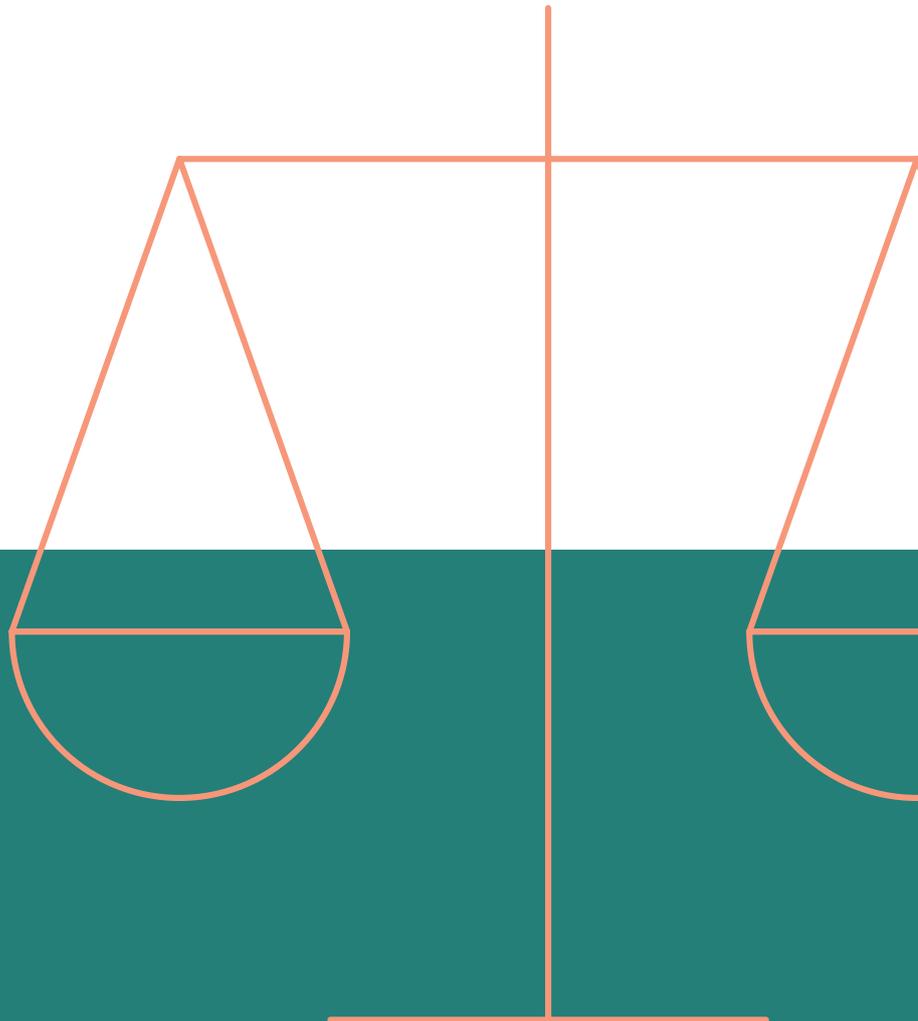




*Empowered lives.  
Resilient nations.*

# Zimbabwe

Legal Environment Assessment  
for HIV, TB, Sexual and  
Reproductive Health & Rights



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, National AIDS Council of Zimbabwe (2019). Zimbabwe: Legal Environment Assessment for HIV, TB, Sexual and Reproductive Health & Rights.*

The views expressed in this publication are those of the authors and do not necessarily represent those of the United Nations, including UNDP, or UN Member States.

UNDP partners with people at all levels of society to help build nations that can withstand crisis, and drive and sustain the kind of growth that improves the quality of life for everyone. On the ground in more than 170 countries and territories, we offer global perspective and local insight to help empower lives and build resilient nations.

Copyright © UNDP 2019

**United Nations Development Programme**

UNDP Zimbabwe

Block 10, Arundel Office Park,  
Norfolk Road, Mount Pleasant,  
Harare,  
Zimbabwe.

Tel: +263 4 338 836-44

Fax: +263 4 338 294

E-mail: [registry.zw@undp.org](mailto:registry.zw@undp.org)

Website: <http://www.zw.undp.org/>

# Contents

<b>Acknowledgements</b>	<b>5</b>
<b>List of Abbreviations and Acronyms</b>	<b>6</b>
<b>Executive Summary</b>	<b>8</b>
Findings	9
Recommendations	12
<b>Part I: Introduction and Background</b>	<b>18</b>
Introduction to HIV, TB and Human Rights in Zimbabwe	19
HIV and TB as a Human Rights Issue	19
HIV and TB in Zimbabwe	20
HIV, TB and Human Rights in Relation to Vulnerable and Key Populations, including Young Key Populations	21
Introduction to Legal Environmental Assessment (LEA) for HIV and TB	25
<b>Part II: International, Regional and National Human Rights Framework</b>	<b>30</b>
What is a Human Rights-based Response to HIV and TB?	31
Application of International and Regional Human Rights in Zimbabwe	32
National Human Rights Standards and Key Human Rights in the Context of HIV and TB	37
National Progress in Implementation of Human Rights within the Context of HIV and TB Legislation and the National HIV and TB Response	39
<b>Part III: Analysis of Laws, Regulations and Policies in Zimbabwe</b>	<b>42</b>
Equality and Non-Discrimination Laws	43
Health Laws, Policies and Plans	46
a) Constitutional Protections Relevant to the Right to Health	52
b) Women, Gender Inequality, Harmful Gender Norms and Gender Based Violence.	59
c) Criminalisation of HIV Transmission, Exposure and Non-Disclosure	64
d) Criminalisation of Key Populations	68
e) Employment	80
F) Social Welfare Assistance in Zimbabwe	84
<b>Part IV: Access to Justice and Law Enforcement in Zimbabwe</b>	<b>88</b>
<b>Part V: Conclusions and Recommendations</b>	<b>94</b>
Conclusion	95
Recommendations	95
<b>References</b>	<b>102</b>
List of Documents Reviewed and Referenced	103
<b>Annexures</b>	<b>110</b>
Annexure 1: List of FGDs Conducted	111
Annexure 2: List of Key Informants	111

## Foreword

Zimbabwe has made significant progress in the national response to HIV, TB and improving sexual and reproductive health and rights. The HIV and TB prevalence and incidence rates have significantly declined over the past 2 decades owing to a number of combination prevention and treatment initiatives and programmes such as scaling up of voluntary testing and counselling, prevention of mother to child transmission and the Antiretroviral treatment. Be that as it may, until recently, the national response to HIV and TB remained largely generalised, leaving behind key and affected populations, including young key populations. This has resulted in disproportionately high HIV and TB prevalence rates amongst key and affected populations necessitating a more targeted and evidence-based approach.

In 2013, Zimbabwe adopted a new Constitution which guarantees a wide range of fundamental rights and freedoms including equality and non-discrimination and the right to access basic health-care and reproductive health by all. The country, through the Constitution, domesticated a number of regional and international human rights conventions' provisions which guarantee the right to health to all and prohibit discrimination on any grounds. It is imperative to ensure that all laws and policies are aligned with the Constitution in order to respect, protect, fulfil and promote the rights of all persons, including key and affected populations, particularly access to health care and sexual and reproductive health.

Stigma, discrimination and other human rights abuses faced by people living with HIV or AIDS and TB as well as by key and affected populations, including young key populations, compromise their ability to access health care services, including HIV and TB prevention, treatment and care services and thus negatively impact on the national response to HIV and TB. While processes to review laws and policies which are inconsistent with the Constitution, insofar as they derogate from the Bill of Rights, are on course, implementation of the recommendations of this Legal and

Environment Assessment will be a progressive step in the bid to end AIDS by 2030.

Implementation of these recommendations will ensure that people living with HIV and key and affected populations at higher risk of HIV infection are afforded a legally protective environment for the protection of their rights.

The Government of Zimbabwe, through the Ministry of Health and Child Care, the National AIDS Council of Zimbabwe and other key public and quasi-public institutions and agencies remains committed to achieving Zero new HIV infections, Zero HIV related deaths and Zero HIV related stigma and discrimination with the goal of ending AIDS by 2030. The country is currently implementing the Global Fund AUP Grant 2018-2020 which has a significant focus on key populations' programmes. The Legal and Regulatory Environment Assessment (LEA) commissioned by the United Nations Development Programme and the National AIDS Council of Zimbabwe is a milestone achievement not only in fostering the health rights of people living with HIV and key and affected populations, but, also in strengthening the country's national response to HIV and TB.



*Raymond Yekeye*  
**Zimbabwe National AIDS Council**

# Acknowledgements

The National AIDS Council of Zimbabwe greatly appreciates and acknowledges the invaluable contributions and timely inputs from the institutions and individuals listed hereunder.

## Zimbabwe National Steering Committee

We greatly appreciate the coordination, leadership and direction provided by the Legal and Regulatory Environment Assessment Steering Committee, including; Sarah Musungwa (UNDP), Dr Ruth Labode, (Parliament of Zimbabwe), Samson Chidiya (USAID), Dr. Gaka (ZPCS), Samson Mutendamambo (JSC), Raymond Yekeye(NAC), Tendai Mbengeranwa (NAC), Garikai Muchemwa (UNDP), Kuzivakwashe Ngodza (ZLHR), Fanuel Ncube (NAC), Sylvester M. Nyamatendedza (GALZ), Tendai Ndori-Mharadze (CESHHAR), Pheoby Kamutambo (WAAD), Kurai Makumbe (ZJHRC), Molline Marume (UN Women), Samuel Nyikahadzoi (Midlands AIDS Caring Organisation, Jokicho Carbinata Tafadzwa, BHASO/Kuyanana, Steady Mapfumo (UNFPA), Abraham Mateta (NASCOH), Rumbidzai Matehwe (ZNNP+) Wilson Box (Zimbabwe Civil Liberties and Drug Network and Aubrey Chacha (Trans-smart).

## Consultants

We appreciate and are sincerely grateful for the dedicated services and technical expertise of consultants including Noriah Mashumba, Farai G. Chiweshe (National Consultants) and Kitty Grant (UNDP-RSCA Consultant) who contributed in varying capacities to this report.

## External Contributors to Supporting Evidence

Our sincere gratitude also goes to the focus group participants and key informants for informing the findings and recommendations of this report.

We greatly appreciate the generous financial support from the Global Fund to fight AIDS, Tuberculosis and Malaria, the Netherlands Government Ministry of Foreign Affairs and the United Nations Development Programme.

We sincerely appreciate the overall coordination by the regional UNDP HHD team including Mesfin Getahun, Senelisiwe Ntshangase and Ian Mungall.

# List of Abbreviations and Acronyms

<b>AAC</b>	AIDS Action Committee	<b>MoJLPA</b>	Ministry of Justice, Legal and Parliamentary Affairs
<b>ACHPR</b>	African Charter on Human and Peoples' Rights	<b>NAC</b>	National AIDS Council
<b>AIDS</b>	Acquired Immune Deficiency Syndrome	<b>NASCOH</b>	National Association of Societies for the Care of the Handicapped
<b>AGYW</b>	Adolescent Girls and Young Women	<b>NACP</b>	National AIDS Co-ordination Programme
<b>AMShER</b>	African Men for Sexual Health and Rights	<b>NATF</b>	National AIDS Trust Fund
<b>AMTO</b>	Assisted Medical Treatment Orders	<b>NBTS</b>	National Blood Transfusion Services
<b>ART</b>	Antiretroviral therapy	<b>NGO</b>	Non-governmental Organisation
<b>ARVs</b>	Antiretroviral medicines	<b>OHCHR</b>	Office of the High Commissioner for Human Rights
<b>ASRHR</b>	Adolescents' Sexual Reproductive Health and Rights	<b>OHS</b>	Occupational Health and Safety
<b>AU</b>	African Union	<b>OT</b>	Opportunistic Infections
<b>CAT</b>	Convention against Torture	<b>OVC</b>	Orphans and Vulnerable Children
<b>CBO</b>	Community Based Organisation	<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>CCM</b>	Country Co-ordinating Mechanism	<b>PHDP</b>	Positive Health Dignity and Prevention
<b>CEDAW</b>	Convention on the Elimination of all Forms of Discrimination against Women	<b>POSA</b>	Public Order and Security Act
<b>CRC</b>	Convention on the Rights of Child	<b>PVOA</b>	Private Voluntary Organisation Act
<b>CRPD</b>	Convention on the Rights of Persons with Disabilities	<b>SADC</b>	Southern Africa Development Community
<b>CSO</b>	Civil Society Organisation	<b>SADC PF</b>	SADC Parliamentary Forum
<b>e-MTCT</b>	Elimination of Mother to Child Transmission	<b>SALC</b>	Southern Africa Litigation Centre
<b>FAO</b>	Food and Agriculture Organisation	<b>SDGs</b>	Sustainable Development Goals
<b>FBO</b>	Faith Based Organisation	<b>SI</b>	Statutory Instrument
<b>FGDs</b>	Focus Group Discussions	<b>SRH</b>	Sexual and Reproductive Health
<b>GALZ</b>	Gays and Lesbians of Zimbabwe	<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>GARPR</b>	Global AIDS Response Progress Report	<b>STI</b>	Sexually Transmitted Infection
<b>GFATM</b>	Global Fund to Fight AIDS, TB and Malaria	<b>TB</b>	Tuberculosis
<b>GBV</b>	Gender Based Violence	<b>TRIPs</b>	Trade Related Aspects of Intellectual Property Rights Agreement
<b>GCHL</b>	Global Commission on HIV and the Law	<b>UDHR</b>	Universal Declaration of Human Rights
<b>GoZ</b>	Government of Zimbabwe	<b>UN</b>	United Nations
<b>HEARD</b>	Health, Economics and HIV and AIDS Research Division	<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>HIV</b>	Human Immunodeficiency Virus	<b>UNDP</b>	United Nations Development Programme
<b>HTC</b>	HIV Testing and Counselling	<b>UNICEF</b>	United Nations Children's Fund
<b>ICCPR</b>	International Covenant on Civil and Political Rights	<b>VCT</b>	Voluntary Counselling and Testing
<b>ICESCR</b>	International Covenant on Economic, Social and Cultural Rights	<b>VFU</b>	Victim Friendly Unit
<b>ICERD</b>	International Convention on the Elimination of All Forms of Racial Discrimination	<b>VIPAA</b>	Vienna International Plan of Action on Ageing
<b>ILO</b>	International Labour Organisation	<b>VMMC</b>	Voluntary Medical Male Circumcision
<b>IPR</b>	Intellectual Property Rights	<b>WHO</b>	World Health Organisation
<b>JLOS</b>	Justice, Law and Order Sector	<b>WILSA</b>	Women and Law in Southern Africa
<b>KII</b>	Key Informant Interview	<b>YKP</b>	Young Key Populations
<b>KP</b>	Key Populations	<b>ZAN</b>	Zimbabwe AIDS Network
<b>LAD</b>	Legal AID Director	<b>ZBCA</b>	Zimbabwe Business Council on AIDS
<b>LEA</b>	Legal Environmental Assessment	<b>ZHRC</b>	Zimbabwe Human Rights Commission
<b>LGBTI</b>	Lesbian, Gay, Bisexual, Transgender and Intersex	<b>ZIMRA</b>	Zimbabwe Revenue Authority
<b>MCAZ</b>	Medical Control Authority of Zimbabwe	<b>ZIMASSET</b>	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
<b>MOHCC</b>	Ministry of Health and Child Care	<b>ZLHR</b>	Zimbabwe Lawyers for Human Rights
		<b>ZNASP</b>	Zimbabwe National HIV and AIDS Strategic Plan
		<b>ZNNP+</b>	Zimbabwe National Network of People Living with HIV

## Key Definitions Used in the Report

**Key populations** are defined groups who, due to specific higher-risk behaviours are at increased risk of HIV, irrespective of the epidemic type or local context. They often have legal and social issues related to their behaviours that increase their vulnerability to HIV. The five key populations are: men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people. ([World Health Organisation \(WHO\) Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations](#))

**Vulnerable populations** are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers. These populations are not affected by HIV uniformly across all countries and epidemics. ([WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations](#))

**Men who have sex with men** refers to all men who engage in sexual and/or romantic relations with other men. The words “men” and “sex” are interpreted differently in diverse cultures and societies and by the individuals involved. Therefore, the term encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with any particular community or social group. ([WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations](#))

**People who inject drugs** refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypo-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. ([WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations](#))

**Transgender** is an umbrella term for all people whose internal sense of their gender (their gender identity) is different from the sex they were assigned at birth. Transgender people choose different terms to describe themselves. Someone born female who identifies as male is a transgender man. He might use the term “transman”, “FtM” or “F2M”, or simply “male” to describe his identity. A transgender woman is someone born male who identifies as female. She might describe herself as a “transwoman” “MtF”, “M2F” or “female”. ([WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations](#)) (In Zimbabwe terminologies such as ‘jengavarume’ and ‘Jengavakadzi’ are often used.

**Adolescents** are defined by the WHO as people aged 10–19 years.

**Young people** are defined by the United Nations (UN) as those aged 10–24 years

**Children** are defined by the Convention on the Rights of the Child (CRC) as people below the age of 18 years, unless, under the law applicable to the child, majority is attained earlier. ([United Nations Convention on the Rights of the Child](#))

**Sex workers** include female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work also varies in the degree to which it is more or less “formal” or organised. ([WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations](#))

# Executive Summary

*“HIV transmission is not a random event: the spread of the virus is profoundly influenced by the surrounding social, economic and political environment. Wherever people are struggling against adverse conditions such as poverty, oppression, discrimination and illiteracy, they are especially vulnerable to being infected by HIV.”<sup>1</sup>*

The Global Commission on HIV and the Law (GCHL) notes that responsive laws and policies can enhance access to prevention and health care services and improve the quality of treatment and social support for affected populations, thereby promoting and protecting their basic rights. Additionally, efficient and accessible justice delivery services complying with internationally recognised standards and the Constitution, can enhance protections, enjoyment of rights and related quality health services for all people, including key populations. Supportive legislation, policies, positive court decisions, strengthening legal literacy, and collaborations with progressive law-makers and law-enforcers can collectively enhance gender-sensitive access to rights, protections and quality health and social services for key populations, including young key populations.

The National AIDS Council (NAC) of Zimbabwe and United Nations Development Programme (UNDP) commissioned a Legal and Regulatory Environment Assessment (LEA). The LEA and Engagement Scan (ES) is supported under the Programme/Project: Linking Policy and Programming: Strengthening Legal and Policy Environments for reducing HIV Risk and Improving Sexual and Reproductive Health and Rights (SRHR) for Young Key Populations in Southern Africa. This is a four-year regional project (2017-2020) under UNDP, African Men for Sexual Health and Rights (AMSHeR) and Health, Economics, and HIV and AIDS Research

Division (HEARD) with financial support from the Netherlands Ministry of Foreign Affairs. The support seeks to strengthen legal and policy environments to reduce HIV risk and improve SRHR of young key populations in five Southern African countries.<sup>2</sup>

As part of the project UNDP supported this LEA and a Civil Society Engagement Scan.<sup>3</sup> This ongoing process builds onto the outcomes of the earlier LEA<sup>4</sup> to identify and examine all important legal and human rights issues affecting in particular people living with HIV, people with tuberculosis (TB) and those at higher risk of HIV exposure, such as key and affected populations – women, young people, gay men and other men who have sex with men, sex workers, prisoners, persons with disabilities and people who inject drugs.<sup>5</sup> An assessment of the key HIV law and human rights issues (stigma, discrimination, and inequality, discriminatory and punitive laws posing barriers to national response access to justice and law enforcement challenges) was conducted with an analysis of the extent to which existing laws and policies and those in the process of development are able to respond to these issues.

## Findings

Zimbabwe is party to several key regional and international human rights treaties that safeguard the rights of all people and includes extensive protection for the rights of all people in its Bill of Rights, including the rights to equality and non-discrimination, gender equality, privacy and dignity; security of the person and access to information; health care; women’s and children’s rights; the rights of the youth and the rights of persons with disabilities, amongst others.

1 UNAIDS, Report on the global AIDS epidemic (2004).

2 Angola, Madagascar, Malawi, Mozambique, and Zimbabwe.

3 A national engagement scan is a process that creates a calendar covering the next two years showing when key political events will occur, such as elections, when relevant policy and strategy is due for review, details of when parliamentarians, relevant ministries and the judiciary meet to address relevant issues. This would enable each country to map out when there are opportunities for advocacy. The ES will build onto the LEA by providing a framework and targeted roadmap collective and practical implementation of the outcomes/recommendations of the LEA.

4 The LEA was commissioned in 2016 leading to a report the outcome of which incorporate this follow-on LEA and ES in 2018.

5 The groups covered included young key populations, Women, persons with disabilities, gay men and men who have sex with men, sex workers, transgender persons, people who inject drugs and prisoners.

HIV is not specifically provided as a protected ground for non-discrimination in the Constitution, nor is there a specific HIV and AIDS statute in Zimbabwe. However, since 1985 Zimbabwe has adopted various policies, plans and strategies to respond to HIV, TB, sexual and reproductive health and related rights to promote the development of all people. This includes the most recent Zimbabwe National AIDS Strategic Plan (ZNASP) 2018-2020. The national response to HIV and TB, including regulatory and policy frameworks, strategies and plans, contributed towards notable reduction in new HIV infections in Zimbabwe.

Despite the noted positive gains, people living with HIV, TB and affected populations, including adolescent girls and young women, people with disabilities, young people and key populations, including young key populations, continue to experience stigma, discrimination and human rights violations in various ways. Stigma, discrimination and a range of human rights violations affect and impact on the lives of people living with HIV, TB, vulnerable and key populations, infringing on their rights to adequate access to health care services such as HIV prevention, treatment, care and support and sexual and reproductive health services, with negative impacts on broader national responses to HIV. Further, institutional and structural frameworks and a number of legal provisions impose limitations to equal access to efficient justice delivery and law enforcement, especially for key populations, including young key populations.

While the LEA found examples of protective laws and policies, there were also gaps within the legal and policy framework failing to protect the rights of people with HIV, TB and vulnerable and key populations. Additionally, the LEA found examples of discriminatory, punitive and coercive laws that created barriers to access to services for some populations – such as young people and key populations, including young key populations. Policies, strategies and plans were also limited in some instances, failing to adequately prioritise the needs of vulnerable populations – such as women, young people and people with disabilities, as well as key

populations, including young key populations. Finally, service providers – including health care service providers and law enforcement officials, were insufficiently sensitised to the rights of people living with HIV, TB, vulnerable and key populations.

In addition, the LEA found that many people appear to be unaware of their rights and unable to access justice for violations of their rights in Zimbabwe.

The LEA identified the following challenges relating to HIV, TB, sexual and reproductive health (SRH) law, policy, human rights, gender equality, and access to justice:

- Vulnerable populations including women, children, people with disabilities and employees in specific professions, key populations, including young key populations are at greater risk of HIV and/or experience increased impact of HIV, AIDS and poor health, due to their vulnerability linked to gaps in laws, policies and practices.
- Stigma and discrimination remain a key concern. HIV-related stigma and discrimination linked to gaps in laws, policies, practices, and religious and cultural beliefs were found to exacerbate the negative impact of HIV. The climate of stigma and discrimination surrounding HIV and AIDS can make public acknowledgement of one's HIV status difficult and risky for vulnerable and key populations, including young key populations.
- Although protective provisions in the law and policies were identified (such as criminal laws to protect women against sexual violence, legal protections ensuring inclusion of people with disabilities in all sectors in the country, children's laws that protect the rights of orphaned children and laws that protect all employees against discrimination in the work place), several laws are not in alignment with the Constitution and further, do not specifically deal with HIV, AIDS, TB health status, or the various inequalities and human rights violations experienced by people living with HIV, vulnerable populations and key populations, including young key populations.

- Access to justice and law enforcement for human rights violations is limited. Key populations are not aware of their rights as provided in the Constitution and relevant legislation and are thus not empowered to claim rights. Free legal aid services are inadequately resourced, are inaccessible and are not decentralised. Enforcement mechanisms are not accessible.
- The government has obligations under the United Nations General Assembly Special Session Political Declaration on HIV and AIDS (2016) and the ZNASP has integrated global commitments to attain the Sustainable Development Goals (SDGs), achieve the Joint United Nations Program on HIV and AIDS (UNAIDS) 90-90-90 targets and to fast-track responses to HIV. It also has committed to the African Union's HIV and AIDS goals, including ensuring domestic sustainable financing to end AIDS by 2030. Zimbabwe has ratified various international human rights conventions.
- The alignment of various relevant pieces of legislation with the Constitution is coordinated by the Ministry of Justice, Legal and Parliamentary Affairs (MoJLPA). However, resource constraints due to competing government priorities has slowed the process, despite commitment and political will by government. The list of all legislation to be aligned with the Constitution is part of the deliverables for the MoJLPA, government Ministries, CSOs and other stakeholders in line with the draft Universal Periodic Review (UPR) National Plan of Action 2017 to 2020.
- The Constitution and various health and sectoral laws and policies, including the National HIV and AIDS Policy, seek to promote the health rights of all people. However, broad public health laws are outdated, out of sync with international and regional guidance and not HIV-specific. In addition, laws and policies are not always adequately implemented due to resource constraints and inadequate training and sensitisation of health care service providers. Efforts to enhance access to health services through Assisted Medical Treatment Orders (AMTOs), especially for people with disabilities and women, have not enhanced quality access, as AMTOs do not cover the provision of essential medicines and drugs. Generally, health laws and policies do not adequately protect people from discrimination and support access to appropriate and affordable services for people living with HIV, TB, women, people with disabilities and key populations, including young key populations.
- Age of consent laws regarding age of consent to sex and to access to medical information, diagnosis, prevention, treatment and care impact on access to health care services for young people, including young key populations. In addition, the attitude of health care providers to young people's sexuality, as well as stigma and discrimination against key populations, including young key populations, creates barriers to access to sexual and reproductive health and rights of young people, particularly young key populations.
- Zimbabwe has committed to attaining gender equality in the Constitution, and the establishment of a Gender Commission. However, key areas still require attention. The Optional Protocol to the Convention on the Elimination of Discrimination Against Women (CEDAW) is yet to be ratified. Additionally, the revised National Gender Policy (2013-2017) is still to be fully implemented. As a result, women and girls are not fully protected from gender inequality, harmful gender norms (including child marriage) and gender-based violence (GBV). Stigma and discrimination against women with HIV in communities and at health service facilities still exists and fuels GBV in the home and in communities and creates barriers to access to health care.
- Laws criminalising HIV transmission, as well as laws criminalising same-sex, sex work and drug use impact on people living with HIV, TB and on key populations, such as LGBT populations, sex workers and prisoners and including young key populations. They exacerbate stigma and discrimination, create barriers to health care and limit access to justice for these populations.

- Employment laws and policies are inadequately implemented and enforced.
- Social assistance needs strengthening to meet the needs of people living with HIV, TB, as well as vulnerable populations and key populations, including young key populations.
- There is ongoing discourse for government to consider enactment of specific legislation on HIV and AIDS. This may include advantages – e.g. dealing with all the rights relevant to people living with HIV and co-infections, and the rights of vulnerable and key populations – but may lead to the possibility of increased risk of punitive, coercive and discriminatory provisions being introduced.

Programmes should consist not only of testing, prevention services and treatment but also support for protective policing and protection from stigma, discrimination and violence.

- Strengthen efforts to reduce stigma, discrimination and violence, review laws and policies to protect human rights, reduce gender inequality, harmful gender norms and gender-based violence and increase access to justice for all people living with HIV, TB and vulnerable and key populations, including young key populations
- Include HIV related stigma and discrimination indicators as part of the National HIV and TB response monitoring and evaluation systems, to assess progress over time.

## Recommendations

The LEA calls for consideration of the following recommendations:

### General Recommendations

- Raise awareness at all levels, starting with the Executive and Parliament to broader communities, on the rights of people living with HIV and TB and related vulnerable and key populations, including young key populations.
- Strengthen and monitor the implementation of health and HIV-related laws and policies and the delivery of health care, including sexual and reproductive health care and prevention, treatment and support services for people living with HIV, TB and vulnerable and key populations, including young key populations.
- Scale up comprehensive integrated HIV and related health care services for vulnerable and key populations, including young key populations, both by creating the specific context for facilitating behaviour change, and by funding targeted and tailored services for these populations.

### Specific Recommendations

#### Equality and Non-discrimination

- Include provisions that protect and promote human rights in the context of HIV and TB in the Public Health Bill that are consistent with the National HIV and AIDS Policy, and prohibit all forms of discrimination, including TB-related discrimination, on the basis of actual or perceived HIV or TB status;
- Amend Part II of the Prevention of Discrimination Act [Chapter 8:18] to include protections of people living with HIV, women, pregnant women, children, people with disabilities and key populations from discrimination; further amend section 5 of the Act to explicitly mention HIV as a ground for non-discrimination to access finance<sup>6</sup>
- Consider an amendment to the Constitution to explicitly include HIV as a prohibited ground of non-discrimination.
- Ensure existing constitutional human rights are enforced;
- Amend the Immigration Act to reflect the provisions of the National HIV and AIDS Policy, so that there is no requirement for HIV testing of visitors or immigrants

<sup>6</sup> A law should be enacted to prohibit exclusion from life, health and other insurance solely on the basis of HIV status and to ensure that in the context of insurance HIV should not be treated differently from analogous chronic medical conditions.

to Zimbabwe and no exclusions based on discrimination against populations.<sup>7</sup>

### Health Laws and Policies

- Clearly provide for an integrated approach to managing HIV and TB in the Public Health Act / Bill.
- Clearly set out in the Public Health Act / Bill, the equality and health rights of vulnerable populations and key populations, including young key populations, to protect them from discrimination, exploitation and abuse.
- Clearly provide in the Public Health Act / Bill and health policy for the rights of vulnerable populations, such as people with disabilities, and key populations, including young key populations, to appropriate health information and health care services, including HIV, TB and sexual and reproductive health (SRH) services, and the right to participate in the design, development and implementation of programmes.
- Review punitive provisions in the Public Health Act / Bill providing for criminalisation and / or involuntary confinement of people with infectious diseases, to ensure that they are consistent with international and regional guidance relating to HIV and TB.
- Clearly set out in law the age of consent to sexual activity, which should be aligned to the age of consent to sexual and reproductive health services, including contraceptives, provided for in public health law.
- Clearly provide in the Public Health Act / Bill for a lowered age of consent to HIV testing, pre- and post-test counselling without parental consent.
- Clearly provide in the Public Health Act / Bill for confidentiality and conditions relating to disclosure, particularly with regards to HIV.
- Clearly provide in the Public Health Act / Bill that health care providers need to respect the views and opinions of adolescents or young persons, including young key populations accessing services, and their right to confidentiality.
- Amend the Patents Act [Chapter 26:03] and or the Medicines and Allied Substances Control Act [Chapter 15:03] in order to bring national law in line with the TRIPs Agreement, including making specific directives on utilising TRIPs flexibilities in relation to public health for increased access to quality and affordable generic medicines.
- Amend the Disabilities Act to strengthen access to health rights and protection from sexual abuse for persons with disabilities.
- Ensure the provision of youth-friendly services in health care facilities that are inclusive of the needs of young key populations and health personnel trained on the rights of YKP.
- Train health care providers in medical ethics and human rights, including non-discrimination, with respect to vulnerable populations and key populations, including young key populations.
- Review the provision of HIV, TB and SRH services to ensure they promote confidentiality to mitigate against indirect disclosure of a person's health or other status.
- Ensure programmes provide for appropriate service delivery for the treatment, care and support of all vulnerable populations, with specific reference to adolescent girls and young women (AGYW), people with disabilities, and key populations, including young key populations.
- Fund and implement AMTOs to ensure quality access to confidential medical, psychological and function treatment, sexual and reproductive health services and HIV and TB treatment and care for people with disabilities.

<sup>7</sup> The GCHL (2012) Risks, Rights & Health recommends that, to ensure an effective, sustainable response to HIV that is consistent with human rights obligations, States should: offer the same standard of protection to migrants, visitors and residents who are not citizens as they do to their own citizens; repeal travel and other restrictions that prohibit people living with HIV from entering a country and/or regulations that mandate HIV tests for foreigners within a country and implement regulatory reform to allow for legal registration of migrants with health services and to ensure that migrants can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens. All HIV testing and STI screening for migrants must be informed and voluntary, and all treatment and prophylaxis for migrants must be ethical and medically indicated.

- Develop strong monitoring and evaluation mechanisms to ensure effective implementation of HIV treatment, care and support.

### Gender Inequality, Harmful Gender Norms and GBV

- In line with the UPR Recommendation, all legislation that fuels harmful gender norms and practices should be reviewed to ensure compliance with the right to equality in the Constitution and to international protocols to which the country is party to, such as CEDAW.
- Strengthen criminal laws relating to violence, including sexual violence, as well as policies to manage those who have been sexually violated.<sup>8</sup>
- Enact legislation for affirmative action to accelerate increased participation in economic and political sectors of the nation. Policies on the economic empowerment of women should be strengthened.
- Amend the Marriage Act and fully implement laws seeking to end early child marriages.
- Ensure that public health law enhances access to integrated, quality health care in general, sexual and reproductive health care and HIV and TB treatment for women and girls including key populations.
- Ensure the meaningful involvement of women, including AGYW, key populations in the drafting of laws, policies and guidelines concerning SRHR.
- Strengthen programmes to sensitise women, AGYW including young key populations, on their rights, including sexual and reproductive health and rights and rights to be protected from gender inequality, harmful gender norms and gender-based violence.
- Undertaken dialogues with FBOs and traditional leaders for collective efforts to address gender inequality, harmful gender

norms and practices, GBV and to end early child marriages.

- Strengthen capacity of health care workers on medical ethics, human rights and gender equality, to reduce stigma and discrimination against women and to protect their sexual and reproductive health and rights
- Establish 'safe corners' at health institutions to address issues of confidentiality and to tackle stigma and discrimination.

### Criminalisation of HIV Transmission

- HIV-specific laws that criminalise HIV transmission and exposure must be reviewed and aligned with international standards.
- Where HIV criminalisation laws still exist, courts must require proof, to the applicable criminal law standard, of intent to transmit HIV. The intent to transmit HIV cannot be presumed or derived solely from knowledge on the part of the accused of positive HIV status and/or non-disclosure of that status; from engaging in unprotected sex; by having a baby without taking steps to prevent mother-to-child transmission of HIV; or by sharing drug injection equipment.
- Governments must prohibit the prosecution under HIV-specific statutes, of women living with HIV for choices they make during and after pregnancy, including about breastfeeding children.
- Whenever HIV arises in the context of a criminal case, police, lawyers, judges and where applicable, juries, must be informed by the best available scientific evidence concerning the benefits and consequences of appropriate therapy, and the individual and community advantages of maintaining such therapy.
- Guidelines should be developed to support law enforcement agents and the judiciary, to ensure that criminal sanctions are applied reasonably, where elements of

---

8 Given that there are also cases of rape amongst key populations and people living with disabilities, it is recommended that its scope should be strengthened to be gender-neutral and to apply to all domestic partnerships. It was also recommended that with the increasing statistics of abuse of children and those for GBV which is associated with HIV, sentences for perpetrators should be equally deterrent, since current sentences are at times too lenient (e.g. and not the current lenient sentences that are given such as community service) for sexual violence.

- foreseeability, intent, causality and consent are clearly and legally established, and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered;
- In the case of sexual offences, such as rape, that result in the transmission of HIV or creates a significant risk of HIV transmission (taking into account medical and scientific evidence regarding transmission), the HIV-positive status of the offender should only be considered an aggravating factor in sentencing if the offender knew he/she was HIV-positive at the time of committing the offence;
  - Counselling measures must be taken to encourage couples/partners to share information about their HIV status with each other in order for them to take informed action to prevent HIV transmission and protect each other from infection and reinfection, with due regard for the protection of vulnerable populations (such as women) in the process.

### LGBTI Populations, including Young Populations

- Strengthen anti-discrimination law to protect the rights of persons to equality and non-discrimination on the basis of sexual orientation and gender identity.
- Review provisions of the Criminal Law and Codification Act to decriminalise adult consensual same-sex sex.
- Ensure transgender people are able to have their affirmed gender recognised in identification documents and that official forms accommodate their gender identity.
- Provide access to effective HIV and health services and commodities for LGBTI populations.
- Establish 'safe corners' at health institutions to enhance confidentiality in accessing health care and to mitigate stigma and discrimination
- Provide access to comprehensive sexuality education that takes into account the issues of sexual orientation and gender identity, including for young LGBTI populations

- Stigma and discrimination reduction programmes, including with traditional authorities and faith-based organisations (FBOs), should be undertaken to reduce stigma, discrimination and violence against LGBTI populations.
- Law enforcement officials, especially the Victim Friendly Unit, should be trained on the rights of LGBTI populations, emphasising the principles of equality and non-discrimination and the right to equality before the law, and equal protection of the law.
- Health care practitioners should be trained on all LGBTI populations, their rights and health needs, to address stigma and discrimination, to increase understanding and to improve health care.
- Increase awareness of rights amongst LGBTI populations
- Promote effective measures to prevent and redress violence against LGBTI populations.

### Sex Workers

- Repeal laws that prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit commercial sex, such as laws against "immoral" earnings, "living off the earnings" of prostitution and brothel-keeping. Complementary legal measures must be taken to ensure safe working conditions to sex workers.
- Improve access to HIV-related health care services for sex workers, including through the training and sensitisation of health care providers in non-discrimination and protection of the health and other rights of sex workers, including young sex workers.
- Take all measures to stop police harassment and violence against sex workers
- Enforce the Court ruling protecting sex workers from unlawful arrest.
- Sensitise law enforcement officials to the rights of sex workers.

### People who Use Drugs

- Conduct further research on people who use drugs in Zimbabwe.

- Based on research, replace criminalisation and punishment of people who use drugs with evidence-based and rights-affirming interventions, including the promotion of referrals to rehabilitation programmes rather than the imposition of custodial services for persons convicted of possession for own use.
- Strengthen access to justice and law enforcement, including the strengthening of stigma and discrimination campaigns, law and human rights information on existing and new laws, education and training for all, including key populations and key service providers such as health workers, strengthening legal support services and mechanisms for enforcing HIV-related human rights complaints;

### Prisoners

- Ensure access to confidential voluntary counselling and testing, non-discrimination on the basis of HIV or TB status and access to prevention, treatment and care.<sup>9</sup>
- Accelerate the provision of integrated HIV and TB health care services treatment to prisoners
- Ensure access to prevention commodities, in accordance with international guidelines for HIV prevention in prisons, including drug treatment for people who use drugs, condoms, disinfectant for tattooing equipment, and safe needles and syringes and PMTCT should also be available for pregnant women in prison;
- Protect the rights of young prisoners, through the implementation of the UPR recommendations aimed at enhancing juvenile justice protection and through adherence to international standards such as the Mandela Rules, to enhance the rights of all prisoners in general and specifically juveniles.
- Allow for compassionate release of prisoners on the basis of health, such as HIV and TB.

- Integrating indicators specific to prisons into the national monitoring and evaluation system for HIV and/or to reinforce local capacity to do so;

### Employment

- Strengthen monitoring of the implementation of rights-based HIV workplace policies, developing the capacity of managers, supervisors, workplace peer educators and counsellors to provide accurate and adequate HIV information to their peers in the workplace, to protect workplace rights and to prohibit HIV-related discrimination, be it before or during employment;
- Train all health care workers and law enforcement officials receive comprehensive training on occupational health and safety measures
- Ensure that the necessary procedures are in place and equipment is accessible and available to enable health care workers and law enforcement officials to implement occupational health and safety measures, including universal precautions at all times;
- Ensure that post-exposure prophylaxis is available for all health care workers and other service providers, including law enforcement officials, who need it and ensure that procedures are in place for access to support and counselling and assistance outside working hours.
- Strengthen access to redress for violations of the rights to equality and non-discrimination within the working environment.

### Education and Information

- Review the Access to Information and Protection of Privacy Act and align it with the right to information provisions in the Constitution and also to ensure provision for the right of all people to information on HIV, AIDS, TB, and STIs, in accordance with Guiding Principle 39 of the National HIV

<sup>9</sup> UNODC, ILO, UNDP *Policy brief HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions* Available at [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/publication/wcms\\_187290.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_187290.pdf)

and AIDS Policy. Alternatively, this could be provided for in the Public Health Act or proposed Public Health Bill provisions and/or HIV and AIDS specific legislation which is recommended in this report.

- Develop a comprehensive sexuality education programme, including information on HIV, AIDS, TB education programme curriculum and ensure that it includes age-appropriate and gender-sensitive information about HIV and TB prevention, including safer sex, as well as information on stigma, discrimination and human rights and sexual orientation and gender identity.
- Provide resources for and establish systematic, visible HIV strategies within schools, so teachers are better guided on how to address HIV within schools.
- Develop community and media awareness and education campaigns on HIV, law and human rights programmes that also specifically target and include information on issues and laws relevant to all vulnerable key populations, including young key populations and on new, protective laws and policies.
- Ensure that tertiary institutions have continually updated HIV and TB policies and programmes, including access to prevention, treatment (including ART), care and support, to respond to the ever-changing nature of HIV and TB in the country and globally.

### Social Security and Social Insurance

- Fully implement section 30 of the Constitution and particular attention paid to people infected and affected by HIV and TB, vulnerable and key populations;
- Review and amend the Social Welfare Assistance Act with a view to making explicit provision for the needs of people living with HIV and TB as well as other vulnerable and key populations
- Mobilise resources to implement social protection programmes for vulnerable and key populations, including OVC, as provided for in the Zimbabwe National HIV and AIDS Strategic Plan 2015–2018.

### Access to Justice and Law Enforcement

- Strengthen stigma and discrimination reduction programmes to reduce stigma and discrimination against people living with HIV, TB, vulnerable and key populations, including young key populations;
- Strengthen access to legal support services for people living with HIV, key populations and young key populations at higher risk of HIV exposure through various possible measures including encouraging pro bono services by private lawyers and the Legal AID Directorate and strengthening access to national human rights institutions;
- Provide training on human rights in the context of HIV and vulnerable and key populations for law and policy makers as well as law enforcers, including work with the judiciary and law enforcement officials;
- Work with law enforcement personnel, and in particular the VFU, to improve the treatment of key populations, including young key populations who come into conflict with the law either as defendants or complainants;
- Criminalise rights violations by law enforcement personnel targeting key populations and young key populations. Appropriate steps must be taken to ensure that all law enforcement personnel perform their duties appropriately, with competency and in a non-discriminatory manner;
- Develop guidelines to support law enforcement agents and the judiciary to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered.

Part I:

# Introduction and Background

## Introduction to HIV, TB and Human Rights in Zimbabwe

Guaranteeing the rights of citizens is a key step towards attaining the Sustaining Development Goals (SDGs) for any country. It is also both a legal and moral responsibility of every government. Hence a human rights-based approach should be at the centre of health legal and policy formulation and the implementation of programmes for all people within the country.

People living with and affected by HIV are among those people whose rights should be guaranteed by the State, owing to their increased vulnerability as a result of their HIV and other related status. However, people living with HIV and TB, vulnerable and key populations, including young key populations are often stigmatised in society in a wide range of community contexts, including legal and structural, the family and immediate community, workplace, health services, religion and the media. Stigma enhances discrimination, violating fundamental human rights to fair and equal treatment and risking the health and development rights of these populations.

Thus, an efficient, effective and sustainable HIV, TB and health response system in any country requires full protection of fundamental human rights as a basic practice. This is only possible where a country has an enabling legal and policy environment for people living with and impacted by HIV and TB as well as vulnerable and key populations, including young key populations.

## HIV and TB as a Human Rights Issue

HIV and, increasingly also TB, are recognised as human rights issue for various reasons, including the following:

**Failure to safeguard human rights is associated with vulnerability to health risks:** For example, vulnerable, marginalised and criminalised populations who live with inequality, prejudice and limited access to basic services such as education, nutrition and health care are often at higher risk of exposure to and infection with HIV and TB and feel the impact of HIV, AIDS and TB, amongst other things, more severely.<sup>10</sup>

**People infected and affected by HIV and TB experience stigma and discrimination which leads to further marginalisation:** Once affected, people living with HIV and/or TB and those affected by HIV and/or TB are stigmatised, discriminated against and even denied access to services because of their health status. For example, people with HIV may have their confidentiality rights breached or treated in a discriminatory way by health care providers. People with TB may be subjected to arbitrary and harmful measures such as involuntary treatment, detention, isolation and incarceration. Stigma and discrimination can affect people's employment, housing, and access to social services.<sup>11</sup>

**HIV, AIDS and TB leads to further impact on human rights:** The impact of HIV, AIDS and TB on affected and key populations in turn leads to further violations of basic human rights<sup>12</sup> as families and communities struggle to cope with the various difficulties brought on by stigma, illness and death.<sup>13</sup> TB, for instance, contributes to poverty, for example, by preventing people from working and by imposing high costs related to treatment and care.<sup>14</sup>

10 Health and Human Rights Resource Guide: Centre for Health and human rights, Harvard, available at <https://www.hhrguide.org/2014/03/08/585/> [Accessed June 2018].

11 Health and Human Rights Resource Guide: Centre for Health and human rights, Harvard, available at <https://www.hhrguide.org/2014/03/08/585/> (accessed June 2018).

12 For example, children may lose the right to parental care as a result of parents dying from AIDS; this may also lead to further impoverishment and loss of rights such as the right to education. UNICEF. Enhanced Protection for Children Affected by AIDS. UNICEF, New York, 2007.

13 UNAIDS and OHCHR, International Guidelines on HIV/AIDS and Human Rights. UNAIDS, Geneva, 2006.

## TB and Human Rights in Africa

Statistics from the World Health Organization point to a decline in TB cases globally. However, poverty, inequalities and economic exclusion which impacts on a broad range of rights, especially access to quality health care services and malnutrition, expose populations in Africa to increased TB incidences with 95% of TB cases and deaths from TB occurring in developing countries, and 75% located in Africa.<sup>15</sup> Entwined with this is the impact of stigma and discrimination on access to health services, loss of personal freedom due to involuntary isolation and detention and arbitrary harmful involuntary treatments. For those in detention or correctional facilities, poor prison conditions, such as lack of hygiene, confined spaces, poor diet, exposure to HIV and poor health care facilities increases vulnerability to TB.

Protecting the rights of all its citizens and addressing HIV, TB and SRH is therefore both a legal and moral responsibility of every government.

## HIV and TB in Zimbabwe

According to the 2012 National Census Report for Zimbabwe, the country has a total population of 13,061,239 people.<sup>16</sup> The majority (67.2%) live in rural areas, while the remaining 32.8% reside in the urban areas. This is rapidly changing as rural-urban migration continues to increase, as people are in search of better livelihoods. The National Census Report also reveals that almost half of Zimbabwe's citizens, 47.8% are children.

HIV prevalence amongst young people aged 15-24 years is estimated at 5.31%.<sup>17</sup> The ZIMPHIA report revealed high HIV prevalence rates in Matabeleland provinces with the highest being 21.7% in Matabeleland South for people aged 15-64 years, followed by 19.5% for Matabeleland North.<sup>18</sup> This high prevalence rate has remained consistent over the years with the Ministry of Health and Childcare confirming in 2017 that the rate remains the highest in the country at 17, 6 % for Matabeleland North province, 14.3% for Bulawayo, Harare 12.8% and Mashonaland Central at 11.9%.

Table 1: Estimated number of people living with HIV<sup>19</sup>

	2012	2013	2014	2015
HIV Population Adults + Children	1,297,889	1,341,589	1,385,651	1,425,762
Adult Population Adults 15+	1,205,840	1,254,619	1,304,681	1,349,070
HIV Population (15-49)	1,039,358	1,074,829	1,109,925	1,138,787
HIV Population Female 15+	617,341	637,960	657,957	675,428
HIV Population (0-14)	92,049	86,971	80,970	76,692

14 Health and Human Rights Resource Guide: Centre for Health and human rights, Harvard, available at <https://www.hhrguide.org/2014/03/08/585/> [Accessed June 2018].

15 Ibid.

16 ZIMSTAT, Population Census National Report (2012).

17 UNAIDS, HIV and AIDS estimates (2015) available at [http://www.unaids.org/sites/default/files/media\\_asset/2016-prevention-gap-report\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf), [Accessed December 2016]. The Constitution of Zimbabwe defines 'youths' as people between the ages of 15 and 35 years.

18 Zimbabwe Population Based HIV Impact Assessment (ZIMPHIA) (2016). The study was however not conclusive in explaining the highest rates in Matabeleland though there was suggestion that a contributory factor could be the proximity to the busy border towns of Plumtree (entry and exit to Botswana) and to Beit bridge (entry to South Africa) which makes the population mobile.

19 Ibid. Zimbabwe National and Sub-national HIV and AIDS Estimates (2015).

From 1997 to 2014, adult HIV prevalence (15-49 years) has almost halved, from 26.5% to 14.3%, and new infections decreased by 50% among adults and 75% in children born from mothers living with HIV in the last decade.<sup>20</sup> The diagram below shows a summary of HIV statistics in Zimbabwe.

Despite this sharp decrease in new HIV infections and AIDS-related deaths in Zimbabwe, challenges remain. For purposes of this assessment, a priority challenge is that people living with HIV, vulnerable and key populations, including young key populations still face stigma and discrimination, including whilst accessing health services. Ongoing stigma, discrimination and human rights violations are recognised as some of the factors contributing towards high prevalence of HIV amongst key populations.<sup>21</sup> Unless stigma is addressed, discriminatory laws, policies and practices are reviewed and programmes to strengthen human rights protection are implemented, Zimbabwe will not reach the 90-90-90 vision of ending HIV by 2030.

Worldwide, 9.6 million people were estimated to have contracted TB in 2014 (5.4-million men, 3.2-million women and 1-million children) and 12% of these were HIV-positive.<sup>22</sup> Of the 22 countries designated by WHO as high TB burden countries, Zimbabwe ranks seventeenth, with an estimated TB incidence rate of 562 per 100,000 of the population.

The TB epidemic in Zimbabwe is fuelled by the severe parallel HIV pandemic, making TB the second leading cause of death in the country. The TB mortality rate (excluding HIV+TB) is 33/100,000, increasing four-fold among patients with both TB and HIV (132/100,000). Amongst people living with TB, 70% also have HIV.<sup>23</sup>

### Zimbabwe (2015)

1.4 million people living with HIV  
14.7% adult HIV prevalence  
64,000 new HIV infections  
29,000 AIDS-related deaths  
61% adults on antiretroviral treatment

Source: UNAIDS Gap Report 2016



## HIV, TB and Human Rights in Relation to Vulnerable and Key Populations, including Young Key Populations

### Women, including Young Women

An estimated 790,000 women in Zimbabwe are living with HIV.<sup>24</sup> Among young women, HIV prevalence is significantly higher than amongst their male peers. For example, in the 20-29-year age group, 20% of women are HIV-positive compared with 10% of men. Young women are infected with HIV earlier, although over a lifetime, men and women face a similar

20 Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2015–2018, p.22 and Zimbabwe National HIV and AIDS Estimates (2013).

21 UNAIDS, Prevention Gap Report (2016).

22 WHO, Global Tuberculosis Report (2015), 20th Edition (2014) available at [http://apps.who.int/iris/bitstream/10665/191102/1/9789241565059\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/191102/1/9789241565059_eng.pdf).

23 International Organisation for Migration (IOM), [http://www.stoptb.org/assets/documents/global/awards/tbreach/w4docs/International%20Organization%20for%20Migration%20\(IOM\),%20Zimbabwe.pdf](http://www.stoptb.org/assets/documents/global/awards/tbreach/w4docs/International%20Organization%20for%20Migration%20(IOM),%20Zimbabwe.pdf).

24 UNAIDS Report (2016), op cit.

level of risk.<sup>25</sup> HIV prevalence in the 15-24-year age group for women is 1.5 times higher than in men, indicating an epidemic prevalent in women.<sup>26</sup>

UNAIDS recognises that women are at increased of HIV due to biological factors, behavioural factors as well as structural factors, such as gender inequality, harmful gender norms and gender-based violence (GBV). These structural factors are dealt with in further detail in the report, below.

## Young Persons

Global data suggests that approximately 36% of new infections are amongst young people. At least 4.1% of young people aged 15-24 years are living with HIV.<sup>27</sup> Since only 45% of young male persons and 62% of young female persons have ever tested for HIV, prevalence among this group is likely to be significantly higher.<sup>28</sup>

The ZIMPHIA report notes that HIV prevalence rates amongst young women increase with age, with 2.7% of women aged 15-17 years living with HIV, increasing to 13.9% of women aged 23-24 years. The same report further notes that amongst young men, HIV prevalence holds steady at around 2.5% until the age of 23-24 years when it increases to 6%.<sup>29</sup>

In 2015, 17% of young women aged 15-19 years in Zimbabwe reported having had sex with a man 10 years older in the past 12 months. This culture can contribute to an elevated risk of HIV for young women. They are exposed to older men who may be more likely to have HIV, or who hold the power in the relationship, tipping the balance for negotiating for safe sex in favour of the older person and therefore increasing the risks of HIV exposure.

UNAIDS recognises that young people are at high risk of HIV exposure and are in danger of being “left behind” in national responses to HIV. This report considers some of the legal and policy issues that create barriers to access to comprehensive sexuality education and sexual and reproductive health services for young people, including young key populations, in Zimbabwe.

## People with Disabilities

In a baseline study in 2012, the UN noted HIV and disability as an emerging issue and cause for concern, as people with disabilities are at a higher risk of exposure to HIV infection due to various factors such as poverty, social exclusion, marginalization, vulnerability to abuse including sexual abuse and barriers in access to health care. For instance, the report noted that apart from being excluded from national HIV and AIDS programmes, people with disabilities also often face lack of confidentiality at voluntary counselling and testing centres due to the presence of an interpreter. The health delivery system has no policy or programme to equip caregivers with the skills and knowledge needed to effectively assist people with disabilities in HIV prevention.

The National Association of Societies for the Care of the Handicapped (NASCOH), estimates that almost 1.8 million people have disabilities.<sup>30</sup> People with disabilities feel that they are overlooked in national HIV prevention strategies, policies and programmes for various reasons, including because they are mistakenly perceived as not being sexually active.<sup>31</sup> The legal and policy barriers and human rights issues facing people with disabilities in Zimbabwe are discussed further, below.

25 Zimbabwe National HIV and AIDS Strategic Plan (ZNASP), Commitment towards fast tracking 90.90.90 targets by 2020 and ending AIDS by 2030 (2015).

26 UNAIDS Report (2016), op cit.

27 UNAIDS, The Gap Report (2014).

28 Zimbabwe National Statistics Agency, Zimbabwe Demographic and Health Survey 2015: Key Indicators.

29 Zimbabwe Population Based HIV Impact Assessment (2016).

30 HIV/AIDS Initiatives Side-lining People with Disabilities, 28 October 2013, available at <http://reliefweb.int/report/zimbabwe/hivaids-isnitiatives-sidelining-people-disabilities>, [Accessed December 2016].

31 Ibid.

## Lesbians, Gay Men and Men who have Sex with Men, Bisexuals, Transgender and Intersex (LGBTI) Populations

There is currently no official data on the population size and HIV and TB prevalence for LGBTI populations, possibly due to their criminalised position in law and their limited recognition in policies and plans. Gay men and men who have sex with men and transgender populations are at high risk of HIV exposure; human rights and gender-related barriers, such as stigma, discrimination, violence and the criminalisation of same-sex sex increase their vulnerability to HIV and create barriers to access to health care services. The legal, policy and human rights barriers in Zimbabwe in relation to LGBTI populations are explored in further detail in the LEA, below.

## Sex Workers

Sex workers and their clients account for approximately 12% of new HIV infections. More than 50% of sex workers in Zimbabwe are said to be living with HIV.<sup>32</sup> This is said to be due to various reasons including the high risk of HIV exposure as a result of sex work, stigma, discrimination and violence against sex workers, including within health care, the criminalisation of sex work and the inadequate access to quality health care services, including due to fear of arrest. The LEA examines these human rights and gender-related barriers in further detail, below.

## Prisoners

About 28% of prison inmates in Zimbabwe are living with HIV.<sup>33</sup> The prevalence rate for male prisoners is 26.8% and 39% for female prisoners.<sup>34</sup> The rise of HIV prevalence in prisons suggests that either most inmates are HIV-positive prior to their incarceration or certain behaviours in prison place them at high risk of HIV exposure, including sex between men.<sup>35</sup> This is a real human and health rights issue that requires objectivity and pragmatism by government, especially after they are released back in to society with the risk of exposing communities to HIV infections.

Inmates are at greater risk of developing TB than people in the general population due to their close, prolonged indoor confinement and other associated conditions common among inmates. According to the United States Agency for International Development (USAID), TB in correctional settings (e.g., jails, prisons, detention centres) remains a growing problem and there are approximately 10 million individuals who are detained worldwide.<sup>36</sup> In 2016, Zimbabwe commenced a TB assessment drive to assess and resolve management of TB in closed environments such as prisons. The Zimbabwe Prison Service recorded an estimated 300 deaths per year due to diseases, with TB being the biggest killer.<sup>37</sup> There are few drugs available for the treatment of TB and other diseases, and the overcrowded and unsanitary conditions promote the transmission of infection.

## National Responses to HIV and TB

After the first case of HIV was diagnosed in Zimbabwe in 1985, it was observed that HIV and AIDS rapidly spread among the population

32 ZDH Survey 2015, op cit. See also Zimbabwe National Statistics Agency, Zimbabwe Demographic and Health Survey 2010-11 (2012).

33 Health Minister Honourable Dr. David Parirenyatwa called for action as it emerged that HIV prevalence in Zimbabwe's crowded prisons has increased to 28%, with homosexual sex blamed for the rise. Available at <http://allafrica.com/stories/201508100903.html> <http://www.herald.co.zw/hiv-prevalence-in-prisons-alarms-health-minister/> [Accessed June 2018].

34 Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2015–2018, op cit.

35 Ibid.

36 Tuberculosis in Prisons: A growing public health challenge: United States Agency for International Development (USAID) available at <https://www.usaid.gov/sites/default/files/documents/1864/USAID-TB-Brochure.pdf> [Accessed June 2018].

37 Alexander, J "Death and Disease in Zimbabwe's Prisons" The Lancet Vol 373, March 21, 2009, Available at [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(09\)60592-4.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(09)60592-4.pdf) [Accessed June 2018].

into the early 90s. This was largely attributable to ignorance and slow behavior change, coupled with the unavailability of treatment at the time. At its peak in the late 90s, HIV prevalence was recorded to be about 30% of the population.<sup>38</sup> The link between HIV and TB has impacted negatively on efforts to address HIV, as many people who are HIV positive are vulnerable to contracting TB, leading to death. At least 242 new cases of TB are being registered per 100,000 people in Zimbabwe, with HIV being the major driver of TB, with an estimated 70% co-infection.<sup>39</sup> Matabeleland South Province, which has the highest HIV prevalence rate in the country, records the highest deaths from TB related illnesses. In 2016 alone, the province registered no less than 309 TB related cases with 96% of patients testing HIV positive during the same year.

The National AIDS Council (NAC) was established in 1999 to provide leadership on the management, coordination and implementation of programmes that reduce the impact of HIV and AIDS.<sup>40</sup> To fund the activities of NAC, the Government of Zimbabwe (GoZ) introduced the AIDS Levy, 3% deduction on taxable income, provided for in the National AIDS Council Act [Chapter 15:14]. Additional funding was provided by UNDP until December 2016, to support project implementation on strengthening the national response to HIV through addressing critical gaps in HIV prevention, treatment, care and support. Areas of focus included stigma, discrimination and human rights violations against people living with HIV and vulnerable and key populations, gender inequality, harmful gender norms and GBV and criminalisation of HIV transmission. This resulted in accelerated action and increasing

local and international investment in HIV prevention and treatment programmes.<sup>41</sup>

The GoZ declared HIV and AIDS a national emergency in 2003 under the Trade Related Aspects of Intellectual Property Rights (TRIPs) Agreement, thus opening up the possibility of benefiting from the Doha Declaration which allows governments to issue compulsory licences for the importation and production of less expensive generic drugs considered essential for public health.

There are increasing efforts to integrate the response to HIV and TB, with the government setting up a dedicated unit for a TB and HIV response in the Ministry of Health and Child welfare. The country's response is on course to end TB by 2030 in line with the UN SDGs.<sup>42</sup> The NAC has increased funding towards ending TB and at the same time is addressing issues of stigma and discrimination that may drive those testing positive for TB underground, creating barriers to their access to treatment and care.

Today, Government has a vision to ensure zero new infections, zero discrimination and zero AIDS-related deaths, leading towards ending AIDS by 2030. This can only be achieved if an enabling environment is created to ensure that every Zimbabwean, irrespective of health status, age, gender identity and sexual orientation, amongst other things, has access to information, treatment and care services.

---

38 UNICEF, Situational Analysis of Children and Women in Zimbabwe (2010).

39 Zim on course to end TB by 2030, <https://www.herald.co.zw/zim-on-course-to-end-tb-by-2030/> [Accessed June 2018].

40 The purpose of NAC is to co-ordinate the efforts of government ministries/departments, the private sector, non-governmental organisations, the churches, communities, community-base organisations, including support groups for people living with HIV and AIDS, the media, and international partners. NAC is also mandated to administer the National AIDS Trust Fund (NATF) collected through the AIDS Levy with the aim of combating the spread of HIV and the management, coordination and implementation of programmes that reduce the impact of HIV and AIDS. See also Guiding Principle 1 of the National HIV and AIDS Policy which says that HIV/AIDS should be addressed through a multi-sectoral approach, which will be co-ordinated by NAC.

41 NAC, 'Smart Investment to End HIV/AIDS in Zimbabwe based on Hotspot Analysis' (2015), <http://nac.org.zw/sites/default/files/Hot%20spot%20Mapping%20Report.pdf>.

42 The United Nations sustainable development goal number three targets a 90 percent reduction in TB deaths, an 80 percent reduction in TB incident rate and ensuring all TB affected families are no longer facing catastrophic costs when accessing TB treatment by 2030.

# Introduction to Legal Environmental Assessment (LEA) for HIV and TB

## Purpose and Scope of the LEA

This process will draw and build on the outcomes of the earlier LEA to identify and further examine all important legal and human rights issues affecting particularly people living with HIV, TB and vulnerable and key populations, including young key populations.

The focus will be on the following key affected populations;

- women;
- young people, including young key populations (below 18 years, taking into consideration issues of ethics and legalities surrounding research with young people);
- LGBTI populations;
- sex workers;
- prisoners;
- persons with disabilities; and
- people who inject drugs.

## Aims of the LEA

The LEA aims to identify and examine

- All important legal and human rights issues affecting people living with HIV and TB as well as key populations – women, young people, gay men and men who have sex with men, sex workers, prisoners, persons with disabilities and people who inject drugs – and including a specific focus on young key populations; and
- The extent to which the current legal framework protects rights and/or acts as a barrier to access to health and HIV-related services.

The findings of the national LEA are expected to build onto the findings and recommendations from the previous LEA, with a stronger

focus on young key populations, to add to recommendations and action planning on the review, development, implementation and enforcement of strengthened laws, regulations and policies, and measures for an effective national response to HIV and TB in accordance with the human rights standards set in the Constitution of Zimbabwe and other relevant laws, the National HIV and AIDS Strategic Plan (ZNASP) III 2015-2020, relevant health plans and applicable regional and international standards. Further, the outcomes are intended to provide concrete recommendations to improve access to justice and law enforcement for health and HIV-related rights.

## Specific Objectives

The specific objectives of the LEA are to:

- a. systematically analyse relevant international and regional agreements, laws, regulations as well as policies and practices, where relevant, to determine how they undermine or support an enabling environment for national responses to HIV and TB;
- b. identify and examine all important legal and human rights issues affecting particularly people living with HIV and TB, and those at higher risk of HIV exposure such as vulnerable and key populations, including young key populations – women, young people, gay men and men who have sex with men, sex workers, prisoners, persons with disabilities and people who inject drugs;
- c. analyse the extent to which affected populations know and are able to access their rights, and to assess whether service providers, lawmakers and law enforcers are sensitised to HIV-related law and human rights issues to enable effective implementation of services, access to justice and enforcement of HIV-related laws and rights;
- d. provide detailed recommendations for strengthening the legal and policy environment in Zimbabwe, to ensure a response which complies with international, regional and national human rights obligations, and which addresses key human rights issues in the context of HIV, including

the rights of all affected populations, promotes universal access, and balances public health and human rights imperatives.

## Key Deliverables

The key deliverables under the LEA are:

- a. detailed work plans for the major project activities including a desk review, key informant interviews (KIIs), Focus Group Discussions (FGDs) and public consultations;
- b. a preliminary analytical report on the desk review of the available documentation on selected laws, regulations and policies, detailing key HIV, law and human rights issues and the impact of the legal framework on the national HIV response in Zimbabwe;
- c. a preliminary analytical report on the findings of KIIs and FGDs, including the nature and extent of stigma and discrimination against affected populations, the extent to which affected populations know their rights and the extent to which service providers, lawmakers and law enforcers are sensitised to HIV-related law and human rights issues to enable effective implementation of services, access to justice and enforcement of HIV-related laws and rights;
- d. a comprehensive final draft report providing a synthesis of findings from the desk review, focus group discussions, and key informant interviews with overall recommendations on actions required to address the identified legal and regulatory issues, to enable effective implementation of services, access to justice and enforcement of HIV-related laws and rights.

## Technical Approach

The LEA was guided by a human rights-based approach to health, HIV, AIDS and TB using national, regional and international human rights commitments made by the GoZ as the starting point for framing the enquiry, designing the tools for analysis, analysing the findings and developing the recommendations. In the context of HIV and TB, this approach aims to promote the right to health and other related rights. The assessment examined

the legal, social, economic and/or cultural contexts which underlie the HIV epidemic in Zimbabwe, with the broader aim of recognising and responding to the underlying inequalities, prejudices and power relationships that impact upon HIV transmission and access to HIV and TB-related health care services.

The guiding principles of the rights-based approach to the LEA were those of equality, stigma and non-discrimination; participation and inclusion of rights-holders; and capacity building of duty-bearers and accountability. The LEA recognised the indivisibility and interrelationship between all human rights, including health and equality rights, and sought to balance public health and human rights goals in developing the rights of all people.

## Research Methodology

The LEA was carried out using the various methodologies set out below:

### Desk Literature Review

The LEA included a desk review of all relevant documentation relating to health and HIV, laws, policies, programmes and human rights issues at national level, as well as regional and international levels in order to determine the scope and content of laws, regulations and policies, as well as issues around how laws are implemented and enforced.

Documents reviewed include:

- relevant international and regional human rights instruments as well as regional and international health and HIV-specific standards and guidance documents;
- relevant national laws, regulations, guidelines, policies and plans;
- case law;
- annual reports, research reports and other documents of CSOs working with health, HIV, people living with HIV and TB and key populations, reports of government ministries, independent commissions (such as the Zimbabwe Human Rights Commission), regional and international organisations, and academic publications; and

- other country reports from Southern Africa, such as Malawi, Lesotho and Zambia.

The desk review aimed to determine the nature, extent, efficacy and impact of the legal and regulatory framework (including laws, regulations, policies, as well as access to justice and law enforcement issues) for protecting rights and promoting universal access to HIV prevention, treatment, care and support. It furthermore identified additional key HIV, law and human rights issues of concern for further exploration during KIIs and FGDs. Key responses from the KIIs and FGDs helped to shape the recommendations for law and policy review and reform, as well as efforts to strengthen access to justice and law enforcement.

### Key Informant Interviews

The KIIs provided qualitative information on key HIV, law and human rights issues in Zimbabwe, the impact of the legal and regulatory framework upon the response to HIV and AIDS, as well as recommendations for strengthening the legal and regulatory framework to protect rights and to promote access to services in the context of HIV, AIDS and TB.

Key informants were selected from across a range of sectors such as government, civil society and the private sector. They included relevant government officials from key ministries such as the MoJLPA, MOHCC, NAC, Zimbabwe Republic Police (ZRP), Zimbabwe Prisons and Correctional Service (ZPCS), relevant Parliamentary Portfolio Committees on (such as Gender, Health, and HIV) and the Zimbabwe Human Rights Commission (ZHRC). Key informants also included representatives of CSOs working with and for people living with HIV and other affected populations, FBOs as well as development partners working on health, HIV and related issues and UN agencies.

### Focus Group Discussions (FGDs)

FGDs were used to obtain qualitative data from selected key populations on their

experiences of stigma, discrimination and human rights violations in the context of HIV, AIDS and TB; how laws, policies and practices impact upon rights and the ability to access services in the context of HIV; and whether affected populations are able to access justice and enforce rights. Focus groups included people living with HIV as well as populations vulnerable to and at higher risk of HIV exposure such as prisoners, people with disabilities, young people, and LGBTI populations. The views and experiences of rights holders are critical to inform specific areas of laws, policies and practices that will need to be addressed. As regards young people, FGDs were conducted with young people between 18 years and 35 years. Inclusion of young people below 18 years was not possible due to legal and ethical considerations. Annexure 3 outlines the list of FGDs conducted.

### Limitations of the LEA

The following were the limitations of the LEA:

- limited availability of existing research on the nature and extent of HIV and, in particular, TB-related stigma and discrimination against key populations, including young key populations;
- limited 'visibility' of people living with HIV and key populations, including young key populations.
- ethical constraints on conducting research with young people below the age of 18 years. This notwithstanding, some young people aged 13 to 18 years were accessed from among the young key populations engaged. Additionally, the young key populations who participated had often transitioned from organisations caring for children aged 8 years and up living with HIV and were therefore able to provide useful insights on sexual reproductive health, stigma, discrimination and treatment, care and support, based on earlier experiences.<sup>43</sup>

<sup>43</sup> The youths used to belong to organisations such as 'Zvandiri' and 'Shaping Health of an Adolescent' and were also interviewed in 2018.

- fears of confidentiality breaches and of HIV-related stigma and discrimination amongst affected populations;
- delays caused by the events following the political transition of November 2017;
- time constraints impacting on the ability to carry out some of the targeted KIs, especially with Government Ministries, who were not interviewed to supply additional statistical information. However, alternative relevant information was obtained from informal consultations and official websites.

The assessment does not purport to provide definitive quantitative evidence of stigmatising and discriminatory practices, but rather seeks to provide qualitative evidence, to give voice to some of the experiences related by affected populations, for purposes of law, policy and practice review.

## The LEA Report

This LEA report reflects the outcome of the process, combining the findings of the desk review, the perspectives of key informants and populations participating within FGDs as well as the comments and feedback provided by key stakeholders throughout the assessment. It consists of five parts.

Part I provides a background to the LEA.

Part II sets out the human rights standards at international and regional level and the nature of State obligations, including limitations with regard to enjoyment of rights. It also deals with the human rights-based response to HIV, AIDS and TB.

Part III reviews the application of human rights standards to HIV and AIDS interventions in Zimbabwe, in terms of key human rights standards enshrined in relevant regional and international instruments and national law such as the rights to health, equality and non-discrimination, work, access justice, information, and education, amongst others.

It also identifies the gaps and challenges to achieving and proposes recommendations to create an enabling environment to realise the 90-90-90 vision of ending AIDS by 2030.<sup>44</sup>

Part IV details the current mechanisms in place relating to access to justice and law enforcement in Zimbabwe, whilst providing an insight on what is currently accessible to key populations and vulnerable populations. It makes recommendations on how to strengthen the system.

Part V deals with LEA conclusions and recommendations.

---

44 UNAIDS new narrative on HIV treatment- By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.



Part II:

# International, Regional and National Human Rights Framework

This Part examines the international, regional and national human rights framework which should inform and govern the national response to HIV in Zimbabwe.

## What is a Human Rights-based Response to HIV and TB?

The obligations of States to respect, protect, fulfil and promote human rights arise from the regional and international human rights treaties to which they are a party to, as well as from national law. States have the duty, regardless of their political, social, economic and cultural systems, to promote and protect all human rights based on the principles of equality and non-discrimination. These obligations apply to Zimbabwe, not only as a member of the regional and international communities, notably the African Union (AU) and the UN, but as a party to a number of the key human rights treaties within the AU and UN human rights systems, as will be discussed below.

A number of the regional and international human rights treaties as well as some non-treaty human rights instruments provide for health rights and other rights that are relevant to the context of HIV and AIDS and the national response to the epidemic.

The Global Fund partnerships and support is grounded in this rights-based approach to end HIV, TB (and Malaria). This is based on a recognition of the inextricable connection and synergies in the promotion and protection of all human rights, as rights are mutually supportive. Violation of one group of rights, for instance, the right to access quality health, has a direct impact on a number of civil and political rights such as the right to life, privacy and equality of all before the law. The Global Fund acknowledges the rights-related barriers and conditions that further aggravate the negative impacts of HIV and TB on vulnerable

### Relevant rights include:

The rights to dignity, life, equality and non-discrimination; the highest attainable standard of mental and physical health; equality before the law and equal protection of the law; social welfare including social security, food, water and sanitation; to freely receive and impart information; to marry and found a family; to work and to work in just and favorable conditions; to attain an adequate standard of living, and to share and benefit from scientific advancement and its benefits.

and key populations in communities. As regards TB, in addition to the programmes promoted for HIV, which also benefit those living with TB, there is a need (and focus) on ensuring confidentiality and privacy, mobilising and empowering patient and community groups, addressing policies regarding involuntary isolation or detention for failure to adhere to TB treatment, and efforts to remove barriers to TB services in prisons.<sup>45</sup>

Where individuals and communities are able to enjoy and realise their rights, this can help in enhancing, among other things, access to health care and in reducing the impact of HIV. The GCHL has found that there are instances where legal and justice systems have played constructive roles in responding to HIV, by respecting, protecting and fulfilling human rights. Compelling evidence shows that it is the way to reduce vulnerability to, and to mitigate the impact of HIV. Good laws can widen access to prevention and health care services, improve the quality of treatment, and enhance social support for the infected and affected. Effective legal aid can make justice and equality a reality for people living with HIV and thus create better health outcomes. Court actions can also help to ensure that human rights are enforced and that aggrieved persons have a remedy.<sup>46</sup>

<sup>45</sup> Global Fund: Human Rights- available at <https://www.theglobalfund.org/en/human-rights/> [Accessed June 2018].

<sup>46</sup> Global Commission on HIV and the Law, Risks, Rights and Health (2012).

Table: Some examples of rights violations<sup>47</sup>

Rights	Examples of violations
Right to equality and non-discrimination	An HIV-positive person dismissed from work simply because of HIV status; a gay man denied access to sexual health services because of his sexual orientation.
Freedom from inhuman and degrading treatment	LGBTI people exposed to degrading treatment when accessing health care for STIs or interacting with law enforcement officers.
Right to life	People living with HIV are denied access to ART; LGBTI populations indirectly denied access to health care due to stigmatisation and discrimination. Other vulnerable groups such as prisoners (serving and those awaiting trial) are exposed to unhygienic and overcrowded conditions that increases exposure to communicable illnesses such as TB and early death with situation exacerbated if one is HIV positive.
Rights to dignity and privacy	People living with HIV categorised when accessing health services in a way that indirectly discloses their HIV status to the public. <sup>48</sup>
Right to health	Lack of access to quality health care services to persons living with HIV or a vulnerable or key population on various grounds e.g. a young person is denied access to health care on the basis of his/her age; prevention services not available to persons with disabilities because of the assumption that they are not sexually active. Other vulnerable groups such as people detained in prison facilities receive insufficient medical attention and treatment.
Right to work and to just and favorable conditions of work	Dismissal or denial of promotion or other job opportunities due to employee's HIV status; failure to employ a prospective employee solely due to HIV, TB status and sexual orientation.

A human rights-based response to HIV is, therefore, based on the obligations of the State with regards to human rights protection, promoting the health and dignity of all people without discrimination and ensuring that violations such as those listed in the Table above do not occur, and where they occur, that victims have access to an adequate remedy.<sup>49</sup>

## Application of International and Regional Human Rights in Zimbabwe

When States ratify or accede to human rights treaties, they assume legal obligations to implement the provisions of the treaties at the national level. These obligations entail respecting, protecting and fulfilling the human

47 These forms of violations were informed by responses from KIIs and FGDs.

48 E.g. green books given to people living with HIV or name calling at clinics (those for \$1 services or "my class", etc). This came from some of the FGDs e.g. with the women's group in Mutare, May 2018.

49 Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, International Guidelines on HIV/AIDS and Human Rights (2006).

rights enshrined in the treaties. States are also expected to promote human rights.

The obligation to respect human rights means that the State, its institutions and its agents must not violate human rights. The obligation to protect human rights requires the State to protect individuals or groups from abuse of their rights by private persons<sup>50</sup> while the obligation to fulfil human rights requires the State to undertake positive measures to achieve the full realisation of human rights e.g. by enacting appropriate laws, implementing budgets or strengthening the functioning of law enforcement, judicial and administrative bodies for the purpose of monitoring and enforcing human rights (remedies). States therefore have both positive and negative human rights obligations. It is in this context that the laws, policies, programmes, plans and practices in Zimbabwe will be assessed in relation to HIV and AIDS interventions and access to health care and related services, and the treatment of people living with HIV, TB and other key populations in this regard.

With the exception of first and last two listed instruments, which are not treaties and therefore not requiring ratification, Zimbabwe is party to these treaties.

The International Guidelines on HIV/AIDS and Human Rights, published by the OHCHR and UNAIDS in 1996 as a tool for all States in designing, coordinating and implementing effective national HIV policies and strategies, provide guidance to States on how human rights standards apply in the context of HIV and can be translated into practical measures that should be undertaken at the national level, based on the following three broad approaches:

- Improving government capacity for multi-sectorial coordination and accountability;

## International and Regional Standards

The LEA reviewed the following regional and international instruments:

- Universal Declaration on Human Rights (UDHR), 1948;
- Convention on the Rights of the Child (CRC), 1989;
- International Covenant on Civil and Political Rights (ICCPR), 1966;
- Convention on All Forms of Discrimination against Women (CEDAW), 1979;
- International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966;
- Convention on the Rights of people with Disabilities (CRPD), 2006;
- African Charter on Human and Peoples' Rights (ACHPR), 1981;
- Protocol to the ACHPR on the Human Rights of Women in African, 2003;
- African Charter on the Rights and Welfare of the Child (ACRWC), 1990;
- UN General Assembly Political Declaration on HIV and AIDS, 2016: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030;
- Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS: International Guidelines on HIV/AIDS and Human Rights, 1996.

50 The African Commission on Human and Peoples' Rights, *Zimbabwe Human Rights NGO Forum v Zimbabwe*, Comm. 245/2002, stated at paragraph 143 that: "Human rights standards do not contain merely limitations on State's authority or organs of State. They also impose positive obligations on States to prevent and sanction private violations of human rights. Indeed, human rights law imposes obligations on States to protect citizens or individuals under their jurisdiction from the harmful acts of others. Thus, an act by a private individual and therefore not directly imputable to a State can generate responsibility of the State, not because of the act itself, but because of the lack of due diligence to prevent the violation or for not taking the necessary steps to provide the victims with reparation. available at <http://caselawihirda.org/doc/245.02/pdf> [Accessed June 2018].

- Reforming laws and legal support services, with a focus on non-discrimination, protection of public health, and improvement of the status of women, children and marginalised groups; and
- Supporting and increasing private sector and community participation to respond ethically and effectively to HIV and AIDS.

In 2016, the UN General Assembly issued a Political Declaration on HIV and AIDS: *On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030*. The Declaration reaffirms the 2001 and 2006 Political Declarations on HIV and AIDS and the urgent need to scale up efforts towards the goal of universal access to comprehensive prevention programmes, treatment, care and support. The Declaration also reaffirms the ICESCR, CRC, CEDAW and CRPD amongst other instruments. It emphasises the importance of implementing the 2015 WHO guidelines and recommends that ART be available to everyone living with HIV at any CD4 cell count, that a more integrated and systemic approach to addressing people's access to quality health care is offered, that health care is of the highest attainable standard regarding physical and mental health and well-being, and that there is universal access to sexual and reproductive rights.<sup>51</sup>

The international and regional frameworks also recognise the rights of vulnerable populations such as children, women and people with disabilities.

## Children and Young People

The CRC and the African Charter on the Rights and Welfare of the Child provide for special protection that includes equality and non-discrimination, life, survival and consideration of the best interests of the child in all actions concerning the child (defined as persons below the age of 18 years).

More specifically in relation to health, HIV and related matters, access to justice and the administration of justice, the two treaties provide for the following:

- Protection from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment, or exploitation, including sexual abuse. In this regard States parties are obliged to take all appropriate legislative, administrative, social and educational measures;<sup>52</sup>
- Special protection for children with disabilities so that they enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate their active participation in the community. Assistance includes access to health care services, which shall be provided free of charge whenever possible in deserving cases;<sup>53</sup>
- The right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States parties have an obligation to strive to ensure that no child shall be deprived of his/her right to such health care services;<sup>54</sup>
- Protection of the child from all forms of sexual exploitation and sexual abuse. States parties shall take measures to prevent, inter alia, the exploitative use of children in prostitution or other unlawful sexual practices;<sup>55</sup> and
- Provision for juvenile justice guidelines and safeguards.<sup>56</sup>

General Comment No.3 of the CRC includes specific and detailed guidance on the rights of the child in the context of HIV and AIDS. Paragraph 2(5) recognises the vulnerability of children to stigma and discrimination based either on their status or that of their parents.

The best interests of the child should always be a primary consideration in relation to HIV

51 [www.unaids.org/sites/default/files/.../2016-political-declaration-HIV-AIDS\\_en.pdf](http://www.unaids.org/sites/default/files/.../2016-political-declaration-HIV-AIDS_en.pdf).

52 Art.19 of CRC; art.16 of ACRWC.

53 Art.23 of CRC; art.13 of ACRWC.

54 Art.24 of CRC; art.14 of ACRWC.

55 Art.34 of CRC; art.27 of ACRWC.

56 Art.40 of CRC; art.17 of ACRWC.

and AIDS interventions or responses. The child should be put at the centre of the response to the pandemic, adapting strategies to children's rights and needs. The same should apply to young persons who are no longer children.

## Women

CEDAW calls on States Parties to eliminate all forms of discrimination against women in all spheres of life. It protects a wide range of women's rights including women's health rights. In terms of article 12 of the Convention, States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure access to health care services, including those related to family planning.

Article 14 of CEDAW requires States Parties to pay particular attention to the specific problems faced by women in rural areas, and this includes ensuring their access to adequate health care facilities, including information, counselling and services in family planning, and to benefit from social security programmes.

In terms of article 6 of CEDAW, States Parties shall take all appropriate measures to suppress of all forms of trafficking in women and sexual exploitation of women.

At regional level, the Protocol to the ACHPR Charter on the Rights of Women in Africa (the African Women's Protocol) also protects women's rights. Like CEDAW, the Protocol obligates States Parties to combat all forms of discrimination against women through appropriate legislative, institutional and other measures (art.2). Women have the right to dignity and to the recognition and protection of their human and legal rights. States Parties must adopt and implement appropriate measures to prohibit any exploitation or degradation of women, and to ensure the protection of every woman's right to respect for her dignity and protection of women from all forms of violence, particularly sexual and verbal violence (art.3).

Other pertinent rights and protection accorded to women include:

- The right of every woman to respect for her life and the integrity and security of her person, and prohibition of all forms of exploitation, cruel, inhuman, or degrading punishment and treatment. Programmes need to be implemented, mechanisms established, and there need to be accessible services for effective information, rehabilitation and reparation for victims of violence against women and provide adequate budgetary and other resources for the implementation and monitoring of actions aimed at preventing and eradicating violence against women (art.4);
- Access to justice and equal protection and benefit of the law. States Parties shall take all appropriate measures to ensure, inter alia, effective access by women to judicial and legal services, including legal aid, the establishment of adequate educational and other appropriate structures with particular attention to women, and to sensitise everyone to the rights of women, and to ensure that law enforcement organs at all levels are equipped to effectively interpret and enforce gender equality rights (art.8);
- Health and reproductive rights – the right to health of women, including SRH, shall be respected and promoted. This includes the right to self-protection and to be protected against STIs, including HIV and the right to be informed of one's health status and the health status of one's partner, in accordance with internationally recognised standards and best practices. Women also have the right to have family planning education, and adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas (art.14);
- Special protection of women with disabilities, including the right of women with disabilities to freedom from violence, including sexual abuse, discrimination based on disability and the right to be treated with dignity (art.23).

CEDAW has specifically recommended that HIV responses should give special attention to the health rights of women and children, and to factors relating to the reproductive

role of women and their subordinate position in society, which makes them especially vulnerable to HIV infection. Governments are also called upon to intensify efforts in disseminating information to increase public awareness of the risk of HIV infection, especially in women and children, and of its effect on them.<sup>57</sup>

The ICCPR and the ACHPR to a large extent reflect the civil rights that are protected in the UDHR, as listed above. For example, they make provision for the rights to non-discrimination, equality before the law and equal protection of the law, to seek a remedy for violation of one's rights, privacy and protection of the family, including the right to found a family. According to the Human Rights Committee, protection of the family includes freedom from arbitrary or unlawful interference while the right to found a family and implies, in principle, the possibility to procreate, and that family planning policies should not be discriminatory or compulsory.<sup>58</sup> Forced or coerced sterilisation on account of HIV status would be inconsistent with international standards. The OHCHR, UN Women, UNAIDS, UNDP, UN Population Fund (UNPFA), UNICEF and WHO call on health care providers to be non-coercive and respectful of autonomy and, privacy and not to restrict reproductive freedom as part of a family planning, HIV prevention or other public health agendas.<sup>59</sup>

## Persons with Disabilities

The Convention on the Rights of Persons with Disabilities (CRPD) provides extensive protection for the rights of people with disabilities and encourages States Parties to take positive steps to protect the equality and health rights of people with disabilities.

These protections are also offered in African instruments such as the Protocol to the ACHPR on the Rights of Women in Africa and the ACRWC and CRC, with particular focus on women with disabilities and children with disabilities respectively, as already discussed above.

## Other Relevant Instruments

At the sub-regional level, the Southern African Development Community Parliamentary Forum (SADC PF) in 2008 developed the Model Law on HIV and AIDS in Southern Africa to guide SADC Member States in developing laws and policies on HIV and AIDS that are consistent with international human rights standards.<sup>60</sup> Its key objectives are highlighted in the table below.

**Table: Key objectives of the SADC Model Law of HIV and AIDS**

Examples of violations
Provide a legal framework for the review and reform of national legislation related to HIV in conformity with international human rights law standards;
Promote the implementation of effective prevention, treatment, care and research strategies and programmes on HIV and AIDS;
Ensure that the human rights of those vulnerable to HIV and people living with or affected by HIV are respected, protected and realised in the response to AIDS; and
Stimulate the adoption of specific measures at national level to address the needs of groups that are vulnerable or marginalised in the context of the AIDS epidemic.

57 Committee on the Elimination of Discrimination against Women, General Recommendation 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of AIDS, UN Document CEDAW, A/45/38, 2 February 1990, [www.un.org/womenwatch/daw/cedaw/recommendations/index.html](http://www.un.org/womenwatch/daw/cedaw/recommendations/index.html).

58 Human Rights Committee, General Comment No.19, Article 23 (Thirty-ninth session, 1990), para.1.

59 See OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO, Eliminating forced, coercive and otherwise involuntary sterilisation, an interagency statement, (2014), p.4, [http://www.unaids.org/sites/default/files/media\\_asset/201405\\_sterilization\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/201405_sterilization_en.pdf). See also <http://www.southernafricalitigationcentre.org/2015/04/24/submission-to-the-human-rights-committee-regarding-the-forced-and-coerced-sterilisation-of-women-living-with-hiv-aids-in-namibia-submitted-in-advance-of-the-consideration-of-the-list-of-issues-for-na/> [Accessed December 2016].

60 Note that the Model legislation not legally binding but merely soft law. They, however, are important insofar as they provide guidance to States on how to bring the laws in line with international standards.

The Model Law prohibits both direct and indirect discrimination, and discrimination based on actual or perceived HIV status. It includes non-discrimination provisions related to specific categories of people living with HIV – namely women, children, prisoners and key populations such as sex workers, people who inject drugs, gay men and men who have sex with men and transgender persons. With respect to key populations, the Model Law further provides for specific services that include access to HIV-related information and education *that* “address misinformation about members of vulnerable groups and devise appropriate messages and strategies targeting members of vulnerable groups”. It guarantees access to HIV-related treatment and care for all and calls for the decriminalisation of sex work and consensual sexual relationships between adult persons of the same sex as specific measures that may enhance HIV prevention.<sup>61</sup>

Furthermore, the Model Law provides for non-discrimination in areas such as education, employment, insurance and social security. The Model Law also guarantees the protection of the right to privacy and confidentiality of people living with HIV. In order to ensure the respect of these rights in the context of partner notification, the Model Law provides for strict conditions governing partner notification, which integrates the recommendations of the UNAIDS International Guidelines. It protects the right to access to HIV-related information, and also guarantees the right to access to treatment for all, especially for children and prisoners.

Other key provisions of the Model Law include article 19, which provides that people living with HIV or affected by HIV are entitled to all sexual and reproductive health rights. They shall have the right to a family, including the right to marry and procreate. Their HIV status alone shall not constitute a valid reason to oppose their marriage. It also recognises that women living with HIV have the right to

motherhood and to benefit from all measures implemented by the State within the context of reproductive health.

At regional level, the African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa was adopted in 2012 to provide guidance to Member States on developing laws, policies and guidelines on HIV and AIDS.<sup>62</sup> With the adoption of the SDGs to replace the Millennium Development Goals (MDGs), new commitments were made. The AU Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030 was developed with the objective of intensifying the implementation of the Abuja +12 commitments by building Africa-wide consensus on the key strategic actions within the context of the existing targets and milestones.<sup>63</sup> Its goals are aligned with the goals and targets set by the SDGs<sup>64</sup> and the AU Agenda 2063. Human rights and gender equality are a central principle to the Catalytic Framework.

## National Human Rights Standards and Key Human Rights in the Context of HIV and TB

Zimbabwe’s Constitution includes various human rights important in the context of HIV, TB and for protecting the rights of vulnerable and key populations. Some of the most important of these are set out below:

### Section 56: Equality and Non-Discrimination

Subsection (1): This right entails among other things the right to equal protection and benefit of the law. Persons who are living with HIV and who are affected or impacted by HIV and AIDS have the right to equal treatment as any other person in the country. They are also entitled

61 [sadcpc.org/index.php?option=com\\_docman&task=doc\\_download&gid](http://sadcpc.org/index.php?option=com_docman&task=doc_download&gid).

62 [http://www.unaids.org/sites/default/files/media\\_asset/JC2447\\_SharedResponsibilityPost2015\\_en\\_0.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2447_SharedResponsibilityPost2015_en_0.pdf), (15/12/2016).

63 [https://au.int/sites/default/files/newsevents/workingdocuments/27513-wd-sa16949\\_e\\_catalytic\\_framework.pdf](https://au.int/sites/default/files/newsevents/workingdocuments/27513-wd-sa16949_e_catalytic_framework.pdf) [Accessed June 2018].

64 UNGASS, Transforming our World: the 2030 Agenda for Sustainable Development: Resolution, 25 September 2015 A/RES/70/1.

to equal protection before the law. Therefore, law enforcement and judicial officials must treat them with equal treatment as any other citizen. For those under arrest or in prisons/ or correctional facilities, government must comply with regulations that ensure access to medication, treatment, care, counselling and related services.

Subsections (3): although section 56 mentions specific grounds of discrimination, it does not include HIV status. However, the list is not exhaustive and can be taken to include protection from discrimination on grounds of health status. Therefore, persons living with HIV should not be subjected either directly or indirectly to a condition, restriction, or disability to which other people are not subjected. Neither should other people be accorded either directly nor indirectly a privilege or advantage which persons living with HIV are not accorded.

### Section 76: Right to Health Care

Section 76 (1): Every citizen and every permanent resident has the right to access to basic health care services including reproductive health care services.

Section 76 (2): While people living with HIV and AIDS are accorded the right to access basic health care services in the broad general provision that is applicable to every citizen, they are further specifically protected under Subsection 76 (2) which provides access to basic health care services for people with chronic illness.

### Section 57: Right to Privacy

This includes the right not to have one's health condition not to be disclosed. In the case of persons living with HIV, Section 57 protects them from being forced to disclose either directly or indirectly their HIV status.

### Section 62: Access to Information

Section 62(2) provides for the right of every person (including the media) to information held by any person including the State, in so

far as that information is required for the exercise or protection of a right. This accords people living with HIV and vulnerable and key populations the right to access relevant information regarding protection, treatment, care, reproductive health and related matters.

### Section 65: Labour Rights

Section 65 (1) provides for the right to fair and safe labour practices and standards, and section 65 (4) ensures just, equitable and satisfactory conditions of work. Therefore, employees living with HIV and AIDS, as well as other vulnerable and key populations, have the right to fair and safe labour standards and to be treated equitably and in a justice manner notwithstanding their HIV status.

### Section 85: Enforcement of Fundamental Human Rights and Freedoms

This provision seeks to enhance enforcement and enjoyment of the rights as outlined by according legal opportunity for any person including those living with HIV or impacted and affected by HIV, as well as vulnerable and key populations, to approach/access the courts in cases where they are of the view that any of their rights are being infringed or are likely to be infringed. This is for the court to provide appropriate relief including a declaration of the rights and where applicable an award for compensation.

Zimbabwe has a dualist legal system, this means that treaties that are concluded, ratified or acceded to by the GoZ have no automatic application in its national legal system. They would require domestication first. In terms of Section 327 of the Constitution of Zimbabwe, an international treaty which has been concluded or executed by the President or under the President's authority does not bind Zimbabwe until it has been approved by Parliament and does not form part of the law of Zimbabwe unless it has been incorporated into the law through an Act of Parliament.

It is therefore necessary to evaluate the extent to which the international standards relevant to HIV and AIDS responses have been made

part of the law of Zimbabwe, are reflected in policies, plans and/or programmes, and are implemented in practice.

The human rights obligations assumed by Zimbabwe at the regional and international levels relevant to HIV and AIDS have largely been domesticated in the Declaration of Rights in the Constitution of Zimbabwe as well as in other laws, policies, programmes and plans, for example:

- National AIDS Council of Zimbabwe Act [Chapter 15:14];
- Criminal Law (Codification and Reform) Act [Chapter 9:23];
- National HIV and AIDS Policy, 1999;
- Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III 2015-2020);
- ZIMASSET (2013-2018);
- The National Health Strategy for Zimbabwe (2016–2020);
- Labour (HIV and AIDS) Regulations, 2014 (Statutory Instrument 105 Of 2014);
- Public Health Act [Chapter 15:09];
- National HIV and AIDS Council 2015-2018 Strategic Plan.

Shortcomings in these laws, policies, programmes and plans have the potential to negatively impact on HIV and TB responses and be a barrier to access to HIV-related services.

## National Progress in Implementation of Human Rights within the Context of HIV and TB Legislation and the National HIV and TB Response

Zimbabwe is at various stages of implementing the provisions in international treaties, aligning national legislation where required, for compliance and translation into reality for the intended beneficiaries. Recommendations from the Human Rights Council adopted for Zimbabwe for domestication of the various international treaties and protocols are outlined in the National Plan of Action for the Implementation of the UPR Recommendations (2017-2020). The plan of action is the outcome of collective efforts and contributions of the GoZ, government ministries and departments, UN Agencies and rights-based CSOs in the country under the umbrella of the National Association of Non-Governmental Organisations (NANGO). All parties have specific areas for which to oversee and support implementation, with the Ministry of Justice, Legal and Parliamentary Affairs taking the lead coordination role. This roadmap will tie in and build onto the targeted advocacy under the Engagement Scan which is part of this research.

Some relevant recommendations include:<sup>65</sup>

- Domesticate and implement all human rights treaties especially repealing of legislation such as the Public Order and Security Alert (POSA) and Private Voluntary Organisation Act (PVOA) which pose considerable restrictions on human rights defenders;

<sup>65</sup> This has been selected from the National Plan of Action for Implementation of UPR Recommendations (2017-2020) and is not exhaustive; the comprehensive list is available at the website of the Ministry of Justice, Legal and Parliamentary Affairs.

- Encourage GoZ to align laws with international human rights standards
- Align domestic legislation with the obligations under the CRPD to enhance the rights of people with disabilities; fully implement CEDAW;
- Amend all statutory and customary law to establish the minimum age of marriage at 18 years and take concrete steps to implement this legislation, in line with the CRC;
- Continue efforts to align training programmes and awareness-raising for all government officials with international human rights law and incorporate more training in child rights in professional development courses;
- Align the Criminal Law (Codification and Reform) Act to the Constitution; Step up efforts to improve detention conditions in prisons and in police holding cells, and to decongest prisons;
- Provide adequate assistance and protection to women who are victims of sexual and GBV, including access to social and legal support;
- Continue to implement Assisted Medical Treatment Orders;
- Provide safety nets for affected vulnerable groups and implement the National Social Protection Policy;
- Sensitise traditional leaders on children's rights and especially on dangers of early child marriages;
- Continue to implement strategies and programmes to reduce malaria incidence; reduce mortality, morbidity and transmission of TB; prevent new HIV infections and reduce deaths due to HIV;
- Continue to take further measures to enhance health care services especially for women and children;

- Upgrade primary and secondary health care infrastructure and increase budgetary allocation to Ministry of Health and Child Care in line with regional and international obligations;
- Encourage gender-responsive budget allocation;
- WHO to continue monitor key reproductive, maternal, child and adolescent health and nutrition trends;
- Support national efforts towards the attainment of 90-90-90 targets (i.e. 90% of people living with HIV are diagnosed, 90% of those diagnosed receive ART, and 90% of the treated have durable viral load suppression by 2020, with the technical support of WHO);
- Encourage Zimbabwe to facilitate implementation of the Abuja Declaration of 2001 targeting increase of the health budget to 15% of the nation's annual budget;
- Encourage Treasury to increase the budget allocation to MoHCC in order to upgrade primary and secondary health care infrastructure;
- Engage GoZ to put measures in place to ensure all citizens access adequate health facilities;
- Continue to increase access to women and children's health care;
- Strengthen social inclusion measures, in particular for persons with physical disabilities.
- Monitor children's access to health services, particularly as regards HIV/AIDS, Malaria and TB;
- Enact the Child Justice law;
- Lobby government to operationalise the National Gender Policy and machinery through adequate financing on the national budget;

- Support programmes on improvement of conditions in prisons and human rights of prisoners;
- Lobby for enhancement and capacitation of LAD;
- Increase and strengthen the capacity of Victim Friendly Court;
- Decentralisation of Legal Aid and the establishment of new courts in rural areas;
- Continuous training of law enforcement agents on the rule of law and awareness campaigns for those protected by the law;
- Strengthen the Victim Friendly Unit (VFU) and Anti-Domestic Violence Council;
- Lobby for criminalisation of torture.

Part III:

# Analysis of Laws, Regulations and Policies in Zimbabwe

Zimbabwe does not have a comprehensive HIV- and TB-specific law but people living with HIV and TB are protected by broad equality and non-discrimination provisions provided for by the Constitution, health and workplace legislation and policies, some of which are discussed below.<sup>66</sup>

## Equality and Non-Discrimination Laws

### HIV and TB-related Stigma and Discrimination

The Stigma Index study (2014) found that 65% of people living with HIV and TB had experienced discrimination, either from other people or in a few circumstances from self-stigma.<sup>67</sup> Research shows that it also affects children with HIV – one of the most common forms of stigma experienced by children affected by HIV and AIDS is teasing and social isolation by peers.<sup>68</sup> This suggests that children adopt societal attitudes towards

HIV and AIDS at an early age and thus should be included in efforts to reduce HIV and AIDS related stigma and discrimination.<sup>69</sup> Issues around birth control, condom use and frank discussion on sexuality with young people are considered taboo and in some cases as sinful and immoral.<sup>70</sup> Older children living with HIV experienced stigma and discrimination which led to unwillingness to disclose their HIV status and difficulties in families accepting potential partners for marriage.<sup>71</sup> Young women found disclosure and negotiating safe sex with a partner, even in cases of discordant couples, a challenge leading to broader family discussions and ultimately violence and or marginalisation.

The climate of stigma and discrimination surrounding HIV, AIDS and TB can make public acknowledgement of one's HIV status difficult and dangerous, especially for members of key populations. Contributing factors to stigma from faith-based perspectives and narrative exacerbate this by associating the epidemic with sexual promiscuity and sin.<sup>72</sup> From evidence gathered, FBOs in general and especially from the Pentecostal community

- 
- 66 See s.3(1) of the Constitution. The Constitution provides for fundamental human rights for all people on the basis of equality and non-discrimination and reaffirms the country's commitment to upholding and defending fundamental human rights and freedoms based on principles and values that include recognition of the inherent dignity and worth of each human being, recognition of the equality of all human beings and gender equality.
- 67 Zimbabwe National Network of People Living with HIV, '[Zimbabwe Stigma Index Research Report](#)' (2014). Self-stigma is a situation whereby a person feels that people are looking at her/him or behaving differently towards them, on the basis of HIV status or perceived HIV status. The other factor is that persons living with HIV and AIDS believe that being seen to take many medication will lead to the perception that they are HIV-positive. Self-stigma may also be a product of a person's low self-esteem or the prevailing stigma and discrimination around HIV. The following internalised forms of stigma were reported in the 2014 HIV Stigma Index:
- 18.9% of the respondents reported that they feel guilty and have low self-esteem because of their HIV status;
  - 17.9% said that they blame themselves, while 16.7% feel ashamed, and 16.5% said that they blame others;
  - over a third (37.2%) of the respondents reported that they fear being gossiped about;
  - when asked of their other fears, 17% reported that they were afraid of sexual rejection, while 15.4% said that they feared being verbally insulted.
- 68 Ibid. A child affected by HIV in rural Zimbabwe is quoted as saying, "*Bullying is a problem at our school and makes me dislike coming to school. It causes me not to learn well because I will be afraid*". In an FGD with Adolescents, Harare, January 2017, the following view was expressed, "*For a child living with HIV in a school, the other students will rush to conclude that student A who is HIV positive is possibly a child of a prostitute. The labelling that then follows may cause a lot of psychological problems for the child and also leads to that child not adhering to their medication during the course of the day at school for fear of being seen and laughed at or labelled*" and that "*Some children fall sick and they cannot really attend school as they are supposed to and once the parents disclose the child's status to the teacher or the school head, there is then some level of stigma associated with the continued education of this infected child within the school. Some teachers, because of lack of information, also tell other kids not to share things with the children that are HIV positive in the school. Teachers may not directly disclose the status of the child but will pass sentiments that indirectly discriminate the child living with HIV.*" Children in schools also encounter stigma and discrimination in that teachers may refuse them participation in certain sports because of their HIV positive status or may not allow them to share play things with other learners.
- 69 HIV Stigma Index, (2014); UNAIDS, Investing in the Future: Psychosocial Support for Children Affected by HIV/AIDS Case Study (2001).
- 70 Ibid.
- 71 Positive status was synonymous to a death sentence, as families expressed that they were not prepared 'to live with two graves' in a family.
- 72 This emerged from some of the FGDs conducted in 2016 and validated by follow-on FGDs with key populations especially young key populations in April-May 2018. For example, in a FGD with women (HIV-positive or affected by HIV, sex workers, young female persons, etc.) in May 2018, it was suggested that the church harbours many people living with HIV who do not come out in the open of fear of victimisation and being shunned and shamed amongst peers.

takes a moralistic view of the pandemic as well as sexual preferences of persons. The participants confirmed that it is not uncommon for leaders from faith-based organisations to suggest that HIV positive persons and those who succumb to AIDS related illnesses are generally promiscuous.<sup>73</sup> Some women reported being labelled and treated differently, with derogatory names such as 'zvigwulwani' meaning 'ill people', at church. The impact of this narrative increases stigma, discrimination and non-disclosure of positive status. As custodians of morals who are held in high regard in communities and with generally significant following or constituencies, the overall impact of these negative messages has the potential to derail the positive strides made in addressing issues of HIV, AIDS and related TB challenges in the country. The deep-rooted stigma and discrimination surrounding HIV and AIDS is a barrier to testing of children and young key populations.<sup>74</sup>

The LEA found that in addition to stigma and discrimination against people living with HIV and TB, certain populations, including adolescents and young people, women and young girls, persons with disabilities and key populations (LGBTI populations and sex workers), including young key populations, experienced their own particular forms of stigma and discrimination over and above HIV- and-TB-related stigma and discrimination.<sup>75</sup> Stigma, discrimination and violence against these populations is discussed in further detail in the specific sections looking at these populations, below.

## Current Position in Zimbabwe

The Constitution guarantees non-discrimination in relation to the enjoyment of human rights. It provides in Section 56, *inter alia*, that women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural

and social spheres, and that every person has the right to be treated in a fair and non-discriminatory manner on such grounds as their sex, gender, marital status, age, pregnancy, disability or economic or social status. While it is not HIV-specific, it should generally protect a wide range of persons, including those living with HIV or TB as well as vulnerable and key populations, including young key populations.

Discrimination against persons living with HIV is explicitly prohibited in the National HIV and AIDS Policy, which states in its preamble that the human rights and dignity of all people irrespective of their HIV status should be respected and that avoidance of discrimination against people living with HIV should be promoted. Guideline 2 of the Policy recommends the implementation of education and information interventions aimed at changing the attitudes of the general public and specific target population groups in support of respect of human rights and avoidance of discrimination of people living with HIV and AIDS. It also recommends the promotion and enforcement of legislation which protects individuals against human rights violation and discrimination in respect of HIV and AIDS.

The National HIV and AIDS Policy also recognises that discrimination against people living with HIV is counter-productive as it increases vulnerability to HIV infection and undermines efforts in response to the epidemic. It further recognises the importance of the need to create and maintain a supportive environment for the prevention, control, and care and impact mitigation of HIV, AIDS and STIs. It also states that no requirement for HIV testing of visitors or immigrants to Zimbabwe will be introduced. However, the Immigration Act [Chapter 4:02] lists included prohibiting any person who is infected or afflicted with or suffering from a prescribed disease, unless he/she is in possession of a permit to enter and

73 Zimbabwe National Network of PLHIV (ZNNP+), Zimbabwe Stigma Index Research Report: Exclusion from Religious Activities or Places of Worship (2014) at p44.

74 IRIN News, "Young Zimbabweans miss out on HIV testing" (9 June 2014)

75 There is a general association of TB with HIV and so people with TB are perceived as HIV-positive without due consideration to things like hygiene and the environment that might cause TB.

remain in Zimbabwe<sup>76</sup> and any person who is a prostitute, homosexual or pimp from entering Zimbabwe.

The Prevention of Discrimination Act is intended to prohibit discrimination on the ground of race, tribe, place of origin, national or ethnic origin, political opinions, colour, creed or gender. It also seeks to provide remedies to persons injured by discrimination. Discrimination on the listed grounds is prohibited in relation to access to public premises, commodities, services and facilities. It does not specifically prohibit discrimination on the basis of health status, sexual orientation or gender identity.

There is no specific legislation protecting vulnerable and key populations. However, the Government has taken proactive steps within the framework of HIV and AIDS interventions to intensify health service provision and address issues of stigma and discrimination among key populations, including young key populations. This is in addition to the general provisions in the Constitution seeking to protect and promote the rights of all persons.

With respect to people with disabilities, the Constitution and the Disabled Persons Act, even with its shortcomings, reflect the international standards set out in the CRPD, African Women's Protocol and CRC with respect to protection of the rights of people with disabilities, including children with disabilities. They protect the rights of people with disabilities to equality and non-discrimination and make efforts to ensure their health rights.

## Gaps and Challenges

Despite the clear anti-stigma and non-discrimination provisions in the Constitution, other laws and policies as discussed above, people living with HIV and vulnerable and key populations continue to experience discrimination. The Prevention of

Discrimination Act does not extend to persons living with HIV and TB, vulnerable populations such as people with disabilities and key populations.

The Immigration Act is open to misinterpretation or abuse and people living with HIV, especially if they are gay men, men who have sex with men or sex workers, could be deemed undesirable, as the Act supersedes the Policy. According to the GCHL (2012) restrictions on entry, stay and residence in a country disempower people, exposing them to exploitation, changing their sexual behaviours and increasing the likelihood of unprotected sexual practices. As a result, migrants face a risk of HIV infection that is three times higher than that faced by people with secure homes.<sup>77</sup> Blanket exclusions of people living with HIV, although argued to be justified on the grounds of safeguarding public health, are argued by the GCHL to give the mistaken impression that outsiders are contaminated, and citizens are pure, and that their health is protected as long as the borders are secured.<sup>78</sup> Harmonisation of the law and the policy is therefore a necessity.

For people with disabilities, the Constitution explicitly provide for access to health care services, and arrangements such as AMTOs are available to people with disabilities; however, they merely facilitate access to the institutions but fall short of providing required essential drugs. Additionally, as health care infrastructure has generally deteriorated across the country, those health care facilities that are still functional are less accessible, and harder to get to, impacting on people with disabilities.

## Recommendations

The UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights recommend, in Guideline 5, that States should enact or strengthen anti-discrimination and other laws that protect people living with HIV and vulnerable populations from discrimination in both the public and the private sectors.

<sup>76</sup> S.44 of the lists the following prescribed diseases: TB, trachoma, favus, framboesia or yaws, syphilis, scabies and leprosy.

<sup>77</sup> Refer to p.59.

<sup>78</sup> GCHL (2012), Risks, Rights & Health, op cit, p. 61.

Strategies should also promote education and training programmes explicitly designed to change attitudes of discrimination and stigmatisation associated with HIV and AIDS.

However, in line with the international and regional guidance, the following general recommendations are made:

- Include provisions that protect and promote human rights in the context of HIV and TB in the Public Health Bill that are consistent with the National HIV and AIDS Policy, and prohibit all forms of discrimination, including TB-related discrimination, on the basis of actual or perceived HIV or TB status;
- Amend Part II of the Prevention of Discrimination Act [Chapter 8:18] to include protections of people living with HIV, women, pregnant women, children, people with disabilities and key populations from discrimination; Amend section 5 of the Act to explicitly mention HIV as a ground for non-discrimination to access finance;<sup>79</sup>
- Ensure existing constitutional human rights are enforced;
- Amend the Immigration Act to reflect the provisions of the National HIV and AIDS Policy, so that there is no requirement for HIV testing of visitors or immigrants to Zimbabwe and there are no exclusions based on discrimination against populations.<sup>80</sup>

## Health Laws, Policies and Plans

### Access to Health Care Services for HIV and TB for all Populations

Appropriate health and HIV-specific prevention, treatment, care and support services should be available, affordable and accessible to all people without discrimination. Access for vulnerable and key populations, including young key populations should be prioritised. Health laws and policies should provide access to affordable and appropriate health care services without discrimination and coercion, provision for young people to access sexual and reproductive health care independently, protection of the right to voluntary testing and treatment and protection for the confidentiality rights of all persons as well as regulation of the actions of health care providers and ensuring they are sensitised to the rights of all persons to non-discrimination and on the provision of HIV-related health care to vulnerable and key populations.

This section of the LEA deals with these various health rights issues, including the specific issues facing people living with HIV and TB, vulnerable and key populations, including young key populations.

### Access to Appropriate and Affordable Health Care Services without Discrimination

The LEA found various barriers to non-discriminatory access to appropriate, affordable and accessible health care services for vulnerable and key populations.

79 A law should be enacted to prohibit exclusion from life, health and other insurance solely on the basis of HIV status and to ensure that in the context of insurance HIV should not be treated differently from analogous chronic medical conditions.

80 The GCHL, Risks, Rights & Health (2012) recommends that, to ensure an effective, sustainable response to HIV that is consistent with human rights obligations, States should offer the same standard of protection to migrants, visitors and residents who are not citizens as they do to their own citizens; repeal travel and other restrictions that prohibit people living with HIV from entering a country and/or regulations that mandate HIV tests for foreigners within a country and implement regulatory reform to allow for legal registration of migrants with health services and to ensure that migrants can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens. All HIV testing and STI screening for migrants must be informed and voluntary, and all treatment and prophylaxis for migrants must be ethical and medically indicated.

KIIs and FGDs with stakeholders and affected populations revealed that populations are aware of their right to free access to HIV-related treatment, care, support and SRH services at health facilities, especially public institutions, as provided for by the law. However, all key populations including young key populations generally experienced challenges, including the following:

Young key populations for instance reported that health care practitioners were not “youth-friendly,” had moral attitudes towards people living with HIV and youth sexuality and were not knowledgeable or experienced in dealing with health care issues specific to young key populations. This limited young key populations’ ability to access health care services, exposing them to the risk of unsafe sex and infection. They also indicated that laws around age of consent impacted on their ability to access health care independently of a parent (this is dealt with in further detail, below).

LGBTI populations, including young LGBTI populations, reported stigma, discrimination and denial of access to health care services at both private and public institutions, when seeking treatment for e.g. an anal infection due to the negative attitudes of health workers, leading to many of them failing to disclose their sexual orientation when accessing health care. They also reported experienced invasive and insensitive questioning, unrelated to their health queries. Identity issues also impact negatively on access to health care for the transgender persons. The broad categorisation of male or female on medical aid forms creates issues of identity and suspicion of medical aid fraud, sometimes resulting in them being denied medical care. FGDs with transgender persons also revealed lack of access to hormonal drugs and other medicines in formalised facilities, resulting in the proliferation of black market

dealings and unsupervised self-medicating, posing a risk to their health. Notably, in Harare and Bulawayo, FGDs with LGBTI populations indicated that constructive dialogue with health care service providers were yielding positive results as they could now access HIV drugs, could be tested, counselled as well as access condoms from specific health institutions that protected their rights to privacy as well as treating them with dignity.<sup>81</sup>

Sex workers also reported stigma and discrimination at health care institutions. Younger sex workers felt they experienced more stigma and discrimination than older sex workers.

Young women reported difficulties in accessing condoms due to stigmatising perceptions of having multiple sex partners or being labelled a sex worker. They reported that discussing issues of sex with health care providers and parents was considered “taboo”. Older women also reported stigma and discrimination when accessing HIV treatment. FGDs revealed that the requirement of bringing a husband or partner when accessing HIV testing and counselling discriminated against single pregnant women, who felt they were stigmatised by health care providers.

People with disabilities reported experiencing stigma and discrimination at the hands of health care service providers who generally held pre-conceived perceptions that people with disabilities were not expected to engage in sexual relations or had no understanding of their vulnerability to HIV as a result of sexual abuse. They also reported government initiatives to respond to HIV side-lined people with disabilities and did not address their challenges – e.g. by providing health information in an accessible format, such as sign language or braille.<sup>82</sup> People with disabilities felt that health care centres were inaccessible. They reported that they do have access to health

81 FGD, Harare, January 2017. One of the participants in the FGDs is quoted as saying: “I think twice before going to the hospital. I don’t want to go there. If I go there, they ask me, how you got this thing [anal STI] because it never happened to straight men... they won’t even attend to me because I said I’m gay.”

82 In FGDs and KIIs and some participants noted that: “Those who have hearing impairment and use sign language have difficulties accessing health services because medical practitioners don’t understand them, and sign language, even though a national language, is not taught at medical school. Where an interpreter is used, it becomes an issue again of breaching their privacy, especially where HIV or STIs are concerned. The cost of interpretation is also very high and unaffordable for them.”

care via AMTOs; however, they provide access to health care but essential HIV drugs (ART) and SRH drugs still have to be purchased privately. As a result, FGDs with people with disabilities reported increasing cases of defaulting on HIV treatment, with fears of developing resistance and not being in a position to afford more expensive second-line ART medications. People with disabilities also expressed limited access to legal support services and access to justice for rights violations, as discussed in the section relating to the UPR.<sup>83</sup>

FGDs also revealed that populations felt there was a lack of knowledge, awareness and experience by health care workers of how to deal with HIV and AIDS, including limited awareness of and training on all guidelines and provision of services and counselling. They also felt unwilling or unable to challenge violations of their rights.

### Age of Consent to Access Health Care Services

Laws, policies and practices should facilitate access to health care services, including sexual and reproductive health care services. Laws regulating the age at which a young person can independently consent to access services – such as HIV testing, contraception, treatment and care, may either facilitate, or create barriers to access to care for young people.<sup>84</sup> Research shows that very few young people are willing to seek their parents' permission to access services, and in many cases even health practitioners are unclear of their patients' rights and their responsibilities with regard to sexual and reproductive health services. This, combined with the poor attitudes of health care workers to young people's access to SRHS, contributes to poor management of reproductive health services for young people, who may be at higher risk of HIV exposure.<sup>85</sup>

### Voluntary and Informed Consent to HIV Testing and Treatment

Protecting the right to HIV testing only on the basis of voluntary and informed consent is viewed as a critical public health response to encourage people's willingness to access health care services, as well as a human rights imperative in terms of human rights commitments.<sup>86</sup>

Statistics show that the number of HIV tests carried out in Zimbabwe has increased from 19.4 million in 2011 to 22 million in 2015, although this figure is below the government's intended target of 25.2 million. Initial findings from the Zimbabwe Demographic Health Survey (ZDHS) 2015 suggests an increase in testing from the previous 2010/2011 survey with 49% of women reporting being tested in the last 12 months compared to 34% in 2011. Among men, this increased from 21% in 2011 to 36% in 2015.<sup>87</sup> Despite this reported increase, estimated overall rates remain low at 40.3% for men and 50.6% for women. It is estimated that only 66% of people living with HIV know their status.<sup>88</sup> In 2015, to increase testing rates, Population Services International and UNITAID began a two-year project to scale up self-testing in Zimbabwe, Malawi and Zambia.<sup>89</sup> This project focuses on places and people where access to testing is restricted, such as rural areas and among female sex workers, gay men and men who have sex with men.

Children and young people who participated in the LEA complained of an unwillingness to use HIV testing services where they were unable to do so independently of a parent or guardian.

Women reported issues with mandatory HIV testing during ante-natal care, which made them vulnerable to violence and conflict with a spouse, whose status was often unknown, and

83 For example, FGD with persons with disabilities held in Mutare in May 2018.

84 GCHL, Supplementary Chapter to Risks, Rights & Health (2018).

85 Republic of Seychelles, Implementation of the Convention on the Elimination of All Forms of Discrimination against Women 1993-2009 (2011). The CEDAW Report cites the Child Well Being study of 2008 which indicates that 46% of children aged 12 to 19 have had sexual intercourse; the majority of both boys and girls indicated they did not use protection.

86 UNAIDS, International Guidelines on HIV/AIDS and Human Rights (2006).

87 Ministry of Health and Health Care, GARPR Zimbabwe Country Progress Report (2016).

88 Ibid.

89 PR News Wire, 'Population Services International and UNITAID launch the largest effort ever to catalyse HIV self-testing in Africa' <http://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zimbabwe>.

being “blamed” for their HIV-positive status within the relationship.

### Confidentiality of Health Information

Privacy over health matters is a basic human right and is a fundamental principle of ethics of medical practice. The South African case of *Jansen van Vuuren v Kruger*<sup>90</sup> has confirmed the medical practitioner’s obligation to, as well as public health importance of, maintaining a patient’s right to confidentiality regarding HIV status.

The LEA found that actual or perceived poor maintenance of confidentiality in current health care services may discourage people from accessing HIV-related services. Participants in FGDs carried out during the LEA spoke of both instances of poor maintenance of confidentiality as well as a general mistrust that confidentiality would not be maintained, leading to fear and discouraging access to HIV testing and other services.

Young key populations, for instance, reported that they did not feel comfortable using health care services, due to infringements of their rights to confidentiality.

Women who participated in FGDs, and TB patients, indicated breaches of confidentiality, sometimes indirectly through the way in which services were provided, which lead to stigma and discrimination that also impacted on them beyond health care, to the broader community.

Specific queues for HIV-related health care, a ‘green book’ for patients with HIV, separate health care facilities for opportunistic

infections (OIs) such as TB, specific health care facility days for the distribution of ART and open plan facilities resulted in indirect disclosure of HIV status.<sup>91</sup> This exposed patients to stigma and discrimination which inevitably spilled over into their broader communities and impacted on their willingness to seek health care services.

### International and Regional Guidance

International and regional guidance recommends that public health and related laws must protect and promote rights in the context of HIV and TB, rather than be coercive, punitive or discriminatory.<sup>92</sup>

The International Guideline 3 on HIV and AIDS and Human Rights recommends that States should review, amend and adopt, where necessary, appropriate public health laws, policies, plans and programmes to protect rights in the context of HIV, with particular attention to vulnerable individuals and key populations. Guideline 6 further provides for universal access to HIV prevention, treatment, care and support for all populations at an affordable price. This includes reviewing intellectual property laws to ensure access to affordable medicines.

The International Guidelines stipulate that public health and related laws should provide for, *inter alia*:

- HIV testing only with voluntary and informed consent (apart from surveillance and other unlinked epidemiological testing)

90 1993 (4) SA 842 (A).

91 FGDs and KIs, 2017. In the words of some of the participants: “When you go to a clinic the opportunistic infections (OI) department is on its own side separated from the main health facility so for people to be seen there it means you are positive, meaning disclosure of their status without their consent. The issue of their privacy is compromised. Like in the rural areas you hear that on Tuesdays, people are going to get ART drugs, so there is no privacy and disclosure of their status is done by a system rather than with their consent. Some health facilities are open facilities where people’s names are being called out for ARV treatment in public and everybody sees you receiving under the OI clinic. People end up not getting their treatment because they are afraid of being seen in the clinic side for the HIV positive, thus leading to adherence issues. The green book given to people living with HIV is another example of indirect disclosure of peoples’ status.”

92 See for instance OHCHR and UNAIDS, International Guidelines on HIV and Human Rights (2006), op cit, UNAIDS, Getting to Zero (201), and GCHL, Risks, Rights & Health (2012).

93 Mandatory HIV testing is discouraged by both WHO and UNAIDS as an ineffective measure to achieve public health goals. In addition, court cases in Southern Africa, such as the South African case of *Hoffmann v South African Airways* and the Namibian case of *Nanditume v Minister of Defence*, have held that HIV testing is not only discriminatory but is also irrational as it cannot serve to determine a person’s fitness to carry out the requirements of a particular job nor can it serve to reduce the risk of HIV infection in the working environment.

and with pre- and post-test counselling.<sup>93</sup>

Any exceptions to voluntary HIV testing shall take place only on specific judicial authorisation, granted only after due evaluation of the important considerations involved in terms of privacy and liberty;

- Protection from coercive measures such as isolation, detention or quarantine on the basis of their HIV status – isolation and detention of patients may be a reasonable public health response in certain circumstances, in order to contain the spread of infectious diseases. However, public health provisions for the isolation and detention of patients should not be inappropriately applied to HIV, AIDS and TB and in the case of TB, should be done in accordance with principles of due process.
- Protection of the right to confidentiality, including ensuring HIV and AIDS cases reported to public health authorities for epidemiological purposes are subject to strict rules of data protection and confidentiality and authorising (but not requiring) disclosures of a person's HIV status by a health care worker in defined circumstances where a real risk of HIV transmission exists, following counselling and discussions with the person with HIV (discussed in further detail, below);
- Encouraging professional societies of health care workers to develop and enforce codes of conduct based on human rights and ethics, including HIV-related issues such as confidentiality and the duty to provide treatment;
- Provision of universal and equal access, without discrimination, to available, accessible, appropriate, affordable and quality medicines, diagnostics and related technologies for HIV and AIDS;<sup>94</sup> and
- Inclusion of positive measures to address factors that block equal access to

prevention, treatment, care and support for vulnerable populations and to strengthen the involvement of communities in the HIV response.

The WHO *Technical Briefs* on young key populations note that adolescents and young key populations face higher discrimination than their older counterparts. In addition to complex psycho-social issues, socio-economic factors and exclusion from access to quality health care especially for SRH, the following key issues need to be addressed:

- Legal hurdles relating to their age which impose restrictions to access, expose them to increased vulnerability to HIV and limit their rights to access health care
- Stigma and discrimination which impede access to essential information and health care services, thus perpetuating exclusion<sup>95</sup>
- Their need for access to quality, integrated health care information and services without discrimination, that addresses their specific needs, including co-infections such as TB and viral hepatitis

The GCHL's *Risks, Rights & Health* recommends that countries develop an effective intellectual property regime that is consistent with international human rights law and public health needs, while safeguarding the rights of inventors. In particular, it recommends, amongst other things:

- All countries must adopt and observe a global moratorium on the inclusion of any intellectual property provisions in any international treaty that would limit the ability of countries to retain policy options to reduce the cost of HIV-related treatment;
- All countries should, where possible, incorporate and use TRIPs flexibilities, consistent with safeguards in their own national laws;

94 WHO Consolidated Guidelines on HIV Prevention, Treatment and Care for Key Populations (2014) says that “the specific needs of young people from key populations are neglected both by programmes designed for youth generally and by programmes for adults from key populations”.

95 WHO Consolidated Guidelines on HIV Prevention, Treatment and Care for Key Populations (2014) says that “the specific needs of young people from key populations are neglected both by programmes designed for youth generally and by programmes for adults from key populations”.

- Countries with manufacturing capacity and those reliant on the importation of pharmaceutical products must retain the policy space to use TRIPs flexibilities as broadly and simply as they can;
- Developing countries should desist from adopting TRIPs-plus provisions including anti-counterfeiting legislation that inaccurately conflates the problem of counterfeit or substandard medicines with generics and thus impedes access to affordable HIV-related treatment;
- Countries must pro-actively use other areas of law and policy, such as competition law, price control policy and procurement law, which can help increase access to pharmaceutical products.

Part IV of the Model Law on HIV and AIDS in Southern Africa provides, inter alia, that States shall take all relevant measures to provide access to affordable, high quality anti-retroviral therapy and prophylaxis to treat or prevent HIV or opportunistic infections for people living with HIV, including children living with HIV and members of vulnerable and marginalised groups. These relevant measures shall include the use of all flexibilities under the TRIPs Agreement and the Doa Declaration on the TRIPs Agreement and Public Health, as well as measures to encourage the local production of medicines. States shall also ensure the following:

- That post-exposure prophylaxis and treatment of sexually transmitted infections and psychological support are available without delay and free of charge for all rape survivors;
- Wide access to accurate information regarding HIV treatment options and widespread treatment literacy campaigns, with access to information on where and how to access treatment, care and support;
- The protection of the population against fake and counterfeit medicines and treatments; and
- The active participation of people living with HIV and members of vulnerable and marginalised groups in the design, development and implementation of a

national plan for the realisation of universal access to treatment, care and support services

The UNAIDS *International Guidelines on HIV/AIDS and Human Rights* (2006) (Commentary to Guideline 3) provide further that public health legislation should authorise, but not require that health care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients' sexual partners of the HIV status of their patient. Such a decision should only be made where:

- the HIV-positive person in question has been thoroughly counselled;
- counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
- the HIV-positive person has refused to notify or consent to the notification of his/her partner(s);
- a real risk of HIV transmission to the partner(s) exists;
- the HIV-positive person is given reasonable advance notice;
- the identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and
- follow-up is provided to ensure support to those involved, as necessary.

The SADC PF Model Law on HIV reiterates international standards relating to HIV and human rights. It also provides specific guidance on confidentiality and exceptions under which disclosure can be done, in uniformity with this international guidance. Section 18 provides that every person is entitled to the right to privacy and confidentiality regarding his/her HIV status and that no person shall disclose any information concerning a person's HIV status to any other person, except:

- In cases stipulated in section 15 of the Model Law e.g. when, in the opinion of the health care provider, there is or was a significant risk of transmission of HIV by the person living with HIV to the sexual partner and the person has been advised of the importance of disclosing his/her status to his/her spouse

or sexual partner(s) and other conditions have been met<sup>96</sup>

- To a health care provider who is directly involved in providing health care to that person, where knowledge of the patient's HIV infection is necessary to making clinical decisions in the best interests of the person;
- For the purpose of an epidemiological study, where the release of information cannot be expected to identify the person to whom it relates; or
- Upon an order of a court, where the information contained in the medical file is directly relevant to the proceedings before the court.

## Current Position in Zimbabwe

### a) Constitutional Protections Relevant to the Right to Health

Section 76 of the Constitution provides for the right to health care. The Constitution recognises the right to health and obliges the State to:

- take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe;
- take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution;
- take all preventive measures within the limits of the resources available to it, including education and public awareness programmes, against the spread of disease.<sup>97</sup>

The right to health entails that every citizen and permanent resident of Zimbabwe has the right to have access to basic health care services, including reproductive health care services; every person living with a chronic illness has the right to have access to basic health care services for the illness and no

person may be refused emergency medical treatment in any health care institution.

Other constitutional provisions relevant to the international standards discussed above include the following:

- Protection of the right to privacy, which includes the right not to have one's health condition disclosed (Section 57);
- The right to inherent human dignity, in one's public and private life, and the right to have that dignity respected and protected (Section 51);
- The right to personal security: Every person has the right to bodily and psychological integrity, which includes the right: (a) to freedom from all forms of violence; (b) to make decisions concerning reproduction; and (c) not to be subjected to medical or scientific experiments, or to the extraction or use of their bodily tissue, without one's informed consent (Section 52). This protects people from mandatory testing and treatment and arguably protects people from unjustifiable detention or quarantine on the basis of HIV or TB; the right may however, be limited in the interest of, inter alia, public health e.g. quarantine, in order to prevent the spread of an infectious or contagious disease which constitute a serious threat to public health;
- The right to equality and non-discrimination, in terms of which, inter alia, all persons are equal before the law and are entitled to equal protection and benefit of the all, men and women have the right to equal treatment, and listed prohibited grounds of discrimination include sex, gender, disability and economic or social status (Section 56).<sup>98</sup>

#### Health Legislation

The Public Health Act does not refer specifically to the rights of people living with HIV, TB or key populations. However, the broad provisions of the Public Health Act, to provide for health care, are applicable to all persons

96 See sections 15 and 16 of the Model Law.

97 Section 29 of the Constitution, which is part of the National Objectives which arguably are not justiciable.

98 Please note that the list of prohibited grounds of discrimination provided in section 56 is not exhaustive.

and to all matters of public health and would therefore also apply equally to people affected by HIV, AIDS and TB, including vulnerable and key populations.

### Restrictive Public Health Provisions

The Act also contains provisions relating to curbing the spread of disease by imposing restrictions on the rights of those already infected or considered most vulnerable to becoming infected. Coercion, compulsion, and restriction have historically been significant components of public health measures and this is the general thrust of the current Public Health Act. The Public Health Act provides for the isolation and detention of patients suffering from infectious diseases (e.g. TB)<sup>99</sup> in suitable hospitals or places of isolation for the accommodation and treatment of such persons (section 23.a). Section 24 of the Act provides in part that: “Where, in the opinion of the medical officer of health, any person certified by a medical practitioner to be suffering from an infectious disease is not accommodated or is not being treated or nursed in such manner as adequately to guard against the spread of the disease, such person may, on the order of the medical officer of health, be removed to a suitable hospital or place of isolation and there detained until such medical officer of health or any medical practitioner duly authorised thereto by the local authority or by the Minister is satisfied that he is free from infection or can be discharged without danger to the public health...”

Zimbabwe’s new Public Health Bill (H.B 7, 2018) seeks to redress some of the imbalances in the Public Health Act. It seeks to strengthen and enhance HIV and TB awareness and generally the rights to access quality health care services for vulnerable groups, and key populations including young key populations. However, it also contains some provisions that have the

potential to impact negatively on people living with HIV or TB. For example:

- Section 57 (c) of the Public Health Bill provides for punishment – by fine or incarceration – of individuals for the “wilful or negligent” exposure of others to infectious disease
- Section 74 provides for punishment – by fine or incarceration – of individuals who fail to comply with compulsory treatment orders for a notifiable sexually transmitted disease.

Section 4 of the Public Health Bill also provide for measures such as hospitalization, isolation and quarantine of infected persons, which would apply to people with TB. There is provision for the establishment and maintenance of places of isolation for treatment of patients.

The provisions of the Public Health Bill also allude to the issue of confidentiality and disclosure, highlighting the need to balance the issue of privacy with the need to protect persons from intentional HIV transmission. The Bill cautions against criminalisation for non-disclosure by the individual or health care practitioner. Currently, confidentiality and disclosure are dealt with in the National HIV and AIDS Policy (discussed in further detail below).

Proposals from provinces placed before Parliament for consideration in May 2018 called for a number of improvements to the Bill aimed at protecting the rights of vulnerable groups and key populations including young key populations<sup>100</sup> (discussed in further detail in Gaps and Challenges, below).

### Regulation of Health Care Providers

Health care workers are regulated by the Health Professions Act [Chapter 27:19]. The Act establishes the Health Professions Authority of Zimbabwe, the Medical and Dental

<sup>99</sup> See sections 15 and 16 of the Model Law.

<sup>100</sup> The Bill has already been introduced in the National Assembly and received a non-adverse report from the Parliamentary Legal Committee [PLC], which means the PLC found the Bill to be consistent with the Constitution (our emphasis). The Bill’s next step in the National Assembly will be its Second Reading Stage, during which the Minister of Health and Child Care will explain the policy and aims of the Bill, and the Portfolio Committee’s chairperson will present the committee’s report.

Practitioners Council of Zimbabwe, the Allied Health Practitioners Council of Zimbabwe, the Natural Therapists Council of Zimbabwe, the Nurses Council of Zimbabwe, the Pharmacists Council of Zimbabwe, the Medical Laboratory and Clinical Scientists Council of Zimbabwe, the Environmental Health Practitioners Council of Zimbabwe and the Medical Rehabilitation Practitioners Council of Zimbabwe. The Act provides for, inter alia, the registration of persons in health professions and the exercise of disciplinary powers in relation to such persons as well as offences in relation to unregistered persons who perform acts specially pertaining to health professions. It also provides for the registration and control of health institutions.

### Health Policies and Plans

Zimbabwe has a number of health policies and plans that provide for non-discriminatory access to health care for HIV and TB.

### The Equality Rights of People Living with HIV

The NAC Strategic Plan 2015-2018 acknowledges that a supportive legal and policy environment plays a key role in enabling a highly multi-sectoral participation in HIV responses from engagement, dialogue, proposal development, programme planning, resource mobilisation, to monitoring and evaluation.

The specific rights of people living with HIV are explicitly provided for in the National HIV and AIDS Policy, 1999. These rights include the prohibition of discrimination against people living with HIV and non-discrimination in access to services. The ZNASP III (2015-2018), Extended (2015-2020) and the National Health Strategy for Zimbabwe (2016-2020) furthermore include HIV as an emergency and note the importance of addressing human rights and gender inequality, amongst other things. ZNASP III 2015-2018 affirms commitment to the UN General Assembly Special Session Declaration of Commitment on HIV and AIDS (UNGASS 2001), the Maseru Declaration on HIV and AIDS, CEDAW, CRC and the UDHR. It also reflects global instruments

and commitments such as 90-90-90, the SDGs, and the African Union roadmap on domestic sustainable financing and ending AIDS by 2030. Principles guiding it include:

- Rights-based and gender transformative approaches, with emphasis on, inter alia, non-discrimination of people living with HIV, key populations, people with disabilities, youths, women, children and others who are socially excluded;
- Equity for fairness and justice;
- Positive Health, Dignity and Prevention (PHDP). There is recognition of the important role played by people living with HIV in the national HIV response.

### Health Care Services

The provision of health care services, including those targeting vulnerable and key populations, is set out in various policies and plans.

Guiding Principle 12 of the National HIV and AIDS Policy expresses the need to have comprehensive, cost-effective and affordable care accessible to people living with HIV. It commits to strengthening the capacity of the health care delivery system through provision of adequate resources; making essential drugs available at all levels of the health care delivery system; providing health workers in the public and private health care delivery system with appropriate training in HIV and AIDS education, counselling and management, eliminating any form of discrimination in the health care delivery in respect of HIV and AIDS through education and information to change attitudes; and promoting good nutritional habits, including information on vitamins and other nutrients. Guiding Principle 13 furthermore provides for access to accurate information regarding orthodox and traditional medicine, requiring traditional medical practitioners to register in terms of section 31(2) and (3) of the Traditional Medical Practitioners Act [Chapter 27: 14]. Nursing care, provided by health professionals in collaboration with care providers from the community, churches, NGOs, traditional medical practitioners etc are expected to be

holistic and of acceptable quality.<sup>101</sup> There is furthermore a recognition that community home-based care should be fully developed and supported as an essential component of the continuum of care for people living with HIV and their families.<sup>102</sup>

The ZNASP III extended 2015-2020 prioritises interventions around social and behaviour change, and increased condom promotion and distribution. It is coupled with intensified awareness on correct and consistent use of condoms, voluntary medical male circumcision (VMMC), and education on the prevention and control of sexually transmitted infections. One of its key outcomes is to have a percentage of key populations, vulnerable and left behind groups reached by prevention programmes. It is designed to promote smart investment for more focused and high impact interventions targeting especially children, adolescents, young people, girls, key populations and women, as well as prioritised geographical locations while building on the successes of the previous five years and commitment to bridging identified gaps.<sup>103</sup>

ZIMASSET 2013-2018 has guidelines relating to the provision of social services which include health care. The National HIV and AIDS Council 2015-2018 Strategic Plan addresses sexual transmission of HIV and anchors the national response, reinforced by the National AIDS Levy as well as solidarity and resource support from Development Partners (DPs) that have both helped the country to plan and execute HIV interventions over the years.

In terms of increasing access to medicines, the Minister of Justice, Legal and Parliamentary Affairs declared a State of Emergency on HIV in 2002 for the purpose of enabling the State or an authorised person to make or use any patented drug, including any ARV drugs, used in the treatment of persons suffering from HIV and AIDS or related conditions and/or to import any generic drug used in the treatment

of persons suffering from HIV or HIV-related conditions. Subsequent to the declaration, Zimbabwean companies have been authorised both to manufacture and to import generic ARV medicines. The 2002 declaration was followed up by a declaration by the GoZ of HIV and AIDS as a national emergency under the TRIPS Doha Declaration, as already noted above.

There are, in addition, various policies and guidelines regarding the provision of and access to HIV-related health care services, such as guidelines on voluntary HIV testing and counselling, home-based care, patients' rights, ART and post-exposure prophylaxis for rape survivors.

#### **Voluntary Informed Consent / Age of Consent to HIV Testing and Treatment**

Section 5.3.2 of the HIV and AIDS Policy makes provision for informed consent to HIV testing and treatment. The preamble to the Policy acknowledges the impediments of non-consensual testing, which include clients' de-motivation to receive and accept the results and denial of one's HIV status. The Policy emphasises the need to provide adequate counselling and education on HIV and AIDS before undertaking any tests. It is also considered important that the client to be given adequate time to make informed decisions on whether to be tested or not. In the case of children below the legal age of consent, consent is required from the parents.<sup>104</sup> Strategies include:

- Obtaining informed consent from the client/patient before doing an HIV test;
- Providing pre- and post- test counselling by people with the appropriate technical and professional ability;
- Offering or referring people with HIV infection for on-going supportive counselling, social support and medical care as required;

101 Guiding Principle 14 of the HIV/AIDS Policy.

102 Principle 15 Section 5:2 of the HIV/AIDS Policy.

103 ZNASP III 2015-2018

104 Guiding Principle 18 of the Policy states that access to information and counselling necessary for informed consent to HIV testing should be ensured as a fundamental human right.

- Making information about informed consent for HIV testing available and accessible to the public; and
- Encouraging couples who envisage marriage, routinely to have HIV voluntary counselling, and testing and to present results to each other.

The HIV Counselling and Testing (HTC) Guidelines are consistent with section 6.5.1 of the National HIV and AIDS Policy and the Children's Act [Chapter 5:06], providing for the legal age of consent to testing and treatment at 16 years. However, section 6.5.1 of the National HIV and AIDS Policy furthermore recognises that young people in Zimbabwe are sexually active before the age of 16, rendering them vulnerable to HIV infection, and should be provided with education, information and counselling about HIV and other STIs, safe sex options and the advantage of behaviour change. In terms of Guiding Principle 29 of the Policy, children and young people below the age of 16 years who have concerns about and/or have an STI have the right to appropriate counselling and care services and advice on means to prevent HIV and STIs. The counselling and professional advice given should depend on each young person's circumstances and potential risk of HIV or other STIs.

### Confidentiality

The right to confidentiality of people living with HIV is provided for in detail in the National HIV/AIDS Policy.<sup>105</sup> The guiding principle of the Policy in this regard is that confidentiality regarding a person's HIV status should be respected while the strategies include the following:

- To promote and maintain confidentiality as a standard approach to the management of HIV and AIDS;

- To encourage individuals through counselling to disclose their HIV status to those who have critical reasons to know;
- To promote appropriate education, information and communication to change people's attitudes in respect of disclosures of their HIV status to those who have critical reason to know;
- To encourage openness about HIV in order to reduce stigma and discrimination;
- To develop legislative provisions to enable professionals to disclose client's/patient's HIV status to a third party (spouse/partner and care giver) who has critical reason to know under certain specific conditions even if consent is denied.<sup>106</sup>

The HIV and AIDS Policy notes the dangers of over emphasis on confidentiality which may lead to increased stigma, discrimination and perpetuate denial of the epidemic. In the cases of spouses, the Policy recognises the potential impact of gender inequality on women's ability to disclose and insist on safer sex within relationships; it however promotes shared confidentiality to consenting couples with adequate counselling.<sup>107</sup>

### Gaps and Challenges

The LEA identified the following important gaps and challenges in national health laws, policies and practices in relation to HIV, TB and vulnerable and key populations:

#### Equality and Non-discrimination in Access to Health Care Services

Despite protection for the rights of all people to health, people living with HIV and TB and vulnerable and key populations continue to experience discrimination in the health care

<sup>105</sup> According to the Preamble to the Policy, confidentiality means not disclosing private or personal information without consent. Confidentiality of medical information about people living with HIV infection is important because of the risk of stigma and discrimination in respect of HIV and AIDS. The Policy recognises that privacy over health matters is a basic human right and is a fundamental principle of ethics of medical practice.

<sup>106</sup> See section 3.1 of the Policy.

<sup>107</sup> The preamble to the policy (s.6.3) notes that in a socio-cultural setting where there is still insufficient gender equality, women are often unable to practice safer sexual behavior because they have little control over their sexual relationships. The implications of non-partner notification in a polygamous marriage can be severe. In accordance with the consensus reached on this issue through the policy debate, a legally approved move toward shared confidentiality is desirable to promote prevention, better care, and coping.

setting. People living with HIV and TB, women, young people, people with disabilities and key populations, including young key populations continue to report discriminatory treatment in access to health care.

### Prioritisation of Health Care Programmes for Vulnerable and Key Populations

The LEA found that health care information and services fail to adequately prioritise and provide appropriate services for vulnerable and key populations. For example, the vulnerabilities and challenges faced by vulnerable populations such as people with disabilities are not adequately addressed within the ZNASP 2015– 2018.

Access to appropriate sexual and reproductive health care services that prioritise the needs of key populations, such as LGBTI populations and sex workers, need to be strengthened. The Public Health Bill has gone some way towards providing for this but needs further strengthening of the rights of vulnerable and key populations. The proposals from engagements with the public on the Public Health Bill noted the need for:

- Enhancing promotion of the rights to equality and equity in the provision of quality health care services, including reproductive health care, and promoting rights-based approaches to health care service provision.
- Ensuring the active inclusion and participation of the public in playing an oversight role of the relevant Ministry in implementing the provisions, through the review of annual reports for public scrutiny, through the inclusion of representatives of key populations, youths and persons with disabilities in the policy making Advisory Board.
- Specific inclusion of protections of the rights to access to quality health care services for vulnerable and key populations.

### Access to Affordable Medicines

There is increased access to affordable medicines through the 2002 declaration of HIV as a State of Emergency. However, the declaration was not followed up with the necessary amendments to the Patents Act [Chapter 26:03] and/or the Medicines and Allied Substances Control Act [Chapter 15:03].

### Regulation of Health Care Providers

While there is legislation providing for the regulation of health care providers, there is no criminal penalisation against health care workers for discrimination, and vulnerable and key populations continue to experience discrimination in health care settings and feel unable to access justice for violations of their rights, beyond that provided for in terms of s86 of the Constitution. The Public Health Bill provides for the right to complain and should be strengthened, to support access to justice for health care violations. Public comments on the Bill recommended that there should be an opportunity to give anonymous complaints, particularly for vulnerable and key populations such as LGBTI populations as well as sex workers and women.

### Coercive / Punitive Public Health Provisions

The Public Health Act and the Public Health Bill contain punitive transmission allowing for isolation and quarantine of people with infectious diseases, such as TB; as well as provisions criminalising the transmission of disease. These provisions should take into account the various recommendations made by international / regional guidance which urge States to be cautious regarding unnecessary isolation / quarantine to ensure it does not unnecessarily limit rights, and to ensure the criminalisation of disease transmission takes into account various factors in any provisions and their implementation.<sup>108</sup>

Public comments on the Public Health Bill were concerned that the provisions, as they stand,

108 The public also recommended decriminalisation of wilful transmission of HIV by repealing Section 79 of the Criminal Law Codification Act

may foster stigma and discrimination and deter people from accessing essential health services such as testing and accessing treatment for HIV and TB, thus eroding the gains made to date on the rights to health services. The provisions are also out of sync with international legal principles which urge States to be cautious regarding unnecessary criminalisation

### Age of Consent to Testing and Treatment

The provisions for the age of consent to testing, including HIV testing, and treatment are dealt with in Policy but not clearly set out in law, including in the Public Health Bill. Public comments on the Public Health Bill noted that the Bill needed to clearly recognise the health rights of young people below the age of 18 years and deal clearly with the age of consent to testing and treatment independently of a parent or guardian, in order to dispel confusion. It was recommended that the age of consent for medical treatment be lowered to between 12-14 years, depending on the maturity of the child and the relevant procedure, taking into account the best interests of the child in line with the CRC. Additionally, the legal age of consent to sex is 16 years of age, presenting challenges to young people below that age who wish to access health care services. HIV and TB prevalence is high amongst young people as confirmed by the most recent ZIMPHIA Report of 2016, and law and policy should reflect this reality.

### Voluntary Counselling and Testing, Confidentiality and Disclosure

The LEA did not receive strong evidence relating to mandatory HIV testing and disclosure, although women reported experiencing mandatory HIV testing during ante-natal services and the problems this raised with disclosure to partners, discrimination and potential violence. Currently, provisions relating to voluntary informed consent and disclosure, however, are set out in Policy, not law. The Public Health Bill is not entirely clear on the conditions under which disclosures may be warranted and does not provide the same level of guidance as that set out in policy.

Legal, regulatory and policy concerns around HIV self-testing were also raised as a concern. Despite the fact that self-testing is not illegal in Zimbabwe, the MOHCC does not allow it as a matter of policy. The distribution of testing kits is not currently regulated by the Medicines Control Authority of Zimbabwe, although legally empowered to do so. ZNASP III (2015-2018) does not provide for self-testing.

### Recommendations

- i. Clearly provide for an integrated approach to managing HIV and TB in the Public Health Act / Bill.
- ii. Clearly set out in the Public Health Act / Bill, the equality and health rights of vulnerable populations and key populations, including young key populations, to protect them from discrimination, exploitation and abuse.
- iii. Clearly provide in the Public Health Act / Bill and Health policy for the rights of vulnerable populations, such as people with disabilities, and key populations, including young key populations, to appropriate health information and health care services, including HIV, TB and SRH services, and the right to participate in the design, development and implementation of programmes.
- iv. Review punitive provisions in the Public Health Act / Bill providing for criminalisation and / or involuntary confinement of people with infectious diseases, to ensure that they are consistent with international and regional guidance relating to HIV and TB.
- v. Clearly set out in law the age of consent to sexual activity, which should be aligned to the age of consent to sexual and reproductive health services, including contraceptives, provided for in public health law.
- vi. Clearly provide in the Public Health Act / Bill for a lowered age of consent to HIV testing, pre- and post-test counselling without parental consent.
- vii. Clearly provide in the Public Health Act / Bill for confidentiality and conditions relating to disclosure, particularly with regard to HIV.

- viii. Clearly provide in the Public Health Act / Bill that health care providers need to respect the views and opinions of adolescents or young persons, including young key populations accessing services, and their right to confidentiality.
- ix. Amend the Patents Act [Chapter 26:03] and/or the Medicines and Allied Substances Control Act [Chapter 15:03] in order to bring national law in line with the TRIPs Agreement, including making specific directives on utilising TRIPs flexibilities in relation to public health for increased access to quality and affordable generic medicines.
- x. Amend the Disabilities Act to strengthen access to health rights and protection from sexual abuse for persons with disabilities.
- xi. Ensure the provision of youth-friendly, including young key population friendly health care facilities and staff.
- xii. Train health care providers in medical ethics and human rights, including non-discrimination, with respect to vulnerable populations and key populations, including young key populations.
- xiii. Review the provision of HIV, TB and SRH services to ensure they promote confidentiality to mitigate against indirect disclosure of a person's health or other status.
- xiv. Ensure programmes provide for appropriate service delivery for the treatment, care and support of all vulnerable populations, with specific reference to AGYW and people with disabilities, and key populations, including young key populations.
- xv. Fund and implement AMTOs to ensure quality access to confidential medical, psychological and function treatment, sexual and reproductive health services and HIV and TB treatment and care for people with disabilities.
- xvi. Develop strong monitoring and evaluation mechanisms to ensure effective

implementation of HIV treatment, care and support.

## b) Women, Gender Inequality, Harmful Gender Norms and Gender Based Violence.

Gender inequality, harmful gender norms and gender-based violence place women at risk of HIV.<sup>109</sup> The GCHL recently updated its landmark report, *Risks, Rights & Health*, noting that there has still been an inadequate response at country level to deal with the various laws, policies and practices that impact on the sexual and reproductive health and rights of women, and particularly adolescent girls and young women.<sup>110</sup>

In Zimbabwe, the largely patriarchal nature of Zimbabwean society means that gender inequality is present within relationships and marriages, with only 68% of men believing a woman has the right to refuse sexual intercourse if she knows he has sex with other women. Similarly, only eight out of ten women believe women have the right to ask their partner to use a condom if he has an STI.<sup>111</sup>

Child marriage places young girls at risk of HIV. Unequal power relations leave them powerless to negotiate safe sex. Many are forced to leave school, resulting in their lack of knowledge and information on sexual and reproductive health care, including HIV. Child marriage violates their rights to protection from exploitation, education, to equal protection before the law and to protection from social and economic exclusion, increasing their vulnerability to GBV and creating barriers to access to health care services. Some young girls are married into faith-based communities that prohibit their access to medical treatment.

More women (and young girls) than men (and young boys) suffer more from various

109 GCHL, *Risks, Rights & Health* (2012).

110 GCHL *Risks, Rights & Health Supplement* (2018).

111 Zimbabwe National Statistics Agency (ZIMSTAT), *Zimbabwe Demographic and Health Survey 2010-11*

forms of violence. More than a quarter of women with a married or stable partner have experienced physical or sexual violence from their partner.<sup>112</sup> This prevents women from being able to negotiate using a condom and puts women at higher biological risk of HIV. About 22% of women also report that their first sexual intercourse was forced or against their will. This rises to almost a third (28%) among women whose first sexual experience was under the age of 15.<sup>113</sup> Economic disempowerment, unemployment, orphanhood, harmful cultural practices and the code of silence are listed as factors that continue to hinder efforts to eliminate GBV. The LEA also found that sentences for sexual violence are at times too lenient, and not a sufficient deterrent to violence.

Fear of violence undermines the capacity of women and girls to negotiate safe sex, and the experience of violence is associated with increased sexual risky behaviour in later years.<sup>114</sup> FGDs during the LEA reported that being found in possession of a condom or negotiating condom use with a partner led to accusations of multiple sexual partnerships and could result in sexual and GBV at the hands of the partner.

Apart from violence leading to more exposure to HIV, women living with HIV appear to be more stigmatised than their male counterparts,<sup>115</sup> reporting instances of being thrown out of homes and dispossessed of property, being blamed for bringing HIV into homes, and violence, amongst other things. The

FGDs conducted during the LEA revealed that in the cases of discordant couples or where one partner's status is unknown, the person known to be HIV-positive may be threatened with disclosure to relatives and friends;<sup>116</sup> women are blamed for their HIV-positive status, deserted and stigmatised as 'akatizwa nemurume'.<sup>117</sup>

Incidences of GBV linked to these scenarios are not uncommon. In the words of a participant in one of the KIIs, "When a man dies first because of HIV, women are normally disinherited by their in-laws after being blamed for causing the HIV and killing their son or brother. They are chased away from the homestead with nothing. In other cases, some women will be aware that their husband died as a result of HIV and will be aware of their own status, but are sometimes pressured into marrying one of the deceased husband's relatives ('kugarwa nhaka'), and they resist at the risk of being sent back to their people while property from them is grabbed by the deceased's relatives, so in many cases they end up agreeing – raising the risk of new infections."<sup>118</sup>

The LEA also revealed high levels of stigma and discrimination against women with HIV at family and community level and in access to health care. This was exacerbated by breaches of confidentiality at public health institutions (discussed in the health care section, above).

## International and Regional Guidance

The UN General Assembly Political Declaration on HIV and AIDS: *On the Fast-Track to Accelerate*

112 UNAIDS, Global AIDS Report (2014).

113 ZIMSTAT, Zimbabwe Demographic and Health Survey 2010-11, op cit. According to some participants in KIIs, "For women, issues of GBV are critical where women are denied taking their drugs by men who confiscate the drugs and throw them away leading to lack of adherence by women." and "Women are also being forced to sleep with their husbands who are actually HIV positive but don't want to use condoms because of male dominance in homes. Once a woman asks a man to put on a condom, the men become violent asking the women where you hear this leading to GBV. The patriarchal society also forces women to subdue themselves to their men and are forced to do whatever it takes to maintain a marriage even if it means having unprotected sex with an infected husband and you cannot also use condoms within the marriage. The husband might even have an S.T.I, but in the woman's mind she was told that do not deny him conjugal pleasure because if you deny him the pleasure and he gets a 'small house' (an adulterous affair with another woman), it's your fault. So that burden on women is always there", KII, Harare, January 2017

114 UNAIDS, Global AIDS Report (2012), p.70.

115 Zimbabwe National Network of PLHIV (ZNNP+) Zimbabwe Stigma Index Research Report (2014) quotes some women as say, "We see this at funerals: they don't want women who are positive to cook or dish food at funerals, sometimes when one is positive even at a gathering no one wants to sit with them as before. The positive sit alone and the negative sit on their own." [http://www.stigmaindex.org/sites/default/files/reports/Zimbabwe%20People%20Living%20with%20HIV%20Stigma%20Index%20Report\\_15-12-14pdf.pdf](http://www.stigmaindex.org/sites/default/files/reports/Zimbabwe%20People%20Living%20with%20HIV%20Stigma%20Index%20Report_15-12-14pdf.pdf), sub-section headed "Exclusion from Social Gatherings" [Accessed June 2018].

116 FGDs and KIIs, 2017.

117 Translated as a woman who has been deserted by her husband.

118 KII, Harare, January 2017.

*the Fight against HIV and to End the AIDS Epidemic by 2030* (2016) acknowledges that the ability of women and girls to protect themselves from HIV continues to be compromised by gender inequalities, including unequal power relations in society between men and women, insufficient health care services, as well as all forms of discrimination against women.

CEDAW calls on States to eliminate all forms of discrimination against women and provides an overarching legal framework to do so, protecting a wide range of women's rights, including women's health rights and protection from all forms of trafficking of women. CEDAW has specifically recommended that HIV responses should give special attention to the health rights of women and children and to factors relating to the reproductive role of women and children and their subordinate position in society, which make them especially vulnerable to HIV infection.<sup>119</sup>

At a regional level, the African Women's Protocol also protects women's rights. Notably, States Parties are obligated to ensure that the right to health of women, including SRH, is respected and promoted. This right includes, *inter alia*, the right to decide whether to have children, the number of children and the spacing of children, the right to choose any method of contraception, the right to self-protection and to be protected against sexually transmitted infections, including HIV and AIDS, the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV, in accordance with internationally recognised

standards and best practices, and the right to have family planning education.<sup>120</sup>

The African Commission on Human and Peoples' Rights *Resolution 201*<sup>121</sup> calls on the Commission to engage all States Parties to repeal laws that facilitate gross human rights violation in the context of HIV and AIDS, such as the sterilisation without consent of positive women, and the denial of quality and reproductive health services to women living with HIV. The Resolution recommends the removal of punitive laws and discriminatory legislative and policy provisions that promote human rights abuses in the context of HIV, including:

- The criminalisation of HIV exposure and transmission
- Mandatory and/or forced HIV testing
- Mandatory and/or forced HIV disclosure
- Restrictions of access to HIV information and services, due to age, sex, gender, sexual orientation and gender identity and/or HIV status.<sup>122</sup>

The Resolution underscores that women's right to health and the principles of autonomy and non-discrimination are recognised under the ACHPR and its Protocol on the Rights of Women in Africa, such as in article 14 as discussed above.

Apart from protection of their health rights, international standards also protect women against GBV. For example, forced sterilisation is regarded as a form of GBV which violates the rights to non-interference with the family,<sup>123</sup> to found a family and right to protection of the family.<sup>124</sup> Forced sterilisations therefore

119 Committee on the Elimination of Discrimination against Women, General Recommendation 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of AIDS, UN Document CEDAW, A/45/38, 2 February 1990.

120 Art.14 of the Protocol.

121 The African Commission on Human and Peoples' Rights, meeting at its 54th Ordinary Session held from 22 October to 5 November 2013, in Banjul, The Gambia.

122 See Gernholtz, L & Grant, C., International, African and country legal obligations on women's equality in relation to sexual and reproductive health, including HIV and AIDS (2010), HEARD and ARASA, Durban, South Africa.

123 For example, ICCPR (art.17) provides for protection against arbitrary or unlawful interference with one's privacy, family, home or correspondence and guarantees the right to the protection of the law against such interference or attacks.

124 Art.23 of the ICCPR recognises the family as the natural and fundamental group unit of society that is entitled to protection by society and the State. The right of men and women of marriageable age to marry and to found a family is recognised. See also General Comment no.19 of the Human Rights Committee which provides, *inter alia*, that the right to found a family implies, in principle, the possibility to procreate and that family planning policies should be compatible with the provisions of the Covenant and should, in particular, not be discriminatory or compulsory. The Committee has stated that the protection of the family should include freedom from arbitrary or unlawful interference.

constitute unlawful interference with the family and permanently deprive one of the possibilities to procreate. A 2014 UN inter-agency statement by the Office of the High Commissioner for Human Rights (OHCHR), UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO refers to forced/coerced sterilisation of women living with HIV/AIDS as being based on “pervasive misconceptions among policy-makers and health care providers regarding HIV transmission”.<sup>125</sup> It calls on health care providers to be “non-coercive and respectful of autonomy, privacy” and not to restrict reproductive freedom “as part of a family planning, HIV prevention or other public health agenda”.<sup>126</sup>

The CRC states that a child is a person under the age of eighteen<sup>127</sup> and should be protected from abuse<sup>128</sup> and sexual exploitation.<sup>129</sup> The Maputo Protocol states that no woman should marry under the age of eighteen.<sup>130</sup> The African Charter on the Rights and Welfare of the Child prohibits child marriage as a practice and specifies that no one should marry under the age of eighteen.<sup>131</sup> Similarly, CEDAW explicitly denounces the betrothal of children into marriage stating that, “The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory”. The AU launched the African Union Campaign to End Child Marriage in 2014, calling on States to take steps to end child marriage, through the adoption of appropriate legal, social and economic measures.

At sub-regional level, the Model Law on HIV and AIDS in Southern Africa also provides for the protection of women living with HIV from

discrimination on the basis of their actual or perceived HIV status (Section 8(1)). It obliges governments to develop laws and policies which protect the sexual and reproductive rights and responsibilities of women and men, including women’s right to refuse sex and the right and ability to negotiate safer sex and the right to access health and reproductive services independently. Section 19 furthermore provides that people living with HIV or affected by HIV are entitled to SRHR. They have the right to a family, including the right to marry and procreate. Their HIV status alone shall not constitute a valid reason to oppose their marriage. Women living with HIV have the right to motherhood and are entitled to benefit from all measures implemented by the State within the framework of the relevant policy on reproductive health.

## Current Position in Zimbabwe

### The Constitution

Section 80 of the Constitution provides for women’s rights to equality and protection from discrimination. Every woman shall enjoy full and equal dignity to men, and this includes equal opportunities in political, economic and social activities. All laws, customs, traditions and cultural practices that infringe the rights of women are void to the extent of their inconsistency with constitutional rights. Section 25 of the Constitution provides for protection of the family, which includes the prevention of domestic violence (although this provision is arguably non-justiciable, since it is located in the National Objectives) and legislative reforms have taken place to strengthen protection against domestic violence.

125 <http://www.southernafricalitigationcentre.org/2015/04/24/submission-to-the-human-rights-committee-regarding-the-forced-and-coerced-sterilisation-of-women-living-with-hiv-aids-in-namibia-submitted-in-advance-of-the-consideration-of-the-list-of-issues-for-na/> [Accessed June 2018].

126 OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO, Eliminating forced, coercive and otherwise involuntary sterilization, an interagency statement, (2014) at p4, [http://www.unaids.org/sites/default/files/media\\_asset/201405\\_sterilization\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/201405_sterilization_en.pdf).

127 Article 19 of the CRC.

128 Article 34 of the CRC.

129 Article 6 (b) of the Maputo Protocol.

130 Article 21 (2) of the ACRWC

131 Article 16 (2) of the CEDAW.

### Laws and Policies to Protect Women's Rights

Zimbabwe has stepped up action over the years to enhance women's rights, through a series of legislative and policy reforms.

The Legal Age of Majority Act, 1982 made all Zimbabweans, regardless of sex, majors upon turning 18 years of age and the Administration of Estates Amendment Act 1997 gave inheritance rights to women, including women in unregistered customary law marriages. The Domestic Violence Act [Chapter 5:16] criminalises all forms of psychological, emotional, economic, physical and sexual violence. The Criminal Law Code also protects women from GBV and the Anti-Domestic Violence Council has been set up to enforce protections.

The revised National Gender Policy (launched in July 2017) has eight priority areas that include gender and health and gender and GBV.<sup>132</sup> The annual 16 Days of Activism against GBV, media and other campaigns have helped to raise awareness. There have also been calls for stiffer penalties on sexual offences while there has been an increase in the number of organisations (including men's forums) supporting survivors of GBV, trafficking and other forms of abuse. Also noteworthy is the Multi-Sectoral Protocol on Sexual Abuse, established in 2012 by the Judicial Service Commission with a view to improve the Government's response to child and adult sex abuse and GBV.

With regard to child marriages, Zimbabwe is party to key regional and international instruments that seek to protect children from harmful practices and sexual abuse. They include the ACRWC,<sup>133</sup> the Protocol to the ACHPR on the Rights of Women in Africa (The Maputo Protocol),<sup>134</sup> CEDAW<sup>135</sup> and the CRC.<sup>136</sup>

Zimbabwe launched the National Chapter of the AU End Child Marriage Campaign on 31 July 2015. Following concerted advocacy by CSOs and FBOs, the ZHRC and government ministries and departments, a landmark court decision was passed outlawing child marriage. In 2016, Zimbabwe's Constitutional Court declared child marriage unconstitutional and set the minimum marriage age at 18 years for boys and girls in all marriages. Since the judgement, the government has committed to developing laws criminalizing the payment of *lobola* (bride wealth) for girls under age 18 years.<sup>137</sup>

### Gaps and Challenges

Despite the protection offered by the law, relevant policies and programmes, gender inequality remains a major driving force behind the AIDS epidemic with women and girls particularly vulnerable to infection and carrying a disproportionate amount of the burden of the pandemic's social and economic impact.<sup>138</sup> Many women continue to fear violence, rejection and abandonment, leading to socio-economic insecurity for them and their children, if they disclose their positive status to their partner or families.<sup>139</sup>

The government has recognised that, despite the guarantees in the Constitution of the rights to health care, food, water and shelter, the National Health Strategy, Reproductive Health Policy and the National HIV and AIDS Policy, health and HIV service delivery is a key concern for women and the high impact of HIV on women necessitates the need to intensify efforts to reduce gender disparities in access to appropriate HIV and sexual and reproductive health and rights.

132 [www.women.gov.zw/downloads?download=3:2013-national-gender-policy](http://www.women.gov.zw/downloads?download=3:2013-national-gender-policy), [Accessed March 2018]

133 Adopted on the 11th July 1990 and came into force on the 29th November 1999 and Zimbabwe ratified on 19 January 1995.

134 Adopted on 7 November 2003. Came into force on 25 November 2005 and Zimbabwe ratified on 15 April 2008.

135 Entered into force on 3 September 1981 and Zimbabwe acceded to it on 13 May 1991.

136 Article 1 of the CRC.

137 <https://www.hrw.org/news/2016/03/31/dispatches-ending-child-marriage-zimbabwe> [Accessed 26 May 2016].

138 UNAIDS Fact Sheet, Gender and HIV/AIDS, [http://www.unaids.org/fact\\_sheets/ungass/html/Esgender\\_en.html](http://www.unaids.org/fact_sheets/ungass/html/Esgender_en.html), cited in "HIV/AIDS and the Humanitarian Catastrophe in Sub Saharan Africa", Report of the Standing Committee on Foreign Affairs and International Trade, B. Patry and I. Cotler, Chairs, (Ottawa; Communications Canada, 2003) at 17.

139 HIV Stigma Index, op cit. See also Feldman et al., Positive Women: Voices and Choices- Zimbabwe Report (2002).

GBV remains a key concern for women, including adolescent girls and young women. The National HIV and AIDS policy furthermore notes that elimination of GBV is, however, far from being achieved as the cases continue to increase.

Early child marriages remain a key concern in the country, despite the court case and other developments. The National UPR Plan of Action urged the Government in one of the key recommendations from the UN Human Rights Council to take concerted steps to end early child marriages and related GBV issues. The government has yet to amend the Marriage Act and other related legislation in line with the judgement and it has not yet put in place structures to ensure that underage girls are protected from child marriage.<sup>140</sup>

## Recommendations

It is recommended as follows:

- i. In line with the UPR Recommendation, all legislation that fuels harmful gender norms and practices should be reviewed to ensure compliance with the right to equality in the Constitution and to international protocols to which the country is party to such as CEDAW.
- ii. Strengthen criminal laws relating to violence, including sexual violence, as well as policies to manage those who have been sexually violated.<sup>141</sup>
- iii. Enact legislation for affirmative action to accelerate increased participation in economic and political sectors of the nation. Policies on the economic empowerment of women should be strengthened.
- iv. Amend the Marriage Act and fully implement laws seeking to end early child marriages.
- v. Ensure that public health law enhances access to integrated, quality health care in general, sexual and reproductive health care and HIV and TB treatment for women and girls.
- vi. Ensure the meaningful involvement of women, including AGYW, in the drafting of laws, policies and guidelines concerning SRHR.
- vii. Strengthen programmes to sensitise women, including AGYW, on their rights, including sexual and reproductive health and rights and rights to be protected from gender inequality, harmful gender norms and gender-based violence.
- viii. Undertaken dialogues with FBOs and traditional leaders for collective efforts to address gender inequality, harmful gender norms and practices, GBV and to end early child marriages.
- ix. Train health care workers on medical ethics, human rights and gender equality, to reduce stigma and discrimination against women and to protect their sexual and reproductive health and rights.
- x. Establish 'safe corners' at health institutions to address issues of confidentiality and to tackle stigma and discrimination.

## c) Criminalisation of HIV Transmission, Exposure and Non-Disclosure

The GCHL confirmed in its 2012 report, *Risks, Rights & Health* that HIV criminalisation fails to encourage safer behaviour and may even result in greater risks.<sup>142</sup> Proponents of using the criminal law to regulate HIV transmission typically emphasise the necessity of ensuring that people behave responsibly towards others, and of protecting innocent members of the

140 Amnesty International, *Lost without knowledge: Barriers to sexual and reproductive health information in Zimbabwe* (2018).

141 Given that there are also cases of rape amongst key populations and people living with disabilities, it is recommended that its scope should be strengthened to be gender-neutral and to apply to all domestic partnerships. It was also recommended that with the increasing statistics of abuse of children and those for GBV which is associated with HIV, sentences for perpetrators should be equally deterrent, since current sentences are at times too lenient (e.g. and not the current lenient sentences that are given such as community service) for sexual violence.

142 GCHL, *Risks, Rights & Health* (2012)

public against the wilful, reckless or negligent conduct of certain ('irresponsible') HIV-positive individuals. However, while acknowledging that it may be appropriate to involve the criminal law in isolated instances where individuals intentionally infect others, public health experts and human rights advocates strongly oppose its overly broad application for a number of reasons, including the following:

- Criminalisation of HIV transmission has a negative impact on the uptake of HIV testing and access to HIV prevention, treatment and care services. Sensational media reports can exacerbate stigma and discrimination and jeopardise HIV prevention strategies currently in place.
- Criminal proceedings may compromise basic civil rights such as the right to privacy, especially among the most vulnerable populations
- These laws, while often believed to protect women, hurt women the most, as they are most likely to be diagnosed with HIV (e.g. through antenatal testing) and thus vulnerable to prosecution. Instead, laws to ensure women's equality inside and outside marriage would protect them more than laws criminalising HIV transmission.<sup>143</sup>

This is particularly relevant for countries such as Zimbabwe, where people living with HIV, vulnerable and key populations already experience high levels of stigma and discrimination, women living with HIV are vulnerable to discrimination and violence and populations have insufficient access to adequate HIV-related health care services.

As of July 2018, 68 countries across the global continue to criminalise HIV non-disclosure, exposure or transmission or allow the use of HIV status to aggravate charges or sentences on conviction. Other countries have applied general laws, such as attempted murder, poisoning, bodily harm or sexual assault laws against people living with HIV. Overly broad criminal laws blatantly disregard up-to-date

knowledge on the science of HIV-related risks and harms. Clinical trials have shown, for instance, that a fully suppressed viral load results in a zero chance of HIV transmission.<sup>144</sup>

## International and Regional Guidance

In 2012, the GCHL recommended the repeal of overly broad laws explicitly criminalising HIV transmission, exposure or non-disclosure (and those that explicitly and effectively criminalise vertical transmission of HIV) and that people should not be prosecuted where no intentional HIV transmission has been proven to take place.<sup>145</sup>

According to the most recent recommendations of the GCHL, to ensure effective, sustainable health responses consistent with universal human rights obligations, the following measures must be adopted as a matter of urgency:

- In countries where HIV criminalisation laws still exist, courts must require proof, to the applicable criminal law standard, of intent to transmit HIV. The intent to transmit HIV cannot be presumed or derived solely from knowledge on the part of the accused of positive HIV status and/or non-disclosure of that status; from engaging in unprotected sex; by having a baby without taking steps to prevent mother-to-child transmission of HIV; or by sharing drug injection equipment.
- Governments must ensure that, where an HIV-specific law has been repealed, there is a restriction on the application of any general laws to the same effect either for HIV or TB.
- Governments must prohibit the prosecution under HIV-specific statutes, drug laws, or child abuse and neglect laws, of women living with HIV for choices they make during and after pregnancy, including about breastfeeding children.
- Whenever HIV arises in the context of a criminal case, police, lawyers, judges and

143 Ibid.

144 GCHL, Risks, Rights & Health Supplement (2018).

145 GCHL, Risks, Rights & Health (2012).

where applicable, juries, must be informed by the best available scientific evidence concerning the benefits and consequences of appropriate therapy, and the individual and community advantages of maintaining such therapy.

- Governments must ensure that HIV status is not used to justify pre-trial detention, segregation in detention or prison, or harsher or more stringent sentences or conditions of parole or probation following release from custody.

### Expert Consensus Statement on the Science of HIV in the Context of Criminal Law 2018: Key Facts<sup>146</sup>

- The possibility of HIV transmission during a single act of vaginal or anal sex ranges from none to low.
- The possibility of HIV transmission during a single act of oral sex ranges from none to negligible.
- There is no possibility of HIV transmission during a single act of vaginal, anal or oral sex where a condom has been used correctly (i.e. it was worn throughout sex and its integrity was not compromised).
- There is no possibility of HIV transmission during a single act of vaginal, anal or oral sex when the HIV-positive partner has an undetectable viral load.
- The possibility of HIV transmission during a single act of vaginal or anal sex when the HIV-positive partner has a low viral load ranges from none to negligible.
- There is no possibility of HIV transmission through saliva even when it contains small quantities of blood.
- The possibility of HIV transmission from biting ranges from none to negligible.

- Modern antiretroviral therapies have improved the life expectancy of most people living with HIV who have access to care to a point similar to their HIV-negative counterparts, transforming HIV infection into a chronic manageable health condition.
- Phylogenetic analysis can be compatible with, but cannot conclusively prove, the claim that a defendant has infected a complainant. Importantly, phylogenetic results can exonerate a defendant when the results are not compatible with the allegation that the defendant infected the complainant.

The Consensus statement notes that “given the evidence... we strongly recommend that more caution be exercised when considering criminal prosecution, including careful appraisal of current scientific evidence on HIV-related risks and harms. This is instrumental to reduce stigma and discrimination and to avoid miscarriages of justice.”

### Current Position in Zimbabwe

The Criminal Law Code makes provision for criminalisation of wilful transmission of HIV. In terms of Section 79 of the Code, any person who “knowing that he/she is infected with HIV or realising that there is a real risk or possibility that he/she is infected with HIV intentionally does anything or permits the doing of anything which he/she knows will infect, or does anything which he/she realises involves a real risk or possibility of infecting another person with HIV, shall be guilty of deliberate transmission of HIV, whether or not he/ she is married to that other person.”

The defence allowed to this charge is for the accused to prove that the other person concerned knew that the accused was infected with HIV and consented to the act in question,

appreciating the nature of HIV and the possibility of becoming infected with it.

The Code also provides, in Section 80, that “where an accused infected with HIV is convicted of rape, aggravated indecent assault or sexual intercourse or performing an indecent act with a young person, involving any penetration of any part of his/her or another person’s body that incurs a risk of transmission of HIV, and it is proved that, at the time of the commission of the crime, the convicted person was infected with HIV, whether or not he/she was aware of his/her infection, he/she shall be sentenced to a mandatory prison term of not less than ten years, unless the convicted person satisfies the court that there are special circumstances peculiar to the case why the penalty should not be imposed.”<sup>147</sup>

The National HIV and AIDS Policy also has some relevant provisions. For instance, Article 6.6 defines wilful transmission of HIV as the deliberate attempt by people who know they are HIV positive to infect other people, normally through unprotected sexual intercourse or deliberate failure to take adequate precautions to prevent the risk of transmission. This depends on the following factors: that the person knew at the time that he/she was HIV-positive and knew how the infection is transmitted; that he/she did not inform the other person of the risk; and that he/she did not attempt to use a barrier method of protection. The Policy recommends that courts “apply severe sentences to sex offenders with HIV infection whether or not they knew they were infected and whether or not they infected the victim. The offender’s HIV status is to be determined by a timely mandatory HIV test done after conviction and before sentencing.”

## Gaps and Challenges

The criminalisation provisions of the Criminal Law Code appear to be overly broad in their

formulation and application, inconsistent with the most up-to-date international and regional guidance. There are examples of prosecutions that have not taken into account medical and scientific evidence relevant to HIV transmission. For example, in *S v Kaiboni Mlambo*, the accused was charged with having sexual intercourse with actual knowledge of his HIV-positive status and that he deliberately or wilfully transmitted HIV to the complainant. The accused argued that he had used a condom and had thus taken steps to prevent transmission of HIV to the complainant. However, he was convicted on the basis of having knowledge of his HIV status (in terms of evidence provided by medical professionals) and on this basis, to have been guilty of acts which had the likelihood to lead another to be infected with HIV.

In the context of the LEA’s findings of stigma, discrimination and violence towards people living with HIV, vulnerable and key populations as well as limited access to appropriate health care services, these overly broad provisions have the potential to negatively impact on public health efforts to end HIV, as well as to result in injustice towards affected persons.

## Recommendations

- i. HIV-specific laws that criminalise HIV transmission and exposure must be reviewed and aligned with international standards.
- ii. Where HIV criminalisation laws still exist, courts must require proof, to the applicable criminal law standard, of intent to transmit HIV. The intent to transmit HIV cannot be presumed or derived solely from knowledge on the part of the accused of positive HIV status and/or non-disclosure of that status; from engaging in unprotected sex; by having a baby without taking steps to prevent mother-to-child transmission of HIV; or by sharing drug injection equipment.

147 The presence in a person’s body of HIV antibodies or antigens, detected through an appropriate test, shall be prima facie proof that the person concerned is infected with HIV. If it is proved that a person was infected with HIV within thirty days after committing a crime referred to in Section 80, it shall be presumed, unless the contrary is shown, that he/she was infected with HIV when he/she committed the crime.

- iii. Governments must prohibit the prosecution under HIV-specific statutes, of women living with HIV for choices they make during and after pregnancy, including about breastfeeding children.
- iv. Whenever HIV arises in the context of a criminal case, police, lawyers, judges and where applicable, juries, must be informed by the best available scientific evidence concerning the benefits and consequences of appropriate therapy, and the individual and community advantages of maintaining such therapy.
- v. Guidelines should be developed to support law enforcement agents and the judiciary, to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established, and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered;
- vi. In the case of sexual offences, such as rape, that result in the transmission of HIV or creates a significant risk of HIV transmission (taking into account medical and scientific evidence regarding transmission), the HIV-positive status of the offender should only be considered an aggravating factor in sentencing if the offender knew he/she was HIV-positive at the time of committing the offence;
- vii. Counselling measures must be taken to encourage couples/partners to share information about their HIV status with each other in order for them to take informed action to prevent HIV transmission and protect each other from infection and reinfection, with due regard for the protection of vulnerable populations (such as women) in the process.

## d) Criminalisation of Key Populations

The HIV epidemic continues to have a disproportionate impact on key populations, including young key populations, such as gay men and other men who have sex with men, sex workers and their clients, transgender people and people who inject drugs.<sup>148</sup> These key populations, like all populations, are entitled to full protection of their rights, including their rights to equality, non-discrimination, dignity, freedom from cruel, inhuman or degrading treatment or punishment and the right to the highest attainable standard of health care. However, key populations often suffer from punitive laws or stigmatising policies, and yet are amongst the most likely to be exposed to HIV. Stigma, discrimination and violence, coupled with punitive laws, create barriers to access to services for such key populations.<sup>149</sup>

Across Africa, including Zimbabwe, key populations, including young key populations, have received limited protective, rights-based responses. Applicable national laws and policies tend to focus narrowly on the rights of people living with HIV while national HIV responses fail to include the participation of and prioritise the needs of key populations in HIV-related law and human rights programmes.<sup>150</sup> This does not only violate rights to equality, dignity and protection from cruel, inhuman or degrading treatment or punishment, but it also impacts upon health rights. Fast-tracking the response to HIV requires creating an enabling, protective legal and regulatory environment in which key populations can ensure their rights are protected and access targeted services.<sup>151</sup>

The report below discusses populations key to the HIV epidemic and response in Zimbabwe: LGBTI populations, sex workers, people who inject drugs, transgender people and prisoners.

148 UNAIDS, Global AIDS Update (2018).

149 GCHL, Risks, Rights & Health (2012).

150 UNAIDS, Desk Review of National Strategic Plans in East and Southern Africa (2011).

151 UNAIDS, Focus on Location and Population (2015).

## LGBTI Populations

Globally, gay men and other men who have sex with men are 19 times more likely to be living with HIV than the general population.<sup>152</sup> However, they are often stigmatised and socially excluded, and have severely diminished access to health care. A set of diverse factors contribute to increased prevalence amongst these key populations:

- High levels of discrimination and human rights violations that increase vulnerability to HIV and deter access to HIV prevention, treatment, care and support services;
- Negative experiences with health care providers.<sup>153</sup> These key populations report strong stigma on the part of health care workers, which they feel results in discrimination against them in health care settings. Many report avoidance rather than dealing with such treatment;<sup>154</sup>
- Most countries in Southern Africa criminalise some sexual acts between same-sex people, even where they are consenting adults;<sup>155</sup> and
- Transgender persons and lesbians are generally marginalised, abused and often rejected by their families and society from an early age, due to their expression of their gender identity.

The LEA found high levels of stigma, discrimination, sexual violence and human rights violations against LGBTI populations in Zimbabwe, including young key populations, as set out below.

LGBTI populations reported stigma and discrimination on the basis of their sexual

orientation or gender identity, which made them hide their sexual orientation and gender identity. For example, some intersex persons only identify as intersex in safe spaces but identify as male in public.<sup>156</sup> Interviews with LGBT populations, especially young LGBTI populations, revealed psycho-social challenges related to stigma, discrimination and the lack of family support. During these early years of their young life transitioning to adults, they find it challenging to cope with issues of revealing identities and sexual orientation and the societal pressure to remain secret imposed a heavy psycho-social burden. Transgender persons revealed a lack of information and high levels of stigma and discrimination, harassment and abuse<sup>157</sup> making them feel ostracised and marginalised by their families and society.<sup>158</sup> Research further reveals that the lifelong impact of exclusion often results in poverty, exclusion from society, homelessness and, in a significant proportion of people, selling sex in order to make a living.<sup>159</sup>

Family non-acceptance also led to forced heterosexual marriages,<sup>160</sup> forced or coerced participation in church and being taken to traditional healers to 'heal' or 'deliver' them from their sexual orientation and gender identity. At a young age and dependant on the economic support of their families, they felt they had limited choices.

Patriarchal attitudes and stereotypes, societal homophobia and transphobia made lesbians, bisexual women, and transgender men forced into relationships, particularly vulnerable to violence, including rape and other sexual abuse. There are also reports of extreme and vicious levels of violence directed at

152 UNAIDS, Gap Report (2014).

153 [http://www.out.org.za/images/library/pdf/Healthcare\\_in\\_Gauteng\\_Research\\_Findings.pdf](http://www.out.org.za/images/library/pdf/Healthcare_in_Gauteng_Research_Findings.pdf), A study conducted by Johns Hopkins University [Accessed 1 March 2018].

154 FGDs with men who have sex with men and gay men.

155 For instance, in terms of S.78(3) of the Constitution, same-sex marriages are not recognised in Zimbabwe.

156 KII January 2017. Populations reported that whether a person is gay, gender diverse or intersex, they are all referred to as "*ngochani*" meaning homosexuals.

157 Culturally specific for transgender persons, such as 'jengavarume' and 'jengavakadzi' point to the fact that the society is aware of their existence.

158 Interview with key informant- TranSMART- April 2018

159 Southern Africa Litigation Centre (SALC), Access to Justice for Healthcare Violations: Background Document (2017); available at <http://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/Background-document-4.0.pdf> [accessed June 2018].

160 For example, FGD, Bulawayo, November 2015 and June 2018 in Harare and Bulawayo.

transgender women and lesbian women, arguably due to the multiple and intersecting layers of discrimination facing women in highly patriarchal African families and societies.

Young key populations experienced stigma and discrimination in access to health care facilities, creating barriers and fears of disclosure of sexual orientation or gender identity.

Rights violations included outright denial of access to health care, insults, degrading treatment and breaches in confidentiality, making them unwilling to access public health facilities or avoid treatment. Also, LGBTI populations in FGDs reported that there are limited programmes to specifically address their diverse needs<sup>161</sup> and health services specific to their needs (e.g. hormonal treatment for transgender persons) as well as knowledge gaps amongst health care workers on their health care requirements.<sup>162</sup> Government condemnation of LGBTI populations also resulted in health professionals being hesitant to provide services.<sup>163</sup> On a positive note, CSO training programmes focusing on the needs of LGBTI people for private health professionals has improved access to health facilities for individuals aware of and able to pay for these services, although many cannot afford them.<sup>164</sup> Also, engagements with some health care service providers has improved service

delivery, although FGDs noted that young LGBTI populations continue to encounter challenges in accessing treatment, care and psycho-social support.

Transgender persons reported that the Births and Deaths Registration Act [Chapter 5:02]'s provision for gender led them to feeling unrecognized in law<sup>165</sup> and official documentation, which led to the avoidance of health services where they were unsure of how to describe their gender and vulnerable to inappropriate treatment by health providers.<sup>166</sup> Obtaining birth certificates and national registration cards remains a challenge.

Organisations supporting the rights of LGBTI populations and their access to HIV services are routinely harassed, their members arrested, offices searched, and documents confiscated, as happened at Gays and Lesbians Zimbabwe (GALZ) in 2012,<sup>167</sup> driving people further away from services.<sup>168</sup> The LEA revealed that many LGBTI populations did not know their rights and were unable or unwilling to access justice for rights violations. Violence, including sexual violence and violence within partnerships,<sup>169</sup> was often not reported since the police do not take these cases seriously and populations feared disclosure of their sexual orientation or gender identity.<sup>170</sup> This further perpetuates the social misconception that violence against LGBTI populations is acceptable, perpetuating violations and

161 KII, Transgender group, 2017.

162 KII, GALZ 2017.

163 Ibid. The former president of Zimbabwe was known to lash out at gays and lesbians and even calling them 'worse than pigs and dogs'.

164 Focus group participant, Bulawayo, November 2015.

165 Zita, Harare, Zimbabwe, November 2015.

166 The Southern Africa Litigation Centre noted in its report dated 27 September 2016 that: 'There are no laws or policies that provide for hormonal treatment or any other gender-affirming healthcare for transgender people. Transgender people who want to access hormonal treatment usually look to the black market or travel outside Zimbabwe – mainly to South Africa – to access this medication.' (Southern Africa Litigation Centre, Laws and Policies Affecting Transgender Persons in Southern Africa (2016) at p51 <http://www.southernafricalitigationcentre.org/1/wpcontent/uploads/2016/09/Transgender-rights-in-Zimbabwe.pdf>) [Accessed June 2018].

167 UNAIDS, 'Homophobia and punitive laws continue to threaten HIV responses and human rights' (2012) Police raided GALZ offices, arrested, detained and assaulted some of its members, including the chairperson. Fortunately, the High Court held that GALZ did not need to register under the Private Voluntary Organisations Act it was not a private voluntary organisation and ordered the police to return all property seized during the police raid. See also ARASA Sexual Orientation, Gender Identity, HIV and Human Rights: An Advocacy Toolkit (2015).

168 In an FGD with gay men and men who have sex with men in 2017 and 2018, some participants said that they are at risk of HIV exposure from unprotected sex because they are not given the chance to protect themselves. For example, they do not seek information nor are they free to negotiate safe sex or protection.

169 FGDs conducted in April 2018 for LGBTI populations validated the presence of intra-group GBV

170 For instance, in a particularly brutal case in 2014, a gay man was gang-raped by nine men. When he reported the case, the police refused to proceed with the case on the basis of his sexual orientation.

exploitation.<sup>171</sup> However, there were some reports of improved relationships with the police and an improved ability to report violations.

## International and Regional Guidance

The GCHL *Risks, Rights & Health* report and the WHO *Technical Briefs on Young Key Populations* provide international guidance on laws, policies and practices to respond to the needs of LGBT populations, including young key populations. They recognise that the various forms of stigma, discrimination and human rights violations experienced by LGBTI populations create barriers to access to quality health services leaving them increasingly vulnerable to HIV exposure and related health risks. These vulnerabilities are exacerbated for young key populations. They include:

- Take steps to reduce stigma, discrimination and violence against LGBT populations, including young populations
- Train health care workers to reduce stigma and discrimination and increase awareness of the rights of, and the provision of health care services for LGBT populations
- Provide access to effective HIV and health services and commodities for LGBT populations
- Provide access to comprehensive sexuality education that takes into account the issues of sexual orientation and gender identity, including for young LGBT populations
- Repeal all laws that criminalise consensual sex between adults of the same sex and/or laws that punish homosexual identity.
- Remove legal, regulatory and administrative barriers to the formation of community organisations by or for LGBT populations.
- Repeal all laws that punish cross-dressing.
- Ensure transgender people are able to have their affirmed gender recognised

in identification documents, without the need for prior medical procedures such as sterilisation, sex reassignment surgery or hormonal therapy.

- Amend anti-discrimination laws expressly to prohibit discrimination based on sexual orientation (as well as gender identity).
- Promote effective measures to prevent violence against LGBT populations, including sensitizing the police to the rights of LGBT populations

## Current Position in Zimbabwe

The Constitution recognises and provides general protections in the Bill of Rights (Fundamental human rights and freedoms). These provisions protect all in the country including key populations against all forms of discrimination, equality of all before the law and equal protection and benefit of the law; right to human dignity and personal security<sup>172</sup> and the right to access to basic health care services, including reproductive health care services.<sup>173</sup>

However, sex between men is illegal in Zimbabwe, in terms of the section 73 of the Criminal Law (Codification and Reform) Act (the law is silent regarding sex between women).<sup>174</sup> In terms of Section 73, any male persons who engage in consensual sexual intercourse involving anal penetration or any act involving physical contact, other than anal penetration, that would be regarded to be an indecent act shall be guilty of sodomy. Where a male person performs anal sexual intercourse with or commits an indecent act upon a young male person who is 12 years or above but below the age of 16 years, with the consent of such young male person, shall be guilty of performing an indecent act with a young person. The section can be interpreted as prohibiting most types of physical contact between male persons such as kissing, holding hands, cuddling or hugging in an intimate manner and is thus

171 ARASA, *Identifying Injustice: Law and Policy on Sexual Orientation, Gender Identity and HIV in Southern Africa* (2016).

172 Sections 51 through to Section 57 of the Constitution.

173 Section 76 of the Constitution of Zimbabwe (2013)

174 Chapter 9:23 of 2004

largely perceived by society as prohibiting homosexuality rather than merely prohibiting sex between men.

Particularly disturbing is the use of non-consensual, forcible anal examinations to obtain evidence of sodomy. Two instances were reported in 2010 of forcible anal examinations involving four individuals, performed without privacy in the presence of multiple health care providers and police officers.<sup>175</sup> There was another reported case in 2011 in which the victim's legs were restrained while he was forced to undergo an anal examination and thereafter to take unknown medication. International human rights treaty monitoring bodies have expressly held that anal examinations under these circumstances amount to torture.<sup>176</sup>

The Censorship Entertainment and Control Act [Chapter 10:04] criminalises importing, printing, publishing, manufacturing, making or producing, distributing, displaying, exhibiting or selling or offering or keeping for sale any publication, picture, statue or record which is undesirable or has been declared by the Censorship and Entertainment Board to be undesirable.<sup>177</sup> This provision may impact on sexual health information for LGBTI populations.

There have been some collaborative government efforts to provide access to health care for LGBTI populations in Zimbabwe. The Ministry of Health recently launched a Pre-Exposure Prophylaxis (PrEP) Strategy 2018-2020 to target key populations, especially men who have sex with other men and sex workers. These are part of overall efforts by government in addition to providing broad access to treatment, care and psycho-social support to meet the target of ending HIV and AIDs by 2030. The efforts of government are enhanced by CSOs working in health care and access to justice. International donors and development agencies such as the Global Fund to Fight AIDS, Tuberculosis and Malaria

(GFATM) and the United States Presidential Emergency Plan for AIDS Relief (PEPFAR) have attempted to ensure some of their funding is directed towards men who have sex with other men. Under PEPFAR, more than 90% of health facilities in Zimbabwe are offering ART through partnership between the government and NGOs. This is evidence of *strong political will* and commitment by the government and partners to address health issues of key populations despite the absence of specific provisions legally recognizing key populations.

Additionally, organisations that support the rights of LGBTI populations and their access to HIV services do exist, such as GALZ. GALZ are able to organise despite relational challenges between the government and the organisations. GALZ is among the CSOs that actively participate in the National Universal Peer Review Processes in the country.

## Gaps and Challenges

Constitutional provisions protecting the rights to life, to personal liberty, human dignity, security of person, equality and non-discrimination, privacy, assembly and association, and freedom of movement do not appear to provide adequate protection for LGBT populations. They continue to experience discrimination and intimidation, leading to exclusion from society, services and job opportunities. This has in turn increased their vulnerability, generally and including to HIV.

The Criminal Law (Codification and Reform) Act criminalising sex between men impacts on the right to privacy and exacerbates stigma, discrimination, violence and access to non-discriminatory, appropriate and accessible health care services for LGBTI populations, particularly young LGBTI populations in Zimbabwe, as has been shown above. As a result, many LGBTI populations do not know their HIV status and are unable to access treatment.

175 Gays and Lesbians of Zimbabwe, LGBTI Rights Violations Report (2011).

176 Ibid.

177 See s.13 of the Act.

There are no national statistics on LGBTI populations and they do not easily access appropriate health care services to meet their needs in the public health care system.<sup>178</sup> While Zimbabwe has developed a National HIV and AIDS Strategic Plan that recognises the need to prioritise key populations, the legal framework is not supportive of their access to services.<sup>179</sup> International funding for key population programmes by donors such as the GFATM and PEPFAR have improved the situation, but restrictions on the rights of LGBTI populations and government action has resulted in these having limited benefit.<sup>180</sup>

The LEA also found that LGBTI populations have limited awareness of their rights and are often unable to access justice for human rights violations.

### Recommendations:

- i. Strengthen anti-discrimination law to protect the rights of persons to equality and non-discrimination on the basis of sexual orientation and gender identity.
- ii. Review provisions of the Criminal Law and Codification Act to decriminalise adult consensual same-sex sex.
- iii. Ensure transgender people are able to have their affirmed gender recognised in identification documents and that official forms accommodate their gender identity.
- iv. Provide access to effective HIV and health services and commodities for LGBTI populations.
- v. Establish 'safe corners' at health institutions to enhance confidentiality in accessing health care and to mitigate stigma and discrimination
- vi. Provide access to comprehensive sexuality education that takes into account the issues of sexual orientation and gender identity, including for young LGBTI populations

- vii. Stigma and discrimination reduction programmes, including with traditional authorities and FBOs, should be undertaken to reduce stigma, discrimination and violence against LGBTI populations
- viii. Law enforcement officials, especially the Victim Friendly Unit, should be trained on the rights of LGBTI populations, emphasising the principles of equality and non-discrimination and the right to equality before the law, and equal protection of the law
- ix. Health care practitioners should be trained on all LGBTI populations, their rights and health needs, to address stigma and discrimination, to increase understanding and to improve health care.
- x. Increase awareness of rights amongst LGBTI populations
- xi. Promote effective measures to prevent and redress violence against LGBTI populations.

### Sex Workers

Sex workers in Zimbabwe are vulnerable to HIV due to the nature of their work, the criminalisation of sex work and inadequate access to quality health care services partly from fear of arrest, stigma and discrimination and the attitudes of health care service providers. Male sex workers faced additionally vulnerabilities through the criminalisation of sex work as well as sex between men.

Sex workers report being highly stigmatised in society and marginalised by family and community members. Extortion, harassment, verbal abuse and violence, including beatings, torture, sexual violence and gang rape, are common occurrences at the hands of their clients as well as law enforcement officials – although this has reported to have decreased since the 2015 Constitutional court judgement (discussed further below).

178 KII, Transgender group, 2017.

179 LGBT People Project, Bridging the Gaps (2016) available at <http://www.hivgaps.org/projects/lesbiangay-bisexual-and-transgender-projects/lgbt-project-zimbabwe/> quoted from Country Policy and Information Note Zimbabwe: Sexual orientation and gender identity, November 2016.

180 amfAR, Achieving an AIDS-Free Generation for Gay Men and Other MSM in Southern Africa, Country Profile: Zimbabwe (2016).

All sex workers, irrespective of gender, report discriminatory treatment in the health-care sector including stigmatisation, denial of services and breaches of confidentiality,<sup>181</sup> making them reluctant to disclose their health needs and impacting on their ability to seek and access treatment.<sup>182</sup> In FGDs conducted during the LEA, young sex workers highlighted increased risk and exposure to HIV as they were particularly vulnerable to stigma and discrimination and felt unable to withstand it, avoiding health care.<sup>183</sup>

Many sex workers find it difficult to negotiate safe sex and reported violence and abuse from clients, including in attempts to negotiate safe sex with clients – this is in addition to violence related to ‘territorial space’ and competition with older sex workers.<sup>184</sup> They reported being reluctant to report abuses or pursue remedies, due to stigma and discrimination, fear of arrest and due to the fact that law enforcement officials are often the perpetrators.<sup>185</sup> Other actions of law enforcers – where the possession of condoms is used as proof of sex work and condoms are confiscated, also hamper sex workers’ ability to negotiate condom use with clients, heightening their risk of HIV.

## International and Regional Guidance

The GCHL found that criminalisation, in collusion with social stigma, render sex workers’ lives more unstable, less safe and far riskier in terms of HIV, where there is no legal protection from discrimination and abuse.<sup>186</sup> It recommended that countries must reform their approach towards sex work. Rather than punishing consenting adults involved in sex work, countries must ensure safe working conditions and offer sex workers and their clients’ access to effective HIV and health

services and commodities. Countries should, amongst other things:

- Repeal laws that prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit commercial sex, such as laws against “immoral” earnings, “living off the earnings” of prostitution and brothel-keeping. Complementary legal measures must be taken to ensure safe working conditions to sex workers.
- Take all measures to stop police harassment and violence against sex workers.
- Prohibit the mandatory HIV and STI testing of sex workers.
- Ensure that the enforcement of anti-human-trafficking laws is carefully targeted to punish those who use force, dishonesty or coercion to procure people into commercial sex, or who abuse migrant sex workers through debt bondage, violence or by deprivation of liberty. Anti-human-trafficking laws must be used to prohibit sexual exploitation and they must not be used against adults involved in consensual sex work.
- Enforce laws against all forms of child sexual abuse and sexual exploitation, clearly differentiating such crimes from consensual adult sex work.
- Ensure that existing civil and administrative offences such as “loitering without purpose”, “public nuisance”, and “public morality” are not used to penalise sex workers and administrative laws such as “move on” powers are not used to harass sex workers.

## Current Position in Zimbabwe

The Criminal Law Code establishes the following crimes relating to sex work:<sup>187</sup>

181 KII, January 2017 and FGD April 2018.

182 KII, January 2017 and FDG May 2018.

183 FDG with sex workers in Bulawayo in May 2018

184 FDG with sex workers in Bulawayo in May 2018

185 KIIs and FGDs with sex workers, January 2017 and April/May 2018.

186 GCHL, Risks, Rights & Health (2012).

187 The Criminal Law Code, which still uses the term ‘prostitute’, defines a prostitute in s.61 as a male or female person who for money or reward allows other persons to have anal or extra-marital sexual intercourse or engage in other sexual conduct with him or her or solicits other persons to have anal or extra-marital sexual intercourse or engage in other sexual conduct with him or her.

- Soliciting – any person who publicly solicits<sup>188</sup> another person for the purposes of prostitution shall be guilty of soliciting;<sup>189</sup>
- Living off or facilitating prostitution – any person who keeps a brothel or demands from a prostitute any payment or reward in consideration of the person keeping, managing or assisting in the keeping of a brothel in which the prostitute is, or has been, living for immoral purposes or commits such other related act shall be guilty of living off or facilitating prostitution;<sup>190</sup>
- Procuring (pimping);<sup>191</sup> and
- A parent or guardian allowing a child to become a prostitute.<sup>192</sup>

Thus, sex work *per se* is not illegal but solicitation is criminalised. Be that as it may, sex work itself has generally been perceived to be illegal, and this appears to have been the attitude of law enforcement officers too.

There has been a general misconception that sex work has been legalised, arising from the Constitutional Court decision of June 2015<sup>193</sup> in which the then Deputy Chief Justice Honourable Justice Luke Malaba, sitting with eight other Constitutional judges, passed the landmark decision primarily protecting the rights to personal liberty and equality before the law. The Court declared the arrest and prosecution of nine sex workers to be *ultra vires* the provisions of the Constitution. Following from this, relationships between the police and sex workers have ‘thawed’ with

hardly any official cases of unlawful arrests being reported. The law stipulates that both the conduct of solicitation must be specified (i.e. evidence of proactive attempt to procure a client rather than based on the person’s location and/or clothing) and the person who was being solicited must be present in court.

On a positive note, one of the strategies employed by the National HIV and AIDS Policy is to ensure that all people with HIV and STIs are treated, whether they are known or believed to be sex workers or not, with respect and dignity and without discrimination. In terms of Guiding Principle 31, government must apply the most effective policies and strategies to deal with sex work in order to reduce the transmission of HIV and STIs and deal appropriately with legislative provisions and revise those which do not comply with current community concerns. Guiding Principle 32 provides that information, education, counselling, and male and female condoms, and STI care services must be made accessible and affordable to all sex workers and their clients.

## Gaps and Challenges

Laws criminalising aspects of sex work in Zimbabwe appear to exacerbate stigma and discrimination, create barriers to access to health care services and create limited access to justice for sex workers.

187 The Criminal Law Code, which still uses the term ‘prostitute’, defines a prostitute in s.61 as a male or female person who for money or reward allows other persons to have anal or extra-marital sexual intercourse or engage in other sexual conduct with him or her or solicits other persons to have anal or extra-marital sexual intercourse or engage in other sexual conduct with him or her.

188 “Publicly soliciting” means soliciting in a public place or any place to which the public or any section of the public have access or publication of the solicitation in any printed or electronic medium for reception by the public.

189 S.81 of the Criminal Law Code.

190 S.82 of the Criminal Law Code.

191 S.83 of the Criminal Law Code.

192 S.87 of the Criminal Law Code.

193 The facts of the case is that nine women who were found walking in the Avenues area of Harare at night by police, who arrested them on the grounds that they were soliciting for the purposes of prostitution. However, there was no proof that they were in actually soliciting for the purposes of prostitution as there was no indication of who was being solicited and how. The Court took the view that the arrest of the women amounted to the deprivation of their liberty and that the police must have both reasonable suspicion and evidence that someone is indeed soliciting for the purposes of prostitution before making an arrest. Prior to this ruling, law enforcement officials had been labouring under the misconception that every woman who moves around in perceived red-light areas at night is a sex worker. This led to the arbitrary arrests of innocent women. The ruling was progressive in that it promotes gender equality as well as ensures respect and the protection of women’s rights. Women, like men, are entitled to enjoy the right to freedom of movement and to liberty and security of person.

## Recommendations

- i. Repeal laws that prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit commercial sex, such as laws against “immoral” earnings, “living off the earnings” of prostitution and brothel-keeping. Complementary legal measures must be taken to ensure safe working conditions to sex workers.
- ii. Improve access to HIV-related health care services for sex workers, including through the training and sensitisation of health care providers in non-discrimination and protection of the health and other rights of sex workers, including young sex workers.
- iii. Take all measures to stop police harassment and violence against sex workers
- iv. Enforce the Court ruling protecting sex workers from unlawful arrest.
- v. Sensitise law enforcement officials to the rights of sex workers.

## People who use drugs

People who inject drugs are at extremely high risk of HIV exposure. HIV prevalence amongst people who inject drugs is estimated at around 28 times greater than amongst the general population.<sup>194</sup> The GCHL Africa Regional Dialogue found that criminalisation of drug use, fear of arrest, harassment and the imprisonment of people who use drugs, accompanied by widespread societal stigma, discourages access to health care services for people who use drugs and creates legal barriers to the provision of needle and syringe programmes and opioid substitution therapy.<sup>195</sup>

As a result of barriers created by criminalisation and widespread societal discrimination,

many countries in Africa fail to recognise people who inject drugs as a key population, have limited data on key populations within their countries and cities, and fail to provide harm-reduction programmes targeting their needs. Zimbabwe is no exception. In FGDs conducted in Harare and Bulawayo with young key populations, the discussions were not conclusive on the extent and magnitude of the challenge among the various groups though some young key populations from transgender, gays and lesbians reported some use of drugs and alcohol and the likelihood of exposure to contracting HIV as a result of engaging in unprotected sex. The transgender groups further alluded to the use of hormonal therapy and related drugs sourced from unregulated sources as these were not readily available in health care facilities.

## International and Regional Guidance

The GCHL 2012 *Risks, Rights & Health* report recommends, *inter alia*, that countries must reform their approach towards drug use. Rather than punishing people who use drugs who do no harm to others, they must offer them access to effective HIV and health services, including harm reduction and voluntary, evidence-based treatment for drug dependence. Countries must:

- Shut down all compulsory drug detention centres for people who use drugs and replace them with evidence-based, voluntary services for treating drug dependence
- abolish national registries of drug users, mandatory and compulsory HIV testing and forced treatment for people who use drugs.
- Repeal punitive conditions such as the United States government’s federal ban on

194 ACHPR, HIV, the Law and Human Rights in the African Human Rights System: Key Challenges and Opportunities for Rights-Based Responses to HIV (December 2016) available at [http://www.achpr.org/files/news/2017/01/d271/hiv\\_the\\_law\\_and\\_human\\_rights\\_in\\_the\\_african\\_human\\_rights\\_system\\_draft\\_study\\_report.pdf](http://www.achpr.org/files/news/2017/01/d271/hiv_the_law_and_human_rights_in_the_african_human_rights_system_draft_study_report.pdf). A study in Zanzibar showed that HIV prevalence was 30% higher amongst people who inject drugs than amongst the general population (MJU Dahoma et al. “HIV and Substance Abuse: The Dual Epidemic Challenging Zanzibar” 5(2) African J of Drug & Alcohol Studies (2006) quoted in HIV, Law and Human Rights in the African Human Rights System, op cit). Research in Mauritius also indicates high rates of sex work amongst people who inject drugs and high rates of injecting drug use amongst sex worker respondents (UNAIDS 2015 quoted in HIV, Law and Human Rights, op cit).

195 GCHL, Report of the GCHL Africa Regional Dialogue on HIV and the Law (2011.)

funding of needle and syringe exchange programmes that inhibit access to HIV services for people who use drugs.

- Decriminalise the possession of drugs for personal use, in recognition that the net impact of such sanctions is often harmful to society.

## Current Position in Zimbabwe

Chapter VII of the Criminal Law Code prescribes crimes involving dangerous drugs. These include unlawfully acquiring or possessing a dangerous drug, ingesting, smoking or otherwise consuming a dangerous drug, or cultivating, producing or manufacturing a dangerous drug for his/her own consumption. Where a court convicts any person of the crime of unlawfully possessing or using a dangerous drug and it is established that the person is an abuser of and addicted to a dangerous drug the court may, additionally or alternatively to any imposable sentence, impose a sentence requiring the person to undergo treatment for such addiction.<sup>196</sup>

## Gaps and Challenges

There is no available data on people who use drugs in Zimbabwe, perhaps because of criminalisation of drug use. From interactions with KIIs and FGDs during the LEA and the resultant inconclusive evidence to establish causal relationship between abuse of drugs and alcohol and risk of enhanced exposure to HIV, further research is recommended.

## Recommendations

Zimbabwe could learn from best practices in countries like Mauritius, which has a rights-based legal and programmatic response to managing HIV and drug use. The HIV and AIDS Act (No. 31 of 2006) of Mauritius provides for people who use drugs to access a range of HIV prevention services, such as accessing clean needles without penalty, even though

drug use is criminalised. This has facilitated a comprehensive programmatic response reaching large numbers of people who use drugs with methadone substitution therapy (including in prisons), needle exchange programmes, a harm-reduction community service and a mobile caravan service for people who inject drugs and other key populations.<sup>197</sup>

More specifically, the following measures could be adopted:

- i. Conducting further research on people who use drugs in Zimbabwe
- ii. Based on research, replacing criminalisation and punishment of people who use drugs with evidence-based and rights-affirming interventions, including the promotion of referrals to rehabilitation programmes rather than the imposition of custodial services for persons convicted of possession for own use.
- iii. Strengthening access to justice and law enforcement, including the strengthening of stigma and discrimination campaigns, law and human rights information on existing and new laws, education and training for all, including key populations and key service providers such as health workers, strengthening legal support services and mechanisms for enforcing HIV-related human rights complaints;

## Prisoners

HIV in prisons is both a public health and a human rights issue that needs to be addressed urgently for an effective response. Like everyone else, prisoners are entitled to enjoy the highest attainable standard of physical and mental health. Human rights norms recognise that prisoners retain their rights, with the exception of those that are either limited or taken away owing to incarceration, such as loss of liberty. States therefore have an obligation to implement legislation, policies and programmes consistent with international

<sup>196</sup> S.157 of the Code.

<sup>197</sup> ACHPR, HIV, Law and Human Rights, op cit.

human rights norms to ensure prisoners are provided a standard of health care equivalent to that available in the outside community.<sup>198</sup>

Various behaviours within prisons place prisoners at high risk of exposure to HIV and sexually transmitted infections, including unprotected sex between men, rape, sex bartering and prison ‘marriages’. In addition, unsafe injecting practices among people who inject drugs, blood exchange and the use of non-sterile needles and other cutting instruments for tattooing are widespread.<sup>199</sup> Overcrowding as well as stress, malnutrition, drugs, and violence weaken the immune system, making prisoners living with HIV more susceptible to getting ill; yet prisoner well-being is often neglected and overlooked.<sup>200</sup> Overcrowding also results in poor supervision and safety, which significantly increases the risk of gang activity and violence. Tension, frustration, and idleness among prisoners is often released through sex and sexual abuse.<sup>201</sup>

Addressing the health needs of prisoners living with HIV can go a long way in achieving the 90-90-90 vision, as prisoners and the prison community should not be isolated from the general population. The majority of prisoners leave prisons and return to society, while many other persons including staff, volunteers and visitors, live and work amongst prisoners, or visit the prisons on a regular basis.

## International and Regional Guidance

The International Guidelines state that “denial to prisoners of access to HIV-related information, education and means of prevention (bleach, condoms, clean injection

equipment), voluntary testing and counselling, confidentiality and HIV-related health care and access to and voluntary participation in treatment trials, could constitute cruel, inhuman or degrading treatment or punishment.”

GCHL recommendations state that to ensure an effective, sustainable response to HIV that is consistent with human rights obligations, countries must ensure that in places of detention:

- Necessary health care is available, including HIV prevention and care services, regardless of laws criminalising same-sex acts or harm reduction. such care includes provision of condoms, comprehensive harm reduction services, voluntary and evidence-based treatment for drug dependence and ART
- Any treatment offered must satisfy international standards of quality of care in detention settings. Health care services, including those specifically related to drug use and HIV, must be evidence-based, voluntary and offered only where clinically indicated.

The Model Law on HIV and AIDS in Southern Africa prohibits the isolation of prisoners on the basis of their HIV status. However, in the event of violence and abuse or real risk thereof, a prisoner living with HIV may be temporally isolated from other prisoners. This decision is subject to judicial review.<sup>202</sup> SADC has also developed extensive guidance on the management of HIV and TB within prisons.

## Current Position in Zimbabwe

The Prisons Act [Chapter 7:11] provides for the right of prisoners to have access to medical officers. Section 36 of the Act provides that

198 UNODC-UNAIDS-WHO Framework for HIV AIDS Prevention, Treatment and Care in Prison (2006). See also HIV and Prisons in Sub-Saharan Africa: Opportunities for Action UNAIDS; World Bank; UN Office for Drugs and Crimes.

199 Ibid.

200 UNAIDS, The Gap Report (2014) available at <https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/prisoners> [Accessed 6 December 2016].

201 According to UNAIDS, Prisons and AIDS (1997): “Prison conditions are often ideal breeding grounds for onward transmission of HIV infection. They are frequently overcrowded. They commonly operate in an atmosphere of violence and fear. Tensions abound, including sexual tensions. Release from these tensions, and from the boredom of prison life, is often found in the consumption of drugs or in sex.”

202 Section 32 of the Model Law.

the relevant Minister may appoint as medical officer of a prison any medical practitioner who is registered as such in accordance with the Health Professions Act [Chapter 27:19]. The duties of the medical officer are to monitor the general health care of prisoners and to visit the prison daily where possible, or when called upon by the officer in charge.<sup>203</sup> The medical officer is also entitled to medically examine every prisoner.<sup>204</sup>

Section 6.8 of the National HIV and AIDS Policy acknowledges the high prevalence of HIV among prisoners in Zimbabwe. Guiding Principle 33 of the Policy affirms that prisoners have basic rights that must be respected and protected, including the right to HIV, AIDS and STI information, counselling and care. It provides for the following strategies:

- Ensuring that all prisoners and detainees have access to HIV voluntary counselling and testing on admission to custodial remand or imprisonment;
- Giving all prisoners access to accurate, clear and relevant information, in the appropriate language, throughout their period of detention and on release to assist them to avoid HIV and STIs;
- Providing appropriate information, education and training on HIV, AIDS and STI prevention, control and care to prison staff;
- Explaining clearly the risks of HIV and STI transmission to prisoners and prison staff in relation to all forms of sexual activity. Prisoners should have access to information and advice on ways to prevent HIV and sexually transmitted infections;
- Initiating and promoting peer education programmes for the prevention of HIV and STIs in prison;
- Promoting the development and implementation of measures to reduce chances of sexual abuse within prison cells; and

- Allocating additional resources to the prison services to improve the quality of prison care.

Section 6.8.1 of the Policy discourages compulsory testing and segregation of prisoners, as an infringement on their basic human rights. The Policy emphasises the importance of HIV testing for prisoners on a voluntary basis, accompanied by both pre- and post-test counselling. Professional and ethical considerations such as confidentiality and informed consent on HIV testing should also apply to prisoners. Routine segregation of HIV infected prisoners is neither desirable nor practical.<sup>205</sup>

## Gaps and Challenges

Health delivery of services in prison are challenging particularly for men who have sex with men. In addition, a particular issue which was raised in a KII is that while the issue of sex between male inmates is well-known to the authorities, government is reluctant to allow prisoners access to condoms, as this would be seen as tacit approval of sexual activities that are prohibited by the law.<sup>206</sup>

## Prisoners

It is recommended that all prisoners are given access to acceptable, affordable and accessible quality HIV voluntary testing and counselling and prevention, treatment and care services including:

- i. Ensuring access to confidential voluntary counselling and testing, non-discrimination on the basis of HIV or TB status and access to prevention, treatment and care.<sup>207</sup>
- ii. Accelerating the provision of integrated HIV and TB health care services treatment to prisoners

203 Section 37 of the Act.

204 section 38 of the Act.

205 Guiding Principle 34 of the Policy.

206 KII, January 2017.

207 UNODC, ILO, UNDP, Policy brief HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions Available at [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/publication/wcms\\_187290.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_187290.pdf)

- iii. Ensuring access to prevention commodities, in accordance with international guidelines for HIV prevention in prisons, including drug treatment for people who use drugs, condoms, disinfectant for tattooing equipment, and safe needles and syringes and PMTCT should also be available for pregnant women in prison;
- iv. Protecting the rights of young prisoners, through the implementation of the UPR recommendations aimed at enhancing juvenile justice protection and through adherence to international standards such as the Mandela Rules, to enhance the rights of all prisoners in general and specifically juveniles.
- v. Allowing for compassionate release of prisoners on the basis of health, such as HIV and TB.
- vi. Integrating indicators specific to prisons into the national monitoring and evaluation system for HIV and/or to reinforce local capacity to do so;

## e) Employment

### Pre-employment HIV Testing, Unfair Dismissals, Occupational Health and Safety

This section considers some of the key issues relating to stigma, discrimination and rights violations in the working environment for people living with HIV, TB, vulnerable and key populations. Rights violations in the working environment create conditions in which vulnerable and key populations are denied their rights to work, creating further vulnerability and increasing the impact of HIV and TB on those affected.<sup>208</sup>

Participants in FGDs during the LEA said that although the law and applicable policies and strategies offer protection to people living

with HIV with regard to employment, they still in practice face hidden or indirect workplace stigma and discrimination and, in some sectors, pre-employment HIV testing. Many employers and fellow employees indirectly discriminate against workers who are or are perceived to be HIV positive. Some reasons for this behaviour as highlighted in the 2014 HIV Stigma Index include:

- Ignorance on facts around HIV transmission and progression of the disease;
- fear by employers or superiors, of reduction in productivity and profits;
- fear of absenteeism (of employees concerned);
- fear by employers or superiors, of medical aid, funeral and other care costs;
- fear of stigmatisation of the organisation in the event that clients ascertain workers are HIV-positive.

The ZNNP+ *Zimbabwe People Living with HIV Stigma Index* (2014) suggests that some people living with HIV lose their jobs or other sources of income, some are denied employment or work opportunity while others have their job description or nature of work changed or are refused promotion as a result of their HIV status. Key informant interviews felt that non-disclosure of HIV status in the working environment made it difficult for superiors and colleagues to offer appropriate accommodation and led to challenges for employees with HIV in getting days off to seek medical attention or to just rest. Continuous illness also led to suspicions, and possible stigmatisation, by fellow employees.<sup>209</sup>

In the health sector, the LEA found that there were concerns amongst health care providers relating to the prevention and management of occupational exposure to HIV and TB.

208 UNAIDS, International Guidelines on HIV/AIDS and Human Rights (2016).

209 One key informant interviewee stated that: "There are also cases where a person who serves tea at work is suspected of being positive and some people become uncomfortable being served tea by such a person and the stigma becomes visible to the person even though it may actually just be suspicion", KII, January 2017.

## International and Regional Guidance

The right to work includes the right of everyone to the opportunity to gain his/her living by work which he/she freely chooses or accepts.<sup>210</sup> Governments are expected to take appropriate steps to achieve full realisation of this right through, inter alia, technical and vocational guidance and training programmes, policies and techniques to achieve steady economic, social and cultural development and full and productive employment under conditions safeguarding fundamental political and economic freedoms to the individual.<sup>211</sup> Associated with this right is the right of every person to work under equitable and satisfactory conditions, which entails, inter alia, safe and healthy working conditions, and equal opportunity for everyone to be promoted in his/her employment based on merit, with special protection for women and persons with disabilities.<sup>212</sup> Based on the principles of equality and non-discrimination, these rights and protections should also extend to persons living with HIV, marginalised groups and key populations.

The International Labour Organisation (ILO) Recommendation No. 200 of 2010 on HIV and AIDS and the World of Work provides guidelines for the development of policies and programmes on HIV and AIDS in the workplace. It commits Member States to tap into the immense contribution that the World of Work can make to ensuring universal access to prevention, treatment, care and support for HIV and AIDS. The recommendations apply to all workplaces, including the private and public sector, as well as to all workers

including employees, job applicants, trainees, interns and members of the armed and security forces. They recognise the need to strengthen workplace prevention efforts and to facilitate access to treatment for persons living with or affected by HIV and AIDS; they call for the design and implementation of national tripartite workplace policies and programmes on HIV and AIDS to be integrated into overall national policies and strategies on HIV and AIDS and on development and social protection. The Recommendation also invites Member States to implement its provisions through amendment or adoption of national legislation where appropriate.

With respect to workers' rights, the ILO Recommendation calls for, inter alia:

- non-discrimination on the basis of real or perceived HIV status;
- gender equality in the working environment;
- reasonable accommodation for workers with HIV within the working environment;
- protection of SRHR of workers;
- prevention, treatment and care strategies within the working environment;
- provision of a safe and healthy working environment for all, including measures to prevent occupational infection with HIV; and
- prohibition of compulsory HIV testing and disclosure of HIV status of workers, including migrant workers, job seekers and job applicants, while encouraging voluntary and confidential HIV testing.<sup>213</sup>

The same rights apply for foreign and migrant workers. According to the Recommendation, migrant workers, or those seeking to migrate for employment, should not be excluded from

210 Art. 7 of ICESCR.

211 Ibid.

212 Art.15, ACHPR; art.7, ICESCR; art.27, CRPD; art.11, CEDAW; art.13, African Women's Protocol.

213 The general principles of the Recommendation include: the response to HIV and AIDS should be recognised as contributing to the realisation of human rights and fundamental freedoms and gender equality for all, including workers, their families and their dependants; HIV and AIDS should be recognised and treated as a workplace issue, which should be included among the essential elements of the national, regional and international response to the pandemic with full participation of organisations of employers and workers; there should be no discrimination against or stigmatisation of workers, in particular jobseekers and job applicants, on the grounds of real or perceived HIV status or the fact that they belong to regions of the world or segments of the population perceived to be at greater risk of or more vulnerable to HIV infection; prevention of all means of HIV transmission should be a fundamental priority; 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; workers' participation and engagement in the design, implementation and evaluation of national and workplace programmes should be recognised and reinforced.

migration by the countries of origin, of transit or of destination on the basis of their real or perceived HIV status.

Where national laws do not comply with the ILO recommendations, Guideline 5 of the *International Guidelines on HIV/AIDS and Human Rights* recommends States to review workplace laws to protect the rights of employees in relation to HIV and AIDS. It recommends the enactment of workplace laws, regulations and agreements to guarantee the following workplace rights: development of a national policy on HIV and AIDS agreed to by employers and employees; prohibition on HIV testing as a prerequisite for employment, promotion, training or benefits; confidentiality regarding HIV status; employment security for workers living with HIV, including reasonable accommodation in the working environment; access to HIV-related prevention, treatment, care and support; protection from HIV-related stigma and discrimination; and protection from occupational infection with HIV.

In terms of accommodating workers with HIV, Recommendation 200 of 2010 provides that States should ensure that persons living with HIV are allowed to work as long as they can carry out the functions of the job. Thereafter, as with any other illness, people living with HIV should be provided with reasonable accommodation to be able to continue working as long as possible and, when no longer able to work, be given equal access to existing sickness and disability schemes. The applicant or employee should not be required to disclose his/her HIV status to the employer nor in connection with his/her access to workers' compensation, pension benefits and health insurance schemes.

The Model Law on HIV and AIDS for Southern Africa also provides model provisions on HIV workplace rights for SADC countries, consistent with international guidance.

## Current Position in Zimbabwe

Zimbabwe has adopted various workplace policies to curb stigma and promote voluntary testing and counselling of employees in accordance with international and regional recommendations. For example, the Labour Act [Chapter 28:01] protects the rights of all employees to non-discrimination, including on the basis of HIV status.<sup>214</sup> The Act is supported by the Labour (HIV and AIDS) Regulations, 2014 which prohibits discrimination in the workplace and mandatory HIV testing for purposes of employment, and protects the rights to confidentiality and protection against unfair dismissals, amongst other things.

The Labour (HIV and AIDS) Regulations make provision for care, support and treatment at the work place. The Regulations protect all persons including workers and their immediate dependants (spouse and children) living with HIV the right to access free or affordable service.<sup>215</sup> Workplaces are also encouraged to provide counselling and psycho-social support to workers living with HIV and AIDS.<sup>216</sup> Where health care exists at the workplace, appropriate treatment must meet the national health standards, and where unavailable, workers must be informed and guided as to where to access the services.<sup>217</sup>

The Regulations also highlight that the HIV status of an employee shall not affect his/her eligibility for any occupational or other benefit schemes provided for employees. In cases where eligibility is required to benefit from a scheme, the employer is not entitled to information related to HIV status of an employee. Linkages with the MOHCC are also encouraged to enhance access to comprehensive health services through referrals to public health systems and private insurance.<sup>218</sup>

There also exist some sector-specific HIV and AIDS policies such as the HIV and AIDS

---

214 Section 5 of the Act.

215 Section 8 of the Regulations.

216 Ibid.

217 Ibid.

218 Ibid.

Policy for the Energy Sector of Zimbabwe, 2009 which recognises the need to ensure adequate resources for medical care, drugs for prophylaxis and treatment, and nutrition, and encourages enterprises to establish innovative health insurance schemes and the HIV/AIDS Policy for the Transport Sector in Zimbabwe which provides that: "...Whilst it is recognised that employers are not responsible for providing insurance services to employees, they should not enforce any testing for insurance purposes, and all information that they already have on the employees' HIV status should remain confidential".<sup>219</sup>

With regard to HIV risk reduction and management in the workplace, the Labour (HIV and AIDS) Regulations provide in section 14 that where a person is employed in an occupation or is required to provide services where there may be a risk of transmitting or acquiring HIV, the employer shall provide appropriate training, together with clear accurate information and guidelines in modes of transmission and measures to prevent exposure to infection. The working conditions and procedures shall be designed to ensure optimal hygienic precautions to prevent the spread of HIV and related transmissible diseases, such as TB. Workers whose occupations put them at risk of exposure to human blood, blood products and other body fluids shall receive additional training in exposure-prevention, exposure-prevention procedures and post-exposure prophylaxis.

## Gaps and Challenges

While the legal and policy environment for managing HIV within the working environment appears to be strong in Zimbabwe, there are still reports of stigma, discrimination and denial of rights in the working environment on the basis of HIV status or perceived HIV status, as detailed above. There was limited information regarding TB-related discrimination in the working environment. Employees are clearly

not always comfortable to disclose their HIV status within the workplace, and do not receive the accommodation required. There are also concerns with the management of occupational exposure to illness within the workplace.

## Recommendations

The State has a clear duty to protect the right to non-mandatory HIV testing and non-disclosure of HIV status. Measures must therefore be taken to ensure that information on HIV status is not disclosed to third parties without the consent of the individual concerned. In this context, the State must also ensure that HIV-related personal information is protected in the reporting and compilation of epidemiological data and individuals are protected from arbitrary interference with their privacy in the context of media investigation and reporting.<sup>220</sup>

Government should put in place measures to ensure:

- i. Strengthened monitoring of the implementation of rights-based HIV workplace policies, developing the capacity of managers, supervisors, workplace peer educators and counsellors to provide accurate and adequate HIV information to their peers in the workplace, to protect workplace rights and to prohibit HIV-related discrimination, be it before or during employment;
- ii. Training for all health care workers and law enforcement officials receive comprehensive training on occupational health and safety measures
- iii. Ensuring that the necessary procedures are in place and equipment is accessible and available to enable health care workers and law enforcement officials to implement occupational health and safety measures, including universal precautions at all times;
- iv. Ensuring that post-exposure prophylaxis is available for all health care workers

219 [http://www.safaid.net/files/HIV/AIDS%20transport\\_sector%20for%20zimbabwe.pdf](http://www.safaid.net/files/HIV/AIDS%20transport_sector%20for%20zimbabwe.pdf), [Accessed December 2016].

220 UNAIDS, International Guidelines on HIV/AIDS and Human Rights (2006).

and other service providers, including law enforcement officials, who need it and ensure that procedures are in place for access to support and counselling and assistance outside working hours.

- v. Strengthening access to redress for violations of the rights to equality and non-discrimination within the working environment.

## F) Social Welfare Assistance in Zimbabwe

The right to social security, which includes social insurance, entails accessing and maintaining social welfare benefits, whether in cash or in kind. Governments are required to put in place measures such as accessible social security schemes targeting especially persons who are faced with circumstances that deprive them of their capacity to fully realise socio-economic rights. The measures must ensure a minimum essential level of benefits to all individuals and families that will enable them to acquire at least essential health care, basic shelter and housing, water and sanitation, foodstuffs, and the most basic forms of education.<sup>221</sup>

For people living with illness or disability, the right to social protection is critical to reducing vulnerability and decreasing the impact of illness on themselves and their families. HIV and AIDS can push people and households into poverty, in part by reducing

household labour capacity and increasing medical expenses. In some cases, HIV-related stigma and discrimination marginalises people living with HIV and households affected by the virus and excludes them from essential services.<sup>222</sup> Social assistance is equally critical for vulnerable populations, such as adolescent girls and young women, children, young people, and key populations, including young key populations, whose socio-economic circumstances increase their vulnerability to rights violations, as has been detailed in the report.

The right to social assistance is also linked with the right to food, which is a basic human right recognised by international law.<sup>223</sup> Adequate food and freedom from hunger must be enjoyed on the basis of equality and non-discrimination.<sup>224</sup> The right to food encompasses the right to all nutritional elements that a person needs to live a healthy and active life, and to the means to access them.<sup>225</sup> This right to food extends to people living with HIV and TB, and is vital to maintaining the immune system, improving the body's response to medical treatment, managing OIs, slowing the progression of the disease and giving optimal quality of life for people living with HIV. There is increasing evidence that malnutrition combined with HIV directly influences morbidity and mortality rates.<sup>226</sup>

These further impact on the ability of households to maintain their socio-economic status and, consequently, the nutritional status of every household member. Time

221 See General Comment No. 19 (2008) of CESCR on the right to social security, <http://www.ohchr.org/EN/Issues/RightSocialSecurity/Pages/SocialSecurity.aspx>. See also the decision of CESCR in *López Rodríguez v. Spain* (Communication No 1/2013), <http://www.ohchr.org/Documents/Issues/ESCR/BulletinJune2016.pdf>.

222 UNICEF, *Enhancing Social Protection for HIV Prevention, Treatment, Care & Support –The State of the Evidence* [https://www.unicef.org/esaro/Social\\_Protection\\_and\\_HIV.pdf](https://www.unicef.org/esaro/Social_Protection_and_HIV.pdf), [Accessed December 2016].

223 E.g. it is protected in the UDHR and the ICESCR.

224 UN Human Rights Office of the Human Rights Commissioner, *The Right to Food* <http://www.ohchr.org/Documents/Publications/FactSheet34en.pdf>, [Accessed December 2016].

225 OHCHR Fact Sheet No. 16 (Rev.1): The Committee on Economic, Social and Cultural Rights. The Committee on Economic, Social and Cultural Rights has said that, "*The right to adequate food is realised when every man, woman and child, alone or in community with others, has physical and economic access at all times to adequate food or means for its procurement.*" The UN Special Rapporteur on the right to food has also said that right to food is also to have regular, permanent and free access, either directly or by means of financial purchases, to quantitatively and qualitatively adequate and sufficient food corresponding to the cultural traditions of the people to which the consumer belongs, and which ensures a physical and mental, individual and collective, fulfilling and dignified life, free of fear (OHCHR Fact Sheet No. 27).

226 Munzara, Angeline, *The Right to Food for People Living with HIV and AIDS*, *The Right to Food and Nutrition Watch* (2010 at p22. [http://www.righttofoodandnutrition.org/sites/www.righttofoodandnutrition.org/files/watch\\_2010\\_eng.pdf](http://www.righttofoodandnutrition.org/sites/www.righttofoodandnutrition.org/files/watch_2010_eng.pdf) [Accessed December 2016].

and household resources are consumed in an effort to care for sick family members, also increasing the burden on women who are generally the primary caregivers within households. A review of cost-impact studies reveals that the multiple consequences of HIV and AIDS can consume 50% of the annual income of poor households. In rural areas the disease generally leads to a decline in agricultural production.<sup>227</sup>

## International and Regional Guidance

Article 25 of the UDHR recognises that every person has the the right to social security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his/her control. This right is also provided in Article 9 of the ICESCR. Specific provision is made in respect of marginalised and vulnerable groups. For example, States are required in terms of CEDAW and the African Women's Protocol to recognise women's right to social security, particularly in cases of retirement, unemployment, sickness, invalidity, old age and any other incapacity to work, as well as the right to paid leave.<sup>228</sup> This right shall also be recognised in respect of children and persons with disabilities, as provided in the ACRWC and CRC and the CRPD respectively. Every child has the right to benefit from social security, including social insurance. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child.<sup>229</sup> In terms of article 28 of the CRPD, States shall recognise the right of persons with disabilities to social protection and to the enjoyment of these rights without discrimination on the basis of disability. In this regard they shall take appropriate steps to safeguard and promote the realisation of this right.

In the context of HIV and AIDS, the UNAIDS International Guidelines, note the link between protecting the right to an adequate standard of living and reducing people's vulnerability to the risk and consequences of HIV infection. Social security is particularly relevant to meeting the needs of people living with HIV and AIDS, and/or their families, who have become impoverished by HIV and AIDS as a result of increased morbidity due to AIDS and/or discrimination which can result in unemployment, homelessness and poverty. People living with HIV should be prioritised as particularly vulnerable in the allocation of resources and States must ensure that people living with HIV are not denied an adequate standard of living and/or social security and support services on the basis of their HIV status.<sup>230</sup> Social protection can help cushion them so that they are able to meet their basic dietary and other needs.

UNAIDS has also identified social protection as a strategic priority in the global HIV response because of its importance in addressing the drivers of the epidemic as well as helping to mitigate its impacts on communities, households and individuals. Moreover, according to the UNAIDS Investment Framework, investments in social protection are necessary to achieving the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths.<sup>231</sup> According the UNAIDS Social Protection Guidance Notes, 2011 social protection should include:

- Financial protection through predictable transfers of cash, food, or other transfers for those affected by HIV and those who are most vulnerable;
- Programmes that support access to affordable quality services, including treatment, health, and education services through for example social health insurance and school fees exemption;

227 Ibid.

228 Art.11, CEDAW; art.13, African Women's Protocol.

229 Art.26, CRC.

230 At para 148.

231 Social Protection and HIV Guidance Note, UNAIDS, 2011.

- Policies, legislation and regulation to meet the needs and uphold the rights of the most vulnerable and excluded.

The Food and Agriculture Organisation (FAO) Voluntary Guidelines to Support the Progressive Realisation of the Right to Adequate Food in the Context of National Food Security 2004 calls for specific attention for people living with HIV and states that governments, "... should take measures to protect all people affected by HIV/AIDS from losing their access to resources and assets." In the UN General Assembly Political Declaration on HIV/AIDS,<sup>232</sup> UN Member States decided to integrate, as part of a comprehensive response to the pandemic, access to sufficient safe and nutritious food to enable people living with HIV and AIDS to live an active and healthy life.

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.

## Current Position in Zimbabwe

In terms of Section 77 of the Constitution, every person has the right to safe, clean and potable water and to sufficient food. The State is required to take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of this right. Additionally, the Constitution provides for social assistance, including protection of the family, which includes the provision of care and assistance to mothers, fathers and other family members of who have charge of children. The State is obliged to provide social security and social care to those who are in need, within the limits of available resources.

The National Objectives, which arguably are not justiciable, also provide for the following:

- Food security – the State must encourage people to grow and store adequate food, secure the establishment of adequate food reserves, and encourage and promote adequate and proper nutrition through mass education and other appropriate means;<sup>233</sup>
- Protection of the family, which includes the provision of care and assistance to mothers, fathers and other family members of who have charge of children (within the limits of available resources);<sup>234</sup>
- Social welfare – the State must take all practical measures, within the limits of the resources available to it, to provide social security and social care to those who are in need.<sup>235</sup>

The Social Welfare Assistance Act [Chapter 17:06] provides for the granting of social welfare assistance to persons in need and their dependants. The form of social welfare is a financial contribution or it takes the form of rehabilitation, institutional nursing, boarding or foster home care; counselling services; the provision of orthopaedic and orthoptic appliances; occupational training; pauper burials; the supply of food or clothing; or any other assistance necessary to relieve destitution.<sup>236</sup> Beneficiaries include destitute or indigent persons who: are over 60 years of age; are handicapped physically or mentally; suffer continuous ill-health; are dependent on a person who is destitute or indigent or incapable of looking after himself/herself.<sup>237</sup> While persons living with HIV or TB are not specifically mentioned, they are not necessarily excluded as they could fall under any one or more of the prescribed categories. Therefore, any person who falls within the targeted vulnerable people including key populations, young people, persons with disabilities, the poor, persons suffering from

232 UNAIDS, op cit.

233 Section 15 of the Constitution.

234 S.25 of the Constitution.

235 S.30 of the Constitution.

236 S.5 of the Act.

237 S.6 of the Act.

health problems (including people with TB) are entitled to benefit from social welfare assistance. Any indigent persons wishing to access health care services are also able to access the Department of Social Welfare Services' Assisted Medical Treatment Orders (AMTO).

The ZNASP 2015–2018<sup>238</sup> provides plans to enhance psychosocial support interventions for adolescents and young people living with HIV so that they are implemented to scale. It seeks to promote appropriate and comprehensive clinical HIV care that is age appropriate and integrated into SRH and psychological, educational and social services in the country. The focus and emphasis of the orphan and vulnerable children (OVC) programme interventions will be on increasing OVC access to HIV-related health and care services and also facilitating access to and provision of support in health, education, nutrition and psychosocial services.

The Basic Education and Assistance Module (BEAM) is intended to provide support for indigent families to send and keep their children in school.

The Department of Social Welfare has attempted to raise awareness of the available social welfare benefits so that the targeted beneficiaries can access the services. However, the Department faces budgetary challenges like any other government department with regard to adequate funding of BEAM and AMTO. Ideally, the Department should specifically target within the vulnerable populations, persons with disabilities, children and young people.

In the case of persons who are no longer working due to illness or disability, there are schemes such as the social securities provided under the Social Security Act.

## Gaps and Challenges

As a result of limited resources due to the economic situation of Zimbabwe, providing social protection is a challenge. For example, the HIV epidemic continues to impact on children's lives. The households where children are affected by HIV (HIV infected children, orphans, children with HIV infected relatives) are often poverty-stricken with members lacking basic needs (food, clothes, medicine) and children live under conditions of limited adult care and support.<sup>2018</sup><sup>239</sup> In Zimbabwe around 17% of children have lost one or both parents to the epidemic, and around 2.5% of children under the age of 14 are themselves HIV-positive<sup>2018</sup><sup>240</sup> leaving children affected by HIV particularly vulnerable to malnutrition, poor physical health, sexual abuse, lack of basic essentials and poor mental health.<sup>241</sup> Many children were reported to come to school hungry and without food, compromising their ability to concentrate and learn, and impairing the health of HIV infected children on ART.<sup>242</sup>

There is a need to strengthen social assistance to reach all vulnerable and key populations in need, to decrease their vulnerability to ill health and strengthen their development rights.

## Recommendations

- i. Section 30 of the Constitution must be fully implemented, and particular attention paid to people infected and affected by HIV and TB, vulnerable and key populations;
- ii. The Social Welfare Assistance Act must be reviewed and amended, with a view to making explicit provision for the needs of people living with HIV and TB as well as other vulnerable and key populations
- iii. Resources must be mobilised to implement social protection programmes for vulnerable and key populations, including OVC, as provided for in the Zimbabwe National HIV and AIDS Strategic Plan 2015–2018.

238 Commitment towards fast tracking 90.90.90 targets by 2020 and ending aids by 2030.

239 Evans and Becker (2012); Skovdal et al, (2009).

240 UNAIDS (2012), op cit.

241 Nyamukapa et al (2010); Parsons (2013).

242 A primary school learner in a rural area is described in the following words, "This illness makes her miserable. She always faints when she is walking. At times she starts to vomit when she is at school this makes her sad because people will be laughing at her", Andersen, Louise et al., The role of schools in supporting children affected by HIV: Stakeholder Report (2014). Biomedical Research and Training Institute, Harare, Zimbabwe.

Part IV:

# Access to Justice and Law Enforcement in Zimbabwe

UNAIDS recognises that, in order to reduce stigma and discrimination and increase access to justice for people in the context of HIV, there are key programmes that are required to be in place, including, amongst others:

- Stigma and discrimination reduction programmes;
- Legal Literacy (“know your rights” campaigns);
- Legal support services; and
- Sensitisation of law-makers and law enforcement officials.

The LEA found that people living with HIV and TB, vulnerable and key populations were not adequately aware of their rights and/or able to access justice for rights violations. For instance, FGDs with vulnerable and key populations revealed that there is a general lack of awareness of the rights protected in the Constitution and very few of the participants have access to the document. There is also very little knowledge of regional and international instruments on rights.

In addition, access to justice is of particular concern for the most vulnerable groups and key populations.<sup>243</sup> Participants interviewed had little knowledge regarding organisations that provided legal aid including the Legal AID Directorate (LAD). Those who were aware reported that CSOs and the LAD were not decentralised, hampering access to information and services.

Vulnerable and key populations, including young key populations reported additional stigma and discrimination in the court system. For instance, people with disabilities reported difficulties with reporting abuse – a visually impaired person is challenged to describe an abuser or to describe the environment in which the abuse took place. A mentally challenged victim will equally find it difficult to prove that they are a credible witness, or the court may be reluctant to accept their evidence on account of the mental challenge.<sup>244</sup>

For LGBT populations and sex workers, access to justice for rights violations was particularly difficult, given their fear of criminal prosecution due to criminal laws.

## International and Regional Guidance

The GCHL’s *Risks, Rights & Health* recognises the importance of taking steps to improve access to justice and law enforcement in relation to HIV and AIDS. It recommends the need to not only enact protective laws and repeal punitive ones, but also to create stronger mechanisms to implement and enforce laws. It urges States to develop and implement humane, workable HIV-related policies and practices and to fund action on law reform, law enforcement and access to justice.<sup>245</sup> Protective laws cannot, on their own, create an enabling environment for people living with HIV and key populations at higher risk of HIV exposure; laws and policies need to be accessed, implemented and enforced by sensitised judiciary and law enforcement agents.

The right to access justice and law is also provided for by the International Guidelines on HIV/AIDS and Human Rights as follows:

- States should implement and back legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilise means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions (Guideline 8);
- States should promote the wide and on-going distribution of creative education, training and media programmes designed explicitly to change attitudes of discrimination and stigmatisation associated with HIV to understanding and acceptance (Guideline 9);

<sup>243</sup> FGD with sex worker, transgender, gay and lesbian and women organisations, January 2017.

<sup>244</sup> Ibid.

<sup>245</sup> GCHL, *Risks, Rights & Health* (2012) at p10.

- States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities (Guideline 11).

The International Guidelines also recommend:

- Support for legal aid systems specialising in HIV casework, possibly involving community legal aid centres and/or legal service services based in AIDS service organisations;
- Support to private sector law firms to provide pro bono services to people living with HIV and affected populations;
- Support for programmes to educate and raise awareness of HIV law and human rights amongst affected populations, lawyers, legal support services and CSOs;
- Support for stigma and discrimination reduction programmes to the broader public, within educational institutions, workplaces and for key leaders and service providers, to promote dignity and respect for people living with HIV and other key populations;
- Support for the monitoring and data collection on HIV and human rights including through the establishment of HIV focal points in relevant government branches, support to CSOs and through new or existing human rights commissions, national legal bodies and law reform commissions.

The WHO Technical Briefs on Young Key Populations note the importance of strengthening access to justice for young key populations, whose contact with law enforcement officials may be higher than their older counterparts.

## Current Position in Zimbabwe

The Government is obligated under international instruments ratified and the Constitution to promote awareness of rights (e.g. Section 7).

### Awareness of Rights

The Government has made efforts to raise awareness of Constitutional provisions including the Declaration of Rights. The Constitution has been translated into some local languages including braille as well as simplifying the Bill of Rights. These efforts have been complemented by awareness raising campaigns of the Zimbabwe Human Rights Commission and CSOs.

### Access to Legal Support Services

Section 69 of the Constitution provides for the right to a fair hearing, which includes the following rights:

- The right of an accused to a fair and public trial within a reasonable time before an independent and impartial court;
- In a civil matter, every person has a right to a fair, speedy and public hearing within a reasonable time before an independent and impartial court, tribunal or other forum established by law;
- Every person has the right of access to the courts, or to some other tribunal or forum established by law for the resolution of any dispute;
- The right of every person, at their own expense, to choose and be represented by a legal practitioner before any court, tribunal or forum.

Under the National Objectives, the State is obliged to take all practical measures, within the limits of the resources available to it, to provide legal representation in civil and criminal cases for people who need it and are unable to afford legal practitioners of their choice.<sup>246</sup> This provision is supported by the Legal Aid Act [Chapter 7:16], which provides for the granting of legal aid to indigent persons. The Act provides that: “[a] person shall be eligible for legal aid if he/she: has insufficient means to obtain the services of a legal practitioner on his/her own account; he/she has reasonable grounds for initiating,

246 S.31 of the Constitution.

carrying on, defending or being a party to the proceedings for which he/she applies for legal aid; and he/she is in need of or would benefit from the services provided in terms of the Act in respect of the proceedings for which he/she seeks legal aid.<sup>247</sup>

In addition to Legal Aid Directorate services, various CSOs provide *pro bono* legal services to vulnerable groups and key populations depending on their mandate. Research conducted by the Royal Danish Embassy in Zimbabwe in January 2016 provides a detailed expose of the various CSOs, their respective mandates and extent of coverage nationwide including for prisoners, women, people with disabilities, LGBTI populations including young key populations.

In principle, any deserving person, whether they are a member of the LGBTI community, are a sex worker, have a disability or are living with HIV or TB, would be entitled to legal aid in terms of the Constitution as read with the Legal Aid Act.

### Law Enforcement

Chapter 8 of the Constitution makes provision for the judiciary and the courts, which range from customary law courts right up to the Constitutional Court.<sup>248</sup> Principles guiding the judiciary include the following:

- Justice must be done to all, irrespective of status;
- Justice must not be delayed – members of the judiciary must perform their duties efficiently and with reasonable promptness;
- The role of the courts is paramount in safeguarding human rights and freedoms and the rule of law.<sup>249</sup>

There is also a national human rights institution in Zimbabwe – the ZHRC – with the mandate to promote and protect human rights.<sup>250</sup>

The functions of the Commission include:

- to promote awareness of and respect for human rights and freedoms at all levels of society;
- to promote the protection, development and attainment of human rights and freedoms;
- to monitor, assess and ensure observance of human rights and freedoms;
- to receive and consider complaints from the public and to take such action in regard to the complaints as it considers appropriate;
- to investigate the conduct of any authority or person, where it is alleged that any of the human rights and freedoms set out in the Declaration of Rights in the Constitution have been violated by the authority or person;
- to secure appropriate redress, including recommending prosecution of offenders, where human rights or freedoms have been violated;
- to direct the Commissioner-General of Police to investigate cases of suspected criminal violations of human rights or freedoms and to report to the Commission on the results of such investigation;
- to recommend to Parliament effective measures to promote human rights and freedoms; conduct research into issues relating to human rights and freedoms and social justice; and
- to visit and inspect prisons, places of detention, refugee camps and related facilities and places where mentally disordered or intellectually handicapped persons are detained, in order to ascertain the conditions under which persons are kept there, and to make recommendations regarding those conditions.<sup>251</sup>

The Zimbabwe Republic Police is established in terms of by Part 3 of Chapter 11 of the Constitution and governed by the Police Act [Chapter 11:10]. It is an important organ

247 S.8 of the Act.

248 S.162 of the Constitution.

249 S.165 of the Constitution.

250 S.242 of the Constitution.

251 S.243 of the Constitution. See also s.4 of the Zimbabwe Human Rights Commission Act [Chapter 10:30].

for the maintenance of law and order and preserving internal security of the country. The police are the entry point into the criminal justice delivery system. They receive and investigate complaints, arrest and sometimes detain suspects and compile dockets.<sup>252</sup> It is a requirement for the police to uphold the provisions of the Constitution of Zimbabwe without fear or favour.<sup>253</sup>

The Prisons Act [Chapter 7:11] regulates the ZPCS, established in terms of Part 5 of Chapter 11 of the Constitution. The ZPCS is responsible for the protection of society from criminals through the incarceration and rehabilitation of convicted persons and others who are lawfully required to be detained, and their reintegration into society, and the administration of prisons and correctional facilities.<sup>254</sup>

It can be seen from the above that there are various mechanisms available to support enforcement of rights and to offer remedies to aggrieved persons in Zimbabwe. HIV- and TB-related employment disputes or grievances in the public and private sector, as well as violations of the employment rights of key populations, may be dealt with by the Labour Court. HIV-related issues of a criminal nature as well as discrimination, violence and other rights violations against vulnerable and key populations may be brought before the Magistrates Court or the High Court. Similarly, civil issues may also be brought before the Magistrates Court or the High Court. In the case of alleged violations of constitutionally guaranteed human rights, an aggrieved person/s may approach the Constitutional Court directly for a remedy.

## Gaps and Challenges

The LEA revealed that, despite existing protections for awareness of rights, legal support services and access to remedies, there continue to be challenges for people living with HIV, TB and vulnerable and key populations, including young key populations.

For example, various informants during the LEA felt they had not received benefited from initiatives by government to raise awareness of rights and strengthen access to justice. Additionally, the Government is constrained in terms of resources to effectively reach out to all populations, a concern which was raised by some of the Human Rights Treaty Monitoring Bodies. The Committee on the Elimination of Discrimination Against Women, for instance, recommended that Government must raise awareness of the rights contained in the Convention to all women including rural women, and also among public officials such as the judiciary, law enforcement officials, health care workers among others.

There is need for the Government and the ZHRC to scale up efforts to raise awareness and to collaborate with other stakeholders such as CSOs who are engaged in parallel efforts to raise awareness. Such efforts can also target specific sections of the population such as children and young people, persons with disabilities, adolescent girls and young women and key populations, including young key populations.

In addition to awareness raising on the rights, participants need increased information on and access to mechanisms for the enforcement of rights – e.g. seeking judicial remedy in terms of Section 86 of the Constitution, access to the services of the ZHRC and the Gender Commission, the courts as well as administrative channels, such as the complaints desks of the Zimbabwe Republic Police.

## Recommendations

- i. Strengthen stigma and discrimination reduction programmes to reduce stigma and discrimination against people living with HIV, TB, vulnerable and key populations, including young key populations;

---

253 Ibid.

254 Section 227 ibid

- ii. Strengthen access to legal support services for people living with HIV, key populations and young key populations at higher risk of HIV exposure through various possible measures including encouraging *pro bono* services by private lawyers and the Legal AID Directorate and strengthening access to national human rights institutions;
- iii. Provide training on human rights in the context of HIV and vulnerable and key populations for law and policy makers as well as law enforcers, including work with the judiciary and law enforcement officials;
- iv. Work with law enforcement personnel, and in particular the VFU, to improve the treatment of key populations, including young key populations who come into conflict with the law either as defendants or complainants;
- v. Criminalise rights violations by law enforcement personnel targeting key populations and young key populations. Appropriate steps must be taken to ensure that all law enforcement personnel perform their duties appropriately, with competency and in a non-discriminatory manner;
- vi. Develop guidelines to support law enforcement agents and the judiciary to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered;

Part V:

# Conclusions and Recommendations

## Conclusion

Stigma, discrimination, violence and various other human rights violations impact on people living with HIV and TB as well as those vulnerable to HIV and TB – such as women, young people, people with disabilities and key populations, including young key populations in Zimbabwe. In addition, populations struggle to access justice for rights violations.

Zimbabwe has a strong Constitution with a Bill of Rights that protects the rights of all persons, as well as a number of important protections in laws, policies and plans for the rights of people with HIV, TB and for vulnerable populations.

However, there are also various discriminatory, punitive and coercive provisions in law that affect adolescent girls and young women, young people and key populations, including young key populations. There are also limitations within existing plans, policies and strategies that fail to adequately protect the health rights of vulnerable and key populations, including young key populations.

The LEA made the following recommendations for law and policy review and reform, strengthened access to justice and law enforcement.

## Recommendations

Based on its assessment of the legal, regulatory and policy frameworks in Zimbabwe, in line with national, regional and international human rights commitments made by Zimbabwe, public health and human rights evidence found in a review of relevant literature, and the views from KIIs and FGDs with selected populations, the LEA calls for consideration of the following recommendations:

### General Recommendations

- Raise awareness at all levels, starting with the Executive and Parliament to broader communities, on the rights of people living

with HIV and TB and related vulnerable and key populations, including young key populations.

- Strengthen and monitor the implementation of health and HIV-related laws and policies and the delivery of health care, including sexual and reproductive health care and prevention, treatment and support services for people living with HIV, TB and vulnerable and key populations, including young key populations.
- Scale up comprehensive integrated HIV and related health care services for vulnerable and key populations, including young key populations, both by creating the specific context for facilitating behaviour change, and by funding targeted and tailored services for these populations. Programmes should consist not only of testing, prevention services and treatment but also support for protective policing and protection from stigma, discrimination and violence.
- Strengthen efforts to reduce stigma, discrimination and violence, review laws and policies to protect human rights, reduce gender inequality, harmful gender norms and gender-based violence and increase access to justice for all people living with HIV, TB and vulnerable and key populations, including young key populations
- Include HIV related stigma and discrimination indicators as part of the National HIV and TB response monitoring and evaluation systems, to assess progress over time.

### Specific recommendations

#### Equality and Non-discrimination

- Include provisions that protect and promote human rights in the context of HIV and TB in the Public Health Bill that are consistent with the National HIV and AIDS Policy, and prohibit all forms of discrimination, including TB-related discrimination, on the basis of actual or perceived HIV or TB status;
- Amend Part II of the Prevention of Discrimination Act [Chapter 8:18] to include protections of people living with HIV,

women, pregnant women, children, people with disabilities and key populations from discrimination; Amend section 5 of the Act to explicitly mention HIV as a ground for non-discrimination to access finance;<sup>255</sup>

- Consider an amendment to the Constitution to explicitly include HIV as a prohibited ground of non-discrimination.
- Ensure existing constitutional human rights are enforced;
- Amend the Immigration Act to reflect the provisions of the National HIV and AIDS Policy, so that there is no requirement for HIV testing of visitors or immigrants to Zimbabwe and no exclusions based on discrimination against populations.<sup>256</sup>

### Health Laws and Policies

- Clearly provide for an integrated approach to managing HIV and TB in the Public Health Act / Bill.
- Clearly set out in the Public Health Act / Bill, the equality and health rights of vulnerable populations and key populations, including young key populations, to protect them from discrimination, exploitation and abuse.
- Clearly provide in the Public Health Act / Bill and health policy for the rights of vulnerable populations, such as people with disabilities, and key populations, including young key populations, to appropriate health information and health care services, including HIV, TB and SRH services, and the right to participate in the design, development and implementation of programmes.
- Review punitive provisions in the Public Health Act / Bill providing for criminalisation and / or involuntary confinement of people with infectious diseases, to ensure that they are consistent with international and regional guidance relating to HIV and TB.
- Clearly set out in law the age of consent to sexual activity, which should be aligned to the age of consent to sexual and reproductive health services, including contraceptives, provided for in public health law.
- Clearly provide in the Public Health Act / Bill for a lowered age of consent to HIV testing, pre- and post-test counselling without parental consent.
- Clearly provide in the Public Health Act / Bill for confidentiality and conditions relating to disclosure, particularly with regard to HIV.
- Clearly provide in the Public Health Act / Bill that health care providers need to respect the views and opinions of adolescents or young persons, including young key populations accessing services, and their right to confidentiality.
- Amend the Patents Act [Chapter 26:03] and/ or the Medicines and Allied Substances Control Act [Chapter 15:03] in order to bring national law in line with the TRIPs Agreement, including making specific directives on utilising TRIPs flexibilities in relation to public health for increased access to quality and affordable generic medicines.
- Amend the Disabilities Act to strengthen access to health rights and protection from sexual abuse for persons with disabilities.
- Ensure the provision of youth-friendly, including young key population friendly health care facilities and staff
- Train health care providers in medical ethics and human rights, including non-discrimination, with respect to vulnerable populations and key populations, including young key populations.
- Review the provision of HIV, TB and SRH services to ensure they promote confidentiality to mitigate against indirect disclosure of a person's health or other status.

255 A law should be enacted to prohibit exclusion from life, health and other insurance solely on the basis of HIV status and to ensure that in the context of insurance HIV should not be treated differently from analogous chronic medical conditions.

256 The GCHL (2012) Risks, Rights & Health recommends that, to ensure an effective, sustainable response to HIV that is consistent with human rights obligations, States should: offer the same standard of protection to migrants, visitors and residents who are not citizens as they do to their own citizens; repeal travel and other restrictions that prohibit people living with HIV from entering a country and/or regulations that mandate HIV tests for foreigners within a country and implement regulatory reform to allow for legal registration of migrants with health services and to ensure that migrants can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens. All HIV testing and STI screening for migrants must be informed and voluntary, and all treatment and prophylaxis for migrants must be ethical and medically indicated.

- Ensure programmes provide for appropriate service delivery for the treatment, care and support of all vulnerable populations, with specific reference to AGYW and people with disabilities, and key populations, including young key populations.
- Fund and implement AMTOs to ensure quality access to confidential medical, psychological and function treatment, sexual and reproductive health services and HIV and TB treatment and care for people with disabilities.
- Develop strong monitoring and evaluation mechanisms to ensure effective implementation of HIV treatment, care and support.
- Ensure the meaningful involvement of women, including AGYW, in the drafting of laws, policies and guidelines concerning SRHR.
- Strengthen programmes to sensitise women, including AGYW, on their rights, including sexual and reproductive health and rights and rights to be protected from gender inequality, harmful gender norms and gender-based violence.
- Undertaken dialogues with FBOs and traditional leaders for collective efforts to address gender inequality, harmful gender norms and practices, GBV and to end early child marriages.
- Train health care workers on medical ethics, human rights and gender equality, to reduce stigma and discrimination against women and to protect their sexual and reproductive health and rights.
- Establish 'safe corners' at health institutions to address issues of confidentiality and to tackle stigma and discrimination.

### Gender Inequality, Harmful Gender Norms and GBV

- In line with the UPR Recommendation, all legislation that fuels harmful gender norms and practices should be reviewed to ensure compliance with the right to equality in the Constitution and to international protocols to which the country is party to such as CEDAW.
- Strengthen criminal laws relating to violence, including sexual violence, as well as policies to manage those who have been sexually violated.
- Enact legislation for affirmative action to accelerate increased participation in economic and political sectors of the nation. Policies on the economic empowerment of women should be strengthened.
- Amend the Marriage Act and fully implement laws seeking to end early child marriages.
- Ensure that public health law enhances access to integrated, quality health care in general, sexual and reproductive health care and HIV and TB treatment for women and girls.

### Criminalisation of HIV Transmission

- HIV-specific laws that criminalise HIV transmission and exposure must be reviewed and aligned with international standards.
- Where HIV criminalisation laws still exist, courts must require proof, to the applicable criminal law standard, of intent to transmit HIV. The intent to transmit HIV cannot be presumed or derived solely from knowledge on the part of the accused of positive HIV status and/or non-disclosure of that status; from engaging in unprotected sex; by having a baby without taking steps to prevent mother-to-child transmission of HIV; or by sharing drug injection equipment.
- Governments must prohibit the prosecution under HIV-specific statutes, of women living with HIV for choices they make during and after pregnancy, including about breastfeeding children.

257 Given that there are also cases of rape amongst key populations and people living with disabilities, it is recommended that its scope should be strengthened to be gender-neutral and to apply to all domestic partnerships. It was also recommended that with the increasing statistics of abuse of children and those for GBV which is associated with HIV, sentences for perpetrators should be equally deterrent, since current sentences are at times too lenient (e.g. and not the current lenient sentences that are given such as community service) for sexual violence.

- Whenever HIV arises in the context of a criminal case, police, lawyers, judges and where applicable, juries, must be informed by the best available scientific evidence concerning the benefits and consequences of appropriate therapy, and the individual and community advantages of maintaining such therapy.
- Guidelines should be developed to support law enforcement agents and the judiciary, to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established, and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered;
- In the case of sexual offences, such as rape, that result in the transmission of HIV or creates a significant risk of HIV transmission (taking into account medical and scientific evidence regarding transmission), the HIV-positive status of the offender should only be considered an aggravating factor in sentencing if the offender knew he/she was HIV-positive at the time of committing the offence;
- Counselling measures must be taken to encourage couples/partners to share information about their HIV status with each other in order for them to take informed action to prevent HIV transmission and protect each other from infection and reinfection, with due regard for the protection of vulnerable populations (such as women) in the process.
- Provide access to effective HIV and health services and commodities for LGBTI populations
- Establish 'safe corners' at health institutions to enhance confidentiality in accessing health care and to mitigate stigma and discrimination
- Provide access to comprehensive sexuality education that takes into account the issues of sexual orientation and gender identity, including for young LGBTI populations
- Stigma and discrimination reduction programmes, including with traditional authorities and FBOs, should be undertaken to reduce stigma, discrimination and violence against LGBTI populations
- Law enforcement officials, especially the Victim Friendly Unit, should be trained on the rights of LGBTI populations, emphasising the principles of equality and non-discrimination and the right to equality before the law, and equal protection of the law
- Health care practitioners should be trained on all LGBTI populations, their rights and health needs, to address stigma and discrimination, to increase understanding and to improve health care.
- Increase awareness of rights amongst LGBTI populations
- Promote effective measures to prevent and redress violence against LGBTI populations.

### LGBTI Populations, including Young Populations

- Strengthen anti-discrimination law to protect the rights of persons to equality and non-discrimination on the basis of sexual orientation and gender identity.
- Review provisions of the Criminal Law and Codification Act to decriminalise adult consensual same-sex sex
- Ensure transgender people are able to have their affirmed gender recognised in identification documents and that official forms accommodate their gender identity.

### Sex Workers

- Repeal laws that prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit commercial sex, such as laws against "immoral" earnings, "living off the earnings" of prostitution and brothel-keeping. Complementary legal measures must be taken to ensure safe working conditions to sex workers.
- Improve access to HIV-related health care services for sex workers, including through the training and sensitisation of health care providers in non-discrimination and protection of the health and other rights of sex workers, including young sex workers.

- Take all measures to stop police harassment and violence against sex workers
- Enforce the Court ruling protecting sex workers from unlawful arrest.
- Sensitise law enforcement officials to the rights of sex workers.

### People who use drugs

- Conducting further research on people who use drugs in Zimbabwe
- Based on research, replacing criminalisation and punishment of people who use drugs with evidence-based and rights-affirming interventions, including the promotion of referrals to rehabilitation programmes rather than the imposition of custodial services for persons convicted of possession for own use.
- Strengthening access to justice and law enforcement, including the strengthening of stigma and discrimination campaigns, law and human rights information on existing and new laws, education and training for all, including key populations and key service providers such as health workers, strengthening legal support services and mechanisms for enforcing HIV-related human rights complaints;

### Prisoners

- Ensuring access to confidential voluntary counselling and testing, non-discrimination on the basis of HIV or TB status and access to prevention, treatment and care.<sup>258</sup>
- Accelerating the provision of integrated HIV and TB health care services treatment to prisoners
- Ensuring access to prevention commodities, in accordance with international guidelines for HIV prevention in prisons, including drug treatment for people who use drugs, condoms, disinfectant for tattooing equipment, and safe needles and syringes and PMTCT should also be available for pregnant women in prison;

- Protecting the rights of young prisoners, through the implementation of the UPR recommendations aimed at enhancing juvenile justice protection and through adherence to international standards such as the Mandela Rules, to enhance the rights of all prisoners in general and specifically juveniles.
- Allowing for compassionate release of prisoners on the basis of health, such as HIV and TB.
- Integrating indicators specific to prisons into the national monitoring and evaluation system for HIV and/or to reinforce local capacity to do so;

### Employment

- Strengthened monitoring of the implementation of rights-based HIV workplace policies, developing the capacity of managers, supervisors, workplace peer educators and counsellors to provide accurate and adequate HIV information to their peers in the workplace, to protect workplace rights and to prohibit HIV-related discrimination, be it before or during employment;
- Training for all health care workers and law enforcement officials receive comprehensive training on occupational health and safety measures
- Ensuring that the necessary procedures are in place and equipment is accessible and available to enable health care workers and law enforcement officials to implement occupational health and safety measures, including universal precautions at all times;
- Ensuring that post-exposure prophylaxis is available for all health care workers and other service providers, including law enforcement officials, who need it and ensure that procedures are in place for access to support and counselling and assistance outside working hours.
- Strengthening access to redress for violations of the rights to equality and non-discrimination within the working environment.

258 UNODC, ILO, UNDP Policy brief HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions Available at [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/publication/wcms\\_187290.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_187290.pdf)

### Education and Information

- Review the Access to Information and Protection of Privacy Act and align it with the right to information provisions in the Constitution and also to ensure provision for the right of all people to information on HIV, AIDS, TB, and STIs, in accordance with Guiding Principle 39 of the National HIV and AIDS Policy. Alternatively, this could be provided for in the Public Health Act or proposed Public Health Bill provisions and/or HIV and AIDS specific legislation which is recommended in this report.
- Develop a comprehensive sexuality education programme, including information on HIV, AIDS, TB education programme curriculum and ensure that it includes age-appropriate and gender-sensitive information about HIV and TB prevention, including safer sex, as well as information on stigma, discrimination and human rights and sexual orientation and gender identity.
- Provide resources for and establish systematic, visible HIV strategies within schools, so teachers are better guided on how to address HIV within schools.
- Develop community and media awareness and education campaigns on HIV, law and human rights programmes that also specifically target and include information on issues and laws relevant to all vulnerable key populations, including young key populations and on new, protective laws and policies.
- Ensure that tertiary institutions have continually updated HIV and TB policies and programmes, including access to prevention, treatment (including ART), care and support, to respond to the ever-changing nature of HIV and TB in the country and globally.

### Social Security and Social Insurance

- Section 30 of the Constitution must be fully implemented, and particular attention paid to people infected and affected by HIV and TB, vulnerable and key populations;
- The Social Welfare Assistance Act must be reviewed and amended, with a view to

making explicit provision for the needs of people living with HIV and TB as well as other vulnerable and key populations

- Resources must be mobilised to implement social protection programmes for vulnerable and key populations, including OVC, as provided for in the Zimbabwe National HIV and AIDS Strategic Plan 2015–2018.

### Access to Justice and Law Enforcement

- Strengthen stigma and discrimination reduction programmes to reduce stigma and discrimination against people living with HIV, TB, vulnerable and key populations, including young key populations;
- Strengthen access to legal support services for people living with HIV, key populations and young key populations at higher risk of HIV exposure through various possible measures including encouraging *pro bono* services by private lawyers and the Legal AID Directorate and strengthening access to national human rights institutions;
- Provide training on human rights in the context of HIV and vulnerable and key populations for law and policy makers as well as law enforcers, including work with the judiciary and law enforcement officials;
- Work with law enforcement personnel, and in particular the VFU, to improve the treatment of key populations, including young key populations who come into conflict with the law either as defendants or complainants;
- Criminalise rights violations by law enforcement personnel targeting key populations and young key populations. Appropriate steps must be taken to ensure that all law enforcement personnel perform their duties appropriately, with competency and in a non-discriminatory manner;
- Develop guidelines to support law enforcement agents and the judiciary to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered.



# References

# List of Documents Reviewed and Referenced

## International Charters, Covenants and Related Documents

1. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000)
2. CESCR, General Comment No. 20, 42nd Session, 2009, Available at <http://www2.ohchr.org/english/bodies/cescr/comments.htm>
3. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health
4. Commission on Human Rights Resolutions 1995/44 of 3 March 1995 and 1996/43 of 19 April 1996
5. Committee on Economic, Social and Cultural Rights 35th session 2005 General Comment No.18
6. Doha Declaration on the TRIPS Agreement and Public Health, Available at [www.wto.org/english/thewto\\_e/minist\\_e/min01\\_e/mindecl\\_trips\\_e.htm](http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm) FAO, The Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security, Section III and article 8.3, Rome, 2004, available at: [www.fao.org/docrep/meeting/009/y9825e/y9825e00.HTM](http://www.fao.org/docrep/meeting/009/y9825e/y9825e00.HTM)
7. Human Rights Committee, 44th Session, 1992, General Comment No. 20
8. Human Rights Committee, General Comment No. 18 (37)
9. ILO (2010) Recommendation 200 Concerning HIV & AIDS in the World of Work
10. International Convention on the Elimination of All Forms of Racial Discrimination 1965
11. International Covenant on Civil and Political Rights 1966
12. International Covenant on Economic and Social Rights 1966
13. International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families
14. UNAIDS International Guidelines on HIV/AIDS and Human Rights, 2006
15. Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS (2006 Consolidated Version) International Guidelines on HIV/AIDS and Human Rights
16. The Siracusa Principles on the limitations and derogation provisions in the international Covenant on civil and political rights. UN Doc. E/CN.4/1985/4
17. U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR, General Comment No. Available at <http://www2.ohchr.org/english/bodies/cescr/comments.htm>
18. Universal Declaration on Human Rights (UNDHR)
19. UNAIDS (2010) Getting to Zero: 2011-2015 Strategy
20. UNAIDS (2012) Guidance Note on HIV and Sex Work
21. UNAIDS, 2004 Report on the global AIDS epidemic. UNAIDS, Geneva, 2004.
22. UNAIDS Key Population Policy Brief —A Gap Analysis and Recommendations for Key Populations and HIV in South Africa
23. UNAIDS (2010) Getting to Zero: 2011-2015 Strategy
24. ZUNGASS Declaration UNDP, UNAIDS, WHO Policy Brief, Using TRIPS flexibilities to improve access to HIV treatment, <http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/>
25. United Nations Economic and Social Council (ECOSOC) (1985)
26. United Nations Joint statement ending acts of violence and related human rights violations based on sexual orientation and gender identity, <http://www.ishr.ch/council/376-council/1033-ground-breaking-statement-on-sexualorientation-and-gender-identity-by-record-number-of-85-states>

27. UNODC, ILO, UNDP Policy brief HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions, [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/publication/wcms\\_187290.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_187290.pdf)
28. Vienna Convention on the Law of Treaties, May 23, 1969, 1155 U.N.T.S.331 [http://untreaty.un.org/ilc/texts/instruments/english/conventions/1\\_1\\_1969.pdf](http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf).
29. Vienna International Plan of Action on Ageing (VIPAA)
30. WHO (1969) International Health Regulations
31. World Health Organisation (2009) A Human Rights Based Approach to Health: Policy Brief

## Regional Instruments

32. Model law on HIV in Southern Africa, 2008
33. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol), adopted in 2003
34. The African Commission on Human and People's Rights (ACHPR) HIV Resolution 2011
35. African Charter on Human and Peoples' Rights
36. Charter of Fundamental Social Rights in SADC
37. Maseru Declaration on the Fight against HIV/AIDS in the SADC Region
38. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
39. Resolution on the Establishment of a Committee on the Protection of the Rights of People Living with HIV
40. Abuja + 12 Declaration, 2013
41. Southern African Development Community Parliamentary Forum (SADC PF) Model Law on HIV & AIDS in Southern Africa
42. African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa, 2012
43. Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa By 2030 Stride towards sustainable health in Africa, 2016

## National Laws

44. Constitution of Zimbabwe, 2013
45. Dangerous Drugs Act of Zimbabwe [Chapter 15:02]3.
46. Legal Aid Act of Zimbabwe (Chapter 7:16)
47. Legal Assistance and Representation Act [Chapter 9:13]
48. Censorship Entertainment and Control Act
49. Miscellaneous Offences Act [Chapter 9:15]
50. National AIDS Council Act [Chapter 15:14]
51. Sexual Offences Act [Chapter 9:21]
52. Public Health Act [Chapter 15:09]
53. Social Welfare Assistance Act [Chapter 17:06]
54. Disabled Persons Act
55. Prisons Act [Chapter 7:11]
56. National AIDS Council of Zimbabwe Act [Chapter 15:14]
57. Criminal Law (Codification and Reform) Act, 2006
58. Prevention of Discrimination Act [Chapter 8:16]
59. Medicines and Allied Substances Control Act [Chapter 15:03]
60. Patents Act [Chapter 26:03]
61. Domestic Violence Act, 2007
62. Social Welfare Assistance Act [Chapter 17:06]
63. Children's Protection and Adoption Act [Chap. 5:06]
64. Education Act [Chap. 25:04]
65. Zimbabwe Human Rights Commission Act, 2012
66. Education Act [Chapter 25:04]
67. Criminal Procedure and Evidence Act
68. Public Order and Security Act Chapter 11:23
69. Zimbabwe Immigration Act [Chapter 4:02]
70. Gender Violence Act of 2011
71. Banking Act

72. Access to Information and Protection of Privacy Act [Chapter 10:27]
73. Guardianship of Minors Act [Chap. 5:08]
74. Legal Age of Majority Act [Chapter 8:07]

## International Reports and Articles

75. UNAIDS (2014) The Gaps Report
76. Global AIDS Report 2012
77. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care of Key Populations, July 201490-90-90, An Ambitious Treatment Target to help end the AIDS Epidemic, UNAIDS
78. Report of the Special Rapporteur on Health: Informed Consent (2009)
79. WHO, UNAIDS, UNFPA, NSWP (2012) Prevention and Treatment of HIV and Other Sexually Transmitted Infections for Sex Workers in Low and Middle-Income Countries: Recommendations for a Public Health Approach
80. UNAIDS (2008) Rapid Assessment on Most-At-Risk-Populations in the Indian Ocean:
81. Global Commission on HIV and the Law, Risks, Right, and Health, July 2012 Injecting Drug Users, Men who have Sex with Men and Sex Workers
82. UN Human Rights Office of the Human Rights Commissioner, The Right to Food, <http://www.ohchr.org/Documents/Publications/FactSheet34en.pdf>
83. International HIV/AIDS Alliance and Commonwealth HIV and AIDS Action Group, (2010) Enabling legal environments for effective HIV responses: A leadership challenge for the Commonwealth
84. A report to UNAIDS on National HIV-related laws, policies and programmes covering various issues including HIV-related law and human rights issues
85. UNICEF, Enhancing Social Protection for HIV Prevention, Treatment, Care & Support The state of the Evidence: [https://www.unicef.org/esaro/Social\\_Protection\\_and\\_HIV.pdf](https://www.unicef.org/esaro/Social_Protection_and_HIV.pdf)
86. <http://www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx>
87. International Federation of Red Cross and Red Crescent Societies and Francois-Xavier Bagnoud Center for Health and Human Rights, "The Public Health – Human Rights Dialogue" in Mann, J et al (eds), Health and Human Rights: A Reader. Routledge, New York, 1999.
88. Eliminating forced, coercive and otherwise involuntary sterilisation, an interagency statement, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO, © World Health Organisation 2014
89. Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak, 15 January 2008, A/HRC/7/3 and UN Committee against, General Comment No. 2: Implementation of Article 2 by States Parties, 24 January 2008, CAT/C/GC/2 paragraph 22
90. Manyara Angeline Munzara, The Right to Food for People Living with HIV and AIDS, The Right to Food and Nutrition Watch 2010, [http://www.righttofoodandnutrition.org/sites/www.righttofoodandnutrition.org/files/watch\\_2010\\_eng.pdf](http://www.righttofoodandnutrition.org/sites/www.righttofoodandnutrition.org/files/watch_2010_eng.pdf)
91. Social Protection and HIV Guidance Note, UNAIDS, 2011
92. The Rights of Older Persons, Protection and Gaps under Human Rights Law, Marthe Fredvang and Simon Biggs Social Policy Working Paper no. 16, August 2012 <http://social.un.org/ageing-working-group/documents/fourth/Rightsolderpersons.pdf>
93. GCHL (2012) Risks, Rights & Health, <http://www.hivlawcommission.org/resources/report/Executive-Summary-GCHL-EN.pdf>
94. UNDP, UNAIDS, WHO Policy Brief, \_Using TRIPS flexibilities to improve access to HIV treatment [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2049\\_PolicyBrief\\_TRIPS\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2049_PolicyBrief_TRIPS_en.pdf)
95. ILOAIDS, A workplace policy on HIV/AIDS: what it should cover [http://www.ilo.org/wcmsp5/groups/public/@ed\\_protect/@protrav/@ilo\\_aids/documents/publication/wcms\\_121313.pdf](http://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@ilo_aids/documents/publication/wcms_121313.pdf)

## Regional Reports and Articles

96. Southern African Litigation Centre (2011) Equal Rights for All: Litigating cases of HIV related discrimination
97. Southern African Litigation Centre (2012) Protecting Rights: Litigating Cases of HIV Testing and Confidentiality of HIV Status
98. Health and Human Rights Resource Guide,- Centre for Health and Human Rights; Harvard University available at <https://www.hhrguide.org/2014/03/08/585/> ( accessed June 2018)
99. SADC. 2006. SADC Framework for Developing and Sharing Best Practices on HIV and AIDS. SADC HIV and AIDS Unit
100. SADC HIV and AIDS Best Practice Series, the Zimbabwe National AIDS Levy Trust (The AIDS Levy), March 2008
101. Malawi (2012) Assessment of Legal, Regulatory & Policy Environment for HIV and AIDS in Malawi
102. Seychelles (2013) Assessment of Legal, Regulatory & Policy Environment for HIV and AIDS in Seychelles
103. The Constitution of the Republic of Malawi, 1994, [http://www.chr.up.ac.za/images/files/documents/ahrdd/malawi/malawi\\_constitution.pdf](http://www.chr.up.ac.za/images/files/documents/ahrdd/malawi/malawi_constitution.pdf)
104. Constitution of the Republic of South Africa, 1996, art. 39(1) available at <http://www.constitutionalcourt.org.za/site/constitution/english-web/ch2.html>
105. Regional Issue Brief: WOMEN, HIV AND THE LAW, For the Africa Regional Dialogue of the Global Commission on HIV and the Law 4 August 2011 Pretoria, South Africa <file:///C:/Users/Angeline%20Munzara/Downloads/Africa-RIB-Women.pdf>
106. Gertholtz, L & Grant, C (2010), International, African and country legal obligations on women's equality in relation to sexual and reproductive health, including HIV and AIDS, HEARD and ARASA, Durban, South Africa
107. Malinga, J. & Ford, L., "Uganda Food Crisis Undermining Efforts to Fight HIV/AIDS" in the Guardian, 21 October 2009, [www.guardian.co.uk/katine/2009/oct/21/food-crisis-hiv-aids](http://www.guardian.co.uk/katine/2009/oct/21/food-crisis-hiv-aids).

108. HIV, the Law and Human Rights in the African Human Rights System: Key Challenges and Opportunities for Rights-Based Responses to HIV Study for the African Commission on Human and Peoples' Rights, December 2016: [http://www.achpr.org/files/news/2017/01/d271/hiv\\_the\\_law\\_and\\_human\\_rights\\_in\\_the\\_african\\_human\\_rights\\_system\\_draft\\_study\\_report.pdf](http://www.achpr.org/files/news/2017/01/d271/hiv_the_law_and_human_rights_in_the_african_human_rights_system_draft_study_report.pdf)
109. Report on Assessment of the Legal Environment on HIV and AIDS in Lesotho, Final Report 2016

## National Reports, Articles Discussion Papers

110. National Health Financing in Zimbabwe 2005: Contribution of the National AIDS Levy to National Healthcare Support, Amon Mporu and Phillip Nyahoda, National AIDS Council of Zimbabwe, EQUINET DISCUSSION PAPER 54, March 2008
111. ZIMSTAT, National Census Report 2012
112. HIV/AIDS statistics map, <http://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zimbabwe> on 4 December 2016
113. Situational Analysis of Children and Women in Zimbabwe, UNICEF, 2010
114. Global AIDS Response Country Progress Report Zimbabwe 2014
115. NAC, 'Smart Investment to End HIV/AIDS in Zimbabwe based on Hotspot Analysis', 2015, <http://nac.org.zw/sites/default/files/Hot%20spot%20Mapping%20Report.pdf>.
116. Simplified Version of the Declaration of Rights: Constitution of Zimbabwe Amendment (No. 20) Act 2013, Centre for Applied Legal Research; Hivos, Legal Resources Foundation
117. UNAIDS (2014) Zimbabwe
118. UNAIDS (2014) Global Report 2013
119. Zimbabwe National Statistics Agency (2012)-Zimbabwe Demographic and Health Survey 2010-11

120. UNAIDS (2012) 'Homophobia and punitive laws continue to threaten HIV responses and human rights' amfAR (2013) 'Achieving an AIDS-Free Generation for Gay Men and Other MSM in Southern Africa, Country Profile: Zimbabwe
121. Cowan, F. M., (2013) 'Engagement with HIV Prevention Treatment and Care among Female Sex Workers in Zimbabwe: a Respondent Driven Sampling Survey', PLOS ONE
122. Maseko, S., and Ndlovo, S., (2012) Condoms as evidence: police, sex workers and condom confiscation in Zimbabwe
123. UNAIDS Fact Sheet, Gender and HIV/AIDS, online, UNAIDS HIV/AIDS and Gender, [http://www.unaids.org/fact\\_sheets/ungass/html/Fsgender\\_en.html](http://www.unaids.org/fact_sheets/ungass/html/Fsgender_en.html), cited in "HIV/AIDS and Humanitarian Catastrophe in Sub Saharan Africa", Report of the Standing Committee on Foreign Affairs and International Trade, B. Patry and I. Cotler, Chairs, (Ottawa; Communications Canada, 2003) Zimbabwe Human Rights NGO Forum, Human Rights Bulletin No.83, <http://www.hrforumzim.org/wp-content/uploads/2013/06/Bulletin-83-Access-to-justice.pdf> The Zimbabwe People Living with HIV Stigma Index, December 2014, ZNPP+
124. The Southern African Development Community Parliamentary Forum (SADC PF) Model Law on HIV & AIDS in Southern Africa, Accessed on 15 December 2016, [file:///C:/Users/Angeline%20Munzara/Downloads/Model%20Law%20in%20Southern%20Africa%20\(1\).pdf](file:///C:/Users/Angeline%20Munzara/Downloads/Model%20Law%20in%20Southern%20Africa%20(1).pdf)
125. Zimbabwe Population Based HIV Impact Assessment, ZIMPHIA, First Report, December 2017, Ministry of Health and Child Care (MoHCC), Zimbabwe The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) The U.S. Centers for Disease Control and Prevention (CDC) Zimbabwe National Statistics Agency (ZIMSTAT) The Biomedical Research and Training Institute (BRTI) Lancet Laboratories Statistical Centre for HIV/AIDS Research and Prevention (SCHARP) Westat ICAP at Columbia University
126. National HIV and AIDS Policy 1999
127. National HIV and AIDS Strategic Framework (2000 – 2004)
128. Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2006 – 2010.
129. National Health Strategy (2011 – 2015).
130. Zimbabwe National HIV and AIDS Strategic Plan (ZNASP 2011 – 2015),
131. Zimbabwe National HIV And AIDS Strategic Plan (ZNASP) 2015 – 2018
132. Zimbabwe National HIV And AIDS Strategic Plan (ZNASP) 2015 – 2020
133. Life Skills, Sexuality, HIV and AIDS Education Strategic Plan 2012-2015
134. HIV and AIDS Policy for the Energy Sector of Zimbabwe September 2009
135. The Labour (HIV and AIDS) Regulations 2014 (SI 105 of 2014)
136. HIV and AIDS Policy for the Energy Sector of Zimbabwe, 2009
137. National Health Policy in the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET)
138. HIV Counselling and Testing (HTC) Guidelines and the HTC Guidelines for Children
139. Ministerial Statement RECORDED COMMERCIAL CHILD SEXUAL EXPLOITATION IN HARARE, National Assembly, Wednesday 4 October 2017
140. GLOBAL AIDS RESPONSE PROGRESS REPORT 2016, Follow Up to the 2011 Political Declaration on HIV/AIDS: Intensifying Efforts to Eliminate HIV/AIDS: Zimbabwe Country Report: Reporting Period, January 2015-December 2015
141. Constitution of Zimbabwe Amendment (No. 20) Act, 2013
142. Dangerous Drugs Act [Chapter 15:02]
143. Legal Aid Act [Chapter 7:16]
144. Censorship Entertainment and Control Act [Chapter 10:04]
145. Customary Law and Local Courts Act [Chapter 7:05]

## References

146. National AIDS Council Act [Chapter 15:14]
147. Public Health Act [Chapter 15:09] and Public Health Bill- 2017
148. Prisons Act [Chapter 7:11]
149. National AIDS Council of Zimbabwe Act [Chapter 15:14]
150. Immigration Act [Chapter 4:02]
151. Criminal Law (Codification and Reform) Act [Chapter 9:23]
152. Income Tax Act [Chapter 23:06]
153. Prevention of Discrimination Act [Chapter 8:16]
154. Medicines and Allied Substances Control Act [Chapter 15:03]
155. Patent Act Patents Act [Chapter 26:03]
156. Medicines and Allied Substances Control Act [Chapter 15:03]
157. Domestic Violence Act [Chapter 5:16]
158. Disabled Persons Act 17:01
159. Banking Act [Chapter 24:20]
160. Social Welfare Assistance Act [Chapter 17:06]
161. Access to Information and Protection of Privacy Act [Chapter 10:27]
162. Children's Act [Chapter 5:06]
163. Zimbabwe Human Rights Commission Act [Chapter 10:30]
164. Children's Protection and Adoption Act [Chap. 5:06]
165. Education Act [Chap. 25:04]
166. Guardianship of Minors Act [Chap. 5:08]
167. Legal Age of Majority Act [Chapter 8:07]
168. HIV and AIDS (Prevention and Management) Malawi, Act No 12 of 2017
172. Joy Mining Machinery (Pty) Ltd v National Union of Metal Workers of South Africa (NUMSA) and others, [2002] ZALC 7, <http://www.saflii.org/za/cases/ZALC/2002/7.html>
173. Monare v Botswana Ash (Pty) Ltd, (2004) IC No 112 of 1998, [www.southernafricalitigationcentre.org/download/6/15](http://www.southernafricalitigationcentre.org/download/6/15)
174. Nanditume v Minister of Defence 2000 NR 103.
175. Hoffmann v SAA 2001 (1) SA 1 (CC)
176. Kingaipe and Another v Attorney-General, Case No. 2009/HL/86 (2010)
177. PFG Building Glass v CEPPAWU, (2003) 5 BLLR 475, para 77
178. Allpass v Mooikloof EStates (Pty) Ltd t/a Mooikloof Equestrian Centre, [2011] ZALC 2
179. S v Banana 2000 1 ZLR 607

## National Policies, Codes, Guidelines, Strategies and Plans

180. Zimbabwe National HIV And AIDS Strategic Plans I to III (ZNASP) Extended Zimbabwe national HIV and AID Strategic Plan (2015 -2020)
181. Life Skills, Sexuality, HIV and AIDS Education Strategic Plan 2012-2015
182. The Labour (HIV and AIDS) Regulations, 2014 (SI 105 of 2014)
183. National Health Strategy- 2016-2020
184. Gender Implementation Plan- 2016-2020
185. HIV in Informal Sector Strategy- 2016-2020
186. Sex Workers Operational Plan
187. Testing Guidelines (Condom Strategy)
188. HIV Counselling and Testing (HTC) Guidelines and the HTC Guidelines for Children
189. Universal Periodic Review (UPR) recommendations accepted by Zimbabwe and the National Plan of Action to implement the recommendations (2017-2022)
190. National Adolescent & Youth Sexual & Reproductive Health (ASRH) II:20

## Case Law

169. Legal Resources Foundation v Zambia, Comm. 211/98, para 60 available at <http://caselaw.ihrda.org/doc/211.98/pdf>
170. Zimbabwe Human Rights NGO Forum v Zimbabwe, Comm. 245/2002, para 143: <http://caselaw.ihrda.org/doc/245.02/pdf>
171. Longwe v Intercontinental Hotel, [1993] 4 LRC 221, paras 233c-233d.

## National & Regional Researches and Surveys Reports and Selected Papers

191. A Baseline Survey on the Legal Framework Governing PWDs in the Country, 2016, 2Legal Aid Survey – January 2016; Royal Danish Embassy Office (Mette Nielsen and Anton Pesten)192.HIV/AIDS statistics map accessed at: <http://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zimbabwe> on 4 December 2016
192. Situational Analysis of Children and Women in Zimbabwe, UNICEF, 2010
193. Global AIDS Response Country Progress Report Zimbabwe 2014
194. NAC, 'Smart Investment to End HIV/AIDS in Zimbabwe based on Hotspot Analysis', 2015, <http://nac.org.zw/sites/default/files/Hot%20spot%20Mapping%20Report.pdf>.
195. Simplified Version of the Declaration of Rights: Constitution of Zimbabwe Amendment (No. 204). Act 2013, Centre for Applied Legal Research; Hivos, Legal Resources Foundation
196. UNAIDS (2014) Global Report 2013
197. Zimbabwe National Statistics Agency (2012)-Zimbabwe Demographic and Health Survey 2010-11
198. UNAIDS (2012) 'Homophobia and punitive laws continue to threaten HIV responses and human rights' amfAR (2013) 'Achieving an AIDS-Free Generation for Gay Men and Other MSM in Southern Africa, Country Profile: Zimbabwe
199. Cowan, F. M., (2013) 'Engagement with HIV Prevention Treatment and Care among Female Sex Workers in Zimbabwe: a Respondent Driven Sampling Survey', PLOS ONE
200. Maseko, S., and Ndlovo, S., (2012) Condoms as evidence: police, sex workers and condom confiscation in Zimbabwe
201. UNAIDS Fact Sheet, Gender and HIV/AIDS, online, UNAIDS HIV/AIDS and Gender Web Page [http://www.unaids.org/fact\\_sheets/ungass/html/Esgender\\_en\\_.html](http://www.unaids.org/fact_sheets/ungass/html/Esgender_en_.html), cited in "HIV/AIDS and Humanitarian Catastrophe in Sub Saharan Africa", Report of the Standing Committee on Foreign Affairs and International Trade, B. Patry and I. Cotler, Chairs, (Ottawa; Communications Canada, 2003)
202. Zimbabwe Human Rights NGO Forum, Human Rights Bulletin No.83, <http://www.hrforumzim.org/wp-content/uploads/2013/06/Bulletin-83-Access-to-justice.pdf>
203. The Zimbabwe People Living with HIV Stigma Index, December 2014, ZNPP+
204. The Southern African Development Community Parliamentary Forum (SADC PF) Model Law on HIV & AIDS in Southern Africa, Accessed on 15 December 2016, [file:///C:/Users/Angeline%20Munzara/Downloads/Model%20Law%20in%20Southern%20Africa%20\(1\).pdf](file:///C:/Users/Angeline%20Munzara/Downloads/Model%20Law%20in%20Southern%20Africa%20(1).pdf)

## Instruments Relevant to the Treatment of Prisoners

205. Body of Principles for the Protection of all Persons Under any Form of Detention or Imprisonment (The Body Principles 1988
206. UN Standards Minimum Rules for the Treatment of Prisoners (Mandela Rules), 2015
207. United Standard Minimum Rules for Non-Custodial measures (The Tokyo Rules
208. Standard Minimum Rules for the Treatment of Female Prisoners and Non-Custodial Measures for Women Offenders
209. UN Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
210. The Kampala Declaration on Prison Conditions in Africa
211. Ouagadougou Declaration and Plan of Action on Accelerating Prisons and Penal Reforms in Africa

# Annexures

## Annexure 1: List of FGDs Conducted

- People living with HIV- Adult men
- People Living with HIV – Adult women
- HIV positive prisoners
- Transgender
- Sex workers (Male)
- Sex workers (Female)
- Gays and Lesbians
- HIV Positive Adolescents (boys and girls)
- Zimbabwe National Network of Positive People (ZNNP+)

### April and May 2018

#### Harare

- Men who have Sex with Men, Transmen and Sex Workers 19 April 2018- Harare)
- Men who Have Sex with Men (Gay) 12 May 2018
- Transgender and some media (19 April – Harare)
- Women who have Sex with Women (Lesbians and Bisexuals) (20th April Harare)
- Young Adolescence Living with HIV and AIDS – Young Positives Incorporating Groups who transitioned from Zvandiri – younger than 16 years (26 April 2018)

#### Bulawayo

- Young Adolescence Living with HIV and AIDS and with Disabilities (26 April- Bulawayo)
- Transgender, Lesbians, Bisexual (25 April Bulawayo)
- Female Sex Workers (26 April- Bulawayo)

#### Mutare

- Women Living with HIV and AIDS and Young Adolescence Living with HIV and AIDS (12 May 2018)
- People with Disabilities and Living with HIV and AIDS (12 May 2018)

## Annexure 2: List of Key Informants

### Organisation

1. NAC
2. UNDP Global Fund/CCM secretariat
3. UNAIDS
4. UN Women
5. UNFPA
6. UNICEF
7. WHO
8. SAFAIDS
9. GALZ (Executive Director) NCPD (People with Disabilities-National Coordinator)
10. Zimbabwe Human Rights Commission
11. Zimbabwe Lawyers for Human Rights-
12. Ministry of Gender and Women Affairs
13. Zimbabwe Business Council on AIDS (ZBCA)
14. Ministry of Health and Child Care(MOHCC)-NAC
15. Ministry of Justice, Legal and Parliamentary Affairs
16. MS-OCA
17. Gays and Lesbians of Zimbabwe (GALZ)
18. New Start Center (PSI)- Waiting for appointment
19. Zimbabwe AIDS Network (wellness)-NAC
20. Africaid- Zvandiri
21. Police
22. Prisons
23. Zimbabwe Congress of Trade Union (ZCTU)
24. Zimbabwe Federation of Trade Union (ZFTU)
25. Women and Law in Southern Africa (WILSA)
26. FACT Mutare
27. Zimbabwe National Network of Positive People (ZNNP+)
28. Parliamentary Committee on HIV/AIDS/ Health/Legal Affairs

29. Center for Sexual Health/HIV/AIDS Research (CESHHAR)
30. National Association of Societies for the Care of the Handicapped (NASCOH)
31. Employers' Confederation of Zimbabwe (EMCOZ)
32. UDACIZA
33. USAID/PEPFAR
34. ZIMSWA
35. TRANSMART
36. Students and Youth Working on Reproductive Health Action Team. (SAYWHAT)
37. Parliamentary Committee on Gender
38. Parliamentary Committee of Chiefs



**United Nations Development Programme**

UNDP Zimbabwe

Block 10, Arundel Office Park,  
Norfolk Road, Mount Pleasant,  
Harare,  
Zimbabwe.

Tel: +263 4 338 836-44

Fax: +263 4 338 294

E-mail: [registry.zw@undp.org](mailto:registry.zw@undp.org)

Website: <http://www.zw.undp.org/>