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About the UPR Project at BCU:

Birmingham City University's Centre for Human Rights was created in 2014 to promote human rights, ensure access to justice, and enhance the rule of law around the world. We seek to achieve this through leading research, education, and consultancy. We submit expert reports to international human rights regions, provide advisory services to governments and nongovernmental organisations, and draft legal opinions and file legal briefs in domestic courts and international human rights courts.

The Centre for Human Rights established the UPR Project in 2018 as part of our consultancy service. We engage with the Human Rights Council's review process in offering support to the UPR Pre-sessions, providing capacity building for UPR stakeholders and National Human Rights Institutions, and the filing of stakeholder reports in selected sessions. The UPR Project is designed to help meet the challenges facing the safeguarding of human rights around the world, and to help ensure that UPR recommendations are translated into domestic legal change in member state parliaments. We fully support the UPR ethos of encouraging the sharing of best practice globally to protect everyone's human rights.

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INTRODUCTION

1. Namibia has the seventh highest rate of HIV across the world,[1] and HIV is the number one cause of death in the country.[2] It is estimated that around 210,000 adults and children in Namibia are living with HIV, which is approximately 8.4% of the country's total population.[3] Whilst the number of people currently living with HIV is still steadily increasing, the number of new infections is decreasing.[4] There are several reasons for this, including a rise in the general population, and an expansion of access to antiretrovirals (HIV medication) in Namibia, meaning that more people infected with HIV are living longer lives. In fact, 180,000 of those infected with HIV can now access antiretrovirals[5] and, in 2018, UNAIDS congratulated Namibia for increasing access to treatment.[6] However, there is still much work to be done in Namibia, particularly in terms of women and girls, as over 60% of those aged over 15 and living with HIV are women.[7]

2. This Stakeholder Report focuses on two key issues for women and girls living with HIV in Namibia: (1) the effect of HIV-related stigmatisation on women and girls, and (2) prevention of mother-to-child transmission of HIV. We make recommendations to the Government of the Republic of Namibia on these two key issues, implementation of which would also see Namibia moving towards achieving Sustainable Development Goal 5 which aims for gender equality.

A. <u>Namibia and International Law</u>

3. It is widely agreed that taking a human rights approach to tackling HIV is both progressive and effective.[8] Namibia is a party to seven of the nine core international human rights treaties,[9] for which the government should be commended. Particularly relevant for the regulation of the right to health, including in the context of HIV, is the International Covenant on Economic, Social and Cultural Rights ('ICESCR'), which Namibia ratified in 1994. Article 12(1) International Covenant on Economic, Social and Cultural Rights states that:

   1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

   2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

   (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; …

   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

   (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

4. Also relevant to the right to health, and in particular ensuring access to antiretrovirals, is Article 27 of the Universal Declaration of Human Rights, which states, "[e]veryone has the right…to share in scientific advancement and its benefits,"[10] and Article 15(1)(b) ICESCR, which recognises the right of everyone "[t]o enjoy the benefits of scientific progress and its applications."[11]

5. Furthermore, Namibia should abide by the International Guidelines on HIV/AIDS and Human Rights ('International Guidelines'), which were published by the OHCHR and UNAIDS to ensure that Member States were implementing international human rights standards on HIV in practice.[12] There are twelve guidelines in place, followed by recommendations for implementation and guidance on how to enact international human rights laws.[13]

B. Implementation of Recommendations from Cycle Two in 2016

6. Namibia received 219 recommendations in the Second Cycle, of which 191 were accepted and 28 were noted.[14] This is a laudable response to the UPR recommendations, but it is also important that accepted recommendations are subsequently implemented by the government.[15]

7. Only four of the 219 recommendations focused on HIV/AIDS, which is a disappointingly low number for such a serious issue. Whilst high numbers of recommendations can be counter-productive,[16] there were many other key points regarding HIV that UN Member States could have recommended on in 2016. Member States should ensure all key areas are being covered in Namibia's third cycle of review in 2021.

8. More positively, each of the four recommendations in 2016 focused on a different issue and all four were supported by Namibia.[17]

9. **South Africa (para. 137.119)** recommended that Namibia should "[i]mplement policies dealing with the stigma and discrimination against people living with HIV/AIDS."[18] Stigma and discrimination continues to be a barrier for those living with HIV, as discussed in Section C below, and there is still much to be done by the Namibian government to implement this recommendation.

10. **Canada (para. 137.191)** recommended that Namibia should "[i]ssue clear directives to health officials to prohibit the sterilization of women living with HIV/AIDS without their informed consent."[19] This was a serious human rights violation that had been discussed in Namibia's first cycle UPR in 2011. The National Women's Health Network had "called on Namibia to take remedial action to prevent further sterilization of HIV-positive women without their informed consent,"[20] and two specific recommendations were made on this point in 2011 from the United Kingdom ("[i]nvestigate reports of forced or coerced sterilisation in HIV-positive women and that it takes steps to ensure women are educated

about the effects of sterilisation and options available to them")[21] and Canada ("[i]ssue clear directives to all health officials prohibiting the sterilization of women living with HIV/AIDS without their informed consent").[22] These two recommendations were accepted[23] and also implemented, as the sterilisation of women without their informed consent was prohibited by the 2016 UPR.[24] Despite this, when the Supreme Court of Namibia ruled that forced sterilisation was unconstitutional, the Court still "failed to consider the level of discrimination and bias faced by women living with HIV in practice in Namibia."[25] This lack of acknowledgement and understanding of the stigma women face limits the positive action taken by the government in terms of HIV, indicating that there is further work to be done by the Namibian government, as discussed in Section C.

11. **Oman (para. 137.192)** asked Namibia to "[i]mplement policies and programmes aimed at preventing HIV/AIDS infections."[26] Whilst, on its face, it seems that further policies and programmes would likely assist in preventing HIV infections, this recommendation is far too broad to ensure any meaningful implementation. Recommendations from Member States would be more effective if they provided details of specific policies and programmes to be employed.[27] Specific recommendations can easily be formulated through utilising information provided in the Compilation and Stakeholder Reports.

12. **Ukraine (para. 137.193)** suggested that Namibia should "[i]ntensify the efforts in fighting against HIV/AIDS, in particular, to improve access to health-care services in rural areas."[28] However, the HIV infection rate continues to be higher in rural areas and, as there is a higher number of women living in rural areas than men, this also affects women more greatly.[29] There is an inequality in the number of healthcare professionals available in the urban areas compared to the rural communities; with a high number of vacancies being left unfilled in rural areas.[30] Furthermore, access to contraception, most specifically, condoms, is sporadic in the rural communities, leaving those living in rural areas more susceptible to HIV transmission.[31] More work is needed by the government to implement this recommendation, in particular relating to healthcare in rural areas.

13. A key point noted is that only one HIV-related recommendation specifically mentioned women in 2016. UN Member States should particularly focus their efforts on making suggestions to improve the safeguarding of the rights of women and girls with HIV in Namibia in the third cycle.

C. Further Points for Namibia to Consider

Effect of HIV-related Stigmatisation on Women and Girls in Namibia

14. The stigma faced by those living with HIV in Namibia is widespread and has a damaging effect upon the positive impact of the government's education and awareness raising of the nature of HIV, the transmission of the disease, and the healthcare and treatment plans for those infected. For example, 13% of those who undertook a UNAIDS survey stated

that they would not buy vegetables from a shopkeeper who had been diagnosed with HIV,[32] and there is a direct link between HIV stigmatisation and depression in Namibia.[33] Moreover, this stigma particularly affects women and girls, despite the commentary on International Guideline 6 stating that, “States should also ensure that their laws, policies, programmes and practices do not exclude, stigmatize or discriminate against people living with HIV or their families.”[34]

15. On its face, Namibia adheres to this, as it has a number of legal provisions and policies in place to combat stigma and discrimination. For example, Article 10 of the Namibian Constitution seeks to protect people from discrimination[35] and this includes those infected with HIV. Furthermore, its National Policy on HIV/AIDS states that “the adverse effects of stigma and discrimination are key barriers to effectively combating the epidemic. Commitments to...reducing stigma and discrimination [are] thus central to an effective response to HIV/AIDS.”[36] Stigmatisation on the basis of HIV/AIDS is also a criminal offence, according to this National Policy.

16. However, the protections laid out in the Namibian Constitution and its National Policy are not going far enough to protect women and girls. Physical and sexual violence is a “key driver” of the transmission of HIV[37] and “[v]arious studies have put the proportion of adolescent girls and/or young women who have experienced sexual violence or abuse to be…around 50% in Namibia.”[38] Potentially half of the women and girls in Namibia are at risk of HIV infection and as such are at risk of experiencing discrimination and stigmatisation. This is even more concerning as it has been found that such stigma and discrimination has led to women being afraid of seeking out testing for HIV and ultimately not receiving antiretroviral treatment.[39] The government must focus its efforts on tackling stigma and discrimination against women and girls infected with HIV in Namibia, with two points of priority, namely, community support and education.

17. A positive approach to overcoming HIV-related stigma for women is through fostering a supportive community environment. International Guideline 8 provides that “States should support the establishment and sustainability of community associations comprising members of different vulnerable groups for peer education, empowerment, positive behavioural change and social support.”[40] Yet women and girls with HIV in Namibia often do not have the benefit of such support.[41] Non-governmental organisations have put a great deal of effort towards engaging community projects and strategies around inclusivity, for example, Frontline AIDS works in Namibia to end stigma and improve education in communities.[42] Whilst these NGOs carry out invaluable work, they often lack the requisite financial support.[43] This lack of support also extends to women and girls accessing healthcare in the community. For example, many HIV-infected pregnant women face stigmatisation both from their general community and healthcare professionals, whilst children are often refused HIV testing and treatment as these professionals are unaware of the legal provisions allowing for testing without parental consent in certain circumstances.[44] Feeling safe within your community environment, particularly in terms of seeking healthcare support, is imperative for women and girls infected with HIV.

18. Further education is needed in Namibia, to inform the general population about the realities of living with HIV, including transmission and treatment, along with the damaging effects of stigmatisation. It is particularly important that this is included within the training of healthcare professionals, to instil the requirement for treating all patients equally. Although formal education and training is necessary, it is not the only way of tackling stigmatisation. International Guideline 9 provides specific ways that the public can be educated on this issue, as "[p]ublic programming explicitly designed to reduce the existing stigma has been shown to help create a supportive environment which is more tolerant and understanding."[45] The Government of Namibia should seek to implement this, using different types of media, "including creative and dramatic presentations, compelling ongoing information campaigns for tolerance and inclusion and interactive educational workshops and seminars,"[46] especially as this approach to educating people on HIV, as a way of reducing stigma, has been supported by scientific studies and academic literature.[47] The government should make use of these studies, looking to the successful implementation of these educative materials as a guide. Importantly, the rural communities must also be considered, ensuring that they have access to this media.

19. It must be noted that Namibia has particularly deep-rooted gender roles and cultural norms, which often lead to negative consequences for women and girls, including in the context of HIV.[48] Whilst this presents a bigger challenge, through careful work with the community the government can tackle the issue of stigma.

Prevention of Mother-to-Child Transmission (PMTCT) of HIV in Namibia

20. Article 2(a) of the ICECSR provides that steps must be taken to ensure "[t]he provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child."[49] In terms of HIV, in order to fully realise Article 2(a) this requires the prevention of mother-to-child transmission ('PMTCT') of the disease.

21. International Guideline 8 provides 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 [i.e. mother-to-child transmission] of HIV."[50] Namibia has made significant progress in this area. In 2019, 95% of HIV-positive pregnant women had access to antiretroviral treatment,[51] which will dramatically decrease the number of babies born with HIV.

22. However, there is still much work to be done. It was estimated that 4% of babies born in 2019 contracted HIV through vertical transmission, including through breastfeeding.[52] Furthermore, according to figures from March 2016 – March 2019, a consistent trend shows that less than a quarter of women sought antenatal care in the first trimester of their pregnancy.[53] As such, there has been an increase in new HIV diagnoses "either late in pregnancy or at labor and delivery."[54] It is therefore imperative that women seek early

antenatal care in order to ensure that HIV-infected women begin antiretroviral treatment to avoid vertical transmission.

23. The data shows that "[p]regnant adolescent girls and young women in particular are less likely than older pregnant women to know their HIV status before starting antenatal care."[55] When they become pregnant, they will not be aware of the urgency in seeking first trimester antenatal care. Moreover, even when young women are aware of their HIV-positive status, they can find it more difficult to engage with treatment for a number of reasons, including the risk of violence or stigma and discrimination, and the need to travel long distances and wait for lengthy periods of time at healthcare clinics.[56]

24. A further problem with PMTCT is the difference in practice between the public and private sectors. Data relating to PMTCT in the private sector is not sent to or amalgamated with Namibia's National Health Information System.[57] This is a cause for concern. In total, 20% of antiretroviral treatment is administered through private sector healthcare facilities.[58] Having a clear and comprehensive data set is imperative to ensuring that there is a reliable national overview not only of PMTCT, but also other, wider HIV statistics in Namibia. The amalgamation of public and private healthcare data should be a priority for the Namibian government, looking to other success stories across the globe for guidance and financial support.[59]

D. <u>Recommendations</u>

We recommend that the Government of the Republic of Namibia should:

i. Fully engage with the International Covenant on Economic, Social and Cultural Rights, in particular Article 12(1) in the context of HIV. If there are difficulties in this Article being fully realised, the government should raise this during the treaty body review.

ii. Continue to prohibit the sterilisation of women with HIV without consent, ensuring that all healthcare professionals across the country also forbid this practice.

iii. Actively seek out opportunities to work with NGOs who are encouraging supportive community environments for women with HIV, providing financial support where possible.

iv. Ensure that all healthcare professionals are trained comprehensively on the laws and policies surrounding HIV in Namibia, to ensure that all who need it can access testing and treatment.

v. Ensure that all people in Namibia are educated about how HIV is transmitted and the dangers of stigmatisation, particularly for women and girls. This should include, but is not limited to, formal education and training, and other, alternative sources of media.

vi. Investigate why over 75% of women do not seek antenatal care in their first trimester. From the findings of this investigation, formulate relevant and sensible

policies to ensure that early antenatal care becomes the norm in Namibia, in order to ensure that any HIV-infected women begin antiretroviral treatment to avoid vertical transmission.

vii. Ensure that the private sector's data on PMTCT is merged with national data, allowing comprehensive statistics to be produced in order to take the necessary action to further limit vertical transmission of HIV from mother-to-child. Should financial assistance be needed to do this, it should be sought from the UN and developed nations.

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[1] World Bank, 'Prevalence of HIV' (2019) <https://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?most_recent_value_desc=true> accessed 9 October 2020.
[2] CDC, 'Global Health – Namibia' <www.cdc.gov/globalhealth/countries/namibia/default.htm> accessed 9 October 2020.
[3] UNAIDS 'Namibia' <www.unaids.org/en/regionscountries/countries/namibia> accessed 9 October 2020.
[4] ibid.
[5] ibid.
[6] UNAIDS, 'UNAIDS Congratulates Namibia on Increasing Access to Treatment' (26 July 2018) <www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2018/july/namibia-increasing-access-to-treatment> accessed 9 October 2020/
[7] UNAIDS, 'Namibia' (n 3).
[8] Bell et al, 'Sexual and Reproductive Health Services and HIV Testing: Perspectives and Experiences of Women and Men with HIV and AIDS' (2007) 19(59) Reproductive Health Matters 113-135.
[9] International Convention on the Elimination of All Forms of Racial Discrimination, ratified in 1982; International Covenant on Civil and Political Rights, ratified in 1994; International Covenant on Economic, Social and Cultural Rights, ratified in 1994; Convention on the Elimination of All Forms of Discrimination Against Women, ratified in 1992; Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ratified in 1994; Convention on the Rights of the Child, ratified in 1990; Convention on the Rights of Persons with Disabilities, ratified in 2007. See, OHCHR, 'Status of Ratification Interactive Dashboard' <http://indicators.ohchr.org> accessed 9 October 2020.
[10] Universal Declaration of Human Rights (adopted 10 December) 1948 UNGA Res 217 A(III), Article 27.
[11] International Covenant on Economic, Social and Cultural Rights*,* 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, Article 15(1)(b).
[12] OHCHR & UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights' (2006) <www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf>.
[13] ibid. The guidelines provide that: (1) There should be a national framework in place to prevent HIV; (2) There is community input in the creation of HIV policies; (3) Public health laws should take HIV into account; (4) Criminal laws should not be misused in the context of HIV; (5) Anti-discrimination laws should be in place to protect those with HIV; (6) All should have access to HIV-related goods, services, and information; (7) Legal support services should be provided; (8) A supportive environment should be created for women, children, and other vulnerable groups; (9) Educative materials should be provided to avoid stigmatisation; (10) Codes of practice for professional responsibility should be developed; (11) Monitoring and enforcement mechanisms should be created; and (12) States should cooperate with UN agencies on HIV.
[14] UNHRC, 'Report of the Working Group on the Universal Periodic Review – Namibia Addendum 1' (14 June 2016) UN Doc A/HRC/32/4/Add1, para 2.
[15] Alice Storey, 'Challenges and Opportunities for the UN Universal Periodic Review: A Case Study on Capital Punishment in the USA' (2021) 90(1) UMKC Law Review (forthcoming Spring 2021)..
[16] ibid.
[17] See UNHRC, 'Report of the Working Group on the Universal Periodic Review – Namibia Addendum 1' (n 14).
[18] UNHRC, 'Report of the Working Group on the Universal Periodic Review – Namibia' (15 April 2016) UN Doc A/HRC/32/4, para 137.119.
[19] ibid para 137.191.
[20] UNHRC, 'Summary of Stakeholders Information – Namibia (8 November 2010) UN Doc A/HRC/WG.6/10/NAM/3, para 14.
[21] UNHRC, 'Report of the Working Group on the Universal Periodic Review – Namibia' (24 March 2011) UN Doc A/HRC/17/14, para 96.54.
[22] ibid para 96.60.
[23] UNHRC, 'Report of the Working Group on the Universal Periodic Review – Namibia Addendum 1' (31 May 2011) A/HRC/17/14/Add1.
[24] See UNHRC, 'Compilation of UN Information – Namibia (23 November 2015) UN Doc A/HRC/WG.6/24/NAM/2, para 57; LM and Others v Namibia.
[25] Alicia Ely Yamin & Corey Prachniak-Rincon, Compounded Injustice and Cautionary Notes for 'Progress' in the Sustainable Development Era: Considering the Case of Sterilization of Women Living with HIV' (2018) 41 Harv. J. L. & Gender 395, 422.
[26] UNHRC, 'Report of the Working Group on the Universal Periodic Review – Namibia' (15 April 2016) (n 18) para 137.192.
[27] Storey (n 15).
[28] UNHRC, 'Report of the Working Group on the Universal Periodic Review – Namibia' (15 April 2016), (n 18), para 137.193.
[29] Republic of Namibia, 'National Strategic Framework for HIV and AIDS' (2017) <www.unaids.org/sites/default/files/country/documents/NAM_2018_countryreport.pdf> 17.
[30] ibid 51.
[31] ibid 24.
[32] UNAIDS, 'Namibia' (n 3).

[33] Eveline Ndii Kalomo et al, 'Associations between HIV-related Stigma, Self-esteem, Social Support, and Depressive Symptoms in Namibia' (2018) 22(12) Aging and Mental Health; Eveline Ndinelao Kalomo, 'HIV Stigma, Resilience and Depressive Symptoms Among Older Adults Living with HIV in Rural Namibia' (2020) African Journal of AIDS Research.
[34] OHCHR & UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights' (n 12) para 30.
[35] Article 10 Namibia Constitution.
[36] Republic of Namibia National Policy on HIV/AIDS (14 March 2007).
[37] Avert, 'Women and Girls, HIV and AIDS' (23 April 2020) <www.avert.org/professionals/hiv-social-issues/key-affected-populations/women#footnote11_ng1fyjj> accessed 9 October 2020.
[38] ibid.
[39] Republic of Namibia, 'National Strategic Framework for HIV and AIDS' (n 29) 43.
[40] OHCHR & UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights', note 12, para 60(a).
[41] Republic of Namibia, 'National Strategic Framework for HIV and AIDS' (n 29) 49.
[42] Frontline AIDS, 'Namibia' <https://frontlineaids.org/we-have-an-impact-in/eastern-and-southern-africa/namibia/> accessed 9 October 2020.
[43] Republic of Namibia, 'National Strategic Framework for HIV and AIDS' (n 29) 49.
[44] ibid 54.
[45] OHCHR & UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights' (n 12) para 63.
[46] ibid.
[47] Thomas J Coates, 'Behavioural Strategies to Reduce HIV Transmission: How to Make them Work Better' (2008) 372(9639) Lancet, 669–684.; Elizabeth Armstrong-Mensah et al, 'Perinatal HIV Transmission Prevention: Challenges Among Women with HIV in sub-Saharan Africa' (2020) 9(3) IJMA, 354–359.
[48] PEPFAR, 'Namibia Country Operational Plan' (10 March 2020) <www.state.gov/wp-content/uploads/2020/07/COP-2020-Namibia-SDS-FINAL.pdf> 11.
[49] International Covenant on Economic, Social and Cultural Rights (n 11) Article 2(a).
[50] OHCHR & UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights (n 12) para 60(f).
[51] UNAIDS, 'Namibia' (n 3).
[52] UNAIDS AIDSINFO <https://aidsinfo.unaids.org> accessed 9 October 2020.
[53] Francina Rusberg & Andrew Agabu, 'PMTCT: Achievement, Challenges and the Way Forward in Namibia' (16 August 2019) <www.namhivsociety.org/media/hivsoc/Pdf/Nurses%20Corner/5-c-pmtct-achievement-challenges-way-forward-f.pdf>.
[54] PEPFAR, 'Namibia Country Operational Plan' (n 48) 9.
[55] UNAIDS, 'Women and HIV' (2019) <www.unaids.org/sites/default/files/media_asset/2019_women-and-hiv_en.pdf>.
[56] ibid.
[57] Rusberg & Agabu (n 54).
[58] Republic of Namibia, 'National Strategic Framework for HIV and AIDS' (n 29) 39.
[59] An example of how this has been positively implemented can be seen from the United Kingdom. The UK's National Health Service has recently implemented a system to collate all patient data, regardless of whether the treatment was private or public. This provides a full and comprehensive record for each person living in the UK, allowing for accurate and timely reporting of national statistics and standards in terms of healthcare: https://digital.nhs.uk/about-nhs-digital/our-work/acute-data-alignment-programme.