

# Angolan HIV and Human Rights Workshop Report

21 – 23 June 2004

Hotel Marinha

Luanda



ALIGNING HIV/AIDS and Human Rights

The workshop was organised with the assistance of SCARJOV in Angola and Muleide in Mozambique

## SCARJOV

Associação de Reintegração dos  
Jovens/Crianças na Vida Social



Associação Mulher, Lei e Desenvolvimento

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### *Annexure*

List of participants

HIV in our Lives: Treatment Action Campaign Publication

Universal Declaration of Human Rights in English and Portuguese

## 1. Introduction and Background History

ARASA hosted its second in-country workshop on HIV and Human Rights in Angola, Luanda during June 2004. The workshop was also attended by participants from Mozambique. Funding for the workshop was provided by Development Cooperation Ireland.

The goal of the workshop was to raise awareness and understanding among HIV/AIDS organizations about HIV/AIDS and Human Rights with a view to promoting the development of a supportive environment to respond to HIV/AIDS and to promoting the adoption of HIV/AIDS policies and programmes at national level that protect human rights and reduce stigma and discrimination.

Angola was chosen as a venue for the workshop on the basis that Lusophone countries in SADC have traditionally been neglected in terms of training on HIV and Human rights. Indeed it was the first time that a workshop on HIV and Human rights had ever been convened in Angola.

The workshop was coordinated by the ARASA regional office, Windhoek, Namibia with the assistance of and input from Mr Venancio Feliciano Simao of SCARJOV, ARASA's focal point in Angola and Rafa Machava from Muleide, the ARASA focal point in Mozambique. SCARJOV was established on 21 December 2000 in Luanda by a group of youth linked to the Forum das Organizações Não-Governamentais Angolanas (FONGA). SCARJOV assists these displaced youth/children in different ways particularly those that suffered the consequences of the prolonged war. *MULEIDE (Associação Mulher, Lei e Desenvolvimento)* is part of the MONASO HIV/AIDS network (*Rede de Organizações Moçambicanas Contra o SIDA*) that is made up of over 40 organizations throughout the country.

## 2. Workshop objectives

The workshop objectives were as follows:-

- Increase the knowledge of the participants to understand the fundamental principles, sources and concepts of human rights and how they apply to HIV/AIDS programming
- Build the skills of the participants to
  - analyse, identify and address human rights issues in HIV Programmes and take action or know where to refer such matters;
  - identify violations of human rights relating to HIV/AIDS- where they occur and their impact; and
  - identify appropriate legal and administrative structures for referral of HIV/AIDS related rights violations for action.
- Enhance exchange of information and experience between Mozambicans and Angolans

- Promote strategic networking for advocacy on HIV/AIDS related human rights issues and strengthen strategic partnerships and networking on HIV/AIDS related human rights issues between:
  - AIDS service organisations
  - Community based organisations
  - Human Rights organisations
  - Organisations of People Living with HIV/AIDS

### **3. Opening Remarks**

The opening session was chaired by Venancio Simao of SCARJOV. Venancio introduced the following people UNAIDS Country Representative, Dr Alberto Stella; Ms. Rafa Machava the Coordinator of Muleide, Mr. Simao Cacumba Morais Faria Executive Secretary of SCARJOV, Ms. Michaela Clayton Coordinator of the AIDS Law Unit and Ms. Collette Campher Coordinator of ARASA as well as Ms. Johanna Ncala who is a trainer of the Treatment Action Campaign in South Africa, Johannesburg

Mr. Simao Cacumba welcomed the participants on behalf of SCARJOV especially those that traveled long distances to attend the workshop. He also expressed his tanks to the organizers and facilitators of the training workshop for their hard work and commitment to making the workshop possible.

He also expressed his special appreciation and thanks to the UNAIDS Special Representative for agreeing to officially open the training workshop.

Mr Cacumba noted that it was his task to oversee the smooth running of the workshop and to see that participants achieve the objectives set for the workshop that include as follows:

- We get to know each other as Southern Africans in order to be in a position to in future address matters of common interest or challenge. Given the low level of development of communication infrastructure and the level of material deprivation of the majority of our people, it is not often that Southern Africans meet and get to know each other first hand.
- To develop an understanding of the regional and international instruments on HIV/AIDS, Human Rights and discrimination, the Southern Africa regional system, in terms of institutional arrangements and mechanisms as well as the substantive norms, standards and procedural requirements governing the practical use of HIV and Human Rights systems;
- To share knowledge and expertise in order to confront HIV/AIDS and Human Rights challenges;
- Use the opportunity to develop common strategies for preparing the independent non-state "shadow reports" in order to enable bodies that receive and assess state reports to have information and explanations that they would other wise find difficult to obtain and verify.

Muleide expressed their appreciation for being involved in the workshop and also for the fact that 20 participants from Mozambique could attend this very important workshop as well. The Mozambicans can share their experience and also learn from the Angolans.

The welcoming was followed by the performance of a drama on HIV/AIDS by local actors.

**Opening address: Dr. Alberto Stella (UNAIDS Country Representative)**

Dr Stella said that holding a conference on HIV/AIDS and Human Rights is of particular importance in Angola. The connection between HIV/AIDS and Human Rights should be linked with the fact that there is no cure for the disease; the fact that the virus is mutilating and that stigma and discrimination are issues that needs to be addressed. Looking from a Human Rights perspective in combating the spread of the disease we find that only through collaborative partnerships where there is respect for our and the respect of others' Human Rights can we manage the disease. He noted that legislation is in dire need of change in Angola and that now is the right time to integrate a Human Rights based approach to the epidemic.

It is important to note the connection between HIV/AIDS and Human Rights and how the interacting agents exacerbate the spread of the disease. Looking at the differences between the percentages of infected people living in Sub-Saharan Africa compared to the global picture and how the disease is spreading; our lack of resources is of grave concern for our future. In a modern world our resources failed and people died.

The statistics from last year reflect that the social and economic situation of most Angolans promises the rapid expansion of the virus among 30 million people, most of whom are the youth. In 2003, 5 million new infections were recorded and 3 million died because of HIV-AIDS. Dr Stella called on the workshop to seek to reflect the causes, and to put strategies in place for redress.

Advocating for the appropriate integration of a human rights based approach to HIV in our laws and policies is surely one means in order to advocate for prevention.

The recent creation of the National Commission against AIDS in Angola guarantees a better organised and better coordinated struggle, because we know that it reaches all the sectors of national life.

Our legislation pertaining to protecting those living with HIV/AIDS is an issue of great concern in Angola. Human Rights calls for careful negotiation in order to protect everyone and should be understood as such.

Dr Stella wished all a good workshop in respect of integrating the element of Human Rights into the national response to HIV/AIDS.

#### **4. Workshop Expectations**

Participants identified the following expectations for the workshop:

- To learn more from experiences from the Mozambicans and to develop a working relationship with them
- How to act in terms of human rights to defend the people
- Human rights as a great concern in Angola and how to address it
- To build capacity among NGOs, CBOs, PLWHAs and Human Rights Organisations
- To learn about advocacy and lobbying skills
- To learn more to help communities
- To exchange experiences with the youth
- To be empowered
- To gain information in order to support PLWHA
- To receive more tools to assist widowers and orphans
- To gain an understanding of HIV and human rights and literacy materials
- Learn about HIV and Gender and to develop partnerships with Mozambique
- To exchange experiences with other partners in the region
- Look at our neighbouring countries and do a comparative analysis.

#### **5. Country Presentations**

Representatives from Angola and Mozambique delivered presentations on the current situation regarding HIV and AIDS in both countries:

##### **5.1 Mozambique**

Joao Mathombe presented an overview of the Mozambican experience. He noted when the HI virus was first diagnosed no capacity existed in civil society in order to positively respond to the needs of those infected and affected. In 1998 civil society started to organize themselves in order to join government to address problem. It was identified by the Ministry of Health that they cannot respond on their own to the problem. Government then created a body organized by the Prime Minister and the national advisory body and also included civil society. The first response was to develop a strategic plan to reduce rates of infection. Currently government together with the national advisory body and civil society is doing a review of a first strategic plan.

Government has a law that protects women with HIV and it was initiated by civil society. They also managed to reduce stigma and discrimination on a large scale. The following actions were also taken in order to enhance outreach programmes to reduce the risk of further spread of the virus:

- Establishment of VCT sites in the cities
- Law on discrimination in the workplace put in place
- Structures were put in place in order for civil society to become involved in the development of strategic plan.

The law on discrimination in the workplace is however not being properly implemented and is also not well known to its citizens.

Civil society is responding well to the pandemic and the number of organizations of PLWHAs is growing constantly throughout the country. It was noted that it is important to protect the rights of PLWHAs since they have a right to be protected as human beings. The trend is to start off by empowering the family circle. It was noted that the labour force should be strengthened to empower and protect its workers against stigma and discrimination in the workplace. The religious groups in the country were initially very difficult to get on board since it was difficult to convince them to become a tool to advocate for using condoms in their communities. The discussions have evolved and now there is a greater understanding on the part of religious leaders of the need for advocating for use of condoms.

The following prevalence rates in the different countries were given: Mozambique 13.6%, Zimbabwe 39%, South Africa 20.5%, Malawi 11.9%, Swaziland, 31.6%

## **5.2 Angola**

Will Bento Tonet of Centro de Apoio aos Jovens (CAJ) did the country presentation on the Angolan situation.

He started off by posing a question to everyone saying that Angolan NGOs have been doing treatment advocacy recently advocating for use of ARVs when no doctors are available to help at the HIV clinic. Civil society is questioning the involvement of doctors in the quest to receive ARVs since it is important for medical staff to provide treatment and care for people in need.

PLWHAs are getting ill and no proper treatment is available to them. The support from government is crucial and action is needed to get the support from government; if not society will remain weak. They suggested the outcome of this workshop should be to make a joint venture of all NGOs to make sure people are not dying.

In Angola civil society is pressurizing government but civil society is not strong enough. It is important that civil society claim their right to assist their communities and government and to strengthen their capacity to advocate for ARVs.

The following problem areas were identified:

- Customary law – wife inheritance
- Religious leaders – what pressure can we put on them to take up issues on behalf the communities that are affected? Churches are not ready yet to promote abstinence or for the use of condoms - they promote moral grounds that are to their advantage. They cannot change the church' philosophy since it is already involved with the work of civil society.
- Laws and policies should be in place to enhance access to treatment to PLWHAs
- Civil society organizations have done a lot to move it forward but to no avail
- Angolan government is not doing enough
- NGOs work in the cities – because of the war they have not been able to work in regions.

## **6. Presentations**

### **6.1 Michaela Clayton: Human Rights and HIV/AIDS: Making the Connection**

Michaela presented an introduction to HIV/AIDS and its relation to Human Rights.

What are human rights?

- International Human Rights law defines what governments can do to us, cannot do to us, and should do for us (Gruskin).
- Human rights should be equally applicable to everyone, everywhere.
- Human rights are universal, interrelated and indivisible.
- Human rights are primarily about the relationship between the individual and the state.
- International human rights law consists of the obligations that governments have agreed they have in order to be effective in promoting and protecting our rights.
- When governments fail in their obligations to us, or when they deliberately restrict our rights without valid justification, they can be seen as being responsible under international law for violating our rights.

International Human Rights Documents Relevant to HIV/AIDS

- 1948: Universal Declaration of Human Rights (UDHR): not legally binding Treaties: Legally binding on nations that have ratified:
- 1965: International Convention on the Elimination of All Forms of Racial Discrimination (M)
- 1966: International Covenant on Economic, Social, and Cultural Rights (A)

- 1966: International Covenant on Civil and Political Rights (A&M)
- 1979: International Convention on the Elimination of All Forms of Discrimination Against Women (A&M)
- 1985: Convention Against Torture (M)
- 1990: Convention on the Rights of the Child (A&M)

#### International Human Rights Documents Related to HIV/AIDS

Selected political consensus documents: not legally binding but set important political commitments

- 1990: World Summit on Children
- 1993: World Conference on Human Rights
- 1994: International Conference on Population and Development
- 1995: Fourth World Conference on Women
- 1995: World Summit for Social Development
- 2000: United Nations Millennium Declaration Resolution
- 2001: United Nations General Assembly Special Session on HIV/AIDS
- 2002: United Nations General Assembly Special Session on Children

#### Declaration of Commitment on HIV/AIDS

- Prevention
- Care, Support and Treatment
- HIV/AIDS and Human Rights
- Reducing Vulnerability
- Children Orphaned and Made Vulnerable by HIV/AIDS
- Alleviating Social and Economic Impact
- Research and Development
- HIV/AIDS in Conflict and Disaster-affected Regions
- Resources
- Follow up:
  - National Level
  - Regional Level
  - Global Level

#### Human rights: Important concepts in defining governmental obligations

- Governments are obliged to:
  - Respect the Right (do not violate the right)
  - Protect the Right (stop others from violating the right)
  - Fulfill the Right (give content to the right)

## Progressive realisation ...

- Human rights, such as the right to the highest attainable standard of health, should be progressively implemented by the state to the “maximum of its available resources.”
- States must “take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the covenant by all appropriate means, including particularly the adoption of legislative measures.” ICESCR, Art 2 (1)

## *Siracusa Principles:*

The restriction must be provided for and carried out:

1. In accordance with the law;
2. In the interest of a legitimate objective of general interest;
3. Strictly necessary to achieve that objective;
4. No less intrusive and restrictive means available to reach the same objective, and;
5. The restriction cannot be unreasonable or otherwise discriminatory in the way that it is written as a law or policy, or in the way that it is applied.

## Non-Discrimination

- Key concept in human rights
- Every person should be treated with equal dignity and respect
- Discrimination on the basis of difference is strictly prohibited
- Can exist in law or practice
- Not every differentiation is discrimination

## Defining the right to health and health related rights

- Article 12 recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”
- The steps to be taken by the States parties...to achieve the full realization of this right shall include those necessary for:
  1. The provision for the reduction of still-birth rate and of infant mortality and for the healthy development of the child;
  2. The improvement of all aspects of environmental and industrial hygiene;
  3. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
  4. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Understanding the connections: HIV/AIDS, stigma, discrimination, racism, sexism, poverty and social inequality

#### Historical and global inequalities

- No coincidence that countries labouring under legacy of social inequalities left behind by colonialism, racism and apartheid are disproportionately affected by HIV/AIDS:
- Denial of education
- Migrant labour
- Civil war
- Structural adjustment and poverty
- Individual choices are undermined

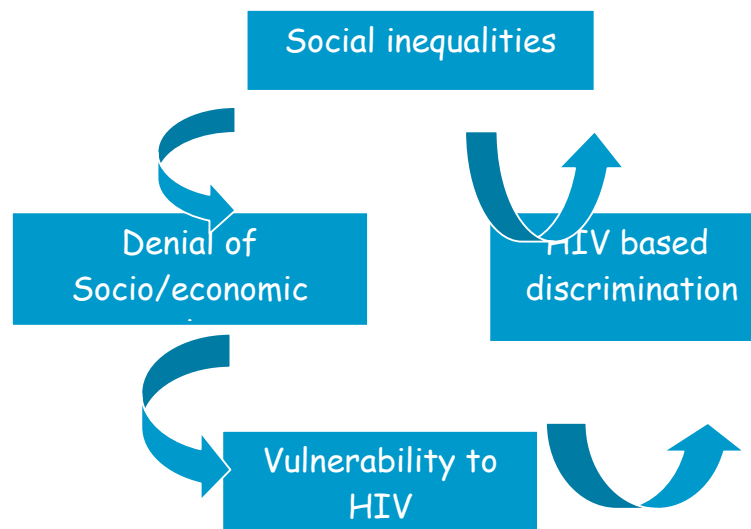
#### Women at particular risk

- Gender inequalities render women particularly vulnerable
- Individual choices regarding behaviour that reduces vulnerability to HIV are limited by racism, sexism, political violence and poverty

#### HIV/AIDS as further catalyst for discrimination

- Link between HIV/AIDS and death
- Fear of contracting HIV
- Association of HIV with “socially unacceptable” behaviours
- Blame associated with religious / moral beliefs: HIV is result of moral fault that deserves punishment
- Negative public health effect

#### Breaking the cycle ...



### Role of human rights

- To effectively intervene we must stop assuming that people have unlimited individual choices
- To break the cycle we must address the symptoms as well as the causes: HIV based discrimination and underlying social inequalities that fuel vulnerability to HIV
- Respect, protect and fulfil the right to freedom from discrimination and the right to health
- Access to affordable treatment is central to both of these

### Right to health

- Prevention, care, support and treatment are mutually reinforcing and inseparable
- Access to affordable ARVs is part of right to highest attainable standard of health
- Also breaks link between AIDS and death and thus addresses discrimination
- Prevention benefits: more likely to go for test and lower viral load
- Paradoxically – very factors of social inequality that render some at greater risk of infection also render them less likely to have access to treatment

### Right to health and treatment

- By July 2002 WHO estimates only 230 000 of 6 million in developing countries who need ARVs have access to them – half of those receiving it live in Brazil.
- This leaves more than 5.7 mil in developing countries, 96% of whom are in urgent need, without treatment
- Primary reasons why not available are:
- Drug pricing
- International patents and trade regime (TRIPS)

### UNCESCR: General Comment 14: 2000

- Committee notes that right contains 4 elements: availability, accessibility, acceptability, quality
- Committee observes that right imposes on States the obligations to respect, protect and fulfil
- Respect: refrain from interfering with enjoyment of right
- Protect: prevent third parties from interfering
- Fulfil: adopt measures towards full realisation of right

### Recap

- Obligations spelled out in international sources.
- Should be progressively realised over time.
- Some human rights are not absolute-may be restricted.
- Non-discrimination is a common underlying human rights principle.
- Health is not only protected by the right to health – inter-relation and indivisibility of rights.
- Health and rights inextricably linked
- Human rights are monitored by UN institutions that engage government, intergovernmental agencies, and NGOs in their processes.

- Standards are set at the international level through human rights treaty bodies, which clarify the meaning of human rights obligations, and incorporate UN international conference targets, as well as norms adopted through declarations by UN charter bodies.
- Monitoring and standards processes can be important opportunities for us to promote and protect health and human rights, and engage with government and civil society.

The meeting was divided into five working groups who were asked to identify rights in the context of HIV/AIDS.

The following rights were identified

- Involvement of civil society in order to help government fight HIV/AIDS.
- Government failed on an integrated approach and cannot keep up with the demand.
- The HIV outreach programmes are being overseen by the Prime Minister of country.
- Outreach programmes are in place that government needs to review.
- Government needs to realize that they need to create all facilities in order for the plan to take action.
- The need for a law in the workplace to prevent stigma and discrimination.
- The need for a strategic plan for Religious and Traditional Leaders that is broad and includes all communities. Currently our religious leaders are doing advocacy work on the need for a law but advocating for a law to protect the rights of PLWHAs will not solve the problem because people need to know the law they are advocating for first. Civil society can help in the development of such a law. Religious leaders are involved with positive talking and people identify with it because they are living in their communities. Religious leaders should also become involved with advocating for the use of condoms; and should become involved for a revision plan for the country.

With regard to the above stories the Mozambican participants had the following questions for the Angolan participants

- Do Angolans have access to ARVs
- Are there policies in place that provide for the use of ARVs
- How does civil society participate in access to resources in the Global Fund and who are they and which organisations receive resources from the GF; which organisations are heading the campaign
- What plans are in place to get civil society involved as well as churches advocating to the use of condoms.
- Mozambique created policy for workers by 2005. This law only help workers
- What are the prevalence rate in north, east, central Angola

## **6.2 Michaela Clayton: Balancing Human Rights and Health: applying the Human Rights Framework to HIV/AIDS Policies and Programmes**

The purpose of this session is to enable participants to recognize the implication of the violation of rights or the promotion of rights in the context of health policies or programmes. This will assist participants to be able to design and implement more effective policies and programmes.

In order for government to validly restrict the rights they can restrict for example movement or information certain criteria have to be met:

### Siracusa Principles

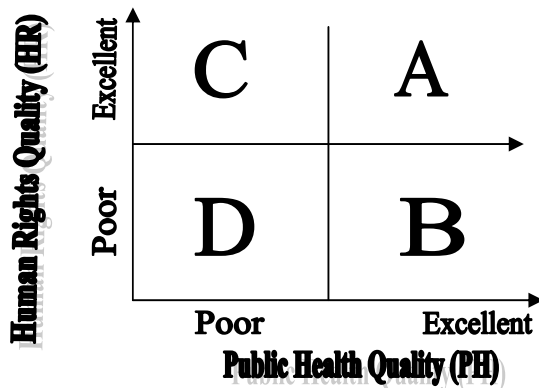
In order for governments to validly restrict the rights they can restrict—for example movement or information—certain criteria have to be met:

The restriction must be provided for and carried out:

- 1) In accordance with the law/policy;
- 2) In the interest of a legitimate objective of general interest;
- 3) Strictly necessary to achieve that objective;
- 4) No less intrusive and restrictive means available to reach the same objective, and;
- 5) The restriction cannot be unreasonable or otherwise discriminatory in the way that it is written as a law or policy, or in the way that it is applied.

Questions to consider

- Is there an existing law or policy?
- Is this an effective public health strategy?
- What evidence exists of its effectiveness?
- Are existing structures and resources sufficient to implement?
- What rights are affected and will any need to be restricted?
- Is this approach the least restrictive alternative?
- Is there a means of redress?
- What system of monitoring, evaluation and accountability exists?



Michaela introduced the participants to the diagrammatic tool set out above which attempts to maximize both the public health and human rights quality of the policies and programmes that participants deal with.

The methodology includes four steps:

- 1) Consideration of the extent to which a policy or programme represents good public health.
- 2) Consideration of the extent to which it is respectful of and promotes rights.
- 3) Consideration of how to get the best balance between health and rights.
- 4) Consideration of whether this is the best approach for dealing with the public health goal it seeks to address.

Michaela asked the participants to break into their groups and to identify whether there is a Public Health strategy in place considering the restriction of rights in the interest of public health? A practical example was made by asking the participants to work with the following case study

*CASE STUDY: Balancing health and human rights:* The Commissioner of Prisons learns that HIV is rampant in a number of facilities under his authority. He takes immediate action and institutes a policy to mandatory test all inmates upon admission to the prison system. Within each facility, all prisoners found to be HIV-infected will be placed in one area and isolated from other prisoners. As there is no budget in the prison system to pay for ARV treatment, none will be made available. Outside the prison system, the State has begun to put into place a strategy to provide ARV treatment to all citizens who need it.

The participants were requested to initially look at the case from a public health point of view only to consider the following three questions:

- Does isolating prisoners reduce the risk of infection
- How does Public Health intervention reduce the risk of infection
- Do you feel giving prisoners ARVs will reduce the risk of contracting HIV

Exercise: Does isolating prisoners reduce the risk of infection

Feedback from the participants was as follows:

<i>Isolation will reduce risk of infection</i>	<i>Isolation will not reduce risk of infection</i>
Civil society establish contact with prisoners in order to know their status	Medical staff and civil society can restore the contact between the Prison Commissioner and prisoners by educating them
Isolated prisoners should have ARVs and should live together with those prisoners that have relationship with infected prisoners	Civil society should get involved in lobbying with prison commissioner to give educational information
In cases where prisoners assault other prisoners they should be isolated with infected prisoners.	Civil society should build a positive relationship with infected and affected
Isolation is correct it is not discrimination but a prevention strategy	Infection and reinfection will continue whether you isolate prisoners or not.
Isolation will avoid rate of infection	Government do no have any budget to treat prisoners with ARVs
Lack of information is a problem and would be better to isolate prisoners	Commissioner is abusing his power due to lack of information
Isolating prisoners will decrease viral load of infection	Isolating Sero positive prisoners will not help; there is also no need in isolating the ill prisoners that are in the final stages in prison. They should rather be sent to hospital

Exercise: How does Public Health intervention reduce the risk of infection.

Feedbacks from participants were as follows:

<i>Intervention will reduce risk of infection</i>	<i>Intervention will not reduce risk of infection</i>
Health officials in prison should be educated and mobilised starting with Commissioner of Prisons	Sero positive also included in government. If not possible to bring ARVs we should organize other protection outside of prison.
Knowing the statistics will assist with intervention Government should put measures in place	There is no Public Health policy in place
Give Commissioner of prisons knowledge how	

disease is transmitted. The sick prisoners should be transferred where they can be treated.	
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Exercise: Do you feel giving prisoners ARVs will reduce the risk of contracting HIV

Feedback:

<i>ARVs will reduce risk of infection</i>	<i>ARVs will not reduce risk of infection</i>
All prisoners that need it should get it. This would be a good public health recommendation.	

The groups were then asked to use the Universal Declaration of Human Rights and look at the same and determine which human rights are restricted by Prisons in the example.

Feedback from the groups was as follows: The Rights of prisoners are infringed in the following Articles of the Universal Declaration of Human Rights: Articles 1, 2, 3, 4, 7, 12, 19, 25.

**Article 1**

**All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.**

**Article 2**

**Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.**

**Article 3**

**Everyone has the right to life, liberty and security of person.**

**Article 4**

**No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.**

**Article 7**

**All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.**

**Article 12**

**No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the rights to the protection of the law against such interference or attacks.**

**Article 19**

**Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.**

**Article 25**

**(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.**

**(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.**

The participants reconvened for a plenary session facilitated by Michaela in a discussion employing the diagrammatic tool to assess the human rights quality of the policy. Further discussion was prompted utilizing the following questions for consideration:

1. How serious is the public health problem?
2. Is the proposed response likely to be effective?
3. What are the severity, scope, and duration of the burdens on human rights resulting from the programme?
4. To what extent is the programme restrictive and intrusive?
5. Is it over inclusive (too broad) or under inclusive (too narrow)?
6. What would you propose to reduce the burden on human rights? How would you improve its human rights quality?
7. What about public health quality? How would you improve that?
8. What does improving the human rights aspects of the case do to the public health? Improve it or worsen it?
9. Where would these changes be put in the policy in the table?
10. And to get back to the original intent of the Commissioner in the case study – prevention HIV transmission in the prison population – is this the best way to do this? Are there better ways?

Michaela summarized the outcomes of this session as follows:

We have the diagramme to illustrate how good policies are those that achieve their public health goal without unnecessary infringement of human rights.

What it is that we want to achieve from our government in terms of our public health and human rights? We want excellent human rights and excellent public health. If you draw a line between human rights and public health we want to move our policies in Angola and Mozambique to excellent human rights and excellent public health. We should keep in mind what currently is happening and how we can make it better in future in order to provide for good public health without unjustified invasions of rights.

Feedback from the participants in order to achieve excellent Public Health Rights and Human Rights were as follows:

- Start by identifying our human rights
- Check whether policy will achieve its public health goal without unnecessary limitation of human rights.

Michaela concluded the session by saying that it is important to note that when you develop a public health policy one should be careful not to restrict rights unnecessarily because it does not mean that it would be more effective. When you start restricting rights you should have good justification.

### **6.3 Michaela Clayton: Relation between HIV/AIDS, Human Rights, Risk and Vulnerability**

Michaela explained the relationship between HIV and health by demonstrating the following areas of vulnerability:

- Discrimination that affects our ability to be effective in our HIV interventions.
- Inequality and discrimination make you vulnerable to HIV infection.
- Displacement of women makes them more vulnerable.
- Programmes often focus on care and support, home based care and counseling but we also need to look at things that make you more vulnerable in first place.

This presentation illustrates factors that make us vulnerable to HIV. Vulnerability is an issue not only in respect of the services available but also in respect of the political and cultural environment in which they are available. The heart of a Rights based approach is the ability to make individual decisions. Many people cannot do so however because of societal inequalities such as gender inequality. Stigma and discrimination impact on all three – prevention, care and support and impact mitigation.

The training session seeks to enable participants to identify the reasons why people do not access services and more generally the factors that make people vulnerable to HIV.

In society we find three levels of vulnerability and they all are interdependent.

#### 1) Individual Vulnerability

It directly links to a person's physical and mental knowledge, characteristics, social relations. These characteristics can make a person more vulnerable eg. illiteracy can make a person more vulnerable, access to resources can make a person more vulnerable.

#### 2) Programmatic Vulnerability

HIV programmes can reduce vulnerability to HIV or increase vulnerability. It is the information, education, health services, human rights that are developed that can make people more vulnerable.

To illustrate the above Michaela takes an example in Namibia. There is talk about building a hydro-electric scheme in order to not import electricity from South Africa. If the plans to develop the scheme continue, people that live on that land will be displaced. The Ovahimba tribe lives in that area and by building the hydro-electric scheme will make people vulnerable. The Ovahimba tribe has little contact with the rest of the world. They are farmers and they live off their land. Displacing these people will impact on their vulnerability. Furthermore, construction workers will come work and live there that will make women in that area vulnerable to commercial sex work since they do not have any income from their land.

### 3) Social Vulnerability

Refers to factors in our society. Factors that influence programme vulnerability would for example be gender relationships. Women cannot or struggle to enforce safer sex relationships. Traditional beliefs and customs such as wife inheritance where the brother takes over the wife place us at risk. We also should look at our attitudes in society towards sexuality. The young people in particular are vulnerable in a society.

In society we find different messages about sex, for example in our schools, our leaders in society and the church. When the message is spread that we should not use condoms this could add to vulnerability. Poverty is also another factor that can add to vulnerability.

All these three issues mentioned can make a person vulnerable to infection. Programmatic vulnerability can make our societies vulnerable. These three levels of vulnerability all work together to influence our behaviour and the situation that we find ourselves in.

After the first cases of HIV/AIDS infection was identified in the 1980s a lot of prevention training was going on but we neglected to look at the underlying factors that made people vulnerable to HIV infection. We neglected to look at strategies that reduce the risk of vulnerability. We therefore need to look at issues that are underlying causes i.e. gender inequality, customs and traditions.

Gender is linked to societal vulnerability. It is a fact that in society women are not equal to men. We therefore have to address issues that make us vulnerable that add to societal vulnerability.

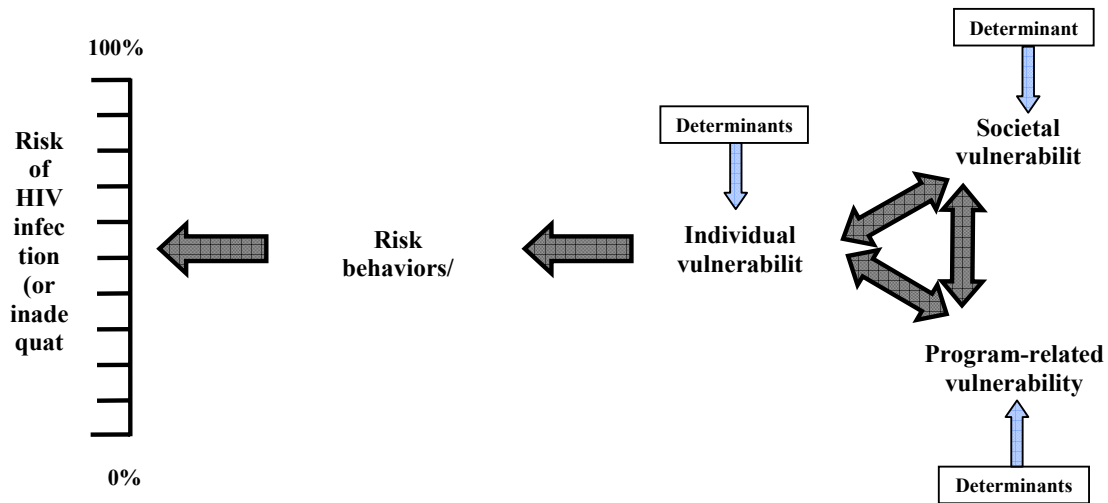
### **A slide presentation of the above presentation follows:**

#### **Interdependent levels of vulnerability**

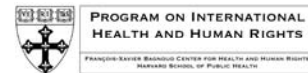
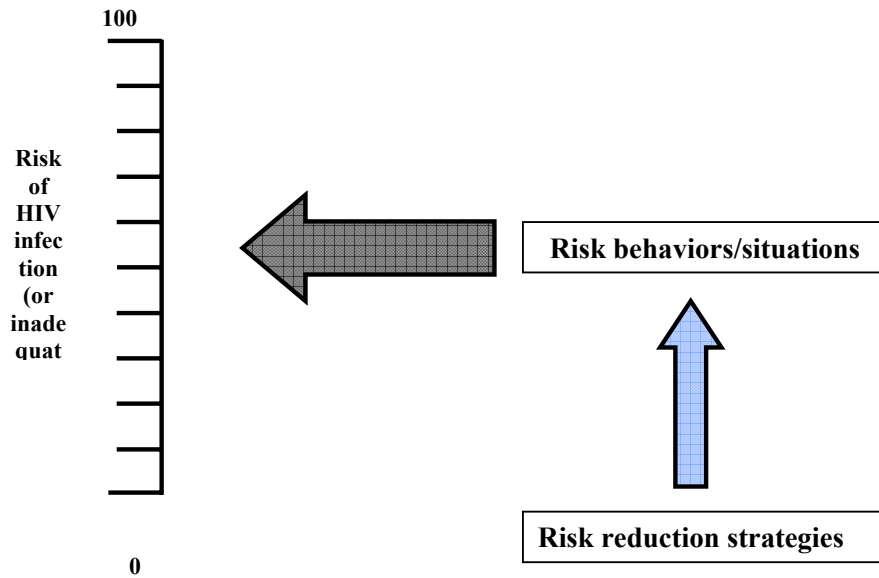
- Personal: focuses on various factors in individual's development or environment that render him more/less vulnerable: physical and mental development, knowledge and awareness, behavioural characteristics, social relations

- ⚠ Programmatic: contributions of HIV programmes to reducing / increasing vulnerability: information and education, health and social services, human rights programmes
- ⚠ Societal: focuses on contextual factors that define and constrain personal and programmatic vulnerability: political structures, gender relationships, attitudes to sexuality, religious beliefs, poverty
- ⚠ (Mann & Tarantola, AIDS in the World II)

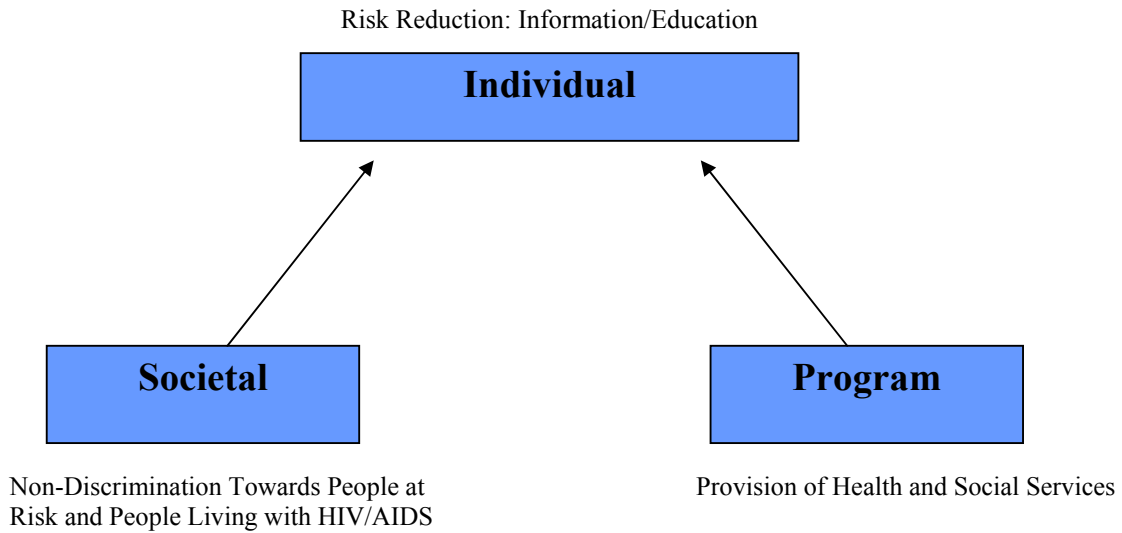
**Risk and Vulnerability**



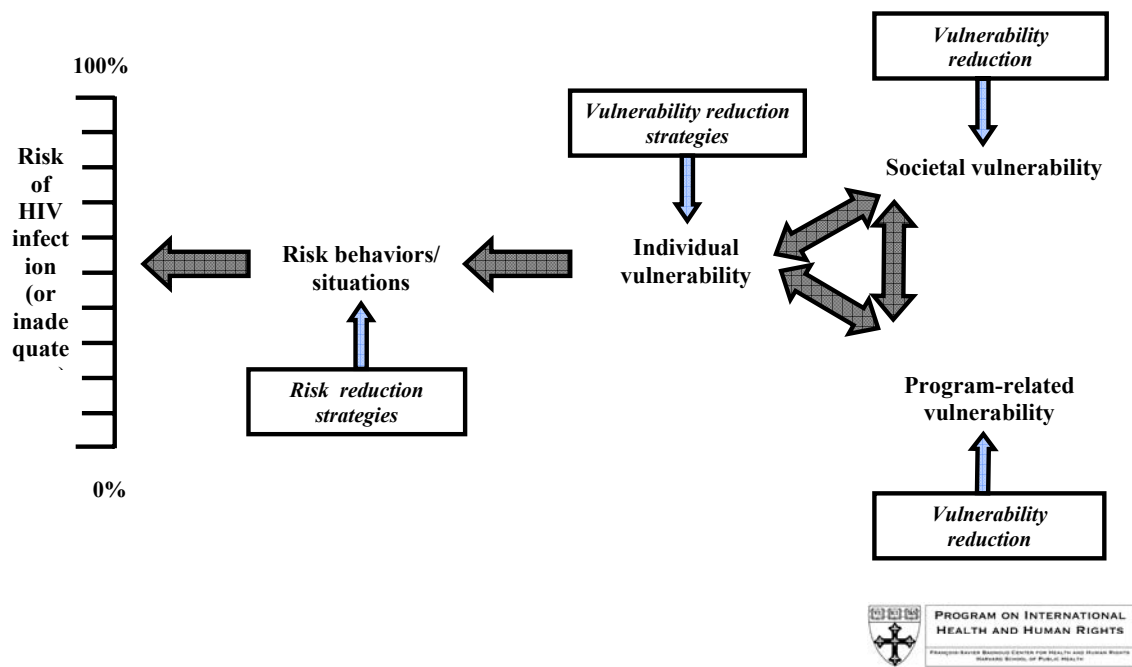
**HIV/AIDS Risk and Risk Reduction Strategies**



### Early Responses to HIV/AIDS



### Risk, Vulnerability and Reduction Strategies



### Governmental Obligations with Respect to Vulnerability

			<b>People vulnerable to HIV/AIDS</b>
<b>Respect</b>			Government to refrain from directly violating human rights which impact on vulnerability.
<b>Protect</b>			Government is responsible for preventing rights violations by non-state actors that may increase people's vulnerability to HIV/AIDS, and for providing some legal means of redress.
<b>Fulfill</b>			Government to take administrative, legislative, judicial and other measures towards the realization of the rights of people in order to minimize their vulnerability to HIV/AIDS.



The participants were then provided with the following case study and convened for group work.

Case study: Louisa is 10 years old, and has three younger sister and brothers. Her father died of AIDS 6 months ago. The youngest to children aged 6 and 4, have tested for HIV and are infected. Her mother is very sick. As soon as her father died, his relatives took possession of the house, and livestock, and the land. The relatives told Sara that the property did not go to her or her mother. They refused to help her mother, even though her mother was very ill and weak. At first, Sara, her siblings and her mother stayed in "their" house; the relatives made Sara's mother sleep outside of the house.

Sara convinced her mother that they should leave and go to the next town where her relatives live. They took the family in but the mother died three months later. Sara's uncle (her mother's brother) told Sara after her mother died that they could not care for her and her brothers and sisters and that they had to leave the house. Neither Sara nor her siblings have been able to attend school since leaving their father's village. They do not have copies of their birth registration papers or any documents that establish their legal identities. Without these papers they are likely not to be able to access health and social services. Sara and her younger siblings are about to move in with a neighbour but it is clear they cannot stay there very long.

The purpose of the exercise is to identify the factors that are relevant to reducing the risk of Louisa and her brothers and sisters. Identify the risk taking behaviour and risk generating situations associated to particular circumstances by looking at the following:

- Individual vulnerability. What makes Louisa and brothers and sisters vulnerable
- Societal vulnerability. What factors of Societal Vulnerability influences their vulnerability
- Programmatic vulnerability – factors individual and societal vulnerability
- Use the Universal Declaration on human rights and look at which rights are infringed according to your Declaration

The groups identified the Articles 1, 3, 4, 5, 7, 12 in the Universal Declaration on human rights that should be looked at in order to reduce the vulnerability and identified the following areas of vulnerability:

Feedback on what the groups expressed

<i>Individual vulnerability</i>	<i>Societal Vulnerability</i>	<i>Programmatic Vulnerability</i>
Traditional violation	No social support from government policies	Lack of health programme
Right to school	No support from civil society	VCT Centre are very basic
Violation acquire nationality not registered before	Prostitution causes frustration and despair	Risk on increase of orphans
Violation of dignity	Good faith help change course of life of children	No integrated approach in communities, institutional level eg. Schools, Health department municipalities, and provinces
Leader of family dies very early		
Lack love of parents		
She will not have access to	Health & education	Inheritance left by fathers

<p>employment</p> <p>Family, support</p>	<p>Discrimination</p> <p>Society does not defend rights of children nor widower</p> <p>Death of father results lack of law protecting children</p> <p>Housing violations right of children and widows</p> <p>Traditional practices impacts right of heritage</p> <p>Social customs such as woman and boy children do not have right heritage because the nephews inherit all possessions; relatives also do not want to intervene</p> <p>Do not talk open about customs</p> <p>No clarity on cultural view and legal aspects</p> <p>Culture is a reality we need to deal with</p>	<p>should go to children</p> <p>Do not have birth certificates</p> <p>Community does not recognize you and rather discriminate</p> <p>War dislocated many families</p> <p>Lack of Identity documents</p>
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Michaela re-convened the session by summarizing that individual vulnerability, societal vulnerability and programmatic vulnerability are all factors that make people vulnerable. Thereafter, the participants assembled for a discussion.

Feedback from the discussion were as follows:-

Looking at the issue of inheritance we need to identify measures that are in place currently that make us vulnerable. We have European values and need to go back to our traditional societies it will help to measure the impact of HIV in traditional societies.

In Mozambique when the man dies the brother takes over the wife according to traditional values.

We try to be realistic because studies showed that there are about 400 people infected daily. It is important to know the issues that make women vulnerable. We also looked at the message the churches are giving and looked at how the churches can positively intervene.

In Angola and Mozambique we have the same problems around traditional and cultural norms. The Universal Declaration on Human Rights is a guide for us in order to identify the issues to deal with.

There are many people infected in the provinces. We should use the Universal Declaration of Human Rights that was ratified to our people. Law of family still allows polygamy and is also not clear. We have to sit down with our legislators to find protection.

In Mozambique our Christian society is very active and the churches in Angola can still learn a lot from the Mozambican experience. The church in Mozambique understands that it must respect peoples' moral values.

We can defend our cultural values and need to be realistic. We need to ask ourselves whether our cultural values increase our vulnerability to HIV/AIDS.

Our cultural issues are our daily lives and our social values must be preserved. We have to educate our people and expose our values in order to decrease our susceptibility. We must understand that our traditional values should be discussed together with our community leaders in order to protect especially our women and children that are our vulnerable groups in society.

In Mozambique and Angola our family rights are all the same. Regarding customary law in our provinces and regions we find that men migrated to work on the diamond field and women find another boyfriend.

Michaela encouraged the team to look which issues make women vulnerable.

Feedback was as follows:

Change our customary laws. Civil society must organize themselves and have a national agenda.

Sex work is a reality and women should be trained to use condoms. We must train trainers that can speak the local languages.

We have a lack of health programmes and therefore needs to sit down with our lawmakers to draft a health programme.

## 6.4 Johanna Ncala: Treatment Literacy Campaign

Johanna presented an overview of TAC in South Africa on the HIV/AIDS situation and the National Response to the Epidemic.

Johanna shared that it is estimated that over 4 million South Africans are infected with HIV, the virus that causes AIDS. It is the biggest health crisis facing South Africa in recent history. The consequences of this disease do not only affect those with HIV, but also their loved ones, their friends, their children and those who will contract the virus in the future. This implies that the vast majority of South Africans are personally affected by the virus.

Given this critical situation, it is essential that South African society and government combats HIV rationally and competently. There are treatments available to increase the life expectancy of HIV positive people and to reduce the risk of mothers with HIV transferring the virus to their newborn children. Unfortunately, these treatments are unavailable to the vast majority of people living in this country and throughout the world's poorest countries. Much of this has to do with over-pricing, draconian patent laws and excessive profiteering by the pharmaceutical industry, as well as government mismanagement of the disease.

The Treatment Action Campaign (TAC) was launched on 10 December 1998, International Human Rights Day. Its main objective is to campaign for greater access to treatment for all South Africans, by raising public awareness and understanding about issues surrounding the availability, affordability and use of HIV treatments. TAC campaigns against the view that AIDS is a 'death sentence'.

The objectives of TAC are to...:

1. Ensure access to affordable and quality treatment for people with HIV/AIDS.
2. Prevent and eliminate new HIV infections.
3. Improve the affordability and quality of health-care access for all.

... and aims to achieve the following objectives:

- Promote treatment awareness and treatment literacy among all people.
- Campaign for AZT and Nevirapine for pregnant women to prevent mother-to-child transmissions.
- Campaign against profiteering by drug companies and other bodies.
- Build a mass TAC membership.
- Build networks and alliances with unions, employers, religious bodies, women and youth organisations, lesbian and gay organisations and other interested sections of the community.
- Maintain TAC visibility through posters, pamphlets, meetings, street activism and letter writing.

- Target pharmaceutical companies to lower the costs of all HIV/AIDS medications and maintain pressure on the government to fulfill its HIV/AIDS obligations.

### **Access to treatment in Angola and Mozambique: the situation on the ground**

The participants acknowledged that no or little access to affordable and quality treatment for people with HIV/AIDS in Angola.

Feedback were:

#### **Angola**

- That there is an overall lack of treatment and very few people have access antiretroviral treatment to prolong their lives
- That access to treatment outside of workplace programmes is almost non-existent
- That the price of medication is very high
- That children's medication is very expensive
- Children take adult medication as paediatric medication is not available
- It is difficult to get an appointment with doctors and have to wait for periods of months
- Many people are dying at home because of lack of treatment
- We fear the danger of drug resistance

#### **Mozambique**

- There is pressure from civil society for government to roll out access to treatment
- Government gives treatment in all provincial hospitals but it could be improved to the urban areas
- Government is prioritizing access to treatment for pregnant women
- There is no sufficient knowledge and programming to trainers of trainers especially in the health care sector
- Our main focus area should be stigma and discrimination problems
- Access to food is also a problem

A discussion followed and the participants were asked to identify issues that are vital in order to gain access to treatment for people living with HIV/AIDS.

- Treatment mainly in provincial hospitals and should be extended to the rural areas
- Policies should be developed
- The health system should be reconstructed health system
- VCT centres should be based in all of the provinces especially in the rural areas
- Civil society needs to unite in our call for change

The Angolan participants identified that there is a great need for the establishment of social movement to demand access and have identified three components that should be developed

- Human Rights for health cost of treatment litigation
- Put pressure on government to sign treaties
- Put policies in place

In Mozambique there was resistance from government's side but responded quickly after civil society started making demands. The need currently is to train trainers in order to take the message to the rural areas as well as have it translated in the different local languages.

Ms Johanna Ncala further explored to illustrate how the disease is transmitted by giving the participants basic understanding of the virus what it entails; how a person gets infected, the terminology that is used, and the medication available to treat opportunistic infections.

The participants had a good understanding of the different ways the virus is transmitted but emphasized that treatment literacy education should go hand in hand with education people from a Human Rights perspective as training regarding the use and understanding of antiretrovirals should be dealt with in the cultural context in order to enhance their knowledge.

The participants also acknowledged that the presentation on opportunistic infections and the various medication that is available is vital knowledge for every person living with HIV to know as well as the health sector and people caring for the ill.

Annexed to this report is the Treatment Action Campaign's treatment literacy information sheets for people living with HIV, support groups and clinics as well as their fact sheet that could be duplicated for further use in order to raise people's awareness and understanding to better the lives of those living with HIV/AIDS.

The final session gathered the participants in order to identify from the training they received what they would recommend to start with a civil society initiative to enhance the living conditions of the needy people in Angola.

## Recommendations

Took place during 21 to 23 June 2004, the workshop on slogan “Aligning HIV/Aids and Human Rights in SADC region”

### Luanda – Angola

Participants at this event were between 80-200 people from Angola, Mozambique, Republic of South Africa and Namibia, representing NGO's and Religious Institutions.

During three days of work, participants produced the following recommendation:

- The next workshop, should focus on the issues of: Gender and HIV/Aids;
- Must be seen on the component of institutional capacity of NGO's and Religious Institutions especially in Angola;
- Realization of donors conference for presentation of Regional Strategic Plan;
- Strengthening of **ANASO**, as away to respond the actually epidemic challenges in the country;
- Promote lobby to the World Food Program, as away to extend the basic nap experience for Angola;
- Realization of common study for better application of legislation already existent in our countries and the possible creation of other complementary law;
- To take advantage of **TAC**- Treatment Action Campaign experience in terms of producing materials of **IEC** – Information Education and Communication;
- Lobby for creation of common found for training and change experience between Mozambique, Namibia, South Africa and Angola;
- Realize exchange between countries of Mozambique, South Africa, Namibia and Angola for change experience and perfection of region good practice regarding to this workshop material;
- Promote exchange as away to secure of improvement of our actions at care domiciliary;
- Make lobby to government in way to guaranty our medical doctors maybe trained in Brazil and other countries who have better experience in ARV management;
- Realize a joined campaign Angola – Mozambique, Republic of South Africa and Namibia as away to press our governments for secure free access of ARV;
- Propose that **ARASA** Aids & Rights Alliance for Southern Africa continues facilitate the process implementation of recommendations of this workshop, internally, as well as to the international organisms in manner to guaranty materialization of our proposes;

Made in Luanda, 23 of June of 2004.-

The closing ceremony followed hereafter.

## 7. Closing Ceremony

During the closing ceremony Antonio Coelho that is the Executive Director of ANASO and the President of SCARJOV, Mr Jose Maria Zita and Ms Michaela Clayton to do the closing.

Mr Jose Maria Zita, thanked the participants from Angola, Mozambique, organizers and facilitators for their input and making the time for this very important workshop. He was pleased to note that a workshop of this magnitude was conducted in Angola especially since it addressed issues of Human Rights and HIV/AIDS as well as at regional and international level. It is Mr Zita's wish that especially children and the youth should be saved since it is their future that is at risk for the years to come.

Mr Antonio Coelho sent his greetings to Mozambique, Angola, representatives from SCARJOV, MULEIDE, TAC and ARASA. He exclaimed that provinces such as Luanda, Cabinda have a high HIV prevalence rate that is 8.6% in Luanda and 8.5% in Cabinda respectively; the fact that the northern and eastern parts of Angola bordering the Democratic Republic of Congo and Namibia could be seen as a high risk area for infection. Furthermore, the Angolan government and international agencies estimated a total prevalence rate of 5.5% at the age of 44 years. HIV is growing rapidly in Angola due to lack of knowledge, poverty, a weak health system, immigration of people infected with HIV, stigma and discrimination and weakness of civil society. He further mentioned that vulnerability to HIV is also linked to high rates of STDs such as syphilis that is estimated at 32% and hepatitis B estimated at 19%. The movement of truck drivers between boarding countries poses a high risk factor, as well as Angola's population that is relatively young and is estimated at 50% under the age of 15 years and 60% over the age of 18 years. Mr Coelho raised the issue that children are sexually active from the age of 14 years. Mr Coelho ended by saying that this workshop can bring about change for civil society organisations working in the area of HIV/AIDS and now is the time through enhancing skills through the exchange of information and training.

Ms Michaela Clayton thanked everyone for their participation and to the Angolan participants for their hospitality and expressed her hope that in future this initiative will narrow the gap between Angola, Mozambique, South Africa and Namibia in terms of promoting a Human Rights based response to HIV/AIDS.

- END -

**DRAFT PROGRAMME: ARASA HIV AND HUMAN RIGHTS TRAINING WORKSHOP:  
LUANDA 21 – 23 JUNE 2004**

**20 JUNE 2004**

Arrival

**DAY ONE: 21 JUNE 2004**

- 09h00-09h45: Welcome, introductions and workshop expectations
- 09h45-10h45: Overview of the HIV and human rights situation in Angola
- 10h45-11h15: Coffee
- 11h15-12h15: Overview of the HIV and human rights situation in Mozambique
- 12h15-13h00: Additions to workshop expectation
- 13h00-14h00: Lunch
- 14h00-15h30: HIV and Human Rights: Making the Connection
- 15h30-16h00: Coffee
- 16h00-17h30: Regional and International Human Rights Instruments: What are they and how can we use them to advance a human rights based response to HIV/AIDS?

**DAY TWO: 22 JUNE 2004**

- 8h30-10h00: Access to treatment in Angola and Mozambique: the situation on the ground.
- 10h00-10h30: Coffee
- 10h30-13h00: Treatment Literacy
- 13h00-14h30: Lunch
- 14h30-15h30: Barriers to treatment: TRIPS and Patents
- 15h30-16h00: Coffee
- 16h00-17h30: Strengthening the civil society response to HIV: Introduction to advocacy and lobbying

**DAY THREE: 23 JUNE 2004**

- 08h30-10h00: Identifying opportunities and building strategic alliances
- 10h00-10h30: Coffee
- 10h30-13h00: Good governance: the key
- 13h00-14h30: Lunch
- 14h30-15h30: HIV and Gender: the SADC Code on Gender and HIV
- 15h30-16h00: Coffee
- 16h00-17h30: The way forward

**24 JUNE 2004**

Departure

