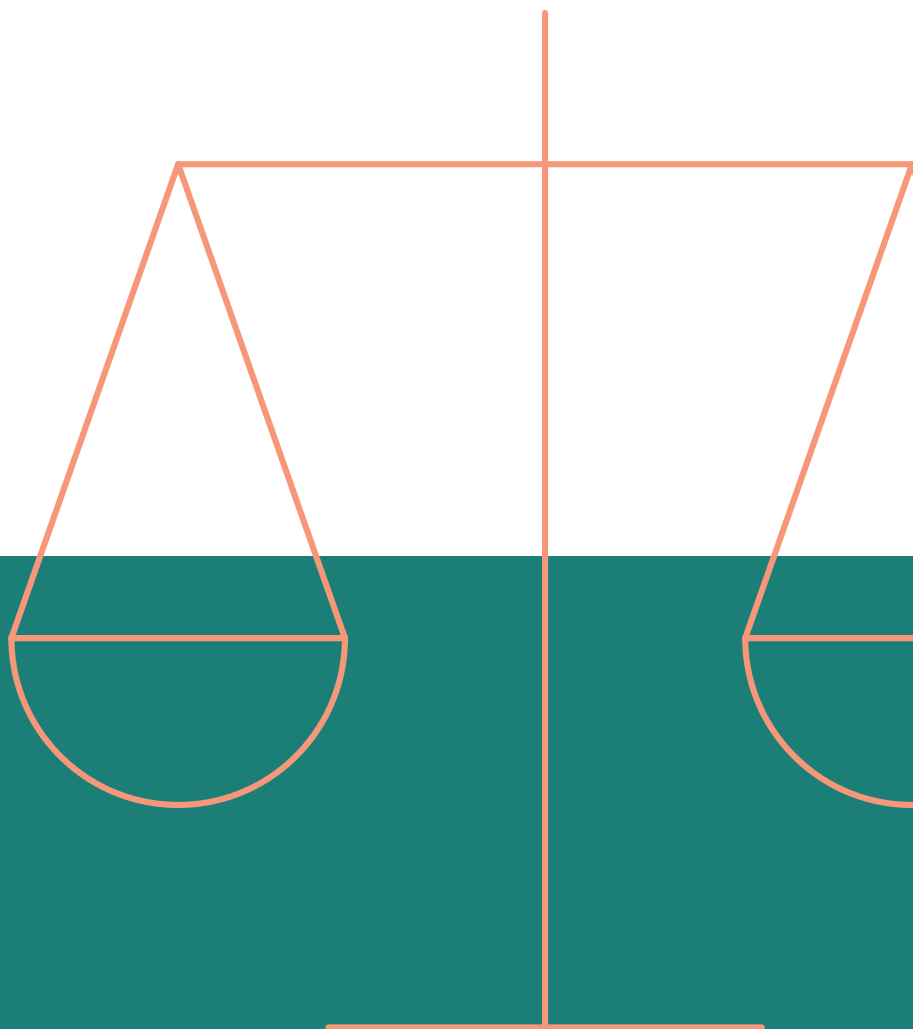




*Empowered lives.  
Resilient nations.*

# Zambia

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



Linking Policy to Programming (LPP) is a regional project seeking to improve sexual and reproductive health outcomes for young key populations in five Southern African Development Community countries – Angola, Madagascar, Mozambique, Zambia, Zimbabwe. The project aims to accomplish this through strengthening the HIV and sexual and reproductive health related rights of young key populations in law, policy and strategy. UNDP implements the project, in partnership with the African Men for Sexual Health and Rights (AMSHeR), and the Health Economics and HIV/AIDS Research Division (HEARD) of the University of KwaZulu-Natal. Funding is provided by a five-year grant (2016 to 2020) from the Netherlands Ministry of Foreign Affairs through its Leave No One Behind initiative. For more information, visit: <http://www.africa.undp.org/content/rba/en/home/about-us/projects/linking-policy-to-programming.html>

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# Contents

<b>Foreword</b>	<b>6</b>
<b>Acknowledgements</b>	<b>7</b>
<b>Abbreviations and Acronyms</b>	<b>8</b>
<b>Executive Summary</b>	<b>10</b>
Equality and Anti-Discrimination	12
Health Laws and Policies	12
Adolescents and Young People	12
LGBTI Populations	13
Sex Workers	13
People Who Use Drugs	14
Inmates	14
Criminalisation of HIV Transmission	15
Employment	15
Education and Information	15
Social Welfare	15
Women, Gender Inequality and GBV	15
Access to Justice	16
<b>Part I: Introduction</b>	<b>18</b>
Country Context	19
Background to the LEA in Zambia	20
Objectives of the Legal Environment Assessment	22
Implementation Modalities/Research Methodology	22
Method 1: Desk Review	22
Method 2: Key Informant Interviews and Focus Groups Discussions (FDGs)	23
Key Deliverables	23
The Situational Analysis: HIV, TB and Human Rights In Zambia	24
HIV, AIDS and TB in Zambia	24
The National Response in Zambia The National HIV/AIDS/STI/TB Council	26
National AIDS Strategic Framework 2017-2021 (NASF 2017-2021)	27

<b>Part II: International, Regional, and National Human Rights Framework</b>	<b>30</b>
The International Perspective	31
Human Rights Standards and State Obligations relating to HIV, TB and SRH	34
Limitation of Rights	36
The Application of Specific Human Rights in The Context of HIV and AIDS in Zambia	36
Right to Health, Education, Employment and Social Protection	37
Right to Privacy	37
Right to Personal Liberty	37
Freedom from Torture and Degrading Treatment	38
Rights of Accused Persons	38
Equality Before the Law	38
Freedom of Expression, Association and Assembly	38
<b>Part III: Assessment of Laws, Regulations, Policies &amp; Plans</b>	<b>40</b>
Equality/Anti-Discrimination Law and Policy	41
HIV- and TB-Related Stigma and Discrimination in Zambia	41
Health Laws, Policies and Plans	43
Access to Non-Discriminatory HIV, TB and SRH Prevention, Diagnosis, Treatment and Care	44
Informed Consent to HIV Testing and Treatment	50
Confidentiality	53
Regulation of Health Service Providers and Professionals	56
Adolescents and Youth	58
Child Marriage	59
Sexual Violence and Exploitation of Children and Young People	61
Limited Access to Sexual and Reproductive Health Information and Services	63
Lesbian Gay Bi-Sexual Transgender Intersex (LGBTI) Populations	68
Stigma and Discrimination Against LGBTI Populations	68
Sex Workers	76
Stigma, Discrimination and Human Rights Violations	77
People Who Inject Drugs	81
Access to Health Care Services	81
Inmates, Including Young Inmates	87
Imprisonment of Young Inmates	88
Access to Health for Inmates, Including Young Inmates	92
Criminalisation of HIV Transmission and Exposure	95
Employment	97
Stigma and Discrimination in the Workplace	97
Occupational Health and Safety	99
Education and Information	101
Social Welfare	104
Women, Gender Equality and Gender Based Violence	106

<b>Part IV: Access to Justice and Law Enforcement in Zambia</b>	<b>110</b>
Awareness of HIV, Law and Human Rights and of Legal Remedies Available	111
Legal Support Services	111
Law Enforcement	114
The Police	114
The Correctional Service	116
<b>Part V: Conclusions and Recommendations</b>	<b>118</b>
Equality and Anti-Discrimination	119
Health Laws and Policies	119
Adolescents and Young People	119
LGBTI Populations	120
Sex Workers	120
People Who Use Drugs	121
Inmates	121
Criminalisation of HIV Transmission	122
Employment	122
Education and Information	122
Social Welfare	122
Access to Justice	123
<b>End Notes</b>	<b>124</b>
<b>References</b>	<b>128</b>
List of Documents Reviewed and Referenced	129
<b>Annexures</b>	<b>136</b>
Annexure 1: Consultation Framework	137
Annexure 2: Key Informants	138
Annexure 3: Focus Group Discussions	139

# Foreword

Zambia has embarked on an ambitious agenda of ending HIV and AIDS by 2030 through adoption of a wide array of policies aimed at increasing access to all HIV services for all populations. Of particular concern to the Government of the Republic of Zambia are adolescents and young people who remain key to the fight against HIV and AIDS because of their vulnerability to HIV infection due to inadequate targeted services as well as an enabling legal environment.

The National HIV/AIDS/STI/TB Council (NAC) in the recent past provided technical input in the development of both regional and national documents seeking a greater inclusion of marginalized populations that have been left behind in the response. NAC's corroborative efforts with the United Nations Development Programme (UNDP) enabled the organization to take part in the development of the SADC Regional Strategy For HIV Prevention, Treatment And Care And Sexual And Reproductive Health And Rights Among Key Populations including the identification of barriers to health access in Zambia through the Sexual Orientation and Gender Identity Rights Project.

The inclusion of Zambia into the Regional Linking Policy and Programming (LPP) Project provided an opportunity to engage with different policy makers as well as institutions in the fight against HIV at a regional level. Thus, the findings from the report have facilitated the identification of key legal and social priority areas to focus on as we combat HIV and AIDS. National laws, policies, strategies and plans remain key to ensuring that the health rights of all populations are protected particularly community members who are most vulnerable to HIV such as young female sex workers. Strengthening partnerships with civil society and community members shall facilitate a comprehensive understanding of the various health needs of young key populations.

As we develop a roadmap towards implementation of the findings in the report, it remains cardinal to include the beneficiaries of these services during both planning and implementation of any interventions in order to achieve maximal impact. Continuous dialogue among the various line ministries shall guarantee a combined effort in the fight against HIV and AIDS as well as facilitate for a common understanding of the issues at hand which include gaps in both law and policy. Empowering young people to be more aware of their health rights shall enable them to reduce the various HIV risks and promote uptake of services.

I would like to thank the various partners, line ministries and stakeholders who participated in the development of this document particularly the community members who came forward to share their stories in order to enrich the findings. Of utmost importance is the support received from UNDP to facilitate the LPP Project within the region and as a country, we are highly grateful for this.

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We express our deep sense of gratitude to our esteemed YKP key informants, focus group participants and key informants for informing the findings and recommendations of this report.

We acknowledge the generous financial support from the Government of Netherlands, Ministry of Foreign Affairs.

Finally, it's our sincere hope that this edition of the Zambia Legal Environment Assessment will further contribute towards the reduction of HIV risk and reproductive health of young key populations in Zambia and the Southern African Development Community as a whole.

# Abbreviations and Acronyms

ACRWC	African Charter on the Rights and Welfare of the Child
AMSHer	African Men for Sexual Health and Rights
ART	Antiretroviral therapy
AU	African Union
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHAZ	Churches Health Association of Zambia
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSE	Comprehensive Sexuality Education
DOTS	Directly Observed Treatment Strategy
ESA	East and Southern Africa
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
IMR	Infant mortality rate
LEA	Legal Environment Assessment
LGBTI	Lesbian, gay, bisexual, transgender and intersex persons
MCP	Multiple concurrent partnerships
MDR-TB	Multi drug-resistant tuberculosis
MMR	Maternal mortality rate
MOH	Ministry of Health
NASF	National AIDS Strategic Framework
NAC	National AIDS Council
NELMP	National Employment and Labour Market Policy
NHSP	National Health Sector Strategic Plan
NSC	National Steering Committee
NSP	Needle and syringe exchange programmes
OHS	Occupational Health and Safety
OST	Opioid substitution therapy
PEP	Post-exposure prophylaxis
PHC	Primary Health Care
PMTCT	Prevention of mother-to-child transmission of HIV
PrEP	Pre-exposure prophylaxis
SADC	Southern African Development Community
SADC PF	Southern African Development Community Parliamentary Forum
SALC	Southern African Litigation Centre
SDGs	Sustainable Development Goals
SOGI	Sexual orientation and gender identity
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights



<b>STI</b>	Sexually Transmitted Infection
<b>TB</b>	Tuberculosis
<b>TRIPs</b>	Trade-Related Aspects of Intellectual Property Rights
<b>UDHR</b>	Universal Declaration of Human Rights
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV & AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNGASS</b>	United Nations General Assembly
<b>UNICEF</b>	United Nations Children's Fund
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>VDPA</b>	Vienna Declaration and Programme of Action
<b>VMMC</b>	Voluntary medical male circumcision
<b>WHO</b>	World Health Organization
<b>ZAMPHIA</b>	Zambia Population HIV Impact Assessment
<b>ZDHS</b>	Zambia Demographic Health Survey

# Executive Summary

The protection and promotion of human rights and gender equality for people living with HIV, vulnerable populations and key populations, including young key populations, is critical to successful responses to HIV, TB and sexual and reproductive health.

Zambia has signed and ratified a number of international and regional human rights treaties that commit to protecting the rights of all persons, particularly vulnerable populations; Zambia also includes the protection of human rights as a central tenet of its national Constitution. The Constitution provides all persons with the right to equality and non-discrimination, life, privacy, liberty, association and assembly, health, fair labour practices, social protection and freedom from torture or degraded treatment, amongst other things; these rights are important for people in the context of health, human rights and gender equality.

In addition, Zambia has enacted a number of laws, policies, strategies, guidelines and plans that further protect the rights of all persons, some of which are specific to the context of health, HIV and vulnerable and key populations. National health, sexual and reproductive health, HIV, TB, youth and gender laws and policies recognise the importance of rights-based development responses that provide for the health of all persons, regulate the professional and ethical conduct of health workers and other service providers, reduce stigma and discrimination and create an enabling framework to reduce human rights and gender-related barriers to the health and well-being of all people. Some HIV-specific policies and guidelines, such as HIV testing and counselling policies and workplace HIV policies, provide detailed protection for the rights of people in the context of HIV and AIDS, including the rights to HIV testing and treatment only with voluntary and informed consent, confidentiality and non-discrimination in the workplace.

National laws, policies, strategies and plans also recognise the needs of vulnerable and key populations such as women, children and young people and, in some cases, key populations. Young people's rights to access

sexual and reproductive health care and to receive comprehensive sexuality education has been set out and strengthened in policies and guidelines. The importance of ending child marriage is highlighted in various policies, plans and campaigns. Women's rights, including their rights to equality in terms of marriage, property and inheritance as well as their rights to be protected from harmful gender norms and gender-based violence, have been strengthened in law and policy. Efforts have been made to strengthen access to justice for sexual violence.

However, there remain ongoing gaps and challenges in law and policy, their implementation and enforcement, many of which impact most severely on vulnerable and key populations, including young key populations. In the absence of HIV-specific protection from discrimination in law, people living with HIV continue to report stigma and discrimination across all sectors of society, including in the workplace, health care, education and within their families and communities, increasing their vulnerability. Laws that criminalise same-sex sex, sex work and drug use impact harshly on the rights of key populations, in particular young key populations, who face discrimination, indignity, harassment from law enforcement officials and violence, in a context where they feel unable to access justice for rights violations and unwilling to access critical services, such as health care, to protect their well-being. Young LGBTI populations cannot access comprehensive sexuality education and information that meets their needs, exacerbating their vulnerability to HIV. Inmates, including young inmates, are kept in prison conditions that expose them to further risks of HIV, TB and sexual violence and have limited access to appropriate health care services. Social protection to support the development of vulnerable and key populations, including young key populations, is limited and underfunded.

Access to justice for these violations is often limited. Vulnerable and key populations have insufficient awareness and understanding of their rights, as do service providers and law

enforcement officials. Access to legal support services, to enforce rights, is inaccessible to many in need.

In order to effectively reduce human rights and gender-related barriers to HIV, TB and SRH, it is critical that protective laws are adequately implemented and enforced in Zambia. Punitive laws that increase stigma and discrimination and block access to health care services require review and reform. Programmes to reduce stigma, discrimination and violence against vulnerable and key populations, including young key populations, need to be strengthened. Comprehensive education and information for young people, particularly young key populations, is critical. Health care workers, law-makers and law enforcers need increased sensitization on the rights of all to health and development. Vulnerable and key populations require increased awareness and understanding of their rights, access to legal support services and a range of effective redress mechanisms in order to be able to claim their rights to equality and non-discrimination. Specific recommendations in order to achieve these goals are set out below.

## Equality and Anti-Discrimination

- Enact specific equality and anti-discrimination provisions to protect the rights of people living with HIV and TB, vulnerable and key populations.
- Integrate, in the review of the National HIV/AIDS/STI/TB Policy, strong equality and anti-discrimination protection for all Zambians, including for people living with HIV and its co-infections, as well as vulnerable and key populations.
- Conduct awareness-raising and sensitization campaigns to reduce HIV and TB related stigma and discrimination, including working in all sectors and with political, traditional and religious leaders.
- Sensitize health careworkers to reduce stigma and discrimination against all people living with HIV, TB, vulnerable and key populations.

- Strengthen access to justice and enforcement of rights for HIV related discrimination.

## Health Laws and Policies

- Strengthen access to appropriate health care services, including psychosocial support and expanded access to PrEP, for key populations, including young key populations.
- Provide in law for voluntary, informed consent to HIV testing and counselling and for the age of consent to HIV testing.
- Consider lowering the age of consent (from 16 years) for access to health services.
- Provide in law for the right to confidentiality with regards to all health information and health status, including information relating to key populations, and for strict conditions under which disclosures may take place.
- Strengthen training for health workers on human rights, gender equality and medical ethics, to reduce stigma and discrimination and protect the health rights of people living with HIV, TB and key populations, including young key populations.
- Strengthen training for health careworkers on the specific and diverse health needs of key populations, including young key populations.
- Integrate youth and key population friendly health services in mainstream health care centers.
- Strengthen access to complaints mechanisms for HIV-related human rights violations within healthcare system.

## Adolescents and Young People

- Harmonise the legal framework to prohibit marriage below 18 years of age.
- Strengthen provision in law and policy for access to adolescent health care information and services, including access to condoms in schools and comprehensive sexuality

education that provides for the rights and needs of all young people, including young key populations.

- Include clear provision in law / policy for the (lowered) age of consent to SRH and HIV services.
- Ensure abortion, where legal, is not subject to minimum age of consent requirements or parental consent and strengthen access to safe abortion, including post-abortion care.
- Train health care workers on the SRHR of young people including LGBTI and the provision of adolescent friendly health care services.
- Strengthen dialogue with and sensitization of traditional authorities and communities to challenge harmful gender norms, particularly child marriage.
- Provide for increased and strengthened mechanisms for reporting and follow-up of sexual violence and abuse of children (e.g. community centres, child protection units in schools; youth-friendly victim/witness offices within Victim Support Units) and support for families.
- Expedite the review of the Anti-GBV Act to provide for prevention of all forms of gender-based violence.
- Strengthen training and sensitization of police to provide child and youth-friendly services including respect for rights of young key populations.
- Promote young people's participation in policies to integrate HIV and sexual and reproductive health and rights services and policies, including comprehensive sexuality education.
- Strengthen community and family participation in adolescent friendly health care services.

## LGBTI Populations

- Support legal reform, through submissions to the Zambia Law Development Commission, to amend the Penal Code and Criminal Procedure Code to decriminalize same-sex sex between consenting adults.
- Ensure the involvement of LGBTI populations in law review and reform processes.

- Sensitise LGBTI populations, including young key populations, on their rights.
- Conduct community awareness-raising and sensitization campaigns to reduce stigma and discrimination against LGBTI populations, including young key populations.
- Provide pre-service and in-service training to health care providers on the human rights of and health care needs of LGBTI populations, including young LGBTI populations.
- Integrate sexual and reproductive health care services, including psycho-social support services, for the needs of LGBTI populations, including young LGBTI populations.
- Sensitise law enforcement officers on the rights of LGBTI populations.
- Strengthen access to justice for LGBTI populations, including through strategic litigation.
- Strengthen access to economic empowerment initiatives for LGBTI populations to overcome marginalisation.
- Prioritise further research on LGBTI populations, including young LGBTI populations.

## Sex Workers

- Make submissions to the Zambia Law Development Commission to review laws criminalizing aspects of sex work and provisions misused against sex workers, in their review of the Penal Code and Criminal Procedure Code.
- Ensure the involvement of sex workers in law review and reform processes.
- Sensitise sex workers on their rights.
- Conduct community awareness-raising and sensitization campaigns to reduce stigma and discrimination against sex workers.
- Train and sensitise health care providers on the rights and health care needs of sex workers.
- Strengthen appropriate sexual and reproductive health care services for sex workers.

- Train and sensitise law enforcement officials on the rights of sex workers and take measures to protect sex workers from violence, harassment and abuse.
- Strengthen appropriate health care services for sex workers.

## People Who Use Drugs

- Review provisions in the Narcotic Drugs and Psychotropic Substances Act that act as barriers to access to harm reduction and health care services for people who use drugs.
- Ensure the involvement of people who use drugs in law review and reform processes.
- Adapt and operationalize the UN system endorsed core package of nine essential harm-reduction services for people who inject drugs, which have been shown to reduce HIV infections (IAWG, 2014):
  - Introduce needle and syringe exchange and distribution programmes
  - Integrate drug dependence treatment, including opioid substitution therapy
  - Intensify HIV testing and counselling for people who inject drugs
  - Provide antiretroviral therapy
  - Prevention and treatment of sexually transmitted infections
  - Implement condom programmes for people who use drugs and their sexual partners
  - Targeted information, education and communication for people who use drugs and their sexual partners
  - Provide diagnosis and treatment of, and vaccination for, viral hepatitis and
  - Prevention, diagnosis and treatment of tuberculosis
  - Train and sensitise health care providers on the rights and health care needs of people who use drugs
- Train and sensitise law enforcement officials on the rights of people who use drugs and take measures to reduce violence and human rights violations against people who use drugs.

## Inmates

- Support the review of the Prisons Act to inter alia, review the Prisons Act, in line with the 2016 Constitution, international standards and act on the Auditor General's 2014 recommendations.
- Ensure the review of the Prisons Act includes strengthened rights of all prisoners and protects all prisoners, including juveniles and women prisoners, from sexual violence.
- Increase access to legal representation to ensure access to justice for all accused persons, including juvenile accused.
- Implement all existing legal provisions to decrease overcrowding in prisons (including allowing for the release of awaiting-trial prisoners, alternative sentencing, where appropriate and for carrying out parole hearings timeously).
- Implement all existing legal provisions to protect juveniles in prisons (including for the elimination of extended pre-trial detention, the expansion of non-custodial sentencing options, the separation of juvenile and adult inmates, the transfer of juveniles to juvenile detention facilities on conviction and for increased reformatory schools).
- Strengthen the investigation and response to prison offences involving sexual violence and exploitation in Zambian prisons, including for young inmates.
- Strengthen access to voluntary HIV, TB and SRH care services for inmates, including the full package of HIV prevention and care services as well as those for TB, regardless of laws criminalising same-sex acts or harm reduction, and including provision of condoms, comprehensive harm reduction services, voluntary and evidence-based treatment for drugs and ART, in line with SADC standards.
- Promote and put in place mechanisms for whistle-blowing on human rights exploitations by both correctional officers and fellow inmates.

## Criminalisation of HIV Transmission

- The enactment of a specific provision criminalizing HIV transmission, exposure or non-disclosure in Zambia is not recommended.
- Develop prosecutorial guidance on the appropriate use of the Anti-Gender-Based Violence Act and Penal Code provisions in relation to HIV.
- Ensure that the review of the Anti GBV-Act and Penal Code exclude overly broad provisions criminalising HIV transmission, exposure or non-disclosure.

## Employment

- Review employment law and policy to specifically prohibit discrimination on the basis of HIV and TB status, health status, sexual orientation and gender identity.
- Review employment law and policy to specifically prohibit pre-employment HIV testing.
- Develop a national occupational health and safety policy that integrates protection from HIV and TB in the working environment.
- Strengthen employer and employee's awareness of access to justice for workplace-related rights violations, in terms of section 36(4) of the Employment Act.
- Strengthen co-ordination, in law, policy and strategies, of TB control and management in Zambian mines between the key Government Ministries of Health, Mines and Labour.
- Strengthen monitoring and evaluation of HIV & TB workplace policies and programmes in all workplaces, and in particular mines and mining communities.

## Education and Information

- Strengthen access to education, including through ensuring adequate funding for all schools and learning institutions.
- Strengthen the provision of comprehensive sexuality education that accommodates the needs of all adolescents, including young key populations, in the school curricula, in line with ESA Commitments.
- Strengthen training of guidance and counselling teachers to provide emotional, social, and psychological support to all young learners, including students affected by HIV, TB as well as young key populations.
- Strengthen efforts to address bullying in schools on the basis of e.g. sexual orientation and gender identity.

## Social Welfare

- Increase resources for social protection programmes, including for vulnerable and key populations in the context of HIV and TB.
- Advocate for livelihood and empowerment support schemes to provide support for key populations, particularly young key populations.

## Women, Gender Inequality and GBV

- Expedite the review of the Anti-GBV Act 2011 to strengthen prevention of GBV and access to justice for violations.
- Develop community awareness campaigns to increase knowledge of rights and redress amongst women and girls and to challenge gender inequality, harmful gender norms and GBV amongst men and boys.
- Increase funding for government implementation of responses to gender inequality, harmful gender norms and gender-based violence (e.g. for Ministry of Gender, Ministry of Health, Ministry of Labour and Ministry of Education).

- Monitor and evaluate the level of mainstreaming and implementation of programmes related to:
  - The National Gender policy;
  - The Matrimonial Causes Act; and
  - The Anti Gender Based Violence Act No. 1 of 2011
- Strengthen databases, through the National Gender Monitoring and Evaluation Technical Working Group and institutions such as the Central Statistical Office (Ministry of Gender, 2014).
- Training and sensitize law makers and law enforcement officials, including at higher level, to the rights of key populations, including young key populations.
- Strengthening access to justice and disciplinary action for police violations of rights.

## Access to Justice

- Strengthen people living with HIV, TB, vulnerable and key populations, including young key populations, awareness and understanding of their human rights.
- Strengthen campaigns to reduce stigma and discrimination against people living with HIV, TB, vulnerable and key populations, including young key populations, amongst communities.
- Train service providers, including health workers, social workers and educators on the rights of people in the context of HIV, TB and SRHR, including the rights of people living with HIV, TB, vulnerable and key populations, including young key populations.
- Strengthen access to legal support services, including pro bono lawyers, legal aid and paralegal support services for people living with HIV, TB, vulnerable and key populations, including young key populations.
- Train members of the judiciary to sensitize them to HIV, SRHR and human rights issues affecting people living with HIV, TB and key populations, including young key populations.
- Strengthen the Zambia Human Rights Commission's role in research, investigation and monitoring of the rights of people living with HIV, TB and key populations, including young key populations.





Part I:

# Introduction

## Country Context

Zambia is a land-locked country in sub-Saharan Africa bordered by 8 countries. It covers a land area of 752 612 square kilometres and is divided into 10 provinces. The administrative and economic capital city is Lusaka (with a population of 1.8 million), located in the south-central part of the country. The population is concentrated mainly around Lusaka, the south-eastern part of the country, the copper belt to the northwest and the main highway to the south-west all the way to Livingstone. Zambia maintained its status as a lower middle-income country (achieved in 2011) with a slowed economic growth rate estimated at 3.4% in 2017 from 3.8% in 2016, and above the sub-Saharan Africa rate at 2.6%. Zambia's income inequality has widened, evidenced by a rise in Gini-coefficient from 0.65 in 2014 to 0.69 in 2017 (0.60 in the rural and 0.61 in urban areas). In addition, the slow performances by the services and mining and construction sectors did not spur growth above the 7% needed to reduce poverty. Gross domestic product growth for 2017 was forecast at 3.8% (down from March forecast of 4.1%) as the services sector's recovery has been slower than expected (WBG, 2018).

The Zambian economy is estimated to have expanded by 3.4% in 2017, despite high copper prices, an expansive monetary policy and a bumper crop harvest. Large public expenditure arrears accumulated in 2016 (resulting in none performing loans) and high public domestic borrowing at high yield constrained the reduction of lending rates, leading to low private sector lending and growth. Public debts have risen sharply over the past few years, and the cost of debt service are crowding out other spending lines and impacting foreign currency reserves (WBG, 2018).

The 2010 census reported a population of 13.1 million and a population growth rate of 3% per annum. The proportion of the population living in urban areas was 40% in 2010, an increase from 35% in 2000. The proportions of adolescents are projected to have been at 25% in 2013 one of the highest in the world,

above the sub-Saharan African average of 23%; nearly 60% of all adolescents lived in rural areas of Zambia in 2010. The estimated total fertility rate of 7.2 births per woman in 1980 declined steadily to 5.9 births per woman in 2010. The 2010 census reported a life expectancy at birth of 49 years for males and 53 years for females (ZCSO, 2012). Maternal mortality ratio (MMR) and infant mortality rate (IMR) have declined from 591 per 100, 000 live births to 398 per 100,000 live births and from 70 per 1,000 live births to 45 per 1,000 live births. Furthermore, under-five mortality also declined from 119 per 1,000 live births to 75 per 1,000 live births (ZDHS 2013/14). According to the Health Management Information System (HMIS), hospital malaria fatalities decreased from 24.6 per 1,000 admissions in 2014 to 19 per 1,000 admissions in 2016 (HMIS, 2016). HIV prevalence in Zambia continued to decline.

The recent Zambia Population Based HIV Impact Assessment (ZAMPHIA, 2016) survey shows a reduction of about 1.7 percentage points from 13.3% in 2014 to 11.6% in 2016. The health sector has also recorded remarkable progress on antiretroviral treatment (ART) coverage, which stands at 72% of the eligible people against the Joint United Nations Programme on HIV/AIDS (UNAIDS) global target of 90%. The findings of the first ever national TB prevalence survey in Zambia states that with the advent of HIV pandemic since 1984, "Zambia has experienced a four-fold increase in TB case notification rates. The disease burden varies among provinces. The highest notification rates reported from Lusaka, followed by Copperbelt and Southern Provinces. The higher notification rates are consistent with regions along the line of rail while the lowest rates of notifications are from provinces off the line of rail" (MOH, ZTBPS, 2014).

The public sector is the biggest health provider; 90% of patients seek care in health facilities owned and run by the Government (MOH, 2017). The main players are the Government, faith-based (not-for-profit) providers, the mines, and private (for-profit) providers. The country has 8 third-level hospitals, 34 second-level hospitals, 99 first-

level hospitals, 1,839 health centres and 953 health posts. All third-level hospitals are Government-owned. Of the second-level hospitals, 26 are Government-owned, and eight are owned by the Churches Health Associations of Zambia (CHAZ). The Provincial Health Officer is the link between the national and district level and is charged with backstopping provincial and district health services. The provincial health officer is also tasked with the provision of second-level referral services (through general hospitals).

The Ministry of Health (MOH)'s focus is the provision of a continuum of care with emphasis placed on strengthening health systems and services using the primary health care (PHC) approach. The 2017-2021 NHSP covers five years and provides guidance on all health interventions in the health sector. The plan details the direction the health sector will take, the achievements and outcomes that will be attained and the interventions that will be undertaken to make sure these targets are met. It also specifies the roles and responsibilities that all actors involved in the health sector will have to perform, the implementation challenges that must be overcome, the monitoring and evaluation required, and the financial resources needed to enable the plan to be successfully implemented.

## Background to the LEA in Zambia

By 2030, Zambians aspire to live in a strong and dynamic middle-income industrial nation that provides opportunities for improving the well-being of all, embodying values of socioeconomic justice, underpinned by the principles of: (i) gender responsive sustainable development; (ii) democracy; (iii) respect for human rights; (iv) good traditional and family values; (v) positive attitude towards work; (vi) peaceful coexistence and; (vii) private-public partnerships (Zambia Vision 2030).

Zambia's Minister of Health, Dr Chitalu Chilufya, in the foreword to the National

AIDS Strategic Framework 2017-2021 (NASF 2017-2021) reassured the nation that the Government of the Republic of Zambia, together with its' development partners, have been unwavering in their support for Zambia's HIV response. Zambia has recorded remarkable accomplishments in halting and beginning to reverse the effects of the epidemic. Estimates of annual new infections among adults aged 15+ have dropped from 67,000 to 46,000 since 2002. For children aged 0-14 years, infections have dropped from 23,000 to 8,900 and annual AIDS-related deaths have seen similar decreases, from 69,000 to 20,000. However, despite these achievements, Zambia is still amongst the top 10 countries in the world with the highest number of people living with HIV.

In its commitment to end the HIV epidemic by 2030, Zambia as a country has adopted the UNAIDS Fast-Track Goals of achieving the 90-90-90 treatment targets by 2020, focusing on high-burden locations and populations affected by the epidemic. However, to achieve these targets, the Minister of Health has acknowledged the importance of focusing on specific populations at higher risk of HIV exposure and in danger of being left behind, as well as on creating an enabling environment that protects human rights and promotes gender equality. Young key populations are included in this, the NASF 2017 – 2021 notes the neglect of key populations – sex workers, gay men and men who have sex with men, transgender people and people who use drugs in the national response. It calls on opinion leaders and other gatekeepers to urgently recognize the implications this has for the general population in crafting, implementing and delivering the related prevention and treatment services.

Responding to the needs of all populations requires an understanding of the legal, regulatory and policy framework and how it impacts on all affected populations, including young key populations. This Legal Environment Assessment (LEA) seek to identify and review HIV, Tuberculosis (TB), sexual and reproductive health (SRH) and other health-related laws, regulations, policies and practices in Zambia

in order to identify how the legal framework impacts on access to HIV and related health services for all people, including young key populations; identify gaps and challenges that create barriers to access to health care and to make recommendations for a strengthened, enabling environment.

## Who are Key Populations? Who are Young Key Populations?

### Key Populations

UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the main **key population** groups. These populations often suffer from punitive laws or stigmatizing policies, systematic disenfranchisement, violence, social and economic marginalization and / or criminalization. They are among those most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere and they are key to the epidemic and key to the response.

Key populations at higher risk also may be used more broadly, referring to additional populations that are most at risk of acquiring or transmitting HIV, regardless of the legal and policy environment. Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

### Young Key Populations

**Young key populations** are young people aged 15 to 24 years who are members of key populations, such as young people living with HIV, young gay men and other men who have sex

with men, young transgender people, young people who inject drugs and young people (18 years and older) who sell sex. Young key populations often have needs that are unique, and their meaningful participation is critical to a successful HIV response.

Young key populations face additional legal and policy barriers to access to HIV, TB and SRH services as a result of their young age.

### Children, Adolescents, Youth and Young People

**Children** are people below the age of 18 years in terms of the Convention on the Rights of the Child (CRC).

**Adolescents** are defined by the World Health Organization (WHO) as people aged 10–19 years. The United Nations (UN) considers **youth** as those between 15 to 24 years of age and **young people** are those aged 10–24 years.

The LEA focuses on young people aged 10 to 24 years, including a specific focus on young key populations aged 15 to 24 years of age, in line with UNAIDS Terminology Guidelines (2015)

### Young Men who have Sex with Men

**Young men who have sex with men** refers to males 10–24 years, including boys 10–17 and men 18–24 years who have sex with other males.

### Sex Workers and Young People who Sell Sex

**Young people who sell sex** in this document refers to people 10–24 years of age and includes adolescents 10 to 17 years who are **sexually exploited** and young people 18–24 years who are **sex workers**.

**Sex workers** are female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work involves consensual sex between adults aged 18 years or older.

**Sexual exploitation of children** aged 10 to 17 years, in terms of article 34 of the CRC, includes the exploitative use of children in prostitution, defined under Article 2 of the Optional Protocol to the CRC on the sale of children, child prostitution and child pornography (2000) as “the use of a child in sexual activities for remuneration or any other form of consideration”. **Child sexual abuse** includes “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society.” Children can be sexually abused by adults or other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power, over the survivor.

## Objectives of the Legal Environment Assessment

The Legal Environment Assessment aims to:

- Identify and examine laws, regulations, policies, practices and all related human rights and gender-related issues affecting particularly people living with HIV, TB, vulnerable and key populations, including young key populations.
- Determine the extent to which the current legal environment protects rights and/or acts as a barrier to access to health services

within the context of HIV, TB and SRH, including for key populations.

- Identify protective laws, regulations, policies and programmes that support human rights and access to health care.
- Identify discriminatory and punitive laws, gaps and challenges that pose barriers to human rights and access to health services within the context of HIV, TB and SRH, including for young key populations.
- Develop recommendations for action for law review and reform to strengthen HIV-related laws, regulations and policies and their implementation and enforcement, including measures to improve access to justice and improved law enforcement.
- Develop, alongside the LEA, a national Engagement Scan to identify key opportunities (such as elections, parliamentary sessions, planning and budgeting processes) and institutions in Zambia for advocating for and impacting on law, policy and strategy.

## Implementation Modalities/Research Methodology

### Method 1: Desk Review

The LEA aims to review all available documents on international, regional and national human rights obligations, particularly those relevant to HIV, TB and SRH, including:

- All relevant national laws and policies, including laws that impact on vulnerable and key populations as well as recent and on-going law reform initiatives and proposals.
- All relevant national public health-related policies, strategies and plans.
- Access to justice for health-related rights violations, including institutional frameworks for access to justice and law enforcement.

The review process identified and analysed existing laws and policies, gaps and challenges

in the legal framework for the HIV response, including for young key populations, with a view to locating:

- What is already known about the legal, regulatory and political responses to HIV, TB and SRH, including for young key populations, in Zambia?
- What is being critically said about what is already known?
- If anyone else has implemented what is proposed or related?
- Where does the LEA and the broader objectives of the YKP project fit in what is being implemented?

## Method 2: Key Informant Interviews and Focus Groups Discussions (FDGs)

Key informant interviews and focus group discussions were undertaken to understand the extent to which laws, policies & practices promote or create barriers to access to health care for all, including young key populations. The FDGs helped to uncover the views, feelings and perceptions of different populations regarding laws, policies, human rights, gender equality and access to health care services for HIV, TB and SRH. This was important to verify or clarify the findings from the desk review and to explore the legal / human rights / gender-related barriers to services – how laws, stigma, discrimination and human rights violations impact on access to health (and other) services, impact on the lives of affected populations and what they believe may be required in order to improve access to health services. See Annexure 2 and 3 for details of key informant interviews and focus group discussions, who was consulted and a summary of key discussion points.

Stakeholder consultations involved key stakeholders and/or organizations working with young key populations to understand their perspectives on the extent to which laws, policies and practices promote or create barriers to access to health care for all.

## Key Deliverables

The LEA project included the following deliverables:

- a. An Inception Report for the LEA.
- b. An LEA Desk Review.
- c. Reports of interviews with key stakeholders and focus group discussions (for both the LEA and the Engagement Scan).
- d. A combined draft LEA Report approved by the United Nations Development Programme (UNDP), National AIDS Council (NAC), the LEA National Steering Committee (NSC) and validated by national stakeholders.
- e. Report of a Validation Workshop.
- f. An updated draft Engagement Scan.
- g. A final LEA Report and Engagement Scan.

# The Situational Analysis: HIV, TB and Human Rights In Zambia

## HIV, AIDS and TB in Zambia

Zambia has one of the highest HIV burdens in sub-Saharan Africa. Data from the latest Demographic and Health Survey (ZDHS 2013-14) estimates HIV prevalence in Zambia at 13.3% for adults aged 15-49, down 1% from the 2007 DHS estimate of 14.3%. The Zambian HIV epidemic is geographically heterogeneous, with provincial HIV prevalence rates ranging from 6% to 18%. There are significant rural-urban differences: the HIV prevalence rate is double in urban areas (18.2%) compared to rural areas (9.1%). According to the Zambia Demographic Health Survey 2013-2014, HIV is still a huge health concern for the country:

### Status of HIV According to the ZDHS 2013-2014

- In Zambia, 13% of adults age 15-49 are infected with HIV (15% of women and 11% of men).
- A comparison of the HIV prevalence estimates from the 2001/02, and 2013/14 ZDHS surveys indicates that HIV prevalence among adults in Zambia has decreased over time (from 16% in 2001/02 to 13% in 2013/14).
- HIV prevalence increases with age, peaking at 23% in the 40-44 age group and declines thereafter.
- HIV prevalence is highest among respondents living in Copperbelt (18%) and lowest among those living in Muchinga (6%).
- The percentage of respondents who are HIV positive generally increases with increasing education and wealth.
- About half of widowed women (48%) are infected with HIV.

- Respondents with a sexually transmitted infection (STI) or STI symptoms in the past 12 months are much more likely to be HIV positive than those who did not have an STI or STI symptoms (25% vs 14%).
- In 81% of the 6,791 cohabiting couples who were tested for HIV in the 2013-14 ZDHS, both partners were HIV negative. In 8% of the couples, both partners were HIV positive, and 11% of the couples were discordant.

HIV prevalence is higher among females (15.1%) than among males (11.3%). The 2013/2014 ZDHS estimated HIV prevalence rates among adolescent girls and boys aged 15-19 at 3.5% for girls and 1.8% for boys. Among adolescents aged 18-19, HIV disproportionately affects girls, with a prevalence of 6.6% compared to a prevalence of 4.5% among boys of the same age. Data on key populations, including young key populations, is limited but a 2016 Population Council study found that HIV prevalence among key populations was generally high, over 35%, as compared to the general population, and that many key populations have broad sexual networks extending into the general population.

PISAF (2013) reported that condom use among sexual minorities was highly inconsistent, posing a high risk for HIV exposure. Generally, 79% of gay men and men who have sex with men indicated that they 'sometimes' use condoms for HIV prevention both with their female and male partners: 49% of those who reported using condoms indicated consistent use of condoms with their regular female partners, and 51.3% indicated consistent use of condoms with non-regular female partners. The study also revealed that 30% of the respondents indicated examples of higher risk sexual behavior under the influence of alcohol and/or drugs.

Other studies on young key populations have found similar high HIV trends among young key populations. For instance, AVERT (2017)



also notes that HIV incidence amongst key populations is 33% among men who have sex with men and 56% among female sex workers. Factors considered to increase the risk of HIV exposure amongst key populations include criminalization of consensual sexual acts by sexual minorities, which denies them their rights to health services, equality, non-discrimination, dignity and, ultimately, life itself. In addition, such criminalization has the potential to reverse the gains made so far in the national response: "This is because it isolates key (at-risk and risky) populations who may be vulnerable or at greater risk of infection (or infecting others) and, hence, creating epidemiological blind spots which may create the necessary critical mass for a sustenance of the epidemic" NAC (2017).

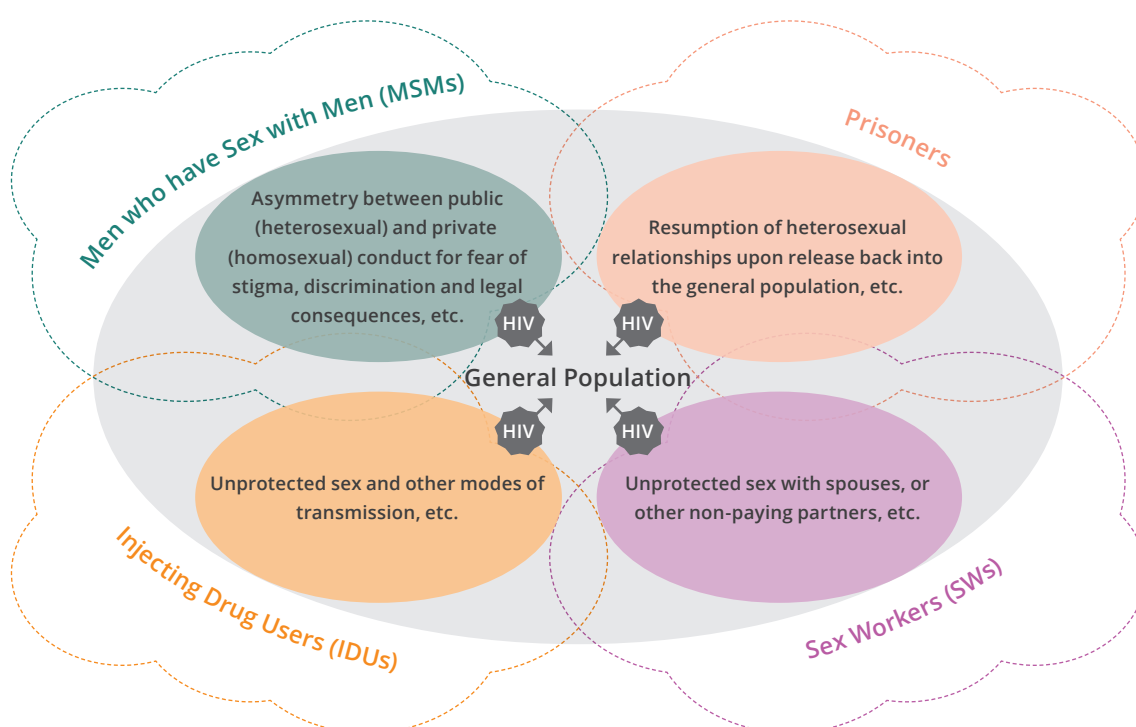
The diagram below further articulates the focus on key populations in the current NASF:

2017-2021. The UNAIDS (2016) *Prevention Gap Report* notes that, while the HIV epidemic in Eastern and Southern Africa (ESA) is for the most part a generalized epidemic, there are high rates of new HIV infections amongst key populations in the region. UNAIDS recognizes that, in order to end AIDS, it is critical to prioritize a multi-sectoral approach that includes interventions and resources for reaching out to key populations with

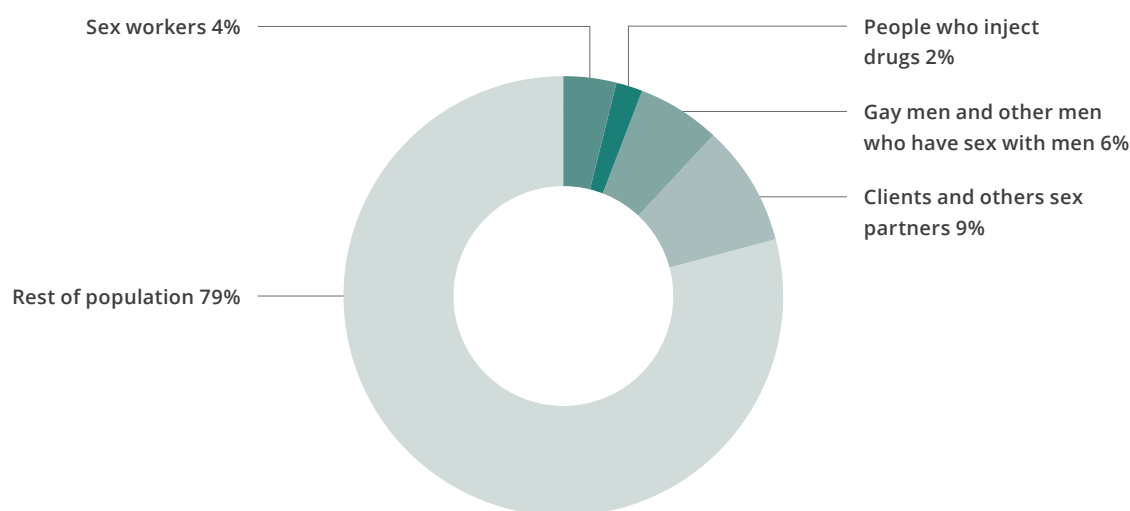
comprehensive health services. This should include structural interventions aimed at addressing barriers created by laws, policies and practices that impact on human rights, gender equality and access to health care.

The WHO Technical brief on HIV and Young men who have sex with men (2015) notes the failure to adequately prioritize key populations, particularly young key populations in responses to HIV: "The global response to HIV largely neglects young key populations. Governments and donors fail to adequately fund research, prevention, treatment and care for them. HIV service-providers are often poorly equipped to serve young key populations, while the staff of programmes for young people may lack the sensitivity, skills and knowledge to work specifically with members of key populations".

The NHSP 2017-2021 notes that according to the WHO, Zambia is one of the 30 countries in the world with a high TB and TB-HIV burden. "Since 2000, Zambia has successfully implemented three national TB strategic plans. The 2014–2016 NSP, which was modelled on the Global Stop TB Strategy, focused on scaling up intensified TB case finding, TB-HIV collaborative services, and building the structure for implementing Programmatic Management of Drug-Resistant Tuberculosis (PMDT)" (MOH, 2017). Zambia successfully conducted the first



## Distribution of New HIV Infections among Population Groups, Eastern and Southern Africa, 2014



Source: UNAIDS special analysis, 2016; for more details, see annex on methods.

ever-national Tuberculosis Prevalence Survey. It is now known that the country has a higher and unevenly distributed TB burden than previously estimated. The prevalence of bacteriologically confirmed TB is 638 (502–774) cases per 100,000 populations. The TB prevalence for all ages and all forms of TB is 455 cases per 100,000 populations (Zambia TB Prevalence Survey, 2014).

## The National Response in Zambia

### The National HIV/AIDS/STI/TB Council

An act of Parliament (NAC Act No. 10 of 2002) established the National HIV/AIDS/STI/TB Council in 2002 to co-ordinate the national response to HIV, AIDS, sexually transmitted infections (STIs) and TB. The Council is a multi-sectoral body appointed by the Minister of Health, represented by various stakeholders including government, civil society organisations (CSOs), the private sector and the general public, to: “coordinate and support the development, monitoring and evaluation of the multi-sectoral national HIV and AIDS response for prevention and combating of the spread of HIV, AIDS, STI, and TB in order to reduce personal social and economic impacts of HIV, AIDS, STI and TB”.

### Functions of the National HIV/AIDS/STI/TB Council

The National HIV/AIDS/STI/TB Council Act (2002) outlined the functions of the Council as to:

1. Support the development and coordination of policies, plans and strategies for the prevention and combating of HIV, AIDS, STI and TB for health and other institutions concerned with the prevention of HIV, AIDS, STI and TB
2. Advise Government, health institutions and other organizations on policies, strategies and plans to prevent and combat HIV, AIDS, STI and TB
3. Ensure provision and dissemination of information and education on HIV, AIDS, STI and TB
4. Develop a national HIV, AIDS, STI and TB research agenda and strategic plan which shall include the quest for a cure for HIV and AIDS as one of the research priorities

5. Support programmes relating to prevention, care, and treatment of HIV, AIDS, STI and TB;
6. Mobilize resources to promote and support identified priority interventions including research in areas related to HIV, AIDS, STI and TB
7. Provide technical support and guidelines to health and other institutions involved in the Prevention and treatment of HIV, AIDS, STI and TB and Care and support of persons infected in relation to HIV, AIDS, STI and TB
8. Collaborate with other research institutions in relation to HIV, AIDS, STI and TB
9. Undertake such other activities as are conducive or incidental to its functions under this Act.

## National AIDS Strategic Framework 2017-2021 (NASF 2017-2021)

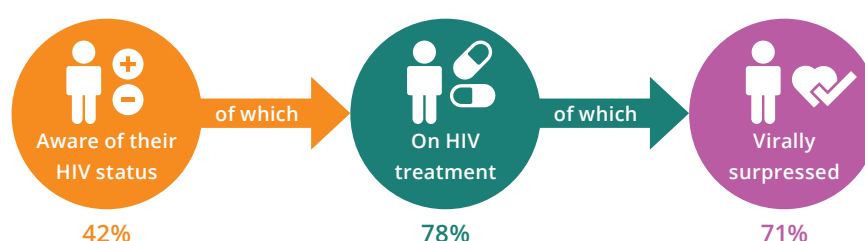
The NASF is driven by a long-term vision for “a nation free from the threat of HIV” and a mission to control the HIV epidemic “by integrating it into the national development agenda and scaling up prioritised actions that are rapid and responsive to the needs of the local community to be served”. The NASF aims to intensify a combination of HIV prevention interventions to reduce new HIV infections and achieve the 90-90-90 targets set for 2020. The diagram below provides a snapshot of the current status towards these targets:

The NASF describe the Zambian HIV epidemic as driven mainly by unprotected heterosexual sex and identifies factors contributing to the spread of HIV as multiple and concurrent partnerships (MCP), low and inconsistent condom use, low medical male circumcision, migration and mobility, mother to child transmission of HIV and marginalized and underserved populations. It also recognizes and includes a focus on key populations and the modes of transmission between populations. The NASF also notes additional structural factors that impact on vulnerable and key populations and increase their risk of HIV exposure, including those set out below. Notably, it recognizes lack of protection in law, stigma, discrimination, gender inequality, harmful gender norms & gender-based violence and their impact on vulnerable and key populations:

- Intergenerational sex
- Transactional sex
- The denial and marginalisation of vulnerable and key populations
- Stigma and discrimination
- Marriage patterns and polygamy
- Religious beliefs against ARVs and condom use
- Gender inequalities including gender-based violence
- Deepening poverty and food insecurity
- Widespread abuse of alcohol and other substances
- Poor enforcement of anti-discrimination laws, and
- Weak social and legal protection of vulnerable populations

The National HIV/AIDS Policy 2005 includes the protection and promotion of human rights and gender equality as guiding principles to the national response to HIV.

### Zambia – Progress Towards 90/90/90 Targets among 15-24 year olds for 2020



Source: PEPFAR (2016) 'PEPFAR Latest Global Results', AVERT.ORG

### Challenges to the Response

The Joint Program of Support 2016-2021 by the UN Joint Team highlights some of the major challenges that contribute to limiting access to health services in Zambia, including geographical barriers to service access, inadequate numbers of health workers, inadequate logistics management of drugs and medical supplies, inadequate electricity and internet connectivity, poverty and overreliance on external funding for HIV.

Furthermore laws, policies and practices allowing for stigma, discrimination and human rights violations are a further challenge to the HIV response in Zambia and require intensified efforts to protect all persons, including vulnerable and key populations, from HIV,

AIDS and TB. “Human rights are codified in international and regional treaties, often also called conventions, covenants and charters, and are also incorporated at the national level in constitutions and laws. National constitutions, laws and highest court decisions thus provide national recognition of the human rights standards that are elaborated in these international and regional human rights treaties, which states ratify. Importantly, national laws often provide guarantees and legal frameworks for the elaboration of sexual health related policies, programmes and services, but sometimes they also impose limitations, and thus have an impact on sexual health, both positive and negative” (WHO, 2015).

### Funding Landscape for the National AIDS Control Programme (2014-2017)

Source	Total USD	Percentage of Available Funding
Current GF Grants	204,826,705	11.75%
GRZ	205,992,925	11.81%
USG	1,164,869,920	66.81%
UK	7,366,328	0.42%
World Bank	8,748,000	0.50%
Sweden	17,100,304	0.98%
Bill and Melinda Gates Foundation	1,205,528	0.07%
Clinton Foundation	1,347,676	0.08%
Unspecified – not disaggregated by sources	13,910,000	0.80%
NFM Allocation	118,230,280	6.78%
Total Available Funds	1,743,597,666	100.00%
Total NSP Budget (2014 -2017)	2,416,615,909	
Financial Gap (2014-2017)	673,018,243	



## Part II:

# International, Regional, and National Human Rights Framework

This section of the Legal Environment Assessment seeks to set out the international, regional and national human rights framework that should oversee and govern the national response to HIV, AIDS and TB in Zambia. The section includes:

- A discussion of the link between human rights, HIV and TB
- How international and regional human rights instruments apply to the regulation of HIV, law and human rights in Zambia
- Existing international and regional human rights instruments, human rights norms, standards and frameworks that support effective national responses to HIV
- National human rights standards and key human rights in the context of HIV and TB
- Limitations of rights

The role of a supportive legal and policy environment in reducing the risk of HIV exposure, improving access to health care services and strengthening responses to HIV, AIDS and TB has been increasingly documented and accepted worldwide (GCHL, 2012).<sup>1</sup> “Laws play an important role in ensuring accountability – a key human rights principle – at many levels, including, among others, establishing transparent monitoring and review processes to record health outcomes across a sexually diverse population, or the impact of various health interventions” (WHO, 2015). The 2016 United Nations General Assembly (UNGASS) Political Declaration noted that “the promotion and protection of, and respect for, the human rights and fundamental freedoms of all, including the right to development, which are universal, indivisible, interdependent and interrelated, should be mainstreamed into all HIV and AIDS policies and programmes, and also reaffirm the need to take measures to ensure that every person is entitled to participate in, contribute to and enjoy economic, social, cultural and political development and that of equal attention and urgent consideration should be given to the promotion, protection and fulfilment of all human rights.”

## The International Perspective

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

‘Signature’ of a treaty is an act by which a state provides a preliminary endorsement of an agreement. Signing does not create a binding legal obligation but does demonstrate the state’s intent to examine the agreement and consider ratifying it. Whilst signing does not commit a state to ratification, it does oblige the state to refrain from acts that would defeat or undermine the treaty’s objective and purpose. ‘Ratification’ is an act by which a state signifies an agreement to be legally bound by the terms of a particular treaty. To ratify a treaty, the state first signs it and then fulfils its own national legislative requirements. Even where states have not signed or ratified conventions or treaties, these can still be binding if their principles form part of what is known as customary international law.

## Ratification of International Human Rights Treaties – Zambia

International Bill of Human Rights	Signature	Ratification	Accession	Succession	Entry into Force
<a href="#">International Covenant on Economic, Social and Cultural Rights</a>			10 Apr 1984		
<a href="#">International Covenant on Civil and Political Rights</a>			10 Apr 1984		
<a href="#">Optional Protocol to the International Covenant on Civil and Political Rights</a>			10 Apr 1984		
Prevention of Discrimination on the Basis of Race, Religion, or Belief; and Protection of Minorities	Signature	Ratification	Accession	Succession	Entry into Force
<a href="#">International Convention on the Elimination of All Forms of Racial Discrimination</a>	11 Oct 1968	4 Feb 1972			
Women's Human Rights	Signature	Ratification	Accession	Succession	Entry into Force
<a href="#">Convention on the Elimination of All Forms of Discrimination against Women</a>	17 Jul 1980	21 Jun 1985			
<a href="#">Optional Protocol to the Convention on the Elimination of Discrimination against Women</a>	29 Sep 2008				
Protection from Torture, Ill-Treatment and Disappearance	Signature	Ratification	Accession	Succession	Entry into Force
<a href="#">Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</a>			7 Oct 1998		
<a href="#">Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</a>	27 Sep 2010				
<a href="#">International Convention for the Protection of All Persons from Enforced Disappearance</a>	27 Sep 2010	4 Apr 2011			
Rights of the Child	Signature	Ratification	Accession	Succession	Entry into Force
<a href="#">Convention on the Rights of the Child</a>	30 Sep 1990	6 Dec 1991			
<a href="#">Convention concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour</a>		10 Dec 2001			



Freedom of Association	Signature	Ratification	Accession	Succession	Entry into Force
<a href="#">Freedom of Association and Protection of the Right to Organise Convention</a>		2 Sep 1996			
<a href="#">Right to Organise and Collective Bargaining Convention</a>		2 Sep 1996			
Employment and Forced Labour	Signature	Ratification	Accession	Succession	Entry into Force
<a href="#">Equal Remuneration Convention</a>		20 Jun 1972			
<a href="#">Abolition of Forced Labour Convention</a>		22 Feb 1965			
<a href="#">Discrimination (Employment and Occupation) Convention</a>		23 Oct 1979			
<a href="#">Employment Policy Convention</a>		23 Oct 1979			
Education	Signature	Ratification	Accession	Succession	Entry into Force
<a href="#">Convention against Discrimination in Education</a>	Not signed				
Persons with Disabilities	Signature	Ratification	Accession	Succession	Entry into Force
<a href="#">Convention on the Rights of Persons with Disabilities</a>	09 May 2008				
War Crimes and Crimes Against Humanity, Genocide, and Terrorism	Signature	Ratification	Accession	Succession	Entry into Force
<a href="#">Rome Statute of the International Criminal Court</a>	17 Jul 1998	13 Nov 2002			
African Regional Conventions	Signature	Ratification	Accession	Succession	Entry into Force
<a href="#">African [Banjul] Charter on Human and Peoples' Rights</a>	17 Jan 1983	10 Jan 1984			
<a href="#">Convention Governing the Specific Aspects of Refugee Problems in Africa</a>	10 Sep 1969	30 Jul 1973			
<a href="#">Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights</a>	9 Jun 1998				
<a href="#">African Charter on the Rights and Welfare of the Child</a>	28 Feb 1992	2 Dec 2008			

Zambia has signed / ratified a number of international and regional human rights treaties and is obligated to report to the international community on its compliance with international human rights law.<sup>2</sup> The Universal Periodic Review is one of the ways through which Zambia's compliance with international commitments is monitored. So far Zambia has been reviewed three times, the latest being in November 2017 in Geneva. During this time Zambia accepted about 90% of the recommendation made by TROICA. Among the 10% of the recommendations that were not supported by the government was the same sex consensual relationship and optional protocols to domesticate International ratified legislations. Zambia is party to the following United Nations human rights treaties. It should be noted that while this is the case Zambia has a dualist system of jurisprudence that considers international law separate from domestic law, until domesticated by Acts of Parliament (Beyani, 2013). Cabinet Ministers are charged with responsibility for recommending domestication of respective internal agreements and treaties, where subject to subsection (2), considerations are made whether it is in the best interests of the State to ratify the international agreement (The Ratification of International Agreements Act 2016).

However, even in dualist countries, international and regional law can still impose obligations on countries that have ratified particular treaties. The African Commission on Human and Peoples' Rights (African Commission), which is responsible for monitoring compliance with regional human rights treaties, has noted that "international treaties which are not part of domestic law and which may not be directly enforceable in the national courts, nonetheless impose obligations on State Parties." Zambia, as a committed member of the global and regional community, is also party to several international and regional declarations, commitments and guidelines that directly apply to HIV and AIDS, human rights and gender equality. These documents, although not legally binding, should guide the interpretation of human rights obligations in

the case of HIV, TB, SRH and vulnerable and key populations.

## Human Rights Standards and State Obligations relating to HIV, TB and SRH

A number of fundamental human rights protect all people in the context of health, HIV, TB and SRH. Central to these is the right to health and the duty of the State to take various measures to respect, protect, promote and fulfil the right to the highest attainable standard of health. The World Health Organization (WHO) in 2015 emphasized that "the right to the highest attainable standard of health has been defined and elaborated as encompassing a variety of facilities, goods and services that must be available, accessible, acceptable and of good quality. These are dimensions that have yet to be fulfilled in many places, and frequently this is due to an inadequate legal framework, including direct legal barriers." The existence of an enabling, appropriate legal and policy framework is vital for delivering quality health services equitably to all that need them.

To start with, The Vienna Declaration and Programme of Action (VDPA), adopted at the World Conference on Human Rights in June 1993, is a basis for fundamental human rights in the context of health, HIV, TB and SRH. Building on the Universal Declaration of Human Rights, the VDPA recognizes that the promotion and protection of human rights must be a matter of the highest priority for both states and the international community. It envisages a strengthening of human rights norms and institutions at the national and international levels and recognizes the critical role that human rights defenders must play in the realization of fundamental rights and freedoms (OHCHR, 1993).

More specifically, the UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights* look specifically at key human rights principles which are essential to effective state responses to HIV. They are based on the application of fundamental human rights in existing international instruments, such as the

Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) which have been highlighted above. The *guidelines* also note other treaties such as the International Labour Organization (ILO) instruments concerning discrimination in employment and occupation, termination of employment, protection of workers' privacy, and safety and health at work. The Guidelines note the indivisibility of a range of human rights in supporting the right to health.

"A human rights approach to HIV is, therefore, based on these State obligations with regards to human rights protection. HIV demonstrates the indivisibility of human rights since the realization of economic, social and cultural rights, as well as civil and political rights, is essential to an effective response. Furthermore, a rights-based approach to HIV is grounded in concepts of human dignity and equality which can be found in all cultures and traditions." Other international and regional commitments important for rights-based responses include those set out below:

### Other related Human Rights Instruments to which Zambia is Party

- UNGASS Declaration of Commitment on HIV/AIDS (2001)
- UN Millennium Development Goals (2000)
- Abuja Declaration on Universal Access: HIV/AIDS/TB/Malaria/STIs (2001)
- Maseru Declaration (2003)
- UNGASS Political Declaration on HIV/AIDS – Universal Access (2006)
- Maputo Plan of Action, 2007
- African Youth Charter (16 Sep 2009)
- UNGASS Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS (2011)

- Windhoek Declaration Women, Girls, Gender Equality and HIV: Progress towards Universal Access (2011)
- African Union Roadmap (2012)
- United Nations Protocol relating to the Status of Refugee
- SADC Protocol on Gender and Development (26 Nov 2012)
- Protocols to the Geneva Conventions
- Seven International Labour Organization Fundamental Human Rights Conventions
- Rome Statute of the International Criminal Court (ICC)
- Political Declaration on HIV and AIDS: On the Fast-Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030 (2016)

Some of the key rights which are considered in the LEA, set out in these international and regional documents include:

- The right to non-discrimination, equal protection and equality before the law (already domesticated in Zambian laws);
- The right to life (already domesticated in Zambian laws);
- The right to the highest attainable standard of physical and mental health (already domesticated in Zambian laws);
- The right to liberty and security of person (already domesticated in Zambian laws);
- The right to freedom of movement (already domesticated in Zambian laws);
- The right to privacy (already domesticated in Zambian laws);
- The right to freedom of opinion and expression and the right to freely receive and impart information;
- The right to freedom of association (already domesticated in Zambian laws);
- The right to work (already domesticated in Zambian laws);

- The right to marry and to found a family;
- The right to equal access to education (already domesticated in Zambian laws);
- The right to an adequate standard of living;
- The right to social security, assistance and welfare;
- The right to share in scientific advancement and its benefits;
- The right to participate in public and cultural life (already domesticated in Zambian laws);
- The right to be free from torture and cruel, inhuman or degrading treatment or punishment (already domesticated in Zambian laws).

## Limitation of Rights

Despite the importance attached to human rights, there are situations where it is considered legitimate to restrict rights to achieve a broader public good to “secure due recognition and respect for the rights and freedoms of others; meet the just requirements of morality, public order, and the general welfare; and in times of emergency, when there are threats to the vital interests of the nation,” as set out in the ICCPR.

Public health is recognised as one such public good and measures to curb the spread of disease may involve restrictions on the rights of affected persons such as isolation, quarantine, detention and mandatory treatment. Excessive measures, however, that fail to consider other valid alternatives, may be abusive of both human rights principles and public health “best practice.”

The internationally accepted Siracusa Principles recognise that limitations of rights may be legitimately justified where actions are taken as a measure of last resort and the following criteria are met:

1. The restriction is provided for and carried out in accordance with the law.
2. The restriction is in the interest of a legitimate objective of general interest.
3. The restriction is strictly necessary in a democratic society to achieve the objective.

4. There are no less intrusive and restrictive means available to reach the same goal.
5. The restriction is not imposed arbitrarily, i.e., in an unreasonable or otherwise discriminatory manner.

Certain rights are absolute and non-derogable; limitations of these rights may not be justified. These include rights such as the right to be free from torture, slavery, or servitude; the right to a fair trial; and the right to freedom of thought. In Zambia the Constitution provides that rights may be limited as provided for in Articles 66, 67 and 68.

## Limitations & Restrictions Under the Law

Article 67 of the bill of rights states “A law that limits or restricts a right or freedom is valid only to the extent that the law -(a) is reasonably required In the interest of public defence and security, public safety, public order, public morality, public health, national, provincial and local spatial planning, taxation or the development, management and utilisation of natural and mineral resources.... (f) Imposes restrictions and duties on defence and security officers, other public officers and Constitutional office holders”.

## The Application of Specific Human Rights in The Context of HIV and AIDS in Zambia

The recently amended Constitution of Zambia (Amendment) Act 2 of 2016 aims to uphold “the human rights and fundamental freedoms of every person” and affirms “...the equal worth of women and men and their right to freely participate in, determine and build

a sustainable political, legal, economic and social order.” The Constitution contains a Bill of Rights that provides for the fundamental rights and freedoms to which each individual is entitled and is the basis of Zambia’s social, political, legal, economic and cultural policies and State action. The rights and freedoms set out in the Bill of Rights are inherent in each individual, protect the dignity of the person and include rights and freedoms consistent with the Constitution and the morals and values of the people of Zambia, including rights and freedoms not expressly provided. Article 8 of the Constitution of Zambia (Amendment) Act 2 of 2016 lists “morality and ethics” as a national value and principle, as well as human dignity, equity, social justice, equality and non-discrimination.

The Bill of Rights includes protection for various important human rights and fundamental freedoms that protect the rights of people living with HIV, vulnerable and key populations in relation to HIV, TB and SRH, ranging from civil and political rights to protect citizens from unlawful interference and promote participation in society – such as the right to life, fundamental freedoms of religion or belief, movement, assembly and association – as well as social, economic, and cultural rights such as the right to health, that require actual fulfillment by the government through the provision of financial and material resources for citizens.

The Constitution and Bill of Rights therefore provides a rights-based framework to guide the HIV response in Zambia, to ensure that all persons – including vulnerable and key populations – have access to universal access to health services.

#### Articles of Rights and Freedoms that Protect all People including Members of Key Populations within the Bill of Rights

6. Fundamental Rights and Freedoms	Located in Article 11
7. Right to life	Located in Article 12
8. Personal Liberty	Located in Article 13
9. Freedom from torture or degrading treatment	Located in Article 15
10. Protection of privacy	Located in Article 17

11. Right of accused persons	Located in Article 18
12. Freedom of expression	Located in Article 20
13. Right to association and assembly	Located in Article 21
14. Protection from discrimination	Located in Article 23
15. Youth rights to personal development, participation in governance, gainful employment and participation in social, economic, political and other spheres of life	Located in Article 62
16. Protection of a young person	Located in Article 63

## Right to Health, Education, Employment and Social Protection

- Article 51(4) of the Bill of Rights provides without limiting a right or freedom, women and men have the right to reproductive health, including family planning and access to related information and education
- Article 52 of the Bill of Rights provides for the right to health care services, education and social protection
- Article 54(1) of the Bill of Rights provides that a person has the right to employment and fair labour practices.

## Right to Privacy

- Article 32 of the Bill of Rights provides that a person has the right to privacy, which includes the right not to be searched; have that person’s home or property searched; have that person’s possessions seized; have information relating to that person’s family, health status or private affairs unlawfully required or revealed; or have the privacy of that person’s communications infringed.

## Right to Personal Liberty

- Article 29 of the Bill of Rights gives every person the right to freedom of the person, which includes the right not to be deprived of that freedom arbitrarily.

## Freedom from Torture and Degrading Treatment

- Article 30 of the Bill of Rights provides every person with the right not to be subjected to torture; or treated or punished in a cruel, inhuman or degrading manner.

## Rights of Accused Persons

- Article 46 of the Bill of Rights gives every person who is suspected of committing an offence the right to remain silent; and to be informed in a language which that person understands of their right.
- Article 47 of the Bill of Rights gives every person the right not to be held in custody without being charged and provides that a person who is held in custody retains that rights and freedoms, except to the extent that a right or freedom is incompatible with being in custody; it also gives a person who is held in custody the right to petition for a writ of habeas corpus.
- Article 48 of the Bill of Rights, subject to Articles 65, 66, 67, 68 and 69, gives an accused person or a detainee has the right to remain silent; to be informed in a language which that person understands of the (i) right to remain silent; and (ii) consequences of remaining silent; and to be informed, as soon as reasonably practicable, of the reasons for the arrest or detention.
- Article 49 of the Bill of Rights provides every person with the right to a fair trial which includes the right to have the trial commenced and judgment given without unreasonable delay; to be represented by a legal practitioner, amongst other things.

## Equality Before the Law

- Article 43 of the Bill of Rights provides that “all persons are equal before the law and have the right to equal protection and benefit of the law.”
- Article 45 of the Bill of Rights provides that every person has the right to access justice.

- Article 49 of the Bill of Rights provides that every person has the right to have a dispute decided timely and to have a fair hearing before a court or, where appropriate, an independent and impartial tribunal.
- Article 70 of the Bill of Rights provides a person with the right to apply for redress to the Constitutional Court for a violation of a human right.

## Freedom of Expression, Association and Assembly

- Article 34 of the Zambian Bill of Rights gives every person the right to freedom of expression, which includes the freedom to hold an opinion and the freedom to receive or impart information or ideas.
- Article 38 of the Bill of Rights provides every person with the right to freedom of association, which includes the right to form, join or participate in the activities of an association.
- Article 39 of the Bill of Rights gives every person the right of freedom of assembly.
- Article 40 of the Bill of Rights gives every person the right to freedom of movement.



## Part III:

# Assessment of Laws, Regulations, Policies & Plans



## Equality/ Anti-Discrimination Law and Policy

### HIV- and TB-Related Stigma and Discrimination in Zambia

Stigma and discrimination remain a barrier to responses to HIV, particularly for vulnerable and key populations, all over the world (GCHL, 2012). In Zambia, stigma and discrimination is still prevalent towards people living with HIV, TB, vulnerable and key populations – particularly sex workers, people who use drugs and lesbian, gay, bisexual, transgender and intersex (LGBTI) populations. TB is frequently associated with HIV and AIDS.

The Zambian Stigma Index (2012) show that stigma remains a challenge. Individuals have reported experiencing stigma in a variety of settings including exclusion from places of worship, homes, workplaces, households, health care facilities; discrimination in access to work and services such as health, education and insurance, forced medical procedures, testing for HIV without voluntary and informed consent or counselling, detention, isolation and quarantine and coerced termination of pregnancy. About 30% of men and 36% of women have reported exclusion from social activities. Some 16.5% of the respondents had been refused employment due to their HIV status and 39.9% reported losing a job or some source of income at least once on account of their HIV status. Over 8% of respondents across all key populations indicated they'd been denied access to health care services. Of those who reported their rights had been abused and sought legal redress, over half reported that nothing had been done (NZP+, GNP+, 2012).

Gay men and men who have sex with men and people who use drugs shun public health facilities for fear of stigma and being reported to law enforcement agencies even when they need help. This is amplified when they have TB, with its perceived connections with

HIV and their sexual orientation and gender identity. They face complex stigma emanating from combinations of several determinants from culture, religion, political, social and economics, as well as ignorance.

*"For us as MSM they embarrass you and even threaten to report you to the police if you made too much trouble complaining"-19-year-old male sex worker, FGD, Livingstone.*

*"Drug Enforcement Commission (DEC) officers will not even educate you, they only arrest you and take you to court...they come to your house and search and if they don't find the drugs, they will place them, so they can arrest you..." – 23-year-old person who uses drugs, FGD, Livingstone.*

LGBTI populations are particularly affected and experience intolerance, discrimination, harassment, and the threat of violence due to their sexual orientation and gender identity (SOGI), (PSAF, 2014, Population Council, 2014 and USAID-Open Doors, 2016). A 2017 study by the Southern African Litigation Center (SALC) on 'LGBTI persons experiences of stigma and discrimination in health care facilities' described significant hostility and poor treatment at health care facilities, as well as the perceived threat of social persecution and legal prosecution. Young LGBTI populations experience bullying and discrimination within the school system. Discrimination against LGBTI populations on the basis of SOGI, including within healthcare, and its impact on the mental and physical health and wellbeing of affected populations, is dealt with in further detail in the LGBTI section, below.

*"The most terrible person for key populations is a nurse, even at PPAZ, the nurse would say you are going to hell" – 28-year-old gay man, FGD, Zambia.*

### International and Regional Guidance on Stigma and Discrimination.

The UNAIDS *International Guidelines on HIV/AIDS and Human Rights* Guideline 5 recommend that States should “enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors...”

The GCHL’s report on *Risks, Rights & Health* recommends that States “ensure that their national HIV policies, strategies, plans and programmes include effective, targeted action to support enabling legal environments, with attention to formal law, law enforcement and access to justice. Every country must repeal punitive laws and enact protective laws to protect and promote human rights, improve delivery of and access to HIV prevention and treatment, and increase the cost-effectiveness of these efforts.”

It also recommends that States “explicitly prohibit discrimination on the basis of actual or perceived HIV status and ensure that existing human rights commitments and constitutional guarantees are enforced. Countries must also ensure that laws and regulations prohibiting discrimination and ensuring participation and the provision of information and health services protect people living with HIV, other key populations and people at risk of HIV.”

The GCHL 2018 *Risks, Rights & Health Supplementary Chapter* includes a further recommendation to deal with the increasing reports of stigma and discrimination on the basis of HIV-related co-infections, such as TB and viral hepatitis. It recommends that governments “prohibit in law all forms of discrimination against people living with and vulnerable to HIV, TB or viral hepatitis. Governments must take steps to repeal or amend any laws or policies that discriminate against people based on HIV, TB or hepatitis status.”

At regional level, the SADC *PF Model Law on HIV in Southern Africa 2008* provides in Article 17 for non-discrimination; it says:

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

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

### Stigma and Discrimination in Zambia

As set out above, Zambia is a signatory to various international conventions that outlaw discrimination on any grounds (including race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status), safeguarding the human rights of all its citizens.

At national level, the *Zambian Constitution* provides protection against discrimination. Article 27 provides that a person shall not be “discriminated against, except under a law that provides for affirmative action”, thus guaranteeing the rights of all people to non-discrimination. Article 266 of the amended *Constitution* prohibits discrimination on the basis of “sex, birth, health and social or economic status.” The extension of these rights towards people living with HIV and TB remains to be tested in the courts of law (NAC, 2016), however in theory the rights to equality and protection from discrimination on the basis of “health status” should apply equally to people living with HIV and TB.

*“The ongoing review of the National HIV/AIDS/STI/TB Framework (R-NASF), which establishes the NAC and sets the policy and strategic orientation of the national response, provides an opportunity to provide stronger guidance on key populations. Stronger and clearer policies supporting human rights and health care access for key populations are necessary for the initiation of an effective, targeted HIV response in Zambia.” NASTAD (2015)*

Voting on proposed amendments to the Bill of Rights, which would have strengthened protection for the anti-discrimination and health rights of people living with HIV, vulnerable and key populations, went to a national referendum in August 2016. Participants voted overwhelmingly in favour of an amended, enhanced Bill of Rights;<sup>3</sup> however voter turnout was 44%, below the 50% threshold required to validate the result.<sup>4</sup>

The National AIDS Commission (NAC) HIV/AIDS/STI/TB Council Act No.10 of 2002 give the NAC and its secretariat a mandate to develop and/or advise government on the policies and plans necessary to combat HIV, AIDS, STIs and TB and mobilise resources for priority interventions including research. It is also mandated to develop guidelines to secure the rights of people living with HIV and strategies for appropriate interventions targeted at the most vulnerable populations.

The 2005 National HIV/AIDS/STI/TB Policy of 2005 (undergoing review since 2014) provides the overall policy framework for managing HIV, STIs and TB in Zambia. It emphasizes:

- The need to create a conducive legal framework for addressing the HIV/AIDS epidemic; address stigma and discrimination; protect human rights; and facilitate a supportive environment for effective prevention of HIV.
- Commitment to ensure that Zambia domesticates international declarations on HIV and AIDS. This would include the *International Guidelines on HIV & Human Rights*, as well as, many other UN declarations such as the UNGASS Political Declaration on HIV and AIDS.

The LEA findings suggest that the broad protection against discrimination in the Constitution does not provide sufficient protection from discrimination for people living with HIV, vulnerable and key populations in Zambia. There is a need to strengthen specific protection from HIV and TB-related discrimination and discrimination against vulnerable and key populations in law, policy and practice. Affected populations also reported difficulties with accessing justice for

rights violations (this is dealt with in further detail in Part IV, below).

#### Recommendations:

- i. Enact specific equality and anti-discrimination provisions to protect the rights of people living with HIV, TB, vulnerable and key populations including YKPs.
- ii. Integrate, in the review of the National HIV/AIDS/STI/TB Policy, strong equality and anti-discrimination protection for all Zambians regardless of their geographical location, gender, age, race, social, economic, and cultural or political status or any other status, and specifically including equality and non-discrimination for people living with HIV, TB, vulnerable and key populations in Zambia.
- iii. Conduct awareness-raising and sensitization campaigns to reduce HIV- and TB-related stigma and discrimination, including working in all sectors and with political, traditional and religious leaders.
- iv. Sensitize health careworkers to reduce stigma and discrimination against all people living with HIV, TB, vulnerable and key populations
- v. Strengthen access to justice and enforcement of rights for HIV-related discrimination.

## Health Laws, Policies and Plans

Health laws, policies and plans provide a critical compass for decision-makers and service providers of the health aspirations for all citizens in Zambia. This section briefly outlines some of the key health and HIV-related laws, policies and plans in Zambia, then looks specifically at four key issues, namely a) non-discriminatory access to appropriate and affordable HIV and related prevention, treatment, care and support, b) voluntary and informed consent to HIV testing; c) medical confidentiality and d) regulation of health careproviders.

## Access to Non-Discriminatory HIV, TB and SRH Prevention, Diagnosis, Treatment and Care

The Constitution provides all people in Zambia with the right to access appropriate and affordable health care services without discrimination, and the legal, regulatory and policy framework as well as practices of health care providers should promote such access. However, it appears that vulnerable populations, and in particular young people and key populations, including young key populations, experience stigma and discrimination in access to health care (as also discussed in the Equality and Anti-Discrimination and the LGBTI Populations sections) and are still not being adequately reached with adequate and appropriate sexual and reproductive health care services.

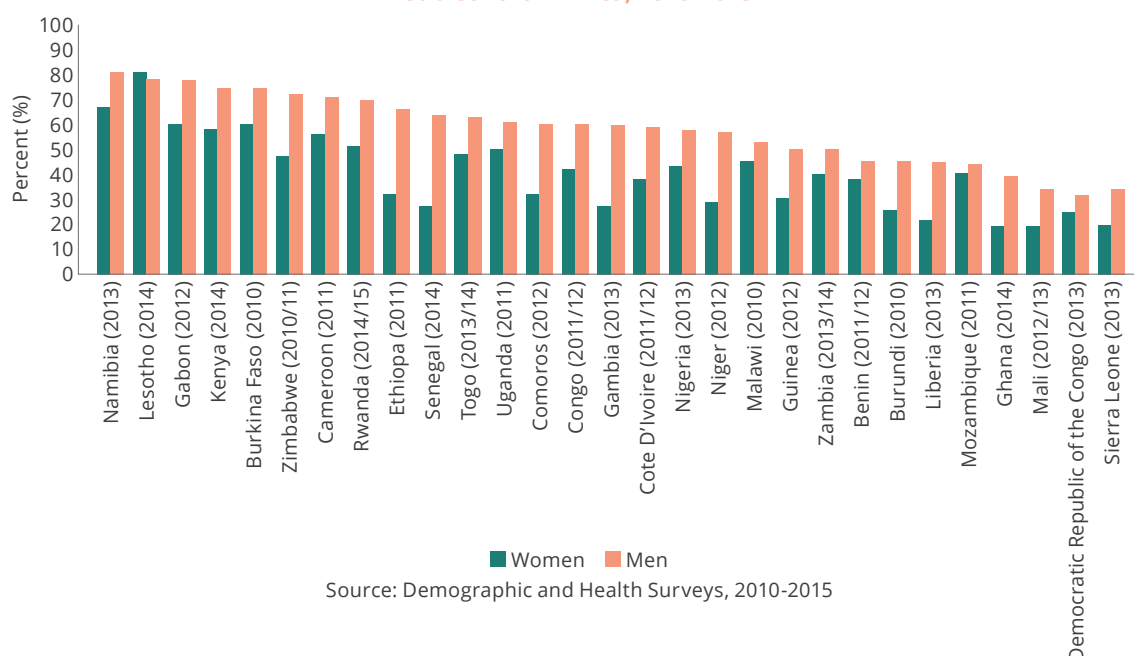
Increases in HIV testing and voluntary medical male circumcision (VMMC) by young people have not impacted on consistent condom use, which remains relatively low amongst the age group 15 – 24 years and amongst sex workers. Among sexually active adolescent girls, over the 2007-2014 period, there was no increase in reported condom use at last sex, with only 36% of girls aged 15-19 reporting condom use.

## International and Regional Guidance

The right to health includes universal access, without discrimination, to HIV testing, prevention, treatment, care and support and is critical to achieving United Nations (UN) commitments to end AIDS and achieve the SDGs. WHO, UNAIDS and UNDP emphasise the importance of rights-based responses to health, including for HIV, TB and SRH. International guidance on creating enabling legal frameworks for HIV responses recommends that public health and related laws protect and promote rights in the context of HIV and AIDS, rather than provide for coercive, punitive and/or discriminatory responses.

The UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights* recommend that states should review, amend and adopt, where necessary, appropriate public health laws, policies, plans and programmes to protect rights in the context of HIV and AIDS and to provide universal access to HIV prevention, treatment, care and support for all populations. This includes reviewing intellectual property laws to ensure access to affordable medicines, as furthermore recommended by the GCHL's 2012 report, *Risks, Rights & Health*. They further recommend that States enact laws to provide

Percent of young women and men (aged 15-24 years) reporting use of a condom at last sexual intercourse with a non-regular partner in the 12 months prior to the survey, sub-Saharan Africa, 2010-2015



for the regulation of HIV-related goods, services and information to ensure widespread availability of quality prevention, treatment, care and support services. They also stress the need to prioritize vulnerable populations.

### Guideline 6: Access to Prevention, Treatment, Care and Support (as revised in 2006)

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

States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.

States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

The GCHL's (2012) *Risks, Rights & Health* recommends that countries develop an effective intellectual property regime consistent with international human rights laws and public health needs, while safeguarding the justifiable rights of inventors, in order to increase access to medicines, including by incorporating and using flexibilities within the

Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement, refraining from adopting TRIPS-plus provisions including anti-counterfeiting legislation that inaccurately conflates counterfeit / substandard medicines with generics, and proactively using other areas of law and policy such as competition law, price control policy and procurement law to increase access to pharmaceutical products.

The SADC PF *Model Law* provides for State obligations related to treatment, care and support and recommends that States take various measures to provide for comprehensive access to health care services in the context of HIV, for all populations. Section 36 furthermore provides for access to affordable medicines through a review of intellectual property law:

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

In Zambia, there is no HIV-specific law. However, there are several relevant laws, policies, guidelines and plans that govern health and related rights and national responses to HIV, TB and SRH. Specific laws and policies are dealt with in more detail in the sub-sections below; however, the general, overall health, HIV, TB and SRH legal and policy framework is set out below.

As set out above, the Constitution contains key rights relevant to health, including those set out below:

- *Article 23 provides protection from discrimination on the basis of race, tribe, gender, place of origin, marital status, political opinions and colour or creed. This right to*



*equality and non-discrimination protects all people from discrimination in access to health care services, including for HIV, TB and SRHR.*

- *Articles 110-112 provide that the State will endeavour to provide adequate medical and health facilities for all persons.*
- *Article 52 of the Bill of Rights provides for the right to health care services, education and social protection*
- *Article 32 of the Bill of Rights provides that a person has the right to privacy, which includes the right not to be searched (this applies to all forced medical examinations) and the right not to have information relating to that person's health status or private affairs unlawfully required or revealed.*
- *Article 51 of the Bill of Rights provides that women and men have the right to equal treatment and opportunities including reproductive health, family planning and access to related information and education.*

Relevant health laws include the following Acts of Parliament set out below:

Chapter 295 of the Laws of Zambia, the Public Health Act provides for the prevention and suppression of diseases and generally to regulate all matters connected with public health in Zambia. The provisions in the Act apply to all persons such as people living with HIV, TB and key populations, including young key populations, and provide for their right to health care services.

The Act also provides for punitive provisions that criminalise the transmission of certain diseases, including venereal disease – although HIV is not included in the definition of venereal disease. (These public health provisions are discussed in the section on Criminalisation of HIV Transmission, below).

The GCHL (2012)'s *Risks, Rights & Health* recommendations have been domesticated in Zambia through Chapter 401 – the Trade Marks Act of the Laws of Zambia – as another measure for increasing access to treatment. This Act enables the government of Zambia to:

- Use its compulsory licensing powers in negotiations to secure access to cheaper HIV and TB treatments;

- Partner with local industry, academics and NGOs to review whether national patent laws include sufficient flexibilities allowing generic competition to drive medicine prices down; and
- Consider whether options such as developing local manufacturing capacity to produce medicines, including TRIPS flexibilities in national patent law or providing for voluntary licensing, will improve access to cheaper HIV, TB and related treatments.

Chapter 304 of the Laws of Zambia, the Termination of Pregnancy Act provides for access to termination of pregnancy under certain conditions. It provides that a pregnancy can be terminated if the continuance of the pregnancy would involve:

- Risk to the life of the pregnant woman; or
- Risk of injury to the physical or mental health of the pregnant woman; or
- Risk of injury to the physical or mental health of any existing children of the pregnant woman.

A pregnancy may also be terminated if there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

The Pharmacy and Poisons Act Chapter 299 of The Laws of Zambia in section 26 (1) provides for the control of the profession of pharmacy and the trade in drugs and poisons. It provides for prohibiting, regulating or restricting the manufacture of drugs, pharmaceutical preparations and therapeutic substances, including those related to HIV, TB and SRH, as provided for in section 26 (2). The Act is important for ensuring the regulation of trade in quality medications and prohibiting false 'miracle AIDS drugs'. The Medicines and Allied Substances Act No. 3 of 2013 of the Laws of Zambia regulates and controls the manufacture, importation, storage distribution, supply, sale and use of medicines and allied substances, to ensure registered medicines, including HIV, TB and SRH medicines in Zambia meet standards of quality, efficacy and safety.

The National Health Insurance Act No. 2 of 2018 provides for sound financing for the national health system and for universal access to quality insured health care services. Section 16 provides that a citizen or established resident that may be exempted from payment of contributions under the Scheme includes in s16(c) a person classified as poor and vulnerable by the Ministry responsible for social welfare; and in s16(e) any other person as may be prescribed by the Minister.

The National HIV and AIDS Strategic Framework 2017-2021 is a multi-sectoral, multi-layer and decentralised response to HIV and AIDS in Zambia for government, communities, civil society organisations, private sector, development partners (bilateral and multi-lateral agencies) to actively participate in the implementation of evidence-based HIV and AIDS programmes. The NASF (2017-2021) HIV Prevention, Treatment, Care and Support programme aims to intensify and scale-up comprehensive prevention, treatment and care programmes so as to reduce HIV new infections, attain the 90-90-90 goals and to promote the fulfilment of human rights and the dignity of all people living with, at risk of, and affected by HIV and AIDS. It defines and highlights the need to include programmes for key populations such as adolescents, sex workers and men who have sex with men, amongst others.

Zambia also has a national Zambia Tuberculosis Programme, including a manual for programme implementation launched in 2017, to manage the national response to TB and ensure access to diagnosis, prevention and treatment for those affected.

Key programmatic achievements for HIV, TB and SRH in Zambia include the following:

- The roll-out of universal access to testing for HIV for adults, guided by the National HIV Testing and Counselling (HTC) Operational Plan 2016-2020. The proportion and number of people tested and counseled for HIV and who have received their results has shown a steady increase from 2,138,961 in 2013 to 2,792,743 in 2014 to 3,270,070 in 2015

(NAC, 2017). By the end of 2015, there were 1,800 health facilities countrywide providing HIV testing and counselling services. Over 3 million HIV tests were conducted among children and adults in 2016 alone (NAC, 2017).

- The treatment programme coverage has also expanded over the years and with a new focus of fast-tracking testing and treatment through the 90-90-90 targets, the prospects for response are encouraging.
- A National Male Circumcision Strategy and Implementation Plan for the period 2010 to 2020 aims to achieve a male circumcision prevalence of 50% by 2020. Due to new and intensified VMMC interventions, by 2015 it was estimated that a total of 184,347 new infections were averted. Adolescent males reporting that they were circumcised also increased by 130% during the same period.
- An implementation framework for pre-exposure prophylaxis (PrEP) was launched in 2018 to guide the implementation of PrEP to select populations; these may include adolescent girls and young women, sero-discordant couples and sex workers.
- An assessment and size estimation of key populations (sex workers and men who have sex with men), conducted by National Alliance of State and Territorial AIDS Directors (NASTAD), Population Council and NAC defined the challenges faced by key populations in accessing medical and prevention services and the training and capacity building needs of healthcare workers. The need for a Key Populations Strategy and Action Plan was identified and a process was set in place to develop such.
- Strategies have been developed to improve outreach and health care access for key populations in Zambia. Implementing partners with support from NAC have been rolling out this and other innovative programmes targeting sex workers and LGBTI communities.

## Other important health policies, strategies and plans to regulate access to health care include:

**The 2017-2021 National Health Strategic Plan** is aimed at reducing the disease burden and accelerating the attainment of the SDGs and other national priorities. The Plan includes four major priority areas: human resources, health service delivery interventions, clinical care and diagnostic service priority interventions, and priority integrated support systems.

**The National HIV/AIDS Policy of 2005** includes the following guiding principles, amongst others:

- The protection and promotion of human rights, equality before the law and freedom from discrimination;
- The promotion of gender equality; and
- The participation of people living with HIV in the national response.

**The Health Policy 2012** sets out the government's commitment to provide equitable access to cost-effective and quality health services as close to the family as possible in a caring, competent and clean environment. It recognizes the importance of, amongst other things, an enabling legal framework and acknowledges the importance of addressing emerging issues such as communicable and non-communicable diseases, health systems strengthening, gender equality, globalization and climate change. The guiding principles of the policy include ensuring equitable access to health care for all the people of Zambia, regardless of their geographical location, gender, age, race,

social, economic, cultural or political status as well as ensure affordability of health care services to all, taking into account the socio-economic status of the people. The policy emphasises measures to "scale-up prevention and control services among vulnerable and high-risk groups" for HIV.

**The National Population Policy 2007** aims to, amongst other things, integrate population variables, reproductive health, gender, and HIV into development planning and programme implementation processes, especially in education, health, and agriculture.

**The National Guidelines for HIV Counselling & Testing (March 2006)** aim to guide quality, available, accessible and expanded HIV testing and counselling services in Zambia. They provide for protection of human rights by ensuring that HIV testing is informed, confidential, conducted on the basis of written or verbal consent, counselling and referrals to appropriate care, treatment and services.

**The Zambia National Guidelines for HIV Counselling & Testing of Children (2011)** aim to provide for the counselling and testing needs of children up to the age of 16 years. They provide for children 7 to 15 years to assent to testing, noting that "at this stage the child may have the capacity to understand implications of the test and can assent; however, consent for HIV testing should be obtained from the parent/guardian unless the child is an 'emancipated minor' (married, pregnant or parent-child)".

Highlights on confidentiality include:

- Confidentiality may be breached in the event of litigation. A counsellor should explain this possibility to the child and the parent/guardian.



- All records of the child's HCT service provision must be managed in accordance with appropriate standards of confidentiality, as prescribed by the Zambia National Guidelines for HIV Counselling and Testing.

**The Zambia Family Planning Guidelines and Protocols (2006)**

provides updated and client centered guidelines to health care providers in Zambia, to guide them in providing appropriate family planning information and services methods to men and women. The guidelines do not provide for young people's access to contraception.

**The National Standards for SRH, HIV and AID Peer Education Programmes (2010)** is a framework to enhance, harmonize and strengthen existing peer education programmes while providing strategic guidance for new HIV, AIDS and Sexual Reproductive Health and Rights (SRHR)-based peer education programmes in Zambia. It includes provision of training for all interested young people on issues around human rights, gender equality, sexual orientation, gender, decision-making and facilitation skills.

**The National Mobile HIV Services Guidelines (2009)** establish mobile/outreach services including mobile counselling and testing, prevention of mother-to-child transmission of HIV (PMTCT) and ART services. This programme covers all populations including key populations.

**The National Reproductive Health Policy 2008** aims to achieve the highest possible level of integrated reproductive health of all Zambians as close to the family as possible so as to promote quality of life. It addresses issues such as safe motherhood, male reproductive health, family planning,

adolescent health, STIs, HIV and AIDS, abortion, infertility, cervical cancer. The policy does not have specific provisions for key populations.

**The National HIV/AIDS Policy for the Education Sector** applies to all learners, employees, managers and providers of education and training in all public and private, formal and non-formal and traditional learning institutions at all levels of the education system in the Republic of Zambia. It provides the framework for responding to concerns and needs of those infected with and affected by HIV and AIDS in the education sector.

**The National Youth Policy (2015)** aims to ensure the development of young people and deals with various issues, including gender issues, health, HIV and AIDS. It stresses the importance of the active participation of youth in decision-making processes, policy development, programming and project implementation. The policy does not specify key populations as a priority group but does refer to "youth who abuse drugs". The Policy stresses that "all youth development initiatives shall not discriminate against any youth on the basis of sex, age, gender, race, disability or any other form of discrimination as enshrined in the constitution of the country. The policy seeks to promote gender equity and equality, including working to eliminate all forms of discrimination at all levels."

### ***LGBTI messages to the Minister of Health***

*“The Minister of Health should talk to the Minister of Religious Affairs not to promote hate speech” – 22 years old gay man*

*“I am asking for my freedom in accessing health services...I have health rights, the Minister should punish providers that discriminate against LGBTI people” – 26-year-old gay man, Zambia*

*“Please legalise lubricants...every time we ask for them they are not available, and we want finger coats and dental dams” – Lesbian woman, Zambia*

Despite the existence of guiding laws and policies, *current gaps and challenges* highlighted in the NASF (2017-2021) include the following:

- Criminal laws continue to impact on the ability of key populations, such as sex workers, gay men and men who have sex with men, transgender people, people who use drugs and prisoners, to access appropriate health careservices without discrimination.
- Key populations, including young key populations, are not adequately reached with health information and programmes and still lack access to specific protection methods including lubricants, finger coats, dental-dams and clean syringes.
- Young people are not adequately reached with appropriate and youth-friendly health services in the health care sector. Programmes in schools do not provide adequate services (e.g. access to condoms).
- Health careworkers are not trained in and aware of their responsibilities to provide treatment and care without discrimination, in particular to key populations.
- Weak health systems, including inadequate numbers of trained medical staff, inadequate and inequitable distribution of health infrastructure and equipment and weak logistical management of drugs and medical supplies, create barriers to access to HIV, TB and SRH services.

*“We need to orient all service providers including those in rural areas as we exist everywhere” – 18-year old lesbian, Zambia*

*“I had a hard time accessing PrEP last week, the providers didn’t even know how to explain PrEP works and how to use the drugs” – 23-year old gay man, Zambia*

### **Recommendations**

- i. Strengthen access to appropriate health careservices, including psychosocial support and expanded access to PrEP for all key populations, including young key populations.
- ii. Strengthen training for health workers on human rights, gender equality, medical ethics, to reduce stigma and discrimination against people living HIV, TB and all key populations, including young key populations.<sup>5</sup>
- iii. Strengthen training for health careworkers on the specific and diverse health needs of key populations, including young key populations.
- iv. Integrate youth and key population-friendly health services in mainstream health care centers and improve access to health information and services for young people in schools.
- v. Strengthen access to complaints mechanisms for HIV-related human rights violations within health care.

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

HIV testing is the gateway to treatment and care, and all efforts should be made to encourage populations, including young key populations, to voluntarily test for HIV. This includes by ensuring non-discrimination, voluntary HIV testing with informed consent and confidentiality as well as independent access to HIV testing for young people, as discussed further below.

While HIV testing has increased in Zambia, it is lowest amongst younger women and men. According to ZDHS (2013-2014), the percentage of women who have been tested for HIV was lowest among those aged 15-19 (49%), those who have never been married and never had sex (32%), those with no education (77%), and those in the lowest wealth quintile (77%). Sixty-four percent of men age 15-49 were, at the time, tested for HIV with a small proportion of men who had been tested not receiving the results (4%). Young men (age 15-19) (32 %) and those who have never been married and never had sex (28%) were less likely than their counterparts to have been tested for HIV.

Hargreaves et.al (2018) in their study in 21 communities in Zambia and South Africa concluded that HIV stigma remains unacceptably high in Zambia and may act as a barrier to HIV prevention and treatment, consistent with findings by the NZP+ and GNP+ *People Living with HIV Stigma Index* study conducted in 2011, which highlighted that 10% of young people and those over 50 years reported being tested without any counseling at all, indicating that adherence guidelines are not being followed. The report by Hargreaves et.al (2018) also noted that stigma experienced in a health care setting was more commonly reported by women than men. Fear of disclosure was also cited as a concern in the Stigma Index study.

The expansion of provider-initiated HIV testing and the adoption of a policy of “test-and-treat” in Zambia has led to some concerns that HIV testing will be mandatory. Instead, HIV and human rights organisations have stressed the need for an enabling legal framework that discourages stigma and discrimination and reduces other human rights and gender-related barriers to access to HIV testing.<sup>6</sup>

### International and Regional Guidance:

The UNAIDS (2006) International Guidelines on HIV and Human Rights recommend that public health and related laws should, amongst other things, provide for HIV testing only with voluntary and informed consent (apart from surveillance and other unlinked epidemiological testing) and with pre- and post-test counselling; exceptions to voluntary HIV testing should only take place where authorized by a court of law.

WHO (2012) defined the five key components of counselling and testing (the “5 Cs”) for all HIV Testing and Counselling (HTC) services:

- People being tested for HIV must give informed **consent** to be tested. They must be informed of the process for HTC, the services that will be available depending on the results, and their right to refuse testing. Mandatory or compulsory (coerced) testing is never appropriate, regardless of where that coercion comes from: health-care providers, partners, family members, employers, or others.
- Testing services must be **confidential**, meaning that the content of discussions between the person tested and the health-care worker, testing provider, or counsellor, as well as the test results, will not be disclosed to anyone else without the consent of the person tested.
- Testing services must be accompanied by appropriate and high-quality pre-test information or **pre-test counselling**, and **post-test counselling**.
- Provision of **correct test results**. Testing must be performed, and quality assurance measures followed according to internationally-recognized testing strategies, norms, and standards based on the type of epidemic. Results must be communicated to the person tested unless that person refuses the results.

- **Connections** to HIV prevention, treatment and care and support services should be supported through concrete and well-resourced patient referral, support, and/or tracking systems.

UNAIDS (2017) *Fast-Track Strategy* suggests that HIV testing programmes must not include coercive approaches and must include informed consent with adequate pretest information that is accessible to, and understandable by, the person being tested.

The WHO *Technical Briefs* for young key populations provide for various recommendations to increase access to health care services for young key populations, including through:

- Reducing stigma and discrimination against young key populations
- Reviewing age of consent laws to ensure young key populations have independent access to HIV testing (and other sexual and reproductive health care services)
- Sensitizing and training health care workers on the rights and needs of young key populations.

Article 13 of the SADC PF *Model Law on HIV in Southern Africa* 2008 provides for HIV testing only with voluntary, informed consent of the person to be tested or, in the case of children 16 years (or a lower age determined by a country, but at least 16 years) and younger, with the consent of the parent / guardian, and with pre- and post-test counselling.

### Informed Consent to HIV Testing and Treatment in Zambia – Law and Policy

There is no provision in law for conditions for HIV testing. However, there is jurisprudence by both the Supreme Court and High Court finding that HIV testing (and treatment) should only be conducted with the free, voluntary and informed consent of the individual – without undue influence, coercion, fraud, misrepresentation or mistake.<sup>7</sup> There are also good provisions in policy.

The Zambia *National Guidelines for HIV Counselling & Testing* (March 2006) provide general guidelines for provision of HTC in line with international and regional guidance. They provide for the need for informed consent for all HIV testing and for children of 16 years and older to consent independently to consent to HIV testing while ensuring that children 7 to 15 years may assent to testing where they have the capacity to understand implications of the test:

- All clients should be helped to understand the importance of HIV testing so that can make an informed decision
- Even if recommended by the health worker, clients may decline an HIV test (opt-out).
- Consent can be given verbally or in writing.
- Those 16 years of age and above requesting counselling and testing should be considered able to give full, informed consent.

As set out above, HIV testing and counselling amongst young people needs improvement. UNAIDS (2016) noted that coverage of HIV testing, and counselling remains significantly low among young people aged 10–24 years. Self-reported survey data from sub-Saharan Africa indicate that only 9% of adolescent boys aged 15–19 years and 13% of adolescent girls from the same age group have been tested for HIV and received the results in the last 12 months and that legal barriers, including age of consent and parental consent laws, continue to hinder access to services, including sexual and reproductive health services for adolescents and youth.

Despite protections for voluntary, informed consent in policy (and jurisprudence), it appears that populations, including young populations, are still reluctant to voluntarily test for HIV and have fears of disclosure of their HIV status. It is important to strengthen Zambian law and policy to create an enabling framework in which all affected populations may feel confident that they can access services, without fear of discrimination.

## Recommendations

- i. Provide for voluntary, informed consent for voluntary HIV testing in law
- ii. Provide for the age of consent to HIV testing (and other sexual and reproductive health care services) in law and policy and consider lowering the age of consent to below 16 years of age.

## Confidentiality

Confidentiality is about respecting and withholding private information. Breaches of confidentiality create fear and discourage people living with HIV from seeking out health services. There are a number of issues that may arise in the context of confidentiality, HIV, TB and SRH, including who receives/is entitled to receive confidential information regarding a person's health status, at what age an adolescent is entitled to confidentiality about his or her health status, at what age a child is entitled to receive information from a parent / guardian about his or her health status and when a disclosure of information is lawful.

UNAIDS (2017) notes that the right to privacy in HIV services must extend beyond just preserving confidentiality of HIV status: it also must protect the confidentiality of other health or personal information obtained in the course of providing services. Disclosure of information may expose a person to stigma, discrimination, criminalization, violence or other abuse. Depending on the setting, this can include information about a person's sexual orientation or particular sexual practices, gender identity or expression, sex work, drug use or dependence (and treatment for drug dependence), ethnicity, migrant status, prior criminal record, socio-economic status, and more.

*"A transwoman had an STI and when she went to the clinic, they tested her positive for HIV and the nurse started publicizing her results..." – lesbian woman, FGD, Livingstone.*

In Zambia, the LEA revealed reports of fear of disclosure, as well as breaches of confidentiality in the health care sector and by community organisations, including breaches of information on sexual orientation and gender identity.<sup>8</sup>

In addition, young people reported instances where they were not told information regarding their health status, when this information was provided to their parents or guardians, and the difficulties this created for them when told. LEA FGDs with young LGBTI populations reported the following experiences with services providers in 2018:

- *"Staff at service centres (cleaners, service providers) (who call themselves straight) – are not properly oriented to deal with key populations"*
- *"They talk key populations down and disclose confidential information to the public"*
- *"At one facility, transgender identity was disclosed by a facility manager and it went viral...this was at one of the friendly corner services in Livingston"*
- *"Overall top leaders in the LGBTI community are the ones disclosing/exposing members to the public"*
- *"Facilities do not keep confidentiality"*

A qualitative study (Mburu et.al. 2014) examining the experiences of adolescents living with HIV in Kitwe, Kalomo and Lusaka in Zambia and fears around disclosure of HIV status amongst adolescents, as well as the source of support provided by disclosures, found that:

Adolescents, especially younger ones, cited numerous cases in which their initial difficulties with and anxieties about initiating antiretroviral therapy were mitigated by encouragement from their close relatives.

- While some participants reported having disclosed their HIV status to their boyfriend or girlfriend, others had not disclosed because they feared abandonment or other negative consequences

- One adolescent narrated an incident in which her status was disclosed by her auntie to other people outside her family without her knowledge
- Along with family members, peers who were also living with HIV featured prominently as a source of psychosocial support and friendship.

*“I used to come to the hospital to [collect] medicine without knowing the reason why, until I finally confronted my father and he told me the truth in 2008. My mother did not want to tell me. Every time I asked her what was wrong with me she would not tell me. When I found out about my status I was shocked, and I felt very sad.” – 14-year-old female, Lusaka: Mburu et.al. (2014)*

### International and Regional Guidance on Confidentiality

International and regional guidance recognizes the importance of protecting people’s right to confidentiality in health care, in order to encourage access to health care and achieve public health goals.

UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights* provide for the right to confidentiality of all persons and prohibit disclosures of HIV status without informed consent. They recognise that disclosures of confidential HIV status may be reasonable in only defined circumstances where a clearly identified 3<sup>rd</sup> party is at risk of HIV exposure and various steps have been taken to ascertain risk and obtain consent for disclosure.

Similarly, Article 15 of the SADC PF *Model Law on HIV in Southern Africa* 2008 provides for every person’s right to confidentiality with regard to his or her HIV test results. It provides for disclosures of HIV status to a third party at risk, in clearly defined circumstances set out below:

“A person providing treatment, care or counselling services to a person living with HIV may notify a third party of the HIV status of that person only where:

- a. the notifying person is requested by the person living with HIV to do so; or
- b. all the following circumstances exist:
  - i. the third party to be notified is at immediate risk of HIV transmission; and
  - ii. the person living with HIV, after appropriate counselling, does not personally inform the third party at risk of HIV transmission; and
  - iii. the person providing treatment, care or counselling services has:
    - (aa) properly and clearly informed the patient that he or she intends to notify the third party under the circumstances; and
    - (bb) ensured that the person living with HIV is not at risk of physical violence resulting from the notification; or
- c. all the following circumstances exist:
  - i. the person living with HIV is dead, unconscious or otherwise unable to give consent to the notification; and
  - ii. is unlikely to regain consciousness or the ability to give consent; and
  - iii. in the opinion of the health care provider, there is or was a significant risk of transmission of HIV by the person living with HIV to the sexual partner(s).

### Policy and Legal Framework on Confidentiality.

Section 2.8.2 of Zambia’s 2005 HIV/AIDS Policy emphasizes the right to confidentiality, noting that “confidentiality is key to ensuring that the right to privacy of infected persons is upheld. It is, therefore, important to allow infected person’s space to conscientiously choose to either make their status public or keep it private. Confidentiality should, however, not apply to one’s sexual partner or spouse as doing otherwise would encourage willful transmission.”

It furthermore provides that “confidentiality of children’s HIV status is strictly maintained and communicated to the child, parents, guardians or prospective foster parents only if the communication does not harm the rights of the concerned child.”



For child who have attained the age of 16, all records of the child's HCT service provision must be managed in accordance with appropriate standards of confidentiality, as prescribed by the *Zambia National Guidelines for HIV Counselling and Testing*.

Confidentiality and anonymity is also provided for in the *National Guidelines for HIV Counselling & Testing* (March 2006), which provide that health care providers must maintain the highest level of confidentiality for all HIV testing; test results should only be shared with those who need to know how to provide appropriate care, with the knowledge and consent of the client.

Other elements of confidentiality applicable in Zambia in line with national guidelines include:

- a. **HIV test results are confidential** and should be shared only with the client
- b. **Shared confidentiality and disclosure** is encouraged to e.g. family members and health care providers to reduce stigma, foster acceptance and ensure continuum of care.
- c. **Breaches of confidentiality** may occur for litigation purposes.
- d. **Parents should share information with a child with HIV:**
  - i. When the child starts asking questions about their health or medication they may be taking.
  - ii. When the child is mature enough to comprehend information being disclosed (i.e. 5-7 years).
  - iii. Readiness of the parent/guardian to talk about it and readiness of the child to understand and change his/her life based on the knowledge of his/her status.
- e. **Confidential record keeping** is also an important element of confidentiality:
  - i. Clients' records must be stored securely.
  - ii. Only personnel with a direct responsibility for clients' medical condition should have access to the records.
  - iii. All personnel with access to medical records on which HIV test results are recorded should be trained in procedures to maintain confidentiality of HIV test results.

f. **Written results** must meet set standards for maintaining confidentiality:

- i. HTC sites should not provide written results.
- ii. Clients requesting testing for official reasons such as employment or to obtain a visa should be referred to the in-charge of the facility who may authorise release of the written results to the requesting organisation.

### Under the health professions code of ethics and discipline of the Health Professionals Council of Zambia, confidentiality can be broken if:

- The patient or next of kin or patient's legal advisor gives express, informed, written or verbal consent. In the case of a minor, the written or verbal consent of a parent or guardian is required.
- The information is required by law.
- The information regarding a patient or client's health is given in confidence to a relative or other appropriate person, in circumstances where the health practitioner believes it is undesirable on medical grounds to seek the patient or client's consent.
- The disclosure is in the public interest.
- The information may be disclosed for the purpose of a medical or health research project. In such a case the project should have been approved by a recognised Ethics Committee appointed for such a purpose and that the participant consented to the disclosure of such research information.
- In the health practitioner's opinion, disclosure of confidential information to a third party is in the best interest of the patient.

Despite protection for the right to confidentiality in policy, it appears that stigma, discrimination, a mistrust of the health care system and fear of disclosure of confidential information (health status and SOGI) continue to act as a barrier to HIV testing, particularly for young people, including young key populations.

The provisions for breaches of the right to confidentiality are not in complete conformity with international and regional guidance and could be strengthened.

*“The health services in Livingstone are messed-up, they don’t maintain confidentiality and providers are judgmental...the LGBT community does not know how to take care of themselves”*  
– 22-year-old gay man in Livingstone

## Recommendations

- i. Provide in law for the right to confidentiality with regard to all health information and health status, including information relating to key populations, and for strict conditions under which disclosures may take place.
- ii. Sensitize and train health careworkers on the rights and needs of all populations in relation to confidentiality, particularly for young people and key populations in all their diversity, including young key populations.
- iii. Strengthen complaints mechanisms to enable affected populations to access remedies for discrimination and rights violations in healthcare.

## Regulation of Health Service Providers and Professionals

Research shows that people living with HIV, vulnerable and key populations experience stigma and discrimination in the health care sector at the hands of health care

professionals. They report various forms of human rights violations, including discriminatory and undignified treatment, verbal, physical and even sexual abuse, denial of access to health care services, conditional access to services and breaches of confidentiality.

The regulation of the health care sector and its professionals is critical to ensure that health care providers comply with standards of health care, follow correct procedures and provide adequate levels of care. Regulation of the health care sector should include setting standards, detection, measuring, monitoring performance and enforcement of the rules and guidelines.

## International and Regional Guidance

The UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights* Guideline 3 recommend that States review their public health laws and policies to address public health issues around HIV and AIDS. They provide that “public health legislation should require that health-care workers undergo a minimum of ethics and or human rights training in order to be licensed to practice and should encourage professional societies of health care workers to develop and enforce codes of conduct based on human rights and ethics, including HIV-related issues such as confidentiality and the duty to provide treatment.”

UNAIDS has identified the training of health care workers in law, ethics, human rights and HIV as one of 7 key programmes to reduce stigma and discrimination in national responses to HIV (UNAIDS, 2012).

Article 6(3) of the SADC PF *Model Law* requires the training of health care providers to include education on HIV-related ethical and human rights issues such as confidentiality, attitudes towards people living with or affected by HIV, the duty to treat and informed consent.

## Regulations of Health Care Providers

In Zambia, various Acts of Parliament contain provisions relating to the regulation of health



service provision. Some of the key acts and their provisions are set out below:

The National Health Services Act Chapter 315 of The Laws of Zambia establishes the Central Board of Health and provides for the establishment of management boards for hospitals and health services.

The Health Professionals Council of Zambia's Professional Code of Ethics and Discipline: Fitness to Practice, 2014 covers professional conduct of all the registered health professionals employed in the public and private sector, apart from nurses who are covered under a different Act. Notable principles include the following:

- A health professional shall not intervene in a patient's or client's treatment or treating a patient/client without obtaining adequate informed consent from the patient/client except in an emergency.
- A health professional shall not willfully neglect, abandon or refuse to attend to a patient/client entrusted into a health practitioner's professional care to such an extent that the neglect or refusal is not in the best interest of the patient/client.
- A health professional shall not discriminate in the management of patients/clients based on the patient's/client's lifestyle, culture, beliefs, race, sex, sexuality, disability, age, ethnicity, social or economic status.
- Any action by a health practitioner which breaches this trust will constitute professional misconduct:
  - i. Improperly disclose information which he/she obtained in confidence from or about a patient or client;
  - ii. Exerting improper influence upon a patient or client to lend him/her money or given other favours;
  - iii. Entering into an emotional and/or sexual relationship with a patient/client or with a member of a patient's/client's family which disrupts the patient's/client's family life or otherwise damages or causes distress to the patient/client or the patient's family.

- It is a health practitioner's duty to strictly observe the rule of patient/client confidentiality by refraining from disclosing voluntarily to any third-party information, which he/she has learned directly, or indirectly in his/her professional relationship with the patient or client.

The Medical and Allied Professions Act Chapter 297 of The Laws of Zambia provides for the regulation of medical, paramedical, dental and allied professions. It provides for a Disciplinary Committee to hear and receive evidence and summon witnesses. In section 58 (4), the Act provides that the High Court may, on any appeal under this section (a) confirm, vary or set aside any finding of, penalty imposed or direction given by the Disciplinary Committee, (b) confirm the rejection by the Disciplinary Committee of the application for restoration or direct the restoration of the name to the register and (c) remit the matter to the Disciplinary Committee for further consideration.

The Nurses and Midwives Act Chapter 30 of The Laws of Zambia provides for the registration, enrolment, control and training of nurses and midwives. Section 27(1) provides that if any registered or enrolled person is, after due inquiry, judged by the Disciplinary Committee to have been guilty of misconduct, the Disciplinary Committee may impose various penalties.

Despite regulation of health care workers, including a professional code of ethics and disciplinary processes, the LEA and SALC (2016) found reports of breaches of health rights to non-discrimination, access to health care services, testing and treatment only with voluntary and informed consent and confidentiality. Key populations, including young key populations, did not feel willing or able to complain and seek redress for health care violations.

### Recommendations

- i. Strengthen training for health careworkers in human rights, gender equality and medical ethics and the rights and diverse needs of people living with HIV, TB,

vulnerable and key populations, including young key populations.

- ii. Strengthen complaints mechanisms to improve access to justice for rights violations in healthcare. Rescued

## Adolescents and Youth

The United Nations Population Fund (UNFPA) in 2016 noted that Zambia, has 4.8 million young people aged 15-35yrs, which accounts for 36.7% of total population, the largest population of youth in its history. This presents an enormous opportunity to transform the country for the future with targeted investments. Zambia's youth have the potential to be the innovators, creators, builders and leaders of sustainable development.

Evidence shows that young people are at high risk of HIV exposure, and reaching young people is critical to end AIDS. According to UNAIDS (2016), in 2015, an estimated 29 adolescents acquired HIV every hour with 250, 000 [180 000–340 000] new HIV infections among adolescents reported in the same year. Of these, 65% occurred among adolescent girls. It is also noted that young women aged 15–24 years are at particularly high risk of HIV infection, accounting for 20% of new HIV infections among adults globally, despite accounting for just 11% of the adult population. In sub-Saharan Africa, young women accounted for 25% of new HIV infections among adults and women accounted for 56% of new HIV infections among adults.

### Saving Rose (16 years) from Child Marriage

Sixteen-year-old Rose Banda, of Mwalumina Village in Chongwe District of Zambia was married off early after failing her grade nine exams in 2016. Thanks to the collective efforts of the ZCCP-KWATU and the

local leadership including the local Chief, Rose was rescued from this life-changing predicament and is now back at pursuing her secondary school education.

*"I work like a slave and my guardians would treat me differently from my cousins. I was treated like the maid for everyone at home."* – Rose

*"Rose was withdrawn at first but after counseling she has now improved in class performance. She will require skills training to be an effective peer educator. We hear she is encouraging other girls to concentrate on school in order to become empowered citizens"* – Ms. Mukuli (Rose's Teacher)

*"I am very happy that am back at school. I am grateful to ZCCP/Kwatu and Chieftainess Nkomesha for helping me. I now just want to focus on my school, complete grade 12 in two years' time, proceed to college before I start thinking about marriage. I want to become a nurse and I will work hard so that I become a role model in my village. I continue to share the challenges that come with marriage with my friends"* – Rose

In Zambia, the ZDHS of 2013-2014 revealed that amongst respondents aged 15 – 24, 15% of young men and 12% of young women have had sex before age 15, noting that "young people who initiate sex at an early age are typically at higher risk of becoming pregnant or contracting an STI/HIV than young people who delay the onset of sexual activity."

Mburu et.al. (2014) contend that "the number of adolescents living with HIV in Zambia is increasing, yet little is known about their experiences in a social context. Such knowledge could enable HIV programs to better respond to their needs." Adolescents and youth in Zambia are a heterogeneous group, varying according to age, social-economic environment, gender vulnerabilities,

and religious background (Mburu et.al. 2014). In this section, we focus on three key issues affecting all young people, particularly adolescent girls and young women: child marriage, sexual violence and exploitation and access to sexual and reproductive health care services. Issues around confidentiality and HIV testing have been dealt with above. Issues affecting young key populations in the context of HIV, TB and SRH are dealt with in the sections on key populations.

## Child Marriage

According to UNAIDS (2016), worldwide, more than 700 million women alive today were married as children (under the age of 18 years): “Approximately 250 million were married before the age of 15 years. Child brides are often unable to effectively negotiate safer sex, which leaves them vulnerable to STIs including HIV and early pregnancy. Around 120 million girls worldwide (slightly more than 1 in 10) have experienced forced intercourse or other forced sexual acts at some point in their lives.”

UNFPA (2016)’s review indicated urgent investments are required to address the development challenges faced by young people in Zambia, reiterating that child marriage is a critical issue requiring action. Zambia is among the top twenty countries with the highest prevalence rate of child marriage in the world. The 2013-2014 ZDHS found that child marriage was more common among girls than boys: 17% of girls aged 15-19 are married compared to only 1% of boys of the same age group. UNICEF (2013) reported that child marriage remains very common in Zambia: about 18 % of adolescent girls aged 15-19 are in marital unions. Although median age at first marriage has remained constant, at 18 years, 11 % of women aged 20-49 have been married by the age of 15, compared with a figure of less than 1% for men; this is especially the case in rural areas. In Zambia, 53.2% of girls with no education marry early between the ages 15-19, in contrast to 23.1% of girls with secondary education for the same age group.

Unintended pregnancies<sup>9</sup> and child marriage impact severely on the developmental rights of

the child. UNICEF’s report revealed that after Grade 7, around the age of puberty girls tend to drop out of school more frequently, largely because of unplanned early pregnancy and marriage. According to the Ministry of Gender (2016), “qualitative research indicates that child marriage and early sexual debut are linked to the limited opportunities available to young people, particularly in rural areas, turning marriage into the ‘best of limited options.’” The Ministry of Gender, 2016 quoted data that showed that 27% of ever-married females in the 12-24 age brackets not only had married before they turned 18 but were also unable to read and write. There are also elevated school dropout rates related to pregnancy recorded in Zambia, with 16,000 girls leaving school due to pregnancy: only about 50% return after delivery, despite the policies in place allowing and encouraging re-entry.

The health impact of child marriage is severe. Adolescents may die from childbirth complications. They are also at risk of getting infected with STIs, including HIV, due to power imbalances and limited ability to negotiate safer sex. The ZDHS found that, for the vast number of women married at 18 years,<sup>10</sup> this increased their vulnerability to a lifetime risk of high fertility (number of children they will have in their lifetime); higher risk of dying from a pregnancy related death; higher risk of limited education and higher risks of struggling to access gainful employment and economic opportunities.

## International and Regional Guidance

International and regional guidance recognises the serious impact child marriage has on the development of the child, particularly the girl child, and recommends prohibiting marriage below the age of 18 years. The African Union (AU) has spearheaded a continental campaign to end child marriage in Africa and SADC PF recently adopted a *Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage*, to encourage Member States to adopt similar legislation in their countries.

Article 21 of the African Charter on the Rights and Welfare of the Child provides for State Parties to take all appropriate measures to

eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child. Article 21(2) specifically recommends that “child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory.” Article 6 of the Maputo Protocol provides similarly.

Articles 16 and 17 of the SADC PF Model Law recommend that the State adopt the following provisions in law:

“Minimum age of marriage and contractual capacity

From the commencement of the law, a person under the minimum age of marriage has no capacity to consent to a marriage or contract a marriage and any marriage purportedly entered into or solemnised is a prohibited marriage and void.

Prohibition of child betrothal and marriage

(1) From the commencement of the law – (a) the betrothal of a child is prohibited; (b) a marriage between a child and an adult or between two children is prohibited; and (c) a person shall not contract, solemnise, abet or aid, promote, permit, coerce or force the betrothal or marriage of a child.”

### Child Marriage in Zambia

The National Gender Policy defines ‘child marriage’ as marriage of children younger than 18 years. There is a supportive political environment in Zambia for ending child marriage and for addressing both the causes and consequences of child marriage, with a nation-wide campaign to end child marriage launched in 2013 that includes engagement with traditional authorities.<sup>11</sup>

In March 2016, the National Strategy on Ending Child Marriage was developed. It is guided by and premised under the following Acts:

- The Constitution, Chapter 1 of the Laws of Zambia which provides for a dualist legal

system and, as a result, allows for marriages to take place in accordance with either customary or statutory law.

- The Marriage Act, Chapter 50 of the Laws of Zambia which allows for marriage (with parental consent) from 16 years of age. The Act establishes the legal age for marriage at 21 years but allows young people below 21 years of age, in terms of s17, to marry subject to written consent being given by a parent or guardian. Section 33 prohibits marriage below 16 years of age, unless consent has been provided by a Judge of the High Court.
- The Juveniles (Amendment) Act, No. 3 of 2011.
- The Adoption (Amendment) Act, No. 24 of 1997.
- The Anti-Gender-Based Violence Act, No. 1 of 2011 which recognises child marriage as a form of gender-based violence and therefore provides for the protection of victims of such violence.
- The Education Act, No.23 of 2011 which provides for offences against any person who marries a student or takes a child out of school to be married. The Act further enables everyone with the right to go to school, regardless of marital status.
- The Penal Code (Amendment) Act, No. 1 of 2012 which provides that defilement or sex with anyone younger than 16 is prohibited.
- The Local Courts (Amendment) Act, No. 18 of 2003.
- The Matrimonial Causes Act, No. 20 of 2007.

Despite a national campaign, child marriage continues to be an issue in Zambia. There is a recognition that the Anti-GBV Act 2011 does not do enough to prevent gender-based violence, which includes child marriage. In addition, the Marriage Act, although setting the age of marriage at 21 years, does allow for children of 16 years to marry, with parental consent. The law is further hindered by inconsistencies with other laws and policies on children and by the existence of a customary legal system that allows girls to be married as soon as they have reached puberty.<sup>12</sup> The Ministry of Justice (2016) noted that, “The legal system is dualist in nature and, as a result, marriages can take place in accordance with either customary or statutory law. The legal

situation regarding the marriage of children is further complicated by differences between statutory and socio-cultural definitions of and understandings of a child.”

#### Recommendations<sup>13</sup>

- i. Expedite the review of the Anti-GBV Act to provide for prevention of all forms of gender-based violence.
- ii. Harmonise the legal framework to prohibit marriage below 18 years of age.
- iii. Strengthen dialogue and sensitization of traditional authorities and communities to challenge prevailing attitudes, behaviours, beliefs and practices around child marriage.
- iv. Mobilize financial resources in order to enable implementation of programmes aimed at preventing and reducing children’s vulnerability to marriage.
- v. Create a national coordinating body to ensure harmonization and effective joint implementation between the various partners.

## Sexual Violence and Exploitation of Children and Young People

Sexual exploitation of young people in Zambia has been identified as a concern. Akani et.al (2015) reported on child sexual abuse in Zambia, including acts involving “forcing or encouraging a child to take part in sexual activity and may include penetration of the vagina, anus, mouth, by the penis, fingers or other objects and non-penetrative activities... Non-penetrative sexual activities may include attempts to do any of the above listed but also fondling with or without clothes on, exhibitionism, watching others engage in sexual acts and pornography.” Akani et al report various physical complaints resulting from sexual abuse, including STIs and physical injuries resulting from violent attack by the assailant. The report noted that:

- All the abusers were males, with the most common being neighbors (24%) and boyfriends (20%).

- Cases of incest (14%) were reported in which uncles were the commonest perpetrators.
- Penile penetration was commonly reported at 69% of the cases and only 5% of the victims reported condom use.
- Most of the victims were abused at least twice.
- In 84 of the cases, physical force was used to achieve submission.

Akani et.al (2015) suggested that awareness and intervention packages need to include family packages, given the high rates of incestuous abuse cited above.

UNFPA (2016) has identified unacceptably high rates of sexual and physical violence, where almost 30% of girls aged 15-19 have experienced physical or sexual violence from a husband or partner. There also reported rising numbers of cases of young people below the age of 18 years who are sexually exploited into selling sex.<sup>14</sup> According to an End Child Prostitution and Trafficking Report (2007), child prostitution is the most common form of commercial sexual exploitation of children in Zambia: “Prostitution is widespread in large cities and constitutes the country’s most serious trafficking problem.”

*“Lulu is a pretty, shy seventeen-year-old girl. Though she is only in her teen years, she has slept with at least twelve men so far. According to her, this is not a lot. She had only started prostitution about two months earlier. She had never slept with a man before she got into the business. Two months, twelve men. At an average of six men a month, or two and half men a week, this girl is on a fast track in this industry, I thought...” – Lusaka Times, 21 February 2017.*



## International and Regional Guidance

All children and young people need to be protected from sexual exploitation. Article 34 of the CRC and Article 27 of the African Charter on the Rights and Welfare of the Child (ACRWC) require the State to protect children from all forms of sexual exploitation and abuse.

The Committee on the Rights of the Child's General Comment 3 (HIV/AIDS and the Rights of the Child) notes the particular importance of protecting children from violence and abuse and recommends that legislation be developed as well as programmes to provide information, and that prevention and detection measures be integrated within HIV programmes.

The GCHL (2012) report *Risks, Rights & Health* recommended that countries "[e]nsure that the enforcement of anti-human-trafficking laws is carefully targeted to punish those who use force, dishonesty or coercion to procure people into commercial sex, or who abuse migrant sex workers through debt bondage, violence or by deprivation of liberty. Anti-human-trafficking laws must be used to prohibit sexual exploitation and they must not be used against adults involved in consensual sex work." It furthermore noted that countries must "[e]nforce laws against all forms of child sexual abuse and sexual exploitation, clearly differentiating such crimes from consensual adult sex work."

Article 7(1) of the SADC PF *Model Law* provides that states protect people from sexual violence and harmful practices:

## 7. Protection Against Violence

(1) The State shall ensure that women and girls are protected against all forms of violence, including sexual violence, rape and other forms of coerced sex, as well as against traditional practices that may negatively affect their health."

## Situation in Zambia

Section 266 of the 2016 amended Constitution defines a child as a person below the age of 18, while an adult is defined as a

person who has attained or is above the age of 19. The Penal Code (Amendment) Act, No. 1 of 2012 provides that defilement or sex with anyone younger than 16 is prohibited.

Section 47 (1) of the Juveniles Act 53 on Causing or Encouraging the prostitution of girls under sixteen provides that "If any person having the custody, charge or care of a girl under the age of sixteen years causes or encourages the seduction, unlawful carnal knowledge, or prostitution of, or the commission of an indecent assault upon, her, he shall be liable to imprisonment for a term not exceeding two years."

UNDP (2018) notes that there is strong political commitment in Zambia to deal with sexual violence against children and young people and to ensure perpetrators are brought to justice, including through a strengthened legal framework, capacity building with judges, law enforcers and Victim Support Units in the police service and the development of infrastructure (fast courts) to handle complaints.

There are also a number of gender and youth policies to support efforts to reduce harmful gender norms and gender-based violence, and to empower young people. According to the Ministry of Gender (2016), the current review and implementation of affirmative action and gender responsive policies including the Child Policy, School Re-Entry Policy, Sexual Reproductive Health Policy, Youth Policy, Education Policy, Social Protection Policy and Gender Policy, have given Government the opportunity to operationalize child- and youth-friendly programmes.

Although there is a protective legal framework in place to protect children from sexual violence, it remains an issue of concern. UNDP (2018) reports that the persistent gender inequality in Zambia is an important factor that contributes to ongoing gender-based violence. In 2016, Zambia ranked 139<sup>th</sup> out of 188 countries with a Gender Inequality Index of 0.526. Empowerment of women and girls remains a challenge; women and girls have limited autonomy and decision-making power and still bear the unequal burden of poverty.

The patriarchal nature of Zambian society exacerbates women and girls' vulnerability to sexual violence.

While the Anti-GBV Act led to the establishment of the GBV Fast-track court and increased access to justice for GBV, criticisms of the Anti-GBV Act of 2011 include concerns that it does not place enough emphasis on prevention of gender-based violence nor does it provide for solutions beyond criminalisation. There are also concerns regarding its application and the implementation of court rules. The Zambia Law Development Commission is currently reviewing the Act to, amongst other things, identify shortfalls in its provisions and areas of improvement, including in court structures, in light of international and regional standards.<sup>15</sup>

In addition, Akani et.al, 2015 noted that many children and young people that experience sexual abuse do not access justice for violations. They report that children need social support in order to go through the justice process and to deal with the trauma associated with sexual abuse, and that many do not report or fail to give adequate details of the abuse or abuser, due to discomfort, fear of litigation and fear of their abuse. They note that "[t]he police station may not be a very child friendly place for reporting of sexual abuse in certain circumstances but perhaps those that end up at the police station may be those that are motivated by litigation."

#### Recommendations<sup>16</sup>

- i. Expedite the review of the Anti-GBV Act of 2011
- ii. Strengthen the availability of community centers (e.g child protection units in schools) for children to report abuse and families to receive support
- iii. Strengthen Victim Support Units or establish specific youth-friendly victim/witness offices, to facilitate arrests, where appropriate, and to monitor and follow-up on complaints of sexual violence against young persons.
- iv. Strengthen referral mechanisms between law enforcement and health services, to

ensure the provision of necessary medical examinations and prophylaxis to protect children from HIV and STIs

- v. Instigate change through strong, clearly-written laws
- vi. Strengthen training and sensitization of police to provide child-friendly services
- vii. Develop community awareness campaigns to increase knowledge of rights and available redress amongst women and girls and change attitudes and behaviours amongst men and boys.

## Limited Access to Sexual and Reproductive Health Information and Services

The Human Rights Commission, in co-operation with UNFPA and other technical partners, conducted an assessment of SRHR in Zambia. The assessment concluded that Zambia is making progress towards meeting its SRHR obligations, but challenges remain.<sup>17</sup> Access to modern contraception increased in Zambia between 2002 – 2014, but married adolescent girls have a higher unmet need for contraception as do women and girls living in rural areas. Zambia has a high rate of adolescent pregnancy (in 2009, 22% of girls between the ages of 15 and 19 already had a child and 6% were pregnant)<sup>18</sup>, suggesting that adolescent girls do not have sufficient access to SRH services, including contraception.<sup>19</sup> UNFPA (2016) noted the impact this has on school retention and completion, where 58% and 44% of girls drop out of school by 9th and 12th grades respectively mainly due to teenage pregnancy and child marriage."

According to HEARD (2015), in 2009, 15,497 teenage pregnancies were reported and, at that time, 22% of girls aged 15-19 already had a child and 6% were pregnant. 9% of girls are married by 15 years (customary law); whilst 42% are married by 18 years.

*“While requiring parental or Spousal consent arguably tends to safeguard adolescents from irrational decisions and poor, if not dangerous, care, in the minds of many observers, it pragmatically limits the options for health care available to adolescents, particularly where such thorny issues as reproductive health care or drug abuse are concerned”. – World Health Organisation*

Young people face several obstacles to obtaining sexual and reproductive health services. A UNFPA (2017) policy brief reports of high teenage pregnancy in Zambia as an indication that adolescent-friendly and responsive family planning services are lacking for adolescents. The lack of access to contraceptive and family planning services affects their well-being. Teenage pregnancy often leads to school dropout, which affects a girl’s future and may lead to child marriage and health complications related to teenage pregnancy, such as fistula and unsafe abortion. “In 2014–15, 33.3% of health facilities provided post-abortion care (PAC), yet only 5% actually performed termination of pregnancy” (UNFPA et.al., 2017), a service that is well provided for within the Zambian law. UNFPA et.al., 2017 found that although abortion is legal under certain circumstances in Zambia, there are still high numbers of unsafe abortions and 13% of maternal deaths in 2014/15 were attributable to complications from unsafe abortions. Women and girls in rural areas experience particular barriers to accessing legal abortion.

They also found that while Zambia has made progress reducing the number of maternal deaths, its maternal mortality ration remains amongst the highest in the world. Factors influencing maternal deaths include delays in receiving care, distance to health facilities and male control over reproductive decision making. Bruni et. al., 2017 found that Zambia also has high rates of cervical cancer and it is the leading cause of cancer amongst women in Zambia. The government rolled out a national HPV vaccination programme in 2013.

HEARD (2018) found that, while data on young key populations’ sexual and reproductive health remains limited, there is enough to suggest that young key populations in Zambia have significantly poorer SRH as a result of a range of factors, including a general context of marginalisation and disadvantage as well as more specific factors linked to the impact of punitive laws and policies, negative socio-cultural beliefs and practices, social exclusion and limited or no access to relevant and acceptable SRH services.

### International and Regional Guidance

*“In most legal systems, parents must ensure that their adolescent children are brought up under circumstances that enhance their health, physical as well as mental. While this may be viewed as an implicit feature of parenthood, such obligations are also explicitly imposed in legislation on child welfare.” – World Health Organisation*

Young people have a right to health, which includes access to SRH. The CRC (in Article 24) and the ACWRC (in Article 14) calls on governments to “recognize the right of the child to the enjoyment of the highest attainable standard of health.” The CRC provisions include access to health facilities (Article 24) and access to information, which will allow them to make decisions about their health (Article 17), including family planning (Article 24). Young people also have the right to be heard, express opinions and be involved in decision-making (Article 12).

The GHCL’s 2018 *Risks, Rights & Health Supplement* notes that adolescent girls and young women are further behind in access to HIV-related and sexual and reproductive health care services and recommends that governments “adopt and enforce laws that protect and promote sexual and reproductive health and rights” and “remove legal barriers to accessing the full range of sexual and reproductive health services.”



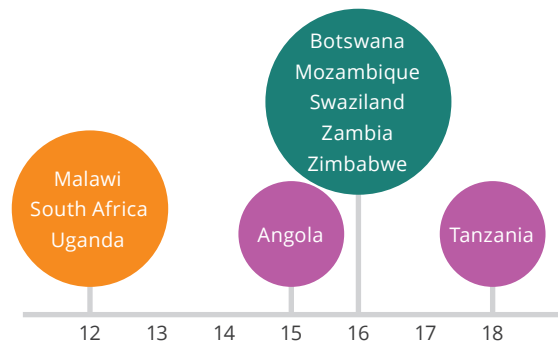
The GCHL (2012) identifies the following SRH services as particularly relevant to HIV: access to contraception; antenatal care, skilled attendance at delivery, and postnatal care; prevention and appropriate treatment of sub-fertility and infertility; safe and legal abortion; management of complications from unsafe abortion; prevention and treatment of reproductive tract infections and sexually transmitted infections; and management of obstetric and neonatal complications and emergencies, including provision of safe blood supplies.

In Southern Africa, age of consent laws may act as a barrier to access to sexual and reproductive health care for young people. According to UNFPA (2017), the lack of legal and policy provision for clear age of consent to issues such as health care, HIV testing, SRH can lead to confusion as to when young people can consent to receive health services, including medical treatment. This uncertainty creates a barrier to accessing sexual and reproductive health services and allows health-care providers to enforce their own belief systems regarding an appropriate age of consent.

UNFPA (2017) has recommended that countries in East and Southern Africa (ESA) should set the age of consent to medical treatment based on an adolescent's sufficient maturity to understand the risks, benefits and consequences of the treatment, and set the age of consent at 12 years for HIV testing, pre and post test counselling without parental consent. It also recommends that countries provide, in law, for health-care providers to respect the views and opinions of the adolescent or young person accessing a service and their right to confidentiality and should guide health-care providers on how they can assess this maturity.

In Zambia, young people may access health care services at 16 years of age as the legally recognised age of independent consent, as set out in relevant guidelines, policies and legislation.

### Status of Age of Consent in East & Southern Africa (UNFPA 2017)



The government has also rolled out the *National Standards and Guidelines for Adolescent Friendly Health Services*, defining the minimum package that health facilities can put in place to increase adolescents and youth access to health services. These have developed in line with UNFPA and International Planned Parenthood Federation standards for youth friendly health services.

The National Youth Policy (2015-2019)'s overall objective for health is "to improve the health and general wellbeing of the adolescents and youth in order to enhance their productivity and contribution to national development". It aims to increase access to a broad range of youth-friendly health services; to increase access to comprehensive, youth-friendly, gender-sensitive sexuality (family life) education; and to promote healthy living and responsible behaviour among adolescents and youth. The specific strategies highlighted to achieve its aims include:

- Strengthen commitment to and support for the sexual and reproductive health and rights and needs of adolescents and youth.
- To increase access to a broad range of youth friendly health services.
- To increase access to comprehensive, youth-friendly, gender-sensitive sexuality (family life) education.
- To promote healthy living and responsible behaviour amongst the youth.
- Promote the provision of Comprehensive Sexuality Education (CSE) and SRH services that meet the specific needs of youth.

- Encourage youth participation in the development, implementation, monitoring and evaluation of comprehensive sexuality education programmes and youth friendly health services.
- Promote access to HTC services by the youth at clinics and youth organizations.
- Raise awareness amongst youth on the dangers of alcohol and drug abuse through partnerships with youth organisations, faith-based organisations and community-based organisations.
- Facilitate the establishment of rehabilitation services / programmes for youth addicted to alcohol and narcotic drug use for effective re – integration into social and economic life.
- Strengthen local, national, regional and international partnerships to eradicate the demand, supply and trafficking of drugs by youth.
- Promote the participation of youth in sport and fitness programmes.

In 2011, the Government of the Republic of Zambia enacted the Education Act No. 23. Section 108(1)(i) of the Act empowers the Minister of Education to amend the curriculum to introduce comprehensive sexuality education. By 2014, the government completed the development of the CSE curriculum, and it has been rolled out to all schools, targeting children aged 10–24 in grades 5–12. In 2015, a curriculum for out-of-school adolescents was developed and plans were made to roll it out by the end of 2016. To ensure the successful implementation of CSE, teacher-training colleges are including CSE in their curricula and CSE has been integrated into various subjects such as Home Economics, Sciences, Social Studies, and languages. Zambia is also part of 21 countries that signed up to the ESA Ministerial Commitment on CSE and SRH services for adolescents and young people (ESA Commitment); these countries will be expanding the provision of CSE in schools (UNESCO, 2016).

As discussed in above sections, abortion in Zambia remains prohibited by the Penal Code: section 151 and 152 prohibits abortion by a pregnant woman herself or assisted by any

other person; a person found guilty of an illegal abortion is liable to imprisonment for a term of 14 years. However, an amendment to the Penal Code in 2005 permits girls under 16 who are raped to access legal abortion. In addition, the Termination of Pregnancy Act of 1972 provides for legal abortion in certain circumstances, namely when the pregnancy poses a risk to the life of the woman, or to her physical or mental health or those of her existing children and where there is a substantial risk that the foetus would be “seriously handicapped.”

Despite these various commitments in policy and programmes, young people continue to face barriers due to the lack of sufficient services, the lack of services designed to specifically meet their needs and age of consent laws requiring those under the age of 16 to gain parental consent, a globally recognized constraint for comprehensive health care delivery.

The National Health Strategic Plan by the Ministry of Health in Zambia (2017) highlights the following as key challenges for addressing adolescents and youth health issues:

- Inadequate implementation of adolescent health strategies at lower levels.
- Inadequate knowledge among adolescents of the existing health services.
- Inadequate knowledge among health care workers of key adolescent health issues.
- Inadequate HIV/SRH outreach services for adolescents.
- Lack of adolescent health-specific indicators in the current HMIS.

Mburu et.al. (2014) concluded that understanding contextual factors (including policies, laws and guidelines) is an indispensable strategy for strengthening services tailored to the needs and circumstances of adolescents living with HIV, as well as a mechanism for facilitating the fulfilment of adolescents’ health-related rights in Zambia. The author points to important influences that are either facilitators or inhibitors to access to health services. “Adolescents’ ability to take up

HIV prevention services in Zambia is heavily influenced by their family relations as well as by societal perception of HIV suggesting that besides focusing on individuals themselves, interventions for adolescents at risk of HIV should also target their family and societal domains” (Mburu et.al., 2014). They note that “many studies tend to focus on adolescents’ sexual knowledge and behaviour at the expense of their wider social contexts...less attention has been directed at understanding how protective factors operating at the family, school and community levels influence sexual risk taking’ and ‘broader experiences’ of young people”. These researchers contend that as a result, “little is known about how environmental circumstances influence Zambian adolescents.”

Specific gaps include the lack of adequate funding for youth-specific health programmes; poor co-ordination between the various sectors responsible for delivering services; age of consent issues for those under 16 years; limits on the distribution of condoms in primary and secondary schools; long distances, problems related to transport and communication, inadequate information on where and how to access health services, particularly for rural areas; inadequate facilities and inadequate skilled personnel; the limited availability of essential drugs and medical supplies; and inequities in income levels at household level” MoH (2011).

There are calls for improving the implementation of the ESA Ministerial Commitment on CSE. Additionally, comprehensive sexuality education, in its current form, arguably does not meet the needs of young LGBTI populations since it fails to deal with issues around sexual orientation and gender identity and fails to deal with same-sex sex.

Guttmacher Institute (2009) notes that abortion is only available in specific circumstances and is also reported to be surrounded by stigma and misinformation. UNFPA (2017) notes that as a result, many women have unsafe abortions outside of public health care facilities, placing their health and welfare at risk. Women and girls in

rural areas experience particular barriers to accessing legal abortion.

### Recommendations

- i. Strengthen access to education for young, vulnerable and key populations.
- ii. Strengthen the policy and regulatory framework for provision and access of adolescent health services, including clear policies and guidelines on age of consent to key SRH and HIV services.
- iii. Strengthen provision in law and policy for access to adolescent health care information and services, including access to condoms in schools and comprehensive sexuality education that provides for the rights and needs of all young people, including young key populations.
- iv. Strengthen access to comprehensive sexuality education that includes provision for the rights and needs of all young people, including young key populations.
- v. Strengthen access to safe abortion, including post-abortion care, and ensure abortion, where legal, is not subject to minimum age of consent requirements or parental consent.
- vi. Train health care workers on the SRHR of young people including LGBTI and the provision of adolescent-friendly health care services.
- vii. Train and strengthen community and family participation in adolescent friendly health care.
- viii. Promote youth-led accountability and participation for the integration of HIV and sexual and reproductive health and rights services and policies, including comprehensive sexuality education.
- ix. Strengthen organization and multi-sectoral coordination for an efficient and effective harmonized response to delivering adolescent-responsive health services, including within schools.

## Lesbian Gay Bi-Sexual Transgender Intersex (LGBTI) Populations

There is limited data on the population size of people of diverse sexual orientation and gender identity (SOGI) or LGBTI populations in Zambia, arguably perpetuating negative stigma and stereotypes against LGBTI populations. The Population Council's 2016 'MARPS study' utilised enumeration and literature review methods to deduce preliminary population size estimates for purposes of effectively targeting key population programming and reported that the number of men who have sex with men in five districts range from 4,211 to 8,857 (median: 6,534). Together with census data, these estimates yielded a prevalence of men who have sex with men of 0.89%. There is no meaningful data on women who have sex with women partly because they are not recognized as key populations for various social and health services including HIV related services (UNDP, 2017).

### Homophobia is a Social Norm in Zambia

*"A newspaper article describing a single, isolated gay man's experiences provoked a vast national controversy. Church leaders, NGO officials, students and professors, and professional politicians all stepped forward to voice their horror of homosexuality. The vice-president and ultimately the president of the country joined the condemnations"* – University of Pretoria (2007)

Key issues relating to LGBTI populations, including young LGBTI populations, are discussed below, namely stigma and discrimination, lack of access to health care services and laws criminalizing same-sex sexual relationships.

## Stigma and Discrimination Against LGBTI Populations

Research in the region has found that in Botswana, Malawi, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, LGBTI populations have been murdered, raped, beaten, assaulted, harassed, and targeted due to their real or imputed sexual orientation, gender identity and/or gender expression (ARASA, 2016). The perceptions of LGBTI persons in Zambia are "mostly negative and coloured by perceptions that homosexuality is immoral and a form of insanity" (Susan's Place, 2010). According to the US State Department, 2015, LGBTI advocacy groups report stigma and discrimination against LGBTI populations in workplaces, housing, access to education and health care. LGBTI groups reported frequent harassment of members and their families, including threats via text message and e-mail, vandalism, stalking, and outright violence.

In 2013, the Panos Institute of Southern Africa's study revealed that incidences of stigma were very high in Zambia: 52% of the male respondents and 61% of the females indicated that they experienced verbal and physical harassment because of their sexual orientation. A study by UNDP (2017) reported of high levels of violations and discrimination from close family members including beatings, forced spiritual exorcism of the "homosexual spirit", exclusions, disowning and being reported to the police. This was confirmed by informants in the Population Council (2016) research: *"Once they expose themselves... they are being marginalized... then being secluded in the community like... they're not human beings"* (Man who has sex with men, FGD, Zambia). Violence was also frequent: *"Like we really avoid going to places... Yes some common places like [name of place] I have got a friend there we once went there with my friend and it was an embarrassment,.... it was a mob, they wanted to beat us, but we ran home."* (Man, who has sex with men, FGD, Ndola).

HEARD (2018) found that young LGBT individuals, and those adolescents for whom their differences of social identity or sexual practice are still forming, bear the weight of this stigma and discrimination, particularly in their

family and community environments, as well as in their churches, schools and other social institutions. UNESCO (2019) found that bullying within schools, including on the basis of sexual orientation and gender identity, significantly affects children's mental health, quality of life, school attendance and academic achievement.

HEARD (2018) also found evidence of negative experiences for young LGBTI persons in access to health care services. Stigma and discrimination in health care takes various forms and impacts on the willingness of LGBTI populations, including young LGBTI populations, to reveal their sexual orientation and/or gender identity: *"I feel shy to reveal my orientation as providers are not oriented and they react badly"* 18-year-old transman). Breaches of privacy and confidentiality, including in relation to SOGI, were reported. The personal impact of public humiliation and abuse in a health facility, and the consequences of breaches of privacy to parents or family members, have deep ramifications for young key populations and result in various negative consequences, including avoidance of health care and emotional and psychological trauma, amongst other things (SALC, 2017). HEARD's research noted that there is limited quantitative data on SRH indicators for transgender young people, although their personal accounts describe poor SRH, including untreated HIV infection or STIs, and other reproductive health concerns (Trans Bantu Zambia, 2014; Hachoonda, 2017).

*"Here lesbians don't go for check-up as most people think we can't get HIV...its rare that lesbians are focused on when it comes to health issues"* – 22-year-old Lesbian in Livingston

SALC's 2016 research on discrimination in access to health care indicated that key populations have a multitude of fears relating to their vulnerable position in society, including fear of confidential information relating to SOGI, HIV status or work (e.g. sex work) being disclosed, resulting in further victimisation, violence, discrimination and

even police action. Respondents identified the stigma, discrimination and threat of health careworkers reporting them to the police as a significant stress and barrier to accessing services (SALC, 2016). These experiences of harassment, discriminations and violations of rights are also perpetuated by other institutions and professionals such as lawyers, police, journalists,<sup>20</sup> traditional, religious and political leaders.<sup>21</sup> A study by Human Dignity Trust (2015) highlighted how police arrested two transgender individuals in Lusaka's Kabwata area, claiming they 'looked gay': "Police told those who attempted to obtain their release that police would use the 24-hour detention period to 'teach them a lesson' and released them with no charges only after extracting a bribe". Other studies (PSAf 2014, SALC 2016, ARASA 2015, USAID-Open Doors, 2017 and UNDP, 2017) confirmed numerous cases of unjustified arrests and police harassment of LGBTI persons, including young LGBTI populations, with limited access to justice for these violations. This was confirmed by young LGBTI populations during the LEA.

*"Police are even worse off in handling key population issues – once you report they end up abusing you even more or humiliate you in front of other people"* – 19-year-old gay man, Livingstone.

### Experiences of Police Harassment and Brutality (USAID-Open Doors, 2017)

- *"An LGBTI person was beaten up by some people on suspicion that he was gay. He went to the police to lodge a complaint, and the cops retorted that his type are beaten up because they are men who make themselves women. He left without formally lodging his complaint."*
- *"In Ndeke township, a trans woman was invited for drinks by a man. After having sex, the man beat her up for pretending*



*to be a woman. She went to the police station to lodge a complaint and the police started counselling her on her need to change from her evil ways. She left without lodging a complaint”.*

- *“Some gay and transgender friends went out for drinks at a place called Flemings Club in Chimwemwe in Kitwe. A group of guys attacked them and beat them up. They threw beer bottles at them but injured one of their own in the process. The group that attacked them managed to catch one of the gay friends and quickly rushed to the police to report an assault. They called witnesses from the club who were also gay. These witnesses testified that the accused was a victim, not a perpetrator and that is why he was let go. They believed that their friend would not have been let go if the witnesses were not one of their own.”*
- A gay man, picked up by police after being reported as gay by a male friend who he was having a drink with at a lodge, was forced to pay K2 000.00 to the police, with no receipt issued for the payment.
- Transgender persons are threatened with arrest for impersonating a member of the opposite sex.

### International and Regional Guidance

All persons have the right to non-discrimination as set out in international and regional treaties. International and regional guidance recognize the need to strengthen anti-discrimination protection for all persons, including LGBTI populations.

The Inter-Agency Working Group on Key Populations (IAWG, 2014) recognises that “governments have a legal obligation to support the rights of those under 18 years of age to life, health and development, and indeed, societies share an ethical duty to ensure this for all young people.” The agency expects states to take steps to lower their risk of acquiring HIV,

while developing and strengthening protective systems to reduce their vulnerability and notes that “young people from key populations are made more vulnerable by policies and laws that demean or criminalize them.”

The GCHL (2012) *Risks, Rights & Health* report and the WHO *Technical Briefs on Young Key Populations* recognise that the various forms of stigma, discrimination and human rights violations experienced by LGBTI populations create barriers to access to quality health services leaving them increasingly vulnerable to HIV exposure and related health risks. Together, they recommend that countries:

- Take steps to reduce stigma, discrimination and violence against LGBT populations, including young populations.
- Train health care workers to reduce stigma and discrimination and increase awareness of the rights of, and the provision of health care services for LGBT populations.
- Provide access to effective HIV and health services and commodities for LGBT populations.
- Provide access to comprehensive sexuality education that takes into account the issues of sexual orientation and gender identity, including for young LGBT populations.
- Repeal all laws that criminalise consensual sex between adults of the same sex and/or laws that punish homosexual identity.
- Repeal all laws that punish cross-dressing.
- Remove legal, regulatory and administrative barriers to the formation of community organisations by or for LGBT populations.
- Ensure transgender people are able to have their affirmed gender recognised in identification documents, without the need for prior medical procedures such as sterilisation, sex reassignment surgery or hormonal therapy.
- Amend anti-discrimination laws expressly to prohibit discrimination based on sexual orientation (as well as gender identity).
- Promote effective measures to prevent violence against LGBT populations, including sensitizing the police to the rights of LGBT populations.

The SADC PF *Model Law* recognizes various populations as being “vulnerable or marginalised groups” such as “children, women and girls, sex workers, injecting drug users, refugees, immigrants, sexual minorities, prisoners, internally displaced persons, indigenous and mobile populations” and recommends that States take measures to promote the acceptance of vulnerable and marginalised groups (Article 4(2)).

### Stigma and Discrimination Against LGBTI Populations in Zambia

Article of 43 of the Zambian Bill of Rights guarantees that “all persons are equal before the law and have the right to equal protection and benefit of the law.” There is no specific anti-discrimination law providing expressly for a prohibition on discrimination against people on the basis of their sexual orientation or gender identity. However, there is broad anti-discrimination protection for all persons in the Constitution. Article 27 of the Bill of Rights provides that a person shall not be “discriminated against, except under a law that provides for affirmative action” thus guaranteeing the rights of all including people of diverse sexual orientation and gender identity.

Article 29 furthermore states that “a person has the right to freedom of the person which includes the right not to be deprived of that freedom arbitrarily”.

Article 193(2)(e) of the Constitution, as amended, specifically imposes an obligation on the Police Service to uphold the Bill of Rights in the enforcement of their duties. The Bill of Rights even provides protection for all people, including those of diverse sexual orientation and gender identity who are accused of breaking the law or are in custody in article on 48.

“Subject to Articles 65, 66, 67, 68 and 69 an accused person or a detainee has the right:

- d. Not to be compelled to make a confession or an admission;
- e. To be held separately from persons who are serving a sentence;

- f. To be released on bond, unless there is compelling reason to the contrary; and
- g. To be brought before a court -
  - i. Within forty-eight hours after being arrested or detained;
  - ii. Not later than the end of the first court day after the expiry of the forty-eight hours, if the forty-eight hours expire outside ordinary court hours;
  - iii. As speedily as possible, if that person is arrested or detained far from a court;
  - iv. For trial within ninety days of being arrested; or
  - v. To be released on bail, as prescribed.”

### The Influence of Religion in Shaping the Legal/Policy Environment in Zambia

*“...The rise of the evangelical Church in Zambia is an especially relevant obstacle in terms of public attitudes as well as cultures which inform legal and policy environments. In 1980, there were 515,000 (9%) evangelical Christians in Zambia, which rose to 800,000 (12.6%) in 1990 and leapt to 2.2 million (25%) in 2000 (Grossman, 2013). There is also evidence that religious leaders in Zambia are urging the public to take the law into their own hands, calling for mob retaliation against LGBTI people (DiDiRi Collective, 2013). Green (2014) discusses how the age of social media may be fuelling surges in hate speech in Zambia....” – Hivos (2014)*

Section 9(2) of the National Registration Act 19 of 1964 could possibly be used to change a person's sex description. It states that: “In any case where a national registration card issued to a registered person ceases in any material particular to accurately represent his identity, such person shall, without undue delay, produce his national registration card and give such particulars as shall be necessary

for the issue of a new national registration card to a registrar who, on payment of any fee and subject to any conditions which may be prescribed, shall issue to such person a new national registration card”.

However, in addition to these various protections, sections 155 through 158 of the Penal Code criminalises same-sex sexual conduct (Unnatural Offences). These laws were introduced during colonial times in 1911 in Zambia (ARASA, 2016).

*“...In the region including Botswana, Malawi, Zambia, Zimbabwe and Swaziland. Being placed in custody increases vulnerability to further abuse, blackmail and other human rights violations. Additionally, LGBTI individuals have been detained or arrested and accused of having committed broadly defined criminal offenses such as “loitering,” and “public indecency,” though often surrounding circumstances indicate that there is little or no legal basis for such arrests, rather LGBTI persons are targeted due to their gender identity, gender expression, or perceived sexual orientation.” – ARASA (2016)*

The Penal Code specifies that any person who:

- a. Has carnal knowledge of any person against the order of nature
- b. Has carnal knowledge of an animal
- c. Permits a male person to have carnal knowledge of him or her against the order of nature; is guilty of a felony and is liable to imprisonment for fourteen years.

Section 156 (Attempt to Commit Unnatural Offences) criminalizes “intent” as it articulates that any person who attempts to commit any of the offences specified in the preceding section is guilty of a felony and is liable to imprisonment for seven years, while section 158 (Indecent Practices Between Males) concerns men who have sex with men as it

states that “male person who, whether in public or private, commits any act of gross indecency with another male person, or procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or private, is guilty of a felony and is liable to imprisonment for five years.”

Other sections of the Penal Code used to harass LGBTI populations include:

- Section 178(e) which refers to “every person who, without lawful excuse, publicly does any indecent act.”
- Section 178(f) which refers to a person who “publicly conducts himself in a manner likely to cause a breach of the peace”.
- Section 178(g) refers to a person who “in any public place solicits for immoral purposes.” All these persons are deemed to be idle and disorderly persons and are liable to imprisonment for one month or to a fine not exceeding 60 penalty units or to both.
- Section 181(d) sets out the offence of being “a rogue and vagabond”. The first offence carries a jail term of three months. Every subsequent offence means imprisonment for one year. These articles negatively impact people of diverse sexual orientation including their health status.

NASTAD (2015) has recognised that the laws that criminalise men who have sex with men (as well as sex workers and people who inject drugs) are inconsistent with international guidance on enabling legal environments with regard to prevention of HIV transmission and the mitigation of the impact of HIV and AIDS. They acknowledge that, denial of access to HIV services is also inconsistent with the Zambian Constitution, which states that the ‘State will endeavour to provide adequate medical care and health facilities for all people.

Zambia’s criminal laws have been cited as one of the major barriers for members of key populations accessing HIV services. The criminal laws reinforce social stigma against gay, lesbian, bisexual and transgender individuals and expose them to the risk of deprivation of liberty, life, physical integrity and health.



***If you were in the same room with the Minister of Justice, what would you say?***

- *“Is our safety guaranteed as the LGBTI community in Zambia...a lot of KPs are being assaulted on a daily basis but the police don’t know how to handle our cases” – 19-year-old lesbian woman, Zambia*
- *“Last week I went to drink with my boyfriend and I was attacked by some men, I went to the police to report the attack and police asked me if I was confessing that I am gay” – Gay man, Zambia.*

Sections 155-157 of the Zambian Penal Code are contrary to the equality principle and anti-discrimination clause of the Zambian Constitution and violate Articles 2(1), 17 and 26 of the ICCPR. Fabeni et.al (2007). Members of key populations in Zambia live in constant fear of arbitrary detention, discrimination in education, employment, housing, and access to services, and extortion propped by the existence of sections 155 – 157 and lack of specific legal protections for LGBT under Zambian law. They are also unable to access justice for rights violations, due to the social stigma, criminal laws and insufficient accountability for violations committed by law enforcement officers in terms of documenting cases of abuse of police power against sexual minorities and actions taken to prevent and punish such acts, as well as due to general problems with access to justice including lack of adequate staffing within the judicial system, miscommunication, lack of transport for accused to the courthouses and backlog of cases for adjudicators and their support staff.

The Human Rights Commission, an institution created by the Human Rights Commission Act, Chapter 48 of the laws of Zambia, offers little hope. The Commission acts as a watchdog over the protection of human right but has had episodes of weakness, as demonstrated by Lillian (2017).

The Zambia Law Development Commission has begun a review of the Penal Code and

Criminal Procedure Code and other allied legislation, in order to remove archaic provisions in the Act, align them with international instruments and harmonise provisions within the various criminal laws, to meet the needs and aspirations of Zambian society.

### **Recommendations**

- Sensitise LGBTI populations on their rights.
- Sensitise law enforcement officers on the rights of LGBTI populations.
- Strengthen access to justice for LGBTI populations, including through strategic litigation.
- Strengthen access to economic empowerment initiatives for LGBTI populations to overcome marginalisation.
- Initiate legal reform through submissions to the Zambia Law Development Commission targeting amendments to the Penal Code and Criminal Procedure Code to decriminalize same-sex sex between consenting adults.
- Ensure the involvement of LGBTI populations in law review and reform processes.
- Prioritise further research on LGBTI populations in Zambia, including young LGBTI populations.

### **LGBTI can Petition the Zambian High Court for Rights Violations**

- A person who thinks that his or her rights have been violated
- A person who acts on behalf of another person whose rights have been violated
- A person acting on behalf of a group of people whose rights have been violated
- A person acting in the interest of all members of the public, who believes that the general public’s rights have been violated
- An association acting on behalf of its members, which thinks that its members’ rights have been violated

## Access to Health Care for LGBTI Populations

Stigma and discrimination against LGBTI populations in the health care sector has been described above. Several studies (USAID 2016, PSAf 2013, Lilly Phiri 2017, SALC 2017, Population Council 2014 and UNDP 2017) conducted in Zambia report of violations in LGBTI populations' ability to access health care services equitably. A study in 2016 by SALC on LGBTI experiences of stigma and discrimination in health care reported of respondents describing accessing health care in terms that indicated "significant hostility and threat of social persecution and legal prosecution" and noted how this impacted on willingness to access health care services and on their physical and mental wellbeing in general. Various issues impacting access to health care were revealed during FGDs with members of the LGBTI community, including young LGBTI populations in Livingstone, including:

- Health care providers were inadequately oriented to deal with LGBTI issues
- Breaches of confidentiality relating to health status and issues of sexual orientation and gender identity
- Treating LGBTI persons with indignity, verbal humiliation

### LGBTI Messages to the Minister of Health

*"The Minister of Health should talk to the Minister of Religious Affairs not to promote hate speech" – 22-year-old gay man*

*"I am asking for my freedom in accessing health services...I have health rights; the Minister should punish providers that discriminate against LGBTI people" – 26-year-old gay man*

*"I went to CRESO for screening with my friend, they told us to come for my results, but I then heard my results from someone else instead of the facility, our own LGBTI leaders are not professional" – 26-year-old gay man in Livingstone.*

*"The health services in Livingstone are messed-up, they don't maintain confidentiality and providers are judgmental...the LGBT community does not know how to take care of themselves" – 22-year-old gay man in Livingstone.*

*"Service providers lack information and are ignorant about LGBTI needs"*

In addition, there appears to be a lack of available and accessible services for LGBTI populations. ARASA (2016) noted of huge gaps in delivery of gender-affirming services to those that need them especially transgender and gender non-conforming individuals who need such services including psychological, hormonal, and/or surgical health services and/or treatments. "In fact, for many transgender individuals, hormonal therapy is a higher priority than HIV care and treatment, illustrating how essential access to gender affirming therapy is for some transgender individuals" ARASA (2016). "Some of the services are readily available in Zambia but trans young people are afraid to ask for them as the nurses ask too many probing questions and people end up self-medicating on things like hormones." In addition, there are still gaps with regards to targeting women who have sex with women as key populations for various health services including HIV related services, despite a HIVos (2014) report of studies in Southern Africa indicating that women who have sex with women are at greater risk for HIV infection than was previously believed.

"Matebeni et al. (2013) indicate that lesbian women cannot be regarded as a 'no-risk' group within the context of HIV in Southern Africa... lesbians surveyed point to male relationships and sexual violence as the reason for their HIV positive status; 38% reported getting HIV from

previous male partners and 33% reported acquiring the virus from being raped.” Lynch & Clayton (2014) point out that there is a “widespread silence regarding the sexual and reproductive health of lesbian and bisexual women and other women who have sex with women in research and policy documents. The study notes that women who have sex with women are at risk of HIV exposure due to a) rape (25%); b) transactional sex (10.5% of women who have sex with women have had transactional sex with men) and woman-to-woman transmission.

### Lesbians at Risk of Contracting HIV

*“The belief that WSW are not at risk of HIV infection ignores the distinction between sexual identity and sexual behaviour – identifying as a lesbian does not mean an individual has never engaged in sex with men. Further, HIV can be transmitted during sex between women. While there is limited data available on risk of transmission, one study found that 21% of HIV positive lesbians surveyed in South Africa, Zimbabwe and Namibia acquired HIV from their female partners”.*  
– ARASA (2016)

### International and Regional Guidance

International and regional guidance notes the need to provide non-discriminatory access to health care services for all people and to prioritise the needs of vulnerable and key populations. UNDP (2017) cautions that laws that criminalize HIV transmission, non-disclosure and exposure, consensual homosexual sex between adults, gender expression, sex work and drug use, as well as legal and policy frameworks and practices that fail to protect the rights of people living with HIV, women, girls and key populations, increase risk and act as major barriers to services for the people who need them most. The GCHL (2012) has noted “countries

must reform their approach towards sexual diversity. Rather than punishing consenting adults involved in same-sex activity, countries must offer such people access to effective HIV and health services and commodities.” The Inter-Agency Working Group on Key Populations (IAWG, 2014) insist that “governments have a legal obligation to support the rights of those under 18 years of age to life, health and development, and indeed, societies share an ethical duty to ensure this for all young people.” The Agency expects states to take steps to lower their risk of acquiring HIV, while developing and strengthening protective systems to reduce their vulnerability. It also notes that “young people from key populations are made more vulnerable by policies and laws that demean or criminalize them or their behaviours, and by education and health systems that ignore or reject them and that fail to provide the information and treatment they need to keep themselves safe.”

The GCHL (2012) *Risks, Rights & Health* report and the WHO *Technical Briefs on Young Key Populations* recognise that the various forms of stigma, discrimination and human rights violations experienced by LGBTI populations create barriers to access to quality health services leaving them increasingly vulnerable to HIV exposure and related health risks. Together, they recommend that countries:

- Take steps to reduce stigma, discrimination and violence against LGBT populations, including young populations
- Train health care workers to reduce stigma and discrimination and increase awareness of the rights of, and the provision of health care services for LGBT populations
- Provide access to effective HIV and health services and commodities for LGBT populations
- Provide access to comprehensive sexuality education that takes into account the issues of sexual orientation and gender identity, including for young LGBT populations

Guideline 3 of the UNAIDS 2006 *International Guidelines on HIV/AIDS and Human Rights* recommend that “public health legislation

should require that health care workers undergo a minimum of ethics and/or human rights training in order to be licensed to practice and should encourage professional societies of health care workers to develop and enforce codes of conduct on human rights and ethics.”

Guideline 4 recommends that states enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination; in particular they note that “anti-discrimination laws and protective laws should be enacted to reduce human rights violations against men who have sex with men.”

Guideline 6 relating to health care notes that “states’ legislation, policies, programmes, plans and practices should include positive measures to address factors that hinder the equal access of vulnerable individuals and populations to prevention, treatment, care and support, such as poverty, migration, rural location or discrimination of various kinds.”

The SADC PF *Model Law on HIV* notes the importance of providing specific HIV prevention (Article 11) as well as treatment, care and support services (Article 36) for all vulnerable and marginalised groups, which includes LGBTI populations by definition. It specifically notes that “the State shall consider the decriminalisation of commercial sex work and consensual sexual relationships between adult persons of the same sex as specific measures that may enhance HIV prevention” in Article 11(4).

### Access to Health Care for LGBTI Populations in Zambia

As set out above, laws in Zambia effectively criminalise same-sex activity. In Zambia, provisions of section 155 to 158 of the Penal Code have resulted in a lack of comprehensive HIV services for men who have sex with men and well as transgender individuals. However, Article 52 of the Bill of Rights provides for the right to health care services, education and social protection for all Zambians, which should include members of the LGBTI community, including young LGBTI populations.

The National Health Strategic Plan (2017-2021) does not refer to key populations as priority group for special attention, however, the National AIDS Strategic Framework for 2017-2022 recognise and prioritises members of LGBTI as a key audience for focus to mitigate HIV and AIDS related challenges in Zambia. It notes the importance of “[t]he national HIV multi-sectoral response to urgently recognize the implications of key population risk for the general population in crafting, implementing and delivering the related prevention and treatment services. Addressing the HIV services needs of key populations—efficiently, effectively, and respectfully— is not just the right thing to do, in a human rights sense” NAC (2017). Various efforts have been made to strengthen programmes (including PrEP) for key populations such as gay men and men who have sex with men.

Laws that criminalise same-sex sex, as well as acts of stigma and discrimination act as barriers to access to health services for key populations – they are treated with indignity within the health care facilities and are not able to access services appropriate to their needs. Health careproviders are also not sensitised to their needs.

### Recommendations

- i. Integrate health care services (including psycho-social support) for the needs of LGBTI populations, including young LGBTI populations, in healthcare
- ii. Provide pre-service and in-service training to health careproviders on the human rights of and health care needs of LGBTI populations, including young LGBTI populations
- iii. Strengthen “know your rights” campaigns for LGBTI populations, including young key populations

## Sex Workers

The most recent data on sex workers is from a 2015 study conducted by Zambia’s National AIDS Council (NAC), FHI360 and the Tropical Diseases Research Centre, which found HIV

prevalence among female sex workers to be 56.4%. Most studies in Zambia and the region report high HIV prevalence among sex workers, including inconsistent condom use with clients. Despite growing recognition of the importance of addressing the health needs of sex workers in Zambia, they are often unable or unwilling to access HIV services because of stigma and discrimination. WHO (2015) has noted that although female sex workers use condoms at a rate that is generally greater than in the wider population, they are at higher risk of HIV because of factors such as poor access to condoms in some settings, the risk of confiscation of condoms to be used as evidence of illegal activity, the lack of labour rights and the unwillingness of some clients to use condoms, the risk of violence and the local prevalence of HIV infection.

The Population Council (2016) reported that sex workers' clients were knowledgeable about HIV/STIs and condom availability but did not always use them due to a number of factors that served as barriers to condom use: "barriers to condom use included intoxication, the level of trust of a partner, and excuses made by both sex worker clients and female sex workers." Around 47% of female sex workers reported having had 5 or more different sex partners in the last seven days and nearly 9% reporting 10 to 14 sex partners over the same period. Around 44% used a condom with a non-paying partner and 78% used a condom with a paying client. "Low self-esteem, depression, emotional stress hopelessness and vulnerability are all prevalent among sex workers." Mellor & Lovell (2011).

*"Sometimes even the police arrest us just to have sex...sometimes you find your client is a soldier and you even get scared to ask for money from him, they even beat us refusing to pay and you can't even take them to the police" – Sex worker, female respondent, FDG Livingstone.*

## Stigma, Discrimination and Human Rights Violations

Sex workers experience high levels of stigma, discrimination and human rights violations, including from law enforcement officials. HEARD (2018) found that young sex workers felt the impact of stigma and discrimination particularly severely.

Across the six districts of Zambia, sex workers reported cases of police harassment and brutalities such as violence, arbitrary arrest, physical abuse (beating, whipping, kicking), extortion, sexual abuse, threatening violence using guns and tear gas canisters, firing tear gas canisters at patrons in clubs, and emotional abuse (insults, name calling) (USAID-Open Doors, 2016). This was confirmed in 2012 when then Inspector General of Police Stella Libongani also warned police officers that are fond of asking for 'sexual favours' from prostitutes to "stop the habit because they will be charged with various offences alongside the prostitutes they coerce into sex in return for freedom after they arrest them."<sup>22</sup> Sex workers are often subjected to harassment, arrest, or detention in police roundups, especially those that operate on the streets or in brothels. Arrests are made on the basis of appearance at time, with no proof having committed an offence (Panos Institute of Southern Africa, 2013).

Sex workers also experience discrimination in access to health care services, as outlined below.

### Sex Workers Experiences in Accessing Health Services in Zambia

(USAID-Open Doors, 2016 & Population Council, 2016)

- *"There are times when we go for services and health care workers ask us if we are married. This gives us fear of going back to the health care institutions."*



- *"The calling out of names at the ART clinic is a problem. Most clinics have separated the ART section from other sections, and it is easy for everyone at the clinic to know who is HIV-positive."*
- *"There are times when we go to see doctors, and it happens that the doctor is also a client. This leads to shunning away in fear of losing them as clients."*
- *"I had a problem with my monthly menstruation; when I went to the clinic the first question I was asked was whether I am married, and I did not understand what that had to do with my problem."*
- *"I think they [SWCs] feel comfortable going to private clinics because there you are not asked a lot of questions... you are not asked to go and look for your partner... or to come with your partner... you will be treated, and you will be charged... Because I think they want money... they will not ask you a lot of questions... they won't even like say... "tamunfwa" (meaning you sleep around)... that is why you are even having this disease... yah... now if you go in those government hospitals... there is that you know.. they embarrass you... so a lot of people shun to go into clinics because immediately you present yourself with STIs they say "you don't listen" ... something like that... you see? So to avoid that kind of embarrassment... they end up going to private doctors."*

Continuity of care constitutes a significant limitation with regards to sex workers, according to Mellor & Lovell (2011): "particularly availability of accessible, acceptable and good quality care integrated to facilitate follow-up appointments, on-going health monitoring and understanding high health risks." Apart from stigma and discrimination by providers, the state of facilities themselves may prevent clients

from returning for service follow and reviews, "government clinics are crowded... they have so many people... so it will be difficult for this person [referring to female sex worker]... to stand on the queue the whole day... in order for...her to access the services that she needs especially CD4 count... so because of that crowd they fear to go there... they are discouraged... they cannot attend the services that they want... so they will stay away..." (Health careprovider, Chipata: Population Council, 2016).

A study report by Chanda et.al (2017) highlighted that HIV stigma and sex worker stigma deterred individual behavior, based on attitudes and beliefs of the self and toward providers, but additionally of institutions as a whole (e.g., clinics and hospitals), "The sex workers also go to the hospital, but they are not many who accept to go the hospital. Like here in Chirundu most are afraid to go to the hospital. They are shy. They have stigma". Chanda et al also found that sex workers struggled to access health care facilities during operating hours and incurred financial losses when seeking care.

The LEA found similar experiences, with complaints of mistreatment, coerced testing and breaches of confidentiality, amongst other experiences.

- *"The problem is that the health providers are old and they don't keep secrets...maybe they can even hire people from the streets (Sex Workers)"* – female sex worker, Livingstone
- *"Sometimes even when you want to get different services, the providers are quick to force you to test even if you only needed Panadol...they recommend check-ups for the big diseases"* – female sex worker, Livingstone
- *"I had stopped taking ARVs because of the nurses talking about my status"* – female sex worker

- *“The way they dispense drugs is also another barrier to accessing services as sometimes you don’t want people to know your status... – female sex worker, Livingstone.*
- *“The government clinics do not do follow-ups like others like CRESO... nurses in government facilities should also become more compassionate about their work...at PPAZ they used call us when one didn’t show-up” – female sex worker*
- *“People sometimes can’t access services because they can’t afford the cards/books for their files...like me today, I don’t even have a coin on me” – female sex worker*

### International and Regional Guidance

The criminalization of sex work does not negate the fundamental human rights of sex workers. They retain their rights set out in international and regional treaties, including the rights set out in the ICCPR such as the right to non-discrimination, the right to free choice of work (Article 6(1)), the right to be free from arbitrary arrest and detention (Article 9(1)) and the right to liberty and security of the person (Article 10(1)) and the right to free association, amongst others. However, Mbagko & Smith (2011) noted that “international human rights law has yet to provide for comprehensive protections specific to the enforcement of the rights of sex workers.”

The GCHL (2012), in its report on *Risks, Rights & Health*, recommends that countries should, amongst other things:

- Ensure safe working conditions and offer sex workers and their client’s access to effective HIV and health services and commodities.
- Repeal laws that prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit commercial sex, such as laws against “immoral” earnings, “living off the earnings” of prostitution and brothel-keeping. Complementary legal measures

must be taken to ensure safe working conditions to sex workers.

- Take all measures to stop police harassment and violence against sex workers.
- Ensure that the enforcement of anti-human-trafficking laws is carefully targeted to punish those who use force, dishonesty or coercion to procure people into commercial sex, or who abuse migrant sex workers through debt bondage, violence or by deprivation of liberty.
- Enforce laws against all forms of child sexual abuse and sexual exploitation, clearly differentiating such crimes from consensual adult sex work.
- Ensure that existing civil and administrative offences such as “loitering without purpose”, “public nuisance”, and “public morality” are not used to penalise sex workers and administrative laws such as “move on” powers are not used to harass sex workers.

Article 11(4) of the SADC PF *Model Law* notes that the decriminalization of sex work should be considered, as a means of enhancing HIV prevention amongst sex workers.

### Sex Work in Zambia

The Zambian Constitution protects the fundamental rights and freedoms of all persons, similarly to that of international law, although there is no specific provision for the rights of sex workers.

A Lusaka Times feature in 2012 on sex workers quotes then Inspector-General of Police Stella Libongani, “...there is no offence known as prostitution under our laws rather the act itself is a ‘nuisance’ under the Penal Code Act Chapter 87 of the Laws of Zambia.”<sup>23</sup> In 2014 the Times of Zambia quoted Zambia Police Service spokesperson Charity Munganga to have confirmed that there is no specific law in Zambia that criminalises prostitution but rather crimes against morality, which are also used in cases of defilement and rape.<sup>24</sup>

However, Zambian law states that living off the earnings of sex work, encouraging others to become sex workers and the use of premises for sex work is illegal. Various



sections of Chapter 87, such as sections 146, 147 and 155 which criminalise men and women from living off the earnings of prostitution or aiding, abetting or compelling prostitution or engaging in “unnatural offences” are misapplied to arrest sex workers. As is the case with LGBTI persons, sex workers can also be prosecuted using sections 178 and 181 of the Penal Code for public indecency, breach of the peace, being an “idle or disorderly person” or a “rogue and vagabond”. Sex workers are also arrested under charges for soliciting for immoral purposes, idling or loitering (USAID-Open Doors 2016, Pop Council 2014).

*“I started sex work very early, I was only 13 years old and I was so unlucky that I got HIV just after trying for a few times...I have had guys who have wanted to marry me, but I turn them down because I don't want them to know I have HIV...if a client offers me ZMK 450 for live sex I will not hesitate as my 3 children need to eat”*  
– 20 year old sex worker

Similarly, section 27 of the Criminal Procedure Code Act Chapter 88 of the Laws of Zambia may also be used to arrest sex workers. It provides that “any officer in charge of a police station may, in like manner, arrest or cause to be arrested:

- Any person found taking precautions to conceal his presence within the limits of such station, under circumstances which afford reason to believe that he is taking such precautions with a view to committing a cognizable offence;
- Any person, within the limits of such station, who has no ostensible means of subsistence, or who cannot give a satisfactory account of himself”.

The Zambia Law Development Commission has begun a review of the Penal Code and Criminal Procedure Code and other allied legislation, in order to remove archaic provisions in the Act, align them with international instruments and harmonise provisions within the various

criminal laws, to meet the needs and aspirations of Zambian society.

Stigma, discrimination and the criminalization of aspects of sex work appears to be a major cause of unlawful arrests, detention and harassment of sex workers. Because of the criminal laws, sex workers are often reluctant to report experiences of rape, which increases their vulnerability to HIV, for fear of further abuse from police (PISAF 2013, Pop Council 2014, USAID-Open Doors 2016 and UNDP 2017). Stigma and discrimination lead to barriers to access to health care services. Laws protecting all persons from discrimination do not appear to provide adequate protection for sex workers, in the criminalized context.

### Recommendations

- i. Make submissions to the Zambia Law Development Commission to review laws criminalizing aspects of sex work and provisions misused against sex workers, in their review of the Penal Code and Criminal Procedure Code.
- ii. Train and sensitize health care providers on the rights and health care needs of sex workers.
- iii. Train and sensitize law enforcement officials on the rights of sex workers and take measures to protect sex workers from violence, harassment and abuse.
- iv. Strengthen appropriate health care services for sex workers.
- v. Ensure the involvement of sex workers populations in law review and reform processes
- vi. Ensure further research on sex workers in Zambia, including young (18+ years) sex workers.

## People Who Inject Drugs

People who inject drugs are at high risk of HIV exposure. The International Harm Reduction Association (IHRA, 2013) suggests that “HIV prevalence among people who inject drugs is 28 times higher than among the rest of the population. This risk arises particularly from sharing needles and injection equipment but is reinforced through criminalisation, marginalisation and poverty.” The same study indicates “Young people are also likely to show more high-risk behaviours such as sharing needles or getting needles from unofficial places”.

*“The most commonly discussed risk-taking behaviors included: sharing needles, reusing needles, and other unhygienic injecting practices. Using tainted drugs and performing sexual favors for drugs was also mentioned.” – Leston (2017)*

### Number of Prisoners Convicted with Substance Abuse

Station	2009	2010	2011	2012
Maximum Security	20	15	24	38
Kabwe Female	13	17	9	8
Kitumba	–	–	–	10
Mkushi	25	23	20	15
Livingstone	44	107	50	61
Katombora	4	3	6	3
Choma	34	47	19	28
Chipata	92	109	121	114
Lundazi	28	48	60	50
Petauke	9	24	4	10
Kamfinsa	233	205	134	302
Kansenshi	156	122	86	110
Chingola	133	71	70	98
Kamfisa Female	–	–	24	15
Lusaka Central	–	–	–	37
<b>Total</b>	<b>791</b>	<b>791</b>	<b>627</b>	<b>899</b>

Source: Prisons

## Access to Health Care Services

Research on young people who use or inject drugs in Zambia, and the relation between drug use and their SRH, is almost non-existent. There is some evidence to suggest that people who inject drugs do not feel able to access health care services in Zambia, due to the criminalized nature of drug use, the fear of arrest and the stigma and discrimination they experience when accessing health care. AVERT (2017) notes of a formative assessment of key populations at risk of HIV infection undertaken in 2013-2015 on people who inject drugs. The findings concluded that despite the increased risk of HIV for people who inject drugs, they are among those with the least access to HIV prevention, treatment and healthcare, because drug use is often criminalised and stigmatised. In Zambia, young people who use drugs spoke of their fears of using health care services due to stigma, discrimination, breaches of confidentiality and fear of arrest.

### Reasons People Who Inject Drugs avoid Public Health Facilities (Population Council, 2016)

- “Have you ever seen a thief go to the police and say that I am a thief? [Laughs]...same as in that [disclosing their drug use behaviors to service providers], because you’ll be scared to be questioned, so it’s because...there is DEC [Drug Enforcement Commission], we are scared of those people.” – Person who uses drugs, age 30, Kitwe.
- “He [a drug user] wouldn’t want them [health care providers] to know ... hence having the fear. You know when he goes to the hospital they will be just like yes these are the problems and we are looking for drug users and you are one of them, so we are arresting you in advance. So, with all these, they become afraid.” – Person who injects drugs, age 22-32, Livingstone.

- *"Yah most times we are not free... [to disclose] ...they are not free because they are also afraid because let me say for the drugs, it's something which is a secret...Yes because what your friend is doing you are the only ones that are supposed to know that and not everyone is supposed to know that."* – Person who injects drugs, age 22-32, Livingstone.
- *"Yah, some it's stigma...because they know maybe if for example the confidentiality is not kept by the clinic...people will look at them differently."* – person who uses drugs, age 25, Kitwe.
- *"Now on these public clinics... Umm... you can just see yourself in the news... you have not even come out of the hospital and the news is all over..."* – person who injects drugs, age 19-25, Kitwe.
- *"So, we shun those places... you are afraid of telling them... okay look excuse me!... I took drugs... please help me... I'm dying you know?... they would actually call the cops... patient and doctor confidentiality are not there."* – person who uses drugs, age 28, Lusaka.

## International and Regional Guidance

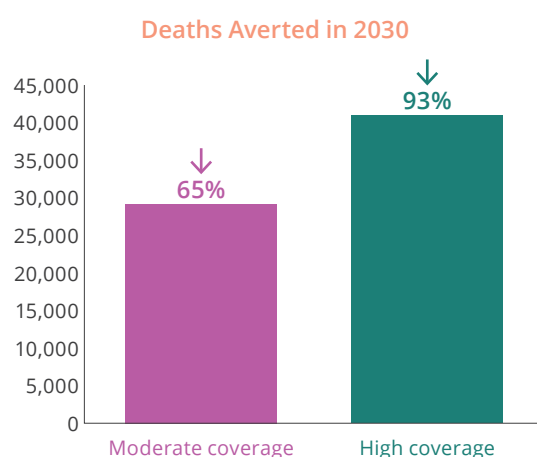
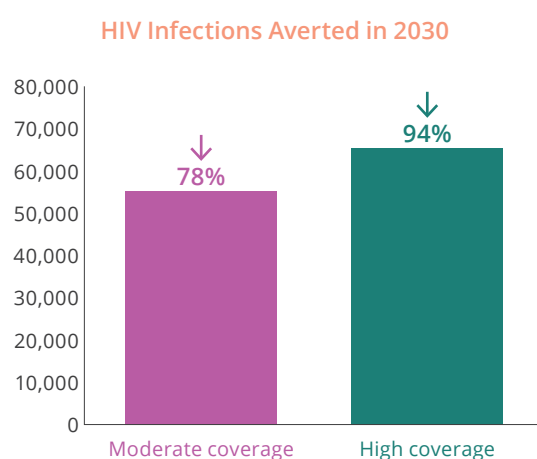
*"Despite their overarching concern for the 'health and welfare of mankind', the international drug conventions have generated an overwhelmingly punitive approach to drug control, one which favors criminalization and punishment over health and welfare, and which has guided national drug laws around the world"* – HRI (2016).

All persons have the right to liberty and security of the person and the right to freedom of association and assembly, as set out in the ICCPR. However, the GCHL's *Risks, Rights & Health* found that laws criminalizing drug use, and the 'war against drugs', in fact effectively led to increased human rights violations and harassment by law enforcement officials against people who use drugs and placed them at increased risk of HIV exposure and discouraging them from accessing health care services and accessing justice for rights violations. The GCHL recommended that: "[c]ountries must reform their approach towards drug use. Rather than punishing people who use drugs who do no harm to others, they must offer them access to effective HIV and health services, including harm reduction and voluntary, evidence-based treatment for drug dependence." They recommended that countries repeal punitive conditions that prohibited the provision of harm reduction programmes – such as needle and syringe exchange programmes – and decriminalise the possession of drugs for personal use, amongst other things.

Harm Reduction International (HRI, 2016) explains that harm reduction aims to reduce the health, social and economic harms associated with drug use, without requiring people to stop using drugs: "Within the current global drug policy framework, with its focus on prohibition and zero tolerance, harm reduction stands alone in its attempt to address the realities of drug-related harms experienced by individuals and their families. It also stands

alone as an approach that has worked, where so many interventions have proven fruitless or even damaging.”

Programmes for harm reduction that are recommended include needle and syringe programmes (NSPs) and opioid substitution therapy (OST). These are also effective in preventing HIV (HRI, 2016 & IHRA, 2013) as they provide clean needles to people who use drugs and offer substitution medicines like methadone as an alternative to injecting drugs. HRI (2016) contends that research suggests that the combined implementation of harm reduction interventions and HIV anti-retroviral therapy for people who inject drugs offers the highest return on investment, as seen in the diagram below:



Source: Harm Reduction International Report (2016)

The IHRA (2013) notes that despite their resounding success in various settings worldwide, “of the 158 countries that report people who inject drugs, only 90 have NSPs, and 80 provide OST.”

UNAIDS (2016) acknowledges that drug dependence is a chronic health condition. “As with other chronic conditions, long-term and continued treatment is often required, and affected people remain vulnerable to relapse throughout their lifetime”. The report notes that systematic reviews of opioid substitution therapy (mostly methadone or buprenorphine maintenance therapy) have demonstrated its effectiveness in the reduction or complete cessation of the use of heroin and other opioids “Methadone maintenance therapy has been associated with a 54% reduction in the risk of HIV infection within populations of people who inject drugs”.

The global leader in the fight against AIDS suggests that methadone as a critical component of harm reduction could prevent 130 000 new HIV infections outside sub-Saharan Africa every year and that substitution therapy increases adherence to antiretroviral therapy for HIV and reduces opioid overdose risk by almost 90%. Social barriers such as stigma, feelings of shame, guilt, and concerns about being judged are among the main reasons for people who inject drugs not accessing harm reduction services.

The UN system has endorsed a core package of nine essential harm-reduction services for people who inject drugs, which have been shown to reduce HIV infections (IAWG, 2014):

- a. Needle and syringe programmes
- b. Drug dependence treatment, including opioid substitution therapy
- c. HIV testing and counselling
- d. Antiretroviral therapy
- e. Prevention and treatment of sexually transmitted infections
- f. Condom programmes for people who use drugs and their sexual partners
- g. Targeted information, education and communication for people who used drugs and their sexual partners

- h. Diagnosis and treatment of, and vaccination for, viral hepatitis
- i. Prevention, diagnosis and treatment of tuberculo-sis

#### Situation of PWUD in Zambia:

*“DEC will not even educate you, they only arrest you and take you to court...DEC will come to your house and search you based on a ‘snitch’ and if they don’t find the drugs, they will place them so they can arrest you...one time they arrested a guy in the neighborhood, the next day, they packed their vehicle in the same neighborhood and it was burnt...they arrested 5 of us drug users and charged us with unlawful assembly, riotous behaviour, malicious damage, theft of motor vehicle and arson...DEC even forces you to confess by beating you...I spent 2 years and 6 months in remand prison.....Morris Maduma died as a result of being in prison” – 23-year-old drug user, Livingstone*

In Zambia, people who inject drugs are considered as law offenders even though from a public health lens, Zambian law grants universal access to health services for all citizens and programmes regardless of their status with the law.

The Narcotic Drugs and Psychotropic Substances Act Chapter 96 of The Laws of Zambia in Section 8 prohibits the possession of narcotic drugs and psychotropic substances, providing that “Any person who, without lawful authority, has in his possession or under his control any narcotic drug or psychotropic substance shall be guilty of an offence and shall be liable upon conviction to imprisonment for a term not exceeding fifteen years”. Section 10 states: “any person who, without lawful authority, takes a narcotic drug or psychotropic substance by smoking, injecting into his body, sniffing, chewing, drinking or otherwise administering such drug or substance shall be guilty of an

offence and shall be liable upon conviction to imprisonment for a term not exceeding ten years”. Section 11 also provides for prosecution of any person who attempts, abets, solicits, incites, and compounds or does any act preparatory to, or in furtherance of, the commission of any offence under this act.”

Punishment upon conviction is imprisonment for a term of not less than five years.

Other sections of that that could be used by enforcement officers include:

- Section 12 on conspiracy to commit drug offences states “where two or more persons act together to commit an offence under this Act, they shall be guilty of an offence and liable upon conviction to a term not exceeding five years.”
- Section 15 provides that any person who, without lawful authority, has in his possession instruments or utensils used in administering narcotic drugs or psychotropic substances shall be guilty of an offence and shall be liable upon conviction to imprisonment for a term not exceeding ten years.
- Section 16 provides that a person who occupies or controls premises, who permits those premises to be used for administering narcotic drugs or psychotropic substances shall be guilty of an offence and shall be liable upon conviction to imprisonment for a term not exceeding five years.
- Section 31 provides that any property which a drug enforcement officer or police officer reasonably suspects to be the subject-matter of an offence under this Act, or which has been used for the commission of that offence or is illegal property shall be liable to seizure.
- Section 43 states that whenever any person is arrested or detained upon reasonable suspicion of his having committed a cognizable offence under this Act, no bail shall be granted when he appears or is brought before any Court.
- Section 48 provides that the Minister may, by statutory instrument, make regulations for the better carrying out of the purposes of this Act and, without prejudice to the

generality of the foregoing, may make regulations for the establishment and management of drug rehabilitation centres.

The Narcotic Drugs and Psychotropic Substances Act Chapter 96 of The Laws of Zambia therefore criminalizes people who use drugs and also implicitly criminalize service providers and programmes that may wish to support people who inject drugs in Zambia. The Zambia Law Development Commission recently conducted a review of various laws to determine the need for law review and reform to align legislation with the new Constitution. The Narcotic Drugs Act was identified as in need of reform, but not in relation to the provisions criminalizing drug possession and/or use.<sup>25</sup>

The NASF (2017-2021) acknowledges that the population of people who use drugs is estimated to be on the increase and that proposes need to articulate guidance and suggest a comprehensive package of services targeting key population so that the Fast-Track targets can be reached. The documents include a strategy to “target and reach key populations such as...people who use drugs and other vulnerable populations” NAC (2017), although it does not detail elements of an effective programmatic response.

The Population Council (2016) recognises the existence of certain access points for services for people who use drugs, including HIV testing at clinics, door-to-door outreach and non-governmental organisations (NGOs) who put up tents on football grounds. “Additional services mentioned by people who use drugs included telephone hotline services that provide counseling and information about HIV/STIs, rehabilitation centers, alcoholic anonymous groups, counseling centers, and more clinical facilities” (Population Council, 2016). Unfortunately, there is limited information on support and rehabilitative types of services such as those facilitating quitting drug use.

The Act not only discourages people who use drugs from accessing health care, it also places health care workers in a difficult position. Population Council (2016)’s research with

health service providers in Livingstone, Ndola, Mansa and Mongu to establish why people who inject drugs shun accessing public health facilities found that health providers felt they were bound by the legal framework, and that people who use drugs avoided services for fear of arrest. According to the Population Council, providers noted that, in fact, key populations are arrested more than the general population, with gay men and men who have sex with men and people who use drugs treated harsher while female sex workers were treated lighter in the eyes of the law” (Population Council, 2016). Further FDGs conducted in Livingstone amongst young people who use drugs by this assessment revealed the following challenges in people who inject drugs accessing health services:

- *“I went to the clinic and I told them I was a junkie, but they only gave me Panadol and flagyl”* 18-year-old person who uses drugs
- *“They treated me well, but they did not have the right services...I needed a drip solution, I was in prison for 9 months, that’s how I learned about that kind of treatment”* 23-year-old person who uses drugs
- *“It was only in prison that I was able to stop taking drugs because I had no other choice”* 24-year-old person who uses drugs

The impact of the criminalization of drug use in Zambia is set out below

### The Narcotic Drugs and Psychotropic Substances Act Chapter 96 of The Laws of Zambia

Current Legal Position	Implications on PWIDs & Programmes/Services
<b>Section 8:</b> Any person who, without lawful authority, has in his possession or under his control any narcotic drug or psychotropic substance shall be guilty of an offence and shall be liable upon conviction to imprisonment for a term not exceeding fifteen years.	This is a major barrier for positioning harm reduction programs as proposed by the UN as most service provider (both government and private facilities) would find it tasking to obtain special concessions from the relevant authorities, such as the Drug Enforcement Commission.



Current Legal Position	Implications on PWIDs & Programmes/Services
<b>Section 10:</b> “any person who, without lawful authority, takes a narcotic drug or psychotropic substance by smoking, injecting into his body, sniffing, chewing, drinking or otherwise administering such drug or substance shall be guilty of an offence and shall be liable upon conviction to imprisonment for a term not exceeding ten years”.	People who inject drugs in need of services may not willingly approach providers for rehabilitation, as they are legally liable for prosecution.
<b>Section 11:</b> Any person who attempts, abets, solicits, incites, and compounds or does any act preparatory to, or in furtherance of, the commission of any offence under this Act shall be guilty of an offence and shall be liable upon conviction to imprisonment for a term of not less than five years.	The term abets means encourages or assists, therefore implying service providers can be culpable for abating if they fail to report their clients to the relevant authorities
<b>Section 11:</b> Any person who attempts, abets, solicits, incites, and compounds or does any act preparatory to, or in furtherance of, the commission of any offence under this Act shall be guilty of an offence and shall be liable upon conviction to imprisonment for a term of not less than five years.	The term abets means encourages or assists, therefore implying service providers can be culpable for abating if they fail to report their clients to the relevant authorities
<b>Section 15:</b> Any person who, without lawful authority, has in his possession instruments or utensils used in administering narcotic drugs or psychotropic substances shall be guilty of an offence and shall be liable upon conviction to imprisonment for a term not exceeding ten years.	This may have a huge negative impact on how needle exchange programmes can be rolled out in Zambia.

Current Legal Position	Implications on PWIDs & Programmes/Services
<b>Section 16:</b> A person who occupies or controls premises, who permits those premises to be used for administering narcotic drugs or psychotropic substances shall be guilty of an offence and shall be liable upon conviction to imprisonment for a term not exceeding five years.	NGOs and private sector services providers that deliver opioid substitution therapy and needles and syringe exchange programmes may be culpable of an offence and may have the property seized
<b>Section 31:</b> Any property which drug enforcement officer or police officer reasonably suspects to be the subject-matter of an offence under this Act, or which has been used for the commission of that offence or is illegal property shall be liable to seizure.	
<b>Section 43:</b> Whenever any person is arrested or detained upon reasonable suspicion of his having committed a cognisable offence under this Act, no bail shall be granted when he appears or is brought before any Court.	This provision places people who inject drugs at higher risk of HIV and TB exposure while in detention
<b>Section 48:</b> The Minister may, by statutory instrument, make regulations for the better carrying out of the purposes of this Act and, without prejudice to the generality of the foregoing, may make regulations for the establishment and management of drug rehabilitation centres.	This article may be used to set-up harm reduction and position opioid substitution therapy and needles and syringe exchange programmes

## Recommendations

- i. Review provisions in the Narcotic Drugs and Psychotropic Substances Act that act as barriers to access to harm reduction and health care services for people who use drugs



- ii. Involve people who use drugs in law review and reform processes
- iii. Adapt and operationalize the UN system endorsed core package of nine essential harm-reduction services for people who inject drugs, which have been shown to reduce HIV infections (IAWG, 2014):
  - a. Introduce needle and syringe exchange and distribution programmes
  - b. Integrate drug dependence treatment, including opioid substitution therapy
  - c. Intensify HIV testing and counselling for people who inject drugs
  - d. Provide antiretroviral therapy
  - e. Prevention and treatment of sexually transmitted infections
  - f. Implement condom programmes for people who use drugs and their sexual partners
  - g. Targeted information, education and communication for people who used drugs and their sexual partners
  - h. Provide diagnosis and treatment of, and vaccination for, viral hepatitis and prevention, diagnosis and treatment of tuberculosis
  - i. Train and sensitise health care providers on the rights and specific health care needs of people who use drugs
  - j. Train and sensitise law enforcement officials on the rights of people who use drugs and take measures to reduce violence and human rights violations against people who use drugs.
  - k. Support further research on people who use drugs, including young people who use drugs in Zambia.

## Inmates, Including Young Inmates

Prisons are a high-risk environment for HIV transmission with drug use and needle sharing, tattooing with homemade and unsterile equipment, sex between men, rape and sexual abuse of prisoners (including female prisoners) common place. Common

high-risk behaviors in the prison environment include unprotected sex between men, rape (including for women prisoners), sex bartering and “prison marriages”. In addition, unsafe injecting practices among people who inject drugs, blood exchange and the use of non-sterile needles and other cutting instruments for tattooing are widespread. While there is no conclusive research to provide accurate statistics on HIV in Zambian prisons, a 2004 report indicated that 449 inmates had died of AIDS-related illness in Zambian prisons. More recently, a small survey conducted in selected prisons, supported by UNODC and other partners, found HIV prevalence of 27% amongst prisoners (UNODC, 2011). Overall, female prisoners have higher HIV prevalence than men, although there are significant variations between regions. PRISCCA et al (2010) report that HIV testing is significantly higher than TB testing, ranging from 54% at Lusaka Central to 86 % at Mukobeko Maximum Security. In smaller facilities’ HIV testing rates ranged from 23% at Mumbwa to 48% at Mwembeshi.

Overcrowding, poor ventilation, sanitation and nutrition also make prisons high risk environments for the spread of TB. AVERT (2017) estimates that 3.8% of the global prison population are living with HIV and 2.8% have active tuberculosis (TB), noting that “[a]mong inmates on ART whom we interviewed, more than half of them (55%) had missed doses, and lack of food was cited by more than a third (38 percent) of those who had missed doses as the cause” (AVERT, 2017). Dolan et al (2016) noted that “in the African regions, active tuberculosis infection was associated with overcrowding, high inmate turnover, and increased frequency or duration of incarceration.

Human Rights Watch report in 2010 showed that TB rates in Zambian prisons are 15-20% higher in the prisons than in the general population, with significant rates of drug resistance and multi-drug resistant TB (MDR-TB). The PRISCCA et al (2010) study revealed that at one prison (Mumbwa), out of a population of 354 inmates, only four prisoners had been tested for TB in the previous year—and all four were found to be positive.

*"I would not want to go back to prison, we would only eat porridge once a day... usually the meal was beans and kapenta with a lot of insects...one day they only fed us mangos, one per inmate the whole day...the food that dogs eat is sometimes even better than what we used to eat... we would sleep about 8 of us in a space the size of this table (2 X 3 meters)...but when ba Chato visits (the commissioner of correctional services) things would suddenly improve in prison for a few days... if it was not for God, we would not be here"*  
– young former inmates incarcerated for drug-related offences, Livingstone

## Prison as a Last Resort for Young Offenders

*"Despite specific provision under international law that children should be detained only as a last resort, for the shortest appropriate time and be held separately from adults, we found that juvenile detainees in Zambia are routinely incarcerated for extended pre-trial periods, denied basic health care, imprisoned with adults, and face significant risk of contracting HIV and TB."* Todrys & Amon (2011)

## Imprisonment of Young Inmates

Prisons in Zambia are overcrowded, housing an average of 19,000 prisoners in prisons designed to hold 8,150 (US Department of State, 2016). Todrys & Amon (2011) report that in 2010, "Zambia's prisons held 414 juvenile inmates (aged 8 to 18 years), representing 2.5% of all Zambian inmates." Just over half (n =218, or 53%) of these inmates, were detained awaiting trial. There are limited separate facilities for young inmates, however. The US Department of State, 2016 report on Human Rights in Zambia reveals that of the total of 86 prisons throughout the country, only one is exclusively dedicated to juveniles. In some instances, juveniles are incarcerated with the adult population at other facilities countrywide. Zambia has 3 juvenile correctional institutions namely the Nakambala

Approved School in Mazabuka district (Southern Province), Insakwe Approved School in Ndola (Copperbelt Province) and Katombora Reformatory School in Kazungula District (Southern Province). The Auditor General (2014) noted that detaining juveniles for long periods and not transferring them to a reformatory school has negative impacts on juveniles such as delayed education and juveniles end up picking up bad habits from adult convicts.

The delayed transfer of juveniles to appropriate facilities has been noted by the Auditor General (2014), who reported that "Juveniles were detained in prisons for long periods ranging from sixteen (16) days to over three (3) years without being transferred to a reformatory school". This was for various reasons including lack of transport and the limited available facilities. The table below is an illustration of the delays between 2009 to 2012:

### Delayed Transfer of Juveniles

Name of prison	2009	2010	2011	2012	Total number of juveniles	Shortest period of stay	Longest period of stay
Chingola	10	16	21	13	60	1 month 1 day	9 months
Chipata	13	23	25	28	89	1 month	4 months
Kabwe Maximum Male	2	1	1	2	6	2 months	3 years 7 months
Kamfinsa Male	35	29	22	31	117	16 days	1 year 6 months
Livingstone Central	48	40	26	34	148	27 days	9 months
Lusaka Central	71	67	42	40	220	1 month 5 days	2 years 1 month
Grand Total					640		

\* Other prisons did not have convicted juveniles in their custody

Juveniles report being incarcerated with adults, despite the legal prohibition on this, placing young people at risk of sexual exploitation and abuse (PRISCAA et al., 2010). PRISCAA et al (2010) quoted a teen who reported of having been threatened by other inmates if he revealed the combined sleeping arrangements: *"We sleep with the adults, but they told us to say we sleep in a juvenile cell. If we don't say we sleep in a separate cell, they will beat us. We are given punishment when we start talking. But we are scared we might die here."* The report highlighted that non-consensual sex takes places in Zambian prisons, with limited redress for violations. Juveniles are frequently forced into sexual relationships, particularly when they are held with adult prisoners. "The prevalence of sexual activity in prisons is largely unknown and under reported due to denial, fear of stigma and homophobia as well as the criminalization of same sex activity". Evans, a 43-year-old inmate confirmed rape being pervasive in prisons, *"sometimes when you are sleeping someone gets under you. He's already in your anus. Others wake up and catch that man...They are brought before the authorities. Sometimes they overlook it, or the officer in charge can take you to the courts of law"*. Participants in the Livingstone FDGs also reported on good practices, where juveniles were separated from adults in facilities within Livingstone, but that cramped conditions often lead to sexual abuse, *"Juveniles are kept separate from the rest, if they didn't, they would get married...you get married there just because of fear... during rainy season you are stuck in very small spaces for days on end...92 people in place that is about 6 X 3 meters...that when sex abuse happens as you can run or even move"*. – 28-year-old, drug user and former inmate in Livingstone. The report also reported consensual and transactional sex in prisons.

### International and Regional Guidance

The United Nations Standard Minimum Rules for the Administration of Juvenile Justice ("The Beijing Rules") were adopted by General Assembly resolution 40/33 of 29 November 1985; Zambia is a party to these Rules. Under these rules, detention and imprisonment of young people is discouraged:

- **Rule 17.1 (b)** for the Administration of Juvenile Justice implies that strictly punitive approaches are not appropriate. Whereas in adult cases, and possibly also in cases of severe offences by juveniles, just desert and retributive sanctions might be considered to have some merit, in juvenile cases such considerations should always be outweighed by the interest of safeguarding the well-being and the future of the young person.
- **Rule 17.1 (c)** aims at avoiding incarceration in the case of juveniles unless there is no other appropriate response that will protect the public safety.
- **Rule 19.1** The placement of a juvenile in an institution shall always be a disposition of last resort and for the minimum necessary period.
- **Rule 24.1** recommends that "efforts shall be made to provide juveniles, at all stages of the proceedings, with necessary assistance such as lodging, education or vocational training, employment or any other assistance, helpful and practical, in order to facilitate the rehabilitative process."

Zambia is also a state party to the 'UN Principles and Guidelines on Access to Legal Aid in Criminal Justice Systems', adopted by the UN General Assembly in 2012. These urge Member States and other donors to provide extra-budgetary resources to ensure an accused access to legal aid at all stages of the criminal process, in accordance with the rules and procedures of the United Nations. Limited access to legal support services, including legal aid, is dealt with in further detail in Part IV, below.

The WHO (2014) *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* recommend, amongst other things, that:

- Countries should work toward developing non-custodial alternatives to incarceration of drug users, sex workers and people who engage in same-sex activity and set targets for reducing prison overcrowding generally.
- Prison authorities should provide adequate staffing, effective surveillance, disciplinary sanctions, and education, work and leisure programmes for prisoners.

- Prisons and other closed settings and their staffs should make efforts to change institutional culture that tolerates rape and other sexual violence.
- Prisons should adopt multiple approaches to combating sexual violence, including policies and programmes for prevention (e.g. prisoner education, classification, and structural interventions such as better lighting, better shower and sleeping arrangements), staff training, investigation, disciplinary action, victim services (e.g. medical and mental health) and documentation of incidents.

Section 33 of the SADC PF *Model Law on HIV in Southern Africa*, 2008 recommends that states protect all prisoners from violence, including sexual violence and ensure they are able to take legal proceedings in the event of violence. They recommend that prison authorities ensure the necessary measures to prevent and respond to violence, including investigating and resolving all complaints of rape and sexual violence. Section 35 of the SADC PF *Model Law* further recommends the development of an HIV and AIDS Policy for prisons.

### Inmates Situation in Zambia:

The Republic of Zambia enacted 'The Prisons Act Chapter 97' of The Laws of Zambia "to provide for the establishment of prisons, for a prison service, for the discipline of prison officers, for the management and control of prisons and prisoners lodged therein; to provide for youth corrective training centres and extra-mural penal employment; to provide for compulsory after care orders; and to provide for matters incidental to or connected with the foregoing". Section 90 and 91 of the Prisons Act protect prisoners from violence – they include a list of minor and major prohibited offences within prisons, which include indecent language or acts, assaults and acts of violence. Section 92 provides that a prisoner charged with an offence may be kept separate from other prisoners pending a hearing and determination of the charge against him or her. The Prisons Act provides for various punishments for minor and major offences, including confinement in a separate cell for certain periods of time.

Section 133 of the Prisons Act empowers the Minister to declare any building, enclosure or place, or any part thereof, to be a youth corrective centre for the purposes of this Act.

The Juveniles Act Chapter 53 of The Laws of Zambia was put in place "to make provision for the custody and protection of juveniles in need of care; to provide for the correction of juvenile delinquents; and to provide for matters incidental to or connected with the foregoing". Under this legal framework "juvenile" means a person who has not attained the age of nineteen years; and includes a child and a young person; "juvenile adult" means a person aged 19 to 20 years or a person aged 21 to 24 years who has been expressly classified as a juvenile in terms of the Act.

The Act provides the legal basis for protecting and caring for young people in detention under police custody or held within the facilities of the correctional services. Section 58 places a duty on the Commissioner of Police to prevent, as far as possible, the association of a juvenile with an adult charged with an offence and for ensuring that juvenile girls are under the care of a woman. This section is meant to ensure that young people are not exposed to any threat of harm (including sexual exploitation) resulting from being placed in the same detention facilities with adults.

There are various provisions within Zambian law that may help to reduce overcrowding in prisons, for example through allowing prisoners to be released on good conduct, by providing for the release of an awaiting-trial juvenile accused person and by providing for alternative sentencing for a juvenile convicted of an offence:

Section 109(2) of the Prisons Act on Remission of part of sentence of prisoners provides that "upon the recommendation of the Commissioner, a convicted criminal prisoner may by reason of meritorious conduct or of his mental or physical state of health be granted remission of the whole or part of his sentence"

Section 59 of the Juveniles Act empowers police:

“where a person apparently under the age of nineteen years is apprehended, with or without a warrant, and cannot be brought forthwith before a court, the police officer in charge of the police station to which he is brought shall inquire into the case, and may in any case, and-

- a. Unless the charge is one of homicide or other grave crime; or
- b. Unless it is necessary in the interest of such person to remove him from association with any reputed criminal or prostitute; or
- c. Unless the officer has reason to believe that the release of such person would defeat the ends of justice; shall release such person on a recognizance, with or without sureties, for such amount as will, in the opinion of the officer, secure the attendance of that person upon the hearing of the charge, being entered into by him, or by his parent or guardian or other responsible person.”

Section 134(1) of the Prisons Act provides that “[n]otwithstanding the provisions of any other written law, where a person who has attained the age of sixteen years but has not attained the apparent age of twenty-one years, is found guilty or convicted of an offence not punishable with death, the court may order or sentence such person to undergo corrective training in a youth corrective centre for a period of six months.”

Despite legal protections for inmates in Zambian law, including for young inmates, the Auditor General’s Report (2014) found that prisoners are kept in outdated conditions that expose them to violence, sexual abuse and ill-health.

Overcrowding and delays in access to justice are exacerbated by delayed parole hearings. Juvenile inmates, in particular, are not provided with adequate protection, not placed or transferred to separate facilities timeously or at all and are not separated from adults and thus adequately protected from sexual violence.

The Zambia Law Development Commission recommended the review of the Prisons Act, to strengthen the rights of prisoners to equality and human dignity, in alignment with the 2016 Constitution.<sup>26</sup> The review and law reform includes the review of the draft Correctional Services Bill and aims to promote prison reform in Zambia in compliance with international and regional human rights standards and the needs of all prisoners, including a focus on vulnerable prisoners such as juveniles, women and prisoners with disabilities, amongst others.

### Recommendations

- i. Implement all existing legal provisions to decrease overcrowding, ensure the separation of juvenile and adult inmates, allow for the release of awaiting-trial prisoners and alternative sentencing, where appropriate.
- ii. Increase the number of reformatory schools to facilitate the separation of juveniles for adult inmates in Zambia prisons
- iii. Strengthen the investigation and response to prison offences involving sexual violence and exploitation in Zambian prisons, including for young inmates
- iv. Increase access to legal representation to ensure access to justice for all accused persons, including juvenile accused
- v. Promote and put in place mechanisms for whistle-blowing on human rights exploitations by both correctional officers and fellow inmates
- vi. Provide adequate transportation facilities for the movement of prisoners and detainees awaiting trial
- vii. Ensure the review of the Prisons Act includes strengthened rights of all prisoners and protection from sexual violence, including for juveniles and women prisoners.



## Access to Health for Inmates, Including Young Inmates

Once incarcerated, inmates are not provided with the services they need, including health care services. The Auditor General (2014) noted that the prison system at the time could not provide services such as counselling to address dysfunctional attitudes, beliefs and values, increased drug usage within the prison, violent tendencies, poor communication and interpersonal skills and high stress levels amongst the inmates.

Prisoners in Zambia are not provided with adequate health care services to protect them from HIV, TB and other health risks. CMAJ News (2013) quoted Ron Nikkel, president of Prison Fellowship International to have said that “access to health care in the prisons ranges very widely from places where there is no access to treatment for medical care at all, to places where it is very minimal and then of course to countries like Canada and the US and much of Europe, Australia and New Zealand where there is very adequate access to health care in the prisons.”

*“...Prison itself exposes people to more communicable diseases and its harshness contributes to higher prevalence of mental illness and drug abuse”. CMAJ News (2013)*

Inmates in Zambian prisons complain of limited access to adequate health care services. FDGs in held in Livingstone saw former prisoners reporting some positive experiences for specialised health services such as access to TB treatment, access to ART and rehabilitation services for people who use drugs, but also reports of limited access to care:

*“When it comes to ART, prison is the best as they make sure you do not miss your treatment program...treatment is mandatory for HIV and TB...TB patients are isolated while on treatment”* – young person who uses drugs and former inmate, Livingstone.

*“They treated me well, but they did not have the right services...I needed a drip solution, I was in prison for 9 months, that’s how I learned about that kind of treatment”* young person who uses drugs and former inmate, Livingstone.

*“Mostly, people come out sick. No one has come out in good health—they change completely in there. They don’t always get taken to the clinic, though, unless the inmates put pressure on [the officers] ...”* – Elijah, 34, Mukobeko Maximum Security Prison, September 30, 2009 (PRISCCA et al, 2010)

*“I asked for help at the clinic and they said they would take me to the hospital – that was seven months ago. They gave me some medicine, but it only makes me sleep, it doesn’t help me breathe”* 17-year-old detainee (PRISCCA et al, 2010)

According to PRISCCA et al (2010), women face a distinct set of risk factors (e.g. sexual abuse) as well as health care needs in detention, including sexual and reproductive health care, yet as a minority they often receive limited health care. Below are some the findings by PRISCCA et al (2010) from interviews with women inmates:

## Challenges to Women’s Health in Zambian Prisons (PRISCCA et al, 2010)

- *“I have not been to the clinic yet, no antenatal care. I went to the clinic once but was told the nurses were not working. Since then I have not asked. I do not feel well, lots of ups and downs...It’s hard...they only count few of us for treatment, then tell the rest of us to wait for tomorrow and restrict us from going. I had no initial exam when*

*I came to the facility, even though I am pregnant. No special treatment is given for pregnant women, I take whatever I can” – Helen, 27-year-old inmate*

- *“I already knew when I came in that I was pregnant. I have accessed care three times since I have been in here. The first day that I went, they felt my tummy and told me that the fetus was too small. The second time, they took a blood sample and told me that the baby was growing. The third time, I had VCT—they tested my blood again and told me I was HIV-positive. They told me my CD4 count was too high for ART. I wasn’t given any HIV drugs to prevent transmission, only folic acid and vitamins.” – Tasila, 24-year-old inmate at Kamfinsa*

The Auditor General (2014)’s audit revealed that “prisons do not subject the prisoners to psychological counseling or therapy. In addition, there is also shortage of Offender Management Officers to conduct social counseling, did not have qualified psychologists to conduct psychological therapy and they did not maintain records for individual or group social, psychological or spiritual counseling.”

### International and Regional Guidance

All persons have the right to health, including prisoners, and the health rights of prisoners are detailed in various international human rights treaties. International and regional guidance also provides specific recommendations for the HIV- and sexual and reproductive related health needs of prisoners.

Rule 13.5 of the “The Beijing Rules” details how correctional systems of member states should care for young people while in custody: “juveniles shall receive care, protection and all necessary individual assistance-social, educational, vocational, psychological, medical and physical-that they may require in view of

their age, sex and personality”. Rule 26.4 of The Beijing Rules also emphasises that young female offenders placed in an institution deserve special attention as to their personal needs and problems. “They shall by no means receive less care, protection, assistance, treatment and training than young male offenders.” It insists that their fair treatment shall be ensured.

The GCHL (2012) *Risks, Rights & Health* report recommends that countries ensure that necessary health care is available in places of detention, including HIV prevention and care services, regardless of laws criminalizing same-sex acts or harm reduction, and including provision of condoms, comprehensive harm reduction services, voluntary and evidence-based treatment for drugs and ART. Services should satisfy international standards of quality of care in detention settings, being evidence-based, voluntary and offered only where clinically indicated.

The GCHL (2018) *Risks, Rights & Health Supplement* recommends further that governments must make every effort to ensure that incarceration is a last resort for drug use and drug-dependence offences and should instead promote alternatives to incarceration for drug use and drug-dependence offences.

The SADC PF *Model Law on HIV in Southern Africa* also provides model law provisions for the management of HIV in prisons. It recommends that Member States ensure that prison authorities provide HIV related health information and education to prisoners as well as prevention services (including condoms, water-based lubricants and harm reduction services, in section 29, notwithstanding criminal laws relating to sex and drug use. It further recommends a prohibition on compulsory HIV testing and emphasizes the rights of prisoners to HIV-related treatment and care.

SADC has also enacted *Minimum Standards for HIV and AIDS, TB, Hepatitis B and C, and Sexually Transmitted Infections Prevention, Treatment, Care and Support in Prisons in the SADC Region*. These standards set out detailed



guidance for the management of HIV and TB in prisons, including for guiding principles of human rights, equity, non-discrimination and confidentiality; health care services on admission, during detention and on release (including for children and young people and LGBTI populations); and the creation of an enabling legal and policy environment and the reduction of imprisonment and pre-trial detention.

### Access to Health Services for Inmates in Zambia:

There is no HIV or TB-specific prisons policy for Zambian prisons.

The Prisons Act provides for health care services for prisoners and, where in-house prison health services are inadequate, for removal of a prisoner to hospital (section 71(1) of the Prisons Act). Section 24 of the Prisons Act recommends that the officer in charge of a prison shall maintain a properly secured prison hospital, clinic or sickbay and shall ensure that prisoners are in safe custody while they are attending such hospital, clinic or sickbay. Part II: Administration of Prisoners with infectious or contagious diseases-Section 108 of the Prisons Act empowers an officer in charge to take steps to place any prisoner found to be suffering from any infectious or contagious disease, under treatment, and to prevent such disease or condition from spreading to other prisoners.

Section 70 of the Juveniles Act instructs that “every officer shall direct the attention of the superintendent to any inmate, whether he complains or not, who appears to be out of health, or whose state of mind appears to be deserving of special notice and care, and the superintendent shall without delay bring such cases to the notice of the medical officer.”

The Juveniles Act and the Prisons Act of Chapter 97 of the Laws of Zambia, combined with international commitments, provide guidance and bestow upon correctional officers and relevant ministries the responsibility and obligation to protect the rights of inmates, including their right to access to health services. However, the Prisons

Act is currently under review to strengthen the rights of prisoners, in line with international and regional guidance.

The Prisons Act CAP 97, Section 91 makes sodomy a major prison offence. This provision is seen to bar service providers from distributing condoms in prisons.

Prisoners do not receive adequate health services in line with international and regional standards, including the SADC *Minimum Standards*. There is no HIV and TB Prisons policy and the LEA and other research found that the Zambian Ministry of Health’s mission statement, “to provide equitable access to cost effective, quality health services as close to the family as possible” is far from being realised for inmates. The Auditor General’s Report (2014) highlighted the various challenges to the health of prisoners, given prison conditions, as set out above. It also noted the gaps in collaboration between governmental departments to provide services to inmates, including young inmates.

There is growing concern amongst public health authorities and government in Zambia that despite the successes in preventing and treating HIV over the last three decades, prisoners continue to have less protection against HIV and other infectious diseases than communities outside prison. This requires a multi-pronged, evidence-informed approach that takes into account the cultural and legal issues that affect HIV transmission in prisons. UNODC has proposed that current HIV and AIDS interventions in prisons be reviewed to respond to the challenge of AIDS in prisons (UNODC, 2013).

### Recommendations

- i. Support the law review and reform process to, *inter alia*, review the Prisons Act, in line with international and regional standards and the Auditor General’s (2014) recommendations, carry out parole hearings timeously, and transfer juveniles to juvenile facilities on conviction.
- ii. Implement provisions in the Juveniles and Prisons Act to eliminate extended pre-trial detention, expand non-custodial

sentencing options and as a last resort, ensure juveniles are housed in juvenile detention facilities

- iii. Strengthen access to voluntary HIV, TB and SRH care services for inmates, including the full package of HIV prevention and care services as well as those for TB, regardless of laws criminalising same-sex acts or harm reduction, and including provision of condoms, comprehensive harm reduction services, voluntary and evidence-based treatment for drugs and ART, in line with SADC standards

## Criminalisation of HIV Transmission and Exposure

A number of countries all over the world, and particularly across Africa, have introduced broad and/or vaguely worded laws criminalizing harmful HIV-related behavior, such as laws criminalizing HIV transmission, exposure or non-disclosure. The GCHL found that these laws are “inconsistent with international human rights law as they result in criminalization of a wide range of negligent or reckless acts by persons who may even be unaware of their HIV status.” The report concluded that many of these laws were poorly drafted and couched in broad language, lowering the standards of proof and widening the net of liability in a way that is legally unacceptable. The GCHL furthermore found the laws to be ineffective in reducing the spread of HIV and to lead to increased stigma, discrimination and injustice, to increase the potential for targeting and ‘scapegoating’ of people perceived to be living with or at higher risk of HIV exposure, to discourage access to HIV testing and access to health care and to have negative consequences for health, including for vulnerable populations such as women with HIV. UNAIDS (2013) guidance on ending overly broad laws criminalizing HIV transmission, exposure and non-disclosure noted that these laws raised significant human rights and public health concerns.

ARASA (2016) has noted the negative impact of laws criminalizing HIV transmission in Africa, particularly for women and recommends that “rather than responding to HIV by creating fear through criminalization, human rights emphasize protecting the dignity – including the sexual rights – of all people and create conditions in which people can make free and informed choices about their health and their lives.” They recommend providing all persons with HIV prevention information and services and protecting all people, in particular women, from violence and inequality to reduce their vulnerability to HIV.

The Zambia LEA found that people living with HIV, vulnerable and key populations, including young key populations experience stigma, discrimination and human rights violations based on their HIV status, perceived HIV status and on other grounds. In this context, laws criminalizing HIV transmission, exposure and/or non-disclosure have the potential to create further stigma and discrimination as well as exacerbate barriers to access to health care.

### International and Regional Guidance

The GCHL’s Risks, Rights & Health recommends against enacting HIV-specific laws to criminalise HIV transmission, exposure and non-disclosure. It recommends, amongst other things:

- Countries not enact, or repeal laws that explicitly criminalize HIV transmission, exposure or non-disclosure and vertical transmission of HIV.
- Countries not prosecute cases where no intentional or malicious HIV transmission has been proven to take place.
- Countries only prosecute HIV transmission that was both actual and intentional, using general criminal law.

The GCHL’s recent, updated *Risks, Rights & Health Supplement* notes the continuance of problematic laws criminalising HIV transmission, exposure and non-disclosure, and the most recent medical and scientific evidence that shows there is no risk of HIV transmission where a person on ART has an undetectable viral load. It provides updated,

detailed recommendations regarding provisions criminalising HIV transmission, including the following:

- In countries where HIV criminalization laws still exist, courts must require proof, to the applicable criminal law standard, of intent to transmit HIV. The intent to transmit HIV cannot be presumed or derived solely from knowledge on the part of the accused of positive HIV status and/or non-disclosure of that status; from engaging in unprotected sex; by having a baby without taking steps to prevent mother-to-child transmission of HIV; or by sharing drug injection equipment.
- Governments must ensure that, where an HIV-specific law has been repealed, there is a restriction on the application of any general laws to the same effect either for HIV or TB.
- Governments must prohibit the prosecution— under HIV-specific statutes, drug laws, or child abuse and neglect laws— of women living with HIV for choices they make during and after pregnancy, including about breastfeeding children.
- Whenever HIV arises in the context of a criminal case, police, lawyers, judges and where applicable, juries, must be informed by the best available scientific evidence concerning the benefits and consequences of appropriate therapy, and the individual and community advantages of maintaining such therapy
- Governments must ensure that HIV status is not used as such to justify pre-trial detention, segregation in detention or prison, or harsher or more stringent sentences or conditions of parole or probation following release from custody.

The SADC PF *Model Law* specifically excludes provision for laws criminalizing HIV transmission. In November 2015, SADC PF unanimously adopted a motion on Criminalisation of HIV Transmission, Exposure and Non-Disclosure, expressing concern that specific laws criminalizing HIV transmission, exposure and non-disclosure are harmful to successful HIV prevention and care and may infringe on human rights. The memorandum

recommended that SADC Member States consider rescinding and reviewing punitive laws specific to the prosecution of HIV transmission, exposure and non-disclosure.

### Criminalisation of HIV and Exposure in Zambia:

Zambia does not have a law specifically criminalizing HIV transmission or exposure. However, the Penal Code Act Chapter 87 of The Laws of Zambia in section 183 declares “any person who unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, is guilty of a misdemeanour”.

The 2011 Anti-Gender Based Violence Act, read with the Penal Code, may further criminalise HIV exposure and transmission. The Act defines sexual abuse (criminalised in terms of the Penal Code) to include “the engagement of another person in sexual contact, whether married or not, which includes .... sexual contact by a person aware of being infected with HIV or any other sexually transmitted infection with another person without that other person being given prior information of the infection”. This broad provision may serve to criminalise a wide range of acts, even those with limited risk of HIV transmission, in the event of non-disclosure of HIV status. The Penal Code and Anti-GBV Act are currently under review.

To date there is no precedence or reports of this having been applied in the context of HIV infection in Zambia. There is no prosecutorial guidance on the appropriate use of this section in relation to HIV or other diseases.

Section 59 of the Public Health Act also provides that “[e]very person who willfully or by culpable negligence infects any other person with venereal disease or does or permits or suffers any act likely to lead to the infection of any other person with any such disease, shall be guilty of an offence, and shall be liable to a fine not exceeding six thousand penalty units or to imprisonment for a period not exceeding six months, or to both. Section 57 notes that the provision is deemed

to apply to syphilis, gonorrhea, gonorrheal, ophthalmia, soft chancre, venereal warts and venereal granuloma – HIV is not specifically included. Section 60(1) furthermore provides for, by order of a magistrate, the removal of a person with a venereal disease who has been sentenced to imprisonment, to a special hospital or place of accommodation for detention and treatment.

The provisions are overly broad and inconsistent with international guidance in relation to criminalisation; there is also no prosecutorial guidance on the appropriate use of the criminal law in relation to HIV or TB.

### Recommendations

- i. The enactment of a specific provision criminalizing HIV transmission, exposure or non-disclosure in Zambia is not recommended.
- ii. Develop prosecutorial guidance on the appropriate use of the Anti-Gender-Based Violence Act and Penal Code provisions in relation to HIV.
- iii. Ensure that the review of the Anti GBV-Act and Penal Code exclude overly broad provisions criminalising HIV transmission, exposure or non-disclosure.

## Employment

The ZDHS (2013-14) reported that 49% of women and 73% of men aged 15-49 were employed at the time of the survey; the agricultural sector remains the primary employer, particularly of rural women and men, in Zambia, with 48 % of women and 49% of men engaged in agricultural occupations. The sales and services sector employ the majority of urban women (69%) and men (32%). Urban respondents such as those in Copperbelt and Lusaka are more likely to work in other occupations such as skilled manual labour, or professional, technical, or managerial jobs. Women and men with more than a secondary education are most likely to work in the professional, technical, and managerial sector.

HIV has had a devastating impact on the labour force and on socio-economic development. Labour intensive sectors such as agriculture, mining, construction, transport, the military and uniformed services are the most affected sectors in the country (UNAIDS, 2009), due to the combination of high numbers of migrants away from families and higher rates of disposable incomes. Whilst some sectors have made good progress in scaling up access to the full range of HIV services to its personnel, employers need increased guidance to support employees.

Similar sentiments can be made about TB: “the onset of HIV in Zambia led to an increase in TB cases and the disease is a significant occupational health problem among copper miners” (Chanda-Kapata et.al, 2016). Routine national TB notification data from the National TB Programme indicate higher TB cases from the towns that are within the Copperbelt, where mining activities are concentrated, than the other provinces. This fact was augmented by the findings of the national TB prevalence survey that was conducted from 2013 to 2014. “From a human rights perspective, with mining being the economic backbone of the country, it is eminent for the government and mining stakeholders to develop strategies that could reduce the risk of TB transmission among miners and ex-miners, their families and surrounding communities” Chanda-Kapata et.al (2016).

## Stigma and Discrimination in the Workplace

Many people living with HIV report experiences of stigma and discrimination in the workplace, as well as being required to test for HIV as part of a pre-employment medical assessment. Hargreaves et.al. (2018) notes that “[s]tigma experienced by people living with HIV can include being gossiped about, insulted or physically assaulted in communities and health care settings. Internalized stigma occurs whenever PLHIV apply the same negative feelings to themselves and can have mental health consequences.”

LGBTI populations also report workplace-related stigma and discrimination. According to the US State Department, 2015, LGBTI advocacy groups reported discrimination in employment (as well as other sectors), including dismissals from employment and refusal of employment due to sexual orientation and gender identity, and a ban on serving in the military.

### International and Regional Guidance

Both UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights* and the International Labour Organisation (ILO)'s *Recommendation 200 of 2010 on HIV/AIDS and the World of Work* have recommended that all workplaces develop HIV workplace policies that prohibit HIV-related discrimination in the workplace, prohibit pre-employment and mandatory HIV testing, protect the rights of employees to confidentiality and promote occupational health and safety of all employees, amongst others.

UNAIDS and ILO have noted that HIV testing is not sufficient to determine a person's fitness to carry out the requirements of an employment position: "UNAIDS/WHO do not support mandatory testing of individuals on public health grounds. Voluntary testing is more likely to result in behaviour change to avoid transmitting HIV to other individuals. Recognising that many countries require HIV testing for immigration purposes on a mandatory basis and that some countries conduct mandatory testing for pre-recruitment and periodic medical assessment of military personnel for the purposes of establishing fitness, UNAIDS/WHO recommend that such testing be conducted only when accompanied by counselling for both HIV positive and HIV negative individuals and referral to medical and psychosocial services for those who receive a positive test result."

Article 23 of the SADC PF *Model Law* recommends that countries take several steps to strengthen workplace rights in the context of HIV and AIDS. Important provisions include the following:

"(1) Any form of discrimination in the workplace against a person, his or her

partner(s) or close relatives on the sole account of his or her actual or perceived HIV status, shall be prohibited.

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

(5) A person's HIV status, the status of his or her partners, or that of his or her close relatives alone shall not constitute a reason for refusal of employment or termination of employment. Fitness to work shall be the relevant standard in all matters related to employment.

(6) HIV testing of a job seeker or an employee for the purpose of recruitment, promotion or any other reason is prohibited.

(7) The employer and other staff members shall not disclose the HIV-status of a job seeker, employee or co-worker if they are aware of that HIV status.

(8) Employers, in consultation with the employee and its representative, shall take measures to reasonably accommodate employees with AIDS-related illnesses. These could include rearrangement of working time, special equipment, opportunities for rest breaks and time off for medical appointments.

(9) When employees with AIDS-related illness are no longer able to fulfil their duties on the account of poor health, they shall benefit from rights pertaining to employees affected by a long-term illness. "

### HIV and Employment in Zambia:

In Zambia, the Employment Act 57 of 1965 provides for the rights and duties of employers and employees, amongst other things. The newly inserted section 36(3) of the Employment Amendment Act 15 of 2015 provides that "[a] contract of service shall not be terminated unless there is a valid reason for the termination connected with the capacity, conduct of the employee or based on the



operational requirements of the undertaking.” Section 36(4) states that it is not a valid reason to terminate a contract on a number of grounds, which include a person’s race, colour, sex, marital status, family responsibilities, pregnancy, religion, political opinion or affiliation, ethnicity, tribal affiliation or social status of the employee.

Other laws relevant to non-discrimination and equity in employment include the following:

- The Industrial and Labour Relations Act, Cap 269 provides for the rights of employees and prohibits ill treatment of workers.
- The Minimum Wages and Conditions of Employment Act, Cap 276 provides for dealing with cases of employee illness that last longer than 26 days.
- The Factories Act, Cap 441, which protects the welfare, health and safety of workers in factory environments, and
- The Occupational Health and Safety Act and the Workmen’s Compensation Act which regulate workplace health, safety and compensation matters.

Section 28 of the Employment Act requires that a qualified and competent Medical Officer shall medically examine every employee before he/she enters into a contract of service of at least six months’ duration, to ascertain the fitness of the employee to undertake the work that he/she is required to do.

The NASF promotes a multi-sectoral approach to HIV, including the development of an HIV & AIDS Workplace Policy to address issues of HIV & AIDS in the working environment as well as the local community. Workplace HIV policies are a requirement for the public sector as part of the institutional employment wellness strategies. Chatora et al (2018) noted that, although few private sector employers had HIV workplace policies, “policy translation was very high suggesting that workplaces with policies are likely to implement programs.” Some workplaces have integrated HIV into wellness policies.

Employees continue to experience HIV-related stigma and discrimination and discrimination based on SOGI. The Employment Act protects

against termination of employment based on workplace-related discrimination but does not specifically protect against discrimination based on HIV status, health status or sexual orientation and gender identity.

Additionally, employees report that pre-employment HIV testing continues to take place. Although the Employment Act does not specifically require that prospective employees be tested for HIV, it appears that some employers still request pre-employment HIV testing under the auspices of a pre-employment medical assessments.

### Recommendations

- i. Review employment law and policy to specifically prohibit discrimination on the basis of HIV and TB status, health status, sexual orientation and gender identity.
- ii. Review employment law and policy to specifically prohibit pre-employment HIV testing.
- iii. Strengthen employer and employee’s awareness of access to justice for workplace-related rights violations, in terms of section 36(4) of the Employment Act, which provides for employees to file complaints, participate in proceedings against an employer or have recourse to administrative authorities, without fear of loss of employment on that basis.

## Occupational Health and Safety

Employees have the right to safe conditions of work and to be protected from illness and injury in the working environment. In the case of HIV and TB, employees have the right to be protected from working conditions that create a risk of HIV and / or TB exposure and employers have an obligation to provide safe working environments, including the necessary policies, procedures and equipment to protect employees from HIV and TB exposure.

### International and Regional Guidance

UNAIDS and the ILO recommends that all working environments take steps to protect employees from occupational injury and

disease. In the case of HIV, there is specific guidance on how to protect employees from HIV transmission in the workplace, in line with their obligations to provide a safe working environment for employees.

At regional level, Article 23 of the SADC PF *Model Law* provides that:

“(3) The employer shall take all necessary measures to implement the universal precautions to reduce the risk of HIV infection through accidental exposure to HIV in the workplace.

(4) In case of accidental exposure to HIV infection occurring in the workplace, the employer shall ensure free access to post-exposure prophylaxis and counselling for the employee in accordance with [relevant national and international guidelines].”

Equally, employers are required to protect employees from TB infection in the workplace. SADC has developed specific guidance relating to managing TB in the mines too. The SADC *Protocol on Health* which came into force in 2004 aims to harmonize and rationalise resources in the implementation and attainment of the health objectives of the Region. Two articles of the Protocol are of specific importance to tuberculosis control: Article 9 relating to Communicable Disease Control and Article 12 relating specifically to Tuberculosis Control.

SADC Member States also adopted the SADC *Framework for the Control of Tuberculosis* which covered the period 2007-2015. The Framework gives the following strategic approaches for the purposes of achieving its objectives:

- Coordination and harmonization of national TB control policies and guidelines in the SADC Region in order to ensure enhanced and expanded quality DOTS services accessible to all TB patients.
- Health system strengthening to support expansion and extension of quality directly-observed treatment (DOTS) services.
- Strengthening of partnerships and collaboration between TB programmes, HIV programmes, NGOs, private sector and civil society and other sectors in the SADC Region.

## Occupational Health and Safety in Zambia

The Occupational Health and Safety Act No 36 of 2010 provides for occupational health and safety in Zambia, including the establishment of the Occupational Health and Safety (OSH) Board to coordinate and collaborate on occupational safety and health issues. Data on occupational diseases is collected by the Occupational Safety and Health Services Department, the Mines Safety Department and the Workers Compensation Fund Control Board. The National Employment and Labour Market Policy furthermore provides for occupational health and safety. There is also a Tripartite Consultative Labour Council, established under the Industrial and Labour Relations Act of 1993, that serves as a forum for dialogue on broader workplace issues, including occupational health and safety (ILO, 2012). However, the ILO (2012) notes that “there is no National OSH Management Systems that have been developed or adopted by OSH authorities for use in workplaces in Zambia.”

The National AIDS Council have recognised HIV and AIDS as a workplace health concern and have advocated for the establishment of HIV and AIDS workplace policies in the private and public sector; it is also highlighted in the National HIV/AIDS/TB Strategic Plan. The public sector have mandated HIV workplace policies and private sector companies have also begun to respond, establishing HIV workplace policies. In order for these policies to be deemed as binding, their structure, content, principles, objectives and aims must be agreed upon and endorsed by employers, employees and workers representatives, such as trade unions.

The Ministry of Health have put measures in place to protect workers from occupational infection with HIV and TB, including post-exposure prophylaxis (PEP), as outlined within the *Comprehensive HIV Prevention Roadmap 2017-2021*.

According to ILO (2012), Zambia does not have a national policy on occupational health and safety, and “the National Employment and Labour Market Policy which was launched in 2005 is the closest there is to a National OSH Policy.” There is a need for a national policy that includes specific guidance to employers and employees on protecting workers from HIV and TB in the workplace.



In addition, tuberculosis, HIV and silicosis programmes for ex-mine workers and mine are fragmented and not always available to all. Their availability is mainly dependent on the motivation of the employer, size of the mine operation and availability of resources (SADC, 2010).

### Recommendations

- i. Develop a national occupational health and safety policy that integrates issues relating to protecting employees from HIV and TB in the working environment.
- ii. Strengthen co-ordination, in law, policy and strategies, of TB control and management in Zambian mines between the key government ministries of Health, Mines and Labour.
- iii. Strengthen monitoring and evaluation of HIV & TB workplace policies and programmes in all workplaces, and in particular mines and mining communities

## Education and Information

All young people have the right to an education as well as to information, including sexual and reproductive health information. In Zambia, however, this right has not yet been fulfilled for all persons do not have adequate access to education; young people, including young key populations also do not have adequate access to HIV and AIDS information and CSE.

### Key Findings on Education by the ZDHS (2013-14)

- 8% of women and 4% of men age 15-49 have no education, a slight decrease from the figures of 10% and 5% reported in the 2007 ZDHS. 45% of women and 57% of men have a secondary education or higher.

- About seven in ten women (68%) and more than eight in ten men (83%) in Zambia are literate.
- 12% of women and 22% of men age 15-49 are exposed to three types of mass media (newspaper, television, and radio) at least once a week. 34% of women and 22% of men are not exposed to any of these mass media.

In addition, young people with HIV, as well as young key populations need to have their rights to equality and non-discrimination protected in schools, to protect them from stigma and discrimination.

### International and Regional Guidance

Guideline 6 of the UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights* recommends that states should enact legislation to provide for adequate HIV prevention and care information, amongst other things. The Commentary to Guideline 8 furthermore recommends that “States should ensure that all women and girls of child-bearing age have access to accurate and comprehensive information and counselling on the prevention of HIV transmission and the risk of vertical transmission of HIV.” It goes on to say that “States should ensure the access of children and adolescents to adequate health information and education, including information related to HIV/AIDS prevention and care, inside and outside school, which is tailored appropriately to age level and capacity and enables them to deal positively and responsibly with their sexuality. Such information should take into account the rights of the child to access to information, privacy, confidentiality, respect and informed consent and means of prevention, as well as the responsibilities, rights and duties of parents. Efforts to educate children about their rights should include the rights of persons, including children, living with HIV/AIDS.”

The Committee on the Rights of the Child's General Comment No. 3 of 2003 on HIV/AIDS and the Rights of the Child sets out the various rights of the child in the context of HIV, including the right to non-discrimination, the best interests of the child, the right to survival, life and development and the right to express views and have them taken into account. To fulfil these rights, General Comment No. 3 recommends that all children have the right to receive, amongst other things, HIV prevention awareness and information, adolescent-friendly health services including HIV testing and counselling, treatment and care, as well as education. It notes at para 15 that "[s]tates parties must make adequate provision to ensure children affected by HIV/AIDS can stay in school and ensure the qualified replacement of sick teachers so that children's regular attendance at schools is not affected, and that the right to education (Article 28) of all children living within these communities is fully protected.

The WHO *Technical Briefs* on young key populations note the importance of ensuring access to comprehensive sexuality education for all young people, including young key populations, which includes issues around sexual and reproductive health and rights and sexual orientation and gender identity, amongst other things.

The SADC PF *Model Law* provides for the rights of children with HIV to education as well as for the integration of HIV and AIDS education and information within schools. It provides that:

"(1) The actual or perceived HIV status of a person, of his or her partners and close relatives shall not constitute an obstacle to the access to education and the enjoyment of the right to education including the allocation of bursaries or scholarships.

(2) The administration of educational institutions including schools and universities has the obligation to keep confidential the HIV status of children, learners, students or that of their parents or close relatives if it receives such information. Enquiries and investigations initiated by the administration in this respect shall be prohibited.

(3) Any isolation, exclusion or suspension of a child, learner or student from an educational institution on the sole account of his or her actual or perceived HIV status or the actual or perceived HIV status of his or her partners and close relatives is prohibited.

(4) The [Ministry or relevant government departments responsible for education] shall provide an educational programme that includes HIV and AIDS in accordance with sections 4 and 5 of this Model Law."

Sections 4 and 5 of the *Model Law* provide for HIV and AIDS education and information within learning institutions, including on sexual health and rights, issues of gender inequality and the acceptance of people living with HIV, vulnerable and marginalized groups.

### Information and Education in Zambia

Zambia aims to provide all young people with basic education. The *Education for All 2015 National Review Report: Zambia* set out the priorities for Zambia's education sector, which have remained unchanged for the past 15 years and include providing children with basic learning skills for entering primary school, achieving universal access to schooling, addressing the learning needs of youth and achieving adult literacy.

In 2013, under the leadership of UNAIDS and with the support of SADC, Zambia endorsed an ESA Commitment setting targets for strengthened collaboration between the health and education sector and young people to deliver on sexual and reproductive health and rights for young people. A Swedish International Development Cooperation Agency-funded UNESCO project also aims to strengthen sexuality education programmes for young people in school settings in Zambia, including strengthening the quality, delivery and effectiveness of CSE curricula to ensure that they are evidence-based, gender transformative, and age- and culturally-appropriate. The project has achieved a number of successes, including the development of CSE materials for Grades 5 to 12, training of a large number of educators and integration of CSE into the Ministry of General Education Policy.

Specific knowledge about HIV and AIDS is reported to be high in general in Zambia. Among young people in ESA, UNAIDS (2016) reports that 94% of female and 92% of male young people aged 15-24 years know of a place to get an HIV test.

The Coalition of NGOs in 2012 (ERI et.al, 2012) in their submission towards the periodic review process on human rights in Zambia, noted that prior to the election of 2011, “schools and learning institutions saw a reduction in funding and in some cases they went without funding for a number of months, resulting in the quality of education being compromised.” The Coalition was also concerned about the impact of HIV and AIDS on both teachers and learners – on the quality of education and on the psycho-social impact on learners of dealing with HIV and AIDS.

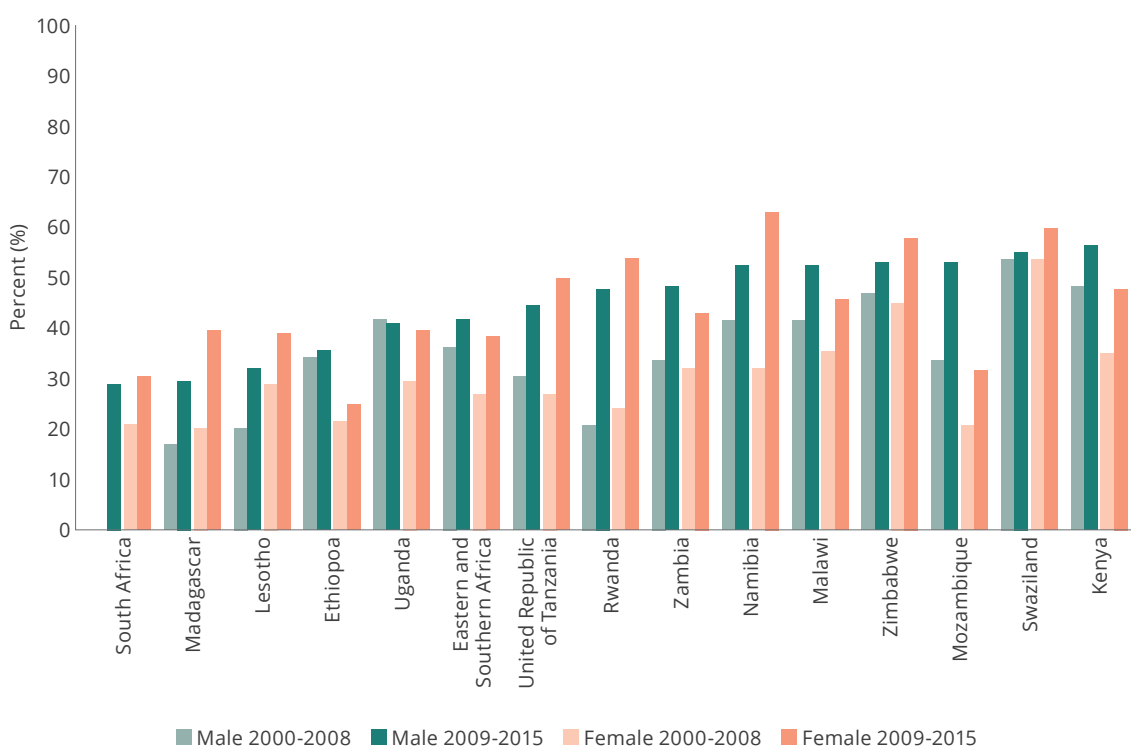
Currently, the CSE programme in Zambian schools does not include the free distribution of condoms and contraceptives in schools even though information regarding condoms and contraceptives is integrated in the curriculum. It also does not include issues relating to

sexual orientation and gender identity and does not address the rights and needs of young key populations.

#### Recommendations<sup>27</sup>

- i. Strengthen access to education, including through ensuring adequate funding for all schools and learning institutions
- ii. Strengthen training of guidance and counselling teachers to provide emotional, social, and psychological support to all young learners, including students affected by HIV and young key populations
- iii. Strengthen links with the health and other sectors to increase access to HIV and SRH health care information and services
- iv. Strengthen the provision of comprehensive sexuality education that accommodates the needs of all adolescents, including young LGBTI persons, in the school curricula, in line with ESA Commitments
- v. Strengthen efforts to address bullying in schools on the basis of e.g. sexual orientation and gender identity.

#### Comprehensive knowledge of HIV prevention among young people (aged 15-24 years), 2000-2015



Source: Demographic and Health Surveys, 2000-2015

## Social Welfare

Social welfare provides aid to those in need, in terms of money or services. Recipients may include families faced with loss of income or illness, vulnerable populations including children and young people, the sick, people with disabilities, the elderly and the unemployed. When possible, services are also directed toward preventing threats to personal or family independence.

Social welfare should also provide for the needs of vulnerable and key populations in the context of HIV and TB. This may include social assistance for young people, those with health issues, those who are unable to work, those living in impoverished households and those who may be without the support of parents or guardians as a result of HIV, AIDS and TB. This may also include social assistance, livelihood support or economic empowerment for e.g. young LGBTI populations who may be marginalised from their families and communities and in need of economic support.

Since socio-economic determinants play a critical role in vulnerability to health, social assistance is critical for those who need socio-economical and development support, such as young people, (Mburu et al, 2014) including young key populations. The Youth Policy highlights the importance of HIV prevention for young people but does not highlight the socio-economic needs of young key populations or early adolescents aged 10 to 14 years. In addition to their particular needs, young people, including young key populations may find it particularly difficult to access social assistance, due to laws relating to the age of consent to access services, as well as laws criminalizing young key populations.

### International and Regional Guidance

Article 25 of the UDHR recognises that every person has the the right to social security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his/her control. This right is also provided in Article

9 of the ICESCR. Specific provision is made in respect of marginalised and vulnerable groups. For example, States are required in terms of Article 11 of CEDAW and Article 13 of the African Women's Protocol to recognise women's right to social security, particularly in cases of retirement, unemployment, sickness, invalidity, old age and any other incapacity to work, as well as the right to paid leave. This right shall also be recognised in respect of children and persons with disabilities, as provided in the ACRWC and CRC and the CRPD respectively. Article 26 of the CRC provides that every child has the right to benefit from social security, including social insurance. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child. In terms of article 28 of the CRPD, States shall recognise the right of persons with disabilities to social protection and to the enjoyment of these rights without discrimination on the basis of disability. In this regard they shall take appropriate steps to safeguard and promote the realisation of this right.

In the context of HIV and AIDS, the UNAIDS *International Guidelines* note the link between protecting the right to an adequate standard of living and reducing people's vulnerability to the risk and consequences of HIV infection. Social security is particularly relevant to meeting the needs of people living with HIV and AIDS and/or their families, who have become impoverished by HIV and AIDS as a result of increased morbidity due to AIDS and/or discrimination which can result in unemployment, homelessness and poverty. People living with HIV should be prioritised as particularly vulnerable in the allocation of resources and States must ensure that people living with HIV are not denied an adequate standard of living and/or social security and support services on the basis of their HIV status.<sup>28</sup> Social protection can help cushion them so that they are able to meet their basic dietary and other needs.

UNAIDS has also identified social protection as a strategic priority in the global HIV

response because of its importance in addressing the drivers of the epidemic as well as helping to mitigate its impacts on communities, households and individuals. Moreover, according to the UNAIDS 2011 *Social Protection and HIV Guidance Note*, investments in social protection are necessary to achieving the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. This should include:

- Financial protection through predictable transfers of cash, food, or other transfers for those affected by HIV and those who are most vulnerable.
- Programmes that support access to affordable quality services, including treatment, health, and education services through for example social health insurance and school fees exemption.
- Policies, legislation and regulation to meet the needs and uphold the rights of the most vulnerable and excluded.

The WHO *Technical Briefs* on young key populations specifically recognise social protection and economic empowerment as a critical factor to strengthen and improve the socio-economic circumstances of young key populations and to reduce their vulnerability, including their vulnerability to HIV and TB.

### Social Welfare System in Zambia

The welfare system is spearheaded by the Ministry of Community Development and Social Services, which aims to empower people to take ownership of improving their living conditions. The Department of Social Welfare is responsible for the provision and promotion of quality social welfare services aimed at alleviating poverty, reducing destitution, promoting family values and reducing juvenile delinquency. The Department of Community Development implements a number of key programmes and projects aimed at uplifting the living standards of vulnerable populations in Zambia. These include:

- Livelihood and Empowerment Support Scheme
- Community Self Help Initiatives Programme

- Food Security Pack Programme
- Community Skills Development Programme
- Community Development Training (supporting women and girls)
- Education and Women's Empowerment and Livelihoods Project.

Past interventions which used to address vulnerable populations included food aid, public works using food for work, cash for work and food for assets. Access to basic services has previously been provided through social investment funds and micro-finance tailored towards the vulnerable. However, some needy groups such as the disabled, chronically sick, the aged and children are often excluded. Key populations are not provided with social assistance, unless they qualify in terms of other characteristics. (Government of the Republic of Zambia, 2006).

Currently, the Zambia Welfare system is far from realizing its aims and objectives and providing for those in need. According to the Ministry of Community Development and Social Services (2014) "currently, social protection programmes in Zambia do not reach enough people". There has been insufficient monitoring of the system to identify whether social protection programmes are functional and adequate and there is inadequate allocation of resources to social protection programmes.

### Recommendations

- i. Increase resources for social protection programmes, including for vulnerable and key populations in the context of HIV and TB.
- ii. Advocate for livelihood and empowerment support schemes to provide support for key populations, particularly young key populations

## Women, Gender Equality and Gender Based Violence

The *Gender Status Report 2012-2014* provides an update on gender indicators and targets set for monitoring of gender mainstreaming in socio-economic development in Zambia. It indicates that gender inequality remains a concern and impacts on the development of young women. For instance, the report found that:

- Females account for 50.7% of the total population in Zambia yet women hold only 11.5% of parliamentary seats.
- Only 25.7 % of adult Zambian women have reached at least a secondary level of education (compared to 44.2% of Zambian men).
- For every 100 000 live births, 440 women die from pregnancy-related causes; the adolescent birth rate is 125.4 births per 1000 live births.
- Female participation in the labour market is 73.2% compared to 85.7% for men.
- Regarding pregnancy and re-admission to schooling, in grades 1-9, the highest number of girls falling pregnant in 2011 was 13 929 decreasing to 13 275 in 2014. There was an 18.5% increase in girls re-admitted to school in 2014 (5 322 as compared to 4 492 in 2013).

According to the Zambia Demographic Health Survey 2013-14, gender-based violence is a critical issue in Zambia. Various population-based studies indicated domestic violence as a reason for poor health, insecurity, and inadequate social mobilisation among women.

### Key Findings of the ZDHS (2013-14)

- 43% of women age 15-49 have experienced physical violence at least once since age 15, and 37% experienced physical violence within the 12 months prior to the survey.

- Overall, 47% of ever-married women age 15-49 report ever having experienced physical, sexual, and/or emotional violence from their current or most recent husband or partner, and 31% report having experienced such violence in the past 12 months.
- Among ever-married women who had experienced spousal physical violence in the past 12 months, 43% reported experiencing physical injuries.
- 10% of women reported experiencing violence during pregnancy.
- 9% of Zambian women who have experienced violence have never sought help and never told anyone about the violence.

Gender inequalities, including gender-based violence, exacerbate women's and girls' physiological vulnerability to HIV and block their access to HIV services. Menon et.al (2015) report on the physical health impact of violence, including "injuries and trauma, unwanted pregnancies, gynecological problems, chronic pelvic pain, sexually transmitted infections including HIV, and infertility". The authors also highlight a link between short birth intervals and the mother's experience of violence, "which has an adverse effect on infant health and survival. Psychological consequences of GBV include fear, anxiety, post-traumatic stress and suicide".

### International and Regional Guidance

CEDAW protects the rights of women and girls to equality, health and protects them from violence, including sexual and gender-based violence. Likewise, the Protocol on the Rights of Women in Africa protects women in Africa's rights to equality, health and prohibits violence against women.

Guideline 8 of the UNAIDS 2006 *International Guidelines on HIV/AIDS and Human Rights*



recommend that States take measures to promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities. The commentary to Guideline 8 notes the need to implement the Cairo Programme of Action and the Beijing Declaration; to include a gender perspective in primary health care and to take measures to eliminate violence against women, harmful traditional practices, sexual abuse, exploitation, early marriage and female genital mutilation.

UNAIDS most recent 2017 guidance on HIV prevention for adolescent girls and young women reiterates the importance of integrating HIV and AIDS issues within programmes to respond to gender-based violence within countries, and of addressing harmful gender norms with women and girls, as well as men and boys.

The SADC PF *Model Law* notes the importance of protecting the rights of women and girls. Article 27 provides, amongst others, that:

“(1) The State shall ensure that women and girls are protected against all forms of violence, including sexual violence, rape and other forms of coerced sex, as well as against traditional practices that may negatively affect their health.

(2) No marriage or other relationship shall constitute a defence to a charge of rape.

(3) Women have the right to refuse sexual acts, including those that put them at risk of infection with HIV or any other sexually transmitted infection. No marriage or other relationship shall deprive them of that right.”

### Women, Gender Equality and GBV in Zambia

The Government of the Republic of Zambia, through the Ministry of Gender, works towards protecting and promoting women’s rights, curbing gender-based violence and reducing gender inequalities by making progressive changes to legislation to strengthen the protective environment. “It aims to prioritise the advancement of women and strengthen

their capacity to influence decision-making at the highest level on matters pertaining to gender equity and equality”. The portfolio functions of the Ministry are coordinating and monitoring the implementation of gender policies and acts, such as the National Gender Policy, the Matrimonial Causes Act and the Anti-Gender Based Violence Act No. 1 of 2011.

The Gender Equity and Equality Act, 2015 provides for “the taking of measures and making of strategic decisions in all spheres of life in order to ensure gender equity, equality and integration of both sexes in society; promote gender equity and equality as a cross cutting issue in all spheres of life and stimulate productive resources and development opportunities for both sexes; prohibit harassment, victimisation and harmful social, cultural and religious practices; provide for public awareness and training on issues of gender equity and equality”. It includes measures such the prohibition of harassment, victimisation and harmful social, cultural and religious practices, awareness and training on issues of gender equity and equality and the elimination of all forms of discrimination against women and women’s empowerment.

In Zambia, the Anti-Gender-Based Violence No. 1 of 2011 provides for the protection of victims of gender-based violence and seeks to address all forms of gender-based violence, including that arising from cultural practices such as forced virginity testing, forced marriages, sexual cleansing and child marriages (Chidoori, 2011). The Act defines abuse to include “abuse perpetrated on a person by virtue of the person’s age, physical or mental incapability, disability or illness.” (Ellsberg & Heise, 2005). The Anti-GBV Act is currently under review.

The Anti-Human Trafficking Act, 2008 aims to prevent and prohibit trafficking in persons, to protect women and children from human trafficking.

Section 32 of the Gender Equity and Equality Act specifically refers to health services. It requires the Minister of health to take appropriate measures to ensure that women have access to health care services on an equal basis with men, including health-related



information and education and sexual and reproductive health services. Section 32(2) provides that:

“(3) A health officer shall—

- a. Respect the sexual and reproductive health rights of every person without discrimination;
- b. Respect the dignity and integrity of every person accessing sexual and reproductive health services;
- c. Provide family planning services to any person demanding the services, irrespective of marital status or whether that person is accompanied or not accompanied by a spouse;
- d. Impart the information necessary for a person to make a decision whether or not to undergo procedures, or to accept any service, affecting their sexual and reproductive health;
- e. Record the manner in which the information imparted to the person seeking reproductive health services was given and whether it was understood; and
- f. Obtain the written consent of a person being offered sexual and reproductive health care services or family planning services before performing any procedure or offering.”

The National Gender Policy (2014) is aimed at ensuring the attainment of gender equality in the development process by redressing the existing gender imbalances. It also provides for equal opportunities for women and men to actively participate and contribute to their fullest ability and equitably benefit from national development. The policy does not address gender from an LGBTI perspective.

Current strategies employed by the Ministry of Gender include supporting gender policy formulation, gender mainstreaming, the economic empowerment of women, the prevention of gender-based violence and the multidisciplinary management of survivors of violence, monitoring and evaluation, communication and advocacy and technical backstopping / institutional capacity building around gender.

The Ministry of Gender is not adequately funded to operationalise many of its strategies. As a result, gender inequality, harmful gender norms and gender-based violence persist.

Women’s rights are not adequately protected, and customary laws and practices often undermine women’s rights to equality. While the Marriage Act provides non-discriminatory rules for property division between husband and wife for civil law marriages, women in customary marriages still experience difficulties. Property grabbing from widows remains a common practice.<sup>29</sup>

The Anti-Gender-based Violence Act was passed in 2011, but implementation has been weak and inconsistent, especially in rural areas. The act makes provision for the establishment of shelters, few of which have been established, and the Anti-GBV Fund, but progress has been slow in setting these up. A review of the Anti-GBV Act in 2017 showed that the offences in the Act were insufficient to protect persons from GBV, there were insufficient penalties, difficulties in applying the new fast-track court rules, difficulties with reporting and investigations.

Women do not seek access to justice for gender-based violence. Findings by Menon et.al (2015) revealed that awareness and uptake of services for gender-based violence survivors is low: “48% of females age 15-49 in Zambia who experienced physical or sexual abuse did not seek help and only 14% of females who were raped and 12% who were physically abused by partners reported the incident to the police”. The report also highlights in relation to partner abuse, “only 7% of physically abused women obtained a protection order against their partner.”

Submissions to the Africa Regional Dialogue on HIV and the Law in 2011 confirmed that harmful cultural practices such as polygamy and the ritual, widespread sexual cleansing of widows and widowers place women and young girls at risk of HIV exposure.<sup>30</sup>

There have been concerted efforts by government to challenge entrenched attitudes

of stigma and discrimination; however, it remains an issue of concern (US Department of State, 2017). The 2011 *People Living with HIV Stigma Index* found that women with HIV report high levels of stigma and discrimination within their families and communities including being forced from their family homes. They also report discriminatory treatment within the health care sector, including reports of coerced terminations of pregnancy and coerced sterilisation.

Although abortion is legal in limited circumstances, women and girls, especially those living in rural areas, struggle to access it. UNFPA (2017) found that not all government facilities provide access and there is a lack of information about where and how to access a legal abortion, and abortion remains highly stigmatized in Zambia.

### Recommendations

- i. Increase funding for government implementation of responses to gender inequality, harmful gender norms and gender-based violence (e.g. for Ministry of Gender, Ministry of Health, Ministry of Labour and Ministry of Education)
- ii. Expedite the review of the Anti-GBV Act 2011 to strengthen prevention of GBV and access to justice for violations.
- iii. Monitor and evaluate the level of mainstreaming and implementation of programmes related to:
  - a. The National Gender policy;
  - b. The Matrimonial Causes Act; and
  - c. The Anti Gender Based Violence Act No. 1 of 2011
- iv. Strengthen databases, through the National Gender Monitoring and Evaluation Technical Working Group and institutions such as the Central Statistical Office (Ministry of Gender, 2014).

# Part IV:

# Access to Justice and Law Enforcement in Zambia

## Awareness of HIV, Law and Human Rights and of Legal Remedies Available

To reduce stigma, discrimination and human rights violations and strengthen access to justice, affected populations need to know their rights. Equally, service providers and officials such as health workers, social welfare workers, educators and law enforcers need to be sensitized on the rights of people in the context of HIV and TB, and legal, ethical and policy protection for these rights, in order to promote respect for rights and non-discrimination. According to the PANOS Institute of Southern Africa (2016) in Zambia, human rights violations continue to take place for various reasons, including a lack of awareness of rights.

### International and Regional guidance

The UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights* recommend that States take measures to increase awareness of HIV, law and human rights amongst all persons, including people living with HIV and vulnerable populations, as well as service providers such as health care workers. Guideline 7 recommends specifically that states “should implement and support legal support services that will educate people affected by HIV/AIDS about their rights...”

The GCHL (2012) *Risks, Rights & Health* recommends that countries ensure that their national HIV policies, strategies, programmes and plans provide for strengthening access to justice. They recommend the development of programmes to educate people about their rights and the law as well as programmes to challenge stigma and discrimination within families, communities and workplaces.

The SADC PF *Model Law* recommends the integration of education and information on rights of people living with HIV, women and girls as well as other vulnerable and marginalized groups within various HIV information and education campaigns.

### HIV, Law and Human Rights Awareness in Zambia

There are some efforts to increase awareness of the rights of people living with HIV, vulnerable and key populations. Many workplaces have adopted HIV workplace policies. There are also programmes to educate, raise awareness among people living with HIV concerning their rights and those designed to change societal attitudes of stigmatisation associated with HIV and AIDS to understanding and acceptance (US Department of State, 2018). In addition, initiatives to end child marriage and GBV have been prioritised with traditional leaders and communities.

There remains an inadequate lack of knowledge of HIV, TB and SRHR-related law, ethics and human rights amongst affected persons, communities, service providers and officials in Zambia.

### Recommendations<sup>31</sup>

- i. Strengthen people living with HIV, TB and key populations’, including young key populations’ awareness and understanding of their human rights
- ii. Strengthen awareness campaigns to reduce stigma and discrimination amongst communities
- iii. Train service providers, including health workers, social workers, educators on the rights of people in the context of HIV, TB and SRHR, including the rights of people living with HIV, TB and key populations, including young key populations.

## Legal Support Services

It is critical that those whose rights are violated are able to access legal support services, to support them to challenge rights violations and access justice either through the courts or through alternative complaints mechanisms. In addition to private law firms, legal support services may also include HIV-specific legal support organisations, paralegal organisations, state-provided legal aid services, health complaints units, commissions or institutions

set up to protect and promote human rights as well as pro bono services provided by private lawyers.

Strategic litigation, to challenge a key law, policy or practice that impacts on the rights of people living with HIV, TB, vulnerable and key populations, strengthens the legal framework and can also strengthen grassroots social movements by mobilizing individuals and communities affected by the issues (Open Society Foundation, 2016): “Where these issues—or the populations affected by them—are stigmatized or criminalized, there may be limited opportunities for building such movements. Strategic litigation and complementary advocacy activities can help carve out the space and generate the momentum needed for individuals and communities to organize a powerful social movement or strengthen existing ones.”

### International and Regional Guidance

There are various HIV-specific international and regional guidelines that recommend the need for strengthening access to legal support for people in the context of HIV.

The UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights* recommends that countries strengthen legal support services for all persons in the context of HIV. Guideline 7 recommends specifically that states “should implement and support legal support services that will educate people affected by HIV/AIDS 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 complaints units and human rights commissions.”

The GCHL’s 2012 report, *Risks, Rights & Health* specifically recommends that countries strengthen access to justice in the context of HIV and AIDS, as set out above.

The SADC PF *Model Law* has even recommended that States set up an HIV Tribunal specifically to hear HIV-related complaints.

### Access to Legal Support Services in Zambia

Article 43 of the Zambian Bill of Rights guarantees that “all persons are equal before the law and have the right to equal protection and benefit of the law.” Article 45 provides all persons with the right to access justice and execute a judgement against the State after a year of delivery of the judgement.

Article 49 provides that every person has the right to have a dispute decided timely and to have a fair hearing before a court or, where appropriate, an independent and impartial tribunal, the right to be represented by a legal practitioner and the right to have a legal practitioner assigned by the State, if substantial injustice would otherwise result.

Zambia’s judicial system is based on English common law as well as customary law – the indigenous law having its source in the customs and practices of people, and in terms of which the majority of people conduct their personal activities (Muna, 2011). Under the constitution of 1997, the Supreme Court is the highest court in Zambia and serves as the final court of appeal. However, marriage, property and inheritance issues are often administered by local customary law courts.

Zambia is a state party to the ‘UN Principles and Guidelines on Access to Legal Aid in Criminal Justice Systems’, adopted by the UN General Assembly in 2012. These urge Member States and other donors to provide extra-budgetary resources of insuring an accused access to legal aid, in accordance with the rules and procedures of the United Nations. The resolution expects states to ensure that a comprehensive legal aid system is in place that is accessible, effective, sustainable and credible. They clarify that legal aid is a duty and responsibility of the state, and sufficient resources should be allocated for it.

The Legal Aid Act provides for legal aid. However, section 17 of the Legal Aid Act provides that the Director “may, in granting legal aid to any person under this Act, require that person to contribute to the cost of that legal aid to an extent which seems to the Director to be just and reasonable having regard to that person’s means”.

## Annex

### *United Nations Principles and Guidelines on Access to Legal Aid in Criminal Justice Systems*

*“...A functioning legal aid system, as part of a functioning criminal justice system, may reduce the length of time suspects are held in police stations and detention centres, in addition to reducing the prison population, wrongful convictions, prison overcrowding and congestion in the courts, and reducing reoffending and re-victimization. It may also protect and safeguard the rights of victims and witnesses in the criminal justice process. Legal aid can be utilized to contribute to the prevention of crime by increasing awareness of the law...”*

The Zambian Human Rights Commission is a national human rights institution established under Article 125 of the Constitution of Zambia and mandated by the Human Rights Commission Act No. 39 of 1996 to, inter alia, investigate and remedy human rights violations, propose measures to prevent violations, conduct human rights research, education and rehabilitation, monitor the conditions under which persons detained in prisons and police cells are kept and to monitor government’s fulfilment of international and regional human rights treaties and human rights obligations under national law.

In 2014, the US State Department reported that the HRC monitored human rights conditions, interceded on behalf of persons whose rights it believed the government denied, and spoke on behalf of detainees and prisoners. It noted that the ZHRC was independent and able to execute its mandate without undue government interference; however, it was underfunded, and government often failed to act on its recommendations.

Access to legal support services is uncertain, even though constitutionally guaranteed. Most Zambians, especially those most vulnerable such as key populations, cannot afford to retain the services of a lawyer and, consultations with LGBTI populations during the LEA found that lawyers are unwilling to take on their cases for fear of breaking the law, professional and social stigma.<sup>32</sup> Access to legal Aid in Zambia is usually elusive, as applicants may need to contribute towards part of the cost for retaining services of a practitioner. In 2015, the Legal Aid Board received 4,314 applications for legal aid, out of which only 1,583 were granted legal assistance and representation (Paralegal Africa, 2017).

*“Legal representation is usually not possible as most members of the LGBTI community may not be able to afford legal services as most lawyers do not provide pro-bono services...especially not for us as they would contradicting the law” – Trans-woman in Lusaka.*

A further barrier is that traditional leaders are the custodians of customary laws and their application (PSAf, 2014). Customary law is directly influenced by local culture and traditions, which imply that the recognition of sexual orientation and gender identity rights is unlikely. Muna (2011) furthermore contends that certain customary law norms undermine the dignity of women and are used to justify treating women as second-class citizens, similarly as with LGBTI communities.

## Recommendations

- i. Strengthen access to legal support services, including *pro bono* lawyers, legal aid and paralegal support services for people living with HIV, TB, vulnerable and key populations, including young key populations.
- ii. Train members of the judiciary to sensitize them to HIV, SRHR and human rights issues affecting people living with HIV, TB and key populations, including young key populations.

- iii. Strengthen the Zambia Human Rights Commission's role in research, investigation and monitoring of the rights of people living with HIV, TB, vulnerable and key populations, including young key populations.

## Law Enforcement

### The Police

*"Sometimes we know what we are supposed to do, but we follow what the laws says"* Zambian Police Officer

*"Because of the law, it is not possible to engage with enforcers as they could have us arrested upon invitation to the meeting"* – LGBTI activist in Lusaka.

*"Police only use their own judgment to decide to charge people of diverse sexual orientation and gender identity as they usually they don't have evidence".* LGBTI activist, Zambia.

The LEA found that the police are responsible for many human rights violations experienced by those in Zambia, particularly with respect to key populations. The US Department of State 2015 report on Human Rights in Zambia recounted that "the most significant human rights problems during the year were abuses by police, including reports of unlawful killings, torture, and beatings; political violence; restrictions on freedom of the press, assembly, association, and speech; and gender-based violence (GBV)." The report also highlighted discrimination against LGBTI communities, quoting the Human Rights Commission reports that "police stated that beating suspects helped in obtaining confessions." This is a matter of concern given the research findings of unjustified arrests and police harassment of key populations (PSAf 2014, SALC 2016, ARASA 2016 and USAID-Open Doors 2017).

### International and Regional Guidance

*"Sometimes even the police arrest us just to have sex...sometimes you find your client is a soldier and you even get scared to ask for money from him, they even beat us refusing to pay and you can't even take them to the police"* Sex worker, Zambia.

The GCHL (2012) report noted the high levels of violence and discrimination experienced by key populations, including sex workers, people who use drugs, gay men and men who have sex with men, from law enforcement officials. The GCHL has recommended that States take the following measures (in addition to decriminalization) to decrease arbitrary arrests, harassment and abuse of key populations by the police:

- Take all measures to stop police harassment and violence against sex workers
- Ensure that anti-human-trafficking laws are used to prohibit sexual exploitation and not used against adults involved in consensual sex work
- Ensure that existing civil and administrative offences such as "loitering without purpose", "public nuisance", and "public morality" are not used to penalize sex workers and administrative laws such as "move on" powers are not used to harass sex workers
- Promote effective measures to prevent violence against men who have sex with men, and
- Repeal all laws that punish cross-dressing.

### Law Enforcement and Human Rights Violations in Zambia:

As has been set out above, the Zambian Penal Code criminalizes same-sex sexual activity for both men and women. According to Cap 87, sections 155 and 156, the Penal Code prohibits same sex relations and calls them "unnatural offences." In the new draft constitution, Article 47 (5) recommends that marriage between people of the same sex be prohibited.



The Zambia Police Act Chapter 107 of The Laws of Zambia provides for the organisation, functions and discipline of the Zambia Police Force. Members of the public are protected from police abuse of authority by section 30(h) of the Act which prohibits the police from an unlawful or unnecessary exercise of their authority, such as an unlawful or unnecessary arrest, or the use of unnecessary violence. Acts done under authority of a lawful warrant are exempted from liability in terms of section 23. The Police Force is furthermore bound by Article 193(2)(e) of the Constitution, as amended, which specifically imposes an obligation on the Police Service to uphold the Bill of Rights in the enforcement of their duties.

The Bill of Rights protects the rights of accused persons, including key populations, in Article 48 which provides:

“Subject to Articles 65, 66, 67, 68 and 69 an accused person or a detainee has the right:

- d. Not to be compelled to make a confession or an admission;
- e. To be held separately from persons who are serving a sentence;
- f. To be released on bond, unless there is compelling reason to the contrary; and
- g. To be brought before a court -
  - i. Within forty-eight hours after being arrested or detained;
  - ii. Not later than the end of the first court day after the expiry of the forty-eight hours, if the Forty-eight hours expire outside ordinary court hours;
  - iii. As speedily as possible, if that person is arrested or detained far from a court;
  - iv. For trial within ninety days of being arrested; or
  - v. To be released on bail, as prescribed.”

Despite protection in law, the rights of people affected by HIV, and particularly key populations, continue to be violated by law enforcers. There continue to be reports of unlawful arrests of key populations, particularly LGBTI populations, in Zambia. The United States Department of State 2015 reports on 18 reported cases of “unnatural

offences” in 2015 compared with 23 for the same period in 2014 and notes that “rather than submit cases for trial, police on several occasions arrested suspected LGBTI persons on bogus charges, forcing them to spend at least one night in jail. In most cases police demanded bribes before releasing the individuals.” LGBTI populations report extortion and bribes, often conducted with police participation (Fabeni et.al 2007, The US Department of State 2015 and Human Dignity Trust 2015). Communities and opinion leaders (including politicians, religious leaders, traditional leaders, media figures) espouse homophobic statements publicly, and are said to influence the police in their enforcement of the law (US State Department, 2015).

Various reasons for these violations have been cited, including ongoing attitudes of stigma and discrimination towards key populations, as well as weaknesses in access to justice – lack of knowledge of rights amongst key populations and law enforcers, and weaknesses within the justice system (inadequate staffing, case backlogs, inaccessibility of courts).

### Recommendations

Various measures are recommended to protect key populations, including young key populations, from police harassment and abuse including:

- i. Training and sensitizing law enforcement officials, including at higher level, to the rights of key populations, including young key populations.
- ii. Strengthening access to justice and disciplinary action for police violations of rights.
- iii. Reviewing and repealing laws that may be used to effect arbitrary arrests of key populations such as sex workers, people who use drugs and LGBTI individuals.

## The Correctional Service

*“An analysis of prisons in Africa found that ‘many are in a deficient condition and their practices are at odds with human rights standards...Few African states have maintained and added prison capacity post-independence with the result that many are now beyond repair and fail to meet minimum requirements generally accepted today.’ – Penal Reform International (2015)*

The various issues concerning correctional services have been dealt with in the section on the rights of prisoners', including young prisoners, in Part III, above. The recommendations for strengthening the rights of prisoners, including their health rights, include those set out below:

### Recommendations

- i. Implement all existing legal provisions to decrease overcrowding, ensure the separation of juvenile and adult inmates, allow for the release of awaiting-trial prisoners and alternative sentencing, where appropriate.
- ii. Increase the number of reformatory schools to facilitate the separation of juveniles for adult inmates in Zambia prisons.
- iii. Investigate and respond to sexual violence and exploitation in Zambian prisons, including for young inmates.
- iv. Increase access to legal representation to ensure access to justice for all accused persons, including juvenile accused.
- v. Promote and put in place mechanisms for whistle-blowing on human rights exploitations by both correctional officers and fellow inmates.
- vi. Provide adequate transportation facilities for the movement of prisoners and detainees awaiting trial.
- vii. Act on the Auditor General's (2014) recommendations to, inter alia, review

the Prisons Act, in line with international standards, carry out parole hearings timeously, and transfer juveniles to juvenile facilities on conviction.

- viii. Implement provisions in the Juveniles and Prisons Act to eliminate extended pre-trial detention, expand non-custodial sentencing options and as a last resort, ensure juveniles are housed in juvenile detention facilities.
- ix. Strengthen access to voluntary HIV, TB and SRH care services for inmates, including prevention and care services, regardless of laws criminalising same-sex acts or harm reduction, and including provision of condoms, comprehensive harm reduction services, voluntary and evidence-based treatment for drugs and ART, in line with SADC standards.



## Part V:

# Conclusions and Recommendations

The LEA finds that, while important steps have been taken to protect human rights and gender equality in Zambia, the rights of people living with HIV, vulnerable populations and key populations, including young key populations, require additional measures in order to be effectively protected and enforced. These include measures to review and reform punitive and discriminatory laws and policies, efforts to strengthen the implementation of protective laws, programmes to reduce stigma and discrimination and increase awareness and understanding of rights, measures to sensitise health workers, law-makers and law-enforcers as well as measures to increase access to legal support services and effective remedies for rights violations. The following recommendations are made in order to protect the rights of all persons in the context of HIV, TB and SRHR, with a particular focus on the rights of people living with HIV, vulnerable populations and key populations, including young key populations.

## Equality and Anti-Discrimination

- Enact specific equality and anti-discrimination provisions to protect the rights of people living with HIV and TB, vulnerable and key populations.
- Integrate, in the review of the National HIV/AIDS/STI/TB Policy, strong equality and anti-discrimination protection for all Zambians, including for people living with HIV and its co-infections, as well as vulnerable and key populations.
- Conduct awareness-raising and sensitization campaigns to reduce HIV- and TB-related stigma and discrimination, including working in all sectors and with political, traditional and religious leaders
- Sensitize health careworkers to reduce stigma and discrimination against all people living with HIV, TB, vulnerable and key populations.
- Strengthen access to justice and enforcement of rights for HIV-related discrimination.

## Health Laws and Policies

- Strengthen access to appropriate health care services, including psychosocial support and expanded access to PrEP, for key populations, including young key populations.
- Provide in law for voluntary, informed consent to HIV testing and counselling and for the age of consent to HIV testing.
- Consider lowering the age of consent (from 16 years) for access to health services.
- Provide in law for the right to confidentiality with regard to all health information and health status, including information relating to key populations, and for strict conditions under which disclosures may take place.
- Strengthen training for health workers on human rights, gender equality and medical ethics, to reduce stigma and discrimination and protect the health rights of people living with HIV, TB and key populations, including young key populations.
- Strengthen training for health careworkers on the specific and diverse health needs of key populations, including young key populations.
- Integrate youth- and key population-friendly health services in mainstream health care centers.
- Strengthen access to complaints mechanisms for HIV-related human rights violations within healthcare.

## Adolescents and Young People

- Harmonise the legal framework to prohibit marriage below 18 years of age.
- Strengthen provision in law and policy for access to adolescent health care information and services, including access to condoms in schools and comprehensive sexuality education that provides for the rights and needs of all young people, including young key populations.
- Include clear provision in law / policy for the (lowered) age of consent to SRH and HIV services.

- Ensure abortion, where legal, is not subject to minimum age of consent requirements or parental consent and strengthen access to safe abortion, including post-abortion care.
- Train health care workers on the SRHR of young people and the provision of adolescent-friendly health care services.
- Strengthen dialogue with and sensitization of traditional authorities and communities to challenge harmful gender norms, particularly child marriage.
- Provide for increased and strengthened mechanisms for reporting and follow-up of sexual violence and abuse of children (e.g. community centres, child protection units in schools; youth-friendly victim/witness offices within Victim Support Units) and support for families.
- Expedite the review of the Anti-GBV Act to provide for prevention of all forms of gender-based violence.
- Strengthen training and sensitization of police to provide child and youth-friendly services.
- Promote young people's participation in policies to integrate HIV and sexual and reproductive health and rights services and policies, including comprehensive sexuality education.
- Strengthen community and family participation in adolescent friendly health care services.
- Provide pre-service and in-service training to health care providers on the human rights of and health care needs of LGBTI populations, including young LGBTI populations.
- Integrate sexual and reproductive health care services, including psycho-social support services, for the needs of LGBTI populations, including young LGBTI populations.
- Sensitise law enforcement officers on the rights of LGBTI populations.
- Strengthen access to justice for LGBTI populations, including through strategic litigation.
- Strengthen access to economic empowerment initiatives for LGBTI populations to overcome marginalisation.
- Prioritise further research on LGBTI populations, including young LGBTI populations.

## LGBTI Populations

- Support legal reform, through submissions to the Zambia Law Development Commission, to amend the Penal Code and Criminal Procedure Code to decriminalize same-sex sex between consenting adults.
- Ensure the involvement of LGBTI populations in law review and reform processes.
- Sensitise LGBTI populations, including young key populations, on their rights.
- Conduct community awareness-raising and sensitization campaigns to reduce stigma and discrimination against LGBTI populations, including young key populations.

## Sex Workers

- Make submissions to the Zambia Law Development Commission to review laws criminalizing aspects of sex work and provisions misused against sex workers, in their review of the Penal Code and Criminal Procedure Code.
- Ensure the involvement of sex workers in law review and reform processes.
- Sensitise sex workers on their rights.
- Conduct community awareness-raising and sensitization campaigns to reduce stigma and discrimination against sex workers.
- Train and sensitise health care providers on the rights and health care needs of sex workers.
- Strengthen appropriate sexual and reproductive health care services for sex workers.
- Train and sensitise law enforcement officials on the rights of sex workers and take measures to protect sex workers from violence, harassment and abuse.
- Strengthen appropriate health care services for sex workers.
- Prioritise further research on sex workers, including young (18+ years) sex workers.

## People Who Use Drugs

- Review provisions in the Narcotic Drugs and Psychotropic Substances Act that act as barriers to access to harm reduction and health care services for people who use drugs.
- Ensure the involvement of people who use drugs in law review and reform processes.
- Adapt and operationalize the UN system endorsed core package of nine essential harm-reduction services for people who inject drugs, which have been shown to reduce HIV infections (IAWG, 2014):
  - Introduce needle and syringe exchange and distribution programmes
  - Integrate drug dependence treatment, including opioid substitution therapy
  - Intensify HIV testing and counselling for people who inject drugs
  - Provide antiretroviral therapy
  - Prevention and treatment of sexually transmitted infections
  - Implement condom programmes for people who use drugs and their sexual partners
  - Targeted information, education and communication for people who used drugs and their sexual partners
  - Provide diagnosis and treatment of, and vaccination for, viral hepatitis and
  - Prevention, diagnosis and treatment of tuberculosis
  - Train and sensitise health care providers on the rights and health care needs of people who use drugs
  - Train and sensitise law enforcement officials on the rights of people who use drugs and take measures to reduce violence and human rights violations against people who use drugs.
  - Prioritise further research on people who use drugs, including young people who use drugs.

## Inmates

- Support the review of the Prisons Act to, *inter alia*, review the Prisons Act, in line with the 2016 Constitution, international standards and act on the Auditor General's 2014 recommendations.
- Ensure the review of the Prisons Act includes strengthened rights of all prisoners and protects all prisoners, including juveniles and women prisoners, from sexual violence
- Increase access to legal representation to increase access to justice for all accused persons, including juvenile accused.
- Implement all existing legal provisions to decrease overcrowding in prisons (including allowing for the release of awaiting-trial prisoners, alternative sentencing, where appropriate and for carrying out parole hearings timeously).
- Implement all existing legal provisions to protect juveniles in prisons (including for the elimination of extended pre-trial detention, the expansion of non-custodial sentencing options, the separation of juvenile and adult inmates, the transfer of juveniles to juvenile detention facilities on conviction and for increased reformatory schools).
- Strengthen the investigation and response to prison offences involving sexual violence and exploitation in Zambian prisons, including for young inmates.
- Strengthen access to voluntary HIV, TB and SRH care services for inmates, including the full package of HIV prevention and care services as well as those for TB, regardless of laws criminalising same-sex acts or harm reduction, and including provision of condoms, comprehensive harm reduction services, voluntary and evidence-based treatment for drugs and ART, in line with SADC standards.
- Promote and put in place mechanisms for whistle-blowing on human rights exploitations by both correctional officers and fellow inmates.



## Criminalisation of HIV Transmission

- The enactment of a specific provision criminalizing HIV transmission, exposure or non-disclosure in Zambia is not recommended.
- Develop prosecutorial guidance on the appropriate use of the Anti-Gender-Based Violence Act and Penal Code provisions in relation to HIV.
- Ensure that the review of the Anti GBV-Act and Penal Code exclude overly broad provisions criminalising HIV transmission, exposure or non-disclosure.

## Employment

- Review employment law and policy to specifically prohibit discrimination on the basis of HIV and TB status, health status, sexual orientation and gender identity.
- Review employment law and policy to specifically prohibit pre-employment HIV testing.
- Develop a national occupational health and safety policy that integrates protection from HIV and TB in the working environment.
- Strengthen employer and employee's awareness of access to justice for workplace-related rights violations, in terms of section 36(4) of the Employment Act.
- Strengthen co-ordination, in law, policy and strategies, of TB control and management in Zambian mines between the key government ministries of Health, Mines and Labour.
- Strengthen monitoring and evaluation of HIV & TB workplace policies and programmes in all workplaces, and in particular mines and mining communities.

## Education and Information

- Strengthen access to education, including through ensuring adequate funding for all schools and learning institutions.
- Strengthen the provision of comprehensive sexuality education that accommodates the needs of all adolescents, including young key populations, in the school curricula, in line with ESA Commitments.
- Strengthen efforts to address bullying in schools on the basis of e.g. sexual orientation and gender identity.
- Strengthen training of guidance and counselling teachers to provide emotional, social, and psychological support to all young learners, including students affected by HIV, TB as well as young key populations.

## Social Welfare

- Increase resources for social protection programmes, including for vulnerable and key populations in the context of HIV and TB.
- Advocate for livelihood and empowerment support schemes to provide support for key populations, particularly young key populations.
- Women, Gender Inequality and GBV
- Expedite the review of the Anti-GBV Act 2011 to strengthen prevention of GBV and access to justice for violations.
- Develop community awareness campaigns to increase knowledge of rights and redress amongst women and girls and to challenge gender inequality, harmful gender norms and GBV amongst men and boys.
- Increase funding for government implementation of responses to gender inequality, harmful gender norms and gender-based violence (e.g. for Ministry of Gender, Ministry of Health, Ministry of Labour and Ministry of Education).

- Monitor and evaluate the level of mainstreaming and implementation of programmes related to:
  - The National Gender policy;
  - The Matrimonial Causes Act; and
  - The Anti Gender Based Violence Act No. 1 of 2011
- Strengthen databases, through the National Gender Monitoring and Evaluation Technical Working Group and institutions such as the Central Statistical Office (Ministry of Gender, 2014).
- Training and sensitize law enforcement officials, including at higher level, to the rights of key populations, including young key populations.
- Strengthening access to justice and disciplinary action for police violations of rights.

## Access to Justice

- Strengthen people living with HIV, TB, vulnerable and key populations', including young key populations', awareness and understanding of their human rights.
- Strengthen campaigns to reduce stigma and discrimination against people living with HIV, TB, vulnerable and key populations, including young key populations, amongst communities.
- Train service providers, including health workers, social workers and educators on the rights of people in the context of HIV, TB and SRHR, including the rights of people living with HIV, TB, vulnerable and key populations, including young key populations.
- Strengthen access to legal support services, including *pro bono* lawyers, legal aid and paralegal support services for people living with HIV, TB, vulnerable and key populations, including young key populations.
- Train members of the judiciary to sensitize them to HIV, SRHR and human rights issues affecting people living with HIV, TB and key populations, including young key populations.
- Strengthen the Zambia Human Rights Commission's role in research, investigation and monitoring of the rights of people living with HIV, TB and key populations, including young key populations.

# End Notes

1. See, for instance, the Global Fund's recognition of the role of law & human rights in ending AIDS, TB and malaria [www.theglobalfund.org](http://www.theglobalfund.org)
2. "However, Zambia reports very late to relevant treaty bodies" UNFPA et.al. (2017) have noted.
3. [https://www.elections.org.zm/results/2016\\_referendum](https://www.elections.org.zm/results/2016_referendum) [Accessed 17 May 2018].
4. <http://www.electionguide.org/elections/id/2898/> [Accessed 17 May 2018].
5. SALC (2016) recommended that discrimination-inclusive ethical guidelines must be included in professional training and education curricula and must be made examinable to ensure trainees' commitment and capacity to uphold ethical obligations; health careworkers should be required to undergo ethical training that includes revised concepts and examples of discrimination for ongoing professional development. Curricular development should include consultations with vulnerable populations such as sex workers, LGBT persons, women living with HIV and persons with disabilities to ensure that their diverse needs and experiences are sensitively accommodated.
6. <https://allafrica.com/stories/201708230846.html#comments> [Accessed 27 Sept 2018]
7. *Lewanika vs. Fredrick Chiluba* (1998) Z.R. 79; *Stanley Kangaibe and Charles Chookole v Attorney-General*, (2009) HL 86
8. A young gay man in the Ndola FGD reported breach of confidential information relating to his sexual orientation: "That is the front page of my most recent file. He wasn't supposed to write staff about my sexual orientation because he knew very well that the file was going to be checked out by everyone including student nurses as I was in the emergency medical ward at this time. I can scan parts of the psychiatrist and psychologists notes as well, which do not have my sexual orientation spelled out"
9. The Ministry of Gender, 2016 noted that teenage pregnancy is a leading cause of child marriage.
10. Over 30% of women currently aged 20-24 years and 45% of women aged 25-49 were married by age 18 years
11. <https://www.girlsnotbrides.org/child-marriage/zambia/> [Accessed 4 Oct 2018].
12. Ibid.
13. Ministry of Gender (2016).
14. "multiple international conventions describe the participation of children under 18 years of age in selling sex as sexual exploitation and a contravention of human-rights law" (WHO, 2015).
15. <http://www.zldc.org.zm/index.php/k2-blog/with-sidebar/item/9-anti-gender-based-violence-act-no-1-of-2011> [Accessed 31 March 2019].
16. Akani et.al., (2015).
17. UN Zambia, *Status of Sexual and Reproductive Health and Rights in Zambia*, June 2017, <http://zambia.unfpa.org/sites/default/files/pub-pdf/SRH%26R%20in%20Zambia%20-%20Part%201.pdf> [Accessed May 2018].
18. HEARD, *Zambia, Country Factsheet, Sexual and Reproductive Health and Rights*, 2017, <https://www.heard.org.za/wp-content/uploads/2015/11/Zambia-country-fact-sheet.pdf>
19. UN Zambia, *Status of Sexual and Reproductive Health and Rights in Zambia*, June 2017, <http://zambia.unfpa.org/sites/default/files/pub-pdf/SRH%26R%20in%20Zambia%20-%20Part%201.pdf>
20. A profile by Johns Hopkins University (2013) noted "many journalists have even openly stated that they support harassment of these men and women, including violence and abuse". A gender columnist Paulin Banda wrote in Daily Mail in 1998 "we have so much work to do, we cannot even afford to think of homosexuality...the energies being channeled toward unproductive ventures like forming gay associations could be used for more meaningful projects like poverty alleviation...".

The use of improper language during reporting is another form of hate speech that is prominent in the Zambian media as evidenced by one of the articles of Zambia daily Mail were a trans-person was referred to as “Fake Woman”. “She was also misgendered by the Court who repeatedly referred to her as male... she was forced to undergo an anal examination to obtain evidence” ARASA (2016).

21. Kerrigan (2013) suggests that the continued practice of politicians in Zambia to tarnish each other with accusations of “gay friendliness” is a kind of politics is that even moderate leaders may sometimes feel compelled to make prevent opponents from opening up a front on this issue. This popular-based politicking and religious dogma escalates misguided social norms and views that may be pervasive and harmful to members of key populations in Zambia.
22. “Zambia Police to soon commence a crackdown on sex workers”, Lusaka Times, April 23, 2012, Accessed at [www.lusakatimes.com/2012/](http://www.lusakatimes.com/2012/)
23. Ibid.
24. Chanda, Davies M.M., Lusaka Times, 13 February 2014.
25. <http://www.zldc.org.zm/index.php/k2-blog/with-sidebar-2/item/49-constitutional-conformity> [Accessed 31 March 2019].
26. <http://www.zldc.org.zm/index.php/k2-blog/with-sidebar-2/item/49-constitutional-conformity> [Accessed 31 March 2019].
27. Including those made by the coalition of NGOs, and the NASF 2017-2021.
28. At para 148.
29. <https://www.genderindex.org/country/zambia/> [Accessed 18 May 2018].
30. Submission by World Vision Zambia, Keembe Area Development Programme, Zambia, *Africa Regional Dialogue on HIV and the Law*, 4 August 2011
31. Including those made by Panos (2014).
32. “Very few lawyers are willing to take on cases involving the LGBTI community” (LGBTI person, Lusaka, 2017).





# References

## List of Documents Reviewed and Referenced

1. **Regional & International Charters, Covenants, Treaties, Declarations, Guidelines and related Documents**
  - a. Abuja Declaration on Universal Access: HIV/AIDS/TB/Malaria/STIs (2001)
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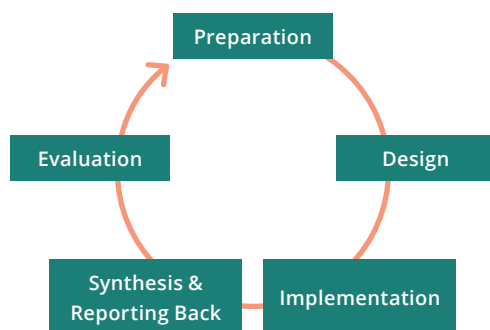
# Annexures

## Annexure 1: Consultation Framework

The framework is composed of nine principles, grouped into three broad themes as illustrated below:



The “Consultation Framework” aided the stakeholder individual consultations as well as the final validation meeting with positive vibes to determine the appropriate nature and extent of stakeholder involvement. A special consideration was required to address the cultural and religious sensitivities on the subject matter and of the YKPs. The framework followed the phases illustrated in the diagram below:



Adapted from Consultation Tool Box, 2004

**1. Preparation:** Managing consultations required strategic planning to ensure that the process remained consistent with project objectives. An early assessment enabled the consultant to identify potential issues and the levels of interest of stakeholders and participants. Informal discussions with internal and external partners provided guidance and insight in these areas such as resources required, roles and responsibilities for project team, time allocation, concerns and coordination.

**2. Design:** The design phase of the consultation process set the stage to meet the expectations laid out in the project concept note. This focused on such details as availability of human and financial resources, geographic scope (District, Provincial or National), range of stakeholders, including members from the LGBTI community, decision-makers’ (UNDP) desired level of participation and how stakeholders prefer to be consulted.

**3. Implementation:** This stage involved actually carrying out the consultation. The success of this stage depended on the management abilities of the programme team and the skills of the facilitator including managing and facilitating the consultation, facilitating the exchange of input and encouraging meaningful participation and continuous evaluation at every stage.

**4. Synthesis and Reporting Feedback:** Synthesis of the feedback from participants/ stakeholders was required in order to understand how to assess the information collected and how to use it for decision-making.

**5. Evaluation:** The consultation process was meant to be evaluated at all phases by monitoring the activities throughout the consultation process (formative method) and after the consultations have concluded (summative method).

**6. Documentation:** This document is part of the documentation process as part of the packaging of information befitting UNDP and stakeholders as well as considering the following:

- Are any issues concerning people of diverse sexual orientation and gender identity (SOGI) still unresolved?
- Is follow-up required for issues that participants raised during the consultations that were unrelated to the objectives of that process?
- Is more information gathering required?
- Was any suggestion made to formalize the relationship with participants or stakeholders?
- How have the participants and other stakeholders evaluated the consultations?
- Is there a desire to work on other related issues impacting people of diverse sexual orientation and gender identity (SOGI)?

## Annexure 2: Key Informants

A stakeholder is anyone who can affect or is affected by the actions of a programme, service, policy or legislation. Stakeholders for this assessment will be divided into two groups; internal and external stakeholders. Internal stakeholders will be drawn from within respective segments of the key Populations as defined in the project concept note while external stakeholders drawn from all those with vested interest in Key Population issues. This may include employees of organisations providing SRHR/ HIV & AIDS services including correctional officers, law enforcement officers, clients of sex workers, funders, partners and policy makers.

The consultations were half a day stakeholder meetings and consultation workshops specifically for the finalization of the LEA report and Engagement Scan. The process enabled the assessment team to consult with individuals and groups who understands realities faced by members of Key Populations. The table below is a detailed illustration of the key stakeholders:

### Summary of Consultations for the LEA and Engagement Scan

Consultation Key Informants or Participants	Relevance to the Assessment
1. Adolescents and Youth Representatives, Adolescents and Youth Program Managers/ Service Providers/ School Teachers/ Peer-Educators	<ul style="list-style-type: none"> <li>• The Adolescents and youth representatives shared their respective perspectives and experiences of legal and policy factors that facilitate or inhibit equitable and easy access to SRHR and HIV services.</li> <li>• Adolescents and Youth Program Managers/Service Providers/School Teachers/ Peer-Educators helped unveil the legal and policy inadequacies that prevent them from effectively providing comprehensive SRHR/HIV &amp; AIDS information and services to young people.</li> </ul>
2. Sex Workers and their Clients	<ul style="list-style-type: none"> <li>• Sex workers informed the assessment team of how they perceive their own health, and consequent needs from services and other professionals. The group also assisted to assess the determinants of health, such as legal environment, substance misuse, violence and social stigma. One key question will also focus on the effectiveness of current services in meeting Sex Workers health needs.</li> <li>• If possible, it would be useful for the assessment to engage SWs clients to explore the reasons for refusal to use a condom and causes of conflict including about prices that leads to GBV during transactions.</li> </ul>
3. LGBTI Community members	<ul style="list-style-type: none"> <li>• To reveal perceptions hindering uptake of SRHR/ HIV &amp; AIDS services among LGBTI community and identify possible solutions to barriers to access comprehensive health care services as well as to identify appropriate legal and policy changes required for improving programmatic strategies and services.</li> </ul>

Consultation Key Informants or Participants	Relevance to the Assessment
4. People Who Inject Drugs and Law Enforcement Officers	<ul style="list-style-type: none"> <li>To understand the challenges faced by PWIDs and explore how harm reduction programs provide an opportunity to reduce barriers for accessing health services as well as to engage PWIDs to define and develop a framework for their own health care services and strategies for positive change around injection drug use and HIV infection prevention. Other key areas to establish include: <ul style="list-style-type: none"> <li>a. PWID Behaviors</li> <li>b. Barriers to accessing clean needles</li> <li>c. Drugs-setting (PWID preference), environment, and purchasing point</li> <li>d. Impact of Addiction</li> <li>e. Harm Reduction Services</li> </ul> </li> <li>To brainstorm on Laws and policing practices that govern injection drug use and how they influence the risk environment for people who inject drugs.</li> <li>To consult with law enforcement officers to establish the best ways of engaging law enforcement agencies in harm reduction programs for people who inject drugs</li> </ul>
5. Inmates and Correctional Officers	<ul style="list-style-type: none"> <li>To establish inmates' own perceptions about their vulnerability with regard to their health</li> <li>To determine inmate's level of access to health service and define what exactly those services are, and how and where they are provided, is</li> <li>Perceptions of Services versus available resources</li> <li>To establish if there is a legal obligation on the state to provide health services for inmates.</li> </ul>

## Annexure 3: Focus Group Discussions

Proposed Cohorts for FGDs	
1	<i>Members of the Adolescents and Youth Steering Committee convened by NAC</i>
2	<i>Health, SRH and HIV/AIDS Implementation partners</i>
3	<i>CSO members working on Adolescent and Youth Health programmes</i>
4	<i>Young MSMs and Young WSM respectively</i>
5	<i>Young Female Sex Workers</i>
6	<i>Girls who are students in Colleges and Universities</i>
7	<i>Representatives of Legislative and policy making institutions</i>
8	<i>Injecting Drug Users</i>
9	<i>Young Inmates</i>
10	<i>Young LGBTI community members</i>

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