

# Namibia Legal Environment Assessment Of HIV and AIDS

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Consultants

AIDS and Rights Alliance for Southern Africa: International Consultant  
Legal Assistance Centre: National Consultant

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## Table of Contents

|   |    |
|---|----|
| Abbreviations.....  | 5  |
| Executive Summary.....  | 6  |
| Part I.....   | 10 |
| Introduction and Background.....  | 10 |
| Aims and Objectives.....  | 11 |
| Aim.....  | 11 |
| Specific objectives.....  | 11 |
| Key Deliverables.....   | 12 |
| Implementation Modalities.....  | 12 |
| Technical Approach.....   | 12 |
| Research Methodology.....   | 13 |
| Desk Review.....  | 13 |
| Key Informant Interviews.....   | 13 |
| Focus Group Discussions.....  | 14 |
| Data Management.....  | 14 |
| Consultative Workshops, Validation and Dissemination of Study Findings.....         | 14 |
| Oversight by Technical Working Group.....   | 14 |
| The Situational Analysis Report.....  | 15 |
| Part II.....  | 15 |
| International/Regional/National human rights framework.....                         | 15 |
| A. International Framework.....   | 16 |
| B. Human rights standards and the nature of State obligations.....                  | 17 |
| C. Limitation of Rights.....  | 19 |
| D. The application of specific human rights in the context of the HIV and AIDS..... | 20 |
| Right to Equality and Non-Discrimination.....                                       | 24 |
| Right to Privacy.....   | 27 |
| Right to Marry and to Found a Family and Protection of the Family.....              | 28 |
| Right to Freedom of Movement.....   | 29 |
| Right to Liberty and Security of Person.....  | 30 |
| Right to Education.....   | 30 |
| Right to the Highest Attainable Standard of Physical and Mental Health.....         | 31 |
| Right to an Adequate Standard of Living and Social Security Services.....           | 33 |
| Right to Work.....  | 34 |
| Freedom from Cruel, Inhuman or Degrading Treatment or Punishment.....               | 36 |
| Part III.....   | 37 |
| A. Equality/Anti-Discrimination Law and Policy.....                                 | 37 |

|  |    |
|--|----|
| HIV-Related Stigma and Discrimination in Namibia .....                 | 37 |
| Foreigners/Migrants .....  | 39 |
| Access to Insurance/Bank loans.....                                    | 41 |
| B. Health laws, policies and plans .....                               | 42 |
| Constitutional Rights .....  | 44 |
| Public Health Legislation.....   | 45 |
| Health and HIV Policies, Strategies and Plans .....                    | 46 |
| Isolation and detention of patients .....                              | 47 |
| Informed Consent to HIV Testing and Treatment .....                    | 48 |
| Confidentiality .....  | 52 |
| Access to HIV Prevention, Treatment, Care and Support .....            | 53 |
| Regulation of Health Care Providers and Health Extension Workers ..... | 55 |
| C. Criminal Law and Law Enforcement .....                              | 56 |
| MEN WHO HAVE SEX WITH MEN .....  | 56 |
| Sex workers.....   | 57 |
| People who use drugs.....  | 61 |
| Criminalization of HIV transmission and exposure.....                  | 64 |
| Inmates.....   | 67 |
| D. HIV/AIDS in the Workplace.....                                      | 70 |
| E. Education and Information.....                                      | 72 |
| F. Social Welfare.....   | 73 |
| Social Security .....  | 74 |
| Pension.....   | 74 |
| Maintenance.....   | 74 |
| Welfare Related Grants.....  | 74 |
| Child Maintenance Grants .....   | 74 |
| Foster Care Grants .....   | 75 |
| Special Maintenance Grant .....  | 75 |
| Place of Safety Allowance .....  | 75 |
| Child Care and Protection Act .....                                    | 75 |
| G. Gender Based Violence and HIV .....                                 | 77 |
| Part IV Access to Justice and Law Enforcement in Namibia .....         | 78 |
| Legal Aid .....  | 79 |
| The court system.....  | 80 |
| Office of the Ombudsman.....   | 80 |
| The Police Service .....   | 80 |
| General access to justice issues.....                                  | 81 |

|   |    |
|---|----|
| Part V Recommendations .....  | 82 |
| A. Equality/Anti-Discrimination Law and Policy.....                   | 82 |
| Foreigners/Migrants.....  | 82 |
| Access to Insurance/Bank loans.....                                   | 82 |
| B. Health laws, policies and plans .....                              | 82 |
| General.....  | 82 |
| Isolation and detention of patients .....                             | 82 |
| Informed Consent to HIV Testing and Treatment .....                   | 82 |
| Confidentiality .....   | 83 |
| Access to HIV Prevention, Treatment, Care and Support .....           | 83 |
| Regulation of Health Care Providers and Health Extension Workers..... | 83 |
| C. Criminal Law and Law Enforcement .....                             | 83 |
| MEN WHO HAVE SEX WITH MEN .....                                       | 83 |
| Sex workers.....  | 84 |
| People who use drugs.....   | 85 |
| Criminalisation of HIV transmission and exposure.....                 | 85 |
| Inmates.....  | 86 |
| D. HIV/AIDS in the Workplace.....                                     | 86 |
| E. Education and Information.....                                     | 86 |
| F. Social Welfare .....   | 87 |
| G. Gender Based Violence and HIV .....                                | 87 |
| Part IV Access to Justice and Law Enforcement in Namibia .....        | 88 |
| ANNEXURE 1 – DOCUMENTS REVIEWED .....                                 | 89 |
| ANNEXURE 2 – KEY INFORMANTS INTERVIEWED.....                          | 94 |
| ANNEXURE 3 – FOCUS GROUP DISCUSSIONS CONDUCTED.....                   | 95 |
| ANNEXURE 4 – MEMBERS OF TECHNICAL WORKING GROUP .....                 | 96 |

## Abbreviations

|        |  |
|--------|--|
| AIDS   | Acquired Immune Deficiency Syndrome  |
| ART    | Antiretroviral Therapy   |
| AU     | African Union  |
| CEDAW  | Convention on the Elimination of All forms of Discrimination against Women |
| CESCR  | Committee on Economic, Social and Cultural Rights                          |
| CSOs   | Civil Society Organisations  |
| CRC    | Convention on the Rights of the Child                                      |
| FGD    | Focus Group Discussions  |
| GBV    | Gender Based Violence  |
| GCHL   | Global Commission on HIV and the Law                                       |
| HCT    | HIV Counselling and Testing  |
| HIV    | Human Immuno-deficiency Virus  |
| HTS    | HIV Testing Services   |
| ICCPR  | International Covenant on Civil and Political Rights                       |
| ICESCR | International Covenant on Economic, Social and Cultural Rights             |
| ILO    | International Labour Organisation  |
| IOM    | International Organisation for Migration                                   |
| IP     | Intellectual Property  |
| KII    | Key Informant Interviews   |
| MC     | Male Circumcision  |
| MDGs   | Millennium Development Goals   |
| MOHSS  | Ministry of Health and Social Services                                     |
| MSM    | Men who have sex with men  |
| NAMAF  | Namibian Association of Medical Aid Funds                                  |
| NCS    | Namibia Correctional Services  |
| NSF    | National Strategic Framework for HIV & AIDS 2010/11 – 2015/16              |
| OHCHR  | Office of the High Commissioner for Human Rights                           |
| OIs    | Opportunistic Infections   |
| PHEIC  | Public Health Emergency of International Concern                           |
| PITC   | Provider-initiated Testing and Counselling                                 |
| PLWHA  | People living with HIV   |
| SADC   | Southern African Development Community                                     |
| SFH    | Society for Family Health  |
| STIs   | Sexually Transmitted Infections  |
| SUDs   | Substance Use Disorders  |
| TB     | Tuberculosis   |
| TRIPS  | WTO Agreement on Trade Related Aspects of Intellectual Property Rights     |
| TWG    | Technical Working Group  |
| UDHR   | Universal Declaration of Human Rights                                      |
| UN     | United Nations   |
| UNAIDS | United Nations Joint Programme on HIV/AIDS                                 |
| UNFPA  | United Nations Populations Fund  |
| UNHCR  | United Nations High Commission for Refugees                                |
| UNGASS | United Nations General Assembly Special Session                            |
| UNODC  | United Nations Office on Drugs and Crime                                   |
| VCT    | Voluntary Counselling and Testing  |
| WHO    | World Health Organisation  |
| WTO    | World Trade Organisation   |

## Executive Summary

Stigma, discrimination and other human rights abuses faced by people living with HIV or AIDS as well as by key populations at higher risk of HIV infection worldwide, compromise their ability to access health care services, including HIV prevention, treatment and care services and thus negatively impact on national responses to HIV and AIDS. The HIV epidemic is one of Namibia's major public health and development challenges. It is estimated that 13.3% of adults aged 15-49 are living with HIV. This means that approximately 200 000 adults have HIV, of which about 120 000 are women. There are around 5000 annual deaths. It has also been reported that around 18 000 children have HIV, while 76 000 are orphans.<sup>1</sup> Namibia has a generalized HIV epidemic. However, there are certain key populations that are at higher risk of HIV. According to data obtained by Society for Family Health from routine programme reporting,<sup>2</sup> HIV prevalence rates among key populations in 2015 stand at 24% for men who have sex with men and 20% for sex workers. There are also those that are vulnerable to HIV exposure due to poverty, gender inequality, age, legal status and other socioeconomic and cultural circumstances, including women and young girls.

The Preamble of the Namibian Constitution recognizes that the inherent dignity of, and the equal and inalienable rights of all members of the human family are indispensable for freedom, justice and peace. These rights include the right of the individual to life, liberty and the pursuit of happiness, regardless of race colour, ethnic origin, sex, religion creed or social or economic status.

Fundamental Human Rights and Freedoms are found in Chapter 3 of the Constitution and includes protection of the rights to equality and freedom from discrimination, the right to privacy, the right to dignity, the right to security of the person and the right to work, amongst others. In addition, Namibia is party to and has ratified various regional and international conventions, declarations, covenants and treaties that safeguard the rights of all people in general as well as a number of which include important rights in the context of HIV and AIDS. Article 144 of the Namibian Constitution provides that unless otherwise provided by the Constitution or Act of Parliament, the general rules of public international law and international agreements binding upon Namibia under this Constitution shall form part of the law of Namibia. Namibia thus follows a monist system in terms of which all international treaties ratified by Namibia immediately become part of the national law.

Key issues relating to HIV and human rights in Namibia include various forms of stigma and discrimination faced by people living with HIV including in accessing health care services and in the workplace. Men who have sex with men face stigma, discrimination and human rights abuses on a daily basis. There is a culture of denial of their existence, which reinforces their invisibility as a population in need of protection.<sup>3</sup>

Women experience various forms of gender inequality, harmful gender norms and gender-based violence that impact on their vulnerability to HIV.

Sex Workers in Namibia report various human rights violations which are exacerbated by the government's failure to recognize sex worker rights in the country.

Legal and human rights challenges have been identified and include:

- The lack of HIV-specific anti-discrimination protection for people living with HIV and key populations at higher risk of HIV exposure in law

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<sup>1</sup> [www.unaids.org/en/regionscountries/countries/namibia/](http://www.unaids.org/en/regionscountries/countries/namibia/)

<sup>2</sup> Source – Anthony Muganza, M&E Programme Manager, Society for Family Health, 21.09.2015.

<sup>3</sup> Ibid, p. 102

- Discriminatory and punitive laws, policies and practices that create barriers to access to HIV testing, prevention, treatment, care and support (including harm reduction measures) for affected populations and that deny people living with HIV access to education, insurance, bank loans and employment in the armed forces
- Punitive laws that criminalise populations at higher risk of HIV exposure (such as men who have sex with men, people who use drugs and sex workers).

Reversing HIV trends and patterns to get to 90:90:90, and the end of AIDS as a public health threat by 2030 requires an effective response underpinned by a supportive and protective environment in the country.<sup>4</sup> The role of a supportive legal and policy environment in improving outcomes of HIV and AIDS interventions has been increasingly documented and recognized to include improving protection of rights, enhancing access to HIV and AIDS services and mitigating the impacts of the epidemic.

The Government of the Republic of Namibia has show continued commitment to improving the national response to HIV through allocation of resources to support interventions at various levels. The National Strategic Framework 2010/11-2015/16 and the National Policy on HIV identify key populations and vulnerable groups in Namibia as people living with HIV, women, orphans and vulnerable children, poor people, sex workers, men who have sex with men, members of the uniformed services, mobile populations, refugees and displaced people, people with disabilities and prisoners.<sup>5</sup> People who use drugs are, however, not recognized a key population, despite evidence of an increasing incidence of people using drugs in southern African countries, including Namibia.<sup>6</sup>

The aim of the legal and regulatory analysis is to improve the availability of information and evidence of legal and regulatory aspects in the context of HIV and AIDS, for purposes of making recommendations for creating and strengthening an enabling environment that promotes an effective national AIDS response in accordance with the Republic of Namibia's National Strategic Framework 2010/11-2015/16 and the National Policy on HIV. The assessment has been conducted by way of a desk review of documentation on selected laws, regulations and policies and a qualitative assessment of the level of knowledge on human rights among key and vulnerable populations; and of the degree of awareness of HIV related laws and human rights among law makers and law enforcers to enable effective implementation of services, access to justice and enforcement of HIV-related laws and rights.

This Legal Environment Assessment identified a number of challenges relating to HIV, law and human rights in Namibia and thus calls for the enactment of the following protections in law for HIV:<sup>7</sup>

1. Government must ensure that migrant workers and foreigners can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens.
2. HIV should not be treated differently from analogous medical conditions for insurance purposes.
3. In the context of health laws and policies, the following are highlighted for action:

<sup>4</sup> UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: [http://www.unaids.org/sites/default/files/media\\_asset/90-90-90\\_en\\_0.pdf](http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf)

<sup>5</sup> National Policy on HIV/AIDS. Republic of Namibia. 2007 and National Strategic Framework for HIV and AIDS Response in Namibia 2010/11-2015/16

<sup>6</sup> ARASA HIV and Human Rights in Southern and East Africa 2014 Report pg. 101

<sup>7</sup> See Part V for detailed recommendations

- 3.1 HIV should not be specified as a notifiable infectious disease once the Public and Environmental Act 1 of 2015 enters into force.
- 3.2 Ensure that the Child Care and Protection Act 3 of 2015 enter into force as soon as possible.
- 3.3 Provision in law as well as in policy for HIV testing to take place only on the basis of voluntary and confirmed consent; and for the protection of confidentiality and disclosure of HIV status to take place only with consent, as is currently provided for in the National HIV policy.
- 3.4 Commission a thorough assessment of the Industrial Property Act no 1 of 2012 to ensure that TRIPS flexibilities are thoroughly catered for in the legislation and subsequently attend to capacity building with stakeholders.
- 3.5 Ensure health care workers have training to adequately implement and provide non-discriminatory services to key populations.
- 3.6 The drafting of legislation providing for the registration of home based care givers and health extension workers should be investigated.
4. The provisions of the common law should be amended to decriminalize consensual sex between adult males.
5. Consensual sex work should be decriminalized and the unjust application of non-criminal laws and regulations against sex workers for harm reduction purposes should be eliminated.
6. Law enforcement officials, and health and social care providers need to be trained to recognize and uphold the human rights of LGBTI and sex workers and should be held accountable if they violate those rights.
7. Scale up evidence based strategies to reduce HIV infection and protect the health of persons who use drugs, including sterile syringe distribution, and invest in an easily accessible range of evidence-based options for the treatment and care for drug dependence, including opioid substitution therapy.
8. HIV-specific laws that criminalize HIV transmission and exposure should not be enacted. Where individuals maliciously and intentionally transmit HIV to others with the express purpose of causing harm, existing laws— including against assault with intent to do grievous bodily harm—suffice to prosecute people in those exceptional cases. Guidelines should be developed to support law enforcement agents and the judiciary to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered.
9. Ensure that inmates have full and appropriate access to the same HIV related prevention information, education, voluntary counselling and testing, means of prevention (including condoms), treatment, care and support as is available in the general population.
10. Provide sufficient amount of nutritious food to all inmates.
11. Ensure that the provisions of the National Code on HIV/AIDS in Employment and the National Policy of HIV and AIDS regarding HIV in the workplace are implemented and enforced to ensure that HIV testing for access to or continued employment or promotion is

not permitted and strengthen the capacity of Labour Inspectors to monitor and enforce their implementation.

12. Halt the practice of excluding recruits from the Namibia Defence Force and Namibian Police on the basis of HIV status alone.
13. Human rights education and training should be strengthened in the school curricula, in the health systems, within the working environment and amongst law enforcement officials.
14. There is a need to introduce a National Medical Benefit as well as an Unemployment Insurance Fund that will cater for people who are not ordinarily employed as well as a need to reform the social welfare grants to ensure that they cover all vulnerable persons.
15. A Universal Basic Income Grant should be introduced.
16. Government and civil society should increase public awareness about the linkages between GBV and HIV, including the provision of information on what to do in such situations and where to get information and help and healthcare providers should be trained on the recognition of cases of GBV and what to do in such cases.
17. Courts and police stations should make sure that complainants can access healthcare information by ensuring that pamphlets about HIV testing, prophylactic treatment and living positively with HIV are available. Similarly, clinics and hospitals should ensure that information about GBV, how to get a protection order and other options in cases of violence are available. This should be extended to all cases of exposure, not just to instances of rape.
18. Consideration should be given to establishing a dedicated unit within the Directorate of Legal Aid that investigates complaints of ALL vulnerable applicants to establish a broader understanding of the difficulties experienced by these communities.
19. The human rights section of the Office of the Ombudsman should be adequately funded in order that it may fulfil its mandate.
20. Civil society should be empowered to monitor the implementation of the National Human Rights Action Plan in order to hold the relevant Ministries accountable for what they have undertaken to implement.

## Part I

### Introduction and Background

The HIV epidemic is one of Namibia's major public health and development changes. It is estimated that 13.3% of adults aged 15-49 are living with HIV. This means that approximately 200 000 adults have HIV, of which about 120 000 are women. There are around 5000 annual deaths. It has also been reported that around 18 000 children have HIV, while 76 000 are orphans.<sup>8</sup>

Namibia has a generalized HIV epidemic. However, there are certain key populations that are at higher risk of HIV. These include gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners.

According to data obtained by Society for Family Health from routine programme reporting<sup>9</sup>, HIV prevalence rates among key populations in 2015 stand at 24% for men who have sex with men and 20% for sex workers. There are also those that are vulnerable to HIV exposure due to poverty, gender inequality, age, legal status and other socioeconomic and cultural circumstances, including women and young girls.

The National Strategic Framework 2010/11-2015/16 and the National Policy on HIV identify key populations and vulnerable groups in Namibia as people living with HIV, women, orphans and vulnerable children, poor people, sex workers, men who have sex with men, members of the uniformed services, mobile populations, refugees and displaced people, people with disabilities and prisoners.<sup>10</sup> People who use drugs are, however, not recognized a key population, despite evidence of an increasing incidence of people using drugs in southern African countries, including Namibia.<sup>11</sup>

Key issues relating to HIV and human rights in Namibia include various forms of stigma and discrimination faced by people living with HIV including in accessing health care services and in the workplace. This has the effect of marginalizing people with HIV. Men who have sex with men face stigma, discrimination and human rights abuses on a daily basis. This includes the denial of housing and access to healthcare. There is a culture of denial of their existence, which reinforces their invisibility as a population in need of protection. Transgender communities in Namibia are ridiculed, sexually assaulted and raped and are not assisted by the police when reporting violations, despite their risk of HIV exposure.<sup>12</sup>

Women experience various forms of gender inequality, harmful gender norms and gender-based violence that impact on their vulnerability to HIV. Harmful customary practices affecting women and children continue in Namibia, despite constitutional protection against discrimination. Practices such as property-grabbing, initiation ceremonies for children, arranged marriages between cousins, and widow inheritance increase the vulnerability of women and children and place them at risk of HIV exposure. Women with HIV have reported forced and coerced sterilization as a result of their HIV status. They also report being provided with insufficient information to give proper consent to the procedures, giving consent under coercive circumstances or being denied access to HIV and health services unless they agree to abortion or sterilization.<sup>13</sup>

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<sup>8</sup> [www.unaids.org/en/regionscountries/countries/namibia/](http://www.unaids.org/en/regionscountries/countries/namibia/)

<sup>9</sup> Source – Anthony Muganza, M&E Programme Manager, Society for Family Health, 21.09.2015.

<sup>10</sup> National Policy on HIV/AIDS. Republic of Namibia. 2007 and National Strategic Framework for HIV and AIDS Response in Namibia 2010/11-2015/16

<sup>11</sup> ARASA HIV and Human Rights in Southern and East Africa 2014 Report pg. 101

<sup>12</sup> Ibid, p. 102

<sup>13</sup> Ibid

Sex Workers in Namibia report various human rights violations which are exacerbated by the government's failure to recognize sex worker rights in the country. Sex workers are vulnerable to violence, exploitation and abuse. As a result of stigmatization and fear of abuse, they struggle to access sexual and reproductive health care services and HIV-related health care services.<sup>14</sup>

Legal and human rights challenges have been identified and include:

- The lack of HIV-specific anti-discrimination protection for people living with HIV and key populations at higher risk of HIV exposure in law
- Discriminatory and punitive laws, policies and practices that create barriers to access to HIV testing, prevention, treatment, care and support (including harm reduction measures) for affected populations and that deny people living with HIV access to education, insurance, bank loans and employment in the armed forces
- Punitive laws that criminalise populations at higher risk of HIV exposure (such as men who have sex with men, people who use drugs and sex workers).

Reversing HIV trends and patterns to get to 90:90:90 and the end of AIDS as a public health threat by 2030 requires an effective response underpinned by a supportive and protective environment in the country.<sup>15</sup> The role of a supportive legal and policy environment in improving outcomes of HIV and AIDS interventions has been increasingly documented and recognized to include improving protection of rights, enhancing access to HIV and AIDS services and mitigating the impacts of the epidemic. Thus, as part of the national response to HIV, targeted actions to create an enabling legal and regulatory environment will also contribute to achieving the Sustainable Development Goals (SDGs).

The purpose of this project is to provide an assessment and analysis of the legal and regulatory aspects in the context of HIV and AIDS in Namibia. The assessment has been conducted by way of a desk review of documentation on selected laws, regulations and policies and a qualitative assessment of the level of knowledge on human rights among key and vulnerable populations; and of the degree of awareness of HIV related laws and human rights among law makers and law enforcers to enable effective implementation of services, access to justice and enforcement of HIV-related laws and rights. This report sets out the findings of the assessment and analysis and provides sound recommendations on actions required to create and strengthen the HIV-related legal and regulatory environment.

## Aims and Objectives

### Aim

The aim of the legal and regulatory analysis is to improve the availability of information and evidence of legal and regulatory aspects in the context of HIV and AIDS, for purposes of making recommendations for creating and strengthening an enabling environment that promotes an effective national AIDS response in accordance with the Republic of Namibia's National Strategic Framework 2010/11-2015/16 and the National Policy on HIV.

### Specific objectives

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<sup>14</sup> Ibid

<sup>15</sup> UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: [http://www.unaids.org/sites/default/files/media\\_asset/90-90-90\\_en\\_0.pdf](http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf)

The Situational Analysis aims to:

- Systematically analyse an agreed list of prioritized, relevant laws, regulations as well as policies and practices, where relevant, to determine how they undermine or support an enabling environment and national AIDS response,
- Analyse the extent to which affected populations know and are able to access their rights and service providers, lawmakers and law enforcers are sensitized to HIV-related law and human rights issues to enable effective implementation of services, access to justice and enforcement of HIV-related laws and rights; and
- Provide detailed and appropriate recommendations of selected laws and regulations considered necessary to be reformed, enacted or better enforced as well as appropriate measures to strengthen access to justice and improve law enforcement, to create an enabling framework for HIV and AIDS.

## Key Deliverables

The key deliverables under the project were as follows:

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

## Implementation Modalities

### Technical Approach

The Situational Analysis has been guided by a human-rights based approach to health, HIV and AIDS<sup>16</sup> using national, regional and international human rights commitments made by Namibia as the starting point for framing the enquiry, designing the tools for analysis, analysing the findings and developing the recommendations. In the context of HIV, this approach aims to promote the right to health and other related rights. It examines the legal, social, economic and/or cultural contexts which underlie the HIV epidemic in Namibia, with the broader aim of recognising and responding to the underlying inequalities, prejudices and power relationships that impact upon HIV transmission and access to HIV-related health care services in the country.

The main principles of the rights-based approaches that are proposed as guiding principles for the Situational Analysis are the principles of equality and non-discrimination; participation and inclusion

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<sup>16</sup>World Health Organisation (2009) *A Human Rights Based Approach to Health: Policy Brief*

of rights-holders; capacity building of duty-bearers and accountability. The Situational Analysis recognises the inter-relationship between all human rights, including health rights and equality rights, and seeks to balance public health and human rights goals in developing the rights of all people.

## Research Methodology

The Situational Analysis has been carried out using the various methodologies set out below:

### Desk Review

The Situational Analysis includes a desk review of all relevant documentation relating to HIV, law and human rights issues at national level, as well as regional and international levels in order to determine the scope and content of laws, regulations and policies as well as issues around how laws are implemented and enforced. Documents reviewed include:

- International and regional human rights commitments as well as regional and international health and HIV-specific commitments and guidance documents;
- Laws, regulations and policies as well as selected policies, plans and guidelines, where relevant;
- Case law; and
- Annual reports, research reports and other documents of civil society organisations working with health, HIV, people living with HIV and key populations; reports of government ministries, statutory bodies (such as the Office of the Ombudsman), regional and international organisations and academic publications.

The desk review aims to determine the nature, extent, efficacy and impact of the legal and regulatory framework (include laws, regulations and policies as well as access to justice and law enforcement issues) for protecting rights and promoting universal access to HIV prevention, treatment, care and support in Namibia. It furthermore makes recommendations for law review and reform as well as efforts to strengthen access to justice and law enforcement.

The desk review includes an initial focus on the key issues identified in the preparatory phase of the project. It furthermore identifies additional key HIV, law and human rights issues of concern within Namibia for further exploration during key informant interviews and focus group discussions.

*See Annexure 1 for a list of documents reviewed*

### Key Informant Interviews

The key informant interviews provided qualitative information on the views of decision-makers on key HIV, law and human rights issues within Namibia; the impact of the legal and regulatory framework upon the response to HIV and AIDS as well as recommendations for strengthening the legal and regulatory framework to protect rights and promote access to services in the context of HIV and AIDS.

Key informants were selected from across a range of sectors, including from government, civil society, the private sector and other partner institutions. They include relevant government officials from key ministries such as the Ministry of Health and Social Services, the Office of the Attorney-General, and the Ministry of Labour amongst others. They also include members of the National

Assembly, legal experts and the Office of the Ombudsman. Key informants also include representatives of Civil Society organisations working with and for people living with HIV and other affected populations, faith based organisations as well as development partners working on health, HIV and related issues.

*See Annexure 2 for a list of key informants interviewed*

### Focus Group Discussions

Focus Group Discussions (FGDs) were used to obtain qualitative data from selected populations on their experiences of stigma, discrimination and human rights violations in the context of HIV and AIDS, how laws, policies and practices impact upon rights and the ability to access services in the context of HIV and whether affected populations are able to access justice and enforce rights.

Focus group discussions included populations vulnerable to and at higher risk of HIV exposure such as persons living with HIV or AIDS, men who have sex with men, sex workers, prisoners and young people. They also included key service providers, such as health care providers at various levels and educators. The views and experiences of rights holders are critical to inform specific areas of laws that will need to be addressed.

*See Annexure 3 for a list of FGDs conducted*

### Data Management

The national consultant transcribed interviews from all KIIs and FGDs conducted; these notes were used for analyses.

### Consultative Workshops, Validation and Dissemination of Study Findings

The Situational Analysis process includes a consultative workshop involving all relevant stakeholders to obtain feedback and build consensus on the Situational Analysis findings and recommendations during the course of the project. The findings and recommendations of the final draft report were shared with a wide range of involved and affected stakeholders at a national stakeholders meeting on 19 November 2015 for feedback and validation. Feedback from this process has been incorporated into the final recommendations of this report.

### Oversight by Technical Working Group

The Situational Analysis was initially overseen by a Technical Working Group (TWG) made up of key stakeholders from a range of disciplines and sectors, including key government ministries, civil society organisations working on HIV and human rights issues and/or representing affected populations, international organisations and UN agencies. Unfortunately the TWG has not met for an extended period of time and has thus not been actively involved in reviewing or finalising this process.

*See Annexure 4 for a list of members of the TWG and Coordination team*

## The Situational Analysis Report

This Situational Analysis report reflects the outcome of the process, combining the findings of the desk review, the perspectives of key informants and populations participating within focus group discussions as well as the comments and feedback provided by key stakeholders throughout the process.

It consists of this and four other parts in total. Part II of the Analysis sets out the international, regional and national human rights framework to which Namibia has committed itself and which frames the investigation of HIV-related rights. Part III of the Analysis further details both the specific international and national perspective of the legal and policy issues relating to Equality and Anti-Discrimination; Health; Criminal Law and Law Enforcement; Employment; Education and Information; and Social Welfare. This part of the Report analyses the current situation and makes recommendations on how to address the gaps identified so as to be in line with international requirements vis a vis HIV, human rights and the law. Part IV details the current mechanisms in place relating to Access to Justice and Law Enforcement in Namibia, whilst providing an insight to actual access to justice by key populations and vulnerable groups and also makes recommendations on how to strengthen the system. Part V of the Report consolidates the Recommendations made in the two preceding parts of the document.

The following limitations to the Situational Analysis should be noted.

- Limited availability of existing research on the nature and extent of HIV-related stigma and discrimination against key populations at higher risk of HIV exposure
- Limited 'visibility' of people living with HIV and key populations at higher risk of HIV exposure
- Fears of confidentiality breaches and of HIV-related stigma and discrimination amongst affected populations
- Infrequent initial meetings of and lack of engagement by the technical working group
- Time and resource constraints

For this reason, the Situational Analysis was able to conduct a limited number of focus group discussions with affected populations. The analysis does not purport to provide definitive evidence of stigmatising and discriminatory practices but rather seeks to give voice to some of the experiences related by affected populations, for purposes of law and policy review. The invaluable perspectives provided by informants and focus groups are gratefully acknowledged.

## Part II

### International/Regional/National human rights framework

This section examines the international, regional and national human rights framework which should oversee and govern the national response to HIV and AIDS. The analysis considers:

- How international and regional human rights instruments apply to the regulation of law and human rights in Namibia;
- Key international and regional human rights instruments and an overview of the important human rights norms and standards within those frameworks that support effective national responses to HIV; and

- A further examination of selected human rights principles set out in international, regional and national law (especially the Constitution of Namibia) and a discussion of their application to HIV and AIDS

It is this understanding of each right, how it is interpreted to apply in the context of HIV and AIDs and what is or is not considered to be a reasonable limitation of the right in particular circumstances, which guides this analysis of the laws relating to HIV in Namibia.

## A. International Framework

International and regional human rights law provides an overarching framework for an analysis of the HIV, law and human rights issues in Namibia. International and regional human rights law is set out in the various charters, treaties and conventions signed and ratified by member states. Once a state has signed and ratified a treaty or convention, it agrees to be legally bound by that convention and to ensure that the principles and provisions of that instrument are domesticated and implemented at a national level. States are then required to report periodically to the relevant treaty monitoring body on their compliance with the provisions of each treaty.

‘Signature’ of a treaty is an act by which a state provides a preliminary endorsement of an agreement. Signing does not create a binding legal obligation but does demonstrate the state’s intent to examine the agreement and consider ratifying it. Whilst signing does not commit a state to ratification, it does oblige the state to refrain from acts that would defeat or undermine the treaty’s objective and purpose. ‘Ratification’ is an act by which a state signifies an agreement to be legally bound by the terms of a particular treaty. To ratify a treaty, the state first signs it and then fulfils its own national legislative requirements.

Article 144 of the Namibian Constitution provides that unless otherwise provided by the Constitution or Act of Parliament, the general rules of public international law and international agreements binding upon Namibia under this Constitution, shall form part of the law of Namibia. Namibia thus follows a monist system in terms of which all international treaties ratified by Namibia immediately become part of the national law.

Namibia is one of the few countries where international law is automatically part of the domestic law and can be enforced in the courts.<sup>17</sup> International law in this context means (a) international agreements that Namibia has entered into in accordance with the Namibian Constitution; (b) customary international law; and (c) general principles of law as recognised by the majority of domestic legal systems and international judicial bodies.

Even where states have not signed or ratified conventions or treaties, these can still be binding if their principles form part of what is known as customary international law.<sup>18</sup>

This legal assessment thus draws on international law and international and regional guidance on HIV, law and human rights, including the UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights*, as well as the findings of international and regional bodies and foreign courts on HIV and human rights matters.

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<sup>17</sup> The Namibian Supreme Court has affirmed that international agreements form “part of the law of Namibia” and must “be given effect to”. *Government of the Republic of Namibia and Others v Mwilima and all other accused in the Caprivi Treason Trial 2002 NR 235 (SC)* (per Strydom CJ) at 260H. Other Namibian cases have made similar statements.

<sup>18</sup> See Vienna Convention on the Law of Treaties, May 23, 1969, 1155 U.N.T.S.331, entered into force on Jan 27, 1980, article 18(1) Available at [http://untreaty.un.org/ilc/texts/instruments/english/conventions/1\\_1\\_1969.pdf](http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf).

## B. Human rights standards and the nature of State obligations

The Vienna Declaration and Programme of Action, adopted at the World Conference on Human Rights in June 1993, affirmed that, “all human rights are universal, indivisible, interdependent and interrelated.” States have the duty, regardless of their political, economic and cultural systems, to promote and protect universal human rights standards and fundamental freedoms. A human rights approach to HIV is, therefore, based on these State obligations with regard to human rights protection and hence promoting the health and dignity of its citizens.<sup>19</sup>

The Global Commission on HIV and the Law (GCHL) has found that there are instances where legal and justice systems have played constructive roles in responding to HIV, by respecting, protecting and fulfilling human rights. Compelling evidence shows that this is the way to reduce vulnerability to and mitigate the impact of HIV. Good laws can widen access to prevention and health care services, improve the quality of treatment, and enhance social support for the infected and affected and thereby protecting their human rights. For example laws that facilitate the implementation of harm reduction programmes such as needle exchange sites can contribute to a significant drop in HIV infection rates for people who use drugs. Even where punitive laws that criminalise key populations remain in place pending reform cooperation between police and community workers can result in increased condom use and a decrease in violence against sex workers. Effective legal aid can make justice and equality a reality for people living with HIV and thus create better health outcomes. Court actions and legislative initiatives can help introduce gender-sensitive sexual assault law and recognize the sexual autonomy of young people.<sup>20</sup>

Namibia has either signed or ratified the following human rights treaties, all of which include important rights in the context of HIV and AIDS:

- African Charter on Human and Peoples’ Rights, 1992
- African Charter on the Rights and Welfare of the Child, 2004
- Convention on the Rights of the Child (CRC), 1990
- Convention on the Rights of Persons with Disabilities, 2007
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1992
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1994
- International Convention on Civil and Political Rights (ICCPR), 1994
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2004

There are also several international and regional declarations, commitments and guidelines which deal specifically with HIV, human rights and gender equality. While not strictly legally binding, they are generally reflections of the application and interpretation of accepted international and regional human rights principles to the HIV epidemic. In this respect, they are important guidance for Namibia in its interpretation of its own human rights standards in the context of HIV and AIDS. In addition, many international and regional strategies and plans include guidance on law and policy responses to HIV and AIDS. As such, they provide important and persuasive guidance for the national response to HIV and AIDS.

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<sup>19</sup> Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS (2006 Consolidated Version) *International Guidelines on HIV/AIDS and Human Rights*

<sup>20</sup> Global Commission on HIV and the Law (2012) *Risks, Rights & Health*

### HIV and AIDS related commitments

- 2001 UNGASS *Declaration of Commitment on HIV/AIDS*
- 2006 UNGASS Political Declaration on HIV/AIDS - *Universal Access*
- 2011 UNGASS *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*
- 2000 UN Millennium Development Goals
- 2001 Abuja *Declaration on Universal Access: HIV/AIDS/TB/Malaria/STIs*
- 2003 Maseru Declaration
- 2006 Brazzaville *Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Supporting Africa in 2010*
- 2011 Windhoek *Declaration Women, Girls, Gender Equality and HIV: Progress towards Universal Access*
- 2012 African Union *Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa*

The key human rights principles which are essential to effective State responses to HIV, found in existing international instruments, are detailed below. Their specific application to the HIV response is further explored in Part C.

### Human rights principles relevant to HIV/AIDS

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

Particular attention should be paid to the human rights of children and women and those of other marginalized, vulnerable populations and key populations at higher risk of HIV exposure.<sup>21</sup> Key populations are defined by the country context and generally include men who have sex with men, transgender people, sex workers, people who use drugs and prisoners. They are often marginalised by society and by law and face unacceptable levels of stigma and discrimination, which hampers their ability to access HIV prevention, treatment and care services, placing them at higher risk of HIV infection.<sup>22</sup>

HIV prevalence amongst key populations tends, as a result, to be higher in communities where legislation does not ensure the protection of their human rights and where national health responses fail to ensure their right to health. High levels of prejudice and moral loading have also been shown to create barriers against accessing prevention, treatment, and other health care services. In 2011, the United Nations Populations Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) conducted a rapid assessment in five towns<sup>23</sup> in Namibia titled “Sex Work and HIV – reality on the ground”. The results indicated in all instances that sex workers were largely treated with disrespect at health care centres. This could include them being made to wait longer than other patients or made to sit in a different area to other patients. Distance to health care centres was also a problem in some instances. In many cases, medical attention was not

<sup>21</sup> UNAIDS and OHCHR (2006) *International Guidelines on HIV/AIDS and Human Rights*

<sup>22</sup> UNAIDS (2010) *Getting to Zero: 2011-2015 Strategy*

<sup>23</sup> Kalkrand, Katima Mulilo, Oshikango, Walvis Bay and Windhoek.

sought for sexually transmitted infections (STIs) due to the unfortunate treatment received and home remedies were utilized. Although the target group of the report was sex workers, anecdotal evidence seems to suggest that the situation of other key populations would be comparable.

### C. Limitation of Rights

Despite the importance attached to human rights, there are situations where it is considered legitimate to restrict rights to achieve a broader public good. As described in the International Covenant on Civil and Political Rights the public good can take precedence to "secure due recognition and respect for the rights and freedoms of others; meet the just requirements of morality, public order, and the general welfare; and in times of emergency, when there are threats to the vital interests of the nation."<sup>24</sup>

Public health is one such recognized public good. Traditional public health measures have generally focused on curbing the spread of disease by imposing restrictions on the rights of those already infected or considered most vulnerable to becoming infected. Coercion, compulsion, and restriction have historically been significant components of public health measures. Although the restrictions on rights that have occurred in the context of public health have generally had as their first concern protection of the public's health, the measures taken have often been excessive. Interference with freedom of movement when instituting quarantine or isolation for a serious communicable disease--for example, Ebola or typhoid--is an example of a restriction on rights that may in some circumstances be necessary for the public good and therefore could be considered legitimate under international human rights law. However, arbitrary measures taken by public health authorities that fail to consider other valid alternatives may be abusive of both human rights principles and public health "best practice." There are countless examples from around the world of this sort of abuse in the context of HIV and AIDS.<sup>25</sup>

Certain rights are absolute, which means that restrictions may never be placed on them, even if justified as necessary for the public good. These include rights such as the right to be free from torture, slavery, or servitude; the right to a fair trial; and the right to freedom of thought. Interference with most rights can be legitimately justified as necessary under narrowly defined circumstances. Limitations on rights, however, are considered a serious issue under international human rights law, regardless of the apparent importance of the public good involved. When a government limits the exercise or enjoyment of a right, this action must be taken only as a last resort and will only be considered legitimate if the following criteria are met:

1. The restriction is provided for and carried out in accordance with the law.
2. The restriction is in the interest of a legitimate objective of general interest.
3. The restriction is strictly necessary in a democratic society to achieve the objective.
4. There are no less intrusive and restrictive means available to reach the same goal.
5. The restriction is not imposed arbitrarily, i.e., in an unreasonable or otherwise discriminatory manner.<sup>26</sup>

The Namibian Constitution does not provide any general authority to limit fundamental rights. Some rights are absolute, while others may only be limited where a strict test set out in the Constitution

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<sup>24</sup> Human Rights and HIV/AIDS, S Gruskin, D Tarantola <http://hivinsite.ucsf.edu/InSite?page=kb-08-01-07#S3X> accessed on 19 March 2013

<sup>24</sup> United Nations Economic and Social Council (ECOSOC) (1985); The Siracusa Principles on the limitations and derogation provisions in the international covenant on civil and political rights. UN Doc. E/CN.4/1985/4, Annex

<sup>25</sup> Ibid.

<sup>26</sup> Human Rights and HIV/AIDS, S Gruskin, D Tarantola Available at <http://hivinsite.ucsf.edu/InSite?page=kb-08-01-07#S3X> accessed on 19 March 2013 and United Nations Economic and Social Council 1985; The Siracusa Principles on the limitations and derogation provisions in the International Covenant on Civil and Political Rights. UN Doc. E/CN.4/1985/4, Annex.

itself is met. This is the reason why in Namibia, unlike in many other countries, the extent of the right is often more important than whether the State is justified in limiting it.<sup>27</sup>

Article 22 of the Namibian Constitution provides:

Whenever or wherever in terms of this Constitution the limitation of any fundamental rights or freedoms contemplated by this Chapter is authorised, any law providing for such limitation shall: (a) be of general application, shall not negate the essential content thereof, and shall not be aimed at a particular individual; (b) specify the ascertainable extent of such limitation and identify the Article or Articles hereof on which authority to enact such limitation is claimed to rest.

It is significant that there is no general authority to limit or restrict the fundamental rights contained in the Bill of Rights. Where a limitation is expressly provided for in the text of the Namibian Constitution, it must pass the test of Article 22.<sup>28</sup>

There are thus two questions that must be asked when considering the limitation of a fundamental right. The first question is: does the right itself provide for limitation? If it does not, then the right is absolute and no limitation is permitted.<sup>29</sup> The second question is: If the right itself provides for limitation, then is that limitation permissible in terms of Article 22? The provision in Article 22(a) that a limitation should not “negate the essential content” of the right means that “it should not go further than what is necessary to achieve the object for which the limitation was enacted”, and the test to be applied is one of proportionality.<sup>30</sup> In *Kauesa* the Supreme Court held that limitations to fundamental rights must be both “reasonable and necessary” and that courts “should be strict in interpreting limitations to rights so that individuals are not unnecessarily deprived of the enjoyment of their rights”.<sup>31</sup>

The HIV epidemic has demonstrated that public health and human rights approaches may, and should be complementary and mutually supportive. The failure to protect the rights of people living with HIV and other vulnerable populations and key populations at higher risk of HIV exposure and the use of coercive or punitive responses may often serve to increase the spread and exacerbate the impact of HIV and AIDS.<sup>32</sup>

*“Public health interests do not conflict with human rights. On the contrary, it has been recognized that when human rights are protected, fewer people become infected and those living with HIV and their families can better cope with HIV and AIDS”*<sup>33</sup>

## D. The application of specific human rights in the context of the HIV and AIDS

### The Constitution of the Republic of Namibia

The Preamble of the Namibian Constitution recognizes that the inherent dignity of, and the equal and inalienable rights of all members of the human family are indispensable for freedom, justice and

<sup>27</sup> Namibian Law on LGBTI Issues, Legal Assistance Centre, 2015, 42

<sup>28</sup> *Alexander v Minister of Justice and Others* 2010 (1) NR 328 (SC) (per Strydom AJA) at para 119. See also *Namunjepo and Others v Commanding Officer, Windhoek Prison and Another* 1999 NR 271 (SC) (per Strydom CJ) at 280I-281J.

<sup>29</sup> In *Attorney-General of Namibia v Minister of Justice and Others*, the Supreme Court confirmed that the absolute prohibition at issue applied also in case of national emergency declared under Article 26. 2013 (3) NR 806 (SC) at paras 21-25 (per Shivute CJ). See also Article 24(3) of the Namibian Constitution.

<sup>30</sup> *Alexander v Minister of Justice and Others* [2010] NASC 2 (Strydom AJA), paras. 121-2.

<sup>31</sup> *Kauesa v Minister of Home Affairs and Others* 1994 NR 102 (HC) (per Dumbutshena AJA) at 190F-G.

<sup>32</sup> Human Rights and HIV/AIDS, S Gruskin, D Tarantola <http://hivinsite.ucsf.edu/InSite?page=kb-08-01-07#S3X> accessed on 19 March 2013

<sup>33</sup> UNAIDS and OHCHR (2006) *International Guidelines on HIV/AIDS and Human Rights*.

peace. These rights include the right of the individual to life, liberty and the pursuit of happiness, regardless of race colour, ethnic origin, sex, religion creed or social or economic status.

The Namibia Charter of Fundamental Human Rights and Freedoms are found in Chapter 3 of the Constitution and are listed as:

Article 5 Protection of Fundamental Rights and Freedoms  
Article 6 Protection of Life  
Article 7 Protection of Liberty  
Article 8 Respect for Human Dignity  
Article 9 Slavery and Forced Labour  
Article 10 Equality and Freedom from Discrimination  
Article 11 Arrest and Detention  
Article 12 Fair Trial  
Article 13 Privacy  
Article 14 Family  
Article 15 Children's Rights  
Article 16 Property  
Article 17 Political Activity  
Article 18 Administrative Justice  
Article 19 Culture  
Article 20 Education  
Article 21 Fundamental Freedoms

In terms of article 140(1) all laws which were in force immediately before the date of Independence shall remain in force until repealed or amended by Act of Parliament or until they are declared unconstitutional by a competent Court.

In *Government of the Republic of Namibia and Another v Cultura 2000 and Another*,<sup>34</sup> the Supreme Court of Namibia had occasion to consider article 140(3) of the Namibian Constitution which imputed the actions of the previous government upon the Government of the Republic of Namibia. In so doing, the Court was moved to outline what was needed for the proper interpretation of the Constitution and according to Mahomed CJ, the following was to be considered:

“A Constitution is an organic instrument. Although it is enacted in the form of a statute, it is sui generis. It must broadly, liberally and purposively be interpreted so as to avoid the austerity of tabulated legalism and so as to enable it to continue to play a creative and dynamic role in the expression and the achievement of the ideals and aspirations of the nation, in the articulation of the values bonding its people and in disciplining its Government. An interpretation of art 140(3) which limits its potential operation only to acts by the previous Administration which were uncompleted would not give to the clear words of the article a construction which is most beneficial to the widest possible amplitude.”

Or as was said by the court *S v Acheson*<sup>35</sup>

“The Constitution of a nation is not simply a statute which mechanically defines the structures of government and the relations between the government and the governed. It is a 'mirror reflecting the national soul', the

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<sup>34</sup> 1993 NR 328 (SC).

<sup>35</sup> 1991 NR 1 (HC) at 10A-C,

identification of the ideals and aspirations of a nation; the articulation of the values bonding its people and disciplining its government. The spirit and the tenor of the Constitution must therefore preside over and permeate the processes of judicial interpretation and judicial discretion.

The Court held in *Minister of Defence, Namibia v Mwandighi*<sup>36</sup> in respect of the Bill of Rights in the Namibian Constitution:

“The whole tenor of chap 3 and the influence upon it of international human rights instruments, from which many of its provisions were derived, call for a generous, broad and purposive interpretation that avoids ‘the austerity of tabulated legalism’”.

Thus even though HIV and AIDS are not listed as a prohibited ground of discrimination per se in the Constitution the Bill of Rights is to be interpreted broadly and expansively to include protection of fundamental rights where possible and thus affords protection against the unjustified limitation of rights solely on the basis of HIV status.

The preamble of the National Policy on HIV/AIDS (2007) highlights that an effective response to HIV/AIDS requires respect for, protection and fulfilment of all human, civil, political, economic, social and cultural rights; where all people are guaranteed freedom from discrimination on grounds of race, colour, sex, language, religion, political, nationality, ethnic or social origin, disability, property, birth or other status including HIV/AIDS status, in accordance with the provisions of the Constitution of Namibia and existing international human rights principles, norms and standards.

#### **Excerpts from the National Policy on HIV (2007)**

##### Policy Goals:

4. Facilitate the reduction of stigma and discrimination against people infected with and affected by HIV and AIDS.
6. Ensure that people infected with and affected by HIV/AIDS enjoy equal rights in a culture of openness and acceptance.

##### 1.5.3 Promotion and protection of human rights

International human rights law guarantees the right to equal protection before the law and freedom from discrimination on grounds, singly or in combination, of race, colour, sex, language, religion, political, nationality, ethnic or social origin, disability, property, birth and HIV/AIDS status. Discrimination on any of these grounds is not only wrong in law but it also creates and sustains conditions leading to vulnerability to HIV infection and to receiving adequate treatment, care and support once infected.

Groups suffering from discrimination which makes them vulnerable in the context of HIV/AIDS include women and young girls, orphans, street children, widows and widowers, children and young people, the poor, sex workers, prisoners, people awaiting trial, marginalized or minority groups, mobile populations, people with disabilities, refugees and displaced groups. An effective response to the epidemic requires the rights to equality before the law and the right to freedom from discrimination to be respected and protected, particularly with regard to gender relations between women and men on the one hand and girls and boys on the other.

<sup>36</sup> 1993 NR 63 (SC) at 71 F-G

## 2.2 Protection, participation and empowerment of people living with HIV/AIDS

In its Declaration of Commitment on HIV/AIDS, the United Nations General Assembly noted that the realisation of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS is an essential and central component of an effective response. Discrimination against people living with HIV/AIDS violates their rights and is counterproductive to an effective response to HIV/AIDS in that it constitutes a significant disincentive for voluntary counselling and testing, threatens voluntary disclosure of HIV status and increases vulnerability to HIV infection, thereby undermining efforts in response to the epidemic.

## 2.3 Protection, participation and empowerment of vulnerable groups

Many factors, such as poverty, gender inequalities, age and alcohol consumption, increase vulnerability to HIV infection. People who are underprivileged socially, culturally, economically or legally, including women and children and vulnerable populations such as orphans, widows and widowers, children and young people, the poor, sex workers, prisoners, people awaiting trial, mobile populations, uniformed services, marginalised or minority groups, street children, people with disabilities, refugees and displaced groups are considerably more vulnerable to the risks of HIV infection and consequently suffer disproportionately from the economic and social impacts of HIV/AIDS.

Persons belonging to these groups may be less able to fully access education, health care and social services and means of HIV prevention. They are often less able to enforce HIV prevention options and to access needed treatment, care and support.

In 1998, the Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS published the *International Guidelines on HIV/AIDS and Human Rights* as a tool for States in designing, coordinating and implementing effective national HIV policies and strategies. The Guidelines were drafted by experts at an international consultation in 1996 and provide the framework for a rights-based response to the HIV epidemic. The drafters of the Guidelines considered key human rights protected by international instruments, their interpretation by international bodies and institutions and their application to HIV, including considerations of where limitations of rights may or may not be reasonable and justifiable. As a result, the *Guidelines* provide an important guidance for all nations, outlining how human rights standards apply in the context of HIV and translating them into practical measures that should be undertaken at the national level, based on three broad approaches:

- improvement of government capacity for multi-sectoral coordination and accountability;
- reform of laws and legal support services, with a focus on anti-discrimination, protection of public health, and improvement of the status of women, children and marginalised groups; and
- support and increased private sector and community participation to respond ethically and effectively to HIV and AIDS.

OHCHR encourages governments, national human rights institutions, non-governmental organisations and people living with HIV and AIDS to use the *Guidelines* for training, policy formulation, advocacy, and the development of legislation on HIV-related human rights.

In light of developments in addressing the epidemic, a Third International Consultation in 2002 revised Guideline 6 on access to prevention, treatment, care and support.

In this report, the *International Guidelines* serve to set the scene for the application of the various rights in the context of HIV and AIDS and to guide recommendations on what steps Namibia needs

to undertake to ensure that these rights are being fulfilled. Their recommendations regarding justifiable and unjustifiable limitations of rights in the context of HIV and AIDS are an important guide to the application of human rights standards in the Namibian context.<sup>37</sup> In addition, the recent Global Commission on HIV and the Law (GCHL) (2012) *Risks, Rights & Health* report provides additional evidence of the harmful effects of punitive, coercive and discriminatory laws, policies and practices and recommendations for rights-based responses to promote universal access to HIV prevention, treatment, care and support.

### Right to Equality and Non-Discrimination

International human rights law guarantees the right to equal protection before the law and freedom from discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.<sup>38</sup>

Although HIV and AIDS is not specifically mentioned as a ground for non-discrimination, the Committee on Economic, Social and Cultural Rights (CESCR) has specifically stated that the list of prohibited grounds of discrimination is not exhaustive. The CESCR urges states to “ensure that a person’s actual or perceived health status is not a barrier to realising the rights under the Covenant”.<sup>39</sup> The Commission on Human Rights has confirmed that “other status” in non-discrimination provisions is to be interpreted to include health status, including HIV/AIDS.<sup>40</sup>

This means that States may not discriminate against people living with HIV or members of groups perceived to be at risk of infection on the basis of their actual or presumed HIV status.

The right to equality and non-discrimination in the context of HIV and AIDS has furthermore been interpreted as imposing an obligation on states to review and, if necessary, repeal or amend their laws, policies and practices to proscribe differential treatment which is based on arbitrary HIV-related criteria.<sup>41</sup>

The Constitution of Namibia also guarantees the right to equal protection of the law of all its citizens and to freedom from discrimination. Article 10 states that all persons shall be equal before the law and that no persons may be discriminated against on the grounds of sex, race, colour, ethnic origin, religion, creed or social or economic status.

In *Muller v President of the Republic of Namibia and Another*,<sup>42</sup> the appellant was a German national who had married a Namibian and was living in Namibia. The crux of the matter related to the fact that appellant wished to take his wife’s surname without following the administrative procedures outlined by relevant legislation. While his wife could take his surname without further ado, appellant could not do so and averred discrimination in terms of article 10 of the Namibian Constitution. The Supreme Court found article 10 could be utilized not only to prevent discrimination and inequality but also, in our context and history, to eliminate them. Additionally, the approach of our Courts towards article 10 of the Constitution should be as follows: that in regard to sub article (1)<sup>43</sup>, the questioned legislation would be unconstitutional if it allowed for differentiation between people or categories of people and that differentiation was not based on a

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<sup>37</sup> <http://www.ohchr.org/EN/Issues/HIV/Pages/InternationalGuidelines.aspx>

<sup>38</sup> Articles 2 and 7 of the UDHR, Article 2 of the ICCPR, Article 2(2) of the ICESCR and Articles 2 and 3

<sup>39</sup> CESCR, General Comment No. 20, 42nd Session, 2009, para. 27 and 33 Available at

<http://www2.ohchr.org/english/bodies/cescr/comments.htm>

<sup>40</sup> Commission on Human Rights Resolutions 1995/44 of 3 March 1995 and 1996/43 of 19 April 1996

<sup>41</sup> Human Rights Committee, General Comment No. 18 (37); Official Records of the General Assembly, Forty-fifth Session, Supplement No. 40 (A/45/40), vol. I, annex VI

<sup>42</sup> 1999 NR 190 (SC).

<sup>43</sup> Namibian Constitution, article 10(1): All persons shall be equal before the law.

rational connection to a legitimate purpose. On the other hand with regard to sub article (2)<sup>44</sup>, the following steps were to be taken to determine whether there was discrimination –

- (i) whether there existed a differentiation between people or categories of people;
- (ii) whether such differentiation was based on one of the enumerated grounds set out in the sub article;
- (iii) whether such differentiation amounted to discrimination against such people or categories of people; and
- (iv) once it was determined that the differentiation amounted to discrimination, it was unconstitutional unless it was covered by the provisions of article 23 of the Constitution (article 23 makes provision for affirmative action policies).

In the case at hand, the court found that the differentiation did not constitute discrimination against the appellant as provided for in the Namibian Constitution.

In the *Frans v Paschke and Others*<sup>45</sup> case, the court had to consider the position of a child born outside marriage in the context of inheritance from the father. Under common law, such child could not inherit intestate. The court found out that such differentiation between children born of a marriage and those born outside marriage, amounted to discrimination against the latter and declared that the common-law rule in terms of which they could not inherit intestate from their fathers, became unenforceable on 21 March 1990 when the Constitution was promulgated.

In *Nanditume v Minister of Defence*<sup>46</sup> the applicant had applied to be enlisted in the Namibian Defence Force. A medical examination and blood test revealed that he was HIV positive. His application for enlistment was refused on this ground. The court held that the exclusion of the applicant from the Defence Force on the ground that he had tested HIV positive constituted unfair discrimination in contravention of section 107 of the Labour Act<sup>47</sup> then in force, especially since the applicant was still in good health. This therefore amounted to discrimination in terms of status under article 10(2) of the Constitution.

Courts in the Southern African Development Community (SADC) have found HIV status to be a protected ground of non-discrimination in broad, constitutional anti-discrimination provisions. For example in the South African case of *Hoffman v South African Airways*<sup>48</sup> the court found that, even though HIV status was not specifically mentioned as a ground for non-discrimination in the Constitution's equality clause, the refusal by an airline company to employ an HIV-positive individual as a cabin attendant violated the right to equality and freedom from discrimination. In the Malawian Industrial Relations Court case of *Banda v Lekha*<sup>49</sup> the court was asked to define the scope of Malawi's constitutional right to be free from discrimination, and whether the right included the basis of HIV status. In answering this question, the Court examined its national law, national HIV policy and its obligations under international and regional law. The court held:

“Section 20 of the Constitution prohibits unfair discrimination of persons in any form. Although the section does not specifically cite discrimination on the basis of one's (*sic*) HIV status, it is to be implied that it is covered under the general statement of anti-discrimination in any form... Malawi ratified the African Charter which came into force on 21 October 1986 and it also ratified Convention 111 on 22 March 1965 both of which, place a constitutional duty on the State to pass protective legislation and formulate national policy

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<sup>44</sup> Namibian Constitution, article 10(2): No persons may be discriminated against on the grounds of sex, race, colour, ethnic origin, religion, creed or social or economic status.

<sup>45</sup> 2007 (2) NR 520 (HC).

<sup>46</sup> 2000 NR 103 (LC).

<sup>47</sup> Act 6 of 1992.

<sup>48</sup> 2001 (1) SA 1 (CC). See also *Nanditume v Minister of Defence* 2000 NR 103.

<sup>49</sup> IRC 277 of 2004

that give effect to fundamental rights entrenched in the Charter and the Convention. Malawi has formulated the National AIDS policy, which among other things is aimed at ensuring that all people affected or infected with HIV are equally protected under the law.”

Additionally, the specific mention of HIV as a ground for non-discrimination in employment legislation is arguably a strong indication that it is considered to be an important factor in national anti-discrimination provisions. Article 5(2)(f) of the Labour Act of 2007, states that a person must not discriminate in any employment decision directly or indirectly, or adopt any requirement or engage in any practice which has the effect of discrimination against any individual on the grounds of AIDS or HIV status.

Article 8 of the Namibian Constitution also guarantees the right to dignity of all persons. It provides that the dignity of all persons shall be inviolable.

In the case of *Ex Parte Attorney-General: In re Corporal Punishment by Organs of State*<sup>50</sup> it was held that the imposition of any sentence by any judicial or quasi-judicial authority, or directing any corporal punishment upon any person is unlawful and in conflict with article 8 of the Constitution of the Republic of Namibia<sup>51</sup>. This would include the infliction of corporal punishment in Government schools pursuant to the then existing code formulated by the Ministry of Education.

The court further stated that in the interpretation of article 8, the Namibian Constitution seeks to articulate the aspirations and values of the new Namibian nation following upon independence. It expresses the commitment of the Namibian people to the creation of a democratic society based on respect for human dignity, protection of liberty and the rule of law. Practices and values which are inconsistent with or which might subvert this commitment are vigorously rejected. Article 8 of the Constitution must therefore be read not in isolation but within the context of a fundamental humanistic constitutional philosophy introduced in the preamble and woven into the manifold structures of the Constitution.

No derogation from the rights entrenched by article 8 is permitted. This is clear from article 24(3) of the Constitution (this article sets out in respect of which constitutional articles derogation is permitted in certain circumstances). The State’s obligation is absolute and unqualified.

In *S v Likuwa*<sup>52</sup> the accused had been convicted of a contravention of section 29(1) (a) of the *Arms and Ammunition Act*<sup>53</sup>. He had been sentenced to the prescribed minimum sentence of 10 years in terms of section 38(2) (a) of the Act. The question on review was whether section 38(2)(a) was unconstitutional, in that such minimum sentence constituted cruel, inhuman or degrading treatment in terms of article 8(2) of the Constitution or in violation of article 10 which provided for equality before the law.

The Court held that the test to be adopted was the disproportionality test, which amounted to the Court asking whether the sentence was so excessive that a reasonable court would not have imposed such sentence. The court found that it was disproportional to the conduct perpetrated.

In *Namunjepo and Others v Commanding Officer, Windhoek Prison and Another*<sup>54</sup>, the appellants were awaiting trial prisoners who had escaped from lawful custody. On their recapture they had been placed in leg-irons for periods ranging between five and six months. In deciding whether there was an infringement of art 8(2) (b), which states that “No persons shall be subject to torture, or to cruel, inhuman or degrading treatment or punishment”, the court had to involve a value judgment

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<sup>50</sup> 1991 NR 178 (SC)

<sup>51</sup> Act 1 of 1990.

<sup>52</sup> 1999 NR 151 (HC).

<sup>53</sup> Act 7 of 1996.

<sup>54</sup> 1999 NR 271 (SC).

based on the current values of the Namibian people, in conjunction with the dreams and aspirations of the citizens entailed in the Namibian Constitution.

The court saw that the people of Namibia shared basic values with all civilised countries and for that reason it was useful and important to look at interpretations of other jurisdictions although the determining factor remained the values expressed by the Namibian people as reflected, *inter alia*, in its various institutions.

Moreover, the court indicated that imprisonment did not deprive a prisoner of all or every basic right which the ordinary citizen enjoyed. It did not mean that a prisoner could be regarded as a person without dignity. Thus the court held that the placing of a prisoner in leg-irons or chains was an impermissible invasion of article 8(2)(a), which state that the “dignity of all persons shall be inviolable” and contrary to article 8(2)(b) of the Constitution as it at least constituted degrading treatment and the Court should therefore declare such practice unconstitutional.

Following on this case and in *Engelbrecht v Minister of Prisons and Correctional Services*<sup>55</sup> the Plaintiff was successful in a claim for damages for injurious treatment and infringement of personal safety. Plaintiff, an awaiting trial prisoner, had been placed in leg-irons. He had also spent some time in solitary confinement. It appeared from the evidence that plaintiff had assaulted prison officers and his behaviour caused some trouble. However, he still remained under the protection of article 8 of the Namibian Constitution. No matter his behaviour, proportional force has to be used to safeguard his right to dignity.

Internationally, in some jurisdictions, the right to equality has been closely linked to the right to dignity. Canadian courts have interpreted human dignity as meaning “that an individual or group feels self-respect and self-worth” and recognises that human dignity is harmed by acts of unfair discrimination.<sup>56</sup> “Human dignity is harmed when individuals and groups are marginalised, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society.”<sup>57</sup>

In the South African *Hoffmann* case, the court held that; “[a]t the heart of the prohibition of unfair discrimination is the recognition that under our Constitution all human beings, regardless of their position in society, must be accorded equal dignity. That dignity is impaired when a person is unfairly discriminated against.” The court used this test of dignity to read HIV status into the list of prohibited grounds in the Constitution, noting that people living with HIV were a minority who had been subjected to systemic disadvantage and discrimination making them one of the most vulnerable groups in society.<sup>58</sup> This suggests that equality and dignity rights should not only protect all people from unfair discrimination but should also pay special attention to the rights of marginalised populations.<sup>59</sup>

The GCHL’s investigation into the impact of people living with HIV and AIDS, and how stigma and discrimination impact on universal access to HIV prevention, treatment, care and support illustrates the importance of rights-based responses to HIV. In Part III A, below, we examine specific acts of HIV-related discrimination in Namibia.

## Right to Privacy

The right to privacy is guaranteed at the international level through various human rights treaties, which include Article 12 of the UDHR, Article 37 of the Convention on the Rights of the Child (CRC)

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<sup>55</sup> 2000 NR 230 (HC).

<sup>56</sup> *Law v Canada* (1999) 1 SCR 497, para 53; See also *Hoffmann v SAA* 2001 (1) SA 1 (CC)

<sup>57</sup> *Law v Canada* (1999) 1 SCR 497, para 53

<sup>58</sup> *Hoffmann v SAA* 2001 (1) SA 1 (CC) at para 28

<sup>59</sup> Malawi (2012) *Assessment of Legal, Regulatory & Policy Environment for HIV and AIDS in Malawi*

and Article 17(1) of the ICCPR. The latter states that “no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence or to unlawful attacks on his honour and reputation”.

In the Namibia, the right to privacy is guaranteed under Article 13 of the Constitution, which provides that no persons shall be subject to interference with the privacy of their homes, correspondence or communications. However, the Constitution also provides that the right to privacy can be limited in accordance with law and as is necessary in a democratic society; in the interests of national security, public safety or the economic well-being of the country, for the protection of health or morals, for the prevention of disorder or crime or for the protection of the rights or freedoms of others.

There is limited Namibian jurisprudence to interpret the right to privacy and what this means for HIV as well as what would be considered to be reasonable limitations of the right to privacy in the context of HIV and AIDS. However, there is both international and regional guidance on the right to privacy, informed consent to HIV testing, confidentiality and disclosure, which is helpful in interpreting the right to privacy in relation to HIV. The UNAIDS *International Guidelines* states that the right to privacy encompasses obligations to respect physical privacy, including the obligation to seek informed consent to HIV testing, as well as privacy of information, including the need to respect confidentiality of all information relating to a person’s HIV status.<sup>60</sup>

The *International Guidelines* argue that limiting the right to privacy, through mandatory HIV testing, is an unjustifiable and discriminatory limitation of human rights.<sup>61</sup> The *Guidelines* furthermore recommend against limiting privacy rights through disclosure of a person’s HIV status without the person’s consent. They recommend that disclosure of a person’s HIV status should only take place under exceptional circumstances, where there is a clear risk to a third person (e.g. a sexual partner) and only after various steps have been taken to encourage voluntary disclosure. These issues are discussed in further detail, in Part III, B dealing with health care laws and policies.

In protecting the right to privacy, the State has a duty to protect the right to privacy, which includes the obligation to guarantee that adequate safeguards are in place to ensure that no testing occurs without informed consent; that confidentiality is protected, particularly in health and social welfare settings, and that information on HIV status is not disclosed to third parties, without the consent of the individual. In this context, States must also ensure that HIV-related personal information is protected in the reporting and compilation of epidemiological data and individuals are protected from arbitrary interference with their privacy in the context of media investigation and reporting.<sup>62</sup>

### Right to Marry and to Found a Family and Protection of the Family

The right to marry and to found a family is protected in the Universal Declaration of Human Rights (UDHR) and encompasses the right of “men and women of full age, without any limitation due to race, nationality or religion...to marry and to found a family”; to be “entitled to equal rights as to marriage, during marriage and at its dissolution” and to protections by society and the State of the family as “the natural and fundamental group unit of society”.<sup>63</sup>

Article 14 of the Namibian Constitution also guarantees the right to family life. The state recognises that men and women of full age - without any limitation due to race, colour, ethnic origin,

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<sup>60</sup> UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights*

<sup>61</sup> International Federation of Red Cross and Red Crescent Societies and Francois-Xavier Bagnoud Center for Health and Human Rights (1999) ‘Human Rights: An Introduction’ in Mann J et al (Eds) *Health and Human Rights: A Reader* Routledge, New York

<sup>62</sup> UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights*

<sup>63</sup> Article 16 of the Universal Declaration of Human Rights

nationality, religion, creed or social or economic status shall have the right to marry and to found a family. They shall be entitled to equal rights as to marriage, during marriage and at its dissolution. Article 14 further provides that marriage shall be entered into only with the free and full consent of the intending spouses and that the family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

The right to form a family extends to all people, including people living with HIV. This is recognised by the National HIV Policy, which provides that strategic programmes for discordant couples must be reoriented and geared towards family stability,<sup>64</sup> and that “special focus will also be placed on ensuring that all seropositive persons’ sexual and reproductive health rights shall be upheld.”<sup>65</sup>

Acts that may violate a person living with HIV’s right to found a family may include acts that coerce or force people living with HIV not to have children, to terminate a pregnancy or to become sterilized.

### Right to Freedom of Movement

The right to freedom of movement encompasses the rights of everyone lawfully within a territory of a State to liberty of movement within that State and the freedom to choose his/her residence, as well as the rights of nationals to enter and leave their own country.

Article 21(g) of the Constitution guarantees that all persons shall have the right to move freely through Namibia. This freedom shall, however be exercised subject to the law of Namibia, in so far as such law imposes reasonable restrictions on the exercise of the rights and freedoms conferred, which are necessary in a democratic society and are required in the interests of the sovereignty and integrity of Namibia, national security, public order, decency or morality, or in relation to contempt of court, defamation or incitement to an offence.

Any limitation of the right to freedom of movement is generally unjustifiable in the context of HIV and AIDS. The UNAIDS *International Guidelines* have examined the issue of restricting freedom of movement (e.g. through HIV screening and denying entry to foreigners on the basis of HIV status) for purposes of public health, in the context of HIV and AIDS. They argue that there is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status and that measures to contain other infectious diseases should not be inappropriately applied to HIV and AIDS. These restrictions are argued to be discriminatory and unjustified by public health concerns.<sup>66</sup> The *Guidelines* furthermore note that “Where States prohibit people living with HIV/AIDS from longer-term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency. In considering entry applications, humanitarian concerns, such as family reunification and the need for asylum, should outweigh economic considerations.”

This issue is discussed in further detail, in Part III, A below

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<sup>64</sup> Para 83

<sup>65</sup> Para 63

<sup>66</sup> UNAIDS and OHCHR (2006) *International Guidelines on HIV/AIDS and Human Rights*. According to the WHO (1969) *International Health Regulations*, the only disease which requires a certificate of inoculation for international travel is yellow fever.

## Right to Liberty and Security of Person

Article 9 of the ICCPR provides that, “everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law”. The right to liberty is also reflected and guaranteed under Article 7 of the Namibian Constitution which states that, “no persons shall be deprived of personal liberty except according to procedures established by law.”

Although there has been limited discussion by UN Committees on the right to liberty and security of the person in the context of HIV testing, the Special Rapporteur on the Right to Health has stated as follows:

“Guaranteeing informed consent is a fundamental feature of respecting an individual’s autonomy, self-determination and human dignity in an appropriate continuum of voluntary health care services . . . Informed consent invokes several elements of human rights that are indivisible, interdependent and interrelated. In addition to the right to health, these include the right to self-determination, freedom from discrimination, freedom from non-consensual experimentation, *security and dignity of the human person*, recognition before the law, freedom of thought and expression and reproductive self-determination.”<sup>67</sup>

The *International Guidelines on HIV/AIDS and Human Rights* note that “compulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of a person” and that “respect for the right to physical integrity requires that testing be voluntary and that no testing be carried out without informed consent”. These *Guidelines* further note that these coercive measures are often used with regard to populations least able to protect themselves because they are within the ambit of government institutions (e.g. soldiers) or the criminal law (e.g. prisoners, sex workers, people who use drugs and men who have sex with men.)<sup>68</sup> The *Guidelines* furthermore provide that deprivations of liberty (e.g. through quarantine, isolation or detention) on the basis of a person’s HIV status are not justified by public health concerns.<sup>69</sup> These issues are discussed in further detail in Part III, B, below.

The UNAIDS *International Guidelines* do recognise that restrictions on the right to liberty and security of the person may be warranted in exceptional cases concerning deliberate or dangerous behaviour - an example may be in the case of sexual violence that places others at risk of HIV infection. However, the *Guidelines* note that such exceptional cases should be handled under the ordinary provisions of public health, or criminal laws, with appropriate due process protection.<sup>70</sup>

## Right to Education

Article 26 of the UDHR states in part that “Everyone has the right to education. Education shall be directed to the full development of the human personality and to the strengthening of respect for

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<sup>67</sup> Report of the Special Rapporteur on Health: Informed Consent (2009) at paras. 18-19, cited in Southern African Litigation Centre (2012) *Protecting Rights: Litigating Cases of HIV Testing and Confidentiality of HIV Status*.

<sup>68</sup> At para 135

<sup>69</sup> At para 133

<sup>70</sup> At para 134

human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship...”

The right to equal access to education is guaranteed under the Constitution of Namibia. Article 20 states that all persons shall have the right to education and that children shall not be allowed to leave school until they have completed their primary education or have attained the age of sixteen years, whichever is the sooner, save in so far as this may be authorised by Act of Parliament on grounds of health or other considerations pertaining to the public interest.

Since all persons have the right to education, this right extends to people living with HIV. States should ensure that both children and adults living with HIV are not discriminatorily denied access to education, including access to schools, universities, scholarships and international education or subject to restrictions because of their HIV status. There is no public health rationale for such measures since there is no risk of transmitting HIV casually in educational settings. In 2013 the Ministry of Education prepared a Policy of Inclusive Education which outlines its purpose as follows:

“Inclusive education does not pertain only to integrating children and young people with disabilities, or those who are vulnerable, into mainstream schools, or only to ensuring that excluded learners have access to education. Inclusive education means ending segregation or the deliberate exclusion of individuals or groups on the grounds of academic performance, gender, race, culture, religion, lifestyle, **health conditions** or disability.”

This policy should therefore also provide for children living with HIV as well as children of people living with HIV. The concern is however that much of success of the interventions will depend on the individual schools, their ethos and their resources. As the policy further states:

“To succeed, every school must have access to resources such as specialist support for addressing learning, language or behaviour needs which may arise.”

## Right to the Highest Attainable Standard of Physical and Mental Health

The Universal Declaration of Human Rights (UDHR) states that; “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including...medical care”.<sup>71</sup> The International Covenant on Economic, Cultural and Social Rights (ICESCR) elaborates on this right, recognizing “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and placing an obligation on states to take steps to “achieve the full realization of this right”.<sup>72</sup> The right to the highest attainable standard of physical and mental health comprises, inter alia, “the prevention, treatment and control of epidemic...diseases” and “the creation of conditions which would assure to all medical service and medical attention in the event of sickness”.<sup>73</sup>

International law obliges states to provide a range of available, accessible, acceptable and quality health care information and prevention and treatment services in recognising health rights. The CESCR’s General Comment No. 14 provides detailed guidance on the scope of Article 12(1) and the rights and duties it imposes on the state.<sup>74</sup> It recognises the importance of making a range of health

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<sup>71</sup> Article 27(1) *Universal Declaration of Human Rights* 1948.

<sup>72</sup> Article 12 *ICESCR* 1976

<sup>73</sup> Article 12, *ICESCR* 1976

<sup>74</sup> CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [*hereinafter* CESCR, General Comment No. 14], Available at <http://www2.ohchr.org/english/bodies/cescr/comments.htm>

services and information *available, accessible and acceptable*, to allow individuals to engage in meaningful decision-making regarding their health. This includes ensuring, *inter alia*, the following:

- Access to essential medicines as defined by the WHO Action Programme on Essential Drugs<sup>75</sup>
- Health education and information, including sexual and reproductive health information should be available to all and should not be censored, withheld or intentionally misrepresented<sup>76</sup>
- Provision for self-determination, including reproductive self-determination, through the protection of the right to freely consent to medical treatment<sup>77</sup>
- Respect for medical ethics, including the confidentiality of medical information<sup>78</sup>
- Provision for a system of health protection which provides equality of opportunity for people to enjoy the highest attainable standard of health,<sup>79</sup> in terms of which “[h]ealth facilities, goods and services have to be accessible to everyone without discrimination...especially the most vulnerable or marginalized sections of the population” including “persons with HIV/AIDS”<sup>80</sup>

#### **CESCR General Comment No 14 on the Right to the Highest Attainable Standard of Health**

“The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation.”<sup>81</sup>

General Comment 14 furthermore recognises that the duties of States includes the duty, *inter alia*, “to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; [and] to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services”.<sup>31</sup>

In order to meet these obligations in the context of HIV, the UNAIDS *International Guidelines* recommend that States should ensure the provision of a range of services without discrimination and with a particular focus on vulnerable populations, including, *inter alia*, HIV-related information, education and support, including access to services for sexually transmitted diseases, the means of prevention (such as condoms and clean injection equipment), voluntary and confidential HIV testing with pre-and post-test counselling as well as to treatment, care and support for those affected by HIV and AIDS.

Given that in practice, availability of medicines depends on affordability, which in turn depends on whether the price is within the reach of users, States are under a clear obligation to adopt measures to make medicines more affordable, and thus accessible. The *International Guidelines* recognise that this requires reviewing bilateral, regional and international agreements (such as those dealing with intellectual property) and national laws to promote access to affordable medicines.<sup>82</sup> Similarly, the recent GCHL report recognises the need for states to develop effective intellectual property regimes for pharmaceutical products that are consistent with international human rights law and public

<sup>75</sup> General Comment No. 14 at para 43 provides that central elements of the right to health also include medical care in the event of sickness, as well as the prevention, treatment and control of diseases, all of which depend upon access to medicines

<sup>76</sup> General Comment 14, para 34

<sup>77</sup> General Comment 14, para 8

<sup>78</sup> General Comment 14, para 12

<sup>79</sup> General Comment No. 14 at para.8

<sup>80</sup> General Comment No. 14 at para 12

<sup>81</sup> *Id.* at para. 8

<sup>82</sup> At para 52 and 53

health needs, while safeguarding the justifiable rights of inventors. Part of the strategy to make medicines affordable must include, amongst other things, a patent framework that is flexible to incorporate public health needs.

With respect to marginalized populations, the *Guidelines* emphasise that “[s]tates may have to take special measures to ensure that all groups in society, particularly marginalized groups, have equal access to HIV-related prevention, care and treatment services. The human rights obligations of States to prevent discrimination and to assure medical service and medical attention for everyone in the event of sickness, require States to ensure that no one is discriminated against in the health-care setting on the basis of their HIV status.”<sup>83</sup>

Article 95 of the Namibian Constitution states provides that the state shall actively promote and maintain the welfare of the people by adopting, inter alia, policies aimed at consistent planning to raise and maintain an acceptable level of nutrition and standard of living of the Namibian people and to improve public health. It further provides that every citizen has a right to fair and reasonable access to public facilities and services in accordance with the law.

### Right to an Adequate Standard of Living and Social Security Services

Article 25 of the Universal Declaration of Human Rights states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”. Similarly, Article 9 of the ICESCR recognise the right of everyone to social security, including social insurance.

In the context of HIV and AIDS, the UNAIDS *International Guidelines* note the link between protecting people’s right to an adequate standard of living and reducing people’s vulnerability to the risk and consequences of HIV infection. They note that social security “is particularly relevant to meeting the needs of people living with HIV and AIDS, and/or their families, who have become impoverished by HIV and AIDS as a result of increased morbidity due to AIDS and/or discrimination which can result in unemployment, homelessness and poverty” and that people living with HIV should be prioritised as particularly vulnerable, in the allocation of resources. States have to ensure that people living with HIV are not discriminatorily denied an adequate standard of living and/or social security and support services on the basis of their health status.<sup>84</sup>

Article 95 of the Namibian Constitution provides that the state shall actively promote and maintain the welfare of the people by adopting, inter alia, policies aimed at enactment of legislation to ensure that the unemployed, the incapacitated, the indigent and the disadvantaged are accorded such social benefits and amenities as are determined by Parliament to be just and affordable with due regard to the resources of the State. It further provides that workers should be paid a living wage adequate for the maintenance of a decent standard of living and the enjoyment of social and cultural opportunities; and consistent planning to raise and maintain an acceptable level of nutrition and standard of living of the Namibian people and to improve public health.

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<sup>83</sup> UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights*, at para 146.

<sup>84</sup> At para 148

## Right to Work

The UDHR protects employment rights. It states that “[e]veryone has the right to work... [and] to just and favourable conditions of work”.<sup>85</sup> Article 6 of the ICESCR furthermore recognises the right to work, which includes “the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts.” At an international level, the concept of non-discrimination on the basis of HIV status in the working environment is well established. Article 6 of the ICESCR read with the principle of non-discrimination in the Covenant has been recognised by the CESCR as requiring States to guarantee that the right to work is exercised without discrimination on the basis of health status, including HIV or AIDS:

“Under its article 2, paragraph 2, and article 3, the Covenant prohibits any discrimination in access to and maintenance of employment on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, or civil, political, social or other status, which has the intention or effect of impairing or nullifying exercise of the right to work on a basis of equality.”<sup>86</sup>

The UNAIDS *International Guidelines on HIV/AIDS and Human Rights* recognise that the right to work entails the right of every person to access to employment without any pre-condition except the necessary occupational qualifications. For this reason, they argue that this right is violated when an applicant or employee is forced to test for HIV, is refused employment, dismissed or refused access to employee benefits on the basis of being HIV-positive.<sup>87</sup> They furthermore recognise that the right to favourable conditions of work (including safe and healthy working conditions) require employers to protect employees from the risk of occupational infection with HIV.<sup>88</sup>

The International Labour Organisation (ILO) has also set out detailed guidance on HIV-related workplace rights. In its most recent *Recommendation concerning HIV & AIDS and the World of Work 200* of 2010, it commits member states “to tap into the immense contribution that the world of work can make to ensuring universal access to prevention, treatment, care and support” for HIV and AIDS. The Recommendations apply to all workplaces, including the private and public sector, as well as to all workers including employees, job applicants, trainees, interns and members of the armed and security forces. They recognise the need to strengthen workplace prevention efforts and to facilitate access to treatment for persons living with or affected by HIV and AIDS and call for the design and implementation of national tripartite workplace policies and programmes on HIV and AIDS to be integrated into overall national policies and strategies on HIV and AIDS and on development and social protection. The Recommendation also invites member States to implement its provisions through amendment or adoption of national legislation where appropriate.<sup>89</sup>

### Recommendation Concerning HIV and AIDS & the World of Work 200 of 2010

<sup>85</sup> Article 23 Universal Declaration of Human Rights

<sup>86</sup> Committee on Economic, Social and Cultural Rights 35<sup>th</sup> session 2005 General Comment No.18 at para 12(b)

<sup>87</sup> At para 149

<sup>88</sup> At para 150

<sup>89</sup> ILO Recommendation 200 of 2010

### **General principles**

- (a) the response to HIV and AIDS should be recognized as contributing to the realisation of human rights and fundamental freedoms and gender equality for all, including workers, their families and their dependants;
- (b) HIV and AIDS should be recognized and treated as a workplace issue, which should be included among the essential elements of the national, regional and international response to the pandemic with full participation of organizations of employers and workers;
- (c) there should be no discrimination against or stigmatization of workers, in particular jobseekers and job applicants, on the grounds of real or perceived HIV status or the fact that they belong to regions of the world or segments of the population perceived to be at greater risk of or more vulnerable to HIV infection;
- (d) prevention of all means of HIV transmission should be a fundamental priority;
- (e) workers, their families and their dependants should have access to and benefit from prevention, treatment, care and support in relation to HIV and AIDS, and the workplace should play a role in facilitating access to these services;
- (f) workers' participation and engagement in the design, implementation and evaluation of national and workplace programmes should be recognised and reinforced.

With respect to workers' rights, the ILO Recommendation calls for, amongst other things:

- Non-discrimination on the basis of real or perceived HIV status
- Gender equality in the working environment
- Reasonable accommodation for workers with HIV within the working environment
- Protecting sexual and reproductive health rights of workers
- Prevention, treatment and care strategies within the working environment
- The provision of a safe and healthy working environment for all, including measures to prevent occupational infection with HIV
- A prohibition on compulsory HIV testing and disclosure of HIV status of workers, including migrant workers, job seekers and job applicants, while encouraging voluntary and confidential HIV testing

### **Recommendation Concerning HIV/AIDS and the World of Work, 200 of 2010**

27. Workers, including migrant workers, jobseekers and job applicants, should not be required by countries of origin, of transit or of destination to disclose HIV-related information about themselves or others. Access to such information should be governed by rules of confidentiality consistent with the ILO code of practice on the protection of workers' personal data, 1997, and other relevant international data protection standards.

28. Migrant workers, or those seeking to migrate for employment, should not be excluded from migration by the countries of origin, of transit or of destination on the basis of their real or perceived HIV status.

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

Other relevant international employment-related documents which States need to consider include the following:

ILO Code of Practice on HIV and AIDS, 2001

Discrimination (Employment and Occupation) Convention, 1958

Termination of Employment Convention, 1982

Occupational Safety and Health Convention, 1981,

Promotional Framework for Occupational Safety and Health Convention, 2006

Joint International Labour Office and WHO guidance documents.

Tripartite Consultation (International Labour Standards) Convention, 1976

Joint ILO/WHO Guidelines on Health Services and HIV/AIDS, 2005

In Namibia Article 5(2) of the Labour Act 11 of 2007 states that, “a person must not discriminate in any employment decision directly or indirectly, or adopt any requirement or engage in any practice which has the effect of discrimination against any individual on one or more of the following grounds;

- (a) race, colour, or ethnic origin;
- (b) sex, marital status or family responsibilities;
- (c) religion, creed or political opinion;
- (d) social or economic status;
- (e) degree of physical or mental disability;
- (f) AIDS or HIV status; or
- (g) previous, current or future pregnancy.”

The case of *Nanditume v Minister of Defence*<sup>90</sup> which has already been referred to in the section on “The Right to Equality and Non-Discrimination” above also has application in this context and is thus repeated here. The applicant had applied to be enlisted in the Namibian Defence Force. A medical examination and blood test revealed that he was HIV positive. His application for enlistment was refused on this ground. The court held that the exclusion of the applicant from the Defence Force on the ground that he had tested HIV positive constituted unfair discrimination in contravention of the Labour Act<sup>91</sup> then in force, especially since the applicant was still in good health.

### Freedom from Cruel, Inhuman or Degrading Treatment or Punishment

Article 7 of the International Covenant on Civil and Political Rights (ICCPR) prohibits the use of torture, cruel, inhuman or degrading treatment or punishment. The Human Rights Committee has said that the aim of article 7 is to “protect both the dignity and the physical and mental integrity of the individual”<sup>92</sup> from not only acts that cause physical pain but also acts that cause mental suffering.

Article 8(2) (b) of the Namibian constitution provides that no persons shall be subject to torture or to cruel, inhuman or degrading treatment or punishment.

<sup>90</sup> 2000 NR 103 (LC).

<sup>91</sup> In particular section 107 of Act 6 of 1992.

<sup>92</sup> Human Rights Committee, 44<sup>th</sup> Session, 1992, General Comment No. 20 at para 2

In international law, the right to freedom from cruel, inhuman or degrading treatment or punishment often focuses on the treatment of prisoners, protecting prisoners from actions that cause physical and mental pain and suffering. In the context of HIV and AIDS, the *International Guidelines* emphasise that while imprisonment is punishment by deprivation of liberty, it should not result in the loss of human rights or dignity. The *Guidelines* provide that the duty of care owed to prisoners includes the duty to protect the rights to life and to health of all persons in custody. In the context of HIV and AIDS, they note that the denial to prisoners of access to HIV-related information, education and the means of prevention (bleach, condoms, clean injection equipment), voluntary testing and counselling, confidentiality and HIV-related health care and access to and voluntary participation in treatment trials, could constitute cruel, inhuman or degrading treatment or punishment.<sup>93</sup> The *Guidelines* furthermore provide that:

- The duty of care towards prisoners also comprises a duty to combat prison rape and other forms of sexual victimisation that may result, *inter alia*, in HIV transmission.
- There is no public health or security justification for mandatory HIV testing of prisoners, nor for segregation or denying inmates living with HIV access to all activities available to the rest of the prison population.
- Prisoners with terminal diseases, including AIDS, should be considered for early release and given proper treatment outside prison.<sup>94</sup>

## Part III

### A. Equality/Anti-Discrimination Law and Policy

#### HIV-Related Stigma and Discrimination in Namibia

The HIV-related stigma has been defined as a “process of devaluation” of people either living with or associated with HIV and AIDS. In contrast, discrimination has been set out as a process that follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. It occurs when a distinction is made against a person that results in being treated unfairly and unjustly on the basis of belonging, or being perceived to belong, to a particular group<sup>95</sup>.

Alternatively, stigma and discrimination on the basis of HIV or AIDS can also be defined as “all unfavorable attitudes, beliefs and policies directed toward people perceived to have HIV/AIDS as well as their significant others and loved ones, close associates, social groups and communities. Patterns of prejudice, which include devaluing, discounting, discrediting, and discriminating against these groups of people, play into and strengthen existing social inequalities- especially those of gender, sexuality, and race- that are at the root of HIV-related stigma”<sup>96</sup>

Due to the impact of stigma and discrimination on people living with or affected by HIV and on the overall response to the epidemic, there is a strong policy and legal framework against stigma and discrimination.

The Constitution of the Republic of Namibia outlaws discrimination on a variety of grounds.

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<sup>93</sup> UNAIDS and OHCHR (2006) *International Guidelines on HIV/AIDS and Human Rights* at para 15

<sup>94</sup> At para 153

<sup>95</sup> Keulder, C.2007. HIV/AIDS and Stigma in Namibia: Results of a qualitative study among support group members, pg. 6

<sup>96</sup> Ibid, pg. 6

## Article 10 – Right to Equality and Freedom from Discrimination

- (1) All persons shall be equal before the law.
- (2) No persons may be discriminated against on the grounds of sex, race, colour, ethnic origin, religion, creed or social or economic status.

Another important legal instrument which has without any ambiguity prohibited discrimination on the basis of HIV or AIDS is the Labour Act, No. 11 of 2007. This will be dealt with in detail under the section focusing on HIV/AIDS in the workplace (See Part III D below).

In terms of policy framework, the Namibia National Policy on HIV/AIDS 2007 clearly prohibits HIV or AIDS related stigma and discrimination. This is reflected in one of the policy guiding principles which states that:

*“the adverse effects of stigma and discrimination are key barriers to effectively combating the epidemic. Commitments to ... reducing stigma and discrimination is thus central to an effective response to HIV/AIDS”<sup>97</sup>*

Section 2.2 of the policy states that:

- (i) *People living with HIV/AIDS shall not be discriminated against in access to health care and related services and respect for privacy and confidentiality shall be upheld,*
- (ii) *HIV/AIDS shall not be used as a reason for denying an individual access to social services, including health care, education and employment.*

Despite the strong legislative and policy framework, stigma and discrimination is still rife against people living with or affected by HIV. The Global Commission on HIV and the Law’s recent investigation into HIV, law and human rights reported that around the world, people living with HIV continue to feel the impact of stigma, discrimination, marginalization and abuse, both verbal and physical, in their homes, families, communities and in public institutions.<sup>98</sup> In Namibia, civil society organisations (CSOs) working with people living with HIV and affected populations have provided anecdotal evidence during focus group discussions<sup>99</sup> of the kinds of stigma and discrimination experienced, including:

- HIV testing for insurance and life cover
- Exclusion of HIV positive students from accessing foreign scholarships<sup>100</sup>
- Pre-employment HIV testing and denial of employment in certain employment sectors (armed forces and law enforcement agencies) Dismissals from employment on the basis of HIV status
- Stigmatizing and discriminatory treatment in access to health care services
- Instances of HIV testing without voluntary and informed consent and without adequate pre- and post-test counseling
- Breaches of confidentiality

<sup>97</sup> National Policy on HIV/AIDS- Republic of Namibia. 2007. Pg. 5

<sup>98</sup> Global Commission on HIV and the Law (2012) *HIV and the Law: Risks, Rights & Health*, pg 17 at <http://www.hivlawcommission.org/index.php/report>

<sup>99</sup> See annexure 3 for list of FGDs.

<sup>100</sup> ‘Denial of Scholarship on Basis of HIV status: Unfair discrimination’ The Namibian, 01 December 2010. Available online at: [http://www.namibian.com.na/index.php?archive\\_id=73617&page\\_type=archive\\_story\\_detail&page=2631](http://www.namibian.com.na/index.php?archive_id=73617&page_type=archive_story_detail&page=2631)

- Social rejection and isolation
- Social ostracism and name-calling

According to participants in these focus group discussions, stigma and discrimination leads to increased isolation, self-stigma and fear amongst affected populations and makes people unwilling or afraid of accessing HIV testing, prevention, treatment, care and support services.

### Current Position

Stigmatising and discriminatory policies and practices continue to affect people living with HIV, despite the constitutional right of every person to equal protection of the law and freedom from discrimination under Article 10 of the Constitution. This section examines discriminatory policies and practices with respect to non-citizens (in particular, foreigners) and with respect to people applying for insurance and bank loans. Discrimination within the health care, employment and education sector is dealt with in further detail in Part III, B, D and E, respectively, below.

### Foreigners/Migrants

According to the report of the Global Commission on HIV and the Law (the 'GCHL Report'), *“—migration policies—restrictions on entry, stay and residence in a country - disempower people, exposing them to exploitation, changing their sexual behaviors and increasing the likelihood of unsafe practices. As a result, migrants face a risk of HIV infection that is as much as 3 times higher than that faced by people with secure homes.*<sup>101</sup>

The rights of migrant workers, whose labour supports the global economy, have been fully articulated in numerous international conventions. The International Labour Organization's 1990 *International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families*, provides migrant workers and their families the right —to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with national of the State concerned. As has been discussed in Part II, the ILO Recommendation 200 of 2010 specifically notes that migrant workers should not be required by countries of origin, transit or destination to disclose their HIV-related information nor should they be excluded from migration on the basis of their real or perceived HIV status.<sup>102</sup>

However, in many countries, laws and policies erect barriers to access to HIV services for migrants. As of 2013, 43 countries place HIV-related restrictions on entry, stay and residence, of which 5 countries maintain a blanket ban on entry by people living with HIV, 5 require proof of HIV-negative status for those seeking to stay for 10–90 days, and at least 19 countries authorize deportation of individuals found to be living with HIV<sup>103</sup>. These restrictions are often justified on the grounds of safeguarding public health.

However, the GCHL report argues that evidence shows that they do no such thing. In fact, such policies create the dangerous mistaken impression that “outsiders” are contaminated and citizens are pure, and that their health is secure so long as the borders are secured.<sup>104</sup>

<sup>101</sup> At page 59

<sup>102</sup> ILO. 2010. Recommendation Concerning HIV&AIDS in the World of Work at paras. 27 and 28

<sup>103</sup> UNAIDS Global Report 2013 at 92,93 accessed at

[http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/unaids\\_global\\_report\\_2013\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/unaids_global_report_2013_en.pdf)

<sup>104</sup> Global Commission on HIV and the Law (2012) op cit at p 61

The GCHL (2012) *Risks, Rights & Health* recommends that, to ensure an effective, sustainable response to HIV that is consistent with human rights obligations States should:

- Offer the same standard of protection to migrants, visitors and residents who are not citizens as they do to their own citizens.
- Restrictions should not be used to prohibit people living with HIV from entering a country and/or regulations that mandate HIV tests for foreigners within a country.
- Implement regulatory reform to allow for legal registration of migrants with health services and to ensure that migrants can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens. All HIV testing and STI screening for migrants must be informed and voluntary, and all treatment and prophylaxis for migrants must be ethical and medically indicated.

### **Current Position**

In terms of section 39(2)(e) of the Immigration Control Act of 1993, any person who enters or has entered or is in Namibia shall be a prohibited immigrant if "such person is infected or afflicted with a contagious disease or is a carrier of such a virus or disease, as may be prescribed;"

In terms of Regulation 13 of the Immigration Control Regulations promulgated in terms of the Immigration Control Act in Government Notice No 134 of 1994 (contained in Government Gazette number 895 of 1994): "For the purposes of paragraph (e) of subsection (2) of section 39 (of the Immigration Control Act), the following diseases or viruses shall be regarded as contagious - (a)-(e).....(f) acquired immune deficiency syndrome virus (aids virus).

In terms of section 42 of the Immigration Control Act, a prohibited immigrant can be arrested, detained and removed from Namibia.

In 2010 the Ministry of Home Affairs amended Regulation 13(f) by removing 'acquired immune deficiency syndrome virus (aids virus)' and replacing this with "Contagious infections or viruses or diseases. Any contagious infection or virus or disease (airborne or transmitted through casual contact) that exists or may develop from time to time that is declared a Public Health Emergency of International Concern (PHEIC) and which warrants restriction of international travel and mobility as per the International Health Regulation adopted by the Fifty-Eight World Health Assembly in 2005 is regarded as contagious".<sup>105</sup>

Travel restrictions on the basis of HIV status have thus been removed from Namibian law. Despite this amendment, visa application forms for entry into Namibia have yet to be amended and still contain the question: 'Are you suffering from tuberculosis, or any other contagious lung disease; trachoma, or any other chronic eye infection, frambesia, yaws, scabies or any other contagious bacterial skin disease; syphilis or any other venereal disease; or leprosy or Acquired Immune Deficiency Syndrome virus (AIDS virus), or any mental illness or affliction?'<sup>106</sup>

The international Organization for Migration (IOM) has highlighted that sub-populations are often overlooked and not sufficiently included in programmes and policies designed to ensure universal access to HIV prevention, care, treatment and support. In most instances migrants and mobile populations are left out of HIV responses, despite potentially playing an important role in the sexual networks of multiple and concurrent.

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<sup>105</sup> Government Notice No. 133, GG No 4514, 1 July 2010.

<sup>106</sup> [http://www.namibianembassyusa.org/sites/default/files/documents/namibia\\_visa\\_application.pdf](http://www.namibianembassyusa.org/sites/default/files/documents/namibia_visa_application.pdf) accessed 12 June 2015

Efforts to ensure HIV prevention and treatment among migrants is further complicated by problems they face in accessing health services overall. Foreign workers at the ports in Walvis Bay for example, are often on three to six-month employment contracts with short-term shore leave as short as two days at times. They are unlikely to receive HIV education prior to arrival in southern Africa, as they typically come from countries with low prevalence where there is little attention to HIV education. Once at the ports, not only do their short periods of stay make them difficult to target, but also language and cultural barriers make it difficult for them to access information and services.<sup>107</sup>

Currently foreigners are classified as private patients. Visitors from neighbouring countries are therefore not able to access state health care unless they are able to pay for such services.

## Recommendations

- Namibia should urgently amend its visa application forms to delete any reference to HIV or AIDS; and
- Ensure that migrant workers and foreigners can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens.

## Access to Insurance/Bank loans

HIV and AIDS impact on the lives of those affected in a multitude of ways. Its impacts are felt at every level of our society including economic impacts due to, for example, costs of medical care or loss of earnings. For this reason, discrimination which denies access to facilities such as insurance or loans, against people living with HIV, serves to exacerbate the impact of HIV and AIDS upon their lives. The UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights* recommend, in Guideline 5, that States should enact or strengthen anti-discrimination and other protective laws that protect people living with HIV and vulnerable populations from discrimination in both the public and the *private* sectors. This should include protection from discrimination in insurance; the *Guidelines* say that — [e]xemptions for superannuation and life insurance should only relate to reasonable actuarial data, so that HIV is not treated differently from analogous medical conditions<sup>108</sup>.

## Current Position

This is supported by the National HIV Policy Objectives which specifically aimed at ensuring that equal opportunities are provided to all in mitigating the socio-economic impacts of HIV/AIDS.<sup>109</sup> In addition the policy provides that insurance companies shall not deny death benefit if a person died of AIDS-related complications.<sup>110</sup>

In Namibia, insurance policies (including life insurance) currently require medical examinations as part of the application process, including HIV tests. A medical practitioner acting on behalf of the insurance company is required to complete the medical report on an applicant's application form. Applicants are asked whether they have undertaken HIV tests or AIDS tests in the past and are required to disclose details of previous HIV test results. In general, an applicant will not receive a life insurance policy should the HIV test result be positive. Applicants with chronic illnesses such as cancer or diabetes are treated in a similar manner. The policy will, however, be honoured for

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<sup>107</sup> International Organisation for Migration, 'Southern Africa Ports as Spaces for HIV vulnerability: Scenarios from South Africa and Namibia' 7 July 2011. Available online at: <http://southafrica.iom.int/southern-africa-ports-as-spaces-of-hiv-vulnerability-scenarios-from-south-africa-and-namibia/>

<sup>108</sup> [http://data.unaids.org/publications/irc-pub03/3797\\_en.html](http://data.unaids.org/publications/irc-pub03/3797_en.html)

<sup>109</sup> At page 4

<sup>110</sup> National Policy para 6.2 (4) at 31

current life insurance policy holders who contract HIV after inception of the policy. In addition, a number of insurance companies offer alternative policies relating to accident coverage. Commercial banks do offer life insurance to HIV positive clients and the premium is calculated taking into account the client's current health status and CD4 count.

## **Recommendations**

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

## **B. Health laws, policies and plans**

International guidance on creating enabling legal frameworks for HIV responses recommends that public health and related laws protect and promote rights in the context of HIV and AIDS, rather than provide for coercive, punitive and/or discriminatory responses. The *International Guidelines on HIV/AIDS and Human Rights* recommend that states should review, amend and adopt, where necessary, appropriate public health laws, policies, plans and programs to protect rights in the context of HIV and AIDS and to provide universal access to HIV prevention, treatment, care and support for all populations. This includes reviewing intellectual property laws to ensure access to affordable medicines, as furthermore recommended by the Global Commission on HIV and the Law.

### **UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights***

#### **Guideline 3: Public Health Legislation**

States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.

#### **Guideline 6: Access to prevention, treatment, care and support (as revised in 2002)**

States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.

States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions. States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

The commentary to these guidelines provides detailed recommendations to states on the kinds of laws, policies and programmes that should be put in place, in line with international and national human rights commitments, in order to develop rights based effective responses to HIV.

They stipulate that public health and related laws should do the following, amongst other things:

- Provide for HIV testing only with voluntary and informed consent (apart from surveillance and other unlinked epidemiological testing) and with pre- and post-test counselling and require any exceptions to voluntary HIV testing to take place only on specific judicial authorization, granted only after due evaluation of the important considerations involved in terms of privacy and liberty.
- Protect people from coercive measures such as isolation, detention or quarantine on the basis of their HIV status.
- Protect the right to confidentiality, including
  - Ensuring that HIV and AIDS cases reported to public health authorities for epidemiological purposes are subject to strict rules of data protection and confidentiality.
  - Authorising (but not requiring) disclosures of a person's HIV status by a health care worker in defined circumstances where a real risk of HIV transmission exists, following counselling and discussions with the person with HIV.

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

**Commentary to Guideline 3:**

“Public health legislation should authorize, but not require, that health-care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients’ sexual partners of the HIV status of their patient. Such a decision should only be made in accordance with the following criteria:

- (i) The HIV-positive person in question has been thoroughly counselled;
- (ii) Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
- (iii) The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
- (iv) A real risk of HIV transmission to the partner(s) exists;
- (v) The HIV-positive person is given reasonable advance notice;
- (vi) The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and
- (vii) Follow-up is provided to ensure support to those involved, as necessary.”

- Ensure that the blood/tissue/organ supply is free of HIV and other blood-borne diseases.
- Require the implementation of “universal precautions” to prevent transmission in settings such as hospitals, doctors’ offices, dental practices and acupuncture clinics.
- Require that health-care workers undergo a minimum of ethics and/or human rights training and encourage professional societies of health-care workers to develop and enforce codes of conduct based on human rights and ethics, including HIV-related issues such as confidentiality and the duty to provide treatment
- Provide (through the review, amendment and adoption of laws, policies, plans and programmes where appropriate) universal and equal access, without discrimination, to available, accessible, appropriate, affordable and quality medicines, diagnostics and related technologies for HIV and AIDS
- Include positive measures to address factors that block equal access to prevention, treatment, care and support for vulnerable populations and to strengthen the involvement of communities in the HIV response.

The Report of the Global Commission on HIV and the Law, *'Risks, Rights & Health'* looks in particular at the impact of intellectual property and other laws on access to treatment for HIV and AIDS. It notes that a growing body of international trade law and the over-reach of intellectual property protections are impeding the production and distribution of low-cost generic medicines, which impacts most severely on low and middle-income countries. It recommends that countries develop an effective intellectual property regime that is consistent with international human rights laws and public health needs, while safeguarding the justifiable rights of inventors. In particular, it recommends amongst other things:

- All countries must adopt and observe a global moratorium on the inclusion of any intellectual property provisions in any international treaty that would limit the ability of countries to retain policy options to reduce the cost of HIV-related treatment
- All countries should, to the extent possible, incorporate and use TRIPS flexibilities, consistent with safeguards in the own national laws
- Countries with manufacturing capacity and those reliant on the importation of pharmaceutical products must retain the policy space to use TRIPS flexibilities as broadly and simply as they can
- Low and middle-income countries must facilitate collaboration and sharing of technical expertise in pursuing the full use of TRIPS exceptions (for instance, by issuing compulsory licences for ARVs and medicines for co-infections such as hepatitis C). Both importer and exporter countries must adopt straightforward, easy-to-use domestic provisions to facilitate the use of TRIPS flexibilities.
- Developing countries should desist from adopting TRIPS-plus provisions including anti-counterfeiting legislation that inaccurately conflates the problem of counterfeit or substandard medicines with generics and thus impedes access to affordable HIV-related treatment.
- Countries must proactively use other areas of law and policy such as competition law, price control policy and procurement law which can help increase access to pharmaceutical products.

## Current position

### Constitutional Rights

In terms of the Namibian Constitution, socio-economic rights including right to health are not entrenched in Chapter 3, the Bill of Rights. These rights are only mentioned under Article 95 and serve as guiding principles for state policy. Article 95 (j) states that;

“the state shall actively promote and maintain the welfare of the Namibian people by adopting, inter alia, policies aimed at the consistent planning to raise and maintain an acceptable level of nutrition and standard of living and to improve **public health**”.

Article 13 furthermore guarantees the right to privacy, which also encompasses obligations to respect a person's physical privacy. This right is also relevant to health rights, particularly since the Constitution states that the right to privacy may be limited for reasons of public health. As discussed in Part II, above, the right to privacy requires that all health interventions (such as HIV testing and sterilization) be undertaken only with an individual's consent. HIV testing specifically should be dealt with due respect for the confidentiality of all information relating to a person's HIV status. Mandatory HIV testing for public health reasons is viewed as an unjustifiable limit on the right to privacy.

Finally, article 7 guarantees the right of every person to liberty and security of the person. This protects the rights of all people, including people living with or affected by HIV, from unjustifiable detention or quarantine and is furthermore argued to protect affected populations from being

forced to undergo medical interventions (such as sterilization without informed consent), as set out in Part II, above.

Although there is no HIV-specific legislation in Namibia, the current health rights of people living with and affected by HIV and AIDS are reflected in national health and related laws, policies, plans and programmes. These are discussed broadly, below. Following that, specific key issues of concern (such as isolation and detention of patients, HIV testing, confidentiality, access to HIV-related prevention, treatment, care and support) are discussed in further detail.

## Public Health Legislation

The current Public Health Act dating back to 1919<sup>111</sup> regulates public health in Namibia and does not contain specific provisions relating to HIV and AIDS. However, the provisions of the Act relating to infectious diseases, which include provision for notification and isolation in certain situations apply equally to people living with HIV. To date there is no record of any of these provisions being invoked against people living with HIV.

A new Public and Environmental Health Act, 1 of 2015 was promulgated in May 2015 and repeals the Public Health Act of 1919. This Act has not however yet entered into force and in terms of section 96 will come into operation on a date to be determined by the Minister of Health by notice in the Government Gazette.

The Public and Environmental Health Act, 1 of 2015 provides for the notification and reporting of notifiable infectious diseases in Part 3. In terms of section 6, the Minister of Health may classify by notice in the Gazette a disease to be (a) an infectious disease, (b) a notifiable infectious disease, or (c) a notifiable infectious disease to be a vaccine preventable notifiable infectious disease. Should HIV be classified as a notifiable infectious disease, this will have far reaching implications for people living with HIV. These include the following:

In terms of section 5(2)(b) a person who suspects that he or she may have a notifiable infectious disease must ascertain whether he or she has a disease and which precautions should be taken to prevent the spreading of the disease. In effect this section makes it mandatory for a person who suspects that he or she has HIV to undergo an HIV test and undermines the internationally accepted rights based principle of voluntary HIV testing with informed consent.

Section 7(3) requires a principal or head of a learning institution, head of a family or a household, employer, owner or occupier of land or premises, traditional leader, chief or headman to report to a local authority the particulars of the patient and his or her symptoms, the occurrence of a case of illness or death coming to his or her notice and suspected to be due to a notifiable infectious disease, or with a history or presenting symptoms or appearances which might reasonable give grounds for the suspicion. Should this section be applied to HIV it would constitute an unjustifiable limitation on the rights to privacy and dignity of people living with HIV.

In terms of section 18(1) (a) a person who knows that he or she is suffering from a notifiable infectious disease may not enter public transport. Should this section be applied to HIV it would constitute an unjustifiable limitation of the right to freedom of movement of people living with HIV.

Part 4 of the Act regulates sexually transmitted infections and in terms of section 34 applies to all sexually transmitted infections *except* the infections as the Minister of Health may specify in the Gazette. Should HIV not be specified as a sexually transmitted infection to which this Part *does not*

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<sup>111</sup> Act 39 of 1919

apply, this will likewise have far reaching implications for people living with HIV. These include the following:

In terms of section 35(1) (c) a medical practitioner or other health practitioner who attends to or advises a patient in respect of a sexually transmitted infection from which the patient is infected, must warn the patient against contracting marriage unless and until the patient has been cured of the infection or is free from infection in a communicable form. Should this section be applied to HIV it would constitute an unjustifiable limitation of the right of a person living with HIV to marry and found a family.

In terms of section 36 a person who is not being treated for a sexually transmitted disease can be ordered under section 36(3) to provide a certificate from a medical practitioner as to whether or not he or she is infected with a sexually transmitted disease in a communicable form and to attend regularly for medical treatment at times and at a place specified in the order. Should this section be applied to HIV it would in effect make it mandatory for a person living with HIV to go onto antiretroviral therapy and would constitute an unjustifiable limitation of the right of a person living with HIV to privacy and autonomy.

It is thus critical that HIV is not specified as a notifiable infectious disease and that HIV is listed as a disease which is exempt from the application of Part 4 of the Act when this Act enters into operation.

#### Health and HIV Policies, Strategies and Plans

Namibia health strategies, policies and plans reflect recognition of health, including sexual and reproductive health, as a fundamental human right and a commitment to protecting human rights in the provision and enjoyment of health.

The Namibian National Policy on HIV/AIDS (2007) supports five broad strategies:

- THE STRENGTHENING OF AN ENABLING ENVIRONMENT so that people infected and affected with HIV/AIDS enjoy equal rights in a culture of acceptance, openness and compassion;
- PREVENTION to reduce new infections of HIV and other STIs;
- ACCESS TO COST EFFECTIVE AND HIGH QUALITY TREATMENT, CARE AND SUPPORT SERVICES for all people living with, or affected by HIV/AIDS;
- Strengthening and expanding the capacity for local responses to MITIGATE SOCIO-ECONOMIC IMPACTS of HIV/AIDS;
- INTEGRATED AND CO-ORDINATED PROGRAMME MANAGEMENT that has effective management structures and systems, optimal capacity and skills, and high quality programme implementation at national, sectoral, regional and local levels.

The Policy has the protection and promotion of human rights as one of its guiding principles and states at 1.5.3 that:” International human rights law guarantees the right to equal protection before the law and freedom from discrimination on grounds, singly or in combination, of race, colour, sex, language, religion, political, nationality, ethnic or social origin, disability, property, birth and HIV/AIDS status. Discrimination on any of these grounds is not only wrong in law but it also creates and sustains conditions leading to vulnerability to HIV infection and to receiving adequate treatment, care and support once infected.

Groups suffering from discrimination which makes them vulnerable in the context of HIV/AIDS include women and young girls, orphans, street children, widows and widowers, children and young people, the poor, sex workers, prisoners, people awaiting trial, marginalised or minority groups, mobile populations, people with disabilities, refugees and displaced groups.

An effective response to the epidemic requires the rights to equality before the law and the right to freedom from discrimination to be respected and protected, particularly with regard to gender relations between women and men on the one hand and girls and boys on the other”.

The policy also outlaws traditional, customary, cultural and religious practices and services that make people more vulnerable to HIV (para 2.4). HIV testing is, in terms of the policy, only to be carried out with informed consent and confidentiality is protected: “There shall be no mandatory testing for HIV. Government and its regulatory bodies, shall ensure that the informed consent of the patient is obtained prior to HIV testing for the purposes of differential diagnosis, that such testing is accompanied by pre and post-test counselling and that the results of such test are not released to any person without the patient’s consent’ (para 4.2 1).

In terms of para 4.3 1, government is required to “progressively provide access on a sustained and equal basis to affordable, quality antiretroviral therapy and to treatment for and prophylaxis to prevent opportunistic infections, to all persons who need it”.

The Ministry of Health’s *National Strategic Framework for HIV/AIDS 2010/11-2015/16 (NSF)* provides a broad overall framework for addressing HIV and AIDS. The *Strategic Framework* priority is to prevent the further occurrence of new HIV infections in the country<sup>112</sup>. It provides for interventions targeting behavioural, biomedical and structural drivers of the epidemic through a combination strategy.

Principles of gender, human rights and equity informed the development of the NSF. The NSF recognises the need for dedicated prevention strategies for most at risk populations and vulnerable groups. Most at risk populations are named as including mobile and migrant populations such as long distance truck drivers, sex workers, men who have sex with men, army, police and prison officers, prisoners and injecting drug users (para 5.1.4).

Below, we consider selected, specific issues of concern in the context of HIV and AIDS in terms of the current legal/regulatory position and the extent to which this meets international, regional and national human rights commitments and promotes effective HIV responses.

## Isolation and detention of patients

### Current Position

Isolation and detention of patients may be a reasonable public health response in certain circumstances, in order to contain the spread of infectious diseases. However, public health provisions for the isolation and detention of patients should not be inappropriately applied to HIV and AIDS.

The current Public Health Act dating back to 1919<sup>113</sup> regulates public health in Namibia and does not contain specific provisions relating to HIV and AIDS. However, the provisions of the Act relating to infectious diseases, which include, as noted above, provision for notification and isolation in certain situations apply equally to people living with HIV. To date there is no record of any of these provisions being invoked against people living with HIV.

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<sup>112</sup> National Strategic Framework for HIV and AIDS Response in Namibia: 2010/11- 2015/16. Pg. Xiv

<sup>113</sup> Act 39 of 1919

A new Public and Environmental Health Act, 1 of 2015 was promulgated in May 2015 and repeals the Public Health Act of 1919. This Act has not however yet entered into force and in terms of section 96 will come into operation on a date to be determined by the Minister of Health by notice in the Government Gazette.

Section 11 of this Act makes provision for the isolation of people suffering from a notifiable infectious disease and states that 'If, in the opinion of a head of health services, a person certified by a medical practitioner to be suffering from a notifiable infectious disease is not accommodated or is not being treated or nursed in a manner as adequately to guard against the spread of the disease, the person may, on the order of the head of health services, be removed to a suitable hospital or place of isolation and be detained until the head of health services.....is satisfied that the person is free from infection or can be discharged. Should HIV be specified by the Minister as a notifiable infectious disease as noted above, this section has the potential to be invoked against people living with HIV and this would constitute an unjustifiable limitation of their right to freedom of movement. It is thus imperative that HIV is not specified as a notifiable infectious disease once the Act enters into force.

### Recommendations

- Ensure that HIV is not specified as a notifiable infectious disease once the Public and Environmental Health Act 1 of 2015 enters into force to prevent the use of section 11 of the Act against people living with HIV.
- Ensure that HIV is excluded from the operation of Part 3 once the Public and Environmental Health Act 1 of 2015 enters into force to prevent the use of this Part against people living with HIV.

### Informed Consent to HIV Testing and Treatment

HIV testing only on the basis of voluntary and informed consent is viewed as a critical public health response to encourage people's willingness to access health care services, as well as a human rights imperative in terms of human rights commitments. Mandatory HIV testing is discouraged by both the World Health Organization and UNAIDS as an ineffective measure to achieve public health goals<sup>114</sup>. The WHO Consolidated Guidelines on HIV Testing Services (July 2015)<sup>115</sup> reiterate that HIV testing should be confidential and performed only with informed consent.

#### **Excerpt from WHO Consolidated Guidelines on HIV Testing Services<sup>116</sup>**

A public health and human rights-based approach is important to delivering HTS. A human rights-based approach gives priority to such concerns as universal health coverage, gender equality and health-related rights such as accessibility, availability, acceptability and quality of services. For all HTS, regardless of approach, the actual public health benefits must always outweigh the potential harm or risk. Moreover, the chief reason for testing must always be both to benefit the individuals tested and to improve health outcomes at the population level.

<sup>114</sup> UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights*

<sup>115</sup> [http://apps.who.int/iris/bitstream/10665/179870/1/9789241508926\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/179870/1/9789241508926_eng.pdf?ua=1)

<sup>116</sup> At p9-10

HTS should be expanded not merely to achieve high testing uptake or to meet HIV testing targets, but primarily to provide access for all people in need to appropriate, quality HTS that are linked to prevention, treatment, care and support services. Thus, HIV testing for diagnosis must always be voluntary, consent must be informed by pre-test information, and testing must be linked to prevention, treatment, care and support services to maximize both individual and public health benefits. All forms of HIV testing should adhere to the WHO 5 Cs: Consent, Confidentiality, Counselling, Correct test results and Connection (linkage to prevention, treatment and care services) (44). Coerced testing is never appropriate, whether that coercion comes from a health-care provider, an employer, authorities (such as immigration services) or a partner or family member.

The 5 Cs are principles that apply to all HTS and in all circumstances

- **Consent:** People receiving HTS must give informed consent to be tested and counselled. (Verbal consent is sufficient; written consent is not required.) They should be informed of the process for HIV testing and counselling and of their right to decline testing.
- **Confidentiality:** HTS must be confidential, meaning that what the HTS provider and the client discuss will not be disclosed to anyone else without the expressed consent of the person being tested. Confidentiality should be respected, but it should not be allowed to reinforce secrecy, stigma or shame. Counsellors should discuss, among other issues, whom the person may wish to inform and how they would like this to be done. Shared confidentiality with a partner or family members – trusted others – and healthcare providers is often highly beneficial.
- **Counselling:** Pre-test information can be provided in a group setting, but all people should have the opportunity to ask questions in a private setting if they request it. All HIV testing must be accompanied by appropriate and high-quality post-test counselling, based on the specific HIV test result and HIV status reported. Quality assurance (QA) mechanisms as well as supportive supervision and mentoring systems should be in place to ensure the provision of high-quality counselling.
- **Correct:** Providers of HIV testing should strive to provide high-quality testing services, and QA mechanisms should ensure that people receive a correct diagnosis. QA may include both internal and external measures and should receive support from the national reference laboratory. All people who receive a positive HIV diagnosis should be retested to verify their diagnosis before initiation of HIV care or treatment.
- **Connection:** Linkage to prevention, treatment and care services should include effective and appropriate follow-up, including long-term prevention and treatment support. Providing HTS where there is no access to care, or poor linkage to care, including ART, has limited benefit for those with HIV.

## Current Position

The National HIV Policy (2007) states that there shall be no mandatory testing for HIV, and government and its regulatory bodies shall ensure that the informed consent of the patient is obtained prior to HIV testing and that such testing is accompanied by pre- and post-test counselling.<sup>117</sup> The policy also provides that VCT shall be confidential and the results of any HIV test shall thus not be disclosed to a third party without the informed consent of the person seeking testing<sup>118</sup>. Provider initiated VCT services are provided in respect of all patients reporting at hospitals and other health service providers with any HIV-related symptoms, including TB and STIs, as well as pregnant mothers<sup>119</sup>.

The *Namibia HIV Testing and Counselling Guidelines (2010)* provides more detailed guidance on national standards for HIV testing and counselling services for all institutions, organizations and

<sup>117</sup> National Policy on HIV/AIDS, 2007. Pg 18

<sup>118</sup> Op cit at 19

<sup>119</sup> Op cit at 18

individuals. The guidelines reiterate the principles of informed consent, pre- and post-test counselling and confidentiality.

The guidelines propose a system of both client-initiated and provider-initiated testing in Namibia.

#### **Excerpt from HIV Testing and Counselling Guidelines on PITC<sup>120</sup>**

HCT should be recommended by the health care providers as part of the normal standard of care provided to the patient, regardless of whether or not the patient shows signs and symptoms of underlying HIV. It should be recommended in medical and surgical services, public and private facilities, inpatient and outpatient settings.

The following should be considered priorities for PITC in Namibia:

1. Medical Wards: Hospital medical wards usually have a high concentration of patients with HIV who would benefit from diagnosis, treatment and care. HCT should be recommended to all patients admitted to hospitals and other inpatient facilities.
2. Tuberculosis clinics: TB is the most common serious infectious complication associated with HIV infection in Namibia.
3. Antenatal and MCH services: HCT should be recommended to all women of unknown HIV status at booking, in the third trimester and post-partum.
4. STI: Services HIV testing and counselling should be recommended to all patients presenting with STIs at their first presentation for treatment, 3 months after any identified exposure and annually if they have recurrent STIs.
5. Male Circumcision (MC): HCT should be recommended to all men seeking circumcision as a means of preventing HIV infection. Conversely, men seeking HCT should be educated about the benefits of MC on HIV prevention.

The *National Strategic Framework for HIV and AIDS Response in Namibia, 2010/11-2015/16* provides for both voluntary and confidential VCT and PITC with informed consent.

#### *Age of consent to testing and treatment*

With regard to age of consent to medical treatment, including HIV testing, there appears currently to be a lack of clarity with conflicts in law and policy. The *Age of Majority Act 57 of 1972* provides that a person attains the age of majority at 21 years, at which point he or she attains full legal capacity. However, the current *Children's Act 33 of 1960* defines a "child" to be a person below the age of 18. It follows therefore that the parental consent required in terms of the latter Act for a minor to undergo any form of medical treatment or procedure, is only required until the age of 18. In contrast, the *National Guidelines on HIV Voluntary Counselling and Testing* state that anyone who is aged 16 years or above is considered able to give informed consent for HCT. For children below the age of 16 a parent or legal guardian's consent is required for testing unless the child is considered to be a mature minor. The HCT counsellor should assess the minor's maturity to receive HCT services. The guidelines furthermore provide that HIV testing should be in the best interests of the child, to improve the child's health, survival, development and social well-being. In the case of children without a parent or guardian, consent may be obtained from the head of the institution, health centre, hospital or clinic<sup>121</sup>.

<sup>120</sup> Namibia HIV Testing and Counselling Guidelines (2010) at 28

<sup>121</sup> Ibid, pg 46

The effect of these contradictory provisions is that although a young person over 16 can legally consent to sex, he or she would still require parental consent in circumstances where they may require HIV testing, treatment for sexually transmitted infections, hormonal contraceptives and other sexual or reproductive health services. Research shows that very few young people are willing to seek their parent's permission to access services and in many cases even health practitioners are unclear of their patient's rights and their responsibilities with regard to sexual and reproductive health services. This, combined with the poor attitudes of health care workers to young people's access to sexual and reproductive health services, contributes to poor management of reproductive health services for young people, who may be at higher risk of HIV exposure.

The *Child Care and Protection Act 3 of 2015* which has been promulgated but is not yet in force sets out in section 10 that "A person attains the age of majority on attaining the age of 18 years", and lists the Age of Majority Act as one of the acts to be repealed.

Section 220 of the Act confirms that a child may consent to his/her own medical intervention if:

- (a) The child is 14 years of age or older;
- (b) In the opinion of the medical practitioner, the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the intervention; and
- (c) In addition, in the case of a surgical operation, the child is duly assisted by a parent, guardian or care-giver.

In terms of section 221(2) of the Act, a child may consent to an HIV test on himself or herself, if the child is:

- (a) 14 years of age or older;
- (b) under the age of 14 years and the person who conducts the pre-test counselling is satisfied that the child is of sufficient maturity to understand the benefits, risks and social implications of such a test."

The Act has thus clarified the issue of HIV testing for children in terms of the age at which consent can be given.

## **Recommendations**

The following law review and reform measures are recommended to strengthen protection for the right to HIV testing only on the basis of voluntary and informed consent:

- Provision in law, as well as in policy for HIV testing to take place only on the basis of voluntary and informed consent (save for exceptional circumstances such as unlinked surveillance testing or testing of blood donations), as is currently provided for in the National HIV Policy
- Ensure that the *Child Care and Protection Act 3 of 2015* enters into force as soon as possible to create legal certainty on the age of consent for medical testing and treatment, and to enable young people of the age of 16 and over who are able to consent to sexual intercourse to also consent to sexual and reproductive health services
- Review and revise the provisions of all laws that relate to the legal capacity of minors to ensure no conflict between these and the provisions of the Child Care and Protection Act regarding the age of consent to medical testing and treatment.

## Confidentiality

The current high level of stigma and discrimination is a deterrent to people finding out and disclosing their HIV status. People need to have confidence that information concerning their health is treated confidentially and is not disclosed to a third person without their informed consent. Confidentiality of medical information, including HIV status, is vital to promoting confidence in public health systems. The South African case of *Jansen van Vuuren v Kruger* has confirmed the medical practitioner's obligation to, as well as public health importance of, maintaining a patient's right to confidentiality regarding HIV status<sup>122</sup>. There are suggestions that actual or perceived poor recognition of the importance of confidentiality in current health care services may discourage people from accessing HIV-related services.

Participants in focus group discussions carried out during the Situational Analysis spoke of both instances of poor maintenance of confidentiality as well as a general mistrust that confidentiality would be maintained, leading to fear and discouraging access to HIV testing and other services.

### Current Position

The National HIV Policy states that VCT shall be confidential and the results of any HIV test shall thus not be disclosed to a third party without the informed consent of the person seeking testing (para 3.3.1).

Disclosure of a person's HIV status to another person without their consent is strongly discouraged and is permissible in terms of the policy only once the following steps have been complied with<sup>123</sup>:

- a. The HIV positive person has been thoroughly counselled on the need for partner notification;
- b. The HIV positive person has refused to notify or consent to the notification of his/her partner(s);
- c. A real risk of HIV transmission to an identifiable partner(s) has been established;
- d. The HIV positive person is given reasonable advance notice of the intention to notify;
- e. Follow up is provided to ensure support to those involved.

The Ministry of Health (2009) *Namibia HIV Testing and Counselling Guidelines* deal extensively with the right to confidentiality with regard to a person's HIV status. They provide that in the event of an HIV test, HIV test results confidentiality also applies to client records. All client records, whether or not they involve HIV related information, should be managed in accordance with appropriate standards of confidentiality. All personnel with access to medical records should be trained in procedures to maintain confidentiality of HIV test results and should sign the code of conduct. Only staff with a direct role in the patient's management should have access to their records.<sup>124</sup>

The Child Care and Protection Act 3 of 2015 referred to in the previous section states in section 223 that no disclosure may be made of the fact that a child is HIV-positive without consent, with some exceptions when disclosure is required under the Act, for legal proceedings or by order of a court. The consent required may be given by a child of 14 years or older and can even be given if the child is younger in cases where it is apparent that the child is of sufficient maturity to comprehend the

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<sup>122</sup> *Jansen van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A)

<sup>123</sup> At para 4.2

<sup>124</sup> Ministry of Health (2009) *Namibia HIV Testing and Counselling Guidelines*, pg. 14

effects of such disclosure. Section 223(4) sanctions any contravention hereof with a fine not exceeding N\$20 000 or imprisonment not exceeding five years or both.

## Recommendations

- Provision in law, as well as in policy for the protection of confidentiality and disclosure of HIV status to take place only with consent as is currently provided for in the National HIV Policy

## Access to HIV Prevention, Treatment, Care and Support

Laws, regulations, policies and guidelines need to provide equitable access to HIV-related health care services in order to ensure effective responses to HIV and AIDS. Access to HIV prevention, treatment, care and support services should be available to all people without discrimination and in particular should prioritize access for key populations at a higher risk of HIV exposure. This requires developing appropriate HIV laws and policies as well as ensuring training for health care workers on non-discrimination and on the provision of HIV-related health care to key populations.

In terms of the National Policy on HIV/AIDS, government shall progressively provide access on a sustained and equal basis to affordable, quality antiretroviral therapy and to treatment for and prophylaxis to prevent opportunistic infections, to all persons who need it. It further pledges to provide an essential package of care to all PLWHA based on internationally accepted standards of care, treatment and support.<sup>125</sup>

In terms of access to medicines for HIV, the policy states that the government shall ensure that the National Essential Medicine List is regularly updated to incorporate essential drugs for HIV/AIDS treatment in accordance with the World Health Organisation (WHO) Essential Drug List. It further states that government shall ensure that medicines for the prevention and treatment of Opportunistic Infections (OIs) and STI's as well as ART, including generic medicines, are made readily available through registration with the Medicines Control Council.<sup>126</sup>

Intellectual property law is a key factor affecting access to treatment. Patents have the potential to restrict access by creating protections on drugs which give patent holders exclusive control to license, manufacture and distribute their product. As a consequence, the lack of competition on many patented drugs generally leads to high prices and unaffordability of essential drugs.

## Current situation

To address the potential restricted access to essential drugs caused by patents, SADC countries, Namibia being one of them, have incorporated the legal flexibilities available under the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). These flexibilities in relation to patents are meant to cater for improved access to essential medicines.

Namibia has a specific patent law in the Industrial Property Act, Act 1 of 2012, which incorporates a number of TRIPS flexibilities but this law, while passed, has not yet come in force. However, Article 144 of the Namibian Constitution confirms that international agreements form part of the laws of Namibia.

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<sup>125</sup> At page 26

<sup>126</sup> At page 26

A report commissioned by HERA in 2012<sup>127</sup>, reveals the following<sup>128</sup>:

- Namibia specifically prohibits the patenting of new use pharmaceutical patents;
- Parallel importation of medicines is allowed;
- Compulsory licensing and government use provisions is incorporated in Namibia's IP legislation;
- While Namibia does not incorporate a research exemption in its IP legislation, what is of additional concern is what would appear to be the creation of increased control of research in terms of the Research, Science and Technology Act 23 of 2004 which came into force in 2011;
- The Bolar exception is catered for in the IP legislation.

Enquiries made to local pharmacies confirm that generic medication obtained in the main from South Africa is freely utilized in the treatment of HIV/AIDS.

Key informant interviews and focus group discussions with stakeholders and affected populations, during the course of the Situational Analysis, revealed the following:

- The issue of lack of physical access to healthcare facilities, due to distance, was raised on a number of occasions;
- Whilst it was felt that medication was generally available, there were concerns that patients could often not take such medication due to a lack of nutrition and that the food that was sometimes provided by government, was insufficient;
- Confidentiality was questioned in regard to healthcare workers with a number of interviewees stating that they had not been informed of their status in private;
- There was a mixed reaction to the manner in which healthcare workers treated patients. A number of patients felt that the healthcare workers did not treat them with respect.

Health care workers themselves reported difficulties they faced in dealing with HIV and AIDS including a shortage of staff and the lack of adequate transport to conduct community and home visits to patients who are unable to access the nearest healthcare centre.

## **Recommendations**

The following measures are recommended to strengthen protection for the rights of people to HIV-related prevention, treatment, care and support services:

- Commission a thorough assessment of the Industrial Property Act, Act no 1 of 2012 to ensure that the TRIPS flexibilities are thoroughly catered for in the legislation;
- Subsequently advocate for the IP legislation to be brought into force;
- Capacity building with stakeholders on TRIPS flexibilities and related issues;
- Provide guidance on good practice for implementation of TRIPS;
- Ensure health care workers have training, including rights-based and sensitization training, to adequately implement and provide non-discriminatory services to key populations at higher risk of HIV exposure;
- Ensure greater access to healthcare services and provide infrastructure to support increased home visits, if necessary;

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<sup>127</sup> Musungu, Sisule F, "Pharmaceutical Patents, TRIPS Flexibilities and Access to Medicines in SADC".

<sup>128</sup> This is based on the potential situation in Namibia should the current IP legislation come into force.

- Consider the implications of the Food Bank to be established and how this could be utilized to ensure sufficient nutrition for persons on ARVs.

## Regulation of Health Care Providers and Health Extension Workers

In terms of the National HIV/AIDS policy, the government shall promote the delivery of quality home-based care as an essential component of the continuum of care for persons living with HIV/AIDS. It further makes provision for a nationally standardized home-based care toolkit and its replenishment for home based caregivers to ensure continuous quality care and proper standards of infection control. The framework further makes provision for volunteers to receive standardized quality training, adequate supervision and a standardized volunteer incentive package<sup>129</sup>.

The National Policy also calls on health care workers and home-based care givers to promote a two-way referral system between home-based care volunteers, traditional health providers and health facilities as well monitoring and evaluation system for home-based care.<sup>130</sup>

### Current Position

The Nurses Act, No. 8 of 2004 establishes the professional council for nursing and midwifery, the Nursing Council of Namibia. It also provides for the registration of nurses and midwives and for their training, qualification and disciplinary control. Section 37 of the Act provides the Council with disciplinary functions. In the event that a nurse or midwife is convicted of an offence punishable with imprisonment or has been guilty of malpractice, negligence or misconduct or has contravened any rule of conduct prescribed under this Act, the Council may order the person's removal from the register. Medical practitioners are regulated by the Medical and Dental Act 10 of 2004, part V of which give disciplinary powers to the Medical and Dental Council.

There is no legislation regulating home based care givers or health extension workers.

Despite the focus group discussions all having raised the issue of unprofessional conduct to some extent, there was no clear awareness as to how such matters should be reported or what further action could be taken.

### Recommendations

- Procedures to report misconduct should be clearly available at all health care facilities in clear and simple language;
- Such pamphlets or posters should be translated into all the languages of Namibia;
- The establishment of a toll free hotline to report misconduct should be investigated;
- Ways in which to access to the complaints systems at the professional disciplinary bodies in a less bureaucratic and time-consuming manner should be investigated;
- The drafting of legislation providing for the registration of home based care givers and health extension workers should be investigated;

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<sup>129</sup> National Policy on HIV/AIDS, pg 27

<sup>130</sup> National Policy on HIV/AIDS, pg 27

## C. Criminal Law and Law Enforcement

### MEN WHO HAVE SEX WITH MEN

Men who have sex with men are disproportionately affected by HIV and AIDS and are often stigmatized, socially excluded and have severely diminished access to health care. While there is limited data available on HIV prevalence, men who have sex with men are at an increased risk of HIV infection in African countries which suffer a generalized HIV epidemic. In 2007, Baral found that men who have sex with men in Africa were 3.8 times as likely to be HIV positive as heterosexual men.<sup>131</sup> Smith (2009) found HIV prevalence rates in men who have sex with men which range from 10.6% in a Namibian to 34.3% in a South African study.<sup>132</sup> A set of diverse factors contribute to this increased prevalence including high levels of discrimination and human rights violations that increase vulnerability to HIV and deter access to HIV prevention, treatment, care and support services. Men who have sex with men report negative experiences with healthcare providers. They report strong stigma on the part of healthcare workers, which they felt resulted in discrimination against them in healthcare settings. Many report avoidance rather than dealing with such treatment.

men who have sex with men needs, issues and concerns are largely ignored in national HIV and AIDS policies (or at best, paid lip service to) and are generally not addressed at all in government interventions. Exclusion from national health surveillance, stigma and discrimination and laws that criminalizes same-sex relations and low access to services hampers HIV prevention efforts. In successive Declarations and commitments on HIV/AIDS such as the Abuja, Maseru and UNGASS Declarations, heads of state have acknowledged that the full realization of human rights and fundamental freedoms is crucial to the global AIDS response, including eliminating discrimination against people living with HIV and vulnerable groups, and ensuring legal protection and access to services. Increased participation by people living with HIV and key populations was also emphasized. Laws that criminalize same-sex relations lead to the virtual exclusion of men who have sex with men from many national HIV/AIDS policies and a lack of implementation of such policies insofar as they refer to men who have sex with men.

The Human Rights Committee has found that the right to privacy is violated by laws that criminalize private homosexual acts between consenting adults and has noted that the criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS and as such criminalization not only interferes with the right to privacy but it also impedes HIV/AIDS education and prevention work.<sup>133</sup>

### Current position

Homosexuality per se is not illegal in Namibia. However, sodomy and related sexual acts between consenting adult males is a criminal offence. It is of no comfort to the men who have sex with men community that these charges are seldom made<sup>134</sup> while the crime still remains in force. Sodomy remains a “schedule 1” crime in terms of the Criminal Procedure Act<sup>135</sup> which places it in the same category as treason or murder. Any person convicted of sodomy in Namibia or elsewhere is

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<sup>131</sup> Baral, S., Sifakis, F., Cleghorn, F., & Beyrer, C. (2007). Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000-2006: a systematic review. *PLoS Medicine*, 4(12), e339.

<sup>132</sup> Smith, A.D., Tapsoba, P., Peshu, N., Sanders, E.J., & Jaffe, H.W. (2009). Men who have sex with men and HIV/AIDS in sub-Saharan Africa. *The Lancet*, 374(9687), 416–422

<sup>133</sup> *Toonen v. Australia*, Communication No. 488/1992, U.N. Doc CCPR/C/50/D/488/1992 (1994)

<sup>134</sup> Namibian Law on LGBTI Issues, Legal Assistance Centre, 2015, at p 66 – “Namibian Police appear to disclose only 4 to 5 arrests for sodomy over the ten-year period for 2003 to 2012”

<sup>135</sup> Act 51 of 1977.

considered to be a prohibited immigrant in terms of the Immigration Control Act.<sup>136</sup> Consensual sexual activity between adult females is not illegal.

Currently the Ministry of Correctional Service does not provide condoms to inmates due to the perception that to do so would be to encourage them to break the law by indulging in sodomy or related sexual acts.

As in many countries in southern Africa, men who have sex with men in Namibia remain hidden and are difficult-to-reach for research purposes due to social stigma and discrimination. Many men who have sex with men often feel the need to hide their same-sex relations from friends and family, thereby increasing their vulnerability to HIV and other infections. In addition, stigma and discrimination towards men who have sex with men foster an environment whereby men who have sex with men marry and have sexual relationships with females in order to maintain a heterosexual persona. This not only increases their own vulnerability for HIV infection, but also increases the risk of HIV transmission to their female sexual partners.

A focus group discussion held with community nurses in the course of this assessment revealed that many community nurses feel that they do not have sufficient expertise or knowledge about men who have sex with men sexual health needs to adequately meet their needs.

## Recommendations

- The provisions of the common law should be amended to decriminalize consensual sex between adult males in accordance with international human rights law and good practice.
- Given the high percentage of men who have sex with men who remain hidden due to social stigma and discrimination, there must be concrete steps and actions to ensure the creation of enabling environment as opposed to “lip service”.
- Law enforcement officials, and health and social care providers need to be trained to recognize and uphold the human rights of LGBTI, and should be held accountable if they violate these rights. The exclusion of the LGBTI community from health care services can result in their specific issues being left out of health care policies in Namibia.
- Consideration should be given to utilizing the provisions of the Correctional Service Act<sup>137</sup> to advocate for the provision of condoms in prisons since the Act requires that “every inmate” should have “access to preventative health measures” and be provided with the “necessary precautionary or prophylactic health measures.”
- The Legislature, church community and traditional leaders should be sensitized to the equal rights of the LGBTI community including in the religious and cultural context
- Consideration should be given to incorporating a human rights component focusing on the equal rights of all in tertiary programmes where relevant
- The role of civil society in creating tolerance should be recognized and acknowledged and resources made available to support this role.

## Sex workers

Sex workers are entitled to the full protection of their human rights, as specified in international human rights instruments. Human rights include the right to non-discrimination; security of person and privacy; recognition and equality before the law; due process of law and the highest attainable

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<sup>136</sup> Act 7 of 1993, section 7-1- and Schedule 1; sections 39-50.

<sup>137</sup> Act 9 of 2012, sections 23(1)(c) and (3)(c) and section 24(1)(b)(v).

standard of health; employment, and just and favourable conditions of employment; peaceful assembly and association; freedom from arbitrary arrest and detention, and from cruel and inhumane treatment; and protection from violence.

Sex workers are essential partners and leaders in effective HIV and sexual health programs, and for developing solutions that respond to the realities of the environments in which they live and work. Laws that directly or indirectly criminalize or penalize sex workers, their clients and third parties, and abusive law enforcement practices, stigma and discrimination related to HIV and sex work can undermine the effectiveness of HIV and sexual health programs, and limit the ability of sex workers and their clients to seek and benefit from these programs.

Of particular concern is the violence perpetrated against sex workers, as well as repressive police practices, including harassment, extortion, arbitrary arrest and detention, and physical and sexual violence. Also of concern are health-care settings where there is stigma, discrimination and denial of health care to sex workers. Since sex worker-led organizations are crucial for enabling sex workers to protect themselves from discrimination, coercion and violence, measures that prevent them from assembling and organizing themselves are also of significant concern.

Attention and resources are needed to prevent, address, report and redress violence against sex workers, especially by supporting sex workers' individual and collective self-organization and self-determination. The promotion of a legal and social environment that protects human rights and ensures access to information, services and commodities related to HIV prevention, treatment, care and support, without discrimination, is essential for achieving an effective and rights-based response to the HIV epidemic and promoting public health, including in the context of sex work.

### Current position

Sex work is not specifically criminalised in Namibia. The Combating of Immoral Practices Act<sup>138</sup> criminalises the following activities related to sex work:

- Keeping of a brothel (section 2)<sup>139</sup>;
- Procuration (section 5);
- Enticing the commission of immoral acts, including soliciting or indecent dress in public (section 7);
- Committing of immoral acts in public (section 8);
- Permitting of offence in terms of this Act by owner or occupier of premises (section 9);
- Living on the earnings of prostitution and assistance in relation to the commission of immoral acts (section 10).<sup>140</sup>

In Windhoek, the municipality has frequently used provisions under the Street and Traffic Regulations of the Municipality of Windhoek<sup>141</sup> against sex workers.

Regulation 12 deals with loitering and provides that no person shall wilfully –

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<sup>138</sup> Act 21 of 1980.

<sup>139</sup> In the case of *Hendricks and others v Attorney-General, Namibia* (High Court, Case 140/2000, judgement 20 August 2002), the court ruled that some sections of the Act were overly broad, such as a portion of the definition of a brothel that included places people “visit for the purpose of having unlawful carnal intercourse” and unconstitutional.

<sup>140</sup> In the case of *S v H 1986 (4) 1095 (T)*, the South African High Court considered the meaning of this offence, and held that the offence does not apply to sex workers, but to persons who trade in or benefit from a sex worker's activities. The same was said in the case of *Hendricks and others v Attorney-General, Namibia* (High Court, Case 140/2000, judgment 20 August 2002).

<sup>141</sup> Government Notice 9 of 1930, as amended by General Notice 27 of 1994.

- Sit, lie, stand or congregate in a street or public place or otherwise act in such a manner as to obstruct free traffic, or jostle or otherwise hinder any other person using the street, or obstruct the free movement of persons in such public place;
- Loiter near the entrance to a public place of assembly in such a manner as to obstruct the free movement of persons into or out of the public place of assembly; or
- Loiter within 1000 metres from the premises of an institution for the care of aged or handicapped people, a school, hospital, church or other similar institution.

In terms of Regulation 16, no person shall in or in view of any street or public place solicit a person in any way for the purpose of prostitution. This section in theory applies to sex workers who solicit clients, pimps who solicit business for sex workers and clients who wish to enter into a sexual transaction with a sex worker. In addition, laws that criminalise same sex sex impact on male and transgender sex workers. Although there is little evidence that these laws are regularly applied their existence and the power that they afford law enforcement officials in and of themselves have an effect on how sex workers operate.

The Report<sup>142</sup> of the UN Special Rapporteur on extreme poverty and human rights, after its mission to Namibia in 2013, noted a number of challenges faced by sex workers:

- The criminalisation of sex work lies at the foundation of a climate of stigma, discrimination and violence surrounding sex work;
- Sex workers experience recurring police abuse and high levels of violence, including the confiscation of condoms, arbitrary detention and rape, which compromise their personal safety and right to equal protection of the law. It further creates a climate of impunity that fosters further violence and discrimination against sex workers.
- Stigma, discrimination and violence discourages sex workers from accessing public services, particularly health care, thereby violating their rights as well as hampering efforts to reduce the spread of HIV/AIDS.

The Special Rapporteur noted: “In line with its human rights obligations, Namibia is obliged to provide all persons equal and effective protection of the law and take measures to prevent and combat indirect systemic discrimination on the form of legal rules, policies, practices or predominant cultural attitudes, either in the public or private sector which create relative disadvantages for some groups in the enjoyment of their rights.” The Rapporteur recommended the repeal of provisions relating to sex work in the Combating of Immoral Practices Act and all similar municipal regulations.

High rates of violence against sex workers have also been reported in other studies.<sup>143</sup> Research has found extensive evidence of abuse of sex workers by police officers, including confiscation of condoms, arbitrary detention, violence, rape and extortion of money.<sup>144</sup> Fear of police abuse increases the need of sex workers to seek assistance from pimps or work in isolated areas, which puts them at risk.

<sup>142</sup> Report of the Special Rapporteur, Ms Magdalena Sepulveda Carmona, 17 May 2013, A/HRC/23/36/Add.1, at page 12.

<sup>143</sup> Matthew Greenall (2011), Sex work and HIV, review of literature, UNFPA, at page 11.

<sup>144</sup> Matthew Greenall (2011), Sex work and HIV, review of literature, UNFPA; Legal Assistance Centre (2002) “Whose body is it?” Commercial sex work and the law in Namibia, Windhoek; Le Beau D (2007) “The economics of sex work and its implications for HIV for sex workers in Namibia” in Hubbard and La Font (2007) Unravelling taboos: gender and sexuality in Namibia, Legal Assistance Centre; Kiremire MK (2007) Prostitution in Windhoek, Namibia: An exploration of poverty, Analyses and Views Series 4:2; Arnot J and Crago AL (2009) Rights not rescue: A report on female, male and trans sex workers’ human rights in Botswana, Namibia and South Africa, OSISA; OSF (2012) Criminalising condoms: How policing practices put sex workers and HIV services at risk in Kenya, Namibia, Russia, South Africa, the United States and Russia.

Interviews with sex workers in Windhoek elicited similar information about recurrent stigma, police abuse and impunity as a result of criminalisation:<sup>145</sup>

“Stigma starts with the law itself”;

“We have tried to contact the police by they don’t help”;

“The police hit us on the streets and we are brutally abused where it is isolated and dark by the police”;

“When it is late... and the superiors go home, the officers on duty book us out and take us to their places [to] have sex with us, make us clean their places then chase us”.

The UNAIDS Guidance Note on HIV and Sex Work (2012) notes that the criminalisation of sex work contributes to the economic and social marginalisation of sex workers and their families, who are seen by society as criminals and often denied access to basic government services. This marginalisation is a barrier to access to health care services and adds to the risk that sex workers will be treated disrespectfully when accessing health services.

The Guidance Note concludes:

“There is very little evidence to suggest that any criminal laws related to sex work stop the demand for sex or reduce the number of sex workers. Rather, all of them create an environment of fear and marginalisation for sex workers, who often have to work in remote and unsafe locations to avoid arrest of themselves or their clients. These laws undermine sex workers’ ability to work together to identify potentially violent clients and their capacity to demand condom use of clients. The approach of criminalising the client has been shown to backfire on sex workers. In Sweden, sex workers who were unable to work indoors were left on the street with the most dangerous clients and little choice but to accept them. Where sex work is criminalised, sex workers are very vulnerable to abuse and extortion by police in detention facilities and elsewhere.”<sup>146</sup>

The UN International Guidelines on HIV/AIDS and Human Rights (2006) requires that States take measures to “reduce the vulnerability, stigmatisation and discrimination that surround HIV and promote a supportive and enabling environment by addressing underlying prejudices and inequalities within societies.” The UNAIDS Guidance Note concludes that municipal laws which give police too wide latitude to arrest tend to contribute to an atmosphere of fear and marginalisation.<sup>147</sup>

Notwithstanding the provisions of the Combating of Immoral Practices Act, the National Strategic Framework recommends that appropriate interventions to address HIV/AIDS should target clients of sex workers with prevention messages and tools including education and supply of condoms. The National Policy on HIV/AIDS states that people engaging in transactional sex shall have access to confidential and respectful healthcare particularly sexual and reproductive health.

## Recommendations

- Consensual sex work should be decriminalized and the unjust application of non-criminal laws and regulations against sex workers for harm reduction purposes should be eliminated.
- States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality and ethics in research

<sup>145</sup> Greenall M (2011) Sex work and HIV – Reality on the ground: Rapid assessments in five towns in Namibia, research report, UNAIDS, page 23.

<sup>146</sup> UNAIDS Guidance Note on HIV and Sex Work, page 4.

<sup>147</sup> UNAIDS Guidance Note on HIV and Sex Work, page 4.

involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.

- Consideration should be given to discontinuing the use of municipal laws as the basis to arrest sex workers in public places.
- Law should be enacted to protect against discrimination and violence, and other violations of rights faced by sex workers in order to realize their human rights and reduce their vulnerability to HIV infection and the impact of AIDS. Anti-discrimination laws and regulations should guarantee sex workers' rights to social, health and financial services.
- Programs should be put in place to provide legal literacy and legal services to sex workers so that they know their rights and applicable laws, and can be supported to access the justice system when aggrieved.
- Health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health.
- Programs should be put in place to sensitize and educate health-care providers on non-discrimination and sex workers' right to high-quality and non-coercive care, confidentiality and informed consent.
- Sex workers groups and organizations should be made essential partners and leaders in designing, planning, implementing and evaluating health services.
- Essential health services for sex workers must include universal access to male and female condoms and lubricants, as well as access to comprehensive sexual and reproductive health services, and equitable access to all available health-care services including primary health care.
- Violence against sex workers is a risk factor for HIV and must be prevented and addressed in partnership with sex workers and sex worker led organizations.
- Violence against sex workers needs to be monitored and reported, and redress mechanisms established to provide justice to sex workers.
- Law enforcement officials, and health and social care providers need to be trained to recognize and uphold the human rights of sex workers, and held accountable if they violate the rights of sex workers, including the perpetration of violence.
- Support services need to be provided to sex workers who experience violence.

## People who use drugs

Treating drug use as a criminal offence fuels the transmission of HIV through several mechanisms<sup>148</sup>. The criminalization of the possession and use of drugs; and the possession of drug injecting paraphernalia; as well as aggressive drug law enforcement practices aimed at suppressing the drug market drive people who use drugs away from public health services and into hidden environments where HIV risk becomes markedly elevated. In addition, police harassment and arrest have been shown to increase risky drug practices among people who use drugs.

Punitive drug law enforcement measures create barriers to HIV testing and treatment. These barriers to treatment include stigma and discrimination within healthcare settings, refusal of services, breaches of confidentiality, requirements to be drug-free as a condition of treatment, and the use of registries that lead to denial of such basic rights as employment and child custody.

As a result, research has repeatedly shown that drug users have lower rates of antiretroviral therapy use and higher HIV/AIDS death rates<sup>149</sup>. Punitive drug law enforcement policies and practices also have broader implications for public health. Given the demonstrated prevention benefits of

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<sup>148</sup><http://www.opensocietyfoundations.org/reports/war-drugs-and-hiv-aids-how-criminalization-drug-use-fuels-global-pandemic>

<sup>149</sup> Mathers BM, Degenhardt L, Ali H, et al. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet*, 2010; 375(9719): 1014-1028.

antiretroviral therapy, the public health benefit of providing all segments of the population, including persons who inject drugs with access to HIV treatment is undeniable.

However, numerous studies have demonstrated that coercive drug law enforcement measures and the frequent incarceration of people who use drugs hinder them from seeking HIV testing and treatment, and contribute to the interruption of HIV treatment once it has begun. The incarceration of non-violent drug law offenders is a significant factor in the epidemic. This is a critical public health issue in many countries where HIV prevalence and AIDS cases behind bars are many times higher than among the general population. High rates of incarceration among drug users with or at risk of HIV infection are a matter of deep concern given that incarceration has been associated with sharing needles, unprotected sex and HIV outbreaks in many places around the world. Incarceration also drives risk of HIV infection and disease by interrupting antiretroviral HIV treatment. Thus drug law enforcement measures often disrupt HIV treatment efforts, promote HIV drug resistance and increase risk of HIV transmission.

Prohibitions or restrictions on opioid substitution therapy and other evidence-based treatment result in untreated addiction and avoidable HIV risk behaviour. Multiple systematic reviews of evidence have shown that countries or jurisdictions that have legalized comprehensive harm reduction services that include needle exchange programmes and opioid substitution therapy have significantly reduced HIV infections among people who use drugs, compared with persistent or growing rates in countries or jurisdictions where such services are restricted or banned by law. In addition, countries that have decriminalized possession and use of small quantities of drugs for own use, such as Portugal, have seen marked reduction in new HIV infections amongst people who use drugs<sup>150</sup>.

### **Current position**

There is lack of data in Namibia about injecting drug users. There have been no official reports of injecting drug use in Namibia. Resources for the Prevention and Treatment of Substance Use Disorders (SUD) Namibia country profile reported no cases of injecting drug users in the country.<sup>151</sup> Anecdotal evidence would suggest that this perception is incorrect although there is no data on HIV prevalence amongst people who use drugs.

The National Strategic Framework refers to people who inject drugs as a most at risk population but also notes that the a review of the third medium term plan on HIV noted that “injecting drug users does not seem to be a problem in Namibia”<sup>152</sup> It is thus not surprising that in Namibia there are currently no harm reduction programmes such as needle exchange programmes in place. It is essential that Namibia develop harm reduction programs to reduce needle sharing, increase access to clean needles and syringes through needle and syringe exchange programs, and to promote safer injecting practices, including the proper cleaning of needles, syringes and other injection equipment.

In addition, there are currently no proven and effective treatment opportunities for addiction such as substitution therapy with methadone and other substitutes.

The Abuse of Dependence-Producing Substances and Rehabilitation Centres Act 41 of 1971 (as amended) distinguishes between dependence-producing drugs, dangerous dependence-producing drugs and potentially dangerous dependence-producing drugs makes it an offence to possess or deal in any of these categories of drugs (section 2). Maximum sentences on conviction range between a

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<sup>150</sup> 17% reduction between 1999 and 2003 after decriminalization in 2001

<sup>151</sup> [http://www.who.int/substance\\_abuse/publications/atlas\\_report/profiles/namibia.pdf](http://www.who.int/substance_abuse/publications/atlas_report/profiles/namibia.pdf)

<sup>152</sup> At 33

fine of N\$ 10 000 and/or 5 years imprisonment to N\$ 50 000 and/or 25 years imprisonment dependent on whether the conviction is for possession or dealing and on whether it is a first offence or not.

Provision is also made in this Act in Part III for treatment and rehabilitation on both voluntary and involuntary bases.

In terms of section 29 a magistrate may commit a person to a rehabilitation centre if he or she is satisfied that the person is dependent on alcoholic liquor or dependence-producing drugs and in consequence thereof squanders his means or injures his health or endangers the peace or in any other manner does harm to his own welfare or the welfare of his family and that he is a type of person who requires and would probably benefit by the treatment and training provided in a rehabilitation centre or registered rehabilitation centre.

Section 44 provides that any person may, either himself or through any other person acting on his behalf, or a parent or guardian may on behalf of a minor child of which he is the parent or guardian, apply to a social worker in the prescribed manner that he or such minor child, as the case may be, be admitted to a rehabilitation centre or registered rehabilitation centre as a voluntary inmate. There is only one state-owned rehabilitation centre, the Etegameno Rehabilitation and Resource Centre, near Brakwater, which admits about 80 people between the ages, of 18- 39 on an annual basis. Most people admitted to the state's rehabilitation centre are treated for alcohol, dagga (Cannabis), Cocaine, Mandrax, Tik (Crystal Meth) and heroin addictions.

Etegameno Rehabilitation and Resource Centre admits people that are referred to the centre by social workers of the ministry operating from the health directorates on a voluntary basis. Treatment provided is in the form of counselling and the provision of vitamins and advice on diet and nutrition. Opioid substitution therapy is not provided.

Okonguarri Psychotherapeutic Centre situated south-east of Outjo is a fully certified mental health hospital, registered in terms of Section 31 of the Hospitals and Health Act 36 of 1994. Participants are housed in semi-private bungalows with en-suite facilities, with each bungalow accommodating a maximum of 3 participants. The Okonguarri Psychotherapeutic Centre is registered with NAMAFA (Namibian Association of Medical Aid Funds) as a private mental health facility. NAMAFA-approved tariffs are applicable for admission and therapy.

Okonguarri acknowledges the importance of modern medicine in the treatment of psychological disorders. They are constantly in tune with the latest developments regarding psychotropic and other drug interventions. This service is rendered by Okonguarri's visiting medical practitioners (including a psychiatrist), the respective referring psychiatrists and the nursing staff. According to Dr. Herman Raath, "every case is evaluated individually which if such a case warrants it, it will include opioid replacement therapy."

The My Wellness 24/7 Drug and Rehabilitation Centre has a license from Ministry of Health and Social Services to treat alcohol and drug related conditions for adults at two centres; Swakopmund (primary program); and Usakos (secondary program). The latter facility is currently closed due to renovations in progress.

The programme is based on the AA 12 Step Programme and no opioid substitution therapy is provided. In the event that any form of detoxification needed, it is done pre-admission in consultation with a Psychiatrist, Clinical Psychologist or Medical Practitioner. If patients are on

Pharma-therapy before admittance or in need of pharma-treatment, the treatment will proceed or be initiated as prescribed by the Medical Practitioner.

## Recommendations

- Replace ineffective measures focused on the criminalization and punishment of people who use drugs with evidence-based and rights affirming interventions proven to meaningfully reduce the negative individual and community consequences of drug use, including the promotion of referrals to rehabilitation programs rather than the imposition of custodial services for persons convicted of possession for own use.
- Consideration should be given to decriminalize possession of drugs for own use and halt the practice of arresting and imprisoning people who use drugs but do no harm to others.
- Scale up evidence based strategies to reduce HIV infection and protect the health of persons who use drugs, including sterile syringe distribution and other safer injecting programs.
- Invest in an easily accessible range of evidence-based options for the treatment and care for drug dependence, including opioid substitution therapy.
- Build the capacity of law enforcement officials, judicial officers and health care service providers on the importance of evidence-based and rights affirming interventions proven to meaningfully reduce the negative individual and community consequences of drug use.

These strategies reduce disease and death, and also limit the size and harmful consequences of drug markets by reducing the overall demand for drugs. International bodies such as WHO and UNAIDS recommend a comprehensive package for the prevention, treatment and care of HIV amongst intravenous drugs users which includes the following<sup>153</sup>:

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

**Source: WHO, UNODC, UNAIDS (2009)**

## Criminalization of HIV transmission and exposure

Recent years have seen the enactment of HIV-specific laws that criminalize HIV transmission and exposure, driven by the wish to respond to serious concerns about the ongoing rapid spread of HIV in many countries, coupled by what is perceived to be a failure of existing HIV prevention efforts. In some instances, particularly in Africa, these laws have been a response to the serious phenomenon of women being infected with HIV through sexual violence or by partners who do not reveal their HIV diagnoses to them. The same debate has been prevalent in Namibia's print media.

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<sup>153</sup> Harm Reduction International, *What is harm reduction?* (2010) Available at [http://www.ihr.net/files/2010/08/10/Briefing\\_What\\_is\\_HR\\_English.pdf](http://www.ihr.net/files/2010/08/10/Briefing_What_is_HR_English.pdf); Global Commission on HIV and the Law (2012) *Risks, Rights and Health*

A closer analysis of the complex issues raised by criminalization of HIV exposure or transmission reveals that criminalization is unlikely to prevent new infections or reduce women's vulnerability to HIV. In fact, it is more likely to harm women rather than assist them, and negatively impact both public health and human rights.

Applying criminal law to HIV transmission can have the negative effect of **detering people from getting tested** and finding out their HIV status, as lack of knowledge of one's status could be the best defence in a criminal lawsuit. In jurisdictions with HIV-specific criminal laws HIV testing counsellors are often obliged to caution people that getting an HIV test will expose them to criminal liability if they find out they are HIV-positive and continue having sex. These same counsellors are sometimes forced to provide evidence of a person's HIV status in a criminal trial. This creates distrust in relationships between PLHIV and their health care providers and thus interferes with the delivery of quality health care and frustrates efforts to encourage people to come forward for testing.

In addition, criminalizing HIV transmission, exposure and non-disclosure **creates a sense of false security** by placing legal responsibility exclusively on people living with HIV for preventing the transmission of the virus. This undermines the public health message that everyone should practice safer behaviours, regardless of their HIV status, and that sexual health should be a shared responsibility between sexual partners. People may (wrongly) assume their partners are HIV-negative because they have not disclosed their status, and thus not take measures to protect themselves from HIV infection.

Applying criminal law to HIV exposure or transmission, except in very limited circumstances **reinforces the stereotype that people living with HIV are immoral and dangerous criminals**, rather than, like everyone else, people endowed with responsibility, dignity and human rights.

Prosecutions for HIV transmission or exposure also **spread myths and misinformation about how HIV is transmitted**. In some jurisdictions, serious criminal charges have been laid against HIV-positive people for activities such as biting, spitting, or scratching, despite evidence that the risk of HIV transmission in this fashion is extraordinarily small (and in some cases, non-existent). Such prosecutions not only undermine efforts to educate the public about HIV, but further engender fear of people living with HIV.

Applying criminal law to HIV transmission also **does very little to address the epidemic of gender-based violence or the deep economic, social, and political inequality that are at the root of women's and girls' disproportionate vulnerability to HIV**. On the contrary, these laws are likely to be used to prosecute women more often than men. That is because women engage with the health system more often (including during pregnancy and child birth), and are thus more likely to find out about their positive HIV status before their male partners. Where laws criminalizing HIV exposure or transmission are in place, women who test HIV-positive have to disclose their HIV status to their partners, refuse to have sex, or insist on condom use to avoid the risk of being prosecuted for exposing their partner to HIV. However, for many women these actions carry the risk of violence, eviction, disinheritance, loss of their children, and other severe abuses. Thus women are faced with an impossible choice: either to risk violence by trying to protect their partners, or to risk prosecution by failing to do so.

Laws that criminalize HIV exposure, transmission and non-disclosure can also be used to prosecute women who transmit HIV to a child during pregnancy or breastfeeding. For millions of women living with HIV/AIDS—but often denied access to family planning, reproductive health services, or medicines that prevent mother-to-child transmission of HIV—this effectively makes pregnancy, wanted or not, a criminal offense. There are many more effective ways to prevent mother-to-child transmission of HIV, beginning with supporting the rights of all women to make informed decisions

about pregnancy and providing them with sexual and reproductive information and services, preventing HIV in women and girls in the first place, preventing unwanted pregnancies among all women, and providing effective medication to prevent mother-to-child transmission of HIV to HIV-positive women who wish to have children.

Given the stigma that still surrounds HIV and the persistence of HIV-related discrimination, criminal sanctions are often directed disproportionately at those who are socially and/or economically marginalized and thus there is a **risk of selective or arbitrary prosecution**. In America for example, a homeless man living with HIV was sentenced to 35 years in prison because he spat at the police officer who was arresting him for disorderly conduct.<sup>154</sup> Many other cases suggest that criminal law is invoked in sensational circumstances, often in relation to those who are most marginalized and stigmatized in a society, including immigrants and refugees, foreigners, or sex workers, and occasionally in response to emotional media campaigns. In 2014, a nurse was sentenced to three years in prison for exposing a child to HIV while she was administering an injection. The nurse was tried and convicted in the public eye by the media, violating her rights and presumption of innocence.<sup>155</sup>

Proving that an accused person was HIV-positive at the time of an alleged offense, as well as proving who infected whom and when, is a serious challenge. To prove guilt, scientific evidence of transmission by the accused person is required. In recent years, where resources exist, prosecutors handling cases of HIV transmission increasingly have resorted to —phylogenetic testing, which seeks to establish a genetic relationship between the HIV viruses of the two parties. However, such evidence only indicates similarities in the viruses; it does not prove beyond a reasonable doubt the source of the virus. Such technical evidence and its limitations are not well understood by police, prosecutors, defence lawyers, courts, the media, or people living with HIV or HIV organizations. Phylogenetic testing is also very expensive to apply and thus unaffordable in many low-resource countries. As a result of all these factors, there is **considerable potential for a conviction without sufficient evidence**.

For these reasons the enactment of HIV-specific laws that criminalize HIV transmission and exposure are counter-productive. The use of criminal law in the response to HIV **is justified under one condition only**: where individuals intentionally transmit HIV to others with the express purpose of causing harm. In the rare instances where this does occur existing criminal laws against assault with intent to do grievous bodily harm suffice to prosecute people in those exceptional cases. Creating specific HIV offences is not warranted and, in fact, violates international human rights standards. The International Guidelines on HIV and Human Rights, Guideline 4 directs States to ensure that their criminal laws —are not misused in the context of HIV/ AIDS or targeted against vulnerable groups.

### **Current position**

There are currently no laws in place that specifically criminalize HIV transmission or exposure in Namibia. However, the Public and Environmental Health Act, 1 of 2015 which was promulgated in May 2015 does contain a section that could potentially be used to prosecute a person for intentional or negligent transmission and exposure. PART 4 of this Act deals with sexually transmitted infections and in terms of section 34, PART 4 applies to all sexually transmitted infections, except the infections as the Minister may specify by notice in the Gazette.

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<sup>154</sup> 'Prison for man with HIV who spit on Police Officer' The New York Times, 16 May 2008. Available online at: [http://www.nytimes.com/2008/05/16/us/16spit.html?\\_r=0](http://www.nytimes.com/2008/05/16/us/16spit.html?_r=0)

<sup>155</sup> AIDS-Free World 'HIV-Positive nurse tried by media' Available online at: <http://www.aidsfreeworld.org/Newsroom/Press-Releases/2014/HIV-Positive-Nurse-Tried-by-Media.aspx>

Section 37 provides that “A person who, knowing that he or she is infected with a sexually transmitted infection - (a) wilfully or negligently infects another person; or (b) wilfully or negligently permits or acts in a way likely to lead to the infection of another person, commits an offence and is liable to a fine not exceeding N\$100 000 or to imprisonment for a period not exceeding 10 years, or to both such fine and such imprisonment.”

This Act has not yet entered into force and in terms of section 96 will come into operation on a date to be determined by the Minister of Health by notice in the Government Gazette. It is also important to note that the Minister has not yet specified the sexually transmitted infections by way of Notice in the Gazette which will be exempt from the application of Part 4 of the Act. It is thus critical that HIV be specified as a sexually transmitted disease which is exempt from the application of Part 4 of the Act in order that an HIV specific offence of transmission or exposure is not created when the Act enters into force.

## Recommendations

It is recommended that HIV-specific laws that criminalize HIV transmission and exposure are not enacted and that in the rare instances where individuals intentionally transmit HIV to others with the express purpose of causing harm, existing laws— including against assault with intent to do grievous bodily harm—suffice to prosecute people in those exceptional cases. In particular it is recommended that HIV be specified as a sexually transmitted disease which is exempt from the application of Part 4 of the newly enacted Public and Environmental Health Act 1 of 2015 in order that an HIV specific offence of transmission or exposure is not created when the Act enters into force.

Guidelines should be developed to support law enforcement agents and the judiciary to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered.

## Inmates

In Namibia, it is estimated that 13.2% of the correctional facility population is living with HIV.<sup>156</sup> A combination of lengthy pre-trial detentions, substandard nutrition and sanitation, violence, rape, consensual unprotected sex and inadequate staffing in prisons contribute to HIV transmission in correctional facilities. International human rights law recognizes the prerogative of the state to deprive people of certain rights—the most obvious one being liberty—through incarceration. But imprisonment does not justify denial of the human rights to humane treatment and dignity<sup>157</sup>. Inmates have a right to a standard of health care equivalent to that available outside of correctional facilities, and agents of the state have an obligation to refrain from inflicting harm on inmates. Among the rights that correctional authorities are obligated to protect, and courts including the European Court of Human Rights have upheld, are those to health and life, which include adequate access to HIV prevention and treatment services. The majority of inmates do not have this access.

The State, through correctional authorities, owes a duty of care to inmates, including the duty to protect the rights to life and to health of all persons in custody. In the context of HIV this includes ensuring access by inmates to HIV-related information, education and means of prevention (bleach,

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<sup>156</sup> UNODC (2014) Situation and Needs Assessment in (Namibian) Correctional Institutions: HIV, Hepatitis B and Syphilis 2011/2012. Unpublished

<sup>157</sup> Article 10, International Convention on Civil and Political Rights. Available at: <http://www2.ohchr.org/english/law/ccpr.htm>

condoms, clean injecting and tattooing equipment), voluntary testing and counselling, confidentiality and HIV treatment and access to and voluntary participation in treatment trials. The duty of care also comprises a duty to prevent rape and other forms of sexual assault in prison that may result, inter alia, in HIV transmission.

There is no public health or security justification for mandatory HIV testing of inmates, nor for denying inmates living with HIV access to all activities available to the rest of the inmate population. Inmates with terminal diseases, including AIDS, should be considered for early release and given proper treatment outside prison<sup>158</sup>. Although female inmates have restricted rights, they have a range of reproductive health needs which need to be addressed to reduce the harm caused to that individual or their community on their release.

### **Current position**

As at January 2015, the thirteen Namibian Correctional Service (NCS) correctional facilities held an estimated inmate population of 3,382, of whom 88 were female of whom seven were accompanied by infants. There were 3,139 sentenced inmates and 239 un-sentenced inmates. The total number of inmates in the Namibian correctional facilities compared to the design capacities comprised 75.5% at the end of January 2015. However, four of the correctional facilities were overcrowded: Oluno at 116% capacity; Omaruru at 137%; Grootfontein at 207% and Evaristus Shikongo at 174%.<sup>159</sup>

The NCS Health Care Services are headed by a Commissioner (Medical Officer) and structured into Nursing Services, Pharmaceutical Services and HIV/AIDS Services. As of July 2015, there were 56 personnel in Health Care Services, of which four are doctors, 39 are nurses and one is a pharmacy assistant. Depending on a correctional facility's and administrative region's size, the medical staffing ranges from two nurses (e.g. Swakopmund) to ten nurses and a Medical Officer (M.D.) (e.g. in Hardap). NCS is currently on a recruitment drive to fill all vacant positions in the Health Care Services.

The NCS aims to provide Primary Health Care Services which are equivalent to the ones provided in the wider community by the MOHSS. These services are comprehensive health services which include screening of offenders for communicable and non-communicable diseases, HIV/AIDS counselling and testing, health education, treatment, referrals and palliative care. At correctional facilities which do not have adequate health service staff capacity, inmates are referred and taken by guards to the nearest MOHSS facility for these services.

In terms of section 23(1) the Correctional Service Act of 2012, the NCS must, as far as is practicable and when so required, provide every inmate with:

- (a) essential health care services;
- (b) reasonable access to non-essential mental health care with an emphasis on the inmate's rehabilitation and successful reintegration into the community; and
- (c) access to preventive health measures.

The National HIV AIDS Policy states that all inmates, people awaiting trial and correctional service members shall have access to the same HIV related prevention information, education, voluntary counselling and testing, means of prevention, treatment, care and support as is available in the general population<sup>160</sup>. It further states that correctional service authorities shall ensure that nutrition, treatment, care and support services are provided to inmates living with HIV/AIDS in a

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<sup>158</sup> UNAIDS and OHCHR (2006) International Guidelines on HIV/AIDS and Human Rights, paras 86 and 87

<sup>159</sup> NCS Unlock Report as on 21 January 2015

<sup>160</sup> National Policy on HIV/AIDS.2007. Republic of Namibia, pg. 11

sensitive and confidential manner and shall guard against inadvertently disclosing the HIV status of any inmate<sup>161</sup>. These policy provisions are however largely not adhered to by the NCS.

Despite assertions by NCS staff that no sex between men occurs in Namibian correctional facilities, a study undertaken by University of Wyoming and AIDS Law Unit of the Legal Assistance Centre in Namibian correctional facilities confirms that sex does take place between male inmates in the form of consensual sex or in the form of coercive sex where an inmate engages in sexual contact or a sexual relationship with another inmate in order to gain a perceived advantage or benefit (for example, submission in return for protection or other favours such as food). Rape also occurs in the correctional facilities.<sup>162</sup> This notwithstanding, the NCS declines to distribute condoms based on the argument that sodomy is a crime in Namibia and that by providing condoms the NCS would be condoning and /or aiding and abetting an illegal act.

Although tattooing is prohibited in Namibian correctional facilities it does take place. No provision is however made by NCS for access to sterile tattooing equipment by inmates.

Whilst inmates do have access to antiretrovirals, correctional facilities typically do not have doctors on-site and inmates requiring care or HIV treatment must request, often repeatedly, to see a physician at a state health facility.<sup>163</sup> Treatment interruptions are common when inmates are transferred from one correctional facility to another. In addition, inmates who are on antiretroviral therapy complain that they do not have access to adequate nutrition in correctional facilities, which makes adherence difficult. Ex-inmates interviewed during a focus group discussion complained that cells are overcrowded and rat-infested with inadequate ventilation and that nutrition is poor. Vegetables and fruits are seldom provided and cooking facilities are unsanitary

No provision is made in Namibian correctional facilities for needle exchange or for the provision of bleach with which to sterilise injecting equipment, which is frequently shared among inmates for injecting drug use. Inmates who are injecting drug users do not have access to any form of opioid substitution therapy.

## Recommendations

- Ensure that inmates have full and appropriate access to the same HIV related prevention information, education, voluntary counselling and testing, means of prevention (including condoms), treatment, care and support as is available in the general population.
- Enact legislation to abolish the common law prohibition on sodomy. This prohibition is a major impediment to the distribution of condoms in correctional facilities and legitimises discrimination against men having sex with men.
- Ensure that victims of rape, assaults and other at-risk inmates have access to Post-exposure prophylaxis in correctional facilities.
- Increase the number of health care workers in the correctional facilities ensuring that each correctional facility has sufficient competent nurses and doctors to provide health care services within prisons.
- Encourage voluntary HIV testing and expand access to post-test counselling and treatment services.
- Increase oversight of inmates to reduce violence, rape, drug use and tattooing.
- Provide sufficient amount of nutritious food to all inmates.

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<sup>161</sup> Ibid, pg 12

<sup>162</sup> Struggle to Survive: A Report on HIV/AIDS and Prisoners Rights in Namibia. 2010. Pg. 27 accessed at <http://www.lac.org.na/projects/alu/Pdf/struggletosurvive.pdf>

<sup>163</sup> Ibid, pg 6

## D. HIV/AIDS in the Workplace

The impact of HIV/AIDS is multi-faceted and stretches across social, economic and political spheres. The HIV/AIDS pandemic is a health issue but also has an impact on economic productiveness of individuals. It affects employees in their most productive years of life, thus leading to reduced earnings, as well as increasing care demands, higher expenditures on health care and premature death. In the long-term, the consumer market is reduced, leading to a drop in resources available for production and investment. This would also lead to reduced consumer demand, resources and investment possibilities which directly affect economic growth. The loss of skilled workers, together with the entry into the labour market of unskilled employees, may lower both the average working age and the skills level.

Unfair discrimination against people living with HIV/AIDS in the workplace has been perpetuated through practices such as pre-employment HIV testing, dismissal for being HIV positive and the denial of promotion and employee benefits. This is clearly in contravention of the National Code on HIV/AIDS in Employment, which was adopted by Cabinet in 2002 and the National Policy on HIV/AIDS (2007). The policy states that<sup>164</sup>:

No employer shall require, whether directly or indirectly, any person to undergo testing for HIV as a precondition for employment. The criteria for employment shall be fitness to do the job for which employment is sought and no person shall be excluded from employment solely on the basis of HIV status.

No employer shall terminate the employment of an employee solely on the grounds of HIV status or family responsibility,

Employees living with HIV shall continue working in their current employment for as long as they are medically fit to do so. When on medical grounds they cannot continue with normal employment, verifiable efforts should be made to offer them alternative employment or other reasonable arrangements without prejudice to their benefits.

Section 5(2) of the Labour Act, No. 11 of 2007 lists HIV/AIDS as one of the prohibited ground of discrimination in employment decisions. This provision has been further supported by National Strategic Framework which one of its interventions is to try and reduce stigma and discrimination<sup>165</sup>.

The case of *Nanditume v Minister of Defence*<sup>166</sup> which has already been referred to in the section on “The Right to Equality and Non-Discrimination” above also has application in this context and is thus repeated here. The applicant had applied to be enlisted in the Namibian Defence Force. A medical examination and blood test revealed that he was HIV positive. His application for enlistment was refused on this ground. The court held that the exclusion of the applicant from the Defence Force on the ground that he had tested HIV positive constituted unfair discrimination in contravention of the Labour Act<sup>167</sup> then in force, especially since the applicant was still in good health.

### Current Situation

The right to work is violated when an applicant or employee is required to undergo mandatory testing for HIV and is refused employment or dismissed or refused access to employee benefits or

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<sup>164</sup> Clause 6.2.2

<sup>165</sup> National Strategic Framework, pg 105

<sup>166</sup> 2000 NR 103 (LC).

<sup>167</sup> In particular section 107 of Act 6 of 1992.

promotion on the grounds of a positive result. The situation regarding discrimination on the basis of HIV in the workplace has ostensibly improved in Namibia as is evidenced by a reduction in the number of complaints in this regard registered at the Legal Assistance Centre however this could be because it remains a challenge to directly link HIV status to denial of employment due to the fact that such matters generally include a number of other relevant factors. .

Institutionalised discrimination on the basis of HIV status does however still exist in, for example, the Namibian Defence Force. In terms of s 7 (1) (c) of the Defence Act No.1 of 2002, no person may be appointed in the Defence Force, unless such person has undergone the prescribed medical examination and it has on account of such examination been established that such person does not have any physical or mental defect or does not suffer any disease or ailment which:

Will impair such person's ability to undergo any form of training required to be undertaken, or to perform such person's duties, as a member of that force,

Is likely to deteriorate to the extent that it will impair such person's ability to undergo any form of training required to be undertaken, or to perform such person's duties, as a member of that force,

Is likely to be aggravated by the undergoing by such person of any form of training required to be undertaken, or by performance of such person's duties, as a member of that force.

The Namibian Defence Force relies on this section of the Act to exclude recruits from the Defence Force on the basis of their HIV status, despite advances in HIV treatment that render HIV a chronic manageable disease.

The same provisions apply in case of employment in the Police Force<sup>168</sup>.

Reports of discrimination on the basis of HIV status are also still received regarding employers in the private and agricultural sectors. The AIDS Law Unit of the Legal Assistance Centre has documented a number of cases of discriminatory nature:

Two applicants for Defence Force were excluded from employment on the basis of positive HIV status,

One employee known to be living with HIV was forced to resign from a private company despite his protest that he was still healthy and productive – the matter was settled to the benefit of client;

An employee being told by a colleague that the reason he was thin is that he was HIV positive and subsequently being requested to take off his overalls whereupon he was left standing in his underwear. The Labour Commissioner ultimately dealt with this matter and the employee is back at work.

## **Recommendations**

- Ensure that the provisions of the National Code on HIV/AIDS in Employment and the National Policy of HIV and AIDS regarding HIV in the workplace are implemented and enforced to ensure that HIV testing for access to or continued employment or promotion is not permitted.
- Strengthen the capacity of Labour Inspectors to monitor and enforce the implementation of the provisions of the National Code on HIV/AIDS in Employment and the National Policy of HIV and AIDS regarding HIV in the workplace
- Halt the practice of excluding recruits from the Namibia Defence Force and Namibian Police Force on the basis of HIV status alone
- Ensure that there is access to PEP at all workplaces.

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<sup>168</sup> See in this regard section 2(2) of the Labour Act 2007.

## E. Education and Information

States should ensure that both children and adults living with HIV are not discriminatorily denied access to education, including access to schools, universities, scholarships and international education or subject to restrictions because of their HIV status. There is no public health rationale for such measures since there is no risk of transmitting HIV casually in educational settings.

In the context of HIV and AIDS, both children and adults have the right to receive age-appropriate HIV-related information and education, particularly regarding prevention and treatment. Access to information and education concerning HIV is an essential life-saving component of effective prevention and treatment programmes. It is the State's obligation to ensure, in every cultural and religious tradition, that appropriate means are found so that effective age-appropriate HIV information and education is included in educational programmes inside and outside schools.

Guideline 9 of the *International Guidelines* furthermore recommends that States also develop creative education, training and media programs to change attitudes of discrimination and stigmatization associated with HIV and AIDS, to understanding and acceptance.

### Current Situation

In January 2003, Government adopted the National Policy on HIV/AIDS for the Education Sector<sup>169</sup> due to the "increasing recognition that the education sector has an important role to play in the prevention of HIV infection, in the support of infected and affected people, and in maintaining service delivery despite the impact of AIDS"<sup>170</sup>. The policy suggests that there should be a dedicated programme dealing with HIV/AIDS education which should also holistically be incorporated in the entire curriculum. Annexure "B"<sup>171</sup> sets out the suggested content of such HIV/AIDS Education Programme and is comprehensive.

Enquiries made to learners at government and private schools seem to suggest, however, that the programme is not being comprehensively followed, particularly in the private schools. Primary school learners indicate that STDs in general are not widely discussed and that HIV/AIDS education seems to be focussed more on dealing with possible exposure via injuries. High school learners confirm the inclusion of HIV and AIDS education in the general curriculum as well as in life skills teaching. Once again, from information received, it seems as if the government schools are more fully incorporating the policy in their daily teachings.

A number of foreign countries offering scholarships to Namibian students through the Ministry of Education require HIV testing to be undertaken. In the first instance it must be said that the value of such testing is highly questionable due to window periods, the fact that it does not exclude a student contracting HIV once he/she already has a scholarship and most importantly, the fact that HIV is now a manageable condition. Secondly, while these requirements may be the result of the immigration restrictions of the foreign countries themselves, it could be suggested that government at least has the responsibility to make a concerted effort to engage with their counterparts in such foreign countries and advocate for the change of such requirements, in particular since it could be perceived that such requirements are condoned by the Ministry of Education.

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<sup>169</sup> [http://www.youth-policy.com/Policies/NBANatl\\_Pol\\_HIV\\_AIDS\\_Education\\_Sector.pdf](http://www.youth-policy.com/Policies/NBANatl_Pol_HIV_AIDS_Education_Sector.pdf)

<sup>170</sup> Ibid page 1: Introduction.

<sup>171</sup> Page 12.

## Recommendations

- Human rights education and training should be strengthened in various sectors including in the school curricula, in the health system, within the working environment and amongst law enforcement officials.
- In particular, the National Policy on HIV/AIDS for the Education Sector should receive renewed attention and government should monitor implementation of HIV/AIDS Education Programmes in both private and government schools.
- The contents of the National Policy should be made available to all those who work in the education sector and should be included in the curriculum in colleges training teachers.
- Government should consider engaging with foreign governments who require HIV testing when offering scholarships to advocate for a change in policy.

## F. Social Welfare

As guaranteed under the UDHR, everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control<sup>172</sup>. In terms of the Namibian Constitution, the issue of social welfare and protection is covered under Article 95. It is important to note that this provision does not form part of the Bill of Rights but rather principles of state policy. Article 101 of the Constitution specifically states that the principles of state policy .. “shall not of and by themselves be legally enforceable by any Court, but shall guide the Government in making and applying laws to give effect to the fundamental objectives of the said principles”. The courts are entitled to have regard to the said principles in interpreting any laws based on them. This is in contrast to Chapter 3 of the Constitution, the Bill of Rights which are enforceable by a court of law. However, state policy and the welfare of the people are addressed specifically in a number of international instruments to which Namibia has bound itself through Article 144 and in that way can be enforced indirectly. Economic, social and cultural rights are an essential part of the normative international code of human rights. They have their place in the UDHR, in universal and regional conventions of human rights and in many human rights treaties aimed at eradicating discrimination and the protection of certain vulnerable groups.

### Current Situation

Article 95 says that the “State shall actively promote and maintain the welfare of the people by adopting, inter alia, policies aimed at the following; .....

- (f) ensurance that senior citizens are entitled to and do receive a regular pension adequate for the maintenance of a decent standard of living and the enjoyment of social and cultural opportunities,
- (g) enactment of legislation to ensure that the unemployed, the incapacitated, the indigent and the disadvantaged are accorded such social benefits and amenities as are determined by Parliament to be just and affordable with due regard to the resources of the State; .....
- (j) consistent planning to raise and maintain an acceptable level of nutrition and standard of living of the Namibian people and to improve public health,”

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<sup>172</sup> Article 25 UDHR

## Social Security

In terms of the statutory framework, the issues of social protection or welfare are dealt with in terms of the Social Security Act No. 34 of 1994. One of the main objectives of the Social Security Commission created by the Act is to provide for payment of maternity and sick leave benefits as well as death benefits to employees and to establish for that purpose a Maternity and Sick Leave and Death Benefit Fund.

While the Act envisages both a National Medical Benefit Fund and a National Pension Fund, neither of these is currently in operation. It should be kept in mind that benefits are only payable to those who contribute to the fund i.e. the employed. With unemployment continuing to be a national concern, this results in a good number of the population being excluded from these benefits.

## Pension

The National Pension Act No. 10 of 1992 provides for national pensions to be paid to the aged, blind and disabled persons; and to provide for matters incidental thereto.

## Maintenance

The Maintenance Act, No. 9 of 2003 (Section 3) states that parents have a legal duty to maintain their children and that both parents are responsible for the support of their children, regardless of any customary law practice that may indicate otherwise regardless also of whether the children were born inside or outside of marriage. The Act further provides that a husband and wife are primarily responsible for each other's maintenance. In the right circumstances the Act could be used to protect individuals against extreme poverty and the necessity to obtain income elsewhere for e.g. transactional sex or multiple sexual partners.

## Welfare Related Grants

It is important that legislative frameworks and subsequent programmatic interventions are in place to deter any form of voluntary entrance of women and young girls into cross-generational sexual relationships, transactional sex or multiple sexual relations or any other forms of HIV/AIDS drivers. In this regard there must be an entrenched social security protection or safety net. The Namibian government has introduced a number of social welfare grants. These are maintenance grants, special maintenance grants, foster care grants and "place of safety" allowances. All these grants are aimed at providing support to vulnerable children and families and may reduce the need of children, especially young girls, to be exposed to any form of sexual exploitation or be engaged in risky sexual behaviour.

## Child Maintenance Grants

This grant is financial assistance that is given to a parent with a child(ren) that is under 18 years and whose spouse passed away and is for the care of the child(ren) if the surviving spouse:

- Receives an income of less than N\$1000;
- or is a pensioner; or
- receives money from the disability grant; or
- has been sent to imprisonment for 6 months or more.

The amount granted to the first child is N\$ 200 per month and thereafter each child following receives N\$ 100 to the maximum of 6 children. These amounts have been constant since 2000. This signifies that the real value has eroded significantly over the decade.

Further challenges are that children who still have both parents who are unemployed and hence struggle to support their children, would not meet the requirements of this grant at all. In the event

that a child has lost both his parents, a “double orphan”, he or she would also not qualify to benefit. However, such children may qualify for a foster grant if they are in foster care. As a result, the children found in the following households might not be able to access maintenance grants:

- Child-headed household;
- Children with one or two parents who cannot be traced;
- Children in households where the income exceeds N\$ 1000 a month, but this income has to be shared among many dependants;
- Children with six or more siblings in a household who are already receiving benefits from the maintenance grant.

### Foster Care Grants

The other form of social protection for children is the foster care grant. This grant has been designed to benefit any person who undertakes the temporary care of any child who has been found in need of care and placed in the person’s custody in terms of the Children’s Act of 1960 ( to be replaced by the Child Care and Protection Act once approved). The grant order is the same as the Child Maintenance Grant, N\$200, then N\$ 100 for every additional foster child, however, with no upper limits on the amount of children in foster care.

In addition to the amount being outdated the other challenge with this grant is that it takes considerable time to finalise as it requires assessment by a social worker followed by a court hearing.

### Special Maintenance Grant

The value of N\$ 200 per month is paid to caregivers of children who are younger than 16 years of age and who have been diagnosed by a state medical doctor or a doctor as being either temporarily or permanently disabled. In order to process this application your are required to provide: A certified copy of the child’s full birth certificate; a certified copy of at least one parent’s ID and birth certificate; a medical certificate from a state medical officer or doctor confirming the state of disability; and a social background report from a social worker.

### Place of Safety Allowance

This allowance is paid to any person or institution taking care of a child younger than 18 who has been placed by a Commissioner of Child Welfare in accordance with section 33 of the Childrens Act of 1960. The value of the grant is N\$160 for the first child and an additional N\$ 60 for each additional child, and the documentation required with the application for the grant are:

- A place of safety Claim form, completed and signed by the Magistrate’s Office and the claimant;
- A Detention Order from the Magistrate’s Office (the wording is unfortunate);
- For the first claim, the social worker’s background report.

### Child Care and Protection Act

The Act aims to promote child welfare while giving effect to the Convention on the Rights of the Child. This Act is critical in the context of the protection of young girls especially orphans in the sense that it will facilitate the removal of a child from a caregiver when necessary and offers protection to children who might be forced into sexual exploitation. The provisions of this Act have been based on international best practice. The Act has been passed but is not yet in operation.

## Current Situation

According to the national MDG report, Namibia has made great progress in the provision of health, education and other critical services. However, Namibia still faces a 'triple threat' in responding to the combination of the devastating HIV/AIDS pandemic, high levels of food insecurity and income poverty at household level, and weakening capacities for governance and delivery of social services. In terms of income distribution statistics of 2010, Namibia was one of the most unequal societies in the world, its measure of inequality at 0.68 and 29% of the whole population still fall under the poverty line.

The State recognizes the right of every citizen to a decent and dignified existence. With a view to facilitating this, it has undertaken to maintain a system of social protection as set out above in compliance with the principles of state policy i.e.

"Article 95: The state shall actively promote and maintain the welfare of the people by adopting, inter alia, policies aimed at (g) enactment of legislation to ensure that the unemployed, the incapacitated, the indigent and the disadvantaged are accorded such social benefits and amenities as are determined by Parliament to be just and affordable with due regards to the resources of the State."<sup>173</sup>

However, as stipulated earlier, it is not an entrenched right under the Bill of Rights and is therefore dependent on the availability of State resources. In terms of the Namibia Labour Force Survey 2014 Report, 47.7% of Namibians are unemployed (including the inactive groups that include children) and are therefore potentially living without any form of social protection unless they qualify for the state grants. Those without any form of social protection are being forced to high risk behaviour's thus rendering them vulnerable to HIV/AIDS.

The National Policy on HIV and AIDS states that the existing social support system will be strengthened and expanded so as to meet the needs of people living with HIV and AIDS, their carers and affected families, including orphans and vulnerable children.

## Recommendations

- There is a need to introduce a National Medical Benefit as well as an Unemployment Insurance Fund that will cater for people who are not ordinarily employed;
- The social welfare grants need to be reformed so to also cover unemployed persons who are suffering from impaired or compromised health conditions;
- Social welfare grants should be reformed to ensure that children whose parents are unemployed and/or who cannot support them, would be able to access the grant.
- Reform the child maintenance grant so as to cater for double orphans as well, who are being cared for by guardians, etc.
- The amounts of the child maintenance grant, foster grant and special maintenance grant should be revisited and adopted;
- The current eligibility criteria for the above mentioned grants strongly focus on the orphaned status of the child and should be revisited to include and consider requirements such as the impoverished situations children may find themselves in, their vulnerabilities including disabilities and the environmental conditions that the specific child in question is facing;

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2. The Namibian Constitution, Article 95, (g)

- There is also a need to revisit and realign the requirements of foster grants from focusing only on legally fostered children to children that are being taken care of by family without legal guardianship so as to allow such vulnerable and orphaned children to benefit from the grants;
- Amending the foster care placement procedures is a real concern and needs serious attention as the procedure is slow and impractical;
- There is a need to introduce a Universal Basic Income Grant;
- The procedure of registration for the various children's grants needs to be revisited to make it less cumbersome.

## G. Gender Based Violence and HIV

Internationally, the role of the healthcare system in the recognition of violence has been recognised, documented and encouraged.<sup>174</sup> This is because there are clear linkages between the GBV and the risk of HIV infection. Some are direct linkages – for example through forced sex. There are also indirect linkages - for example when violence or threats of violence reduce women's and girls' options to negotiate safer sexual practices. Violence can also make the victim afraid to disclose their HIV status and access services.<sup>175</sup> Best practice now focuses on a multi-sector response to the problem.

### Current situation

In Namibia approximately one third of women in Namibia have experienced violence at the hands of an intimate partner;<sup>176</sup> Research also shows that pre-adolescent and adolescent girls are at increased risk of HIV infection. This is because of the high incidence of coerced sex amongst these age groups. Research conducted in Namibia in 2006 found that 25% of the respondents aged 10-14 and 15% of the respondents aged 15-24 had experienced one or more forms of sexual abuse. Of the group who had already engaged in sex, 42% of the 10-14 year-olds and 18% of the 15-24 year olds said that they had been forced to have sex.<sup>177</sup>

The Combating of Rape Act contains a list of circumstances for the highest minimum sentences for a conviction of rape. One of these is knowingly spreading HIV.<sup>178</sup> The Combating of Domestic Violence Act does not make specific reference to risk of HIV or other sexually-transmitted infection but does recognise sexual abuse as a form of domestic violence.

Further to the provisions in the law recognising the linkages between HIV and GBV, according to policy, the state must provide treatment to rape survivors if they are considered to be at risk of contracting HIV or any other STI.<sup>179</sup> This is in line with the provisions for testing, treatment and care of survivors of sexual offences as contained in the SADC Protocol on Gender and Development, to which Namibia is a signatory.

<sup>174</sup> García-Moreno V, Hegarty K, Flavia A *et al*, The health-systems response to violence against women, *The Lancet*, 2015; 385: 1567–79.

<sup>175</sup> World Health Organization, *Violence against women and HIV/AIDS: Setting the research agenda*, Geneva: World Health Organization, 2000, at 7.

<sup>176</sup> Andersson N, Cockcroft A, Shea B, Gender-based violence and HIV: relevance for HIV prevention in hyperendemic countries of southern Africa, *AIDS*, vol 22 (suppl 4), 2008, pages S73–S86.

<sup>177</sup> UNICEF, *HIV and AIDS Knowledge, Attitudes, Practices and Behaviour (KAPB) Study in Namibia: Key Findings*, Windhoek: UNICEF, 2006.

<sup>178</sup> Combating of Rape Act 8 of 2000. Section 3(1).

In the case of a first conviction, if the convicted person is infected with any serious sexually-transmitted disease and at the time of the commission of the rape knew that he or she is so infected, the minimum sentence is not less than fifteen years.

<sup>179</sup> Ministry of Gender Equality and Child Welfare, *National Plan of Action on Gender-Based Violence 2012-2016* at 2.4

In 2013 the Legal Assistance Centre produced a circular on the linkages between domestic violence and HIV which was distributed to front-line service providers. The intention of the circular was to provide recognition of the linkages between GBV and HIV and to give suggestions of how the relevant provisions in Namibian law and policy can be implemented.<sup>180</sup>

### Recommendations

- Government and civil society should increase public awareness about the linkages between GBV and HIV, including the provision of information on what to do in such situations and where to get information and help.
- Courts and police stations should make sure that complainants can access healthcare information by ensuring that pamphlets about HIV testing, prophylactic treatment and living positively with HIV are available. Similarly, clinics and hospitals should ensure that information about GBV, how to get a protection order and other options in cases of violence are available. This should be extended to all cases of exposure, not just to instances of rape.
- Healthcare providers should be trained on the recognition of cases of GBV and what to do in such cases.
- Service providers who assist victim of GBV and healthcare providers who treat victims of GBV should receive cross-training on each other's respective areas.

## Part IV Access to Justice and Law Enforcement in Namibia

The Global Commission on HIV and the Law's *Risks, Rights & Health* recognizes the importance of taking steps to improve access to justice and law enforcement in relation to HIV and AIDS. In addition, the GCHL urges countries to develop and implement humane, workable HIV-related policies and practices and to fund action on law reform, law enforcement and access to justice<sup>181</sup>. It recommends that states need to enact protective laws and repeal punitive ones as well as create stronger mechanisms to implement and enforce laws. It is clear that legislation alone cannot effectively address inequity. The manner in which laws are implemented and the ability of the law enforcement mechanisms to properly fulfil their mandates is equally important.

This is recognized by the UNAIDS *International Guidelines on HIV/AIDS and Human Rights (2006 Consolidated version)*<sup>182</sup> which recommends various actions to improve access to justice and law enforcement in the context of HIV and AIDS, including legal support services, education and awareness and the strengthening of monitoring and enforcement mechanisms.

### Guideline 7: Legal Support Services

"States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions."

The specific steps to be taken in relation to this guideline include support for legal aid systems specializing in HIV casework as well as giving support to law firms in the private sector in order that they may provide *pro bono* services to people living with HIV and affected populations. In addition,

<sup>180</sup> Legal Assistance Centre, *Domestic Violence and HIV: Increasing awareness of the impact of domestic violence in Namibia*, Circular No. 2, 2013.

<sup>181</sup> GCHL (2012) *Risks, Rights & Health* at pg 10

<sup>182</sup> [www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf](http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf).

programs to educate and raise awareness on HIV and human rights must be conceived and supported to ensure that these rights can be claimed and enforced. These awareness raising programs should target not only the rights holders, but also the legal profession, legal support services and civil society organisations.

**Guideline 11:**

“States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities.” Specifically, states should support monitoring and data collection on HIV and human rights which would include the establishment of HIV focal points in relevant government branches, support to civil society organizations and the utilization of new or existing human rights commissions, national legal bodies and law reform commissions.

## Current situation

### Legal Aid

The Legal Aid Act, No. 29 of 1990 provides for the establishment of a Legal Aid Directorate. The purpose of the Directorate *“is to provide for the granting of legal aid in civil and criminal matters to persons whose means are inadequate to enable them to engage practitioners to assist and represent them”*.

Although legal aid can be granted in both criminal and civil matters, the Director of the Legal Aid division confirms that criminal matters take precedence since, in fact, the majority of requests are for criminal matters. According to him, 80% to 90% of criminal matters in the lower courts are currently supported by legal aid. In addition, 100% of the applications that qualified for legal aid over the past year were granted. These are admirable statistics. It must be mentioned though that the threshold for income in order to apply for legal aid is very low.<sup>183</sup> Consequently a large segment of the population who are technically indigent, would not be able to access legal aid assistance. Legal aid therefore does not play a major part in civil claims such as a claim of discrimination based on HIV status for the reasons outlined above.

According to a baseline study conducted by the University of Namibia for the Office of the Ombudsman, the general public feels that government is not providing adequate legal support services to support people to access justice. Attesting to this fact, in the 2011/2012 financial year, 7051 applications for legal aid were received of which 4 666 (66%) were approved. A total of 1339 (19%) were refused. Another 1046 (15%) are awaiting further information<sup>184</sup>. This is recognised also by the UNHRC when it observed that *“Legal Aid is not universally ensured in practice in Namibia”*<sup>185</sup>.

Civil litigation in defence of human rights violations is therefore largely entertained by public interest law firms, of which there is only one in Namibia currently, namely the Legal Assistance Centre. The concern in this regard is that NGOs are donor funded and have found it increasingly difficult to access sufficient funding. Litigation in particular does not attract much donor funding.

<sup>183</sup> Current N\$1500 per month – source Legal Aid Directorate.

<sup>184</sup> Ombudsman Namibia.2013. Baseline Study Report on Human Rights in Namibia. Unam, pg 117

<sup>185</sup> *ibid*, pg. 117

## The court system

Article 78 of the Namibian Constitution provides for an independent judiciary subject only to the Constitution and other laws of the Republic of Namibia. The judiciary consists of:

The Supreme Court of Namibia - the highest court which hears final appeals from the High Court and has jurisdiction in constitutional matters.

The High Court of Namibia – first court of appeal from the lower courts and has jurisdiction in more serious matters, both civil and criminal – also has jurisdiction in constitutional matters

The Magistrate’s Court of Namibia – lower court which has limited jurisdiction in both criminal and civil matters.

In addition a number of tribunals which address in particular labour matters are also in use.

The justice system is currently undergoing reform in order to improve access to justice in Namibia. The High Court has adopted a judicial case management system in terms of which judges do not allow the parties to litigation to dictate the pace of such litigation, which should allow for prompt finalisation of matters. It is too soon to assess whether the new system is an overall improvement given the anecdotal evidence that it is an increased burden on the time of legal practitioners and is thus more expensive, thereby impeding access in another manner. Compulsory court accredited mediation has also been introduced and initial statistics suggest that this has proven to be a success.

## Office of the Ombudsman

The Ombudsman Act 7 of 1990 bestows the Office of the Ombudsman with the power to enquire and investigate allegations of human rights violations, review safeguards for the protection of human rights and recommend actions to ensure the full enjoyment of human rights. The Ombudsman also has the traditional role of investigating public maladministration.

According to baseline data, one of the main challenges facing the Office of the Ombudsman is the credibility of its independence. For example, when respondents were asked as to which institution protects human rights, only 4.2% indicated the Ombudsman<sup>186</sup>. The UN Committee on the Elimination of Racial Discrimination has expressed concerns about the limited mandate of the Ombudsman and encouraged Namibia to take all necessary steps to strengthen the legislative mandate and the capacity of the office<sup>187</sup>. Another hurdle faced however is the lack of resources provided to this office in particular in relation to its human rights mandate. As an indication of this, it was made clear by the Ombudsman that he was required to source additional funding to compile the human rights baseline report which formed the basis for the National Human Rights Action Plan. Government has also previously indicated that no Human Rights Commission will be created in Namibia since the Office of the Ombudsman has that mandate.

## The Police Service

There is limited, specific research on the experiences of people living with HIV and key populations at higher risk of HIV exposure at the hands of law enforcement. According to the baseline data, most at risk populations indicated repeated violence, extortion and detention by law enforcement

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<sup>186</sup> Ombudsman Baseline Report, pg 38.

<sup>187</sup> Ombudsman Baseline Report, pg 16.

officers<sup>188</sup>. The same assessment indicated that the Namibian Police is not sensitive to the plight of LGBTI's and their safety in various communities. The police are said to ridicule LGBTI persons when they report cases of abuse<sup>189</sup>. Focus group discussions during this assessment reported experiences of bribery, corruption and harassment of key populations by the police<sup>190</sup> and that it was difficult to report violations by law enforcement officials. This issue has been dealt with in further detail in Part III, C, above and suggests the need for sensitization of law enforcement officials to protect the rights of key populations and to reduce the risk of HIV exposure.

## General access to justice issues

The National Human Rights Action Plan 2015 – 2019 as launched by government in December 2014 documents the following relevant shortcomings highlighted under the theme “The Right to Access to Justice”<sup>191</sup>:

- Inadequate facilities, standards and regulatory environment for juvenile justice
- Inadequate legal and social protection for victims of crime
- Inadequate infrastructure for the administration of justice in terms of existing and additional courts
- Problems experienced with the administration of the Legal Aid scheme
- Cost of private legal services
- Ill-equipped/ill-trained police force that compromise quality of justice
- Outdated and inadequate legal and regulatory framework
- Limited awareness on access to justice.

## Recommendations

- Consideration should be given to establishing a dedicated unit within the Directorate of Legal Aid that investigates complaints of ALL vulnerable applicants to establish a broader understanding of the difficulties experienced by these communities;
- Incentives should be considered to encourage law firms in the private sector to provide *pro bono* services to people living with HIV;
- Research should be conducted to establish whether the changes in the court system have contributed to broader access to justice, such research to inform future interventions;
- The human rights section of the Office of the Ombudsman should be adequately funded in order that it may fulfil its mandate;
- Civil society should be empowered to monitor the implementation of the National Human Rights Action Plan in order to hold the relevant Ministries accountable for what they have undertaken to implement;
- Sensitization and awareness raising interventions with police officials should form an integral part of their training and should be continued on an annual basis.

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<sup>188</sup> Ibid, pg 100.

<sup>189</sup> Ibid,

<sup>190</sup> Focus Group Discussion with MARPS Groups, Otjiwarongo.

<sup>191</sup> At page 31.

## Part V Recommendations

### A. Equality/Anti-Discrimination Law and Policy

#### Foreigners/Migrants

- Government should urgently amend its visa application forms to delete any reference to HIV or AIDS; and
- Ensure that migrant workers and foreigners can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens.

#### Access to Insurance/Bank loans

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

### B. Health laws, policies and plans

#### General

- Ensure that HIV is not specified as a notifiable infectious disease once the Public and Environmental Health Act 1 of 2015 enters into force to prevent the use of section 11 of the Act against people living with HIV.
- Ensure that HIV is excluded from the operation of Part 3 once the Public and Environmental Health Act 1 of 2015 enters into force to prevent the use of this Part against people living with HIV.

#### Isolation and detention of patients

Ensure that HIV is not specified as a notifiable infectious disease once the Public and Environmental Health Act 1 of 2015 enters into force to prevent the use of section 11 of the Act against people living with HIV.

#### Informed Consent to HIV Testing and Treatment

The following law review and reform measures are recommended to strengthen protection for the right to HIV testing only on the basis of voluntary and informed consent:

- Provision in law, as well as in policy for HIV testing to take place only on the basis of voluntary and informed consent (save for exceptional circumstances such as unlinked surveillance testing or testing of blood donations), as is currently provided for in the National HIV Policy
- Ensure that the *Child Care and Protection Act 3 of 2015* enters into force as soon as possible to create legal certainty on the age of consent for medical testing and treatment, and to align the age of consent to sexual and reproductive health services to that of consent to sexual intercourse

- Review and revise the provisions of all laws that relate to the legal capacity of minors to ensure no conflict between these and the provisions of the Child Care and Protection Act regarding the age of consent to medical testing and treatment.

#### Confidentiality

- Provision in law, as well as in policy for the protection of confidentiality and disclosure of HIV status to take place only with consent as is currently provided for in the National HIV Policy

#### Access to HIV Prevention, Treatment, Care and Support

The following measures are recommended to strengthen protection for the rights of people to HIV-related prevention, treatment, care and support services:

- Commission a thorough assessment of the Industrial Property Act, Act no 1 of 2012 to ensure that the TRIPS flexibilities are thoroughly catered for in the legislation;
- Subsequently advocate for the IP legislation to be brought into force;
- Capacity building with stakeholders on TRIPS flexibilities and related issues;
- Provide guidance on good practice for implementation of TRIPS;
- Ensure health care workers have training, including rights-based and sensitization training, to adequately implement and provide non-discriminatory services to key populations at higher risk of HIV exposure;
- Ensure greater access to healthcare services and provide infrastructure to support increased home visits, if necessary;
- Consider the implications of the Food Bank to be established and how this could be utilized to ensure sufficient nutrition for persons on ARVs.

#### Regulation of Health Care Providers and Health Extension Workers

- Procedures to report misconduct should be clearly available at all health care facilities in clear and simple language;
- Such pamphlets or posters should be translated into all the languages of Namibia;
- The establishment of a toll free hotline to report misconduct should be investigated;
- Ways in which to access to the complaints systems at the professional disciplinary bodies in a less bureaucratic and time-consuming manner should be investigated;
- The drafting of legislation providing for the registration of home based care givers and health extension workers should be investigated;

### C. Criminal Law and Law Enforcement

#### MEN WHO HAVE SEX WITH MEN

- The provisions of the common law should be amended to decriminalize consensual sex between adult males in international human rights law and good practice.
- Given the high percentage of men who have sex with men who remain hidden due to social stigma and discrimination, there must be concrete steps and actions to ensure the creation of enabling environment as opposed to “lip service”.

- Law enforcement officials, and health and social care providers need to be trained to recognize and uphold the human rights of LGBTI, and should be held accountable if they violate these rights. The exclusion of the LGBTI community from health care services can result in their specific issues being left out of health care policies in Namibia.
- Consideration should be given to utilizing the provisions of the Correctional Service Act<sup>192</sup> to advocate for the provision of condoms in prisons since the Act requires that “every inmate” should have “access to preventative health measures” and be provided with the “necessary precautionary or prophylactic health measures.”
- The Legislature, church community and traditional leaders should be sensitized to the equal rights of the LGBTI community including in the religious and cultural context
- Consideration should be given to incorporating a human rights component focusing on the equal rights of all in tertiary programmes where relevant
- The role of civil society in creating tolerance should be recognized and acknowledged and resources made available to support this role.

### Sex workers

- Consensual sex work should be decriminalized and the unjust application of non-criminal laws and regulations against sex workers for harm reduction purposes should be eliminated.
- States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.
- Consideration should be given to discontinuing the use of municipal laws as the basis to arrest sex workers in public places.
- Law should be enacted to protect against discrimination and violence, and other violations of rights faced by sex workers in order to realize their human rights and reduce their vulnerability to HIV infection and the impact of AIDS. Anti-discrimination laws and regulations should guarantee sex workers’ rights to social, health and financial services.
- Programs should be put in place to provide legal literacy and legal services to sex workers so that they know their rights and applicable laws, and can be supported to access the justice system when aggrieved.
- Health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health.
- Programs should be put in place to sensitize and educate health-care providers on non-discrimination and sex workers’ right to high-quality and non-coercive care, confidentiality and informed consent.
- Sex workers groups and organizations should be made essential partners and leaders in designing, planning, implementing and evaluating health services.
- Essential health services for sex workers must include universal access to male and female condoms and lubricants, as well as access to comprehensive sexual and reproductive health services, and equitable access to all available health-care services including primary health care.
- Violence against sex workers is a risk factor for HIV and must be prevented and addressed in partnership with sex workers and sex worker led organizations.
- Violence against sex workers needs to be monitored and reported, and redress mechanisms established to provide justice to sex workers.

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<sup>192</sup> Act 9 of 2012, sections 23(1)(c) and (3)(c) and section 24(1)(b)(v).

- Law enforcement officials, and health and social care providers need to be trained to recognize and uphold the human rights of sex workers, and held accountable if they violate the rights of sex workers, including the perpetration of violence.
- Support services need to be provided to sex workers who experience violence.

### People who use drugs

- Replace ineffective measures focused on the criminalization and punishment of people who use drugs with evidence-based and rights affirming interventions proven to meaningfully reduce the negative individual and community consequences of drug use, including the promotion of referrals to rehabilitation programs rather than the imposition of custodial services for persons convicted of possession for own use.
- Consideration should be given to decriminalize possession of drugs for own use and halt the practice of arresting and imprisoning people who use drugs but do no harm to others.
- Scale up evidence based strategies to reduce HIV infection and protect the health of persons who use drugs, including sterile syringe distribution and other safer injecting programs.
- Invest in an easily accessible range of evidence-based options for the treatment and care for drug dependence, including opioid substitution therapy.
- Build the capacity of law enforcement officials, judicial officers and health care service providers on the importance of evidence-based and rights affirming interventions proven to meaningfully reduce the negative individual and community consequences of drug use.

These strategies reduce disease and death, and also limit the size and harmful consequences of drug markets by reducing the overall demand for drugs. International bodies such as WHO and UNAIDS recommend a comprehensive package for the prevention, treatment and care of HIV amongst intravenous drugs users which includes the following<sup>193</sup>:

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

### Criminalisation of HIV transmission and exposure

It is recommended that HIV-specific laws that criminalize HIV transmission and exposure are not enacted and that in the rare instances where individuals intentionally transmit HIV to others with the express purpose of causing harm, existing laws— including against assault with intent to do grievous bodily harm—suffice to prosecute people in those exceptional cases. In particular it is recommended that HIV be specified as a sexually transmitted disease which is exempt from the application of Part 4 of the newly enacted Public and Environmental Health Act 1 of 2015 in order

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<sup>193</sup> Harm Reduction International, *What is harm reduction?* (2010) Available at [http://www.ihr.net/files/2010/08/10/Briefing\\_What\\_is\\_HR\\_English.pdf](http://www.ihr.net/files/2010/08/10/Briefing_What_is_HR_English.pdf); Global Commission on HIV and the Law (2012) *Risks, Rights and Health*

that an HIV specific offence of transmission or exposure is not created when the Act enters into force.

Guidelines should be developed to support law enforcement agents and the judiciary to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered.

## Inmates

- Ensure that inmates have full and appropriate access to the same HIV related prevention information, education, voluntary counselling and testing, means of prevention (including condoms), treatment, care and support as is available in the general population.
- Enact legislation to abolish the common law prohibition on sodomy. This prohibition is a major impediment to the distribution of condoms in correctional facilities and legitimises discrimination against men having sex with men.
- Ensure that victims of rape, assaults and other at-risk inmates have access to Post-exposure prophylaxis in correctional facilities.
- Increase the number of health care workers in the correctional facilities ensuring that each correctional facility has sufficient competent nurses and doctors to provide health care services within prisons.
- Encourage voluntary HIV testing and expand access to post-test counselling and treatment services.
- Increase oversight of inmates to reduce violence, rape, drug use and tattooing.
- Provide sufficient amount of nutritious food to all inmates.

## D. HIV/AIDS in the Workplace

- Ensure that the provisions of the National Code on HIV/AIDS in Employment and the National Policy of HIV and AIDS regarding HIV in the workplace are implemented and enforced to ensure that HIV testing for access to or continued employment or promotion is not permitted.
- Strengthen the capacity of Labour Inspectors to monitor and enforce the implementation of the provisions of the National Code on HIV/AIDS in Employment and the National Policy of HIV and AIDS regarding HIV in the workplace
- Halt the practice of excluding recruits from the Namibia Defence Force and Namibian Police on the basis of HIV status alone
- Ensure that there is access to PEP at all workplaces.

## E. Education and Information

- Human rights education and training should be strengthened in various sectors including in the school curricula, in the health system, within the working environment and amongst law enforcement officials.

- In particular, the National Policy on HIV/AIDS for the Education Sector should receive renewed attention and government should monitor implementation of HIV/AIDS Education Programmes in both private and government schools.
- The contents of the National Policy should be made available to all those who work in the education sector and should be included in the curriculum in colleges training teachers.
- Government should consider engaging with foreign governments who require HIV testing when offering scholarships to advocate for a change in policy.

## F. Social Welfare

- There is a need to introduce a National Medical Benefit as well as Unemployment Insurance Fund that will cater for people who are not ordinarily employed;
- The social welfare grants need to be reformed so to also cover unemployed persons who are suffering from impaired or compromised health conditions;
- Social welfare grants should be reformed to ensure that children whose parents are unemployed and/or who cannot support them, would be able to access the grant.
- Reform the child maintenance grant so as to cater for double orphans as well, who are being cared for by guardians, etc.
- The amounts of the child maintenance grant, foster grant and special maintenance grant should be revisited and adopted;
- The current eligibility criteria for the above mentioned grants strongly focus on the orphaned status of the child and should be revisited to include and consider requirements such as the impoverished situations children may find themselves in, their vulnerabilities including disabilities and the environmental conditions that the specific child in question is facing;
- There is also a need to revisit and realign the requirements of foster grants from focusing only on legally fostered children to children that are being taken care of by family without legal guardianship so as to allow such vulnerable and orphaned children to benefit from the grants;
- Amending the foster care placement procedures is a real concern and needs serious attention as the procedure is slow and impractical;
- There is a need to introduce a Universal Basic Income Grant;
- The procedure of registration for the various children's grants needs to be revisited to make it less cumbersome.

## G. Gender Based Violence and HIV

- Government and civil society should increase public awareness about the linkages between GBV and HIV, including the provision of information on what to do in such situations and where to get information and help.
- Courts and police stations should make sure that complainants can access healthcare information by ensuring that pamphlets about HIV testing, prophylactic treatment and living positively with HIV are available. Similarly, clinics and hospitals should ensure that information about GBV, how to get a protection order and other options in cases of violence are available. This should be extended to all cases of exposure, not just to instances of rape.
- Healthcare providers should be trained on the recognition of cases of GBV and what to do in such cases.
- Service providers who assist victim of GBV and healthcare providers who treat victims of GBV should receive cross-training on each other's respective areas.

## Part IV Access to Justice and Law Enforcement in Namibia

- Consideration should be given to establishing a dedicated unit within the Directorate of Legal Aid that investigates complaints of ALL vulnerable applicants to establish a broader understanding of the difficulties experienced by these communities;
- Incentives should be considered to encourage law firms in the private sector to provide *pro bono* services to people living with HIV;
- Research should be conducted to establish whether the changes in the court system have contributed to broader access to justice, such research to inform future interventions;
- The human rights section of the Office of the Ombudsman should be adequately funded in order that it may fulfil its mandate;
- Civil society should be empowered to monitor the implementation of the National Human Rights Action Plan in order to hold the relevant Ministries accountable for what they have undertaken to implement;
- Sensitization and awareness raising interventions with police officials should form an integral part of their training and should be continued on an annual basis.

## ANNEXURE 1 – DOCUMENTS REVIEWED

### Regional & International Charters, Covenants, Treaties, Declarations, Guidelines and related Documents

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

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55. National Policy on HIV/AIDS for the Education Sector
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62. Combating of Immoral Practices Act 21 of 1980
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66. Criminal Procedure Act 51 of 1977
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78. *Government of the Republic of Namibia and Others v Mwilima and all other accused in the Caprivi Treason Trial* 2002 NR 235 (SC)
79. *Hendricks and Others v Attorney-General, Namibia* (High Court, Case 140/2000)
80. *Hoffmann v South African Airways* 2001 (1) SA 1 (CC)
81. *Jansen van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A)
82. *Kauesa v Minister of Home Affairs and Others* 1994 NR 102 (HC)
83. *Law v Canada* (1999) 1 SCR
84. *Minister of Defence, Namibia v Mwandighi* 1993 NR 63 (SC)
85. *Muller v President of the Republic of Namibia and Another* 1999 NR 190 (SC)
86. *Namunjepo and Others v Commanding-Officer, Windhoek Prison and Another* 1999 NR 271 (SC)
87. *Nanditume v Minister of Defence* 2000 NR 103 (LC)
88. *S v Acheson* 1991 NR 1 (HC)
89. *S v H* 1986 (4) 1095 (T)
90. *S v Likuwa* 1999 NR 151 (HC)
91. *The Government of the Republic of Namibia and Another v Cultura 2000 and Another* 1993 NR 328 (SC)
92. *Toonen v Australia*, Communication No. 488/1992 U.N. Doc CCPR/C/50/D/488/1992 (1994)

## ANNEXURE 2 – KEY INFORMANTS INTERVIEWED

Attorney-General of Namibia

Ombudsman of Namibia

Chairperson of the Law Reform and Development Commission

Note: efforts were made to arrange personal interviews with stakeholders Ministries and other government offices but these proved unsuccessful. However, the consultative process incorporated their inputs in the forms of the workshops and electronic input.

## ANNEXURE 3 – FOCUS GROUP DISCUSSIONS CONDUCTED

|                |                                 |                  |
|----------------|---------------------------------|------------------|
| July 2014      | Omwene Tatalulua Support Group  | Ohangwena Region |
| July 2014      | Tetu Ambata (police officers)   | Omusati Region   |
| August 2014    | Health care workers             | Khomas Region    |
| August 2014    | Sex workers group               | Khomas Region    |
| August 2014    | King's Daughter's Support Group | Khomas Region    |
| September 2014 | Sawuyema Support Group          | Kavango Region   |
| September 2014 | Sex workers group               | Rundu Rural      |
| October 2014   | PLWHA Epako Support Group       | Omaheke Region   |
| October 2014   | Epako Clinic Volunteers         | Omaheke Region   |

## ANNEXURE 4 – MEMBERS OF TECHNICAL WORKING GROUP

Legal Assistance Centre

Namibia Planned Parenthood Association

Positive Vibes

Outright Namibia

Rights not Rescue

Aids and Rights Alliance for Southern Africa

Society for Family Life

UNFPA

UNDP

UNAIDS

NASOMA