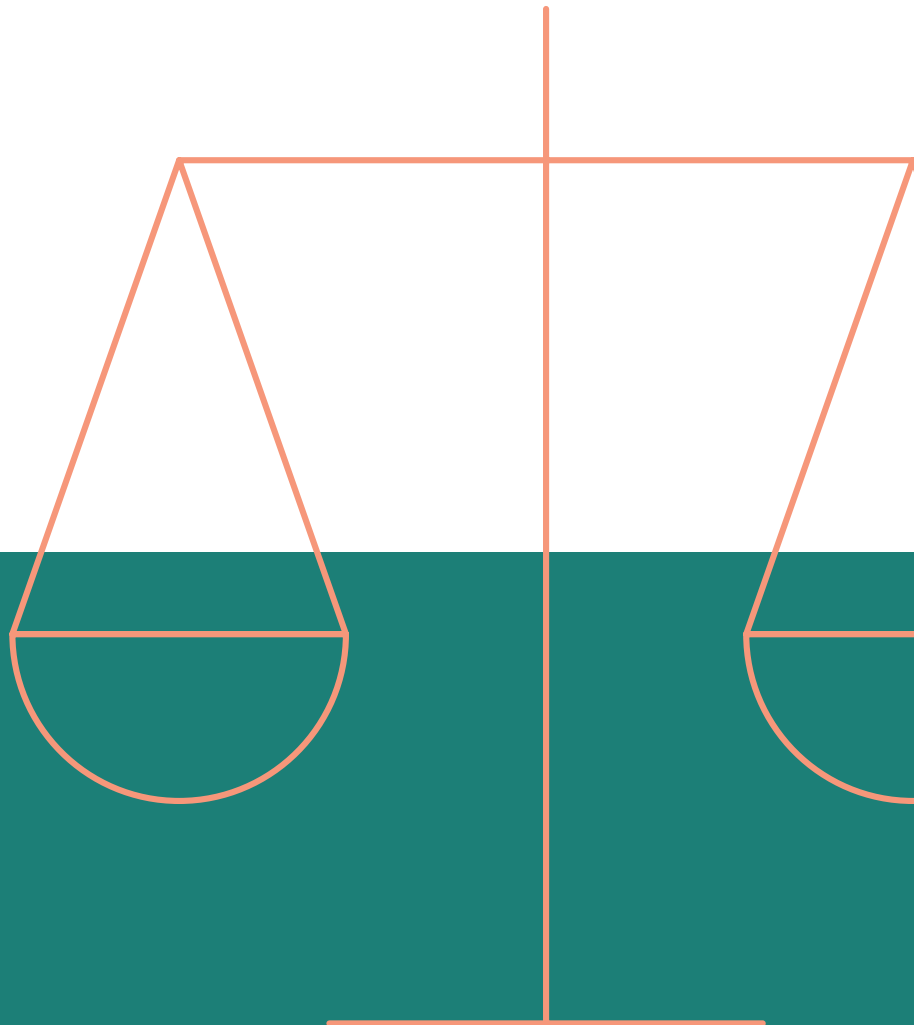




Angola

Legal Environment Assessment
for HIV and the Right to Sexual
and Reproductive Health



Linking Policy to Programming (LPP) is a regional project seeking to improve sexual and reproductive health outcomes for young key populations in five Southern African Development Community countries – Angola, Madagascar, Mozambique, Zambia, Zimbabwe. The project aims to accomplish this through strengthening the HIV and sexual and reproductive health related rights of young key populations in law, policy and strategy. UNDP implements the project, in partnership with the African Men for Sexual Health and Rights (AMSHeR), and the Health Economics and HIV/AIDS Research Division (HEARD) of the University of KwaZulu-Natal. Funding is provided by a five-year grant (2016 to 2020) from the Netherlands Ministry of Foreign Affairs through its Leave No One Behind initiative. For more information, visit: <http://www.africa.undp.org/content/rba/en/home/about-us/projects/linking-policy-to-programming.html>

Proposed citation:

UNDP, November (2020). Angola: Legal Environment Assessment for HIV, and the Right to Sexual and Reproductive Health Rights.

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Foreword

In 2016, Angola endorsed the United Nations Political Declaration “Ending AIDS by 2030”. Angola is one of the countries with the lowest prevalence rate in the southern African region, estimated at 2.1% in adults aged 15 to 49 years. However, the growing number of new infections and the high rate of mother-to-child transmission requires an expanded and accelerated response, best illustrated by the “Born free to shine” campaign, led by the First Lady of the Republic.

The protection and promotion of human rights is an integral part of the response strategies used by national AIDS programs. In Angola, this includes the protection of Human Rights in national laws, including the Constitution of the Republic of 2010, the Penal Code of 2019, the HIV/AIDS Law, the Law against Domestic Violence, the Law for the Protection and Comprehensive Development of the Child, the General Labor Law, among others that, despite having their specificity, also clearly illustrate the importance and protection of Human Rights.

Institutions such as the Ministry of Justice and Human Rights, the Ombudsman and the National Assembly, show the country’s commitment to the realization of human rights and constitutional freedoms, including those of people living with HIV and AIDS, affected people, key and vulnerable populations.

Despite constitutional guarantees regarding access to justice and the exercise of human rights in the country, key and vulnerable populations continue to impose challenges on the Executive, in the progressive elimination of cultural and idiosyncratic barriers, to overcome stigma and discrimination, unequal treatment, physical and or psychological abuse, routinely reported by organizations of people living with HIV and AIDS and associations representing key populations.

The Legal Environment Assessment provides Angola with a clear picture of what is necessary and fundamental for strengthening the human rights component and its role in the national response to the HIV epidemic, with a view to empowering needy populations. Each chapter contains valuable recommendations on how to effectively achieve a legal environment conducive to the realization of people’s rights to equality and non-discrimination, access to sexual and reproductive health, access to information and education and access to justice, in order to protect human dignity in the face of HIV. Therefore, this report should be used to inform the necessary urgent interventions, aimed at removing barriers related to human rights and gender, access to HIV, sexual and reproductive health services, among others, or catalyzing access to justice and redress for human rights violations.

The Angolan State, through the National Commission for the Fight against HIV/AIDS and Major Endemics, the Ministry of Health and the National Institute for the fight against AIDS (INLS) remain committed to the objectives of 90-90-90: zero new HIV infections, zero HIV-related deaths and zero stigma and discrimination. We rely on all members of society to achieve these goals, regardless of age, ethnicity, gender, sexual orientation, sexual practices or HIV status.



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Acknowledgements

The National Institute for the Fight against AIDS (INLS) recognizes the efforts, dedication and participation of all parties and entities involved, in the different stages of assessing the legal environment around HIV and AIDS and sexual reproductive health in Angola.

Indeed, we are pleased to address special and profound thanks to the Directorate of the Ministry of Health, the Ministry of Justice and Human Rights, the National Assembly and the Ombudsman. The engagement of their corresponding work teams was decisive in demonstrating the strong commitment of the Republic of Angola to ensure the protection of human rights of people living with or affected by HIV, including key populations.

The involvement of the HIV focal points of the various ministerial departments, the Technical Working Group and its Secretariat, for the coordination and leadership, as well as the active participation of all members of civil society and international organizations, the list of which is contained in the annexes, ensured an inclusive participatory process, for this, our thanks to all!

To the United Nations System, UNAIDS, UNFPA and UNICEF for their commitment to the process. To UNDP Angola for the initiative, technical support and coordination of this process, in particular to the Resident Representative a.i. Henrik Fredborg Larsen, to the Global Fund Project Coordinator, Mamisoa Rangers and her team, our thanks!

We are sincerely grateful for the dedicated services and technical knowledge of consultants Dr Gervyz Augusto Manuel Domingos (National Consultant), Dr Emil Sirgado Díaz, LLM (UNDP Consultant) and Kitty Grant (UNDP-RSCA Consultant) who contributed in various capacities to this report. We sincerely thank for the overall coordination the Regional HHD UNDP team including Mesfin Getahun, Senelisiwe Ntshangase and Ian Mungall.

Finally, our thanks to the tireless INLS team, for their strong engagement and commitment throughout this process. A great well-being and extensive gratitude to all who remain anonymous!

List of Abbreviations and Acronyms

ACHPR	African Charter on Human and Peoples' Rights	ENSP	Escola Nacional de Saúde Pública [National School of Public Health]
AIDS	Acquired Immunodeficiency Syndrome	<i>et seq</i>	<i>et sequens (et al)</i>
AJPD	Associação Justiça, Paz e Democracia [Justice, Peace and Democracy Association.]	EU	European Union
ANASO	Angolan Network of AIDS Service Organizations	FGD	Focus Group Discussion
ARASA	Aids & Rights Alliance for Southern Africa	GC	General Comment
ART	Antiretroviral Treatment	GCHL	Global Commission on HIV and Law
Art	Article	GNP +	Global Network of People Living with HIV
ASCAM	Associação Solidariedade Cristã e Ajuda Mutua [Christian Solidarity and Mutual Aid Association]	GR	General Recommendation
AU	African Union	HCT	HIV Counselling and Testing
CAJ	Centro de Apoio aos Jovens [Youth Support Centre]	HIV	Human Immunodeficiency Virus
CARRA	Centre for the Reception and Reintegration of Refugees in Angola	ICCPR	International Covenant on Civil and Political Rights
CATV	Centro de Aconselhamento e Testagem Voluntária [Voluntary Counselling and Testing Centre]	ICPPED	International Convention for the Protection of All Persons from Enforced Disappearances
CESCR	Committee on Economic, Social and Cultural Rights	ICRMW	International Convention on the Protection of the Rights of All Migrant Workers
CNR	Conselho Nacional para os Refugiados [National Council for Refugees]	ID	Identity Card
CP	Código Penal [Penal Code]	IFAL	Instituto de Formação para a Administração Local [Training Institute for Local Administration]
CPP	Código de Processo Penal [Code of Criminal Procedure]	IIMS	Inquérito de Indicadores Múltiplos de Saúde [Multiple Health Indicators Survey]
CRC	Committee on the Rights of the Child	ILM	International Legal Materials
CIERNDH	Comissão Intersectorial de Elaboração de Relatórios nacionais de Direitos Humanos [Intersectoral Commission for the Preparation of National Reports on	ILO	International Labour Organization
Human Rights]		INALUD	Instituto Nacional de Luta Anti-Drogas [National Institute for the Fight Against Drugs]
CRPD	Convention on the Rights of Persons with Disabilities	INAC	Instituto Nacional da Criança [National Children's Institute]
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women	INDH	Instituição Nacional de Direitos Humanos [National Human Rights Institution]
CEDR	Convention on the Elimination of All Forms of Racial Discrimination	INE	Instituto Nacional de Estatística [National Institute of Statistics]
CNCD	Chronic Noncommunicable Diseases	INEFOP	Instituto Nacional de Emprego e Formação Profissional [National Institute of Employment and Vocational Training]
CR	Concluding Remarks	INFORFIP	Instituto de Formação das Finanças Públicas [Institute of Public Finance Formation]
CSOs	Civil Society Organizations	INFQE	Instituto Nacional de Formação de Quadros da Educação [National Institute for the Training of Teachers of Education]
CRA	Constitution of the Republic of Angola	INLS	Instituto Nacional de Luta Contra a SIDA [National Institute for the Fight Against AIDS]
DL	Decree Law	ISRI	Instituto Superior de Relações Internacionais [Higher Institute of International Relations]
DNSP	Direcção Nacional de Saúde Pública [National Directorate of Public Health]	KP	Key Population
DNTFP	Direcção Nacional do Trabalho e da Formação Profissional [National Directorate of Labour and Vocational Training]	Kz	<i>Kwanzas</i>
DRC	Democratic Republic of the Congo	LEA	Legal Environment Assessment
<i>e.g.</i>	<i>exempli gratia (e.g.)</i>	LBSNS	Lei de Base do Sistema de Saúde [Basic Law of the Health System]
ENAD	Escola Nacional de Administração [National School of Administration]	LGBT+	Lesbian, Gay, Bisexual and Transgender
		LGT	Lei Geral do Trabalho [General Labour Law]

LTS	Long Term Strategy	PNCT	Programa Nacional de Controlo da Tuberculose [National Tuberculosis Control Program]
MAPTSS	[Ministério da Administração Pública, Trabalho e Segurança Social] Ministry of Public Administration, Labour and Social Security	PNDJ	Plano Nacional de Desenvolvimento da Juventude [National Youth Development Plan]
MASFAMU	Ministério da Acção Social, Família e Promoção da Mulher [Ministry of Social Action, Family and Promotion of Women]	PNDS	Plano Nacional de Desenvolvimento Sanitário [National Health Development Plan]
MCN	Mecanismo de Coordenação Nacional [National Coordination Mechanism]	PNFQ	Plano Nacional de Formação de Quadros [National Training Plan]
MDGs	Millennium Development Goals	PNS	Política Nacional de Saúde [National Health Policy]
MDR-TB	Multidrug-resistant Tuberculosis	PMTCT	Prevention of Mother-to-Child Transmission of HIV
MEP	Ministério da Economia e Planeamento [Ministry of Economy and Planning]	PWID	People who Inject Drugs
MINFAMU	Ministério da Família [Family Ministry]	PWUD	People Who Use Drugs
MINFIN	Ministério das Finanças [Ministry of Finance]	Res.	Resolution
MININT	Ministério do Interior [Ministry of the Interior]	RIFAP	Rede de Instituições de Formação da Administração Pública [Network of Public Administration Training Institutions]
MINJUD	Ministério da Juventude e Desportos [Ministry of Youth and Sports]	SADC	Southern Africa Development Community
MINJUSDH	Ministério da Justiça e Direitos Humanos [Ministry of Justice and Human Rights]	SCARJoV	Associação de Reintegração dos Jovens/ Crianças na Vida Social [Association of Reintegration of Young People / Children in Social Life]
MINPLAN	Ministério do Planeamento e do Desenvolvimento Territorial [Ministry of Planning and Territorial Development]	SDGs	Sustainable Development Goals
MINSA	Ministério da Saúde [Ministry of Health]	SNS	Sistema Nacional de Saúde [National Health System]
MSM	Men who have sex with men	SRH	Sexual and Reproductive Health
NHRC	National Human Rights Commission	SRHR	Sexual and Reproductive Health and Rights
No.	Number	STD	Sexually Transmitted Disease
NSP	National Strategic Plan	STI	Sexually Transmitted Infection
OAA	Ordem dos Advogados de Angola [Angola Bar Association]	SW	Sex Work
OHCHR	Office of the High Commissioner for Human Rights	TOR	Terms of Reference
OF	Concluding Remarks	TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
OGE	Orçamento Geral do Estado [General State Budget]	UDHR	Universal Declaration of Human Rights
OMA	Ordem dos Médicos de Angola [Order of Doctors of Angola]	UN	United Nations
op. cit.	<i>Opus citatum</i> (work cited)	UNDP	United Nations Development Program
OSISA	Open Society Initiative for Southern Africa	UNAIDS	Joint United Nations Program for HIV / AIDS
PDN	Plano de Desenvolvimento Nacional [National Development Plan]	UNGA	United Nations General Assembly
PEJ	Plano Estratégico 2014-2017 do Sector da Juventude [Youth Sector Strategic Plan 2014-2017]	UNGASS	Special Session of the United Nations General Assembly
PEN V	V Plano Estratégico Nacional de Resposta às ITS/VIH-SIDA e Hepatites Virais-2015-2018 [V National Strategic Plan for STI / HIV-AIDS and Hepatitis Response Viral 2015-2018]	UNICEF	United Nations Children's Fund
PESR	Plano Estratégico de Saúde Reprodutiva [Strategic Reproductive Health Plan]	UNODC	United Nations Office on Drugs and Crime
PLHIV	People living with HIV	UT	Unidade de Tratamento [Treatment Unit]
		WHO	World Health Organization

Executive Summary

The Report of the Global Commission on HIV and the Law (GCHL) (2012) and Supplementary Report (2018) recognise that the legal context has a crucial role in the well-being of people affected by HIV and AIDS. Good laws, equipped with the necessary resources and implemented rigorously, facilitate access to prevention and health care services, improve the quality of treatment and reinforce social assistance to people affected by the epidemic, thus ensuring the protection of human rights of those affected while maximizing investments in public health. For these reasons, the Global Commission recommends countries ensure that their national HIV policies, strategies, plans and programmes include effective action aimed at achieving favourable legal environments. This suggests that countries should repeal punitive and discriminatory laws and enact protective laws that promote human rights, so as to improve the provision of HIV and AIDS prevention, treatment, care and support services (available, accessible in all its forms, acceptable and quality health care).

Furthermore, efficient and accessible justice systems that comply with internationally recognized norms, as set out in various international and regional human rights instruments as well as the country's Constitution, are undoubtedly a prerequisite for the enjoyment of the rights enshrined therein.

In light of the GCHL recommendations, the United Nations Development Program (UNDP) and the Instituto Nacional de Luta Contra a SIDA (INLS), in collaboration with Ministério da Justiça e Direitos Humanos (MINJUSDH) of Angola, engaged in a Legal Environment Assessment on HIV and AIDS as well as a follow-up analysis of opportunities for civil society engagement in drafting, approving and enacting protective laws, policies and strategies. These two processes sought to identify and examine legal and human rights issues that impact people affected by HIV and, to a certain extent, Tuberculosis (TB), including those at higher risk of exposure to HIV, such as women, youth and adolescents, children, LGBT + persons, men who have sex with men,

sex workers, prisoners, people who use drugs, migrants and refugees. The Legal Environment Assessment included an examination of stigma, discrimination and inequality, punitive and discriminatory laws as well as access to justice and law enforcement in the context of HIV, key and vulnerable populations.

This Legal Environment Assessment was supported under the “Linking Policies to Programming: Strengthening Legal Environments and Policies to Reduce HIV Risk and Improve the Right to Sexual and Reproductive Health for Young Key Populations in Southern Africa” programme. The four-year regional project (2017-2020), a collaboration between UNDP, African Men for Health and Sexual Rights (AMShEr) and the Division of HIV / AIDS, Economics and Health Research (HEARD) at Kwazulu Natal University, with the support of the Dutch Ministry of Foreign Affairs, seeks to strengthen legal and political environments to reduce the risk of HIV and improve the sexual and reproductive health and rights (SRHR) of young key populations in five countries in southern Africa.

Results of the Legal Environment Assessment

Angola has committed to several international and regional human rights treaties that provide legal guarantees to safeguard people's rights. These treaties commit Angola to protect a wide range of rights including the right to equality and the prohibition of discrimination, the right to health, including sexual and reproductive health and rights, the right to privacy, the right to life and physical integrity, the right to give and receive information, the rights of children, women, people with disabilities, etc. In terms of Angolan law, although there is no specific constitutional protection against discrimination on the basis of HIV status, ordinary legislation, Government plans and strategies include a series of provisions that seek to protect people living with HIV, and to some extent to people affected by the disease. Law 8/04 (Law on HIV / AIDS) and the different Strategic Plans for HIV / AIDS have contributed to reducing the spread

of HIV and managing the epidemic.

Despite the positive gains in the country's response to the HIV epidemic, affected people continue to experience stigma, discrimination and violations of their human and constitutionally protected rights, freedoms and guarantees in several ways as a result of gaps and challenges in law and policy and their implementation and enforcement. The Assessment found that a number of legal provisions, as well as the institutional and structural frameworks to respond to HIV in Angola are due for review, in order to guarantee a rights-based response, in harmony with both international standards as well as constitutional precepts in relation to HIV and AIDS, including jurisdictional and non-jurisdictional mechanisms that guarantee the realization of rights.

While the Legal Environment Assessment found very positive and promising laws and policies protecting rights in the context of HIV, it also identified challenges and gaps. Examples of problematic provisions include punitive laws that create serious barriers to accessing health services e.g. the criminalization of exposure, non-disclosure and transmission of HIV which have been found to discourage people from seeking testing and adhering to treatment. The age of consent for minors, with the requirement that those under 18 years of age require parental consent to access HIV testing, arguably creates barriers for sexually active teenagers. Law 8/04, policies, strategies and plans were also limited in some cases, failing to adequately prioritize the needs of key and vulnerable populations. The LEA also found limited awareness of rights of affected people, amongst those affected and including amongst service providers, such as health service providers and law enforcement officials, and limited access to the mechanisms that protect their rights. These are discussed in further detail below:

Angola has an HIV Law 8/04, enacted in 2004. However, the law is outdated and contains various gaps and challenges, particularly for key and vulnerable populations, as well as punitive provisions deserving of review. In

some instances, these same issues are also seen in other national laws. In particular, the following key challenges were noted:

Access to health care information and services for HIV, TB and sexual and reproductive health and rights: The HIV Law 8/04, coupled with various health laws, policies, regulations and directives is in harmony with the Constitution of Angola (CRA) (2010) and international and regional commitments, providing for access to health information and services for HIV. However, Angolan health laws appear outdated in some respects, e.g. in the lack of special protection for key and vulnerable populations and inclusion of sexual and reproductive health strategies and / or policies. While advances have been made to ensure the availability, accessibility, acceptability and quality of health information and services, the challenges are enormous, particularly for rural areas. For e.g. sanitation is insufficient, health units are poorly maintained, health information materials, human and technical resources for health are limited with insufficient health personnel in rural and peri-urban areas, financial resources are inadequate and there are major problems related to the underlying and social determinants of health. In the context of HIV, TB and SRHR, access to health information and services is limited including for key populations; multisectoral institutional mechanisms are weak and resource mobilization is precarious.

HIV-related stigma and discrimination: The HIV Law 8/04 protects people from HIV-related discrimination, as does the National Strategic Plan, PEN V. However, the 2015-2016 IIMS states that about one-third of men and women aged 15-49 revealed discriminatory attitudes towards people living with HIV, and the LEA found ongoing reports of stigma and discrimination particularly within families and health care, limited awareness of rights and training of health care providers, as well as limited access to justice for redress.

Criminalisation of HIV transmission and exposure: Article 15 of HIV Law 8/04 places a responsibility upon people living with HIV to disclose their HIV status to their sexual

partners. It also states that the “wilful transmission” of HIV is a crime and is punished under Article 353 of the (former) Penal Code. The provisions of the new Penal Code also contain overly broad provisions criminalizing HIV transmission, exposure and non-disclosure in a way that is inconsistent with the most updated international and regional guidelines. They also fail to take into account scientific advances in relation to HIV (e.g. almost zero risk of transmission for those who are virally suppressed). Using the criminal law to respond to HIV disturbs the distinction between the constitutional axiological order (e.g. right to health, particularly the right to sexual and reproductive health, the right to intimacy) and the criminal order, replacing criminal law with other means available to the state (e.g. health law and policy) to meet health responsibilities.

Key populations: Key populations, including young key populations, experience a high degree of stigma, discrimination and even violence in both public and private settings, including health centres and public services in general, in schools and within the family and from law enforcers, and also report limited access to health care services. Law 8/04 on HIV /AIDS is silent on protection for the equality, health and social security rights of key populations (with the exception of people deprived of their liberty) and support for key population organisations. Similarly, with the exception of the new provisions in the Penal Code (2019) creating a crime of discrimination based on sexual orientation, the broader legislative framework does not guarantee full realization and enjoyment by transgender persons, men who have sex with men, sex workers and other key populations of their rights, freedoms and fundamental guarantees established in the constitution. For example, Article 130 of the Civil Registry does not adequately protect the rights of transgender persons to their gender identity. Same-sex marriages and de facto unions are not permitted, denying various rights – such as inheritance rights – to same-sex partners, and LGBT organisations and associations face administrative barriers to legal recognition. Drug use is criminalized in law and there is limited understanding of the vulnerabilities

of people who use drugs in the context of HIV. The National Strategic Plan for HIV, PEN V provides limited information on key populations, and the lack of seroprevalence and socio-behavioural studies prevent the development of effective and sustainable strategies.

Young people: Despite a paradigm shift in recognizing the right to sexual health, young people still experience many social, cultural, legal and policy barriers preventing the realization of their sexual and reproductive health and rights. The HIV Law 8/04 provides inadequate protection for the equality, health and social security rights of children and young people in the context of HIV and does not recognize their specific vulnerability. It also prohibits independent consent to HIV testing for young people below 18 years, requiring the consent of a parent or legal guardian of a child – although the national Protocol on HIV Testing allows for exceptions for adolescents aged 15-18 where a counsellor considers them to have the ability to understand the test and the implications of the test result. Similarly, Article 75 of the Law on the Comprehensive Development of the Child fails to provide for the specific needs of children in the context of HIV. In addition, there is no basic law for youth, as required under Art 81.2 CRA (2010), nor are there adequate policies, plans or strategies focused on the integral development of the child through all phases of childhood, including adolescence. In addition, structures and resources are insufficient to adequately provide for social protection. Structures are not yet sufficient or adequate to comply with the requirements of national law itself. In terms of children’s rights related to the family, there are cases of family abandonment due to sexual orientation and gender identity. Human and financial resources are insufficient to implement adequate social protection and health policies and programmes for children, adolescents and young people.

Gender inequality, harmful gender norms and gender-based violence: Patriarchal attitudes and cultural patterns, often perpetuated in customary law, perpetuate gender inequalities in Angola despite various advances in law and

policy towards gender equality, increasing the vulnerability of women to HIV. The HIV Law 8/04 does not specifically address the vulnerability of women, including adolescent girls and young women, to HIV. National policies and strategies for responding to HIV do not adequately reflect the various vulnerabilities experienced by women in the context of HIV. Problematically, the Family Code allows for child marriage at 15 for girls and 16 for boys in circumstances where marriage is considered the 'best solution' and the person with the legal authority provides consent. Additional challenges include limited awareness of and discourse around the sexual and reproductive health and rights of adolescent girls and young women, amongst decision makers, public officials, health professionals and the general population; harmful cultural practices including child marriage, unequal inheritance and property rights for women and limited implementation of legal protections against violence, including domestic violence and violence perpetuated by police authorities.

Employees and the workplace: The HIV Law 8/04 provide protection for the rights of employees with HIV, as do various other national regulations. However, there is a need to harmonize and update labour laws and regulations. There are also no specific plans, policies or regulations on combating stigma and discrimination in the workplace and unlawful practices – such as pre-employment testing, dismissals and discrimination on the basis of actual or perceived HIV status – persist. At a broader level, there are limited plans and policies on access to work for people in general and, especially, for people living with HIV. Sex workers are not recognized as employees and enjoy no protection of labour rights, impacting on their socio-economic security and access to health services.

Migrants, refugees, asylum seekers and stateless persons are not recognized as a vulnerable population in the HIV Law 8/04 and the Asylum Law (10/15 Act) is not yet fully implemented. They face various barriers to access to health care services, due to lack of required documentation, and there is limited

information and evidence on their specific vulnerabilities in the context of HIV, TB and sexual and reproductive health and rights.

Awareness of rights and access to justice: There is limited access to information on laws, policies, plans or strategies in Angola in hard copy or electronical format, with a few exceptions – e.g. websites of the National Assembly, Constitutional Court and the Ministry of Justice and Human Rights. Law 08/04 is silent on access to knowledge of rights and does not include provisions regarding access to justice nor procedures for the realization of legal rights. The LEA found that health facility complaints mechanisms and User Offices are not functional in many facilities. In addition, users are unwilling to access mechanisms due to fear of discrimination, breaches of confidentiality and the total lack of faith in the health complaints mechanism.

The Legal Environment Assessment on HIV/AIDS in Angola asks that the following recommendations be considered:

General recommendations

- Strengthen the legal and policy framework for people affected by and living with HIV, particularly in relation to key (including young key) populations (LGBTB+ persons, MSM, prisoners, sex workers, and people who use drugs) and vulnerable populations (women, adolescents, children, migrants, and refugees).
- Review HIV/AIDS Law 8/04 to incorporate various provisions to strengthen equality and anti-discrimination protection for PLHIV, key and vulnerable populations, including young key populations, to remove punitive provisions and to ensure that the law is up to date with current medical and scientific evidence.
- Increase awareness (education and information) at all levels within the Executive, Legislative and Judiciary, as well as the wider community on the rights of people living with HIV and TB, and key populations (including young key populations) and vulnerable populations.

- Provide adequate human and financial resources for the implementation and monitoring of health and HIV laws and policies, including sexual and reproductive health and prevention, treatment, care and support services for people affected by and living with HIV, key and vulnerable populations, including young people.
- Strengthen efforts to reduce stigma, discrimination and violence, particularly with regard to people living with HIV, key and vulnerable populations, including young key populations.
- Conduct socio-behavioural studies and further research to improve understanding of the legal, human rights and gender-related barriers to health care for key and vulnerable populations, including young key populations.
- Strengthen mechanisms for access to justice for PLHIV, key and vulnerable populations, including young key populations.
- Incorporate actions aimed at combating stigma and discrimination into national plans for Sexual and Reproductive Health as well as the national Plan for the elimination of mother-to-child transmission (2019-2022)
- Develop and implement a Stigma Index study to measure stigma and discrimination against PLHIV, key and vulnerable populations.
- Introduce a special quota for key populations in political participation bodies.
- Collaborate with the United Nations system on a human rights approach to the HIV national response based on the principle of equality and the prohibition of discrimination.

Specific Recommendations

A. Equality and Anti-discrimination Laws

- Revise Law 8/04 “HIV/AIDS Law” to adopt measures to provide general anti-discrimination protection for all persons affected by stigma and discrimination and to promote substantive equality.
- Validate and implement the draft National Key Populations strategy (2018)
- Promote a comprehensive anti-discrimination law in political, social and cultural spheres and includes non-discrimination for people living with and affected by HIV and key populations.
- Include and implement concrete actions in policies, strategies and plans to combat inequality and discrimination against PLHIV, key and vulnerable populations, including young key populations.
- Inform, educate and disseminate material that contributes to eliminating stigmatising and discriminatory attitudes and increases awareness of rights and how to access justice.
- Incorporate actions aimed specifically at combating stigma and discrimination in the National Youth Development Plan.

B. Health Legislation, Policies and Plans

- Assign adequate resources from the OGE to guarantee lines of sustainable, adequate, domestic funding for the realisation of the right to health, including the right to sexual and reproductive health and rights in compliance with international and regional commitments, including the Abuja Declaration.
- Allocate adequate resources, both domestic and external, to HIV prevention, in line with Angola’s commitments within the Global Alliance for HIV Prevention
- Allocate adequate resources for community-based interventions which are led by national civil society organisations, including associations representing youth, key and vulnerable populations, and cater for their organisational development needs.
- Expand the range and scope of community-based services through mutual support groups for adolescent PLHIV; nutritional support for PLHIV and TB patients; and by addressing social determinants of health
- Establish specific provisions in the Basic Law of the National Health System to strengthen available, accessible, non-discriminatory and quality health services for people affected by and living with HIV. Revise Art. 1 (b) on the promotion of equality with a view to provide for the substantive or de facto guarantee of equality.

- Provide for the specific needs of people affected by HIV in the revision of the Basic Law of the National Health System, including in terms of sexual and reproductive health and rights.
- Ensure that the draft Guidelines for Health Professionals working with Key Populations (2018) are validated, operationalised and disseminated
- Incorporate the needs of Key and vulnerable Populations in the Ministry of Health's initiative for the humanisation of health services
- Revise Law 8/04 to establish provisions that ensure substantive equality for both people living with HIV as well as key and vulnerable populations.
- Revise Law 8/04 to ensure humane services for all patients, regardless of sexual orientation or gender identity or any other situation e.g. drug use, migrancy.
- Revise Law 8/04 to guarantee independent access to HIV testing for adolescents.
- Eliminate punitive provisions on HIV non-disclosure and transmission, as discussed further below
- Adopt administrative measures for improving health services by strengthening the links between primary care and hospital care;
- Apply disciplinary sanctions to health professionals and other relevant actors who violate codes of good practice and the rights of PLHIV, people with TB, key and vulnerable populations, including through breaches of the right to confidentiality;
- Pursue and sustain the efforts made by Government to date to reduce the cost of health products – condoms, diagnostics and treatment products – through pooled and international procurement, with UN support.

C. Criminalisation of HIV Transmission, Exposure and Non-disclosure.

- Align (existing and proposed) criminal legislation with international standards, including standards to ensure that the judiciary takes into account medical and scientific advances as evidence in criminal proceedings relating to non-disclosure,

exposure and transmission of HIV. Where HIV arises in the context of a criminal case, the police, lawyers, judges and, wherever appropriate, juries, should be informed by the best scientific evidence available on the benefits and consequences of appropriate therapy.

- Prohibit the prosecution of women living with HIV for choices made during and after pregnancy, including breastfeeding children.
- Develop guidelines to support law enforcement agents and the judiciary to ensure that criminal sanctions are fairly applied.
- Repeal the provisions in Law 8/04 the HIV/ AIDS Law regarding non-disclosure, exposure and transmission OR revise such provisions to only criminalise intentional transmission: “[w]hen an individual transmits the HIV virus maliciously and intentionally, with the express purpose of causing harm”.
- Adopt counselling measures to encourage couples/partners to share information about their HIV status with each other in order to take informed action to prevent HIV transmission and to protect each other from infection and reinfection.
- Use other legal and public health alternatives to criminal law to prevent the spread of the HIV epidemic, including increased resources and focus on HIV prevention, and addressing stigma and discrimination
- In the case of sexual offences such as rape, which result in HIV transmission or create a significant risk of HIV transmission (taking into account medical and scientific evidence related to transmission), the HIV positive status of the offender should only be considered an aggravating factor in the sentence, if the offender knew that he was HIV positive at the time of committing the offence.

D. Women: Gender Inequality, Harmful Gender Norms and Gender-Based Violence

- Adopt legislative measures to strengthen gender equality, either through special gender equality legislation or through general anti-discrimination legislation that takes into account gender issues and

the specific needs of women, as has been recommended by the various international human rights mechanisms to Angola.

- Revise Law 8/04 in order to recognise women as a vulnerable population, in line with that proposed by the SADC Model Law on HIV, and to protect women from discrimination.
- Revise Law 8/04 in order to protect women's rights to autonomy in decision-making in relation to their sexual and reproductive health, in accordance with international human rights law.
- Adopt administrative and financial measures to ensure women's access to health services, including HIV prevention, treatment and care services, and to improve the living conditions of women in rural and peri-urban areas.
- Take measures to protect and promote the rights of women and girls to accurate sexual and reproductive health information and education
- Eliminate the cultural and customary barriers that prevent the full enjoyment of women's rights, specifically the rights to equality, dignity and the right to health, including sexual and reproductive health, based on an audit of customary norms that constitute harmful practices and that act as barriers to the enjoyment of women's rights.
- Adopt legislative measures to regulate abortion, in order to empower women to make decisions in relation to their sexual and reproductive health and to comply with recommendations made by international and regional human rights mechanisms.
- Strengthen training and resources for health professionals, the police, judiciary and penitentiary systems in order to ensure effective and sustainable implementation of the Domestic Violence Act.
- Strengthen enforcement mechanisms (e.g. disciplinary regimes) for police and penitentiary violence, abuse and unjustified use of force
- Adopt educational measures in the health, police, penitentiary and amongst traditional authorities on gender equality and the fight to eliminate discrimination towards women; expand and sustain current initiatives for

the sensitisation of police hierarchy and front line officers to the human rights of female sex workers; pursue and reinforce existing collaboration for adequate gender-based violence responses

- Consider revising Art. 24.2 of the Family Code to prohibit early marriage.
- Strengthen national HIV policies and strategies, including the NSP and the National Strategy for Key and Vulnerable Populations, to recognise the vulnerability of women to HIV.
- Strengthen institutional coordination mechanisms, especially with regards to sexual and reproductive health.

E. Children and Adolescents

- Revise Law 8/04 to recognise the vulnerability of children in a holistic manner, considering the child's right to health and all other rights; and the specific needs of children of various ages, especially adolescents. Revise Law 8/04 to allow for access to HIV testing without parental consent for children, according to the child's physical and mental developmental capacities, and at the very least for children aged 14 years and older in accordance with the SADC PF Model Law on HIV
- Revise Law 8/04 to ensure that children who are capable of providing independent consent also have an independent right to confidentiality regarding their HIV status, including in special psychosocial support services.
- Revise Law 8/04 to adopt measures for combating discrimination and violence against children and young people, in particular for discriminatory acts, family abandonment and mistreatment due to actual or perceived HIV status, sexual orientation, gender identity, involvement in transactional sex, or when they are the victims of sexual exploitation.
- In the process of revising Law 8/04 on HIV/AIDS and developing a comprehensive child focused legislation, take into account the provisions of Law 25/12 on the comprehensive development of the child in order to avoid conflicts of law.

- Develop and enact a Youth Law which contains specific provisions on young people and HIV as well as on the rights of young people to sexual and reproductive health and rights.
- Develop and approve a national policy focused specifically on children, with a holistic approach that considers the specific needs of each age group and containing results, actions and indicators in relation to HIV, and sexual and reproductive health.
- Integrate sexual and reproductive health and rights and sexual orientation and gender identity within the National Youth Policy
- Continue to strengthen administrative measures to facilitate children's birth registration across the country.
- Continue efforts to reduce mother-to-child transmission through measures that strengthen access to health services for mothers while protecting their human rights and right to confidentiality of HIV status
- Include all children as a vulnerable population in the draft National Strategy for Key and Vulnerable Populations.
- Allocate financial resources to support orphaned children and strengthen social protection mechanisms.
- Adopt legislative, administrative and educational measures to ensure the realisation of children's sexual and reproductive health and rights.
- Strengthen coordination mechanisms between INLS, MINJUD, MINSA on sexual and reproductive health and rights and strengthen coordination mechanisms with the National Social Action Council.
- Adopt legislative, educational and educational measures to combat early marriage.
- Adopt educational measures to combat stereotypes and cultural barriers that negatively affect the development of children, particularly with regards to their sexual and reproductive health (e.g. through national, provincial and municipal information campaigns). Specifically, request support from the promotion committee of the Provincial Human Rights Committees.

- Conduct socio-behavioural studies on adolescents in relation to attitudes that put them at risk of HIV.
- Strengthen the integration of HIV and SRH services; mobilise domestic and international resources for the expansion of STI/HIV prevention services and the continued supply of health products required for the prevention of STIs, HIV and teenage pregnancy.

F. Key Populations including Young Key Populations

i) Lesbian, Gay, Bisexual, Transgender and Men who have Sex with Men (LGBT+ and MSM)

- Revise Law 8/04 on HIV/AIDS to protect the LGBT+ community against stigma and discrimination
- Review Law 8/04 on HIV/AIDS to promote substantive equality and protect from all forms of discrimination, family abandonment, violence and police abuse and to promote access to health services, social assistance – including for young key populations – and to freedom of association, amongst other things.
- Strengthen enforcement mechanisms against stigma and discrimination and health rights violations e.g. disciplinary procedures in the sectors of health, police, education, etc.
- Strengthen the protection of LGTB+ minorities rights and inclusion in health programmes including through resource mobilisation and training of health professionals of the rights of LGBT+ persons, including young LGBT+ persons
- Provide training for police officers and legal practitioners on sexual orientation and gender identity
- Allow transgender persons to have their gender affirmed and recognised in identification documents and official forms; repeal the provision of Art 130 of the Civil Registry Code.
- Adopt measures to promote access to justice for LGBT+ people, including young LGBT+ persons

- Provide access to comprehensive sexual education that includes issues of sexual orientation and gender identity in schools to reduce stigma and discrimination against young LGBT+ persons
- Raise awareness amongst the general population on the rights of LGBT+ populations, including young LGBT+ persons
- Conduct studies to understand the dynamics of key populations in relation to HIV
- Conduct a legal audit of sexual orientation and gender identity rights.
- Adopt legislative and other measures to reducing discrimination and violence amongst families towards their young LGBT+ members.
- Carry out behavioural studies on sex work, differentiating male, female and transgender sex workers and further disaggregated by age.
- Adopt financial measures to ensure the implementation of programmes for sex workers.
- Strengthen awareness of rights and access to legal support services for sex workers, including young sex workers, to enable them to respond to rights violations.
- Strengthen enforcement mechanisms to eliminate police violence and discrimination within health services, e.g. administrative sanctions, employment sanctions, etc.
- Provide training to inform and educate police officers and health professionals on the rights of sex workers, including young sex workers.

ii) Sex Workers

- Review the Penal Code criminalisation of sex work, with a view to repeal.
- Revise Law 8/04 on HIV/AIDS to provide special protection for sex workers. Specifically, establish provisions in Law 8/04 on HIV/AIDS on occupational health and safety conditions to protect sex workers and their clients.
- Establish provisions in Law 8/04 to guarantee non-discrimination against sex workers.
- Establish provisions in Law 8/04 on HIV/AIDS to ensure the availability of specific health services that prioritise the prevention, treatment, care and support needs of sex workers, including the availability of preventive methods, e.g. condoms.
- Ensure that prioritised, differentiated activities for male, female, transgender and young sex workers are also specifically provided for in the national strategic plan for HIV, the National Strategy for Key Populations, national health programmes including activities to address stigma, discrimination and human rights violations and to provide prevention, treatment, care and support.
- Carry out studies on seroprevalence, socio-behavioural patterns and overlapping risks to better understand the dynamics of sex work and sex workers.

iii) Prisoners

- Revise Law 8/04 on HIV/AIDS to recognise the specific needs of prison inmates, including young prison inmates, particularly in relation to access to health services, including SRHR – with an emphasis on education, information and access to the means of prevention as well as treatment and care – and the elimination of stigma, discrimination and violence, particularly sexual violence.
- Establish prisoners' right to health to ensure that community-based HIV prevention and treatment services are also provided to people in prison and in other closed facilities and that services include a focus on the needs of young prisoners.
- Revise Law 8/08 (Penitentiary Law) to introduce specific provisions on prevention and treatment of HIV and TB in Prisons, including Juvenile detention centres.
- Ensure access to information on prevention, education, voluntary testing and counselling for all those in detention, including young detainees.
- Provide access to the means of prevention, such as condoms and lubricants.
- Carry out studies in prisons to obtain evidence on the dynamics of the epidemic, including overlapping risks e.g. drug use, sex work, and the specific vulnerabilities of young persons in detention.

- Carry out training in prisons for prisoners and prison officers on the rights, including health rights, of prison inmates. Strengthen coordination mechanisms between the Ministry of the Interior and the Ministry of Health to strengthen access to health care services for prison inmates. Treat prisoners as a key population.

iv) People Who use Drugs

- Review Law 8/04 to ensure the special protection of people who use drugs; especially to prohibit stigma, discrimination and violence, detention or compulsory isolation and compulsory HIV testing and to establish provisions to improve access to comprehensive access to services for HIV, TB and viral hepatitis, including harm reduction services.
- Review with a view to decriminalising the consumption, possession and cultivation of drugs for personal use. Specifically, it is recommended that a “Technical Opinion” is prepared to evaluate decriminalising the consumption, possession and cultivation of drugs for personal use, aiming to revise Art. 23 of Law 3/99 “Law on Trafficking and Consumption of Narcotic Drugs, Substances Psychotropic and Precursors”.
- Include comprehensive interventions for people who use drugs in PEN V, including education and information on the HIV-related health risks of drug use, access to harm reduction services, prevention, treatment, care and support.
- Include in the CILAD Strategic Plan, actions related to the link between HIV and drug use, especially with regard to overlapping vulnerabilities and behaviours that increase risk of HIV exposure (e.g. drugs and sex work, drugs within the prison environment, drugs and unprotected sex between men).
- Carry out studies and develop evidence to increase understanding of the dynamics of people who use drugs in the context of HIV.
- Strengthen institutional links between the different institutions working with these issues, e.g. strengthen the link between INLS and INALUD.

G. Employment

- Revise Law 8/04 to include more extensive workplace protection for the rights of PLHIV and key populations, particularly young key populations, in line with international guidance.
- Revise Law 8/04 to provide workers and employers with comprehensive information on HIV, including employment rights, education, information and prevention, treatment, care and support services.
- Revise Law 8/04 to strengthen provisions in relation to occupational exposure to HIV and to ensure that post-exposure prophylaxis (PEP) is available to all health professionals and other service providers, including law enforcement officers, who may require it, and to guarantee procedures to access support, counselling and care during out-of-work hours.
- Standardise Law 8/04 and Decree No. 43/03 of 4 July (Regulation on HIV/AIDS, Employment and Vocational Training) and take steps to implement and monitor their provisions.
- Adopt legislative measures to guarantee non-discrimination in the workplace and HIV-related labour rights for key populations, including for sex workers.
- Adopt HIV-specific workplace policies on employment, the right to work and employee’s rights within the workplace, which take into account the provisions of ILO Recommendation No. 200 of 2010.
- Adopt educational measures aimed at eliminating stigma and discrimination, and fears associated with HIV and AIDS in co-workers and employers.
- Strengthen procedures for access to justice in cases of breaches or non-compliance with legal provisions by colleagues or employers in the workplace, to ensure punishment for those who violate employment rights for employees living with HIV, e.g. equal opportunities within employment, a prohibition on pre-employment HIV testing and disclosure of employee’s HIV status without consent.

H. Social Security

- Revise Law 8/04 to include specific provisions in relation to social protection benefits, specifically to provide social protection for key and vulnerable populations, including young key populations.
- Revise Decree 43/03 in order to extend social security coverage to take into account the specific needs of PLHIV and those affected by the epidemic, such as key populations, including young key populations.
- Revise Law No. 7/04, of 15 October, “Basic Law on Social Protection” to include HIV as a ground for special protection and to consider inclusion of grounds to protect the needs of other key and vulnerable populations, including young key populations.
- Incorporate concrete actions into the NSP to achieve the goal of establishing social assistance and protection programmes, especially for key and vulnerable populations. Create and disseminate social assistance and reintegration policies for sex workers, men who have sex with men, and transgender persons, including young key populations.
- Strengthen coordination mechanisms with the various ministerial departments responsible for social security in relation to HIV and AIDS.

I. Refugees, Asylum-Seekers, Stateless Persons and Migrants

- Ratify the United Nations Convention for the Protection of the Rights of Migrant Workers and their Family Members, (2003)
- Provide migrants, refugees, asylum-seekers and stateless persons the right to health on equal terms with Angolan and foreign residents, including access to the full range of health services, particularly in relation to HIV, irrespective of migrant status.
- Revise Law 8/04 on HIV/AIDS to recognise the vulnerability of migrant populations and to ensure equality and non-discrimination in access to health services.
- Include provisions in the CARRA Regulations (reception centre for refugees and asylum seekers) that guarantee health care, including access to basic shelter, housing and sanitation, adequate provision of safe drinking water, access to medicines, counselling, prevention of diseases, access to SRH information as well as information on prevention, treatment and control of HIV, TB and viral hepatitis.
- Implement Law 10/15 “Asylum Law and Refugee Status”, including the allocation of financial resources and the training of competent authorities on human rights issues, including SRHR, HIV, AIDS, TB and Viral Hepatitis.
- Include specific provision for refugees within the NSP, including recognition as a vulnerable population and provision for socio-behavioural studies, and the collection of statistical data on the health of migrants, refugees, asylum seekers and stateless persons.
- Approve a National Policy or Strategy for Migrants, Refugees, Asylum Seekers and Stateless Persons that includes the protection of these groups in relation to SRH and HIV.
- Adopt administrative measures to ensure the quality of refugee documentation as provided in Art. 35 of Law 10/15 (right to documentation)
- Adopt administrative measures to ensure the birth registration of children of migrant, refugee and stateless persons.
- Develop education campaigns in migrant detention centres and refugee settlements in order for people to realise their right to receive education and information, including health information.
- Adopt legislative and administrative (disciplinary) measures to ensure that personal data is confidential, and that personal data is not shared without the consent of the individual concerned; including data on the health status of the individual.
- Strengthen collaboration with international and regional organisations serving the health rights of migrants, refugees and asylum seekers, particularly UNHCR.

- Strengthen the position of migrants, asylum seekers and refugees by improving institutions and structures to address and manage individual applications for asylum, including reducing bureaucratic procedures, as well as respecting the deadlines established in Law 10/15 for different procedures (e.g. Granting of Asylum)

J. Education and Information

- Revise Law 8/04 to clarify the obligations of public and private media and various institutions to ensure access to education and information to protect the sexual and reproductive health and rights of people living with HIV, key and vulnerable populations – particularly young key populations. This should include, amongst other things:
 - education and information on HIV and AIDS in plain language
 - information designed to transform HIV-related stigma and discrimination into attitudes of understanding and acceptance for PLHIV, (young) key and vulnerable populations;
 - information on the SRHR of PLHIV, (young) key and vulnerable populations for health professionals, educators, social workers, judges, lawyers, police officers, prison authorities and officials, civil servants in general, and employers as well as for affected populations themselves.
- Ensure that government ministries and institutions, at both central and local levels develop and disseminate information on HIV, TB, law and human rights of PLHIV, (young) key and vulnerable populations; e.g.
 - ensure that the National Commission to Combat HIV/AIDS and Great Endemic Diseases develops and enacts the Information Guidelines on issues relating to STIs/HIV/AIDS.
- Ensure that the National AIDS Institute sets up a website with information on prevention, treatment and control of the epidemic, as well as on scientific advances in HIV and AIDS, including by keeping the website up-to-date, mainly regarding laws that impact on HIV/AIDS.
- Ensure that the National AIDS Institute provides legal information, accessible to all persons including PLHIV, (young) key and vulnerable populations, on the rights of persons and the obligations of the State and that complaint procedures are available for reporting rights violations.
 - Ensure that the Ombudsman disseminates information regarding the content of the right to health, including SRH and the impact that HIV has on this right.
 - Ensure that the Commissions for the Promotion Human Rights of the Provincial Human Rights Committees disseminates and promotes the right to health including sexual and reproductive health and the impact of HIV and AIDS on this right.
- Adopt financial measures to ensure adequate sexual and reproductive education.
- Domesticating the SADC Strategy for Key Populations and disseminate widely to policy makers and programme development officers.

K. Access to Law and Justice

- Ratify the Optional Protocol of the ICESCR.
- Fully implement Law 2/15 on Judicial Reform.
- Revise Law 8/04 to include provisions to increase awareness of rights and access to justice, including through establishing a competent authority to receive confidential complaints and to process patients' complaints on the basis of equity in access to law and justice in relation to, e.g. access to health regarding HIV, discrimination and violence.
- Revise Law 8/04 to provide free legal services to enforce the rights established by law, including provisions to provide legal advice to persons affected by the epidemic and who are within the scope of law, in particular to persons living with HIV, key and vulnerable populations, including young key populations.
- Revise and adapt the Basic Law of the National Health System (Law No. 21-B/92) to include provisions ensuring the confidential receipt, processing and follow-up of complaints, claims or suggestions from patients.

- Revise the Statute of the Ombudsman so that it is aligned with the Paris Principles or establish a National Human Rights Institution in accordance with these principles.
- Encourage the Ombudsman to prepare a thematic report on HIV and Human Rights in Angola.
- Advocate for the Ministry of Justice and Human Rights to conduct a study on access to law and justice.
- Include objectives, actions and goals in health plans to promote compliance with administrative justice and ensure legal resources are available to patients for the realisation of their rights.
- Adopt financial measures to strengthen the judicial organisational systems, including infrastructure, digital technology, human resource and continuous capacity building of judges, etc.
- Adopt educational measures in the health, penitentiary and police sectors on the rights of people affected by the HIV epidemic, in particular those of (young) key and vulnerable populations; as well as the criminal, civil, administrative and disciplinary consequences of discriminatory attitudes and the misuse of force.
- Develop guidelines on HIV and rights in the health, penitentiary and police sectors, as well as in the judiciary system.

Part I:

Introduction

1.1 Introduction

The Global Commission on HIV and the Law (GCHL) is an independent body, convened by the United Nations Development Programme (UNDP) on behalf of the Joint United Nations Programme on HIV/AIDS (UNAIDS). The GCHL has published two reports, the Global Commission on HIV and the Law, *Risks, Rights & Health* in 2012 and a supplementary report in 2018, which extensively analyses the relationship between legal responses, human rights and HIV and further suggests actionable, evidence-informed and human rights-based recommendations for the effective management of the HIV response, that protect and promote the human rights of persons affected by the epidemic¹.

In its 2012 Report, the GCHL *found* that ‘the law’ plays a critical role in the response to HIV and AIDS, bad laws and law enforcement allow stigma, discrimination and human rights violations to proliferate, exacerbating the risk and vulnerability of people living with HIV and key populations. The report also found examples of country-level protective laws and policies that protected the rights of key populations and helped to curb the spread of HIV. It called on countries to review their legal frameworks, outlaw discrimination, repeal punitive laws and enact protective laws to promote public health and human rights for effective HIV responses.

The Legal Environment Assessment (LEA) on HIV, AIDS, Tuberculosis (TB), Sexual and Reproductive Health (SRH) and Human Rights (HR) in Angola responds to the GCHL recommendations. It assesses the legal framework in the country from the perspective of human rights and other international standards. The LEA was conducted by the Angolan Executive, led by the Instituto Nacional de Luta Contra a SIDA (INLS) [National Institute for the Fight against AIDS], in collaboration with the Ministry of Justice

and Human Rights, and supported by United Nations Development Programme (UNDP) Angola. The primary objective of the LEA is to identify and examine any challenges and gaps in the Angolan legal framework and to issue recommendations in accordance with international and regional standards and guidance on HIV and human rights.

1.2 Context and National Response

Context

Angola covers 1,246,700 Km². It is divided into 18 provinces with Luanda being the capital of the country. It is bordered by the Democratic Republic of Congo and Congo Brazzaville in the North, by the Republic of Zambia to the East, by the Republic of Namibia to the South, and by the Atlantic Ocean to the West.²

Angola’s political system is based on popular sovereignty, on the primacy of the Constitution and the law, on the separation of powers and the interdependence of functions, on national unity and on pluralism of expression and of organisation to promote and defend the fundamental rights and freedoms of human beings as individuals or as members of organised groups.³ There is currently a focus on improving justice and legal reform, which is ongoing and at an advanced stage, with the prospect of improving the country’s legal framework and, consequently, social justice. Major examples of this reform are the promulgation and progressive implementation of Law No 2/15 which establishes the principles and general rules of the organisation and operation of the Courts of Common Jurisdiction or the promulgation of the new Criminal Code.

Projections on Angola’s population estimates that by 2019 nearly two-thirds (64 per cent)

1 Global Commission on HIV and the Law *Risks, Rights and Health* Report 2012; 2018;

2 Ref. Local Administration – MAT; Ministry of Justice and Human Rights, *Angola in the Periodic and Universal Assessment*, 2010-2015.

3 Ref. CRA; Ministry of Justice and Human Rights, *Angola in the Periodic and Universal Assessment*, 2010-2015.

of its populations will be below the age of 24 years and a growth rate of 3.7%. At this rate, Angola's population will double in twenty years. Fertility rates have slightly reduced from 7.2% in 2001 to 6.2% in 2016. However, adolescent fertility rate is among the highest in the region, with 163 births per 1,000 adolescent girls aged 15-19, 239 per 1,000 in rural areas. Coverage of family planning usage is at 14%, up from 6.6% in 2001, while unmet need for family planning among adolescent girls aged 15 to 19 is 43%. Maternal, neonatal and child health indicators reflect a country's development and quality of life for its population as well as the efficiency of its health system. In Angola, despite significant efforts to improve sexual and reproductive health, main indicators continue to raise concern. Antenatal consultation coverage is 69% for one or more visits and the rate of births attended by a skilled health professional has increased from 36% to 49.6%. The coverage of emergency obstetric and neonatal is insufficient and community involvement interventions are at an initial stage.⁴

With regards to HIV and AIDS, Angola has an HIV prevalence rate of 2% amongst the general population aged 15 to 49 years of age.⁵ The HIV prevalence in women is 2.6% and in men it is 1.2%. In young people aged 15-24 years, the HIV prevalence is 0.9%, being relatively higher in women at 1.1%, and in the age group 20-22 years the HIV prevalence rate is 2.1%. Notwithstanding Angola's low seroprevalence rate, the epidemic is characterised as widespread and nevertheless represents a large number of people living with HIV.⁶

The prevalence rates per province suggest a higher incidence in the southwest region, especially Cunene province with 6.1%, Cuando Cubango with 5.5% and Moxico with 4.0%. The provinces in the North of the country

represent the lowest HIV prevalence rates, with Zaire registering 0.5%, Cabinda 0.6% and Uíge 0.9%⁷. The provinces of Lunda Norte, Lunda Sul and Luanda are also highly affected, the latter being the most populated province in the country.⁸

National Response

Despite the context of civil war in Angola, the country has made numerous efforts to combat the HIV epidemic. However, as a result of the peace and political stability achieved in 2002, the Angolan State adopted decisive legislative measures to strengthen the national response against HIV. For example, the Regulation on HIV/AIDS Employment and Vocational Training (Decree 43/03, of 4 July) establishes, defines and regulates workplace behaviour for the protection of workers in the context of HIV. Additionally, the law 8/04 on HIV/AIDS was enacted in 2004. This law urged the country to adopt urgent and effective measures aimed at both controlling and preventing HIV and promoting the protection of people living with HIV.

The Angolan State has also taken steps to strengthen the institutional framework for the national response to HIV and AIDS. In January 2003, the Government approved Decree 01/03 which establishes the National Commission to Fight HIV/AIDS and Large Endemics, under the chairmanship of the President of the Republic.⁹ The Commission is the coordinating and governing body for the fight against STDs, HIV, AIDS and Large Endemics, where the Minister of Health coordinates the National Technical Committee to Fight STDs, HIV, AIDS and Large Endemics. This institution was created due to the need to establish broader and more effective prevention, treatment and care initiatives, and the recognition that adequate

4 Funding request to the Global Fund, "Resilient and sustainable systems for health", Country Coordination Mechanism, Angola, 2019, pp. 6-7.

5 Ref. National Institute of Statistics (NIS), *et. al.*, 2017. *Survey of Multiple Indicators and Health in Angola 2015-2016*. Luanda, Angola and Rockville, Maryland, USA: INE, MINSA, MINPLAN and ICF, p. 247 segments.

6 José Carlos Van-Dúnem (Deputy Director General of INLS), in *Jornal de Angola*, 1 Dec. 2017.

7 IIMS p. 247

8 José Carlos Van-Dúnem (Deputy Director General of INLS), in *Jornal de Angola*, 1 Dec. 2017.

9 The presidency of this Commission has been delegated to the Vice President of the Republic. Presidential Order 93/11 delegates the Commission presidency to the Vice-President. Official State Gazette, Series 1, No. 234 of 6 December 2011

solutions for the various problems related to HIV, AIDS and major endemic diseases required a framework of reflection and multi-sectoral intervention. In addition, Decree 7/05 of March 2005 created the INLS. INLS is a central body of Ministério da Saúde (MINSA), with the mandate to implement Ministry policies to respond to STIs, HIV, AIDS and Viral Hepatitis.

To date, the country has adopted five national strategic plans for combating HIV and AIDS, the most recent being the “National Strategic Plan V for Responding to STDs/HIV-AIDS and Viral Hepatitis – Angola 2015 – 2018” (PEN V) and the subsequent National Strategic Plan (NSP) 2019 – 2022 has been finalised. These plans have been funded primarily by the Global Fund to fight AIDS, TB and Malaria (‘the Global Fund’), with complementary funding from the Angolan Government.

Health Sector in Angola

The National Health System is divided into the public, the for profit and non-profit and the traditional sector. However, the Ministry of Health maintains a prominent role in the definition and implementation of the health sector policy; in the promotion and execution of the Government health programmes, which aim for universal health coverage by 2025. The public sector is structured into the three hierarchical levels of the health administrative system: central, provincial and municipal. The public sector also covers the health services provided by the Angolan Armed Forces, the Interior Ministry, and public-owned companies such as Sonangol, Endiama among others. The private sector, under the supervision of the General Health Inspection Department, is concentrated in urban and peri-urban areas where the health service network is limited or non-existent. The traditional sector is not regulated.¹⁰

The Angolan Government has also made significant efforts to facilitate access to health services, including the construction and reconstruction of infrastructure and the decentralisation of the national health system, with an emphasis on the “municipalisation of health services”. However, there is concern regarding poor access to basic services, especially in rural areas due to, amongst other reasons, insufficient resources allocated to the health sector.¹¹

According to the proposal submitted by the Global Fund’s Country Coordination Mechanism despite significant improvement in the main global health indicators, the country still has high maternal, child and youth mortality rates; a high incidence of infectious and parasitic diseases, in particular HIV, TB and malaria; and persistent surges of cholera, rage and measles. While communicable diseases still account for more than 50% of registered deaths, an exponential increase in chronic, non-communicable diseases, fatal road accidents and physical violence is being reported.

The Plano Nacional de Desenvolvimento 2012-2025 (PDNS) [National Health Development Plan]- highlights that the problems faced by the National Health System are linked to limitations of human, material and financial resources and that these constitute a huge challenge for achieving the objectives of the plan itself. Among these challenges, the PDNS points to ongoing, insufficient health coverage and inadequate maintenance of health centres; the weak referral systems between the three different levels of the National Health Service; a lack of skilled human resources and health practitioners, poor distribution of personnel in rural and peri-urban areas; weaknesses in the Health Management System, including the information, logistics and communication system; insufficient financial resources, an inadequate funding model and limited access to safe drinking water, sanitation and energy.¹²

10 Funding request to the Global Fund, “Resilient and sustainable systems for health”, Country Coordination Mechanism, Angola, 2019, p.9.

11 CIERNDH – Angola in the Implementation of Economic, Social and Cultural Rights – issued by the Ministry of Justice and Human Rights, Luanda, 2017.

12 PDNS, 2012-2025, p. 22

The Protection of Human Rights in Angola

The Constitution of the Republic of Angola (CRA), 2010 recognises that constitutional and legal precepts regarding fundamental rights must be interpreted and integrated in accordance with the Universal Declaration of Human Rights (UDHR), the African Charter on Human and Peoples' Rights (ACHPR) and the treaties ratified by the Republic of Angola. Moreover, the Angolan Constitution provides that in the assessment of disputes by the Angolan courts relating to the matter of fundamental rights, the above-mentioned international instruments shall apply, even if not invoked by the parties.¹³ It should be noted that, to this day, Angola has submitted all required national human rights reports in terms of its treaty commitments within the United Nations (UN) system and the African Union (AU) system. In addition, Angola is currently a member of the Human Rights Council.

The courts are the sovereign body with jurisdiction to administer justice in Angola.¹⁴ The Attorney General's Office, through the agency of the Public Protector's Office, represents the State in prosecutions, the defence of the rights of natural and legal persons and the defence of legality in the exercise of judicial function, the investigation phase of proceedings and the enforcement of sentences. The Executive of the Ministério da Justiça e Direitos Humanos (MINJUSDH) [Ministry of Justice and Human Rights] is responsible for developing, implementing and monitoring justice policies and the promotion, protection and observance of human rights.¹⁵ There are still the Provincial Committees for Human Rights which are an inter-sectoral bodies mandated to implement the Executive's policies for the promotion and protection of

human rights and to prevent human rights violations at the local level.

In addition, the CRA 2010 establishes the institution of the Ombudsman as an independent public body whose purpose is to defend citizens' rights, freedoms and guarantees through ensuring the justice and legality of activities of the Public Administration.¹⁶ Citizens and legal persons may submit complaints for acts or omissions by public authorities to the Ombudsman, who assesses them and makes recommendations for preventing and remedying rights violations to the relevant bodies. The Ombudsman's activity is independent of the executive and judiciary. Organs and agents of the public administration have a duty to cooperate with the Ombudsman's Office in its functions.¹⁷

Angola does not have a national human rights institution (NHRI);¹⁸ however, the Ombudsman is in fact accredited with a broad mandate for monitoring human rights. The Angolan State has recognised as much in its response to the recommendations of the Human Rights Council regarding the need for an NHRI in accordance with the Paris Principles. As a result, the Ombudsman of Angola can act as an NHRI.

1.3 Key and Vulnerable Populations

Internationally, 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 laws or stigmatizing policies, systematic disenfranchisement, violence, social and economic marginalization

13 Art 26. CRA (Constitution of the Republic of Angola) 2010

14 Article 174 (1) and Article 177 of the CRA.

15 Article 1.1 Presidential Decree 77/18 of 15 March

16 Ref. Article 192 (1) of the CRA in conjunction with the provisions of Law No. 04/06, of 28 April (Organic Statute of the Ombudsman's Office).

17 Ref. Article 192, paragraphs 4 and 5 of the CRA.

18 Global Alliance of National Human Rights Institutions

and / or criminalization. They are among those most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere and they are key to the epidemic and key to the response. Key populations at higher risk also may be used more broadly, referring to additional populations that are vulnerable and most at risk of acquiring or transmitting HIV, regardless of the legal and policy environment. Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

Young key populations are young people aged 15 to 24 years who are members of key populations, such as young people living with HIV, young gay men and other men who have sex with men, young transgender people, young people who inject drugs and young people (18 years and older) who sell sex. Young key populations often have needs that are unique, and their meaningful participation is critical to a successful HIV response. Young key populations face additional legal and policy barriers to access to HIV, TB and SRH services as a result of their young age.

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.

According to the “Analysis Situation on Key and Vulnerable Populations” populations carried out by INLS in 2018,¹⁹ an increasing number of researchers have been proposing that, in cases of generalized epidemics (as is the case in Angola) socially marginalized population groups with specific risk factors for the acquisition and transmission of HIV, are considered relevant to understanding the dynamics of HIV. In Angola, sex workers (SW), men who have sex with men (MSM), transgender women (TG), people who use drugs, prison populations, adolescents and out-of-school youth, among others, are part of these groups. They face considerable obstacles in accessing HIV/SRH/TB prevention, treatment and health services.²⁰

There is limited data available on HIV and key and vulnerable populations in Angola, however data collection has recently improved.

Sex Workers

During the last few years data on sex work in Angola has increased. The Study on the Prevalence of HIV and other STD among Key Populations of Angola (PLACE Study 2017), for example, offers relevant quantitative epidemiological data and information on risk factors and behavioural issues. This study carried out in five provinces of the country (Luanda, Benguela, Bié, Cabinda and Cunene), estimates that sex workers comprise between 0.5 and 1.8% of the adult female population in the five provinces studied and 47% are young people aged 15-24. The HIV prevalence rate for SW was 12% in Bié, 8% in Luanda, 6% in

¹⁹ For the definition of key and vulnerable populations See Section F, Part III (using the WHO definition of 2016)

²⁰ See Analysis of the situation of key and vulnerable populations in relation to HIV in Angola, p.4, INLS 2018. However, PEN V presents the following as “population groups identified as vulnerable for all the interventions contained in the PEN V-AIDS”: PLHIV (people living with HIV/AIDS); children, AIDS orphans, very poor families and populations; women of childbearing age, especially pregnant women; adolescents and young persons in and out of school; homeless teenagers; serodiscordant couples (one has HIV and the other does not); co-infected individuals; sex workers, MSM and transsexuals; prisoners (Ref. MINSA, INLS, National Strategic Plan V for Responding to STD/HIV-AIDS and Viral Hepatitis – Angola 2015 – 2018, p. 72 and 73). In turn, the Testing Service Protocol makes distinctions between the Target Public, Priority Populations, Key Populations and Vulnerable Populations (Ref. MINSA, INLS, Testing Services for HIV – Protocol, 3rd Edition, Luanda, 2017, p. 16 and 17).

Cabinda, 5% in Benguela, and 5% in Cunene. However, data on male sex work is still lacking. Further detail on incidence, prevalence, structural drivers including law, human rights and gender are dealt with in a specific section of this LEA.

LGBTB+

The LGBTB+ community is led by ÍRIS-Angola,²¹ an association that promotes and engages the rights of the group as a whole, and subgroups of IRIS, e.g. the Divas (a subgroup of transgender women) and H Maiúsculo (a subgroup of men who have sex with other men). Advocacy around LGBTB+ policy issues have opened important spaces, demonstrated by the MINJUSDH's legal recognition of IRIS Angola and the criminalisation of discrimination based on sexual orientation in the new Penal Code in 2019. However, the excessively reserved culture within Angola, due to cultural, religious and traditional issues within Angolan society, hinders progress in enjoying these new freedoms. As a result, there is limited relevant data, information or studies on this important key population in Angola. Members of the LGBTB+ community face a range of barriers to their full participation in society, manifest through stigmatising attitudes that lead to identity conflicts and create barriers to access to education, employment and health care. According to the PLACE Study 2017, the prevalence of HIV and syphilis among MSM is 7% in Bié, 3% in Cabinda, 3% in Benguela, 2% in Luanda, and 2% in Cunene.

Inmates

There is limited, available data on HIV prevalence amongst inmates, nor studies or data identifying competing risk factors amongst inmates, e.g. drug use, sex work, sex between men. However, globally prisons are recognised as a high-risk environment for HIV transmission due to factors such as drug use and needle sharing, tattooing with homemade

and unsterile equipment, sex between men, rape, sexual abuse and sex bartering. During the fieldwork carried out for this study, it was found that prisoners have knowledge of HIV, its prevention, treatment and care. However, there are weaknesses in access to prevention and treatment services in all penitentiary units. For example, at present, no condoms are allowed into Angolan prisons, while the National Strategy for Key and Vulnerable Populations (INLS 2018), considers inmates a vulnerable population to be prioritised in HIV/ TB/ SRH service provision.

People who use drugs

Globally, people inject drugs are at high risk of HIV exposure, particularly as a result of sharing needles however, this is reinforced through criminalisation, marginalisation, discrimination, harsh law enforcement practices and poverty. There is limited information available on people who use drugs in Angola. Nonetheless, key informants interviewed for this study emphasised that drug use is being observed in the more affluent parts of the country. The National Strategy for Key and Vulnerable populations (INLS 2018) recognises the consumption of *liamba* (marijuana) and alcohol as risk factors for HIV, noting that people who use drugs for non-medical purposes are highly vulnerable to HIV exposure, particularly as a result of unsafe sex.

Adolescents and Young People

The other segment of the Angolan population that stands out for its high vulnerability to HIV is out-of-school adolescents and young people. Globally, around 3 million children and adolescents were living with HIV in 2017; 9 out of 10 of these were from sub-Saharan Africa. Adolescent girls and adolescents who are members of key populations are particularly affected. Worldwide, an adolescent girl (15-19) was infected every three minutes in 2017. Adolescent girls account for two out of every

21 Organisation that fights to defend the rights of sexual minorities.

three new HIV infections in the 15-19 age group. Adolescents girls and adolescent key populations tend to be the groups at most risk of contracting HIV. They are also least likely to have access to treatment.²² Different social and cultural factors affect their ability to access health services, including restrictions imposed by law, *e.g.* requiring proxy consent for HIV testing, and the lack of access to sexual and reproductive health information, education and services are some of the factors that increase their vulnerability.

1.4 Introduction to the Legal Environment Assessment (LEA) for HIV & TB

Many countries in the Southern African Development Community (SADC) region and worldwide have reported on how stigma, discrimination, punitive laws, police violence and ineffective access to justice continue to fuel the HIV epidemic. The report of the Global Commission on HIV and the Law (2012) and its Supplement (2018) focused on various aspects of the legal environment in the context of HIV and AIDS, including laws and practices that discriminate against people affected by and living with HIV; laws and practices that criminalise those living with HIV and those who are most vulnerable to it; laws and practices that support violence and discrimination against women; laws and practices that facilitate or prevent access to HIV-related treatment; and legal issues relating to children and young people in the context of HIV.²³ Following the Global Commission's conclusions and recommendations, a number of countries have undertaken a National Legal Environment Assessment (LEA) of laws, policies and practices affecting people living with HIV, key populations (including young key populations) and vulnerable populations, and society in

general, from the perspective of human rights and international and regional standards. LEAs help countries to identify gaps and challenges in their legal frameworks that increase vulnerability to HIV, in order to address these legal and policy barriers.

1.5 Purpose and Scope of the LEA

This LEA is general broad in scope, it examines the relevant laws, policies and plans in Angola and analyses how they relate to HIV and Human Rights. In other words, the LEA aims to review national laws, policies and practices to identify the gaps and challenges that hinder effective responses to HIV and TB from a human rights perspective. The identification of these legal barriers makes it possible to establish recommendations aimed at improving the domestic legal and policy environment in accordance with regional and international HIV, health and human rights standards.

The LEA focuses on those who live with and are affected by the epidemic, in response to the need to ensure adequate protection for key and vulnerable populations, including young key populations. It covers issues related to sex workers, the LGBT+ community (including men who have sex with men), prisoners, people who use drugs, children, adolescents, women, migrants, refugees, asylum-seekers and stateless persons. This also requires a detailed examination of related issues such as health care, discrimination (and stigma), access to justice, employment, social security, education and information.

In order to achieve its objectives, the *national legal environment assessment* covers:

1. A review of international, regional and national human rights obligations and commitments, particularly those relevant to HIV and AIDS;

²² <https://www.unicef.org/hiv> (accessed 28 October 2019).

²³ *Global Commission on HIV and the Law – Risk, Law and Health*, July 2012, New York. Available at: <<http://VIHlawcommission.org/index.php/report>>. Accessed on 11 January 2018.

2. A review of national laws or proposed laws, including, jurisprudence, regulations; policies and codes of conduct relevant to HIV, health and human rights;
3. A review of planning strategies and documents related to HIV, health and other areas and key populations at greater risk of HIV exposure, including national HIV strategic plans, national gender strategies, institutional frameworks, etc.; and
4. Research, reports and case studies related to legal and human rights issues in relation to HIV.

Thus, although the Assessment requires cross-disciplinary and multidisciplinary research, its scope is of an eminently legal nature.

1.6 Objectives

The LEA aims to identify and examine the strengths as well as challenges and gaps in the Angolan legal framework in the context of HIV and make recommendations in line with international and regional HIV and human rights standards. The LEA process examines how these laws, policies and strategies are implemented in Angola and determines the extent to which the legal framework protects rights and promotes a legal environment conducive to the national response to HIV, particularly for people living with and affected by HIV, or the extent to which it creates barriers to access to HIV-related healthcare. It also analyses the experiences of persons affected by and living with HIV.

1.7 Specific objectives

1. To identify and examine all significant rights issues, in particular, human rights affecting people living with HIV and TB, vulnerable and key populations, including young key populations;
2. To determine the extent to which the current legal framework and national policies and strategies protect rights and/or act as a barrier to accessing HIV-related services, particularly for young key populations;

3. To form the basis for recommendations and action planning regarding the review, implementation and enforcement of HIV laws, policies and regulations, as well as measures to improve access to justice and the enforcement of HIV and related laws.

1.8 Main Deliverables

The main tasks of the LEA were:

- a. **Inception Report:** Provided guidance to the entire assessment process and established a clear plan of action for carrying out the assessment activities of the national LEA, e.g. document review, group discussions, interviews with key informants, the national dialogue and meetings of the Technical Working Group (TWG).
- b. **Desk Review Report:** A report on the review of all applicable laws, plans, strategies and documents in the country related to HIV and AIDS. The review includes international human rights law, especially relating to sexual and reproductive health and rights, including for key populations, including young key populations, and vulnerable populations.
- c. **Fieldwork Report:** this is the outcome of the interviews, consultation and focus group discussions with key populations and stakeholders comprising state institutions (Parliament, Courts, Attorney General, Ministerial Departments), CSOs, international governmental and non-governmental organisations and donors, among others.
- d. **Consolidated Report:** this, merges and reconciles the results of the desk review and the fieldwork. It contains an assessment of the current legal framework, identifies successes, gaps and challenges and makes preliminary recommendations.
- e. **Report of the Consultation Workshop:** this contains the consensus on the preliminary findings and recommendations for relevant stakeholders who have participated and are affected by the LEA.

- f. **Final Report:** this contains the final results of the LEA. It is based on the outcome of the entire consultative process.

1.9 Technical Approach

The Angolan LEA takes a health, HIV and human rights approach in line with international and regional commitments and standards. In order to understand the burden and impact of HIV and AIDS in Angola, it examines the political, social, cultural, economic, and legal context of Angola, looking at issues such as equality and non-discrimination, the criminalisation of HIV, access to justice and the protection of people living with HIV, key populations, including young key populations, and vulnerable people. This approach was the basis for developing the tools used to carry out the LEA.

The Assessment was guided by human rights characteristics such as the universality, interdependence, interrelation and indivisibility of human rights. It has also been guided by human rights principles such as the principle of equality and non-discrimination; the principles of participation and inclusion of right holders, and capacity-building and accountability. Particular attention was paid to the right to health, including sexual and reproductive health and rights.

1.10 Research Methodology

Based on a literature review, the LEA discusses the response to HIV to mitigate the direct and indirect effects of the epidemic. A comparative analysis of all national, regional and international legislation identified strengths, gaps and shortcomings to the national response and proposed solutions, including measures to improve access to justice and law enforcement for all affected persons.

The LEA was also based on a set of interviews, consultations, focus group discussions and questionnaires with interested parties.

Their valuable information, based on their experiences and knowledge, supported the analysis and solutions for an appropriate legal framework to protect and promote human rights.

Desk Review

The desk review included:

- a. Review and analysis of different sources of human rights, both United Nations' sources as well as African Union (AU) documents e.g. human rights treaties, general comments made by treaty bodies as well as those of special mechanisms such as special rapporteurs, Universal Periodic Reviews (UPRs) and recommendations made by various human rights mechanisms (both within the United Nations and at the level of the African Union)
- b. Review and analysis of SADC instruments on human rights, HIV and AIDS
- c. Review and analysis of the different international health standards developed by institutions such as WHO, UNAIDS and OHCHR.
- d. Comprehensive analysis of the Report of the Global Commission on HIV and the Law (2012) and its Supplement (2018)
- e. Analysis of the Constitution of the Republic of Angola (2010)
- f. Review and analysis of common laws, regulations and other national legislation relevant to HIV and AIDS;
- g. Review and analysis of national plans, policies and strategies relevant to the response to HIV and AIDS
- h. Review and analysis of relevant studies and statistical data available
- i. Review and analysis of other Legal Environment Assessments in the southern Africa Region.

Focus Group Discussion (FGD)

Based on the results obtained in the documentary analysis, focus group discussions (FGDs) were held in three provinces of the

country, namely, Luanda, Bié and Benguela. This selection was based on the availability of data, health infrastructure and the relevance of the provinces. The aim of these discussions was to obtain qualitative data about the different population groups involved, specifically young key populations and on specific topics, such as the availability, accessibility and quality of health services; stigma, discrimination and equality; gender violence and police violence; the use of criminal law; access to justice, including the application and enforcement of law, education and access to information. The FGDs helped to obtain qualitative information on the lived experiences of people in relation to law enforcement and the implementation of plans, policies and strategies in the country, as well as practices surrounding the interaction between society (and its members), HIV and the state. Meetings were also held between different public institutions, through the HIV focal points in different ministerial departments and health service providers. For these discussions, surveys and informed consent forms were prepared.

Key Interviews

Interviews were developed to obtain qualitative information on human rights and national response mechanisms for the disease. These were carried out with specific State institutions, e.g. members of the National Assembly (Parliament), members of various ministerial departments, such as the Ministry of Health, the Ministry of Justice and Human Rights, the Ministry of the Interior (specifically prisons), and the Ministry of Youth and Sports. Interviews were also carried out with protected bodies such as the INLS and the National Institute for the Fight against Drugs (INALUD). Interviews were conducted with civil society organisations and groups, particularly with organisations of people living with HIV. Interviews were conducted with members of the United Nations family, including UNAIDS, UNFPA and UNHCR, among others.

Joint Consultative Dialogues

Four joint dialogues were held, three at the provincial level (Luanda, Bié and Benguela) and one at the national level (a final consultative workshop) with the participation of members of government, civil society and key populations, including young key populations. The purpose of these dialogues was to verify the degree of consensus between rights-holders and duty bearers and to build consensus on alignments to improve the country's legal and policy framework and to identify priorities for achieving that goal.

1.11 Limitations

The most significant limitations of the LEA were:

- Delays caused by serious difficulties in accessing legislation and other secondary sources such as national and sectoral plans, policies and strategies and limited specific sources on HIV and the law.
- Limited availability of legal commentary relating to the Constitution of the Republic.
- Limited availability of jurisprudence.
- Limited availability and accessibility of research reports on the nature and extent of HIV in Angola and the extent of stigma and discrimination.
- Lack of socio-behavioural studies on key (young) populations and vulnerable populations.
- The development of the questionnaire without any comprehensive practical process to pre-test it amongst potential respondents; this meant that interviewees may have understood the use of technical language differently to the way in which it was intended. It is not known to what extent this has affected the results.
- To gain knowledge on the practical experiences of key populations, Interviews were limited to only three of the country's eighteen provinces, namely Bié, Benguela and Luanda.

- The delays caused by the general elections, resulting in the renewal of Members of Parliament and the restructuring of the Executive (held in August 2017).
- The delays caused by the reform of the Penal Code (approved in January 2019).

1.12 The LEA Report

The Report comprises four parts and an Executive Summary summarising the main strengths, gaps and challenges of the legal environment in Angola in relation to HIV and AIDS. The Executive Summary also sets out the main recommendations of the assessment.

Part I, this section, presents an overview of the report, including its general and specific objectives and the methodology used to carry out the report. This Part also discusses Angola's national response to the HIV epidemic.

Part II is devoted to the international, regional (including the SADC subregion) and constitutional frameworks in relation to human rights, freedoms, constitutional rights and guarantees, and HIV and AIDS. In this part, all international laws, different international standards and benchmarks for health developed by institutions such as WHO, UNAIDS, OHCHR and the standards of the Angolan Constitution are analysed.

Part III contains a thorough examination of the situation in the country regarding HIV, TB, SRH and human rights, focussing on young key and vulnerable populations, with a special focus on issues such as equality and non-discrimination, health rights, criminalisation of key populations and social protection of key and vulnerable populations, with a special focus on children, adolescents, women, refugees, asylum seekers and stateless persons. This part is divided into thematic sections either by population groups, or by the different subjects covered. Each section ends with recommendations on how to improve the legal and policy environment. The last section is devoted to access to justice.

Part IV of the report provides general conclusions and addresses the recommendations made in the report.

Part II:

International, Regional and National Human Rights Framework

2.1 Introduction

This section of the report presents the relevant legal framework for HIV based on international and regional standards (including the sub-regional SADC framework) on human rights, and further examines the Angolan constitutional framework relevant to HIV and AIDS. This chapter goes on to analyse Angolan constitutional law in order to describe its constitutional freedoms, rights and guarantees and their interaction with international human rights law. The analysis seeks to identify the norms and standards that govern the international and national response to HIV and AIDS. These standards are examined in further detail in specific sections of Part III.

2.2 Human rights-based response to HIV

Human rights are closely linked to HIV, and its impact on both individuals and communities throughout the world. Human rights, inequality, limited access to enjoyment of fundamental rights and rights violations, have played a significant role in the spread of new infections of HIV. The Office of the United Nations High Commissioner for Human Rights (OHCHR)²⁴ has highlighted that the link between human rights and HIV and AIDS is particularly visible in three areas:

1. **Vulnerability:** Certain groups are more vulnerable to HIV exposure because they are unable to exercise their civil, political, economic, social and cultural rights.
2. **Discrimination and stigma:** The rights of people living with HIV are often violated because of their presumed or known HIV status, leading people to suffer both the burden of the disease as well as the consequent loss of other rights.

3. **Effective response:** Strategies to deal with the epidemic are hindered in an environment where human rights are not respected.

According to UNAIDS, in the history of the HIV response, there has been a growing consensus among governments, UN agencies, donor institutions and civil society that human rights are critical to an effective response to HIV.²⁵ A human rights-based HIV response states that wherever individuals and communities are able to exercise their rights, the impact of the epidemic at both individual and community level is reduced. The existence of a favourable (supportive) environment for people affected by HIV, including key and vulnerable populations, encourages individuals to seek health care services, such as HIV testing, treatment, psychosocial support and care. **Favourable legal environments** are essential for **preventing the spread** of HIV and **mitigating the social and economic impact** of the pandemic.

The UNGASS “Political Declaration on HIV and AIDS: On the fast track to accelerating the fight against HIV and to ending the AIDS epidemic by 2030”²⁶ is particularly significant in highlighting the central role of human rights in responses to HIV. The Declaration reaffirms that “the promotion, protection and respect for human rights and fundamental freedoms for all, including the right to development, which are universal, indivisible, interdependent and interrelated, must be integrated into all HIV and AIDS policies and programmes”.²⁷ The Declaration calls for “leadership and commitment shown in all aspects of the response to HIV/AIDS by governments, United Nations agencies and relevant regional and sub-regional bodies, as well as people living with HIV, at risk of contracting it and affected by it, community leaders and political leaders, parliamentarians, communities, families, religious organisations, scientists, health

24 Available at: <https://www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx> checked 19.08.2018

25 “Sustaining the Human Rights Response to HIV” UNAIDS 2015, p.7

26 Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and Ending the AIDS Epidemic by 2030 UNGA A/RES/70/266 of 22 June 2016 paragraph 70, *See also* Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. UNGA A/RES/65/277 of 11 July 2011, paragraphs 39, 11, 53, 78, 83

27 Political Declaration 2016, paragraph 7

professionals, donors, the philanthropic community, the workforce, the private sector, the media and civil society, including women and community organisations, feminist groups, youth-led organisations, national human rights institutions and human rights defenders”.²⁸

The Political Declaration (2016) emphasises Agenda 2030 for Sustainable Development and the Sustainable Development Goals (SDGs),²⁹ referring to Agenda 2030 as an opportunity to intensify action and reformulate State approaches to AIDS. Important commitments within the Declaration include:

1. To promote laws, policies and practices to enable access to services and to end HIV-related stigma and discrimination³⁰
2. To engage and support people living with, at risk of contracting, and affected by HIV, as well as other stakeholders in the AIDS response.³¹

Despite considerable efforts, human rights violations continue to occur, even where countries establish protective legal frameworks and, in some cases, even where there are specific anti-discrimination HIV laws. This may be due to a number of reasons, e.g. a lack of knowledge or understanding of how human rights relate to HIV and AIDS, a lack of human or financial resources to implement and enforce rights and limited access to justice in affected countries, amongst other things.³² What has been reiterated, however, is that efforts to eliminate HIV to date have proved more effective when they were based on the protection of human rights and respect for human dignity within national law,³³ and a recognition of the indivisibility, interdependence and interrelationships between all human rights.

Human Rights Relevant to HIV and AIDS include:³⁴

- the right to life;
- the right to liberty and security of the person;
- the right to work;
- the right to equal access to education;
- the right to an adequate standard of living;
- the right to social security, care and welfare;
- the right to be free from torture or cruel, inhuman or degrading treatment or punishment
- the right to the highest attainable standard of mental and physical health;
- the right to non-discrimination, equal protection and equality before the law; the right to freedom of movement;
- the right to benefit from scientific progress and its applications;
- the right to participate in public and cultural life;
- the right to seek and enjoy asylum;
- the right to privacy;
- the right to freedom of expression and opinion and the right to freely receive and transmit information;
- the right to freedom of association;
- the right to marry and have a family;

28 *Idem.* paragraph 30

29 *See* for example, Political Declaration (2016) paragraphs 1, 3, 9, 32, 58, 59(d), 63(b), 77

30 *Idem.*, paragraphs 63(a)-63(g)

31 *Idem.*, paragraphs 64(a)-64(i)

32 Practical Handbook, Assessment of the Legal Environment for HIV. UNDP. 2014, p. 12

33 13th Human Rights Council A/HRC/32/25 of 26 April 2016, paragraph 35

34 Available at: <https://www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx> visited Office of the United Nations High Commissioner for Human Rights 19.08.2018. These rights are all enshrined in the international human rights regime.

2.3 International, Regional and Sub-regional Human Rights Framework for Angola

2.3.1 United Nations

In 1948, the United Nations General Assembly adopted the Universal Declaration of Human Rights (UDHR) as an expression of the common aspirations of the human family. This manifesto proclaims a common universal standard to which all mankind must strive. It is one of the most important pronouncements of the 20th century, since it constitutes an indispensable source of inspiration for the respect and protection of the individual at a universal level.

Although the UDHR has not been adopted as a binding instrument of international law, it has a significant influence on the formation of international standards. For example, Article

25.1 of the UDHR, states that “everyone has the right to an adequate standard of living for their **health** and **well-being** and for their family, in **particular** as regards food, clothing, housing and **medical care** and necessary social services, and they have the right to **security** in respect of unemployment, **sickness**, **invalidity**, **widowhood**, **old age** or **other loss of means of subsistence due to circumstances beyond their control**.”³⁵

In addition to the UDHR, there are nine international human rights instruments that are considered **fundamental** and binding for Member States. Each of these instruments establishes a Committee, composed of experts, to monitor the implementation of the provisions of the respective treaty by its Member States. Some of the Treaties are complemented by Optional Protocols dealing with specific themes or establishing treaty monitoring mechanisms e.g. Complaints and Inquiries.

The following are the nine main Human Rights treaties and the ratification status of Angola:³⁶

Instrument	Ratification Status
<i>International Covenant on Civil and Political Rights</i> ³⁷ , 1966, ICCPR <ul style="list-style-type: none"> • Optional Protocol to the ICCPR • Second Optional Protocol to the ICCPR on the Abolition of the Death Penalty 	Accession 10 January 1992 Acceptance 10 January 1992 Ratification 2 October 2019
<i>International Covenant on Economic, Social and Cultural Rights</i> ³⁸ , (1966), ICESCR <ul style="list-style-type: none"> • 1st Optional Protocol to the ICESCR 	Accession 10 January 1992 NOT signed
<i>Convention on the Elimination of All Forms of Racial Discrimination</i> , 1969 <ul style="list-style-type: none"> • Individual complaints on the Convention on the Elimination of All Forms of Racial Discrimination 	Ratification 2 October 2019 NOT signed
<i>Convention on the Elimination of All Forms of Discrimination Against Women</i> ³⁹ , 1981 <ul style="list-style-type: none"> • Optional Protocol to the Convention Against All Forms of Discrimination Against Women, • CEDAW Inquiry Implementation Procedure 	Accession 17 September 1986 Acceptance 1 November 2007 ⁴⁰ Acceptance 1 November 2007 ⁴¹
<i>Convention against Torture and Other Cruel, Inhuman or Degrading Treatment</i> , 1987 <ul style="list-style-type: none"> • Optional Protocol to the Convention against Torture • Individual Procedures on the Convention against Torture • Survey on the Convention against Torture 	Ratification , 2 October 2019 Signed , 24 September 2013 NOT signed NOT signed

34 Available at: <https://www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx> visited Office of the United Nations High Commissioner for Human Rights 19.08.2018. These rights are all enshrined in the international human rights regime.

35 Emphasis added.

36 Article 13 CRA 2010 establishes the relationship between international law and domestic law. This constitutional precept is complemented by the Law of Treaties (Law No. 4/11)

37 Adopted by Resolution AN No. 26-B/91 of 27 December 1991

38 Adopted by Resolution AN No. 26-B/91 of 27 December 1991

39 Adopted by Resolution AN No. 15/84 of 19 September 1984

40 Adopted by Resolution AN No. 23/07 of 23 June 2007

41 Adopted by Resolution AN No. 23/07 of 23 June 2007

Instrument	Ratification Status
<i>Convention on the Rights of the Child</i> ⁴² , 1990 <ul style="list-style-type: none"> Optional Protocol to the Convention on the Rights of the Child Involved in Armed Conflict⁴³ Optional Protocol to the Convention on the sale of Children, Child Prostitution and Pornography⁴⁴ Optional Protocol to the Convention on the Rights of the Child, relating to complaints 	Ratification 5 December 1990 Accession 11 October 2007 Accession 24 March 2005 NOT signed
<i>International Convention for the Protection of the Rights of Migrant Workers and Members of Their Families</i> , 2003 <ul style="list-style-type: none"> Individual complaints on the Convention on the Protection of the Rights of Migrant Workers and Members of Their Families 	NOT signed NOT signed
<i>Convention on the Right of Persons with Disabilities</i> ⁴⁵ , 2008 <ul style="list-style-type: none"> Optional Protocol to the Convention on the Rights of Persons with Disabilities -complaints⁴⁶ Procedures and Inquiry, relating to the Implementation of the Convention on the Rights of Persons with Disabilities 	Accession 19 May 2014 Accepted 05 March 2013 Accepted 05 March 2013 ⁴⁷
<i>Convention for the Protection from Forced and Involuntary Disappearance</i> , 2010 <ul style="list-style-type: none"> Individual complaints on the Protection of Persons and Forced Disappearance Inquiry into the procedure concerning the Convention on Forced and Involuntary Disappearance 	Signed 24 September 2014 NOT signed NOT signed

Other Relevant Human Rights Instruments in the context of this assessment include:⁴⁸

Refugees and Stateless Persons

- Convention Relating to the Status of Refugees, (1951)⁴⁹
- Protocol Relating to the Status of Refugees, (1967)⁵⁰
- Convention relating to the Status of Stateless Persons, (1954)⁵¹
- Convention on the Reduction of Statelessness, (1961)⁵²

Development

- Declaration on the Right to Development
- Sustainable Development Goals (SDGs)

Drugs

- Single Convention on Narcotic Drugs (1961) and the 1972 Protocol thereto⁵³
- 1971 UN Convention on Psychotropic Substances,⁵⁴ (1971)
- 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, (1988)⁵⁵

42 Adopted by Resolution AN No. 20/90 of 10 November 1990

43 Adopted by Resolution AN No. 21/02 of 13 August 2002

44 Adopted by Resolution AN No. 21/02 of 13 August 2002

45 Adopted by Resolution AN No. 01/13 of 11 January 2013

46 Adopted by Resolution AN No. 01/13 of 11 January 2013

47 Adopted by Resolution AN No. 01/13 of 11 January 2013

48 The list presented here is not exhaustive. For a more exhaustive list consult the OHCHR website: available at: <https://www.ohchr.org/EN/ProfessionalInterest/Pages/UniversalHumanRightsInstruments.aspx>. Last visited on 21.08.2018

49 UNTC, 23 June 1981 (*accessed*)

50 UNTC, 23 June 1981 (*accessed*)

51 UNTC, 7 October 2019 (*accessed*)

52 UNTC, 7 October 2019 (*accessed*)

53 Approved by Resolution AN No. 17/99 of 30 July (*accessed*)

54 Approved by Resolution AN No. 18/99 of 30 July (*accessed*)

55 Approved by Resolution AN No. 19/99, of 30 July (*accessed*)

Prisoners

- United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)⁵⁶
- United Nations Rules for the treatment of female prisoners and non-custodial measures for female offenders (Bangkok Rules)
- United Nations Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules)
- United Nations Standard Minimum Rules for the preparation of non-custodial measures (Tokyo Rules)

International Organisations

There are also a number of specific international recommendations and guidelines for managing HIV and AIDS, including:

- The recommendations of the Global Commission on HIV/AIDS and the Law (GCHL) (2012) Risks, Rights & Health
- The GCHL (2018) Supplementary Report
- The UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights
- The WHO (2016) Consolidated Guidelines on prevention, diagnosis, treatment and care for key populations
- The WHO (2014) Technical Note for the prevention, diagnosis, treatment and care of HIV for key populations

- The SADC (2018) Regional Strategy for the Prevention, Treatment and Care of HIV and Sexual and Reproductive Health Rights among Key Populations
- The Southern African Development Community Parliamentary Forum (SADC PF) Model Law on HIV in Southern Africa, 2008.

Human Rights Bodies

The Human Rights Council sponsors a number of mechanisms, e.g. the Universal Periodic Review, the Special Procedures of the Human Rights Council⁵⁷ and the Human Rights Council Complaint Procedure⁵⁸.

Universal Periodic Review

The Universal Periodic Review (UPR) is a unique process that involves a review of the human rights situation within all United Nations Member States.⁵⁹ So far, Angola has had two such reviews.⁶⁰ The UPR recommendations for Angola (2nd cycle of the UPR) contain specific mention of HIV and AIDS:

- *"Promote and develop the national HIV plan" (Lebanon);*⁶¹
- *"Continue efforts to improve health care, especially for children and the elderly, as well as those suffering from HIV" (Santa Sé);*⁶²
- *"Further strengthen efforts to combat discrimination, in particular with regard to children with disabilities, children living with HIV/AIDS and San children" (Israel);*⁶³

⁵⁶ Angola has pledged to adhere to these rules according to its Voluntary Commitments, expressed in its candidacy for member of the Council of Human Rights 2018-2022. Doc. A/72/79, paragraph 6; 26 April 2017

⁵⁷ The Special Procedures of the Human Rights Council are independent experts on human rights with mandates to report and advise on human rights from a thematic or country-specific perspective. OHCHR website: <https://www.ohchr.org/EN/Pages/Home.aspx> under Human Rights Bodies. 19.08.2018

⁵⁸ The complaints procedure deals with communications sent by individuals, groups or non-governmental organisations who claim to be victims of human rights violations or who have a direct and reliable knowledge of such violations. OHCHR website: <https://www.ohchr.org/EN/Pages/Home.aspx> under Human Rights Bodies. 19.08.2018

⁵⁹ See A/RES/60/251, paragraph 5 (e) (United Nations General Assembly in conjunction with A/HRC/RES/16/21 of the Human Rights Council).

⁶⁰ The 2nd Universal Periodic Review of Angola was held during the 20th Session of the Working Party on 29 October 2014. During the interactive dialogue, 101 delegations made statements that resulted in a total of 226 recommendations, of which 192 were accepted and 34 were left for later responses to the Human Rights Council. These pending recommendations were "annotated" and answered by Angola at a later date. The recommendations were analysed in the Working Group on 30 October 2014 and adopted in the Plenary on 19 March 2015. See A/HRC/28/11 "Report of the Working Party on the Universal Periodic Review"; A/HRC/28/11/Add.1 "Report of the Working Party on the Universal Periodic Review, Angola. Opinions on conclusions and/or recommendations, voluntary commitments and responses submitted by the State that are under review." See also "Angola, Periodic and Universal Assessment. Main Documents of the First and Second Cycles 2010-2015". Ministry of Justice and Human Rights. Republic of Angola. 2016.

⁶¹ A/HRC/28/11, paragraph 134,162

⁶² *Idem.*, paragraph 134,158

⁶³ *Idem.*, paragraph 134.66

Recommendations concerning other rights, such as the right to health, education, women's rights, children, access to justice, include, among others:

- *"Continue efforts to increase women's access to employment, public life, education, housing and health through full participation in the political, economic, social and cultural fields"* (Ecuador);⁶⁴
- *"Allocation of additional efforts and resources to improve the country's health system"* (Turkey);⁶⁵
- *"Continue to improve infrastructure and public services, especially medical and educational facilities in rural areas"* (Thailand);⁶⁶
- *"Continue implementing the municipal health service programme and the national development programme 2012-2015"* (Dominican Republic);⁶⁷

Relevant Special Procedures which may support protection of rights in the context of HIV include the following:

- Special Rapporteur on the rights of persons with disabilities;
- Special Rapporteur on the right of all to enjoy the highest attainable standard of physical and mental health;
- Special Rapporteur on the human rights of migrants;
- Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity;
- Special Rapporteur on violence against women, its causes and consequences;

Bodies established by the United Nations Treaties on Human Rights

Human rights treaties have also established various bodies to give life to the applicability and effectiveness of human rights. *e.g.* Human Rights Committee (established by the ICCPR)

and the Committee on Economic, Social and Cultural Rights (established by the ICESCR).

One of the main obligations of State Party to the Human Rights Treaties is to report periodically to these committees on the national human rights situation in relation to treaty provisions. The recommendations made to the State by the different Committees are an essential mechanism for the effective realisation of human rights in the country. These observations are complemented by those made through the Special Procedures of the Council of Human Rights. **Both mechanisms are not only supplementary but also mutually reinforcing.**

It should be noted that Angola has submitted all of its reports to the different Human Rights Committees. The national reports of the Republic of Angola are prepared by the Inter-sectoral Commission for the Preparation of National Reports on Human Rights. This commission was created by Presidential Order No. 29/14, of 26 March, and is coordinated by the Ministry of Justice and Human Rights.⁶⁸ It is composed of several Ministries, including the Ministry of the Interior; Media; Social Action, Family and Empowerment of Women; Education; **Health**; Culture; National Institute of Statistics. In the process of reporting, the Commission has always consulted civil society.

2.3.2 African Human Rights System

The African system responds to global human rights standards and reconciles these with the African context. For instance, one of the distinctive features of the African human rights system is the African Charter's emphasis on collective, as well as individual human rights, so-called third-generation rights such as the right to peace, the right to solidarity, the right to a healthy environment and, above all, **the right to development.**

64 *Idem.*, paragraph 134.70

65 *Idem.*, paragraph 134,163

66 *Idem.*, paragraph 134,139

67 *Idem.*, paragraph 134,156

68 The Inter-Sectoral Commission for the Preparation of National Reports on Human Rights was created by Resolution 121/09 of 22 December and its coordination was entrusted to the Ministry of Foreign Affairs with the assistance of the Ministry of Justice. Currently, it is coordinated by the Ministry of Justice and Human Rights, according to Presidential Order No. 29/14, of 26 March.

Regional Instruments

Instrument	Ratification Status
African Charter on Human and Peoples' Rights, ⁶⁹ (1981)	Ratified
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, ⁷⁰ (2003)	Ratified
African Charter on the Rights and Welfare of the Child, ⁷¹ (1990)	Ratified
Protocol to the African Charter on Human and Peoples' Rights on the Establishment of the African Court on Human and Peoples' Rights, (1998).	Ratified
African Charter on Democracy, Elections and Governance, (2011)	NOT signed
AU Convention Governing Specific Aspects of Refugee Problems in Africa, ⁷² (1969)	Ratified

Regional Mechanisms

Article 30 of the African Charter on Human and Peoples' Rights states that: "An African Commission on Human and Peoples' Rights (...) is hereby established together with the Organisation of the African Union." The main functions of the Commission are the implementation and interpretation of the African Charter on Human and Peoples' Rights, as well as the protection and promotion of the rights established therein. Within this framework, Member States periodically report to the Commission on the human rights situation in their respective countries. Angola has reported periodically and is one of the few countries that has no reports outstanding. Angola presented the Sixth and Seventh Report on the Implementation of the African Charter on Human and Peoples' Rights and the Initial Report on the Protocol on the Rights of Women in Africa for the period 2012-2016. The Cumulative Report (6th and 7th) was considered by the Commission in May 2018. It is currently awaiting Conclusive Remarks/Recommendations from the Commission.

During the 2010-2012 cycle, the Commission made several observations and recommendations to Angola:⁷³

- *"The African Commission is concerned about the 30% reduction in 2009 in health sector spending and the fact that the overall health budget has fallen from 3.2% to 2.38%."*⁷⁴
- *"The [Angolan] Report does not indicate measures taken to ensure the access of women and adolescents to reproductive health and family planning services."*⁷⁵
- *"It does not provide any information on the prevalence of harmful practices and practices that affect women and young girls, nor does it refer to any measures taken by the Government to prohibit early marriages nor to protect the rights of widows in rural areas."*⁷⁶

The African Commission has made the following recommendations, among others:

- *"Take the necessary steps to ratify and domesticate the following regional issues and international legal instruments: a) The Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights (the Tribunal*

69 Adopted by Resolution AN No. 1/91, 19 Jan. 1991, filed 9 October 1990

70 Adopted by Resolution AN No. 25/07, 16 Jul 2007, filed 09 November 2007

71 Adopted by Resolution AN No. 1-B/92, 15 May 1992, filed on 7 October 1999

72 Filed on 3 December 1982

73 Concluding Observations and Recommendations on the 2nd, 3rd, 4th and 5th Periodic Reports (Cumulative) of the Republic of Angola. Adopted at the 12th Special Session of the African Commission on Human and Peoples' Rights held from 30 July to 4 August 2012 in Algiers, Algeria.

74 Paragraph 32. Concluding Observations and Recommendations on the 2nd, 3rd, 4th and 5th Periodic Reports (Cumulative) of the Republic of Angola

75 *Idem.*, paragraph 33.

76 *Idem.*, paragraph 33.

*Protocol), and make a declaration under Article 34 (6) to allow direct access of individuals and NGOs to the African Court on Human and Peoples' Rights.*⁷⁷

- *"Take all necessary measures to ensure the allocation of the necessary budget for the health sector."*⁷⁸
- *"Strengthen reproductive health programmes and policies to ensure greater access to family planning for women and adolescents."*⁷⁹
- *"Increase the number of health centres in order to reduce the high maternal and infant mortality rate, with emphasis on providing free, appropriate and affordable services to rural women and women of indigenous communities."*⁸⁰

Specifically, on HIV and AIDS, the African Commission recommended:

- *"Ensure free access to antiretroviral drugs, ensuring access to groups, specifically women, children and indigenous communities."*⁸¹
- *"Strengthen HIV/AIDS awareness programmes, in particular youth programme."*⁸²

Angola has responded to the observations and recommendations of the Commission in the 6th and 7th Periodic Reports (Cumulative)⁸³. The country responded to recommendation 30 on constraints and challenges in relation to HIV and presented the different strategies and programmes developed to combat the epidemic.⁸⁴

The African Commission on Human and Peoples' Rights also establishes special procedures. Of critical importance for HIV and AIDS is the Committee for the Protection of the

Rights of People Living with HIV (PLHIV) and those at risk, vulnerable to and affected by HIV.⁸⁵

2.3.3 Southern African Development Community

Angola is a member of the Southern African Development Community (SADC). Article 4 (c) of the SADC Treaty stipulates that "human rights, democracy and the rule of law" are guiding principles for the acts of its members. In addition, according to Art. 5.1 (i), one of SADC's objectives is to combat AIDS and other deadly and communicable diseases.

SADC has developed an HIV programme as well as various strategies, protocols and declarations relating to HIV and AIDS.⁸⁶ This includes the 2018 Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations, to which Angola adheres.⁸⁷ The guiding principles of the 2018 Regional Strategy deals with fundamental rights, especially the right to equality and non-discrimination, the right to health and the right to information. There are also principles relating to political commitment; effective partnerships, **respect for diversity**; participation, inclusion and equality, the use of quality data, and ultimately, to not cause harm to key populations. The strategy notes the need to identify the different barriers facing key populations in accessing health services related to HIV and SRH and identifies the following as **barriers: stigma and discrimination, violence, a lack of sufficiently**

77 *Idem.*, paragraph 41. III a)

78 *Idem.*, paragraph 41. XIV

79 *Idem.*, paragraph 41. XV.

80 *Idem.*, paragraph 41. XVI.

81 *Idem.*, paragraph 41. XXIX

82 *Idem.*, paragraph 41. XXX.

83 The report is available on the website of the African Commission on Human and Peoples' Rights: <http://www.achpr.org/states/angola/reports/6th-2011-2016/> last visited 21.08.2018

84 See paragraphs 95-98. The 6th and 7th Periodic Report (Cumulative), Available at: <http://www.achpr.org/states/angola/reports/6th-2011-2016/> last visited 21.08.2018

85 The Committee was established by the African Commission on Human and Peoples' Rights with the adoption of Resolution 163 at the 47th Ordinary Session, held in Banjul, Gambia, in May 2010.

86 Available on SADC website: <https://www.sadc.int/issues/hiv-aids/> last visited 21.08.2018

87 Most of the definitions adopted by this Strategy are based on the World Health Organisation's Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations.

protective legal and policy environments, a lack of data, and the lack of specific programmes, funds and services for key populations.

Another important guideline is the SADC PF Model Law on HIV and AIDS in Southern Africa, 2008. The Model Law provides a recommended rights-based legal framework for HIV in Southern Africa and is based on principles of non-discrimination, equality, respect for voluntary and informed consent to testing and treatment, confidentiality and non-disclosure. It deals with respect for rights in various contexts and for specific populations, including within the working environment, for children and young people, for women, for research participants and for key populations, amongst others.

2.4 Domestic Law (Republic of Angola)

The Constitution of the Republic of Angola 2010⁸⁸ (CRA 2010) establishes the freedoms, rights and guarantees for the people under the jurisdiction of the State. Art.1 of the Angolan Constitution establishes the fundamental principle that “Angola is a sovereign and independent republic, based on the **dignity of the human person** and the will of the Angolan people, whose fundamental objective is the construction of a free, **fair**, democratic, society of solidarity, peace, **equality and social progress**.”

CRA 2010 establishes a series of individual and collective rights and freedoms,⁸⁹ as well as their guarantees.⁹⁰ It also establishes a separate section devoted exclusively to economic, social and cultural rights and responsibilities.⁹¹

The State guarantees fundamental freedoms and rights in terms of the Constitution. This creates a mechanism to ensure compliance

Individual and collective rights and freedoms, CRA 2010

- Right to life;
- Right to personal integrity;
- Right to identity, privacy and intimacy;
- Right to Family, marriage and parentage; Freedom of assembly and demonstration; Freedom of association;
- Freedom of professional and business association;
- Freedom of union association
- Freedom of expression and information
- Freedom of conscience, religion and worship;
- Freedom of cultural and scientific creation;
- Freedom of the press;
- Freedom of residence, movement and emigration
- Right to strike; Participation in public life; Access to public office;
- Right of suffrage;
- Freedom of establishment of political associations and political parties
- Right to physical liberty and personal security;

by the state. According to the constitutional precept established in Art. 56 of CRA, 2010:

- *The State recognises as inviolable the fundamental rights and freedoms enshrined in the Constitution and creates the political, economic, social, cultural conditions, and conditions of peace and stability that guarantee their fulfilment and protection, in accordance with the Constitution and the law.*

⁸⁸ Constitution No. 2010/10; National Assembly “Constitution of the Republic of Angola, 2010” Official Gazette, Series 1, No. 23, of 5 February 2010

⁸⁹ Art. 30-55, CRA 2010

⁹⁰ *Idem.*, Art. 56-75

⁹¹ *Idem.*, Art. 76-88

- *All public authorities have a duty to respect and ensure the free exercise of fundamental rights and freedoms and the fulfilment of constitutional and legal duties*

The following guarantees of fundamental rights and freedoms are significant:

- **Restriction of rights, freedoms and guarantees** *i.e.* "The law may only restrict rights, freedoms and guarantees in cases expressly provided for in the Constitution, and the restrictions should be limited to that which is necessary, proportional and reasonable in a free and democratic society, in order to safeguard other constitutionally-protected rights or interests."⁹²
- **Limitation or suspension of rights, freedoms and guarantees** *i.e.* "The exercise of citizens' rights, freedoms and guarantees can only be limited or suspended in case of a state of war, siege or emergency, in accordance with the Constitution and the law."⁹³

According to CRA, 2010, other **fundamental guarantees** include:

Prohibition of the death penalty; **Prohibition of torture and degrading treatment**; Rights of detainees and prisoners; Deprivation of liberty; Limits of penalties and security measures; **Right of asylum**; Right to a fair and proper trial; **Right to petition, report, complaint and claim.**

Economic, social and cultural rights and duties are considered critical to responding to HIV. The CRA, 2010 guarantees socio-economic and cultural rights to persons under its jurisdiction, such as:

Right to work; **Right to health and social protection**; Right to education, culture and sport; Rights of the Child; Rights of Young People; Rights of the Elderly; Disabled citizens; Right to housing and to quality of life.

Article 77 on health and social protection, CRA, 2010 states that:

1. *The State promotes and guarantees the necessary measures for guaranteeing the right to medical and health care for all, as well as the right to care for children, pregnant women, incapacitated persons, disabled persons, the elderly and anyone in a situation of incapacity to work, under the law.*
2. *In order to guarantee the right to medical and health care, it is incumbent upon the State to:*
 - a. *Develop and ensure the functionality of a health service throughout the national territory;*
 - b. *Regulate the production, distribution, trade and use of chemical, biological, pharmaceutical and other methods of treatment and diagnosis;*
 - c. *Encourage the development of medical-surgical education and medical and health research.*
3. *The private and cooperative initiative in the fields of health, welfare and social security is overseen by the State and is exercised under the conditions provided for in law.*

Scope, Regime and Legal Force of Constitutional Rights, Freedoms and Guarantees:

The scope, legal regime and legal force of the Constitution's rights, freedoms and guarantees are regulated by Arts. 26, 27 and 28 of CRA, 2010. They provide that the fundamental rights established by the CRA, 2010 do not exclude others contained in the applicable

⁹² *Idem.*, Art. 57.1

⁹³ *Idem.*, Art. 58.1

⁹⁴ African Charter on Human and Peoples' Rights

laws and rules of international law. CRA, 2010 also provides that fundamental rights must be interpreted in accordance with the UDHR, the African Charter and international treaties on the subject, where ratified by Angola. Moreover, the Angolan courts are required to apply the UDHR, ACHPR and international instruments ratified by the country, in adjudicating on fundamental rights, even if these international treaties are not invoked by the parties. With regard to the legal regime of rights, freedoms and guarantees enshrined in the Constitution, it is important to emphasise that constitutional principles apply to the rights, freedoms and guarantees and to the fundamental rights of a similar nature established by the Angolan Constitution or recognised in law or in international convention.⁹⁵

Art. 28 of CRA, 2010 provides that: *(1) The constitutional provisions regarding fundamental rights, freedoms and guarantees are directly applicable and binding on all public and private entities, and (2) the State must adopt legislative initiatives and other measures appropriate to the progressive and effective implementation, according to available resources and economic, social and cultural rights.*

Legal framework for HIV and AIDS

Angola has a vast body of legislation which ensures a human rights framework for the legislative response to HIV consistent with international and regional norms. Despite significant advances in the ratification of international human rights treaties and broad constitutional protection of rights, freedoms and guarantees; gaps and challenges exist in the structure and implementation of human rights norms.

In addition to the constitutional human rights binding on the Republic of Angola, the most relevant national legislation is Law No. 8/04 on Human Immunodeficiency Virus – HIV and Acquired Immunodeficiency Syndrome

– AIDS.⁹⁶ However, this 2004 law presents several challenges, including:

- No special protection for key populations, including young key populations
- Insufficient provision for vulnerable populations.
- Prohibition of HIV testing for minors without consent of parents or designated person or authority proscribed by law.
- Lack of a specific competent authority to respond to complaints e.g. regarding discrimination, violence and access to health services.
- Need for provisions guaranteeing the right of association for key and vulnerable populations.
- Lack of express reference to the right to sexual and reproductive health.

While Law No. 8/04, other relevant laws, policies and programmes all contribute to create an effective structure for the country response to HIV, the lack of implementation of relevant laws and policies fails to adequately protect people affected by HIV.

⁹⁵ Art. 26 and 27, CRA 2010

⁹⁶ Law No. 8/04; National Assembly "On Human Immunodeficiency Virus – HIV and Acquired Immunodeficiency Syndrome – AIDS."; Official Gazette Series 1, No. 88, of 1 November 2004

Part III:

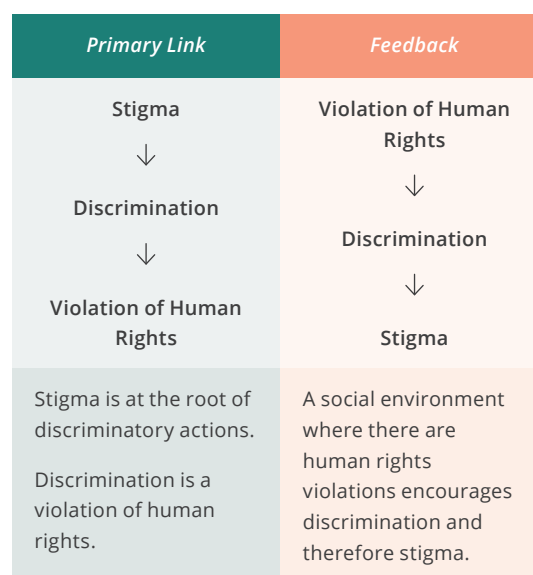
Analysis of Laws, Policies and Strategies in Angola

A. Equality and Anti-discrimination Laws

1. Analysis of the situation

This Section provides an analysis of the impact of national laws and public policies relating to HIV-based stigma and discrimination and HIV related diseases such as tuberculosis (TB), in relation to international and regional guidance.

Stigma is a dynamic process of devaluation that significantly discredits an individual in the eyes of others. With regards to HIV, mainly due to how the international AIDS response was initially carried out, perceived or actual HIV infection carries stigma. Stigma also affect marginalised individuals and groups such as those practicing sex work, drug use; men who have sex with men, transgender persons as well as prisoners. Stigma is powerful in the sense that it reinforces social inequalities based on gender, race, ethnicity, sexual orientation and gender identity. It drives discriminatory attitudes, behaviours, practices that ultimately reduce or deny access to services, access to justice or the human rights of others. Discrimination refers to any form of arbitrary distinction, exclusion or restriction that affects a person or group of persons according to their characteristics. In relation to HIV, discrimination occurs in various forms, in families and communities (isolation, verbal harassment, physical violence) as well as in institutional spaces (health services, schools, places of employment, prisons). From the perspective of HIV, discrimination consists of actions or omissions that derive from stigma and are directed towards those individuals who are stigmatised for being potentially or actually HIV positive or associated with HIV. As such, discrimination is a violation of human rights. Furthermore, a social environment where human rights violations exist tends to foster stigma and discrimination. The table below illustrates the reinforcing causal effects between stigma, discrimination and the violation of human rights.



As in many countries,⁹⁷ in Angola, HIV-related discrimination is based on stigma, which is fuelled by fear and misinformation about the virus and how it can be transmitted. Stigma also has its roots in the association of HIV with behaviours that are considered “bad” or “immoral” or not in line with the prevailing cultural and social norms in the country.⁹⁸

During the field work phase of this assessment, focus group discussions held with 150+ representatives of PLHIV and Key Populations demonstrated how much HIV-associated stigma and discrimination is a common life experience. The situation is compounded by the existence of punitive laws, recurrent of police violence against particular groups such as female sex workers. As such, ineffective access to justice and violations of fundamental rights related to HIV potentially contribute to the HIV epidemic and associated diseases such as TB. As elsewhere in the world, fear of stigma and expectation of discrimination leads to sections of the HIV affected population, particularly key and vulnerable populations, to avoid health services. Stereotypical behaviours and attitudes, stigmatising and discriminatory processes, and various forms of casual denigration of persons living with HIV and/or members of Key Populations have reduced

⁹⁷ Ref. UNDP, *Report on Assessment of the Legal Environment for HIV and AIDS in Lesotho – Final Report*, 2015, pp. 32-34; UNDP *et al.*, *Situation Analysis of Legal and Regulatory Aspects of HIV and AIDS in Seychelles – Final Report*, 2013, p. 44.

⁹⁸ Ref. United Nations Human Rights Council, *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)*, paragraphs 5 and 11.

their levels of self-esteem and potentially made individuals hide their HIV status. Their direct or indirect exclusion from social life further limits their access to health information, prevention, treatment and health care services.

A People Living with HIV Stigma Index study, which will adequately measure HIV-related stigma and discrimination, is yet to be undertaken in Angola. However, the 2015-2016 IIMS states that about one-third of men and women aged 15-49 revealed discriminatory attitudes towards people living with HIV.⁹⁹ Stigma and discrimination can negatively impact on access and adherence to HIV testing, care and treatment services. Reducing its prevalence is critical to the success of the HIV response.¹⁰⁰

2. International Standards

Human rights are rights inherent to all human beings, regardless of nationality, place of residence, sex, national or ethnic origin, colour, religion, language or any other status. All human beings are rights holders, without discrimination. The UDHR recognises that “All human beings may invoke the rights and freedoms set forth in this Declaration without any kind of distinction, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or any other status.(...)”¹⁰¹

Both the International Covenant on Economic, Social and Cultural Rights (ICESCR)¹⁰² as well as the International Covenant on Civil and Political Rights (ICCPR)¹⁰³ establish clauses prohibiting discrimination.¹⁰⁴ HIV-related stigma and discrimination violate the right to freedom from discrimination. In addition,

discrimination towards people living with HIV of affected by HIV leads to violations of other human rights.

The UN Commission on Human Rights has held that the prohibition of discrimination on various grounds, including the term “or any other status” (a term used in various human rights instruments) should be interpreted as covering health status, including HIV and AIDS.¹⁰⁵ This means that discrimination based on HIV status is prohibited by existing human rights standards. Additionally, the CESCR (Committee on Economic, Social and Cultural Rights) has clarified that the term “any other status” of Art. 2 of the International Covenant on Economic, Social and Cultural Rights should be interpreted to include health status, including HIV status.¹⁰⁶ The CESCR has also noted that “any other status”, recognised in Art. 2.2 of the Covenant, includes sexual orientation and gender identity.¹⁰⁷ Likewise, the CRC (Convention on the Rights of the Child) has explained that the general principle of non-discrimination in the CRC should be one of the “guiding themes” for responding to HIV and AIDS.¹⁰⁸

In terms of human rights, formal equality means that all individuals are treated equally. However, substantive equality allows for differential treatment. This latter dimension of equality establishes criteria for legitimate differentiation. In other words, to achieve substantive equality, positive discrimination is allowed. Positive discrimination, in turn, must meet certain requirements: it must be (a) reasonable; (b) objective; and (c) pursue a legitimate purpose.

In the context of sexual and reproductive health, ICESCR has reaffirmed that non-discrimination and equality go beyond legal

99 *Idem.*, p. 215.

100 Survey of Multiple Indicators and Health in Angola 2015-2016, cited, p. 218.

101 Art. 2 UDHR, *See also* Art. 7 UDHR

102 Art. 2 ICESCR, *See also* Art. 3 ICESCR

103 Art. 2 ICCPR, *See also* Art 3, Art. 26 ICCPR

104 Other Human Rights treaties that prohibit discrimination include: CDM, Art 5 CRPD (Convention on the Rights of Persons with Disabilities), ICERD (International Convention on the Elimination of All Forms of Racial Discrimination), ICCPED (International Convention for the Protection of All Persons from Enforced Disappearance)

105 Res. 1995/44 of 3 March 1995 and Res. 1996/43 of 19 April 1996, Commission on Human Rights

106 GC No. 14, CESCR, E/C.12/2000/4

107 CG 20 CESCR, paragraph 32. *See* Section on Key Populations

108 GC 3, CRC, CRC/GC/2003/3

and formal equality, requiring substantive equality. In other words, it is not enough to have “neutral” laws and policies that can perpetuate inequality; it is necessary to develop laws that address the distinct sexual and reproductive health needs of particular groups, as well as any barriers that these specific groups may face. Substantive equality requires rules that protect equality, mitigating the disadvantage inherent in specific groups.¹⁰⁹ In the case of multiple discrimination – that is, discrimination on various grounds – groups such as women, people with disabilities, migrants, adolescents, LGBT+ and people living with HIV are more likely to suffer multiple discrimination. This requires laws, policies and programmes, including temporary special measures, to prevent and eliminate discrimination, stigmatisation and negative stereotypes that hinder access to sexual and reproductive health, e.g. ensure access to sexual and reproductive information, health commodities and health care; ensure that individuals are not subjected to harassment for exercising their right to sexual and reproductive health; devote greater resources to traditionally neglected groups; ensure that anti-discrimination laws and policies are implemented in practice by public officials and others.

ICESCR committee has expressed its concern regarding the lack of comprehensive anti-discrimination legislation in Angola. It has recommended therefore, that the country adopt comprehensive anti-discrimination legislation covering all prohibited grounds of discrimination set out in Article 2 of the Covenant, including discrimination on the basis of “any other status”.¹¹⁰

The GCHL (2012) *Risks, Rights & Health* report recommends that countries should explicitly prohibit discrimination based on actual or suspected HIV status and ensure that existing human rights commitments as well as constitutional guarantees are put into practice.¹¹¹ It also recommended that countries enact anti-discrimination laws and regulations and that they ensure the participation, dissemination of information, and provision of health services to people living with HIV as well as those at risk of infection.¹¹² The GCHL (2018) *Supplementary Report* reaffirmed the 2012 recommendations¹¹³ and furthermore recommended extending anti-discriminatory policies to TB and Hepatitis.

The GCHL (2012) also recommends that countries review their approaches to sexual diversity. Instead of punishing adults who engage in a consensual homosexual relationship, countries should provide these people with efficient access to HIV and other health services.¹¹⁴ In order to achieve this, the Global Commission lays down a series of duties, highlighting the need to amend anti-discrimination laws to explicitly prohibit discrimination based on sexual orientation (as well as gender identity), amongst other things.¹¹⁵ With regards to key populations, the 2018 Supplement also recommends that governments adopt legal protections to prevent discrimination against people who use drugs.¹¹⁶

Guideline 5 of UNAIDS *International Guidelines* also deals with discrimination. It notes that “states should adopt or strengthen legislation to combat discrimination, or other legislation that protects vulnerable groups, people living with HIV and persons with disabilities from discrimination in the public and private sectors”¹¹⁷

109 GC 22, CESCR, E/C.12/GC/22, paragraph 23 *etc.*

110 OC of IV and V of the Angolan periodic report, E/C.12/AGO/CO/4-5, 15 July 2016, paragraphs 21 and 22

111 CGVD (2012), Recommendation 1.1, p. 21.

112 *Idem.*, Recommendation 1.2, p. 21.

113 Supplement to the Global Commission, Recommendation 1, p. 19

114 *Idem.*, Recommendation 3.3, p. 57

115 *Idem.*, Recommendation 3.3.4, p. 57

116 *Idem.*, Recommendation 10, p. 34

117 International Guidelines on HIV/AIDS and Human Rights. *See also* Guideline 9

At a continental level, the African Charter on Human and Peoples' Rights recognises that "Everyone has the right to the enjoy the rights and freedoms recognised and guaranteed by this Charter without any kind of distinction, such as race, ethnicity, colour, sex, language, religion, political opinion or any other opinion, national or social origin, property, birth or any other status."¹¹⁸ The Charter considers equality to be a right of all human beings.¹¹⁹ With regard to HIV, the AU called on African governments to allocate national resources to reflect their determination to combat the spread of HIV and ensure the protection of the human rights of those living with HIV in combating discrimination.¹²⁰ Res. 290 of the African Commission (2014) recognised the need to conduct a study on HIV, law and human rights, based on its concern that PLHIV continue to experience discrimination, stigma, prejudice and violence generated by their health status and harmful customary practices in the Party States. In addition, ACHPR Resolution 275 on the Protection Against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity calls upon state parties to stop violence and other human rights violations against LGBT+ persons.¹²¹

The SADC (2018) Regional Strategy for the prevention, treatment and care of HIV and SRHR among key populations identifies stigma and discrimination as one of the most significant barriers to key populations accessing health services.¹²²

3. Current situation in Angola

Equality and non-discrimination are enshrined in Art. 23 of the CRA, 2010, which provides that "all are equal before the Constitution and the law". This enunciate, lays down a general rule on equality and the prohibition of discriminatory treatment. These rules are reinforced by Articles 56 which provide a general guarantee of the protection of fundamental rights¹²³. The Constitution does not explicitly recognise a prohibition of discrimination based on sexual orientation and gender identity (SOGI) or HIV status. However, the new Penal Code (approved in January 2019) establishes a crime of "discrimination", which includes criminalisation of discriminatory acts based on sexual orientation.

Ordinary legislation

Although there is no explicit prohibition of discrimination in Law 8/04 on HIV/AIDS, the law protects equality rights within provisions relating to, *e.g.* the right to employment, the rights of persons deprived of their liberty and the right to access bank financing.¹²⁴ Law 8/04 also provides for the protection and promotion of health through measures for the prevention, control, treatment and research relating to HIV and AIDS. It also deals with the rights and responsibilities of people living with HIV, health personnel and others at risk of HIV exposure, as well as the general population.¹²⁵ However, there are no specific provisions relating to key and vulnerable populations, and the provisions protecting PLHIV from stigma and discrimination are arguably insufficient.

118 Art. 2 CADHP

119 *Idem.*, Art. 3

120 ACHPR/Res.53 (XXIX) 01 (2001) on the HIV/AIDS pandemic – Threat to human rights and humanity

121 ACHPR Res. 275 (LV) 2014

122 Regional Strategy for HIV and Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations, p. 15, SADC, 2018

123 Art. 56 CRA (2010) states that: 1. The state shall recognise as inviolable the fundamental rights and freedoms enshrined in the Constitution and shall create the political, economic, social and cultural conditions and conditions of peace and stability that guarantee their effective realisation and protection, under the terms of the Constitution and the law. 2. It shall be the duty of all public authorities to respect and guarantee the free exercise of fundamental rights and freedoms and the fulfilment of constitutional and legal duties.

124 Art. 5 *etc.*, Law 8/04

125 *Idem.*, Art 1

Regulations on HIV/AIDS, Employment and Vocational Training provide for the equality of workers and trainees.¹²⁶ A person's HIV-positive status may not be a factor in the dismissal and promotion of workers or trainees and their conditions of employment and training opportunities should be based on equal opportunity criteria based on the job function or vocational training.¹²⁷ The law criminalises acts that constitute offences, stigma and discrimination against workers living with HIV.¹²⁸

The Basic Law of the National Health System¹²⁹ also safeguards equality and non-discrimination in access to health care: "Health policy is national in scope and conforms to the following lines: (...) The promotion of equality of citizens in accessing health services, regardless of their economic situation and place of residence."¹³⁰ The Basic Law of the National Health System also asserts that the National Health Service is universal, in terms of populations covered and equality of access to services, with the aim of mitigating the effects of economic, geographical and other inequalities in access to care.¹³¹

Regarding restrictions on entry into Angolan territory, the Law on the Legal Status of Foreigners in Angola does not place any conditions on people living with HIV, although it requires foreigners to present a health card certified by the Angolan health authorities.¹³²

Plans and Policies

The National Development Plan 2018-2022 makes a vague allusion to (non) discrimination, urging the combatting of violence and discrimination against women and girls¹³³

and non-discrimination in sports.¹³⁴ However, Programme 1.4.3 for the fight against major endemic diseases prioritises training and capacity-building of integrated specialists for Tuberculosis and HIV; PMTCT; ART; Viral Hepatitis and other sexually transmitted infections; Adherence, Counselling and Testing, Stigma and Discrimination.¹³⁵

PEN V also notes that all actions should be based on reducing stigma and discrimination to promote human rights, cultural diversity, gender equality and reduction of differences between generations. Indicator No. 48 of the PEN V measures the percentage of PLHIV who have suffered discrimination in the past 12 months, with a target of reducing the numbers from 51% in 2013 to 15% in 2018. However, it is unclear how this data will be collected and whether a PLHIV Stigma Index study will be undertaken.

The National Youth Development Plan 2014-2017 makes no explicit mention of discrimination but does outline actions to combat HIV and AIDS in schools.¹³⁶ The plan calls for reproductive health projects to prevent STIs (including HIV), early pregnancy and harmful cultural norms that impact on the health of young people; as well as facilitating access to treatment for young people living with HIV.¹³⁷ The Action Plan provides for an HIV and leisure project entitled "Enjoy life with care" which aims to prevent the risk of STIs and reduce the incidence of HIV and AIDS. It is unclear whether this project carries out stigma and discrimination reduction activities.

The Strategic Reproductive Health Plan (SREP) 2009-2015 envisages a series of objectives, actions and targets directly linked to HIV

126 *Idem.*, No. 1 of Art. 9

127 Ref. No. 1, Article 8, Regulation on HIV/AIDS, Employment and Vocational Training Decree No. 43/03

128 *Idem.*, No. 2 of Art. 15.

129 Law No. 21-B/92, of 28 August (Basic Law of the National Health System).

130 *Idem.*, (No. 1 b), Art. 2

131 *Idem.*, (a) and (d), Art. 23

132 Art. 3 Law No. 02/07 of 31 August (Legal System of Foreigners in Angola) in conjunction with Art. 3, No. 1 and 4 and No. 2 Decree No. 06/01, of 19 January (Regulation on the Exercise of the Professional Activity of Non-Resident Foreign Workers).

133 National Development Plan 2018-2022, paragraph 244, Vol. I, Luanda, 2018, GOVERNMENT OF ANGOLA

134 *Idem.*, paragraph 286.

135 *Idem.*, p. 104

136 PNDJ 2014-2017, p.71

137 *Idem.*, p. 40

prevention, treatment and care. The plan recognises adolescence as a difficult and critical stage of transformation in which adolescents become aware of their sexuality and are exposed to various associated risks.¹³⁸ Although the plan specifically aims to increase access to SRH services, including HIV services, it does not include stigma and discrimination reduction activities.

Stakeholder consultations revealed a discrepancy between laws, policies and what happens in practice.

International partners note the limited dissemination of information relating to HIV and human rights and the insufficient documentation of discriminatory and stigmatising attitudes within health care, by both health professionals and administrative officers. **CSOs** report frequent stigma and discrimination due to the lack of information and knowledge on rights and ability to access justice for violations. For example, in the city of Kuito (Bié province), respondents noted high levels of stigma and discrimination, even amongst educated people and governing authorities. Discriminatory terms are used to describe PLHIV and key populations, such as *"pagina"*, *"naina"*, *"virado"* for MSM and *"prostitute"* for sex workers. **Churches** advocate for further awareness-raising amongst communities and especially in relation to key populations and for the translation of Law 8/04 into national languages. They also recommend the reactivation of the *jangos*¹³⁹ as a space for community dialogue, in order to achieve equality and a culture of non-discrimination. **Health professionals** interviewed reported that equality protection was sufficient in law but was not well applied. They noted the lack of protection for themselves, as health practitioners, in carrying out their activities. They further recommended that administrative sanctions be applied to practitioners who violate the health rights of PLHIV.

Key and vulnerable populations¹⁴⁰ themselves noted that the current Angolan legal framework contains provisions that undermine equality and non-discrimination. For example, inmates at the Prison Hospital of Luanda described that: *"[t]he laws, policies, regulations and even the Constitution do not sufficiently defend or protect the prisoner, or at least it feels like they don't, because, for example, I know there is a law that guarantees conjugal rights of the prisoner, but that is not our experience."* (Inmate/Prison Hospital of Luanda). Members of the **LGBT+ community** reported blatant social exclusion and recommended the need for recognition of the rights of key populations in accordance with the supremacy of the Constitution and international and regional HIV and human rights instruments. MSM interviewees reported experiences of discrimination in access to health services, in schools and workplaces, in the community and within families and also felt discriminated against in relation to political participation. They recommended ensuring that members of key populations are represented in Parliament and form part of decision-making forums. **Female sex workers** reported being aware of equality and non-discrimination laws in Angola; however, they considered these to be only on paper: *"In general, society looks at us with derision and indifference including some clients and the law does not protect us"* (Sex worker, Luanda).

4. Gaps and Challenges

The main shortcomings in relation to equality and anti-discrimination protection relate to the lack of explicit and sufficient protection for and inclusion of PLHIV, key populations, particularly LGBT+ persons, sex workers people who use drugs and other vulnerable groups.

138 PESR 2009-2015, p.15

139 It is a traditional physical space where traditional authorities invite the community to resolve/debate particular subjects.

140 In the context of this assessment and according to the INLS categories, the key populations are MSM, TS and Transgender. Vulnerable populations include people who use drugs, including licit drugs such as alcohol and cigarettes, persons deprived of liberty, out-of-school adolescents, truck drivers and miners.

Although the new Penal Code criminalises discrimination, including on the basis of sexual orientation, this does not appear to provide adequate protection in the context of HIV and AIDS. There are also no ordinary legislative anti-discrimination standards to protect PLHIV and affected persons from stigma, and the anti-discrimination provisions in Law 8/04 appear to be insufficient. Stigma continues to be a barrier to access of SRH services and the root cause of discriminatory practices, attitudes and actions. People living with HIV, key and vulnerable populations report ongoing stigma and discrimination, both within families and the healthcare setting. They furthermore report limited knowledge of their rights and how to access justice for rights violations.

Although public policies and plans relating to equality and non-discrimination exist, they are limited, fragmented in both approach and analysis. Key national plans supporting the sexual and reproductive health and rights of young people fail to deal with stigma and discrimination. There is poor and almost non-existent, specialised anti-discrimination training for practitioners to manage HIV and TB, nor are there any mechanisms to measure and track levels of stigma and discrimination, although monitoring indices are included in PEN V. Angola legal frameworks does have provisions that deal with equality and non-discrimination, however a set of laws, regulations, policies and programmes are required to operationalise them in order to achieve substantive equality. Among the major challenges for policy makers is the lack of awareness of the existence of stigma and discrimination, and insufficient policies and plans which will enhance social inclusion in general and of PLHIV, key and vulnerable populations in particular, and the limited implementation of protective provisions.

5. Recommendations

In order to combat inequality and discrimination, the following is recommended:

- Revise Law 8/04 “HIV/AIDS Law” to adopt measures to provide general anti-discrimination protection for all persons affected by stigma and discrimination and to promote substantive equality.
- Validate and implement the draft National Key Populations strategy (2018)
- Promote a comprehensive anti-discrimination law in political, social and cultural spheres and includes non-discrimination for people living with and affected by HIV and key populations.
- Include and implement concrete actions in policies, strategies and plans to combat inequality and discrimination against PLHIV, key and vulnerable populations, including young key populations.
- Inform, educate and disseminate¹⁴¹ material that contributes to eliminating stigmatising and discriminatory attitudes and increases awareness of rights and how to access justice.
- Incorporate actions aimed specifically at combating stigma and discrimination in the National Youth Development Plan.
- Incorporate actions aimed at combating stigma and discrimination into national plans for Sexual and Reproductive Health as well as the national Plan for the elimination of mother-to-child transmission (2019-2022)
- Develop and implement a Stigma Index study to measure stigma and discrimination against PLHIV, key and vulnerable populations.
- Introduce a special quota for key populations in political participation bodies.
- Collaborate with the United Nations system on a human rights approach to the HIV national response based on the principle of equality and the prohibition of discrimination.

141 See recommendations in the Section on Education and Information.

B. Health Legislation, Policies and Plans

1. Analysis of the situation

This Section addresses the engagement of the health sector in the lives of citizens and communities, with a focus on access to health services for HIV, TB and SRH; testing and treatment for HIV and TB with voluntary and informed consent; confidentiality, isolation/detention/quarantine and priority services targeted towards key populations, amongst others. The main objective is to assess the degree to which legislation, policies and health plans provide for these services.

Health is a fundamental human right. The right to medical and health care in childhood, maternity, invalidity, old age and in any situation of incapacity for work, is constitutionally guaranteed to all citizens of Angola. Health care is provided by State services and establishments or under their supervision, by other public agents or private entities, whether for profit or not.¹⁴²

Angola has one of the lowest HIV prevalence amongst countries in Southern Africa. However, the IIMS data¹⁴³ (INE/MINSA 2016) demonstrates significant variations in terms of geography, age and gender. While national HIV prevalence is at 2.1%¹⁴⁴, seven provinces, in particular Southern and Eastern border provinces, are identified as “high disease burden”. Prevalence among women is 2.6% (1.2% among men); 1.5% among 15-24-year-old. Adolescent Girls and Young Women (AGYW) (0.8% among adolescent boys and young men); 7.8% among Female Sex Workers and 2.4% among Men who have sex with men. Nearly 1% of 15-24 years old are living with HIV. Besides young people, PEN V recognizes

vulnerable groups such as orphans, street children, people with disabilities, discordant couples, refugees and migrant workers, mobile workers such as truck drivers, miners and the military forces.¹⁴⁵

Angola also remains among the 30 high TB burden countries globally and TB incidence rates remain high (370/100,000, in 2015)¹⁴⁶. Case notification rate (CNR, 222/100,000 in 2016), and Treatment success rate (TSR, 69.7% in 2016) are slowly increasing but remain low. High loss to follow up (LTFU, 22% in 2016) rates remain a major concern. MDR/RR-TB case notification is rising. TB affects all parts of the country with 7 provinces regarded as high TB disease burden regions. The incidence of TB in the seven provinces is above the national average. Children under 15 years old represent 15% of the total number of cases reported, while in 7 provinces this rate has reached 20% to 31% of the total TB cases reported. In 2016, an estimated 45% of TB patients had an HIV test and 10% of TB patients newly diagnosed with HIV received anti-retroviral treatment in 2016, whereas 10% of PLHIV in care were screened for TB. Key populations for the TB response include children, elderly people, prisoners, miners, refugees, people living with diabetes and PLHIV¹⁴⁷.

As elsewhere on the African continent, main drivers of the HIV and TB epidemics are socio-economic factors such as economic poverty, social marginalisation, gender-based inequality and violence, stigma and discrimination, and limited access to accurate information on prevention methods and commodities¹⁴⁸. In relation to HIV and Tuberculosis, stigma within families, communities and health facilities reported by patients, and in particular key and vulnerable populations, may help explain treatment drop-out rates (46.2% for HIV and 22 % for TB). Structural factors related to the health system such as limited domestic

142 Ref. Art. 1 of Law 21-B/92

143 See Multiple Health Indicators Survey p. 215 Etc. INE 2017

144 Source: Angola IMMS 2017

145 Ref. MINSA, INLS, Testing Services for HIV Protocol, 3rd Edition, Luanda, 2017, p. 16 and 17.

146 Global TB report 2016

147 Extracts from the Angola HIV/TB Funding Concept Note to the Global Fund, September 2017

148 Bed nets, condoms and other contraceptives, lubricants etc.

financing for health, scarceness of community-based health promotion services, limited availability of quality health services, and high cost of treatment can potentially be correlated with the high mortality and morbidity of the Angolan population, particularly women, to both communicable and non-communicable diseases.

Against this backdrop, the Angolan Government has adhered to global commitments such as the Political Declaration to End AIDS by 2030 or the End TB Strategy. The Ministry of Health and associated disease programmes are investing efforts to align themselves with the latest changes in international normative guidance on HIV and TB responses. New Strategic Plans are in place for the HIV and TB responses, for the 2018-2022 period. A new National Plan for the Elimination of mother-to-child transmission of HIV has been developed in 2018 and the related campaign, called “Born to Shine” was launched by the First Lady in 2019. On World AIDS Day 2017, the National AIDS Programme launched Test and Treat in four pilot provinces. And in March 2018, a ministerial decree which decentralises TB diagnostic services was issued while a Plan for the expansion of GenXpert services was finalised with a view to increasing TB detection rates. Pooled procurement of diagnostic and treatment products was successfully promoted by the Ministry, with support from the UN system, with the objective of maximising resources available to Government and increasing treatment coverage. A new cadre of health human resources was hired and deployed primarily in underserved regions. However significant, these efforts to increase the coverage of services continue to be hampered by an adverse economic context and health systems strengthening related issues.

2. International Standards

The UDHR considers that every human being has the right to a standard of living that can provide them and their family with health and well-being, including food, clothing, housing, medical care and essential social services.¹⁴⁹ The ICESCR urges States to recognise the right of all persons to enjoy the best possible physical and mental health, and urges them to develop conditions for guaranteeing health services to all person in case of illness.¹⁵⁰ Several international human rights treaties recognise the right to health.¹⁵¹

In the context of HIV and AIDS, the CESCR has stated that sexual and reproductive health and rights are an integral part of the right to health enshrined in article 12 of the Covenant.¹⁵² The Committee uses the definition of sexual health as being a state of physical, emotional, mental and social well-being in relation to sexuality, and defines reproductive health as that related to reproductive capacity and freedom to take informed, free and responsible reproductive health decisions.¹⁵³ The Committee points out the need to take account of underlying determinants of health in order to achieve this right, *e.g.* access to safe drinking water, adequate sanitation, adequate food and nutrition, health-related education and information as well as social determinants *e.g.* poverty, discrimination and marginalisation.¹⁵⁴

SRHR implies a set of freedoms and rights such, as (i) the right to make free and responsible decisions and choices (i.e. free of violence, coercion and discrimination) in relation to the body and sexual and reproductive health; and (ii) unrestricted access to a range of health facilities, goods, services and information. In addition to the characteristic elements of health rights (availability, accessibility – including

149 Art. 25, DUDH

150 Art. 12 PIDESC

151 Art. 25 Convention on the Rights of Persons with Disabilities, Art. 24, Convention on the Rights of the Child, Art. 12 of the Convention on the Elimination of All Forms of Discrimination against Women.

152 GC 22, paragraph 1, CDESC,

153 *Idem.*, paragraph 6. *See also* WHO, Sexual Health, Human Rights and Law (2015), p.4 and UNFPA, Programme of Action of the International Conference on Population and Development, chapter 7 (1994)

154 GC 22, paragraph 7, CDESC

accessibility to information – acceptability and quality)),¹⁵⁵ the issue of discrimination deserves special mention. The CESCR has held that non-discrimination includes the right of all persons, including men, women, lesbian, gay, bisexual, transgender and intersex persons, to be fully respected for their sexual orientation, gender identity or intersex status.¹⁵⁶ The failure to provide formal and substantive equality in sexual and reproductive health is a violation of this right.

The GCHL (2012) advises countries to ensure that the provision of health services protects those living with HIV and other key populations, as well as those at risk of HIV exposure.¹⁵⁷ Access to medicines is critical for effective responses to HIV. The GCHL: recommends that countries develop an intellectual property regime consistent with international human rights law and public health needs, while safeguarding the rights of the inventors: In particular, it recommends that countries proactively use other areas of law, as well as their own policies, to help increase access to pharmaceutical products, *e.g.* competition law, price control policy and public procurement law.¹⁵⁸ The GCHL Supplement (2018) goes further by recommending that Governments ensure that all those living with or at risk of contracting HIV, TB or Viral Hepatitis have economic access to the most effective and highest-quality health technologies, including diagnostics, drugs and vaccines against HIV, TB and Viral Hepatitis.

Guideline 3 of the UNAIDS International Guidelines on HIV/AIDS and Human Rights (2006) establishes that States should review and amend public health legislation to ensure that they respond adequately to public health issues raised by HIV and that their applicable provisions for infectious diseases are not inadequately applied to HIV and are consistent with international human rights

obligations.¹⁵⁹ This Guideline specifies that public health legislation should finance and train public health professionals to provide a comprehensive range of HIV prevention and treatment services, including relevant information and education, access to voluntary testing and counselling for STIs and sexual and reproductive health, provision of condoms and antiretroviral treatment, as well as treatment for opportunistic infections. It also recommends that in addition to monitoring and other testing for epidemiological purposes, public health legislation should ensure that HIV testing be carried out with the informed consent of the person and that exceptions to voluntary testing require judicial authorisation. Additionally, public health legislation should ensure that information regarding the serological status of the person is protected from unauthorised collection, use or disclosure.¹⁶⁰ The Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, adopted by the United Nations General Assembly in 2016, reiterates the Member States' commitments to achieving universal access to HIV and associated health services, based on a human rights informed approach, with a commitment to reducing the vulnerability of youth, women and girls and members of key populations to HIV infection. The Declaration followed similar UN General Assembly resolutions adopted in 2001, 2006 and 2011. Angola is also part of the Global Alliance for HIV Prevention, catalysed by UNAIDS and UNFPA.

WHO's (2014) Technical Note for Key Populations¹⁶¹ emphasises that interventions in the health sector should be directed towards HIV prevention, harm reduction, voluntary testing and counselling, treatment and care, prevention and management of co-infections and co-morbidities as well as sexual health and reproductive health. It highlights the enabling

155 These are all elements of the Right to Health, Art. 12, PIDESC See CG No. 14, paragraph 12, CDESC

156 GC No. 22, paragraph 23, CDESC, *See also* Section on Equality and Non-discrimination

157 CGVD 2012, p. 21.

158 CGVD 2012, pp. 98-99

159 International Guidelines on HIV/AIDS and Human Rights UNAIDS/EACDH (2006)

160 International Guidelines on HIV/AIDS and Human Rights UNAIDS/EACDH, 2006, p. 26 *etc.*

161 Technical Note for HIV prevention, diagnosis, treatment and care for key populations, WHO, 2014

factors for these interventions: the creation of a legal and favourable environment with anti-discriminatory and protective laws for the rights of the key populations, the availability, accessibility and acceptability of the health services for key populations, measures to reinforce the participation of key populations as well as efforts to reduce violence against them.

In the regional context, the ACHPR recognises the right to physical and mental health for all, and urges Member States to take the necessary measures to protect the health of their populations and to provide them with medical care in case of illness.¹⁶² The Maputo Protocol to the African Charter also specifically recognises the right to reproductive health in Article 14, and includes specific protection for women's right to self-protection from HIV. The African Charter on the Rights and Welfare of the Child¹⁶³ also provides for the right to physical, mental and spiritual health of the child through several measures including measures to reduce prenatal and infant mortality; ensure the provision of health care for all children; etc. In addition, the African Union's solemn declaration on gender equality stresses the need to accelerate the implementation of gender-specific measures to combat the HIV epidemic and to act on the Abuja and Maputo Declarations on Malaria, HIV/AIDS, Tuberculosis and other related Infectious Diseases.¹⁶⁴

The SADC PF Model Law on HIV and AIDS addresses HIV from a human rights perspective. Additionally, the SADC regional integration agenda is guided by a Regional Indicative Strategic Development Plan (RISDP) with four priorities for 2015-2020. Priority D: Special Programmes of the Regional Dimension (Human Development and special programmes including Health, Gender and

Employment) includes a commitment to improved access and availability of quality services and medical goods in the field of health, HIV and AIDS.¹⁶⁵

3. Current situation in Angola

It is the constitutional responsibility of the Angolan State to promote, guarantee and control, without discrimination, the necessary measures to ensure medical and health care for all. To guarantee this right, the State must, among other things, develop and ensure the functionality of the health service throughout the national territory.¹⁶⁶ Also the CRA, 2010 requires the State to promote " policies that make it possible to provide universal and free primary health services".¹⁶⁷

In terms of access to health services, the **Basic Law of the National Health System** aims to promote equal access to consolidated health services for all citizens, regardless of their economic condition or place of residence.¹⁶⁸ The health care delivery system is made of the public, private and traditional sectors. The public sector includes national health services, the health service of the FAA (Angolan Armed Forces) and the Ministry of the Interior, as well as public enterprises. The private sector is subdivided into profit-making private sector and non-profit-making private sector, mostly linked to religious entities and NGOs. The Traditional medicine sector incorporates a vast majority of traditional therapists and herbalists.

The system is subdivided into three hierarchical levels of health care, based on the primary health care strategy (*See* National Health Policy 2010). The first level or primary health care is represented by Health Clinics and Health Centres, Municipal Hospitals, nursing clinics and/or medical practices, thus

¹⁶² No. 2 Art. 16, Banjul Charter.

¹⁶³ No. 2, Art. 14, of the African Charter on the Rights and Welfare of the Child

¹⁶⁴ AFRICAN UNION, Solemn Declaration on Gender Equality, CONFERENCE OF THE AFRICAN UNION, Third Ordinary Session, 6-8 July 2004, Addis Ababa, 2004.

¹⁶⁵ Available at: https://extranet.sadc.int/files/1514/6095/3074/Approved_RISDP.pdf last visited> 14.03.2019

¹⁶⁶ Art. 77, CRA 2010

¹⁶⁷ (f), Art. 23 (Basic Tasks of the State), CRA 2010

¹⁶⁸ Art. 2 (b) of Law No. 21-B/92, of 28 August (Basic Law of the National Health System)

constituting the first point of contact of the population with the health system. 1 650 Health Posts; 331 Health Centres; 43 Maternal and Child Centres; 165 Municipal Hospitals; 83 untypified health facilities make up this level. The secondary or intermediate level, represented by 25 General Hospitals, is the level of reference for the first level units. The tertiary level represented by the 20 Central and Specialty Hospitals is the level of reference for the Health Units at the secondary level.

As far as HIV is concerned, 1448 health facilities provide HIV counselling and testing services; 650 provide Prevention of mother-to-child transmission services and 735 offer antiretroviral treatment services. Viral load measurement services are available in Luanda province only. A viral load service expansion is in place with Benguela and neighbouring provinces put in priority position. The TB service network includes 133 Diagnostic and Treatment Units, 146 Treatment Units, 155 sputum smear laboratory network and 15 GeneXpert (2016). TB treatment remains hospital-based and is delivered through 13 Sanatorium Hospitals and 9 Dispensaries.

As far as community-based health services are concerned, to date, Angola's primary health system has been a standard three-tier health facility-based health care delivery model without a structured community-based health system. In 2015, a new cadre of community workers, called Agentes de desenvolvimento comunitários (ADECOS) was introduced by the Ministry of Territorial Administration, with joint Government and development partner funding. Recruited by local administrations, ADECOS are civil servants who are part and parcel of the health system and are active in 18 out of Angola's 164 municipalities. The health component of their vast portfolio includes: awareness-raising and counselling for HIV prevention and access to treatment; identification and referral of suspected or lost to follow-up TB cases; community DOT; contact tracing; maternal health monitoring, with referral of pregnant women to ante and

post-natal visits; promotion of family planning; immunisation schedule monitoring; malaria rapid testing and treatment; primary response to incidence of diarrhea and pneumonia in children under five years old; family support, using the Family Handbook of social and health indicators; record keeping; health commodity management (malaria rapid tests).

Besides ADECOS, Angola has a history of civil society response to HIV and TB, embodied by the members of Angola's Network of Civil Society Organisations (ANASO). While the Network reports 300+ members, drastic reduction in both Government and development aid funding has reduced the number of ANASO members with funded activities to less than 15. Such activities are carried out by Community "activistas", a generic definition which covers peer educator, community mobiliser, community health worker roles. In 2018, several hundreds of activists were active in HIV prevention, Key Populations, community support to PMTCT, ART, community DOT interventions funded by the Global Fund and PEPFAR in selected municipalities of a total of 12 provinces.

The **Basic Law of the National Health System** provides for the right of citizens to use public health services according to their legitimate interests, to choose services and health care professionals, to be treated appropriately, with humanity, respect and privacy, to be informed about possible treatments and their state of health¹⁶⁹ (level 1).

The National Health Service provides equal access to universal health coverage for free at the point of delivery. Decentralised participatory health management allow health services to be accessed by all Angolan citizens; foreigners residing in Angola on conditions of reciprocity, and stateless citizens residing in Angola.¹⁷⁰

In Angola, all health legislation is a matter of public interest; non-compliance implies criminal, civil and disciplinary liability¹⁷¹

169 *Idem.*, Art 5 and 13

170 *Idem.*, Art. 23 and 24

Health professionals must meet essential requirements in the performance of their duties.¹⁷² MINSA is also responsible for promoting the control of and fight against endemic and epidemic diseases¹⁷³.

In addition to the Constitution and the LBSNS (Basic Law of the National Health System), the **Law on HIV/AIDS** guarantees and promotes the health of people living with HIV, establishing their rights and responsibilities.¹⁷⁴ The Law on HIV/AIDS recognises the right of access to health services for PLHIV and other STIs, making the State responsible for creating mechanisms to ensure the realisation of this right.¹⁷⁵ It further provides that every person living with HIV is entitled to free public health care and antiretroviral drugs, information on the evolution of the disease and treatment options and programmes, and to make decisions about the options presented.¹⁷⁶ The Law also establishes rights for employees living with HIV¹⁷⁷ e.g. prohibition of HIV testing as a condition of employment¹⁷⁸ and duties for employers e.g. the obligation to educate and inform about HIV.¹⁷⁹ Although the law recognises certain rights of people living with HIV, it is silent on the rights of key populations at higher risk of HIV exposure e.g. sex workers, men who have sex with men, people who use drugs, transgender persons, prisoners and other vulnerable populations, e.g. migrants, mobile workers, children, adolescents, and women.

Section 14 of the law also establishes responsibilities for people living with HIV, providing that they should be sexually responsible to limit HIV transmission to

others, use condoms and disclose their HIV status to sexual partners. These provisions may be criticised for placing sole responsibility on people living with HIV to prevent HIV transmission, particularly since they are followed by provisions in Section 15 criminalising transmission through “negligence, inconsideration or failure to observe regulations”. This is discussed in further detail, below, in the Section on criminalisation. Section 14 also requires people living with HIV to disclose their HIV status to health professionals to reduce the risk of transmission and promote health management; and inform their spouse or sexual partners of their HIV status.¹⁸⁰

HIV testing is expressly prohibited without voluntary consent.¹⁸¹ Notwithstanding this prohibition, the law provides for mandatory testing under certain conditions e.g. where testing is necessary to protect the health of the patient, for donation of blood and blood derivatives, breast milk, semen, human organs and tissues, for purposes of criminal proceedings and by order of a judicial authority.¹⁸² It is unclear what criteria the courts would consider in ordering HIV testing.

With regard to consent for HIV testing of minors (persons below the age of 18 years, in terms of the Constitution), the HIV law provides that HIV testing can only be carried out with the permission of a parent or legal guardian of a child; the parent / guardian should be informed of the need for the test and provide written authorisation.¹⁸³ Provisions on HIV testing are complemented

171 *Idem.*, Art. 3

172 *Idem.*, Art. 14 and 15

173 Ref. Presidential Decree No. 21/18, of 30 January 2018 (Organic Statute of the Ministry of Health).

174 Ref. Art. 5 etc. of Law 8/04

175 See “Art. 5.1 (e) In the fight against the Human Immunodeficiency Virus – HIV and Acquired Immunodeficiency Syndrome – AIDS, the State is responsible for the following: e) Ensuring public health services and actions for the prevention, treatment and control of OI/STIs/HIV/AIDS, based on the principle of equal and universal access for all”;

176 Art. 5 (a), (b) Law 8/04 “Law on HIV/AIDS”

177 *Idem.*, Art. 7 etc.

178 *Idem.*, Art. 9

179 *Idem.*, Art. 7.3

180 *Idem.*, Art. 14

181 *Idem.*, Art. 22.1

182 *Idem.*, Art. 22.1 (a), (b), (c) and Art. 6.1

183 *Idem.*, Art. 22 (2). See Children and Adolescents Section

by the Protocol on HIV Testing,¹⁸⁴ which allows for some exceptions regarding the age of consent to testing. Adolescents aged 15-18 are considered eligible to give their own consent for testing, however the counsellor has to make an assessment of the actual ability to understand and absorb whatever the test result is. It also provides that for adolescents under 15 years of age, access to health services for HIV counselling and testing should be with their parents.

Confidentiality and privacy are also incorporated into the Angolan Law on HIV and AIDS. The law urges health institutions and those who assist individuals living with HIV to maintain confidentiality about a health consultation, diagnosis and follow-up, except in the case of minors, where parents must be informed.¹⁸⁵ Confidentiality is also safeguarded in the Protocol on HIV/AIDS Testing which provides that confidentiality is vital, but that HIV and AIDS must not be a source of shame, prejudice or discrimination. The Protocol recommends that the counsellor discusses with people living with HIV on the advantages of disclosing to partners, family, friends and other support providers.¹⁸⁶ Failure to comply with the standards provided by health professionals will result in civil, criminal or disciplinary liability depending on the circumstances of the case and the law, in the public interest and to maintain public order.¹⁸⁷

The **Penitentiary Law** establishes the guarantee of medical health assistance to persons deprived of freedom. The law requires the establishment of medical nursing services to treat prisoners.¹⁸⁸ The same law provides that inmates with serious illnesses can be admitted to non-prison hospitals until necessary.¹⁸⁹

In relation to the General State Budget (OGE), about 97% of the financial resources from the State Budget for the health sector are drawn from the State's own funds, with only 3% originating from external cooperation.¹⁹⁰ Under Basic Law No. 21-B/92, it is the responsibility of the State, either through the OGE, or through the mobilisation and coordination of external assistance, to bear most of the costs of health. In Article 27, the LBSNS also makes it possible for third parties and citizens to participate in health-related costs.¹⁹¹ However, state funds for health have fallen far short of the real needs of the sector. In the fiscal year 2018,¹⁹² for example, only 18% of the total value for the entire Social Sector was allocated to the Health Sector,¹⁹³ with expenditures being mainly concentrated in the provinces of Luanda, Malange, Huambo, Benguela and Huíla¹⁹⁴.

Policies, Directives and Plans

The public policies adopted by the Angolan State for the health sector aim to strengthen the capacity of state institutions, CSOs and families to mitigate the harmful effects of HIV.¹⁹⁵

184 HIV Testing Services – Protocol (MINSA, INLS), 3rd Ed., Luanda, 2017.

185 Art. 5 (f) and Art. 12, Law 8/04 “Law on HIV/AIDS”

186 HIV Testing Services – Protocol (MINSA, INLS), 3rd Ed., Luanda, 2017, p. 15.

187 Ref. Art. 3 of Law No. 21-B/92, of 28 August (Basic Law of the National Health System)

188 Art. 54 (Guarantee of medical-health assistance) and Art.55 (Medical assistance and medicine) both under Law No. 8/08, of 29 August (Penitentiary Law).

189 *Idem.*, Art. 20.1

190 Ministry of Justice and Human Rights, in “*Angola in the Periodic and Universal Assessment*”. Main documents of the first and second cycle. 2010-2015. Statement by the Secretary of State for Health, p. 24.

191 ...“Contribution in the payment of care provided...” [(d), No. 2, Art. 27], of Basic Law No. 21-B/92.

192 Ref. Republic of Angola (Ministry of Finance), General State Budget 2018, Luanda, 2018.

193 The units that make up the Social Sector include: Education, Health, Social Protection, Housing and Community Services, Recreation, Culture and Religion.

194 OGE, 2018, p. 81.

195 These policies include the following: National Development Plan 2018-2022; National Health Development Plan 2012-2025; National Strategic Plan V for Response to STI/HIV-AIDS and Viral Hepatitis 2015 – 2018; HIV Testing Services – Protocol; Strategic Plan for Reproductive Health 2009-2015; National Health Policy; National Policy of APDECOS (National Policy for the Development of Community Health Agents); National Youth Development Plan 2014-2017

National Development Plan

Axis 1 of the NDP 2018-2022 integrates eight policies, with an emphasis on population, education and health policies.¹⁹⁶ The Population policy envisions reproductive health projects aimed at preventing STIs (including HIV), early pregnancy and the negative effects of certain habits and customs on the health of young people.¹⁹⁷ The NDP's National Health Policy' Programme 1.4.3 focuses on combating major endemics by addressing the underlying determinants of health. This National Health Policy¹⁹⁸ Programme of the NDP provides for the reduction of morbidity and mortality from communicable and non-communicable diseases through promotion, prevention, complete treatment and rehabilitation measures, as well as the improvement of inter-sectoral interventions with regard to the social determinants of health. The goals of the NHP include increasing access to and use of health services at all levels of care, improving the quality of services and improving the population's access to medicines, medical devices and other quality health products.¹⁹⁹ Specifically, Programme 1.4.3 on combating major endemics addresses the determining factors of health and aims to reduce the prevalence of HIV and AIDS and mitigate the damage caused by TB, amongst other things.²⁰⁰

However, the NDP targets focus primarily on treatment, limiting prevention goals. For example, Goal 2 aims to reduce HIV-related morbidity and mortality through improved access to treatment for those in need, procurement of antiretrovirals, diagnostic tests for HIV and Viral Hepatitis, CD4 reagents, viral load testing and genotyping. The NDP also prioritises training and skills development of integrated specialists (e.g. for TB and HIV, vertical transmission of

HIV, ART, Viral Hepatitis and other STIs and Adherence, Counselling and Testing, Stigma and Discrimination interventions), as set out earlier, above.

National Health Policy (PNS)²⁰¹

The PNS provides relevant data regarding the challenges of the health system. According to the Plan, the main problems of the health system are inadequate health coverage, reaching less than 40% of the population; and inadequately skilled workforce. The Executive has taken efforts to increase skills through various health education institutions. However, despite these efforts, many professionals are not yet part of the national health system. In addition, resources are insufficient, if available they are poorly managed, and there is poor health promotion of programmes, despite an environment and socio-economic context favourable to endemic diseases and epidemics.²⁰²

National Health Development Plan (PNDS)

The PNDS 2012-2025 aims to promote compliance with the right to health enshrined in the Constitution, ensuring universal access to health care, and equity in care, improving the management and financing mechanisms of the National Health System (NHS), providing services that are high quality, timely and humane, with a view to combating poverty and strengthening the well-being of the population.²⁰³

The PNDS has been developed based on several priorities that ensure the sustainable development of the health sector. These priorities include (i) consolidation of the legislative and organisational reform process of the National Health System as well as

196 NDP 2018-2022 paragraph 36

197 *Idem.*, Programme 1.1.5 on the integral development of young persons

198 *Idem.*, paragraph 263 *etc.*

199 *Idem.*, p. 98

200 *Idem.*, p. 102

201 National Health Policy, approved by Presidential Decree No. 262/10, of 24 November.

202 Cited, National Health Policy.

203 GOVERNMENT OF ANGOLA, Ministry of Health. National Health Development Plan 2012-2025 – More and Better Health, Vol. 1, August 2012, p. 8.

institutional capacity, namely at central, regional, provincial and municipal levels; and (ii) expansion of the health network at all levels.²⁰⁴ The Plan foresees the revision and adaptation of the Basic Law of the National Health System (Law No. 21-B/92, of 28 August), of the Regulation of the Practice of Private Medicine (Decree No. 34-B/92, of 17 July) and of the General Regulation of Health Units (Presidential Decree, No. 54/03, of 5 August). The PNDS 2012-2025 recommends focusing on Programmes to Fight Major Endemic Diseases, highlighting, amongst other HIV/AIDS and TB.²⁰⁵

The Plan underscores the current problems within the national health system: (i) insufficient health coverage and poor maintenance of health units; (ii) poor referral and reference systems between the three levels of the national health service; (iii) reduced quantity and poor distribution of human resources and health specialists in rural and peri-urban areas; (iv) weaknesses in the health management system, including information, logistics and communication systems; (v) insufficient financial resources and an inadequate health care model; and (vi) reduced access to clean water, sanitation and energy.

Fifth National Strategic Plan for STIs/HIV-AIDS and Viral Hepatitis²⁰⁶

Access to prevention of HIV infection, treatment, care and support should be recognised as key to achieving universal access to health, based on human rights and ethical principles.²⁰⁷ PEN V points out that the health status of the Angolan population is characterised by low life expectancy at birth, high rates of maternal and infant mortality, a

high burden of communicable diseases and increasing chronic and degenerative diseases, as well as premature mortality.²⁰⁸ The Plan also notes that health indicators in Angola in recent years have improved, but are still among the lowest in sub-Saharan Africa.²⁰⁹

Regarding access to health services for people living with HIV, key populations and vulnerable groups, the highly comprehensive PEN V states that:

- Access to the prevention of HIV infection, treatment, care and support should be recognised as fundamental to achieve universal access to health care based on principles of human rights and ethics;²¹⁰ (PEN V, p.5).
- There are still constraints in access to health and education services, especially in rural areas and the densely populated periphery of urban areas;²¹¹ (PEN V, p.16)
- HIV control is closely linked to access to the health care network for quality counselling, testing, treatment, continuing care, support for PLHIV and their families;²¹² (PEN V, p.24)
- To ensure universal access to prevention, multi-sectoral measures have been intensified in both the community and the workplace in public and private enterprises, as well as in community-based interventions involving national, political, religious and traditional leaders; (PEN V, p.41)
- One of the strategies to reduce the impact of HIV and AIDS on the individual, family and community is access to ART for adults, pregnant women and children, which has been ongoing and successful since 2004; (PEN V, p.56)

204 *Idem.*, p. 8.

205 NHDP 2012-2025, p. 32

206 The National Strategic Plan V for STIs/HIV-AIDS and Viral Hepatitis – Angola 2015 – 2018 (PEN V), is an instrument with a multidisciplinary and multi-sectoral approach, encompassing political, legal and technical frameworks, and is a normative reference for the national response to STIs/HIV-AIDS and viral hepatitis, the Strategic Axes of which are expected to deepen and strengthen the diversity of interventions. The document provides answers to questions about the AIDS epidemic situation in the country and provides the framework for the joint efforts and vision of the different national, international and United Nations actors which support the National Health Development Plan 2012 – 2025.

207 Ref. PEN V, p. 5.

208 *Idem.*, p. 17.

209 *Idem.*, p. 17.

210 Ref. PEN V, p. 5.

211 *Idem.*, p. 16.

212 *Idem.*, p. 24.

- People living with HIV and AIDS will have access to continuing quality care and social support, with their rights respected, protected and promoted, without being stigmatised or discriminated against, and they will be actively involved in defining policies and programmes to combat AIDS, and in the development of the country; (PEN V, p.80)
- There is a need to increase access to PMTCT in ANC services and to reduce mother-to-child transmission of HIV; (PEN V, p.84)
- The expansion of PMTCT is recommended, with greater access to HIV testing, humanised care, adherence to treatment and breast milk substitutes; (PEN V, p.84)
- There is a need for the promotion of increased access to early diagnosis of HIV infection and STIs within the general population and vulnerable groups in particular; (PEN V, p.84)
- Efforts should be made to strengthen decentralisation to facilitate universal access and increase patient retention, create incentives for staff recruitment and relocation to the periphery, and strengthen the integration of HIV, TB and SRH programmes; (PEN V, p.88)
- There is a need to increase access among the general population and vulnerable groups to HIV counselling; (PEN V, p.94)
- Efforts should be made to increase the number of tuberculosis patients with access to counselling, HIV testing and vice versa; (PEN V, p.94)
- There is a need to ensure access to the regular psychosocial and nutritional support programme from the perspective of continuity of care among all those infected and affected by HIV, with special attention to orphans and vulnerable children; (PEN V, p.94)
- The links between INLS and PNLT are to be strengthened, in order to guarantee access to TB screening for people living with HIV, and vice versa, and to guarantee

appropriate referral to health services for follow-up purposes. (PEN V, p.95)

Institutional framework

With regards to the institutional framework for responding to HIV, in addition to MINSA [Health Ministry of Angola], the National Commission against HIV/AIDS and Major Endemic Diseases was established in Angola in 2003, as a body for the coordination and orientation of efforts in the fight against HIV/AIDS and Major Endemic Diseases.²¹³ Its main responsibilities include the promotion, mobilisation, monitoring and coordination of synergies aimed at seeking a national response to HIV/AIDS and Major Endemic Diseases. The Commission, which has been virtually inactive since its inception, had its first meetings in 2018 and 2019. In addition, the National Institute for the Fight Against Aids (INLS) was created in 2015. It is an autonomous institute of a normative and technical character which depends on MINSA. Its main responsibilities include : ensure the implementation of national policies, programmes and plans to respond to STIs, HIV / AIDS and Viral Hepatitis; propose clinical and laboratory operating norms and norms for biomedical, pedagogical and labor research, in relation to STIs, HIV / AIDS and Viral Hepatitis; define and coordinate training, information, education, communication, counseling, treatment and follow-up in the area of STIs, HIV / AIDS and Viral Hepatitis; collaborate with international organizations that work in the areas of STIs, HIV / AIDS and Viral Hepatitis.²¹⁴

During field work conducted for this Report, **health professionals**, attested to the fact that health services, including HIV testing, counselling and referrals, are provided to people living with HIV, key and vulnerable populations without discrimination. They reported having received training on stigma and discrimination and how to care for key populations. People living with HIV, MSM and sex workers attending at health facilities are generally accompanied by peer educators.

213 Decree No. 1/03, of 10 January, Creates CNLS and Major Endemic Diseases. (Ref. Art. 2 and 3).

214 Decree No. 7/05, of 9 March. Creates INLS as normative, technical and coordinating body in the country (Ref. Art. 5).

Health facilities reported offering a range of services (e.g. counselling, testing, screening, and follow-up examinations), despite difficulties such as disruptions in the supply of medicines. In terms of legal aspects, health professionals felt that health laws and policies were acceptable, although not well applied. They did express dissatisfaction with their working conditions.

However, participants in FGDs, particularly those carried out with organisations of **PLHIV, sex workers, men who have sex with men and LGTB+**, described a different reality, with a high degree of stigma and discrimination in health facilities impacting on access to healthcare. Many PLHIV also reportedly withdraw from treatment due to limited financial resources.

The majority of LGBT+ persons interviewed for this study reported going to public hospitals when they require health services, and some reported going to private clinics in certain situations. They reported poor quality health care services, except where they are attended to by HIV focal points such as health professionals with specific training for HIV patients placed at health facilities or if they return to health facilities they have used previously. A transgender interviewee reported that: *"I was ill and was taken to the hospital where, due to my serious condition, I was immediately admitted. When the health professional (doctor) entered the room to provide care and asked for my registration name (male name) and I replied, he refused to provide medical care, claiming that he did not put his hands on "men who dress as women." I immediately replied that I did not choose to be what I am. The doctor simply ignored me, using offensive and discriminatory words that forced me to react proportionally, requiring the intervention of the hospital management to resolve the disturbance that resulted. A week later I was discharged even though I was in a very weak condition."*

A number of **MSM** respondents reported not being aware of any laws or regulations that protected their rights. They noted that some

MSM had been trained as peer educators to support HIV testing for other MSM, with the help of testing support centres. MSM respondents reported attending public hospitals and not disclosing their sexual practices, when in need of health care.

Positive reports of health care treatment were received in Benguela. Most respondents reported being well treated by health professionals, even in cases where they identified themselves as MSM. Respondents in Kuito generally do not publicly identify themselves as MSM therefore the problem is less visible.

Female Sex workers reported knowing about and accessing condoms through a CSO, but encountering resistance from clients in using condoms, who offer increased pay for unsafe sex. They reported attending at hospitals for health care, but not identifying themselves as sex workers for fear of discrimination. They also reported barriers to complaints mechanisms for discriminatory treatment. They did not report mandatory HIV testing except in the case of pregnancy for purposes of preventing vertical transmission of HIV. However, they did report common breaches of confidentiality, a practice that appears to be widespread for all patients living with HIV and for LGBT+ persons.

Sex workers in Kuito were not aware of laws protecting their health and other rights. They reported being treated well in health services because they do not disclose their work, similar to members of the LGBT+ community.

In conclusion, opinions differ greatly about the care provided by health professionals. Generally, it appears that care is better in private clinics than in the public sector.

In terms of prevention, most key populations²¹⁵ reported using condoms to prevent HIV and other STIs (with the exception of inmates who did not have access to condoms). FGDs demonstrated high levels of knowledge regarding transmission of HIV, STIs and TB. **Prisoners** with TB are accommodated in an

215 In the consultations with PDFs, they report that they do not have access to condoms.

exclusive ward/wing and receive medical monitoring and differential treatment, which is not the case with people living with HIV who are not co-infected.

Key populations organisations expressed difficulties in registering and obtaining funding for their organisations. For instance, LGBT+ organisations struggle to receive formal recognition, impacting on access to funding. Iris Angola secured official registration in 2019, after more than five years of coming into existence. PLHIV organisations also reported difficulties accessing state CSO funding.

4. Gaps and Challenges

Angola's public policies, plans, regulations and health sector guidelines for HIV provide the framework required for efforts aimed at raising awareness and mitigating the effects of the HIV epidemic and related diseases such as TB; advocating for the rights of PLHIV, key populations and vulnerable groups; and mobilising resources for the continued expansion of prevention and treatment services. However, such services remain limited in coverage. Comprehensive knowledge of HIV and condom use at last sex with non-regular partner remains low among young people aged 15-24-year-old. PMTCT coverage is lagging at only 38% in 2018. ART coverage is estimated at roughly 30% of needs for adults and only 10% for children living with HIV. TB deaths among HIV positive patients have increased, putting the country on a track far from the UNAIDS 2020 target of 75% reduction²¹⁶.

Community services in particular remain scarce in the absence of a national Community Health Strategy which would define a set of strategic objectives and related indicators for community interventions. In addition, due to the current fiscal crisis, access to Government funding by civil society organisations is virtually impossible. At the same time, Angola's middle-income status

has meant that its Global Fund and PEPFAR funding is diminishing. In such a policy and funding context, non-medical, community-based interventions remain limited in scope and unsustainable beyond donor funding cycles. Key Populations specific interventions such as FSW or MSM peer outreach, condom and lubricant provision, response to gender-based violence, access to STI services, treatment adherence support – are entirely funded by either the Global Fund or PEPFAR, making them vulnerable to donor priorities. Also, critical support packages such as nutritional support, psycho-social support or organisational development support for CSO and KP groups remain by and large unfunded, even by development partners, both for HIV and TB.

In a country where 47% of new infections among adult females are among 15-24 year adolescent girls and young women²¹⁷ and where prevalence among female sex workers is estimated at 7.8%²¹⁸, domestic and international funding for HIV prevention among youth, and in particular young key populations, is tragically lacking when compared to funding for antiretroviral treatment.

Existing health policies, plans and guidelines are generally in accordance with the CRA, 2010 and international and regional instruments on the subject. However, given new scientific developments in HIV, Angola's framework is, in some respects, outdated, e.g. it fails to provide special protection for key and vulnerable populations or include strategies and/or policies to protect sexual and reproductive health and rights. This is compounded by the absence of the national community health strategy mentioned above.

Additionally, realising and enforcing rights protected by law is a significant challenge, recognised in the various health plans and strategies which note limitations such as insufficient health coverage, poor maintenance

216 INLS figures as reported by UNAIDS

217 Source: UNAIDS Estimates, 2019

218 Source: The Place Study, LINKAGES Project, 2018

of health units, insufficient skilled health personnel, limited health personnel in rural and peri-urban areas, insufficient financial resources, an inadequate health financing model and major problems related to the underlying social determinants of health.

Law 8/04 addresses some equality rights issues in the context of HIV. However, there is limited provision for key and vulnerable populations.²¹⁹ Law 8/04 also prohibits minors from accessing health services without the consent of a person with legal authority (e.g. parent / guardian) and provides for exceptions to voluntary, informed consent. It also places onerous responsibilities on persons living with HIV to protect others from infection and to disclose their HIV status – to sexual partners and to health care professionals.²²⁰

Despite protective health laws, policies and plans, including the Ministry's initiative for the "humanisation" of health services, the reality is key populations report discriminatory treatment in some health centres, primarily in Luanda. They describe the services rendered as generally poor, except in cases where they are dealt with by the HIV/AIDS focal points of the hospitals and health facilities used previously. They also report frequent breaches of confidentiality. Key populations are insufficiently aware of their rights and how to access remedies for discrimination in health care. Their organisations are reportedly insufficiently funded to provide the necessary support.

Although the country has advanced in terms of availability, accessibility and other elements of the right to health, broader health challenges are still huge, especially in rural areas, where health indicators are significantly lower than in urban areas. Among the various gaps and challenges, the following stand out:

- Insufficient financial resources assigned in the OGE for the health sector.

- The lack of information on HIV, the rights of PLHIV, and issues related to stigma and discrimination;
- Poor information on the rights of key and vulnerable populations as well as on sexual and reproductive health and rights;
- Weak mechanisms to enforce confidentiality, ethics and professional codes of conduct;
- Socio-economic vulnerabilities that prevent access to health care for all members of the population;
- The lack of continuous professional training for health professionals, including on the rights of PLHIV, key and vulnerable populations;
- The lack of remuneration incentives for professionals treating PLHIV and people with TB, inadequate infrastructure and constant disruptions of drug availability;
- Prohibition of condoms in prisons and irregularities in realising the right to conjugal visits in prison.

5. Recommendations

Due to the challenges and constraints presented, the following is recommended

- Assign adequate resources from the OGE to guarantee lines of sustainable, adequate, domestic funding for the realisation of the right to health, including the right to sexual and reproductive health and rights in compliance with international and regional commitments, including the Abuja Declaration.
- Allocate adequate resources, both domestic and external, to HIV prevention, in line with Angola's commitments within the Global Alliance for HIV Prevention
- Allocate adequate resources for community-based interventions which are led by national civil society organisations, including associations representing youth, key and vulnerable populations, and cater for their organisational development needs.

219 See Art. 22.2 Law 8/04 (HIV Act).

220 e.g. Arts 14 and 15 Law 8/04 (HIV Act).

- Expand the range and scope of community-based services through mutual support groups for adolescent PLHIV; nutritional support for PLHIV and TB patients; and by addressing social determinants of health
- Establish specific provisions in the Basic Law of the National Health System to strengthen available, accessible, non-discriminatory and quality health services for people affected by and living with HIV. Revise Art. 1 (b) on the promotion of equality with a view to provide for the substantive or *de facto* guarantee of equality.
- Provide for the specific needs of people affected by HIV in the revision of the Basic Law of the National Health System, including in terms of sexual and reproductive health and rights.
- Ensure that the draft Guidelines for Health Professionals working with Key Populations (2018) are validated, operationalised and disseminated
- Incorporate the needs of Key and vulnerable Populations in the Ministry of Health's initiative for the humanisation of health services
- Revise Law 8/04 to establish provisions that ensure substantive equality for both people living with HIV as well as key and vulnerable populations.
- Revise Law 8/04 to ensure humane services for all patients, regardless of sexual orientation or gender identity or any other situation e.g. drug use, migrancy.
- Revise Law 8/04 to guarantee independent access to HIV testing for adolescents.
- Eliminate punitive provisions on HIV non-disclosure and transmission, as discussed further below
- Adopt administrative measures for improving health services by strengthening the links between primary care and hospital care;
- Apply disciplinary sanctions to health professionals and other relevant actors who violate codes of good practice and the rights of PLHIV, people with TB, key and vulnerable populations, including through breaches of the right to confidentiality;
- Pursue and sustain the efforts made by Government to date to reduce the cost of health products – condoms, diagnostics and treatment products – through pooled and international procurement, with UN support

C. Criminalisation of HIV Transmission, Exposure and Non-Disclosure

1. Analysis of the Situation

The UNAIDS Policy Statement on the Criminalisation of HIV Transmission (2018)²²¹ notes that in some countries, criminal law continues to be applied to those who transmit or expose others to HIV infection, despite the lack of up to date data showing that the application of criminal law to HIV transmission, exposure and non-disclosure will achieve criminal justice or prevent HIV transmission.²²² On the contrary, the use of criminal law to respond to HIV transmission undermines public health and human rights. Criminalising HIV transmission, exposure and/or non-disclosure of a person's HIV status creates barriers to the realisation of the right to health, SRHR, privacy, freedom and security of the person, freedom from discrimination, and equality before the law. UNAIDS shows that

221 Policy Brief "Criminalisation of HIV Transmission", UNAIDS and UNDP available at: http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalisation_en.pdf last visited: 30 September 2018. See also Guidance Note, UNAIDS, 2013 "Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations".

222 The UNAIDS Joint Guidelines and the Office of the United Nations High Commissioner for Human Rights (EACDH) provide in guideline 4 (a) that criminal or public health legislation should not include specific offences against deliberate and intentional acts of HIV transmission, but general criminal offences are applied to these exceptional cases. This application shall ensure that elements such as predictability, intent, causality and consent are clearly specified in the law.

the excessive or inappropriate use of criminal law in cases of HIV transmission increases stigma and, consequently, discrimination against PLHIV. Moreover, criminal prosecutions often disproportionately target members of marginalised groups, key populations and vulnerable groups i.e. women, migrants, refugees, etc.²²³

The GCHL (2012) and its Supplement (2018) note that criminalisation does not promote the well-being of any party. The GCHL (2012) argues that the use of the criminal law in fact criminalises the sexual relations of PLHIV,²²⁴ and there is no evidence that laws criminalising or regulating PLHIV's sexual behaviour can change their conduct. They **do not** motivate people living with HIV to reduce their risk of transmitting the virus. **They do not** motivate them either to protect themselves against re-infection. On the contrary, such laws generate the fear of prosecution and isolate PLHIV. They ultimately discourage people who are potentially affected by the epidemic from seeking HIV testing and treatment services, or from informing their sexual partners or relatives about their health status. In this sense the penal system conflicts with the aims of the public health system.²²⁵ As a reminder, UNAIDS 90-90-90 targets recommends that 90% of people living with HIV should know their status, 90% of those should receive antiretroviral treatment and 90% of those should be virally suppressed. The fear related to potential HIV prosecution defeats any attempts towards the achievement any of these set 90-90-90 targets.

Moreover, the criminalisation of HIV transmission poses serious risks to evidence as an essential element of procedural guarantees in conducting criminal justice. In most cases it is very difficult to prove who transmitted HIV to whom, e.g. when both parties had more than one sexual partner in a

given period. Whether it was the complainant or the defendant who infected the other cannot be based on who was the first to carry out the HIV test nor who accused the other of HIV transmission. Likewise, objective forms of proof such as phylogenetic testing can only determine the degree of relationship between two HIV samples and therefore cannot establish **beyond reasonable doubt**, the source, route or timing of infection.²²⁶ As a result, it is extremely difficult, legally and scientifically, to prove the transmission of HIV from the complainant to the defendant, and beyond reasonable doubt.

Scientific evidence relating to treatment is also relevant. Clinical trials have shown, for example, that a fully suppressed viral load results in a zero chance of HIV transmission. As explained on AIDSMAP website, “when a person is living with HIV and is on effective treatment, it lowers the level of HIV (the viral load) in the blood. When the levels are low (below 200 copies/ml of blood measured) it is referred to as an “undetectable” viral load. This is also medically known as virally suppressed. At this stage, HIV cannot be passed on sexually. This scientific evidence was gathered from several studies. The studies included thousands of heterosexual and gay couples in which one partner had HIV and the other did not. Over the course of the studies, they found that there was not a single HIV transmission from an HIV-positive partner who had an undetectable viral load. When a person is undetectable, condoms are not required to prevent HIV transmission, but being undetectable does not protect against other sexually transmitted infections”²²⁷. Also, the U=U or Undetectable = Untransmittable equation only applies to transmission through sex only. In such a context, excessively broad criminal laws related to HIV simply fail to take into account up-to-date scientific knowledge about HIV-related risks and harms.

223 Policy Brief “Criminalisation of HIV transmission”, UNAIDS and UNDP (2018)

224 GCHL 2012, p. 25

225 *Idem.*, p. 22

226 Policy Brief “Criminalisation of HIV transmission”, UNAIDS and UNDP (2018). *See also* Barre-Sinoussi, *et al.* “Expert consensus statement on the science of HIV in the context of criminal law” 2018. Available at: <https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.25161> Last visited: 19.03.2019

227 <http://www.aidsmap.com/about-hiv/what-does-undetectable-untransmittable-uu-mean>

Finally, there are alternatives to the use of criminal law to reduce the spread of HIV. States are called to make available and accessible programmes that are proven to reduce HIV transmission. The GCHL (2012) argues that “criminalisation is justified under **one condition only**: when individuals intentionally transmit or expose others with the express purpose of causing harm”.²²⁸ More recently, some countries have repealed laws criminalising HIV transmission, exposure and non-disclosure. *e.g.* Ghana, Greece, Honduras, Kenya, Malawi, Mongolia, Switzerland, Tajikistan, Venezuela, Zimbabwe and two states in the USA.

2. International Standards

The Global Commission on HIV and the Law²²⁹ (2012) therefore recommends that:

- i. Countries should not enact legislation that explicitly criminalises HIV transmission, exposure to HIV or non-disclosure of HIV status. Where such laws exist, they are counter-productive and must be abolished.
- ii. Police and judicial authorities should not prosecute persons in cases of non-disclosure of HIV or exposure to HIV where intentional or malicious transmission is not proven. Invoking criminal laws in cases of consensual sexual activity between adults is disproportionate and counter-productive to improving public health.
- iii. Countries should revise or abolish any law that explicitly or effectively criminalises vertical HIV transmission. While the process of review and abolition is under way, Governments must declare a moratorium on the application of such laws.
- iv. Countries can legitimately bring a lawsuit against the actual and intentional transmission of HIV, using general criminal law. Court actions must be carefully adopted and require a high level of evidence and proof.

- v. Convictions of those who have been prosecuted for HIV exposure, its non-disclosure and transmission should be reviewed. Such convictions should be set aside or those who have been accused must immediately be released from prison with pardons or similar actions to ensure that these charges are not in their criminal records and that they do not feature or remain on any sexual offenders list.

The Supplement²³⁰ (2018) of the Global Commission further recommends that:

1. In countries where HIV criminalisation laws still exist, courts must require proof of intent to transmit HIV, according to applicable criminal law. The intent to transmit HIV cannot be presumed or derived solely from the accused’s knowledge of positive HIV status and/or non-disclosure; by engaging in unprotected sex; having a child without taking steps to prevent mother-to-child transmission of HIV; or by sharing drug injection apparatus.
2. Governments should ensure that, where a specific HIV law has been repealed, there is a restriction on the application of any general laws to the same effect for both HIV and TB.
3. Governments should prohibit prosecution – according to specific HIV statutes, drug laws or laws on child abuse and neglect – of women living with HIV for choices made during and after pregnancy, including breastfeeding.

The UNAIDS International Guidelines on HIV/AIDS and Human Rights Guideline No. 4 establishes that “States shall review and amend criminal law and correctional systems in order to ensure their compatibility with international human rights obligations and prevent their misuse in the context of HIV or against affected, vulnerable groups”.

International standards recommend using alternatives to criminal law. States should

228 CGVD, p. 26

229 *Idem.*, p. 29

230 Supplement (2018) 18-21, p.9

therefore adopt measures that protect human rights, such as the provision of HIV-related information, support and health products; increasing access to voluntary HIV testing and counselling; addressing HIV-related stigma and discrimination against PLHIV and key and vulnerable populations; empowering PLHIV and members of key and vulnerable populations; preventing and responding to violence against women, children and key populations; and improving the effectiveness of justice systems. In short, States should adopt measures which help realise the right to health instead of focusing on the criminalisation of HIV transmission.

3. Current situation in Angola

In January 2019, the National Assembly of the Republic of Angola approved a new Penal Code. However, as of 23.01.2020, the Penal Code has not yet been published in the Official Gazette.

Law 8/04 “HIV / AIDS law” establishes in its Art 15 that: (1) The transmission of HIV in a wilful manner is a crime and is punished under the terms of Article 353 of the Penal Code. It further establishes that (2) Anyone who negligently, disregards or without observations of regulations to infect others is punished under Article 368 of the Penal Code. Law 8/04 on HIV/AIDS equates HIV transmission with the crime of poisoning, imposing a term of up to eight years in prison. For negligent transmission, the penalty corresponds to the crime of involuntary manslaughter punishable by up to two years in prison.²³¹ These provisions appear, prima facie, to cease to have effect from the date of entry into force of the new Penal Code referred above. The case of “negligent transmission” may remain subject to interpretation since the new Criminal code does not expressly derogate Section 15 of the HIV Law (Law 8/04). However, the New Criminal Code establishes a general rule for offenses to physical integrity through negligence.²³²

New Penal Code

After the signing of the peace agreements in 2002, Angola carried out a series of legal reforms as part of the process of national reconciliation and in order to adapt its legal order to current realities. This included the development of the new 2010 Constitution and the reform of the Penal Code (in force since 1886) in line with the new constitutional framework and to reflect constitutional rights, freedoms and guarantees. The preliminary draft of the new Penal Code has already been approved by the National Assembly (but not yet published as of 23.01.2020 in the Official Gazette). The new Penal Code is founded on the principle of using the criminal law only when strictly necessary, when other branches of law fail to prevent conduct.

However, the preliminary draft provides in two instances for the criminalisation of HIV transmission, exposure and non-disclosure by establishing a provision criminalising non-disclosure, exposure to and transmission of STI, with or without intention – with the highest penalty being for intentional exposure where transmission occurs – in Art. 207. It also establishes a general rule relating to intentional exposure (with an increased penalty for actual transmission) of a serious illness, in Art. 208 (Chapter V (Placement of People in Danger), Title I (Crimes Against People), Book II (Special Part)), as set out below.

Article 207 (Contagion of sexually transmitted disease)

1. Whosoever, in the knowledge that he or she has a sexually-transmissible viral or bacterial disease, that could endanger another person's life, has sexual relations with another person without first informing him or her of this fact shall be punished with imprisonment for up to 2 years or with a fine of up to 240 days.

231 A Lei 8/04 “lei de VIH/SIDA” estabelece no seu Art 15 que: (1) A transmissão do VIH de forma dolosa constitui crime e é punido nos termos do Artigo 353 do Código Penal. (2) Aquele que por negligência, inconsideração ou falta de regulamentos infectar outrem, é punido nos termos do Artigo 368 do Código Penal

232 See Section below on New Penal Code

2. If the victim is contaminated or infected, the penalty is imprisonment of 2 to 4 years.
3. If the agent acted with the intention of contaminating the victim, but failed to do so, the penalty is imprisonment of 4 to 6 years.
4. If the agent acted with the intention of contaminating the victim and did effectively contaminate him or her, the penalty is imprisonment of 6 to 10 years.
5. The penalty provided for in the preceding paragraph is applicable to anyone who intentionally contaminates another person by any other means.
6. Criminal procedure depends on complaint.

Article 208 (Contagion of serious illness)

1. Anyone who intends to transmit a serious illness of which he or she suffers, practices an act likely to infect another person, shall be punished with imprisonment up to 3 years or with a fine of up to 360 days.
2. If the disease is transmitted, the penalty is imprisonment of 3 to 5 years.

Therefore, contrary to international standards, the new Penal Code criminalises:

- Sexual intercourse by a person living with HIV who does not disclose their HIV status
- Transmission of HIV regardless of whether the person living with HIV had the intention of infecting others
- Exposure to HIV, even if there has been no effective transmission.

With regards to negligent transmission, the Criminal Code establishes that in its Section 166.1 entitled “Offense to physical integrity through negligence” that “[w]ho, through negligence, offends another person’s body or health is punishable by imprisonment for up to one year or a fine of up to 120 days”. After listing some aggravated forms, it finally provides in paragraph 4 that criminal proceedings depend on complaint.

Additionally, contrary to international standards, the new Penal Code includes specific provisions criminalising the transmission of Sexually Transmitted Infections (STIs).

4. Gaps and Challenges

The provisions of the new Penal Code are overly broad, criminalising HIV transmission, exposure as well as non-disclosure of HIV serological status. This is inconsistent with current international and regional guidelines nor does it take into account scientific advances and evidence in relation to HIV transmission in order to provide justification in defence against criminalisation charges. Although Art. 207 does not specifically mention HIV infection, it criminalises the non-disclosure, exposure and transmission of sexually transmitted diseases, which would include HIV. This study²³³ found that public health and related laws in Angola do not adequately deal with HIV in addition to the fact that the realisation of the right to health is facing a series of challenges. The law should guarantee that people living with HIV and their sexual partners have access to health services, including education, information, prevention and counselling services, to reduce the risk of transmission and re-infection.

More critically, Art. 207 of the new Penal Code does not reflect the principle of minimal intervention through criminal law. Other branches of law – such as health law and policy – may be better placed to promote health rights. The State could also adopt preventive and educational measures to guarantee the availability and accessibility of quality HIV-related medical and health services.

Additionally, using criminal law to respond to HIV infection disturbs the distinction between constitutional and public health rights and the criminal order. Criminal law should not replace other means available to the State to realise its responsibilities. The CRA, 2010 provides in Art. 21 that “[t]he fundamental

233 See the other sections of this Assessment, e.g. health, access to justice, equality and anti-discrimination, women, children, etc.

tasks of the Angolan State are: b) To ensure the fundamental rights, freedoms and guarantees; f) To promote policies that make primary health care universal and free; [...].” Other constitutional rights and guarantees, such as the right to health, oblige the State to fulfil the rights of the people in its jurisdiction, without unnecessary recourse to the criminal law.

Moreover, in accordance with the principle of Fragmentation of Criminal Law, criminal law should deal only with serious offences against protected legal interests. These principles are reinforced in the Angolan Constitution itself; Article 57.1 which provides that “[t]he law may only restrict rights, freedoms and guarantees in cases expressly provided for in the Constitution, **and the restrictions should be limited to what is necessary, proportional and reasonable** in a free and democratic society, to safeguard other constitutionally protected rights or interests.” For this reason, intentional transmission, with the express purpose of causing harm, should be the only circumstance punishable by criminal law.

International guidance indicates that criminalising HIV transmission not only fails to serve its purpose of protecting others from HIV infection, it also criminalises sexual relations, thereby violating the right to sexual and reproductive health, the right to privacy, and other fundamental rights. Art. 207 proposes to punish those who know their HIV status. The possibility of complaint and punishment may discourage people living with HIV from seeking HIV testing and counselling, from accessing and staying on HIV treatment, causing further risks of HIV re-infection of self and transmission to others. As such, criminalisation may ultimately defeat the national purpose of ending the HIV epidemic. This is particularly the case for key and vulnerable populations who are characterised by a higher exposure to HIV infection.

The proposed criminalisation of non-disclosure, exposure and transmission of HIV status violates the right to health – particularly

sexual and reproductive health – as well as the right to privacy²³⁴, by criminalising sexual relations of persons with STIs. The proposed new law (as set out in Art. 207.1 of the new Penal Code) also criminalises attempted transmission, contrary to international guidance recommending the use of criminal law only in cases of effective transmission.

5. Recommendations

- Align (existing and proposed) criminal legislation with international standards, including standards to ensure that the judiciary takes into account medical and scientific advances as evidence in criminal proceedings relating to non-disclosure, exposure and transmission of HIV. Where HIV arises in the context of a criminal case, the police, lawyers, judges and, wherever appropriate, juries, should be informed by the best scientific evidence available on the benefits and consequences of appropriate therapy.
- Prohibit the prosecution of women living with HIV for choices made during and after pregnancy, including breastfeeding children.
- Develop guidelines to support law enforcement agents and the judiciary to ensure that criminal sanctions are applied.
- Repeal the provisions in Law 8/04 the HIV/AIDS Law regarding non-disclosure, exposure and transmission OR revise such provisions to only criminalise intentional transmission: “[w]hen an individual transmits the HIV virus maliciously and intentionally, with the express purpose of causing harm”.
- Adopt counselling measures to encourage couples/partners to share information about their HIV status with each other in order to take informed action to prevent HIV transmission and to protect each other from infection and reinfection.
- Use other legal and public health alternatives to criminal law to prevent

²³⁴ According to the UNAIDS Policy Statement on the Criminalisation of HIV Transmission (2018), “Everyone has the right to privacy about their health and should not be required by law to disclose such information, especially where it may lead to serious stigma, discrimination and possibly violence, as in the case of HIV serostatus”.

the spread of the HIV epidemic, including increased resources and focus on HIV prevention, and addressing stigma and discrimination

- In the case of sexual offences such as rape, which result in HIV transmission or create a significant risk of HIV transmission (taking into account medical and scientific evidence related to transmission), the HIV positive status of the offender should only be considered an aggravating factor in the sentence, if the offender knew that he was HIV positive at the time of committing the offence.

D. Women: Gender Inequality, Harmful Gender Norms and Gender-Based Violence

1. Analysis of the Situation

Disregard for women's rights fuels the HIV epidemic and simultaneously exacerbates its impact.²³⁵ In fact, the Special Rapporteur on violence against women pointed out in their report on the intersections between violence and HIV that gender inequality is both the cause and consequence of the specific gender manifestations of the disease.²³⁶

The UNGASS Political Declaration on HIV and AIDS (2016)²³⁷ emphasises its deep concern that women and girls are most affected by the

HIV epidemic, noting that progress towards gender equality and the empowerment of all women and girls has been “**unacceptably slow**”. The Declaration recognises that the ability of women and girls to protect themselves from HIV continues to be compromised by a number of factors,²³⁸ such as physiological factors, gender inequalities, including unequal power relations between men and women and between boys and girls, inequalities in relation to economic, social and legal status, insufficient access to health services, including sexual and reproductive health services, discrimination and violence in the public and private spheres. It notes with “**alarm**” the “slow progress in reducing new infections” due, amongst other things, to the insufficient access of women and girls to HIV prevention, testing and treatment programmes.²³⁹

The GCHL (2012) emphasises that gender inequality, discrimination, stigma, and violence, when underscored by harmful cultural norms and the law, deprive women and girls of the power to make autonomous decisions, thus aggravating the risk of exposure to HIV.²⁴⁰ Examples of violence against women include early marriage, forced marriage, female genital mutilation and other forms of violence related to harmful practices; rape, physical violence and other forms of intimate partner violence and/or sexual exploitation. It recommends removing these barriers to facilitate access to SRH services, in order to reduce the risk of infection.²⁴¹

In Angola gender inequality is recognised as one of the social, economic and cultural factors contributing to the epidemic.²⁴² The

235 Report of the Special Rapporteur on violence against women, its causes and consequences. Integration of the human rights of women and the gender perspective: violence against women intersections of violence against women and HIV/AIDS. E/ CN.4/2005/72 of 17 January 2005, paragraph 16, Commission on Human Rights

236 *Idem.*, Summary;

237 Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and Ending the AIDS Epidemic by 2030, UNGA A/RES/70/266, 8 June 2016, paragraph 41

238 See also RG No. 24 CEDAW, 1999 paragraph 12

239 Declaration on HIV and AIDS (2016), UNGA A/RES/70/266, 8 June 2016, paragraph 42

240 Global Commission for HIV and the Law p. 71 etc. For more information on cultural practices affecting the realisation of women's rights See Report by the Rapporteur Special report on violence against women, its causes and consequences. E/ CN.4/2002/83 of 31 January 2002, Commission on Human Rights

241 *Idem.*, p. 74 etc.

242 VII Periodic Report CEDAW (National Report of Angola) See CEDAW/C/AGO/7 of 18 December 2017, paragraph 174. Other factors are the high rate of illiteracy; early sexual debut, lack of knowledge and the existence of prejudice about the risk of sexually transmitted infections and HIV, multiple, concurrent sexual relationships by male partners, and cultural and religious barriers to the use of prevention methods.

Human Rights Council has made the following recommendations to Angola on gender equality: (a) take measures, in collaboration with civil society organisations, to ensure the right of women to non-discrimination and equality; (b) pursue efforts to increase women's access (...) to health care through their full participation in the political, economic, social and cultural fields; (c) further improve the conditions of women in rural areas; and (d) continue to address the existence of certain practices and stereotypes derived from cultural practices that can result in discrimination against women and girls.²⁴³

The CEDAW Committee has already expressed concern about women's rights to health, noting the disproportionately high number of women living with HIV in Angola; the limited access to basic health services, in particular for rural women; the existence of sociocultural factors that prevent women from accessing these services; the lack of adequate health infrastructure and human and financial resources allocated to the health sector; the high teenage pregnancy rates; the lack of SRHR information provision services, including for family planning; and the criminalisation of abortion (except in exceptional circumstances).²⁴⁴ The African Commission on Human and Peoples' Rights recommends that Angola provide free access to antiretrovirals, particularly for women,²⁴⁵ and strengthen awareness-raising programmes, especially for young people, including girls.²⁴⁶

During fieldwork conducted for this study, the theme of violence²⁴⁷ came out strongly, including intimate partner violence against women, sexual violence and family abandonment e.g. expulsion of sexually

exploited minors and LGBT+ from the family. Within communities, verbal, physical and sexual violence against women is also a reality, especially in sub-urban areas, often associated with the use of alcohol, cannabis, and other substance abuse. FGD participants also reported violence and police abuse against female sex workers. Culture and religion, limited awareness of rights, were reported to contribute to violence against women, including female sex workers.

Stigma and discrimination against women was highlighted as an issue in Kuito, Bié province. CSOs reported that women choose not to deliver in hospitals, due to stigma and discrimination, including verbal abuse, from health professionals. The low rate of access to ante-natal care services and health-facility based delivery is a consequent of a combination of factors such as catastrophic costs of access to services and fear of a hostile environment in maternity clinics. The result is the inability of the health system to adequately capture and retain women living with HIV for PMTCT and treatment.

2. International Standards

The UDHR recognises the equal rights of men and women to social progress and to improved living conditions, set against a backdrop of wider freedoms.²⁴⁸ The ICCPR²⁴⁹ and the ICESCR²⁵⁰ contain provisions obliging State Parties to ensure equality for men and women in the enjoyment of all rights within the conventions. In addition, the Convention on the Elimination of All Forms of Discrimination against Women also includes the right to health.²⁵¹

243 2nd Cycle of the Universal Periodic Review Angola, A/HRC/28/11 (2014), paragraphs 134.67, 1344.70, 134.71, 134.72

244 The CEDAW Committee specifies that, in practice, abortion is allowed in cases of rape and risks to the child's development, according to the Angolan State. *See* OF, CEDAW/C/AGO/CO/6, 2013, paragraph 31 (d)

245 Recommendation XXIX, Concluding Observations and Recommendations on the 2nd, 3rd, 4th and 5th Cumulative Regular Reports of the Republic of Angola, 12th Special Session 30 July – 4 August 2012, Algiers, Algeria

246 *Idem.*,

247 PEN V reports that 23% of women suffered physical or sexual violence by a male partner (in the last 12 months), p.42 Source INCAPSIDA (2010) – Survey on knowledge, attitudes and practices and seroprevalence in Angola, study conducted in 2010 by the Ministry of Health, INLS, Global Fund, UNAIDS

248 Preamble, UDHR

249 Art. 3 ICCPR

250 Art. 3 PIDESC

251 Art. 12 CEDAW

The Global Commission (2012) examined the intersection between HIV and women's rights and recommended that countries take action to protect the rights of women and girls, including those disproportionately affected by HIV.²⁵² It further recommended that States take measures to ensure gender equality, especially in cases of separation or divorce, e.g. establish presumption of marital co-ownership of family assets, and measures to stop police harassment. It called upon States to stop all forms of violence against women and girls, including acts such as forced abortion or coerced sterilisation of HIV-positive women and girls;²⁵³ to ensure that those responsible for applying religious and customary laws did not discriminate, and to discourage and prohibit harmful practices that increase the risk of HIV exposure.²⁵⁴

The GCHL (2012) also recommends the full implementation of existing laws aimed at protecting women and girls such as those prohibiting early marriage or those aimed at protecting women from violence, e.g. through the formulation and implementation of comprehensive national strategies, endowed with the necessary resources and including robust mechanisms to prevent, investigate and punish violence.²⁵⁵ The Global Commission Supplement (2018) emphasises the barriers women face in accessing sexual and reproductive health information and services, as well as violence against women living with HIV, including compulsory HIV testing, which constitute a barrier to accessing antenatal care.²⁵⁶

The CEDAW Committee states that issues related to HIV, AIDS and other STIs are central to the rights of women and adolescent girls to sexual health. It recommends that State

Parties should ensure, without prejudice or discrimination, the right to information on sexual health, education²⁵⁷ and services for all women and girls, including programmes that respect their right to privacy and confidentiality.

The UNAIDS International Guidelines on HIV/ AIDS and Human Rights (2006) establish standards for effectively combating the epidemic in relation to women. Guideline 5 on anti-discrimination and protective laws recommends that favourable legal measures be taken to reduce human rights violations against women in the context of HIV, in order to reduce women's vulnerability to HIV infection.²⁵⁸ Furthermore, Guideline 8 is dedicated to vulnerable groups and makes explicit mention of women. This guideline recommends the establishment of national and local forums to examine women's vulnerability to HIV, including not only their role in society and within the family, but also in relation to cultural norms that adversely affect women.

Regarding abortion, the CEDAW Committee specifically recommends that legislation criminalising abortion should be amended in order to remove the punitive measures imposed on women that resort to abortion.²⁵⁹ In this regard, the CESCR emphasises that the ban on abortion contributes to maternal mortality and morbidity, violating the right to life and safety and security of the person, and may in certain circumstances constitute torture or cruel, inhuman or degrading treatment.²⁶⁰ Art. 3 of the ICESCR on women's rights and gender equality requires that laws be reformed in order to eliminate restrictive provisions on abortion and ensure women and girls have access to safe abortion services

252 Global Commission on HIV and the law: Not a pipe dream: Gender equality and the end of AIDS. Available at: <https://hivlawcommission.org/>. Last visited: 22 May 2018.

253 Ref. CGVD (2012), Recommendations 3; 3.2.2; 3.2.5, p. 49; and p. 78, Recommendations. 4.1; 4.2 and 4.4.

254 *Ibid.*, pp. 76, 79 and 115.

255 *Idem.*, 2012, pp. 78-79

256 Supplement to the Global Commission (2018), p.35 etc.

257 RG No. 24 CEDAW, 1999, paragraph 15 and especially paragraph 31 (b) See Recommendation No. 15 (a) and (b), CEDAW 1990 See also Recommendations section Education and Information

258 Guideline No. 5 (f), Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, WHO, 2016

259 General Recommendation No. 24 CEDAW, 1999, paragraph 31 (c)

260 General Comment No. 22 (sexual and reproductive health), CESCR, E/C.12/GC/22, paragraph 10, 2016

and quality post-abortion care, including the training of health professionals. WHO further recommends that abortion laws and policies protect women's health and human rights, by removing legal and programmatic barriers to accessing timely provision of abortion care (pre and post abortion).²⁶¹

The ESCR Committee reminds States to respect the rights of women to make autonomous decisions about their SRH.²⁶² SRHR also implies an obligation to eliminate discrimination, requiring States to repeal or reform laws and policies that reinforce inequality and nullify or limit people's ability to make autonomous decisions. Such limitations on women prevent their full enjoyment of the right to SRH. The Committee cites abortion laws as an example of discriminatory laws.²⁶³ Additionally, the obligation to respect SRHR requires States to avoid interfering directly or indirectly in the exercise of SRHR, which means that States cannot limit or deny abortion through criminal laws,²⁶⁴ creating a barrier to accessing SRH services.²⁶⁵ The obligation to provide SRHR implies the provision of safe abortion services and failure to comply with these obligations violates SRHR.²⁶⁶

In the African context, the Banjul Charter²⁶⁷ and the Maputo Protocol guarantee women their sexual and reproductive rights,²⁶⁸ such as the right to control their fertility; the right to decide whether to have children and the number of children they want to have; the right to choose any method of contraception; the right to protection from STIs, including HIV and AIDS; the right to be informed about their state of health. The Protocol obliges States to protect the reproductive rights of women.

In SADC, the 2008 Model Law for HIV recognises women as a vulnerable population. It also provides specific rights for women and girls to education and information, protection against violence and equality, and non-discrimination.²⁶⁹ The Strategy for Sexual and Reproductive Health in the SADC Region (2019 – 2030) calls on Member States to align their policy and legal frameworks with global and regional commitments and standards in order to achieve the desired SRHR outcomes desired for the region. These include “universal access to integrated, comprehensive SRH services, particularly for young people, women, and key and other vulnerable populations, including in humanitarian settings”.

3. Current situation in Angola

According to the census from 2014, women represent 52% of the population (12.5 million) compared to 48% for men (11.8 million),²⁷⁰ and therefore the majority of the population. Women of childbearing age are estimated to constitute 21% of the population (3.8 million). The fertility rate is 6.2 (INE, 2016). Thirty five percent (35%) of the households are headed by women (INE, 2017). Over half of the population (51%) is less than 15 years old (INE, 2016).

PEN V recognises that sexual intercourse is the main means of transmission of HIV in the country (79.2% of reported cases), with heterosexual transmission being the most frequent. This puts women at a greater risk of HIV infection, since 60% of cases are women²⁷¹. As mentioned earlier in this Study, while national HIV prevalence is at 2.1%²⁷², prevalence among women is 2.6% (1.2% among

261 WHO, Safe abortion: Technical & policy guidance for health systems (2012)

262 GC No. 22 (sexual and reproductive health) CDESC, E/C.12/GC/22, 2016 paragraph 28 *See also* GC No. 28 on Equal Rights for Men and Women, Human Rights Committee; CCPR /C/21/Rev.1/Add.10, 2000, paragraphs 5, 10, 11, 20 Add.10)

263 GC No. 22 CDESC, E/C.12/GC/22, 2016 paragraph 34

264 *Idem.*, paragraph 40

265 *Idem.*, 2016 paragraph 41

266 *Idem.*, paragraphs 57 and 59

267 Art. 2 prohibition of discrimination, Art. 3 equality before the law, Art. 18.3 equality of women, Art. 16 right to health

268 Art 14. right to health and reproductive rights

269 Arts. 26, 27 and 28, SADC Model Law for HIV, 2008

270 PEN V p. 14

271 *Idem.*, p. 27

272 Source: Angola IMMS 2017

men), 1.5 % among 15-24-year-old Adolescent Girls and Young Women (0.8% among adolescent boys and young men) and 7.8% among Female Sex Workers. And in 2018, an estimated 47% of new infections among adult females were among 15-24-year adolescent girls and young women. The epidemiological evidence of the higher vulnerability and exposure of women, particularly young women and young key populations, therefore abounds. Such vulnerability results from the combination of biological factors, economic poverty, cultural norms and gender inequality.

According to the World Economic Forum (2017), Angola occupies the 123th position among 144 countries concerning gender inequality. Gender inequality in Angola is related to the following factors: the feminization of poverty; the low level of education of women and girls (22% of women 15 – 49 years old are illiterate whereas for men it is 8%); the high presence of women in the informal sector of the economy in rural and urban areas; the high fertility rate ; early sexual debut – around 35% of women and girls aged 15 – 19 years old have already initiated their reproductive life, 29% have had a child and 6% are pregnant for the first time; early pregnancy, mostly in rural areas; weak decision-making power; parental abandonment; domestic violence; high exposure to sexually transmitted infections²⁷³.

The CRA, 2010 enshrines the **right to equality and non-discrimination** as a fundamental principle of the Democratic State of Law, giving the State the task of “promoting equality, respect and mutual tolerance between men and women”, without any discrimination.²⁷⁴ Under Article 35 (3) of CRA, 2010 “men and women are equal within the family, society and the State, enjoying the same rights and having the same duties”. The CEDAW Committee recommended that Angola strengthen gender equality by undertaking awareness-raising

actions “to change negative attitudes towards disabled women and girls, albinism, those living with HIV/AIDS, women in prostitution, LGBTI women, ensuring that severe penalties are imposed on the perpetrators of violations against them”.

Law 8/04 on HIV and AIDS is silent on the issue of gender equality although it guarantees rights to “every person infected by HIV”. The law does not address the vulnerability of women and girls to HIV.²⁷⁵

In 2011, Angola approved a law to protect family members against sexual violence and other forms of domestic violence in 2011.²⁷⁶ 32% of women aged 15 – 49 years have been exposed to physical violence since they were 15 years old, 8% of women in the same age group have been exposed to sexual violence at any moment in their lives and 34% of married women between 15 and 49 years old have been exposed to marital violence, either physical or sexual²⁷⁷.

Law 25/11 or the “Law against domestic violence” aims to protect society from acts of violence against women, men, children, the elderly and adolescents. It has a broad scope reaching beyond the family to other spaces, such as hospitals, schools and relevant community or social spaces. It applies based on proximity, affection, natural relations and education.²⁷⁸ However, Law 25/11 does not regulate situations of violence that make women and girls vulnerable to HIV, specifically abuse from police or law enforcement officers.

Law 25/11 recognises various forms of domestic violence, *i.e.* sexual violence, patrimonial violence, psychological violence, verbal violence, physical violence and abandonment by family.²⁷⁹ It also outlines principles to prevent violence, such as gender equality and social assistance to protect pregnant women, children and the elderly

273 Report of the Assessment of the Adolescent Girls and Young Women component under the Global Fund grant, UNDP, 2018

274 Art. 21, (h) and (k); Art. 22, No. 3 (b) and Art. 23 of the CRA (2010)

275 OC, VII Report, CEDAW/C/AGO/CO/7 of 6 March 2019, paragraph 44 (a)

276 Law No. 25/11, of 14 July (Law against Domestic Violence)

277 IMS 2015-2016

278 Art. 2 Law No. 25/11 (Law against Domestic Violence)

279 *Idem.*, Article 3.

within the family and social environment.²⁸⁰ The Law is supported by a Regulation,²⁸¹ the Executive Plan Against Domestic Violence and a Schedule of Actions. However, the law is not fully implemented due to weaknesses in public administration and the justice sector.²⁸²

Angola's Constitution states that the law shall regulate the requirements for, and the effects of, marriage and de facto union, as well their dissolution²⁸³. Act No. 1/88 "Family Code"²⁸⁴, establishes in its Article 23 that all persons in which some of the impediments to marriage provided for in the Family Code or another special law are not met can marry. Article 24 of the Family Code further establishes that only persons over 18 years of age may marry. However, Article 24.2²⁸⁵ states that in exceptional cases, men aged 16 and women aged 15 may be allowed to marry, when marriage is deemed to be the best option in the light of the circumstances and the interests of the minors. Under Article 24.3 authorization for minors to marry is granted by the parents, guardians or other persons with responsibility for the minor; a court may also authorize the marriage of minors, after hearing the opinion of the Family Council when non-authorization is deemed unjustified. Under Act No. 25/11 "Law against Domestic Violence", all forms of marriage, traditional or not, between children under 14 is considered a crime. The same provision also prohibits marriage with persons deprived of their legal capacity.

De facto unions are regulated in Articles 112 et seq. of the Family Code. By virtue of Article 113 (Family Code), a de facto union can only be recognized if all legal requirements for the celebration of marriage are met, which include

marital capacity; therefore, age of consent to marriage set in Article 24 of the family Code.

Marriages of adolescents below 18 years of age has life-threatening health consequences for children, especially adolescent girls. Pregnancy and childbirth complications are the second leading cause of death among adolescent girls aged 15 to 19 years old worldwide. Young girls are also more vulnerable to HIV, especially in countries with generalized epidemics.

With regards to harmful practices against women and customary law, Art 7 of the CRA, 2010 recognises the validity and legal force of a custom where it is not contrary to the Constitution and does not violate the dignity of a person. However, there is limited jurisprudence and norms relating to the application of these principles. Discriminatory and harmful gender norms derived from cultural and custom create barriers to gender equality and limit women's autonomy, including their sexual and reproductive health and rights.

The PND 2018-2022 supports gender equality and women's empowerment in the Policies related to Axis I²⁸⁶ and sets out a series of goals²⁸⁷ and priority actions²⁸⁸ with the aim of promoting equal opportunities between men and women²⁸⁹.

According to PEN V, the context and current state of the national health system continue to be detrimental to women's health, especially at reproductive age. Gender inequalities impact negatively on women's health and consequently, children's health. The proportion of women living with HIV is higher compared to men as described above.²⁹⁰ PEN

280 *Idem.*, Article 4

281 Presidential Decree No. 124/13, of 28 August (Approves the Regulation of the Law against Domestic Violence).

282 See Section on Access to Justice. For issues related to the structural and instrumental challenges facing Angola See also PND 2018-2022 p. 201 *etc.*

283 Article 35.4 Constitution Republic of Angola (2010)

284 Act 1/88 "Family Code" See also Article 24- Age of Consent, Article 25 Absolute Impediments and Article 26 Relative impediments

285 Article 23 "Family Code"

286 Government of Angola, National Development Plan 2018-2022, Vol. I, Luanda, 2018, p. 16.

287 Article 25.1.f Act 25/11 (Lei contra a Violência Doméstica)

288 *Idem.*, p. 84, e.g. Hold seminars for gender mainstreaming in development policies and plans; improve statistical information on gender issues in all areas of society

289 Second sentence, Article 25.1.f Act 25/11

290 PEN V, p. 14

V recognises women's limited participation in decision-making as affecting their SRH, ability to use preventive methods and negotiate safe sex, as well as affecting the development of a healthy sexual and reproductive life. The National Health Development Plan 2012-2025 states that this burden is compounded by the fact that women, as well as children, are also the main victims of domestic violence.²⁹¹ PEN V therefore calls for the mainstreaming of gender in programming in order to address inequalities and empower women for greater capacity, freedom and autonomy in SRH decision-making. PEN V prioritises pregnant women, mother-to-child transmission of HIV and strengthening the legal environment, in particular to eliminate discrimination and violence.²⁹² The national strategy for Key and Vulnerable Populations, on the other hand, does not recognise women as a vulnerable group.

4. Gaps and Challenges

Patriarchal attitudes and cultural norms, often perpetuated in customary law, create several gender-related challenges in Angola. Despite significant advances, there are laws as well as norms that increase the vulnerability of women to HIV, *e.g.* early marriage, lack of protection for widows in customary law, difficulties in accessing property and a prohibition of abortion (with some exceptions). The HIV Law does not expressly recognise the vulnerability of women to HIV, nor do national HIV policies and strategies comprehensively address gender-related issues in the context of HIV and AIDS. The new Penal Code prohibits abortion or termination of pregnancy although it does provide certain exceptions in some circumstances.

The absence of effective provisions to empower women and combat the discrimination that they face acts as a barrier to achieving gender equality in accessing SRHR.

In addition, protective laws are inadequately enforced. For instance, the law against domestic violence is still insufficiently implemented, due to lack of awareness of rights, lack of financial and human resources, lack of infrastructure and other key elements within the health, law enforcement and justice sectors. Eliminating violence against women by police authorities is an even greater challenge, with the authorities acting with impunity in an environment where violence against women is widespread. An illustration in this regard, are the findings from the LINKAGES Project which indicate that "11% of the Luanda-based FSW served by the Project (n=5,750) from May 2016 to January 2017 responded that they are victims of some form of violence. Seventy three percent (73%) of the violence cases reported occurred at hot spots, generally with sex worker clients making up 41% of the cases of violent acts. Further analysis showed that 13% of the violence cases took place in the street, with police as the perpetrators 21% of the time"²⁹³.

A further major challenge is the lack of awareness on the part of policy-makers, civil servants, health professionals and the general public of the importance of women's sexual and reproductive health and rights and the fact that punitive / discriminatory laws and practice (*e.g.* criminalisation of abortion, early marriage, violence, discrimination) violate human rights. Lack of information and education on gender equality and particularly on sexual and reproductive health and rights remains a challenge, especially in rural areas of the country where the trend and prevalence of customary law and harmful gender norms, including tolerance of intimate partner violence, remain strong. Lack of information includes ignorance of laws, policies and mechanisms to protect women's rights. FSW "do not perceive the violence they are subjected to as a psychological issue that requires professional care and group support even though it may be painful and traumatic for them"²⁹⁴. Nor do they see the violence as a human rights issue.

291 Ministry of Health, National Health Development Plan 2012 – 2025, Vol. 1, 2012, p. 21.

292 PEN V, p.103 *etc.*

293 Source: LINKAGES Project, 2017

294 Source: LINKAGES Project, Lessons Learned Report from UNDP/Global Fund Project, 2018

5. Recommendations

Based on the gaps and challenges, the following is recommended.

- Adopt legislative measures to strengthen gender equality, either through special gender equality legislation or through general anti-discrimination legislation that takes into account gender issues and the specific needs of women, as has been recommended by the various international human rights mechanisms to Angola.
- Revise Law 8/04 in order to recognise women as a vulnerable population, in line with that proposed by the SADC Model Law on HIV, and to protect women from discrimination.
- Revise Law 8/04 in order to protect women's rights to autonomy in decision-making in relation to their sexual and reproductive health, in accordance with international human rights law.
- Adopt administrative and financial measures to ensure women's access to health services, including HIV prevention, treatment and care services, and to improve the living conditions of women in rural and peri-urban areas.
- Take measures to protect and promote the rights of women and girls to accurate sexual and reproductive health information and education
- Eliminate the cultural and customary barriers that prevent the full enjoyment of women's rights, specifically the rights to equality, dignity and the right to health, including sexual and reproductive health, based on an audit of customary norms that constitute harmful practices and that act as barriers to the enjoyment of women's rights.
- Adopt legislative measures to regulate abortion, in order to empower women to make decisions in relation to their sexual and reproductive health and to comply with recommendations made by international and regional human rights mechanisms.
- Strengthen training and resources for health professionals, the police, judiciary and penitentiary systems in order to ensure effective and sustainable implementation of the Domestic Violence Act.
- Strengthen enforcement mechanisms (e.g. disciplinary regimes) for police and penitentiary violence, abuse and unjustified use of force
- Adopt educational measures in the health, police, penitentiary and amongst traditional authorities on gender equality and the fight to eliminate discrimination towards women; expand and sustain current initiatives for the sensitisation of police hierarchy and front line officers to the human rights of female sex workers; pursue and reinforce existing collaboration for adequate gender-based violence responses
- Review Art. 24.2 of the Family Code to prohibit early marriage and align with the ICRC.
- Strengthen national HIV policies and strategies, including the NSP and the National Strategy for Key and Vulnerable Populations, to recognise the vulnerability of women to HIV.
- Strengthen institutional coordination mechanisms, especially with regards to sexual and reproductive health.

E. Children and Adolescents

1. Analysis of the Situation

HIV and AIDS also affects adolescents and children. UNAIDS data for Angola shows that in 2016, there were 27,000 children aged 0 to 14 years living with HIV; 5,500 children 0 to 14 years old newly infected with HIV; 3,300 AIDS deaths among children aged 0-14, and 14% of children 0-14 years were receiving ART.²⁹⁵

294 Source: LINKAGES Project, Lessons Learned Report from UNDP/Global Fund Project, 2018

295 <http://www.unaids.org/en/regionscountries/countries/angola> last visited 07.11.2018

296 Global Commission (2012) p. 81

The Global Commission on HIV and the Law states that the needs of children are closely related to those of adults.²⁹⁶ HIV infection amongst children is directly related to women's vulnerability to HIV. Women are physiologically more vulnerable to infection and are also at a higher risk due to reported low rates of condom use²⁹⁷, prevalence of practices of multiple, concurrent sexual partnerships among men²⁹⁸, and strong social norms that restrict autonomy within relationships. This is aggravated by the fact that illiteracy levels among women are higher, while access to information is lower, limiting women's ability to prevent and seek treatment for HIV and AIDS.²⁹⁹ UNAIDS estimates³⁰⁰ the coverage of pregnant women receiving ART for PMTCT at 34% in 2016. 7 088 pregnant women of the 21 000 estimated pregnancies received ART to prevent vertical transmission (PMTCT services). The number of new HIV infections avoided was 1 200.³⁰¹ The failure to reach all women in need is recognised as a challenge in PEN V, which notes that there is still limited data on the impact of the PMTCT programme on reducing HIV infections in children³⁰² and that adherence of pregnant HIV+ women to ART for preventing vertical transmission is poor.³⁰³

The HIV epidemic constitutes a serious threat to adolescent health. As such, adolescents are recognised as a vulnerable population due to the HIV epidemic in Angola. A Ministry of Youth and Sports' behavioural study of adolescents and young people conducted with the support of UNICEF and UNAIDS (2013)³⁰⁴ identified several adolescent populations in vulnerable situations. Out-of-school youth, homeless adolescents and young people on the streets,³⁰⁵ with fragile family and social

protection networks, exposed to alcohol, drug use or violence, receive limited education, let alone information on HIV transmission and prevention. According to UNAIDS (2016), knowledge about HIV prevention among young people aged 15-24 is 32.25%, 32.5% among girls and 31% among boys. Children and young people who are sexually exploited and/or involved in sex work face the same risks, living the same life circumstances of survival within non-existent or fragile social support networks.

Stigma and discrimination within the family, school and broader social environments are the greatest challenges for children affected by HIV and AIDS, according to the feedback received from NGOs working with children. Domestic violence, family abandonment, bullying and social isolation are all reported to be faced by children affected by HIV through parental illness, parental transmission of HIV infection or for being a suspected HIV/aids orphan. In the case of young key populations from the LGBTIQ community, expulsion from the family environment is a common experience.

Birth registration remains a challenge in Angola, with only 25% of children under 5 having been registered by the authorities (INE 2014). Yet "the availability of data that is up-to-date, including birth registration, is crucial for planning high-quality health service provision for all".³⁰⁶ Children whose births are not registered may be denied basic public services such as health care or education. From a human rights perspective, registering children at birth ensures their recognition before the law to safeguard their rights and ensure that violations are responded to.³⁰⁷

297 Respectively 30% and 24% of men and women who have had 2 or more sexual partners in the last 12 months, had used a condom during the last sexual intercourse, IMS, 2016

298 18% of men against 2% men reported having had 2 or more sexual partners in the last 12 months, INLS, 2016

299 See Section on Women, especially recommendations.

300 <http://www.unaids.org/en/regionscountries/countries/angola> last visited 07.11.2018

301 <http://www.unaids.org/en/regionscountries/countries/angola> last visited 07.11.2018

302 PEN V p. 54

303 PEN V p. 63

304 Behavioural Risks Among Adolescents and Young People Regarding HIV and AIDS, Research (2013) p. 8

305 Children working or begging on the street often maintain family connections that homeless children do not have, although they may only have sporadic or inadequate family support. They usually work on the street all day and return home at night, "Behavioural Risks Between Adolescents and Young People Regarding HIV and AIDS, Research" MIJUD, 2013.

306 The key to children accessing their rights in Angola, UNICEF, 2015, p. 17

307 <https://data.unicef.org/topic/child-protection/birth-registration/> last visited 7.11.2018

Sexual and reproductive health information and education is critical to the country's response to the HIV epidemic.³⁰⁸ In the words of the GCHL (2012) "[a] complete and age-appropriate sexual education (...) is beneficial to the health of young people." For the Angolan Executive, information, education and communication are indispensable for HIV-related behaviour change, particularly amongst key populations.³⁰⁹ In Angola, cultural and linguistic diversity requires a multi-lingual and multicultural approach to behaviour change communication, since the majority of the population conserves its cultural inheritance.³¹⁰

Regulating the age of consent to access sexual and reproductive health services is also of vital importance in responding effectively and sustainably to the epidemic. In a context where 77% and 71% of, respectively young men and women aged 15-24 years old had their sexual debut before the age of 18³¹¹, there is an urgent need for HIV prevention services and for ensuring access of adolescent minors to quality sexual and reproductive health services.

2. International Standards

Children are defined by the Convention on the Rights of the Child (CRC) as persons under 18 years old unless, according to a country's law, the age of majority is reached earlier.³¹² Adolescents are defined by the WHO as people aged 10 to 19 years of age.

According to General Comment No. 20 of the Committee on the Rights of the Child, the approaches adopted to ensure the realisation of the rights of adolescents differ significantly from those adopted for young children.³¹³ Responding to children's HIV and human rights requires a holistic approach involving a wide range of rights, not only the right to health. As such, the impact of HIV/AIDS affects all children's rights.³¹⁴ Key rights include the right of access to appropriate information (Art. 17), the right to health and medical services, especially the right to preventive care, sexual education, and family planning services (Art. 24), the right to an appropriate standard of living³¹⁵ (Art. 27), the right to privacy (Art. 16), the right not be separated from parents (Art. 9), the right to be protected from violence (Art. 19), the rights to protection by the State (Art. 20), the right to education (Art. 28), the right to leisure (Art. 31), the right to physical and psychological recovery and the right to social reintegration (Art. 39).³¹⁶

General Comment No. 3 of the Committee on the Rights of the Child deals with issues such as the availability, accessibility and quality of health services in relation to the needs of persons under 18 years of age, in particular adolescents.³¹⁷ A rights-based HIV response should provide services that are friendly, information tailored to their needs, guarantee their opportunity to participate in decisions affecting their health, and provide services that are accessible, confidential, and free from judgement. Access to such services should not require parental consent and should not discriminate. Children's privacy,

308 See section on Education and Information

309 PEN V p. 13

310 PEN V p. 24

311 IMS 2016

312 Art. 1 CDC

313 GC No. 20 Committee on the Rights of the Child, CRC/C/GC/20, 2016, paragraph 1

314 A holistic approach such as this must take into account the general principles established in the CDC, i.e. the right to non-discrimination (Art. 2), the principle of the best interest of the child (Art. 3), the right to life, survival and development (Art. 6) and the right to have their views respected (Art. 12). *See also* GC No. 3 Committee on the Rights of the Child, CRC/GC/2003/1, 2003, paragraph 3,

315 The child has the right to a standard of living that is adequate for his or her physical, mental, spiritual, moral and social development.

316 GC No. 3 of the CDC also recognises the rights of children with disabilities (Art. 23), the right to social security, including social welfare (Art. 26), the right to be protected from exploitation and economic abuse (Arts. 32, 33, 34 and 36), the right to be protected from abduction, sale and trafficking, as well as torture or other cruel, inhuman or degrading treatments or punishments (Arts. 35 and 37)

317 GC No. 3 Committee on the Rights of the Child, CRC/GC/2003/1, 2003, paragraph 17

voluntary counselling and testing, confidential sexual and reproductive health services, free contraception (e.g. condoms) or low-cost services should also be ensured.

The Global Commission³¹⁸ (2012) recommends that States ensure that the birth of all children is recorded. This measure is key to enabling children to access essential services. The Committee on the Rights of the Child highlighted the critical implications of proof of identity for children affected by HIV and AIDS with respect to ensuring recognition as a person before the law as a means of safeguarding the protection of their rights, in particular rights to inheritance, education, health and other social services. Therefore, to ensure an effective response to the HIV epidemic, States must fulfil their obligation to ensure the registration of all children shortly after birth under the terms of Art. 7 of the CRC.³¹⁹

With regards to children affected and/or orphaned by HIV and AIDS, legal, economic and social protections must be provided for them to ensure their continued access to education, inheritance, shelter, health and social services, as well as to feel secure in revealing their HIV status and that of their relatives. For orphans, the State should support and strengthen the capacity of families and communities of children orphaned by AIDS and provide them with a standard of living appropriate to their physical, mental, spiritual, moral, economic and social development needs, including access to psychosocial care. The country must make efforts for children to remain within existing family structures. Institutional care should be considered as a last resort, and when used, it should be temporary. At the same time, the State must adopt measures to successfully reintegrate children into their communities.³²⁰

The Global Commission (2012) made specific recommendations for supporting orphaned children such as the appointment of an appropriate adult guardian or older siblings who can ensure their well-being. In choosing a guardian, preference should be given to adults from the biological family or the extended family. Additionally, in the absence of a guardian, the State should promote the placement of orphaned children within host families as an alternative to specialised institutions. It should be ensured that children orphaned by AIDS are not prohibited from their inherited rights.³²¹

UNAIDS International Guidelines: Guideline No. 5 on anti-discrimination and protection laws aims to reduce the vulnerability of children to HIV infection and reduce the impact of the disease on children.³²² In the specific case of Angola, the Committee on the Rights of the Child recommended that the country should continue to strengthen its activities to combat discrimination, particularly regarding children with disabilities, pregnant adolescent girls, children with HIV or AIDS, lesbians, gays, bisexuals, transgender and intersex persons and street children, who are still exposed to discriminatory attitudes and behaviours.³²³ Likewise, the Human Rights Council recommended in the 2nd cycle of the Universal Periodic Review that Angola strengthen actions to combat discrimination against children living with HIV or AIDS.³²⁴

Guideline No. 8 also addresses the specific issue of children's vulnerability in order to foster, in collaboration with, and through the community, an approach to issues such as prejudice and inequality. This recommendation is of importance in relation to adolescents, because under this Guideline, States should ensure that adolescents have adequate access to confidential sexual and

318 Global Commission on HIV and the Law – Risk, Law and Health, July, 2012, p. 116.

319 GC No. 3 Committee on the Rights of the Child, CRC/GC/2003/1, 2003, paragraph 29

320 GC No. 3 Committee on the Rights of the Child, CRC/GC/2003/1, 2003 paragraphs 28-32

321 Global Commission 2012, Recommendations 5.1 and 5.2, p. 85

322 Guideline No. 5, International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version, UNAIDS/EACDH

323 Concluding Observations, Committee on the Rights of the Child, CRC/C/AGO/CO/5-7, June 2018, paragraph 15

324 Report of the Working Group on the Universal Periodic Review, Angola 2nd cycle, A/HRC/28/11, December 2014, paragraph 134.66

reproductive health services, including HIV information, counselling, testing and access to means of protection, such as condoms and social support services. Guideline No. 8 also reaffirms the principle that the provision of services to children and adolescents “should reflect the appropriate balance between the rights of children and adolescents to be involved in decision-making in accordance with their evolving capacities, and the rights and duties of parents or those responsible for the health and well-being of the child or adolescent”.³²⁵

With regard to adolescents, the Committee on the Rights of the Child warned that this is the only age group where deaths due to AIDS are increasing worldwide.³²⁶ The Committee highlights the barriers they face in accessing and remaining on antiretroviral treatment, as well as in obtaining the consent of legal guardians for access to HIV-related services. The Committee points out that adolescent girls are disproportionately affected by the epidemic and that adolescent lesbians, gay men, bisexuals and transgendered teenagers who exchange sex for money, goods or favours and teenagers who inject drugs are also at increased risk of HIV infection.³²⁷ The Committee therefore recommends recognising the diverse realities of adolescents and recommends ensuring that they have access to confidential HIV testing and counselling services, as well as prevention and treatment programmes.³²⁸

The Human Rights Council recommended that Angola address the existence of certain practices and stereotypes derived from cultural patterns that could result in discrimination against girls.³²⁹ The Committee on the Rights of the Child recommended,

based on the criteria on adolescent health and development in the context of the Convention,³³⁰ and on the implementation of children’s rights during adolescence,³³¹ the strengthening of national adolescent reproductive health programmes to ensure access to life skills education, accurate information on STI/HIV prevention, prevention of unwanted pregnancies, responsible parenthood and sexual behaviour, confidential counselling and support to pregnant adolescents. The Committee specifically recommended decriminalisation of abortion or termination of pregnancy in all circumstances when revising the Penal Code, ensuring access to safe abortion services and post-abortion care for adolescent girls and that the latter’s views are always heard and considered as part of any decision-making process.³³²

The African Charter on the Rights and Welfare of Children and UNICEF defines children as every human being under the age of 18. It guarantees children the right to access basic health services. It assigns States the responsibility of creating mechanisms to reduce child mortality; ensuring the provision of medical care and health care to all children; combating disease and malnutrition in primary health care through the application of appropriate technology; and ensuring health care for pregnant women and infants.³³³ The Charter also gives States the responsibility of taking appropriate specific legislative, administrative, social and educational measures for protecting children from all forms of inhuman or degrading treatment, including the exploitation and sexual abuse of minors.³³⁴

325 Guideline No 8, International Guidelines (2006) Consolidated Version, UNAIDS/EACDH

326 GC No. 20 Committee on the Rights of the Child, CRC/C/GC/20, 2016, paragraph 62

327 See section on key populations

328 GC No. 20 Committee on the Rights of the Child, CRC/C/GC/20, 2016, paragraph 63

329 Report of the Working Group on the Universal Periodic Review, Angola 2nd cycle, A/HRC/28/11, December 2014, paragraph 134.72

330 GC No. 4, 2003, Committee on the Rights of the Child

331 CG No. 20, 2016 Committee on the Rights of the Child

332 OF, Committee on the Rights of the Child, CRC/C/AGO/CO/5-7, June 2018, paragraph 29. *See also* section on Women

333 Articles 2, 3 and 14 of the African Charter on the Rights and Welfare of the Child, 1990.

334 *Idem.*, Articles 16 and 27.

The SADC PF Model Law on HIV, 2008, provides for the protection of children living with HIV, particularly orphaned and vulnerable children. It also provides for consent to HIV testing in the case of children. Section 13(5) states that “HIV tests performed on a child under [16 or any suitable age decided in the state but not above 16] or a mentally incapacitated person shall be conducted with the consent of the parents or the legal guardian of the child or that person. When the best interest of the child requires otherwise or if the child is an emancipated minor, the absence of parental or guardian’s consent shall not constitute an obstacle to testing and counselling. In the event of a dispute, the [relevant court] has jurisdiction to decide.”

3. Current Situation in Angola

The Constitution of the Republic of Angola (2010) enshrines the right to special protection for children³³⁵ and young people.³³⁶ According to Art. 24 CRA (2010), the age of majority is acquired at age 18.³³⁷ Fundamental rights of the child include harmonious and integral education and the protection of their health, schooling and living conditions by the family, society and the State.³³⁸ “The best interest of the child” is a key principle in guaranteeing their full physical, psychological and cultural development.³³⁹ The Constitution also

provides young people with special protection for the realisation of their economic, social and cultural rights. It calls for the enactment of a law establishing the foundations for developing youth policies to promote conditions for the development of young people.³⁴⁰

However, this Study was not able to locate a basic law for young people. Law 8/04 on HIV is silent on the special needs of children and adolescents. It does however provide for HIV testing of minors (Art. 22) and confidentiality (Art. 12.1). Paragraph 2 of Art. 22 of Law 8/04 states that HIV tests for minors require the permission of parents or legal guardians.³⁴¹ With regards to confidentiality, health institutions should inform those who exert parental authority over the child, of a child’s HIV status.³⁴² Law 8/04 on HIV/AIDS does not provide for older children to provide independent consent to testing and treatment and maintain their confidential health status. It does not take into account children’s vulnerability in a way that would consider the evolution and development of the capacities of children in different phases of their lives.

Law 25/12 “On the Development and Comprehensive Protection of the Child” provides in Art. 75 for children in the context of HIV. This law³⁴³ applies to all persons under 18 years of age³⁴⁴ and establishes the best

335 Article 80 (CRA 2010). Article 2, (1.c) of Law No. 21-B/92, LBSNS lays down as a general line of health policy, special measures for groups at greatest risk of transmitting sexually transmitted diseases and non-sexually transmitted diseases, such as children and infants.

336 Art. 81 of the CRA 2010

337 Article 12; 14 and 22 (2) Law No. 8/04, of 1 November (Law on HIV/AIDS). According to Art. 133 of the Civil Code, the full capacity to exercise rights is also granted to emancipated persons. Although, in exceptional cases provided for by law (and always in the best interest of the child), children may be exempted from the prior consent of their legal representatives. *See also* Art. 2 of Law No. 68/76, Law of Majority, which establishes that persons of less than 18-years-of-age, of either sex, are legally considered to be minors.

338 Article 35 (6), Article 80 (1) and (2) of the CRA (2010)

339 Article 80 (2); article 21 (i) and 35 (6) of the CRA (2010)

340 Article 81 CRA (2010)

341 However, the Protocol on HIV Testing Services (INLS 2017) is more in line with international standards. It states that adolescents between the ages of 15 and 18 are considered eligible to give their consent for testing, although the counsellor should make an assessment of the actual capabilities for the understanding and absorption of any test results. It also establishes that for adolescents under 15 years of age, access to health services for HIV counselling and testing should be in the company of parents or guardians. However, in cases where adolescents are not accompanied by parents or guardians, the counsellor should provide just counselling to the adolescent and should advise him or her to return with a parent or guardian. In exceptional cases, HIV testing of adolescents without parents or guardians can be considered where: a) the adolescent is sexually active, namely in cases where he or she already has children or is pregnant; b) the adolescent suffers sexual exploitation or abuse, they should receive counselling and be encouraged to take the HIV test as a prophylaxis measure; or, c) the adolescent is homeless and doesn’t have a guardian who can consent to the test. *See* HIV Testing Services – Protocol (MINSa, INLS), 3rd Ed., Luanda, 2017, p. 14

342 *See* Section on Health, entitled Situation in Angola

343 Law No. 25/12, of 22 August (Law on the Protection and Comprehensive Development of the Child).

344 Art. 2 of Law No. 25/12.

interests of the child as a guiding principle.³⁴⁵ In addition to Art. 75, the law establishes a series of rights such as the right to life and health,³⁴⁶ the protection of pregnant women,³⁴⁷ care for pregnant women and newly born,³⁴⁸ and the prevention of diseases.³⁴⁹ The Act also includes the so-called “11 Commitments to the Child”. Commitment 7 is to prevent and reduce the impact of HIV/AIDS on families and children.³⁵⁰ Law 25/12 recognises the rights related to family and community coexistence. For example, Art. 21 states that “the child has the right to have a family, to know and to live with his or her parents and other family members, in a healthy and harmonious way”. Furthermore, under Art. 22 of this law, every child “has the right to be raised and educated within the family and to be assured of family and community harmony”. The law also recognises the child’s right to grow up surrounded by love, affection, care and understanding, in an atmosphere of family harmony, security and peace.³⁵¹

Although Article 75 of Law 25/12 provides guidance for managing children with HIV, in terms of Commitment 7, it does not contain provisions that would help manage the various vulnerabilities to which children might be exposed, particularly in relation to adolescents and sexual and reproductive health nor sexual orientation and gender identity.³⁵²

The Family Code deals with marriage and provides that only those over 18 years of age may marry. However, it creates exceptions to this general rule. In exceptional cases, boys of 16 and girls of 15 years may marry if, when considering the circumstances of the case and

taking into account the interest of minors, marriage is considered the best solution. This authorisation is granted by the parents or by the person who has the child under their care.³⁵³ The latter contravenes with the international law and the rights of the child (ICRC).

PEN V advocates for strengthening HIV care provision with an emphasis on children, orphans and their families, amongst others.³⁵⁴ The Plan contains a series of actions to expand integrated services for children, which includes access to Counselling and Testing, PMTCT, paediatric ART treatment with quality and confidentiality; monitoring and decentralisation of services with continuous and integrated care (medical, psychosocial, nutritional and economic support) and improvements to the procurement and supply management of HIV related health products to avoid disruptions. However, the Plan appears to have prioritised access to treatment and lesser emphases on prevention. Likewise, in terms of a multisectoral approach, the Plan does not propose concrete actions aimed at improving the status of orphans and street children, nor does it identify the main institutional bodies that are essential for an effective and sustainable response to HIV and AIDS.

In relation to adolescents, PEN V recognises adolescents and youths who are in or out of school (boys and girls of both sexes from 9 to 18 years of age and young people from 19 to 24 years of age) to be at a highest risk for the purpose of primary prevention, counselling, HIV testing and prevention of early pregnancy.

345 Art. 6 Law No. 25/12..

346 Art. 14 Law No. 25/12.

347 Art. 16 Law No. 25/12.

348 Art. 17 Law No. 25/12.

349 Art. 20 Law No. 25/12.

350 Art. 50.2 (g) Law No. 25/12.

351 Art. 26 Law No. 25/12.

352 However, the rule provides for compulsory minimum services, e.g. voluntary counselling and testing for mothers and children, access to treatment, free care and support for children with HIV, prevention of institutionalisation of care of child orphans, media outreach and promotion, prevention and control of HIV/AIDS in pregnant women, dissemination and media promotion to improve accurate knowledge of HIV and combat discrimination against People living with HIV. In 2018, the INLS developed a new National strategy for the elimination of mother-to-child transmission of HIV, syphilis and hepatitis B over the 2019-2022 period, with support from UNDP and the Global Fund.

353 Art. 24 Family Code Law No. 1/88

354 National Strategic Plan V for Response to STIs/HIV-AIDS and Viral Hepatitis – Angola 2015 – 2018, p. 9

In addition, PEN V distinguishes homeless adolescents as a particularly vulnerable group.³⁵⁵ The Plan therefore provides the basis for the creation of spaces for the promotion of healthy lifestyles for out-of-school adolescents and young people. The draft National Strategy for Key and Vulnerable Populations³⁵⁶ recognises adolescents and young people as a vulnerable population.

Responsibility for SRH is fundamentally that of the National Reproductive Health Programme within the National Directorate of Public Health of MINSA. The 2009 – 2015 National Reproductive Health Plan advocates for the prevention of STIs.³⁵⁷ The Ministry of Youth and Sports also made efforts to promote the SRHR of adolescents, through the 2014 – 2017 National Youth Development Plan. The latter calls for reproductive health projects aimed at preventing STIs (including HIV), early pregnancy, reducing behaviours with harmful effects on the health of young people, facilitating access of young people living with HIV to antiretroviral treatment.³⁵⁸ However, both Plans reflect a focus on reproductive health alone, and do not incorporate the issue of sexuality. As such, they are not aligned with current international standards on HIV and SRHR. However, the Comprehensive Health Care Strategy for Adolescents and Young People 2016-2020 developed by MINSA warrants recognition. It focuses on STI prevention (including HIV and AIDS) in the context of sexual and reproductive health. It is also informed by a rights-based perspective³⁵⁹ and highlights violence as one of the health issues affecting adolescents and young people.³⁶⁰

Birth registration is regulated by the Civil Registry Code (Decree-Law No. 47 678 of 1967) and supplementary legislation,³⁶¹ which includes executive measures to facilitate registration of children e.g. free registration of the child in early childhood. The Committee on the Rights of the Child made a series of concluding remarks in June 2018³⁶² which reaffirm its previous recommendations of 2010,³⁶³ aimed at strengthening existing efforts, e.g. to carry out awareness campaigns; to allocate financial resources; to eliminate existing barriers such as high bureaucratic burden; and to extend the large-scale roll-out of registration campaigns across the country.

4. Gaps and Challenges

The country has made great efforts to align its domestic legislation and its policy framework with respect to the rights of children and adolescents to international standards. Such efforts include measures such as the enactment of the Law on the Protection and Development of Children and the National Youth Development Policy 2014-2017. A paradigm shift, away from a purely medical approach, and into a rights-based approach, has been observed. The Ministry of Health's Comprehensive Care Strategy for Adolescents and Young People 2016-2020 identifies issues such as violence and sexual health as essential in the care of adolescents. Also, this strategy refers to a multi-sectoral approach to HIV and identifies critical components, such as gender equality, sexuality and communication, as central to ensuring good health for adolescents and young people. In turn, INLS through its new Strategy for key and vulnerable populations, pays due attention to adolescents.

355 PEN V, p. 73

356 National Strategy for Key Populations 2018-2022, INLS/UNDP, p. 6 etc. (draft version)

357 National Reproductive Health Plan 2009-2015, p. 1, pp.12-13, pp.14-15 (sexual and reproductive health), MINSA

358 National Youth Development Plan 2014-2017, p. 40, MINJUD

359 Strategy for Comprehensive Care for the Health of Adolescents and Young People 2016-2020, pp. 21-29, MINSA

360 *Idem.*, pp. 29-31, MINSA

361 The Civil Registration Act is part of the legal regime for civil registration (Decree-Law No. 47 852 of 1967; Decree Law No. 49 053 of 1969; Law No. 10 of 1977), which establishes new standards for acts of civil registration; Law No. 10/85 on the composition of the name; Decree 31/07 of 2007 on the free registration of births and deaths.

362 CRC/C/AGO/CO/5-7, 2018, paragraph 19

363 CRC/C/AGO/CO/2-4, 2010, paragraph 35

However, the national legal and policy framework presents a number of challenges in relation to early marriage, same-sex marriage, age of consent to access quality sexual and reproductive health services, HIV counselling and testing and assurance of confidentiality. In the specific case of orphaned children and street children, social protection structures are neither adequate nor sufficient when compared with the requirements of national law. Cases of family abandonment due to sexual orientation, gender identity or sex work were reported through the focus group discussions with young vulnerable and key populations held for this Study. The very circumstance of being a child living with HIV is not explicitly regulated in Law 8/04 and therefore this law is silent regarding the special vulnerability of children. Art 75 of Law 25/12 contains gaps regarding the specific needs of children, especially in relation to the last stages of childhood and sexual and reproductive health.

Due to a chronic lack of domestic and international resources, HIV prevention and other SRH interventions are under-funded and limited in scope in Angola. The country acutely lacks the provision of a comprehensive package of youth friendly RH services on an ongoing basis. Such a package would be nationally defined, monitored and would include access to accurate RH and STI/HIV prevention information; access to contraception commodities, male and female condoms, lubricants or PEP kits; access to STI and HIV counselling and treatment.

The low birth registration rate in Angola continues to be a barrier for children to access health and HIV-related services. Human and financial resources needed to implement child/adolescent focused programmes are by and large lacking.

The most significant legal and policy gap in relation to young people is the lack of a specific law that promotes and protects the rights of young people as per recommendation under Art. 81.2 of the CRA 2010. Another significant gap is the lack of a policy, plan or strategy focused on the comprehensive development of the child, covering all phases of childhood,

including adolescence. Despite the paradigm shift with regards to sexual health, socio-normative barriers remain, based on customary practices, behaviours and moral or religious norms, that prevent the realisation of sexual and reproductive health and rights. The draft National Strategy for Key and Vulnerable Populations does not specifically address the issue of children in their earliest stages of childhood, especially in the case of orphaned children.

5. Recommendations

In light of the above, the following is recommended

- Revise Law 8/04 to recognise the vulnerability of children in a holistic manner, taking into account the child's right to health and all other rights; and the specific needs of children of various ages, especially adolescents.
- Revise Law 8/04 to allow for access to HIV testing without parental consent for children, according to the child's physical and mental developmental capacities, and at the very least for children aged 14 years and older in accordance with the SADC PF Model Law on HIV.
- Revise Law 8/04 to ensure that children who are capable of providing independent consent also have an independent right to confidentiality regarding their HIV status, including in special psychosocial support services.
- Revise Law 8/04 to adopt measures for combating discrimination and violence against children and young people, in particular for discriminatory acts, family abandonment and mistreatment due to actual or perceived HIV status, sexual orientation, gender identity, involvement in transactional sex, or when they are the victims of sexual exploitation.
- In the process of revising Law 8/04 on HIV/AIDS and developing a comprehensive child focused legislation, take into account the provisions of Law 25/12 on the comprehensive development of the child in order to avoid conflicts of law.

- Develop and enact a Youth Law which contains specific provisions on young people and HIV as well as on the rights of young people to sexual and reproductive health and rights.
- Develop and approve a national policy focused specifically on children, with a holistic approach that considers the specific needs of each age group and containing results, actions and indicators in relation to HIV, and sexual and reproductive health.
- Integrate sexual and reproductive health and rights and sexual orientation and gender identity within the National Youth Policy
- Continue to strengthen administrative measures to facilitate children's birth registration across the country.
- Continue efforts to reduce mother-to-child transmission through measures that strengthen access to health services for mothers while protecting their human rights and right to confidentiality of HIV status
- Include all children as a vulnerable population in the draft National Strategy for Key and Vulnerable Populations.
- Allocate financial resources to support orphaned children and strengthen social protection mechanisms.
- Adopt legislative, administrative and educational measures to ensure the realisation of children's sexual and reproductive health and rights.
- Strengthen coordination mechanisms between INLS, MINJUD, MINSA on sexual and reproductive health and rights and strengthen coordination mechanisms with the National Social Action Council.
- Adopt legislative, educational and educational measures to combat early marriage.
- Adopt educational measures to combat stereotypes and cultural barriers that negatively affect the development of children, particularly with regard to their sexual and reproductive health (through

national, provincial and municipal information campaigns). Specifically, request support from the promotion committee of the Provincial Human Rights Committees.

- Conduct socio-behavioural studies on adolescents in relation to attitudes that put them at risk of HIV.
- Strengthen the integration of HIV and SRH services; mobilise domestic and international resources for the expansion of STI/HIV prevention services and the continued supply of health products required for the prevention of STIs, HIV and teenage pregnancy.

F. Key Populations

1. Analysis of the Situation

UNAIDS (2015) terminology guideline “considers gay men and other men who have sex with men, sex workers and their clients, transgender people and people who inject drugs as the four main key population groups (...). Countries should therefore define the specific populations that are key to their epidemic and response based on the epidemiological and social context³⁶⁴. As such, in PEN V, Angola's National AIDS Programme defines the following as key to its epidemic: Female sex workers (FSW), Men who have sex with men (MSM), Prisoners, Truck Drivers and Miners. The guide further states that population groups who should also be considered “key” are those who “often suffer from punitive laws, stigmatizing and discriminating policies, and those most likely to be exposed to HIV”. The engagement of Key Populations (KP) in the reduction of new infections is therefore critical for a successful national HIV response. They are “key to the epidemic and key to the response”³⁶⁵.

“Young Key Populations”, as per UNAIDS Terminology guidelines, refers to “young people aged 15 to 24 years who are members

364 UNAIDS 2015 Terminology Guidelines, pages 31 and 50

365 UNAIDS 2015 Terminology Guidelines, pages 31 and 50

of key populations, such as young people living with HIV, young gay men and other men who have sex with men, young transgender people, young people who inject drugs and young people (18 years and older) who sell sex. Young key populations often have needs that are unique, and their meaningful participation is critical to a successful HIV response". This Assessment related to the young key populations among Female Sex Workers (FSW), Men who have sex with Men (MSM), Transgender Persons,³⁶⁶ People who use drugs and Prisoners.

The WHO (2016) Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations define key populations as groups that, due to certain patterns of high-risk behaviour, are placed in a situation of increased vulnerability to HIV infection, regardless of the type of epidemic or the local context.³⁶⁷ According to the Guidelines, key populations are significant in the dynamics of HIV transmission, while at the same time, being key partners for an effective national response to the epidemic.³⁶⁸

The GCHL (2012) reports that, in many countries, both laws and moral norms dehumanise key populations.³⁶⁹ Stigma and discrimination, societal violence, legal barriers to forming associations, criminalisation of HIV transmission and criminalisation of behaviours such as drug use all potentially contribute towards the epidemic. Members of key populations tend not to access health, justice or psycho-social support services for fear of stigma, marginalisation, detention, verbal or physical abuse and human rights violations. The GCHL Supplement (2018) reaffirmed that HIV continues to be a

disease of the vulnerable, marginalised and criminalised, such as key populations who in 2017, accounted for 47% of new HIV infections globally, against 20% for adolescent girls and young women (AGYW) aged 15 to 24.³⁷⁰

In the 2016 Political Declaration to HIV, the United Nations reaffirmed its Member States' commitments to prioritise the needs of Key Populations in their responses. However, addressing such needs requires more than delivering HIV/STI prevention and treatment services for key populations. It first and foremost requires creating an enabling environment, through legal, policy and systemic changes, so as to tackle the social determinants that create key populations' vulnerability while preventing their access to services.³⁷¹

From a health service delivery perspective, the global response to HIV requires governments, international agencies and donors to adequately fund research, prevention, treatment and care. It also requires that HIV service providers be adequately trained and equipped to serve key populations, particularly young people. In Angola, this was done recently through training of health and police workers on Key Populations' related stigma³⁷², and through the drafting of Guidelines for Health Professionals attending to Key Populations³⁷³ and the draft National Strategy for the Prevention, Care and Treatment of STI/ HIV-AIDS for Key and Vulnerable Populations in Angola (2018 – 2022).

SADC Regional Strategy for HIV prevention, treatment and care and sexual and reproductive health and rights among key populations (2018) describes the barriers

366 Transgender persons are included under the term LGBTI, which is a broad representative term emphasising a diversity of sexualities and gender identities, according to the draft National Strategy for the Prevention, Care and Treatment of STIs/HIV-AIDS for Key and Vulnerable Populations in Angola 2018-2022, Luanda, 2018, pp. 3-4.

367 In contrast, vulnerable populations, according to WHO, are groups of people particularly vulnerable to HIV infection in certain situation or contexts. These populations are not uniformly affected by HIV in all countries. WHO refers to some vulnerable groups such as adolescents (especially adolescent girls), orphans, street children, people with disabilities and migrant and mobile workers. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, WHO, 2016, xii

368 *Idem.*, at xii, WHO (2016)

369 CGVD (2012), p.12

370 Supplement 2018. Global Commission for HIV and the Law, p. 6

371 Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, WHO, 2016, p.4

372 MSH Quarterly Narrative Reports, 2017-2018, UNDP/Global Fund Project

373 Draft National Guidelines for Health Professionals working with Key Populations, INLS/UNDP, 2018

faced by the latter in accessing health services. These include (i) stigma and discrimination in public and private spaces;³⁷⁴ (ii) different forms of violence, *e.g.* gender-based violence, police violence, physical violence, psychological violence, family abandonment; (iii) lack of a favourable legal environment, *e.g.* restrictive, discriminatory laws and policies that criminalise certain behaviours; (iv) lack of data on the dynamics, realities and needs of key populations; and (v) the lack of programmes, services and funds specifically targeting key populations³⁷⁵. SADC Member States, which include Angola, are called on to report on the objectives of the Strategy and its expected results on a periodic basis.

2. Lesbian, Gay, Bisexual, Transgender and Men who have Sex with Men (LGBT+ and MSM)

Debates surrounding the human rights of the LGBT+ community, including protection from stigma and discrimination, and access to adequate sexual and reproductive health services, have not received national visibility in Angola for contextual reasons. However, the PEN V recognises Men who have sex with Men (MSM) as a specific population for the national response to HIV. Until 2017, data on the impact of HIV in the MSM community has been lacking. According to the PLACE Study (2017), HIV prevalence rate among MSM is estimated at 2.4%³⁷⁶. Members of the LGBT and MSM community interviewed for this Study reported a range of human rights barriers in accessing sexual and reproductive health services. Discriminatory and derogatory attitudes were reported to start at home and extended to the community. Censorship of sexuality-related issues within the family environment often results in self-exclusion, rejection by the family and expulsion from the home environment in some reported cases. At school or in places of employment and worship, LGTB+ and

MSM interviewed encounter rejection. Non-acceptance by society causes fear of being openly LGBT+ and/or MSM and psychological personal conflicts in terms of sexual orientation and/or gender identity. Non-inclusion also creates barriers to accessing or remaining in education, employment, health care, formal association, etc.

Focus group Interviewees reported stigma and discrimination, bullying and/or mistreatment from public institutions health, the Civil Registry, and educational institutions as a major barrier and challenge to accessing public services. Outside the walls of institutions, in public spaces, physical and verbal violence from community members is common.

As mentioned in previous sections, most members of the LGBT+ and MSM community go to the hospitals or nearest health facility when they require sexual and reproductive health services, *i.e.* STI/HIV treatment and prevention services. Some of the hospitals are supported by the Linkages Project and staffed with MSM focal points who provide direct services to key populations without having to disclose their sexual orientation or gender identity status. This increases access and utilisation of health services and the probability to return to the facility. In general, they would not disclose their sexual orientation or gender identity unless it relates to STI treatment due to the need to undertake contact tracing as per public health guidelines. It is noted that opinions vary regarding the quality of care from health professionals. There are varying reports of positive, and poor quality of treatment received from health facilities. Some respondents to this Study reported that their human dignity was not respected or that they were gossiped about by health professionals, lack of confidentiality.

Regarding freedom of association, the LGBT+ and MSM community in Angola is organised under IRIS-Angola, an association³⁷⁷ which promotes LGBT+ rights. Other associations

374 See Section on Discrimination

375 Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health Rights among Key Populations; SADC 2018, p. 15 etc.

376 Jornal de Angola, 1 Dec. 2017 (António Coelho/ANASO).

377 Angola has Law No. 6/12, of 18 January (Law of Associations).

not yet legally recognised by the government include AIA³⁷⁸ (self-identified lesbian or gender non-conforming members), H Maiúsculo (self-identified gay or MSM members), The Divas, Mulheres de coração (self-identified transgender women members). None of these associations has received official recognition as associations based on sexual orientation and/or gender identity. IRIS, which has been active since 2013, finally received official recognition by the state as a human rights-based organisation in 2019. IRIS, AIA, H Maiúsculo, The Divas, Mulheres de coração all sprung up from HIV prevention interventions funded by international partners (USAID, PEPFAR, Global Fund, Dutch Government). As such the organisations primary line of support is HIV/AIDS prevention and treatment, and advocacy for access to human rights and justice. The sustainability of these organisations is also a major concern as they are largely dependent on international donor support for their outreach interventions and organisational development. Additionally, the LGBT+ and MSM participants in this study reported administrative barriers during the process of securing official registration.

As implied earlier, members of the LGBT+ and MSM community experience barriers in expressing their personal and/or gender identity and the ways in which they may present in the public space (e.g. Transgender persons. Registering a change in a person's gender marker (on Identity Cards) represents a significant challenge when other factors that may alter a person's identity are not subject to registration.³⁷⁹

A FGD respondent in Luanda lamented: *"My family does not approve of my sexual orientation for religious and political reasons. They consider homosexuality to be something abhorrent and outside of heteronormative standards. For them, women must have emotional and physical relations to men (...) Unfortunately, my family does not accept my sexual orientation, they say*

they respect me, but they do not accept me. Judging by their attitude, they do not accept me".

International standards

The principles of equality and non-discrimination guide the approach to rights on sexual orientation and gender identity.³⁸⁰ The CESCR clarified that "other status" as recognised in Art. 2.2 of the Covenant includes sexual orientation. The Committee notes that a person's sexual orientation cannot be a barrier to the realisation of the rights of the Covenant. The CESCR also stated that gender identity is recognised as prohibited grounds for discrimination.³⁸¹

The following human rights are relevant in cases relating to violations based on sexual orientation and gender identity:

- *the right to non-discrimination and freedom from violence and harassment (for being LGBTI);*
- *the right to be free from torture or cruelty, inhuman or degrading treatment (which may be violated through police practices, investigations or detention or through the practices of health professionals);*
- *the arbitrary arrest ban (for being MSM, SW, PWUD);*
- *the right to life (LGBTI Killings and gender assignment for intersex infants);*
- *the right to a fair trial (which may be affected by the prejudices of judges and other legal operators);*
- *the right to work (Transgender denied employment & Identification Card Registration; Sex work not considered as 'work');*
- *the rights to security and social assistance (State Protection, and acknowledge vulnerabilities related to SOGI);*
- *the right to form a family (which may be denied by governments in not recognising same-sex families and in not extending the rights granted by the state to heterosexual families);*

378 Angolan Identity File

379 Arts. 1 and 2 of the Civil Registry Code.

380 See Section on equality and non-discrimination

381 GC No. 20 CDESC paragraph 32

- *the right to privacy (Confidentiality in health facilities);*
- *the rights to freedom of expression (including the right to receive and impart information),*
- *the right to free association (legal recognition and registration of organisation and associations); and*
- *the right to physical and mental health (access to comprehensive health services).*

Art. 12 of the ICESCR states that “The States that are party to this Covenant recognise the right of all persons to enjoy the highest attainable standard of physical and mental health”. CESCR clarified that the normative content of this provision of the Covenant should not be understood only as a right to be healthy, but as a right containing other freedoms and rights such as the right to have power over one’s health and one’s body, including sexual and reproductive freedom.³⁸²

The GCHL (2012) and the Supplement (2018) have pointed out that key populations must have access to effective prevention and treatment. In the case of the LGBT+ and MSM communities, the Commission recommends revising approaches to sexual diversity through legislative, administrative, financial, educational, and other measures, so as to repeal all laws that criminalise adult consensual same-sex sex and/or those which punish homosexual identity; respecting the right to privacy, removing legal, regulatory and administrative barriers to the formation of community organisations by or for members of the LGBT+ and/or MSM communities; promoting efficient measures for the prevention of violence against LGBT+ and MSM; repealing all laws that criminalise cross-dressing and changing anti-discrimination laws to explicitly prohibit discrimination based on gender identity (as well as sexual orientation). It also recommends ensuring that transgender persons can have their gender affirmed in identification documents without going through any prior medical procedures, such as

sterilisation, sex change surgery, or hormonal therapy.³⁸³

WHO proposes five **critical facilitators** to support an enabling response for key populations: a) a legal environment, policies and practices favourable to key populations; (b) implementation and enforcement of anti-discriminatory provisions; c) availability, accessibility and quality of health services; (d) empowerment of key populations; and, (e) reducing violence.³⁸⁴ These critical facilitators operate at various levels – individual, community, institutional, corporate, national, regional and global. WHO concludes that these factors are critical to an effective and sustainable national response.

In the UNAIDS Division of Labour on HIV, UNDP is the co-convener, alongside UNFPA for the empowerment of men who have sex with men, sex workers and transgender people to protect themselves from HIV infection and to fully access antiretroviral therapy. UNDP is also the convener for the removal of punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS. As such, UNDP prioritises the inclusion of key populations at risk of HIV and other excluded groups in its 2016-2022 HIV, Health and Development Strategy. Key UNDP service offerings include policy and programme support on: 1) Working with government, civil society and UN partners to implement the findings and recommendations of the Global Commission on HIV and the Law on issues affecting key populations; 2) Promoting rights-based HIV and health responses for key populations at risk of HIV and other excluded groups; 3) Integrating programming for key populations and other excluded groups in national HIV and other health programmes; and 4) Strengthening the evidence base and capacities on inclusion of LGBTI and other excluded group.

In the African context, the SADC Strategy for Prevention, Treatment and Care and SRHR

382 Non-discrimination is an immediate and cross-sectional obligation in the Covenant which requires State Parties to ensure non-discrimination in the exercise of each economic, social and cultural right. See CG No. 20, CDESC paragraph 8.

383 Global HIV and Law Commission (2012) p. 57, p. 62. Supplement (2018) p. 8 paragraphs 5-8

384 Consolidated Guidelines – Key Populations-, WHO, 2016, p. 83 etc.

for Key Populations (2018) mentioned earlier is based on seven guiding principles: (i) equal access to health services; (ii) increased political commitment to ensure universal access to health services; (iii) effective partnerships between all stakeholders – government, key populations, civil society and the private sector; (iv) respect for diversity; (v) involvement of key populations in the development of strategies; (vi) development of evidence-based programmes of high quality; and (vii) avoidance of harm to key populations.

Angolan legal framework

Art. 23.1 of CRA, 2010 establishes that “everyone is equal before the Constitution and the law.” This is complemented by Article 21 (h) of the CRA, which sets out the responsibility of the State to promote equal rights and opportunities amongst Angolans, without discrimination on the grounds of, *inter alia*, origin and sex. Art. 26 (2) of the CRA provides that the interpretation and integration of constitutional rights must be in accordance with the ACHPR and the UDHR. *This indicates that key populations are within the scope of constitutional protection.*

The new Penal Code approved in January 2019 (not yet published) prohibits, in Art. 214, discrimination on the grounds of sexual orientation, making it a crime. Art. 385 criminalises incitement to discrimination on the grounds of sexual orientation. The new Penal Code also repeals Art. 70.4 of the previous Code which criminalised same-sex sex, having provided that “security measures are applicable: (...) 4. To those who habitually surrender to the practices of vices against nature”.

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Law 8/04 on HIV/AIDS is silent on the LBTG+ community, focusing only on people living with HIV. This law not only fails to reflect the LGTB+ community in its diversity, but also other key populations at higher risk of HIV exposure, contrary to international human rights standards and the recommendations of WHO and the Global Commission. This leaves LGTB+ persons legally unprotected against discrimination, violence and police abuse and fails to protect other key rights, such as their rights to health information and services, including sexual and reproductive health information, and their rights to freedom of association. This is despite the fact that the context clearly justifies measures to promote formal and substantive equality.

Issues of sexual orientation are governed by the principles of equality, autonomy, liberty and security of the person and privacy.³⁸⁶ The right to autonomy and liberty and security of the person grants every person control and ownership over their own body. Sexual self-determination, which is embodied in a person’s freedom to decide with whom to have (consensual) sex, should prevent this from being depend on the will of the State or third parties.

Regarding gender identity, the law obliges a person to register any change of name, modifications to identity or the marital status in the civil registry.³⁸⁷ Article 130 of the Civil Registry Code provides, however, that a given name should not create legitimate doubts as to the sex of the person registered.

³⁸⁵ Art. 71 (4) of the PC-1886- In the past, sex was considered the essential function of reproduction and therefore, the practice of sex between people of the same biological gender was seen as an act against nature. In this context, Art. 70 (4) of the Criminal Code -1886- (Caution for good conduct) classed homosexuality and bisexuality as vices against nature, considered dangerous states that could criminally damage property and therefore should be prevented by the application of a safety measure.

³⁸⁶ Art. 23, Art. 32, and Art. 36, paragraph 3, (d), all of the CRA, combined with Article 80 of the Civil Code.

³⁸⁷ Ref. Art. 87, of the Civil Registration Code (Endorsements on birth certificates).

In terms of the right to form a family, the CRA (Art. 37) permits marriage between a man and a woman.³⁸⁸ Art. 20 of the Family Code provides that “marriage is the voluntary union between a man and a woman...”.³⁸⁹ This standard discriminates against LGBT+ persons and contravenes the constitutional principles of human dignity, equality and freedom enshrined in the foundations of the Angolan State.

PEN V recognises that strategic interventions should prioritise key populations identified by WHO (2014),³⁹⁰ appropriate to the Angolan reality. However, the plan itself only provides for epidemiological surveillance studies amongst key and/or vulnerable populations. The INLS’ National Strategy for the Prevention, Care and Treatment of STIs/HIV/AIDS in Key and Vulnerable Populations in Angola 2018-2022 highlights various factors that increase the vulnerability of key populations, including high levels of stigma and violence; limited HIV/AIDS prevention services; limited access to diagnostic, continuing care and HIV treatment services; lack of information on HIV amongst key and vulnerable populations; poor integration and multi-sectoral articulation; insufficient capacity; and inadequate resources. The strategic axes of the plan were defined around each of these factors.

Gaps and Challenges

The LGBT+ community in Angola has challenges both as individuals and as a collective, as there are barriers to recognition of LGBT+ associations. The legislative framework does not guarantee their fundamental rights, freedoms and guarantees established in the Constitution. Law 8/04 on HIV/AIDS is silent on their rights. There are high levels of stigma and discrimination, human rights violations, in both the public and private sector, including

in schools, health centres and public services in general, and within the family. Access to health services is limited and not inclusive; multi-sectoral institutional mechanisms are weak and resource mobilisation is precarious. Additionally, access to comprehensive sexual education is also inadequate, it does not include the specific information relevant to young key populations. The study also could not explore the extent to which young key populations are expelled from their homes or abandoned due to their sexual orientation and gender identity status.

In terms of plans and policies, PEN V only provides for studies into the dynamics of LGBT+ populations, something which is also recognised as necessary by the National Strategy for Key Populations. It does not provide for other interventions, however.

Transgender persons are not adequately involved with drafting laws, policies and strategies and are not consulted on issues that concern them, even more so than other members of the LGBT+ community. Article 130 of the Civil Registry Code provides that only changes of first name that do not create doubts as to the sex of the registered person, are permitted.

Same-sex marriage and same-sex unions are not allowed, restricting the rights of LGBT+ persons to a family and to benefits granted to heterosexual couples in law, e.g. the right to inheritance. Alignment of marriage laws to reflect the aspirations of the new penal code will be critical.

Financial and human resources for sexual and reproductive health services are inadequate and there is limited evidence, as set out above, regarding the dynamics of LGBT+ populations. Further research is critical to produce scientific evidence to strengthen the national response for key populations.

388 Ref. Art. 35 No. 1 of the CRA.

389 Ref. Section 20 of the Family Code.

390 Men who have sex with men (MSM); Prisoners; Injecting Drug Users (IDUs); Sex Workers (SWs) and Transsexuals; Strategic Plan V (2015-2018), Angola, p.12. The plan recognises that there is a paucity of actions to address HIV prevalence and vulnerability within the five key populations considered by the WHO (2014) (Men Who Have Sex with Men (MSM), Transsexuals and Sex Workers (SWs), Inmates, Injecting Drug Users (IDU), and other groups, such as: migrant workers, refugees, truck drivers, military personnel and miners. p. 72

Recommendations:

In order to improve the national HIV/AIDS response for LGBT+ people, the following is recommendations

- Revise Law 8/04 on HIV/AIDS to protect the LGBT+ community against stigma and discrimination
- Review Law 8/04 on HIV/AIDS to promote substantive equality and protect from all forms of discrimination, family abandonment, violence and police abuse and to promote access to health services, social assistance – including for young key populations – and to freedom of association, amongst other things.
- Strengthen enforcement mechanisms against stigma and discrimination and health rights violations e.g. disciplinary procedures in the sectors of health, police, education, etc.
- Strengthen the protection of LGTB+ minorities rights and inclusion in health programmes including through resource mobilisation and training of health professionals of the rights of LGBT+ persons, including young LGBT+ persons
- Provide training for police officers and legal practitioners on sexual orientation and gender identity
- Allow transgender persons to have their gender affirmed and recognised in identification documents and official forms; repeal the provision of Art 130 of the Civil Registry Code.
- Adopt measures to promote access to justice for LGBT+ people,³⁹¹ including young LGBT+ persons
- Provide access to comprehensive sexual education that includes issues of sexual

orientation and gender identity in schools to reduce stigma and discrimination against young LGBT+ persons

- Raise awareness amongst the general population on the rights of LGBT+ populations,³⁹² including young LGBT+ persons
- Conduct studies to understand the dynamics of key populations in relation to HIV
- Conduct a legal audit of sexual orientation and gender identity rights.
- Adopt legislative and other measures to reducing discrimination and violence amongst families towards their young LGBT+ members.

3. Sex Workers (SW)

Although sex work is widespread in Angola, there is little information on sex workers as a result of the silence, stereotypical attitudes, stigma, discrimination and cultural values surrounding sex work. There is little statistical data on size estimates, gender distribution and HIV prevalence of sex workers.^{393 394} In Angola references to sex workers primarily focus on female sex workers.³⁹⁵

An INLS study revealed important data³⁹⁶ estimating the adjusted HIV prevalence among sex workers in Luanda and Benguela to be 10.5%, a number significantly higher than the estimated prevalence in the general population of adults in Angola, being 2.0% in 2018. Another study by SCARJoV found no statistics on sex workers in health services, since sex workers do not identify as such when presenting for health care, for fear of discrimination.³⁹⁷ The PLACE study³⁹⁸ estimated

391 See Recommendations in the Section on Access to Justice

392 See Recommendations in the Information and Education Section

393 Regarding HIV prevalence in SW, António Coelho/ANASO, estimated it to be 7% (*in* Jornal de Angola, 1 Dec. 2017).

394 They are often blamed as being at the root of the spread of HIV

395 Ref. REPUBLIC OF ANGOLA, Progress Report on the Political Declaration on HIV/AIDS – UNGASS 2012, p. 40-43; SCARJoV, Study of the Social Conditions and Legal Framework of Sex Workers in Angola, Luanda, 2015; CPLP/UNAIDS, HIV Epidemic in Portuguese Speaking Countries – Current situation and future perspectives towards universal access to prevention, treatment and care, 2nd Ed., Brasília, 2010, 16 to 36.

396 e.g. National Institute for the Fight against AIDS *et al.*, HIV Prevalence, Biological and Behavioural Factors of Infection among Sex Professionals, 2016.

397 Ref. SCARJoV, Study of the Social Conditions and the Legal Framework of Sex Workers in Angola, Luanda, 2015, pp. 28, 29, 52.

398 INLS/PEPFAR/USAID/Linkages/Univ. North Carolina/Tchicos, PLACE, 2017.

that sex workers comprise 0.5 to 1.8% of the adult female population; provincial estimates were: Cunene (0.5%), Benguela (1.0%), Bié (1.6%) and Luanda (1.8%), increasing to 4.4% in Cabinda province. Young women aged 15-24 years (47%) are in the majority,³⁹⁹ followed closely by women aged 25-34(44%); 13% of the population studied are over the age of 35.

Most sex workers are marginalised by society, which impacts negatively on their self-esteem and leaves them vulnerable to HIV, TB and other diseases. Some SW interviewed in Luanda reported arrests, detention and sexual violence by the police as well as being forced to pay fines or have sex in exchange for their release. Such violations have been reported to the Police Stations however such crimes are never recorded, hence difficult to track; Sex workers feel that they are not treated seriously, are generally mocked and told they shouldn't be out at night-time. Respondents complained of feeling powerless or helpless when dealing with the police, due to the violence and lack of response. In a focus group discussion, a SW from Luanda reported that: *"I was found by a friend of my fathers at my workplace, this person happens to be a police officer. He took me to the Police Unit where he works. He insulted me and threatened to inform my father about everything. Afraid to be exposed to my family, especially my father, I offered my services at the disposal of the officer and his work colleagues who readily accepted, because they asked. Although the sexual act was not consummated, because at that moment, I undressed, a female police officer appeared, and threatened to report her colleagues. So, it was thanks to her that I was saved, by threatening to report the police officers if they messed with me."*

A SW in Benguela reported that: *"Where I am with the police, they treat me rudely, they start to put their hands in my anus and in other places that they shouldn't be touching; and on top of that, they ask for money"*. This shows that young sex workers may experience specific

vulnerabilities relating to their young age e.g exploitation, violence, abuse within the profession and relationship with their families.

In general LEA did not find specific issues related to young sex workers i.e.18yrs and above. However, when dealing specifically with adolescents and children it was clear that the age factor constitutes a major vulnerability for contracting HIV and exposure to sex work as means for survival. Hence, the combination of both conditions (sex work -exploitation in the case of children- and being young) suffice the affirmation that young sex workers are especially vulnerable for HIV in Angola.

International Standards

According to the WHO Consolidated Guidelines (2016) sex workers include "female, male and transgender adults (18 years of age or older) who receive money or goods in exchange for sexual services, either on a regular basis or occasionally. Sex work is consensual sex between adults, it can take many forms and varies between and within countries and communities".⁴⁰⁰

UNAIDS/OHCHR Guideline 4 (c) on Criminal Law provides that adult sex work that does not involve victimisation should not be criminalised. Furthermore, occupational health and safety conditions to protect sex workers and their clients, including support for practising safe sex during sex work, should be regulated.⁴⁰¹ The GCHL (2012) recommends that States should reform their approach to sex work; instead of penalising adults involved in consensual sex work, countries should guarantee safe working conditions and allow access for sex workers and their clients to effective HIV and health services such as condoms, lubricants, etc. They should also repeal laws that prohibit "immoral" gains and ensure safe working conditions and the punishment of police harassment and violence against sex workers. It also recommends that

399 Note that, in accordance with WHO and other international guidance, young women below 18 years who sell sex are not viewed as sex workers in this study, but rather as persons who are sexually exploited.

400 Consolidated Guidelines -Key Populations-, WHO, 2016, p.xiii (Author's translation)

401 Guideline 4 (c) UNAIDS/EACDH (2016)

States apply laws against all forms of sexual abuse and sexual exploitation of children, in a way that clearly distinguishes these crimes from consensual sex work by adults.⁴⁰²

International standards on sex work also include ensuring that existing civil and administrative provisions, such as “loitering with intent,” “public nuisance,” and “public morality”, are not used to penalise sex workers, and that administrative laws such as the order to “move on” are not used to persecute sex workers.⁴⁰³ The GCHL Supplement (2018) provides that governments should not enact laws that prohibit, penalise or permit legal action against Internet site owners or other media that accept advertisements for sex work.⁴⁰⁴

Legal framework in Angola

The new Penal Code revokes old provisions that were used to criminalise aspects of sex work.⁴⁰⁵ In terms of the Civil Law, it is debatable whether a person, fully exercising his or her right to sexual self-determination and contractual freedom, could “sell” sex. Given that contractual freedom is limited by law, public order and morality, in accordance with the combined provisions of Articles 405 (2), 280 and 281 of the Civil Code, it appears that selling sex would not be permissible. Law 8/04 on HIV/AIDS is silent regarding sex work and sex workers. As a result, sex workers do not receive special protection under current legislation.

PEN V recognises the need to prioritise key populations, including sex workers,⁴⁰⁶ and notes the lack of surveillance to monitor the prevalence of and vulnerability to HIV amongst sex workers.⁴⁰⁷ The plan provides for HIV

prevalence and socio-behavioural studies among sex workers.⁴⁰⁸

The objectives of the National Strategy for Key and Vulnerable Populations aim to significantly reduce HIV infection and the impact of HIV amongst key populations, including sex workers. However, the Action Plan or Activity Matrix⁴⁰⁹ does not provide for differentiated activities for female or male or transgender and or young sex workers, nor does it focus on specific activities for sex workers. The Strategy’s Matrix dealt at length with issues of key and vulnerable populations but not with the specific problematic affecting sex workers. It is also silent on intersections and risks of sex work and drug abuse, sex work and transgender persons, sex work and prisons etc.

Gaps and challenges.

Stigma and discrimination, both in the public and private sphere, as well as police violence are serious problems that prevent an effective response to HIV amongst sex workers. Fear of abuse, extreme violence and discrimination discourage sex workers from attending health services. Sex workers do not enjoy their basic rights, such as access to safe working conditions, access to health services and access to justice. The lack of research into seroprevalence, socio-behavioural patterns and overlapping risks of sex workers hinders effective strategies.

Recommendations

- Review the Penal Code criminalisation of sex work, with a view to repeal.
- Revise Law 8/04 on HIV/AIDS to provide special protection for sex workers. Specifically, establish provisions in Law 8/04

402 CGVD (2012), p. 49

403 *Idem.*, p. 49

404 Supplement to the Global Commission (2018) p. 9 to 24

405 The Penal Code -1886- contains provisions that can be interpreted as punishing sexual work. Sex work can be considered a dangerous state, e.g. prostitutes who cause public scandal or repeatedly disobey police orders, pursuant to paragraphs 3, 5 and 6 of Art. 71, sanctioned with the security measures provided for in Art. 70. These provisions are revoked by the new Criminal Code adopted in January 2019

406 PEN V, p. 12

407 *Idem.*, p. 74

408 *Idem.*, p. 96

409 National Strategy for Key Vulnerable Populations p. 22 etc

on HIV/AIDS on occupational health and safety conditions to protect sex workers and their clients.

- Establish provisions in Law 8/04 to guarantee non-discrimination against sex workers.
- Establish provisions in Law 8/04 on HIV/AIDS to ensure the availability of specific health services that prioritise the prevention, treatment, care and support needs of sex workers, including the availability of preventive methods, *e.g.* condoms.
- Ensure that prioritised, differentiated activities for male, female, transgender and young sex workers are also specifically provided for in the national strategic plan for HIV, the National Strategy for Key Populations, national health programmes including activities to address stigma, discrimination and human rights violations and to provide prevention, treatment, care and support.
- Carry out studies on seroprevalence, socio-behavioural patterns and overlapping risks to better understand the dynamics of sex work and sex workers.
- Carry out behavioural studies on sex work, differentiating male, female and transgender sex workers and further disaggregated by age.
- Adopt financial measures to ensure the implementation of programmes for sex workers.
- Strengthen awareness of rights and access to legal support services for sex workers, including young sex workers, to enable them to respond to rights violations.
- Strengthen enforcement mechanisms to eliminate police violence and discrimination within health services, *e.g.* administrative sanctions, employment sanctions, etc.
- Provide training to inform and educate police officers and health professionals on the rights of sex workers, including young sex workers.

4. Prisoners

The updated WHO Consolidated Guidelines (2016) indicate that the prevalence of HIV, STIs, hepatitis B and C and TB in prison populations is generally estimated to be two to ten times higher than in the general population. Two key factors increase the risk of HIV, hepatitis B and C, and TB in prisons: behaviours that create the risk of HIV exposure, such as unsafe sex, drug use and tattoos; and structural issues such as prison infrastructure, prison management and the criminal justice system. Prison conditions, including overcrowding, sexual violence, drug use and lack of access to HIV prevention products (*e.g.* condoms and lubricants) disproportionately increase the risk of HIV transmission.⁴¹⁰

According to the GCHL (2012), inmates may engage in consensual and non-consensual relations in prison. Measures – such as condom distribution and punishment of sexual violence – are critical to stem the spread of HIV. The Commission reports that the use of drugs in prisons is an overlapping risk factor which increases the risk of HIV exposure.⁴¹¹ The GCHL Supplement (2018) notes that incarceration increases susceptibility to disease.⁴¹²

Although there is no precise information about the prison population in Angola, ANASO considers the TB rate amongst inmates to be very high, as one of the main HIV-related diseases.⁴¹³

With a view to bringing health services closer to the prison population and prison authorities, the Angolan Government, through the Ministry of the Interior/the National Directorate of Prison Services, has focused on creating health centres in all prisons throughout the country. However, due to limited resources, they were only installed in the centres of six provinces, namely Luanda, Bié, Malanje, Cuanza Norte, Lunda Norte and Bengo,⁴¹⁴ where they offer counselling and

410 Consolidated Guidelines – Key Populations-, WHO, 2016, p.5

411 Global Commission on HIV and the Law (2012) p. 64

412 Supplement to the Global Commission (2018) p. 31

413 Jornal de Angola, 1 December 2017 (António Coelho/ANASO).

414 Data gathered at the meeting with the heads of CATV at the São Paulo Prison Hospital.

testing services. Prison services also provide various interventions such as training of peer educators, counselling and antiretroviral therapy (ART) management for inmates.

During fieldwork for this study, prisoners in São Paulo prison hospital were found to have knowledge of HIV transmission and to take preventive measures *e.g.* not sharing razor blades. However, they did not have access to condoms, which were considered as potentially dangerous and thus not distributed. The study could not reach out to interview young prisoners due to factors beyond the team during the period of review.

International Standards

The WHO Consolidated Guidelines for Key Populations (2016) establish specific recommendations for persons in detention. The Guidelines recommend that HIV prevention and treatment services available in the community should also be provided to people in prisons and other closed facilities, and that the improvement of health care in these settings, should be the responsibility of the Ministry of Health, rather than the Ministry of Justice or the Interior.⁴¹⁵ WHO endorses the United Nations Office of Drug Control (UNODC) recommendations regarding a comprehensive package of HIV prevention and treatment in prisons and other closed facilities (2013).⁴¹⁶

The Global Commission on HIV and the Law (2012) recommends that states ensure that detention centres provide health care, including HIV prevention, quality treatment and support services (condoms, risk reduction services, voluntary treatment, etc.). The Supplement (2018) further recommends that States should ensure that HIV status is not

used to justify pre-trial detention, segregation during detention or imprisonment, or tougher or harsher sentences, or conditions for parole after release from custody.⁴¹⁷

UNAIDS HIV/AIDS and Human Rights International Guidelines: Guideline No. 4 on criminal law and correctional systems recommends that correctional systems should ensure that they are consistent with international human rights obligations and that measures are not misused in the context of HIV. Guideline 4 specifies⁴¹⁸ that prison authorities take all necessary measures, including the provision of adequate personnel, effective monitoring and appropriate disciplinary measures to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate) with access to information on prevention, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care, and voluntary participation in HIV-related clinical trials, as well as guarantee confidentiality. Likewise, it specifies the prohibition of compulsory testing, segregation and denial of access to prison facilities, privileges and release programmes for seropositive prisoners.

The Mandela Rules⁴¹⁹ contain various provisions relating to health. Paragraph 1 of Rule 24 prescribes that “[t]he provisions of health care for prisoners is the responsibility of the State. Inmates should enjoy the same standards of health care that are available in the community and must have access to the necessary health care services free of charge, without discrimination based on their legal status.” Pursuant to paragraph 2 of this Rule “health services organisation

415 Consolidated Guidelines – Key Populations-, WHO, 2016, p.23

416 Policy Brief, HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions, 2013 UNODC/ILO/UNDP/WHO/UNAIDS. The 15 interventions are: Information, education and communication; Condom programmes; Prevention of sexual violence; Treatment of drug dependence, including opioid substitution therapy; Needle and syringe programmes; Prevention of transmission through medical or dental services; Prevention of transmission through tattoos, piercings and other forms of skin penetration; Post-exposure prophylaxis; HIV testing and counselling; HIV treatment, care and support; Prevention, diagnosis and treatment of tuberculosis (TB); Prevention of mother-to-child transmission of HIV; Prevention and treatment of sexually transmitted infections (STIs); Vaccination, diagnosis and treatment of viral hepatitis; and, Protection of staff from occupational hazards

417 Supplement to the Global Commission (2018) p. 34

418 See Guideline No. 4 (e) UNAIDS/EACDH

419 *United Nations Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules)*

should be closely related to the general public health administration and in such a way that it ensures continuity of treatment and care, including for HIV, TB and other infectious diseases, as well as for drug addiction.”⁴²⁰

Legal Framework in Angola

In addition to the guiding principles of the Constitution, the prison population is governed by revised prison legislation, as part of the reform of the prison system: Law No. 8/08 of 29 August; Special Care Regime of Prison Services (Decree 43/99 of 24 December) and the Regulations for Labour Organisation in Prison Establishments (Decree No. 64/04 of 1 October). The organs of the Prison Service also rely on the Law on HIV and AIDS (Law 8/04, of 1 November), the Prison Procedures Booklet in Prison Establishments,⁴²¹ as well as other prisoner-related standards that include recommendations by the UNODC and WHO.

Law 8/08 (Penitentiary Law) is based on the principles of non-discrimination and respect for human dignity. It also enshrines the right of all prisoners to health.⁴²² Arts. 6⁴²³ and Arts 54 – 57 of Law 8/08, regulate medical-health care for the prevention and treatment of diseases, especially transmissible disease. However, the Penitentiary Law does not establish any specific provisions regarding HIV.

Law 8/04 on HIV/AIDS refers to the rights of persons deprived of their liberty.⁴²⁴ However, provisions are limited to the prohibition of compulsory testing (with some exceptions) and the right of prisoners to medical care and medicines. The HIV/AIDS Act doesn’t take into account the special needs of prisoners, including issues related to sexual health, violence, discrimination and drug-related issues.

The Penitentiary Law regulates conjugal rights of prisoners. Conjugal visits are defined as intimate contact between the prisoner and his/her spouse or partner in an appropriate place that is separate to his/her cell.⁴²⁵ The law further provides for such visits to take place at least once a month, lasting from one to three hours.⁴²⁶ However, the provision seems to limit conjugal visits to heterosexual “couples” only.

PEN V identifies prisoners as a vulnerable population and recognises their vulnerability to HIV, as a closed population exposed to risky behaviours. The plan provides for HIV counselling and testing and prevention.⁴²⁷ It recommends training for prison employees and a socio-behavioural study of HIV within prisons.

The National Strategy for Key and Vulnerable Populations recognises prisoners as a vulnerable population and establishes actions to improve the country’s response to HIV within prisons. It emphasises that the country’s response to HIV poses a significant challenge to the penitentiary and public health authorities and calls for coordinated action.⁴²⁸ Significantly it provides for the provision of condoms for prisoners and prison staff.

Gaps and challenges

In general, the provision of health services in prisons is a major challenge due to structural issues such as the scarce availability of health services and the poor quality of these services.

The lack of information and evidence regarding prisoners and HIV prevents the development of an effective and sustainable response.

In addition, a major gap is the lack of specific provision for comprehensive services for prisoners in various key laws, policies and

420 Author’s translation

421 Prison Procedures Booklet in Prison Establishments.

422 *Idem.*, Chapter II, Rights (d).

423 Art. 6.2 (b) right to health (Law 8/08, Penitentiary Law)

424 Art. 6 Law 8/04 on HIV/AIDS

425 Art. 40 No. 1 of the Penitentiary Law

426 *Idem.*, Art. 40, paragraphs 2 and 3

427 PEN V, p. 74

428 National Strategy for Key and Vulnerable Populations p. 7

plans, including dealing with issues such as providing preventive measures (e.g. condoms) and ensuring access to measures to reduce stigma, discrimination, violence (including sexual violence) and promote access to health and access to justice.

Recommendations

The following is recommended

- Revise Law 8/04 on HIV/AIDS to recognise the specific needs of prison inmates, including young prison inmates, particularly in relation to access to health services, including SRHR – with an emphasis on education, information and access to the means of prevention as well as treatment and care – and the elimination of stigma, discrimination and violence, particularly sexual violence.
- Establish prisoners' right to health to ensure that community-based HIV prevention and treatment services are also provided to people in prison and in other closed facilities and that services include a focus on the needs of young prisoners.
- Revise Law 8/08 (Penitentiary Law) to introduce specific provisions on prevention and treatment of HIV and TB in Prisons, including Juvenile detention centres.
- Ensure access to information on prevention, education, voluntary testing and counselling for all those in detention, including young detainees.
- Provide access to the means of prevention, such as condoms and lubricants.
- Carry out studies in prisons to obtain evidence on the dynamics of the epidemic, including overlapping risks e.g. drug use, sex work, and the specific vulnerabilities of young persons in detention.
- Carry out training in prisons for prisoners and prison officers on the rights, including health rights, of prison inmates.

- Strengthen coordination mechanisms between the Ministry of the Interior and the Ministry of Health to strengthen access to health care services for prison inmates.
- Treat prisoners as a key population.

5. People who use drugs

The GCHL Supplement (2018) report shows that people who use drugs generally remain excluded from treatment for HIV, TB and hepatitis.⁴²⁹ It points out that levels of co-infection are very high among people who use drugs. For example, of an estimated 15.6 million people worldwide who inject drugs, nearly one in six are living with HIV. Extreme measures such as criminalising the possession, use and cultivation of small quantities of illicit drugs results in harmful consequences for people living with HIV and their co-infections.⁴³⁰ The GCHL notes that punitive laws against people who use drugs fuel the spread of HIV, discouraging people who use drugs from using HIV harm reduction services.⁴³¹

WHO notes that many key populations are involved in more than one risk behaviour (e.g. drug use and sex work, or a man who has sex with other men who also use drugs). Because of this, the HIV prevalence rate amongst people who belong to several key population groups is higher than those who only have one type of risk.⁴³²

There is limited information on people who use drugs in Angola, including young people who use drugs.

International Standards

The GCHL (2012) recommended that countries reform their attitudes and practices towards the management of drug use so as to decriminalise drug use and provide people who use drugs with access to evidence-based HIV-related health services, including harm reduction and voluntary treatment.

429 Supplement to the Global Commission (2018) p. 7

430 Idem., p. 31

431 CGVD (2012) p. 33

432 Consolidated Guidelines -Key Populations-, WHO, 2016, p.6

The Commission also recommends closing compulsory drug addiction detention centres for people who use drugs and replacing them with voluntary services to treat drug addiction. Drug possession for personal use should be decriminalised, recognising that the ultimate impact of such sanctions is generally detrimental to society. Compulsory HIV testing as well as forced treatment for people who use drugs should also be prohibited.

The GCHL (2018) Supplement, in addition to reaffirming its 2012 recommendations, added that governments should take measures to prevent discrimination against people who use drugs and ensure access to appropriate health care services, including for HIV, TB and viral hepatitis.⁴³³

At the regional level, the SADC Strategy for Key Populations recognises the rights of all key populations to equitable access to health services, including people who use drugs, and provides a series of measures to ensure effective implementation of State responsibilities, with the participation of key populations. The Strategy notes that punitive and restrictive laws raise the vulnerability of people in prisons and people who use drugs to HIV – e.g. legal prohibitions on the provision of sterile needles and opioid substitution treatment (OST) directly impede HIV prevention efforts. It includes measures for people who use drugs, defined as people who use illegal psychotropic substances through any administration route, including injection, oral, inhalation, transmucosal (sublingual, rectal, intranasal) or transdermal.⁴³⁴ Recommended measures include those to address the legal and policy environment to protect the rights of people who use drugs, efforts to reduce stigma, discrimination and violence against people who use drugs and efforts to ensure access to comprehensive services, including for young people who use drugs.

Legal Framework in Angola

Law 8/04 on HIV/AIDS is silent on people who use drugs, an indication that people who use drugs are unprotected from violence, stigma and risks of HIV exposure.

Law 3/99 “Law on Trafficking and Consumption of Narcotic Drugs, Psychotropic Substances and Precursors”⁴³⁵ establishes a set of penal rules concerning, amongst other things, the cultivation, possession and consumption of drugs. Particularly noteworthy are the Art. 8 provisions regarding trafficking and Art. 9 on the trafficker-consumer.⁴³⁶ Art. 23 of Chapter III deals with Consumption and Treatment and criminalises anyone who illegally consumes, or cultivates, acquires, or holds unlawful plants, substances or preparations for his own consumption. It criminalises excessive amounts of drugs – if the quantities of plants, substances or preparations grown, held or purchased exceed the amount for average individual consumption within a three-day period, the penalty shall be imprisonment of up to 1 year. Law 3/99, on the one hand, criminalises illicit consumption, and on the other hand, criminalises activities that are directly associated with personal consumption. The criminalisation of possession, acquisition and cultivation of drugs for personal use, although it does not carry a serious sentence, is nevertheless contrary to GCHL recommendations.

PEN V recognises that there is no data on HIV transmission among people who inject drugs and that future epidemiological research is required. The National Strategy for Key Populations also highlights that people who inject drugs are not included as key population in the national response due to the lack of evidence on this population.⁴³⁷

⁴³³ Supplement to the Global Commission (2018) p. 9, paragraphs 26 and 28

⁴³⁴ Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health Rights among Key Populations; SADC 2018, p. 7. The Strategy uses the WHO definition of Consolidated Guidelines for Key Populations (2014)

⁴³⁵ Law 3/99; National Assembly “On trafficking in and consumption of narcotic drugs, psychotropic substances and precursors” Official Gazette, Series 1, No. 32, of 6 August 1999.

⁴³⁶ In fact, the legal regime for trafficking and other offences is regulated in Chapter II of Law 3/99 (Arts. 4 to 22) and includes other crimes such as criminal association (Art. 11) or trafficking and consumption in public places of meeting (Art. 13).

⁴³⁷ National Strategy for Key Populations, note No. 1

The CILAD (Inter-Ministerial Committee on Drug Control) Strategic Plan is based on several principles including the recognition of the dignity of people who use drugs and the principle of preventive interventions.⁴³⁸ The Plan establishes strategic guidelines for raising awareness in society and amongst young people on the adverse effects of drug use, as well as reinforcing prevention and ensuring better information on drugs and drug addiction.⁴³⁹ It also provides for research and training, primarily the issue of policing and intelligence rather than the interrelationship between drug use and the HIV epidemic. The Plan makes no specific reference to people living with HIV, nor the risk of infection inherent to the use of drugs. Furthermore, it is silent about the stigma experienced by people who use drugs.⁴⁴⁰

Gaps and Challenges

In Angola, the law punishes people who cultivate, acquire or possess certain plants, substances or preparations (included in Tables I to IV of the Law 3/99) for personal consumption. It creates more severe punishment if the quantities exceed those required for the average individual to consume within a three-day period. People who use drugs experience stigma, discrimination and violence (mainly from police), and it goes unchallenged, perhaps due to the criminalised nature of drug use.

The lack of evidence and specialised studies on drug use and HIV is a major challenge for institutions, making it impossible to develop policies and strategies for these specific populations. Law 8/04 makes no reference to people who use drugs, nor does it allow for special protection. The convergence of high-risk behaviour patterns that people who use drugs may be involved with, e.g. sex work and unprotected sex, is not recognised and unregulated.

HIV policies and plans do not contain sufficient reference to and prioritisation of people who use drugs; likewise, drug policies and plans contain no reference to HIV and harm reduction. E.g. PEN V contains limited reference to people who use drugs, confining its provisions to a recognition of the lack of evidence on people who use drugs and HIV and providing for research activities. The National Strategy for Key Populations does not recognise people who inject drugs as a key population, due to a lack of evidence. The CILAD Strategic Plan does not provide specific actions on prevention, research and training relating to HIV, AIDS and drug use.

Recommendations:

The following is therefore recommended.

- Review Law 8/04 to ensure the special protection of people who use drugs; especially to prohibit stigma, discrimination and violence, detention or compulsory isolation and compulsory HIV testing and to establish provisions to improve access to comprehensive access to services for HIV, TB and viral hepatitis, including harm reduction services.
- Review with a view to decriminalising the consumption, possession and cultivation of drugs for personal use. Specifically, it is recommended that a "Technical Opinion" is prepared to evaluate decriminalising the consumption, possession and cultivation of drugs for personal use, aiming to revise Art. 23 of Law 3/99 "Law on Trafficking and Consumption of Narcotic Drugs, Substances Psychotropic and Precursors".
- Include comprehensive interventions for people who use drugs in PEN V, including education and information on the HIV-related health risks of drug use, access to harm reduction services, prevention, treatment, care and support.
- Include in the CILAD Strategic Plan, actions related to the link between HIV and drug

438 Strategic Plan-CILAD, 2013, p. 6

439 *Idem.*, 2013, p. 17

440 See, for example, the CILAD-p Strategic Plan. 42 *etc.* about Reinsertion

use, especially with regard to overlapping vulnerabilities and behaviours that increase risk of HIV exposure (e.g. drugs and sex work, drugs within the prison environment, drugs and unprotected sex between men).

- Carry out studies and develop evidence to increase understanding of the dynamics of people who use drugs in the context of HIV.
- Strengthen institutional links between the different institutions working with these issues, e.g. strengthen the link between INLS and INALUD.

G. Employment

1. Analysis of the Situation

Protecting the fundamental workplace rights of people living with and affected by HIV is essential to ensure effective responses to the epidemic. In the early stages of the HIV epidemic, cultural, religious and, above all, misinformation and fear led to many PLHIV being dismissed from their jobs, under the pretext of protecting other employees and the public with whom they came into contact.

The National Development Plan 2018-2022 shows that, based on the 2014 Census, the activity ratio between the economically active population and the working age population aged 15 and over was 53% at the national level, being 61% in men and 45% in women. These employment ratios are significantly lower than those estimated by the International Labour Organisation for Angola (70% at national level, 76.9% and 63.3% respectively for men and women) and in sub-Saharan Africa (70%) and in the Low Human Development Countries (68%).⁴⁴¹

Angola has legislation that allows everyone, whether they are members of key or vulnerable populations, equal opportunities to employment, prohibits dismissal on the

grounds of HIV status, prohibits compulsory HIV testing and protects workers at risk of exposure to HIV and TB.⁴⁴²

In Angola the public sector has the most significant number of employees. Despite progress made over the years, there are concerns regarding pre-employment testing, dismissals and health and safety in the public sector workplace. HIV-related stigma and discrimination persist in many places of work. During the fieldwork for this study, respondents reported illegal practices such as pre-employment HIV testing and unfair dismissals, albeit in a hidden or indirect way. Many employers and co-workers indirectly discriminate against employees perceived to be HIV-positive.

These unlawful practices are often based on ignorance of the facts surrounding HIV transmission, progression of the disease as well as of the different means of prevention, treatment and care, or employers or supervisors' concern about a reduction in productivity and profits due to medical care costs, funeral and other care costs, and fear of losing business due to HIV-related stigma.

2. International Standards

The UDHR guarantees to all people, the right to work, to free choice of employment, to just and favourable conditions of work, and to protection against unemployment. It also provides for non-discrimination with regards pay.⁴⁴³ The ICESCR regulates the right to work in Articles 6, 7 and 8. Article 6 provides for the right to work; Article 7 protects the right of everyone to the enjoyment of just and favourable conditions of work, in particular safe working conditions and Article 8 protects the collective dimension of the right to work, providing for the right of everyone to form trade unions and join the union of his/her choice and the right of trade unions to function freely.

⁴⁴¹ NDP 2018-2022, p. 39.

⁴⁴² See below under Section on Current Situation (Employment), specially Art. 7 Law 8/04, HIV Act.

⁴⁴³ Art. 23 UDHR. See also Art. 24 UDHR. In addition to the UDHR, other international instruments recognise the right to work, e.g. Art. 8. 3 (a) ICCPR, Art. 5 CEDR, Art. 11. CEDAW, Art. 32 CRC, Art. 25 CDTM, Art. 27 CRPD.

According to General Comment No. 18 of the ESCR Committee “[t]he right to work is essential for the realisation of other human rights and constitutes an inseparable and inherent part of human dignity. Every individual has the right to work, allowing him/her to live with dignity. The right to work at the same time contributes to the survival of the individual and to that of his/her family, insofar as work is freely chosen or accepted, to his/her development and recognition within the community”.⁴⁴⁴

The exercise of work in all its forms and at all levels requires the existence of several elements that are interdependent and essential, namely a) availability, b) accessibility, c) acceptability, and, d) quality. With regards to accessibility, the right to work means, among other things, that the labour market should be open to all under the jurisdiction of States Parties to the Covenant. It also means that under Art. 2, paragraph 2 and Art. 3, the ICESCR prohibits any discrimination in access to and maintenance of employment on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV status), sexual orientation, or civil, political, social, or other status, which has the intention or effect of impairing or nullifying exercise of the right to work on a basis of equality.⁴⁴⁵

The sources of international labour law have expanded since the creation of the ILO in 1919, and the United Nations in 1945. International and regional standards, together with national

legislation, have provided key resources for the treatment and resolution of HIV-related labour conflicts, thereby ensuring the guarantees of workers in general, and in particular the work of people living with HIV.⁴⁴⁶ The 2010 HIV and AIDS Recommendation (No. 200)⁴⁴⁷ and Convention (No. 111) on Discrimination in relation to Employment and Occupation, 1958⁴⁴⁸ of the ILO established a set of principles and recommendations to improve countries’ responses in relation to work and the HIV epidemic.

The provisions of Recommendation No. 200 of 2010 include: a) there should be no discrimination against or stigmatisation of workers, in particular job seekers or job applicants, on the grounds of real or perceived HIV status; b) prevention of all means of HIV transmission should be a fundamental priority; c) workers, their families and their dependants should have access to and benefit from prevention, treatment, care and support in relation to HIV and AIDS, and the workplace should play a role in facilitating access to these services; d) workers should benefit from programmes to prevent specific risks of occupational transmission of HIV and related transmissible diseases, such as tuberculosis; e) workers, their families and their dependants should enjoy protection of their privacy, including confidentiality related to HIV and AIDS, in particular with regard to their own HIV status; f) no worker should be required to undertake an HIV test or disclose their HIV status;⁴⁴⁹ and, g) measures to address HIV and AIDS in the world of work should be

444 GC No. 23, E/C.12/GC/18 of 6 February 2006, paragraph 1

445 *Idem.*, paragraph 12

446 Within the framework of the ILO, there are eight “core” Conventions. These are: Convention (No. 87) on Freedom of Association and Protection of the Right to Organise, 1948; Convention (No. 98) on the Right to Organise and Collective Negotiation, 1949; Convention (No. 29) on Forced Labour, 1930; Convention (No. 105) on the Abolition of Forced Labour, 1957; Convention (No. 138) on the Minimum Age of Admission to Employment, 1973; Convention (No. 182) on the Worst Forms of Child Labour, 1999; Convention (No. 100) on Equality of Remuneration, 1951; Convention (No. 111) on Discrimination in relation to Employment and Occupation, 1958.

447 INTERNATIONAL LABOUR ORGANISATION, HIV and AIDS and Labour Rights: A Handbook for Judges and Legal Professionals, Geneva, 2013, p. 49.

448 *Idem.*, p. 43.

449 With regards testing, privacy and confidentiality, Recommendation 200 includes: a) testing must be genuinely voluntary and free of any coercion; b) HIV testing or other forms of screening for HIV should not be required of workers, including migrant workers, job-seekers and job applicants; c) The results of HIV testing should be confidential, d) migrant workers or those seeking to migrate for employment, should not be excluded from doing so by the countries of origin, of transit or of destination on the basis of their real or perceived HIV status; and, e) the creation of dispute resolution procedures. *See* Recommendation 200 (...) § 24 to 29 (Testing, privacy and confidentiality). *See also* §§ 30-34 on health and safety at work and § 21 on support for workers living with HIV/AIDS.

part of national development policies and programmes, including those related to labour, education, social protection and health.

Recommendation 200 further provides that an employee's real or perceived HIV status should not be a ground of discrimination preventing the recruitment or continued employment, or the pursuit of equal opportunities consistent with the provisions of the Discrimination (Employment and Occupation) Convention, 1958. Real or perceived HIV status should not be a cause for termination of employment. Temporary absence from work because of illness or care-giving duties related to HIV or AIDS should be treated in the same way as absences for other health reasons, considering the Termination of Employment Convention, 1982.

UNAIDS/OHCHR Guideline No. 5 recommends that States revise labour laws to protect employees' rights in relation to HIV and AIDS, for example by enacting laws, regulations and workplace agreements to ensure prohibition of HIV testing as a prerequisite for employment, promotion, training or benefits. Guideline No. 5 also recommends establishing legal provisions to ensure confidentiality with respect to HIV status; job security for workers living with HIV, including reasonable accommodation in the workplace; access to HIV-related prevention, treatment, care and support. Furthermore, this Guideline recommends adopting measures to protect against HIV-related stigma and discrimination and protection against occupational infection of HIV.

In relation to the African standard, the ACHRP guarantees everyone the right to work under fair and favourable conditions and to receive equal pay for equal work. The SADC PF Model

Law on HIV and AIDS for southern Africa, 2008 also contains provisions consistent with the international guidelines on rights in the workplace for SADC countries, e.g. Art. 23 and Art. 28, protecting the right of employees to non-discrimination, equal opportunities, confidentiality and reasonable accommodation in the workplace and prohibiting unfair employment practices such as pre-employment HIV testing, dismissals and demotions on the basis of a person's HIV status. They also protect the right to safety in the workplace and protection from occupational infection with HIV.

3. Current situation in Angola

Under CRA 2010, work is recognised as “a right and a duty of all”,⁴⁵⁰ with the State being responsible for ensuring the right to work, without any discrimination; the standard in question also establishes that “dismissal without just cause is illegal”.⁴⁵¹ The State is also assigned the fundamental task of “progressively creating the conditions necessary to realise the economic, social and cultural rights of citizens”.⁴⁵² Among the workers' rights established in the Angolan Constitution, the following are highlighted: the right to professional training; fair remuneration; rest; holidays; protection; hygiene and safety at work; all recognised in accordance with current ordinary laws.⁴⁵³ With respect to duties, CRA, 2010 establishes an indemnification obligation of an employer where there is illegal dismissal (without just cause).⁴⁵⁴

In Angola,⁴⁵⁵ the General Labour Law applies to all workers in the country who provide remunerated services for an employer

450 Art 76.1 (Right to Work), CRA 2010

451 *Idem*, Art 76

452 Art. 21 c) (State main tasks), CRA 2010.

453 *Idem.*, No. 2 Art. 76 (Right to work).

454 *Idem.*, No. 3 Art. 76 (Right to work).

455 The legal system for labour in Angola includes the General Labour Law (Law 7/15, of 15 of June); Law on HIV/AIDS (Law 8/04, of 1 November); Regulation on HIV/AIDS, Employment and Vocational Training (Approved by Decree 43/03, of 4 July); Disciplinary System for Civil Servants and Public Officials (Approved by Decree 33/91, of 26 July); Legal System of Occupational Accidents and Diseases (Decree 53/05, of 15 August); Regulation of Health Boards (Approved by Decree 3/90, of 13 January); Regulation for the Organisation of Prison Labour in Prison Establishments (Law No. 64/04, October); Legal System for Foreigners in Angola (Law No. 02/07, of 31 August); Regulation on the Exercise of Professional Activity of Non-Resident Foreigners in Angola (Approved by Decree 06/01, of 19 January).

within the organisation and under the supervision and direction of the employer, specifically in public, private and cooperative organisations.⁴⁵⁶ Art 4.4 of this Law states that the conditions under which labour is performed must respect the freedom and dignity of the worker, enabling him or her to meet his own needs and those of his or her family's, protecting his/her health and enjoying decent living conditions.

The General Labour Law, in addition to recognising the inseparability of the right to work and the duty to work, recognises limitations in work capacity arising from common or occupational illness and/or invalidity.⁴⁵⁷ In the General Labour Law, unjustified absences from work have a cumulative effect resulting in loss in remuneration, decreases in annual leave and disciplinary offences, if they exceed three days in each month or twelve days in each year, or regardless of the number, where absences cause serious harm and risk that are known to the worker.⁴⁵⁸ Absences can however be justified and unjustified.⁴⁵⁹

The rights of people living with HIV to work is enshrined in the Law on HIV/AIDS and in the HIV/AIDS, Employment and Vocational Training Regulations. The Law on HIV/AIDS, which enumerates the rights of people living with HIV, highlights work, employment and vocational training. Under this Act, every person living with HIV has the right to work, employment and vocational training.⁴⁶⁰ Workers with HIV have the right to equal opportunities and employment stability and cannot be disadvantaged due to their HIV status. It is also the employer's duty to

educate, inform, train and raise awareness among their workforce about HIV and respect for the rights of employees living with HIV.⁴⁶¹ Employee rights violations are punished in accordance with the respective regulations.⁴⁶²

The HIV/AIDS Law also provides for sick leave for employees with HIV: absences due to illness that do not exceed a period of 120 days are justifiable; absences for up to 180 days require medical documentation.⁴⁶³

An employee who acquires occupational infection with HIV, resulting from carrying out professional duties, is entitled to compensation, as regulated by statute.⁴⁶⁴

The HIV/AIDS, Employment and Vocational Training Regulation⁴⁶⁵ "applies to the bodies and institutions of the centralised and local state administration, to public, mixed and private companies, both national and foreign, as well as cooperatives, and occupational and vocational training institutions, regardless of their size".⁴⁶⁶ This statute prevents HIV testing as a prerequisite for admission to and continuation of employment. It stipulates that workers are not obliged to declare their HIV status to the employer or to any other person in a supervisory role, and it prohibits dismissal or non-promotion or relegation of duties simply on the basis of HIV status; it aims at achieving equal treatment and opportunities without discrimination.⁴⁶⁷

The Regulation provides for fair compensation or damages to be awarded to employees acquiring occupational HIV infection,⁴⁶⁸ noting that "workers infected with HIV in the course of their professional activity or during their professional training are entitled to

456 No. 1 Art. 1 (Scope), of Law 7/15, of 15 June (General Labour Law).

457 *Idem.*, No. 2 and 4, Art. 4 (Right to work).

458 *Idem.*, Art. 153 (Effects of unjustified absences).

459 *Idem.*, Paragraph (a) and (g), Art. 145 (Justified absences).

460 Art. 5 paragraph and Law 8/04 on HIV/AIDS

461 *Idem.*, Art. 7, paragraphs 1, 2 and 3 (Labour Rights)

462 *Idem.*, Art. 7 (4) (Rights of the Employee)

463 *Idem.*, Art. 8. (Justified Absences) and 7 (2) (Rights of the Employee).

464 *Idem.*, Art. 11 (Occupational exposure)

465 Decree No. 43/03 of 4 July (Regulation on HIV/AIDS, Employment and Vocational Training).

466 *Idem.*, Art. 2 (Scope)

467 *Idem.*, Art. (Access and Control), Art. 7 (Confidentiality) and Art. 8 (Employment and training situation)

468 *Idem.*, Art. 14 (compensation)

compensation or damages, according to the law". However, there is no specific mention of access to post-exposure prophylaxis (PEP) for HIV exposure. The Regulation also protects workers living with HIV from stigma or discrimination by an organisation's management, colleagues and clients. It recognises discriminatory and stigmatising behaviour as a serious violation requiring disciplinary sanctions.⁴⁶⁹ Rights violations are punishable with a fine, without prejudice to the possibility of criminal prosecution.⁴⁷⁰ The Regulation on HIV, Employment and Vocational Training pre-dates the Law on HIV/AIDS.

Decree No. 53/05 of 15 August (Legal System for Workplace Accidents and Occupational Diseases) applies to all those covered by the General Labour Law, exception for civil servants and agents of public administrations and non-resident foreign national workers entitled to compensation for occupational injuries and diseases in their country of origin.⁴⁷¹

The National Development Plan (2018-2022) includes a series of programmes to mitigate unemployment, including Programme for the Promotion of Employability and the Programme for Improvements to Organisation and Working Conditions. However, there are no provisions to improve access to employment for people living with HIV or from the perspective of the HIV epidemic.⁴⁷²

PEN V provides for expanded prevention programmes in the workplace,⁴⁷³ with a strong focus on the right to work.⁴⁷⁴ It identifies the role of employers to prevent HIV and reduce stigma and discrimination.⁴⁷⁵ It includes a strategic intervention within Strategic Axis III: "Promotion of a favourable ethical and legal environment", advocating for a more active involvement in the Fight against AIDS in the workplace.⁴⁷⁶

4. Gaps and Challenges

On the one hand, the Angolan legal framework provides protection for HIV-related workplace rights. In addition, PEN V provides for various activities on HIV and the right to employment and in the workplace. However, there is a need to harmonise the existing laws on HIV, AIDS and employment, namely Law 8/04 on HIV/AIDS and Decree No. 43/03 of 4 July (Regulation on HIV/AIDS, Employment and Vocational Training). On the other hand, legislation and administrative measures are not fully aligned with international standards, specially there are not provisions that reflect access to the benefits of science as it is the case with the availability of post-exposure prophylaxis (PEP) to all health professionals and other service providers, including law enforcement officers.

In addition, there are limited HIV/AIDS workplace plans, policies or strategies that operationalise the State guidelines in place or regulating access to employment and combating unfair practices in the workplace within companies or public sector entities, including stigma and discrimination in the workplace, dismissal, absences, and inadequate health and safety in the workplace for people living with HIV and particularly, for key populations.

Sex work is not recognised as 'work' in Angola, this has resulted in the exposure of sex workers to HIV infections and a total lack of protection for sex workers' labour rights, and negatively affects to accessing to public services, particularly access to health services.

In addition to the lack of specific workplace plans and strategies for PLHIV or key populations, besides campaigns to integrate PLHIV within the workplace, discriminatory practices prohibited by national legislation

469 Art. 15 (Protection against injury). Decree No. 43/03

470 *Idem.*, Art. 16 (Infringement)

471 *Idem.*, Art. 2 (Exceptions)

472 PND 2018-2022, p. 188

473 PEN V p.72

474 *Idem.*, p.79

475 *Idem.*, p.75

476 *Idem.*, p.144

(e.g. pre-employment HIV testing) are still commonplace. During fieldwork for this study, respondents reported stigmatising and discriminatory practices, both directly and indirectly, in the public as well as private sectors. In some workplaces, employers require compulsory testing of job applicants, as well as existing employees, including within the health sector. Another major challenge is the lack of knowledge of HIV-related workplace laws, rights, plans and policies which are poorly disseminated.

5. Recommendations

Therefore, the following is recommended:

- Revise Law 8/04 to include more extensive workplace protection for the rights of PLHIV and key populations, particularly young key populations, in line with international guidance.
- Revise Law 8/04 to provide workers and employers with comprehensive information on HIV, including employment rights, education, information and prevention, treatment, care and support services.
- Revise Law 8/04 to strengthen provisions in relation to occupational exposure to HIV and to ensure that post-exposure prophylaxis (PEP) is available to all health professionals and other service providers, including law enforcement officers, who may require it, and to guarantee procedures to access support, counselling and care during out-of-work hours.
- Standardise Law 8/04 and Decree No. 43/03 of 4 July (Regulation on HIV/AIDS, Employment and Vocational Training) and take steps to implement and monitor their provisions.

- Adopt legislative measures to guarantee non-discrimination in the workplace and HIV-related labour rights for key populations, including for sex workers.
- Adopt HIV-specific workplace policies on employment, the right to work and employee's rights within the workplace, which takes into account the provisions of ILO Recommendation No. 200 of 2010.
- Adopt educational measures aimed at eliminating stigma and discrimination, and fears associated with HIV and AIDS in co-workers and employers.
- Strengthen procedures for access to justice in cases of breaches or non-compliance with legal provisions by colleagues or employers in the workplace, to ensure punishment for those who violate employment rights for employees living with HIV, e.g. equal opportunities within employment, a prohibition on pre-employment HIV testing and disclosure of employee's HIV status without consent.

H. Social Security

1. Analysis of the Situation

Individualised or specialised assistance provided to vulnerable populations e.g. people with disabilities, children and the elderly, sick or those belonging to minority groups, is part of the government's social assistance, within the global vision of ensuring the survival, protection and development of the human person, based on that established in the Constitution and the law. This section addresses social assistance mechanisms⁴⁷⁷ provided to those who, for some reason, such as old age, childhood, pregnancy, diseases, disabilities, etc., are vulnerable to HIV.

⁴⁷⁷ Although the doctrine makes a technical distinction between concepts, in the context of this assessment, for pragmatic reasons, the following expressions will be considered indistinctly: **Social protection**: interpreted as being more comprehensive than social security (including, in particular, the protection afforded between family members or by members of a local community). **Social security**: covers all measures that provide cash benefits, or in kind, to provide protection, in particular against: lack of work-related income (or insufficient income) due to illness, invalidity, maternity, work-related accident, unemployment, old age or death a family member; lack of access to health care or access at unbearably high financial costs; insufficient family benefits, in particular for dependent children and adults; general poverty and social exclusion. **Social assistance**: are benefits that are conditional on the beneficiary's level of income. (Ref. FEDERAL GOVERNMENT, For a Culture of Human Rights – Right to Social Security – Secretary of Human Rights of the Presidency of the Republic – SDH/PR Brasília – 2013, p. 19-20).

Angola has laws and policies on social protection, obligating the State to guarantee the effectiveness of these mechanisms, mitigating social risk and correcting inequalities in national income. Although the Angolan Government has undertaken a number of legislative initiatives and developed and subsequently implemented social protection and assistance plans and policies, results are not visible on the ground.

This study examined whether social protection and social security standards exist for people living with HIV, key and vulnerable populations. CSOs interviewed for the study noted that there are no specific norms of social assistance for PLHIV, key and vulnerable populations, but they may benefit from general provisions that apply to all. MSM and sex worker respondents did not know of social assistance to provide for their needs, although sex workers in Benguela identified the Oblatas Sisters' Centre as an institution providing assistance in the form of information, food, psychological and spiritual counselling and support for infant children.

As far as children and young people are concerned, there are protection networks for Angolan children, which effectively reach the most vulnerable children and girls and report cases of violence to justice services and institutions. UNICEF has supported the National Children's Institute to strengthen child protection networks to respond to violence, exploitation and abuse of children.

2. International Standards

The UDHR provides in Art. 22 that "every person, as a member of society, has the right to social security; and can legitimately demand the satisfaction of the necessary economic, social and cultural rights, thanks to national efforts as well as international cooperation, in accordance with the organisation and

resources of each country". Furthermore, Art. 25 recognises a series of rights closely linked to social security, *e.g.* the right to security in unemployment, sickness, invalidity, widowhood, old age or other cases of loss of means of subsistence due to circumstances beyond a person's control.⁴⁷⁸

Art. 9 of the ICESCR establishes the right of all persons to social security, including the availability of social security systems⁴⁷⁹ that include medical care – *i.e.* health systems capable of providing adequate access to health services for everyone. In addition, the right to social security is critical to the realisation of other rights and measures to strengthen access to health care are necessary to supplement the right to social security, *e.g.* measures for disease prevention and for improvement of health facilities, goods and services.⁴⁸⁰

The ICESCR has highlighted the special importance of the right to social security in the context of endemic diseases such as HIV and AIDS, tuberculosis and malaria and the need to provide access to preventive and curative measures. The Committee stresses the importance of assisting children orphaned as a result of AIDS to social security plans, especially where they are left without family and without community support. Additionally, the obligation of Party States to guarantee the right to social security without any discrimination and with equality between men and women requires a prohibition on the discrimination, in law or in practice, directly or indirectly, on the grounds of, among other things, health (including HIV and AIDS) or sexual orientation.⁴⁸¹

The concept of "social security" was developed in the ILO Convention 102 of 1952 as "the social protection that society provides to its members through a series of public measures against economic and social

478 Art. 25.1 UDHR

479 The nine main focus areas of social security are: health care, sickness, old age, unemployment, workplace accidents, family and child support, maternity, disability, and AIDS survivors and orphans. GC No. 19 of the CDESC, E/C.12/GC/19 of 4 February 2008, paragraphs 13-21.

480 *Idem.*, paragraph 28

481 *Idem.*, paragraphs 13, 21, 29.

deprivations which, otherwise, would result in the disappearance or severe reduction of their income as a result of illness, maternity, workplace accident, occupational disease, unemployment, disability, old age and death, as well as medical care and support for families with children”.⁴⁸²

The UNAIDS HIV and Human Rights International Guidelines require countries to take measures to ensure that access to social security and adequate support services is not discriminatory and denied to PLHIV based on their health status.⁴⁸³ In addition, the UNAIDS Guidance Note on HIV and Social Protection⁴⁸⁴ provides for key elements including social protection interventions to protect cash flows of individual and families affected by HIV, in order to guarantee the minimum income required for care, child care, education, food and nutrition, water, housing and other basic essentials. It further provides that social protection interventions should guarantee and increase access to essential medical and social services for people in need, including adolescents, women and key populations; as well as enact appropriate laws, policies and programmes to reduce stigma and discrimination; and, reduce barriers to employment, housing and social services. This includes protecting the right of employees living with HIV to maintain their jobs in terms of guaranteeing access to general health services as well as medical services.

The WHO Technical Briefs on Young Key Populations furthermore recognise the importance of providing access to social assistance for young key populations, in order to reduce their vulnerability in general, including their vulnerability to HIV and sexual and reproductive health risks.

The African Charter on Human and Peoples’ Rights makes no express provision for the right to social security; however, some aspects of this right may be derived from Article 16 (Right to health) and Article 18.4 (Right of the elderly and disabled to special protective measures). However, the Protocol to the Banjul Charter on the Rights of Women (Art. 13 f) and the Protocol on the Rights of the Elderly (Art. 7) recognise this right.

3. Current situation in Angola

To some extent, social assistance is enshrined in Article 77 of the CRA, 2010 which refers to health and social protection. Art 77 provides that “[t]he State promotes and guarantees the necessary measures to guarantee to everyone the right to medical and health care, as well as the right of children to receive care, and in maternity, invalidity, disability, old age and any situation of incapacity to work, under the terms of the law”. The right to social security is specifically guaranteed to young people in the CRA, 2010;⁴⁸⁵ the National Assembly is responsible for legislating for national systems of education, health and social security.⁴⁸⁶

Other ordinary laws in force in Angola also address the issues of social assistance to vulnerable people.⁴⁸⁷ In 2004, Angola approved the Basic Law on Social Protection with the main objectives of a) mitigating the effects of income reduction amongst workers for various reasons including reduced work capacity, maternity and unemployment, and to ensure family survival in the event of death; b) compensating for the increased burden to families in especially fragile circumstances; and c) providing subsistence to residents in need to promote their integration into the community.

482 Ref., ILO, Convention (No. 102) Regarding the Minimum Standards for Social Security, 1952. ILO Convention No. 102 (1952) on Social Security (Minimum Standard) was confirmed by the ILO Governing Body in 2002 as an instrument corresponding to current needs and circumstances.

483 International Guidelines 2006 (Consolidated Version), UNAIDS/EACDH paragraph 148

484 HIV and Social Protection, Guidance Note, UNAIDS 2014, p.4

485 Art. 81. 1 (b) CRA (2010)

486 *Idem.*, Art. 165.1 (i)

487 e.g. Law No. 7/04, of 15 October (Basic Law of Social Protection); Decree No. 52/05, of 8 August (Defines and regulates maternity protection); Decree No. 53/05, of 15 August (On the legal system for workplace accidents and occupational diseases)

The law establishes three levels of social protection: basic social protection, compulsory social protection and supplementary social protection. Basic social protection covers persons with no or reduced income who cannot provide for themselves; families or persons living in extreme poverty; disadvantaged women, children and adolescents with special needs or at risk; people with disabilities etc. Basic social protection also includes specific actions for specific persons or populations, e.g. social support services provided through integrated local development services, facilities, integrated local development programmes and projects or targeted at groups with specific needs in terms of housing, health, food, education or other appropriately targeted services.

Law 8/04, of 1 November does not specifically provide social protection for people living with HIV, key and vulnerable populations. However, the Regulation on HIV, Employment and Vocational Training provides for the same employee benefits for people living with HIV as for workers with tuberculosis, leprosy, cancer or psychological diseases.⁴⁸⁸

The Basic Law of the National Health System⁴⁸⁹ includes standards for special care for disadvantaged citizens, such as orphans, the elderly, the disabled, etc. Article 2 (1) of the LBSNS (Basic Law of the National Health System) stipulates that the National Health Policy should include health promotion and disease prevention to ensure equality in the distribution of resources and use of services; the promotion of equality of citizens in access to health care, and special measures for populations at highest risk, such as children and infants, pregnant women, the elderly, the disabled, with priority for disabled war veterans, and people disabled through their work activities.

The National Development Plan (NDP) 2018-2022 includes a “Social Assistance and Protection Policy”, in its section on “Strategic Development Policies and Action Programmes”.⁴⁹⁰ The Social Assistance and Protection Policy focuses on support for Former Combatants and War Veterans and victims of domestic violence and human trafficking. It aims to improve the living conditions of specific vulnerable populations.⁴⁹¹

PEN V, in Strategic Axis No. 3 to create a favourable ethical and legal environment, foresees the establishment of social assistance and protection programmes for children living with HIV, those orphaned by AIDS, vulnerable women and vulnerable families. However, the actions planned to achieve these goals (e.g. meeting with MINARS, MINFAMU and MAPTSS to coordinate activities and implement income-generating projects among PLHIV, OVCs, family units and NGOs, or carrying out training for project management and skill development)⁴⁹² are not sufficient to ensure social protection, in particular against (a) the lack of income from work caused by sickness, disability, maternity, accident at work, unemployment, old age or death of a family member; b) the funds needed to access health care; c) insufficient family support, especially for children, dependants of people affected by the HIV/AIDS epidemic, and d) support for young key populations who lose family and community support and have limited access to educational and employment opportunities.⁴⁹³

4. Gaps and Challenges

The main shortcomings of existing laws are the lack of explicit reference to social protection mechanisms for people affected by HIV, specifically children living with HIV or orphaned by AIDS, and key and vulnerable populations. Law 8/04 on HIV/AIDS does not provide, in

488 Art. 10 (Social Security), Decree No. 43/03 (Regulation on HIV/AIDS, employment and vocational training).

489 Law No. 22-B/92, of 28 August (Basic Law of the National Health System-LBSNS below).

490 GOVERNMENT OF ANGOLA, National Development Plan (NDP) 2018-2022, Vol. I, Luanda, 2018, p. 76-129.

491 *Idem.*, p. 124.

492 PEN V p. 116

493 From a human rights perspective. *See* GC No. 19 of the CDESC, E/C.12/GC/19 of 4 February 2008, paragraph 2

its current form, specific social assistance to protect key and vulnerable populations. Decree 43/03 limits social security to workers on the same terms as general assistance.

Although PEN V specifically aims to establish social assistance and protection programmes for children living with and affected by HIV, vulnerable women and vulnerable families, there are no concrete actions to achieve this goal. Additionally, PEN V focuses on some groups and excludes other important ones such as key populations, including young key populations.

5. Recommendations

In view of the above, the following is recommended:

- Revise Law 8/04 to include specific provisions in relation to social protection benefits, specifically to provide social protection for key and vulnerable populations, including young key populations.
- Revise Decree 43/03 in order to extend social security coverage to take into account the specific needs of PLHIV and those affected by the epidemic, such as key populations, including young key populations.
- Revise Law No. 7/04, of 15 October, “Basic Law on Social Protection” to include HIV as a ground for special protection and to consider inclusion of grounds to protect the needs of other key and vulnerable populations, including young key populations.
- Incorporate concrete actions into the NSP to achieve the goal of establishing social assistance and protection programmes, especially for key and vulnerable populations.

Create and disseminate social assistance and reintegration policies for sex workers, men who have sex with men, and transgender persons, including young key populations.

- Strengthen coordination mechanisms with the various ministerial departments responsible for social security in relation to HIV and AIDS.

I. Refugees, Asylum-Seekers, Stateless Persons and Migrants

1. Analysis of the Situation

Angola receives a large number of migrants, asylum seekers, refugees and stateless persons, mainly from West Africa and the DRC in particular.⁴⁹⁴ According to the Special Rapporteur on Human Rights, in April 2017 the Government of Angola indicated that there were 200,000 foreigners in Angola.⁴⁹⁵ According to the data available from the Office of the United Nations High Commissioner for Refugees in Angola,⁴⁹⁶ in 2015 the total number of persons under its protection was 43,283,⁴⁹⁷ primarily in urban areas. Refugee communities are scattered throughout the country, with the largest number residing in Luanda and in the province of Lunda Norte. They are responsible for their own maintenance.⁴⁹⁸

Health studies in Angola do not include information regarding migrants. The IIMS (Survey of multiple health indicators) 2015-2016, coordinated by the National Institute for Statistics, in collaboration with MINSA, does not provide data on migrants, refugees, asylum seekers or stateless persons. Nor are there any published studies or statistics

494 Report of the Special Rapporteur on Human and Migrant Rights, mission to Angola; A/HRC/35/25/Add.1 paragraph 6, 2017

495 *Idem*.

496 Angola Information Sheet Available at: <http://www.unhcr.org/afr/protection/operations/524d80079/angola-fact-sheet.html> last visited: 27.09.2018

497 These include refugees, returnees, stateless persons, internally displaced persons and asylum seekers.

498 The last revision of LEA data on migrants and refugees have considerably change for two main reasons. With regards to migrants at the end of 2018 mass expulsion of migrants in irregular situation took place in the country. In addition, by the end of 2019 voluntary repatriation of RDC's Refugees from Kasai took place.

available from other sectors that refer to HIV incidence or prevalence amongst refugees, although information regarding sex work has been reported. However, it is recognised internationally that undocumented migrants, refugees, asylum seekers and stateless persons are at increased risk of exposure to HIV infection.⁴⁹⁹

2. International Standards

There are a number of international instruments to which Angola is signatory, that protect refugees, asylum seekers, stateless persons and migrants, the most important being: The Convention Relating to the Status of Refugees (1951)⁵⁰⁰ and the Protocol Relating to the Status of Refugees (1961). At the regional level, the then Organisation of African Unity (OAU) Convention governing Specific Aspects of Refugees in Africa (1969), to which Angola is also a signatory, deserves mention. The Convention on the Status of Stateless Persons (1954) and the Convention for the Reduction of Cases of Stateless Persons have been acceded by the Angola in October 2019 and will enter into force in January 2020. The International Convention for the Protection of the Rights of Migrant Workers and Members of Their Families (2003), has not yet been signed.⁵⁰¹

In addition to these specific international treaties, other broad international treaties also apply e.g. ICCPR, ICESCR and the CRC. General Comment No. 14 of the ICESCR establishes that “states are obliged to **respect** the right to health, among other things, by not denying or limiting equal access to all persons, including prisoners or detainees, minorities, **asylum**

seekers and illegal immigrants, to preventive, curative and palliative health services”.⁵⁰²

It also clarifies that the right to prevention, treatment and control of diseases (Art.12(2) (c) of the ICESCR) includes the establishment of a **system of urgent medical care** in cases of accidents, **epidemics** and other health hazards, as well as the provision of support in cases of disaster and humanitarian assistance in **emergency situations**.⁵⁰³

The Human Rights Council recommended, through the UPR, the need to further “measures to guarantee the rights of migrants, asylum seekers and refugees, in particular to stop acts of discrimination and violence, and to investigate, to prosecute and punish the perpetrators”.⁵⁰⁴

The Global Commission (2012)⁵⁰⁵ recommends that countries should offer migrants, visitors and residents who are not citizens, the same level of protection they offer their own citizens, e.g. revoking travel and other restrictions that prohibit people living with HIV from entering a country and/or regulations that require HIV testing of foreigners within a country; adopting measures that allow migrants to legally register with health services, and that ensure that migrants have access to the same quality of HIV prevention, treatment and care, as well as essential medical items available to their own citizens. All HIV testing and STI screening for migrants should be well-founded and voluntary, and all treatment and prophylaxis for migrants should be ethically and medically indicated.

The GCHL Supplement (2018)⁵⁰⁶ is even more specific: it urges governments to ensure that

499 S-26/2. Declaration of Commitment on HIV/AIDS, adopted by the UNGA on 27 June 2001, paragraph 75

500 Angola has established a number of provisos to the 1951 Convention relating to the Status of Refugees, the most significant being Article 17 on the right to work, and Article 26 on freedom of movement. The country has expressed in its voluntary commitments for its candidacy to the Human Rights Council 2018-2022 that it will consider the withdrawal of its proviso to Article 26 of the 1951 Convention relating to the Status of Refugees, and ratification of the Conventions of the International Labour Organisation, including those relating to migrant workers (No. 97 and 143). See Doc A/72/79, 26 April 2017, paragraphs 11 (f) and (b)

501 See, Section II on ratification of treaties

502 GC No. 14 of the CDESC paragraph 34

503 *Idem.*, paragraph 16

504 Universal Periodic Review, Angola 2nd Cycle; A/HRC/28/11, paragraph 134.98

505 See recommendations 3.6. 1 etc CGHD (2012)

506 See recommendations 16 and 17 of the Supplement (2018) of the Global Commission (2012)

refugees and asylum-seekers have access to the full range of health services, including for HIV, TB and viral hepatitis, regardless of their migratory status, and to extend this care to places of detention and confinement. The Supplement (2018) also recommends changing laws and policies, such as requirements to show national identification documents or residence cards, that prevent migrant populations from seeking health care.

The UNGASS Political Declaration on Ending AIDS 2016 commits States to promoting the development of and access to comprehensive HIV prevention services for migrants; addressing vulnerabilities to HIV and the specific health needs of migrants and refugees; taking measures to reduce stigma, discrimination and violence; and reviewing policies related to entry restrictions based on HIV status, and ultimately for supporting the access of these groups to prevention, treatment, care and support.⁵⁰⁷

3. Current situation in Angola

The right of asylum is recognised in Art. 71 of the CRA, 2010.⁵⁰⁸ Law No. 10/15 of 17 June 2015⁵⁰⁹ on the Right of Asylum and the Status of Refugees was “the opening of a new phase for the establishment of a fair and efficient asylum process in Angola”.⁵¹⁰ Under Art. 33 of Law 10/15, granting the Refugee Status to a person cannot prejudice the rules of international law for refugees. In 2018 the National Council for Refugees was created, a multi-sectoral advisory body for the

implementation of public policies relative to asylum and refugee law.⁵¹¹

Art. 3 of Law 2/07 recognises the same rights and guarantees for foreign citizens who reside within, or happen to be in, the Republic of Angola, subject to the same duties as Angolan citizens, except for certain exceptions.⁵¹² Art. 24 of Law No. 21-B/92 (LSNS) establishes that “all Angolan citizens, foreigners residing in Angola on reciprocal conditions, and stateless citizens residing in Angola, are beneficiaries of the National Health Service.” Art. 26 of Law 10/15 grants asylum seekers the right to medical care and medicines under the same conditions as nationals. Art. 28 of Law 10/15 regulates the provision of services to vulnerable persons, including children, the elderly, pregnant women and people with disabilities; granting them a preferential right of access to basic services such as food, shelter and health. This does not include people who require daily medication to maintain their health.

Migrant populations experience problems not only in access to health services, but also experience violence and discriminatory attitudes from other service providers – e.g. in schools, despite their rights being enshrined in Angolan law and international conventions, including the rights to identification,⁵¹³ education⁵¹⁴ and work.⁵¹⁵ This further impacts on access to health services⁵¹⁶ – for example, their lack of documentation and the bureaucratic hurdles in the country (e.g. issuance of work visas, renewal of asylum application certificates, as well as refugee cards) hinders access to paid employment

507 See Political Declaration (2016) paragraphs 62 (e) and 63 (g)

508 Article 71 (Right of asylum).1) “Every foreign citizen or stateless person is guaranteed the right of asylum in case of (...)”.2) “The law defines the status of the political refugee.”

509 Law No. 10/15; National Assembly “Law on the Right of Asylum and the Status of Refugee. – Revokes Law 8/90, Official Gazette, Series 1, No. 89 of 17 June 2015

510 Report and Recommendations of the Dialogue on Asylum in Angola. Luanda, Angola 20 October 2015. Media library of Luanda, p.6. UNHCR

511 Presidential Decree No. 200/18; President of the Republic “Establishes the National Council for Refugees and approves its Regulation. - Official Gazette, Series 1, No. 130 of 27 August 2018

512 Law 13/19; National Assembly “Law on the legal regime for foreign citizen in the Republic of Angola”; Official Gazette, Series 1, No. 71 of 23 May 2019 entered into force after conclusion of this LEA. Law 13/19 derogates Law No. 2/07; National Assembly “Regulates the legal situation of foreigners in the Republic of Angola”; Official Gazette, Series 1, No. 105, of 31 August, 2007.

513 Art. 35 Law 10/15

514 Art. 38 Law 10/15

515 Art. 39 Law 10/15

516 For detailed information on the situation of migrants, refugees, asylum seekers and stateless persons See Report of the Special Rapporteur on Human Rights and Migrants A/HRC/35/25/Add.1

and to basic services such as health,⁵¹⁷ particularly where health costs are high. Also, undocumented migrants do not seek health services for fear of reprisals. Even with identification documents, the poor quality of the refugee identification card, coupled with discriminatory attitudes towards migrants, refugees and asylum seekers makes access to health care difficult.

The LBSNS allows for private health care as well as for financial contributions from patients towards health costs. However, the PNDS 2020-2025 acknowledges that the private sector operates primarily in and around large urban centres and that **prices are a factor in exclusion and inequity**,⁵¹⁸ impacting on vulnerable populations. Their lack of employment aggravates their economic vulnerability preventing access to private health services, highly specialised health services, and services of a generally higher quality.

Law 8/04 on HIV and AIDS does not provide for these populations. It recognises that every person living with HIV is entitled to free medical care and antiretroviral drugs,⁵¹⁹ but does not recognise the vulnerability of specific populations nor the multiple layers of stigma and discrimination they experience. PEN V emphasises the need for a **survey of vulnerability** amongst vulnerable populations (as defined by WHO, 2014), including **migrant workers, refugees, truck drivers, military personnel and miners**. The Plan also recommends the involvement of MINARS⁵²⁰ to reach refugee populations.⁵²¹ Finally, the Plan calls for **socio-behavioural studies into vulnerable groups (migrant workers,**

refugees, truck drivers, military personnel and miners)⁵²² to be made available.

The PND 2018-2022 has as its specific objective in Priority C) a better system of migration and refugee management. In this regard, it creates a programme of “Improving the Control of National Borders and Immigration”⁵²³, while indicating as priority actions, among others, the modification of immigration legislation through the revision and adoption of legal instruments, such as the Legal Regime of Foreigners in the Republic of Angola, the Regulations of the CNR and the Centre for the Reception of Refugees and Asylum Seekers. In relation to employment, it creates a programme for the Improvement of Organisation and Working Conditions⁵²⁴ which aims to protect workers’ rights and promote safe and secure working environments for all workers, including **migrant workers**, in particular women, and persons in precarious employment. For its part, the PNDS 2012-2025 makes no specific mention of these population groups. The specific objectives related to this context set out in the PNDS 2012-2025 are 1.1. “Strengthening the fight against communicable and non-communicable diseases”; 1.2. “Provision of health care to certain vulnerable population groups, including women and children **and disadvantaged social groups**”.⁵²⁵ This provides opportunities to consider these groups.

The Strategic Reproductive Health Plan 2009-2015 recognises that SRHR belong to all people. However, it establishes a number of priority populations; this does not include migrants, refugees, asylum seekers and stateless persons.⁵²⁶ The vulnerability of these

517 “Excessive bureaucracy and small corruption have disproportionate effects on the protection of rights, since they limit the access of irregular migrants to social services, education, health care and justice” A/HRC/35/25/Add.1, paragraph 11

518 GC No. 14 of the CDESC stipulates that the obligations to be protected [the right to health] include the obligations of States to adopt legislation or take other measures to ensure equal access to health care services rendered by third parties; ensuring that the privatisation of the health sector does not pose a threat to the availability, accessibility, acceptability and quality of health facilities, supplies and services.

519 Art. 5 (a) Law 8/04

520 Former Ministry of Action and Social Reintegration, current Ministry of Social Action, Family and Empowerment of Women (MASFAMU)

521 Section 4.2 PEN V

522 *Idem.*, Section 5.9.6 Expected Outcomes: Monitoring & Evaluation and Strategic Information Management

523 Programme 6.2.2, PND 2018-2022

524 *Idem.*, Programme 2.5.3

525 The population group we dealt with in this section could fit this objective.

526 Strategic Plan for Reproductive Health 2009-2015, Angola, p. 29 (Target Groups)

populations is exacerbated by the fact that Angolan laws and policies contain limited protections for their sexual and reproductive health and rights, including in the context of HIV.

4. Gaps and Challenges

Although the HIV law protects people living with HIV in general, it makes no specific reference to migrants, refugees, asylum seekers and stateless persons, nor does it recognise their vulnerability. Nor do relevant health policies and development plans recognise the specific needs of migrants, asylum seekers and refugees to HIV-related health care services.

The Law of Asylum, Law 10/15 is not yet fully implemented. The challenge is to interpret its provisions broadly so as to guarantee the rights of migrant populations in accordance with human rights and constitutional freedoms, rights and guarantees.

Access to advanced health care or social care is limited, in part because of discriminatory attitudes, corruption and high costs. Administrative barriers to obtaining quality identity documentation pose barriers to health services (e.g. lack of quality identification documentation), so refugees and asylum seekers are left in a highly vulnerable situation, at risk of stigma, discrimination, police abuse, violence and corruption in health facilities.

As a result, notwithstanding efforts made by the Angolan State, access to fundamental rights, such as the right to education, the right to identification, the right to work, the right to sexual and reproductive health, and the right to receive information, are restricted or limited for migrants, refugees, asylum seekers and stateless persons.

There are no socio-behavioural studies available on vulnerable populations e.g., migrant workers and refugees, in relation to HIV and other diseases. There are no statistics on the health of migrants, refugees, asylum seekers and stateless persons, although there are references to the need for further information (e.g. in PEN V). Resource

constraints have devastating consequences on their enjoyment of human rights, constitutional freedoms and guarantees and rights enshrined in national laws.

5. Recommendations

The following is recommended:

- Ratify the United Nations Convention for the Protection of the Rights of Migrant Workers and their Family Members, (2003)
- Provide migrants, refugees, asylum-seekers and stateless persons the right to health on equal terms with Angolan and foreign citizens, including access to the full range of health services, particularly in relation to HIV, irrespective of migrant status.
- Revise Law 8/04 on HIV/AIDS to recognise the vulnerability of migrant populations and to ensure equality and non-discrimination in access to health services.
- Include provisions in the CARRA Regulations (reception centre for refugees and asylum seekers) that guarantee health care, including access to basic shelter, housing and sanitation, adequate provision of safe drinking water, access to medicines, counselling, prevention of diseases, access to SRH information as well as information on prevention, treatment and control of HIV, TB and viral hepatitis.
- Implement Law 10/15 “Asylum Law and Refugee Status”, including the allocation of financial resources and the training of competent authorities on human rights issues, including SRHR, HIV, AIDS, TB and Viral Hepatitis.
- Include specific provision for refugees within the NSP, including recognition as a vulnerable population and provision for socio-behavioural studies, and the collection of statistical data on the health of migrants, refugees, asylum and stateless persons.
- Approve a National Policy or Strategy for Migrants, Refugees, Asylum Seekers and Stateless Persons that includes the protection of these groups in relation to SRH and HIV.

- Adopt administrative measures to ensure the quality of refugee documentation as provided in Art. 35 of Law 10/15 (right to documentation)
- Adopt administrative measures to ensure the birth registration of children of migrant, refugee and stateless persons.
- Develop education campaigns in migrant detention centres and refugee settlements in order for people to realise their right to receive education and information, including health information.
- Adopt legislative and administrative (disciplinary) measures to ensure that personal data is confidential, and that personal data is not shared without the consent of the individual concerned; including data on the health status of the individual.
- Strengthen collaboration with international and regional organisations serving the health rights of migrants, refugees and asylum seekers, particularly UNHCR.
- Strengthen the position of migrants, asylum seekers and refugees by improving institutions and structures to address and manage individual applications for asylum, including reducing bureaucratic procedures, as well as respecting the deadlines established in Law 10/15 for different procedures (e.g. Granting of Asylum)

J. Education and Information

1. Analysis of the Situation

The Political Declaration (2016) recognizes that “the AIDS response can be fast-tracked only by protecting and promoting access to appropriate, high-quality, evidence-based HIV information, education and services without

stigma and discrimination.”⁵²⁷ Education and information are one of the best forms of defence against HIV infection. Providing and receiving health information is a human right and should be an essential element of the policies and strategies that make up a country’s national response to HIV. Education provides essential information to strengthen awareness and understanding of the HIV epidemic and to prevent negative attitudes towards people living with HIV,⁵²⁸ to eliminate stereotypes and fight discrimination. The right to benefit from scientific progress and its applications,⁵²⁹ especially in relation to the dissemination of advances in diagnosis and treatment, is closely linked with these rights.

A major challenge to an effective response to HIV is the lack of sexual and reproductive education amongst young people. The Global Commission noted that where young people have access to sexual education and quality sexual and reproductive health services, as well as HIV treatment, the HIV prevalence rate declines.⁵³⁰ Studies show that education and information on sexual and reproductive health result in more frequent use of condoms, a decrease in the number of sexual partners, and also very importantly, result in a reduction in risky behaviour. The Commission itself also recognises that laws should protect, among other things, the right to comprehensive sexuality education (CSE).⁵³¹

Education, particularly for those at a sexually active age, enables people to protect themselves against the risk of infection. Education in schools or through public or private media is particularly relevant for adolescents, women, sex workers, LGBT+ persons and other key and vulnerable populations. It contributes to various prevention goals, including reducing vertical transmission of HIV, and also supports access to treatment and support. Additionally, people who are informed are less likely to stigmatise and discriminate.

527 Political Declaration (2016) para. 62 a)

528 With this in mind, *see* OG No. 3 CRC/GC/2003/1 of the Committee on the Rights of the Child “HIV/AIDS and the rights of the child.

529 Art. 15 (b), ICESCR

530 Global Commission on HIV and the Law (2012), p. 8

531 *Idem.*, p. 11

Another important issue for information and education is the need for PLHIV and those affected by HIV to know what their rights are and how to exercise them. Citizens or people therefore have to be informed about their rights and the institutional mechanisms and procedures to exercise these rights. In addition to the general public, women, adolescents, key and vulnerable populations need to be informed of their rights, service providers such as health professionals, educators and social workers as well as judges, lawyers, police officers, prison authorities and officials, civil servants and employers need to be informed of HIV related human rights.⁵³² Legislators and the executive, particularly those in charge of formulating policies and strategies, need to know and understand human rights in the context of HIV and AIDS. International human rights law prohibits discrimination and denial of education based on a person's HIV status. This right includes the obligation by the state to promote understanding, respect, tolerance and non-discrimination towards PLHIV within education.

2. International Standards

The right to education and the right to information are recognised in international human rights law. The UDHR recognises in Art. 26 that every human being has the right to education (free at least at infant and primary levels). The UDHR also acknowledges that education should be directed towards the full development of the human personality and the strengthening of respect for human rights

and fundamental freedoms.⁵³³ Art. 19 of the UDHR provides that every human being has the right to (...) have opinions and seek, receive and transmit information and ideas by any means and regardless of borders.⁵³⁴

The ICESCR⁵³⁵ also recognises the right of all people to education "directed towards the full development of the human personality and the awareness of his or her dignity."⁵³⁶ The ICESCR itself recognises the link between the right to education and the right to health.⁵³⁷ For example, Art. 12.1 of the ICESCR should be interpreted as an inclusive right that includes the main determinants of health, such as access to education and information on health-related issues, including sexual and reproductive health.⁵³⁸

The right to health includes the right to prevention and treatment of diseases⁵³⁹ and obliges the State to establish both prevention and education programmes that address behavioural health concerns, e.g. STIs, in particular HIV, that negatively affect SRHR. Moreover, the right to disease prevention, treatment and control implies an obligation to promote social determinants of good health. Education is one of these determinants.⁵⁴⁰

Education also plays an indispensable role in people's right to access health facilities, medical supplies and services.⁵⁴¹ Creating conditions that ensure all medical services in case of illness not only includes the provision of equal and timely access to basic preventive, curative and rehabilitative care, but also to health education.⁵⁴² In addition, the obligation to respect a person's health rights includes

532 UNAIDS, Handbook on HIV and Human Rights for National Human Rights Institutions, p.22 etc.

533 Art. 26.2 first sentence, UDHR

534 *Idem.*, Art. 19

535 Other international instruments that recognise the Right to Education are: Art. 49 CEDAW; Art. 24 CRPD; Art. 28-29 CRC; Art. 30, 43.1, 45.1 CTM; Art. 22 Convention relating to the Status of Refugees

536 Art. 13.1 ICESCR

537 paragraph 3, GC No. 14, CDESC

538 *Idem.*, paragraph 11

539 Art. 12 (2) (c) ICESCR "The measures which the States Party to this Covenant take with a view to ensuring the full exercise of this right [to health], shall include measures necessary to ensure: (...) c) prevention, treatment and control of epidemic, endemic, occupational and other diseases;"

540 paragraph 16, GC No. 14, CDESC

541 Art. 12 (2) (d) ICESCR "The measures which the States Party to this Covenant take with a view to ensuring the full exercise of this right [to health] shall include the measures necessary to ensure: (...) the creation of conditions for the provision of medical services and medical assistance in the event of sickness;"

542 paragraph 17, GC No. 14, CDESC

ensuring there are no limits to access services to maintain SRH, this includes providing education and sexual and reproductive health information.⁵⁴³

Ensuring adequate education and information is urgently needed for key and vulnerable groups, such as women, children,⁵⁴⁴ adolescents, LGTB+,⁵⁴⁵ etc., and including young key populations. The Committee on the Rights of the Child has already stated that appropriate measures can only be taken if the rights of children and adolescents are fully respected, including the right to information and material to promote their social, spiritual and moral well-being, as well as their physical and mental health, which includes sexuality education.⁵⁴⁶

Children's rights to freedom of expression (Art. 13), access to appropriate information (Art. 17) and health (Art. 24) imply their right to access adequate information on HIV and AIDS prevention and care through official channels (e.g. public media), and also through unofficial channels. Adequate information implies an obligation on the part of the State to refrain from censoring information or distorting health-related information, including education and information on sexuality. The State also has a positive obligation to realise the rights to health, adequate information and expression so that it ensures that the child acquires the knowledge and skills to protect him or herself and protect others, from the moment he/she begins to manifest his/her sexuality.⁵⁴⁷ The State has an obligation to

ensure that all children affected by HIV and AIDS (e.g. children whose parents are carriers of the disease, orphaned children) have access to primary education.

In the case of women, the CEDAW Committee has recommended that States intensify their efforts to disseminate information in order to increase awareness of the risk of HIV infection.⁵⁴⁸ The Committee has also urged States to effectively implement education and public information programmes aimed at eliminating prejudices and practices that prevent the full implementation of the principle of social equality for women.⁵⁴⁹

The recommendations of the GCHL (2012) as well as its Supplement (2018) also deal with education and information. Recommendation 5.3 of the 2012 report recommends that countries enact and enforce laws that guarantee the right of every child, whether attending school or not, to full sexuality education so that he/she can protect him/herself and protect others from HIV infection, or be capable of living positively with the virus.⁵⁵⁰ The 2018 Supplement adds that governments should suspend censorship and restriction of access to the internet and communication, except in cases provided for by law and whenever these are consistent with universal human rights law. Governments should facilitate the use of the internet and evidence-based information, education and communication platforms to promote access to health information and services, and rights.⁵⁵¹

543 *Idem.*, paragraph 34

544 e.g. Discrimination is the root cause of increased vulnerability of children with HIV and AIDS, as well as the serious impacts of the epidemic on the lives of the children affected. Sons and daughters of parents living with HIV/AIDS are often victims of stigma and discrimination, as they are often considered to be infected. Discrimination results in children being denied access to information, education, health services and social care or to a social life. GC No. 3, paragraph 7 CRC/GC/2003/3 of 17 March 2003

545 e.g. In the context of lesbian, bisexual, transsexual and intersex students, the CEDAW Committee has stated that intimidation, harassment and threats against these students by peers and teachers constitute barriers to their right to education. Schools perpetuate and reinforce social prejudices, often as a result of poor policy implementation by school governance bodies, as well as irregular enforcement of non-discrimination policies by teachers, principals and other school authorities. Limited education and cultural taboos are among the factors that prevent lesbian, bisexual, transgender and intersex students from achieving social mobility, which increases their vulnerability to violence. paragraph 45, General Recommendation No. 36, CEDAW/C/GC/36 of 27 November 2017

546 paragraph 6, GC No. 3, Committee on the Rights of the Child, CRC/GC/2003/3 of 17 March 2003

547 *Idem.*, paragraphs 16-17,

548 GR No. 15, CEDAW, doc. A/45/38; 1990

549 GR No. 3, CEDAW, doc. A/42/38; 1987

550 In this regard, another relevant guideline is GC No. 3 of the Committee on the Rights of the Child, paragraphs 16-17

551 Recommendation No. 13, Supplement 2018. Global Commission on HIV and the Law, p. *See also* Recommendation 12.

With regard to SRH, the Global Commission Supplement 2018 recommends, on the one hand, that States should adopt and enforce laws that protect and promote sexual and reproductive health and rights. And it also recommends that States should revoke and replace laws that create barriers to the full range of sexual and reproductive health services.⁵⁵²

The UNAIDS/OHCHR (2006) International Guidelines on HIV and Human Rights are clear in relation to education and information. Guideline 6 (as revised in 2002) recommends that States adopt legislation to ensure HIV information, in order to ensure the widespread availability of adequate information on HIV prevention and treatment. It also recommends that measures be taken to guarantee the availability and accessibility of quality information for HIV prevention, treatment, care and support to all people on a sustainable and equal basis. Guideline 7 refers to Education in the context of creating and strengthening legal awareness. Under this guideline, States should create and support legal support services that educate people affected by HIV on their rights. Furthermore, Guideline 9 reinforces the issue of information inasmuch as it recommends that States promote the widespread and constant dissemination of creative education, training and communication programmes specifically designed to transform attitudes of HIV-related discrimination and stigmatisation into attitudes of understanding and acceptance.

The African Union has also recognised the role of education and information. The Banjul Charter recognises the right to education⁵⁵³ and the right to information.⁵⁵⁴ Additionally, the African Union has already addressed the importance of these rights in the context of HIV and AIDS. The General Comment of the African Commission on Article 14 (1) (d) and (e) of the Maputo Protocol,⁵⁵⁵ recognises women's

right to self-protection and to be protected from HIV infection, as well as their right to be informed about their HIV status and that of their partners. With regard to information and education, the Commission urges States to ensure information and education, both in and out of schools, on SRHR (including HIV), and that this information is provided to women, particularly adolescents and young women. States should ensure that the content of the information is supported by evidence, i.e., based on facts and rights, and without judgements. States should ensure that information is understandable in content and language. Moreover, the General Comment stipulates that the content should "address taboos and misconceptions related to sexual and reproductive health issues, deconstruct the roles of men and women in society and challenge traditional notions of masculinity and femininity that perpetuate stereotypes detrimental to the health and well-being of women."⁵⁵⁶

3. Current situation in Angola

Art. 40 of CRA, 2010 stipulates that "everyone has the right to freely express, disseminate and share his or her thoughts, ideas and opinions, by word, image or any other means, as well as the right and freedom to inform, to inform him/herself and to be informed, without hindrance or discrimination." Paragraph 2 provides that the exercise of these rights and freedoms cannot be prevented or limited by any type or form of censorship. CRA 2010 also guarantees the right to education⁵⁵⁷ inasmuch as it stipulates that "the State shall promote access for all to literacy, education, culture and sport, encouraging the participation of the various private agents in their implementation, in accordance with the law."

With regard to HIV/AIDS, Law 8/04 has important provisions that guarantee

552 *Idem.*, Recommendation No 29, p. 9

553 Art. 17, ACHPR

554 *Idem.*, Art. 9,

555 GC Article 14 1 (d) and (e) of the Maputo Protocol, ADHP (African Commission on Human and Peoples' Rights), paragraphs 26-28

556 *Id.*

557 Art. 79 CRA 2010

education, health education and the right to information. Firstly, Art. 3.1 stipulates that it is incumbent upon the State to manage HIV through prevention and control of HIV transmission, with training and education, amongst other things.

The right to education is critical for the full development of the person,⁵⁵⁸ and Art. 5 of Law 8/04 ensures that every person living with HIV has a right to access the education system⁵⁵⁹ without discrimination. This clause refers only to people living with HIV, not those affected, such as key populations.

Education also has a specific role to inform or educate people about HIV, AIDS and sexual and reproductive health; this is in many respects guaranteed by Law 8/04. For example, Art. 7.3 protects employees and obliges the employer to educate, inform, train and raise awareness among workers about HIV and AIDS, under penalty of punishment in terms of the regulations (however, these regulations are not well known). Law 8/04 also devotes a chapter to⁵⁶⁰ Information, Education and Research: Art. 16 provides that both public and private media channels should ensure that STI/HIV/AIDS information is made available free of charge. It stipulates that the entire population should be informed about aspects of STI/HIV/AIDS in accordance with Guidelines to be developed by the National Commission to Combat AIDS and Great Endemic Diseases. It is unclear whether these Guidelines have been enacted. The law also provides that people should be informed and educated to prevent discrimination and stigmatisation; however, the law is silent regarding key and vulnerable populations such as prisoners, people who use drug, the LGBT+ community, and sex workers.

Furthermore, Art. 18 provides for the Ministry of Education to introduce sexuality education, STI/HIV/AIDS in all school curricula. In 2014, the Ministry of Education with the support of UNICEF, prepared a Peer Education Manual on Sexuality and a guide for peer educators. Despite this, there is no information available on the acceptance and implementation of this educational material in the school curricula.

PEN V has, among its strategic guidelines, the right to information, education and communication, aimed at changing high-risk behaviours, taking into account human rights, cultural diversity, gender and the differences between generations.⁵⁶¹ One of the main tasks of the INLS is to define and coordinate training, information, education, communication, counselling, treatment and follow-up actions in the field of STIs and HIV and AIDS.⁵⁶² This responsibility empowers it to lead other governmental departments in education and information e.g. the Department of Reproductive Health of the National Directorate of Public Health of MINSA.⁵⁶³

The Youth Sector Strategic Plan 2014-2017 (PEJ),⁵⁶⁴ establishes "...the need to integrate STIs/ HIV and AIDS, and Sexual and Reproductive Health into the Sector Programme".⁵⁶⁵ The Youth sector proposes working with young people aged 15 to 35 in urban and rural areas to deal with problems such as the lack of access to information. In fact, PEJ 2012-2017's Goal 4.5 on HIV/AIDS, Sexual and Reproductive Health and Juvenile Violence aims to carry out sexuality, HIV, AIDS and STIs education programmes through radio, TV, community theatre, group discussions and games, promote peer education; and produce, reproduce and distribute IEC material and disseminate the Law on HIV and AIDS.⁵⁶⁶

558 See GC No. 14, CDESC, E/C.12/1999/10 of 8 December 1999, paragraph 4 on the purposes and objectives of Education

559 Art. 17.3, Law 17/16 The levels of teaching are: Preschool, Primary, Secondary and Higher

560 Ref. Chapter III of Law 8/04

561 PEN V, p.7

562 Art. 5 c) Decree No. 7/05; Council of Ministers "Creates the National Institute for the Fight Against AIDS"; Official Gazette, Series 1, No. 29, of 9 March 2005

563 PEN V: According to the Plan "The Ministry of Education, as it deals with young people and teachers who are in privileged positions in terms of training and preparation of Angolans, should play an important role in actions related to information, education and communication, aimed at changing behaviour patterns, and promoting a healthy life that will keep young people away from the spectre of AIDS. The same role is expected from the Departments of Youth, Sports and Transport", p. 90

564 Ministry of Youth and Sports, 2012

565 PEJ 2012-2017, p. 16

566 *Idem.*, pp. 43-44

The lack of legal information, that is, information on the rights of individuals and the obligations of the State, is critical. People's legal awareness⁵⁶⁷, and that of those in public service, is poor. During research for this study, it was clear that people were unaware of Law 8/04 on HIV/AIDS or were aware of the law but not its provisions due to information being neither available nor accessible. Information that is available, such as the laws published in the Official Gazette, are generally difficult to obtain. This situation is worse in the provinces.

4. Gaps and Challenges

Although the CRA, 2010 provides for the right to education and the right and freedom to inform, to inform oneself, and to be informed, without impediment or discrimination, and Law 8/04 provides for HIV-related education and information, these rights are not fully realised. Plans and strategies recognise the limited access to information and provide for actions to inform and educate society on HIV, AIDS and sexual and reproductive health. However, there is still limited resources to implement these actions. The situation may be worse outside the capital and in rural areas.

Law 8/04 on HIV/AIDS does not fully guarantee non-discrimination to all people affected by and living with HIV; it provides for the rights of PLHIV to access education without discrimination but does not provide for key and vulnerable populations.

Public and private media houses are not fully engaged in issuing information related to HIV/AIDS free of charge especially print and television media as requested by the duty of information established in article 16 of Law 8/04. While it is unclear whether Art. 16 of Law 8/04 establishes a real obligation rather than a duty to assure information or provide it for free, there is still a need for strengthened sexuality, STI, HIV and AIDS education and information campaigns, particularly given government's obligation to fight HIV in terms of Art 3.1. It is also unclear of the extent

to which issues of sexual orientation and gender identity are addressed in HIV and AIDS education and information, as well as CSE within schools for young people.

The National AIDS Commission has not yet developed the STI/HIV/AIDS Guidelines. There is also no information on access to redress for discrimination in access to education.

With regard to legal literacy, there are no libraries or book shops with up to date legal publications and there are virtually no up-to-date government department websites with links to recent legislation. Access to information was available and accessible only in a small number of cases, *e.g.* The National Assembly, Constitutional Court, Ministry of Justice and Human Rights. There is also no up-to-date information or news on the websites of government departments on the existence of national plans or strategies, and the National Institute for the Fight against AIDS itself does not have a website.

5. Recommendations

In light of the above, the following is recommended:

- Revise Law 8/04 to clarify the obligations of public and private media and various institutions to ensure access to education and information to protect the sexual and reproductive health and rights of people living with HIV, key and vulnerable populations – particularly young key populations. This should include, amongst other things:
 - education and information on HIV and AIDS in plain language
 - information designed to transform HIV-related stigma and discrimination into attitudes of understanding and acceptance for PLHIV, (young) key and vulnerable populations;
 - information on the SRHR of PLHIV, (young) key and vulnerable populations for health professionals, educators, social workers,

567 See section on Access to Justice

judges, lawyers, police officers, prison authorities and officials, civil servants in general, and employers as well as for affected populations themselves.

- Ensure that government ministries and institutions, at both central and local levels develop and disseminate information on HIV, TB, law and human rights of PLHIV, (young) key and vulnerable populations; *e.g.*
 - ensure that the National Commission to Combat HIV/AIDS and Great Endemic Diseases develops and enacts the Information Guidelines on issues relating to STIs/HIV/AIDS.
- Ensure that the National AIDS Institute sets up a website with information on prevention, treatment and control of the epidemic, as well as on scientific advances in HIV and AIDS, including by keeping the website up-to-date, mainly regarding laws that impact on HIV/AIDS.
- Ensure that the National AIDS Institute provides legal information, accessible to all persons including PLHIV, (young) key and vulnerable populations, on the rights of persons and the obligations of the State and that complaint procedures are available for reporting rights violations.
 - Ensure that the Ombudsman disseminates information regarding the content of the right to health, including SRH and the impact that HIV has on this right.
 - Ensure that the Commissions for the Promotion Human Rights of the Provincial Human Rights Committees disseminates and promotes the right to health including sexual and reproductive health and the impact of HIV and AIDS on this right.
- Adopt financial measures to ensure adequate sexual and reproductive education.
- Domesticating the SADC Strategy for Key Populations and disseminate widely to policy makers and programme development officers.

K. Access to Law and Justice

1. Analysis of the Situation

Access to Law and Justice is fundamental in ensuring an effective response to HIV epidemics. According to the Political Declaration (2016) access to justice and legal services is fundamental for preventing and challenging human rights violations.⁵⁶⁸ The GCHL (2012) clearly says that countries must ensure that their national HIV policies, strategies, plans and programmes include effective, targeted action to support enabling legal environments, with attention to formal law, law enforcement and access to justice.

Despite Angola's vast legislative framework, access to justice faces a series of fundamental challenges. The NDP 2018-2022⁵⁶⁹ recognises challenges related to the availability of infrastructure, technical and human resources to support the justice sector's activities, such as maintaining archives, customer service centres, courts, observation centres, and juvenile justice facilities, and insufficient trained judicial magistrates, public prosecution services and judicial officers. CESCR in its Concluding Observations (2016) reiterated its recommendation to intensify efforts to improve the administration of justice, in particular access to justice, the independence of the judiciary, the availability of legal assistance, and resources allocated to the justice system.⁵⁷⁰

According to MINJUSDH sources, as of November 2017 there were a total of 19 Provincial Courts, 20 Municipal Courts and 8 Palaces of Justice. There are 400 judicial magistrates and 500 Public Prosecutors. In 2016 there were 3,954 lawyers and jurists.⁵⁷¹ Other statistics illustrate the challenges to the judicial system in Angola. For example, in

⁵⁶⁸ Political Declaration (2016) para. 63 e)

⁵⁶⁹ See NDP 2018-2022, p.201

⁵⁷⁰ E/C.12/AGO/CO/4-5, Committee on Economic, Social and Cultural Rights, Concluding Observations, paragraph 12, 2016

⁵⁷¹ Data presented by Angola in the 2nd Periodic Report to the Human Rights Committee. CCPR/C/AGO/2 of 28 November 2017, paragraph 130

ordinary courts in 2015, the procedural volume (overall) in the provincial courts was 142,612. The provinces with the highest volume were Luanda (40%), Benguela (15%, including the Lobito Provincial Court) and Huambo (6%). Of the 142,612 cases in 2015, the highest incidence was verified in cases in the Criminal Chamber with 71,003 cases (50%, more than half), followed by Civil and Administrative Chamber cases (28,434) and Family cases (27,727). Only 27% of cases were completed, while the remainder are in progress.⁵⁷²

2. International Standards

The GCHL 2012 recommends that countries ensure that their national HIV policies, strategies, plans and programmes include effective and targeted action to support enabling legal environment, including laws, their implementation and access to justice.⁵⁷³

Access to justice is an acknowledged right in key international and regional instruments, including within the AU. For example, Art. 7 and 8 of the UDHR establish the right to equality before the law, without discrimination, equal protection by the law, and the right to an effective appeal in a competent national court. Art. 2 of the ICCPR provides for non-discrimination; Art 3(a) provides that Member States must undertake to ensure that any person who has had their rights or freedoms as recognised in the Covenant violated shall have an effective appeal. Art. 3 (b) provides further that a competent judicial, administrative or legislative authority or any other competent authority provided for by the legal system of the State shall decide on the rights of any person bringing such an appeal and shall examine the possibilities of judicial appeal. The ICCPR refers to rights related to the administration of justice in its Art. 14.

General Comment No. 9 of the ICESCR⁵⁷⁴ clarifies the scope of Member States' obligations in their domestic legal systems. Party States are obliged to give effect to the rights contained in the ICESCR "by all appropriate means"; this broad and flexible approach allows States to take into account the particularities of their legal and administrative system.⁵⁷⁵ However, each Party State should use all the means at its disposal to give effect to these rights, by e.g. recognising these rights in the domestic legal system. Disadvantaged groups must have adequate means of redress and this requires that appropriate mechanisms be established to ensure accountability.⁵⁷⁶

The right to an effective appeal should not necessarily be interpreted as the exclusive use of the judicial appeal, but rather that administrative appeals are also appropriate. These administrative appeals should be accessible, inexpensive, quick and effective.⁵⁷⁷

At regional level, Article 8 of the Banjul Charter establishes the right of access to justice and equality before the law. The Protocol to the ACHPR on the Establishment of the African Court on Human and Peoples' Rights is a fundamental instrument to ensure access to justice for persons within the jurisdiction of the Member States. The Republic of Angola has ratified the protocol recently.

Guideline 6 of the UNHCR/OHCHR Guidelines on HIV/AIDS and Human Rights recommend that States should establish and uphold legal support services that educate people affected by HIV on their rights, provide free legal services to enforce these rights, develop expertise on HIV-related legal issues, and use means of protection in addition to the courts, such as ministries of justice, providers, health complaint units and human rights commissions. Guideline No. 7 implies adopting

572 Data presented by Angola in the 2nd Periodic Report to the Human Rights Committee. CCPR/C/AGO/2 of 28 November 2017, paragraph 131. The 2nd Report cites as a source the Directory 2015 of the Ministry of Justice and Human Rights.

573 *Global Commission on HIV and the Law – Risk, Law and Health*, July, 2012, p. 21.

574 E/C.12/1998/24, Committee on Economic, Social and Cultural Rights, 3 December 1998.

575 General Comment No. 9 CESCR, paragraph 1

576 General Comment No. 9 CESCR, paragraph 2

577 The existence of an administrative appeal is not to the detriment of establishing a final right of judicial appeal in relation to the original administrative procedures. On the contrary, where a right recognised in the Covenant cannot be fully exercised without intervention of the judiciary, judicial appeals must be sought. *See* General Comment No. 9, CESCR, paragraph 9

measures, such as: a) specialised legal assistance for HIV cases; b) state incentives (e.g. tax reductions) for law offices to provide free services to PLHIV; c) educational measures on law and HIV; d) protection through a variety of institutions such as Ministry of Justice, prosecutors, health claim units, Ombudsman, and National Human Rights Institutions.⁵⁷⁸ Guideline No. 11 on the monitoring and implementation of human rights by the State reaffirms, in the sense of their indivisibility and interdependence, that to realise the right to health, it is necessary to guarantee access to justice.

3. Current situation in Angola

The CRA, 2010 guarantees everyone access to the law and to the courts to defend their legally protected rights and interests, preventing the denial of justice to those with financial constraints. Effective judicial protection presupposes timely decisions, speedy processes, equity and priority in the face of violations of citizens' fundamental rights, freedoms and guarantees.⁵⁷⁹ The Constitution also guarantees to all citizens the right to sponsorship and legal aid for those without the means to cover costs of legal representation and guarantees the possibility of legal support and exemption from court costs.⁵⁸⁰ The courts⁵⁸¹ in Angola are the sovereign bodies responsible for administering

justice on behalf of the people.⁵⁸² CRA, 2010 also recognises key institutions for justice, e.g. the Ombudsman, access to law and justice, and public defence, amongst others.⁵⁸³

Law 2/15 establishes the organisation and operation of courts of common jurisdiction.⁵⁸⁴ The State guarantees to all citizens access to the law and to the courts for the defence of their legitimate rights and interests. The Courts are governed by principles of independence, guarantee of access to the law and the courts, effective judicial protection, guarantees of criminal procedure and the presumption of innocence.⁵⁸⁵ At no time can courts and judges deny justice or make a decision to the detriment of claimants, due to insufficient financial means.⁵⁸⁶ The State guarantees to everyone the right to judicial proceedings that are fast and equal.⁵⁸⁷ However, the reform of the judicial system, spearheaded by Law 2/15, has not been implemented in its entirety.

Decree-Law No. 15/95 of 10 November 1995 on Legal Assistance⁵⁸⁸ is intended to provide legal aid for citizens with insufficient financial means and is applied in all courts, regardless of the type of case.⁵⁸⁹ Legal aid includes the total or partial waiver of costs, or its deferment, as well as payment for the services of a lawyer⁵⁹⁰.

Law 8/04 on HIV/AIDS does not provide mechanisms for access to justice, nor does it establish complaint mechanisms. In this sense,

578 Guideline No. 7, International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version, UNAIDS/EACDH paragraph 55

579 See Article 29 (1), (4) and (5) of the CRA.

580 *Idem.*, Art. 29 (2).

581 See Part II, p. x

582 Art. 174.1 CRA 2010

583 Art. 192 etc. CRA (Constitution of the Republic of Angola) 2010

584 Law 2/15; National Assembly "Establishes the principles and general rules of organisation and functioning of the Courts of Common Jurisdiction, which are also designated by the Courts of Justice. – It revokes Law 18/88, of 31 December – Law of the Unified System of Justice, and all legislation that contravenes the provisions of this Law" Official Gazette, Series 1, No. 17 of 2 February 2015

585 Art. 10 etc. Law 2/15

586 *Idem.*, Art. 11.

587 *Idem.*, Art. 12.

588 Decree Law No. 15/95; Council of Ministers "On Judicial Assistance" Official Gazette, Series 1, No. 45 of 10 November 1995

589 Art. 2 and 5 DL 15/95

590 Art. 4 DL 15/95 It may be requested by the interested party in its concession; by the Public Prosecution, or on behalf of the person concerned; by an Attorney or Trainee Lawyer, representing the interested party, with this representation being sufficient for joint signatures of the interested party and the employer; or by the employer appointed by the Bar Association at the request of the interested party, expressed in court. The evidence to be attached to the request for legal aid is: Attestation of poverty given by the Provincial Government or by the Municipal Administrations, and a medical certificate. The concession is the responsibility of the judge of the case for which it is requested, and is processed as an incident, admitting opposition from the opposing party. See Art. 8 and 10 (Competence of the concession), DL 15/95

Law 8/04 is silent regarding access to justice. However, the normal mechanisms for redress of rights violations can always be used by those affected by the epidemic, such as civil claims for compensation for damages, labour claims for dismissal, complaints procedure in Health Units for health care discrimination, Ombudsman, and complaints procedure before the National Assembly.

The LBSNS (Basic Law of the National Health System)⁵⁹¹ also establishes complaint mechanisms. Art 13(1)(g) on the Patients' Statutes guarantees to patients the right to complain and lodge a claim about how they are treated and, where appropriate, receive compensation for damages; this is particularly important in cases of discrimination.

The Legal System for Hospital Management⁵⁹² prescribes that the Governing Board is the competent body to monitor and respond to complaints and claims lodged by patients and to control and propose sanctioning measures in the case of irregularities (e.g. payments made to hospital staff).⁵⁹³ Section XV establishes a Patient's Office⁵⁹⁴ whose duties include a) to inform patients about their rights and duties relating to health service; b) to receive complaints and suggestions about the operation of services and the behaviour of professionals; c) to receive suggestions from patients; e) to forward patients' complaints and suggestions to the competent authorities, with a view to improving service delivery. The Director of the Office is responsible for

taking note of responses and determining appropriate measures in response to complaints from patients.⁵⁹⁵ The Presidential Decree also provides that pharmacies must keep a book of complaints and suggestions, to regulate pharmaceutical delivery.⁵⁹⁶

Law 25/11 (Law against Domestic Violence)⁵⁹⁷ and its Rules of Procedure are tackling the country's legislative efforts to combat violence. The Department of Reproductive Health of the National Directorate of Public Health has prepared a Guidance Manual for notification, care and referral of cases of suspected or confirmed domestic violence, sexual violence and/or other violence.⁵⁹⁸ The manual aims not only to mitigate the health consequences of violence, but also to ensure that the judiciary enforces rights enshrined in law. The effective use of this Manual could not be verified.

Other relevant laws are: Law 8/08 (Penitentiary Law)⁵⁹⁹ which guarantees that any incarcerated person has the right to file petitions and complaints, Law No. 16/03 On voluntary arbitration,⁶⁰⁰ and Law No. 12/16 on Conflict and Conciliation Mediation⁶⁰¹. In labour matters, conflicts can be resolved out of court through conciliation, mediation or arbitration, or by judicial means, through an appeal or labour dispute.⁶⁰²

The NDP 2018-2022⁶⁰³ has been concerned with the issue of access to justice and the law. Taking into account the challenges facing the country and in order to consolidate the justice administration system in Angola, the Plan

591 Law No. 21-B/92; Assembly of the People "Based on the National Health System"; Official Gazette, Series 1, Supplement No. 34 of 28 August 1992

592 DP 260/10

593 Art. 26 (n) DP 260/10

594 Art. 42 DP 260/10

595 Art. 48 DP 260/10

596 Presidential Decree 191/10

597 Law No. 25/11; National Assembly "Against Domestic Violence"; Official Gazette, Series 1, No. 133, of 14 July 2011 and Presidential Decree No. 124/13; President of the Republic "Approves the Regulation of the Law against Domestic Violence. – Revoking all legislation that contravenes the provisions of this Law"; Official Gazette, Series 1, No. 165 of 28 August 2013.

598 Ministry of Health, Republic of Angola. 2017

599 Art. 50-53, Law 8/08

600 Law No. 16/03; National Assembly "On voluntary arbitration" Official Gazette, Series 1, No. 58 of 25 July 2003

601 Law No. 12/16; National Assembly "Law on Conflict Mediation and Conciliation, which establishes the rules on the constitution, organisation and procedure of mediation and conciliation, as alternative dispute resolution mechanisms"; Official Gazette, Series 1, No. 137 of 12 August 2016

602 Article 273 ff. of the General Labour Law.

603 Presidential Decree No. 158/18; President of the Republic "Approves the National Development Plan 2018-2022" Official Gazette, Series 1, No. 94 of 29 June 2018

creates a specific programme for reforming and modernising justice administration.⁶⁰⁴ It aims to strengthen the legal and judicial framework not only at the structural level but also at the instrumental level, as it aims to “consolidate the independence of the judicial system, ensure protection of the rights defined by Law and the Constitution, and ensure equal access for citizens to the justice system, as well as restructure and strengthen the correctional system, to modernise and strengthen the justice administration system and to improve the qualification of human resources, with a particular focus on judges.”⁶⁰⁵

The PNDS 2012-2025 establishes an Institutional Framework Development Programme which provides for the updating of health regulations in order to guarantee access to health, and which includes the revision and adaptation of the Basic Law of the National Health System (Law No. 21-B/92).⁶⁰⁶ PEN V recognises the protection of human rights⁶⁰⁷ as one of its transversal principles, although it is silent on access to law and justice.

At the institutional level, in cases of violation of human rights and constitutional rights, freedoms and guarantees, citizens have a series of mechanisms at their disposal to lodge claims such as the Provincial Human Rights Committees, the Ombudsman; the Attorney General's Office (PGR); the National Assembly through citizen's petitions, Complaints and Suggestions in the Parliament; and the Courts.⁶⁰⁸

The Ombudsman is particularly relevant; it is an independent public body whose purpose is to defend citizens' rights, freedoms and guarantees by ensuring the justice and legality of public administration. This body plays an important role in public scrutiny of government actions. Its mandate allows it to issue recommendations to remedy violations. The Ombudsman's mandate enshrines protection for fundamental constitutional rights and freedoms, in line with international commitments, since Art. 26(1) of the CRA, 2010 states that the fundamental rights set out in the Constitution should not exclude others contained in the applicable laws and rules of international law, including international human rights law.

International human rights mechanisms have recommended that Angola review the Statute of the Ombudsman to ensure its compliance with the Paris Principles,⁶⁰⁹ or establish a new national human rights institution with a broad mandate with respect to human rights, in accordance with these Principles.⁶¹⁰

A major concern arising from this study related to the lack of legal literacy and its relationship to access to justice. Legal literacy is low in Angola, especially in rural areas. The coexistence of formal law and customary law also results in strong discrepancies between the two systems. Many citizens do not make use of legal procedures due to procedural delays and lack of credibility in the judiciary.

604 NDP 2018-2022, Axis 4, Policy 19, Programme 4.2.3

605 NDP 2018-2022, paragraph 368,

606 See PNDS 2012-2015 p. 71 etc.

607 PEN V, p. 80

608 Ref. Law No. 04/06, of 28 April (Organic Statute of the Ombudsman of the Republic); Law No. 22/12, of 14 August (Organic Law of the Attorney of the Republic); Law No. 2/16 of 2 February (Establishes the principles and general rules of the organisation and functioning of the Courts of Common Jurisdiction); etc.

609 Res. 48/134 United Nations General Assembly

610 See Human Rights Council RPU, A/HRC/28/11, 2014 paragraphs 134.44 Establish and operationalise a national human rights institution for the promotion and protection of human rights (Morocco); 134.45 Monitor and establish a national human rights institution (Niger); 134.46 Confer on the Ombudsman the legal framework necessary for it to function effectively as a National Human Rights Institution (Portugal); 134.47 Promote accreditation of the Ombudsman as National Institution of Human Rights with status “A” in accordance with the Paris Principles (Portugal); 134.48 Strengthen the mandate of the Ombudsman and ensure its functions in accordance with the Paris Principles (South Africa); 134.49 Assume the objective of ensuring the establishment of a body similar to the National Human Rights Committee (Republic of Korea); 134.50 Bring the Ombudsman in line with the Paris Principles (Sierra Leone); 134.51 Consider the establishment of a National Human Rights Institution and [...] (Slovenia); 134.52 Make greater efforts to create a National Human Rights Institution to address issues of promotion and protection of human rights (Sudan); 134.53 Consider setting up an independent national human rights institution to oversee and monitor human rights situations in the country and to promote public awareness on the promotion and protection of human rights (Thailand). See also Human Rights Committee, Concluding Observations, CCPR/C/AGO/CO/1, paragraph 7, 2013, See also Committee on Economic, Social and Cultural Rights, Concluding Observations, E/C.12/AGO/CO/4-5, paragraph 14, 2016.

4. Gaps and Challenges

Law 08/04 is silent on access to justice and does not establish provisions or statements relating to access to the law, nor procedures for achieving them. Any claim must be made through general mechanisms, such as those established in Law 21-B/95 of the Basic Law of the National Health System.

Although there are a wide range of regulations regarding complaints and claims, this research found that many mechanisms are not well operationalised. For instance, complaints books are not available in all health units. In addition, the Employer's Offices are not functional. This creates barriers to access to justice.

The FGD also found that patients do not use remedies for fundamental reasons: the lack of knowledge of rights and how to access justice, the fear of HIV-related discrimination, exacerbated for key population, including young key populations, and the total lack of credibility of complaints mechanisms within the health system. Additionally, patients mistrust that information contained in complaints books will be delivered. The research found that disciplinary measures are not often taken against acts of discrimination by health professionals.

PLHIV and key populations, including young key populations, are afraid of public exposure and consequent stigmatisation or discrimination. This is worst in rural areas and small towns where key populations such as SW and MSM report lacking legal protection from the authorities, suffering from stereotyped, stigmatising and discriminatory attitudes and social exclusion, often promoted by public media and law enforcement agencies. This was also so for migrants, asylum seekers, refugees and stateless persons.⁶¹¹

The research also found widespread violence, including several forms of domestic violence against women, sexual violence and family

abandonment e.g. expulsion of LGBT+ children and adolescents from the family environment. During the FGDs, police violence was reported particularly by key and vulnerable populations, and also by refugees, migrants, asylum seekers and stateless persons.

Although there are structures in place to disseminate information about human rights, such as the Commission for the Promotion of Provincial Committees on Human Rights, or The Ombudsman,⁶¹² in reality citizens are unaware of their rights and even where they are aware of them, barriers hinder effective access to justice. Despite the favourable legal framework, people living with HIV, key and vulnerable populations, including young key populations, struggle to access justice in Angola.

5. Recommendations

Therefore, the following is recommended to strengthen access to justice:

- Ratify the Optional Protocol of the ICESCR.
- Fully implement Law 2/15 on Judicial Reform.
- Revise Law 8/04 to include provisions to increase awareness of rights and access to justice, including through establishing a competent authority to receive confidential complaints and to process patients' complaints on the basis of equity in access to law and justice in relation to, e.g. access to health regarding HIV, discrimination and violence.
- Revise Law 8/04 to provide free legal services to enforce the rights established by law, including provisions to provide legal advice to persons affected by the epidemic and who are within the scope of law, in particular to persons living with HIV, key and vulnerable populations, including young key populations.
- Revise and adapt the Basic Law of the National Health System (Law No. 21-B/92) to include provisions ensuring the confidential

611 Report of the Special Rapporteur on Human Rights and Migrants in his mission to Angola; A/HRC/35/25/Add.1 paragraphs 65-67

612 Art. 18 (c) Statute of the Ombudsman

receipt, processing and follow-up of complaints, claims or suggestions from patients.

- Revise the Statute of the Ombudsman so that it is aligned with the Paris Principles or establish a National Human Rights Institution in accordance with these principles.
- Encourage the Ombudsman to prepare a thematic report on HIV and Human Rights in Angola.
- Advocate for the Ministry of Justice and Human Rights to conduct a study on access to law and justice.
- Include objectives, actions and goals in health plans to promote compliance with administrative justice and ensure legal resources are available to patients for the realisation of their rights.
- Adopt financial measures to strengthen the judicial system, in particular with regard to *e.g.* creating infrastructure, training of judges, etc.
- Adopt educational measures in the health, penitentiary and police sectors on the rights of people affected by the HIV epidemic, in particular those of (young) key and vulnerable populations; as well as the criminal, civil, administrative and disciplinary consequences of discriminatory attitudes and the misuse of force.
- Develop guidelines on HIV and rights in the health, penitentiary and police sectors, as well as in the judiciary system.

Part IV:

Conclusions and Recommendations

Angola has an HIV prevalence rate of 2% in the general population aged 15 and 49, being 2.6% in women and 1.2% in men. In young people aged 15-24 years, the prevalence is 0.9%. As a result, it is characterised as a widespread epidemic.

Under Angolan law, although there is no specific constitutional provisions for HIV and AIDS, the Angolan State has adopted decisive legislative measures to strengthen the national response to HIV. At the legislative level, Law 8/04 on HIV/AIDS stands out as foremost. This law responds to the needs of the country to adopt urgent and effective measures aimed at both controlling and preventing HIV and protecting the rights of people living with HIV. The Regulation on HIV/AIDS and Employment and Vocational Training (Decree No. 43/03 of 4 July) is also one of the most important legal sources in Angola. It establishes, defines and regulates the forms, methods and behaviours related to the protection of workers.

The Angolan executive has already adopted five national strategic plans for combating HIV, including the “National Strategic Plan for STIs/HIV-AIDS V and Viral Hepatitis – Angola 2015 – 2018” (PEN V). As of January 2020, the PEV VI has undergone a revision (December 2019) and is currently in its approval phase. INLS has developed a National Strategy for the Prevention, Care and Treatment of STIs/HIV/AIDS for Key and Vulnerable Populations in Angola 2018-2022, also in approval phase.

The Angolan State has also adopted important measures to create an institutional response to HIV. In January 2003 the Government approved Decree 01/03 establishing the National Commission to Combat HIV/AIDS and Great Endemic Diseases. The Commission is the coordinating and governing body for the fight against STDs, HIV and AIDS and Large Endemics and the Minister of Health coordinates the National Technical Committee to Fight STD/HIV-AIDS and Large Endemics. The Commission was created to establish broader and more effective prevention, treatment and care initiatives through multisectoral interventions. Additionally, Decree 7/05 of March 2005 creates the National Institute for the Fight (INLS) against AIDS. INLS is a central

body of MINSA, mandated to implement the Ministry’s HIV policies. The Commission, however, is not functional, which significantly limits the multisectoral response and it is imperative that it be strengthened.

The Angolan Constitution, 2010 provides for fundamental rights to be interpreted and integrated in accordance with the UDHR, the ACHPR and other relevant international treaties ratified by the Republic of Angola. Angola has submitted all required national human rights reports both within the UN and AU system. In addition, Angola is currently a member of the Human Rights Council until 2020. Despite this, the observations and recommendations of the different human rights mechanisms, have noted difficulties in the realisation of various human rights in the country.

In cases of generalised epidemics, such as Angola, it is important to understand the dynamics of HIV and how it impacts on socially marginalised populations at higher risk of HIV exposure. This LEA study found that, in Angola, key populations (including young key populations) and vulnerable populations face significant stigma, discrimination and human rights violations, creating barriers to accessing prevention, treatment, support and care. They experienced difficulties in defending, protecting and realising the right to health, in particular the right to sexual and reproductive health and in the materialisation of other human rights, e.g. the right to equality and non-discrimination, the right to dignity, privacy, the right to employment, social security, education, information, freedom of association and access to justice. Furthermore, women, children – particularly adolescents – and migrants, refugees, asylum seekers and stateless persons also struggle to realise their basic rights.

The LEA found that Law 8/04 is outdated and does not respond to the full realisation of the rights of PLHIV and those affected by the epidemic. It is particularly ineffective in not addressing key and vulnerable populations, including young key populations – recognising their specific vulnerabilities and accommodating their rights. In addition, the

law contains punitive provisions that fail to respond to scientific advances in HIV and AIDS, such as provisions criminalising HIV non-disclosure, exposure and transmission.

Other laws, for the most part, do not expressly address the issue of HIV and AIDS.

HIV plans and those relating to development, youth and sexual and reproductive health include, to some extent, activities to respond to HIV. Other plans and strategies have included consultations with adolescents on specific interventions aimed at combating HIV and AIDS. However, there is a lack of sufficient recognition of the various forms of stigma, discrimination, inequality and human rights violations that exacerbate the vulnerability of young people, including young key populations to HIV and other sexual and reproductive health risks. There is also insufficient relevant data to monitor and evaluate the implementation of plans, strategies and policies.

Despite positive gains in the country's response to the epidemic, PLHIV, key and vulnerable populations, including young key populations continue to experience stigma, discrimination and violations of their human rights and their constitutional rights, freedoms and guarantees in various ways. For example, there are no provisions to specifically protect transgender persons, MSM, SW, and other key and vulnerable populations against HIV-related stigma and discrimination. Punitive laws create serious barriers to accessing health services e.g. the criminalisation of HIV exposure, non-disclosure and transmission and the criminalisation of sex work and drug use. Both domestic violence and police violence are still a major challenge in the fight against HIV and AIDS affecting people living with HIV, key and vulnerable populations, including young key populations, and these populations struggle to access justice for violence and abuse. Health service providers and law enforcement personnel, particularly the police, were not sufficiently aware of the rights of those

affected by the epidemic, and many people were unaware of their rights and did not have or felt unable to access redress mechanisms, due to various fears and concerns.

The current legal framework, including national policies and strategies in Angola, while protecting PLHIV and, to some extent, key populations (including young key populations), is still not sufficient to ensure an efficient and sustainable response to HIV and AIDS and to protect rights. There are still persistent forms of discrimination, harmful norms, attitudes and practices that act as barriers to accessing HIV-related services.

The following general recommendations form the basis for specific recommendations and action planning for the revision, implementation and enforcement of HIV laws, policies and regulations, as well as measures to improve access to justice and enforcement of HIV-related laws.

- Strengthen the legal and policy framework for people affected by and living with HIV, particularly in relation to key (including young key) populations (LGTB+ persons, MSM, prisoners, sex workers, and people who use drugs) and vulnerable populations (women, adolescents, children, migrants, and refugees).
- Review HIV/AIDS Law 8/04 to incorporate various provisions to strengthen equality and anti-discrimination protection for PLHIV, key and vulnerable populations, including young key populations, to remove punitive provisions and to ensure that the law is up to date with current medical and scientific evidence.
- Increase awareness (education and information) at all levels within the Executive, Legislative and Judiciary, as well as the wider community on the rights of people living with HIV and TB, and key populations (including young key populations) and vulnerable populations.
- Provide adequate human and financial

resources for the implementation and monitoring of health and HIV laws and policies, including sexual and reproductive health and prevention, treatment, care and support services for people affected by and living with HIV, key and vulnerable populations, including young people.

- Strengthen efforts to reduce stigma, discrimination and violence, particularly with regard to people living with HIV, key and vulnerable populations, including young key populations.
- Conduct socio-behavioural studies and further research to improve understanding of the legal, human rights and gender-related barriers to health care for key and vulnerable populations, including young key populations.
- Strengthen mechanisms for access to justice for PLHIV, key and vulnerable populations, including young key populations.

Specific recommendations can be found at the end of each section of Part III of this LEA.

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Presidential Decree No. 19/18; President of the Republic *"Approves the Organic Statute of the Ministry of Social Action, Family and the Promotion of Women"*; Official Gazette, Series 1, No. 12 of 29 January 2018.

Presidential Decree No. 17/18; President of the Republic *"Approves the Organic Statute of the Ministry of Education"*; Official Gazette, Series 1, No. 10 of 25 January 2018.

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National Health Policy, Presidential Decree No. 262/10; President of the Republic; Official Gazette, Series 1, No. 222 of 24 November 2010.

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National Strategic Plan V for Response to STI/HIV-AIDS and Viral Hepatitis 2015 – 2018; INLS/MINSA, Government of Angola. 2014

National Strategy for the Prevention, Care and Treatment of STIs/HIV/AIDS for Key and Vulnerable Populations in Angola 2018-2022 (in the approval phase), INLS/MINSA, Government of Angola

Strategic Plan for Reproductive Health 2009-2015, MINSA; Government of Angola

National Youth Development Plan 2014-2017; Presidential Decree No. 71/14; President of the Republic, Official Gazette, Series 1, No. 57 of 25 March 2014.

Strategy for Comprehensive Care of the Health of Adolescents and Young People 2016-2020, MINSA, Government of Angola

Strategic Plan for HIV and Education. MINEDU, Government of Angola

Strategic Plan of the CILAD (Interministerial Committee on the Fight against Drugs); MINJUSDH, Government of Angola

National Policy for Equality and Gender Equity and the respective Advocacy Strategy and Resource Mobilisation for Policy Implementation and Monitoring; Presidential Decree No. 222/13; President of the Republic, Official Gazette, Series 1, No. 247 of 24 December 2013.

National Programme to Support Rural Women; Presidential Decree No. 138/12; President of the Republic; Official Gazette, Series 1, No. 117 of 20 June 2012.

Executive Plan against Domestic Violence and its Schedule of Actions; Presidential Decree No. 26/13; President of the Republic, Official Gazette, No. 85 of 8 May 2013.

Appendix 1 – List of Focal Groups Discussions and Joint Consultative Dialogues

Focus Group Discussions

Ministerial Focal Groups at the Central Level,
May 24, 2018, Luanda

International Cooperation, May 25, 2018,
Luanda

Traditional Authorities (*Sobas*) and Churches,
29 May 2018, Luanda

Health Professionals, 31 May 2018, Luanda

Key Populations: Prisoners, 4 June 2018,
Luanda

Adolescents, Civil Society Project GIRO, 4 June
2018, Luanda

Key Population, LGTB+, 5 June 2018, Luanda

Key Population, MSM, 5 June 2018, Luanda

Key Population, Drug Users, 6 June 2018,
Luanda

Key Population, Sex Workers, 6 June 2018,
Luanda

Key Population, MSM & SW, 8 June 2018, Bié

Key Population, MSM & SW, 11 June 2018,
Benguela

Mixed Consultative Dialogues

Civil Society, State Institutions, 30 May 2018,
Luanda

Civil Society, State Institutions, 7 June 2018,
Bié

Civil Society, State Institutions, 11 June 2018,
Benguela

**Civil Society, State Institutions, Key
Populations, International Organisations,
Private Sector, Seminar for Preliminary LEA
Report Validation,** 20-22 November 2018,
Luanda

Appendix 2 – List of Key Interviews

List of Key Interviews

Ministry of Health; National Institute for the Fight against AIDS (INLS)

Ministry of Health, National Institute for the Fight against Drugs (INALUD)

Ministry of Health, Legal Directorate

Ministry of Health, Public Health Directorate

Ministry of Health, Provincial Health Delegation of Bié

Ministry of Health, Provincial Health Delegation of Benguela

Ministry of Justice and Human Rights, National Directorate of Human Rights

Ministry of the Interior, Penitentiary Services

Ministry of Social Action, Families and the Promotion of Women

Ministry of Youth and Sports

Ministry of Transport

Ministry of Defence

Ministry of Territorial Planning and Housing

Ministry of Environment

National Assembly, 6th Commission (Health)

National Assembly, 7th Commission (Youth)

National Assembly, 10th Commission (Petitions and Human Rights)

Agostinho Neto University, Faculty of Law

IRIS Association (LGTB+)

H Maiúsculo (MSM)

AIA (Angolan Identity File -LGTB+)

ANASO (Angolan Network of AIDS Organisations and Services)

MWENHO, Civil Society

ASCAM (Association of Christian Solidarity of Angola)

CICA (Council of Christian Churches in Angola)

ASSOGE (Women's Rights)

Project "It's us of the Ghetto" for drug users

Project "JIRO" for Adolescents.

Project "Linkages" for Key Populations

AJUSIDA – Civil Society

HEALTHY LIFE – Civil Society

APDES Development Agency, Civil Society

Caritas, Civil Society

IHO, Civil Society

Action for Rural Development and Environment (ADRA – Civil Society)

Institute for the Promotion and Coordination of Community Aid (IPROCAC -Civil Society)

Oblate Sisters Centre – Civil Society

CAJ, (Youth Support Centre), Civil Society

Blue Cross, Civil Society

United States Agency for International Development (USAID)

United Nations Children's Fund (UNICEF)

World Health Organisation (WHO)

Joint United Nations Programme on HIV and AIDS (UNAIDS)

United Nations Population Fund (UNFPA)

International Organisation for Migration (IOM)

United Nations High Commissioner for Refugees (UNHCR)

United Nations Development Programme (UNDP)

United Nations Development Programme

UNDP Angola

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