Legal Environment Assessment Of HIV and AIDS In the Republic of Mauritius

Consultants

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Commissioned by PILS
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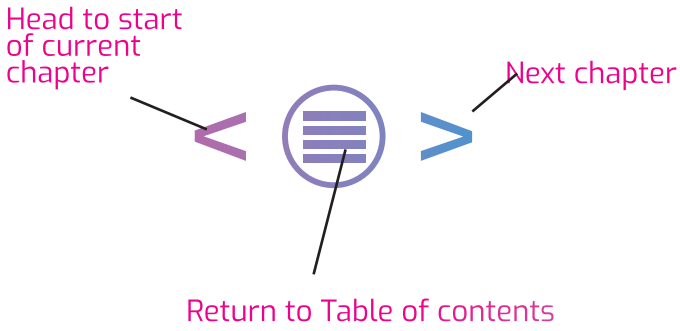

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respondence from the National Preventive Mechanism Division or to implement recommendations made by them.

The Police Service

Focus group discussion with people who use drugs revealed that the Anti-Drug and Smuggling Unit ("ADSU") of the Police are often over-zealous or are not sufficiently knowledgeable in all aspects of the law when it concerns the distribution of syringes and needles, albeit done pursuant to the relevant authorizations and in compliance with the laws of Mauritius.

The HIV and AIDS Act stipulates that an institution (meaning a hospital, a laboratory, a pharmacy or a centre for the rehabilitation of drug addicts) or non-governmental organization may supply syringes and needles to any person dependent on a dangerous drug, provided that the new syringe or the new needle has been prescribed by the Permanent Secretary of the Ministry of Health and Quality of Life, after consultation with the Medical Council and the Dental Council, with the approval of the Commissioner of Police (Vide Section 14 of the HIV and Aids Act).

Notwithstanding the above provisions of the HIV and AIDS Act, the ADSU apparently focuses solely on Section 34 (1) (c) of the Dangerous Drugs Act, in complete disregard of Section 14 of the HIV and Aids Act, to apprehend persons in possession of syringes.

Section 34 (1) (c) of the Dangerous Drugs Act provides that:

'Any person who unlawfully has in his possession any pipe, syringe, utensil, apparatus or other article for use in connection with smoking, inhaling, sniffing, consuming or the administration of any dangerous drug shall commit an offence and shall, on con-

FOREWARD

It is my pleasure, privilege and duty to share some thoughts on this important achievement in the HIV and AIDS response in Mauritius.

The National Legal Environment Assessment aims at reviewing laws, regulations and policies, access to justice and law enforcement in the context of HIV to identify the nature and extent of stigma, discrimination, gender inequality, gender-based violence and human rights abuses a□ecting people living with HIV and key populations and is an important step in the HIV and AIDS response.

Drug trafficking and consumption is becoming a world phenomenon and undermines institutions and is a threat to public health, social security and damage development efforts. Effective evidence-based strategies need be developed and implementation in response to this situation.

I acknowledge the efforts being made to tackle this threat in Mauritius. When we talk about drug and HIV policies, we lament that we could have done more, but we need to acknowledge that much has been done in the last ten years. However, we need not be complacent, there is need for harmonising health and human right policies on this matter.

Evidence shows that protective legal environments improve the lives of people living with HIV and reduce vulnerability to infection. It has also shown that stigma, discrimination, and ine□ective access to justice could fuel the HIV epidemic.

I would like to thank, PILS for commissioning the national Legal Environment Assessment, under the aegis of the Global Fund to Fight Aids, Tuberculosis and Malaria, the consultant from the AIDS and Rights Alliance of South Africa (ARASA), the local consultant, and the multi-sectorial technical committee for working on this assessment.

My office and the United Nations Country Team stand ready to support the development of health and human right centred policies as we work together toward the Sustainable Development Goals.

Ms. Christine N. Umutoni
UN Resident Coordinator for Mauritius and Seychelles

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Abbreviations

AIDS Acquired Immune Deficiency Syndrome
ART Antiretroviral Therapy
AU African Union
CBOs Community-based Organisations
CEDAW Convention on the Elimination of All forms of Discrimination against Women
CESCR Committee on Economic, Social and Cultural Rights
COM Constitution of Mauritius
CSOs Civil Society Organisations
CRC Convention on the Rights of the Child
FGD Focus Group Discussions
GBV Gender Based Violence
GCHL Global Commission on HIV and the Law
HCT HIV Counselling and Testing
HIV Human Immuno-deficiency Virus
HTS HIV Testing Services
ICCPR International Covenant on Civil and Political Rights
ICESCR International Covenant on Economic, Social and Cultural Rights
ILO International Labour Organisation
IOM International Organisation for Migration
IP Intellectual Property
KII Key Informant Interviews
LGBTI Lesbian, Gay, Bisexual, Transgender and Intersex
MC Male Circumcision
MSM Men who have sex with men
NDCCI National Day Care Centre for the Immuno-suppressed
OHCHR Office of the High Commissioner for Human Rights
OIs Opportunistic Infections
PITC Provider-initiated Testing and Counselling
PLHIV People living with HIV
SADC Southern African Development Community
SDGs Sustainable Development Goals
STIs Sexually Transmitted Infections
TB Tuberculosis
TRIPS WTO Agreement on Trade Related Aspects of Intellectual Property Rights
TWG Technical Working Group
UDHR Universal Declaration of Human Rights
UN United Nations
UNAIDS United Nations Joint Programme on HIV/AIDS
UNFPA United Nations Populations Fund
UNHCR United Nations High Commission for Refugees
UNGASS United Nations General Assembly Special Session
UNODC United Nations Office on Drugs and Crime
VCT Voluntary Counselling and Testing
WHO World Health Organisation
WTO World Trade Organisation

Executive Summary

[1] LINK (Accessed 31 January 2018).
[2] IBBS, 2013 cited in UNAIDS Mauritius Country Progress Report 2015; Available at LINK (Accessed 31 January 2018).
[3] TG IBBS 2017
[4] MSM IBBS 2012
[5] LINK (Accessed 31 January 2018).
[6] Submission by Chrysalide, Mauritius, Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August, 2011
[7] UNAIDS Mauritius Country Progress Report 2015; Available at LINK (Accessed 31 January 2018).
[8] National AIDS Secretariat, People living with HIV Stigma Index Report, Mauritius, 2013

Stigma, discrimination and other human rights abuses faced by people living with HIV or AIDS as well as by key populations at higher risk of HIV infection worldwide, compromise their ability to access health care services, including HIV prevention, treatment and care services and thus negatively impact on national responses to HIV and AIDS. The HIV epidemic is a major public health and development challenge in Mauritius. There are 8 200 people living with HIV, of which only 31% are on **ART**[1].

Mauritius has a concentrated HIV epidemic with a low prevalence of HIV amongst the general population and high prevalence of HIV amongst key populations and in particular amongst people who inject drugs who were found to have an HIV prevalence of 44.3% in a 2013 **study**[2].Other key populations include sex workers and gay men and other men who have sex with men (MSM). Transgender people have the second highest HIV prevalence, currently estimated at **28%**[3] , followed by MSM **(20%)**[4] female sex workers (15%) and prisoners with a prevalence of **11%**[5] Many sex workers also inject **drugs**[6]. There is no data on HIV prevalence amongst lesbian, bisexual and intersex people. Young people are also recognised as a key population in **Mauritius.**[7]

HIV-related stigma and discrimination remain high in Mauritius, despite protective **laws.**[8] People living with HIV, especially people with HIV who use drugs, complain of stigma and discrimination, particularly within health care settings. Examples include being refused medicines or access to facilities, poor or inadequate services, stigmatizing treatment from health care providers, HIV testing without consent and in particular, breaches of the right to confidentiality, often fuelled by stigmatising attitudes and ignorance on the part of doctors, midwives, nurses and hospital staff of HIV transmission routes. The 2013 Stigma Index Report found that 28% of respondents reported being denied access to health services due to HIV, 40.5% reported discriminatory or very discriminatory responses to disclosures of their HIV status to health care workers and 26.8% of respondents said that health care workers had disclosed their HIV status without their consent. A number of respondents reported being tested for HIV on admission to an institution – 23.5% were tested for HIV on admission into prison and 12.2% were tested on admission to hospital. Respondents also reported relatively low

[9] Ibid.
[10] UNAIDS Mauritius Country Progress Report 2015; Available at LINK (Accessed 31 January 2018).
[11] LINK (Accessed 31 January 2018).
[12] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[13] Submission by Chrysalide, Mauritius, Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August, 2011
[14] GCHL (2012) Risks, Rights & Health
[15] Ibid.

levels of access to **ART.**[9] The most recent BSS reported that 10.3% of people had discriminatory attitudes towards people living with **HIV.**[10]

Discrimination against LGBTI populations was also reported to be a matter of **concern.**[11]

Employees living with HIV are discriminated against in the work place. Complaints of unfair dismissals on the basis of HIV status or drug use (where employees using methadone substitution therapy are dismissed) are reported, although the general attitudes of stigma towards HIV and drug use discourage employees from seeking legal **remedies.**[12]

Sex workers report many experiences of stigma and discrimination including verbal and physical abuse from the general public; assault, sexual violence and rape, harassment, theft and extortion from brothel owners, clients and law enforcement officials and discriminatory treatment, denial of access to health care, degrading treatment and breaches of the right to confidentiality within the health care setting. Sex workers note being unable to report these violations since there is a general perception that due to the criminalised nature of their work they are not deserving of **protection.**[13]

The criminalisation of drug use exacerbates stigma, discrimination and violence against people who use drugs and creates barriers to access to health care **services.**[14]Needle exchange programmes conflict with the law since possession of needles for purposes of injecting drug use is illegal. The Dangerous Drugs Act is a barrier to access to both harm reduction and HIV-related health care **services.**[15] The provision in the HIV and AIDS Act, 2006 for needle exchange programmes is in conflict with the provisions of the Dangerous Drugs Act and if this provision is to be effectively implemented the two pieces of legislation should be harmonised.

Criminalised populations such as people who inject drugs and sex workers face barriers to accessing employment as employers require a Certificate of Character from prospective employees that details their criminal record for the past 10 years.

There are also reports of discrimination against children affected by HIV – such as being denied access

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

to education on the basis of a child's perceived **HIV status.**[16]

Criminal laws that criminalise same-sex sex act as barriers to the provision of and the access to health services for men who have sex with men and transgender **people.**[17]

HIV positive migrant workers are also not allowed to work in **Mauritius.**[18] Migrants are required to test for HIV in order to apply for a work permit; if they test HIV-positive, they are denied a permit to work legally within the **country.**[19]
Legal and human rights challenges have been identified and include:

- The lack of HIV-specific anti-discrimination protection for people living with HIV and key populations at higher risk of HIV exposure in law
- Discriminatory and punitive laws, policies and practices that create barriers to access to HIV testing, prevention, treatment, care and support (including harm reduction measures) for affected populations and that deny people living with HIV access to education, insurance, bank loans and employment in the armed forces
- Punitive laws that criminalise populations at higher risk of HIV exposure (such as men who have sex with men, people who use drugs and sex workers).

Reversing HIV trends and patterns to get to 90:90:90 and the end of AIDS as a public health threat by 2030 requires an effective response underpinned by a supportive and protective environment in the **country.**[20] The role of a supportive legal and policy environment in improving outcomes of HIV and AIDS interventions has been increasingly documented and recognized to include improving protection of rights, enhancing access to HIV and AIDS services and mitigating the impacts of the epidemic. Thus, as part of the national response to HIV, targeted actions to create an enabling legal and regulatory environment will also contribute to achieving the Sustainable Development Goals (SDGs).

The Government of Mauritius has shown continued commitment to improving the national response to HIV through allocation of resources to support interventions at various levels. Both the National HIV Policy (2012) and the National Action Plan for HIV and AIDS (2017 – 2021) recognise the need for human rights to be at the centre of an effective response to HIV and AIDS.

[21] See Part V for detailed recommendations

Commissioned by Prêvention Information Lutte contre le SIDA (PILS), the purpose of this project is to provide an assessment and analysis of the legal and regulatory aspects in the context of HIV and AIDS in Mauritius for purposes of making recommendations for creating and strengthening an enabling environment that promotes an effective national AIDS response. The assessment has been conducted by way of a desk review of documentation on selected laws, regulations and policies and a qualitative assessment of the level of knowledge on human rights among key and vulnerable populations; and of the degree of awareness of HIV-related laws and human rights among law makers and law enforcers to enable effective implementation of services, access to justice and enforcement of HIV-related laws and rights. This report sets out the findings of the assessment and analysis and provides sound recommendations on actions required to create and strengthen the HIV-related legal and regulatory environment.

This Legal Environment Assessment identified a number of challenges relating to HIV, law and human rights in Mauritius and thus calls for the enactment of the following protections in law for **HIV**:[21]

- Repeal those provisions of immigration legislation and regulations that exclude migrant workers from employment or foreigners from residing or studying in Mauritius solely on the basis of their HIV status.
- Implement regulatory reform to ensure that migrant workers and foreigners can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens.
- Legal provisions should be enacted to prohibit exclusion from life, health and other insurance solely on the basis of HIV status and to ensure that in the context of insurance, HIV should not be treated differently from analogous chronic medical conditions.
- Amend the Public Health Act to exclude HIV and AIDS from the operation of section 42 and also to ensure that notification provided for in section 41 is anonymous and unlinked and is undertaken only for the purposes required for disease surveillance.
- Amend the Public Health Act to exclude HIV and AIDS from the operation of section 48 to ensure that the provisions of this Act regarding isolation and detention cannot be inappropriately in-

voked against people living with HIV.

- Amend the law to align the age of consent to sexual and reproductive health services and to HIV treatment to that of consent to sexual intercourse.
- Ensure the Industrial Property Bill is brought into force.
- Amend the provisions of the Criminal Code to decriminalise sodomy.
- Provision should be made for legal recognition of self-identified gender under national law without the need for surgery and related medical procedures.
- Amend existing definitions in Mauritian legislation to include same-sex couples on the same basis as spouses of opposite sexes and legalise same-sex marriage.
- Amend the provisions of the Criminal Code to decriminalise consensual adult sex work.
- Enact law to protect against discrimination and violence, and other violations of rights faced by sex workers in order to realize their human rights and reduce their vulnerability to HIV infection and the impact of AIDS. Anti-discrimination laws and regulations should guarantee sex workers' rights to social, health and financial services.
- Decriminalise possession of drugs for own use and halt the practice of arresting and imprisoning people who use drugs but do no harm to others.
- Amend the Dangerous Drugs Act to bring it in line with the HIV and AIDS Act and decriminalise the possession of needles and syringes as part of a needle exchange programme.
- Amend the Criminal Code to decriminalise consensual same-sex sex.
- Amend the Constitution to stipulate that in addition to the Public Bodies Appeals Tribunal and the Supreme Court, the Equal Opportunities Commission should also be exempt from the general rule provided for in Section 118(4) of the Constitution.
- Expand the definition of gender-based violence in law and policy to provide for 'socially ascribed differences based on gender identity and sexual orientation.
- Amend the definition of "domestic violence" in the Protection from Domestic Violence Act 6 of 1997 to include all acts of physical, sexual,

psychological or economic violence that occur within the family or between former or current spouses or partners, regardless of gender identity of sexual orientation, whether or not the perpetrator shares or has shared the same residence with the victim.

Part 1

Introduction and Background

[22] LINK ; (Accessed 31 January 2018).
[23] IBBS, 2013 cited in UNAIDS Mauritius Country Progress Report 2015; Available at LINK (Accessed 31 January 2018).
[24] TG IBBS 2017
[25] MSM IBBS 2012
[26] LINK (Accessed 31 January 2018).
[27] Submission by Chrysalide, Mauritius, Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August, 2011
[28] UNAIDS Mauritius Country Progress Report 2015; Available at LINK (Accessed 31 January 2018).
[29] National AIDS Secretariat, People living with HIV Stigma Index Report, Mauritius, 2013
[30] Ibid.
[31] UNAIDS Mauritius Country Progress Report 2015; Available at LINK (Accessed 31 January 2018).
[32] LINK (Accessed 31 January 2018).

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HIV-related stigma and discrimination remains high in Mauritius, despite protective **laws.**[29] People living with HIV, especially people with HIV who use drugs, complain of stigma and discrimination, particularly within health care settings. Examples include being refused medicines or access to facilities, poor or inadequate services, stigmatizing treatment from health care providers, HIV testing without consent and in particular, breaches of the right to confidentiality, often fuelled by stigmatising attitudes and ignorance on the part of doctors, midwives, nurses and hospital staff of HIV transmission routes. The 2013 Stigma Index Report found that 28% of respondents reported being denied access to health services due to HIV, 40.5% reported discriminatory or very discriminatory responses to disclosures of their HIV status to health care workers and 26.8% of respondents said that health care workers had disclosed their HIV status without their consent. A number of respondents reported being tested for HIV on admission to an institution – 23.5% were tested for HIV on admission into prison and 12.2% were tested on admission to hospital. Respondents also reported relatively low levels of access to **ART.**[30] The most recent BSS reported that 10.3% of people had discriminatory attitudes towards people living with **HIV.**[31]

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[35] GCHL (2012) Risks, Rights & Health
[36] Ibid.

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[37] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[38] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[39] UNAIDS, Mauritius NCPI Report, 2010
[40] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[41] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

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Reversing HIV trends and patterns to get to 90:90:90 and the end of AIDS as a public health threat by 2030 requires an effective response underpinned by a supportive and protective environment in the **country.**[41] The role of a supportive legal and policy environment in improving outcomes of HIV and AIDS interventions has been increasingly documented and recognized to include improving protection of rights, enhancing access to HIV and AIDS services and mitigating the impacts of the epidemic. Thus, as part of the national response to HIV, targeted actions to create an enabling legal and regulatory environment will also contribute to achieving the Sustainable Development Goals (SDGs).

Commissioned by Prévention Information Lutte contre le SIDA (PILS), the purpose of this project is to provide an assessment and analysis of the legal and regulatory aspects in the context of HIV and AIDS in Mauritius. The assessment has been conducted by way of a desk review of documentation on selected laws, regulations and policies and a qualitative assessment of the level of knowledge on human rights among key and vulnerable populations; and of the degree of awareness of HIV related laws and human rights among law makers and law enforcers to enable effective implementation of services, access to justice and enforcement of HIV-related laws and rights. This report sets out the findings of the assessment and analysis and provides sound recommendations on actions required to create and strengthen the HIV-related legal and regulatory environment.

Aims and Objectives

Aim

The aim of the legal and regulatory analysis is to improve the availability of information and evidence of legal and regulatory aspects in the context of HIV and AIDS, for purposes of making recommendations for creating and strengthening an enabling environment that promotes an effective national AIDS response in Mauritius.

Specific objectives

The Legal Environment Assessment aims to:

- Systematically analyse an agreed list of prioritized, relevant laws, regulations as well as policies and practices, where relevant, to determine how they undermine or support an enabling environment and effective national HIV response,
- Analyse the extent to which affected populations know and are able to access their rights and service providers, lawmakers and law enforcers are sensitized to HIV-related law and human rights issues to enable effective implementation of services, access to justice and enforcement of HIV-related laws and rights; and
- Provide detailed and appropriate recommendations of selected laws and regulations considered necessary to be reformed, enacted or better enforced as well as appropriate measures to strengthen access to justice and improve law enforcement, to create an enabling framework for HIV and AIDS.

Key Deliverables

The key deliverables under the project were as follows:

- Detailed work plans for the major project activities including a desk review, key informant interviews (KIIs), focus group discussions (FGDs) and public consultations
- A preliminary desk review of the available documentation on selected laws, regulations and policies, detailing key HIV, law and human rights issues and the impact of the legal framework on the national HIV response in Mauritius as well as on the findings of key informant interviews and focus group discussions, including the nature

[42] World Health Organisation (2009) A Human Rights Based Approach to Health: Policy Brief

and extent of stigma and discrimination against affected populations, the extent to which affected populations know their rights and the extent to which service providers, lawmakers and law enforcers are sensitized to HIV-related law and human rights issues to enable effective implementation of services, access to justice and enforcement of HIV-related laws and rights

- A comprehensive final draft report providing a synthesis of findings from the desk review, focus group discussions, and key informant interviews with overall recommendations on actions required to address the identified legal and regulatory issues, to enable effective implementation of services, access to justice and enforcement of HIV-related laws and rights.

Implementation Modalities

Technical Approach

The Legal Environment Assessment has been guided by a human-rights based approach to health, HIV and **AIDS**[42] using national, regional and international human rights commitments made by Mauritius as the starting point for framing the enquiry, designing the tools for analysis, analysing the findings and developing the recommendations. In the context of HIV, this approach aims to promote the right to health and other related rights. It examines the legal, social, economic and/or cultural contexts which underlie the HIV epidemic in Mauritius, with the broader aim of recognising and responding to the underlying inequalities, prejudices and power relationships that impact upon HIV transmission and access to HIV-related health care services in the country.

The main principles of the rights-based approaches that are proposed as guiding principles for the Legal Environment Assessment are the principles of equality and non-discrimination; participation and inclusion of rights-holders; capacity building of duty-bearers and accountability. The Legal Environment Assessment recognises the inter-relationship between all human rights, including health rights and equality rights, and seeks to balance public health and human rights goals in developing the rights

of all people.

Research Methodology

The Legal Environment Assessment has been carried out using the various methodologies set out below:

Desk Review

The Legal Environment Assessment includes a desk review of all relevant documentation relating to HIV, law and human rights issues at national level, as well as regional and international levels in order to determine the scope and content of laws, regulations and policies as well as issues around how laws are implemented and enforced. Documents reviewed include:

- International and regional human rights commitments as well as regional and international health and HIV-specific commitments and guidance documents;
- Laws, regulations and policies as well as selected policies, plans and guidelines, where relevant;
- Case law; and
- Annual reports, research reports and other documents of civil society organisations working with health, HIV, people living with HIV and key populations; reports of government ministries, statutory bodies (such as the Office of the Ombudsman), regional and international organisations and academic publications.
- The desk review aims to determine the nature, extent, efficacy and impact of the legal and regulatory framework (include laws, regulations and policies as well as access to justice and law enforcement issues) for protecting rights and promoting universal access to HIV prevention, treatment, care and support in Mauritius. It furthermore makes recommendations for law review and reform as well as efforts to strengthen access to justice and law enforcement.
- The desk review includes an initial focus on the key issues identified in the preparatory phase of the project. It furthermore identifies additional key HIV, law and human rights issues of concern within Mauritius for further exploration during key informant interviews and focus group discussions.

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

See Annexure 1 for a list of documents reviewed

Key Informant Interviews

The key informant interviews provided qualitative information on the views of decision-makers on key HIV, law and human rights issues within Mauritius; the impact of the legal and regulatory framework upon the response to HIV and AIDS as well as recommendations for strengthening the legal and regulatory framework to protect rights and promote access to services in the context of HIV and AIDS.

Key informants were selected from across a range of sectors, including from government, civil society, the private sector and other partner institutions. They include relevant government officials from key ministries such as the Ministry of Health and Quality of Life, the Office of the Attorney-General, and the Ministry of Labour, Industrial Relations, Employment and Training amongst others.

They also include members of the National Assembly, legal experts and the Office of the Ombudsman.

Key informants also include representatives of Civil Society organisations working with and for people living with HIV and other affected populations, faith-based organisations as well as development partners working on health, HIV and related issues. See Annexure 2 for a list of key informants interviewed

Focus Group Discussions

Focus Group Discussions (FGDs) were used to obtain qualitative data from selected populations on their experiences of stigma, discrimination and human rights violations in the context of HIV and AIDS, how laws, policies and practices impact upon rights and the ability to access services in the context of HIV and whether affected populations are able to access justice and enforce rights.

Focus group discussions included populations vulnerable to and at higher risk of HIV exposure such as persons living with HIV or AIDS, men who have sex with men, sex workers, prisoners and young people. They also included key service providers, such as health care providers at various levels and educators.

[21] See Part V for detailed recommendations

The views and experiences of rights holders are critical to inform specific areas of laws that will need to be addressed.
See Annexure 3 for a list of FGDs conducted

Data Management

The consultants transcribed interviews from all KIIs and FGDs conducted and these notes were used for analyses.

Consultative Workshops, Validation and Dissemination of Study Findings

The Legal Environment Assessment process includes a consultative workshop involving all relevant stakeholders to obtain feedback and build consensus on the Legal Environment Assessment findings and recommendations during the course of the project. The findings and recommendations of the final draft report were shared with a wide range of involved and affected stakeholders at a national stakeholders meeting on 19 March 2018 for feedback and validation. Feedback from this process has been incorporated into the final recommendations of this report.

Oversight by Technical Working Group

The Legal Environment Assessment has been overseen by a Technical Working Group (TWG) made up of key stakeholders from a range of disciplines and sectors, including key government ministries, civil society organisations working on HIV and human rights issues and/or representing affected populations, international organisations and UN agencies.

See Annexure 4 for a list of members of the TWG and Coordination team

The Legal Environment Assessment Report

This Legal Environment Assessment report reflects the outcome of the process, combining the findings of the desk review, the perspectives of key informants and populations participating within focus group discussions as well as the comments and feedback provided by key stakeholders throughout the

- The Legal Environment Assessment Report

process.
It consists of this and four other parts in total. Part II of the Analysis sets out the international, regional and national human rights framework to which Mauritius has committed itself and which frames the investigation of HIV-related rights. Part III of the Analysis further details both the specific international and national perspective of the legal and policy issues relating to Equality and Anti-Discrimination; Health; Criminal Law and Law Enforcement; Employment; Education and Information; and Social Welfare. This part of the Report analyses the current situation and makes recommendations on how to address the gaps identified so as to be in line with international requirements vis-à-vis HIV, human rights and the law. Part IV details the current mechanisms in place relating to Access to Justice and Law Enforcement in Mauritius, whilst providing an insight into actual access to justice by key populations and vulnerable groups and also makes recommendations on how to strengthen the system. Part V of the Report consolidates the Recommendations made in the two preceding parts of the document.

The following limitations to the Legal Environment Assessment should be noted:

- Limited availability of existing research on the nature and extent of HIV-related stigma and discrimination against key populations at higher risk of HIV exposure
- Limited ‚visibility' of people living with HIV and key populations at higher risk of HIV exposure
- Fears of confidentiality breaches and of HIV-related stigma and discrimination amongst affected populations
- Time and resource constraints

For this reason, the Legal Environment Assessment was able to conduct a limited number of focus group discussions with affected populations. The analysis does not purport to provide definitive evidence of stigmatising and discriminatory practices but rather seeks to give voice to some of the experiences related by affected populations, for purposes of law and policy review. The invaluable perspectives provided by informants and focus groups are gratefully acknowledged.

Part 2

International/Regional/National human rights framework

This section examines the international, regional and national human rights framework which should oversee and govern the national response to HIV and AIDS. The analysis considers:

- How international and regional human rights instruments apply to the regulation of law and human rights in Mauritius;
- Key international and regional human rights instruments and an overview of the important human rights norms and standards within those frameworks that support effective national responses to HIV; and
- A further examination of selected human rights principles set out in international, regional and national law (especially the Constitution of Mauritius) and a discussion of their application to HIV and AIDS

It is this understanding of each right, how it is interpreted to apply in the context of HIV and AIDS and what is or is not considered to be a reasonable limitation of the right in particular circumstances, which guides this analysis of the laws relating to HIV in Mauritius.

A. International Framework

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

'Signature' of a treaty is an act by which a state provides a preliminary endorsement of an agreement. Signing does not create a binding legal obligation but does demonstrate the state's intent to examine the agreement and consider ratifying it. Whilst signing does not commit a state to ratification, it does oblige the state to refrain from acts that would defeat or undermine the treaty's objective and purpose. 'Rati-

21 See Vienna Convention on the Law of Treaties, May 23, 1969, 1155 U.N.T.S.331, entered into force on Jan 27, 1980, article 18(1) Available at: LINK
44 Malawi (2012) Assessment of Legal, Regulatory & Policy Environment for HIV and AIDS in Malawi
45 J D Mujuzi, 'The Supreme Court of Mauritius and Its Reliance on International Treaties to Interpret Legislation: Reconciling the Tension Between International Law and Domestic Law', Statute Law Review, 2016, Vol 00, No. 00 1-16
46 See the Botswana case of Attorney General V Dow 1964 6 BCLR 1 per Ammisah JP 27-30 and Aguda JA 43-47; Jawara v The Gambia (2000) AHRLR 107 (ACHPR 2000) para 46; the Saro-Wiwa case (n 8 above) para 113. See also J Dugard International law: A South African perspective (1992) 266. See also DJ Harris Cases and materials on international law (1991) 747.
47 Art 14 of the Vienna Convention provides that '[t]he consent of a state to be bound by a treaty is expressed by ratification when, inter alia, the treaty provides for such consent to be expressed by means of ratification, or the consent of a state to be bound by a treaty is expres-

fication' is an act by which a state signifies an agreement to be legally bound by the terms of a particular treaty. To ratify a treaty, the state first signs it and then fulfils its own national legislative requirements.

Even where states have not signed or ratified conventions or treaties, these can still be binding if their principles form part of what is known as customary international law.

Although Mauritius has signed and ratified a number of such instruments, in dualist countries such as Mauritius, these instruments require to be domesticated within national laws in order to apply.
However, even in dualist countries, international and regional law can still impose obligations on countries that have ratified particular treaties. The African Commission on Human and Peoples' Rights (African Commission), which is responsible for monitoring compliance with regional human rights treaties, has noted that "international treaties which are not part of domestic law and which may not be directly enforceable in the national courts, nonetheless impose obligations on **State Parties."**[44]

In some countries, domestic constitutional provisions explicitly command courts to look at international, regional and comparative law in reaching their decisions. Unfortunately the Constitution of Mauritius is silent on this point. In addition the jurisprudence of the Supreme Court of Mauritius is inconsistent when dealing with the question of whether treaties which have not been domesticated impose domestic obligations on **Mauritius.**[45]

Nevertheless, it is trite that by signing and ratifying international treaties, states signify their intention to be bound by and to adhere to the obligations arising therefrom, even if they do not enact domestic legislation to effect domestic **incorporation.**[46] This principle is expressed in article 14 of the Vienna Convention on the Law of Treaties of **1969.**[47] Article 27 of the Vienna Convention further provides that a state ‚cannot (consequently) plead provisions of its own law or deficiencies in that law' in answer to a claim it is in breach of a treaty **obligation**[48]. In terms of the principle of pacta sunt **servanda**[49], which is to the effect that agreements are binding on parties, and are to be implemented in good faith, the ratification by Mauritius of international treaties creates for Mau-

sed by acceptance or approval under conditions similar to those which apply to ratification'.
[48] See the Inter-American Court's decision in Caso Loayza Tamayo v Peru http://www.wcl.american.edu/hrbrief/v7i2/newsasystem.htm
[49] Art 26 of the Vienna Convention on the Law of Treaties explains the principle of pacta sunt servanda as meaning that '[e]very treaty in force is binding upon the parties to it and must be performed by them in good faith'. Art 31(1) of the Vienna Convention on the Law of Treaties further stipulates that a treaty must be interpreted in good faith in the light of its objects and purpose.

ritius an obligation that demands concrete **results**[50] . Therefore, irrespective of whatever system of governance may be in place, a state is constrained by norms prescribed in a treaty and must discharge the duties established thereunder. As a result, a state cannot invoke the provisions of its domestic legislation, including its constitution, to evade its treaty **obligations**[51]. Thus, domestication notwithstanding, Mauritius is obliged to uphold the principles in these treaties and accordingly international and regional human rights obligations, including findings by international bodies on such rights, as well as foreign law, is significant for our understanding of HIV-related rights and obligations in Mauritius.

This legal assessment thus draws on international law and international and regional guidance on HIV, law and human rights, including the UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights, as well as the findings of international and regional bodies and foreign courts on HIV and human rights matters.

[50] As the Permanent Court of International Justice articulated, 'A state which has contracted valid international obligations is bound to make in its legislation such modifications as may be necessary to ensure the fulfilment of the obligations undertaken'; Advisory Opinion No 10, Exchange of Greek and Turkish Populations, 1925 PCIJ (ser B) 10 at 20
[51] Art 27 Vienna Convention: 'A party may not invoke the provisions of its internal law as justification for its failure to perform a treaty.'
[52] Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS (2006 Consolidated Version) International Guidelines on HIV/AIDS and Human Rights

B. Human rights standards and the nature of State obligations

The Vienna Declaration and Programme of Action, adopted at the World Conference on Human Rights in June 1993, affirmed that, "all human rights are universal, indivisible, interdependent and interrelated." States have the duty, regardless of their political, economic and cultural systems, to promote and protect universal human rights standards and fundamental freedoms. A human rights approach to HIV is, therefore, based on these State obligations with regard to human rights protection and hence promoting the health and dignity of its **citizens**[52].

The Global Commission on HIV and the Law (GCHL) has found that there are instances where legal and justice systems have played constructive roles in responding to HIV, by respecting, protecting and fulfilling human rights. Compelling evidence shows that this is the way to reduce vulnerability to and mitigate the impact of HIV. Good laws can widen access to prevention and health care services, improve the quality of treatment, and enhance social support

[53] Global Commission on HIV and the Law (2012) Risks, Rights & Health
[54] Available at LINK

for the infected and affected and thereby protecting their human rights. For example, laws that facilitate the implementation of harm reduction programmes such as needle exchange sites can contribute to a significant drop in HIV infection rates for people who use drugs. Even where punitive laws that criminalise key populations remain in place pending reform cooperation between police and community workers can result in increased condom use and a decrease in violence against sex workers. Effective legal aid can make justice and equality a reality for people living with HIV and thus create better health outcomes.

Court actions and legislative initiatives can help introduce gender-sensitive sexual assault law and recognize the sexual autonomy of young **people.**[53]

Mauritius has either signed or ratified the following human rights treaties, all of which include important rights in the context of HIV and AIDS:

- African Charter on Human and Peoples' Rights, 1992
- African Charter on the Rights and Welfare of the Child, 1991
- Convention on the Rights of the Child (CRC), 1990
- Convention on the Rights of Persons with Disabilities, 2010
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1984
- International Convention on Economic, Social and Cultural Rights (ICESCR), 1973
- International Convention on Civil and Political Rights (ICCPR), 1973
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (signed in 2005 – yet to be ratified)

The Mauritian government has taken several positive steps on the international stage including being in support of some of the major Resolutions and Declarations at the UN on Sexual Orientation and Gender Identity, including endorsing and supporting a United Nations Joint Statement ending acts of violence and related human rights violations based on sexual orientation and gender **identity.**[54]

There are also several international and regional declarations, commitments and guidelines which deal specifically with HIV, human rights and gen-

der equality. While not strictly legally binding, they are generally reflections of the application and interpretation of accepted international and regional human rights principles to the HIV epidemic. In this respect, they are important guidance for Mauritius in its interpretation of its own human rights standards in the context of HIV and AIDS. In addition, many international and regional strategies and plans include guidance on law and policy responses to HIV and AIDS. As such, they provide important and persuasive guidance for the national response to HIV and AIDS.

HIV and AIDS related commitments

- 2001 UNGASS Declaration of Commitment on HIV/AIDS
- 2006 UNGASS Political Declaration on HIV/AIDS - Universal Access
- 2011 UNGASS Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS
- 2016 UNGASS Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight Against HIV and To End the AIDS Epidemic by 2030
- 2000 UN Millennium Development Goals
- 2001 Abuja Declaration on Universal Access: HIV/AIDS/TB/Malaria/STIs
- 2003 Maseru Declaration
- 2006 Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Supporting Africa in 2010
- 2011 Windhoek Declaration Women, Girls, Gender Equality and HIV: Progress towards Universal Access
- 2012 African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa
- 2013 Agenda 2063
- 2015 Sustainable Development Goals

The key human rights principles which are essential to effective State responses to HIV, found in existing international instruments, are detailed below. Their specific application to the HIV response is further explored in Part C.

Human rights principles relevant to HIV/AIDS

The right to non-discrimination, equal protection and equality before the law; The right to life; The right to

[55] UNAIDS and OHCHR (2006) International Guidelines on HIV/AIDS and Human Rights
[56] UNAIDS (2016) On the Fast-Track to end AIDS: 2016-2021 Strategy
[57] IBBS, 2013 cited in UNAIDS Mauritius Country Progress Report 2015; Available at LINK (Accessed 31 January 2018).
[58] LINK (Accessed 31 January 2018).

the highest attainable standard of physical and mental health; The right to liberty and security of person; The right to freedom of movement; The right to seek and enjoy asylum; The right to privacy; The right to freedom of opinion and expression and the right to freely receive and impart information; The right to freedom of association; The right to work; The right to marry and to found a family; The right to equal access to education; The right to an adequate standard of living; The right to social security, assistance and welfare; The right to share in scientific advancement and its benefits; The right to participate in public and cultural life; The right to be free from torture and cruel, inhuman or degrading treatment or punishment.

Particular attention should be paid to the human rights of children and women and those of other marginalized, vulnerable populations and key **populations.**[55] Key populations include gay men and other men who have sex with men, transgender people, sex workers, people who use drugs and prisoners. They are often marginalised by society and by law and face unacceptable levels of stigma and discrimination, which hampers their ability to access HIV prevention, treatment and care services, placing them at higher risk of HIV **infection.**[56]

HIV prevalence amongst key populations tends, as a result, to be higher in communities where legislation does not ensure the protection of their human rights and where national health responses fail to ensure their right to health. High levels of prejudice and moral judgment have also been shown to create barriers against accessing prevention, treatment, and other health care services. This is evidenced in Mauritius by the high prevalence of HIV amongst key populations and in particular amongst people who inject drugs who were found to have an HIV prevalence of 44.3% in a 2013 **study.**[57] Other key populations include sex workers and gay men and other men who have sex with men. Men who have sex with men have the second highest HIV prevalence, currently estimated at 17.2%, followed by female sex workers with an HIV prevalence of 15% and prisoners with a prevalence of **11%.**[58]

[59] Human Rights and HIV/AIDS, S Gruskin, D Tarantola LINK accessed on 6 February 2018
[59] United Nations Economic and Social Council (ECOSOC) (1985); The Siracusa Principles on the limitations and derogation provisions in the international covenant on civil and political rights. UN Doc. E/CN.4/1985/4, Annex

C. Limitation of Rights

Despite the importance attached to human rights, there are situations where it is considered legitimate to restrict rights to achieve a broader public good. As described in the International Covenant on Civil and Political Rights the public good can take precedence to "secure due recognition and respect for the rights and freedoms of others; meet the just requirements of morality, public order, and the general welfare; and in times of emergency, when there are threats to the vital interests of the **nation."**[59]

Public health is one such recognized public good. Traditional public health measures have generally focused on curbing the spread of disease by imposing restrictions on the rights of those already infected or considered most vulnerable to becoming infected. Coercion, compulsion, and restriction have historically been significant components of public health measures. Although the restrictions on rights that have occurred in the context of public health have generally had as their first concern protection of the public's health, the measures taken have often been excessive. Interference with freedom of movement when instituting quarantine or isolation for a serious communicable disease--for example, Ebola or typhoid--is an example of a restriction on rights that may in some circumstances be necessary for the public good and therefore could be considered legitimate under international human rights law. However, arbitrary measures taken by public health authorities that fail to consider other valid alternatives may be abusive of both human rights principles and public health "good practice." There are countless examples from around the world of this sort of abuse in the context of HIV and AIDS.

Certain rights are absolute, which means that restrictions may never be placed on them, even if justified as necessary for the public good. These include rights such as the right to be free from torture, slavery, or servitude; the right to a fair trial; and the right to freedom of thought. Interference with most rights can be legitimately justified as necessary under narrowly defined circumstances. Limitations on rights, however, are considered a serious issue under international human rights law, regardless of the apparent importance of the public good involved. When a government limits the exercise or enjoyment of a last resort and will only be considered legitimate if the following criteria are met:

[60] The Syracusa Principles on the limitations and derogation provisions in the International Covenant on Civil and Political Rights. UN Doc. E/CN.4/1985/4, Annex.
[61] Human Rights and HIV/AIDS, S Gruskin, D Tarantola LINK accessed on 12 February 2018
[62] UNAIDS and OHCHR (2006) International Guidelines on HIV/AIDS and Human Rights.

1. The restriction is provided for and carried out in accordance with the law.
2. The restriction is in the interest of a legitimate objective of general interest.
3. The restriction is strictly necessary in a democratic society to achieve the objective.
4. There are no less intrusive and restrictive means available to reach the same goal.
5. The restriction is not imposed arbitrarily, i.e., in an unreasonable or otherwise discriminatory **manner.**[60]

Article 3 of the Mauritian Constitution provides:
'It is hereby recognised and declared that in Mauritius there have existed and shall continue to exist without discrimination by reason of race, place of origin, political opinions, colour, creed or sex, but subject to respect for the rights and freedoms of others and for the public interest, each and all of the following human rights and fundamental freedoms –

- (a) the right of the individual to life, liberty, security of the person and the protection of the law;
- (b) freedom of conscience, of expression, of assembly and association and freedom to establish schools; and
- (c) the right of the individual to protection for the privacy of his home and other property and from deprivation of property without compensation,

and the provisions of this Chapter shall have effect for the purpose of affording protection to those rights and freedoms subject to such limitations of that protection as are contained in those provisions, being limitations designed to ensure that the enjoyment of those rights and freedoms by any individual does not prejudice the rights and freedoms of others or the public interest.'
The HIV epidemic has demonstrated that public health and human rights approaches may, and should be complementary and mutually supportive. The failure to protect the rights of people living with HIV and other vulnerable populations and key populations at higher risk of HIV exposure and the use of coercive or punitive responses may often serve to increase the spread and exacerbate the impact of HIV and **AIDS.**[61]
"Public health interests do not conflict with human rights. On the contrary, it has been recognized

[62] UNAIDS and OHCHR (2006) International Guidelines on HIV/AIDS and Human Rights.

that when human rights are protected, fewer people become infected and those living with HIV and their families can better cope with HIV and **AIDS"**[62]

D. The application of specific human rights in the context of the HIV and AIDS

The Constitution of the Republic of Mauritius

Chapter II provides for the protection of the fundamental rights and freedoms of the individual, which are listed as:

- Section 3 Fundamental Rights and Freedoms of the Individual
- Section 4 Protection of Right to Life
- Section 5 Protection of Right to Personal Liberty
- Section 6 Protection from Slavery and Forced Labour
- Section 7 Protection from Inhuman Treatment
- Section 8 Protection from Deprivation of Property Section 9 Protection for Privacy of Home and Other Property
- Section 10 Provision to Secure Protection of Law
- Section 11 Protection of Freedom of Conscience
- Section 12 Protection of Freedom of Expression
- Section 13 Protection of Freedom of Assembly and Association
- Section 14 Protection of Freedom to Establish Schools
- Section 15 Protection of Freedom of Movement
- Section 16 Protection from Discrimination

Moreover, the Mauritian Constitution does not expressly provide for the right to equality before the law unlike the entrenched equal protection of law provisions set out in Article 7 of the Universal Declaration of Human Rights or Article 26 of the International

In the case of Matadeen v Pointu (Privy Council No.14 of 1997), the Law Lords of the Judicial Committee of the Privy Council have said that Section 3 of the COM does not purport to express a general justiciable principle of equality. It was held that Section 3 and Section 16 of the COM do not apply to inequality of treatment on grounds falling outside those enumerated in the said Sections which are not therefore subject to constitutional review.

Given the narrow interpretation afforded by the courts to the non-discrimination The

National Policy on HIV/AIDS (2012) provides that approaches to HIV prevention and care should be guided by human rights principles.

Excerpts from the National Policy on HIV (2012)

Guiding Principles:

- Approaches to HIV and AIDS prevention and care shall follow international best practice and shall be guided by Human Rights principles. They shall also be consistent with the religious and cultural values of Mauritius.
- People with HIV and AIDS shall have the same rights as all other citizens, and shall not be discriminated against on the basis of their HIV status, gender, socioeconomic status, sexual orientation or HIV-risk factors.

5.1 Reducing HIV and AIDS stigma and discrimination

People with HIV and AIDS and people thought to be at risk of HIV infection shall enjoy the same rights that are afforded to all citizens of Mauritius. They shall be treated with dignity and respect when they seek health and welfare services and this will encourage them to maintain contact with these services. They shall be cared for in communities in the same manner that other people are cared for and their participation in the design, delivery and evaluation of HIV and AIDS prevention and care initiatives shall be encouraged and valued. Health services shall pay particular attention to reducing the barriers that prevent people with HIV and AIDS from coming forward for counselling and treatment. Health workers shall be provided with training and support to ensure that they can provide non-judgemental care and support for people affected by HIV and AIDS. Employers shall be assisted to modify their policies to ensure that people with HIV and AIDS have continued access to employment. Anti-discrimination

laws shall be amended to make it illegal to discriminate against people perceived to be at particular risk of HIV infection. The Media shall be empowered to play a constructive role in the response to HIV and AIDS through reporting that increases access to accurate information and decreases HIV-related stigma and discrimination.

5.2 Establishing a supportive legislative and policy framework

Existing laws and policies shall be reviewed to ensure that they do not constitute a barrier to HIV prevention, treatment, care and support, or work against the vision and objectives of the national HIV and AIDS response. All agencies involved in the response shall be encouraged to examine their policies to ensure that they do not inadvertently contribute to HIV risk, or to HIV-related stigma and discrimination. The need for specific Public Health Legislation will be examined within this process.

The National Action Plan for HIV and AIDS (2017 – 2021) ("NAP") also recognises the need for human rights to be at the centre of an effective response to HIV and AIDS and aims to achieve zero discrimination by 2020.

Excerpts from the National Action Plan

1.5 Guiding Principles

1.5.8 Human Rights
Strategies to address the HIV epidemic are hampered in an environment where human rights are not respected. For example, discrimination against and stigmatization of key populations such as FSWs, PWIDs and MSM drives these populations underground which then impedes efforts to reach these populations with prevention and treatment initiatives, thereby increasing their vulnerability to HIV. Similarly, failure to provide access to appropriate information about HIV, or treatment, care

and support services further fuels the AIDS epidemic. An effective response to HIV and AIDS is hampered if these rights are not respected. Human rights will therefore be safeguarded through promoting gender equity and equality in HIV services along with ensuring a stigma-free environment and protection of patient rights in facilities. The strategy of protection and promotion of human rights will be essential in preventing the spread of HIV and mitigating the social and economic impact of the pandemic. Efforts should be made to engage police and other law enforcement apparatus to ensure human rights are observed, hence reducing vulnerabilities of risk groups to HIV.

1.5.9 Gender

According to UNAIDS 2013, HIV continues to be driven by gender inequalities and harmful norms that promote unsafe sex and reduce access to HIV and sexual reproductive health services for men, women and transgender persons. The pervasive social, legal and economic disadvantages faced by women reduce their ability to protect themselves from HIV infection.

8. National Action Plan Objective 5: Zero Stigma and Discrimination

More than three decades into the HIV epidemic, stigma and discrimination continue to hamper efforts to prevent new infections and engage people in HIV treatment, care and support programmes. Numerous studies have linked HIV-related stigma with refusal of HIV testing, non-disclosure to partners and low uptake of biomedical prevention services and commodities, including condoms, pre- and post-exposure prophylaxis and ART.

Effective interventions to reduce stigma and discrimination are crucial to the success of biomedical prevention. Such interventions need to be integrated into national responses and address the stigmatization process. Stigma and discrimination inter-

feres with HIV prevention, diagnosis and treatment, and can become internalised by people living with HIV/AIDS. Importantly, stigma and discrimination are often enacted through discrimination (defined as the rejection or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, health status or gender), hostility and prejudice against PLHIV (as well as their partners and families), denying them equal access to essential services in many cases.

Stigmatisation associated with HIV/AIDS is underpinned by many factors, such as lack of understanding of the disease (including misconceptions about modes of transmission), lack of access to treatment, irresponsible media reporting, and the incurability of AIDS. Stigmatization is additionally conflated with widespread prejudice and fears relating to HIV-related stigma and discrimination drive the risk of, and vulnerability to, HIV infection by keeping people from accessing prevention, treatment, care and support services thereby depriving them of their human rights. Consistent with UNAIDS vision to getting to zero discrimination, this result focuses on actions that ensures that persons infected and/or affected by HIV and AIDS have their fundamental rights respected, that they have the same access to services as the rest of the community, and that being infected and/or affected by HIV/AIDS does not constitute a barrier or obstacle to accessing health, social, economic and psychosocial services. Where rights are found to have been violated, access to justice programme for affected people and communities are also going to be important.

Interventions under this impact area will assist in alleviating the impact of HIV and AIDS on health, social and economic well-being of people infected and affected by HIV. It is well known that HIV has negative effects on the health of individuals and families, but also on their economic and social wellbeing. It is evident that increased access to ARV helps PLHIV to remain healthier and contributes towards zero HIV-related death which allows them to be

economically active for longer. In addition, the social environment of PLHIV has to

8.2 Improved Social and Legal Protection for PLHIV

Responding effectively to HIV and AIDS requires the provision of laws and policies that consistently support the decisions of individuals and communities to prevent HIV infection and to provide care and support for people and families affected by HIV and AIDS, i.e. to achieve reduction in stigma and discrimination related to HIV. Hence it is imperative to improve social and legal protection for PLHIV in the medium term.

8.2.1 Reduced Legal Barriers to Access HIV Prevention, Treatment and Care

In line with the National HIV Policy, the existing laws and policies will be reviewed to ensure that they do not encourage stigma and discrimination or constitute a barrier to HIV prevention, treatment, care and support, or work against the vision and objectives of the national HIV and AIDS response.

In order for PLHIV to enjoy full human rights, it is important that they operate within an equal opportunity environment. To create this environment, it is imperative that policies, laws and practices do not inadvertently contribute to HIV risk, or to HIV-related stigma and discrimination. Any dissonance in the laws therefore has to be repealed or amended.

This outcome implies identifying all these laws and reviewing them for a harmonization with the international commitments that were made.

The HIV and AIDS Act 2006 clearly points out that no form of discrimination and stigma will be tolerated against PLHIV on the grounds of HIV status in terms of employment, promotion and within health care settings. However, PLHIV do not know their rights. This situation is exacerbated by the lack of financial resources for the legal fees to bring a case to court. Under this

NAP, there will be interventions that will encourage PLHIV and KAPs to know their rights so that they can assert them and make use of the existing legal provisions: 'Know your rights' literacy programmes will be conducted. The HIV and AIDS Act 2006 provides a framework for the protection of the rights of PLHIV and for the implementation of the Needle Exchange Programme among others. The Equal Opportunities Act 2012 makes provision for recourse to justice for the many people infected and affected by HIV whose rights are violated or who face stigma and discrimination and have difficulty accessing legal services due to lack of finances. Increasing access to legal aid for PLHIV-KAPs will ensure that victims of stigma and discrimination have the possibility to obtain free legal advice and services so that cases can proceed.

8.2.2 Social and Legal Protection for Persons Living With HIV and Aids and Key Populations

The following interventions will be considered in the 2017-2021 NAP:

Advocate for legal reform – Laws, regulations and policies relating to HIV can negatively or positively impact the HIV epidemic, as well as the lives and human rights of those living with and affected by HIV. Therefore, it is crucial to monitor and reform laws, regulations and policies so that they support, and not hinder, access to HIV and health services. HIV infected and/or affected individuals should have the same access to all health services as the rest of the community. Being infected and/or affected by HIV/AIDS should not constitute a barrier to accessing services such as socioeconomic, and psychosocial support. Strengthening the provision of non-discriminatory services (police, health care providers and legal personnel) and setting up and/or scale-up of safe spaces/ drop in centres is the focus of this output. This strategy will be strengthened at all levels of the community to reach members

of key population groups, PLHIV and their families.
Advocacy for legal reviews will be conducted to formalize the rights of key populations (MSM, FSW PWIDs, transgender and prison inmates). Awareness of the rights of people living with HIV and AIDS will also be used to sensitise the general public, including Parliamentarians, Ministers, religious and traditional leaders.
For key populations, efforts are required of everyone including the organizations working with key populations, human rights groups, healthcare institutions and other civil society organizations to improve the legal and policy contexts so that all persons, regardless of sexual orientation or behaviour have access to the necessary health services and support to deal with HIV and AIDS.

Advocacy and sensitisation on PLHIV rights -

Laws in Mauritius do not discriminate against PLHIV on the grounds of HIV status in terms of employment, in society and in health services access. However, most people remain ignorant of the rights of PLHIV (including PLHIV). This is even more critical for women living with HIV and young PLHIV. Education of PLHIV on their rights is the main activity for this output and this can be implemented through access to justice programmes so PLHIV can claim their rights. Education programmes will be implemented broadly through social behaviour change interventions, interpersonal communication, and mass media for hard-to-reach areas (community radios). Advocacy for observance of these rights will be conducted at all levels, including awareness-raising campaigns that provide information about rights and laws related to HIV through media (e.g. TV, radio, print and Internet) and community mobilization and education.

Responsiveness of the social legal environment to the health needs of PLHIV and KPs -

PLHIV are becoming increasingly aware of their rights, but few access them. This area of focus will look into influencing change in the social and legal arenas mainly through advocacy for building capacity around legal literacy and access to justice; and promotion of the enactment and implementation of laws, regulations and guidelines that prohibit discrimination and support access to HIV prevention, treatment, care and support; workplace policies; policies for young PLHIV; and review of the interpretation and application of laws that affect FSW, PWIDs, MSM, transgender individuals and prison inmates.

Activities will also extend to strengthening organisations providing support and services to MSM, transgender people and female sex workers, and other similar bodies dealing with HIV and AIDS related issues that affect the key populations. Advocacy work will be done at all levels including communities and service providers as well as legal fraternity and law enforcement institutions to ensure the protection of all key populations and PLHIV.

Reducing discrimination in access to services -

Programmes aimed at reducing stigma and discrimination against people living with HIV or people at risk of HIV infection should address the actionable causes of stigma and discrimination and empower people living with and vulnerable to HIV. This NAP will address discrimination. In addition to respecting and protecting people's rights to have access to services, it is important to facilitate the achievement of broader public health goals by ensuring that no person eligible for the identified services is denied access on an arbitrary basis. Denial of access may take place in a number of ways,

including by way of services being provided in a manner that fails to address or understand a person's specific needs. This may include staff attitudes that discourage people from accessing social services.

Increased capacity training to prevent discrimination -

While it is important to hold all social service providers accountable through professional disciplinary mechanisms, it is also vital that such professionals have access to dedicated human rights training programmes designed to equip them with the necessary skills to respect, protect and promote equality in the provision of social services and be sensitized on the needs of key populations. This intervention is, therefore, aimed at all bodies that train social service providers in HIV and TB care, as well as dedicated services for pregnant women, children and adolescents. In particular, this intervention seeks to ensure that all public and private bodies providing training in HIV and/or TB include modules dealing with discrimination, with a focus on key and vulnerable populations that include people with special needs.

8.2.3 Human Rights of PLHIV Are Respected and Promoted

Reduction of HIV related stigma and discrimination can become a reality only if the rights of PLHIV are respected and promoted. Apart from the HIV and AIDS Act, Mauritius has enacted the Protection of Human Rights Act in 1998 and established a Human Rights Commission for the purposes of this Act. The functions of the Commission are to enquire into any written complaint from any person alleging that any of his/her human rights have been or are being or is likely to be violated; review the factors or difficulties that inhibit the enjoyment of human rights and exercise such other functions as it may consider to be conducive to

the promotion and protection of human rights.

8.3 Reduced Level of Vulnerability in Respect Of Key Populations in the Context of HIV

Economic and social deprivation usually leads to vulnerability and constitutes a barrier to universal access to health. The 2017-2021 NAP encapsulates a range of support designed to help key populations to cope with the economic and social impacts of HIV. The Government has demonstrated its unrelenting drive to combat poverty in all forms and improve the standard of living of less fortunate families. It remains strongly committed to deal with this problem and will continue to eradicate extreme poverty in the medium term.
With the partnership of Social Services, empowerment programs will help to foster a culture of entrepreneurship that will enable beneficiaries to develop their economic activities for social reintegration. Factors that constitute socio-economic barriers will be identified and removed.
Existing entities such as the Ministry for Social Integration and the National Empowerment Foundation have the shared mission of fighting poverty and social exclusion by offering training, job placements and other empowerment programmes. It is important that Government and non-Governmental HIV services collaborate to provide interventions supporting socio economic empowerment of key populations in the fight against stigma and discrimination as well as for the sustainability of HIV responses. This will contribute substantially to re-integrating key populations into the social fabric of society.

8.4 Increased Promotion and Protection of the Rights of Women and Girls in the Context of HIV

Advancing human rights, as enunciated in

the Universal Declaration of Human Rights, and gender equality for the HIV response means ending the HIV-related stigma, discrimination, gender inequality against women and girls that drive the risk of, and vulnerability to, HIV infection by keeping the said people from accessing prevention, treatment, care and support services. It means putting laws, policies and programmes in place to create legal environments that protect people from infection and support access to justice. At the core of these efforts is protecting fundamental human rights in the context of HIV— including the rights of women, young boys and girls, men who have sex with men, and other sexual minorities (LGBT).

8.4.1 Increased Protection of Women and Girls

Acknowledging the fact that gender inequality hinders social and economic development, the achievement of gender equality remains one of the critical components of the HIV agenda. Mauritius, like many other countries continue to face gender-based violence especially against women, with sexual assault and intimate partner violence contributing to increased risks for HIV infection. Within targeted geographic settings, CSOs, CBOs, and communities are critical players in the delivery of comprehensive community packages which address gender barriers across the continuum.

Additionally, a package including both clinical and social services will be promoted and provided to survivors to mitigate the harms associated with GBV. Timely and appropriate provision of healthcare screening as well as medical documentation for individuals wishing to pursue legal redress (assistance and referral in seeking police and legal services), trauma counselling, access to sexual and reproductive health services including emergency contraception, and post-exposure prophylaxis will be

made easily accessible. Patient intake at appropriate healthcare services (including STI and HTS providers) will include screening questions to identify GBV survivors. Training and sensitization for healthcare providers will include content on appropriate management of GBV survivors. Social and Behavioural Change Communication activities and promotional materials will increase awareness and acceptability of these services among target audiences

In 1998, the Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS published the International Guidelines on HIV/AIDS and Human Rights as a tool for States in designing, coordinating and implementing effective national HIV policies and strategies. The Guidelines were drafted by experts at an international consultation in 1996 and provide the framework for a rights-based response to the HIV epidemic. The drafters of the Guidelines considered key human rights protected by international instruments, their interpretation by international bodies and institutions and their application to HIV, including considerations of where limitations of rights may or may not be reasonable and justifiable. As a result, the Guidelines provide an important guidance for all nations, outlining how human rights standards apply in the context of HIV and translating them into practical measures that should be undertaken at the national level, based on three broad approaches:

- mprovement of government capacity for multi-sectoral coordination and accountability;
- reform of laws and legal support services, with a focus on anti- discrimination, protection of public health, and improvement of the status of women, children and marginalised groups; and
- support and increased private sector and community participation to respond ethically and effectively to HIV and AIDS.

[63] LINK
[64] Articles 2 and 7 of the UDHR, Article 2 of the ICCPR, Article 2(2) of the ICESCR and Articles 2 and 3

OHCHR encourages governments, national human rights institutions, non-governmental organisations and people living with HIV and AIDS to use the Guidelines for training, policy formulation, advocacy, and the development of legislation on HIV-related human rights.

In this report, the International Guidelines serve to set the scene for the application of the various rights in the context of HIV and AIDS and to guide recommendations on what steps Mauritius needs to undertake to ensure that these rights are being fulfilled. Their recommendations regarding justifiable and unjustifiable limitations of rights in the context of HIV and AIDS are an important guide to the application of human rights standards in the Mauritian **context.**[63] In addition, the Global Commission on HIV and the Law (GCHL) (2012) Risks, Rights & Health report provides additional evidence of the harmful effects of punitive, coercive and discriminatory laws, policies and practices and recommendations for rights-based responses to promote universal access to HIV prevention, treatment, care and support.

Right to Equality and Non-Discrimination

International human rights law guarantees the right to equal protection before the law and freedom from discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other **status.**[64]

Although HIV and AIDS is not specifically mentioned as a ground for non-discrimination, the Committee on Economic, Social and Cultural Rights (CESCR) has specifically stated that the list of prohibited grounds of discrimination is not exhaustive. The CESCR urges states to "ensure that a person's actual or perceived health status is not a

[65] CESCR, General Comment No. 20, 42nd Session, 2009, para. 27 and 33 Available at LINK
[66] Commission on Human Rights Resolutions 1995/44 of 3 March 1995 and 1996/43 of 19 April 1996
[67] Human Rights Committee, General Comment No. 18 (37); Official Records of the General Assembly, Forty-fifth Session, Supplement No. 40 (A/45/40), vol. I, annex VI

barrier to realising the rights under the **Covenant".**[65] The Commission on Human Rights has confirmed that "other status" in non-discrimination provisions is to be interpreted to include health status, including **HIV/AIDS.**[66]

This means that States may not discriminate against people living with HIV or members of groups perceived to be at risk of infection on the basis of their actual or presumed HIV status.
The right to equality and non-discrimination in the context of HIV and AIDS has furthermore been interpreted as imposing an obligation on states to review and, if necessary, repeal or amend their laws, policies and practices to proscribe differential treatment which is based on arbitrary HIV-related **criteria.**[67]

The Constitution of Mauritius (COM) also provides that in Mauritius there have existed and shall continue to exist without discrimination by reason of race, place of origin, political opinions, colour, creed or sex all human rights and fundamental freedoms (vide Section 3).
Section 16 of the COM (Protection from Discrimination) further states that no law shall discriminate by itself or in its effect (vide Section 16 (1) COM) and that no person shall be treated in a discriminatory manner by any person acting in the performance of a public function conferred by law, by any person acting in the performance of any public office and/or by any person acting in the performance of any public authority (vide Section 16 (2) COM).

Subsection 3 of Section 16 of the COM defines a discrimination as affording a different treatment due mainly or wholly to a person's race, caste, place of origin, political opinion, colour, creed and/or sex.

health status or sexual orientation. This void has however been filled by the coming into force of the Equal Opportunities Act (EOA) which provides for additional Protected Grounds such as "Impairment" and "Sexual Orientation". The EOA provides that to discriminate means (a) to do directly on the ground of status and (b) to do so indirectly on the ground of status. "Status" means age, caste, colour, creed, ethnic origin, impairment, marital status, place of origin, political opinion, race, sex or sexual orientation.

Similar provisions are also to be found in the Employment Rights Act (ERA) which stipulates that:

- (a) no worker shall be treated in a discriminatory manner by his employer in his employment or occupation
- (b) no person shall be treated in a discriminatory manner by a prospective employer in respect of access to employment or occupation.
- Discrimination is defined as "affording different treatment to different workers attributable wholly or mainly to their respective descriptions by age, race, colour, caste, creed, sexual orientation, HIV status, religion, political opinion, place of origin, national extraction or social origin, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation".

In addition, Section 3 (1) of the HIV and AIDS Act stipulates that any person who is HIV positive or has AIDS shall not be considered as having a disability or incapacity by virtue of any enactment and his status or presumed status shall not be used as a ground to discriminate against that person. Courts in the Southern African Development Community (SADC) have found HIV status to be a protected ground of non-discrimination in broad, constitutional anti-discrimination provisions. For example in

68 2001 (1) SA 1 (CC). See also Nanditume v Minister of Defence 2000 NR 103.
69 IRC 277 of 2004
70 Law v Canada (1999) 1 SCR 497, para 53; See also Hoffmann v SAA 2001 (1) SA 1 (CC)

the South African case of Hoffman v South African **Airways**[68] the court found that, even though HIV status was not specifically mentioned as a ground for non-discrimination in the Constitution's equality clause, the refusal by an airline company to employ an HIV-positive individual as a cabin attendant violated the right to equality and freedom from discrimination. In the Malawian Industrial Relations Court case of Banda v **Lekha**[69] the court was asked to define the scope of Malawi's constitutional right to be free from discrimination, and whether the right included the basis of HIV status. In answering this question, the Court examined its national law, national HIV policy and its obligations under international and regional law. The court held:

"Section 20 of the Constitution prohibits unfair discrimination of persons in any form. Although the section does not specifically cite discrimination on the basis of one's (sic) HIV status, it is to be implied that it is covered under the general statement of anti-discrimination in any form... Malawi ratified the African Charter which came into force on 21 October 1986 and it also ratified Convention 111 on 22 March 1965 both of which, place a constitutional duty on the State to pass protective legislation and formulate national policy that give effect to fundamental rights entrenched in the Charter and the Convention. Malawi has formulated the National AIDS policy, which among other things is aimed at ensuring that all people affected or infected with HIV are equally protected under the law."

Internationally, in some jurisdictions, the right to equality has been closely linked to the right to dignity. Canadian courts have interpreted human dignity as meaning "that an individual or group feels self-respect and self-worth" and recognises that human dignity is harmed by acts of unfair **discrimination:**[70] "Human dignity is harmed when individuals and groups are marginal-

71Law v Canada (1999) 1 SCR 497, para 53
72 Hoffmann v SAA 2001 (1) SA 1 (CC) at para 28
73 Malawi (2012) Assessment of Legal, Regulatory & Policy Environment for HIV and AIDS in Malawi

ised, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian **society."**[71]

In the South African Hoffmann case, the court held that; "(a)t the heart of the prohibition of unfair discrimination is the recognition that under our Constitution all human beings, regardless of their position in society, must be accorded equal dignity. That dignity is impaired when a person is unfairly discriminated against." The court used this test of dignity to read HIV status into the list of prohibited grounds in the Constitution, noting that people living with HIV were a minority who had been subjected to systemic disadvantage and discrimination making them one of the most vulnerable groups in **society.**[72] This suggests that equality and dignity rights should not only protect all people from unfair discrimination but should also pay special attention to the rights of marginalised **populations.**[73]

Unfortunately in Mauritius judicial interpretation of the right to non-discrimination as set out in the Constitution has been restrictive. In the case of Matadeen v Pointu (Privy Council No.14 of 1997), the Law Lords of the Judicial Committee of the Privy Council have said that Section 3 of the COM does not purport to express a general justiciable principle of equality. It was held that Section 3 and Section 16 of the COM do not apply to inequality of treatment on grounds falling outside those enumerated in the said Sections which are not therefore subject to constitutional review.

The GCHL's investigation into the impact of people living with HIV and AIDS, and how stigma and discrimination impact on universal access to HIV prevention, treatment, care

and support illustrates the importance of

rights-based responses to HIV. In Part III A, below, we examine specific acts of HIV-related discrimination in Mauritius.

Right to Privacy

The right to privacy is guaranteed at the international level through various human rights treaties, which include Article 12 of the UDHR, Article 37 of the Convention on the Rights of the Child (CRC) and Article 17(1) of the ICCPR. The latter states that "no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence or to unlawful attacks on his honour and reputation".
In Mauritius, the right to privacy is not stricto sensu protected by the Constitution. Article 9 of the Constitution merely protects the right to privacy of the home and other property and is restricted to search and seizure.

In Madhewoo v State of Mauritius [2015] SCJ 1977, the Mauritian Supreme Court confirmed that Article 9 of the Constitution did not create nor confer any right of privacy to the person but only afforded protection for the privacy of a person's home and property.

However, Article 22 of the Mauritian Civil Code provides that every person is entitled to the protection of his private life and enables the courts to order such measures as are necessary to restrain any breach of one's privacy.

There is both international and regional guidance on the right to privacy, informed consent to HIV testing, confidentiality and disclosure, which is helpful in interpreting the right to privacy in relation to HIV. The UNAIDS International Guidelines states that the right to privacy encompasses obligations to respect physical privacy, including the obligation to seek informed consent to HIV testing, as well as privacy of infor-

74 UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights
75 International Federation of Red Cross and Red Crescent Societies and Francois-Xavier Bagnoud Center for Health and Human Rights (1999) 'Human Rights: An Introduction' in Mann J et al (Eds) Health and Human Rights: A Reader Routledge, New York

mation, including the need to respect confidentiality of all information relating to a person's HIV **status.**[74]

The International Guidelines argue that limiting the right to privacy, through mandatory HIV testing, is an unjustifiable and discriminatory limitation of human **rights.**[75] The Guidelines furthermore recommend against limiting privacy rights through disclosure of a person's HIV status without the person's consent. They recommend that disclosure of a person's HIV status should only take place under exceptional circumstances, where there is a clear risk to a third person (e.g. a sexual partner) and only after various steps have been taken to encourage voluntary disclosure. These issues are discussed in further detail, in Part III, B dealing with health care laws and policies.

In protecting the right to privacy, the State has a duty to protect the right to privacy, which includes the obligation to guarantee that adequate safeguards are in place to ensure that no testing occurs without informed consent; that confidentiality is protected, particularly in health and social welfare settings, and that information on HIV status is not disclosed to third parties, without the consent of the individual. In this context, States must also ensure that HIV-related personal information is protected in the reporting and compilation of epidemiological data and individuals are protected from arbitrary interference with their privacy in the context of media investigation and **reporting.**[76]

Right to Marry and to Found a Family and Protection of the Family

The right to marry and to found a family is protected in the Universal Declaration of Human Rights (UDHR) and encompasses the right of *"men and women of full age, without any limitation due to race, nationality or*

76 UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights
77 Article 16 of the Universal Declaration of Human Rights
78 National Action Plan para 1.5.5

religion…to marry and to found a family"; to be "entitled to equal rights as to marriage, during marriage and at its dissolution" and to protections by society and the State of the family as *"the natural and fundamental group unit of* **society".**[77]

The Constitution of Mauritius is silent on the right to family life.

The right to marry is provided for in the Civil Code. Although neither the Civil Code nor the Civil Status Act explicitly prohibit marriage between two people of the same sex, all relevant provisions in the Civil Code and the Civil Status Act clearly refer to 'husband' and 'wife' and 'father' and 'mother' and thus preclude same sex marriage.

The right to form a family extends to all people, including people living with HIV. This is recognised by the National HIV Policy, which provides that '*Family Planning (FP) is the second prong of PMTCT; widely accessible and consistently available FP services through multiple points of contact with patients/clients are a critical component to controlling the HIV* **epidemic'78.**

Acts that may violate a person living with HIV's right to found a family may include acts that coerce or force people living with HIV not to have children, to terminate a pregnancy or to become sterilized. Indeed fear of being forced to terminate a pregnancy on the basis of HIV status was expressed by 16 respondents who participated in the 2017 Stigma Index survey.

Right to Freedom of Movement

The right to freedom of movement encompasses the rights of everyone lawfully within a territory of a State to liberty of movement within that State and the freedom to choose his/her residence,

79 UNAIDS and OHCHR (2006) International Guidelines on HIV/AIDS and Human Rights. According to the WHO (1969) International Health Regulations, the only disease which requires a certificate of inoculation for international travel is yellow fever.

as well as the rights of nationals to enter and leave their own country.
Article 15 of the Constitution provides that no person shall be deprived of his freedom of movement, and for the purposes of this section, that freedom means the right to move freely throughout Mauritius, the right to reside in any part of Mauritius, the right to enter

Mauritius, the right to leave Mauritius and immunity from expulsion from Mauritius. This freedom shall, however be exercised subject to the law of Mauritius, insofar as such law imposes restrictions on the movement or residence within Mauritius of any person in the interests of defence, public safety, public order, public morality or public health.

Any limitation of the right to freedom of movement is generally unjustifiable in the context of HIV and AIDS. The UNAIDS International Guidelines have examined the issue of restricting freedom of movement (e.g. through HIV screening and denying entry to foreigners on the basis of HIV status) for purposes of public health, in the context of HIV and AIDS. They argue that there is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status and that measures to contain other infectious diseases should not be inappropriately applied to HIV and AIDS. These restrictions are argued to be discriminatory and unjustified by public health **concerns.**[79]
The Guidelines furthermore note that "Where States prohibit people living with HIV/AIDS from longer-term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency. In considering entry applications, humanitarian concerns, such as family

reunification and the need for asylum, should outweigh economic considerations." This issue is discussed in further detail, in Part III, A below

Right to Liberty and Security of Person

Article 9 of the ICCPR provides that, "everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law".

The right to liberty is also reflected and guaranteed under Article 5 of the Mauritian Constitution which states that, "No person shall be deprived of his personal liberty save as may be authorised by law for, inter alia, the purpose of preventing the spread of an infectious or contagious disease; or in the case of a person who is, or is reasonably suspected to be, of unsound mind or addicted to drugs or alcohol, for the purpose of his care or treatment or the protection of the community".

Although there has been limited discussion by UN Committees on the right to liberty and security of the person in the context of HIV testing, the Special Rapporteur on the Right to Health has stated as follows:
"Guaranteeing informed consent is a fundamental feature of respecting an individual's autonomy, self-determination and human dignity in an appropriate continuum of voluntary health care services . . . Informed consent invokes several elements of human

rights that are indivisible, interdependent and interrelated. In addition to the right to health, these include the right to self-determination, freedom from discrimination, freedom from non-consensual experimentation, security and

80 Report of the Special Rapporteur on Health: Informed Consent (2009) at paras. 18-19, cited in Southern African Litigation Centre (2012) Protecting Rights: Litigating Cases of HIV Testing and Confidentiality of HIV Status.
81 At para 135
82 At para 133
83 At para 134

*dignity of the human person, recognition before the law, freedom of thought and expression and reproductive self-**determination.**"*[80]

The *International Guidelines on HIV/AIDS and Human Rights* note that "compulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of a person" and that "respect for the right to physical integrity requires that testing be voluntary and that no testing be carried out without informed consent". These *Guidelines* further note that these coercive measures are often used with regard to populations least able to protect themselves because they are within the ambit of government institutions (e.g. soldiers) or **the criminal law (e.g. prisoners, sex workers, people who use drugs and men who have sex with men.)**[81] The *Guidelines* furthermore provide that deprivations of liberty (e.g. through quarantine, isolation or detention) on the basis of a person's HIV status are not justified by public health ***concerns.***[82]

These issues are discussed in further detail in Part III, B, below.

The UNAIDS *International Guidelines* do recognise that restrictions on the right to liberty and security of the person may be warranted in exceptional cases concerning deliberate or dangerous behaviour - an example may be in the case of sexual violence that places others at risk of HIV infection. However, the *Guidelines* note that such exceptional cases should be handled under the ordinary provisions of public health, or criminal laws, with appropriate due process ***protection.***[83]

Right to Education

Article 26 of the UDHR states in part that *"Everyone has the right to education. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance*

and friendship…" Since all persons have the right to education, this right extends to people living with HIV. States should ensure that both children and adults living with HIV are not discriminatorily denied access to education, including access to schools, universities, scholarships and international education or subject to restrictions because of their HIV status. There is no public health rationale for such measures since there is no risk of transmitting HIV casually in educational settings.

Whilst the Constitution of Mauritius provides in Article 14 for the protection of freedom to establish schools, it does not specifically guarantee the right to equal access to education. Article 14 provides inter alia that '*no religious denomination and no religious, social, ethnic or cultural association or group shall be prevented from establishing and maintaining schools at its own expense*' (14(1); and further that *No person shall be prevented from sending to any such school a child of whom that person is parent or guardian by reason only that the school is not a school established or maintained by the Government' (14(3).*

However the Education Act No 39 of 1957 (as amended) makes provision for free, compulsory education until the age of 16 for all children (s37). In addition the Equal Opportunities Act prohibits discrimination on the basis of age, caste, colour, creed, ethnic origin, impairment, marital status, place of origin, political opinion, race, sex or sexual orientation. As this Act binds the education sector, it provides protection against discrimination in access to education based on 'impairment' which may be interpreted to include HIV status.

84 Article 27(1) Universal Declaration of Human Rights 1948.
85 Article 12 ICESCR 1976
86 Article 12,ICESCR 1976
87 CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12).
U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR, General Comment No. 14].
Available at LINK

88 General Comment No. 14 at para 43 provides that central elements of the right to health also include medical care in the event of sickness, as well as the prevention, treatment and control of diseases, all of which depend upon access to medicines
89 General Comment 14, para 34

Right to the Highest Attainable Standard of Physical and Mental Health

The Universal Declaration of Human Rights (UDHR) states that; "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including…medical **care".**[84] The International Covenant on Economic, Cultural and Social Rights (ICESCR) elaborates on this right, recognizing "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and placing an obligation on states to take steps to "achieve the full realization of this **right".**[85] The right to the highest attainable standard of physical and mental health comprises, inter alia, "the prevention, treatment and control of epidemic…diseases" and "the creation of conditions which would assure to all medical service and medical attention in the event of **sickness".**[86]

International law obliges states to provide a range of available, accessible, acceptable and quality health care information and prevention and treatment services in recognising health rights. The CESCR's General Comment No. 14 provides detailed guidance on the scope of Article 12(1) and the rights and duties it imposes on the **state.**[87] It recognises the importance of making a range of health services and information available, accessible and acceptable, to allow individuals to engage in meaningful decision-making regarding their health. This includes ensuring, inter alia, the following:

- Access to essential medicines as defined by the WHO Action Programme on Essential **Drugs**[88]
- Health education and information, including sexual and reproductive health information should be available to all and should not be censored, withheld or intentionally **misrepresented**[89]
- Provision for self-determination,

including reproductive self-determination, through the protection of the right to freely consent to medical **treatment**[90]

Respect for medical ethics, including the confidentiality of medical **information**[91]

- Provision for a system of health protection which provides equality of opportunity for people to enjoy the highest attainable standard of **health,**[92] in terms of which "(h)ealth facilities, goods and services have to be accessible to everyone without discrimination…especially the most vulnerable or marginalized sections of the population" including "persons with **HIV/AIDS"**[93]

CESCR General Comment No 14 on the Right to the Highest Attainable Standard of Health

"The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and **experimentation."**[94]

In order to meet these obligations in the context of HIV, the UNAIDS *International Guidelines* recommend that States should ensure the provision of a range of services without discrimination and with a particular focus on vulnerable populations, including, inter alia, HIV-related information, education and support, including access to services for sexually transmitted diseases, the means of prevention (such as condoms and clean injection equipment), voluntary and confidential HIV testing with pre- and post-test counselling as well as to treatment, care and support for those affected by HIV and AIDS.

Given that in practice, availability of

90 General Comment 14, para 8
91 General Comment 14, para 12
92 General Comment No. 14 at para.8
93 General Comment No. 14 at para 12
94 Id. at para. 8
95 At para 52 and 53

medicines depends on affordability, which in turn depends on whether the price is within the reach of users, States are under a clear obligation to adopt measures to make medicines more affordable, and thus accessible. The International Guidelines recognise that this requires reviewing bilateral, regional and international agreements (such as those dealing with intellectual property) and national laws to promote access to affordable **medicines.**[95] Similarly, the recent GCHL report recognises the need for states to develop effective intellectual property regimes for pharmaceutical products that are consistent with international human rights law and public health needs, while safeguarding the justifiable rights of inventors. Part of the strategy to make medicines affordable must include, amongst other things, a patent framework that is flexible to incorporate public health needs.

With respect to marginalized populations, the Guidelines emphasise that "(s)tates may have to take special measures to ensure that all groups in society, particularly marginalized groups, have equal access to HIV-related prevention, care and treatment services. The human rights obligations of States to prevent discrimination and to assure medical service and medical attention for everyone in the event of sickness, require States to ensure that no one is discriminated against in the health-care setting on the basis of their **HIV status."**[96]

The Constitution of Mauritius is silent on the right to health. However the Equal Opportunities Act prohibits discrimination on the basis of age, caste, colour, creed, ethnic origin, impairment, marital status, place of origin, political opinion, race, sex or sexual orientation. As this Act binds health facilities, it provides protection against discrimination in access to health

services based on 'impairment' which has been interpreted to include HIV status. In addition the National HIV Policy (2012) specifically provides that 'People with HIV and AIDS and people thought to be at risk of HIV infection shall enjoy the same rights that are afforded to all citizens of Mauritius. They shall be treated with dignity and respect when they seek health and welfare services and this will encourage them to maintain contact with these services' (para 5.1).

Right to an Adequate Standard of Living and Social Security Services

Article 25 of the Universal Declaration of Human Rights states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and 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". Similarly, Article 9 of the ICESCR recognise the right of everyone to social security, including social insurance.

In the context of HIV and AIDS, the UNAIDS International Guidelines note the link between protecting people's right to an adequate standard of living and reducing people's vulnerability to the risk and consequences of HIV infection. They note that social security "is particularly relevant to meeting the needs of people living with HIV and AIDS, and/or their families, who have become impoverished by HIV and AIDS as a result of increased morbidity due to AIDS and/or discrimination which can result in unemployment, homelessness and poverty" and that people living with HIV should be prioritised as particularly vulnerable, in the allocation of resources. States have to ensure that people living with HIV are not discriminatorily denied an

96 UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights, at para 146.
97 At para 148

98 Article 23 Universal Declaration of Human Rights
99 Committee on Economic, Social and Cultural Rights 35th session 2005 General Comment No.18 at para 12(b)

adequate standard of living and/or social security and support services on the basis of their health **status.**[97]

Whilst the Constitution of Mauritius is silent on the right to an adequate standard of living and social security services the National Pensions Act 44 of 1976 provides for a comprehensive grants scheme.

Right to Work

The UDHR protects employment rights. It states that "(e)veryone has the right to work… (and) to just and favourable conditions of **work".**[98] Article 6 of the ICESCR furthermore recognises the right to work, which includes "the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts." At an international level, the concept of non-discrimination on the basis of HIV status in the working environment is well established. Article 6 of the ICESCR read with the principle of non-discrimination in the Covenant has been recognised by the CESCR as requiring States to guarantee that the right to work is exercised without discrimination on the basis of health status, including HIV or AIDS:

"Under its article 2, paragraph 2, and article 3, the Covenant prohibits any discrimination in access to and maintenance of employment on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, or civil, political, social or other status, which has the intention or effect of impairing or nullifying exercise of the right to work on a basis of **equality."**[99]

The International Guidelines on HIV/AIDS and Human Rights recognise that the right to work entails the right of every person to access to employment without

100 At para 149
101 At para 150
102 ILO Recommendation 200 of 2010

any pre-condition except the necessary occupational qualifications. For this reason, they argue that this right is violated when an applicant or employee is forced to test for HIV, is refused employment, dismissed or refused access to employee benefits on the basis of being **HIV-positive.**[100] They furthermore recognise that the right to favourable conditions of work (including safe and healthy working conditions) require employers to protect employees from the risk of occupational infection with **HIV.**[101]

The International Labour Organisation (ILO) has also set out detailed guidance on HIV-related workplace rights. In its most recent Recommendation concerning HIV & AIDS and the World of Work No. 200 of 2010, it commits member states "to tap into the immense contribution that the world of work can make to ensuring universal access to prevention, treatment, care and support for HIV and AIDS". The recommendations apply to all workplaces, including the private and public sector, as well as to all workers including employees, job applicants, trainees, interns and members of the armed and security forces. They recognise the need to strengthen workplace prevention efforts and to facilitate access to treatment for persons living with or affected by HIV and AIDS and call for the design and implementation of national tripartite workplace policies and programmes on HIV and AIDS to be integrated into overall national policies and strategies on HIV and AIDS and on development and social protection. The Recommendation also invites member States to implement its provisions through amendment or adoption of national legislation where **appropriate.**[102]

Recommendation Concerning HIV and AIDS and the World of Work, No. 200 of 2010

General principles

- the response to HIV and AIDS should be recognized as contributing to the realisation of human rights and fundamental freedoms and gender equality for all, including workers, their families and their dependants;
- HIV and AIDS should be recognized and treated as a workplace issue, which should be included among the essential elements of the national, regional and international response to the pandemic with full participation of organizations of employers and workers;
- there should be no discrimination against or stigmatization of workers, in particular jobseekers and job applicants, on the grounds of real or perceived HIV status or the fact that they belong to regions of the world or segments of the population perceived to be at greater risk of or more vulnerable to HIV infection;
- prevention of all means of HIV transmission should be a fundamental priority;
- workers, their families and their dependants should have access to and benefit from prevention, treatment, care and support in relation to HIV and AIDS, and the workplace should play a role in facilitating access to these services;
- workers' participation and engagement in the design, implementation and evaluation of national and workplace programmes should be recognised and reinforced.

With respect to workers' rights, the ILO Recommendation calls for, amongst other things:

- Non-discrimination on the basis of real or perceived HIV status

- Gender equality in the working environment
- Reasonable accommodation for workers with HIV within the working environment
- Protecting sexual and reproductive health rights of workers
- Prevention, treatment and care strategies within the working environment
- The provision of a safe and healthy working environment for all, including measures to prevent occupational infection with HIV
- A prohibition on compulsory HIV testing and disclosure of HIV status of workers, including migrant workers, job seekers and job applicants, while encouraging voluntary and confidential HIV testing

Recommendation Concerning HIV/AIDS and the World of Work, No. 200 of 2010

27. Workers, including migrant workers, jobseekers and job applicants, should not be required by countries of origin, of transit or of destination to disclose HIV-related information about themselves or others. Access to such information should be governed by rules of confidentiality consistent with the ILO code of practice on the protection of workers' personal data, 1997, and other relevant international data protection standards.

28. Migrant workers, or those seeking to migrate for employment, should not be excluded from migration by the countries of origin, of transit or of destination on the basis of their real or perceived HIV status.

In terms of accommodating workers with HIV, Recommendation No. 200 of 2010 provides that States should ensure that persons with living with HIV are allowed to work

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

as long as they can carry out the functions of the job. Thereafter, as with any other illness, people living with HIV should be provided with reasonable accommodation to be able to continue working as long as possible and, when no longer able to work, be given equal access to existing sickness and disability schemes. The applicant or employee should not be required to disclose his or her HIV status to the employer nor in connection with his or her access to workers' compensation, pension benefits and health insurance schemes.

Other relevant international employment-related documents which States need to consider include the following:

- ILO Code of Practice on HIV and AIDS, 2001
- Discrimination (Employment and Occupation) Convention, 1958
- Termination of Employment Convention, 1982
- Occupational Safety and Health Convention, 1981,
- Promotional Framework for Occupational Safety and Health Convention, 2006
- Joint International Labour Office and WHO guidance documents.
- Tripartite Consultation (International Labour Standards) Convention, 1976
- Joint ILO/WHO Guidelines on Health Services and HIV/AIDS, 2005

The Employment Rights Act in Mauritius specifically prohibits discrimination in the workplace on the basis of HIV status. The Act provides that:

- (a) no worker shall be treated in a discriminatory manner by his employer in his employment or occupation
- (b) no person shall be treated in a discriminatory manner by a prospective employer in respect of access to employment or occupation.

[21] See Part V for detailed recommendations

However, any distinction, exclusion or preference in respect of a particular occupation based on the inherent requirements thereof shall not be deemed to be a discrimination.

Also, a person does not discriminate against another person by imposing or proposing to impose, on that other person, a condition, requirement or practice that has, or is likely to have, a disadvantaging effect, where the condition, requirement or practice is reasonable in the circumstances.

Matters to be taken into account in determining whether or not a condition, requirement or practice is reasonable in the circumstances include:

- (a) the nature and extent of the disadvantage resulting or likely to result, from the imposition of the condition, requirement or practice;
- (b) the feasibility of overcoming or mitigating the disadvantage; and
- (c) whether the disadvantage is proportionate to the result sought to be achieved by the person who imposes, or proposes to impose the condition, requirement or practice.

For the purposes of this Act, discrimination is defined as "affording different treatment to different workers attributable wholly or mainly to their respective descriptions by age, race, colour, caste, creed, sexual orientation, HIV status, religion, political opinion, place of origin, national extraction or social origin, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation".

As referred to above the Equal Opportunities Act also prohibits discrimination on the basis of 'impairment', which may be interpreted to include HIV status, in employment.

103 Human Rights Committee, 44th Session, 1992. General Comment No. 20 at para 2
104 UNAIDS and OHCHR (2006) International Guidelines on HIV/AIDS and Human Rights at para 15
105 At para 153

Freedom from Cruel, Inhuman or Degrading Treatment or Punishment

Article 7 of the International Covenant on Civil and Political Rights (ICCPR) prohibits the use of torture, cruel, inhuman or degrading treatment or punishment. The Human Rights Committee has said that the aim of article 7 is to "protect both the dignity and the physical and mental integrity of the **individual"**[103] from not only acts that cause physical pain but also acts that cause mental suffering.

Article 7 of the Mauritian Constitution provides that no person shall be subjected to torture or to inhuman or degrading punishment or other such treatment.

In international law, the right to freedom from cruel, inhuman or degrading treatment or punishment often focuses on the treatment of prisoners, protecting prisoners from actions that cause physical and mental pain and suffering. In the context of HIV and AIDS, the International Guidelines emphasise that while imprisonment is punishment by deprivation of liberty, it should not result in the loss of human rights or dignity. The Guidelines provide that the duty of care owed to prisoners includes the duty to protect the rights to life and to health of all persons in custody. In the context of HIV and AIDS, they note that the denial to prisoners of access to HIV-related information, education and the means of prevention (bleach, condoms, clean injection equipment), voluntary testing and counselling, confidentiality and HIV-related health care and access to and voluntary participation in treatment trials, could constitute cruel, inhuman or degrading treatment or **punishment.**[104] The Guidelines furthermore provide that:

- The duty of care towards prisoners also comprises a duty to combat prison rape and other forms of sexual victimisation that may result, inter alia, in HIV transmission.
- There is no public health or security justification for mandatory HIV testing of prisoners, nor for segregation or

105 At para 153

denying inmates living with HIV access to all activities available to the rest of the prison population.

- Prisoners with terminal diseases, including AIDS, should be considered for early release and given proper treatment outside **prison.**[105]

Part 3

A. Equality/Anti-Discrimination Law and Policy

106 Keulder, C.2007. HIV/AIDS and Stigma in Namibia: Results of a qualitative study among support group members, pg. 6
107 Ibid, pg. 6
108 Focus Group Discussions Port Louis 4 to 7 December 2017.

HIV-Related Stigma and Discrimination in Mauritius

The HIV-related stigma has been defined as a "process of devaluation" of people either living with or associated with HIV and AIDS. In contrast, discrimination has been set out as a process that follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. It occurs when a distinction is made against a person that results in being treated unfairly and unjustly on the basis of belonging, or being perceived to belong, to a particular **group**[106].

Alternatively, stigma and discrimination on the basis of HIV or AIDS can also be defined as "all unfavorable attitudes, beliefs and policies directed toward people perceived to have HIV/AIDS as well as their significant others and loved ones, close associates, social groups and communities. Patterns of prejudice, which include devaluing, discounting, discrediting, and discriminating against these groups of people, play into and strengthen existing social inequalities- especially those of gender, sexuality, and race- that are at the root of HIV-related **stigma"**[107]

The Global Commission on HIV and the Law reported that around the world, people living with HIV continue to feel the impact of stigma, discrimination, marginalization and abuse, both verbal and physical, in their homes, families, communities and in public institutions.

Current Position

In the Mauritius, Focus Group Discussions with people living with HIV, sex workers, LGBTI people and people who use drugs have provided anecdotal evidence of the kinds of stigma and discrimination experienced to lesser and greater degrees, including:

- HIV testing and denial of insurance and/ or bank loans to people living with HIV

108 Focus Group Discussions Port Louis 4 to 7 December 2017.
109 PILS, The People Living with HIV Stigma Index, 2017

- Discrimination in schools against children affected by HIV and AIDS
- Discrimination in places of worship
- Discrimination by family members
- Denial of employment or promotion or change in work conditions on the basis of HIV status
- Dismissals from employment on the basis of HIV status
- Stigmatizing and discriminatory treatment in access to health care services
- Instances of HIV testing without voluntary and informed consent and without adequate pre- and post-test counselling (e.g. in health care services; for prisoners, on entry into prisons)
- Breaches of **confidentiality**[108]

According to participants in these focus group discussions, stigma and discrimination lead to increased isolation, self-stigma and fear amongst affected populations and make people unwilling or afraid of accessing HIV testing, prevention, treatment, care and support services.

The main findings of the Stigma Index Report 2017[109] are as follows:

- Gossiping was the form of stigma which was mostly faced by respondents.
- Respondents were mostly excluded from family activities because of their HIV status.
- A lack of understanding on HIV and a fear of being infected was the main cause of stigma and discrimination.
- Few have experienced stigma and discrimination in employment, accommodation, education or health settings.

- Internal fears and self-stigma were high. Self-blame, low self- esteem, guilt and shame were mainly felt.
- Few have felt that their rights have been violated. But among those who did feel that their rights were violated, little action was taken, main reasons being feeling intimidated, procedures seeming too bureaucratic or having been advised against.

This section examines discriminatory policies and practices with respect to foreigners and migrant workers and with respect to people applying for insurance and bank loans. Discrimination within the health care, employment and education sectors is dealt with in further detail in Part III, B, D and E, respectively, below.

Foreigners/Migrants

According to the report of the Global Commission on HIV and the Law (the 'GCHL Report'), "—migration policies—restrictions on entry, stay and residence in a country - disempower people, exposing them to exploitation, changing their sexual behaviors and increasing the likelihood of unsafe practices. As a result, migrants face a risk of HIV infection that is as much as 3 times higher than that faced by people with secure **homes.**[110]

The rights of migrant workers, whose labour supports the global economy, have been fully articulated in numerous international conventions. The International Labour Organization's 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, provides migrant workers and their families the right —to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with national of the State concerned. As has been discussed in Part II, the ILO Recommendation No.200 of 2010 specifically notes that migrant workers should not be required by countries of

108 Focus Group Discussions Port Louis 4 to 7 December 2017.
109 PILS, The People Living with HIV Stigma Index, 2017

112 To be inserted
113 Global Commission on HIV and the Law (2012) op cit at p 61

origin, transit or destination to disclose their HIV-related information nor should they be excluded from migration on the basis of their real or perceived **HIV status.**[111]

However, in many countries, laws and policies erect barriers to access to HIV services for migrants. As of 2016, 35 countries still place HIV-related restrictions on entry, stay and residence for people living with **HIV**[112]. These restrictions are often justified on the grounds of safeguarding public health.

However, the GCHL report argues that evidence shows that they do no such thing. In fact, such policies create the dangerous mistaken impression that "outsiders" are contaminated and citizens are pure, and that their health is secure so long as the borders are **secured.**[113]

The GCHL (2012) Risks, Rights & Health recommends that, to ensure an effective, sustainable response to HIV that is consistent with human rights obligations States should:

- offer the same standard of protection to migrants, visitors and residents who are not citizens as they do to their own citizens.
- not use restrictions to prohibit people living with HIV from entering a country and/ or regulations that mandate HIV tests for foreigners within a country.
- Implement regulatory reform to allow for legal registration of migrants with health services and to ensure that migrants can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens. All HIV testing and STI screening for migrants must be informed and voluntary, and all treatment and prophylaxis for migrants must be ethical and medically indicated.

Current Position

In terms of Section 8(1) (entitled "Prohibited Immigrants") of the Immigration Act 13 of

112 To be inserted
113 Global Commission on HIV and the Law (2012) op cit at p 61

108 Focus Group Discussions Port Louis 4 to 7 December 2017.
109 PILS, The People Living with HIV Stigma Index, 2017

1970, persons afflicted with any infectious or contagious disease, other than citizens and residents of Mauritius, shall be deemed to be prohibited immigrants and shall not be admitted to Mauritius. However, in terms of Section 8(2) of the Immigration Act the Minister may in writing authorize the admission to Mauritius of any of the persons referred to in the preceding paragraph who satisfies the immigration office that he intends to marry a citizen of Mauritius to whom he has disclosed that he is HIV positive or has AIDS.

Section 19A of the Civil Status Act 23 of 1981 provides, inter alia, that, notwithstanding any other enactment, no marriage shall take place between a non-citizen and a citizen of Mauritius unless:

- the non-citizen and the citizen declare, at the time of making the application for the publication of the marriage, that they have disclosed to each other whether or not they are HIV positive or have AIDS

Section 3(3) of the HIV and AIDS Act 31 of 2006 provides that a Civil Status Officer may, where he is authorized to do so pursuant to an enactment, require a person, before celebrating his marriage, to disclose to his intending spouse whether or not he is HIV positive or has AIDS.

Furthermore, Section 6(2) of the HIV and AIDS Act stipulates that nothing shall prevent the requirement of an HIV test in connection with any application relating to immigration, citizenship, defence or public safety.

In effect then, with the exception of tourists and non-citizens entering Mauritius for the purpose of marrying a citizen to whom they have disclosed their HIV status, no person living with HIV may enter Mauritius for the purpose of residence, work or study.

Whilst non-citizens are not generally permitted to utilise public health care in Mauritius, exceptions are made on the basis of humanitarian grounds.

Recommendations

- Repeal those provisions of immigration legislation and regulations that exclude migrant workers from employment or foreigners from residing or studying in Mauritius solely on the basis of their HIV status.
- Ensure that medical examinations for purposes of immigrant or study visa applications do not include a compulsory HIV test.
- Implement regulatory reform to ensure that migrant workers and foreigners can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens. All HIV testing and STI screening for migrant workers and foreigners must be confidential, voluntary and with informed consent.
- Ensure that employers' contracts with migrant workers and foreigners make provision for the employer to assume responsibility for all health care costs of the employee during the period of the employee's employment with the employer.
- Ensure that migrant workers and foreigners can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens.

Access to Insurance/Bank loans

HIV and AIDS impact on the lives of those affected in a multitude of ways. Its impacts are felt at every level of our society including economic impacts due to, for example, costs of medical care or loss of earnings. For this reason, discrimination which denies access to facilities such as insurance or loans, against people living with HIV, serves to exacerbate the impact of HIV and AIDS upon their lives. The UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights recommend, in Guideline 5, that States should enact or strengthen anti-discrimination and

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other protective laws that protect people living with HIV and vulnerable populations from discrimination in both the public and the private sectors. This should include protection from discrimination in insurance; the Guidelines say that — (e)xemptions for superannuation and life insurance should only relate to reasonable actuarial data, so that HIV is not treated differently from analogous medical **conditions**[114].

Current Position

When applying for life insurance there is a duty on the applicant to disclose any information that is relevant for the purpose of the life insurance policy failing which the said contract of insurance may be declared void in law.

Insurance companies routinely require applicants for life insurance to undergo medical assessment, including an HIV test, with a view, inter alia, to determining the terms of the cover.

The Equal Opportunities Act prohibits discrimination (i.e. giving less favourable treatment) on one of the Protected Grounds listed in the said Act. The relevant ground for person living with HIV would obviously be that of "impairment" as defined in the Act and reproduced in this Report under the heading Equality/Anti-Discrimination.

The general rule enshrined in Section 18 of the Equal Opportunities Act (under the heading "Provision of goods and services") provides that:

"No person who, for payment or otherwise, provides goods, services or facilities, shall discriminate against another person:

- (a) by refusing or failing to provide him with those goods, services or facilities; or
- (b) In the same terms and conditions on which, or the manner in which, he provides that other person with those goods, services or facilities."

However, there are exceptions to this

general rule. For example, Section 4 (1) (a) of the same Act stipulates that:

"Nothing in this Act shall:

Prohibit the provision of different treatment to a person in relation to an annuity, life insurance policy, accident insurance policy, or similar matter involving the assessment of risk, whether the treatment:

- (a) is determined by actuarial or other data from a source on which it was reasonable to rely; and
- (b) is reasonable having regard to those data and any other relevant factors."

Although an insurance company may impose more stringent conditions on the life insurance policy of the HIV positive person, it cannot altogether refuse granting him the insurance cover by purporting to rely on the provisions of Section 4 (1) (a) of the Equal Opportunities Act as such a refusal would constitute discrimination on the basis of impairment under the Equal Opportunities Act.

Focus group discussions with people living with HIV held in the preparation of this report have unfortunately revealed that some individuals have been refused health insurance or a life insurance policy and hence a bank loan or other facilities by reason of the mere fact that they were living with HIV.

Recommendations

HIV should not be treated differently from analogous medical conditions for insurance purposes. Legal provisions should be enacted to prohibit exclusion from life, health and other insurance solely on the basis of HIV status and to ensure that in the context of insurance, HIV should not be treated differently from analogous chronic medical conditions.

B. Health laws, policies and plans

International guidance on creating enabling legal frameworks for HIV responses recommends that public health and related laws protect and promote rights in the context of HIV and AIDS, rather than provide for coercive, punitive and/or discriminatory responses. The International Guidelines on HIV/AIDS and Human Rights recommend that states should review, amend and adopt, where necessary, appropriate public health laws, policies, plans and programs to protect rights in the context of HIV and AIDS and to provide universal access to HIV prevention, treatment, care and support for all populations. This includes reviewing intellectual property laws to ensure access to affordable medicines, as furthermore recommended by the Global Commission on HIV and the Law.

UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights

Guideline 3: Public Health Legislation

States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.

Guideline 6: Access to prevention, treatment, care and support (as revised in 2002)

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

States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines,

diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions. States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

The commentary to these guidelines provides detailed recommendations to states on the kinds of laws, policies and programmes that should be put in place, in line with international and national human rights commitments, in order to develop rights based effective responses to HIV.

They stipulate that public health and related laws should do the following, amongst other things:

- Provide for HIV testing only with voluntary and informed consent (apart from surveillance and other unlinked epidemiological testing) and with pre- and post-test counselling and require any exceptions to voluntary HIV testing to take place only on specific judicial authorization, granted only after due evaluation of the important considerations involved in terms of privacy and liberty.
- Protect people from coercive measures such as isolation, detention or quarantine on the basis of their HIV status.
- Protect the right to confidentiality, including o Ensuring that HIV and AIDS cases reported to public health authorities for epidemiological purposes are subject to strict rules of data protection and confidentiality.
- Authorising (but not requiring) disclosures of a person's HIV status by a health care worker in defined circumstances where a real risk of HIV transmission exists, following counselling and discussions with the person with HIV.

UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights

Commentary to Guideline 3:

"Public health legislation should authorize, but not require, that health-care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients' sexual partners of the HIV status of their patient. Such a decision should only be made in accordance with the following criteria:

- (i) The HIV-positive person in question has been thoroughly counselled;
- (ii) Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
- (iii) The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
- (iv) A real risk of HIV transmission to the partner(s) exists;
- (v) The HIV-positive person is given reasonable advance notice;
- (vi) The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and
- (vii) Follow-up is provided to ensure support to those involved, as necessary."

- Ensure that the blood/tissue/organ supply is free of HIV and other blood-borne diseases.
- Require the implementation of "universal precautions" to prevent transmission in settings such as hospitals, doctors' offices, dental practices and acupuncture clinics.
- Require that health-care workers undergo a minimum of ethics and/or human rights training and encourage

professional societies of health-care workers to develop and enforce codes of conduct based on human rights and ethics, including HIV-related issues such as confidentiality and the duty to provide treatment

- Provide (through the review, amendment and adoption of laws, policies, plans and programmes where appropriate) universal and equal access, without discrimination, to available, accessible, appropriate, affordable and quality medicines, diagnostics and related technologies for HIV and AIDS

Include positive measures to address factors that block equal access to prevention, treatment, care and support for vulnerable populations and to strengthen the involvement of communities in the HIV response.

The Report of the Global Commission on HIV and the Law, 'Risks, Rights & Health' looks in particular at the impact of intellectual property and other laws on access to treatment for HIV and AIDS. It notes that a growing body of international trade law and the over-reach of intellectual property protections are impeding the production and distribution of low-cost generic medicines, which impacts most severely on low and middle-income countries. It recommends that countries develop an effective intellectual property regime that is consistent with international human rights laws and public health needs, while safeguarding the justifiable rights of inventors. In particular, it recommends amongst other things that:

- All countries must adopt and observe a global moratorium on the inclusion of any intellectual property provisions in any international treaty that would limit the ability of countries to retain policy options to reduce the cost of HIV-related treatment

- All countries should, to the extent possible, incorporate and use TRIPS flexibilities, consistent with safeguards in the own national laws
- Countries with manufacturing capacity and those reliant on the importation of pharmaceutical products must retain the policy space to use TRIPS flexibilities as broadly and simply as they can
- Low and middle-income countries must facilitate collaboration and sharing of technical expertise in pursuing the full use of TRIPS exceptions (for instance, by issuing compulsory licences for ARVs and medicines for co-infections such as hepatitis C). Both importer and exporter countries must adopt straightforward, easy-to-use domestic provisions to facilitate the use of TRIPS flexibilities.
- Developing countries should desist from adopting TRIPS-plus provisions including anti-counterfeiting legislation that inaccurately conflates the problem of counterfeit or substandard medicines with generics and thus impedes access to affordable HIV-related treatment.
- Countries must proactively use other areas of law and policy such as competition law, price control policy and procurement law which can help increase access to pharmaceutical products.

Public Health Legislation

In the Public Health Act Cap 277 of 1925 the term "infectious or communicable disease" is defined as "any disease declared as such by regulations". The Public Health (Infectious or Communicable Diseases) Regulations 1987 include HIV and AIDS in the definition of the term "infectious or communicable disease".

Furthermore, the word "patient" in

the Public Health Act is defined as "a person suffering from an infectious or communicable disease".

Notification of Infectious or Communicable Disease

Section 41 of the Public Health Act stipulates that:

- (a) The occupier of any premises in which resides a patient shall as soon as he becomes aware of the fact, give notice to the Sanitary Authority or the Health Inspector of the relevant district.

- (b) Where the occupier is prevented by illness or otherwise from giving notice, the nearest relative of the patient present on the premises or being in attendance on the patient, and where there is no relative, any person in charge of or in attendance on the patient shall give notice.

"Premises" includes, inter alia, any land, house, building, structure, open place, covered or enclosed place, any vehicle, ship or floating craft.

The Public Health Act also imposes a duty of notification on medical practitioners and failure to notify constitutes an offence in law.

Section 42 (1) of the Public Health Act stipulates that every medical practitioner attending on or called in to visit a patient shall, on being aware that the patient is suffering from an infectious or communicable disease, give notice to the Sanitary Authority or the Health Inspector of the relevant district of the following information:

- (a) the existence of the disease;
- (b) the name of the patient;
- (c) the situation of the premises; and
- (d) the name of the occupier of the premises.

Civil Status Officers must also report to the Sanitary Authority or to the Health Inspector of the relevant District any death from an infectious or communicable disease which may be declared to him or of which he may become aware in his official capacity.

The Sanitary Authority: Powers of Entry and Inspection

On receipt of a notification by an occupier of premises, a medical practitioner or on becoming aware of the existence of an infectious or communicable disease on any premises, the Sanitary Authority or the Health Inspector of the district, may enter the premises between sunrise and sunset and take such steps as may be authorized or prescribed by the Public Health Act.
The Sanitary Authority and/or any Health Inspector, as the case may be, may

- (a) enter during the day or night and inspect any premises where he may have reasonable grounds to believe that an infectious or communicable disease exists or has recently existed whether or a notification has received;
- (b) enter upon any premises between sunrise and sunset to exercise such supervision and control as may be necessary over any case of infectious or communicable disease existing upon the premises;
- (c) enter upon any premises between sunrise and sunset to enforce due observance of the Public Health Act; and
- (d) enter any common lodging house.
- Even in the absence of any notification as seen above, the Sanitary Authority may examine any person found on any premises with a view to ascertaining whether that person is suffering, or has recently suffered, from an infectious or communicable disease.

There is no evidence that the provisions of the Public Health Act relating to notification or entry and inspection have ever been invoked in respect of HIV and AIDS. Should they however be applied to HIV it would constitute an unjustifiable limitation on the rights to privacy and dignity of people living with HIV.

Recommendations:
It is critical that the Public Health Act be amended to exclude HIV and AIDS from the operation of section 42 and also to ensure that notification provided for in section 41 is anonymous and unlinked and is undertaken only for the purposes required for disease surveillance.

Health and HIV Policies, Strategies and Plans

The National HIV/AIDS Policy (2012) contains comprehensive provisions on HIV prevention, treatment and care:

5.10 HIV Prevention

Prevention efforts shall be concentrated on the populations most at risk and shall involve working with government and private health services, civil society and community groups to put in place a range of targeted interventions aimed at reducing risk behaviour. Strategies shall include targeted condom promotion, outreach to particular populations at sexual risk, integration of HIV into sexual and reproductive health services, HIV Counselling and Testing, provision of optimum treatment and care, needle exchange outreach to people who inject drugs and referral to drug treatment services, and harm reduction in prisons.

Efforts shall be made to ensure that accurate and relevant information about HIV and AIDS and the behaviours that put people at risk for HIV infection shall be made available to people in a language

and format that they understand and from sources that they respect. There shall be particular focus on reaching people with little formal education, people who cannot read and people from marginalized groups and communities. The assistance of groups that reach into particular communities shall be sought to ensure that HIV and AIDS information reaches deep into these communities.

Appropriate HIV and AIDS information shall be included in school curricula and in teachers' training programs to ensure that in-school youth receive accurate information about HIV.

In line with the focus on populations most at risk, the particular HIV prevention needs of out-of-school youth, migrant workers, mobile populations and prisoners shall be addressed through targeted government and NGO/community programs.

5.12 HIV testing and counselling

HIV testing and counselling shall be actively promoted as a key prevention strategy and a bridge to treatment, care and support for people living with HIV and AIDS, in those circumstances where effective pre- and post-test counselling are ensured. HIV testing and counselling shall be voluntary and confidential, and testing shall be accompanied by access to information and counselling. People who test HIV positive shall be assisted in accessing on-going counselling, treatment, care and support. Test results shall be confidential and systems put in place to ensure the privacy of people who undergo HIV testing. In cases of provider-initiated testing because of perceived risk or as a diagnostic measure in the presence of illness, the specific consent of the person shall be obtained before testing. Particular attention shall be paid to reducing barriers to access to voluntary testing and counselling, particularly for women.

5.13 Access to treatment, care and support

People with HIV and AIDS shall have the same access to health services as other citizens of Mauritius. To improve access, health services shall take steps to decentralize HIV treatment, care and support services so that they are located as close as possible to the people who need them. Standards of treatment and care shall be set and monitored and the active participation of people with HIV and AIDS shall be encouraged as a way of improving the quality of health services. Health services shall work towards achieving consistent access to the medicines that prevent or treat opportunistic infections and increased access to anti-retroviral therapies. Treatment and care, including anti- retroviral therapy and laboratory services, shall be provided free of charge to people living with HIV and AIDS and shall be integrated into a comprehensive program.

This comprehensive care shall include specific attention to nutritional needs of People living with HIV and AIDS. It shall also include counselling and services for fertility control.
Government shall ensure that HIV-related treatment, care and support provided by private health institutions comply with national standards and protocols.

The National Action Plan on HIV and AIDS (2017-2021) contains similar provisions on access to prevention, treatment and care:

8.2.1 Reduced Legal Barriers to Access HIV Prevention, Treatment and Care

In line with the National HIV Policy, the existing laws and policies will be reviewed to ensure that they do not encourage stigma and discrimination or constitute a barrier to HIV prevention, treatment, care & support, or work against the vision and objectives of the national HIV and AIDS response.

In order for PLHIV to enjoy full human rights, it is important that they operate within an equal opportunity environment. To create this environment, it is imperative that policies, laws and practices do not inadvertently contribute to HIV risk, or to HIV-related stigma and discrimination. Any dissonance in the laws therefore has to be repealed or amended. This outcome implies identifying all these laws, and reviewing them for a harmonization with the international commitments that were made.

The HIV and AIDS Act 2006 clearly points out that no form of discrimination and stigma will be tolerated against PLHIV on the grounds of HIV status in terms of employment, promotion and within health care settings. However, PLHIV do not know their rights. This situation is exacerbated by the lack of financial resources for the legal fees to bring a case to court. Under this NAP, there will be interventions that will encourage PLHIV and KAPs to know their rights so that they can assert them and make use of the existing legal provisions: 'Know your rights' literacy programmes will be conducted. The HIV and AIDS Act 2006 provides a framework for the protection of the rights of PLHIV and for the implementation of the Needle Exchange Programme among others. The Equal Opportunities Act 2012 makes provision for recourse to justice for the many people infected and affected by HIV whose rights are violated or who face stigma and discrimination and have

difficulty accessing legal services due to lack of finances. Increasing access to legal aid for PLHIV-KAPs will ensure that victims of stigma and discrimination have the possibility to obtain free legal advice and services so that cases can proceed.

Reducing discrimination in access to services - Programmes aimed at reducing stigma and discrimination against people living with HIV or people at risk of HIV infection should address the actionable causes of stigma and discrimination and empower people living with and vulnerable to HIV. This NAP will address discrimination. In addition to respecting and protecting people's rights to have access to services, it is important to facilitate the achievement of broader public health goals by ensuring that no person eligible for the identified services is denied access on an arbitrary basis. Denial of access may take place in a number of ways, including by way of services being provided in a manner that fails to address or understand a person's specific needs. This may include staff attitudes that discourage people from accessing social services.

Isolation and detention of patients

Isolation and detention of patients may be a reasonable public health response in certain circumstances, in order to contain the spread of infectious diseases. However, public health provisions for the isolation and detention of patients should not be inappropriately applied to HIV and AIDS.

Current Position

In the Public Health Act Cap 277 of 1925 the term "infectious or communicable disease" is defined as "any disease declared as such by regulations". The Public Health (Infectious or Communicable Diseases) Regulations 1987 include HIV and AIDS in the definition of the term "infectious or communicable disease".

Furthermore, the word "patient" in the Public Health Act is defined as "a person suffering from an infectious or communicable disease".

In terms of section 48 of the Public Health Act, "Where, in the opinion of the Sanitary Authority, any person, certified by a medical practitioner to be suffering from an infectious or communicable disease, is not accommodated or is not being treated or nursed so as to guard against the spread of the disease, that patient may, on the order of the Sanitary Authority, be removed to and detained in a hospital or temporary place which, in the opinion of the Sanitary Authority is suitable for his reception until the Sanitary Authority or any medical practitioner authorised by the Permanent Secretary of the Ministry of Health is satisfied that he is free from infection or can be discharged without danger to the public health". (Emphasis added)

There is no evidence that the provisions of the Public Health Act relating to detention have ever been invoked in respect of HIV and AIDS. Should they however be applied to HIV it would constitute an unjustifiable limitation on the rights to liberty, privacy and dignity of people living with HIV.

Recommendations

It is critical that the Public Health Act be amended to exclude HIV and AIDS from the operation of section 48 to ensure that the

115 UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights
116 LINK
117 At p9-10

provisions of this Act regarding isolation and detention cannot be inappropriately invoked against people living with HIV.

Informed Consent to HIV Testing and Treatment and Confidentiality

HIV testing only on the basis of voluntary and informed consent is viewed as a critical public health response to encourage people's willingness to access health care services, as well as a human rights imperative in terms of human rights commitments. Mandatory HIV testing is discouraged by both the World Health Organization and UNAIDS as an ineffective measure to achieve public health **goals**[115]. The WHO Consolidated Guidelines on HIV Testing Services **(July 2015)**[116] reiterate that HIV testing should be confidential and performed only with informed consent.

Excerpt from WHO Consolidated Guidelines on HIV Testing Services (HTS)[117]

A public health and human rights-based approach is important to delivering HTS. A human rights-based approach gives priority to such concerns as universal health coverage, gender equality and health-related rights such as accessibility, availability, acceptability and quality of services. For all HTS, regardless of approach, the actual public health benefits must always outweigh the potential harm or risk. Moreover, the chief reason for testing must always be both to benefit the individuals tested and to improve health outcomes at the population level.

HTS should be expanded not merely to achieve high testing uptake or to meet HIV testing targets, but primarily to provide access for all people in need to appropriate, quality HTS that are linked to prevention, treatment, care and support services. Thus,

HIV testing for diagnosis must always be voluntary, consent must be informed by pre-test information, and testing must be linked to prevention, treatment, care and support services to maximize both individual and public health benefits. All forms of HIV testing should adhere to the WHO 5 Cs: Consent, Confidentiality, Counselling, Correct test results and Connection (linkage to prevention, treatment and care services). Coerced testing is never appropriate, whether that coercion comes from a health-care provider, an employer, authorities (such as immigration services) or a partner or family member.

The 5 Cs are principles that apply to all HTS and in all circumstances

- Consent: People receiving HTS must give informed consent to be tested and counselled. (Verbal consent is sufficient; written consent is not required.) They should be informed of the process for HIV testing and counselling and of their right to decline testing.
- Confidentiality: HTS must be confidential, meaning that what the HTS provider and the client discuss will not be disclosed to anyone else without the expressed consent of the person being tested. Confidentiality should be respected, but it should not be allowed to reinforce secrecy, stigma or shame. Counsellors should discuss, among other issues, whom the person may wish to inform and how they would like this to be done. Shared confidentiality with a partner or family members – trusted others – and healthcare providers is often highly beneficial.
- Counselling: Pre-test information can be provided in a group setting, but all people should have the opportunity to ask questions in a private setting if they request it. All HIV testing must be

118 Jansen van Vuuren and Another NNO v Kruger 1993 (4) SA 842 (A)

accompanied by appropriate and high-quality post-test counselling, based on the specific HIV test result and HIV status reported. Quality assurance (QA) mechanisms as well as supportive supervision and mentoring systems should be in place to ensure the provision of high-quality counselling.

- Correct: Providers of HIV testing should strive to provide high-quality testing services, and QA mechanisms should ensure that people receive a correct diagnosis. QA may include both internal and external measures and should receive support from the national reference laboratory. All people who receive a positive HIV diagnosis should be retested to verify their diagnosis before initiation of HIV care or treatment.

- Connection: Linkage to prevention, treatment and care services should include effective and appropriate follow-up, including long-term prevention and treatment support. Providing HTS where there is no access to care, or poor linkage to care, including ART, has limited benefit for those with HIV.

The current high level of stigma and discrimination is a deterrent to people finding out and disclosing their HIV status. People need to have confidence that information concerning their health is treated confidentially and is not disclosed to a third person without their informed consent. Confidentiality of medical information, including HIV status, is vital to promoting confidence in public health systems. The South African case of Jansen van Vuuren v Kruger has confirmed the medical practitioner's obligation to, as well as public health importance of, maintaining a patient's right to confidentiality regarding HIV **status**[118]. There are suggestions that actual or perceived poor recognition of the

119 Sections 7, 11 and 13
120 Personal comm with NHRC representative 6 December 2017.

importance of confidentiality in current health care services may discourage people from accessing HIV-related services.

Current Position

Para 5.12 of the National HIV/AIDS Policy provides that 'HIV testing and counselling shall be actively promoted as a key prevention strategy and a bridge to treatment, care and support for people living with HIV and AIDS, in those circumstances where effective pre-and post-test counselling are ensured. HIV testing and counselling shall be voluntary and confidential, and testing shall be accompanied by access to information and counselling. People who test HIV positive shall be assisted in accessing on-going counselling, treatment, care and support. Test results shall be confidential and systems put in place to ensure the privacy of people who undergo HIV testing. In cases of provider initiated testing because of perceived risk or as a diagnostic measure in the presence of illness, the specific consent of the person shall be obtained before testing. Particular attention shall be paid to reducing barriers to access to voluntary testing and counselling, particularly for women'.

The HIV and AIDS Act No. 31 of 2006 also provides for HIV testing only with informed consent and protects the confidentiality of HIV test **results.**[119]

Despite these policy and legal provisions informed consent to testing and confidentiality regarding HIV status appears to be compromised in some settings. For example, all prisoners are offered an HIV test on entry into prison in line with the policy of provider initiated testing and counselling. Prisoners have however reported that HIV testing on entry is not always voluntary and that the option to refuse a test is not entertained. Whilst

119 Sections 7, 11 and 13
120 Personal comm with NHRC representative 6 December 2017.
121 See Medical Council (Code of Practice) Regulations 2000 Schedule Part II (3)

prisoners do have access to antiretrovirals, confidentiality in the dispensing of ART is not always respected. It has been reported that, for example, prisoners are called out publicly in the prison courtyard to 'come and fetch their **ARVs'.**[120]

Age of consent to testing and treatment

In terms of section 7 (2)(b) of the HIV and AIDS Act of 2006, a minor (defined as being under the age of 18 in Mauritian law) requires the informed consent of his or her parent or legal guardian in order to have an HIV test. A minor cannot access treatment for HIV or for any other condition without the consent of his or her parent or legal **guardian.**[121]

The age of consent to sex is 16. The potential effect of the difference between the age of majority and the age of being able to consent to sex is that although a young person over 16 can legally consent to sex, he or she would still require parental consent in circumstances where they may require HIV testing, treatment for sexually transmitted infections, hormonal contraceptives and other sexual or reproductive health services. Research shows that very few young people are willing to seek their parent's permission to access services and in many cases even health practitioners are unclear of their patient's rights and their responsibilities with regard to sexual and reproductive health services. This, combined with the poor attitudes of health care workers to young people's access to sexual and reproductive health services, contributes to poor management of reproductive health services for young people, who may be at higher risk of HIV exposure.

However this potential impediment to access to HIV testing by minors is ameliorated by section 7(5) of the HIV and AIDS Act of 2006 which provides that

121 See Medical Council (Code of Practice) Regulations 2000 Schedule Part II (3)

'A person may undertake an HIV test on a minor without the consent of his legal administrator or guardian where the minor makes a written request for such test and that person is satisfied that the minor understands the nature of his request'. This is in line with international good practice on access of minors to HIV testing. The same is not true for access to treatment by minors.

Recommendations

- Consideration should be given to amending the law to align the age of consent to sexual and reproductive health services and to HIV treatment to that of consent to sexual intercourse.

Ensure that health care providers and prison service members are provided with training on a regular basis to ensure that testing is only conducted with informed consent and that confidentiality regarding HIV status is maintained and all times.

Access to HIV Treatment, Care and Support

Laws, regulations, policies and guidelines need to provide equitable access to HIV-related health care services in order to ensure effective responses to HIV and AIDS. Access to HIV prevention, treatment, care and support services should be available to all people without discrimination and in particular should prioritize access for key populations at a higher risk of HIV exposure. This requires developing appropriate HIV laws and policies as well as ensuring training for health care workers on non-discrimination and on the provision of HIV-related health care to key populations.

Intellectual property law is a key factor affecting access to treatment. Patents have the potential to restrict access by creating protections on drugs which give patent holders exclusive control to license, manufacture and distribute their product. As a consequence, the lack of competition

[21] See Part V for detailed recommendations

on many patented drugs generally leads to high prices and unaffordability of essential drugs.

Current position

Both the National Policy of HIV/AIDS and the National Action Plan on HIV and AIDS make provision for access to HIV prevention, treatment, care and support for all who need it, without discrimination

Excerpts from the National Policy on HIV (2012)

5.1 Reducing HIV and AIDS stigma and discrimination

People with HIV and AIDS and people thought to be at risk of HIV infection shall enjoy the same rights that are afforded to all citizens of Mauritius. They shall be treated with dignity and respect when they seek health and welfare services and this will encourage them to maintain contact with these services. They shall be cared for in communities in the same manner that other people are cared for and their participation in the design, delivery and evaluation of HIV and AIDS prevention and care initiatives shall be encouraged and valued. Health services shall pay particular attention to reducing the barriers that prevent people with HIV and AIDS from coming forward for counselling and treatment. Health workers shall be provided with training and support to ensure that they can provide non-judgemental care and support for people affected by HIV and AIDS. Employers shall be assisted to modify their policies to ensure that people with HIV and AIDS have continued access to employment. Anti-discrimination laws shall be amended to make it illegal to discriminate against people perceived to be at particular risk of HIV infection. The Media shall be empowered to play a constructive role in the response to HIV and AIDS

through reporting that increases access to accurate information and decreases HIV-related stigma and discrimination.

Excerpts from the National Action Plan

8. National Action Plan Objective 5: Zero Stigma and Discrimination

More than three decades into the HIV epidemic, stigma and discrimination continue to hamper efforts to prevent new infections and engage people in HIV treatment, care and support programmes. Numerous studies have linked HIV-related stigma with refusal of HIV testing, non-disclosure to partners and low uptake of biomedical prevention services and commodities, including condoms, pre- and post-exposure prophylaxis and ART.

Effective interventions to reduce stigma and discrimination are crucial to the success of biomedical prevention. Such interventions need to be integrated into national responses and address the stigmatization process. Stigma and discrimination interfere with HIV prevention, diagnosis and treatment, and can become internalised by people living with HIV/AIDS. Importantly, stigma and discrimination are often enacted through discrimination (defined as the rejection or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, health status or gender), hostility and prejudice against PLHIV (as well as their partners and families), denying them equal access to essential services in many cases. Stigmatisation associated with HIV/AIDS is underpinned by many factors, such as lack of understanding of the disease (including misconceptions about modes of transmission), lack of access to treatment, irresponsible media reporting, and the

incurability of AIDS. Stigmatization is additionally conflated with widespread prejudice and fears relating to socially sensitive issues (including sexuality and sex work) which themselves contribute to HIV risks and vulnerability among members of key populations. Not only is HIV/AIDS-related discrimination a human rights violation, but it is also necessary to address such discrimination and stigma in order for public health goals related to HIV/AIDS prevention and management to be achieved.

HIV-related stigma and discrimination drive the risk of, and vulnerability to, HIV infection by keeping people from accessing prevention, treatment, care and support services thereby depriving them of their human rights. Consistent with UNAIDS vision to getting to zero discrimination, this result focuses on actions that ensures that persons infected and/or affected by HIV and AIDS have their fundamental rights respected, that they have the same access to services as the rest of the community, and that being infected and/or affected by HIV/AIDS does not constitute a barrier or obstacle to accessing health, social, economic and psychosocial services. Where rights are found to have been violated, access to justice programme for affected people and communities are also going to be important.

Interventions under this impact area will assist in alleviating the impact of HIV and AIDS on health, social and economic wellbeing of people infected and affected by HIV. It is well known that HIV has negative effects on the health of individuals and families, but also on their economic and social wellbeing. It is evident that increased access to ARV helps PLHIV to remain healthier and contributes towards zero HIV related death which allows them to be economically active for longer. In addition, the social environment of PLHIV has to

be supportive and free from stigma and discrimination, and the legal framework must be clear regarding the rights of PLHIV and those at perceived risk of HIV. Interventions to support achievement of this result will be directed towards Policy Makers, People infected and affected by HIV, Key Affected Populations, Women, Sex workers, People of actual or perceived diverse sexual orientations and gender identity.

8.2.1 Reduced Legal Barriers to Access HIV Prevention, Treatment and Care

In line with the National HIV Policy, the existing laws and policies will be reviewed to ensure that they do not encourage stigma and discrimination or constitute a barrier to HIV prevention, treatment, care & support, or work against the vision and objectives of the national HIV and AIDS response.

8.2.2 Social and Legal Protection for Persons Living With HIV and Aids and Key Populations

The following interventions will be considered in the 2017-2021 NAP:
Advocate for legal reform – Laws, regulations and policies relating to HIV can negatively or positively impact the HIV epidemic, as well as the lives and human rights of those living with and affected by HIV. Therefore, it is crucial to monitor and reform laws, regulations and policies so that they support, and not hinder, access to HIV and health services. HIV infected and/or affected individuals should have the same access to all health services as the rest of the community.

For key populations, efforts are required of everyone including the organizations working with key populations, human rights groups, healthcare institutions and other civil society organizations to improve

the legal and policy contexts so that all persons, regardless of sexual orientation or behaviour have access to the necessary health services and support to deal with HIV and AIDS.

Advocacy and sensitisation on PLHIV rights - Laws in Mauritius do not discriminate against PLHIV on the grounds of HIV status in terms of employment, in society and in health services access.

Responsiveness of the social legal environment to the health needs of PLHIV and KPs - PLHIV are becoming increasingly aware of their rights, but few access them. This area of focus will look into influencing change in the social and legal arenas mainly through advocacy for building capacity around legal literacy and access to justice; and promotion of the enactment and implementation of laws, regulations and guidelines that prohibit discrimination and support access to HIV prevention, treatment, care and support.

Reducing discrimination in access to services - Programmes aimed at reducing stigma and discrimination against people living with HIV or people at risk of HIV infection should address the actionable causes of stigma and discrimination and empower people living with and vulnerable to HIV. This NAP will address discrimination. In addition to respecting and protecting people's rights to have access to services, it is important to facilitate the achievement of broader public health goals by ensuring that no person eligible for the identified services is denied access on an arbitrary basis. Denial of access may take place in a number of ways, including by way of services being provided in a manner that fails to address or understand a person's specific needs. This may include staff attitudes that discourage people from accessing social services.

Increased capacity training to prevent discrimination - While it is important to hold all social service providers accountable through professional disciplinary mechanisms, it is also vital that such professionals have access to dedicated human rights training programmes designed to equip them with the necessary skills to respect, protect and promote equality in the provision of social services and be sensitized on the needs of key

populations. This intervention is, therefore, aimed at all bodies that train social service providers in HIV and TB care, as well as dedicated services for pregnant women, children and adolescents. In particular, this intervention seeks to ensure that all public and private bodies providing training in HIV and/or TB include modules dealing with discrimination, with a focus on key and vulnerable populations that include people with special needs.

Mauritius is experiencing an increasing Hepatitis C and HIV co-infection among people who inject drugs. According to the 2016 UNAIDS data, this is at 99.4% in an estimate of 11 677 per of 100,000 **population.**[122]

Health care in Mauritius is free, and this includes medical consultation, laboratory tests, medicines and other health commodities, hospital stay and any other related costs. Due to its relatively small population, the quantities of medicines procured are also correspondingly small. According to the Principal Pharmacist at the Ministry of Health, the country only has a few patients receiving second line ARV regimen - namely raltegravir, tenofovir and darunavir. However, it is noted that procurement for diabetes medicines is consuming much of the budget as prevalence rises.

There have been access barriers to newer

122 UNAIDS LINK
123 Per Sarita Boollel, Principal Pharmacist in the Ministry of Health, with her whole team comprised of Ms Catmarow, Mr Auleear, Mr Narrainen, Mr Jawaheer and Mr Elyhee.

medicines in the country, caused mainly by intellectual property barriers. Previously, the treatment for Hepatitis C virus infection in Mauritius was pegylated interferon and ribavirin. However, the country started using Harvoni - a combination sofosbuvir and ledipasvir, which is a more efficacious treatment regimen.123 Although available, access is restricted by the fact that access to Hepatitis C diagnostics is severely restricted as it is only available privately and the cost is beyond the reach of most people who need it, in particular people who use drugs or who are on methadone substitution therapy.

Medicines regulatory and procurement environment

The country's national Essential Medicines List is regulated by the Pharmacy Board. It is regularly updated to incorporate the essential drugs in accordance to the World Health Organisation (WHO) Essential Medicines. The Pharmacy Board is regulated by the Ministry of Health & Quality of Life. Mauritius does not have a Medicines Regulatory Authority that assesses the quality of medicines submitted for registration - this work is currently mandated to the Pharmacy Board. Currently, medicines procurement is done by way of public tender followed by adjudication of bids by a Committee. A bi-annual audit of all procurement processes is carried out and the report is submitted to Parliament for consideration. This Board is made up of doctors and pharmacists and a representative from the Ministry of Trade. All

Government tenders are published on the official website for public procurement.124 An analysis of the tenders awarded reveals that the medicines procured from European suppliers are more expensive than those procured from **India[125].**

124 LINK
125 LINK
126 SARPAM Procurement of Patent Medicines by SADC Member States (2014), at 6. Available at LINK

Mauritius has two pharmacy laboratories, and one of these is an accredited Level 3 laboratory. This laboratory infrastructure is crucial for medicines regulation, especially when the country decides to utilise parallel importation of medicines.

Intellectual property legislation

Mauritius is a member of the World Trade Organisation (WTO) and is therefore obliged to comply with the Agreement on Trade-Related Intellectual Property Rights (TRIPS). To sustain the country's growing non-communicable disease burden, Mauritius would benefit from consideration of some of the flexibilities provided for under the TRIPS - as an avenue to move towards a sustained access to medicines. Mauritius has proved to be a progressive WTO member. This was evident in the country's acceptance of the Protocol amending the TRIPS Agreements to formally include the 2003 August 30th decision in the Agreement – thus supporting regional approaches to procurement and joint notifications by countries with similar **needs.**[126]

The relevant legislation regulating intellectual property and access to medicines in Mauritius include the Patents, Industrial Designs and Trademarks Act No. 25 of 2002, the Pharmacy Act 60 of 1983 and the Mauritius Institute of Health Act 36 of 1989. The Patents Act, which came into effect on 6 January 2003 required a number of amendments in order to fully incorporate TRIPS flexibilities. Gaps identified within the Mauritius Patent/ IP legislation included the following; (i) the need to strengthen the patent law to facilitate the challenge of patenting of known medicines for newer uses, or the discovery of a new form of a known substance which does not result in the enhancement of the known efficacy of that substance – a concept known as "ever-greening"; (ii) the need to add a provision to allow parallel importation; (iii) the need

127 The Mauritius Industrial Property Bill is available at LINK

to add a provision to allow early working exceptions; and (iv) the need to incorporate provisions of Article 31bis of TRIPS into its national legislation.

In 2011, Mauritius developed an Intellectual Property Development Plan for Mauritius with technical assistance from the World Intellectual Property Organisation (WIPO). The Plan is mostly focused on the use of intellectual property rights for economic development, and does not mention the use of flexibilities provided for in the Agreement on Trade-Related Intellectual Property Rights (TRIPS).

In 2014, the Medicines Patent Pool (MPP) signed a Voluntary license with Gilead, the originator company of sofosbuvir. The license granted non-exclusive licenses initially to 11 Indian companies to produce generic versions of sofosbuvir and ledipasvir/sofosbuvir for use in 101 countries, and included the single-tablet regimen of sofosbuvir/velpatasvir. Mauritius was one of the countries currently procuring these medicines from India.

In order to comply with the WTO/TRIPS agreement, Mauritius published the Industrial Property Bill in **December 2016.**[127] The Bill covers a variety of intellectual property areas including specific provisions which incorporate the TRIPS flexibilities. These are covered under Sections 10 to 25 - "Patents, Utility Models and Patent Cooperation Treaty". Although some of these provisions require strengthening and numerous submissions have been made to the Ministry of Foreign Affairs, Regional Integration and International Trade in this regard, the Bill is progressive in its intent to incorporate the flexibilities. The Bill provides express provision on matters excluded from patent protection; a definition of what is considered as

'inventive step', compulsory licensing, and parallel importation. Additionally, a clear mandate is granted to the Industrial Property Office. The Bill also establishes the Industrial Property Tribunal (Section 8) with jurisdiction to grant and/ or reject patents; as well as an Intellectual Property Council, under Section 7 to provide strategic advice to the Minister.

Recommendations

- Advocate for the Industrial Property Bill to be brought into force;
- Capacity-building with stakeholders on TRIPS flexibilities and related issues;
- Provide guidance on good practice for implementation of TRIPS;
- Ensure health care workers have training, including rights-based and sensitization training, to adequately implement and provide non-discriminatory services to key populations and young people;
- Ensure greater access to healthcare services and provide infrastructure to support increased home visits, if necessary;
- Ensure better linkages between needle exchange and MST programmes and HIV testing and treatment.
- Develop national ARV and HIV diagnosis protocols in collaboration with PLHIV and NGOs working directly with key populations.
- Government to organize regular training of staff involved in activities such as storage, inventory management, distribution and dispensation of products.

- Strengthen managerial and technical capacity of NDCCI staff to manage and treat HIV, especially in regard to adherence counselling, patient monitoring and research.

- Ensure stronger supervision and support to staff working at NDCCI and other units to maintain and improve quality of prevention, treatment and care services provided. This includes ongoing training to intermediary cadres (pharmacy assistants, methadone dispenser etc) and specialists from other departments (dermatology, gynaecology, paediatrics) on stigma and discrimination so that they can work more effectively with key populations and PLHIV.

- The Central Laboratory should introduce a system for routine surveillance of priority STI pathogens to monitor prevalence and resistance patterns as well as Hepatitis C virus.

- Monthly HIV data should be provided to NGOs to enable them to monitor the national HIV surveillance and have access to such key data. It is additionally recommended that HIV cascade be provided for key populations as well as for the general population.

- MoH should commit to using viral load with PLHIV as a measure of understanding, control and motivation to adhere to treatment and understand their HIV infection, coupled with appropriate counselling to address, among others, the implication of a detectable or undetectable viral load.

Establish a national Hepatitis committee to create and implement a national Hepatitis plan with the meaningful involvement of people living with Hepatitis to address mainly the issue of access

to diagnosis (viral load and genotyping) and treatment for people living with HIV, people currently injecting or on MST.

Regulation of Health Care Providers

Current Position

Section 12(a) of the Medical Council Act 1999 (as amended) stipulates that the Medical Council, among its many functions, shall "exercise and maintain discipline in the practice of medicine". Accordingly, the Medical Council has the responsibility to investigate any complaint of medical negligence, professional misconduct, malpractice or any breach of the Code of Practice against a registered person.

During the preliminary investigation, the Investigating Committee of the Council may summon and hear the registered person and witnesses. It may call for relevant documents including from clinics and hospitals. Additionally, the person whose conduct, act or omission is under investigation is notified about the nature of the complaint.

In case a person refuses to give evidence or to communicate any document on the ground of confidentiality, the Registrar may apply to a Judge sitting in Chambers for an order directing that person to disclose the evidence required or communicate any document needed for the purposes of the investigation.

After the preliminary investigation, the Investigating Committee makes a report on the case to the Medical Council. A decision is then taken as to whether the case has to be set aside or whether the concerned registered person has committed a fault and has to be sanctioned. The Medical Council can inflict a warning or a severe warning to the registered person. In case Council considers the case more serious,

it may institute disciplinary proceedings against the registered person before the Medical Disciplinary Tribunal.

If the Council considers that public interest requires the registered medical practitioner to instantly cease to practise medicine, it can suspend the registered person instantly.

The Tribunal, after having enquired into the case, submits a report and a copy of its proceedings to Council stating whether the charge levelled against the registered person

has been proved or not. In cases where the charges have been proved, Council may inflict the following sanctions:-

- administer a warning or a severe warning,
- administer a reprimand or a severe reprimand,
- suspend the medical practitioner from medical practice for a period not exceeding 12 months, or
- remove the name of the registered person from the register.

Recommendations

- Procedures to report misconduct should be clearly available at all health care facilities in clear and simple language;
- The establishment of a toll-free hotline to report misconduct should be investigated;
- Ways in which to access the complaints systems at the professional disciplinary bodies in a less bureaucratic and time-consuming manner should be investigated.

C. Criminal Law and Law Enforcement

128 See, for instance, GCHL (2012) Risks, Rights & Health; AMSHeR and CAL (2013) Violence Based on Perceived or Real Sexual Orientation and Gender Identity in Africa
129 Sexual Orientation, Gender Identity, HIV and Human Rights: An Advocacy Toolkit, ARASA available at LINK

SEXUAL ORIENTATION AND GENDER IDENTITY

Human rights abuses and violations significantly undermine the right to health of LGBTI people and increase their vulnerability and risk of exposure to HIV, including by limiting access to sexual and reproductive health care such as HIV prevention, treatment, care and support. Multiple and overlapping forms of stigma and discrimination, based on sexual orientation, gender identity, gender, actual and perceived HIV status, socio-economic status and race diminish the ability of LGBTI individuals to realize their human rights, including their right to access health care. The failure to access appropriate health care services timeously to prevent the risk of HIV transmission and to treat HIV and AIDS makes LGBTI persons particularly vulnerable in the context of **HIV**[128]**.**
Stigma and discrimination undermine access to health care, including HIV-related **health care**[129]:

- Transgender persons face particular forms of stigma and discrimination that undermine their access to health care, work and education. For example, they may not be able to obtain identity documents, including passports, which reflect their gender. This can complicate medical aid insurance for various reasons. Another example is that medical aid companies are not only reluctant to cover transition-related medical procedures; they will also only cover expenses specific to the gender listed in their legal documents. This results in regular sexual and reproductive health services being excluded, which would otherwise be covered.

- LGBTI persons report fear of and may avoid accessing health care services for various reasons. They fear unfair

[9] Ibid.
[10] UNAIDS Mauritius Country Progress Report 2015; Available at LINK (Accessed 31 January 2018).
[11] LINK (Accessed 31 January 2018).
[12] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[13] Submission by Chrysalide, Mauritius, Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August, 2011
[14] GCHL (2012) Risks, Rights & Health
[15] Ibid.

and discriminatory treatment at the hands of health service providers with limited understanding of sexual orientation, gender identity and transgender issues. This leads to prejudice, mistrust, discriminatory treatment, denial of health care and even abuse. LGBTI persons also express fears relating to disclosure of information regarding their HIV status, sexual orientation or gender identity. As a result, LGBTI persons may not seek out health services that they need.

- As a result of criminal laws, stigma and discrimination and the general 'invisibility' of LGBTI populations in countries, health information and services are not designed to meet specific health care needs relating to LGBTI person's sexual orientation and gender identity. LGBTI report that HIV-related and sexual and reproductive health information and services do not target or address their specific risks and concerns. Many staff at health facilities and service providers fail to understand gender identity and expression and display outdated approaches towards those. Health care services fail to provide appropriate sexual and reproductive health services for LGBTI populations such as appropriate barrier methods for lesbian, gay, bisexual, transgender or intersex persons (e.g. condoms with lubricants for men who have sex with men); hormone replacement therapy or gender affirming surgery. This further discourages access to health care.

- The Civil Status Office does not recognise transgender persons who would like their identity documents (National Identity Card, passport) to reflect their self-identified gender.

130 Toonen v. Australia, Communication No. 488/1992, U.N. Doc CCPR/C/50/D/488/1992 (1994)

The criminalisation of same-sex sexual conduct has had a profoundly negative impact on the human rights of LGBTI persons, including undermining their right to health. Criminalisation pushes vulnerable people away from important health services and information about their sexual and reproductive health needs. This in turn makes it difficult for health care providers to provide accessible, non-judgmental and effective access to HIV prevention, treatment, care and support.

In successive Declarations and commitments on HIV/AIDS such as the Abuja, Maseru and UNGASS Declarations, heads of state have acknowledged that the full realization of human rights and fundamental freedoms is crucial to the global AIDS response, including eliminating discrimination against people living with HIV and vulnerable groups, and ensuring legal protection and access to services. Increased participation by people living with HIV and key populations was also emphasized. Laws that criminalize same-sex relations lead to the virtual exclusion of LGBTI people from many national HIV/AIDS policies and a lack of implementation of such policies insofar as they refer to men who have sex with men.

The Human Rights Committee has found that the right to privacy is violated by laws that criminalize private homosexual acts between consenting adults and has noted that the criminalisation of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS and as such criminalisation not only interferes with the right to privacy but it also impedes HIV/AIDS education and prevention **work**.[130]

131 MSM IBBS 2012
132 TG IBBS 2017
133 National HIV/AIDS Policy, 2012 at para 4
134 National Action Plan on HIV and AIDS 2017-2021 at p 100
135 LGBTI FGD 6 December 2017
136 LGBTI FGD 6 December 2017

Current position

HIV prevalence amongst MSM **(20%)**[131] and transgender people **(28%)**[132] is higher than in the general population. There is no data on HIV prevalence amongst lesbian, bisexual and intersex people.

The National HIV/AIDS Policy (2012) recognises only MSM as a key population and provides that:
'

The primary focus of the HIV prevention effort shall be on reducing HIV infection amongst these populations. This shall involve a public health approach that seeks to work in partnership with these populations, and that takes care not to further stigmatize them. These are populations defined by behaviours and the people within these populations are members of the community at large. Reaching these populations shall involve working with health services, NGOs and community groups to determine approaches, strategies and messages that are accessible, appropriate and acceptable to these **populations'**[133].

The National Action Plan of HIV and AIDS 2017-2021 provides for Training of police officers and parliamentarians on LGBTI issues as an activity aimed at reducing HIV-related stigma and **discrimination.**[134]

In terms of Article 250 of the Criminal Code sodomy is a crime and is punishable with imprisonment for a term not exceeding 5 years. There are on average 15 prosecutions a year for sodomy and these are portrayed in the media in a sensational manner.135 Consensual sexual activity between adult females is not illegal.

Whilst the Constitution of Mauritius provides no protection against discrimination on the basis of sexual orientation or gender identity, both the Equal Opportunities Act

137 Clements-Nolle K, Marx R, Guzman R, Katz M: HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. Am J Public Health 2001;91:915–921.
138 Budge SL, Adelson JL, Howard KAS: Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping. J Consult Clin Psychol 2013;81:545–557.
139 Ibid at 36
140 LGBTI FGD 6 December 2017
141 "Male Sex Workers in Mauritius – The MSM Perspective", study conducted by Collectif Arc-en-Ciel under the Global Fund, 2015

and the Employment Rights Act prohibit discrimination on the basis of sexual orientation in employment, education, qualifications for a profession, trade or occupation, the provision of goods, services, facilities or accommodation, the disposal of property, companies, partnerships, "sociétés", registered associations, sports clubs and access to premises which the public may enter or use.

Despite the protection afforded by these laws, members of the LGBTI community have **reported**[136] high levels of stigma and other problems at public health care facilities:

- "The health services are not LGBTI friendly. The staff make distasteful remarks about the way that we dress. That is why so few of us go there."

- "Sodomy is illegal so I am reluctant to admit to health workers that I am engaging in anal sex or to seek assistance if injuries occur during anal sex. There are no health services that are MSM friendly."

- "Hormone treatment is not available through public health facilities so we have to buy them ourselves over the counter at a cost of around 30 000 Rupees."

"The public health system does not offer gender transformation surgery".

Roughly one third or less of TG reported experiences with stigma or discrimination due to their transgender identity Stigma and discrimination against TG are known to contribute to depression and other mental health **issues**[137],[138] and 33% of TG were found to have attempted suicide due to their transgender **identity.**[139]Transgender inmates are placed in male prisons and are required to shave off their **hair.**[140] In 2015, CAEC conducted an interview-based **study**[141] that revealed that more than 45%

142 LGBTI FGD 6 December 2017

of transgender people are unemployed and 73% stated that they engaged in sex work.

Currently the Mauritius Prison Service does not provide condoms to inmates due to the perception that to do so would to encourage prisoners to break the law by indulging in sodomy or related sexual acts.

Members of the LGBTI community report that although many of them are aware of the protection afforded against discrimination on the basis of sexual orientation by the Equal Opportunities Act and the Employment Rights Act, they perceive that complaints made to the Equal Opportunities Commission are treated as trivial complaints. They also report that they are dissuaded from lodging complaints with the Equal Opportunities Commission as the lodging of a complaint entails a disclosure of the complainant's identity and they fear the associated **publicity**[142].

Recommendations

- The provisions of the Criminal Code should be amended to decriminalise sodomy.
- The National HIV/AIDS Policy should be reviewed and amended to widen the definition of key population beyond MSM to include all LGBTI people.
- The Legislature, law enforcement officials, communities and religious leaders need to be trained to recognize and uphold the human rights of LGBTI, and should be held accountable if they violate these rights.
- The role of civil society in creating tolerance should be recognized and acknowledged and resources made available to support this role.
- The Mauritius Prison Service should provide prisoners with condoms.

- The Mauritius Prisons Service should accommodate transgender prisoners in a prison with people from their chosen non-birth gender, whether or not they have changed their physical sex appearance.
- The complaints procedure at the Equal Opportunities Commission should be amended to make provision for the suppression of identity of the complainant.
- Advocacy to increase awareness and an environment that supports the health and well-being of LGBTI people is crucial. The provision of health care provider sensitivity training to ensure access to LGBTI-friendly health care services, as well as the incorporation of mental health services into HIV prevention programs targeting LGBTI people should be expanded.
- Provision should be made for legal recognition of self-identified gender under national law without the need for surgery and related medical procedures.
- Ensure that any requirements for individuals to provide information on their sex or gender are relevant, reasonable and necessary as required by the law for a legitimate purpose in the circumstances where it is sought, and that such requirements respect all persons' right to self-determination of gender.
- Amend existing definitions in Mauritian legislation to include same-sex couples on the same basis as spouses of opposite sexes and legalise same-sex marriage.
- Expand the definition of 'gender' used in all policies and programmes to become fully trans-inclusive.

- Ensure that all national programmes addressing gender equality and violence against women and girls also address the particular issues faced by lesbian, bisexual and trans women.

- Promote education and awareness by integrating the issue of sexual orientation and gender identity into the educational curriculum including through human rights education and/or through specific age-appropriate courses focussing on sexual orientation and gender identity.

Sex workers

Sex workers are entitled to the full protection of their human rights, as specified in international human rights instruments. Human rights include the right to non-discrimination; security of person and privacy; recognition and equality before the law; due process of law and the highest attainable standard of health; employment, and just and favourable conditions of employment; peaceful assembly and association; freedom from arbitrary arrest and detention, and from cruel and inhumane treatment; and protection from violence.

Sex workers are essential partners and leaders in effective HIV and sexual health programs, and for developing solutions that respond to the realities of the environments in which they live and work. Laws that directly or indirectly criminalize or penalize sex workers, their clients and third parties, and abusive law enforcement practices, stigma and discrimination related to HIV and sex work can undermine the effectiveness of HIV and sexual health programs, and limit the ability of sex workers and their clients to seek and benefit from these programs.

Of particular concern is the violence perpetrated against sex workers, as well as repressive police practices, including harassment, extortion, arbitrary arrest and detention, and physical and sexual violence. Also of concern are health-care settings where there is stigma, discrimination and denial of health care to sex workers. Since sex worker-led organizations are crucial for enabling sex workers to protect themselves from discrimination, coercion and violence, measures that prevent them from assembling and organizing themselves are also of significant concern.

Attention and resources are needed to prevent, address, report and redress violence against sex workers, especially by supporting sex workers' individual and collective self-organization and self-determination. The promotion of a legal and social environment that protects human rights and ensures access to information, services and commodities related to HIV prevention, treatment, care and support, without discrimination, is essential for achieving an effective and rights-based response to the HIV epidemic and promoting public health, including in the context of sex work.

Current position

Sex work is not specifically criminalised in Mauritius. The Criminal Code (Supplementary) Act 196 – 7 November 1870 as amended criminalises the following activities related to sex work:

- Keeping of a brothel:
- Article 90 provides that:
- '(1) Any person who –
- (a) keeps or manages, or assists in the keeping or management of a brothel;
- (b) being the tenant, lessee or occupier, or person in charge of any premises, permits those premises or any part of them to be used as a brothel; or

- (c) being the landlord or lessor of any premises or the agent of such landlord or lessor, lets or continues to let the premises or any part of them with the knowledge that the premises or any part of them are or is to be used as a brothel, or is wilfully a party to the continued use of the premises or any part of them as a brothel, shall commit an offence and shall, on conviction, be liable subject to subsection (2), to a fine not exceeding 200,000 rupees together with imprisonment for a term not exceeding 10 years. [Amended 36/08]
- (2)
- (a) Notwithstanding sections 150 to 153 of the Criminal Procedure Act, a person charged under subsection (1) (b) for having permitted a minor to use the premises as a brothel shall, on conviction, be liable to imprisonment for a term of not less than 2 years.
- (b) Part X of the Criminal Procedure Act and the Probation of Offenders Act shall not apply to a person liable to be sentenced under paragraph (a).
- (3) In this section, "brothel" means any premises or any part thereof resorted to by persons of both sexes for the purpose of prostitution.
- (4) No prosecution shall be entered under this section except by direction of the Director of Public Prosecutions.
- · Procuration (Importuning):
-
- Article 91A provides that 'Any person who solicits or importunes another person in a public place for an immoral purpose, shall commit an offence and shall, on conviction, be liable to imprisonment for a term not exceeding 2 years or to a fine not exceeding 50,000 rupees. [Amended 5/99; 36/08]'
- In addition, Article 253 of the Criminal Code provides that:
- (1) Any person who, to gratify the passions of another and for gain –
- (a) procures, entices or leads away,

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

for purposes of prostitution, another person;

- (b) exploits, or is an accomplice in, the prostitution of another person, even with the consent of that person;
- (c) draws a benefit from the prostitution of some other person, shares the earnings of, or receives subsidies from, another person who habitually indulges in prostitution, shall commit an offence.
- (2) Any person who commits, or is an accomplice in the commission of, any of the offences mentioned in subsection (1) shall commit an offence regardless of motives or gain where –
- (a) the person procured, enticed, led away, exploited, in relation to whose prostitution a benefit is drawn, whose earnings are shared or from whom subsidies are received is less than 18 years of age at the time of the offence;
- (b) the person is procured, enticed, led away or exploited for the purpose of being sent abroad;
- (c) the person is procured, enticed, led away or exploited by the use of fraud, deceit, threat, violence or any other means of duress.
- (3) No person shall be convicted of an offence under this section upon the evidence of one witness, unless such witness is corroborated in some material particular by evidence implicating the accused.
- (4) Any person guilty of an offence under this section shall be liable on conviction to imprisonment for a term which, notwithstanding section 152 of the Criminal Procedure Act, shall be not less than 2 years nor more than 10 years together with a fine not exceeding 100,000 rupees.
- (5) Part X of the Criminal Procedure Act and the Probation of Offenders Act shall not apply to a person liable to be sentenced under this section. [Amended 29/90; 13/98]
- In addition to these laws that criminalise

[21] See Part V for detailed recommendations

specific aspects of sex work, the following laws are also used to arrest and prosecute sex workers:

- Article 26 of the Criminal Code (Supplementary) Act 196 – 7 November 1870, which provides that:
- (1) Every person shall be deemed an idle and disorderly person who –
- (a) being a common prostitute, is found wandering in any public place and behaving in a riotous or indecent manner;
- (b) wilfully exposes to view in any public place, or wilfully causes to be exposed to public view in a window or other part of any shop or other building, situated in any public place, any obscene print, picture or other indecent exhibition;
- (c) wilfully and obscenely exposes his person in any public place;
- (2) Every person who is an idle and disorderly person shall commit an offence and shall, on conviction, be liable to a fine not exceeding 50,000 rupees and to imprisonment for a term not exceeding one year, and where he is again convicted as an idle and disorderly person within 12 months of a conviction for any offence under this section or section 28, he shall commit an offence and shall, on conviction, be liable to a fine not exceeding 50,000 rupees and to imprisonment for a term not exceeding one year.
- Article 28 provides that:
- (1) Every person shall be deemed a rogue and vagabond who (inter alia) –
- (a) frequents or loiters about or in any enclosed or private land or dwelling or place adjacent to a street, road or highway with intent to commit an offence;
- (b) in a public place, makes use of obscene, indecent or offensive words or gestures whether or not such words or gestures are addressed to any other person.
- (2) Every person who is a rogue and

143 National HIV and AIDS Policy, 2012 at para 4.

> vagabond shall commit an offence and shall, on conviction, be liable to a fine not exceeding 50,000 rupees and to imprisonment for a term not exceeding 2 years. [Amended 36/08] [Amended 10/85; 29/90; 5/99]

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Notwithstanding the provisions of the Criminal Code, the National HIV and AIDS Policy (2012) recognises that 'Mauritius has a concentrated HIV and AIDS epidemic that shall be most efficiently controlled by working in a targeted manner through the key populations most likely to be exposed to HIV', which include sex workers. The Policy provides that 'The primary focus of the HIV prevention effort shall be on reducing HIV infection amongst these populations. This shall involve a public health approach that seeks to work in partnership with these populations, and that takes care not to further stigmatize **them'**[143]. Para 5 provides that 'Responding effectively to HIV and AIDS requires a consistent and comprehensive approach guided by Human Rights principles across all sectors and at all levels of government and community. This is assisted by providing a set of consistent laws and policies that support the decisions of individuals and communities to avoid HIV infection and to provide care and support for people and families affected by HIV and AIDS. The key aim of the legal and policy framework shall be to provide and maintain an enabling environment for HIV and AIDS prevention, treatment, care and support programs and services.'

Para 5.2 of the Policy provides that 'Existing laws and policies shall be reviewed to ensure that they do not constitute a barrier to HIV prevention, treatment, care and support, or work against the vision and objectives of the national HIV and AIDS response.'

The National Action Plan for HIV and AIDS

2017-2021 recognises the impact of punitive laws on key populations, including sex workers, and the need to replace laws that penalise key populations with laws that protect against discrimination and support access to voluntary testing, counselling and treatment. Para 5.3.3 provides that 'Mauritius needs to use an expedited legal and policy review to eliminate impediments to HIV treatment uptake. Laws and law enforcement practices that penalize key populations, such as treatment of sex workers and people who use drugs, should be replaced with laws that protect against discrimination and support access to voluntary HIV testing, counselling and treatment.'

Para 8.2.1 provides that 'In line with the National HIV Policy, the existing laws and policies will be reviewed to ensure that they do not encourage stigma and discrimination or constitute a barrier to HIV prevention, treatment, care & support, or work against the vision and objectives of the national HIV and AIDS response' and 'In order for PLHIVs to enjoy full human rights, it is important that they operate within an equal opportunity environment. To create this environment, it is imperative that policies, laws and practices do not inadvertently contribute to HIV risk, or to HIV-related stigma and discrimination. Any dissonance in the laws therefore has to be repealed or amended. This outcome implies identifying all these laws, and reviewing them for a harmonization with the international commitments that were made.'

Para 8.2.2 provides for the following interventions to improve the social and legal protection for people living with HIV and key populations, including sex workers:

'a) Advocate for legal reform – Laws, regulations and policies relating to HIV can negatively or positively impact the HIV

epidemic, as well as the lives and human rights of those living with and affected by HIV. Therefore, it is crucial to monitor and reform laws, regulations and policies so that they support, and do not hinder access to HIV and health services. HIV-infected and/or affected individuals should have the same access to all health services as the rest of the community. Being infected and/or affected by HIV/AIDS should not constitute a barrier to accessing services such as socioeconomic, and psychosocial support. Strengthening the provision of non-discriminatory services (police, health care providers and legal personnel) and setting up and/or scale-up of safe spaces/ drop-in centres are the focus of this output. This strategy will be strengthened at all levels of the community to reach members of key population groups, PLHIV and their families.

Advocacy for legal reviews will be conducted to formalize the rights of key populations (MSM, FSW PWIDs, transgender and prison inmates).

c) Responsiveness of the social legal environment to the health needs of PLHIV and KPs - PLHIV are becoming increasingly aware of their rights, but few access them. This area of focus will look into influencing change in the social and legal arenas mainly through advocacy for building capacity around legal literacy and access to justice; and promotion of the enactment and implementation of laws, regulations and guidelines that prohibit discrimination and support access to HIV prevention, treatment, care and support; workplace policies; policies for young PLHIV; and review of the interpretation and application of laws that affect FSW, PWIDs, MSM, transgender individuals and prison inmates.

d) Reducing discrimination in access to services - Programmes aimed at reducing

stigma and discrimination against people living with HIV or people at risk of HIV infection should address the actionable causes of stigma and discrimination and empower people living with and vulnerable to HIV. This NAP will address discrimination. In addition to respecting and protecting people's rights to have access to services, it is important to facilitate the achievement of broader public health goals by ensuring that no person eligible for the identified services is denied access on an arbitrary basis. Denial of access may take place in a number of ways, including by way of services being provided in a manner that fails to address or understand a person's specific needs. This may include staff attitudes that discourage people from accessing social services'.

A focus group discussion with sex workers in Port Louis in December 2017 revealed that the current laws in place that criminalise aspects of sex work and the enforcement of laws relating to 'idle and disorderly persons' and 'rogues and vagabonds' indeed act as barriers to access to HIV prevention, treatment and care services by sex workers, as well as to harm reduction services, and serve to exacerbate the stigma and discrimination faced by sex workers at the hands of communities, families, health care workers, law enforcement agents and other service providers.

Sex workers described various instances of stigma, discrimination and violence surrounding sex work as well as recurring police abuse and high levels of violence, including the confiscation of condoms, arbitrary detention and rape, which compromise their personal safety and right to equal protection of the law and create a climate of impunity that fosters further violence and discrimination against sex workers. "I was raped in 2014 and went to the police to report it. 7 months later they called me to say there was no evidence of

rape despite the fact that I pointed out the evidence to them"
"I was arrested by the anti-drug unit. They beat me up. I am asthmatic and they took me to the hospital. The hospital staff refused to give me treatment for asthma because of the way I was dressed and only gave me Panadol.'
'My family told me it would be better for me to go and steal than to be a sex worker'.
'I was arrested for soliciting and they made me strip naked and dance for them. They told me this was the procedure".
'The police made me engage in fellatio with them and have sex with them without condoms in order to escape being charged.'
'The police use possession of condoms as evidence of soliciting. They told me that a decent woman does not walk around with condoms'.
'Sometimes when the police arrest us they arrange for the child protection unit to take away our children rather than leave them with our families.'
'We are denied social housing because we are sex workers'
"I have been arrested by police when I go to collect methadone – they said I was soliciting the night before - as a result I no longer go and collect methadone but rather buy black market methadone'.

The UNAIDS Guidance Note on HIV and Sex Work (2012) notes that the criminalisation of sex work contributes to the economic and social marginalisation of sex workers and their families, who are seen by society as criminals and often denied access to basic

government services. This marginalisation is a barrier to access to health care services and adds to the risk that sex workers will be treated disrespectfully when accessing health services.

The Guidance Note concludes:

"There is very little evidence to suggest that any criminal laws related to sex work stop the demand for sex or reduce the number of sex workers. Rather, all of them create an environment of fear and marginalisation for sex workers, who often have to work in remote and unsafe locations to avoid arrest of themselves or their clients. These laws undermine sex workers' ability to work together to identify potentially violent clients and their capacity to demand condom use of clients. The approach of criminalising the client has been shown to backfire on sex workers. In Sweden, sex workers who were unable to work indoors were left on the street with the most dangerous clients and little choice but to accept them. Where sex work is criminalised, sex workers are very vulnerable to abuse and extortion by police in detention facilities and elsewhere." 144

The UN International Guidelines on HIV/AIDS and Human Rights (2006) requires that States take measures to "reduce the vulnerability, stigmatisation and discrimination that surround HIV and promote a supportive and enabling environment by addressing underlying prejudices and inequalities within societies." The UNAIDS Guidance Note concludes that municipal laws which give police too wide latitude to arrest tend to contribute to an atmosphere of fear and marginalisation.145

Recommendations

- Consensual adult sex work should be decriminalised and the unjust application of other criminal laws and regulations against sex workers should be stopped.
- Law should be enacted to protect against discrimination and violence, and other violations of rights faced by sex workers in order to realize their human rights and reduce their vulnerability to HIV infection and the impact of AIDS. Anti-discrimination laws and regulations should guarantee sex workers' rights to social, health and financial services.
- Programs should be put in place to provide legal literacy and legal services to sex workers so that they know their rights and applicable laws, and can be supported to access the justice system when aggrieved.
- Health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health.
- Programs should be put in place to sensitize and educate health care providers on non-discrimination and sex workers' right to high-quality and non-coercive care, confidentiality and informed consent.
- Sex workers groups and organizations should be made essential partners and leaders in designing, planning, implementing and evaluating health services.
- Essential health services for sex workers must include universal access to male and female condoms and lubricants, as well as access to comprehensive sexual and reproductive health services, and

equitable access to all available health care services including primary health care and harm reduction services.

- Violence against sex workers is a risk factor for HIV and must be prevented and addressed in partnership with sex workers and sex worker led organizations.
- Violence against sex workers needs to be monitored and reported, and redress mechanisms established to provide justice to sex workers.
- Law enforcement officials, magistrates and health and social care providers need to be trained to recognize and uphold the human rights of sex workers, and held accountable if they violate the rights of sex workers, including the perpetration of violence.
- Support services need to be provided to sex workers who experience violence.

146 LINK
147 Mathers BM, Degenhardt L, Ali H, et al. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. Lancet, 2010; 375(9719): 1014-1028.

People who use drugs

Treating drug use as a criminal offence fuels the transmission of HIV through several **mechanisms**[146]. The criminalisation of the possession and use of drugs; and the possession of drug injecting paraphernalia; as well as aggressive drug law enforcement practices aimed at suppressing the drug market drive people who use drugs away from public health services and into hidden environments where HIV risk becomes markedly elevated. In addition, police harassment and arrest have been shown to increase risky drug practices among people who use drugs.

Punitive drug law enforcement measures create barriers to HIV testing and treatment. These barriers to treatment include stigma and discrimination within healthcare settings, refusal of services, breaches of confidentiality, requirements to be drug-free as a condition of treatment, and the use of registries that lead to denial of such basic rights as employment and child custody.

As a result, research has repeatedly shown that drug users have lower rates of antiretroviral therapy use and higher HIV/AIDS death **rates**[147]**.** Punitive drug law enforcement policies and practices also have broader implications for public health. Given the demonstrated prevention benefits of antiretroviral therapy, the public health benefit of providing all segments of the population, including persons who inject drugs with access to HIV treatment is undeniable.

However, numerous studies have demonstrated that coercive drug law enforcement measures and the frequent incarceration of people who use drugs hinder them from seeking HIV testing and treatment, and contribute to the interruption of HIV treatment once it has

148 Global Commission on HIV and the Law (2012) Risks, Rights & Health pages 29-35
149 17% reduction between 1999 and 2003 after decriminalisation in 2001

begun. The incarceration of non-violent drug law offenders is a significant factor in the epidemic. This is a critical public health issue in many countries where HIV prevalence and AIDS cases behind bars are many times higher than among the general population. High rates of incarceration among drug users with or at risk of HIV infection are a matter of deep concern given that incarceration has been associated with sharing needles, unprotected sex and HIV outbreaks in many places around the world. Incarceration also drives risk of HIV infection and disease by interrupting antiretroviral HIV treatment. Thus drug law enforcement measures often disrupt HIV treatment efforts, promote HIV drug resistance and increase risk of HIV transmission.

Prohibitions or restrictions on opioid substitution therapy and other evidence-based treatment result in untreated addiction and avoidable HIV risk behaviour.

Multiple systematic reviews of evidence have shown that countries or jurisdictions that have legalised comprehensive harm reduction services that include needle exchange and opioid substitution therapy have significantly reduced HIV infections among people who use drugs, compared with persistent or growing rates in countries or jurisdictions where such services are restricted or blocked by **law.**[148]

In addition, countries that have decriminalised possession and use of small quantities of drugs for own use, such as Portugal, have seen marked reduction in new HIV infections amongst people who use **drugs**[149].

Current position

Mauritius is experiencing a concentrated HIV epidemic in PWID. HIV infection rates among PWID stand at 44.5 percent. Women account for approximately 10 percent of the estimated 11,677 PWID population, and are significantly more affected: HIV prevalence among women who use drugs is 61.8 percent, and among men, 42.5 percent (PWID IBBS 2013). Hepatitis C rates in PWID are 96.5 percent (PWID IBBS 2013). Mauritius has a strong policy framework that effectively supports and guides key elements of the national harm reduction program, notably NEP and MST.

The HIV and AIDS Act, No. 31 of 2006 makes specific provisions for needle exchange programmes:

Section 14(1) provides that 'an institution or non-governmental organisation may supply, syringes and needles to any person dependent on a dangerous drug'.
Significantly section 16 states that 'A person who is in possession of a syringe or needle, in compliance with this Act, shall not, by reason only of that possession, be considered as having committed an offence under the Dangerous Drugs Act'.

The HIV/AIDS Policy (2012) provides at para 5.11 that 'HIV prevention efforts through Harm Reduction Programs for People who inject Drugs shall be strengthened and expanded to reach more People who inject drugs, as well as other populations who are at high-risk of problematic drug use. Acknowledging that there is no ultimate solution to the problem of drugs in a free society, and that many different interventions may work, the Harm Reduction Program shall run alongside the Demand Reduction and Supply Reduction Programs. The two pillars of the Harm Reduction Program shall be the Needle Exchange Program and the Opioid

Substitution Program.

In the Needle Exchange Program, Government and non-Government actors shall provide clean needles, syringes and paraphernalia, and safely dispose of used ones for People who inject Drugs. In addition, the program shall provide the clients with HIV Testing and Counselling, and referrals to the maintenance program, detoxification, social services, and primary health care. Police collaboration shall be sought for the smooth running of the program.

The Opioid Substitution Program shall absorb more People who inject drugs desiring to go on Drug Replacement Treatment or Detoxification. Dispensing of Methadone shall be further decentralized for ease of access of clients at the national level. A special focus will be placed on providing psychosocial support to clients, whilst rendering the program more client-centred for improved outcomes.
Outreach, Peer Education and education to all populations at risk of harm associated with illicit drug use shall be strengthened.

A minimum package of Information Education and Communication (IEC) materials related to prevention of HIV and other injecting drug use associated harms shall be developed and disseminated for use by all relevant organisations and services. Harm Reduction Education and community mobilization shall be promoted throughout the island.'

The National Action Plan on HIV and AIDS (2017-2021) reiterates the need for and specifically provides for increased access to existing harm reduction services. It states that 'The provision of opiate substitution therapy through the methadone programme as well as provision of sterile injection equipment to injecting drug users, through the implementation of the NEP, is generally

150 National action Plan on HIV and AIDS at p53
151 Section 3 read with Schedules I and II

considered as essential components of a comprehensive risk minimization in the HIV and AIDS prevention strategy. The NEP is an efficient way to reduce the incidence of HIV and AIDS among Injecting Drug Users and it is cheap and easily **applicable'**[150]**.**

The Dangerous Drugs Act (DDA), No 41 of 2000 is however at odds with the HIV and AIDS Act, 2006, the National HIV/ AIDS Policy (2012) and the National Action Plan for HIV and AIDS 2016-2021. The DDA classifies heroin and methadone as **dangerous drugs**[151]. In terms of section 6 no person shall at any time produce, manufacture, trade by wholesale or retail, distribute, transport, possess, supply, transfer (free or for payment), purchase, use, import, export or transit across Mauritius any of the plants, substances and preparations listed in Schedule 1. Heroin is listed in Schedule I. In terms of section 8 (1) Subject to subsection (2), no person shall cultivate, produce, manufacture, trade by wholesale or retail, distribute, or use any of the plants, substances and preparations listed in Schedules II and III unless he is expressly licensed for that purpose, and no person shall do so at any establishment or on any premises not expressly licensed for that purpose. (2) Subsection (1) shall not apply to State-owned enterprises specially authorised in writing by the Minister or to their employees acting in that capacity. Methadone is listed in Schedule II.

In terms of section 34 (1), any person who unlawfully (a) smokes, inhales, sniffs, consumes or administers to himself in any way whatsoever any dangerous drug; (b) purchases, transports or possesses any dangerous drug for his personal consumption; (c) has in his possession any pipe, syringe, utensil, apparatus or other article for use in connection with smoking, inhaling, sniffing, consuming or the administration of any dangerous drug, shall commit an offence and shall, on

conviction, be liable to a fine not exceeding 10,000 rupees and, subject to subsection (2), in the case of a second or subsequent conviction, to imprisonment for a term not exceeding one year.

Although section 16 of the HIV and AIDS Act, 2006 states that 'A person who is in possession of a syringe or needle, in compliance with this Act, shall not, by reason only of that possession, be considered as having committed an offence under the Dangerous Drugs Act', focus group discussions with people who use drugs revealed that people are still arrested by police for being in possession of needles and syringes obtained at needle exchange programmes.

Despite the anomalies in its legal and policy framework, Mauritius has historically been at the forefront of harm reduction in Africa. In 2005, when PWID accounted for 92 percent of new HIV infections, the country promulgated the HIV and AIDS Act, established a harm reduction program and started offering needle and syringe programs and methadone substitution therapy (MST). The effort paid off as by 2014, the proportion of new infections attributable to injection drug use had fallen to 31 percent.

However in 2015, the harm reduction programme began to face a series of significant challenges and changes. Government began to pressure the NGO providing needle exchange (NEP) to provide the National Identity Card numbers of its clients. In February 2015, MST was "decentralized" and MST was provided via mobile units parked in police station yards. Dispensing hours were severely cut to just 1-2 hours, largely finishing by 8am. In July 2015, the MST programme stopped taking on new clients. In January 2016, a new suboxone/naltrexone detoxification program began under the MoHQL. Also in 2016, the National Agency for the Treatment

152 Focus group discussion with people who use drugs, Port Louis, 5 December 2018

and Rehabilitation of Substance Abusers (NATReSA), whose primary function was to coordinate government and NGOs work in harm reduction, was closed down and all its activities moved to the Harm Reduction Unit of the MoHQL. Although the MST programme again commenced taking on new clients in 2017, people who use drugs have reported that they experience many problems, both with the MST programme and with access to health care and social services as well as in **employment[152].** These include the following:

Discrimination at the hands of health care workers:

- "They refuse to take our blood or administer injections if they suspect that we are people who use drugs".
- "There is no confidentiality at the HIV clinic".
- "The doctors do not treat us as people. Attitudes are better at private facilities but we cannot get ART there – only at state facilities'.
- "We have to pay for diagnostics for hepatitis C as it is not available in the country. Many of us cannot afford this and the doctors refuse to put us on treatment for hepatitis C unless we have the test."
- "The health care worker called me "drug addict" rather than by my name and called me out in front of everyone to get my methadone."

Problems with the MST programme:

- "The police have a list of everyone who takes methadone and if there is a warrant out for someone's arrest they will wait for them to come to the police station for their methadone and then arrest them".
- "The fact that methadone is only

[21] See Part V for detailed recommendations

distributed between 6am and 8 am makes it very difficult for those of us who are employed work to be on time for work."

- "Often the doses of methadone are diluted. The seals on the doses have been tampered with by the time they arrive at the distribution points. The people who are distributing the methadone are siphoning methadone off from the doses and selling it. Because the doses are diluted the effect wears off after 6 hours instead of between 22 and 24 hours".

- • "We need to see doctors regularly but there are no doctors at the methadone distribution points and many of us cannot afford the transport to go and see a doctor".
- · "Trafficking in methadone is a problem. At the methadone distribution centre in Port Louis people pay the police 100 Rupees a week not to be arrested for selling their methadone. If they do not pay the police arrest them."
- · Methadone is not available in Rodrigues. It is sent to Rodrigues by the Ministry but the Chief Commissioner refuses to distribute it."
- *Problems with employment:*
- · "If you have a conviction under the Dangerous Drugs Act it reflects on your Certificate of Character and even if you are on methadone employers do not want to employ you".
- · "My employer saw me collecting my methadone at a distribution point at a police station and fired me."

Problems with law enforcement and social services:

- "Normally in the case of divorce, custody of a child under the age of 5 is given to the mother. If they think

you are a drug user or a sex worker they will not give you custody even if you are on methadone and are a good parent".

- "When I tried to report gender-based violence to the police they don't believe me because I am a drug user."

Young people under 18 have limited access to harm reduction services. Both the NEP guideline and the MST protocol are silent on eligibility based on age criteria. Similarly, there is no clear protocol for MST regarding pregnant women. There have been reports of women having no access to MST while going through labour, and consequently bring removed from the MST programme since they have missed their doses for 3 days.

Recommendations

- Replace ineffective measures focused on the criminalisation and punishment of people who use drugs with evidence-based and rights-affirming interventions proven to meaningfully reduce the negative individual and community consequences of drug use, including the promotion of referrals to MST programs rather than the imposition of custodial services for persons convicted of possession for own use.
- Consideration should be given to decriminalise possession of drugs for own use and halt the practice of arresting and imprisoning people who use drugs but do no harm to others.
- Amend the Dangerous Drugs Act to bring it in line with the HIV and AIDS Act and decriminalise the possession of needles and syringes as part of a needle exchange programme.
- Reconsider the location of methadone distribution at police stations and

increase the hours that methadone distribution points are open to ensure that all who need it are able to access methadone without fear of persecution.

- Improve the integration of methadone distribution in medical services to ensure that people who use drugs have access to the full range of prevention, treatment and care services.
- Build the capacity of law enforcement officials, judicial officers and health care service providers on the importance of evidence-based and rights-affirming interventions proven to meaningfully reduce the negative individual and community consequences of drug use.
- The development of gender-sensitive programming for women using drugs such as linking harm reduction programme to SRHR services.
- Establishment of protocols and ensuring the protocols are followed for pregnant women who use drugs or who are on MST programme so that they receive their methadone during and after delivery.
- Harm reduction unit to train and support service providers in the gynaecology ward to increase their expertise and skills to treat pregnant women with methadone and treatment for neonatal abstinence syndrome.
- Review and amend guidelines of NEP and MST to ensure that the full package of harm reduction is available to adolescents.
- Establish linkage to prevention, treatment and care following HIV testing for adolescents.
- Increase linkage for government and NGOs regarding HIV services to expand

community outreach activities as well as for a stronger psychosocial support.

These strategies reduce disease and death, and also limit the size and harmful consequences of drug markets by reducing the overall demand for drugs.

Criminalisation of HIV transmission and exposure

Recent years have seen the enactment of HIV-specific laws that criminalize HIV transmission and exposure, driven by the wish to respond to serious concerns about the ongoing rapid spread of HIV in many countries, coupled by what is perceived to be a failure of existing HIV prevention efforts. In some instances, particularly in Africa, these laws have been a response to the serious phenomenon of women being infected with HIV through sexual violence or by partners who do not reveal their HIV diagnoses to them.

An analysis of the complex issues raised by criminalisation of HIV exposure or transmission reveals that criminalisation is unlikely to prevent new infections or reduce women's vulnerability to HIV. In fact, it is more likely to harm women rather than assist them, and negatively impact both public health and human rights.

Applying criminal law to HIV transmission can have the negative effect of **deterring people from getting tested** and finding out their HIV status, as lack of knowledge of one's status could be the best defence in a criminal lawsuit. In jurisdictions with HIV-specific criminal laws, HIV testing counsellors are often obliged to caution people that getting an HIV test will expose them to criminal liability if they find out they are HIV-positive and continue having sex. These same counsellors are sometimes forced to provide evidence of a person's HIV status in a criminal trial. This creates distrust in relationships between PLHIV

and their health care providers and thus interferes with the delivery of quality health care and frustrates efforts to encourage people to come forward for testing.

In addition, criminalizing HIV transmission, exposure and non-disclosure **creates a sense of false security** by placing legal responsibility exclusively on people living with HIV for preventing the transmission of the virus. This undermines the public health message that everyone should practice safer behaviours, regardless of their HIV status, and that sexual health should be a shared responsibility between sexual partners. People may (wrongly) assume their partners are HIV-negative because they have not disclosed their status, and thus not take measures to protect themselves from HIV infection.

Applying criminal law to HIV exposure or transmission, except in very limited circumstances **reinforces the stereotype that people living with HIV are immoral and dangerous criminals,** rather than, like everyone else, people endowed with responsibility, dignity and human rights.

Prosecutions for HIV transmission or exposure also spread myths and misinformation about how HIV is transmitted. In some jurisdictions, serious criminal charges have been laid against HIV-positive people for activities such as biting, spitting, or scratching, despite evidence that the risk of HIV transmission in this fashion is extraordinarily small (and in some cases, non-existent). Such prosecutions not only undermine efforts to educate the public about HIV, but further engender fear of people living with HIV.

Applying criminal law to HIV transmission also **does very little to address the epidemic of gender-based violence or the deep economic, social, and political inequality that are at the root of women's**

and girls' disproportionate vulnerability to HIV. On the contrary, these laws are likely to be used to prosecute women more often than men. That is because women engage with the health system more often (including during pregnancy and child birth), and are thus more likely to find out about their positive HIV status before their male partners. Where laws criminalizing HIV exposure or transmission are in place, women who test HIV-positive have to disclose their HIV status to their partners, refuse to have sex, or insist on condom use to avoid the risk of being prosecuted for exposing their partner to HIV. However, for many women these actions carry the risk of violence, eviction, disinheritance, loss of their children, and other severe abuses. Thus women are faced with an impossible choice: either to risk violence by trying to protect their partners, or to risk prosecution by failing to do so.

Laws that criminalize HIV exposure, transmission and non-disclosure can also be used to prosecute women who transmit HIV to a child during pregnancy or breastfeeding. For millions of women living with HIV/AIDS—but often denied access to family planning, reproductive health services, or medicines that prevent mother-to-child transmission of HIV—this effectively makes pregnancy, wanted or not, a criminal offence. There are many more effective ways to prevent mother-to-child transmission of HIV, beginning with supporting the rights of all women to make informed decisions about pregnancy and providing them with sexual and reproductive information and services, preventing HIV in women and girls in the first place, preventing unwanted pregnancies among all women, and providing effective medication to prevent mother-to-child transmission of HIV to HIV-positive women who wish to have children.

Given the stigma that still surrounds

153 'Prison for man with HIV who spit on Police Officer' The New York Times, 16 May 2008. Available online at: LINK
154 AIDS-Free World 'HIV-Positive nurse tried by media' Available online at: LINK

HIV and the persistence of HIV-related discrimination, criminal sanctions are often directed disproportionately at those who are socially and/or economically marginalized and thus there is a risk of selective or arbitrary prosecution. In America for example, a homeless man living with HIV was sentenced to 35 years in prison because he spat at the police officer who was arresting him for disorderly **conduct.**[153] Many other cases suggest that criminal law is invoked in sensational circumstances, often in relation to those who are most marginalized and stigmatized in a society, including immigrants and refugees, foreigners, or sex workers, and occasionally in response to emotional media campaigns. In 2014, a nurse was sentenced to three years in prison for exposing a child to HIV while she was administering an injection. The nurse was tried and convicted in the public eye by the media, violating her rights and **presumption of innocence.**[154]

Proving that an accused person was HIV-positive at the time of an alleged offense, as well as proving who infected whom and when, is a serious challenge. To prove guilt, scientific evidence of transmission by the accused person is required. In recent years, where resources exist, prosecutors handling cases of HIV transmission increasingly have resorted to phylogenetic testing, which seeks to establish a genetic relationship between the HIV viruses of the two parties. However, such evidence only indicates similarities in the viruses; it does not prove beyond a reasonable doubt the source of the virus. Such technical evidence and its limitations are not well understood by police, prosecutors, defence lawyers, courts, the media, or people living with HIV or HIV organizations. Phylogenetic testing is also very expensive to apply and thus unaffordable in many low-resource countries. As a result of all these factors, there is considerable potential for a conviction without sufficient evidence.

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

For these reasons the enactment of HIV-specific laws that criminalize HIV transmission and exposure are counter-productive. The use of criminal law in the response to HIV is justified under one condition only: where individuals intentionally transmit HIV to others with the express purpose of causing harm. In the rare instances where this does occur, existing criminal laws against assault with intent to do grievous bodily harm suffice to prosecute people in those exceptional cases. Creating specific HIV offences is not warranted and, in fact, violates international human rights standards. The International Guidelines on HIV and Human Rights, Guideline 4 directs States to ensure that their criminal laws are not misused in the context of HIV/ AIDS or targeted against vulnerable groups.

Current position

There are currently no laws in place that specifically criminalizes HIV transmission or exposure in Mauritius.

The Public Health Act of 1925 does however provide at section 49 that 'Any person who knowing that he has an infectious or communicable disease, wilfully or negligently exposes himself in such manner as to be likely or liable to spread the disease in any street, public place, public building, shop, inn, hotel, church, or other place used, frequented or occupied in common by persons, other than the members of the family or household to which he belongs; shall commit an offence and shall, on conviction, be liable to a fine not exceeding 500 rupees and to imprisonment for a term not exceeding 3 months'.

The same punishment is also applicable to the following persons:

- (a) a person who, being in charge of a patient, exposes the patient in the manner mentioned above;

[21] See Part V for detailed recommendations

- (b) a person who being the occupier of a dwelling and knowing that a patient has died in it fails to take reasonable steps to prevent persons, other than members of his household, from coming in contact with the body of the patient;

- (c) a person who, without previous effective disinfection to the satisfaction of the Sanitary Authority knowingly gives, lends, sells, pawns, transmits, removes or exposes or sends to or permits to be washed or exposed in any washing place, laundry or other place at which articles are washed, cleansed or dyed, any clothing, bedding, rag, or any other article which has been exposed to or is considered by the Sanitary Authority to be contaminated with the infection of any infectious or communicable disease;

- (d) a person who, knowing that that he has an infectious or communicable disease:

- (i) handles, conveys, or otherwise comes in contact with any food, dairy produce, aerated water or other article intended for consumption by man;

- (ii) carries on any trade or occupation in such manner as to be likely or liable to spread his disease; or

- (iii) enters any public conveyance.

- (e) a person, in charge of a person who he knows has an infectious or communicable disease, places that person in a public conveyance or carries the body of the dead patient or other contaminated article in a public conveyance without first informing the owner or driver or conductor of the conveyance of the fact of the infection; and

- (f) the owner, driver or conductor of a public conveyance who knows that the

said conveyance has been so used as particularized in paragraph (e) above and who has failed, as soon as it was reasonably practicable to do so, to have the said conveyance disinfected to the satisfaction of the Sanitary Authority.

The term "public conveyance" includes a tramcar, omnibus, cab, motor car, boat vessel, aircraft or any other vehicle, if the conveyance is for hire or is used by members of the public.

Although there is no evidence that this section has even been invoked against people living with HIV, this section could potentially be used to prosecute a person for intentional or negligent transmission and exposure.

Recommendations

- It is recommended that HIV-specific laws that criminalize HIV transmission and exposure are not enacted and that in the rare instances where individuals intentionally transmit HIV to others with the express purpose of causing harm, existing laws— including against assault with intent to do grievous bodily harm—suffice to prosecute people in those exceptional cases. It is thus critical that the Public Health Act be amended to exclude HIV and AIDS from the operation of section 49 of the Act.

- Guidelines should be developed to support law enforcement agents and the judiciary to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered.

155 Personal comm NHRC, 6 December 2017
156Article 10, International Convention on Civil and Political Rights. Available at: LINK
157 UNAIDS and OHCHR (2006) International Guidelines on HIV/AIDS and Human Rights, paras 86 and 87

Prisoners

There are currently an estimated 2300 prisoners in Mauritius of which approximately 25% are living with **HIV**[155].

A combination of lengthy pre-trial detentions, substandard nutrition and sanitation, violence, rape, consensual unprotected sex, lack of access to condoms and harm reduction programmes and inadequate staffing in prisons contribute to HIV transmission in prisons. International human rights law recognizes the prerogative of the state to deprive people of certain rights—the most obvious one being liberty—through incarceration. But imprisonment does not justify denial of the human rights to humane treatment and **dignity**[156]. Inmates have a right to a standard of health care equivalent to that available outside of correctional facilities, and agents of the state have an obligation to refrain from inflicting harm on inmates. Among the rights that correctional authorities are obligated to protect, and courts including the European Court of Human Rights have upheld, are those to health and life, which include adequate access to HIV prevention and treatment services. The majority of inmates do not have this access.

The State, through prison authorities, owes a duty of care to inmates, including the duty to protect the rights to life and to health of all persons in custody. In the context of HIV this includes ensuring access by inmates to HIV-related information, education and means of prevention (bleach, condoms, clean injecting and tattooing equipment), voluntary testing and counselling, confidentiality and HIV treatment and access to and voluntary participation in treatment trials. The duty of care also comprises a duty to prevent rape and other forms of sexual assault in prison that may result, inter alia, in HIV transmission.

- There is no public health or security

justification for mandatory HIV testing of inmates, nor for denying inmates living with HIV access to all activities available to the rest of the inmate population. Inmates with terminal diseases, including AIDS, should be considered for early release and given proper treatment outside **prison**[157]. Although female inmates have restricted rights, they have a range of reproductive health needs which need to be addressed to reduce the harm caused to that individual or their community on their release.

Current position

In terms of section 23 of the Reform Institutions Act, 1988, 'Every detainee shall on his admission, or where not possible, within twenty-four hours of admission be examined by an officer who shall record the state of health of the detainee'.

- In terms of section 31:

(1) Such medical officers as may be designated by the Permanent Secretary, Ministry of health, shall be responsible for the health of detainees.

- (2) The medical officer –
- (a) shall cause every detainee to be examined at such time as may be prescribed;
- (b) may, with or without the detainee's consent, take, cause or direct the taking of such action as he thinks fit in the interests of the health of a detainee;
- (c) shall keep in such form as may be prescribed –
- (i) a case book showing the name, disease, ailment or complaint and treatment of every detainee who is sick, ill or injured;
- (ii) a journal containing his comments on the state of sanitation and hygiene of the institution and detainees;
- (iii) a case book giving full details of the medical history, treatment and cause of death of every detainee who dies in the

institution; and

- (iv) a record of the nature and quality of the food of the detainee both before and after cooking.
- (3) The Commissioner shall, following the written report of a medical officer, take such steps as may be necessary for improving the state of hygiene of an institution or any part thereof.
- Section 32 provides for hospitalisation of prisoners and states that 'The medical officer, or in case of emergency, the officer-in-charge, may, where there is no suitable accommodation in the institution, arrange for the removal to hospital of a detainee who is ill or injured'.
- Regulation 3 of the Prison Regulations (1989) lists the duties of prison staff in respect of detainees, which include the duty to '(c) to provide for detainees as full a life as is consistent with the fact of custody and in particular to make available to them (i) the physical necessities of life; (ii) medical care; (iii) advice on and help with personal problems; (iv) work, education, training, exercise and recreation; (v) the opportunity to practise their religion; and (d) to enable detainees to retain links with the community and where possible assist them to prepare for their reintegration into the community'.
- Regulation 8 regulates the provision of medical services in prisons and requires a medical officer to attend at the prison for which he is responsible either daily or at such other regular intervals as required by the Commissioner (8(1)). A medical officer is also required to examine a detainee— (a) as soon as possible after admission and thereafter as necessary; and (b) within 24 hours of his complaining of illness. (8(2)). The medical officer shall regularly advise the officer-in-charge upon— (a) the quantity, quality, preparation and service of food; (b) the hygiene and cleanliness

of the prison and of the detainees; (c) the sanitation, lighting and ventilation of the prison; (d) the suitability and cleanliness of the detainees' clothing and bedding; (e) the observance of any order concerning physical education and sports (8(6)).

- Annexure 'C' to the Mauritius Prison Service Strategic Plan 2013 to 2023 outlines the planned improvements to the Prison Health Service. The aims are to:

- 1. improve the physical and mental well-being of detainees during detention;

  2. provide prevention, care, treatment and support to detainees living with HIV/AIDS; and
- 3. promote a healthy drug-free environment within prisons by providing treatment and rehabilitation programmes for drug addicts.

According to the plan, 'prison has hosted 51.9% of national cumulative HIV positive cases, among which about 33% are injecting drug users. The daily average of HIV/ AIDS inmates in prison is about 800, representing 31% of the actual prison **population'**[158].

Planned HIV activities include:

- prison-based services to offer care, support and treatment to HIV-infected detainees will be reinforced;
- Treatment literacy program will be introduced to ensure ART adherence.

The plan also recognises that 'drug users are among the most vulnerable among prisoners, and are over-represented within the prison population, often due to a growing trend towards the criminalisation of drug use and possession and the use of custodial sentences for drug-related crime'; and makes provision for methadone substitution therapy. The aim of the plan is to 'promote a healthy drug-free environment

within prisons by providing treatment and rehabilitation programmes for drug addicts' and provides for the following activities:

- A package of services (psychosocial support, support group therapy, assistance with ARV, vocational and empowerment programmes, VCT screenings) will be made available to IDUs in prison.
- Peer Education programs will also be enhanced to facilitate penetration of Information, Education and Communication (IEC) into the IDU prison population.
- Methadone Induction, detoxification and rehabilitation programs will be strengthened in prisons.
- Psychosocial support will be provided through all phases of Methadone Maintenance Treatment.
- Prison staff will be trained on psychosocial support, and on client-oriented dispensing of Methadone. IEC activities will be reinforced among prison population.
- Capacity-building of all service providers on management of substance abuse and illicit drugs will be strengthened.
- Increase capacity in the prison health service to ensure that medical treatment and follow-up for PLWHA are in line with national standards.
- Strengthen security and closer monitoring of Methadone recipients during distribution, as misuse could result into adverse and even fatal consequences.
- Drug-free units will be established in three other institutions.

In view of the increasing number of

159 Focus Group Discussion with people who use drugs
160 Personal comm with NHRC representative 6 December 2017.

detainees on methadone, and to curb the problem of diversion, a separate institution will be identified to accommodate methadone recipients in prison.

The only reference to prisoners in the National HIV/AIDS Policy is in the context of prevention. The policy provides at para 5.10 that 'In line with the focus on populations most at risk, the particular HIV prevention needs of out-of-school youth, migrant workers, mobile populations and prisoners shall be addressed through targeted government and NGO/community programs'.

The National Action Plan on HIV and AIDS refers to the need to scale up provider-initiated testing and counselling for prisoners (at para 4.1). The Plan also:

- under the short-term outcome category, "Increased utilization of new or sterile injecting equipment," states the following activity: "Reinforce NEP service package; include prison inmates in harm reduction services"; and
- under the short-term outcome category, "Reduced HIV prevalence in key populations," states the following activity: "Provision of condoms and lubricants to KAP including youth and in prisons; set up and maintain condom dispensers."

This notwithstanding, neither condoms nor needle exchange programmes are available in prisons in Mauritius.
Prisoners do have access to methadone substitution therapy. As is the case in the general population there have however been reports by prisoners of variation in methadone **dosages**[159]**.**

All prisoners are offered an HIV test on entry into prison in line with the policy of provider-initiated testing and counselling.

160 Personal comm with NHRC representative 6 December 2017.

Prisoners have however reported that HIV testing on entry is not always voluntary and that the option to refuse a test is not entertained. Whilst prisoners do have access to antiretrovirals, confidentiality in the dispensing of ART is not always respected. It has been reported that, for example, prisoners are called out publicly in the prison courtyard to 'come and fetch their **ARVs".**[160]

Ventilation in the Beau-Bassin prison is extremely poor and this exacerbates the risk of TB infection amongst prisoners.

Recommendations

- Ensure that prisoners have full and appropriate access to the same HIV-related prevention information, education, voluntary counselling and testing, means of prevention (including condoms and needle exchange), treatment, care and support as is available to the general population.
- Amend the Criminal Code to decriminalise consensual same-sex sex. The criminalisation of sodomy is a major impediment to the distribution of condoms in prisons and legitimises discrimination against men having sex with men.
- Ensure that victims of rape, assaults and other at-risk prisoners have access to Post-exposure prophylaxis in prisons.

  Ensure that HIV testing in prisons is based on informed consent and with respect for confidentiality.
- Ensure that confidentiality of prisoners living with HIV is respected.
- Increase oversight of inmates to reduce violence and rape.
- Ensure that prisons are adequately

ventilated to reduce the risk of TB transmission.

Attention should be given to increasing non-custodial sentencing options, including for example, community service.

D. HIV/AIDS in the Workplace

161 Available at LINK accessed 22 February 2018
162 Available at LINK accessed 22 February 2018

Unfair discrimination against people living with HIV/AIDS in the workplace has been perpetuated across the world through practices such as pre-employment HIV testing, dismissal for being HIV positive and the denial of promotion and employee benefits.

Guideline 5 of the International Guidelines on HIV and Human Rights (2006)161 provides that:

'Laws, regulations and collective agreements should be enacted or reached so as to guarantee the following workplace rights:

- (i) A national policy on HIV and the workplace agreed upon in a tripartite body;
- (ii) Freedom from HIV screening for employment, promotion, training or benefits;
- (iii) Confidentiality regarding all medical information, including HIV status;
- (iv) Employment security for workers living with HIV until they are no longer able to work, including reasonable alternative working arrangements;
- (v) Defined safe practices for first aid and adequately equipped first-aid kits;
- (vi) Protection for social security and other benefits for workers living with HIV, including life insurance, pension, health insurance, termination and death benefits;
- (vii) Adequate health care accessible in or near the workplace;
- (viii) Adequate supplies of condoms available free to workers at the workplace;
- (ix) Workers' participation in decision-making on workplace issues related to

HIV and AIDS;

- (x) Access to information and education programmes on HIV, as well as to relevant counselling and appropriate referral;
- (xi) Protection from stigmatization and discrimination by colleagues, unions, employers and clients; and
- (xii) Appropriate inclusion in workers' compensation legislation of the occupational transmission of HIV (e.g. needle stick injuries), addressing such matters as the long latency period of infection, testing, counselling and confidentiality.

In addition the ILO Code of Practice on HIV and the World (2001)162 provides that:

4.2. In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention.

4.6. Screening for purposes of exclusion from employment or work processes HIV/AIDS screening should not be required of job applicants or persons in employment.

4.7. There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO's code of practice on the protection of workers' personal data, 1997.

4.8. Continuation of employment relationship HIV infection is not a cause for termination of employment. As with many

163 Paras 4 and 5

other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in available, appropriate work.

8.1. HIV testing should not be required at the time of recruitment or as a condition of continued employment. Any routine medical testing, such as testing for fitness carried out prior to the commencement of employment or on a regular basis for workers, should not include mandatory HIV testing.

Current Situation

Mauritius has a strong legal and policy framework to address discrimination on the basis of HIV in the workplace.

The Policy for HIV/AIDS at the Workplace (2011) provides at paragraph 3 that:

- The employer shall not discriminate against an employee with HIV and AIDS with regard to job employment including training and promotion, in line with existing legislation;
- The employer shall accommodate employees with HIV and AIDS as with any other illness as long as they meet acceptable standards of work performance and attendance.

The Policy further provides that:

- Strict confidentiality shall be maintained regarding employees' HIV status;
- Mandatory testing for HIV shall not be conducted routinely while in employment;
- Testing will be voluntary with individual consent for employees wishing to know their HIV status;
- Adequate pre and post-test counselling shall be provided when tests are carried out;
- Test results shall remain confidential and shall not be disclosed to a third party without prior informed written consent of the **employee**.[163]

164 Section 3 (1)
165 Section 6(1)
166 Section 2

The HIV and AIDS Act 31 of 2006 stipulates that any person who is HIV positive or has AIDS shall not be considered as having a disability or incapacity by virtue of any enactment, and his status or presumed status shall not be used as a ground to discriminate against that **person**[164].

The Act further provides that no person shall induce or cause another person to undergo an HIV test:

- (a) as a condition for employment, continued employment benefits and promotion or continued employment of the other person;
- (b) as a condition for procurement or offer of goods and services from the other **person**[165].

In terms of section 18(3) any person who treats any other person or his relative:

- (a) unfairly, unjustly, or less favourably than a third person would have been treated in comparable circumstances;
- (b) with hatred, ridicule or contempt, on account of being, or being perceived as being infected with HIV shall commit an offence and shall, on conviction, be liable to a fine not exceeding 50,000 MRU rupees.

The Equal Opportunities Act 42 of 2008 prohibits discrimination (either direct or indirect) on the ground of status, which is defined as 'age, caste, colour, creed, ethnic origin, impairment, marital status, place of origin, political opinion, race, sex or sexual orientation'. It also includes one's criminal record.

Discrimination in terms of this Act is not limited to treating an aggrieved person less favourably on the ground of status but also includes a proposal to treat that person less favourably on the ground of status.
"Impairment" is defined as:

- (a) total or partial loss of a bodily function;

166 Section 2

- (b) the presence in the body of organisms that may cause disease;
- (c) total or partial loss of a part of the body;
- (d) malfunction of a part of the body, including:
    - (i) a mental or psychological disease or disorder;
    - (ii) a condition or disorder that results in a person learning more slowly than people who do not have that condition or disorder;
- (e) malformation or disfigurement of a part of the **body**[166].

The definition of 'impairment' is sufficiently broad to cover HIV status and discrimination on the basis of HIV status is thus prohibited in terms of this Act.
Section 10 provides that: "No employer or prospective employer shall discriminate against another person—

- (a) in the advertisement of a job;
- (b) in the arrangements he makes for

the purpose of determining who should be offered employment;

- (c) in determining who should be offered employment;
- (d) in the terms or conditions on which employment is offered; or
- (e) by refusing or deliberately omitting to offer employment to that person.
- In terms of Section 11 "No employer shall discriminate against an employee—
- (a) in the terms or conditions of employment that the employer affords that employee;
- (b) in conditions of work or occupational safety and health measures;
- (c) in the provision of facilities related to or connected with employment;

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

- (d) by denying the employee access, or limiting access, to opportunities for advancement, promotion, transfer or training, or to any other benefit, facility or service associated with employment;
- (e) by terminating the employment of the employee; or
- (f) by placing the employee at a disadvantage in any other manner.
- An employer may however justify its decision of not recruiting a person with an impairment where specific conditions prevail.
- Section 13(3) provides that "Notwithstanding sections 10 to 12, an employer or prospective employer may discriminate against a person who has an impairment where
- (a) Taking into account the person's past training, qualifications and experience relevant to the particular employment, and in case the person is already employed by that employer, that person's performance as an employee, and all other factors that is reasonable to take into account, that person because of his impairment
  - (i) would be unable to carry out the inherent requirements of the particular employment; or
  - (ii) would, in order to carry out those requirements, require services or facilities that are not required by persons without an impairment and the provision of which would impose an unjustifiable hardship on the employer
- (b) Because of the nature of the impairment, the work environment or the nature of the work involved, there is likely

[21] See Part V for detailed recommendations

to be:

- (i) a substantial risk that the person will injure himself; or
- (ii) a risk that the person will injure others and it is not reasonable in all the circumstances to take that risk

In determining what constitutes unjustifiable hardship on the employer, all relevant circumstances of the particular case shall be taken into account including:

- (a) The nature of the benefit, facility or detriment likely to accrue or be suffered by any person concerned; and
- (b) The financial circumstances of and the estimated amount of expenditure required to be made by the employer

In terms of Section 6, which provides for indirect discrimination, an employer can rely on the Justifiable Condition Concept to avoid falling foul of the provisions of the Act.

A person discriminates indirectly against another person "the aggrieved person" on the ground of the status of the aggrieved person where:

- (a) he imposes, or proposes to impose, a condition, a requirement or practice on the aggrieved person;
- (b) the condition, requirement or practice is not justifiable in the circumstances;
- (c) the condition, requirement or practice has, or is likely to have, the effecting of disadvantaging the aggrieved person when compared to other persons.

However, if the alleged discriminator can prove that the said conditions, requirements and/or criteria are justifiable in the circumstances then it is not an indirect dis-

crimination.

Factors to be taken into consideration in determining whether the Justifiable Condition Concept is present are:

- (a) The nature and extent of the disadvantage resulting, or likely to result, from the imposition of the condition, requirement or practice;
- (b) The likelihood of overcoming or mitigating the said disadvantage; and
- (c) Whether the disadvantage is proportionate to the result sought to be achieved by the alleged discriminator.

The burden of proving the Justifiable Condition Concept lies on the alleged discriminator.

The Act, which binds the State of Mauritius, applies to employment, education, qualifications for a profession, trade or occupation, the provision of goods, services, facilities or accommodation, the disposal of property, companies, partnerships, "sociétés", registered associations, sports clubs and access to premises which the public may enter or use.

"Employer" is defined as "a person, an enterprise, the State, a statutory corporation, a body of persons employing a worker, or a group of employers or a trade union of employers". The prohibition of discrimination in terms of this Act thus applies to both employers in the private sector as well as the State.

The application of the provisions of this Act to the State as an employer is however limited by Section 118 (4) of the Constitution of Mauritius which provides that save and except for the Public Bodies Appeals Tribunal (PBAT) set up under Section 91A of the Constitution, no authority (including therefore the Equal Opportunities Commission) established in terms of the Equal Opportu-

167 Section 4

nities Act or person can subject the Public Service Commission (PSC), the Local Government Service Commission (LGSC) and the Disciplined Forces Service Commission (DFSC) to its directive or control.

The Equal Opportunities Commission (EOC) is thus precluded, in effect, from conducting an investigation into claims of discrimination on the part of the PSC, the LGSC or the DFSC, all of which are the recruiting arms of the State of Mauritius. The PBAT can review decisions taken by the PSC, the LGSC and the DFSC. However the PBAT can only review decisions pertaining to promotions and not to recruitments, whereas the EOC can take employers to task in relation to recruitments.

Thus whilst the State falls under the definition of an employer for the purposes of the Equal Opportunities Act , the recruiting arms of the State are not answerable to the EOC and as a result may potentially act with impunity in committing acts of discrimination in recruitment to State institution.

Similar provisions are also to be found in the Employment Rights Act 33 of 2008 (ERA) which **stipulates**[167] that:
(a) no worker shall be treated in a discriminatory manner by his employer in his employment or occupation
(b) no person shall be treated in a discriminatory manner by a prospective employer in respect of access to employment or occupation.

However, any distinction, exclusion or preference in respect of a particular occupation based on the inherent requirements thereof shall not be deemed to be a discrimination. Also, a person does not discriminate against another person by imposing or proposing to impose, on that other person, a condition, requirement or practice that has, or is likely to have, a disadvantaging effect,

where the condition, requirement or practice is reasonable in the circumstances.

Matters to be taken into account in determining whether or not a condition, requirement or practice is reasonable in the circumstances include:

- (a) the nature and extent of the disadvantage resulting or likely to result, from the imposition of the condition, requirement or practice;
- (b) the feasibility of overcoming or mitigating the disadvantage; and
- (c) whether the disadvantage is proportionate to the result sought to be achieved by the person who imposes, or proposes to impose the condition, requirement or practice.

For the purposes of the ERA, discrimination is defined as "affording different treatment to different workers attributable wholly or mainly to their respective descriptions by age, race, colour, caste, creed, sexual orientation, HIV status, religion, political opinion, place of origin, national extraction or social origin, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation".

With regard to the right of workers to freedom of associations, the Employment Relations Act 32 of 2008 stipulates that every worker shall have the right to establish or join as member a trade union of his own choice without previous authorization and without distinction whatsoever or discrimination of any kind including discrimination as to occupation, age, marital status, sex, sexual orientation, colour, race, religion, HIV status, national extraction, social origin, political opinion or affiliation.

Data from the 2017 Stigma Index shows that only 10% of respondents had been denied employment on the basis of HIV status in the last 12 months and only 6.5% of

respondents had experienced a change in job description or had been refused promotion on the basis of HIV status in the last 12 months.

Recommendations

· In order to afford better protection against discrimination on the basis of HIV status or sexual orientation for employees or prospective employees of the State, amend the Constitution to stipulate that in addition to the Public Bodies Appeals Tribunal and the Supreme Court, the Equal Opportunities Commission should also be exempt from the general rule provided for in Section 118(4) of the Constitution.

E. Education and Information

States should ensure that both children and adults living with HIV are not discriminatorily denied access to education, including access to schools, universities, scholarships and international education or subject to restrictions because of their HIV status.

There is no public health rationale for such measures since there is no risk of transmitting HIV casually in educational settings.
In the context of HIV and AIDS, both children and adults have the right to receive age-appropriate HIV-related information and education, particularly regarding prevention and treatment. Access to information and education concerning HIV is an essential life-saving component of effective prevention and treatment programmes. It is the State's obligation to ensure, in every cultural and religious tradition, that appropriate means are found so that effective age-appropriate HIV information and education is included in educational programmes inside and outside schools.

Guideline 9 of the International Guidelines furthermore recommends that States also develop creative education, training and media programs to change attitudes of discrimination and stigmatization associated with HIV and AIDS, to understanding and acceptance.

Current Situation

Whilst there is no specific mention in the National HIV Policy or the National Action Plan on HIV and AIDS of the need for the provision of age-appropriate sex education in schools, the National Sexual and Reproductive Health Policy (2007) provides the following policy statement at para 3.6.3:
"To provide the community, teachers, parents and young people with accurate information, skills, counselling and user friendly services in order to attain quality sexual and reproductive health for young people".

In order to achieve this, the policy provides at para 3.6.4 for the need to:

'I. Equip parents, guardians, teachers and community leaders with information and skills on adolescents and youth SRH/STI/HIV/AIDS needs, so that they can effectively communicate and guide the adolescents and youth.

II. Promote communication between adolescents/youth and parents, guardians, teachers and community leaders on SRH/STI/HIV/AIDS through all possible channels.

III. Ensure that components of Family Life Education begins at the family level continues in primary schools and at all levels of education. Special efforts should be made to address the needs of out-of-school children and youth as well as those with special needs.

IV. Ensure that all adolescents and youth have access to accurate information on SRH/STI/HIV/AIDS through school programmes, mass media, health facilities and youth centres in order to promote safe and healthy life styles.

V. Make readily accessible and available relevant IEC/BCC materials on SRH/STI/HIV/AIDS for use by adolescents and youth.
VI. Advocate for the establishment of counselling services in all existing youth centres'.

Despite this policy statement it would appear that access to age-appropriate information on SRH, STIs and HIV for adolescents and young people is not universal in Mauritius.

Reasons for this include the following:

- Some parents are very reluctant to have third parties outside the family spectrum speaking to their children about sexual issues.

- SRH and sex education in schools is seen by some parents as an invitation for young people to indulge in sexual activities.

· SRH and sex education curricula in schools are not standardised and the decision to conduct these programmes as well as the content of the programmes is left to the discretion of education institutions.

Recommendations

· The Ministry of Education and Human Resources should develop and adopt a standardised national SRH and sex education curriculum, and ensure that this curriculum is taught in all government and private schools and ensure that all teachers are adequately equipped to deliver age-appropriate comprehensive sexuality education in all schools. Similar training should be included in the curriculum of teacher training colleges.

F. Social Welfare

168 Article 25 UDHR

As guaranteed under the UDHR, everyone has the right to a standard of living adequate for the health and well-being of himself and 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**[168].

Current Situation

Mauritius has an elaborate set of laws which cater for the social welfare of its people.

Free education, health and public transport service

The country has a free education system both at primary and secondary level in all State schools as well as a free medical care system. Free public transport is also afforded to students under the age of 18 and to old age pensioners. In addition to this, there are also several other social security benefits and pensions schemes.

Pension on demise of spouse

Before 2016 only widows were, on the death of their husbands, entitled to a monthly widow's pension irrespective of their age and whether they were earning a living or not. A complaint alleging discrimination on the ground of sex under the Equal Opportunities Act was brought before the Equal Opportunities Commission in 2015, questioning the discriminatory nature of such a provision of the law. The Equal Opportunities Commission, acting within the purview of its conciliatory powers, took up the matter with the responsible authority, namely the Ministry of Social Security. Acting upon the recommendations of the Equal Opportunities Commission, Government proceeded to an amendment of the law whereby both

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

widows and widowers are now entitled to this pension benefit. The monthly pension is currently Rs 5,450. As it only applies to persons who have been civilly married and not to cohabiting couples, it therefore automatically excludes as potential beneficiaries same-sex couples, particularly as same-sex marriage is not allowed under the Mauritian Civil Code. The said pension is only payable when the surviving spouse is less than 60 years of age and ceases upon remarriage of the surviving spouse. It is a non-contributory pension.

Old age pension

Citizens of Mauritius (and in some cases non-citizens) will benefit from a monthly old age pension on attaining the age of 60 whether they are still earning their living or not. The old age pension is also known as the Basic Retirement pension. It is a non-contributory pension. The beneficiary of the old age pension must not only have reached 60 years of age but must also have resided in Mauritius for an aggregate period of 12 years since attaining the age of 18. The residence qualification does not apply to a Mauritian citizen aged 70 or over. Non-citizens must have resided in Mauritius for at least 15 years in aggregate since attaining the age of 40, three of those fifteen years being immediately before the attaining 60. The amounts payable are as follows:

- (i) For a person aged 60 and below 90 years Rs 5,450
- (ii) For a person aged 90 years and below 100 years Rs 15,450
- (iii) For a person aged 100 years and above Rs 20,450

It is apposite to note that a beneficiary of an old age pension who has a disability of at least 60 percent and who needs the constant care and attention of another person, will also obtain an additional sum of Rs 3,000 per month by way of what is known

[21] See Part V for detailed recommendations

as a carer's allowance.

Orphan's Pension

Orphans are entitled to what is known as a Basic Orphan's pension. If the child is under 15 years and not in full time education, he will obtain Rs 2,950 per month. Children in full-time education will obtain Rs 4,450 per month. The orphan's pension is also extended to non-citizens provided that one of the parents who has passed away has resided in Mauritius for at least five years in aggregate in the ten years preceding the claim, one of those five years being immediately before the claim.

Allowance for Orphans' Guardian

A person looking after an orphan will obtain a monthly allowance of Rs 1,000. If the guardian is a non-citizen, he should have resided in Mauritius for at least five years in aggregate in the ten years preceding the claim, one of those five years being immediately before the date of the claim. If the same guardian looks after more than one orphan at a time, the monthly allowance will still be of the same amount.

Pension for Invalid Person

A person aged between 15 to 60 years who has been certified by a Medical Board to be incapacitated to a degree of at least 60 percent for a period of at least 12 months will benefit from a non-contributory monthly pension of Rs 5,450 pension due to his invalidity. A beneficiary of the invalid pension who needs the constant care and attention of another person will also obtain an additional carer's allowance of Rs 2,500 per month.

Child's Allowance

The beneficiary of a Widow's Pension or a Pension for an Invalid Pension will obtain a child allowance for his child. This Child's Allowance is obtainable if the child is under the age of 15 or if is less than 20 years of age and if in full-time education. The amount of this allowance is Rs 1,400 per month for a child under the age of 10 and Rs 1,500 for a child over 10 years of age. The allowance is payable for a maximum of 3 children. If a person receiving a widow's pension remarries, she will still be eligible for the child allowance but not for the widow's pension.

Temporary or permanent incapacity at earning a living

The Social Aid Act 2 of 1983 has been enacted to help persons who cannot earn a living and sustain themselves whether temporarily or permanently.

The law provides for the grant of financial aid (known as "Social Aid Grants") to any person who is temporarily or permanently incapable of earning adequately his livelihood and has insufficient means to support himself and his dependents as a result of:

- (a) any mental or physical disability;
- (b) any accident or sickness certified by a medical practitioner approved by Government;
- (c) any sudden loss of employment which has lasted continuously for at least 6 consecutive months; or
- (d) being abandoned by his or her spouse or being the spouse of the head of a household who is in police custody, has been remanded to jail or is serving a term of imprisonment.

The amount of the Social Aid Grant varies on a case to case basis depending on the specific circumstances of the recipient and his needs over a particular period of time.

The Social Aid Grants are however not available on the basis of HIV status alone.
Persons living in absolute poverty

Mauritius has also enacted the Social Integration and Empowerment Act 26 of 2016 to promote, within the philosophy of enhancing social justice and national unity, social integration and empowerment of persons living in absolute poverty.

The Social Integration and Empowerment Act provides for the keeping of records of people living in absolute poverty in what is known as the Social Register of Mauritius. The said register is kept by the Ministry of Social Security which assigns to the National Empowerment Foundation the responsibility of identifying persons living in absolute poverty and assessing their needs. The National Empowerment Foundation has also the responsibility of implementing and harmonizing any integration and empowerment programme for curtailing absolute poverty.

Persons who are listed in the Social Register of Mauritius and persons who, according to the provisions of the Social Integration and Empowerment Act, qualify as "persons living in absolute poverty" are eligible to financial support and other facilities such as low-cost housing, school materials. The amount of the financial support depends on the monthly income of the beneficiaries, the number of adults and children living in the same household, the number of dependents under the charge of the beneficiaries as well as other social benefits accruing to them either under the pension schemes or under the Social Aid Act. The nature of the support and the exact amount of financial aid vary on a case to case basis depending on the needs of the recipients as assessed by the National Empowerment Foundation.

A person living in absolute poverty is defined in the Act as "an adult or, as the case may be, the 2 or 3 adults living under the same roof referred to in the First Column of the Schedule, whose assessed monthly income, or as the case may be, the combined monthly income of the 2 or 3 adults is less than the corresponding amount specified in the Second Column of the Schedule".

The Schedule to the Act provides as follows:
1 adult Rs. 2720
1 adult + 1 child Rs. 4080
1 adult + 2 children Rs. 5440
1 adult + 3 children Rs. 6800
2 adults Rs. 5440
2 adults + 1 child Rs. 6800
2 adults + 2 children Rs. 8160
2 adults + 3 children Rs. 9520
3 adults Rs. 8160
3 adults + 1 child Rs. 9520
3 adults + 2 children Rs. 9520
3 adults + 3 children Rs. 9520.

Social housing scheme

There are several State institutions providing social housing schemes namely the National Empowerment Foundation, the National Housing Development Corporation and the Mauritius Housing Company.
However, the housing schemes of the National Empowerment Foundation, acting under the aegis of the Ministry of Social Integration, are the ones which are accessible to persons who are the poorest i.e. those considered as living in absolute poverty and who are on the Social Register of Mauritius.

Although, over the last years, there has often been an overlap and some confusion between the aforesaid institutions, the actual policy of Government is to limit access to the houses falling under the responsibility of the National Empowerment Foundation only to those listed on the Social Register of Mauritius. These houses are usually dis-

posed of by way of a hire-purchase scheme whereby the beneficiary pays a monthly sum of approximately Rs. 800 for the first year, which sum thereafter increases by Rs. 200 every calendar year until it reaches a maximum of Rs. 2300 per month. After that period, the beneficiary ceases to pay the monthly contributions and is given the freehold title in the property.

For those who earn more than the absolute poverty bracket but who are still considered to be low-income earners, they may upon application, be granted National Housing Development Corporation and Mauritius Housing Company types of social housing. Each application is treated on a case-to-case basis and the conditions applying will differ considerably depending on the circumstances of each and every case.

The procedure for obtaining National Empowerment Foundation social housing is simple and very accessible. Once a person is on the Social Register of Mauritius, his or her application for housing will be readily processed.

In the case of National Housing Development Corporation and Mauritius Housing Company types of social housing, the situation is different as the means of each and every applicant and the relevant conditions will vary considerably on a case-to-case basis.

Recommendations

· Consideration should be given to appointing an HIV clinician on the Social Security Board to facilitate access by people living with HIV to social aid for those who need it.

G. Gender-Based Violence (GBV) and HIV

169 García-Moreno V, Hegarty K, Flavia A et al, The health-systems response to violence against women, The Lancet, 2015; 385: 1567–79.
170 World Health Organization, Violence against women and HIV/AIDS: Setting the research agenda, Geneva: World Health Organization, 2000, at 7.

Internationally, the role of the healthcare system in the recognition of violence has been recognised, documented and encouraged.[169] This is because there are clear linkages between GBV and the risk of HIV infection. Some are direct linkages, for example through forced sex. There are also indirect linkages, for example when violence or threats of violence reduce women's and girls' options to negotiate safer sexual practices. Violence can also make the victim afraid to disclose their HIV status and access services.[170] International good practice now focuses on a multi-sectoral response to the problem.

Current situation

The National Action Plan 2017-2020 acknowledges "the fact that gender inequality hinders social and economic development, the achievement of gender equality remains one of the critical components of the HIV agenda". It states that "Mauritius, like many other countries continue to face gender-based violence especially against women, with sexual assault and intimate partner violence contributing to increased risks for HIV infection."

The Action Plan underlines the need for "structural interventions" to improve "human rights protection for all population groups including key population, community protection mobilization for legal action against sexual offenders and gender-based violence (GBV) reduction programme". These efforts will have to be combined with the mobilization and sensitization of religious and community leaders.

Amongst the key objectives of the Action Plan is the elimination of stigma and discrimination (Key objective no.5). This has been broken down into the following components: "Implementing anti-stigma programmes; reducing gender-based violence; sensitizing communities about

[9] Ibid.
[10] UNAIDS Mauritius Country Progress Report 2015; Available at LINK (Accessed 31 January 2018).
[11] LINK (Accessed 31 January 2018).
[12] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[13] Submission by Chrysalide, Mauritius, Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August, 2011
[14] GCHL (2012) Risks, Rights & Health
[15] Ibid.

drug-related issues; supporting the rights of PLHIV and reducing barriers to access treatment, care and support; discussing the legalization of drug paraphernalia."

The Action Plan also explains that "priority must be given to preventing new infections among key populations through empowerment strategies targeting individual risk factors, stigma and discrimination, gender-based violence and facilitated access to a complete package of health services including condoms and family planning".

Concerning female sex workers, the Plan advocates for empowering them to help establish a peer-to- peer approach, which would "help women educate each other on (their) rights and impress risk reduction behaviours. (...) recognizing that the vulnerability of this population is closely linked to behaviours and attitudes of their sex partners and community norms, deliberate efforts will be made to engage community leaders to modify harmful cultural practices, increase male involvement campaigns, gender-based violence reduction programmes, and psychosocial support." Increased access to legal aid services is seen as also a way to help female sex workers from overcoming the obstacles linked with gender-based violence, including violence from clients and from law enforcers.

The Protection from Domestic Violence Act 6 of 1997 provides protection for victims of domestic violence.

The definition of domestic violence in the enactment is exhaustive and all-encompassing.

The term "domestic violence" includes any of the following acts committed by a person against his spouse, a child of his spouse or another person living under the same roof:

- (a) Wilfully inflicting, or attempting to inflict, a wound or blow, or threat-

ening to inflict a wound or blow;

- (b) wilfully or knowingly placing or attempting to place, or threatening to place the spouse or the other person in fear of physical injury to himself or to one of his children;
- (c) intimidating, harassing, talking, ill-treating, insulting, brutality or cruelty;
- (d) compelling the spouse or the other person by force or threat to engage in any conduct or act, sexual or otherwise, from which the spouse or the other person has the right to abstain;
- (e) confining or detaining the spouse or the other person, against his will;
- (f) harming, or threatening to harm, a child of the spouse;
- (g) causing or attempting to cause, or threatening to case, damage to the spouse's or the other person's property;
- (h) depriving, without any reasonable excuse, the spouse of resources which the spouse is entitled to, or of payment for rent in respect of shared residence.

The definition of 'spouse' is however limited and means a person who:

- (a) is or has been civilly or religiously married to a person of the opposite sex;
- (b) is living or has lived with a person of the opposite sex as husband and wife; or
- (c) whether living together or not with a person of the opposite sex, has a common child with that person.

A victim of domestic violence can rapidly and effectively obtain several types of urgent remedies for his or her immediate protection and welfare as well as for that

of the child.

Several orders may be sought and obtained from a District Magistrate by means of a fast, simple and highly effective mechanism.

Such interim orders are:
- (a) a protection order;
- (b) an occupation order; or
- (c) a tenancy order of an interim nature.

Protection Order

A protection order is an interim or permanent protection order restraining a spouse from engaging in conduct which may constitute an act of domestic violence.

Any person who has been the victim of an act of domestic violence and who reasonably believes that his spouse is likely to commit any further act of domestic violence against him, may apply to the Court for a protection order restraining the respondent spouse from engaging in any conduct which may constitute an act of domestic violence and ordering him to be of good behaviour towards the applicant. On an application being made for a protection order, the Court shall cause notice thereof to be served on the respondent spouse who shall further be summoned to appear before Court on such day as may be fixed by the Court (not later than 14 days of the date of the application) to show cause why the order applied for should not be made.

In determining an application for a protection order, the Court shall have regard to the following:
- (a) the need to ensure that the aggrieved spouse is protected from domestic violence;
- (b) the welfare of any child affected or likely to be affected, by the respondent

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

spouse's conduct;

- (c) the accommodation needs of the aggrieved spouse, his children as well as those of the respondent and his children;
- (d) any hardship that may be caused to the respondent spouse or to any of his children as a result of the making of the order; and
- (e) any other matter which the Court may consider relevant.

Where a protection order is issued, the Court may further:

- (a) prohibit the respondent spouse from being on premises on which the aggrieved spouse resides or works;
- (b) prohibit the respondent spouse from being on premises specified in the order, being premises frequented by the aggrieved spouse;
- (c) prohibit the respondent spouse from approaching within a specified distance of the aggrieved spouse;
- (d) prohibit the respondent spouse from contacting, harassing, threatening or intimidating the aggrieved spouse;
- (e) prohibit the respondent spouse from damaging property of the aggrieved spouse;
- (f) prohibit the respondent spouse from causing or attempting to cause another person to engage in conducts referred to in paragraphs (d) and (e) above;
- (g) specify the conditions on which the respondent spouse may:
  - (i) be on premises on which the aggrieved spouse resides, works or which he frequents; or
  - (ii) approach or contact the aggrieved spouse or a child of the ag-

[21] See Part V for detailed recommendations

grieved spouse;

(h) of its own motion, make a provisional occupation or tenancy order for such time as it thinks fit, where it is satisfied that such an order, although not applied for, is necessary for the protection of the aggrieved person.

Where the Court is satisfied that there is a serious risk of harm being caused to the applicant before the application may be heard and that the circumstances revealed in the application are such as to warrant the intervention of the Court even before the respondent spouse is heard, the Court may:

- (a) issue an interim protection order restraining the respondent spouse from engaging in any conduct which may constitute an act of domestic violence and ordering him to be of good behaviour towards his spouse;

- (b) order the Commissioner of Police to provide Police protection to the applicant until such time as the interim order is served on the respondent spouse or for such time as the particular circumstances of the case may justify.

- Where a protection order is in force, either party may apply to the Court for a variation or revocation of same.

Occupation order

Any person who has been the victim of an act of domestic violence and who reasonably believes that his spouse is likely to commit any further act of domestic violence against him, may apply to the Court for an occupation order granting him the exclusive right to live in the residence belonging to him, the respondent spouse or both of them.

The Court will issue an occupation order where it is satisfied that it is necessary for the protection of the aggrieved spouse or

of a child of the aggrieved spouse and that it is in the best interest of the family.

The occupation order shall not be for a period exceeding 24 months.

Where an occupation order is in force, either party may apply to the Court for a variation or revocation of same.

Where the court is satisfied that there is a serious risk of harm being caused to the applicant before the application may be heard and that the circumstances revealed in the application are such as they warrant the intervention of the Court even before the respondent spouse is heard, the Court may issue an interim occupation order granting the applicant the applicant the exclusive right to live in and occupy the residence.

Tenancy order

Any spouse who has been the victim of an act of domestic violence and who reasonably believes that his spouse is likely to commit any further act of domestic violence against him, may apply to the Court for a tenancy order so that the tenancy of the residence occupied by him should vest in him.

The Court shall not make a tenancy order unless it is satisfied that such an order is necessary for the protection of the aggrieved spouse and/or of a child of the aggrieved spouse and that it is in the best interest of the family.

Where a tenancy order is in force, either party may apply to the Court for a variation or revocation of same.

Where the Court is satisfied that there is a serious risk of harm being caused to the

applicant before the application may be heard and that the circumstances revealed in the application are such as to warrant the intervention of the Court even before the respondent spouse is heard, the Court may issue an interim tenancy order granting the applicant the exclusive right to live in the residence.

An interim tenancy order shall, unless the Court directs otherwise, remain in force until such time as the court pronounces itself on the application for the tenancy order.
On the taking effect of a tenancy order, the aggrieved spouse shall be deemed to become the tenant of the dwelling house subject to the terms and conditions of the tenancy in force at the time of the making of that order. However, except where the Court orders otherwise, the spouse who, before the tenancy order was, by the terms of the contact of tenancy, responsible for the payment of the rent, shall continue to be so responsible.

Probation Report

Where any of the aforementioned order is issued, a probation report of compliance may be made in relation to the order. The Court may, where it so deems appropriate, direct a probation officer to report to it on the compliance of such order at, such intervals as it may determine.

Ancillary order for alimony

In addition to any protection, occupation and/or tenancy order, the Court may also order a respondent spouse to pay to an aggrieved spouse and any child of the parties' alimony in such terms and conditions as the Court thinks fit. But no such order may be made where the respondent spouse is already paying alimony to the aggrieved spouse or the child of the parties by virtue of a judicial order of the Family Division of the Supreme Court.
Confidentiality Preserved

The hearing of any of the above proceedings shall be held in camera. This is also a constitutional measure which empowers any Court from excluding any person from the proceedings other than the parties and their lawyers if it thinks that publicity will prejudice the interests of justice, public morality, public order, the welfare of minors or the right to privacy of any person concerned by the proceedings. (Vide Section 10 (10) of the Constitution of Mauritius)

The Role of Enforcement Officers

In addition to the Court, victims of domestic violence may also resort to the assistance of the Enforcement Officers working in the various specialized units set up by the Ministry of Women, Family Welfare and Child Development.
Where an Enforcement Officer reasonably suspects that a person is, has been or is likely to be the victim of an act of domestic violence, he shall:

- (a) as soon as possible, cause investigation to be made into the matter; and
- (b) where the act of domestic violence requires immediate action or further enquiry or amounts to an offence, forthwith report the matter to the nearest police station.

Where, after investigation, the Enforcement Officer reasonably believes that action should be taken to protect the victim of an act of domestic violence from any further violence, he shall:

- (a) explain to the victim his rights to protection against domestic violence; and
- (b) provide or arrange transportation for the victim to an alternative residence or a safe place of shelter, if such transportation is required;
- (c) provide or arrange transportation

for the victim to the nearest hospital or medical facility for the treatment of injuries, if such treatment is needed;

- (d) assist the victim to file a complaint regarding the domestic violence;

- (e) accompany and assist the victim to his or her residence or previous residence for the collection of his personal belongings.

An Enforcement Officer may, with the consent of the victim of an act of domestic violence, make, on behalf of the victim, an application for a protection, occupation or tenancy order and shall, to that effect, swear to an affidavit reciting the facts on which he relies to make the application on behalf of the victim. Furthermore, the Enforcement Officer may, without the consent of the victim of an act of domestic violence, make such an application where the victim is unable to give his consent.

Any person who has reason to believe that an act of domestic violence has been, is being or is likely to be committed, may give information in respect thereof to an Enforcement Officer. And no liability, civil or criminal, shall be incurred by the well-wisher for information given in good faith.

The Role of the Police

In 2016 amendments were brought to the Protection from Domestic Violence Act in order to enhance the duties and powers of police officers under the law. It is clearly spelt out that the police shall act with diligence in any case where an offence under this Act is reported to it.
Where a report is made to a police station:

(a) by a victim of an act of domestic violence, an Enforcement Officer or another person, that an act of domestic violence has been, is being or is likely to be committed against the victim; or

(b) by an aggrieved spouse, an Enforcement Officer or another person, that the respondent spouse has failed to comply with any domestic violence order,

the officer in charge of the police station shall immediately cause the circumstances of the offence to be enquired into.
Where an offence is so reported, a police officer not below the rank of Assistant Superintendent may, where:

- (a) physical injury has ensued; or
- (b) he has reason to suspect that a person has failed to comply with any domestic violence order,

cause the person to be arrested and brought before a Magistrate at the earliest opportunity.

Furthermore, a police officer to whom an offence has been so reported shall, notwithstanding the ongoing police enquiry, report the matter forthwith to:

(a) to the nearest hospital or other medical institution, where the victim of the offence is in urgent need of medical assistance;
(b) to the Ministry of Women, Family Welfare and Child Development, where the victim of the offence is in urgent need of counselling or any other form of psycho

logical support.

Where the matter is reported to the Ministry, the latter shall forthwith arrange for the victim of the offence to consult a psychologist or other suitable person for counselling or such other support as may be required.

Severity of Punishment

Having regard to the punishment to which offenders are liable, it is clear that it was the intention of the legislator to send a strong message with the hope that the en-

actment would not only more effectively protect victims of domestic violence but also act as a powerful deterrent.

Any person who wilfully fails to comply with any interim order, protection order, occupation order, tenancy order or ancillary order made under this Act shall commit an offence and shall, on conviction, be liable:

- (a) on a first conviction, to a fine not exceeding 50,000 rupees and to imprisonment for a term not exceeding one year;
- (b) on a second conviction, to a fine not exceeding 100,000 rupees and to imprisonment for a term not exceeding 2 years;
- (c) on third or subsequent conviction, to imprisonment for a term not exceeding 5 years.
- Any person who does an act of domestic violence shall commit an offence and shall, on conviction, be liable:
  - (a) on a first conviction, to a fine not exceeding 50,000 rupees;
  - (b) on a second conviction, to a fine not exceeding 100,000 rupees and to imprisonment for a term not exceeding 2 years;
  - (c) on third or subsequent conviction, to imprisonment for a term not exceeding 5 years.

However, the Courts do not unfortunately often give enough weight to the intention of the legislator, in as much as a rather lenient approach is noted in sentencing generally, save for a few exceptions. A tougher approach would certainly be recommended as it would definitely serve as a strong deterrent if not contribute to a change of mindset in a society which is by and large considered to be rather customarily patriarchal.

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

GBV: The Reality

Women are more likely to be victims of domestic violence, and gender-based violence remains the most telling indicator of inequalities between women and men in Mauritian society.

Generations of acceptance have, to some degree, normalised gender-based violence. There are an alarming number of cases of domestic violence which are not even reported especially by married women. Identifying and trying to understand the reasons why victims of domestic violence do not report or seek support is of paramount importance in fighting this problem. Stigmatization and further victimization is often feared. And the fact of telling one's intimate stories to public officers is often seen as degrading and daunting especially in the white-collar workers segment of the population.

There is an urgent need for a radical change in mindsets. Such a change not only depends on Government-led actions but also on a sensitization of the population at large. The more so as it appears that the culture of silence predominates. Those who speak out and stand for their rights are in some quarters even cast away by their own families. The fight against gender-based violence often meets with resistance in established patriarchal structures.

Whilst almost every woman interviewed for the purpose of the present Legal Environment Assessment has admitted having experienced some form of domestic violence at least once in their lifetime, only an astonishing 20% of men has admitted having ever perpetrated some form of domestic violence. The discrepancy is not due to a

lack of information as to the law but rather a symptomatic trivialisation of domestic violence on the part of the male component

[21] See Part V for detailed recommendations

of couples.

Self-righteousness is often the predominant factor due to a mismatch in the evolution of mindsets. It is also an unrebutted fact that domestic violence is rather considered by men as being limited to physical and sexual abuse whilst verbal threats and other forms of emotional abuse are often seen by them as being part and parcel of the usual tribulations of living as a couple. Also, non-consensual sexual intercourse with a woman spouse or partner is not in the eyes of many men regarded as rape. Some, on this specific issue, even go as far as invoking what is termed "devoirs conjugaux" (marital duties) in the Mauritian Civil Code.

That being said, domestic violence experiences have more often than not devastating repercussions and impacts in life. Symptoms of depression are very recurring and lack of self-respect is rampant. Some women even show signs of suicidal thoughts in some rare cases.

Sexual education should not be limited to giving information about contraceptive methods but should also address behavioural attitude differences, emotional facts and human rights in general. The education system in Mauritius lags behind on this aspect. There is a very conservative set-up whereby education is often seen as merely preparing the adults of tomorrow on the purely academic front whilst totally undermining the emotional intelligence aspect and ignoring the necessity of creating more awareness as to the rights of the individual.

Although the Mauritian legislation on domestic violence was amended in 2016, sexual orientation or gender identity were not included in this legislation. The current legislation reinforces the vulnerability of LGBTI persons as it fails to protect part-

ners in same sex relationships against domestic violence. The narrow redefinition of "spouse" (limited to two persons of opposite sexes) in the Protection from Domestic Violence Act perpetuates discrimination against same-sex couples and reinforces their vulnerability.

Relevant Government policies and programmes such as the National Gender Policy Framework or the National Action Plan on Gender, National Action Plan to end Gender-based violence, and in particular those of the line Ministry of Gender Equality, Child Development and Family Welfare, are limited to "men and women" and exclude other genders such as transgender, non-binary gender or gender free.

In addition the definition of domestic violence in the Protection from Domestic Violence (Amendment) Act 10 of 2016 is narrow in the sense that it provides (in section 3) only for violence against a spouse, child of a spouse or other person living under the same roof.

Recommendations

- Government and civil society should increase public awareness about the linkages between GBV and HIV, including the provision of information on what to do in such situations and where to get information and help.

- Courts and police stations should make sure that complainants can access healthcare information by ensuring that pamphlets about HIV testing, prophylactic treatment and living positively with HIV are available. Similarly, clinics and hospitals should ensure that information about GBV, how to get a protection order and other options in cases of violence are available. This should be extended to all cases of exposure, not just to instances of rape.

- The definition of gender-based violence should be expanded in law and policy to provide for socially ascribed differences based on gender identity and sexual orientation.
- Provision should be made for a more comprehensive definition of "domestic violence" in the Protection from Domestic Violence Act 6 of 1997 to include all acts of physical, sexual, psychological or economic violence that occur within the family or between former or current spouses or partners, regardless of gender identity of sexual orientation, whether or not the perpetrator shares or has shared the same residence with the victim.
- Healthcare providers should be trained on the recognition of cases of GBV and what to do in such cases. Service providers who assist victims of GBV and healthcare providers who treat victims of GBV should receive cross-training on each other's respective areas.
- Sexual education in schools should be expanded to include education on gender stereotypes and equality between partners in relationships and marriage.
- Magistrates should be sensitised on the linkages between GBV and HIV and on the need to treat cases of GBV with the seriousness that they deserve, including in sentencing.

Part 4

Access to Justice and Law Enforcement in Mauritius

171 GCHL (2012) Risks, Rights & Health at pg 10
172 www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf.

The Global Commission on HIV and the Law's Risks, Rights & Health recognizes the importance of taking steps to improve access to justice and law enforcement in relation to HIV and AIDS. In addition, the GCHL urges countries to develop and implement humane, workable HIV-related policies and practices and to fund action on law reform, law enforcement and access to **justice**[171]. It recommends that states need to enact protective laws and repeal punitive ones as well as create stronger mechanisms to implement and enforce laws. It is clear that legislation alone cannot effectively address inequity. The manner in which laws are implemented and the ability of the law enforcement mechanisms to properly fulfil their mandates are equally important.

This is recognized by the UNAIDS International Guidelines on HIV/AIDS and Human Rights **(2006 Consolidated version)**[172] which recommends various actions to improve access to justice and law enforcement in the context of HIV and AIDS, including legal support services, education and awareness and the strengthening of monitoring and enforcement mechanisms.

Guideline 7: Legal Support Services

"States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions."

The specific steps to be taken in relation to this guideline include support for legal aid systems specializing in HIV casework as well as giving support to law firms in the private sector in order that they may provide pro bono services to people living with

HIV and affected populations. In addition, programs to educate and raise awareness on HIV and human rights must be conceived and supported to ensure that these rights can be claimed and enforced. These awareness raising programs should target not only the rights holders, but also the legal profession, legal support services and civil society organisations.

Guideline 11:

"States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities." Specifically, states should support monitoring and data collection on HIV and human rights which would include the establishment of HIV focal points in relevant government branches, support to civil society organizations and the utilization of new or existing human rights commissions, national legal bodies and law reform commissions.

Current situation

The Law Practitioners
Members of the legal profession are governed by the Law Practitioners Act 55 of 1984. Law practitioners include attorneys, barristers and notaries.

The attorney does the work of the solicitor in the UK as Mauritius also has a split legal profession. The barrister conducts litigation in Courts of law save and except before the Judge in Chambers, the Bankruptcy Division of the Supreme Court, the Master's Court and in formal matters; an attorney may address the Court.

The Chief Justice may in specific circumstances grant a right of audience before the Supreme Court to a foreign lawyer subject to such terms and conditions as may be prescribed.

The notary, as in France, is responsible for the drawing-up and safe-keeping of deeds and wills.

Access to law practitioners are more often than not rather prohibitive from a financial perspective for the average earners.

The Legal Aid System

A system of legal aid exists in Mauritius to ensure that those who cannot afford the expenses of legal fees may be allotted a law practitioner at the State's expense.

A person worth less than Rs 500,000 and drawing monthly earnings of less than Rs 10,000 is entitled to the services of barristers and/or attorneys at the State's expense.

The Legal Aid and Legal Assistance Act does not apply:

- (a) to Courts established under a disciplinary law; and
- (b) in respect of criminal proceedings at first instance save and except where penal servitude may result.

It is apposite to note that:

- (a) legal aid is de facto granted in respect of a minor charged with a crime or misdemeanour; and
- (b) the law does not only provide for legal aid but also for legal assistance where the services of a barrister are required to assist a person in statements to the Police and for bail applications.

The relatively high cost of legal fees makes them unaffordable for the majority of people and consideration should be given to increasing the financial threshold criteria for accessing legal aid services.

The Attorney General

The Constitution of the Republic of Mauritius provides that the Attorney General shall be the principal legal adviser to the Government of Mauritius and the office of Attorney General shall be the office of a

Minister.
The Attorney General must be a citizen of the State and a qualified candidate for the legislative election. No person shall be qualified to hold the office of Attorney General unless he is entitled to practise as a barrister in Mauritius.

Where the person holding the office of Attorney-General is not a member of the Assembly, he shall be entitled to take part in the proceedings of the Assembly, and this Constitution and any other law shall apply to him as if he were a member of the Assembly, however he shall not be entitled to vote in the Assembly.

The Attorney General's Office consists, inter alia, of the following Officers: - Attorney General; Solicitor General; Deputy Solicitor General; Parliamentary Counsel; Chief State Attorney; Assistant Solicitor General; Principal State Attorney; Legal Secretary; Curator of Vacant Estates; State Counsel and State Attorney.

The Attorney General and his Officers advise the State and various departments; handle all litigation in which the State, its agencies, or officers, is a party. This includes defending the State in the different courts as well as filing suits on behalf of the State. The Parliamentary Counsel, assisted by a number of Officers, prepares Bills and reviews existing legislation.

The Director of Public Prosecutions

There is also a Director of Public Prosecutions who is appointed by the Judicial and Legal Service Commission as per the Constitution. No person shall be qualified to act as the Director of Public Prosecutions unless he is entitled to be appointed as a Judge of the Supreme Court.

The Director of Public Prosecutions has the power in any case in which he considers it

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

desirable to do so:

- (a) to institute and undertake criminal proceedings before any Court of law;
- (b) to take over and continue any such criminal proceedings that may have been instituted by any other person or authority; and
- (c) to discontinue at any stage before judgement is delivered any such criminal proceedings instituted or undertaken by himself or any other person or authority.

In the exercise of his powers, the Director of Public Prosecutions shall not be subject to the direction or control of any person or authority.

That being said, the vesting of such vast powers exclusively in the hands of a single person has often been the subject matter of debate in Mauritius. Recently, Government attempted to introduce a Prosecution Bill in order to instil some degree of accountability in the decisions of the Director of Public Prosecutions, whose decisions would have been reviewed by a Prosecution Commission. This was however seen as an attempt by the Executive to submit the Director of Public Prosecutions to its control. The Prosecution Bill has thus not been passed into law and the Constitution was not amended for that purpose in the absence of the required three-quarter majority in Parliament following a split in the coalition Government.

The Ombudsman

The Ombudsman holds a public office by virtue of the Constitution and is appointed by the President of the Republic of Mauritius in consultation with the Prime Minister and the Leader of the Opposition.
The Ombudsman may investigate upon any action taken by any officer or authority in the exercise of administrative functions by the said office or authority in any case

[21] See Part V for detailed recommendations

in which a member of the public claims, or appears to the Ombudsman, to have sustained injustice in consequence of maladministration in connection with the exercise of such functions and in which:
(a) a complaint is made;
(b) he is invited to do so by any Minister or other member of Parliament; or
(c) he considers it desirable to do so of his own motion.

The above applies mainly to the officers of any department of Government, any local authority, the Police Force, the Mauritius Prisons Service or any other service controlled and maintained by Government.

In the exercise of his powers, the Ombudsman shall not be subject to the direction or control of any person or authority. However, as is the case with the EOC, the Ombudsman has no power to investigate decisions taken by the PSC, the LGSC and/or the DFSC, which are the recruiting arms of the State.

The Public Bodies Appeal Tribunal

The Public Bodies Appeal Tribunal can hear and determine appeals against "final decisions" taken by the recruiting arms of the State namely the PSC, the LGSC and/or the DFSC.

Such "final decisions" do not relate to any issue related to recruitment as we have already seen under the heading "Equality/ Anti-Discrimination" above.

The National Human Rights Commission

In 1998 the Protection of Human Rights Act (19 of 1998) was enacted to provide for a National Human Rights Commission, for the better protection of human rights, for the better investigation of complaints against members of the Police Force, and for matters connected herewith or incidental thereto.

In 2012, three (3) separate and distinct divi-

sions were created within the National Human Rights Commission namely:

- (a) the Human Rights Division;
- (b) the Police Complaints Division; and
- (c) the National Preventive Mechanism Division.

The Composition Structure

The Chairperson of the National Human Rights Commission also acts as Chairperson of all 3 divisions and is therefore the head of each of these entities whereas 3 Deputy Chairpersons are said to have been "assigned to a Division".

The meetings held with key informants and the focus group discussions conducted for the purpose of the present Legal Environment Assessment has shown that the composition of the above 3 divisions as presently structured does not function ideally. No decision, however urgent, may be taken by any of the Deputy Chairpersons "assigned" to his division without the approval of the Chairperson of the National Human Rights Commission whose accessibility has often been questioned. In a recent press interview, the Deputy Chairperson of the National Preventive Mechanism Division has even stated it took no less than a whole week to have a mere letter issued by the said division albeit the urgency of the matter in as much as the approval of the Chairperson of the National Human Rights Commission was not readily forthcoming. It is therefore advisable to have the present structure reviewed in order to confer more powers and autonomy to the Deputy Chairpersons of the aforementioned divisions.

Functions of the National Human Rights Commission

The duties of the National Human Rights Commission are as follows:

- (a) promote and protect human rights;

- (b) review the safeguard provided by or under any enactment for the protection of human rights;
- (c) review the factors or difficulties that inhibit the enjoyment of human rights;
- (d) submit to the Minister any opinion, recommendation, proposal or report on any matter concerning the promotion and protection of human rights;
- (e) prepare reports on the national situation with regard to human rights in general, and on more specific matters;
- (f) inform the Minister of situations of violation of human rights and advise on ways in which such situations can be ended;
- (g) promote and ensure the harmonisation of national legislation and practices and with the international human rights instruments to which Mauritius is a party, and their effective implementation;
- (h) encourage ratification or accession to the instruments referred to in paragraph (g), and ensure their implementation;
- (i) contribute to the reports which Mauritius is required to submit to United Nations bodies and committees, and to regional institutions, pursuant to its treaty obligations and, where necessary, to express an opinion on the subject, with due respect for its independence;
- (j) cooperate with the United Nations and any other organisation in the United Nations system, the regional institutions and the national institutions of other countries that are competent in the areas of the protection and promotion of human rights;

- (k) assist in the formulation of programmes for the teaching of, and research into, human rights and take part in their execution in schools, universities and professional circles;

- (l) publicise human rights and efforts to combat all forms of discrimination by increasing public awareness, especially through information and education and by making use of all press organs; and

- (m) exercise such other functions as it may consider to be conductive to the promotion and protection of human rights.

Public Awareness and Public Trust

Focus group discussions conducted in the course of the present Legal Environment Assessment exercise have revealed that there is a perception that the National Human Rights Commission does not do enough to:

- assist in the formulation of programmes for the teaching of, and research into, human rights and take part in their execution in schools, universities and professional circles; and

- publicise human rights and efforts to combat all forms of discrimination by increasing public awareness, especially through information and education and by making use of all press organs.

There appears to be a lack of public awareness of the role that ought to be played by the National Human Rights Commission. In addition the institution lacks visibility and is relatively silent on issues that it should speak out on. Most importantly, there is also a growing perception in the public that when members of the National Human Rights Commission deem it fit and appropriate to speak out in the media on issues of public interest, they expose themselves to the discontent of their superiors.

Functions of the Human Rights Division

The Human Rights Division may, without prejudice to the jurisdiction of the Courts or the powers conferred on the Director of Public Prosecutions or the appropriate Service Commission:

- (a) enquire into any written complaint from any person alleging that any of his human rights has been, is being or is likely to be violated by the act or omission of any other person acting in the performance of any public function conferred by any law or otherwise in the performance of the functions of any public office or any public body; and

- (b) where it has reason to believe that an act or omission such as is referred to in paragraph (a) has occurred, is occurring or is likely to occur, of its own motion enquire into the matter.

However, the Human Rights Division shall not enquire into any matter after the expiry of 2 years from the date on which the act or omission which is the subject of a complaint is alleged to have occurred.

The Human Rights Division is also precluded from exercising its functions and powers in relation to any of the officers and authorities specified in the proviso to section 97(2) of the Constitution i.e. where only the Ombudsman has jurisdiction as seen above under the heading "The Ombudsman".

In the exercise of its functions under paragraphs (a) or (b) above, the Human Rights Division may, where appropriate, refer the matter to one of the 2 other Divisions of the National Human Rights Commission (the Police Complaints Division or the National Preventive Mechanism Division) to enquire into the case.

The Human Rights Division shall, in the first

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

place, attempt to resolve any complaint by a conciliatory procedure. Where the Human Rights Division has not been able to resolve a matter through conciliation, it shall, on the completion of its enquiry:

- (a) where the enquiry discloses a violation of human rights or negligence in the prevention of such violation, refer the matter to:
    - (i) the Director of Public Prosecutions where it appears that an offence may have been committed;
    - (ii) the appropriate Service Commission where it appears that disciplinary procedures may be warranted;
    - (iii) the Chief Executive Officer of the appropriate public body where it appears that disciplinary action is warranted against an employee of a public body who is not within the jurisdiction of a Service Commission;
    - (b) recommend the grant of such relief to the complainant or to such other person as the Human Rights Division thinks fit; and
- (c) inform the complainant, if any, of any action taken by it pursuant to paragraphs (a) or (b) above.

The Human Rights Division may be called upon to act upon an application by a convicted person for reference to the Court of Criminal Appeal of the Supreme Court under the provisions of the Criminal Appeal Act. In fact, a convicted person, or his representative, may apply to the Human Rights Division for an enquiry to be conducted as to whether there exists sufficient fresh and compelling evidence that may satisfy the Human Rights Division that a reference should be made to the Court of Criminal Appeal. On receipt of such an application, the Human Rights Division shall:
(a) conduct such preliminary inves-

[21] See Part V for detailed recommendations

tigation as it considers necessary;

- (b) determine, within a period of 30 days from receipt of the application, whether it will conduct an enquiry into the matter; and

- (c) inform the convicted person, or his representative, accordingly.

The Human Rights Division shall conduct the said enquiry in such manner as it considers appropriate and shall as far as practicable, complete its enquiry within 6 months from receipt of the complaint. And on completion of the enquiry, the Human Rights Division may:

- (a) grant the application and refer the conviction to the Court of Criminal Appeal; or

- (b) reject the application.

Functions of the National Preventive Mechanism Division

The National Preventive Mechanism Division was set up with the enactment of the National Preventive Mechanism Act 21 of 2012 which amended the Protection of Human Rights Act to give effect in Mauritius to the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the General Assembly of the United Nations on 18 December 2002 and acceded to by the government of Mauritius on 21 June 2005 and also to provide for the setting-up of a National Preventive Mechanism Division within the National Human Rights Commission.

The duties of the National Preventive Mechanism Division are:

- (a) to visit places of detention on a regular basis so as to examine the treat-

ment of persons deprived of their liberty with a view to ensuring their protection against torture and inhuman or degrading treatment or punishment;

- (b) to investigate any complaint whi ch may be made by a detainee and, where the detainee so requests, investigate the complaint privately;

- (c) to make to the Minister recommendations regarding the improvement of the treatment and conditions of persons deprived of their liberty in places of detention, taking into consideration the relevant norms of the United Nations;

- (d) to submit to the Minister and other relevant authorities proposals and observations concerning legislation relating to places of detention and the treatment of persons deprived of their liberty; and

- (e) to work, where appropriate, in co-operation or consultation with any person or body, whether public or private, in connection with the discharge of any of its functions.

- "Place of detention" is defined as follows:

- (a) any place where a person is or may be deprived of his liberty by virtue of an order given by a public authority or at its instigation or with its acquiescence; and

(b) it includes a police cell, a prison, a Correctional Youth Centre, a Rehabilitation Youth Centre and a mental health care centre;

The National Preventive Mechanism Division has the following powers:

- (a) all such powers as may be necessary to effectively discharge its functions under the law and the Optional Protocol;
- (b) full access to all information concerning the number of persons deprived of their liberty in places of detention, as well as the number of places and their location;
- (c) access to all information referring to the treatment of those persons as well as their conditions of detention;
- (d) access to any place of detention and its installations and facilities;
- (e) the opportunity to have private interviews with persons deprived of their liberty, personally or with a translator where necessary, as well as with any other person whom they have reason to believe may supply relevant information;
- (f) the freedom to choose the places it wants to visit and the persons it wants to interview;
- (g) the freedom to determine its own procedures, including its programmes of visits; and
- (h) the freedom for its members to be accompanied, if needed, by such expert with the relevant professional expertise, experience and knowledge as the Chairperson may determine, on visits to detention centres;
- [Emphasis added]

Key informant interviews conducted in the preparation of this report have revealed challenges faced by the National Preventive Mechanism Division, which include failure on the part of the Commissioner of Prisons to respond to cor-

viction (...), be liable to a fine not exceeding 50,000 rupees and to imprisonment for a term not exceeding 2 years."
(Emphasis added)

Although a Police officer has the right to act on a mere reasonable suspicion, there is more and more a propensity at arresting and detaining persons before even properly ascertaining whether all the ingredients of a suspected offence are in truth and in fact present. The highlighted word in Section 34 (1) (c) of the Dangerous Drugs Act seems, more often than not, to escape the attention of some ADSU officers.

In order to better safeguard the fundamental rights of human beings, it is therefore highly recommended to further strengthen the training of Police officers especially when it comes to technical aspects such as the one depicted above.

In view of the number of complaints voiced out by the public against acts and doings of some members of the Police Force especially alleging intimidation, brutality and breach of fundamental human rights and having regard to the growing public mistrust in the Police Force, the Legislature has enacted in 2012 the Police Complaints Act (20 of 2012) with a view to providing for the setting up, within the National Human Rights Commission, of a Police Complaints Division for the investigation of complaints made against members of the Police Force and for any other related matter.

This was a laudable initiative especially as some serious events have often shaken public trust in the Police Force. Some years ago, Mauritius was disrupted by severe social unrest, riots and pillage following the death of a well-known popular singer whilst in police custody. This self-proclaimed Rastafarian was arrested for having allegedly made the apology of weed consumption during a major public gathering. His wid-

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

ow was, following a Supreme Court case, financially compensated by the State without admission of liability on the part of the latter. More recently, a police officer arrested in connection with an alleged case of drug trafficking died in police custody whilst he was expected to make damming revelations. The Police alleged that he had hung himself to a waist-high sink in his cell.

Following this incident, a member of the National Human Rights Commission who publicly voiced out some of her concerns about this case was summarily dismissed. Finally, a man in public custody was found strip-naked and chained to a chair in a Police station. On seeing this, his lawyer alerted public opinion by posting the shocking photo on social media. The Director of Public Prosecutions rapidly intervened in the said case and dropped the provisional charges levelled against that person for lack of sufficient evidence. The same prompt reactiveness was not noted at the level of the Police Complaints Division of the National Human Rights Commission against which the Deputy Chairperson of the National Preventive Mechanism Division of the National Human Rights Commission, publicly passed rather disturbing remarks by, inter alia, pointing the finger at the lack of willpower at the very head of the National Human Rights Commission

The Police Complaints Division is chaired by the Chairperson of the National Human Rights Commission, a former Judge of the Supreme Court of Mauritius, who is more often than not abroad and consequently almost inaccessible in Mauritius. The Police Complaints Division also comprises of a Deputy Chairperson who is the Deputy Chairperson of the National Human Rights Commission to whom the Police Complaints Division has been assigned and 2 other members.

Without prejudice to the jurisdiction of the

[21] See Part V for detailed recommendations

Courts or the powers conferred upon the Ombudsman, the Director of Public Prosecutions or the Disciplined Forces Service Commission, the Police Complaints Division has the power to:

- (a) investigate any complaint made by any person, or on his behalf (including but not limited to cases where the complainant has passed away), against any act, conduct or omission of a police officer in the performance of his duty, other than a complaint made in relation to an act of corruption or a money laundering offence (in which cases, the matter is handled by the Independent Commission Against Corruption);
- (b) investigate the death of any person which occurred when the person was in police custody or as a result of police action;
- (c) advise on ways in which police misconduct may be addressed and eliminated; and
- (d) perform such other function as may promote better relations between the public and the police.

For the purpose of its investigations, the Police Complaints Division also has the power, inter alia, to:

- (a) visit any police station, prison or other place of detention; and
- (b) enter and search any premises used by the Police Force.

It is apposite to note that a complaint shall not be investigated upon by the Police Complaints Division unless it is made within one year of the day on which the complainant first had notice of the matter alleged in the complaint. However, this timeline may be extended if the Police Complaints Division considers that there are special circumstances warranting the same.

Focus group discussions conducted in the preparation of this report have revealed that there is general percep-

tion that the Police Force:

- (a) acts arbitrarily by carrying out hasty arrests and then proceeding to a preliminary assessment of the evidence; if any;
- (b) abuses the Provisional Charge System to detain suspects;
- (c) has a stigma-based approach especially when dealing with drug users, sex workers and previous offenders; and
- (d) often focuses on obtaining confessions from suspects rather than carrying out a proper, thorough and full-fledged investigation.

Recommendations

- Develop general as well as targeted programmes and campaigns to reduce stigma and discrimination against PLHIV and key populations.
- Provide information and education on HIV, law and human rights issues to increase awareness and understanding of HIV-related law and rights and how to claim and enforce rights through existing legal support services and enforcement mechanisms such as the police, the National Human Rights Commission, the Ombudsman, the Equal Opportunities Commission and the courts.
- Strengthen access to legal support services for people living with HIV and key populations through various possible measures including: o Encouraging pro bono services through private lawyers;
- Supporting civil society organisations to provide legal support for HIV-related complaints
- Ensure that justice system reforms consider and integrate the specific vulnerabilities, difficulties and concerns of people living with HIV and other key populations.

- Sensitize judiciary on law and human rights issues affecting people living with HIV and other vulnerable and key populations.
- Consider making specific provisions in the rules of court and other tribunals to permit the suppression of identity of the plaintiff or complainant in order to protect the confidentiality of same.
- The financial threshold for access to legal aid should be lowered to improve access to justice.
- Incentives should be considered to encourage law firms in the private sector to provide pro bono services to people living with HIV.
- Ensure that members of the Police Service receive regular training on the rights of people living with HIV and of key populations.

Part 4

Recommendations

A.Equality/Anti-Discrimination Law and Policy

Foreigners/Migrants

Recommendations

· Repeal those provisions of immigration legislation and regulations that exclude migrant workers from employment or foreigners from residing or studying in Mauritius solely on the basis of their HIV status.

· Ensure that medical examinations for purposes of immigrant or study visa applications do not include a compulsory HIV test.

· Implement regulatory reform to ensure that migrant workers and foreigners can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens. All HIV testing and STI screening for migrant workers and foreigners must be confidential, voluntary and with informed consent.

Ensure that employers' contracts with migrant workers and foreigners make provisions for the employer to assume responsibility for all health care costs of the employee during the period of the latter's employment with the employer.

· Ensure that migrant workers and foreigners can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens.

Access to Insurance/Bank loans

Recommendations

HIV should not be treated differently from analogous medical conditions for insurance purposes. Legal provisions should be enacted to prohibit exclusion from life, health and other insurance solely on the basis of HIV status and to ensure that in the context of insurance, HIV should not be treated differently from analogous chronic medical conditions.

B. Health laws, policies and plans

Public health legislation

Recommendations:

It is critical that the Public Health Act be amended to exclude HIV and AIDS from the operation of section 42 and also to ensure that notification provided for in section 41 is anonymous and unlinked and is undertaken only for the purposes required for disease surveillance.

Isolation and detention of patients

Recommendations:

It is critical that the Public Health Act be amended to exclude HIV and AIDS from the operation of section 48 to ensure that the provisions of this Act regarding isolation and detention cannot be inappropriately invoked against people living with HIV.

Informed Consent to HIV Testing and Treatment and Confidentiality

Recommendations

Consideration should be given to amending the law to align the age of consent to sexual and reproductive health services and to HIV treatment to that of consent to sexual intercourse.

Ensure that health care providers and prison service members are provided with training on regular basis to ensure that testing is only conducted with informed consent and that confidentiality regarding HIV status is maintained and all times.

[16] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[17] Ibid. See also Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[18] UNAIDS, Mauritius NCPI Report, 2010
[19] Key Informant Interview, Nicolas Ritter, PILS, 6 December 2017
[20] UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic: LINK

Access to HIV Prevention, Treatment, Care and Support

Recommendations

- Advocate for the Industrial Property Bill to be brought into force;
- Capacity building with stakeholders on TRIPS flexibilities and related issues;
- Provide guidance on good practice for implementation of TRIPS;
- Ensure health care workers have training, including rights-based and sensitization training, to adequately implement and provide non-discriminatory services to key populations and young people;
- Ensure greater access to healthcare services and provide infrastructure to support increased home visits, if necessary;
- Ensure better linkages between needle exchange and MST programmes and HIV testing and treatment.
- Develop national ARV and HIV diagnosis protocols in collaboration with PLHIV and NGOs working directly with key populations.
- Government to organize regular training of staff involved in activities such as storage, inventory management, distribution and dispensation of products.
- Strengthen managerial and technical capacity of NDCCI staff to manage and treat HIV, especially in regards to adherence counselling, patient monitoring and research.
- Ensure stronger supervision and support to staff working at NDCCI and other units to maintain and improve quality of prevention, treatment and

[21] See Part V for detailed recommendations

care services provided. This includes ongoing training to intermediary cadres (pharmacy assistants, methadone dispenser etc) and specialists from other departments (dermatology, gynaecology, paediatrics) on stigma and discrimination so that they can work more effectively with key populations and PLHIV.

- The Central Laboratory should introduce a system for routine surveillance of priority STI pathogens to monitor prevalence and resistance patterns as well as Hepatitis C virus.

- Monthly HIV data should be provided to NGOs to enable them to monitor the national HIV surveillance and have access to such key data. It is additionally recommended that HIV cascade be provided for key populations as well as for the general population.

- MoH should commit to using viral load with PLHIV as a measure of understanding, control and motivation to adhere to treatment and understand their HIV infection, coupled with appropriate counselling to address, among others, the implication of a detectable or undetectable viral load.

- Establish a national Hepatitis committee to create and implement a national Hepatitis plan with the meaningful involvement of people living with Hepatitis to address mainly the issue of access to diagnosis (viral load and genotyping) and treatment for people living with HIV, people currently injecting or on MST.

Regulation of Health Care Providers

Recommendations

· Procedures to report misconduct should be clearly available at all health care facilities in clear and simple language;

· The establishment of a toll-free hotline to report misconduct should be investigated;

· Ways in which to access to the complaints systems at the professional disciplinary bodies in a less bureaucratic and time-consuming manner should be investigated;

C. Criminal Law and Law Enforcement

Sexual orientation and gender identity

Recommendations

· The provisions of the Criminal Code should be amended to decriminalise sodomy.

· The National HIV/AIDS Policy should be reviewed and amended to widen the definition of key population beyond MSM to include all LGBTI people.

· The Legislature, law enforcement officials, communities and religious leaders need to be trained to recognize and uphold the human rights of LGBTI, and should be held accountable if they violate these rights.

· The role of civil society in creating tolerance should be recognized and acknowl-

edged and resources made available to support this role.

· The Mauritius Prison Service should provide prisoners with condoms.

· The Mauritius Prisons Service should accommodate transgender prisoners in a prison with people from their chosen non-birth gender, whether or not they have changed their physical sex appearance.

· The complaints procedure at the Equal Opportunities Commission should be amended to make provision for the suppression of identity of the complainant.

· Advocacy to increase awareness and an environment that supports the health and well-being of LGBTI people is crucial. The provision of health care provider sensitivity training to ensure access to LGBTI-friendly health care services, as well as the incorporation of mental health services into HIV prevention programs targeting LGBTI people should be expanded.

· Provision should be made for legal recognition of self-identified gender under national law without the need for surgery and related medical procedures.

· Ensure that any requirements for individuals to provide information on their sex or gender are relevant, reasonable and necessary as required by the law for a legitimate purpose in the circumstances where it is sought, and that such requirements respect all persons' right to self-determination of gender.

· Amend existing definitions in Mauritian legislation to include same-sex couples on the same basis as spouses of opposite sexes and legalise same sex marriage.
· Expand the definition of 'gender' used in all policies and programmes to become fully trans-inclusive.

· Ensure that all national programmes addressing gender equality and violence against women and girls also address the particular issues faced by lesbian, bisexual and trans women.

· Promote education and awareness by integrating the issue of sexual orientation and gender identity into the educational curriculum including through human rights education and/ or through specific age-appropriate courses focussing on sexual orientation and gender identity.

Sex workers

Recommendations

· Consensual adult sex work should be decriminalised and the unjust application of other criminal laws and regulations against sex workers should be stopped.

· Law should be enacted to protect against discrimination and violence, and other violations of rights faced by sex workers in order to realize their human rights and reduce their vulnerability to HIV infection and the impact of AIDS. Anti-discrimination laws and regulations should guarantee sex workers' rights to social, health and financial services.

· Programs should be put in place to provide legal literacy and legal services to sex workers so that they know their rights and applicable laws, and can be supported to access the justice system when aggrieved.

· Health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health.

· Programs should be put in place to sensitize and educate health care providers on non-discrimination and sex workers'

right to high-quality and non-coercive care, confidentiality and informed consent.

· Sex workers groups and organizations should be made essential partners and leaders in designing, planning, implementing and evaluating health services.

· Essential health services for sex workers must include universal access to male and female condoms and lubricants, as well as access to comprehensive sexual and reproductive health services, and equitable access to all available health care services including primary health care and harm reduction services.

· Violence against sex workers is a risk factor for HIV and must be prevented and addressed in partnership with sex workers and sex worker-led organizations.

· Violence against sex workers needs to be monitored and reported, and redress mechanisms established to provide justice to sex workers.

· Law enforcement officials, magistrates and health and social care providers need to be trained to recognize and uphold the human rights of sex workers, and held accountable if they violate the rights of sex workers, including the perpetration of violence.

· Support services need to be provided to sex workers who experience violence.

People who use drugs

Recommendations

· Replace ineffective measures focused on the criminalisation and punishment of people who use drugs with evidence-based and rights affirming interventions proven

to meaningfully reduce the negative individual and community consequences of drug use, including the promotion of referrals to MST programs rather than the imposition of custodial services for persons convicted of possession for own use.

· Consideration should be given to decriminalising possession of drugs for own use and halting the practice of arresting and imprisoning people who use drugs but do no harm to others.

· Amend the Dangerous Drugs Act to bring it in line with the HIV and AIDS Act and decriminalise the possession of needles and syringes as part of a needle exchange programme.

· Reconsider the location of methadone distribution at police stations and increase the hours that methadone distribution points are open to ensure that all who need it are able to access methadone without fear of persecution.

· Improve the integration of methadone distribution medical services to ensure that people who use drugs have access to the full range of prevention, treatment and care services.

· Build the capacity of law enforcement officials, judicial officers and health care service providers on the importance of evidence-based and rights affirming interventions proven to meaningfully reduce the negative individual and community consequences of drug use.

· The development of gender-sensitive programming for women using drugs such as linking harm reduction programme to SRHR services.

· Establishment of protocols and ensuring the protocols are followed for pregnant women who use drug or who are on MST programme so that they receive their methadone during and after delivery.

· Harm reduction unit to train and support service providers in the gynaecology ward to increase their expertise and skills to treat pregnant women with methadone and treatment for neonatal abstinence syndrome.

· Review and amend guidelines of NEP and MST to ensure that the full package of harm reduction is available to adolescents.

· Establish linkage to prevention, treatment and care following HIV testing for adolescents.

· Increase linkage for government and NGOs regarding HIV services to expand community outreach activities as well as for a stronger psychosocial support.

These strategies reduce disease and death, and also limit the size and harmful consequences of drug markets by reducing the overall demand for drugs.

Criminalisation of HIV transmission and exposure

Recommendations

· It is recommended that HIV-specific laws that criminalize HIV transmission and exposure are not enacted and that in the rare instances where individuals intentionally transmit HIV to others with the express purpose of causing harm, existing laws—including against assault with intent to do grievous bodily harm—suffice to prosecute people in those exceptional cases. It is thus critical that the Public Health Act be amended to exclude HIV and AIDS from the operation of section 49 of the Act.

· Guidelines should be developed to support law enforcement agents and the judiciary to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established

and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered.

Prisoners

Recommendations

· Ensure that prisoners have full and appropriate access to the same HIV-related prevention information, education, voluntary counselling and testing, means of prevention (including condoms and needle exchange), treatment, care and support as is available in the general population.

· Amend the Criminal Code to decriminalise consensual same-sex sex. The criminalisation of sodomy is a major impediment to the distribution of condoms in prisons and legitimises discrimination against men having sex with men.

· Ensure that victims of rape, assaults and other at-risk prisoners have access to Post-exposure prophylaxis in prisons.

· Ensure that HIV testing in prisons is based on informed consent and with respect for confidentiality.

· Ensure that confidentiality of prisoners living with HIV is respected.

· Increase oversight of inmates to reduce violence and rape.

· Ensure that prisons are adequately ventilated to reduce the risk of TB transmission.

· Attention should be given to increasing non-custodial sentencing options, including for example, community service.

D. HIV/AIDS in the Workplace

Recommendations

· In order to afford better protection against discrimination on the basis of HIV status or sexual orientation for employees or prospective employees of the State, amend the Constitution to stipulate that in addition to the Public Bodies Appeals Tribunal and the Supreme Court, the Equal Opportunities Commission should also be exempt from the general rule provided for in Section 118(4) of the Constitution.

E. Education and Information

Recommendations

· The Ministry of Education and Human Resources should develop and adopt a standardised national SRH and sex education curriculum and ensure that this curriculum is taught in all government and private schools and ensure that all teachers are adequately equipped to deliver age-appropriate comprehensive sexuality education in all schools. Similar training should be included in the curriculum of teacher training colleges.

F. Social Welfare

Recommendations

· Consideration should be given to appointing an HIV clinician on the Social Security Board to facilitate access by people living with HIV to social aid for those who need it.

G. Gender-Based Violence and HIV

Recommendations

· Government and civil society should increase public awareness about the linkages between GBV and HIV, including the provision of information on what to do in such situations and where to get information and help.

· Courts and police stations should make sure that complainants can access healthcare information by ensuring that pamphlets about HIV testing, prophylactic treatment and living positively with HIV are available. Similarly, clinics and hospitals should ensure that information about GBV, how to get a protection order and other options in cases of violence are available. This should be extended to all cases of exposure, not just to instances of rape.

· The definition of gender-based violence should be expanded in law and policy to provide for socially ascribed differences based on gender identity and sexual orientation.

· Provision should be made for a more comprehensive definition of "domestic violence" in the Protection from Domestic Violence Act 6 of 1997 to include all acts of physical, sexual, psychological or economic violence that occur within the family or between former or current spouses or partners, regardless of gender identity of sexual orientation, whether or not the perpetrator shares or has shared the same residence with the victim.

· Healthcare providers should be trained on the recognition of cases of GBV and what to do in such cases.

· Service providers who assist victims of

GBV and healthcare providers who treat victims of GBV should receive cross-training on each other's respective areas.

· Sexual education in schools should be expanded to include education on gender stereotypes and equality between partners in relationships and marriage.

· Magistrates should be sensitised on the linkages between GBV and HIV and on the need to treat cases of GBV with the seriousness that they deserve, including in sentencing.

Part IV Access to Justice and Law Enforcement in Mauritius

Recommendations

· Develop general as well as targeted programmes and campaigns to reduce stigma and discrimination against PLHIV and key populations.

· Provide information and education on HIV, law and human rights issues to increase awareness and understanding of HIV-related law and rights and how to claim and enforce rights through existing legal support services and enforcement mechanisms such as the police, the National Human Rights Commission, the Ombudsman, the Equal Opportunities Commission and the courts.

· Strengthen access to legal support services for people living with HIV and key populations through various possible measures including o Encouraging pro bono services through private lawyers
o Supporting civil society organisations to provide legal support for HIV-related complaints

· Ensure that justice system reforms consider and integrate the specific vulnera-

bilities, difficulties and concerns of people living with HIV and other key populations.

· Sensitize judiciary on law and human rights issues affecting people living with HIV and other vulnerable and key populations.

· Consider making specific provision in the rules of court and other tribunals to permit the suppression of identity of the plaintiff or complainant in order to protect the confidentiality of same.

· The financial threshold for access to legal aid should be lowered to improve access to justice.

· Incentives should be considered to encourage law firms in the private sector to provide pro bono services to people living with HIV.
|
· Ensure that members of the Police Service receive regular training on the rights of people living with HIV and of key populations.

ANNEXURE 1 – DOCUMENTS REVIEWED

Regional and International Treaties, Declarations and Related Documents

2001 Abuja Declaration on Universal Access: HIV/AIDS/TB/Malaria/STIs
2001 UNGASS Declaration of Commitment on HIV/AIDS
2003 Maseru Declaration
2006 Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Supporting Africa in 2010
2006 UNGASS Political Declaration on HIV/AIDS - Universal Access
2011 UNGASS Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS
2011 Windhoek Declaration Women, Girls, Gender Equality and HIV: Progress towards Universal Access
2012 African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa
2013 Agenda 20632015 Sustainable Development Goals
2016 UNGASS Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight Against HIV and To End the AIDS Epidemic by 2030
African Charter on Human and Peoples' Rights, 1992
African Charter on the Rights and Welfare of the Child, 1991
CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health
CESCR, General Comment No. 18
Commission on Human Rights Resolutions 1995/44 of 3 March 1995 and 1996/43 of 19 April 1996
Convention of the Rights of Persons with Disabilities 2010
Convention of the Rights of the Child 1990
Convention on the Elimination of All forms of Discrimination against Women 1984
Convention on the Rights of Persons with Disabilities, 2010
Convention on the Rights of the Child (CRC),

1990
Discrimination (Employment and Occupation) Convention, 1958
Human Rights Committee, General Comment No. 18(37)
Human Rights Committee, General Comment No. 20
ILO (2010) Recommendation 200 concerning HIV & AIDS in the World of Work
International Convention on Civil and Political Rights (ICCPR), 1973
International Convention on Economic, Social and Cultural Rights (ICESCR), 1973
Occupational Safety and Health Convention, 1981,
Promotional Framework for Occupational Safety and Health Convention, 2006
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (signed in 2005 – yet to be ratified)
Termination of Employment Convention, 1982
The Siracusa Principles on the limitations and derogation provisions in the international covenant on civil and political rights. UN Doc. E/CN/4/1985/4
Tripartite Consultation (International Labour Standards) Convention, 1976
Universal Declaration on Human Rights
Vienna Convention on the Law of Treaties, 1969

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'Prison for man with HIV who spit on Police Officer' The New York Times, 16 May 2008

AIDS-Free World, 'HIV-Positive nurse tried by media' Available online at: http://www.aidsfreeworld.org/Newsroom/Press-Releases/2014/HIV-Positive-Nurse-Tried-by-Media.aspx

AMSHeR and CAL, 'Violence Based on Perceived or Real Sexual Orientation and Gender Identity in Africa' (2013)

ARASA, 'Sexual Orientation, Gender Identity, HIV and Human Rights: An Advocacy Toolkit'

Budge SL, Adelson JL, Howard KAS, 'Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping'. J Consult Clin Psychol 2013; 81:545–557

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García-Moreno V, Hegarty K, Flavia A et al, 'The health-systems response to violence against women', The Lancet, 2015; 385: 1567–79.

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International Federation of Red Cross and Red Crescent Societies and Francois-Xavier Bagnoud Center for Health and Human Rights 'Human Rights: An Introduction' in Mann J et al (Eds) Health and Human Rights: A Reader Routledge, New York (1999)

J D Mujuzi, 'The Supreme Court of Mauritius and Its Reliance on International Treaties to Interpret Legislation: Reconciling the Tension Between International Law and Domestic Law', Statute Law Review, 2016, Vol 00, No. 00 1-16

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National AIDS Secretariat, 'People living with HIV Stigma Index Report', Mauritius, 2013
S Gruskin, D Tarantola, 'Human Rights and HIV/AIDS'
SARPAM 'Procurement of Patent Medicines by SADC Member States' (2014)
Southern African Litigation Centre, 'Protecting Rights: Litigating Cases of HIV Testing and Confidentiality of HIV Status' (2012)
Submission by Chrysalide, Mauritius, Africa Regional Dialogue on HIV and the Law, Pretoria, 3-4 August, 2011
TG IBBS 2017
UNAIDS Mauritius Country Progress Report 2015
UNAIDS, Mauritius NCPI Report, 2010
UNDP, 'Assessment of Legal, Regulatory & Policy Environment for HIV and AIDS in Malawi' (2012)
WHO, 'Violence against women and HIV/AIDS: Setting the research agenda', 2000

Policies, Codes, Guidelines, Strategies and Plans

Joint ILO/WHO Guidelines on Health Services and HIV/AIDS, 2005
Mauritius National Action Plan to end Gender-based violence 2012-2015
Mauritius National Action Plan on HIV and AIDS 2017-2021
Mauritius National Gender Policy Framework 2008
Mauritius National HIV and AIDS Policy, 2012
Mauritius National Sexual and Reproductive Health Policy (2007)
UNAIDS & OHCHR (2006 consolidated version) International Guidelines on HIV/AIDS

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Code Civil Mauricien Act 105 of 1805
Civil Status Act 23 of 1981
Criminal Code (Supplementary) Act 196 – 7 November 1870,
Criminal Procedure Act Cap 169 of 1883
Probation of Offenders Act 58 of 1946
Dangerous Drugs Act (DDA), No 41 of 2000
Domestic Violence (Amendment) Act 10 of 2016
Education Act No 39 of 1957
Employment Relations Act 32 of 2008
Employment Rights Act 33 of 2008
Equal Opportunities Act 42 of 2008
HIV and AIDS Act 31 of 2006
Immigration Act 13 of 1970
Law Practitioners Act 55 of 1984
Legal Aid and Legal Assistance Act 57 of 1973
Mauritius Institute of Health Act 36 of 1989
Medical Council (Code of Practice) Regulations 2000 Schedule Part II (3)
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National Pensions Act 44 of 1976
National Preventive Mechanism Act 21 of 2012
Patents, Industrial Designs and Trademarks Act No. 25 of 2002
Pharmacy Act 60 of 1983
Police Complaints Act 20 of 2012
Protection from Domestic Violence Act 6 of 1997
Protection of Human Rights Act 19 of 1998
Public Health Act of 1925 Public Health Act Cap 277 of 1925
Reform Institutions Act, 1988
Social Aid Act 2 of 1983
Social Integration and Empowerment Act 26 of 2016 and Human Rights
UNAIDS (2015) 90-90-90 An ambitious treatment target to help end the AIDS epidemic
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Advisory Opinion No 10, Exchange of Greek and Turkish Populations, 1925 PCIJ (ser B) 10 at 20
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Caso Loayza Tamayo v Peru IACHR, 1997
Hoffmann v SAA 2001 (1) SA 1 (CC)
Jansen van Vuuren and Another NNO v Kruger 1993 (4) SA 842 (A)
Jawara v The Gambia (2000) AHRLR 107 (ACHPR 2000) para 46
Law v Canada (1999) 1 SCR 497
Matadeen v Pointu [Privy Council No.14 of 1997
Nanditume v Minister of Defence 2000 NR 103
Toonen v. Australia, Communication No. 488/1992, U.N. Doc CCPR/C/50/D/488/1992 (1994)

ANNEXURE 2 –
KEY INFORMANTS INTERVIEWED

Key informant interviews were conducted with representatives of:

- Human Rights Commission
- Ministry of Health and Quality of Life
- UNDP
- PILS

ANNEXURE 3 –
FOCUS GROUP DISCUSSIONS CONDUCTED

Focus group discussions were conducted with representatives of the following:

- People who use drugs
- Sex workers
- LGBTI people
- Ex-prisoners

ANNEXURE 4 – MEMBERS OF TECHNICAL WORKING

Organisation	Representative	Title
Office of the Resident Coordinator, United Nations Development Programme	Mrs. Doorgawatee Ram-Gopal	
UN Coordination Analyst/ Head of the Resident Coordinator Office		
National Preventive Mechanism Division, National Human Rights Commission, Mauritius	Mr Herve Lassemillante	Deputy Chairman
National Preventive Mechanism Division, National Human Rights Commission, Mauritius	Mr. Vijay Ramanjooloo	Clinical Psychologist
Centre Idrice Goomany	Mr. Samad Dulloo	Social Worker
Gender Links	Mrs. Anoushka Virahsawmy	Country Manager and Gender Links Regional Training Manager
AILES	Miss. Cindy Trevedy	Peer Educator
Prime Minister's Office	Mr. D. Gopaul	Deputy Permanent Secretary
Law Reform Commission	Mr. Sabir Kadel	Senior Law Reform Officer
Balgobin Chambers	Mr. Nilen Vencadasmy	Barrister in Law
AIDS Unit, Ministry of Health and Quality of Life	Dr Ponnoosamy	Ag Head of AIDS Unit
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