



Lesotho

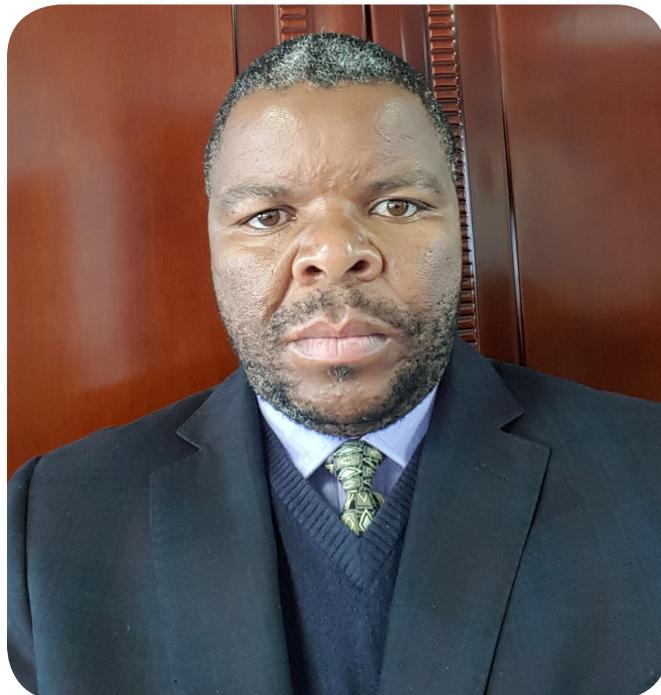
REPORT ON ASSESSMENT OF THE LEGAL ENVIRONMENT FOR HIV AND AIDS IN LESOTHO

FINAL REPORT 2016



Compiled by: Libakiso Matlho

FOREWORD



Minister of Law, Constitutional Affairs and Human Rights
Kingdom of Lesotho

The Kingdom of Lesotho has already initiated and implemented a wide range of interventions in HIV prevention, treatment, care and support and impact mitigation. Although to a large extent the national efforts have stabilised the epidemic at a very high prevalence rate, the HIV response has not achieved the desired and necessary changes in the policy, legal and regulatory aspects governing HIV-related issues in the country. Law prohibits or permits specific behaviours, and in so doing, it shapes politics, economics and society. At the same time the social and structural drivers and the factors that influence the epidemic in Lesotho have not changed. HIV-related stigma and discrimination remain an issue in the country, and people living with HIV, women, youth and other key populations vulnerable to HIV exposure continue to experience violations of their human rights.

The HIV and AIDS Legal Environment Assessment report presents the review of laws and policies in the country and how they are infringing on people's rights and their access to services. It explores and suggests recommendations for creating and strengthening an enabling environment that promotes an effective national HIV response in accordance with the National Strategic Framework for HIV and AIDS and sexually transmitted infections (STIs) 2012/13-2015/16 in Lesotho. There is no law dealing solely with HIV in Lesotho, and there are limited HIV-specific provisions in law. Existing HIV-related laws and policies tend not to extend protection beyond people living with HIV to include other vulnerable and key populations while reversing HIV trends and patterns to get to zero HIV infections, zero discrimination and zero deaths in Lesotho will require reinvigorated and accelerated responses, buttressed by a supportive and protective policy and legal environment in the country. Creating an enabling environment is a critical element towards an effective national HIV and AIDS response.



This report presents persuasive evidence and recommendations that can save lives, save money and help end the AIDS epidemic. The recommendations appeal to strengthening anti-discrimination in law on the basis of HIV and AIDS, eradicating gender inequality, harmful gender norms and gender based violence, promoting the rights of all employees to non-discrimination in the working environment, strengthening the rights of key populations to equality and non-discrimination and access to health care, including access to treatment, as well as access to justice and law enforcement and conducting Awareness Raising, Education and Stigma and Discrimination Reduction Campaigns. With these areas the recommendations appeal to what is common to all our cultures and communities—the innate humanity of recognizing and respecting the inherent worth and dignity of all individuals..

We are confident that the Assessment of the HIV Legal and Policy Environment report will adequately inform the existing policy and legal machinery and the operational instruments and catalyze the necessary reform for better provision of HIV and AIDS services to all manners of people within the realms of human rights obligation at both national and international level.

Hon. Mr. Motlalentoa Letsosa
Minister of Law, Constitutional Affairs and Human Rights
Kingdom of Lesotho



ACKNOWLEDGEMENTS

The Lesotho HIV and AIDS Legal Environment Assessment Report 2014 is the result of dedicated efforts from many organisations, individuals and institutions.

We appreciate the immense contributions of members of the Technical Working Group (TWG) for their practical input, oversight and rich experiences that were greatly beneficial to the study. Their expertise included providing information, reviewing different drafts of this report and vetting its findings and recommendations.

We are grateful for the commitment, passion and invaluable technical support provided by Women and Law - Southern Africa - Lesotho (WLSA), who met with different key informants and focus groups. They tirelessly collected and transcribed the data that informed the findings and recommendations of this study.

We greatly appreciate the work done by the research team who developed the field research tools, led field activities and contributed to the write-up of results from the key populations. We also appreciate the inputs from the stakeholders who participated in the various workshops and meetings, including their validation of this report.

Finally, we acknowledge the generous financial and technical support of the United Nations Development Programme (UNDP), UNAIDS, Regional Service Centre for Africa and the UNDP Lesotho Country Office. The team of UNDP experts provided strong leadership and guidance during the entire process. They reviewed the various drafts and provided tireless guidance both in conducting the assessment and compiling the assessment report.



Table of Contents

FOREWORD	i
ACKNOWLEDGEMENTSiii
ABBREVIATIONS AND ACRONYMS	vii
LIST OF TABLESix
EXECUTIVE SUMMARY	x
PART I: INTRODUCTION AND BACKGROUND	1
1.1 Introduction	1
1.2 Background	1
1.3 Terms of reference	3
1.4 Overall goal of the assignment	3
1.5 Objectives of the assignment	3
1.6 Key deliverables	4
1.7 Implementation modalities	5
1.7.1 Technical approach	5
1.7.2 Qualitative assessment	6
1.7.3 Key informant interviews (KIIs)	6
1.7.4 Focus group discussions (FGDs)	7
1.8 Technical working group	8
1.9 Analysis of the report	8
PART II: INTERNATIONAL AND REGIONAL HUMAN RIGHTS FRAMEWORK	10
2.1 Introduction	10
2.2 International and Regional Frameworks	11
2.2.1 Overview	11
2.2.2 Continental and sub-regional legal frameworks and guidance documents . .	15
2.2.3 Conclusion	19
PART III: FUNDAMENTAL HUMAN RIGHTS IN THE CONTEXT OF HIV IN	

LESOTHO	20
3.1 Overview.	20
3.2 Analysis of the Constitution.	20
PART IV: ANALYSIS OF KEY FINDINGS	32
4.1 HIV-related stigma, discrimination and human rights violations	32
4.1.1 Position in Lesotho	32
4.1.2 Challenges	34
4.1.3 Recommendations for addressing HIV-related stigma, discrimination and human rights	35
4.2 Criminalization of HIV transmission	35
4.2.1 Position in Lesotho	36
4.2.2 Challenges	38
4.2.3 Recommendations for addressing the criminalization of HIV transmission	38
4.3 Women, girls and gender equality	39
4.3.1 Position in Lesotho	43
4.3.2 Provision of post-exposure prophylaxis (PEP) for women	48
4.3.3 Challenges	48
4.3.4 Recommendations for addressing women, girls and gender equality and HIV	49
4.4 Children	51
4.4.1 Position in Lesotho	52
4.4.2 Challenges	56
4.4.3 Recommendations for addressing children’s HIV-related rights	56
4.5 Employees.	56
4.5.1 Position in Lesotho	57
4.5.2 Challenges	59
4.5.3 Recommendations for addressing employees’ HIV-related rights	59
4.6 Populations at higher risk of HIV infection	60
4.6.1 Men who have sex with men (MSM)	60
4.6.2 Sex work	62
4.6.3 Prisoners	66
4.6.4 Migrant Workers	69
4.7 Access to Health Care Services	72
4.7.1 Position in Lesotho	73
4.7.2 Challenges	75
4.7.3 Recommendations for addressing access to health care services.	75
4.8 Access to Justice	75

4.8.1 Position in Lesotho	76
4.8.2 Institutions and bodies	78
4.8.3 Challenges	79
4.8.4 Recommendations for addressing access to justice and HIV-related rights . .	80
PART V: GENERAL CONCLUSIONS	81
PART VI: RECOMMENDATIONS	82
REFERENCES	86
Annexure 1: National Policies, Laws and Regulations.	89
Annexure 2: List of Key Organisations Interviewed	90
Annexure 3: Research Participant Groups	91
Annexure 4: List of Members of the Technical Working Group	92
Annexure 5: List of domestic legal frameworks	93
Annexure 6: List of cases	94



ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CA	Court of Appeal
CCE-CC	Community Capacity Enhancement through Community Conversation
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CPWA	Children’s Protection and Welfare Act
CRC	Convention on the Rights of the Child
FGD	Focus group discussion
FIDA	Federation of Women Lawyers
GCHL	Global Commission on HIV and the Law
GOL	Government of Lesotho
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organisation
IP	Intellectual property
KII	Key informant interview
LCS	Lesotho Correctional Services
LDF	Lesotho Defence Force
LENEPWA	Lesotho Network of People Living with HIV and AIDS
LGBTI	Lesbians, Gays, Bisexual, Transgender and Intersex
LPPA	Lesotho Planned Parenthood Association
MDG	Millennium Development Goals
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-governmental organization
NSP	National Strategic Plan

OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother-to-child transmission
SADC	Southern African Development Community
SCTA	Speedy Court Trial Act
SOA	Sexual Offences Act
STIs	Sexually transmitted infections
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 and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization
WLSA	Women and Law in Southern Africa Research and Education Trust
WTO	World Trade Organization



LIST OF TABLES

[Table 1. International declarations, resolutions or guidelines](#)

[Table 2. Continental and sub-regional declarations, resolutions or guidelines](#)

[Table 3. Key drivers of the HIV epidemic in Lesotho](#)



EXECUTIVE SUMMARY

An assessment of the legal environment for HIV and AIDS in Lesotho was commissioned by the Government of the Kingdom of Lesotho under the leadership of the Ministry of Law and Constitutional Affairs and was supported by the United Nations Development Programme (UNDP) Lesotho. The rationale for the assessment was to improve the availability of information and evidence of the policy, legal and regulatory aspects governing HIV-related issues in Lesotho. It was also to ensure that the government takes greater action and enhances a supportive and protective environment for people living with HIV and other populations who are vulnerable to, and at higher risk of, HIV exposure. Moreover, the study was intended to explore and suggest recommendations for creating and strengthening an enabling environment that promotes an effective national HIV response in accordance with the National Strategic Framework for HIV and AIDS and sexually transmitted infections (STIs) 2012/13-2015/16 in Lesotho. The following is a summary of the key findings of the assessment.

The country has already initiated and implemented a wide range of interventions in HIV prevention, treatment, care and support and impact mitigation.^[1] Although to a large extent the national efforts have stabilised the epidemic at a very high prevalence rate,^[2] the HIV response has not achieved the desired and necessary changes in the policy, legal and regulatory aspects governing HIV-related issues in the country. This impacts negatively on the lives of all affected populations and in particular, people living with HIV, key populations (e.g., sex workers, men who have sex with men [MSM], transgender people, people who use drugs, prisoners and migrant workers), and others who are vulnerable to exposure (e.g., women, girls). As in many countries throughout the world, in Lesotho these populations are battling with stigma, discrimination and a range of human rights abuses, in some cases because criminal law creates barriers to their access to HIV prevention, treatment and care services. For example, the Lesotho National Commitments and Policies Instrument (NCPI) Report showed that discrimination and stigma against MSM remains a critical challenge due to criminal laws impacting on same sex relationships.^[3]

Lesotho has a sound, broad framework protecting human rights. The Lesotho Constitution^[4] is the supreme law of the land and includes a Bill of Rights Chapter.^[5] Protection of these rights under the Constitution is two-fold. Chapter II provides for rights that are justiciable and thereby protectable in the judicial system. These include the right to equality and freedom from discrimination,^[6] the right to personal liberty and the right to respect for private life^[7] and family life.^[8] Chapter III covers rights labelled “Principles of State Policy,” which the government is obliged to take steps to realize on a progressive basis, for example, through policy frameworks

1 Lesotho Cabinet Office, ‘Independent Sector Institutional Assessment of the HIV and AIDS Sector Report,’ December 2012.

2 Revised National Strategic Plan on HIV and AIDS 2012/13-2015/16.

3 ‘National Commitments and Policies Instrument Report,’ 2012.

4 Lesotho Constitution, 1993.

5 Ibid. Chapter II.

6 Ibid. Section 18.

7 Ibid. Section 11.

8 Ibid. Section 6.

and law reforms. The right to health is provided for under these Principles, with Section 27 stating that Lesotho shall adopt policies aimed at ensuring the highest attainable standard of physical and mental health for its citizens.^[9]

Lesotho is also a party to and has ratified various regional and international conventions, declarations, covenants and treaties that safeguard the rights of all people. These regional and international commitments, though not binding unless they have been domesticated, are persuasive in nature. Lesotho has a commitment to ensure compliance and realisation of the rights enshrined therein.

Nonetheless, while in a broad sense one can safely argue that all people in Lesotho, including people living with HIV and other vulnerable and key populations, are accorded equality, human rights and protection from discrimination, there is no broad protection against discrimination in law on the basis of HIV status or for key populations (e.g. sex workers, MSM).^[10] In fact, there is no law dealing solely with HIV in Lesotho, and there are limited HIV-specific provisions in law. Moreover, existing HIV-related provisions in law and policy tend not to extend protection beyond people living with HIV to other vulnerable and key populations and are reported to be rarely implemented and enforced. There is a National HIV and AIDS Policy that affords protection to people living with HIV based on more general human rights,^[11] but it does not include mention of key populations. Therefore, stronger protection of these populations is needed both in legislation and in policy.

HIV-specific protection in more recent laws such as workplace laws and children's laws has been seen to be a positive step, although there remain reports of stigma and discrimination. For instance, the Labour Code (Amendment) Act of 2006 requires employers to develop and implement a workplace HIV and AIDS policy. It also stipulates that HIV testing, confidentiality and non-disclosure must be respected by all employers.^[12] There is limited case workplace related case law, but there was a recent constitutional case related to unfair dismissal from the Lesotho Defence Force based on positive HIV status, which was decided by the courts as infringement of constitutional rights. The recently enacted Children's Welfare and Protection Act, 2011 includes provisions that should support increased access to sexual and reproductive health and rights for young people, in the context of HIV and AIDS.

In addition to the fact that there is limited and insufficient rights protection, the LEA also found examples of laws, policies and practices that were punitive or discriminatory, placing populations at higher risk, such as is detailed below in the case of women, girls and young people, and in criminal laws affecting people living with HIV and key populations.

Given the gender bias of the HIV epidemic, with more women aged 15-49 infected than men (27 per cent versus 18 per cent),^[13] it is notable that several national laws and policies provide preventive and protective measures against the discrimination of women and girls. For

9 Ibid. Section 27.

10 Lesotho Constitution, 1993.

11 National HIV and AIDS Policy, 2006.

12 Labour Code (Amendment) Act, 2006.

13 Revised National Strategic Plan on HIV and AIDS 2012/13-2015/16.

example, the National Action Plan on Women, Girls and HIV and AIDS^[14] provides protection of women and girls against HIV and identifies gender-based violence as an issue that needs to be addressed in the context of HIV. There are also more general laws and policies that protect women and girls against discrimination and violence such as the Legal Capacity of Married Persons Act of 2006,^[15] which promotes the economic rights of women. However, it appears that laws promoting the equality rights of women are not always known or, given prevailing cultural norms and practices, are not respected so that in many cultural contexts women are still regarded as minors and are not capacitated to enforce and claim their rights.^[16] In addition, although the Lesotho Constitution provides for non-discriminatory laws and practices with regard to women, national laws governing property and inheritance rights allow discrimination against women and girls resulting from the application of customary law principles.^[17] Inconsistencies in laws governing the minimum marriage age also result in early marriages. These inequalities and harmful gender norms have been shown to impact on the vulnerability of women and girls to HIV, either by directly exposing them to HIV or by indirectly increasing their vulnerability, through their economic and social dependency upon men for survival.^[18] Inconsistencies in the laws relating to age of consent to sex and age of consent to medical treatment and HIV testing may result in denial of young girls' and boys' rights to access sexual and reproductive health care services

In Lesotho there are no laws that specifically criminalise HIV transmission or exposure. However, the Penal Code provides that non-disclosure of HIV status to a sexual partner is an offence. Additionally, the Sexual Offences Act (SOA) provides for compulsory HIV testing for the purposes of sentencing a person charged with a sexual offence, and aggravated sentencing for offenders who are HIV positive, both knowingly (carries the death penalty) or unknowingly (10 years imprisonment), at the time of committing a sexual offence.^[19] Although the Penal Code provision appears not to have been used and equally, no person has been sentenced to death as a result of invoking the provisions of the SOA, the laws are in conflict with international and regional guidance relating to harmful HIV-related behaviour. The purpose and application of the SOA law appears to have caused some uncertainty and may result in indiscriminate punishment of a person simply for being HIV positive. In relation to other criminal laws, the Criminal Procedure and Evidence Act of 1981 criminalises sodomy as an offence for which arrests may be made without a warrant,^[20] and sex workers are also criminalised under the Penal Code of 2010.^[21] High levels of discrimination and limited recourse to justice has been noted as a critical concern for MSM and sex workers, as a result.^{[22] [23]}

14 National Action Plan on Women, Girls and HIV and AIDS 2012-2017.

15 Legal Capacity of Married Persons Act, 2006.

16 Ministry of Health and Social Welfare, 'Lesotho Demographic and Health Survey,' 2009.

17 Lesotho Constitution, Section 18 (4) (c), 1993.

18 The United Nations 'Compilation of UN info for the second cycle of the Universal Periodic Review (UPR) mechanism: Lesotho,' 2013, notes that based on data collected by UNICEF between 2000 and 2009, an estimated 23 per cent of women between the ages of 20 and 24 were married before the age of 18.

19 Sexual Offences Act, 2003. It provides for the death penalty as an aggravating factor if it is proven that the accused had prior knowledge of his or her positive HIV status at the time of committing the offence.

20 Criminal Procedure and Evidence Act, 1981.

21 Penal Code, Section 55 (1), 2010.

22 UNAIDS, 'Global Report: UNAIDS report on the global AIDS epidemic,' 2013.

23 United Nations, 'Compilation of UN info for the second cycle of the Universal Periodic Review (UPR) mechanism: Lesotho,' 2013.

Migrant workers who work in the textile factories and mines of South Africa, although recognised as key populations requiring prioritisation in the response, are not adequately addressed in the implementation of HIV programming. Prisoners, too, though potentially benefiting from the Lesotho Correctional Services (LCS) Strategic Plan on HIV and AIDS 2009-2014, the LCS Health and Social Welfare Policy, the LCS HIV Policy and the provision, amongst other things, of condoms in prisons despite criminal laws, reported a variety of challenges to accessing HIV-related human rights due to prison conditions. ^[24]

Access to HIV prevention, treatment, care and support is the most effective strategy for HIV prevention and for improving the quality of life for those already living with and affected by HIV. Laws, regulations, policies and guidelines have gone some way towards improving equitable access, without discrimination, to HIV-related health care services in Lesotho including for vulnerable and key populations. The Government of Lesotho has in place various laws and policies dealing with access to medicines. In addition, health policies have made provisions for prohibiting restrictive patent laws, regulating the price of essential medicines and providing for free medication for various populations, including people living with HIV, and the public health system or social health insurance schemes provide free medicines for particular conditions like HIV. ^[25] However, the lack of a fully enabling legislative framework around IP remains a barrier to making optimal use of TRIPs flexibilities in order to contribute to innovation and to promote public health.

Access to justice is granted by the Lesotho Constitution. ^[26] However, the high cost of legal fees precludes many key and vulnerable populations from being able to obtain legal representation. ^[27] Barriers to complainants being able to access the courts include the location of and distance to the courts, and the poor or limited quality of legal representation. Although a number of civil society organisations do provide legal support services, including legal aid services in the form of support interventions for domestic violence and other human rights violations, lack of financial and human capacity limit the support they are able to provide.

Furthermore, there is limited sensitisation of law enforcement agencies regarding the rights of people living with HIV and key populations at risk of HIV exposure and the challenges they experience accessing justice. Key populations interviewed during the LEA reported experiences of bribery, corruption, assault and harassment by the police, ^[28] making these populations unwilling or unable to report any criminal act for fear of re-victimization by the police.

The LEA recommended the following, in order to strengthen the legal and regulatory framework for HIV:

24 Lesotho Correctional Service HIV Zero-Prevalence And Behavioural Study, 2011.

25 National Medicines Policy, 2008.

26 Lesotho Constitution, 1993.

27 Pholo, M, 'Lesotho Justice Sector and the Rule of Law: A review by AfriMAP and the Open Society Initiative for Southern Africa,' Open Society Foundations, 2013.

28 Focus group discussion in this assessment.

- **Strengthening anti-discrimination in law on the basis of HIV and AIDS by, for example:**
 - o Mainstreaming HIV in related laws and policies to address equality and non-discrimination on the basis of HIV status or AIDS
 - o Considering an amendment to the Constitution to explicitly include HIV status as a prohibited ground for discrimination;
 - o Reviewing the Penal Code provision providing for broad criminalisation of non-disclosure of HIV status
 - o Developing prosecutorial guidance on the application of criminal laws applicable to HIV, including s52 of the Penal Code and s32 of the Sexual Offences Act, to ensure the provisions are applied in a manner that is (i) guided by the best available scientific and medical evidence relating to HIV, (ii) uphold the principles of legal and judicial fairness (including key criminal law principles of legality, foreseeability, intent, causality, proportionality and proof) and (iii) promote equality and non-discrimination and protect the human rights of those involved.
- **Eradicating gender inequality, harmful gender norms and gender based violence and strengthen the rights of women and girls in law and policy by, for example:**
 - o Including the equality rights of women and girls in the context of HIV, in all related laws; Including non-discrimination on the basis of sex, gender or gender identity in (e.g. the proposed review of the Constitution of Lesotho, Enacting domestic violence legislation which also addresses intimate partner violence)
 - o Reviewing the Marriage Act of 1974 and Laws of Lerotoli to create a uniform age of consent to marriage with that set out in the Children's Protection and Welfare Act, 2011 and Convention on the Rights of the Child (18 years)
 - o Reviewing the inconsistencies between the age of consent to medical treatment and HIV testing with those relating to age of consent to sexual activity
 - o Reviewing and reforming inheritance laws to promote equality in inheritance for women, girls, men and boys
 - o Developing regulations for the effective implementation of the Anti-Trafficking in Persons Act, 2011
 - o Strengthening policies and procedures to provide for broader access to post-exposure prophylaxis and to furthermore provide for comprehensive referrals between health care, legal and law enforcement services for survivors of sexual violence and other gender-based violence *to ensure access to appropriate information regarding sexual and reproductive health and rights, HIV testing and counselling services, post-exposure prophylaxis, treatment and support with laying a complaint.*
- **Promoting the rights of all employees to non-discrimination in the working environment**
 - o Reviewing and clarifying the protection of confidentiality in the Public Service HIV and AIDS Workplace Policy to prohibit unreasonable disclosures of a public officials HIV status
- **Strengthening the rights of key populations to equality and non-discrimination:**

- o Recognising the equality and health rights of key populations such as men who have sex with men, sex workers, migrants and prisoners in HIV related laws including the right to non-discrimination on the basis of sexual orientation and gender identity in general anti-discrimination legislation
- o Considering an amendment to the Constitution to explicitly include sexual orientation and gender identity as a prohibited ground for discrimination;
- o Reviewing and harmonising sexual offence law with other global best practices;
- **Strengthening access to health care, including access to treatment**
 - o Updating intellectual property laws to incorporate TRIPS flexibilities in the Medicines Bill, to increase universal access to affordable medicines
- **Conducting Awareness Raising, Education and Stigma and Discrimination Reduction Campaigns**
 - o Conducting stigma and discrimination campaigns country wide, including at community level, to reduce stigma and discrimination against people living with HIV and all vulnerable and key populations
 - o Sensitising traditional and religious leaders to recognize and uphold the rights of people living with HIV, vulnerable and key populations
 - o Conducting awareness raising campaigns on the rights of women and girls to gender equality and to be protected from harmful gender norms and gender-based violence
 - o Raising the awareness of the sexual and reproductive health rights of young people amongst parents and service providers
 - o Raising awareness amongst employers and employees, including public officials and members of the uniformed services, of HIV-related rights in the working environment, including the rights to non-discrimination, voluntary HIV testing and confidentiality.
 - o Training and sensitising parliamentarians, members of the judiciary, police and health and social welfare providers to recognize and uphold the human rights of people living with HIV and vulnerable and key populations.
 - o Programmes should be put in place to provide legal services to key populations so that they know their rights and applicable laws and can be supported to access the justice system when aggrieved.
- **Strengthening Access to Justice**
 - o Sensitising the judiciary, prosecutors and legal practitioners, including through the development of prosecutorial guidance, to respond to HIV-related complaints, including workplace-related HIV discrimination and criminal law matters, before the courts
 - o Strengthening and decentralising legal support services for people living with HIV, vulnerable and key populations, including through the encouragement of private lawyers to take on *pro bono* cases and support to civil society to provide legal support

- o Establishing a human rights commission to protect human rights in the context of HIV, amongst other things

- ***Strengthening Law Enforcement through***

- o Sensitising law enforcement officials on the rights of people living with HIV, vulnerable and key populations to prohibit human rights violations and to support appropriate enforcement of existing human rights and constitutional guarantees
- o Train law enforcement officials on the rights of survivors of sexual violence to sexual and reproductive health care services and appropriate and timely referrals.

PART I: INTRODUCTION AND BACKGROUND

1.1 Introduction

This report presents the findings of the assessment of the legal environment for HIV and AIDS in Lesotho commissioned by the Government of Lesotho under the leadership of the Ministry of Law and Constitutional Affairs and supported by UNDP Lesotho.

1.2 Background

Lesotho has a total population of 1.8 million people, 900,000 (54.9 per cent) of which are women.^[29] Over three fourths (76.26 per cent) of the population lives in rural areas, with the remainder (23.74 per cent) living in urban areas. Over half (56 per cent) of the population lives below the national poverty line, while 43.3 per cent live on less than one dollar a day.^[30]

Like many sub-Saharan African countries, Lesotho has a generalised HIV epidemic with small pockets of concentrated sub-epidemics.^[31] It is estimated that at least 23 per cent of the total population is infected with HIV.^[32] Over 27 per cent of women aged 15-49 and 18 per cent of men aged 15-49 are estimated to be living with HIV. The Modes of Transmission Report showed that an estimated 3-4 per cent of all new HIV infections are likely to come from MSM and their female partners.^[33] HIV prevalence is higher in urban areas (27.2 per cent) compared to rural areas (21.1 per cent).^[34]

The HIV epidemic remains one of the major public health and development challenges in Lesotho, but some progress has been made. For example, current research indicates that the country's HIV epidemic is fuelled by behavioural, biomedical and structural drivers,^[35] and that significant progress has been made in addressing the biomedical drivers. There are also positive signs of a continued commitment to improving the national response to HIV through political leadership and by allocating resources to support interventions at various levels.^[36] Furthermore, there has been some progress in HIV programmes, strategy and policy development. For example, interventions for the prevention-of-mother-to-child transmission (PMTCT) and antiretroviral therapy (ART) have resulted in a reduction of new HIV infections in children 0-14 years, dropping from 6,100 to 3,700 between 2002 and 2012.^[37]

Nonetheless, the social and structural drivers and the factors that influence the epidemic

29 'Lesotho Census Report,' 2006.

30 Revised Lesotho National HIV and AIDS Strategic Plan 2011/12–2015/16.

31 Lesotho National HIV Prevention Strategy, 2011-2016.

32 Ministry of Health and Social Welfare, 'Lesotho Demographic and Health Survey,' 2009, p9.

33 'Lesotho Modes of Transmission Report,' 2009.

34 Ministry of Health and Social Welfare, 'Lesotho Demographic and Health Survey,' 2009.

35 Revised Lesotho National HIV and AIDS Strategic Plan 2011/12 – 2015/16.

36 The government funds 70 per cent of the ARVs and allocates 2 per cent to the budgets of individual public ministries' HIV workplace programmes.

37 Lesotho National HIV and AIDS Strategic Plan 2011/12–2015/16. Lesotho also put in place the National Behaviour Change Communication Strategy (2008-2013).

in Lesotho have not changed.^[38] Research shows that HIV-related stigma and discrimination remain an issue in the country, and that people living with HIV, women, youth and other key populations vulnerable to HIV exposure continue to experience violations of their human rights.^[39]

There is no law dealing solely with HIV in Lesotho, and there are limited HIV-specific provisions in law. Existing HIV-related laws and policies tend not to extend protection beyond people living with HIV to include other vulnerable and key populations and participants in the LEA reported that they are rarely implemented and enforced.

The report of the Global Commission on HIV and the Law, entitled *Risks, Rights and Health*, revealed that although governments and international donors have been investing millions of dollars to address HIV, efforts to overcome this global epidemic have not been successful due to the fact that legal environments in many countries are hindering rather than helping HIV responses.^[40] The report further indicated that in many instances, public health programmes aimed at addressing HIV are undermined by laws that criminalize the very practices that public health efforts promote and depend on, such as distributing clean needles and providing opioid substitution therapy to people who use drugs, providing condoms and harm reduction measures to prisoners or supporting organisations of sex workers for the purposes of mutual support and education. The report stated that “if law makers do not amend these laws so that all resources are marshalled against the same enemy (HIV), not people living with HIV, the virus will be the victor and the world’s people, especially its most vulnerable, the vanquished.”^[41]

Reversing HIV trends and patterns to get to zero HIV infections, zero discrimination and zero deaths in Lesotho will require reinvigorated and accelerated responses, buttressed by a supportive and protective policy and legal environment in the country.^[42] Strengthening the legal and policy environment in the context of HIV requires greater government action and commitment to enhance a supportive and protective environment for people living with HIV and other populations who are vulnerable to and at higher risk of HIV exposure. Strengthening HIV-related law and policy, as well as promoting and protecting human rights in access to justice and law enforcement, such as by the police, the judiciary and health service providers, have been noted as a critical challenge for Lesotho.

Despite various HIV-related legal challenges, Lesotho has never undertaken a systematic and comprehensive analysis of critical legal aspects of HIV to obtain evidence and clarity on

38 Ibid.

39 Revised Lesotho National HIV and AIDS Strategic Plan 2011/12–2015/16. UNAIDS, ‘UNAIDS Terminology Guidelines,’ 2011: “Key populations at higher risk of exposure: The term ‘key populations’ or ‘key populations at higher risk of HIV exposure’ refers to those most likely to be exposed to HIV or to transmit it—their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and seronegative partners in serodiscordant couples are at higher risk of HIV exposure to HIV than other people. There is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms.”

40 Global Commission on HIV and the Law, ‘Risks, Rights and Health,’ 2012.

41 Ibid.

42 UNAIDS, ‘Global Report: UNAIDS report on the global AIDS epidemic,’ 2013.

the extent to which the existing policies, laws and regulations either support or constrain the national response to HIV. Therefore, the Government of Lesotho in collaboration with United Nations' (UN) agencies under the Delivering as One Framework initiated this project as an important step towards providing information and evidence to inform actions for strengthening the legislative environment for an effective HIV response. The findings from this study will help the country to strengthen an effective HIV response that protects and promotes the human rights of people living with HIV and populations vulnerable to and at higher risk of exposure to HIV. A rights-based approach will afford Lesotho's citizens, in particular people living with HIV and populations most vulnerable to and at higher risk of HIV exposure, full enjoyment of the ability to access their human rights.

1.3 Terms of reference

The Government of Lesotho, assisted by UNDP Lesotho Office and with the technical support of UNDP Regional Service Centre for Africa, engaged the services of a local legal expert to undertake an assessment of Lesotho's legal, regulatory and policy frameworks in order to identify and clarify the key legal and human rights issues acting as barriers to the national response to HIV. The assessment is also intended to guide the development, implementation and enforcement of laws, regulations and policies that protect rights and promote access to HIV-related services.

The role of a supportive legal and policy environment in improving outcomes of HIV-related interventions has been increasingly documented and recognized to include improving protection of rights, enhancing access to HIV-related health services and mitigating the impact of the epidemic. Thus, targeted actions within the national HIV response to create enabling environments will also contribute to achieving and maintaining universal access targets, Millennium Development Goals (MDGs) and, beyond 2015, Sustainable Development Goals.

1.4 Overall goal of the assignment

The aim of the study was to improve the availability of information on and evidence of the policy, legal and regulatory aspects governing HIV, for the purposes of making recommendations for creating and strengthening an enabling environment that promotes an effective national HIV response in accordance with the national strategic frameworks for HIV and sexually transmitted infections (STIs) in Lesotho.

1.5 Objectives of the assignment

This review was intended to:

- Make recommendations for the Kingdom of Lesotho for creating and strengthening an enabling environment that protects human rights while promoting an effective national response to the HIV epidemic
- Provide an assessment and analysis of legal and regulatory aspects in the context of HIV and AIDS in Lesotho
- Undertake a desk review of selected laws, policies and other key documents related to HIV
- Conduct a qualitative assessment of issues related to access to justice and law

enforcement, including the levels of knowledge about HIV, law and human rights among key and vulnerable populations; access to programmes and services to reduce stigma and discrimination, as well as access to and enforcement of human rights; and the degree of awareness of HIV-related laws and human rights among law makers and law enforcers to enable the effective implementation of services

- Provide sound recommendations on the actions required to create and strengthen the HIV legal and regulatory environment to respond to identified gaps and challenges
- Develop the dissemination and advocacy report

Specific objectives were to:

- Systematically analyse an agreed-upon list of prioritized, relevant laws, regulations and policies to determine how they protect human rights and support universal access to services, or how they undermine an enabling environment for the national HIV response
- Analyse the extent to which affected populations know their rights and are able to access services and mechanisms to enforce their rights
- Analyse the extent to which service providers, law makers and law enforcers are sensitized to HIV-related law and human rights issues to enable effective implementation of services and to support access to justice and enforcement of HIV-related laws and rights
- Identify gaps and challenges within the legal and regulatory framework and provide detailed and appropriate recommendations for developing, reviewing, reforming or strengthening laws, regulations and policies and their implementation and enforcement, as well as recommendations for measures to strengthen access to justice, in order to create and strengthen legislative environments for HIV

1.6 Key deliverables

The key deliverables were:

- Detailed work plans for the major project activities, including: desk review, key informant interviews (KIIs), focus group discussions (FGDs) and public consultations
- Preliminary analytical report on the desk review of selected laws, regulations and policies as agreed, detailing issues identified and how they impact on the HIV response in Lesotho
- Preliminary analytical report on the extent to which affected populations know their rights, and service providers, law makers and law enforcers are sensitized to HIV-related law and human rights issues to enable effective implementation of services, access to justice (for instance, access to legal support services, courts, Ombudsman, legal aid and probation services, etc.) and enforcement of HIV-related laws and rights
- A comprehensive final draft report providing a synthesis of findings from the desk review, KIIs and FGDs, and 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

- A final dissemination and advocacy draft report

1.7 Implementation modalities

1.7.1 Technical approach

The situational analysis was guided by a human rights-based approach to health and HIV using international, regional and national human rights commitments 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 that underlie the HIV epidemic in Lesotho, with the broader aim of recognising and responding to the underlying inequalities, prejudices and power relationships that impact on HIV transmission and access to HIV-related health care services in the country.

The main principles of the human rights-based approach used as guiding principles for the situational analysis are the principles of equality and non-discrimination; participation and inclusion of rights-holders; capacity building of duty-bearers and accountability. In this regard, 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.

To address the specific objectives of this assessment, the consultant conducted a literature review of public health and human rights documentation. This included a review of laws, regulations and policies directly or indirectly related to HIV and AIDS. Documents reviewed include:

- International and regional human rights commitments, as well as regional and international health and HIV-specific commitments and guiding documents
- Relevant national laws, regulations, policies and strategies, plans and guidelines
- International, regional and national case law
- Annual reports, research reports and other documents of civil society organisations working with health, HIV and AIDS, people living with HIV and key populations
- Reports of government ministries, statutory bodies (such as the Law Reform Commission), regional and international organisations and academic publications

The desk review was aimed at determining the nature, extent, efficacy and impact of the legal and regulatory framework (including 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 Lesotho. The desk review included an initial focus on the key issues identified in the preparatory phase of the project. It also identified additional key HIV, law and human rights issues of concern within Lesotho for further exploration during KIs and FGDs. Based on the literature review, recommendations for review and reform of laws were

made. In addition, strategies to strengthen access to justice and law enforcement in the country were also proposed.

See [Annexure 1 for a list of documents reviewed.](#)

1.7.2 Qualitative assessment

The consultant conducted a qualitative study utilising KIIs and FGDs with relevant stakeholders and members of the community to identify key HIV, law and human rights issues affecting people living with HIV and other key populations at higher risk of HIV exposure.

Thus, from the literature review, KIIs and FGDs, the following information was explored:

- The background to the HIV epidemic in Lesotho, including an understanding of populations who are at higher risk of HIV exposure and/or are particularly vulnerable in the context of Lesotho, and the kinds of HIV-related human rights issues affecting these populations
- Human rights principles, norms and standards to guide the HIV response, based on national standards set forth in the Lesotho Constitution, HIV-related policies and regional and international human rights documents
- Laws and policies regulating HIV-related issues, including laws and policies that impact on key populations at higher risk of HIV exposure and populations vulnerable to HIV
- Specific reforms for regulating HIV-related issues in Lesotho

1.7.3 Key informant interviews (KIIs)

A total of 24 qualitative KIIs were conducted in the capital and administrative district of Maseru. They provided information on the views of decision makers on key HIV-related law and human rights issues within Lesotho; they also explored the impact of the legal and regulatory framework on the national response to HIV. In addition, KII participants provided recommendations for strengthening the legal and regulatory framework to protect the human rights of people living with HIV and to promote access to services in the context of HIV.

As a strategy to ensure that a range of opinions was elicited, key informants were selected through consultation with the Technical Working Group (TWG) from across a range of sectors, including from government ministries/departments, civil society organisations, the private sector and other partner institutions working on issues of HIV, health, law and human rights issues. These included the Ministries of Health, Social Development, Justice and Human Rights, Law and Constitutional Affairs, Labour, Police and Home Affairs. KIIs with civil society organisations included representatives from women's rights organisations, organisations working with key populations, faith-based organisations, and organisations of people living with HIV. They also included legal experts, members of the judiciary and development partners working on health, HIV and related issues.

See [Annexure 2 for a list of key institutions interviewed.](#)

1.7.4 Focus group discussions (FGDs)

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. They were also intended to find out the level of knowledge of laws, policies and how these laws and policies impact on the rights of people living with HIV. Further, this methodology was employed to learn the extent to which populations in Lesotho affected by and infected with HIV are able to access health services, access justice and claim and enjoy their human rights.

CCE-CC tools or steps used to guide the FGDs:

- » **Introduction:** Laws and policies and their importance were defined. Participants were probed to mention laws and policies they knew in relation to HIV and AIDS.
- » **Reflection:** In this process, participants introspected on HIV and AIDS challenges they have faced as individuals and as a community and how they handled such challenges.
- » **Stock-taking:** Participants had the opportunity to reflect on the interventions that were done to curb the spread of HIV and AIDS, and why certain approaches succeeded and others failed. Participants also introspected on whether there are HIV and AIDS policies and human rights interventions and programs carried out to empower communities to reduce stigma and discrimination, promote knowledge or rights and provide access to justice and health services.
- » **Sociocultural dynamics:** Participants were probed to reflect on norms, values, beliefs and power relations, since HIV is fuelled by the way people live and the way they relate to one another as individuals, as well as within families, communities and cultures.
- » **Mapping:** Participants identified institutions in their communities that were supposed to address legal matters and how well those institutions were functioning and whether they were accessible. They also mapped out different groups that they believed to be vulnerable in the context of HIV and which laws and policies should be in place to protect them.
- » **Storytelling:** Different stories were told relating to HIV, reflecting the problems people face on the ground. For example, stories related to stigma and discrimination were used to help participants gain an in-depth understanding of these issues and to stimulate discussion.
- » **Strategic questioning:** This was used to get participants' points of view with regard to HIV and AIDS laws and policies. Strategic questioning probed participants to reflect on issues that affect them and deepen their understanding of concerns and options for transformation.
- » **Focus group individual perspectives:** Participants' views were captured and written down and pasted on the walls so that each could see his/her own concerns. Common concerns reflected the seriousness and value of community concerns on specific issues.
- » **Future Vision creation:** Participants were asked to suggest HIV and AIDS laws and policies that they would like to see in place in order to create a desired change

FGDs were undertaken using the Community Capacity Enhancement through Community Conversation (CCE-CC) methodology, described below.

Thirteen FGDs were conducted with a total of 175 participants in the districts of Maseru, Mophale's Hoek, Thaba Tseka and Leribe (Maputsoe). Besides Maseru, where 6 FGDs were conducted, there were two FGDs in each district—one in the urban council and the other in a rural council. FGDs were made up of vulnerable and key populations at higher risk of HIV exposure (e.g., people living with HIV, sex workers, prisoners and lesbian, gay, bisexual, transgender and

intersex [LGBTI] persons), service providers (e.g., village health workers, law enforcement) and community leaders (e.g., religious leaders, community councillors, and chiefs).

See [Annexure 3 for a list of FGDs conducted](#).

1.8 Technical working group

A TWG was formed to oversee the assignment. The TWG was made up of key stakeholders from a range of disciplines and sectors, including key government ministries, civil society organisations working on HIV, health, law and human rights issues and/or representing affected populations, international organisations and UN agencies. The TWG met regularly and worked closely with the consultants to guide the situational analysis. This included providing assistance in the selection of key informants and districts for the qualitative assessment, provision of inputs on the data collection instruments for KIIs and FGDs and the planning and implementation of activities; regularly reviewing the research process; providing inputs on the report, findings and recommendations throughout the various stages of the project and ensuring that the views of decision makers and key affected populations were reflected in the analysis process.

See [Annexure 4 for a list of members of the TWG](#).

1.9 Analysis of the report

The report reflects the outcome of the process, combining the findings of the desk review, the perspectives of key informants in the KIIs and key populations participating in FGDs, as well as the comments and feedback provided by key stakeholders throughout the process.

Part II of the situational analysis sets out the international, regional and national human rights framework to which Lesotho has committed itself and that frames the investigation of HIV-related rights. Part III analyses the legal and regulatory framework governing specific HIV-related human rights issues or populations at higher risk, such as equality and anti-discrimination; gender equality; health rights; criminal law and law enforcement; key populations such as MSM and sex workers; and employee rights. It also analyses the current situation and makes recommendations for how to address the gaps in line with national, regional and international human rights commitments. Part IV details the current mechanisms in place relating to access to justice and law enforcement in Lesotho, whilst providing findings from the qualitative assessment where relevant. Part V of the report provides general conclusions. Finally, Part VI consolidates the recommendations made in Part IV with the aim of strengthening the legal and regulatory framework for HIV in Lesotho.

The following limitations of 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
- Fear of confidentiality breaches and of HIV-related stigma and discrimination amongst affected populations

- Time and resource constraints

For these reasons, a limited number of FGDs were conducted with people living with HIV, community workers, community councillors, chiefs, sex workers, prisoners and LGBTI persons. The qualitative findings do not purport to provide definitive statistical evidence of the extent of stigmatising and discriminatory practices but rather seek to give voice to some of the experiences related by affected populations for purposes of the law and policy review. The invaluable perspectives provided by key informants and focus group participants are gratefully acknowledged.

PART II: INTERNATIONAL AND REGIONAL HUMAN RIGHTS FRAMEWORK

2.1 Introduction

Lesotho's human rights framework consists of the following elements: international treaties and conventions, regional treaties and conventions, the Constitution and national laws (statutes, the common law and customary law). This section examines the international, regional and national human rights frameworks in the context of the HIV response in Lesotho.

Some have indicated that failure to address the HIV epidemic may constitute an international crime against humanity^[43] because of its threat to the universally recognized human right to life. Within the context of the HIV pandemic, the defence and promotion of this right to life, as well as socio-economic, civil and political rights, is imperative. Because HIV is mostly transmitted sexually, issues of morality inevitably come into play. In turn, this results in stigmatization of those who have become infected, including key populations who may already experience stigma and discrimination.^{[44] [45]}

[W]ithout a rights-based response to HIV, the impact of and vulnerability to infection will increase, and the community's ability to respond will be hampered [...]. The protection of the uninfected majority is inextricably bound to upholding the rights of people living with HIV and AIDS^[46].

In Lesotho, the HIV epidemic has shown a consistent pattern through which discrimination, marginalization, stigmatization and a lack of respect for human rights and dignity of individuals and groups heighten their vulnerability to HIV.^[47] Cameron argues that "respect for individual human rights does not impede [HIV] prevention and containment of HIV, but actually enhances it."^[48] Striking a balance between the rights of people affected by HIV and those who consider themselves 'unaffected' may appear as seeking to reconcile conflicting goals (e.g. in the case of the right to privacy and confidentiality and the rights of sexual partners to be protected from harm).^[49] However, Cameron and others argue that experience has shown that protecting the rights of all affected persons in essence promotes public health by encouraging all people to take responsibility for HIV, inspiring confidence in people to come forward for HIV testing and to access prevention, treatment, care and support. This is more likely to achieve the goals of reducing HIV transmission and achieving universal access to HIV-related health care than restrictive and

43 Farrell, Nicholas and Kuhn, John, 'Has Mbeki heard of Nuremberg?' Mail & Guardian, 7-13 December, 2001, p29.

44 UNAIDS/IPU, 'Handbook for Legislators on HIV/AIDS, Law and Human Rights' 1999.

45 For example, according to a Health Officer interviewed in this assessment, some people still hold perceptions that people acquire HIV as a result of being "sexually immoral."

46 UNAIDS/IPU, 'Handbook for Legislators on HIV/AIDS, Law and Human Rights' 1999, p109

47 Letuka, P., et al., Gender, HIV and the Law in Lesotho: Embracing Rights-Based Approach to Realise Sexual and Reproductive Health in Lesotho, LSA Publication, Morija, 2008.

48 Jackson, Helen. AIDS Africa: Continent in Crisis, SAfAIDS, Harare, 2002, p345.

49 Letuka, P., et al., Gender, HIV and the Law in Lesotho: Embracing Rights-Based Approach to Realise Sexual and Reproductive Health in Lesotho, WLSA Publication, Morija, 2008.

punitive policies requiring mandatory HIV testing, mandatory disclosure in all circumstances, isolation, quarantine or criminalisation.

Thus, the respect for human rights is imperative, regardless of the scale and stage of the HIV epidemic. In a community with high HIV prevalence like Lesotho, the promotion of human rights and gender equality is critical to a comprehensive response to the HIV epidemic.

2.2 International and Regional Frameworks

2.2.1 Overview

One essential lesson learned from the HIV and AIDS epidemic is that universally recognized human rights standards should guide policy makers in formulating the direction and content of HIV-related policy and form an integral part of all aspects of national and local responses to HIV and AIDS.^[50]

The dynamic between international, regional and national human rights standards remains the guiding principle to navigate HIV and human rights issues. International, regional and national human rights law provides an overarching framework for an analysis of HIV, law and human rights issues in Lesotho. International and regional human rights law is set out in the various charters, treaties and conventions signed and ratified by Member States. Signature and ratification of an international instrument by a Member State implies that said Member State commits itself to be legally bound by the provisions of the instrument.

In Lesotho, international treaties are only enforceable by the courts to the extent that they have gone through the process of adoption by Parliament.^[51] However, they are an important aid for interpretation of the national law. The courts appear to have adopted the principle that where there is uncertainty regarding domestic legislation, an international treaty becomes relevant because there is a prima facie presumption that the legislature does not intend to act in breach of international law, including treaty obligations.^[52] Some treaty provisions have been adopted in the justiciable Bill of Rights (Part II) provisions of the Lesotho Constitution, while others are reflected in the non-justiciable Principles of State Policy (Part III) provisions of the Constitution.^[53]

In addition to treaties, declarations by the international community on human rights in relation to HIV serve as additional important guidelines for States in their efforts to meet international obligations.

In its attempt to adhere to international and regional human rights norms, including in the context of HIV, the international declarations, resolutions or guidelines outlined in Table 1 have been adopted by the Government of Lesotho.

50 UNAIDS, 'HIV/AIDS and Human Rights: International Guidelines,' 1996 at p41 para.77

51 Molefi v. Government of Lesotho 1967-1970 LLR 237(CA); Director of Private Prosecutions v. Ts'oenyane & Others CR 299/99 (unreported).

52 Tšepe v. Independent Electoral Commission and Others (C of A [Civ] No. 11/05 CC 135/05) (unreported).

53 'Lesotho African Peer Review Mechanism (APRM) Report,' 2008.

Table 1. International declarations, resolutions or guidelines

Year	Declaration, Resolution or Guideline	Purpose	Relevance to HIV, health, human rights and gender equality
1948	The Universal Declaration on Human Rights (UDHR)	It provides that “all human beings are born free and equal in dignity and rights.” It is based on the “inherent dignity” of all people and affirms the equal rights of all men and women, in addition to their right to freedom.	UDHR recognises a range of basic civil, political, economic, social and cultural human rights principles applicable to all people and that apply equally to people living with HIV and key populations. Article 25 recognises the right to health, including access to medical care.
1976	International Covenant on Economic, Social and Cultural Rights (ICESCR)	Encourages State parties to promote and protect economic, social and cultural rights, also known as second-generation rights.	The ICESCR obliges Member States to take the steps necessary to protect economic, social and cultural rights including rights to health for the prevention, treatment and control of the HIV epidemic.
1976	International Covenant on Civil and Political Rights (ICCPR)	Calls for the right to equality, freedom from non- discrimination and access to justice without any discrimination to equal protection of the law.	The ICCPR recognises a range of civil and political rights, such as rights to equality, non-discrimination, privacy and protection from cruel, inhumane and degrading treatment or punishment, that protect all people, including those affected by HIV, from rights violations.
1979	Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	Calls for elimination of all forms of discrimination against women, including reviewing and reforming laws that discriminate against women.	The rights of women and girls to gender equality and to the protection and promotion of all rights is important for women and girls affected by HIV. Importantly, CEDAW promotes the sexual and reproductive health rights of women, and interpretative commentary by the Committee on CEDAW specifically recognises that issues of HIV and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health.

	General Recommendation 19 of CEDAW		The recommendation recognises issues of gender-based violence that deprive girls and women of their liberty; ending gender-based violence is critical in the context of HIV and AIDS.
1989	Convention on the Rights of the Child (CRC)	Advocates for promotion of human rights of children and imposes measures on State parties aimed at the protection of children's best rights.	The recognition of a range of rights for children is critical to protecting children affected by HIV from discrimination and human rights violations, as well as to promoting their access to health care in the context of the HIV epidemic. The CRC Committee recognises that policies and programmes for the prevention, care and treatment of HIV and AIDS must be designed, taking into consideration "the best interests of the child."
2006	Convention on the Rights of Persons with Disabilities	Serves to promote, protect and ensure full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for inherent dignity.	The CRPD highlights the need for States Parties to recognize that persons with disabilities have the right to the enjoyment of all human rights, including the right to the highest attainable standard of health without discrimination on the basis of disability. States Parties are required to take all appropriate measures to ensure access for persons with disabilities to the same range, quality and standard of accessible, acceptable and affordable health care as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.

1977	UN Standard Minimum Rules for the Treatment of Prisoners	Sets out standard minimum rules to protect the rights of prisoners.	The standard minimum rules include protection for the rights, including health rights, of prisoners, which would include the context of HIV.
1993	World Health Organization (WHO) Guidelines on HIV Infection and AIDS in Prisons	Provides standards for managing HIV in prisons.	The Guidelines recognise the rights of prisoners with HIV to, amongst other things, equality, non-discrimination and receiving health care on the same basis as others, without discrimination.
2011	United Nations General Assembly Special Session (UNGASS) Political Declaration	To review progress achieved in realizing the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS, with a view to guiding and intensifying the global response to HIV and AIDS by promoting continued political commitment and engagement of leaders in a comprehensive response at the community, local, national, regional and international levels.	UNGASS provides Member States with guidelines and strategies to halt and reverse the HIV epidemic and mitigate its impact, including through the creation of enabling legal and policy frameworks that promote human rights and gender equality.
2000	The UN Millennium Development Goals	UN commitments to establish peace and a healthy global economy by focusing on major issues like poverty, children's health, empowerment of women and girls, sustainable environment, disease, and development.	Goal 3 calls Member States to promote gender equality and empower women. Goal 6 urges States to halt and reverse the spread of HIV and AIDS by 2015.
2010	The International Labour Organisation (ILO) Recommendation 200 of 2010 on HIV and the World of Work	The Recommendation is instrumental in helping to prevent the spread of the epidemic, protect the rights of employees, mitigate the impact of HIV and AIDS on workers and their families and provide social protection to help cope with the disease.	The Recommendation covers key principles such as the recognition of HIV and AIDS as a workplace issue, non-discrimination in employment, gender equality, screening and confidentiality, social dialogue and, prevention care and support, as the basis for addressing the epidemic in the workplace.

2.2.2 Continental and sub-regional legal frameworks and guidance documents

At the regional and sub-regional (Southern African Development Community [SADC]) level, African States have ratified various legal charters, resolutions and other frameworks and guidance documents relating to human rights and HIV. Lesotho has signed and ratified the documents listed in Table 2.

Table 2. Continental and sub-regional declarations, resolutions or guidelines

Year	Declaration, Resolution or Guideline	Purpose	Relevance to HIV, health, human rights and gender equality
1979	African Charter on Human and Peoples' Rights (ACHPR)	Article 5 provides that every individual shall have the right to respect of the dignity inherent in a human being and the right to recognition of his legal status.	The ACHPR provides for a range of basic human rights relevant to HIV and AIDS, including equality, non-discrimination, protection against cruel and inhumane or degrading punishment and treatment and the right to the highest attainable standard of health, amongst others.
1998	Protocol to the ACHPR on the Rights of Women in Africa	The Protocol emphasizes the particular rights of women in the context of the African Charter on Human and Peoples' Rights	The Protocol provides for important rights such as the right to equality and non-discrimination; the right to human dignity; the right to health and reproductive rights, including protection against sexually transmitted infections (STIs) such as HIV and a right to abortion in given circumstances; as well as the right to be informed of one's health status and on the health status of one's partner (including HIV status), in accordance with international recognised standards and best practices.

1990	African Charter on the Rights and Welfare of the Child	The Charter provides for the rights of children to a range of basic rights including civil and political rights as well as socio-economic rights such as health rights. It provides that every child has the right to enjoy best attainable state of physical, mental and spiritual health.	The rights in the African Charter protect children, including children affected by HIV from discrimination, sexual exploitation and abuse, and provide for their welfare, amongst other things and promote the best interest of the child in matters relating to children. ^[54] The African Charter further provides right to access to information, access to sexual and reproductive health education.
Sub-Regional Declarations			
2004	Solemn Declaration on Gender Equality	It encourages States to develop concerted and collective leadership efforts to challenge issues related to gender inequalities.	Member States are obliged to, amongst other things, accelerate the implementation of measures aimed at addressing the HIV and AIDS pandemic and effectively implement the Abuja Declaration and the Maputo Declaration on Malaria, HIV and AIDS, Tuberculosis (TB) and other related diseases. Member States also agreed to launch campaigns for the prohibition of abuse of girl children as wives and sex slaves.

54 Protocol to the African Charter on Human Rights and Peoples' Rights on the Rights of Women in Africa, Article 1, 1986.

54 Ibid. Article 2

54 Ibid. Article 3

54 Ibid. Article 14

54 Ibid.

2006	The Continental Framework for Harmonisation of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV and AIDS in Africa	The objective of this document is to harmonise related approaches and integrate the rights of people living with HIV, including migrants or people in conflict situations, within national human rights frameworks. ^[55]	Member States are obliged to ensure that national human rights frameworks protect the rights of all people in the context of HIV and AIDS.
2001	Resolution on the HIV and AIDS Pandemic-Threat Against Human Rights and Humanity	The ACHPR declared that the HIV pandemic is a human rights issue that is a threat to humanity. As a result of this Resolution, African governments were called upon to allocate national resources that reflect a determination to reduce the spread of HIV, ensure human rights protection of those living with HIV against discrimination, provide support to families for the care of those dying of AIDS, devise public health care programmes of education and carry out public awareness. ^[56]	The Resolution is directly relevant to HIV and human rights, showing a commitment to protecting the rights of people affected by HIV within the rights protected by the African Charter.

55 Ibid. p70-71.

56. Ibid. p80

2003	The SADC Code on HIV and AIDS and Employment ^{57]}	The Code aims at creating regional standards on the best ways to manage HIV and AIDS in the employment setting. It also intends to guide employers, employees and governments towards the most economically sustainable and human ways to respond to HIV and AIDS in the workplace.	The SADC Code includes key principles for a rights-based response to HIV in the working environment, including non-discrimination, the right to confidentiality, a prohibition on pre-employment HIV testing, the right to be protected from unfair labour practices and unlawful dismissals, the right to a safe working environment and compensation for occupational infection with HIV.
2014	African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria	The Roadmap is intended to support African countries to exercise leadership to meet AIDS, TB and malaria targets by 2015 and source African solutions to ensure universal access to health-related services for all those in need on a sustainable basis.	Pillar 3 of the Roadmap includes an obligation for Member States to address stigma and discrimination, create enabling frameworks and empower communities to know their rights and access services.
2008	SADC PF Model Law on HIV & AIDS in Southern Africa,	Its objective is to set out a model rights-based legal framework to encourage Member States to address HIV and AIDS.	The Model Law recognises the importance of a human rights-based and gender-sensitive approach that protects the rights and promotes the participation of people affected by HIV and vulnerable populations; it encourages Member States to adopt legal frameworks based on the Model Law.

57 The Code was approved in 1997 by Southern African Development Community Heads of State Government

2.2.3 Conclusion

As indicated above, there are several international and regional human rights conventions and treaties, as well as declarations, commitments and guidelines that deal specifically with HIV, human rights and gender equality, of which Lesotho is a party. While the declarations and guidelines are not legally binding, they are generally reflections of the application and interpretation of accepted international and regional human rights principles set out in the treaties and conventions in the context of the HIV epidemic. In this respect, they provide important guidance for Lesotho in its interpretation of its own human rights standards in the context of HIV. In addition, many international and regional strategies and plans include guidance on law and policy responses to HIV. As such, they provide important and persuasive guidance for a national response to HIV that the Government of Lesotho can easily implement. The international and regional guidance set out above is used throughout this Legal Environment Assessment in guiding the analysis and recommendations for rights-based responses to HIV in Lesotho with respect to the national human rights framework, current laws, policies and plans.

PART III: FUNDAMENTAL HUMAN RIGHTS IN THE CONTEXT OF HIV IN LESOTHO

3.1 Overview

Lesotho as a State is accountable and assumes obligations to provide for and protect the human rights of its citizens either directly or through a delegated process or both.^[58] However, major human rights violations still exist in certain areas, with widespread violence and societal discrimination on the basis of HIV and AIDS towards populations affected by them.^[59] This section discusses specific constitutional human rights provisions that are relevant to issues of HIV and AIDS in Lesotho.

3.2 Analysis of the Constitution

The Constitution of any country is considered to be so important that it should be called the “mother of Law” in the land.^[60] The Lesotho Constitution provides that Lesotho shall be a sovereign democratic kingdom.^[61] It further provides that the Constitution is the supreme law of Lesotho and if any other law is inconsistent with the Constitution, that other law shall, to the extent of the inconsistency, be declared null and void.^[62] No other law, including laws relevant to HIV, people living with HIV and key populations, can afford to be in conflict with the Constitution.

Most of the civil, political, social and economic rights in international instruments have been provided for in the Lesotho Constitution. For example, civil and political rights are provided for in Chapter II, while social, economic and cultural rights are set forth in Chapter III. Chapter II provides for justiciable rights, thereby protectable in the judicial system, while the rights in Chapter III are not justiciable but are rather “Principles of State Policy.” Principles of State Policy place an obligation upon the government to take steps to realize them on a progressive basis, for example, through policy frameworks and law reforms. The effect is that socio-economic rights including rights such as the rights to livelihood, work, health and education, amongst others, while they cannot simply be claimed and enforced through the courts on the basis of the Constitution,^[63] should be reflected in a relevant statute or policy document. Since all rights are interlinked and the enjoyment of civil and political rights is premised on the realisation of socio-economic rights, it is critical that States give meaning to these socio-economic rights in law and policy.

Section 4 (1) of the Constitution provides that “every person is entitled to fundamental human rights and freedoms despite their race, colour, sex, language, religion, political or other

58 Likoti F.J., Obioha E.E., Matobo T.A., Tanga P.T., and Manyeli T.F., ‘Lesotho CGPU Evaluation Report,’ 2007.

59 Bureau of Democracy, Human Rights and Labour, ‘Lesotho Country Report on Human Rights Practices,’ 2006.

60 Kasozi, George W.K.L., *Introduction to Law of Lesotho*, 1999, p20.

61 Lesotho Constitution, Section 2, 1993.

62 Ibid.

63 Kathang Tema Baitsokele & Another v. Maseru City Council & Others Constitutional Case 1/2004(HC) (unreported); Baitsokele & Another v. Maseru City Council & Others C of A (Civ) No.4/05 (CA) (unreported).

opinion, national or social origin, property, birth or other status.”^[64] Notably, unlike the South African Constitution, the Constitution of Lesotho does not *specifically* include sexual orientation as a prohibited ground of discrimination.

Below we discuss some of the fundamental human rights that are guaranteed to every person under Chapter II of the Lesotho Constitution and their application in the context of HIV.

Some fundamental human rights guaranteed under Chapter II of the Lesotho Constitution:

- Right to equality and freedom from discrimination
- Right to a private life and the right to personal liberty
- Right to respect for private and family life
- Right to protection from inhumane treatment
- Right to health
- Right to education

◇ Right to equality and freedom from discrimination

Section 4 of the Lesotho Constitution protects the fundamental human rights and freedoms of all people and provides that “...every person in Lesotho is entitled, whatever his race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status to fundamental human rights and freedoms.”^[65]

This provision makes no specific mention of grounds that may affect vulnerable or key populations in the context of HIV, such as “HIV status” or “sexual orientation” – to date, the understanding of sex has tended to refer to the biological understanding of sex rather than issues such as sexual orientation.

Sections 18 and 19 provide for equality before the law, equal protection of the law and the enjoyment of the rights free from discrimination on any ground. Section 18 which deals with freedom from discrimination provides in subsections 1 and 2 that no law shall make any provision that is discriminatory either of itself or in its effect. It goes further to say that no person shall be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of any public office or authority. The wording of Section 18 does not specifically refer to categories of people, such as people living with HIV, but to people in general. However, it does provide for protection from discrimination on *any ground* and prohibits “affording different treatment to different persons attributable to ... birth or other status whereby persons of one such description are subjected to...restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description.”^[66] As a result, it can be argued that the non-discrimination clause covers grounds such as *HIV status* as well as other grounds such as *sexual*

64 Lesotho Constitution, Section 4, 1993.

65 Ibid.

66 Lesotho Constitution, Section 18 (3), 1993.

orientation. This would protect people living with and affected by HIV from being discriminated against on the basis of HIV status as well as protect key populations from discrimination on the basis of other grounds, such as sexual orientation.

However, section 18 (4) (c) condones discrimination on the basis of culture and customary law relating to Basotho^[67]; this means that where customary laws are discriminatory in nature (e.g. against women or against sexual minorities) they may arguably be justified on the basis of culture or tradition.

HIV and AIDS have not been specifically mentioned as grounds for non-discrimination under the global instruments, but the Committee on Economic, Social and Cultural Rights has specifically stated that the list of prohibited grounds of discrimination is not exhaustive. The Committee on Economic, Social and Cultural Rights urges States to ensure that a person's actual or perceived health status must not be a barrier to realising the rights which are protected under national laws such as the Lesotho Constitution. The UN Human Rights Treaty Bodies^[68] have from time to time issued General Comments that affirm the right to non-discrimination on the basis of HIV status.^[69]

Furthermore, in the African context, although HIV is not explicitly prohibited as a ground for non-discrimination by current regional human rights treaties, it is generally accepted that such discrimination is implicitly prohibited under international and regional human rights instruments through "reading" into the equality and non-discrimination clauses as has been done at an international level. The ACHPR Resolution and regional declarations by the African Union Commission may be seen as an indication of the seriousness with which HIV-related discrimination is viewed and is seen as implicit within the African Charter on Human and Peoples' Rights.

67 Basotho defines the South Sotho people, living mainly in the Kingdom of Lesotho; here it refers to all Lesotho Citizens

68 The UN Human Rights Treaty Bodies are committees of experts created to monitor governments' implementation of specific human rights conventions

69 Committee on Economic, Social and Cultural Rights, 'General Comment 14: The Rights to the Highest Attainable Standard of Health,' 2000, paragraphs 28-29; Committee on the Convention on the Rights of the Child, 'General Comment 3: HIV/AIDS and the Rights of the Child,' 2003, paragraphs 7-9; Committee on Economic, Social and Cultural Rights, 'General Comment 20: Non-Discrimination in Economic, Social and Cultural Rights,' E/C.12/GC/20 25, May 2009, especially paragraphs 15, 27 and 33.

Additionally, since the provisions in the “Bill of Rights” ought to be interpreted to promote rather than to restrict human rights, extending protection from discrimination to HIV is a constitutional imperative. In the South African case of *Hoffmann v South African Airways*,^[70] the court *read* HIV status into the constitutional protection of equality and non-discrimination. The Constitutional Court was asked to consider whether the refusal by South African Airways to employ Hoffmann as an airline flight attendant on the grounds of his HIV status constituted unfair discrimination contrary to section 9 (3) of the South African Constitution. Although HIV status was not listed as a specific ground for non-discrimination, the Court held that HIV was an analogous ground and that the conduct of the airline constituted unfair discrimination contrary to section 9 (3) of the Constitution. The Court followed a flexible and inclusive approach, noting that the grounds listed in section 9 (3) are inclusive rather than exhaustive.

Lesotho, like any other country, does not have static provisions of law. As a result, in interpreting and reforming its laws, it should be flexible and take into consideration the prevailing circumstances and consider other grounds such as HIV, which may, from time to time, call for interventions by all stakeholders.

◇ **Right to a private life and the right to personal liberty**

In Lesotho, the right to personal liberty is guaranteed under Section 6 of the Constitution.^[71] This section stipulates that “every person shall be entitled to personal liberty, that is to say, he shall not be arrested or detained save as may be authorised by law.” This right is not absolute because it can be derogated from, for example, in the execution of the sentence or order of a court or of a tribunal made to secure the fulfilment of any obligation imposed by law. The Lesotho Constitution also provides for the right to respect for a person’s private life. The other constitutional provision that offers protection in the context of HIV is the freedom of expression clause in section 14 (2) (b), which prohibits disclosure of information received in confidence.

The rights to privacy and personal liberty and security of the person are provided for under the International Covenant on Cultural and Political Rights (ICCPR). The ICCPR states as follows: “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.”^[72] It further provides that “no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home

70 *Hoffmann v South African Airways* 2001 (1) SA 1 (Constitutional Court of South Africa). For a similar approach outside of the countries that have been surveyed see also *Makuto v State* (2000) 5 LRC 183 (Court of Appeal of Botswana), where the equality and non-discrimination clause in Section 15 of the Constitution of Botswana was interpreted as implicitly including protection against discrimination on the grounds of HIV status. Section 15 prohibits discrimination on the basis of “race, tribe, place or origin, political opinions, colour or creed.” The Court said that the drafters of Section 15 did not envisage a closed category of protected grounds. The case concerned an applicant who had been convicted of rape and had been given a more severe sentence for the reason that an HIV test that was performed for the purpose of assessing his possible sentence had revealed that he was HIV positive. The applicant appealed against the sentence on the ground that it constituted unfair discrimination contrary to Section 15 of the Constitution. The Court said that Section 15 permits justifiable limits to non-discrimination and that if the applicant knew of his HIV status at the time of rape, the limitation and the heavier sentence would be justified. In this instance the Court held that the applicant did not know of his HIV status at the time of rape, and therefore, the limitation and the heavier sentence were not justified. The Court substituted a 10-year prison sentence for a 16-year sentence that had been passed by the trial court.

71 Lesotho Constitution, Section 6, 1993.

72 International Covenant on Civil and Political Rights, Article 9, 1976.

or correspondence, nor to unlawful attacks on his honour and reputation.^[73] Like the right to equality, the right to privacy also flows from the right to human dignity. Respecting an individual's privacy means respecting his inherent dignity as a person.

The rights to privacy and personal liberty and security of the person are important in the context of HIV and AIDS. The United Nations Joint Programme on HIV and AIDS (UNAIDS) *International Guidelines on HIV/AIDS and Human Rights* note that protection of the right to liberty and security of the person protects populations from coercive health responses to HIV, such as compulsory HIV testing, quarantine, isolation or detention—measures that are often used against 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 MSM).^[74] The Guidelines provide that compulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of a person; respect for the right to physical integrity requires that testing be voluntary and that no testing be carried out without informed consent. 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 human rights violations and are not justified by public health concerns.^[75] They 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 indicate that such exceptional cases should be handled under the ordinary provisions of public health, or criminal laws, with appropriate due process protection.^[76]

The right to privacy is understood to protect the right to confidentiality and to be tested only on the basis of voluntary and informed consent. Any invasions of the right to privacy should be justified. The UNAIDS *International Guidelines* provide 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.^[77] Where HIV testing is conducted, it must be conducted with the informed consent of the individual concerned and must include safeguards to ensure that the information is used for the purpose for which it was obtained and not for unfair discrimination or other illegitimate purposes. Any derogation from the protection of privacy and confidential information should be lawful and justifiable.

In addition, at an international level the Human Rights Committee has also found that the right to privacy is violated by laws that criminalise private homosexual acts between consenting adults. It notes that “the criminalisation of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV and AIDS [...]” as such criminalization not only interferes with the right to privacy but it also

73 International Covenant on Civil and Political Rights, Article 17, 1976.

74 'Report of the Special Rapporteur on Health: Informed Consent,' 2009, paragraph 135.

75 Ibid. paragraph 133.

76 Ibid. paragraph 134.

77 UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights,' 2006.

impedes HIV and AIDS education and prevention work.^[78]

In summation, the rights to privacy and personal liberty place an obligation upon Lesotho to promote voluntary, non-coercive approaches to addressing HIV and AIDS which include voluntary HIV testing with informed consent, protection of the right to confidentiality as well as rejection of the criminalisation of private and consensual same-sex sexual relationships.

Lesotho has an obligation to ensure that adequate safeguards are put in place to guarantee the right to privacy during HIV testing and counselling, promote confidentiality and protect the sexual and reproductive health and rights of all persons.

◇ **Right to respect for private and family life**

Section 11 (1) of the Constitution of Lesotho provides that every person is “entitled to respect for his private and family life and his home.”^[79] This implies that Lesotho recognises that the family is the natural and fundamental element of society; recognises the right of everyone to form a family and undertakes to promote the legal, economic and social protection of the family.

Article 56 of the UDHR similarly provides for 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 protection by society and the State of the family as “the natural and fundamental group unit of society.”^[80]

The right to form a family extends to all people, including people living with and affected by HIV. Acts that may violate the right of a person living with HIV to found a family may include pre-marital HIV testing that denies those testing positive the right to marry, as well as acts that coerce or force people living with HIV not to have children, to terminate a pregnancy or to get sterilized.^[81]

◇ **Right to protection from inhumane treatment**

The ICCPR prohibits the use of torture, cruel, inhumane or degrading treatment or punishment under Article 7.^[82] The Human Rights Committee has interpreted this to mean the right to “protect both the dignity and the physical and mental integrity of the individual” from not only acts that cause physical pain but also acts that cause mental suffering.^[83] While the right to freedom from cruel, inhumane 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 the emphasis is on upholding human rights or dignity. The *Guidelines* provide that the duty of care owed to prisoners includes the duty to protect the rights to

78 Human Rights Committee, Communication No 488/1991, *Nicholas Toonen v Australisa* (views adopted on 31 March 1994, fiftieth session). *Official Records of the General Assembly, Forty-ninth Session, Supplement No. 40 (a/49/40)*, vol. II, annex IX EE, para 8.5

79 Lesotho Constitution, Section 11 (1), 1993.

80 Universal Declaration of Human Rights (UDHR), Article 16, 1948.

81 ‘Report of the Seychelles Legal Environment Assessment of HIV and AIDS,’ 2013.

82 International Covenant on Civil and Political Rights, Article 7, 1976.

83 Human Rights Committee, ‘General Comment No. 20,’ 1992, paragraph 2.

life and to health of all persons in custody. In the context of HIV, they note that denying prisoners access to HIV-related information, education and means of prevention (e.g., bleach, condoms, and clean injection equipment), voluntary testing and counselling, confidentiality, HIV-related health care and access to and voluntary participation in treatment trials, could constitute cruel, inhumane or degrading treatment or punishment.^[84] The *Guidelines* furthermore provide that:

- The duty of care towards prisoners also comprise a duty to address prison rape and other forms of sexual victimization that may result, *inter alia*, in HIV transmission.
- There should be 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.^[85]

◆ Right to health

Section 27 of the Lesotho Constitution provides for protection of health as a Principle of State Policy. While Principles of State Policy are not enforceable by a court of law, they oblige the authorities and agencies of Lesotho and other public authorities in the performance of their functions with a view to achieving progressively, by legislation or otherwise, the full realisation of these principles.^[86] Section 27 states that Lesotho shall adopt policies aimed at ensuring the highest attainable standard of physical and mental health for its citizens, including policies designed to:

- a. Provide for the reduction of stillbirth rate and of infant mortality and for the healthy development of the child
- b. Improve environmental and industrial hygiene
- c. Provide for the prevention, treatment and control of epidemic, endemic, occupational and other diseases
- d. Create conditions which would assure medical services and medical attention to all in the event of sickness
- e. Improve public health^[87]

In terms of international commitments to the right to health, Member States are obliged to provide a range of available, accessible, acceptable and quality health care information and prevention and treatment services in recognising health rights. According to the UDHR, “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.”^[88] 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 services and medical

84 UNAIDS, ‘International Guidelines on HIV/AIDS and Human Rights.’ 2006.

85 Ibid.

86 Lesotho Constitution, Section 25, 1993.

87 Lesotho Constitution, Section 27, 1993.

88 Universal Declaration of Human Rights, Article 25, 1948.

attention in the event of sickness.”^[89]

General Comment 12 of the Covenant on Economic, Social and Cultural Rights^[90] and General Recommendation 24 of the Committee on the Women’s Convention^[91] have contributed immensely to the elucidation of accessibility as a necessary element of the right to health. Accessibility requires health services to be non-discriminatory and attuned to the needs of a class that has been historically disadvantaged. It means services that are available and accessible physically, economically and in terms of being known by social groups and persons who need them. Equally, accessibility means services that are rendered using methods and practices that are safe and ethically acceptable.

At a regional level, Article 16 of the African Charter guarantees the right to the “best attainable state of physical and mental health.”^[92] The African Children’s Charter furthermore guarantees the right to health to children along substantively similar terms as the African Charter, albeit with some of the State obligations spelt out more elaborately, including the need to develop and implement primary health care services that are accessible to all children.^[93] Though as yet no cases that directly impact on access to health services related to sex and sexuality have emanated from the treaty bodies of the African Charter, it is important to note that in two communications the African Commission has embraced an expansive approach to the right to health akin to the approach that has been adopted by the Committee on Economic, Social and Cultural Rights.

In *Purohit and Another v The Gambia*,^[94] the Commission said: “Enjoyment of the human right to health as it is widely known is vital to all aspects of a person’s life and well-being, and is crucial to the realisation of all other fundamental human rights and freedoms. The right includes the right to health facilities, access to goods and services to be guaranteed without discrimination of any kind. In language reminiscent of that employed by the Committee on Economic, Social and Cultural Rights when interpreting the right to health, the African Commission said that regardless of domestic economic constraints, it would ‘read into article 16 the obligation on [the] part of states party to the African Charter to take concrete and targeted steps, while taking full advantage of available resources, to ensure that the right to health is fully realised in all aspects without discrimination of any kind.’”^[95]

Whilst the right to health care may not be immediately realisable in Lesotho on account of constraints in available resources, it is accepted under global jurisprudence that, as part of progressive realisation, fulfilling a right means, at a minimum, taking concrete and targeted steps towards the realisation of the right, including expending resources as well as prioritising

89 International Covenant on Economic, Social and Cultural Rights, Article 12, 1976, 12.

90 Committee on Economic, Social and Cultural Rights, General Comment 14 ‘The Rights to the Highest Attainable Standard of Health,’ E/C.12.2000/4, 2000.

91 Committee on the Women’s Convention, General Recommendation 24, ‘Women and Health,’ UN GAOR Doc. No. A.54/38/Rev.1.

92 African Charter on Human and People’s Rights, Article 16, 1986.

93 African Charter on the Rights and Welfare of the Child, 1999

94 *Purohit and Another v The Gambia*, 2003, paragraph 80.

95 African Charter on Human and People’s Rights, Article 16, 1986.

vulnerable populations.

The UNAIDS *International Guidelines* recommend that States should ensure the provision of a range of services without discrimination and with a particular prioritisation of vulnerable populations, including, *inter alia*, HIV-related information, education and support, including access to services for sexually transmitted diseases, means of HIV prevention and voluntary and confidential HIV testing with pre-and post-test counselling, as well as access to treatment, care and support for those affected by HIV.^[96]

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 UNAIDS *International Guidelines* recognise that this requires reviewing bilateral, regional and international agreements and national laws to promote access to affordable medicines.

With respect to marginalized populations, the Guidelines emphasise that States 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 HIV status.^[97]

There is limited litigation in Africa relating to access to health services. In South Africa, the landmark case of *Minister of Health and Others v Treatment Action Campaign and Others*^[98] challenged the government's failure to provide access to antiretroviral treatment to prevent mother-to-child transmission of HIV beyond 18 pilot sites in the country. It was argued that this constituted a breach of section 27 of the Constitution,^[99] which provides that "[everyone has the right to have access to (a) health care services, including reproductive health care and that the state must take reasonable and other measures, within its available resources, to achieve a progressive realisation of each of these rights and finally that no one may be refused emergency medical treatment."^[100] In this case the court held that the government's nevirapine programme fell short of a reasonable measure to realize the right of access to health care under section 27. An order was granted requiring the State to make nevirapine universally available in the public sector. The court also ordered the State to plan and implement forthwith a comprehensive national program to prevent mother-to-child transmission of HIV.

96 UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights,' 2006.

97 South Africa Constitution, Section 24, 1996

98 *Minister of Health and Others v Treatment Campaign and Others* 2002 (10) BCLR 1033 (Constitutional Court of South Africa).

99 The other provisions of the Lesotho Constitution that were allegedly contravened were: 7 (2), which enjoins the State to respect, protect, promote and fulfil the rights in the Bill of Rights; Section 10, which guarantees everyone a right to human dignity; Section 12 (2) (a), which guarantees everyone a right to bodily and psychological integrity, including the right to make decisions about reproduction; section 27, which guarantees everyone a right to access to health services, including reproductive health care; section 28 (1) (c), which, *inter alia*, guarantees a child a right to basic health care; section 195, which, *inter alia*, requires that public administration must be governed by democratic values enshrined in the Constitution and that a high standard of professional ethics must be promoted and maintained; and section 237, which provides that all constitutional obligations must be performed diligently and without delay.

100 *Ibid.*

In Kenya, the Anti-Counterfeit Act of 2008 was declared unconstitutional by the High Court since its provisions may result in restrictions on access to cheaper generic medicines.^[101] In promoting the right of access to medicines, Justice Mumbi Ngugi ruled that “...the right to health, life and human dignity are inextricably bound. There can be no argument that without health, the right to life is in jeopardy, and where one has an illness that is as debilitating as HIV/AIDS is now generally recognised as being, one’s inherent dignity as a human being with the sense of self-worth and ability to take care of oneself is compromised.”^[102]

In Lesotho, while access to health services is not included in the Bill of Rights but rather under Principles of State Policy, it places an obligation upon the State to respond. It is also an important variable in the realization of other rights, such as the right to life. Non-enforceability of the right to health should not undermine national responses to health and HIV by the Government of Lesotho.^[103] A decline in external resources, coupled with shifting donor priorities, threatens the gains achieved over the past decades and therefore increases the risk of service delivery gaps and intensifies the competition for funding among various public health priorities.^[104] This is also likely to have profound implications for HIV programmes in Lesotho. Interpretation of the State’s inability to put adequate health responses in place due to conditions such as socio-economic factors (including access to and availability of resources), is tantamount or likely to violate the right to health of its citizens. It is therefore critical to ensure that current health policies and programmes at the very least reflect adequate steps to “progressively realise” State obligations towards the right to health particularly in the context of HIV, which affects vulnerable populations most severely.

◆ **Right to education**

Article 26 of the UDHR provides that “[e]veryone has the right to education. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship [...]”^[105]

Section 28 of the Constitution provides for education for all and includes the adoption of policies that:

- Ensure that education contributes to the complete development of the human personality and to a sense of dignity
- Strengthen respect for human rights and fundamental freedoms^[106]
- Ensure that primary education is compulsory and available to all^[107]

This universal right to education precludes exclusion and discrimination based on a learner’s HIV status. It also encompasses ensuring that learners living with HIV are supported to

101 Petition No. 409 of 2009, High Court of Kenya at Nairobi

102 Ibid.

103 Key informant interview from the Ministry of Health.

104 UNAIDS, ‘Getting to Zero HIV in Eastern and Southern Africa’, 2013.

105 Universal Declaration of Human Rights, Article 26, 1948.

106 Lesotho Constitution, Section 28, 1993.

107 Education Act, 2010.

continue their education when possible. The same holds true for learners affected by HIV who are unable to attend school—such as when children leave school to take care of ailing parents or when in the case of deceased parents they become the head of household and must take care of the family.^[108]

◇ **Right to work**

The UDHR states that “[e]veryone has the right to work [...] [and] to just and favourable conditions of work.”^[109] Additionally, article 6 of the International Covenant on Economic, Social and Cultural Rights 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.”^[110]

Section 29 of the Constitution of Lesotho provides for the opportunity to work. It states that Lesotho shall endeavour to ensure that every person has the opportunity to gain a living by work that is freely chosen or accepted and that there shall be policies aimed at achieving and maintaining as high and stable a level of employment as possible; providing technical and vocational guidance and training programmes; and achieving steady economic, social and cultural development and full and productive employment under conditions safeguarding fundamental political and economic freedoms to the individual.^[111] It is therefore argued that people who are HIV positive should not be denied the opportunity to work on the basis of their status.

Furthermore, the UNAIDS *International Guidelines on HIV/AIDS and Human Rights* recognize that the right to work entails the right of every person to have access to employment without any precondition. Hence, it can be argued that any applicant or employee who is forced to test for HIV and is refused employment, dismissed or refused access to employee benefits on the basis of being HIV positive must claim violation of his or her rights on that basis.^[112]

The International Labour Organisation (ILO) *Recommendation concerning HIV & AIDS and the World of Work* 200 of 2010 sets out detailed recommendations for managing HIV in the workplace and call 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,

108 Ibid.

109 Universal Declaration of Human Rights, Article 23, 1948.

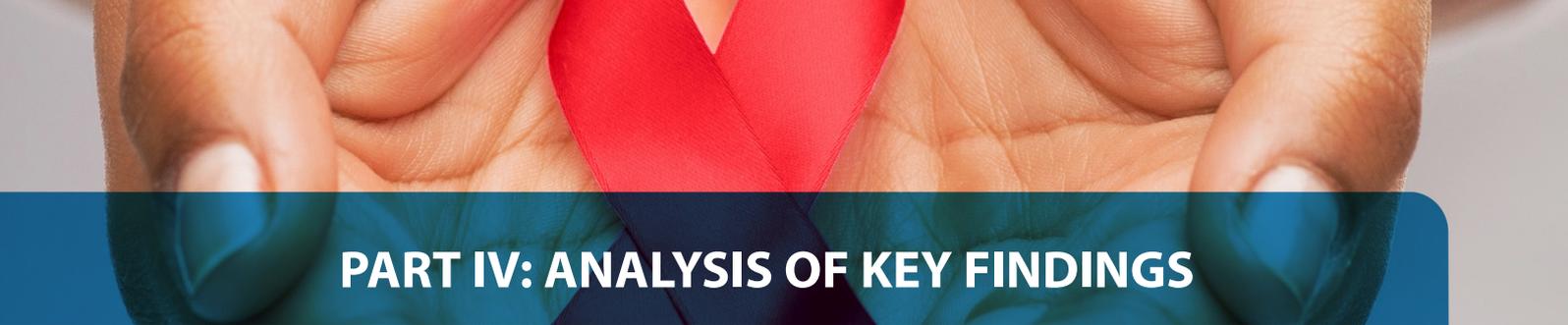
110 International Covenant on Economic, Social and Cultural Rights, Article 6(1), 1976.

111 Lesotho Constitution, Section 29, 1993.

112 'Report of the Seychelles Legal Environment Assessment of HIV and AIDS', 2013.

including migrant workers, job seekers and job applicants, while encouraging voluntary and confidential HIV testing

At a regional level, the SADC PF *Model Law on HIV & AIDS in Southern Africa, 2008* provides that “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” and includes various protections for employees, including the protection of confidentiality, the prohibition of HIV testing of a job seeker or an employee for the purpose of recruitment, promotion or any other reason and the prohibition of unfair dismissals simply on the basis of a person’s HIV status.



PART IV: ANALYSIS OF KEY FINDINGS

This section examines the national laws, policies and practices in relation to HIV and AIDS. It identifies some of the key issues and looks at the extent to which Lesotho's national laws and policies has domesticated and used the international and regional instruments for rights-based responses to HIV, especially in the context of people living with HIV and vulnerable and key populations.

4.1 HIV-related stigma, discrimination and human rights violations

The year 2014 marked the twenty-eighth year since the first case of AIDS was reported in Lesotho in 1986, and Lesotho continues to deal with the effects of the HIV epidemic, which are being felt by all sectors of the population. HIV has spread rapidly throughout the country, transcending the urban-rural, highland-lowland divide, rich and poor, skilled and unskilled.

4.1.1 Position in Lesotho

Lesotho's geographical position of being landlocked and situated within the Republic of South Africa has added to its economic vulnerability and the spill over effects of HIV and other opportunistic infections, especially tuberculosis (TB). The country's peculiar geographic position ensures constant mobility between Lesotho and South Africa. External and internal labour migration is commonplace and contributes to the spread of HIV. Because of its small population (1.8 million), Lesotho is particularly vulnerable to the effects of HIV and AIDS.^[113] Furthermore, HIV and AIDS have also been found to present a real and surmountable challenge for Lesotho because of limited resources and high-risk sexual behaviours, especially among young people.

The continued existence of stigma and discrimination hampers efforts to respond to HIV and AIDS. The findings of the Global Commission on HIV and the Law,^[114] as well as the findings of the People Living with HIV Stigma Index Studies^[115] conducted in several countries across Africa show that people living with HIV and key populations continue to feel the impact of stigma, discrimination, marginalization and both verbal and physical abuse in their homes, families and communities, as well as in public institutions.

The Lesotho National Commitments and Policies Instrument (NCPI) Report has also shown that discrimination and stigma against MSM and transgender people remain a critical challenge due to laws criminalising same sex sexual relationships and ambiguity in the legal status of these populations.^[116] Similarly, the NCPI Report indicates that sex workers continuously experience physical and sexual abuse by police and are often subjected to discrimination in the provision

113 'Lesotho Census Report,' 2006.

114 Global Commission on HIV and the Law, 'Report of the Africa Regional Dialogue of the Global Commission on HIV and the Law,' 2011.

115 See www.stigmaindex.org

116 'National Commitments and Policies Instrument Report,' 2012.

of health services and in the courts.^[117] Findings from the FGDs conducted for this assessment highlight that HIV-related stigma and discrimination, especially that directed at key populations, is escalating.^[118] Stigma and discrimination against key populations is discussed in more detail in section 4.6, below.

The Lesotho Demographic and Health Survey found that HIV-related stigma and discrimination may be less overt and open; however communities still hold discriminatory attitudes towards people living with HIV, and discrimination is more “indirect.”^[119] Also, the People Living with HIV Stigma Index (SI) Study^[120] showed that people living with HIV are still experiencing stigma and discrimination. There remain major barriers to their ability to access HIV-related health care services due to fear of discrimination and stigma.^[121] The SI report also described experiences of stigma and discrimination related to HIV ranging from household to either religious or social communities,^[122] further noting that these experiences are either verbal or psychological, and even physical in some instances.^[123] Women living with HIV reported violations of their human rights when seeking services in their own homes, schools, hospitals and workplaces.

As has been discussed above, the Constitution protects all people’s rights to equality and freedom from discrimination; however it does not contain specific protection from discrimination for people living with HIV. Also, there is no HIV-specific law in Lesotho dealing with the rights of people living with HIV, nor is there a broad anti-discrimination law. Health policies do recognise human rights in the context of HIV and AIDS. The revised National Strategic Plan (NSP) and the Lesotho National HIV and AIDS Policy both aim to promote and protect human rights and ensure non-discrimination for people living with HIV, women and girls, orphaned and vulnerable children, prisoners, and on grounds such as sexual orientation and disability. The National HIV Policy reiterates, in various sections, the importance of promoting the sexual and reproductive health rights of all persons, including those with HIV.^[124] Yet this protection in policy is perhaps inadequate, given the ongoing reports of stigma and discrimination.

The impact of stigma and discrimination and the lack of a sufficiently protective legal framework are felt in various ways. For instance, they may impact on a person’s willingness to test for HIV, as well as to disclose his or her HIV status.^[125]

117 Almost all key informants interviewed during this study were of the opinion that sex workers experience both physical and sexual abuse from the police. In addition, sex workers interviewed in the study informed the researchers that they were afraid to access health services or even lay charges against the police who harass them for fear of double victimisation due to an absence of laws that protect them.

118 This was revealed during focus group discussions with LGBTI in Maseru and sex workers in Maputsoe.

119 Ministry of Health and Social Welfare, ‘Lesotho Demographic and Health Survey,’ 2009.

120 HIV Stigma Index Study (validated March 2014).

121 United Nations, ‘Compilation of UN info for the second cycle of the Universal Periodic Review (UPR) mechanism: Lesotho,’ 2013.

122 ‘Stigma Index Report,’ 2014.

123 Ibid.

124 National HIV and AIDS Policy 2006 and Revised National Strategic Plan on HIV and AIDS 2012/13–2015/16.

125 Focus group discussions with women living with HIV.

Perspectives on the complexities of disclosing HIV status:

The focus group discussion (FGD) and key informant interview (KII) data from our qualitative assessment illustrate the complexity of disclosing HIV status in the face of the potential for stigma and discrimination.

For example, many FGD respondents indicated that many people do not want to test or disclose their HIV-positive status, pointing out that “it is better to lie about one’s sickness rather than expose oneself to ridicule.”^[126] Respondents felt that disclosure is a complex issue and is dependent on several issues including personal relations, compassion, fear of eviction and confidence that one’s relationship will stay the same irrespective of a person’s HIV status. Some respondents opted to keep their HIV status a secret from their spouses, while others were assisted by non-health practitioners (HIV counsellors) to disclose. Traditional leaders noted that communities hide sick family members with HIV-related illness and are reluctant to allow other villagers to check on them. FGDs revealed a range of experiences of families and caregivers protecting members from disclosures of their HIV status during and even after illness and death in order to protect themselves from discrimination, providing important evidence of the level of the fear of discrimination.^[127]

A magistrate interviewed as a key informant in the assessment pointed out that when the person convicted of a sexual offence is HIV positive, it is difficult to determine his intention at the time of committing the crime, as many people are afraid to know their status, and even those who know do not disclose their HIV status.^[128]

Other negative impacts cited in KIIs and FGDs include poor access to treatment, non-adherence to medication, death, a high rate of new HIV infections (high incidence), substance abuse, isolation, abandonment, psychological trauma and susceptibility to suicide.

It appears from our data that the constitutional protection against non-discrimination is unable to sufficiently protect people living with and affected by HIV from discrimination. A key informant working in the legal field felt that there was a need for specific protection on the grounds of HIV status in order to encourage people who have been victimised to freely institute their cases in courts of law.^[129] Where stigma and discrimination persist, even in contexts where there is broad constitutional protection from discrimination, such as in Lesotho, it is important to consider how to strengthen protection from discrimination in law as well as to ensure the implementation and enforcement of equality and non-discrimination.

4.1.2 Challenges

- Persistence country-wide of high levels of stigma and discrimination against people affected by HIV, including at the community level, despite broad protection against discrimination in the Constitution

126 Focus group discussions in Thaba-Tseka.

127 One female focus group respondent in the district of Molepolole told researchers that she had not disclosed to the villagers that she had a sick person (her husband) in the house, as she felt they would pry, laugh about it and gossip.

128 Sexual Offences Act, Section 32(vii), 2003.

129 Key informant interview from Women and Law in Southern Africa Research and Education Trust.

- Weak specific protection in law against discrimination on the basis of HIV status

4.1.3 Recommendations for addressing HIV-related stigma, discrimination and human rights

- Strengthen protection in law against discrimination and stigmatisation on the basis of HIV status.
- Conduct stigma and discrimination reduction campaigns country-wide, including at the community level.

4.2 Criminalization of HIV transmission

The domestic principles of criminal law in Lesotho and other African countries can be applied to cases of deliberate transmission of HIV by one person to another either through the interpretation and application of common law crimes or through the penal codes.

Notwithstanding this, a number of countries have enacted specific criminal law offences for the intentional and even the negligent transmission of, or exposure of another to, HIV; this is referred to as the criminalization of HIV transmission.

There have been various arguments raised both in favour of and against criminalisation of HIV transmission, exposure or non-disclosure. Those arguing in favour of criminalisation argue that principles of deterrence, retribution, prevention and rehabilitation are the penological justifications.^[130] The underlying deterrent rationale is that creating a specific offence would serve to protect health and life by impressing upon potential perpetrators the importance of avoiding conduct that injures others, for fear of punishment by the State. In terms of the punishment rationale, it is argued that by punishing the offender, criminal law expresses societies' stance regarding those that knowingly or recklessly expose others to HIV infection, sending a message that such conduct cannot be indulged in with impunity. It allows the victim and society to feel that justice has been done and that the State is discharging its duty to protect its citizens from harmful conduct and to respect, protect and fulfil the realisation of human rights, including the rights to health and life. Proponents argue that the duty of the State to protect human rights justifies efforts to deter, punish and rehabilitate perpetrators of deliberate or negligent transmission of HIV.^[131]

However, international guidance on public health, HIV and human rights cautions that creating specific laws for the criminalization of HIV as a routine response to HIV is counter-productive.^[132] Criminalization has not proven effective in reducing the spread of HIV and in fact has a tendency to undermine public health. It creates an environment that promotes further stigmatization of HIV and AIDS, discourages voluntary HIV testing and counselling, creates barriers to access to health care services, undermines prevention messages that promote the responsibilities of all, creates a false sense of security^[133] and leads to violations of human rights

130 Ngwenya, C., 'Criminalisation of HIV in Africa,' 2011.

131 Ibid.

132 Global Commission on HIV and the Law, 'Risks, Rights and Health,' 2012.

133 Burris, S., and Cameron, E., 'The Case against Criminalization of HIV Transmission.' *JAMA*, 300 (5), 2008, pp578-81.

of people living with and affected by HIV and key populations.^[134] Consequently, it is postulated that criminalization is unlikely to prevent new infections or reduce vulnerability to HIV.^[135] Further, laws that criminalise HIV exposure and transmission can also be used to prosecute women who transmit HIV to a child during pregnancy or breast feeding. This means that millions of women who are living with HIV but are often unable to access family planning, reproductive health services or medicines that prevent mother-to-child transmission of HIV may face criminal liability. Notable, the SADC PF Model Law on HIV & AIDS in Southern Africa 2008 does not include provision for criminalisation of HIV transmission.

Finally, scholars and international guidance also note the difficulties in prosecuting cases of transmission, exposure or non-disclosure to HIV and the various challenges in identifying which acts should be unlawful, proving fault, causation and protecting privacy. Prosecuting, at a large scale, 'bedroom' offences where violence was not used is notoriously difficult and is unlikely to be a good investment for public resources that could otherwise be used for preventive strategies.^[136]

Recent international guidance from both the Global Commission on HIV and the Law^[137] and UNAIDS^[138] recognises that, in exceptional cases of intentional and actual transmission of HIV, countries may wish to legitimately prosecute HIV transmission in the interests of retribution or justice. However, they argue that these prosecutions should take place through the application of general criminal law provisions, rather than by means of laws that explicitly criminalise HIV non-disclosure, exposure or transmission. Additionally, they should be:

- i) Guided by the best available scientific and medical evidence relating to HIV,
- ii) Uphold the principles of legal and judicial fairness (including key criminal law principles of legality, foreseeability, intent, causality, proportionality and proof) and
- iii) Protect the human rights of those involved.^[139]

4.2.1 Position in Lesotho

There are currently no laws in Lesotho that specifically criminalise HIV transmission or exposure. However, section 52 of the Penal Code criminalises the non-disclosure of person's HIV status. It provides that the failure to disclose HIV status prior to a sex amounts to an unlawful sexual act. Criminalising non-disclosure of HIV status is contrary to international, as well as regional guidance on legal responses to HIV, as has been set out above. Women living with HIV face high levels of discrimination and even violence, often on disclosure of their HIV status and this provision may impact disproportionately upon women.^[140]

134 Weait, M. 'The Criminalisation of HIV Exposure and Transmission: A Global Review.' Working Paper prepared for the Third Meeting of the Technical Advisory Group, Global Commission on HIV and the Law, 7-9 July, 2011.

135 Ibid.

136 Ibid.

137 Global Commission on HIV and the Law, 'Risks, Rights and Health,' 2012.

138 UNAIDS, 'Ending Overly Broad Criminalisation of HIV non-disclosure, exposure and transmission,' 2013.

139 Ibid. See also UNAIDS and UNDP, 'Policy Brief: Criminalization and HIV transmission,' 2013, and UNAIDS, 'Ending Overly Broad Criminalisation of HIV Non-disclosure, Exposure and Transmission: Critical Scientific, Medical and Legal Considerations,' 2013.

140 GCHL, 'Risks, Rights & Health,' 2012

Furthermore, The Sexual Offences Act (SOA) provides for compulsory HIV testing for purposes of sentencing of a person charged with a sexual offence, and aggravated sentencing for offenders who are HIV positive, both knowingly or unknowingly, at the time of committing a sexual offence.

Section 30 of the SOA provides that:

- 1) A person charged with a sexual act involving the insertion of a sexual organ into another person's sexual organ or anus shall have his blood substance taken by a medical practitioner within a week of the preferment of the charge
- 2) The blood substance referred to in subsection (1) shall be tested for Human Immunodeficiency Virus Infection and the results shall be disclosed by the medical practitioner to the accused and the complainant only.

Section 32 deals with penalties and provides for imprisonment of 10 years for a person convicted of a sexual offence who at the time of committing the offence had no knowledge or reasonable suspicion of such,^[141] and for the death penalty in the case of a person who knew or had reasonable suspicion of being HIV positive at the time of committing the offence.^[142]

There are various challenges with these provisions in Sections 30 and 32. Compulsory HIV testing of a person charged with a sexual offence can only provide evidence of a person's HIV status at that time; it cannot provide evidence of HIV status at the time of the offence or of a person's knowledge of his or her HIV status. The aggravated penalty is also applied on the basis of exposure (that is, on the basis of having penetrative sex), not on the basis of transmission of HIV. This means it may be applied even where there may be a low risk of transmission and where transmission does not in fact take place. The law actually punishes a person convicted of a sexual offence simply for being HIV-positive during the commission of a sexual offence. Some judicial officers and public prosecutors have noted the difficulties in proving knowledge on the part of the perpetrator during commission of the criminal act, hence, making it difficult to apply provisions of Section 32 (a) (vii) of the SOA.

Additionally, the provision appears to have created some uncertainty regarding its scope and application given that courts have made reference to the intention of the accused at the time of the offence. In the recent case of *Rex Vs Tšotleho Thulo*,^[143] Thulo was convicted of a sexual offence. Evidence of medical records was tendered during proceedings at the Trial Court showing that Thulo was on ART at the time. During sentencing, the Defence Counsel had argued that the accused was subjected to some compulsory testing upon arrest, and the Crown Counsel advised the High Court that "the record [from the Magistrate's Court] show[s] the handing in of an envelope with a report from the doctor about accused HIV status from 2008 to date of the hearing of the matter."^[144] The Court ruled that knowledge of one's HIV status at the time of committing the sexual offence would have warranted the punishment of death, and the intention of the accused to commit the sexual offence was not negated by the fact that he was drunk. Rather, drunkenness "...only worked for him [the accused] to escape the rope as an extenuating

141 Sexual Offences Act, Section 32 (iv), 2003.

142 Sexual Offences Act, Section 32 (vii), 2003.

143 Rex vs Tšotleho Thulo CRI/S/04/2013.

144 Rex vs Tšotleho Thulo CRI/S/04/2013, Paragraph 10.

circumstance.”^[145] It is important to note, however, that the SOA is a sentencing provision – it makes no provision for an intentional transmission offence and simply relates to whether or not the accused was HIV-positive at the time and whether the accused was knowingly HIV-positive at the time. Knowledge of HIV status cannot be equated with intention to transmit HIV.

Other case law shows that while almost all suspects of penetrative sexual offences have been subjected to mandatory HIV testing, there seems to be little reference made to their HIV status during sentencing. An exception is found in the case of *R vs Mohale*,^[146] where in sentencing, the judge also considered the fact that the accused had tested HIV negative. To date, no person has been sentenced to death as a result of invoking the provisions of the SOA.

4.2.2 Challenges

- Non-disclosure of HIV status is a criminal offence, contrary to regional and international guidance on criminalisation HIV transmission, exposure or non-disclosure.
- There is a lack of clarity on the interpretation of the sentencing provision under Section 32 of the SOA and there are no prosecutorial guidelines to guide prosecutors and the judiciary on the application of the HIV testing and sentencing provision within the SOA; this has led to some uncertainty regarding the application and usefulness of the testing and sentencing provisions. Section 32 of the SOA should not be conflated with punishing the intentional transmission of HIV when a perpetrator is found to be HIV-positive at the time of committing the offence.
- There are inadequate training and capacity-building programmes for the judiciary and prosecutors on HIV and human rights issues that would serve to strengthen judicial responses to HIV-related complaints brought before them.

4.2.3 Recommendations for addressing the criminalization of HIV transmission

- Review the Penal Code provision for the creation of an offence for non-disclosure of HIV status
- Develop prosecutorial guidelines to guide prosecutors and the judiciary on the application of the Penal Code and the HIV testing and sentencing provision of the SOA so that they are clear on issues that may impact on its application in different circumstances. Guidance may include discussion of the ambit of the provision (i.e. aggravated sentencing for an HIV-positive sexual offender as opposed to criminalising HIV transmission), the evidence provided by the results of an HIV test, the limits to the court’s ability to determine HIV status or knowledge of status at the time of the offence, the risks of HIV transmission and the ways in which such risks may be reduced and the impact this may have, if any, on sentencing. This would ensure that prosecutors and the judiciary know how to apply the provision and

145 Ibid.

146 *R vs Mohale* CRI/S/4/2005 (unreported). The accused was committed to High Court under section 31 of Sexual Offences Act for sentencing as the magistrate who tried this case did not have appropriate jurisdiction. The High Court Judge in this matter exercised his discretion under Section 33 thereof, which allowed him to pass an appropriate sentence if the accused was under 18 years of age when he committed the offence, thus disregarding the minimum sentences prescribed under section 32.

that judgements are standardised.

- The judiciary, prosecutors and legal practitioners should receive sensitisation training on issues concerning HIV and human rights to strengthen judicial responses to HIV-related complaints brought before them.

4.3 Women, girls and gender equality

Women continue to be disproportionately infected and affected in sub-Saharan Africa, where they still account for approximately 57 per cent of all people living with HIV, according to UNAIDS.^[147] HIV prevalence in Lesotho is estimated at over 23 per cent in adults aged 15-49, making it one of the highest in the world. Available evidence indicates that women bear the burden of HIV and AIDS in Lesotho; more than 27 per cent of women 15-49 and 18 per cent of men are estimated to be living with HIV. This reflects a trend that has not changed much since 2004.^[148] The prevalence peaks at age 35-39 years for women; then declines with increasing age at 40-49 years. In addition, young women between the ages of 15 and 29 have been found to be one of the most vulnerable populations in Lesotho,^[149] given that they often have sexual relationships with older men. (Among this group HIV prevalence rises rapidly, from 3 per cent between 15 and 17 years of age, to 20 per cent between the ages of 20 and 22, to 32 per cent between the ages of 23 and 24.)^[150]

Various factors are associated with high HIV prevalence amongst women in Lesotho, including biological factors that place women at higher risk of HIV infection in general; social and economic factors contributing to gender inequality; cultural factors that limit a women's autonomy over her own body and her ability to control her sexual and reproductive life; and early marriages permitted under customary law as well as practices that fail to prescribe the minimum age of marriage.^{[151] [152]} Food insecurity and poverty have also increasingly worsened, becoming notable drivers of the epidemic and impacting significantly on women.^[153]

The mid-term review of the National Strategic Plan (NSP) carried out in 2013 has shown that current drivers and other factors that fuel the spread of HIV have not changed. These behavioural, social and structural drivers are shown in Table 3.^[154]

147 UNAIDS, 'Global Report: UNAIDS report on the global AIDS epidemic,' 2013.

148 National Action Plan on Women, Girls and HIV/AIDS, 2012-2017.

149 Out of 24 key informants interviewed, 12 alluded to the fact that women and girls are the groups most vulnerable to HIV infection.

150 'Lesotho Modes of Transmission Report,' 2009.

151 **Letuka, P., et al.,** *Gender, HIV and the Law in Lesotho: Embracing Rights-Based Approach to Realise Sexual and Reproductive Health in Lesotho*, **WLSA Publication, Morija, 2008.**

152 Women and Law in Southern Africa Research and Education Trust, LSA, 'Sexual Violence of Women in Lesotho,' 2012.

153 Ibid.

154 Revised National Strategic Plan on HIV and AIDS 2012/13- 2015/16.

Bio-Medical	Behavioural	Social	Structural
Low levels of safe MMC Presence of STIs Early age of sexual debut among young females. High viral load levels	Low and inconsistent condom use. Multiple and concurrent partnerships Alcohol and drug abuse. Low perception of personal risks to HIV infection	Peer pressure. Inter-generational sex. Transactional sex. Male dominated gender norms. Sexual and gender based violence. Erosion of traditional values	Gender inequality Poverty / Income disparities. Mobility and migration Food insecurity

Table 3. Key drivers of the HIV epidemic in Lesotho

Source: MOH Workshop for Parliamentary Committees on HIV and AIDS & MDGs Presentation, May 2014

Heterosexual sex is the main mode of HIV transmission in Africa and as such places married women at a particular risk, given the gender inequalities within marriage and sexual relationships. The Global Report on the AIDS Epidemic shows that the epidemic imposes a particular burden on women and girls as a result of gender inequalities and harmful gender norms that promote unsafe sex and limit women's autonomy to access HIV and sexual and reproductive health services directed at women.^[155] In Lesotho, social and economic power imbalances between men and women are likewise associated with limitations in access to services in that women lack the economic independence as well as autonomy to access health care independently of their male partners. Furthermore, due to gender norms and inequalities many women and girls have little capacity or power within their relationships to negotiate safe sex, insist on condom use or otherwise take steps to protect themselves from HIV.^[156]

Women's economic dependence on others is another factor in their vulnerability to HIV exposure in Lesotho, particularly where property and inheritance laws come into play upon loss of a partner. Research indicates that where such property laws and inheritance laws are discriminatory they may perpetuate economic dependence, and consequently potential exposure to HIV, as well as limit the ability of women living with HIV to seek care, support and treatment.^[157] Denial of property and inheritance rights means that many women remain economically dependent on others for survival and often lose their homes, possessions, livelihoods and custody of their children if they lose their partner. This may force women to adopt survival strategies that increase their vulnerability to HIV.^[158] For example, the Lesotho Poverty Reduction Strategy shows that "as productive members of the household fall ill or die [due to HIV], women are often forced to seek other means of survival, such as commercial sex work which places them at a high risk of contracting [or becoming exposed to] HIV [...]."^[159] Due to legal dualism applicable in Lesotho,

155 UNAIDS, 'Global Report: UNAIDS report on the global AIDS epidemic,' 2013.

156 'Lesotho Modes of Transmission Report,' 2009.

157 Ahmed, A., 'Property and Inheritance Laws: The Impact on Women and OVC in the Context of HIV,' Global Commission on HIV and the Law Working Paper, 2011.

158 Women and Law in Southern Africa Research and Education Trust, LSA, 'Inheritance and Property Rights of Women,' 2000.

159 Lesotho Poverty Reduction Strategy Plan 2012/13–2016/17.

issues of inheritance are governed by both customary and common law.^[160]

While the effects of HIV and AIDS are on the whole disastrous to all sectors of the population, there is evidence that the burden is also relatively heavier on women than on men due to their care giving role in the family and community.^[161] For example, over 92 per cent of HIV and AIDS caregivers in Lesotho are female, presenting an unsustainable burden on women and girls.^[162] Care giving results in social, physical and psychological/emotional stress and lost opportunities for education, careers and income. Previous research indicates that “the burden of HIV and AIDS care has dehumanized women; it has feminized poverty and turned women into workhorses in the name of volunteering and caring for the community.”^[163]

Perspectives on women's vulnerability to HIV

A participant in an FGD with women in Moleleke's Hoek noted that “those women without basic human rights are indeed particularly vulnerable victims of the AIDS pandemic.” In addition, women who become infected with HIV also report suffering from high levels of discrimination. In our assessment, women described human rights violations when seeking services in their own homes, schools, hospitals and employment places.

Access to education is a critical factor in promoting the development of and thus indirectly protecting young girls from HIV - this is because gender parity in education is not only a human right but is a foundation for equal opportunity and a source of economic growth, employment creation and productivity.^[164] However, in Lesotho, early marriage and family responsibilities can take girls out of school early, especially because of the burden of care exacted by HIV and AIDS. In some instances, sexual harassment can make girl learners unsafe and as such, all these factors can undermine girls' ability to enjoy their right to education.^[165]

Gender-based violence, both a cause and an effect of HIV, is widespread, even though often its existence is denied or dismissed as a private issue between men and women.^[166] Research shows that around the world, “as many as one woman in every three women has been beaten, coerced into sex, or abused in some other way—most often by someone she knows, including by her husband or another male family member.”^[167] If violence against women is tolerated and accepted in a society, its eradication becomes more difficult.^[168] The WHO notes that gender-based violence has serious consequences for the mental and physical well-being of women and girls, including their reproductive and sexual health.^[169] The report reiterates that any of these

160 Maqutu, W.C.M., *Contemporary Family Law: The Lesotho Position*, National University of Lesotho Publishing House, 2005.

161 Revised National Strategic Plan on HIV and AIDS 2012/13-2015/16.

162 National Action Plan for Women, Girls and HIV and AIDS 2012-2017.

163 **Letuka, P., et al.**, *Gender, HIV and the Law in Lesotho: Embracing Rights-Based Approach to Realise Sexual and Reproductive Health in Lesotho*, **WLSA Publication, Morija, 2008.**

164 Gender Links, 'Southern Africa Development Community Protocol on Gender and Development Barometer', 2013.

165 Ibid.

166 **Chaka-Makhooane, L., et al.** *Sexual Violence in Lesotho. The Realities of Justice for Women*, **Morija Printing, Lesotho, Women and Law in Southern Africa Research and Education Trust, 2002.**

167 Gender Links, 'Southern Africa Development Community Protocol on Gender Development Barometer', 2013.

168 Ministry of Health and Social Welfare, 'Lesotho Demographic and Health Survey', 2009.

169 World Health Organization, 'The world health report - making a difference', 1999.

abuses can leave deep psychological scars, damage the health of women and girls in general, including their reproductive and sexual health, and in some instances result in death.

Evidence shows that gender-based violence, particularly sexual violence, is on the increase in Lesotho.^[170] The Lesotho Demographic and Health Survey report shows that 15 per cent of men feel that denying sex to the husband is justification for wife beating.^[171] A recent study in the prevalence of gender-based violence reflects underreporting in police statistics, as many survivors prefer non-legal redress due to fear of victimisation and violence by the partners or perpetrators.^[172] Additionally, in a study conducted by Women and Law in Southern Africa (WLSA) Lesotho,^[173] it was indicated that “fear which may be attributed to threats made by the perpetrator or what the victims thinks he might do in retaliation to having been reported” contributes as one of the reasons for under reporting of gender-based violence. The study further revealed that “...the victim has no protection against the perpetrator even if he is arrested since the likelihood is that he will be out on bail.”^[174]

Perspectives on reporting gender-based violence

Findings in our assessment show an unwillingness to report gender-based violence due to weak law enforcement, lengthy court processes and unsuccessful outcomes.^[175]

The SADC Gender Protocol Barometer report indicates that in Lesotho, there is urgent need to enact the Domestic Violence Legislation, as it has been shown that violence against women and girls constitutes a form of discrimination and is a violation of their human rights.^[176] There are, however, insufficient data on the linkages between gender-based violence and HIV, such that responsible agencies are unaware of their impact. There is also a lack of institutional programmes targeting behaviour change and patriarchal mind-sets, further contributing to the high incidence of gender-based violence cases and the high incidence of HIV infection among Basotho women.^[177]

Below, we discuss the following laws, policies and action plans to determine whether they promote gender equality in marriage as well as in access to property and inheritance, and whether they respond to harmful gender norms and gender-based violence to reduce the vulnerability of women in relation to HIV:

- a) National Gender and Development Policy, 2003
- b) The National Action Plan on Women, Girls and HIV and AIDS and the National Strategic

170 UNFPA, ‘Rapid Assessment on Sexual and Gender Based Violence and Food Insecurity in Lesotho’, 2010.

171 Ministry of Health and Social Welfare, ‘Lesotho Demographic and Health Survey’, 2009.

172 UNFPA, ‘Rapid Assessment on Sexual and Gender Based Violence and Food Insecurity in Lesotho’, 2010.

173 **Chaka-Makhooane, L., et al.** *Sexual Violence in Lesotho. The Realities of Justice for Women*, Morija Printing, Lesotho, Women and Law in Southern Africa Research and Education Trust, 2002.

174 Ibid.

175 **Key informant interview with a legal practitioner in this study. This is also supported by evidence cited in Chaka-Makhooane, L., et al.** *Sexual Violence in Lesotho. The Realities of Justice for Women*, Morija Printing, Lesotho, Women and Law in Southern Africa Research and Education Trust, 2002.

176 Gender Links, ‘Southern Africa Development Community Protocol on Gender and Development Barometer’, 2013.

177 **Chaka-Makhooane, L., et al.** *Sexual Violence in Lesotho. The Realities of Justice for Women*, Morija Printing, Lesotho, Women and Law in Southern Africa Research and Education Trust, 2002.

- Plan (NSP) on HIV and AIDS
- c) Legal Capacity of Married Persons Act, 2006
- d) Marriage Act, 1974
- e) Customary marriage
- f) Land Act, 2010
- g) Inheritance Act 26, 1873
- h) Administration of Estates Proclamation No. 19, 1935
- i) Intestate Succession Proclamation No.2, 1953
- j) Concept of heirship under customary law
- k) Penal Code, 2010 and the Sexual Offences Act (SOA), 2003
- l) Sexual Offences Act (SOA), 2003
- m) Anti-Trafficking in Persons Act No.1, 2011

4.3.1 Position in Lesotho

In a community like Lesotho with a high prevalence of HIV, the promotion of gender equality and human rights is critical to a comprehensive response to the HIV pandemic.

a) **National Gender and Development Policy, 2003** (*currently being reviewed*)^[178]

This policy enjoins both the government and the private sector to take account of gender equality and equity in the development and implementation of programs in order to provide better opportunities for men and women, boys and girls. This policy is meant to close gender gaps and also brings about equality of opportunities between the sexes. It addresses issues of HIV and AIDS and sexual and reproductive well-being and rights, and it advocates for the provision of facilities and services to address the needs of men and women. One of the policy's objectives is to promote equal decision-making in sexual matters in order to reduce the transmission of STIs and HIV. In addition, it promotes ongoing awareness-raising for government and civil society organisations on the causes and consequences of gender-based violence.

Article 3 of the National Gender and Development Policy aims to develop an integrated system of education that provides equal opportunities to all, irrespective of sex, while Article 10 promotes gender equality in vocational education and training.^[179]

b) **The National Action Plan on Women, Girls and HIV and AIDS and the National Strategic Plan (NSP) on HIV and AIDS**

These two plans both aim, amongst other things, to reduce gender-based violence that places women and girls at higher risk of HIV exposure. The Action Plan is a major pillar, as it sets out the commitments of both government and development partners to provide financial and human resources to minimise the impact of HIV upon women and girls. There have been challenges in implementation of the Action Plan due to resource constraints. The NSP has gender as a cross-cutting theme and also has a section dedicated to gender, human rights and gender-based violence.

¹⁷⁸ The Policy is currently being reviewed in line with the 'Southern African Development Community Gender and Development Protocol', 2008.

¹⁷⁹ National Gender and Development Policy, 2003 (currently under review).

c) Legal Capacity of Married Persons Act, 2006

This law treats married persons equally and abolishes marital power, entitling both men and women to the same rights and obligations regarding their marital rights and duties. It also mandates married couples to consult one another in all matrimonial matters—which was never the case under common law.^[180] Of importance is the fact that the Legal Capacity of Married Persons Act brings on board principles of equality between men and women. As a result, married women have been emancipated from matrimonial oppression that used to expose them to a high risk of poverty and cause them to maintain economic dependence on their husbands; this should serve to reduce their vulnerability to HIV exposure.^[181]

Findings from this study reveal that most respondents are aware of the existence of the Legal Capacity of Married Persons Act. Despite the wide popularity of this law, the provision that seems more commonly known is the removal of the minority status of married women.^[182] The issue of mandatory consultation in all matrimonial issues such as alienation of property is not commonly known, yet issues such as these are the ones that increase poverty within families, placing women at higher risk of HIV exposure. Another barrier is that despite the legal environment that is conducive to women's empowerment in some respects, cultural norms and practices still dominate mind-sets such that in cultural contexts women are still regarded as minors and are not capacitated to enforce and claim their rights.^[183]

d) Marriage Act, 1974

The Marriage Act of 1974 prescribes the age of entering into a valid marriage to be 21. However, the law makes exceptions, allowing a boy 18 years old or a girl of 16 years to enter into a valid marriage with either parental or a guardian's consent. These provisions are discriminatory in setting different ages for boys and girls and expose girl children to early marriage and vulnerability to HIV, contrary to the provisions of the Convention on the Rights of the Child (CRC), which puts marriageable age at 18 and promotes the best interests of the child.

e) Customary marriage

Customary marriages do not set an age for consent to marriage and are by nature polygamous.^[184] Under Part II of the Laws of Lerotholi (customary law), a man may marry more than one wife. The law further only obliges the husband to marry subsequent wives upon *consultation* with the first wife.^[185] It must be reiterated that consent of the first wife to these other subsequent marriages is immaterial as long as she has been consulted.

f) Land Act, 2010

Since the enactment of the Land Act of 2010, all individuals above the age of 18 have

180 Before 2006, married women were minors due to the marital power that gave men power over the property and persons of their wives.

181 **Letuka, P, et al.,** *Gender, HIV and the Law in Lesotho: Embracing Rights-Based Approach to Realise Sexual and Reproductive Health in Lesotho, WLSA Publication, Morija, 2008.*

182 These views were generally expressed in both the key informant interviews and focus group discussions, especially amongst participants who did not have a legal background or training.

183 Ministry of Health and Social Welfare, 'Lesotho Demographic and Health Survey,' 2009.

184 Laws of Lerotholi, Section 11, 1903.

185 Laws of Lerotholi, 1903.

the right to hold title to land irrespective of their gender. This advances women's rights to own property. However, in Lesotho, land that is not cultivated for three consecutive years or used for five consecutive years (abandoned) automatically reverts back to the allocating land authority.^[186] This factor may put people, particularly the poor who may not be able to cultivate their land, under pressure to pass title (sell) to the next person rather than risk losing it to the State, contributing to their continued economic marginalisation.^[187]

g) Inheritance Act 26, 1873

Section 3 of the Inheritance Act provides for freedom of testation.^[188] It allows anybody competent to make a will "...a right to disinherit a child, parent, relative or descendent without giving any reason regardless of any law, usage or custom in force in the country."^[189] The same law in Section 6 limits the testator by providing that anybody writing a will should take note of the application of customary law.^[190] Under customary law (the Laws of Lerotholi) a girl child—unlike a boy child—can inherit a maximum of 50 per cent of the estate left behind by the deceased. In contrast, the eldest boy child (heir) can inherit up to a maximum of 100 per cent of the estate when there is no will and a minimum of 50 per cent of the estate where there is a will – since the eldest male heir may not be disinherited of more than 50 per cent of the estate according to the Laws of Lerotholi.^[191] Thus, girls are always at a disadvantaged position compared to boys, as this legislated inequality cannot be changed even when a will has been left behind. Economic vulnerability of girl children impacts on their lives in myriad ways, including making them more vulnerable to HIV exposure.

h) Administration of Estates Proclamation No. 19, 1935

This law provides for the administration of testate succession. Section 3 (b) of the Proclamation excludes the estates of Africans from its application unless such Africans are "married under European law and have abandoned the customary way of life and adopted a European mode of life."^[192] In the Case of *Senate Qhabasheane Masupha*, Monaphathi J., stated, "[The mode of life test] remains part of our law. It is doubtful if the Applicant would qualify under this 'mode of life' test. She is a single, educated career woman whose last or most recent job was representing the country as a diplomat in Rome. She may not fit the customary law mode of life test."^[193] Brief facts of the case were as follows: The Applicant was claiming to be declared the rightful successor to the chieftainship post left by her late parents on the basis that she was the only "girl" child of her parents' marriage. Therefore, issues of succession in Lesotho, like those of inheritance, only regard the first-born male child as opposed to the girl child. In justifying the discrimination, the Court stated that "Lesotho's cultures and customs are unique and therefore

186 Land Act, Section 43, 2010.

187 Ahmed, A., 'Property and Inheritance Laws: The Impact on Women and OVC in the Context of HIV', Global Commission on HIV and the Law Working Paper, 2011.

188 Inheritance Act 26, Section 3, 1873.

189 Ibid.

190 Ibid. Section 6.

191 Laws of Lerotholi, 1903.

192 Administration of Estates Proclamation No.19, Section 3(b), 1935.

193 *Senate Gabashane Masupha v His Worship, Senior Magistrate for the Subordinate Court of Berea & 10 Others* Constitutional Case No. 5, 2010.

could not rely on international human rights law to decide a 'customary law' issue."^[194] This discrimination against women has the effect of putting women in a situation of vulnerability including to HIV infection due to their economic dependence on men.

i) Intestate Succession Proclamation No.2, 1953

The law of intestate succession permits the surviving spouse to get an equivalent of a child's share of the marital property. The law also distinguishes between spouses married in community or out of community of property; a marriage in community of property entitles a surviving spouse to half of the estate and a child's share, whereas a marriage out of community of property entitles a surviving spouse only to inherit a child's share. Thus, when a man dies first, leaving a widow, it often leads to conflict over the deceased estate as well as to the validity of the surviving spouse's marriage to the deceased. The discriminatory application of laws of inheritance impacts on women's economic situation, further impacting on vulnerability to HIV.^[195]

j) Customary law (Laws of Lerotholi)

The Laws of Lerotholi lay down principles of inheritance and administration of the deceased's estate under customary law that are fundamentally different to the common law of inheritance. Under customary law, a woman is expected to leave her maternal home when she marries, "and that is where her inheritance will be." As a result, women are not given priority by their own families during allocation of resources such as land and cattle, since the assumption is that they will marry. This practice leaves women who get married under custom as dependents of their husbands, while those that remain unmarried depend on the wealth of their fathers or the appointed heir. This practice unfairly discriminates against women as it increases their economic dependence upon men.^[196]

k) Concept of heirship under customary law

The Laws of Lerotholi discriminate on the basis of gender and provide that the heir shall be the first male son born in the first house, or the first male son born in the second house, or the third house if there is no male son in the first house, second house and so on. Where the heir is still a minor, a guardian is appointed (usually the mother) and she has to keep an inventory of the assets, which will be subject to inspection by the uncles.^[197] They do not recognise girls as legitimate heirs to their parents' estate, including land—thus deepening economic inequalities between men and women and making it impossible for women to exercise their property rights.

l) Penal Code, 2010 and the Sexual Offences Act (SOA), 2003

An important law reform measure relating to sexual relations between spouses is provided

- i) the complainant spouse was sick
- ii) violence or threats of violence were used in order to have sex
- iii) the complainant spouse had obtained a judicial order of restraint against the other

194 Ibid.

195 Ahmed, A., 'Property and Inheritance Laws: The Impact on Women and OVC in the Context of HIV,' Global Commission on HIV and the Law Working Paper, 2011.

196 Letuka, P., et al., *Family Belonging for Women in Lesotho*, Morija Printing Works, Morija, 1998.

197 Laws of Lerotholi, Section 12, 1903.

- iv) the complainant spouse was separated from the other by judicial
- v) order one of the spouses had deserted

for under the Penal Code^[198] and the SOA, which criminalises marital rape.^[199] The law is limited in that it criminalises marital rape under certain circumstances only. It provides that marriage may not be a defence against a charge of sexual offence where:

The Penal Code also criminalises various forms of violence and assault and is used in cases of domestic violence. However, there is no specific domestic violence legislation in Lesotho, which is a major gap given the increase in intimate partner violence in Lesotho.^[200] The Law Reform Commission has conducted the relevant research into domestic violence and consulted with various stakeholders in government and civil society and is now awaiting further instruction on the drafting of Domestic Violence Legislation. The enactment of the legislation is an imperative and in line with the target set out by SADC States compelling all members to enact and enforce legislation prohibiting all forms of gender-based violence and trafficking by 2015. The SADC Protocol also stipulates that the law must provide for a comprehensive package of treatment and care for survivors of gender-based violence, including access to post-exposure prophylaxis (PEP) and the establishment of special courts to address these cases.^[201]

m) Sexual Offences Act (SOA), 2003

With respect to the SOA, as discussed previously an offender who is HIV positive at the time of the offence receives an aggravated sentence—10 years in the case of unknowingly being HIV positive and the death penalty in the case of a person with knowledge of positive HIV status. Strengthened protection for women from sexual offences, including marital rape and exposure to HIV, are to be welcomed. However, the various concerns with the implementation of section 32 of the SOA have been set out above.

A further issue impacting on women is the failure to explicitly link the outcome of the sexual offender's HIV test with PEP for women. The Act does make provisions for disclosure of the HIV test result to the complainant (and alleged offender); however, in order to support a woman to make decisions regarding PEP, HIV testing of an alleged offender would need to take place within 72 hours of the alleged offence.

Perspectives on awareness of the Penal Code and SOA

Significantly, respondents from both FGDs and KIs were not aware of the Penal Code or SOA and their provisions.^[202] Participants in the FGDs with women living with HIV expressed not feeling protected by new laws,^[203] perhaps due to poor dissemination and sensitisation of the legal instruments in the country generally.

198 Penal Code, Section 52, 2010.

199 Sexual Offences Act, Section 3, 2003.

200 Gender Links, 'Southern Africa Development Community Protocol on Gender and Development Barometer', 2013.

201 Southern African Development Community (SADC) Gender and Development Protocol, Articles 20-25, 'Gender Based Violence', 2008.

202 Responses from focus group discussions and key informant interviews.

203 Focus group discussions with women living with HIV and AIDS, Thaba- Tseka and Maseru districts.

n) **Anti-Trafficking in Persons Act No.1, 2011**

The Anti-Trafficking in Persons Act of 2011 was enacted with the aim of protecting all people from exploitative trafficking in persons, preventing trafficking and prosecuting the offenders. The law provides for the prohibition, prevention, prosecution and punishment of perpetrators of the offence of trafficking in persons and other related offences. It also provides measures for protection, rehabilitation, and reintegration of victims of trafficking in persons and related matters.^[204] Trafficking in persons is therefore defined as: the recruitment, transportation, transfer, harbouring and legal or illegal adoption, sale or receipt of persons within and across the borders of Lesotho by use of threat, force or other means of coercion, abduction, kidnapping, fraud or deception, and, the giving or receiving of payment or benefit to obtain the consent of persons for purposes of exploitation.^[205] By criminalising trafficking, this act protects adults and children from being forced into sex work against their will, thereby protecting them from exposure to HIV.

4.3.2 Provision of post-exposure prophylaxis (PEP) for women

While PEP is given to survivors of sexual offences who have reported their cases to the police, this is not available to those women who engage in consensual sex. This limitation contributes to the spread of HIV for those engaging in unprotected, consensual sex, even though PEP has been shown to minimise the risk of infection.

Similarly, in the case of unreported non-consensual sex, women are equally unable to access PEP. This is significant given that research shows that not all victims of sexual violence report the matter to the police or other legal authorities, especially where intimate partner violence exists.^[206]

Finally, note must be taken of the fact that victims of sexual abuse must report the case to the police first and fill in the medical form before they can go to the health facility where they can be given PEP. Sometimes the distance from both legal and health services may negatively affect reporting of gender-based violence cases (including sexual offences), as well as access to health care services including PEP. Many police stations/posts, clinics/health centres and hospitals in Lesotho are located either in towns or very far from villages. Providing access to PEP in a way that is not linked to the reporting of a sexual offence may help to increase victims' access to it.

4.3.3 Challenges

- Women remain at high risk of HIV exposure in Lesotho due to negative cultural and patriarchal stereotypes that do not recognise the equality of women.
- Many women are not aware of their rights provided for under new, protective laws and policies.
- Marriage laws are discriminatory in setting different marriageable ages for boys and girls (Marriage Act, 1974) and in exposing girl children to early marriage and vulnerability to HIV, contrary to the provisions of the CRC, which puts marriageable age at 18 and promotes the best interests of the child.

204 Anti-Trafficking in Person's Act, Act No.1, 2011.

205 Ibid.

206 Focus group discussion in this study.

- Gender equality laws do not deal with gender issues beyond women and girls (e.g. issues around gender identity and sexual orientation)
- Women and girls cannot inherit under customary law; this maintains their economic dependence upon men.
- There has been a lack of implementation of the National Action Plan for Women, Girls & HIV and AIDS.
- There is no specific enacted legislation dealing with intimate partner violence in Lesotho.
- There are no policies or guidelines for referral procedures (including medical and legal referrals) to cater for provision of comprehensive HIV testing, treatment and care of survivors of sexual offences (and other survivors of gender-based violence in general), including those who have not reported their cases to the police authorities.
- PEP is only provided to victims of sexual violence and does not extend to individuals who have engaged in other types of unprotected sexual activity, regardless of whether the act was unlawful or not.
- There is slow and ineffective disposal of criminal offences, resulting in lengthy delays in criminal trials, including gender-based violence cases.
- There are no comprehensive or integrated services for survivors of gender-based violence.
- There are no regulations for the effective implementation of the Anti-Trafficking in Persons Act of 2011.
- There is limited research and awareness on the extent of and linkages between domestic violence and HIV.
- There are no rights-based comprehensive indicators to measure responses to gender-based violence.

4.3.4 Recommendations for addressing women, girls and gender equality and HIV

- Raise awareness on negative cultural and patriarchal stereotypes that do not recognise the equality of women.
- Sensitise and raise awareness on the rights provided for under new, protective laws and policies such as the SOA and Legal Capacity of Married Persons Act.
- Review the Marriage Act of 1974 and ensure that it is in conformity with CRC and Children's Protection and Welfare Act (CPWA) regarding the permissible age of marriage for boys and girls.
- Broaden the scope of gender equality laws to deal with issues beyond women and girls (e.g. sexual orientation, gender identity) (see section 4.3).
- Review and reform inheritance laws to allow women and girls opportunities to inherit equally with men and boys.

- Support implementation of the National Action Plan for Women, Girls & HIV and AIDS on the part of the government.
- Advocate for domestic violence legislation to also include issues of intimate partner violence.
- Ensure that laws and policies are in place that provide for comprehensive HIV testing and counselling services, including referrals/linkages with law enforcement to ensure survivors' access to health care/PEP.
- Develop and implement policies or guidelines for referral procedures (including medical and legal referrals) to cater for provision of comprehensive HIV testing, treatment and care of survivors of sexual offences (and other survivors of gender-based violence in general), including those who have not reported their cases to the police authorities.
- Review policy regarding provision of PEP so that it is given to all individuals who have engaged in unprotected sexual activity, regardless of whether the act was unlawful or not.
- Raise judicial advocacy for speedy disposal of criminal cases, including gender-based violence cases.
- Develop regulations for the effective implementation of the Anti-Trafficking in Persons Act of 2011.
- Conduct more research to assess the extent of and linkages between domestic violence and HIV, and conduct campaigns to raise awareness on these linkages.
- Develop and implement rights-based comprehensive indicators to measure responses to gender-based violence.

4.4 Children

A child is defined as a human being under age 18.²⁰⁷ Young people, particularly young women, are a vulnerable population at higher risk of HIV infection across the world. There are 4 million young people aged 15 to 24 years old living with HIV (2.9 million of whom are from sub-Saharan Africa), with 29 per cent of this 4 million adolescents aged 15–19. Globally, 15 per cent of all women 15 years and older living with HIV are young women 15 to 24 years old. Of these, 80 per cent live in sub-Saharan Africa.²⁰⁸

HIV and AIDS impacts upon children in various ways. Children may be vulnerable to HIV transmission when they're unable to access appropriate HIV prevention services and may similarly be unable to access services once HIV-positive. For instance, children who are denied the right to access confidential sexual and reproductive health services independently of their parents may choose not to use health care services, thereby denying them the opportunity to access vital health care.²⁰⁹ Failure to protect girl children from early marriage may place affected girl children in a position where they are unable to negotiate safer sex.²¹⁰ HIV-related stigma and discrimination may increase the impact of HIV on their lives. Stigma and discrimination may discourage children living with HIV from disclosing their HIV status to caregivers and sexual partners, further limiting their access to prevention, treatment, care and support services.

At the international level, States' responsibilities to realise children's rights are outlined under the Convention on the Rights of the Child (CRC). The CRC is founded on the principles of non-discrimination and best interests of the child and to this end promulgates "[i]n all actions concerning [all] children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies, the best interests of the child shall be a primary consideration." State parties to the CRC are further charged with the responsibility of employing all possible legal and administrative measures in safeguarding the protection, care, well-being, as well as survival and development of all children.²¹¹

Article 34 explicitly expresses:

"States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

- (a) The inducement or coercion of a child to engage in any unlawful sexual activity;
- (b) The exploitative use of children in prostitution or other unlawful sexual practices..."²¹²

The CRC is thus regarded by parties as the basis on which to found child protection legislation and services. Failure to protect children's rights (e.g. protection from sexual exploitation

207 The Convention on the Rights of the Child, 1989.

208 UNAIDS, 'Global Report: UNAIDS report on the global AIDS epidemic,' 2013

209 Global Commission on HIV and the Law, 'Risks, Rights & Health,' 2012.

210 Ngwenya, C., 'Early Marriages in Southern African Countries,' 2011.

211 Ibid.

212 Ibid.

and abuse, the rights to family care and access to health care services) may place them at risk of HIV exposure and infection.

The UN Committee on the Rights of the Child's General Comment No. 3 has identified the following broad-based legal strategies to promote children's rights in the context of HIV:

- **Non-discrimination:** Laws, policies, strategies and practices should address all forms of discrimination that contribute to increasing the impact of HIV and AIDS. This includes HIV-related stigma and unfair discrimination, as well as inequality and human rights violations that increase the risk of HIV exposure amongst already vulnerable and marginalised populations.
- **Survival and Development:** Laws, policies and programmes should give children opportunities to survive to adulthood and to develop to the fullest extent possible. In the context of HIV, this requires laws and policies to realise children's rights and access to services to protect them from HIV, to provide for the needs of children and young people affected by HIV, as well as to prohibit harmful practices that increase a child's risk of HIV exposure.
- **Participation:** Laws and policies should provide for the rights of children and young people to participate, in accordance with their evolving capacities, in responses to HIV. Mechanisms should be created to encourage children to express their views and to have their views considered, in accordance with their age and maturity.
- **The Best Interests of the Child:** Finally, laws, policies and programmes should be adapted to ensure that responses to HIV prioritise a child's best interests, rights and needs.²¹³

4.4.1 Position in Lesotho

In Lesotho, girl-children have been identified as a particularly vulnerable population in the context of HIV,²¹⁴ with HIV prevalence amongst young women 15-29 years (14 per cent) considerably higher than amongst young men (4 per cent).²¹⁵ Reports indicate that almost one in 10 persons aged 15-24 years is HIV positive.²¹⁶ HIV prevalence among pregnant women is estimated at 24.3 per cent²¹⁷ with approximately 14,706 infants born to HIV-positive women every year.²¹⁸ Some progress has been made in the country in terms of reducing HIV infection amongst children through prevention of mother-to-child transmission (PMTCT) of HIV. In addition, the Ministry of Health (MOH) reports that there is an increased coverage of infants that receive prophylaxis at birth from 77 per cent in 2007 to 96 per cent in 2012.²¹⁹

213 UN Committee on the Rights of the Child, Comment 3.

214 Letuka, P, et al., *Gender, HIV and the Law in Lesotho: Embracing Rights-Based Approach to Realise Sexual and Reproductive Health in Lesotho*, WLSA Publication, Morija, 2008.

215 Lesotho Demographic and Health Survey, 2009; Revised National Action Plan on Women, Girls and HIV and AIDS 2012-2017; Ministry of Health and Social Welfare, National HIV and AIDS Estimates for 2009

216 Ibid.

217 Revised National Strategic Plan on HIV and AIDS 2012/13-2015/16.

218 Ibid.

219 Ibid.

Perspectives on the impact of orphan hood on girl children

Key informants in our assessment discussed the impact of HIV on children orphaned by HIV. They indicated that girl children often take on responsibilities for heading up households, are dispossessed of their parents' property, denied access to education and information or even subjected to early marriages in order to cope with and adjust to new roles after their parents' death due to HIV-related illnesses.²²⁰ These economic pressures may expose girls to early sexual debut and the risk of HIV infection.

Lesotho has made positive steps in certain regards such as legal frameworks that are responsive to current needs and are duly in consonance with the CRC. For example, the recent CPWA,²²¹ whose mandate is to consolidate child protection laws and to update them to address emerging concerns, was recently enacted. The Act seeks to promote the inherent and socioeconomic rights of children while recognising their potential and progressive development.²²² It also recognises the rights of children to reside with parents and to grow up in caring environments, among other fundamental rights.²²³ The CPWA,²²⁴ as well as the Penal Code,²²⁵ unequivocally define a child as a person who is below the age of 18. In tandem with the CRC, both the CPWA and Penal Code establish a climate conducive to the protection of children in Lesotho.

a) Penal Code, 2010 and the Sexual Offences Act (SOA), 2003

Both the Penal Code²²⁶ and SOA²²⁷ declare sexual intercourse with children—defined as persons under 18 years of age—as unlawful. The Penal Code furthermore provides that any sexual act with a child under 12 years of age constitutes sexual molestation.²²⁸

The SOA provides that any person “who commits a sexual act with a child for financial or other reward, favour or compensation to the child or to any other person” commits an offence.²²⁹ The same applies to causing a child to engage in sex work.²³⁰ The SOA furthermore makes it an offence for any person to fail to report a sexual offence against a child.²³¹

The SOA also provides for varying ages at which an act qualifies as being a sexual offence

220 Key informant interviews in Maseru.

221 Children's Protection and Welfare Act No. 7, 2011.

222 Children's Protection and Welfare Act No. 7, Section 2 (1); Section 5, 2011.

223 Ibid. Section 10.

224 Ibid.

225 Penal Code, Act No. 6, 2010.

226 Penal Code, Act No. 6, Section 49 (1), 2010.

227 Sexual Offences Act, No. 3, Section 8 (1), 2003.

228 Ibid.

229 Ibid. Section 10 (1).

230 Ibid. Section 10 (2), (3).

231 Sexual Offences Act, No. 3, Section 8 (3), 2003.

against a child, from 16 years (Part IV offences) to 18 years (Part III offences).²³² This means that there are different provisions relating to consensual sex between adolescents of similar ages, in order to recognise and acknowledge the rights of young people to have sex. For example, depending on the age of the child victim or offender and the age difference between them, the law regulates the lawfulness of consent differently. This is commendable and is seen to be in congruence with the principle of recognising the evolving capacity of the child, as stipulated by the CPWA.

b) **Children's Protection and Welfare Act (CPWA), 2011**

The CPWA of 2011 defines a child as a person below 18 years of age and provides for a holistic approach to the human rights of children. The Act has domesticated the provisions of the CRC, providing for principles such as the best interests of the child, recognition of the evolving capacities of the child and protection of a child's right to equality on various grounds, including "gender", "disability", "health status" and "other status" (Part II: Principles), which should ensure broad protection for children affected by HIV to equality and non-discrimination.

Other key issues relevant in the context of children, HIV and AIDS are discussed below:

Health Rights: Section 11 of the Act provides for a child's right to survival and development, including health rights. Section 11(1) states that "a child has a right to access education, adequate diet, clothing, shelter, medical attention, social services or any other services required for the child's development." Section 11(6) notes that "a child has a right to sexual and reproductive health information and education appropriate to his age". Part XXV of the Act deals with consent to medical treatment and HIV testing. Section 232 provides that a child of 12 years of age with sufficient maturity and mental capacity may consent independently to medical treatment. Section 233 provides that a child of 12 years may consent independently of his or her parents / guardians to HIV testing, provided where testing is in the best interests of the child. Furthermore, in terms of s234(1) and (2), a child who is a survivor of abuse, including sexual abuse and exploitation must be provided with emergency legal, medical or health assistance and reproductive health information. These provisions are important for children in the context of HIV, helping to promote access to sexual and reproductive health and rights for young people. However, there is an inconsistency between the age of consent to medical treatment and HIV testing, and the age of consent to sexual activity.²³³ Although laws that determine the age at which young people may lawfully consent to sexual activity intend to protect young people, they may complicate (or be interpreted to complicate) laws concerning consent to access sexual and reproductive health services.²³⁴ It is therefore argued that these laws may create barriers to adolescent's access to these services, may increase stigma surrounding the sexual activity of young people, and may create uncertainty among health care workers of the services they should provide to young people.²³⁵ The IPPF Report notes that "where ages of consent are low, particularly for girls, young people could be more vulnerable to sexual violence and health risks

232 Part III offences relate to offences committed by adults against children, while Part VI relates to sexual offences committed by children against children.

233 Ibid.

234 International Planned Parenthood Federation, Qualitative Research on legal barriers to young people's access to sexual and reproductive health services, 2014.

235 Ibid.

associated with early sexual activity. Alternatively, where the age of consent to sexual activity is set high, adolescents are likely to be denied the education and services that they need to make healthy and autonomous decisions about their sexual and reproductive health, which could also have serious emotional, social and health implications.”²³⁶

Protection for children in need: Part IV of the Act provides for children in need of care and protection, Part VI of the Act identifies offences in relation to the health and welfare of children, Part VIII of the Act provides for the adoption and fostering of children and Part IX deals with the trafficking and abduction of children . These provisions help to ensure that children who are identified as being in need (e.g. children who are sexually abused or children who are in need of alternative care) are identified and protected and that offenders are prosecuted. Sections 66-72 of the CPWA, with respect to trafficking and abduction of children, provide for the unlawfulness of the act of trafficking and abduction and for investigation and protection measures for the child who has been trafficked. This means that children in Lesotho have strengthened legal protection from sexual exploitation by adults on both commercial and non-commercial grounds. However, the combined international instruments and State laws cannot reliably protect all categories of vulnerable children and significant challenges remain.

Marriage: The CPWA law has not been harmonised with other marriage laws, which means that it does not reform other marriage laws; these laws continue to create tensions.²³⁷ As discussed previously the CPWA prohibits a child (person below 18 years) from entering into any legal marriage Section 17 of the CPWA also protects children from being subjected to harmful cultural rites, custom and traditional practices and states that “ a child shall not be subjected to any cultural rites, customs or traditional practices that are likely to negatively affect the child’s life, health, welfare, dignity or physical, emotional, psychological, mental and intellectual development. However, the Marriage Act of 1974 provides that a girl can enter into marriage at the age of 16 years with the consent of her parents and the Minister’s consent (yet for a boy, the age is 18 years). Similarly, customary law (Laws of Lerotholi) does not prescribe a minimum age for a legal marriage. This results in many girls getting married under customary law before they reach age 18.”²³⁸

Due to poverty, most parents whose children elope (*chobeliso*) often hesitate to take legal recourse as provided for under the Laws of Lerotholi as they hope to get “*bohali*.” This means that a man who marries a girl aged 12 years may escape criminal liability as long as there has been compliance with all the requirements of a legal Sesotho marriage. However, research shows that early sexual debut, low condom use and a host of other risk-taking behaviours, combined with

236 World Health Organization, ‘Adolescent Consent to HIV Testing: A Review of Current Policies and Issues in Sub-Saharan Africa,’ 2013 report: Adolescence is defined as the period between 10 and 19 years of age in order to capture the range of developmental changes occurring during this time and to correspond with national information systems often aggregated in 5-year age bands; International Planned Parenthood Federation, Qualitative Research on legal barriers to young people’s access to sexual and reproductive health services, 2014, p20.

237 Marriage Act, 1974.

238 Requirements for valid customary marriage are: parties must agree to enter into marriage, parents or guardians of the parties must agree to marry the children, there must be an agreement as to the amount of bohali, and the payment of the bohali is done in cattle or in newer days in the money value of cattle. There is no mention of the age at which parties can enter into marriage.

biological vulnerability (in adolescent girls), do contribute to the high risk of HIV acquisition.²³⁹

4.4.2 Challenges

- Currently in Lesotho, negative attitudes and stereotypes amongst parents and service providers against sexual activity amongst young people create barriers to access to HIV testing and counselling services, despite the legal and policy measures in place.
- The laws relating to age of consent to HIV testing and treatment are also inconsistent with those relating to age of consent to sexual activity.
- There are also contradictory laws relating to the minimum age at which a girl may enter into lawful marriage (i.e. the Marriage Act of 1974 sets the minimum age as 16 years, the CPWA sets the minimum age for all children to enter into marriage as 18 and customary law does not set a minimum age).

4.4.3 Recommendations for addressing children's HIV-related rights

- Raise awareness of sexual and reproductive health rights of young people amongst parents and service providers to promote access by adolescents to sexual and reproductive health services.
- Review the age of consent to sexual activity with the age of consent to medical treatment and HIV testing, to ensure that the inconsistencies in these laws do not create barriers to the right of young people to access confidential sexual and reproductive health care. Harmonise the Marriage Act, the CPWA, and customary law to set a uniform minimum age of marriage at 18 years.

4.5 Employees

Discrimination in the workplace may present a substantial obstacle to the ability of persons living with HIV to secure and sustain employment.²⁴⁰ Despite laws in many countries prohibiting employment HIV testing for purposes of discrimination, HIV-related discrimination continues to occur in the workplace.²⁴¹

The SADC Model Law on HIV & AIDS in Southern Africa provides that “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.”²⁴² It advises against pre-employment HIV testing and promotes non-discrimination, voluntary HIV testing, confidentiality and reasonable accommodation of employees with HIV in the workplace. Furthermore, the International Labour Organisation’s (ILO) recommendations on HIV in the workplace provide that the response to HIV should contribute to the realisation of human rights, fundamental freedoms and gender equality for all, including workers, their families and their dependents. The ILO recommends that HIV and AIDS should be treated as a workplace issue and included in the

239 Fox, K., et al., ‘Adolescent Consent to HIV Testing: A Review of Current Policies and Issues in Sub-Saharan Africa,’ World Health Organization Report, 2013.

240 World Bank, ‘Legal Aspects of HIV and AIDS,’ 2007.

241 Ibid.

242 Southern African Development Community Model Law, Article 23, 2012.

national, regional and international response to the HIV epidemic, with the full participation of organizations of employers and workers.²⁴³ Both the ILO Code of Practice on HIV/AIDS and the more recent Recommendations on HIV and the World of Work²⁴⁴ support non-discrimination on the basis of HIV in the workplace and reject HIV testing for purposes of employment, stating that “HIV testing should not be required at the time of recruitment or as a condition of continued employment.” In addition, the ILO Code of Practice endorses the approach that “governments, private insurance companies and employers should ensure that information relating to counselling, care, treatment and receipt of benefits is kept confidential . . .”²⁴⁵

4.5.1 Position in Lesotho

The right to work is enshrined in the Lesotho Constitution.²⁴⁶ This right is guaranteed under Principles of State Policy and is therefore non-justiciable.²⁴⁷ While the Constitution guarantees just and favourable conditions of work and the protection of worker’s rights and interests, these are broad, generic rights not specific to each labour sector. In addition, the union movement in Lesotho is weak and fragmented.²⁴⁸ Thus, while there is strong protection for workers’ rights in the Constitution, this has not been adequately translated into sector-specific protections in the Labour Code or other relevant laws.

a) **Labour Code (Amendment) Act, 2006**

In 2006 the Government of Lesotho amended the Labour Code Order of 1992 to include provisions dealing with HIV and AIDS. Section 36 makes provision for HIV information and education for employees, confidentiality, non-discrimination, eligibility for employee benefits, risk assessments and the development of workplace HIV and AIDS policies. In terms of the Labour Code (Amendment) Act of 2006, an employer shall not discriminate against an employee on the basis of his or her HIV status in relation to promotion, transfer, training or other employee development programme, job status or other terms of reference of employment.²⁴⁹ Sub-section (4) of the Labour Code (Amendment) Act states that an employer who discriminates against his or her employee or job applicant on the grounds of HIV status commits an unfair labour practice.²⁵⁰

The Labour Code also prohibits sexual harassment at the workplace and provides that “any person who offers employment or who threatens dismissal or who threatens the imposition of any other penalty against another person in the course of employment as a means of obtaining sexual favours or who harasses workers sexually shall commit an unfair labour practice.”²⁵¹ It is evident that where sexual harassment occurs within the workplace, the possibility of HIV

243 International Labour Organisation, ‘Recommendations on HIV and the World of Work 200’, 2010.

244 World Bank, ‘Legal Aspects of HIV and AIDS’, 2007.

245 www.ilo.org/aids

246 Lesotho Constitution, Section 29, 1993.

247 Lesotho Constitution, Chapter III, 1993.

248 United Nations, ‘Compilation of UN info for the second cycle of the Universal Periodic Review (UPR) mechanism: Lesotho’, 2013

249 Labour Code (Amendment) Act, Section 235 (E) (I), 2006.

250 Ibid. Section 235 (E)(4).

251 Labour Code, Order, Section 200, 1992.

transmission exists. Again, poor reporting of cases of this nature may contribute to increasing the risk of HIV transmission, as in most cases employees may fear losing their jobs if they report their employers.²⁵² Among public servants, harassment and victimisation of HIV-positive public officers will result in disciplinary action being taken against the perpetrators.²⁵³

The Labour Code (Amendment) Act of 2006 compels all employers to develop and implement a workplace policy on HIV and AIDS aimed at prevention of new HIV infections and protecting employees from discrimination and stigma related to HIV and AIDS, among other factors.²⁵⁴ Lesotho also has the Public Service HIV and AIDS Workplace Policy, which provides guidelines for addressing the pandemic in the public service through prevention, treatment, care and support, and for mitigating its impact on infected and affected public officers. Section 5 of the Policy provides that the policy will be operating within the legal and regulatory framework of, among others, section 10 (2) of the Public Service Act of 2005, the Public Service Regulations of 2008, the National AIDS Policy of 2006 and the Gender Policy of 2003.²⁵⁵ The Public Service HIV and AIDS Workplace Policy also serves as a basis for the development of HIV and AIDS programmes by all Government Ministries/Departments/Agencies.²⁵⁶ Public servants are guaranteed easy access to HIV testing and counselling programmes as part of health care service provided by Ministries/Departments/Agencies.²⁵⁷ Although the discretion to disclose the public officer's HIV status lies solely with said officer, this right may be overridden where it is for the benefit of the individual and/or the public good.²⁵⁸ This provision is concerning, since HIV is not transmitted through casual contact in the working environment. However, the HIV response by the public sector is generally seen as a positive policy measure that the Government of Lesotho has put in place insofar as public servants are concerned. The authors have noted, however, that popularization of this policy among public officers across all Ministries/ Departments/Agencies is limited.

b) **Lesotho Defence Force (LDF) Act, No.4, 1996**

The LDF Act governs the relationship between the LDF and its employees—that is, members of the defence force. The Act does not explicitly refer to HIV as grounds on which one may be denied employment. However, it does refer to medical conditions of employment, medical examinations as a requirement of employment and the failure to succeed in the medical examination as a reason for denial of employment; by implication, and it seems in practice, this affects people living with HIV.²⁵⁹

Additionally, the LDF HIV and AIDS Policy, which deals with issues of deployment of HIV-positive persons already employed by the LDF, provides that all active duty members of the LDF “will be offered HIV testing every two years.” The policy wording implies that such testing is not mandatory, although it does provide for mandatory HIV testing for pregnant female members.

252 Key informant during this study.

253 Public Service HIV and AIDS Workplace Policy, Section 7.5.1, 2007.

254 Labour Code (Amendment) Act, (K), 2006.

255 Public Service HIV and AIDS Workplace Policy, Section 5, 2007.

256 Public Service HIV and AIDS Workplace Policy, 2007.

257 Ibid. Section 7.9.

258 Ibid.

259 Lesotho Defence Force Act, No.4, 1996.

Nevertheless, there have been reports of pre-employment HIV testing for purposes of admission to the armed forces over the years.²⁶⁰ The policy further provides for protection of confidentiality rights and states that no disclosure of the HIV status of a member of LDF may be made without the consent of the said member.

The importance of a prohibition on mandatory HIV testing of members of the armed forces, which could result in discrimination, is illustrated by the case of *Thabo Fuma v Lesotho Defence Force*, which shows the discrimination that may result from a member's HIV-positive status. The applicant had retired from the LDF on medical grounds in terms of Sec 24 of the LDF Act, after having been diagnosed as legally blind due to *HIV-related sequelae* and being recommended for retirement based on an inability to execute his duties. The Applicant's claim, amongst others, was that his right to equality and freedom from discrimination under sections 18 and 19 of the Constitution of Lesotho had been violated, due to actions that discriminated against him on the basis of his HIV status. The court found in favour of the Applicant, finding that his constitutional right to non-discrimination had been infringed by the Commander of the LDF and the Minister of Defence, and his right to human dignity had been violated by the inhumane treatment and by denying him a hearing before considering adverse decisions against him.

While the case does not illustrate HIV testing in the armed forces, it does indicate discrimination on the basis of a person's HIV status and is therefore cautionary for members of the armed forces. Clear policy guidance on the prohibition of HIV testing in the armed forces, save for voluntary HIV testing for purposes of access to HIV-related health care, would help towards safeguarding the rights of members of the armed forces.

4.5.2 Challenges

- There is limited knowledge of the Public Service HIV and AIDS Workplace Policy provision among public servants, making it difficult for employees to evoke the protective measures in the policy.
- There is provision for disclosure of a public officer's HIV status in the Public Service policy on the broad grounds of "public interest"
- There is lack of a clear prohibition against pre-employment or pre-deployment HIV testing in the LDF that would be in line with national efforts to prohibit HIV-related discrimination in the workplace.
- There are inefficient and ineffective implementation mechanisms for the provisions of the Policy on HIV and AIDS in the Workplace.
- There is poor implementation of HIV and wellness programmes in both private and public sector workplaces.

4.5.3 Recommendations for addressing employees' HIV-related rights

- Sensitise and raise awareness among public servants and make the Public Service HIV and AIDS Workplace Policy accessible.
- Review and clarify the protection of confidentiality in the Public Service HIV and AIDS Workplace Policy in conformity with related workplace policies at national,

²⁶⁰ ARASA, HIV/AIDS and Human Rights in Southern Africa, 2009.

regional and international level.

- Strengthen implementation, monitoring, evaluation and reporting mechanisms of the Policy on HIV and AIDS in the Workplace on the part of Ministries/Departments/Agencies.
- Encourage HIV wellness programmes in both private and public sector workplaces.

4.6 Populations at higher risk of HIV infection

4.6.1 Men who have sex with men (MSM)

Lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals are disproportionately affected by HIV. Although there are limited data available on HIV prevalence within MSM and LGBTI communities in Southern Africa, existing research shows that MSM in particular are at an increased risk of HIV infection in African countries.²⁶¹

Criminalization of consensual, private, same-sex activities between adults has its origins in the religious and moral censure of homosexuality. Virtually all Southern African jurisdictions, including Lesotho, inherited statutes in the form of penal codes that proscribed and punished same-sex relationships. Despite the lack of clarity on same-sex activities under customary law, there has been a tendency, particularly recently, to argue that same-sex sexuality is “un-African.” In the Botswana Constitutional court case of *Kanane v The State*,²⁶² the Court of Appeal interpreted the absence of penalization of same-sex activities under African customary law as evidence that such activities are not indigenous to Africa. The Court held that same-sex activities offend African morality, were introduced as part of a colonial importation and ought to be penalized in African settings.

In the context of HIV and AIDS, the criminalisation of same-sex sexual relationships has created barriers to national responses to HIV. The Global Commission on HIV and the Law concluded that “punitive laws, discriminatory and brutal policing and denial of access to justice for people with and at risk of acquiring HIV are fuelling the epidemic. These legal practices create and punish vulnerability. They promote risky behaviour, hinder people from accessing prevention tools and treatment, and exacerbate the stigma and social inequalities that make people more vulnerable to HIV infection and illness.”²⁶³

4.6.1.1 Position in Lesotho

LGBTI populations are also stigmatized and socially excluded in Lesotho. Research recognises that sexual minorities are at a very high risk of HIV infection with a self-reported HIV prevalence of 11.6 per cent (22/190).²⁶⁴ Thus, it can be argued that the limited “visibility” and information on LGBTI populations in Lesotho has led to further denial of their existence, resulting

261 Global Commission on HIV and the Law, ‘Men Who Have Sex With Men (MSM)’, 2012.

262 *Kanane v State* 2003 (2) BLR 67 (CA).

263 Global Commission on HIV and the Law Report, ‘Risks, Rights & Health’, 2012.

264 UNDP Report, 2011. Baral, S., ‘A cross sectional assessment of population demographics, HIV risks And Human Rights Contexts among men who have sex with men in Lesotho,’ *J Int AIDS Soc.* Jul 4 2006 (14), p36.

in limited recognition, or complete non-recognition, of their human rights in general. This stigma, discrimination and social exclusion, coupled with the populations being criminalised in law, results in severely diminished access to health care, impacting further on their vulnerability and risk.²⁶⁵ For instance, where their rights are violated, LGBTI populations are afraid to seek redress due to fear of discrimination and stigma, as well as due to the fact that they are criminalised in law. In the words of an FGD respondent from our assessment, LGBTI persons because of "...being discriminated against, tend to conceal their feelings, emotions and preferences."

Perspectives on stigma and discrimination of LGBTI

FGDs conducted for this assessment indicated that LGBTI experience discriminatory treatment from communities and service providers. MSM and transgender women reported verbal and physical abuse on the basis of their sexual orientation or gender identity. Discrimination MSM have experienced when accessing health care services includes denial of services, often when the identity of their sexual partner (same-sex partner) becomes known. However, note must be taken of the fact that this experience is not general across all health facilities. Exceptions include the Lesotho Planned Parenthood Association (LPPA) and some government health centres, where respondents explained that they have not been discriminated against on the basis of sexual orientation.

a) Criminal Procedure and Evidence Act, 1981

The Criminal Procedure and Evidence Act deals with the *consummation of a sexual relationship by men*. The prohibition on sodomy in Lesotho has been given a statutory flavour by Section 185 (5) of the Criminal Procedure and Evidence Act, which lists sodomy under Schedule 1 Part II of the Act as an offence for which arrests may be made without a warrant.²⁶⁶ The section provides that "any person charged with sodomy or assault with intent to commit sodomy may be found guilty of indecent assault or common assault, if such be the facts proved."²⁶⁷ However, unlike other former English Colonies or Protectorates (of which Lesotho was one), female same-sex acts have never been criminalised.

b) Penal Code, 2010

The Penal Code criminalises public indecency, which occurs either in the private or public spheres. It provides that "a person who creates or takes part in any indecent spectacle or performance, or who does in public or in private any indecent acts which is calculated to offend any reasonable member of the public, commits an offence."²⁶⁸ The common interpretation that had been given to this section includes the presumption that it includes sex between men. As a result, this has led to scholars arguing that sodomy is criminalised under the Code as a form of public indecency. Despite the fact that police data records between April 2010 and February 2012 show that there have been approximately 12 sodomy cases reported to the Police, there are no records of reports of consensual sodomy cases, which would in any event be difficult to investigate or even prosecute.

c) Sexual Offences Act (SOA), 2010

²⁶⁵ Global Commission on HIV and the Law, 'Risks, Rights & Health', 2012.

²⁶⁶ Criminal Procedure and Evidence Act, 1981.

²⁶⁷ Criminal Procedure and Evidence Act, Section 185(5), 1981.

²⁶⁸ Penal Code, Section 56, 2010.

Section 2 of SOA defines a sexual act as any “(a) direct or indirect contact with anus, breasts, penis, buttocks, thighs or vagina of one person and any other part of the body of another person”; by definition, sex between men would be encompassed in this definition. It further states that a “sexual act” between adults is unlawful only if it takes place under coercive circumstances. This suggests that in terms of the SOA, non-consensual sex between men is unlawful. By implication, it may be argued that the SOA does not explicitly criminalise *consensual* sex between men, implying this is not unlawful at least in terms of the SOA.

d) **Marriage laws and same-sex marriages in Lesotho**

The institution of marriage in Lesotho is governed by statutory and customary laws. The Marriage Act of 1974 defines marriage as “a union of one *man* with one *woman* [emphasis added], to the exclusion, while it lasts, of all others.”²⁶⁹ This definition excludes same-sex unions from civil marriage in Lesotho.

4.6.1.2 Challenges

- Criminalisation of same-sex relationships in terms of the Criminal Procedure and Evidence Act as well as a lack of clarity and harmonisation of additional, related sexual offence and penal laws with respect to same-sex sexual activity
- Prohibition on marriage between members of the same sex
- Lack of clear protection in the Constitution, laws and policies for equality and non-discrimination on the basis of sexual orientation and gender identity
- High levels of ongoing stigma and discrimination against LGBTI populations, impacting negatively on their access to health care services and the justice system
- Lack of awareness regarding the human rights of LGBTI populations

4.6.1.3 Recommendations for addressing MSM HIV-related rights

- Review and harmonise sexual offence laws with global best practices.
- Lobby for constitutional, legal and policy reforms with the view of promoting and protecting the human rights of all persons irrespective of their sexual orientation and gender identity.
- Adopt a rights-based approach with a view to promoting and protecting the human rights of LGBTI populations in order to reduce stigma and discrimination against them and promote universal access to health care and justice systems.
- Raise awareness on the human rights of LGBTI populations.

4.6.2 Sex work

Sex work and aspects of sex work are generally criminalized in many African countries,²⁷⁰ where criminal laws prohibit soliciting sex, living off of the earnings of sex work, keeping a brothel, procuring another person for sex work and coercing another person into sex. Often the

²⁶⁹ Marriage Act, Section 3, 1974.

²⁷⁰ UNAIDS, ‘Making the law work for the HIV Response: A Snapshot’, 2009.

laws purport not to criminalize sex work *per se* but rather the activities surrounding it, but the application of these laws results in *de facto* criminalisation of sex work.²⁷¹

Sex workers are stigmatised and discriminated against by society and subjected to harassment, violence and abuse. Furthermore, criminalization of sex work creates barriers to sex workers accessing health services to prevent the spread of STIs such as HIV.²⁷² As Ngwenya postulates, “fear of arrest, prosecution and imprisonment deters sex workers from accessing health care services and undermines HIV policies and prevention strategies premised on mobilising communities to participate in prevention and early treatment.”²⁷³ Some scholars argue that the police practices of using possession of condoms as evidence to support criminal charges in relation to sex work is a deterrent against using condoms in sex work and places sex workers at higher risk of HIV exposure.²⁷⁴ The Global Commission on HIV and the Law (GCHL) report confirmed that there is no legal protection from discrimination and abuse where sex work is criminalised.²⁷⁵ It creates opportunities for blackmail and violence, including rape by clients, “pimps” and even law enforcement officers. Complainants are unlikely to report crimes perpetrated against sex workers to law enforcement agencies for fear of secondary victimization.²⁷⁶ For example, evidence revealed that rape and assault are difficult to report when the sex worker fears that she will be arrested, and sexual violence heightens exposure to HIV.²⁷⁷

From a human rights perspective, criminalization of sex work implicates several human rights violations including the rights to health, self-determination, human dignity, privacy and equality.²⁷⁸ According to Ngwenya, the barriers to access to HIV-related health care services that criminalization of sex work creates detract from the duty of the State to fulfil the right to health. Limiting a person’s right to undertake sex work is an infringement of their right to privacy, liberty and self-determination.²⁷⁹ Additionally, the right to privacy is also at risk of violation in policing sex work-related charges since it may involve interfering in consensual adult sexual activities.²⁸⁰ Criminalising sex work furthermore violates the equality rights of sex workers and may also violate the rights of women, who are disproportionately impacted by sex work laws.²⁸¹

In the South African case of *Jordan*, the court said that the criminalisation of sex work in the SOA was unfairly discriminatory since it made sex workers (generally women) the primary offenders and regarded clients as accomplices, at most.²⁸² This reinforced sexual double standards and perpetuated gender stereotypes in a way that was argued to be impermissible in a society committed to advancing gender equality.

271 Ibid.

272 Global Commission on HIV and the Law, ‘Sex Workers’, 2012.

273 Charles Ngwenya, ‘Criminalisation of HIV in Africa’, 2011.

274 Ibid.

275 Global Commission on HIV and the Law, ‘Risks, Rights and Health’, 2012.

276 Ibid.

277 Ibid.

278 Global Commission on HIV and the Law, ‘Sex Workers’, 2012.

279 Charles Ngwenya, ‘Criminalisation of HIV in Africa’, 2011.

280 Ibid.

281 Ibid.

282 *Jordan and Others v The State* 2002 (6) SA 642 Constitutional Court.

4.6.2.1 Position in Lesotho

In Lesotho, like in many parts of the world, many young women (and some young men) engage in sex work as a means of escaping poverty and earning income to support themselves and their families.²⁸³ The UNGASS Report indicates that in Lesotho, the level of involvement of young women in sex work varies between those who engage in it on a full-time basis and those who engage in it only when they are in need of additional income or other practical support (e.g. for food, clothing or school fees for children).²⁸⁴

b) Roman-Dutch law

Roman-Dutch law, introduced during the era of British colonialism and commonly referred to as common law, made 'prostitution' a criminal offence; which, while not clearly defined, included the provision of sex, sexual stimulation or erotic services in exchange for cash or goods.²⁸⁵

c) Penal Code, 2010

The Penal Code repealed the common law offences applicable in Lesotho and created a statutory prohibition on sex work as a first schedule offence, in terms of s55. The Code defines a prostitute as a person who engages in sexual activity for payment. It provides that any person who incites, instigates or engages or procures another to engage in prostitution either in Lesotho or elsewhere commits an offence.²⁸⁶ Furthermore, it prohibits solicitation in public.²⁸⁷ Section 55 (3) of the Penal Code provides that "any person who lives habitually and or associates with a prostitute or is proved to have exercise control, direction or influence over other movement of prostitution, in such manner as to show aiding or compelling prostitution for commercial gain, commits an offence."²⁸⁸

a) Lesotho National HIV and AIDS Policy, 2006

The Lesotho National HIV and AIDS Policy of 2006 expressly acknowledges the importance of prioritising the needs of 'commercial sex workers' recognising their vulnerability to sexual violence and their marginalisation, which limits their access to health care services. The Policy recognises the importance of guaranteeing access to targeted confidential and user-friendly health services for sex workers and encouraging the participation of sex workers in HIV prevention. However, the policy does not recognise the criminalisation of sex work as an issue to be dealt with.

The Penal Code has broadened the elements and the definition of sex work, limiting the rights of those who practice sex work and impacting on access to both health and legal services for fear of victimization or even prosecution, as has been set out above.²⁸⁹ The GCHL report emphasises that criminalisation of sex work creates a climate in which civilian and police violence is rife and

283 Lesotho UNGASS Country Report, 2012.

284 Ibid.

285 Lesotho common law.

286 Penal Code, Section 55 (1), 2011.

287 Penal Code, Section 55 (2), 2011.

288 Penal Code, Section 55 (4), 2011.

289 Global Commission on HIV and the Law, 'Risks, Rights and Health', 2012.

legal redress for victims impossible.²⁹⁰ Thus, fear of arrest drives key populations (including sex workers) underground, away from HIV and harm reduction programmes.²⁹¹ Although findings from the FGDs conducted for the assessment indicate that most sex workers in Lesotho are fully aware of the risk of HIV transmission and usually insist on condoms, respondents stated that sometimes they have to give in to what the client wants (non-use of condoms), irrespective of the health risk to which they may be exposing themselves, as clients would be willing to pay a higher price in such circumstances.²⁹² This has been reiterated by the UNGASS Report, which has shown that “the offer of more money or the threat of violence will sometimes push one of these women not to insist on condoms.”²⁹³ Sex workers interviewed in this study have also reported that they face the constant threats of sexual and physical violence and abuse from clients and police.²⁹⁴ Additionally, they also endure high levels of stigma and discrimination when accessing HIV services from other health care providers.²⁹⁵

The UNDP Africa Regional Dialogue reported that some of the sex workers had “told stories of serious discrimination that they had faced from the abuse of official power: including from the conduct of some police officers in confiscating condoms or using such protections as evidence of illegal activities, thereby actually discouraging safer sex practices. Several sex workers described the demands of police officers for sex as the price sometimes extracted for release from official custody.”²⁹⁶

Further, the UNAIDS report noted with concern that sex workers and LGBTI persons in Lesotho are continually discriminated against, as they are considered immoral and to be engaging in illegal activities.²⁹⁷ In the absence of a human rights commission, as well as a national HIV and AIDS coordinating authority, these vulnerable populations have no institution advocating for their rights—especially given the weak civil society capacities and low levels of engagement with government and stakeholders.²⁹⁸

The GCHL reiterated that countries must ensure an effective, sustainable response to HIV that is consistent with human rights obligations, and must prohibit police violence against key populations, sex workers included. It also urged countries to support programmes that reduce stigma and discrimination against key populations and protect their rights.²⁹⁹

Currently, the focus of work with sex workers is on provision of health care and income

290 Ibid.

291 Ibid.

292 Focus group discussions in this assessment.

293 Lesotho UNGASS Country Report, 2012.

294 Focus group discussions in this assessment.

295 Ibid.

296 Ibid.

297 Lesotho UNGASS Country Report, 2012.

298 Ibid.

299 Global Commission on HIV and the Law, ‘Risks, Rights and Health,’ 2012.

generation. There are outreach programmes currently being implemented by non-governmental organisations (NGOs) such as the Lesotho Planned Parenthood Association (LPPA) and Care Lesotho/South Africa, in collaboration with the Ministry of Health, which are aimed at helping sex workers to transition to other ways of earning income, including provision of peer education and support interventions to strengthen sex worker's self-esteem and to help them avoid HIV infection.³⁰⁰ However, it is clear that more is needed to protect the rights of sex workers in Lesotho.

4.6.2.2 Challenges

- Criminalisation of sex work in Lesotho
- On-going stigma, discrimination, violence and abuse due to:
- Negative attitudes towards sex workers
- Inadequate legal protection for sex workers with respect to stigma, discrimination, violence and abuse perpetrated by clients, service providers (e.g. police and health care providers) and communities
- Lack of programmes that reduce stigma and discrimination against key populations amongst a range of stakeholders
- Lack of sufficient protective enforcement mechanisms for sex workers
- Poor awareness and understanding of the rights of sex workers on the part of law enforcement officers, judiciary lawmakers, Parliamentarians and relevant stakeholders

4.6.2.3 Recommendations for addressing issues around sex workers' HIV-related rights

- Strengthen legal and policy frameworks, create law enforcement training programmes and support services and create stigma- and discrimination-reduction programmes for appropriate stakeholders to protect the rights of key populations.
- Conduct awareness campaigns and sensitisation on the reduction of stigma, discrimination and harassment by service providers, including health care providers, and others in order to reduce discrimination and stigmatization against sex workers.
- Build capacity amongst law enforcement officers, judiciary lawmakers, Parliamentarians and relevant stakeholders regarding the human rights of sex workers and other key populations.

4.6.3 Prisoners

In the context of HIV, the rights to health and life of prisoners include ensuring access to HIV-related information, education and prevention (i.e. bleach, condoms and clean injecting equipment), voluntary HIV testing and counselling, confidentiality, 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.³⁰¹ The GCHL report echoes these recommendations, pointing out that there is a need for provision of necessary health care within prisons, including HIV prevention and care

³⁰⁰ Lesotho UNGASS Country Report, 2012, and key informant interviews in this assessment.

³⁰¹ UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights', 2006.

services, regardless of laws criminalising same-sex acts or harm reduction, including provision of condoms, comprehensive harm reduction services, voluntary and evidence-based treatment for drug dependence and ART. Any treatment offered must satisfy international standards of quality of care in detention settings. Health care services, including those specifically related to drug use and HIV, must be evidence-based, voluntary and offered only where clinically indicated.³⁰²

There is no public health or security justification for mandatory HIV testing of prisoners, nor for denying inmates living with HIV access to all activities available to the rest of the prison population. Prisoners with terminal illnesses, including AIDS, should be considered for early release and given proper treatment outside prison. Although inmates have restricted rights, they may have a range of reproductive health needs that need to be addressed to reduce the harm caused to that individual or to their community upon their release. Overcrowding abets the spread of opportunistic infections, and stress, malnutrition, violence and drugs weaken the immune system, making HIV-positive individuals within the correctional system more susceptible to getting ill.³⁰³ TB is also a major concern for prisoners, particularly those with HIV.

Imprisonment does not justify denial of the human rights to humane treatment and dignity and other basic rights.³⁰⁴ Detainees have a right to a standard of health care equivalent to that available outside of prisons, and prison authorities have an obligation to refrain from inflicting harm on prisoners; they owe a duty of care to prisoners that include the duty to protect the rights to health and life of all prisoners in their care. The European Court of Human Rights has consistently upheld the rights to health and life, which include adequate access to HIV prevention and health services, of all prisoners.³⁰⁵

4.6.3.1 Position in Lesotho

The revised National HIV and AIDS Strategic Plan 2012/13 - 2015/16 creates a greater focus on the needs of all key populations, including prisoners, in the national response to HIV. In Lesotho, a recent mode of transmission study found prisoners to be a key population at higher risk of HIV.³⁰⁶ The 2011 Lesotho Correctional Services (LCS) study showed a rapid escalation of HIV amongst prisoners. Of the prisoners participating in the study, 463 (or 17 per cent) within LCS facilities at the time identified themselves as HIV positive. During this assessment, respondents in the FGD believed that they had become HIV positive from sex between men while in prison.³⁰⁷ HIV rates among detainees are estimated to be two to 50 times those of general adult populations for various reasons including sex, sexual assault, tattooing with homemade and unsterile equipment, drug use and needle sharing.³⁰⁸

a) Lesotho Correctional Service (LCS) Strategic Plan on HIV and AIDS 2009-2014

The LCS Strategic Plan provides for prevention, treatment, care and support and impact

302 Global Commission on HIV and the Law, 'Risks, Rights and Health,' 2012.

303 Ibid.

304 Ibid.

305 African Charter on Prisoners' Rights, 2003.

306 Lesotho Correctional Service, HIV Zero-Prevalence And Behavioural Study, 2011.

307 Focus group discussion of inmates in Maseru.

308 Lesotho Correctional Service, HIV Zero-Prevalence and Behavioural Study, 2011.

mitigation for HIV and AIDS within the correctional system. Under treatment, care and support, the LCS plans to strengthen its health care services, support adherence to ART on various levels and increase protection and support for vulnerable populations within the prison population, particularly female prisoners, prisoners with disabilities, and adolescents and young adults in detention.³⁰⁹ Under impact mitigation, the plan commits the LCS to providing additional support to staff and their families affected by HIV, and in particular for orphans of deceased correctional officers. Finally, the plan proposes the on-going provision of condoms and other commodities to prevent HIV transmission and to maintain the sexual and reproductive health of both prisoners and staff; to provide life skills and vocational training opportunities to prisoners and to improve recreational opportunities that may reduce sexual activity; to provide on-going, appropriate HIV education and awareness interventions; to encourage confidential and voluntary HIV testing and counselling for prisoners, staff and recruits; to reduce overcrowding; to improve sanitation systems; and to improve policies and procedures for infection control. Despite uncertainty in laws relating to the criminalisation of sex between men, a positive development is the provision of condoms to prisoners within the correctional services.

b) **LCS Health and Social Welfare Policy**

The LCS Health and Social Welfare Policy addresses health issues such as HIV, amongst other policy objectives. Through information provision and education it promotes voluntary testing, safe blood transfusions and promotes behaviour change to reduce HIV transmission.

c) **LCS HIV Policy**

The LCS has an HIV policy that promotes, amongst others:

- The routine provision of HIV information and education to prisoners and staff within facilities, on admission to prison and during the training process for new recruits
- Making available quality-assured, confidential and voluntary HIV testing and counselling services both within facilities for inmates and staff, and through partnerships with external service providers
- Ensuring the on-going availability of condoms and other commodities to prevent HIV transmission amongst inmates and to reduce the incidence of other STIs
- The increased availability of life skills programmes, vocational training opportunities and recreational programmes to discourage sexual activity and to prevent rape and other forms of sexual coercion³¹⁰

Prisoners and staff interviewed for our assessment identified various challenges despite current policies, including the fact that the requirements for effective ART, including adherence and proper nutrition, were not fully provided for within facilities. Procedures used by staff, including searches and lockups, disrupted ART regimens. Nutritional requirements were rarely, if ever, addressed.³¹¹ They also identified ongoing behaviour within prisons that places people at risk of HIV exposure, including sex between men, overcrowding in cells, poor and inadequate

³⁰⁹ Lesotho Correctional Service Strategic Plan on HIV and AIDS 2009-2014.

³¹⁰ Lesotho Correctional Service HIV and AIDS Policy, 2009.

³¹¹ Lesotho Correctional Service, HIV Sero-Prevalence and Behavioural Study, 2011.

washing and sanitation facilities and the exchange of sharp objects, such as razors used for shaving and haircuts and needles used for tattooing and some traditional healing rituals.³¹² The lack of appropriate infection control procedures and equipment, including gloves to avoid exposure to blood and other bodily fluids, masks to avoid exposure to airborne infections such as TB and isolation facilities for inmates with highly contagious illnesses, was reported as placing staff at risk.

However, respondents described that the positive aspect of prisons is that condoms are available free-of-charge for inmates and staff in all facilities, although shortages or stock outs occur frequently.³¹³

More generally, it was noted that the lack of a specific HIV programme within LCS gives rise to confusion and mistrust regarding its commitment to respond to HIV and to show a commitment to supporting staff and prisoners under the care of the LCS.³¹⁴

4.6.3.2 Challenges

- Despite an enabling policy framework, there is the need to strengthen the implementation of the LCS HIV Policy, including through improved access to HIV testing and counselling, preventing the spread of HIV within prisons and improving access to ART.

4.6.3.3 Recommendations for addressing prisoners' HIV-related rights

- The LCS should effectively implement and enforce its policies and plans on HIV and AIDS. In particular there is said to be a need for intensified voluntary testing and counselling and prevention, treatment and care services including: information, education and communication; HIV testing and counselling, treatment, care and support; prevention, diagnosis and treatment of TB; condom programmes and the prevention and treatment of STIs.

4.6.4 Migrant Workers

In 2005, there were approximately 191 million migrants globally, a figure that has more than doubled since 1960; migrants now constitute almost 3 per cent of the world population. The movement of migrants can be for a few days, months, or years.³¹⁵ The GCHL has urged countries to offer the same standard of protection to non-citizen migrants, visitors and residents as they do to their own citizens in matters relating to HIV and AIDS.³¹⁶ Countries are further encouraged to repeal travel and other restrictions that prohibit people living with HIV from entering a country

312 Key informant interview from Lesotho Correctional Service.

313 Lesotho Correctional Service, HIV Zero-Prevalence And Behavioural Study, 2011.

314 Key informant interview with Lesotho Correctional Service officer.

315 United Nations Department of Economic and Social Affairs, Trends in Total Migrant Stock: The 2005 Revision, POP/DB/MIG/Rev.2005/DocFebruary2006, 2005.

316 Global Commission on HIV and the Law, 'Risks, Rights and Health', 2012.

and/or regulations that mandate HIV tests for foreigners within a country.³¹⁷

4.6.4.1 Position in Lesotho

In Southern Africa, including Lesotho, some of the major causes of migration have been poverty, conflict, war and apartheid policies. As with the rest of Southern Africa, Lesotho has a long history of internal and external migration. Traditionally, migrant labour has been a male preserve, with men constituting the majority of migrant workers largely employed in South African mines.³¹⁸ While mobility and migration increase the number of concurrent sexual partners as well as individual vulnerability, they also shape the distribution of the epidemic and the rate at which the epidemic spreads.³¹⁹ In Lesotho, while government remains the major source of formal employment, the other sources of formal employment are the textile factories and mines in neighbouring South Africa.³²⁰

In 2013, the Government of Lesotho adopted the Lesotho National Migration and Development Policy.³²¹ The Policy stresses the importance of aligning migration –related policy, legislative and institutional interventions to achieve developmental outcomes with international and regional standards and comparative benchmarks.³²² For example, the Policy also points out that context and gender –sensitive protection should be extended to women who migrate or are affected by migration. The Policy further indicates that a dedicated policy framework is required, which indicates group- specific and context sensitive responses in relation to various internal migration streams: (rural- urban migration – including women who have migrated to urban areas to take up employment in the garment industry, ii) child mobility within Lesotho and across borders; and (iii) households that compulsorily have had to migrate as a result of major development projects³²³ such as the Highlands Water Project.

On the issue of migration and HIV epidemic in Lesotho, the Government recognises rural-urban mobility as a contributing factor to the spread of HIV/AIDS as well as the highly vulnerable, often marginalised position of migrant populations, which face a lack of access to information and services. The Plan seeks to ensure that migrants access HIV and AIDS services for prevention, treatment, care and support, and provides a framework for the promotion of HIV outreach services for male and female sex workers.³²⁴

At least 60 per cent of migrant workers in the Lesotho textile factories come from other parts of the country.³²⁵ The UNGASS report shows that HIV prevalence amongst textile workers, where 88 per cent are women, is 40.1 per cent.³²⁶ As a result of interventions by Apparel Lesotho

317 Ibid.

318 Wilson, D., 'Lesotho and Swaziland: HIV/AIDS assessments at cross-border and migrant sites in Southern Africa', FHI, USAID, IMPACT, 2002 p9.

319 Revised National Strategic Plan on HIV and AIDS 2012/13-2015/16.

320 Lesotho UNGASS Country Report, 2009.

321 Lesotho National Migration and Development Policy, 2013

322 Lesotho National Migration and Development Policy, 2013

323 Lesotho National Migration and Development Policy, 2013

324 National HIV Prevention Strategy for Multi- Sectoral Response to the HIV Epidemic in Lesotho – 2011/12- 2015/16

325 UNGASS Report, 2009.

326 Ibid.

Alliance to Fight AIDS (ALAFA) on programmes regarding the reduction of stigma and behaviour change within the textile industries, it is reported that there has been a greater rate of consistent condom use, a lower frequency of sexual relations with non-regular partners and a lower frequency of multiple and concurrent partnerships.³²⁷ The imminent closure of ALAFA due to financial challenges is likely to have a negative impact on textile workers, as the Government of Lesotho does not have specific programmes targeting this population and Lesotho will likely lose gains that were made through ALAFA interventions.

While migrant remittances have had a positive impact on the economy of Lesotho and have contributed significantly to the income of rural households, migrant labour has been identified as one of the key drivers of the HIV epidemic.³²⁸

Chiefs and villagers in Lesotho's rural areas report that the sexual behaviour of men working outside their home areas differs significantly from that of men who stay home with their families, due to increased freedom and decreased subjection to their home communities' disapproval. The wives of these migrant workers are therefore exposed to a higher incidence of STIs and HIV. These women may also have extramarital relationships while their husbands are away, placing each spouse at risk of exposure to HIV.³²⁹

As for cross-border migrant workers, Lesotho is working with its SADC partners to harmonize HIV-related protocols and data collection tools.³³⁰ As of 2010, Lesotho became part of other SADC countries harmonizing and coordinating approaches to HIV, other STIs and TB.³³¹ This initiative was aiming at ensuring that wherever migrant labourers seek out HIV-related services, a basic package of interventions is always available.³³² Further, another aim of this initiative is to ensure that data collection and analysis related to mobile populations is standardized so that the impact of the cross-border initiative can be monitored and additional evidence-based interventions developed and implemented.³³³

a) **National HIV and AIDS Policy, 2006**

The National HIV and AIDS Policy of 2006 recognizes population mobility and rural-urban migration as key drivers of the HIV epidemic. It provides a guiding framework for the development of strategies to ensure that mobile populations, including marginalized segments of the mobile population, can access HIV-related services. Nonetheless, there has been poor implementation of these strategies, which has resulted in migrant workers being left behind in HIV programming.

4.6.4.2 Challenges

- The government does not have specific legislation addressing HIV-related issues

327 Ibid.

328 Nthunya, M., 'The Study of Farm and Mine Workers in Lesotho', 2000.

329 Family Health International, 'Lesotho and Swaziland: HIV AND AIDS Risk Assessments at Cross-border and Migrant Sites in Southern Africa', 2001.

330 Lesotho UNGASS Country Report, 2012.

331 Ibid.

332 Ibid.

333 Ibid.

among migrant workers.

- Successful programmes such as ALAFA are externally funded and not subsumed into government programming and so are not sustainable.
- A lack of programmes or interventions directed at communities and migrants' family members regarding consistent condom use, HIV testing and counselling, general knowledge on HIV infection and the vulnerabilities of migrant workers to exposure to HIV.
- Poor coordination and effective collaboration between Lesotho and other SADC countries on intergovernmental programmes on issues related to migrant worker populations and HIV.

4.6.4.3 Recommendations for addressing migrant workers' HIV-related rights

- Develop, review and strengthen legal and institutional frameworks to give effect to Lesotho's Migration and Development Policy
- The government must have specific programmes on HIV and AIDS issues for migrant workers.
- Conduct advocacy campaigns on HIV information, consistent condom use, HIV testing and counselling and general knowledge about HIV infection and the vulnerabilities of migrant workers to exposure to HIV.
- Expand/develop programmes like ALAFA within the private sector, but funded through the government budget.
- Strengthen effective collaboration between Lesotho and other SADC countries regarding intergovernmental programmes on HIV and AIDS in relation to migrant worker populations.

4.7 Access to Health Care Services

Access to HIV prevention, treatment, care and support is the most effective strategy for HIV prevention and for improving the quality of life for those already living with and affected by HIV. Laws, regulations, policies and guidelines need to provide equitable access, without discrimination, to HIV-related health care services in order to ensure effective responses to HIV and in particular should prioritise access by vulnerable and key populations.

Patent law is a key factor affecting access to treatment. Patents often restrict access by creating protections on drugs that 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, meaning that poor patients cannot afford and therefore access essential medicines. The TRIPS Agreement enforces intellectual property rights, such as patents; however the TRIPS flexibilities or provisions allow countries to balance intellectual property protection with public health needs (by, for example, allowing countries to access generic medicines). These flexibilities must, however, be implemented into national law to have any effect. In the 2001 Declaration on the TRIPS Agreement and Public Health (the "Doha Declaration"), the WTO Ministerial unequivocally affirmed that the TRIPS Agreement "does not

and should not” prevent WTO Members from taking measures to protect public health.³³⁴

In an effort to address the issue of access to treatment in Southern Africa, in 2012 SADC Member States met to discuss, amongst others, the World Trade Organization’s (WTO) Agreement and its impact on access to medicines, challenges and options for the SADC Region and to deliberate on “Pharmaceutical Patents, TRIPS Flexibilities and Access to Medicines in SADC.” The meeting resulted in the development of action plans for national implementation, especially on maximizing the TRIPS flexibilities within the TRIPS Agreement, avoiding TRIPS plus measures and dealing with various intellectual property (IP) rights issues impacting on access to medicines.

4.7.1 Position in Lesotho

Health law in Lesotho is outdated and does not deal specifically with HIV and AIDS, access to HIV-related health care and/or patients’ individual rights. The Health Order of 1970 fails to provide legal direction with regard to issues such as consent to HIV testing, confidentiality of HIV status and other patient rights.

The National HIV and AIDS Policy of 2006 does however protect the rights to voluntary HIV testing and to confidentiality and notes specific instances where disclosure may be beneficial, for example, beneficial disclosure by health care workers, notably between patient and sexual partner, next of kin or guardians while maintaining confidentiality.³³⁵ The Policy notes that it is only in exceptional cases where a properly counselled HIV-positive person refuses to disclose his or her status to sexual partners that the health care provider may be permitted to notify those partners without the consent of the source client in line with established protocols.³³⁶ This appears to be in keeping with constitutional guarantees to the right to a private life and to personal liberty, with limitations of this right only where justifiable. It is also in keeping with guidance from the UNAIDS *International Guidelines* and the SADC PF Model Law’s recommendations regarding disclosure of HIV status to a sexual partner at risk of infection, in certain circumstances and provided certain steps take place.

Access to HIV-related health care is set out in the Lesotho National HIV and AIDS Strategic Plan 2011/2012 – 2015/2016. The Plan provides for HIV-related prevention, treatment (including free ART), care and support services and prioritises the needs of key populations (men who have sex with men, sex workers, inmates and migrant workers) as well as vulnerable populations (people with disabilities, orphaned and vulnerable children, herd boys, women and girls, people living with HIV and mobile populations).

In terms of intellectual property rights and access to medicines, the government of Lesotho has in place various laws and policies dealing with access to medicines. The Industrial Property Order of 1989 provides for patents to manufacturers and extends to pharmaceutical products. Where medicines are no longer patent protected, Lesotho is able to rely on generic manufacturers based in different countries like China, India and Southern African countries.

334 Doha Declaration on the TRIPS Agreement and Public Health, 2001.

335 National HIV and AIDS Policy, 2006, under Beneficial Disclosure.

336 Ibid.

In addition, health policies have made provisions for free medication for various populations, including people living with HIV, and the public health system or social health insurance schemes provide free medicines for particular conditions like HIV. The National Medicines Policy provides an important enabling environment for opportunities to access medicines. It regulates the price of essential medicines to keep costs down. The Policy also prohibits restrictive patent laws to increase access to medicines.³³⁷

Lesotho is a Member of WTO and as such is a party to the TRIPS Agreement. However, due to its WTO status as a least-developed country, it does not yet have an obligation to adhere to the full range of TRIPS provisions until at least 2021. Despite this, the intellectual property (IP) laws applied in Lesotho prior to the commencement of TRIPS remain in force, and the full range of TRIPS flexibilities have not been incorporated into these national laws. Lesotho, like many least-developed countries, lacks the resources and expertise to independently implement and evaluate their treaty obligations in the fashion that will be best benefit them. The Intellectual Property Order No. 5 of 1989 and Copyright Order No. 13 of 1989, despite being amended in 1997, is still not in conformity with the TRIPS Agreement. Lesotho needs to update its legislation to incorporate TRIPS flexibilities, and has the transition period (until 2021) to become fully TRIPS compliant. In addition, the Medicines Bill, intended to provide universal access to medicine, remains in draft form.

The lack of a fully enabling legislative framework around IP remains a barrier to making optimal use of TRIPs flexibilities in order to contribute to innovation and to promote public health. Lesotho has begun the process of developing an IP policy that will lead to revised laws. Although no new legal provisions have yet been developed, several sensitization meetings on IP rights organized by the Ministry of Trade and Industry have been held in the country.³³⁸ Most recently, in August 2014, workshops on access to medicines (focusing on IP law reform but also on procurement and manufacturing) were held in Lesotho and were jointly hosted by the Government of Lesotho, UNDP and the Southern African Regional Program on Access to Medicines (SARPAM).

Perspectives on access to HIV treatment and care

According to key informants in our assessment, access to HIV-related treatment and care has improved significantly with the advent of free medication.³³⁹ There are approximately 87,352 people currently on ART.³⁴⁰ However, 150,000 require ART, and this assessment found that participants of both the KIIs and FGDs still noted access to health facilities (particularly in rural areas) and treatment as concerns.³⁴¹ FGDs with various populations, in particular key populations, also raised issues around discriminatory treatment from health service providers, which deters them from going to clinics to access health care and treatment.³⁴²

337 National Medicines Policy, 2008.

338 Lesotho UNGASS Country Report, 2012.

339 Key informant interview.

340 Revised National Strategic Plan on HIV and AIDS 2012/13–2015/16.

341 Lesotho UNGASS Country Report, 2012.

342 Focus group discussions in Leribe.

4.7.2 Challenges

- Although access to affordable HIV-related medicines has been made universal, implementation has not been universal, and challenges with regard to availability of those medicines in all health centres remain.
- Key populations report barriers to access to health care services due to stigma and discrimination
- Legislative and policy reforms to increase access to medicines have been slow to take place. IP laws in Lesotho do not contain TRIPS flexibilities, including the transition period for least-developed countries to become fully TRIPS compliant and the Medicines Bill remains in draft form.

4.7.3 Recommendations for addressing access to health care services

- Ensure the implementation of programmes to increase access to HIV-related health care across the country
- Sensitise health care providers on the rights of key populations to non-discriminatory access to health care services
- Enact the long overdue Medicines Bill intended to provide universal access to medicines.
- Given that the process to review IP laws has begun, Lesotho is at a critical point. Lesotho should update its IP legislation to incorporate TRIPS flexibilities.

4.8 Access to Justice

Access to justice is critical to creating strengthened legal and regulatory frameworks for effective HIV responses. The GCHL's *Risks, Rights & Health* discusses the importance of taking steps to improve access to justice and law enforcement in relation to HIV and AIDS.³⁴³ The recommendations note that there is a "need to not only enact protective and repeal punitive laws, but also to create stronger mechanisms to implement and enforce laws."³⁴⁴ 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."³⁴⁵ Furthermore, the report shows that protective laws cannot, on their own, create an enabling environment for people living with HIV and key populations at higher risk of HIV exposure. It urges that in order to strengthen the legal frameworks at the national level, laws and policies need to be accessed, implemented and enforced by sensitized judiciary and law enforcement agents.³⁴⁶

The UNAIDS 2006 *International Guidelines on HIV/AIDS and Human Rights* also recommend various forms of support to improve access to justice and law enforcement in the context of HIV, including legal support services, education and awareness and the strengthening of monitoring and enforcement mechanisms.³⁴⁷ Guideline 8 mandates States to implement and support

343 Global Commission on HIV and the Law, 'Risks, Rights and Health,' 2012.

344 Ibid.

345 Global Commission on HIV and the Law, 'Risks, Rights and Health,' 2012, p10.

346 Ibid.

347 UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights,' 2006.

legal aid 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.³⁴⁸

4.8.1 Position in Lesotho

The Government of Lesotho has put in place institutions and bodies intended to advance access to justice; namely, the Lesotho Constitution provides for an independent judiciary subjected only to the Constitution and other laws of Lesotho.³⁴⁹ The judiciary consists of the following levels of courts:

- The Court of Appeal
- The Constitutional Court
- High Court
- The Subordinate's/Magistrate's courts
- The Judicial Commissioner's Court
- The Local/Basotho Courts

The Court of Appeal is the highest court of the land. It is the final appellate court for all matters, including matters emanating from both the Constitutional Court and the High Court. The High Court is vested with powers to handle all matters and hears appeals from both the Subordinate's and the Judicial Commissioner's Courts. In addition, the High Court sits as court of first instance in all matters that are above the jurisdictional powers of the Subordinate's Courts. It is presided over by the Chief Justice or any other judge of the High Court.

The Constitutional Court is the court of first instance for all constitutional law matters. It is a division of the High Court and a constitutional matter must be heard by at least three judges of the High Court. There are 10 magistrate's courts located in each district of Lesotho. These courts have limited jurisdiction for lower value civil claims and less serious criminal charges. They also handle the initial stages of remanding suspects into custody. The head of the magistracy is the Chief Magistrate.

There are also a number of lower tribunals intended to address specific claims, including the Small Claims Court, Directorate of Disputes Prevention Resolution, the Land Tribunal, Children's Court, the Labour Court and the Commercial Court. All appeals from these courts also go to the High Court.

Barriers to accessing these courts include distance to and difficulties locating the courts. The Court of Appeal, Constitutional and High Courts are all located in the districts of Maseru. However, access to these courts is not easy, neither by foot nor by car, due to their location.³⁵⁰ Furthermore, a study conducted by the Federation of Women Lawyers (FIDA) in Lesotho found

348 Ibid. Guideline 8.

349 Lesotho Constitution, 1993.

350 Pholo, M., 'Lesotho Justice Sector and the Rule of Law,' AfriMAP and the Open Society Initiative for Southern Africa, 2013.

that a lack of road signs contributes to difficult access to these courts.³⁵¹ In addition, although the magistrate's courts are located in each district of Lesotho, they are inaccessible to those who live in remote rural areas in the country's mountainous terrain since these residents must travel long distances and pay high transports fees to access these areas.³⁵² On a par with the Magistrate's court is the Judicial Commissioner's Court, which is in Maseru and has rotational sittings within the districts. However, the Lesotho Justice Sector and Rule of Law study indicated that the limited information available to direct people to particular courts where sessions are to be held also impedes access to the justice system.³⁵³

Access to justice in Lesotho is also impeded by financial barriers. Although court fees in Lesotho are low and therefore unlikely to deter many people from taking their matters to court, most people cannot afford legal fees to pay private lawyers. This is particularly an issue for matters that are instituted in the higher courts like the High Court, Constitutional Court and the Court of Appeal, all of which require legal representation because of the complex procedures followed in these courts.³⁵⁴

An additional barrier to access to justice is that the quality of legal representation is often poor. Although most civil society organisations do provide victim support services, including legal aid services in the form of support interventions for victims of domestic violence and human rights violations, lack of financial and human capacity limit the support they are able to provide.

Perspectives on barriers to access to justice

- **Lengthy delays:** Lesotho has put in place various measures aiming to ensure that all people have access to justice. However, in our assessment, participants of the FGDs with key populations indicated that access to justice remains a huge challenge, particularly with the barrier of lengthy delays. For example, prisoners described that cases often take a long time before they are finalised. Some of the prisoners had been in custody for more than 2 months, but their trials had not yet commenced, irrespective of the provisions of Speedy Courts Trial Act (SCTA) of 2003. The SCTA was enacted in order to address delays that occur in judicial processes. Section 3 (1) of the Act states that, "any charge against a person must be filed within 48 hours of his or her arrest."³⁵⁵ Further, section 4 of the same Act provides that "a person should not be remanded in custody for a period exceeding 60 days."³⁵⁶ However, discussions with prisoners interviewed during this assessment revealed that postponements of their cases without good cause had caused their cases to be prolonged beyond the period allowed by law. Most of them felt that they were being punished for acts they did not commit in having to remain in

351 FIDA- Lesotho, 'Report on a Research on Court Systems Effectiveness for Lesotho Justice Sector Development Programme', 2004.

352 Pholo, M., 'Lesotho--Justice Sector and the Rule of Law,' AfriMAP and the Open Society Initiative for Southern Africa (OSISA), Open Society Foundations (OSF), 2013.

353 Ibid.

354 Ibid.

355 Speedy Courts Trial Act, Section 3 (1), 2003.

356 Speedy Courts Trial Act, Section 4, 2003.

custody while awaiting trial for unreasonably long periods of time.³⁵⁷

- **Lawyers' lack of engagement in HIV-related cases:** Information from practicing lawyers interviewed under this study indicates that they rarely deal with HIV-related matters in practice.³⁵⁸ However, there are some lawyers who do *pro bono* cases in relation to HIV-related matters.³⁵⁹
- **General mistrust of justice system:** Members of LGBTI populations and other vulnerable key populations reported feeling alienated and intimidated by the justice system and court proceedings due to poor administration and limited commitment of State counsels.³⁶⁰ Further, they also indicated that general mistrust of the justice system results in few people bothering to access formal justice services, instead turning to religious leaders and groups for support.³⁶¹
- **Low level of awareness of HIV-related law and human rights issues:** In a KII with a representative from the Ministry of Health, the respondent noted that there is limited information available on the extent to which the general public and key populations are aware of HIV-related law and human rights issues and able to access remedies for HIV-related human rights violations.³⁶² Data from the FGDs with sex workers and LGBTI persons indicated that people are not aware of their HIV-related rights and that there is generally limited awareness of law and rights, as well as of legal support services, remedies and procedures amongst members of the public.³⁶³

4.8.2 Institutions and bodies

A research report on access to justice further indicates that other concerns relating to access to justice concern the existing mechanisms in Lesotho. The absence of a human rights commission or similar institution makes it difficult for aggrieved persons, including key populations and people at high risk of HIV exposure, to bring complaints regarding human rights violations.

a) **The Office of the Ombudsman**

The Constitution provides for an Ombudsman to assist people to deal with complaints against the public service. The Ombudsman has the power to investigate corruption in the public service and assist people whose constitutional rights have been affected, as well as to take up a case to declare a law unconstitutional. The Ombudsman may potentially play an important role in supporting people living with HIV and other affected populations in remedying violations of their rights, as well as in challenging unconstitutional laws and policies. It may also assist people affected by HIV to challenge any HIV-related discrimination they experience in their dealings with the public service.

357 Focus group discussion with prisoners.

358 Key informant interviews with practicing lawyers.

359 E.g. V.V.M. Kotelo & Co.

360 Focus group discussions with sex workers and LGBTI groups.

361 Ibid.

362 Key informant interview with a representative from the Ministry of Health.

363 Focus group discussions with sex workers and LGBTI groups.

However, although the Office of the Ombudsman is mandated to address maladministration, corruption, injustice and violation of human rights, the fact that this office is only located in Maseru makes it difficult for people outside of Maseru to access it. In addition, information regarding the office, e.g. its location or purpose, is poorly disseminated among the general public.

b) The police service

The Constitution of Lesotho also makes provisions for the police service, which assists in investigations and arrests of perpetrators for all criminal cases that are reported. However, there is limited capacity in law enforcement agencies regarding human rights approaches that would allow them to appreciate the challenges facing people living with HIV and key populations at risk of HIV exposure when it comes to accessing justice.

In addition, there is limited research that specifically explores the experiences of people living with HIV and key populations at higher risk of HIV exposure at the hands of law enforcement officials. Research on access to justice indicates that delays and backlogs in bringing cases to justice in Lesotho very often start with the police, with delays in the investigation of cases.³⁶⁴

Perspectives on the police service and access to justice

Participants of FGDs with key populations during this assessment reported experiences of bribery, corruption and harassment by the police.³⁶⁵ For example, sex workers reported that the police assault them, making it difficult to report any criminal act for fear of re-victimization by the police. This was reiterated by the police officer interviewed in a KII, who indicated that through her office (the Child Gender Protection Unit), they have heard reports of police assaults against sex workers, even though she could not prove whether those reports are true or false:

I have heard that the police usually arrest sex workers, assault and rape them. But I am not sure whether those reports about assaults and rape are true or not. What I know is that when sex workers are arrested, they are usually removed from the streets and are charged with the offence of loitering, which is prohibited under Criminal Procedure and Evidence Act, 1981.

4.8.3 Challenges

- Barriers to complainants (including people living with HIV and those at higher risk of exposure) accessing the courts, including the location of and distance to the courts, coupled with difficulties locating the courts due to inadequate signage and directions.
- Financial barriers related to the high legal fees for private lawyers, who are needed to handle the complex procedures of the courts
- Poor and/or limited legal representation, given civil society organisations' limited provision of legal aid due to financial and human resource barriers; civil society organisations do not have any government funding and as a result are not able to provide legal aid for HIV-related complaints.

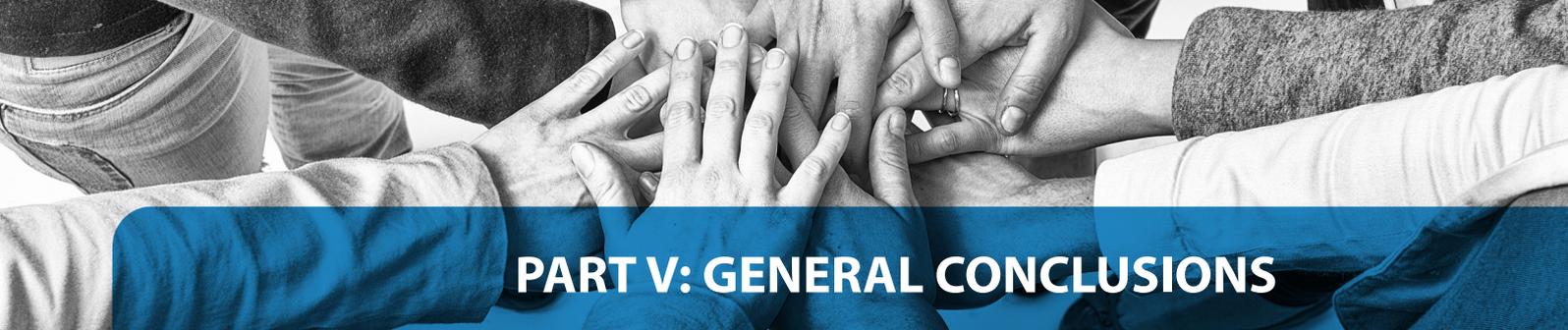
³⁶⁴ Chaka-Makhooane, L. 'In search of Justice: Where do women go?' Women and Law in Southern Africa Publication, 2000.

³⁶⁵ Focus group discussion in this assessment.

- Lengthy delays in cases being tried despite the SCTA
- General mistrust of the justice system by people living with HIV and key populations
- Low levels of awareness of HIV-related law and human rights, as well as legal support services and procedures
- Poor access to the Office of the Ombudsman for people outside of Maseru, where the office is located, as well as a lack of knowledge about the Office and its function
- Low awareness on the part of law enforcement of the challenges facing people living with HIV and key populations.
- Intimidation limiting access to the justice sector system—most key populations still experience human rights abuses, such as being verbally or physically harassed by law enforcement, and are afraid to access legal aid because of threats by law enforcement authorities.

4.8.4 Recommendations for addressing access to justice and HIV-related rights

- Speed up the establishment of a human rights commission to ensure necessary protection of human rights for all people, including people living with HIV and vulnerable and key populations.
- Advocate for the promotion and protection of the human rights of key populations by law enforcement authorities so that these populations are able to seek legal redress where necessary.
- Strengthen the justice system and sensitise the judiciary on key human rights issues affecting people living with HIV and other vulnerable and key populations.
- Decentralise legal support services to increase access to all, including people living with HIV and key populations at higher risk of HIV exposure.
- Encourage private lawyers to take cases, including HIV-related complaints, *pro bono* to support those who cannot afford high legal fees.
- Support civil society organisations to provide legal aid support for HIV-related complaints.
- Raise awareness and undertake education on the rights of people living with HIV and key populations with the affected populations, as well as with law enforcement officials.



PART V: GENERAL CONCLUSIONS

Southern Africa is continuing to bear the burden of the HIV epidemic, with Lesotho recently moving into second position globally.^[366] The intersection of HIV, on the one hand, and people living with HIV and vulnerable and key populations at high risk of HIV exposure, on the other, has brought the issue of an enabling legal and regulatory framework for HIV to the fore.

What this assessment has shown is that although there are over arching protections of the human rights of all people in Lesotho as set forth in the Constitution as well as in legislation for specific sectors (such as rights in the workplace) and populations (such as children), HIV-specific legislation and protections are limited. Specific protection against discrimination on the basis of HIV status is not included in the Constitution. There are furthermore limited HIV-specific protections in law, although there is a protective HIV policy and national plan. . Furthermore, the findings in this assessment have shown that where HIV-related legislation exists, it has rarely been evoked or enforced.

Attempts to address some systematic barriers related to HIV are evident in the current legal and policy environment in Lesotho, e.g. to increase access to treatment and strengthening protection for children's rights and employee's rights. Nonetheless, specific challenges facing people living with HIV and key populations—namely, stigma and discrimination; criminalisation of non-disclosure of HIV status; gender inequality contributing to women and girls' risk of exposure; human rights violations of LGBTI populations, sex workers, prisoners, and migrant workers; and poor access to justice—are in urgent need of attention in law.

With regard to access to justice, the LEA found that awareness of HIV-related human rights was low amongst people living with HIV, key populations, judiciary, and law enforcement officials. In addition, most law enforcement agencies did not have the capacity to address issues affecting people living with HIV and vulnerable and key populations. Access to justice is also crippled by physical barriers, such as distance to the courts and inadequate signage, as well as financial barriers to engaging legal counsel.

Thus, the justice system is currently not able to yield the results that promote and protect the rights of people living with HIV and key populations in an effective manner. Policy and legal frameworks should create an environment that allows key populations and others at risk of HIV exposure, the necessary protection of the law and advancement of their human rights.

366 UNAIDS, 'The Gap Report', 2014.



PART VI: RECOMMENDATIONS

Current laws in place do not adequately address challenges related to HIV, especially with regard to protecting the rights of people living with HIV and vulnerable and key populations. The following actions are therefore recommended:

Law and Policy Development, Review and Reform:

Laws and policies must be developed, updated, reviewed, strengthened and/or enacted to protect and promote the human rights of people living with HIV and key populations at higher risk of HIV exposure and to promote universal access to HIV-related health care services. This should include:

- ***Strengthening anti-discrimination in law on the basis of HIV and AIDS by, for example:***
 - o Mainstreaming HIV in related laws and policies to address equality and non-discrimination on the basis of HIV status or AIDS
 - o Considering an amendment to the Constitution to explicitly include HIV status as a prohibited ground for discrimination;
 - o Reviewing the Penal Code provision providing for broad criminalisation of non-disclosure of HIV status
 - o Developing prosecutorial guidance on the application of criminal laws applicable to HIV, including s52 of the Penal Code and s32 of the Sexual Offences Act, to ensure the provisions are applied in a manner that is (i) guided by the best available scientific and medical evidence relating to HIV, (ii) uphold the principles of legal and judicial fairness (including key criminal law principles of legality, foreseeability, intent, causality, proportionality and proof) and (iii) promote equality and non-discrimination and protect the human rights of those involved.
- ***Eradicating gender inequality, harmful gender norms and gender based violence and strengthen the rights of women and girls in law and policy by, for example:***
 - o Including the equality rights of women and girls in the context of HIV, in all related laws; Including non-discrimination on the basis of sex, gender or gender identity in (e.g. the proposed review of the Constitution of Lesotho, Enacting domestic violence legislation which also addresses intimate partner violence)
 - o Reviewing the Marriage Act of 1974 and Laws of Lerotoli to create a uniform age of consent to marriage with that set out in the Children's Protection and Welfare Act, 2011 and Convention on the Rights of the Child (18 years)
 - o Reviewing the inconsistencies between the age of consent to medical treatment and HIV testing with those relating to age of consent to sexual activity
 - o Reviewing and reforming inheritance laws to promote equality in inheritance for

women, girls, men and boys

- o Developing regulations for the effective implementation of the Anti-Trafficking in Persons Act, 2011
- o Strengthening policies and procedures to provide for broader access to post-exposure prophylaxis and to furthermore provide for comprehensive referrals between health care, legal and law enforcement services for survivors of sexual violence and other gender-based violence *to ensure access to appropriate information regarding sexual and reproductive health and rights, HIV testing and counselling services, post-exposure prophylaxis, treatment and support with laying a complaint.*
- **Promoting the rights of all employees to non-discrimination in the working environment**
 - o Reviewing and clarifying the protection of confidentiality in the Public Service HIV and AIDS Workplace Policy to prohibit unreasonable disclosures of a public officials HIV status
- **Strengthening the rights of key populations to equality and non-discrimination:**
 - o Recognising the equality and health rights of key populations such as men who have sex with men, sex workers, migrants and prisoners in HIV related laws including the right to non-discrimination on the basis of sexual orientation and gender identity in general anti-discrimination legislation
 - o Considering an amendment to the Constitution to explicitly include sexual orientation and gender identity as a prohibited ground for discrimination;
 - o Review and harmonise the Sexual Offence Law with other global best practices.
- **Strengthening access to health care, including access to treatment**
 - o Updating intellectual property laws to incorporate TRIPS flexibilities in the Medicines Bill, to increase universal access to affordable medicines
- **Reducing Stigma and Discrimination and Strengthening Access to Justice**
 - o Conducting Awareness Raising, Education and Stigma and Discrimination Reduction Campaigns
 - o Conducting stigma and discrimination campaigns country wide, including at community level, to reduce stigma and discrimination against people living with HIV and all vulnerable and key populations
 - o Sensitising traditional and religious leaders to recognize and uphold the rights of people living with HIV, vulnerable and key populations
 - o Conducting awareness raising campaigns on the rights of women and girls to gender equality and to be protected from harmful gender norms and gender-based violence
 - o Raising the awareness of the sexual and reproductive health rights of young people

amongst parents and service providers

- o Raising awareness amongst employers and employees, including public officials and members of the uniformed services, of HIV-related rights in the working environment, including the rights to non-discrimination, voluntary HIV testing and confidentiality.
- o Training and sensitising parliamentarians, members of the judiciary, police and health and social welfare providers to recognize and uphold the human rights of people living with HIV and vulnerable and key populations.
- o Programmes should be put in place to provide legal services to key populations so that they know their rights and applicable laws and can be supported to access the justice system when aggrieved.

- **Strengthening Access to Justice**

- o Sensitising the judiciary, prosecutors and legal practitioners, including through the development of prosecutorial guidance, to respond to HIV-related complaints, including workplace-related HIV discrimination and criminal law matters, before the courts
- o Strengthening and decentralising legal support services for people living with HIV, vulnerable and key populations, including through the encouragement of private lawyers to take on *pro bono* cases and support to civil society to provide legal support
- o Establishing a human rights commission to protect human rights in the context of HIV, amongst other things

Improved law enforcement for people living with HIV, vulnerable and key populations

- **Strengthening Law Enforcement through**

- o Sensitising law enforcement officials on the rights of people living with HIV, vulnerable and key populations to prohibit human rights violations and to support appropriate enforcement of existing human rights and constitutional guarantees
- o Train law enforcement officials on the rights of survivors of sexual violence to sexual and reproductive health care services and appropriate and timely referrals.

In addition, there are instances where improved implementation, monitoring and evaluation of existing policies and plans is required in order to strengthen universal access to HIV-related prevention, treatment, care and support services for people living with HIV, vulnerable and key populations. Recommendations from the LEA include:

- Implementing programmes to increase access to HIV-related prevention, treatment, care and support, particularly for vulnerable and key populations
- Strengthening the provision of health care services for migrant workers
- Strengthening the implementation, monitoring, evaluation and reporting of workplace HIV policies in the private and public sectors
- Strengthening the implementation, monitoring, evaluation and reporting of

correctional services HIV programmes

- Strengthening the implementation of the National Action Plan on Women, Girls and HIV and AIDS
- Conducting further research on the link between intimate partner violence and HIV
- Developing and implementing rights-based comprehensive indicators to measure responses to gender-based violence



REFERENCES

1. Administration of Estates Proclamation No.19, 1935.
2. African Charter on the Rights and Welfare of the Child, 1990.
3. African Charter on Human and People's Rights, 1986. Available at: www.achpr.org/instruments/achpr
4. African Charter on Prisoners' Rights, 2003.
5. Ahmed, A., 'Property and Inheritance Laws: The Impact on Women and OVC in the Context of HIV,' Global Commission on HIV and the Law Working Paper, 2011.
6. Anti-Trafficking in Person's Act, Act No.1, 2011.
7. ARASA, 'HIV/AIDS and Human Rights in Southern Africa,' 2009.
8. Burris, S., and Cameron, E., 'The Case against Criminalization of HIV Transmission.' JAMA, 300 (5), 2008, pp578-81.
9. Chaka-Makhooane, L., et al. Sexual Violence in Lesotho. The Realities of Justice for Women, Morija Printing, Lesotho, Women and Law in Southern Africa Research and Education Trust, 2002.
10. Chaka-Makhooane, L., 'In search of Justice: Where do women go?' Women and Law in Southern Africa Publication, 2000.
11. Children's Protection and Welfare Act No. 7, 2011.
12. Committee on Economic, Social and Cultural Rights, 'General Comment 14: The Rights to the Highest Attainable Standard of Health E/C.12.2000/4 (2000).
13. Committee on the Convention on the Rights of the Child, 'General Comment 3: HIV/AIDS and the Rights of the Child,' 2003.
14. Committee on Economic, Social and Cultural Rights, 'General Comment 20: Non-Discrimination in Economic, Social and Cultural Rights,' E/C.12/GC/20 25, May 2009
15. Committee on the Women's Convention, General Recommendation 24, 'Women and Health,' UN GAOR Doc. No. A.54/38/Rev.1.
16. Convention on the Elimination of All Forms of Discrimination against Women, 1993-2009.
17. Criminal Procedure and Evidence Act, 1981.
18. Doha Declaration on the TRIPS Agreement and Public Health, 2001. Available at: www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm
19. Family Health International, 'Lesotho and Swaziland: HIV AND AIDS Risk Assessments at Cross-border and Migrant Sites in Southern Africa,' 2001.
20. Farrell, N. and Kuhn J, (2001) 'Has Mbeki heard of Nuremberg?' Mail and Guardian, December 7 to 13.
21. FIDA- Lesotho, 'Report on a Research on Court Systems Effectiveness for Lesotho Justice Sector Development Programme,' 2004.
22. Fox, K., et al., 'Adolescent Consent to HIV Testing: A Review of Current Policies and Issues in Sub-Saharan Africa,' World Health Organization Report, 2013.
23. Gender Links, 'Southern Africa Development Community Protocol on Gender and Development Barometer,' 2013.
24. Global Commission on HIV and the Law, 'Report of the Africa Regional Dialogue of the Global Commission on HIV and the Law,' 2011. Available at www.hivlawcommission.org
25. Global Commission on HIV and the Law, 'Risks, Rights and Health, 2012. Available at

- www.hivlawcommission.org
26. HIV/AIDS and Human Rights, (1998) International Guidelines HR/PUB/98/.
 27. Human Rights Committee, 'General Comment No. 20,' 1992.
 28. Inheritance Act 26, 1873.
 29. International Covenant on Civil and Political Rights (ICCPR), 1976.
 30. International Covenant on Economic, Social and Cultural Rights (ICESCR), 1976. Available at: www.un-documents.net/icescr
 31. International Labour Organisation, 'Recommendations on HIV and the World of Work 200,' 2010.
 32. International Planned Parenthood Federation, Qualitative Research on legal barriers to young people's access to sexual and reproductive health services, 2014. Available at www.ippf.org
 33. Jackson, Helen. AIDS Africa: Continent in Crisis, SAfAIDS, Harare, 2002.
 34. Kasozi, George W.K.L., Introduction to Law of Lesotho, 1999.
 35. Labour Code (Amendment) Act, 2006.
 36. Land Act, 2010.
 37. Laws of Lerotholi, 1903.
 38. Legal Capacity of Married Persons Act, 2006.
 39. Lesotho African Peer Review Mechanism (APRM) Report,' 2008.
 40. Lesotho Cabinet Office, 'Independent Sector Institutional Assessment of the HIV and AIDS Sector Report,' December 2012.
 41. Lesotho Census Report,' 2006.
 42. Lesotho Constitution, 1993.
 43. Lesotho Correctional Service HIV and AIDS Policy, 2009.
 44. Lesotho Correctional Service, HIV Zero-Prevalence and Behavioural Study, 2011.
 45. Lesotho Correctional Service Strategic Plan on HIV and AIDS 2009-2014.
 46. Lesotho Demographic and Health Survey, 2009
 47. Lesotho Modes of Transmission Report,' 2009.
 48. Lesotho National HIV and AIDS Strategic Plan 2011/12-2015/16
 49. Lesotho UNGASS Country Report, 2009.
 50. Lesotho UNGASS Country Report, 2012.
 51. Lesotho Universal Periodic Review Mechanism,' 2013.
 52. Letuka, P., et el., Gender, HIV and the Law in Lesotho: Embracing Rights-Based Approach to Realise Sexual and Reproductive Health in Lesotho, LSA Publication, Morija, 2008.
 53. Letuka, P., et el., Family Belonging for Women in Lesotho, Morija Printing Works, Morija, 1998.
 54. Likoti F.J., Obioha E.E., Matobo T.A., Tanga P.T., and Manyeli T.F., 'Lesotho CGPU Evaluation Report,' 2007.
 55. Marriage Act, 1974.
 56. Ministry of Health and Social Welfare (MOHSW), 'Lesotho Demographic and Health Survey,' 2009.
 57. National Action Plan on Women, Girls and HIV and AIDS, 2012-2017.
 58. National Behaviour Change Communication Strategy (2008- 2013).
 59. 'National Commitments and Policies Instrument Report,' 2012.
 60. National Gender and Development Policy, 2003
 61. National HIV and AIDS Policy, 2006.
 62. Ngwenya, C., 'Criminalisation of HIV in Africa,' 2011.
 63. Ngwenya, C., 'Early Marriages in Southern African Countries,' 2011.
 64. Nthunya, M., 'The Study of Farm and Mine Workers in Lesotho,' 2000.
 65. Penal Code, 2010.

66. Petition No. 409 of 2009, High Court of Kenya at Nairobi.
67. Pholo, M. 'Lesotho Justice Sector and the Rule of Law: A review by AfriMAP and the Open Society Initiative for Southern Africa,' Open Society Foundations, 2013.
68. Report of the Seychelles Legal Environment Assessment of HIV and AIDS,' 2013. Report of the Special Rapporteur on Health: Informed Consent,' 2009.
69. Revised Lesotho National HIV and AIDS Strategic Plan 2011/12 – 2015/16.
70. Revised National Strategic Plan on HIV and AIDS 2012/13- 2015/16.
71. Southern African Development Community (SADC) Gender and Development Protocol, 2008.
72. Sexual Offences Act, 2003.
73. 'Stigma Index Report,' 2014.
74. South Africa Constitution, 1996.
75. Southern African Development Community Model Law, 2012.
76. The Convention on the Rights of the Child (CRC), 1989. Available at: www.unicef.org/crc
77. UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights,' 2006.
78. UNAIDS, 'Ending Overly Broad Criminalisation of HIV Non-disclosure, Exposure and Transmission: Critical Scientific, Medical and Legal Considerations,' 2013.
79. UNAIDS, 'Getting to Zero HIV in Eastern and Southern Africa,' 2013.
80. UNAIDS, 'Global Report: UNAIDS report on the global AIDS epidemic,' 2013.
81. UNAIDS/IPU, 'Handbook for Legislators on HIV/AIDS, Law and Human Rights' 1999
82. UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights,' 2006.
83. UNAIDS, 'The Gap Report,' 2014.
84. UNAIDS, 'UNAIDS Terminology Guidelines,' 2011.
85. UNAIDS and UNDP, 'Policy Brief: Criminalization and HIV transmission,' 2013. Available at http://data.unaids.org/pub/BaseDocument/2008/20080731_jc1513_policy_criminalization_en.pdf
86. UNDP, UNAIDS, WHO, Policy Brief, 'Using TRIPS flexibilities to improve access to HIV treatment,' 2011. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2049_PolicyBrief_TRIPS_en.pdf
87. UNFPA, 'Rapid Assessment on Sexual and Gender Based Violence and Food Insecurity in Lesotho,' 2010.
88. United Nations, 'Compilation of UN info for the second cycle of the Universal Periodic Review (UPR) mechanism: Lesotho,' 2013.
89. United Nations (UN) Committee on the Rights of the Child, Comment 3.
90. United Nations Department of Economic and Social Affairs, 'Trends in Total Migrant Stock: The 2005 Revision, OP/DB/MIG/Rev.2005/DocFebruary2006, 2005.'
91. Universal Declaration of Human Rights (UDHR), 1948. Available at: www.un.org/en/documents/udhr/
92. Wait, M. 'The Criminalisation of HIV Exposure and Transmission: A Global Review.' Working Paper prepared for the Third Meeting of the Technical Advisory Group, Global Commission on HIV and the Law, 7-9 July, 2011.
93. Wilson, D. 'Lesotho and Swaziland: HIV/AIDS assessments at cross-border and migrant sites in Southern Africa,' FHI, USAID, IMPACT, 2002.
94. World Bank, 'Legal Aspects of HIV and AIDS,' 2007.



Annexure 1: National Policies, Laws and Regulations

a) National policies

- » Behaviour Change Communication in Lesotho: National Behaviour Change Communication Strategy (2008-2013)
- » Draft Gender and Development Policy, 2014
- » Draft Implementation Plan of Gender and Development Policy, 2008-2010
- » Lesotho National HIV Prevention Strategy, 2011-2016.
- » National Action Plan on Women, Girls and HIV and AIDS, 2012-2017
- » National Gender and Development Policy, 2003
- » National Health Policy, 2010
- » National Medicines Policy, 2008
- » National HIV and AIDS Policy, 2006
- » National Strategic Development Plan, 2011/12-2015/16,
- » Orphans and Vulnerable Children's Policy, 2005
- » Public Service Workplace HIV and AIDS Policy, 2007
- » Revised Lesotho National HIV and AIDS Strategic Plan 2011/12–2015/16
- » Revised National Strategic Plan on HIV and AIDS 2012/13-2015/16
- » Vision 2020

b) National laws and regulations

- » Administration of Estates Proclamation No.19, Section 3 (b), 1935
- » Anti-Trafficking in Person's Act, Act No.1, 2011
- » Children's Protection and Welfare Act, 2010
- » Criminal Procedure and Evidence Act, 1981
- » Draft HIV and AIDS Bill, 2006
- » Education Act, 2010
- » Inheritance and Property Laws (Civil and customary),
- » Inheritance Act 26, 1873.
- » Labour Code (Amendment Act), 2006
- » Labour Code Order, 1992
- » Land Act, 2010.
- » Laws of Lerotholi, 1903.
- » Legal Capacity of Married Persons Act, 2006
- » Lesotho Constitution, 1993
- » Marriage laws (Customary and civil),
- » Penal Code, 2010
- » Sexual Offences Act, 2003
- » Speedy Courts Trial Act, 2003.
- » Anti-Trafficking in Persons Act, 2011



Annexure 2: List of Key Organisations Interviewed

Organizations
ADAAL
ALAFA
Baylor College of Medicine – Children’s Foundation Lesotho
Blue Cross
Ex-miners Association
High Court
Informative Newspaper
Law Enforcement Officials
Lesotho Council of NGOs (LCN)
Lesotho Planned Parenthood Association (LPPA)
Magistrate
Masters of Healing
MATRIX Support Group
Ministry of Health
Ministry of Home Affairs
Ministry of Justice and Correctional Services
Ministry of Law, Human Rights & Constitutional Affairs
Ministry of Social Development
NUL
Prosecution
SWALEES
V.M Kotelo & CO
WLSA



Annexure 3: Research Participant Groups

Focus group discussions

Chiefs

Community councilors

Community health caregivers

Elderly people

Lactating mothers

People living with HIV and AIDS

Religious leaders

Traditional healers

Youth

Key populations

LGBTI

Prisoners

Sex workers

Women



Annexure 4: List of Members of the Technical Working Group

Names	Organisation
Ms. Puleng Letsie	UNAIDS
Mr. Boshepha Ranthithi	LENEPWA
Mr. L. Mkorosi	Law Reform Commission (R)
Ms. M. Mohasi	FWL
Ms. 'Mamosa Mohlabula- Nokana	WLSA
Mr. Tampose Mothopeng	Matrix Support Group
Mr. Mojela Mafike	LIRAC
Ms. Poloko Phakoa	Assistant Researcher
Ms. Mabolae Mohasi	FIDA Lesotho
Mr. Phoka Scout	Correctional Services



Annexure 5: List of domestic legal frameworks

- Administration of Estates Proclamation No.19, 1935
- Criminal Procedure and Evidence Act No. 9, 1981
- Education Act No. 3, 2010
- Inheritance Act, 1873
- Labour Code order 24, 1992 as Amended
- Land Act No.8, 2010
- Laws of Lerotholi, 1903
- Lesotho Constitution, 1993
- Lesotho Correctional Services HIV Policy, 2009
- Lesotho Defence Force Act No.4, 1996
- Marriage Act No.10, 1974
- National Gender and Development Policy, 2003 (currently under review)
- National HIV and AIDS Policy, 2006
- National Medicines Policy, 2008
- Penal Code No. 6, 2010
- Sexual Offences Act No. 29, 2003



Annexure 6: List of cases

- Baitsooli & another v. Maseru City Council & Others C of A (Civ) No.4/05 (CA) (unreported)
- Director of Private Prosecutions v. Ts'oenyane & Others CR 299/99 (unreported)
- Hoffmann v South African Airways 2001 (1) SA 1 (Constitutional Court of South Africa)
- Jordan and Others v. The State 2002 (6) SA 642 Constitutional Court
- Kanane v. The State 2003 (2) BLR 67 (CA)
- Kathang Tema Baitsooli & Another v. Maseru City Council & Others Constitutional Case 1/2004(HC) (unreported)
- Makuto v State (2000) 5 LRC 183 (Court of Appeal of Botswana)
- Minister of Health and Others v. Treatment Campaign and Others 2002 (10) BCLR 1033 (Constitutional Court of South Africa)
- Molefi v. Government of Lesotho 1967-1970 LLR 237(CA)
- Purohit and another v. The Gambia, African Commission on Human and Peoples' Rights, Comm. No. 241/2001 (2003)
- R vs Mohale CRI/S/4/2005 (unreported)
- Rex vs Tšotleho Thulo CRI/S/04/2013
- S v. Chapman 1997 (3) SA (SCA) 341 at 345 A-D
- Senate Gabashane Masupha v His Worship, Senior Magistrate for the Subordinate Court of Berea & 10 Others Constitutional Case No. 5, 2010
- Tšepe v. Independent Electoral Commission and Others (C of A [Civ] No. 11/05 CC 135/05) (unreported)