HIV in Africa in the 21st Century
Brief for the Judiciary

This material has been prepared for the
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Note:

The present briefing note provides a synopsis of key HIV-related facts and issues, their relevance to sub-Saharan Africa, and some legal considerations arising from them.

Unless otherwise indicated, the information and data contained in the present briefing note are broadly excerpted from the following:

- UNAIDS *AIDS Epidemic Update* December 2009
- WHO, UNAIDS and UNICEF *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector* September 2009

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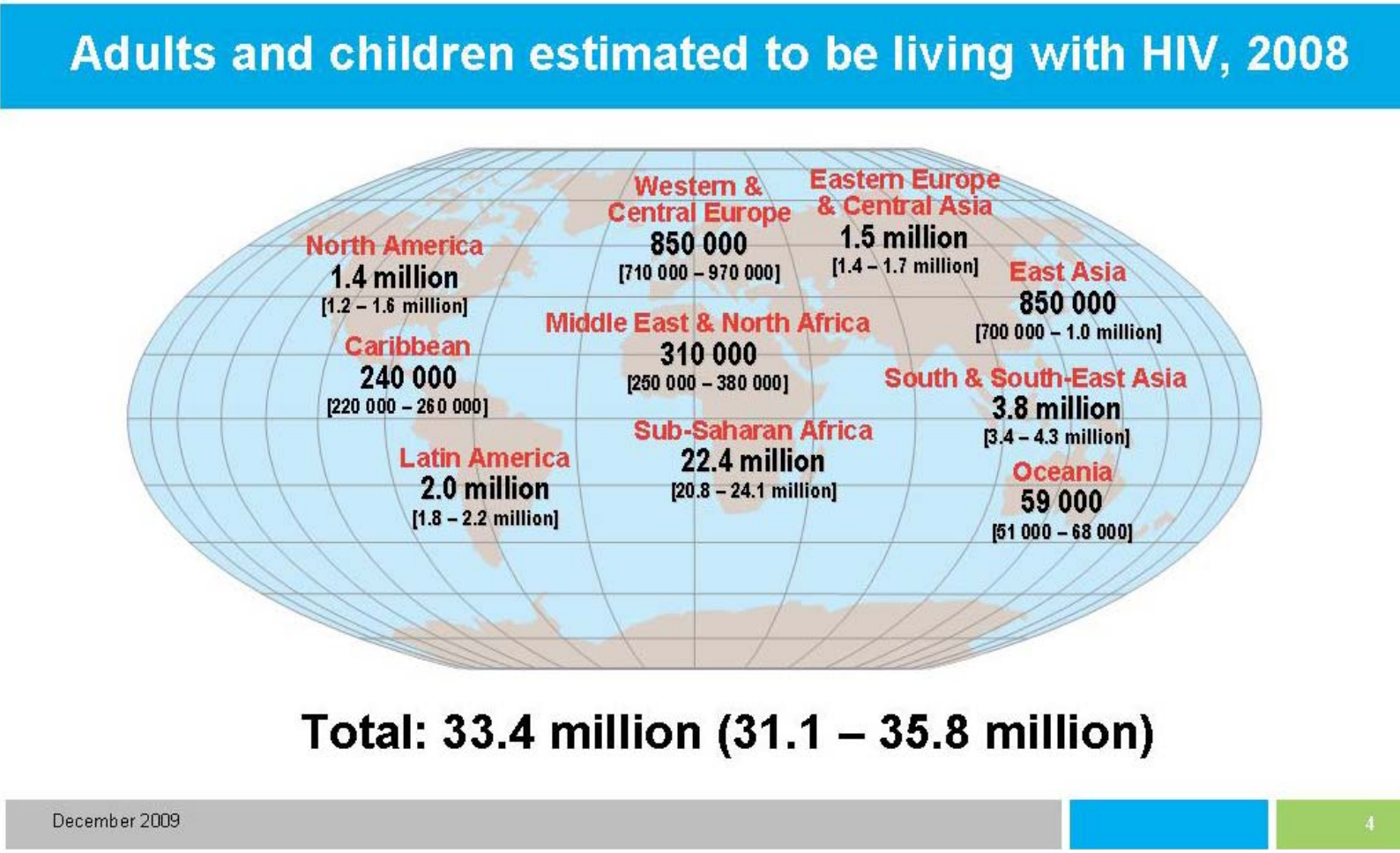


Source: UNAIDS, *2009 AIDS epidemic update*, November 2009

THE GLOBAL HIV EPIDEMIC

We, Heads of State and Government and representatives of States and Governments, [are] concerned that the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world. United Nations General Assembly, *Declaration of Commitment on HIV/AIDS,* 27 June 2001

FACTS

- The number of people living with HIV worldwide continued to grow in 2008, reaching an estimated 33.4 million.
- Of these, 15.7 million are women, and 2.1 million are children under 15.
- In 2008, 2.5 million people were newly infected with HIV.
- Of these, 2.3 million were adults and 430,000 were children under 15.
- In 2008, 2 million people died of AIDS-related disease.
- Of those who died, 1.7 million were adults and 280,000 were children under 15.
- Tuberculosis (TB) continues to be the leading cause of death among people living with HIV. About 456 000 people living with HIV died from TB in 2007, 23% of the estimated 2 million HIV-related deaths in that year. In 2007, only 16% of people with notified TB knew their HIV status.
- Since the beginning of the epidemic, some 25 million have died of AIDS.
- Sub-Saharan Africa remains the region most heavily affected by HIV.
- Data indicates that globally the spread of HIV peaked in 1996. In 2008, the number of new infections was some 30% lower than in 1996.
- The response to AIDS involves three major efforts to reach *all in need* (universal access) with:
  - Access to HIV prevention modalities and services
  - Access to HIV care and support, and
  - Access to HIV treatment.

GENERAL CONSIDERATIONS

- AIDS remains a major global health priority.
- There is great variation in epidemics between and within countries and regions.
- The nature, level and scope of HIV infection in a particular country lead to distinguishing between low, concentrated, generalised and hyper-endemic epidemics:
  - In low level epidemics: HIV prevalence is below 1% and HIV has not spread to significant levels within any subpopulation.
  - In concentrated epidemics: HIV prevalence is high enough in one or more sub-populations, such as men who have sex with men or people who use drugs to maintain the epidemic in that sub-population, but the virus is not circulating in the general population.
  - In generalised epidemics: HIV prevalence is between 1–15% in pregnant women attending antenatal clinics, indicating that HIV is present among the general population at sufficient levels to enable sexual networking to drive the epidemic.
  - In hyper-endemic settings: HIV prevalence exceeds 15% in the adult population; driven by extensive heterosexual multiple concurrent partnerships with low and inconsistent condom use.[1]

[1] The definitions above are broadly abstracted from UNAIDS *Practical guidelines on prevention: Towards Universal Access*, 2007, p 1. Available at http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf.

- There is evidence of successes in HIV prevention, but there is also increased evidence of HIV risk among key populations.
- Improved access to HIV treatment is having an impact.
- Over time, the political and financial commitment to respond to AIDS has grown enormously, but is still not enough.
- In 2009, UNAIDS endorsed a specific set of priorities necessary to achieve an effective HIV response. One of these is the "removal of punitive laws, policies, practices, stigma and discrimination that block effective response to AIDS".[2]

POSSIBLE LEGAL CONSIDERATIONS

- The need, to the degree possible, of the commitments of the Executive Branch of governments being supported by the other two branches, the Judiciary and Legislative.
- The need for legal support for evidence-informed and rights-based approaches to HIV that have proven to be effective.
- The opportunity for the law to have a major positive impact on access to HIV prevention, treatment, care and support through the creation of an enabling legal environment.

THE HIV EPIDEMIC IN SUB-SAHARAN AFRICA

We are ever mindful of the disproportionate share and severe impact of the HIV and AIDS burden borne by Africa, especially by women and girls, and the limitations in our ability to match this epidemic in either its scale or complexity. *Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010*, 8 March 2006

FACTS

- Sub-Saharan Africa remains the region most affected by HIV.
- In 2008, the region accounted for 67% of HIV infections worldwide, 68% of new HIV infections among adults, 91% of new infections among children, and 72% of the world's deaths due to AIDS.
- In sub-Saharan Africa as a whole, women account for approximately 60% of estimated HIV infections.
- In 2008, more than 14.1 million children in sub-Saharan Africa were estimated to have lost one or both parents to AIDS.
- Sub-Saharan Africa's HIV epidemics vary significantly in scale and nature among regions and countries as well as within countries with a mixture of low level, concentrated and generalised HIV epidemics.
- Several countries in West and Central Africa are experiencing low level epidemics. Most countries in East and Southern Africa are faced with generalised epidemics, with some 7 countries reporting hyper-endemic epidemics.

[2] UNAIDS *Joint Action for results: UNAIDS Outcome Framework 2009-2011*, July 2009. Available at http://data.unaids.org/pub/Report/2009/jc1713_joint_action_en.pdf.

CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- The HIV epidemic continues to have tremendous impact on households, communities, public services and national economies in sub-Saharan Africa.
- In several countries, especially in Southern Africa, HIV has severely reduced life expectancy.
- Heterosexual intercourse remains the primary mode of HIV transmission in Africa with significant transmission to newborns babies.
- However, recent studies reveal that injecting drug use and unprotected anal sex between men represent a more important factor in the epidemics in sub-Saharan Africa than generally thought.
- Several countries in the region are reporting decrease in HIV prevalence, which is sign of some successes in terms of prevention.
- The rapid scaling up of ART in recent years in sub-Saharan Africa is generating considerable public health gains. As of December 2008, ART coverage in the region was 44% of people in need in 2008 of treatment compared to only 2% five years earlier.

POSSIBLE LEGAL CONSIDERATIONS

- The need for the law to support national commitments to HIV prevention, treatment, care and support.
- The need for the law to protect access to HIV prevention and treatment for all groups.
- The need to address gender inequality and the low status of women as enforced in formal and customary law and in societal practices.
- The need to address the legal status of same sex relations, sex work and drug use and its impact on vulnerability and resilience to HIV and AIDS.
- The need for the law to promote access to age-appropriate and evidence-informed HIV-related information, prevention, treatment and care services for children and young people.

HIV TRANSMISSION

We, the Heads of State of Member States of the African Union [are] [a]ware that the overwhelming majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. Assembly of Heads of State and Government of the African Union, *Africa's Common Position to the High Level Meeting of the UN General Assembly Special Session on AIDS,* May 2006

FACTS

- HIV is *only* transmitted through the exchange of HIV infected blood or bodily fluids through: (1) unprotected sex (vaginal and anal); (2) the use of syringes, needles or other sharp instruments that are contaminated with HIV; (3) from HIV positive mother to child during pregnancy, childbirth or breast feeding; and (4) the transfusion of contaminated blood or blood products. All these modes of HIV transmission are preventable.
- The risk of HIV transmission through unprotected sex is extremely low with the per-act risk estimated to be 0.182%.[3]

[3] Marie-Claude Boily, Rebecca F Baggaley, Lei Wang, Benoit Masse, Richard G White, Richard J Hayes, Michel Alary (2009), "Heterosexual risk of HIV-1 infection per sexual act: systematic review and meta-analysis of observational studies", *Lancet Infectious Diseases* 9: 118–29.

- Women are biologically more susceptible to HIV infection than men. The risk of HIV infection for women and girls is increased in cases of rape and/or rough penetrative sex due to higher chances of tearing in the mucosal surface of their genital organs.
- HIV is *not* transmitted through day-to-day contact or insect bites, (e.g. shaking hands, preparing and serving food, hugging, sharing glasses and plates).
- Consistent and correct use of male and female condoms is highly effective in protecting against sexual transmitted infections including HIV.
- Post-exposure prophylaxis, or "PEP", is a course of antiretrovirals prescribed no later than 72 hours, ideally within 48 hours, to prevent infection from exposure to HIV that often occur through rape or needle-stick injuries.
- Without the provision of antiretroviral treatment (ART) to reduce mother to child transmission, the risk of HIV transmission from a mother to her child is between 15-35%. With the provision of ART to the mother and the infant, the risk of HIV transmission is reduced to 1-2%.
- Male circumcision reduces the likelihood HIV infection for men during unprotected vaginal sex.

GENERAL CONSIDERATIONS

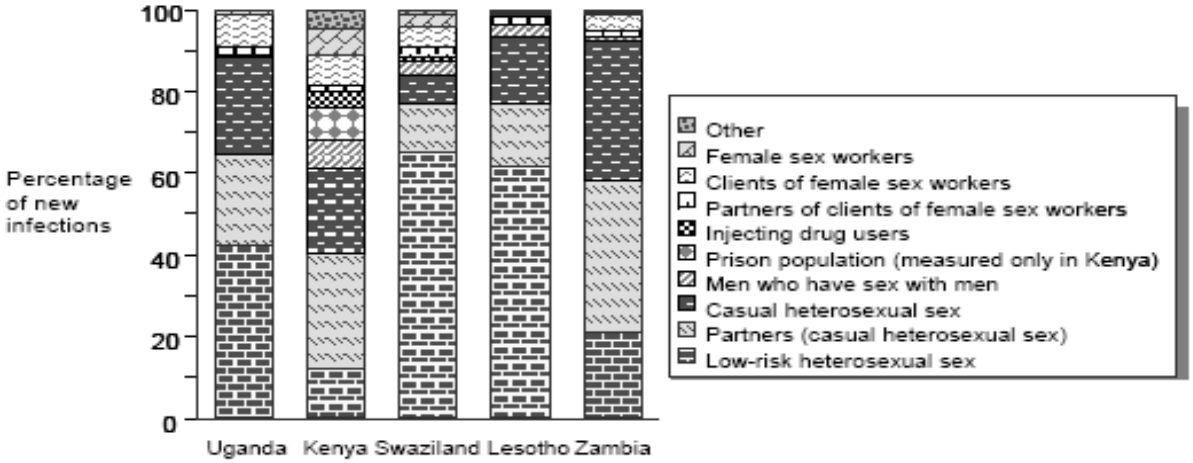
- A recent study found that under certain conditions people on ART cannot transmit HIV through unprotected sexual contact. These conditions are: (a) the person adheres to antiretroviral therapy, the effects of which must be evaluated regularly by the treating physician, (b) the viral load has been suppressed (< 40 copies/ml) for at least six months, and (c) there are no other sexually transmitted infections.[4]
- In settings with high HIV prevalence, important incidence of rape and sexual coercion, women and girls are more susceptible to HIV infection.

CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- In many countries of the region, rape and sexual coercion are endemic and contribute to high HIV prevalence among women and girls.
- Timely post exposure prophylaxis for survivors of rape is generally not available in sub-Saharan Africa.
- All 13 countries with the highest rates of heterosexual HIV transmission and low rates of male circumcision, in the region, have established policies and programmes to scale up male circumcision with the view of reduce the risk of heterosexual transmission of HIV in men.

[4] P Vernazza et al (2008), "Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle", *Bulletin des médecins suisses* 89:165-169. Available at http://www.saez.ch/pdf_f/2008/2008-05/2008-05-089.PDF

Figure V
Modes of transmission in people newly infected with HIV in various sub-Saharan countries



Source: Report of the Secretary-General, "Progress made in the implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS". UN Document A/63/812, May 2009

POSSIBLE LEGAL CONSIDERATIONS

- Need for great caution in invoking the criminal law in cases related to HIV exposure or transmission through unprotected sexual intercourse due to low risk of transmission per-act and to the low probability of HIV transmission by people on treatment.
- The law should help ensure, not hamper, access to prevention services and means for key populations including people who use drugs, men who have sex with men and sex workers.
- Need for strong legal protections against rape and sexual coercion, inside and outside, marriage.

EVIDENCE-INFORMED APPROACHES TO HIV

We, Heads of State and Government and representatives of States and Governments,[…] Pledge to provide the highest level of commitment to ensuring that costed, inclusive, sustainable, credible and evidence-based national HIV/AIDS plans are funded and implemented. United Nations General Assembly, *Political Declaration on HIV/AIDS*, 2 June 2006

FACTS

- Combination HIV prevention (a mix of biomedical, behavioural and structural interventions) reduces HIV transmission.[5]
- To be effective, HIV prevention should offer targeted individuals and populations with choices of prevention methods that they are willing and able to use.
- Reducing the number of sexual partners contributes to reducing the risk of HIV infection. However, it does not protect in case one (or more) of those partners is HIV positive.
- The effectiveness of proper and consistent use of condoms in protecting against HIV infection is well documented.
- Recent studies on the impact of ART on people living with HIV illustrate the effectiveness of ART in prolonging lives.
- Abstaining from sex prevents HIV transmission; however, studies of programmes that promote "abstinence *only*" as the means to prevent transmission have shown that these programmes are ineffective because people do not adhere to abstinence.

[5] For more information, see section on "HIV prevention".

- Recent studies indicate that being on treatment significantly reduces a person's infectiousness and therefore the risk of HIV transmission.
- Male circumcision reduces the risk of HIV transmission in men, during unprotected vaginal sex, by approximately 60 per cent.
- Evidence-informed approaches require that the needs in terms of HIV-related prevention and treatment of *all* people are addressed, including those criminalised or highly stigmatised, such as men who have sex with men, sex workers, people who use drugs and prisoners.

GENERAL CONSIDERATIONS

- Many approaches to HIV are based on ideology or ignorance and do not take into account evidence of what works.
- Many approaches to HIV are restricted to a small array of prevention services and do not address the whole spectrum of interventions that have proven effective.
- Many approaches to HIV do not address controversial issues and groups, including sexuality, gender inequality and people who are stigmatised, marginalised or criminalised.
- Counterfeit drugs and bogus cures are common and harm many people.
- "Know your epidemic and your response" is an evidence-informed approach in which countries orient their response to address the key drivers of the epidemic in their country, including behaviours and social conditions that impede access and use HIV information, services and treatment.
- A rights-based response, combined with an evidence-informed approach, is essential for an effective response to AIDS.[6]

CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- In the region, there have been some HIV responses which have been driven by ideology and/or restriction to a few HIV prevention methods.
- High levels of new infections have been reported among young people, particularly young women; among people in stable relations or with a single partner, including those in marriages; among older adults; and among men who have sex with men, sex workers and people who inject drugs in many sub-Saharan African countries.
- However, prevention strategies in many countries fail to address these populations, or the deep rooted cultural, social, economic and legal constructs that fuel the vulnerability of women and girls and marginalised populations.
- There is insufficient policing of counterfeit drugs and bogus cures, including among traditional healers.

POSSIBLE LEGAL CONSIDERATIONS

- Need to ensure that legislation, policy and court decisions are grounded in sound evidence about HIV and its modes of transmission.
- Irrelevance of restrictive measures, such as quarantine, isolation and other infringements to liberty and movement, because HIV is not a transmitted through non-sexual casual contacts.
- Use the law to support evidence-informed approaches that ensure access to scientifically-accepted treatment, the full range of HIV prevention modalities and non-discriminatory treatment for *all* those at risk.
- In assessing risk of HIV infection in criminal matters, need to take into account reduction in level of risk of transmission through use of condoms, other forms of safer sex (non-penetration) and being of ART treatment.

[6] For more information, see section on "Rights-based approaches".

RIGHTS-BASED APPROACHES TO HIV

We, Heads of State and Government and representatives of States and Governments,[…] recognis[e] that the full realisation of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic. United Nations General Assembly, *Declaration of Commitment on HIV/AIDS*, 27 June 2001

FACTS

- Most countries have ratified human rights treaties and/or have recognised human rights in national constitutions that are relevant to HIV.
- Virtually all countries have recognised the importance of protecting human rights in the context of the response to HIV.
- The constitutions and/or other laws of most countries contain provisions that recognise human rights or civil liberties that are necessary in the response to HIV.

GENERAL CONSIDERATIONS

- A rights-based approach to HIV is based on two recognitions: (a) such an approach is necessary to protect the rights of *all* citizens and (b) a rights-based approach is more effective than a punitive approach.
- A rights-based approach to HIV seeks to:
    - Create a protective environment where everyone in need (including the most vulnerable and marginalised) is willing and able to come forward to access and use HIV prevention, treatment, care and support
    - Reduce stigma and discrimination related to HIV
    - Hold Governments and other duty-bearers accountable
    - Enable those affected by HIV to participate in the response and have access to justice (be empowered to claim their relevant rights).
- Key programmatic components of a rights-based approach involve: "know your rights/laws" campaigns; sensitisation of service providers (e.g. health care workers, justice officials) in non-discrimination, informed consent and confidentiality; relevant law reform; programmes to empower women and prevent violence against them, and programmes to train police in non-discrimination, the prevention and prohibition of violence against women and key populations at risk.

CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- Many countries have laws in place which criminalise men who have sex with men, people who use drugs and sex workers, and which drive these populations underground and away from HIV services.
- Many countries in the region have begun to pass laws criminalising HIV transmission and failure to disclose status rather than create a legal environment which will encourage and protect people to seek HIV testing, disclose their status, use HIV prevention and receive treatment.
- Access to justice is low and can be improved through creating better access to both the courts and less formal administrative redress systems.
- Traditional and customary law are often more utilised than formal justice systems, leading to the need for much greater sensitisation and interaction between traditional leaders and jurists.

POSSIBLE LEGAL CONSIDERATIONS

- Using the law to create an environment that will enable people to come forward for HIV services without fear of legal or social repercussions.
- Using the law to protect people from discrimination, gender inequality, gender-based violence, unauthorised disclosure of status, property-grabbing.
- Using the law to hold governments to account for human rights obligations regarding HIV prevention, treatment, and non-discrimination.

UNVERSAL ACCESS TO HIV PREVENTION, TREATMENT, CARE AND SUPPORT

We, Heads of State and Government and representatives of States and Governments ...[c]ommit ourselves… to achieve ...with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, ... the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010. United Nations General Assembly, Political Declaration on HIV/AIDS, 2 June 2006

FACTS

- In the *Political Declaration on HIV/AIDS* (2006), Governments committed to achieve universal access to HIV prevention, treatment, care and support by 2010.
- This goal is considered a necessary step toward achieving the Millennium Development Goals (MDG) in 2015, including the MDG 6 target – to halt and reverse the HIV epidemic.
- To reach this goal, governments in most countries have set targets based on their national epidemics.
- Though much has been achieved towards this goal, efforts remains to be done.
- By end 2008, 4 million people were receiving antiretroviral therapy in low- and middle-income countries, 1 million more than the previous year. However, more than 5 million people in need of antiretroviral therapy still did not have access to it.
- In 2008, 21% of pregnant women received an HIV test, up from 15% in 2007.
- Almost half of all pregnant women living with HIV in low- and middle-income countries received antiretrovirals to prevent vertical transmission ("mother-to-child transmission").
- Knowledge about the modes of HIV transmission ranges from universal in some countries to as low as 10% among women in other countries.
- Between 2000-2007 there was a trend towards safer sex among both young men and women.
- Though in some places, condom use has risen, overall it remains low in many parts of the region.
- Medical male circumcision is being expanded but needs to be accelerated.
- Countries report having laws that constitute barriers to access to HIV-related services for vulnerable populations.[7]

[7] UNGASS Reports 2008. Available at http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgressAllCountries.asp.

GENERAL CONSIDERATIONS

- There are many obstacles to achieving universal access, including insufficient funds from national and international sources, poor financing systems, weak procurement systems and supply chains, weak health care systems, weak education systems, weak civil society and lack of nutrition to support adherence to treatment.
- Stigma, discrimination, gender inequality and marginalization of key populations at risk have been and continue to be major obstacles to achieving universal access.
- The failure to adapt the response to the needs of those highly vulnerable to HIV and its impact, including women, young people, men who have sex with men, people who use drugs, sex workers and their clients, negatively affects access to HIV services.

CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- In sub-Saharan Africa, antiretroviral therapy coverage was 44% in 2008 compared with 33% in 2007.
- Differences in coverage among sub-regions are increasing: 48% of those in need had access to antiretroviral therapy in Eastern and Southern Africa versus 30% in Western and Central Africa.
- In 2007, about 79% of the estimated total people living with HIV and TB were in this region, of whom about one quarter were living in South Africa.

POSSIBLE LEGAL CONSIDERATIONS

- Need to continue judicial interpretations of constitutional provisions and national legislation in the context of health to protect access to HIV prevention and treatment.[8]
- Need to reduce discrimination and increase redress for it.
- Need to review and reform laws that may constitute obstacles to HIV prevention, treatment, care and support, including those that maintain gender inequality, criminalise key populations, involve mandatory disclosure of HIV status and overly broad criminalisation of HIV.

[8] UNAIDS and Canadian HIV/AIDS Legal Network (2006), *Courting Rights: Case studies in litigating the human rights of people living with HIV.* Available at http://data.unaids.org/Publications/IRC-pub07/JC1189-CourtingRights_en.pdf.

HIV-RELATED STIGMA AND DISCRIMINATION

We the Heads of State and Government of the African Union [are] [a]ware that stigma and discrimination negate the human rights of people infected and affected by HIV/AIDS, and still constitute a major barrier to an effective response to the HIV/AIDS pandemic. Assembly of Heads of State and Government of the African Union, *Africa's Common Position to the High Level Meeting of the UN General Assembly Special Session on AIDS,* May 2006

FACTS

- HIV-related stigma is based on fear, lack of sufficient knowledge about HIV, and/or on moralising attitudes which associate people living with HIV with "improper" behaviour.
- HIV-related stigma—whether measured by stigmatising attitudes, fear or enacted stigma — is pervasive and negatively impacts the quality of life of people living with HIV.
- Stigma and discrimination may be against people living with HIV and their family members or associates or it may be against most at risk groups: sex workers, people who use drugs and men who have sex with men.
- Research shows that stigma and discrimination impede uptake of HIV testing, treatment and care and adherence to treatment.
- In recent years, progress has been made in measuring stigma, but it has been hard to compare data across different settings.
- There are effective programmes to reduce stigma and discrimination, but they are seldom significantly funded or taken to the scale needed to make a difference.
- Effective programmes use approaches which involve the media, stigma reduction work in communities, strengthening networks of people living with HIV to take the lead in addressing stigma, training of health care professionals, and the use of government leaders and celebrities talking against stigma.

GENERAL CONSIDERATIONS

- Governments and many others have long recognised the fact that high levels of stigma and discrimination make effective responses to HIV hard to achieve.
- In 2005-2006, country and regional consultations on universal access to HIV prevention, treatment, care and support showed that stigma and discrimination against people living with HIV were major barriers to universal access and undermined national responses to HIV.

CONSIDERATIONS FOR SUB-SAHARAN AFRICA:

- Stigma and discrimination against people living with HIV and against populations at risk (men who have sex with men, sex workers and people who use drugs) is very high in the region.
- Stigma and discrimination do not necessarily decrease even in contexts of high HIV prevalence, high rates of HIV testing and high rates of treatment. However, increased access to treatment may have led to slight reduction of stigma in some places.

POSSIBLE LEGAL CONSIDERATIONS

- Need to ensure non-discrimination against people living with HIV and those most at risk of infection.
- Need to protect against unethical disclosure of HIV status.
- Consider the leadership role of the judiciary as champions against any form of discrimination, including that related to HIV.

HIV PREVENTION

We, Heads of State and Government and representatives of States and Governments,[…] acknowledg[e] that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic. United Nations General Assembly, *Declaration of Commitment on HIV/AIDS*, 27 June 2001

FACTS

- HIV prevention can work, and is working in some places.
- The annual number of new infections globally has declined.
- HIV infections among young people have fallen in many countries.
- The drop in new infections among children suggests that efforts to prevent mother to child transmission are yielding results. However, in 2008, only 45% of pregnant women living with HIV in low and middle-income countries received ART to prevent mother-to-child transmission.
- There are still major gaps in prevention coverage for many populations.
- For every 2 people put on treatment, 5 people become infected.

GENERAL CONSIDERATIONS

- HIV prevention is not easy and must be tailored to the needs of specific age groups and populations.
- UNAIDS promotes *combination prevention* which is the right blend of biomedical, behavioural and structural interventions:
  - Biomedical interventions include provision of ART to pregnant women, treatment for sexually transmitted infections, male circumcision, provision of post-exposure prophylaxis; and opioid substitution treatment for drug-dependence.
  - Behavioural interventions include access to HIV information; voluntary testing and counselling either initiated by the clients or by the provider; age-appropriate sexuality and life-skills education; safer sex through abstinence, use of condoms, fidelity, reduction in partners; and use of safe drug-injecting equipment.
  - Structural interventions include changing harmful gender norms; reducing violence against women; reducing stigma and discrimination; removing punitive laws, policies and practices; protecting the human rights of those vulnerable to infection and living with HIV.

CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- Proportions of new infections among people in stable partnerships, including marriage, are often high.
- Women and girls account for more than half of infections.
- There is a high level of HIV prevalence among couples where one person is living with HIV and the other is not (“serodiscordant” couples).
- Medical male circumcision is being expanded but needs this needs to accelerate.
- Though experiencing high HIV prevalence, sex workers, men who have sex with men and people who inject drugs, have limited access to services due to their criminalised and/or stigmatised status.

POSSIBLE LEGAL CONSIDERATIONS

- States' duties to ensure access to combination HIV prevention, including HIV information; sexuality and life-skills education for young people; access to male circumcision, treatment for sexually transmitted infections, condoms and prevention of mother to child transmission.
- Importance of leadership and law to reduce stigma and discrimination.
- Importance of leadership and law to reduce violence against women and girls (including in schools and in marriage) and harmful traditional practices and gender norms.

HIV PREVENTION FOR WOMEN

We, Heads of State and Government and representatives of States and Governments, […] Pledge to eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection.
United Nations General Assembly, *Political Declaration on HIV/AIDS*, 2 June 2006

FACTS

- Globally, AIDS is the leading cause of death among women of reproductive age.[9]
- Women have greater biological vulnerability to HIV and are significantly more likely than men to contract HIV infection during vaginal intercourse.
- Although many young girls have heard about HIV, only 38% were able to describe correctly the main ways to avoid HIV infection.
- Women are often afraid to test for HIV, to disclose their status or to take up treatment for themselves or to prevent transmission to their unborn child due to fear of negative consequences (e.g. violence, abandonment, discrimination, loss of property and custody of children).
- Women who are sex workers are significantly more likely to be infected with HIV.
- Women and girls face sexual violence and coercion (including in schools) that can increase their risk of infection.

[9] WHO (2009), *Women & health: today's evidence tomorrow's agenda.* Available at http://www.who.int/gender/documents/9789241563857/en/index.html.

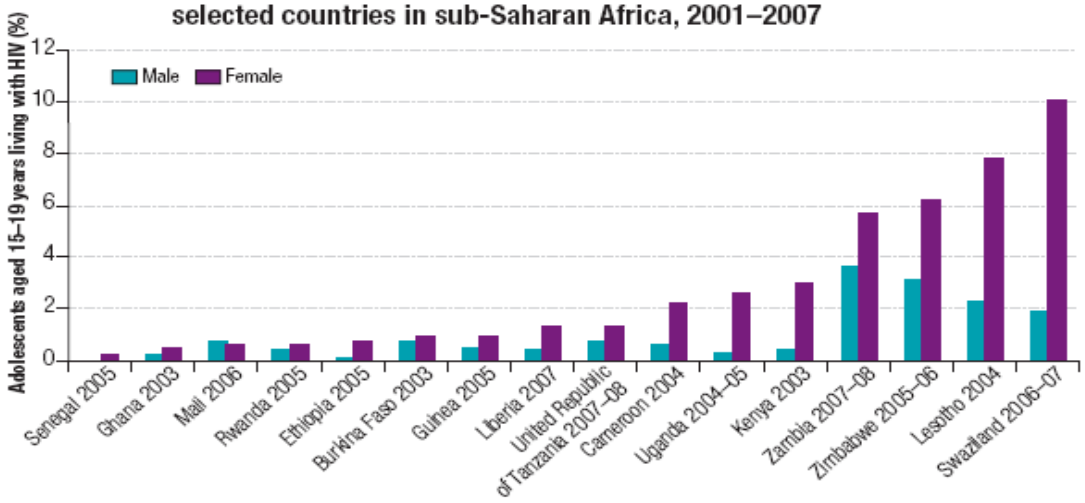
GENERAL CONSIDERATIONS

- To be effective, HIV prevention services and modalities should be tailored to the realities and conditions of the lives of women and young girls.
- HIV prevention services should be integrated into primary health care, family planning, and antenatal and child health services so as to better reach women and girls.
- HIV prevention services for women should be accompanied by equal efforts to reduce violence against women, eliminate rape inside and outside marriage, and protect women living with HIV from abandonment and destitution.
- Female adolescents should have independent access and use health services, particularly for sexual, reproductive and mental health care.

CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- In sub-Saharan Africa, 76 per cent of the young people (aged 15-24 years) living with HIV are female.
- In the 9 most affected countries, HIV prevalence among young women was on average 3 times higher than among young men of the same age.
- Young women tend to have sex with older men who are more sexually experienced and more likely to be infected with HIV and the social prevalence of intergenerational partnerships may play an important role in the disproportionate risk of young women.

Figure 3 **HIV prevalence among adolescents aged 15–19 years, by sex, selected countries in sub-Saharan Africa, 2001–2007**



Source: Demographic and Health Surveys in 16 countries, sub-Saharan Africa, 2001–2007.

POSSIBLE LEGAL CONSIDERATIONS

- Important judicial opportunity to protect women and girls from exploitation and abuse, including early and/or forced marriage, intimate partner violence and sexual violence; and to enforce gender equality through the law in public and private spheres.
- Need to reform laws which restrict the independent access of women and girls to sexual and reproductive health services.

HIV PREVENTION FOR YOUNG PEOPLE

We must recognise not only the vulnerability of young people to HIV infection, but that they provide a window of opportunity to eventually break the chain of transmission. We must therefore encourage and develop strong prevention strategies and interventions (for) young people. Assembly of Heads of State and Government of the OAU, *Tunis Declaration on AIDS and the Child in Africa*, adopted in June 1994, AHG/Decl. 1 (XXX) 1994

FACTS[10]

- Young people remain at the centre of the HIV epidemic in terms of rates of infection, vulnerability, impact, and potential for change.
- Of 1.7 billion young people worldwide, 5.4 million are estimated to be living with HIV (2007).
- About 40 per cent of new HIV infections are among young people.
- Young people are particularly vulnerable to HIV infection for social, political, cultural, biological, and economic reasons.
- HIV prevention generally fails to address the diversity of experiences and needs of young people.
- Moral, religious, legal and other barriers impede access to evidence-informed and age appropriate information, commodities and services for HIV prevention among young people.

GENERAL CONSIDERATIONS

- HIV interventions should be tailored to meet the individual characteristics and circumstances of young people, such as age, sex, religion, socioeconomic and marital status and domestic arrangements, among other factors.
- Biological factors, entrenched social constructs, gender inequalities and economic conditions contribute to the increased vulnerability of young girls to HIV.
- Expanding rights-based policies and programmes that promote healthy adolescents development and provide them with age-appropriate knowledge and tools to make informed choices and protect themselves against HIV is key to an effective response to HIV among young people.

CONSIDERATION FOR SUB-SAHARAN AFRICA

- The level of information and knowledge of HIV generally are low among young people and lower among young girls.
- The majority of young people living with HIV in sub-Saharan Africa have been infected through unprotected sexual intercourse.
- Young girls represent three quarters of young people living with HIV in sub-Saharan Africa.
- In several countries, early sexual debut may contribute to higher risk as it is associated with low use of condoms.
- Legal, policy and other barriers to HIV-related prevention services for young people have been reported in several sub-Saharan African countries.

[10] The facts summarised below are extracted from UNFPA 'Young People: The Greatest Hope for Turning the Tide'. Available at http://www.unfpa.org/hiv/people.htm.

POSSIBLE LEGAL CONSIDERATIONS

- Importance of ensuring that the legal age to make independent decisions about health care and treatment, including HIV testing, correspond with median age of sexual debut as determined through accurate scientific means.
- The need to ensure access to age-appropriate sexual education, HIV information and life-skills training in schools and outside schools.
- The need to enforce legal provisions related to the prosecution of defilement in order to discourage intergenerational sex involving minors.

POPULATIONS MOST AT RISK OF HIV INFECTION

We, Heads of State and Government and representatives of States and Governments, … commit ourselves to intensifying efforts …to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups. United Nations General Assembly, *Political Declaration on HIV/AIDS*, 2 June 2006

FACTS

- In all types of epidemics - generalized, concentrated and low level - there are key populations who are most at risk of HIV infection.
- These generally comprise sex workers, people who use drugs and men who have sex with men.
- In the absence of access to comprehensive HIV prevention, these populations are at high risk of acquiring HIV.
- Depending on conditions in prisons, prisoners can also be at high risk of HIV infection.
- Although some evidence indicates that access to HIV interventions is expanding in many settings, populations at high risk of HIV infection continue to face technical, legal and socio-cultural barriers in accessing health care services.

GENERAL CONSIDERATIONS

- These populations generally have very low access to HIV prevention, treatment care and support for two reasons: (a) governments do not expend resources or efforts sufficient to cover the needs of these populations and (b) these populations are often criminalised and/or highly stigmatised.
- Sex workers are not only a priority population for HIV prevention programmes in their own right, but also their clients are a potential bridge to other populations. This can be true of men who have sex with men who often also have sex with women, sometimes as a cover in places where they are highly stigmatised or criminalised. It is also the case that people who inject drugs have spouses or sexual partners as well as children – all of whom may be vulnerable to HIV.

CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- In the region as a whole, there was a median reported HIV prevalence among sex workers of 19%, ranging from a low of zero to a high of 49%.
- In recent years, an increase in research in the region has found that men who have sex with men are an important, previously undocumented component of many national epidemics.
- More than 30 countries in the region have laws prohibiting same-sex activity between consenting adults.
- An estimated 221,000 people who inject drugs are HIV-positive, representing 12:4% of all people who inject drugs in the region.

- The lack of reliable data on the size of national populations of people who inject drugs inhibits the development of sound prevention strategies.

POSSIBLE LEGAL CONSIDERATIONS

- Consideration of decriminalizing homosexuality, drug users and sex workers (not applying criminal sanctions).
- Legalising needle-exchange programmes, as well as opioid substitution therapy for those dependent on drugs.
- Reform of prison conditions to ensure access to HIV prevention, treatment, care and support in prisons.
- Reform of criminal justice to prevent extended and overcrowded pre-trial detention and replace incarceration with alternative sentences for non-violent offenders.

HIV TESTING AND COUNSELLING

We recommend that the following actions to overcome the identified obstacles to universal access be undertaken in an urgent and exceptional manner, ... expand opportunities for counselling and testing and access to ARVs, while preserving confidentiality. *Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS prevention, treatment, care and support in Africa by 2010*, 8 March 2006

FACTS

- HIV testing and counselling are gateways to HIV prevention, treatment, care and support.
- In 2008, ninety percent of low- and middle-income countries reported that they have national HIV testing and counselling policies, up from 70% in 2007.
- However, more than 80% of people living with HIV still do not know their status.
- Fear of stigma and discrimination remains one of the biggest obstacles to people coming forward for HIV testing and counselling.
- Anecdotal evidence indicates that fear of being prosecuted for HIV transmission where this is the law is a barrier to coming forward for testing and counselling.
- Low uptake of HIV testing and counselling is one of the reasons for delayed access to antiretroviral therapy for people in need and is responsible for high mortality.
- Recent data suggests that inadequate testing rates contribute to unknowing HIV transmission, especially within serodiscordant couples.
- Knowledge of HIV status has been associated with lower risk taking.

GENERAL CONSIDERATIONS

- All HIV testing should be done under the conditions of the three Cs: informed consent, confidentiality and counselling.
- Increasing access to HIV testing and counselling requires addressing barriers such as the limited availability of services and testing commodities, social and gender constructs, stigma and discrimination, and legal obstacles.
- While expanding HIV testing is important, testing should not be considered an end in itself. In order to have a positive impact on individual health and on national responses to HIV, HIV testing should be conducted with necessary counselling, and should be linked to referral services to HIV prevention and treatment, care and support services for those who need it.

CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- Stigma and discrimination remain major obstacles to testing and counselling in the region.
- The legal and policy environment in several countries of the region continues to preclude access to HIV-related testing and counselling for adolescents.
- Low levels of knowledge of HIV status have prompted many countries to adopt more assertive strategies for HIV testing and counselling including provider initiated testing and counselling, community-based testing and mass testing campaigns.

POSSIBLE LEGAL CONSIDERATIONS

- The need to determine an age of consent to independent HIV testing and counselling for adolescents based on evidence about the median age of sexual relations, the evolving capacity and best interests of the adolescent.
- The need to protect confidentiality and informed consent in relation to testing and counselling and authorise disclosure only in cases where the individual has been counselled to disclose, is posing an imminent and real threat to a sexual partner, refuses to disclose and support will be available if negative consequences result from disclosure.[11]
- The need to understand and address the legal and human rights implications of expanded testing (including mass testing, community-based testing, home-based testing, etc).

HIV-RELATED TREATMENT

States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS ... treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics, and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions. UNAIDS & OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, Consolidated version, 2006

FACTS

- At the end of 2008, more than 4 million adults and children were receiving antiretroviral therapy in low- and middle-income countries - a 36% increase in one year and a 10-fold increase in 5 years.
- Increased access to ART has resulted in sharp declines of AIDS-related deaths in high income countries and in comparable improvements in longevity among people living with in low and middle income countries.
- Despite progress, antiretroviral therapy coverage in low- and middle-income countries stood at 42% of the 9.5 million people in need at the end of 2008.
- Access to prophylaxis and treatment for opportunistic infections in low and middle income countries remains insufficient.
- Antiretroviral therapy coverage among people living with HIV/TB remains low.
- The availability of generic medicines dramatically reduced the cost of first-line antiretroviral drugs from US $10 000 per patient annually in 2000 to less than US $90 per patient in 2007.[12]
- However, emerging drug resistance led to the introduction of more expensive second line antiretroviral drugs[13] which by mid 2007, cost least developed countries, on average more than nine times the price of first line therapies.
- The cost of antiretroviral therapy, particularly the high price of several drugs under patent, remains a major barrier to access to treatment.

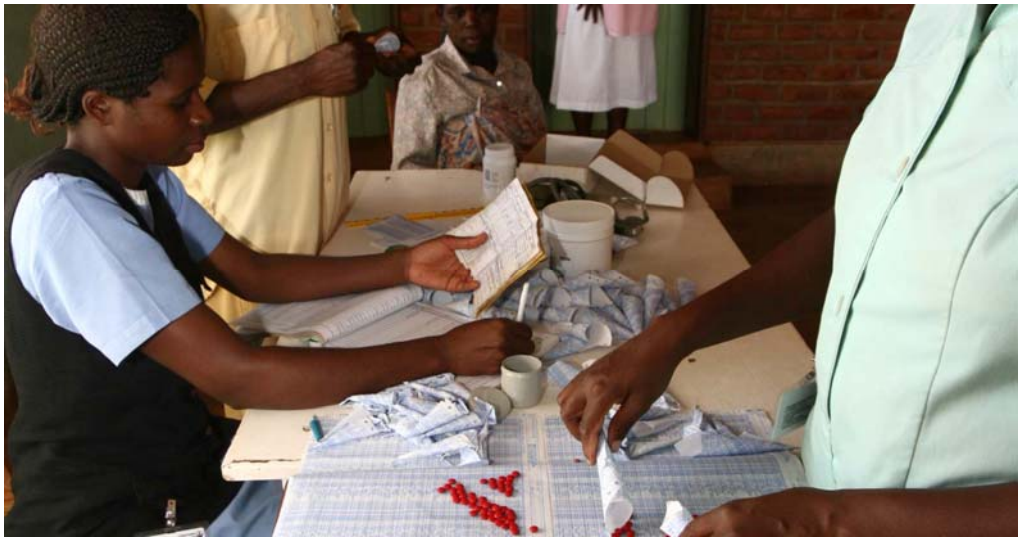
[11] OHCHR/UNAIDS, *International Guidelines on HIV/AIDS and Human Rights (Consolidated Version) 2006.*

[12] Refer to the WHO global Price Reporting Mechanism report of October 2007 at http://www.who.int/hiv/amds/GPRMsummaryReportOct07.pdf.

[13] In addition, new and improved first line regimes that are more durable, efficacious and tolerable cost up to three times more than older first line therapies.

GENERAL CONSIDERATIONS

- Expanding access to treatment requires that specific attention be paid to the needs and challenges related to access to services among particular populations (e.g. children, men who have sex with men, sex workers and people who use drugs).
- The proposed revision of WHO's ART treatment guidelines to raise the CD4 count threshold - for initiation of ART - to 350 cells/mm3 is likely to translate into early initiation of treatment and increased life expectancy but may augment pressure on already weak and overburdened health care systems in low and middle income countries.



CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- The greatest increase in the number of people receiving treatment in 2008 was in sub-Saharan Africa, where about 2.9 million people were receiving antiretroviral therapy at the end of 2008 in this region versus 2.1 people in 2007.
- Access to HIV-related treatment for key populations such as men who have sex with men, drug users, sex workers and prisoners remains limited.
- While some countries have reported stabilising retention of patients in ART programmes, late diagnostic and late initiation of treatment continue to adversely affect survival of patients on ART.
- Stock out of HIV-related drugs and laboratory commodities, weak health systems, and shortage of health care workers, are among, key challenges to access to treatment in sub-Saharan Africa
- High levels of stigma and discrimination are considered to negatively impact on early diagnostic of HIV leading to late initiation of ART and poor drug adherence.
- Access to treatment for opportunistic infections including TB and prophylaxis to prevent them, such as Cotrimoxazole, are scantly available.
- Large numbers of people drop off of treatment because they do not have sufficient food to support treatment or money for regular visits to treatment centres.
- In most of sub-Saharan Africa, patent laws remains inappropriate to take full advantage of the flexibilities under the current international patent regime as examples of such use remain exceptional.

POSSIBLE LEGAL CONSIDERATIONS

- Recognising access to treatment as a legal entitlement, including for people in detention.
- Full exploitation of intellectual property laws for the production and import of HIV-drugs.
- Judicious use of laws against fake medicines to protect the public while not unduly hindering access to legitimate HIV drugs.
- Using the law to overcome barriers posed by tariffs and trade regulations.

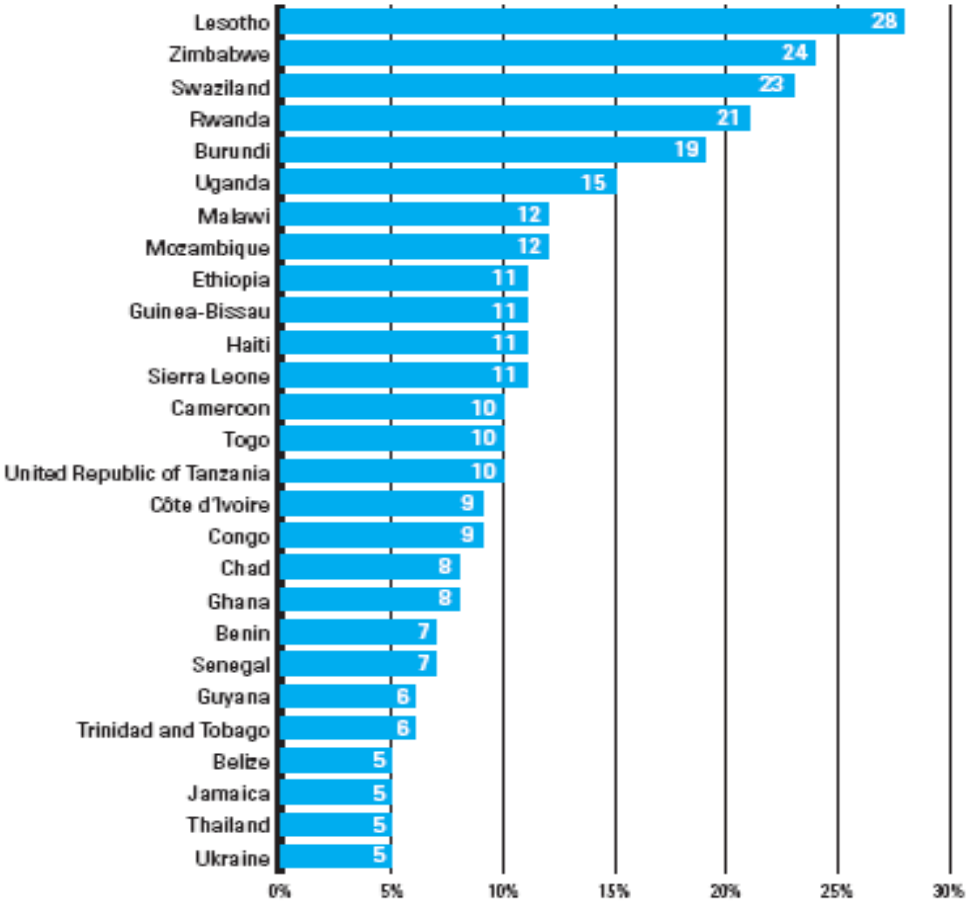
HIV CARE AND SUPPORT TO ORPHANS

We note that [...] [a]s a consequence of less-than-aggressive preventive efforts in the past, millions of children will die from AIDS or be orphaned over the coming decade and will require care and supportive efforts. Assembly of Heads of State and Government of the OAU, *Tunis Declaration on AIDS and the Child in Africa*, adopted in June 1994, AHG/Decl. 1 (XXX) 1994

FACTS

- More than 15 million children under 18 have lost one or both parents to AIDS, including nearly 12 million children in sub-Saharan Africa.
- The results of a recent study in Uganda show that among uninfected children under age 10, there was an 81 per cent reduction in mortality and a 93 per cent reduction in orphanhood if their HIV-infected parents were receiving antiretroviral therapy and Cotrimoxazole prophylaxis, compared with children whose parents received no intervention.[14]

Figure 9. Percentage of children under 18 who have lost one or both parents, in countries with HIV prevalence greater than 1 per cent, 2003–2007



Source: UNICEF, *Progress Report for Children Affected by HIV and AIDS*, draft dated June 2008.

GI

[14] Jonathan Mermin et al. (2008), "Mortality in HIV-Infected Ugandan Adults Receiving Antiretroviral Treatment and Survival of their HIV-uninfected Children: A prospective cohort study", *Lancet* 371(9614): 752–759.

- Most pregnant women living with HIV do not have access to antiretroviral therapy: for their own health, to further reduce the likelihood of HIV transmission and to prevent orphaning.[15]
- The HIV epidemic impacts not only children who have been orphaned by AIDS but also children living in households that are burdened by additional foster care, or living with adults who are chronically ill or disabled.
- The health of children affected by AIDS is threatened, as well as opportunities for education and development more broadly.
- Children affected by AIDS experience significant levels of stigma and discrimination, including deprivation of inheritance and educational opportunities.

CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- There are insufficient resources for implementing national plans of action to support orphans.
- In 18 countries where household surveys were conducted between 2005 and 2007 (14 of which were in Sub-Saharan Africa), 12 per cent of orphans and vulnerable children received basic external support with a range between 1 per cent in Sierra Leone and 41 per cent in Swaziland. Such support included education assistance, medical care, clothing, financial support and psychosocial services.[16]

[15] UNICEF (2008), *Children and AIDS: Third Stocktaking Report, 2008*. Available at http://www.unicef.org/publications/files/CATSR_EN_11202008.pdf.

[16] UNAIDS, Regional Support Team for Eastern and Southern Africa, 'Universal Access'. Available at http://www.unaidsrstesa.org/progress-universal-access.

POSSIBLE LEGAL CONSIDERATIONS

- Need to adopt and enforce laws prohibiting property grabbing and safeguard of inheritance rights for children, including girls, as well as laws that provide social security to care-givers and families affected by AIDS.
- Need to protect access to HIV related treatment and care for children through the law and the court.
- Need to adopt and enforce rights-based alternative care laws including adoption for orphaned children
- Need to protect children affected by AIDS from violence, discrimination and sexual exploitation
- Need to protect children in child-headed households.

CRIMINALISATION OF HIV TRANSMISSION[17]

HIV prevention and care programmes with coercive or punitive features result in reduced participation and increased alienation of those at risk of infection. UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, Consolidated Version, 2006

FACTS

- At least 49 countries have *HIV-specific* laws criminalising the transmission of HIV as well as the failure to disclose one's HIV positive status.
- In addition to the overly-broad criminalisation of HIV transmission, there are increasing concern about the criminalisation of key behaviours (e.g. sex work, same sex, drug use) and the impact such criminalisation has on national responses to HIV and efforts to reach universal access.
- A recent study found that under certain conditions people on ART cannot transmit HIV through sexual contact.[18]

GENERAL CONSIDERATIONS

- There are no data indicating that the broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission.
- There are major issues of proof, foresee ability and culpability in most cases involving HIV transmission.
- The criminal law is a blunt tool for achieving deterrence of HIV transmission and may do more harm than good.
- Applicability of the criminal law to transmission is problematic as most transmission occurs when someone is first infected, is therefore most infectious and least likely to know his or her status.
- It is feared that the overly-broad criminalisation of non-disclosure and of HIV transmission or exposure may lead to:
  - Disincentives to taken up HIV testing, prevention, and treatment
  - A reduction in adherence to the principle of shared and joint responsibility to avoid transmission
  - Risk of selective enforcement of the laws, including against women and key populations.
  - Reinforcement of stigma and discrimination against people living with HIV and vulnerable groups, and
  - Potential human rights violations.

[17] The information in this section are adapted from UNAIDS & UNDP *Criminalisation of HIV transmission: Policy brief*, 2008. Available at http://data.unaids.org/pub/BaseDocument/2008/20080731_jc1513_policy_criminalization_en.pdf.

[18] For more information, see section on "HIV transmission".

CONSIDERATIONS FOR SUB-SAHARAN AFRICA

- As of December 2008, at least 18 countries in sub-Saharan Africa had adopted HIV specific laws that criminalise HIV transmission or exposure.
- Many HIV-specific laws adopted to criminalise HIV transmission in sub-Saharan Africa are overbroad in that they are poorly worded, standards of culpability are not clear, they could be to acts that pose no/or little risk of HIV transmission and to cases of mother to child transmission.
- There are increasing reports of harassment of, and criminal measures targeting, key populations in sub-Saharan Africa, including men who have sex with men and sex workers.

POSSIBLE LEGAL CONSIDERATIONS

- Providing protection against HIV transmission by using the law to address determinants of HIV vulnerability, such as rape, sexual violence and gender-based violence.
- Restricting the use of the criminal law to clearly culpable cases, i.e. the intentional transmission of HIV.
- Using general criminal provisions not HIV specific laws.
- Not applying criminal penalties to cases where there is no significant risk of transmission or where the person:
  - did not know that s/he was HIV positive
  - did not understand how HIV is transmitted;
  - disclosed his or her HIV-positive status to person at risk
  - did not disclose his or her HIV-positive status because of fear of violence or other serious consequences
  - took reasonable measures to reduce risk of transmission, such as practicing safer sex through using a condom or other precautions to avoid higher risk acts; or
  - previously agreed on a level of mutually acceptable risk with the other person.

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