



#WeBelongAfrica



# A Training Resource for Judicial Officers: HIV, TB, Key and Vulnerable Populations and the Law in Africa



**#WeBelongAfrica brings together multiple initiatives that enable inclusive, just, affirming, safe, productive and fulfilling lives for all people in Africa, irrespective of sexual orientation, gender identity, gender expression or sex characteristics, and irrespective of HIV status or risk.**

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## Foreword

Progressive jurisprudence is a powerful tool to achieve just, peaceful and inclusive societies. It plays an essential role in supporting countries in Africa to achieve the Sustainable Development Goals - advancing the health and well-being of populations, challenging discrimination and gender inequality, facilitating social inclusion of marginalized populations, and supporting good governance and democratic freedoms.

In its landmark report “Risks, Rights & Health”, the UNDP-supported Global Commission on HIV and the Law found that where good laws are resourced, implemented, and enforced, people affected by HIV are protected. They are able to access life-saving prevention, treatment and social support, enhancing their own and other people’s health, well-being and development. And the same laws and jurisprudence that support effective responses to HIV contribute more broadly to human rights and development as well, challenging gender-based violence, supporting the progressive achievement of universal health care, recognizing gender and sexual diversity, supporting civil society organizing and participating, and so on.

On the other hand, the Commission saw evidence of how bad laws, and the poor enforcement of laws, reinforce marginalization and exclusion, create fear and discourage people from getting the services they need across the world, including in Africa.

Africa currently accounts for over 25 million of the 39 million people living with HIV worldwide. Marginalized people continue to experience heightened risk and vulnerability to becoming infected with HIV and to feeling the impact of HIV more severely, due to various characteristics and underlying social and structural factors. In sub-Saharan Africa, new HIV infections among key populations represented 25 percent of the total new infections in 2022, demonstrating that key populations continue to be disproportionately affected by the epidemic. Adolescent girls and young women, some of who are involved in transactional sex or sex work, accounted for more than 77 percent of new infections among young people aged 15-24 years.

This Training Resource for Judicial Officers, borne out of a resolution of the African Regional Judges’ Forum (ARJF) on HIV, TB, Key and Vulnerable Populations, recognizes the powerful role of sensitized judiciary in advancing the health and well-being of people living with and vulnerable to HIV in Africa. It builds on the successes of the ARJF, a Forum supported by UNDP since 2014, which has provided a safe space for eminent African jurists to discuss and exchange knowledge and understanding of the complex scientific, medical, ethical and rights-based challenges facing people living with HIV, key and vulnerable populations in the region. Forum members, aware of the ways in which their learning and sharing has shaped progressive jurisprudence, determined to expand and sustain judicial sensitization amongst their peers through this training resource. The materials build on the generous inputs, expertise and time made available by Forum members, led by the Forum’s Judicial Education Sub-Committee, supplemented by UNDP’s research and technical expertise. The updated 2024 version, available in English, French and Portuguese, was developed for the 10-year anniversary of the Judges’ Forum and is updated to include jurisprudence discussed at three Forum meetings held in Anglophone, Francophone and Lusophone African countries from 2022 to 2023.

The Training Resource aligns with and supports UNDP’s Strategic Plan 2022-2025 and HIV and Health Strategy 2022-2025, which recognize the importance of reducing inequalities, promoting inclusive governance and empowering marginalized communities, to leave no-one behind in achieving the goals of the 2030 Agenda for Sustainable Development. It also aims to contribute to global efforts to achieve the 10-10-10 goals set out in the Global AIDS Strategy 2021-2026 and 2021 Political Declaration on HIV/AIDS: less than 10 percent of countries have punitive laws and policies, and less than 10 percent of people experience stigma and discrimination, as well as gender-based inequality and gender-based violence.

UNDP and the African Regional Judges' Forum take great pride in being able to share this Training Resource for Judicial Officers: HIV, TB, Key and Vulnerable Populations and the Law in Africa with judicial education institutions across the continent. Despite the complex issues, the Training Resource aims to provide practical, evidence-informed information and useful examples of African jurisprudence on this important topic. We hope that the Resource supports trainers to increase awareness of the complex legal and human rights issues affecting key and vulnerable populations, supporting informed and reasoned decision-making and sustaining judicial excellence on HIV, health and human rights of marginalized populations.



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We are grateful to the ARJF Steering Committee, in particular Honourable Justice Professor Oagile Key Dingake, currently with the National and Supreme Courts of Papua New Guinea, and Honourable Justice Zukisa Tshiqi of the Constitutional Court in South Africa, for their oversight, guidance, commitment and valuable contributions towards the Judicial Training Resource from inception to finalization.

Special thanks also go to the Judicial Education Sub-Committee, made up of Justice Mumbi Ngugi of the Court of Appeal, Kenya; Judge Shanaaz Mia of the Gauteng Division of the High Court, South Africa; and Judge Paul Kihwelo of the Court of Appeal and Principal of the Institute of Judicial Administration Lushoto in Tanzania; who gave of their time and effort over a number of years in seeing the Judicial Training Resource through to completion. This included overseeing a judicial training needs assessment, sourcing materials and supporting the writing of the Resource, as well as liaising with the ARJF Steering Committee to ensure bi-directional feedback with the Forum. Special thanks are due to Dr Freda Githiru of the Kenya Judiciary Academy for considerable work on the founding drafts of the Training Resource.

The Judicial Training Resource draws on the collective experience, expertise, learnings and sharing of the African Regional Judges' Forum over the past 10 years. The ARJF is grateful for and acknowledges the role of its members in helping to galvanise and shape this Resource. Similarly, thanks go to members of UNDP's #WeBelongAfrica team, and their partners from civil society organizations and key population networks, who provided technical expertise, examples of jurisprudence, key issues and related inputs over many years, all of which have supplemented and enriched the focus and content of the updated Judicial Training Resource.

Finally, UNDP and the African Regional Judges' Forum would like to give special thanks to the Swedish International Development Cooperation Agency (SIDA) for making the updated version of this Resource possible, through their support to UNDP's Inclusive Governance Initiative. Thanks also to the Global Fund to Fight AIDS, TB and Malaria who provided support for the groundwork and first drafts of the Judicial Training Resource - which formed the basis for this updated version - under the Africa Regional Grant on HIV: Removing Legal Barriers (2016-2019).

## Table of acronyms

<b>ACHPR</b>	African Charter on Human and Peoples' Rights
<b>ACRWC</b>	African Charter on the Rights and Welfare of the Child
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ARJF</b>	Africa Regional Judges' Forum
<b>ART</b>	Antiretroviral therapy
<b>ARV</b>	Antiretroviral medicine
<b>AU</b>	African Union
<b>CEDAW</b>	Convention on the Elimination of All Forms of Discrimination Against Women
<b>CESCR</b>	Committee on Economic, Social and Cultural Rights
<b>CRC</b>	Convention on the Rights of the Child
<b>CRPD</b>	Convention on the Rights of Persons with Disabilities
<b>DRC</b>	Democratic Republic of Congo
<b>GCHL</b>	Global Commission on HIV and the Law
<b>GBV</b>	Gender based violence
<b>HIV</b>	Human Immunodeficiency Virus
<b>ICCPR</b>	International Covenant on Civil and Political Rights
<b>ICESCR</b>	International Covenant on Economic, Social and Cultural Rights
<b>ILGA</b>	International Lesbian, Gay, Bisexual, Trans and Intersex Association
<b>ILO</b>	International Labour Organization
<b>LEGABIBO</b>	Lesbians, Gays and Bisexuals of Botswana
<b>LGBTI</b>	Lesbian, gay, bisexual, transgender and intersex
<b>MDR TB</b>	Multidrug-resistant TB
<b>NGO</b>	Non-governmental Organization
<b>OHCHR</b>	Office of the High Commissioner for Human Rights
<b>OST</b>	Opioid Substitution Treatment
<b>PEP</b>	Post-Exposure Prophylaxis
<b>PrEP</b>	Pre-Exposure Prophylaxis
<b>SOGI</b>	Sexual orientation and gender identity
<b>STI</b>	Sexually Transmitted Infection
<b>TB</b>	Tuberculosis
<b>TNA</b>	Training Needs Assessment
<b>UDHR</b>	Universal Declaration of Human Rights
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNCAT</b>	United Nations Convention Against Torture
<b>UNDP</b>	United Nations Development Programme
<b>WHO</b>	World Health Organization

# Purpose, structure, content and delivery of the training resource

## Purpose of the resource

The purpose of this training manual is to support trainers to carry out a training programme, and to provide judges and magistrates with increased knowledge and understanding of law and human rights issues facing people living with HIV, people with TB and the key and vulnerable populations affected by HIV and TB, so as to empower them to preside over these cases with knowledge, evidence, empathy and compassion. The training manual will also serve as a resource on HIV, TB, law and human rights.

The training manual is an initiative of the African Regional Judges' Forum (ARJF) Steering Committee, through the Judicial Education Sub-Committee. The ARJF is a regional forum of judges, established in 2014, who network to exchange knowledge, experiences and ideas on matters relating to HIV, law and human rights affecting key and vulnerable populations.

The manual is primarily aimed at training for judges and magistrates. However, it may also serve as training for other justice sector stakeholders with an interest in law, human rights, HIV, TB, key and vulnerable populations.

## Structure and content of the training resource

This manual is a prototype. It is intended to act as a guide for the development of country-specific training programmes by ARJF member countries and their judicial training institutes. This allows the training manual to provide key information and resources and to be adapted to fit within the context and training programmes of each country.

The content of the manual was informed by a Training Needs Assessment (TNA) carried out in December 2018, and incorporates the identified gaps within judicial training in various jurisdictions within the continent. It has been updated in 2021 to include updated information and jurisprudence and to increase the focus on key and vulnerable populations.

The manual is structured in four independent training modules, each of which can be used separately or in preferred combinations, to provide trainers with flexibility to adapt the modules into customized programmes:

- Module I deals with understanding HIV and TB amongst key and vulnerable populations, providing critical information on how HIV and TB is transmitted, prevented and treated and who is most affected, to support evidence-informed jurisprudence.
- Module II deals with human rights issues arising in the context of HIV, TB, health, well-being and the development of all persons.
- Module III deals with the adjudication of HIV and TB in the context of criminal laws, many of which impact on people living with HIV, people with TB and key populations. It also considers human rights issues affecting other, vulnerable populations.
- Module IV deals with the adjudication of gender inequality and gender-based violence in the context of HIV and TB.

Each module contains the following:

- An overview of the training objectives and outcomes for the module.
- An overview of key points discussed in the module.
- Recommended readings for the module.
- Recommended facilitators to support the trainer in delivering the module.



- Key points highlighted in the text.
- Limited Notes to the trainer on selected key issues, discussion points and tips.
- Key considerations for courts.

## Delivery of the training resource

The four modules contain important information and are a guide for training. They may be adapted to the needs of each jurisdiction, the context and the audience. The training modules may be delivered as a complete training programme, of around 4 days or more. The modules may also be offered separately, as stand-alone training sessions or combined to focus on thematic areas. Selected manual content can also be integrated into the curricula of specific training institutions, and may be used as a source of information and resources for so doing.

This overview section contains some very general guidance to trainers on how best to plan for the training and ensure that the training is interactive and practical, adapted for the circumstances and audience. In addition, each module includes recommended readings, links to useful websites, recommended facilitators to support the delivery of various modules, and some notes and tips in relation to discussion points, throughout. For the main part, however, the manual has been developed on the understanding that existing trainers have experience in designing, developing, implementing, monitoring and evaluating training programmes suited to their particular audiences and including interactive activities that encourage participation and discussion.

A suggested first step would be for the trainer to read through the training manual and recommended readings as well as to access useful links. Based on an assessment of the target and needs of the training participants, the trainer may then be well positioned to determine how to use the information and suggested discussions within each module, to develop a suitable programme that fits within the time availability and that includes presentations, readings and handouts for participants, exercises, group work, discussion questions and discussion points, and also inputs by facilitators.

Trainers are encouraged to incorporate different pedagogical methods including lecture/presentation by the trainer or invited speakers, discussion points, direct questions, brainstorming, small and larger group work, written and visual exercises, debates, role play, interactive plenary sessions, panel discussions, case studies and experience sharing in the delivery of the manual.

For each of the modules trainers are encouraged to access and review recommended readings, prepare presentations, including accessing updated annual information, invite speakers or facilitators, as well as plan and develop exercises and discussion points.

## Facilitators

Trainers are encouraged to call on experts from various fields including medical researchers and professionals, epidemiologists, public health and human rights specialists, judges, lawyers, academia, civil society actors and representatives of key and vulnerable populations, to provide inputs, including providing updated information, new research findings, jurisprudence and/or real-life experiences. Feedback from the African Regional Judges' Forum found that interventions from people directly representing the affected populations, and facilitators who provided medical and scientific information, were critical to the success of sensitization sessions. However, there are a wide range of potential facilitators with professional expertise and direct experiences in issues relating to HIV, TB, key and vulnerable populations, law and human rights issues. This information and experience sharing can greatly enrich the training, creating a powerful tool for discussion and interaction.

Whatever the choice of facilitators, the core team should have the relevant background knowledge, methodological competencies, skills, attitudes and values to support the training. Their mode of interaction should seek to encourage participation and inclusivity and maintain independent and respectful interaction and debate.

## **Module I:**

# **Understanding HIV, AIDS and TB amongst key and vulnerable populations**

## Objectives of the module

### By the end of this module participants will be able to:

- Understand what HIV and TB are, and how they are diagnosed, transmitted, prevented and treated.
- Understand the incidence and prevalence of HIV and TB in Africa.
- Identify key and vulnerable populations and understand their vulnerability to HIV and TB from a social and structural perspective.
- Understand how stigma and discrimination affects and impacts on affected populations.
- Consider how this information impacts on justice systems and on related jurisprudence.

### Key points covered in this module

- Globally, African countries carry the main burden of the HIV epidemic.
- Globally, African countries account for 25 percent of all new TB cases.
- Key populations and vulnerable populations have heightened risk and vulnerability to HIV and TB.
- Social and structural factors, like stigma, discrimination, marginalization, gender inequality, violence, punitive laws, limited access to health care, and poverty and associated poor living conditions, create various barriers, making key populations and vulnerable populations less able to protect themselves from HIV and TB and / or less able to access services for treatment, care and support.
- HIV and TB are both preventable and treatable. If people receive adequate health information and services, they are able to prevent transmission of HIV and TB, and are able to live productive lives on treatment.

### Recommended readings/documents for this module

- [Global Fund: Key Populations](#)
- [Stigma Index Study for your country](#)
- [UNAIDS \(2024\) New HIV infections data among key populations in 2010 and 2022](#)
- [UNAIDS \(2024\) Tuberculosis and HIV: Fact Sheet](#)
- [UNAIDS \(2023\) Fact Sheet](#)
- [UNAIDS \(2023\) HIV and adolescent girls and young women: 2023 Global AIDS Update Factsheet](#)
- [UNAIDS \(2023\) The path that ends AIDS: UNAIDS Global AIDS Update 2023](#)
- [UNAIDS \(2020\) Evidence for Eliminating HIV-Related Stigma and Discrimination](#)
- [UNAIDS \(2015\) Terminology Guidelines](#)
- [UNAIDS FAQ](#)
- [UNDP Capacity Development for Health: Legal and Policy: Key and Vulnerable Populations](#)
- [WHO \(2023\) Fact Sheet: Tuberculosis](#)
- [WHO \(2023\) Global Tuberculosis Report](#)

Note: Some of these reports are updated annually, in which case please look for updated versions.

## Recommended facilitators

It would be useful to request an input from people with updated knowledge of HIV and TB itself, including prevention and treatment, as well people with epidemiological information about HIV and/or TB in the country or region.

It may also be useful to consider requesting an input from a person who works with, for or represents people living with HIV, people with TB, key or vulnerable populations. There are many individuals and organizations with knowledge and experience of HIV and TB in specific regions and populations, and the various factors that contribute towards vulnerability to HIV and TB, e.g.:

- An epidemiologist or staff member from the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO) or the United Nations Development Programme (UNDP) HIV, Health and Development Team.
- A medical researcher or medical professional.
- A staff member of a civil society organization or network working on HIV, TB and on HIV and TB amongst key and vulnerable populations.

## Understanding HIV and AIDS

### Note to the trainer

Before beginning the training, find out how much the participants know about the causes, transmission and management of HIV, AIDS and TB and who is most affected by HIV. Note down all the answers, and ensure that the facts are clarified by the end of the training session.

UNAIDS website has a list of [Frequently Asked Questions](#) about HIV, which may be helpful to keep this section updated.

### Human Immunodeficiency Virus (HIV)

HIV is a blood borne retrovirus that damages or destroys the (white blood) cells of the human immune system. The damage to the immune system makes the body unable to fight infections and diseases.

Unless treated, people living with HIV are more susceptible to a wide range of infections and cancers, most of which are rare among people without immune deficiency. These infections and cancers are known as opportunistic infections, because they arise and take advantage of a person's weakened immune system.

HIV is the underlying cause of AIDS; if HIV is left untreated, a person infected with HIV may develop AIDS:

### Acquired Immune Deficiency Syndrome (AIDS)

AIDS refers to the most advanced stages of HIV infection. Most people, if left untreated, will develop AIDS in 8 to 10 years.

AIDS describes a *collection* of symptoms and infections in a person with a weakened immune system.

So, the appearance of certain infections or cancers are used as indicators that HIV infection has progressed to AIDS. Also, the level of a person's immune deficiency – measured by the amount of CD4-positive T-cells in a person's blood - critical to the immune system's ability to fight off disease – can be an indicator. The U.S. Centers for Disease Control defines AIDS as having a CD4-positive T-cell count of less than 200 per mm<sup>3</sup> of blood.

## Epidemiological aspects of HIV and AIDS

### Note to the trainer

This section will provide participants with a brief overview of global and regional epidemiological aspects of HIV and AIDS in Africa, including amongst certain key and vulnerable populations. While global and regional information will need updating over the years, certain trends highlighted by the evidence – such as the burden of HIV in Africa and on certain populations – may continue to be issues of concern. These trends are important for participants, because they help participants to understand why HIV is a global and regional human rights and development issue, affecting those ‘left behind’.

Global and regional information should not only be updated from time to time, but also be supplemented by country-level information, since the HIV epidemic has unfolded and been managed differently in countries across the world. The epidemiological, social and legal context all impact on the vulnerability of populations within each country. So, this section suggests the kinds of country-level information that is important for participants, and includes links to websites for more specific, updated information and/or details for organizations that may be able to assist with updated, and country-level information.

### Global HIV statistics 2023

Total no of people living with HIV in 2022 <sup>1</sup>	39 million
No. of adults	37.5 million
No. of children 0 – 14 years	1.5 million
<i>53 percent of all people living with HIV were women and girls</i>	
<i>Median HIV prevalence was higher among key populations than other adults</i>	
No. of new infections in 2022	1.3 million
<i>Women and girls account for 46 percent in 2022</i>	
No. of AIDS-related deaths in 2022	630,000
No of people accessing antiretroviral therapy in 2022	29.8 million

Through the decades, Africa has been the continent most affected by the HIV epidemic. In 2022 Africa accounted for the vast majority of the 39 million people living with HIV globally.<sup>2</sup> East and Southern Africa is most affected by HIV.

**Table 1: HIV in regions of Africa**

Region	No. of people living with HIV in 2022	No. of new HIV infections in 2022	No. of AIDS-related deaths in 2022
Eastern and Southern Africa	20.8 million	500,000	260,000
West and Central Africa	4.8 million	160,000	120,000
Middle East and North Africa	190,000	17,000	5,300
<b>Total</b>	<b>24.99 million</b>		

1 [UNAIDS \(2023\) World AIDS Day 2023: Fact Sheet](#)

2 [UNAIDS \(2023\) World AIDS Day 2023: Fact Sheet](#)

## Note to the trainer: Where to find updated global and regional statistics on HIV and AIDS

The [UNAIDS website](#) provides global and regional information on the HIV epidemic, which is updated annually. The website and the reports provide updated epidemiological information globally and across regions of the world, and among specific key and vulnerable populations. The website also includes slides for presenting epidemiological information on HIV and AIDS.

See, for example, the following resources or look out for similar, updated reports:

- [UNAIDS \(2023\) The path that ends AIDS: 2023 UNAIDS Global AIDS Update](#)
- [UNAIDS \(2023\) World AIDS Day Fact Sheet 2023 with global and regional facts on HIV](#)
- [UNAIDS Core Epidemiology Slides 2023](#)

These reports also highlight trends, progress and remaining challenges in prevention, treatment, care and support, including to achieve global targets for preventing HIV, providing treatment and care and for reducing HIV-related stigma, discrimination and violence (discussed in more detail, below).

## HIV amongst key populations and vulnerable populations

The epidemiological information, as well as the social context across a region and within countries, will show that certain populations are more affected by HIV than others. These key populations and vulnerable populations, due to various characteristics and underlying social and structural factors, have heightened risk and vulnerability to becoming infected with HIV and experiencing the impact of HIV more severely than others.

### Definition of key populations and vulnerable populations for HIV

Key and vulnerable populations are based on the epidemiological and social context across the world, and in specific countries.

#### Key populations

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 suffer from punitive, criminal laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere—they are key to the epidemic and key to the response.

Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. The term key populations at higher risk also may be used more broadly, referring to additional populations that are most at risk of acquiring or transmitting HIV, regardless of the legal and policy environment.

#### Vulnerable populations

UNAIDS defines vulnerability as referring to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to HIV infection and developing AIDS.

The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk, and they may be outside of their control. These factors may include: lack of the knowledge and skills required to protect oneself and others; limited accessibility, quality and coverage of services; and restrictive societal factors, such as human rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatize and disempower certain populations). These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.

Vulnerability refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk, and they may be outside of their control.

These factors may include: lack of the knowledge and skills required to protect oneself and others; limited accessibility, quality and coverage of services; and restrictive societal factors, such as human rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatize and disempower certain populations). These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.

Vulnerable populations may include adolescent women and young girls, people with disabilities, migrants and internally displaced persons.

Source: [UNAIDS Terminology Guidelines 2015](#)

## HIV amongst key populations

In 2020, key populations (sex workers and their clients, gay men and other men who have sex with men, people who inject drugs, transgender people) and their sexual partners accounted for 65 percent of HIV infections globally:

- 93 percent of new HIV infections outside of sub-Saharan Africa.
- 35 percent of new HIV infections in sub-Saharan Africa.

The risk of acquiring HIV is:

- 29 times higher among people who inject drugs than for the rest of the population.
- 13 times higher for transgender and gender-diverse people than for other adults aged 15–49 years.
- 30 times higher for sex workers than the general female population.
- 26 times higher among gay men and other men who have sex with men than for the rest of the adult male population.

Source [UNAIDS Fact Sheet: World AIDS Day 2021](#)

## Note to the trainer: HIV amongst key populations in Africa

It is important to highlight that epidemiological data and structural contexts show that key and vulnerable populations are at higher risk of, and more vulnerable to HIV in Africa as a region, and within countries. According to UNAIDS' latest estimates, globally, more than half (55 percent) of all new HIV infections in 2022 were among key populations and their sexual partners, up from 44 percent in 2010. New HIV infections amongst 15-49 year olds declined by 35 percent between 2010 and 2022 globally, but only by 11 percent among key populations - primarily among sex workers and their clients. Annual numbers of new HIV infections actually increased for men who have sex with men and transgender women, by 11 percent and 3 percent respectively. In sub-Saharan Africa, new HIV infections among key populations represented 25 percent of the total new infections, with an increasing proportion amongst men who have sex with men and transgender women.<sup>3</sup>

Globally, 4,000 adolescent girls and young women (aged 15–24 years) were infected with HIV every week in 2022. Of these, 3,100 infections were in sub-Saharan Africa. 82 percent of adolescent girls and young women who acquired HIV in 2022 live in sub-Saharan Africa, including two thirds in Eastern and Southern Africa. HIV prevalence among adolescent girls and young women in sub-Saharan Africa is more than three times higher than among their male counterparts.<sup>4</sup>

3 UNAIDS (2024) New HIV infections data among key populations: proportions in 2010 and 2022: UNAIDS Explainer

4 UNAIDS (2023) HIV and adolescent girls and young women: 2023 Global AIDS Update Factsheet

## Understanding how social and structural barriers increase risk and vulnerability

Social and structural factors, like stigma, discrimination, gender inequality, violence, punitive laws, limited access to health care and poverty create various barriers, making key populations and vulnerable populations less able to protect themselves from HIV infection and / or less able to access services for treatment, care and support. This has been well documented in various reports, such as the [Global Commission on HIV and the Law \(2012\) Risks, Rights and Health](#) report. For instance:

- **Stigma and discrimination**, based on a person's HIV positive status, TB status, or status as a member of a key population can discourage people from talking openly about their lives and using services. Stigmatizing attitudes and discriminatory practices toward key populations due to moral judgements about their economic activity (sex work) or illegal practices (injecting illicit drugs) are common in the community and at health facilities.
- **Gender inequalities** and power dynamics create vulnerabilities for women and adolescent girls, particularly in the context of intimate relationships. For instance, due to gender inequality and harmful gender norms, women and young girls may have limited autonomy and economic power to make decisions about sexual relationships and to access sexual and reproductive health care services independently of their partners. Gender-based violence also places them at direct risk of HIV transmission.
- Laws that hinder key populations' access to HIV services – including **laws that criminalize** sex work and same-sex sexual relationships – are often associated with police arrests, violence, social marginalization and exclusion, forcing some key population groups 'underground'. This creates barriers not only to their ability to access health services, but also to getting good data on these key populations' health needs and providing appropriate, quality services.
- **Age of consent laws** that make it difficult for young people to access health care information and services without a parent or guardian, discourage young people from accessing sexual and reproductive health care, increasing their risks of poor sexual health, unintended pregnancies, unsafe abortions and other health and social issues.
- **Poverty** and lack of schooling are also formidable barriers to health and HIV services. For instance, family planning services for women and voluntary medical male circumcision for men and boys are much less likely to be accessed by people living in poverty. In 2020, the number of voluntary medical male circumcisions dropped by more than 30 percent in 15 priority countries in Eastern and Southern Africa.
- Poverty is also a driver of **migration**, which has been shown to severely impact access to HIV services and put lives in danger as migrants flee conflict and poverty in the hope of safety and economic security.
- **Health facility-level barriers** including those relating to the accessibility and quality of services (e.g. inconvenient opening times, costly services, commodity stock-outs, poor quality services) as well as to non-discriminatory services (e.g. discriminatory practices or stigmatizing attitudes of the health workers).

**Note to the trainer: Where to find updated national statistics on HIV and AIDS, including for key and vulnerable populations**

### UNAIDS

The UNAIDS website provides regional pages, with country-level data on the status and development of the HIV epidemic in various African countries. Information is available here for countries within [Eastern and Southern Africa](#), [West and Central Africa](#), and [Middle East and North Africa](#), including data on:

- Adults and children living with HIV.
- Adult and child deaths due to AIDS.
- Epidemic transition metrics.
- HIV testing and treatment cascade.



- Antiretroviral therapy (ART).
- The elimination of mother-to-child transmission.
- HIV among key populations and vulnerable populations.
- Stigma and discrimination.

The [AIDS Info](#) page also provides information on each country, including HIV data, as well as analytics of relevant laws and policies etc.

Similarly, the [HIV Policy Lab](#), a collaboration between Georgetown University, various UN agencies and other organizations, also provides updated information on HIV-related laws and policies in countries across the world which is useful for discussions of key and vulnerable populations in specific countries.

## WHO

WHO's [HIV Country Intelligence](#) webpage provides an overview of HIV related information for each African country, including:

- Demographic and socioeconomic data.
- 90-90-90 progress towards 2020 targets.
- Epidemiological HIV data.
- Key populations.
- National HIV policies and plans.

## Contact organizations

Staff from organizations like UNDP, UNAIDS and WHO are well placed to support training, providing presentations on epidemiological aspects of HIV, AIDS (and TB), as well as HIV, health and human rights issues impacting on key and vulnerable populations, in your region and country.

## Regional offices

Contact information of the regional offices can be found here:

**UNDP:** See the UNDP webpage [FAQs: Where is UNDP located?](#)

**UNAIDS:** See the UNAIDS webpage [Where we Work: Regions](#)

**WHO, Regional Office for Africa:** See the WHO Regional Office for Africa webpage: [Contact Us: Countries](#)

The Regional Offices can provide further details for country offices.

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## Transmission of HIV

HIV is found in body fluids, such as blood, semen, vaginal fluids and breast milk. Transmission can occur through:

- Unprotected penetrative sex (vaginal and anal).
- By contaminated syringes, needles or other sharp objects (in health care settings and drug injection).
- Blood transfusion.
- Between mother and infant during pregnancy, childbirth, and breastfeeding.

## Key point

HIV does not survive well outside the body. So, fluids like sweat, urine, tears and saliva do not contain sufficient HIV to transmit to others.

The virus is quite difficult to transmit. It needs a significant amount of virally active material in the body fluid to enter another person's body. Skin acts as an effective barrier. Contact between body fluids and healthy skin, without any lesions, is safe.

## What do we know about the risks of transmission?

### Sexual transmission

- The risk of infection through a single act of vaginal sex is low.
- The risk of transmission through anal sex is 10 times higher than by vaginal sex.
- A person with an untreated sexually transmitted infection (STI) is 6 to 10 times more likely to transmit, or get, HIV during sex.
- Oral sex is a low-risk sexual activity.
- A person taking ART with a suppressed viral load is no longer infectious.

### Transmission through needles and syringes

- HIV is transmitted very efficiently through contaminated needles or syringes.
- Using clean needles and disposing of contaminated needles correctly, prevents transmission.

### Transmission of HIV from mother to infant

- There is a 15 to 30 percent risk of transmission before and during child birth.
- The viral load of the mother at birth influences the risk of infection.
- Transmission can also occur during breastfeeding.
- The chances of transmission are very low if the mother is on ART during pregnancy and when breastfeeding.

## Prevention

HIV transmission can be prevented by:

- Consistent and correct use of male or female condoms.
- Monogamous relations between uninfected partners.
- Monogamous relations with a person living with HIV, but on ART and with an undetectable viral load.
- Non-penetrative sex.
- Post-exposure prophylaxis taken by a person exposed to HIV.
- Pre-exposure prophylaxis taken by people who are not infected with HIV.

- Treatment as prevention (consistent adherence to ART, to reduce viral load – and the risk of transmission to others - in a person living with HIV).
- For men, voluntary medical male circumcision to reduce the chances of acquiring HIV.
- For women, taking ART during pregnancy, delivery and breastfeeding.
- For people who use drugs, using new needles and disposable syringes, or those that have been properly sterilized before re-use.
- Ensuring that blood and blood products are tested for HIV and that blood safety standards are implemented.

### What is post-exposure prophylaxis?

Post-exposure prophylaxis (PEP) is antiretroviral medicine (ARVs) taken after a single, high-risk event to prevent a person from getting HIV. PEP must be taken as soon after possible HIV exposure (ideally within two hours and not later than 72 hours).

### What is pre-exposure prophylaxis?

Pre-exposure prophylaxis (PrEP) is medicine taken before exposure, to prevent getting HIV. It is highly effective when taken as prescribed.

For more information, see Center for Disease control webpage [HIV Risk and Prevention](#)

## HIV diagnosis and treatment

Most people infected with HIV do not know that they have become infected as it often does not cause any symptoms. However, even though they are asymptomatic, a person newly infected with HIV is infectious and can transmit the virus to another person. They can determine whether HIV infection has occurred by taking an HIV test.

About one or two months after becoming infected, when people develop antibodies to HIV ('seroconvert'), some people may experience illness (fever, rash, joint pains and enlarged lymph nodes).

An infected person may show few or no signs of infection for years, depending on their lifestyle, genetic characteristics and exposure to infections. But HIV infection, if untreated, causes the immune system to weaken over time, resulting in increasing infections and cancers.

There is no cure for HIV, but there is effective treatment. If treatment is started soon and taken regularly, a person living with HIV can live a good, long life. The advances of science have changed HIV from what was once a terminal disease to a chronic and manageable condition.

Antiretroviral treatment works by slowing down the reproduction and spread of HIV in the body, to reduce its impact on the immune system. Importantly, this means that when a person living with HIV is on effective antiretroviral therapy, they are no longer infectious. Even with ART, frequent monitoring is required to ensure timely intervention in case the virus develops resistance to any one form of treatment.

It is now confirmed that access to and treatment using ARVs is critical in preventing further transmission of HIV. When a person living with HIV is on effective antiretroviral therapy, and the virus is suppressed or undetectable, they are no longer infectious.

### Key point

A person living with HIV on effective ART is no longer infectious and cannot transmit HIV through sex. So, 'treatment as prevention' – access to treatment – is critical in preventing further transmission of HIV.

## Understanding tuberculosis (TB)

TB is caused by bacteria called *Mycobacterium tuberculosis* that most often affects the lungs. The disease mostly affects adults in their most productive years although all age groups are at risk.

### Epidemiological aspects of TB, and HIV and TB

#### Note to the trainer

This section will provide participants with a brief overview of global and regional epidemiological aspects of TB in Africa, including amongst certain key populations. As with HIV, while global and regional information will need updating over the years, certain important trends highlighted by the evidence – such as the burden of TB in Africa and on certain populations – may continue to be issues of concern. These trends are important for participants, because they help participants to understand the link between HIV, TB, health, human rights and development.

Global and regional information should not only be updated from time to time, but should also be supplemented by country-level information. This section suggests the kinds of country-level information that is important for participants, and includes links to websites for more specific, updated information and/or details for organizations that may be able to assist with updated, and country-level information.

#### Global TB statistics

Globally, more than 10 million people developed TB in 2022:

55 percent of them were adult men

33 percent of them were adult women

12 percent of them were children (0-14 years)

Drug-resistant TB continues to be a major concern. Worldwide in 2022, 410,000 people developed rifampicin-resistant TB (RR), and/or multidrug-resistant TB (MDR TB). Only about 1 in 3 people with drug-resistant TB accessed treatment in 2020.

Globally, there were an estimated 1.3 million TB deaths in 2022. Of these, 167,000 were people living with HIV. TB was the second leading cause of death from infectious disease (after COVID-19) in 2022. In Africa, around 500,000 adults died from TB.

Sources: [WHO \(2023\) Global Tuberculosis Report](#)

[WHO \(2023\) Tuberculosis in the WHO African Region: 2023 progress update](#)

[WHO \(2021\) Global Tuberculosis Report](#)

In 2022, 2.5 million people fell ill with TB in the African region, accounting for a quarter of new TB cases worldwide.<sup>5</sup> More than half of the 49 countries on WHO's list of TB high burden countries are African. Three countries in Africa accounted for close to 10 percent of cases to global TB cases: Nigeria (4.4 percent), Democratic Republic of the Congo (2.9 percent), and South Africa (2.1 percent).<sup>6</sup>

**Table 2: TB in the Africa region 2022<sup>7</sup>**

No. of new TB infections	No. of new TB infections in people living with HIV	No. of TB-related deaths in HIV-negative people	No. of TB-related deaths in people living with HIV
2.5 million (2022)	461,000 (2022)	310,000 (2022)	114,000 (2022)

5 [WHO \(2023\) Global Tuberculosis Report 2023](#)

6 [WHO \(2023\) WHO Africa Country Disease Outlook](#)

7 See WHO Global TB database [Tuberculosis profile: WHO African Region, 2022](#)

## Note to the trainer: Where to find updated global and regional TB statistics

### WHO

The WHO webpage on [Tuberculosis](#) and the annual Global Tuberculosis Report provide global and regional epidemiological information on the TB epidemic and TB/HIV, including amongst specific populations. It also provides information on TB strategies, resolutions and guidelines.

Also see:

- The StopTB Partnership webpage [Tuberculosis TB: Maps](#) which provides global, regional and country-level data.
- The Global Fund to Fight AIDS, TB and Malaria webpage on [Tuberculosis](#), which provides global information and a Results Report on progress against HIV, TB and malaria.
- The UNAIDS webpage on [Tuberculosis](#) which provides global, regional and country level data, updated reports and information on the link between TB and HIV.

See the following recent resources or look out for similar, updated reports:

- [Global Fund \(2023\) Results Report](#)
- [StopTB Partnership \(2023\) A Deadly Divide: Priorities to Close the Deadly Divide Final Report 2023](#)
- [UNAIDS \(2024\) Tuberculosis and HIV](#)
- [WHO \(2023\) Global Tuberculosis Report 2023](#)

The annual global TB report provides a comprehensive and up-to-date assessment of the TB epidemic, and of progress in prevention, diagnosis and treatment of the disease at global, regional and country levels.

## TB amongst key and vulnerable populations

As with HIV, there are certain key and vulnerable populations who are more likely to be affected by TB. Epidemiological evidence shows that TB is prevalent amongst members of socially and economically disadvantaged groups, marginalized and vulnerable sectors in society, people living with HIV, prisoners and people who use drugs. People living with HIV are around 19 times more likely to develop active TB disease than people without HIV. HIV infection is the strongest risk factors for TB infection progressing to TB disease, and TB remains the leading cause of death among people living with HIV, accounting for around one in three AIDS related deaths.

Other risk factors include malnutrition, diabetes, drug use, excessive alcohol use, silicosis, cancer or cancer treatment and old age.

### Definition of key and vulnerable populations for TB

Experiencing significant marginalization, decreased access to quality services and human rights violations make some groups highly vulnerable to TB. In the context of TB, the Global Fund mention the following groups as key populations:

- **People living with HIV:** People living with HIV are 19 times more likely to become ill with TB.
- **Prisoners and incarcerated populations:** TB in prisons is reported to be 100 times higher than in the general population. Prisoners often live in over-crowded and poorly ventilated conditions and have poor access to nutrition; this may increase their vulnerability to TB.

- **Migrants and refugees:** Migrant workers and refugees are made more vulnerable to TB since they are often unable to access basic health care services due to being mobile and/or not having the correct or appropriate documentation to access local health care.
- **Miners:** There are many reasons why miners are at risk of TB including the fact that many have been exposed to silicosis through the dusty conditions in mine shafts, they often live in poorly ventilated hostels or informal settlements, and they may also be living with HIV.
- **Children:** Around 10 percent of all TB cases are amongst children. Very young children may have compromised immune systems, making them vulnerable to TB. Others live in households where others have TB. Malnourished and children with HIV are particularly vulnerable to TB.

Source: [Global Fund: Key Populations](#)

## TB amongst key populations in Africa

Key populations in Africa are at higher risk of falling ill with TB and struggling to access appropriate treatment and care, due to their marginalized status. For instance:

- The UNAIDS (2024) [Tuberculosis and HIV](#) factsheet notes that people living with HIV are up to 16 times more likely to fall ill with TB and in 2022, approximately 170,000 died from AIDS-related TB. According to the WHO (2023) [Global Tuberculosis Report](#), the proportion of TB cases co-infected with HIV was highest in countries in the WHO African Region, exceeding 50 percent in parts of Southern Africa. Among people living with HIV who develop TB, both TB treatment and ART for HIV are required to prevent unnecessary deaths. The global coverage of ART for people living with HIV estimated to have developed TB in 2022 was only 54 percent. This demonstrates that large gaps remain in screening, testing and treatment for both HIV and TB.
- Miners in Southern Africa, are [reported](#) to have greater incidence of TB than any other working population in the world, and TB incidence among migrant miners is 10 times higher than in the communities from which they originate.

## Note to the trainer: Where to find updated national statistics on TB, including for key and vulnerable populations

### StopTB Partnership

The StopTB Partnership website has an interactive webpage [Tuberculosis TB: Maps](#) which provides global data, and country-level data on TB. The following information is available for each country:

- Number of people with TB.
- Number of people with drug-resistant TB.
- Number of people under 15 years with TB.
- Number of people living with HIV and TB.
- Number of key populations with TB.
- Number of people dying from TB.
- Number of people under 15 years dying from TB.
- Number of people dying from HIV-TB co-infection.
- Number of people accessing / missing from care.
- Treatment coverage and treatment success rates.

## Contact organizations

Staff from organizations like UNAIDS, WHO, the StopTB Partnership and the Global Fund are well placed to support training, providing presentations on epidemiological aspects of TB (and HIV), as well as issues impacting on key and vulnerable populations, in your region and country.

**UNAIDS:** See the UNAIDS webpage [Where we Work: Regions](#)

**WHO, Regional Office for Africa:** See the WHO Regional Office for Africa webpage: [Contact Us: Countries](#)

**Global Fund:** See the Global Fund [Contact Us](#) page for details of the head office.

**StopTB Partnership:** See the StopTB Partnership [Our Partners](#) page for details of country-level partners

The Head or Regional Offices can provide further details for country-level contact persons.

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## Transmission of TB

TB is spread from person to person through the air. When people with lung TB cough, sneeze or spit, others may become infected if they inhale the germs in the air. People with active TB who are not on effective treatment can infect 5–15 other people through close contact over the course of a year.

The risk of transmission depends on the duration of exposure. It is assumed to be greatest for people sharing an enclosed space repeatedly for long periods, particularly if this is a damp enclosed space with little ventilation or direct sunlight - such as overcrowded informal housing or prisons.

About one-quarter of the world's population has latent TB, which means people have been infected by TB bacteria but are not (yet) ill with the disease and cannot transmit the disease. However, if a person's immune system becomes weakened, the TB bacteria are much more likely to multiply, spread and cause active disease.

### Key point

**TB infection** refers to when a person has *Mycobacterium tuberculosis* in the body but does not have any symptoms of the TB disease. The bacilli are inactive but remain alive in the body and can become active later. This condition is also referred to as latent TB infection.

TB infection does not always result in active TB disease. Most healthy people are able to contain or destroy the TB bacteria.

A person who has TB infection, but no active disease, cannot transmit TB. Only someone with active TB of the lungs is infectious and can transmit TB to others.

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## Prevention, diagnosis and treatment of TB

TB can be detected by a skin test, a blood test or a test of sputum (phlegm).

TB is both preventable and curable. TB can be prevented by a Bacille Calmette-Guérin vaccination, which is 80 percent effective in preventing TB for 15 years. The vaccine is more effective in children. As TB is an airborne infection, the risk of infection can also be reduced by using a few simple precautions:

- **Good ventilation:** TB can remain suspended in the air for several hours with no ventilation
- **Good natural light:** UV light kills off TB bacteria
- **Good hygiene:** covering the mouth and nose when coughing or sneezing reduces the spread of TB bacteria.

People with latent TB infection can also take medication to prevent it from developing into active TB. Case finding and early diagnosis and treatment are therefore also an effective way to prevent the spread of tuberculosis to others. Once a person has been diagnosed with TB, and started on treatment, the majority of patients are no longer infectious and cannot transmit TB, after just two weeks of taking the medication.

### Key point

TB is both preventable and curable.

**TB disease:** When a person is infected with *Mycobacterium tuberculosis* and shows signs and symptoms of the disease.

A healthy immune system is the best form of defence against TB: 60 percent of adults with a healthy immune system can completely kill TB bacteria.

When a person develops active TB disease, the symptoms (such as cough, fever, night sweats, or weight loss) may be mild for many months. This can lead to delays in seeking care, resulting in poor health for the person and also increasing the risk of transmission to others. However, TB disease can be treated with a combination of several medications for around 6 to 9 months. At the moment, the most common treatment for active TB is isoniazid in combination with 3 other drugs. However, research is ongoing to find shorter drug regimens.

It is important that people who have TB disease are treated, finish the medicine and take the drugs as prescribed, to prevent them from becoming sick again or from developing drug-resistant TB.

Drug-resistant TB means that some drugs initially used to treat TB will no longer be able to fight the TB germs in the body. TB that is resistant to more than one drug, called MDR TB, is complicated and expensive to treat. The treatment for this type of TB takes much longer to complete, and contains a risk of more side effects. People living with HIV are at greater risk of ill health from drug-resistant TB.

## HIV and TB

HIV and TB each speed the other's progress. People living with HIV with no TB symptoms need TB preventative therapy, which lessens the risk of developing TB and reduces TB/HIV death rates by around 40 percent. Without treatment, people living with HIV are at significant risk. Treatment of drug-sensitive TB can, however, be relatively low cost (depending on the country), effective and can be safely combined with antiretroviral therapy.

## Stigma against people living with HIV, TB, key and vulnerable populations

### Note to the trainer

Find out what the participants think about people living with HIV, people with TB, and key populations. Do they associate HIV with certain categories of people? Who do they feel is most likely to get HIV? Why? What about TB? What are the various associations they may have with affected populations?

Ask participants to consider some basic questions about affected populations. Would they share cutlery used by a person living with HIV? Would they employ a domestic worker living with HIV in their homes? Would they remain in the same room as a person with TB? Would they blame a person for their infection? How about other people they know, how would others react?

This discussion will help open up discussions about fears and the myths associated with HIV, AIDS and TB and the people affected by it, and stigma that they may also hold.



UNAIDS (2020) Evidence for Eliminating HIV-Related Stigma and Discrimination describes stigma, and how it leads to discrimination experienced by people living with HIV, people with TB, key and vulnerable populations. External stigma refers to a social phenomenon characterized by disapproval, discredit, disregard or underestimation of an individual or group of individuals with certain characteristics, behaviours or beliefs, not aligned with social or cultural norms. It is a mark of disgrace which comes about when society attaches negative attributes to a group of people, in this case to people living with HIV, or people at risk of HIV or perceived to be at risk of HIV. It portrays the biases that are present as a result of the fears, myths and prejudices held against certain people. External stigma often leads to marginalization and discrimination, and even more so for those who may experience stigma based on several characteristics or behaviours (e.g. being a woman with a disability and living with HIV; being a transgender sex worker; being a person who uses drugs, living with HIV and TB).

Internal stigma on the hand has to do with feelings of devaluation or shame felt by stigmatized people. So, people living with HIV may feel internal stigma because of their HIV status; gay men may feel internal stigma because of their sexual orientation; and sex workers may feel internal stigma because of their livelihood. It often leads to self-exclusion from family, friends and society and from access to services and opportunities, for fear of this information being revealed and the shame or discrimination they may experience. It may result in loss of self-esteem and self-castigation.

Some people experience 'double' stigma or intersectional stigma – stigma based on and that intersects with various other factors that cause society to stigmatize their characteristics, identities or behaviours. For instance, in areas of high HIV prevalence, where HIV and TB co-infection is common, the link between the two diseases has contributed towards the stigmatization of TB. TB is perceived as a marker for HIV positivity, therefore HIV-associated stigma is transferred to people with TB. Similarly, key populations for HIV who may experience stigma on the basis of grounds such as their sexual orientation, use of drugs or sex work, may experience further stigma due to their perceived association to be at higher risk of HIV. Populations who experience stigma on various grounds are particularly vulnerable.

Stigma may also arise for different reasons. Moral stigma arises from an association between a person and immoral behaviours. So, in the case of HIV, moral stigma may arise from an association with immoral sexual behaviours including multiple sexual partners, sex outside of marriage, sex work, same-sex sex, and lack of personal responsibility, amongst other things. Society views certain groups of persons as responsible for transmitting HIV, and these are often persons who experience stigma on other grounds too (like, gay, bisexual, and other men who have sex with men, transgender and gender-diverse people; people who use drugs and sex workers). In the context of HIV, these groups are often regarded as 'responsible' for the spread of HIV and deserving of punishment for being irresponsible.

Physical stigma arises, for instance, out of fear of infection. This is characterized by people avoiding contact with people living with HIV. People may be afraid to shake hands or share spaces with people living with HIV. Clothes and items used by a person living with HIV are considered objectionable. Fear of infection, perceived risks and lack of knowledge regarding TB are also the most common causes of TB stigma.

Stigma may also be associated with socio-economic status – arising from the perceived associations of HIV and TB with malnutrition, poverty and lower socio-economic status.

## **Stigma may lead to discrimination**

Stigma is distinct from discrimination. Discrimination occurs when stigmatizing thoughts, perceptions and attitudes lead to acts of discrimination against the stigmatized person. As a result, discrimination may have legal consequences.

Discrimination can include gossiping about a person, verbal threats or insults, excluding a person from family and social activities, physical threats or attacks and even extreme violence (murder, rape). Discrimination can also result in restricting a stigmatized person's access to opportunities, like work, education, housing or any social service. For example, people living with TB have lost their jobs due to their health status. Women living with HIV have been coerced to become sterilized. Young transgender and gender-diverse adolescents are thrown out of their homes and drop out of schools, because of discrimination based on their gender identity. Sex workers complain of being denied sexual and reproductive health care because of the work they do.

So, discrimination creates social and economic consequences for people living with HIV, people with TB, and key populations, including loss of jobs and economic opportunities, loss of family, community and relationships

as well as shame and fear. This can further impact on people's willingness and ability to access services, impacting on effective responses to manage HIV and TB and to promote the health and well being of all people.

Human rights violations experienced by people living with HIV, people with TB, key and vulnerable populations are dealt with in more detail in the next modules.

See [Stigma Index Studies](#) for country-level evidence of stigma and discrimination against people living with HIV, people with TB, and key populations.

Stigma remains a serious barrier in Africa to understanding and addressing the prevention and treatment of HIV and TB. It contributes to the worsening of the spread of the disease, as it inhibits access to disclosure of status, testing, prevention, treatment and care, including psychosocial support and home care. Stigma also affects the way affected people experience HIV and makes it difficult for people to live well. In order to deal with stigma, it is important to separate facts from myth and to confront prejudices, stereotypes and blame associated with HIV, TB and other characteristics, identities and behaviours of key and vulnerable populations that attract stigma.

### Note to the trainer

Consult with a person living with HIV, TB survivor and / or a member of a key population, to participate as an educator in the training, to share experiences and provide information. This will allow participants to hear and learn from an affected person, help to address any stigma and any conscious or subconscious bias, as well as to explain the impact of stigma and discrimination on vulnerability and to demystify myths about HIV, TB and other issues.

### Note to the trainer

Engage participants on some key considerations they may wish to take into account in their court rooms, and what they may wish to do differently. Some suggestions are set out below.

## Key considerations for the courts

- Up-to-date medical and scientific facts about HIV and TB – how it is diagnosed, transmitted, prevented, treated and cured and who is most affected – are critical to ensuring well-reasoned jurisprudence relating to HIV, TB and affected populations. Similarly, research and evidence regarding the specific vulnerabilities of key and vulnerable populations – including stigma and discrimination, fear and misinformation – and how that impacts on the lives of affected populations – is also important in relevant cases. Judicial officers should be open to the use of expert witnesses and *amicus curiae* to provide expert, updated evidence to the courts.
- Judicial officers need to be aware of their, or others' attitudes, perceptions and fears towards people living with HIV, people with TB and key and vulnerable populations.
- The stigma associated with both HIV, TB and that directed towards many key populations, may be a traumatizing experience. The court may be invited to make appropriate orders where lawyers request privacy during the hearing or when people are testifying.
- Access to justice does not necessarily require a call for unusual treatment, but may require the system to consider reasonable requests to accommodate people living with HIV, people with TB and key populations. For instance, in the case of illness or the need for medical treatment, special accommodation may be required. A pre-trial conference may help to determine the specific needs of people living with HIV, people with TB or key populations. Deliberate intervention may be required to allow for access and adherence to treatment and other forms of medical attention and care.
- HIV is not casually transmitted, and there is no need to avoid contact with people living with HIV in court or to segregate people living with HIV e.g. in holding cells. Similarly, not all TB is contagious. However, it may be important to prioritize proceedings in properly ventilated court rooms, and to seek

medical expertise on the needs of those with active TB disease, for their health and the health of others. Arrangements may be made for holding in isolation wards in hospital rather than prison cells, where this is medically necessary.

- Prison conditions may allow for disease transmission and also may impact more severely on people living with TB, people with TB and key populations, for various reasons discussed above. For instance, TB is spread readily in prison settings. The health of people with TB and people living with HIV may deteriorate faster in prison conditions. People who use drugs may experience severe withdrawals and health care issues if not provided access to health care and harm reduction. Transgender and gender-diverse prisoners may be at increased risk of sexual violence. Judicial officers should make orders for effective administrative, environmental and health controls, including sound policies for access to diagnostics, prevention and treatment, environmental administration and safety and security.
- Where laws allow, it will be at the discretion of the court to allow people with TB and people living with HIV to benefit from medical parole or arrangements may be made for them to serve their sentences in hospitals or under house arrest, taking into consideration the medical condition of the detainee, risk of re-offending and supervision within the community.
- Where applicable bail should be considered for people living with HIV, people with TB and other accused persons who are at risk, as opposed to holding them in remand, to enable them continue to access treatment as they await trial.
- Isolation where necessary should be at home or in a hospital and not in prison cells. Even where a person with TB is to be detained, the detention period should take into consideration the public health impact of detaining a person with TB.

## Comparative jurisprudence

There are a number of resources and compendiums of case law relevant to HIV, TB, key and vulnerable populations. Select case law is set out below.

### Right to non-discrimination in workplace: Refusal to employ

#### ***Medical / scientific issues: HIV, disease progression and fitness to work***

**Court: Labour Court of Namibia**

**Parties: Nanditume v Minister of Defence**

**Citation: (2000) ILJ 999**

#### **Facts**

An Applicant living with HIV applied to be enlisted in the Namibian Defence Force. He was required to undergo an HIV test as part of the medical examination provided for by the Defence Act. He was denied employment on the basis of his HIV-positive test result, despite a medical report showing that he was otherwise in good health and did not have medical conditions likely to interfere with the performance of his duties.

He applied to the Court for an order directing the Namibian Defence Force to process his application for enlistment without regard to his status.

#### **Held**

- Based on the medical evidence, a person living with HIV is not necessarily either ill or unable to perform the normal functions required in the Defence Force. A person who is found to be HIV-positive may be fit and healthy for several years.
- The blanket policy, and the exclusion of the Applicant from the military solely because he was HIV-positive, constituted unfair discrimination in breach of the Labour Act.

- The Court did not rule out all pre-employment HIV testing for the Namibian Defence Force, but said it could not, alone, determine fitness and ability. Expanded CD4 count and viral load testing should be part of the medical examination of recruits, allowing the exclusion of those who failed to meet certain thresholds on CD4 and viral load tests, from the Namibian Defence Force.
- The Applicant was ordered to undergo these additional tests for CD4 count and viral load and the Namibian Defence Force was ordered to enlist him if he met the thresholds.

## Right to a fair trial; criminalization of HIV transmission: Breastfeeding and HIV transmission

### **Medical / scientific issues: Medical evidence regarding HIV transmission**

**Parties: E.L. v The Republic**

**Citation: Criminal Case No. 36 of 2016**

**Court: High Court of Malawi, Zomba**

### **Facts**

The Appellant, E.L., was a breastfeeding mother living with HIV and on ART. She was reported to the police after another woman's child, who she was holding, breastfed from her at a community meeting. The child did not contract HIV and the evidence indicated that the breastfeeding was accidental and unintended. The accused did not have legal representation at her trial. The only evidence admitted was a hospital document indicating she was on ART. The Magistrates Court recorded a guilty plea, convicted her under the Penal Code for "transmitting a disease dangerous to life" and sentenced her to nine months' imprisonment with hard labour.

The accused appealed to the High Court arguing that the State failed to prove that a single exposure of a child to breastmilk of a woman living with HIV on ART was likely to spread HIV, denying intent or negligence and arguing that the crime was unconstitutional for being vague and overbroad.

### **Held**

- It is important to uphold traditional standards of proof in adjudicating cases involving the criminalization of HIV transmission.
- Expert evidence indicated that there was an "extremely low" risk of HIV transmission from breastfeeding, when a woman is on ART.
- The State did not and could not have proved that the accused had knowledge or reasonable belief that breastfeeding was likely to spread HIV. The court noted that the breastfeeding of another's child was accidental and the child did not contract HIV.
- The Applicant's right to a fair trial, dignity and privacy had been infringed as a result of bringing evidence of her HIV status before court, procedural irregularities and blatant bias in the lower court. The conviction and sentence were set aside.
- The Court noted further, *obiter dictum*, that the application of criminal laws to HIV should be sensitive to various issues and consistent with international human rights obligations.
- The criminal law should not be applied to cases where there is no significant risk of transmission or where the person did not know that he/she was HIV positive, did not understand how HIV is transmitted, did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences.
- The court declined to rule on the constitutionality of the offence but stated that the argument was "convincing."

## Criminalization of HIV transmission : Reduced viral load

**Parties: Association de lutte contre le sida (ALCS) (Appellants)**

**Citation: 2016**

**Court: Morocco, Fez Court of Appeal**

### Facts

A young man living with HIV was charged with intentional transmission of HIV to two women without their knowledge. The man was under treatment and tests showed a negative viral load.

### Held

- The man was acquitted of the HIV-related charges (although he was found guilty of sexual relations outside marriage, in terms of Article 490 of the Penal Code).
- According to ALCS, the judge's decision was probably motivated by consideration of his undetectable viral load, which meant that the likelihood of transmission of HIV was near zero.

## Criminalization of HIV transmission : Disclosure

**Parties: (Defendants) Association de lutte contre le sida (ALCS)**

**Citation: February 2015**

**Court: High Court of Tanger**

### Facts

A married woman living with HIV was charged with premeditated assault under Article 400 of the Penal Code, for exposing two men, with whom she had unprotected sex, to HIV. She had disclosed her HIV status to her partners beforehand.

### Held

- The accused was acquitted on the grounds that she had disclosed her HIV status to her partners before having sex.

## Right to liberty and freedom of movement; freedom from torture and other cruel, inhuman and degrading treatment: Imprisonment of TB patients

**Medical / scientific issues: TB transmission and disease progression in prisons**

**Court: Constitutional Court of Kenya**

**Parties: Daniel Ng'etich & 2 others v Attorney General & 3 others**

**Citation: Petition 329/2014 [2016] eKLR**

### Facts

Two men were arrested and charged on the allegation that they had failed to take their TB medication prescribed to them. The 3rd Respondent, a Public Health Officer, applied for their imprisonment pursuant to the Public Health Act and the court issued an order for their confinement in isolation for purposes of TB treatment, for a period of 8 months. They were subsequently confined in prison for 46 days. They challenged their imprisonment, seeking a declaration that their confinement was not authorized by the Public Health Act and that the confinement of patients with infectious diseases in prison facilities for the purposes of treatment was a violation of their rights.

## Held

- Under certain circumstances, confinement of TB patients is a justified limitation of their rights and complies with the Siracusa Principles. However, their confinement in penal institutions “was not in accordance with the Public Health Act, or international guidelines and principles regarding isolation of patients with TB.” It violated the Petitioners’ and other similarly-situated patients’ rights to liberty and freedom of movement, to be free from torture and cruel, inhuman and degrading treatment as well as their rights to freedom of association and assembly. Such confinement could not meet its intended health purposes, given the conditions in Kenyan prisons (i.e. overcrowding and lack of both basic and isolation facilities).
- The Petitioners’ confinement in prison was not authorized under Section 27 of the Public Health Act. The Minister for Public Health and Sanitation to issue a circular, within 30 days, to medical facilities and public health officers clarifying this.
- The Minister to develop, within 90 days and in consultation with county governments, a policy on confinement of people with TB and other infectious diseases that is compliant with the Constitution and best practices, and to file an affidavit with the Court detailing the measures put in place.

## Right to conditions of detention consistent with human dignity; right to access health care services in prisons: Failure to provide adequate health care

### *Medical / scientific issues: TB disease progression and transmission in prisons*

**Court: Constitutional Court of South Africa**

**Parties: Lee v Minister of Correctional Services**

**Citation: 2013 (2) SA 144 (CC)**

## Facts

Mr Lee spent nearly 5 years in Pollsmoor prison before being acquitted. He was in reasonably good health on entry, but was diagnosed with TB after 3 years in custody. He challenged the failure of the prison system to protect his health – through preventive and precautionary measures - and to provide adequately for his health needs, once he had TB. He claimed damages for the unlawful detention and failure to provide adequate conditions of imprisonment, which had resulted in his illness.

## Held

- Pollsmoor prison was overcrowded and held detainees in close conditions with poor ventilation; this provided an ideal condition for TB transmission.
- There is a legal duty on the Department of Correctional Services to provide adequate health care services as part of the constitutional right of all prisoners to conditions of detention that are consistent with human dignity.
- The Department of Correctional Services was aware that TB was prevalent in the prison facility, and yet failed to implement a comprehensive system to identify and manage TB cases. The Department had also failed to provide Mr Lee with adequate medical treatment to cure and prevent the further spread of TB to others, once he was diagnosed with TB.
- The Department of Correctional Services had breached its constitutional obligation to provide adequate health care and conditions of detention that respected his human dignity.
- On a balance of probabilities, the negligent omissions by the Department caused Mr Lee’s illness and he should be entitled to damages.



## Module II:

# HIV, TB, health and human rights



## Objectives of the module

### By the end of this module participants will be able to:

- Understand how HIV, TB and human rights are inextricably linked.
- Understand how the regional and international human rights framework relates to and supports public health goals for HIV, TB and key and vulnerable populations.
- Understand the role of international (and regional) human rights in domestic courts and guidance on how it may be applied.
- Understand why and how the courts may be asked to consider the rights of key and vulnerable populations in the context of HIV, TB and health.

### Key points covered in this module

- Human rights are guaranteed by international and regional treaties and apply to all persons affected by HIV and TB.
- A human rights-based response to HIV and TB is critical to protect the rights of key and vulnerable populations and to promote public health goals.
- Litigation on the rights of people living with HIV, people with TB, key and vulnerable populations will often require the interpretation of domestic Constitutions, laws and policies to deal with emerging issues. International law and comparative jurisprudence may support courts in this regard.

### Recommended readings/documents for this module

- [African Commission \(2023\) Resolution 552 on the Promotion and Protection of the Rights of Intersex Persons in Africa](#)
- [African Commission \(2014\) Resolution 275](#)
- [CESCR \(2000\) General Comment No 14 on the Right to the Highest Attainable Standard of Health \(Art 12\)](#)
- [CESCR \(2009\) General Comment No. 20: Non-discrimination in economic, social and cultural rights](#)
- [Committee on the Rights of the Child \(2003\) General Comment No. 3: HIV/AIDS and the Rights of the Child](#)
- [Committee on the Rights of the Child \(2003\) General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child](#)
- [Dingake \(2017\) Human Rights, TB, Legislation and Jurisprudence](#)
- [Global Commission on HIV and the Law \(2018\) Risks, Rights & Health Supplement](#)
- [Global Commission on HIV and the Law \(2012\) Risks, Rights & Health](#)
- [Kavanagh, M et al \(2020\) Tuberculosis, human rights and law reform: Addressing the lack of progress in the global tuberculosis response](#)
- [OHCHR \(2006\) International Guidelines on HIV/AIDS and Human Rights](#)
- [Southern African Litigation Centre \(2012\) Litigating Cases on HIV Discrimination](#)
- [UNDP Capacity Development: TB, law, human rights and gender equality](#)

## Recommended facilitators

It may be useful to request an input from experts in human rights law, particularly those with expertise in HIV, TB, health and human rights-related law affecting key populations. This may include academics from relevant research organizations and academic institutions, senior staff from UN agencies, national human rights institutions, human rights and legal organizations and/or senior lawyers who have successfully used regional and international human rights treaties in domestic courts.

## What are human rights?

Human rights are a set of basic entitlements inherent to all humans. They apply equally to all human beings irrespective of their sex, nationality, religion, culture or other status. Human rights are guaranteed by international and regional treaties and in the national Constitutions of many countries (see Human Rights Framework, below). They require that every human being be treated with dignity and respect, including people living with HIV, people with TB, lesbian, gay, bisexual, transgender and intersex (LGBTI) people, sex workers, people who use drugs, prisoners and migrant and mobile populations, amongst others.

### The basic characteristics of human rights include:

- They are **universal**: all human beings have human rights, at all times.
- They are **fundamental**: human rights are essential to human dignity and survival.
- They **treat everyone equally**: human rights recognize that all human beings are born free and equal.
- They are **inalienable**: human rights cannot be forfeited, transferred, lost or restricted except as provided by law.

## The human rights framework

### Domestic Constitutions

Constitutions in Africa tend to contain an extensive bill of rights. The content of the bill of rights ought to be looked at within the context of the rights of people living with HIV, people with TB and key populations in each individual jurisdiction.

### International human rights instruments and their application to HIV, TB, key and vulnerable populations

The key human rights principles which are essential in the intervention of HIV and TB are found in existing international treaties. These treaties have been derived from the Universal Declaration of Human Rights (UDHR). The relevant treaties are as follows:

- International Covenant on Civil and Political Rights (ICCPR).
- International Covenant on Economic, Social and Cultural Rights (ICESCR).
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).
- Convention on the Rights of the Child (CRC).
- Convention against Torture and Other Cruel, Inhuman and Degrading Treatment and Punishment (CAT).
- Convention on the Rights of Persons with Disabilities (CRPD).
- Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.

International and regional law, as well as a number of national Constitutions, protect the right to the enjoyment of the highest attainable standard of physical and mental health. (See Table 4, below).

## What is the right to health?

International law has expanded on the meaning of the right to health:

- It is an inclusive right extending beyond access to health services to include a wide range of factors, and related rights (e.g. the right to equality, including gender equality), that support the full development of all persons, leaving no-one behind.
- The right to health contains freedoms, such as the right to be free from non-consensual medical treatment, and to be free from torture and other cruel, inhuman and degrading treatment or punishment.
- The right to health also contains entitlements, such as the right to non-discriminatory access to information services, the right to prevention, treatment and control of disease, access to essential medicines, and the right to participation in health-related decision-making.
- Health goods, facilities and services must be provided to all without discrimination.
- All services, goods and facilities must be available, accessible, acceptable and of good quality.

Source: [OHCHR \(2008\) The Right to Health: Fact Sheet](#)

International human rights treaties prohibit discrimination on the basis of health status, which is interpreted to include HIV and TB status.

The ICCPR provides in Article 2 that “Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.” [emphasis added]. A similar clause is replicated in the preamble to the UDHR, ICESCR under Article 2(2), and the CRC under Article 2(1).

The Committee on Economic, Social and Cultural Rights (CESCR) has noted that the term “other status” includes health status, including HIV and AIDS. This has been confirmed by the Committee on Civil and Political Rights. Similarly, Article 2 of the CRC has been interpreted by the Committee on the Rights of the Child to include the HIV status of the child and their parent(s).

International human rights treaties also prohibit discrimination based on sexual orientation and gender identity. In 1994, the Human Rights Committee in *Toonen v. Australia* noted that countries were required to protect individuals from discrimination on the basis of their sexual orientation. This was affirmed by the CESCR, the Committee on the Rights of the Child, the Committee against Torture and the Committee on the Elimination of Discrimination against Women. For instance, the CESCR in General Comment No. 20 noted that “other status” included sexual orientation and that “gender identity is recognized as among the prohibited grounds of discrimination.”<sup>8</sup>

### Key point

The right to equality and non-discrimination has been held to include non-discrimination on the basis of HIV status, as well as non-discrimination on the basis of sexual orientation and gender identity. United Nations human rights treaty bodies have confirmed that sexual orientation and gender identity are included among prohibited grounds of discrimination under international human rights law. This position has been confirmed repeatedly in decisions and general guidance issued by several treaty bodies, such as the United Nations Human Rights Committee, the Committee on Economic, Social and Cultural Rights, the Committee on the Rights of the Child, the Committee against Torture, and the Committee on the Elimination of Discrimination against Women.

## Regional instruments and their application to HIV, TB, key and vulnerable populations

The core regional human rights instruments include the African Charter on Human and Peoples' Rights (ACHPR), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the African Women's Protocol) and the African Charter on the Rights and Welfare of the Child (ACRWC).

The African Charter on Human and Peoples Rights was adopted in 1981 and entered into force on 21st October 1986. The adoption of the charter marked a new beginning in the subject of human rights in the African continent. While the charter is strongly inspired by the UDHR and other international and regional instruments, it is said to embody the African culture and legal philosophy, and is specifically directed towards the African context. It is a diversion from other core instruments namely the ICCPR and the ICESCR, in that it protects both socio-economic and cultural rights (so-called 'second generation rights') and collective rights (so-called 'third generation' rights) in one document.

The African Charter on the Rights and Welfare of the Child was adopted in 1990 and came into force on 29th November 1999. The Charter is an embodiment of social, cultural and economic rights of the child from an African perspective.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (also known as Maputo Protocol) was adopted in 2003 and came into force in 2005. The Maputo Protocol provides for the rights of women in Africa, including their right to health and equality.

Like the international treaties, the African Commission on Human and Peoples' Rights has made clear that the ACHPR prohibits discrimination on the basis of sexual orientation and gender identity. In Resolution 275, the African Commission expressed concern at the high levels of violence against people on the basis of their real or imputed sexual orientation and gender identity and their allies and urged countries to end all such acts of violence and abuse.

Recently, the African Commission called upon States to promote and protect the rights of intersex persons and to prohibit non-consensual genital surgical, hormonal and/or sterilization practices, which violate their right to bodily integrity, physical integrity and self-determination in Resolution 552 on the Promotion and Protection of the Rights of Intersex Persons in Africa.

### Note to the trainer

Obtain the full text of relevant treaties, and updated information on human rights by country - which countries have ratified which treaties - from the Office of the High Commission for Human Rights website.

Similarly, obtain information on African human rights instruments from the African Union webpage: Treaties

## Using international and regional law in domestic courts

Litigation on the rights of people living with HIV, people with TB and key populations will involve the interpretation of domestic Constitutions, policies and laws. Since this often involves emerging issues, there will also be instances where the courts may need to draw from international human rights law. This is particularly true where the rights jurisprudence in domestic law is undeveloped.

There are at least two ways in which international human rights law can play a role in domestic courts:

- It may be directly enforceable, where the treaty is determined to be self-executing or the domestic bill of rights is not considered exhaustive.
- It can assist courts in determining the breadth and scope of domestically-enshrined rights.

How this is done will depend on whether the domestic system is monist or dualist.

## Monism v dualism

In general, civil law countries are monist. Monism sees a unity between international law and domestic law as a result of which international law is binding and automatically incorporated into domestic law (through adoption).

Common law countries in general are dualist. Dualism favours the distinction of domestic law and international law based on sovereignty of nations. In these jurisdictions, domestic law and international law are regarded as two distinct systems of law. Individual States have a right to determine how to deal with international norms. The result of this is that international human rights norms ratified by dualist states are generally not directly enforceable until they have been incorporated into domestic law. However even in dualist countries, courts can take into account international law when determining the nature and scope of domestically-enshrined constitutional rights.

Despite this dichotomy, modern day Constitutions have adopted seemingly hybrid positions making the monism/dualism debate increasingly dependent on the interpretation of the court.

### Key point

Given the limited and still emerging law and jurisprudence around HIV, TB, key and vulnerable populations, jurists have drawn on international and regional human rights norms, as well as national policies in interpreting domestic Constitutions and laws in the context of HIV, TB, key and vulnerable populations. This has helped expand the breadth and scope of domestic provisions.

**Table 3: Excerpts from select African Constitutions on application of international law**

Country	Constitutional provision on application of international law
Cameroon	Art 45 Duly approved or ratified treaties and international agreements shall, following their publication, override national laws, provided the other party implements the said treaty or agreement.
Benin	Art 18(3) It shall be the duty of the State to ensure the elimination of all discrimination against women and the protection of the rights of women and the child as stipulated in international declarations and conventions.
Burkina Faso	Art 151 Treaties or agreements that have been duly ratified or adopted have, upon publication, an authority superior to that of laws, provided that each agreement or treaty is applied by the other party.
Côte d'Ivoire	Art 87 Treaties or agreements that have been duly ratified shall, from the time of their publication, take precedence over laws, subject to each treaty or agreement being applied by the other party.
DRC	Art 45 It shall be the duty of the public authorities to ensure the dissemination and teaching of the Constitution, the Universal Declaration of Human Rights, the African Charter on Human and Peoples' Rights and all duly ratified regional and international conventions relating to human rights and international humanitarian law.
Ethiopia	Art 13(2) The fundamental rights and freedoms specified in this Chapter shall be interpreted in a manner conforming to the principles of the Universal Declaration of Human Rights, international human rights covenants and conventions ratified by Ethiopia.
Ghana	Art 33(5) The rights, duties, declarations and guarantees relating to the fundamental human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned which are considered to be inherent in a democracy and intended to secure the freedom and dignity of man.
Kenya	Art 2(5) The general rules of international law shall form part of the law of Kenya.  Art 2(6) Any treaty or convention ratified by Kenya shall form part of the law of Kenya under this Constitution.
Malawi	Section 11(2)(c) In interpreting the provisions of this Constitution a court of law shall...where applicable, have regard to current norms of public international law and comparable foreign case law.

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Mozambique	<p>Art 17(2) The Republic of Mozambique shall accept, observe and apply the principles of the Charter of the United Nations and of the Charter of the Organization of African Unity.</p> <p>Art 18(1) Validly approved and ratified international treaties and agreements shall enter into force in the Mozambican legal order once they have been officially published and while they are internationally binding on the Mozambican State.</p> <p>Art 18(2) Norms of international law shall have the same force in the Mozambican legal order as have infra-constitutional legislative acts of the Assembly of the Republic and the Government, according to the respective manner in which they are received.</p>
Namibia	<p>Art 144: Unless otherwise provided by this Constitution or Act of Parliament, the general rules of public international law and international agreements binding upon Namibia under this Constitution shall form part of the law of Namibia.</p>
Nigeria	<p>Art 12(1) No treaty between the Federation and any other country shall have the force of law to the extent to which any such treaty has been enacted into law by the National Assembly.</p>
South Africa	<p>Art 39(1) When interpreting the Bill of Rights, a court, tribunal or forum...must consider international law; and may consider foreign law.</p> <p>Art 231(2) An international agreement binds the Republic only after it has been approved by resolution in both the National Assembly and the National Council of Provinces, unless it is an agreement referred to in subsection (3).</p> <p>Art 231(3) An international agreement of a technical, administrative or executive nature, or an agreement which does not require either ratification or accession, entered into by the national executive, binds the Republic without approval by the National Assembly and the National Council of Provinces, but must be tabled in the Assembly and the Council within a reasonable time.</p> <p>Art 231(4) Any international agreement becomes law in the Republic when it is enacted into law by national legislation; but a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament.</p> <p>Art 231(5) The Republic is bound by international agreements which were binding on the Republic when this Constitution took effect.</p>
Zimbabwe	<p>Section 34 The State must ensure that all international conventions, treaties and agreements to which Zimbabwe is a party are incorporated into domestic law.</p> <p>Section 46 When interpreting this Chapter, a court, tribunal, forum or body... must take into account international law and all treaties and conventions to which Zimbabwe is a party.</p>

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## Note to the trainer

Participants may have views on the place and role of the use of international law in domestic courts, as well as examples to share of how they or their peers may have used international law and regional treaties or guidelines in their courts. These may differ between Anglophone, Francophone and Lusophone jurisdictions. It may be useful to allow sharing of views and experiences at national level, as well as the approaches of neighbouring countries.

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## Note to the trainer

Even where national Constitutions do not contain all of the human rights protected in international human rights treaties (such as e.g. the right to health, or the right to privacy), other rights can be interpreted broadly to incorporate fundamental freedoms and entitlements. Ask participants to discuss how their countries may have interpreted other rights (such as the right to life, and the right to dignity) to protect the health rights of key and vulnerable populations.

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## Towards a human rights-based response to HIV, TB, health and development

HIV, TB, health and human rights for key and vulnerable populations are inextricably linked. The Global Commission on HIV and the Law (GCHL) documented the importance of a human rights-based response to HIV and TB, and how stigma, discrimination, violence, punitive laws and discriminatory practices against people living with HIV, people with TB and key populations obstruct their access to education, employment, housing,

health information and services and other rights. This undermines public health, exacerbating the spread of HIV and negatively impacting on the health of those affected when they fail to seek necessary care.

### Key point

Strategies to address the epidemic and reach people living with HIV, people with TB, key and vulnerable populations with health information, prevention, treatment, care and support services are ineffective in an environment where human rights are not respected.

Punitive laws and policies – such as those requiring compulsory detention of people with TB for non-compliance with medicine – potentially undermine health responses.

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A human rights-based response to both HIV and TB provides a comprehensive framework for responding to both by preventing transmission, reducing the adverse impact on those affected, and empowering society to respond to both HIV and TB. The approach also:

- Focuses on the factors that make people vulnerable to HIV and TB, including socio-economic and structural factors such as poverty, stigmatization and discrimination against people living with HIV, people with TB and key populations, in education, health, and other sectors.
- Protects and respects the domestic, regional and international human rights of all actors and takes steps to prevent violations of such rights.
- Requires that people living with HIV, people with TB and key populations have access to effective remedies for human rights violations.
- Creates an enabling legal environment for an effective HIV and TB response, including through providing for research and new tools for preventing and treating HIV and TB through the application of the right to benefit from scientific progress.

**Table 4: Human Rights relevant for jurisprudence involving HIV, TB, key and vulnerable populations**

<b>Nature of Right</b>	<b>References</b>	<b>HIV related violations</b>	<b>Impact on HIV and human rights</b>
Right to equality and non-discrimination	Art 2, 7 UDHR Art 2, 26 ICCPR Art 2, 3, 26 ICESCR Art 2 CRC	Discrimination on the basis of HIV and TB in access to employment, health care, education, access to benefits from social security programmes and in working conditions.  Discrimination on the basis of gender, sexual orientation and gender identity, including in access to health services, employment and education.	Discrimination denies people living with HIV, people with TB, and key populations access to HIV and TB prevention, treatment, care and support services.  Places key populations at increased risk of HIV and TB.  Creates fear and forces key populations to remain 'invisible' in society, limiting their access to important services and negatively impacting on their health.
Right to life	Art 3 UDHR Art 6 ICCPR Art 4 ACHPR	State failing to take appropriate action to reduce HIV and TB transmission, and provide treatment for HIV and TB for key and vulnerable populations.	Unjustified restriction of access to life-saving treatment or prevention measures threatens the right to enjoyment of life for people living with HIV and TB and key populations.
Right to human dignity	Art 22 UDHR Art 10 ICCPR Art 4,5 ACHPR	People living with HIV and TB being held in prisons under deplorable conditions that sometimes cause death or denying them access to activities available to other inmates.  Stigma and discrimination against people living with HIV, people with TB and key populations that undermines the dignity of people.	Places key populations at increased risk of HIV and TB depending on the conditions they live under and aggravates HIV.  Makes it less likely that affected populations can access necessary health care services.
Rights of persons detained, held in custody or imprisoned	Arts 9, 10 ICCPR Art 24 ACHPR	Denial of interventions and health services to key populations, people living with HIV and people with TB, including ARVs, for prevention, testing, treatment and care.  Exposure to environments that predispose them to higher risk of HIV, TB and other related conditions.	Places key populations at increased risk of HIV and TB depending on the conditions they live under.
Right to liberty, security of the person and protection from cruel, inhuman or degrading treatment	Art 3, 5 UDHR Art 5, 7, 9 ICCPR Art ACPHR Art 37 CRC	People perceived to be at higher risk of HIV exposure (e.g. sex workers) may be subjected to mandatory HIV testing without their voluntary and informed consent.  People may be coerced into treatment, or placed into quarantine / isolation without due process.  Key populations, including e.g. sex workers, people who use drugs, gay, bisexual and other men who have sex with men and transgender and gender-diverse people may experience violence and harassment by law enforcement.	Mandatory HIV testing laws and policies and violence and harassment create fear, discouraging key and vulnerable populations from accessing health care services and increasing their risk of HIV exposure.



Right to privacy	Art 12 UDHR Art 17 ICCPR Art 16 CRC	People living with HIV and TB experience breaches of their right to confidentiality about their status.  Criminalization of consensual same-sex sexual activity violates the right to privacy.	Breaches of confidentiality create fear and discourage people living with HIV or TB from seeking out health services.  Criminalization of same-sex sex makes LGBTI people less likely to access health care services and vulnerable to poor health, including HIV.
Right to marry and found a family	Art 16 UDHR Art 18 ACHPR Art 23 ICCPR	People living with HIV are subjected to mandatory pre-marital HIV testing and AIDS free certificates before marriage, are denied access to reproductive health care services, pressured to have an abortion, not to have children or to have sex, and even forcibly sterilized.	Denying people living with HIV equal access to marriage, reproductive and family rights denies them an opportunity for the psychological and emotional satisfaction and fulfilment of family.
Freedom of assembly and association	Art 20, 23(4) UDHR Art 8 ICESCR Art 21, 22 ICCPR Art 15 CRC Art 10 ACHPR	People living with HIV and TB are denied the right to organize and form support organizations.  Organizations focusing on the rights and health of key populations, including e.g. organizations of people who use drugs, sex workers, LGBTI people, are denied registration and therefore the ability to operate.	Where laws or practices prevent key populations from organizing, they lose an important source of information and support to promote their health.
Right to freedom of movement	Art 13 UDHR Art 12, 13 ICCPR Art 12 ACHPR	HIV and TB being treated differently from other diseases with regard to immigration, long-term residency or short-term visits to any country.	Countries that require information about HIV status, that deport people who are living with HIV, and who treat HIV differently from other diseases, can undermine access to health care, information and other human rights.
Right to access to information	Art 19 UDHR Art 9 ACPHR	Laws and policies in some countries prohibit adolescents, children and key populations from getting appropriate HIV information and education	Affected and key populations do not receive appropriate HIV information so they are less able to prevent HIV infection or access available services.
The right to work and to remuneration and safety at work/fair labour practices	Art 23 UDHR Art 6, 7 ICESCR Art 15 ACHPR	Dismissal/termination of people living with HIV or TB on the basis of their health status and of individuals on the basis of their real or imputed sexual orientation and gender identity.  Discrimination against e.g. LGBTI people in the working environment denies them the right to work.	Workplace discrimination denies employees with HIV or TB and key populations the ability to earn a living when they may need income most. This increases the impact of HIV on their lives and their vulnerability to HIV.
Right to social security	Art 22, 25 UDHR Art 9, 11 ICESCR Art 26, 27 CRC Art 26 CRC	The right to access and maintain benefits, whether in cash or in kind, in order to secure protection from, among other things: lack of income from work caused by sickness, disability, maternity, employment injury, unemployment, old age or death of a family member; unaffordable access to health care; or insufficient family support for children and adult dependents.	Lack of access to social security renders people affected with TB, key populations and people living with HIV vulnerable and desperate.

Right to property	Art 17 UDHR Art 14 ACHPR	Discrimination causes loss of inheritance and property arbitrarily taken away from people living with HIV and key populations simply because of their status and/or real or imputed sexual orientation and gender identity.	Entrenches poverty because people living with HIV and key populations are not able to enjoy property rights.
Right to education	Art 26 UDHR Art 13 ICESCR Art 17 ACHPR Art 28, 29 CRC	People living with HIV and TB and key populations are denied an opportunity for education, being denied enrolment or being expelled because of their HIV and TB status or real or imputed sexual orientation and gender identity.	Denies people living with HIV and TB and key populations an opportunity for full development and entrenches the discrimination and stigma against key populations, people living with HIV and people with TB.
Right to highest attainable standard of health	Art 25 UDHR Art 12 ICESCR Art 16 ACHPR Art 24, 25 CRC	People living with HIV and TB and key populations are denied accessible, available and high-quality health care in a dignified manner free from coercion and stigmatization. This includes those who have been incarcerated or otherwise denied their liberty.	Denies people living with HIV and TB and key populations the benefit of treatment which fails to eliminate HIV, TB and its adverse effects.
Right to adequate standard of living including food, clothing and housing	Art 25 UDHR Art 11 ICESCR	People living with HIV and TB and key populations lack access to sufficient, nutritionally adequate and safe food, to affordable, accessible and habitable housing, to safe and adequate drinking water.	Living in deplorable conditions heightens vulnerability to HIV and TB, especially for key populations, and exacerbates the condition for those living with HIV and/or TB.

## Note to the trainer

Request participants to share their experiences with adjudication of human rights and some of the limitations in implementing human rights, including in the context of HIV, TB, key and vulnerable populations. These may include:

- Insufficient capacity building for lawyers, judges and magistrates on the application of international human rights law generally, and including in the context of HIV, TB, key and vulnerable populations.
- Lack of political commitment to fully implement human rights that protect the rights of marginalized populations.
- Lack of political commitment to fully implement social and economic rights including the right to adequate food, housing and health immediately, despite international law requiring the ‘progressive realization’ of these rights and ensuring, even amongst resource constrained countries, that equal access to rights is guaranteed and that continuous steps are taken to provide and improve access to health for all within resources.
- Limited jurisprudence applying international, regional and national human right to HIV, TB, key and vulnerable populations amidst a constantly changing medical and scientific field.

Reading into their national human rights protection, referring to international and regional law and findings in other jurisdictions, courts across Africa have made various progressive findings relating to HIV, TB and the rights of key and vulnerable populations. For instance:

- Courts have recognized that, despite specific anti-discrimination for people on the basis of, for example, HIV, TB, sexual orientation, gender identity and other grounds, people are still entitled to protection under broad equality and non-discrimination rights and provisions.

- Courts across the region have recognized and responded to discrimination and human rights violations against people living with HIV, people with TB, key and vulnerable populations in various sectors, including the health care sector, the working environment, the education sector and within places of detention, amongst others.
- In addition, case law has recognized and responded to a multitude of rights violations, including violations of the right to equality and non-discrimination, health, life, privacy, dignity, security of the person, right to be protected from cruel, inhuman and degrading treatment or punishment and the right to fair labour practices, amongst others.
- Notable findings in the health care sector include (i) the right to be protected from discrimination in health care; (ii) the right to HIV testing and other medical procedures (e.g. sterilization) only with voluntary and informed consent; (iii) the right to be protected from unreasonable restrictions on freedom of movement, liberty (e.g. isolation, imprisonment); and (iv) the duty on the State to provide access to health care services.
- Notable findings in the prison setting and guidance from the UN Standard Minimum Rules for the Treatment of Prisoners include that (i) prisons should take necessary measures to protect the health rights of all detained persons; including providing adequate access to screening, prevention and treatment as well as conditions of detention that promote health e.g. access to HIV and TB related information, education, testing, counselling and means of prevention (including condoms and clean injection equipment); (ii) prisons officers should be encouraged to take all necessary measures including adequate staffing, surveillance and appropriate disciplinary measures to protect prisoners from sexual violence; (iii) prisons should prohibit mandatory testing and ensure confidentiality of information; (iv) segregation and denial of prison facilities should be prohibited; and (v) compassionate and early release of prisoners living with HIV and TB may be considered.
- Notable findings in the workplace include (i) that compulsory screening has the potential to violate rights to voluntary, informed consent and confidentiality, and does not, as a matter of course, determine a person's suitability to fulfil the requirements of a job; (ii) people living with HIV and people with TB should be provided with 'reasonable accommodation' within the working environment, allowing them to continue to work as long as they remain medically fit for appropriate work; (iii) employment relationships should only be terminated, under appropriate conditions, where a worker is too ill to continue to work and where alternative working arrangements, including extended sick leave have been exhausted; and (iv) reasonably accommodating workers with AIDS-related illnesses and TB including rearrangement of working time, special equipment, opportunities for rest breaks, time off for medical appointments and to undergo treatment, flexible sick leave, part-time work and return-to-work arrangements.

## Key considerations for the courts

Various cases involving HIV, TB stigma, discrimination and rights violations may come before the courts, including e.g.:

- Cases involving discrimination in health care, including denial of care or the provision of inadequate services, forced or involuntary HIV testing and other medical procedures including coercive sterilization of women living with HIV and forced surgery on intersex children, unjustified isolation and quarantine without due process or inadequate access to health care treatment, amongst other things.
- Cases involving stigma and discrimination in the workplace such as mandatory pre-employment HIV testing and unfair dismissals on the basis of a person's HIV status.
- Cases involving stigma and discrimination in education, such as denying enrolment and limiting access to opportunities such as scholarships to learners with HIV.
- Cases involving stigma, discrimination and limited access to health care for a range of populations such as sex workers, LGBTI people, people who use drugs, prisoners, people with disabilities, migrants and mobile populations, etc.
- Courts have a growing body of jurisprudence which they may refer to, in which other jurisdictions have applied broad rights – such as rights to equality, non-discrimination, life, privacy, security of the person, and health – to disputes involving people affected by HIV and TB.

- In addition, there is a growing body of evidence on the nature and extent of stigma and discrimination, and its impact on people living with HIV, people with TB, key and vulnerable populations. This evidence may also be useful for adjudicating cases of stigma and discrimination against affected populations.
- Courts and other people who interact with people living with HIV and people with TB, key and vulnerable populations should use language with care, so as not to entrench stigma and discrimination. In cases involving gender identity, it is important for courts to refer to the parties by their preferred pronouns.

## Comparative jurisprudence

There are a number of resources and compendiums of case law relevant to HIV, TB, key and vulnerable populations. Select case law is set out below.

### Right to dignity; right to privacy: Breach of confidentiality regarding HIV status

**Parties:** *C.O.M. v Standard Group Limited and Another*

**Citation:** Petition 192 of 2011

**Court:** High Court of Kenya, Nairobi

#### Facts

C.O.M. conducted an interview with the Respondent, Standard Group Limited, regarding people living with HIV. Several photographs were taken during the interview, and the subsequent article included a photograph of the Petitioner, with his name.

The Petitioner claimed he had not agreed for his photograph and name to be included in the article and had not consented to disclosure of his health status. As a result of the publication, he claimed he lost respect from friends, suffered heightened discrimination and loss of business and was forced to move his children to a different school.

He challenged the Respondent's disclosure in terms of the HIV and AIDS Prevention and Control Act No 14 of 2006, and on the basis that his constitutional rights to privacy and dignity had been violated. He sought an injunction against any further use of his photograph and name, and damages under the Constitution.

#### Held

- The HIV and AIDS Prevention and Control Act requires written consent for disclosure of a person's HIV status, with such consent to be given "without any force, fraud or threat and with full knowledge and understanding of the medical and social consequences of the matter to which the consent relates."
- There was no clear evidence that the Petitioner had consented to the publication of his photograph and name.
- The disclosure of the Petitioner's personal details was a violation of his dignity and his right to privacy.
- The court declined to grant the Petitioner special or punitive and exemplary damages, or general damages for pain and suffering but did order compensation generally, in terms of the Constitution.

## Right to be free from discrimination in health care: Refusal of health care

**Parties:** *Georgina Ahamefule v. Imperial Medical Centre*

**Citation:** Suit No. ID/16272000

**Court:** High Court of Lagos State, Nigeria, 2012

### Facts

The Plaintiff was a nurse at the Defendant medical centre. While under the employment of the Defendant she became pregnant and developed a skin disorder. She sought medical attention and a doctor at the Defendant's centre performed several diagnostic tests. She was referred to a hospital for further testing. At the hospital, blood samples were taken from both the Plaintiff and her husband, but the nature of the tests was not disclosed. The Plaintiff was later informed that she had tested positive for HIV, and her husband had tested negative. She was terminated from her position at the medical centre.

The Plaintiff subsequently suffered a miscarriage as a result of trauma from the incident but the Defendants denied her access to medical care at the medical centre and refused to perform the requisite cleaning operation following the miscarriage, because of her HIV status.

### Held

- The court found a direct violation of rights in international and regional human rights treaties; the Defendant's action in denying the Plaintiff medical care on grounds of her HIV-positive status was a violation of the right to health as guaranteed under article 16 of the Banjul Charter and article 12 of the ICESCR.
- The Defendant was ordered to pay damages to the Plaintiff.

## Right to health, right to equality: Government failure to provide access to medicines

**Parties:** *Minister of Health and Others v Treatment Action Campaign and Others*

**Citation:** 2002 (5) SA 721

**Court:** Constitutional Court, South Africa

### Facts

The Medicines Control Council registered Nevirapine for use to reduce the risk of mother-to-child transmission of HIV in South Africa, and doctors in private practice began to prescribe it to pregnant women living with HIV. However, it was not yet available in the public health sector. In 2000, the South African government was provided Nevirapine free of charge for 5 years by the manufacturers, and introduced a pilot programme to provide nevirapine to pregnant mother living with HIV at two research and training sites per province.

The Treatment Action Campaign challenged the government's failure to provide nevirapine (ART) to all pregnant women living with HIV as a violation of various rights, including the right to access to health care services without discrimination, the rights of the child, and the right to equality, in that the government discriminated against poor women (and their newborn children) by allowing nevirapine to be available in the private health care system and not allowing it to be widely available in the public health care system. The case went on appeal from the High Court.

### Held

- Socio-economic rights are enforceable under the Constitution of South Africa. The State must take reasonable steps to progressively realize these rights.
- The government policy limiting the supply of nevirapine to its research sites will primarily affect and exclude the poor who cannot pay for nevirapine, and who live outside of the research site areas and cannot access the services.

- Government policy should take into account the difference between those who can afford to pay for services, and those who cannot.
- The right to health requires government to implement, within its available resources, a programme to realize progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV.
- The current policy falls short of this because doctors at public hospitals outside of the research sites were not able to prescribe nevirapine to reduce mother-to-child transmission, even where it was medically indicated.

Note: The Court did not specifically deal with the infringement of the right to equality, but did note that the lack of accessibility would primarily affect the poor.

## Right to life, human dignity and health: Government duty to provide access to medicines

### ***Parties: PAO & 2 Others v AG***

**Citation:** [2012] eKLR; Petition 409/2009

**Court:** Constitutional Court Kenya

### **Facts**

The Petitioners were people living with HIV who had been taking ART for periods ranging from 8-19 years. An earlier statute, the Kenya Industrial Property Act, 2001 had allowed the use of generic drugs and by this, the Petitioners had been able to access free and cheap generic drugs. The enactment of the Anti-Counterfeit Act 2008 sought to disallow the use of generic drugs. The Petitioners feared that this would drive the cost of ARVs up and make the medicine inaccessible thereby infringing on their rights. They sought a declaration of the court that their rights to life, human dignity and health would be infringed and any other orders that the court deemed fit.

### **Held**

- The right to life, human dignity and health encompasses access to affordable and essential drugs and medicines including generic drugs for HIV.
- In so far as the Anti-Counterfeit Act severely limits or threatens to limit access to affordable and essential drugs, it was a violation of these rights.
- The State was required to consider the provisions of the Act alongside the constitutional obligation to ensure that its citizens have access to the highest attainable standards of health.

## Freedom of movement: Isolation of people with TB

### ***Parties: Minister of Health v Goliath & Others***

**Citation:** (2) SA 248

**Court:** High Court of SA, Cape of Good Hope Provincial Division

### **Facts**

The Applicants were diagnosed with highly infectious drug-resistant TB. They were voluntarily admitted to hospital for treatment, but in the course of treatment some Applicants refused to be isolated or treated. They also regularly absconded from the facility, citing deplorable conditions at the facility as well as family and financial obligations.

They brought an action against the Minister for Health challenging their forced isolation, arguing that it was an infringement of their freedom of liberty.

## Held

- The State did not violate the Applicants' rights to personal freedom by enforcing their compulsory admission and continued isolation in hospital.
- Though the Applicants rights to liberty was infringed, the infringement was justified given the public health concerns. The court cited provisions from the Constitution of Ghana which permits limitations on the right to liberty "in case of a person suffering from an infectious or contagious disease for the purpose of his care or treatment or protection of the community."
- The Court relied on the ICCPR and the European Convention on Human Rights when assessing whether the infringement on liberty was justified.

## Right to access to health care; prisoners' rights: Prisoner's health

### ***Parties: Lohé Issa Konaté v Burkina Faso***

**Citation: Application No. 004/2013**

**Court: African Court on Human and Peoples' Rights**

## Facts

Lohé Issa Konaté applied to the African Court of Human and Peoples' Rights arguing that his term of imprisonment and fine for libel in Burkina Faso was a violation of his right to freedom of expression and asked the African Court to declare the sentence a violation of his rights, to declare the laws in Burkina Faso with regard to libel inconsistent with the right to freedom of expression, and to be released or, failing release, to be provided with adequate medical care for the rest of his term of imprisonment.

## Held

- The Applicant's health had deteriorated since his imprisonment and he was in need of medical attention. A lack of adequate medical care might cause irreparable harm and he was entitled to access all the medical care that he needed.
- The Court ordered the State to provide the Applicant with the medication and health care required.

## Right to freedom from torture; right to highest attainable standard of health: Rights of prisoners to antiretroviral treatment

### ***Parties: Odafe v Attorney General***

**Citation: (2004) AHRLR 205**

**Court: High Court of Nigeria**

## Facts

The Applicants, 4 prisoners awaiting trial, had tested positive for HIV while in detention. They had all been awaiting trial for periods ranging from over 2 to 4 years. They alleged that their continued detention, without trial, constituted torture. They further alleged that the refusal of treatment and segregation by prison officials and inmates amounted to inhuman and degrading treatment.

## Held

- The Applicants had been awaiting trial for an unreasonable period of time, and whether brought before a court or not, had a right to be treated for any serious illness.
- The refusal to provide pre-trial prisoners with HIV access to antiretroviral treatment violated their right to freedom from torture and their right to enjoy the best attainable state of physical and mental health guaranteed under the African Charter on Human and Peoples' Rights.

- Though there is no right to health care in the Nigerian Constitution, Nigeria was obliged to provide for adequate medical treatment under the ACHPR, as it had been ratified by Nigeria.
- The State was ordered to take the necessary measures to protect the health of the Applicants.

## Right to dignity: Rights of prisoners with HIV to parole

**Parties: Stanfield v. Minister of Correctional Services & Others**

**Citation: (2003) 12 BCLR 1384**

**Court: High Court (Cape of Good Hope Provincial Division)**

### Facts

The Applicant was a 48-year-old inmate who had served about one third of a six-year sentence and who was terminally ill. He was judged by several medical experts to have at most one year to live because of small-cell carcinoma complicated by advanced ischemic heart disease. The Respondents were officials of the Correctional Services Department.

The Applicant sought immediate release on parole in view of the short time remaining in his life, which he wished to spend with his family. The Parole Board rejected his request and he appealed that decision to the High Court.

### Held

- The court granted the Applicant's request for parole.
- The Applicant had the right to die with dignity, relying on the Bill of Rights in the South African Constitution (section 10), which referred to the inherent dignity of every human being.

## Right to privacy; right not to be subjected to inhuman and degrading treatment: Pre-employment / mandatory HIV testing

**Parties: Kingaipe and Another v Attorney-General**

**Citation: Case No 2009/HL/86 (2010)**

**Court: High Court, Zambia**

### Facts

The two Petitioners had formerly served in the Zambia Air Force. While in service, they were asked to appear before a Medical Board of Inquiry to assess their illnesses and determine their fitness to serve. They were also required to undergo compulsory medical examinations, including blood tests. They were not informed that an HIV test would be conducted, and were not informed, at a later stage, that they were being treated with prescribed medication for HIV. They were subsequently dismissed from the Air Force as unfit for service, but never informed that they had HIV. The Petitioners challenged the mandatory HIV testing without informed consent and dismissals as a violation of their constitutional rights and of the Government Policy and Guidelines on HIV/AIDS.

### Held

- The Petitioners were subjected to mandatory and compulsory HIV testing.
- Mandatory HIV testing violated their right to freedom from inhuman and degrading treatment, guaranteed by the Zambian Constitution.
- This right was also protected by the African Charter on Human and Peoples' Rights and the ICCPR, which Zambia had ratified.



- The court was not persuaded that the Petitioners were discharged due to their HIV status, noting extensive evidence of declining health that restricted their mobility, prior to the HIV testing.

## Right to be free from discrimination in employment: Pre-employment / mandatory HIV testing

**Parties:** *Hoffmann v. South African Airways*

**Citation:** Case CCT 17/00 (2000); 2001 (1) SA 1 (CC); 2000 (11) BCLR 1235 (CC)

**Court:** Constitutional Court of South Africa

### Facts

In September 1996, Hoffman applied for employment as a cabin attendant with South African Airways. At the end of the interview process he was found a suitable candidate for employment and underwent a pre-employment medical examination including an HIV antibody test. The medical examination found him to be clinically fit and suitable for employment. The HIV antibody test returned a positive result. As a result, the medical report was altered to read that Hoffmann was unsuitable for employment because he was HIV-positive. South African Airways' policy prohibited the employment of people living with HIV as cabin attendants because in part they argued that cabin attendants had to be fit for worldwide duty, which required them to be vaccinated against yellow fever in accordance with National Department of Health guidelines, and persons living with HIV may react negatively to this vaccine. They also argued that people living with HIV were prone to contracting opportunistic infections and, as a result, would not be able to perform the required emergency and safety procedures. Finally, they argued that the life expectancy of people living with HIV was too short to warrant the costs of training them.

Hoffmann challenged the constitutionality of the refusal to employ him.

### Held

- The Court held that the constitutional protection against non-discrimination extended to non-discrimination on the basis of a person's HIV status.
- The Court noted the range of anti-discrimination conventions ratified by South Africa, including the African Charter on Human and Peoples' Rights and the International Labour Organization Convention 111, and the obligations on South Africa to dismantle discrimination.
- South African Airways had infringed Hoffman's right to be free from discrimination.
- South African Airways was ordered to offer to employ Hoffmann as a cabin attendant.
- South African Airways was ordered to pay Hoffmann's costs in both the High Court and in the Constitutional Court.

Note: South African Airways' medical expert gave evidence that only those persons whose CD4 cell count had dropped below 300 cells/microlitre were prone to medical, safety and occupational hazards. At the time of Hoffman's medical examination, there was nothing to indicate that he was unwell. Medical evidence, with which the South African Airways' expert concurred, demonstrated that an asymptomatic HIV-positive person can perform the work of a cabin attendant. It also demonstrated that even immuno-suppressed persons are not prone to opportunistic infections and may be vaccinated against yellow fever as long as their CD4 cell counts were above a certain level.

## Right to be free from discrimination; right to fair labour practices: Dismissal of employee with HIV

**Parties:** *Banda v Lekha*

**Citation:** Matter No. IRC 277 of 2004; [2005] MWIRC 44  
**Court:** Industrial Relations Court of Malawi

### Facts

The Respondent, Lekha, dismissed the Applicant, Banda, “immediately and without any formality”, from employment for reasons relating to the Applicant’s health. Banda had attended voluntary HIV counselling and testing, and had tested positive for HIV. Banda challenged the dismissal on the basis that she had never been incapacitated as a result of her HIV status and had consistently performed her job duties to the satisfaction of her employer.

### Held

- An employee may be lawfully dismissed for incapacity due to ill health where a person is so sick that she cannot perform the functions for which she was employed. However, the Applicant was healthy and at no time unable to perform her job duties.
- The only reason proffered for the employee’s dismissal was her HIV status. As a result, the court held that the Applicant was dismissed solely on account of her HIV status.
- The Malawi Constitution protects from discrimination, but does not list HIV as an enumerated ground for non-discrimination.
- However, based on ACHPR jurisprudence, the court read into the domestic prohibition on discrimination, including HIV as a ground for non-discrimination.
- The country’s obligation under the Constitution, the African Charter of Human and Peoples’ Rights and its national HIV policy required Malawi to dismantle all forms of discrimination and to protect people living with HIV under the law.
- The dismissal violated the Applicant’s rights to equality and to fair labour practices under the Constitution.



## **Module III:**

# **Criminal law, key and vulnerable populations**

## Objectives of the module

### By the end of this module participants will be able to:

- Discuss the application of criminal law in HIV and TB cases.
- Apply scientific and medical facts on HIV transmission and harm in legal contexts.
- Reflect on criminal law provisions in the context of HIV and TB in a way that serves justice and respects human rights.
- Balance considerations in sentencing in HIV and TB cases.
- Understand how criminal laws impact on key populations in terms of HIV and TB.
- Understand how laws, policies and inequalities makes some populations vulnerable in the context of HIV and TB.

## Key points covered in this module

- International guidance recommends against enacting specific laws to criminalize HIV transmission, exposure and non-disclosure.
- However, in many jurisdictions, criminal sanctions are applied to target what is deemed to be harmful HIV-related behaviour.
- Adjudicating cases of non-disclosure, exposure and transmission of HIV, as well as TB cases, must be based on medical and scientific facts.
- In HIV and TB transmission cases, courts have to strike a balance between achieving justice and respecting human rights vis-à-vis public health. Responses that limit human rights should be reasonable and justifiable and achieve public health goals.
- In many countries across Africa and the world, criminal laws apply to key populations – gay men and other men who have sex with men, transgender and gender-diverse people, sex workers, people who use drugs, people in prisons and other closed settings – exacerbating stigma, discrimination and rights violations and placing them at higher risk of HIV transmission.
- In addition, inequalities and discriminatory laws and policies make key populations, as well as migrant and mobile populations and people with disabilities more vulnerable to and affected by HIV and TB.
- Courts may be called upon to adjudicate upon cases where the rights of key and vulnerable populations are violated, or cases that challenge the constitutionality of laws criminalizing or discriminating against key and vulnerable populations. The impact of these punitive or discriminatory laws on their rights, including health rights, and on broader public health goals, may arise.

### Recommended readings/documents for this module

- [HIV Policy Lab, UNDP, O’Neill Institute and GNP+ \(2023\) Progress and the Peril: HIV and the Global De/criminalization of Same-Sex Sex](#)
- [Global Commission on HIV and the Law \(2018\) Risks, Rights & Health Supplement](#)
- [UNAIDS \(2023\) HIV and gay men and other men who have sex with men: 2023 Global AIDS Update: Factsheet](#)
- [UNAIDS \(2023\) HIV and sex workers: 2023 UNAIDS Global AIDS Update Factsheet](#)
- [UNAIDS \(2023\) HIV and transgender people: 2023 Global AIDS Update Factsheet](#)

- [UNAIDS \(2021\) HIV and Gay Men and Other Men who have sex with Men: Human Rights Fact Sheet](#)
- [UNAIDS \(2021\) HIV and People who Use Drugs: Human Rights Fact Sheet](#)
- [UNAIDS \(2021\) HIV and Sex Work: Human Rights Fact Sheet 2021](#)
- [UNAIDS \(2021\) HIV and Transgender and other gender-diverse people: Human Rights Fact Sheet](#)
- [UNAIDS \(2021\) HIV Criminalization: Human Rights Fact Sheet](#)
- [UNAIDS \(2017\) Disability and HIV](#)
- [UNAIDS \(2013\) Ending overly broad criminalization of HIV non-disclosure, exposure and transmission](#)
- [UNDP \(2021\) Guidance for Prosecutors on HIV-Related Criminal Cases](#)
- WHO (2017) Ethics Guidance for the Implementation of the End TB Strategy on Isolation and Involuntary Isolation

## Recommended facilitators

It may be useful to request an input from legal experts, particularly those with expertise in criminal, punitive or discriminatory laws that impact on people living with HIV, people with TB, key and vulnerable populations, including e.g.

- lawyers from human rights, legal and other civil society organizations working on HIV, TB and the rights of key and vulnerable populations.
- senior staff from UN agencies working on HIV, health and human rights issues.

It may also be useful to request an input from medical experts who can provide updated medical and scientific information on how HIV and TB are diagnosed, prevented, transmitted and treated, to establish concrete medical and scientific evidence critical to understanding and adjudicating on cases that involve criminal or punitive measures against people living with HIV and people with TB, including e.g.

- senior staff from international agencies such as UNAIDS, UNDP or WHO.
- a medical researcher, academic, or medical practitioner.

Finally, it is important to request an input from people who work with, for or represent people living with HIV, people with TB, key or vulnerable populations who can explain terms, and talk about the real-life impact of punitive and discriminatory laws, policies and practices on key and vulnerable populations, and how this impacts on their rights to health, well-being and development.

## Criminal sanctions in HIV-related cases

In many jurisdictions, criminal sanctions are applied to directly target what is deemed to be harmful HIV-related behaviour of people living with HIV by providing for the following crimes:

- Engaging in certain sexual acts with another person without disclosing one's HIV-positive status (non-disclosure).
- Exposing another person to HIV (exposure).
- Transmitting HIV to another person, especially through sex (transmission).

### Note to the trainer

Since criminalization is often a controversial and misunderstood issue, it may be useful to let participants debate the issue. Consider asking participants to debate, allowing one set of participants to support, and another set to

object to the criminalization of HIV transmission, exposure and non-disclosure. Their debate could consider the *purpose* of criminalizing harmful HIV-related behaviour, taking into account factors such as:

- The purpose of the criminal law (punishment, deterrence etc.).
- The role and efficacy of the criminal law in achieving public health goals.
- The impact of the criminal law on human rights.

Summarize the key arguments, with some suggestions as per the table below, and provide inputs on international guidance on criminalization of HIV.

The arguments from both sides are an indication of the challenges present when adjudicating, of balancing between achieving justice and respecting human rights vis-à-vis public health.

**Table 5: Arguments for and against criminalization**

<b>Proponents of criminalization</b>	<b>Critics of criminalization</b>
Criminal law serves as a deterrence.	Criminalizing sexual acts between consenting adults that expose a person to HIV does not necessarily deter sexual acts from taking place and is based on an outdated understanding of risk and harm. However, it may deter people from being tested for HIV, which does not necessarily benefit public health.
Crimes should be subjected to punishment in order to reduce further transmission of HIV.	Criminalization assigns responsibility for HIV prevention to, and punishes people living with HIV, instead of encouraging everyone to take responsibility for their own sexual health.
Criminalization helps to reduce the spread of HIV and to promote public health.	Criminalization undermines prevention, treatment, care and support because fear of prosecution discourages people from testing for HIV, talking openly about their HIV status and sexual practices, seeking advice to minimize risk or accessing ART. This does not prevent the spread of HIV or support those affected. It also contributes to misconceptions about HIV transmission (especially where low-to negligible risk activities such as vaginal sex with a condom or oral sex, are criminalized) and prevention.
Criminalization provides an opportunity for rehabilitation for the offender.	Criminalization often disproportionately impacts already marginalized populations including women, and in many jurisdictions it does not consider the intention of the 'offender' or even the risk of the act in question. 'Offenders' may be convicted for acts unlikely to cause harm (e.g. non-disclosure of HIV status during protected sex, sex with a person with undetectable viral load, biting), acts where HIV is not transmitted and acts where there is no culpability (e.g. where HIV status is not known, where the 'offender' is unable to refuse sex).
Criminal sanctions save costs on public health.	Criminalization is a waste of public resources; these funds are better spent on HIV information and education, prevention treatment and care services.
Sanctions control society's moral behaviour.	Criminalization reinforces stigma and discrimination against people living with HIV and people perceived to be at risk of HIV.  It scapegoats people living with HIV as 'criminals', opens them up to potential false accusations and creates a false sense of security that the law, rather than prevention, can protect people from exposure to HIV.
The law is a useful tool to ensure that people living with HIV use protective measures in engaging in sexual conduct and also divulge their HIV status.	The law is not an ideal tool for preventing the spread of HIV. It may lead to unjust applications of provisions without due consideration of medical and scientific facts about HIV transmission, actual transmission, intention, voluntariness and autonomy.

## **International perspectives on use of criminal law as a reaction to HIV**

International guidance recommends against enacting specific laws to criminalize HIV non-disclosure, exposure or transmission.

## Guidance

Where countries choose to criminalize non-disclosure, exposure and transmission of HIV, the following should be taken into account:

- Criminalization of harmful HIV-related behaviour should ideally take place under the application of general criminal laws, rather than specific laws.
- The acts to be criminalized should be limited to intentional acts of transmission, where the person knows their HIV status and acts with intention to transmit HIV. Criminal law should not be applied where the accused did not know that they were HIV-positive and did not understand how HIV is transmitted. Intention should also not be presumed, solely based on knowledge of HIV status, non-disclosure, engaging in unprotected sex, having a baby without taking steps to prevent mother-to-child transmission or sharing injecting drug equipment.
- Criminal law should not be applied where a person disclosed their HIV-positive status to the person at risk, or honestly believed the other person was aware of their status through some other means. Consideration should also be given to circumstances where they did not disclose their HIV-positive status because of fear of violence or other serious negative consequences.
- Criminal law should not be applied where there is no significant risk of HIV transmission, including where a person had a low viral load, or where a person took reasonable measures to reduce risk of transmission (e.g. using a condom).
- Criminal law should never apply to vertical transmission, including breastfeeding.
- There must be medical evidence where HIV is used as aggravating factor that indeed HIV was transmitted by the offender; judicial officers should do away with assumptions in this area.
- The offender's rights must also be protected by law. For instance investigators must apply in court to extract fluids from the offenders for purpose of investigating HIV infection and transmission on survivors.

## Key point

International guidance recommends that cases involving criminalization of HIV transmission take careful consideration of various factors such as intention, disclosure and medical and scientific evidence relating to the risk of HIV transmission, and evidence of whether or not HIV was transmitted and the individual circumstances of the parties.

## Example: HIV laws in Africa

In Africa, particularly in West and Central Africa following the Ndjamenan Model Law in West Africa, 2004, a large number of countries enacted HIV specific criminal legislation, introducing a range of criminalized activities targeting people living with HIV. However, a number of countries have taken steps to repeal overly broad laws, such as Togo, Guinea, Niger, Mozambique, the DRC and Zimbabwe; and a number of later HIV laws such as in Senegal, Congo, Côte d'Ivoire, Cameroon, Gabon and Central African Republic are more protective. In 2015, the Kenyan courts suspended the criminalization provision in the HIV law, and in 2024, the Ugandan Constitutional Court struck down the death penalty for unintentional transmission of HIV through same-sex sex.

## Note to the trainer

Refer to the HIV Justice Network [Global HIV Criminalization Database](#) to identify laws and policies regarding the criminalization of HIV transmission, exposure and non-disclosure in your jurisdiction.



## Issues for consideration in adjudicating cases of non-disclosure, exposure and wilful transmission of HIV

### Note to the trainer

Encourage participants to discuss some of the inherent challenges in adjudicating cases of HIV transmission, including proving various elements of an offence. Discuss issues around HIV testing, HIV transmission, culpability, harm etc, with reference to the information below.

## Transmission of HIV

Scientific and medical facts on transmission were discussed in Module I. They are summarized below:

### The science

#### Conditions required to transmit HIV from one person to another

- Presence of a bodily fluid known to transmit HIV.
- Contact of the fluid with an area of the body through which transmission can occur.
- Entry into the body of sufficient virus to establish infection.

There are no known cases of transmission through saliva, even when it contains small quantities of blood.

#### Transmission routes

- Unprotected vaginal intercourse.
- Unprotected anal intercourse.
- Sharing contaminated syringes, needles or other sharp instruments.
- Transmission from an HIV-positive mother to a foetus or infant ('vertical transmission').

The possibility of HIV transmission during a single episode of condomless sex with a person not on HIV treatment is low, ranging between 0.08 percent for penile-vaginal sex, to 1.4 percent for penile-anal sex. HIV is not transmissible by air or casual contact.

#### Activities with no or negligible risk of HIV transmission

- Kissing.
- Spitting or biting (where there is minimal or no blood).
- Masturbation.
- Oral sex.

Even where the person living with HIV has a lot of blood in their mouth that makes contact with an open wound, and the person's viral load is not low / undetectable, the possibility still ranges from none to negligible.

#### Factors affecting the level of risk of HIV infection from various sexual acts

- Type of sexual activity (non-penetrative and/or penetrative, vaginal, anal and/or oral intercourse).
- Roles of sexual partners during penetrative sex (i.e. insertive or receptive).

- Frequency and overall number of sexual events.
- Whether or not a condom or other barrier that is effective at preventing HIV exposure during penetrative sex was used correctly and consistently.
- Whether or not the insertive partner was circumcised.
- The presence or absence of other STIs in the individuals involved.
- The concentration of HIV (viral load) in the bodily fluid to which the at-risk person has been exposed.
- Whether or not the person living with HIV was on antiretroviral therapy that significantly reduced the concentration of HIV in bodily fluids to non-infectious levels.

### **Factors known to reduce the risk of sexual transmission**

- Correct condom use.
- Taking of antiretroviral treatment so that a person has an undetectable viral load.
- Where a person exposed to HIV is using PrEP or takes PEP.

### **Factors known to increase the risk of sexual transmission**

- Where the person living with HIV has a high viral load.
- Where the individuals have other sexually transmitted infections.

### **Proving HIV transmission**

International guidance recommends the use of criminal charges only where HIV transmission occurred, amongst other things. Challenges in evidentiary process include:

- It must be established that the defendant is the source of the complainant's HIV infection for there to be a conviction. It is not enough to assume that because a former or current sexual partner has tested positive for HIV, the complainant's infection necessarily originated with that partner.
- The direction of transmission must also be established. It could be that the complainant transmitted HIV to the accused, rather than vice versa.
- A combination of scientific evidence and medical records may be used (including evidence of diagnosis, symptoms, treatment and viral load) and testimony. Useful scientific evidence may include evidence about HIV itself ('virological evidence') or *phylogenetic analysis* (a scientific process used by experts to analyse the genetic code of individual strains of HIV and establish whether two samples may be genetically related).

### **Evidence of HIV transmission**

Judicial officers must move cautiously in assessing evidence of HIV transmission from one person to another.

Phylogenetic analysis can only determine the degree of relatedness of two samples. It cannot create a definitive 'match' between two samples. Strains of HIV, even if closely related, will not be unique to the two individuals, but could extend to other people who are part of the same transmission network. Also, phylogenetic analysis that suggests one person's virus is closely related to another person's virus also does not provide any information on the direction of transmission. So, phylogenetic analysis alone cannot prove beyond a reasonable doubt that one person infected another person.

Phylogenetic analysis can be used to exclude the possibility that a Defendant was responsible for HIV transmission to a particular complainant, by showing that the two strains are not closely related.

The Recent Infection Testing Algorithm is a scientific method used to estimate the likelihood of recent HIV infection. The test is designed to estimate recency and calculate incidence rates at the population level, for

public health purposes, not the individual level. It is not a reliable indicator of recent infection at the individual level. Significant rates of false results indicating recent infection have been documented.

### Key point

Results of Recent Infection Testing Algorithm tests should be interpreted with caution and only used in the context of all available evidence. The test results should not be considered conclusive in establishing when one person was infected. Judicial officers must therefore be careful about the weight they place on such evidence.

## HIV infection and harm

In adjudicating over cases of HIV infection it is important to determine the level of harm of the HIV infection resulting from transmission. The level of harm will determine the offence (if any) and sentence to be applied.

The harm to a person should not be assumed based on preconceived notions, but based on scientific and medical facts. It should reflect current advances in HIV treatment and the reality of living with HIV today (if an individual is on treatment and under care). The fact that treatment drastically improves the length and quality of life of people living with HIV, means that HIV infection is no longer necessarily life-threatening and cannot reasonably be the basis of criminal charges of murder, attempted murder, manslaughter etc.

### Key points

HIV is a serious medical condition, now seen as a chronic, but manageable health condition. If untreated, most people living with HIV will develop signs of HIV-related illness within 5–10 years.

Modern antiretroviral therapies have improved the life expectancy of most people living with HIV to a point similar to their HIV-negative counterparts, however, and greatly reduced the impact of HIV on people's lives.

HIV infection may impact on quality of life in other ways. E.g. a person may experience stigma and discrimination. Life-long treatment may also create hardships, side effects, the potential for resistance etc.

## Evidence of a culpable mind

Like in all criminal offences, *mens rea* or mental evidence needs to be proven where the law requires that the accused should have acted with the intention to transmit HIV. This creates an obvious challenge in terms of how to prove *mens rea*.

Intentional transmission should not be presumed merely because a person living with HIV has engaged in unprotected sex or has had sex without disclosing their HIV-positive status to their partner. Similarly, while active deception, including lying about one's HIV-positive status, may be taken into account when assessing an accused's state of mind, it should not be conclusive. This is because there may be a variety of considerations for why a person does not disclose HIV status:

- Some people living with HIV choose to engage in lower-risk sexual activities (e.g. using condoms for intercourse or only engaging in oral sex) in order to prevent passing the virus on to sexual partners.
- Some people living with HIV may understand that there is no appreciable risk of them transmitting HIV through sex because of their treatment and/or low viral load.
- Fear of violence, discrimination, abandonment and loss of privacy may affect disclosure practices and condom use.
- Concerns that condom use signals a lack of trust or infidelity, along with the desire to conform to social and cultural norms, affect people's sexual and disclosure practices, as does the desire to have children.
- People living with HIV may engage in higher-risk behaviours and/or not disclose their status as a result of denial, mental health or substance abuse issues.

Similarly, criminal liability on the basis of negligence may allow overly broad criminalization of people living with HIV, even those who did not know they were HIV positive, on grounds that “a reasonable person should have known.” It becomes important to consider whether an accused person knew that they had HIV, that they understood how HIV is transmitted and whether they took measures to prevent the transmission. There should be a conscious disregard of these facts and a significant risk of HIV transmission in order for negligence to be considered as sufficient, to prevent problems such as:

- Allowing criminal charges even where there is no substantial risk of transmission.
- Placing greater responsibility on those who are perceived to be at higher risk of HIV infection, such as sex workers or people who use drugs, even for acts that represent an insignificant risk of HIV transmission.

In some jurisdictions offences relating to HIV are strict liability offences such that evidence of any mental state is not required. However, this may not allow for considerations of the risk of HIV infection and the resultant harm, on a case-by-case basis.

### Note to the trainer

HIV status is also raised in sexual offence cases, where there may be calls for, or even laws requiring mandatory HIV testing of accused persons in sexual offence cases, criminal charges of HIV transmission in addition to charges of rape, and/or the use of the accused’s HIV status as an aggravating factor in sentencing.

Similar cautionary principles should be taken into account to avoid unsound assumptions, bias and discrimination and to ensure a sufficient evidentiary basis for a prosecution. Ask participants to discuss the possible limitations to HIV testing of an accused, for determining e.g. culpability, risk of HIV transmission etc.

Refer to the case of *Makuto v State*, below, for discussion purposes.

Source: [UNDP \(2021\) Guidance for Prosecutors on HIV-related criminal cases](#)

## Defences to HIV transmission

The following defences to HIV transmission have been considered by courts:

### Consent and disclosure

The defence of consent and disclosure can be raised in jurisdictions where it is a crime for people living with HIV to engage in unprotected sex without prior disclosure, and even where the law criminalizes the exposure or transmission of HIV and not necessarily the lack of disclosure. From a human rights perspective this defence recognizes the right of all people to autonomy and to a private life, and respects the personal decisions made by consenting adults, including e.g. discordant couples who wish to have a sexual life and children. The defence is an affirmation that all sexually active people living with HIV and their sexual partners have sexual rights, and that a person living with HIV is not at risk of prosecution every time they engage in intercourse.

The challenges that may arise include the fact that consent and disclosure is usually a private affair between partners and therefore difficult to prove. Disclosure may be a process and not a one-step issue, depending on the nature of the sexual relationship, the mental capacity and acceptance of the diagnosis by the person living with HIV. The court may also be faced with circumstances where the disclosure is made by someone else other than the person living with HIV. The question of whether general knowledge of the risks associated with unprotected sex can be considered as sufficient consent to exposure also arises.

Because there are so many reasons why people may not disclose their HIV status, public health messages on HIV prevention have cautioned people against relying on disclosure of HIV status by their sexual partners to protect them from HIV infection.

Instead, public health messages urge people to engage in safer sex through the use of condoms and other means when their partner’s HIV status is unknown, highlighting the shared responsibility for protecting health.

Source: [UNAIDS \(2013\) Ending overly broad criminalization of HIV non-disclosure, exposure and transmission](#)

## Use of reasonable care and precautions to protect a partner

The use of reasonable precautions to protect a partner from HIV infection and an assertion that the accused did not act negligently or recklessly, may be taken into account when assessing the mental culpability of the accused. Taking precautions may demonstrate a sense of care for the complainant's safety. It can also be taken into account to assess risk of transmission involved in a particular case and whether such risk warrants a conviction. Use of reasonable precautions to protect a partner may include the use of a condom and other safer sex measures (e.g. engaging only in oral sex or non-penetrative sex).

## Effective treatment or low viral load

Scientific and medical evidence has established that effective HIV treatment or a low viral load results in a significant – almost zero – risk of HIV transmission. This should be taken into account when applying the criminal law to HIV non-disclosure, exposure and transmission.

Other defences include fear of violence, abandonment or other abuse, including sexual abuse within marriage (applicable in jurisdictions where there is no offence for marital rape) should be a consideration. This may particularly impact on vulnerable populations in abusive or coercive relationships who feel less able to negotiate sexual relationships, condom use and safer sex.

## Sentencing in HIV transmission cases

When imposing sentences in prosecutions for HIV non-disclosure, exposure or transmission, various considerations are important, including aggravating or mitigating circumstances and the impact of imprisonment on a person living with HIV. A range of sentencing options should be considered, including non-custodial measures, with imprisonment imposed only when it is justified, necessary and proportional to the aim.

### Guidance: Considerations in sentencing

- The negative health and safety consequences of imprisonment for a person living with HIV. Prison is usually a source of stress, depression and fatigue. This, coupled with the prison environment and conditions may increase the likelihood of opportunistic infections and co-infections, such as TB, reducing a person's CD4 cell count further with potentially devastating consequences for the health of people living with HIV and people with TB. Imprisonment may also result in interruptions in HIV treatment, inadequate access to necessary treatment and care services, leading to serious illness and even death for a person living with HIV or a person with TB.
- Mitigating factors may include:
  - Where the accused is a marginalized or vulnerable population who lacked the means to access appropriate information, treatment and care .
  - Where the person living with HIV disclosed their HIV status to a consenting sexual partner (in jurisdictions where this is not a defence).
  - Where the Defendant does not take steps to reduce HIV transmission (e.g. using a condom or disclosing HIV status) for fear of violence or other serious negative consequences.
  - A sexual act with no real risk of transmission.
  - The absence of transmission (where criminal liability is not dependent on transmission).
- Aggravating factors may include actual transmission of HIV, in jurisdictions where it is not a required element of the offence.

Source: [UNDP \(2021\) Guidance for Prosecutors on HIV-related criminal cases](#)

## Note to the trainer

Allow participants to come up with answers and share experiences on alternative sentences and diversion measures that can be applied for people living with HIV.

In an unreported decision, the New South Wales Court of Criminal Appeal (Australia) affirmed that AIDS is a “special circumstance” and that the period in detention should be reduced to account for the harsher effects of imprisonment. Similarly, in Canada, a woman living with HIV who was convicted in an HIV non-disclosure case received a 12-month conditional sentence to be served in the community. The judge noted in the sentencing decision that the woman’s health had seriously deteriorated and that her life would be endangered if she did not have proper access to a new medication requiring regular follow-up by her doctor. She was also suffering from depression and was considered by an expert to be suicidal.

## Application of criminal law sanctions in TB cases

In some jurisdictions within Africa, criminal, civil, public health or administrative laws or regulations apply punitive and coercive measures to people living with TB, aimed at preventing TB transmission.

Examples that may come before the courts include:

- Challenges to the use of isolation, detention or even incarceration for lengthy periods of time, removing people with TB from homes, families and communities.
- Challenges to laws authorizing compulsory medical treatment.
- Criminal charges against people for non-compliance with detention or treatment orders.

While limitations of rights may be necessary and justifiable to achieve public health goals, these laws are often outdated, involving potentially arbitrary actions that are unable to achieve the stated goals, and do not take into account scientific development and international best practice. Similarly with criminal laws around HIV, they may also involve severe rights limitations, fail to achieve their aims and may also result in stigmatizing TB further. At the heart of these cases is the delicate balance between individual freedoms and public health. Coercive measures, particularly where they involve deprivation of liberty, necessarily trigger due process rights. Some courts have upheld isolation or detention, where basic procedural safeguards have been upheld. Others have struck down laws as unjustifiable.

The right to health and liberty are guaranteed under numerous international and regional human rights treaties and are relevant to cases involving involuntary detention and compulsory medical treatment. In addition, international guidelines provide the following guidelines on isolation and detention in TB cases.

### Guidance: Isolation of people with TB

- Isolation should only be applied where a person with TB is highly contagious and there is a public benefit to the community.
- Isolation should always be voluntary except in exceptional circumstances using the least restrictive means possible.
- Involuntary isolation should never be a routine component of TB prevention, testing, treatment and care.
- Involuntary isolation should be limited to exceptional circumstances when an individual, known to be contagious, refuses effective treatment and all reasonable measures to ensure adherence have been unsuccessful, or, where the person lacks capacity to get the treatment at home and refuses inpatient care, or, where the person refuses to undergo assessment for TB.

The Guidelines outline the limited cases where involuntary isolation may be justified:

- It is necessary to prevent the spread of TB.
- A person refuses to be in isolation despite being adequately informed of the risks, meaning and reasons for isolation.
- The person's refusal puts others at risk.
- Other less restrictive means have been tried prior to forced isolation.
- Other rights and liberties besides that of movement are protected.
- Due process and all other appeal mechanisms are in place.
- The person's basic needs have been met.
- The isolation time given is the minimum necessary to achieve its goals.

Source: WHO (2017) Ethics Guidance for the Implementation of the End TB Strategy on Isolation and Involuntary Isolation

## Criminalization of key populations

In many countries across Africa and the world, criminal laws apply to key populations who are at higher risk of HIV transmission - such as gay men and other men who have sex with men, transgender and gender-diverse people, sex workers and people who use drugs.

### Note to the trainer

If need be, review the definition of key populations in Module I.

This Module considers the following key populations whose behaviours are often criminalized:

- Sex workers.
- Gay, bisexual and other men who have sex with men.
- Transgender and gender-diverse people.
- People who use drugs.
- Prisoners.

It also considers how law and human rights affects other vulnerable populations, including:

- Migrant and mobile populations.
- People with disabilities.

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International human rights treaties oblige states to protect and promote the human rights of all people. These human rights include the rights to life, privacy, liberty and security of the person (which encompass protection against threats of physical violence), the right to be protected from arbitrary arrest or detention, torture, inhuman and degrading treatment, as well as freedoms of expression, association, peaceful assembly and information (see module 2). Key populations experience violations of many of these rights.

The GCHL's 2012 report, [Risks, Rights & Health](#), found that criminal laws make key populations more vulnerable to HIV in various ways. They exacerbate stigma, discrimination and violence against key populations; the fear of discrimination, arrest and abuse – including from law enforcers - marginalizes key populations, driving them 'underground' and away from HIV, harm reduction and other health services. Incarceration and detention also

exposes them to conditions that place them at further risk – the risk of unprotected sex, sexual assault, unsafe injection practices, poor nutrition – and limited access to services such as harm reduction or antiretroviral treatment, to protect their health. It called for the removal of criminal laws, to decriminalize key populations, and for enacting human rights-based laws that facilitate and enable effective responses to HIV prevention, care, treatment and support for all key populations.

## Sex workers

### Sex workers and HIV

Sex workers are at higher risk of HIV infection. In 2022, the relative risk of acquiring HIV was four times higher for sex workers.<sup>9</sup> A study in 10 countries in sub-Saharan Africa found that the odds of living with HIV were over 7 times higher for a sex worker in a country that criminalizes sex work, compared to a country that partially legalized sex work.<sup>10</sup>

#### Note to the trainer

See Module I for more epidemiological information on Key populations and HIV in Africa.

Across Africa, the vast majority of countries criminalize aspects of sex work. The HIV Policy Lab reports that buying or selling sex, or other activities associated with the buying or selling of sex are crimes in 81 percent of countries in East and Southern Africa, and 76 percent of Western and Central African countries. UNAIDS reports that 34 of 46 countries<sup>11</sup> have criminal provisions against sex work, including provisions prohibiting the selling and buying of sex, the selling of sex, the buying of sex, and provisions prohibiting associated activities (e.g. living from the proceeds of sex work, keeping a brothel or solicitation), and in 7 of 46 countries, prosecutions take place based on general laws.

#### Note to the trainer

Refer to [HIV Policy Lab](#) and UNAIDS webpage: [AIDS Info: Laws and Policies](#) for updated information on criminal laws on sex work across the world.

The [Global Commission on HIV and the Law](#) found that punitive laws that criminalize aspects of sex work, accompanied by societal stigma and discrimination, create inequalities and result in various rights violations, also preventing sex workers from being able to access justice for rights violations and from being able to protect their health, safety and well-being.

For instance, sex workers often work under exploitative labour conditions, or in secluded areas, making them vulnerable to violence and abuse. Their vulnerable position often results in their feeling unable to negotiate safer sex with clients, placing them at risk. They also experience challenges in accessing health services, disclosing information to health providers and receiving appropriate treatment and care.

9 UNAIDS (2023) HIV and sex workers: 2023 UNAIDS Global AIDS Update Factsheet UNAIDS (2021) HIV and Sex Work: Human Rights Fact Sheet

10 UNAIDS (2021) HIV and Sex Work: Human Rights Fact Sheet

11 UNAIDS (2022). AIDS Info: Laws and Policies.



## Human rights violations experienced by sex workers

In 2019, UNAIDS reported that 45 percent to 75 percent of adult female sex workers were assaulted and abused at least once in their lifetime.

Research and court challenges in Africa, as across the world, document wide-ranging stigma, discrimination, violence and other rights violations against sex workers, including the following:

- Physical and sexual abuse and violence, including rape and murder, at the hands of clients, the police and others.
- Confiscation of condoms, harassment and arbitrary arrests, including misuse of municipal by-laws - by law enforcers, even when there is no violation of the law.
- Discrimination, verbal abuse, degradation and denial of services within health care – often more severe for transgender and migrant sex workers.
- Mandatory HIV testing.
- Denial of access to housing.

Criminal laws and harsh policing also impacts on access to justice. Sex workers are reluctant to report crimes, for fear of further harassment, abuse or arrest.

Source: UNAIDS (2021) HIV and Sex Work: Human Rights Fact Sheet 2021

Irrespective of whether sex work is criminalized or regulated in a country, all people engaged in sex work retain various rights, including e.g. the right to be protected from unfair discrimination, the right to safe working conditions and labour protections, the right to liberty and security of the person, the right not to be subjected to violence, including sexual violence, the right to the highest attainable standard of health, and the right to receive the full protection of the law if they are assaulted or arbitrarily arrested.

Internationally, UNAIDS, UNDP, WHO and other international health and human rights bodies have recommended the decriminalization of sex work and the protection of sex workers' rights as a key human rights issue and public health strategy, to lower the risk of HIV transmission. For instance, the WHO (2014) Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations recognize this as a critical element of providing health services to sex workers.

Article 6 of CEDAW urges States to “take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.” CEDAW is not based on the premise that all sex work should be eradicated or suppressed, but instead on the need to protect women from all forms of discrimination, including violence.

## Key findings

The Committee on the Elimination of Discrimination Against Women has, amongst other things:

- Recognized the duty of States to address violence against sex workers.
- Consistently recommended that sex work be decriminalized, noting the disproportionate, negative impact of criminalization on women sex workers (General Recommendation 35).
- Called for States to pay special attention to sex workers' health and human rights.
- Held that mandatory HIV and health tests for sex workers are a human rights violation, recommending that States rather provide accessible, acceptable, available and quality health services.

Source: Global Network of Sex Work Project (2019) CEDAW

Human rights set out in numerous other international conventions – including the ICCPR and the ICESCR – further affirm every human being’s (including sex workers’) rights, including their rights to equal protection of the law.

## Key considerations for the courts

Various cases involving sex work may come before the courts, including e.g. :

- Charges under laws criminalizing sex work or aspects of sex work.
- Charges under vagrancy or nuisance laws.
- Challenges to laws criminalizing aspects of sex work.
- Challenges to police violence, harassment, unlawful arrests of sex workers.
- Cases considering labour rights of sex workers and unfair labour practices.

Key considerations for the courts may include:

- The elements of the offence of sex work in the specific country, to ensure that there is in fact evidence of an offence (e.g. selling sex) and not misuse of other evidence (e.g. possession of condoms, HIV status, presence on the streets).
- The potential misuse of ‘vagrancy’, ‘nuisance’, ‘idle and disorderly’ and related laws and by-laws to target sex workers for arrest and charges.
- The rights of sex workers to challenge unlawful violations, including assault, sexual assault, extortion, unlawful arrest, and even unfair labour practices.

## Gay and bisexual men, other men who have sex with men and links to other sexual minorities

### Note to the trainer

Experience has shown that many people do not understand key terms relating to sexual orientation and gender identity. Consider getting outside assistance e.g. from an LGBTI organization, to explain key terms such as lesbian, gay, bisexual, transgender, gender-diverse, non-binary, intersex, sexual orientation, gender identity, gender expression and sex characteristics to participants.

### Gay, bisexual and other men who have sex with men and HIV

Gay, bisexual and other men who have sex with men are disproportionately impacted by HIV.

In 2022, the HIV prevalence among gay men and other men who have sex with men was 11 times higher than among adults in the general population (aged 15–49 years).

Between 2010 and 2022, the rate of new infections among gay men , bisexual and other men who have sex with men increased by 11 percent. Discrimination, stigma and violence continue to impede access to health care for gay men and other men who have sex with men.

Source: [UNAIDS \(2023\) HIV and gay men and other men who have sex with men: 2023 Global AIDS Update: Factsheet](#)

Gay, bisexual and other men who have sex with men who live in countries that criminalize same-sex sexual relations are more than twice as likely to be living with HIV as those in countries without criminal penalties.

Gay, bisexual and other men who have sex with men living in countries with severe criminalization are almost 5 times as likely to be living with HIV than those living in countries without such criminal penalties.

Source: UNAIDS (2021) HIV and Gay Men and Other Men who have sex with Men: Human Rights Fact Sheet

### Note to the trainer

See Module I for more epidemiological information on key populations and HIV in Africa.

In December 2020, the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA)'s annual report on *State-Sponsored Homophobia* found that around 67 UN Member States across the world had legal provisions criminalizing same-sex conduct, and in 11 of those States the death penalty is the legally prescribed punishment, or may be imposed, for consensual same-sex sexual acts.

While there have been some recent progressive law reforms and court challenges, the majority of countries in Africa still criminalize same-sex sexual acts impacting on gay, bisexual and other men who have sex with men, as well as other LGBTI persons. In addition, some countries have introduced new laws with harsher sentences and a broader range of crimes associated with same-sex sex.

### Example: Regressive and progressive same-sex sex law reform across Africa

In Nigeria, the 2013 Same-Sex Marriage (Prohibition) Act introduced a range of new provisions and harsh penalties for same-sex sex and related activities. For instance, the law restricts additional rights to freedom of expression and association, including a prohibition on a “public show of same-sex amorous relationship”; and imposes a 10 year sentence on anyone who “registers, operates or participates in gay clubs, societies and organizations” or even supports the activities of such organizations.

In Uganda, the Anti-Homosexuality Act of 2023 broadened existing penal code provisions criminalizing same-sex sex. It introduced life imprisonment for some sexual acts, the death penalty for “aggravated homosexuality” and criminalized the “promotion of homosexuality.” In April 2024, Uganda’s Constitutional Court upheld most of the provisions in its ruling on the constitutionality of the Act.

The Ghana Human Sexual Rights and Family Values Act 2024 introduces new same-sex offences, criminalizing “any person who holds out as a lesbian, gay, transgender, transsexual, queer, pansexual or non-binary”, as well as criminalizing various acts and organizations that are said to protect or promote sexual and gender minority rights.

In Angola, the new Penal Code which came into force in 2021 excludes provisions criminalizing same-sex sexual acts.

In Gabon, the criminalization of “sexual relations between persons of the same-sex”, enacted in 2019, was reversed in 2020.

In Botswana, the Supreme Court of Appeal declared penal code provisions criminalizing same-sex sex were a violation of rights and were unconstitutional in 2021. Similarly, in October 2023 the Mauritian Supreme Court declared the criminalization of same-sex sex to be unconstitutional.

See the [ILGA](#), [HIV Policy Lab](#) and [UNAIDS](#) webpage [AIDS Info: Laws and Policies](#) for updated information on laws affecting same-sex sexual acts.

[ILGA](#) reports that 31 of 56 countries have laws penalizing consensual same-sex sexual acts in Africa, with punishments ranging from up to 14 years imprisonment, over 14 years to life, and even including the death penalty.

UNAIDS reports that gay men and other men who have sex with men are at heightened risk of stigma, discrimination and violence compared with the rest of the population.

## Example: Rights violations

Examples of human rights violations reported against individuals and organizations of gay, bisexual and other men who have sex with men (as well as other LGBTI persons) include:

- Verbal and physical abuse and assault, including murder.
- Sexual violence, including rape.
- Harassment, threats and extortion, including by law enforcers.
- Unlawful arrest, police abuse in detention and forced anal examinations.
- Acts to prohibit the existence of, deny registration to, censor, harass or otherwise limit the working of LGBTI organizations.
- Denial of access to health care or sub-standard health care.
- Forced medical examinations, HIV testing, and even including forced surgery in the case of intersex children.
- Unfair discrimination within the working environment.
- Discrimination in access to housing.
- Discrimination in access to social services.

Source: [Global Commission on HIV and the Law \(2012\) Risks, Rights & Health](#)

Stigma, discrimination and violence based on sexual orientation (and gender identity), and laws criminalizing same-sex sex impact negatively on the rights of gay, bisexual and men who have sex with men, as well as other LGBTI persons - and their organizations and networks - including on their health rights. [SALC's research into discrimination in health care facilities in Botswana, Malawi and Zambia](#) found numerous examples of harsh stigma and discrimination against LGBTI persons in health care. The criminalization of same-sex sexual relations has a detrimental impact on public health, including the alienation from health-care services of men who have sex with men. [UNAIDS](#) reports on surveys in sub-Saharan Africa that found that between 10–40 percent of gay, bisexual and other men who have sex with men delay or avoid health care due to fear of stigma.

## Note to the trainer

There is increasing evidence of the impact of harsher laws on LGBTI communities, including how harsh new laws lead to a surge in rights violations, exacerbating violence, discrimination, police abuse and arbitrary arrests, extortion, loss of employment, evictions and homelessness. There is also growing evidence of the ways in which these laws have blocked access to life-saving health care services.

See, for instance, [Tell Me Where I Can Be Safe: The Impact of Nigeria's Same-Sex Marriage \(Prohibition\) Act and Uganda: Anti-Homosexuality Act's Heavy Toll](#)

Ask participants to discuss how evidence of the impact of criminal laws prohibiting same-sex sex may be used in their courts.

## Key point

Other laws may include 'morality clauses' which are also used to punish LGBTI communities. Article 264 of the Cameroon Penal Code criminalizes "immoral speech" in public and Article 564 of the Burundi Penal Code prohibits songs, pamphlets and images "contrary to good morals." In the DRC, public indecency laws have been interpreted to prosecute same-sex couples engaging in public displays of affection, such as kissing. Progressive judicial interpretation of these clauses is critical to facilitate protection of LGBTI rights.

Laws criminalizing same-sex sex also create barriers to the formation and registration of LGBTI organizations in a number of countries. Organizations report being denied registration by administrative authorities, on the basis that their objectives or activities are unlawful.

However, African courts in some countries, such as Botswana and Kenya, have highlighted that specific actions are criminalized, rather than being LGBTI in itself; and have granted organization's the right to registration (see case law, below).

Criminalization is also reported to impact on access to justice. Many LGBTI people are physically or sexually assaulted because of their sexual orientation, yet they do not report such attacks for fear of reprisals, exposure to further police abuse, and/or criminal liability where same-sex sex is prohibited. A number of courts around the world have invalidated laws criminalizing homosexuality on the basis of human and constitutional rights, and international guidance e.g. from UNAIDS, UNDP, Office of the High Commissioner for Human Rights (OHCHR) and WHO, amongst others, has recommended decriminalization.

The Committees responsible for various international human rights treaties have affirmed the rights of LGBTI people to equality, non-discrimination and protection from violence. In Africa, [Resolution 275](#) of the African Commission on Human and Peoples' Rights recognizes, condemns and urges States to use law and access to justice to end acts of violence and other human rights violations, including murder, rape, assault, arbitrary imprisonment and other forms of persecution of persons on the basis of their imputed or real sexual orientation or gender identity. More recently, the Commission's [Resolution 552](#) calls on State Parties to promote and protect the rights of intersex persons to prohibit non-consensual genital normalization practices, respect their autonomy, and end stigma, discrimination and other human rights violations.

### Key findings

- The Human Rights Committee responsible for monitoring compliance with the ICCPR has urged States to guarantee equality to all persons regardless of sexual orientation and gender identity.
- The Committee on Economic, Social and Cultural Rights has affirmed that the non-discrimination guarantee of the Covenant includes sexual orientation and gender identity and intersex status.
- The Committee on the Rights of the Child interprets the right to non-discrimination in Article 2 of the Convention on the Rights of the Child to include sexual orientation, gender identity and intersex status / sex characteristics.
- The Committee against Torture has also underscored that State obligations under the Convention against Torture apply to all persons regardless of sexual orientation, gender identity or sex characteristics.
- The Committee on the Elimination of Discrimination against Women has emphasized the intersectionality of all forms of discrimination and has addressed human rights violations against lesbian, bi, trans and intersex women.
- The Committee on Migrant Workers has expressed concern about violence targeting LGBTI people and discriminatory migration provisions based on sexual orientation and gender identity.
- The Committee on the Rights of Persons with Disabilities has expressed concern about discrimination against LGBTI people with disabilities and sterilization and other procedures on intersex children.
- The Committee on the Elimination of Racial Discrimination has expressed concern with regard to discrimination faced by LGBTI people of African descent.

Source: [OHCHR \(2019\) Born Free and Equal](#)

International human rights mechanisms and experts have also held that criminalization of same-sex sexual acts violates the right to privacy and non-discrimination, amongst others. The report of the [GCHL](#) found that criminalization “creates climates in which civilian and police violence is rife and legal redress for victims

impossible. Fear of arrest drives key populations underground.” It found that criminalizing same-sex sex made it more likely that HIV interventions for gay, bisexual and other men who have sex with men and other LGBTI populations will continue to be inadequate and inaccessible, impacting on national responses to HIV and TB; and urged States to decriminalize consensual same-sex sex, remove barriers to the formation and work of LGBTI organizations and take steps to protect LGBTI persons from violence.

Whether or not same-sex relations are criminalized, the universality principle as discussed in Module II requires that all people have the right not to be subjected to violence and to receive the full protection of the law if they are assaulted. States have an obligation to protect against discrimination and to take positive steps to ensure the equal enjoyment of human rights for all gay, bisexual and other men who have sex with men, as with all sexual and gender minorities. This includes protection from violence and intersecting forms of discrimination on the basis of gender identity and expression, race, disability and other factors.

### Key point

The rights to privacy, equality and non-discrimination, amongst others, have been referred to in cases examining laws criminalizing same-sex sex.

## Key considerations for the courts

Courts may deal with cases involving LGBTI populations such as:

- Prosecutions for same-sex sexual acts and related offences (e.g. promotion of same-sex sex) for individuals and organizations, under a range of laws.
- Challenges to laws criminalizing same-sex sexual activities.
- Challenges to laws, policies and administrative procedures prohibiting the formation and operation of LGBTI organizations.
- Challenges to stigma, discrimination and rights violations against LGBTI people in various sectors of society, including within communities, in education, health care, and the workplace.
- Challenges to hate crimes, violence – including sexual violence - harassment, exploitation and abuse, including by law enforcers.

Key considerations for the courts may include the following:

- Since LGBTI people are often brought before the court charged with offences that are difficult to prove, or are broad and sometimes vague offences (e.g. sodomy, gross indecency, acts against the order or nature), it is important that courts avoid assumptions and circumstantial evidence in findings.
- It is critical that all the elements of the specific offence under which persons / organizations are charged (e.g. the offence of sodomy, gross indecency, acts against the order of nature) are met, to ensure that there is in fact evidence of an offence and not misuse of other evidence or abuse of procedure (e.g. lubricants, anal examinations).
- Courts may be faced with the potential misuse of ‘nuisance’, ‘public decency’, ‘morality’ and related laws and by-laws to target LGBTI persons for arrest and charges.
- Being lesbian, gay, bisexual, transgender or intersex is not, of itself, an offence in national law.
- LGBTI persons have the right to challenge unlawful violations, including assault, sexual assault, extortion and unlawful arrest, even when their sexual behaviour is criminalized.

## Note to the trainer

In cases involving the criminalization of same-sex sex, as with cases involving transgender people and sex work, it may be difficult to produce evidence of a sexual act or of a specific offence.

This has been seen to lead to the use of other evidence (e.g. condoms, lubricants) and invasive procedures (e.g. anal examinations, medical examinations, HIV tests) as sufficient proof of an offence.

Discuss the merits / dangers of this with participant judges, with reference to a case where circumstantial evidence was not considered adequate to prove the offence (see for instance [Zambia: Two Men Accused of “Carnal Knowledge Against the Order of Nature”](#) and the case of *The Prosecution v Diogomaye Sene and 6 others*, below).

## Transgender and gender-diverse people

### HIV amongst transgender and gender-diverse people

Transgender and gender-diverse describe a wide range of gender identities for people whose gender identity is different from the sex they were assigned at birth. People may not identify as completely male, or completely female. Some people may identify as non-binary.

In 2022, HIV prevalence among transgender people was 14 times higher than among other adults aged 15-49 years. HIV incidence rates have not decreased for transgender women, as with other women. In some settings, up to 58 percent of transgender people are living with HIV.<sup>12</sup>

## Note to the trainer

See Module I for how to find updated epidemiological information on key populations and HIV globally, and in Africa.

Transgender and gender-diverse people are criminalized or subjected to other punitive and discriminatory laws, policies and practices across the world, including in Africa. [UNAIDS](#) reports that in West, Central, East and Southern Africa, 8 countries criminalize transgender people (e.g. under vagrancy and nuisance laws).

### Example: Namibian Combating of Immoral Practices Act 21 of 1980

In Namibia, transgender persons face harassment under the Combating of Immoral Practices Act 21 of 1980.

Section 7(b) makes it an offence for a person to “wilfully and openly exhibits himself in an indecent dress or manner at any door or window within view of any public street or place or in any place to which the public have access.”

A person can be liable on conviction to a fine or to imprisonment for a period not exceeding two years – or to both such fine and such imprisonment.

[SALC \(2016\) Laws and Policies Affecting Transgender Persons in Southern Africa](#)

### Example: The use of vagrancy, nuisance, loitering and other laws against transgender persons

Transgender people are often harassed and prosecuted unlawfully under ‘public morality’, ‘nuisance’ laws or vagrancy provisions.

E.g. in Zambia, transgender persons are reportedly harassed under vagrancy provisions in the Penal Code including:

- S178(e) which refers to “every person who, without lawful excuse, publicly does any indecent act.”
- S178(f) refers to a person who “publicly conducts himself in a manner likely to cause a breach of the peace.”
- S178(g) refers to a person who “in any public place solicits for immoral purposes.”

All these persons are deemed to be idle and disorderly persons, and are liable to imprisonment for one month or to a fine.

Source: [SALC \(2016\) Laws and Policies Affecting Transgender Persons in Southern Africa](#)

### Key findings

In 2020, the African Court noted the following regarding the use of vagrancy laws:

“vagrancy laws, effectively, punish the poor and underprivileged, including but not limited to the homeless, the disabled, the gender-nonconforming, sex workers, hawkers, street vendors, and individuals who otherwise use public spaces to earn a living. Notably, however, individuals under such difficult circumstances are already challenged in enjoying their other rights including more specifically their socio-economic rights.”

“...many poor and marginalized women across Africa earn a living by engaging in activities that put them at constant risk of arrest under vagrancy laws. By sanctioning the arrest of poor and marginalized women on the ground that they have “no means of subsistence and cannot give a satisfactory account” of themselves, vagrancy laws undermine Article 24 of the Women’s Protocol.”

Source: [Advisory Opinion of the African Court on Human and Peoples’ Rights, No. 1/2018, 4 December 2020](#)

### Note to the trainer

Ask participants to discuss the use of ‘vagrancy’ and other ‘nuisance’ laws in their jurisdictions to punish transgender persons and other marginalized populations.

Stigma, discrimination and violence against transgender and gender-diverse people is rife. [UNAIDS](#) has reported on a study in 8 sub-Saharan African countries where 33 percent of the transgender women surveyed said that they had been physically attacked at some point in their lives, 28 percent had been raped and 27 percent said that they were too afraid to use health care services. The [GCHL](#) reported on various examples of punitive and discriminatory laws, policies and practices that violated the rights of transgender and gender-diverse people, recognizing the impact this had on their access to health care services and the barriers this created for transgender and gender-diverse people in various ways, including access to education, employment and social services. Examples include:

- Laws that criminalize cross-dressing.
- Barriers to participation and access to services arising from a failure to recognize a person’s self-identified gender in law (e.g. in identity documentation).
- Verbal and physical abuse and assault, including hate crimes against transgender and gender-diverse persons.



- Violence, including sexual violence, harassment, torture, ill-treatment and unlawful arrest and detention by law enforcers.
- Harassment, ill-treatment and denial of care in health facilities.

### Impact of stigma, discrimination and violence

Evidence shows that the impact of stigma, discrimination and violence on transgender and gender-diverse people includes profound negative impacts on mental health, as well as discouraging transgender and gender-diverse people from accessing health care and other services. [UNAIDS](#) reports that 47 percent to 73 percent of people avoid HIV testing due to stigma and discrimination. Studies also found that previous experiences of stigma in health care makes transgender people 3 times more likely to avoid health care, and those who had experienced police violence were twice as likely to avoid health care than other transgender women.

A study on the impact of law reform to allow change of gender on identity documents found that reports of stigma and discrimination fell from 80 percent to 30 percent after the law was introduced.

Before the law reform, almost 50 percent of transgender women interviewed reported needing to abandon their education because of stigma, and this dropped to 4 percent after the law was introduced.

Source: [UNAIDS \(2021\) HIV and Transgender and other gender-diverse people: Human Rights Fact Sheet](#)

As set out above, international and regional human rights treaties, declarations, statements, resolutions and guidance have affirmed the rights of LGBTI people to equality, non-discrimination and protection from violence. OHCHR has recognized five core obligations of States towards all LGBTI persons, including transgender and gender-diverse persons, based on international human rights norms and standards contained in key treaties.

More specifically, the GCHL have recommended that countries, amongst other things, repeal all laws that punish cross dressing; provide for legal recognition of a person’s self-identified gender including for gender-diverse and non-binary persons, without additional requirements that may violate human rights (e.g. surgery); enact anti-discrimination laws and policies that prohibit discrimination on the basis of gender identity, and remove legal, regulatory or administrative barriers to organizations for transgender and gender-diverse persons.

**Table 6: Core human rights obligations protecting LGBTI persons**

Core Obligation	Right(s)	Treaties
Protect individuals from violence.	Right to life	UDHR
	Right to liberty and security of the person	ICCPR CRC
	Right to protection from violence	CEDAW
Prevent torture and cruel, inhuman and degrading treatment or punishment.	Right to protection from torture	UDHR
		ICCPR
		CAT
		CRC
		CRPD
Repeal discriminatory laws.	Right to equality before the law	UDHR
	Right to non-discrimination	ICCPR
	Right to protection from arbitrary arrest, detention	
	Right to privacy	

Prohibit and address discrimination.	Right to equality before the law	UDHR
	Right to non-discrimination	ICCPR
	State obligations towards equality and non-discrimination	ICESCR
		CEDAW
Respect freedom of expression, assembly and association.	Right to freedom of thought and expression	UDHR
	Right to freedom of assembly and association	ICCPR
		Declaration on Human Rights Defenders

## Key considerations for the courts

Courts can be faced with various issues related to transgender and gender-diverse persons such as:

- Prosecution under cross-dressing, broad laws used to prosecute same-sex sex (e.g. gross indecency) or ‘nuisance’ and vagrancy laws.
- Challenges to laws criminalizing cross-dressing or aspects of gender expression.
- Challenges to laws, policies and administrative procedures prohibiting the formation and operation of LGBTI organizations.
- Challenges to laws, policies and administrative procedures relating to gender markers on identity and other documentation.
- Challenges to stigma, discrimination and rights violations against LGBTI people in various sectors of society, including within communities, in education, health care, the workplace.
- Challenges to hate crimes, violence – including sexual violence - harassment, exploitation and abuse, including by law enforcers.

Key considerations for the courts may include:

- The elements of the specific offence under which persons (or their organizations) are charged (e.g. the offence of cross-dressing, gross indecency etc.), to ensure that there is in fact evidence of an offence and not misuse of other evidence or abuse of procedure.
- The potential misuse of ‘nuisance’ and related laws and by-laws to target LGBTI persons for arrest and charges.
- The rights of transgender persons to challenge unlawful violations, including assault, sexual assault, extortion and unlawful arrest.
- The potentially difficult experiences of transgender persons in detention facilities that do not recognize their gender identity (e.g. a transgender woman housed in a male prison).
- The importance of providing for the dignity and respect of the person before the court, including in relation to respect for their gender identity.

### Key point

Even where laws do not expressly criminalize transgender persons, in a number of jurisdictions other laws have been used / misused to charge transgender persons for an offence, such as in the Ricky Nathanson case (below).

## People who use drugs

### Note to the trainer

Potential discussion questions for this session:

1. How is the criminal law in your country enforced against people who use drugs?
2. Are there laws against harm reduction services in your country? What are they and what role do judges play in their enforcement?
3. Are there legal requirements for treatment of people who use drugs in your country? What has been your experience in enforcing these laws?

Among the greatest risks of drug use is heightened exposure to HIV and TB infections. Although sharing infected needles and syringes is the most widespread route of HIV and TB transmission amongst people who use drugs, other drug-taking practices can also put people at risk. Sharing of some other drug paraphernalia may also share HIV and TB, and many different kinds of drugs can lead to higher rates of sexual risk-taking. TB is a leading cause of mortality among people who inject drugs living with HIV.

### HIV amongst people who use drugs

People who use and inject drugs are at high risk of acquiring HIV, yet are marginalized and unable to access health and social services.

In 2022, the relative risk of acquiring HIV was 14 times higher for people who inject drugs than for the rest of the population globally. In sub-Saharan Africa, while annual new adult HIV infections have fallen over 50 percent between 2010 and 2022 in the population, there has not been similar progress amongst people who inject drugs.

Source: [UNAIDS \(2023\) New HIV infections data among key populations: proportions between 2010 and 2022](#)

### Note to the trainer

See Module I for how to find updated epidemiological information on key populations and HIV globally, and in Africa.

In sub-Saharan Africa injecting drug use is increasingly a factor in the HIV epidemics of various countries, including Kenya, Mauritius, South Africa and Tanzania. There is inadequate data on the rates of injecting drug use in Africa.

People who use drugs are extremely marginalized and vulnerable to violence and abuse. Rates of intimate partner violence and gender-based violence are nearly 5 times higher for women who inject drugs. People who use drugs experience stigma, discrimination and violence, and fail to access adequate health services.

Evidence shows that punitive drug control laws and policies do not address crime, reduce drug use or drug-related harm. They have also been shown to be amongst the largest obstacles to health care in many countries, worsening health, failing to reduce HIV infection, and contributing to human rights violations against people who use drugs.

## Impact of criminalization of drug use and possession for personal use

A study in 2017 found that criminalization has a negative effect on HIV prevention and treatment. Criminalization of drug use and harsh punishment drives people who use drugs 'underground', leading to unsafe practices (e.g. needle sharing), difficulties in accessing harm reduction and health care services, and increased HIV incidence. People who use drugs experience human rights violations, and organizations providing harm reduction services may also be prosecuted or harassed for their work and charged under drug laws.

On the other hand, evidence has linked decriminalization of drug use with decreases in HIV incidence amongst people who inject drugs.

Source: [UNAIDS \(2021\) HIV and People who Use Drugs: Human Rights Fact Sheet](#)

In addition, when people who use drugs are imprisoned for contravening drug laws, they face further health risks. For instance, where people who use drugs are imprisoned in overcrowded facilities lacking proper ventilation, hygiene and sanitation, this makes them vulnerable to TB. Where they are unable to access harm reduction programmes, they may also be vulnerable to HIV infection.

## What is harm reduction?

Harm reduction refers to policies, programmes and practices aimed at reducing the harms associated with the use of illegal drugs—but not prevention or cessation of drug use itself. Harm reduction focuses on people who, for whatever reason, continue to use drugs, helping them protect their health and that of their companions who use drugs, sexual partners or children. The UN General Assembly, the UN Commission on Narcotic Drugs, UN human rights bodies and specialized agencies such as WHO recommend a comprehensive package for the prevention, treatment and care of HIV among people who inject drugs, including:

- Clean-needle and syringe programmes.
- Opioid substitution therapy and other evidence-based drug dependence treatment.
- HIV testing and counselling.
- Antiretroviral therapy.
- Prevention and treatment of STIs.
- Condom distribution.
- Targeted information and education.
- Vaccination, diagnosis and treatment of viral hepatitis.
- Prevention, diagnosis and treatment of tuberculosis.

Harm reduction models are legitimate alternatives to conviction or punishment, in appropriate cases of a minor nature and for offences related to personal consumption, or as additional measures to conviction or punishment for other drug-related offences. Harm reduction programmes increase chances of recovery, reduce crime and costs involved in the criminal justice system. They can also help in preventing TB and other infectious diseases.

## International regime on illicit use of drugs

**Table 7: International Instruments that provide standards relevant to drug use**

International Instrument	Regulation and provision
Single Convention on Narcotic Drugs	Narcotic drugs, including opium, coca, marijuana and their derivatives can only be produced, distributed, possessed and be used for medical and scientific purposes.
Convention on Psychotropic Substances	Synthetic psychotropic substances, such as amphetamines, barbiturates, benzodiazepines and psychedelics and their precursor chemicals be used only for medical and scientific purposes.
Convention Against Illicit Traffic in Narcotic Drug and Pyschotropic Substances	Promotes cooperation among States to address the international dimension of trafficking.
ICESCR	Protects the right of every person to the enjoyment of the highest attainable standard of physical and mental health.
ACHPR	Protects the right of every individual to enjoy the best attainable state of physical and mental health.
ICCPR, ICESR, CAT	Protects rights to life, liberty and personal security, to be free from ill treatment and discrimination, and to enjoy other human rights.

International law regimes, while providing for the controlled use and supply of illicit drugs, do not provide for criminalization of drug use *per se*. Instead, they allow for a rehabilitative approach to treatment, after care, rehabilitation and social reintegration for people with drug dependency rather than a law enforcement, punishment model.

### Key point

Drug dependence is a treatable health issue that requires treatment as opposed to punishment. Punishment for an illness results in a violation of a person's rights.

## Key considerations for the courts

- Courts can confront cases of people who use drugs prosecuted for drug-related offences, including possession or sale of drugs.
- Courts can also confront cases involving abuse, marginalization and mistreatment faced by people who use drugs. This abuse increases the vulnerability of people who use drugs to HIV and continuing drug use, and limits opportunities for employment, education and treatment.

Courts can play a significant role in creating an enabling environment for HIV prevention, care and treatment among people who use drugs in a number of ways:

- Determining whether to issue a non-custodial sentence rather than a custodial sentence. Non-custodial sentences can have a significant impact by diverting a person who uses drugs away from prison, which is a high-risk environment for the transmission of HIV, TB and Hepatitis C. In determining whether a custodial sentence is necessary the court may want to consider the following questions:
  - Is incarceration a necessary response for the drug-related offence?
  - To what extent can incarceration result in the achievement of the desired objective (e.g. rehabilitation, treatment)?
  - Does the response go beyond what is needed to meet that desired objective?

- Aggressive, overly broad implementation of drug laws by courts can impede HIV prevention programmes, including harm reduction programmes.

## Prisoners

### HIV and TB amongst detainees

There are around 11 million people in prisons around the world, and Africa has high levels of people incarcerated in prisons and overcrowding in prisons.

Prisoners have high rates of HIV, TB and Hepatitis B and C. People in prisons are 7.2 times more likely to be living with HIV than adults in the broader population.

Source: [UNAIDS \(2021\) HIV and People in Prisons and Other Closed Settings: Human Rights Fact Sheet](#)

Incarceration in prison significantly increases vulnerability to HIV and TB. Overcrowding, inadequate nutrition, poor prison conditions, such as poor ventilation, tattooing with homemade and unsterile equipment, drug use and needle sharing, unprotected sex and sexual violence all contribute to HIV and TB rates among detainees.

#### Note to the trainer

See UNAIDS webpage on [AIDS Info Key Populations Dashboard](#) for data on HIV prevalence amongst prisoners in Africa, Hepatitis C and HIV co-infection, and ART coverage, amongst other.

Punitive and restrictive laws also raise the vulnerability of people in prisons to HIV and TB. Legal prohibitions on the provision of sterile needles and opioid substitution treatment (OST) directly impede HIV prevention efforts. Criminal laws prohibiting same-sex sexual activity and correctional laws prohibiting sex in prisons, are often raised as a barrier to providing condoms – necessary to lower the risk of HIV transmission – in prisons. People in prisons rarely have access to adequate HIV and TB services putting their and the community's health at risk.

### Preventing HIV in prisons

In 2019, of the countries reporting to UNAIDS:

- Only 6 of 104 countries had needle and syringe programmes.
- Only 20 of 102 countries had OST programmes.
- Only 37 of 99 countries had condoms and lubricants in some prisons.

#### Key point

Prison authorities are obliged to take steps to ensure protection from violence and to promote the health and safety of prisoners, including in the context of HIV and TB.

International human rights law recognizes the ability of the State to deprive people of certain rights, such as the right to liberty, through incarceration. But States also have an obligation to protect, promote and respect other rights, including the rights to humane treatment and dignity. Further, people in prison have a right to a standard of health care equivalent to that available outside of prisons, which would include adequate access to HIV prevention and treatment services and other health services.

## Key considerations for the courts

Courts are confronted with various issues related to people in prisons and HIV and TB:

- Courts can address cases involving the mistreatment faced by people in prisons, to ensure people living with HIV, people with TB and others in prison receive adequate food and nutrition, address overcrowding and other sub-standard prison conditions, and ensure people living with HIV and TB in prisons have access to quality health services.
- Issuing a non-custodial sentence rather than a custodial sentence can have a significant impact by diverting a person away from prison where their vulnerability to HIV and TB is high. In determining whether a custodial sentence is necessary the court may want to consider the following questions:
  - Is incarceration a necessary response for the offence?
  - To what extent can incarceration result in the achievement of the desired objective (e.g. rehabilitation, treatment)?
  - Does the response go beyond what is needed to meet that desired objective?
- Courts can be mindful that aggressive, overly broad implementation and enforcement of criminal laws can impede HIV prevention programmes.

## Migrant and mobile populations

People may move from one place to another – temporarily, seasonally or permanently – for a host of reasons: in search of professional or economic opportunity, to join family members, pushed by war, human rights abuses, ethnic tensions, violence, famine and/or persecution.

The International Organization for Migration notes that migration is the strongest single predictor of HIV risk and prevalence in sub-Saharan Africa. In many countries, regions reporting higher seasonal and long-term mobility also have higher rates of infection, and higher rates of infection can also be found along transport routes and in border regions. Such studies indicate that migration and mobility increase vulnerability to HIV both for those who are mobile and for their partners back home.

Migrant and mobile populations, including migrant and mobile workers such as truck drivers, traders, and those in the armed forces; refugees and asylum seekers and internally displaced persons, are vulnerable to HIV and experience the impact of HIV severely for a number of reasons:

- Social exclusion (e.g. due to language and socio-cultural barriers).
- Xenophobia, stigma and discrimination.
- Poverty and sub-standard living conditions.
- Vulnerability to exploitation and violence, including sexual violence.
- Separation from families and partners.
- Engagement in risk behaviours due to instability and trauma.
- Limited access to health and social services, including health information, prevention, diagnosis and treatment for HIV and TB.
- Limited continuity of care, impacting on adherence to treatment.

Source: [Facts about migration, mobility and HIV in sub-Saharan Africa 2017](#)

Migrant and mobile populations living with HIV are also more vulnerable to poorer health outcomes because of barriers to access to services, including language and cultural barriers, stigma and discrimination, and limited

continuity of care. A large body of research has shown that migrants are more likely to enter into the health care system late and are less likely to be retained at successive stages of treatment. In addition, in some cases, countries have laws denying entry to migrants living with HIV or have health care policies that exclude access to services for migrant and mobile populations.

The [HIV Policy Lab](#) reports that only 71 percent of countries in East and Southern Africa and 68 percent of countries in Western and Central Africa have national laws and policies that make primary health care and HIV services accessible to all migrants under the same conditions as citizens.

See HIV Policy Lab webpage on [Migrant Access to Health Care](#) for more information.

International human rights apply to all migrants and mobile populations. Human rights treaties permit a distinction to be made between nationals and non-nationals in respect of only two rights, and only in limited circumstances:

- The right to vote and take part in public affairs under article 25 of the ICCPR.
- The right to freedom of movement within a country under article 12 is limited to foreigners who are lawfully present within the country.

However, any limitation must be narrowly construed, done in accordance with the law and be related to a legitimate aim.

## Key considerations for the courts

Courts can be faced with issues related to migrants and mobile populations and HIV including in the following ways:

- Addressing violations of the human rights of migrant and mobile populations, especially those which make them more vulnerable to HIV. These include migrants and mobile populations experiencing stigma and discrimination in accessing work, housing, health services, amongst others, and violence, including sexual violence.
- Migrants and mobile populations may appear before courts on charges related to their migrant status, such as violations of immigration laws, or as a perpetrator of a crime.

## People with disabilities

People with disabilities have been excluded and neglected in all of the sectors responding to HIV.

HIV prevalence data among people with disabilities is scarce.

However, data from sub-Saharan Africa suggests an increased risk of HIV infection of 1.48 times in men with disabilities and 2.21 times in women with disabilities compared with men without disabilities.

Source: [UNAIDS \(2017\) Disability and HIV](#)

Access to HIV prevention, care, treatment and support and sexual and reproductive health and rights services is equally important, and in some cases even more important, for people with disabilities compared with their peers without disabilities.

This access is hindered by several factors:

- **Stigma and discrimination:** people with disabilities, in particular women and girls, may be turned away from sexual and reproductive health and rights and HIV services, may be considered a low priority, or may not be provided with accessible education and information material. People with disabilities may experience multiple forms of stigma and discrimination in all spheres of life, including health, education,



work and the justice system. This applies particularly to women and girls with disabilities who experience discrimination based on gender and disability, as well as other people with intersecting vulnerabilities.

- **Exclusion from violence prevention:** people with disabilities are less likely to report violence, seek care or access justice despite being 1.3 times more likely to experience sexual, physical and emotional violence than their peers without disabilities. In particular, women, girls and people with mental and intellectual impairments are two to eight times more likely to experience sexual violence than their non-disabled peers.
- **Inaccessibility:** health and education services are often not physically accessible and lack support for alternative modes of communication, such as sign language, Braille, and simplified easy-to-read and adapted tools. In the context of HIV and sexual and reproductive health and rights, people with disabilities may experience attitudinal barriers relating to the expectation that they are not sexually active and therefore not in need of such services.
- **Exclusion from sexuality education:** young people with disabilities may be sexually active and may engage in behaviours that put them at risk of acquiring HIV, but they may have little knowledge about HIV and sexuality. Children with disabilities are 2–10 times more likely to be out of school than their peers without disabilities; those who are at school may lack access to comprehensive sexuality education.
- **Increased economic vulnerability:** people with disabilities and their families are economically more vulnerable due to exclusion and discrimination in the labour market, lower employment rates and lower household incomes. They also experience higher out-of-pocket costs than the general population due to additional disability-related costs. Women with disabilities are more affected.

## What is disability?

The Convention on the Rights of Persons with Disabilities states that: “persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

Disability results “from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.”

People living with HIV may also identify as people with disabilities. In some countries, high courts have ruled that laws prohibiting discrimination based on disability protect people living with HIV based on their sero-status, and that this includes both actual and perceived disability. Further, diverse aspects of disability are experienced by a high number of people living with HIV, including those on antiretroviral therapy. These include impairments (e.g. sensory, musculoskeletal, cardiovascular, mental), activity limitations (e.g. mobility, daily activities) and participation restrictions (e.g. work, social life).

The CRPD requires countries to protect, promote and respect the rights of people with disabilities to participate and be included in all spheres of life, to be free from discrimination, equal access to education, including HIV information and comprehensive sexuality education, justice, health, including sexual and reproductive health, HIV services and rehabilitation, and the right to freedom from exploitation, violence and abuse. CRPD also recognizes that “women and girls with disabilities are at greater risk” and need specific protection from negligence and violence.

## Key considerations for the courts

Courts may confront issues related to people with disabilities and HIV in a number of ways, including:

- Courts may be asked to address abuse, marginalization and mistreatment faced by people with disabilities. This includes cases involving stigma and discrimination in access to education, work and employment, health services, among others, violence and sexual violence, including barriers to reporting mistreatment and violence, and denial of services due to inaccessibility.
- Courts may also confront issues of accessibility in courtrooms as there may be barriers to the participation of people with disabilities in court processes, such as a lack of wheelchair access and alternative modes of communication, including sign language interpretation.

## Comparative jurisprudence

There are a number of resources and compendiums of case law relevant to HIV, TB, key and vulnerable populations. Select case law is set out below.

### Overly broad criminalization of HIV transmission: Review of criminalization provision

**Parties:** *Aids Law Project v Attorney General & 3 others*

**Citation:** Petition 97/2010; [2015] eKLR

**Court:** Nairobi High Court

#### Facts

The AIDS Law Project, a non-governmental organization, sued the Attorney General, among others, challenging section 24 of the HIV and AIDS Prevention and Control Act No. 14 of 2006, which broadly criminalized HIV transmission. They argued that it was unconstitutional on the grounds that being broad and vague it discriminated against people living with HIV, women and members of vulnerable groups and that it was likely to promote fear and stigma.

#### Held

- Section 24 of the HIV and AIDS Prevention and Control Act No. 14 of 2006 is unconstitutional for being vague and lacking in certainty. The same is also overbroad and is likely to violate the rights to privacy as enshrined under Article 31 of the Constitution.
- The State Law Office ordered to review the HIV and AIDS Prevention and Control Act, No. 14 of 2006 with a view to avoiding further litigation surrounding the said piece of legislation.

### Criminalization of HIV transmission: Breastfeeding and HIV transmission

**Parties:** *Semba v S*

**Citation:** [2017] ZWHHC 299

**Court:** Zimbabwe High Court

#### Facts

A breast-feeding mother with HIV, who was aware of her status, was convicted of the offence of deliberate transmission of HIV and sentenced to 10 years imprisonment for having breast-fed her co-tenants baby. Medical tests established that the baby was not infected with HIV. The Appellant appealed against conviction.

#### Held

- The offence created by s79 of the Criminal Law (Codification and Reform) Act was not intended to criminalize HIV transmission through an act such as breastfeeding. The intention of the law maker was to criminalize the deliberate transmission of HIV through sexual conduct.
- Actual transmission, and not mere exposure, must be proven.
- The standard of proof requires knowledge of the real risk of HIV transmission through conduct and intention, actual or legal, to transmit HIV. There was no proof that the woman intended to transmit HIV.

Note: The Court noted that “there is scientific evidence pointing to several defences in light of new knowledge and recent break-through in research. Clearly, the legislature was at war with the disease resulting in a law that is difficult of application. The defences available from latest research findings must be recognized at law.”

## Right to liberty, freedom of movement: Decriminalizing vagrancy

**Parties:** *Francis Tumwesige Ateenyi v Attorney General*

**Citation:** (Constitutional Petition No. 36 of 2018) 2022 UGCC 5

**Court:** Uganda Constitutional Court

### Facts

The Constitutional Court was asked to declare sections 168(1)(c) and 168(1)(d) of the Penal Code - deeming that any suspected person who had no visible means of subsistence to be a 'rogue and vagabond' and a person unable to give a proper account for themselves in a public place to be there for illegal or disorderly purposes - to be unconstitutional. The provisions were argued to permit the police to arbitrarily arrest and detain people in the absence of reasonable suspicion and on the assumption of illegal and disorderly purpose.

### Held

- The Court found that sections 168(1)(c) and 168(1)(d) of the Penal Code Act Cap 120, creating the offences of being a 'rogue and vagabond' and being present for an 'illegal and disorderly' purpose, were overly broad and vague offences. They were contrary to the presumption of innocence as an element of the right to a fair trial.
- Arresting a person on the basis of vague offences is a violation of the right to liberty and freedom of movement.
- The provisions were declared to be unconstitutional.

## Right to freedom of association and non-discrimination: Registration of LGBTI organization

**Parties:** *Non-Governmental Organizations Co-Ordination Board v Eric Gitari & 5 others*

**Citation:** Petition No.16 of 2019 [2023]

**Court:** Kenya Supreme Court

### Facts

In 2013, Eric Gitari, the former executive director of the National Gay and Lesbian Human Rights Commission (NGLHRC), challenged the Kenya Non-Governmental Organizations (NGO) Coordination Board's decision not to allow registration of the NGO. In 2015 the High Court found that the NGO Board's decision violated the right to freedom of association under Art. 36 and the right to non-discrimination under Art. 27 of the Kenyan Constitution. The NGO Board appealed the decision.

### Held

- Denying registration to the NGO on the basis of sexual orientation of the applicants was an unreasonable and unjustifiable limitation of the rights of LGBTI people to freedom of association.
- The refusal to register the NGO on the grounds of criminalization of same-sex sex was discrimination on the grounds of sexual orientation, violating the constitutional prohibition against non-discrimination.

## Right to freedom of expression, assembly and association: Registration of LGBTI organization

**Parties:** *Attorney General of Botswana v. Thuto Rammoge & 19 Others*

**Citation:** [2016] CACGB-128-14

**Court:** Botswana Court of Appeal

### Facts

Rammoge and 19 others filed a case before the High Court of Botswana, asking the Court to review the decision by the Director of Civil and National Registration and the Minister of Labour and Home Affairs to refuse to register the organization, Lesbians, Gays and Bisexuals of Botswana (LEGABIBO). The High Court held that the refusal to register LEGABIBO violated their rights to freedom of expression, assembly and association and there was no legitimate justification for the infringement. This decision was appealed by the government.

### Held

- The Court of Appeal set aside the Minister's refusal to register LEGABIBO and ordered the Registrar to take the necessary steps to register it. It found the refusal to register LEGABIBO was unconstitutional.
- In reaching its decision, the Court of Appeal noted that the Constitution did not exclude LGBTI people from its protection and affirmed that all people in Botswana, including LGBTI people, enjoy the rights enshrined in the Constitution, subject only to the public interest and respect for the rights and freedoms of others.
- The Court further emphasized that being a homosexual was not unlawful in Botswana, only engaging in same-sex sex was unlawful.

## Right to dignity; right to privacy; right to freedom from inhuman and degrading treatment: Publication of identity of LGBTI persons

**Parties:** *Jacqueline and Others v Rolling Stone Ltd. and Another*

**Citation:** (2010) Miscellaneous Cause No 163

**Court:** Uganda High Court, Kampala

### Facts

Jacqueline and two others sued the publishers of Rolling Stone Magazine for a published story entitled "Hang Them; They are After our Kids!!!! Pictures of Uganda's 100 Homos Leak." They sought a permanent injunction against the magazine from publishing injurious information and damages. They argued that the story put them at risk of violence, ridicule, hatred and mob justice in violation of their rights to dignity, freedom from inhuman treatment, liberty, privacy and life.

### Held

The High Court found that the publishers of Rolling Stone violated the right to dignity, freedom from inhuman treatment and the right to privacy. The Court held that publishing the identity of the three Applicants and calling for them to be hanged, the magazine clearly violated the right to human dignity. The Court noted that the case was not about homosexuality, but about whether Rolling Stone infringed the rights of Jacqueline and the two others. It further emphasized that though sodomy was criminalized, being gay was not criminalized.

## Right to a fair trial: Evidence used to convict on same-sex sex offences

**Parties:** *The Prosecution v Diogomaye SENE and 6 others* **Citation:** *DKR/TGI/MP v Diogomaye et al* [21 August 2015]

**Court:** Tribunal of 1st degree of Dakar - Senegal

### Facts

Based on a tip-off, police broke into the home of Youssou, arrested 7 individuals and confiscated various personal items. The police returned to the property 3 days later and seized further evidence, including male condoms, oils, tablets, mobile phones and other personal effects, retaining them as “evidence allowing the manifestation of the truth.” The accused were brought before the Tribunal de Grande Instance of Dakar, charged with the offence of indecent acts against nature between persons of the same sex, in terms of s319(3) of the Penal Code.

### Held

- Evidence of used condoms, pornographic films, illegal drugs and compromising pictures and positions are sufficient to prove the offence of indecent acts against nature between persons of the same sex as criminalized by article 319(3) of the Penal code.
- The accused were sentenced to terms of imprisonment of 2 years, of which 18 months were suspended.

## Right to protection from cruel, inhuman and degrading treatment or punishment: Police harassment

**Parties:** *Victor Juliet Mukasa and Yvonne Oyo v Attorney General*

**Citation:** *Miscellaneous Cause No. 247/06*

**Court:** High Court of Uganda, Kampala Civil Division

### Facts

The Petitioners, two women, claimed they were harassed and unlawfully detained by a local authority and later by the police. The second Petitioner claimed she was forcibly removed from the home of the first Petitioner, the home was ransacked, and she was detained at the local authority’s office for a considerable period of time without access to a toilet. At the local police station, the Second Petitioner further claimed she was forced to undress by the officer in charge in order to confirm her sex. She alleged the officer in charge fondled her breasts and other officers ridiculed her. The Petitioners requested compensation for damages, claiming infringements of their rights to privacy, personal liberty and protection from torture and cruel, inhuman or degrading treatment in terms of the Ugandan Constitution.

### Held

- The actions of the police officer in charge amounted to humiliating and degrading treatment in violation of her constitutional right to protection from torture and cruel, inhuman or degrading treatment.
- The Court observed the actions also to violate Article 1 of the UDHR and women’s rights to liberty and security of the person, equal protection under the law and freedom from torture or other cruel, inhuman or degrading treatment or punishment under CEDAW.

## Right to non-discrimination: Decriminalization of same-sex sex

### **Parties: *Ah Seek v The State of Mauritius***

**Citation: Record No. 119259**

**Court: Supreme Court of Mauritius**

#### **Facts**

The complainant, Ah Seek, has been in a same-sex relationship for 10 years. He challenged the constitutionality of section 250 of the Mauritian Criminal Code, dating back to 1838, which criminalizes ‘sodomy’ with a maximum penalty of five years’ imprisonment.

#### **Held**

- The prohibition against discrimination on the grounds of “sex” in Article 16 of the Constitution should be interpreted to include “sexual orientation”.
- As a State party to the International Covenant on Civil and Political Rights, Mauritius was expected to interpret its Constitution in line with this treaty.
- Article 250(1) of the Penal Code discriminated, in its effect, against the complainant because of his sexual orientation and thus violated Article 16 of the Constitution, in so far as it prohibited acts of anal sex between consenting male adults in private.
- There must exist particularly serious reasons for the State to justifiably interfere with the manner in which homosexual men choose to have consensual sex in private. The provision should be interpreted so as to exclude these consensual acts from its scope.

Note: The judges also recognised that Section 250 was not reflective of the domestic democratic will of the country but rather an inherited colonial-era law “imposed on Mauritius and other colonies by British rule.”

## Right to non-discrimination, dignity, privacy: Decriminalization of same-sex sex

### **Parties: *Attorney General v Motshidiemang***

**Citation: Civil Appeal No. CACGB-157-19**

**Court: Botswana Court of Appeal**

#### **Facts**

In September 2016, a man identifying as gay challenged the constitutionality of sections 164(a) and (c) of the Botswana Penal Code, which prohibit anal sex. On 11 June 2019, the High Court declared that s164 and s167 of the Penal Code violated the rights to liberty, dignity, privacy and freedom from discrimination in Botswana’s Constitution.

The State appealed the 2019 decision arguing that (i) the High Court had no power to overturn the Court of Appeal’s decision in a previous case (*Kanane v the State*), (ii) on the basis of the principle of separation of powers; and (iii) that the Penal Code pre-dated the Constitution and is not subject to the prohibition against discrimination.

#### **Held**

- The Constitution prohibits discrimination on several grounds, including sex, which should be read to include sexual orientation and gender identity.
- The Penal Code was a colonial-era piece of legislation; it has changed significantly since its adoption including more recently, to make sexual offences gender-neutral. It ought to be subject to the Constitution.

- The court noted the discriminatory effect of the Penal Code on the rights to liberty, dignity, equal protection of the law and privacy. It noted that the right to privacy, read with the right to security of the person, extends to the right to make personal choices about one's lifestyle, choice of partner and intimate relationships.
- Sections 164(a) and (c) of the Penal Code are unconstitutional and unnecessarily harmful to and stigmatizing of gay men.

Note: the Court of Appeal did not address the constitutionality of s167 of the Penal Code, which criminalizes acts of gross indecency, whether performed in public or in private and whether consensual or not.

## Right to dignity, equality: Immigration rights of same-sex spouses

***Parties: Digashu and Others v Government of the Republic of Namibia and Others; Seiler-Lilles v Government of the Republic of Namibia***

**Citation: Case No. SA 7/2022**

**Court: Namibia Supreme Court**

### Facts

Mr Digashu and Ms Seiler-Lilles settled in Namibia with their respective Namibian same-sex spouses, whom they had lawfully married outside of Namibia. They applied and were refused residency by the Ministry of Home Affairs and Immigration. They then applied to the Supreme Court to determine the lawfulness of the Ministry's refusal, since the Immigration Control Act provides that a spouse of a Namibian citizen doesn't need to apply for permanent residence, employment permits or other permits to stay and work in Namibia.

### Held

- Both Mr Digashu and Ms Seiler-Lilles had lawful, valid same-sex marriages outside of Namibia, which should be recognised in Namibia in terms of the principles of common law.
- The constitutional right to dignity and equality, in light of Namibia's constitutional values, clearly recognises the equal worth of all human beings. Any law that impedes a person's ability to honour their spousal commitments infringes their rights to dignity and equality.
- A foreign spouses should be regarded as a spouse with immigration rights under the Act, because they entered into valid marriages in another country.

## Right to change gender marker: Transgender person

***Parties: Mervin Jezabel Barbe v Chief Officer of Civil Status***

**Citation: Civil Appeal SCA 08/2015 [2017] SCCA 23 (11 August 2017)**

**Court: Seychelles Court of Appeal**

### Facts

The Appellant, Barbe, was registered as a male and recorded as such on a birth certificate issued by the Civil Status Officer in Seychelles, in 1972, under the Civil Status Act. In 2003, the Appellant underwent surgery and later obtained an identity document as a female, in Italy, where the Appellant resided. In 2009, Barbe applied to the Civil Status Office in Seychelles to change her birth certificate from male to female, which was refused. Barbe filed a Plaintiff in the Supreme Court seeking that change, which was also refused, and consequently appealed against the judgement of the Supreme Court.

### Held

- Section 100 of the Civil Status Act is limited and provides for a change in registration in the case of an error. The court held that there had been no error; the Appellant did not dispute that at the time of birth

the Appellant's gender was male; the Appellant requested an amendment not due to any error but due to a change in circumstances.

- The Appellant may have succeeded if an application had been brought under other sections of the Civil Status Act; however, based on the provisions on which the original case and appeal were brought, the court dismissed the appeal.
- The court recognized the limited law in Seychelles to provide for gender recognition, and recommended that the legislature consider recognition of gender change, in conformity with the Charter of Human Rights in the Seychelles Constitution.

## Right to non-discrimination: Rights of transgender prisoner

**Parties:** *September v Soobramoney NO and Others*

**Citation:** (2019) ZAEQC 4

**Court:** Equality Court of South Africa, Western Cape

### Facts

The Applicant is a transgender woman incarcerated at Malmesburg prison. While incarcerated, the Respondent had refused to allow her to express her gender identity in prison, for example by wearing make-up, wearing her hair long, and referring to herself and requesting others to refer to her as a woman; and had detained her in segregation. The Applicant brought the application to be allowed to express her gender identity while in prison, arguing that not allowing her to do so amounted to unfair discrimination and a violation of her right to dignity.

### Held

- The Court noted the severe mental suffering caused to the Applicant, resulting in fear, anguish and feelings of inferiority leading to humiliation, by denying her a normal wish, as a transgender woman, to want to present herself as a woman.
- It further held that the right to dignity includes the Applicant's right to express her gender identity.
- The Court held that the Respondent's conduct infringed her right to freedom of expression in terms of the Constitution; her right to dignity and her right to non-discrimination.
- The Court ordered the Respondent to allow the Applicant to remain in a single cell in either a male or female prison and to be allowed to express her gender identity.
- The Court furthermore ordered the Respondent to introduce pre- and in-service transgender sensitivity training for new and current employees.
- The court held that, while it would not be effective to order major physical changes to the current correctional centres to provide separate transgender accommodation, certain changes should be made to ensure all detainees, including the Applicant, would be treated with the necessary dignity and respect.

## Unlawful arrest: Sex work

**Parties:** *Sex Worker Education and Advocacy Task Force (SWEAT) v Minister of Safety and Security and Others*

**Citation:** [2009] ZAWCHC 64; 2009 (6) SA 513

**Court:** South African High Court

### Facts

SWEAT, a sex worker rights organization, sought from the High Court a determination on whether the police can lawfully arrest sex workers in circumstances where the arresting officers know with a high degree of probability that no prosecution will result.



## Held

The High Court held that the police were targeting sex workers by arresting and detaining them and then failing to prosecute, in violation of their rights to dignity and freedom and security of the person. The Court found that the arrests of sex workers amounted to social control. The Court interdicted and restrained the police from arresting sex workers for any purpose other than to bring the arrestees before a court of law to face prosecution.

## Right to security of the person: Decriminalization of sex work

**Parties:** *Canada v Bedford*

**Court:** Supreme Court of Canada

**Citation:** 2013 SCC 72

## Facts

Three current and former sex workers sought a declaration that three provisions of the Criminal Code, which criminalize various activities related to sex work, infringed on their right to free expression and their rights to life, liberty and security of person guaranteed under the Canadian Charter of Rights and Freedoms. They argued that the criminal penalties put the safety and lives of sex workers at risk, by preventing them from implementing certain safety measures — such as hiring security guards or screening potential clients — that could protect them from violence.

## Held

- The Supreme Court found that the three provisions criminalizing activities related to sex work violated the right to security of the person in that they put sex workers, an activity the Court noted was itself legal, at risk of harm.
- The Court further found that some of the provisions were grossly disproportionate to their objective and others were overbroad and thus not justifiable.
- In reaching this conclusion, the Court noted that by criminalizing “bawdy houses”, sex workers have only the options of working in the street or conducting out-calls.
- The Court further found that the criminal law prevented sex workers from hiring body guards, drivers and others who can ensure their safety, as the law criminalizes living off the proceeds of a sex worker.
- Finally, the Court held that criminalizing communication isolates sex workers, placing them in more dangerous positions.
- Given its finding on the right to security of the person, the Court did not address whether the provisions violated freedom of expression under the Charter.

## Right to privacy: Mandatory HIV testing of sex workers

**Parties:** *S v Mwanza Police, Mwanza District Hospital, Ministries of Justice, Internal Affairs, Health, Attorney-General and Ex parte: HB, JM (o.b.o 9 others)*

**Court:** Malawi High Court

## Facts

The Applicants were arbitrarily arrested in Mwanza on two separate occasions in September and November 2009 by the police as they were presumed to be sex workers. On both occasions, a number of women were detained overnight at the Mwanza Police Station. The women were then taken to the Mwanza District Hospital and subjected to blood tests without their informed consent. Their names and test results were handed over to the police. Thereafter, some of the women were charged with spreading venereal diseases in contravention of

section 192 of the Penal Code. Some of the women became aware of their HIV status for the first time when the particulars of the offence, including their HIV-positive status, were read out loud in the Magistrate's Court.

The women challenged the forced testing and public disclosure of their HIV status arguing that it violated their constitutional rights to privacy and liberty of the person, non-discrimination, freedom from cruel, inhuman and degrading treatment and dignity.

## Held

The Court held that mandatory HIV testing violated the Applicants' rights to privacy, dignity, equality and freedom from cruel, inhuman and degrading treatment.

## Right to privacy: Decriminalization of drug possession for private consumption

**Parties: Minister of Justice and Constitutional Development & Others v Prince; National Director of Public Prosecutions & Others v Rubin; National Director of Public Prosecutions and Others v Act**

**Citation: [2018] ZACC 30**

**Court: Constitutional Court South Africa**

## Facts

Prince, a law graduate, was using cannabis for spiritual, medicinal, culinary and ceremonial purposes as a way of manifesting his religion as a Rastafarian. Due to a previous conviction of possessing cannabis, the Law Society rejected his request for registration as a candidate attorney. In 2002, he unsuccessfully challenged the constitutionality of the prohibition on the use and possession of cannabis for religious purposes in the High and Supreme Court of Appeal. In 2017, he and other Applicants again challenged the constitutionality of s4(b) and 5(b) of the Drugs and Drug Trafficking Act 140 of 1992 read with Part III of Schedule 2 of that Act, and s22A(9)(a) (1) of the Medicines and Related Substances Control Act 1010 of 1965, on the basis of infringement of the right to privacy, freedom of religion and dignity. The High Court heard the various applications together, and found in favour of the Applicants. In 2018, the matter went to the Constitutional Court.

## Held

- The right to privacy provides a high level of protection to the individual's intimate personal sphere of life; with regards to the most intimate core of privacy, not justifiable limitations can take place. This inviolable core is left behind once an individual enters into relationships with persons outside this closest intimate sphere.
- The right to privacy entitles an adult person to use, cultivate or possess cannabis in private for his or her personal consumption.
- The State failed to show that the limitation of the right to privacy was reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. The court found that the prohibition on the use of cannabis by adults in the confines of their private dwellings is an unjustifiable limitation on the right to privacy and is inconsistent with the Constitution. The provisions of the legislation in question were invalid to that extent.
- The prohibition on dealing in cannabis, however, was a justifiable limitation on the right to privacy and served a legitimate purpose in light of the chronic challenge of dealing in cannabis in South Africa.
- The court considered a number of factors, including that the history of cannabis use in South Africa is "replete with racism"; there is a long history of the use of cannabis by indigenous South Africans, subsequently outlawed by colonial authorities. The harm of cannabis use was not as severe as previously argued by government "experts" and the adverse health and social consequences appear to be less severe than those reported by persons dependent on alcohol or opioids. Attitudes towards cannabis use have changed over the past 10 years.

## Right to life; right to protection from inhuman and degrading treatment: Rights of prisoners with HIV

**Parties:** *Mwanza and Another v Attorney General*

**Citation:** [2016] eKLR

**Court:** Supreme Court of Zambia

### Facts

Two prisoners living with HIV sued the Government alleging that poor prison conditions and the lack of adequate food provided to prisoners living with HIV on treatment in the Lusaka Central Prison violated their human rights.

### Held

- The Supreme Court held that failure to provide prisoners with a balanced diet, and exposing them to congested prison conditions, violated their right to life and to protection from inhuman and degrading treatment.
- The Supreme Court ordered that the State immediately takes measures to decongest the Lusaka Central Correctional facility and increase the allocation of resources to Lusaka Central Prison for purposes of improving the dietary needs of prisoners.

Note: The Zambian Constitution does not provide protection of socio-economic rights. Significantly, however, the court 'read' protection of health rights into the right to life and right to protection from cruel, inhuman and degrading treatment or punishment.

See also Module II: Freedom of movement: Isolation / Criminalization of people with TB: Minister of Health v Goliath and Others (2) SA 248.

## **Module IV:**

# **Adjudicating gender inequality, harmful gender norms and gender-based violence within the context of HIV and TB**

## Objectives of the module

### By the end of this module participants will be able to:

- Understand the complexities of gender, gender identity and sex.
- Understand the links between gender inequality, harmful gender norms and gender-based violence (GBV).
- Identify different forms of GBV and cases of GBV within the context of HIV.
- Discuss the way in which laws, policies, stigma, discrimination and GBV impact on populations in the context of HIV and health.

### Key points covered in this module

- Women, girls and gender minorities such as transgender women are at higher risk of and more vulnerable to HIV in Africa, and within countries.
- Social and structural issues such as gender inequality, harmful gender norms and gender-based violence continue to be issues of concern in relation to HIV and TB, impacting on vulnerability to HIV and other health issues.
- GBV may take many forms, not all of which may be recognized in laws prohibiting violence within countries, such as sexual offence laws, laws on domestic or intimate partner violence (including marital rape), and laws on sexual harassment within the working environment.
- Gender-based violence can violate a broad range of human rights, including the right to life, freedom from torture and degrading treatment, freedom from discrimination and the right to safety and security.

### Recommended readings/documents for this module

- [GCHL \(2012\) Risks, Rights and Health](#)
- [Global Commission on HIV and the Law \(2018\) Risks, Rights & Health Supplement](#)
- [UNAIDS \(2023\) HIV and adolescent girls and young women: 2023 UNAIDS Global AIDS Update Factsheet](#)
- [UNAIDS \(2020\) Zero Discrimination Against Women and Girls: Fact Sheet](#)

### Recommended facilitators

It may be useful to request an input from legal experts working on issues of gender inequality, harmful gender norms and gender-based violence, particularly those with expertise in how gender-related discrimination, inequality and violence impacts on people living with HIV, people with TB, key and vulnerable populations, including e.g.:

- Lawyers from human rights, legal and other civil society organizations working on gender equality, HIV, TB and health, including sexual and reproductive health and rights, such as women's rights organizations and LGBTI organizations, amongst others.
- Senior staff from international organizations and UN agencies (e.g. UNDP, UNAIDS, UN Women) working on gender equality, HIV, health and human rights issues.

It may also be useful to request an input from medical experts who can provide updated medical and scientific information on the health-related impacts of gender inequality, harmful gender norms and gender-based violence, to establish concrete medical and scientific evidence critical for adjudicating cases, including for instance:

- Senior staff from international agencies such as UNAIDS, UNDP or WHO.
- A public health practitioner specializing in sexual and reproductive health and rights.

- A medical researcher, academic, or medical practitioner.

Finally, it is important to request an input from a person who works with or is personally affected by gender inequality, harmful gender norms or gender-based violence who can explain key terms and talk about the real-life impact of gender inequality and gender-based violence on health, well-being and development.

## Gender or sex?

### Note to the trainer

It may be useful to ask participants to give their understanding of the differences between sex and gender. Summarize the results into the following significant differences:

Sex	Gender
Biologically determined	Constructed by society
Universal for all human beings	Differs depending on culture, socio-diversity etc
Unchanging	Dynamic

### Sex, gender and gender identity

Sex refers to the different biological and physiological characteristics of females, males and intersex persons, such as chromosomes, hormones and reproductive organs.

Gender intersects with, but is different to sex. Gender refers to the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours and roles associated with being a woman, man, girl or boy, as well as relationships with each other. As a social construct, gender varies from society to society and can change over time.

Gender and sex are related to but different from gender identity. Gender identity refers to a person's deeply felt, internal and individual experience of gender, which may or may not correspond to the person's physiology or designated sex at birth.

Gender is hierarchical and produces inequalities that intersect with other social and economic inequalities. Gender-based discrimination intersects with other factors of discrimination, such as ethnicity, socioeconomic status, disability, age, geographic location, gender identity and sexual orientation, among others. This is referred to as intersectionality

For more information, see WHO webpage: [Gender and Health](#)

### HIV and gender

- In sub-Saharan Africa, there were 210 000 new HIV infections among adolescent girls and young women (aged 15–24 years) in 2022. Women and girls (all ages) accounted for 63 percent of all new HIV infections.
- Eighty two percent of adolescent girls and young women who acquired HIV in 2022 live in sub-Saharan Africa, including two thirds in Eastern and Southern Africa.

Source: [UNAIDS \(2023\) HIV and adolescent girls and young women: 2023 Global AIDS Update Factsheet](#)

- Female and transgender sex workers are 11 times more likely to be living with HIV than other women.
- Women in prison are 5 times more likely than other women to be living with HIV.
- Women who inject drugs are 17 times more likely than other women to be living with HIV.

- Transgender people are 13 times more likely to acquire HIV than others.

Source: UNAIDS (2020) [Zero Discrimination Against Women and Girls: Fact Sheet](#)

### Note to the trainer

It is important to highlight that women and girls, including transgender women, are at higher risk of, and more vulnerable to HIV in Africa as a region, and within countries.

For more information, see UNAIDS webpage [AIDSInfo](#). Refer also to Module I for various websites and links to updated epidemiological information and reports such as [UNAIDS Data 2023](#).

Module I also talks about the various social and structural factors, including gender inequality, that impact on vulnerability to HIV, TB and other health issues.

Social and structural issues such as gender inequality, harmful gender norms and gender-based violence continue to be issues of concern across the world, including in Africa.

### Gender inequality, harmful gender norms, GBV and HIV

- At least 117 countries allow child marriage for girls, and globally more than 1 in 5 women are child brides. In sub-Saharan Africa, 34 percent of women are child brides.
- Across sub-Saharan Africa, 4 million girls (and 2 million boys) will never attend school.
- Existing statutory and customary laws limit women's access to land and other property in most countries in Africa.
- Over one third of women aged 18-24 years reported being sexually abused during childhood in Kenya (32 percent), Uganda (35 percent) and Eswatini (38 percent).
- Women with disabilities are up to 10 times more likely to experience sexual violence.
- 14 million refugees and displaced women and girls were targets of sexual violence in 2019.
- In sub-Saharan Africa, almost 50 percent of adult women have unmet needs for modern contraception. This is almost 60 percent for adolescent girls 15-19 years.

[UNAIDS \(2020\) Zero Discrimination Against Women and Girls: Fact Sheet](#)

The [World Health Organization](#) recognizes that gender inequality, harmful gender norms and GBV impact on health, including vulnerability to HIV and TB, in various ways:

- The way health care services are organized and provided can limit – or enable – a person's access to health care information and services. All health services should be affordable, accessible and acceptable to all without discrimination.
- Gender inequality and discrimination puts people's health at risk. For instance, women and girls may lack decision-making power to access health services, lower literacy levels may create barriers to access to health information, and the negative attitudes of health providers towards sexual and reproductive health and rights may discourage young girls from accessing health services. They may not receive adequate prevention, treatment, care and support for HIV and other STIs.
- Harmful gender norms can affect women, girls, men, boys and transgender and gender-diverse people negatively. Notions of masculinity may encourage boys and men to take sexual and other health risks and

not seek care. Rigid gender norms may lead to stigma, discrimination and violence against people with diverse gender identities, including in health care settings, placing them at higher risk of HIV.

- Violence, including sexual violence and harmful practices such as female genital mutilation place women and girls at direct risk of HIV infection.

### Key point

Gender-based violence, particularly sexual violence, has a clear role in placing people at risk of HIV. However, gender inequalities and harmful gender norms also create or exacerbate vulnerability to HIV.

## What is gender-based violence?

### Note to the Trainer

It may be useful to ask participants to discuss what they understand by GBV. GBV is often confused with violence against women, and it is important to guide participants towards a broader understanding of violence against women, girls, men, boys and sexual and gender minorities.

GBV is not the same as violence against women. It is broader and encompasses violence against men and boys and includes violence against sexual and gender minorities. GBV is violence rooted in structural inequalities based on notions of gender.

### Working definition of GBV

GBV is violence that is directed at an individual on the basis of his or her biological sex, sexual orientation, gender identity, characteristics or expression or perceived adherence to socially defined norms of masculinity or femininity. It includes sexual, physical, and psychological abuse, threats, coercion, extortion, arbitrary deprivation of liberty and economic deprivation whether in public or private life.

### Key point

GBV is not restricted to violence against women and girls, nor to physical and sexual violence.

### Types of GBV

GBV may take many forms, all of which may, or may not be recognized in laws prohibiting violence within countries, such as sexual offence laws, laws on domestic or intimate partner violence and laws on sexual harassment within the working environment, amongst others.

### Table 8: Types of GBV

Physical violence	Aggression directed at someone that results in bodily harm. Includes kicking, hitting, beating, biting, pushing, tying up and excess work. It may include domestic or intimate partner violence within a family / household setting.
Psychological/emotional violence	Acts or omissions aimed at controlling or destroying another person's actions, behaviours, beliefs and decisions through intimidation, manipulation, humiliation, insults, threats or isolation. It also includes any other conduct that adversely affects the mental health or self determination of a person.



Sexual violence	Acts or conduct imposed on a person to make them take part in or maintain unwanted sexual relations. This is done through intimidation, threats, coercion or use of force. It may include e.g. rape, marital rape, sexual abuse, sex trafficking.
Patrimonial/economic violence	An action or omission that may endanger the property of the family including destruction of property, refusal to transfer property or inheritance, deprivation of basic needs, denying a person the opportunity to work or controlling their income or in any other way denying a person the opportunity to make economic decisions that affect their life.
Socio-cultural violence	Traditional and cultural practices that affect and endanger a person's self-esteem, health and life. These include female genital mutilation, child marriage, forced labour, widow cleansing, wife inheritance, forced sexual exposure.

GBV can make individuals more vulnerable to HIV and TB. In addition, there is evidence that people living with HIV are more vulnerable to GBV too. Key issues include the following:

- Violence within a relationship may limit people's autonomy to take charge of their health, including getting tested for HIV, accessing prevention, treatment, care and support and making health choices.
- Violence makes it impossible for people to negotiate safer sex methods (e.g. condom use or refusal).
- In many jurisdictions, survivors of violence have limited access to PEP to reduce the risk of HIV infection.
- Traditional gender norms can make it difficult for people to report and access justice for GBV.

## Key considerations for the courts

Gender-based violence can violate a broad range of human rights, including the right to life, freedom from torture and degrading treatment, freedom from discrimination and the right to safety and security.

Rights implicated in cases involving GBV can be found in national constitutions, and numerous international and regional treaties, including the ICCPR, ICESCR, CEDAW, ACHPR and the Maputo Protocol. In addition at the national level, the Penal Code, family law, and laws against domestic violence may be relevant in GBV-related cases.

Some of the potential ways courts may grapple with GBV-related cases include the following:

- Challenges to laws that perpetuate gender inequality, harmful gender norms and GBV, such as laws allowing for child marriage or laws limiting women's economic power or denying inheritance rights to women and girls.
- Cases involving the rights of people who have experienced various forms of GBV, including requests for protection orders from perpetrators of GBV and adjudicating criminal cases, such as cases of gender-based violence, including rape.

A few overarching issues that may arise in GBV-related cases are discussed below:

- **Privacy concerns:** Privacy with respect to personal information, including a party's HIV status, may be of particular concern in GBV-related cases. Such information may come into evidence during a trial, and efforts should be taken to protect the personal information of all parties.
- **Evidentiary considerations:** Cautionary rules and corroboration requirements violate the human rights of complainants and are increasingly being set aside, where they still exist. These rules of evidence undermine successful prosecution of sexual assault or rape cases, re-victimize complainants or result in them withdrawing their cases.

Cautionary rules require the court to exercise special caution when considering the evidence of certain witnesses — such as complainants in sexual assault cases, women and children — on the grounds that the evidence of such witnesses is inherently unreliable. The requirement for corroboration is a rule found in some jurisdictions that prohibits a criminal conviction upon the uncorroborated testimony of a

complainant. Sexual assault cases are particularly affected by these two rules of evidence because sexual violence is often perpetrated in private, where the complainant is the only witness to the offence.

Legislatures and courts are restricting the admissibility of evidence of a complainant's previous sexual conduct or experience, because such inferences can be prejudicial and irrelevant to the case at bar. Admission of a complainant's previous sexual conduct or experience into evidence has been found to be an invasion of their privacy, such that a significant number of complainants either chose to not report or to withdraw their cases. Oftentimes, this evidence relating to previous sexual conduct is used by the defence to suggest that the complainant is more likely to have consented to the sexual interaction and is less worthy of belief.

- **Protection of complainant:** Where a complainant or a witness finds it distressing to be in the same room as the accused, it might mean that they are unable to give evidence effectively or that the complainant or witness suffers further stress and trauma from testifying. Courts should consider various alternative options for providing evidence, such as allowing complainants and witnesses to give evidence from a remote location through video link or changing the typical courtroom seat arrangements.

### Note to the trainer

Encourage participant judges who have adjudicated GBV cases to share experiences of ways in which the rights of parties in court proceedings can be protected.

## Comparative jurisprudence

There are a number of resources and compendiums of case law relevant to HIV, TB, key and vulnerable populations. Select case law is set out below.

### Children's rights: Child marriage

**Parties:** *Mudzuru & Another v The Minister of Justice, Legal and Parliamentary Affairs & 2 Others*

**Citation:** CCZ 2015-12

**Court:** Zimbabwe Constitutional Court

#### Facts

Two Zimbabwean women who had been in a union since an early age, brought a constitutional challenge, seeking to declare child marriage under both civil and customary law in violation of various sections of the Zimbabwean Constitution.

#### Held

- Zimbabwe has ratified the CRC and ACRWC, committing to take all measures to protect and enforce the rights of the child.
- The meaning of section 8(1) of the Constitution dealing with children's rights, section 78 of the Constitution dealing with marriage rights, and the provisions of the Marriage Act, had to be understood with regard to these obligations and the emerging consensus of values in the international community.
- The Court took note of detailed evidence of child marriage on a child's education, economic opportunities in life and sexual and reproductive health, noting that a law that authorized child marriage could not be in the best interests of the child.
- The Court held that provisions of the Marriage Act and the Customary Marriages Act are unconstitutional in failing to set a minimum age of marriage at 18 years.
- The Court ordered that from the date of the judgement, no marriage of a person below the age of 18 years (boy or girl) would be legal.

## Right to medical treatment / operation with informed consent: Forced sterilization of women living with HIV

**Parties:** *Government of Namibia v LM and Others*

**Citation:** Case No: SA 49/2012

**Court:** Supreme Court of Namibia

### Facts

The Government of Namibia appealed a High Court ruling finding that three women living with HIV had been sterilized without their consent at public hospitals in violation of their rights under Namibian law.

### Held

- The Supreme Court affirmed the factual findings of the High Court, namely that all three women had not provided their informed consent to the sterilization. The Court outlined the relevant law on informed consent, finding that it requires knowledge of the procedure and its effects, appreciation of that information and of alternative options including advantages and disadvantages, and consent.
- The Court further noted that in the context of sterilization, a woman must comprehend the nature and consequences of the operation.
- The Court also cautioned against medical paternalism, finding that medical paternalism cannot replace obtaining the patient's informed consent.
- The Court failed to find, on the evidence, that the three women were sterilized as a result of their HIV status.

## Right to non-discrimination; right to life; right to integrity of the person: Rape during armed conflict

**Parties:** *Democratic Republic of Congo v Burundi, Rwanda and Uganda*

**Citation:** Communication 227/99

**Court:** African Commission on Human and Peoples' Rights

### Facts

The DRC alleged that armed forces from Burundi, Uganda and Rwanda had been occupying its border provinces in the eastern part of the country and committing mass violations of human rights and international law. The DRC argued that these violations included, among others, the mass killing of civilians and, in particular against the Ugandan soldiers, the deliberate spread of HIV amongst the local population by the perpetration of rape.

### Held

The African Commission on Human and Peoples' Rights found that the rape was during an effective occupation and was inconsistent with the Geneva Convention relative to the Protection of Civilian Persons in Time of War 1949 and Additional Protocol 1. Further, the Commission found the raping of women to be in violation of the right to non-discrimination, and Article 4, which guarantees respect for life and the integrity of one's person and prohibits the arbitrary deprivation of rights. Finally, the Commission also noted that the rape also contravened the Convention on the Elimination of All Forms of Discrimination against Women.

## Right to non-discrimination: Independent corroboration in sexual offences

**Parties:** *Mukungu v Republic*

**Citation:** 2003 e[KLR]

**Court:** Court of Appeal Kenya

### Facts

A woman was raped by a man whom she allegedly knew, but not by name. She reported the rape and the assailant, Mukungu was charged. Mukungu was not medically examined, and there was no medical evidence to connect him to the alleged offence. Nor was there any other independent evidence connecting him to the crime, although there was ample evidence that the woman was raped. The Trial Court believed the woman and convicted Mukungu. When Mukungu appealed, the High Court confirmed his conviction. Mukungu then sought review at the Court of Appeal, arguing that his conviction was based on uncorroborated evidence.

### Held

- The Court considered the provisions of the Kenyan Constitution that stipulate the right to non-discrimination, and concluded that the requirement for independent corroboration in sexual offences against adult women and girls is unconstitutional.
- The Court went on to say that “[w]e think that the time has now come to correct what we believe is a position which the courts have hitherto taken without a proper basis, if any basis existed for treating female witnesses differently in sexual cases, such basis cannot properly be justified presently. The framers of the Constitution and Parliament have not seen the need to make provision to deal with the issue of corroboration in sexual offences. In the result, we have no hesitation in holding that the decisions which hold that corroboration is essential in sexual offences before a conviction are no longer good law as they conflict with Section 82 of the Constitution.”
- The Court concluded that the requirement that a conviction of rape must be based on independent corroborated evidence is unconstitutional.

# Evaluating the outcome and impact of training

It is important to assess the outcome and impact of judicial training on HIV, TB, key and vulnerable populations on participants knowledge, skills, attitudes and ability to use this to administer justice in matters before them. This can be done using various assessment methods over a period of time, including:

- Baseline assessments carried out before the training.
- In-training evaluations (e.g. evaluation forms given to participants after units are completed).
- Post-training analysis (e.g. evaluation of written judgements) done over a period of time after training has taken place.

Evaluations should seek to determine:

- How the participants react to the training.
- To what degree the participants acquired the intended knowledge, skills or attitudes from the training.
- What change there has been / will be in the participants' behaviour after the training.
- What the overall results and wider benefits of the training will be.

There are many resources available to support the evaluation of judicial training, as well as international standards for assessing judicial performance. See for instance:

- [European Judicial Training Network \(2017\) Guidelines for Evaluation of Judicial Training Practices](#)
- [OHCHR \(2020\) Evaluating Human Rights Training Activities: A Workshop Guide](#)
- [OHCHR \(2020\) Evaluating the Impact of Human Rights Training: Guidance on Developing Indicators](#)
- [OHCHR \(2011\) Evaluating Human Rights Training Activities](#)

Ultimately, the training and sensitization on HIV, TB, key and vulnerable populations and the law seeks to provide information, increase awareness and understanding of key legal and human rights issues facing affected populations, challenge attitudes and misconceptions, and advance rights-based jurisprudence on issues affecting HIV, TB, key and vulnerable populations. Evaluation of the training outcomes, as well as the impact over time, can help to strengthen and improve judicial training programmes and support resource mobilisation for continued training.



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