I. EXECUTIVE SUMMARY

Introduction

Deeply entrenched gender inequities perpetuate the HIV/AIDS pandemic in Botswana and Swaziland, the two countries with the highest HIV prevalence in the world.[10] The legal systems in both countries grant women lesser status than men, restricting property, inheritance and other rights. Social, economic and cultural practices create, enforce and perpetuate legalized gender inequalities and discrimination in all aspects of women's lives. Neither country has met its obligations under international human rights law. As a result, women continue to be disproportionately vulnerable to HIV/AIDS. This is most starkly demonstrated by the association of gender discriminatory beliefs and sexual risk-taking documented in this report. In Botswana, participants who held three or more gender discriminatory beliefs had 2.7 times the odds of having unprotected sex in the past year with a non-primary partner as those who held fewer beliefs. In Swaziland, those surveyed who held 6 or more discriminatory attitudes had twice the odds of having multiple sexual partners than those who held less than 6.

Despite their distinct demographic and policy profiles, the epidemic in each country exemplifies many of the key dimensions of the pandemic that is ravaging the southern African region: [11] an infection primarily transmitted through sexual practices rooted in women's disempowerment and lack of human rights and facilitated by poverty and food insufficiency. Young women are disproportionately affected: 75 percent of HIV-positive 15-25 year olds in sub-Saharan Africa are female.[12]

Conducting a population-based study in each country, Physicians for Human Rights (PHR) found four key factors contributing to women's vulnerability to HIV: 1) women's lack of control over sexual decision making, including the decision of whether to use condoms; 2) persistent HIV-related stigma and discrimination, hindering testing and engendering individuals' fears of learning their HIV status; 3) gender-discriminatory beliefs held by the majority of those surveyed — reflecting and accepting women's inferior legal, cultural and socio-economic status — that are predictive of sexual risk-taking; and 4) the failure of leadership to demonstrate the will and allocate the resources to prioritize and implement actions to promote the equality, autonomy and economic independence of women and people living with HIV/AIDS (PLWA).

In both Botswana and Swaziland, a substantial percentage of PHR community survey participants who had been tested for HIV reported that they could not refuse the test. The continuing extraordinary prevalence of HIV in Botswana, particularly among women, demonstrates that campaigns, scaled-up HIV testing, including routine testing, and anti-retroviral (ARV) treatment are not enough. Women must be empowered with legal rights, sufficient food and economic opportunities to gain agency of their own lives. Men must be educated and supported to acknowledge women's equal status and throw off the yoke of socially- and culturally-sanctioned discriminatory beliefs and risky sexual behavior.

HIV/AIDS interventions focused solely on individual behavior will not address the factors creating vulnerability to HIV for women and men in Botswana and Swaziland, nor protect the rights and assure the wellbeing of those living with HIV/AIDS. National leaders, with the assistance of foreign donors and others, are obligated under international law to take immediate steps to change the unequal social, legal and economic conditions of women's lives which facilitate HIV transmission and impede testing, care and treatment. Without these immediate and comprehensive reforms, they cannot hope to halt the deadly toll of HIV/AIDS on their populations.

Methods

This study was designed and implemented by Physicians for Human Rights and two local field partners: the Faculty of Nursing at the University of Botswana in Gaborone, Botswana, and Women and Law in Southern Africa Research Trust (WLSA) in Mbabane, Swaziland.

Community Surveys

The surveys were conducted in Botswana in November and December 2004 by 26 trained local field researchers and in Swaziland in May 2005 by 21 trained local field researchers. Participants were adults, age 18-49,[13] randomly selected from households in the five districts of Botswana with the highest number of HIV-infected indi-

viduals[14] and in all 4 regions of Swaziland.[15] The study design was a stratified two-stage probability sample, constructed with the assistance of statisticians from the Central Statistics Office in each country. Up to two repeat visits were made to interview selected individuals.

The survey instruments, which consisted primarily of close-ended questions, were pilot tested on 20 individuals in each country, and subsequently revised.[16] All surveys and consent forms were translated into the local language (Setswana or siSwati) and back-translated into English.

PLWA Interviews

To provide more detailed insights into the patterns of experiences of people living with HIV/AIDS, qualitative interviews were conducted with self-identified PLWA in November and December, 2004, in Botswana, and in May, 2005, in Swaziland.[17] Interviews were semi-structured, consisting primarily of open-ended questions. The questions were translated at the time of the interview, when needed, by a trained local field researcher.[18]

In Botswana, PLWA interview subjects were 24 members, leaders, volunteers or counselors from support groups for people infected or affected with HIV/AIDS from Gaborone, Serowe and surrounding villages and rural areas. In Swaziland, 58 individuals were recruited in the Mbabane and Manzini areas from voluntary counseling and HIV testing (VCT) patients, members of support groups and clients of HIV-related services.

Human Subject Protections

For all surveys and interviews, informed consent was obtained from participants. All interviews, except key informant interviews, were anonymous, and all were conducted in a private setting. Study subjects were not compensated. The research protocol and instruments were approved for Botswana by the Human Subjects Committee at the University of California, San Francisco and the Botswana Ministry of Health Research and Development Committee, and for Swaziland by a PHR Ethics Review Board[19] and the chairperson of the Ethics Committee of the Swaziland Ministry of Health.

BOTSWANA

Country Background

Government, Population and Economy

Prior to the advent of the HIV/AIDS epidemic in 1985, Botswana had some of the best health indicators in the region. A country of 1.64 million people,[20] Botswana is a stable parliamentary democracy and relatively prosperous country, largely due to its diamond mining industry.[21] There is a high level of income inequality, however, and nearly a quarter of the population lives under the poverty line of US$1 per day.[22] The official unemployment rate is nearly 24 percent[23] and over half the population in rural areas depends on subsistence farming.[24]

HIV Prevalence and AIDS Policy

Botswana consistently reported the highest HIV prevalence in the world until surpassed by Swaziland in 2004. Despite the availability of VCT and preventing mother to child transmission (PMTCT) services, and the introduction of a program ("Masa" or new dawn) of universal access to ARVs in 2002, HIV testing rates and treatment participation remained low.[25] In response, in January 2004, the Government introduced a policy of "routine testing." While the initial policy was unclear, the Government has subsequently stated that the policy is one of "opt-out" testing.[26] By mid-2005, Botswana reported a significant increase in HIV testing and ARV treatment enrollment.[27] Botswana has implemented national HIV/AIDS prevention education on the ABC (abstinence, be faithful, use condoms) model.[28] With generous support from international donors, including the US President's Emergency Program for AIDS Relief program (PEPFAR), Botswana has augmented its national response, financially and in terms of research and the creation of health infrastructure for testing and treatment.[29]

Women's Rights

Botswana has a dual system of civil and customary law, and the extent of women's rights varies depending on which system is applied. Though reforms were made in 2004 to civil law regarding married women's status, implementation has been incomplete and customary law, under which women are subordinated to men, is unaffected by the reforms.[30] Moreover, civil laws that circumscribe women's property and other rights, which also remain severely restricted under the traditional system, are still in place, disenfranchising women in most instances.[31] Intimate partner violence and marital rape are not criminalized in Botswana and there are few resources for women living in situations of violence.[32] Economically, women are significantly disadvantaged compared with men and normatively have little control over their sexuality and reproduction.[33]

The Government has promulgated several ambitious national policies related to gender, including, in 1996, the National Policy of Women and Development.[34] Several population health and gender equality indicators

attest to improvements for women in Botswana in the last decade.[35] Policies are limited, however, by being operational only at the national level,[36] in isolation from many Batswana women, and by a lag in implementation. As a result, political and social change addressing gender inequalities in Botswana has progressed, albeit slowly, as a result of the initiation and insistence of a small but active civil society of women's, PLWA and human rights organizations working on these issues.[37]

PHR Study Findings[38]

Participant Characteristics

Fifty-two percent of the 1,268 respondents in the community survey were women and the mean age was 28.7 years. The majority, 77 percent of women and 70 percent of men, lived in an urban area or urban village outside of one of the main cities. Fifty percent of women and 41 percent of men were either married or living with a sexual partner. A greater proportion of women than men surveyed had monthly household incomes less than or equal to 1000 *pula* (US$220) per month (50 versus 39 percent) and one or more dependents (73 versus 60 percent) and were unemployed (34 versus 27 percent). More women than men also reported experiencing difficulty getting enough food to eat in the past twelve months (28 percent compared with 19 percent).

Of the 24 PWLA informants, 21 were women. The mean age was 32 years and 5 were married or living with a sexual partner. Five were employed, all in positions relating to HIV/AIDS activities. Twenty-three out of the 24 were receiving ARV treatment and one was not, due to lack of resources for transport.

Gaps in HIV Knowledge

The majority of participants in the community survey correctly answered questions about modes of HIV prevention and transmission: 82 percent of women and 89 percent of men met this standard.[39] Ninety-nine percent of Batswana community respondents were aware of sexual transmission as a mode of HIV infection and 97 percent correctly identified the protective role of condoms when used consistently and correctly. A minority of respondents believed that HIV could be transmitted by mosquito bites (29 percent of women and 22 percent of men), public toilets (29 percent of women and 17 percent of men) or sharing meals with an HIV-positive person (19 percent of women and men), and that praying (10 percent) or traditional medicine (8 percent) could prevent HIV infection.

Experiences with HIV Testing and Barriers to Testing

While 84 percent of community survey participants reported access to testing, 52 percent of women and 44 percent of men had tested for HIV. Examination of the most common facilitators and barriers to testing reported by participants suggest that expanding testing interventions, including media messages and routine testing, will not be sufficient to increase uptake without targeted measures to address the fear of knowing one's status and lack of readiness to test. Projections of stigma and discrimination should one test HIV-positive and disclose one's status, and concerns about maintaining livelihoods and supporting dependents, appear to underlie some of these fears. A majority reported a perception that they could not refuse the test, which highlights the importance of assuring the voluntariness of testing.

Participants Tested

Of the 605 participants who had tested, 43 percent of women and 63 percent of men tested at VCT centers. Fifteen percent had tested under the routine testing program. Experiences with routine testing as compared with testing at a VCT site differed in two respects: 6 percent of those tested by routine testing reported poor treatment related to testing compared with 2 percent of those tested by VCT; and 93 percent routinely tested received pre-test counseling, versus 97 percent for VCT.

Ninety-three percent reported that it was their decision to get the test and 98 did not regret testing. However, 62 percent of women and 76 percent of men believed they could not refuse the test. The majority informed their partner of the test (85 percent) and nearly all who had tested denied experiencing partner violence as a result (99 percent). Most received pre-test (96 percent) and post-test counseling (93 percent of women and 87 percent of men).

Facilitators to testing, for more than three-fifths of those tested, were public education messages on television or radio, knowing that treatment was available and knowing that test results would be confidential.[40] Women's and men's reported facilitators to testing differed. Women were more likely to report encouragement from PMTCT. Men were more likely to report treatment availability, advice from family or friends or encouragement from someone who had tested, media messages and confidentiality as influential factors.

Participants Not Tested

The most common barrier to testing, for the 658 individuals in the sample who had not tested, was being

afraid to know one's positive status (49 percent of women and men). Forty-three percent reported having no reason to believe they were infected. Proportionally more women reported lack of permission from a spouse or partner (10 percent of women versus 3 percent of men). More men identified frequent migration (25 percent of men versus 15 percent of women), not wanting to change sexual practices (39 percent of men compared with 27 percent of women) and concerns about social support (20 percent men, 12 percent of women).

Routine Testing

Fifty-four percent of respondents had heard of "routine testing" before the survey. After an explanation,[41] 82 percent of community survey participants were "very much" or "extremely" in favor of the policy overall, agreeing that it would facilitate access to testing (89 percent) and treatment (93 percent) and may result in less discrimination against HIV-positive people (60 percent) and less violence against women (55 percent).

On the other hand, survey participants projected some negative outcomes. Forty-three percent of the community survey respondents believed that opt-out testing could cause people to avoid seeing their health provider for fear of being tested. Fourteen percent thought that routine, opt-out testing could lead to more violence against women.

PLWA Experiences and Opinions Regarding Barriers to Testing and Routine Testing

PLWA interviewed suggested that many women feared that testing, regardless of outcome, could jeopardize their primary relationship by leading to abandonment by partners. Men, on the other hand, were influenced by cultural norms that sanctioned multiple sexual partners for men. Men's low participation in testing was also attributed to a climate of AIDS denial which fostered failure to take responsibility to prevent HIV transmission through knowing one's status and practicing safe sex. Many interview participants also mentioned HIV-related stigma and discrimination as a barrier to testing. For women, stigma was multiplied, characterized by prejudice against PLWA and belief in norms of monogamy and virginity for women.

> *Women don't want to be tested because of stress, stigma and discrimination. Women are also afraid to lose their partners. When women tell their partners they are HIV-positive, the men run away. This happened to me. My partner left. My partner initially encouraged me to get tested when he saw I was sick. He refused to get tested himself.*

A key facilitator to testing for the PLWA interviewed was the availability of ARVs. Interviewees voiced strong support for the idea of routine, opt-out testing, primarily as a means to reduce HIV-related stigma and thus facilitate increased testing. They expressed concerns, however, that counseling would no longer be universal, leaving individuals unprepared to learn their status and cope with the consequences of a possible positive test.

HIV-Related Stigma and Discrimination

Fear of knowing one's HIV-positive status was rooted in the existence of HIV-related stigma and discrimination in Botswana and the fear of being subject to social exclusion and poor treatment if that status is suspected or disclosed. Both stigmatizing views and fear of stigma were reported by a majority of those surveyed, though a lessening of stigma and discrimination since the advent of treatment was also reported. PLWA interviewed confirmed the latter views. At the same time, many reported experiences of poor treatment and all agreed that women bore the brunt of discriminatory experiences in Botswana. This was believed to be a result of the lack of women's rights and women's low status.

Stigmatizing/Discriminatory Attitudes

More than half of those surveyed, 54 percent of women and 51 percent of men, reported at least one stigmatizing or discriminatory attitude toward PLWA.[42] For certain attitudes, persistent discriminatory beliefs may reflect lack of knowledge regarding transmission of HIV. For example, 23 percent of women and men would not buy food from a shopkeeper or food seller they believed to have the AIDS virus. At the same time, there was clear support for the rights of PLWA among those surveyed: 97 percent of women and men believed that HIV-positive students who are not sick should be allowed to attend school and if a teacher has HIV but is not sick, that they should be allowed to continue teaching. Sixty-nine percent of women and 58 percent of men in the community survey thought that there was less discrimination in Botswana since the advent of ARV treatment.

Fear of Stigma or Discrimination

All community survey respondents were asked to project potential consequences if they were to test HIV-positive and disclose their status to others. Overall, men exhibited a higher level of projected fears than women.[43] Fifty percent of women and 57 percent of men thought they would be treated as a social outcast, 40 percent of women and men expected to lose friends

and 28 percent of women and 34 percent of men projected that they would be treated badly at work or school. Thirty percent agreed that testing positive would result in the break up of their marriage or relationships.

PLWA Experiences with Disclosure

PLWA interviewed reported that stigma and discrimination had lessened over time in Botswana, crediting this to the availability of ARV treatment and to the activism of PLWA. They reported positive experiences with disclosure of their status.

> *I told my elder sister and my mother. They accepted my status. They were upset to start but felt better about it when they knew that you can get well if you take the treatment.*

Nevertheless, PLWA reported that stigma and discrimination persist in Botswana, resulting in poor treatment at home, work and in the community, particularly for women. They attributed this to gender inequality, specifically, the expected norms of behavior that disenfranchise women, entrench gender stereotypes and sanctify male power and discriminatory attitudes towards women.

> *There is more stigma for women who are HIV positive. Some women are sex workers; people think if you have HIV, you are a prostitute.*
>
> *Women are valued less in our society. Men are the only ones making the decisions. The leaders in our country are all men.*

Sexual Practices: Risk-Taking and Risky Circumstances

Sexual behavior that increases the risk of HIV transmission — having multiple sexual partnerships and not using condoms in a correct and consistent manner — was prevalent among participants in the community survey. The findings suggest that targeting individual behavior change will have very limited success without taking into account the limited power of women to control sexual decision making and the entrenchment of gender norms that encourage risk-taking practices among men.

Women's Lack of Control

Eighty-nine percent of community survey participants reported having engaged in sexual intercourse. Of those sexually active,[44] 30 percent of women and less than 2 percent of men reported that their partner alone made the decision whether or not to have sex. Five percent of women and 31 percent of men agreed that they themselves alone made that decision. Regression analyses[45] confirm the association between lack of control over sexual decision making and sexual risk: women who reported that their partner usually or always decided whether or not to have sex had nearly two times the odds of having multiple partners as others surveyed.[46]

Multiple Sexual Partners

Multiple sexual partners (serial or concurrent) in the past year were reported by 25 percent of women and 40 percent of men.[47] Of those who had ever had sex, 8 percent of women and less than 5 percent of men reported not having a sexual partner in the past year.

Reasons for Unprotected Sex

Forty-six percent of sexually active community survey participants reported having sexual intercourse without a condom over the past year. Eleven percent of sexually active respondents had unprotected sex with a non-primary partner in the past year.[48] The most common reasons for unprotected sex were that the belief that condoms decrease sexual pleasure (46 percent of women and 69 percent of men); a partner's refusal (53 percent of women and 13 percent of men); and wanting to become pregnant (32 percent of women and men).

As the reasons suggest, women's lack of control was evident in reports of condom non-use. Fifty-three percent of women surveyed, compared with 13 percent of men, reported not using a condom in the past year in at least one instance because their partner refused; 22 percent of women, versus 7 percent of men, agreed that they had no control over whether their partner used a condom or not.

PLWA — Women's Experiences of Lack of Control and Unprotected Sex

PLWA reported that women's lack of control in sexual relationships and economic dependence on men underlie women's lack of autonomy in deciding whether to have sex.

> *I was given things in exchange for sex. I had trouble saying no to sex because he was supporting me. … After he gave me money, I felt I had to have sex.*

Similar coercive dynamics mitigate against condom use, even when a woman knows she may be at risk of HIV infection.

I trusted my husband; he did not know his status. My husband had other partners. He refused to use a condom. I could not say no. We fought because I said no to sex without a condom. He abused me physically because of this, and afterwards I was afraid to say no.

Several interviewees, female and male, had reduced their number of sexual partners and increased condom use after learning of their status. Women who reported no change said that they lacked control over sexual decision making. One 22 year-old woman, nine months pregnant, explained that she had reduced her number of partners but not changed her patterns of condom use because "If he refuses, I have no say."

Gender Norms and Beliefs and Vulnerability to HIV/AIDS

Gender discriminatory beliefs — accepting and reflecting women's inferior legal, cultural and socio-economic status — were held by a majority of those surveyed. Regression analyses demonstrate that these beliefs predict engagement in the sexual risk-taking that renders women and men vulnerable to HIV infection. PLWA experiences confirmed that the consequences of such beliefs are devastating, and the way forward lies in social, economic, legal and cultural reform. Such legal reform would find overt support among the majority of community survey participants.

Prevalence of Gender Discriminatory Beliefs and Beliefs in Women's Rights

Among community survey participants, 5 percent of women and 10 percent of men reported no discriminatory attitudes; 68 percent of women and 65 percent of men reported one to two such attitudes; and 26 percent of women and 25 percent of men reported three or more.[49] Each specific belief was held by a minority of those surveyed. For example, 19 percent of all community survey respondents agreed with the statement that it is more important for a woman to respect her spouse or partner than it is for a man to respect his spouse or partner. Where there were differences between responses of women and men, they were quite small or statistically insignificant.

Eighty-eight percent of women and 84 percent of men reported believing in equal rights for women in the legal sphere, pointing to a divergence between participants' attitudes and the existing legal system in Botswana. Ninety percent agreed that women should be legally entitled to inherit their husband's property or estate.

Associations of Discriminatory Beliefs with Sexual Risk-Taking

Analysis of the community survey data demonstrates that holding gender discriminatory attitudes is predictive of the sexual risk-taking that increases vulnerability to HIV. Participants who held three or more gender discriminatory beliefs had 2.7 times the odds of having unprotected sex in the past year with a non-primary partner as those who held fewer beliefs.[50] Certain specific beliefs were also associated with unprotected sex for women or men; for example, women who believed that a man may beat his spouse or partner if he believes she is having sex with other men had 2.8 times the odds of unprotected sex with a non-primary partner.[51]

PLWA — Women's Economic Dependence on Men

In interviews, PLWA highlighted women's dependency on male partners as the most significant contributor to women's greater vulnerability to HIV when compared to men. Testimony also revealed that women's lesser status in Botswana fosters ongoing harm to women even after they become infected, and moreover, increases the precariousness of their ability to meet basic needs for food, shelter and transport.

Most women depend on men. We started income generation projects, so women can tell men to 'go away' if they don't use a condom. Because if men go away [now], we will be eating our children tomorrow.

Failures of Leadership on HIV/AIDS

When asked general questions about the degree to which leaders had addressed the problem of HIV/AIDS in Botswana, 46 percent of women and 38 percent of men in the community survey did not believe that political leaders had done enough. Forty-seven percent of women and men reported that their own village chiefs had not done enough. Thirty-seven percent of participants did not believe that their church leaders had done enough.

PLWA interviewed gave mixed reports on leadership, and leaders as role models, for the HIV/AIDS response in Botswana.

...Some [leaders] are good and some are not. At a panel discussion last week in one village, few came. ...There is one chief who is very good, who knows what I am talking about when I talk about HIV. He likes each and every activity [that we do]. As a chief and a counselor, you have to be an example to the community.

Recommendations

To the Government of Botswana:

I. Comprehensively Advance Women's Human Rights and Address Violations

- Systematically end gender discrimination in marriage, inheritance, property and employment laws and harmonize laws with international human rights instruments.
- Strengthen and enact pending Domestic Violence Bill to end impunity for gender-based violence and ensure women have recourse and protection from violence in all its forms.
- Reform and strengthen the Women's Affairs Department by partnering with civil society organizations in the process of drafting the gender policy and the report to Committee on the Elimination of Discrimination against Women (CEDAW); support documentation of discrimination to inform policymaking and implementation of reforms.

II. Mitigate Poverty and Meet Basic Needs

- Expand existing aid programs to assist vulnerable populations, in particular PLWA and poor women, to meet basic needs for food sufficiency, potable water and irrigation, and shelter.
- Provide skills training and sustainable programs, directed at creating economic opportunities particularly for women, PLWA and families affected by HIV/AIDS.

III. Eradicate HIV/AIDS-Related Stigma and Discrimination and Assure PLWA Rights

- Adopt comprehensive legislation and policy addressing HIV/AIDS and employment, and strengthen enforcement of prohibitions against discrimination.
- Adapt a systematic and coordinated approach to public education, addressing key knowledge gaps in prevention, support and rights, including messages that address risk, vulnerability and fear of stigma directly and integrate gender concerns.
- Support those seeking testing with resources to overcome barriers such as lack of food or transport and with protection from discrimination and partner violence through guidelines and training of personnel.

To the US Government:

- Mandate that the Government ensure that the "3 Cs" (confidentiality, counseling and informed consent) are implemented and monitored in all HIV testing programs; provide technical assistance as necessary.
- In PEPFAR reauthorization legislation, clearly identify gender inequality as a key issue propelling the AIDS pandemic, and require that a gender focus be incorporated into PEPFAR-funded prevention, treatment and care programs. Increase PEPFAR's investment in programs that promote women's and girls' access to income and resources, support primary and secondary education for girls and strengthen women's legal rights.

To All Donors:

- Mobilize resources, including financial, informational and technical assistance to build skills and capacity in the Ministries, Attorney General's Office and Parliament to draft and implement gender reforms.
- Provide training, technical assistance and financial resources to women's organizations and other civil society actors to undertake advocacy, civic education and mobilization, and popular campaigns relating to women's rights.
- Support PLWA organizations and networks to increase their visibility and services by funding the expansion and coordination of national networks, training officers for NGOs and support capacity building for community mobilization efforts.

SWAZILAND
Country Background

Government, Population and Economy

Swaziland is the last absolute monarchy in Africa and the smallest country in the southern hemisphere, with a population of less than 1.14 million.[52] The King serves as head of state with legislative and judicial powers.[53] Political parties have been banned since the declaration of a state of emergency in 1973, though their current status is unclear.[54] It remains to be seen what political and civil liberties reforms will take place under the new Constitution which took effect in February 2006. The Swazi economy is one of stark inequity and widespread poverty; 69 percent of the population lives below the poverty line[55] and more than 80 percent practices subsistence farming.[56] The UN World Food Programme projects that it will provide food to 200,000 people in Swaziland in 2007.[57]

HIV Prevalence and AIDS Policies

Swaziland saw its HIV prevalence rise in a steep ascent over ten years, from 3.9 percent in 1992 to 38.6 percent

in 2002.[58] When this data was reported in 2004, Swaziland surpassed Botswana as the country with the highest HIV prevalence in the world.[59] The most recent surveillance, based on data collected in 2006, marks the first time that prevalence among pregnant women has decreased, from 42.6 percent in 2004 to 39.2 percent.[60]

In 1999 King Mswati III declared HIV/AIDS a national disaster.[61] The National Emergency Response Committee on HIV/AIDS (NERCHA) was created in 2001 to oversee and coordinate a comprehensive and multisectoral approach to managing the epidemic. By its own admission, however, Swaziland has been slow to ramp up and coordinate its HIV/AIDS response.[62] While the current (second) national strategic plan and its implementing policy include human rights, gender equality and equity as three of its guiding principles,[63] Swaziland has in the past failed to put into practice the laudatory language of its national policies. Program implementation has lagged and remained small-scale. The government undertook a controversial national prevention education campaign for the first time in 2006,[64] created a VCT network only over the past few years and launched a free ARV program in 2004. The latter has been plagued with problems regarding access and a sufficient supply of drugs.[65] Substantial donors to Swaziland include the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, the European Union and the United States.

Women's Rights

A dual civil and customary law system denying equal rights to women remains a powerful determinant of women's subordination to men and resultant gender inequity in Swaziland. Swazi women are economically disadvantaged as compared with men.[66] While the new Constitution contains some potential victories for women's human rights, including the right of women to be free from customs to which they are opposed,[67] the situation is unclear pending the passage of implementing laws and clarification through test cases in the courts.[68] It is also uncertain as to whether widespread popular education efforts will be promulgated, and with sufficient strength, to address the unequal status of women in Swazi law and society. Swaziland has yet to approve a national gender policy, though it has several gender focal points in government ministries charged with drafting programs and mainstreaming gender issues.[69] Though a small and politically repressive country, Swaziland has a vibrant civil society working to promote the rights and concerns of women and PLWA and to establish democratic governance.

PHR Study Findings

Participant Characteristics[70]

Half of the 788 individuals in the community survey sample were women, and the mean age was 29 years. A greater proportion of women than men reported low incomes (90 versus 84 percent), one or more dependents (72 versus 62 percent), not completing high school (64 versus 52 percent) and food insufficiency in the past year (38 compared with 29 percent). Of the food insufficient, 65 percent reported that food or water shortages had affected their health care decisions; 82 percent said that these shortages had affected their ability to support dependents; and 85 percent reported that shortages had made them economically dependent on someone else.

Fifty-seven percent of women and 47 percent of men were either married or living with a sexual partner. A quarter of marriages were polygamous. Slightly more than half of participants were urban residents.

Forty-five of the 58 PLWA interviewed were women and the mean age was 34 years.[71] Forty-eight reported that they had been affected by lack of food or water at some point and 36 reported hunger as a consequence. Forty were urban residents. Thirty-two were married or living with a sexual partner, 3 were in polygamous marriages and 12 had been widowed in their lifetime. Nearly all had one or more dependents and 40 had not completed high school. Forty-three were receiving some form of care and treatment for AIDS, most commonly ARVs (33 individuals)[72] or food/food supplements (17 interviewees).

Gaps in HIV Knowledge

Eighty-one percent of community survey participants scored as having correct knowledge based on their responses to survey questions, with no statistically significant differences overall between women and men.[73]

Almost all respondents (98 percent) in the community survey understood that HIV could be transmitted by sexual intercourse without a condom and that using a condom correctly every time you had sex could prevent it (96 percent of women and 90 percent of men). Being faithful with one uninfected partner (91 percent) and abstinence (93 percent) were also identified as effective prevention methods. At the same time, a minority believed that HIV could be acquired through mosquito bites (34 percent) or sharing meals with an HIV-positive person (17 percent), and that praying (18 percent) or traditional medicine (7 percent) could prevent transmission.

PWLA interviewed suggested the possibility that people may have knowledge of HIV transmission and prevention but rely on myths to avoid or deny their own responsibility regarding the infection of others. Men's refusal to use condoms was described as subject to misinformation concerning their role in causing AIDS, stigmatized as something non-Swazi or not masculine, and derided as decreasing enjoyment of sex. Some of those interviewed suggested that these excuses stem from men's denial of their own HIV-positive status or wish to rationalize not testing in order to avoid having to change risk-taking behavior.

Experiences with HIV Testing and Barriers to Testing

HIV testing in Swaziland appears to hinge on psychological readiness, coupled with issues of access to testing. Fifty-nine percent of community survey participants reported access to testing, but 78 percent had not tested. More women (25 percent) than men (18 percent) had tested for HIV. Far outstripping other factors, the most common facilitator for testing was the desire to know one's HIV status. At the same time, many of those tested perceived some coercion associated with testing. The most common barrier to testing was lack of readiness to know one's status. PLWA similarly perceived themselves as self-motivated to test, by illness or by wanting to know their status. They suggested that lack of emotional capacity, fear of stigma and not wanting to change behavior underlie lack of readiness to test for men. Women's lack of personal autonomy and fear of blame from partners were reported as barriers specific to women.

Participants Tested

Of the 170 community survey participants who had tested, the most common facilitator reported was wanting to know their status (58 percent); the second most common reason was concern about a sexual contact (11 percent).[74] This likely reflects, at least in part, the lack of other facilitators in Swaziland, such as widespread media campaigns and universal ARV treatment.

Women's and men's experiences with HIV testing did not differ in statistically significant ways. While most tested voluntarily, 13 percent reported that they did not make the decision to test and 41 percent felt they could not refuse the test. Ninety-four percent of those surveyed found out their test results. Five percent reported ill treatment in the community related to testing and 4 percent that they regretted testing; 6 percent reported that someone learned their results from the testing center or doctor without their permission. Eighty-four percent received pre-test counseling and 75 percent post-test counseling. Seventy-three percent reported that their partner knew that they had tested; of these, 2 percent reported being hurt or threatened on account of this disclosure.

Participants Not Tested

For the 616 participants in the community survey who had not tested, the most commonly reported barriers to testing were not being ready to know their status (43 percent), not being sick (28 percent) and the believing that they had no risk of being infected (14 percent).

Several types of testing programs, including VCT, couples testing, mobile testing and routine (opt-out testing) were described to all community survey participants for their opinions of whether each would be appropriate for them and which would be best. More than half chose VCT as best (59 percent), followed by couples testing (27 percent); 8 and 6 percent, respectively, chose mobile or routine testing.

PLWA Experiences and Opinions Regarding Barriers to Testing

Of those interviewed, 29 were motivated to test by being sick and 24 by wanting to know their status. Half felt that physical access to testing was a problem in Swaziland, including lack of transportation and sufficient clinic hours and queues, and that there was a dearth of testing sites. Interviewees connected readiness to test and access:

> *There are not enough testing centers. Many people are waiting in line for the testing facilities. No one likes to wait in line. Even if you wanted to test, when you are in line, many things could come into your mind no matter how prepared you were to test. Then you would have time to think about your fears, and will not keep waiting in line.*

Forty-three of those interviewed reported that barriers to testing differ based on sex, and that men in particular were less willing to want to know their status. Participants identified lack of women's empowerment as a key barrier to testing for both sexes.

> *Women are afraid of their men; that is the main barrier for women. If they test, they can be hurt by their men who will blame them for the HIV. For men, it is pride that prevents them from testing. Men know that they can do whatever they want without consulting their wives. So they don't need to test if they don't want to.*

HIV- Related Stigma and Discrimination

HIV-related stigmatizing and discriminatory attitudes towards PLWA, and fear of being stigmatized for suspected HIV-positive status, were reported by the majority of community survey participants. While nearly all the PLWA interviewed had disclosed their status, hurtful and inequitable treatment was prevalent and coexistent with experiences of acceptance and support. By interviewees' accounts, female PLWA in particular suffered discriminatory treatment, the result of HIV-related stigma multiplied by gender inequity.

Stigmatizing/Discriminatory Attitudes

Sixty-one percent of women and men held at least one stigmatizing or discriminatory attitude toward people with HIV.[75] Certain attitudes may reflect incomplete knowledge about the transmission of HIV, for example, 27 percent that they would not buy food from an HIV-positive seller. Others appear to reflect social stigma or prejudice: that PLWA should not be able to marry or have an equal opportunity to serve in Parliament (19 percent) or should be denied jobs (10 percent) or property rights (8 percent).

Fear of Stigma or Discrimination

Women surveyed exhibited a higher level than men of projected fears of being stigmatized and experiencing discrimination should they test positive for HIV.[76] Some responses did not differ significantly based on sex: a majority of women and men expected to lose friends and be treated like a social outcast by their community and more than a third expected bad treatment at work or school. Greater proportions of women feared abandonment or violence from partners: 44 percent of women (versus 34 percent of men) feared the break up of their marriage or relationship and 27 percent of women (8 percent of men) predicted intimate partner abuse upon disclosure of the participant's HIV-positive status.

PLWA Experiences of Disclosure and its Consequences

PLWA interviews indicate that, despite many positive experiences with disclosure, stigma and discrimination persist as an unjust and demoralizing fact of life for Swazi PLWA. Fifty-five of the 58 interviewed said that they had told someone of their status, whether a sexual partner, parent or some other relative or close friend. Most reported positive consequences from telling others. Thirty-six reported receiving support from families, though achieved piecemeal or over time.

At the same time, 32 PWLA interviewed reported that, once their status was disclosed, they had experienced some form of stigma and social exclusion. Sixteen lost friends and 14 experienced poor or unequal treatment at school, work, hospitals or other public places.

> *I told my boss my status. He fired me. His excuse was that I am too sick, but really he did not want to work with someone who is HIV-positive.*

Twenty of the PLWA interviewed believed stigma and poor treatment were worse for HIV-positive women than for men in Swaziland. This situation was attributed to normative assumptions concerning sexual practices and gender roles that ascribed HIV-positive status to "bad women" and blamed and condemned them for "spreading" the virus.

> *Women tend to be discriminated against because it is assumed they became infected because they are promiscuous. But in men promiscuity is condoned in most circles.*

Sexual Practices: Risk-Taking and Risky Circumstances

Women's lack of autonomy and the entrenchment of social and cultural norms that encourage multiple sexual partnerships for men and facilitate unprotected sex come through clearly in the community survey results. While a majority of PLWA interviewed reported a reduction of risk-taking in their sexual practices after learning their status, women's experiences stood out for the persistent lack of control over sexual decision making they reported.

Women's Lack of Control

Eighty-eight percent of participants in the community survey reported ever having engaged in sexual intercourse. Forty percent of sexually active[77] women reported that their partner alone decided when to have sex, compared with 3 percent of men. Conversely, 47 percent of men, and only 5 percent of women, agreed that "I alone decide when I have sex."

Multiple Sexual Partnerships

Eight percent of women compared with 39 percent of men in the community survey reported having more than one sexual partner (serial or concurrent) in the past 12 months. Of those who had at least one partner in the past year, one percent of women and 21 percent of men reported having more than one partner (serial or concurrent) in the past month.

Reasons for Unprotected Sex

Among sexually active participants, 78 percent of women and 67 percent of men reported not using a condom at some time over the past year. Two percent of women, and 13 percent of men, said that they had engaged in unprotected sex with a non-primary partner in the past year.[78]

Eighteen percent of women, compared with 3 percent of men, reported that their partners had sole decision-making authority with respect to condom use. Thirty-four percent of women, compared with 4 percent of men report not being permitted to use a condom by a sexual partner at least once in the past year.

Abstinence

Forty-five percent of women surveyed and 40 percent of men reported that they were currently practicing abstinence in order to prevent HIV transmission.[79] Of those who ever had sex, however, 19 percent of women and 7 percent of men reported having no sexual partners in the past year and 20 percent of women and 17 percent of men reported no partners in the past month. Knowledge of the efficacy of abstinence, and desire to practice it, in contrast to actual experience of barriers such as lack of control or social pressure to have sexual partners may account in part for this discrepant response.

PLWA — Women's Lack of Autonomy

The link between women's lack of economic resources and sexual partnership choices came through clearly in the PLWA interviews.

> *Women are having sex because they are hungry. If you give them food, they would not need to have sex to eat.*

At the same time, 38 of 58 interviewees reported that there was social pressure on men to have multiple sexual partners.

> *Women have multiple partners because they need money. With men, it's Swazi pride that you can get any woman you want.*

PLWA interviewed reported that women often have little power to refuse sex to their partners, even in the context of long-term relationships, or to demand the use of condoms from a husband or boyfriend, even when they knew or suspected that he had multiple partners. Women who refused sex were beaten or accused of being unfaithful or prostituting themselves. Sixteen female PLWA interviewed, compared with none of the men, reported that they no control over the decision of whether or not to have sex in their current relationship(s).

> *When I'm about to have sex, it reminds me of my HIV status. I wouldn't want to have sex at all, but I can't refuse my husband.*

Fifty of those interviewed reported that learning their HIV status was a catalyst for a number of changes they regarded as positive, including reducing the number of sexual partners they had and increasing their use of condoms. Women, however, reported losing interest in sexual relationships or not being able to find a partner, or a partner with whom they felt comfortable disclosing their HIV-status or could successfully insist on condom use.

Gender Norms and Beliefs and Vulnerability to HIV/AIDS

A picture emerged from the community survey results of women and men endorsing social expectations of women's role as subservient to male sexual partners, ceding power in relationships to men and being primarily valued by childbearing as a measure of their worth in families. Holding discriminatory beliefs predicts sexual risk-taking. At the same time, a majority of survey participants believed in women's rights. The views of PLWA confirm that Swaziland's HIV/AIDS epidemic is rooted in unequal intimate relationships, norms and legal structures that disempower women in favor of men.

Prevalence of Gender Discriminatory Beliefs and Beliefs in Women's Rights

Ninety-seven percent of community survey participants held at least one gender discriminatory belief.[80] Sixty-one percent of women and 80 percent of men held 3 or more discriminatory beliefs and 24 percent of women, compared with 44 percent of men, held 6 or more.

At least one-third of men agreed that: 1) men should control significant decisions in relationships (33 percent); 2) it was more important for a women to respect her spouse or partner than for a man to do so (33 percent); 3) women should not insist on condom use if their partner refuses (35 percent); and 4) a man could marry a second wife if his current spouse does not bear children (36 percent). Fewer women, 17 to 27 percent, held these beliefs.

Support for women's rights was articulated by the majority of those surveyed. For example, 85 percent of women and 75 percent of men were in favor of women's non-discriminatory access to employment and 80 per-

cent of women and 63 percent of men endorsed property ownership for women.

Associations of Beliefs with Sexual Risk-Taking

In regression analyses, those surveyed who held 6 or more discriminatory attitudes had twice the odds of having multiple sexual partners than those who held less than 6.[81] Holding certain individual beliefs predicted sexual risk-taking. For example, women and men who felt that men should control decisions in relationships with women had more than 1.5 times the odds of having multiple sexual partnerships[82] and nearly twice the odds of having unprotected sex with a non-primary partner.[83] Conversely, beliefs in women's rights were associated with decreased odds of sexual risk: participants who agreed that women should be able to end relationships with men had 50 percent decreased odds of having unprotected sex with a non-primary partner than did those who disagreed.[84]

PLWA — Prevalence and Significance of Gender Inequality and Discrimination

Interviewees discussed the link between the lack of women's rights and women's, and men's, vulnerability to HIV.

> *Here in Swaziland, the husband is the one that bosses you around so there is nothing you can do without him. My rights lie with my husband. He decides whether we use condoms. I don't have a choice about prevention.*

Wife inheritance was one traditional discriminatory practice given as an example of this association.

> *When you have lost your husband, you have to take another husband in the family. For example, my husband died of HIV. I am supposed to marry his brother. I got a good counselor, and she advised me not to marry his brother.*

Failures of Leadership on HIV/AIDS

The need for mobilization of political will by the leadership in Swaziland to reform discriminatory legal and social structures, address the effects of poverty on vulnerable populations, educate the general public and, by their personal actions, set a good example to address the HIV/AIDS crisis in Swaziland, came through clearly in the surveys and interviews. Nearly half of participants voicing an opinion in the community survey found fault with each category of leader in every domain. National political leaders and chiefs were found lacking across the board by the majority of those surveyed. Criticism was levied in particular on national leaders (73 percent) and chiefs (89 percent) for not spending enough on HIV prevention and on all leaders, including the King (77 percent), for not setting a good example by their personal behavior.

In contrast to the poor marks (41-64 percent) given to leaders in terms of providing assistance to PLWA and others affected by HIV/AIDS, nearly all of those surveyed agreed that PLWA should receive food or other assistance from the government (98 percent). They also nearly universally supported income generation projects for HIV-positive women to decrease the impact of HIV/AIDS in Swaziland (98 percent).

Whereas 90 percent of participants in the community survey agreed that violence is an important contributor to the spread of HIV in Swaziland, more than half believed that chiefs (67 percent), national leaders (59 percent) and the King (57 percent) had not done enough to protect women and children from abuse, and 40 percent agreed that church leaders had not done enough.

PLWA — the Need for Urgent Action

PLWA interviewed discussed mixed feelings about leadership. They cited barriers to ARV treatment, such as inaccessibility in terms of distance and transport costs, long queues and drug shortages. More than half of interview participants commented on the dire nature of the situation.

> *I think the whole African nation will be cut in half by this. Of course I'm worried about the Swazi nation — the nation will die.*

Recommendations

To the Government of Swaziland:

Comprehensively Advance Women's Human Rights and Address Violations

- Systematically end discrimination in marriage, inheritance, property and employment laws, and harmonize laws with international human rights instruments, to ensure that women and men enjoy equal status under civil law and to enable women to have equal access to economic resources, such as credit, land ownership and inherited property.
- Enact domestic and sexual violence legislation to end impunity for gender-based violence and ensure women recourse and protection from violence in all its forms, including marital rape.

- Build capacity in the Attorney General's Office and the Gender Desk at the Ministry of Home Affairs.

II. Mitigate Poverty and Meet Basic Needs

- Mobilize donors, local organizations and farmers to assist vulnerable populations, in particular PLWA and poor women, to meet basic needs for food sufficiency, potable water and irrigation, and shelter.
- Undertake efforts to strengthen rural livelihoods, including providing land for communities and PLWA for both subsistence and commercial farming to improve nutrition and raise resources.
- Provide skills training and sustainable programs directed at creating economic opportunities particularly for women, PLWA and families affected by HIV/AIDS.

III. Eradicate HIV/AIDS-Related Stigma and Discrimination and Assure PLWA Rights

- Create a coordinated media campaign, including television and radio messages on prevention and testing, including messages that address risk, vulnerability and stigma directly and integrate gender concerns.
- Work with PLWA groups and other civil society organizations to create or adapt and widely disseminate information on prevention, testing and treatment.

To the US Government:

- Increase and sustain funding, including through USAID, for HIV/AIDS prevention, testing and treatment in Swaziland and assure that funded programs, including public education campaigns, promote women's rights and empowerment.
- In the short-term, increase funding to the World Food Programme; in the longer term, adopt policies and legislation that promote the local population's capacity for self-sufficiency in food production.

To All Donors:

- Mobilize resources, including financial, informational and technical assistance to build skills and capacity in the Ministries, Attorney General's Office and Parliament to draft and implement gender reforms.
- Provide training, technical assistance and financial resources to women's organizations, the PLWA network and organizations and other civil society actors to foster collaborations and undertake political advocacy, civic education and community mobilization.
- Increase food aid and aid for other basic needs, particularly to poor women and PLWA, including supporting food and farming initiatives and economic empowerment programs to foster local capacity.
- Assist the government to scale-up and monitor current HIV testing and ARV treatment programs.

Human Rights Obligations

Botswana and Swaziland have acceded to, signed or ratified international human rights instruments that prohibit the disparities and abuses documented in this report and safeguard human rights essential to the prevention, care and treatment of HIV/AIDS.[85] These include the International Covenant on Civil and Political Rights (ICCPR),[86] the International Covenant on Economic, Social and Cultural Rights (ICESCR),[87] the Convention on the Elimination of Discrimination Against Women (Women's Convention),[88] the Convention on the Rights of the Child,[89] the African "Banjul" Charter on Human and People's Rights[90] and the African Charter on the Rights and Welfare of the Child.[91]

Women's Inequality and Discrimination Against Women

International law requires the promotion of gender equality in every aspect of life. Legal equality[92] and legal capacity "identical to that of men and the same opportunities to exercise that capacity"[93] are explicitly required, and the rights to contract, administer property and have equal access to the justice system are singled out for special notice.[94] The Women's Convention also directs states to eliminate discrimination against women.[95] It obligates party states to modify their legal and cultural systems to comport with the principle of gender equality.[96] CEDAW, the monitoring body for the Women's Convention, has issued a General Recommendation that specifically speaks to the elimination of gender discrimination in the context of national AIDS policy, suggesting 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 ... ."[97]

This report documents numerous instances of gender inequality and discrimination. The 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 practices create, enforce and perpetuate legalized gender inequalities and support and allow discrim-

ination in all aspects of women's lives. The demographic profile of survey participants illustrates the various impacts of the inequitable situation of women, who are poorer and more food insufficient than men in both countries. The findings present strong evidence of how many women lack control over matters of sexuality and reproduction, including the decision whether to have sex or use condoms. This represents a failure to secure reproductive rights for women. The starkest evidence of persistent gender discrimination is the prevalence of gender discriminatory beliefs among participants in the community surveys. Furthermore, the predictive association of these beliefs with sexual risk bolsters the conclusion that the failure to promote rights for women corresponds to a failure of these governments to comply with the obligation to protect women, and men, from potential HIV infection, among other harms.

Discrimination Against PLWA

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."[98] The UN Commission on Human Rights has explicitly confirmed that health status, including HIV/AIDS, is a prohibited basis for discrimination.[99] The study findings demonstrate that discrimination on the basis of HIV status occurs in Botswana and Swaziland. The absence of legislation specifically protecting the rights of those living with HIV/AIDS, in addition to educational or other measures, speaks to the governments' failure to protect the rights of PLWA. As the study findings show, 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 charged with ensuring equality for those within its borders.

Failure to Progressively Realize the Right to Health

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."[100] 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."[101]

In General Comment 14 to the ICESCR, the UN Committee on Economic, Social and Cultural Rights (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.[102] 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.[103] Popular participation in all levels of decision-making regarding health is an aspect of the right,[104] which encompasses availability, accessibility, acceptability and quality.[105]

In many respects, for example the persistent food insufficiency, economic deprivation and gender inequality described previously, 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 an 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. 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.

Denial of the 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."[106] In General Comment 6, the Human Rights Committee, monitor of the ICCPR, stated that 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."[107]

It should be evident that the drivers and impacts of the HIV/AIDS epidemic detailed in this 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 correct information about HIV 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/AIDS. While both countries, and in particular Botswana, have taken steps to address the epidemic, for example by establishing testing and treatment programs, the study findings identified persistent gaps in these programs, as evidenced by the proportions of community respondents who had not tested for HIV. Moreover, survey participants in both countries identified their leaders' failure to take positive measures, as required by the ICCPR, to address the pandemic.

Donor States' and International Organizations' Obligations for International Assistance and Cooperation

Human rights obligations are not only borne by states to their own citizens. Under the human rights framework, third parties, including foreign donors, corporations, and international and inter-governmental organizations, also have obligations not to violate rights nor impede their realization, and to structure their aid policies and programs consonant with the protection of rights. 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.[108]

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 discussed here. 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 remedial interventions by the countries to address the human rights abuses that perpetuate the HIV/AIDS pandemic.

Conclusion

In the struggle to prevent HIV and alleviate the suffering caused by the AIDS pandemic, realization of human rights is imperative and essential, particularly for women who bear the brunt of the epidemic. Botswana and Swaziland, though different in many respects, are accountable for failing to meet many of the same human rights obligations. The study findings describe the deleterious impacts of gender inequality and discrimination, discrimination on the basis of HIV-positive status, failure to provide essential information and access to HIV testing and treatment, and the life-threatening consequences of the lack of adequate food to meet basic needs, particularly for women. Implementation of the recommendations outlined in this report will be challenging, requiring prioritization, resources and political will, but remedial actions are urgent and essential if women in Botswana and Swaziland are to gain control over their lives and freedom from the threat of HIV/AIDS.

Notes

[1] United Nations Development Programme. "High-Level Meeting on HIV/AIDS: Discussion Paper for the Round Table on Human Rights, Gender and HIV/AIDS: to be Convened by the United Nations Development Programme, the Office of the United Nations High Commissioner for Refugees, the United Nations Development Fund for Women and the Global Coalition on Women and AIDS." Fifty-ninth Session; Agenda Item 43. Available at:http://www.undp.org/hiv/docs/HR_and_gender_ENGLISH.pdf. Accessed May 5, 2006.

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

[3] Rao Gupta G. "Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How." Plenary Address, XIIIth International AIDS Conference. Durban, South Africa. July 12, 2000. [ICRW Website.] Available at: http://www.icrw.org/docs/Durban_HIVAIDS_speech700.pdf. Accessed January 24, 2007.

[4] Castro A, Farmer P. "Understanding and Addressing AIDS-Related Stigma: From Anthropological Theory to Clinical Practice in Haiti." *American Journal of Public Health*. 2005;95(1):53-59.

[5] Parker R, Aggleton P. "HIV and AIDS-Related Stigma and Discrimination: A Conceptual Framework and Implications for Action." *Social Science Medicine*. 2003;57(1):13-24.

[6] Rankin W et al. "The Stigma of Being HIV-Positive in Africa." *PLoS Medicine*, August 2005; 2(8):0703.

[7] World Health Organization. "Health Action in Crises." [WHO website.] 2005. Available at: http://www.who.int/hac/crises/international/safrica/en. Accessed November 19, 2005.

[8] [World Bank website.] Available at:http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20382855~pagePK:116743~piPK:36693~theSitePK:4607,00.html. Accessed April 27, 2006.

[9] *See* Whelan D. "Human Rights Approaches to an Expanded Response to Address Women's Vulnerability to HIV/AIDS." *Health and Human Rights*, 1997;3(1):21-36.

[10] Botswana HIV prevalence is 37.4 percent and Swaziland's is 39.2 percent, according to data from the most recent sero-surveillance surveys of women attending antenatal clinics in each country. *See* Botswana National AIDS Coordinating Agency. *Botswana 2003 Second Generation HIV/AIDS Surveillance*. 2003:26 and Swaziland Ministry of Health and Social Welfare. *Highlights of the 10th HIV Sentinel Surveillance Among Pregnant Women*. 2006:1.

[11] Southern Africa includes Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. Some lists also include Madagascar. "Health Action in Crises." [WHO website.] 2005. Available at: http://www.who.int/hac/crises/international/safrica/en. Accessed November 19, 2005. It is home to home to approximately 70 percent of all people living with HIV/AIDS, despite having only 2 percent of the world's population. "Health Profile: Southern Africa Region." [USAID website.] December 2004. Available at: http://www.usaid.gov/our_work/global_health/aids/Countries/africa/saregional.html. Accessed March 1, 2007.

[12] The Global Fund Website. "HIV/AIDS, Tuberculosis, and Malaria: The Status and Impact of the Three Diseases." 2005;8. Available at: http://www.theglobalfund.org/en/files/about/replenishment/disease_report_en.pdf. Accessed February 17, 2006; Sub-Saharan Africa encompasses 47 countries, including those in southern Africa. World Bank website. Available at: http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20382855~pagePK:116743~piPK:36693~theSitePK:4607,00.html. Accessed April 27, 2006.

[13] Participants were excluded if they did not meet the age criteria, had cognitive disabilities, did not speak either English or Setswana/siSwati, were not residents of the country or if there was inadequate privacy at any point to conduct the survey. Participants in the community survey were not asked to disclose their HIV status.

[14] The five districts were Gaborone, Kweneng East, Francistown, Serowe/Palapye and Tutume. These districts represent a population of 725,000 in the eastern corridor of the country, out of a population of 1.64 million.

[15] The four regions are Hhohho, Lubombo, Shiselweni and Manzini.

[16] All study instruments are in the Appendix.

[17] PLWA were excluded if they did not meet the same criteria as community survey participants.

[18] The exact words (translated if necessary) of participants are used as testimony in the findings, wherever possible, to give full expression to participants' ideas and narratives.

[19] This Board included individuals with expertise in public health, clinical medicine, bioethics, gender, HIV/AIDS and international human rights research, including the co-founder of a PLWA support group in Swaziland, faculty from the University of Swaziland and UN country representatives.

[20] *CIA World Factbook 2006*. Available at: https://www.cia.gov/cia/publications/factbook/geos/bc.html. Accessed February 23, 2007.

[21] Hope K. *From Crisis to Renewal: Development Policy and Management in Africa.* Leiden, The Netherlands: Brill; 2002; "Lessons from the Fastest-Growing Nation: Botswana?" *BusinessWeek*. Available at: http://www.businessweek.com/magazine/content/02_34/b3796629.htm. Accessed March 23, 2006.

[22] UNDP. Human Development Report 2006: *Beyond Scarcity: Power, poverty and the global water crisis.* Botswana Country Table. Available at: http://hdr.undp.org/hdr2006/statistics/countries/data_sheets/cty_ds_BWA.html. Accessed February 23, 2007.

[23] *CIA World Factbook 2006*. Available at: http://www.cia.gov/cia/publications/factbook/geos/bc.html. Accessed February 23, 2007.

[24] U.S. Department of State. "Background Note: Botswana." Available at: http://www.state.gov/r/pa/ei/bgn/1830.htm. Accessed March 23, 2006.

[25] In a 2004 national survey, just over a quarter of Batswana reported being tested for HIV. National AIDS Coordination Agency. *Botswana AIDS Impact Survey II.* 2004:45.

[26] Steen TW, Seipone K, de la Hoz Gomez F, Anderson M, Kejelepula M, Keapoletswe K, Moffat HJ. "Two and a half years of routine HIV testing in Botswana." *JAIDS*. January 4, 2007; In "opt-out" testing patients at clinic visits (generally, or for a defined subset of visits/criteria) are tested unless they explicitly refuse. In contrast, "opt-in" or "routine offer" testing refers to health worker-initiated testing to which the patient must give explicit informed consent. Based on PHR's information concerning the Botswana policy at the time of data collection, the following explanation was given to study participants: "Routine testing is a new approach to HIV testing announced in January 2004. It means that almost everyone who visits a health clinic or hospital will get a number of tests, including an HIV test, unless they say no to it." As Botswana has not conducted extensive monitoring of this intervention, the nature, extent and uniformity of the implementation of routine testing in Botswana remains unclear.

[27] Id., Steen TW, Seipone K, de la Hoz Gomez F, Anderson M, Kejelepula M, Keapoletswe K, Moffat HJ. January 4, 2007.

[28] This is the central HIV prevention philosophy of the US Government, which is highly influential throughout the region. "The President's Emergency Plan for AIDS Relief: Sexual transmission of HIV and the ABC approach to prevention." December 2005. US Department of State Slideshow. Available at: http://www.state.gov/documents/organization/58270.pdf. Accessed on February 21, 2006; Leading AIDS activists, including Stephen Lewis, the UN Special Envoy for AIDS in Africa, have criticized the ABC approach as ineffective and as a "one size fits all" epidemiologically-inappropriate intervention, imposed in contexts in which the practices of premarital abstinence and monogamous relationships are not available to many women. *See* Altman L. "US Blamed for Condom Shortage in Fighting AIDS in Uganda." *New York Times.* August 30, 2005; UNGASS Advocacy Brief. "Broken Promises: The US Response to the UNGASS Declaration of Commitment on HIV/AIDS 2001." April 2006. Available at: http://72.14.203.104/search?q=cache:lpWRtsTLFSwJ:www.ungasshiv.org/index.php/ungass/content/download/1642/17802/file/United%2520States.pdf+PEPFAR+monetary+committment&hl=en&gl=us&ct=clnk&cd=10. Accessed May 8, 2006.

[29] "A Model for Combating AIDS." *IRIN.* May 28, 2003. Available at: http://www.irinnews.org/pnprint.asp?ReportID=2089. Accessed on September 17, 2005.

[30] Abolition of Marital Power Act.

[31] There is a draft Statute Law (Miscellaneous Amendments) that seeks to align various statutes with the Abolition of Marital Power Act.

[32] Datta E. *Beyond Inequalities: Women in Botswana*. WIDSAA. 1998; Hurlburt H. *Botswana's Strategy to Combat HIV/AIDS*. CSIS Task Force on AIDS. 2004.

[33] Phaladze N and Ngwenya B. "Women Social Statuses, Customs and Traditions in Contemporary Tswana Society." in Kaye, Sylivia, Machacha, Lilybert and Maundeni, Tapologo (eds.) *Gender: Opportunities and Challenges, 1st National Conference of the Gender Policy and Programme Committee*, University of Botswana, October 22-24; Associated Printers, Gaborone: September 2002.

[34] UNDP Gender Programme. *Country Profile: Botswana*. Available at: http://www.unbotswana.org.bw/undp/gender_country.html. Accessed September 30, 2005.

[35] UNFPA and Population Reference Bureau. *Country Profiles for Population and Reproductive Health, Policy Development and Indicators 2005.* Available at: http://www.unfpa.org/profile/botswana.cfm. Accessed January 29, 2007.

[36] Warioba C. "The role of national mechanisms in promoting gender equality and the empowerment of women: SADC experience." United Nations Division for the Advancement of Women (DAW). *The role of national mechanisms in promoting Gender equality and the empowerment of women: Achievements, gaps and challenges,* 29 November 2004 - 2 December 2004, Rome, Italy; UN Doc. EGM/National Machinery/2004/EP.8; 31 January 2005:10.

[37] UNDP. *Gender Programme: Country Profile*. Available at: http://www.unbotswana.org.bw/undp/gender_country.html. Accessed September 24, 2005.

[38] Throughout this report, sex-stratified data is only presented where sex differences were statistically significant (p←0.05).

[39] Participants were asked 15 questions about HIV transmission and prevention, based on questions modified from the UNAIDS General Population Survey and the DHS (demographic health survey) AIDS module. See http://www.emro.who.int/gfatm/guide/tools/dhsaids/dhsaids.html. Using the UNAIDS knowledge indicator scoring system, individuals were scored as having correct HIV knowledge if they correctly identified the two most common modes of HIV prevention in Botswana (consistent condom use and abstinence).

[40] Respondents could agree with more than reason in identifying facilitators and barriers in their experiences of testing.

[41] Steen TW, Seipone K, de la Hoz Gomez F, Anderson M, Kejelepula M, Keapoletswe K, Moffat HJ. "Two and a half years of routine HIV testing in Botswana". *JAIDS*. January 4, 2007.

[42] Respondents were asked 7 questions adapted from the UNAIDS general population survey and the DHS (demographic health survey) AIDS module. Following the UNAIDS scoring system, any participant who reported a stigmatizing or discriminatory attitude on any of 4 principal questions was categorized as having such attitudes.

[43] Based on survey responses, PHR created a 9-item index on "projected HIV stigma" with higher scores on a continuous scale of 0-9 associated with a greater number of reported adverse social consequences associated with testing positive. The mean score for men was 2.04 (plus/minus a standard deviation of 2.1) and for women it was 1.67 (+/- 1.8), a statistically significant difference.

[44] "Sexually active" is defined as having had at least one sexual partner in the past 12 months.

[45] This association was also statistically significant for men reporting lack of control. Analyses were adjusted for other participant characteristics: age, monthly income, marital status, residency location, fair or poor health status, frequency of visits to a medical doctor, alcohol use, HIV testing, HIV knowledge, HIV-related stigma, a positive screen for depression and experience of an intergenerational sexual relationship.

[46] Adjusted odds ratio (AOR): 1.79, 95 percent confidence interval (CI) (1.12-2.86).

[47] Thirteen percent of women and 19 percent of men reported having more than one partner in the past month.

[48] Unprotected sexual intercourse with a non-primary partner is the traditional indicator or predictor of high-risk sexual practices (a practice likely to lead to HIV transmission). A non-regular sexual partner is likely to be non-monogamous and HIV status is less likely to be disclosed between such partners.

[49] This variable was constructed from responses to 14 statements, including affirmative responses to 6 items expressing discriminatory beliefs, negative responses to 2 items endorsing women's rights and 3 pairs of variables expressing different expectations concerning the roles of women and men.

[50] 95 percent CI (1.01-7.1).

[51] 95 percent CI (1.22-6.61).

[52] *CIA World Factbook 2006*. Available at: http://www.cia.gov/cia/publications/factbook/geos/wz.html. Accessed February 15, 2007.

[53] The Constitution of the Kingdom of Swaziland Act (2005).

[54] Political parties are not mentioned as protected in Chapter 4, Article 26, Section 4a of the Constitution; however, some experts believe there is a basis for legalization under the new freedoms of speech and assembly. See "Politics Makes a Tentative Comeback." *IRIN*. August 9, 2006. Available at: http://www.irinnews.org/report.asp?ReportID=55058&SelectRegion=Southern_Africa&SelectCountry=SWAZILAND. Accessed October 4, 2006.

[55] UNDP. *Millennium Development Goals Country Report: Swaziland*. 2003:6. Available at: http://www.undp.org.sz/documents/mdg-part1.pdf#search=%22Swaziland%20Income%20and%20Expenditure%20Survey%2C%202002%22. Accessed October 4, 2006.

[56] *CIA World Factbook 2006*. Available at: http://www.cia.gov/cia/publications/factbook/geos/wz.html. Accessed February 15, 2007.

[57] World Food Programme. *Projected Needs for WFP Projects and Operations Swaziland.* Available at: http://www.wfp.org/country_brief/indexcountry.asp?country=748 Accessed February 15, 2007.

[58] Swaziland Ministry of Health and Social Welfare. *Highlights of the 10th HIV Sentinel Surveillance Among Pregnant Women*. December 2006:2.

[59] "World's Highest Rate of HIV Infection." *IRIN*. March 19, 2004. Available at: http://www.aegis.com/news/irin/2004/IR040333.html. Accessed October 27, 2005.

[60] Swaziland Ministry of Health and Social Welfare. *Highlights of the 10th HIV Sentinel Surveillance Among Pregnant Women*. December 2006.

[61] Hall J. *Life Stories: Testimonies of Hope from People with HIV and AIDS*. UNICEF; 2002:v.

[62] NERCHA. Report of the Joint Review of the National Response to HIV and AIDS in Swaziland. March, 2005.

[63] The Government of the Kingdom of Swaziland. The National Multisectoral HIV and AIDS Policy. June 2006. Available at: http://www.nercha.org.sz/public.html?FrameLoad=100. Accessed September 26, 2006.

[64] "Anti-AIDS Text Messaging Campaign Raises Hackles." *IRIN*. July 21, 2006. Available at: http://www.irinnews.org/report.asp?ReportID=54748&SelectRegion=Southern_Africa&SelectCountry=SWAZILAND. Accessed September 8, 2006; "'Illicit SMS' Swaziland Aids Campaign sparks furor." *The Mail & Guardian*. August 10, 2006. Available at: http://www.mg.co.za/articlepage.aspx?area=/breaking_news/breaking_news__africa/&articleid=280351. Accessed September 8, 2006.

[65] For example, see "Hospitals Run out of ARVs." *IRIN*. November 18, 2005. Available at: http://www.irinnews.org/report.asp?ReportID=50180&SelectRegion=Southern_Africa&SelectCountry=SWAZILAND. Accessed December 23, 2005.

[66] Swazi women earned an estimated PPP (purchasing power parity) of US$2,576 per year in 2004, 29 percent of men's income. UNDP. Human Development Report 2006: *Beyond Scarcity: Power, poverty and the global water crisis.* Swaziland Country Table. Available at: http://hdr.undp.org/hdr2006/statistics/countries/data_sheets/cty_ds_SWZ.html. Accessed February 23, 2007.

[67] The Constitution of the Kingdom of Swaziland Act, (2005), Ch. III, sec. 28(3).

[68] Personal communication with Women and Law in Southern Africa Research Trust (WLSA), September 6, 2006, and with Amnesty International, January 19, 2007.

[69] Warioba C. *The Role of National Mechanisms in Promoting Gender Equality and the Empowerment of Women: SADC Experience*. United Nations Division for the Advancement of Women. 2005.

[70] Throughout this report, sex-stratified data is only presented where sex differences were statistically significant (p←0.05).

[71] Given that the vast majority of respondents were female, the data for Swazi PLWA is presented as a total sample, rather than disaggregated by sex.

[72] Of the 23 PLWA not receiving ARVs, 16 reported that they had CD4 counts too high to qualify for treatment and one said that s/he was "not sick".

[73] Participants were asked 11 questions about HIV transmission and prevention, based on questions modified from the UNAIDS General Population Survey and the DHS (demographic health survey) AIDS module. See http://www.emro.who.int/gfatm/guide/tools/dhsaids/dhsaids.html. Using the UNAIDS knowledge indicator scoring system, individuals were scored as having correct HIV knowledge if they correctly identified the two most common modes of HIV prevention in Swaziland (consistent condom use and abstinence).

[74] Respondents could agree with more than reason in identifying facilitators and barriers in their experiences of testing.

[75] Respondents were asked 7 questions adapted from the UNAIDS general population survey and the DHS (demographic health survey) AIDS module. Following the UNAIDS scoring system, any participant who reported a stigmatizing/discriminatory attitude on any of 4 principal questions was categorized as having such attitudes.

[76] Based on survey responses, PHR created a 9-item index on "projected HIV stigma" with higher scores on a continuous scale of 0-9 associated with a greater number of reported adverse social consequences associated with testing positive. The mean score for women was 2.80 (plus/minus a standard deviation of 2.07) and for men it was 2.46 (+/-1.86), a statistically significant difference.

[77] "Sexually active" is defined as having at least one sexual partner in the past 12 months.

[78] Unprotected sexual intercourse with a non-primary partner is the traditional indicator or predictor of high-risk sexual practices (a practice likely to lead to HIV transmission). A non-regular sexual partner is likely to be non-monogamous and HIV status is less likely to be disclosed between such partners.

[79] Abstinence was defined as "not having sex at all, as a way to prevent yourself or others from becoming infected with HIV/AIDS."

[80] This variable was constructed from responses to 22 statements, including affirmative responses to 12 items expressing discriminatory beliefs, negative responses to 6 items endorsing women's rights and 2 pairs of variables expressing different expectations concerning the roles of women and men.

[81] AOR: 1.99, 95 percent CI (1.17-3.39) for the whole sample (N=768) and AOR: 2.40, 95 percent CI (1.29-4.47) for men only (N=386). For all models, the odds ratio was adjusted for sex, age, education level, monthly household income, food insufficiency, marital status, residency location, HIV knowledge, HIV-related stigma and fears of HIV-related stigma.

[82] AOR: 1.56; 95 percent CI (1.04-2.32).

[83] AOR: 1.87; 95 percent CI (1.02-3.43).

[84] AOR: 0.50; 95 percent CI (0.28-0.90).

[85] Both countries are also bound by the principles and policies of several declarations and conference documents relevant to the findings of the study. These include the Declaration of Commitment on HIV/AIDS, the Declaration on the Elimination of Violence Against Women and the Beijing Declaration and Platform of Action.

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

[87] Available at: http://www.ohchr.org/english/law/cescr.htm. Accessed March 27, 2007. Swaziland has acceded to the ICESCR; Botswana has taken no action to bind itself to the Covenant.

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

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

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

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

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

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

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

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

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

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

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

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

[100] ICESCR, Article 12(1).

[101] 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.

[102] ICESCR General Comment 14(3).

[103] ICESCR General Comment 14(4).

[104] ICESCR General Comment 14(11).

[105] ICESCR General Comment 14(12).

[106] ICCPR, Article 6(1).

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

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