ARE THERE LAWS AND POLICIES PROTECTING PEOPLE INFECTED AND AFFECTED BY HIV/AIDS IN SOUTHERN AFRICA? AN UPDATE OF A REVIEW OF THE EXTENT TO WHICH COUNTRIES WITHIN THE SOUTH AFRICAN DEVELOPMENT COMMUNITY HAVE IMPLEMENTED THE *HIV/AIDS AND HUMAN RIGHTS INTERNATIONAL GUIDELINES*

1 Introduction

A review published in 2007 (Strode and Grant "A Critical Review of the Extent to which the HIV/AIDS and Human Rights International Guidelines have been Implemented in the Southern African Development Community" 2007 *Obiter* 70) of the extent to which countries in the Southern African Development Community (SADC) region were implementing the HIV/AIDS and Human Rights International Guidelines was completed in 2006. (This note is based on a report commissioned by the AIDS and Rights Alliance of Southern Africa (ARASA) entitled *HIV/AIDS and Human Rights in Southern Africa* (2009) available from http://www.arasa.info/. All data contained within this report is reproduced with the permission of both ARASA and its funders. However, all the views expressed in this article are those of the authors rather than those of ARASA or its partners.) In summary the review found that almost all SADC countries were committed, in principle, to responding to HIV and AIDS as a human rights issue because most had begun to implement key legal and policy reforms based on human rights principles. However, at the same time the criminal law was being used to respond to HIV in a coercive manner, thus undermining human rights-based responses. Finally, there were a number of emerging human rights issues that needed to be addressed, including a lack of access to antiretroviral treatment and the undermining of civil and political rights by policy reforms aimed at enhancing access to HIV testing and treatment.

This note is an update of the findings of the review published in 2007. It critically examines the progress, or lack of it, made in the last three years by comparing the legislative and policy steps taken by SADC countries in responding to the HIV epidemic.

2 HIV and AIDS within the SADC

Sub-Saharan Africa continues to bear the global burden of HIV infection and AIDS deaths (http://www.aids.gov.pl/index_en.php?page=epidemiologia&act=world&id=13 accessed 2010-02-04). Sixty seven percent of all people living with HIV throughout the world live in Sub-Saharan Africa and seventy five percent of all AIDS-related deaths occurred in this region (HIV/AIDS Factsheet, http://www.kff.org/hivaids/upload/7391-071.pdf accessed 2010-02-04).

Furthermore seven SADC countries have national HIV prevalence rates of above 15%. These countries are Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The highest prevalence rates are found in Swaziland, with an infection rate of 26.1 % in adults between the ages of 15 and 49 (http://www.avert.org/aids-swaziland.htm accessed 2010-02-04). The table below illustrates the distribution of prevalence rates in SADC countries (the source of the table is the UNAIDS *2008 Report on the Global AIDS Epidemic*).

Table 1: HIV Prevalence Rates in SADC countries

COUNTRY	ADULT % 15-49 yrs	ADULT No. 15 yrs +	WOMEN No. 15 yrs +	ADULT & CHILDREN No.
ANGOLA	2.1	180 000	110 000	190 000
BOTSWANA	23.9	280 000	170 000	300 000
LESOTHO	23.2	260 000	150 000	270 000
MADAGASCAR	0.1	13 000	3 400	14 000
MALAWI	11.9	840 000	490 000	930 000
MAURITIUS	1.7	13 000	3 800	13 000
MOZAMBIQUE	12.5	1 400 000	810 000	1 500 000
NAMIBIA	15.3	180 000	110 000	200 000
S.AFRICA	18.1	5 400 000	3 200 000	5 700 000
SWAZILAND	26.1	170 000	100 000	190 000
TANZANIA	6.2	1 300 000	760 000	1 400 000
ZAMBIA	15.2	980 000	560 000	1 100 000
ZIMBABWE	15.3	1 200 000	680 000	1 300 000

The human rights landscape: changes between 2006 and 2008

There have been a number of changes in the macro-public health and human rights landscape since 2007. All of these developments are beginning to impact on human rights responses to the epidemic.

Firstly, a number of new prevention strategies are being debated in some of these countries. The most prominent of these is the use of male circumcision as a method to reduce the rate of infection between HIV negative men and HIV positive women and the possible use of universal annual HIV testing, coupled with highly active anti-retroviral HIV treatment to prevent new infections (Granicle, Gilks, Dye, De Cock and Williams "Universal Voluntary HIV Testing with Immediate Anti-retroviral Therapy as a

Strategy for the Elimination of HIV Transmission: A Mathematical Model" 2009 373(9657) *The Lancet* 7-9.)

Both of these new prevention approaches may have human rights implications. With regard to male circumcision, concerns have been raised that this prevention strategy may well have a negative impact on women's rights. For example, it has been suggested that a woman may be coerced into unprotected sex by her circumcised male partner who believes that he is no longer vulnerable to HIV after circumcision (UNAIDS, *Legal and Regulatory Self-Assessment Tool for Male Circumcision in Sub-Saharan Africa*, 2008, http://www.malecircumcision.org/programs/documents/unaids regulatory_selfassessment_en.pdf accessed 2010-03-31.) There are also human rights concerns regarding the possibility of universal testing. Some human rights activists have argued that such a robust approach where all patients are tested for HIV unless they specifically request not to be tested may undermine the current desirable focus on voluntary HIV testing (Personal communication, Ms Michaela Clayton, Director, AIDS and Rights Alliance of Southern Africa, 15 March 2010). In this new public health context, a greater emphasis appears to being placed on population-based interventions and risk, as opposes to individual human rights. This is a shift from the traditional focus in HIV responses which have almost always focused on individual human rights protection.

Secondly, at a human rights level, there has been political commitment towards the development of a set of legislative norms for the SADC region through the adoption of a model law on HIV by the SADC Parliamentary Forum in 2008 (http://www.sadcpf.org/index.php?disp=Announcing%20the%20adoption%20of%20the%20SADC%20PF%20Model%20law%20on%20HIV accessed 2010-02-04). This model law proposes that SADC countries adopt comprehensive HIV and AIDS legislation aiming at:

- providing a legal framework for the review and reform of HIV-related legislation so as to ensure that it is in conformity with international human rights standards;
- promoting effective prevention, treatment, care and research strategies in relation to HIV and AIDS;
- ensuring that the human rights of People Living with HIV or AIDS (PLWAs) are protected; and
- stimulating the adoption of special measures to protect HIV-affected vulnerable or marginalized groups (http://www.sadcpf.org/Announcement-Model%20law%20Endorsement.pdf accessed 2010-02-04).

Although it is too early to establish whether the model law is influencing legislative approaches in a sweeping manner within the region, legal reforms in late 2008 and 2009 appear to be based on the principles established under the model law.

Finally, two new advocacy efforts have begun to shape the international human rights agenda. Following pressure by non-governmental organizations (NGOs), there is an increasing recognition that responses to

tuberculosis (TB) should be based on human rights principles (ARASA Newsletter, Vol. 1, Issue 1, http://arasa.info/sites/default/files/ARASA%20April%20Newsletter%20final%20compressed_0.pdf accessed 2010-03-30). Accordingly, many NGOs appear to be broadening their human rights responses to deal with both HIV and TB issues in a similar manner. This may mean that future reports of this nature will need to begin include data on TB-related laws and policies.

There has also been an intensification of international advocacy efforts to end the use of the criminal law in responses to HIV. In 2008 the Open Society Initiative published *Ten reasons to oppose the criminalisation of HIV exposure or transmission*, (available from http://www.soros.org/initiatives/health/focus/law/articles_publications/publications/10reasons_20080918 accessed 2010-03-30) in an effort to promote an awareness and rejection of the use of criminal sanctions in this area. However, as will be seen later in this article, these advocacy efforts appear to have little or no impact on the approach being taken by legislators in the region.

3 Findings

The methodology used was more focused in this review. Information for this second legislative and policy review was obtained from 12 presentations made by partners of the AIDS and Rights Alliance (ARASA) at a partner meeting held on the 18-19 November 2008 in Johannesburg, South Africa. Presentations had a fixed structure and partners submitted written questionnaires which supplemented the information within the presentations. The purpose of the presentations was to update and revisit existing data. The information on laws and policies within each country was supplemented with a broad-based literature review.

The key findings discussed in this article have been classified in four broad categories: models of law and policy reform; public health laws; laws outlawing unfair discrimination; and laws dealing with access to treatment.

3 1 Models of law and policy reforms

The review found that countries were using a range of different approaches to review, update and implement law and policy reform measures including:

(a) six had adopted dedicated HIV-related legislation based to some extent on human rights principles (a classic example of this type of law is the Angolan Law on HIV and AIDS No. 8/04 which creates a framework for the prevention, control and treatment of HIV. It sets out the obligations on the state, the rights and duties of PLHAs and other vulnerable groups such as prisoners);

(b) five had integrated HIV and human rights issues into other laws (*eg*, in South Africa there is no dedicated HIV and AIDS Act as such, however, HIV related provisions have been inserted into amongst others, the Children's Act 38 of 2005, the Employment Equity Act 55 of 1998, the

Criminal Procedure Second Amendment Act 85 of 1997, Criminal Law Amendment Act 105 of 1997, Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 and the Equality and Prevention of Unfair Discrimination Act 4 of 2000); and

(c) three had set out human rights principles in HIV policies (*eg*, in Swaziland there is no HIV-specific legislation and the principles governing the state's response to the epidemic are set out in the Government of Swaziland National Multi-sectoral HIV and AIDS Policy of 2006).

This appears to indicate a new trend within the region towards using and adapting the SADC model law on HIV as a basis for legislative reform. It also appears to confirm a move away from the use of disability legislation to protect PLHIV, which has been the model of reform used in the USA, Canada and Europe (*Bragdon v Abbot* (1998) 524 US 624; and *Quebec (Commission des droits de la personne et des droits de la jeunesse) v Montreal (City)* 2000 SCC 27.)

Table 2: Law and policy reform models

DEDICATED HIV LEGISLATION	HIV-SPECIFIC REFORMS INTEGRATED INTO NEW / EXISTING LAWS	HIV POLICY PROTECTS HUMAN RIGHTS
Angola	Botswana	Malawi
DRC	Lesotho	Swaziland
Madagascar	Namibia	Zambia
Mauritius	South Africa	
Mozambique	Zimbabwe	
Tanzania		

3 2 Public health laws

The review found that all 14 SADC countries surveyed, had taken steps towards developing a legal or policy framework to respond to HIV and AIDS in a manner that was consistent with human rights. This was a significant change from the 2007 review which found that progress had been made in some but not all countries. In particular the 2009 review found that four of the fourteen countries had adopted new HIV and AIDS public health laws in the last two years (the 2007 review found that Angola and Madagascar were the only SADC countries with dedicated HIV/AIDS public health legislation. This review has established that in the intervening period a further four countries, the Democratic Republic of the Congo, Mauritius, Mozambique and Tanzania have passed HIV-specific public health laws).

The review found that 42.8 % (n = 6) countries had introduced HIV-specific public health legislation which was based on human rights principles. One country, had HIV-specific public health regulations that was coercive in nature (in South Africa the Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, GNR 2438 of 1987 in *GG* 11014 of 1987-10-30 provide for

coercive steps to be taken against PLHIV (although the Regulations have never been implemented they have not been repealed despite a recommendation by the South African Law Reform Commission that the Minister of Health ought to remove "AIDS" from the schedule of communicable diseases)) and 50 % (n = 7) had public health legislation that pre-dated HIV and AIDS.

In the 2007 review it was found that SADC countries had slowly begun to develop HIV-specific public health laws. This review found that there has been increased momentum around law reform which has resulted in new HIV laws being passed in the DRC, Mauritius, Mozambique and Tanzania. Law reform processes have also been put in place in Botswana, Lesotho and Malawi.

Table 3: Use of public health legislation to deal with HIV in SADC countries

HIV-SPECIFIC PUBLIC HEALTH LAW BASED ON HUMAN RIGHTS PRINCIPLES	HIV-SPECIFIC PUBLIC HEALTH REGULATIONS BASED ON COERCIVE PRINCIPLES	GENERAL PUBLIC HEALTH LAW NOT NECESSARILY BASED ON HUMAN RIGHTS PRINCIPLES
Angola	South Africa	Botswana
DRC		Lesotho
Madagascar		Malawi
Mauritius		Swaziland
Mozambique		Zambia
Tanzania		Zimbabwe
		Namibia

3 3 Laws outlawing unfair discrimination

The review found that 100 % (n = 14) countries had laws or policies prohibiting unfair discrimination against PLHAs. In 50 % (n = 7) of these countries this protection was found within the law. The remaining 50 % (n = 7) protected PLHAs through provisions in national policy. This shows an improvement from 2006 when only 91.6 % (n = 11) countries had a law or policy prohibiting unfair discrimination (Strode and Grant 2007 *Obiter* 79). Since 2006 the DRC and Mozambique have passed relevant legislation (in Mozambique, the HIV/AIDS Law 08/011 of 2008 has been passed and in the DRC a similar provision, the Defending the Rights and the Fight against the Stigmatization and Discrimination of People Living with HIV and AIDS (2008) has been enacted) and Tanzania has moved from a policy-only framework to having an HIV-related public health law.

Table 3: Equality laws prohibiting unfair discrimination on the basis of HIV status

HIV SPECIFIC LAW PROHIBITING UNFAIR DISCRIMINATION	GENERAL EQUALITY LAW	POLICY PROHIBITING UNFAIR DISCRIMINATION
Angola	South Africa	Botswana
DRC		Lesotho
Madagascar		Malawi
Mauritius		Namibia
Mozambique		Swaziland
Tanzania		Zambia
		Zimbabwe

Despite equality laws prohibiting discriminatory HIV testing within the workplace in 80 %% (n = 8) SADC countries (on which there was information available HIV testing and the exclusion of HIV-positive soldiers from the military continued to occur. This reflects limited change to the position in 2007. The only significant development in the last three years was the South African court victory in *South African Security Forces Union v Surgeon General* (case no: 18683/07 dated 16 May 2008), where the AIDS Law Project obtained an order from the Pretoria High Court confirming that the South African National Defence Force (SANDF)'s HIV policy constituted unconstitutional discrimination against HIV-positive recruits and SANDF members. In terms of the order, the SANDF was required to employ one of the individual applicants immediately, reconsider another applicant for foreign deployment and or promotion, and develop a new health classification policy within six months of the order.

Table 4: HIV testing within the Military

COUNTRY	NO PROHIBITION OF HIV TESTING IN LAW	LEGAL PROHIBITION OF HIV TESTING	MILITARY EXPRESSLY EXCLUDED FROM PROHIBITION	MILITARY TESTED FOR HIV IN PRACTICE
Angola		✗		
Botswana	✗			✗
DRC		✗		✗
Lesotho		✗	✗	✗
Madagascar		✗		No info available
Malawi	✗			No info available
Mauritius		✗		✗
Mozambique		✗		✗
Namibia		✗	✗	✗
South Africa		✗	✗ ✗	
Swaziland	✗			No info available
Tanzania		✗		No info available
Zambia	✗			✗
Zimbabwe		✗	✗	✗

3 4 Laws providing a right of access to treatment

This review found that 61.5 % (n = 8) countries had a constitutional right to health, 100 % (n = 8) of the countries on which there was information, had national ARV policies or plans in place to facilitate access to treatment. 100 % (n = 8) of countries on which there was information had clear criteria for when ARV treatment ought to be started in the national ARV policy or plan.

In contrast, the 2007 review found that fewer countries had an ARV policy framework in place. Of the 13 countries surveyed only 71.4 % (n = 10) countries had national ARV policies and in only 50 % (n = 7) of these countries were specific criteria for accessing anti-retrovirals established.

Table 5: Right to health and ARV plans

COUNTRY	CONSTITUTIONAL RIGHT TO HEALTH	NATIONAL ARV POLICY OR PLAN	ARV CRITERIA IN POLICY OR PLAN
Angola	✓	No information	No information
Botswana	No clause	✓	✓
DRC	✓	No information	No information
Lesotho	✓	✓	✓
Madagascar	✓	No information	No information
Malawi	✓	✓	✓
Mauritius	No clause		No information
Mozambique	✓	✓	✓
Namibia	Contained under "Principles of State Policy"	✓	✓
South Africa	✓	✓	✓
Swaziland	No clause	✓	✓
Tanzania	No clause	✓	No information
Zambia	No clause	✓	✓
Zimbabwe	No clause	✓	No information

3 5 Reform of the criminal law

This review found that 42.8 % (n = 6) of SADC countries had special legislation creating new offences to deal with harmful HIV-related behaviour. 54.5 % (n = 6) countries on which information could be obtained had introduced legislation requiring the courts to impose harsher sentences on HIV-positive rapists. 15.3 % (n = 2) had introduced legislation providing for HIV testing of all sexual offenders. Whilst in 30.7 % (n = 4) countries courts may order HIV testing of sexual offenders in certain circumstances.

This review showed that more countries had created HIV-related criminal offences in the last 2 years. Angola, the DRC, Mozambique and Tanzania have all introduced legislation creating HIV-specific crimes. It was only in Swaziland that the legislation remained a draft bill. With regard to imposing harsher sentences on HIV-positive sexual offenders, only the DRC implemented new legislation in the form of Law 06/19 from July 2006. This provides in article 174 (i) that HIV is considered an aggravating factor in a

case of rape, and HIV-positive offenders may face life imprisonment (HIV/AIDS & Human Rights in Southern Africa, 2009 Report http://www.safaids.net/files/ARASA_Human_rights_report_2009.pdf at 26).

Finally, since 2007 a further five countries, Angola, the DRC, Mozambique, South Africa and Tanzania had introduced legislation allowing sexual offenders to be tested for HIV in certain circumstances (HIV/AIDS & Human Rights in Southern Africa, 2009 Report http://www.safaids.net/files/ARASA_Human_rights_report_2009.pdf 26).

Table 6: Use of criminal law in responding to HIV in SADC countries

COUNTRY	HIV-SPECIFIC CRIME	HARSHER SENTENCE FOR HIV+ OFFENDER	COMPULSORY HIV TESTING OF SEXUAL OFFENDER
Angola	✗	No information	A judge may order testing
Botswana		✗	✗
DRC	✗	✗	
Lesotho		✗	✗
Madagascar	✗	No information	
Malawi	Proposed law before parliament		
Mauritius			
Mozambique	✗		A judge may order testing
Namibia	Calls for new legislation		
South Africa	Calls for new legislation	✗	A judge may order testing
Swaziland	Draft legislation		
Tanzania	✗		A judge may order testing
Zambia	Calls for new legislation	No information	No information
Zimbabwe	✗	✗	

This review found further that in 57.1 % (n = 8) countries homosexuality remains illegal. Consequently, in 53.8 % (n = 7) countries condoms are not distributed in prisons as authorities argue that they cannot promote illegal sexual activity (HIV/AIDS & Human Rights in Southern Africa, 2009 Report, supra 81). This reflects almost no change from 2007 in which a similar position existed (Strode and Grand 2007 *Obiter* 78).

Table 7: Access to Condoms within Prisons

COUNTRY	SE- BETWEEN MEN UNLAWFUL	CONDOM DISTRIBUTION IN PRISON
Angola	✗	Yes
Botswana	✗	No
DRC	✗	No
Lesotho		No
Madagascar		Yes
Malawi	✗	No
Mauritius		Yes, by NGOs
Mozambique	✗	No
Namibia	✗	No
South Africa		Yes
Swaziland	✗	No information
Tanzania	✗	No
Zambia	✗	Yes, but not always available in practice
Zimbabwe	✗	Yes

4 Cursory observations

Nevertheless, three primary concerns remain regarding the legislative frameworks which are in place. Firstly, it is of concern that many countries are using criminal sanctions in public health legislation, for example, a number of SADC countries have criminal sanctions if PLHIV do not "immediately" disclose their HIV status to others. In the Angolan Law No 8/04, the intentional transmission of HIV is a crime and is punishable in terms of section 353 of the Penal Code. Additionally, a person who, through negligence, inconsideration or failure to observe regulations, infects another may be punished under section 368 of the Penal Code. Countries also continue to pass a range of coercive criminal law measures alongside public health reforms. International advocacy against the use of the criminal law to respond to HIV appears to have had limited impact. This has resulted in a discordant approach by countries which base their public health interventions on human rights principles, but undermine these principles by using the criminal law to punish PLHIV. For example, in Botswana, the testing is carried out post conviction and test results are disclosed to the accused and the complainant. The court may consider the offenders' HIV status during sentencing (s 30 of the Panel Code Amendment Act 3 of 2003). Convicted persons are liable for increased sentences even if they were unaware of their HIV status.

These coercive provisions undermine social support programmes which aim to facilitate a process of disclosure. They also fail to recognize the reality facing many PLHIV who may face being evicted from homes, physical violence and rejection if they disclose their HIV status without support.

Secondly, gaps in legal and policy frameworks have meant that it continues to be possible to discriminate against for example, soldiers, men having sex with men and displaced persons. Furthermore, many of the

recently passed public health laws are very narrow in their approach and fail to respond to the social impact of HIV. For example, the Mauritian HIV and AIDS Preventive Measures Act (2006) is limited by the fact that it deals only with HIV testing, confidentiality, the transmission of HIV and syringe and needle exchange programmes. This narrow approach to legislating exclusively on HIV has the unintended impact of excluding many other vulnerable groups from protection. Often those infected with HIV are also burdened by other forms of disadvantage such as their sexual orientation, gender, or race; however, there has been limited change regarding the general right to equality, with few if any non-HIV milestones having been reached in advocacy for general equality legislation.

Thirdly, in a number of instances the new rights contained within public health legislation have been "clawed" back by provisions which undermine these rights, for example, in a number of countries the right to informed consent has been expressly limited and HIV testing may continue without consent on vulnerable populations such as immigrants. For example, Article 25 of Defending the Rights and the Fight against the Stigmatization and Discrimination of People Living with HIV and AIDS Act (2008) in Mozambique, there is a prohibition of HIV testing without consent except "(w)hen, at the consideration of the physician, the patient's clinical condition requires such a test exclusively for the treatment and care of the patient". This claw-back provision gives enormous discretion to doctors to decide when to test patients for HIV and may result, for example, in groups that are perceived to be at higher risk of HIV being stigmatized by the health-care system.

The impact in changes in public health approaches are not being felt at a legislative level as yet, as most proposals for new prevention approaches are contained within policies rather than legislation.

Positive changes include the growing treatment, care and support programmes within the region, with increasing state commitment towards ensuring universal access. In many countries, legal frameworks have been put in place to support the roll-out of such programmes in a way that is consistent with human rights principles.

Finally, as the epidemic evolves so do the human rights issues. Looking forward, the 2007 Report found that the key emerging issues related to the enforcement of socio-economic rights and securing greater access to treatment, care and support. This Review found a slight shift towards issues such as, the rights or people with TB, enhancing access to treatment for children, facilitating access to PMTC for positive women and the development of new prevention technologies, such as an HIV vaccine.

5 Conclusion

Thirteen years have passed since the development of *International Guidelines.* Both new and old challenges exist to human rights-based responses to HIV. Legal frameworks based on human rights principles, as imperfect as they may be, are now for the most part in place in SADC

countries. Also of importance has been the adoption of a regional standard describing the key human rights norms that ought to be contained within HIV/AIDS legislation. A new focus is therefore needed on the emerging human rights issues and on using the legal frameworks to monitor and enforce rights.

As we look forward, there is little doubt that there is a steady improvement in the ways in which countries are attempting to contribute to the fights against the HIV/AIDs pandemic. There are, however, critical issues that need to be addressed to expedite the SADC region's victory. Of paramount importance is a focused attempt to provide sufficient access to health-care services; a willingness by countries to provide HIV and TB treatment for migrants and mobile populations; the integration of sexual and reproductive health-care services into existing health programmes; the criminalization of wilful HIV transmission and the upsurge of laws with such provisions in the region; and a rational, legal strategy to the issues of the criminalization of lesbian, gay, bi-sexual and transgender communities and their subsequent limited access to HIV and TB services (ARASA Newsletter, Vol. 1, Issue 2 (April 2009) http://arasa.info/sites/default/files/ARASA%20April%20Newsletter%20final%20compressed_0.pdf accessed 2010-03-30).

In conclusion, it is encouraging to note that all the SADC countries have now begun a process of HIV-related law reform. This reflects a new move towards ensuring that the human rights principles underpinning national responses are set out in law and is a significant change from the findings in the 2007 Report. This move is centred within what appears to be greater regional commitment to ensuring that all SADC countries have dedicated HIV legislation through the adoption of the SADC model law. Given that most countries in the region now have some legal frameworks in place to deal with HIV-related issues, a new advocacy focus will be needed to lobby governments to implement new, proactive legislation for adequate and effective implementation of all the strategies. This will have to include ensuring governments allocate appropriate budgets, train staff adequately in the use of new laws and create public awareness of the rights and responsibilities created by dedicated HIV-related laws.

Furthermore, vigilant monitoring of the use and effectiveness of the laws and policies in place will greatly assist countries to identify strengths and weaknesses in their systems, in order to redress and develop more effective strategies, laws and policies to deal with obstacles faced in their attempt to deal with HIV/AIDs.

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