

# MODEL LAW ON HIV & AIDS IN SOUTHERN AFRICA



SADC Parliamentary Forum

# **Model law on HIV in Southern Africa**

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# Model law on HIV in Southern Africa

Developed by the Southern African Development Parliamentary Forum, headquartered in Windhoek, Namibia.



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ISBN:

SADC Parliamentary Forum  
SADC Forum House  
P/Bag 13361  
Erf578, Love Street  
Windhoek  
Namibia

Email: [info@sadcpf.org](mailto:info@sadcpf.org) / [bsekgoma@sadcpf.org](mailto:bsekgoma@sadcpf.org)

Compiled by: Professor Frans Viljeon and Patrick Eba

Edited by: Ms Boemo Sekgoma (HIV/AIDS Policy Advisor SADC Parliamentary Forum)

Designed and laid out by Mr. Bongani Mkhalihi (Resource Centre Officer, SADC Parliamentary Forum)



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## Executive Summary of the substantive provisions and approach of the Model Law

The Model Law guarantees the respect for human rights principles, rejects coercive approaches, addresses the root causes of vulnerability to infection and ensures the protection of members of vulnerable and marginalised groups.

### **It is based on and incorporates human rights principles**

The Model Law devotes several provisions to the protection of human rights. It pays specific attention to the often forgotten or neglected issues and groups, and integrates them into the legal response to HIV.

In more recent times, to some degree since the advent of ARVs in 1996, the biomedical and public health approaches have been in ascendancy, with some of their proponents advocating that there should be a “return” to “public health principles” in the response to HIV, sometimes in explicit contrast to “human rights approaches”, and sometimes in opposition to what is seen as failed multi-sectoralism.

However, the human rights based approach is still at the core of most successful proven strategies to address the epidemic. Failing and failed attempts are often the result of an inadequate implementation of human rights based strategies, such as voluntary counselling and testing, education and access to treatment. Frustration with the implementation of human rights based strategies should not lead to discarding the human rights approach. In fact, the potential of the human rights based approach has not been fully utilised or explored. In any event, all the states in SADC are party to numerous international human rights instruments and have domestic systems of human rights protection in place. The Model Law upholds human rights standards as provided in international human rights conventions at the global, regional and sub-regional level.

**Global inspiration:** Many SADC member states are party to treaties relevant to HIV and AIDS, such as the International Covenant on Civil and Political Rights (1966), the Convention on the Rights of the Child (1989), and the Convention on the Elimination of All Forms of Discrimination Against Women (1979). In addition, there are numerous non-binding but persuasive documents that inspired the Model Law, such as the International Guidelines, the UNGASS Declaration of Commitment on HIV/AIDS (2001), and the Millennium Development Goals (2000).

**Regional inspiration:** All SADC members are party to the African Charter on Human and Peoples’ Rights (1981), and subscribe to the Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001), and the the Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Related Infectious Disease (2003).

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Sub-regional inspiration: The Model law also build on instruments previously adopted under the auspices of SADC, such as the SADC Protocol on Health (1999), the SADC Code on HIV/AIDS and Employment (1997), the SADC Declaration on Gender and Development (1997) and the Addendum to the Declaration on Gender and Development by SADC (1998), the Maseru Declaration on the Fight against HIV/AIDS in the SADC Region (2003) and the SADC Protocol on Gender and Development (2008).

In line with the International Guidelines, which prohibit discrimination, the Model Law provides for a very broad definition of non-discrimination. The Model Law prohibits both direct and indirect discrimination, and discrimination based on the actual or perceived HIV status. In addition to a general prohibition of discrimination, the Model Law also includes non-discrimination provisions related to specific categories of people namely women, children and prisoners living with HIV. Furthermore, the Model Law provides for non-discrimination in areas such as education, employment, insurance and social security. The Model Law also guarantees the protection of the right to privacy and confidentiality of people living with HIV. In order to ensure the respect of these rights in the context of partner notification, the Model Law provides for strict conditions governing partner notification, which integrates the recommendations of the International Guidelines. The Model Law protects the right to access to HIV-related information, and also guarantees the right to access to treatment for all and especially for children and prisoners two categories known to receive very little access to HIV-related treatment in most Southern African countries.

### **It provides for the protection of vulnerable and marginalised groups**

The Model Law provides for a non-limitative enumeration of vulnerable and marginalised groups which includes children, women and girls, sex workers, and injecting drug users. Other refugees, immigrants, prisoners, internally displaced persons, indigenous and mobile populations, men who have sex with men, lesbians, transgenders and bisexuals. The Model Law also provides for specific services to members of vulnerable groups including access to HIV-related information and education that 'address misinformation about members of vulnerable groups and devise appropriate messages and strategies targeting members of vulnerable groups'. Further, it guarantees access to HIV-related treatment and care for all, including members of vulnerable and marginalised groups, and calls for the 'decriminalisation of commercial sex work and consensual sexual relationships between adult persons of the same sex as specific measures that may enhance HIV prevention'.

### **It addresses the root causes of HIV transmission such as cultural practices and attitudes**

The Model law requires State, in partnership with relevant actors including Parliamentarians, civil society, religious and traditional leaders, to sensitise communities to the danger of harmful cultural practices that contribute to HIV transmission, such as early marriages, female genital mutilation, forced marriages and widow inheritance, and to take steps to

eradicate these practices.

Studies indicate that cultural practices such as female genital circumcision/mutilation, polygamy, forced marriage; and other harmful cultural practices contribute to the spread of HIV. Female circumcision has been considered to increase the likelihood of HIV transmission via increased exposure to blood in the vaginal canal. Using unsterilised or shared instruments for circumcision is another means of transmission. Polygamy, which is a very common practice in Africa, also contributes to HIV transmission. Forced marriage, which most of the times happens to children, is also considered a factor for the spread of HIV. Children and women who are forced into marriage lack the power to either negotiate sex or the use of condoms to prevent HIV transmission.

### **It rejects coercive approaches to HIV**

Moving away from coercive approaches to HIV-related legislation, the Model Law pledges to 'ensure that the human rights of people living with or affected by HIV are respected, protected and realised in the response to AIDS'. A careful analysis of the Model Law shows that this pledge has been upheld throughout its content. Indeed, the Model Law does not include any provision that restricts access to information, or that provides compulsory disclosure of HIV status or that subjects certain groups to compulsory HIV testing. Most importantly, the Model Law does not provide for the criminalisation of HIV transmission.

### **It emphasises the importance of information, education and communication**

The Model law acknowledges that education and public information are essential to successful HIV prevention efforts. These elements build general support for safe behaviour and support for personal risk reduction, and also encourage volunteerism and informs persons, in particular those at risk, of infection and how to obtain specific services. Moreover, information and education discourages prejudice against people with the virus.

Ms Boemo Mandu sekgoma  
HIV/AIDS Policy Advisor

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### To order

Ms Boemo Mandu Sekgoma  
HIV and AIDS Policy Advisor  
SADC Parliamentary Forum  
SADC House  
Parliament Gardens, Love Street  
Private Bag 13361  
Windhoek, Namibia

**Website: [www.sadcpf.org](http://www.sadcpf.org)**

**Email: [bsekgoma@sadcpf.org](mailto:bsekgoma@sadcpf.org)**

**Contacts: +264 61 2870010/ +264 61 220784**

**Cell: +264 81 214 3770/ +264 81 122 5976**

**Fax: +264 61 254 642/ +264 61 247 569**

## An introduction to the Model Law on HIV in Southern Africa

On 24 November 2008, at its 24th Plenary Assembly session convened in Arusha, Tanzania, the Southern African Development Community (SADC) Parliamentary Forum (hereinafter referred to as the Forum) adopted the Model Law on HIV in Southern Africa (Model Law). In accordance with the International Guidelines on HIV/AIDS and Human Rights (International Guidelines) and other relevant documents related to HIV and human rights, the Model Law guarantees the respect for human rights principles, rejects coercive approaches, addresses the root causes of vulnerability to infection and ensures the protection of members of vulnerable and marginalised groups. The Model Law integrates a human rights-based approach as a fundamental element for the effective response to the pandemic.

As an association and convener of national Parliaments of the SADC member states, the Forum aims to create capacities for intervention of national parliaments on issues relevant to the citizens of SADC. The Forum through its HIV and AIDS regional standing committee has been playing an important role in assisting national parliaments in their response to HIV. The Forum embarked on the adoption of the model legislation on HIV based on the recognition of the important role of the law in the context of HIV and AIDS and the central role that parliamentarians are tasked with to endorse or make laws and ultimately perform oversight in the monitoring of its Implementation.

### What is model legislation?

To discuss the significance of the Model Law is to debate the value of model legislation in general. Model legislation is regarded as a type of 'soft law' with no binding effect. The value of a model law is merely persuasive and inspirational. Its persuasive value strictly depends on the quality of its substantive content and on the nature, composition and legitimacy of the institutions or organs that adopt it.

Even if model laws are adopted by international organisations, they do not constitute treaties. While a treaty is open for ratification, model legislation is not. While treaty provisions become binding on a state upon ratification, the provisions of a model law are not binding under international law. Similar to model legislation, international declarations are not binding. Declarative standards guide states and are often vaguely formulated.

A model law has some of the characteristics of both treaties and declarations. As it stands, a model law is not binding. Similar to international declarations, its provisions serve as examples, benchmarks and inspiration to domestic law-makers. In some sense, then, treaties and model laws both require states to "domesticate" their provisions. However, model legislation is usually much more precise than both treaties and declarations, as it is framed in the legal language of law-makers rather than in the rhetorical terms of international law. Both treaties and model laws need to be given effect in the domestic legal arena. Domestication of

treaties may take one of two main forms – direct incorporation, when the whole of the treaty is adopted as a domestic law, or transformation, when parts of national law are amended to reflect the standards in the treaty.

On the one hand, either of these methods may culminate in the constitutionalisation of norms. As constitutional provisions, these norms remain quite vague and open-ended, often requiring further clarification of their scope and content by legislatures and courts.

On the other hand, domestication could be in the form of national legislation. Because international treaties are mostly framed in vague terms, they do not necessarily inspire detailed domestic legal reform. When they do, questions may arise about the conformity of national legislation with international norms, due to the imprecise obligations in these treaties. Accepting that local legal cultures and circumstances differ, some leeway must exist in the process of adapting a broader, internationally agreed consensus position to the narrower, and more immediate concerns of a particular country.

There are several examples of model legislation that have been adopted over the years by various institutions. For example, the African Union (AU) developed the Model Law on Rights of Local Communities, Farmers, Breeders and Access (2000).

## **The aim of model legislation**

### **Model legislation serves as guidance to national legislators**

The goal of model legislation is to enable the relevant individual countries to consider adapting and adopting provisions of the model legislation. Model legislation is therefore aimed at assisting states – in particular policy-makers and legislative drafters – to address all of the relevant areas in need of legislative reform. At the same time, it should be stressed that a model law does not aim to usurp the authority of national legislatures or undermine the domestic sovereignty of states. Rather, model legislation builds on the collective experience of other legislatures and provides a pool of wisdom from which a particular legislature may select and adapt provisions to suit its own circumstances and needs.

### **It serves as a yardstick to national legislators for reviewing existing legislation**

The guidance of model legislation should also be normative, providing a yardstick against which to assess legislative responses.

### **It reinforces a commonality of approach and legal harmonisation**

Model legislation reinforces a common approach to a common regional problem. Increasing globalisation and the inherent transnational nature of issues such as terrorism, the regulation of the internet, child pornography and human trafficking affect countries collectively, rather than separately. Spreading easily across borders, HIV also falls into this category. A harmonised

regional approach could also address issues such as minimising change in treatment options open to persons moving around in the region, and strengthening bargaining power to ensure more affordable medicines to people in the region.

When a model law is developed in a particular region, such as the SADC region, it builds on existing best precedents and reinforces a commonality of approach. At the same time, the ideal is not uniformity for uniformity's sake. Country-specific differences need to be accommodated. The aim of the model law should therefore not be to ensure uniformity of law, which would imply a rigid similarity between the legal regimes of participating states, but rather to ensure harmony in the fundamental approach of each state's legal system.

### **The adoption of model legislation underlines the need for appropriate legislative action and may serve as a stimulus for debate and advocacy**

The adoption of a model law is further likely to highlight the importance of legislation at the national level, thereby stressing the urgency of legal reform as a crucial part of the response to a particularly pressing issue, such as HIV.

The process of adoption and domestication, both at the sub-regional and national levels, may, in itself, serve the important goals of raising awareness, exposing issues that are ordinarily not discussed pertaining to gender, condoms in prison, same sex relationships, some cultural practice, and multiple concurrent partnerships informing and stimulating national and parliamentary debates. The process of domestication/adoption of the model law at national level could serve as an information and advocacy tool and a vehicle to garner awareness about appropriate responses, for each particular country's HIV/AIDS epidemic.

Once interrogated/debated, domesticated and adapted, the model legislation may serve as a catalytic tool to address issues of stigma, human rights, access to medicine, among parliaments, judiciary, government, networks of people living with HIV and AIDS, human rights organisations and other civil society actors for advocacy targeted at legal and policy reform.

### **The need for model legislation on HIV in Southern Africa**

Southern Africa is the epicentre of the AIDS pandemic. In 2005, Southern Africa was home to 14.8 million of the 38.6 million people living with HIV in the world. These HIV prevalence estimates conceal the much more appalling reality of the pandemic's impact on the human, social, economic and development structures of most Southern African states. More than twenty five years of AIDS in the sub-region have contributed to reduce life expectancy, orphaned millions, affected food security, economic growth and compromised hard-gained improvement in social and development structures.

The primary government response in SADC countries towards HIV and AIDS has come in the form of policy development. Virtually all Southern African countries have some form of policy

framework in place to address their country's HIV epidemic. Some countries have developed excellent policy and guidelines with complementary sector-specific interventions ranging from Prevention of Mother to Child Transmission, anti-retroviral rollout, and protection and care of orphans and vulnerable children. These efforts are critical and are encouraging developments but they are not enough.

However, the main weakness of policies is that they are not legally enforceable. While governments may express vision for the direction of the response, if efforts fall short of those promises, there is no repercussion of structure allowing for accountability. Similarly, while policies may express that discrimination against people living with HIV ought not to take place, when it does occur, the victims have no enforceable rights on which to hang their complaints and initiate legal action to secure real protection.

It is for this reason that there has been a significant push to launch a legislative overhaul in the region in order to secure legal protection for people living with HIV. Another advantage of legislative provisions (over policy and other measures) is the clarity and certainty it brings, and also the potential for accessibility and visibility.

It is certainly correct that numerous SADC member states have taken some steps to legislate in this area. Examples are numerous, and include countries like Angola, Botswana, Lesotho, Madagascar, Mauritius, South Africa and Zimbabwe. In spite of legal reforms and new legislation on HIV adopted or being considered for adoption in several Southern African countries, they have often fallen short of comprehensively integrating human rights standards, ensuring the protection of vulnerable groups and translating sound medical and public health considerations into binding documents. The major limitations of these efforts are the focus on the employment sphere and on steps to "criminalise" HIV transmission. For instance, the majority of legislative activity in relation to equality and nondiscrimination has occurred in the area of labour law (employment). Most of the legislation fails to address the root causes of HIV and does not address issues of property rights, inheritance and harmful cultural practices that make women and children more vulnerable to HIV.

### **The process of drafting and adoption of the Model Law**

The process culminating in the adoption of the sub-regional model legislation involved various stakeholders and civil society groups, who worked in close consultation with the Forum.

The idea of SADC Parliamentary Forum model legislation on HIV emerged in 2007 during the meeting of the Forum's HIV and AIDS standing committee. The HIV and AIDS Committee subsequently instructed its Secretariat to engage the necessary consultations for the development of a SADC model legislation on HIV that would provide specific guidance on HIV-related legislative reform in southern Africa. Acting on that instruction, the Forum Secretariat convened a number of meetings involving legal drafters, members of Law Reform Commissions, organisations of people living with HIV, human rights lawyers, academics,



HIV activists, judges and human rights experts from across the sub-region.

In October 2007, an expert meeting was held at the University of Pretoria; and in November 2007, a Regional Deliberative Session for Members of Parliament and Legal Drafters on Model Legislation on HIV and AIDS in the SADC Region was organised in Dar Es Salaam, Tanzania. The deliberative session was attended by fifty participants, including members of parliament, legal experts, civil society, inter-governmental organisations and academics from twelve SADC member states: Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe. Following this session, the Forum Secretariat prepared a draft Model Law on HIV in Southern Africa, which the Executive Committee of Forum in June 2008 endorsed 'in principle'.

In July 2008, under the leadership of the AIDS and Rights Alliance for Southern Africa (ARASA) and the AIDS and Human Rights Research Unit (Centre for the Study of AIDS and Centre for Human Rights) at the University of Pretoria, and in collaboration with the Forum Secretariat, a civil society consultation on the draft Model Law was organised at the University of Pretoria for further input by civil society groups. The draft Model Law was thus a product of various consultations and has benefited from input from a wide range of stakeholders from the sub-region.

In August 2008, Forum organised a satellite session to present its Draft Model Law on HIV in Southern Africa (Draft Model Law) at the XVII International AIDS Conference in Mexico City. The satellite session was attended by parliamentarians, civil society representatives and government officials from southern Africa and beyond. It marked a further step towards the finalisation of the Draft Model Law which illustrates the leadership role that parliamentarians from across the sub-region could and, in many cases, are playing to help turn the tide of the pandemic.

### **The way forward: Duty on governments to domesticate**

The Model Law provides that National legislatures shall, without delay, undertake a process of legislative reform to give effect to the Model Law. Adoption of the Model Law is not, as such, an end point, but should be followed by domestication. States may choose to –

- (1) adopt the model law as a whole, as it is;
- (2) adapt and adopt the model law as a whole;
- (3) adopt selected provisions from the model law in parts of its legislation, as they are; or
- (4) adapt and adopt selected provisions from the model law in parts of its legislation.

Domestication may be slow or may see the watering down of the Model Law's provisions. The Model Law should therefore be as exact and detailed as possible, leaving little room for states to proclaim adherence to the Model Law while deviating from its ethos by requiring national legislatures, when they adapt the Model Law, to observe its objectives.

Domestication must be supported by other efforts to ensure effective implementation of the model law. Civil society organisations and the media have an important role to play in making this happen.

## PREAMBLE

*Painfully aware that Southern Africa is the region with the highest HIV prevalence rate, and that the region forms the global epicentre of the HIV pandemic;*

*Recalling that one of the objectives of SADC, according to article 5(1)(i) of the SADC Treaty, is to “combat HIV/AIDS and other deadly or communicable diseases”;*

*Acknowledging the role that SADC has thus far played in addressing the HIV epidemic, notably by adopting the SADC Code on HIV/AIDS and Employment (1997), the SADC Protocol on Health (1999), and the Maseru Declaration on the Fight against HIV/AIDS in the SADC Region (2003);*

*Aware of the potential role of legislation in addressing the spread and effects of HIV and AIDS;*

*Recognising the importance of a human rights-based and gender-sensitive approach and the involvement of those vulnerable to and living with HIV, in adopting effective legislation;*

*Fully aware that many states in Southern Africa have already taken or are taking legislative and other steps to address the epidemic;*

*Accepting that model legislation may serve a useful role as a yardstick for legislative review and may inspire further legislative reform;*

*Acknowledging that model legislation builds on best practices in the region and elsewhere;*

*Acknowledging the urgent need to continue our legislative reform efforts in specific areas such as family law, inheritance and property law, children’s and women’s rights and sexual offences;*

*We, members of SADC PF, adopt the following Model Law on HIV in Southern Africa as a guide to legislative efforts on HIV-related issues in Southern Africa.*

## PART I: PRELIMINARY

### 1. Objectives

The Model Law aims to:

- (a) Provide a legal framework for the review and reform of national legislation related to HIV in conformity with international human rights law standards;
- (b) Promote the implementation of effective prevention, treatment, care and research strategies and programmes

on HIV and AIDS;

- (c) Ensure that the human rights of those vulnerable to HIV and people living with or affected by HIV are respected, protected and realised in the response to AIDS; and
- (d) To stimulate the adoption of specific measures at national level to address the needs of groups that are vulnerable or marginalised in the context of the AIDS epidemic.

## 2. Domestic adoption

National legislatures shall, without delay, undertake a process of legislative reform to give effect to the Model Law. When national legislatures adapt the Model Law, they shall observe its objectives.

## 3. Interpretation

In this Model Law:

**"AIDS"** means Acquired Immunodeficiency Syndrome.

**"Affected"** in relation to HIV and AIDS includes a person who:

- (a) is related to, or is associated with, a person who is, or is perceived to be, living with HIV; or
- (b) Is, or is perceived to be, a member of or associated with a group, activity or occupation, or living in an environment, which is commonly associated with, or perceived to be associated with, infection by, or transmission of, HIV.

**"Anonymous testing"** refers to an HIV testing procedure whereby the persons being tested do not reveal their true identity.

**"Child"** refers to anyone under the age of 18, unless provided for differently under national law.

**"Child-headed household"** refers to households in which only children below the age of 18 live together.

**"Children orphaned by AIDS"** refers to children below the age of 18 who have lost one or both parents to AIDS-related illnesses.

**"Community home-based care"** refers to any form of care given to sick people in their homes. Such care includes physical, psychosocial, palliative and spiritual activities.

Community home-based care may be

provided by, among others, family members, friends or volunteers working for a non-governmental organisation.

**"Compulsory HIV testing"** refers to HIV testing that is not conducted with the informed and voluntary consent of the person to be tested or that of his or her parents or legal guardian in the case of a child below the age of [16 or any suitable age decided in the state but not above 16] or a mentally incapacitated person. Such testing is characterised by the lack of or vitiated consent, the use of physical force, intimidation or any form of compulsion.

**"CD4 count"** refers to the number of helper T-lymphocytes in a cubic millimetre of blood. With HIV, CD4 count declines as the infection progresses. CD4 count is used to monitor the level of damage to the immune system in people living with HIV.

**"Discrimination"** refers to any distinction, exclusion or restriction made on the basis of the actual or perceived HIV status of a person living with or affected by HIV which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by that person on a basis of equality with other members of the community, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

**"Emancipated minor"** refers to a child who has been granted the status of adulthood by a court order or other formal arrangement.

**"GIPA"** refers to the greater involvement of people living with HIV in the response to HIV.

The GIPA principle aims to realise the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives.

**"Harmful cultural practices"** means all behaviour, attitudes or practices which negatively affect the rights of persons such as their rights to life, dignity, health,

education, physical and moral integrity and development.

**“HIV”** means Human Immunodeficiency Virus.

**“HIV testing”** refers to any validated, medically recognised and virally sensitive test for determining the presence or absence of HIV in a person.

**“HIV transmission”** refers to the transfer of HIV from a person living with HIV to an uninfected person who subsequently seroconverts and becomes HIV positive.

**“Indirect discrimination”** with regard to people living with HIV shall be taken to occur where an apparently neutral provision, criterion or practice would put people living with HIV at a particular disadvantage compared with other persons, unless that provision, criterion or practice is objectively justified by a legitimate aim and the means of achieving that aim are appropriate and necessary.

**“Male circumcision”** refers to the removal of all or a significant part of the foreskin from the penis.

**“Members of sexual minorities”** include men who have sex with men, lesbians, homosexuals, transgendered and bisexuals persons, whether they define themselves as such or not.

**“Mentally incapacitated person”** refers to a person who due to a reason such as mental illness, stroke, accident, ageing, inability to communicate because of a physical or other disability, or is in a permanent or a prolonged condition that renders him or her unable to offer informed consent.

**“Pap smear”** refers to a medical method for the early detection of cancer and other abnormalities of the female genital tract. Women living with HIV often have abnormal results of pap smear tests, usually resulting from human papillomavirus (HPV) infection.

**“Person living with HIV”** refers to a person whose HIV test result reveals the presence of HIV or HIV antibodies.

**“Post-exposure prophylaxis”** refers to a procedure of administering antiretroviral drugs to a person within 72 hours of a high-risk exposure, including unprotected sex, needle sharing, or occupational needle stick injury, to help prevent HIV infection in that person.

**“Post-test counselling”** refers to the process of providing risk-reduction information and emotional support to a person who submitted to HIV testing at the time that the result is released.

**“Pre-test counselling”** refers to the process of providing information to a person on the biomedical and other aspects of HIV and AIDS before that person is subjected to the test. It also includes emotional support on the psychological implications of undergoing HIV testing and the test result.

**“Prevention of mother-to-child transmission”** refers to all medically proven strategies that aim at reducing the likelihood of HIV transmission from a mother living with HIV to her child during pregnancy, labour or thereafter.

**“Prisoner”** includes:

- (a) A person who is in a prison pursuant to a sentence for an offence; or who has been convicted of an offence and is awaiting imposition of a sentence; or who is in prison because of a condition imposed by the [relevant authority] in connection with parole or statutory release;
- (b) A person who, having been sentenced, committed or transferred to prison, is temporarily outside prison by reason of a temporary absence or work release authorized under [relevant legislation]; or is temporarily outside prison for reasons other than a temporary absence, work release,

parole or statutory release, but is under the direction or supervision of a staff member or of a person authorised by the [relevant authority]; and

- (c) A person who is in prison awaiting trial.

**“Reasonable accommodation”** refers to any modification or adjustment to a job or to the workplace that is reasonably practicable and will enable a person living with HIV to have access to, participate or advance in employment.

**“STI”** means Sexually Transmitted Infection.

**“Universal precautions”** refers to a set of precautions designed to prevent the transmission of HIV, hepatitis B virus (HBV), and other blood-borne pathogens from one person to another in the workplace or any other setting. Under universal precautions, blood and certain body fluids of all persons are considered potentially infectious for HIV, HBV and other blood-borne pathogens.

**“Viral load”** refers to the amount of HIV genetic material or Ribonucleic Acid (RNA) in a blood sample, reported as number of HIV RNA copies per millilitre of blood plasma. The viral load provides information about the number of cells infected with HIV and is an important indicator of HIV progression and how well treatment is working in a person living with HIV.

**“Voluntary testing”** refers to HIV testing done on a person who, after having undergone pretest

counselling, voluntarily grants informed consent to such test. Voluntary consent also refers to informed consent given by a parent or a legal guardian in the case of a child below the age of [16 or any suitable age decided in the state but not above 16] or a mentally incapacitated person.

**“Vulnerable or marginalised groups”** refers to members of groups such as children, women and girls, sex workers, injecting

drug users, refugees, immigrants, sexual minorities, prisoners, internally displaced persons, indigenous and mobile populations.

**“Youth”** refers to persons between childhood and maturity; in particular those aged 15 to 24

## PART II: PREVENTION

### CHAPTER I: INFORMATION, EDUCATION AND COMMUNICATION

#### 4. HIV and AIDS education and information

- (1) The State shall promote public awareness about the nature, causes, modes of transmission, consequences and means of prevention and management of HIV and AIDS for all, including members of vulnerable and marginalised groups, through a comprehensive nationwide education and information campaign conducted through its [relevant ministries, departments, authorities or other agencies] at national and local levels.
- (2) The education and information campaign referred to in subsection (1) shall:
  - (a) Use evidence-based approaches that have proven successful;
  - (b) Be adapted to the age, gender, nature of activities and sexual orientation of target groups and address social and cultural constructs including masculinities and unequal gender relations;
  - (c) Be carried out in schools and other institutions of learning, prisons and places of detention, workplaces, and in rural

and urban communities;

- (d) Be guided by evidence on potential opportunities for and barriers to behavior change and include effective measures to ensure that information, education and communication translate into behaviour change;
  - (e) Challenge stigma and discrimination and address misinformation about HIV, people living with HIV and members of vulnerable and marginalised groups;
  - (f) Promote the acceptance of people living with HIV and members of vulnerable and marginalised groups; and
  - (g) Devise appropriate messages and strategies targeting vulnerable and marginalised groups.
- (3) In conducting the education and information campaign referred to in this section, the State shall collaborate with relevant public and private stakeholders and ensure the meaningful involvement and participation of people living with HIV.

## **5. HIV and AIDS education in learning institutions**

- (1) [The Ministry responsible for education] in collaboration with [the Ministry responsible for health] shall include instruction on the nature, causes, modes of transmission, means of prevention of HIV and other sexually transmitted infections in public and private institutions at primary, secondary, and tertiary levels, including vocational, non-formal and indigenous learning systems.

(2) In realising the provisions of subsection (1), the above-mentioned ministries shall ensure that:

- (a) The content, scope and methodology of HIV and AIDS prevention and management courses at each educational level are based on aged appropriate, scientifically accurate, evidence-informed and human rights-based information;
- (b) Every teacher or instructor of an HIV and AIDS prevention and management course referred to in this section is adequately trained and duly qualified to teach such course; and
- (c) The course content includes sexual health and rights education and provides opportunity for students to discuss and analyse gender inequality, and the acceptance of people living with HIV and members of vulnerable and marginalised groups.

## **6. HIV and AIDS education and information as a health care service**

- (1) Providing HIV and AIDS education and information shall form part of the delivery of health care services by all health care providers at public and private health care facilities.
- (2) For the purposes of subsection (1), the State shall ensure that all health care providers are trained on providing information and education on HIV and AIDS.
- (3) The training of health care providers under this section shall include education on HIV related ethical and human rights issues such as confidentiality, attitudes towards people living with
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or affected by HIV, the duty to treat and informed consent.

## **7. HIV and AIDS education and information and the media**

- (1) The State and its relevant departments shall design and implement accessible HIV prevention programmes in the media that take into consideration cultural, age, sexual orientation and gender specificities. These programmes shall challenge gender inequality, gender-based violence and attitudes of discrimination and stigmatisation against people living with or affected by HIV.
- (2) The State shall encourage the development of policies and codes of conduct for the media and the advertising industry, in order to increase sensitivity to HIV and human rights issues and prevent the sensationalisation of HIV-related issues and the use of inappropriate language and stereotypes in reporting and advertising, especially in relation to people living with HIV and members of vulnerable and marginalised groups.

## **8. Cultural practices**

The State, in partnership with relevant actors including civil society, religious and traditional leaders, shall sensitise communities to the danger of harmful cultural practices that contribute to HIV transmission, such as early marriages, female genital mutilation, forced marriages and widow inheritance, and shall take steps to eradicate these practices.

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## **CHAPTER II: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV**

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### **9. Availability of programmes**

- (1) The State shall ensure that HIV test-

ing is available to pregnant women as part of antenatal care services.

- (2) Women living with HIV shall have access to counselling, information and services enabling them to make informed and voluntary decisions in matters affecting their health and reproduction.
- (3) The State shall ensure that programmes on the prevention of mother-to-child transmission of HIV are available to all pregnant women living with HIV. Such programmes shall include psychosocial support, follow-up services and nutritional support for disadvantaged mothers. The State shall also provide pregnant women living with HIV with relevant and scientifically proven information regarding breastfeeding and alternatives to breastfeeding with the view to reducing the risk of HIV transmission.
- (4) When possible, and with the consent of the pregnant woman living with HIV, her partner or spouse shall receive information and counselling on the implications of the prevention of mother-to-child transmission programme.

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## **CHAPTER III: PARTICULAR MEANS OF PREVENTION**

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### **10. Availability of means of prevention**

The State shall ensure that means of HIV and STI prevention, including quality female and male condoms, are available and accessible to the population.

### **11. Special measures of prevention**

- (1) The State shall take special measures to ensure effective protection against the transmission of HIV, in particular for members of vulnerable and marginalised groups, through means



such as the provision of information, education, and male and female condoms.

- (2) The State shall take specific and appropriate measures to protect health care workers against any risk of infection in the course of performing their duties including measures related to the use of universal precautions, and ensuring timely and free access to post exposure prophylaxis in the event of an occupational exposure.
- (3) The State shall ensure access to effective harm reduction programmes for drug users, including needle exchange programme and drug substitution therapy.
- (4) The State shall consider the decriminalisation of commercial sex work and consensual sexual relationships between adult persons of the same sex as specific measures that may enhance HIV prevention.

*[Section 11(5) is an option for countries where male circumcision is legal as well as culturally and religiously acceptable.]*

- (5) Where male circumcision is considered as a means of HIV prevention, the [relevant government ministries and department] shall ensure that:
  - (a) male circumcision is only performed in accordance with standard safety and quality measures and with prior voluntary and informed consent of the person or his parents or legal guardian in the case of a child under [16 or any suitable age in the State but not above 16] or a mentally incapacitated person; and
  - (b) prevention and sensitisation campaigns on male circumcision, clearly emphasising that male circumcision may reduce

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## CHAPTER IV: EPIDEMIOLOGICAL SURVEILLANCE

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but does not eliminate the risk of HIV transmission, are made available to men and women.

### 12. Monitoring and notification of cases

- (1) The State must establish a system for the regular monitoring of HIV prevalence rates at the national level. Such monitoring shall provide specific information related to members of vulnerable and marginalised groups.
- (2) All public and private health institutions shall notify the authority so mandated by the [Ministry or government department responsible for health] of confirmed cases of HIV, AIDS and AIDS-related deaths recorded by their services. Such notification shall be done by way of anonymous and coded information.

## PART III: HIV TESTING AND COUNSELLING

### 13. Availability and regulation of HIV testing

- (1) The [Ministry or government department responsible for health] shall ensure that HIV testing facilities are available and accessible free of charge to the population. The [Ministry or government department responsible for health] shall also ensure that laboratory facilities providing services such as CD4 count, viral load test and pap smear are available and accessible to all.
- (2) HIV testing shall be voluntary, anonymous and confidential unless otherwise provided under this Model Law.

- (3) Pre-test counselling shall precede every HIV test. Pre-test counselling shall include, at a minimum, information on the following:
- (a) the nature of HIV and of AIDS;
  - (b) the nature and purpose of an HIV test;
  - (c) the clinical and prevention benefits of testing, and the potential risks, such as discrimination, abandonment or violence;
  - (d) the services that are available in the case of either an HIV-negative or an HIV positive test result, including whether antiretroviral treatment is available;
  - (e) the fact that the test result will be treated confidentially and will not be disclosed contrarily to the provisions of this Model Law;
  - (f) the fact that the patient has the right to decline the test;
  - (g) the fact that declining an HIV test will not affect the patient's access to services that do not depend upon knowledge of HIV status;
  - (h) in the event of an HIV-positive test result, encouragement of disclosure to other persons who may be at risk of exposure to HIV; and
  - (i) an opportunity to ask the health care provider questions.
- (4) The informed consent of the person to be tested must be obtained prior to any HIV test unless otherwise provided for under this Model Law.
- (5) HIV tests performed on a child under [16 or any suitable age decided in the state but not above 16] or a mentally

incapacitated person shall be conducted with the consent of the parents or the legal guardian of the child or that person. When the best interest of the child requires otherwise or if the child is an emancipated minor, the absence of parental or guardian's consent shall not constitute an obstacle to testing and counselling. In the event of a dispute, the [relevant court] has jurisdiction to decide.

- (6) The provisions of subsection (5) regarding the consent to HIV testing for children and mentally incapacitated persons also apply to their consent to treatment and care.
- (7) No public or private health institution or non-governmental organisation may carry out HIV testing unless it is registered with [the relevant government institutions].
- (8) All HIV testing centres shall comply with the provisions of this Model Law and other national regulations and guidelines related to the conduct of HIV testing and counselling in conformity with this Model Law.

#### **14. Testing of donated bodily fluids and products**

- (1) [The relevant ministry or government department] shall ensure that all bodily fluids and products including blood, tissues, organs and germinal cells donated for transfusion or transplant are tested for HIV and other blood-borne pathogens.
- (2) Donors of bodily fluids and products including blood, tissues, organs and germinal cells for transfusion or transplant shall receive pre and post-test counselling and shall provide informed consent to HIV testing.

## 15. HIV test results

- (1) Subject to subsection (2), the results of an HIV test shall be confidentially and directly communicated to the person concerned.
- (2) The results of a test conducted on a child under [16 or any suitable age in the State but not above 16] or a mentally incapacitated person shall be given, in the presence of the parents or the legal guardian of that child or that person, unless the best interest of the child requires otherwise or if the child is an emancipated minor. In the event of a dispute, the [relevant court] has jurisdiction to decide.
- (3) A person providing treatment, care or counselling services to a person living with HIV may encourage that person to inform his or her sexual partner(s) of his or her HIV status. That person shall, upon request, receive or be referred for psychological, social or legal support to facilitate disclosure.
- (4) A person providing treatment, care or counselling services to a person living with HIV may notify a third party of the HIV status of that person only where:
  - (a) the notifying person is requested by the person living with HIV to do so; or
  - (b) all the following circumstances exist:
    - (i) the third party to be notified is at immediate risk of HIV transmission; and
    - (ii) the person living with HIV, after appropriate counselling, does not personally inform the third party at risk of HIV transmission; and
    - (iii) the person providing treat-

ment, care or counselling services has:

- (aa) properly and clearly informed the patient that he or she intends to notify the third party under the circumstances; and
- (bb) ensured that the person living with HIV is not at risk of physical violence resulting from the notification; or
- (c) all the following circumstances exist:
  - (i) the person living with HIV is dead, unconscious or otherwise unable to give consent to the notification; and
  - (ii) is unlikely to regain consciousness or the ability to give consent; and
  - (iii) in the opinion of the health care provider, there is or was a significant risk of transmission of HIV by the person living with HIV to the sexual partner(s).
- (5) In the case of notification provided under subsection (4), the person providing treatment, care or counselling services shall ensure that follow-up services in the form of counselling are provided to those involved, as necessary.

## 16. Post-test counselling

- (1) Post-test counselling shall be provided after every HIV test.
- (2) Where the test is positive, the person providing treatment, care or counselling service:
  - a. shall counsel the tested person or in the case of a child under

[16 or any suitable age in the state but not above 16] or a mentally incapacitated person, the parents or the legal guardian of that child or that person, on appropriate matters including:

- (i) the medical consequences of living with HIV;
- (ii) the modes of prevention and transmission of HIV and other opportunistic infections;
- (iii) the importance to disclose his or her status to his or her spouse or sexual partner(s);
- (iv) the medical treatment and social benefits available; and

b. shall refer the tested person to such centre as may be prescribed for follow up or treatment.

(3) Any person who suffers an act of discrimination based on his or her actual or perceived HIV status or that of another person may institute legal proceedings against the person who committed the discrimination to claim damages.

(4) Legal proceedings on discrimination involving a person living with HIV shall, at the request of that person, be held in camera. The reporting of such a case shall be done anonymously and identifying facts related to the parties shall not be revealed.

## 18. Right to privacy and confidentiality

(1) Every person is entitled to the right to privacy and confidentiality regarding his or her HIV status.

(2) No person shall disclose any information concerning a person's HIV status to any other person, except:

(a) in the cases provided for under section 15(2) and (4) of this Model Law;

(b) to a health care provider who is directly involved in providing health care to that person, where knowledge of the patient's HIV infection is necessary to making clinical decisions in the best interests of the person;

(c) for the purpose of an epidemiological study, where the release of information cannot be expected to identify the person to whom it relates;

(d) upon an order of a court, where the information contained in the medical file is directly relevant to the proceedings before the court.

## PART IV: PROTECTION OF THE RIGHTS OF PEOPLE LIVING WITH OR AFFECTED BY HIV

### CHAPTER I: GENERAL PROTECTION

#### 17. Non-discrimination

(1) People living with or affected by HIV shall enjoy all human rights under the law and in international human rights instruments.

(2) Any direct or indirect discrimination against people living with or affected by HIV based on their or another person's actual or perceived HIV status is prohibited.

## 19. Sexual and reproductive health rights and right to family

- (1) People living with HIV or affected by HIV are entitled to all sexual and reproductive health rights.
- (2) People living with or affected by HIV shall have the right to family including the right to marry and procreate. Their HIV status alone shall not constitute a valid reason to oppose their marriage.
- (3) Women living with HIV have the right to motherhood. They shall benefit from all measures implemented by the State within the framework of the [relevant policy] on reproductive health.

## 20. Right to access to health care

People living with HIV have the right of access to health care services, including antiretroviral treatment and the management of opportunistic infections such as tuberculosis. These health care services shall include palliative treatment and care to address pain and other symptoms associated with AIDS.

## 21. Retirement, insurance and social security

- (1) The actual or perceived HIV status of a person shall not constitute the only reason to deny or exclude him or her from:
  - (a) the benefits of health insurance or terminate such contract;
  - (b) entering into a life insurance contract; or
  - (c) the enjoyment of any retirement benefit, social security or other right he or she may claim.

- (2) The protection under subsection (1) extends to all people affected by HIV.

## 22. The right to education

- (1) The actual or perceived HIV status of a person, of his or her partners and close relatives shall not constitute an obstacle to the access to education and the enjoyment of the right to education including the allocation of bursaries or scholarships.
- (2) The administration of educational institutions including schools and universities has the obligation to keep confidential the HIV status of children, learners, students or that of their parents or close relatives if it receives such information. Enquiries and investigations initiated by the administration in this respect shall be prohibited.
- (3) Any isolation, exclusion or suspension of a child, learner or student from an educational institution on the sole account of his or her actual or perceived HIV status or the actual or perceived HIV status of his or her partners and close relatives is prohibited.
- (4) The [Ministry or relevant government departments responsible for education] shall provide an educational programme that includes HIV and AIDS in accordance with sections 4 and 5 of this Model Law.

## 23. The right to work

- (1) Any form of discrimination in the workplace against a person, his or her partner(s) or close relatives on the sole account of his or her actual or perceived HIV status, shall be prohibited.
- (2) Employers shall initiate disciplinary

procedures against any employee who discriminates against another employee on the account of the latter's actual or perceived HIV status. The person who suffered the discrimination may also undertake legal proceedings against that employee.

- (3) The employer shall take all necessary measures to implement the universal precautions to reduce the risk of HIV infection through accidental exposure to HIV in the workplace.
- (4) In case of accidental exposure to HIV infection occurring in the workplace, the employer shall ensure free access to post-exposure prophylaxis and counselling for the employee in accordance with [relevant national and international guidelines].
- (5) A person's HIV status, the status of his or her partners, or that of his or her close relatives alone shall not constitute a reason for refusal of employment or termination of employment. Fitness to work shall be the relevant standard in all matters related to employment.
- (6) HIV testing of a job seeker or an employee for the purpose of recruitment, promotion or any other reason is prohibited.
- (7) The employer and other staff members shall not disclose the HIV-status of a job seeker, employee or co-worker if they are aware of that HIV status.
- (8) Employers, in consultation with the employee and its representative, shall take measures to reasonably accommodate employees with AIDS-related illnesses. These could include rearrangement of working time, special equipment, opportunities for rest breaks and time off for medical appointments.
- (9) When employees with AIDS-related

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## **CHAPTER II: CHILDREN LIVING WITH OR AFFECTED BY HIV**

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illness are no longer able to fulfil their duties on the account of poor health, they shall benefit from rights pertaining to employees affected by a long-term illness.

### **24. Protection of rights**

- (1) Children living with or affected by HIV, including orphans, shall enjoy all the rights under the law and in international instruments pertaining to children, in particular the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child.
- (2) When exercising their rights, children may not be subjected to any discrimination on the account of their actual or perceived HIV status, the status of their parents or legal guardians or close relatives.
- (3) The State shall ensure the protection of children against abuse and exploitation and adopt specific measures to safeguard inheritance rights, land tenure and property rights for children.

### **25. Care of children orphaned by AIDS**

- (1) The State shall ensure that any surviving children of persons deceased due to AIDS-related illnesses are given appropriate alternative care, including through foster care or adoption. If these are not available, children shall be cared for in public or private institutions registered with and regulated by the State.
  - (2) In deciding what type of alternative care shall be ensured to children orphaned by AIDS, the best interest of
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the children shall be the primary consideration.

- (3) The State shall ensure that quality public and private institutional care facilities are available and function effectively for the purpose of subsection (1).
- (4) When in spite of all these measures, children are living in a child headed household, they shall be placed under the supervision of an adult person designated by [the relevant court].
- (5) Children orphaned by AIDS and children living in child-headed household shall receive the necessary support and assistance from the State. This assistance and support shall include access to health care, education and the facilitation of their access to all other social assistance schemes available in the State.

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### **CHAPTER III: PROTECTION OF WOMEN AND GIRLS**

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#### **26. Information and education**

- (1) Notwithstanding the provisions of Part II of this Model Law, women and girls, regardless of their marital status, shall have equal access to adequate and gender sensitive HIV-related information and education programmes, means of prevention and health services including women-specific and youth-friendly sexual and reproductive health services for all women of reproductive age and women living with HIV.
- (2) Information and education programmes provided under subsection (1) shall ensure the sensitisation of men on HIV prevention, gender-based violence, gender inequality and challenge dominant / traditional conceptions of masculinity.

#### **27. Protection against violence**

- (1) The State shall ensure that women and girls are protected against all forms of violence, including sexual violence, rape and other forms of coerced sex, as well as against traditional practices that may negatively affect their health.
- (2) No marriage or other relationship shall constitute a defence to a charge of rape.
- (3) Women have the right to refuse sexual acts, including those that put them at risk of infection with HIV or any other sexually transmitted infection. No marriage or other relationship shall deprive them of that right.

#### **28. Equality and non-discrimination**

- (1) Women shall have equal legal rights in all areas including in matters such as marriage, divorce, inheritance, child custody, property and employment, and shall not be discriminated against on the ground of their sex, or their actual or perceived HIV status.
- (2) The [Ministries responsible for health, gender and/or women affairs] in collaboration with and key national and local stakeholders, must develop and implement strategies, policies and programmes that respect, protect and fulfil the human rights of women and girls in the context of HIV. With the aim of promoting gender equality and the full enjoyment by women and girls of their human rights, these strategies, policies and programmes shall address issues such as:
  - (a) equality of women and men, and girls and boys in all aspects of public and private life;
  - (b) the sexual and reproductive

rights and responsibilities of women and men, including women's right to refuse sex and the right and ability to negotiate safer sex and the right to access health and reproductive services independently;

- (c) men's responsibilities to take equal responsibility for sexual and reproductive health and outcomes and to avoid rape, sexual assault and domestic violence, inside and outside marriage;
- (d) strategies for increasing educational, economic, employment and leadership opportunities for women;
- (e) sensitising service providers and improving health care and social support services for women; and
- (f) strategies for reducing inequalities entrenched in formal, customary and religious laws and customs with respect to marriage, divorce, property, custody of children, inheritance and others.

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## **CHAPTER IV: PRISONERS**

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### **29. Prevention of HIV transmission**

- (1) Notwithstanding the provisions of Part II of this Model Law, prison authorities shall ensure access to information and education about the causes, modes of transmission, means of prevention and management of HIV and AIDS messages on HIV and AIDS, as well as the actual provision of means of HIV prevention, including condoms, water-based lubricants and clean injecting drug equipments to prisoners.

- (2) The distribution and possession of condoms and other safer sex materials in prisons in accordance with this Model Law shall not constitute a criminal nor administrative offence, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offence.

### **30. HIV testing and counselling**

- (1) No prisoner may be subjected to compulsory HIV testing.
- (2) The rules related to informed consent, pre-test information and post-test counselling in this Model Law apply equally to prisoners.

### **31. Rights of prisoners living with HIV**

- (1) A prisoner living with HIV shall enjoy the same rights recognised to prisoners living with other illnesses. Prisoners living with HIV are entitled to free health care services including anti-retroviral therapy and medication for the management of all opportunistic infections.
- (2) All information on the health status and health care of prisoners shall be confidential. All health care procedures shall be designed to preserve the confidentiality of prisoners. Health information, including HIV status, shall only be disclosed in accordance with section 18(2) of this Model Law.
- (3) Prison authorities shall ensure that the health of people living with HIV in prisons is regularly monitored by health authorities and that they receive medical follow-up, as well as adequate treatment when necessary.



### 32. Prohibition of isolation

- (1) Subject to subsection (2), no prisoner may be isolated from prisoners on the account of his or her actual or perceived HIV status.
- (2) In the event of violence and abuse or real risk thereof, a prisoner living with HIV may be temporarily isolated from other prisoners. The decision by the [Official in charge of the prison or detention facility] to temporarily isolate a prisoner shall be confirmed by the [competent judicial authority] within a [reasonable period], failing which the measure of isolation shall be lifted.

### 33. Protection against violence

- (1) Any prisoner shall be entitled to be protected against violence, including sexual violence, and shall retain his or her right to institute legal proceedings, notwithstanding disciplinary sanctions against the author of the act of violence. The competent authorities shall ensure that the necessary measures are taken to that end.
- (2) Prison authorities shall investigate and resolve all complaints of rape and sexual violence in prisons.

### 34. Compassionate release on medical grounds

- (1) Any person serving any sentence in a prison and who, based on the written evidence of the medical practitioner treating him or her, is diagnosed as being in the final stage of the AIDS disease should be granted compassionate early release by [the relevant authority] to die a consolatory and dignified death.
- (2) Prison authorities should expeditiously identify those persons whose state

of health may qualify for compassionate release under subsection (1) and inform them of the possibility of early release. Prison authorities shall assist prisoners who are unable to apply for compassionate release themselves with such applications

- (3) [The relevant authorities] shall, without delay, process applications for compassionate release.

### 35. HIV and AIDS policy for prisons

The [relevant ministries and government departments responsible for prisons and health] shall formulate and ensure the effective implementation of policies and guidelines to address HIV in prisons in accordance with this Model Law.

## PART V: TREATMENT, CARE AND SUPPORT

### 36. State obligations related to treatment, care and support

- (1) The State shall take all the relevant measures to provide access to affordable, high quality anti-retroviral therapy and prophylaxis to treat or prevent HIV or opportunistic infections for people living with HIV including children living with HIV and members of vulnerable and marginalised groups. These relevant measures shall include the use of all flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) and the Doha Declaration on the TRIPS Agreement and Public Health as well as measures to encourage the local production of medicines.
- (2) The State shall ensure that post-exposure prophylaxis and treatment of

sexually transmitted infections and psychological support are available without delay and free of charge for all rape survivors.

- (3) The State shall ensure wide access to accurate information regarding HIV treatment options and shall promote widespread treatment literacy campaigns, with access to information on where and how to access treatment, care and support.
- (4) The State shall ensure the protection of the population against fake and counterfeit medicines and treatments.
- (5) The State shall ensure the active participation of people living with HIV and members of vulnerable and marginalised groups in the design, development and implementation of a national plan for the realisation of universal access to treatment, care and support services.

## PART VI: RESEARCH AND CLINICAL TRIAL

### 37. Requirements for research and clinical trials

No person may undertake HIV-related human biomedical research or a clinical trial on

another person, or on any tissue or blood removed from such person, unless such research

conforms to the requirements under this Model Law and [relevant national regulation].

### 38. Consent to research and clinical trial

- (1) No person may undertake HIV-related human biomedical research or clinical

trial on another person or on any tissue or blood removed from such person except:

- (a) with the written informed consent of that other person; or
  - (b) if that other person is a child or a mentally incapacitated person, with the written informed consent of a parent or the legal guardian of the child or that person.
- (2) The person whose consent is to be obtained under subsection (1) shall be adequately informed of the aims, methods, anticipated benefits and the potential risks and discomforts of the research.
  - (3) No research or clinical trial referred to under subsection (1) shall take place without the approval of the ethical research body established under section 39 of this Model Law or under [relevant national legislation].

### 39. Ethical research body

- (1) The State shall establish an ethical research body constituted, among others, by persons with relevant expertise and experience in the field of biomedical, social and clinical research.
- (2) The mandate of the ethical research body established under subsection (1) shall include reviewing and, when appropriate, approving applications for conducting HIV-related human biomedical research or a clinical trial on persons, or on any tissue or blood removed from such persons.
- (3) When reviewing applications under subsection (2), the ethical research institution shall take into account the provisions of this Model Law and relevant national legislation, as well as

international human rights and ethical norms and principles applicable to human biomedical research or clinical trial.

## **PART VII: SUPPORT TO PEOPLE LIVING WITH HIV AND THEIR ORGANISATIONS**

### **40. Support to organisations of people living with or affected by HIV and regulation of community home-based care**

- (1) The State shall encourage and support the creation and functioning of support groups, community home-based care groups and other organisations of people living with or affected by HIV.
- (2) The State shall ensure the meaningful application of the GIPA principle by involving people living with HIV, including women and children living with HIV, in the design and implementation of HIV-related legislation, programmes and policies at both national and local levels.
- (3) The State shall adopt a framework for the regulation and support of community homebased caregivers to ensure the respect of their human rights and the provision of quality services to their patients.

### **41. Legal proceeding on behalf of people living with and affected by HIV**

Non-governmental organisations shall have the capacity to institute legal proceedings for and on behalf of a person living with or affected by HIV even if that person is not a member of those associations.

### **42. Training of people living with HIV**

People living with HIV shall be provided with adequate training to ensure their self-reliance and mutual self-assistance and meaningful participation in the design and implementation of HIV and AIDS activities at national and community level.

## **PART VIII: OFFENCES AND PENALTIES**

### **43. Breach of confidentiality and unlawful disclosure**

Any person who contravenes the provisions of sections 15, 18, 22(2) or 31(2) of this Model Law shall commit an offence and be liable, upon conviction, to either a fine of up to XXXX, or imprisonment for up to XXXX, or both.

### **44. Violation of other provisions relating to testing and counselling**

Any person who contravenes the provisions of sections 13(2) or 30(1) of this Model Law shall commit an offence and be liable, upon conviction, to either a fine of up to XXXX, or imprisonment for up to XXXX, or both.

### **45. Lack of informed consent to research and clinical trials**

Any person who contravenes the provisions of sections 37 or 38 of this Model Law shall commit an offence and be liable, upon conviction, to either a fine of up to XXXX, or imprisonment for up to XXXX, or both.

### **46. Violation of other provisions of the Model Law**

Any person who contravenes the provisions

of sections 19(2), 21, 22(3), 23(5), (6) or 32 of this Model Law shall commit an offence and be liable, upon conviction, to either a fine of up to XXXX, or imprisonment for up to XXXX, or both.

## PART IX: ENFORCEMENT

*[Two options are provided under this part. One or the other should be selected, not both.]*

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### Option 1:

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#### 47. Establishment of tribunal

Within a year after adopting this Model Law, the State shall establish a Tribunal to be known as the HIV Tribunal, which shall consist of members appointed by [the Attorney General or the official in the State with similar competencies] as follows:

- (a) a chairperson who shall be an advocate of [the High Court or the Court of the State with similar status] of not less than seven years standing;
- (b) two advocates of [the High Court or the Court of the State with similar status] of not less than five years standing, one of whom shall be a woman;
- (c) two medical practitioners recognised by [the Medical Practitioners and Dentists Board or the body in the State with similar function] as specialists under the [relevant laws and regulations], one of whom shall be a woman; and
- (d) two persons living with HIV or representing people living with HIV, one of whom shall be a woman.

#### 48. Jurisdiction of the tribunal

- (1) The Tribunal shall have jurisdiction:
  - (a) to hear and determine complaints arising out of any breach of the provisions of this Model Law;
  - (b) to hear and determine any matter or appeal as may be made to it pursuant to the provisions of this Model Law; and
  - (c) to perform such other functions as may be conferred upon it by this Model Law or by any other legislation.

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### Option 2:

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#### 47. Jurisdiction

Notwithstanding [the relevant national legislation related to the jurisdiction of the Courts] the [High Court or a jurisdiction of equivalent level] has jurisdiction to try any violation of the provisions under this Model Law or any subsidiary enactment made under it.

#### 48. Relationship with other laws

Where the provisions of this Model Law or any valid regulation made hereunder are inconsistent with the provisions of any other law, the provisions of this Model Law or such regulation shall prevail.





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