS Prevention and Control Act.[13] This Act was criticised on the grounds that it raised both human rights and public health concerns similar to those in the N'Djamena Model Law.[14]

More than a decade after the first HIV-specific laws were adopted in sub-Saharan Africa, there is merit in conducting a comprehensive analysis of these laws to examine their key provisions against human rights and public health standards relating to HIV. The present desk research does this by focusing on 26 of the 27 HIV-specific laws that have been adopted in the region as of 31 July 2014.[15] The study first describes global, regional and sub-regional human rights norms and public health recommendations that are relevant to HIV. It then uses these norms and recommendations as the framework for assessing how HIV-specific laws address four key issues, namely, HIV-related discrimination, rights violations in the workplace, HIV testing and the criminalisation of HIV non-disclosure, exposure and transmission. The study concludes with remarks on whether HIV-specific laws advance human rights in the context of HIV and makes specific recommendations for improving them.

2 Human rights norms applicable in the context of HIV

Although no global human rights treaty expressly addresses HIV, there are a wealth of norms and principles in general human rights treaties that are relevant to HIV and to the protection of people living with or affected by the epidemic. In particular, the open-ended grounds for prohibiting discrimination based on 'other status' in the International Covenant on Civil and Political Rights (ICCPR),[16] the International

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http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2008/20080912_alternativelanguage_ndajema_legislation_en.pdf (accessed 25 January 2015); D Grace 'Legislative epidemics: The role of model law in the transnational trend to criminalise HIV transmission' (2013) 39 *Medical Humanities* 77-84.

13 R Ninsiima 'Uganda: HIV law – After assent, Museveni under fire' *The Observer* 22 August 2014 http://allafrica.com/stories/201408220430.html (accessed 8 November 2014).

14 As above.

15 The analysis does not cover the HIV law of Equatorial Guinea. Although research confirmed the existence of HIV-specific law in this country, efforts to secure a copy of this legislation were not successful.

16 International Covenant on Civil and Political Rights, adopted 16 December 1966, GA Res 2200A (XXI), 21 UN GAOR Supp (No 16) 52, UN Doc A/6316 (1966), 999 UNTS 171. See art 2.

Covenant on Economic, Social and Cultural Rights (ICESCR),[17] and the Convention on the Rights of the Child (CRC)[18] have been or can be interpreted to include non-discrimination based on health and HIV status.[19] The provisions in these global treaties relating to the rights to liberty, security, equality, health, education, free and fair trial, among others, are also relevant to the HIV epidemic and for people living with or affected by HIV.[20] The monitoring bodies established under these treaties have on several occasions in General Comments and Concluding Observations affirmed relevant norms as being applicable to HIV.[21]

Similar to the situation at the global level, regional African human rights treaties – with the exception of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol)[22] – do not explicitly address HIV. However, key provisions, such as those relating to non-discrimination, liberty and security, health, education, prohibition of torture, inhuman and degrading treatment in the African Charter on Human and Peoples' Rights (African Charter),[23] the African Women's Protocol and the African Charter on the Rights and Welfare of the Child (African Children's Charter)[24] are relevant and applicable to HIV.[25] For example, in *Odafe & Others v Attorney-General & Others*,[26] the High Court of Nigeria invoked article 16 of the African Charter to vindicate the right of access to HIV treatment for prisoners.

In contrast to the silence of global and regional treaties on HIV, there is a wealth of non-binding instruments that assert human rights and public health recommendations in the context of HIV. Chief among these are the international guidelines on HIV/AIDS and human

17 International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966, GA Res 2200A (XXI), 21 UN GAOR Supp (No 16) 49, UN Doc A/6316 (1966), 993 UNTS 3. See art 2.

18 Convention on the Rights of the Child, adopted 20 November 1989, GA Res 44/25, annex, 44 UN GAOR Supp (No 49) 167, UN Doc A/44/49 (1989). See art 2(1).

19 See, in particular, ESCR Committee 'General Comment No 20: Non-discrimination in economic, social and cultural rights (art 2, para 2 of the International Covenant on Economic, Social and Cultural Rights)' 2 July 2009 E/C 12/GC/20; Committee on the Rights of the Child 'General Comment No 3 (2003): HIV/AIDS and the rights of the child' CRC/GC/2003/1.

20 See AIDS and Human Rights Research Unit *Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa* (2007).

21 As above.

22 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted 13 September 2000, CAB/LEG/66.6. Art 14 of the African Women's Protocol explicitly addresses HIV and AIDS under health and reproductive rights.

23 African Charter on Human and Peoples' Rights, adopted 27 June 1981, OAU Doc CAB/LEG/67/3 Rev 5; reprinted in C Heyns & M Killander (eds) *Compendium of key human rights documents of the African Union* (2013) 29.

24 African Charter on the Rights and Welfare of the Child, adopted 11 July 1990, OAU Doc CAB/LEG/24.9/49; reprinted in Heyns & Killander (n 23 above) 77.

25 See AIDS and Human Rights Research Unit (n 20 above).

26 (2004) AHRLR 205 (NgHC 2004).

rights (International Guidelines) developed by the Second International Consultation on HIV/AIDS and Human Rights convened by UNAIDS and the Office of the United Nations High Commissioner for Human Rights (OHCHR) in September 1996.[27] In addition, the resolutions adopted by the UN General Assembly Special Session on HIV in 2001,[28] the High-Level Meetings on HIV in 2006[29] and 2011,[30] as well as the resolutions on HIV of the Commission on Human Rights and later the Human Rights Council, also provide specific standards for the protection of human rights in the context of HIV.[31] Finally, best practice recommendations for legislating on HIV, including those issued by the Inter-Parliamentary Union (IPU), UNAIDS, the United Nations Development Programme (UNDP) and the International Labour Organisation (ILO) are relevant to legal responses to HIV.[32]

At regional and sub-regional levels in Africa, several non-binding instruments have been adopted in relation to HIV by the African Union (AU), the African Commission on Human and Peoples' Rights (African Commission), the East African Community (EAC), the Inter-Governmental Authority on Development (IGAD) and the Southern African Development Community (SADC).[33]

Finally, general human rights provisions in the constitutions, legislation and case law of many sub-Saharan African countries offer standards for addressing HIV and for ensuring the protection of people living with or affected by the epidemic. For example, in *Banda v Lekha*,[34] the Industrial Court of Malawi asserted the applicability of the right to non-discrimination to HIV provided under the country's

27 Commission on Human Rights 'The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)' E/CN.4/RES/1997/33 11 April 1997 http://ap.ohchr.org/documents/alldocs.aspx?doc_id=4480 (accessed 7 March 2015). The International Guidelines were revised in 2002 (Guideline 6) and a consolidated version was published by UNAIDS and OHCHR in 2006. Reference to the International Guidelines in the present article relates to this consolidated version. UNAIDS & OHCHR *International Guidelines on HIV/AIDS and Human Rights, 2006 consolidated version* (2006).

28 UN General Assembly Special Session on HIV/AIDS Declaration of Commitment on HIV/AIDS (A/RES/S-26/2) June 2001.

29 UN General Assembly Political Declaration on HIV/AIDS (A/RES/60/262) 15 June 2006.

30 UN General Assembly Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS UN Doc A/RES/65/277 10 June 2011.

31 For an overview of the resolutions on HIV of the Commission on Human Rights and the Human Rights Council, see http://www2.ohchr.org/english/issues/hiv/document.htm (accessed 7 March 2015).

32 See, notably, UNAIDS & IPU *Handbook for legislators on HIV/AIDS, law and human rights: Action to combat HIV/AIDS in view of its devastating human, economic and social impact* (1999); UNAIDS, UNDP & IPU *Taking action against HIV and AIDS: Handbook for parliamentarians* (2007); UNDP *Legal environment assessment: An operational guide to conducting national legal, regulatory and policy assessments for HIV* (2014); International Labour Conference *Recommendation 200: Recommendation concerning HIV and AIDS and the world of work* 99th session, 17 June 2010.

33 AIDS and Human Rights Research Unit (n 20 above).

34 (2005) MWIRC 44.

Constitution. The Court held that '[s]ection 20 of the Constitution prohibits unfair discrimination of persons in any form. Although the section does not specifically cite discrimination on the basis of ... HIV status, it is to be implied that it is covered under the general statement of anti-discrimination in any form.'

3 A human rights analysis of four key areas covered in HIV-specific laws

A review of HIV-specific laws in sub-Saharan Africa shows that these laws cover a broad range of issues, from non-discrimination based on HIV status to HIV education and information, blood and tissue safety, HIV testing and counselling, disclosure and notification of HIV test results and the criminalisation of HIV non-disclosure, exposure or transmission (Table 1). However, this analysis focuses on: HIV-related discrimination, HIV-related protection in the workplace, HIV testing and the criminalisation of HIV non-disclosure, exposure and transmission. Three reasons motivate the selection of these issues. First, they are among those most covered in HIV-specific legislation in sub-Saharan Africa (Table 1) and, as such, allow for a comparative analysis. Second, they are among the most critical to effective HIV responses and to the protection of the rights of people living with HIV. Finally, they have attracted the most criticism and concerns.[35]

Table 1: Key issues addressed in HIV-specific laws in sub-Saharan Africa

Issue/area	Non-discrimination	Employment	HIV testing and counselling	Criminalisation of HIV non-disclosure, exposure and transmission
Number of HIV-specific laws addressing the issue (out of 26)	26	26	26	24 (except Comoros and Mauritius)

35 See, eg, Pearshouse (n 11 above); Canadian HIV/AIDS Legal Network (n 12 above); 'Africa: "Terrifying" new HIV/AIDS laws could undermine AIDS fight' (n 12 above); C Kazatchkine 'Criminalising HIV transmission or exposure: The context of Francophone West and Central Africa' (2010) 14 *HIV/AIDS Law and Policy Review* 1-11; P Sanon et al 'Advocating prevention over punishment: The risks of HIV criminalisation in Burkina Faso' (2009) 17 *Reproductive Health Matters* 146-153; IPPF *Verdict on a virus: Public health, human rights and criminal law* (2008).

3.1 HIV-related discrimination

Translating international norms into specific guidance on non-discrimination in the context of HIV, the International Guidelines recommend that[36]

> [g]eneral anti-discrimination laws should be enacted or revised to cover people living with asymptomatic HIV infection, people living with AIDS and those merely suspected of HIV or AIDS. Such laws should also protect groups made more vulnerable to HIV/AIDS due to the discrimination they face … Direct and indirect discrimination should be covered, as should cases where HIV is only one of several reasons for a discriminatory act.

In terms of the International Guidelines and other relevant legislative guidance,[37] appropriate HIV-related non-discrimination provisions should cover the following: (i) actual or perceived HIV status; (ii) the HIV status of a person and that of others associated with them (eg family members or friends); (iii) indirect discrimination; and (iv) critical areas of protection, such employment, education, health and insurance and credit.

All 26 HIV-specific laws include one or more provisions that prohibit discrimination based on HIV status. In a significant number of countries (19 out of 26), these provisions prohibit discrimination based on both actual and presumed (or perceived) HIV status.[38] A handful of countries (five out of 26)[39] explicitly prohibit discrimination based on another person's HIV-positive status, and only one country (Chad)[40] explicitly prohibits indirect discrimination.

In 12 HIV-specific laws, anti-discrimination provisions include both a general prohibition of discrimination as well as specific provisions that prohibit discrimination in particular areas, such as employment, education, health, housing and insurance.[41] Twelve countries prohibit discrimination in specific areas without an overarching non-discrimination provision.[42] A total of 24 HIV-specific laws address HIV-related discrimination in specific areas. Only two countries (Mauritania and Mauritius) have a general non-discrimination provision without other clauses addressing discrimination in specific areas.[43] The areas most covered by the prohibition of discrimination include

36 OHCHR & UNAIDS (n 27 above) 31-32.

37 See n 32 above.

38 Burkina Faso (art 2); Cape Verde (arts 24(1) & 25); Comoros (art 17); Congo (art 27); Côte d'Ivoire (art 18); DRC (arts 10 & 20); Guinea-Bissau (art 29); Kenya (arts 31 & 32); Liberia (art 18(28)); Madagascar (arts 2 & 44); Mali (art 30); Mauritania (art 21); Mauritius (art 3); Niger (art 29); Senegal (art 24); Sierra Leone (art 39); Tanzania (arts 30 & 31); Togo (art 23); and Uganda (art 32).

39 Congo (art 27); DRC (arts 18 & 20); Madagascar (arts 2 & 39); Niger (art 29); and Togo (art 23).

40 Chad (art 28).

41 Benin, Burkina Faso, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Madagascar, Mozambique, Niger, Tanzania and Togo.

42 Angola, Burundi, Cape Verde, DRC, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Senegal, Sierra Leone and Uganda.

43 Mauritania (art 21) and Mauritius (art 3).

employment, education, health care, and access to insurance and credit. All 24 laws covering specific areas of discrimination either explicitly prohibit HIV-related discrimination in employment or forbid HIV testing as a condition for employment. Some 20 countries explicitly prohibit discrimination based on HIV status in education.[44] A total of 19 countries prohibit HIV-related discrimination in access to health care,[45] and some 17 countries prohibit HIV-related discrimination in accessing insurance and credit.[46]

The prohibition of discrimination based on actual or perceived HIV status in almost all HIV-specific laws is important to protect individuals who may face discrimination, not because they are HIV positive, but for belonging to a group that is perceived to be at a higher risk of HIV infection, particularly sex workers, men who have sex with men and people who inject drugs. Members of these populations may experience HIV-related discrimination because their lifestyle, behaviour or life circumstances often lead to suspicion that they are living with HIV.

Of concern is the limited number of countries that explicitly cover non-discrimination based on someone else's HIV status. The failure to address this form of discrimination constitutes a gap because the fear and stigma relating to HIV may lead to many individuals being discriminated against, not because of their own HIV status, but because of that of their parents, spouses, relatives or associates. This gap particularly may affect children who could experience discrimination based on their parents' or caregivers' HIV-positive status.[47] The lack of attention in HIV-specific laws to indirect discrimination is also concerning because only one country explicitly addresses it. Indirect discrimination refers to 'laws, policies or practices which appear neutral at face value, but have a disproportionate impact on the exercise of … rights as distinguished by prohibited

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44 Angola (sec 5(g)); Benin (art 2); Burkina Faso (art 16); Burundi (art 32); Cape Verde (art 25); Chad (art 29); Comoros (art 23); Congo (art 29); DRC (art 16); Guinea-Bissau (art 30(1)); Kenya (art 32); Liberia (art 18(28)(c)); Madagascar (art 39); Mali (art 31); Mozambique (art 17); Niger (art 32); Senegal (art 25); Sierra Leone (art 40); Togo (art 26); and Uganda (art 33).

45 Angola (sec 5(a)); Benin (art 2); Burkina Faso (art 16); Cape Verde (art 29); Central African Republic (art 14); Comoros (art 21); Congo (art 26); DRC (art 10); Guinea (art 15); Guinea-Bissau (art 34); Kenya (art 36); Liberia (art 18(28)(c)); Madagascar (art 62); Mali (art 35); Senegal (art 29); Sierra Leone (art 44); Tanzania (art 29); Togo (arts 39 & 40); and Uganda (art 37).

46 Angola (sec 9); Benin (art 22); Burkina Faso (art 19); Burundi (art 38); Cape Verde (art 28); Chad (art 39); Comoros (art 26); Guinea (art 6); Guinea-Bissau (art 33); Kenya (art 35); Liberia (art 18(28)(c)); Mali (art 34); Niger (art 34); Senegal (art 28); Sierra Leone (art 43); Togo (arts 34 & 36); and Uganda (art 36).

47 See, eg, J Cohen 'Southern Africa: AIDS-affected children face systemic discrimination in accessing education' (2005) 10 *HIV/AIDS Policy and Law Rev*iew 24-25; Human Rights Watch 'Letting them fail: Government neglect and the right to education for children affected by AIDS' October 2005 http://www.hrw.org/sites/default/files/reports/africa1005.pdf; PJ Surkan et al 'Perceived discrimination and stigma toward children affected by HIV/AIDS and their HIV-positive caregivers in central Haiti' (2010) 22 *AIDS Care* 803-815.

grounds of discrimination'.[48] For example, a law or policy requiring a physical medical examination as a pre-condition to enrol in schools could constitute indirect discrimination towards children living with HIV who may not be able to pass the test.[49]

A further weakness in several non-discrimination provisions is that they do not prohibit discrimination generally but rather forbid specific discriminatory acts. For instance, in relation to non-discrimination in education, some HIV-specific laws only prohibit the refusal to allow entry into schools without attention to other measures that could be discriminatory towards HIV-positive learners in the context of education. This is, for instance, the case in the HIV laws of Niger,[50] Togo[51] and Guinea-Bissau.[52] Such provisions are too narrow in scope and would leave persons living with HIV, particularly children, without explicit protection in many instances.

In general, provisions in HIV-specific laws relating to non-discrimination in employment are more comprehensive than those dealing with non-discrimination in other areas. While one would understand the importance of devoting specific attention to non-discrimination in employment, there is no reason why areas such as education and health would not merit similar emphasis. Laconic non-discrimination provisions may in particular be problematic in areas such as insurance and access to credit. Most of the 17 HIV-specific laws with provisions relating to insurance and credit merely state that denial of insurance to people living with HIV is prohibited without elaborating on the nature or scope of insurance coverage or providing for subsequent regulations to appropriately address access to insurance and credit for people living with HIV.[53] Failure to precisely regulate these issues may, in practice, leave people living with HIV with limited protection against discriminatory practices by insurers.

3.2 HIV in employment

General human rights treaties (such as the ICCPR, the ICESCR and the African Charter) and specific HIV instruments (such as the International Guidelines) provide relevant principles on non-discrimination that apply to HIV and employment.[54] In addition, norms and principles on HIV in the workplace developed by the ILO

48 ESCR Committee (n 19 above) para 10(b).
49 A Meerkotter *Equal rights for all: Litigating cases of HIV-related discrimination* (2011) 25.
50 Art 32 HIV law of Niger.
51 Art 26 HIV law of Togo.
52 Art 30(1) HIV Law of Guinea-Bissau.
53 See, eg, sec 9 of the HIV law of Angola and art 18(28)(c) of the HIV law of Liberia.
54 In addition to general human rights treaties, all ILO Conventions applicable to the workplace are relevant in the context of HIV. ILO *HIV and AIDS and labour rights: A handbook for judges and legal professionals* (2013) 30-33.

provide frameworks for legislating on HIV in the workplace.[55] Chief among these is the ILO Recommendation concerning HIV and AIDS and the World of Work No 200 (Recommendation 200), which provides comprehensive guidance on addressing HIV in the context of employment.[56] Though not binding, Recommendation 200 is a standard adopted by ILO constituents (governments, employers and workers), which sets out key principles and rights relating to HIV in the workplace.[57]

On the basis of Recommendation 200 and other norms applicable to HIV in the workplace, this study identified six areas for assessing the provisions of HIV-specific laws relating to the workplace. The areas for assessment are (i) non-discrimination in employment; (ii) the prohibition of HIV testing as a condition for employment; (iii) privacy and confidentiality in the workplace; (iv) reasonable accommodation for HIV-positive workers; (v) access to post-exposure prophylaxis in case of occupation exposure and compensation in case of occupational HIV infection; and (vi) the requirement for HIV policies and programmes in the workplace.

As discussed in the section on non-discrimination above, all but two HIV-specific laws address HIV-related discrimination in the workplace.[58] In 11 countries, the prohibition of HIV-related discrimination in employment explicitly addresses both actual and perceived HIV status.[59] In two countries (Burkina Faso and Burundi), the provisions addressing HIV in the workplace are narrowly drafted and only prohibit HIV testing as a condition for employment.[60] None of the 26 countries with HIV-specific laws have adopted the full set of six measures that are necessary to effectively address HIV in the workplace. Nineteen countries have provisions that explicitly require governments or employers to put in place HIV employment policies,

55 For a discussion of ILO norms and principles applicable to HIV in the workplace, see ILO *HIV and AIDS and labour rights: A handbook for judges and legal professionals* (2013).

56 International Labour Conference (n 32 above). Also important is the *ILO Code of practice on HIV/AIDS and the world of work* (ILO Code of Practice on HIV) adopted in 2001. Unlike Recommendation 200 which is a standard, the ILO Code of Practice on HIV only sets out practical guidelines for consideration by public authorities, employers and workers. It is not a binding instrument and does not create a particular obligation on states.

57 ILO *Rules of the game: An introduction to international labour standards* Revised edition (2009) http://ilo.org/wcmsp5/groups/public/-ed_norm/-normes/documents/publication/wcms_108393.pdf (accessed 5 November 2014); L Swepston 'The future of ILO standards' (1994) 117 *Monthly Labour Review* 16-23.

58 The two exceptions are Mauritania and Mauritius.

59 Cape Verde (art 24); DRC (art 20); Guinea-Bissau (art 29); Kenya (art 31); Liberia (art 18(28)(b)); Madagascar (art 44); Mali (art 30); Senegal (art 24); Sierra Leone (art 39); Tanzania (art 30); and Uganda (art 32(1))

60 See art 19 of the HIV law of Burkina Faso and art 30(b) of the HIV law of Burundi.

training and programmes.[61] For example, the HIV law of Tanzania provides that[62]

> [e]very employer in consultation with the Ministry shall establish and co-ordinate a workplace programme on HIV and AIDS for employees under his control and such programmes shall include provision of gender-responsive HIV and AIDS education, distribution of condoms and support to people living with HIV and AIDS.

Twelve countries have provisions that explicitly provide for access to post-exposure prophylaxis in the workplace, for compensation in case of occupational transmission of HIV, or both.[63] For example, the HIV law of Uganda provides that '[e]very health institution shall, within sixty days of the commencement of the Act, ensure that the universal precautions on post exposure prophylaxis … are complied with'.[64] Six countries have provisions allowing for reasonable accommodation of people living with HIV to ensure that they remain employed with the necessary adjustments to their work, taking into account their health condition.[65] Finally, five countries have provisions that protect medical confidentiality in the workplace.[66]

Effective responses to HIV in the context of employment require a broad range of measures, provided under Recommendation 200, that range from the prohibition of discrimination in the workplace to measures aimed at protecting HIV-positive employees and creating an enabling and non-discriminatory environment. The fact that a significant number of HIV-specific laws (19 out of 26) provide for HIV education and programmes in the workplace is positive. These programmes could contribute to create a positive and supportive environment for people living with HIV, provided that they are of sufficient quality and appropriately resourced.[67]

However, the fact that none of the countries with HIV-specific laws has adopted the full set of six measures to address HIV in the workplace raises serious concerns. It is particularly worrying that in two countries, legislative responses to HIV in the workplace are limited to the prohibition of HIV testing as a condition for employment. Such

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61 Angola (sec 7(3)); Benin (art 20); Cape Verde (arts 8 & 11); Central African Republic (art 23); Chad (art 40); Côte d'Ivoire (art 34); DRC (art 19); Guinea (art 3); Guinea-Bissau (art 3); Kenya (art 7); Liberia (art 18(7)); Madagascar (art 45); Mali (art 3); Mauritania (art 4); Mozambique (article 43); Niger (art 9); Senegal (art 6); Sierra Leone (art 22); and Tanzania (art 9).

62 Art 9 HIV law of Tanzania.

63 Angola (sec 11); Benin (art 21); Comoros (art 11); Côte d'Ivoire (art 17); DRC (art 23); Kenya (art 6); Madagascar (art 54); Niger (article 25); Senegal (art 10); Sierra Leone (art 26(3)); Tanzania (art 12(2)); and Uganda (art 32(5)).

64 Art 32(5) HIV law of Uganda.

65 Angola (sec 7); Benin (art 19); Chad (art 36); Central African Republic (art 22); Comoros (art 24); and Congo (art 31).

66 Chad (art 35); Côte d'Ivoire (art 31); DRC (art 26); Madagascar (art 49); and Tanzania (art 17(1)).

67 AP Mahajan et al 'An overview of HIV/AIDS workplace policies and programmes in Southern Africa' (2007) 21 *AIDS* 31-39.

narrow provisions are likely to be ineffective in addressing the multifaceted nature of discrimination and other HIV-related human rights violations in the workplace. For instance, employers may become aware of, or suspect, the HIV-positive status of their employees through, for example, the monitoring of sick leave patterns, and may then subject these workers to less favourable treatment in the workplace. Under provisions that only ban HIV testing as a condition for employment, such behaviour will not be deemed discriminatory.

In a number of HIV-specific laws, the prohibition of HIV testing as a condition for employment is relative and may be waived. In Liberia, HIV testing may take place as a condition for employment where 'it can be shown, on the testimony of competent medical authorities, that [an HIV-positive person] is a clear and present danger of HIV transmission to others'.[68] Because of the widespread fear, stigma and misconception relating to the risks of HIV transmission, such provisions could in practice lead to abusive application that would deny people living with HIV access to employment. This was, for instance, the case when South African Airways refused to hire an HIV-positive person as cabin attendant on 'safety, medical and operational grounds'.[69] These grounds were ultimately dismissed by the South African Constitutional Court, who ruled that 'the denial of employment to the appellant because he was living with HIV impaired his dignity and constituted unfair discrimination'.[70]

Confidentiality regarding one's health status is a critical element of the right to privacy which should be protected in all settings, including in the workplace.[71] The fact that only five countries explicitly address the protection of medical confidentiality in the workplace is a concern. Although many HIV-specific laws have general provisions on confidentiality regarding HIV test results,[72] it is unclear whether these general confidentiality provisions pertaining to the obligation of health care workers to maintain patients' confidentiality in the workplace will in practice be interpreted as also applying to non-health care personnel.[73]

With only six countries explicitly addressing this, the insufficient attention devoted to reasonable accommodation for HIV-positive workers is concerning. This is because, in spite of recent progress, access to anti-retroviral treatment in many sub-Saharan African

68 Art 18(28)(b) HIV law of Liberia.

69 *Hoffmann v South African Airways* (CCT17/00) [2000] ZACC 17 para 7.

70 *Hoffmann* (n 69 above) para 40. For a discussion of this decision, see C Ngwena 'Constitutional values and HIV/AIDS in the workplace: Reflections on *Hoffman v South African Airways*' (2001) 1 *Developing World Bioethics* 42-56.

71 See, eg, International Labour Conference (n 32 above) paras 24-29; C Ngwena 'HIV in the workplace: Protecting rights to equality and privacy' (1999) 15 *South African Journal on Human Rights* 513.

72 See, eg, art 25 of the HIV law of Mali.

73 As above.

countries remains limited and the quality of care for people living with HIV remains substandard. In the context of HIV, reasonable accommodation refers to 'any modification or adjustment to a job or to the workplace that is reasonably practicable and enables a person living with HIV or AIDS to have access to, or participate or advance in, employment'.[74] The failure to provide for reasonable accommodation leaves HIV-positive employees at the mercy of unfair dismissal. Moreover, in two of the countries that address reasonable accommodation, it is considered an option.[75] Therefore, employers have no obligation to provide for such measures for HIV-positive employees.

3.3 HIV testing in HIV-specific laws

HIV counselling and testing (HCT) is considered the gateway to HIV-related prevention, treatment, care and support services.[76] Those who test positive for HIV can be linked to HIV-related treatment and care services and they can receive specific counselling and support that enable them to lead safer and healthier lives. Those who test negative for HIV can also receive information and counselling that may reinforce HIV prevention messages and behaviour.[77] Despite the importance of HIV testing, more than half the adults living with HIV in sub-Saharan Africa are not aware of their HIV status.[78] This high percentage of people with an unidentified HIV status often leads to the late diagnosis of HIV infection, which compromises the effectiveness of HIV treatment and increases the odds of HIV-related morbidity and mortality.[79]

Fear of stigma, discrimination and other human rights violations is considered to be among the main determinants of low and delayed HIV testing.[80] Human rights standards, together with 30 years of public health experience in addressing HIV, recommend that the most effective approaches to encouraging people to test for HIV are those

74 International Labour Conference (n 32 above) para 1(g).

75 Reasonable accommodation is an option in Angola (art 7) and Central African Republic (art 22). However, in Benin (art 19), Chad (art 36), Comoros (art 24) and Congo (art 31), it is an obligation for the employer.

76 UNAIDS 'Treatment 2015' (2013) 17.

77 WHO 'The right to know: New approaches to HIV testing and counselling' 2003 http://www.who.int/hiv/pub/vct/en/Right_know_a4E.pdf?ua=1 (accessed 21 February 2015).

78 UNAIDS (n 1 above) 12.

79 See IM Kigozi et al 'Late disease stage at presentation to an HIV clinic in the era of free anti-retroviral therapy in sub-Saharan Africa' (2009) 52 *Journal of Acquired Immune Deficiency Syndrome* 280; M May et al 'Impact of late diagnosis and treatment on life expectancy in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) Study' (2011) 343 *British Medical Journal* 6016.

80 A Mukolo et al 'Predictors of late presentation for HIV diagnosis: A literature review and suggested way forward' (2013) 17 *AIDS and Behaviour* 5-30.

that protect human rights.[81] Respecting people's rights to liberty, security and privacy, including their rights to informed consent, autonomy and confidentiality, is instrumental in increasing the uptake of HIV testing.[82] These experiences and best practices led to the adoption of voluntary HIV counselling and testing (VCT), anchored in the principles of confidentiality, pre- and post-test counselling and informed consent, also known as the '3Cs'.[83] Over the years, and in an effort to expand access to HCT, global and national public health policies have also endorsed provider-initiated testing and counselling (PITC).[84] In spite of this shift in policy,[85] the core principles of confidentiality, counselling and informed consent are still maintained in the context of HIV testing services.[86]

Informed consent to medical procedures is derived from the rights to privacy, liberty and security, dignity, protection against cruel, inhuman and degrading treatment, and to health provided for under global and regional human rights law. As stated by the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (Special Rapporteur on Health):[87]

> Informed consent invokes several elements of human rights that are indivisible, interdependent and interrelated. In addition to the right to health, these include the right to self-determination, freedom from discrimination, freedom from non-consensual experimentation, security and dignity of the human person, recognition before the law, freedom of thought and expression and reproductive self-determination. All states parties to [ICESCR] have a legal obligation not to interfere with the rights conferred under the Covenant.

81 UNAIDS & WHO *UNAIDS/WHO Policy statement on HIV testing* (2004) 1; MA Chesney & AW Smith 'Critical delays in HIV testing and care: The potential role of stigma' (1999) 42 *American Behavioral Scientist* 1162-1174.

82 UNAIDS & OHCHR (n 27 above).

83 See UNAIDS & WHO (n 81 above). More recently, WHO and UNAIDS have been referring to '5Cs' by adding 'correct test results' and 'connection/linkage to prevention, care and treatment' to the original '3Cs'. WHO & UNAIDS 'Statement on HIV testing and counseling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing' 2012 http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/ (accessed 8 March 2015).

84 WHO & UNAIDS *Guidance on provider-initiated HIV testing and counselling in health facilities* (2007). PITC refers to HIV testing and counselling recommended by a health-care provider in a clinical setting. It is defined in contrast to client-initiated testing, where an individual takes the initiative to seek information on his or her HIV status. PITC has now been endorsed by many countries in sub-Saharan Africa; see R Baggaley et al 'From caution to urgency: The evolution of HIV testing and counselling in Africa' (2012) 90 *Bulletin of the World Health Organization* 652-658B.

85 For a presentation on the debates and issues on evolving HIV testing policies, see R Jürgens 'Increasing access to HIV testing and counselling while respecting human rights – Background paper' 2007 http://www.unaids.org.cn/pics/20120821114907.pdf (accessed 8 February 2015).

86 See WHO & UNAIDS (n 84 above); UNAIDS & WHO (n 81 above) 1.

87 Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health A/64/272, 10 August 2009 para 19.

Informed consent to HIV testing involves two complementary elements: access to information and knowledge, on the one hand, and full agreement, on the other.[88] Informed consent by a person to a medical procedure such as HIV testing,[89] therefore, requires that the person be provided with full information and knowledge, that they understand the information and, as a result, fully and freely agree to undergo HIV testing.[90] The Special Rapporteur on Health has also stressed that '[i]nformed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of a patient to be involved in medical decision making'.[91] In this regard, the Supreme Court of Namibia has held that 'individual autonomy and self-determination are overriding principles … require[ing] that in deciding whether or not to undergo an elective procedure, the patient must have the final word'.[92] A similar patient-centred approach to informed consent was introduced into South African law in *Castell v De Greef*.[93]

Confidentiality regarding HIV test results, and HIV status in general, is derived from the right to privacy which is enshrined in global and regional human rights treaties, including the ICCPR,[94] CRC[95] and African Children's Charter.[96] In particular, article 17 of the ICCPR provides:

> No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

The International Guidelines further note that in the context of HIV, the 'right to privacy encompasses obligations to respect physical privacy, including the need to respect confidentiality of all information relating to a person's HIV status'.[97] The protection of confidentiality regarding HIV status is also important because of the negative consequences of unwarranted disclosure. As highlighted by the then Appellate Division in South Africa:[98]

88 K Grant & A Meerkotter *Protecting rights: Litigating cases of HIV testing and confidentiality of status* (2012) 11.

89 HIV testing is recognised as a medical procedure. *C v Minister of Correctional Services* 1996 (4) SA 292 (T).

90 The High Court of South Africa concluded that the failure to provide pre-test counselling was an unlawful 'deviation from the accepted norm of informed consent'. *C v Minister of Correctional Services* (n 89 above).

91 Report of the Special Rapporteur on Health (n 87 above) para 9.

92 *Government of the Republic of Namibia v LM* [2014] NASC (3 November 2014) para 106.

93 1994 (4) All SA 63 (c) (S Afr).

94 Art 17 ICCPR.

95 Art 16 CRC.

96 Art 10 African Children's Charter.

97 UNAIDS & OHCHR (n 27 above) para 119.

98 *Van Vuuren & Another NNO v Kruger* 1993 (4) SA 842 (SAA) para 10.

> There are in the case of HIV and AIDS special circumstances justifying the protection of confidentiality. By the very nature of the disease, it is essential that persons who are at risk should seek medical advice or treatment. Disclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full-blown AIDS.

All 26 HIV-specific laws under review include provisions relating to HCT. The three principles of confidentiality, pre- and post-test counselling and informed consent are explicitly provided for in the great majority of these HIV-specific laws. All 26 HIV-specific laws affirm the principle of confidentiality regarding HIV test results, and assert informed consent as a condition for HIV testing or prohibit compulsory HIV testing. Furthermore, all but five countries have provisions on pre- and post-test counselling.[99] In a number of countries, such as Congo[100] and Guinea,[101] specific provisions in the HIV law even detail the content of pre- and post-test counselling.

However, most HIV-specific laws allow for exceptions or limitations to the principles of informed consent and confidentiality. In general, HIV-specific laws allow for informed consent to HIV testing to be waived in three types of circumstances. First, some laws allow health care workers to perform an HIV test without informed consent in the context of access to treatment and care. For example, in Uganda informed consent is not needed if the patient 'unreasonably withholds' it.[102] Similarly, informed consent is not required in Angola if it appears that HIV testing is needed for appropriate medical care.[103] Second, HIV-specific laws allow for non-consensual HIV testing in the context of personal relationships. For instance, in Burkina Faso, HIV testing is allowed to settle matrimonial disputes.[104] Thirdly, and most commonly, several statutes allow for compulsory HIV testing within the criminal justice system.

Exceptions to confidentiality in HIV-specific laws range from compulsory disclosure of HIV test results within the criminal justice system to the personal realm, with laws allowing the disclosure of HIV status to the parents or guardians of minors (persons below the age of 18) and non-voluntary disclosure to sexual partners. Although many of these exceptions raise concern, the analysis below focuses on two of these, namely, compulsory HIV testing in the context of sexual offences as an exception to informed consent, and non-voluntary

99 The five countries that do not explicitly provide pre- and post-test counselling in their HIV-specific laws are Angola, Burundi, Central African Republic, Madagascar and Niger.

100 Arts 21 & 22 HIV law of Congo

101 Art 1 HIV law of Guinea.

102 Art 11(a) HIV law of Uganda.

103 Art 22(1)(a) HIV law of Angola.

104 Art 19 HIV law of Burkina Faso.

notification of the partners of people living with HIV as an exception to confidentiality.[105]

3.3.1 Compulsory HIV testing in the context of sexual offences

In terms of the International Guidelines, any exception to informed consent, including compulsory HIV testing, should be carefully considered. The International Guidelines stress in this regard that 'exceptions to voluntary testing would need specific judicial authorisation, granted only after due evaluation of the important considerations involved in terms of privacy and liberty'.[106] They further point out that 'compulsory HIV testing can constitute a depravation of liberty and a violation of the right to security of the person'.[107] Similarly, the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Special Rapporteur on Torture) emphasised that '[f]orced or compulsory HIV testing is also a common abuse that may constitute degrading treatment if it is "done on a discriminatory basis without respecting consent and necessity requirements"'.[108] To meet human rights standards, provisions relating to compulsory HIV testing should satisfy general requirements relating to any limitation of human rights. Compulsory testing provisions should therefore (i) be provided under the law; (ii) be based on a legitimate interest; (iii) be proportionate to that interest; and (iv) constitute the least restrictive measure available and actually achieving that interest in a democratic society.[109]

The analysis of HIV-specific laws adopted in sub-Saharan Africa shows that just over one-third of them (eight out of 26) explicitly allow for compulsory HIV testing in the context of sexual offences.[110] Of these, five require compulsory HIV testing in the case of rape.[111] Five countries allow for compulsory HIV testing in the case of prosecution for HIV non-disclosure, exposure or transmission.[112] Four countries allow for compulsory HIV testing in case of sexual offences without defining which particular sexual acts fall under their ambit.[113]

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105 For a discussion of the other exceptions, see Pearshouse (n 11 above).

106 UNAIDS & OHCHR (n 27 above) para 20(b).

107 UNAIDS & OHCHR para 135.

108 Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment A/HRC/22/53, 1 February 2013 para 71.

109 See UN Commission on Human Rights *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights* 1984 E/CN.4/1985/4; *Media Rights Agenda & Others v Nigeria* (2000) AHRLR 200 (ACHPR 1998); *Enhorn v Sweden* ECHR (Application 56529/00) 25 January 2005.

110 Burkina Faso (art 19); Guinea-Bissau (art 17(3)(a)); Kenya (sec 13(3)); Liberia (sec 18(21)(2)(b)); Mali (art 18(b)); Mauritania (art 15); Tanzania (sec 15(4)(c)); and Uganda (sec 12).

111 Burkina Faso (art 19); Cape Verde (art 15(2)(b)); Liberia (sec 18(21)(2)(b)); Mali (art 18(b)); and Mauritania (art 15).

112 Burkina Faso (art 19); Cape Verde (art 15(2)(a)); Guinea-Bissau (art 17(3)(a)); Liberia (sec 18(21)(2)(a)); and Mali (art 18(a)).

113 Guinea-Bissau (art 17(3)(b)); Kenya (sec 13(3)); Tanzania (sec 15(4)(c)); and Uganda (sec 12).

In addition to these, there are ten countries with provisions allowing for compulsory HIV testing when ordered by a court, which may be applied to sexual offences.[114] For example, the HIV law of Mozambique allows for compulsory HIV testing 'when it is required for the purpose of criminal procedures with the prior order of a competent judicial authority'.[115]

The provisions allowing for compulsory HIV testing in the context of sexual offences raise a number of human rights and public health issues.[116] The human rights concerns raised by these provisions relate, first, to the fact that many of the provisions are silent on the nature of sexual offences for which an HIV test is considered compulsory. This implies that compulsory HIV testing can occur in relation to all sorts of sexual offences, whether they involve a risk of HIV infection or not.

Second, many HIV-specific laws allow for compulsory HIV testing of individuals who are *charged* with a sexual offence. Some laws, such as that of Uganda, even allow for HIV testing of a 'person who is *apprehended* for a sexual offence'.[117] In either case, the person being subjected to HIV testing has not yet been found guilty of an offence and should consequently benefit from the presumption of innocence. To subject such a person to HIV testing without consent represents an infringement of the right to liberty, security and a fair trial provided for under international human rights law.[118] The violation of these rights is particularly acute in the case of persons who are merely 'apprehended' for sexual offences, as is the case under the HIV law of Uganda. There is no justification, under human rights norms and in terms of public health, for blanket HIV testing of all people living with HIV accused of sexual offences. In a case relating to the blanket denial of bail to HIV-positive people alleged to have committed rape, the Botswana Court of Appeal rejected all justifications to such restrictions by noting, among others:[119]

> It is beyond … comprehension how depriving a person of his liberty merely because he is alleged to have committed rape – not, it must be stressed, because he is found guilty of it – can in any way reduce the crime rate, including rape or serve to contain or restrict the incidence of HIV/AIDS.

Thirdly, most HIV-specific laws that allow for compulsory HIV testing of sexual offenders are generally silent on the conditions, initiator,

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114 Angola (sec 22(c)); Burundi (art 11(c)); Chad (art 4); Guinea (art 22(d)); Mozambique (art 25(1)(c)); Niger (art 11); Senegal (art 12); Tanzania (sec 15(4)(a)); Togo (art 6); and Uganda (sec 14).

115 Art 25(1)(c) HIV law of Mozambique.

116 Similar concerns have been raised about the provisions on compulsory HIV testing of sexual offenders under the Sexual Offences Act 2007 of South Africa. See S Roehrs 'Implementing the unfeasible: Compulsory HIV testing for alleged sexual offenders' (2007) 22 *South African Crime Quarterly* 27-32; K Naidoo & K Govender 'Compulsory HIV testing of alleged sexual offenders – A human rights violation' (2011) 4 *South African Journal of Bioethics and Law* 95-101.

117 Sec 12 HIV law of Uganda (my emphasis).

118 Naidoo & Govender (n 116 above) 95-101.

119 See *Attorney-General's Reference: In re The State v Marapo* [2002] 2 BLR 26.

process and timeline for conducting these tests, thus leaving these critical issues open to interpretation by law enforcement agents and courts. This lack of precision is likely to lead to procedural unfairness. There is also uncertainty, in most HIV-specific laws, about the rationale for imposing compulsory HIV testing in the context of sexual offences. Is the HIV test aimed at informing victims of sexual offences? Or is it intended to support a guilty verdict in a criminal law case? Or is the HIV test result expected to serve as an element for the imposition of higher penalties in the context of sexual offences? Who receives the result of the HIV test? Is it only the court? Does the alleged offender also receive it? None of these questions is clearly addressed under these laws.

Several HIV-specific laws in sub-Saharan Africa can also be criticised from a public health perspective because they may lead in practice to (over)focusing on the alleged offender to the detriment of survivors of sexual offences.[120] Instead of focusing on the alleged perpetrator of a sexual offence, HIV-specific laws should rather ensure that public health authorities and law enforcement agents provide and facilitate access to post-exposure prophylaxis (PEP) and support services for the survivors of sexual offences to prevent the transmission of HIV and other sexually-transmitted infections.[121] In fact, most HIV-specific laws that allow explicitly for compulsory HIV testing of sexual offenders do not provide for PEP and other necessary medical and psychological services for survivors of sexual offences.

Finally, compulsory HIV testing for sexual offenders appears to be unnecessary from a public health perspective.[122] This is because a negative HIV test result of the alleged offender does not conclusively prove that the survivor of the sexual offence was not exposed to HIV infection. Some alleged offenders might indeed be in the 'window period', during which period the rapid test used in the majority of sub-Saharan African countries will not detect the antibodies that indicate HIV infection.[123] Similarly, a positive HIV result of the offender does not mean that the survivor has contracted HIV. It is therefore precarious from a public health perspective to base access to HIV services for survivors of sexual offences on the HIV test results of the alleged offender. Also, by providing for compulsory HIV testing for all sexual offences without any consideration of the nature of sexual acts and the actual risk of HIV that they involve, HIV-specific laws contribute to perpetuating misinformation and prejudice about HIV and its modes of transmission.

120 Roehrs (n 116 above); Naidoo & Govender (n 116 above).

121 See DJ Mcquoid-Mason 'Free provision of PEP and medical advice for sexual offence victims: What should doctors do?' (2008) 98 *South African Medical Journal* 847-848.

122 Roehrs (n 116 above); Naidoo & Govender (n 116 above).

123 As above.

Arguably, provisions relating to compulsory HIV testing of sexual offenders in HIV-specific laws may be deemed to violate human rights because they are overly broad, unnecessary and do not hold any health benefit for survivors of sexual violence.[124]

3.3.2 Partner notification

Partner notification is a public health measure that seeks to reduce the 'burden of asymptomatic disease in the community and to shorten the average period of infectiousness for a given disease' with the expectation that this will reduce the transmission of the disease.[125] It consists of identifying the sexual partners of people living with HIV and informing them that they may have been exposed to HIV, so as to ensure that they are tested and receive treatment, if required.[126] Well established in the context of sexually-transmitted diseases (STDs), at least in Western countries,[127] partner notification raises human rights and ethical concerns in the context of HIV and its utility is often questioned.[128] Yet, in recent years, the recognition of the prophylactic and prevention benefits of early initiation of anti-retroviral therapy seems to be leading to a renewed consideration of partner notification.[129]

From a human rights perspective, partner notification requires striking a balance between the preservation of the individual right to privacy of the person living with HIV and the protection of public health, particularly in relation to the partner who may be at risk of HIV transmission or who may be HIV positive but may not be aware of it.[130] Unlike partner notification done with the consent of the person

124 As above.

125 M Adler & F Cowan 'Sexually-transmitted infections' in R Detels et al (eds) *Oxford textbook of public health Volume 3 The practice of public health Fourth edition* (2002) 1449.

126 As above.

127 EP Richards III 'HIV: Testing, screening and confidentiality – An American perspective' in R Bennett & CA Erin (eds) *HIV and AIDS: Testing, screening and confidentiality* (1999) 75-90.

128 See CG Pottker-Fishel 'Improper bedside manner: Why state partner notification laws are ineffective in controlling the proliferation of HIV' (2007) 17 *Health Matrix* 147-179; LA Gostin & JG Hodge Jr 'Piercing the veil of secrecy in HIV/AIDS and other sexually-transmitted diseases: Theories of privacy and disclosure in partner notification' (1998) 9 *Duke Journal of Gender, Law and Policy* 10-88; S Bott & CM Obermeyer 'The social and gender context of HIV disclosure in sub-Saharan Africa: A review of policies and practices' (2013) 10 *Journal of Social Aspects of HIV/AIDS* s5-s16.

129 See, eg, European Centre for Disease Prevention and Control 'Technical report: Public health benefits of partner notification for sexually-transmitted infections and HIV' 2013 http://www.ecdc.europa.eu/en/publications/Publications/Partner-notification-for-HIV-STI-June-2013.pdf (accessed 10 February 2015); National AIDS Trust 'HIV partner notification: A missed opportunity?' 2012 http://www.nat.org.uk/media/files/policy/2012/may-2012-hiv-partner-notification.pdf (accessed 15 February 2015).

130 S Roehrs 'Privacy, HIV/AIDS and public health interventions' (2009) 126 *South African Law Journal* 381-382; Pottker-Fishel (n 128 above); Gostin & Hodge (n 128 above) 62-68.

living with HIV, it is involuntary partner notification that raises serious ethical, human rights and practical issues.[131] As it overrides the right to privacy of the person living with HIV, involuntary partner notification must be strictly framed so as to prevent abuse.[132]

In practice, partner notification involves disclosure of confidential information about a patient by the health care worker, either directly to sexual partners or indirectly through public health officers.[133] This raises issues about the privileged nature of the relationship between patients and health practitioners.[134] The protection of the doctor-patient relationship is not just an ethical and legal duty on health care workers. It is also necessary to ensure trust in health care systems so that people come forward to seek HIV and other health services. As noted by the European Court of Human Rights:[135]

> Respecting the confidentiality of health data is a vital principle … It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general.

The International Guidelines, therefore, provide narrow circumstances for regulating involuntary partner notification so as to protect human rights, while pursuing public health goals.[136] On the basis of the International Guidelines and best available recommendations, the following four key elements are highlighted to assess the provisions on involuntary partner notification in HIV-specific laws adopted in sub-Saharan Africa. These are that (i) the opportunity to notify should first be given to the HIV-positive person; (ii) partner notification is an option (not an obligation) for the health care provider; (iii) notification should only occur where there is a risk of HIV infection to another;[137] and (v) fear of violence and other serious negative consequences should preclude partner notification by health care workers.[138]

The assessment of HIV specific laws in sub-Saharan African countries shows that nearly all of them (21 out of 26) have provisions allowing for involuntary partner notification. In 17 of these countries, involuntary partner notification can occur only after the person living with HIV has first been given the opportunity to inform the sexual partner but did not do so. In a significant number of countries (17 out

131 As above.
132 As above.
133 Richards (n 127 above).
134 Roehrs (n 130 above) 381-382; Pottker-Fishel (n 128 above) 156-157; Gostin & Hodge Jr (n 128 above) 62-68.
135 *I v Finland* ECHR (Application 20511/03) 17 July 2008 para 38.
136 UNAIDS & OHCHR (n 27 above) para 20(g).
137 As above.
138 This element is not part of the provisions on involuntary partner notification of the International Guidelines, but is recommended by UNAIDS because of the serious negative consequences of non-voluntary HIV disclosure, particularly for women. See UNAIDS (n 12 above).

of 21), partner notification is an option (choice) for health care workers who can decide whether to notify the sexual partner. Some 11 countries require the existence of a risk of HIV transmission to the sexual partner as a condition for involuntary notification. Only four countries provide for fear of violence as a reason that precludes involuntary partner notification (see Table 2).

Table 2: Involuntary partner notification in HIV-specific laws

Countries allowing for involuntary partner notification (21 countries)	**Opportunity first given to HIV positive person to notify** (17 countries)	**Option to notify for health care worker** (17 countries)	**Risk of HIV infection as reason for notification** (11 countries)	**Fear of violence as reason for not notifying** (4 countries)	**Timeline for notification** (7 countries)
Angola (sec 13(2))	No	Yes	Yes	No	No
Benin (arts 4 & 6)	Yes	Yes	Yes	No	No
Burkina Faso (arts 7 & 8)	Yes	No (obligation)	No	No	Yes (immediately, art 7)
Burundi (art 28)	Yes	No (obligation)	No	No	No
Cape Verde (art 22)	Yes	Yes	No	No	Yes (6 weeks, art 22(1))
Chad (art 51)	Yes	No (obligation)	No	No	No
Central African Republic (art 8(4))	No	Not provided	Yes	No	No
Comoros (art 33)	Yes	Yes	Yes	Yes	No
Cote d'Ivoire (arts 11 &12)	Yes	Yes	No	No	Yes (3 months, art 12)
DRC (art 41)	Yes	Yes	No	No	Yes (immediately art 41)
Guinea (art 23)	Yes	Yes	Yes	Yes	No
Guinea-Bissau (art 26)	Yes	Yes	No	No	Yes (6 weeks, art 26(1))
Kenya (sec 24(7))	Yes	Yes	No	No	No
Liberia (sec 18(24))	Yes	Yes	Yes	Yes	No
Madagascar (art 63)	Yes	Yes	Yes	No	No
Mali (art 27)	Yes	Yes	No	No	Yes (6 weeks, art 27(1)).
Niger (arts 15 to 17)	Yes	Yes	Yes	No	Yes (6 weeks, art 15)
Senegal (art 22)	Yes	Yes	Yes	No	No

Tanzania (sec 16(2)(c).	No	Yes	No	No	No
Togo (art 10)	Yes	Yes	Yes	Yes	No
Uganda (sec 18(2)(e)	No	Yes	Yes	no	No

There are two positive elements that stem from this analysis. First, a significant number of countries (17 out of 21) allowing for involuntary partner notification give the opportunity to notify others to the person living with HIV. Second, the same number of countries (17) has made involuntary partner notification an option for health care workers, not an obligation (see Table 2). Yet, involuntary partner notification provisions in HIV-specific laws raise several serious human rights, public health and practical concerns. Ten countries allow for involuntary partner notification even in cases where there is no risk of HIV infection to the sexual partner of the person living with HIV (see Table 2). For instance, under these laws, sexual partners with whom the person living with HIV engaged only in protected sex or sexual acts that carry no risk of HIV infection may still be notified. Such provisions are overly broad and unnecessary.

Under the conditions provided in the International Guidelines, there is no set timeline for involuntary partner notification. In view of the complexity of partner notification, the determination of the moment for notifying should be done on a case-by-case basis, taking into consideration the personal circumstances of those involved, including the psychological state of the HIV-positive person and the partner to be notified. The International Guidelines recommend in this regard that 'health-care professionals decide, on the basis of each individual case'.[139] Despite this recommendation, seven countries set strict timelines after which involuntary partner notification can take place (see Table 2). In DRC and Burkina Faso, people living with HIV must disclose immediately after becoming aware of their HIV status. In Cape Verde, Guinea-Bissau, Mali and Niger, the timeline for disclosure is six weeks. In Côte d'Ivoire, it is three months. Past these periods, involuntary partner notification may take place. There is no scientific or medical rationale for the selection of the six-week or three-month periods as the threshold for involuntary notification. It rather seems that the six-week timeline was replicated from article 26 of the N'Djamena Model Law.[140] In fact, countries that have adopted this period have also adopted several other problematic provisions from this Model Law.[141]

Involuntary partner notification provisions also pose serious practical and resource issues. It is unclear from most of these

139 UNAIDS & OHCHR (n 27 above) para 20(g).

140 See art 26 of Model Legislation on HIV/AIDS for West and Central Africa; Pearshouse (n 11 above) 6-7.

141 Pearshouse (n 11 above).

provisions which specific category of health workers can conduct partner notification. Is it a doctor, an HIV counsellor, or any person who provides health care services to people living with HIV? The determination of this issue is not a moot point. In sub-Saharan African countries where health care workers and health systems are already overburdened, the implementation of partner notification is likely to create serious additional constraints. In a region where the average density of physician per 1 000 people is less than 0,5,[142] one cannot reasonably expect medical doctors to take on the task of identifying and notifying the sexual partners of persons living with HIV. In fact, the critical issues of training and of human and financial resources to adequately undertake partner notification are eluded in most HIV-specific laws.

Involuntary partner notification can also lead to discrimination, violence and other forms of human rights violations, particularly for women.[143] Yet, only four out of the 21 countries allowing for involuntary partner notification recognise fear of violence and other serious negative consequences as reasons for not notifying. As noted by the Special Rapporteur on Torture, '[u]nauthorised disclosure of HIV status to sexual partners … is a frequent abuse against people living with HIV that may lead to physical violence'.[144] By failing to address fear of violence as a limitation to disclosure and partner notification, these HIV-specific laws are likely to expose people living with HIV to violence, but also to the possibility of overly-broad criminal prosecution for HIV non-disclosure, exposure and transmission. These provisions are also likely to have negative public health consequences because fear of involuntary disclosure has been shown to be among the factors that prevent people from seeking HIV testing and other services.[145]

Ultimately, only four countries (Comoros, Guinea, Liberia and Togo) have adopted all four key conditions relating to involuntary partner notification under the International Guidelines and UNAIDS recommendations (see Table 2).

142 See WHO 'Health workforce density of physicians (total number per 1 000 population): Latest available year' http://gamapserver.who.int/gho/interactive_charts/health_workforce/ PhysiciansDensity_Total/atlas.html (accessed 7 March 2015).

143 KH Rothenberg & SJ Paskey 'The risk of domestic violence and women with HIV infection: Implications for partner notification, public policy, and the law' (1995) 85 *American Journal of Public Health* 1569-1576; JE Maher et al 'Partner violence, partner notification, and women's decisions to have an HIV test' (2000) 25 *Journal of Acquired Immune Deficiency Syndromes* 276-282.

144 Report of the Special Rapporteur on Torture (n 108 above) para 71.

145 A Medley et al 'Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: Implications for prevention of mother-to-child transmission programmes' (2004) 82 *Bulleting of the World Health Organization* 299-307; S Maman et al 'HIV status disclosure to families for social support in South Africa (NIMH Project Accept/HPTN 043)' (2014) 26 *AIDS Care* 226-232.

3.4 Criminalisation of HIV non-disclosure, exposure and transmission

Under international law, each country can choose which behaviours and practices should be subject to the criminal law.[146] However, there are principles of criminal law and human rights that should guide the definition and content of criminal law offences and related penalties.[147] In the context of HIV, it has been argued that the appropriateness of criminal law provisions applicable to the epidemic can be questioned, and their compliance with criminal law principles and human rights standards interrogated, if it appears that these provisions undermine efforts to address HIV.[148]

In particular, serious concerns have over the years been raised about the application of criminal law, through HIV-specific provisions or general criminal law offences, to prosecute individuals who allegedly do not disclose their HIV status prior to sexual relations (HIV non-disclosure), who expose others to HIV (HIV exposure), or who transmit HIV (HIV transmission).[149] These concerns are related to the human rights and public health consequences of such application of the criminal law in the context of HIV.[150] Human rights concerns point to the fact that such criminalisation (i) often ignores the latest scientific and medical knowledge relevant to HIV; (ii) disregards generally-applicable criminal law principles; and (iii) frequently results in disproportionately harsh sentences.[151] Public health arguments stress that there is no evidence that criminal law is an effective tool for HIV prevention and points to the possible negative impact on access and uptake of HIV services because of such criminalisation.[152] On their part, proponents of the criminalisation of HIV non-disclosure, exposure or transmission argue that it may help prevent behaviour that leads to HIV transmission, educate the public on HIV and

146 See, eg, J Pradel *Droit penal général* (2007) 24-25.

147 See, eg, C Bassiouni 'Human rights in the context of criminal justice: Identifying international procedural protections and equivalent protections in national constitutions' (1993) 3 *Duke Journal of Comparative and International Law* 235-297.

148 Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health A/HRC/14/20 27 April 2010 15-22; UNAIDS *Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations* (2013) 7-10.

149 See S Burris & E Cameron 'The case against criminalisation of HIV transmission' (2008) 300 *Journal of the American Medical Association* 578-581; CL Galletly & SD Pinkerton 'Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV' (2006) 10 *AIDS and Behaviour* 451-461; UNAIDS (n 148 above) 7-10; EJ Bernard *HIV and the criminal law* (2010); Report of the Special Rapporteur on Health (n 148 above).

150 As above.

151 As above.

152 As above.

reinforce social norms against 'reprehensible HIV-related behaviour'.[153]

The UNAIDS guidance note on ending the overly-broad criminalisation of HIV non-disclosure, exposure and transmission (guidance note)[154] is, to date, the most elaborated global document specifically addressing and providing recommendations on the criminalisation of HIV non-disclosure, exposure and transmission. The guidance note expounds on earlier UN recommendations on HIV and the criminal law.[155] It reiterates that there is no evidence that the criminalisation of HIV non-disclosure, exposure and transmission is an effective measure to address HIV, and sets out key principles that should guide any use of the criminal law in this area.[156] Six of these principles will be used here to assess the content of provisions criminalising HIV non-disclosure, exposure and transmission in the HIV-specific laws adopted in sub-Saharan African countries. These principles are (i) to limit criminal liability to cases of intentional HIV transmission (negligent or reckless transmission should not be criminalised); that there is (ii) no criminal liability in cases of mere non-disclosure or exposure where transmission has not occurred; (iii) no criminal liability in cases involving condom use; (iv) no criminal liability where the person living with HIV has a low viral load or is on effective treatment; (v) no criminal liability when the person did not know his or her HIV status; and (vi) no criminal liability in case of disclosure of HIV status prior to a sexual act.[157]

The review of HIV-specific laws in sub-Saharan Africa shows that nearly all of the countries (24 out of 26) criminalise HIV non-disclosure, exposure or transmission (see Table 3).[158] Of these, only nine countries restrict criminalisation to cases involving actual transmission of HIV (see Table 3). Eight countries criminalise HIV non-disclosure and 12 countries criminalise HIV exposure where transmission did not occur. Seven countries allow for criminal liability on the basis of negligence or recklessness (see Table 3). Only eight countries exclude criminal liability in cases involving condom use or the practice of safe sex (see Table 3). Seven countries have provisions that could be interpreted to bar criminal liability when a person has a

153 C van Wyk 'The need for a new statutory offence aimed at harmful HIV-related behaviour: The general public interest perspective' (2000) 41 *Codicillus* 2-10; DHJ Hermann 'Criminalising conduct related to HIV transmission' (1990) 9 *Saint Louis University Public Law Review* 351.

154 UNAIDS (n 148 above).

155 UNAIDS *Criminal law, public health and HIV transmission: A policy options paper* (2002); UNAIDS & United Nations Development Programme (UNDP) 'Criminalisation of HIV transmission: Policy brief' 2008 http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/dataimport/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf (accessed 7 March 2015).

156 UNAIDS (n 148 above) 7-8.

157 UNAIDS (n 148 above).

158 Comoros and Mauritius are the only two countries with HIV-specific laws that do not criminalise HIV non-disclosure, exposure and transmission.

low viral load or is on effective HIV treatment (see Table 3). Finally, seven countries allow for criminal liability only for people who are aware of their HIV status and eight countries recognise disclosure to the sexual partner as a shield against criminal liability (see Table 3).

The fact that almost all countries with HIV-specific laws in sub-Saharan Africa criminalise HIV non-disclosure, exposure and transmission is often cited to epitomise the embrace of coercive approaches in HIV-specific laws in the region.[159] The significant number of countries that allow for prosecution without an intention to transmit HIV and, in the case of HIV non-disclosure and exposure where HIV has not been transmitted, raises serious concerns relating to the fair application of the criminal law.[160] That 16 countries allow for the criminalisation of people living with HIV even when they engage in protected sex is also a major concern as it clearly contravenes HIV prevention efforts based on condom use and introduces a disincentive for protected sex.[161] Condom use is a central element of HIV prevention efforts among sexually-active individuals.[162] For people living with HIV, the consistent and correct use of latex condoms is recommended to protect themselves (against the risk of re-infection with HIV or infection with other sexually-transmitted infections) and others (against the risk of onward transmission).[163] Therefore, allowing the criminal prosecution of individuals who use condoms would not only be unfair, but it also risks undermining HIV prevention efforts.

Although no country explicitly addresses low viral load and effective HIV treatment, the provisions in HIV-specific laws limiting criminal liability to acts involving a significant risk of HIV transmission can be interpreted to cover this situation. This is the case in Congo, Côte d'Ivoire, Guinea, Liberia, Mozambique, Senegal and Sierra Leone (see Table 3). Medical and scientific advances in the context of HIV demonstrate that people with a low viral load or who are on effective HIV treatment pose no significant risk of transmission.[164] Recognising these two elements as excluding criminal liability is, therefore, in line with best scientific and medical evidence relating to HIV. Recently, a number of scientists, public health authorities and courts in Europe

159 Pearshouse (n 11 above); Kazatchkine (n 35 above); Eba (n 8 above).

160 UNAIDS explicitly opposes the application of criminal sanction in cases where people did not know their HIV status and where HIV was not transmitted. See UNAIDS (n 148 above).

161 The failure to promote the use of condoms is also identified as a major flaw in HIV-specific criminal laws adopted in the United States. See Galletly & Pinkerton (n 149 above) 453-456.

162 UNAIDS, WHO & UNFPA 'Position statement on condoms and HIV prevention' July 2004 http://www.unfpa.org/upload/lib_pub_file/343_filename_Condom_statement.pdf (accessed 14 December 2008).

163 When used consistently and correctly, latex condoms significantly reduce the risk of HIV transmission. See SC Weller & K Davis-Beaty 'Condom effectiveness in reducing heterosexual HIV transmission (Review)' (2002) 1 *Cochrane Database of Systematic Reviews* 1-22.

and Canada have concluded that people with a low viral load or who are on effective HIV treatment should not be criminalised for HIV non-disclosure, exposure and transmission.[165] However, in most HIV-specific laws, criminal liability is not limited to acts that carry a significant risk of HIV transmission. In countries such as Mauritania and Guinea-Bissau, HIV transmission is defined as 'any attempt to a person's life by the inoculation of substance infected with HIV, regardless of how these substances were used or employed and independently of the consequences thereof'.[166] This provision is extremely vague and may be used to target a wide range of activities without consideration of the reality of the risk of HIV transmission involved.

In 16 countries, vague criminal law provisions could be invoked to prosecute a woman who transmits HIV to her child during pregnancy, delivery or breast-feeding (see Table 3). In Sierra Leone, the HIV Act of 2007 explicitly provided for such prosecution.[167] The outcry created by this provision and its potential negative impact on women's willingness to come forward for HIV services led to the revision of Sierra Leone's HIV law to explicitly exclude the prosecution of mother-to-child transmission of HIV.[168] Similarly, recently adopted HIV-specific laws in six countries also explicitly exclude the criminalisation of mother-to-child transmission of HIV.[169]

The failure to recognise HIV disclosure by the person living with HIV as a barrier to criminal liability in 16 countries is worrying and also paradoxical. In fact, in many of these laws, disclosure is encouraged and the failure to disclose is often punished. The failure to protect those who disclose their HIV status and obtain the informed consent

164 MS Cohen et al 'Prevention of HIV-1 infection with early anti-retroviral therapy' (2011) 365 *New England Journal of Medicine* 493-505; TC Quinn et al 'Viral load and heterosexual transmission of human immunodeficiency virus type 1' (2000) 342 *New England Journal of Medicine* 921-929; J Castilla et al 'Effectiveness of highly active anti-retroviral therapy in reducing heterosexual transmission of HIV' (2005) 40 *Journal of Acquired Immune Deficiency Syndromes* 96-101.

165 See M Loutfy et al 'Canadian Consensus Statement on HIV and its transmission in the context of the criminal law' (2014) 25 *Canadian Journal of Infectious Diseases and Medical Microbiology* 135-140; *'S' v Procureur Général*, Arrêt, 23 February 2009 (Chambre pénale) (Genève); P Vernazza et al 'Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle' (2008) 89 *Bulletin des médecins suisses* 165-169.

166 Arts 1 & 23 HIV law of Mauritania and art 37 and '*concept de base*' HIV law of Guinea-Bissau.

167 Art 21(2) of the Prevention and Control of HIV and AIDS Act 2007 of Sierra Leone provides that '[a]ny person who is and is aware of being infected with HIV or is carrying and is aware of carrying HIV antibodies shall not knowingly or recklessly place another person, and in the case of a pregnant woman, the foetus, at risk of becoming infected with HIV, unless that other person knew that fact and voluntarily accepted the risk of being infected with HIV'.

168 Sec 37(2)(g) of the HIV law of Sierra Leone of 2011 explicitly excludes the criminalisation of mother-to-child transmission of HIV.

169 Congo (art 42); Côte d'Ivoire (art 51); Guinea (art 37); Liberia (sec 18(27)(b)(viii)); Senegal (art 36); and Togo (art 36).

of their sexual partners before sex further illustrates the conflict between HIV-specific laws and public health messages.[170] Indeed, in spite of its many challenges,[171] the disclosure of HIV status to sexual partners is encouraged as a measure of HIV prevention and as an element that may foster support for the person living with HIV and help reduce stigma.[172] Furthermore, disclosure and informed consent to sexual acts are important elements of the sexual and reproductive health rights of people living with HIV who may agree with their partners to have unprotected sex for several reasons, including procreation.[173] The prosecution of people living with HIV who inform their partners and obtain their consent is unfair and is likely to have a negatively impact on disclosure.

A further problem in HIV-specific laws is what can be termed 'over-criminalisation'.[174] This refers to the fact that, in the same HIV-specific law, several provisions can be used to prosecute HIV non-disclosure, exposure or transmission. A typical example of over-criminalisation can be found in the HIV law of Burkina Faso. This HIV law contains three separate provisions with different constitutive elements that may be applied to the criminalisation of HIV non-disclosure, exposure or transmission. These are article 20, which criminalises the sexual transmission of HIV; article 22, which addresses 'transfer of substances' infected with HIV and could also be used to punish the sexual transmission of HIV; and, finally, article 26, which criminalises any person living with HIV who does not take the necessary precautions to protect his or her partners.[175] This over-criminalisation is likely to be a source of confusion for people living with HIV as well as for those responsible for implementing HIV-specific laws. For instance, on the basis of a provision of the law, a person living with HIV may consistently practise sex with condoms, yet another vague provision in the same law may be invoked to prosecute that person for HIV non-disclosure, exposure or transmission. This problem is also evident in the HIV laws of the Central African Republic and Mauritania which have provisions that prevent the prosecution of people living with HIV who engage in 'protected sex' (which includes the use of condoms).[176] However, these provisions are made irrelevant by the

170 See Galletly & Pinkerton (n 149 above) 453-456.

171 There are several challenges associated with the promotion of disclosure, especially for women who have been reported to face negative reactions ranging from abandonment to violence. See Medley et al (n 145 above); Maman et al (n 145 above).

172 See Chesney & Smith (n 81 above); EN Waddell & PA Messeri 'Social support, disclosure, and use of anti-retroviral therapy' (2006) 10 *AIDS and Behaviour* 263-272.

173 See GNP+ et al *Advancing the sexual and reproductive health and human rights of people living with HIV: A guidance package* (2009).

174 Eba (n 8 above) 5.

175 Arts 20, 21 & 22 HIV law of Burkina Faso.

176 See art 34 of the HIV law of Central African Republic and art 23 of the HIV law of Mauritania.

fact that these laws also contain other provisions that may be used to prosecute people living with HIV even when they use condoms.[177]

As described above, the majority of provisions criminalising HIV non-disclosure, exposure and transmission in HIV-specific laws do not meet the standards set in the UNAIDS guidance note. Many ignore basic criminal law principles of legality, foreseeability, intent, causality, proportionality and proof that should serve as the basis for the definition of offences and the imposition of penalties.[178] These criminal law provisions allow for the prosecution for acts that constitute no or very little risk of HIV infection; they fail to recognise condom use, low viral load and effective HIV treatment; and allow for the criminalisation of people who have taken steps to inform their sexual partners and obtain their consent prior to sex. Laws that allow for such use of the criminal law are overly broad, violate criminal law principles, trump human rights and are unfair.[179] These provisions are often based on myths and misconceptions about HIV and its modes of transmission, and they risk undermining effective public health efforts that are based on the use of condoms and on encouraging disclosure. At a time when efforts are being made to end the AIDS epidemic in Africa and to globally focus on expanding access to HIV testing,[180] these overly-broad criminal law provisions are likely to be counterproductive. The provisions will discourage people from coming forward for HIV testing and will negatively impact the patient-doctor relationship.[181]

4 Conclusion and recommendations

HIV-specific laws are now part of the legal frameworks of a majority of countries in sub-Saharan Africa and the trend in favour of these laws is still increasing.[182] An analysis of these laws shows that they include both protective and punitive provisions. Protective provisions often covered in these laws relate to non-discrimination. Yet, many of these protective clauses, such as general non-discrimination provisions and protection in the context of employment, are often not strong

177 See arts 35, 37, 38 & 39 of the HIV law of Central African Republic and art 23 of the HIV law of Mauritania.

178 UNAIDS (n 147 above) 7.

179 UNAIDS (n 147 above).

180 UNAIDS 'Fast-Track: Ending the AIDS epidemic by 2030' 2014 http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf (accessed 8 February 2015).

181 See Galletly & Pinkerton (n 149 above); P O'Byrne et al 'Non-disclosure prosecutions and population health outcomes: Examining HIV testing, HIV diagnoses, and the attitudes of men who have sex with men following non-disclosure prosecution media releases in Ottawa, Canada' (2013) 13 *BMC Public Health* 94.

182 Only in 2014, three countries (Côte d'Ivoire, Comoros and Uganda) have adopted such laws and, at the time of writing, at least one country (Malawi) was working towards the development of an HIV-specific law.

enough to effectively guarantee the human rights of people living with HIV and those affected by the epidemic. Typically, most general non-discrimination provisions cover discrimination based solely on one's actual HIV status. However, many omit critical areas such as discrimination based on another person's status, discrimination based on perceived or presumed HIV status as well as indirect discrimination. The strength of non-discrimination provisions covering specific areas such as education, housing, health and insurance varies greatly. These weaknesses are concerning because a central reason for adopting HIV-specific laws is that they provide clarity and specific protection of the human rights of people living with HIV, rather than leaving it to the courts to guarantee those rights in the context of litigation. The clarity of legislative provisions is also important in sub-Saharan Africa where access to justice remains a serious challenge, particularly for people living with HIV.

Punitive provisions appear to be a defining feature of HIV-specific laws, both in terms of the number of countries that have adopted punitive provisions and with regard to the diversity of restrictive provisions provided in these laws. This situation is paradoxical because a main argument for the adoption of these laws has been the 'need to protect people living with HIV'.[183] Restrictive provisions often covered in these laws include compulsory HIV testing, particularly for alleged sexual offenders, involuntary partner notification and the criminalisation of HIV non-disclosure, exposure and transmission. In the great majority of cases, these provisions are overly broad, they disregard best available recommendations for legislating on HIV, fail to pass the human rights test of necessity, proportionality and reasonableness, consecrate myths and prejudice about people living with HIV, and risk undermining effective responses to the HIV epidemic. Exceptionally, recently-adopted or revised HIV-specific laws appear to have more evidence-informed and rights-based provisions. In addition, criminal law provisions and limitation of rights under these recent laws are often more narrowly drafted. This is due to the increased scrutiny by, and involvement of, key actors, including civil society, human rights groups and the UN in the development of these laws in recent years following the concerns raised by the N'Djamena Model Law and the laws based thereon.

The study, therefore, concludes that the content of HIV-specific laws in sub-Saharan Africa is generally inadequate. Most of the laws fail to uphold human rights standards and best available public health recommendations relating to HIV. By embracing various coercive and overly-broad provisions against people living with HIV, these laws are unlikely to support efforts to break the stigma and fear that still keep people from seeking HIV services. Furthermore, by failing to adopt enabling provisions for populations such as sex workers, young people and men who have sex with men, who are particularly vulnerable to

183 Eba (n 8 above) 1.

HIV, these laws appear as symbolic responses that do not address critical issues of protection and access to services for key populations in sub-Saharan Africa. It has been argued that, in many instances, HIV-specific laws were adopted in an attempt by parliamentarians and governments to signal to the population that they were taking 'tough measures' to address HIV.[184]

While acknowledging the glaring gaps and serious concerns in HIV-specific laws, the study also concludes that these laws do have some merit as they offer some human rights protection, particularly in relation to non-discrimination. The study, therefore, calls for a two-pronged approach in dealing with HIV-specific laws in sub-Saharan Africa. First, the study calls for a thorough analysis of the content of HIV-specific laws in all countries where they exist. The benefit of a general overview, such as the one presented in this study, must be completed by an analysis of each HIV-specific law through a process that involves human rights and public health experts, people living with HIV, HIV programme implementers and parliamentarians, among others. Such an analysis will ensure that the gaps and concerns in HIV-specific laws are outlined and that efforts urgently are put in place to address these concerns. Where possible, these gaps should be addressed through regulations that could clarify the content of the law. In contexts where these issues cannot be addressed through regulations, amendments or legislative reform should be pursued.

Second, this study calls for paying more attention to the enforcement of protective provisions in existing HIV-specific laws. While efforts are to be continued for reforming the most concerning aspects of HIV-specific laws,[185] these efforts should be accompanied by renewed action by civil society, people living with HIV and others to identify and support the implementation of protective provisions under these laws, such as those relating to the prohibition of discrimination in employment or in schools and equal access to health care services. Such an approach seems to have been adopted in Kenya, where civil society organisations have successfully challenged the provisions in the HIV law criminalising HIV transmission,[186] while at the same time playing a critical role in supporting the establishment of the HIV and AIDS Tribunal provided for under this law, as an important mechanism for the protection of the rights of people living with HIV.[187] If effectively pursued, this two-pronged approach could ensure that HIV-specific laws deliver on their stated

184 See Pearshouse (n 11 above); Grace (n 12 above).

185 Efforts to change problematic HIV-specific laws are by their very nature a protracted endeavour. While in countries such as Sierra Leone, Congo and Togo these efforts have succeeded in reforming key punitive provisions, in other countries, such as Burkina Faso, DRC, Mauritania and Niger, reform efforts have stalled.

186 *AIDS Law Project v Attorney General & 3 Others* Kenya High Court [2015] eKLR.

187 See D Njagi 'HIV-positive Kenyans need tribunal to address rights violations' *IPS* 3 August 2010 http://www.ipsnews.net/2010/08/hiv-positive-kenyans-need-tribunal-to-address-rights-violations/ (accessed 7 March 2015).

objective: the protection of people living with, vulnerable to or affected by HIV.

Table 3: Criminalisation of HIV non-disclosure, exposure and transmission in HIV-specific laws

Country	Criminalises HIV non-disclosure	Criminalises HIV exposure	Criminalises HIV transmission	Limited to Intentional acts	Negligent or reckless acts	Applicable to MTCT	Elements that exclude criminal liability			
							Knowledge of HIV infection	Disclosure or informed consent	Condom use and other precautions	Effective HIV treatment or low viral load
Angola (arts 14 & 15)	Yes (art 14)	No	Yes (art 15(1))	Yes (art 15(1))	Yes (art 15(2))	Yes	No	No	No	No
Benin (art 27)	Yes (art 27)	No	No	No	No	No (specific to sex)	Yes	Yes	No	No
Burkina Faso (arts 20, 22 & 26)	Yes (art 20)	No	Yes (art 22)	Yes (art 22)	No	Yes (art 22)	No	No	Yes (arts 20 & 26)	No
Burundi (art 42)	No	No	Yes (art 42)	Yes (art 42)	No	Yes	No	No	No	No
Cape Verde (art 30)	No	No	Yes (art 30)	No (arts 30 & 2)	No	Yes	No	No	No	No
CAR (arts 34, 35, 37, 38 & 39)	Yes (art 39)	Yes (art 37)	Yes (art 35)	Yes (art 35)	Yes	Yes (arts 37 & 38)	No	No	No	No
Chad (arts 54 & 55)	No	No	Yes	No	Yes (art 55)	Yes	No	No	No	No
Congo (arts 41 & 42)	No	No	Yes	Yes	No	No (excluded by art 42)	Yes (art 42)	Yes (art 42)	Yes (art 42)	Yes

Côte d'Ivoire (arts 48 to 51)	Yes (art 48)	Yes (arts 48 & 49)	No	Yes (art 48)	No	No (excluded by art 51)	Yes (art 51)	Yes (art 51)	Yes (art 51)	Yes
DRC (art 45)	No	No	Yes	Yes	No	Yes	No	No	No	No
Guinea (arts 34, 35, 36 & 37)	Yes (art 35)	Yes (art 35)	Yes (art 34)	Yes (art 34)	No	No (excluded by art 37)	Yes (art 37(c))	Yes (art 37(e))	Yes (art 37(d))	Yes
Guinea-Bissau (art 37)	No	Yes	Yes	No	No	Yes	No	No	No	No
Kenya (sec 24)	Yes (sec 24(1))	Yes (sec 24(2))	No	Yes (sec 24(2))	Yes (sec 24(2))	Yes	Yes	Yes	No (sec 24(2))	No
Liberia (secs18(27)(a) & 18(27)(b))	No	Yes (sec 18(27)(a))	Yes (18(27)(a))	Yes (sec 18 (27)(a)	No	No (sec 18(27)(b)(viii))	Yes (sec 18(27)(b)(ii))	Yes (sec 18(27)(b)(v))	Yes (sec 18(27)(b)(iv))	Yes
Madagascar (art 67)	No	No	Yes (art 67)	No (art 67)	Yes (art 67)	Yes	No	No	No	No
Mali (art 37)	No	Yes	No	Yes	No	Yes	No	No	No	No
Mauritania (art 23)	Yes	Yes (art 23)	No	No	Yes (art 23)	Yes	No	No	No	No
Mozambique (art 52)	No	No	Yes	No	No	Yes	No	No	Yes (art 52(2)	Yes (art 52(2)
Niger (arts 39 & 40)	No	Yes (arts 39 & 40)	No	Yes (art 39)	Yes (art 40)	Yes (arts 39 & 40)	No	No	No	No
Senegal (art 36)	No	Yes (art 36)	No	Yes	No	No (excluded by art 36)	Yes	No	Yes	Yes (art 36)

Sierra Leone (secs 37(1) & 37(2))	No	No	Yes (sec 37(1))	Yes (sec 37(1))	No	No (excluded by sec 37(2)(g))	Yes (sec 37(2)(b)	Yes (sec 37(2)(e)	Yes (sec 37(2)(d)	Yes (sec 37(2)(a)
Tanzania (sec 47)	No	No	Yes (sec 47)	Yes (sec 47)	No	Yes (sec 47)	No	No	No	No
Togo (art 61)	No	Yes (art 61)	Yes (art 61)	Yes (art 61)	No	No (excluded by art 61)	Yes	Yes	Yes	No
Uganda (secs 41 & 43)	No	Yes (sec 41)	Yes (sec 43)	Yes (sec 43)	No	Yes (secs 41 & 43)	No	No (sec 41)	No (sec 41)	No

Annex: HIV-specific laws in sub-Saharan Africa

Country	Title of HIV-specific law	Year of adoption
1 Angola	Lei No 8/04 sobre o Virus da Immunodeficiência Humana (VIH) e a Sindroma de Immunodeficiência Adquirida (SIDA)	2004
2 Benin	Loi No 2005-31 du 5 Avril 2006 portant prévention, prise en charge et contrôle du VIH/SIDA	2006
3 Burkina Faso	Loi No 030-2008/AN portant lutte contre le VIH/SIDA et protection des droits des personnes vivant avec le VIH/SIDA	2008
4 Burundi	Loi No 1/018 du 12 Mai 2005 portant protection juridique des personnes infectées par le Virus de l'Immunodéficience Humaine et des personnes atteintes du Syndrome Immunodéficience Acquise	2005
5 Cape Verde	Loi No 19/VII/2007	2007
6 Central African Republic	Loi 06.030 de 2006 fixant les droits et obligations des personnes vivant avec le VIH/SIDA	2006
7 Chad	Loi No 19/PR/2007 du 15 Novembre 2007 portant lutte contre VIH/SIDA/IST et protection des droits des personnes vivant avec le VIH/SIDA	2007
8 Comoros	Loi No 14-011/AU du 21 avril 2014, relative aux droits des personnes vivant avec le VIH et leur implication dans la réponse nationale	2014
9 Congo	Loi No 30 - 2011 du 3 juin 2011 portant lutte contre le VIH et le SIDA et protection des droits des personnes vivant avec le VIH	2011
10 Côte d'Ivoire	Loi No 2014-430 du 14 juillet 2014 portant régime de prévention, de protection et de répression en matière de lutte contre le VIH et le SIDA	2014
11 Democratic Republic of Congo	Loi No 08/011 du 14 Juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées	2008
12 Equatorial Guinea	Ley No 3/2005 sobre la prevención y la lucha contra las infecciones de transmisión sexual (ITS), el VIH/SIDA y la defensa de los derechos de las personas afectadas	2005
13 Guinea	Ordonnance No 056/2009/PRG/SGG portant amendement de la loi L/2005/025/AN du 22 Novembre 2005 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA en République de Guinée	2009, amended HIV Law of 2005
14 Guinea-Bissau	Loi No 5/2007 du 10 septembre 2007 de la prévention, du traitement et du contrôle du VIH/sida	2007
15 Kenya	HIV and AIDS Prevention and Control Act, No 14 of 2006	2006
16 Liberia	An Act to Amend the Public Health Law, Title 33, Liberian Code of Laws Revised (1976) to Create New Chapter 18 Providing for the Control of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)	2010
17 Madagascar	Loi No 2005-040 du 20 Février 2006 sur la lutte contre le VIH/SIDA et la protection des droits des personnes vivant avec le VIH/SIDA)	2006

18 Mali	Loi No 6-028 du 29 Juin 2006 fixant les règles relatives à la prévention, à la prise en charge et au contrôle du VIH/ SIDA	2006
19 Mauritania	Loi No 2007-042 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA	2007
20 Mauritius	HIV and AIDS Act, No 31 of 2006	2006
21 Mozambique	Lei No 12/2009, estabelece os direitos e deveres da pessoa vivendo com HIV e SIDA, e adopta medidas necessárias para a prevenção, protecção e tratamento da mesma	2009
22 Niger	Loi No 2007-08 du 30 Avril 2007 relative à la prévention, la prise en charge et le contrôle du Virus de d'Immunodéficience Humaine (HIV)	2007
23 Senegal	Loi No 2010-03 du 9 avril 2010 relative au VIH/SIDA	2010
24 Sierra Leone	The National HIV and AIDS Commission Act of 2011	2011, amended HIIV Law of 2007
25 Tanzania	HIV and AIDS (Prevention and Control) Act, No 28 of 2008	2008
26 Togo	Loi No 2010-018 du 31 Décembre 2010 modifiant la loi No 2005 – 012 du 14 Décembre 2005 portant protection des personnes en matière de VIH/SIDA	2010, amended HIV Law of 2005
27 Uganda	HIV Prevention and Control Act of 2014	2014

Chapter Six

Reviewing independent access to HIV testing, counselling and treatment for adolescents in HIV-specific laws in sub-Saharan Africa: Implications for the HIV response

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Abstract

Introduction: AIDS is a leading cause of death among adolescents in sub-Saharan Africa. Yet, legal, policy and social barriers continue to restrict their access to HIV services. In recent years, access to independent HIV testing and treatment for adolescents has gained increased attention. The 2013 WHO Guidance on HIV testing and counselling and care for adolescents living with HIV (WHO Guidance) calls for reviewing legal and regulatory frameworks to facilitate adolescents' access to comprehensive HIV services. As of 31 August 2014, some 27 countries in sub-Saharan Africa have adopted HIV-specific legislation. But there is limited understanding of the provisions of these laws on access to HIV services for adolescents and their implication on efforts to scale up HIV prevention, testing, treatment and care among this population.

Methods: A desk review of 26 out of 27 HIV-specific laws in sub-Saharan Africa complemented with the review of HIV testing policies in four countries using human rights norms and key public health recommendations from the 2013 WHO Guidance. These recommendations call on countries to: (i) lower the age of consent to HIV testing and counselling and allow mature adolescents who have not reached the age of consent to independently access HIV testing, (ii) ensure access to HIV counselling for adolescents, (iii) protect the confidentiality of adolescents living with HIV, and (iv) facilitate access to HIV treatment for adolescents living with HIV.

Results: Most HIV-specific laws fail to take into account human rights principles and public health recommendations for facilitating adolescents' access to HIV services. None of the countries with HIV-specific laws has adopted all four recommendations for access to HIV services for adolescents. Discrepancies exist between HIV laws and national policy documents. Inadequate and conflicting provisions in HIV laws are likely to hinder access to HIV testing, counselling and treatment for adolescents.

Conclusions: Efforts to end legal barriers to access to HIV services for adolescents in sub-Saharan Africa should address HIV-specific laws. Restrictive provisions in these laws should be reformed and their protective norms effectively implemented including by translating them into national policies, and ensuring sensitisation and training of health care workers and communities.

Introduction

Adolescence (10 to 19 years)[1] is a period of dynamic transitions to adulthood characterised by rapid cognitive and physical changes, including sexual and reproductive maturation [1]. While introducing a period of positive changes, adolescence also enhances vulnerability to HIV and other sexually transmitted infections due to limited knowledge, skills and support for adolescents [1].

Although AIDS-related deaths fell by 30% globally between 2005 and 2012, they have increased by 50% among adolescents [2]. More than 80% of the 2 million adolescents living with HIV worldwide are in sub-Saharan Africa [2]. Access to HIV services among this population remains worryingly low [3]. Globally, only 10% of young men and 15% of young women are aware of their HIV status [2]. Coverage of antiretroviral treatment (ART) among adolescents is largely inadequate resulting in AIDS being a leading cause of death among this population in sub-Saharan Africa [3].

Access to HIV services is particularly limited for adolescents who belong to key populations at higher risk of HIV infection, including adolescents who engage in same-sex sexual relations, sell sex or use drugs [2,3]. For these young key populations, general vulnerabilities and barriers affecting adolescents are further compounded by stigma, discrimination and other human rights violations linked to punitive laws and practices punishing their sexual practices, behaviour or circumstances [4].

Evidence and data showing that the AIDS response is failing adolescents have recently prompted calls for facilitating their independent (autonomous) and non-discriminatory access to evidence-informed HIV prevention, testing and treatment services. In its final report, the Global Commission on HIV and the Law recommended that States address legal and policy barriers to access to HIV testing and treatment services for children [5]. Similarly, the 2013 WHO Guidance on HIV testing and counselling and care for adolescents living with HIV (WHO Guidance)

[1] Although there is no universally agreed definition of adolescence, the United Nations understands adolescents to include persons aged 10-19 years. See Adolescent and youth demographics: A brief overview. New York: UNFPA; 2012. Available from: http://www.unfpa.org/sites/default/files/resource-pdf/One%20pager%20on%20youth%20demographics%20GF.pdf [cited 2017 Feb 25].

called for reviewing legal and regulatory frameworks to facilitate adolescents' access to comprehensive HIV services [2].

Global and regional human rights norms and principles require States to ensure that adolescents receive voluntary, non-discriminatory and confidential services with due attention to their best interest and evolving capacity (Table 4). In particular, States must set "a minimum age for sexual consent…and the possibility of medical treatment without parental consent" [1]. They must also ensure that the principles of the five "Cs" (Consent, Confidentiality, Counselling, Correct test results and Connections to treatment, care and prevention services) which underpin HIV testing and counselling services in general, are upheld for adolescents [2,6].

In sub-Saharan Africa, 27 countries have adopted HIV-specific laws over the last 10 years with the aim to create an enabling environment for the AIDS response, including for adolescents [7]. In countries where they exist, HIV-specific laws are much more likely to address access to HIV services for children and adolescents than any other legislation. Unlike policy documents which are not binding, laws obligate national actors, including public health institutions, to abide by their stipulations and to take specific measure to ensure implementation. This article reviews the normative content of HIV-specific laws in sub-Saharan Africa on access to HIV testing, counselling and treatment for adolescents. It examines these laws against four key recommendations in the WHO Guidance, namely: (i) lower the age of consent to HIV testing and counselling and allow mature adolescents who have not reached the age of consent to independently access HIV testing, (ii) ensure access to HIV counselling for adolescents, (iii) protect the confidentiality of adolescents living with HIV, and (iv) facilitate access to HIV treatment for adolescents living with HIV (Box 1).

In four countries (Burkina Faso, Chad, Kenya and Tanzania), the article further provides a comparative analysis of the provisions of HIV-specific laws against those of existing policies and guidelines relating to HIV testing for adolescents. In these four countries, the study aims to ascertain whether the provisions in HIV-specific laws are translated into policy guidance for HIV implementers and health workers.

The overall aim of this study is to contribute to better knowledge and understanding of the provisions of HIV-specific laws relating to access to HIV services for adolescents, as well as the implication of these provisions on efforts to scale up HIV testing, treatment and care for adolescents. It is expected that identifying progress and barriers in HIV-specific laws will inform law and policy reform and implementation to facilitate access to HIV services for adolescents in sub-Saharan Africa.

Box 1: Key public health recommendations relating to independent access to HIV services for adolescents in the WHO Guidance

Age of consent to HIV testing

- Countries should consider best approaches within their legal and social contexts to lower the age of consent to HIV testing and counselling (p 20).
- Adolescents who have not reached the set age of consent but have reached sufficient level of maturity and understanding should be allowed to consent to HIV testing (pp x and 12).

HIV counselling

- In the context of HIV testing and counselling, pre- and post-test counselling are critical for adolescents with or without HIV (pp 15 and 19).

Confidentiality and disclosure of HIV results

- Adolescent services must be confidential. Disclosure should be done with the consent of the adolescent tested (p 47).
- Decisions concerning to whom to disclose test results should be made with the support of the provider or counsellor and a family member or friend if possible (p 47).

Consent to HIV Treatment

- Adolescents who legally are given the right to access HIV testing and counselling services should also have autonomous access to HIV prevention and treatment services (p 12).

World Health Organization. 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: Word Health Organization; 2013.

Methods

This article is based on desk research. It sets international and regional human rights principles and norms applicable to adolescents in the context of health and HIV (Table 4). The human rights framework provides bases to identify key public health principles relating to access to HIV

testing, counselling, disclosure and treatment for adolescents as provided under the WHO guidance on adolescents (Box 1). These human rights norms, principles and public health frameworks are employed to review the normative content of 26 out of the 27 HIV-specific laws adopted in sub-Saharan Africa as of 31 August 2014 [8]. HIV-specific laws in the region were collected from January to August 2014 through a search of existing databases of HIV-related laws and policies such as ILO-AIDS, HIV and health education clearinghouse and AIDSPortal as well as compendiums of HIV-related legal materials, and publications relating to HIV laws and policies in Africa [9,10,11,12,13]. Official gazettes, websites of national parliaments and other online national repositories of laws were used to secure official versions of legislation.

A thematic analysis was used to ascertain whether each HIV-specific legislation addresses HIV testing, counselling and treatment for adolescents. HIV-specific laws without explicit provisions on adolescents were excluded from the analysis. Those with provisions on adolescents were systematically reviewed using a data extraction and coding tool to ascertain how they address key issues relating to age of consent to HIV testing, counselling, confidentiality and disclosure, and HIV treatment for adolescents [14]. HIV-specific laws that set an explicit age of consent were identified and the age of consent provided under these laws was noted in ascending order (i.e. from the lowest to the highest). In countries where no age of consent was explicitly set, the study searched for expressions such as “child” “children” and “minors” which may be used as alternative to specific ages. Where such terms were used, we searched for any definition in the HIV law or explicit reference to another legislation defining the terms. The study also reviewed HIV-specific laws for the use of “maturity” as condition for allowing access to HIV services for adolescents below the set age of consent, as recommended by the WHO Guidance. We further reviewed the laws for any specific provision relating to HIV counselling or protection of confidentiality for adolescents. Finally, we searched HIV-specific laws for provisions on access to independent HIV treatment for adolescents.

In addition to the general analysis of the 26 HIV-specific laws, the study also reviewed existing policy documents on access to HIV testing and counselling for adolescents in Burkina Faso, Chad, Kenya and Tanzania. This analysis compares the provisions of HIV-specific laws in these countries with national policies on HIV testing and counselling. The four countries were selected

because the development of their HIV policy took place after the passing into law of the HIV-specific legislation. Furthermore, these countries represent all four sub-regions of sub-Saharan Africa and can illustrate the situation in the region more broadly.

Results

Almost all HIV-specific laws reviewed address one or more of the four public health recommendations provided in the WHO Guidance. However, none of these laws addresses all four recommendations. Two laws (Burundi and Chad) are silent on all aspects of HIV testing, counselling and treatment for children, adolescents or minors [15,16]. Some nine countries explicitly set an age of consent for access to HIV testing services ranging from 11 years to 18 years (Table 1). Of these, only six allow for independent consent to HIV testing below 18 years (Table 1). Some 14 countries do not provide for an explicit age of consent to HIV testing but rather exclude "minors" or "children" from independent access to HIV testing. This means that in these 14 countries, only those who have reached majority or adults can consent to HIV testing (Table 1). The notions of "minors" or "children" are not defined in the 14 HIV laws thus leaving it to other provisions to determine the age of majority for independent access to HIV services (Table 1). These laws are also unclear about the type of majority foreseen for the purposes of HIV testing, notably whether it is legal majority or majority for sexual acts.

Table 1: Age of consent in HIV-specific laws

Age of consent to HIV testing	**Countries**
a) Explicit age of consent	9 countries: Burkina Faso [17], Congo [18], Cote d'Ivoire [19], DRC [20], Guinea [21], Kenya [22], Mozambique [23], Senegal [24], Uganda [25]
11 years	Mozambique (article 23(3))[23]
12 years	Uganda (sections 1 and 10)[25]
14 years	Guinea (article 22)[21]

15 years	Congo (article 18)[18], Senegal (article 12)[24]
16 years	Côte d'Ivoire (article 4)[19]
18 years	Burkina Faso (article 2 & 9)[17], Kenya (sections 2 & 14)[22], DRC (articles 2(4) & 37)[20]
b) Reference to "minors" or "children" (not defined in the law)	14 countries: Angola [26], Benin [27], Central African Republic [28], Comoros [29], Guinea Bissau [30], Liberia [31], Madagascar [32], Mali [33], Mauritania [34], Mauritius [35], Niger [36], Sierra Leone [37], Tanzania [38], Togo [39]

In 7 countries that have set the age of consent in their HIV laws at 18 years or above, adolescents can still independently consent to HIV testing if they are considered to have reached sufficient maturity or fall into certain circumstances (Table 2). In three of these countries (Comoros, Mauritius and Togo), the law refers explicitly to the notion of "sufficient maturity" to allow access to HIV testing for adolescents below 18 years (Table 2). In these three countries, the law does not define the notion of sufficient maturity.

HIV-specific laws also refer to various other notions and circumstances – intended to reflect sufficient maturity – to grant access to HIV testing for adolescents. They include whether the adolescent is: an emancipated minor (Comoros and Madagascar), pregnant (Kenya and Sierra Leone), married (Kenya and Madagascar), a parent (Kenya and Sierra Leone), or at risk of HIV infection (Kenya and Sierra Leone) (Table 2). Some countries allow for several of these circumstances to apply while others only allow for one. Three countries (Comoros, DRC and Madagascar) refer to the best interest of the child for granting independent access to HIV services for adolescents below the set age of consent. However, the notion of best interest of the child is not defined in these laws.

Table 2: Maturity and other circumstances enabling access to HIV testing for adolescents below the age of consent in HIV-specific laws

Maturity and other circumstances	**Countries**
Sufficient maturity	Comoros (Article 18)[29], Mauritius (Section 7(5))[35], Togo (Article 6)[39]

Emancipated minor	Comoros (Article 18) [29], Madagascar (Article 5) [32]
Pregnant	Kenya (Section 14) [22], Sierra Leone (Section 29(1)(b))[37]
Married	Kenya (Section 14) [22], Madagascar (Article 5)[32]
Parent	Kenya (Section 14) [22], Sierra Leone (Section 29(1)(b)) [37]
At risk of HIV infection	Kenya (Section 14)[22], Sierra Leone (Section 29(1)(b)) [37]
Best interest of the child requires independent testing	Comoros (article 18) [29], DRC (Article 37) [20], Madagascar (Article 5) [32]

Only two countries (Guinea Bissau and Mali) have specific provisions in their HIV legislation on HIV counselling for adolescents [40,41]. Yet in these two countries, these provisions are of very limited significance because their HIV laws restrict independent consent to HIV testing to those who have reached majority. Madagascar is the only country that addresses access to independent HIV treatment for adolescents. In terms of article 13 of the HIV law of Madagascar, children may access HIV treatment and care without parental consent where it is in their best interest or in the case of emancipated minors.

Only four out of all countries with HIV-specific laws that allow for HIV testing for adolescents below 18 years (either through lower age of consent or maturity) have provisions explicitly ensuring confidentiality and protection against disclosure of HIV results. These are Congo, Kenya, Sierra Leone and Uganda. This means that in the other countries, the HIV law may ensure independent access to HIV testing below 18 years, yet it does not protect against disclosure of HIV test results of adolescents to parents, guardians or other care-givers.

In the four countries (Burkina Faso, Chad, Kenya and Tanzania) where HIV testing policies were reviewed against the provisions of HIV-specific laws, there are discrepancies between the age of consent for independent access to HIV testing. In Burkina Faso, the HIV policy introduces exceptions that permit independent access to HIV testing contrary to the provisions of the HIV Act (Table 3). In Kenya, the age of consent provided in the HIV policy is lower than that

provided in the HIV law at 15 years compared to 18 years in the HIV law (Table 3). In addition, the HIV policy of Kenya allows all children below 15 to independently consent to testing under exceptional circumstances (Table 3). In Tanzania, the HIV testing policy provides for exceptional cases of access to HIV testing and counselling services for adolescents which are not recognised under the HIV law (Table 3). In the case of Chad, both the HIV law and the HIV testing policy are silent on access to HIV testing for adolescents and the HIV policy merely refers to majority for independent access (Table 3).

Table 3: Comparing HIV testing provisions in HIV-specific laws and national HIV testing policies in four countries

Issue	**Normative source**	**Country**			
		Burkina	**Chad**	**Kenya**	**Tanzania**
Age of consent	**Law**	18 years	N/A	18 years	Refers to child (age not defined in HIV law)
	Policy	18 years	Refers to minor (not defined) [42]	15 years [43]	18 years [44]
Maturity and other circumstances for independent access for adolescents below the set age of consent	**Law**	N/A	N/A	Below 18: - Pregnant - Married - Parent - At risk of HIV infection	N/A
	Policy	15 to 18 years if: - maturity - Married	N/A	Below 15 years if: - married, - a mother/father of a child	Below 18 if: - married - have children

		- Pregnant [45]		- otherwise no longer dependent on the parents [43]	- sexually active [44]

Discussion

This study shows that provisions in HIV-specific laws relating to HIV testing, counselling and treatment for adolescents are generally inadequate as they fail to take into account human rights principles and public health recommendations from the WHO Guidance. None of the countries with HIV-specific laws has adopted all four recommendations aimed at ensuring appropriate access to HIV services for adolescents. Overall, countries with HIV-specific laws can be divided into those with no provisions relating to independent access to HIV services for adolescents, those that explicitly exclude independent access to HIV services for adolescents and those that contain progressive provisions enabling some form of independent access to HIV testing, counselling and treatment for adolescents.

The fact that only 6 out of 26 countries reviewed have lowered the age of consent in their HIV-specific laws below 18 years is concerning because reducing the age of consent is one of the key guarantees for independent access to HIV services. Lowering the age of consent removes the discretion of health care workers which in practice may lead to denial of services due to social constructs. For instance, under the Children's Act of South Africa, the age of consent to HIV testing is set at 12 years (Box 2). Age of consent adopted in these HIV-specific laws range from 11 to 18 years raising questions on the reasons and criteria for adopting a specific age of consent in each country. In general, age of consent seem to reflect special circumstances and agreements reached in each context based on the actors involved in the law-making process and their ability to effectively advocate in favour of adolescents' rights and health. From this perspective, the lack of clear direction to countries in the WHO Guidance for setting the age of consent represents a weakness as it is likely to perpetuate inconsistency across countries in the norms relating to access to HIV services for adolescents [2].

The recognition in several countries of sufficient maturity as a criterion for independent access to HIV testing for adolescents as provided in the WHO Guidance note is welcomed. However, these provisions often raise questions. First, the notion of "maturity" is not defined under the laws. In some countries, several circumstances have been provided under the law which may imply a reference to maturity. These include reference to adolescents who are pregnant, married, parents, or at risk of HIV infection. However, such notions are narrow and may in practice lead to denying HIV services to many adolescents who are mature enough "to understand the meaning and consequences of HIV testing" but may not be married or pregnant. The introduction of the notion of the "best interest of the child" in Comoros, the DRC and Madagascar for access to HIV testing services for adolescents is a positive development. However, this notion of best interest needs to be clearly defined through regulations in a manner that effectively allows accept to HIV testing for children and adolescents.

Generally, the adoption of lower age of consent, and maturity and other exceptions in HIV-specific laws mostly apply to adolescents' access to HIV testing. Almost no attention has been given in these laws to access to age-appropriate and adolescent-sensitive HIV counselling services. Similarly, the laws are silent on access to independent HIV treatment for adolescents except in Madagascar. Even countries that have lowered the age of consent to allow autonomous HIV testing for adolescents do not allow for independent access to HIV treatment. This situation contradicts the WHO Guidance which provides not only for adolescents' independent access to HIV testing but also to counselling, treatment and care services.

These serious discrepancies in HIV laws are likely to undermine adolescents' independent access to the full continuum of HIV services. This situation is also likely to lead to confusion among health care workers who are mandated to provide independent access to HIV testing under HIV-specific laws yet cannot provide independent access to HIV counselling and treatment services for the same adolescents. As noted in the WHO Guidance, HIV testing is not 'an end in itself', but an entry-door to comprehensive post-test services for all adolescents living with or without HIV [2]. Similarly, the fact that HIV-specific laws do not address access to other sexual and reproductive health services for adolescents – including prevention services adapted to their needs – is a missed opportunity for the HIV response and for public health.

The study highlights contradictions between HIV-specific laws and policy documents relating to HIV testing for adolescents. These include discrepancies between age of consent in HIV laws and in policy documents, and in the circumstances for independent access below the set age of consent. This situation is likely to lead to confusion among health care providers and adolescents seeking HIV services. While health care workers at facility level are more likely to be aware of, and to apply, the provisions of policies relating to HIV testing, it is expected that conflict of norms between HIV laws and policies on age of consent to HIV services will negatively impact their willingness or ability to provide services to adolescents.

Although the provisions of HIV-specific laws apply in principle to all adolescents, experiences and evidence from across Africa shows that adolescents key populations particularly those whose sexual practices, gender identity, life-choices and circumstances are criminalised may not enjoy the protections provided by these laws [2,3,4]. The fact that HIV-specific laws are often silent on key populations may further compromise the application of enabling HIV testing and counselling provisions in HIV-specific laws to young key populations [46].

Key recommendations

Efforts by HIV stakeholders to advance access to HIV services for adolescents in sub-Saharan Africa should pay due attention to national laws and policies, and particularly to HIV-specific laws in countries where they exist. In these countries, approaches for facilitating access to HIV services for adolescents should be based on the content of the HIV legislation and they should involve the steps below.

Where HIV-specific laws are silent on adolescents' access to HIV services: Countries should adopt appropriate measures to facilitate access to services through law reform or through regulations as they do not require parliamentary processes. These reform efforts should be based on best available public health evidence and human rights standards as provided under the WHO Guidance. The Children's Act of South Africa is a best practice that could be considered by countries (Box 2).

Where HIV-specific laws explicitly exclude or limit independent access for adolescents: These are legal barriers that should be removed. Reform should focus on lowering age of consent for independent access to HIV testing, counselling and treatment as well as for other prevention and sexual and reproductive health services. Pending amendment and reform of restrictive provisions in HIV laws, regulations and policies should be adopted to enable independent access to HIV testing and treatment for children.

Where HIV-specific laws have progressive and enabling provisions on access to HIV services for adolescents: Countries should ensure effective implementation of these enabling provisions, including through the adoption of guidelines where necessary. Education and sensitisation on the enabling provisions should be prioritised together with training for health care providers on appropriate and ethical HIV testing, counselling and treatment of adolescents. Sensitisation should also target the general public, youth-led organisations as well as parents and other caregivers on the content of the law and importance of facilitating access to HIV services for adolescents.

Box 2: Provisions on independent HIV testing, counselling and treatment for children in South Africa

Independent consent to HIV testing (Section 130(2))
"Consent for a HIV-test on a child may be given by-
(a) the child, if the child is-
(i) 12 years of age or older; or
(ii) under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a test"
Counselling before and after HIV-testing for children (Section 132)
"(1) A child may be tested for HIV only after proper counselling, by an appropriately trained person, of-
(a) the child, if the child is of sufficient maturity to understand the benefits, risks and social implications of such a test; and
(b) the child's parent or care-giver, if the parent or care-giver has knowledge of the test.
(2) Post-test counselling must be provided by an appropriately trained person to -
(a) the child, if the child is of sufficient maturity to understand the implications of the result; and
(b) the child's parent or care-giver, if the parent or care-giver has knowledge of the test."
Independent consent to treatment (Section 129(2))
"A child may consent to his or her own medical treatment or to the medical treatment of his or her child if-
(a) the child is over the age of 12 years; and
(b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment."
Abstracted from Children's Act 2005 of South Africa, No 38 of 2005.

Conclusions

While recognising that various laws influence access to health and HIV services for adolescents, this study notes that efforts to facilitate access to HIV services for this population in sub-Saharan Africa should address HIV-specific laws. Restrictive provisions in HIV-specific laws should be reformed. Protective norms contains in the laws, such as lower age of consent and the recognition of maturity for access to HIV services should be effectively implemented including by translating them into national HIV testing and treatment policies, and ensuring sensitisation and training of health care workers, communities, youth-led organisations and care givers on the rationale and content of laws and regulations that enable access to HIV services for adolescents.

Table 4: HIV services and adolescents: The human rights framework

Key human rights principles & norms	Applicable treaties and other binding instruments	General comments addressing the norm	Concluding Observations (examples)
Health	UDHR Art. 25; CRC Art. 24; ICESCR Art. 12; CEDAW Art. 12; ACHPR Art. 16; ACRWC Art. 14; Maputo Protocol Art. 14	CRC GC No. 15 (2013); CRC GC No. 4 (2003); CRC GC No. 3 (2003); CESCR GC No. 14 (2000)	"… Improve access to high-quality, age-appropriate HIV/AIDS, sexual and reproductive health services, including by providing for a minor to undergo HIV treatment on a voluntary basis without the consent of a legal administrator or guardian…" CRC, Mauritius (2015)
Non-discrimination	UDHR Art. 1 & 2; CRC Art. 2; ICCPR Art. 2(1); Art. 3; ICESR Art. 2(2), Art. 3; CEDAW Art. 1 & 2; ACHPR Art. 2 & 18; ACHPR Art. 3; Maputo Protocol Art. 2	CRC GC No. 4 (2003) para 2; CESCR GC No. 20 (2009); CCPR GC No. 18 (1989)	"… to eliminate stereotypes and practices that discriminate against girls…" CRC, Eritrea (2015) "…enact a general law against discrimination with a view to incorporating the prohibition of discrimination included in the Covenant…" CCPR, Cote d'Ivoire (2015)
Best interest of the child	CRC Art 3(1); ACRWC Art. 20	CRC GC No. 14 (2013)	"… develop procedures and criteria to provide guidance to all relevant persons in authority for determining the best interests of the child in every area and for giving those interests due weight as a primary consideration…" CRC, Congo (2014)
Evolving capacity of the child and Right to be heard and freedom of expression	UDHR Art. 19; ICCPR 19(2); CRC Art. 12(1), (2) & 13; ACHPR Art. 9(2); ACRWC Art. 7	CRC GC No. 4 (2003); CRC GC No. 12, para 80, 81; CCPR GC No. 10 (1983) & No. 34 (2011)	"… promote and facilitate… respect for views of children and their participation in all matters affecting them in accordance with their evolving capacity." CRC, Cote d'Ivoire (2001)

Education and Information	ICESCR Art. 13; CRC Art. 17, 28 & 29; CEDAW 10; ACHPR Art. 9(2) & 17; Maputo Protocol Art. 12	CRC GC No. 3 (2003) para 22; CRC GC No. 12, para 82; CESCR GC No. 22 (2016)	"… include initiatives to provide education and services to adolescents on reproductive health with information on preventing HIV/AIDS and STIs." CRC, Guinea Bissau (2013)
Harmful cultural practices	CRC Art. 24(3); CEDAW Art. 5(a); ACRWC Art. 21; Maputo Protocol Art. 5;	Joint CRC & CEDAW GC Harmful Practices	"…modify or eliminate negative cultural practices and stereotypes that are harmful to, and discriminatory against, women." CRC, Niger (2009)
Prohibition of torture, inhumane and degrading treatment	UDHR Art. 5; ICCPR Art. 7; CRC Art. 37(a); ACRWC Art. 16	CRC GC No. 8 (2006); CCPR GC No. 20 (2000)	"…review its legislation in order to ensure that infliction of torture or cruel, inhuman or degrading treatment or punishment upon children is considered as an aggravating factor". CRC, Tunisia (2010)
Privacy (including confidentiality)	UDHR Art. 12; CRC Art. 16(1); ACRWC Art. 10	CRC GC No. 4, para 7(l) CRC GC No. 3, para 24; CCPR GC 17 (1988)	"… provide for system of voluntary testing for HIV/AIDS with full respect for right to privacy and confidentiality." CRC, Benin (2006)

Universal Declaration on Human Rights (UDHR), International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic Social and Cultural Rights (CESCR), Convention on the Rights of the Child (CRC), Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), African Charter on Human and Peoples' Rights (ACHPR), Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), African Charter on the Rights and Welfare of the Child (ACRWC). GC = General comment.

Competing interests [Mandatory]

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Authors' contributions [Mandatory]

Patrick M. Eba identified the HIV-specific laws in sub-Saharan Africa and conducted the review of the laws. He developed the conceptual framework for analysing the HIV laws. He wrote the first draft of the paper. He co-wrote the second and final draft of the paper. HyeYoung Lim developed the human rights framework in Table 4. She provided inputs into the first draft, and co-wrote the second and final draft of the article.

Additional files [Optional]

None.

Author information [Optional]

List of abbreviations [Optional]

Universal Declaration on Human Rights (UDHR), International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic Social and Cultural Rights (CESCR), Convention on the Rights of the Child (CRC), Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), African Charter on Human and Peoples' Rights (ACHPR), Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), African Charter on the Rights and Welfare of the Child (ACRWC). GC = General comment.

References

1. General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child, Committee on the Rights of the Child CRC/GC/2003/4, 1 July 2003. Available from: http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GC4.pdf [cited 2016 Aug 10].

2. 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: World Health Organization; 2013. Available from: http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf [cited 2016 Aug 10].

3. Idele P, Gillespie A, Porth T, Suzuki C, Mahy M, Kasedde S, Luo C. Epidemiology of HIV and AIDS among adolescents: Current status, inequities, and data gaps. J Acquir Immune Defic Syndr. 2014 Jul; 66(2):S144-S153.

4. Delany-Moretlwe S, Cowan FM, Busza J, Bolton-Moore C, Kelley K, Fairlie L. Providing comprehensive health services for young key populations: needs, barriers and gaps. J Int AIDS Soc. 2015; 18(2Suppl 1): 19833:29-40.

5. HIV and the law: Risks, rights and health. Global Commission on HIV and the Law. New York: UNDP; 2012. Available from: http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf [cited: 2016 Aug 8].

6. Consolidated guidelines on HIV testing services: 5Cs: consent, confidentiality, counselling, correct results and connection. Geneva: World Health Organization; 2015. Available from: http://apps.who.int/iris/bitstream/10665/179870/1/9789241508926_eng.pdf?ua=1 [cited 2016 Aug 8].

7. Eba PM. HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis. African Human Rights Law Journal 2015; 15: 224-262. http://dx.doi.org/10.17159/1996-2096/2015/v15n2a1.

8. The analysis does not include the HIV-specific law of Equatorial Guinea because the authors were not able to secure a copy of this law.

9. International Labour Organization, HIV legislation and policies [internet]. Available from http://www.ilo.org/aids/legislation/lang--en/index.htm [cited 2016 Aug 8].

10. HIV and health education clearinghouse. UNESCO [internet]. Available from: http://hivhealthclearinghouse.unesco.org [cited 2016 Aug 8].

11. AIDSPortal [internet]. Available from: http://www.aidsportal.org/web/guest/home [cited 2016 Aug 8].

12. Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa. AIDS and Human Rights Research Unit. United Nations Development Programme; 2008. Available from: http://www1.chr.up.ac.za/undp/tools/UNDPtools/UNDP_Compendium.pdf [cited 2016 Aug 8].

13. Fox K, Ferguson J, Ajose W, Singh J, Marum E, Baggaley R. Annex 15: Adolescent consent to HIV testing: A review of current policies and issues in sub-Saharan Africa. HIV and adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV. Geneva: World Health Organization; 2013. Available from: http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf?ua=1 [cited 2016 Aug 8].

14. Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. Int J Qual Methods 2006 Mar; 5(1):1-11.

15. Loi No 1/018 du 12 Mai 2005 portant protection juridique des personnes infectées par le Virus de l'Immunodéficience Humaine et des personnes atteintes du Syndrome Immunodéficience Acquise of Burundi.

16. Loi No 19/PR/2007 du 15 Novembre 2007 portant lutte contre VIH/SIDA/IST et protection des droits des personnes vivant avec le VIH/SIDA of Chad.

17. Loi No 030-2008/AN portant lutte contre le VIH/SIDA et protection des droits des personnes vivant avec le VIH/SIDA of Burkina Faso.

18. Loi No 30 - 2011 du 3 juin 2011 portant lutte contre le VIH et le SIDA et protection des droits des personnes vivant avec le VIH of Congo.

19. Loi n° 2014-430 du 14 juillet 2014 portant régime de prévention, de protection et de répression en matière de lutte contre le VIH et le SIDA of Côte d'Ivoire.

20. Loi No 08/011 du 14 Juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées of DRC.

21. Ordonnance No 056/2009/PRG/SGG portant amendement de la loi L/2005/025/AN du 22 Novembre 2005 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA en République de Guinée of Guinea.

22. HIV and AIDS Prevention and Control Act, No 14 of 2006 of Kenya.

23. Lei No 19/2014 Lei de Protecçao da Pessao, do trabalhador e do Candidato e Emprego Vivendo com VIH e SIDA of Mozambique.

24. Loi n° 2010-03 du 9 avril 2010 relative au VIH/SIDA of Senegal.

25. The HIV and AIDS Prevention and Control Act of 2014 of Uganda.

26. Lei No 8/04 sobre o Virus da Immunodeficiência Humana (VIH) e a Sindroma de Immunodeficiência Adquirida (SIDA) of Angola.

27. Loi No 2005-31 du 5 Avril 2006 portant prévention, prise en charge et contrôle du VIH/SIDA of Benin.

28. Loi 06.030 de 2006 fixant les droits et obligations des personnes vivant avec le VIH/SIDA of Central African Republic.

29. Loi N° 14-011/AU du 21 avril 2014, relative aux droits des personnes vivant avec le VIH et leur implication dans la réponse nationale of Comoros.

30. Loi n° 5/2007 du 10 septembre 2007 de la prévention, du traitement et du contrôle du VIH/sida of Guinea Bissau.

31. An Act to Amend the Public Health Law, Title 33, Liberian Code of Laws Revised (1976) to Create New Chapter 18 Providing for the Control of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) of Liberia.

32. Loi No 2005-040 du 20 Février 2006 sur la lutte contre le VIH/SIDA et la protection des droits des personnes vivant avec le VIH/SIDA) of Madagascar.

33. Loi No 6-028 du 29 Juin 2006 fixant les règles relatives à la prévention, à la prise en charge et au contrôle du VIH/SIDA of Mali.

34. Loi No 2007-042 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA of Mauritania.

35. HIV and AIDS Act, No 31 of 2006 of Mauritius

36. Loi No 2007-08 du 30 Avril 2007 relative à la prévention, la prise en charge et le contrôle du Virus de d'Immunodéficience Humaine (HIV) of Niger

37. The National HIV and AIDS Commission Act of 2011 of Sierra Leone.

38. HIV and AIDS (Prevention and Control) Act, No 28 of 2008 of Tanzania.

39. Loi No 2010-018 du 31 Décembre 2010 modifiant la loi No 2005 – 012 du 14 Décembre 2005 portant protection des personnes en matière de VIH/SIDA of Togo.

40. Article 27 of Loi n° 5/2007 du 10 septembre 2007 de la prévention, du traitement et du contrôle du VIH/sida of Guinea Bissau.

41. Article 28 of Loi No 6-028 du 29 Juin 2006 fixant les règles relatives à la prévention, à la prise en charge et au contrôle du VIH/SIDA of Mali.

42. Manuel de Formation en Counselling VIH/SIDA/IST. Ministère de la Santé Publique du Chad ; 2011. Available from: http://www.emtct-iatt.org/wp-content/uploads/2016/01/hts_policy_chad.pdf [cited 2016 Aug 8].

43. The Kenya HIV Testing Services Guidelines. Ministry of Health of Kenya; 2015. Available from: http://www.emtct-iatt.org/wp-content/uploads/2016/01/hts_policy_chad.pdf [cited 2016 Aug 8].

44. Standard Operating Procedures for HIV Testing and Counselling (HTC) Services. Ministry of Health and Social Welfare of Tanzania; 2009. Available from: http://www.jica.go.jp/project/tanzania/001/materials/pdf/vct_10.pdf [cited 2016 Aug 8].

45. Normes et directives nationales de conseil dépistage de l'infection à VIH au Burkina Faso. Conseil National de Lutte Contre le VIH/SIDA et les IST; 2008. Available from https://aidsfree.usaid.gov/sites/default/files/hts_policy_burkina-faso.pdf [cited 2016 Aug 10].

46. Eba P. Towards smarter HIV laws: considerations for improving HIV-specific legislation in sub-Saharan Africa. Reprod Health Matters. 2016; 1 – 7; Doi: 10.1016/j.rhm.2016.06.007.

PART THREE: FROM HIV LAW MAKING TO IMPLEMENTATION – THEORIES, PRACTICES AND PARTICIPATION

This part is based on the premise that the importance and impact of legislation rests mainly on whether it is effectively implemented and enforced. It discusses critical issues of theory, practice and participation that are pertinent to the implementation of legislation relating to HIV, through three chapters.

Chapter Seven explores key theories and themes in the literature on policy implementation. It uses the notion of 'smarter statutes' identified in this literature to articulate a framework for understanding key determinants in the content of HIV-specific laws that enable or hinder their effective implementation. The chapter then applies the framework of 'smarter statutes' to identify flaws in the normative content of HIV-specific laws that have contributed to hinder their implementation. It closes with recommendations for developing 'smarter' HIV legislation with greater likelihood to be implemented and enforced.

Chapter Eight moves from the theoretical discussion on implementation to the analysis of a practical mechanism for the implementation and enforcement of HIV-related human rights, namely the HIV and AIDS Tribunal of Kenya. Through a combination of desk research and semi-structured interviews of key informants conducted in Kenya, this chapter analyses the composition, mandate, procedures, practice and case-law of the HIV and AIDS Tribunal. It discusses the achievements as well as the challenges facing the Tribunal. Through this assessment, the chapter offers critical considerations for effective implementation and enforcement of HIV-related human rights.

Chapter Nine focuses on the participation and role of civil society in HIV-related lawmaking. It uses two case studies from West and Central Africa and from Eastern Africa to review the extent to which civil society participates into, and can influence the content of, HIV-related legislation in sub-Saharan Africa. Of importance to the issue of implementation, the chapter shows that civil society participation and the integration of their concerns relating to human rights determine their support to HIV legislation and its implementation.

Together, these three chapters shed light on the factors that hinder the effective implementation of legislation relating to HIV. They suggest avenues for responding to these challenges, including through better theoretical understanding and practical approaches for strengthening implementation involving judicial or quasi-judicial mechanisms and increased participation by civil society.

RESEARCH ARTICLE

A framework for understanding and addressing intrinsic challenges to the implementation of HIV-specific laws in sub-Saharan Africa

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Abstract

In sub-Saharan Africa – the region of the world most affected by HIV – calls to address the legal and human rights issues raised by the HIV epidemic have led 27 countries to adopt HIV-specific laws, as of 31 July 2014. Yet, more than ten years after the first HIV-specific laws in the region came into force, there is limited evidence of their effective implementation and enforcement. Qualitative studies conducted among people living with HIV in many of the countries that have adopted HIV-specific laws show that there is little knowledge of the laws and in many cases, regulations, directives and other measures that are critical to ensuring their effective implementation have not been adopted. Using key theories and themes in the implementation literature relating to "smarter statutes", this article argues that inadequate provisions in HIV-specific laws are the reasons for many implementation challenges. The article applies a theoretical framework based on "smarter statutes" to the normative content of HIV-specific laws and highlights various flaws in these laws that have contributed to thwarting their implementation. The authors thus make recommendations for developing HIV or health legislation with greater likelihood to be implemented and enforced.

Key words: HIV/AIDS; legislation; public policy

Introduction

From the beginning of the HIV epidemic, the law was considered as an important structural tool to influence individual behaviour, ensure the protection of those living with HIV and create the conditions for an effective response (Hamblin, 1991; Cameron & Swanson, 1992; Gable, Gostin & Hodge, 2009). The recognition of this role of the law has grown over time as it became clear that serious social, legal and policy issues, such as stigma, discrimination, gender inequality and other negative social norms contribute to making people vulnerable to HIV and hinder access to HIV services (Joint United Nations Programme on HIV/AIDS [UNAIDS] & Office of the High Commissioner for Human Rights [OHCHR] 2006; Global Commission on HIV and the Law, 2012). Parliamentarians and other policy makers were therefore called upon to adopt laws and policies to address the legal issues and challenges raised by the HIV epidemic (United Nations [UN] General Assembly, 2001, 2006). The use of the law in the response to HIV has also been shown to raise serious human rights concerns as national legislators and authorities in many countries have resorted to punitive and other restrictive measures against people living with HIV (PLHIV) and those vulnerable to the epidemic (Global Commission on HIV and the Law, 2012).

In sub-Saharan Africa – the region of the world most affected by HIV – calls to legislate on HIV have resulted in the adoption of a range of legislative and policy measures. Most countries in sub-Saharan Africa have promulgated HIV-specific laws. Sometimes referred to as omnibus HIV legislation, HIV-specific laws are legislative texts that address, in a single document, several aspects of HIV, such as HIV-related education and communication, HIV testing, non-discrimination based on HIV status, HIV prevention, treatment, care and support and HIV-related research (Eba, 2015). As of 31 July 2014, 27 countries in the region had adopted such legislation (See Table 1).

While most HIV-specific laws in sub-Saharan Africa proclaim that they aim to protect human rights and advance responses to HIV, there is little evidence that they are indeed achieving these goals. Whether legislation achieves its objectives and the goals of its framers depends primarily on its implementation and enforcement (Jacobson & Wasserman, 1999). Yet, more than ten years after the first HIV-specific

laws were promulgated, there is very little evidence of their effective implementation and enforcement. In the absence of a systematic analysis of the nature and level of implementation of HIV-specific law, existing qualitative studies on the experiences of PLHIV in countries that have adopted HIV-specific laws suggest that there is limited implementation and enforcement of these laws (National Council of People Living With HIV/AIDS Tanzania [NACOPHA], 2013; Kenya AIDS NGOs Consortium [KANCO] & Kenya Legal and Ethical Issues Network on HIV [KELIN], 2012; Liberia National AIDS Commission, 2013). These surveys also show that there is little knowledge of the laws among PLHIV who are arguably among their primary beneficiaries. In many cases, regulations, directives and other measures that are critical to ensuring the effective implementation of these laws have not been adopted. For example, in Côte d'Ivoire, some two years after the adoption of the HIV law, necessary implementation regulations had not been issued (African Commission on Human and Peoples' Rights, 2016). Similarly, in Niger, PLHIV and human rights organisations have pointed to the lack of effective implementation of the HIV legislation adopted in 2007 (Irinnews, 2009).

While acknowledging that the implementation of legislation is influenced by multiple factors, this article argues that several critical reasons that explain the limited implementation of HIV-specific laws in sub-Saharan Africa are to be found in the normative content of these laws. Intrinsic flaws in the content of these HIV-specific laws appear to have seriously hampered their effective implementation.

In many sub-Saharan African countries, HIV-specific laws were adopted as a symbolic measure by policy makers to show that they were "serious" about addressing the HIV epidemic (Pearshouse, 2007). The development of these laws in the region was directly influenced by global and local calls to legislate on the epidemic and the use of the problematic N'Djamena Model law on HIV supported by a well-funded donor programme (Grace, 2012). The so-called N'Djamena model law contained several coercive and ill-informed provisions contrary to public health evidence and human rights standards alongside protective provisions that were aimed at ending discrimination (Eba, 2015; Grace, 2015). The adoption of national laws based on the N'Djamena model in many sub-Saharan African countries has thus raised concerns about the likelihood and impact of their implementation

(Pearshouse 2008).

This article describes the findings of a desk review on the extent to which HIV-specific laws in sub-Saharan Africa have addressed critical issues relevant to their implementation within their normative content. The analysis covers 26 out of the 27 HIV-specific laws in force in the region as of 31 July 2014. The analytical framework used in the review and analysis of the implementation issues in these HIV-specific laws is based on key theories and themes in the implementation literature that relate to “smarter statutes”, which posits that inadequate legislative provisions are the reasons for many implementation challenges. These theories have informed the development of a framework composed of three elements to analyse the normative content of HIV-specific laws, namely whether the laws are: (i) based on sound human rights and public health approaches; (ii) clearly drafted; and (iii) identify supportive implementation agencies. These three elements were then used to systematically review the provisions of the 26 HIV-specific laws in sub-Saharan Africa. The findings from the analysis are described below. These findings are then reflected upon in a discussion section and the article concludes with a call for paying greater attention to implementation issues in HIV-related law making.

Table 1: HIV-specific laws in sub-Saharan Africa (as of 31 July 2014, with amendments where applicable)

Country	Title of HIV-specific law
1. Angola	• Lei No 8/04 sobre o Virus da Immunodeficiência Humana (VIH) e a Sindroma de Immunodeficiência Adquirida (SIDA), 2004
2. Benin	• Loi No 2005-31 du 5 Avril 2006 portant prévention, prise en charge et contrôle du VIH/SIDA, 2006
3. Burkina Faso	• Loi No 030-2008/AN portant lutte contre le VIH/SIDA et protection des droits des personnes vivant avec le VIH/SIDA, 2008
4. Burundi	• Loi No 1/018 du 12 Mai 2005 portant protection juridique des personnes infectées par le Virus de l’Immunodéficience Humaine et des personnes atteintes du Syndrome Immunodéficience Acquise, 2005
5. Cape Verde	• Lei No 19/VII/2007, 2007
6. Central African Republic	• Loi 06.030 de 2006 fixant les droits et obligations des personnes vivant avec le VIH/SIDA, 2006
7. Chad	• Loi No 19/PR/2007 du 15 Novembre 2007 portant lutte contre VIH/SIDA/IST et protection des droits des personnes vivant avec le VIH/SIDA, 2007
8. Comoros	• Loi N° 14-011/AU du 21 avril 2014, relative aux droits des personnes vivant avec le VIH et leur implication dans la réponse nationale, 2014
9. Congo	• Loi No 30 - 2011 du 3 juin 2011 portant lutte contre le VIH et le SIDA et protection des droits des personnes vivant avec le VIH, 2011

10. Côte d'Ivoire	• Loi n° 2014-430 du 14 juillet 2014 portant régime de prévention, de protection et de répression en matière de lutte contre le VIH et le SIDA, 2014
11. Democratic Republic of Congo	• Loi No 08/011 du 14 Juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées, 2008
12. Equatorial Guinea	• Ley No 3/2005 sobre la prevención y la lucha contra las infecciones de transmisión sexual (ITS), el VIH/SIDA y la defensa de los derechos de las personas afectadas, 2005
13. Guinea	• Ordonnance No 056/2009/PRG/SGG portant amendement de la loi L/2005/025/AN du 22 Novembre 2005 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA en République de Guinée, 2009 • Loi L/2005/025/AN du 22 Novembre 2005 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA en République de Guinée, 2005
14. Guinea Bissau	• Loi n° 5/2007 du 10 septembre 2007 de la prévention, du traitement et du contrôle du VIH/sida, 2007
15. Kenya	• HIV and AIDS Prevention and Control Act, No 14 of 2006
16. Liberia	• An Act to Amend the Public Health Law, Title 33, Liberian Code of Laws Revised (1976) to Create New Chapter 18 Providing for the Control of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), 2010
17. Madagascar	• Loi No 2005-040 du 20 Février 2006 sur la lutte contre le VIH/SIDA et la protection des droits des personnes vivant avec le VIH/SIDA), 2006
18. Mali	• Loi No 6-028 du 29 Juin 2006 fixant les règles relatives à la prévention, à la prise en charge et au contrôle du VIH/SIDA, 2006
19. Mauritania	• Loi No 2007-042 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA, 2007
20. Mauritius	• HIV and AIDS Act, No 31 of 2006
21. Mozambique	• Lei No 19/2014 Lei de Protecçao da Pessao, do trabalhador e do Candidato e Emprego Vivendo com VIH e SIDA, 2014 • Lei n°12/2009, estabelece os direitos e deveres da pessoa vivendo com HIV e SIDA, e adopta medidas necessárias para a prevenção, protecção e tratamento da mesma, 2009
22. Niger	• Loi No 2007-08 du 30 Avril 2007 relative à la prévention, la prise en charge et le contrôle du Virus de d'Immunodéficience Humaine (HIV), 2007
23. Senegal	• Loi n° 2010-03 du 9 avril 2010 relative au VIH/SIDA, 2010
24. Sierra Leone	• The National HIV and AIDS Commission Act of 2011 • The Prevention and Control of HIV and AIDS Act of 2007
25. Tanzania	• HIV and AIDS (Prevention and Control) Act, No 28 of 2008
26. Togo	• Loi No 2010-018 du 31 Décembre 2010 modifiant la loi No 2005 – 012 du 14 Décembre 2005 portant protection des personnes en matière de VIH/SIDA, 2010 • Loi No 2005-012 portant protection des personnes en matière de VIH/SIDA
27. Uganda	• HIV Prevention and Control Act of 2014

"Smarter statutes": A theoretical framework for understanding intrinsic implementation challenges

Effective laws are those that do not merely exist but actually achieve their goals through effective implementation and enforcement. Though related, the notions of implementation and enforcement have distinct meanings. Implementation is a broad term that refers to all the processes, actors, mechanisms and rules by which laws or

policies are put into effect (Lane, 1983). Enforcement is an element of implementation which refers to the methods (judicial or non-judicial) that are employed to ensure compliance with the law or policy (Stigler, 1974). This article refers to implementation as the broader term and addresses enforcement only in specific instances relating to compliance with legal provisions.

Several factors influence whether and how laws or policies are implemented. Our review of key literature in the large body of research on implementation leads to broadly dividing these elements into distinct but inter-related factors, namely intrinsic and extrinsic factors (Palumbo & Calista, 1990; Mazmanian & Sabatier, 1981; Bardach, 1977; Pressman & Widavsky, 1984; Ingram & Mann, 1980; Ingram & Schneider, 1990; Sabatier & Mazmanian, 1979; May & Winter, 2009). Extrinsic or socio-ecological factors involve a mix of social, political, economic, financial, administrative and other elements that are specific to a particular country or context, and that directly or indirectly influence whether and how legislation is implemented. These factors are generally not found in the law or policy itself and include issues such as the political system of the state (whether federal or unitary); the nature of legal or legislative tradition (common law or civil law); human and technical resources available for implementation, including the nature and strength of agencies tasked with implementation or courts responsible for enforcement; financial resources; and the general political situation in the country, including factors such as political or social unrest or conflict. Intrinsic factors, on the other hand, are those that emerge directly from the provision of the law or policy under consideration. Intrinsic factors that influence implementation and enforcement relate to the quality of the normative content of the law.

Effective implementation depends on a combination of these intrinsic and extrinsic factors. However, most studies devoted to the implementation and enforcement of legislation and policy have focused mainly on extrinsic or socio-ecological factors (Schneider and Ingram, 1990; Lipsky, 1978; Palumbo & Calista 1990). In their seminal study describing the characteristic of “smarter statutes”, Ingram and Schneider (1990) call for giving closer consideration to intrinsic factors that influence the implementation and enforcement of legislation. They argue that “[f]lawed statutes are the source of many implementation problems and failed

policies" and note that limited attention has been devoted to these issues, thus resulting into a lack of clear direction for framing "smarter laws" with a greater likelihood of being effective (Ingram & Schneider, 1990, p 67).

Ingram and Schneider (1990) provide insight into conceptualising and measuring the characteristics of laws that are most likely to be implemented in different situations. The authors suggest key elements of legislative implementation that should be addressed in the content of laws, including: (i) the identification of rules, tools and assumptions that are likely to influence implementers and target populations to take action consistent with policy objectives; (ii) clear identification of the implementation agency; (iii) clarity and specificity of legislative content and goals; and (iv) attention to the environment in which the law is to be implemented. Several of these elements were further elaborated by Ingram and Schneider in subsequent research (Schneider & Ingram 1997; Schneider & Ingram 2005).

Moreover, Sabatier and Mazmanian (1979) suggest five conditions that should be present for a law to be effectively implemented. These five conditions combine intrinsic and extrinsic factors. They require that the statute: (i) be based on sound theory; (ii) contains unambiguous policy directive; (iii) be implemented by agencies that have the skills and necessary commitment to pursue the statutory goals; (iv) be supported by key constituencies; and (v) be related to an issue that remains a priority (Sabatier & Mazmanian, 1979).

A framework for reviewing implementation measures in HIV statutes

Drawing from the above theories, the present study outlines three key intrinsic factors that may be critical to determining the effective implementation of HIV-specific laws. These factors require that HIV-specific laws be: (i) based on sound human rights and public health approaches; (ii) be clearly drafted; and (iii) identify supportive implementation agency. These three elements focus on those implementation factors that are directly related to the content of legislation. Although pertinent, other elements identified by Ingram and Schneider or by Sabatier and Mazmanian that require an analysis of extrinsic factors are not included as they are beyond the scope of the present study.

Sound public health and human rights approaches

Ingram and Schneider (1990) submit that the quality of the policy rests on the quality of the information upon which it is based. In relation to HIV, this means that prescriptions in HIV-specific laws should be based on the best available scientific and public health evidence and, at the same time, should uphold human rights principles. Almost four decades of response to HIV have generated great evidence on the public health approaches that are most likely to advance HIV prevention, treatment, care and support for PLHIV and for those vulnerable to HIV (UNAIDS & OHCHR, 2006; Stemple, 2008; Global Commission on HIV and the Law, 2012). These approaches include addressing factors of vulnerability to HIV for specific populations, particularly those most affected by the epidemic such as women, young people, prisoners, men who have sex with men and sex workers. Similarly, it is widely acknowledged that the most effective responses to HIV are those that create an enabling legal environment through human rights protection for those living with or vulnerable to HIV (UNAIDS & OHCHR, 2006; Stemple, 2008; Global Commission on HIV and the Law, 2012). These protections are critical to ensuring that people come forward to access HIV services. Resultantly, HIV-specific laws adopted in sub-Saharan Africa can be considered to be based on sound public health and human rights approaches if they:

- are informed by public health approaches to HIV that recognise and address key factors of vulnerability and ensure access to HIV prevention, treatment, care and support services for all, as endorsed by UNAIDS and the World Health Organisation (WHO); and
- are consistent with international human rights norms, including those provided in the International guidelines on HIV/AIDS and human rights (UNAIDS & OHCHR, 2006).

Clearly drafted provisions

Clarity and specificity of legislative provisions and directives increase the likelihood of their implementation and enforcement. Sabatier and Mazmanian (1979) consider this the second condition for effective implementation. This condition requires that “the statute contains unambiguous policy directive and structures …so as to maximise the likelihood that target groups will perform as desired” (Sabatier &

Mazmanian 1979, p 487). While acknowledging that clear policy directions do not always result in expected outcomes, this study argues that in relation to a highly stigmatised condition such as HIV, failure to provide clear direction may lead to implementers not taking action on various grounds, including discomfort with the values embedded in the legislation. We argue that in order to meet this standard of clarity, HIV-specific laws ought to:

- contain clear goals or objectives;
- be written in clear and unambiguous language that provide direction to target populations or implementing agencies; and
- clarify the relationship between their provisions and other relevant pieces of legislation.

Identify supportive implementing agency

Sabatier and Mazmanian (1979) note that implementation should be "assigned to agencies supportive of statutory objectives that will give the new program high priority". Whether legislation is implemented and enforced depends to a large extent on the engagement and support of the implementation agency that is designated for this purpose. This condition requires that HIV-specific laws first identify an implementation agency responsible for ensuring that their prescriptions are translated into action and that problems in implementation are addressed. Such implementation agency may include a relevant ministry, directorate, or other structure or actor. The notion of implementation agency is to be understood broadly and can include existing as well as newly established mechanisms tasked with the implementation or enforcement of provisions of the HIV legislation. Second, it is critical that the implementation agency or actor designated under the law be supportive of the policy objectives provided in the legislation. Third, this condition requires attention to the identification of an institution or mechanism for overseeing or monitoring the implementation and enforcement of HIV-specific laws (Sabatier & Mazmanian, 1979).

Consequently, we argue that in order to satisfy the requirement relating to the identification of a supportive implementation agency, HIV-specific laws ought to:

- identify which ministry, agency or actor will implement the Act or specific provisions;
- describe which action the implementing agency or actor should take to advance the legislative objectives, and provide a timeline for such actions;
- specify whether any other agency has any defined role in the implementation and enforcement of the Act; and
- mandate mechanisms or institutions for monitoring or securing implementation and enforcement of key provisions.

The elements outlined in the above framework are used to assess implementation issues within HIV-specific laws in Sub-Saharan Africa. It is submitted that those laws that satisfy most of the intrinsic characteristics described in this framework are better placed to achieve their goals of protecting human rights and contributing to the HIV response. In other words, those statutes with the least attention devoted to these issues will see their implementation and enforcement compromised.

Applying the evaluation framework to HIV-specific laws in sub-Saharan Africa: Key findings

Sound public health and human rights approaches in HIV-specific laws

Most HIV-specific laws in sub-Saharan Africa stress that their objectives are to contribute to the response to HIV and ensure the protection of the human rights of PLHIV or affected by HIV. Yet, the scope and normative quality of these provisions varies greatly (Eba, 2015). Serious public health and human rights gaps and concerns have been noted in HIV-specific laws (Pearshouse, 2007; Canadian HIV/AIDS Legal Network, 2007). There are, at least, four elements that illustrate the failure to address sound public health evidence and human rights principles in these laws.

First, the great majority of HIV-specific laws do not address the needs for protection and access to HIV services of populations particularly vulnerable to HIV and affected by the epidemic in sub-Saharan Africa such as women and girls, men

who have sex with men and sex workers (Pearshouse, 2007). Of the 26 HIV-specific laws reviewed, only nine have specific provisions addressing the need of women and girls; four countries have provision explicitly applicable to sex workers; four countries address explicitly people who inject drugs; and only two have provisions relating to or explicitly applicable to men who have sex with men (Table 2). With the exception of Mauritius, provisions relating to sex workers, men who have sex with men and people who inject drugs in these laws are very general and do not address key issues of human rights protection and access to services for these populations such as harm reduction services for people who inject drugs.

Table 2: Explicit provisions on selected vulnerable populations

Vulnerable populations	**Women and girls**	**Sex workers**	**Men who have sex with men (MSM)**	**People who inject drugs**
Number of HIV-specific laws addressing specific the vulnerable population (out of 26)	**9 HIV laws:** Comoros (art 12); Congo (arts 14 – 16); Cote d'Ivoire (arts 39 – 42); Liberia (sect 18(19)); Madagascar (arts 20, 21 & 26); Mozambique (arts 7 & 8); Senegal (art 15); Togo (arts 49 – 53); Uganda (sect 15).	**4 HIV laws:** Burkina Faso (art 6); Madagascar (art 26); Senegal (art 15 and terminology); Togo (art 58).	**2 HIV Laws:** Madagascar (art 26); Senegal (art 15 and terminology);	**4 HIV laws:** Madagascar (art 26); Mauritius (sects 14-17); Mozambique (arts 7 & 12); Senegal (art 15 and terminology)

Secondly, a study on the content of HIV-specific laws found that many of them contain restrictions to access to HIV testing services for people below the age of 18 (Eba & Lim, 2017). Recent data show that AIDS is a leading cause of death among adolescents in Africa (UNAIDS, 2014a, 2014b). Facilitating adolescents' access to all HIV services is therefore critical, particularly ensuring their access to HIV testing which is the entry door into treatment, care and support (Kurth et al., 2015). In this regard, recent WHO guidelines on HIV and adolescents call for removing all barriers to independent access to HIV testing for adolescents and young people (WHO, 2013).

Third, all HIV-specific laws allow for either broad exceptions to voluntary HIV testing or for mandatory disclosure of HIV status contrary to public health and human rights standards (UNAIDS & OHCHR, 2006). In addition, some 17 HIV-specific laws have provisions allowing involuntary notification of a person's HIV-status by medical

practitioners which are contrary to the International guidelines on HIV/AIDS and human rights and UNAIDS' recommendations (Eba, 2015).

Fourth, 24 out of the 26 HIV-specific laws adopted in sub-Saharan Africa allow for criminalisation of HIV non-disclosure, exposure or transmission (Eba, 2015). There is no evidence that such criminal law provisions support the response to HIV. To the contrary, it has been shown that criminalisation negatively affect PLHIV and their relationships with health care providers (Galletly & Pinkerton, 2006; Global Commission on HIV and the Law, 2012; UNAIDS, 2013; O'Byrne et al., 2013; Mykhalovskiy, 2015). Serious human rights concerns have also been laid against these criminal provisions for disregarding generally applicable criminal law principles, and frequently resulting in disproportionately harsh sentences (Burris & Cameron, 2008; UNAIDS, 2013).

Clearly drafted HIV-specific laws

The review of HIV-specific laws in sub-Saharan African countries shows that most of these laws have vague and aspirational provisions that lack in clarity, and may result in uncertainty in their interpretation and application.

HIV-specific laws often lack clarity on what action ought to be taken by the target population or the implementing agency. For example, article 12 of the HIV law of the Democratic Republic of Congo urges the State to ensure economic, social and geographical access to anti-retroviral therapy. In a country where access to HIV treatment is particularly low, at 12.4 % in 2009 when the HIV Law was adopted, it is understandable that legislators would want to bind the state to increasing access to anti-retroviral therapy (Gouvernement de la République Démocratique du Congo, 2010, p 19). However, the provisions of article 12 are unlikely to do much to support the implementation and enforcement of this goal because they are not specific on the measures that are to be taken to address the barriers to access to HIV treatment.

The vagueness of provisions in HIV-specific laws may also compromise their interpretation and application. Provisions allowing for overly broad criminalisation of HIV non-disclosure, exposure and transmission in 24 HIV-specific laws are often vague and do not provide clear instruction or warning for PLHIV on what specific

behaviour or sexual practices are prohibited. In a ruling on a petition challenging overly broad criminalisation of HIV transmission in the HIV law of Kenya, the High Court stressed that "legislation ought not to be too vague that the subjects have to await the interpretation given to it by the judges before he can know what is and what is not prohibited" (High Court of Kenya, 2015). The Court therefore held that section 24 of the HIV Prevention and Control Act of Kenya is "vague and overbroad and lacks certainty" and as such declared it unconstitutional.

A further illustration of the lack of clarity in HIV-specific laws is the failure of these laws to address their relationship with other similar or related legislation. Of the 26 laws reviewed in this study, only 12 have provisions that explicitly address their relationship with other laws (Table 3).

Table 3: Other intrinsic challenges in HIV-specific laws

Issue/area	Relations with other legislation	Identification of implementation agency for at least one provision of legislation
Number of HIV-specific laws addressing the issue (out of 26)	**12 HIV laws:** Burundi (art 45); Chad (art 65); Comoros (art 39); DRC (art 46); Guinea (art 49); Guinea Bissau (art 38); Kenya (secs 46); Madagascar (art 69); Mali (art 39); Mozambique (art 57); Niger (art 49); Togo (art 78)	**24 HIV laws:** Angola (art 18); Benin (art 17); Burkina Faso (arts 4 & 5); Cape Verde (arts 3 & 5); Chad (art 16); Comoros (arts 9 & 10); Congo (arts 12 & 13); Cote d'Ivoire (art 35); DRC (art 28); Guinea (arts 2 & 3); Guinea Bissau (arts 1 & 7); Kenya (arts 4 – 6); Liberia (arts 18(3) & 18(8)); Madagascar (arts 27 & 61); Mali (art 2, 3 & 8); Mauritania (art 2 & 16); Mauritius (sect 5); Mozambique (art 5); Niger (art 5); Senegal (art 5 & 14); Sierra Leone (sects 19 & 29 (4)); Tanzania (sect 5); Togo (art 8) and Uganda (sect 24)

This situation is likely to create confusion in terms of implementation and enforcement in cases where the provisions of HIV-specific laws are in conflict or different from the stipulations of other laws. This is because in many countries that have adopted HIV-specific legislation, other laws, sometime adopted around the same period, also address similar HIV-related issues. For instance, in Benin, Burkina Faso and Senegal, issues of HIV prevention and education as well as criminalisation of HIV non-disclosure, exposure and transmission that are addressed in HIV-specific

laws are also dealt with in the sexual and reproductive health laws in force in these countries (Eba, 2015). In contexts where the HIV law does not explicitly address the question of its relationship with other laws, it is then unclear whether it is the provisions of HIV-specific laws or those of other legislation that should apply on particular issues.

Identify supportive implementing agency

HIV-specific laws cover several issues including HIV-related information and education, HIV-related discrimination, HIV testing, access to HIV treatment and care, and the criminalisation of behaviours that are deemed harmful in the context of HIV (Eba, 2015). The review of the HIV-specific laws shows that 24 out of 26 of these laws identify implementation agencies for at least one of their provisions (see Table 3). In general, provisions relating to HIV education and sensitisation are among those for which most HIV-specific laws assign specific implementing agencies, namely the ministry responsible for health, education, or the National AIDS Commission. In rare cases, such as that of section 52 of the HIV law of Tanzania, these laws mandate specific institutions to develop regulations and guidelines to ensure their implementation.

However, most statutes fail to specify which entity or government ministry is responsible for implementing or taking action to address issues involving human rights violations. For example, article 22 of the HIV Law of Burundi provides that public authorities should take measures to end all forms of discrimination. While the intent of such a provision is salutary, it is unlikely to result in actual implementation or enforcement as it does not indicate which particular “public authority” should take action against discrimination. Similarly, article 26 of the HIV Law of Madagascar provides that special measures should be taken to protect vulnerable populations including sex workers, women, children, men who have sex with men and drug users against HIV. Again, there is no indication of which government agency will be responsible for implementing the provision.

Generally, HIV-specific laws do not provide clear timelines within which designated implementation agencies (where identified) are expected to take action such as the development of regulations or the setting up of institutions mandated by

the law.

The review of these laws shows that only one has established or mandated a mechanism for monitoring its implementation or enforcement. The failure to designate mechanisms for monitoring and supporting implementation of HIV-specific laws means that countries are lacking a structured recourse for identifying, preventing and addressing difficulties that are inherent to the implementation of legislation on a complex and far-reaching issue such as HIV. The HIV law of Kenya constitutes an exception in this regard. It provides for the establishment of the HIV and AIDS Tribunal of Kenya under section 25 of the Act. The Tribunal is mandated to adjudicate violations of the provisions of the HIV law, including those relating to the protection of human rights (Eba, 2016).

Discussion

This study found that drafters of HIV-specific laws did not appear to have devoted much attention to addressing intrinsic issues in these laws that might have ensured their effective implementation and enforcement. Serious gaps and concerns in the normative framework of these laws help to understand why in so many countries, their implementation has stalled or has been less than adequate. These gaps can be summarised into four key elements.

Failure to uphold sound public health and human rights approaches

Almost all countries with HIV-specific laws have embraced punitive provisions and ignored best available scientific and medical evidence relating to HIV. Important considerations for effective HIV responses such as attention to the populations most affected by HIV, removal of legal barriers to access to services for adolescents and young people, and the protection of informed consent and confidentiality have not been appropriately taken into consideration in these laws. To the contrary, most HIV-specific laws are characterised by an over-reliance on punitive and coercive measures such as involuntary HIV testing, mandatory disclosure and the overly-broad criminalisation of HIV transmission. These coercive provisions have led to contestation of HIV-specific laws, including by civil society organisations, and legal challenges. In many countries, these contestations and court challenges have delayed or thwarted the implementation and enforcement of HIV-specific laws. By

antagonising civil society actors which, in many countries, are critical to supporting and facilitating the implementation of legal and policy measures, coercive provisions in HIV-specific laws have prevented the positive engagement and contribution of actors who could have played a key role in supporting their effective implementation.

Lack of clarity and vague provisions

This challenge is common across almost all HIV-specific laws. Lack of clarity and vagueness of legislative stipulations compromise their effective implementation as target populations are uncertain about the actions that they should to take; and the implementation agencies do not have explicit indications of the nature, scope and timeline for measures to be taken for the effective implementation of HIV-specific laws. In the context of HIV – where many actors are not readily willing to act or adopt measures that may be politically or socially sensitive – the failure to provide clear legislative stipulations is very likely to result in lack of implementation and enforcement.

In many instance, general or vague provisions in HIV-specific laws could have potentially been addressed by specifying under these laws, the requirement for guidelines or regulations to enable effective implementation and enforcement. However, only a handful of HIV-specific laws include specific provisions for the adoption of guidelines on key issues. In some countries, such as Niger and Mauritius, there is a broad provision in the law that provides for adopting regulations and other implementing measures. In these cases, there is no indication of the ministry or competent authority that is to initiate the guidelines or regulations, the issue in relation to which the guidelines are to be adopted, and no clarity about when and how these guidelines or directives are to be adopted.

Limited attention to implementing or monitoring entity

HIV-specific laws do not provide for mechanisms or frameworks for monitoring or supporting their implementation. The failure to identify a specific entity tasked with implementing key provisions in HIV-specific laws compromises the likelihood that they will ultimately be implemented. In turn, lack of implementation and failure to designate specific agencies responsible for implementation may lead to frustration and mistrust on the part of the beneficiaries and target populations who are not able

to notice the impact of the laws and are unclear about which particular agency or entity to hold accountable for failure of implementation.

The establishment of the HIV Tribunal of Kenya can be regarded as a promising example of efforts to implement and enforce HIV-specific legislation, although the effectiveness of this mechanism has been hampered by a number of challenges (Eba, 2016). Beyond courts, which are tasked with enforcement of laws, there are additional options that sub-Saharan African countries could have considered for monitoring the implementation of HIV-specific laws. All the countries reviewed in this study have established national AIDS commissions (NAC) to coordinate their HIV responses. These bodies could be tasked with monitoring the implementation of HIV-specific laws. In fact, in most countries, these bodies have been playing key roles, under the framework of the United Nations General Assembly Special Session on AIDS (UNGASS) and high level meetings on AIDS, in coordinating the monitoring of policy environments relating to HIV (Alfven et al., 2014; Gruskin, Ferguson, Alfven, Rugg, & Peersman, 2013). In order to strengthen and support implementation of HIV-specific laws, a specific role could be given to NAC in ensuring that agencies, ministries and stakeholders relevant to the implementing of these laws are performing their functions.

Conclusion and recommendations

Effective implementation is the ultimate goal of any legislation or policy. Without implementation, any law, including HIV-related legislation, is merely a symbolic statement about the commitment of law-makers to address a particular issue. It is in fact effective implementation that can enable the emergence of enabling and protective legal environments that are critical to addressing the challenges raised by the HIV epidemic.

This article shows that there are a number of intrinsic conditions that are essential to framing “smarter legislation” with the greatest likelihood of implementation. The review of HIV-specific laws in sub-Saharan Africa found that these laws generally do not take into consideration key factors that are important to ensuring their effective implementation and enforcement namely: (i) be based on sound human rights and public health approaches; (ii) be clearly drafted; and (iii)

identify supportive implementation agency. On the contrary, most HIV-specific laws in the region have embraced punitive laws and ignored best available scientific and medical evidence relating to HIV, thus leading to their contestation, and legal challenges that have compromised their implementation.

This lack of appropriate attention to implementation in HIV-specific laws is both concerning and surprising. In fact, the importance of implementation was one of the main arguments together with certainty and clarity that was invoked to justify the adoption of these laws in the first place. It was argued that having an omnibus HIV law will ensure that its norms are known, more easily implemented, better enforced, and that it will potentially encourage monitoring as opposed to the difficulties that would have been inherent to implementing and enforcing multiple pieces of legislation relating to HIV.

The review of existing HIV-specific laws in sub-Saharan Africa found that in spite of these arguments, most of these laws do not integrate critical considerations for framing “smarter statutes” with greater likelihood for effective implementation. The findings from this study thus call for renewed attention to the factors that can help advance the effective implementation of HIV-related legislation in Africa. This study explicitly acknowledges that intrinsic factors alone cannot explain the challenges to implementation which often are also due to the extrinsic and environmental factors. However, it calls for more attention to the content of legislation or intrinsic factors together with extrinsic or socio-ecological factors of implementation (which are not addressed in this study). Several studies conducted on the implementation of tobacco legislation and regulations show the importance of research to assess both intrinsic and extrinsic (socio-ecological) factors influencing the implementation of health-related legislation and policies, so as to identify key challenges and address them (Jacobson & Wasserman 1999; Satterland, Lee, Moore, & Antin, 2009).

Achieving the goals of HIV-specific laws will require legislators, civil society organisations and others with interest in the emergence of protective legal environments for HIV to devote more attention to issues of implementation. In particular, intrinsic factors of legislative implementation – which are in the control of

law makers – should receive greater care. Addressing these intrinsic factors will help frame “smarter legislation” that are most likely to achieve their goals.

Note

1. The analysis does not cover the HIV law of Equatorial Guinea. Although research confirmed the existence of HIV-specific law in this country, efforts to secure a copy of this legislation were not successful.

References

African Commission on Human and Peoples’ Rights (2016). “Press Release on the Visit of the Committee on the Protection of the Rights of People Living with HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV of the African Commission on Human and Peoples’ Rights to the Republic of Côte d’Ivoire” 28 May 2016. Retrieved from http://www.achpr.org/press/2016/05/d302/.

Alfven, T., et al. (2014). A decade of investments in monitoring the HIV epidemic: how far have we come? A descriptive analysis.” *Health Research Policy and Systems,* 12, 62.

Bardach, E. (1977). *The implementation game: What happens after a bill becomes a law*. Cambridge, Massachusetts: MIT Press.

Burris, S., & Cameron E. (2008). The case against criminalization of HIV transmission. *Journal of the American Medical Association,* 300, 578–581.

Cameron, E., & Swanson, E. (1992). Public health and human rights – The AIDS crisis in South Africa.” *South African Journal of Human Rights,* 8, 201–202.

Canadian HIV/AIDS Legal Network. (2007). *A human rights analysis of the N’Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo*. Retrieved from http://www.aidslaw.ca/site/wp-content/uploads/2013/03/LN_HumanRtLegislnRvw_en.pdf.

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

Eba, P. M. (2016). The HIV and AIDS Tribunal of Kenya: An effective mechanism for the enforcement of HIV-related human rights? 18(1) *Health and Human Rights Journal*.

Eba, P.M., & Lim, H.Y. (2017). Reviewing independent access to HIV testing, counselling and treatment for adolescents in HIV-specific laws in sub-Saharan Africa: Implications for the HIV response (on file with author).

Elmore, R. (I982). 'Backward Mapping: Implementation Research and Policy Decisions,' in Walter Williams (ed), *Studying Implementation: Methodological and Administrative Issues*. Chatham, NJ: Chatham House.

Gable, L., Gostin L., & Hodge J. G. (2009). A global assessment of the role of law in the HIV/AIDS pandemic. *Public Health,* 123, 260–264.

Galletly, C. L., & Pinkerton, S. D. (2006). Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV. *AIDS and Behavior,* 10, 451–461.

Global Commission on HIV and the Law (2012). *HIV and the law: Risks, rights and health.* New York: United Nations Development Programme.

Gouvernement de la République Démocratique du Congo. 2010. “Rapport National UNGASS de la République Démocratique du Congo, janvier 2008 – décembre 2009”. Retrieved from http://www.unaids.org/sites/default/files/en/ dataanalysis/ knowyourresponse/countryprogressreports/2010countries/democraticrepublicofthecongo_2010_country_progress_report_fr.pdf (accessed 20 March 2016).

Grace, D. (2015). Criminalizing HIV transmission using model law: troubling best practice standardizations in the global HIV/AIDS response. Critical Public Health, 25(4): 441-454.

Grace, D. (2013). Legislative epidemics: The role of model law in the transnational trend to criminalise HIV transmission. *Medical Humanities*, 39, 77–84.

Grace, D. (2012). *This is not a law: the transnational politics and protest of legislating an epidemic* (Unpublished Doctoral Thesis, University of Victoria). Retrieved from https://dspace.library.uvic.ca//handle/1828/3944.

Gruskin, S., Ferguson, L., Alfven, T., Rugg, D., & Peersman, G. (2013). Identifying structural barriers to an effective HIV response: Using the national composite policy index data to evaluate the human rights, legal and policy environment. *Journal of the International AIDS Society,* 16:18000. http://dx.doi.org/10.7448/IAS.16.1.18000.

Hamblin, J. (1991). The role of the law in HIV/AIDS policy. *AIDS,* 5, s239–s243.

High Court of Kenya. (2015). *Aids Law Project v Attorney General & 3 others*. Retrieved from http://kenyalaw.org/caselaw/cases/view/107033/.

Ingram, H. M., & Mann, D. E. (Eds.). (1980). *Why policies succeed or fail*. Beverly Hills: Sage Publication.

Ingram, H. M., & Schneider, A. (1990). Improving implementation through framing smarter statutes. *Journal of Public Policy,* 10(1), 67–88.

Irinnews (2009). “La faible application de la loi VIH frappe plus durement les femmes“. 19 August 2009. Retrieved from http://www.irinnews.org/fr/report/85808/niger-la-faible-application-de-la-loi-vih-frappe-plus-durement-les-femmes.

Jacobson, P. D., & Wasserman, J. (1999). The implementation and enforcement of tobacco control laws: policy implications for activists and the industry. *Journal of Health Politics, Policy and Law,* 24(3); 567–598.

KANCO & KELIN. (2012). *Study on human rights violations against people living with HIV and AIDS in Kenya*. Retrieved from http://kelinkenya.org/wp-content/uploads/2010/10/Human-Violation-book-final.pdf.

Kurth, A. E., et al. (2015). HIV testing and linkage to services for youth. *Journal of the International AIDS Society,* 18(2Suppl 1), 19433. doi: 10.7448/IAS.18.2.19433.

Lane, J-E. (1983). The concept of implementation. *Statsvetenskaplig tidskrift,* 86, 17–40.

May, P. J., & Winter, S. C. (2009). Politicians, managers, and street-Level bureaucrats: Influences on policy implementation. *Journal of Public Administration Research and Theory,* 19(3), 453–476.

Mazmanian, D. A., & Sabatier, P. A. (Eds). (1981). *Effective policy implementation*. Lexington, MA: Lexington Books.

Mykhalovskiy, E. (2015). The public health implications of HIV criminalization: past, current, and future research directions. *Critical Public Health,* 25(4), 373–385.

NACOPHA. (2013). The people living with HIV stigma index report: Tanzania. Retrieved from http://stigmaindex.org/sites/default/files/reports/Tanzania%20STIGMA%20INDEX %20REPORT%20-%20Final%20Report%20pdf.pdf.

O’Byrne, P., et al. (2013). Nondisclosure prosecutions and population health outcomes: Examining HIV testing, HIV diagnoses, and the attitudes of men who have sex with men following nondisclosure prosecution media releases in Ottawa, Canada. *BMC Public Health,* 13: 94.

OHCHR & UNAIDS (2006). *International Guidelines on HIV/AIDS and Human Rights, 2006 consolidated version*, HR/PUB/06/9. Retrieved from http://data.unaids.org/Publications/IRC-pub07/JC1252-InternGuidelines_en.pdf.

Palumbo, D. J., & Calista, D. J. (Eds). (1990). *Implementation and the policy process: Opening up the black box*. New York: Greenwood Press.

Pearshouse, R. (2007). Legislation contagion: The spread of problematic new HIV laws in Western Africa. *HIV/AIDS Policy and Law Review,* 12, 1–12.

Pearshouse, R. (2008). Legislation contagion: building resistance. *HIV/AIDS Policy & Law Review* Vol 13(2/3) 1-11.

Pressman, J. L., & Widavsky, A. (1984). *Implementation: how great expectations in Washington are dashed in Oakland: or, why it's amazing that federal programs work at all, this being a saga of the Economic Development Administration as told by two sympathetic observers who seek to build morals on a foundation of ruined hopes* 3rd ed Berkeley: University of California Press.

Lipsky, M. (1978). 'Standing the Study of Policy Implementation on Its Head,' in Walter Burnham and Martha Weinberg, (ed.) *American Politics and Public Policy*. Boston: MIT Press.

Sabatier, P. A., & Mazmanian, D. A. (1979). The conditions of effective implementation: A guide to accomplishing policy objectives. *Policy Analysis,* 5(4), 481–504.

Satterland, T. D., Lee, J. P., Moore, R. S., & Antin T. M. J. (2009). Challenges to implementing and enforcing California's smoke-free workplace policy Act in bars. *Drugs (Abingdon Engl)*, 16(5); 422–435.

Schneider, A. & Ingram, H (1990). 'Behavioral Assumptions of Policy Tools'. *The Journal of Politics* 52(2): 510-529.

Schneider, A & Ingram, I. (1997). Policy Design for Democracy. Lawrence, Kansas: University Press of Kansas.

Schneider, A & Ingram, H. (2005). Policy Analysis for Democracy. In Martin Rein, Michael Moran and Robert E. Goodin (ed), Oxford Handbook of Public Policy. Oxford University Press.

Stemple, L. (2008). Health and human rights in today's fight against HIV/AIDS. *AIDS,* Suppl 2, S113–121.

Stigler, G. J. (1974). The optimum enforcement of laws. In Becker, G. S., & Landes, W. M. (Eds), *Essays in the economics of crime and punishment*, (pp 55-67). New York: National Bureau of Economic Research.

UNAIDS. (2013). *Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations*. Geneva, Switzerland: UNAIDS.

UNAIDS. (2014a). *The gap report*. Geneva, Switzerland: UNAIDS.

UNAIDS. (2014b). "Fact sheet, World AIDS Day 2014". Retrieved from http://www.unaids.org/sites/default/files/documents/WAD2014_FactSheet_en.pdf .

UN General Assembly. (2001). *Declaration of commitment on HIV/AIDS*, (A/RES/S-26/2).

UN General Assembly Resolution. (2006) *Political declaration on HIV/AIDS*, (A/RES/60/262).

WHO. (2013). *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, Switzerland: WHO.

The HIV and AIDS Tribunal of Kenya: An Effective Mechanism for the Enforcement of HIV-related Human Rights?

Patrick Michael Eba

Abstract

Established under Section 25 of the HIV Prevention and Control Act of 2006, the HIV and AIDS Tribunal of Kenya is the only HIV-specific statutory body in the world with the mandate to adjudicate cases relating to violations of HIV-related human rights. Yet, very limited research has been done on this tribunal. Based on findings from a desk research and semi-structured interviews of key informants conducted in Kenya, this article analyzes the composition, mandate, procedures, practice, and cases of the tribunal with the aim to appreciate its contribution to the advancement of human rights in the context of HIV. It concludes that, after a sluggish start, the HIV and AIDS Tribunal of Kenya is now keeping its promise to advance the human rights of people living with and affected by HIV in Kenya, notably through addressing barriers to access to justice, swift ruling, and purposeful application of the law. The article, however, highlights various challenges still affecting the tribunal and its effectiveness, and cautions about the replication of this model in other jurisdictions without a full appraisal.

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Introduction

Kenya has the fourth-largest HIV epidemic globally.[1] Some 1.6 million people were living with HIV in the country in 2013, of whom 100,000 were infected that year alone.[2] Since the country identified its first AIDS case in 1984, HIV has remained a serious public health concern that has claimed hundreds of thousands of lives and orphaned millions of children.[3] Despite recent progress in the response to the epidemic in Kenya, pervasive stigma, discrimination, and human rights violations associated with HIV remain serious challenges.[4] To address these challenges, Kenya adopted the HIV and AIDS Prevention and Control Act (HAPCA) in 2006.[5] A defining feature of HAPCA is the establishment of the HIV and AIDS Tribunal (hereinafter "tribunal").[6] The tribunal's role is to "determine complaints arising out of any breach" of HAPCA. Unlike the 26 other sub-Saharan African countries that have adopted HIV-specific legislation, Kenya, through the creation of the tribunal, sought to address the often forgotten yet critical issue of enforcement of its HIV legislation.[7] The tribunal was established as a statutory body to ensure the protection of human rights in the context of HIV within the limits described by HAPCA.[8]

While the tribunal is often lauded as a tool for access to justice, limited research has been done on this mechanism.[9] Beyond the curiosity that it may generate as the first and only HIV-specific judicial body in the world, is the tribunal an effective mechanism for ensuring the implementation and enforcement of HIV-related human rights?

Several elements are generally taken into consideration when assessing the effectiveness of judicial and quasi-judicial bodies, including the ability to compel parties to appear before them and to comply with their decisions, the accessibility to the court for complainants, the timeline for decision, and the extent to which the decisions are based on sound interpretation of the law.[10] For people living with HIV and their advocates, key concerns relating to access to justice and effective adjudication include court procedures that do not maintain confidentiality, limited knowledge of HIV and the legal issues that it raises within the judiciary, and lack of sensitivity to people living with HIV.[11]

This article therefore assesses whether the HIV and AIDS Tribunal of Kenya addresses some of these challenges to access to justice and to the judicial protection of human rights in the context of HIV. In doing so, the article describes and discusses the composition, procedures, and practice, as well as a key decision of the tribunal. This study is mainly based on a desk analysis of primary and secondary materials relating to HAPCA and the tribunal. The desk research was completed through semi-structured interviews with 11 key informants, conducted in Nairobi, Kenya, from August 20-29, 2014. Further information was also sought through email exchanges and phone interviews with two additional informants in September 2015. The interviewees included key informants involved in the development of HAPCA or in the work of the tribunal, such as the current and former chairpersons of the tribunal, the executive director of National Empowerment Network of People Living With HIV and AIDS in Kenya (NEPHAK), a member of the Commission for the Implementation of the Constitution, a judge of the High Court and the executive director of Kenya Ethical and Legal Issues Network on HIV and AIDS (KELIN).

The research was limited by challenges in accessing tribunal decisions which were not publicly available. Furthermore, while the author was able to interview members of organizations that have supported complainants before the tribunal, he was not in a position to directly interview individual complainants.

This article is divided into three sections. Section 1 provides a brief background to, and an analysis of, HAPCA. Section 2 discusses the composition, mandate, and work of the tribunal, including a review of its cases and an analysis of one of its key decisions. Section 3 assesses the challenges facing the tribunal. The article concludes with remarks regarding the contribution of the tribunal in enforcing HIV-related human rights.

Process and normative content of HAPCA

The making and entry into force of HAPCA

The proposal for an HIV-specific law in Kenya can be traced to the Task Force on Legal Issues Relating to HIV and AIDS (hereinafter "task force"), established in June 2001 by the country's attorney general, Amos Wako.[12] The task force was chaired by Ambrose Rachier, a lawyer and then-chairperson of KELIN, and comprised 13 members, four ex-officio members, and two secretaries.[13] The members were lawyers, medical experts, religious leaders, and people living with HIV. The task force was mandated to review existing laws, policies, and practices relating to HIV in Kenya, and to recommend an appropriate response to the epidemic.[14] Over the course of 11 months, the task force met with relevant ministries, members of parliament, medical professionals, religious leaders, non-governmental organizations, people living with HIV, sex workers, and members of the gay community.[15] In its final report, submitted in June 2002, the task force highlighted 12 HIV-related legal issues of concern and made recommendations for addressing them.[16] Among these recommendations, the task force called for the enactment of HIV-specific legislation "to be referred to as the HIV and AIDS Prevention and Control Act" and for the establishment of an "Employment Equity Tribunal for HIV and AIDS."[17] The main reason for recommending a special tribunal on HIV issues stemmed from concern that existing courts were too slow in delivering justice, had cumbersome procedures that hindered access to justice for people living with HIV, and were not sufficiently knowledgeable on HIV and the related legal and human rights issues.[18] In September 2003, the HIV and AIDS Prevention and Control Bill was tabled before Parliament.[19] The idea of the tribunal recommended by the task force was retained in the HIV bill, but as a broader mechanism with a mandate to enforce all provisions in the bill, not just those relating to employment. Parliament finally adopted HAPCA on December 5, 2006, and the president of Kenya assented to it on December 30, 2006.[20]

More than two years after HAPCA was adopted, however, it was still not in effect, due to a delay on the part of the responsible minister in setting a date for its commencement.[21] HAPCA was finally commenced on March 30, 2009. By that time, the delay in operationalization of the act had created great concern among civil society and contributed to legal action to compel the minister to operationalize this law.[22] Despite the act's commencement in 2009, the minister still did not bring several of its provisions into effect, namely sections 14 (consent to HIV testing), 18 (results of HIV test), 22 (disclosure of information), 24 (criminalization of HIV non-disclosure and exposure), and 39 (requirement for research).[23] Finally, in November 2010, all HAPCA provisions were brought into effect except for section 39, which was still not in effect as of January 2016.[24] According to Ambrose Rachier, opposition from the "research community" is responsible for the delay in operationalizing this provision, which requires that any HIV-related biomedical research conforms to the requirements of the Science and Technology Act of Kenya.[25]

Normative content of HAPCA

Two elements are worth highlighting in relation to the content of HAPCA. First, it contains a number of provisions that protect human rights and can advance the HIV response. Second, these positive norms exist alongside restrictive provisions which infringe upon human rights and risk undermining the response to HIV.

HAPCA contains a series of protective provisions that either explicitly protect the rights of people living with HIV or create an enabling environment for the HIV response. Key provisions explicitly protecting people living with HIV include sections 31 (non-discrimination in the workplace), 32 (non-discrimination in schools), 36 (non-discrimination in health institutions), 18 and 21 (protecting confidentiality of HIV results), and 33 (prohibition of restrictions to travel for people living with HIV). Protective measures supporting the HIV response in HAPCA include sections 4 (HIV education and information), 9 and 10 (blood

and tissue safety), 19 and 36 (access to HIV treatment) and 43(c) (involvement of people living with HIV in information and education campaigns).

Coercive provisions in HAPCA include restrictive measures for access to HIV testing for children (sections 14 and 22), mandatory HIV testing for alleged sexual offenses (section 13(3)) and overly broad criminalization of HIV non-disclosure, exposure, or transmission (section 24). These provisions have raised concerns among public health and HIV experts, as well as people living with HIV.[26] In particular, section 24 creates a broad obligation on people living with HIV to disclose their status and criminalizes any act that exposes another person to HIV. This section has been the focus of intense advocacy and litigation efforts by civil society on grounds that it lacks certainty, creates a risk of unfair prosecution against people—particularly women—living with HIV, and that it is likely to deter people from accessing HIV services.[27] In a groundbreaking ruling on March 18, 2015, the High Court of Kenya declared section 24 unconstitutional on grounds that it is "vague and lacking in certainty" and therefore likely to violate the right to privacy.[28]

Composition, mandate, and powers of the HIV and AIDS Tribunal

The HIV and AIDS Tribunal of Kenya came into effect with the commencement of HAPCA in 2009. Part VII of HAPCA deals specifically with the tribunal. It outlines in some detail the composition, jurisdiction, and powers of the tribunal, as the main body tasked with enforcing HAPCA.

Composition of the tribunal

The tribunal comprises seven members: six regular members and a chairperson.[29] The attorney general appoints members to three-year terms.[30] HAPCA distinguishes three categories of tribunal members.[31] These are: legal experts (three members), medical practitioners (two members) and persons with "specialised skill or knowledge necessary for the discharge of the functions of the Tribunal" (two members).[32] The three legal experts are the chairperson, who "shall be an advocate of the High Court of not less than seven years standing" and two advocates of the High Court of "not less than 5 years standing."[33] HAPCA does not require that these members have judicial experience, or that they have expertise in specific areas such as human rights or HIV-related legal and ethical issues. However, in practice, the legal experts who have thus far been appointed to the tribunal have involved renowned legal practitioners with knowledge on HIV-related legal and ethical issues. For instance, the first chairperson was Ambrose Rachier, who chaired the Task Force on Legal Issues Relating to HIV and AIDS.[34]

The second category of tribunal members comprises two "medical practitioners recognized by the Medical Practitioners and Dentist Board as specialists under the Medical Practitioners and Dentists Act."[35] The inclusion of medical practitioners in the tribunal is important; it is aimed at ensuring that the work and decisions of the tribunal are informed by best-available scientific knowledge relating to HIV, its modes of transmission, and its impact. However, while requiring that these medical practitioners be specialists, HAPCA does not explicitly state that their specialization must be related to HIV.

The third category of tribunal members comprises two "persons with specialized skills or knowledge necessary for the discharge of the functions of the Tribunal." This category is unclear and could create uncertainty about what "skills and knowledge" are to be taken into consideration. In practice, however, people living with HIV and members of non-governmental organizations have been appointed as members of the tribunal under this category. For instance, since its launch, the tribunal has had among its members Joe Muruiki, the first Kenyan who publicly announced his HIV-positive status in September 1989.[36] HAPCA finally requires that at least two tribunal members be women.[37] While this requirement for gender diversity is positive, the threshold of two female members out of seven may appear insufficient. For instance, the Kenyan Constitution of 2010 calls on the state to take measures to ensure that "not more

than two-thirds of the members of elective or appointive bodies shall be of the same gender."[38]

Ultimately, the multi-disciplinary composition of the tribunal with a "unique mix of legal, medical and social expertise coupled with a requirement of gender balance" is an important feature.[39] It is necessary to enable the tribunal to address the complex legal and social issues raised by the HIV epidemic, provided that the current practice of ensuring representation of HIV experts and people living with HIV (although not explicitly stated in HAPCA) is maintained.

Mandate of the tribunal

The tribunal is granted a broad mandate to "hear and determine complaints arising out of any breach of the provisions of the Act."[40] However, HAPCA explicitly excludes criminal jurisdiction from the mandate of the tribunal.[41] In addition to its mandate to adjudicate complaints, the tribunal is also mandated to "perform any other such functions as may be conferred upon it by [HAPCA] or by any other written law being in force." This provision may be interpreted to recognize an "extra-judicial" mandate to the tribunal that may entail actions such as making recommendations for the effective implementation of HAPCA. For its current chairperson, Jotham Arwa, the tribunal can and should engage in such a role and recommend actions that the government and others should take to effectively implement HAPCA.[42] Arwa stressed in this regard that "what we intend to do is not only to deal with reported cases, we want to develop the law in the area of HIV/AIDS so that the public health environment is more friendly to the protection of rights of people living with the disease."[43] In practice, the tribunal chairperson has, for example, written to the cabinet secretary for health requesting the swift development of guidelines on privacy and confidentiality of HIV status in health care settings, as required by section 20 of HAPCA.[44]

Powers of the tribunal

In hearing cases brought before it, the tribunal has been granted the powers of a subordinate court.[45] It can therefore summon witnesses, take evidence under oath, or call for the production of books or other documents as evidence.[46] Failure to attend or give evidence before the tribunal, without sufficient reason, when summoned is a criminal offense.[47]

In deciding on complaints, the tribunal has the power to make any order that it deems appropriate.[48] These orders may include payment of damages for present and future financial loss or for impairment of dignity or emotional and psychological suffering.[49] This broad applicability of reasons for awarding damages is important in the context of HIV, where stigma and discriminatory attitudes encroach upon individual dignity and inflict emotional and psychological pain that may not necessarily be recognized before normal courts. Parties in whose favor damages or costs are awarded can obtain a certificate from the tribunal which, upon filing before the High Court, is deemed and executed as a decree of the High Court.[50] Orders by the tribunal can also involve requiring that specific steps be taken to stop a discriminatory practice.[51] Finally, the tribunal has the power to require respondents to make regular progress reports regarding the implementation of its orders.[52]

Practice and cases of the tribunal

In this section, an overview of the practice before the tribunal and the nature of its cases is presented, followed by a discussion of YBA v. Brother Nicholas Banda and Three Others, which sheds light on the approach of the tribunal in handling HIV-related complaints.[53] The case of YBA was selected for analysis because it is one of the best-reasoned rulings of the tribunal that the author was able to secure as part of this study.

Overview of practice and cases

Although the first members of the tribunal were announced in 2009, they were only sworn into office in June 2011, some two years later.[54] Following the swearing-in, the tribunal started handling and hearing some of the cases that it had already received, which had started to pile up.[55] With no Rules of Procedures, the tribunal adopted a pragmatic and flexible approach to receiving and adjudicating

complaints.[56] The tribunal does not require that lawyers assist complainants. However, in cases where complainants need legal support, the tribunal has directed them to non-governmental organizations such as KELIN and the Law Society of Kenya.[57] The tribunal allows individuals to submit cases through simple letters, and there is no cost involved in filing a complaint. The tribunal pays particular attention to issues of privacy and confidentiality in its handling of complaints. It holds its hearings in camera and complainants have the option to withhold names and other personal details in decisions and in other tribunal papers. When the complainant so requests, the tribunal rather uses identifiers to protect privacy and confidentiality. The concerns relating to the protection of privacy and confidentiality of complainants has also been cited as a reason for not reporting or publicly releasing the decisions of the tribunal.[58] While these reasons may appear legitimate, the lack of access to the decisions of the tribunal represents a barrier for creating awareness of its work, practice, and effectiveness in advancing human rights in the context of HIV.

Complaints filed before the tribunal are first handled by the registry. Cases that fall within the tribunal's jurisdiction are referred for consideration while the others are sent to other suitable jurisdictions or mechanisms.[59] The tribunal is not permanent; it sits in sessions during which it considers six to ten cases. Complaints brought before the tribunal are generally settled within a few weeks to three months. This is a significant improvement in terms of swift administration of justice, particularly as disputes before normal courts in Kenya often take several years to be determined.[60] The decisions of the tribunal are subject to appeal and to judicial review before the High Court of Kenya. This was explicitly stated by the High Court in Republic v. HIV and AIDS Tribunal & Another, a case in which a party challenged a tribunal decision.[61]

In a period of two years, November 2011 to November 2013, the tribunal received 232 complaints.[62] The tribunal considered 68.5% (159) of these complaints, while the others (31.5%) were referred to normal courts and other institutions with the mandate to handle them.[63] As of December 2014, the tribunal had handled some 300 complaints, either through rulings on the merits, settlement between the parties, or referral to other bodies.[64] Many complaints filed before the tribunal are indeed settled by the parties before a ruling is made. In general, the tribunal does not become involved in the process and terms of the settlements between the parties, but it does allow the parties to record the terms of their settlements through an order of the tribunal.[65] While such settlements may be expedient for the parties, who do not have to go through a judicial process of several weeks or months, the tribunal has expressed concern that in the long run, settlements may impair its ability to make precedent-setting rulings on critical issues.

Those complaints which the parties do not settle proceed to the tribunal for decision on the merits. When deciding on cases, the tribunal relies primarily on the provisions of HAPCA. It also uses and invokes relevant other legislation with bearing on HIV, including the Employment Act as well as the Constitution of Kenya. Where the tribunal finds that a violation of the provisions of HAPCA has occurred, it explicitly states so and provides appropriate relief to the complainants, including, in several cases, financial compensation. The persons in whose favor the damages and costs are awarded can apply for a certificate from the tribunal stating the amount of the damages or costs.[66] The beneficiary may then file the certificate in the High Court, after which it is considered an order of the High Court and is executed as such.[67]

The majority of the complaints that the tribunal receives relate to HIV in the workplace. These include cases of mandatory HIV testing as a prerequisite for employment, and HIV-related discrimination in the workplace, such as denial of promotion, demotion, or irregular transfer of workers based on their HIV status.[68] The second category of cases relates to access to HIV services, including HIV treatment. These cases involve discrimination and abuse in health care settings and denial of services based on HIV status.[69] The third category of cases relates to issues such as domestic violence, property, and inheritance, which are often filed by women.[70] Although the overwhelming ma-

jority of complaints before the tribunal have been submitted by people living with HIV, the tribunal can hear any case relating to a breach of HAPCA regardless of the HIV status of the complainant.[71]

Human rights organizations and people living with HIV in Kenya have praised the tribunal for its smooth, flexible, and sensitive approach to justice in the context of HIV.[72]

The case of YBA v. Brother Nicholas Banda and Three Others

The case was filed on August 24, 2012, by a complainant anonymously identified as YBA, who worked for the Registered Trustees of Marist Brothers (the fourth respondent in the case) from 1992 to 2012. YBA tested positive for HIV in 2003 and alleged that her supervisor (the first respondent) compelled her to submit her medical record, including the HIV test result, to her employer. YBA further alleged that her HIV status was disclosed by her supervisor to other employees, and that she had since then been the victim of derogatory and abusive comments, as well as discriminatory acts and practices, based on her HIV status. YBA also alleged that her employment was terminated in 2012 because of her HIV-positive status. In her prayers, she sought that the tribunal declared the respondents' actions illegal for violating HAPCA and the Constitution of Kenya, and also asked that it ordered damages for emotional distress and other violations.

The ruling of the tribunal in this case is significant for a number of reasons. First, it found that the complainant's right to non-discrimination, privacy, and confidentiality, as provided under HAPCA and the Kenyan Constitution, had been violated.[73] Second, it awarded significant compensation for the damages suffered by YBA, including for emotional and psychological distress caused by the disclosure of her HIV status, in violation of her right to privacy and confidentiality. In total, the tribunal awarded her Ksh958,614, which at the time was the equivalent of approximately US$11,000. This amount is substantive for the complainant, who was earning a monthly salary of Ksh14,000 (approximately US$164). Third, and probably most importantly, the tribunal in its ruling dealt with whether it has jurisdiction to hear employment-related disputes. This question is a critical issue since the great majority of cases that have come before the tribunal relate to workplace issues, including compulsory HIV testing as a precondition for employment and unfair dismissal based on HIV status. The question of the tribunal's jurisdiction to hear employment cases arises in light of section 87(2) of the Employment Act, which grants exclusive jurisdiction to the Industrial Court in employment-related disputes. In its decision in YBA, the tribunal held that section 87(2) could not be construed as barring its jurisdiction on HIV-related employment issues. Rather, the tribunal stressed that its composition made it a specialist court with expert knowledge on HIV, as opposed to the generalist expertise on employment of the Industrial Court. The tribunal thus held that:

> *this tribunal also has in its membership, at least two medical practitioners, at least one person experienced in matters of HIV and AIDS, and finally, at least one person living with HIV virus. This tribunal is therefore equipped with the requisite intellectual resources to effectively address all legal, medical, social and psychological issues that may emerge in the context of HIV and AIDS litigation, and is therefore better placed to adjudicate cases of violation of the rights of persons living with HIV and AIDS in the workplace than a single judge of the Industrial Court.*[74]

The tribunal therefore concluded that it has jurisdiction to hear cases relating to the violation of the rights of people living with HIV in the workplace, provided that "such violations are proved to be *solely on account of the HIV status* of the concerned individuals" [emphasis added].[75] Through this purposeful interpretation of HAPCA and other relevant laws, the tribunal addressed a key uncertainty relating to its mandate and further cemented its jurisdiction on HIV-related employment issues.

In its decision, the tribunal also held that it has jurisdiction to hear cases alleging violation of fundamental rights pursuant to Articles 20(4) and 169(1) of the Kenyan Constitution. According to Article 20(4), "[i]n interpreting the Bill of Rights, a court, tribunal or other authority shall promote – (a) the values that underlie an open and democratic

society based on human dignity, equality equity and freedom and; (b) the spirit, purport and objects of the bill of rights". In a July 2015 ruling, however, the High Court of Kenya held that in the absence of legislation explicitly conferring such power, the tribunal does not have jurisdiction to entertain matters relating to violation of the Constitution.[76] While a setback, this decision has no impact on the mandate of the tribunal to advance the protection of human rights as provided under HAPCA.

Challenges affecting the tribunal

While noting the achievements of the tribunal over the past three years, many challenges still hinder its effectiveness and threaten to compromise the realization of its objectives. These challenges are multi-faceted and relate to structural, financial, and operational issues. In addition, the limited public awareness of the tribunal remains a concern.

Structural, operational, and financial challenges

Complaints before the tribunal can only be lodged in Nairobi, where it is located. For a tribunal initially created to address concerns of access to justice, the fact that people cannot access it closer to where they live creates a serious hurdle. The tribunal is currently considering options for addressing this issue, including through the possibility for people to submit their complaints to the tribunal at the registry of courts in the areas where they live, or by holding mobile hearings of the tribunal at the county level.[77]

The quorum for sittings of the tribunal has been raised as a challenge. The fact that all tribunal members have other occupations and commitments makes the five-out-of-seven-member quorum hard to achieve, thus leading to delays in scheduling its sittings.[78]

The tribunal still does not have its own Rules of Procedures. It relies for its work on the provision of the HIV Act and adapts general rules applicable before normal courts. This situation leads to uncertainty and lack of clarity for those seeking justice before the tribunal. In response, the tribunal has developed draft rules of procedures, which were transmitted to the Chief Justice of Kenya in 2014.[79]

While its staffing has recently increased from one employee in 2013 to some 20 employees in 2014, the tribunal still does not have sufficient numbers of qualified lawyers to support its work.[80] It also lacks appropriate physical infrastructure. As of December 2014, it was located within the premises of the National AIDS Control Council of Kenya. This situation is not ideal for the smooth and confidential administration of justice on a highly stigmatized condition such as HIV. It also may contribute to the limited awareness of the tribunal; as its former chairperson said, "How do you want people to go to a tribunal that does not exist?"[81]

Finally, the tribunal is still confronted with financial constraints. During its first two years of activities, it was mainly supported by donors, including the United Nations.[82] In recent years, however, the Kenyan government sharply increased the tribunal's funding from Ksh11 million (US$113,000) in the financial 2013-2014 to Ksh126 million (US$1.2 million) in 2014-2015.[83] This financial commitment should be maintained and expanded so the tribunal can recruit the necessary legal and other staff, rent appropriate premises, hold sessions at county levels, and undertake other activities necessary to fulfill its mandate.

Limited awareness of the tribunal

Knowledge of the tribunal and its mandate and work remains limited. Key informants within the National Human Rights Commission and the judiciary interviewed as part of this study knew little about it. A 2012 study conducted in 15 counties found that only 32.5% of people living with HIV knew about the tribunal, as opposed to nearly 70% who were aware of HAPCA.[84] In general, knowledge of the tribunal is greater among HIV organizations and people living with HIV in Nairobi.[85]

The delays in setting up and operationalizing the tribunal, its lack of appropriate offices, its location only in Nairobi, as well as the fact that its decisions are not reported or publicized, have been cited among the reasons for the limited awareness

of this body.[86] Also, the tribunal has not yet conducted a meaningful communication and public awareness campaign to educate people on its existence and work. Although the tribunal has in some cases referred complainants to non-governmental organizations working on legal issues, it has not yet developed a deliberate and systematic collaboration with these organizations and people living with HIV, including for orienting potential complainants.[87]

In July 2014, the tribunal launched an ambitious 2013-2017 strategic plan in an effort to address these challenges.[88] The plan provides a candid assessment of the tribunal's strengths and weaknesses. It also sets three strategic objectives: 1) to deliver justice, in a judicially transformative environment, for people living with and affected by HIV; 2) to build the institutional capacity of the tribunal so as to effectively and efficiently discharge its mandate; and 3) to build partnerships and collaboration with stakeholders in order to enhance access to justice.[89] It is expected that the implementation of the plan for the five-year period will cost Ksh1.873 billion (US$19 million).[90] To date, the plan remains largely unfunded.

Conclusion and recommendations

The tribunal is a defining feature of HAPCA. After a sluggish start, due mainly to the delays in the entry into force of HAPCA, it is now starting to keep its promise of ensuring justice for people living with and affected by HIV in Kenya. Through its composition, mandate, procedures, and decisions, the tribunal is emerging as a positive experiment for enforcing HAPCA and for protecting the rights of people living with HIV. The tribunal addresses some of the challenges relating to access to justice and rights-based judicial decisions for people living with HIV, thanks, notably, to a bench that is sensitive to and knowledgeable on HIV issues, less cumbersome proceedings that protect confidentiality and privacy, and speedy rulings. Furthermore, as evidenced in its ruling in the case of YBA v. Brother Nicholas Banda and Three Others, the tribunal has adopted a purposeful interpretation of HAPCA and the Constitution of Kenya that advances the protection of fundamental rights for people living with HIV. The tribunal should be encouraged to more proactively use its mandate to recommend measures for the effective implementation of HAPCA, including by calling for the elaboration of guidelines on critical HIV-related human rights issues where they are needed to address unlawful practices such as involuntary sterilization.[91] There is also a need to strengthen collaboration with non-governmental organizations and more systematically engage actors involved in the response to HIV, including health professionals and employers, as part of efforts to advance the implementation of HAPCA.

However, these promises risk being undermined by the many challenges that still confront the tribunal. These include operational, structural, and financial challenges, as well as limited awareness on its work. The tribunal's strategic plan for 2013-2017 offers solutions to some of these challenges, but this plan remains largely unfunded two years after it was developed, and steps to ensure its effective implementation have been lacking. Realizing the potential of the tribunal will require continued commitment on the part of the Kenyan government, as well as other partners involved in the response to HIV, to ensure that it has the resources needed to fulfill its mandate.

As the only judicial mechanism in the world specifically dedicated to the epidemic, can the HIV and AIDS Tribunal of Kenya serve as possible model in other countries? Is such a tribunal a viable and effective option for consideration in other jurisdictions, particularly in sub-Saharan Africa? The Model Law on HIV in Southern Africa explicitly recommends such a tribunal as an option to enforce HIV-related human rights and advance justice for people living with HIV and those affected by the epidemic.[92]

This study shows that the establishment of an HIV-specific tribunal is a complex endeavor. The author therefore calls for caution, particularly in light of the political, financial, staffing and other challenges confronting the HIV and AIDS Tribunal of Kenya. This research highlights the need for further studies to appraise the tribunal and its contribution to enforcing HAPCA and advancing

HIV-related human rights, particularly now that some of the challenges to its operation are being addressed. Additional research should also provide insights into the perspectives of complainants and other parties who appeared before the tribunal. Such research is critical to understanding whether and under which circumstances an HIV-specific tribunal may be worth considering in other jurisdictions.

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References

1. UNAIDS Eastern and Southern Africa, "Kenya: Country profile." Available at http://www.unaidsrstesa.org/region/countries/kenya.

2. UNAIDS, The gap report (Geneva: UNAIDS, 2014), pp. A21 and A36.

3. Kenyan National AIDS Control Council (NACC), Kenya AIDS response progress report 2014: Progress towards zero (Nairobi: NACC, 2014). Available at http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/KEN_narrative_report_2014.pdf.

4. See, among others, Human Rights Watch, In the shadow of death: HIV/AIDS and children's rights in Kenya (New York: Human Rights Watch, 2001); Kenya AIDS NGOs Consortium (KANCO) and Kenya Legal and Ethical Issues Network on HIV (KELIN), Study on human rights violations against people living with HIV and AIDS in Kenya (Nairobi: KANCO, 2012), pp. 77–78; National Empowerment Network of People Living With HIV and AIDS in Kenya (NEPHAK) and Global Network of People Living with HIV, PLHIV stigma index Kenyan country assessment (Nairobi: NEPHAK, 2011). Available at http://www.stigmaindex.org/sites/default/files/reports/Kenya%20People%20Living%20with%20HIV%20Stigma%20Index%20Report%202009.pdf.

5. HIV and AIDS Prevention and Control Act, No. 14 of 2006, CAP. 246A (hereinafter "HAPCA"). Available at http://www.kenyalaw.org:8181/exist/kenyalex/actview.xql?actid=CAP.%20246A.

6. HAPCA (see note 5), section 25.

7. P.M. Eba, "HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis," African Human Rights Law Journal 15 (2015), pp. 224–262; R. Pearshouse, "Legislation contagion: The spread of problematic new HIV laws in Western Africa," HIV/AIDS Policy and Law Review 12 (2007), pp. 1–12; D. Grace, "Legislative epidemics: the role of model law in the transnational trend to criminalise HIV transmission," Medical Humanities 39 (2013), pp. 77–84.

8. K. Sinclair, "Kenyan government to establish special tribunal for HIV-related issues," HIV/AIDS Law and Policy Review 14 (2010), pp. 26–27.

9. Ibid.

10. L.R. Helfer and A.M. Slaughter, "Toward a theory of effective supranational adjudication," The Yale Law Journal 107 (1997), pp. 273–391.

11. M. Kirby, "HIV/AIDS - Implications for law and the judiciary," Fiji Law Society, 50th Anniversary Convention, May 27, 2006. Available at http://www.hcourt.gov.au/assets/publications/speeches/former-justices/kirbyj/kirbyj_27may06a.pdf; UNAIDS, Judging the epidemic: A judicial handbook on HIV, human rights and the law (Geneva: UNAIDS, 2013), p. 3.

12. Kenyan Office of the Attorney General and National AIDS Control Council, Report of the Task Force on Legal Issues Relating to HIV and AIDS: Summarised version (Nairobi: Office of the Attorney General and National AIDS Control Council, 2002), p. vii.

13. Ibid.

14. Ibid, p. vi.

15. Ibid, p. 13.

16. Ibid.

17. . Ibid, pp. 125–128.

18. . See Kenyan HIV and AIDS Tribunal, Strategic plan 2013-2017 (Nairobi: HIV and AIDS Tribunal, 2013). Available at http://www.undp.org/content/dam/kenya/docs/Democratic%20Governance/HIV%20and%20AIDS%20TRIBUNAL%20STRATEGIC%20PLAN.pdf.

19. The HIV and AIDS Prevention and Control Bill 2003, Kenya Gazette Supplement No 76.

20. AIDS Law Project Kenya, HIV and AIDS Prevention and Control Act Kenya: Simplified version (Nairobi: AIDS Law Project, 2010).

21. HAPCA (see note 5), section 1.

22. AIDS Law Project Kenya (see note 20), p. 4.

23. Legal Notice No. 34, Kenya Gazette Supplement, No. 16, March 6, 2009.
24. Legal Notice No. 180, Kenya Gazette Supplement No. 81, November 5, 2010.
25. Interview with Ambrose Rachier (former chairperson of HIV Tribunal), August 26, 2014, Nairobi, Kenya.
26. KELIN, Punitive laws and practices affecting HIV responses in Kenya (Nairobi: KELIN, 2014); and KELIN Advisory note on the provisions of section 24 of the HIV and AIDS Prevention and Control Act 2006, November 30, 2010. Available at http://kelinkenya.org/wp-content/uploads/2010/12/Advisory-Note-on-Section-24-of-HAPCA.pdf.
27. Ibid.
28. . AIDS Law Project v Attorney General & 3 Others (2015) (High Court of Kenya). Available at http://kenyalaw.org/caselaw/cases/view/107033/.
29. HAPCA (see note 5), section 25(1).
30. HAPCA (see note 5), section 25(6)(a).
31. HAPCA (see note 5), section 25(1).
32. Ibid.
33. Ibid.
34. The current chairperson of the HIV Tribunal, Jotham Arwa, is a founding member of KELIN.
35. HAPCA (see note 5), section 25(1)(c).
36. INB Africa News, "I've lived a full life despite being HIV positive, says PhD candidate Joe Muriuki" (November 9, 2014). Available at http://www.standardmedia.co.ke/health/article/2000140872/i-ve-lived-a-full-life-despite-being-hiv-positive-says-phd-candidate-joe-muriuki.
37. HAPCA (see note 5), section 25(2).
38. The Constitution of Kenya, 2010, section 27(8). Available at http://www.kenyalaw.org:8181/exist/kenyalex/actview.xql?actid=Const2010.
39. YBA v. Brother Nicholas Banda and Three Others (2013) (HIV and AIDS Tribunal of Kenya, Tribunal Case No. 007 of 2012).
40. HAPCA (see note 5), section 26(1)(a).
41. HAPCA (see note 5), section 26(2).
42. P. Eba, Interview with Jotham Arwa (current chairperson of HIV and AIDS Tribunal) August 26, 2014, Nairobi, Kenya.
43. See J. Muraya, "Tribunal to hear HIV/AIDS cases sworn in" (April 11, 2013). Available at http://www.capitalfm.co.ke/news/2013/04/tribunal-to-hear-hivaids-cases-sworn-in/.
44. Eba (see note 42).
45. HAPCA (see note 5), section 27(1).
46. Ibid.
47. HAPCA (see note 5), section 28.
48. HAPCA (see note 5), section 27(7)(b).
49. HAPCA (see note 5), section 27(7)(c)(i).
50. HAPCA (see note 5), section 29 and also Republic v. HIV and AIDS Tribunal and another ex parte Dyncorp International (2015) (High Court of Kenya, EKLR para. 26). Available at http://kenyalaw.org/caselaw/cases/view/105138/.
51. HAPCA (see note 5), section 27(7)(c)(ii).
52. HAPCA (see note 5), section 27(7)(c)(iv).
53. YBA v Brother Nicholas Banda and Three Others (see note 39).
54. Kenya News Desk, "Kenyans await delayed HIV/AIDS Tribunal" (August 24, 2010). Available at http://www.globalpressjournal.com/africa/kenya/kenyans-await-delayed-hivaids-tribunal#sthash.UnjUJQQB.dpuf.
55. I. Karambu, "Tribunal expected to herald new dawn for people living with Aids" (June 29, 2011). Available at http://www.businessdailyafrica.com/-/539444/1190786/-/121e3s1z/-/.
56. Eba (see notes 25 and 42).
57. Ibid.
58. P. Eba, Interview with staff member of HIV Tribunal, August 27, 2014.
59. Kenyan HIV and AIDS Tribunal (see note 20).
60. P. Mbote and M. Akech, Kenya Justice sector and rule of law: A review by AfriMAP and the Open Society Initiative for Eastern Africa (Nairobi: Open Society Foundations, 2011).
61. Republic v HIV and AIDS Tribunal & Another Ex Parte Dyncorp International (see note 50).
62. Kenyan HIV and AIDS Tribunal (see note 18), p. 19.
63. Ibid.
64. Eba (see note 42).
65. P. Eba, Phone interview with Nelson Osiemo, a lawyer who has represented complainants before the HIV Tribunal, September 29, 2015.
66. HAPCA (see note 5), section 29.
67. Ibid.
68. Kenyan HIV and AIDS Tribunal (see note 18), p. 19.
69. Ibid, p. 19.
70. Ibid, p. 19.
71. Eba (see note 42).
72. P. Eba, Interview with Nelson Otwoma, Executive Director of National Empowerment Network of People Living With HIV and AIDS in Kenya (NEPHAK), August 25, 2014, Nairobi, Kenya.
73. YBA v Brother Nicholas Banda and Three Others (see note 39).
74. Ibid, p. 15.
75. Ibid.
76. Royal Media Services Ltd v Attorney General & 6 others (2015) (High Court of Kenya, eKLR, para 48, p. 11).
77. Eba (see note 42).
78. Eba (see note 25).
79. Draft HIV and AIDS Tribunal (Practice and Procedure) rules, 2014 (on file with author).
80. Eba (see note 42).
81. Eba (see note 25).
82. Eba (see notes 25 and 42).
83. Kenyan HIV and AIDS Tribunal (see note 18), p. 19.

84. KANCO and KELIN (see note 4).

85. Eba (see notes 25 and 42).

86. Kenyan HIV and AIDS Tribunal (see note 20); and Eba (see notes 25 and 42).

87. R. Taylor Williamson, P. Wondergem and R. Amenyah, "Using a reporting system to protect the human rights of people living with HIV and key populations: A conceptual framework," Health and Human Rights 16/1 (2014), pp. 148–156.

88. Kenyan HIV and AIDS Tribunal (see note 18).

89. Ibid.

90. Ibid, p. 50.

91. African Gender and Media Initiative (GEM), Robbed of choice: Forced and coerced sterilization experiences of women living with HIV in Kenya (Nairobi: GEM, 2012) and Kenya National Commission on Human Rights (KNCHR), Realising sexual and reproductive health rights in Kenya: A myth or reality? (Nairobi: KNCHR, 2012).

92. Southern African Development Community (SADC) Parliamentary Forum, Model Law on HIV in Southern Africa (Windhoek: SADC Parliamentary Forum, 2008), section 47.

Chapter Nine

The contribution of civil society to rights-based legislative responses to HIV in sub-Saharan Africa: A comparison of civil society engagement on the Model Law on HIV in West Africa and the East African Community HIV legislation

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Summary

The role of civil society organisations in supporting access to HIV prevention and treatment services, and in providing psycho-social and other support to people living with or affected by HIV in sub-Saharan Africa is widely acknowledged. However, civil society's contribution to influencing, supporting or challenging HIV-related laws that have recently proliferated in the region, remains little known and largely anecdotal. This article provides insight into the role of civil society organisations in the context of HIV-related law making in sub-Saharan Africa by describing and comparing two case studies: (i) the Model law on STI/HIV/AIDS for West and Central Africa and its impact on national legislation, and (ii) the regional law on HIV in East Africa. This article shows that although not readily involved in HIV-related legislative processes, civil society organisations have been central to addressing serious human rights concerns in the Model law on STI/HIV/AIDS for West and Central Africa. Similarly, civil society organisations in East Africa were instrumental to initiating and influencing the adoption of a regional law which offers the promise of advancing rights-based responses to HIV in that region. The article reflects on the conditions, patterns and challenges relating to civil society's engagement in the two case studies. It then calls for more support to civil society involvement in HIV-related law making and implementation on the grounds of human rights, public health and good governance.

Key words: HIV, AIDS, legislation, civil society, participation, Africa

1 Introduction

Civil society organisations are at the forefront of the global response to the HIV epidemic.[1] In sub-Saharan Africa, as in other regions of the world, community organisations were often the first to mobilise in favour of people living with HIV at the beginning of the epidemic, in the face of government inaction, denial or opposition.[2] Civil society organisations have supported access to HIV prevention, treatment and care services for people living with or vulnerable to HIV.[3] They have also used human rights norms and frameworks to challenge ill-informed policies, denial of HIV services and other human rights violations through litigation or street protest, sometimes with resounding victories of global significance.[4] This was the case, for instance, when the Treatment Action Campaign - a South African civil society organisation - secured a groundbreaking ruling by the Constitutional Court ordering the government to ensure access to antiretroviral therapy (ART) for the prevention of mother-to-child transmission of HIV.[5] While the role of civil society organisations in supporting access to HIV prevention and treatment services and in providing psycho-social and other support to people living with HIV is widely acknowledged, their contribution in influencing, supporting or challenging HIV-related legislation, particularly in sub-Saharan Africa, remains little known and largely anecdotal.

[1] For an overview of the role of civil society organisations in the global response to HIV, see among others, R Shilts *And the band played on: Politics, people, and the AIDS epidemic* (1987); D Altman *Power and community: Organizational and cultural responses to AIDS* (1994); R Parker 'Grassroots activism, civil society mobilization, and the politics of the global HIV/AIDS epidemic' (2011) 17 *Brown Journal of World Affairs* 21-37; RG Wamai 'Civil society's response to the HIV/AIDS crisis in Africa' in E Obadare (ed) *The handbook of civil society in Africa* (2014) 361-398. While this article stresses the important role played by civil society organisations in advancing HIV-related human rights and access to HIV services, it is important to note that not all civil society organisations support the protection of human rights and that some actually work to undermine human rights.

[2] As above.

[3] As above.

[4] As above.

[5] *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) (CCT8/02) [2002] ZACC 15. For a discussion of this case and the role of the Treatment Action Campaign and other civil society organisations, see M Heywood 'Civil society and uncivil government: The Treatment Action Campaign (TAC) versus Thabo Mbeki, 1998- 2008' in D Glaser (ed) *Mbeki and after. Reflections on the legacy of Thabo Mbeki* (2010) 128-162; Z Achmat 'The Treatment Action Campaign, HIV/AIDS and the government' (2004) 54 *Transformation: Critical perspectives on Southern Africa* 76-84; M Pieterse *Can rights cure? The impact of human rights litigation on South Africa's health system* (2014) 65-70.

Sub-Saharan Africa - the region of the world most impacted by HIV - is also the region that has seen the most legislative developments relating to the HIV epidemic.[6] All countries in the region have adopted some form of legislation to address the legal and social impact of the HIV epidemic.[7] In particular, some 27 countries in sub-Saharan Africa had adopted HIV-specific legislation as of 31 July 2014, and the trend is still growing.[8] The drive to legislate on HIV in Africa and other regions originates from the recognition that supportive legal environments in general, and legislation, in particular, can play an important role in advancing the response to the HIV epidemic.[9]

In general, the extent to which law making in a particular country involves the public, including civil society actors, is considered a marker of good governance and strong constitutionalism.[10] In the context of HIV, there is a further rationale for the involvement of civil society, including people living with HIV, in law making. It is considered that the lived-experiences of people living with HIV and the expertise of civil society in supporting HIV prevention, treatment and care programmes can contribute to evidence-informed and rights-based legislation and policies in the context of the epidemic.[11] The importance of involving civil society, and particularly people living with and vulnerable to HIV, in the response to HIV was stated in the 1994 Declaration of the Paris AIDS Summit in which heads of governments and representatives of 42 countries committed to 'support a greater involvement of people living with HIV at all…levels…and to…stimulate the creation of supportive

[6] PM Eba 'HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis' (2015) 15 *African Human Rights Law Journal* 227-228.
[7] As above.
[8] As above.
[9] See, for example, J Hamblin 'The role of the law in HIV/AIDS policy' (1991) 5 *AIDS* s239-s243; Eba (n 6 above).
[10] J Mukuna & MLM Mbao 'Popular participation in legislative law-making under the new democratic dispensation in Kenya' (2014) 5 *Mediterranean Journal of Social Sciences* 438-446; A Fung & E Wright 'Deepening democracy: Innovations in empowered participatory governance' (2001) 29 *Politics and Society* 5-41; J Manor 'Democratisation with inclusion: Political reforms and people's empowerment at the grassroots' (2004) 5 *Journal of Human Development* 5-29.
[11] O Morolake, D Stephens & A Welbourn 'Greater involvement of people living with HIV in health care' (2009) 12 *Journal of the International AIDS Society* 4; UNAIDS 'Policy brief: Greater involvement of people living with HIV' March 2007 http://data.unaids.org/pub/BriefingNote/2007/jc1299_policy_brief_gipa.pdf (accessed 6 September 2016).

political, legal and social environments'.[12] This commitment - later known as the GIPA (greater involvement of people living with and affected by HIV/AIDS) principle[13] - was reaffirmed by United Nations (UN) members states in the 2001 Declaration of Commitment on HIV/AIDS.[14]

However, the serious criticisms laid by civil society against the HIV-specific laws adopted in sub-Saharan Africa suggest that, in many instances, these organisations were not consulted or involved in these law making processes or that their contributions were ignored.[15] Acting on these concerns, civil society organisations have mobilised against many HIV laws through advocacy for law reform or litigation to challenge their inadequate and coercive provisions.[16]

To provide insight into the role of civil society organisations in the context of HIV-related law making in sub-Saharan Africa, this article describes two case studies relating to: (i) challenging the Model law on STI/HIV/AIDS for West and Central Africa and its impact on national legislation, and (ii) securing rights-based regional law on HIV in East Africa. While many examples of civil society engagement in HIV-related legislative processes exist in sub-Saharan Africa, these two cases were selected for their regional and global significance and because they illustrate the context, challenges as well as successes of civil society efforts in influencing the development and reform of HIV-related legislation.

The article is structured into three parts. First, it discusses theories relating to the notion and typology of civil society organisations and applies this conceptual framework in the context of HIV. Second, the article describes - through the two case studies - the role played by civil society in influencing or contesting regional and national laws on HIV in West and Central Africa as well as in East Africa. Third, the

[12] UNAIDS *From principle to practice: Greater involvement of people living with or affected by HIV/AIDS* (1999) http://data.unaids.org/Publications/IRC-pub01/JC252-GIPA-i_en.pdf (accessed 6 September 2016).
[13] For a discussion of the GIPA principle, see Morolake *et al* (n 11 above); UNAIDS (n 11 above); UNAIDS (n 12 above).
[14] UN General Assembly Special Session on HIV/AIDS Declaration of Commitment on HIV/AIDS (A/RES/S-26/2), June 2001, para 33.
[15] R Pearshouse 'Legislation contagion: The spread of problematic new HIV laws in Western Africa' (2007) 12 *HIV/AIDS Policy and Law Review* 1-12; D Grace *This is not a law: The transnational politics and protest of legislating an epidemic* (unpublished PhD Thesis) https://dspace.library.uvic.ca//handle/1828/3944 (accessed 6 September 2016); Eba (n 6 above).
[16] Eba (n 6 above).

article offers critical reflections on the conditions, approaches, impact and challenges of civil society engagement in HIV-related legislative processes. It then closes with concluding remarks stressing the importance of civil society to HIV-related legislative processes.

2 Civil society and the HIV response: conceptual considerations and practice

Although the notion of civil society has become a central element of governance discourse at national and global levels, its definition remains elusive.[17] Differences in the meaning and composition of civil society have been noted in the literature as well as in the practice of governments and inter-governmental bodies.[18] Some understandings of civil society include in this category 'for profit' entities such as businesses. Other conceptions of civil society refer only to the 'not-for-profit' sector.[19] Often, the term civil society is used interchangeably with 'non-governmental organisation' thus implying some level of 'organisation', which potentially excludes individuals and groups that are not constituted as organisations. In light of these differences and complexities, Edward noted in his seminal book *Civil Society* that the notion of civil society is 'a concept that seems so unsure of itself that definitions are akin to nailing jelly on a wall'.[20]

Yet, in spite of these definition challenges, there are key elements or characteristics that help understand and describe the notion and components of civil society. The notion of civil society refers to a wide range of actors that are not under the control of government and that are value driven rather than profit driven.[21] Civil society actors include community-based organisations, faith-based organisations, trade unions, farmers associations and women's organisations.[22] Civil society also involves individuals and groups that are not necessarily constituted as *organisations* in a structural or legal sense of the term.

[17] L Pedraza-Fariña 'Conceptions of civil society in international lawmaking and implementation: a theoretical framework' (2013) 34 *Michigan Journal of International Law* 102-173.
[18] As above.
[19] As above.
[20] M Edward *Civil society* (2014) 4.
[21] A Sall 'Reflection on civil society driven change: an overview' in African Research and Resource Forum *Discourses on civil society in Kenya* (2009) 2-7.
[22] As above; JA Scholte 'Civil society and democracy in global governance' (2002) 8 *Global Governance* 281-304.

Building on theories from political science and sociology, Pedraza-Fariña provides a framework for 'characterizing the diverse assortment of groups and interests that can be said to make up civil society'.[23] This author outlines a typology of civil society actors based on their functions that distinguishes between (a) inward-looking functions, (b) outward-looking functions, (c) inward-outward boundary functions, and (d) boundary-crossing functions.[24] Inward-looking functions seek to develop a sense of identity among individuals through value or skills-based interactions, and are characterised by a lack of a broader agenda for political or policy change.[25] Outward-looking functions are directed towards sections of society or the whole society and seek to influence policy making or implementation.[26] The inward-outward functions combine inward characteristics with outward-looking public discourse.[27] Boundary-crossing functions describe collaborations between civil society and the state in policy making or implementation.[28]

This typology of civil society based on functions provides a helpful framework for describing the multitude of actors that make up civil society in the context of HIV. All four functions outlined in the theoretical framework correspond to specific types of civil society actors engaged in the HIV response, including: (i) self-help groups which can be said to play inward-looking functions; (ii) advocacy organisations such as Health Gap in the United States or the AIDS and Rights Alliance for Southern Africa in Namibia that are more outward-looking; (iii) advocacy and support organisations such as the Treatment Action Campaign in South Africa that are inward-outward; and (iv) HIV service delivery organisations that provide HIV testing or treatment which can be considered to play boundary-crossing functions.

While helpful, these elements of typology of civil society based on their functions cannot be considered definitive or mutually exclusive. In the context of HIV, many civil society organisations play several of the four functions at the same time or have transitioned from one to another of these functions due to shifts in global and

[23] Pedraza (n 17 above) 110.
[24] Pedraza (n 17 above) 110-112.
[25] As above.
[26] As above.
[27] As above.
[28] As above.

national HIV responses over the past three decades of the epidemic.[29] For Parker, the evolution of civil society's role in the response to HIV can be summarised in three phases:

> First, from the very early years of the epidemic to roughly the early to mid-1990s, an initial phase of relatively intense activist mobilization took place to combat severe social stigma, denial, and inaction on the part of governments and public health officials. Then, from roughly the mid-1990s to the mid-2000s, a growing transnational activist movement took shape around issues of treatment access and health equity; this movement played a critical role in shaping a global commitment to HIV treatment and service scale-up. Finally, from the mid-2000s to the present, the global activist movement has become fragmented, as some sectors of civil society have engaged in the implementation of treatment access and scale-up, while others have focused on a range of more localized struggles related to specific population groups and policy issues.[30]

It is also worth noting that civil society actors engaged in the response to HIV are not necessarily health or HIV organisations. In light of the diverse social, legal and policy issues raised by HIV, civil society actors working on broader human rights, advocacy and governance issues have also become involved in the response to HIV.[31] In addition, the breadth and scope of issues covered by civil society actors engaged in the HIV response varies greatly. While some civil society actors deal with several aspects of the epidemic including HIV education, prevention and treatment, others only specialise on one issue such as HIV education. Similarly, some civil society actors address HIV and its impact on multiple populations while others focus on one particular population such as women, children, migrants, sex workers, prisoners, people who inject drugs or men who have sex with men.[32]

The discussion below takes into account this diversity of civil society actors involved in the response to HIV as well as the different functions that they play. The description of the role of civil society in relation to HIV-specific laws draws on the functions of civil society with a focus on the outward-looking function which relates directly to efforts to influence legislation and policy.

[29] Parker (n 1 above).
[30] Parker (note 1 above) 21-22.
[31] Wamai (n 1 above).
[32] As above.

3 The tale of two regions: Responding to coercive HIV legislation in West and Central Africa, and in Eastern and Southern Africa

3.1 Addressing the impact of the Model law on STI/HIV/AIDS for West and Central Africa

3.1.1 'Legislation contagion'

The Model law on STI/HIV/AIDS for West and Central Africa was adopted in September 2004 at a regional workshop for parliamentarians, HIV programme implementers and policy makers held in N'Djamena, the capital of Chad.[33] The workshop was organised by Action for the West African Region on HIV/AIDS (AWARE-HIV/AIDS) - a project funded by the United States Agency for International Development - together with the Forum of African and Arab Parliamentarians for Population and Development (FAAPPD), the Center for Studies and Research on Population for Development (CERPOD), the Parliament of the Economic Community of West African States (ECOWAS Parliament), the West African Health Organisation (WAHO), and the Chadian Network of Parliamentarians for Population and Development.[34] Civil society participation at the workshop was extremely limited. Of the 50 participants to the workshop, representing some 13 countries and over 10 regional, sub-regional, donor and technical organisations, only three participants represented people living with HIV.[35]

The Model law on STI/HIV/AIDS for West and Central Africa (hereinafter referred to as 'N'Djamena model law' or 'model law') is a non-binding instrument containing template provisions on various HIV-related issues that was submitted to country delegations for promotion and use in their national jurisdictions.[36] As noted in the justification to the model law, the text was intended as 'a flexible tool that will enable [countries] to legislate, taking into account their legal, social, political and cultural context'.[37] The N'Djamena model law contains 37 articles divided into eight chapters

[33] AWARE-HIV/AIDS 'Regional workshop to adopt a model law for STI/HIV/AIDS for West and Central Africa: General report, N'Djamena, 8 - 11 September 2014' (on file with author).
[34] As above.
[35] As above.
[36] F Viljoen 'Model legislation and regional integration: Theory and practice of model legislation pertaining to HIV in the SADC' (2008) 41 *De Jure* 383-398.
[37] AWARE-HIV/AIDS (n 33 above) 8.

relating to education and information (chapter 1), secure practices and procedures (chapter 2), traditional medicines (chapter 3), voluntary counselling and testing (chapter 4), health and counselling services (chapter 5), confidentiality (chapter 6), discriminatory acts (chapter 7) and willful transmission of HIV (chapter 8).[38]

While the N'Djamena model law includes articles that guarantee the protection of human rights, it also contains several provisions that raised serious human rights and public health concerns, including: restrictions on access to information and education for children (article 2), mandatory HIV testing for pregnant women (article 18), the obligation for people living with HIV to disclose their HIV status within six weeks (article 26), restrictions to access to HIV testing for minors (articles 17 and 27) and overly broad criminalisation of HIV exposure and transmission (article 36).[39]

Four years after the development of the N'Djamena model law, some 13 countries in West and Central Africa had adopted HIV-specific legislation largely based on this model.[40] The analysis of the content of national legislation based on the N'Djamena model law shows that many of these laws had replicated the provisions of concern in the regional text, sometimes with even more stringent stipulations.[41] For instance, article 2 of the HIV Law of Guinea added to the restrictions on HIV information and education for children provided in the N'Djamena model law by prohibiting all HIV education for children under the age of 13.[42] The HIV Law of Sierra Leone broadened the scope of criminalisation of HIV exposure and transmission to explicitly include under its section 21 'the case of the pregnant woman' who places 'the foetus, at risk of becoming infected with HIV'.[43] The restrictive provisions of the N'Djamena model law that created an obligation to disclose one's HIV status to sexual partners within six weeks was replicated - with the same six-week timeline for disclosure - in four countries, namely Cape Verde (article 22(1) of HIV Law), Guinea Bissau (article

[38] AWARE-HIV/AIDS (n 33 above) 9-19, also partially reprinted in AIDS and Human Rights Research Unit *Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa* (2007) 279-283.
[39] As above. For an analysis of the N'Djamena model law, see Pearshouse (n 15 above).
[40] These are Burundi (2005), Benin (2006), Cape Verde (2007), Central African Republic (2006), Chad (2007), Guinea Equatorial (2005), Guinea (2005), Guinea Bissau (2007), Mali (2006), Mauritania (2007), Niger (2007), Sierra Leone (2007) and Togo (2005). See Eba (n 6 above).
[41] Eba (n 6 above); Pearshouse (n 15 above).
[42] Pearshouse (n 15 above) 9.
[43] Art 21 of the Prevention and Control of HIV and AIDS Act 2007 of Sierra Leone.

26 of HIV Law), Mali (article 27(1) of HIV Law) and Niger (article 15 of HIV Law).[44] Finally, all the countries that used the N'Djamena model as a basis for their national legislation adopted provisions that allow for overly broad criminalisation of HIV non-disclosure, exposure or transmission.[45]

Four reasons might explain the rapid enactment of national legislation in West and Central African countries based on the N'Djamena model law. First, parliamentarians and governments in the region were keen to 'do something' against HIV.[46] For these actors, adopting legislation that proclaimed their commitment to addressing the epidemic was a natural and sufficient response. In many countries, law makers have used HIV legislation to create stringent obligations on people living with HIV with little or no consideration of whether such obligations were achievable or based on scientific evidence. Pearshouse refers to this as 'legislation by intuition' and cites as example an early version of the HIV Bill of Mozambique that provided a legislative obligation for all people living with HIV to undertake 'regular physical activity' and to 'permanently raise awareness of other people […] in all matters regarding the illness'.[47] Second, the provisions of the N'Djamena model law were ready-made and available for use, thus facilitating its adoption by national legislators. Countries in the region that sought to adopt HIV legislation could use the provisions of the N'Djamena model law and 'adapt them to their national contexts'.[48] In reality, many countries have translated the provisions from the N'Djamena model into national laws, often with very little changes. Third, the impact and influence of the N'Djamena model law had a lot to do with the institutional backing that it benefited from reputable regional institutions in West and Central Africa, notably WAHO, CERPOD, the ECOWAS Parliament and FAAPDD. This impact was also facilitated by the role played by key national parliamentarians who championed the model law at regional and country levels. Fourth, the financial and technical support provided by AWARE-HIV/AIDS

[44] Eba (n 6 above) 247.
[45] Eba (n 6 above).
[46] Pearshouse (n 15 above).
[47] See R Pearshouse 'Legislation contagion: building resistance' (2008) 13(2/3) *HIV/AIDS Policy & Law Review* 1; F Viljoen & P Eba 'A human rights assessment of the Draft Bill on Defending Human Rights and the Fight Against the Stigmatisation and Discrimination of People Living with HIV and AIDS of Mozambique' (2008) 3-4 http://www.chr.up.ac.za/chr_old/centre_projects/ahrru/docs/Comments%20Mozambique%20Draft%20HIV%20Bill.pdf (accessed on 6 September 2016). This provision was removed from the final version of the Bill following the outcry by civil society and other organisations.
[48] AWARE-HIV/AIDS (n 33 above).

and other donors for the promotion of the N'Djamena model law at national level greatly contributed to its dissemination and impact.

3.1.2 'Building resistance': The fusion of global advocacy and local action

The rapid adoption of national laws across West and Central Africa with punitive provisions based on the N'Djamena model law surprised many, including global, regional and local civil society actors and international organisations working on HIV. The first concerns relating to the N'Djamena model law and the national laws that it inspired emerged in 2007 when global civil society organisations, particularly the Canadian HIV/AIDS Legal Network and the Centre for Reproductive Rights, became aware of restrictive provisions contained in these texts.[49]

These civil society organisations demanded a response to the restrictive provisions in HIV-specific laws from governments, AWARE/HIV-AIDS (the initiator of the model law) and the UN.[50] The UN response came from UNAIDS whose independent advisory group on human rights - the UNAIDS Reference Group on HIV/AIDS and Human Rights - had also been informed of the issue by civil society actors.[51] In July 2007, UNAIDS together with the Open Society Initiative for West Africa (OSIWA), the United Nations Development Fund for Women (UNIFEM), WAHO and AWARE-HIV/AIDS convened an expert meeting on human rights and gender in HIV-related legal frameworks in Dakar to discuss the issues raised by the N'Djamena model law and national HIV laws in West and Central Africa.[52] The meeting was attended by some 50 participants, including members of parliament from countries that had adopted national legislation based on the N'Djamena model law, representatives of

[49] Pearshouse (n 15 above).
[50] See Elisa Slaterry 'Forward of sign-on letter expressing concern over "Model Law" on HIV for West and Central Africa', email message to Martin Laourou, Head of the Policy and Advocacy Component at AWARE-HIV/AIDS, 2007 (on file with author).
[51] UNAIDS Reference Group on HIV and Human Rights 'Issue paper: Model legislation on HIV', 8th meeting, 3-5 December 2007, http://www.hivhumanrights.org.vs2.korax.net/commitmenttohumanrights/wp-content/uploads/downloads/2012/03/5-Law-RGHR8.pdf (accessed 6 September 2016). The UNAIDS Reference group on HIV and human rights is primarily composed of civil society actors from different regions of the world with expertise on HIV and human rights issues. For a presentation of this Reference group, see http://www.hivhumanrights.org/ (accessed 9 September 2016).
[52] M Grunitzky Bekele 'Invitation letter: Consultative meeting on HIV law focusing on gender and human rights' RST-WCA/DIR/07/047/L, 9 July 2007 (on file with author).

AWARE-HIV/AIDS, and regional and UN organisations.[53] Importantly, the meeting was also attended by civil society, including some of the global organisations such as the Canadian HIV/AIDS Legal Network and the Centre for Reproductive Rights that had raised the initial concerns on the N'Djamena Model law.[54] Several civil society organisations from West and Central Africa attended the meeting as well as non-governmental organisations from Kenya, Zambia and South Africa who were invited to share insights on their approaches to legal and human rights issues in the context of HIV.[55]

The meeting exposed sharp differences of views between civil society and UN actors, on the one hand, and the promoters of the N'Djamena model law and West African parliamentarians, on the other hand.[56] For the latter, it seemed difficult to comprehend the criticisms on a regional 'template' and national laws that were adopted 'with good intentions' and which had provisions protecting people living with HIV against discrimination.[57] These actors resisted calls to review national HIV laws that had just been adopted based on the N'Djamena model.[58] For them, the priority was to be placed on effective dissemination, implementation and enforcement of these new HIV laws. In spite of these disagreements, the meeting concluded with the recognition of the need to ensure a better integration of human rights and gender in national HIV legal frameworks.[59] The meeting was critical in furthering alliances against the N'Djamena law among global non-governmental organisations, and regional and local civil society groups that attended the meeting.[60]

At the urging of civil society organisations, a much broader regional consultation was convened a few months later on 16-18 April 2008 by UNAIDS together with AWARE-HIV/AIDS, ECOWAS, FAAPPD, OSIWA, UNIFEM, the International Labour Organisation (ILO), the Office of the High Commissioner for Human Rights (OHCHR), the United Nations Development Programme (UNDP), the United Nations

[53] T Niang 'Compte rendu de la réunion consultative d'experts sur le cadre légal du VIH tenant compte des droits humains et du genre' Hotel N'Gor Diarama, Dakar, 24-25 juillet 2007 (on file with author).
[54] As above.
[55] As above.
[56] As above.
[57] As above.
[58] As above.
[59] As above
[60] As above.

Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations Office on Drug and Crime (UNODC), and the World Health Organisation (WHO).[61] The aim of this regional meeting was to further the agreement reached at the July 2007 workshop and secure commitment from countries in the region to effectively take action to address the concerns in their national HIV laws.[62] The regional meeting brought together some 100 participants from 15 West and Central African countries.[63] Country delegations included members of parliament from the parliamentary committees responsible for health and HIV, representatives of national AIDS commissions, legal experts and representatives of civil society organisations, including people living with HIV. In addition to these participants, representatives of the convening organisations, members of the UNAIDS Reference Group on HIV/AIDS and Human Rights, and facilitators from the Canadian HIV/AIDS Legal Network, and the AIDS and Human Rights Research Unit at the University of Pretoria also attended the regional meeting.[64] Ahead of the consultation, UNAIDS, with the support of the Canadian HIV/AIDS Legal Network, developed alternative language on provisions of concerns in the N'Djamena model law and the national legislation that had been adopted based on it.[65] The document was to be discussed at the meeting and considered by national stakeholders to guide the reform of their national HIV laws.

While the workshop was taking place, civil society organisations from across the world issued an open letter stressing that this 'meeting is a vital opportunity to update these [problematic] laws so that the region of West and Central Africa reflects the very best guidance on how countries respond to HIV with legislation'.[66] The open

[61] See P Eba 'Capacity building workshop on human rights and gender in HIV legal frameworks, Dakar, Senegal, 16 – 18 April 2008: Final report' (on file with author); UNAIDS 'Human rights and gender in HIV-related legal frameworks' 28 April 2008 http://www.unaids.org/en/Resources/PressCentre/Featurestories/2008/April/20080428HumanrightsandgenderinHIVrelatedle/ (accessed 6 September 2016).
[62] As above.
[63] As above.
[64] As above.
[65] UNAIDS 'UNAIDS recommendations for alternative language to some problematic articles in the N'Djamena legislation on HIV (2004)' 2008 http://data.unaids.org/pub/Manual/2008/20080912_alternativelanguage_ndajema_legislation_en.pdf (accessed 6 September 2016).
[66] Human rights Watch *et al* "Capacity building workshop on human rights and gender in HIV legal framework: Open civil society letter to the participants" 14 April 2008, https://www.hrw.org/news/2008/04/14/capacity-building-workshop-human-rights-and-gender-hiv-legal-framework (accessed 6 September 2016).

letter urged participants to agree on 'concrete plans, within established time periods, to amend the limited number of articles in national HIV laws that are at variance with international human rights law', and to make a 'clear commitment to genuine participation with civil society partners […] throughout the drafting, amendment, and implementation of these laws'.[67]

The consultation was a key moment in efforts to challenge punitive laws in the context of HIV in West and Central Africa. It concluded with a commitment from country representatives to amend their newly adopted HIV laws or draft legislation to ensure a better integration of human rights and gender norms and principles.[68] A major breakthrough at the meeting was a letter to participants signed by Constella Futures, a key implementing partner of AWARE-HIV/AIDS, in which they acknowledge the 'concerns raised regarding individual country laws […] including mandatory testing, criminalization, education restrictions, informing others of HIV status and other related human rights issues'.[69] The letter further stated the commitment of AWARE-HIV/AIDS to support the improvement of national laws and to ensure an 'ongoing process of civil society inclusion, transparency and open communication in the revision, implementation and enactment of the N'Djamena and country laws'.[70]

Following the 2008 Dakar consultation, national working groups composed among others of parliamentarians, national AIDS commissions, members of the judiciary, and civil society organisations including people living with HIV, were put in place and supported by UNAIDS and UNDP in a number of countries to improve HIV-specific laws or draft laws.[71] Galvanised by global partners, local civil society actors in West and Central Africa also intensified their engagement against these laws and played key roles in efforts to improve HIV legal frameworks at national level. These efforts have led, among others, to the revision of the HIV laws of Guinea (in 2009), Togo (in 2010), and Sierra Leone (2011), and have also benefited the elaboration of improved

[67] As above.
[68] Eba (n 61 above).
[69] 'Open letter from Constella Futures, a key implementing partner of AWARE-HIV/AIDS to participants of the capacity building workshop on human rights and gender in HIV legal frameworks' Dakar, 15 April 2008 (on file with author).
[70] As above.
[71] See Pearshouse (n 47 above).

new HIV-specific laws in Senegal (2010) and in Congo (2011).[72] In all these countries, local civil society organisations played key roles in national consultations, working groups and other platforms that were set up to improve national laws or draft laws. While these law reforms efforts have not resulted in the removal of all punitive provisions; in several instances, they led to addressing the most egregious provisions or to limiting their effect.[73] For example, in Sierra Leone, the explicit criminalisation of mother-to-child transmission of HIV was removed.[74] In Guinea, the prohibition of all HIV education for children and adolescents was amended.[75]

Although efforts to reform restrictive national HIV legislation inspired by the N'Djamena model law are far from over, progress made since 2008 are worth celebrating. Much of these successes are tribute to the alliances and fusion between global advocacy by international NGOs and the actions of civil society actors at national level to advance rights-based responses to HIV.

3.2 The East African HIV law: A regional approach to challenging restrictive national HIV legislation

3.2.1 Imagining a regional response to punitive HIV legislation in East African countries

In the East African Community (EAC) - the regional intergovernmental organisation comprising Burundi, Kenya, Tanzania, Rwanda, South Sudan and Uganda - the development of national HIV laws was generally based on 'home grown' processes unlike in West and Central Africa.[76] The first country in the East African Community

[72] Eba (n 6 above).
[73] Eba (n 6 above).
[74] As above.
[75] See Ordonnance No 056/2009/PRG/SGG portant amendement de la loi L/2005/025/AN du 22 Novembre 2005 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA en République de Guinée.
[76] The EAC was created by the Treaty for the Establishment of the East African Community adopted on 30 November 1999 and entered into force on 7 July 2000 following its ratification by the original three Partner States of EAC namely Kenya, Tanzania and Uganda. Rwanda and Burundi joined EAC in 2007 and South Sudan became a Partner State in 2016. See EAC 'Overview of EAC' http://www.eac.int/about/overview (accessed 6 September 2016). The discussion below does not cover South Sudan as the issues and facts described below were anterior to the joining of EAC by South Sudan.

to adopt HIV-specific legislation was Burundi (2005) followed a year later by Kenya (2006), then Tanzania (2008) and Uganda (2014).[77]

The process for developing these laws and the degree of involvement of civil society varied greatly between the countries in the sub-region. For example, the limited engagement of civil society organisations in the development of the HIV law of Burundi can be contrasted with the broad and inclusive consultations that were initiated in Kenya for the development of the HIV Act of 2006.[78] In Tanzania and Uganda, civil society organisations were involved in consultative meetings and hearings organised by the parliament and national AIDS commission in relation to the HIV legislation.[79] However, even with civil society participation, the HIV laws that emerged from these national processes did not address key demands for human rights protections.[80]

As of December 2008, the HIV laws adopted in three EAC countries (Burundi, Kenya and Tanzania) had come under serious criticism by civil society organisations in the region and beyond.[81] The main concerns raised about these laws relate to the embrace of punitive provisions, including compulsory disclosure, overly broad criminalisation of HIV non-disclosure, exposure and transmission, restriction of access to HIV services for adolescents and lack of attention to the legal issues affecting women and other key populations. For example, in Burundi, article 28 of the HIV law gives broad and unconditional power to medical practitioners to disclose the HIV status of people living with HIV to their spouse or sexual partner.[82] In Kenya, section 24 of the HIV law allowed for overly broad criminalisation of HIV non-

[77] Eba (n 6 above).
[78] On the process for the development of the HIV law of Kenya, see PM Eba 'The HIV and AIDS Tribunal of Kenya: An effective mechanism for the enforcement of HIV-related human rights? (2016) 18 *Health and Human Rights Journal* 169-180.
[79] See for example on Tanzania, Health Policy Initiative 'Tanzania adopts HIV law' August 2008 http://www.healthpolicyinitiative.com/Publications/Documents/589_1_TZ_HIV_Legislation_FINAL_8_26_08.pdf (accessed 6 September 2016).
[80] See on the concerns relating to the HIV law of Kenya, Eba (n 78 above). For an overview of the concerns with the other HIV-specific laws in the region, see Eba (n 6 above).
[81] As above.
[82] Loi No 1/018 du 12 Mai 2005 portant protection juridique des personnes infectées par le Virus de l'Immunodéficience Humaine et des personnes atteintes du Syndrome Immunodéficience Acquise au Burundi.

disclosure and transmission.[83] In Tanzania sections 15 and 16 of the HIV Law restrict access to HIV testing and counselling for adolescents.[84]

In the wake of the global mobilisation against overly-broad HIV criminalisation and the concerns raised by the N'Djamena model law, civil society organisations in East Africa initiated consultations on approaches to respond to the challenges caused by national HIV laws in their region.[85] The urgency to address these laws grew as a fourth country in the region (Uganda) was also in the process of developing HIV-specific legislation with similar provisions of concern.[86]

Under the auspices of the Eastern Africa National Networks of AIDS Service Organisations (EANNASO) and its charismatic leader, Lucy Ng'ang'a, civil society organisations in East African countries resolved to adopting a regional approach to address the concerns in national HIV laws. They resorted to engaging the East African Legislative Assembly (EALA) – the law making body of EAC – on the adoption of a regional law on HIV in East Africa.[87]

Based in Arusha where the headquarters of EAC institutions are located, EANNASO had gained knowledge of key actors and processes at the regional level. To advance

[83] HIV and AIDS Prevention and Control Act, No 14 of 2006 of Kenya.
[84] HIV and AIDS (Prevention and Control) Act, No 28 of 2008 of Tanzania.
[85] Eba (n 6 above).
[86] The HIV law finally adopted in Uganda in 2014 also raises similar concerns to those of other countries in the region. See L Paulat 'HIV Prevention Act angers Ugandan AIDS activists' *VoA News*, 27 August 2014 http://www.voanews.com/a/hiv-prevention-act-aids-activists/2429821.html (accessed 6 September 2016); M Nalugo 'Rights bodies protest HIV/AIDS Bill' *Daily Monitor* 15 May 2014 http://www.monitor.co.ug/News/National/Rights-bodies-protest-HIV-Aids-Bill/688334-2314774-92xccfz/index.html (accessed 6 September 2016).
[87] Four reasons seem to have justified this approach. First, under the EAC Treaty, a regional law passed by the regional parliament – the East African Legislative Assembly (EALA) – and assented to by all heads of states of the EAC countries takes precedence over national legislation in the same area. Thus a regional law on HIV with protective provisions would take precedence over national HIV laws with punitive provisions. Second, the regional approach was deemed most expedient for dealing with the concerns raised by the laws as it offered the possibility to address the concerns in all laws already adopted in the region and those to be adopted in the future rather than initiating advocacy processes in individual countries in relation to their HIV laws. Third, it seemed unlikely that there would be impetus, particularly among national parliamentarians, for reviewing and reforming HIV-specific laws that had just recently been adopted in the countries. Fourth, there was great enthusiasm among civil society organisations in engaging regional parliamentarians of EALA on the issue of HIV which was described as a regional issue warranting a regional response. This enthusiasm was also related to the anticipation of the entry into force of the regional common market in the EAC in 2010. See M Wambi 'East Africa: Move towards common HIV/AIDS law' 4 December 2009 http://www.ipsnews.net/2009/12/east-africa-move-towards-common-hiv-aids-law/ (accessed 7 September 2016); and also East African Law Society, UNAIDS, EANNASO and EAC 'Why a regional HIV and AIDS law for East Africa' 2010 (on file with author).

this regional approach, civil society organisations established in August 2008 a Regional Task Force on AIDS Law and Policy in East Africa (Task force) comprised of key organisations from all EAC countries.[88] While EANNASO chaired the Task force, the East African Law Society (EALS) chaired the legal committee of the Task force. Also based in Arusha, EALS was a key member of the Task force with strong knowledge and relationships with regional institutions whose role was to rally support and expertise for the initiative among the legal community in the region.[89]

The Task force was further encouraged in its regional approach by the experience of the Southern African Development Community Parliamentary Forum (SADC PF) model legislation on HIV adopted in November 2008 in Arusha.[90] This SADC PF Model law was heralded as a good practice because its provisions – which contain strong protections for people living with HIV and those vulnerable to the epidemic – are rights-based and evidence-informed.[91] Although not binding, the SADC PF Model law was a testimony that a carefully crafted strategy that brought together members of parliament and civil society could lead to the adoption of protective framework on HIV.

3.2.2 The long way to the East African regional law on HIV

Following the formulation of its regional strategy, the Task force initiated contacts with key stakeholders in EALA and other EAC institutions while also seeking financial and technical support for the initiative. At EALA, the Task force found a strong ally in Lydia Wanyoto Mutende, chairperson of the General Purposes Committee of EALA, who would become the main champion of the proposal and would build alliances for its successful adoption. In February 2009, the Task force presented the proposal of the regional Bill on HIV together with a work plan for its development to the General Purpose Committee of EALA which approved the

[88] Lucy Ng'ang'a 'Letter to partners: Development of a regional Bill on HIV and AIDS for East Africa' 1 September 2009 (on file with author).
[89] EALS 'Report of the regional consultative meeting on East Africa HIV law' Arusha, Tanzania, 3-4 December 2009 (on file with author).
[90] R Johnson 'The Model law on HIV in Southern Africa: Third World approaches to international law insights into a human rights-based approach' (2009) 9 *African Human Rights Law Journal* 120-159.
[91] For a discussion on the SADC PF Model law see Viljoen (n 36 above) and Johnson (n 89 above).

initiative.[92] The work plan towards the regional Bill included three steps, namely (i) conducting reviews of the legal environment relating to HIV in all EAC countries; (ii) conducting national and regional workshops to engage relevant stakeholders in the development on the law and secure their inputs; (iii) and developing a draft regional Bill through a consultative process for consideration by the EALA General Purposes Committee.

With initial funding from the UNAIDS Regional Support Team for Eastern and Southern Africa, the Task force recruited in mid-2009 a team of legal experts to undertake reviews of the strength and gaps in national legal frameworks relating to HIV in the EAC countries.[93] In undertaking these reviews, the legal experts conducted country missions in all EAC states to interview key stakeholders and hold workshops with government officials, civil society, HIV programme implementers, parliamentarians and others actors. On 3-4 December 2009, the legal experts presented the findings from the country missions at a regional consultative workshop held in Arusha, Tanzania.[94] The consultation was attended by a broad range of stakeholders from across the region, and by international experts on HIV and the law.[95] It highlighted key gaps and concerns in national laws, as well as issues to be addressed in the proposed regional HIV law.[96]

At the end of 2009, the legal team initiated the drafting of the regional HIV Bill based on the findings of the national legal reviews and inputs from the regional consultation. The preliminary draft of the Bill was discussed at a meeting attended by the EAC principal legal officer and the legislative draftsmen from the attorney general offices (or equivalent) of EAC countries in early February 2010.[97] The ensuing draft HIV Bill was presented for inputs at a regional stakeholders meeting held in Kampala on 22-23 February 2010.[98] Participants at the meeting included legal drafters,

[92] EANNASO 'Workshop report: Building partnerships towards rights-based HIV and AIDS legislation in East Africa' Report of the regional Workshop held on 8 and 9 July 2011 at Whitesands Hotel, Dar-es-Salaam, Tanzania http://www.eannaso.org/resources/eac-regional-integration-resources/19-report-on-building-partnership-towards-rights-based-hiv-and-aids-legislation-in-east-africa/file (accessed 7 September 2016).
[93] Further funding for the initiative was later provided by UNDP and other donors.
[94] EALS (n 89 above).
[95] As above.
[96] As above.
[97] EANNASO (n 92 above) 13.
[98] As above.

national parliamentarians, members of EALA, civil society, international organisations and other stakeholders working on HIV in the region.

The Draft HIV Bill presented at the meeting included strong features relating to human rights protection including non-discrimination provisions, the prohibition of compulsory HIV testing, the recognition of the role of civil society as key actors of the HIV response and the protection of specific populations such as women and girls, prisoners and persons with disabilities.[99] While participants generally agreed on key provisions in the draft Bill, critical divergences emerged on two points. First, participants were divided on the inclusion in the Bill of a provision addressing the criminalisation of HIV non-disclosure, exposure and transmission.[100] Those supporting the inclusion of a provision on HIV criminalisation argued that a carefully-crafted provision in the regional Bill that only punished intentional transmission of HIV would help prevent the recourse to vague and overly broad provisions in the existing HIV-specific laws adopted at country level, thus offering greater protection. Those opposed to the inclusion of a provision on HIV criminalisation argued that criminal law is not an area of cooperation under the EAC Treaty and that including the criminalisation of HIV exposure or transmission in the regional Bill would 'legitimise' recourse to such punitive provisions at domestic level.[101]

Second, participants were divided on whether the Bill should include explicit provisions relating to the protection and access to services for key populations that are criminalised in the region, such as sex workers, men who have sex with men and people who inject drugs.[102] Some participants at the Kampala meeting feared that the explicit inclusion of these populations in the regional Bill would compromise its adoption by EALA and the subsequent assent by the heads of states of the EAC countries.[103]

Ultimately, in March 2010, the Task force submitted its final version of the draft Bill to EALA. The submitted version did not include a provision on criminalisation of HIV

[99] Proposed Draft East African Community HIV and AIDS Prevention and Management Bill, February 2010 version (on file with author).
[100] 'One region, one HIV law' *Irinnews* 31 March 2010 http://www.irinnews.org/report/88635/east-africa-one-region-one-hiv-law (accessed 7 September 2016).
[101] As above.
[102] EANNASO (n 92 above).
[103] As above.

non-disclosure, exposure or transmission.[104] The draft Bill also did not include explicit provisions on the protection and access to services for the abovementioned criminalised key populations.[105] However, it comprised a broad provision (section 38) on 'other vulnerable populations' which applies to

> any group which for the time being has high or increasing rates of HIV infection or which from available public health information, is more vulnerable or at higher risk to new infection on account of such factors as poverty, livelihood, sexual practices, disrupted social structures or population movements.[106]

Section 38 on vulnerable populations further calls on governments 'in consultation with relevant stakeholders [to] develop and implement strategies, policies and programmes to promote and protect the health of vulnerable groups and most at risk populations'.[107] Though not mentioning the criminalised key populations, this provision can be interpreted to apply to them.

Following its submission to EALA, the East African Community HIV and AIDS Prevention and Management Bill, 2012 (EAC HIV Bill), as it became officially known, was presented to the General Purposes Committee as a private member's Bill by Lydia Wanyoto.[108] Meanwhile, members of the Task force continued lobbying EALA members and other regional stakeholders for the adoption of the Bill. The EAC HIV Bill was finally adopted by EALA on 23 April 2012. In a press release published after the adoption, EALA stated that the 'passage of the Bill is a major score for the civil society who were instrumental in birthing the law'.[109] EALA also recognised EANNASO and the Task force for its critical role in this process leading to the Bill.[110] The final Bill adopted by EALA maintained key provisions protecting human rights in the context of HIV, including evidence-informed and rights-based HIV education and

[104] 'East African Community HIV and AIDS Prevention and Management Bill' March 2010 http://kelinkenya.org/wp-content/uploads/2010/10/PROPOSED-DRAFT-4-OF-THE-EAST-AFRICAN-COMMUNITY-HIV-AND-AIDS-PREVENTION-AND-MANAGEMENT-BILL-2010-.pdf (accessed 7 September 2016).
[105] As above.
[106] As above.
[107] As above.
[108] EALA 'Official report of the proceedings of the East African Legislative Assembly, fourth meeting – fifth session – second assembly, 19 April 2012 http://www.eala.org/uploads/19%20April%202012.pdf (accessed 7 September 2016).
[109] EALA "EALA passes regional Bill on HIV and AIDS" 23 April 2012 http://www.eala.org/new/index.php/media-centre/press-releases/343-eala-passes-regional-bill-on-hiv-and-aids- (accessed 7 September 2016).
[110] As above.

information tailored for specific populations (part 2 of the EAC HIV Bill); informed consent, confidentiality and the prohibition of compulsory HIV testing (part 4 of the EAC HIV Bill); protection against discrimination, including in employment, insurance and health care services (part 5 of the EAC HIV Bill); and the protection and access to HIV and health services for vulnerable groups and most at risk populations, although these populations are not explicitly mentioned (part 6).[111] Unlike other HIV-specific legislation adopted in sub-Saharan Africa which paid limited attention to issues of implementation, enforcement, the relations to existing legislation and the role of people living with HIV, the EAC HIV Bill addresses these issues under Part 8.[112]

Having achieved this milestone, Task force members continued lobbying for the assent of the regional HIV Act by all the heads of states of EAC countries which was necessary for the entry into force of the Act. After three years of advocacy, the EAC HIV Act was finally assented to by the five EAC heads of states in October 2015, almost seven years after the beginning of this initiative.[113]

4. Reflections and comments

The two case studies described in this article raise critical considerations and reflections relating to the approaches, enablers, alliances and challenges relating to civil society's engagement and influence in HIV-related law making processes in sub-Saharan Africa. These considerations are discussed below with elements of comparison between East Africa, and West and Central Africa.

4.1 HIV law making as an illustration of the general participation deficit in legislative processes in sub-Saharan Africa

The adoption of the N'Djamena model law epitomises and reflects the general top-down approaches and the participation deficit in law making that generally prevails across sub-Saharan Africa.[114] The drafting of this model legislation in West and

[111] EALA (n 108 above).
[112] As above.
[113] ICW Weekly bulletin 'The East African partner states assent to the East Africa HIV and AIDS Prevention and Management Bill, 2012' 27 October 2015 http://www.iamicw.org/CampaignProcess.aspx?A=View&Data=UmSlGuoOqWuJHK8E06yawQ%3d%3d (accessed 7 September 2016).
[114] See, for instance, Mukuna & Mbao (n 10 above).

Central Africa did not involve any civil society organisation from the region, and the workshop that led to the adoption of the model law was attended by only three civil society representatives out of more than 50 participants.[115] Similarly, the processes leading to the adoption of HIV legislation at national level based on the N'Djamena model law between 2004 and 2008 only involved limited participation by civil society.[116] Many civil society organisations became aware of these laws after they had already been introduced in parliament or had been passed.

Several reasons might explain the challenges and limitations to effective public and civil society participation in legislative processes in West and Central Africa. These include the limited technical and advocacy capacity of HIV civil society organisations in the region.[117] The great majority of civil society organisations working on HIV in the region focus on inward-looking or cross-boundary functions and very few of them have the capacities to engage in outward-looking functions such as advocacy for law reform or legal monitoring.

In EAC countries, where there are more civil society organisations with expertise and capacity to engage in outward-looking functions, the situation is different. Civil society in EAC was able to engage in HIV-related law making processes, including through written submissions and participation in stakeholders' consultations. Since some of their key concerns were not reflected in the national laws that were adopted, these civil society organisations initiated efforts to address HIV laws, including through the regional HIV legislation.

The limited engagement and influence of civil society in law making processes raise important question relating to public participation in democratic process in general. This situation calls for legal and other approaches to support more participatory law making. In South Africa, this issue is addressed by the Constitution which explicitly mandates public participation in legislative making processes.[118] Such provisions

[115] AWARE-HIV/AIDS (n 33 above).
[116] Grace (n 15 above).
[117] Médecins Sans Frontières *Out of focus: How millions of people in West and Central Africa are being left out of the Global AIDS Response* (2016) 24 http://www.msf.org/sites/msf.org/files/2016_04_hiv_report_eng.pdf (accessed 26 August 2016).
[118] KS Czapanskiy & R Manjoo 'The right of public participation in the law making process and the role of the legislature in the promotion of this right' (2008) 19 *Duke Journal of Comparative and International Law* 1-40. The issue of public participation in parliamentary processes was addressed by

could ensure better, more timely and meaningful engagement of civil society in legislative processes including on HIV.

Participation in public affairs is a human right that is provided under global and regional human rights treaties, including the International Covenant on Civil and Political Rights and the African Charter on Human and Peoples' Rights.[119] This right can be interpreted to involve the participation of civil society in law making of significant legal and social impact such as HIV legislation. In this regard, the African Charter on Democracy, Elections and Governance states as one of its objectives the need to promote 'the necessary conditions to foster citizen participation, transparency, access to information, freedom of the press and accountability in the management of public affairs'.[120] Although the African Charter on Democracy, Elections and Governance is not yet in force, its provisions elaborate on the principles enshrined in the Constitutive Act of the African Union which affirms the significance of good governance, popular participation, the rule of law and human rights in Africa.[121] It can be argued that in fulfilling their obligations in terms of the right to public participation in the context of HIV, states should ensure that legislative processes relating to HIV enable the consultation and participation of civil society, including people affected by the HIV epidemic.

Beyond the legal arguments, there are practical benefits in ensuring the meaningful involvement of civil society in HIV-related legislative processes. First, civil society contributes to ensuring that HIV-related laws are based on human rights and address the needs of the communities most affected by the epidemic. Second, the meaningful involvement of civil society helps generate support among civil society for HIV legislation and avoid the risk of criticism that may lead to legal challenges against the law.

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the Constitutional Court of South Africa in *Doctors for Life International v the Speaker of the National Assembly & Others* 2006 (12) BCLR 1399 (CC) (S. Afr.).

[119] See art 25 International Covenant on Civil and Political Rights, adopted 16 December 1966, GA Res 2200A (XXI), 21 UN GAOR Supp (No 16) 52, UN Doc A/6316 (1966), 999 UNTS 171; and art 13 African Charter on Human and Peoples' Rights, adopted 27 June 1981, OAU Doc CAB/LEG/67/3 Rev 5, reprinted in C Heyns & M Killander (eds) *Compendium of key human rights documents of the African Union* (2013) 29.

[120] Art 2 of African Charter on Democracy, Elections and Governance, adopted 30 January 2007.

[121] See arts 3 and 4 of Constitutive Act of the African Union, adopted 11 July 2000, OAU Doc. CAB/LEG/23.15.

4.2 Alliances for change: Reflecting on the blending of global and local actions

Global civil society organisations working on HIV and reproductive health issues were the first to become aware of the restrictive provisions in the N'Djamena model law. Initially, the reaction of civil society in West and Central Africa, including people living with HIV, against the law was timid. Several reasons could explain this situation. First, most civil society organisations in the region were not aware of the full extent of the concerns in the N'Djamena model law and the national legislation that it had influenced. Secondly, the critical human rights concerns involved in these laws were not necessarily understood. For instance, to some civil society actors, the idea of prosecution for HIV exposure or transmission under these new laws was not necessarily appalling, particular because some women rights organisations in the region supported such criminalisation.[122] Finally, some of the leading civil society actors in the region had been aware of the N'Djamena model law and had not expressed concern about its content.[123]

In this context, the leadership role assumed by global civil society organisations in criticising and calling for the removal and reform of the N'Djamena model law and national HIV laws risked being perceived in the region through the prism of unwarranted foreign interference. However, three elements helped to mitigate these fears. First, the global civil society organisations were able to engage national and regional civil society groups and rally them to their concerns through networks such as the International Community of Women Living with HIV and the African Network of People Living with HIV. These networks relayed the concerns to their branches in West African countries and mobilised them on the issue. Regional and national civil society organisations also attended the workshops held in Dakar in 2007 and 2008 to address the N'Djamena model law and called for reform.[124] Local civil society actors in West and Central Africa - that are traditionally focused on inward-looking or

[122] See Athena Network *et al* '10 reasons why criminalization of HIV exposure or transmission harms women' http://www.athenanetwork.org/assets/files/10%20Reasons%20Why%20Criminalization%20Harms%20Women/10%20Reasons%20Why%20Criminalisation%20Harms%20Women.pdf (accessed 7 September 2016).
[123] This was notably the case for the African Network of People Living with HIV and the Society for Women and AIDS in Africa which were represented at the meeting in N'Djamena. AWARE-HIV/AIDS (n 33 above).
[124] Niang (n 53 above); Eba (n 61 above).

boundary-crossing functions - were provided with human rights and public health arguments on the concerns in the HIV laws, thus allowing them to engage on the issue. Second, global civil society groups urged UN organisations working on HIV and human rights - particularly UNAIDS and UNDP - to speak against the laws and commit to supporting efforts for reforming them. By engaging in efforts to address the HIV laws and calling for reform, these international organisations validated the concerns of global civil society organisations. Third, these civil society organisations successfully framed the N'Djamena model law as a symbol of foreign importation of coercive and ill-informed legislation because this model law was supported through a foreign donor.[125] Together, these three approaches helped generate support for the efforts against the laws in West Africa and pushed national governments in several countries to reform them. Still, perceptions of outside interference by global civil society actors lingered among some of the parliamentarians and other actors in the region who had supported the adoption of the N'Djamena model Law.[126]

Eventually, local civil society actors played key role in efforts to reform legislation at domestic level. They lobbied members of parliamentarians and maintained pressure on national AIDS authorities to undertake reform of the laws or draft laws that had been based on the N'Djamena model law. The engagement of these local civil society actors was critical to the successful revision of national HIV laws in several countries.

While the adoption of the East African HIV law was an indigenous process initiated by actors from the region, it also provides lessons on engaging global and other regional civil society. In this process, regional and national actors in East Africa engaged global civil society for technical inputs and also for validation of the approach and content of the law. Such inputs and validation were also sought from UN agencies, including UNAIDS and UNDP. Global and other regional civil society actors as well as UN officials were invited to meetings organised as part of the legislative process. However, EANNASO and other members of the task force retained the leadership and coordination of civil society engagements.

[125] See Pearshouse (n 15 above).
[126] See Niang (n 53 above); Eba (n 61 above).

4.3 Seeking solutions: The diversity of approaches used by civil society organisations to address HIV legislation

In responding to the concerns raised by HIV-related legislation in sub-Saharan Africa, civil society organisations have resorted to various approaches that relate to their outward-looking and the boundary-crossing functions. In exercising their outward-looking function, civil society organisations have denounced and sought to directly influence change in national and regional HIV legislation in the two regions. In advancing this function in the context of HIV laws, civil society actors have used the media at national and international levels to denounce coercive measures in the laws and to call for reform.[127] The use of the media and other platforms by civil society was particularly effective to bringing global attention to the concerns in the N'Djamena Model Law and national laws in West and Central Africa.[128] Outward-looking functions in the two case studies also involved lobbying UN entities to ensure their involvement, and engaging national and regional parliamentarians to secure the adoption or revision of the laws. Civil society used their knowledge of national, regional and international actors and processes to identify effective entry points and partners to engage. In the case of West and Central Africa, UNAIDS and UNDP proved critical allies in efforts to respond to the concerns in the law through convening regional workshops with key partners and by supporting national action plans to reform some of the national laws.

The case of East Africa is exceptional because the idea, momentum and process for the regional legislation were led by civil society. Through the Task force, civil society identified the opportunity offered by regional legislation in addressing the concerns in national laws and directly influenced the development, adoption and entry into force of the regional law. In achieving this milestone, civil society members of the Task force built strategic alliances with regional parliamentarians of EALA, national legislative drafters, national AIDS commissions and other key regional and national actors.

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[127] See for instance 'Africa: "Terrifying" new HIV/AIDS laws could undermine AIDS fight' Irinnews 7 August 2008 http://www.irinnews.org/report/79680/africa-terrifyingnew-hiv-aids-laws-could-undermine-aids-fight (accessed 7 September 2016); 'West Africa: HIV law "a double-edged sword"' Irinnews 1 December 2008 http://www.irinnews.org/report/81758/west-africa-hiv-law-a-double-edged-sword (accessed 7 September 2016).

[128] As above.

The strategies used by civil society organisations in response to HIV legislation also involved boundary-crossing functions. For instance, in West and Central Africa, efforts to reform national HIV laws led some civil society organisations to provide direct assistance in the drafting of new legislative provisions. In East Africa, the civil society Task force was directly responsible for recruiting and managing the consultants who developed the draft of the regional law. These boundary-crossing functions enabled civil society to collaborate directly with law makers and influence the content of national and regional legislation. However, in some cases, this 'intimate' involvement required trade-off as was the case concerning the EAC HIV Act which does not explicitly address some key populations. Civil society actors who supported the drafting process were allegedly faced with the choice of not addressing the issue or 'compromising' the legislative process and their collaboration with key regional parliamentarians involved.[129] In cases where civil society organisations are so closely involved with law making processes, questions of accountability and responsibility for the ensuing legislation may be laid at them, as was the case in relation to the silence of the EAC HIV Act on key populations.[130]

4.4 Civil society and the implementation of HIV legislation

While civil society organisations have been critical to challenging coercive HIV legislation and to securing improved legislation in the two case studies, their engagement often did not continue after the adoption of laws. In West and Central Africa, there are limited evidence and examples of meaningful civil society engagement in advocacy and monitoring for the effective implementation of the improved laws that were adopted after several years of intense efforts to secure them.

In East Africa, some three years elapsed between the adoption of the East African HIV Bill by EALA and its official assent into law of regional application by the five EAC heads of states. In addition, after the coming into force of the regional law, there has been no comprehensive and strategic approach and actions from civil

[129] Irinnews (n 100 above); EANNASO (n 92 above).
[130] See on a discussion of similar challenges, K Papadakis & L Baccaro 'The promise and perils of participatory policy making' (2008) 117 *Research Series*.

society actors to ensure its effective implementation in EAC countries to amend the provisions of concern in the national HIV laws of the region.

Civil society actors should ensure that their efforts to influence the adoption or reform of laws go beyond parliamentary adoption.[131] Monitoring and influencing the effective implementation of HIV legislation is also a key role that civil society could and should play in sub-Saharan Africa. Engaging in these monitoring activities will require technical and financial resources to build more outward-looking capacity of civil society organisations.

4.5 Funding and support for civil society engagement in HIV law making and implementation

Securing the results described in the two cases studies requires that civil society has the expertise and skills on various areas, including advocacy, policy and legislative analysis, strategy, media and campaigning. These successes also require resources to build long term partnership with key parliamentarians and other allies.

Such resources are generally not available through domestic sources, because law reform on HIV is too often politically and socially sensitive. Civil society is therefore left with relying on external sources of funding for supporting their outward-looking functions of advocacy and monitoring of the legal environment. Yet, in the current context of shrinking funding for HIV, these activities are not prioritised by donors. In 2012, funding for human rights programmes, including for law reform advocacy, represented less than 1% of the total 19.1 billion spent on HIV globally.[132] Limited funding for human rights advocacy in the context of HIV is likely to hinder the ability of civil society organisations to continue their work and progress on critical legislative reform.

[131] PM Eba 'Towards smarter HIV laws: considerations for improving HIV-specific legislation in sub-Saharan Africa' (2016) 24 *Reproductive Health Matters* 178-184.
[132] UNAIDS, *Sustaining the human rights response to HIV: An analysis of the funding landscape and voices from community service providers*, 2015 http://www.unaids.org/sites/default/files/media_asset/JC2769_humanrights_en.pdf (accessed 8 September 2016.

5 Conclusion

Although not widely known and recognised, advocacy for policy and law reform is a critical function of civil society in the context of HIV. The two case studies described in this article have highlighted examples of the role of civil society actors in law reform efforts in sub-Saharan Africa. Through a combination of their outward-looking and boundary-crossing functions, civil society organisations were essential to mobilising global, regional and national attention, and generating action against the N'Djamena model law and the national legislation that it had influenced. Similarly, in East Africa, civil society organisations have used their knowledge of the region and expertise and experience on HIV, the law and human rights to initiate and influence the adoption of a regional law which offers the promise of responding to concerns in national HIV legislation.

These case studies demonstrate the importance of civil society as key actors who can support rights-based and evidence-informed law making on HIV. However, the failure to meaningfully engage civil society in the development of regional and national HIV law making processes, particularly in West and Central Africa raise broader questions relating to public participation and democratic governance. The study has also highlighted the advocacy and legal capacity challenges facing mostly inward-looking organisations in West Africa with limited skills and resources to monitor and support law reform and advocacy efforts. In this context, the engagement of international civil society was essential to supporting the involvement of local West African civil society organisations against the N'Djamena model law. However, such leadership from global civil society organisations may lead to perceptions of external interference. The case studies have also offered critical insights into the commonalities and differences of approaches used by civil society in engaging HIV-related law making.

Yet, the important roles and achievements of civil society in influencing HIV law and policy reform as well as their potential engagement in monitoring legislative implementation are under threat. On the one hand, shifts in the global HIV response towards essentially service-delivery models of civil society to support the scaling up of HIV prevention, treatment and care, together with reducing donor resources for

HIV is translating into funding cuts for advocacy and law reform functions of civil society. On the other hand, new laws and regulations in a number of sub-Saharan African States are threatening the ability of civil society to engage in advocacy and law reform issues relating to the protection and access to HIV and health services for criminalised populations such as sex workers, people who inject drugs, and men who have sex with men.[133]

In the context of increased calls for leaving no one behind and for addressing the legal and social determinants of inequalities in the HIV response and in the Sustainable Development agenda,[134] HIV donors should expand their support for essential civil society advocacy and monitoring functions, not retreat from them. In addition, appropriate responses are needed to address the restrictive laws, regulations and practices that hinder the space and work of civil society, including in the context of HIV.

[133] See for instance, M Davis *The perfect storm: The closing space for LGBT civil society in Kyrgyzstan, Indonesia, Kenya, and Hungary* http://globalphilanthropyproject.org/2016/04/22/perfectstormreport/ (accessed 7 September 2016).
[134] UN General Assembly, Transforming our world: the 2030 Agenda for Sustainable Development, Resolution A/RES/70/1, adopted on 25 September 2015.

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PART FOUR: CONCLUSION

This final part concludes the thesis with two complementary chapters. Chapter Ten draws on the issues and analyses related to the normative content and implementation of HIV-specific laws in sub-Saharan Africa. It sums up the key findings from Chapters Five to Nine and makes specific recommendations for developing 'smarter' HIV legislation with improved content that would enable their effective implementation.

Chapter Eleven is broader in scope and deeper in its analysis. It closes the overall study by laying out and reflecting on key findings in relation to the role and applicability of human rights in the context of HIV and health. It also reflects on the value of human rights as a framework for assessing the normative content and implementation challenges in HIV-related legislation. The chapter, and the thesis, then end with critical considerations for shifting the understanding and approaches to HIV- and health-related lawmaking in sub-Saharan Africa.

REPRODUCTIVE HEALTH matters

Chapter Ten

FEATURE

Towards smarter HIV laws: considerations for improving HIV-specific legislation in sub-Saharan Africa

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Abstract: *As of 31 July 2014, some 27 countries in sub-Saharan Africa had adopted HIV-specific legislation to respond to the legal challenges posed by the HIV epidemic. However, serious concerns raised about these laws have led to calls for their repeal and review. Through the theory of "smarter legislation", this article develops a framework for analysing the concerns relating to the process, content and implementation of HIV-specific laws. This theoretical framework provides specific guidance and considerations for reforming HIV-specific laws and for ensuring that they achieve their goals of creating enabling legal environments for the HIV response.*

Keywords: HIV/AIDS, Legislation, sub-Saharan Africa, HIV-specific laws

Introduction

Experience and evidence from more than 30 years of the HIV epidemic have shown that enabling legal environments – including protective legislation – can play an important role in advancing the HIV response.[1] However, early reviews of the legal environment relating to HIV in countries across the world found that existing legislative frameworks were not adapted to the legal, social and human rights challenges raised by the epidemic.[2] Many countries have taken legislative measures to address the legal and human rights issues relating to HIV.[3] In sub-Saharan Africa, the majority of countries adopted HIV-specific legislation. As of August 2014, 27 sub-Saharan African countries had adopted such laws (see Figure 1).

HIV-specific laws, a single piece of legislation exclusively dedicated to HIV, cover issues such as HIV education and information, HIV testing and counselling, biomedical HIV research, non-discrimination based on HIV status, HIV prevention, treatment, care and support as well as penalties for various acts such as HIV non-disclosure, exposure or transmission.[4]

Since their adoption, the great majority of HIV-specific laws have raised serious concerns relating to coercive provisions.[4,5] Research has also identified several flaws in the content of HIV-specific laws, such as lack of clarity, contradictory provisions, and failure to identify implementation agencies.[6]

These concerns have generated questions about the rationale, process, content and implementation of most HIV-specific laws in sub-Saharan Africa. However, repealing HIV-specific laws in sub-

Figure 1. Sub-Saharan African countries with HIV-specific laws as of 31 July 2014

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Saharan African countries will prove challenging, with likely resistance from parliamentarians and other stakeholders at country and regional levels who have supported their adoption.[7] In addition, the removal of HIV-specific laws will create gaps in national HIV legal frameworks because in many countries they are the only legally binding instruments that explicitly guarantee some protection for people living with HIV and address legal issues relevant to the epidemic. On the other hand, efforts to review and improve HIV-specific laws have proved successful in a few countries in the region, including Sierra Leone, Guinea and Togo, thus suggesting that this approach is worth pursuing.[4]

This article explores the application of the principles and approaches of "smarter legislation" to guide the review of HIV-specific laws. Following an overview of the human rights and implementation challenges in HIV-specific laws in sub-Saharan Africa, the article introduces the notion of "smarter legislation" and its application on key issues and challenges in the context of HIV-related law-making.

Human rights and implementation concerns in HIV-specific laws

Analyses of HIV-specific laws adopted in sub-Saharan Africa have shown that they contain some human rights protections covering areas such as non-discrimination, access to HIV information and education, protection in the workplace and informed consent in the context of research relating to HIV.[4,5] These laws also contain various forms of restrictive and coercive measures.[4,5] A recent review of HIV-specific laws in 26 sub-Saharan African countries found that 17 countries have broad provisions that allow for involuntary disclosure of HIV status of people living with HIV to their sexual partners, and 24 countries have provisions allowing for criminalisation of HIV non-disclosure, exposure or transmission (see Table).[4]

These coercive provisions not only infringe upon human rights, including the rights to autonomy, privacy and security; they have also been proved to negatively impact efforts to advance effective responses to HIV, as highlighted by the *International Guidelines on HIV/AIDS and Human Rights*:

"People will not seek HIV related counselling, testing, treatment, and support if this could mean facing discrimination, lack of confidentiality and other negative consequences…[C]oercive public health measures drive away the people most in need of such services and fail to achieve their public health goals of prevention through behavioural change, care and health support." [8]

A further concern in HIV-specific laws is the limited or lack of attention to the legal and human rights issues affecting many key populations, such as women and girls, sex workers and men who have sex with men, in spite of evidence on their greater vulnerability to HIV.[4]

More than ten years after the first HIV-specific laws were adopted, there is limited evidence of their effective implementation and enforcement. Findings from surveys conducted in a number of countries that have adopted HIV-specific laws suggest that there is insufficient awareness of these laws among key stakeholders, including people living with HIV, who are arguably their primary beneficiaries.[9] In several countries, critical implementation measures that are expected to translate or accompany these laws have not been adopted several years after they were passed.[10]

Intrinsic flaws in the normative content of HIV-specific legislation are considered to have

Table 1. Example of coercive and restrictive provisions in HIV-specific laws

Provisions/measures	Countries
Overly broad partner notification	17 countries: Angola, Benin, Burkina Faso, Burundi, Cape Verde, Central African Republic, Chad, Côte d'Ivoire, DRC, Guinea Bissau, Kenya, Madagascar, Mali, Niger, Senegal, Tanzania and Uganda
Criminalisation of HIV non-disclosure, exposure or transmission	24 countries: Angola, Benin, Burkina Faso, Burundi, Cape Verde, Central African Republic, Chad, Congo, Côte d'Ivoire, DRC, Guinea, Guinea Bissau, Kenya, Liberia, Madagascar, Mali, Mauritania, Mozambique, Niger, Senegal, Sierra Leone, Tanzania, Togo and Uganda

hindered their implementation and enforcement. These challenges include vague provisions that are difficult to implement or enforce. In several countries, HIV-specific laws fail to address their relationships with other legislation dealing with similar issues. This situation is likely to lead to confusion among target populations and implementing actors regarding which law is to be applied in specific circumstances. Another important implementation and enforcement challenge is that HIV-specific laws often do not designate specific implementation agencies for ensuring that they are enforced or for addressing gaps and challenges in their implementation and enforcement.[6]

Conceptual framework: "smarter legislation" in the context of HIV

To be effective, HIV legislation should be informed by the principles and approaches of "smarter" legislation. The notion of "smarter legislation" was coined by Ingram and Schneider. According to these authors, "[f]lawed statutes are the source of many implementation problems and failed policies."[11] Ingram and Schneider argue that whether any legislation is effectively implemented and enforced depends largely on the normative content of the law and how it addresses key issues such as sound policy, clarity of provisions and supportive implementation agency.[11] On the basis of this theory of "smarter legislation" and the principle of participation – which is central to HIV policy – the present article highlights three key considerations that should guide the development of smarter HIV legislation.

First, smarter HIV legislation should be based on participatory law-making processes. Ensuring public participation in law-making processes, particularly on issues with important legal and social implications such as HIV, is an indicator of good and inclusive governance.[12] Public participation in law-making is a human right guaranteed under a number of global, regional and national norms.[12] In the context of HIV, the involvement of key stakeholders, including people living with HIV and populations most affected by the epidemic, in policy and decision making is considered essential to effective responses. This imperative is enshrined in the principle of the greater involvement of people living with HIV (GIPA) in all aspects of the response to HIV. GIPA was championed by people living with HIV and has been endorsed by countries globally through the Declaration of Commitment on HIV/AIDS.[13]

Second, the content of smarter HIV legislation should be based on sound public health policy and human rights principles. Evidence and experience from more than 30 years of HIV response have shown that effective responses are those that protect individuals against coercion and other restrictive measures in access to HIV prevention, treatment and care services.[8] These include the protection of informed consent and confidentiality, and eliminating overly broad HIV criminalisation and other criminal measures against key populations at higher risk of HIV infection.[8]

Third, smarter HIV legislation should give due consideration to factors that influence whether and how legislation is implemented. In general, the implementation of law or policy is influenced by multiple factors. Some are extrinsic factors relating to the broader environment, such as social, political, economic, financial and administrative conditions in a given context.[6] Others are intrinsic factors, which relate to the normative content of the legislation and policy. Intrinsic factors address issues such as the clarity of normative provisions, the precision of the directives provided to the target population and implementers of the law as well as the identification of implementing agencies to advance the legislative goals identified in the law.[6] Since these intrinsic elements are under the direct control of the drafters of legislation, it is recommended that they be given due consideration in HIV-related law-making for ensuring the effective implementation of the resulting legislation.

"Making smarter HIV laws: applying the conceptual framework to HIV-specific laws in sub-Saharan Africa

This section explores approaches for ensuring that the content of HIV-specific laws takes into account key elements that will contribute to improving their normative content and implementation.

Participatory process in HIV-related law-making

The great majority of HIV-specific laws adopted in sub-Saharan Africa did not allow the meaningful participation of key stakeholders in their development. For instance, in hearings and consultations relating to HIV-specific laws adopted in West and Central African countries between 2005 and 2007, people living with HIV and human rights organisations were often not included.[5]

These actors should participate in parliamentary hearings and other consultations organised in the

context of HIV-related law-making, and their involvement should not be symbolic; their concerns should be addressed in the laws. This requires specific and strategic engagement of civil society and law-makers on issues of concern to people living with HIV and key populations in order to identify solutions in each national context. For instance, recent HIV-related laws that have been developed through more inclusive processes in countries such as Senegal, Guinea and Côte d'Ivoire are considered to have better human rights provisions and to take into account best available public health recommendations.[4]

Sound public health and human rights-based provisions

The great majority of HIV-specific laws in sub-Saharan Africa have embraced coercive and restrictive measures that ignore sound public health and human rights recommendations. Creating smarter HIV-specific laws will require addressing existing coercive provisions in these laws. Review efforts should focus on those provisions that have attracted the most criticisms and concerns and that are likely to have greatest impact on the HIV response. This includes provisions allowing for overly broad criminalisation of HIV non-disclosure, exposure and transmission which are often used to illustrate the embrace of coercive approaches in HIV legislation.

Over the years, civil society organisations have mobilised against HIV criminalisation provisions, demanding their removal. In some instances, these calls for change have been successful. This was the case for example in Sierra Leone where the provision allowing for explicit criminalisation of mother-to-child transmission of HIV was removed by parliament in 2011.[4] More recently, in Kenya, the provision criminalising HIV exposure and transmission was declared unconstitutional by the High Court.[14] Efforts should therefore continue to support countries to remove or, at the very least, amend the provisions relating to HIV non-disclosure, exposure or transmission to ensure that they are in line with sound public health evidence and human rights principles.

Creating smarter HIV legislation will also require addressing the silence or inappropriate provisions on women, children and other key populations. Across sub-Saharan Africa, women and girls constitute a population particularly impacted by the epidemic.[15] AIDS is also the leading cause of death among young people in Africa.[16] Yet, the vulnerabilities to HIV and the need for HIV services of these populations are not addressed in HIV laws.[5] The drafters' justification is that most countries already have legislation applicable to women and children and that it is not necessary to replicate in HIV laws norms that already exist in other laws.[17] Some also argue that issues relating to these populations could be addressed through regulations, policies and programmes which may be best suited for responding to their vulnerabilities.[17]

In spite of these arguments, failure to address the specific HIV vulnerabilities and needs for HIV services of women and girls, young people and other key populations in HIV-specific laws is a gap and concern. Provisions in other legislation relating to women, children and other key populations are often inadequate to address HIV issues pertinent to these populations. In almost all countries in the region, there are no legal provisions relating to the protection of key populations, such as sex workers, men who have sex with men and people who inject drugs, and their access to HIV services. In addition, as compared to regulations and policy documents, laws are best suited for setting general principles relating to the protection and access to services for populations that face multiple forms of legal, social and health barriers and vulnerabilities. This is because legislation provides rights-holders with a clear claim on which to hold government accountable.

Implementation and enforcement of HIV-specific laws

Smarter HIV-specific laws should comprise clearly drafted provisions that explicitly address their relations with other legislation dealing with similar subjects.[6] Since HIV touches upon various areas, this would prevent potential conflict of laws rather than leaving the determination of the applicable legislation to the discretion of implementers or judges.[6] Clarity is also important because implementers and law enforcement agents are inclined to apply provisions that deal directly with the issue at hand. For instance, in relation to HIV and employment, implementers and law enforcement agents will "naturally" implement existing employment legislation rather than the provisions relating to HIV and employment that are provided in the HIV-specific legislation. This is because implementers and law enforcement actors are more likely to know about and be conversant with the provisions of existing legislation dealing with a specific area such as employment, rather than the provisions of lesser known HIV legislation.

In many countries, the recourse to coercive provisions in HIV-specific laws has led to serious

opposition, resulting in lengthy law reform processes or court cases that have thwarted the implementation of the law.[4,14] For instance, in a number of West and Central African countries, coercive provisions in HIV-specific laws, such as restrictions to HIV education for adolescents, compulsory HIV testing for sex workers and overly broad criminalisation of HIV non-disclosure, exposure and transmission have generated mistrust among civil society actors who perceived these laws as violating rather than supporting human rights.[5,18] This situation has reportedly hindered the willingness and ability of civil society to invoke and use these laws.[19]

HIV-related legislation should clearly designate agencies responsible for implementing key provisions. For instance, specific directorates within ministries of employment with relevant expertise could be explicitly tasked with the implementation of measures addressing discrimination in employment. HIV-specific laws should also provide a timeline within which the implementation agency is to take action and deliver on specific issues. In particular, such timelines should be set for the development of regulations or the setting up of institutions mandated by the law. In addition, to ensure progress in the overall implementation and enforcement of HIV legislation, it is important to task an entity with monitoring the implementation of the law. The only country with a mechanism to ensure the overall enforcement of its HIV legislation is Kenya, which has established an HIV-specific Tribunal under its HIV law.[20] This Tribunal has been given broad powers to ensure the implementation and enforcement of this legislation. A review of the composition, mandate and work of the Tribunal has concluded that in spite of the financial and resource challenges that it faces, the Tribunal can be an effective mechanism for ensuring the implementation and enforcement of the HIV law of Kenya.[20]

Discussion

Human rights and public health concerns and gaps in HIV-specific laws call for urgent efforts to address and review them in order to support effective responses to HIV. Enabling legislative environments, including protective HIV laws, are necessary to unlock the barriers that prevent people living with or vulnerable to HIV from accessing HIV prevention, treatment and care services. Advocacy by civil society has shed light on these concerns and, in some countries, created momentum for change through law reform or litigation. International organisations, including UNAIDS and UNDP (in the context of the follow up to the recommendations of the Global Commission on HIV and the Law) are also supporting HIV-related law reform efforts through financial and technical assistance to legal assessments and national dialogues.[21]

Efforts to review HIV-specific laws have proven complex and challenging, often requiring several years of engagement. Yet, they are worthwhile endeavours because in many countries, HIV-specific laws are the only binding legal instruments explicitly addressing the HIV epidemic. Ending punitive provisions in these laws, and strengthening the implementation and enforcement of their protective norms is therefore important for creating an enabling environment for the HIV response. A number of tools to guide national legal assessments and consultative processes have been developed to enable law makers and other stakeholders to identify and address key issues and gaps in the review of HIV legislation.[22] Effective use of such tools will help improve the content of HIV-specific laws.

Ultimately, securing "smarter HIV laws" is not merely a technical endeavour requiring solely sound theory, and the application of public health and human rights principles. Smarter HIV laws require "smart politics". This includes identifying key allies in parliament, government and among other key constituencies who will support the content and objectives of HIV-related legislation, particularly on socially sensitive issues.[23] Since several issues, such as age of consent to HIV services for children and the protection of prisoners and other key populations, are controversial in many sub-Saharan African countries, law reforms should seek to build understanding and support around these issues among key allies and leaders who could champion appropriate legal provisions. For instance, in Mauritius, sensitisation and engagement of members of parliament and other key national actors have enabled the adoption of HIV legislation that protects and ensures access to HIV services for people who inject drugs in spite of existing punitive laws against people who use drugs.[24] Similarly, in Senegal, effective engagement by civil society, the national AIDS programme and other stakeholders has ensured explicit mention of HIV services for men who have sex with men in the HIV law in spite of existing criminal legislation punishing same sex relations.[25] While these examples of protective provisions for key populations remain rare, they demonstrate that "smart" politics can translate into smart HIV laws in spite of political, social and religious sensitivities and challenges.

As the world mobilises to achieve the vision of ending the AIDS epidemic by 2030 within the integrated framework of inclusion, equality and rule of law provided by the Sustainable Development Goals, creating enabling and protective legal environments is expected to receive renewed attention which would support efforts by civil society and others working to end punitive laws and other legal barriers to HIV responses.[26]

Finally, even the smartest HIV-related legislation will have little impact unless it is accompanied by financial and other measures to support its implementation and enforcement. These include adopting rights-based implementing regulations (where necessary), providing resources to disseminate the law, and taking all needed measures to inform and train duty bearers (including health care workers, police and employers) and rights-holders (including people living with and affected by HIV and civil society) on the content of the law and avenues for obtaining redress in case of rights violations.

Conclusion

HIV-specific laws are now part of the legislative framework of a majority of countries in sub-Saharan Africa, with 27 countries having adopted such laws as of July 2014. In spite of serious concerns with these laws, much can be done to improve them. Reforms should be guided by considerations and approaches of "smarter legislation" that are based on participatory process, sound public health evidence and human rights principles, and that pay due attention to intrinsic factors that affect legislative implementation and enforcement. Building political alliances and leadership among lawmakers and other key national stakeholders to support efforts to review and improve HIV-specific legislation is also key. Adopting the measures and approaches presented in this article will contribute to ensure the emergence of "smarter HIV legislation" in sub-Saharan Africa which will be critical to efforts to remove the legal barriers to the HIV response and to ensuring that no one is left behind in efforts to end the AIDS epidemic as a public health threat.

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References

1. Gostin LO. The AIDS pandemic: Complacency, injustice, and unfulfilled expectations. Chapel Hill: University of North Carolina Press, 2004.
2. In: Frankowski, editor. Legal responses to AIDS in comparative perspectives. The Hague: Kluwer Law International, 1998.
3. D'Amelio R, Tuerlings E, Perito O, et al. A global review of legislation on HIV/AIDS: the issue of HIV testing. Journal of Acquired Immune Deficiency Syndromes, 2001; 28(2):173–179.
4. Eba PM. HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis. African Human Rights Law Journal, 2015;15:224–262.
5. Pearshouse R. Legislation contagion: The spread of problematic new HIV laws in Western Africa. HIV/AIDS Policy & Law Review, 2007;12:1–12.
6. Eba PM, Strode A. A framework for understanding and addressing intrinsic challenges to the implementation of HIV-specific laws in Sub-Saharan Africa. 2016. (forthcoming).
7. Pearshouse R. Legislation contagion: building resistance. HIV/AIDS Policy & Law Review, 2008;13:1–10.
8. UNAIDS, OHCHR. International guidelines on HIV/AIDS and human rights, 2006 consolidated version. Geneva: UNAIDS, 2006.
9. National Council of People Living With HIV/AIDS Tanzania (NACOPHA). The people living with HIV stigma index report: Tanzania. Dar es Salam: NACOPHA, 2013. At http://stigmaindex.org/sites/default/files/reports/Tanzania%20STIGMA%20INDEX %20REPORT%20-%20Final%20Report%20pdf.pdf.
10. IRIN. La faible application de la loi VIH frappe plus durement les femmes. 19 August 2009At. https://www.irinnews.org/fr/report/85808/niger-la-faible-application-de-la-loi-vih-frappe-plus-durement-les-femmes.
11. Ingram H, Schneider A. Improving implementation through framing smarter statutes. Journal of Public Policy, 1990;10(1):67–88.
12. Czapanskiy KS, Manjoo R. The right of public participation in the law-making process and the role of legislature in

the promotion of the right. Duke Journal of Comparative and International Law, 2008;19:1–40.
13. Stevens D. Out of the shadows: greater involvement of people living with HIV / AIDS (GIPA) in policy. Washington DC: Futures Group, POLICY Project, 2004. At http://www.policyproject.com/pubs/workingpapers/WPS14.pdf.
14. High Court of Kenya. Aids Law Project v Attorney General & 3 others. 2015At. http://kenyalaw.org/caselaw/cases/view/107033/.
15. UNAIDS. The gap report. Geneva: UNAIDS, 2014. At http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf.
16. UNAIDS. Leaders from around the world are All In to end the AIDS epidemic among adolescents. 17 February 2015At. http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/february/20150217_PR_all-in.
17. Eba PM. Capacity building workshop on human rights and gender in HIV legal frameworks – Final report. 16-18 April 2008. (on file with author).
18. Kazatchkine C. Criminalizing HIV transmission or exposure: the context of francophone West and Central Africa. HIV/AIDS Policy & Law Review, 2010;14:1–11.
19. Liberia Network of People Living with HIV. Liberia PLHIV stigma index report. Monrovia: Liberia National AIDS Commission, 2013. At http://www.stigmaindex.org/sites/default/files/reports/Liberia%20%20People%20Living%20with%20HIV%20Stigma%20Index%20Final%20Report%202013.pdf.
20. Eba PM. The HIV and AIDS Tribunal of Kenya: An effective mechanism for the enforcement of HIV-related human rights? Health and Human Rights Journal, 2016;18(1):169–180.
21. UNAIDS. UBRAF thematic report: Ending punitive laws, June 2015. 2014At. https://results.unaids.org/sites/default/files/documents/C1_Ending_punitive_laws_Jun2015.pdf.
22. UNDP. Legal environment assessment for HIV: An operational guide to conducting national legal, regulatory and policy assessments for HIV. New York: UNDP, 2014. At http://www.undp.org/content/dam/undp/library/HIV-AIDS/Governance%20of%20HIV%20Responses/UNDP%20Practical%20Manual%20LEA%20FINAL%20web.pdf.
23. Altman D, Buse K. Thinking politically about HIV: Political analysis and action in response to AIDS. Contemporary Politics, 2012;18(2):127–140.
24. HIV and AIDS Act, No 31 of 2006 of Mauritius.
25. Loi n° 2010-03 du 9 avril 2010 relative au VIH/SIDA of Senegal.
26. UNAIDS. UNAIDS Strategy 2016-2021: On the fast track to end AIDS. Geneva: UNAIDS, 2015. At http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf.

Résumé

Au 31 juillet 2014, près de 27 pays d'Afrique subsaharienne avaient adopté une législation spécifique sur le VIH pour répondre aux questions juridiques posées par l'épidémie de VIH. Néanmoins, les graves préoccupations suscitées par ces lois ont donné lieu à des appels pour qu'elles soient abrogées et révisées. Moyennant la théorie de la « législation plus intelligente », cet article fournit un cadre pour analyser les préoccupations relatives au processus, au contenu et à l'application de lois spécifiques relatives au VIH. Ce cadre théorique donne des conseils précis et des considérations en vue de réformer ces lois et veiller à ce qu'elles parviennent à leur objectif qui est de créer des environnements juridiques habilitants pour la réponse au VIH.

Resumen

Para el 31 de julio de 2014, unos 27 países en África subsahariana habían adoptado legislación referente al VIH específicamente, con el fin de responder a los retos jurídicos que presenta la epidemia del VIH. Sin embargo, graves inquietudes planteadas acerca de estas leyes han producido llamados a su revocación y revisión. Por medio de la teoría de "legislación más inteligente", este artículo crea un marco para analizar las inquietudes relacionadas con el proceso, contenido y aplicación de leyes referentes al VIH. Este marco teórico ofrece orientación y consideraciones específicas para reformar las leyes referentes al VIH y asegurar que logren sus objetivos de crear ambientes legislativos que propicien la respuesta al VIH.

Chapter Eleven: Concluding reflections

This thesis has made key findings on the continued value of human rights for health in general, and for HIV in particular. It also has provided insights into the progress and challenges related to the application of human rights in legislative frameworks on HIV in sub-Saharan Africa.

This chapter reflects on the broader political, legal and social considerations of these findings and uses them to formulate recommendations for better legal responses to HIV. The following sections discuss the finding of this thesis in greater detail.

11.1 Respecting human rights remains critically important in public health and HIV responses

11.1.1 Public health evidence and a broad recognition of the value of human rights continue to support rights-based approaches to health and HIV

Scientific and medical advances in the response to HIV have changed the face and impact of the epidemic. Thanks to the significant increase in the number of people on anti-retroviral therapy (ART), particularly in middle- and low-income countries, and to the multiplication of HIV prevention options and tools, AIDS has become a manageable chronic condition for those who can access ART.[1]

Despite this progress, structural, social and legal barriers continue to contribute to vulnerability to HIV infection and prevent people – particularly those most vulnerable to the epidemic – from receiving HIV prevention, treatment, care and support services.[2] In the face of these challenges, there is a broad recognition that human rights norms and

[1] SG Deeks, SR Lewin & DV Havlir 'The end of AIDS: HIV infection as a chronic disease' (2013) 382(9903) *Lancet* 1525-1533; LF Johnson, J Mossong, RE Dorrington, M Schomaker, CJ Hoffmann, O Keiser, MP Fox, R Wood, H Prozesky, J Giddy, DB Garone, M Cornell, M Egger & A Boulle 'Life expectancies of South African adults starting antiretroviral treatment: collaborative analysis of cohort studies' (2013) 10 *PLoS Medicine* e1001418; F Nakagawa, M May & A Phillips 'Life expectancy living with HIV: recent estimates and future implications' (2013) 26 *Current Opinion in Infectious Diseases* 17-25.

[2] P Piot, SSA Karim, R Hecht, H Legido-Quigley, K Buse, J Stover, S Resch, T Ryckman, S Møgedal, M Dybul, E Goosby, C Watts, N Kilonzo, J McManus & M Sidibé 'Defeating AIDS—advancing global health' (2015) 386(9989) *Lancet* 171–218; Global Commission on HIV and the Law *HIV and the Law: Risks, Rights and Health* (2012).

rights-based responses remain critical to addressing the HIV epidemic.[3] The importance of human rights to HIV responses was reiterated in the Political Declaration on HIV adopted by the UN General Assembly in June 2016.[4] Across the world, the language and framework of human rights continue to be used to highlight structural vulnerability to HIV and barriers to services, to demand protection and access to services for populations most affected by the epidemic, and to challenge discriminatory and restrictive HIV legislation and policies.

As was shown in Chapter Three in relation to prisoners, the value of a human rights-based approach is that it questions broader structural factors that make certain populations more vulnerable to ill-health (including HIV).[5] A rights-based approach to HIV and prisons further interrogates inequalities that affect minorities and other marginalised populations, as well as the unfair application of criminal law that leads to over-incarceration among these populations.[6] It also challenges substandard healthcare and the denial of health and HIV services, and it condemns violence, abuse and other forms of human rights violations against prisoners.[7]

Human rights-based approaches also are critical to identifying and prioritising responses to the challenges faced by the populations most affected by HIV. In light of evidence showing that key populations are left behind in the response to HIV and receive limited access to services, human rights-based responses call for shifting priorities to focus on the needs of those most affected.[8] In doing so, human rights-based responses require identifying and addressing the legal and social barriers that hinder access to HIV services for these populations. In the case of adolescents – discussed in

[3] Ibid.
[4] UN General Assembly Political Declaration on HIV and AIDS: On the Fast-Track to accelerate the fight against HIV and to end the AIDS epidemic by 2030 (A/70/L.52) 8 June 2016.
[5] LS Rubenstein, JJ Amon, M McLemore, P Eba, K Dolan, R Lines & C Beyrer 'HIV, prisoners, and human rights' (2016) *Lancet* http://dx.doi.org/10.1016/S0140-6736(16)30663-8.
[6] Ibid.
[7] Ibid.
[8] P Piot et al (note 2 above); UNAIDS *The gap report* (2014) 26-48 available at *http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf*, accessed on 26 August 2016.

Chapter Six – legal restrictions to accessing HIV testing, counselling and treatment represent key barriers that should be addressed.

Human rights norms also have been used by civil society as tools for monitoring, assessing and challenging HIV-specific legislation in Africa. They have enabled civil society and other actors to bring attention to key concerns in HIV-specific laws, and they have served as frameworks for improving the normative content of several national laws.

It has been argued that without a human rights-based approach to HIV, structural, legal and social factors of vulnerability – as well as barriers to service access – will remain unaddressed. As the case of the Ebola outbreak (discussed in Chapter Four) has highlighted, failure to apply rights-based approaches often leads to coercive responses that are likely to alienate the populations affected and hinder effective public health responses.

11.1.2 Despite evidence supporting the inclusion of human rights in HIV-specific legislation in sub-Saharan Africa, most countries have only paid lip service to such approaches

The rapid adoption of HIV-specific legislation and other HIV-related laws across sub-Saharan Africa illustrates the recognition and acceptance of the role of the law as a structural tool in the response to HIV. Almost all of the 27 countries that have adopted HIV-specific legislation in the region have endorsed, at least on a rhetorical level, the importance of the law and human rights in creating an enabling environment for the response to HIV.[9] This endorsement is often explicitly noted in the preamble or objectives of these laws.

Beyond the symbolic endorsement of human rights, the great majority of HIV-specific laws also include protections for people living with HIV. All 26 HIV-specific laws reviewed as part of this thesis include one or more provisions that prohibit discrimination

[9] PM Eba 'HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis' (2015) 15 *African Human Rights Law Journal* 227-228.

based on HIV status.[10] In addition to the general non-discrimination provisions, several countries prohibit HIV-related discrimination in areas such as employment, education, health, housing and insurance. HIV-specific laws also include rights-based measures on HIV-related education and information, blood and tissue safety, and ethical research in relation to HIV.[11]

The adoption of these protective and rights-based provisions in HIV-specific legislation is significant for two reasons. First, it shows the contrast between HIV and other public health conditions, which are characterised by legislative inertia. In fact, public health laws in most sub-Saharan African countries are decades-old relics that often have received little attention in terms of legislative modernisation or amendment. Second, the elevation of human rights and their translation into protective provisions in HIV-related laws in many countries across sub-Saharan Africa is unprecedented in the context of health. No other health condition has led to similar attention to human rights in legislative frameworks.

In general, the affirmation of human rights norms in HIV-related laws in sub-Saharan Africa focuses mainly on the protection of people living with HIV. In some exceptional cases, lawmakers also have extended protections and access to HIV services to key populations. For example, the HIV legislation in Mauritius specifically addresses the protections for people who inject drugs and their access to HIV services, including needle and syringe exchange programmes.[12] The fact that injecting drug use is the main route of HIV transmission in Mauritius, together with the leadership of the Ministry of Health and key parliamentarians on the issue, were among the reasons for the breakthrough that led to the adoption of this law.[13] Further research on the context, approaches and actors that enabled the adoption of these protective HIV provisions in Mauritius – despite the criminalisation of drug use in the country – could provide critical

[10] Ibid.
[11] Ibid.
[12] PM Eba 'Towards smarter HIV laws: considerations for improving HIV-specific legislation in sub-Saharan Africa' (2016) 24 *Reproductive Health Matters* 2016 178-184.
[13] Ibid.

insights for ensuring protective legislation for key populations in other sub-Saharan African countries.

While important, the recognition of the role of the law in relation to HIV and the inclusion of human rights norms in HIV-related legislative frameworks should not mask the continued challenges that face rights-based responses to health and HIV in sub-Saharan Africa.

11.2 HIV-specific laws are inadequate at many levels and do not provide a comprehensive framework for rights-based responses to HIV

Various challenges continue to confront efforts to advance rights-based responses to HIV in sub-Saharan Africa. These challenges are apparent in the human rights gaps that have been noted in HIV-specific legislation, the limited attention to implementation issues, and the lack of involvement of civil society in HIV-related legislative processes (among other areas).

11.2.1 Limited commitment to human rights has led to insufficient human rights protections in HIV-specific legislation, particularly for key populations

In most sub-Saharan African countries, human rights protections in HIV-specific laws remain insufficient and inadequate. The comprehensive review of these laws provided in Chapter Five of this thesis shows that many of their protective clauses (such as non-discrimination provisions) are limited in scope and leave out key issues and areas, such as discrimination based on another person's status, discrimination based on perceived or presumed HIV status, and indirect discrimination.

In addition, HIV-specific laws contain several restrictive provisions, including compulsory HIV testing for alleged sexual offenders, involuntary partner notification, restricted access to HIV services for adolescents, and criminalisation of HIV non-disclosure, exposure and transmission. For instance, all countries with HIV-specific laws, except Mauritius and Comoros, criminalise HIV non-disclosure, exposure or

transmission.[14] Furthermore, as shown in Chapter Six, only six out of 26 countries have lowered the age of consent to HIV testing to below 18 years. These restrictive provisions often infringe upon human rights and undermine effective responses to HIV.

Serious gaps also have been noted in HIV-specific laws in relation to their silence on the protection and access to HIV services for members of key populations, including women, young people, sex workers, men who have sex with men and people who use drugs.[15] In spite of evidence from across sub-Saharan Africa showing that these populations are among those most vulnerable to HIV, the great majority of HIV-specific laws fail to explicitly address their needs.[16]

In general, human rights gaps and challenges in HIV-related laws can be attributed to two types of causes: some are due to limited technical capacities, while others are attributable to contestations of human rights entitlements for certain populations. On one hand, the imperfections and gaps in protective provisions relating to areas such as discrimination against people living with HIV often are attributable to poor drafting and limited technical expertise in the process of making legislation. Consequently, these gaps have proven easy to address in the context of law reform. In effect, recently adopted or revised HIV-specific laws in countries such as Comoros, Côte d'Ivoire and Sierra Leone have stronger provisions on non-discrimination because parliamentarians took into consideration recommendations for strengthening these provisions that were made by civil society and technical agencies (including UNAIDS and UNDP).[17]

On the other hand, the recourse to coercive approaches and the failure to address the protection of key populations and their access to HIV services in HIV-specific laws appears to be motivated by political and social sensitivities relating to issues such as adolescent sexuality, criminal law and human rights protections for certain populations (such as sex workers, people who inject drugs and LGBT people). Current polarisation around the human rights of LGBT people and other key populations – including at the

[14] Eba (note 9 above).
[15] Eba (note 12 above).
[16] Ibid.
[17] Eba (note 9 above).

global, regional and country levels – appears to hinder progressive HIV-related lawmaking on these issues.

11.2.2 HIV laws fail to adequately address implementation issues

This study shows that most HIV-specific laws fail to take into account critical considerations that ensure the effective implementation of legislation. As described in Chapters Seven and Ten, the provisions of HIV-specific laws in sub-Saharan Africa are often unclear and fail to provide explicit directions to both their implementers and the populations that are their focus. More than half of the laws (14 out of 26) fail to explicitly specify their relationships in terms of precedence with other legislation dealing with similar issues.[18] In most countries, HIV-specific laws do not identify specific agencies for the implementation of key provisions, including those relating to human rights (such as the prohibition of discrimination in employment or healthcare).[19] These flaws in the normative content of HIV-specific laws are due to a lack of understanding and knowledge among legislative drafters and lawmakers about critical considerations that relate to 'smarter' legislation.

Furthermore, the failure of these laws to address evidence-informed and rights-based policy – as well as their recourse to coercive measures – has led to opposition from civil society and challenges to their provision. The lack of support from civil society actors (who could have played key roles in supporting the laws), the criticism of those laws by various stakeholders, and the litigation for their reform also have compromised the likelihood of their implementation.[20]

Of all the national HIV-specific laws adopted in sub-Saharan Africa, only that of Kenya establishes a specific mechanism for the implementation and enforcement of its provisions: namely the HIV and AIDS Tribunal of Kenya.[21] As described in Chapter Eight, the inclusive composition, broad mandate, accessible procedure and purposeful

[18] Eba (note 12 above).
[19] Ibid.
[20] Ibid.
[21] PM Eba 'The HIV and AIDS Tribunal of Kenya: An effective mechanism for the enforcement of HIV-related human rights? (2016) 18(1) *Health and Human Rights Journal* 169-180.

application of the law by the HIV Tribunal are contributing to the protection of HIV-related human rights in Kenya. The human, financial and other challenges facing the Tribunal, however, should be duly appraised by other countries that are considering such HIV-specific mechanisms.

Other approaches are available to countries to ensure the effective implementation of protective provisions in HIV laws without resorting to specific judicial bodies. One approach includes creating or strengthening access to justice programmes for people living with and affected by HIV; another involves increasing sensitisation on HIV and human rights, both for key actors who are responsible for the implementation of HIV-related legislation and for the public as a whole. Such programmes could explicitly be mandated in HIV-related legislation.

11.2.3 The challenges of HIV-specific laws are further compounded by the limited space for civil society in HIV lawmaking, which negatively impacts the inclusivity and legitimacy of these laws

Civil society organisations are generally not meaningfully involved in the development of HIV-related legislation in sub-Saharan African countries. Where civil society has been consulted as part of lawmaking processes, their views and concerns often were not reflected in the final legislation. The study shows that the existence of civil society organisations with more capacity to perform advocacy and legal monitoring functions, particularly in East African countries, has enabled them to become involved and express their concerns during the development of national and regional laws. This was not the case for civil society in most West and Central African countries, which lacked such legal advocacy and monitoring capacity; instead, civil society actors involved in the HIV response in West and Central Africa are generally focused on delivering HIV-related services. As discussed in Chapter Nine, this explains civil society's silence and initial lack of awareness about the serious human rights and public health concerns related to the N'Djamena Model Law.

Ultimately, the limited involvement and influence of civil society in lawmaking processes in many sub-Saharan African countries reflects the broader challenges related to

insufficient public and civil society participation in national governance. In contexts where civil society has been able to engage in public debates on broader social and legal issues, they were more ready to engage in HIV legislative processes. This was the case in countries such as Kenya and Uganda, for instance, two countries that have vibrant civil society organisations with the experience and capacity to engage in advocacy and law reform efforts.

In spite of these challenges, the two case studies of civil society engagement in HIV lawmaking described in Chapter Nine show that civil society can be key actors for ensuring rights-based and evidence-informed legislative responses to HIV. Civil society has been central to the reform of provisions of concerns in national HIV laws in West and Central Africa. Similarly, civil society in East Africa has championed the adoption of protective regional HIV legislation to address the concerns related to national HIV laws in the region. These successes have been achieved through various approaches, including the following:

- creating alliances between global, regional and national civil society;
- collaborating with key regional and local actors who can influence legislative processes (including parliamentarians and legal drafters);
- securing the support of international HIV standard-setting and advocacy organisations; and
- challenging external promoters of coercive laws.

11.3 Moving forward: The need to shift understanding and approaches to HIV-related legislation

Findings from this thesis show that broad acknowledgement of legal and human rights norms in the response to HIV – comprehensively articulated 20 years ago in the International Guidelines on HIV/AIDS and Human Rights[22] – does not necessarily

[22] UNAIDS & OHCHR *International guidelines on HIV/AIDS and human rights, 2006 consolidated version* (2006).

translate into their effective application, including in relation to HIV legislation. This thesis thus recommends three shifts in understanding and approaches that may support better integration of human rights in HIV-related legislative frameworks:

1. Address HIV lawmaking as a political issue.
2. Ensure ‘smarter’ legislation by focusing on normative content and intrinsic factors of implementation.
3. Involve civil society as central to rights-based responses.

While these three shifts are specifically formulated in relation to HIV, it is argued that they are also of relevance to lawmaking on other health issues.

11.3.1 HIV lawmaking as a political issue

At its core, HIV-related lawmaking is a politically sensitive endeavour. This is because it often addresses issues related to social values, cultural taboos, and the protection and access to health services for vulnerable, marginalised and criminalised populations that are not prioritised by governments and who often experience socially stigma. Consequently, legislative processes on these issues often involve tensions and pressures for legislators to defer to public views that may be contrary to human rights norms and public health evidence.

The recognition of these social, legal and political challenges calls for ensuring that legislative processes relating to HIV take place in an enabling context where parliamentarians and other key actors involved have the understanding and tools to appreciate critical human rights norms and public health evidence, and to negotiate their translation into legislation. This should involve capacity building for parliamentarians to ensure that they understand key rights-based and evidence-informed issues relating to HIV legislation. Similarly, consensus or common ground on sensitive and contested issues should be created among lawmakers and policymakers involved in these processes.

Challenges related to lawmaking on HIV may lead to questions about the appropriateness of legislation to respond to the serious legal challenges involved in the HIV response. Judicial responses enshrined in human rights interpretation may sometimes appear better suited and more effective for responding to the legal challenges faced by many vulnerable and criminalised populations in the context of HIV. Indeed, these judicial avenues have been used in several countries across sub-Saharan Africa to secure protection of populations such as prisoners, migrants and women living with HIV, and to ensure their access to HIV services.[23] Judicial avenues, however, are not a magic bullet, and they often are out of reach for the majority of people living with or vulnerable to HIV.[24]

In reality, the challenges relating to lawmaking and HIV in sub-Saharan Africa are generally due to the fact that lawmakers in most sub-Saharan African countries are ill-prepared for leadership on sensitive human rights issues. In most countries, national legislators have been encouraged to legislate on HIV without clear and timely advice on effective approaches that take into account local challenges. In this context, 'legislation by intuition'[25] became the rule, and easily-replicable (yet ill-informed) models such as the N'Djamena Model Law were used by countries as reference documents for their HIV legislation. Addressing these challenges call for giving particular attention to building capacity and 'HIV legislative competence' among national legislators as they are called upon to legislate on the epidemic. Such capacity and competence building will ensure that legislators are guided by sound public health evidence and human rights approaches when addressing the sensitive and complex legal issues raised by the epidemic.

[23] See UNDP *Compendium of judgments: HIV, human rights and the law for the judicial dialogue on HIV, human rights and the law in Eastern and Southern Africa, Nairobi, Kenya, 28–31 October 2013* (2013) available at *http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/compendium-of-judgment-for-judicial-dialogue-on-hiv--human-right.html*, accessed on 3 September 2016.
[24] See AE Yamin & S Gloppen (eds) *Litigating health rights: Can courts bring more justice to health?* (2011).
[25] R Pearshouse 'Legislation contagion: building resistance' (2008) 13(2/3) *HIV/AIDS Policy & Law Review* 1-11.

11.3.2 Ensuring ‘smarter’ laws that address implementation issues in the content of HIV laws

‘Smarter’ HIV laws are those that meet two sets of criteria: 1) they are based on human rights norms and sound public health evidence relating to HIV, and 2) they pay due attention to the intrinsic issues in the normative content of the law that would influence its effective implementation. As discussed above, ensuring that HIV legislation is based on scientific evidence and human rights norms is both a technical and a political issue. It is therefore critical to build the capacity and competence of lawmakers to ensure that they understand the relevant technical issues and are able to negotiate sensitive political pitfalls in order to secure protective legislation that benefits everyone affected by HIV.

In general, the limited attention to intrinsic flaws in the content of legislation and their impact on implementation is due to the popular belief that legislative proclamation is sufficient for change. For many actors involved in legislative efforts, the job is done when the legislation or policy is adopted. As a result, the content of the law and how it might enable or hinder effective implementation is not a priority for actors supporting legislative or policy reform. Changing this understanding of lawmaking requires popularising the importance of elements of ‘smarter’ legislation that increase the likelihood that laws are effectively implemented, and then training legislators, civil society and other health and HIV actors in that approach. Key intrinsic issues that are significant to the implementation of legislation that legislators should consider include the following:

- promoting better legislative drafting in order to ensure that injunctions are clear to implementers;
- designating implementation agencies that are responsible for the effective application of key human rights provisions; and
- addressing relationships of HIV laws vis-à-vis other similar laws (including in terms of which law takes precedence).

Legislators and drafters of HIV laws also could ensure that provisions in HIV legislation enable parliament or other national bodies with expertise on HIV (such as national AIDS commissions) to undertake thorough and consultative reviews of the implementation of the legislation several years after it comes into force, and then at regular intervals thereafter. Such provisions could help identify progress and barriers to implementation, and it could enable the adoption of corrective legislative or other measures.

11.3.3 Enhancing the involvement of civil society as key actors in HIV lawmaking

Ensuring the meaningful involvement of civil society actors, including people living with and vulnerable to HIV, is essential to ensuring rights-based and evidence-informed legislation. Civil society organisations can play important roles in disseminating HIV-related legislation and informing key constituencies about their existence and stipulations. They also can assist individuals in accessing courts and other fora for the protection of their rights that are guaranteed under HIV-specific laws. Additionally, civil society can initiate or support advocacy efforts to demand the adoption of regulation or other measures to ensure effective implementation of the legislation. HIV-related and health-related lawmaking processes should therefore create space for the contribution and involvement of civil society.

Civil society organisations, however, can only play their legal monitoring and advocacy roles and deliver on them if they have the financial, technical and other resources to effectively contribute to the emergence of enabling legal environments for the HIV response.

In light of the challenges relating to restrictive HIV-specific legislation in sub-Saharan Africa, some have called for renouncing the use of legislative reform for creating an enabling legal environment on HIV.[26] The main contribution of this thesis is to debunk such wholesale views by providing a better understanding of the contexts, conditions and approaches that are necessary for developing ‘smarter’ HIV legislation that contains

[26] See R Pearshouse ‘Legislation contagion: The spread of problematic new HIV laws in Western Africa’ (2007) 12 *HIV/AIDS Policy and Law Review* 1-12; Eba (note 9 above) 226-227.

evidence-informed and rights-based provisions and that has a greater likelihood of being effectively implemented. This thesis concludes that legislating on HIV – whether through HIV-specific laws or otherwise – is not inherently bad. What is problematic, however, is engaging in any HIV-related or health-related legislative process without due attention to the principles of ‘smarter’ legislation and to the other key considerations outlined in this thesis.

Bibliography

1 Primary sources

1.1 Cases

AIDS Law Project v Attorney General & 3 Others Kenya High Court [2015] eKLR.

Alver v Estonia 64812/01 (2005) ECHR

Attorney General and Others v Dickson Tapela and Others, Court of Appeal of Botswana, Case No CACGB-096-14

Attorney-General's Reference: In re The State v Marapo [2002] 2 BLR 26

Banda v Lekha (2005), Industrial Relations Court of Malawi, MWIRC 44

C v Minister of Correctional Services 1996 (4) SA 292 (T)

Castell v De Greef 1994 (4) All SA 63 (c) (S Afr).

Doctors for Life International v Speaker of the National Assembly and Others 2006 (12) BCLR 1399 (CC)

EN and Others v Government of RSA and Others (2006) AHRLR 326 (SAHC 2006)

Enhorn v Sweden 56529/00 (2005) ECHR

Government of the Republic of Namibia v LM [2014] NASC

Herczegfalvy v Austria 10533/83 (1992) ECHR

Hoffmann v South African Airways (CCT17/00) [2000] ZACC 17

I v Finland 20511/03 (2008) ECHR

Khudobin v Russia 59696/00 (2006) ECHR

Malawi African Association and Others v Mauritania (2000) AHRLR 149 (African Commission on Human and Peoples' Rights 2000)

Media Rights Agenda & Others v Nigeria (2000) AHRLR 200 (African Commission on Human and Peoples' Rights 1998)

Minister of Health and Others v Treatment Action Campaign and Others (No 2) (CCT8/02) [2002] ZACC 15

Odafe and Others v Attorney-General and Others (2004) AHRLR 205 (NgHC 2004)

Pantea v Romania 33343/96 (2003) ECHR

Pedro Orlando Ubaque v. Director, National Model Prisons Constitutional Court of Colombia, Decision No. T-502/94 (1994)

Republic v HIV and AIDS Tribunal and another ex parte Dyncorp International (2015) (High Court of Kenya, EKLR)

Royal Media Services Ltd v Attorney General & 6 others (2015) (High Court of Kenya, eKLR)

'S' v Procureur Général, Arrêt, 23 February 2009 (Chambre pénale) (Genève)

Sahadath v Trinidad and Tobago, Human Rights Committee Communication No. 684/1996 (2002) CCPR/C/74/D/684/1996

Staykov v Bulgaria 49438/99 (2006) ECHR

Testa v Croatia 20877/04 (2007) ECHR

Van Vuuren & Another NNO v Kruger 1993 (4) SA 842

YBA v Brother Nicholas Banda and Three Others (2013) (HIV and AIDS Tribunal of Kenya, Tribunal Case No. 007 of 2012)

1.2 Statutes

An Act to Amend the Public Health Law, Title 33, Liberian Code of Laws Revised (1976) to Create New Chapter 18 Providing for the Control of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), (2010) of Liberia

Children's Act 2005 of South Africa, No 38 of 2005 of South Africa

Constitution of Kenya, 2010

Constitution of the Republic of South Africa, No 108 of 1996

East African Community HIV and AIDS Prevention and Management Act, 2015

East African Community HIV and AIDS Prevention and Management Bill, March 2010

HIV and AIDS (Prevention and Control) Act, No 28 of 2008 of Tanzania

HIV and AIDS Act, No 31 of 2006 of Mauritius

HIV and AIDS Prevention and Control Act, No 14 of 2006 of Kenya

HIV and AIDS Prevention and Control Bill 2003

HIV Prevention and Control Act 2014 of Uganda

Lei n°12/2009 estabelece os direitos e deveres da pessoa vivendo com HIV e SIDA, e adopta medidas necessárias para a prevenção, protecção e tratamento da mesma, 2009 de Moçambique

Lei No 19/2014 Lei de Protecçao da Pessao, do trabalhador e do Candidato e Emprego Vivendo com VIH e SIDA, 2014 de Moçambique

Lei No 8/04 sobre o Virus da Immunodeficiência Humana (VIH) e a Sindroma de Immunodeficiência Adquirida (SIDA) 2004 de Angola

Ley No 3/2005 sobre la prevención y la lucha contra las infecciones de transmisión sexual (ITS), el VIH/SIDA y la defensa de los derechos de las personas afectadas, (2005) de Guinea Ecuatorial

Loi 06.030 de 2006 fixant les droits et obligations des personnes vivant avec le VIH/SIDA de la République Centrafricaine

Loi L/2005/025/AN du 22 Novembre 2005 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA en République de Guinée

Loi No 030-2008/AN portant lutte contre le VIH/SIDA et protection des droits des personnes vivant avec le VIH/SIDA 2008 du Burkina Faso

Loi No 08/011 du 14 Juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées de la République Démocratique Congo

Loi No 1/018 du 12 Mai 2005 portant protection juridique des personnes infectées par le Virus de l'Immunodéficience Humaine et des personnes atteintes du Syndrome Immunodéficience Acquise du Burundi

Loi No 14-011/AU du 21 avril 2014 relative aux droits des personnes vivant avec le VIH et leur implication dans la réponse nationale des Comores

Loi No 19/PR/2007 du 15 Novembre 2007 portant lutte contre VIH/SIDA/IST et protection des droits des personnes vivant avec le VIH/SIDA du Tchad

Loi No 19/VII/2007 de Cabo Verde

Loi No 2005-012 portant protection des personnes en matière de VIH/SIDA du Togo

Loi No 2005-040 du 20 Février 2006 sur la lutte contre le VIH/SIDA et la protection des droits des personnes vivant avec le VIH/SIDA de Madagascar

Loi No 2005-31 du 5 Avril 2006 portant prévention, prise en charge et contrôle du VIH/SIDA du Bénin

Loi No 2007-042 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA (2007) de Mauritanie

Loi No 2007-08 du 30 Avril 2007 relative à la prévention, la prise en charge et le contrôle du Virus de d'Immunodéficience Humaine (HIV) du Niger

Loi No 2010-018 du 31 Décembre 2010 modifiant la loi No 2005 – 012 du 14 Décembre 2005 portant protection des personnes en matière de VIH/SIDA du Togo

Loi No 2010-03 du 9 avril 2010 relative au VIH/SIDA du Sénégal

Loi No 2014-430 du 14 juillet 2014 portant régime de prévention, de protection et de répression en matière de lutte contre le VIH et le SIDA de la Côte d'Ivoire

Loi No 30 - 2011 du 3 juin 2011 portant lutte contre le VIH et le SIDA et protection des droits des personnes vivant avec le VIH du Congo

Loi No 5/2007 du 10 septembre 2007 de la prévention, du traitement et du contrôle du VIH/sida de la Guinée Bissau

Loi No 6-028 du 29 Juin 2006 fixant les règles relatives à la prévention, à la prise en charge et au contrôle du VIH/SIDA du Mali

National HIV and AIDS Commission Act 2011 of Sierra Leone

Ordonnance No 056/2009/PRG/SGG portant amendement de la loi L/2005/025/AN du 22 Novembre 2005 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA en République de Guinée

Prevention and Control of HIV and AIDS Act 2007 of Sierra Leone

Sexual Offences Act, No 3 of 2006 of Kenya

1.3 National regulations and policies

Conseil National de Lutte Contre le VIH/SIDA et les IST *Normes et directives nationales de conseil dépistage de l'infection à VIH au Burkina Faso* (2008) available at https://aidsfree.usaid.gov/sites/default/files/hts_policy_burkina-faso.pdf (accessed on 7 September 2016).

Legal Notice No. 180, Kenya Gazette Supplement No. 81, November 5, 2010.

Legal Notice No. 34, Kenya Gazette Supplement, No. 16, March 6, 2009.

Ministère de la Santé Publique du Chad *Manuel de formation en counselling VIH/SIDA/IST* (2011), available at http://www.emtct-iatt.org/wp-content/uploads/2016/01/hts_policy_ chad.pdf (accessed on 7 September 2016).

Ministry of Health and Social Welfare of Tanzania *Standard operating procedures for HIV testing and counselling (HTC) services* (2009) available at http://www.jica.go.jp/project/tanzania/001/materials/pdf/vct_10.pdf (accessed on 7 September 2016).

Ministry of Health of Kenya *The Kenya HIV Testing Services Guidelines* (2015) available at http://www.emtct-iatt.org/wp-content/uploads/2016/01/hts_policy_chad.pdf (accessed on 7 September 2016).

1.4 Treaties

African Charter on Democracy, Elections and Governance, adopted 30 January 2007, available at http://www.au.int/en/sites/default/files/treaties/7790-file-african_charter_on_democracy_ elections_ and_governance.pdf (accessed 20 August 2016).

African Charter on Human and Peoples' Rights, adopted 27 June 1981, OAU Doc CAB/LEG/67/3 Rev 5.

African Charter on the Rights and Welfare of the Child, adopted 11 July 1990, OAU Doc CAB/LEG/24.9/49.

Constitutive Act of the African Union, adopted 11 July 2000, OAU Doc. CAB/LEG/23.15.

Convention on the Elimination of All Forms of Discrimination against Women, adopted 18 December 1979, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46.

Convention on the Rights of Persons with Disabilities, adopted 13 December 2006, G.A. Res. 61/106, Annex I, U.N. GAOR, 61st Sess., Supp. No. 49, at 65, U.N. Doc. A/61/49 (2006).

Convention on the Rights of the Child, adopted 20 November 1989, GA Res 44/ 25, annex, 44 UN GAOR Supp (No 49) 167, UN Doc A/44/49 (1989).

International Covenant on Civil and Political Rights, adopted 16 December 1966, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171.

International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966, GA Res 2200A (XXI), 21 UN GAOR Supp (No 16) 49, UN Doc A/6316 (1966), 993 UNTS 3.

Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, adopted 18 December 2002, A/RES/57/199.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted 13 September 2000, CAB/LEG/66.6.

The Treaty for the Establishment of the East African Community, adopted November 1999 available at *http://www.eac.int/sites/default/files/docs/treaty_eac_amended-2006_1999.pdf* (accessed 9 August 2016).

World Health Organisation *International Health Regulations (2005)* 2nd ed Geneva, Switzerland: WHO (2008).

1.5 Resolutions, general comments and similar documents

African Commission on Human and Peoples' Rights, *General comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, adopted at the 55th Ordinary Session of the African Commission on Human and Peoples' Rights in 2014 available at http://www.achpr.org/instruments/general-comment-two-rights-women/ (accessed on 25 February 2017).

African Commission on Human and Peoples' Rights, *General comment on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, adopted at the 52nd Ordinary Session, Yamoussoukro, Côte d'Ivoire, 9-22 October 2012 available at http://www.achpr.org/instruments/general-comments-rights-women/ (accessed on 25 February 2017).

African Commission on Human and Peoples' Rights *Resolution 163 on the Establishment of a Committee on the protection of the rights of people living with HIV and those at risk, vulnerable to and affected by HIV*, 47th Ordinary Session, Banjul, The Gambia, 26 May 2010, available at *http://www.achpr.org/sessions/47th/resolutions/163/* (accessed on 10 September 2016).

African Commission on Human and Peoples' Rights *Resolution 275 on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity*, adopted at the 55th

Ordinary Session of the African Commission on Human and Peoples' Rights in Luanda, Angola, 28 April - 12 May 2014, available at http://www.achpr.org/sessions/55th/resolutions/275/ (accessed on 10 September 2016).

African Commission on Human and Peoples' Rights *Guidelines on the conditions of arrest, police custody and pre-trial detention in Africa*. Banjul: African Commission on Human and Peoples' Rights (2015) available at http://www.achpr.org/files/instruments/guidelines_arrest_detention/guidelines_on_arrest_police_custody_detention.pdf (accessed on 10 September 2016).

African Union *Decision on the promotion of cooperation, dialogue and respect for diversity in the field of human rights*, Doc. Assembly/AU/17(XV) Add.9, Kampala Summit, 2010, available at http://www.au.int/en/sites/default/files/decisions/9630-assembly_en_25_27_july_2010_bcp_assembly_of_the_african_union_fifteenth_ordinary_session.pdf (accessed on 27 August 2016).

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment *CPT standards: "Substantive" sections of the CPT's general reports*, Strasbourg: Council of Europe: CPT, (2015), available at http://www.cpt.coe.int/en/documents/eng-standards.pdf (accessed 10 August 2016).

Inter-American Commission on Human Rights, *Resolution 1/08, Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas*, 13 March 2008, No. 1/08, available at http://www.refworld.org/docid/48732afa2.html (accessed 9 August 2016).

International Labour Organisation *Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200),* adopted at the 99th session of the International Labour Conference: Geneva, 17 June 2010, available at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/normativeinstrument/wcms_142706.pdf (accessed 9 August 2016).

International Labour Organisation *The ILO Code of Practice on HIV/AIDS and the World of Work* (2001) available at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_113783.pdf (accessed 9 August 2016).

Joint United Nations Programme on HIV/AIDS and Office of United Nations High Commissioner for Human Rights *International Guidelines on HIV/AIDS and Human Rights, 2006 consolidated version*, HR/PUB/06/9, OHCHR and UNAIDS (2006) available at http://www.refworld.org/docid/4694a4a92.html (accessed 10 August 2016).

Southern African Development Community Parliamentary Forum *Model Law on HIV in Southern Africa*, Windhoek: SADC Parliamentary Forum (2008) available at http://www.justice.gov.za/vg/hiv/docs/2008_Model-Law-on-HIV-in-Southern-Africa.pdf (accessed on 10 August 2016).

United Nations Commission on Human Rights *Protection of human rights in the context of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)*, adopted on 9 March 1993, E/CN.4/RES/1993/53, available at: http://ap.ohchr.org/documents/alldocs.aspx?doc_id=4480, (accessed 7 March 2015).

United Nations Commission on Human Rights *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)* E/CN.4/RES/1997/33 11 Avril 1997 available at http://ap.ohchr.org/documents/alldocs.aspx?doc_id=4480 (accessed on 26 August 2016).

United Nations Commission on Human Rights *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, 28 September 1984, E/CN.4/1985/4, available at: http://www.refworld.org/docid/4672bc122.html (accessed 10 August 2016).

United Nations Committee on Economic, Social and Cultural Rights (CESCR) *General comment No. 20: Non-discrimination in economic, social and cultural rights* (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 2 July 2009, E/C.12/GC/20, available at: http://www.refworld.org/docid/4a60961f2.html (accessed 10 August 2016).

United Nations Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4 available at: http://www.refworld.org/docid/4538838d0.html (accessed 9 August 2016).

United Nations Committee on the Rights of the Child (CRC) *General comment No. 3 (2003): HIV/AIDS and the Rights of the Child*, 17 March 2003, CRC/GC/2003/3, available at http://www.refworld.org/docid/4538834e15.html (accessed 5 August 2016).

United Nations Committee on the Rights of the Child (CRC), *General comment No. 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, 1 July 2003, CRC/GC/2003/4 available at: http://www.refworld.org/docid/4538834f0.html (accessed 10 August 2016).

United Nations Committee on the Rights of the Child (CRC), *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, 17 April 2013, CRC/C/GC/15 available at: http://www.refworld.org/docid/51ef9e134.html (accessed 10 August 2016).

United Nations General Assembly *Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS* (UN Doc A/RES/65/277) 10 June 2011 available at http://www.unaids.org/sites/default/files/sub_landing/files/ 20110610 _UN_A-RES-65-277_en.pdf (accessed 10 August 2016).

United Nations General Assembly *Political Declaration on HIV and AIDS: On the Fast-Track to accelerate the fight against HIV and to end the AIDS epidemic by 2030*

(A/70/L.52) June 2016, available at http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/266 (accessed 5 August 2016).

United Nations General Assembly *Political Declaration on HIV/AIDS*, A/RES/60/262, June 2006 available at http://data.unaids.org/pub/Report/2006/20060615_HLM_Political Declaration _ARES60262_en.pdf (accessed 10 September 2016).

United Nations General Assembly Special Session on HIV/AIDS *Declaration of Commitment on HIV/AIDS* (A/RES/S-26/2) June 2001 available at http://www.un.org/ga/aids/docs/aress262.pdf (accessed 10 August 2016).

United Nations General Assembly *Transforming our world: the 2030 Agenda for Sustainable Development*, Resolution A/RES/70/1, adopted on 25 September 2015, available at http://www.un.org/pga/wp-content/uploads/sites/3/2015/08/120815_outcome-document-of-Summit-for-adoption-of-the-post-2015-development-agenda.pdf (accessed 10 August 2016).

United Nations General Assembly *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)* 8 January 2016, A/RES/70/175 available at http://www.refworld.org/docid/569_8a3a44._Html (accessed 9 August 2016).

United Nations Human Rights Committee (HRC), *CCPR General Comment No. 18: Non-discrimination*, 10 November 1989 available at http://www.refworld.org/docid/453883fa8.html (accessed 10 August 2016).

United Nations Human Rights Committee (HRC), *CCPR General Comment No. 10: Article 19 (Freedom of Opinion)*, 29 June 1983, available at http://www.refworld.org/docid/453883f80.html (accessed 10 August 2016).

United Nations Human Rights Committee (HRC), *General Comment no. 34, Article 19, Freedoms of opinion and expression*, 12 September 2011, CCPR/C/GC/34 available at http://www.refworld.org/docid/4ed34b562.html (accessed 10 August 2016).

United Nations Human Rights Council, *Resolution 17/19 Human rights, sexual orientation and gender identity,* 14 July 2011, A/HRC/RES/17/19, available at: http://www.refworld.org/docid/512f0bd22.html (accessed 10 August 2016).

United Nations Human Rights Council, *Resolution 27/32 Human rights, sexual orientation and gender identity*, 2 October 2014, A/HRC/RES/27/32, available at: http://www.refworld.org/docid/55ed69214.html (accessed 10 August 2016).

Universal Declaration of Human Rights, adopted 10 December 1948, G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948).

World Health Assembly *AIDS: Avoidance of discrimination in relation to HIV-infected people and people with AIDS*, Resolution WHA 41/24 Geneva: WHO (1988) available at http://apps.who.int/iris/bitstream/10665/164520/1/WHA41_R24_eng.pdf (accessed on 28 August 2016).

1.6 Interviews

Eba P ‘Interview with Allan Maleche’ (Executive Director of Kenya Legal and Ethical Issues Network on HIV (KELIN)) 26 August 2014, Nairobi, Kenya.

Eba P ‘Interview with Ambrose Rachier’ (former chairperson of HIV Tribunal), 26 August 2014, Nairobi, Kenya.

Eba P ‘Interview with Belice Odamna’ (Lawyer at the Kenya Legal and Ethical Issues Network on HIV (KELIN)) 20 August 2014, Nairobi, Kenya.

Eba P ‘Interview with Catherine Mumma’ (Member of the Commission for the Implementation of the Kenyan Constitution) 24 August 2014, Nairobi, Kenya.

Eba P ‘Interview with David Kuria Mbote’ (Health Policy Project Kenya) 25 August 2014, Nairobi, Kenya.

Eba P ‘Interview with Dominic Rono’ (National Human Rights Commission of Kenya) 22 August 2014, Nairobi, Kenya.

Eba P ‘Interview with Jotham Arwa’ (current chairperson of HIV and AIDS Tribunal) 26 August 2014, Nairobi, Kenya.

Eba P ‘Interview with Justice Isaac Lenaola’ (Judge of the High Court of Kenya) 22 August 2014.

Eba P ‘Interview with Ludfine Anyango (staff member of UNDP Kenya) 28 August 2014, Nairobi, Kenya.

Eba P ‘Interview with Nelson Otwoma’, (Executive Director of National Empowerment Network of People Living with HIV and AIDS in Kenya) (NEPHAK) 25 August 2014, Nairobi, Kenya.

Eba P ‘Interview with Ruth Laibon-Masha’ (staff member of UNAIDS Kenya) 28 August 2014, Nairobi, Kenya.

Eba P ‘Interview with staff member of HIV Tribunal’ 27 August 2014, Nairobi, Kenya.

Eba P ‘Phone interview with Nelson Osiemo’ (a lawyer who has represented complainants before the HIV Tribunal) 29 September 2015.

2 Secondary sources

2.1 Books

Aggleton P, Davies P and Hart G *AIDS: Rights, risk, and reason* London: RoutledgeFalmer (1992).

Aggleton P, Davies P and Hart G *AIDS: Safety, sexuality and risk* London: Taylor Francis (1995).

AIDS and Human Rights Research Unit *Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa* Pretoria: Pretoria University Law Press (2008).

AIDS and Human Rights Research Unit *Human rights protected? Nine Southern African country profiles on HIV, AIDS and the law* Pretoria: Pretoria University Law Press (2007).

Altman D *AIDS in the mind of America: The social, political and psychological impact of a new epidemic* New York: Anchor Press/Doubleday (1986).

Altman D and Buse K (eds) *Thinking politically about HIV* London: Routledge (2014).

Altman D *Power and community: Organizational and cultural responses to AIDS* London: Taylor and Francis (1994).

Bardach E *The implementation game: What happens after a Bill Becomes a Law* Massachusetts: MIT Press (1977).

Bernard EJ *HIV and the criminal law* London: NAM/Aidsmap (2010), available at http://www.aidsmap.com/law (accessed 10 August 2016).

Chan J *Politics in the corridor of dying: AIDS activism and global health governance* Baltimore: Johns Hopkins University Press (2015).

Clapham A *Human rights: A very short introduction* Oxford: Oxford University Press (2007).

Cochrane M *When AIDS began: San Francisco and the making of an epidemic* London: Routledge (2004).

Detels R, McEwen J, Beaglehole R and Tanaka H (eds) *Oxford textbook of public health* 4th ed Oxford University Press (2002).

Donnelly J *Universal human rights in theory and practice* 3rd ed Cornell University Press (2013).

Eba PM *Stigma(ta): re-exploring HIV-related stigma* Pretoria: Centre for the Study of AIDS, University of Pretoria (2007).

Edward M *Civil society* 3rd ed Cambridge: Polity Press (2014).

Engel J *The epidemic: A global history of AIDS* Washington DC: Smithsonian (2006).

Fink AG *Conducting research literature review: From the internet to paper* 3rd ed Sage Publications (2009).

Frankowski SJ (ed) *Legal responses to AIDS in comparative perspectives* The Hague: Kluwer Law International (1998).

Glaser D (ed) *Mbeki and after. Reflections on the legacy of Thabo Mbeki* Wits University Press (2010).

Gostin LO *Public health law: power, duty, restraint* Berkeley: University of California Press (2000).

Gostin, LO *The AIDS pandemic: Complacency, injustice, and unfulfilled expectations* Chapel Hill: University of North Carolina Press (2004).

Grodin MA, Tarantola D, Annas GJ and Gruskin S *Health and human rights in a changing world* 3rd ed New York and London: Routledge (2013).

Heyns C and Killander M (eds*) Compendium of key human rights documents of the African Union* 5th ed Pretoria: Pretoria University Law Press (2013).

Ingram HM and Mann DE (eds) *Why policies succeed or fail* Beverly Hills: Sage Publication (1980).

International Labour Organisation *Rules of the game: a brief introduction to International Labour Standards* 2nd revised ed Geneva: ILO (2009).

Jacobson PD and Wasserman J *Tobacco control laws: Implementation and enforcement*, Santa Monica. CA: RAND (1997).

Joint United Nations Programme on HIV/AIDS *Judging the epidemic: A handbook for the judiciary on HIV, human rights and the law* Geneva: UNAIDS (2013).

Mann J, Tarantola DJM and Netter TW (eds) *AIDS in the world: A global report* Cambridge, MA: Harvard University Press (1992).

Marais H *Buckling: The impact of AIDS in South Africa* Centre for the Study of AIDS: University of Pretoria (2005).

Mazmanian DA and Sabatier PA (eds) *Effective policy implementation* Lexington, MA: Lexington Books (1981).

Mazmanian DA and Sabatier PA *Implementation and public policy* Boston: University Press of America (1983).

McConville M and Chui WH (eds) *Research methods for law* Edinburgh: Edinburgh University Press (2007).

Palumbo DJ and Calista DJ (eds) *Implementation and the policy process: Opening up the black box* New York: Greenwood Press (1990).

Papadakis K and Baccaro L *The promise and perils of participatory policy making,* 117 Research Series. International Labour Organisation: Geneva (2008).

Perry MJ *The idea of human rights: Four inquiries* Oxford: Oxford University Press (1998).

Pieterse M *Can rights cure? The impact of human rights litigation on South Africa's health system* Pretoria: Pretoria University Law Press (2014)

Piot P *AIDS: Between science and politics* New York: Columbia University Press (2015).

Pradel J *Droit pénal général* 16eme ed, Cujas (2007).

Pressman JL and Wildavsky A *Implementation: How great expectations in Washington are dashed in Oakland: or, why it's amazing that federal programs work at all, this being a saga of the Economic Development Administration as told by two sympathetic observers who seek to build morals on a foundation of ruined hopes* 3rd ed Berkeley: University of California Press (1984).

Quetel C *History of syphilis* Cambridge: Polity Press (1990).

Schuklenk U (eds) *AIDS: Society, ethics and law* New York and London: Routledge (2001).

Shilts R *And the band played on: Politics, people and the AIDS epidemic* New York: St Martin's Press (1987).

Tomuschat C *Human rights: Between idealism and realism* Oxford: Oxford University Press (2003).

Van Hoecke M *Methodologies of legal research: Which kind of method for what kind of discipline?* Oxford and Portland: Hart publishing (2011).

Van Niekerk AA and Kopelman LM (eds) *Ethics and AIDS in Africa: the challenge to our thinking* London: Routledge (2006).

Viljoen F and Precious S (eds) *Human rights under threat: four perspectives on HIV, AIDS, and the law in Southern Africa* Pretoria: Pretoria University Law Press (2007).

Viljoen F *International human rights law in Africa* 2nd ed Oxford University Press (2012).

Watts S *Epidemics and history: Disease, power and imperialism* Wiltshire: Redwood Books (1997).

Yamin AE and Gloppen S (eds) *Litigating health rights: Can courts bring more justice to health?* Cambridge, Massachusetts: Harvard University Press (2011).

2.2 Chapters in books

Adams M 'Doing what doesn't come naturally. On the distinctiveness of comparative law' in M Van Hoecke *Methodologies of legal research: Which kind of method for what kind of discipline?* Oxford and Portland: Hart publishing (2011) 229-240.

Adler M and Cowan F 'Sexually-transmitted infections' in R Detels, J McEwen, R Beaglehole and H Tanaka (eds) *Oxford textbook of public health* 4th ed Oxford University Press (2002) Vol 3 1441-1452.

Dara M, Chorgoliani M and de Colomban P 'TB prevention and control care in prisons' in S Enggist, L Møller, G Galea and C Udesen (eds) *Prisons and health* Copenhagen: World Health Organisation (2014) 56-72.

Heyns C 'A "struggle approach" to human rights' in A Soeteman (ed) *Pluralism and law* Kluwer Academic Publishers: Norwell (2001) 171-190.

Heywood M 'Civil society and uncivil government: The Treatment Action Campaign (TAC) versus Thabo Mbeki, 1998 - 2008' in D Glaser (ed) *Mbeki and after. Reflections on the legacy of Thabo Mbeki* Wits University Press (2010) 128-162.

Richards EP III 'HIV: Testing, screening and confidentiality – An American perspective' in R Bennett and CA Erin (eds*) HIV and AIDS: Testing, screening and confidentiality* Clarendon Press (1999) 75-90.

Sall A 'Reflection on civil society driven change: an overview' in African Research and Resource Forum *Discourses on civil society in Kenya* Nairobi: Morven Kester (EA) Ltd (2009) 1-7.

Stigler GJ 'The optimum enforcement of laws' in GS Becker and WM Landes (eds) *Essays in the economics of crime and punishment* Columbia University Press (1974) 55-67.

Tomasevski K, Gruskin S and Lazzarini Z, Hendriks A 'AIDS and human rights' in J Mann, DJM Tarantola and TW Netter (eds) *AIDS in the World: A global report* Cambridge, MA: Harvard University Press (1992) 537-574.

Van Niekerk AA 'Moral and social complexities of AIDS in Africa' in AA van Niekerk and LM Kopelman (eds) *Ethics and AIDS in Africa: the challenge to our thinking* London: Routledge (2005) 53-70.

Viljoen F and Precious S 'Human rights under threat in attempts to address HIV and AIDS' in F Viljoen and S Precious (eds) *Human rights under threat: four perspectives on HIV, AIDS, and the law in Southern Africa* Pretoria: Pretoria University Law Press (2007) 1-13.

Wamai RG 'Civil society's response to the HIV/AIDS crisis in Africa' in E Obadare (ed) *The handbook of civil society in Africa* New York: Springer (2014) Vol 20(4) 361-398.

Webley L 'Qualitative approaches to empirical legal research' in P Cane & HM Kritzer (eds) *The Oxford handbook of empirical legal research* Oxford: Oxford University Press (2010) 926-950.

2.3 Journal articles

Achmat Z 'The Treatment Action Campaign, HIV/AIDS and the government' (2004) Vol 54(1) *Transformation: Critical Perspectives on Southern Africa* 76-84.

Aerts A, Hauer B, Wanlin M and Veen J 'Tuberculosis and tuberculosis control in European prisons' (2006) Vol 10(11) *The International Journal of Tuberculosis and Lung Disease* 1215-1223.

Alfven T, McDougal L, Frescura L, Aran C, Amler P and Gill W 'A decade of investments in monitoring the HIV epidemic: how far have we come? A descriptive analysis' (2014) Vol 12(1) *Health Research Policy and Systems* 62-75.

Altman D and Buse K 'Thinking politically about HIV: Political analysis and action in response to AIDS' (2012) Vol 18(2) *Contemporary Politics* 127-140.

Ammar D and Cordova A 'HIV/AIDS in Lebanese prisons: challenges and proposed actions' (2014) Vol 10(3) *International Journal of Prisoner Health* 147-154.

Amon JJ, 'The political epidemiology of HIV' (2014) Vol 17(1):19327 *Journal of the International AIDS Society* http://dx.doi.org/10.7448/IAS.17.1.19327

Amon JJ, Wurth M and McLemore M 'Evaluating human rights advocacy on criminal justice and sex work' (2015) Vol 17(1) *Health and Human Rights Journal* e91-e101.

Baggaley R, Hensen B, Ajose O, Grabbe KL, Wong VJ, Schilsky A, Lo YR, Lule F, Granich R and Hargreaves J 'From caution to urgency: the evolution of HIV testing and counselling in Africa' (2012) Vol 90(9) *Bulletin of the World Health Organisation* 652-658.

Baillargeon, J, Giordano, TP, Rich, JD, Wu, ZH, Wells, K, Pollock, BH. and Paar, DP 'Accessing antiretroviral therapy following release from prison' (2009) Vol 301(8) *Journal of the American Medical Association* 848-857.

Barr D, Amon J and Clayton M 'Articulating a rights-based approach to HIV treatment and prevention interventions' (2011) Vol 9(6) *Current HIV Research* 396-404.

Bassiouni C 'Human rights in the context of criminal justice: Identifying international procedural protections and equivalent protections in national constitutions' (1993) Vol 3 *Duke Journal of Comparative and International Law* 235-297.

Bayer R 'Public health policy and the AIDS epidemic. An end to HIV exceptionalism?' (1991) Vol 324(21) *New England Journal of Medicines* 1500-1504.

Bayer R and Fairchild AL 'Changing the paradigm for HIV testing – The end of exceptionalism' (2006) Vol 355(7) *New England Journal of Medicine* 647-649.

Bayer R and Fairchild-Carrino A 'AIDS and the limits of control: public health orders, quarantine, and recalcitrant behavior' (1993) Vol 83(10) *American Journal of Public Health* 1471-1476.

Belenko S, Dembo R, Copenhaver M, Hiller M, Swan H, Garcia CA, O'Connell D, Oser C, Pearson F and Pankow J 'HIV Stigma in prisons and jails: Results from a staff survey' (2016) Vol 20(1) *AIDS and Behavior* 71-84.

Beletsky L, Agrawal A, Moreau B, Kumar P, Weiss-Laxer N and Heimer R 'Police training to align law enforcement and HIV prevention: preliminary evidence from the field' (2011) Vol 101(11) *American Journal of Public Health* 2012-2015.

Bi S and Klusty T 'Forced sterilizations of HIV-positive women: A global ethics and policy failure' (2015) Vol 17(10) *American Medical Association Journal of Ethics* 952 -957.

Binswanger IA, Nowels C, Corsi KF, Glanz J, Long J, Booth RE and Steiner JF 'Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors' (2012) Vol 7(1) *Addiction Science and Clinical Practice* 1-9.

Bor J, Herbst AJ, Newell ML and Bärnighausen T 'Increases in adult life expectancy in rural South Africa: Valuing the scale-up of HIV treatment' (2003) Vol 339(6122) *Science* 961-965.

Bott S and Obermeyer CM 'The social and gender context of HIV disclosure in sub-Saharan Africa: A review of policies and practices' (2013) Vol 10 (Suppl 1) *SAHARA J: Journal of Social Aspects of HIV/AIDS Research Alliance* S5-S16.

Brandt AM 'AIDS in historical perspective: four lessons from the history of sexually transmitted diseases' (1988) Vol 78(4) *American Journal of Public Health* 367-371.

Brennan J, Kuhns LM, Johnson AK, Belzer M, Wilson EC and Garofalo R 'Syndemic theory and HIV-related risk among young transgender women: the role of multiple,

co-occurring health problems and social marginalization' (2012) Vol 102(9) American *Journal of Public health* 1751-1757.

Brinkley-Rubinstein L 'Understanding the effects of multiple stigmas among formerly incarcerated HIV-positive African American men' (2015) Vol 27(2) *AIDS Education and Prevention* 167-179.

Brinkley-Rubinstein L and Turner WL 'Health impact of incarceration on HIV-positive African American males: a qualitative exploration' (2013) Vol 27(8) *AIDS Patient Care and STDs* 450-458.

Burris S 'Public Health, 'AIDS exceptionalism' and the law' (1994) Vol 27(2) *The John Marshall Law Review* 251-272.

Burris S and Cameron E 'The case against criminalisation of HIV transmission' (2008) Vol 300(5) *Journal of the American Medical Association* 578-581.

Burris S and Strathdee SA 'To serve and protect? Toward a better relationship between drug control policy and public health' (2006) Vol 20(1) *AIDS* 117-118.

Buse K, Dickinson C and Sidibé M 'HIV: know your epidemic, act on its politics' (2008) Vol 101(12) *Journal of the Royal Society of Medicine* 572-573.

Cameron E and Swanson E 'Public health and human rights – The AIDS crisis in South Africa' (1992) Vol 8 *South African Journal on Human Rights* 200-233.

Castilla J, Del Romero J, Hernando V, Marincovich B, García S and Rodríguez C 'Effectiveness of highly active antiretroviral therapy in reducing heterosexual transmission of HIV' (2005) Vol 40(1) *Journal of Acquired Immune Deficiency Syndromes* 96-101.

Castro A and Farmer P 'Understanding and addressing AIDS-related stigma: From anthropological theory to clinical practice in Haiti' (2005) Vol 95(1) *American Journal of Public Health* 53-59.

Chesney MA and Smith AW 'Critical delays in HIV testing and care: The potential role of stigma' (1999) Vol 42(7) *American Behavioral Scientist* 1162-1174.

Choi P, Kavasery R, Desai MM, Govindasamy S, Kamarulzaman A and Altice FL 'Prevalence and correlates of community re-entry challenges faced by HIV-infected male prisoners in Malaysia' (2010) Vol 21(6) *International Journal of STD & AIDS* 416-423.

Closen ML and Wojcik ME 'International health law, international travel restrictions, and the human rights of persons with AIDS and HIV' (1990) Vol 1(2) *Touro Journal of Transnational Law* 285-305.

Cohen J ‘Southern Africa: AIDS-affected children face systemic discrimination in accessing education’ (2005) Vol 10(3) *HIV/AIDS Policy and Law Review* 24-25.

Cohen MS, Chen YQ, McCauley M, Gamble T, Hosseinipour MC, Kumarasamy N, Hakim JG, Kumwenda J, Grinsztejn B, Pilotto JH and Godbole SV ‘Prevention of HIV-1 infection with early antiretroviral therapy’ (2011) Vol 365(6) *New England Journal of Medicine* 493-505.

Csete J, Kamarulzaman A, Kazatchkine M, Altice F, Balicki M, Buxton J, Cepeda J, Comfort M, Goosby E, Goulão J, Hart C, Kerr T, Lajous AM, Lewis S, Martin N, Mejía D, Camacho A, Mathieson D, Obot I, Ogunrombi A, Sherman S, Stone J, Vallath N, Vickerman P, Zábranský T, Beyrer C ‘Public health and international drug policy’ (2016) Vol 387(10026) *The Lancet* 1427-1480.

Czapanskiy KS and Manjoo R ‘The right of public participation in the law-making process and the role of legislature in the promotion of the right’ (2008) Vol 19(1) *Duke Journal of Comparative and International Law* 1-40.

D'Amelio R, Tuerlings E, Perito O, Biselli R, Natalicchio S and Kingma S ‘A global review of legislation on HIV/AIDS: the issue of HIV testing’ (2001) Vol 28(2) *Journal of Acquired Immune Deficiency Syndromes* 173-179.

Davtyan M, Brown B and Folayan M ‘Addressing Ebola-related stigma: lessons learned from HIV/AIDS’ (2014) Vol 7:26058 *Global Health Action* 1-4.

De Cock KM, Mbori-Ngacha D and Marum E ‘Shadow on the continent: public health and HIV/AIDS in Africa in the 21st century’ (2002) Vol 360(9326) *The Lancet* 67-72.

Decker MR, Crago AL, Chu SK, Sherman SG, Seshu MS, Buthelezi K, Dhaliwal M and Beyrer C ‘Human rights violations against sex workers: burden and effect on HIV’ (2015) Vol 385(9963) *The Lancet* 186-199.

Deeks SG, Lewin SR and Havlir DV ‘The end of AIDS: HIV infection as a chronic disease’ (2013) Vol 382(9903) *The Lancet* 1525-1533.

Degenhardt L, Mathers B, Vickerman P, Rhodes T, Latkin C and Hickman M ‘Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed’ (2010) Vol 376(9737) *The Lancet* 285-301.

Delany-Moretlwe S, Cowan FM, Busza J, Bolton-Moore C, Kelley K and Fairlie L ‘Providing comprehensive health services for young key populations: needs, barriers and gaps’ (2015) Vol 18(2 Suppl 1):19833 *Journal of the International AIDS Society* 29-40.

Dennis AC, Barrington C, Hino S, Gould M, Wohl D and Golin CE '"You're in a world of chaos": Experiences accessing HIV care and adhering to medications after incarceration' (2015) Vol 26(5) *Journal of the Association of Nurses in AIDS Care* 542-555.

Dolan K, Moazen B, Noori A, Rahimzadeh S, Farzadfar F and Hariga F 'People who inject drugs in prison: HIV prevalence, transmission and prevention' (2015) Vol 26(sup 1) *International Journal of Drug Policy* S12-S15.

Dolan K, Wirtz AL, Moazen B, Ndeffo-mbah M, Galvani A, Kinner SA, Courtney R, McKee M, Amon JJ, Maher L, Hellard M, Beyrer C and Altice FL 'Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees' (2016) Vol 388(10049) *The Lancet* 1089-1102.

Eba PM 'HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis' (2015) Vol 15(2) *African Human Rights Law Journal* 224-262.

Eba PM 'One size punishes all…A critical appraisal of the criminalisation of HIV transmission or exposure through HIV-specific laws in sub-Saharan Africa' (2008) Vol 10(11) *AIDS Legal Quarterly* 1-10.

Eba PM 'The HIV and AIDS Tribunal of Kenya: An effective mechanism for the enforcement of HIV-related human rights?'(2016) Vol 18(1) *Health and Human Rights Journal* 169-180.

Eba PM 'Towards smarter HIV laws: considerations for improving HIV-specific legislation in sub-Saharan Africa' (2016) Vol 24(47) *Reproductive Health Matters* 178 -184.

Eba PM and Lim HY 'Reviewing independent access to HIV testing, counselling and treatment for adolescents in HIV-specific laws in sub-Saharan Africa: Implications for the HIV response' *Journal of the International AIDS Society* (Forthcoming in 2017).

Eba PM and Strode A 'A framework for understanding and addressing intrinsic challenges to the implementation of HIV-specific laws in sub-Saharan Africa' *Critical Public Health* (Forthcoming in 2017).

Emanuel EJ, Wendler D, Killen J and Grady C 'What makes clinical research in developing countries ethical? The benchmarks of ethical research' (2004) 189 *Journal of Infectious Diseases* 930-937.

Epprecht M 'Sexual minorities, human rights and public health strategies in Africa' (2012) Vol 111(443) *African Affa*irs 223-243.

Erausquin JT, Reed E and Blankenship KM 'Police-related experiences and HIV risk among female sex workers in Andhra Pradesh, India' (2011) Vol 204 (Suppl 5) *Journal of Infectious Diseases* S1223-S1228.

Esposito M '"Double burden": a qualitative study of HIV positive prisoners in Italy' (2012) Vol 8(1) *International Journal of Prisoner Health* 35-44.

Fereday J and Muir-Cochrane E 'Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development' (2006) Vol 5(1) *International Journal of Qualitative Methods* 1-11.

Fung A and Wright EO 'Deepening democracy: Innovations in empowered participatory governance' (2001) Vol 29(1) *Politics and Society* 5-42.

Gable L, Gamharter K, Gostin LO, Hodge JG and Van Puymbroeck RV 'Legal aspects of HIV and AIDS: A guide for policy and law reform' (2007) *Wayne State University Law School Research Paper* 8-24.

Gable L, Gostin L and Hodge JG 'A global assessment of the role of law in the HIV/AIDS pandemic' (2009) Vol 123(3) *Public Health* 260-264.

Galletly CL and Pinkerton SD 'Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV' (2006) Vol 10 *AIDS and Behaviour* 451-461.

Gilbert L, Raj A, Hien D, Stockman J, Terlikbayeva A and Wyatt G 'Targeting the SAVA (Substance Abuse, Violence, and AIDS) syndemic among women and girls: A global review of epidemiology and integrated interventions' (2015) Vol 69(02) *Journal of Acquired Immune Deficiency Syndromes* S118-S127.

Gostin LO and Hodge JG Jr 'Piercing the veil of secrecy in HIV/AIDS and other sexually-transmitted diseases: Theories of privacy and disclosure in partner notification' (1998) Vol 9 *Duke Journal of Gender, Law and Policy* 10-88.

Gostin LO 'A Tribute to Jonathan Mann: Health and human rights in the AIDS pandemic' (1998) Vol 26(1) *The Journal of Law, Medicine & Ethics* 256-258.

Grace D 'Criminalizing HIV transmission using model law: troubling best practice standardizations in the global HIV/AIDS response' (2015) Vol 25(4) *Critical Public Health* 441-454.

Grace D 'Legislative epidemics: the role of model law in the transnational trend to criminalise HIV transmission' (2013) Vol 39(2) *Medical Humanities* 77-84.

Granich RM, Gilks CF, Dye C, De Cock KM and Williams BG 'Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model' (2009) Vol 373(9657) *The Lancet* 48-57.

Grossman CI and Stangl AL (eds) 'Global action to reduce HIV stigma and discrimination' (2013) Vol 16(Suppl 2): 18881 *Journal of the International AIDS Society* 1-6.

Gruskin S and Tarantola D 'Universal access to HIV prevention, treatment and care: assessing the inclusion of human rights in international and national strategic plans' (2008) Vol 22(Suppl 2) *AIDS* S123-S132.

Gruskin S, Ferguson L and Bogecho DO 'Beyond the numbers: using rights-based perspectives to enhance antiretroviral treatment scale-up' (2007) Vol 21(Suppl 5) *AIDS* S13-S19.

Gruskin S, Ferguson L, Alfven T, Rugg D and Peersman G 'Identifying structural barriers to an effective HIV response: using the National Composite Policy Index data to evaluate the human rights, legal and policy environment' (2013) Vol 16(1):18000 *Journal of the International AIDS Society* 1-7.

Guin S 'A qualitative exploration of HIV/AIDS health care services in Indian prisons' (2009) Vol 15(3) *Journal of Correctional Health Care* 179 – 189.

Hamblin J 'The role of the law in HIV/AIDS policy' (1991) Vol 5(Suppl 2) *AIDS* s239 – s244.

He T, Li K, Roberts MS, Spaulding AC, Ayer T, Grefenstette JJ and Chhatwal J 'Prevention of hepatitis C by screening and treatment in US prisons' (2016) Vol 164(2) *Annals of Internal Medicine* 84-92.

Helfer LR and Slaughter AM 'Toward a theory of effective supranational adjudication' (1997) Vol 107(2) *The Yale Law Journal* 273-391.

Herek GM 'Thinking about AIDS and stigma: A psychologist's perspective' (2002) Vol 30(4) *Journal of Law, Medicine and Ethics* 594-607.

Hermann DH 'Criminalizing conduct related to HIV transmission' (1990) Vol 9(2) *Saint Louis University Public Law Review* 351-378.

Heywood M 'Debunking 'Conglomo-talk': A case study of the amicus curiae as an instrument for advocacy, investigation and mobilisation' (2001) Vol 5(2) *Law, Democracy & Development* 133 – 162.

Heywood M 'The routine offer of HIV counseling and testing: A human right' (2005) Vol 8(2) *Health and Human Rights Journal* 13-19.

Hutchinson TC and Duncan N 'Defining and describing what we do: doctrinal legal research' (2012) 17(1) *Deakin Law Review* 83-119.

Iacomi F, Iannicelli G, Franceschini A, Migliorisi P, Rosati S, Piselli P, Scognamiglio P, De Carli G, Marcellini S and Palmieri F 'HCV infected prisoners: should they be still considered a difficult to treat population?' (2013) Vol 13(1) *BMC Infectious Diseases* 374-381.

Ibrahim AM 'LGBT rights in Africa and the discursive role of international human rights law' (2015) Vol 15(2) *African Human Rights Law Journal* 263-281.

Idele P, Gillespie A, Porth T, Suzuki C, Mahy M, Kasedde S and Luo C 'Epidemiology of HIV and AIDS among adolescents: Current status, inequities, and data gaps' (2014) Vol 66(2) *Journal of Acquired Immune Deficiency Syndromes* S144-S153.

Ingram H and Schneider A 'Improving implementation through framing smarter statutes' (1990) Vol 10(1) *Journal of Public Policy* 67-88.

Iroh PA, Mayo H and Nijhawan AE 'The HIV care cascade before, during, and after incarceration: a systematic review and data synthesis' (2015) Vol 105(7) *American Journal of Public Health* e5-e16.

Jacobson PD and Wasserman J 'The implementation and enforcement of tobacco control laws: Policy implications for activists and the industry' (1999) Vol 24(3) *Journal of Health Politics, Policy and Law* 567-598.

Johnson LF, Mossong J, Dorrington RE, Schomaker M, Hoffmann CJ, Keiser O, Fox MP, Wood R, Prozesky H, Giddy J and Garone DB 'Life expectancies of South African adults starting antiretroviral treatment: collaborative analysis of cohort studies' (2013) Vol 10(4) *PLoS Medicine* 1-4.

Johnson R 'The model law on HIV in Southern Africa: Third world approaches to international law insights into a human rights-based approach' (2009) Vol 9(1) *African Human Rights Law Journal* 120-159.

Jürgens R, Ball A and Verster A 'Interventions to reduce HIV transmission related to injecting drug use in prison' (2009) Vol 9(1) *The Lancet Infectious Diseases* 57-66.

Jürgens R, Csete J, Amon JJ, Baral S and Beyrer C 'People who use drugs, HIV, and human rights' (2010) Vol 376(9739) *The Lancet* 475-485.

Jürgens R, Nowak M and Day M 'HIV and incarceration: prisons and detention' (2011) Vol 14(26) *Journal of the International AIDS Society* 1-17.

Kalamar M, Maharaj P and Gresh A 'HIV-prevention interventions targeting men having sex with men in Africa: field experiences from Cameroon' (2011) Vol 13(10) *Culture, Health and Sexuality* 1135-1149.

Kazatchkine C 'Criminalizing HIV transmission or exposure: the context of francophone West and Central Africa' (2010) Vol 14(3) *HIV/AIDS Law and Policy Review* 1-12.

Kelly-Hanku A, Kawage T, Vallely A, Mek A and Mathers B. 'Sex, violence and HIV on the inside: cultures of violence, denial, gender inequality and homophobia

negatively influence the health outcomes of those in closed settings' (2015) Vol 17(8) *Culture, Health and Sexuality* 990-1003.

Kigozi IM, Dobkin LM, Martin JN, Geng EH, Muyindike W, Emenyonu NI, Bangsberg DR and Hahn JA 'Late disease stage at presentation to an HIV clinic in the era of free antiretroviral therapy in sub-Saharan Africa' (1999) Vol 52(2) *Journal of Acquired Immune Deficiency Syndromes* 280-289.

Kirby M 'The never-ending paradoxes of HIV/AIDS and human rights' (2004) Vol 4 *African Human Rights Law Journal* 163-180.

Kirby M 'The new AIDS virus – ineffective and unjust laws' (1988) Vol 1(3) *Journal of Acquired Immune Deficiency Syndromes* 304-312.

Kumar RA 'Ethical and human rights dimensions in prenatal HIV/AIDS testing: Botswana in global perspective' (2012) Vol 5(1) *South African Journal of Bioethics and Law* 20-26.

Kurth AE, Lally MA, Choko AT, Inwani IW and Fortenberry JD 'HIV testing and linkage to services for youth' (2015) Vol 18(2 Sppl 1) *Journal of the International AIDS Society* 19433.

Kyomya M, Todyrs KW and Amon JJ 'Laws against sodomy and the HIV epidemic in African prisons' (2012) Vol 380(9839) *The Lancet* 310-312.

Lane JE 'The concept of implementation' (1983) Vol 86(1) *Statsvetenskaplig Tidskrift* 17-40.

Larney S and Dolan K 'A literature review of international implementation of opioid substitution treatment in prisons: equivalence of care?' (2009) Vol 15(2) *European Addiction Research* 107-112.

Leach D and Oliver P 'Drug-related death following release from prison: a brief review of the literature with recommendations for practice' (2011) Vol 4(4) *Current Drug Abuse Reviews* 292-297.

Lines R 'The right to health of prisoners in international human rights law' (2008) Vol 4(1) *International Journal of Prisoner Health* 3-53.

Link BC and Phelan JC 'Conceptualising stigma' (2001) Vol 27 *Annual Review of Sociology* 363-385.

London L 'What is a human-rights based approach to health and does it matter?' (2008) Vol 10(1) *Health and Human Rights Journal* 65-80.

Loutfy M, Tyndall M, Baril JG, Montaner JS, Kaul R and Hankins C 'Canadian consensus statement on HIV and its transmission in the context of criminal law'

(2014) Vol 25(3) *Canadian Journal of Infectious Diseases and Medical Microbiology* 135-140.

Mahajan AP, Colvin M, Rudatsikira JB and Ettl D 'An overview of HIV/AIDS workplace policies and programmes in southern Africa' (2007) Vol 21(Suppl 3) *AIDS* S31-S39.

Maher JE, Peterson J, Hastings K, Dahlberg LL, Seals B, Shelley G and Kamb ML 'Partner violence, partner notification, and women's decisions to have an HIV test' (2000) Vol 25(3) *Journal of Acquired Immune Deficiency Syndromes* 276-282.

Makofane K, Gueboguo C, Lyons D and Sandfort T 'Men who have sex with men inadequately addressed in African AIDS national strategic plans' (2013) 8(2) *Global Public Health* 129-143.

Malcolm A, Aggleton P, Bronfman M, Galvao J, Mane P and Verrall J 'HIV-related stigmatization and discrimination: its forms and contexts' (1998) Vol 8(4) *Critical Public Health* 347-370.

Maluwa M, Aggleton P and Parker R 'Stigma, Discrimination, and Human Rights: A Critical Overview' (2002) Vol 6(1) *Health and Human Rights Journal* 1-18.

Maman S, Van Rooyen H and Groves AK 'HIV status disclosure to families for social support in South Africa (NIMH Project Accept/HPTN 043)' (2014) Vol 26(2) *AIDS Care* 226-232.

Mann JM 'Statement at an informal briefing on AIDS to the 42nd Session of the United Nations General Assembly' (1988) Vol 151(1) *Journal of the Royal Statistical Society, Series A* 131-136.

Manor J 'Democratisation with inclusion: political reforms and people's empowerment at the grassroots' (2004) Vol 5(1) *Journal of Human Development* 5-29.

Martin NK, Vickerman P, Goldberg D and Hickman M 'HCV treatment as prevention in prison: Key issues' (2015) Vol 61(1) *Hepatology* 402-403.

May M, Gompels M, Delpech V, Porter K, Post F, Johnson M, Dunn D, Palfreeman A, Gilson R, Gazzard B and Hill T 'Impact of late diagnosis and treatment on life expectancy in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) Study' (2011) Vol 343 *British Medical Journal* 1-11.

May PJ and Winter SC 'Politicians, managers, and street-Level bureaucrats: Influences on policy implementation' (2009) Vol 19(3) *Journal of Public Administration Research and Theory* 453-476.

McLemore M ‘Access to condoms in US prisons’ (2008) Vol 13(1) *HIV/AIDS Policy & Law Review* 20-24.

McQuoid-Mason D ‘Free provision of PEP and medical advice for sexual offence victims: What should doctors do?’ (2008) Vol 98(11) *South African Medical Journal* 847-848.

Medie PA ‘Fighting gender-based violence: The women’s movement and the enforcement of rape law in Liberia’ (2013) Vol 112(448) *African Affairs* 377-397.

Medley A, Garcia-Moreno C, McGill S and Maman S ‘Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes’ (2004) Vol 82(4) *Bulletin of the World Health Organisation* 299-307.

Meng J and Burris S ‘The role of the Chinese police in methadone maintenance therapy: A literature review’ (2013) Vol 24(6) *International Journal of Drug Policy* e25 -e34.

Millett GA, Jeffries WL, Peterson JL, Malebranche DJ, Lane T, Flores SA, Fenton KA, Wilson PA, Steiner R and Heilig CM ‘Common roots: a contextual review of HIV epidemics in black men who have sex with men across the African diaspora’ (2012) Vol 380(9839) *The Lancet* 411-423.

Milloy MJ, Montaner JS and Wood E ‘Incarceration of people living with HIV/AIDS: implications for treatment-as-prevention’ (2014) Vol 11(3) *Current HIV/AIDS Reports* 308-316.

Moloney KP, van den Bergh BJ and Moller LF ‘Women in prison: The central issues of gender characteristics and trauma history’ (2009) Vol 123(6) *Public Health* 426-430.

Morolake O, Stephens D and Welbourn A ‘Greater involvement of people living with HIV in health care’ (2009) Vol 12(1) *Journal of the International AIDS Society* 4.

Mukolo A, Villegas R, Aliyu M and Wallston KA ‘Predictors of late presentation for HIV diagnosis: a literature review and suggested way forward’ (2013) Vol 17(1) *AIDS and Behavior* 5-30.

Mukuna J and Mbao ML ‘Popular participation in legislative law-making under the new democratic dispensation in Kenya’ (2014) Vol 5(20) *Mediterranean Journal of Social Sciences* 438-446.

Musumari PM, Feldman MD, Techasrivichien T, Wouters E, Ono-Kihara M and Kihara M ‘“If I have nothing to eat, I get angry and push the pills bottle away from

me": A qualitative study of patient determinants of adherence to antiretroviral therapy in the Democratic Republic of Congo' (2013) Vol 25(10) *AIDS care* 1271-1277.

Mykhalovskiy E 'The public health implications of HIV criminalization: past, current, and future research directions' (2015) Vol 25(4) Critical *Public Health* 373-385.

Naidoo K and Govender K 'Compulsory HIV testing of alleged sexual offenders – a human rights violation' (2011) Vol 4(2) *South African Journal of Bioethics and Law* 95-101.

Nakagawa F, May M and Phillips A 'Life expectancy living with HIV: recent estimates and future implications' (2013) Vol 26(1) *Current Opinion in Infectious Diseases* 17-25.

Ndashe S 'Seeking the protection of LGBTI rights at the African Commission on Human and Peoples' Rights' (2011) Vol 15 *Feminist Africa Legal Voice* 17-37.

Ngwena C, Brookman-Amissah E and Skuster P 'Human rights advances in women's reproductive health in Africa' (2015) 129 *International Journal of Gynaecology & Obstetrics* 184-187.

Ngwena C 'Constitutional values and HIV/AIDS in the workplace: Reflections on *Hoffman v South African Airways*' (2001) Vol 1(1) *Developing World Bioethics* 42-56.

Ngwena C 'HIV in the workplace: Protecting rights to equality and privacy' (1999) Vol 15 *South African Journal on Human Rights* 513-540.

O'Byrne P, Willmore J, Bryan A, Friedman DS, Hendriks A, Horvath C, Massenat D, Bouchard C, Remis RS and Etches V 'Nondisclosure prosecutions and population health outcomes: examining HIV testing, HIV diagnoses, and the attitudes of men who have sex with men following nondisclosure prosecution media releases in Ottawa, Canada' (2013) Vol 13(1) *BMC Public Health* 94.

Parker R 'Grassroots activism, civil society mobilization, and the politics of the global HIV/AIDS epidemic' (2010) Vol 17(2) *Brown Journal of World Affairs* 21-37.

Parker R and Aggleton P 'HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action' (2003) Vol 57(1) *Social Science and Medicine* 13-24.

Pearshouse R 'Legislation contagion: building resistance' (2008) Vol 13(2/3) *HIV/AIDS Policy & Law Review* 1-11.

Pearshouse R 'Legislation contagion: The spread of problematic new HIV laws in Western Africa' (2007) Vol 12(2-3) *HIV/AIDS Policy and Law Review* 1-12.

Pedraza-Fariña L ‘Conceptions of Civil Society in international law-making and Implementation: A Theoretical Framework’ (2013) Vol 34(3) *Michigan Journal of International Law* 102-173.

Person B, Sy F, Holton K, Govert B, Liang A, Garza B, Gould D, Hickson M, Mcdonald M, Meijer C, Smith J, Veto L, Williams W and Zauderer L ‘Fear and stigma: The epidemic within the SARS outbreak’ (2004) Vol 10(2) *Emerging Infectious Diseases* 358-363.

Piot P, Karim SS, Hecht R, Legido-Quigley H, Buse K, Stover J, Resch S, Ryckman T, Møgedal S, Dybul M, Goosby E, Watts C, Kilonzo N, McManus J and Sidibé M ‘Defeating AIDS—advancing global health’ (2015) Vol 386(9989) *The Lancet* 171-218.

Pont J, Stöver H and Wolff H ‘Dual loyalty in prison health care’ (2012) Vol 102(3) *American Journal of Public Health* 475-480.

Poteat T, Wirtz AL, Radix A, Borquez A, Silva-Santisteban A, Deutsch MB, Khan SI, Winter S and Operario D ‘HIV risk and preventive interventions in transgender women sex workers’ (2015) Vol 385(9964) *The Lancet* 274-286.

Pottker-Fishel CG ‘Improper bedside manner: Why state partner notification laws are ineffective in controlling the proliferation of HIV’ (2007) Vol 17 *Health Matrix* 147-179.

Price L ‘The treatment of homosexuality in the Malawian justice system: *R v Steven Monjeza Soko and Tiwonge Chimbalanga Kachepa*’ (2010) Vol 10(2) *African Human Rights Law Journal* 524-533.

Quinn TC, Wawer MJ, Sewankambo N, Serwadda D, Li C, Wabwire-Mangen F, Meehan MO, Lutalo T and Gray RH ‘Viral load and heterosexual transmission of human immunodeficiency virus type 1’ (2000) Vol 342(13) *New England journal of medicine* 921-929.

Rehman L, Gahagan J, DiCenso AM and Dias G ‘Harm reduction and women in the Canadian National Prison System: policy or practice?’ (2005) Vol 40(4) *Women & health* 57-73.

Rennie S and Behets F ‘Desperately seeking targets: the ethics of routine HIV testing in low-income countries’ (2006) Vol 84(1) *Bulletin of the World Health Organisation* 52-57.

Rich JD, Beckwith CG, Macmadu A, Marshall BD, Brinkley-Rubinstein L, Amon JJ, Milloy MJ, King MR, Sanchez J, Atwoli L and Altice FL ‘Clinical care of incarcerated people with HIV, viral hepatitis, or tuberculosis’ (2016) *The Lancet* 1-11.

Roehrs S 'Implementing the unfeasible: Compulsory HIV testing for alleged sexual offenders' (2007) Vol 22 *South African Crime Quarterly* 27-32.

Roehrs S 'Privacy, HIV/AIDS and public health interventions' (2009) Vol 126(2) *South African Law Journal* 360-397.

Rosen DL, Golin CE, Grodensky CA, May J, Bowling JM, DeVellis RF, White BL and Wohl DA 'Opt-out HIV testing in prison: informed and voluntary?' (2015) Vol 27(5) *AIDS Care* 545-554.

Rothenberg KH and Paskey SJ 'The risk of domestic violence and women with HIV infection: Implications for partner notification, public policy, and the law' (1995) Vol 85(11) *American Journal of Public Health* 1569 – 1576.

Rubenstein LS, Amon JJ, McLemore M, Eba P, Dolan K, Lines R and Beyrer C 'HIV, prisoners, and human rights' (2016) *The Lancet* http://dx.doi.org/10.1016/S0140-6736(16)30663-8.

Sabatier, PA and Mazmanian DA 'The conditions of effective implementation: A guide to accomplishing policy objectives' (1979) Vol 5(4) *Policy Analysis* 481-504.

Sanders EJ, Jaffe H, Musyoki H, Muraguri N and Graham SM 'Kenyan MSM: no longer a hidden population' (2015) Vol 29(Suppl 3) *AIDS* S195-S199.

Sanjari M, Bahramnezhad F, Fomani FK, Shoghi M and Cheraghi MA 'Ethical challenges of researchers in qualitative studies: the necessity to develop a specific guideline' (2014) 7 *Journal of Medical Ethics and History of Medicine* 14.

Sanon P, Kaboré S, Wilen J, Smith SJ and Galvão J 'Advocating prevention over punishment: the risks of HIV criminalization in Burkina Faso' (2009) Vol 17(34) *Reproductive Health Matters* 146-153.

Satterland TD, Lee JP, Moore RS and Antin TMJ 'Challenges to implementing and enforcing California's smoke-free workplace policy Act in bars' (2009) Vol 16(5) *Drugs: Education, Prevention and Policy* 422-435.

Scholte JA 'Civil society and democracy in global governance' (2002) Vol 8(3) *Global Governance* 281-304.

Schwartz SR, Nowak RG, Orazulike I, Keshinro B, Ake J, Kennedy S, Njoku O, Blattner WA, Charurat ME, Baral SD and TRUST Study Group 'The immediate effect of the Same-Sex Marriage Prohibition Act on stigma, discrimination, and engagement on HIV prevention and treatment services in men who have sex with men in Nigeria: analysis of prospective data from the TRUST cohort' (2015) Vol 2(7) *The Lancet HIV* e299-e306.

Semugoma P, Beyrer C and Baral S 'Assessing the effects of anti-homosexuality legislation in Uganda on HIV prevention, treatment, and care services' (2012) Vol 9(3) *SAHARA-J: Journal of Social Aspects of HIV/AIDS Research Alliance* 173-176.

Shalihu N, Pretorius L, Van Dyk A, Vander Stoep A and Hagopian A 'Namibian prisoners describe barriers to HIV antiretroviral therapy adherence' (2014) Vol 26(3) *AIDS Care* 968-975.

Shannon K, Strathdee SA, Goldenberg SM, Duff P, Mwangi P, Rusakova M, Reza-Paul S, Lau J, Deering K, Pickles MR and Boily MC 'Global epidemiology of HIV among female sex workers: influence of structural determinants' (2015) Vol 385(9962) *The Lancet* 55-71.

Sinclair K 'Kenyan government to establish special tribunal for HIV-related issues' (2010) Vol 14(3) *HIV/AIDS Law and Policy Review* 26 – 27.

Solomon L, Montague BT, Beckwith CG, Baillargeon J, Costa M, Dumont D, Kuo I, Kurth A and Rich JD 'Survey finds that many prisons and jails have room to improve HIV testing and coordination of postrelease treatment' (2014) Vol 33(3) *Health Affairs* 434-442.

Stemple L 'Health and human rights in today's fight against HIV/AIDS' (2008) Vol 22(Suppl 2) *AIDS* S113-S121.

Stemple L and Meyer IH 'The sexual victimization of men in America: New data challenge old assumptions' (2014) Vol 104(6) *American Journal of Public Health* e19-e26.

Strathdee SA, West BS, Reed E, Moazan B, Azim T and Dolan K 'Substance use and HIV among female sex workers and female prisoners: risk environments and implications for prevention, treatment, and policies' (2015) Vol 69(01) *Journal of Acquired Immune Deficiency Syndromes* S110-S117.

Surkan PJ, Mukherjee JS, Williams DR, Eustache E, Louis E, Jean-Paul T, Lambert W, Scanlan FC, Oswald CM and Fawzi MC 'Perceived discrimination and stigma toward children affected by HIV/AIDS and their HIV-positive caregivers in central Haiti' (2010) Vol 22(7) *AIDS Care* 803-815.

Swepston L 'Future of ILO Standards' (1994) Vol 117 *Monthly Labour Review* 16-23.

Todrys KW, Amon JJ, Malembeka G and Clayton, M 'Imprisoned and imperiled: access to HIV and TB prevention and treatment, and denial of human rights, in Zambian prisons' (2011) Vol 14(1) *Journal of the International AIDS Society* 1-11.

Todrys, KW and Amon JJ 'Criminal justice reform as HIV and TB prevention in African prisons' (2012) Vol 9(5): e1001215 *PLoS Medicine* 1-5.

Todrys, KW and Amon, JJ 'Health and human rights of women imprisoned in Zambia' (2011) Vol 11(8) *BMC International Health and Human Rights* 1-7.

Van Wyk C 'The need for a new statutory offence aimed at harmful HIV-related behaviour: The general public interest perspective' (2000) Vol 41(1) *Codicillus* 2-10.

Varan AK, Mercer DW, Stein MS and Spaulding AC 'Hepatitis C seroprevalence among prison inmates since 2001: still high but declining' (2014) Vol 129(2) *Public Health Reports* 187-195.

Vernazza P, Hirschel B, Bernasconi E and Flepp M. 'Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle' (2008) Vol 89(5) *Bulletin des Médecins Suisses* 165-169.

Viljoen F 'Model legislation and regional integration: Theory and practice of model legislation pertaining to HIV in the SADC' (2008) Vol 41 *De Jure* 383-398.

Waddell EN and Messeri PA 'Social support, disclosure, and use of anti-retroviral therapy' (2006) Vol 10(3) *AIDS and Behaviour* 263-272.

Weller SC and Davis-Beaty K 'Condom effectiveness in reducing heterosexual HIV transmission (Review)' (2002) Vol 1 *Cochrane Database of Systematic Reviews* 1-22.

Williamson RT, Wondergem P and Amenyah RN 'Using a reporting system to protect the human rights of people living with HIV and key populations: A conceptual framework' (2014) Vol 16(1) *Health and Human Rights Journal* 148-156.

Wilson D, Ford N, Ngammee V, Chua A and Kyaw MK 'HIV prevention, care, and treatment in two prisons in Thailand' (2007) Vol 4(6): e204 *PLoS Medicine* 0988-0992.

Wilson E, Pant SB, Comfort M and Ekstrand M 'Stigma and HIV risk among Metis in Nepal' (2011) Vol 13(3) *Culture, Health and Sexuality* 253-266.

Worth HB 'HIV does need a special response' (2005) Vol 330 *British Medical Journal* 492.

Wurth MH, Schleifer R, McLemore M, Todrys KW and Amon JJ 'Condoms as evidence of prostitution in the United States and the criminalization of sex work' (2013) Vol 16(1) *Journal of the International AIDS Society* 1-3.

Zampino R, Coppola N, Sagnelli C, Di Caprio G and Sagnelli E 'Hepatitis C virus infection and prisoners: Epidemiology, outcome and treatment' (2015) Vol 7(21) *World Journal of Hepatology* 2323-2330.

Zelenev A, Marcus R, Kopelev A, Cruzado-Quinones J, Spaulding A, Desabrais M, Lincoln T and Altice FL 'Patterns of homelessness and implications for HIV health after release from jail' (2013) Vol 17(2) *AIDS and Behavior* 181-194.

2.4 Reports and similar documents

African Gender and Media Initiative *Robbed of choice: forced and coerced sterilization experiences of women living with HIV in Kenya* Nairobi: African Gender and Media Initiative (2012) available *at* http://gem.or.ke/release-of-report-robbed-of-choice-forced-and-coerced-sterilization-experiences-of-women-living-with-hiv-in-kenya/ (accessed on 10 August 2016).

African Men for Sexual health and Rights, African Sex Worker Alliance, GenderDynamiX and TransBantu Association Zambia *African key populations' engagement with global heath financing institutions: A rapid review* (2016) available at http://www.amsher.org/wp-content/uploads/2016/07/AFRICAN-KEY-POPULATIONS%E2%80%99-ENGAGEMENT-WITH-GLOBAL-HEALTH-FINANCING-INSTITUTIONS-A-RAPID-REVIEW.pdf (accessed on 7 September 2016).

AIDS and Rights Alliance for Southern Africa *HIV, TB and human rights in Eastern and Southern Africa*: *Report 2016,* ARASA, (2016), available at http://www.arasa.info/files/4514/6902/5171/ARASA_AnnualReport2016_-_for_web.pdf (accessed on 26 August 2016).

AIDS Law Project Kenya *HIV and AIDS Prevention and Control Act Kenya: Simplified version* Nairobi: AIDS Law Project (2010).

Amnesty International '*Rule by Law': Discriminatory legislation and legitimized abuses in Uganda* London: Amnesty International (2014) available at https://www.amnesty.org/en/documents/AFR59/006/2014/en/ (accessed on 28 August 2016).

Amnesty International *'We ask for justice': Europe's failure to protect Roma from racist violence,* (2014), London: Amnesty International (2014) available at http://www.amnesty.eu/content/assets/Reports/08042014_Europes_failure_to_protect_Roma_from_racist_violence.pdf (accessed on 28 August 2016).

Athena Network *et al 10 reasons why criminalization of HIV exposure or transmission harms women ATHENA*, available at: http://www.athenanetwork.org/assets/files/10%20Reasons%20Why%20Criminalization%20Harms%20Women/10%20Reasons%20Why%20Criminalisation%20Harms%20Women.pdf (accessed 7 September 2016).

AWARE-HIV/AIDS 'Regional workshop to adopt a model law for STI/HIV/AIDS for West and Central Africa: General report N'Djamena, 8 - 11 September 2014' (on file with author).

AWARE-HIV/AIDS *Model law on STI/HIV/AIDS for West and Central Africa* in 'Regional workshop to adopt a model law for STI/HIV/AIDS for West and Central Africa: General report, N'Djamena, 8-11 September 2014' (on file with author).

Canadian HIV/AIDS Legal Network (2007) *A human rights analysis of the N'Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo,* Canadian HIV/AIDS Legal Network, (2007), available at http://www.aidslaw.ca/site/a-human-rights-analysis-of-the-ndjamena-model-legislation-on-aids-and-hiv-specific-legislation-in-benin-guinea-guinea-bissau-mali-niger-sierra-leone-and-togo/ (accessed 7 September 2016).

Carroll A and Itaborahy L *State sponsored homophobia 2015. A world survey of laws: criminalisation, protection, and recognition of same-sex love* (2015) Geneva: International Lesbian, Gay, Bisexual, Trans and Intersex Association available at http://ilga.org/downloads/02_ILGA_State_Sponsored_Homophobia_2016_ENG_WEB_150516.pdf (accessed on 27 August 2016).

Centers for Disease Control and Prevention, 'Pneumocystis pneumonia – Los Angeles' 5 June 1981 30(21) Mortality and Morbidity Weekly Report, 1 – 3, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/june_5.htm (accessed 27 August 2016).

Centre for Human Rights *Ending violence and other human rights violations based on sexual orientation and gender identity: A joint dialogue of the African Commission on Human and Peoples' Rights, Inter-American Commission on Human Rights and United Nations* Pretoria University Law Press (2016) available at http://www.ohchr.org/Documents/Issues/Discrimination/Endingviolence_ACHPR_IACHR_UN_SOGI_dialogue_EN.pdf (accessed on 10 August 2016).

Crewe M and Viljoen F *Testing times, routine HIV testing: A challenge to human rights* (Unpublished discussion paper prepared for the International HIV Testing Email Discussion Group, 2005).

Csete J 'In the shadow of death: HIV/AIDS and children's rights in Kenya' (2001) Vol 13(4A) *Human Rights Watch* 1-35.

Davis M *The Perfect storm: The closing space for LGBT civil society in Kyrgyzstan, Indonesia, Kenya, and Hungary,* ISSUELAB, (2016), available at: http://globalphilanthropyproject.org/2016/04/22/perfectstormreport/ (accessed on 7 September 2016).

East African Law Society 'Report of the regional consultative meeting on East Africa HIV law' Arusha, Tanzania, 3-4 December 2009 (on file with author).

East African Legislative Assembly 'Official report of the proceedings of the East African Legislative Assembly, fourth meeting – fifth session – second assembly, 19 April 2012, available at http://www.eala.org/uploads/19%20April%202012.pdf (accessed on 7 September 2016).

East African Legislative Assembly 'Official report of the proceedings of the East African Legislative Assembly, fourth meeting – fifth session – second assembly, 23 April 2012, available at http://www.eala.org/uploads/23%20April%202012.pdf (accessed on 7 September 2016).

Eastern Africa National Networks of AIDS Service Organisations 'Workshop report: Building partnerships towards rights-based HIV and AIDS legislation in East Africa' Report of the regional workshop held on 8 and 9 July 2011 at Whitesands Hotel, Dar-es-Salaam, Tanzania, EANNASO: Arusha, available at: http://www.eannaso.org/resources/eac-regional-integration-resources/19-report-on-building-partnership-towards-rights-based-hiv-and-aids-legislation-in-east-africa/file (accessed on 7 September 2016).

Eba P 'Capacity building workshop on human rights and gender in HIV legal frameworks, Dakar, Senegal, 16 – 18 April 2008: Final Report' (on file with author).

European Centre for Disease Prevention and Control *Technical report: Public health benefits of partner notification for sexually-transmitted infections and HIV,* ECDC, (2013) available at http://www.ecdc.europa.eu/en/publications/Publications/Partnernotification-for-HIV-STI-June-2013.pdf (accessed 10 February 2015).

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Response of the Czech Government to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to the Czech Republic from 1 to 10 April 2014*, (2015), available at: http://www.refworld.org/docid/561bd06a4.html (accessed 8 June 2016).

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Response of the Bulgarian Government to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to Bulgaria from 13 to 20 February 2015*, (2015), available at http://www.refworld.org/docid/5666f75f4.html (accessed 8 June 2016).

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *23rd General Report of the CPT: European Committee for*

the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1 August 2012 - 31 July 2013), 6 November 2013, CPT/Inf (2013) 29, available at *http://www.refworld.org/docid/528490ba4.html* (accessed 8 June 2016).

Fox K, Ferguson J, Ajose W, Singh J, Marum E and Baggaley R *Annex 15: Adolescent consent to HIV testing: A review of current policies and issues in sub-Saharan Africa. HIV and adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV,* Geneva: World Health Organisation (2013) available at *http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf?ua=1* (accessed on 8 August 2016).

Global Commission on HIV and the Law *HIV and the law: Risks, rights and health.* United Nations Development Programme, (2012) available at *http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/hiv-and-the-law--risks--rights---health.html* (accessed 7 September 2016).

Global Commission on HIV and the law *Regional issue brief: Laws and practices relating to criminalisation of people living with HIV and populations vulnerable to* HIV (2012) available at *http://www.hivlawcommission.org/index.php/regional-dialogues-main/high-income-countries/regional-issue-brief-laws-and-practices-relating-to-criminalisation-of-people-living-with-hiv-and-populations-vulnerable-to-hiv/download* (accessed on 10 August 2016).

Gouvernement de la République Démocratique du Congo *Rapport National UNGASS de la République Démocratique du Congo, janvier 2008 – décembre 2009*, (2010), available at *http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/democraticrepublicofthecongo_2010_country_progress_report_fr.pdf* (accessed 20 March 2016).

Grace D *This is not a law: the transnational politics and protest of legislating an epidemic* (Unpublished Doctoral Thesis, University of Victoria), available at: *https://dspace.library.uvic.ca//handle/1828/* (accessed on 6 September 2016).

Grant K and Meerkotter A *Protecting rights: Litigating cases of HIV testing and confidentiality of status*, The Southern Africa Litigation Centre (Litigation Manual Series) (2012), available at *http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2012/11/Litigating-Cases-of-HIV-Testing-and-Confidentiality-of-Status-Final.pdf* (accessed on 6 September 2016).

Hanssens C, Moodie-Mills AC, Ritchie AJ, Spade D and Vaid U *A roadmap for change: Federal policy recommendations for addressing the criminalization of LGBT people and people living with HIV* New York: Center for Gender and Sexuality Law, Columbia Law School (2014) available at *https://web.law.columbia.edu/sites/default/files/microsites/gender-sexuality/files/roadmap_for_change_full_report.pdf* (accessed on 10 August 2016).

Harm Reduction International *The global state of harm reduction 2014,* HRI, (2014), available at https://www.hri.global/files/2015/02/16/GSHR2014.pdf (accessed on 27 August 2016).

Health Policy Initiative *Tanzania adopts HIV law,* HIP August 2008, available at http://www.healthpolicyinitiative.com/Publications/Documents/589_1_TZ_HIV_Legislation_FINAL_8_26_08.pdf (accessed on 6 September 2016).

Heinrich Boll Stiftung 'Struggle for equality: Sexual orientation, gender identity and human rights in Africa' (2010) 4(10) *Perspectives; Political analysis and commentary from Africa* available at https://www.boell.de/sites/default/files/perspectives_africa_4-2010_struggle_for_equality_lgbti_africa.pdf (accessed on 27 August 2016).

Human Rights Watch 'Letting them fail: Government neglect and the right to education for children affected by AIDS' (2005) Vol 17(13A) *Human Rights Watch* 1-59.

Human Rights Watch and Amnesty International *Uganda: Anti-Homosexuality Act's heavy toll. Discriminatory law prompts arrests, attacks, evictions, flight* 14 may 2014 available at: https://www.hrw.org/news/2014/05/14/uganda-anti-homosexuality-acts-heavy-toll, (accessed on 28 August 2016).

International Labour Organisation *HIV and AIDS and labour rights: A handbook for judges and legal professionals* (2013) available at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_228498.pdf (accessed on 27 August 2016).

International Labour Organisation *National legislation and policies related to HIV/AIDS and the world of work,* ILO, (2016), available at: http://www.ilo.org/aids/legislation/lang--en/index.htm (accessed on 08 August 2016).

International Planned Parenthood Federation *Verdict on a virus: Public health, human rights and criminal law,* IPPF (2008), available at http://www.ippf.org/sites/default/files/verdict_on_a_virus.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *2013 Global Report. UNAIDS report on the Global AIDS Epidemic.* Geneva, Switzerland: UNAIDS (2013) available at http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *2015 Progress report on the global plan towards the elimination of new HIV infections among children and keeping their mothers alive,* Geneva, Switzerland: UNAIDS (2015) available at: http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf (accessed on 26 August 2016).

Joint United Nations Programme on HIV/AIDS *37th Meeting of the UNAIDS Programme Coordinating Board, Geneva*, Switzerland: UNAIDS (2015) available at

http://www.unaids.org/sites/default/files/media_asset/20151028_UNAIDS_PCB37_Decisions.pdf (accessed June 8, 2016).

Joint United Nations Programme on HIV/AIDS *AIDS by the number*s (2016) available at: http://www.unaids.org/sites/default/files/media_asset/AIDS-by-the-numbers-2016_en.pdf (accessed on 26 August 2016).

Joint United Nations Programme on HIV/AIDS *An ambitious treatment target to help end the AIDS epidemic,* Geneva, Switzerland: UNAIDS (2014) available at: http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS and International HIV/AIDS Alliance *Making it work: Lessons learnt from three regional workshops to integrate human rights into national HIV strategic plans* (2012), available at: http://www.hst.org.za/sites/default/files/making-it-work.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS and Inter-Parliamentary Union *Handbook for legislators on HIV/AIDS, law and human rights. Action to combat HIV/AIDS in view of its devastating human, economic and social impact*, Geneva, Switzerland: UNAIDS and IPU (1999) UNAIDS/99.48E, available at: http://www.refworld.org/docid/46cc49632.html (accessed on 6 September 2016).

Joint United Nations Programme on HIV/AIDS and United Nations Development Programme *Criminalisation of HIV transmission: Policy brief* (2008) available at: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/dataimport/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *Criminal law, public health and HIV transmission: A policy options paper,* Geneva, Switzerland: UNAIDS (2002) available at http://data.unaids.org/publications/IRC-pub02/jc733-criminallaw_en.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations*, Geneva, Switzerland: UNAIDS, (2013) available at: http://www.unaids.org/sites/default/files/media_asset/20130530_Guidance_Ending_Criminalisation_0.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *Fact sheet, World AIDS Day 2014*, (2014) available at http://www.unaids.org/sites/default/files/documents/WAD2014c_FactSheet_en.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *Fast-Track: Ending the AIDS epidemic by 2030,* Geneva, Switzerland: UNAIDS (2014) available at http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf (accessed 8 February 2015).

Joint United Nations Programme on HIV/AIDS *From principle to practice: Greater involvement of people living with or affected by HIV/AIDS,* Geneva, Switzerland: UNAIDS (1999) available at http://data.unaids.org/Publications/IRC-pub01/JC252-GIPA-i_en.pdf (accessed on 6 September 2016).

Joint United Nations Programme on HIV/AIDS *Guidance note: Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses* (2012) Geneva, Switzerland: UNAIDS, (2012) available at http://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Programmes_en_May2012_0.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *How AIDS changed everything. MDG 6: 15 years, 15 lessons of hope from the AIDS response,* Geneva, Switzerland: UNAIDS (2015) available at http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf (accessed on 26 August 2016).

Joint United Nations Programme on HIV/AIDS *Making the law work for the HIV response: A snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support,* Geneva, Switzerland: UNAIDS, (2010), available at http://files.unaids.org/en/media/unaids/contentassets/documents/priorities/20100728_HR_Poster_en.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *On the Fast-Track to end AIDS by 2030: Focus on locations and populations,* Geneva, Switzerland: UNAIDS (2015) available at http://www.unaids.org/sites/default/files/media_asset/WAD2015_report_en_part01.pdf (accessed on 26 August 2016).

Joint United Nations Programme on HIV/AIDS *Policy brief: greater involvement of people living with HIV,* Geneva, Switzerland: UNAIDS (2007) available at: http://www.unaids.org/sites/default/files/media_asset/jc1299-policybrief-gipa_en_0.pdf (accessed on 6 September 2016).

Joint United Nations Programme on HIV/AIDS *Prevention gap report,* Geneva, Switzerland: UNAIDS (2016) available at http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf (accessed on 26 August 2016).

Joint United Nations Programme on HIV/AIDS Reference Group on HIV and Human Rights *Issue paper: Model legislation on HIV, 8th meeting, 3-5* (December 2007), available at http://www.hivhumanrights.org.vs2.korax.net/commitment

tohumanrights/wp-content/uploads/downloads/2012/03/5-Law-RGHR8.pdf (accessed on 6 September 2016).

Joint United Nations Programme on HIV/AIDS *Report of the International Task Team on HIV-related Travel Restrictions: findings and recommendations,* Geneva, Switzerland: UNAIDS (2008) available at http://www.unaids.org/sites/default/files/media_asset/jc1715_report_inter_task_team_hiv_en_0.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *Sustaining the human rights response to HIV: An analysis of the funding landscape and voices from community service providers*, Geneva, Switzerland: UNAIDS (2015) available at: http://www.unaids.org/sites/default/files/media_asset/JC2769_humanrights_en.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *The gap report*. Geneva, Switzerland: UNAIDS (2014) available at http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *Treatment 2015,* Geneva, Switzerland: UNAIDS (2013) available at http://www.unaids.org/sites/default/files/sub_landing/files/JC2484_treatment-2015_en.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *UBRAF thematic report: Ending punitive laws* (2015) available at https://results.unaids.org/sites/default/files/documents/C1_Ending_punitive_laws_Jun2015.pdf (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS *UNAIDS recommendations for alternative language to some problematic articles in the N'Djamena legislation on HIV* (2004) Geneva, Switzerland: UNAIDS, (2008), available at: http://data.unaids.org/pub/Manual/2008/20080912_alternativelanguage_ndajema_legislation_en.pdf (accessed on 6 September 2016).

Joint United Nations Programme on HIV/AIDS *UNAIDS Strategy 2016-2021: On the fast track to end AIDS,* Geneva, Switzerland: UNAIDS, (2015) available at: http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf (accessed on 6 September 2016).

Joint United Nations Programme on HIV/AIDS *UNAIDS terminology guidelines,* Geneva, Switzerland: UNAIDS (2015), available at http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf (accessed on 5 March 2017).

Joint United Nations Programme on HIV/AIDS, World Health Organisation and United Nations Population Fund *Position statement on condoms and HIV prevention* (2004) available at http://www.unfpa.org/upload/lib_pub_file/343_filename_Condom_statement.pdf (accessed on 6 September 2016).

Jürgens R *Taking action against HIV and AIDS: Handbook for parliamentarians* UN Joint Programme on HIV/AIDS, Inter-Parliamentary Union and United Nations Development Programme (2007) available at http://data.unaids.org/pub/Manual/2007/20071128_ipu_handbook_en.pdf (accessed on 6 September 2016).

Jürgens, R *Increasing access to HIV testing and counselling while respecting human rights – Background paper*, New York: Public Health Program of the Open Society Institute, (2007) available at http://www.unaids.org.cn/pics/20120821114907.pdf (accessed on 6 September 2016).

Kageni A, Mwangi L, Mugyenyi C and Macintyre K *Representation and participation of key populations on Country Coordinating Mechanisms (CCMs) in six countries in Southern Africa: final report* Aidspan: Independent Global Fund Observer (2015) available at http://www.aidspan.org/publication/representation-and-participation-key-populations-country-coordinating-mechanisms-ccms (accessed on 26 August 2016).

Kenya AIDS NGOs Consortium (KANCO) and Kenya Legal and Ethical Issues Network on HIV (KELIN) *Study on human rights violations against people living with HIV and AIDS in Kenya* Nairobi: KANCO (2012) available at http://kelinkenya.org/wp-content/uploads/2010/10/Human-Violation-book-final.pdf (accessed on 10 August 2016).

Kenya Legal and Ethical Issues Network on HIV and AIDS *Punitive laws and practices affecting HIV responses in Kenya* Nairobi: KELIN (2014) available at: http://kelinkenya.org/wp-content/uploads/2010/10/punitive-laws-practices-affecting-HIV-responses-in-Kenya.pdf (accessed on 7 September 2016).

Kenya National Commission on Human Rights *Realising sexual and reproductive health rights in Kenya: A myth or reality? A Report of the public inquiry into violations of sexual and reproductive health rights in Kenya,* Nairobi: KNCHR (2012) available at http://www.knchr.org/portals/0/reports/reproductive_health_report.pdf (accessed on 10 August 2016).

Kenyan National AIDS Control Council (NACC), *Kenya AIDS response progress report 2014: Progress towards zero* Nairobi: NACC (2014) available at http://www.unaids.org/sites/default/files/country/documents/KEN_narrative_report_2014.pdf (accessed on 10 August 2016).

Kenyan Office of the Attorney General and National AIDS Control Council *Report of the Task Force on Legal Issues Relating to HIV and AIDS: Summarised version* Nairobi: Office of the Attorney General and National AIDS Control Council (2002).

Liberia Network of People Living with HIV *Liberia PLHIV stigma index report. Monrovia: Liberia National AIDS Commission, 2013* available at

http://www.stigmaindex.org/sites/default/files/reports/Liberia%20%20People%20Living%20with%20HIV%20Stigma%20Index%20Final%20Report%202013.pdf (accessed on 10 August 2016).

Maruschak M 'HIV in prisons, 2001–2010' (2015) Washington, DC: US Department of Justice, Bureau of Justice Statistics available at http://www.bjs.gov/content/pub/pdf/hivp10.pdf (accessed on 10 August 2016).

Mbote PK and M Akech *Kenya Justice sector and rule of law: A review by AfriMAP and the Open Society Initiative for Eastern Africa* Nairobi: The Open Society Initiative for Eastern Africa (2011) available at https://www.opensocietyfoundations.org/sites/default/files/kenya-justice-law-20110315.pdf (accessed on 10 August 2016).

Médecins Sans Frontières *Out of focus: How millions of people in West and Central Africa are being left out of the global AIDS response* (2016) available at http://www.msf.org/sites/msf.org/files/2016_04_hiv_report_eng.pdf (accessed on 26 August 2016).

Meerkotter, A *Equal rights for all: Litigating cases of HIV-related discrimination,* The Southern Africa Litigation Centre (SALC Litigation Manual Series), (2011), available at http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2012/10/HIV-and-Discrimination-Manual-pdf.pdf (accessed on 10 August 2016).

Møller L, Gatherer A, Jürgens R, Stöver H and Nikogosian H (eds) 'Health in prisons: a WHO guide to the essentials in prison health' Copenhagen: World Health Organisation (2007) available at http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf (accessed on 10 August 2016).

Muntingh L 'Reducing Prison Violence: Implications from the literature in South Africa' (2009) Report No. 17 *Civil Society Prison Reform Initiative Research* 1 – 39, available at http://cspri.org.za/publications/research-reports/Reducing%20_Prison%20Violence.pdf (accessed on 10 August 2016).

National AIDS Trust *HIV partner notification: A missed opportunity?* NAT (2012) available at http://www.nat.org.uk/media/files/policy/2012/may-2012-hiv-partner-notification.pdf (accessed on 10 August 2016).

National Council of people living with HIV *The people living with HIV stigma index report: Tanzania Country Assessment,* Dar es Salaam: NACOPHA, (2013) available at http://www.stigmaindex.org/sites/default/files/reports/Tanzania%20STIGMA%20INDEX%20REPORT%20-%20Final%20Report%20pdf.pdf (accessed on 10 August 2016).

National Network of Persons Living with HIV in Ghana *Persons living with HIV Stigma Index Study Ghana* (2014) xii, available at: http://www.stigmaindex.org/sites/default/files/reports/GHANA%20Stigma%20Index%20report%202014.pdf (accessed 27 August 2016).

Niang T 'Compte rendu de la réunion consultative d'experts sur le cadre légal du VIH tenant compte des droits humains et du genre' Hotel N'Gor Diarama, Dakar, 24-25 juillet 2007 (on file with author).

Open Society Justice Initiative *The Presumption of guilt: The Global overuse of pretrial detention,* New York: Open Society Foundations, (2014), available at: *https://www.opensocietyfoundations.org/sites/default/files/presumption-guilt-09032014.pdf* (accessed 27 August 2016).

Penal Reform International *Global prison trends 2015*: *Report,* London: Penal Reform International, (2015), available at *https://www.penalreform.org/resource/global-prison-trends-2015/* (accessed 27 August 2016).

Réseau National des Associations des Positifs du Congo *Index de stigmatisation et de discrimination envers les personnes vivant avec le VIH au Congo : rapport d'enquête* (2015) avalable at *http://www.stigmaindex.org/sites/default/files/reports/Rapport%20final-%20Index%20de%20Stigma%20au%20Congo.pdf* (accessed on 26 August 2016).

Schafer R and Range E *The Political use of homophobia: Human rights and persecution of LGBTI activists in Africa* Frierich-Ebert-Stiftung, Africa Department, (2014) available at *http://library.fes.de/pdf-files/iez/10610.pdf* (accessed on 26 August 2016).

Shields A *Criminalizing Condoms: How policing practices put sex workers and HIV services at risk in Kenya, Namibia, Russia, South Africa, the United States, and Zimbabwe* Open Society Foundations (2012) available at *https://www.opensocietyfoundations.org/sites/default/files/criminalizing-condoms-20120717.pdf* (accessed on 10 August 2016).

Stevens D 'Out of the shadows: greater involvement of people living with HIV / AIDS (GIPA) in policy' Policy Working Paper Series No. 14, *Future Group, Policy Project* (2004) available at *http://www.policyproject.com/pubs/workingpapers/WPS14.pdf* (accessed 27 August 2016).

Stone K (ed) *The Global State of Harm Reduction* London: Harm Reduction International (2014) available at *https://www.hri.global/files/2015/02/16/GSHR2014.pdf* (accessed 27 August 2016).

The Global Network of People Living with HIV/AIDS, EngenderHealth, International Community of Women Living with HIV, Young Positives, International Planned Parenthood Federation and Joint United Nations Programme on HIV/AIDS *Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV: A Guidance Package* (2009) available at *https://www.unfpa.org/sites/default/files/resource-pdf/guidance_package.pdf* (accessed 27 August 2016).

The Pew Charitable Trust *Collateral costs: Incarceration's effect on economic mobility* Washington, DC: The Pew Charitable Trusts (2010) available at

http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2010/collateralcosts1pdf.pdf (accessed on 10 August 2016).

Thoreson R and Cook S (eds) *Nowhere to turn: Blackmail and extortion of LGBT people in sub-Saharan Africa* International Gay and Lesbian Human Rights Commission (2011).

United Nations Children's Fund *Towards an AIDS-Free Generation. Children and AIDS: Sixth Stocktaking Report 2013,* UNICEF: New York (2013) available at http://www.unaids.org/sites/default/files/media_asset/20131129_stocktaking_report_children_aids_en_0.pdf (accessed on 26 August 2016).

United Nations Committee on the Rights of the Child (CRC), *Concluding observations on the combined third to fifth periodic reports of Mauritius*, 27 February 2015, CRC/C/MUS/CO/3-5, available at http://www.refworld.org/docid/566e7d9f4.html (accessed on 10 August 2016).

United Nations Committee on the Rights of the Child (CRC), *Concluding observations on the fourth periodic report of Eritrea*, 2 July 2015, CRC/C/ERI/CO/4, available at http://www.refworld.org/docid/566fbf7a4.html (accessed on 10 August 2016).

United Nations Committee on the Rights of the Child *Concluding Observations of the Committee on the Rights of the Child, Benin,* U.N. Doc. CRC/C/BEN/CO/2 (2006) available at http://hrlibrary.umn.edu/crc/benin2006.html (accessed on 10 August 2016).

United Nations Committee on the Rights of the Child *Concluding observations of the Committee on the Rights of the Child, Tunisia*, U.N. Doc. CRC/C/TUN/CO/3 (2010) available at http://hrlibrary.umn.edu/crc/tunisia2010.html (accessed on 10 August 2016).

United Nations Committee on the Rights of the Child *Concluding observations of the Committee on the Rights of the Child, Niger,* CRC/C/NER/CO/2 (2009) available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC/C/NER/CO/2&Lang=En (accessed on 10 August 2016).

United Nations Committee on the Rights of the Child *Concluding Observations of the Committee on the Rights of the Child, Guinea-Bissau*, U.N. Doc. CRC/C/GNB/CO/2-4 (2013) available at http://hrlibrary.umn.edu /crc/guinea bissau2013.html (accessed on 10 August 2016).

United Nations Committee on the Rights of the Child *Concluding Observations of the Committee on the Rights of the Child, Côte d'Ivoire*, U.N. Doc. CRC/C/15/Add.155 (2001) available at http://hrlibrary.umn.edu/crc/ cotedivoire2001.html (accessed 10 August 2016).

United Nations Committee on the Rights of the Child *Concluding Observations of the Committee on the Rights of the Child, Congo*, U.N. Doc. CRC/C/COG/CO/2-4 (2014)

available at http://hrlibrary.umn.edu/crc/congo2014.html (accessed on 10 August 2016).

United Nations Development Programme *Compendium of judgments: HIV, human rights and the law for the judicial dialogue on HIV, human rights and the law in Eastern and Southern Africa, Nairobi, Kenya, 28–31 October 2013* UNDP: New York (2013) available at http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/compendium-of-judgment-for-judicial-dialogue-on-hiv--human-right.html (accessed on 3 September 2016).

United Nations Development Programme *Legal protections against HIV-related human rights violations: Experiences and lessons learned from national HIV laws in Asia and the Pacific*. Bangkok: UNDP available at: http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/legal-protections-against-hiv-related-human-rights-violations.html (accessed on 3 September 2016).

United Nations Development Programme *Practical Manual: Legal environment assessment: An operational guide to conducting national legal, regulatory and policy assessments for HIV,* UNDP (2014) available at: http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/practical-manual--legal-environment-assessment-for-hiv--an-opera.html# (accessed on 26 August 2016).

United Nations High Commissioner for Refugees, World Health Organisation and Joint United Nations Programme on HIV/AIDS *Policy statement on HIV testing and counselling in health facilities for refugees, internally displaced persons and other persons of concern to UNHCR* (2009) available at http://www.unhcr.org/4b508b9c9.pdf (accessed on 26 August 2016).

United Nations Human Rights Committee *Concluding observations on the initial report of Côte d'Ivoire* CCPR/C/CIV/CO/1 (2015) available at http://ccprcentre.org/doc/2015/04/CCPRCCIVCO1.pdf (accessed on 10 August 2016).

United Nations Human Rights Council *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Paul Hunt: annex: mission to GlaxoSmithKline, 18 May 2009, A/HRC/11/12/Add.2 available at http://www.refworld.org/docid/4a1d0af22.html (accessed on 26 August 2016).

United Nations Human Rights Council *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, 1 February 2013, A/HRC/22/53, available at http://www.refworld.org/docid/51136ae62.html (accessed on 26 August 2016).

United Nations Office of Drugs and Crime and World Health Organisation Europe *Women's health in prisons: correcting gender inequity in prison health* (2009) Copenhagen: World Health Organisation available at http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf?ua=1 (accessed on 10 August 2016).

United Nations Office of Drugs and Crime, Joint United Nations Programme on HIV/AIDS and World Health Organisation *Policy brief: HIV testing and counselling in prisons and other closed settings* (2009) https://www.unodc.org/documents/hiv-aids/UNODC_WHO_UNAIDS_2009_Policy_brief_HIV_TC_in_prisons_ebook_ENG.pdf (accessed on 10 August 2016).

United Nations Office on Drugs and Crime *Handbook on strategies to reduce overcrowding in prisons: Criminal Justice Handbook Series* New York: United Nations (2013) available at https://www.unodc.org/documents/justice-and-prison-reform/Overcrowding_in_prisons_Ebook.pdf (accessed on 10 August 2016).

United Nations Office on Drugs and Crime, *Good governance for prison health in the 21st century: A policy brief on the organization of prison health*, UNODC, 2013 available at http://www.refworld.org/docid/5375e708a.html (accessed 9 August 2016).

Viljoen F and Eba P *A human rights assessment of the Draft Bill on Defending Human Rights and the Fight Against the Stigmatisation and Discrimination of People Living with HIV and AIDS of Mozambique* (2008) available at: http://www.chr.up.ac.za/chr_old/centre_projects/ahrru/docs/Comments%20Mozambique%20Draft%20HIV%20Bill.pdf (accessed on 6 September 2016). ¨

World Health Organisation and Joint United Nations Programme on HIV/AIDS *Guidance on provider-initiated HIV testing and counselling in health facilities,* Geneva: WHO (2007) available at: http://www.who.int/hiv/pub/guidelines/9789241595568_en.pdf (accessed on 10 August 2016).

World Health Organisation and Joint United Nations Programme on HIV/AIDS *Treating 3 million by 2005: Making it happen. The WHO and UNAIDS global initiative to provide antiretroviral therapy to 3 million people with HIV/AIDS in developing countries by the end of 2005,* WHO and UNAIDS (2003) available at: http://www.who.int/3by5/publications/documents/en/3by5StrategyMakingItHappen.pdf?ua=1 (accessed on 27 August 2016).

World Health Organisation and United Nations Centre for Human Rights *Report of an International Consultation on AIDS and Human Rights, Geneva, 26-28 July 1989* New York: United Nations (1991).

World Health Organisation *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*, Geneva: WHO (2014) available at: http://apps.who.int/iris/bitstream/10665/128049/1/WHO_HIV_2014.8_eng.pdf (accessed on 10 August 2016).

World Health Organisation *Ebola response roadmap*, Geneva: WHO (2014) available at *http://apps.who.int/iris/bitstream/10665/131596/1/EbolaResponseRoadmap.pdf* (accessed on 10 August 2016).

World Health Organisation *Global tuberculosis report 2015,* Geneva: WHO (2015) available at *http://apps.who.int/iris/bitstream/10665/191102/1/ 9789241565059_eng.pdf* (accessed on 26 August 2016).

World Health Organisation *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 (2013) available at *http://apps.who.int/iris/bitstream/10665/ 94334/1/9789241506168_eng.pdf* (accessed on 10 August 2016).

World Health Organisation *WHO: Ebola response roadmap situation report*, Geneva: WHO (2014) available at *http://www.who.int/csr/disease/ebola/evd-sitrep1-20140828.pdf* (accessed on 10 August 2016).

World Health Organisation, United Nations Office on Drugs and Crime and Joint United Nations Programme on HIV/AIDS *Interventions to address HIV in prisons: prevention of sexual transmission* Geneva: WHO (2007) available at *https://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20sexual_transmission.pdf* (accessed 10 August 2016).

2.5 Newspaper articles and press releases

‘Africa: “Terrifying” new HIV/AIDS laws could undermine AIDS fight’ *IRIN News Online*, 7 August 2008 available at *http://www.irinnews.org/report/79680/africa-terrifyingnew-hiv-aids-laws-could-undermine-aids-fight* (accessed 8 November 2014).

‘Fear and ignorance aid spread of Ebola’ *Irinnews* 11 June 2014 available at *http://www.irinnews.org/report/100195/fear-and-ignorance-aid-spread-of-ebola* (accessed Sept 16, 2014).

‘Kenyans await delayed HIV/ AIDS Tribunal’ *Kenya News Desk,* 24 August 2010, available at *https://globalpressjournal.com/africa/kenya/kenyans-await-delayed-hiv-aids-tribunal/* (accessed on 6 September 2016).

‘La faible application de la loi VIH frappe plus durement les femmes’ *Irinnews 19 August 2009, available at https://www.irinnews.org/fr/report/85808/niger-la-faible-application-de-la-loi-vih-frappe-plus-durement-les-femmes* (accessed on 7 September 2016).

‘Nigeria anti-gay laws: Fears over new legislation’ *BBC News* 14 January 2014, available at: http://www.bbc.com/news/world-africa-25728845, (accessed on 27 August 2016).

‘One region, one HIV law’ *Irinnews* 31 March 2010, available at: http://www.irinnews.org/report/88635/east-africa-one-region-one-hiv-law (accessed on 7 September 2016).

‘West Africa: HIV law “a double-edged sword”’ *Irinnews* 1 December 2008 available at http://www.irinnews.org/report/81758/west-africa-hiv-law-a-double-edged-sword (accessed 8 November 2014).

“I’ve lived a full life despite being HIV positive, says PhD candidate Joe Muriuki” *INB Africa News*, 9 November 2014, available at http://www.standardmedia.co.ke/health/article/2000140872/i-ve-lived-a-full-life-despite-being-hiv-positive-joe-muriuki (accessed on 7 September 2016).

African Union *African* ‘Union’s Executive Council urges lifting of travel restrictions related to Ebola outbreak’, AU: Press release nº 211/2014. (2014), available at: http://pages.au.int/sites/default/files/Press%20Release%20-En_0.pdf (accessed on 12 September 2014).

Altman LK ‘Rare cancer seen in 41 homosexuals’ *The New York Times* 3 July 1981 available at http://www.nytimes.com/1981/07/03/us/rare-cancer-seen-in-41-homosexuals.html (accessed on 27 August 2016).

Associated Press, Reuters ‘MSF: Sierra Leone lockdown will not stem Ebola spread’ *Deutsche Welle* 7 September 2014 available at: http://www.dw.de/msf-sierra-leone-lockdown-will-not-stem-ebola-spread/a-17906558 (accessed 12 September 2014).

Butty J ‘Liberia’s West Point: life after Ebola quarantine’ *Voice of America* 1 September 2014 available at http://www.voanews.com/content/liberias-west-point-ebola-quarantine-lifted/2434374.html (accessed 12 September 2014).

East African Legislative Assembly ‘EALA passes regional Bill on HIV and AIDS’ EALA Press Releases 23 April 2012 available at: http://www.eala.org/new/index.php/media-centre/press-releases/343-eala-passes-regional-bill-on-hiv-and-aids- (accessed on 7 September 2016).

Global Forum for Men who have Sex with Men & HIV ‘A High-Level Failure for the United Nations on Key Populations’ *MSMGF* 8 June 2010, available at: http://msmgf.org/gay_men_transgender_people_and_sex_workers_express_outrage msmgf-expresses-outrage-unacceptably-weak-political-declaration-adopted-today-

united-nations-high-level-meeting-ending-aids/#ixzz4IdO267wc (accessed on 27 August 2016).

Hildebrandt A 'Ebola outbreak: why Liberia's quarantine in West Point slum will fail' *CBC News* 25 August 2014, available at: *http://www.cbc.ca/news/world/ ebola-outbreak-why-liberia-s-quarantine-in-west-point-slum-will-fail-1.2744292* (accessed 12 September 2014).

Human Rights Watch 'West Africa: respect rights in Ebola response' 15 September 2014 available at *http://www.hrw.org/news/2014/09/15/west-africa-respect-rights-ebola-response* (accessed 12 September 2014).

Human rights Watch *et al* 'Capacity building workshop on human rights and gender in HIV legal framework: Open civil society letter to the participants', 14 April 2008, available at *https://www.hrw.org/news/2008/04/14/capacity-building-workshop-human-rights-and-gender-hiv-legal-framework* (accessed on 6 September 2016).

International Community of Women Living with HIV 'The East African Partner States Assent to the East Africa HIV and AIDS Prevention and Management Bill, 2012' *ICW Weekly Bulletin* 27 October 2015 available at: *http://www.iamicw.org/CampaignProcess.aspx?A=View&Data=UmSlGuoOqWuJHK8E06yawQ%3d%3d* (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS 'Human rights and gender in HIV-related legal frameworks' 28 April 2008 available at: *http://www.unaids.org/en/Resources/PressCentre/Featurestories/2008/April/20080428HumanrightsandgenderinHIVrelatedle/* (accessed on 27 August 2016).

Joint United Nations Programme on HIV/AIDS 'Leaders from around the world are All In to end the AIDS epidemic among adolescents' (2015) available at: *http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/february/20150217_PR_all-in* (accessed on 10 August 2016).

Joint United Nations Programme on HIV/AIDS 'UNAIDS expresses concern over proposed 'Anti-Homosexuality Bill' in Uganda' Geneva, Switzerland: UNAIDS, 10 May 2011, available at: *http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011/may/20110510psuganda* (accessed on 28 August 2016).

Joint United Nations Programme on HIV/AIDS 'UNAIDS expresses serious concern over ruling in Malawi' 20 May 2010 available at *http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2010/may/20100520psmalawi* (accessed on 28 August 2016).

Karambu I 'Tribunal expected to herald new dawn for people living with Aids' *Business Daily,* 29 June 2011, available at http://www.businessdailyafrica.com/-/539444/1190786/-/121e3s1z/-/.56 (accessed 12 September 2014).

Karimi F and Thompson N 'Uganda's President Museveni signs controversial anti-gay bill into law' *CNN* 25 February 2014, available at http://edition.cnn.com/2014/02/24/world/africa/uganda-anti-gay-bill/ (accessed on 27 August 2016).

Mapondera G and Smith D 'Human rights campaigners attack Malawi gay couple conviction' *The Guardian* 18 May 2010 available at https://www.theguardian.com/world/2010/may/18/malawi-gay-couple-jailed (accessed on 27 August 2016).

McNeil Jr DG 'Using a tactic unseen in a century, countries cordon off Ebola-racked areas' *The New York Times* 12 August 2014 available at http://www.nytimes.com/2014/08/13/science/using-a-tactic-unseen-in-a-century-countries-cordon-off-ebola-racked-areas.html?_r=0 (accessed 12 September 2014).

Muraya J 'Tribunal to hear HIV/AIDS cases sworn in' *AllAfrica* 11 April 2013 available at http://www.capitalfm.co.ke/news/2013/04/tribunal-to-hear-hivaids-cases-sworn-in/ (accessed 12 September 2014).

Nalugo M 'Rights bodies protest HIV/AIDS Bill' *Daily Monitor* 15 May 2014, available at http://www.monitor.co.ug/News/National/Rights-bodies-protest-HIV-Aids-Bill/688334-2314774-92xccfz/index.html (accessed on 6 September 2016).

Ninsiima, R 'Uganda: HIV law – After assent, Museveni under fire' *The Observer* 22 August 2014 available at http://allafrica.com/stories/201408220430.html (accessed on 6 September 2016).

Njagi D 'HIV-positive Kenyans need tribunal to address rights violations' *Inter Press Service*, 3 August 2010, available *at* http://www.ipsnews.net/2010/08/hiv-positive-kenyans-needtribunal-to-address-rights-violations/ (accessed on 6 September 2016).

Nossiter A 'At heart of Ebola outbreak, a village frozen by fear and death' *The New York Times*, 11 August 2014, available at: http://www.nytimes.com/2014/08/12/world/africa/at-heart-of-ebola-outbreak-a-village-frozen-by-fear-and-death.html (accessed on 6 September 2016).

Nossiter A 'Ebola reaches capital of Guinea, stirring fears' *The New York Times*, 1 April 2014, available at http://www.nytimes.com/2014/04/02/world/africa/ebola-reaches-guinean-capital-stirring-fears.html (accessed on 6 September 2016).

Nossiter A 'Sierra Leone to impose 3-day Ebola quarantine' *The New York Times* 6 September 2014 available at *http://www.nytimes.com/2014/09/07/world/africa/sierra-leone-to-impose-widespread-ebola-quarantine.html* (accessed on 6 September 2016).

Office of the High Commissioner for Human Rights 'Council establishes mandate on protection against violence and discrimination based on sexual orientation and gender identity' 30 June 2016 available at *http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20220* (accessed on 27 August 2016).

Paulat L 'HIV Prevention Act angers Ugandan AIDS activists' *VoA News* 27 August 2014 available at *http://www.voanews.com/a/hiv-prevention-act-aids-activists/2429821.html* (accessed on 6 September 2016).

Reuters 'Guinean security forces break up riot in Ebola-racked south' *Reuters*, 29 August 2014, available at *http://www.reuters.com/article/2014/08/29/us-health-ebola-guinea-idUSKBN0GT0ZM20140829* (accessed on 6 September 2016).

Roy-Macauley C 'Sierra Leone makes hiding Ebola patients illegal' *Associated Press*, 23 August 2014, available at *http://www.aol.com/article/2014/08/23/sierra-leone-makes-hiding-ebola-patients-illegal/20951542/* (accessed on 6 September 2016).

Wambi M 'East Africa: Move towards common HIV/AIDS law' *Inter Press Service* (IPS) 4 December 2009, available at *http://www.ipsnews.net/2009/12/east-africa-move-towards-common-hiv-aids-law/* (accessed on 7 September 2016).

World Health Organisation and Joint United Nations Programme on HIV/AIDS 'Statement on HIV testing and counselling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing' WHO and UNAIDS (2012) available at *http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/* (accessed on 10 August 2016).

2.6 Internet resources

'AIDSPortal' *http://www.aidsportal.org/web/guest/home* accessed 7 September 2016.

'East African Community HIV and AIDS Prevention and Management Bill' March 2010 *http://kelinkenya.org/wp-content/uploads/2010/10/PROPOSED-DRAFT-4-OF-THE-EAST-AFRICAN-COMMUNITY-HIV-AND-AIDS-PREVENTION-AND-MANAGEMENT-BILL-2010-.pdf* (accessed on 7 September 2016).

‘Southern African Legal Information Institute’ *http://www.saflii.org/* accessed 7 September 2016.

East African Community ‘Overview of EAC’ available at: *http://www.eac.int/about/overview* (accessed on 6 September 2016).

International Labour Organisation ‘HIV legislation and policies’ *http://www.ilo.org/aids/legislation/lang--en/index.htm* accessed 7 September 2016.

The South African Law Reform Commission Reports available at *http://www.justice.gov.za/salrc/dpapers.htm* (accessed on 28 August 2016).

United Nations Educational, Scientific and Cultural Organisation ‘HIV and health education clearinghouse’ *http://hivhealthclearinghouse.unesco.org* (accessed on 7 September 2016).

Annexes

Annex 1: HIV-specific laws in sub-Saharan Africa (as of August 2014, with amendments where applicable)

Country	Title of HIV-specific law
1. Angola	• Lei No 8/04 sobre o Virus da Immunodeficiência Humana (VIH) e a Sindroma de Immunodeficiência Adquirida (SIDA), 2004
2. Benin	• Loi No 2005-31 du 5 Avril 2006 portant prévention, prise en charge et contrôle du VIH/SIDA, 2006
3. Burkina Faso	• Loi No 030-2008/AN portant lutte contre le VIH/SIDA et protection des droits des personnes vivant avec le VIH/SIDA, 2008
4. Burundi	• Loi No 1/018 du 12 Mai 2005 portant protection juridique des personnes infectées par le Virus de l'Immunodéficience Humaine et des personnes atteintes du Syndrome Immunodéficience Acquise, 2005
5. Cape Verde	• Lei No 19/VII/2007, 2007
6. Central African Republic	• Loi 06.030 de 2006 fixant les droits et obligations des personnes vivant avec le VIH/SIDA, 2006
7. Chad	• Loi No 19/PR/2007 du 15 Novembre 2007 portant lutte contre VIH/SIDA/IST et protection des droits des personnes vivant avec le VIH/SIDA, 2007
8. Comoros	• Loi N° 14-011/AU du 21 avril 2014, relative aux droits des personnes vivant avec le VIH et leur implication dans la réponse nationale, 2014
9. Congo	• Loi No 30 - 2011 du 3 juin 2011 portant lutte contre le VIH et le SIDA et protection des droits des personnes vivant avec le VIH, 2011

10. Côte d'Ivoire	• Loi n° 2014-430 du 14 juillet 2014 portant régime de prévention, de protection et de répression en matière de lutte contre le VIH et le SIDA, 2014
11. Democratic Republic of Congo	• Loi No 08/011 du 14 Juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées, 2008
12. Equatorial Guinea	• Ley No 3/2005 sobre la prevención y la lucha contra las infecciones de transmisión sexual (ITS), el VIH/SIDA y la defensa de los derechos de las personas afectadas, 2005
13. Guinea	• Ordonnance No 056/2009/PRG/SGG portant amendement de la loi L/2005/025/AN du 22 Novembre 2005 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA en République de Guinée, 2009 • Loi L/2005/025/AN du 22 Novembre 2005 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA en République de Guinée, 2005
14. Guinea Bissau	• Loi n° 5/2007 du 10 septembre 2007 de la prévention, du traitement et du contrôle du VIH/sida, 2007
15. Kenya	• HIV and AIDS Prevention and Control Act, No 14 of 2006
16. Liberia	• An Act to Amend the Public Health Law, Title 33, Liberian Code of Laws Revised (1976) to Create New Chapter 18 Providing for the Control of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), 2010
17. Madagascar	• Loi No 2005-040 du 20 Février 2006 sur la lutte contre le VIH/SIDA et la protection des droits des personnes vivant avec le VIH/SIDA), 2006
18. Mali	• Loi No 6-028 du 29 Juin 2006 fixant les règles relatives à la prévention, à la prise en charge et au contrôle du VIH/SIDA, 2006
19. Mauritania	• Loi No 2007-042 relative à la prévention, la prise en charge et le contrôle du VIH/SIDA, 2007

20. Mauritius	• HIV and AIDS Act, No 31 of 2006
21. Mozambique	• Lei No 19/2014 Lei de Protecçao da Pessao, do trabalhador e do Candidato e Emprego Vivendo com VIH e SIDA, 2014 • Lei n°12/2009, estabelece os direitos e deveres da pessoa vivendo com HIV e SIDA, e adopta medidas necessárias para a prevenção, protecção e tratamento da mesma, 2009
22. Niger	• Loi No 2007-08 du 30 Avril 2007 relative à la prévention, la prise en charge et le contrôle du Virus de d'Immunodéficience Humaine (HIV), 2007
23. Senegal	• Loi n° 2010-03 du 9 avril 2010 relative au VIH/SIDA, 2010
24. Sierra Leone	• The National HIV and AIDS Commission Act of 2011 • The Prevention and Control of HIV and AIDS Act of 2007
25. Tanzania	• HIV and AIDS (Prevention and Control) Act, No 28 of 2008
26. Togo	• Loi No 2010-018 du 31 Décembre 2010 modifiant la loi No 2005 – 012 du 14 Décembre 2005 portant protection des personnes en matière de VIH/SIDA, 2010 • Loi No 2005-012 portant protection des personnes en matière de VIH/SIDA
27. Uganda	• HIV Prevention and Control Act of 2014

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Annex 2: Ethical approval for the study

07 August 2014

Mr Patrick Michael Eba (214584943)
School of Law
Pietermaritzburg Campus

Protocol reference number: HSS/0472/014D
Project title: The HIV Tribunal of Kenya: A viable mechanism for enforcing HIV-related legislation?

Dear Mr Eba,

Full Approval – Expedited Application

In response to your application dated 13 April 2014, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....

Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Dr Ann Strode
Cc Academic Leader Research: Dr Shannon Bosch
Cc School Administrator: Mr Pradeep Ramsewak

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 **Facsimile:** +27 (0) 31 260 4609 **Email:** ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

Annex 3: Gatekeeper's letter welcoming the study

REPUBLIC OF KENYA

MINISTRY OF HEALTH

HIV AND AIDS TRIBUNAL

Landmark Plaza 6th Floor
ArgwingsKodhek Road
P.O. Box 37953-00100
NAIROBI.

Tel. 0735121318
Email: ceohivtribunal@gmail.com
hivtribunal@gmail.com

When replying please Quote

Your Ref. No.

Our Ref. No. **HAT/RES/1/Vol. I** Date: **31st July, 2014**

Mr. Patrick M. Eba
PhD Candidate
University of Kwazulu-Natal

Dear Mr. Eba,

RE: LETTER OF INTEREST IN RESEARCH ON THE IMPLEMENTATION AND ENFORCEMENT OF HIV-SPECIFIC LEGISLATION IN SUB-SAHARAN AFRICA

I acknowledge receipt of your electronic letter dated 15 July 2014 in which you inquire on the interest within the HIV Tribunal of Kenya regarding the abovementioned research.

Research of this nature is important to better understanding current practices and challenges relating to the implementation and enforcement of HIV-specific legislation in sub-Saharan Africa. In particular, the focus of your study on the HIV Tribunal of Kenya would be helpful to the Tribunal as it works to ensure the effective enforcement of the *HIV Prevention and Control Act, No 14 of 2006* of Kenya.

I look forward to hearing more on the research and your findings.

Best wishes,

Mr. Jotham Arwa
CHAIRPERSON - HIV & AIDS TRIBUNAL

Annex 4: Interview questionnaire for qualitative study in Kenya

The purpose of the interviews will be to obtain an in-depth understanding on the practice, issues and challenges relating to the implementation and enforcement of the HIV Prevention and Control Act, No 14 of 2006 of Kenya*. Key informants to be interviewed will include relevant personnel of the National Human Rights Commission and the National AIDS Control Council of Kenya, members of Parliament, representatives of non-governmental organisations and members of the HIV Tribunal of Kenya. This interview guide will be used with all interviewees but prompting questions will be determined by the nature of their role in enforcing the HIV Prevention and Control Act.*

About the interviewee and his/her institutional affiliation

- Which institution or organisation do you work for?
- Is this a government entity or non-governmental organisation?
- What is your position in this institution?
- What is the main role of your institution/organisation?
- What role does your institution play in responding to the HIV epidemic?

General questions on the implementation and enforcement of the *HIV Prevention and Control Act 2006* of Kenya

- Are you aware of the existence of the *HIV Prevention and Control Act of* 2006?
- Do you think that the public is aware of the existence of this law and its key provisions?
    - If yes, why?
    - If no, why not?
- Do you think that people living with HIV are aware of this legislation?
    - If yes, why?
    - If no, why not?
- Do you think that this legislation is being effectively implemented or enforced?
    - If yes, why?
    - What are the key elements of this effective enforcement?
    - Is it that there is:
        - Funding for enforcement?
        - Political commitment to enforcement?
        - Skilled enforcement agencies?
        - Confidence in the systems by the community?
        - High levels of awareness of enforcement mechanisms by the public?
        - Others?
    - Are there parts of the Act that are being implemented and others not?
        - If yes, why and what parts are these?
        - If no, explain
    - If the legislation is not being effectively implemented, why not?
        - What are some of the reasons why the Act is not being successfully enforced? Is it:
            - A lack of funding?
            - No trained personnel?

  - People Living with HIV feeling that using an HIV specific court is stigmatising?
  - Fears of the public becoming aware of the dispute?
  - The public is not aware of the Tribunal?
- Are key institutions tasked with implementing or enforcing the legislation aware of it? (National AIDS Commission, Ministry of Health, Ministry of Justice, National Human Rights Commission, members of the judiciary, etc)
    - If yes, why?
    - If no, why not?
- Do you think that these institutions are effectively implementing or enforcing the *HIV Prevention and Control Act of* 2006?
    - If yes, what are they doing to enforce its provisions?
    - If no, why not? What are the obstacles? (Are these obstacles related to human resources? Financial resources? Political commitment? Technical capacity? Time? Etc).
- Are you aware of any efforts to publicise the *HIV Prevention and Control Act 2006* or sensitise the public on it?
- Do you consider these efforts to be effective?
    - If yes, why?
    - If no, why not?
- Has there been any regulation or guidance adopted/issued since the enactment of the *HIV Prevention and Control Act* in 2006 to implement specific provisions such as those related to partner notification, guidance to health care workers, HIV in prisons?
    - If yes, who issued this guidance? What is the quality of this guidance? Is it being effective? Are there gaps?
- Has your institution played any role in implementing or enforcing the *HIV Prevention and Control Act*?
    - If yes, please describe it.
    - If not, please explain why.
- Has there been any study or research conducted on the implementation or enforcement of this legislation?
- What do you consider to be the challenges to the implementation or enforcement of the *HIV Prevention and Control Act*?
    - Maintaining confidentiality?
    - Funding?
    - Lack of trained staff?
- Do you think that the content of the *HIV Prevention and Control Act 2006* particularly the vagueness of some of its provisions and the embrace of punitive approaches have an impact on its implementation and enforcement?
    - If yes, why?
    - If no, why not?
- How do you think that the challenges to the implementation and enforcement of this law can be addressed?

Specific questions on the HIV Tribunal of Kenya as an enforcement mechanism of the *HIV Prevention and Control Act* of Kenya

- Are you aware of the HIV Tribunal of Kenya? Do you know of its role and work?

    - How many people does it employ?
    - Where is it based?
    - Is it open every day of the week?
    - Can any person go to the court and get assistance?
    - Can disabled persons access the Tribunal?
    - How do you lodge a complaint at the Tribunal?
- Do you think that there was a need for a specific tribunal on HIV? Don't you think that existing courts would have been equally suited or best placed to handle HIV-related issues?
- Are you aware of any judicial decision rendered by this Tribunal?
- Has your institution or organisation ever engaged with the HIV Tribunal? If so, when and for which purpose?
- Do you consider the HIV Tribunal to be an effective mechanism for the enforcement of the *HIV Prevention and Control Act*? If so, why?
    - Is it accessible to the poor?
    - Does it protect the privacy of the litigants?
    - Is it able to deal with HIV-related discrimination?
    - Would People Living with HIV see it as credible/acceptable?
    - Are its proceedings informal?
    - Do litigants require the services of a legal representative?
    - Does it attempt to use a restorative justice approach?
- What do you consider to be the challenges to the work and effectiveness of the HIV tribunal?
- How do you think that these challenges can be addressed?
- What could other African countries learn from the HIV Tribunal in Kenya?

Annex 5: Informed consent document for interviews

ETHICAL CLEARANCE APPLICATION
HUMANITIES AND SOCIAL SCICENCES RESEARCH ETHICS COMMITTEE

Information Sheet: Background to the research project and the nature of the interview

Good morning, my name is Patrick Michael Eba. I am a PhD student at the School of Law at the University of Kwazulu Natal, South Africa. My PhD study is on the implementation and enforcement of HIV-specific legislation in sub-Saharan Africa. I would like to invite you to participate in my study by agreeing to be interviewed. I will read through this information sheet with you to explain the nature of the study and what participation in it will mean. You will be given a copy of this sheet to keep as a record of our discussion. If you have any queries I can be contacted at:

Tel : +33450452513
michaeleba@yahoo.fr

My supervisor for this study is Dr Ann Strode, a Senior Lecturer at the University of Kwazulu-Natal. She can be contacted at:

Tel: + 27 33 2605731
strode@ukzn.ac.za

The contact details of the Humanities and Social Sciences Research Ethics Committee of the University of Kwazulu-Natal are as follows: Ms Phumele Ximba, University of Kwazulu-Natal, Research Office, Email: ximbap@ukzn.ac.za, Tel: +27312603587.

What is this study about?

This study is aimed at gaining better understanding of the current practices and challenges relating to the implementation and enforcement of HIV-specific legislation in sub-Saharan Africa. Kenya is one of the case studies in my research because it has adopted an HIV-specific law in 2006 and it is the only country in the world to have established an HIV-specific tribunal to ensure the enforcement of that law.

What will I have to do if I agree to participate?

As part of this research, I will ask you a few questions on your views, experiences and expertise in relation to the implementation and enforcement of this Act, the *HIV Prevention and Control Act, No 14 of 2006* of Kenya.

The interview is expected to take approximately 30 – 45 minutes and it will be done at a time and venue that is convenient for you.

If you agree, I will make a tape recording of the interview. This will help me to ensure that I capture all your thoughts and opinions accurately.

Will anyone know that I participated in the study?

Your responses and the information you provide in this interview will be treated in a confidential manner. Your name and/or affiliation as a respondent will only be disclosed in the findings of the research if you so wish. In this case, kindly indicate that you agree to such disclosure in the form below. If not, I will disguise your name and your institution by referring to your answers as being provided by an 'unnamed respondent'.

Do I have to participate?

No. Participation is voluntary. You are free to decline to participate in the study and there will be no negative consequences for not participating. If you decide to participate, I will ask you to read the attached informed consent form, and sign it.

You are free to stop the interview at any time or refuse to respond to specific questions which you may not feel comfortable answering. There will be no negative or undesirable consequence to you or to your institution in relation to your withdrawal from the study or decision not to answer a specific question.

Will I be paid for participation in the study?

No. There will not be any payment for participating in this study.

Are there any benefits to me if I participate in this study?

No. There will be no direct benefit to you or to your institution in relation to your participation in this research except the access to the findings of the research when it is completed and published. If you wish to receive an electronic copy of the study when it is completed, please provide your e-mail address to me.

Are there any risks to me if I participate?

There are no risks associated with participating in this study.

Has this study received ethical approval?

This study has been approved by the Health and Social Sciences Research Ethics Committee at the University of KwaZulu Natal in South Africa.

Informed consent form

I ……., hereby certify that I am fully aware that my participation in the following interview is voluntary. I am fully aware that this interview is related to a PhD research project on the implementation and enforcement of HIV-specific legislation in sub-Saharan Africa conducted by Mr Patrick Michael Eba, PhD student at the University of Kwazulu-Natal in South Africa.

If for any reason, or at any time, I wish to stop the interview or decide not to answer any question, I am free to do so without having to give any explanation. I understand that there will be no negative or undesirable consequence to me or to my institution in relation to the withdrawal from the study or the decision not to answer a specific question.

I am fully aware and understand that there will be no direct benefit to me or to my institution in relation to my participation as interviewee in this research except access to the findings of the research when it is completed and published.

I am fully aware and understand that the information collected during this interview will be used for the purpose of the above mentioned PhD research and for related publications. The information gathered during this interview is confidential and anonymous. My personal identity and/or that of my institution will not be disclosed unless I expressly indicate otherwise below:

I grant permission to: *[please tick when applicable. Do not tick any in case you would like your personal details to remain anonymous]*

□ use my full name only

□ make reference to my institutional affiliation only

□ use my full name and make reference to my institutional affiliation

I have read the present form, and certify that I have understood its content. I therefore consent to today's interview.

---------- ----------
Interviewee's signature Date

---------- ----------
Interviewer's signature Date

I agree to my interview being tape recorded.

---------- ----------
Interviewee's signature Date

---------- ----------
Interviewer's signature Date

I wish to obtain a copy of the findings of this study.

E-mail address:

Annex 6: Turn-it-in reports

Introduction

by Patrick Eba

FILE	CHAPTER1_INTRODUCTIONFROMEDITOR_13SEPTEMBER2016.PDF (464.81K)		
TIME SUBMITTED	18-SEP-2016 06:59PM	WORD COUNT	17440
SUBMISSION ID	693375082	CHARACTER COUNT	93294

Chapter One: Introduction – Human rights in the context of HIV and their application to HIV-specific laws in sub-Saharan Africa

1.1 Overview

This thesis is a contribution to the literature on the role of the law and human rights norms in public health responses generally, and in the response to the Human Immunodeficiency Virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS) epidemic,[1] in particular. It uses human rights norms and frameworks to review how laws and policies influence vulnerability to HIV and barriers to effective HIV prevention, treatment and care. It also briefly reflects on the role of human rights in other public health challenges such as the outbreak of Ebola in West Africa in 2014-2015. The thesis offers the first comprehensive human rights analysis of the normative content and intrinsic implementation issues in 26 of the 27 HIV-specific laws adopted across sub-Saharan Africa in the past 15 years. It concludes with recommendations for improving law-making on HIV and other health-related issues.

It is premised on two inter-related postulates. First, laws that ignore human rights norms and public health evidence contribute to increasing vulnerability to HIV and often represent barriers to accessing HIV services, particularly for the populations that are most affected by the epidemic. Second, the thesis posits that human rights norms and sound public health evidence are critical to effective law making in the context of HIV. It argues that HIV-related laws that ignore these human rights norms and the principles of sound HIV policy are likely to face challenges in their implementation.

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[1] HIV refers to the virus that causes AIDS and AIDS describes a clinical syndrome. This thesis uses the term that is most specific and appropriate in each context so as to avoid confusion. In line with the UNAIDS terminology guidelines, this thesis will generally use the following expressions 'people living with HIV', 'HIV prevalence', 'HIV epidemic', 'AIDS epidemic', 'HIV prevention', 'HIV testing and counselling', 'HIV-related disease', 'AIDS diagnosis', 'children orphaned by AIDS', 'AIDS response' and 'national AIDS programme'. In general HIV will be the preferred term used in the thesis as it is more inclusive. For more on the use of the terms 'HIV' and 'AIDS' and other HIV-related terminology, see UNAIDS *UNAIDS terminology guidelines Revised version* (2011) available at *http://www.unaids.org/sites/default/files/media_asset/JC2118_terminology-guidelines_en_1.pdf* , accessed on 26 August 2016.

This introduction Chapter sets the background to the thesis. It succinctly shows that, in spite of recent progress, the HIV epidemic remains a serious public health challenge. This Chapter also discusses the role of the law and human rights norms in the context of HIV. It interrogates the pertinence and 'resilience' of human rights at a time of increased calls for accelerating biomedical responses to HIV centred on scaling up highly active antiretroviral treatment (HAART) and in the context of contestation of the human rights of some population groups. The Chapter also describes the emergence of HIV-specific laws in sub-Saharan Africa and the criticisms that they have generated. It concludes with the specific objectives, research questions, premise, limitations and structure of the thesis.

1.2 HIV in sub-Saharan Africa: A serious epidemic in spite of recent progress

Across sub-Saharan Africa, the HIV epidemic continues to represent a major public health challenge. In 2015, there were an estimated 25.5 million people living with HIV in sub-Saharan Africa, representing some 69.4% of the global total.[2] In that year alone, there were some 800,000 deaths due to AIDS-related illnesses in the region.[3] The HIV epidemic is also contributing to the high Tuberculosis (TB) incidence and deaths, as TB is the leading cause of deaths among people living with HIV in the region.[4] The impact of the HIV epidemic on families is significant. As of December 2012, an estimated 15 million children in sub-Saharan Africa – 85% of the global total – had lost one or both parents to AIDS.[5]

The HIV epidemic in sub-Saharan Africa is far from homogenous. Countries in Eastern and Southern Africa are generally more affected by HIV than those in West and Central Africa (see Table 1). All six countries in the world with HIV prevalence in the adult population above 15% (also referred to as hyperendemic countries) are in

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[2] UNAIDS *AIDS by the number* (2016) 12-13 available at *http://www.unaids.org/sites/default/files/media_asset/AIDS-by-the-numbers-2016_en.pdf*, accessed on 26 August 2016.

[3] Ibid.

[4] WHO *Global tuberculosis report 2015* (2015) 8 available at *http://apps.who.int/iris/bitstream/10665/191102/1/9789241565059_eng.pdf*, accessed on 26 August 2016.

[5] UNICEF *Towards an AIDS-Free Generation. Children and AIDS: Sixth Stocktaking Report 2013* (2013) available at *http://www.unaids.org/sites/default/files/media_asset/20131129_stocktaking_report_children_aids_en_0.pdf* (accessed on 26 August 2016).

Southern Africa. With the exception of Equatorial Guinea, all countries in West and Central Africa have an HIV prevalence of less than 5% in the adult population aged 15-49 (see Table 1).

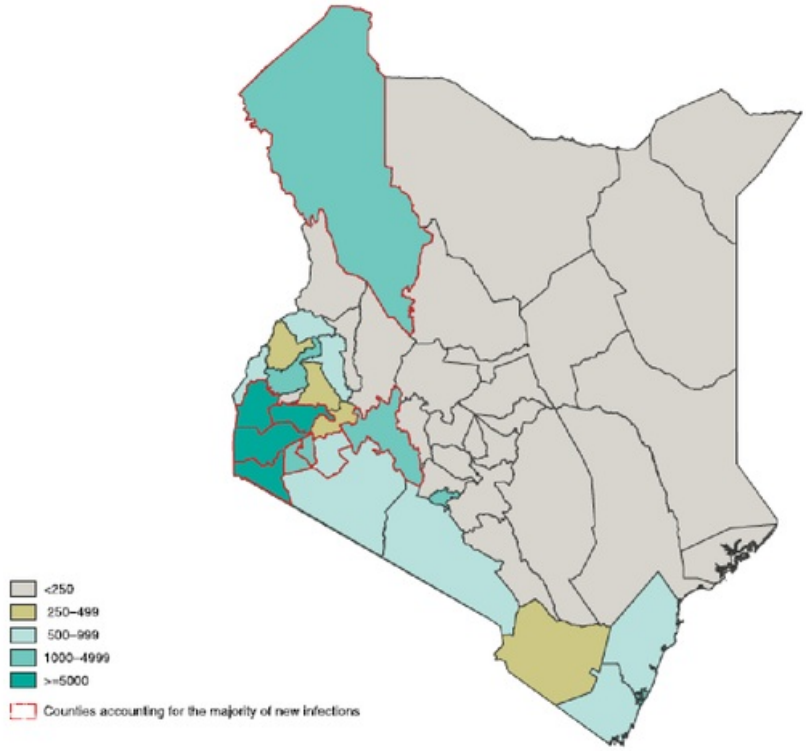
Table 1: Estimated HIV prevalence (persons aged 15-49 years) in sub-Saharan African countries in 2014[6]

Sub-region	HIV prevalence below 1%	HIV prevalence between 1 and 5%	HIV prevalence between 5 and 10%	HIV prevalence above 10%
West and Central Africa	Burkina Faso (0.9%), Mauritania (0.7%), Niger (0.5%), Sao Tome and Principe (0.8%), Senegal (0.5%),	Benin (1.1%), Burundi (1.1%), Cameroon (4.8%), Cape Verde (1.1%), Central African Republic (4.3%), Chad (2.5%), Congo (2.8%), Cote d'Ivoire (3.5%), DRC (1%), Gabon (3.9%), Gambia (1.8%), Ghana (1.5%), Guinea (1.6%), Guinea Bissau (3.7%), Liberia (1.2%), Mali (1.4%), Nigeria (3.2%), Sierra Leone (1.4%), Togo (2.4%)	Equatorial Guinea (6.2%)	
Eastern and Southern Africa	Eritrea (0.7%), Madagascar (0.3%), Mauritius (0.9%),	Angola (2.4), Ethiopia (1.2%), Rwanda (2.8%), South Sudan (2.7%)	Kenya (5.3%), Malawi (10%), Uganda (7.3%), Tanzania (5.3%),	Botswana (25.2%), Lesotho (23.4%), Mozambique (10.6%), Namibia (16%), South Africa (18.9%), Swaziland (27.7%), Zambia (12.4%), Zimbabwe (16.7%)

Great differences in HIV prevalence and incidence also exist within countries. In Kenya, 65% of all new HIV infections in 2014 occurred in nine of the 47 counties (see Figure 1). Similar trends are reported across sub-Saharan Africa, with higher HIV prevalence and incidence being concentrated in some specific parts of the countries.

[6] UNAIDS *How AIDS changed everything. MDG 6: 15 years, 15 lessons of hope from the AIDS response* (2015) available at http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf, accessed on 26 August 2016.

Figure 1: Estimated new HIV infections in Kenya in 2014 by county[7]



Important progress has been made in recent years against HIV in sub-Saharan Africa. The number of people receiving antiretroviral therapy (ART) in the region increased from less than 100,000 in 2000 to 11.8 million in 2015.[8] Coverage of programmes for the prevention of mother-to-child transmission (PMTCT) has increased drastically, particularly in Eastern and Southern Africa where 90% of pregnant women living with HIV were reported to receive effective antiretroviral medicines for PMTCT in 2015.[9] Consequently, in some countries such as Botswana where PMTCT coverage is above 90%, vertical HIV transmission rates have been

[7] UNAIDS *On the Fast-Track to end AIDS by 2030: Focus on locations and populations* (2015) 14 available at *http://www.unaids.org/sites/default/files/media_asset/WAD2015_report_en_part01.pdf*, accessed on 26 August 2016.
[8] UNAIDS (note 2 above; 13).
[9] UNAIDS *Prevention gap report* (2016) 236 available at *http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf*, accessed on 26 August 2016.

reduced to below 5%.[10] In general, new HIV infections in sub-Saharan Africa have dropped from 2.3 million in 2000 to 1.4 million in 2014.[11]

Notable differences exist between countries in their progress against the HIV epidemic. In general, countries in Eastern and Southern Africa are witnessing more robust progress in access to ART compared to countries in West and Central Africa. For instance, just 29% of adults living with HIV in West and Central Africa have access to ART compared to 53% in Eastern and Southern Africa. Only 20% of children below the age of 15 living with HIV in West and Central Africa were accessing ART in 2015 compared to some 63% in Eastern and Southern Africa.[12]

A recent report by the Non-Governmental Organisation (NGO), Médecins Sans Frontières, blames the situation in West and Central Africa on several factors, including: high stigma and discrimination; weak health systems and inadequate service delivery models; limited role of civil society; low prioritisation of HIV and lack of political leadership; and delayed response to the needs of people living with HIV in the context of recurrent humanitarian crises in the region.[13]

In all sub-Saharan African countries – and regardless of the nature and level of the HIV epidemic – data shows that specific population groups, including women and girls, prisoners, gay men and men who have sex with men, transgender people, people who inject drugs and sex workers, are particularly impacted by the epidemic.[14] These populations, also referred to as key populations,[15] experience

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[10] UNAIDS *2015 Progress report on the global plan towards the elimination of new HIV infections among children and keeping their mothers alive* (2015) 9 available *http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf*, accessed on 26 August 2016.

[11] UNAIDS (note 6 above; 457).

[12] UNAIDS (note 2 above; 14).

[13] Médecins Sans Frontières *Out of focus: How millions of people in West and Central Africa are being left out of the Global AIDS Response* (2016) available at *http://www.msf.org/sites/msf.org/files/2016_04_hiv_report_eng.pdf*, accessed on 26 August 2016.

[14] UNAIDS *The gap report* (2014) 26-48 available at *http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf*, accessed on 26 August 2016.

[15] The term 'key populations' refers to those who are most likely to be exposed to HIV or to transmit it. It is considered that the engagement of these populations is critical to a successful HIV response meaning that they are key to the epidemic and the response to it. While many populations are included in the term key populations, this thesis often focuses on those key populations that face criminal and other punitive and restrictive laws and practices, notably gay men and men who have

higher HIV prevalence and incidence and often have limited access to HIV prevention, treatment and care services.[16] Even in high prevalence settings, HIV prevalence among members of key populations is higher than among the general populations. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), 17 of the 18 countries where HIV prevalence among sex workers exceeds 20% are located in sub-Saharan Africa.[17] HIV prevalence among men who have sex with men in Western and Central Africa is over 10% compared to less than 2% in the general population.[18] Available data on HIV among people who inject drugs and among prisoners in sub-Saharan Africa also point to particularly high HIV prevalence among this population.[19]

High HIV prevalence among members of these populations cannot be justified by biology or sexual practices. Stigma, discrimination, violence, negative gender and heteronormative constructs, as well as criminal laws against members of key populations have been shown to increase their vulnerability to HIV and to limit their access to HIV services.[20] For instance, harassment, violence (including by police) and denial of prevention services such as harm reduction programmes contribute to higher vulnerability to HIV among people who use drugs and their sexual partners.[21] HIV-positive people who inject drugs experience barriers in their access to ART and other health care services due to discrimination in health care settings, abuse, detention and denial of care including in prisons.[22] Other members of key populations face similar vulnerabilities and barriers as described in this thesis in relation to prisoners (see Chapter Three).

In light of the above, effective responses to the HIV epidemic in sub-Saharan Africa

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sex with men, sex workers, people who inject drugs, prisoners and adolescents. See UNAIDS (note 1 above).

[16] See UNAIDS (note 14 above).

[17] UNAIDS (note 14 above; 45).

[18] UNAIDS (note 14 above; 205).

[19] UNAIDS (note 14 above).

[20] WHO *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (2014) available at http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1, accessed on 26 August 2016.

[21] R Jurgens, J Csete, J Amon, S Baral & C Beyrer 'People who use drugs, HIV, and human rights' (2010) 376(9739) *Lancet* 475-485.

[22] Ibid.

should take into due account the variety of epidemics and their differentiated impacts on countries, locations and populations. Tailored responses are needed to respond to the particular challenges facing specific populations and locations.[23] In particular, vulnerabilities and barriers – including in law, policy and practices – experienced by key populations in each context must be identified and addressed.

1.3 The law as a 'sword or shield'[24] in the context of HIV

From its inception, the HIV epidemic has generated fear, prejudice and stigma and led to discrimination and other human rights violations against people living with, affected by or perceived to be vulnerable to HIV.[25] Without seeking to excuse, several reasons may explain the high level of stigma and discrimination associated with HIV.

First, because the early cases of what would later become known as AIDS were discovered among young gay men, the AIDS epidemic was associated with homosexuality.[26] Later, sex workers and people who inject drugs were also

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[23] See UNAIDS (note 7 above).

[24] This expression is borrowed from E Cameron, *Using the law in the AIDS epidemic: sword or shield?* Birkbeck College, 28 June 2007.

[25] HIV is not the first or only health condition to generate fear, stigma and discrimination. Diseases such as leprosy, the bubonic plague, syphilis and, more recently, Severe Acute Respiratory Syndrome (SARS) or Ebola have often provided a context for social labelling, differentiation, and the expression of prejudice and blame. The emergence and spread of epidemics throughout history have generated blame and often violence towards 'others' who are identified on the ground of their origin, race, social position and other perceptions of their difference. See, among others, C Quetel *History of syphilis* (1990); S Watts *Epidemics and history: Disease, power and imperialism* (1997); H Marais 'Buckling: The impact of AIDS in South Africa' (2005) *AIDS Review*; B Person *et al* 'Fear and stigma: The epidemic within the SARS outbreak' *Emerging Infectious Diseases*, 2004, 10(4), pp 358-363; M Davtyan, B Brown & MO Folayan 'Addressing Ebola-related stigma: Lessons learned from HIV/AIDS' (2014) 7 Global Health Action 26058.

[26] It is widely considered that the first scientific account of AIDS occurred on 5 June 1981 when the United States Centers for Disease Control (CDC) published in its bulletin, *Mortality and Morbidity Weekly Report*, an article on '*Pneumocystis* pneumonia – Los Angeles'. See CDC, *Mortality and Morbidity Weekly Report*, 5 June 1981, 30(21) 1-3, available at *http://www.cdc.gov/mmwr/preview/mmwrhtml/june_5.htm*, (accessed 27 August 2016). The article revealed that between October 1980 and May 1981, five young men (aged 29 to 36 years), all sexually active gay men, were treated for pneumonia in three hospitals in Los Angeles, California. A month after the release of CDC's report, *The New York Times* published an article describing cases of Kaposi's Sarcoma in 41 gay men. See LK Altman 'Rare cancer seen in 41 homosexuals' The New York Times 3 July 1981 available at *http://www.nytimes.com/1981/07/03/us/rare-cancer-seen-in-41-homosexuals.html*, accessed on 27 August 2016. These early reports created the enduring link between AIDS and homosexuality. This association led to homophobic stereotyping and blaming as the sexual practices, lifestyle and behaviour of gay men became the centre of fantasies and myths. For a general description of early responses to the AIDS epidemic in the United States, see R Shilts

associated with the epidemic. Before AIDS, these populations were already facing high levels of prejudice and marginalisation in many countries and communities that will become exacerbated in the context of the epidemic.[27] Although heterosexual populations constitute the great majority of people living with HIV today in sub-Saharan Africa, early (mis)representations of AIDS as a condition that affects gay men and other 'social deviants' such as sex workers and people who use drugs continues to endure.

Second, the fact that sexual contact is the primary route of HIV transmission in Africa has played into cultural, social and religious taboos relating to sexuality. This has often led to the labelling of people living with HIV as promiscuous.[28]

Third, fear and blame towards HIV and people living with HIV is related to social constructs of death. Widely publicised images of the emaciated bodies of people at advanced stages of AIDS in the early years of the epidemic have contributed to shock the public and instilled a fear of AIDS as a deadly condition that required decisive measures to protect the public.[29] Increased availability and accessibility to HIV treatment has contributed to addressing some of the fear relating to the epidemic yet perceptions of AIDS as a deadly condition remains pervasive.[30]

Early fears of AIDS and prejudice towards people living with or vulnerable to HIV were translated into coercive responses by governments and authorities in many parts of the world.[31] These measures were often motivated by traditional

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And the band played on: Politics, people and the AIDS epidemic (1987); M Cochrane *When AIDS began: San Francisco and the making of an epidemic* (2004).

[27] P Aggleton, P Davies & G Hart *AIDS: Rights, Risk, and Reason* (1992); D Altman *AIDS in the mind of America* (1986); J Engel *The Epidemic: A global history of AIDS* (2006).

[28] P Eba *Stigma(ta): Re-exploring HIV-related stigma* (2007).

[29] For a thorough discussion of the causes and mechanisms of HIV-related stigma, see, among others, A Malcolm, P Aggleton, M Bronfman, J Galvao, P Mane, J Verral 'HIV-related stigmatization and discrimination: Its form and context' (1998) 8(4) *Critical Public Health* 347-370; R Parker & P Aggleton 'HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action' (2003) 57 *Social Science and Medicine* 13-24; C Link & J C Phelan 'Conceptualising stigma' (2001) 27 *Annual Review of Sociology* 363-385; GM Herek 'Thinking about AIDS and stigma: A psychologist's perspective' (2002) 30(4) *Journal of Law, Medicine & Ethics* 594-607.

[30] Eba (n 28 above).

[31] See, among others, K Tomasevski, S Gruskin, Z Lazzarini, A Hendriks 'AIDS and human rights' in J Mann, DJM Tarantola & TW Netter *AIDS in the world: A global report* (1992) 559-574; LO Gostin *The AIDS Pandemic: Complacency, injustice, and unfulfilled expectations* (2004); R Bayer & A Fairchild-Carrino 'AIDS and the limits of control: public health orders, quarantine, and recalcitrant behavior'

understanding of public health responses that sought to identify and control those who are perceived to be affected or at risk of disease through *direct* and *indirect* coercive measures.[32] In the context of HIV, direct measures were aimed at targeting known or presumed HIV-positive individuals through quarantine, isolation, restriction to travel or criminal prosecution. For example, as of 1991, some 12 countries provided for the placement of people living with HIV under surveillance and 17 more countries allowed for compulsory hospitalisation or isolation of people living with HIV.[33] Until 2008, some 59 countries, territories and areas had adopted measures restricting the entry, stay or residence on their territory for people living with HIV on the basis of their HIV status.[34] Indirect measures were aimed at enforcing often existing measures prohibiting conducts that were considered to lead to HIV transmission, including injecting drugs, sex work or sodomy.[35]

However, as understanding of HIV and its modes of transmission grew, people living with HIV and their advocates started challenging coercive measures as violations of human rights. Leading global institutions also joined in calling for transforming the role of the law in the context of the AIDS epidemic. In 1988, Resolution WHA 41.24 of the 41st World Health Assembly called on States to protect people living with HIV against discrimination and other coercive measures.[36] In 1989, the UN Centre for Human Rights (the predecessor to today's Office of the High Commissioner for Human Rights - OHCHR) convened the first international consultation on HIV/AIDS and human rights. The consultation stressed the importance of protecting human

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(1993) 83(10) *American Journal of Public Health* October 1471-1476; ML Closen & ME Wojcik 'International health law, international travel restrictions, and the human rights of persons with AIDS and HIV' (1990) 1(2) *Touro Journal of Transnational Law* 285-305.

[32] E Cameron & E Swanson 'Public health and human rights – The AIDS crisis in South Africa' *South African* (1992) 8 *Journal of Human Rights* 201-202.

[33] Mann, Tarantola, Netter (note 31 above; 548).

[34] UNAIDS *Report of the International Task Team on HIV-related Travel Restrictions: findings and recommendations* (2010) 4 available at *http://www.unaids.org/sites/default/files/media_asset/jc1715_report_inter_task_team_hiv_en_0.pdf*, accessed on 27 August 2016.

[35] Ibid.

[36] World Health Assembly *AIDS: Avoidance of discrimination in relation to HIV-infected people and people with AIDS*, WHA 41.24, 13 May 1988 available at *http://apps.who.int/iris/bitstream/10665/164520/1/WHA41_R24_eng.pdf*, accessed on 28 August 2016.

rights as an obligation on all States and as a public health necessity.[37] These calls for changing the paradigm of the application of the law in the context of HIV from coercion to protection were summed up in the impassioned plea made before the United Nations General Assembly by Jonathan Mann[38] the first director of the World Health Organisation's (WHO) Global Programme on AIDS:

> Fear and ignorance about AIDS continue to lead to tragedies: for individuals, families and entire societies. Unfortunately, as anxiety and fear cause some to blame others, AIDS has unveiled the dimly disguised prejudices about race, religion, social class, sex and nationality [...] [T]hreatening infected persons with exclusion – or worse – will drive the problem 'underground', wreaking havoc with educational efforts and testing strategies. Therefore, how societies treat AIDS virus-infected people will not only test fundamental values, but will likely make the difference between success and failure of AIDS control strategies at the national level. To the extent that we exclude AIDS-infected persons from society, we endanger society, while to the extent that we maintain AIDS-infected persons within society, we protect society. This is the message of realism and of tolerance.[39]

At the core of Mann's perspective lie the following questions: what should be the response of the society, and particularly of the law, to the HIV epidemic? Should the law be, as is often the case in the context of public health, a sword that is used as a structural tool to constrain, ostracise or punish people living with HIV and those vulnerable to it? Should the law be used to restrict the human rights of the minority (those living with HIV) for the protection of the majority, as is generally the case in public health approaches? Or should the law be a shield that protects people living with or vulnerable to HIV against stigma, discrimination and other human rights violations, and supports their access to HIV services?

The conception of the law as a shield and enabling framework for the HIV response was ultimately endorsed by the WHO Global Programme on AIDS and its successor,

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[37] Centre for Human Rights & World Health Organization Global Programme on AIDS *Report of an International Consultation on AIDS and Human Rights, Geneva, 26-28 July 1989* (1989).

[38] Jonathan Mann is considered by many as the first global public health leader to have articulated the importance of human rights in the context of HIV. For a representation of Jonathan Mann's approach to HIV and human rights, see, among others, LO Gostin 'A Tribute to Jonathan Mann: Health and human rights in the AIDS pandemic' (1998) 26 *The Journal of Law, Medicine & Ethics* 256-258.

[39] J Mann 'Statement at an Informal Briefing on AIDS to the 42nd Session of the United Nations General Assembly' (1988) 151(1) *Journal of the Royal Statistical Society. Series A (Statistics in Society)* 134.

UNAIDS. This recognition of the enabling role of the law came from the realisation that traditional public health approaches that were centred on individual behaviour were not suited for a socially complex epidemic like HIV. The enabling role of the law was also considered necessary to respond to the social factors of vulnerability to the epidemic. Furthermore, great doubts had been raised about the effectiveness of coercive measures such as quarantine and isolation in responding to the HIV epidemic.[40]

Michael Kirby – a then Justice of the High Court of Australia – referred to this paradigm shift from the reliance on coercion to the endorsement of protection as the first paradox of HIV:

> The first and central paradox of HIV/AIDS, in the first decade after it manifested itself, was the one that became best known and best understood. According to this AIDS paradox, the most effective means of preventing the spread of the virus, at that stage, was protection of the human rights of the people most at risk of acquiring the virus. This was a paradox because it was contrary to intuitive responses to the spread of a dangerous virus in society. Instinctively, in such a case, citizen and public health experts thought in terms of the public health paradigm. Citizens, moreover, thought of punishment. Their minds were in tune with the moralising and stigmatising response that those who had and spread the virus were unclean, immoral and dangerous to the community — people who needed to be controlled, checked and sanctioned.[41]

The recognition of the protective role of the law in the context of HIV did not come without tensions and oppositions as voices emerged that this 'first HIV paradox' was contrary to effective public health approaches and contributed to make AIDS exceptional.[42] However, these charges of 'exceptionalism'[43] in these years did not

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[40] Kirby refers to these coercive legal measures as Highly Inefficient Laws or 'HIL' in reference and parallel to 'HIV'. M Kirby 'The new AIDS virus – ineffective and unjust laws' (1988) 1(3) *Journal of Acquired Immune Deficiency Syndromes* 304-312.

[41] M Kirby 'The never-ending paradoxes of HIV/AIDS and human rights' (2004) 2 *African Human Rights Law Journal* 167.

[42] R Bayer 'Public health policy and the AIDS epidemic. An end to HIV exceptionalism?' (1991) 324(21) *New England Journal of Medicines* 1500-1504.

[43] 'HIV exceptionalism' or 'AIDS exceptionalism' was described by Bayer as efforts 'to sustain a set of policies treating HIV as fundamentally different from all other public health threats'. According to Bayer, the exceptionalist perspective was impressed during the 'first decade of the AIDS epidemic [by] an alliance of gay leaders, civil libertarians, physicians and public health officials'. He predicted that in the wake of the second decade of AIDS, 'HIV exceptionalism will be viewed as a relic of the

hold sway as people living with HIV and human rights activists started to effectively use international and national human rights norms and courts to address the legal issues raised by HIV.

1.4 Human rights norms and their application in the context of HIV

Human rights are entitlements that are recognised to all individuals by their virtue of being human.[44] At the global level, human rights norms are enshrined in the Universal Declaration on Human Rights and in a number of human rights treaties including the International Covenant on Civil and Political Rights (ICCPR),[45] the International Covenant on Economic Social and Cultural Rights (ICESCR),[46] the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC),[47] and other subsequent human rights treaties such as the Convention on the Rights of Persons with Disabilities[48]. While none of these treaties explicitly addresses HIV, their provisions relating to non-discrimination, liberty, security, equality, health, education, free and fair trial are pertinent to HIV.[49] Monitoring bodies established under these treaties have on several occasions in general comments and concluding observations affirmed relevant norms applicable in the context of HIV. [50]

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epidemic's first years'. Bayer (note 42 above). For a discussion on HIV exceptionalism, see S Burris 'Public Health, 'AIDS exceptionalism' and the law' (1994) 27 *The John Marshall Law Review* 251-272.

[44] See, among others, F Viljoen *International human rights law in Africa* (2012); J Donnelly Universal human rights in theory and practice (2013); A Clapham *Human rights: A very short introduction* (2007); MJ Perry *The idea of human rights: Four inquiries* (1998); C Tomuschat *Human rights: Between idealism and realism* (2003).

[45] International Covenant on Civil and Political Rights (ICCPR), adopted 16 December 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171. See article 2.

[46] *International Covenant on Economic, Social and Cultural Rights* (ICESCR), adopted on 16 December 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3. See article 2.

[47] Convention on the Rights of the Child, adopted on 20 November 1989, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989). See article 2(1).

[48] Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, Annex I, U.N. GAOR, 61st Sess., Supp. No. 49, at 65, U.N. Doc. A/61/49 (2006).

[49] PM Eba 'HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis' (2015) 15 *African Human Rights Law Journal* 227-228.

[50] See, for example, Committee on ESCR 'General Comment no 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)' 2 July 2009 E/C.12/GC/20; and Committee on the Rights of the child 'General Comment No. 3 (2003): HIV/AIDS and the rights of the child' CRC/GC/2003/1.

In Africa, regional human rights treaties are also relevant to HIV. Key provisions such as those relating to non-discrimination, liberty and security, education, health, prohibition of torture, inhuman and degrading treatment in the African Charter on Human and Peoples' Rights (African Charter),[51] the African Charter on the Rights and Welfare of the Child (ACRWC)[52] or in the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) are relevant to HIV.[53] The Maputo Protocol even has specific provisions addressing HIV under its article 14 on health and reproductive rights.[54]

In addition to treaty norms, a multitude of global and national non-binding legal instruments have also been adopted that affirm the centrality of human rights in HIV responses. Chief among these are the International guidelines on HIV/AIDS and human rights developed by the Second International Consultation on HIV/AIDS and Human Rights convened by UNAIDS and OHCHR in September 1996.[55] The International guidelines were developed by a group of 35 experts from across the world, comprising government officials, people living with HIV, academics, human rights activists, and representatives of NGOs and United Nations bodies.[56] They provide a set of 12 action-oriented guidelines aiming to assist all countries in complying with their international human rights obligations in the context of HIV through appropriate laws, regulations, policies and programmes.[57] The guidelines were endorsed in 1997 by the United Nations (UN) Commission on Human Rights (the predecessor of the Human Rights Council) as part of a report of the UN

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[51] African Charter on Human and Peoples' Rights, adopted on 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5.

[52] African Charter on the Rights and Welfare of the Child, adopted on 11 July 1990, OAU Doc. CAB/LEG/24.9/49.

[53] See AIDS and Human Rights Research Unit *Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa* (2007)

[54] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted by on 13 September 2000, CAB/LEG/66.6.

[55] UNAIDS & OHCHR *International guidelines on HIV/AIDS and human rights, 2006 consolidated version* (2006). 10.

[56] Ibid.

[57] Following the elaboration of the International guidelines in 1996, Guideline 6 on HIV-related prevention and treatment goods, services and information was revised during the Third International Consultation on HIV/AIDS and Human Rights convened by OHCHR and UNAIDS on 25-26 July 2002 in Geneva. See UNAIDS & OHCHR (note 55 above; 11-12).

Secretary General.[58]

In addition to the International guidelines, the resolutions adopted by the UN General Assembly Special Session on HIV in 2001,[59] and by the High Level Meetings on HIV in 2006[60], 2011[61] and 2016[62] as well as the resolutions on HIV of the Commission on Human Rights and later the Human Rights Council also provide specific standards for the protection of human rights in the context of HIV.[63] In Africa, several non-binding instruments have been adopted in relation to HIV by the African Union, the African Commission on Human and Peoples' Rights (African Commission), the Inter-governmental Authority on Development (IGAD), the East African Community (EAC), and the Southern African Development Community (SADC).[64]

Global and human rights norms relating to HIV have been used at national level around three streams. First, human rights have been invoked to ensure the protection of people living with HIV against discrimination, violence and coercion including in the context of HIV services. This has taken the form of advocacy campaigns as well as court cases to respond to discrimination in areas such as employment, housing and inheritance.[65] Second, human rights norms have been used to claim health services and other entitlements in the context of HIV, including access to evidence-informed HIV-related prevention and treatment services. This is illustrated, among others, by the successful litigation initiated by the Treatment

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[58] The International guidelines were presented to the Commission on Human Rights as part of the report of the United Nations Secretary General in January 1997. At its 53rd session, the Commission on Human Rights '[w]elcome[ed] the report of the Secretary-General on the Second International Consultation on HIV/AIDS and Human Rights …including the Guidelines recommended by the expert participants' and invited 'all states to consider them'. Commission on Human Rights 'The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)' E/CN.4/RES/1997/33 11 Avril 1997 available at *http://ap.ohchr.org/documents/alldocs.aspx?doc_id=44* accessed on 26 August 2016.

[59] UN General Assembly Special Session on HIV/AIDS *Declaration of Commitment on HIV/AIDS* (A/RES/S-26/2) June 2001.

[60] UN General Assembly *Political Declaration on HIV/AIDS* (A/RES/60/262) 15 June 2006.

[61] UN General Assembly *Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS* (UN Doc A/RES/65/277) 10 June 2011

[62] UN General Assembly *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030* (A/70/L.52) 8 June 2016.

[63] For an overview of the resolutions on HIV of the Commission on Human Rights and the Human Rights Council, see *http://www.ohchr.org/EN/Issues/HIV/Pages/Documents.aspx*, accessed 26 August 2016.

[64] AIDS and Human Rights Research Unit (note 53 above).

[65] Ibid.

Action Campaign against the South African government to secure access to ART to prevent mother-to-child transmission of HIV.[66] Third, human rights norms and approaches have been used to demand specific actions to address factors of vulnerability and barriers to access to HIV services, including for specific groups including key populations. For instance, the Court of Appeal of Botswana held in 2015 that the denial of HIV treatment to foreign prisoners living with HIV was unlawful and ordered the government to provide HIV-positive foreign prisoners, on the same basis with citizen prisoners, with 'free testing and assessment and treatment with ARVs and HAART where appropriate'.[67]

Over the years, progress has been made along these three streams and the commitment to non-discrimination in the context of HIV – at least at symbolic and rhetorical level – is now part of the discourse and policy on AIDS in most countries in sub-Saharan Africa. For instance, a great number of HIV policies and strategic plans currently in place in sub-Saharan African countries refer to the importance of human rights in the context of HIV.[68]

However, discrimination and other human rights violations remain pervasive in the context of HIV across sub-Saharan Africa. People living with HIV continue to experience high level of discrimination in access to health care, employment, housing and insurance, among others.[69] For instance, in Tanzania, 29.6% of people living with HIV were forced to change place of residence or were unable to rent accommodation due to their HIV status.[70] In Ghana, 16.2% of people living with HIV

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[66] *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) (CCT8/02) [2002] ZACC 15.

[67] *The Attorney General and Others v Dickson Tapela and Others*, Court of Appeal of Botswana, Case No CACGB-096-14, available at *http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2015/04/Court-of-Appeal-Judgment_Tapela_26-08-20151.pdf*, accessed on 27 August 2016.

[68] UNAIDS & International HIV/AIDS Alliance *Making it work: Lessons learnt from three regional workshops to integrate human rights into national HIV strategic plans* (2012); S Gruskin & D Tarantola 'Universal Access to HIV prevention, treatment and care: assessing the inclusion of human rights in international and national strategic plans' (2008) 22 (suppl 2) *AIDS* S123-S132.

[69] UNAIDS (note 9 above).

[70] National Council of People Living With HIV/AIDS Tanzania (NACOPHA) *The people living with HIV Stigma Index report Tanzania* (2013) 18 available at http://www.stigmaindex.org/sites/default/files/reports/Tanzania%20STIGMA%20INDEX%20REPORT%20-%20Final%20Report%20pdf.pdf, accessed on 27 August 2016.

reported having lost their jobs in the last 12 months because of their HIV status.[71] In Congo, 15.3% of people living with HIV report to have been denied employment and 6.3% of people living with HIV report discrimination in health care due to their HIV status.[72] Involuntary sterilisation of women living with HIV has been reported in various sub-Saharan African countries, including Namibia, South Africa and Kenya.[73] Other human rights violations often reported in the context of HIV include infringement of confidentiality, violation of informed consent as well as violence and ill-treatment of people living with HIV or vulnerable to or affected by HIV.[74]

1.5 Human rights and HIV paradigm: Current challenges

In addition to the existing HIV-related human rights challenges, two important trends are today leading to greater questioning of rights-based approaches to the epidemic. First, human rights norms and approaches are being challenged in the context of efforts to scale up HIV services. Second, the application of human rights to specific populations at higher risk of HIV infection is being challenged in a context of broader opposition to perceived attempts to 'impose concepts or notions pertaining to … private individual conduct'.[75]

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[71] National Network of Persons Living with HIV in Ghana *Persons living with HIV Stigma Index Study Ghana* (2014) xii available at http://www.stigmaindex.org/sites/default/files/reports/GHANA%20Stigma%20Index%20report%202014.pdf accessed 27 August 2016.

[72] Réseau National des Associations des Positifs du Congo *Index de stigmatisation et de discrimination envers les personnes vivant avec le VIH au Congo : rapport d'enquête* (2015) 27 available at http://www.stigmaindex.org/sites/default/files/reports/Rapport%20final-%20Index%20de%20Stigma%20au%20Congo.pdf, accessed on 26 August 2016.

[73] S Bi & T Klusty 'Forced sterilizations of HIV-positive women: A global ethics and policy failure' (2015) 17(10) *American Medical Association Journal of Ethics* 952-957; African Media and Gender Initiative *Robbed of Choice: Forced and Coerced Sterilization Experiences of Women Living with HIV in Kenya* (2012) available at *http://kelinkenya.org/wp-content/uploads/2010/10/Report-on-Robbed-Of-Choice-Forced-and-Coerced-Sterilization-Experiences-of-Women-Living-with-HIV-in-Kenya.pdf*, accessed on 26 August 2016.

[74] See, among others, AIDS and Rights Alliance for Southern Africa *HIV, TB and human rights in Eastern and Southern Africa: Report 2016* (2016) available at http://www.arasa.info/files/4514/6902/5171/ARASA_AnnualReport2016_-_for_web.pdf, accessed on 26 August 2016.

[75] See African Union, *Decision on the promotion of cooperation, dialogue and respect for diversity in the field of human rights*, Doc. Assembly/AU/17(XV) Add.9, Kampala Summit, 2010, available at *http://www.au.int/en/sites/default/files/decisions/9630-assembly_en_25_27_july_2010_bcp_assembly_of_the_african_union_fifteenth_ordinary_session.pdf*, accessed on 27 August 2016.

1.5.1 HIV responses at a time of scale up: The end of the HIV paradox?

The effectiveness of HAART in treating AIDS was demonstrated in the mid-1990s. HAART was then quickly adopted in developed countries and made available to people living with HIV in those countries. However, the cost of these medicines was prohibitive and less than 100,000 out of the millions living with HIV in sub-Saharan Africa were receiving ART in 2000.[76]

This situation evolved with intense civil society advocacy and global pressure that led to lowering the cost of antiretroviral medicines and also generated increased funding for the global response to AIDS with the establishment of the Global Fund to Fight AIDS, TB and Malaria.[77] In this context, WHO and UNAIDS launched '3 by 5', an initiative to put 3 million people living with HIV in low- and middle-income countries on HIV treatment by 2005.[78] The expected increase in the number of people on antiretroviral treatment was to require new efforts to identify people living with HIV through testing in order to provide them with treatment. As noted by the WHO Director General

> Lack of access to antiretroviral treatment is a global health emergency…To deliver antiretroviral treatment to the millions who need it, we must change the way we think and change the way we act.[79]

Some seized this opportunity to call for more aggressive approaches to HIV testing arguing that the prevailing testing model, based essentially on voluntary testing and counselling –where individuals come forward voluntarily to seek an HIV test – was not suited for the urgency of the HIV epidemic in sub-Saharan Africa. At the centre of these calls was a view that 'AIDS exceptionalism' – which was perceived to elevate individual rights in the context of a public health emergency such as HIV – was no

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[76] UNAIDS (n 6 above).
[77] UNAIDS (n 6 above).
[78] WHO and UNAIDS *Treating 3 million by 2005: Making it happen. The WHO and UNAIDS global initiative to provide antiretroviral therapy to 3 million people with HIV/AIDS in developing countries by the end of 2005* (2003) available at *http://www.who.int/3by5/publications/documents/en/3by5StrategyMakingItHappen.pdf?ua*=1, accessed on 27 August 2016.
[79] Cited in WHO & UNAIDS (note 78 above; 1).

longer warranted.[80] These views supported a return to traditional biomedical and public health approaches, thus turning away from the path set by Mann and others who advocated rights-based responses to HIV.

According to Bayer – who predicted the demise of 'AIDS exceptionalism' a decade earlier – the return to biomedical responses to HIV was inevitable.[81] He stressed that as scientific advances emerged and the effectiveness of treatment was established, public health officials have regained confidence in asserting 'their professional dominance…and the relevance of their own professional traditions to the control of AIDS'.[82] This confidence was manifested in increased calls to change HIV testing guidelines in order to introduce routine or other forms of 'simplified' testing that did not require 'cumbersome' consent and counselling procedures.[83] In the context of sub-Saharan Africa, calls for change further added that human rights considerations of confidentiality and consent in the context of HIV were ill-suited for the magnitude and reality of the epidemic in the region.[84] The most influential charge in favour of 'simplified' forms of HIV testing in sub-Saharan Africa came from Kevin de Cock who was to later become the head of the WHO's HIV Department. In a joint publication, he called for routine diagnostic HIV testing to allow medical practitioners to test any person whom they believed might be at risk of HIV without their consent. In support of this approach, de Cock and his colleagues noted that

> Human-rights based approaches to HIV/AIDS prevention might have reduced the role of public health and social justice, which offer a more applied and practical framework for HIV/AIDS prevention and care in Africa's devastating epidemic.[85]

The debates on the return to traditional public health approaches in the context of

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[80] For a critique of these calls, see F Viljoen & S Precious 'Human rights under threat in attempts to address HIV and AIDS' in F Viljoen & S Precious (eds) *Human rights under threat: four perspectives on HIV, AIDS, and the law in Southern Africa* (2007) 1-13.
[81] Bayer (note 42 above).
[82] Bayer (note 42 above: 1502).
[83] R Bayer & AL Fairchild 'Changing the Paradigm for HIV Testing – The end of exceptionalism' (2006) 355(7) *New England Journal of Medicine* 647-649.
[84] For a critique and discussion of these arguments, see M Crewe & F Viljoen Testing Times, Routine HIV Testing: A Challenge to Human Rights (Unpublished discussion paper prepared for the International HIV Testing Email Discussion Group, 2005); M Heywood 'The routine offer of HIV counselling and testing: A human right' (2005) 8(2) *Health and Human Rights Journal* 13-19.
[85] K de Cock, D Mbori-Ngacha & E Marum 'Shadow on the continent: public health and HIV/AIDS in Africa in the 21st century' (2002) 360 *Lancet* 67-72.

HIV testing were translated in the 2007 WHO/UNAIDS Guidance on provider-initiated HIV testing and counselling in health facilities.[86] While endorsing new forms of HIV testing, including the routine offer of HIV testing, these guidelines seek to strike a balance with human rights by emphasising that

> At the same time as provider-initiated HIV testing and counselling is implemented, equal efforts must be made to ensure that a supportive social, policy and legal framework is in place to maximise positive outcomes and minimise potential harms to patients.[87]

WHO/UNAIDS Guidance on provider-initiated HIV testing and counselling in health facilities further notes that:

> Implementation of provider-initiated HIV testing and counselling must include measures to prevent compulsory testing and unauthorised disclosure of HIV status, and potential negative outcomes of knowing one's HIV status. Potential negative outcomes include discriminatory attitudes of health care providers; financial burden associated with testing and/or unauthorised disclosure of an individual's HIV status resulting in discrimination or violence.[88]

In the end, these WHO/UNAIDS guidelines were taken forward and implemented in the great majority of African countries.[89] As of 2010, some 42 African countries have adopted provider initiated HIV testing and counselling.[90] But, as was expected, little attention has been devoted to creating the enabling conditions for routine HIV testing. As shown in a study on the routine offer of HIV testing in Botswana, important concerns relating to informed consent and confidentiality have emerged following the implementation of this approach to HIV testing.[91]

More recently, the demonstrated prevention benefits of antiretroviral treatment have

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[86] WHO & UNAIDS *Guidance on provider-initiated HIV testing and counselling in health facilities* (2007) available at *http://www.who.int/hiv/pub/guidelines/9789241595568_en.pdf*, accessed on 27 August 2016.
[87] WHO & UNAIDS (note 86 above; 32).
[88] WHO & UNAIDS (note 86 above; 30).
[89] R Baggaley, B Hensen, O Ajose, KL Grabbe, VJ Wong, A Schilsky, Y-R Lo, F Lule, R Granich & J Hargreaves 'From caution to urgency: the evolution of HIV testing and counselling in Africa' (2012) 90 *Bulletin of the World Health Organization* 652-658.
[90] Ibid.
[91] RA Kumar 'Ethical and human rights dimensions in prenatal HIV/AIDS testing: Botswana in global perspective' (2012) 5(1) *South African Journal of Bioethics and Law* 20-26.

also translated in renewed calls for even more aggressive public health approaches involving earlier detection and immediate treatment of people living with HIV.[92] These calls were endorsed in UNAIDS' 90-90-90 targets which urges countries to ensure that by 2020, 90% of those living with HIV know their HIV status, 90% of those who know their HIV status are on ART and 90% of those on ART reach viral suppression.[93] While these targets are laudable for realising the right to health, they also raise key legal and human rights issues and challenges that require attention.[94] In particular, there is a fear that in 'desperate' efforts to reach targets, some countries will resort to coercive approaches or undermine human rights.[95]

In general, charges against human rights and rights-based approaches in the context of HIV are based on the view that current challenges in addressing the epidemic, including low HIV testing, limited access to treatment and unabated rates of new HIV infections are due to the protection of human rights. These assumptions are misguided and deceptive at least for three reasons. First, human rights approaches were central to the early successes in responding to the HIV epidemic, particularly in developed countries where community-led responses enabled the rapid scale up of condoms and safer sex among gay men that resulted in a sharp decrease in new HIV infections.[96] Similarly, human rights norms, arguments and tools have played a significant role in advancing HIV responses, including through challenging government inaction, securing significant reductions in pricing of antiretroviral medication and also by demanding protection and access to HIV and health services

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[92] RM Granich, CF Gilks, C Dye, KM De Cock, BG Williams 'Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model' (2009) 37[illegible]*ancet* 48-57.

[93] UNAIDS *90-90-90: An ambitious treatment target to help end the AIDS epidemic* (2014) available at *http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf*, accessed on 27 August 2016.

[94] D Barr, JJ Amon & M Clayton 'Articulating a rights-based approach to HIV treatment and prevention interventions' (2011) 9 *Current HIV Research* 396-404; S Gruskin, L Ferguson & DO Bogecho 'Beyond the numbers: using rights-based perspectives to enhance antiretroviral treatment scale-up' (2007) 21 (suppl 5) *AIDS* S13-S19.

[95] S Reenie & F Behets 'Desperately seeking targets: the ethics of routine HIV testing in low-income countries' (2006) 84(1) *Bulletin of the World Health Organization* 52-57; Barr, Amon & Clayton (note 94 above).

[96] HB Worth 'HIV does need a special response' (2005) 330 *British Medical Journal* 492.

for the populations most affected by the epidemic.[97]

Second, in most contexts, human rights approaches have not been implemented in the response to HIV beyond rhetorical endorsements and patchwork pilot projects. Data by UNAIDS shows that less than 1% of the $19 billion invested in HIV in 2014 were related to human rights programmes.[98]

Third, human rights provided under global and regional treaties, as well as national constitutions are binding on States, which must ensure that they respect, protect, promote and fulfill them, including in the measures and programmes that they put in place to respond to HIV and other health challenges.[99] While most human rights may be limited on public health grounds, these limitations should be human rights compliant and must be in line with the conditions and circumstances provided under the Siracusa principles on the limitation and derogation provisions in the International Covenant on Civil and Political Rights.[100]

1.5.2 HIV, human rights and key populations: Contested ground

Evidence from across the world, including sub-Saharan Africa, shows high vulnerability to HIV and poor access to HIV services among key populations, particularly young women, men who have sex with men, prisoners, people who inject drugs and sex workers (see section 1.2 above). States have therefore been called to give due consideration to the human rights and access to HIV services for these populations. These calls are made against the background of criminal and other punitive laws in the great majority of African countries that are targeting populations at higher risk of HIV infection, thus increasing their vulnerability to the epidemic. Some 36 countries in sub-Saharan Africa have laws criminalising same-sex sexual

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[97] L London 'What is a human-rig[illegible]based approach to health and does it matter?' (2008) 10(1) *Health and Human Rights* 65-80; M Heywood 'Debunking 'Conglomo-talk': A case study of the amicus curiae as an instrument for advocacy, investigation and mobilisation' (2001) 5(2) *Law, Democracy & Developme*[illegible]33-162.

[98] UNAIDS *Sustaining the human rights response to HIV: Funding landscape and community voices* (2015) available at *http://www.unaids.org/sites/default/files/media_asset/JC2769_humanrights_en.pdf*, accessed on 27 August 2016.

[99] London (note 97 above).

[100] United Nations, Economic and Social Council, Siracusa principles on the limitation and derogation provisions in the International Covenant on Civil and Political Rights, U.N. Doc. E/CN.4/1985/4, Annex (1985).

relations.[101] All countries in the region have laws criminalising some aspects of sex work.[102] Possession of a small amount of drugs for personal use is an offence in almost all sub-Saharan African countries.[103]

Across sub-Saharan Africa, reactions of political, health, social, religious leaders and authorities and the public to calls for human rights protection and access to health services for gay men and men who have sex with men, sex workers and people who inject drugs have been varied. Often, these calls have been met by indifference, silence, rejection, contestation, violence, increased criminalisation and other forms of human rights violations.[104]

Contestations are not new in the context of a deeply political and socially-loaded epidemic such as HIV. The denialism that plagued the early years of the response to AIDS in South Africa,[105] as well as the decades-long opposition to condoms by religious institutions illustrate some of the political debates surrounding the epidemic.[106]

However, current contestations relating to key populations in the response to HIV

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[101] International Lesbian, Gay, Bisexual, Trans and Intersex Association *State sponsored homophobia 2016. A world survey of sexual orientation laws: criminalisation, protection and recognition* (2016) 36 available at *http://ilga.org/downloads/02_ILGA_State_Sponsored_Homophobia_2016_ENG_WEB_150516.pdf*, accessed on 27 August 2016.

[102] UNAIDS *Making the law work for the HIV response: A snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support* (2010) available at http://files.unaids.org/en/media/unaids/contentassets/documents/priorities/20100728_HR_Poster_en.pdf accessed on 27 August 2016.

[103] Harm Reduction International *The Global State of Harm Reduction 2014* (2014) available at https://www.hri.global/files/2015/02/16/GSHR2014.pdf, accessed on 27 August 2016.

[104] See, among others, Heinrich Boll Stiftung 'Struggle for equality: Sexual orientation, gender identity and human rights in Africa' (2010) 4(10) Perspectives; Political analysis and commentary from Africa available at https://www.boell.de/sites/default/files/perspectives_africa_4-2010_struggle_for_equality_lgbti_africa.pdf, accessed on 27 August 2016; R Thoreson & S C (eds) *Nowhere to turn: Blackmail and extortion of LGBT people in sub-Saharan Africa* (2011); M Epprecht 'Sexual minorities, human rights and public health strategies in Africa' (2012) 111(443) *African Affairs* 223-243. In spite of these challenges, progress has also been made in the region in relation to the human rights of LGBT people including through national courts that have asserted the human rights of LGBT people. See Viljoen (note 44 above; 266-267).

[105] See AA Van Niekerk 'Moral and social complexities of AIDS in Africa' in AA van Niekerk & LM Kopelman (eds) *Ethics and AIDS in Africa: the challenge to our thinking* (2005) 58-59; H Marais 'Building: The impact of AIDS in South Africa' (2005) *AIDS Review*.

[106] AA van Niekerk & LM Kopelman (eds) Ethics and AIDS in Africa: the challenge to our thinking (2005); J Chan Politics in the Corridor of Dying: AIDS Activism and Global Health Governance (2015); P Piot *AIDS: Between science and politics* (2015).

involve a new element. They are taking place in a broader global context of the struggle[107] for the recognition and protection of the human rights of several members of these key populations, including lesbian, gay, bisexual and transgender (LGBT) people, people who inject drugs and sex workers. While calls for the protection of sex workers and people who inject drugs in the context of HIV have also intensified in the past few years,[108] the struggle for the protection of LGBT people is arguably the one that best encapsulates the current challenges as well as opportunities for the protection of key populations globally and in sub-Saharan Africa, in particular. It is thus used below to illustrate and discuss the issues involved.

Over the past decade, the protection of the human rights of LGBT people, including their rights to access health and HIV services, have received great attention at global, regional and national levels, including in sub-Saharan Africa. At the global level, important developments have taken place in the UN General Assembly and the UN Human Rights Council.[109] These advances have also unveiled the tensions relating to sexual orientation and gender identity, particularly with sub-Saharan African countries. For instance, in June 2011, the Human Rights Council adopted the first UN resolution on 'human rights, sexual orientation and gender identity'[110] and a follow up resolution on the issue in September 2014.[111] These resolutions were opposed by the great majority of sub-Saharan African countries that are members of the Human Rights Council.[112] Of the 13 African States that are members of the

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[107] C Heyns 'The struggle approach to human rights' in A Soeteman (ed) *Pluralism and law* (2001) 171-190.

[108] Global Commission on HIV and the Law *HIV and the law: Risks, rights and health* (2012); M Decker, A-L Crago, SKH Chu, SG Sherman, MS Seshu, K Buthelezi, M Dhaliwal & C Beyrer 'Human rights violations against sex workers: burden and effect on HIV' (2015) 385 *Lancet* 186-199; Jurgens, Csete, Amon, Baral & Beyrer (note 21 above).

[109] S Kara 'Norms, case law and practices relevant to sexual orientation, gender identity and intersex status in the United Nations system' in Centre for Human Rights *Ending violence and other human rights violations based on sexual orientation and gender identity: A joint dialogue of the African Commission on Human and Peoples' Rights, Inter-American Commission on Human Rights and United Nations* (2014) 64-78.

[110] Human Rights Council *Resolution 17/19 Human rights, sexual orientation and gender identity* (A/HRC/RES/17/19) 17 June 2011.

[111] Human Rights Council *Resolution 27/32 Human rights, sexual orientation and gender identity* (A/HRC/RES/27/32) 26 September 2014.

[112] Both resolutions called for reports by the High Commissioner for Human Rights that were considered by the Human Rights Council. Kara (note 109 above). In addition to the Resolutions and reports by the High Commissioner on Human Rights on sexual orientation and gender identity, the Human Rights Council has also addressed the issues in the context of the Universal Periodic Review.

Human Rights Council, only two (South Africa and Mauritius) voted in favour of the 2011 resolution and only one (South Africa) voted in favour of the 2014 Resolution.[113]

In 2016, the Human Rights Council adopted a resolution establishing an independent expert on protection against violence and discrimination based on sexual orientation and gender identity.[114] The adoption of this resolution illustrated the great global divide in relation to sexual orientation and gender identity. Of the 13 African members of the Human Rights Council, none voted in favour of the resolution.[115] Nine African States voted against and four abstained.[116] Even South Africa, the only country in sub-Saharan Africa that explicitly recognises sexual orientation and gender identity as a ground for non-discrimination in its Constitution abstained, allegedly in reaction to the methods and approaches of the sponsors of the resolution.[117]

Similarly, these contestations are increasingly manifested in the context of global negotiations of HIV-related technical and political agreements that address gay men, men who have sex with men and other key populations. This was notably the case in relation to the 2016 High Level Meeting on AIDS and its ensuing Political Declaration on HIV and AIDS which was 'dismissed' by several civil society organisations for allegedly failing to prominently address the legal challenges faced by key

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Issues relating to discrimination and other human rights violations based on sexual orientation and gender identity have been raised in relation of many sub-Saharan African countries. Specific recommendations have been made to these countries. In general, these recommendations have been rejected by the countries concerned. However, as of October 2015, some 36 recommendations on on sexual orientation and gender identity issued as part of the Universal Periodic Review have been accepted in relation to areas such as investing attacks and threats, protecting LGBT and intersex human rights defenders, and responding to violence and discrimination based on sexual orientation and gender identity. Kara (note 109 above; 77).

[113] See Human Rights Council (notes 110 & 111 above).

[114] OHCHR 'Council establishes mandate on protection against violence and discrimination based on sexual orientation and gender identity' 30 June 2016 available at *http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20220*, accessed on 27 August 2016.

[115] Ibid.

[116] Ibid.

[117] The explanation provided by the South African Ambassador before the vote noted that the draft resolution was created 'unnecessary divisiveness' and the approach to its adoption was 'arrogant'. As a result, South Africa did not support the resolution and abstained. OHCHR (note 114 above).

populations.[118]

At the regional level in Africa, political and human rights bodies have also made pronouncements on sexual orientation and gender identity or have been called to do so. For instance, the African Union expressed concerns on the application of human rights in relation to sexual orientation and gender identity during its Kampala Summit in 2010. Without explicitly referring to sexual orientation or gender identity, the Summit adopted a decision that 'strongly' rejected

> any attempt to undermine the international human rights system by seeking to impose concepts or notions pertaining to social matters, including private individual conduct, that fall outside the internationally agreed human rights legal framework, taking into account that such attempts constitute an expression of disregard for the universality of human rights.[119]

In 2014, the African Commission on Human Rights adopted a resolution on ending violence, discrimination and other human rights violations based on sexual orientation and gender identity.[120] In a preceding resolution relating to the establishment of a Committee on the protection of the rights of people living with HIV and those at risk, vulnerable to and affected by HIV, the African Commission also explicitly referred to men who have sex with men and to other key populations as being covered under the mandate of this Committee.[121] However, the protracted and challenging process relating to the granting of observer status to the Coalition of African Lesbian (an NGO) by the African Commission illustrates the present struggles for the protection of the human rights of LGBT people within the African

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[118] See, for instance, Global Forum for MSM & HIV 'A High-Level Failure for the United Nations on Key Populations' 8 June 2010 available at *http://msmgf.org/gay_men_transgender_people_and_sex_workers_express_outragemsmgf-expresses-outrage-unacceptably-weak-political-declaration-adopted-today-united-nations-high-level-meeting-ending-aids/#ixzz4ldO267wc*, accessed on 27 August 2016.

[119] African Union (note 75 above).

[120] African Commission on Human and Peoples' Rights *Resolution 275 on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity*, adopted at the 55th Ordinary Session of the African Commission on Human and Peoples' Rights in Luanda, Angola, 28 April - 12 May 2014.

[121] African Commission on Human and Peoples' Rights *Resolution 163 on the Establishment of a Committee on the protection of the rights of people living with HIV and those at risk, vulnerable to and affected by HIV*, 47th Ordinary Session, Banjul, The Gambia, 26 May 2010.

regional human rights system.[122]

At national levels, developments and challenges have also been noted in relation to the human rights of LGBT people, with differences across countries in terms of the intensity, approaches and actors involved.[123] In spite of these differences, some elements are worth noting in terms of their relation to health and HIV.

First, HIV stakeholders, including national AIDS Commissions and ministries responsible for health in a number of countries, are engaging LGBT people and members of other key populations and showing various degrees of support for their protection and access to health services.[124] These involve the inclusion of representatives of LGBT people and other key populations in national HIV bodies such as Country Coordinating Mechanisms established under the architecture for oversight of grants provided by the Global Fund to Fight HIV, Tuberculosis and Malaria; the explicit reference to the needs and concerns of these populations in national HIV documents; and more recently the establishment of programmes in some countries to address the health and HIV needs of key populations.[125] Policy and funding requirements from HIV donors and technical agencies as well as the demands of civil society organisations representing gay men and men who have sex

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[122] For a discussion on the granting of observers status to the Coalition of African Lesbians, see Viljoen (note 11 above); Viljoen (note 44 above; 266-267). For a general description of the developments relating to sexual orientation and gender identity within the African human rights system, see F Viljoen 'Norms, case law and practices relevant to sexual orientation and gender identity in the African human rights system' in Centre for Human Rights (note 109 above; 29-42), and S Ndashe 'Seeking the protection of LGBTI rights at the African Commission on Human and Peoples' Rights' (2011) 15 *Feminist Africa* 17.

[123] See, among others, AM Ibrahim 'LGBT rights in Africa and the discursive role of international human rights law' (2015) 15 *African Human Rights Law Journal* 263-281; Heinrich Boll Stiftung (note 14 above); Thoreson & Cook (note 104 above); R Schafer & E Range *The Political use of homophobia: Human rights and persecution of LGBTI activists in Africa* (2014) available at *http://library.fes.de/pdf-files/iez/10610.pdf*, accessed on 26 August 2016.

[124] Epprecht (note 104).

[125] A Kageni, L Mwangi, C Mugyenyi & K Macintyre *Representation and participation of key populations on Country Coordinating Mechanisms (CCMs) in six countries in Southern Africa: final report* (2015), available at http://www.aidspan.org/publication/representation-and-participation-key-populations-country-coordinating-mechanisms-ccms, accessed on 26 August 2016; African Men for Sexual health and Rights (AMSHeR), African Sex Worker Alliance (ASWA), GenderDynamiX and TransBantu Association Zambia *African key populations' engagement with global health financing institutions: A rapid review* (2016); K Makofane, C Gueboguo , D Lyons & T Sandfort 'Men who have sex with men inadequately addressed in African AIDS national strategic plans' (2013) 8(2) *Global Public Health* 129-143; EJ Sanders, H Jaffe, H Musyoki, N Muraguri & SM Graham 'Kenyan MSM: no longer a hidden population' (2015) 29 (Suppl 3) *AIDS* S195-S199.

with men are among the reasons for these advances.[126]

Second, progress in the recognition, representation, protection and access to HIV services for LGBT people and other key populations in many sub-Saharan African countries remains symbolic and fragile. Political, religious and moral motivations conflated with claims of imposition of foreign sexual norms and behaviours are still used to contest the application of human rights to these populations and are invoked to justify coercive approaches against them. Throughout the region, this is illustrated by multiple cases of discrimination, violence, harassment, denial of health care services and other human rights violations towards LGBT people and other key populations.[127]

In Malawi, Uganda and Nigeria, the contestation of the human rights of LGBT people and its implication in the context of health and HIV were particularly illustrative of the challenges facing the HIV response. The arrest, prosecution and sentencing of a gay couple (Malawi in 2009-2010),[128] and the introduction of new legislation to increase penalties for same sex sexual relations, and to criminalise support to LGBT people or individuals or to prohibit same-sex sexual marriages (Uganda and Nigeria in 2014)[129] have put HIV actors in the frontline of justice demands for LGBT people.

In these three countries, civil society organisations working on the health and human rights of gay men and men who have sex with men were at the forefront of the challenges against these laws.[130] Civil society used the language and evidence of HIV, particularly data and research on the negative health and HIV impact of criminalisation, detention and other punitive laws against men who have sex with

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[126] Ibid.

[127] 25.

[128] L Price 'The treatment of homosexuality in the Malawian justice system: R v Steven Monjeza Soko and Tiwonge Chimbalanga Kachepa' (2010) 10 *African Human Rights Law Journal* 524-533.

[129] F Karimi & N Thompson 'Uganda's President Museveni signs controversial anti-gay bill into law' CNN 25 February 2014 available at *http://edition.cnn.com/2014/02/24/world/africa/uganda-anti-gay-bill/*, accessed on 27 August 2016; 'Nigeria anti-gay laws: Fears over new legislation' BBC News 14 January 2014, available at *http://www.bbc.com/news/world-africa-25728845*, accessed on 27 August 2016.

[130] See, for instance, G Mandera & D Smith 'Human rights campaigners attack Malawi gay couple conviction' *The Guardian* 18 May 2010 available at *https://www.theguardian.com/world/2010/may/18/malawi-gay-couple-jailed*, accessed on 27 August 2016.

men to demand the release of those arrested and the removal of the new laws.[131] Other civil society organisations working on general advocacy for the human rights of LGBT people in these countries also used similar HIV and health arguments.[132] Bilateral and multilateral donors involved in the HIV response as well as global public health institutions such as UNAIDS referred to the same arguments in their calls for freeing those arrested and for removing the new criminal laws.[133]

The above developments and challenges illustrate the complex political, social and legal environments relating to the human rights and health of key populations in sub-Saharan Africa. These challenges together with intensifying calls for a return to biomedical responses to HIV represent serious threats to the human rights-based approach to the epidemic. Understanding and addressing these manifestations of contestation of human rights in the context of HIV and their impact should be a priority for HIV actors. Thus far, limited critical and strategic reflections have been undertaken by HIV actors, academics and researchers working on HIV in relation to these issues.[134] The 'legitimacy' and continued reliance on the language and tools of human rights in the response to HIV will require responses to these threats. Failure to do so might compromise the future of rights-based responses in the context of HIV

[131] SR Schwartz, RG Nowak, I Orazulike, B Keshinro, J Ake, S Kennedy, O Njoku, WA Blattner, ME Charurat & SD Baral 'The immediate effect of the Same-Sex Marriage Prohibition Act on stigma, discrimination, and engagement on HIV prevention and treatment services in men who have sex with men in Nigeria: analysis of prospective data from the TRUST cohort' (2015) 2(7) *Lancet HIV* e299-e306; P Semugoma, C Beyrer, S Baral 'Assessing the effects of anti-homosexuality legislation in Uganda on HIV prevention, treatment, and care services' (2012) 9(3) *SAHARA-J: Journal of Social Aspects of HIV/AIDS* 173-176.

[132] See, for instance, Amnesty International *'Rule by Law': Discriminatory legislation and legitimized abuses in Uganda* (2014) available at https://www.amnesty.org/en/documents/AFR59/006/2014/en/, accessed on 28 August 2016; Human Rights Watch and Amnesty International 'Uganda: Anti-Homosexuality Act's heavy toll. Discriminatory law prompts arrests, attacks, evictions, flight' 14 may 2014 available at *https://www.hrw.org/news/2014/05/14/uganda-anti-homosexuality-acts-heavy-toll*, accessed on 28 August 2016.

[133] See, for instance, UNAIDS 'UNAIDS expresses serious concern over ruling in Malawi' 20 May 2010 available at *http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2010/may/20100520psmalawi*, accessed on 28 August 2016; UNAIDS 'UNAIDS expresses concern over proposed 'Anti-Homosexuality Bill' in Uganda' 10 may 2011 available at *http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011/may/20110510psuganda*, accessed on 28 August 2016.

[134] While some research has been conducted in recent years on the above challenges and their political implication for the HIV response, these existing studies do not appear to fully articulate and offer approaches for addressing the fundamental challenges that these developments represent to the AIDS response. D Altman & K Buse (eds) *Thinking politically about HIV* (2014); K Buse, C Dickinson & M Sidibé 'HIV: know your epidemic, act on its politics' (2008) 101(12) *Journal of the Royal Society of Medicine* 572-573.

and of health, more broadly.

1.6 HIV-specific laws and human rights

In all sub-Saharan African countries, there are several general laws that could be interpreted and invoked to ensure the protection of people living with HIV and those vulnerable to the epidemic. These include constitutional provisions prohibiting discrimination on grounds of health or other statuses.[135] Similarly, employment legislation guaranteeing equality and fairness could be applied to HIV-related issues in the workplace.[136] Beyond these general laws, many countries in sub-Saharan Africa have adopted HIV-specific legislation to address the legal issues raised by the HIV epidemic.

1.6.1 The proliferation of HIV-specific laws

HIV-specific laws or 'omnibus HIV legislation' are legislative provisions that regulate, in a single document, several aspects of HIV including HIV-related education and communication; HIV testing, prevention, treatment, care and support; HIV-related research; and non-discrimination based on HIV status.[137] As of July 2014, some 27 countries in sub-Saharan Africa have adopted such HIV-specific laws.[138]

Three inter-related factors seem to have generated the impetus for HIV-specific legislation in sub-Saharan Africa. First, the drive for legislating on HIV in Africa and in other regions, originates from the broad recognition that the law and, legislation in particular, can play an important role in the response to HIV. The law is considered, in the context of HIV, to be a structural tool that can help shape individual attitudes and behaviour, and orient the manner in which States respond to the issues and challenges posed by the epidemic.[139]

Second, HIV-specific laws have the advantage of expediency. They offer the

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[135] AIDS and Human Rights Research Unit (note 53 above).
[136] Ibid.
[137] P Eba 'One size punishes all: A critical appraisal of the criminalisation of HIV transmission or exposure through HIV-specific laws in sub-Saharan Africa' (2008) *AIDS Legal Quarterly* 1.
[138] PM Eba 'HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis' (2015) *African Human Rights Law Journal* 224-262.
[139] See J Hamblin 'The role of the law in HIV/AIDS policy' (1991) 5(Suppl 2) *AIDS* s239-s243.

possibility, in a single piece of legislation, to address several aspects of HIV, as opposed to the challenges and delays inherent to the drafting, introduction through parliament, debate and eventual voting on a multitude of legislative texts dealing with aspects of HIV.

Third, calls for a legal response to HIV found fertile ground in sub-Saharan Africa – the region of the world that is most affected by HIV. For policy makers in the region, adopting HIV-specific legislation illustrates political and societal commitment to addressing the epidemic.[140] It is not surprising that sub-Saharan Africa has become the region of the world that is 'most legislated' in the context of HIV.[141]

In some countries such as South Africa, Lesotho and Botswana, calls to legislate on HIV did not lead to the adoption of HIV-specific laws, but have rather resulted in the reform of particular aspects of existing legislation to cover new issues raised by the HIV epidemic.[142] In South Africa, the Law Reform Commission has conducted a series of analyses of national laws relevant to HIV which identified existing legislation that needed revision to better respond to HIV and protect human rights.[143]

The recourse to HIV-specific legislation in sub-Saharan Africa is a rather recent phenomenon. The first HIV-specific legislation on HIV on the continent was adopted in 2004 in Angola.[144] However, it is the adoption on 11 September 2004 of the Model Law on HIV in West Africa that would transform the legislative landscape on HIV in the region and, most specifically, in West and Central Africa.[145] This Model Law is generally known as the N'Djamena Model Law in reference to the capital of Chad, where it was adopted. Five years following the adoption of the N'Djamena Model Law, some 15 countries in West and Central Africa had adopted HIV-specific

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[140] R Pearshouse 'Legislation contagion: The spread of problematic new HIV laws in Western Africa' (2007) 12 *HIV/AIDS Policy and Law Review* 1-12

[141] Ibid.

[142] Eba (note 138 above; 226).

[143] Under its project 85, the South African Law Reform Commission considered various legal issues relating to HIV including discrimination in schools, the criminalisation of HIV exposure or transmission, compulsory HIV testing of alleged sexual offenders. The reports of the Commission are available at *http://www.justice.gov.za/salrc/dpapers.htm*, accessed on 28 August 2016.

[144] See Lei No 8/04 sobre o Virus da Immunodeficiência Humana (VIH) e a Sindroma de Immunodeficiência Adquirida (SIDA) of Angola.

[145] Eba (note 138 above).

legislation broadly based on its provisions.[146] This Model Law also influenced the adoption of HIV-specific laws in other African sub-regions.[147] Serious concerns have been raised about the provisions of this Model Law and its embrace of coercive measures.[148]

In Southern Africa, the Parliamentary Forum of the Southern African Development Community (SADC PF) initiated in 2007 a process to develop a model legislation on HIV for countries in the region.[149] The development of the model law involved members of parliament, civil society organisations, HIV experts, human rights advocates and members of the judiciary.[150] The final model legislation was adopted in November 2008 in Arusha, Tanzania and has been heralded as a rights-based and evidence-informed instrument for legislating on HIV.[151] The model law is used by actors in the region as a yardstick to influence the development of HIV related legal and policy norms.[152]

In the East African Community (EAC) – an intergovernmental organisation comprising Burundi, Kenya, Tanzania, Rwanda and Uganda – a regional legislation on HIV came into force in 2015.[153] The law was adopted by the East African Legislative Assembly (EALA) following a process initiated and supported by civil society organisations working on HIV in an attempt to respond to the provisions of concern in their national HIV laws.[154] Under the EAC Treaty, laws passed by EALA and assented to by all heads of States of the five community countries take

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[146] Ibid.
[147] See D Grace *This is not a law: Th…nsnational politics and protest of legislating an epidemic* (unpublished PhD Thesis), available at https://dspace.library.uvic.ca:8443/handle/1828/3944?show=full (accessed on 3 November 2013).
[148] Pearhous… note 140 above); Grace (note 147 above); Eba (note 137 above).
[149] F Viljoen 'Model legislation and regional integration: Theory and practice of model legislation pertaining to HIV in the SADC' (2008) *De Jure* 383-398.
[150] R Johnson 'The Model law on HIV in Southern Africa: Third World approaches to international law insights into a human rights-based approach' (2009) 9(1) *African Human Rights Law Journal* 120-159.
[151] Ibid.
[152] Ibid.
[153] ICW Weekly Bulletin 'The East African Partner States Assent to the East Africa HIV and AIDS Prevention and Management Bill, 2012' 27 October 2015 available at http://www.iamicw.org/CampaignProcess.aspx?A=View&Data=UmSlGuoOqWuJHK8E06yawQ%3d%3d, accessed on 27 August 2016.
[154] EALA 'EALA passes regional Bill on HIV and AIDS' 23 April 2012, available at *http://www.eala.org/media/view/eala-passes-regional-bill-on-hiv-and-aids*, accessed 27 August 2016.

precedence over national legislation in the same area.[155]

1.6.2 Human rights concerns in HIV-specific laws

In most countries where they have been adopted, HIV-specific laws were often intended to express the commitment to the protection of the rights of people living with HIV. This 'commitment' to human rights is generally proclaimed in HIV-specific laws. For instance, the preamble of the HIV law of Guinea Bissau states that its objective is to *'ensure that every person living with HIV or presumed to be living with HIV enjoys the full protection of his or her human rights and freedoms'*.[156] Similar proclamations of intent can be found, among others, under section 3 of the HIV law of Kenya,[157] and article 1 of the HIV law of Madagascar[158].

The normative content of HIV-specific legislation confirms some attention to human rights and the protection of people living with HIV in these laws, through provisions that, among others, prohibit HIV-related discrimination, affirm the right of people living with HIV to access health and other services, set principles and conditions on the right to confidentiality and autonomy, and spell out the nature and content of HIV prevention, treatment and care services to be provided in the country.[159]

However, a careful review of HIV-specific laws in sub-Saharan African countries shows that in many instances they raise serious human rights concerns.[160] First, all HIV-specific laws adopted across sub-Saharan Africa also contain, alongside their rights-proclaiming provisions, other provisions that restrict the rights of people living

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[155] Article 8(4) & (5) of the Treaty for the Establishment of the East African Community available at *http://www.eac.int/sites/default/files/docs/treaty_eac_amended-2006_1999.pdf*, accessed on 28 August 2016.

[156] See *Lei No 5/2007 de prevençao, tratamento e controle do VIH/SIDA* of Guinea Bissau (unofficial translation).

[157] HIV Prevention and Control Act of Kenya, No 14 of 2006.

[158] Loi No 2005-040 du 20 Février 2006 sur la lutte contre le VIH/SIDA et la protection des droits des personnes vivant avec le VIH/SIDA of Madagascar.

[159] Eba (note 138 above).

[160] For a discussion of the criticisms laid against HIV-specific laws in sub-Saharan Africa, see, among others, Pearshouse (note 140 above), Pearshouse 'Legislation contagion: building resistance' (2008) 13(2/3) *HIV/AIDS Policy & Law Review* 1-11, Irinnews 'Africa: Terrifying' new HIV/AIDS laws could undermine AIDS fight' 7 August 2008 available at *http://www.irinnews.org/report/79680/africa-terrifying-new-hiv-aids-laws-could-undermine-aids-fight*, accessed on 28 August 2016; Irinnews 'West Africa: HIV law 'a double-edged sword''1 December 2008, available at *http://www.irinnews.org/report/81758/west-africa-hiv-law-a-double-edged-sword*, accessed on 28 August 2016.

with HIV or endorse some forms of coercive measures in responding to the epidemic.[161] This is the case, for instance, regarding provisions that institute compulsory HIV testing, allow for denial of access to HIV education for adolescents, or introduce overly-broad criminalisation of HIV non-disclosure, exposure and transmission.[162] Second, the great majority of HIV-specific laws have failed to address the human rights challenges faced by members of key populations at higher risk of HIV infection, particularly men who have sex with men, sex workers and people who inject drugs.[163] Third, concerns have been raised about the process for the adoption of HIV-specific laws and the lack of (or minimal) consultation with HIV stakeholders, particularly civil society organisations, people living with HIV and members of key populations.[164] In some countries, intense advocacy on these concerns has led to the revision of some aspects of HIV-specific laws.[165]

Although more than half of the countries in sub-Saharan Africa have introduced HIV-specific laws, limited academic research has been devoted to them. Existing studies on HIV-specific laws in sub-Saharan Africa can broadly be summarised into two categories. The first category relates to studies published in the wake of the adoption by several West African States of HIV-specific laws based on the N'Djamena model law.[166] The second category of research is comprised of a handful of studies that analyse some aspects of HIV-specific laws, particularly provisions criminalising HIV exposure and transmission.[167] In addition to these two main categories, there is also a small number of publications that address the process, nature and politics of HIV-specific legislation-making through the analysis of model legislation in West and

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[161] Ibid.

[162] P Sanon, S Kaboré, J Wilen, SJ Smith & J Galvão 'Advocating prevention over punishment: the risks of HIV criminalization in Burkina Faso' (2009) 17(34) *Reproductive Health Matters* 146-153; C Kazatchkine 'Criminalizing HIV transmission or exposure: the context of francophone West and Central Africa'(2010) 14(3) *HIV/AIDS Law and Policy Review* 1-11.

[163] Canadian HIV/AIDS Legal Network *A human rights analysis of the N'Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo* (2007) available at *http://sagecollection.ca/fr/system/files/ln_humanrtlegislnrvw_en_0.pdf*, accessed on 28 August 2016.

[164] Grace (note 147 above).

[165] This was the case in Guinea (2009), Togo (2010) and Sierra Leone (2011).

[166] See notably Pearshouse (note 140 above); Pearshouse (note 169); Canadian HIV/AIDS Legal Network (note 163).

[167] See, among others, D Grace 'Criminalizing HIV transmission using model law: troubling best practice standardizations in the global HIV/AIDS response' (2015) 25(4) *Critical Public Health* 441-454; Eba (note 137 above); Sanon (note 162 above); Kazatchkine (note 162 above).

Central Africa and in the Southern Africa.[168] While important to understanding some of the questions around the process and content of HIV-specific laws, existing studies are not sufficient to obtain a complete insight into the rationale for structure and normative content of these laws. The comprehensive analysis of the content of HIV-specific laws offered in this thesis is therefore needed to fully appreciate their extent and strength of human rights protections and challenges in these laws.

1.6.3 The question of implementation and enforcement of HIV-specific laws

More than a decade after the first HIV-specific laws come into force there has been very limited evidence on their effective implementation and enforcement. Qualitative studies conducted among people living with HIV in some of the countries that have adopted HIV specific laws suggest challenges relating to the implementation and enforcement of these laws.[169] Surveys also indicate little knowledge of the laws among people living with HIV who are arguably among the primary beneficiaries of these laws.[170] In many cases, regulations, directives and other measures that are critical to ensuring the effective implementation of these laws have not been adopted.[171]

These challenges in the implementation and enforcement of HIV-specific laws are both concerning and surprising. In fact, the importance of implementation was one of the main arguments together with certainty and clarity that motivated the adoption of these laws in the first place. It was argued that having HIV-specific laws would ensure that their norms were known, better implementated, and that such laws would facilitate and encourage monitoring as opposed to the difficulties that would have been inherent to the implementation of multiple pieces of legislation relating to HIV.[172]

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[168] See Grace (note 147 above); D Grace 'Legislative epidemics: The role of model law in the transnational trend to criminalise HIV transmission' (2013) 39(2) *Medical Humanities* 77-84; Viljoen (note 149 above); Johnson (note 150 above).
[169] PM Eba 'Towards smarter HIV laws: considerations for improving HIV-specific legislation in sub-Saharan Africa' (2016) 24 *Reproductive Health Matters* 178-184.
[170] Ibid.
[171] Ibid.
[172] Eba (note 137 above).

Understanding the issues and challenges relating to the implementation of HIV-specific laws is important because the mere adoption of HIV-specific laws – even with the most protective provisions – is not sufficient to create the 'enabling environment' called for by the promoters of laws in the context of HIV.[173]

This thesis notes that although related, the notions of implementation and enforcement have distinct meanings. Implementation is a broad term that refers to all the processes, actors, mechanisms and rules by which laws or policies are put into effect.[174] Enforcement is an element of implementation which refers to the methods (judicial or non-judicial) that are employed to ensure compliance with the law or policy.[175] This thesis refers mostly to implementation as the broader term and addresses enforcement only in specific instances where discussing issues pertinent to compliance with legal provisions. In particular, the thesis focused on intrinsic factors that influence legislative implementation. These are factors that emerge directly from the provision of the law under consideration and are related to the quality of its normative content (see 1.7.3 below for a discussion on intrinsic and extrinsic factors of legislative implementation).

1.7 Objectives, research questions, premise, methodology, limitations and structure of the thesis

1.7.1 Objectives

This thesis aims to contribute to the literature on the role of the law and human rights norms in the response to HIV in subs-Saharan Africa. It endeavours to do so by reflecting on the application of human rights in the context of HIV at a time of increased calls for accelerating biomedical responses to HIV and of contestation on the human rights of key populations; by applying this framework in the context of prisons and to Ebola; by providing a comprehensive human rights analysis of the normative content of HIV-specific laws in sub-Saharan Africa and the intrinsic challenges affecting their implementation; by reflecting on the role of civil society in

[173] Eba (note 169 above).
[174] J-E Lane 'The Concept of Implementation' (1983) 86 *Statsvetenskaplig tidskrift* 17-40.
[175] GJ Stigler, G. J 'The optimum enforcement of laws' in GS Becker & WM Landes (eds) *Essays in the economics of crime and punishment* (1974) 55-67.

the context of HIV-related legislative development and implementation; and by making proposals for developing 'smarter' HIV-related legislation and for creating legal environments that effectively advance the response to HIV. Accordingly, the specific objectives of the thesis are the following:

(i) Reflect on the role of the law and human rights in the response to HIV as well as recent challenges confronting rights-based responses in the context of the epidemic.

(ii) Use the normative framework, language and tools of human rights laws to analyse the vulnerability to HIV and barriers to effective HIV prevention, treatment and care in prisons, as well as to critique responses to the outbreak of the Ebola in West Africa in 2014-2015.

(iii) Develop a theoretical framework for assessing and reviewing intrinsic challenges in HIV-related legislation and applying it to HIV-specific laws.

(iv) Analyse and interrogate the effectiveness of the HIV Tribunal of Kenya as a mechanism for ensuring the implementation of the HIV-related legislation and for the protection of human rights in the context of HIV.

(v) Analyse and critique the role of civil society organisations in the development and challenging of HIV-specific legislation.

(vi) Contribute towards the development of considerations for improving the normative content and likelihood of effective implementation of HIV-specific and other HIV-related or health legislation.

1.7.2 Research questions

The study investigates four key research questions. The first is: How do human rights norms apply to and guide responses to vulnerability to HIV and barriers to access HIV services? This question is answered (a) by describing and reflecting on the development and challenges to the human rights framework in the context of HIV as was done in this introduction chapter, and (b) by using human rights norms, tools and approaches to discuss HIV in prisons and to critique coercive approaches to the outbreak of the Ebola in West Africa.

The second research question is: To which extent do HIV-specific laws adopted in sub-Saharan Africa reflect human rights norms and best available public health recommendations on HIV? This question is addressed by providing a comprehensive analysis of the normative content of 26 out of the 27 HIV-specific laws that have been adopted in sub-Saharan Africa as of July 2014.[176] Key provisions in these laws are assessed against rights-based and evidence informed recommendations.

The third research question is: Does the process of HIV-specific laws and their normative provisions appropriately address intrinsic issues that influence the effective implementation of legislation? In other words, does the process and content of these laws reflect the principles and approaches of 'smarter' legislation? This research question is addressed (a) by describing the notion and principles of 'smarter' legislation and systematically applying them to 26 HIV-specific laws in sub-Saharan Africa, and (b) by presenting and discussing the HIV Tribunal of Kenya as an example of a mechanism for implementing and enforcing HIV related human rights.

The fourth research question is: What has been the role of civil society organisations in the development and implementation of HIV-specific laws in sub-Saharan Africa? This question is specifically addressed by describing and reflecting on the role of civil society organisations in challenging the N'Djamena model law and in supporting the development and adoption of the East African Community HIV and AIDS Prevention Management Act 2012.

It should be noted that the purpose and approach of this thesis is not to provide definitive or exhaustive responses to all the questions above. The thesis responds to the second and third research questions by offering comprehensive analyses of 26 HIV-specific laws in sub-Saharan Africa. However, in relation to the first and fourth research questions, it provides critical contributions and reflections that highlight key human rights considerations involved and raises areas that may require further research.

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[176] For this thesis, the author has set the date of 31 July 2014 as cut-off date for inclusion of HIV specific laws in the analysis. However, for the article on independent access to HIV services for children (Chapter Six), an amended version of the HIV law of Mozambique adopted in August 2014 was included. For more, see methodology (Chapter Two).

1.7.3 Central premises of the thesis

This thesis is built on three central premises. First, it subscribes to the proposition that effective legislative responses to HIV are those that are based on human rights and grounded in sound public health evidence. Upholding human rights norms in the context of HIV advances the structural role of the law as a tool for addressing vulnerability to disease and for removing barriers to accessing HIV and health services. Equally, sound medical and public health evidence ensures the legitimacy and effectiveness of the legal measures in achieving their goals of supporting the response to HIV.

Second, this thesis is also premised on the position that ensuring rights-based and evidence informed HIV-related laws is critical to their effective implementation, because the normative content of laws directly impacts on whether and how they are implemented. This premise is informed by publications relating to policy and legislative implementation literature which link effective implementation to normative policy content. [177] The thesis also subscribes to the view that legislative implementation is ultimately influenced by two sets of distinct yet interrelated factors, namely intrinsic and extrinsic factors.[178] Extrinsic or socio-ecological factors involve a mix of social, political, economic, financial, administrative and other elements that are specific to a particular country or context and that directly or indirectly influence whether and how legislation is implemented.[179] These factors are generally not found in the law or policy itself and include issues such as the political system of the states (whether federal or unitary); the nature of legal or legislative tradition (common law or civil law); human and technical resources available for implementations including the nature, strength of agencies tasked with implementation or courts responsible for enforcement; financial resources; and the general political situation in the country,

[177] See H Ingram & A Schneider 'Improving implementation through framing smarter statutes' (1990) 10(1) *Journal of Public Policy* 67-88.
[178] PA Sabatier & DA Mazmanian 'The conditions of effective implementation: A guide to accomplishing policy objectives' (1979) 5(4) *Policy Analysis* 481-504; PJ May & SC Winter 'Politicians, managers, and street-Level bureaucrats: Influences on policy implementat (2009) 19(3) *Journal of Public Administration Research and Theory* 453-476; PD Jacobson & J Wasserman 'The implementation and enforcement of tobacco control laws: policy implications for activists and the industry' (1999) 24(3) *Journal of Health Politics, Policy and Law* 567–598.
[179] Ibid.

including factors such as political or social unrest or conflict.[180] Intrinsic factors, on the other hand, are those that emerge directly from the provision of the law or policy under consideration.[181] Intrinsic factors that influence implementation and enforcement are those that relate to the quality of the normative content of the law.[182] While recognising that effective implementation in all contexts depends on a combination of these intrinsic and extrinsic factors, this study focuses on describing and addressing intrinsic factors.

Third, this thesis underscores that the application of human rights in the context of an epidemic with deep social, legal and moral implications such as AIDS is an imminently political issue. Even more, legislating on such an issue is poised to bring to bear significant differences relating to social values, protection, access to social goods and the reach of public control in relation to the epidemic that may sometime be impermeable to public health evidence or human rights arguments. This thesis therefore calls for 'thinking more politically' about HIV and human rights and about HIV-related legislation.[183] It highlights considerations that may guide actors involved in supporting law making or law reform in the context of HIV and other similar public health challenges.

1.7.4 Overview of methodology

This study combines desk review and qualitative research. The desk study involved a comprehensive and systematic analysis of 26 out of the 27 HIV-specific laws that have been adopted in sub-Saharan Africa as of July 2014. In addition, the desk study also researched existing literature on human rights and law-making and implementation and their application in the context of HIV.

The qualitative research used in this study consisted of a series of interviews with key informants conducted in Nairobi, Kenya from 20 to 29 August 2014. The interviews focused on the development of the HIV Prevention and Control Act 2006 of Kenya as well as on the composition and practice of the HIV Tribunal which was

[180] Ibid.
[181] Ingram and Schneider (note 177 above).
[182] Ibid.
[183] Altman & Buse (note 134 above).

established under this law. Chapter Two of the thesis provides a detailed description of the methodology used in this study.

1.7.5 Limitations

Three limitations to the study are worth noting. First, the study focuses solely on HIV-specific legislation and leaves out other relevant legislation that may apply to HIV. A key reason that explains the focus on HIV-related legislation is that these laws exist in a majority of countries in sub-Saharan Africa yet little is known of the full normative content of these laws and the issues that affect their implementation.

Second, the analysis of factors that prevent implementation in this study focuses only on intrinsic factors of legislation implementation. While acknowledging that implementation and enforcement of legislation depend on both intrinsic and extrinsic factors, this study focuses primarily on the latter. This is because extrinsic or ecological factors do not offer themselves easily to analysis in the context of a predominantly desk-oriented study. These factors are context-driven and their influence on implementation and enforcement varies across countries. It is therefore difficult to extrapolate and draw conclusions about how a particular intrinsic issue may impact the implementation and enforcement of legislation in different countries. In light of their complexities, this study did not focus on ecological factors. However, the analysis of the HIV Tribunal of Kenya allowed for the review of some of the ecological determinants of legislative implementation and enforcement.

Finally, while 27 sub-Saharan African countries have HIV-specific laws, the author was only able to conduct qualitative research in one country, namely Kenya. As described above, this country was selected for pertinent reasons related to its HIV tribunal as a mechanism for implementation and enforcement of HIV legislation.

1.7.6 Overview of the structure of the thesis

The thesis is based on eight articles published or submitted for publication in peer-reviewed journals by the author over the last three years. These articles together with the present introduction, the methodology and the conclusion to this thesis

provide a cohesive discussion of human rights norms and frameworks in the context of HIV, offer a comprehensive analysis of the normative content and intrinsic implementation issues in 26 of the 27 HIV-specific laws adopted in sub-Saharan Africa in July 2014 and suggest approaches for creating more enabling legislative environments for the HIV response in the region.

The thesis is divided into four Parts which are preceded by an introduction (Chapter One) and a description of the methodology (Chapter Two).

Part One of the thesis is comprised of two articles relating respectively to HIV, prisoners, and human rights (Chapter 3) and to Ebola and human rights in West Africa (Chapter 4).

Part Two relates to the application of human rights norms and evidence-informed public health recommendations to HIV-specific laws in sub-Saharan Africa. It includes two articles on: a comprehensive human rights analysis of HIV-specific laws (Chapter Five) and independent access to HIV testing, counselling and treatment for adolescents in HIV-specific laws (Chapter Six).

Part Three focuses on the considerations, mechanisms and challenges relating to the implementation and enforcement of HIV-specific laws. It comprises of three articles. The first article develops a framework for effective HIV legislation and applies it to the laws in sub-Saharan Africa (Chapter Seven). The second article analyses the HIV Tribunal of Kenya as a mechanism for supporting implementation and enforcement of HIV legislation (Chapter Eight). The third article reflects on the role of civil society in supporting and challenging HIV-specific laws (Chapter Nine).

Part Four is the conclusion to the thesis. It is composed of two chapters, namely: a summing up article that draws on the three preceding parts of the thesis to formulate specific concluding remarks on the issues raised and recommendations for amending and improving HIV-specific laws (Chapter Ten); and a note on recommendations and reflections that closes the study with broader considerations for rights-based legal responses to HIV and other health challenges.

1.8 Conclusion

Human rights norms and approaches provide a critical framework, language and tools for understanding and responding to vulnerability and barriers to services in the context of a socially, morally and politically-influenced health challenge such as HIV.

Growing consensus has been built over the years on the application of the law, and particularly of human rights law, in responding to discrimination and supporting access to health and HIV services for people living with HIV. However, new calls for accelerated access to HIV services involve the risk that some of these gains may be eroded in the pursuit of targets. Similarly, evidence on the increased vulnerability of key populations whose occupations, life-choices or sexual practices are criminalised, and the need to address their protection and access to HIV services are confronting many sub-Saharan African countries and HIV actors with new challenges in a context of contestation and (over)politicisation of the human rights of LGBT people and other key populations.

Progress in the recognition of the role of the law as a structural tool for addressing HIV has been translated in sub-Saharan Africa by the adoption of HIV-specific laws in 27 countries as of July 2014. However, the content of these laws reflects many of the challenges relating to the recognition and protection of human rights in the context of HIV in sub-Saharan Africa. The comprehensive analysis of the normative content as well as the review of the intrinsic implementation challenges in these laws offer the opportunity to identify the strength and areas of these laws that require reform and support for better implementation.

Introduction

ORIGINALITY REPORT

%36	%32	%23	%16
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

www.unaids.org Internet Source	%2
Eba, Patrick Michael. "Towards smarter HIV laws: considerations for improving HIV-specific legislation in sub-Saharan Africa", Reproductive Health Matters, 2016. Publication	%2
ohchr.org Internet Source	%1
dev.csa.za.org Internet Source	%1
www.chr.up.ac.za Internet Source	%1
www.hhrjournal.org Internet Source	%1
www.hivlawcommission.org Internet Source	%1
www.salamandertrust.net Internet Source	%1
www.aidslaw.ca	

Internet Source %1

fxb.harvard.edu
Internet Source %1

www.hrw.org
Internet Source %1

Submitted to Birkbeck College
Student Paper %1

www.ahrlj.up.ac.za
Internet Source %1

www.etharc.org
Internet Source %1

www.unodc.org
Internet Source %1

hivlawcommission.org
Internet Source <%1

www.msf.org.uk
Internet Source <%1

www.interights.org
Internet Source <%1

Submitted to Kenyatta University
Student Paper <%1

Submitted to University of Edinburgh
Student Paper <%1

Submitted to University of Pretoria

Student Paper <%1

wwda.org.au
Internet Source <%1

www.amnesty.ca
Internet Source <%1

Submitted to University College London
Student Paper <%1

www.pulp.up.ac.za
Internet Source <%1

www.unicef.org
Internet Source <%1

Aggleton, Peter, and Richard Parker. "Moving Beyond Biomedicalization in the HIV Response: Implications for Community Involvement and Community Leadership Among Men Who Have Sex with Men and Transgender People", American Journal of Public Health, 2015.
Publication <%1

www.queeramnesty-berlin.de
Internet Source <%1

ippf.org
Internet Source <%1

www.acdhrs.org
Internet Source <%1

Submitted to National Model United Nations
Student Paper
<%1

www.snap-undp.org
Internet Source
<%1

Submitted to University of Greenwich
Student Paper
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gaspp.stakes.fi
Internet Source
<%1

www.hivpolicy.org
Internet Source
<%1

Submitted to University of Nottingham
Student Paper
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Submitted to University of Bath
Student Paper
<%1

Submitted to University of Sunderland
Student Paper
<%1

www.ncbi.nlm.nih.gov
Internet Source
<%1

Submitted to University of Minnesota System
Student Paper
<%1

Submitted to University of Sheffield
Student Paper
<%1

irinnews.org
Internet Source
<%1

media.wix.com

Internet Source <%1

Harris, Magdalena, Eliot Albers, and Tracy Swan. "The promise of treatment as prevention for hepatitis C: Meeting the needs of people who inject drugs?", International Journal of Drug Policy, 2015. <%1
Publication

apps.who.int <%1
Internet Source

www.who.int <%1
Internet Source

uir.unisa.ac.za <%1
Internet Source

www.ohchr.org <%1
Internet Source

www1.umn.edu <%1
Internet Source

www.udhr60.ch <%1
Internet Source

www.partnersnorge.no <%1
Internet Source

Submitted to University of Leeds <%1
Student Paper

192.138.214.75 <%1
Internet Source

qrd.org
Internet Source
<%1

www.projectinform.org
Internet Source
<%1

www.humandignitytrust.org
Internet Source
<%1

unaidspcbngo.org
Internet Source
<%1

Gausset, Q.. "The ambivalence of stigma and the double-edged sword of HIV/AIDS intervention in Burkina Faso", Social Science & Medicine, 201204
Publication
<%1

publications.iom.int
Internet Source
<%1

Marius Pieterse. "Health, Social Movements, and Rights-based Litigation in South Africa.", Journal of Law & Society/0263323X, 20080901
Publication
<%1

hdr.undp.org
Internet Source
<%1

cdrwww.who.int
Internet Source
<%1

www.rand.org
Internet Source
<%1

geneva.usmission.gov
Internet Source
<%1

Submitted to University of Melbourne
Student Paper
<%1

ilga.org
Internet Source
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afao.org.au
Internet Source
<%1

skylla.wz-berlin.de
Internet Source
<%1

aidslaw.ca
Internet Source
<%1

psi.org
Internet Source
<%1

www.whatworksforwomen.org
Internet Source
<%1

Submitted to University of Cape Town
Student Paper
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www.freedomhouse.org
Internet Source
<%1

Submitted to 7034
Student Paper
<%1

Submitted to Monash South Africa
Student Paper
<%1

data.unaids.org

Internet Source <%1

Submitted to Eiffel Corporation
Student Paper <%1

kelinkenya.org
Internet Source <%1

www.ajph.org
Internet Source <%1

Chase, Anthony Tirado. "Human rights contestations: sexual orientation and gender identity", The International Journal of Human Rights, 2016.
Publication <%1

tac.org.za
Internet Source <%1

www.aidslex.org
Internet Source <%1

www.justice.gov.za
Internet Source <%1

www.aber.ac.uk
Internet Source <%1

Grace, Daniel. "Criminalizing HIV transmission using model law: troubling best practice standardizations in the global HIV/AIDS response", Critical Public Health, 2015.
Publication <%1

eiop.or.at
Internet Source
<%1

radionamaskar.org
Internet Source
<%1

www.saflii.org.za
Internet Source
<%1

www.law-lib.toronto.edu
Internet Source
<%1

www.aids-info.ch
Internet Source
<%1

www.unaidsrstesa.org
Internet Source
<%1

hiv-legalaid.org
Internet Source
<%1

www.rainbow-ethiopia.org
Internet Source
<%1

www.outinperth.com
Internet Source
<%1

www.aidsindonesia.or.id
Internet Source
<%1

lup.lub.lu.se
Internet Source
<%1

Submitted to South Bank University
Student Paper
<%1

Hamzic, V.. "The Case of 'Queer Muslims':

Sexual Orientation and Gender Identity in International Human Rights Law and Muslim Legal and Social Ethos", Human Rights Law Review, 2011. Publication	<%1
www.ichrp.org Internet Source	<%1
www.unjobmonster.com Internet Source	<%1
www.policyproject.com Internet Source	<%1
www.crin.org Internet Source	<%1
asiacatalyst.org Internet Source	<%1
www.phrusa.org Internet Source	<%1
www.brookings.edu Internet Source	<%1
Submitted to Laureate Higher Education Group Student Paper	<%1
"COUNCIL ESTABLISHES MANDATE ON PROTECTION AGAINST VIOLENCE AND DISCRIMINATION BASED ON SEXUAL ORIENT", States News Service, June 30 2016 Issue	<%1

Publication

www.saifac.org.za
Internet Source
<%1

Submitted to 130
Student Paper
<%1

abhilfe.net
Internet Source
<%1

Introduction to Gender Studies in Eastern and Southern Africa, 2016.
Publication
<%1

Submitted to University of Lancaster
Student Paper
<%1

www.hivhumanrightscode.org
Internet Source
<%1

Khosla, Rajat Van Belle, Nuna Temmerman,. "Advancing the sexual and reproductive health and human rights of women living with HIV: a review of ", Journal of the International AIDS Societ, Dec 2015 Issue
Publication
<%1

Lara Stemple. "Health and human rights in today's fight against HIV/AIDS", AIDS, 08/2008
Publication
<%1

www.youandaids.org
Internet Source
<%1

nationalgrocers.org

Internet Source <%1

www.mmegi.bw
Internet Source <%1

Cross-Cultural Research in Health Illness and Well-Being, 2016.
Publication <%1

Adejumo, Olurotimi A. Malee, Kathleen M.. "Contemporary issues on the epidemiology and antiretroviral adherence of HIV-infected adolescents in ", Journal of the International AIDS Societ, Jan 2015 Issue
Publication <%1

Submitted to University of Westminster
Student Paper <%1

The Right to Health, 2014.
Publication <%1

srhhivlinkages.org
Internet Source <%1

www.hivjustice.net
Internet Source <%1

Ebenezer Durojaye. "Addressing Human Rights Concerns Raised by Mandatory HIV Testing of Pregnant Women through the Protocol to the African Charter on the Rights of Women", Journal of African Law, 04/2008
Publication <%1

www.ilo.org
Internet Source
<%1

www.socialmedicine.info
Internet Source
<%1

Submitted to University of Mauritius
Student Paper
<%1

ats-sea.agr.gc.ca
Internet Source
<%1

www.un.org
Internet Source
<%1

www.mipj.org
Internet Source
<%1

dare.uva.nl
Internet Source
<%1

www.amnesty.org
Internet Source
<%1

Maman, S.. "Changes in HIV Testing Policies and the Implications for Women", Journal of Midwifery and Women's Health, 200805
Publication
<%1

www.guardian.co.uk
Internet Source
<%1

global2015.net
Internet Source
<%1

www.changelingaspects.com
Internet Source
<%1

hhrguide.org
Internet Source
<%1

www.mdri.org
Internet Source
<%1

www.unhcr.org
Internet Source
<%1

www.rhhr.net
Internet Source
<%1

Piot, Peter, Salim S Abdool Karim, Robert Hecht, Helena Legido-Quigley, Kent Buse, John Stover, Stephen Resch, Theresa Ryckman, Sigrun Møgedal, Mark Dybul, Eric Goosby, Charlotte Watts, Nduku Kilonzo, Joanne McManus, and Michel Sidibé. "Defeating AIDS—advancing global health", The Lancet, 2015.
Publication
<%1

www.plurpol.org
Internet Source
<%1

www.ceped.org
Internet Source
<%1

Bor, Jacob Rosen, Sydney Chimbindi, Nats. "Mass HIV treatment and sex disparities in life expectancy: demographic surveillance in rural South A", PLoS Medicine, Nov 2015 Issue
Publication
<%1

hivhub.ir
Internet Source
<%1

allafrica.com
Internet Source
<%1

nonkilling.org
Internet Source
<%1

Csete, Joanne Pearshouse, Richard Syming. "Vertical HIV transmission should be excluded from criminal prosecution.", Reproductive Health Matters, May 2009 Issue
Publication
<%1

European Yearbook of International Economic Law, 2016.
Publication
<%1

"HEARS ADDRESS BY THE PRIME MINISTER OF TUVALU.", States News Service, March 5 2015 Issue
Publication
<%1

Women and Children as Victims and Offenders Background Prevention Reintegration, 2016.
Publication
<%1

unaids.org
Internet Source
<%1

Amon, Joseph J.. "The political epidemiology of HIV.(Viewpoint)", Journal of the
<%1

International AIDS Societ, Jan 2014 Issue
Publication

www.safaids.net
Internet Source
<%1

www.soros.org
Internet Source
<%1

www.pepfar.gov
Internet Source
<%1

El Feki, Shereen Avafia, Tenu Fidalgo, Tania Martins Divan, Vivek Chauvel, Charles Dhaliwal, Mandeep. "The global commission on HIV and the law: recommendations for legal reform to promote sexual and rep", Reproductive Health Matters, Nov 2014 Issue
Publication
<%1

jiasociety.org
Internet Source
<%1

siteresources.worldbank.org
Internet Source
<%1

boell.org.za
Internet Source
<%1

health.accel-it.lt
Internet Source
<%1

www.stopaidsnow.org
Internet Source
<%1

www.science.gov
Internet Source
<%1

aidsdagen.se
Internet Source
<%1

www.ikat-us.org
Internet Source
<%1

srap.ca
Internet Source
<%1

Submitted to Graduate Institute of International and Development Studies
Student Paper
<%1

www.unaidsstrategy2021.org
Internet Source
<%1

Grover, Elise, Ashley Grosso, Sosthenes Ketende, Caitlin Kennedy, Virginia Fonner, Darrin Adams, Bhekie Sithole, Zandile Mnisi, Sibusiso Lulu Maziya, and Stefan Baral. "Social cohesion, social participation and HIV testing among men who have sex with men in Swaziland", AIDS Care, 2016.
Publication
<%1

www.euro.who.int
Internet Source
<%1

www.glc.edu
Internet Source
<%1

Kamarulzaman, Adeeba, Stewart E Reid, Amee Schwitters, Lucas Wiessing, Nabila El-Bassel, Kate Dolan, Babak Moazen, Andrea L Wirtz, Annette Verster, and Frederick L
<%1

Altice. "Prevention of transmission of HIV, hepatitis B virus, hepatitis C virus, and tuberculosis in prisoners", The Lancet, 2016.
Publication

Kay, K.. "AIDS-a global concern", Midwifery, 198906 <%1
Publication

Huang, Ming-Bo, Li Ye, Bing-Yu Liang, Chuan-Yi Ning, William Roth, Jun-Jun Jiang, Jie-Gang Huang, Bo Zhou, Ning Zang, Michael Powell, Hao Liang, and Vincent Bond. "Characterizing the HIV/AIDS Epidemic in the United States and China", International Journal of Environmental Research and Public Health, 2015. <%1
Publication

"ERADICATING AIDS BY 2030 REQUIRES BALANCED PREVENTION, TREATMENT, CARE POLICIES, SPEAKERS HEAR AS HI", States News Service, June 9 2016 Issue <%1
Publication

Sofia Gruskin. "Universal Access to HIV prevention, treatment and care: assessing the inclusion of human rights in international and national strategic plans", AIDS, 08/2008 <%1
Publication

Obermeyer, Carla Makhlouf, Sarah Bott, Ron Bayer, Alice Desclaux, and Rachel Baggaley. "HIV testing and care in Burkina Faso, Kenya, <%1

Malawi and Uganda: ethics on the ground", BMC International Health and Human Rights, 2013.
Publication

Decker, Michele R, Anna-Louise Crago, Sandra K H Chu, Susan G Sherman, Meena S Seshu, Kholi Buthelezi, Mandeep Dhaliwal, and Chris Beyrer. "Human rights violations against sex workers: burden and effect on HIV", The Lancet, 2015. <%1
Publication

Durojaye, E, and G Mirugi-Mukundi. "States' obligations in relations to access to medicines: Revisiting Kenyan High Court decision in *P.A.O* and Otheres v Attorney-General and another", Law Democracy & Development, 2013. <%1
Publication

Sagy, T.. "Do Human Rights Transcend Citizenship? Lessons from the Buduburam Refugee Camp", Social & Legal Studies, 2014. <%1
Publication

EXCLUDE QUOTES ON
EXCLUDE BIBLIOGRAPHY ON
EXCLUDE MATCHES < 5 WORDS

Conclusion

by Patrick Eba

Chapter Eleven: Concluding reflections

This thesis has made key findings on the continued value of human rights in the context of health in general, and HIV in particular. It has also provided insights on the progress and challenges relating to the application of human rights in legislative frameworks on HIV in sub-Saharan Africa. These findings highlight broader political, legal and social considerations that are reflected upon in this section and used to formulate recommendations for better legal responses to HIV. In conclusion, this thesis finds that:

1 Respecting human rights remains critically important in public health and HIV responses

1.1 Public health evidence and a broad recognition of the value of human rights continue to support rights-based approaches to health and HIV

Scientific and medical advances in the response to HIV have changed the face and impact of the HIV epidemic. Thanks to the significant increase in the number of people on antiretroviral therapy (ART), particularly in middle- and low-income countries, and to the multiplication of HIV prevention options and tools, AIDS has become a manageable chronic condition for those who can access ART.[1]

Yet, in spite of these changes and progress, structural, social and legal barriers continue to contribute to vulnerability to HIV infection and prevent people – particularly those most vulnerable to the epidemic – from receiving HIV prevention, treatment, care and support services.[2] In the face of these challenges, there is a broad recognition that human rights norms and rights-based responses remain critical to addressing the HIV epidemic.[3] The importance of human rights to HIV responses was reiterated in the Political Declaration on HIV adopted by the UN General Assembly in June 2016.[4] Across the world, the language and framework of human rights continue to be used to highlight structural vulnerability to HIV and barriers to services, to demand protection

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[1] SG Deeks, SR Lewin & DV Hav 'The end of AIDS: HIV infection as a chronic disease' (2013) 382(9903) *Lancet* 1525-1533; LF Johnson, J Mossong, RE Dorrington, M Schomaker, CJ Hoffmann, O Keiser, MP Fox, R Wood, H Prozesky, J Giddy, DB Garone, M Cornell, M Egger & A Boulle 'Life expectancies of South African adults starting antiretroviral treatment: collaborative analysis of cohort studies' (2013) 10 *PLoS Medicine* e1001418; F Nakagawa, M May & A Phillips 'Life expectancy living with HIV: recent estimates and future implications' (2013) 26 *Current Opinion in Infectious Diseases* 17-25.

[2] P Piot, SSA Karim, R Hecht, H Legido-Quigley, K Buse, J Stover, S Resch, T Ryckman, S Møgedal, M Dybul, E Goosby, C Watts, N Kilonzo, J M Manus & M Sidibé 'Defeating AIDS—advancing global health' (2015) 386(9989) *Lancet* 171–218; Global Commission on HIV and the Law *HIV and the Law: Risks, Rights and Health* (2012)

[3] Ibid.

[4] UN General Assembly Political Declaration on HIV and AIDS: On the Fast-Track to accelerate the fight against HIV and to end the AIDS epidemic by 2030 (A/70/L.52) 8 June 2016.

and access to services for the populations most affected by the epidemic, and to challenge discriminatory and restrictive HIV legislation and policies.

As was shown in this thesis in relation to prisoners, the value of a human rights-based approach is that it questions broader structural factors that make certain populations more vulnerable to ill-health, including HIV.[5] A rights-based approach in the context of HIV and prisons further interrogates inequalities that affect minorities and other marginalised populations, as well as the unfair application of the criminal law that leads to over-incarceration among these populations.[6] It also challenges sub-standard health care and the denial of health and HIV services; and it condemns violence, abuse and other forms of human rights violations towards prisoners.[7]

Human rights based-approaches are also critical to identifying and prioritising responses to the challenges faced by the populations most impacted by HIV. In light of evidence showing that key populations are left behind in the response to HIV and receive limited access to services, human rights-based responses call for shifting priorities to focus on the needs of those most impacted.[8] In doing so, human rights-based responses call for identifying and addressing the legal and social barriers that hinder access to HIV services for these populations. In the case of adolescents – discussed in Chapter Six of this thesis – legal restrictions to access to HIV testing, counselling and treatment represent key barriers that should be addressed.

Human rights norms have also been used by civil society as tools for monitoring, assessing and challenging HIV-specific legislation in Africa. They have enabled civil society and other actors to bring attention to key concerns in HIV-specific laws and have served as frameworks for improving the normative content of several national laws.

It is argued that without a human rights-based approach to HIV, structural, legal and social factors of vulnerability as well as barriers to access to services will remain unaddressed. As highlighted in the case of the Ebola outbreak, discussed in Chapter Two, failure to apply rights-based approaches often lead to coercive responses that are likely to alienate the populations affected and to hinder effective public health responses.

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[5] LS Rubenstein, JJ Amon, M McLemore, P Eba, K Dolan, R Lines & C Beyrer 'HIV, prisoners, and human rights' (2016) *Lancet* http://dx.doi.org/10.1016/S0140-6736(16)30663-8.

[6] Ibid.

[7] Ibid.

[8] P Piot et al (note 2 above); UNAIDS *The gap report* (2014) 26-48 available at *http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf*, accessed on 26 August 2016.

1.2 Despite evidence supporting the inclusion of human rights in HIV-specific legislation in sub-Saharan Africa, most countries have only paid lip service to such approaches

The rapid adoption of HIV-specific legislation and other HIV-related laws across sub-Saharan Africa illustrates the recognition and acceptance of the role of the law as a structural tool in the response to HIV. Almost all the 27 countries that have adopted HIV-specific legislation in the region have endorsed, at least at rhetorical level, the importance of the law and human rights in creating an enabling environment for the response to HIV.[9] This endorsement is often explicitly noted in the preamble or objectives of these laws.

Beyond the symbolic endorsement of human rights, the great majority of HIV-specific laws also include protections for people living with HIV. All 26 HIV-specific laws reviewed as part of this study include one or more provisions that prohibit discrimination based on HIV status.[10] In addition to the general non-discrimination provisions, several countries prohibit HIV-related discrimination in areas such as employment, education, health, housing and insurance. HIV-specific laws also include rights-based measures on HIV-related education and information, blood and tissue safety and ethical research in the context of HIV.[11]

The adoption of these protective and rights-based provisions in HIV-specific legislation is significant for two reasons. First, it shows the contrast between HIV and other public health conditions which are characterised by legislative inertia. In fact, in most sub-Saharan African countries, public health laws are decade-old relics of the past which have often received little attention in terms of legislative modernisation or amendments. Second, the elevation of human rights and their translation into protective provisions in HIV-related laws in many countries across sub-Saharan Africa is unprecedented in the context of health. No other health condition has thus far led to similar attention to human rights in legislative frameworks.

In general, the affirmation of human rights norms in HIV-related laws in sub-Saharan Africa focuses mainly on the protection of people living with HIV. In some exceptional cases, law makers have also extended protections and access to HIV services to key populations. For example, in Mauritius, the HIV legislation specifically addresses the protections and access to HIV services for people who inject drugs, including needle

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[9] PM Eba 'HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis' (2015) 15 *African Human Rights Law Journal* 227-228.
[10] Ibid.
[11] Ibid.

and syringe exchange programmes.[12] The fact that injecting drug is the main route of HIV transmission in Mauritius, together with the leadership of the ministry of health and key parliamentarians on the issue, were among the reasons for the breakthrough that led to the adoption of this law.[13] Further research on the context, approaches and actors that enabled the adoption of these protective HIV provisions in Mauritius despite the criminalisation of drug use in the country could provide critical insights for ensuring protective legislation for key populations in other sub-Saharan African countries.

While important, the recognition of the role of the law in the context of HIV, and the inclusion of human rights norms in HIV-related legislative frameworks should not mask the continued challenges that face rights-based responses to health and HIV in sub-Saharan Africa.

2 HIV-specific laws are inadequate at many levels and do not provide a comprehensive framework for rights-based responses to HIV

Various challenges continue to confront efforts to advance rights-based responses to HIV in sub-Saharan Africa. These challenges are apparent, among others, in the human rights gaps that have been noted in HIV-specific legislation, in the limited attention to implementation issues, and in the lack of involvement of civil society in HIV-related legislative processes.

2.1 Limited commitment to human rights has led to insufficient human rights protections in HIV-specific legislation, particularly for key populations

In most sub-Saharan African countries, human rights protections in HIV-specific laws remain insufficient and inadequate. The comprehensive review of these laws provided in Chapter Five of this study shows that many of their protective clauses such as non-discrimination provisions are limited in scope and leave out key issues and areas such as discrimination based on another person's status, discrimination based on perceived or presumed HIV status as well as indirect discrimination.

In addition, HIV-specific laws contain several restrictive provisions, including compulsory HIV testing for alleged sexual offenders, involuntary partner notification, criminalisation of HIV non-disclosure, exposure and transmission, and restrictions to access to HIV services for adolescents. For instance, except in two cases, all countries with HIV-specific laws criminalise HIV non-disclosure, exposure or transmission.[14] Further, as shown in Chapter Six of this thesis, only six out of 26 countries have

[12] PM Eba 'Towards smarter HIV laws: considerations for improving HIV-specific legislation in sub-Saharan Africa' (2016) 24 *Reproductive Health Matters* 2016 178-184.
[13] Ibid.
[14] Eba (note 9 above).

lowered the age of consent to HIV testing to below 18 years. These restrictive provisions often infringe upon human rights and are considered to undermine effective responses to HIV.

Serious gaps have also been noted in HIV-specific laws in relation to their silence on the protection and access to HIV services for members of key populations, including women, young people, sex workers, men who have sex with men and people who use drugs.[15] In spite of evidence from across sub-Saharan Africa showing that these populations are among those most vulnerable to HIV, the great majority of HIV-specific laws fail to explicitly address their needs.[16]

In general, human rights gaps and challenges in HIV-related laws can be attributed to two sorts of causes. Some are due to limited technical capacities while others are attributable to contestations of human rights entitlements to certain populations. On the one hand, the imperfections and gaps in protective provisions relating to areas such as discrimination against people living with HIV are often attributable to poor drafting and limited technical expertise in the legislative making process. Consequently, these gaps have proved easy to address in the context of law reform. In effect, recently adopted or revised HIV-specific laws in countries such as Comoros, Côte d'Ivoire and Sierra Leone have stronger provisions on non-discrimination as parliamentarians took on board recommendations made by civil society and technical agencies including UNAIDS and UNDP for strengthening these provisions.[17]

On the other hand, the recourse to coercive approaches and the failure to address the protection and access to HIV services for key populations in HIV-specific laws appears motivated by political and social sensitivities relating to issues such as adolescents' sexuality, criminal law and human rights protections of populations such as sex workers, people who inject drugs and lesbian, gay, bisexual and transgender (LGBT) people. Current polarisation, including at global, regional and country levels around the human rights of LGBT people and other key populations appears to hinder progressive HIV-related law making on these issues and calls for better approaches for understanding and addressing these political challenges.

2.2 HIV laws fail to adequately address implementation issues

This study shows that most HIV-specific laws fail to take into consideration critical considerations that ensure the effective implementation of legislation. As described in Chapters Seven and Ten, the provisions of HIV-specific laws in sub-Saharan Africa are

[15] Eba (note 12 above).
[16] Ibid.
[17] Eba (note 9 above).

often unclear and fail to provide explicit directions to target populations and implementers. More than half of the laws (14 out of 26) fail to explicitly specify their relationships in terms of precedence with other legislation dealing with similar issues.[18] In most countries, HIV-specific laws do not identify specific agencies for the implementation of key provisions including those relating to human rights such as the prohibition of discrimination in employment or health care.[19] These flaws in the normative content of HIV-specific laws are due to a lack of understanding and knowledge among legislative drafters and lawmakers on critical considerations relating to 'smarter' legislation.

Further, the failure of these laws to address evidence-informed and rights-based policy as well as their recourse to coercive measures have led to opposition by civil society and the challenging of their provision. The lack of support by civil society actors – who could have played key roles in supporting the laws – as well as criticisms and litigation for the reform of these laws have also compromised the likelihood of their implementation.[20]

Of all the national HIV-specific laws adopted in sub-Saharan Africa, only that of Kenya establishes a specific mechanism for the implementation and enforcement of its provisions, namely an HIV Tribunal.[21] As described in Chapter Eight, the inclusive composition, broad mandate, accessible procedure and purposeful application of the law by the HIV Tribunal are contributing to the protection of human rights in the context of HIV in Kenya. However, the human, financial and other challenges facing the Tribunal should be duly appraised by other countries that are considering such HIV-specific mechanisms. Other approaches are available to countries to ensure the effective implementation of protective provisions in HIV laws without resorting to specific judicial bodies. These include creating or strengthening access to justice programmes for people living with and affected by HIV, and increasing sensitisation on HIV and human rights for the public and for key actors responsible for the implementation of HIV-related legislation. Such programmes could be explicitly mandated in HIV-related legislation.

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[18] Eba (note 12 above).
[19] Ibid.
[20] Ibid.
[21] PM Eba 'The HIV and AIDS Tribunal of Kenya: An effective mechanism for the enforcement of HIV-related human rights? (2016) 18(1) *Health and Human Rights Journal* 169-180.

2.3 The challenges of HIV-specific laws are further compounded by the limited space for civil society in HIV law making which negatively impacts the inclusivity and legitimacy of these laws

Civil society organisations are generally not meaningfully involved in the development of HIV-related legislation in sub-Saharan African countries. Where civil society has been consulted as part of law making processes, their views and concerns were often not reflected in the final legislation. The study shows that the existence of civil society organisations with more capacity to perform advocacy and legal monitoring functions, particularly in East African countries has enabled them to become involved and to express their concerns during the development of national and regional laws. This was not the case for civil society in most West and Central African countries that lacked such legal advocacy and monitoring capacity. Civil society actors involved in the HIV response in West and Central Africa are generally focused on delivering HIV-related services. As discussed in Chapter Nine of the thesis, this explains the initial lack of awareness and silence of civil society in this region on the serious human rights and public health concerns in the N'Djamena Model Law.

Ultimately, the limited involvement and influence of civil society in law making processes in many sub-Saharan African countries reflects the broader challenges relating to insufficient public and civil society participation in national governance. In contexts where civil society has been able to engage in public debates on broader social and legal issues, they were more ready to engage in HIV legislative processes. This was for instance the case in countries such as Kenya and Uganda that have vibrant civil society organisations with the experience and capacity for engaging in advocacy and law reform efforts.

In spite of these challenges, the two case studies of civil society engagement in HIV law making described in Chapter Nine of this thesis show that civil society can be key actors for ensuring rights-based and evidence-informed legislative responses to HIV. Civil society has been central to the reform of provisions of concerns in national HIV laws in West and Central Africa. Similarly, civil society in East Africa has championed the adoption of protective regional HIV legislation to address the concerns in national HIV laws in the region. These successes have been achieved through various approaches including alliances between global, regional and national civil society; collaboration with key regional and local actors with influence on legislative processes including parliamentarians and legal drafters; securing the support of international HIV standard-setting and advocacy organisations; and challenging external promoters of coercive laws.

3 Moving forward: The need to shift understanding and approaches to HIV-related legislation

Findings from this thesis show that broad acknowledgement of legal and human rights norms in the response to HIV – comprehensively articulated in the International Guidelines on HIV/AIDS and Human Rights 20 years ago[22] – does not necessarily translate into their effective application, including in the context of HIV legislation. This thesis thus recommends three shifts in understanding and approaches that may support better integration of human rights in HIV-related legislative frameworks, namely: i) addressing HIV law making as a political issue; ii) ensuring 'smarter' legislation by focusing on normative content and intrinsic factors of implementation; and iii) involving civil society as central to rights-based responses. While these three shifts are specifically formulated in relation to HIV in this thesis, it is argued that they are also of relevance to law-making on other health issues.

3.1 HIV law making as a political issue

At its core, HIV-related law making is a politically sensitive endeavour. This is because it often addresses issues related to social values, cultural taboos, and the protection and access to health services for vulnerable, marginalised and criminalised populations that are not prioritised by governments and are often socially stigmatised. Consequently, legislative processes on these issues often involve tensions and pressures for legislators to defer to public views that may be contrary to human rights norms and public health evidence.

The recognition of these social, legal and political challenges calls for ensuring that legislative processes relating to HIV take place in an enabling context where parliamentarians and other key actors involved have the understanding and tools to appreciate critical human rights norms and public health evidence, and to negotiate their translation into legislation. This should involve capacity building for parliamentarians to ensure that they understand key rights-based and evidence-informed issues in the context of HIV legislation. Similarly, consensus or common ground on sensitive and contested issues should be created among law and policy makers involved in these processes.

These challenges relating to law making in the context of HIV may lead to questioning the appropriateness of legislation to respond to the serious legal challenges involved in the HIV response. Judicial responses enshrined in human rights interpretation may sometimes appear better suited and more effective to respond to the legal challenges

[22] UNAIDS & OHCHR *International guidelines on HIV/AIDS and human rights, 2006 consolidated version* (2006).

faced by many vulnerable and criminalised populations in the context of HIV. These judicial avenues have indeed been used in several countries across sub-Saharan Africa to secure protection and access to HIV services for populations such as prisoners, migrants and women living with HIV.[23] However, judicial avenues are not a magic bullet and are often out of reach for the majority of people living with or vulnerable to HIV.[24]

In reality, the challenges relating to law making and HIV in sub-Saharan Africa are generally due to the fact that law makers in most sub-Saharan African countries were ill-prepared for leadership on sensitive human rights issues. In most countries, national legislators have been encouraged to legislate on HIV without clear and timely advice on effective approaches taking into account local challenges. In this context, 'legislation by intuition'[25] became the rule and the easily-replicable yet ill-informed models such as the N'Djamena law were used by countries as reference documents for their HIV legislation. These challenges call for giving particular attention to building capacity and 'HIV legislative competence' among national legislators as they are called upon to legislate on the epidemic. Such capacity and competence building will ensure that legislators are guided by sound public health evidence and human rights approaches when addressing the sensitive and complex legal issues raised by the epidemic.

3.2 Ensuring 'smarter' laws that address implementation issues in the content of HIV laws

'Smarter' HIV laws are those that meet two sets of criteria. First, they are based on human rights norms and sound public health evidence relating to HIV. Second, they pay due attention to the intrinsic issues in the normative content of the law that would influence its effective implementation. As discussed above, ensuring that HIV legislation is based on scientific evidence and human rights norms is both a technical and a political issue. It is therefore critical to build the capacity and competence of law makers to ensure that they understand the relevant technical issues and that they are able to negotiate the sensitive political pitfalls to secure protective legislation that benefits all those affected by HIV.

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[23] See UNDP *Compendium of judgments: HIV, human rights and the law for the judicial dialogue on HIV, human rights and the law in Eastern and Southern Africa, Nairobi, Kenya, 28–31 October 2013* (2013) available at *http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/compendium-of-judgment-for-judicial-dialogue-on-hiv--human-right.html*, accessed on 3 September 2016.

[24] See AE Yamin & S Gloppen (eds) *Litigating health rights: Can courts bring more justice to health?* (2011).

[25] R Pearshouse 'Legislation contagion: building resistance' (2008) 13(2/3) *HIV/AIDS Policy & Law Review* 1-11.

In general, the limited attention to intrinsic flaws in the content of legislation and their impact on implementation is due to the popular belief that legislative proclamation is sufficient for change. For many actors involved in legislative efforts, the job is done when the legislation or policy is adopted. As a result, whether the content of the law might enable or hinder effective implementation is not a priority for actors supporting legislative or policy reform. Changing these understandings on law-making will require popularising, and training legislators, civil society and other health and HIV actors on the importance of elements of 'smarter' legislation that increase the likelihood that laws are effectively implemented. Key intrinsic issues of significance to implementation that legislators should pay attention to include better legislative drafting so as to ensure clarity of injunctions to implementers, the designation of implementation agencies responsible for the effective application of key human rights provisions, and explicitly addressing the relationships of HIV laws vis-à-vis other similar laws (including in terms of which law takes precedence).

Legislators and drafters of HIV laws could also ensure that provisions in HIV legislation enable parliament or other national bodies with expertise on HIV such as national AIDS Commissions to undertake thorough and consultative reviews of the implementation of the legislation a few years after they come into force and then at regular intervals afterwards. Such provisions could help identify progress and barriers to implementation and enable the adoption of corrective legislative or other measures.

3.3 Enhancing the involvement of civil society as key actors in HIV law making

Ensuring the meaningful involvement of civil society actors, including people living with and vulnerable to HIV, is essential to ensuring rights-based and evidence-informed legislation. Civil society organisations can play important roles in disseminating HIV-related legislation and informing key constituencies about their existence and stipulations. They can also assist individuals in accessing courts and other fora for the protection of their rights guaranteed under HIV-specific laws. Civil society can also initiate or support advocacy efforts to demand the adoption of regulation or other measures to ensure effective implementation of the legislation. Law making processes in the context of HIV and health should therefore create space for the contribution and involvement of civil society.

However, civil society organisations can only play and deliver on their legal monitoring and advocacy roles if they have the financial, technical and other resources to effectively contribute to the emergence of enabling legal environments for the HIV response.

In light of all the challenges relating to restrictive HIV-specific legislation in sub-Saharan Africa, some have called for renouncing the use of legislative reform for creating an enabling legal environment in the context of HIV.[26] The main contribution of this thesis is to debunk such wholesale views by providing a better understanding of the contexts, conditions and approaches that are necessary for developing 'smarter' HIV legislation with evidence-informed and rights-based provisions and a greater likelihood to be effectively implemented. This thesis concludes that legislating on HIV – whether through HIV-specific laws or otherwise – is not inherently bad. What is precarious, however, is to engage in any HIV- or health-related legislative process without due attention to the principles of 'smarter' legislation and other key considerations outlined in this thesis.

[26] See R Pearshouse 'Legislation contagion: The spread of problematic new HIV laws in Western Africa' (2007) 12 *HIV/AIDS Policy and Law Review* 1-12; Eba (note 9 above) 226-227.

Conclusion

ORIGINALITY REPORT

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SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Eba, Patrick Michael. "Towards smarter HIV laws: considerations for improving HIV-specific legislation in sub-Saharan Africa", Reproductive Health Matters, 2016. Publication	%4
2	El Feki, Shereen, Tenu Avafia, Tania Martins Fidalgo, Vivek Divan, Charles Chauvel, Mandeep Dhaliwal, and Clifton Cortez. "The Global Commission on HIV and the Law: recommendations for legal reform to promote sexual and reproductive health and rights", Reproductive Health Matters, 2014. Publication	%1
3	fxb.harvard.edu Internet Source	%1
4	www.hhrjournal.org Internet Source	%1
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	Submitted to Monash University	

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10	www.journals.co.za Internet Source	%1
11	Submitted to University of Nottingham Student Paper	%1
12	www.undp-globalfund-capacitydevelopment.org Internet Source	<%1
13	www.msf.org Internet Source	<%1
14	Submitted to University of Queensland Student Paper	<%1
15	Greet Peersman. "Increasing Civil Society Participation in the National HIV Response: The Role of UNGASS Reporting :", JAIDS Journal of Acquired Immune Deficiency Syndromes, 12/2009 Publication	<%1

16	www.aidslaw.ca Internet Source	<%1
17	www.hivlawcommission.org Internet Source	<%1
18	www.ahrlj.up.ac.za Internet Source	<%1
19	El Feki, Shereen Avafia, Tenu Fidalgo, Tania Martins Divan, Vivek Chauvel, Charles Dhaliwal, Mandeep. "The global commission on HIV and the law: recommendations for legal reform to promote sexual and rep", Reproductive Health Matters, Nov 2014 Issue Publication	<%1
20	ndarc.med.unsw.edu.au Internet Source	<%1
21	Climate Change and the Law, 2013. Publication	<%1
22	Deeks, Steven G, and Peter W Hunt. "Antiretroviral therapy: stubborn limitations persist", The Lancet, 2014. Publication	<%1
23	www.safaids.net Internet Source	<%1
24	apps.who.int Internet Source	<%1

25	"ERADICATING AIDS BY 2030 REQUIRES BALANCED PREVENTION, TREATMENT, CARE POLICIES, SPEAKERS HEAR AS HI", States News Service, June 9 2016 Issue Publication	<%1
26	www.aidsdatahub.org Internet Source	<%1
27	www.pepfar.gov Internet Source	<%1
28	etheses.bham.ac.uk Internet Source	<%1
29	Fried, S.T.. "Gender, Race + Geography = Jeopardy: Marginalized Women, Human Rights and HIV in the United States", Women's Health Issues, 201111/12 Publication	<%1
30	www.zlsc.or.tz Internet Source	<%1
31	www.aidslex.org Internet Source	<%1
32	unaids.org.cn Internet Source	<%1
33	www.jiasociety.org Internet Source	<%1

Rich, Josiah D, Curt G Beckwith, Alexandria

34	Macmadu, Brandon D L Marshall, Lauren Brinkley-Rubinstein, Joseph J Amon, M-J Milloy, Maximilian R F King, Jorge Sanchez, Lukoye Atwoli, and Frederick L Altice. "Clinical care of incarcerated people with HIV, viral hepatitis, or tuberculosis", The Lancet, 2016. Publication	<%1
35	"HUMAN RIGHTS COUNCIL HOLDS INTERACTIVE DIALOGUE WITH HIGH COMMISSIONER FOR HUMAN RIGHTS ON HIS ANNUA", States News Service, March 5 2015 Issue Publication	<%1
36	Das, Pamela, and Richard Horton. "On both sides of the prison walls—prisoners and HIV", The Lancet, 2016. Publication	<%1

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