

Nine Countries' Compliance with International Human Rights Standards for HIV/AIDS Prevention

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EXECUTIVE SUMMARY

National level laws and policies can facilitate or hinder HIV/AIDS prevention efforts. For example, laws that criminalize same-sex sex, prohibit condoms in prisons, and disallow needle exchange have been identified by UNAIDS and others as obstacles to prevention. Only six in ten countries in the world have laws and regulations that prohibit discrimination against those living with HIV/AIDS, despite recognition that discrimination and stigma interfere with an effective response to the disease.¹ Legal regimes that fail to address patient confidentiality, sexual violence prevention, and gender equality also impede progress.

This report, undertaken by UCLA School of Law's new International Human Rights Law Program,² aims to identify countries with national level laws that are out of compliance with international legal norms concerning HIV/AIDS prevention. The report's goal is to inform the law school's strategy to raise additional funds to undertake national-level law reform projects in collaboration with locally based advocates, government agents, and policymakers.

Last year, Professor Lara Stemple taught a law school course in which upper division law students conducted research on the national-level laws of the following nine countries: China, India, Jamaica, Kenya, Malawi, Mexico, South Africa, Thailand, and Zimbabwe.

Professor Stemple worked with one researcher to conduct a textual analysis of international human rights instruments to create a model for evaluating state compliance. All United Nations-sponsored treaties, general comments, consensus documents, resolutions, and declarations which address HIV/AIDS prevention were analyzed. Examples include the UN Committee on Economic, Social and Cultural Rights General Comment, "The Right to Health" (2000), the UN Declaration of Commitment on HIV/AIDS (2001), The Committee on the Rights of the Child, General comment on HIV/AIDS (2003), the Political Declaration on HIV/AIDS (2006), and International Guidelines on HIV/AIDS and Human Rights (2006), the UNAIDS publication, which translates international human rights norms into recommendations for state-level action. These international human rights instruments were used to develop the 34 standards in the evaluative model (see Appendix A).

Nine students were each assigned one country and tasked with researching its laws and policies through legal databases, online libraries, and collaboration with UCLA's international law

¹ UNAIDS. Report on the Global AIDS Epidemic: a UNAIDS 10th Anniversary Special Edition. Geneva: UNAIDS, 14 (2006).

² Professor Lara Stemple served as the principal investigator, overseeing all research and writing. Lindsey Zwicker, JD candidate 2010, UCLA MPP candidate 2010, drafted this report. Shawn Kravich, UCLA JD graduate 2009, drafted the model against which state compliance was measured. Taraneh Abdollahi-Fard, UCLA JD graduate 2009 drafted the first report on Kenya. Carolina Bruce, UCLA LLM graduate 2009 drafted the first report on Malawi. Chantal Hwang, UCLA JD candidate 2010 drafted the first report on South Africa. Emily Nagisa Keehn, UCLA JD candidate 2010, drafted the first report on Thailand and conducted research for the first report on Malawi. Vivian Lo, UCLA JD graduate 2009, drafted the first report on China. Cassaundra Pick, UCLA JD graduate 2009, drafted the first report on India. Jacqueline Serna, UCLA JD candidate 2010, drafted the first report on Mexico. Lauren Tarantello, UCLA JD candidate 2010, drafted the first report on Jamaica. Katie Viggiani, UCLA JD graduate 2009, drafted the first report on Zimbabwe.

librarian. The relevant laws were then coded by issue category, analyzed against the model and rated for compliance. Four-to-five researchers collaborated in coding each country's laws as (1) compliant, (2) partially compliant, (3) nonexistent, or (4) in conflict with the model.

This report analyzes the countries' patterns of compliance and conflict with the model and, more briefly, discusses the political, economic, and social contexts that inform relevant laws' enforceability. Taken together, they inform this report's recommendations for the Law School's future collaborative work on HIV/AIDS prevention efforts.

The research found the following about each state:

China

The People's Republic of China boasts the second highest rate of compliance with international norms (after Kenya), with a compliance rate of 44%. It is partially compliant with 38% of the standards, lacks relevant policies for 9% of the standards, and conflicts with 9%.

Judicial and other venues for vindicating rights related to HIV/AIDS prevention are largely absent or ineffectual. This, together with China's impenetrable authoritarian regime, make it an impractical choice for UCLA law reform efforts.

India

India's level of compliance with the standards ranks low among the nine countries. It has laws in conflict with 21% of the 34 standards, it lacks laws or policies on 47% of the standards, and is partially compliant with 21%. Its laws reflect complete compliance with only 12% of the standards, the second lowest rate among the nine countries.

India's vastness and diversity, its fragmented political structure, and the courts' recognition of personal laws pose challenges for a student legal clinic. On the other hand, its low levels of compliance, together with proposed legislation that has the potential to transform the legal framework into one with significantly higher levels of compliance, may provide opportunities for advocacy around implementation. India's reasonably active NGO sector may also offer fruitful opportunities for partnership.

Jamaica

Relative to the other nine states, Jamaica is moderately compliant with the 34 standards. It possesses laws that conflict with 9% of the standards, it is silent on 35%, partially compliant with 29%, and completely compliant with 26% of the standards.

With this legal framework, including low rates of directly conflicting laws and policies, Jamaica is poised for further progress toward conformity with international norms. The country's bicameral legislature and its common law legal system are familiar, and the relatively active NGO community may offer ample opportunities for partnership with UCLA.

Kenya

Kenya possesses the highest rate of compliance among the nine countries at 47%. It is partially compliant with 38% of the standards, conflicts with 12%, and lacks legislation on only on 3% of the standards – the lowest conflict rate among the nine states.

Kenya's 2006 HIV and AIDS Prevention and Control Act ("HAPCA" includes movement toward compliance with international norms, as well as steps back. Should its proposed HIV and AIDS Tribunal become operational, this could become an important venue for reform efforts, providing an opportunity for students to collaborate on cases. In the meantime, reform efforts are needed around some of HAPCA's more problematic provisions.

Malawi

With a compliance rate of only 9%, Malawi ranks lowest among the nine countries. Most notably, Malawi altogether lacks laws and policies on 68% of the 34 standards. The makes Malawi the most legally underdeveloped state among the nine by a wide margin.

With penal code amendments and HIV/AIDS-specific bills in progress but stalled, Malawi hovers on the brink of compliance with many important legal standards. Notably, there are currently only 300 qualified lawyers for 11 million people in Malawi.³ If and when legal reforms do take place, there will be an acute need for the capacity to enforce them.

Mexico

Mexico achieves a middling rank with respect to its rate of complete compliance: 26%. However, it boasts the highest rate of partial compliance among the nine countries: 47%. It lacks legislation on 24% of the standards and has the second lowest rate of conflict: 3%.

Mexico possesses promising federal legislation but faces many challenges in terms of local enforcement of national norms. Legislative reform efforts may therefore be less important than addressing local politics, and the latter project falls outside the scope of potential UCLA collaboration.

South Africa

With a compliance rate of 41%, South Africa ranks third highest for compliance among the nine countries. It is partially compliant with 41% of the standards and ranks third lowest for nonexistent laws or policies. It conflicts with 6% of the standards.

South Africa has had a sustained dialogue about rights and equality over the last decades. It is a society that has shown itself open to change, and yet its needs, particularly concerning HIV/AIDS prevention, are acute. While the NGO sector is vibrant and well respected, staff capacity shortages hold back reform efforts. Though many of South Africa's laws conform to international human rights norms, implementation challenges – and therefore opportunities – remain.

³ Hillery Anderson, *Justice Delayed in Malawi's Criminal Justice System: Paralegals vs. Lawyers*, 1 INT. J. CRIM. JUSTICE SCI. 1, at 2 (2006).

Thailand

Thailand's rate of compliance with the 34 standards is high, relative to the other eight countries examined. It is the only country to have no conflicting laws with any of the 34 standards. It is silent on 24% of the 34 standards, partially compliant with 44% of the standards, and completely compliant with 32%.

Most of Thailand's HIV/AIDS-related policies are created through NACAP's non-binding regulatory codes. Because the majority of regulation is composed of non-binding policy, and not enforceable legislation, opportunities for traditional legal intervention are limited. Moreover, Thailand's extraordinarily robust NGO sector, and the country's proven ability to lower transmission rates⁴ may indicate a lesser need for UCLA's services than other countries.

Zimbabwe

Zimbabwe's laws conflict with 26% of the 34 standards – the greatest degree of conflict among the nine countries studied. It is partially compliant with 24% of the standards and fully compliant with 29% of the 34 standards, which is the third lowest compliance rate among the nine countries.

More than any country studied, Zimbabwe has enacted laws that are in direct conflict with international norms in many cases. Law reform efforts are acutely needed to address these conflicts. However, if one assumes that hostility is more difficult to overcome than mere inertia, reform in Zimbabwe will not come easily. Moreover, extreme violence, political instability, and the ongoing challenges faced by potential NGO partners create insurmountable obstacles for student work at this time.

In sum, of the countries studied, those most amenable to law reform efforts with UCLA are India, Jamaica, Kenya, Malawi, and South Africa.

⁴ See Ministry of Public Health, Thailand & World Health Organization, External Review of the Health Sector Response to HIV/AIDS in Thailand 19 (2005) [Hereinafter WHO, External Review], *available at* http://www.searo.who.int/LinkFiles/News_and_Events_ThailandProgrammeReviewNEW.pdf (last visited Dec. 17, 2008), for a comparison of HIV/AIDS prevalence between 2001 and 2007.

INTRODUCTION AND PURPOSE

This “seed” project, funded by the UCLA AIDS Institute and the UCLA Program in Global Health, aims to preliminarily identify how and where UCLA School of Law’s International Human Rights Law Program can contribute to the development, implementation, and expansion of HIV/AIDS prevention efforts through policy and law reform work. The research project has culminated in this report, the aim of which is to inform the law school’s fundraising for and development of new national-level law reform projects in collaboration with locally based advocates, government agents, and policymakers.

The report analyzes nine countries’ patterns of compliance with international human rights standards for HIV/AIDS prevention. It evaluates each of the nine countries’ degree of compliance with a 34-category model developed to capture current international human rights standards found in UN instruments and recommendations. The nine countries, all of which are UCLA AIDS Institute and UCLA Program in Global Health priority countries, include China, India, Jamaica, Kenya, Malawi, Mexico, South Africa, Thailand, and Zimbabwe. Secondly, this report identifies relevant social and political characteristics that may make a given country more or less well suited to collaborative law and policy work with the International Human Rights Law Program.

A HUMAN RIGHTS APPROACH TO HIV/AIDS PREVENTION

The health and human rights framework holds many promises for HIV/AIDS prevention and treatment efforts. A decade ago Jonathan Mann identified three categories of social factors relevant to HIV/AIDS prevention: (1) political and governmental; (2) sociocultural; and (3) economic. He explained that “[p]olitical factors include the inattention or lack of concern about HIV/AIDS, as well as governmental interference with the free flow of complete information about HIV/AIDS. Sociocultural factors involve social norms regarding gender roles and taboos about sexuality. Economic issues include poverty, income disparity and the lack of resources for prevention programs. . . It has become clear that a deeper understanding of the societal nature of the pandemic and the societal preconditions for HIV vulnerability is now required.”⁵

Mann and his colleagues advocated for the use of a “health and human rights” framework as a key tool to inspire social reform. Since then, the human rights canon has expanded to include a greater range of health rights, and the health and human rights framework has been embraced by UN agencies and NGOs alike. Indeed, this project identified 34 standards in human rights instruments which are directly relevant to HIV/AIDS prevention.

Of course, the existence of international human rights standards is not enough to reduce the spread of the disease. At a minimum, each country must adopt national-level laws and policies that implement these global norms, and ensure that they are enforced. This project endeavors to determine just how far each of the nine countries has come in adopting compliant national laws.

⁵ Mann JM. Human rights and AIDS: the future of the pandemic. In: Health and human rights: a reader. Edited by Mann JM, Gruskin S, Grodin MA, Annas GJ. New York: Routledge, 223 (1999).

It should be noted that the international standards do not require states to use specific statutory language, thereby leaving room for each state to adopt country-specific laws and policies.

Future large-scale research should include an examination of how law and policies directly improve HIV/AIDS prevention. When it can be demonstrated that human rights-based interventions result in positive health outcomes, such evidence will go a long way toward building the case for increased resource commitments for these strategies. Currently, such data are sorely lacking.

SOURCES OF INTERNATIONAL HUMAN RIGHTS STANDARDS

The United Nations Charter calls on the UN General Assembly, a body comprised of delegates from every member state, to undertake the progressive codification and development of international law.⁶ Though its power is limited, the United Nations General Assembly is the foremost authority on the construction of international legal authority.⁷ United Nations member states have a continuing obligation to observe the Charter of the United Nations, including a commitment to the body of international law created by the UN.⁸

More than 500 conventions, treaties, resolutions, and standards provide a framework for promoting international peace, security, and development.⁹ Where HIV/AIDS is concerned, the United Nations has taken significant, although late, steps toward creating norms focused on prevention and treatment.

It is important to highlight the fact that not all international standards are legally binding to the same degree. International *treaties* are fully binding upon nations: as parties to treaties, nations assent to the terms of the instrument.¹⁰ The UN General Assembly's *declarations and resolutions* are held to unanimous vote; therefore, all member states to the UN are bound to accept, enforce, and protect those laws.¹¹ Still, because the UN General Assembly is comprised of states' delegates and not states' legislators, these declarations and resolutions do not rise to the level of treaties.¹² *General comments and general recommendations*, issued by UN Committees charged with overseeing the details of a particular treaty or convention provision, are not binding but purport to state the international law on a subject.¹³ States themselves have not formally acceded to the content of comments and general recommendations; nevertheless, they are given

⁶ Article 13 of the Charter of the United Nations, ratified October 24, 1945.

⁷ Arts. 2 (1) (b), 14 (1) and 16, Vienna Convention on the Law of Treaties 1969.

⁸ American Jurisprudence, Second Edition (2008) International Law § 16.

⁹ The United Nations Treaty Collection, Database on "Status of Multilateral Treaties Deposited with the Secretary-General", available at <http://untreaty.un.org/English/overview.asp> (last visited November 17, 2008).

¹⁰ 74 Am. Jur. 2d Treaties § 35.

¹¹ The United Nations Treaty Collection, available at <http://untreaty.un.org/English/overview.asp> (last visited November 17, 2008).

¹² Corpus Juris Secundum, June 2008, International Law § 63.

¹³ Third Restatement of the Foreign Relations Law of the U.S., §103 (c).

substantial weight in the body of international law.¹⁴ Guidelines issued by UN agencies are advisory in nature and have not been acceded to by states.

This project's model for evaluating state compliance with international human rights norms concerning HIV/AIDS prevention comprises a checklist of 34 standards, each of which was taken directly from a United Nations-sponsored treaty, general comment, resolution, declaration, or guideline that addresses HIV/AIDS prevention. All such UN instruments were reviewed, and any language that dealt directly with HIV/AIDS prevention was included in the model.

Documents found to have such language include: the 2001 UN Declaration of Commitment on HIV/AIDS, the 2006 Political Declaration on HIV/AIDS, a General Recommendation for the Convention on the Elimination of All Forms of Discrimination Against Women, a General Comment for the International Convention on Economic, Social and Cultural Rights, and a General Comment for the Convention on the Rights of the Child. The UNAIDS publication, *International Guidelines on HIV/AIDS and Human Rights*, which translates international human rights norms into recommendations for state-level action, was also included.

THE LEGAL RESEARCH AND EVALUATION PROCESS

Researchers undertook comprehensive legal research aiming to uncover all national-level civil and criminal laws and policies that were included in the model's 34 categories. Research methods included utilizing the legal databases LexisNexis and Westlaw as well as the following periodical databases: Index to Foreign Legal Periodicals, Worldwide Political Science Abstracts, and Public Affairs Information Services International. The following databases were consulted for country-specific laws: Thailaws, Thailand Law Forum, Southern African Legal Information Institute, Kenya Law Reports, and the Library of Congress. Researchers also consulted with UCLA School of Law international law librarians.

After each researcher completed his or her research, two teams of additional researchers (which did not include the person who conducted the original research) evaluated each country's laws against the model. For each of the 34 categories, each research group assigned the country's laws one of four evaluative categories: (1) compliant, (2) partially compliant, (3) nonexistent, or (4) in conflict with the model.

After each group completed the evaluation process separately (they were not privy to the other team's conclusions), any differences in the ratings were identified. If one team determined that a country's law pertaining to a given standard was, for example, "compliant" while the other team determined that the law was only "partially compliant," the two groups deliberated and consulted with Prof. Stemple until they agreed on an appropriate compliance rating for all 34 standards. Often discrepancies were due to human error, while in other cases the two teams had made different judgment calls. In the latter case, consensus came quite easily once the arguments on the merits were made aloud. By the end of this process, between five and seven researchers had reached consensus as to each country's level of compliance with all 34 standards.

¹⁴ Id.

After the group evaluation process, each researcher received the completed compliance checklist for his or her assigned country and drafted an analysis based on it. Background on each country's legal system, political history, HIV prevalence data, and implementation track record were added to provide context. These analyses were edited and synthesized into this report.

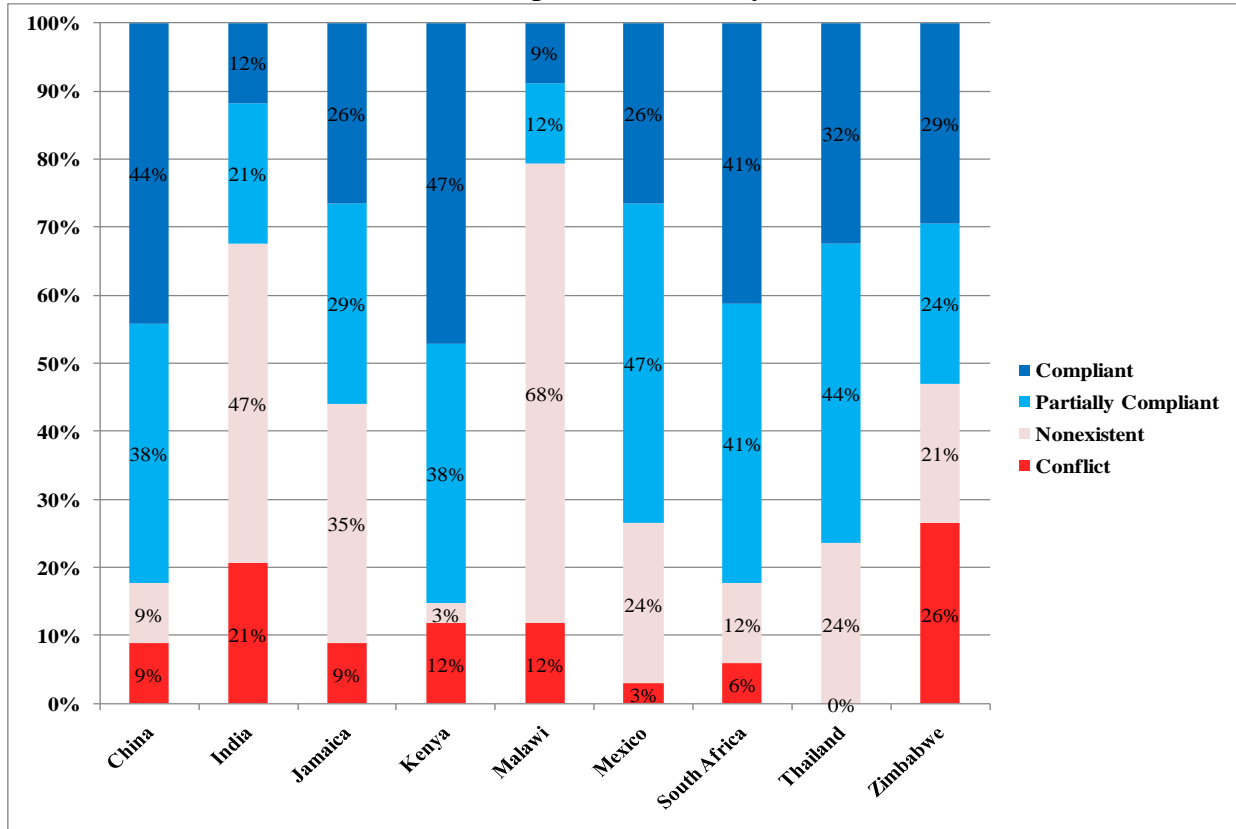
OVERALL PATTERNS AMONG THE NINE COUNTRIES

Based on this data we calculated the compliance level for each country. For example, Jamaica's laws fully comply with 9 of the 34 standards. Thus, Jamaica is fully compliant with 26% of the standards. Each country's compliance levels will be discussed in detail at the beginning of each country summary, below.

Overall, the nine countries vary in their levels of full compliance with the 34 standards. Kenya's laws and policies displayed the highest level of compliance, fully satisfying 47% of the 34 standards. China had the second highest rate of compliance (44%); South Africa came in third (41%), then Thailand at fourth (32%). Twenty-nine percent of Zimbabwe's laws were fully compliant. Jamaica and Mexico tied, with compliance rates of 26%. India and Malawi ranked eighth and ninth, respectively, with 12% and 9% full compliance rates.

Zimbabwe exhibited the greatest degree of conflict with international standards; its relevant laws and policies conflicted with 26% of the standards. India's laws and policies exhibited conflicts with 21% of the standards; Malawi and Kenya conflicted with 12%; China and Jamaica conflicted with 9%; South Africa conflicted with 6%; Mexico conflicted with 3%; and Thailand had no conflicts with the 34 standards.

States' Compliance Levels by Percent



We also calculated the percentage of compliance with each of the 34 standards. For example, the researchers determined that four out of the nine countries have laws that conflict with Standard 1: states must create laws that "ensure that women can exercise their right to have control over...matters related to their sexuality... including their sexual and reproductive health."¹⁵

Some interesting patterns emerged. All nine countries possess laws and policies that completely comply with Standard 7: states' laws must seek to "eliminate 'all forms of violence against women...including...rape and other forms of sexual violence.'"¹⁶ All countries were either partially compliant or completely compliant with Standard 8: states' laws must seek to "eliminate all types of sexual exploitation of...girls and boys...including for commercial reasons...and trafficking in girls."¹⁷

Standards with high levels of conflict include those that address women's reproductive autonomy, commercial sex work, and men who have sex with men ("MSM"). For example, none of the nine countries possess any legislation that is compliant with Standard 31, which calls on

¹⁵ United Nations Resolution adopted by the General Assembly, 60/262 Political Declaration on HIV/AIDS (2006) [hereinafter, "2006 Pol. Decl."], at paragraph 30.

¹⁶ 2006 Pol. Decl. at paragraph 31.

¹⁷ Id.

states to “[decriminalize] sex work that involves no victimization.”¹⁸ Seven countries conflict with the standard by criminalizing sex work.

Concerning protections for MSM, none of the countries fully comply with Standard 33, which calls on states to “reduce human rights violations against men having sex with men [by]...providing penalties for vilification of people who engage in same-sex relationships.”¹⁹ Four of the countries – Malawi, Kenya, India, and Zimbabwe – possess criminal penalties for men who engage in same-sex relationships. South Africa is the only country to comply with Standard 34: states’ laws must seek to “reduce human rights violations against men having sex with men [by]...giving legal recognition to same-sex marriage and/or relationships.”²⁰

As for prevention efforts in prison settings, none of the countries possess policies that provide “prisoners (and prison staff as appropriate), with access to...means of prevention (condoms, bleach, and clean injection equipment),”²¹ as in Standard 32. Three countries – South Africa, China, and Kenya – possess partially compliant policies, while the rest possess no relevant laws or policies.

Another notably high rate of conflict pertains to Standard 30, which instructs states to “refrain from including ‘specific offenses against the deliberate and intentional transmission of HIV.’”²² Five of the nine countries (56%) have laws that criminalize it.²³

¹⁸ *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version, UNAIDS [hereinafter, “*International Guidelines on HIV/AIDS*”], at 30, paragraph 21 (c).

¹⁹ *Id.* at 36, paragraph 22 (h).

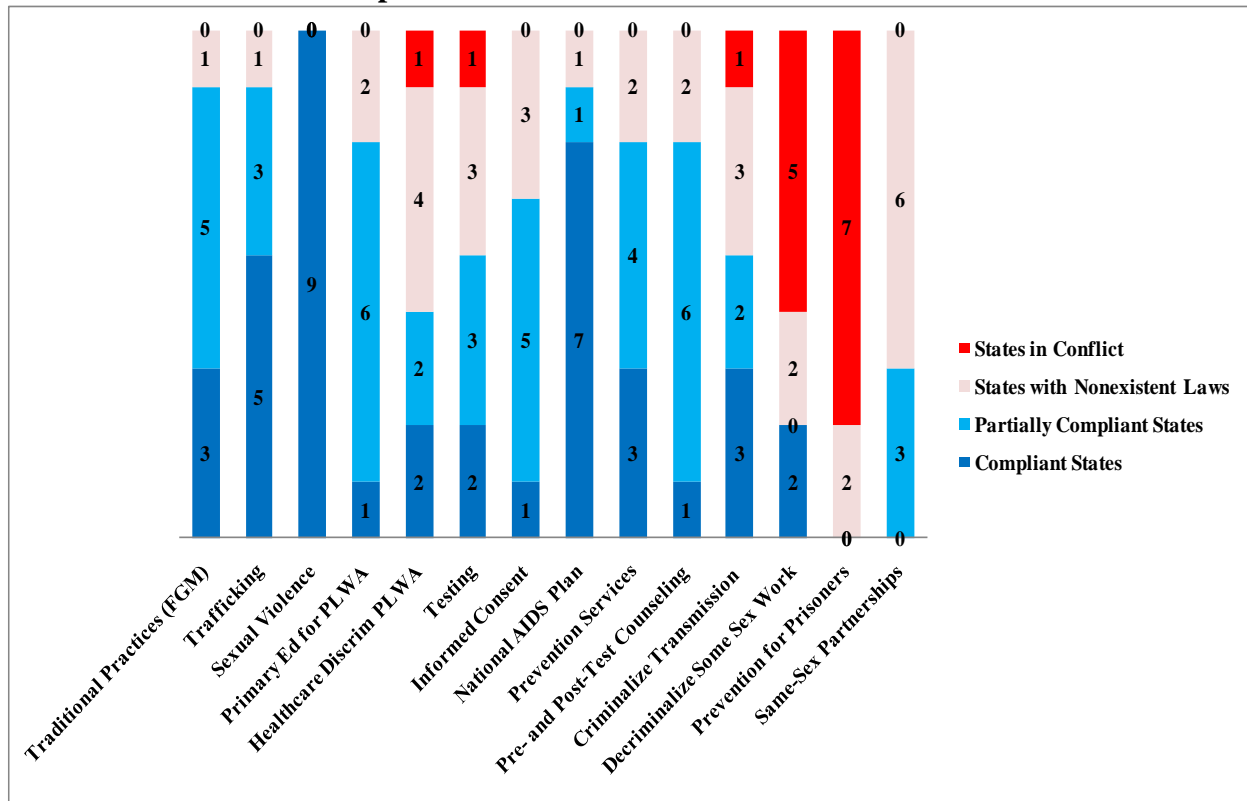
²⁰ *Id.*

²¹ *Id.* at 31, paragraph 21(e).

²² *Id.* at 29, paragraph 21 (a).

²³ Criminalization of transmission raises concerns among policy analysts and human rights advocates. There is no epidemiological evidence to prove that such laws have a deterrent effect on behavior. Efforts to prosecute and incarcerate might detract from prevention and education efforts, which more effectively stem the spread of HIV. Laws of this nature also raise concerns on behalf of potential targets of criminalization. Many analysts question whether such policies can extend to HIV-positive mothers who give birth to HIV-positive babies, or victims of sexual or domestic violence who fail to disclose their status out of fear for their safety. Joint United Nations Programme on HIV/AIDS, *International Consultation on the Criminalization of HIV Transmission, Summary of Main Issues and Conclusions*, Geneva, Switzerland, at 1, 31 October - 2 November 2007, available at http://data.unaids.org/pub/Report/2008/20080919_hivcriminalization_meetingreport_en.pdf.

Overall Compliance Levels for a Select Number of Standards²⁴



²⁴ The fourteen standards represented in this graph have been abbreviated. The full names and numbers for these standards are as follows: Standard 3: States' laws must seek to "prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation."; Standard 6: States' laws must seek to eliminate "trafficking in women and girls."; Standard 7: States' laws must seek to eliminate "all forms of violence against women...including...rape and other forms of sexual violence."; Standard 12: States' laws must seek to "ensure that primary education is available to all children, whether infected, orphaned or otherwise affected by HIV/AIDS."; Standard 18: States' laws must forbid "any discrimination in access to health care and underlying determinants of health ... on the grounds of ... health status (including HIV/AIDS)."; Standard 19: States' laws must guarantee "full protection of confidentiality" with respect to HIV testing and status.; Standard 20: States' laws must guarantee "full protection... of informed consent" with respect to HIV testing and status.; Standard 22: States' laws must create a "national HIV/AIDS [plan]... funded and implemented with transparency, accountability and effectiveness."; Standard 27: States' public health laws must "fund and empower public health authorities to provide ... services for the prevention ... of HIV and AIDS."; Standard 28: States' laws must ensure that "pre-and post-test [HIV] counseling [is] provided."; Standard 29: States' laws must "ensure that information relative to the HIV status of an individual [is] protected from unauthorized collection, use or disclosure."; Standard 30: States' laws must refrain from including "specific offenses against the deliberate and intentional transmission of HIV."; Standard 31: States' laws must aim at "[decriminalizing] sex work that involves no victimization."; Standard 32: States' laws must provide "prisoners (and prison staff as appropriate), with access to... means of prevention (condoms, bleach, and clean injection equipment)."

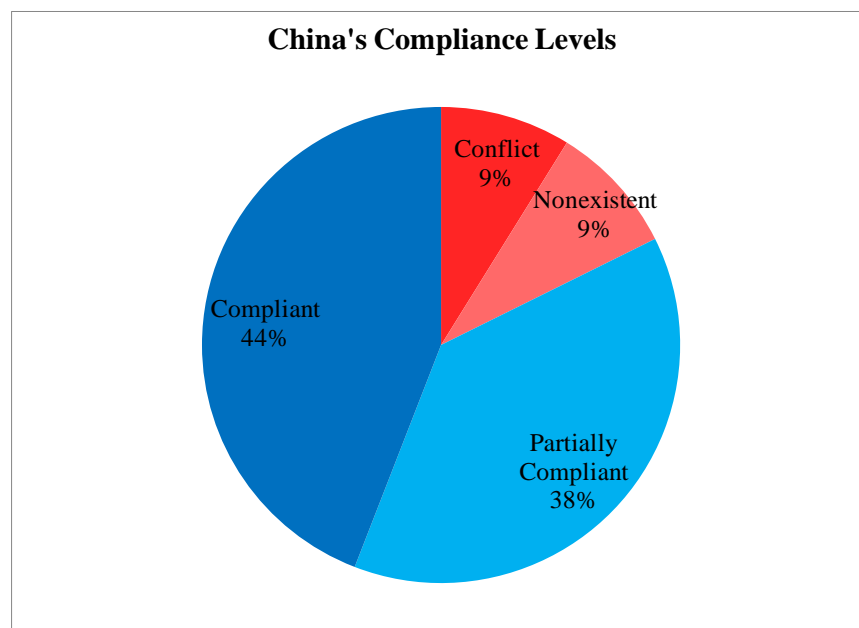
STATES SUMMARIES

The People's Republic of China

The People's Republic of China boasts the second highest rate of compliance with international norms (after Kenya), with a compliance rate of 44%. It is partially compliant with 38% of the standards, lacks relevant policies for 9% of the standards, and conflicts with 9%.

China's HIV prevalence is relatively low. An estimated 700,000 people were HIV-positive by the end of 2007, and the infection rate among China's population is about 0.05%.²⁵ Among people living with HIV/AIDS ("PLWHA"), 38.5% were injecting drug users ("IDUs"), 19.3% were infected through former blood and plasma collection, 17.8% were infected through heterosexual sex, 1% through homosexual sex, 4.3% via blood transfusion and blood products, and 1.2% through mother-to-child transmission.²⁶ The transmission mode for the remaining 17.9% is unknown.²⁷

China is most compliant in areas related to children and education. Its greatest weaknesses include lack of protections for patient confidentiality, government transparency in HIV-related policies and support for NGOs that provided HIV-related services.



The People's Republic of China is governed by the Communist Party of China, which is guaranteed power by the constitution. The National People's Congress ("NPC") comprises an elected body of officials and legislates on Constitutional and civil rights issues.²⁸ The NPC

²⁵ NACO, UNGASS Country Progress Report-China, i (2008), available at http://data.unaids.org/pub/Report/2008/china_2008_country_progress_report_en.pdf.

²⁶ Id.

²⁷ Id.

²⁸ Xianfa [Constitution], art. 2 (2004).

appoints justices to the Supreme People's Court, China's high court.²⁹ The Standing Committee – the representative body of the NPC – interprets and regulates the enforcement of the laws that the NPC passes.³⁰

China's one-party, authoritarian system of government hampers individuals' ability to seek redress for rights violations. Although the Constitution enumerates individual rights, the Chinese government can make political decisions that are not constitutionally sanctioned.³¹ The courts do not necessarily rely on Constitutional provisions to decide cases, nor do they possess the power to review legislation for its constitutionality.³²

Against this political backdrop, China has nevertheless made formal legal strides in some areas of women's rights related to HIV/AIDS. Under the Law of the People's Republic of China on the Protection of Women's Rights and Interests ("Protection of Women's Rights"), for example, women enjoy rights of "self-determination" in marriage, pregnancy, privacy, and protection from violence.³³ China is also compliant with Standard 7, which compels states to seek to eliminate "all forms of violence against women...including...rape and other forms of sexual violence."³⁴

Legislation on Maternal and Infant Health Care grants women the right to maternal and sexual health care and contraception.³⁵ China's coercive one-child policies, however, conflict with Standard 2, which requires that "all health services [are] consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice."³⁶

Children as a class enjoy many protections, particularly in education. The Chinese Constitution establishes children's right to education and specifically enumerates girls' inclusion in its protections for children.³⁷ Regulations on AIDS Prevention and Treatment ("Regulations") were passed into law in 2006,³⁸ and they guarantee the legal right to education for PLWHA and their family members affected by HIV/AIDS. Children who have lost parents to HIV/AIDS are

²⁹ The Central People's Government of the People's Republic of China, The Supreme People's Court, available at http://English.gov.cn/2008-03/16/content_921794.htm (last visited Dec. 18, 2008).

³⁰ Xianfa [Constitution], arts. 67(1)–(2), (4).

³¹ See Albert Chen, *Constitutional Crisis in Hong Kong: Congressional Supremacy and Judicial Review*, 33 INT'L LAW. 1025, for a discussion of Chinese courts' limited ability to review congressional acts for their constitutionality.

³² Chris Buckley, "Human rights provisions added to Chinese Constitution," *The New York Times* (online), Beijing, Monday, March 15, 2004; *China Daily*, March 31, 2004; BBC Worldwide Monitoring, March 30, 2004, Text of white paper on China's human rights record in 2003 (through Xinhua news agency).

³³ Law of China on the Protection of Women's Rights and Interests (promulgated by the Nat'l People's Cong., Aug. 28, 2005, effective Oct. 1, 1992) Chap. I, Art. 1 (P.R.C.).

³⁴ 2006 Pol. Decl. at paragraph 31.

³⁵ Measures for Implementation of the Law of China on Maternal and Infant Health Care (promulgated by St. Council, June 20, 2001, effective June 20, 2001) Cahp. I, Art. 4, Chap. II, Art. 9, Chap III, Art. 17 (P.R.C.).

³⁶ UN Committee on the Elimination of Discrimination against Women ("CEDAW"), General Recommendation 24, Women and Health (Twentieth session, 1999), Paragraph 31, E also suggests that a country's laws "require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice".

³⁷ Xian Fa (promulgated by the Nat'l People's Cong., Mar. 14, 2004, effective Dec. 4, 1982) Preamble (P.R.C.).

³⁸ Regulations on AIDS Prevention and Treatment (promulgated by St. Council, Jan. 18, 2006, effective Mar. 1, 2006) Chap. I, Art. 3.

provided books, tutors and reduced tuition.³⁹ China is therefore compliant with Standard 12 – states’ laws must seek to “ensure that primary education is available to all children, whether infected, orphaned or otherwise affected by HIV/AIDS.”⁴⁰

The Regulations further provide healthcare for all PLWHA and protect against HIV-based discrimination in healthcare settings,⁴¹ rendering China compliant with Standard 18, which calls on states to forbid “any discrimination in access to health care and underlying determinants of health ... on the grounds of ... health status (including HIV/AIDS).”⁴² The Regulations also protect the confidentiality of medical information for PLWHA,⁴³ which complies with Standard 19: states’ laws must guarantee “full protection of confidentiality” with respect to HIV testing and status.⁴⁴

With regard to issues of informed consent (Standard 20) and confidentiality in testing (Standard 19), the Regulations contravene some human rights standards. Although the Regulations delineate sanctions for people who breach the confidentiality of an individual’s HIV/AIDS-related information,⁴⁵ prisoners and government employees are required to submit to HIV tests and disclose HIV/AIDS-related medical information.⁴⁶ The Regulations further impose criminal liability on the intentional transmission of HIV/AIDS⁴⁷ which conflicts with Standard 30, requiring states’ laws to refrain from including “specific offenses against the deliberate and intentional transmission of HIV.”⁴⁸

Standard 26 requires states to facilitate “[t]he contribution of...NGOs...and people living with HIV [as] an essential part of the overall national response to the epidemic.”⁴⁹ But, the Bureau of NGO Administration, the government agency charged with monitoring NGOs operating in China, maintains extensive files on individuals associated with NGOs,⁵⁰ and the government often uses this information to intimidate and persecute political dissidents.⁵¹

³⁹ *Id.* at Chap. IV, Art. 45.

⁴⁰ UN Committee on the Rights of the Child, General Comment No. 3, HIV/AIDS and the Right of the Child, CRC/GC/2003/3 (2003), paragraph 18.

⁴¹ Regulations on AIDS Prevention and Treatment, *supra* note 36, at Chap. II, Art. 10.

⁴² UN Committee on Economic, Social, and Cultural Rights: General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000), at paragraph 18.

⁴³ Regulations on AIDS Prevention and Treatment, at Chap. I, Art. 3.

⁴⁴ 2006 Pol. Decl. at paragraph 252006 Pol. Decl. at paragraph 25..

⁴⁵ Regulations on AIDS Prevention and Treatment, at Chap. III, Art. 39, Chap. VI, Art. 56.

⁴⁶ Regulations on AIDS Prevention and Treatment, at Chap. III, Art. 31

⁴⁷ *Id.* at Chap VI, Art. 62.

⁴⁸ International Guidelines on HIV/AIDS, at 29, paragraph 21 (a).

⁴⁹ International Guidelines on HIV/AIDS, at 25, paragraph 18.

⁵⁰ Shehui Tuanti Dengji Guanli Tiaoli [Regulations on Registration and Management of Social Organizations], State Council Order No. 250, art. 3 (1998); Minban Feiqiye Danwei Dengji Zhanxing Tiaoli [Provisional Regulations for the Registration and Management of Non-Governmental and Non-Commercial Enterprises], State Council Order No. 251, arts. 5–7 (1998); Shiye Danwei Dengji Guanli Zhanxing Tiaoli [Regulations on Registration and management of Non-Commercial Institutions], State Council Order No. 252, art. 3 (1998).

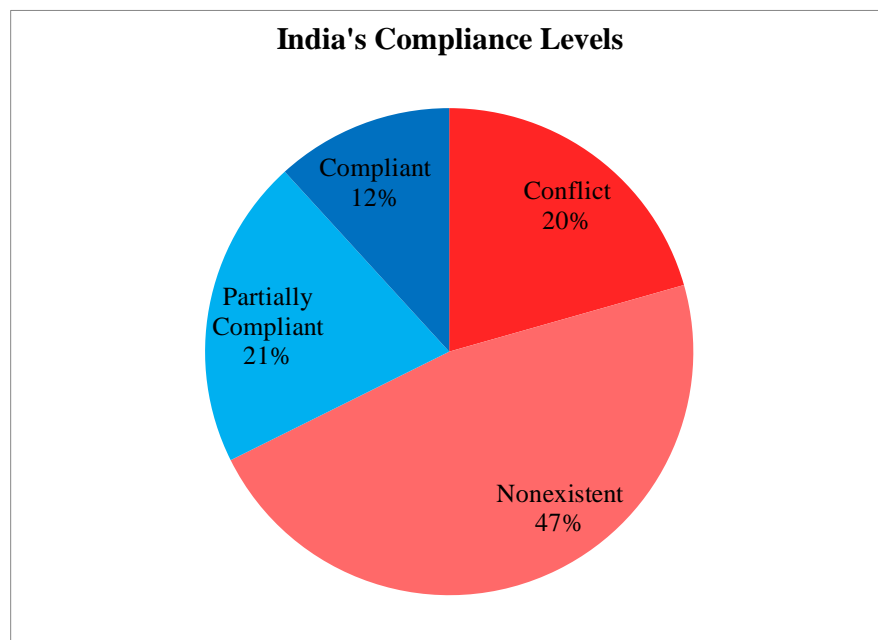
⁵¹ Amnesty International USA: 2008 Annual Report for China, *available at* <http://www.amnestyusa.org/annualreport.php?id=ar&yr=2008&c=CHN> (last access, April 4, 2010).

Recommendation:

The People’s Republic of China is somewhat compliant with international norms on HIV/AIDS prevention. Judicial and other venues for vindicating these rights, however, are largely absent or ineffectual. This, together with China’s impenetrable authoritarian regime, make it an impractical choice for UCLA law reform efforts.

India

India’s level of compliance with the 34 standards ranks low among the nine countries. It has laws in conflict with 20% of the 34 standards, the second highest rate of conflict after Zimbabwe. India lacks laws or policies on 47% of the standards, and is partially compliant with 21% of them. India’s laws reflect complete compliance with only 12% of the standards, the second lowest rate among the nine countries.



India’s laws are generally inconsistent in their compliance with standards that address gender-based violence and discrimination. India lacks laws concerning informed consent and confidential access to testing and treatment.

In India the primary mode of HIV transmission is through heterosexual sex (87.4%).⁵² Prevalence rates vary among vulnerable populations, depending on the region. Prevalence among intravenous drug users and commercial sex workers are increasing in several states, while declining in others.⁵³ Mother-to-child transmission accounts for 4.1% of incidents.⁵⁴

⁵² NACO, UNGASS Country Progress Report-India, 8 (2008), http://data.unaids.org/pub/Report/2008/india_2008_country_progress_report_en.pdf.

⁵³ Id. at 4

⁵⁴ Id.

India's unique legal system complicates the assessment of its overall compliance with HIV/AIDS policy standards. The Indian government comprises a central government ("The Union") and 28 state governments. The Union, under the direction of the prime minister, enacts legislation concerning "fundamental laws." The "State List," composed of powers reserved to the states, includes issues of public health, hospitals, and sanitation. Laws and policies concerning HIV/AIDS vary among the 28 states. In addition, different religious groups are governed by separate "personal law codes," and the federal government maintains a policy of "non-interference" in the absence of specific requests for involvement. The personal law codes primarily apply to the institutions of marriage and family and generally supersede state laws.⁵⁵

With regard to women and girls, laws vary across jurisdictions. The central government has legislated prohibitions on child marriage,⁵⁶ dowry payments,⁵⁷ and dowry deaths.⁵⁸ However, these protections are often mitigated by religious personal laws that permit polygamy and young ages of marriage,⁵⁹ rendering India only partially compliant with Standard 9, which calls on states to eliminate to eliminate "harmful traditional and customary practices [against girls]."⁶⁰

The Suppression of Immoral Traffic in Women and Girls Act codifies anti-trafficking policies; however, it lacks protections for male children involved in trafficking.⁶¹ Thus, India is partially compliant with Standard 8, which requires states to eliminate "all types of sexual exploitation of ... girls and boys... including for commercial reasons ... and trafficking in ... girls."⁶² Although the Indian penal code criminalizes sexual violence, it does not recognize the existence of marital rape,⁶³ rendering India partially compliant with Standard 7 – states must seek to eliminate "all forms of violence against women...including...rape and other forms of sexual violence."⁶⁴

India has no universal guarantee of access to sexuality and HIV/AIDS education, which is required by Standard 5: states' laws must "ensure the removal of all barriers to women's access to ... education and information, including in the area of sexual and reproductive health."⁶⁵ There is also great variability in jurisdictions' policies on AIDS education in schools: some states have created advanced sexual education programs, while some states have actually banned AIDS education in public schools.⁶⁶

⁵⁵ Chun-Chi Young, *Modern Legal Systems Cyclopedic*, The Legal System of the Republic of India (Kenneth Robert Redden & Linda L. Schlueter eds., 2001), vol. 9, § 1.5(A), at 9.80.30.

⁵⁶ Child Marriage Restraint Act, No. 19 (1929) (India).

⁵⁷ Dowry Prohibition Act, No. 28 (1961) (India).

⁵⁸ Pen. Cod. Section 304 (B) (India).

⁵⁹ "Laws and Policies Affecting their Reproductive Lives," 92.

⁶⁰ 2006 Pol. Decl. at paragraph 31.

⁶¹ Suppression of Immoral Traffic in Women and Girls Act, No. 104 (1956) (India).

⁶² 2006 Pol. Decl. at paragraph 31.

⁶³ Pen. Cod, No. 45 § 375 (Exception) 376-A (India).

⁶⁴ 2006 Pol. Decl. at paragraph 31.

⁶⁵ CEDAW, at paragraph 31, b.

⁶⁶ Kritivas Mukherjee, *Sex Education Creates Storm in AIDS-Stricken India*, Reuters, May 14, 2007, *available at* <http://aegis.com/news/re/2007/RE070515.html>.

Policies relating to HIV/AIDS and children's well-being are similarly inconsistent. The Constitution recognizes a right to primary education. However, there are no specific protections for children orphaned by HIV/AIDS, which is required by Standard 12 – states must “ensure that primary education is available to all children, whether infected, orphaned or otherwise affected by HIV/AIDS.”⁶⁷

Since the establishment of the National AIDS Control Organization in 1992, the Central Government has dedicated funding to implement the National AIDS Control Plans,⁶⁸ which complies with Standard 22's requirement to fund a national HIV/AIDS plan.⁶⁹

However, the failure of the 2007 HIV/AIDS Bill, which would have explicitly banned discrimination based on HIV status and provided for confidentiality, informed consent, and counseling with HIV testing, constitutes a major setback for prevention efforts. India thus remains out of sync with Standard 18, which requires states to forbid “any discrimination in access to health care and underlying determinants of health ... on the grounds of ... health status (including HIV/AIDS);”⁷⁰ Standard 19, which requires states' laws to guarantee “full protection of confidentiality” with respect to HIV testing and status;⁷¹ Standard 20, which requires states to guarantee “full protection... of informed consent” with respect to HIV testing and status;⁷² Standard 21, which requires states' laws to seek to “eliminate all forms of discrimination against... people living with HIV”⁷³; and Standard 23, which requires states' laws to seek to prevent “discrimination in access to health care... on the grounds of health status (including HIV/AIDS).”⁷⁴

Despite the high prevalence rates among sex workers and rates of transmission through heterosexual sex, India's criminalization of all solicitation in public places, some of its nuisance laws, and its restrictions of sex work to certain regions⁷⁵ interfere with prevention and education efforts to curb risky behavior among sex workers. There are also no policies that provide for the distribution of prevention programs – bleach, clean needles, or condoms – in correctional institutions, required by Standard 32.⁷⁶ Thus, some of India's most vulnerable populations lack explicit, national-level protections.

Recommendation:

India's vastness and diversity, its fragmented political structure, and the courts' recognition of personal laws pose challenges for a student legal clinic. On the other hand, India currently has a

⁶⁷ Committee on the Rights of the Child, General Comment No. 3, paragraph 18.

⁶⁸ NACO, Know Your Rights (2007), available at http://www.nacoonline.org/Quick_Links/Know_Your_Rights/ (last visited Dec. 18, 2008).

⁶⁹ United Nations Resolution adopted by the General Assembly, S-26/2 Declaration of Commitment on HIV/AIDS (“S-26/2”) (2001) [hereinafter, “Decl. of Com.”], at paragraph 38.

⁷⁰ Committee on Economic, Social, and Cultural Rights, General Comment 14, paragraph 18.

⁷¹ 2006 Pol. Decl. at paragraph 25.

⁷² Id.

⁷³ Id. at paragraph 29; however, the UN's use of the phrase “commit ourselves to intensifying efforts to enact” seems to make this question of law non-binding.

⁷⁴ Committee on Economic, Social, and Cultural Rights, at paragraph 18.

⁷⁵ Suppression of Immoral Traffic in Women and Girls Act, No. 104 (1956) (India).

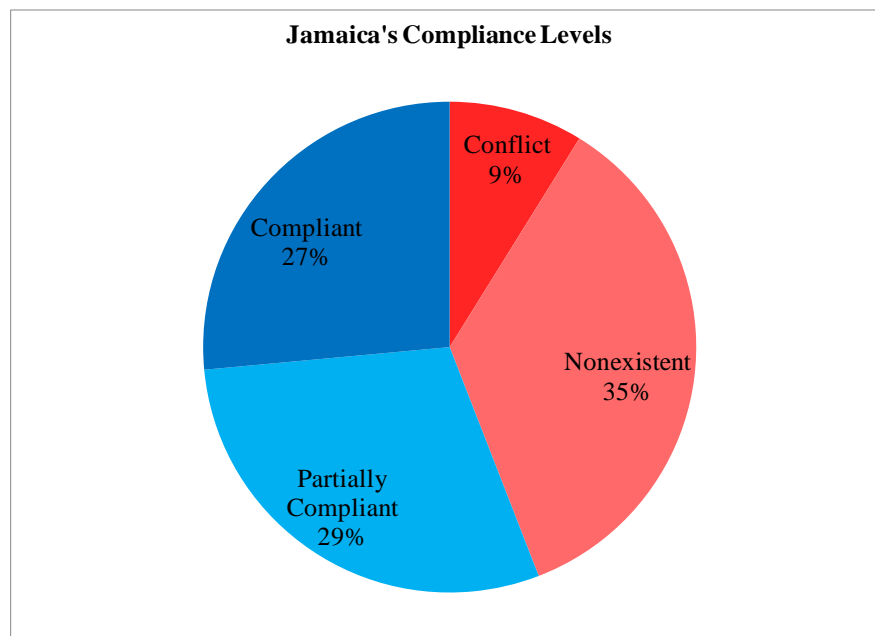
⁷⁶ International Guidelines on HIV/AIDS, at 31, paragraph 21(e).

low level of compliance with international human rights standards on HIV/AIDS prevention, as well as proposed legislation that has the potential to transform the legal framework into one with significantly higher levels of compliance, with opportunities for advocacy around implementation. India's reasonably active NGO sector may also offer fruitful opportunities for partnership.

Jamaica

Relative to the other nine states, Jamaica is moderately compliant with the 34 standards. It possesses laws that conflict with 9% of the standards; it is silent on 35%; partially compliant with 29%; and completely compliant with 27% of the standards.

HIV prevalence in Jamaica is estimated to be 1.3% in the general population, 9% among sex workers, and an estimated 25% to 30% among MSM.⁷⁷ Jamaica's laws are generally compliant on issues related to gender-based violence and child welfare. Jamaica's laws are either non-existent or in direct conflict with the model on issues related to discrimination based on HIV status and protections for same-sex partners and sex workers, despite high prevalence rates among these two vulnerable populations.



Jamaica's constitution contains an antidiscrimination provision, but discrimination is prohibited against a limited set of identities: "race, place of origin, political opinions, color, or creed."⁷⁸ There are no constitutional bans on discrimination based on health status, for example, and

⁷⁷ NATIONAL HIV PROGRAM, JAMAICA: *UNGASS Country Progress Report 2008*, at 5.

⁷⁸ JAM. CONST., Ch. III, §24(4)(b).

Jamaica is elsewhere silent on Standard 18, requiring states to protect against “discrimination in access to health care...on the grounds of...health status.”⁷⁹

Jamaica does not have a constitutional ban on gender discrimination. It does, however, possess protections against gender-based violence. Jamaica’s Offenses Against the Person Act provides criminal sanctions for sexual assault and statutory rape;⁸⁰ Article 40 of the Act protects all females from assault or battery.⁸¹ Thus, Jamaica is in compliance with Standard 7: states’ laws are required to seek to eliminate “all forms of violence against women...including...rape and other forms of sexual violence.”⁸² The Trafficking in Persons Act codifies anti-trafficking laws⁸³ as required by Standard 8, but these laws are deficient to the extent that they do not extend protections to male children.

Jamaica’s policies on protections for vulnerable children are mixed. The Child Care and Protection Act prohibits child labor and provides regulations for child welfare services,⁸⁴ in compliance with Standard 11: states must “[build and support] social security systems that protect [children].”⁸⁵ Jamaica’s Education Act of 1980 guarantees universal public primary education;⁸⁶ however, there are no explicit policies that instruct education on sexual health or HIV/AIDS prevention.⁸⁷ None of the legislation on child welfare includes specific protections for children affected by HIV/AIDS. Thus, Jamaica is silent on Standard 12, which requires states to “ensure that primary education is available to all children, whether infected, orphaned or otherwise affected by HIV/AIDS.”⁸⁸

There are no laws that specifically remove barriers to women’s access to general, reproductive, or sexual health care or education, rendering Jamaica silent on Standard 5: states must “ensure the removal of all barriers to women’s access to... education and information, including in the area of sexual and reproductive health.”⁸⁹

Although the HIV/AIDS National Strategic Plan identifies informed consent, confidential testing and confidential counseling as important protections goals, there are no laws that guarantee informed consent with regard to HIV testing.⁹⁰ Jamaica’s legal system is therefore silent on Standard 19, which calls for “full protection of confidentiality” with respect to HIV testing and status,⁹¹ and Standard 20, which calls for “full protection... of informed consent” with respect

⁷⁹ Committee on Economic, Social, and Cultural Rights, at paragraph 18.

⁸⁰ Jamaica’s Offenses Against the Person Act, art. 44.

⁸¹ *Id.*, at art. 40.

⁸² 2006 Pol. Decl. at paragraph 31.

⁸³ See U.S. Dept. of State: Trafficking in Persons Report 2008-Jamaica.

⁸⁴ See Child Care and Protection Act, available at:

<http://www.moj.gov.jm/laws/statutes/The%20Child%20Care%20and%20Protection%20Act.pdf>.

⁸⁵ 2006 Pol. Decl. at paragraph 32.

⁸⁶ The Education Act, available at: <http://www.moj.gov.jm/laws/subsidiary/Education%20Act.pdf>.

⁸⁷ NATIONAL HIV PROGRAM, JAMAICA: UNGASS Country Progress Report 2008, at 7.

⁸⁸ Committee on the Rights of the Child, at paragraph 18.

⁸⁹ CEDAW, at paragraph 31, b.

⁹⁰ *Jamaica HIV/AIDS/STI National Strategic Plan 2002-2006*, at 15-17.

⁹¹ 2006 Pol. Decl. at paragraph 25.

to HIV testing and status.⁹² Despite Standard 21, which requires states to implement laws that seek to “eliminate all forms of discrimination against... people living with HIV,”⁹³ Jamaica has no law that penalizes such discrimination.⁹⁴

Although the federal government has earmarked funds for NGOs committed to advancing public health and for the HIV/AIDS National Strategic Plan’s prevention goals, domestic laws and policies that either criminalize or fail to protect vulnerable populations thwart many service providers’ efforts to serve vulnerable populations. Men who have sex with men constitute the largest population of PLWHA in Jamaica.⁹⁵ Sex between same-sex partners is criminalized, which obstructs access to prevention and treatment services for a vulnerable social group. Furthermore, Jamaica fails to comply with Standard 33, which calls on states to seek to “reduce human rights violations against men having sex with men [by]...providing penalties for vilification of people who engage in same-sex relationships.”⁹⁶

Sex workers make up nine percent of PLWHA, and the epidemic is quickly spreading among this population.⁹⁷ Jamaica’s criminalization of sex workers conflicts with Standard 31, which requires states to “[decriminalize] sex work that involves no victimization.”⁹⁸

Recommendation:

With a moderately compliant legal framework, including low rates of directly conflicting laws and policies, Jamaica is poised for further progress toward conformity with international norms. The country’s bicameral legislature and its common law legal system are familiar, and the relatively active NGO community may offer ample opportunities for partnership with UCLA.

Kenya

Kenya possesses the highest rate of compliance among the nine countries at 47%. It is partially compliant with 38% of the standards, conflicts with 12%, and lacks legislation on only 3% of the standards – the lowest rate among the nine states.

The overall HIV/AIDS prevalence rate is 4.7% to 5.0%⁹⁹ and the prevalence among 15- to 24-year-olds is an alarming 10.8%.¹⁰⁰

⁹² Id.

⁹³ 2006 Pol. Decl. at paragraph 29; however, the UN’s use of the phrase “commit ourselves to intensifying efforts to enact” seems to make this question of law non-binding.

⁹⁴ NATIONAL HIV PROGRAM, JAMAICA: UNGASS Country Progress Report 2005, at 26.

⁹⁵ Id. at 5.

⁹⁶ International Guidelines on HIV/AIDS, at 36, paragraph 22 (h).

⁹⁷ NATIONAL HIV PROGRAM, JAMAICA: UNGASS Country Progress Report 2005, at 5.

⁹⁸ International Guidelines on HIV/AIDS, at 30, paragraph 21 (c).

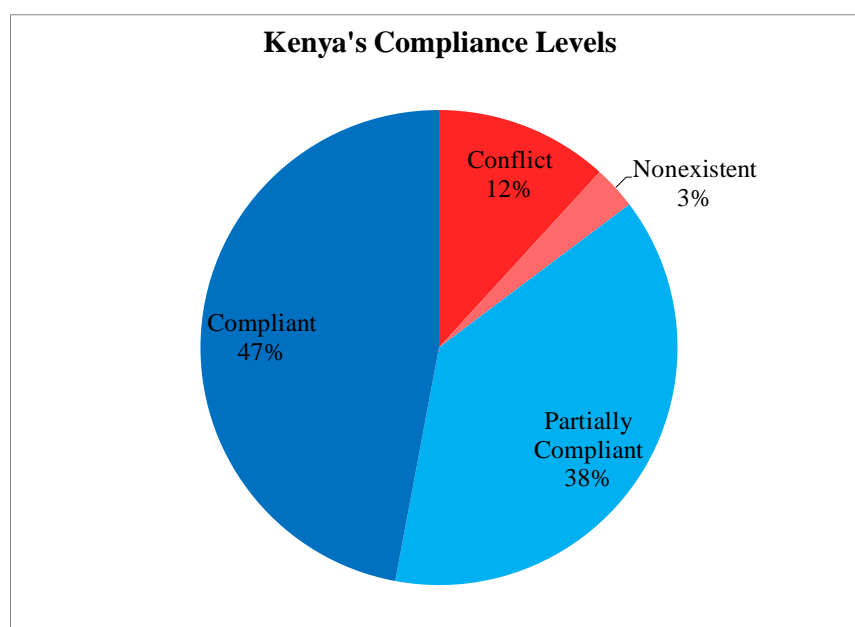
⁹⁹ UNAIDS Home Page, Country Responses: Kenya,

<http://www.unaids.org/en/CountryResponses/Countries/kenya.asp> (last visited Dec. 15, 2008).

¹⁰⁰ United Nations Population Fund (UNFPA) Home Page, *available at*

<http://www.unfpa.org/worldwide/indicator/do?filter=getIndicatorValues> (follow “View Country Profile” drop-down to Kenya and click “Go”) (last visited Dec. 15, 2008).

Although Kenya has enacted a number of laws designed to promote children’s rights in other contexts, Kenya’s national HIV/AIDS policies are silent regarding children-specific needs. Kenya’s laws also conflict with standards regarding protections for same-sex partners.



In 2006, Kenya’s legislature – the National Assembly – passed the HIV and AIDS Prevention and Control Act (“HAPCA”) to “promote public awareness about the causes... means of prevention and control of HIV and AIDS.”¹⁰¹ Unfortunately, violations of rights provided within HAPCA are not actionable until the Minister of Health develops implementing guidelines and “appoints a date” upon which the legislation becomes operational.¹⁰² The Honorable Attorney General must also appoint members and a chairman to serve the HIV and AIDS Tribunal, pursuant to section 25 of HAPCA.¹⁰³ Victims of HIV/AIDS-related human rights violations lack legal recourse and mechanisms through which to seek remedies. Thus Kenya is partially compliant with Standard 22, which calls on states to create a “national HIV/AIDS [plan]...funded and implemented with transparency, accountability and effectiveness.”¹⁰⁴

Kenya has enacted a number of laws designed to promote children’s rights. The Children Act of 2001 provides several protections that comport with international standards for children’s rights. The Children Act’s statutory body, The National Council for Children’s Services, advises and directly reports to the National Assembly and monitors the provision of general social welfare services for children,¹⁰⁵ rendering Kenya compliant with Standard 11, which requires states to

¹⁰¹ The HIV and AIDS Prevention and Control Act, (2006) Cap. 14 § 3(a), 19. (Kenya).

¹⁰² *Id.* at §§ 1, 45.

¹⁰³ Kenya Nat’l Comm’n on Human Rights, KNCHR wants HIV/AIDS Prevention & Control Act 2006 given Commencement Date, Dec. 1, 2008, http://www.knchr.org/index.php?option=com_content&task=view&id=96&Itemid=1&date=2008-12-01 (last visited on Dec. 15, 2008).

¹⁰⁴ 2001 Decl. of Com., at paragraph 38.

¹⁰⁵ The Children Act, (2001) Cap. 8 § 30. (Kenya).

establish laws that “[build and support] social security systems that protect [children].”¹⁰⁶ The Act outlaws female circumcision¹⁰⁷ and endeavors to eliminate “harmful traditional and customary practices [against girls].”¹⁰⁸ The Children Act and The Sexual Offenses Act enumerate criminal penalties for child labor, forcing children into armed conflict, abuse, sexual exploitation, defilement, and torture,¹⁰⁹ compliant with Standard 8 (States must seek to eliminate “all types of sexual exploitation of...girls and boys...including for commercial reasons...and trafficking in...girls.”¹¹⁰) The Children Act guarantees a universal right to primary education,¹¹¹ but does not specify children “infected, orphaned or otherwise affected by HIV/AIDS” as required by Standard 12.¹¹²

The HAPCA protects against discrimination in the healthcare setting and enumerates rights to “the provision of basic health care and social services for [all] persons infected with HIV/AIDS.”¹¹³ However, there is no separate provision to ensure access to healthcare, social welfare services, or education for children affected by HIV and AIDS, required by Standard 12. Standard 14 compels states to “ensure that [HIV-related] services are provided to the maximum extent possible to all children living within their borders, without discrimination.”¹¹⁴ Gender-specific needs and interests are similarly absent from HIV/AIDS policies.¹¹⁵

Kenya also lacks specific protections for commercial sex workers and MSM. The penal code criminalizes sex work that involves no victimization,¹¹⁶ thereby conflicting with Standard 31.¹¹⁷ The HAPCA contains a provision that outlaws same-sex sex and imposes felony charges and a fourteen year prison sentence for people who engage in same-sex sexual practices.¹¹⁸

Recommendation:

HAPCA contains movement toward compliance with international norms, as well as steps back. Should its HIV and AIDS Tribunal become operational, this could become an important venue for reform efforts, providing an opportunity for students to collaborate on cases. In the meantime, reform efforts are needed around some of HAPCA’s more problematic provisions.

¹⁰⁶ 2006 Pol. Decl. at paragraph 32.

¹⁰⁷ The Children Act, (2001) Cap. 8 § 30.

¹⁰⁸ Id.

¹⁰⁹ See Id. §§ 10, 12, 13, 15, 18; The Sexual Offences Act, (2006) Cap. 3 §§ 8, 9, 11. (Kenya).

¹¹⁰ 2006 Pol. Decl. at paragraph 31.

¹¹¹ The Children Act, (2001) Cap. 8 § 7.

¹¹² Committee on the Rights of the Child, General Comment No. 3, paragraph 18.

¹¹³ The HIV and AIDS Prevention and Control Act, (2006) Cap. 14 § 3. (Kenya).

¹¹⁴ Committee on the Rights of the Child, General Comment No. 3, paragraph 21.

¹¹⁵ Id.

¹¹⁶ The Penal Code, (2005) Cap. 63 §§ 153-56. (Kenya).

¹¹⁷ International Guidelines on HIV/AIDS, at 30, paragraph 21 (c).

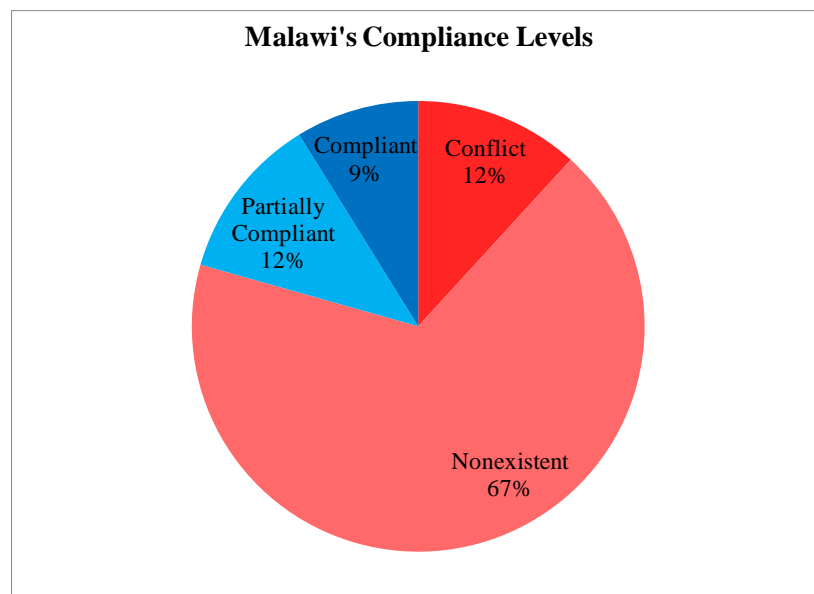
¹¹⁸ The HIV and AIDS Prevention and Control Act, (2006) Cap. 14 §§162, 163, 165. (Kenya).

Malawi

With a compliance rate of only 9%, Malawi ranks lowest among the nine countries. Most notably, Malawi altogether lacks laws and policies on 67% of the 34 standards. This makes Malawi the most legally underdeveloped state among the nine by a wide margin.

The current HIV prevalence is estimated to be 14.2%, nearly twice the prevalence rate of Sub-Saharan Africa.¹¹⁹ Women make up about 57% of adults living with HIV/AIDS.¹²⁰

Malawi's laws are most compliant with standards related to gender violence and government support for NGO and service providers. However, its criminal and civil codes are outdated, and many laws relevant to the model's standards simply do not exist. New legislation on a host of health and human rights issues is sorely needed.



Malawi's population has been particularly hard hit by the HIV/AIDS pandemic. Recent data estimates an HIV prevalence rate of 14.2%.¹²¹ Women make up about 57% of adults living with HIV/AIDS.¹²² In the mid-1990s prevalence among women at antenatal clinics rose to an estimated 30%.¹²³

¹¹⁹ HIV/AIDS Fact Sheet: The HIV/AIDS Epidemic in Malawi, The Henry J. Kaiser Family Foundation 1(2005), available at <http://www.kff.org/hivaids/upload/7359.pdf>.

¹²⁰ *Id.*

¹²¹ HIV/AIDS Fact Sheet, *supra* note 117.

¹²² *Id.*

¹²³ *History of the AIDS Crisis in Malawi*, Averting HIV and AIDS, Jun. 16, 2009, available at <http://www.avert.org/aids-malawi.htm>.

Since the year 2000, Malawi's government has made only minimal efforts to stem the spread of HIV/AIDS through education and policy. In 2000, a National AIDS Commission ("NAC") was created to monitor the impact of government efforts on prevalence.¹²⁴

Malawi's current penal code dates back to 1930.¹²⁵ Despite a handful of amendments – both during and immediately after the colonial period – the penal code has remained largely unchanged for the past 70 years.¹²⁶ In 1994, the Malawian Parliament enacted the version of the Constitution that is currently in force.¹²⁷ Chapter IV of the Constitution comprises a catalog of human rights for Malawians: freedom from discrimination "on grounds of race, colour, sex, language, religion, political or other opinion, nationality, ethnic or social origin, disability, property, birth or other status."¹²⁸ Section 24 grants women the right to freedom from discrimination on the basis of gender or marital status, freedom from sexual abuse, and deprivation of property.¹²⁹

Despite the progressive and rights-protective tone of the 1994 Constitution, the outdated penal code fails to give teeth to many of the constitutional provisions. For example, although the Constitution recognizes women's rights to enter into marriage based on consent, cultural practices like widow cleansing – where a newly widowed woman is compelled to marry her dead husband's male relative – persist and remain unaddressed in codified law.¹³⁰ Malawi is thus silent on Standard 3, requiring states to "prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation."¹³¹

Likewise, the Constitution protects every person's right to personal liberty and freedom from torture, cruel, inhuman and degrading treatment, slavery, servitude and forced labor.¹³² However, the National Assembly has not yet adopted an anti-trafficking law. The penal code prohibits "abduction," although it does not specifically protect against trafficking,¹³³ despite Standard 6, which calls on states' laws to eliminate "trafficking in women and girls."¹³⁴

Chapter XV of the penal code does, however, criminalize rape or "unlawful carnal knowledge of a female without her consent..."¹³⁵ While the language is outdated, Malawi is nevertheless

¹²⁴ *Id.*; See also Malawi National AIDS Framework 2005-2009 ("NAF"). Created by the NAC, the Framework defines "Eight Priority Areas" that warrant immediate attention from legislators and policy-makers.

¹²⁵ Law Commission Report on Review of the Penal Code, p. 8(May, 2000).

¹²⁶ *Id.*; The United Nations Office on Drugs and Crime (UNODC) and the Southern African Development Community (SADC), COMBATING TRAFFICKING IN PERSONS: A 2005 ASSESSMENT OF THE LAWS AND MEASURES RELEVANT TO HUMAN TRAFFICKING IN SELECTED SADC COUNTRIES 24 (2007), http://www.ungift.org/docs/ungift/pdf/knowledge/3330_UNODC_Trafficking_Law.pdf.

¹²⁷ MALAWI CONST., "Drafting of the Constitution."

¹²⁸ MALAWI CONST., Ch. IV, §20(1).

¹²⁹ *Id.*, § 24

¹³⁰ The Henry J. Kaiser Family Foundation, "HIV/AIDS Fact Sheet: The HIV/AIDS Epidemic in Malawi,"

¹³¹ Committee on Economic, Social, and Cultural Rights, General Comment 14, paragraph 35.

¹³² MALAWI CONST., § 18.

¹³³ The Penal Code, § 135 (Malawi).

¹³⁴ 2006 Pol. Decl. at paragraph 31.

¹³⁵ The Penal Code, Ch. XV, §132 (Malawi).

compliant with Standard 7, which calls on states to pass laws to eliminate “all forms of violence against women...including...rape and other forms of sexual violence.”¹³⁶

The current penal code prohibits “procurement of females for prostitution,” the management of brothels, or males and females who “live on the proceeds of prostitution.”¹³⁷ Thus, Malawi is in conflict with Standard 31, which obligates states to “[decriminalize] sex work that involves no victimization.”¹³⁸

Children similarly enjoy specific rights enshrined in the Constitution, but lack updated provisions within the legal codes. The Constitution grants children the right to be free from economic exploitation or any treatment “likely to be hazardous to or interfere with their education”¹³⁹ and lists education as a human right. However, no Malawian statutory codes address implementation of this right.¹⁴⁰

The penal code prohibits “unnatural offenses” and “public indecency” between men,¹⁴¹ and conflicts with Standard 34, which compels states to “reduce human rights violations against men having sex with men [by] ... giving legal recognition to same-sex marriage and/or relationships.”¹⁴² The criminalization of same-sex sex validates the resistance by corrections officials to condom distribution in prisons. Malawi is noncompliant with Standard 32, which calls on states to provide “prisoners (and prison staff as appropriate), with access to...means of prevention (condoms, bleach, and clean injection equipment).”¹⁴³

In 1998, Malawi’s Law Commission on Criminal Justice was charged with reviewing the penal code and recommending amendments to address provisions “which are not in consonance with contemporary thinking and with economic and social trend.”¹⁴⁴ In 2000, the Commission published a report in which it identified “cumbersome procedures which give rise to unwarranted delays, backlog of cases, congestion in prisons, and impaired access to justice.”¹⁴⁵ The Report’s recommendations have not yet been enacted and are currently languishing in National Assembly committees.¹⁴⁶

Although the NAC has created a National AIDS Policy (“Policy”) which identifies key areas of need and makes recommendations for action, the document is not legally enforceable. The Policy recognizes the right to confidential testing and counseling,¹⁴⁷ and freedom from discrimination

¹³⁶ 2006 Pol. Decl. at paragraph 31.

¹³⁷ The Penal Code, §§ 140(a), 140 – 146 (Malawi).

¹³⁸ International Guidelines on HIV/AIDS, at 30, paragraph 21 (c).

¹³⁹ MALAWI CONST. § 24.

¹⁴⁰ *Id.*

¹⁴¹ The Penal Code, §§ 153, 156 (Malawi).

¹⁴² International Guidelines on HIV/AIDS, at 36, paragraph 22 (h).

¹⁴³ *Id.* at 31, paragraph 21(e).

¹⁴⁴ Law Commission Report on Review of the Penal Code, 3 (2000).

¹⁴⁵ *Id.* at 4.

¹⁴⁶ Interview with Joseph Mfutso-Bengo, Professor, University of Malawi College of Medicine, in Blantyre, Malawi (Jun. 3, 2009).

¹⁴⁷ Malawi National HIV/AIDS Policy Final Draft, 11-12 (2003).

based on HIV status in healthcare settings, schools and employment.¹⁴⁸ The Policy addresses the unique needs of children affected or orphaned by HIV/AIDS.¹⁴⁹ It addresses harmful cultural practices that exacerbate transmission rates among women and seeks to improve access to education on effective prevention methods.¹⁵⁰

Notably, the Policy further recommends protections for persons engaged in same-sex relationships. It recommends, “Government and partners shall put in place mechanisms to ensure that HIV/AIDS/STI prevention, treatment, care and support...can be accessed by all without discrimination, including [persons engaged in same sex relationships].”¹⁵¹ Under the Policy, prisoners should receive confidential, consensual treatment and prevention services, and provision of condoms.¹⁵² Many of these provisions comport with the international human rights standards identified in our model, but their utility is limited because the policy is legally unenforceable.

It should also be noted that the Policy maintains some provisions that do not comply with international standards. For example, it recommends the creation of a provision in healthcare codes that would compel healthcare providers to notify sexual partners of infected individuals. It also calls for compulsory testing of all pregnant women. One expert believes that these provisions will appear in future legislative acts seeking to codify HIV/AIDS policies.¹⁵³

The NAC and the Human Rights Commission (mandated by the Constitution to monitor all matters related to human rights issues) have drafted HIV/AIDS legislation which would be binding. This work-in-progress is currently languishing in both Commissions’ discussion processes.¹⁵⁴ There is no clear date for introduction to the National Assembly for a vote.¹⁵⁵ No draft of this legislation is available or accessible to members of the public. To the extent that it does indeed mirror the Policy’s substantive provisions, it will share its strengths and weaknesses.

Recommendation:

Of the countries studied, Malawi has the lowest rate of compliance with international human rights norms related to HIV/AIDS prevention. With penal code amendments and HIV/AIDS-specific bills in progress but stalled, Malawi hovers on the brink of compliance with many important legal standards. Notably, there are currently only 300 qualified lawyers for 11 million people in Malawi.¹⁵⁶ If and when legal reforms do take place, there will be an acute need for the capacity to enforce them.

¹⁴⁸ Id. at 26.

¹⁴⁹ Id. at 20-21.

¹⁵⁰ Id. at 19-20.

¹⁵¹ Id. at 23.

¹⁵² Id. at 22.

¹⁵³ Interview with Joseph Mfutso-Bengo, Professor, University of Malawi College of Medicine, in Blantyre, Malawi (Jun.3, 2009).

¹⁵⁴ Id.

¹⁵⁵ Id.

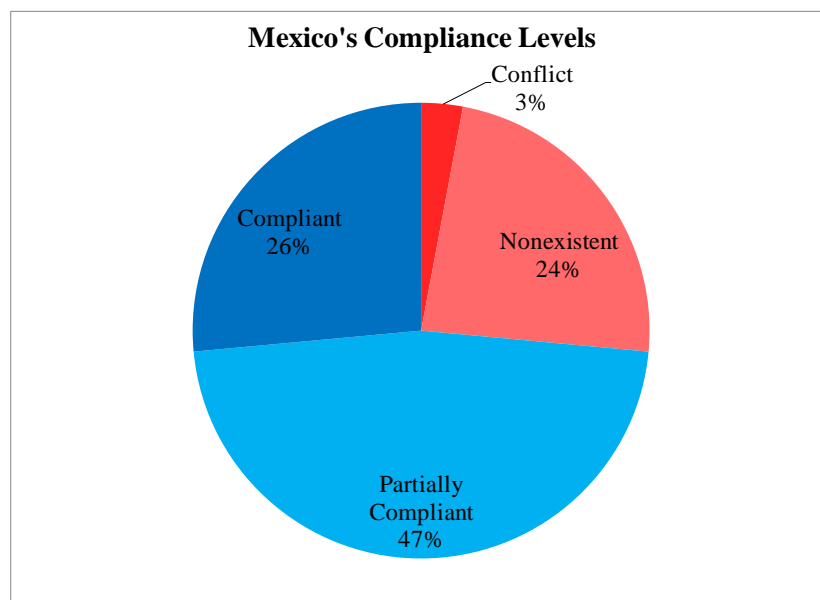
¹⁵⁶ Justice Delayed in Malawi’s Criminal Justice System, *supra*, note 3, at 2.

Mexico

Mexico achieves a middling rank with respect to its rate of complete compliance: 26%. However, it boasts the highest rate of partial compliance among the nine countries: 47%. It lacks legislation on 24% of the standards and has the second lowest rate of conflict: 3%.

With one of the lowest prevalence rates in Latin America and the Caribbean, Mexico has an estimated 180,000 people (less than 1% of the population) living with HIV/AIDS.¹⁵⁷ The infection is concentrated among MSM, sex workers and their clients, and IDUs.¹⁵⁸ Sexual transmission accounts for the majority of reported cases.¹⁵⁹

Mexico is generally noncompliant with standards that address the rights of same-sex sexual partners, despite the fact that MSM constitute the largest group of PLWHA in Mexico (57% of PLWHA).¹⁶⁰ Commercial sex workers, migrant populations, prisoners, and injecting drug users constitute a rapidly growing portion of new cases yet lack sufficient legal protections.¹⁶¹ Mexico's laws are moderately compliant with standards related to gender-based violence and sexual and reproductive health and rights.



In recent years, Mexico's federal government has made a concerted effort to integrate human rights standards into legislation. The Federal Congress, Mexico's legislative branch, recently passed two pieces of legislation to address HIV/AIDS and other STIs: the Official Mexican

¹⁵⁷ USAID, *HIV/AIDS Health Profile: Mexico*, 1 (2008),

http://www.usaid.gov/our_work/global_health/aids/Countries/lac/mexico_profile.pdf.

¹⁵⁸ Id.

¹⁵⁹ Id.

¹⁶⁰ The Henry J. Kaiser Family Foundation, *HIV/AIDS Policy Fact Sheet*, 1 (July 2008).

¹⁶¹ Centro Nacional para la Prevencion y Control del VIH/SIDA (CENSIDA), *INFORME UNGASS MEXICO 2008*, at 35.

Regulation for the Prevention and Control of Infection by the Human Immunodeficiency Virus (“NOM-HIV”),¹⁶² and the Official Mexican Regulation for the Prevention and Control of Sexually Transmitted Infections (“NOM-STI”).¹⁶³ Mexico therefore complies with Standard 22, which calls on states to create a national HIV/AIDS plan.¹⁶⁴

Despite this progress, Mexico’s decentralized government structure poses challenges for widespread implementation. In 1990, the National Commission on Human Rights (“NCHR”) was created through presidential decree and achieved constitutional status in 1992.¹⁶⁵ NCHR is a human rights monitoring body composed of a branch in each of Mexico’s 31 states and the Federal District.¹⁶⁶ However, the NCHR’s fragmented structure inhibits the commission’s effectiveness in protecting rights.

On paper, NOM-HIV and NOM-STI prohibit discrimination in healthcare settings based on health status;¹⁶⁷ safeguard confidentiality of counseling, testing results, and STI medical information; and require informed consent.¹⁶⁸ The laws thus comply with Standard 18, requiring states’ laws must forbid “any discrimination in access to health care and underlying determinants of health ... on the grounds of ... health status (including HIV/AIDS);”¹⁶⁹ Standard 19 requiring “full protection of confidentiality” with respect to HIV testing and status;¹⁷⁰ and Standard 20 requiring “full protection... of informed consent” with respect to HIV testing and status.¹⁷¹ NOM-HIV further prohibits termination from work, expulsion from school, eviction from a dwelling, and denial of entry into the country based on HIV status.¹⁷²

NOM-HIV fails to address the specific needs of vulnerable populations. It does not explicitly address the unique issues that commercial sex workers face. Furthermore, municipal laws criminalize all sex work, thereby hampering sex workers’ access to testing, counseling and treatment services granted by NOM-HIV and NOM-STI. These laws conflict with Standard 31, which requires states to “[decriminalize] sex work that involves no victimization.”¹⁷³

Despite Mexico’s progressive inclusion of proscriptions against discrimination based on sexual orientation in the antidiscrimination law, NOM-HIV fails to address widespread social stigmatization of same-sex partnerships¹⁷⁴ and is silent on Standard 34, which requires states’

¹⁶² Regulations NOM-010-SSA2-1993 of 1993 on the Prevention and Control of HIV Infection (2000).

¹⁶³ Regulations NOM-039-SSA2-2002 on the Prevention and Control of Sexually Transmitted Infections (2003).

¹⁶⁴ 2001 Decl. of Com., at paragraph 38.

¹⁶⁵ Interior Ministry, “Decreto por el que se crea la Comision Nacional de Derechos Humanos como un organo desconcentrado de la Secretaria de Gobernacion” [Decree by which the National Commission on Human Rights is created as a de-concentrated agency of the Interior Ministry], June 5, 1990.

¹⁶⁶ Octavio Gomez-Dantes, Julio Frenk, Patricia Zorrilla, *Monitoring and Protecting Health and Human Rights in Mexico*, 1 HEALTH AND HUMAN RIGHTS 3, 287 (1995).

¹⁶⁷ Regulations NOM-010-SSA2-1993, at Sec. 11.

¹⁶⁸ *Id.*

¹⁶⁹ Committee on Economic, Social, and Cultural Rights, General Comment 14, paragraph 18.

¹⁷⁰ 2006 Pol. Decl. at paragraph 25.

¹⁷¹ *Id.*

¹⁷² Regulations NOM-010-SSA2-1993, at Sec. 11.

¹⁷³ International Guidelines on HIV/AIDS, at 30, paragraph 21 (c).

¹⁷⁴ *Id.* at 36, paragraph 22 (h).

laws to “reduce human rights violations against men having sex with men [by] ... giving legal recognition to same-sex marriage and/or relationships.”¹⁷⁵ Mexico’s laws are thus inconsistent with respect to the rights of people involved in same-sex relationships.

The General Law on Women’s Access to a Life Free of Violence¹⁷⁶ is in compliance with Standard 7, which requires states to eliminate “all forms of violence against women... including... rape and other forms of sexual violence.”¹⁷⁷ A recently enacted antidiscrimination law guarantees women the right to information on reproductive health and family planning practices.¹⁷⁸ The Supreme Court of Mexico recently upheld the Federal District legislature’s vote to legalize abortion within the first 12 weeks of pregnancy, a decision limited to the Federal District (the seat of the Mexican capital).

The Federal Law on the Protection of the Rights of Children and Adolescents (“LRCA”) protects against “any acts of omissions affecting [children’s] physical or mental health.”¹⁷⁹ The LRCA explicitly criminalizes trafficking of children.¹⁸⁰ The Federal Penal Code and the Federal Law on Organized Crime criminalizes “corruption of minors, child prostitution, and child pornography.”¹⁸¹ Mexico therefore complies with Standard 8, which calls on states’ laws to eliminate “sexual exploitation of ... girls and boys... including for commercial reasons ... and trafficking in ... girls.”¹⁸²

The LRCA recognizes children’s rights to HIV/AIDS treatment services, preventative programs, and information.¹⁸³ But, HIV test administrators are obliged to notify a child’s guardian if a child tests positive,¹⁸⁴ in contravention of Standard 16, which requires states’ laws to “protect the confidentiality of HIV test results... of children.”¹⁸⁵ Mexico’s laws are silent on issues relevant to Standard 15, which requires states to “ensure that [HIV-related] services sufficiently take into account differences in gender, age and the social, economic, cultural and political context in which children live.”¹⁸⁶

Recommendation:

Mexico possesses promising legislation but faces many challenges in terms of local enforcement of national norms. Legislative reform efforts may therefore be less important than addressing local politics, and the latter project falls outside the scope of potential UCLA collaboration.

¹⁷⁵ International Guidelines on HIV/AIDS, at 36, paragraph 22 (h).

¹⁷⁶ General law on Women’s Access to a Life Free of Violence, at Art. 1-3.

¹⁷⁷ 2006 Pol. Decl. at paragraph 31.

¹⁷⁸ Federal Law on the Prevention and Elimination of Discrimination, at Sec. 9 (2007).

¹⁷⁹ Law on the Protection of the Rights of Children and Adolescents (hereinafter, “LRCA”), art. 21, D.O., May 29, 2000, <http://www.diputados.gob.mx/LeyesBiblio/pdf/185.pdf>.

¹⁸⁰ Id.

¹⁸¹ Federal Criminal Code, as amended), D.O., Aug. 14, 1931, <http://www.diputados.gob.mx/LeyesBiblio/pdf/9.pdf>. See also Federal Law on Organized Crime, as amended), D.O., Nov. 7, 1996, <http://www.diputados.gob.mx/LeyesBiblio/pdf/101.pdf>.)

¹⁸² 2006 Pol. Decl. at paragraph 31.

¹⁸³ LRCA, art. 21, D.O., sec. 28.

¹⁸⁴ Regulations NOM-010-SSA2-1993.

¹⁸⁵ Committee on the Rights of the Child, General Comment No. 3, paragraph 21.

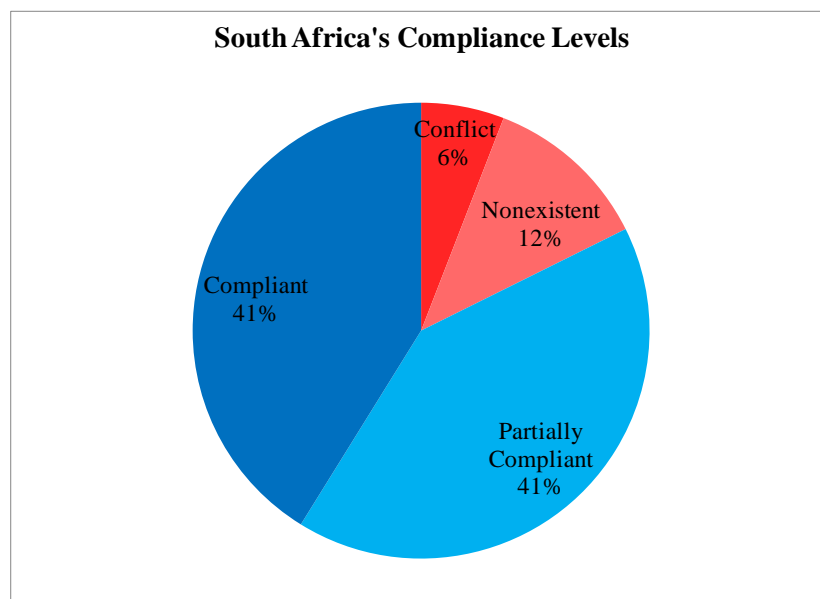
¹⁸⁶ Id.

South Africa

With a compliance rate of 41%, South Africa ranks third highest for compliance among the nine countries. It is partially compliant with 41% of the standards and ranks third lowest for nonexistent laws or policies. It conflicts with 6% of the standards.

South Africa's HIV prevalence rate is 11%. There were an estimated 5.7 million PLWHA in 2007.¹⁸⁷ Prevalence among women ages 20 to 24 is 28%.¹⁸⁸ Predominant modes of transmission are heterosexual sex and mother-to-child transmission.¹⁸⁹

South Africa's relatively new constitution and post-apartheid policies reflect concerted efforts to codify fundamental human rights. Its laws' most notable strengths lie in gender equality and same-sex partnerships. Its weaknesses lie in children-specific HIV/AIDS policies.



South Africa's constitution constitutes the supreme law of the nation. All laws, whether enacted at the local, provincial or national level, are subject to constitutional review by the Constitutional Court. South African law is composed of Roman-Dutch law (which governs personal law, contracts, and tort law) and African customary law (which is actionable to the extent that courts can ascertain its standards and they do not conflict with public policy or principles of justice).¹⁹⁰

The HIV & AIDS and STI Strategic Plan for South African 2007-2011 ("Strategic Plan") identifies the integral roles that civil society and NGOs play in implementation and collaboration

¹⁸⁷ UNAIDS. 2008 Report on the Global AIDS Epidemic. Annex: HIV and AIDS Estimates and Data. UNAIDS; 2008, at 214.

¹⁸⁸ NATIONAL HIV PROGRAM, SOUTH AFRICA: *UNGASS Country Progress Report 2008*, at 11.

¹⁸⁹ AVERT, HIV Prevention Campaigns in South Africa (Nov. 26, 2008), <http://www.avert.org/aidssouthafrica.htm>.

¹⁹⁰ LAW OF EVIDENCE AMENDMENT ACT 45 of 1988. See also CENTER FOR REPRODUCTIVE RIGHTS, *South Africa, in Women OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES – ANGLOPHONE AFRICA* 90, 95 (2003), available at <http://www.reproductiverights.org/pdf/wowaapr-southafrica.pdf>.

with the South African National AIDS Council (SANAC), the government agency charged with monitoring government prevention efforts.¹⁹¹

Of the nine countries, South Africa possesses the most wide-ranging protections for women. It is the only country to legalize abortion and confer to women complete reproductive autonomy with a right to informed consent for abortion.¹⁹² It is compliant with Standard 1, which requires states to “ensure that women can exercise their right to have control over ... matters related to their sexuality ... including their sexual and reproductive health.”¹⁹³ The Promotion of Equality and Prevention of Unfair Discrimination Act of 2000 protects women and female children from harmful traditional practices, such as female genital mutilation, gender-based violence, and obstacles to healthcare.¹⁹⁴ These provisions render South Africa compliant with Standard 3: states are required to “prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation,” and Standard 9: states are required to proscribe “harmful traditional and customary practices [against girls].”¹⁹⁵ The Domestic Violence Act and the Sexual Offences Act criminalize a wide range of gender-based violence acts and provide survivors of violence with legal frameworks through which to seek redress.¹⁹⁶ These acts comply with Standard 7, which requires states’ laws to seek to eliminate “all forms of violence against women...including...rape and other forms of sexual violence.”¹⁹⁷

South Africa has limited protections for vulnerable children. The Children’s Act and Sexual Offences Act enumerate protections against the sexual exploitation of children, including protections against trafficking.¹⁹⁸ These acts comply with Standard 8, which requires states to seek to eliminate “all types of sexual exploitation of ... girls and boys... including for commercial reasons ... and trafficking in ... girls.”¹⁹⁹ Although The Children’s Act and Sexual Offences Act provide protections against trafficking, they do not explicitly protect women. South Africa’s laws are therefore only partially compliant with Standard 6, requiring states’ laws to seek to eliminate “trafficking in women and girls.”²⁰⁰

The Children’s Act requires a child’s informed consent for HIV testing and post-test counseling, and prohibits disclosure of a child’s HIV status.²⁰¹ Thus, it is compliant with Standard 16, which requires states to “protect the confidentiality of HIV test results... of children.”²⁰² However, South Africa’s policies fail to explicitly express an obligation to provide HIV/AIDS treatment services to the maximum extent possible for all children. Such policies are required by Standard

¹⁹¹ South African National AIDS Council (SANAC), “About us: Introduction,” *available at* <http://www.sanac.org.za/about-us/introduction>.

¹⁹² Choice on Termination of Pregnancy Act 92 of 1996 § 7.

¹⁹³ 2006 Pol. Decl. at paragraph 30.

¹⁹⁴ Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 § 8.

¹⁹⁵ 2006 Pol. Decl. at paragraph 31.

¹⁹⁶ Domestic Violence Act 116 of 1998 § 1; Sexual Offences Act 23 of 1972 § 11.

¹⁹⁷ 2006 Pol. Decl. at paragraph 31.

¹⁹⁸ Children’s Act 38 of 2005 § 284; Sexual Offences Act 23 of 1957 § 4.

¹⁹⁹ 2006 Pol. Decl. at paragraph 31.

²⁰⁰ *Id.*

²⁰¹ Children’s Act 38 of 2005 § 151.

²⁰² Committee on the Rights of the Child, General Comment No. 3, paragraph 21.

14.²⁰³ South Africa is also silent on Standard 15, which requires laws seeking to “ensure that [HIV-related] services sufficiently take into account differences in gender, age and the social, economic, cultural and political context in which children live.”²⁰⁴

As to general healthcare provision for PLWHA, South Africa’s laws are a mixed bag. Currently, no laws forbid “discrimination in access to health care and underlying determinants of health ... on the grounds of ... health status (including HIV/AIDS),”²⁰⁵ which is explicitly required by Standard 18. However, South Africa’s laws provide “full protection of confidentiality” with respect to HIV testing and status,²⁰⁶ required by Standard 19. It also codifies into law “full protection... of informed consent” with respect to HIV testing and status,²⁰⁷ required by Standard 20. South Africa currently lacks comprehensive antidiscrimination legislation on the basis of HIV status. Thus, it is silent on Standard 21, which requires states’ laws to “eliminate all forms of discrimination against... people living with HIV.”²⁰⁸

South Africa is one of the few countries to formally recognize prisoners’ rights to dignity in incarceration. The Correctional Services Act, enacted in 1998 and amended in 2001, grants prisoners rights to adequate health care services. However, the provisions of this act do not enumerate prisoners’ rights to HIV/AIDS-related prevention and treatment services, or condom, bleach and clean injection equipment provision. Its laws are thus silent on Standard 32, which calls for “prisoners [to be able to] access... means of prevention (condoms, bleach, and clean injection equipment).”²⁰⁹

South Africa also holds the distinction of being the only country of the nine to recognize the rights of same-sex partners. It is the first nation in the world to include in its constitution a provision against discrimination based on sexual orientation.²¹⁰ Its Civil Union Bill recognizes same-sex marriage. South Africa is thus compliant with Standard 34, which requires states to provide “legal recognition to same-sex marriage and/or relationships.”²¹¹

Despite South Africa’s extensive legislation on HIV/AIDS and human rights legislation, implementation of and full access to legal protections remain tenuous. Women experience sexual harassment and violence, while school authorities and law enforcement agencies respond to complaints with indifference or hostility.²¹² Survivors of sexual assault often meet with condemnatory and unsympathetic healthcare workers when seeking post-exposure prophylaxis or

²⁰³ Committee on the Rights of the Child, General Comment No. 3, paragraph 21.

²⁰⁴ Id.

²⁰⁵ Committee on Economic, Social, and Cultural Rights, General Comment 14, paragraph 18.

²⁰⁶ 2006 Pol. Decl. at paragraph 25.

²⁰⁷ Id.

²⁰⁸ Id. at paragraph 29; however, the UN's use of the phrase "commit ourselves to intensifying efforts to enact" seems to make this question of law non-binding.

²⁰⁹ International Guidelines on HIV/AIDS, at 31, paragraph 21(e).

²¹⁰ Constitutional Court of South Africa, *Gay and Lesbian Rights*, *available at* <http://www.constitutinoalcourt.org/az/text/rights/know/homoscu.html#why>

²¹¹ International Guidelines on HIV/AIDS, at 36, paragraph 22 (h).

²¹² Human Rights Watch, *South Africa: Sexual Violence Rampant in Schools* (Mar. 26, 2001), *available at* <http://www.hrw.org/en/news/2001/03/26/south-africa-sexual-violence-rampant-schools-0>.

emergency contraception.²¹³ Low literacy levels, language diversity, and inadequate outreach efforts have excluded large swaths of the population from progress on HIV/AIDS prevention.²¹⁴

Recommendation:

South Africa has had a sustained dialogue about rights and equality over the last decades. It is a society that has shown itself open to change, and yet its needs, particularly concerning HIV/AIDS prevention, are acute. While the NGO sector is vibrant and well respected, staff capacity shortages hold back reform efforts. Though many of South Africa's laws conform to international human rights norms, implementation challenges and opportunities remain.

Thailand

Thailand has been touted as a success story in the context of HIV prevention, “illustrat[ing] that resource-limited governments do not need a free pass regarding accountability for taking concrete prevention steps.”²¹⁵ Indeed, Thailand's rate of compliance with the 34 standards is high, relative to the other eight countries examined. It is the only country to have no conflicting laws with any of the 34 standards. It is silent on 24% of the 34 standards, partially compliant with 44% of the standards, and completely compliant with 32%.

As of 2007, an estimated 610,000 people are living with HIV, which is 0.95% of Thailand's population.²¹⁶ The rate of mother-to-child transmission reduced from 6.4% in 2004 to 2.3% in 2006.²¹⁷ Prevalence among IDUs is 35% as of 2007.²¹⁸ Among commercial sex workers, prevalence was reduced from 33.2% in 1994 to 5.3% in 2007.²¹⁹

HIV/AIDS is a central policy concern in Thailand. Its policies are most compliant on issues related to gender-based violence and sexual and reproductive rights. It is generally silent on issues related to barriers to healthcare.

²¹³ Human Rights Watch, *South Africa: Medico-Legal System Fails Women Victims of Violence* (Aug. 7, 1997), <http://hrw.org/en/news/1997/08/07/south-africa-medico-legal-system-fails-women-victims-violence>.

²¹⁴ AVERT, *HIV Prevention Campaigns in South Africa* (Nov. 26, 2008), <http://www.avert.org/aidssouthafrica.htm>.

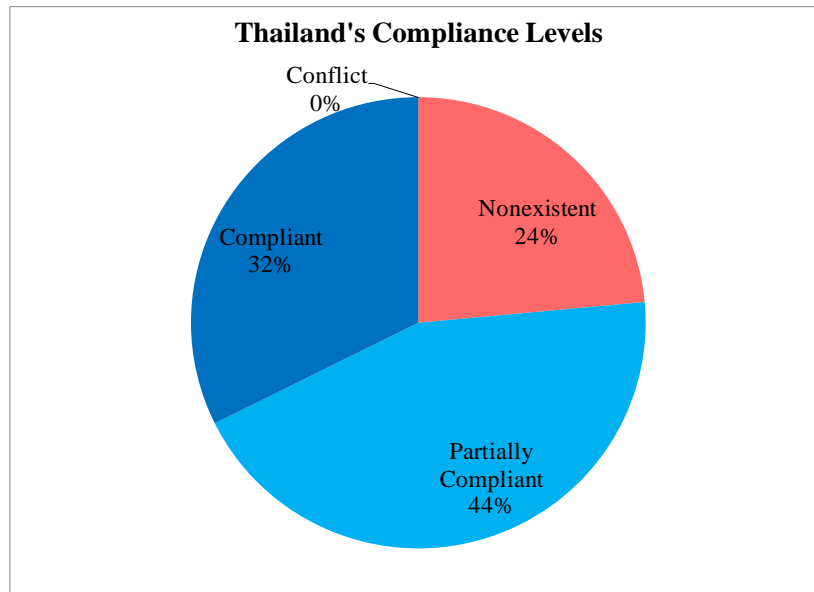
²¹⁵ Lara Stemple, *Health and Human Rights in Today's Fight Against HIV/AIDS*, 22 AIDS 114, 119 (2008).

²¹⁶ UNAIDS and World Health Organization (WHO), *Epidemiological Fact Sheet on HIV and AIDS, Thailand*, (September 2008) [hereinafter UNAIDS Fact Sheet], available at http://www.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_TH.pdf (last visited Dec. 17, 2008).

²¹⁷ *Id.* at 25.

²¹⁸ *Id.* at 26.

²¹⁹ *Id.*



The National AIDS Prevention and Alleviation Committee (“NACAP”), chaired by the Prime Minister, creates and implements national policies for prevention and treatment. NACAP allocates funds for prevention services for each region throughout the country. The Inspector General is charged with overseeing and ensuring regions’ appropriate use of funds and compliance with national policy guidelines. These structures comply with Standard 27, which calls on states’ governments to “fund and empower public health authorities to provide...services for the prevention...of HIV and AIDS.”²²⁰ A robust NGO community is also central to these efforts, playing a significant role in Thailand’s prevention strategies and provision of social welfare services.²²¹ As of 2005, there were over 500 NGOs providing HIV/AIDS-related services and over 800 groups that involved the direct participation of PLWHA.²²²

Since 1998, NACAP has created policies that proscribe discrimination on the basis of HIV/AIDS status in healthcare settings, which comports with Standard 23, which requires states to create laws that seek to prevent “discrimination in access to health care...on the grounds of health status (including HIV/AIDS).”²²³

In Thailand, IDUs constitute the population that is most vulnerable to HIV transmission. As of 2007, the prevalence in this population declined to under 35% from its peak of 50.8% in 1999.²²⁴ NGOs have provided the majority of prevention and treatment for IDUs: clean needle exchange

²²⁰ International Guidelines on HIV/AIDS, at 26, paragraph 20 (a).

²²¹ CENTER FOR REPRODUCTIVE RIGHTS, *Thailand, in Women OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES – EAST AND SOUTHEAST ASIA* 27, at 34 (2003), available at <http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Thailand.pdf>.

²²² WHO, External Review, at 19.

²²³ Committee on Economic, Social, and Cultural Rights, General Comment 14, paragraph 18

²²⁴ WHO, External Review, at 26.

programs, coupled with education and outreach.²²⁵ However, the government has undermined such efforts through its regular police harassment of clients outside drug treatment centers and syringe exchange sites.²²⁶

Some of Thailand's most notable efforts to address HIV/AIDS include its policies relating to sexual and gender violence. For example, Thailand's anti-trafficking laws comply with Standard 6.²²⁷ Criminal codes also contain statutes specifying protections for women against rape (including within marriage), indecent acts, rape irrespective of the perpetrator's sex, and domestic violence²²⁸ in compliance with Standard 7.²²⁹

Thailand also complies with many human rights standards aimed at protecting children's interests. Social welfare services for "children in difficult circumstances" are codified through legislation.²³⁰ These services comply with Standard 11, which calls on states to "[build and support] social security systems that protect [children]."²³¹ However, Thai laws and policies are silent on children's right to confidential HIV testing services, required by Standard 16.²³² Thailand also lacks policy designed to de-stigmatize children orphaned or made vulnerable by HIV/AIDS, required by Standard 17.²³³

Despite some of Thailand's commendable efforts to create effective HIV/AIDS policies, persistent violations of state policies thwart such efforts. About 40% of PLWHA have reported breaches of confidentiality,²³⁴ children with HIV have been denied entry to primary school, employees have been dismissed because of their HIV status, and employers have requested HIV tests of job applicants, despite policies that explicitly proscribe such activity.²³⁵ There are also widespread reports of police fining or arresting sex workers, MSM, and young people found carrying condoms.²³⁶

²²⁵ Human Rights Watch & Thai Treatment Action Group, *Deadly Denial: Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand*, 4 (2007) [hereinafter HRW, *Deadly Denial*], available at <http://www.hrw.org/en/reports/2007/11/28/deadly-denial> (last visited Dec. 17, 2008).

²²⁶ *Id.*

²²⁷ 2006 Pol. Decl. at paragraph 31; The Anti-Trafficking in Persons Act B.E. 2551 §6-10, (2008) (Thail.), available at [http://www.baliprocess.net/files/Legislatoin/Q-Z/Trafficking_in_Persons_Act_B%20E%202551%20\(English\).pdf](http://www.baliprocess.net/files/Legislatoin/Q-Z/Trafficking_in_Persons_Act_B%20E%202551%20(English).pdf) (last visited Dec. 17, 2008).

²²⁸ Penal Code, §277; *Thailand Passes Marital Rape Bill*, BBC news, June 21, 2007, available at <http://news.bbc.co.uk/2/hi/asia-pacific/6225872.stm> (last visited Dec. 17, 2008).

²²⁹ 2006 Pol. Decl. at paragraph 31.

²³⁰ Penal Code, §306.

²³¹ 2006 Pol. Decl. at paragraph 32.

²³² Committee on the Rights of the Child, *General Comment No. 3*, paragraph 21.

²³³ 2001 Decl. of Com., at paragraph 66.

²³⁴ U.N. Dev. Programme [UNDP], *Thailand's Response to HIV/AIDS: Progress and Challenges 13,5* (2004), available at http://www.un.or.th/pdf/HIV_AIDS_Report_ENG.pdf.

²³⁵ *Id.*

²³⁶ Ministry of Public Health, Thailand & World Health Organization, *External Review of the Health Sector Response to HIV/AIDS in Thailand 19, 24* (2005) [hereinafter WHO, *External Review*], available at http://www.searo.who.int/LinkFiles/News_and_Events_ThailandProgrammeReviewNEW.pdf.

Recommendation:

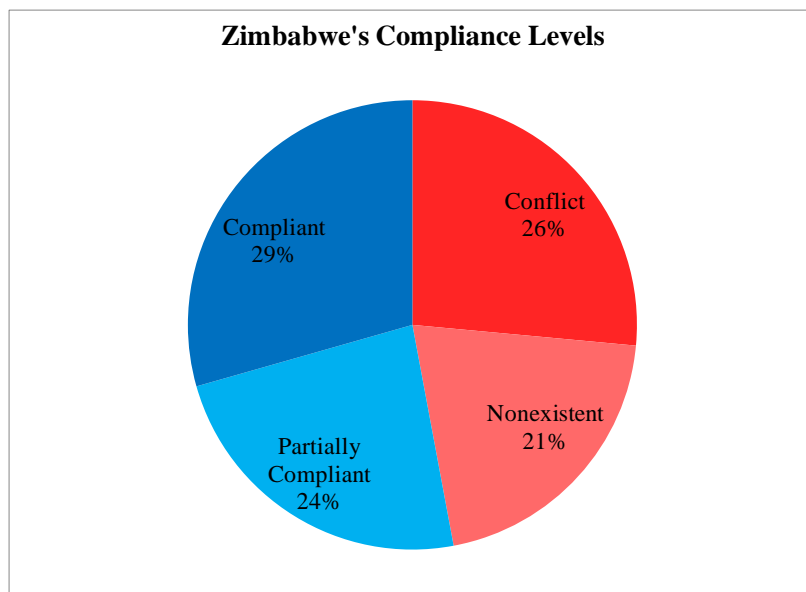
Compared to the other states studied, Thailand’s policies (if not always its practices) are largely compliant with international human rights standards. However, most HIV/AIDS-related policies are created through NACAP’s non-binding regulatory codes. Because the majority of regulation is composed of non-binding policy, and not enforceable legislation, opportunities for traditional legal intervention are limited. Moreover, Thailand’s extraordinarily robust NGO sector, and the country’s proven ability to lower transmission rates²³⁷ may indicate a lesser need for UCLA’s services than other countries.

Zimbabwe

Zimbabwe’s laws conflict with 26% of the 34 standards – the greatest degree of conflict among the nine countries studied. It is partially compliant with 24% of the standards and fully compliant with 29% of the 34 standards, which is the third lowest compliance rate among the nine countries.

Zimbabwe’s estimated HIV prevalence among adults 15-49 years is 15.6%.²³⁸ Women make up 57% of PLWHA. Heterosexual contact is the primary source of transmission.²³⁹

Zimbabwe’s policies regarding sexual violence and services and protections for vulnerable children are generally satisfactory. Policies regarding sex-based or HIV status-based discrimination, patient confidentiality, and guarantees of healthcare service provision are either non-existent or directly conflict with international standards.



²³⁷ See WHO, External Review, at 3, for a comparison of HIV/AIDS prevalence between 2001 and 2007.

²³⁸ NATIONAL HIV PROGRAM, ZIMBABWE: *UNGASS Country Progress Report 2008*, at 4.

²³⁹ *Id.* at 5.

Zimbabwe's government has been tainted by corruption, hampered by opaque policymaking processes, and widely criticized for recent episodes of extreme political violence. The country's tumultuous political landscape likely contributes to many of its deficiencies in complying with international human rights standards concerning HIV/AIDS.

The National AIDS Council, created by parliament, promulgated the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) in July 2006. ZNASP outlines goals for extending treatment and prevention and for funding NGOs and service providers to realize these goals. However, the government has since frozen funding to NGOs in an effort to stymie potential dissent.²⁴⁰

Zimbabwe's HIV/AIDS policies are particularly problematic where patient confidentiality is concerned. ZNASP does not instruct healthcare providers to protect the confidentiality of HIV test results, which violates Standard 19.²⁴¹ Indeed, the ZNASP provides that PLWHA may be required to disclose their status in order to receive certain employment-related benefits.²⁴² Furthermore, the Public Health Act authorizes the Minister of Health and Child Welfare to classify sexually transmitted diseases as "notifiable,"²⁴³ which allows local authorities to report a person's health status to The National AIDS Council in certain cases.²⁴⁴ The Act also authorizes school principals to notify local authorities when students are known to be suffering from infectious diseases.²⁴⁵

The most common form of HIV transmission in Zimbabwe is through heterosexual sex, and women make up 60% of adults aged 15-45 living with HIV/AIDS.²⁴⁶ Despite this, Zimbabwean lawmakers have made very few efforts to address women's specific needs. The laws are silent on women's rights to education and information on sexual and reproductive health. There are also no laws to ensure that existing HIV-related services comply with Standard 15, under which state laws must seek to "ensure that [HIV-related] services sufficiently take into account differences in gender, age and the social, economic, cultural and political context in which children live."²⁴⁷

Same-sex marriage is not recognized, which violates Standard 34, concerning state efforts to "reduce human rights violations against men having sex with men [by]...giving legal recognition to same-sex marriage and/or relationships."²⁴⁸ Zimbabwe possesses no anti-trafficking laws or policies, and all sex work is criminalized, which conflict with Standards 6 and 31 respectively.²⁴⁹ Thus, Zimbabwe does little to protect populations that UNAIDS has identified as vulnerable to HIV/AIDS.

²⁴⁰ See Walter Marwizi & Vusumuzi Sifile, *New Rules Stymieing NGO Operations*, THE STANDARD (ZIMBABWE), Sept. 13, 2008, available at http://www.kubatana.net/html/archive/demg/080913zimstand.asp?sector=FOODSE&year=0&range_start=1.

²⁴¹ 2006 Pol. Decl. at paragraph 25.

²⁴² Statutory Model 202 of 1998 Zimbabwe Labour Relations (HIV and AIDS) Regulations § 7.

²⁴³ Public Health Act § 17. The Minister has not actually classified HIV/AIDS as "notifiable," but the Act empowers him to do so.

²⁴⁴ Public Health Act §§ 17-18, 21.

²⁴⁵ *Id.* at paragraph 24.

²⁴⁶ NATIONAL HIV PROGRAM, ZIMBABWE: UNGASS Country Progress Report 2008, at 9.

²⁴⁷ Committee on the Rights of the Child, General Comment No. 3, paragraph 21.

²⁴⁸ International Guidelines on HIV/AIDS, at 36, paragraph 22 (h).

²⁴⁹ 2006 Pol. Decl. at paragraph 31.

Recommendation:

In contrast to countries that have simply failed to, thus far, implement laws and policies that bring them into line with international human rights standards, Zimbabwe has enacted laws that are in direct conflict with international norms in many cases. Law reform efforts are acutely needed to address these conflicts. However, if one assumes that hostility is more difficult to overcome than mere inertia, reform in Zimbabwe will not come easily. Moreover, extreme violence, political instability, and the ongoing challenges faced by potential NGO partners create insurmountable obstacles for student work at this time.

APPENDIX A

Evaluative Standards

1. Do the country's laws seek to “ensure that women can exercise their right to have control over ... matters related to their sexuality ... including their sexual and reproductive health”?²⁵⁰
2. Do the country's laws “require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice”?²⁵¹
3. Do the country's laws seek to “prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation”?²⁵²
4. Do the country's laws seek to “ensure the removal of all barriers to women's access to health services”?²⁵³
5. Do the country's laws seek to “ensure the removal of all barriers to women's access to... education and information, including in the area of sexual and reproductive health”?²⁵⁴
6. Do the country's laws seek to eliminate “trafficking in women and girls”?²⁵⁵
7. Do the country's laws seek to eliminate “all forms of violence against women... including... rape and other forms of sexual violence”?²⁵⁶
8. Do the country's laws seek to eliminate “all types of sexual exploitation of ... girls and boys... including for commercial reasons...and trafficking in...girls”?²⁵⁷
9. Do the country's laws seek to eliminate “harmful traditional and customary practices [against girls]”?²⁵⁸
10. Do the country's laws seek to eliminate “all forms of violence against... girls, including... abuse, rape and other forms of sexual violence”?²⁵⁹

²⁵⁰ 2006 Pol. Decl. at paragraph 30.

²⁵¹ CEDAW, at paragraph 31, E also suggests that a country's laws “require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.”

²⁵² Committee on Economic, Social, and Cultural Rights, General Comment 14, paragraph 35.

²⁵³ Committee on the Elimination of Discrimination against Women, General Recommendation 24, paragraph 31, b.

²⁵⁴ Id.

²⁵⁵ 2006 Pol. Decl. at paragraph 31.

²⁵⁶ Id. at paragraph 31.

²⁵⁷ 2006 Pol. Decl. at paragraph 31.

²⁵⁸ Id.

11. Do the country's laws “[build and support] social security systems that protect [children]”?²⁶⁰
12. Do the country's laws seek to “ensure that primary education is available to all children, whether infected, orphaned or otherwise affected by HIV/AIDS”?²⁶¹
13. Do the country's laws seek to “prevent ... the inducement or coercion of a child to engage in any unlawful sexual activity”?²⁶²
14. Do the country's laws seek to “ensure that [HIV-related] services are provided to the maximum extent possible to all children living within their borders, without discrimination”?²⁶³
15. Do the country's laws seek to “ensure that [HIV-related] services sufficiently take into account differences in gender, age and the social, economic, cultural and political context in which children live”?²⁶⁴
16. Do the country's laws seek to “protect the confidentiality of HIV test results... of children”?²⁶⁵
17. Do the country's laws seek to promote “an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS”?²⁶⁶
18. Do the country's laws forbid “any discrimination in access to health care and underlying determinants of health ... on the grounds of ... health status (including HIV/AIDS)”?²⁶⁷
19. Do the country's laws guarantee “full protection of confidentiality” with respect to HIV testing and status?²⁶⁸
20. Do the country's laws guarantee “full protection of...informed consent” with respect to HIV testing and status?²⁶⁹

²⁵⁹ Id.

²⁶⁰ 2006 Pol. Decl. at paragraph 32.

²⁶¹ Committee on the Rights of the Child, General Comment No. 3, paragraph 18.

²⁶² Id. paragraph 19.

²⁶³ Committee on the Rights of the Child, General Comment No. 3, paragraph 21.

²⁶⁴ Id.

²⁶⁵ Id. at paragraph 24.

²⁶⁶ 2001 Decl. of Com., at paragraph 66.

²⁶⁷ Committee on Economic, Social, and Cultural Rights, General Comment 14, paragraph 18.

²⁶⁸ 2006 Pol. Decl. at paragraph 25

²⁶⁹ Id.

21. Do the country's laws seek to “eliminate all forms of discrimination against... people living with HIV”?²⁷⁰
22. Do the country's laws create a “national HIV/AIDS [plan]... funded and implemented with transparency, accountability and effectiveness”?²⁷¹
23. Do the country's laws seek to prevent “discrimination in access to health care... on the grounds of health status (including HIV/AIDS)”?²⁷²
24. Do the country's laws seek to prevent “discrimination in access to...the underlying determinants of health...on the grounds of health status (including HIV/AIDS)”?²⁷³
25. Do the country's laws seek to "ensure widespread availability of [affordable], quality prevention measures"?²⁷⁴
26. Do the country's laws facilitate “[t]he contribution of...NGOs...and people living with HIV [as] an essential part of the overall national response to the epidemic”?²⁷⁵
27. Do the country's public health laws “fund and empower public health authorities to provide...services for the prevention...of HIV and AIDS”?²⁷⁶
28. Do the country's laws ensure that “pre-and post-test [HIV] counseling [is] provided”?²⁷⁷
29. Do the country's laws “ensure that information relative to the HIV status of an individual [is] protected from unauthorized collection, use or disclosure”?²⁷⁸
30. Do the country's laws refrain from including “specific offenses against the deliberate and intentional transmission of HIV”?²⁷⁹
31. Do the country's laws aim at “[decriminalizing] sex work that involves no victimization”?²⁸⁰

²⁷⁰ Id. at paragraph 29.

²⁷¹ 2001 Decl. of Com., at paragraph 38.

²⁷² Committee on Economic, Social, and Cultural Rights, General Comment 14, paragraph 18

²⁷³ Id. "Determinants of health" later appear in the document and include "nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions". Id. at paragraph 36.

²⁷⁴ *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version, UN AIDS., at 18, paragraph 6.

²⁷⁵ Id. at 25, paragraph 18.

²⁷⁶ Id. at 26, paragraph 20 (a).

²⁷⁷ Id. at 27, paragraph 20 (c).

²⁷⁸ Id. at 28, paragraph 20 (f).

²⁷⁹ Id. at 29, paragraph 21 (a).

²⁸⁰ Id. at 30, paragraph 21 (c).

32. Do the country's law provide “prisoners (and prison staff as appropriate), with access to... means of prevention (condoms, bleach, and clean injection equipment)”?²⁸¹

33. Do the country's laws seek to “reduce human rights violations against men having sex with men [by]...providing penalties for vilification of people who engage in same-sex relationships”?²⁸²

34. Do the country's laws seek to “reduce human rights violations against men having sex with men [by]...giving legal recognition to same-sex marriage and/or relationships”?²⁸³

²⁸¹ Id. at 31, paragraph 21(e).

²⁸² Id. at 36, paragraph 22 (h).

²⁸³ Id.