IX. HUMAN RIGHTS FRAMEWORK AND APPLICATION TO THE FINDINGS

The promotion, protection and fulfillment of human rights are necessary to realize social, economic, cultural and political conditions that will decrease vulnerability to HIV infection, eliminate HIV-related stigma and discrimination, and assure universal access to prevention, care and treatment for affected individuals and communities. International consensus on this understanding is reflected in the UN General Assembly's 2001 Declaration of Commitment on HIV/AIDS:

> *... the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic ... .*[814]

Recognition of the human rights dimensions of the AIDS pandemic has evolved over time, from a matter of individual privacy rights[815] to include an understanding of the centrality of the lack of women's rights to the perpetuation of HIV. This is evidenced, for example, by the appointment in 2003 of a UN Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa.[816] Despite this acknowledgement, however, human rights obligations are rarely reflected in national action plans or HIV/AIDS policies and programs.[817]

The findings from this study show a failure to comply with human rights obligations on the part of the Governments of Botswana and Swaziland. Both countries have agreed to meet the requirements of international human rights law; neither country has met these obligations. An egregious result is women's continued vulnerability to HIV/AIDS.

While international law requires the promotion of gender equality and non-discrimination, the study findings describe the economic and social disparities that persist for women in Botswana and Swaziland, the existence of harmful cultural practices and the prevalence of gender discriminatory beliefs. These circumstances are the product of women's unmet rights. Moreover, women's lack of control over sexual decision making stems from denial of equal rights to property, employment and other resources and resultant dependence on male partners. Violence against women — which neither country has addressed through legislation, remediation and prevention — also contributes to women's lack of control. Failure to address women's diminished autonomy violates reproductive rights. The resultant risk of HIV transmission impinges on the right to health and the right to life for both women and men.

Discrimination against PLWA is prohibited under international law. Neither country has created comprehensive legal, economic and social responses to address the social stigma and discrimination documented in the study findings. The lack of adequate information related to HIV transmission and prevention, and the need for educational interventions around testing and treatment access, suggest infringements of rights guaranteed under the International Bill of Rights. Moreover, gaps in testing programs in both countries reveal that remedial actions need to be taken to meet international policy guidelines, which should guide a rights-based approach to HIV/AIDS.

Regional instruments, binding on Botswana and Swaziland as signatories, reiterate the responsibilities of these governments to promote, protect and fulfill human rights in the context of the pandemic. Obligations to respect rights and not impede their realization also extend to international assistance to Botswana and Swaziland by donor states and international organizations. This cooperation and aid are essential to enable the two countries to meet their obligations under international law.

Relevant Treaties

Swaziland and Botswana have acceded to,[818] signed[819] or ratified[820] international human rights treaties and conventions that safeguard human rights essential to the prevention, care and treatment of HIV/AIDS and prohibit the abuses and omissions documented in this report. These are listed in Table 1.

The treaties are enforced by corresponding monitoring bodies. The ICCPR is monitored by the Human Rights Committee, a UN body of international experts which receives state parties' reports on ICCPR compliance and hears individual and inter-state complaints

TABLE 1: International Treaties Acceded to, Signed or Ratified by Botswana or Swaziland

Treaty Name	Botswana	Swaziland
International Covenant on Civil and Political Rights (December 16, 1966, entered into force March 23, 1976) (ICCPR)[821]	Ratified January 8, 2000	Acceded March 26, 2004
International Covenant on Economic, Social and Cultural Rights (December 16, 1966, entered into force January 3, 1976) (ICESCR)[822]		Acceded March 26, 2004
Convention on the Elimination of All Forms of Discrimination against Women (December 18, 1979, entered into force September 3, 1981)[823] (Women's Convention)	Acceded August 13, 1996	Acceded March 26, 2004
Convention on the Rights of the Child (November 20, 1989, entered into force September 2, 1990) (Children's Convention)[824]	Acceded April 13, 1995	Ratified October 6, 1995
African "Banjul" Charter on Human and Peoples' Rights (June 27, 1981, entered into force October 21, 1986) (ACHPR)[825]	Ratified July 17, 1986	Ratified September 15, 1995
African Charter on the Rights and Welfare of the Child (1990, entered into force November 29, 1999) (ACRWC)[826]	Ratified July 10, 2001	Signed June 29, 1992
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (November 13, 2000, entered into force November 25, 2005) (PPACHPR)[827]		Signed December 7, 2004

regarding violations of the ICCPR.[828] Botswana submitted a report in 2006, five years overdue. Swaziland has yet to report regarding compliance.[829] Compliance with the ICESCR is monitored by the UN Committee on Economic, Social and Cultural Rights (ESC Rights Committee).[830] Swaziland did not submit an initial report and has not yet reached its threshold for periodic submission. The Women's Convention is monitored by the Committee on the Elimination of Discrimination against Women (CEDAW).[831] Botswana has not reported on its compliance with the Women's Convention. Swaziland did not submit an initial report and has not yet reached its four-year threshold for periodic submission.[832] The Committee on the Rights of the Child (CRC) plays a similar oversight role for the Children's Convention.[833] Botswana and Swaziland have submitted reports to the CRC, in 2003 and 2005 respectively, each a number of years overdue.[834] The African Commission on Human and Peoples' Rights monitors the African Charter on Human and Peoples' Rights (ACHPR).[835] Botswana has never submitted a report, due every two years, to the Commission. Swaziland has failed to submit reports since an initial combined submission in 2000 of the first two biannual reports.[836]

One set of concluding observations that speak directly to HIV/AIDS was made by the CRC in response to Botswana's report. The Committee expressed concern over the high HIV prevalence rate for childbearing women, which it found was "compounded, in part, by inappropriate traditional practices, stigmatization and lack of knowledge on prevention methods."[837]

Additional Human Rights Obligations

As UN members, Botswana and Swaziland have committed themselves to abide by the principles and policy norms of several declarations and conference documents issued or endorsed by the General Assembly which are relevant to the abuses recounted in this report.[838] While these obligations do not legally bind states in the same manner as treaties, they can be considered evidence of the content of international law when they are approved by a majority of states[839] and serve to elaborate on the rights set forth in treaty documents. Moreover, when such declarations create state monitoring mechanisms, as in the case of the Declaration on Commitment on HIV/AIDS,[840] they provide states with an incentive to comply with the norms contained therein.[841]

Relevant declarations include the Universal Declaration of Human Rights (UDHR),[842] the Declaration of Commitment on HIV/AIDS, the Vienna Declaration and Programme of Action[843] and the Declaration on the Elimination of Violence against Women.[844] Among conference documents, the Programme of Action of the International Conference on Population and Development (Cairo

Programme)[845] and the Beijing Declaration and Platform of Action (Beijing Platform)[846] are particularly significant.

With regard to the status of women in Botswana and Swaziland, the Cairo Programme is instructive, declaring that "[c]ountries should act to empower women and should take steps to eliminate inequalities between men and women as soon as possible …" including through political mechanisms; education, skills development and employment opportunities "giving paramount importance to the elimination of poverty, illiteracy and ill health among women;" elimination of discriminatory practices and violence; the provision of assistance for the realization of women's rights; and measures to ensure economic independence and provide for social security for women.[847]

Key Rights and Application to the Study Findings

Selected treaty-based rights most relevant to the findings of the study are shown in Table 2 and described briefly in the context of the study results.

Equality and Non-Discrimination Based on Sex

International law requires the promotion of gender equality in every aspect of life. The Women's Convention directs that:

> States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.[863]

Legal equality,[864] and legal capacity "identical to that of men and the same opportunities to exercise that capacity"[865] are explicitly required, and the right to contract, to administer property and to have equal access to the justice system are singled out for special notice.[866] The Women's Convention also directs states to eliminate discrimination against women and to ensure their equal rights with their husbands "in respect of the ownership, acquisition, management, administration, enjoyment and disposition" of property.[867] The ACHPR protects the property rights of all people.[868]

The right to equality in marriage is explicitly stated in the treaties. For example, in addition to equality, including property rights, within the relationship, the Women's Convention[869] and the ICCPR[870] accord women and men equal rights concerning entry into marriage. Reproductive rights are also firmly established in international law. The Women's Convention protects the rights of women to choose the number and spacing of their children[871] and to access family planning.[872] It also directs states to ensure gender equality in access to health services.[873] The Cairo Programme and the Beijing Platform explicitly and in detail affirm these rights.

International instruments also address cultural factors that may promote gender discrimination. For example, the Women's Convention obligates party states to modify their legal and cultural systems to comport with the principle of gender equality.[874] The ESC Rights Committee directs states to "ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women's right to equality before the law and to equal enjoyment of all Covenant rights."[875] The Protocol to the ACHPR on the Rights of Women in Africa stipulates that "States Parties shall prohibit and condemn all forms of harmful

TABLE 2: Selected Human Rights Essential to Addressing the HIV/AIDS Epidemic

Right	Treaty
Equal Protection and Non-Discrimination Norms	ICCPR,[848] ICESCR[849]
Right to Health	ICESCR,[850] Women's Convention,[851] Children's Convention,[852] ACRWC,[853] ACHPR[854]
Right to Food	ICESCR[855]
Right to Life	ICCPR[856]
Right to Information	ICCPR,[857] ACHPR,[858] Children's Convention[859]
Right to be Free from Violence	Women's Convention,[860] ACRWC,[861] Children's Convention[862]

practices which negatively affect the human rights of women and which are contrary to recognized international standards."[876]

The ACHPR also vests states with the duty to protect all people from discrimination.[877] The same charter extends the non-discrimination principle to women and children specifically:[878] "[t]he State shall ensure the elimination of discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions."[879]

In 1990, CEDAW issued a General Recommendation that specifically spoke to the elimination of gender discrimination in the context of national AIDS policy. The Recommendation suggests that countries "intensify efforts in disseminating information to increase public awareness" of HIV/AIDS in women; incorporate women's needs and rights into program planning and "give special attention … to the factors relating to the reproductive role of women and their subordinate position in some societies" and ensure women's participation in primary care. It directs countries to include in their reporting the effect of AIDS on the national situation for women and actions taken to serve female PLWA and prevent gender discrimination in the national AIDS response.[880]

As discussed in the country background chapters, the dual legal systems in Botswana and Swaziland grant women lesser legal status than men, and restrict their capacity to contract and own property, among other rights. Social, economic and cultural structures create, enforce and perpetuate legalized gender inequalities and support and allow discrimination in all aspects of women's lives. The study findings from Botswana and Swaziland are replete with examples of gender inequality and discrimination left unaddressed by the Governments. For example, the unmitigated effects of harmful traditional practices were noted by PLWA interviewed in both countries, including the practices of wife inheritance and widow eviction, which deny women access to family property and homesteads on equal basis with men. In Swaziland in particular, the role of customary law and practice in the creation and maintenance of women's low social status was voiced by nearly all the interview participants. This unequal status was directly linked to the inability of women to choose to be pregnant and to prevent HIV.

The demographic profile of survey participants illustrates the harmful disparate impacts of inequity and gender discrimination. In the Botswana community survey, female participants were poorer than male participants, and food insufficiency and unemployment were also more prevalent among women. Interviews described the dependency and vulnerability created for women by these conditions. Women in the Swaziland community survey likewise had lower incomes and a higher frequency of food insufficiency than their male counterparts. Similar narratives of lack of autonomy and sexual risk were told by Swazi women living with HIV/AIDS. Neither country has addressed these disparities through property law or other reforms, nor incorporated measures to address the impoverishment and subordination of women into HIV/AIDS program planning as directed by CEDAW.

The results present evidence of many women's lack of control over matters of sexuality and reproduction, including the decision whether to have sex, use condoms or bear children. This represents the Governments' failure to secure reproductive rights for women, including access to family planning, as required by the Women's Convention and the conference documents. Testimony made clear that the diminished autonomy experienced by women was in turn derived from patriarchal norms and power dynamics in families and intimate relationships which are underpinned by social, cultural, legal and economic inequities which remain unaddressed, in contravention to legal obligations.

The most striking evidence of unlawful gender discrimination is the prevalence of gender discriminatory beliefs among community survey participants in both countries, and particularly in Swaziland, where a quarter of women and nearly half of men held 6 or more such beliefs. Agreement that "it is more important for women to respect her spouse/partner than for a man to," that men should control decisions in relationships and women should have sex with their partners against their will reflect socially sanctioned subordination of women's rights to men's prerogatives. Impunity for violence against women and other forms of discrimination and disempowerment create the environments that nurture and support these normative beliefs. Likewise, beliefs in childbearing obligations based on customs such as bride price and the permissibility of polygamous relationships for men derive from customary law and practices which discriminate against women. As regression analyses establishing associations between holding discriminatory beliefs and sexual risk-taking demonstrate, the failure to address this form of discrimination increases women's vulnerability to HIV transmission in both countries.

On the other hand, beliefs in women's rights had a protective effect among Swaziland community survey participants. For example, those who believed that "women should be able to hold the same jobs at the same pay as men" had 51 percent lower odds of multiple sexual partners and 42 percent lower odds of unprotected sex with a non-primary partner in the past year. This suggests that women having work rights equal to those of men could not only grant women economic independence, but potentially perpetuate non-discriminatory beliefs among women and men, in turn promoting decreased risk-taking and women's increased control over sexual situations. It is in Botswana, however, and not Swaziland, where some steps towards the gender equality required by the Women's Convention have been taken. The support of a significant majority of community survey participants for equality for women in property ownership, employment, marriage and decision making (in Swaziland) and legal rights and inheritance (in Botswana) indicates the failure on the part of the Governments to take advantage of a widely held desire for the full panoply of rights for women.

Non-Discrimination and Rights to Equal Protection Based on HIV/AIDS Status

Discrimination based on any ground is prohibited under human rights law, including "race, color, sex, language, religion, political or other opinion, natural or social origin, property birth or other status."[881] The former UN Commission on Human Rights (CHR) has explicitly confirmed that health status, including HIV/AIDS, is an included ground.[882] Furthermore, the CHR has noted that this includes actual or presumed HIV-positive status or AIDS, and applies to members of groups perceived to be at risk for HIV/AIDS.[883]

The study findings demonstrate that discrimination on the basis of HIV status exists in Botswana and Swaziland. It appears that incorrect knowledge with regard to HIV/AIDS has served to perpetuate certain reported discriminatory practices, such as unwillingness to share a meal with someone perceived to be HIV-positive (27 percent in the Botswana survey, 30 percent in Swaziland), or to purchase food from a suspected HIV-positive vendor (23 percent of Batswana, 27 percent of Swazis). In Swaziland, community survey participants were queried as to their views on equal rights for PLWA, and 19 percent agreed that PLWA should not be able to marry or participate in Parliament to the same degree as those who were HIV-negative. A quarter of Swazi PLWA interviewed reported discriminatory treatment at work, school, hospitals or other public places, and a third agreed that women experienced this to a greater degree than men. These human rights abuses are clearly prohibited under the ICCPR and must be addressed through the justice system to hold both public and private actors accountable.

While proportionally fewer Batswana PLWA reported experiences of discrimination, the persistence of stigmatizing attitudes, particularly for female PLWA, was noted in those interviews. The majority of community survey participants in both countries (53 percent in Botswana and 61 percent in Swaziland) held at least on stigmatizing or discriminatory attitude toward PLWA. Such attitudes potentially serve as an obstacle to the exercise of equal rights. The perceived need for secrecy and projected fears of being stigmatized and experiencing bad treatment should an individual test positive for HIV have clear implications for whether individuals will take preventive measures and seek testing or care. As with gender discriminatory beliefs, affirmatively addressing these fears is the responsibility of states parties charged with ensuring equality and promoting the rights to life and health for those within its borders. The absence of legislation in both countries specifically protecting the rights of those living with HIV/AIDS, in addition to the lack of anti-stigma education and other preventive measures, speaks to the Governments' failure to meet their obligations of promoting non-discrimination.

Right to Health[884]

In conferring the obligation to ensure the right to health, the ICESCR states that, "[t]he States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[885] Among other obligations, states must take steps to realize "[t]he prevention, treatment and control of epidemic, endemic ... and other diseases" and "[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness."[886] Article 2 directs that each party to the ICESCR:

> ... undertakes to take steps, individually ... to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

In General Comment 14 to the ICESCR, the ESC Rights Committee explained that the right to health "is closely related to and dependent on the realization of other human rights ..." set forth in the Universal Declaration of Human Rights and the two Covenants.[887] It "embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health," such as access to food and water, sanitation, housing, and health-promoting labor and environmental conditions.[888] Popular participation in all levels of decision making regarding health is an aspect of the right,[889] which encompasses availability, accessibility, acceptability and quality.[890] Accessibility is comprehensive, including non-discrimination, physical access, affordability and the right to seek, receive and impart information with due confidentiality.

With regard to the right to the prevention, treatment and control of diseases, General Comment 14 states that this Article,

> requires the establishment of prevention and education programmes for behavior-related health concerns such as sexually transmitted diseases, particularly HIV/AIDS ... and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity.[891]

The ESC Rights Committee advocates a gender perspective that "recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women"[892] and situates the need for a comprehensive strategy to promote women's health in the obligation to eliminate gender-based discrimination.[893] This includes the need to "undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights."[894]

In many respects, for example the persistent food insufficiency, economic deprivation and gender inequality described elsewhere in this chapter, Swaziland is not meeting its right to health obligations. The survey and the interviews describe a situation where a significant proportion of participants, in particular women and PLWA, lack access to sufficient food, safe living conditions and a secure work situation, which translate into elevated risk of becoming infected with HIV or being less able to cope with positive status. Swaziland community survey participants fault leadership across the board for failing to support people infected or affected with HIV/AIDS with subsistence levels of food, water, shelter and land and to spend sufficient resources on HIV prevention. When asked whether a particular category of leaders had given the basic necessities to PLWA or others affected, a substantial proportion agreed that church leaders (41 percent) and the King had not done so (42 percent) and the majority reported that national political leaders (56 percent) and chiefs (64 percent) had failed in this regard.

The failure to achieve universal coverage of comprehensive prevention education is particularly egregious given the devastation of the epidemic. Nearly 20 percent of Swazi community survey respondents demonstrated incorrect knowledge of HIV prevention and transmission. Eighty-nine percent of Swazi participants agreed that chiefs in particular had not spent enough on HIV prevention such as educational campaigns and 73 percent that national leaders had not done so. Swaziland's obligations under the ICESCR require that the Government take such steps to implement its national HIV/AIDS policy, and in particular, adopt a gender perspective in terms of both strategy and implementation.

Right to Food

National governments bear responsibility for ensuring the right to food.[895] Specifically, food must be "in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture."[896] Food must be available from either land or adequate distribution[897] as well as economically and physically accessible.[898] While poor countries are not expected to fulfill this right on the same level as rich countries, each must ensure the right to food to the extent of its resources.[899]

The findings demonstrate a high prevalence of food insufficiency in Swaziland, where nearly a fifth of the population is projected to receive direct food aid in 2007. Food insufficiency was particularly notable among women: 38 percent of women surveyed in Swaziland reported difficulty in getting enough to eat in the past year. Sufficient food is necessary not only from a nutritional standpoint, particularly for PLWA, but also as a protective factor with regard to decreasing vulnerability created by dependence on others, particularly for women. The majority of Swaziland community survey participants affected by food shortages reported the direct effects of lack of food on their decisions about health care (65 percent) and their standard of living, including the ability to support themselves (85 percent) and their dependents (82 percent). At least half of

PLWA interviewed in Swaziland clearly articulated the influence of lack of food and economic dependence on women's sexual decision making and resultant vulnerability to relationships where they lacked control over sexual and reproductive choices. The failure to meet the right to food with programs that promote long-term food security for the population is thus particularly harmful in the context of a generalized AIDS epidemic, and contributes to the violation of economic and reproductive rights for women.

Right to Life

The ICCPR states: "[e]very human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."[900] In General Comment 6, the Human Rights Committee explicitly states that the right to life "is the supreme right from which no derogation is permitted ... . It is a right which should not be interpreted narrowly."[901] Positive measures to protect the right to life include interventions to reduce infant mortality and increase life expectancy and "especially ... to eliminate malnutrition and epidemics."[902]

It should be evident that the drivers and impacts of the HIV/AIDS epidemic detailed in the report fall squarely within the mandate of the protection of the right to life. In order to meet their obligations under the ICCPR, affirmative measures must be taken by Botswana and Swaziland to correct food insufficiency; lack of access to correct information about prevention and transmission; lack of access and literacy concerning life-saving ARV treatment; and the persistence of gender and HIV-related discrimination that increase vulnerability to HIV.

While both countries, particularly Botswana in its ambitions towards universal coverage, have taken steps to address the epidemic, for example by establishing testing and treatment programs, the study findings identified persistent gaps in these programs. Less than a quarter of Swazis surveyed (25 percent of women and 18 percent of men) and less than half of participants in the Botswana community survey (52 percent of women and 44 percent of men) had tested, despite acknowledged risk of HIV infection. Perceived access to testing, and to confidential testing, among community survey participants was less than universal. In Swaziland, 59 percent agreed they had access to testing and 66 percent that it was possible for a person in their village to get a confidential HIV test. Fear of knowing one's status was the chief barrier to testing for untested participants in both countries (49 percent in Botswana, 43 percent in Swaziland). In order to fulfill their obligations to promote and protect the right to life, the Governments of Botswana and Swaziland need to take a comprehensive and participatory approach to the intervention of HIV testing. This includes identifying and addressing underlying rights-related factors for not testing, such as fear of stigmatization, HIV-related discrimination and lack of access to services.

Community survey participants in both countries identified their leaders' failure to take positive measures, as required by the ICCPR, to address the life-threatening AIDS epidemic. For example, asked a general question about leadership of the HIV/AIDS response, 46 percent of female and 38 percent of male participants in the Botswana community survey did not think that political leaders had done enough to address the epidemic; 47 percent of all survey participants reported that chiefs had not done enough.

Right to Information

The freedom to seek, receive and impart information and ideas of all kinds is a right protected under Article 19 of the ICCPR.[903] In General Comment 10, the Human Rights Committee emphasizes the comprehensiveness of this right and that it applies to all media.[904] General Comment 12 highlights information concerning health matters as a dimension of accessibility.[905] The Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression has particularly highlighted that meaningful exercise of the right "is of the utmost importance for ensuring effective education and information campaigns to prevent HIV/AIDS."[906] Furthermore, that information should not only comprise HIV prevention and transmission and sexual and reproductive matters, but also include stigma, discrimination and equality[907] and explicit linkage to the right itself.[908]

The results of the study indicate that potentially life-threatening mistaken beliefs persist concerning both the transmission and prevention of HIV in Botswana, despite extensive national public education and mobilization campaigns. As mentioned above, a similar situation exists in Swaziland, where a national campaign is only nascent. Moreover, as described previously, persistent stigmatizing and gender-discriminatory beliefs were expressed by a majority of participants in both countries; many of these are rooted in a failure to educate community members concerning not only the etiology of HIV/AIDS, but women's rights and human rights generally. The lack of universal knowledge regarding the modes of prevention and transmission of a deadly virus

that infects over one-third to two-fifths of the populations of these countries clearly demonstrates the need to assess and redress the messages and coverage of educational interventions to comport with international law.

Right to be Free from Violence

International law recognizes the right of all people, particularly women and children, to be free from violence. According to the CEDAW, the Women's Convention prohibits all forms of violence against women: "[g]ender-based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence."[909] The Women's Convention specifically forbids traditional practices that may subject women to discriminatory violence[910] as well as the trafficking and prostitution of women.[911] The prohibition of gender-based violence is echoed in the non-discrimination provisions of the ACHPR[912] and the ICCPR[913] and is further elaborated upon in the Declaration on the Elimination of Violence Against Women, which offers UN member states guidance on how to promote women's right to be free from violence in a national context. For example, it suggests that governments modify domestic laws such that "women who are subjected to violence should be provided with access to the mechanisms of justice and ... to just and effective remedies for the harm that they have suffered."[914] The Declaration also advises governments to draft national action plans to promote women's safety[915] and to create prevention programs.[916]

Neither Botswana nor Swaziland has taken actions appropriate to meeting these obligations. This despite the fact that, as described in the background research and suggested by PLWA interviewees and key informants, violence against women in intimate relationships, and sexual violence in general, are of particular concern in the context of the HIV/AIDS pandemic. For example, almost half of the female PLWA interviewed in Swaziland reported being hurt or forced to have sex by a partner in their lifetime. The failure of both countries to condemn intimate partner and other forms of gender-based violence, including the absence of criminalization, violates the rights of women and contributes to endemic HIV in those countries.

Relevant UN Guidelines

Over the past ten years, the UN system and inter-governmental agencies have responded to the HIV/AIDS pandemic with a series of guidelines and policy statements.[917] For example, a 2001 Commission on Human Rights resolution urged member states to reform laws in response to the epidemic as well as to improve HIV prevention, education and treatment programs.[918] While the provisions of these documents do not have the force of international law, they offer important, authoritative guidance in the implementation of state action plans to ensure an effective, rights-based response to HIV/AIDS.

Several UN bodies have issued guidelines pertinent to the gender issues discussed in this report. The most relevant guidance is found in the International Guidelines on HIV/AIDS and Human Rights jointly promulgated by the UN Commissioner for Human Rights and UNAIDS.[919] The International Guidelines offer governments specific suggestions in the areas of legal reform, civil and private sector involvement and state capacity-building as means of addressing the HIV/AIDS epidemic. The guidelines call upon states to take into account the needs of women when planning a response to the epidemic:

> States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.[920]

Swaziland community survey participants particularly faulted national political leaders, chiefs and the King for not have protected women and children from abuse or done enough to oppose bad treatment of PLWA.

Of particular relevance to the findings in this study related to HIV testing is the UNAIDS/WHO Policy Statement on HIV Testing.[921] This policy reiterates the prerequisite conditions for HIV testing that complies with human rights principles, known as the "3 Cs:" confidentiality, counseling and informed consent. The right to refuse the test is one element of informed consent. The Policy distinguishes four different types of HIV testing: 1) VCT (a client-initiated test provided through voluntary counseling and testing); 2) diagnostic testing (in response to signs or symptoms consistent with HIV-related disease or AIDS); 3) routine offer of HIV testing (a health worker-initiated test offered to patients being seen under three categories of circumstances, including those who are asymptomatic seen in clinical and community-based health services where HIV is prevalent and ARVs available); and 4) mandatory testing for blood or organ donors.

Significant gaps in compliance with the guidelines appear to remain in each country's HIV testing policy and

its implementation. Forty-eight percent of participants in the Botswana community survey and 22 percent of Swazi community respondents had tested for HIV. Ninety-five percent of tested Batswana reported overall positive experiences with testing, including confidentiality, and reported that they had made the decision to test; however, 68 percent did not believe they could refuse the test. Among tested Swazi respondents, positive overall experiences were also reported, though 6 percent reported a breach in confidentiality, 13 percent had not made the decision to test and 41 percent felt that they could not refuse the test. This raises serious questions regarding privacy and consent. Though in both surveys the vast majority reported pre- and post-test counseling, gaps in coverage were evident, particularly in Swaziland, and for post-test counseling in both countries.

Regional Guidelines

Many international human rights obligations are reiterated in regional human rights consensus documents. As signatories to these documents, this further suggests acknowledgement on the part of Botswana and Swaziland that accountability for the protection, promotion and fulfillment of human rights, and particularly women's equality, is essential to an effective response to the HIV/AIDS epidemic. Both Botswana and Swaziland are members of the Southern African Development Community (SADC),[922] which has issued a Code of HIV/AIDS and Employment in SADC,[923] the SADC Health Protocol[924] and the SADC Declaration on HIV/AIDS.[925] SADC has also issued an HIV/AIDS Strategic Framework to guide member states in implementing policies and programs to curb the HIV/AIDS epidemic.[926] In 2003, several southern African NGOs drafted a code for SADC to promote gender equality and reduce women's risk of HIV transmission.[927] The purpose of the code is to guide community and national policy makers in designing HIV/AIDS prevention and treatment programs that take women's vulnerability into account.

The African Union, of which Botswana and Swaziland are members,[928] has also issued several documents prohibiting the abuses outlined in this report. These include the Resolution on Regular Reporting of the Implementation Status of OAU Declarations on HIV/AIDS in Africa,[929] the Tunis Declaration on AIDS and the Child in Africa[930] and the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases.[931] The Abuja Declaration was issued with the Abuja Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases which offers governments suggestions for how to implement the principles enumerated in the Declaration.[932] For example, the Framework suggests that governments improve access to PMTCT programs and ensure access to voluntary counseling and testing as strategies to curb HIV/AIDS transmission.[933] As a means to realizing reproductive rights in an HIV-prevention policy context, the Abuja Framework suggests that states "strengthen existing legislation to address human rights violations and gender inequities… ."[934]

Obligations of Donor States and International Organizations

Under the human rights framework, donor states and international organizations have minimum obligations to respect rights in other countries and not to impede their realization through their own actions. These include policymaking and funding, whether in the context of bilateral aid or membership in international organizations. The ICESCR states,

> 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 realization of the rights recognized in the present Covenant by all appropriate means … (emphasis added).[935]

The ESC Rights Committee has noted that this obligation rests with all states under international law, and is particularly the responsibility of more developed countries.[936]

The US, through PEPFAR and other aid programs, and the UN agencies, among other donors to Botswana and Swaziland, are obliged under international human rights law to assist Botswana and Swaziland to address the failures detailed in this chapter. In particular, it is incumbent on these third parties to encourage immediate measures to reform discriminatory laws and enact protections for women and PLWA; to provide funds and technical assistance for legal aid, sustainable food programs and the scaling-up of HIV testing and treatment; and to facilitate capacity-building and cooperation between the Governments and civil society in each country and in the region. Without such efforts, fragmented and uncoordinated aid and policies may create obstacles to good-faith efforts by the countries to address the human rights abuses that perpetuate the HIV/AIDS pandemic.

Conclusion

Botswana and Swaziland have significantly different country profiles, particularly when it comes to HIV/AIDS policies and some gender indicators, yet both governments are accountable for failing to meet many of the same human rights obligations. Each country has bound itself to the rights articulated in the ICCPR, the Women's Convention, the Children's Convention, the ACHPR and the ACRCW. Both countries have failed, however, to address discriminatory or harmful laws, practices and circumstances that have led to human rights abuses prohibited by these treaties.

The study findings describe the deleterious impacts of gender inequality and discrimination, discrimination against PLWA, failure to provide essential information and life-saving access to HIV testing and treatment, and the life-threatening consequences of the lack of adequate food to meet basic needs, particularly for women. Swaziland, moreover, though it acceded to the ICESCR, has failed to fulfill its responsibilities to progressively realize the right to the highest attainable standard of health. Donor states and international organizations could also do much more in this regard, to assist Swaziland to develop and implement economic, social and legal reforms regarding gender, HIV/AIDS and food sufficiency, and indeed are obliged to do so under international law. Similar obligations are owed to Botswana, which though a greater beneficiary of international aid and attention than Swaziland, must still be assisted to meet and be held accountable for long overdue reforms and safeguards. These include legislation to guarantee equal rights for women and protect them from violence, the enactment of protections and provision of education to eliminate persistent HIV-related stigma and discrimination and the monitoring of the "3 Cs" in the national HIV testing program.

In the struggle to prevent and alleviate the suffering caused by the HIV/AIDS pandemic, realization of human rights is imperative and essential, particularly for women who bear the brunt of the global epidemic. Human rights are not an alternative approach or a suggestion, but legal obligations that bind Botswana, Swaziland and donor states and international organizations to specific remedial actions. It is thus necessary, as a matter of health and of human rights, that all actors undertake to urgently address the human rights abuses discussed in this chapter and to follow the recommendations outlined in this report.

Notes

[814] UN General Assembly. Declaration of Commitment on HIV/AIDS (A/Res/S-26/2). 2001. Available at: http://www.unhchr.ch/huridocda/huridoca.nsf/e06a5300f90fa0238025668700518ca4/7e8440165be48ce0c1256aaa0052d754/$FILE/N0143484.pdf.

[815] Amon J. *Preventing the further spread of HIV/AIDS: the essential role of human rights*. Human Rights Watch. January 2006. Available at: http://hrw.org/wr2k6/hivaids/hivaids.pdf. Accessed September 21, 2006.

[816] "Facing the Future Together." Report of the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa. July 2004. Available at: http://womenandaids.unaids.org/regional/docs/Report%20of%20SG%27s%20Task%20Force.pdf. Accessed May 12, 2006.

[817] Cross reference country backgrounds.

[818] "Accession occurs when a state which did not sign a treaty, already signed by other states, formally accepts its provisions." (Brownlie I. *Principles of Public International Law*. Oxford: Oxford University Press; 1990:609). Under these circumstances, accession has the same legal effect as ratification. While it usually occurs after a treaty enters into force, it may also take place beforehand; the conditions under which accession may occur and the procedure involved depend on the provisions of the treaty. Arts.2 (1) (b) and 15, Vienna Convention on the Law of Treaties 1969.

[819] Signature is a step in the ratification process, without creating an obligation to ratify. Signatory states have a good faith obligation to refrain from creating obstacles to meeting the treaty goals. (Brownlie I. *Principles of Public International Law*. Oxford: Oxford University Press; 1990:606-7).

[820] Ratification is a binding consent to the treaty's provisions. (Brownlie I. *Principles of Public International Law*. Oxford: Oxford University Press; 1990:609).

[821] Available at: http://www.ohchr.org/english/law/ccpr.htm. Accessed March 27, 2007.

[822] Available at: http://www.ohchr.org/english/law/cescr.htm. Accessed March 27, 2007.

[823] Available at: http://www.ohchr.org/english/law/cedaw.htm. Accessed March 27, 2007.

[824] Available at: http://www.ohchr.org/english/law/crc.htm. Accessed March 27, 2007.

[825] Available at: http://www.hrcr.org/docs/Banjul/afrhr.html. Accessed March 27, 2007.

[826] Available at: http://www1.umn.edu/humanrts/africa/afchild.htm. Accessed March 27, 2007.

[827] Available at: http://www.achpr.org/english/_info/women_en.html. Accessed March 27, 2007.

[828] *Civil and Political Rights: The Human Rights Committee,* Fact Sheet No. 15 (Rev. 1). Available at: http://www.ohchr.org/english/bodies/hrc/index.htm. Accessed April 4, 2006.

[829] *See* UN Treaty Body Database. Available at: http://193.194.138.190/tbs/doc.nsf. Accessed May 6, 2006.

[830] *The Committee on Economic, Social and Cultural Rights.* Fact Sheet No. 16 (Rev.1). Available at: http://www.ohchr.org/english/about/publications/docs/fs16.htm. Accessed April 4, 2006.

[831] *Convention on the Elimination of All Forms of Discrimination against Women.* Art. 18.

[832] See UN Treaty Body Database. Available at: http://193.194.138.190/tbs/doc.nsf. Accessed May 6, 2006.

[833] *Convention on the Rights of the Child,* Art. 44.

[834] See UN Treaty Body Database. Available at: http://193.194.138.190/tbs/doc.nsf. Accessed January 22, 2007.

[835] "African Commission on Human and Peoples' Rights Mandate." Available at: http://www.achpr.org/english/_info/mandate_en.html. Accessed April 4, 2006.

[836] *See* http://www.achpr.org/english/_info/status_submission_en.html. Accessed January 22, 2007.

[837] Concluding Observations: Botswana. D. 50.

[838] Botswana became a UN member on October 17, 1966. Swaziland became a UN member on September 24, 1968.

[839] Brownlie I. "Principles of Public International Law." 4th ed; 1990:15.

[840] Adopted by the UN General Assembly on June 27, 2001.

[841] Patterson D and London L. "International Law, human rights and HIV/AIDS." *Bulletin of the World Health Organization.* 80(12), 966.

[842] Adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948.

[843] Adopted by the World Conference on Human Rights on June 25, 1993.

[844] Adopted by the UN General Assembly on December 20, 1993.

[845] Programme of Action, Report of the International Conference on Population and Development, 5-13 September 1994, A/CONF.171.13 (18 October 1994).

[846] Beijing Declaration and Platform for Action, Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995). All Southern Africa Development Community member states have adopted the recommendations of the Beijing Platform, including Botswana and Swaziland. UN Economic Commission for Africa (UNECA). Report on the Economic and Social Conditions in Southern Africa, 2000, Section V [Advancement of Women]. Available at: www.uneca.org/sros/sa/publications/economic_report_2000/Woman.htm. Accessed September 29, 2006.

[847] Cairo Programme. Chapter IV(a) Empowerment and status of women: Actions.

[848] ICCPR, Article 26.

[849] ICESCR, Article 3.

[850] ICESCR, Article 12.

[851] Women's Convention, Article 11.1(f).

[852] Children's Convention, Article 24(1).

[853] ACRWC, Article 5.

[854] ACHPR, Article 16.

[855] ICESCR, Article 11.

[856] ICCPR, Article 6(1).

[857] ICCPR, Article 19(2).

[858] ACHPR, Article 9.

[859] Children's Convention, Article 17.

[860] CEDAW, General Recommendation No. 19 (11th session, 1982), paragraph 6 (referring to the definition of "discrimination against women" in Article 1 of the Women's Convention).

[861] ACRWC, Article 16(1).

[862] Children's Convention, Article 19(1).

[863] Women's Convention, Article 3.

[864] Women's Convention, Article 15(1).

[865] Women's Convention, Article 15(2).

[866] Women's Convention, Article 15(2).

[867] Women's Convention, Article 16(1)(h).

[868] ACHPR, Article 14.

[869] Women's Convention, Article 16(1).

[870] ICCPR, Article 23(3). See also General Comment No. 19, paragraph 8.

[871] Women's Convention, Article 16(1)(e).

[872] Women's Convention, Article 14(2)(b).

[873] Women's Convention, Article 12(1).

[874] Women's Convention, Article 2(f).

[875] General Comment No. 28, paragraph 5.

[876] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. Article 5.

[877] ACHPR, Article 3 and 19.

[878] ACHPR, Article 18(3).

[879] ACHPR, Article 18(3).

[880] General Recommendation 15. Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS) (1990). February 2, 1990.

[881] For example, see ICCPR, Article 2 (1), ICESCR, Article 2(2).

[882] *See* Commission on Human Rights Resolutions 1995/44 (3 March 1995) and 1196/43 (19 April 1996).

[883] For example, see Human Rights Resolution 2005/85. Available at: http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2005-84.doc. Accessed October 2, 2006.

[884] As shown in Table 1, Swaziland has formally consented to be bound by the ICESCR, where the rights to health and to food are prominently articulated; Botswana has not.

[885] ICESCR, Article 12(1).

[886] ICESCR, Article 12(2)(c), 12(2)(d). The ESCR Committee has clarified that these are "illustrative, non-exhaustive examples" of obligations. ICESCR General Comment 14(7). "The Right to the Highest Attainable Standard or Health." UN Doc. E/C.12/2000/4. August 11, 2000.

[887] General Comment 14(3).

[888] ICESCR General Comment 14(4).

[889] ICESCR General Comment 14(11).

[890] ICESCR General Comment 14(12).

[891] ICESCR General Comment 14(16).

[892] ICESCR General Comment 14(20).

[893] ICESCR General Comment 14(21).

[894] ICESCR General Comment 14(21).

[895] Ziegler J. *Economic, Social and Cultural Rights: The Right to Food.* Economic and Social Council UN Doc. E/CN.4/2006/44, 16 March 2006, para. 18.

[896] "The Right to Food." General Comment 12, Committee on Economic, Social and Cultural Rights, UN Doc. E/C.12/1999/5, December 5, 1999, para. 8.

[897] Id., Committee on Economic, Social and Cultural Rights, UN Doc. E/C.12/1999/5, December 5, 1999, para. 12.

[898] Id., Committee on Economic, Social and Cultural Rights, UN Doc. E/C.12/1999/5, December 5, 1999, para. 13.

[899] Ziegler J. *Economic, Social and Cultural Rights: The Right to Food.* Economic and Social Council UN Doc. E/CN.4/2006/44, 16 March 2006, para. 26.

[900] ICCPR, Article 6(1).

[901] General Comment No. 6, paragraph 1.

[902] General Comment No. 6, paragraph 5.

[903] ICCPR, Article 19(2).

[904] General Comment No. 10, paragraph 2 (19th Session, 1983). Available at: http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/2bb2f14bf558182ac12563ed0048df17?Opendocument. Accessed October 2, 2006.

[905] ICESCR, General Comment 12(12)(b).

[906] Commission on Human Rights. "Civil and political rights, including the question of freedom of expression." The right of freedom of opinion and expression. Report of the Special Rapporteur, E/CN.4.2003/67, 30 December 2002, paragraph 41.

[907] Report of the Special Rapporteur, paragraph 44.

[908] Report of the Special Rapporteur, paragraphs 51, 52.

[909] General Recommendation No. 19. Section 6. 11th Session, 1992.

[910] Women's Convention, Article 5.

[911] Women's Convention, Article 6.

[912] ACHPR, Article 18(3).

[913] ICCPR, Article 2 and 3.

[914] Declaration on the Elimination of Violence Against Women. Section 11(d).

[915] Declaration on the Elimination of Violence Against Women. Section 11(e).

[916] Declaration on the Elimination of Violence Against Women. Section 11(f).

[917] For a list of guidelines and policy statements, see: http://www.ohchr.org/english/issues/hiv/document.htm

[918] "The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) Commission on Human Rights resolution 2001/51." Para. 5, UN Doc. E/CN.4/RES/2001/51 (April 24, 2001).

[919] Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS. *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version). Geneva: UNAIDS (2006).

[920] UNAIDS and OCHR. *HIV/AIDS and Human Rights International Guidelines.* 2002:Guideline 8.

[921] UNAIDS and WHO. *UNAIDS Policy Statement on HIV Testing*. June, 2004. Available at: http://data.unaids.org/unadocs/hivtestingpolicy_en.pdf#search='UNAIDS%2FWHO%20Policy%20Statement%20on%20HIV%20Testing. Accessed September 21, 2006. WHO and UNAIDS are in the process of revising this policy, having released for comment a draft *Guidance on Provider-Initiated HIV Testing and Counseling in Health Facilities* document in November 2006. Available at: http://www.who.int/hiv/topics/vct/publicreview/en/. Accessed April 5, 2007.

[922] SADC Treaty signed August 17, 1992.

[923] Adopted by SADC Council of Ministers September 1997.

[924] Adopted by SADC member states August 1999.

[925] Signed by SADC Heads of State July 2003.

[926] *Managing the Impact of HIV/AIDS in SADC.* 2000. Available at: http://www.doh.gov.za/aids/docs/sadc-aug00.pdf. Accessed November 18, 2005.

[927] AIDS and Rights Alliance of Southern Africa. *Proposed Code for the Southern African Development Community (SADC): Urgent Measures Needed to Promote the Equality of Women and the Reduction of Women's Risk of Infection with HIV.* 2004:5-6.

[928] Constitutive Act of the African Union. July 11, 2000.

[929] Adopted July 1996.

[930] Adopted June 1994.

[931] Adopted April 27, 2001.

[932] Abjua Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases.

[933] Id., Abuja Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Section XII.

[934] Id., Abuja Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Section III.

[935] ICESCR, Article 2(1).

[936] General Comment No. 3, paragraphs 13-14.