

HIV/AIDS AND HUMAN RIGHTS IN SWAZILAND



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1. INTRODUCTION

This country report on HIV/AIDS and human rights in Swaziland is the result of a one-year joint project between the Centre for the Study of AIDS and the Centre for Human Rights, both based at the University of Pretoria, South Africa. The research project was made possible through funds provided by the Open Society Foundation. This report is one of a series of eight reports focusing on HIV/AIDS and human rights in the following countries within the Southern African Development Community (SADC): Botswana, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. These countries have some of the highest and fastest growing rates of HIV/AIDS infection in the world, with the number of reported cases of HIV infection having tripled since the mid-1980s.

This research project was inspired by the need to develop a new approach to the HIV/AIDS epidemic in the SADC, an approach that is rights-based and that guarantees basic human rights to all people living with or affected by HIV/AIDS in the region. The study was guided by the document *HIV/AIDS and Human Rights – International Guidelines*¹ of 1996, adopted by UNAIDS and the Office of the United Nations High Commissioner for Human Rights. The Foreword of these *Guidelines* declares:

“In the context of HIV/AIDS, an environment in which human rights are respected ensures that vulnerability to HIV/AIDS is reduced, those infected with and affected by HIV/AIDS live a life of dignity without discrimination and the personal and societal impact of HIV infection is alleviated.”²

The aim of this research report, within the *SADC HIV/AIDS Framework for 2000-2004*, is to assist decision-makers to make informed policy choices for individual SADC countries. It is also intended for legislators, the judiciary, members of non-governmental organisations and people living with or affected by HIV/AIDS. All of these groups need: firstly, to be informed about

those human rights in the context of HIV/AIDS that are already protected within their countries; secondly, to be able to identify areas where there is a gap and a need to lobby for change; and finally, to initiate change in an effort to move towards a rights-based approach to HIV/AIDS.

This report is a summary of national HIV/AIDS policies, strategic frameworks, legislation, guidelines and court cases in Swaziland as they relate to HIV/AIDS and human rights. A national consultant in Swaziland collected the relevant documents, answered a questionnaire that was developed to structure the research, and commented on the final report.³ This report begins by briefly sketching the HIV/AIDS background for SADC and Swaziland, through listing some critical statistics. The report then provides an analysis of the most important international, regional and SADC principles for HIV/AIDS and human rights, providing an overall framework against which the country report should be seen. The country report is a summary of the legal and policy framework for the protection of the human rights of those living with or affected by HIV/AIDS in Swaziland, and addresses areas such as labour, health, gender, children, prisons and criminal law. This is followed by a concluding chapter with some recommendations regarding moving towards a rights-based approach to HIV/AIDS in the SADC.

It needs to be emphasised that this study focuses on the legal framework alone and does not set out to establish empirically the extent to which the respective governments are implementing the provisions in place – that is beyond the scope of this study and will require further research. Furthermore, while all efforts have been made to ensure that the information presented is reliable and up-to-date as at the end of 2003, the study’s authors do not accept any responsibility for any errors or omissions in the country reports.

¹ Available at: <http://www.unhchr.ch/hiv/guidelines.htm>

² The Foreword was written by Peter Piot, Executive Director of UNAIDS, and Mary Robinson, the former United Nations High Commissioner for Human Rights.

³ Sabelo Gumedze, BA Law, LLB (Swaziland), Attorney of the High Court of Swaziland.

2. BACKGROUND

Swaziland is one of four countries in SADC described by UNAIDS as dealing with “rampant epidemics”, where “the national adult HIV prevalence has risen higher than thought possible, exceeding 30%.”⁴ Swaziland has an adult HIV prevalence of 33,4%, in an adult population of about 450 000.

The tables below provide statistical information on all the SADC countries, with the statistics for Swaziland highlighted.

2.1 Geographical size and population

The following two tables illustrate the size and population of the SADC countries in this study:⁵

Geographical size			
Botswana	581 730 km ²	South Africa	1 220 088 km ²
Malawi	118 484 km ²	Swaziland	17 365 km²
Mozambique	801 590 km ²	Zambia	752 614 km ²
Namibia	824 268 km ²	Zimbabwe	390 759 km ²

Population size		
Country	Total population	Adult population
Botswana	1 564 000	762 000
Malawi	11 572 000	5 118 000
Mozambique	18 644 000	8 511 000
Namibia	1 788 000	820 000
South Africa	43 792 000	23 666 000
Swaziland	933 000	450 000
Zambia	10 649 000	4 740 000
Zimbabwe	12 652 000	5 972 000

2.2 First reported instances of HIV infection⁶

Country	First reporting year	Number of cases
Botswana ⁷	1985	3
Malawi	1985	17
Mozambique	1986	1
Namibia ⁸	1986	1
South Africa	1982	2
Swaziland	1987	1
Zambia ⁹	1984	1
Zimbabwe	1987	119

4 UNAIDS Fact Sheet 2002 'Sub-Saharan Africa,' available at: <http://www.unaids.org/worldaidsday/2002/press/index.html#facts>.

5 Data from Africa Fact Sheet, published by African Institute of South Africa, July 1997.

6 According to the Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections (Update 2002), compiled by UNAIDS, UNICEF and WHO. Available at http://unaids.org/hivaidsinfo/statistics/fact_sheets/all_countries_en.html#N.

7 Doctors in Princess Marina Hospital in Gaborone documented the first HIV/AIDS case in 1985.

8 Reported by UNAIDS in the *International Partnership against AIDS in Africa - Namibia Country Visit Report*, 1 May-4 June 1999.

9 Reported in the *National HIV/AIDS/STD/TB Policy* published in October 2001 by the Zambian Ministry of Health.

2.3 HIV prevalence rates

The following figures are provided by the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, which works in close collaboration with national AIDS programmes.¹⁰ Statistics are also obtained from the *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 Update*, issued by UNAIDS, UNICEF and the WHO.¹¹

Population with AIDS					
Country	Adults and children	Adults (15-49 years)	Adults (%)	Women (15-49 years)	Children (0-14 years)
Botswana	333 000	300 000	39,9%	170 000	28 000
Malawi	850 000	780 000	15%	440 000	65 000
Mozambique	1 100 000	1 000 000	13%	630 000	80 000
Namibia	230 000	200 000	22,5%	110 000	30 000
South Africa	5 000 000	4 700 000	20,1%	2 700 000	250 000
Swaziland	170 000	150 000	33,4%	89 000	14 000
Zambia	1 200 000	1 000 000	21,5%	690 000	150 000
Zimbabwe	2 300 000	2 000 000	33,7%	1 200 000	240 000

HIV prevalence rates in young people aged 15-24 years				
Country	Female		Male	
	Low estimate	High estimate	Low estimate	High estimate
Botswana	29,99%	44,98%	12,86%	19,29%
Malawi	11,91%	17,87%	5,08%	7,62%
Mozambique	10,56%	18,78%	4,41%	7,84%
Namibia	19,43%	29,15%	8,88%	13,32%
South Africa	20,51%	30,76%	8,53%	12,79%
Swaziland	31,59%	47,38%	12,18%	18,27%
Zambia	16,78%	26,18%	6,45%	9,68%
Zimbabwe	26,40%	39,61%	9,9%	14,86%

Tuberculosis (TB) infection rates	
Country	TB prevalence for the year 2000 (unless otherwise stated)
Botswana	8 649 ¹²
Malawi	22 570
Mozambique	Unknown
Namibia	10 497
South Africa	One sentinel site (Port Shepstone) outside major urban areas: 52% minimum, 52% median, 52% maximum.
Swaziland	2 143
Zambia	161 056. The average tuberculosis rate between 1964 and 1984 remained constant at 100 per 100 000 people. The rate of TB infections increased dramatically to nearly five-fold to over 500 per 100 000 people due to the impact of HIV/AIDS in 1996. ¹³ TB co-infection has resulted in an increased mortality rate of TB patients on treatment by over 15%. ¹⁴
Zimbabwe	51 805

¹⁰ The estimates are from the *Table of Country-specific HIV/AIDS Estimates and Data, End 2001*, available at www.unaids.org/barcelona/presskit/barcelona%20reports/table.html. The estimates produced by UNAIDS/WHO draw on advice from the UNAIDS Reference Group on HIV/AIDS Estimates, Modelling and Projections. A measure of uncertainty applies to all estimates, depending on the reliability of the data available. Most of the data are from routine sentinel surveillance. For a detailed description of the general methodology used to produce the country-specific estimates, see Annexure 1 at <http://www.unaids.org/barcelona/presskit/barcelona%20report/annex1.html>.

¹¹ Available at: http://www.unaids.org/hivinfo/statistics/fact_sheets/all_countries_en.html#N. The methodology used in updating and compiling these country-specific estimates is summarised in the publication as follows: "In 2001 and during the first quarter of 2002, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates of people living with HIV/AIDS. These calculations are based on the previously published estimates for 1997 and 1999 and recent trends in HIV/AIDS surveillance in various populations. A methodology developed in collaboration with an international group of experts was

used to calculate the new estimates on prevalence and incidence of HIV and AIDS deaths, as well as the number of children infected through mother-to-child transmission of HIV. Different approaches were used to estimate HIV prevalence in countries with low-level, concentrated or generalised epidemics. The current estimates do not claim to be an exact count of infections. Rather, they use a methodology that has thus far proved accurate in producing estimates which give a good indication of the magnitude of the epidemic in individual countries. However, these estimates are constantly being revised as countries improve their surveillance and collect more information."

¹² Southern African Development Community *Health Annual Progress Report 2000-2001*.

¹³ *National HIV/AIDS/STD/TB Policy* published in October 2001 by the Ministry of Health of the Republic of Zambia. See par 1.2.3.

¹⁴ *Ibid*, par 1.2.4.

Number of pregnant mothers who are HIV positive								
Country	HIV prevalence in antenatal clinics in urban areas (%)				HIV prevalence in antenatal clinics outside major urban areas (%)			
	Year	Median	Min	Max	Year	Median	Min	Max
Botswana	2001	44,9%	39,1%	55,8%	2001	34,8%	25,8%	50,9%
Malawi	2001	20,1%	18,6%	28,5%	2001	16,1%	4,5%	35,8%
Mozambique	2000	14,4%	13,0%	15,7%	2000	10,6%	4,0%	31,2%
Namibia	2000	29,6%	28,2%	31,0%	2000	17,3%	6,6%	32,5%
South Africa	2000	24,3%	8,7%	36,2%	2000	22,9%	11,2%	29,7%
Swaziland	2000	32,3%	32,3%	32,3%	2000	34,5%	27,0%	41,0%
Zambia	2001	30,7%	30,7%	30,7%	1998	13,0%	5,2%	31,0%
Zimbabwe	2000	31,1%	30,0%	33,5%	2000	33,2%	13,0%	70,7%

According to the 2002 Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, the highest prevalence of HIV infection was recorded amongst women aged 25-29 years.

2.4 AIDS deaths in adults and children in 2001

Botswana	26 000	South Africa	360 000
Malawi	80 000	Swaziland	12 000
Mozambique	60 000	Zambia	120 000
Namibia	13 000	Zimbabwe	200 000

2.5 Number of HIV/AIDS orphans (up to 14 years) by end of 2001

Botswana	69 000	South Africa	660 000
Malawi	470 000	Swaziland	35 000
Mozambique	420 000	Zambia	570 000
Namibia	47 000	Zimbabwe	780 000

3. OVERVIEW OF APPLICABLE INTERNATIONAL, REGIONAL AND SADC LEGAL NORMS

This section examines the international, regional and SADC framework for the protection of human rights, as it relates to HIV/AIDS, to form the backdrop against which the national framework of Swaziland should be considered. The international and regional human rights treaties examined do not include any HIV/AIDS-specific provisions. Nevertheless, a number of articles can be highlighted in the various treaties as they indirectly impact on people living with HIV/AIDS or their families. For instance, the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* affirms that state parties to the *Covenant* should recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.¹⁵ The *Covenant* then continues that state parties, in order to achieve this right, should prevent, treat and control epidemic, endemic, occupational and other diseases.¹⁶ These provisions would clearly apply to HIV/AIDS.

This section also briefly summarises the state reports submitted by Swaziland in terms of its obligations under the various treaties that it has ratified, with a specific focus on HIV/AIDS reporting and recommendations made by the treaty monitoring bodies in relation to HIV/AIDS.¹⁷

Finally, SADC and Organisation of African Unity (OAU)/African Union (AU) HIV/AIDS instruments and policies are discussed, followed by a short discussion on *HIV/AIDS and Human Rights – International Guidelines*, issued by UNAIDS and the Office of the United Nations High Commissioner for Human Rights.

¹⁵ Article 12(1) of the *ICESCR*

¹⁶ Article 12(2)(c).

¹⁷ State reporting is a useful tool to monitor a state party's progress in implementing the various provisions of a treaty. Usually, states submit a report shortly after ratifying a treaty (initial report) and thereafter the state must report to the monitoring body every two

3.1 Applicable international legal norms

There are no HIV/AIDS-specific treaties within the international legal framework. The *International Covenant on Civil and Political Rights (ICCPR)* and the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* both came into force in 1976, about four years before the first HIV/AIDS case was documented. Nevertheless, specific provisions of these treaties may be applied to various legal situations affecting people living with or affected by HIV/AIDS. The *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)* is similar, having been adopted in the early days of the epidemic. The *Convention on the Rights of the Child (CRC)*, however, was adopted in 1989, nearly ten years after the first reported case of HIV/AIDS. The fact that in the CRC no mention is made of HIV/AIDS with respect to children can be viewed as a missed opportunity to develop policy for this vulnerable group.

The status of these treaties is as follows (all dates denote ratification or accession, except when marked with 's,' in which case the treaty has only been signed by the state party):¹⁸

Country	ICCPR	ICCPR First Optional Protocol	ICESCR	CEDAW	CEDAW Optional Protocol	CRC
Botswana	08/01/2000			12/09/1996		13/04/1995
Malawi	22/03/1994	11/09/1996	22/03/1994	11/04/1987	7/09/2000 ^s	01/02/1991
Mozambique	21/10/1993			16/05/1997		26/05/1994
Namibia	28/02/1995	28/02/1995	28/02/1995	23/12/1992	22/12/2000	30/10/1990

years. Unfortunately, most African states are behind in submitting reports internationally and regionally.

¹⁸ Status of ratification of international human rights treaties as of 02 November 2003 provided by the Office of the United Nations High Commissioner for Human Rights. Available at www.unhcr.ch/pdf/report.pdf. Date accessed: 24 November 2003.

Country	ICCPR	ICCPR First Optional Protocol	ICESCR	CEDAW	CEDAW Optional Protocol	CRC
South Africa	10/03/1999	28/11/2002	03/10/1994*	14/01/1996		16/07/1995
Swaziland						06/10/1995
Zambia	10/07/1984	10/07/1984	10/07/1984	21/07/1985		05/01/1992
Zimbabwe	13/08/1991		13/08/1991	12/06/1991		11/10/1990

States parties submit reports to the various treaty monitoring bodies that are established in terms of the treaties. These reports may include details of measures taken by the state to address the issue of HIV/AIDS, but it is not compulsory to report in this form. Treaty bodies in turn examine the state reports and issue Concluding Observations.

In general, international treaties do not have a direct impact on the domestic legal systems of specific countries. These treaties can – and should – guide legislators to draft national laws to fulfil their obligations and to incorporate the treaty rights into domestic legislation. However, it will become clear in Section Four that this has seldom been the case.

Various provisions in the selected treaties that are particularly relevant for HIV/AIDS are described below.

International Covenant on Civil and Political Rights (ICCPR)

- *Article 2:*
 - (1) Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognised in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
 - (3) Each State Party to the present Covenant undertakes:
 - (a) To ensure that any person whose rights or freedoms as herein recognised are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;
 - (b) To ensure that any person claiming such a remedy shall have his right thereto determined

by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;

(c) To ensure that competent authorities shall enforce such remedies when granted.

- *Article 6:* (1) Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.
- *Article 7:* No one shall be subjected to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.
- *Article 17:*
 - (1) No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.
 - (2) Everyone has the right to protection of the law against such interference or attacks.
- *Article 19:* (2) Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally in writing or in print, in the form of art, or through any other media of his choice.
- *Article 22:* Everyone shall have the right to freedom of association with others ...
- *Article 24:* (1) Every child shall have, without any discrimination as to race, colour, sex, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State.
- *Article 26:* All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

First Optional Protocol to the International Covenant on Civil and Political Rights

- *Article 1:* A State Party to the Covenant that becomes a Party to the present Protocol recognises the competence of the Committee to receive and consider communications from individuals subject to its jurisdiction who claim to be victims of a violation by that State Party of any of the rights set forth in the Covenant. No communication shall be received

by the Committee if it concerns a State Party to the Covenant which is not a party to the present Protocol.

International Covenant on Economic, Social and Cultural Rights (ICESCR)

- *Article 2:*
(1) Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.
(2) The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
- *Article 6:* (1) The States Parties to the present Covenant recognise 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, and will take appropriate steps to safeguard this right.
- *Article 7:* The States Parties to the present Covenant recognise the right of everyone to the enjoyment of just and favourable conditions of work which ensure in particular: ... (b) Safe and healthy working conditions; (c) Equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence ...
- *Article 9:* The States Parties to the present Covenant recognise the right of everyone to social security, including social insurance.
- *Article 10:* The States Parties to the present Covenant recognise that: ... (3) Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.
- *Article 11:* (1) The States Parties to the present Covenant recognise the right of everyone to

an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions ...

- *Article 12:*
(1) The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
(2) The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.
- *Article 13:* (1) The States Parties to the present Covenant recognise the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms ...
- *Article 15:* (1) The States Parties to the present Covenant recognise the right of everyone: ... (b) To enjoy the benefits of scientific progress and its applications ...

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

- *Article 1:* For the purposes of the present Convention, the term “discrimination against women” shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.
- *Article 2:* States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:
(a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law

- and other appropriate means, the practical realisation of this principle;
- (b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;
 - (c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;
 - (d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;
 - (e) To take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise;
 - (f) To take all appropriate measures, including legislation, to modify or abolish existing law, regulations, customs and practices which constitute discrimination against women;
 - (g) To repeal all national penal provisions which constitute discrimination against women.
- *Article 10:* States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women: ... (f) The reduction of female student drop-out rates and the organisation of programmes for girls and women who have left school prematurely; (h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.
 - *Article 11:* (1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular: (a) The right to work as an inalienable right of all human beings; ... (e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave; (f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.
 - *Article 12:*
 - (1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
 - (2) Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-

natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

- *Article 14:* (2) States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right: ... (b) To have access to adequate health care facilities, including information, counselling and services in family planning; (c) To benefit directly from social security programmes; (d) To obtain all types of training and education, formal and non-formal, including that relating to functional literacy, as well as, inter alia, the benefit of all community and extension services, in order to increase their technical proficiency; ... (h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.

Optional Protocol to the Convention on the Elimination of Discrimination against Women

- *Article 1:* A State Party to the present Protocol (“State Party”) recognises the competence of the Committee on the Elimination of Discrimination against Women (“the Committee”) to receive and consider communications submitted in accordance with Article 2.
- *Article 2:* Communications may be submitted by or on behalf of individuals or groups of individuals, under the jurisdiction of a State Party, claiming to be victims of a violation of any of the rights set forth in the Convention by that State Party ...

Convention on the Rights of the Child (CRC)

- *Article 1:* For the purposes of the present Convention, a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier.
- *Article 2:*
 - (1) States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
 - (2) States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed

- opinions, or beliefs of the child's parents, legal guardians or family members.
- *Article 3:* (1) In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
 - *Article 6:*
 - (1) States Parties recognise that every child has the inherent right to life.
 - (2) States Parties shall ensure to the maximum extent possible the survival and development of the child.
 - *Article 13:* (1) The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.
 - *Article 15:* (1) States Parties recognise the rights of the child to freedom of association and to freedom of peaceful assembly.
 - *Article 16:*
 - (1) No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.
 - (2) The child has the right to the protection of the law against such interference or attacks.
 - *Article 17:* States Parties recognise the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health ...
 - *Article 24:*
 - (1) States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services;
 - (2) States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the frame-

work of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water; (d) To ensure appropriate pre-natal and post-natal health care for mothers; (f) To develop preventive health care, guidance for parents and family planning education and services.

(3) States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

- *Article 26:* (1) States Parties shall recognise for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realisation of this right in accordance with their national law.
- *Article 27:* (1) States Parties recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.
- *Article 28:* (1) States Parties recognise the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular: (a) Make primary education compulsory and available free to all; (b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child and take appropriate measures such as the introduction of free education and offering financial assistance in case of need; (c) Make higher education accessible to all on the basis of capacity by every appropriate means; (d) Make educational and vocational information and guidance available and accessible to all children; (e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.
- *Article 33:* States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances ...
- *Article 34:* States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent: (a) The inducement or coercion of a child to engage in any unlawful sexual activity; (b) The exploitative use of children in prostitution or other unlawful sexual practices; (c) The exploitative use of children in pornographic performances and materials.
- *Article 36:* States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

3.2 State reporting

Under all treaties, states must report periodically to the Committee established under the treaty. Swaziland has not submitted any state reports to date.

3.3 Applicable regional legal norms

The *African Charter on Human and Peoples' Rights (ACHPR)* was adopted in 1981 but makes no specific reference to HIV/AIDS. The *African Charter on the Rights and Welfare of the Child (ACRWC)* was adopted nearly ten years later, in 1990, but still does not include any reference to HIV/AIDS. It is only within the *Guidelines on State Reporting to the African Committee on the Rights and Welfare of the Child* that mention is made of HIV/AIDS. The *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, which has been adopted but is not yet in force, mentions HIV/AIDS in a cursory manner.¹⁹ This is very unfortunate, given the impact of HIV/AIDS on African women.

The status of these treaties in respect of the states under discussion is as follows (all dates denote ratification or accession, except when marked with 's,' in which case the treaty has only been signed by the state party):²⁰

Country	ACHPR	ACRWC
Botswana	17 July 1986	
Malawi	17 November 1989	16 September 1999
Mozambique	22 February 1989	15 July 1998
Namibia	30 July 1992	13 July 1999 ^s
South Africa	09 July 1996	07 January 2000
Swaziland	15 September 1995	29 June 1992^s
Zambia	19 January 1984	28 February 1992 ^s
Zimbabwe	30 May 1986	19 January 1995

²⁰ Article 14(1) states that: "States Parties shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted. This includes:... (d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS ..."

Excerpts from various provisions in the regional treaties that are particularly relevant for HIV/AIDS are listed below.

African Charter on Human and Peoples' Rights (ACHPR)

- *Article 2:* Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status.
- *Article 4:* Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.
- *Article 5:* Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status ...
- *Article 6:* Every person shall have the right to liberty and to the security of his person ...
- *Article 9:*
 - (1) Every individual shall have the right to receive information.
 - (2) Every individual shall have the right to express and disseminate his opinions within the law.
- *Article 10:* (1) Every individual shall have the right to free association, provided that he abides by the law.
- *Article 11:* Every individual shall have the right to assemble freely with others. The exercise of this right shall be subject only to necessary restrictions provided for by law, in particular those enacted in the interest of national security, the safety, health, ethics, and rights and freedoms of others.
- *Article 12:* (1) Every individual shall have the right to freedom of movement and residence within the borders of a State provided he abides by the law.
- *Article 15:* Every individual shall have the right to work under equitable and satisfactory conditions, and shall receive equal pay for equal work.
- *Article 16:*
 - (1) Every individual shall have the right to enjoy the best attainable state of physical and mental health.

¹⁹ Status of ratification and signature of the *ACHPR* and *ACRWC* compiled by the University of Minnesota, Human Rights Library as of 1 January 2000. Available at www1.umn.edu/humanrts/instree/afchildratifications.html and www1.umn.edu/humanrts/instree/ratzlafchr.htm. Accessed: 13 September 2002.

- (2) States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.
- *Article 17:*
 - (1) Every individual shall have the right to education.
 - (2) Every individual may freely take part in the cultural life of his community.
 - (3) The promotion and protection of morals and traditional values recognised by the community shall be the duty of the State.
 - *Article 18:*
 - (1) The family shall be the natural unit and basis of society. It shall be protected by the State which shall take care of its physical health and morals.
 - (2) The State shall have the duty to assist the family which is the custodian of morals and traditional values recognised by the community.
 - (3) The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.
 - (4) The aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs.
 - *Article 19:* All peoples shall be equal; they shall enjoy the same respect and shall have the same rights. Nothing shall justify the domination of a people by another.
 - *Article 24:* All peoples shall have the right to a general satisfactory environment favourable to their development.

African Charter on the Rights and Welfare of the Child (ACRWC)

- *Article 3:* Every child shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in this Charter irrespective of the child's or his/her parents' or legal guardians' race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status.
- *Article 4:* (1) In all actions concerning the child undertaken by any person or authority the best interests of the child shall be the primary consideration.
- *Article 5:* (1) Every child has an inherent right to life. This right shall be protected by law.
- *Article 8:* Every child shall have the right to free association and freedom of peaceful assembly in conformity with the law.
- *Article 10:* No child shall be subject to arbitrary or unlawful interference with his privacy, family home or correspondence, or to the attacks upon his honour or reputation, provided that parents or legal guardians shall have the right to exercise reasonable supervision over the conduct of their children. The child has the right to the protection of the law against such interference or attacks.
- *Article 11:*
 - (1) Every child shall have the right to an education.
 - (2) The education of the child shall be directed to: ... (h) the promotion of the child's understanding of primary health care.
 - (3) States Parties to the present Charter shall take all appropriate measures with a view to achieving the full realisation of this right and shall in particular: ... (e) take special measures in respect of female, gifted and disadvantaged children, to ensure equal access to education for all sections of the community.
- *Article 14:*
 - (1) Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
 - (2) State Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures: (a) to reduce infant and child mortality rate; (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) to ensure the provision of adequate nutrition and safe drinking water; (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology; (e) to ensure appropriate health care for expectant and nursing mothers; (f) to develop preventative health care and family life education and provision of service; (g) to integrate basic health service programmes in national development plans ...
- *Article 21:* (1) States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices prejudicial to the health or life of the child; and (b) those customs and practices discriminatory to the child on the grounds of sex or other status.
- *Article 24:* State Parties which recognise the system of adoption shall ensure that the best interest of the child shall be the paramount consideration ...

- *Article 25:* (2) State Parties to the present Charter: (a) shall ensure that a child who is parentless, or who is temporarily or permanently deprived of his or her family environment, or who in his or her best interest cannot be brought up or allowed to remain in that environment shall be provided with alternative family care, which could include among others, foster placement, or placement in suitable institutions for the care of children;
- *Article 27:* States Parties to the present Charter shall undertake to protect the child from all forms of sexual exploitation and sexual abuse and shall in particular take measures to prevent:
 - (a) the inducement, coercion or encouragement of a child to engage in any sexual activity;
 - (b) the use of children in prostitution or other sexual practices;
 - (c) the use of children in pornographic activities, performances and materials.
- *Article 28:* States Parties to the present Charter shall take all appropriate measures to protect the child from the use of narcotics and illicit use of psychotropic substances ...

According to Article 43(1) of the ACRWC, state parties must undertake to submit to the African Committee of Experts of the Rights and Welfare of the Child, through the Chairperson of the Commission of the African Union, reports on the measures that have been adopted to give effect to the provisions of the ACRWC, and the progress made in the enjoyment of the rights guaranteed in the Charter. The *Guidelines* for reporting specify that the state parties should indicate what measures are in place for children in need of special protection, specifically in reference to AIDS orphans, in terms of Article 26 of the *Charter*.²¹ States are also encouraged to provide specific statistical information and indicators relevant to children in need of special protection.²² The first report under ACRWC is due within two years of the state's ratification of the *Charter*, and thereafter reports are due every third year. Unfortunately, not one of the eight countries in this study has submitted reports to date.

3.4 SADC framework for addressing HIV/AIDS

In September 1997, the SADC Council of Ministers adopted the first relevant document addressing HIV/AIDS-related issues, the *Code of HIV/AIDS and Employment in SADC*, as developed by

the Employment and Labour Sector. The main objectives of the *Code* are to sensitise employers to the issue of employee rights and HIV/AIDS, and to provide a framework for states to consolidate national employment codes on HIV/AIDS-related issues. It addresses public sector employers, legislators, employees and trade unions.

In August 1999, the 14 member states adopted the *SADC Health Protocol*.²³ Article 10 specifically deals with HIV/AIDS and sexually transmitted diseases (STDs). The article urges states parties to harmonise policies and approaches for the prevention and management of HIV/AIDS and STDs, and to develop regional policies and plans that work towards an inter-sectoral approach to the epidemic.

In December 1999, the SADC HIV/AIDS Task Force adopted the vision document *A SADC Society with Reduced HIV/AIDS*. It was adopted to guide the work of the SADC in the development and implementation of a multi-sectoral *HIV/AIDS Framework for 2000-2004* (hereinafter referred to as the *Strategic Framework*). The *Strategic Framework* is in principle guided by Article 10 of the *SADC Health Protocol*; all SADC sectors agree to use their comparative advantages to address the needs of those sectors and the communities they serve, whether transport, mining, tourism, etc. One of the principles that has been acknowledged as important in the development of the *Strategic Framework* is the respect for the rights of individuals.²⁴

The only sector in the *Strategic Framework* that specifically mentions stigmatisation and discrimination is the Human Resources Development. This sector aims to provide information to reduce stigma and to change attitudes by, amongst other initiatives, integrating HIV/AIDS education and life skills into school curricula across the region.²⁵

In September 2000, the SADC Council of Ministers approved the *Health Sector Policy Framework Document*, as developed by the SADC Health Ministers.²⁶ A significant part of the programme focuses on HIV/AIDS and sexually transmitted diseases. One of the policy objectives in the programme, geared towards HIV/AIDS control, is to protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV/AIDS.

21 Par 21 (g) of the (Adopted) Guidelines for Initial Reports of State Parties under the ACRWC.

22 Par 22.

23 *SADC Health Protocol*. Available at: <http://196.36.153.56/doh/department/sadc/docs/protocol99.html>.

24 *Managing the impact of HIV/AIDS in SADC*, August 2000, at page 8. Available at: <http://196/36/153/56/doh/department/sadc/docs>.

25 *Ibid*, at p 28.

26 Available at: <http://196.36.153.56/doh/department/sadc/docs/framework/html>.

A month prior to the adoption of the *Health Sector Policy Framework*, the SADC Health Ministers adopted *Principles to Guide Negotiations with Pharmaceutical Companies on Provision of Drugs for Treatment of HIV/AIDS-Related Conditions in SADC Countries*.²⁷ These principles focus on enabling SADC countries to make informed decisions in their negotiations with pharmaceutical companies and to consider factors such as sustainability, affordability, accessibility, appropriateness, acceptability and equity before accepting offers for free drugs or reduced prices on HIV/AIDS-related drugs.

In July 2003, the SADC Heads of Government signed the *SADC Declaration on HIV/AIDS*.²⁸ The *Declaration* affirms the commitment to address the pandemic and the issues relating to HIV/AIDS in the SADC region through multi-sectoral intervention. A new *SADC HIV/AIDS Strategic Framework and Programme of Action 2003-2007* was also issued.

3.5 Relevant OAU/AU resolutions on HIV/AIDS

Over the years, the Assembly of Heads of State and Government of the Organisation of African Unity (OAU, now called the African Union or AU) adopted a number of resolutions addressing the HIV/AIDS epidemic. Only those relevant to HIV/AIDS and human rights are discussed here.

In June 1994, the *Tunis Declaration on AIDS and the Child in Africa* was adopted by the OAU at the Assembly of Heads of State and Government in Tunis, Tunisia.²⁹ The *Declaration* declares a commitment to: “Elaborate a national policy framework to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues.”³⁰

In July 1996, at the Thirty-Second Ordinary Session of the Heads of State and Government of the OAU, a *Resolution on Regular Reporting of the Implementation Status of OAU Declarations on HIV/AIDS in Africa* was adopted by the Assembly.³¹ The *Resolution* urged African leaders to

implement those declarations and resolutions that had been adopted in the past, specifically referring to the *Tunis Declaration*.

On 27 April 2001, the Heads of State and Government gathered for a special summit devoted specifically to address the exceptional challenges of HIV/AIDS, tuberculosis and other related infectious diseases. This resulted in the *Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases*, and the *Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, aimed at implementation of the principles set forth in the *Abuja Declaration*.³²

In the *Abuja Declaration*, the Heads of State acknowledged that “stigma, silence, denial and discrimination against people living with HIV/AIDS increases the impact of the epidemic and constitutes a major barrier to an effective response to it.”³³ The *Abuja Framework* conceptualises the commitments made in the *Abuja Declaration* into strategies followed by subsequent activities to be implemented by member states in collaboration with all stakeholders. The protection of human rights is recognised as one of the priority areas, and the following strategies are identified:

- develop a multi-sectoral national programme for awareness of and sensitivity to the negative impact of the pandemic on people, especially vulnerable groups;
- enact relevant legislation to protect the rights of people infected and affected by HIV/AIDS and TB;
- strengthen existing legislation to: (a) address human rights violations and gender inequities, and (b) respect and protect the rights of infected and affected people;
- harmonise approaches to human rights between nations for the whole continent; and
- assist women in taking appropriate decisions to protect themselves against HIV infection.

3.6 International guidelines on HIV/AIDS and human rights

In 1996 UNAIDS, in collaboration with the Office of the United Nations High Commissioner for Human Rights, adopted *HIV/AIDS and Human Rights – International Guidelines*. The *Guidelines*

27 Available at: http://196.36.153.56/doh/department/sadc/docs/negotiate_principles.html.

28 Available at: http://www.sadc.int/index.php?lang=english&pth=legal/declarations/&page=declaration_on_HIV_AIDS

29 AHG/Decl I (XXX) 1994.

30 Par 2(I).

31 AHG/Res 247 (XXXII) 1996. Available at: <http://www.onusida-aoc.org/Eng/Abuja%20Declaration.html>.

32 Available at: <http://www.onusida-aoc.org/Eng/Abuja%20Declaration.htm>.

33 Par 12.

34 See Foreword in the *Guidelines*.

focus on three crucial areas: “(1) improvement of governmental capacity for acknowledging the government’s responsibility for multi-sectoral co-ordination and accountability; (2) widespread 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 (3) support for increased private sector and community participation in the response to HIV/AIDS, including building the capacity and responsibility of civil society to respond ethically and effectively.”³⁴

The *Guidelines* deal with the following human rights principles:

- *Guideline 1*: Encourage states to adopt a multi-sectoral approach through an effective national framework.
- *Guideline 2*: Enable community organisations to carry out activities in the field of ethics, human rights and law. Consult widely with such organisations in drafting all HIV policies.
- *Guideline 3*: Review and reform public health laws to adequately address HIV/AIDS.
- *Guideline 4*: Review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and address HIV/AIDS without targeting vulnerable groups.
- *Guideline 5*: Enact or strengthen anti-discrimination laws to protect vulnerable groups. Ensure privacy, confidentiality and ethics in research involving human subjects.
- *Revised Guideline 6*: Enact legislation to provide for the regulation of HIV-related goods, services and information in order 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. Ensure that all persons on a sustained and equal basis have access to quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including anti-retroviral and other safe and effective medicines, diagnostics and related technologies for the treatment of HIV/AIDS and related opportunistic infections.³⁵
- *Guideline 7*: Implement and support legal support services to educate people affected by HIV/AIDS about their rights, develop expertise on HIV-related legal issues and use means other than courts such as human rights commissions to protect the rights of people affected by HIV/AIDS.

- *Guideline 8*: States, together with communities, should promote an enabling and prejudice-free environment for women, children and other vulnerable groups.
- *Guideline 9*: Promote the distribution of creative education, training and media programmes designed to change attitudes of discrimination and stigmatisation around HIV/AIDS.
- *Guideline 10*: Translate human rights principles into codes of conduct with accompanying mechanisms to implement and enforce these codes.
- *Guideline 11*: States should ensure monitoring and enforcement mechanisms to guarantee and protect HIV-related human rights.
- *Guideline 12*: States should share experiences concerning HIV-related human rights issues at an international level and through UN agencies such as UNAIDS.

³⁵ Guideline 6 was revised in 2002 and is available at: <http://www.unhchr.ch/hiv/g6.pdf>.

4. LEGAL FRAMEWORK FOR THE PROTECTION OF HIV/AIDS AND HUMAN RIGHTS IN BOTSWANA

4.1 National legal system: General background

4.1.1 The form of government and the domestic legal system within the country

Swaziland is an absolute monarchy. The King has all legislative, executive and judiciary powers vested in him. The kingdom's political system is based on the *tinkhundla* system of government, which is a system of local government organisation that allows for local representatives nominated by people at centres known as *tinkhundlas*, to be their local spokespersons in the national Parliament. The *tinkhundla* system does not accommodate a number of parties. Swaziland does not have a written constitution or a bill of rights.

The national legal system is a mixture of Swazi law and custom, which is currently being codified (since 1998), and Roman-Dutch law, which was “imported” into Swaziland by the *General Administration Proclamation, No. 4 of 1907*.³⁶

The highest court in Swaziland is the Court of Appeal, which has an appellate jurisdiction, followed by the High Court, with both an appellate and inherent jurisdiction. Ascending from the High Court is the Magistrate's Court, which entertains both criminal and civil matters, and finally the Swazi Court, which exclusively applies Swazi law and custom. An Industrial Court hears industrial/labour matters and the Industrial Court of Appeal has appellate jurisdiction.

4.1.2 Human rights provisions within the National HIV/AIDS Strategic Framework and the National HIV/AIDS Policy

Swaziland introduced its first HIV/AIDS plan in 1987 to cover a 12-month period. This was followed by the *First Medium Term Plan (1990-1992)*. In 1993, the HIV/AIDS programme was restructured into two subsequent *National HIV/AIDS Strategic Plans* covering the periods 1994-1997 and 1998-2000. In September 2000, Swaziland introduced the *Swaziland National Strategic Plan for HIV/AIDS 2000-2005*.³⁷ The *Strategic Plan* provides a guiding framework for a multi-sectoral, national response, which particularly addresses three critical areas of concern: risk reduction, response management, and impact mitigation. Impact mitigation includes the following: “Developing policies and legislation that address the HIV/AIDS issues, including to identify and change laws and policies that increase risks of HIV spread, review and adapt laws which are endangering the welfare of widows and orphans, and enact laws to protect vulnerable groups ... Reducing stigmatisation of people living with AIDS, and promoting counselling and voluntary testing, including building the capacity of PLWHAs to promote the concept of positive living.”³⁸

The “policies and legislation” under the impact mitigation category also involve the establishment of networks within government ministries, as well as co-operation between these ministries, national and international NGOs, and intergovernmental organisations and institutions dealing with HIV/AIDS. The main objective of such networks and co-operation is to minimise the impact of HIV/AIDS. The Cabinet Committee on HIV/AIDS has the overall mandate to supervise the national response to the HIV/AIDS epidemic, whilst the co-ordination of the

³⁶ Section 2 of the *Proclamation* provides that “Roman Dutch common law shall be the law of Swaziland save in so far as the same has been heretofore or may from time to time hereinafter be modified by statute.” According to Subsection 2, all the statute laws of the Transvaal (a former province of South Africa), which were in force on 15 October 1904, were incorporated into the laws of Swaziland. These laws were meant to apply *mutatis mutandis* (with necessary changes) to Swaziland.

³⁷ The *Strategic Plan* was drafted by the HIV/AIDS Crisis Management and Technical Committee with the co-operation of the UNAIDS Country Programme Office.

³⁸ Page 10 of the *Strategic Plan*.

multi-sectoral response lies with the HIV/AIDS Crisis Management and Technical Committee (CMTC). The *Strategic Plan* addresses stigma and discrimination in Section 3.5.6, whilst Section 3.6.1. sets forth strategies to ensure that “legislation and policies” include provisions that address HIV/AIDS. Section 3.6.8 of the Strategic Plan deals specifically with people living with HIV/AIDS and recognises the need to enact policies and legislation that protect the rights of HIV/AIDS-infected and affected persons.³⁹

According to the *Strategic Plan*, the Ministry of Justice and Constitutional Affairs is tasked with ensuring the following in terms of HIV/AIDS and human rights: “development and review of all laws, policies and guidelines by respective sectors, in terms of their appropriateness to HIV/AIDS and human rights to secure compliance with all laws and policies related to HIV/AIDS.”⁴⁰ The Ministry is also responsible for the development of educational materials on human rights and HIV/AIDS within the legal framework of Swaziland.

In August 1998, the government’s *Policy Document on HIV/AIDS and STD Prevention and Control* was released to form the policy basis for the development and implementation of the *Swaziland National Strategic Plan for the Prevention and Control of HIV/AIDS*.⁴¹ The specific objectives of this *Policy Document* include: “increas[ing] the capacity of women, youth and other vulnerable or disadvantaged groups (e.g. disabled persons, sex workers, street children, etc.) to protect themselves against HIV/AIDS and other STDs”⁴² and to attempt to safeguard the human rights of people living with HIV/AIDS.⁴³

4.1.3 Domestication of international and regional human rights treaties

Swaziland adopts a dualist approach for treaty domestication, which means that the courts can only apply international treaties if and when they are transformed into local legislation. The Minister of Foreign Affairs and Trade negotiates, ratifies and accedes to international instruments on behalf of the Swaziland government. The ministry that is responsible for the subject matter of the treaty, along with the Office of the Attorney General, is responsible for drafting a bill incorporating that international instrument. The bill is then tabled by the minister concerned

and debated by Parliament. Once Parliament passes the legislation, it has to be assented to by His Majesty, the King, and published in a Gazette. It is only then that the Swazi courts can apply the legislation.

There is no institutional arrangement for the implementation of human rights treaties and there is no specific government department with the primary responsibility of implementation. The government has to date not adopted any specific implementing legislation.

4.2 HIV/AIDS-specific regulations

4.2.1 Litigation on HIV/AIDS and human rights within domestic courts

Thus far no domestic court has dealt with questions relating to HIV/AIDS and human rights.

4.2.2 National legislation that addresses (directly or indirectly) issues in relation to HIV/AIDS

Currently there is no national legislation addressing (directly or indirectly) issues relating to HIV/AIDS. According to the *Policy Document on HIV/AIDS and STD Prevention and Control*: “Existing laws will be reviewed to ensure that they adequately address the public health and human rights issues raised by HIV/AIDS. Where necessary, appropriate laws will be passed and regulations made that will facilitate and enforce the implementation of HIV/AIDS-related policies. These will include issues related to sexual violence and rape.”⁴⁴

Similarly, the *Swaziland National Strategic Plan for HIV/AIDS 2000-2005* states that one of the strategies to be adopted is to enact laws that will protect vulnerable groups from HIV/AIDS.⁴⁵

4.2.3 HIV/AIDS policies, guidelines and programmes

- *Swaziland National Strategic Plan for HIV/AIDS 2000-2005*, September 2000
- *Policy Document on HIV/AIDS and STD Prevention and Control*, August 1998

³⁹ Page 35 of the *Strategic Plan*.

⁴⁰ Page 72 of the *Strategic Plan*.

⁴¹ The *Policy Document* was drafted by the Ministry of Health and Social Welfare.

⁴² Page 3 of the *Policy Document*.

⁴³ Ibid.

⁴⁴ At page 11.

⁴⁵ Ibid.

The Ministry of Health and Social Welfare is responsible for HIV/AIDS policies and programmes. The National Emergency Response Committee on HIV/AIDS is responsible for the review and adoption of HIV/AIDS-related policies and makes strategy recommendations to the National HIV/AIDS Directorate.⁴⁶

4.2.4 Domestic incorporation of the International Guidelines on HIV/AIDS and Human Rights

The government of Swaziland is aware of the *HIV/AIDS and Human Rights - International Guidelines*. These *International Guidelines* have been taken into account in the drafting of policies on HIV/AIDS.⁴⁷ In developing the *Strategic Plan*, the Joint United Nations Programme on HIV/AIDS (UNAIDS) was fully involved. In particular, the UN Theme Group provided technical and financial contribution for development of the *Strategic Plan*, which involved the use of the *International Guidelines*.⁴⁸ A UNDP study on Human Rights, Ethical Issues and HIV/AIDS also recognises that: “Swaziland has accepted and is committed through the World Health Organization (WHO) Programme on AIDS to embrace the promotion of human rights and dignity of HIV-infected people and people with AIDS.”⁴⁹

4.2.5 HIV/AIDS within the government’s social assistance plan

There is no specific provision for social security and assistance for people living with HIV/AIDS within the Swaziland legal framework. PLWHAs also do not qualify for disability grants. The UNDP study states that: “Currently, Swaziland does not have legislation that addresses the issues of HIV/AIDS.”⁵⁰ However, the *Policy Document on HIV/AIDS and STD Prevention and Control* recognises the special social needs of people infected with HIV/AIDS and their families. According to the *Policy Document*: “the government of Swaziland will support the formation of self-supporting groups of PLWHAs.”⁵¹ The provision of support falls under the portfolio

of the Ministry of Health and Social Welfare, which is tasked with implementing the following strategies in terms of the *Swaziland National Strategic Plan on HIV/AIDS*:⁵²

- inform the public on the eligibility requirements for social benefits and support;
- provide support to infected and affected individuals through the public assistance programme; and
- ensure that PLWHAs have access to high quality and affordable services.

4.3 Health sector

4.3.1 HIV/AIDS and the right of access to health care

On 19 February 1999, King Mswati III declared HIV/AIDS a national disaster requiring emergency intervention. With the assistance of the World Health Organization (WHO), the Ministry of Health and Social Welfare established the Swaziland National AIDS Programme (SNAP) to respond to the HIV/AIDS pandemic and to decentralise the planning and implementation of programmes. The Ministry also appointed a Task Force on AIDS, which involves all sectors, key players, stakeholders and interest groups, in formulating a collective and representative national response to HIV/AIDS.

However, there is no right of access to health care in Swaziland presently.

4.3.2 HIV testing, notification and confidentiality

The *Policy Document on HIV/AIDS and STD Prevention and Control* provides as follows on the issue of HIV testing:⁵³ HIV testing may be conducted for the purposes of diagnosis, ensuring safe

46 The National Emergency Response Committee on HIV/AIDS was established in 2002 in terms of the *National Emergency Response Committee on HIV/AIDS Notice No 16 of 2002*. See Section 4 of the Notice for an outline of the functions of the Committee.

47 Ngwenya, C. ‘HIV Testing in Swaziland in the wake of AIDS: A Human Rights Framework’ in C. Okpaluba et al. (ed.) *Human Rights in Swaziland: The Legal Response (1997)* 228. The first International Consultation on AIDS and Human Rights was organised by the then United Nations Centre for Human Rights, in co-operation with the World Health Organization, in Geneva from 26 to 28 July 1989. In the report of the first Consultation (HR/PUB/90/2), the elaboration of guidelines to assist policy makers and others in compliance with the international human rights standards regarding law, administrative practice and policy had already been proposed. See Par. 3 of the *HIV/AIDS and Human Rights - International Guidelines*. Ngwenya argues that from the standpoint of human rights: “Swaziland has accepted the WHO Global Programme on HIV/AIDS which is modelled on the rights and freedoms as contained in the Bill of Rights

of the 1948 United Nations Universal Declaration of Human Rights and subsequent covenants.”

48 Notable members of the Theme Group included Dr Sobbie Mulindi and Banardette Olowo-Frees. See the Acknowledgements in the *Swaziland National Strategic Plan For HIV/AIDS (2000-2005)*, page 4.

49 United Nations Development Programme. *Human Rights, Ethical Issues and HIV/AIDS in Swaziland: A Rapid Situational Appraisal Study (2002)*, at page 35.

50 Ibid.

51 Page 7.

52 See page 71 of the *Strategic Plan*.

53 Page 6 of the *Policy Document*.

blood transfusion, surveillance and research. For the purpose of diagnosis, HIV testing will be voluntary, linked and confidential. Pre-test counselling and informed consent will be required and test results will only be provided after post-test counselling. HIV testing for diagnosis will not be mandatory. To ensure safe blood transfusions, HIV testing will be mandatory and will not require pre-test counselling and informed consent. HIV testing for sentinel surveillance will be unlinked and anonymous, i.e. part of a blood sample taken for other purposes, and will be tested for HIV after all identifiers have been removed from the sample. This is the only instance where persons may be tested without their knowledge. HIV testing without consent can be undertaken where persons are unconscious and HIV testing is considered essential for their medical care.

The *Policy Document* states further that HIV test for research purposes will require pre-test counselling and informed consent. Test results will be kept confidential. The principle of shared confidentiality applies where appropriate, i.e. those who need to know in order for appropriate health and social welfare care to be provided should be told. This would include medical professionals and/or family members who are providing care for the infected person and stand some risk of infection themselves. Disclosure may be allowed in certain circumstances. For example, in cases where counselling of the HIV-positive person has failed to achieve appropriate behavioural change, and/or the HIV-positive person has failed to notify or consent to the notification of his/her partner even after repeated counselling, disclosure is allowed after the individual has been informed that confidentiality will no longer apply. The *Policy Document* also prohibits the use of test results for discriminatory practices. Access to voluntary HIV testing is also to be increased through the establishment of voluntary counselling and testing centres. The government aims to institute quality assurance measures for HIV testing conducted in all laboratories, both those of the government and in the private sphere.

AIDS is a notifiable disease, but the reporting of AIDS cases is anonymous.⁵⁴ This notification is confined to research and surveillance. The *Policy Document* further provides that the government shall continue to support the conduct of the annual HIV sentinel surveillance system and that other HIV/AIDS/STD surveillance systems will be established, as appropriate. Since 1991, the

government has, through the Ministry of Health, supported and funded a programme of “anonymous and unlinked” testing of HIV.⁵⁵

4.3.3 Patients’ rights

Swaziland does not have a written constitution or a bill of rights. As a result, there are no constitutionally guaranteed rights for patients living with HIV/AIDS when using public or private health care services. There are no ethical guidelines that exist within the medical profession to regulate the behaviour of doctors and health care workers specifically towards those patients that test positive for HIV or who are affected by HIV/AIDS. However, doctors and health care workers have a duty to ensure confidentiality of information relating to an individual’s personal medical details.

4.3.4 Access to essential HIV/AIDS drugs

The *Policy Document on HIV/AIDS and STD Prevention Control* provides that: “Appropriate health facility-based care for persons, including counselling, will be provided to persons with HIV-related conditions and AIDS. The capacity of health and social workers to provide care and support will be strengthened. Adequate quantities of appropriate drugs for treating opportunistic infections will be made available.”⁵⁶

According to the *Swaziland National Strategic Plan for HIV/AIDS (2000-2005)*, to provide a continuum in care, treatment and counselling to those infected and affected by HIV/AIDS, it is necessary to strengthen the management of drugs and medical suppliers and to subsidise drugs.⁵⁷ The *Policy Document* is silent on the issue of generic substitution, compulsory licensing and parallel importing. However, the government is engaged in negotiations with various pharmaceutical companies (including GlaxoSmithKline) in an endeavour to procure lower priced drugs for managing patients with HIV/AIDS.⁵⁸ Pfizer Laboratories, through a special Memorandum of Understanding with the Ministry of Health and Social Welfare, is providing the drug Fluconazole (Diflucan) free to those patients with certain opportunistic infections on condition that the patients are treated in public health facilities. The Ministry of Health and Social Welfare has

54 Page 8 of the *Policy Document*.

55 Ngwena, at 245. Anonymous and unlinked testing means that, as part of periodic or sentinel surveys, blood taken from patients for other purposes is tested for HIV.

56 Page 7 of the *Policy Document*.

57 Page 28 of the *National Strategic Plan*.

58 Dr J. M. Kunene, Principal Secretary of the Ministry of Health and Social Welfare, in a press statement published in *The Swazi Observer* dated 3rd December 2002, on page 15.

been in consultation with Boehringer-Ingelheim, the company that manufactures Nevirapine, and other drug manufacturers with a view to securing a memorandum of understanding to ensure rapid procurement once funding is available.

The Ministry and its development partners have, over the past couple of years, been involved in infrastructure and human resources development for health in preparation for a prevention of mother-to-child transmission (PMTCT) programme. Included in this capacity development is the ongoing upgrading of laboratory services and the establishment of voluntary testing and counselling services.

4.3.5 Medical trials on human subjects

Currently, there are no guidelines in place protecting the rights of volunteers in medical experiments in general or in HIV-specific research. There are also no formal legal guarantees in this regard.

The following guidelines are contained in the *Swaziland Policy Document on HIV/AIDS and STD Prevention and Control* to guide HIV/AIDS research and surveillance:⁵⁹

- HIV/AIDS-related research requires ethical clearance from the relevant clearance committees; and
- HIV/AIDS-related research must conform to the *International Guidelines for Biomedical Research involving Human Subjects*.

4.3.6 Condoms

According to a 2002 study by the UNDP, condoms are accessible in most urban areas but not in the rural areas of Swaziland.⁶⁰ In rural areas, condoms are supplied by Rural Health Motivators, clinics and NGOs, but these are often far away, which limits access. One of the objectives of the *Swaziland National Strategic Plan on HIV/AIDS* is to “have accessible, affordable, high quality

condoms available nation wide.”⁶¹ To achieve this objective, there is a social marketing scheme for condom distribution, and availability and access to female condoms is to be increased.

4.3.7 HIV/AIDS and the mentally ill

The *Swaziland National Strategic Plan on HIV/AIDS* states that the Ministry of Health and Social Welfare must ensure that disabled people and their families have access to appropriate HIV/AIDS information and support.⁶² The *Strategic Plan*, however, does not outline how the Ministry should realise this goal.

4.4 Equality and non-discrimination

4.4.1 The Constitution and the right to equality and non-discrimination

Swaziland does not have a final constitution. A draft constitution, with a bill of rights and an equality clause, is currently being debated.⁶³

4.4.2 Specialised legislation on equality and non-discrimination

There is no special legislation in place that guarantees the right to equality and non-discrimination. Nevertheless, certain legislation such as the *Employment Act* refers to employees’ rights to non-discrimination and some policy documents on HIV/AIDS refer to the rights of PLWHAs to non-discrimination and protection against stigmatisation. Section 3.5.6 of the *Swaziland National Strategic Plan on HIV/AIDS* deals with stigma and discrimination and aims to: “create a conducive and an enabling environment for PLWHAs.”⁶⁴ The *Strategic Plan* lists the following strategies with respect to stigma and discrimination:⁶⁵

- enacting legislation that ensures eradication of stigmatisation and discrimination;
- developing policies that protect the rights of PLWHAs;
- sensitising communities on positive support for PLWHAs; and
- ensuring continuous counselling for infected and affected persons.

⁵⁹ See page 8 of the *Policy Document*.

⁶⁰ The United Nations Development Programme, *Gender-focused responses to HIV/AIDS in Swaziland - The needs of women infected and affected by HIV/AIDS 2002*, pages 27-28.

⁶¹ See page 27 of the *Strategic Plan*.

⁶² Page 71 of the *Strategic Plan*.

⁶³ The bill of rights is found in Chapter 4, which is entitled “Protection and Promotion of Fundamental Rights and Freedoms.” Section 21 is the equality clause. The draft *Constitution* is available at: www.constitution.org.sz/english/.

⁶⁴ See page 30 of the *Strategic Plan*.

⁶⁵ *Ibid*, at 30-31.

Within the multi-sectoral response guided by the *Strategic Plan*, Parliament has to ensure that legislation is enacted which supports prevention of HIV/AIDS and deals with discrimination against people living with HIV/AIDS.⁶⁶

In terms of the *Policy Document on HIV/AIDS and STD Prevention and Control*, the government will lead a broad multi-sectoral response to promote the human rights of PLWHAs and attempt to deal with the discrimination against them. The *Policy Document* recommends the following:⁶⁷

- implementing information and education programmes aimed at removing unfounded fears and myths about HIV/AIDS;
- guaranteeing that PLWHAs have the same rights as any individual, especially the right to non-discrimination; and
- supporting persons who suffer from discrimination due to HIV/AIDS to seek legal recourse through the appropriate channels.

4.5 Labour rights

4.5.1 HIV/AIDS in the workplace

According to the 2002 study by the UNDP, there is a need to review existing labour legislation to take into account HIV/AIDS-related issues.⁶⁸

The *Swaziland Policy Document on HIV/AIDS and STD Prevention and Control* deals with HIV testing, human rights and non-discrimination, as well as HIV/AIDS in the workplace. Section 4.7 states: “HIV testing will not be part of pre-employment medical examination of the would-be employee. Employees will be encouraged to provide HIV/AIDS/STD education to their employees at their workplace. Discrimination in the workplace against those infected with HIV will be avoided. For as long as an HIV-infected employee is medically fit he/she will not be denied employment opportunities.”

⁶⁶ See page 53 of the *Strategic Plan*.

⁶⁷ Page 7 of the *Policy Document*.

⁶⁸ United Nations Development Programme, *Human Rights, Ethical Issues and HIV/AIDS in Swaziland: A Rapid Situational Appraisal Study* (2002), at 18.

The *Swaziland National Strategic Plan for HIV/AIDS* recommends the following with respect to HIV/AIDS in the workplace:⁶⁹

- providing care and support to infected and affected employees;
- encouraging employers to develop non-discriminatory HIV/AIDS policies;
- advocating for inclusion of HIV/AIDS issues in labour legislation; and
- ensuring confidentiality in voluntary counselling and testing.

Section 29 of the *Employment Act of 1980* provides that an employer shall, in any contract of employment between himself and an employee, not discriminate against any person or between employees on the grounds of race, colour, marital status, national origin, tribal clan extraction, political affiliation or social status. Social status may be interpreted to include HIV/AIDS status.

There is no clear policy on pre-employment testing for companies. In a recent study carried out by the UNDP,⁷⁰ it was found that only one large company occasionally carried out pre-employment HIV testing as part of the medical examination, if the applicant approved it, and only after proper counselling. According to the study, a positive HIV result did not exclude the applicant from being employed, but enabled the medical team to recommend appropriate medication and lifestyle changes.

Labour disputes are resolved by the Industrial Court or the High Court. The High Court has inherent jurisdiction to hear labour disputes. The Court of Appeal may also hear appeals on the grounds of law.

4.5.2 HIV/AIDS and medical schemes

Medical aid schemes in Swaziland include the Swazi-Medical Aid Scheme, the Swaziland Health Maintenance Scheme and the Swaziland Medical Aid Fund. The Swaziland Medical Aid Fund offers its HIV-positive members and dependants certain benefits to access medicines to treat

⁶⁹ See page 26 of the *Strategic Plan*.

⁷⁰ United Nations Development Programme *Human Rights, Ethical Issues and HIV in Swaziland: A Rapid Situational Appraisal Study* (2002), at page 19.

HIV, drugs to prevent mother-to-child transmission, ARVs after rape or needle-stick injury, and treatment to prevent opportunistic infections such as certain serious pneumonias and tuberculosis.⁷¹

4.5.3 Insurance and HIV/AIDS

There are no legislative provisions regulating the granting of life insurance to people with HIV/AIDS. Insurance companies generally require testing. At the Royal Swaziland Insurance Company (RSIC), HIV testing is required for any amount exceeding E25 000.00 and HIV testing may be required for smaller amounts depending on the client's medical record. If, for example, the medical record indicates that the applicant has been suffering from ailments that could be HIV-related, that applicant is requested to undergo the HIV test before the application is considered. The criterion used depends on the industry's underwriting standards designed to minimise the risk faced by the life fund.

There is no provision for pre- and post-test counselling in the insurance industry. The applicant's personal doctor relates the HIV test results. Insurance companies usually refuse life insurance to applicants that test HIV positive. The only alternative schemes for people living with HIV/AIDS are investment policies and Unit Trusts. There are no HIV/AIDS-specific life insurance policies.

Further, testing for HIV is not necessarily restricted to life insurance policies. An HIV test is also required by the Swaziland Royal Insurance Company for a Mortgage Protection Policy exceeding E100 000.00. With respect to Level Term Insurance, HIV testing is required for a policy exceeding E25 000.00, whilst for groups HIV testing is required for a policy exceeding E100 000.00.⁷²

The *Swaziland Policy Document on HIV/AIDS and STD Prevention and Control*, in reference to the insurance industry and HIV/AIDS, states that:⁷³ (1) Persons with HIV shall not be denied access to insurance. (2) HIV testing for obtaining an insurance policy shall not be done without pre- and post-test counselling.

71 Swaziland Medical Aid Fund, 2003.

72 According to an interview with a staff member of the Royal Swaziland Insurance Corporation, who wishes to remain anonymous.

73 Page 10 of the *Policy Document*.

74 United Nations Development Programme, *Gender-focused responses to HIV/AIDS in Swaziland: The needs of women infected and effected by HIV/AIDS* (2002), at page 2.

4.6 Gender rights

4.6.1 Legal status of women and the role of cultural practices

Women have minority status under both the customary law and civil law. There are also customary practices that result in women being subordinate and submissive to men. These include practices which allow men to have multiple sexual partners, polygyny, *kwendziswa* (arranged marriages), *kungenwa* (widow inheritance), and *umhlanga* (the reed dance). A study by the UNDP found that these practices were viewed as contributing to the spread of HIV to women.⁷⁴ The following cultural practices were found to be positive in curbing the spread of HIV in the study: virginity testing of young girls, lusekwane (age regiment of young men), and umcwasho (the wearing of woollen tussles to indicate virginity by young girls).⁷⁵ No measures have been taken to change or eradicate these practices because there is a feeling that they are important Swazi traditions. Moreover, popular media such as the radio programme *Khala Mdumbadumbane* strongly advocate for these practices.

One practice that has been challenged in court is the practice of *kutekwa*, whereby a woman is smeared with red ochre as a sign of establishing a Swazi customary marriage, whether or not the woman consents to such marriage. In the case of *R v Fakudze and others*,⁷⁶ the High Court of Swaziland ruled that smearing a woman with red ochre is an essential part of a Swazi marriage and that the act of smearing determines whether a valid marriage exists. Thus, the practice was upheld.

4.6.2 Legislation and policies protecting women and the most vulnerable in society

There is no legislation in place to protect the basic rights of women.⁷⁷ The *Swaziland National Strategic Plan on HIV/AIDS* specifically identifies the need to review cultural norms, values and customs on inheritance, forced marriages and polygamy as one of the strategies to be pursued by the Ministry of Home Affairs.⁷⁸

The *Strategic Plan* identifies the need for special efforts to increase women's access to accurate and comprehensive information and counselling on HIV transmission, as well as access to avail-

75 It should however be mentioned that these practices can be seen as negative cultural practices that encourage the sexual abuse of young girls in particular, and thereby spread HIV.

76 1970-76 SLR 422. See also *R v Timothy Mabuza and another* 1979-81 SLR 8.

77 The draft *Constitution* in Section 21 recognises that all people are equal and gender is listed as a grounds for non-discrimination.

78 Page 74 of the *Strategic Plan*. The same sentiment is expressed in the 1998 *Policy Document on HIV/AIDS and STD Prevention and Control*, at page 9.

able resources to minimise women's risk, including the female condom; targeted training for women to increase self-esteem, assertiveness and capacity building for decision making in order to improve their negotiating position in sexual relationships; HIV/AIDS and STD prevention and care services as a major component of reproductive health services to be integrated into primary health care programmes; and the review of religious and cultural traditions that impact negatively on women.

4.6.3 Administering ARVs to rape survivors

There are currently no measures in place to ensure the administration of anti-retroviral drugs to women who have been raped in an effort to minimise their chances of HIV infection. There is no legislation or policy addressing this situation.⁷⁹

4.6.4 Commercial sex workers

Sex work is illegal in Swaziland under the *Crimes Act*,⁸⁰ which determines that it is a criminal offence to engage in prostitution in public.⁸¹ The *Crimes Act* makes it a criminal offence to keep a brothel,⁸² and to operate as a prostitute boss, i.e. as a man or woman who manages a business of prostitution by collecting and keeping girls or women under his or her control.⁸³ The Act further prohibits a male from living on the earnings of prostitution,⁸⁴ or loitering in a public place or resort for purposes of prostitution.⁸⁵ The Act provides that any person who is the keeper or has the management of a place of public resort and who knowingly permits pimps or prostitutes to frequent such place, or knowingly allows prostitution to be carried out in or about such place shall be guilty of an offence and liable on conviction for a fine of 600 Emalangeni (the equivalent of R600) or imprisonment for two years.⁸⁶ There is no move towards the decriminalisation of sex work.

4.6.5 Homosexuality and HIV/AIDS

There is no specific legislation prohibiting homosexual relationships in Swaziland. Nevertheless the common law criminal offence of sodomy applies to both males and females and prohibits men of the same sex engaging in a sexual relationship. The possible penalty is imprisonment or a fine. The last offence was tried in 1983.

Behind the Mask,⁸⁷ a website on gay and lesbian affairs in Africa, reported the following in terms of lesbian relationships in Swaziland: "In 1992 a judge in the state of Swaziland ruled that a marriage between two lesbians was valid. According to Swazi tradition, two women can lawfully contract a marriage, and the woman who pays the "bride price" (*lobola*) can delegate a man to father children on her behalf. The judgment confirming the legality of this ancient practice was issued following a trial in which Thalita Mngomezulu had accused a man of defrauding her of four cows. Ms Mngomezulu gave evidence before the President of the Lubuli National Tribunal, Mbalekelwa Mngomezulu (no relation) that the cattle had been given as *lobola* for a woman she wished to marry. Her brother was to have the task of fathering children for the woman, whose name was not revealed during the hearing. Judge Mngomezulu, ruling in favour of the plaintiff, stated that such an arrangement was not new according to Swazi law and custom, and was valid so long as the parents of both women gave their consent."⁸⁸

4.7 Children's rights

4.7.1 Health care, orphans and HIV/AIDS

The *Policy Document on HIV/AIDS and STD Prevention and Control* states that: "The government of Swaziland recognises the difficulties faced by orphans as they grow up and the need for them to receive the love, care and education requisite for growing into responsible adults and productive members of society. Children who become orphans as a result of HIV/AIDS will enjoy the same facilities as other orphans and will not suffer discrimination. Whenever appropriate, members of extended families will be encouraged and assisted to care for orphans. Government institutions and NGOs will be supported to establish and maintain proper caring facilities for orphans."⁸⁹

Swaziland aims to develop programmes to ensure that all orphans have their basic needs fulfilled in terms of Section 3.6.2 of the *Swaziland National Strategic Plan on HIV/AIDS*. Amongst the strategies to be pursued, the Strategic Plan recommends the development of an orphan

79 The Minister for Health and Social Welfare issued a press statement on 1 December 2002 to the effect that measures for the provision of anti-retroviral drugs will be put in place as from 2003.

80 No. 6 of 1889.

81 Part 5.

82 Sections 32 - 40 & 45.

83 Sections 41 - 44.

84 Section 45.

85 Section 49.

86 Section 50 read together with Section 47.

87 www.mask.org.za

88 Available at http://www.mask.org.za/SECTIONS/AfricaPerCountry/ABC/swaziland/swaziland_index.html.

89 Page 11 of the *Policy Document*.

policy and the establishment of an orphan team chaired by a representative of the Ministry of Health and Social Welfare to facilitate effective orphan programmes.⁹⁰

Currently, the Ministry of Health and Social Welfare is looking at the possibility of reducing mother-to-child transmission (MTCT) of HIV. The prevention of MTCT is also one of the objectives of the *Swaziland National Strategic Plan for HIV/AIDS*, which aims to facilitate access to available treatment and develop policy on MTCT and infant feeding.⁹¹ At present, children do not have access to anti-retroviral therapy at the government's expense.

4.7.2 HIV/AIDS and the educational system

One of the strategies to be followed by Swaziland in terms of the *Swaziland National Strategic Plan for HIV/AIDS 2000-2005* is the integration of HIV/AIDS in pre-school, school and institution of higher learning curricula.⁹² Furthermore, Section 3.6.6 of the *Strategic Plan* states that gender issues should be mainstreamed into all curricula at all levels in schools and that policies and guidelines should be developed on HIV/AIDS in the education sector.⁹³ The *Strategic Plan* also provides for the distribution of condoms at secondary, high schools and the university. According to the *Strategic Plan*, it is the Ministry of Education's responsibility to ensure training of trainers from the Swaziland National Teachers' Association to support HIV/AIDS awareness campaigns for teachers, parents and students.⁹⁴

There are anti-AIDS clubs within schools, which are formed by children in an effort to sensitise their peers on HIV/AIDS. This is undertaken in close collaboration with the *Schools Health, AIDS/HIV and Population Education in Schools (SHAPE)*. There has been no reported case whereby a child was refused access to school on the basis of his/her HIV status.

4.8 Criminal law and HIV/AIDS

There are no HIV/AIDS specific provisions within Swaziland's criminal law. There is no known case of assault or murder solely because of HIV status. Swaziland is in the process of drafting

a public health bill that will include penalties for knowingly transmitting HIV/AIDS.⁹⁵ There is currently no legislation providing for harsher sentences for HIV-positive rapists.

4.9 HIV/AIDS and prisons

The Department of Correctional Services is required to undertake the following:⁹⁶

- provide education on HIV/AIDS to inmates, officers and their families;
- prevent overcrowding of inmates;
- distribute condoms to officers and their families, as well as inmates;
- provide proper treatment of STDs; and
- maintain confidentiality.

The *Policy Document on HIV/AIDS and STD Prevention and Control* recommends additional guidelines in terms of prisoners:⁹⁷

- inmates, staff and their families must be provided with access to HIV-related prevention information, education, voluntary testing and counselling, treatment and care;
- measures should be taken to protect prison inmates from rape, sexual violence and coercion;
- inmates known to be HIV positive must not be discriminated against; and
- inmates with terminal AIDS should be considered for possible compassionate early release.

Currently it appears that prisoners are receiving information on the dangers of HIV/AIDS. However, condoms are not accessible because prison authorities believe that by distributing condoms, they will be promoting sodomy, which is a punishable common law offence. There is currently no national policy on HIV testing and education for prisons. There are no statistics as to the number of HIV-positive prisoners. HIV-positive prisoners do not have access to anti-retroviral drugs. All prisoners are kept together regardless of their HIV/AIDS status.

⁹⁰ Page 32 of the *Strategic Plan*.

⁹¹ See page 25 of the *Strategic Plan*.

⁹² See page 25, Section 3.4.3 of the *Strategic Plan*.

⁹³ Page 33 of the *Strategic Plan*.

⁹⁴ See page 66 of the *Strategic Plan*.

⁹⁵ See UNDP *Human Rights, Ethical Issues and HIV/AIDS in Swaziland: A Rapid Situational Appraisal Study* (2002), page 37.

⁹⁶ Page 93 of the *Strategic Plan*.

⁹⁷ Pages 10-11 of the *Policy Document*.

5. CONCLUSIONS AND RECOMMENDATIONS

This research project has shown that although HIV/AIDS has not been included in any international or regional treaties, relevant resolutions and guidelines do exist, and specific provisions in the major treaties will apply to the situations of people living with or affected by HIV/AIDS. Some states have included the measures that they undertook to address HIV/AIDS in their state reports, and the treaty monitoring bodies have often commented on these efforts in Concluding Observations. Clearly, most, if not all, of the 8 SADC countries surveyed have yet to incorporate treaty obligations into domestic legislation. It is also clear that most countries still operate with a policy-based approach to HIV/AIDS, rather than a rights-based approach, even though the UNAIDS and OHCHR *HIV/AIDS and Human Rights – International Guidelines* offers guidance to move from policy to rights.

It is against this background that the country reports should be analysed. Firstly, the aim is to identify those human rights principles that already exist which can assist with the adoption of a human rights-based approach, and secondly, to identify and make recommendations where the governments' responses have not included human rights.

Three general trends should be highlighted:

- Firstly, the HIV/AIDS responses in the various countries from the reporting of the first case in the mid-1980s has followed a very similar approach. Initially, in each country the Ministry of Health co-ordinated the response through a short-term plan, which focused mainly on issues of blood screening. This was followed by one or more medium-term plans in the mid-to late 1990s, ultimately heralding the multi-sectoral approach adopted by all the countries by the end of the 1990s. Thus, all eight countries adopted national strategic frameworks on HIV/AIDS and all except South Africa, Namibia and Mozambique adopted further national policies on HIV/AIDS to give effect to the goals in the strategic frameworks. To varying degrees, this development from short-term plans to multi-sectoral strategic frameworks was also

accompanied by a gradual inclusion of human rights provisions in the HIV/AIDS discourse. This coincided with an overall trend in the SADC countries to adopt new constitutions with a bill of rights. For example, new constitutions were adopted by Namibia in 1990, and by both South Africa and Malawi in 1994.

- Secondly, the legislative frameworks analysed indicate overwhelmingly that in addressing the HIV/AIDS epidemic, and affording protection to the rights of those affected or infected, states elect to respond by introducing policies, codes or guidelines, rather than legislation. This means that government interventions are not legally binding and generally cannot be enforced in the courts. Thus, people living with or affected by HIV/AIDS have few specific enforceable rights. Obligations with respect to human rights are further minimalised by states' reluctance to transform ratified human rights treaties into domestic legislation.
- Thirdly, where legislation does address HIV/AIDS issues, it tends to be limited to the areas of criminal law and labour law. Countries are inclined to promulgate criminal laws that try to "contain" the disease based on a model of "control" over the spread of the disease. Botswana, Namibia, South Africa and Zimbabwe have amended their criminal laws to provide for harsher sentencing of HIV-positive sexual offenders, whilst Zimbabwe has also criminalised the deliberate transmission of HIV. Swaziland and Zambia have declared that they will follow suit in the near future. With the exception of South Africa (in relation to homosexuality), governments have targeted homosexuals and commercial sex workers, groups that are already stigmatised in society, by criminalising their behaviour. In terms of labour legislation, governments have attempted to secure economic stability by focusing on the "economic active," people between the ages of 19 and 45 years, which is the age group that is hardest hit by the epidemic. Mozambique, Namibia, South Africa and Zimbabwe have adopted workplace legislation that outlaws discrimination on the basis of HIV status, prohibits pre-employment testing and secures medical benefits for HIV-positive employees. These efforts with respect

to labour rights are commendable; however, governments' efforts should not end with employment, but rather with an attempt to guarantee human rights in all spheres.

To guide governments toward a more inclusive human-rights-based response, the following steps are recommended:

- Those countries that have not developed a national HIV/AIDS policy to complement the national strategic framework should do so.
- In revising the current strategic frameworks and national policies (usually revised every two or five years), the inclusion of human rights provisions in all spheres/sectors should be a priority. Currently, most frameworks merely mention discrimination and stigmatisation.
- Countries should comply with international and regional treaty obligations and domesticate the provisions of these treaties through national legislation.
- Countries should review and revise national legislation on social assistance and security to provide specifically for AIDS orphans, families caring for people with AIDS, and people living with AIDS. This would avoid the difficulties of interpreting claims in terms of disability grants.
- Countries should develop a separate national policy on voluntary HIV testing, pre- and post-test counselling and factors affecting confidentiality (such as informing an HIV-positive person's partner of his/her status), and avoid the principle of shared confidentiality.
- Countries should develop legislation protecting the rights of volunteers in medical trials testing the effects of new HIV drugs and vaccines. Legislation should also regulate the treatment of HIV-positive patients by private and public health care services, specifically prohibiting discrimination against HIV-positive patients.
- HIV/AIDS-specific legislation prohibiting discrimination on the grounds of HIV status should be developed for all spheres.
- Where countries have not developed HIV/AIDS-specific legislation for the workplace, this must be made a priority, focusing on issues such as non-discrimination against HIV-positive employees, prohibition of pre-employment HIV testing, offering medical benefits that cater for the special needs of HIV-positive employees, and ensuring that employees have access to information and educational programmes on HIV/AIDS.
- Governments should ensure that national strategic frameworks and policies address the needs of the mentally ill and the disabled. Currently, only Botswana has undertaken a programme

to ensure that people with disabilities have access to HIV/AIDS education and information.

- Where legislation does not already exist, states need to legislate on the rights and treatment of orphan children and children in difficult circumstances.
- Governments need to focus on the provision of HIV/AIDS medicines. The focus to date has been on negotiations with pharmaceutical companies for price reductions. The possibility of compulsory licensing and importation (production) of generic substitutes has not received much attention. The exceptions allowed for under the WTO's *Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)* should be exploited fully.
- Legislation should be promulgated to regulate public and private medical schemes in an effort to ensure that people living with HIV/AIDS are not discriminated against or excluded.
- Governments should investigate ways of addressing the issue of restrictions on HIV-positive persons applying for and being granted life insurance.
- Customary practices that increase the risk of HIV infection in women and men should be addressed through a comprehensive approach, including involving traditional leaders and healers, sensitising communities about the dangers of such practices, suggesting alternatives, and ultimately legislating against harmful (inhuman and degrading) practices.
- Practices that put women in a vulnerable position in society and increase their risk of HIV infection – such as domestic violence and restrictive inheritance laws – should be made a priority and legislation must be adopted to secure women's rights.
- Steps should be taken to decriminalise commercial sex work and homosexuality.
- Only Botswana and South Africa have specific policies on HIV/AIDS and prisons. The other countries in this study have included some guidelines in their national policies or strategic frameworks, but with the special conditions prevailing in prisons that increase the risk of HIV infection, every country should adopt a separate policy or legislation on HIV/AIDS and prisons. Issues that should be addressed include the dissemination of education on HIV/AIDS and STDs, voluntary testing and counselling, non-segregation of prisoners, condom distribution, and access to treatment for opportunistic infections.
- The lack of capacity to develop appropriate legislative frameworks has been invoked by states to explain the legislative impasse. A comprehensive model code on HIV/AIDS should be developed, providing a general framework for states to develop a specific legislative response to the pandemic.
- Heads of state need to take an active lead in the lobbying and reform efforts regionally and internationally.

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ANNEXURE: HIV/AIDS and human rights in SADC – summary of findings

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
Form of government	Constitutional democracy	Constitutional democracy	Semi-presidential constitutional democracy	Constitutional democracy	Constitutional democracy	Absolute monarchy with no Constitution	Constitutional democracy	Constitutional democracy
Domestic legal system	English Common law and Roman-Dutch law	English Common law	Civil or Continental law system inherited from Portugal	English Common law and Roman-Dutch law	Roman-Dutch law and English Common law	Roman-Dutch law and Swaziland customary law	English Common law	Roman-Dutch law and English Common law
National HIV/AIDS Strategic Framework (NSF): time frame, human rights provisions	2003-2009 NSF refers to human rights	2000-2004 NSF refers to human rights	2000-2002 National Strategic Plan to Combat STDs/HIV/AIDS makes almost no reference to human rights	1999-2004 National Strategic Plan on HIV/AIDS (MTPII) refers to human rights	2000-2005 HIV/AIDS/STD Strategic Plan for South Africa refers to human rights	2000-2005 Swaziland National Strategic Plan for HIV/AIDS refers to human rights	2002-2005 National HIV/AIDS/STI/TB Intervention Strategic Plan refers to human rights	2000-2004 NSF provides for human rights
National HIV/AIDS Policy: human rights provisions	2002 National AIDS Policy refers to human rights	2002 Draft Malawi National HIV/AIDS Policy. Policy refers to human rights with emphasis on rights based approach.	None	None	None	1998 Swaziland Policy Document on HIV/AIDS and STD Prevention and Control refers to human rights	2002 National HIV/AIDS/STI/TB Policy refers to human rights	1999 National HIV/AIDS Policy refers to human rights
HIV/AIDS jurisprudence	Yes	None	None	Yes	Yes	None	None	None
HIV/AIDS specific legislation¹	Yes. (In realm of criminal law)	None	Yes (Labour law)	Yes	Yes	None	Yes	Yes
Government awareness of UNAIDS guidelines on HIV/AIDS and human rights	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Social security and PLWHA	No specific assistance is provided for PLWHA. Revising the <i>National Destitute Policy</i> to cater for PLWHA and orphans does form part of the NSF for 2003-2009	No special provisions are made to cater for the social assistance needs of PLWHA.	No special provisions are made to cater for the social assistance needs of PLWHA.	Social assistance is provided for PLWHA in terms of a disability grant and a special grant for HIV/AIDS orphans.	PLWHA can qualify for a disability grant in terms of the <i>Social Assistance Act</i> . In August 2002 the <i>National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS</i> were published.	No special provisions, NSF however refers to access to social services for PLWHA.	No special provisions, do qualify for assistance applicable to all Zambians.	No special provisions, do qualify under general <i>Social Security Act</i> .

¹ None of the eight countries that formed part of the study have a comprehensive HIV/AIDS specific law in place. This section was answered in reference to sections of existing or new legislation that included specific reference to HIV or AIDS.

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
Constitutional protection of the right to health	None	Equal access to basic health services is incorporated in the right to development, section 30(2) of the <i>Constitution</i> .	Article 94 of the <i>Constitution</i> guarantees the right to health subjected to the law in place.	Article 95 of the <i>Constitution</i> refers to public health but as a matter of state policy and not as a fundamental right.	Article 27(1)(a) of the <i>Constitution</i> .	<i>Constitution</i> is suspended, the drafting of a new <i>Constitution</i> is underway.	The right to health care is provided for under the <i>Directive Principles of State Policy</i> incorporated in Part IX of the <i>Constitution</i> . ²	None
HIV/AIDS as a notifiable disease	No	No, although it is foreseen in the draft <i>National HIV/AIDS Policy</i> of 2002.	No	No	No	Yes	Yes	No
Rights of HIV positive patients	No HIV specific guidelines exist currently within the health profession, according to Bonera ³ a policy is in the pipeline.	No special protection exists currently but it is foreseen in the draft <i>National HIV/AIDS Policy</i> of 2002.	Ethical guidelines for health workers are foreseen in the <i>2000-2002 National Strategic Plan</i> .	HIV specific guidelines and a <i>Namibian Charter on HIV/AIDS</i> exist. (non-binding)	Protected by the 2001 HPCSA guidelines on the <i>Management of Patients with HIV Infection or AIDS</i> and the <i>SAMA Guidelines on Human Rights, Ethics and HIV</i> .	None	No special provisions.	Provisions within the (non-binding) <i>Patient's Charter</i> .
Constitutional and legislative protection of equality and non-discrimination	Section 15 of the <i>Constitution</i> lists grounds for non-discrimination (non-exhaustive list). HIV is not a listed ground. No special legislation addressing discrimination exists.	Section 20 of the <i>Constitution</i> lists grounds for non-discrimination (non-exhaustive list). HIV is not a listed ground. No special legislation addressing discrimination exists.	Section 66 of the <i>Constitution</i> lists grounds for non-discrimination (exhaustive list). HIV is not a listed ground. Law no 5/2002 deals specifically with discrimination against employees and candidate employees and HIV/AIDS is covered by the law.	Section 10 of the <i>Constitution</i> lists grounds for non-discrimination (exhaustive list). HIV is not a listed ground. Section 107(1) of the <i>Labour Act</i> lists grounds of non-discrimination in employment. Although it does not include HIV status, see the Labour Court ruling on exclusion. ⁴	Section 9(3) of the <i>Constitution</i> lists grounds for non-discrimination (non-exhausted list). HIV is not a listed ground. Specialised legislation on non-discrimination: <i>Promotion of Equality and Prevention of Unfair Discrimination Act</i> no 4 of 2000, section 34 provides for the possibility of including HIV status as a ground for non-discrimination.	Swaziland does not have a <i>Constitution</i> although negotiations around the drafting of a <i>Constitution</i> with a bill of rights are being considered.	Section 23 of the <i>Constitution</i> lists grounds for non-discrimination (exhausted list). HIV is not a listed ground. No special legislation addressing discrimination exists.	Section 23 of the <i>Constitution</i> lists grounds for non-discrimination (exhausted list). HIV is not a listed ground. <i>Statutory Instrument 202 of 1998</i> prohibits discrimination on the basis of HIV status in the workplace.

2 The Directive Principles of State Policy are not in themselves binding and are subject to the availability of funds under article 110.

3 Botswana Network on Ethics, Law and HIV/AIDS.

4 *Haindongo Nghidiphamba Nanditume v Minister of Defence* Case No. LC 24/98.

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
HIV/AIDS and the workplace: discrimination and pre-employment testing	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing.	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing.	Law no 5/2002 outlaws discrimination on the ground of HIV status in employment and prohibits pre-employment HIV testing.	Guidelines were promulgated in terms of section 112 of the Labour Act for the implementation of the <i>National Code on HIV/AIDS in Employment</i> and for application of relevant provisions of the <i>Labour Act</i> in respect of HIV/AIDS. The guidelines outlaw discrimination on HIV status and pre-employment testing for HIV.	Article 6 of the <i>Employment Equity Act</i> no 55 of 1998 lists HIV status as a ground for non-discrimination. HIV testing of an employee is prohibited by section 7(2) unless justifiable by the Labour Court in terms of section 50(4).	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing.	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing. The Defence Force requires HIV tests and do not recruit HIV positive candidates.	<i>Statutory Instrument</i> 202 of 1998 prohibits discrimination based on HIV status in the workplace and states that pre-employment testing should not be required except where fitness for work is a precondition to the offer of employment. <i>Labour Relations Amendment Bill</i> of 2001 includes HIV status as a ground for non-discrimination.
Legislative protection of PLWHA in medical schemes	No	No	No	No, although the <i>2002 Health Plan</i> provides policy protection in terms of the Aid for AIDS benefit scheme.	Yes	No	No	No
HIV/AIDS and insurance policies	No legislative regulation, policies for PLWHA determined by companies at higher premiums or not at all.	Currently no legislative protection, the issuing of policies is up to the private company (no granting of life insurance to HIV positive people).	No legislative regulation of the insurance industry, life insurance policies do not cover PLWHA.	No legislative regulation of the insurance industry.	No legislative regulation of the insurance industry. The Life Office's Association's <i>HIV Testing Protocol</i> clearly states that life insurance will not be granted to people who test HIV positive. Those companies that do offer special packages do it at higher premiums or limit the amount of insurance.	No legislative regulation of the insurance industry.	No legislative regulation of the insurance industry.	No legislative regulation of the insurance industry.
Existence of cultural practices that enhance spread of HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Legality of commercial sex work	Illegal	Illegal	Illegal	Illegal	Illegal	Illegal	Illegal	Illegal
Legality of same sex relationships	Illegal	Illegal	Illegal	Illegal	Legal	Illegal according to common law offence of sodomy, last case tried in 1983. Lesbianism seems legal according to 1992 judgment. ⁵	Illegal	Illegal

5 Mngomezulu case discussed on http://www.mask.org.za/SECTIONS/AfricaPerCountry/ABC/swaziland/swaziland_index.html.

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
HIV education in schools: non-discrimination in schools	HIV/AIDS education (for pupils and teachers) is provided for in the 1998 <i>Policy on HIV/AIDS Education</i> , the <i>National Strategic Plan</i> and the <i>National Policy on HIV/AIDS</i> .	HIV/AIDS education is included in formal primary and secondary school curricula. This effort is expanded upon in the NSF and <i>National HIV/AIDS Policy</i> .	NSF sets forth the policy on education in schools whilst also declaring that implementation has been delayed. ⁶	<i>National Teachers Union Policy on HIV/AIDS</i> (2000) together with the <i>National Policy on HIV/AIDS</i> for the education sector (4th draft) 2002 provides for HIV education in schools and non-discrimination.	1999 <i>National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions</i> . The <i>South African Schools Act</i> protects learners from unfair discrimination.	NSF provides for integration of HIV education in pre-schools, schools and institutions of higher learning and provides for training of teachers.	HIV/AIDS education is integrated in the school curricula. No special training is provided for teachers. No specific policy on non-discrimination in schools exist.	AIDS education was introduced in schools in 1993. HIV/Life Skills Desk in Ministry of Education trains teachers and coordinates HIV teaching in schools. <i>National Policy on HIV</i> includes provisions on non-discrimination in schools.
Criminal legislation on HIV/AIDS	Harsher sentencing for HIV positive rapists in terms of the <i>Penal Code (Amendment) Act No 5 of 1998</i> .	No HIV/AIDS specific provisions in the Malawi criminal law rather the 2002 <i>National HIV/AIDS Policy</i> aims to promote the use of generic criminal law and not HIV specific criminal codes and to apply HIV status only as a mitigating or aggravating factor.	No HIV/AIDS specific provisions in Mozambique criminal law.	Harsher sentencing for HIV positive rapists provided in the <i>Combating of Rape Act of 2000</i> .	<i>Criminal Law Amendment Act of 1997</i> provides for harsher sentences for HIV positive rapists. <i>Criminal Procedure Second Amendment Act</i> – more difficult to obtain bail in rape cases involving HIV positive accused. New <i>Sexual Offences Bill</i> and <i>Compulsory HIV Testing of Alleged Sexual Offenders Bill</i> tabled in 2003.	No HIV/AIDS specific provisions in Swaziland criminal law although the <i>Public Health Bill</i> envisages penalties for knowingly transmitting HIV.	No HIV/AIDS specific provisions in Zambian criminal law. Rape carries life sentencing in the <i>Penal Code</i> regardless of HIV status. <i>National AIDS Policy</i> recommends criminalising of wilful HIV transmission.	<i>Sexual Offences Act No 8 of 2001</i> , harsher sentencing for HIV positive rapists and criminalizing of deliberate transmission of HIV.
HIV/AIDS and prisons: education, testing, condoms and separation	The following policies are in place: <i>National Policy on HIV testing and education in prisons</i> , the <i>Health Care Delivery Policy</i> , a <i>Policy on HIV/AIDS/STD for inmates</i> and a <i>HIV/AIDS Policy and Procedure Manual for Prison Staff and their families</i> .	No official policy on HIV/AIDS in prisons the only reference to prisons is found in the 2002 draft <i>Malawi National HIV/AIDS Policy</i> . Addressing issues such as voluntary testing and counselling, non-segregation of prisoners and the distribution of condoms.	No official policy on HIV/AIDS in prisons guidelines are however included in the <i>National Strategic Plan on HIV/AIDS</i> . Prisoners have access to education on HIV/AIDS and condoms. Prisoners are not separated.	No official policy on HIV/AIDS in prisons. Non-separation of HIV positive inmates. Condoms are not distributed. AIDS campaign training inmates to counsel fellow inmates exist, voluntary testing is provided.	2002 <i>Policy on Management Strategy of HIV/AIDS in Prisons</i> : 1) Voluntary testing, counselling and education. 2) Non-segregation. 3) Condoms are distributed.	The <i>Swaziland National Strategic Plan on HIV/AIDS</i> and the <i>Policy Document on HIV/AIDS</i> set forth guidelines on prisons on education, non-separation and voluntary testing and counselling. Condoms are not distributed.	No official policy on HIV/AIDS in prisons exist. Condoms are not distributed in prisons, prisoners are not separated.	Prisons are addressed in the <i>National Policy on HIV/AIDS</i> : 1) Voluntary testing and counselling together with education is provided. 2) Condoms are not distributed. 3) HIV positive prisoners are not separated.

The table above is not conclusive as to all the findings of the study for certain areas analysing access to essential HIV/AIDS drugs, the rights of volunteers in HIV/AIDS medical trials, condom distribution or discussions around legislation and policies protecting women and the most

vulnerable in society could not be comparatively tabled. For a discussion on these areas the individual country reports should be accessed.

⁶ Page 15 of the *Mozambique National Strategic Plan on HIV/AIDS*.



The University of Pretoria established the Centre for the Study of AIDS in 1999 to 'mainstream' HIV/AIDS through all aspects of the University's core business and community-based activities. Its mission is to understand the complexities of the HIV/AIDS epidemic in South Africa and to develop effective ways of ensuring that all the students and staff of the University are prepared both professionally and personally to deal with HIV/AIDS as it unfolds in South African society.

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