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**PHR**

Physicians for  
Human Rights

# Epidemic of Inequality

**Women's Rights and HIV/AIDS  
in Botswana & Swaziland**

An Evidence-Based Report on the Effects of  
Gender Inequity, Stigma and Discrimination

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An Evidence-Based Report on the Effects of  
Gender Inequity, Stigma and Discrimination

A Report by Physicians for Human Rights

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Cambridge, Massachusetts  
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Printed in the United States of America  
ISBN: 1-879707-51-9  
Library of Congress Control Number: 2007928206  
Design: Glenn Ruga/Visual Communications

# PHYSICIANS FOR HUMAN RIGHTS

**P**hysicians for Human Rights (PHR) mobilizes health professionals to advance health, dignity, and justice and promotes the right to health for all.

Since 1986, PHR members have worked to stop torture, disappearances, and political killings by governments and opposition groups and to investigate and expose violations, including: deaths, injuries, and trauma inflicted on civilians during conflicts; suffering and deprivation, including denial of access to health care caused by ethnic and racial discrimination; mental and physical anguish inflicted on women by abuse; exploitation of children in labor practices; loss of life or limb from landmines and other indiscriminate weapons; harsh methods of incarceration in prisons and detention centers; and poor health stemming from vast inequalities in societies.

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As one of the original steering committee members of the International Campaign to Ban Landmines, PHR shared the 1997 Nobel Peace Prize.

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# GLOSSARY

## Definitions

**Agency:** Having the empowerment and authority to make decisions and act on one's own behalf.

**Batswana:** Persons from Botswana (plural of Motswana).

**Discrimination:** Unfair or bad treatment directed at those who belong to, or are perceived as belonging to, a marginalized group, such as women or people living with HIV or AIDS. Discrimination reinforces social stereotypes and inequities and, for populations marginalized on more than one basis (for example, women living with HIV/AIDS), it has a harmful multiplicative effect.<sup>1</sup> Discrimination based on "race, color, sex, language, religion, political or other opinion, natural or social origin, property birth or other status" is prohibited under international human rights law.<sup>2</sup>

**Food Insecurity:** The condition of not having a quantity of food available to meet the hunger or nutritional needs of an individual at any time in the past 12 months.

**Gender:** A social and cultural construct; the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics, roles and relationships.<sup>3</sup>

**Hunger:** The uneasy or painful sensation caused by the lack of food.

**Routine Testing:** In general, HIV testing in the context of a health services visit for primary care or other routine clinical care, such as antenatal appointments. Routine testing can be "opt-out" (health worker-initiated testing which is done unless the patient refuses) or "opt-in" (testing to which the patient affirmatively consents). This is a broad policy category encompassing many definitional variables, including the existence or types of symptoms presented by the patient, the national context (HIV prevalence and treatment availability, for example) and standards for counseling and informed consent. The chief distinction is with voluntary counseling and HIV testing (VCT), which takes place in a stand-alone facility created exclusively for the purpose of HIV testing, and in some contexts, follow-up AIDS treatment or other HIV-related care.

**Sex:** A biological category, defined by characteristics related to reproduction (e.g., male or female).

**Sexual Risk-Taking:** Practices or circumstances that are likely to expose an individual to the risk of HIV transmission through sexual intercourse; markers or predictors for sexual intercourse without a condom with a person infected with HIV. These include having multiple sexual partners, having a relationship with an older and more experienced partner ("intergenerational relationships") where the younger partner is also likely to lack control over condom use and other aspects of the relationship, and other intimate relationships where the partner, and not the individual herself, makes decisions regarding sexual matters ("lack of control").

**Stigma:** A loss of status and the social sanctioning of prejudice, domination and inequity based on membership in a particular group.<sup>4,5</sup> Stigma arises when a community or authority links social differences to negative stereotypes and categorizes these "others" as different from and inferior to themselves. HIV-related stigma developed out of an early association of AIDS with already marginalized populations — the poor, ethnic minorities, women, men who have sex with men, sex workers and IV drug users — as well as the association of AIDS with death.<sup>6</sup>

**Southern Africa:** This region includes Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. Some lists also include Madagascar.<sup>7</sup>

**Sub-Saharan Africa:** This region encompasses forty-seven countries including the southern African countries.<sup>8</sup>

**Vulnerability:** The risk of being exposed to HIV infection, including due to social factors and determinants in the external environment which are beyond an individual's control. Women and girls are a population group with an elevated vulnerability to HIV infection as a result of unequal gender relations and entrenched gender inequity and sex discrimination.<sup>9</sup>



## Acronyms

**ACHPR:** African “Banjul” Charter on Human and Peoples’ Rights

**ACRWC:** African Charter on the Rights and Welfare of the Child

**AIDS:** Acquired Immune Deficiency Syndrome

**AOR:** Adjusted odds ratio

**ARV:** Anti-retroviral

**CEDAW:** Committee on the Elimination of Discrimination against Women

**CHR:** UN Commission on Human Rights

**CI:** Confidence interval

**CRC:** Committee on the Rights of the Child

**CSO:** Civil society organization

**GDP:** Gross domestic product

**HIV:** Human Immunodeficiency Virus, the cause of AIDS

**ICCPR:** International Covenant on Civil and Political Rights

**ICESCR:** International Covenant on Economic, Social and Cultural Rights

**NACA:** National AIDS Coordinating Agency (Botswana)

**NERCHA:** National Emergency Response Council on HIV/AIDS (Swaziland)

**NGO:** Non-governmental organization

**PEPFAR:** (United States) President’s Emergency Plan for AIDS Relief

**PHR:** Physicians for Human Rights

**PLWA:** People living with HIV or AIDS

**PMTCT:** Preventing mother-to-child transmission

**PPACHPR:** Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa

**SADC:** Southern African Development Community

**TCM:** Total Community Mobilization

**UDHR:** Universal Declaration of Human Rights

**UNAIDS:** The Joint United Nations Programme on HIV/AIDS

**UNDP:** United Nations Development Programme

**UNFPA:** United Nations Population Fund

**UNICEF:** United Nations Children’s Fund

**VCT:** Voluntary counseling and HIV testing

**WFP:** World Food Programme

**WHO:** World Health Organization

**WLSA:** Women and Law in Southern Africa Research Trust

# ACKNOWLEDGEMENTS

This report was written and edited by Karen Leiter, JD, MPH, Senior Research Associate, Physicians for Human Rights (PHR) with substantial contributions by Amy Senier, joint Masters/JD student at the Fletcher School of Law and Diplomacy and Northeastern University Law School (Botswana and Swaziland Backgrounds, Human Rights Framework); Lynley Rappaport, MPH, Consultant, PHR (Botswana and Swaziland Backgrounds and Study Findings); Leonard Rubenstein, JD, Executive Director, PHR (Executive Summary); Vincent Iacopino, MD, PhD, Senior Medical Advisor, PHR (Human Rights Framework); and Ingrid Tamm, MS, Consultant, PHR (Botswana Study Findings).

Contributions to the Botswana community survey analysis were drawn from draft manuscripts by Sheri Weiser, MD, MPH, Epidemiology and Prevention Interventions Center and Center for AIDS Prevention Studies (CAPS), University of California, San Francisco. The PLWA testimony was drawn from written analyses prepared by Fiona Percy-de Korte, MBA, DPh, Consultant, PHR (Botswana) and David Tuller, Consultant, PHR (Swaziland) and from PLWA data analysis contributed by William Wolfe, MD, Department of Psychiatry, University of California, San Francisco (Swaziland). Key informant interview analysis for Swaziland was contributed by Ms. Senier. The authors are grateful to the participants in the Gender and HIV Workshop, co-sponsored by PHR and the Centre for the Study of AIDS at the University of Pretoria, South Africa, 15-17 November, 2006, for their contributions to the report recommendations. The authors thank Kate Krauss, Health Action AIDS Media Relations Coordinator, PHR, for her contribution to the US recommendations. The authors also thank the Gender and PEPFAR Working Group of the Global Health Council for sharing their draft recommendations for PEPFAR reauthorization.

A background chapter on HIV/AIDS in Southern Africa [available on the PHR website, [www.physiciansforhumanrights.org](http://www.physiciansforhumanrights.org)] was written and edited by Ms. Leiter with Ms. Senier, Ms. Rappaport, Mr. Tuller and Madhavi Dandu, MD, MPH, Division of General Medicine, Department of Internal Medicine, University of Michigan. Dr. Weiser reviewed the chapter.

The report is based on a study conducted by Ms. Leiter, Dr. Weiser, Dr. Percy-de Korte and (in Botswana) Nthabiseng Phaladze, PhD, RN, Department of Nursing Education, University of Botswana and (in Swaziland) Zakhe Hlanze, MA, Women and Law in Southern Africa Research Trust — Swaziland (WLSA), Mr. Tuller and Dr. Wolfe, and local field researchers. The authors are very grateful for the hard work and dedication of these local researchers. In Botswana: Tefo Atholang, Lillian Buzwani, Bettsally Chemutai, Diane, Elton Katlholo, Lesley Kentse, Bonolo Kgabaetsile, Sellah Lusweti, Onneetse Makhumalo, Victor Makwati, Mpho Masale, Jobela Masole, Kaone Matswiki, Khumo Mokane, Lebogeng Mokhure, Duduetsang Molephe, Obonye Monamati, Geoffrey Nkoro, Matshidiso Nthela, Kelebile Nthomiwa, Onkabetse Obe, Mpho Kennedy Okopeng, Frank Radebe, Kgalalelo Seanana, Rachel Taukobong and Kagiso Tlhalogang.

In Swaziland: Cebile Dlamini, Khangezile Dlamini, Lungile Dlamini, Sakhile Dlamini, S'bongile Dlamini, Sindi Dube, Gugu Gumedze, Nondumiso Hlanze, Thobile Khumalo, Lwati Manana, Cebile Manzini, Sikelela Mazibuko, Sibonelo Mdluli, Philile Mlotshwa, Sithembiso Nhlengethwa, Hlobisile Nkambule, Nomakhosi Nxumalo, Bonginkosi Sengwayo, Dumsani Sithole, Jabulile Tsabedze and Phumelele Thwala.

The authors also thank the drivers: Joe Ramhago, Paul Letshotelo and Enoch Ngwenga (Botswana), Mazoco Dlamini and Samuel Gama (Swaziland).

Many individuals assisted with the realization of the two investigations. The authors would like to thank the following individuals and organizations for their contributions to the study design and/or support for implementation of the fieldwork in Botswana: Sheila Tlou, PhD, former HIV/AIDS Coordinator, University of Botswana; Dr. David Bangsberg, CAPS, University of California, San Francisco; Christine Stegling, Executive Director, Botswana Network on Ethics and Law (BONELA); David Ngele, Executive Director and the staff of the Botswana Network of People Living with HIV/AIDS (BONEPWA); the Centre for Youth of Hope (CEYOH); the Coping Centre for People Living with HIV/AIDS (COCEPWA); Dr. Ibou Thior, Project Director, Botswana Harvard AIDS Institute Partnership (HAI); Dr. Howard Moffat, Princess Marina Hospi-

tal; Dr. Banu Khan, former National Coordinator, National AIDS Coordinating Agency (NACA); Elaine Kabogo, NACA; Dr. Agathe Latre-Gato Lawson, United Nations Population Fund (UNFPA) Representative (Botswana); Dr. Peter Kilmarx, Todd Kopenhagen, Marion Carter and Dawn Smith, The BOTUSA Project; Deborah Stanford, African Comprehensive HIV/AIDS Partnership (ACHAP); and Dr. Diana Dickinson, the Independence Surgery. The authors are grateful to Shenaaz El-Halabi and the Health Research Unit at the Ministry of Health for granting permission to conduct the study in Botswana and to Dr. Thior for facilitating the ethics review process.

The authors are especially grateful to Minnehy Mukoma for acting as administrative assistant to the field study in Botswana. The authors are indebted to Dr. Vijai Dwivedi, Botswana Central Statistics Office, for the sampling frame for the Botswana community survey and to Mr. Mabaka and Tutu of the Cartography Section of the Census Office, Ministry of Finance and Development Planning, for providing maps.

In Swaziland, the authors thank Swaziland for Positive Living (SWAPOL); Swaziland AIDS Support Organisation (SASO); Swaziland Infant Nutrition Action Network (SINAN); Pilot Operational Research and Community Based Project (PORECO); Women Together; the International Community of Women Living with HIV/AIDS, and Swaziland Network of People Living with HIV/AIDS (SWANNEPHA) for assisting with recruitment for the PLWA interviews.

The authors especially thank Sibongile Maseko, MPH, formerly with the United Nations Development Programme (UNDP) Swaziland, for her contributions to the study design and implementation; Lomcebo Dlamini, Acting Coordinator, WLSA; Sipiwe Hlophes, Director, SWAPOL, and Tenele Dlamini, WLSA, for acting as administrative assistant to the field study. The authors thank Dr. Lawson, Non-Resident UNFPA Representative (Swaziland); Lynne Lackey, PhD, former Fulbright Lecturer at the University of Swaziland; Professor George Vukor-Quarshie, University of Swaziland, and Rudolph Maziya, National Coordinator of the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL), for early guidance and support.

The authors are grateful to Choice Ginindza, Statistician and Head of the Agriculture Statistics Unit, Swaziland Central Statistics Office (CSO), for his work creating the Swaziland community survey sampling frame, and to Gerald Dlamini of the CSO for providing census maps.

Drs. Nonhlanhla Sukati, Mildred Mkhabela and Murmly Mathunjwa of the Department of Community Health Nursing and the General Nursing Program, Fac-

ulty of Health Sciences, University of Swaziland, assisted with piloting and adaptation of the community survey in Swaziland.

The authors thank Dr. LT Kanya, Deputy Director, Health Services, Swaziland Ministry of Health and Social Welfare, for ethics review and Patricia Thuli Mngadi, National Programme Officer, United Nations Population Fund (UNFPA) Swaziland, for assisting with this process.

Chen Reis, JD, MPH, former PHR Senior Research Associate, Lynn Amowitz, MD, MSPH, MSc; former PHR Senior Medical Researcher, Claire Beiser, MD; Ms. Leiter; Dr. Weiser; Dr. Percy-de Korte; Dr. Phaladze; Dr. Tlou, and Dr. Iacopino were pivotal to the conception and development of the project. Michele Heisler, MD, MPA, Division of General Medicine, Department of Internal Medicine, University of Michigan contributed to the project design and community survey development, and Dr. Heisler and Sonya DeMonner, MPH, Consultant, PHR, analyzed the community survey data. The authors thank Mechelle LeFleur, Michelle Schaan, Jill Baker and Jodi Talley for data entry for the community surveys.

The authors thank the following PHR interns for contributing literature reviews, desk research and/or data analysis to the report: Jutta Bosch, Philip Kellmeyer, Megan Bremer, Tali Averbuch, MPP, and Jeremy Goldberg. Jessica Cole, PHR Research Assistant, provided research updates. The authors are grateful to Uyapo Ndadi of BONELA for updating the section on women's legal status in Botswana.

The report was reviewed (all or in part) by: Mr. Rubenstein; Susannah Sirkin, MEd, PHR Deputy Director; Gina Cummings, PHR Deputy Director for Operations; Alicia Ely Yamin, JD, MPH, PHR Director of Research and Investigations; Barbara Ayotte, PHR Director of Communications; Nancy Marks, PHR Director of Outreach; Gina Copton-Newfield, PHR Health Action AIDS Campaign Director; Eric Friedman, JD, PHR Senior Global Health Policy Advisor; Frank Davidoff, MD, PHR Board Member; Justice Richard Goldstone, PHR Board Member; Ronald Waldman, MD, MPH, PHR Board Member; Dr. Weiser; Dr. Percy-de Korte; Ms. Hlanze; Dr. Phaladze; Mary Rayner, MD, International Secretariat of Amnesty International; and Farhana Zuberi, LLB, LLM, Centre for the Study of AIDS, University of Pretoria. Caitriona Palmer copyedited the report. Judith Brackley, PHR Marketing and Publications Director, prepared the manuscript for publication.

Support for this research was provided by the Foundation Open Society Institute (Zug), The Moriah Fund, The Overbrook Foundation, Tides Foundation and two anonymous donors.

# I. EXECUTIVE SUMMARY

## Introduction

**D**eeply entrenched gender inequities perpetuate the HIV/AIDS pandemic in Botswana and Swaziland, the two countries with the highest HIV prevalence in the world.<sup>10</sup> 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:<sup>11</sup> 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.<sup>12</sup>

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,<sup>13</sup> randomly selected from households in the five districts of Botswana with the highest number of HIV-infected indi-

viduals<sup>14</sup> and in all 4 regions of Swaziland.<sup>15</sup> 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.<sup>16</sup> 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.<sup>17</sup> 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.<sup>18</sup>

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<sup>19</sup> 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,<sup>20</sup> Botswana is a

stable parliamentary democracy and relatively prosperous country, largely due to its diamond mining industry.<sup>21</sup> 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.<sup>22</sup> The official unemployment rate is nearly 24 percent<sup>23</sup> and over half the population in rural areas depends on subsistence farming.<sup>24</sup>

### **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.<sup>25</sup> 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.<sup>26</sup> By mid-2005, Botswana reported a significant increase in HIV testing and ARV treatment enrollment.<sup>27</sup> Botswana has implemented national HIV/AIDS prevention education on the ABC (abstinence, be faithful, use condoms) model.<sup>28</sup> 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.<sup>29</sup>

### **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.<sup>30</sup> 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.<sup>31</sup> Intimate partner violence and marital rape are not criminalized in Botswana and there are few resources for women living in situations of violence.<sup>32</sup> Economically, women are significantly disadvantaged compared with men and normatively have little control over their sexuality and reproduction.<sup>33</sup>

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

attest to improvements for women in Botswana in the last decade.<sup>35</sup> Policies are limited, however, by being operational only at the national level,<sup>36</sup> in isolation from many Botswana 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.<sup>37</sup>

## **PHR Study Findings**<sup>38</sup>

### **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.<sup>39</sup> Ninety-nine percent of Botswana 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.<sup>40</sup> 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,<sup>41</sup> 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.<sup>42</sup> 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.<sup>43</sup> 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,<sup>44</sup> 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<sup>45</sup> 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.<sup>46</sup>

#### *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.<sup>47</sup> 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.<sup>48</sup> 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.<sup>49</sup> 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.<sup>50</sup> 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.<sup>51</sup>

#### *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.<sup>52</sup> The King serves as head of state with legislative and judicial powers.<sup>53</sup> Political parties have been banned since the declaration of a state of emergency in 1973, though their current status is unclear.<sup>54</sup> 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<sup>55</sup> and more than 80 percent practices subsistence farming.<sup>56</sup> The UN World Food Programme projects that it will provide food to 200,000 people in Swaziland in 2007.<sup>57</sup>

#### 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.<sup>58</sup> When this data was reported in 2004, Swaziland surpassed Botswana as the country with the highest HIV prevalence in the world.<sup>59</sup> 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.<sup>60</sup>

In 1999 King Mswati III declared HIV/AIDS a national disaster.<sup>61</sup> The National Emergency Response Committee on HIV/AIDS (NERCHA) was created in 2001 to oversee and coordinate a comprehensive and multi-sectoral approach to managing the epidemic. By its own admission, however, Swaziland has been slow to ramp up and coordinate its HIV/AIDS response.<sup>62</sup> While the current (second) national strategic plan and its implementing policy include human rights, gender equality and equity as three of its guiding principles,<sup>63</sup> 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,<sup>64</sup> 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.<sup>65</sup> 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.<sup>66</sup> 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,<sup>67</sup> the situation is unclear pending the passage of implementing laws and clarification through test cases in the courts.<sup>68</sup> 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.<sup>69</sup> 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<sup>70</sup>**

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.<sup>71</sup> 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)<sup>72</sup> 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.<sup>73</sup>

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).<sup>74</sup> 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.<sup>75</sup> 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.<sup>76</sup> 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<sup>77</sup> 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.<sup>78</sup>

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.<sup>79</sup> 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.<sup>80</sup> 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.<sup>81</sup> 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<sup>82</sup> and nearly twice the odds of having unprotected sex with a non-primary partner.<sup>83</sup> 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.<sup>84</sup>

### *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 sup-

porting 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.<sup>85</sup> These include the International Covenant on Civil and Political Rights (ICCPR),<sup>86</sup> the International Covenant on Economic, Social and Cultural Rights (ICESCR),<sup>87</sup> the Convention on the Elimination of Discrimination Against Women (Women's Convention),<sup>88</sup> the Convention on the Rights of the Child,<sup>89</sup> the African "Banjul" Charter on Human and People's Rights<sup>90</sup> and the African Charter on the Rights and Welfare of the Child.<sup>91</sup>

### **Women's Inequality and Discrimination Against Women**

International law requires the promotion of gender equality in every aspect of life. Legal equality<sup>92</sup> and legal capacity "identical to that of men and the same opportunities to exercise that capacity"<sup>93</sup> are explicitly required, and the rights to contract, administer property and have equal access to the justice system are singled out for special notice.<sup>94</sup> The Women's Convention also directs states to eliminate discrimination against women.<sup>95</sup> It obligates party states to modify their legal and cultural systems to comport with the principle of gender equality.<sup>96</sup> 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 ...".<sup>97</sup>

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."<sup>98</sup> The UN Commission on Human Rights has explicitly confirmed that health status, including HIV/AIDS, is a prohibited basis for discrimination.<sup>99</sup> 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."<sup>100</sup> 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."<sup>101</sup>

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.<sup>102</sup> 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.<sup>103</sup> Popular participation in all levels of decision-making regarding health is an aspect of the right,<sup>104</sup> which encompasses availability, accessibility, acceptability and quality.<sup>105</sup>

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."<sup>106</sup> 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."<sup>107</sup>

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.<sup>108</sup>

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**

<sup>1</sup> 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](http://www.undp.org/hiv/docs/HR_and_gender_ENGLISH.pdf). Accessed May 5, 2006.

<sup>2</sup> For example, see ICCPR, Article 2 (1), ICESCR, Article 2(2).

<sup>3</sup> 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](http://www.icrw.org/docs/Durban_HIVAIDS_speech700.pdf). Accessed January 24, 2007.

<sup>4</sup> 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.

<sup>5</sup> 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.

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

<sup>7</sup> 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.

<sup>8</sup> [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.

<sup>9</sup> 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.

<sup>10</sup> 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 10<sup>th</sup> HIV Sentinel Surveillance Among Pregnant Women*. 2006:1.

- <sup>11</sup> 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](http://www.usaid.gov/our_work/global_health/aids/Countries/africa/saregional.html). Accessed March 1, 2007.
- <sup>12</sup> 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](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.
- <sup>13</sup> 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.
- <sup>14</sup> 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.
- <sup>15</sup> The four regions are Hhohho, Lubombo, Shiselweni and Manzini.
- <sup>16</sup> All study instruments are in the Appendix.
- <sup>17</sup> PLWA were excluded if they did not meet the same criteria as community survey participants.
- <sup>18</sup> 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.
- <sup>19</sup> 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.
- <sup>20</sup> *CIA World Factbook 2006*. Available at: <https://www.cia.gov/cia/publications/factbook/geos/bc.html>. Accessed February 23, 2007.
- <sup>21</sup> 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](http://www.businessweek.com/magazine/content/02_34/b3796629.htm). Accessed March 23, 2006.
- <sup>22</sup> 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](http://hdr.undp.org/hdr2006/statistics/countries/data_sheets/cty_ds_BWA.html). Accessed February 23, 2007.
- <sup>23</sup> *CIA World Factbook 2006*. Available at: <http://www.cia.gov/cia/publications/factbook/geos/bc.html>. Accessed February 23, 2007.
- <sup>24</sup> U.S. Department of State. "Background Note: Botswana." Available at: <http://www.state.gov/r/pa/ei/bgn/1830.htm>. Accessed March 23, 2006.
- <sup>25</sup> In a 2004 national survey, just over a quarter of Botswana reported being tested for HIV. National AIDS Coordination Agency. *Botswana AIDS Impact Survey II*. 2004:45.
- <sup>26</sup> 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.
- <sup>27</sup> Id., Steen TW, Seipone K, de la Hoz Gomez F, Anderson M, Kejelepula M, Keapoletswe K, Moffat HJ. January 4, 2007.
- <sup>28</sup> 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%20States.pdf+PEPFAR+monetary+commitment&hl=en&gl=us&ct=clnk&cd=10>. Accessed May 8, 2006.
- <sup>29</sup> "A Model for Combating AIDS." *IRIN*. May 28, 2003. Available at: <http://www.irinnews.org/pnprint.asp?ReportID=2089>. Accessed on September 17, 2005.
- <sup>30</sup> Abolition of Marital Power Act.
- <sup>31</sup> There is a draft Statute Law (Miscellaneous Amendments) that seeks to align various statutes with the Abolition of Marital Power Act.
- <sup>32</sup> Datta E. *Beyond Inequalities: Women in Botswana*. WIDSAA. 1998; Hurlburt H. *Botswana's Strategy to Combat HIV/AIDS*. CSIS Task Force on AIDS. 2004.
- <sup>33</sup> Phaladze N and Ngwenya B. "Women Social Statuses, Customs and Traditions in Contemporary Tswana Society." in Kaye, Sylvia, 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.
- <sup>34</sup> UNDP Gender Programme. *Country Profile: Botswana*. Available at: [http://www.unbotswana.org/bw/undp/gender\\_country.html](http://www.unbotswana.org/bw/undp/gender_country.html). Accessed September 30, 2005.
- <sup>35</sup> 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.

<sup>36</sup> 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.

<sup>37</sup> UNDP. *Gender Programme: Country Profile*. Available at: [http://www.unbotswana.org/bw/undp/gender\\_country.html](http://www.unbotswana.org/bw/undp/gender_country.html). Accessed September 24, 2005.

<sup>38</sup> Throughout this report, sex-stratified data is only presented where sex differences were statistically significant ( $p < 0.05$ ).

<sup>39</sup> 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).

<sup>40</sup> Respondents could agree with more than reason in identifying facilitators and barriers in their experiences of testing.

<sup>41</sup> 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.

<sup>42</sup> 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.

<sup>43</sup> 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.

<sup>44</sup> "Sexually active" is defined as having had at least one sexual partner in the past 12 months.

<sup>45</sup> 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.

<sup>46</sup> Adjusted odds ratio (AOR): 1.79, 95 percent confidence interval (CI) (1.12-2.86).

<sup>47</sup> Thirteen percent of women and 19 percent of men reported having more than one partner in the past month.

<sup>48</sup> 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.

<sup>49</sup> 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.

<sup>50</sup> 95 percent CI (1.01-7.1).

<sup>51</sup> 95 percent CI (1.22-6.61).

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

<sup>53</sup> The Constitution of the Kingdom of Swaziland Act (2005).

<sup>54</sup> 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](http://www.irinnews.org/report.asp?ReportID=55058&SelectRegion=Southern_Africa&SelectCountry=SWAZILAND). Accessed October 4, 2006.

<sup>55</sup> 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.

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

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

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

<sup>59</sup> "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.

<sup>60</sup> Swaziland Ministry of Health and Social Welfare. *Highlights of the 10<sup>th</sup> HIV Sentinel Surveillance Among Pregnant Women*. December 2006.

<sup>61</sup> Hall J. *Life Stories: Testimonies of Hope from People with HIV and AIDS*. UNICEF; 2002:v.

<sup>62</sup> NERCHA. Report of the Joint Review of the National Response to HIV and AIDS in Swaziland. March, 2005.

<sup>63</sup> The Government of the Kingdom of Swaziland. The National Multi-sectoral HIV and AIDS Policy. June 2006. Available at: <http://www.nercha.org.sz/public.html?FrameLoad=100>. Accessed September 26, 2006.

<sup>64</sup> "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](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](http://www.mg.co.za/articlepage.aspx?area=/breaking_news/breaking_news_africa/&articleid=280351). Accessed September 8, 2006.

<sup>65</sup> 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](http://www.irinnews.org/report.asp?ReportID=50180&SelectRegion=Southern_Africa&SelectCountry=SWAZILAND). Accessed December 23, 2005.

<sup>66</sup> 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](http://hdr.undp.org/hdr2006/statistics/countries/data_sheets/cty_ds_SWZ.html). Accessed February 23, 2007.

- <sup>67</sup> The Constitution of the Kingdom of Swaziland Act, (2005), Ch. III, sec. 28(3).
- <sup>68</sup> Personal communication with Women and Law in Southern Africa Research Trust (WLSA), September 6, 2006, and with Amnesty International, January 19, 2007.
- <sup>69</sup> 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.
- <sup>70</sup> Throughout this report, sex-stratified data is only presented where sex differences were statistically significant ( $p < 0.05$ ).
- <sup>71</sup> 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.
- <sup>72</sup> 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”.
- <sup>73</sup> 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).
- <sup>74</sup> Respondents could agree with more than reason in identifying facilitators and barriers in their experiences of testing.
- <sup>75</sup> 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.
- <sup>76</sup> 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.
- <sup>77</sup> “Sexually active” is defined as having at least one sexual partner in the past 12 months.
- <sup>78</sup> 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.
- <sup>79</sup> Abstinence was defined as “not having sex at all, as a way to prevent yourself or others from becoming infected with HIV/AIDS.”
- <sup>80</sup> 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.
- <sup>81</sup> 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.
- <sup>82</sup> AOR: 1.56; 95 percent CI (1.04-2.32).
- <sup>83</sup> AOR: 1.87; 95 percent CI (1.02-3.43).
- <sup>84</sup> AOR: 0.50; 95 percent CI (0.28-0.90).
- <sup>85</sup> 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.
- <sup>86</sup> Available at: <http://www.ohchr.org/english/law/ccpr.htm>. Accessed March 27, 2007.
- <sup>87</sup> 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.
- <sup>88</sup> Available at: <http://www.ohchr.org/english/law/cedaw.htm>. Accessed March 27, 2007.
- <sup>89</sup> Available at: <http://www.ohchr.org/english/law/crc.htm>. Accessed March 27, 2007.
- <sup>90</sup> Available at: <http://www.hrcr.org/docs/Banjul/afhr.html>. Accessed March 27, 2007.
- <sup>91</sup> Available at: <http://www1.umn.edu/humanrts/africa/afchild.htm>. Accessed March 27, 2007.
- <sup>92</sup> Women’s Convention, Article 15(1).
- <sup>93</sup> Women’s Convention, Article 15(2).
- <sup>94</sup> Women’s Convention, Article 15(2).
- <sup>95</sup> Women’s Convention, Article 16(1)(h).
- <sup>96</sup> Women’s Convention, Article 2(f).
- <sup>97</sup> 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.
- <sup>98</sup> For example, see ICCPR, Article 2 (1), ICESCR, Article 2(2).
- <sup>99</sup> See Commission on Human Rights Resolutions 1995/44 (3 March 1995) and 1196/43 (19 April 1996).
- <sup>100</sup> ICESCR, Article 12(1).
- <sup>101</sup> 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 of Health.” UN Doc. E/C.12/2000/4. August 11, 2000.
- <sup>102</sup> ICESCR General Comment 14(3).
- <sup>103</sup> ICESCR General Comment 14(4).
- <sup>104</sup> ICESCR General Comment 14(11).
- <sup>105</sup> ICESCR General Comment 14(12).
- <sup>106</sup> ICCPR, Article 6(1).
- <sup>107</sup> General Comment No. 6, paragraph 5.
- <sup>108</sup> General Comment No. 3, paragraphs 13-14.

## II. STUDY METHODS

### Purpose

The goal of the Botswana/Swaziland study was to understand the effects of women's social, economic and legal status on HIV/AIDS; assess current attitudes, policies, and practices; and propose pragmatic solutions to protect and promote the health and human rights of women and men in Botswana and Swaziland.

To this end, qualitative and quantitative fieldwork was designed to: 1) identify and understand the barriers and facilitators to HIV prevention, testing and treatment in Botswana and Swaziland and how these may differ for women and men; 2) assess the attitudes of the general population towards PLWA in Botswana and Swaziland and describe how stigmatizing attitudes may relate to prevention and access to care; 3) describe the relationship between rights and prevention, testing and treatment; in particular, the ways that women's legal status and traditional customary practices relate to HIV risk for women and men; 4) formulate recommendations based on these findings and based on the opinions of Botswana and Swazi study participants who assessed the strengths and weaknesses of leadership in addressing the HIV/AIDS epidemic in each country.

### Subjects

Participants in the surveys and qualitative interviews were women and men, ages 18-49. Participants were excluded if they did not meet the age criteria for the study, had cognitive disabilities, did not speak either English or Setswana (in Botswana) or siSwati (in Swaziland), were not residents of the country or if there was inadequate privacy to conduct the survey or qualitative interview. Participants in the community surveys were not asked to disclose their HIV status; participants in the PLWA interviews self-identified as HIV-positive.

Key informants were individuals and representatives from a range of organizations including local NGOs, international agencies and government offices. Agencies included those that provide health services related to HIV/AIDS or support for PLWA, devise policies and programs for the prevention and treatment of

HIV/AIDS, engage in community mobilization or human rights advocacy, or work in women's empowerment, development or other relevant areas.

### Sampling

#### Botswana Community Survey

The Botswana community survey sample was a probability sample of 1,268 adults selected from the five districts of Botswana with the highest numbers of HIV-positive individuals. The Botswana Central Statistics Office at the Ministry of Finance and Development Planning assisted with the design of the sampling frame and the provision of maps. The five districts were Gaborone, Kweneng East, Francistown, Serowe/Palapye and Tutume; they represent a population of 725,000 in the eastern corridor of the country, out of a total population of 1.64 million.

A stratified two-stage probability sample design was used. In the first stage of sampling, 89 enumeration areas were selected with probability proportional to measures of size, where measures of size were the number of households in the enumeration area as defined by the 2001 Botswana Population and Housing Census. Out of 89 randomly selected enumeration areas, 69 were from large urban settlements and small urban villages, and 20 were from rural villages, agricultural lands and cattle posts.

At the second stage of sampling, households were systematically selected in each enumeration area by trained field researchers under the guidance of field supervisors. With a target sample of 1,200 households and 15 percent oversampling (for an anticipated 85 percent response rate), 1,433 households were selected. Within each household, random number tables were used to select one adult resident from a list of residents meeting the study criteria for subjects. Up to two repeat visits were made to the household to survey that person.

#### Swaziland Community Survey

The Swaziland community survey sample was a probability sample of 788 adults selected from all four regions of Swaziland (Hhohho, Lubombo, Shiselweni

and Manzini), with a combined population of less than 1.2 million people. The Swaziland Central Statistical Office assisted with the design of the sampling frame and the provision of maps; a stratified two-stage probability sample design was used. In the first stage of sampling, 54 enumeration areas were selected with probability proportional to measures of size, where measures of size were the number of households in the enumeration area as defined by the 1997 Swaziland Population and Housing Census. Out of 54 randomly selected enumeration areas, 31 were from urban and peri-urban areas and 23 were from rural villages.<sup>109</sup>

At the second stage of sampling, households were systematically selected in each enumeration area by trained field researchers under the guidance of field supervisors. With a target sample of 800 households and a 10 percent oversampling (for an expected 90 percent response rate), 876 households were selected to participate. Within each household, random number tables were used to select one adult resident from a list of residents meeting the study criteria for subjects. Up to two repeat visits were made to the household to survey that person.

### **Botswana and Swaziland PLWA Interviews**

A purposeful approach was used to identify HIV-positive women and men in Botswana and Swaziland for qualitative interviews regarding their experiences and perspectives. The 24 Botswana respondents were HIV-positive members, leaders, volunteers or counselors from support groups for people infected or affected by HIV/AIDS from Gaborone, Serowe and the surrounding villages and rural areas. The 58 Swazi participants were drawn from patients visiting the Mbabane VCT center, those attending support groups in the Mbabane and Manzini areas, and referrals from health care workers and NGO representatives providing HIV-related services, including PMTCT. This sample included people from diverse geographical areas in Swaziland.

### **Botswana and Swaziland Key Informant Interviews**

Thirty-eight key informants from Botswana and Swaziland were identified for their expertise in HIV/AIDS, human rights, gender, health services and other fields relevant to the subject of the study.

### **Survey Questionnaires and Interview Instruments**

All surveys and semi-structured interview instruments are included in the Appendix to this report.

Domains of inquiry for the study included: a) demographics; b) food insufficiency; c) knowledge of HIV transmission and prevention; d) availability of HIV testing and treatment and experiences with testing; e) gender-specific barriers to prevention, testing and treatment; f) HIV/AIDS-related stigma, including participants' attitudes towards PLWA and (for PLWA only) experiences with poor treatment; g) depression symptoms; h) HIV-related risk behaviors and sexual practices; i) attitudes towards women and beliefs about gender roles and norms; j) participants' recommendations regarding decreasing women's and men's risk of HIV and eliminating barriers to prevention, testing and treatment; and l) participants' assessment of leaders' efforts to address the HIV/AIDS crisis.

### **Community Surveys**

The surveys consisted primarily of close-ended questions. The questionnaires were written in English, one of two official languages in each country, translated into Setswana (in Botswana) and siSwati (in Swaziland), and back-translated into English. The community surveys were piloted with 20 individuals from Gaborone, Botswana and 29 in Mbabane, Swaziland and surrounding areas. Revisions were made for clarity and cultural appropriateness based on the pilot testing. Researchers administered the survey in the language chosen by the participant. All answers were recorded on English language surveys and reviewed in the field for completeness by the researchers and checked daily by supervisors. Researchers returned to households to complete incomplete interviews when feasible. Surveys took approximately 45-60 minutes.

### **PLWA Interviews**

For the qualitative interviews in both countries, semi-structured surveys consisting primarily of open-ended questions were used. In Swaziland certain close-ended questions adapted from the community survey were added to the instrument. The interview instruments were written in English and administered by PHR staff or consultants, working with one of the trained local field researchers as a translator when needed. Interviews lasted 45-60 minutes. 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.

### **Key Informant Interviews**

Key informants were interviewed with a semi-structured instrument consisting of open-ended questions.

All key informant interviews were conducted by PHR staff or consultants in English, lasted approximately 45-90 minutes and took place in the workplace or another private setting chosen by the participant. In the results, where possible, the exact words of participants are used in quotations.

## **Interviewer Training**

The Botswana community surveys were conducted by 26 Botswana women and men trained by the PHR/University of Botswana field team in Gaborone, Botswana. The Swaziland community surveys were conducted by 21 Swazi women and men trained by the PHR/WLSA field team in Mbabane, Swaziland. All local field researchers had prior survey experience and many had expertise in HIV/AIDS. The training, which included detailed instruction in the study protocols and research ethics, consisted of classroom teaching and role play for 4 days in Botswana and 2 days in Swaziland, followed by field practice in interviewing and continuous field supervision throughout the study. Additional training was given to field researchers interpreting or administering PLWA interviews in Swaziland. Three to 5 members of the field team served as field supervisors in each country. The supervisory team had extensive expertise in applied research, human rights, gender, mental health and HIV/AIDS.

## **Data Collection**

In Botswana, the community surveys and PLWA interviews were administered in November and December 2004. In Swaziland, the community survey and the PLWA interviews were conducted in May 2005. Key informant interviews were conducted in September 2004 in Botswana and in March and May 2005 in Swaziland.

## **Human Subjects Protections**

This research was conducted in accordance with the Declaration of Helsinki (as revised in 2000). The Botswana research protocol was reviewed and approved by the Human Subjects Committee at the University of California, San Francisco and the Botswana Ministry of Health Research and Development Committee. The Swaziland research protocol was reviewed and approved by an Ethics Review Board convened by PHR consisting of individuals with expertise in public health, clinical medicine, bioethics, gender, HIV/AIDS and international human rights research, including the co-founder of a Swazi PLWA support group, faculty from

the University of Swaziland and UN country representatives. The research protocol and instruments were additionally approved by the chair of the newly reconstituted Ethics Committee of the Swaziland Ministry of Health.

Written consent was obtained from participants in the Botswana community surveys and the Botswana PLWA interviews in either English or Setswana, depending on the preference of the participant. Oral consent was obtained from Swaziland community survey and PLWA interview respondents and from key informants in both countries. Participants were informed of the purpose of the surveys and interviews in general terms and how the data would be collected and used. Participants in the community surveys were informed that they would not be asked to disclose their HIV status. Participants in the PLWA interviews who were referred by treatment clinics or other organizations were assured that any services that they were receiving would not be affected in any way by participating or refusing to participate in the study.

All interviews (except key informant interviews) were anonymous and all were conducted in a private setting. At the conclusion of the survey or interview, participants (except key informants) were offered literature regarding HIV/AIDS testing, prevention and treatment, and information concerning domestic violence victims' assistance. Respondents who self-identified in the depression symptoms screen as having suicidal thoughts were referred by field interviewers to one of the clinician field supervisors.

Study subjects were not compensated. Participants in the surveys received a token gift of a value equal to or less than US\$1-2 after the completion of the interview and were not informed of this beforehand. Participants in the PLWA interviews were given money for transport, and a snack and beverage were made available during the interview and while waiting.

## **Statistical Analysis**

The survey data were analyzed using STATA statistical software.<sup>110</sup> Descriptive statistics were used to characterize the study populations and distribution of responses. Multivariate logistic regression analyses were employed to examine factors associated with testing, holding gender discriminatory beliefs and sexual risk. Pearson chi-square tests of association were used to determine differences in responses based on gender or other respondent characteristics (testing/not-testing, for example) and two-sample t-tests were run for comparison of means. Based on literature reviews and consulta-



tions with colleagues, a conceptual model was developed to guide the selection of variables for the multivariate models. Relevant variables are explained in the findings sections. For all statistical determinations, significance levels were established at  $p < 0.05$ . Regression diagnostic procedures yielded no evidence of multi-collinearity or overly influential outliers in any of the models.

## Limitations

Given the cross-sectional nature of the study, the direction of causality cannot be established from the findings. The prevalence of sexual and other gender-based violence and risk-taking sexual practices or circumstances were likely under-reported due to the intimate and/or stigmatized nature of these experiences and the likelihood that participants in a brief survey would be reluctant to reveal such matters to field researchers. In addition, given widespread awareness of the existence of the HIV/AIDS epidemic in both countries, participants' responses may have been biased by a desire to give socially "correct" answers or please interviewers on matters related to testing, prevention and attitudes towards those living with HIV/AIDS. They may therefore have over-reported their engagement in safe sex practices, willingness to test, support for PLWA and related matters. To minimize self-report bias, measures to safeguard the privacy of the interview and assurances of anonymity and confidentiality were incorporated into the study protocol.

## Generalizability of Study Results

A random sample design was used in order that the community survey results would be generalizable to the five districts with the highest prevalence of HIV-positive individuals in Botswana and to a nationally representative sample in Swaziland. Because individuals from the most remote areas in Botswana and the company town communities in Swaziland were excluded, the results may not be generalizable to the entire Botswana and Swazi populations.

Testimony from the Botswana and Swaziland PLWA interviews, each a convenience sample, only represent the

views and experiences of those who participated in the study. HIV-positive individuals who have ascertained their status and made some disclosure to others, and who have joined support groups or accessed services, are likely to be different from those who have not. Moreover, those who agree to be interviewed and desire to share their stories may have a different perspective and distinct experiences from those who did not make themselves available or were not presented with the opportunity to speak with researchers in the limited time period for data collection.

While the results of the Botswana and Swaziland PLWA interviews were not intended to represent larger populations of PLWA, comparison of these assessments along consistent domains of inquiry with the responses in the community surveys allowed PHR to consider converging and diverging lines of evidence. These interviews assisted in the interpretation of the findings of the community inquiries by providing insight into the patterns of experiences of those infected and affected by HIV/AIDS. Likewise, the key informant interviews, while not an exhaustive survey of expertise on gender and HIV/AIDS in Botswana and Swaziland, comprise a credible contribution, framed by background research, to assist in understanding the data collected. These interviews also assisted with the formulation of a range of recommendations to address the health and human rights concerns documented in this report.

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## Notes

<sup>109</sup> The Swazi population is classified at the household level, into regular and irregular households; the latter, which comprise compounds like teachers' quarters, boarding schools and military barracks, are generally excluded from household-based sampling frames. Company towns, where laborers for a particular corporation live, with or without their families, may be classified as either regular or irregular households, depending on whether they comprise individual houses or compounds. All irregular households and company towns were excluded from the PHR study sample, the latter given difficulties in obtaining access and the consideration that residents may differ from the general population in ways that could bias study responses.

<sup>110</sup> STATA 9.2 (Intercooled) for Windows. STATA Corporation, College Station, TX, 1984-2006.

# III. BOTSWANA COUNTRY BACKGROUND

## Geography and Population

The Republic of Botswana (Botswana) is a sub-tropical<sup>111</sup> landlocked nation of approximately 581,730 square kilometers located in southern Africa.<sup>112</sup> It is bordered by Namibia to the west and north, Zimbabwe to the east and north and South Africa to the south.<sup>113</sup> The yearly climate is generally characterized by warm winters and hot summers<sup>114</sup> that often result in drought.<sup>115</sup>

Botswana has a relatively small population of 1,639,833 with an estimated -0.04 percent growth rate.<sup>116</sup> Settlement is primarily concentrated in the eastern reaches of the country where enough rain falls for land cultivation and grazing. Nearly 57 percent of the population lives in urban areas.<sup>117</sup> While Botswana's economic growth has precipitated an increase in urban migration over the past two decades, people maintain strong ties to rural villages.<sup>118</sup>

Thirty-eight percent of the general population is under the age of 15.<sup>119</sup> Approximately 555,000 people are between 15 and 29 years of age, 393,000 people are between the ages of 30 and 49 and over 260,400 are above the age of 50.<sup>120</sup>

Eighty percent of men and 82 percent of women were literate in 2004.<sup>121</sup> Nearly 12 percent of the total population has never attended school, while over 34 percent has completed primary school and over 41 percent has finished secondary school. Only slightly more than 3 percent are university graduates.<sup>122</sup>

The major ethnic groups of the country include the Tswana (or Setswana) who are the vast majority of the population, 79 percent; the Kalanga who make up 11 percent of the population; and the Basarwa (or San people, the original bush population) at 3 percent.<sup>123</sup> Other groups, such as the Kgalagadi and Europeans, comprise the remaining 7 percent of the population.<sup>124</sup> Seventy-two percent of the population identifies as Christian.<sup>125</sup> Twenty-one percent of Botswana claim no religious affiliation.<sup>126</sup>

As one of the more prosperous and stable nations in southern Africa, Botswana plays host to a sizeable contingent of immigrants as day laborers, refugees or undocumented migrants. It has been estimated that thousands of Zimbabweans have fled to Botswana since



Zimbabwean President Robert Mugabe instituted a controversial land reform scheme in 2000.<sup>127</sup> In addition, by the end of 2005, approximately 3,000 refugees were living in Botswana,<sup>128</sup> primarily from Namibia and Angola.<sup>129</sup> The vast majority of refugees are housed in the Dukwi refugee camp located in the central west of Botswana.<sup>130</sup>

## History and Politics

Botswana gained its independence from the United Kingdom in 1966.<sup>131</sup> Since then it has been held up as a model of good governance and prudent economic policy throughout the continent.<sup>132</sup>

Botswana is a tri-cameral democracy comprised of an executive, a legislature and a judiciary.<sup>133</sup> The president is both the head of state and head of government<sup>134</sup> and is elected by the National Assembly for a five-year term.<sup>135</sup> The current president, Festus G. Mogae, came into office in 1998, was elected in 1999 and reelected in

2004.<sup>136</sup> The president, the National Assembly and the House of Chiefs comprise the National Parliament.<sup>137</sup> The National Assembly is a 63-member chamber, of which 57 representatives are directly elected by the populace.<sup>138</sup> Four seats are filled by appointments from the ruling party.<sup>139</sup> The president is also an *ex officio* member of the National Assembly, as is the Attorney General, which raises questions about the separation of powers.<sup>140</sup> The House of Chiefs is a fifteen-member advisory body of permanent and non-permanent members which consists of the major tribal chiefs and indirectly elected and appointed sub-chiefs.<sup>141</sup> The House has limited powers, of which perhaps the most important is the ability to delay passage of legislation regarding tribal affairs and chieftainship.<sup>142</sup> All Assembly members and non-permanent House members serve five-year terms. The next national election will take place in 2009.

President Mogae's Botswana Democratic Party (BDP) has been the ruling party since Independence.<sup>143</sup> In the 2004 National Assembly elections, the BDP took 52 percent of the vote.<sup>144</sup> Other parties include the Botswana National Front (BNF), the Botswana Congress Party (BCP), the Botswana People's Party and the Botswana Independence Party, though the BDP and the BNF are the most popular.<sup>145</sup>

Botswana ranked 37 out of 163 countries on a corruption perceptions index, the "least corrupt" ranking of any African country.<sup>146</sup> The country scored 5.6 out of 10 on a scale where 0 indicates a "highly corrupt" country and 10 denotes a "highly clean" country.<sup>147</sup>

The legal system is a mix of both customary and Roman-Dutch law.<sup>148</sup> Customary law is largely unwritten and applied by tribal courts, while Roman-Dutch common law and statutes are utilized by civil courts.<sup>149</sup> Customary courts have only limited criminal jurisdiction but general civil jurisdiction, meaning that Botswana have a choice of forum when seeking the resolution of civil disputes.<sup>150</sup> The levels of state courts include the Court of Appeals, the High Court, the Industrial Court, as well as Magistrates and Customary Courts.<sup>151</sup> Magistrates can hear all matters save for capital offenses.<sup>152</sup> Customary courts have limited jurisdiction over civil and criminal matters.<sup>153</sup> Civil judicial officers are appointed by the president in consultation with the Judicial Services Commission.<sup>154</sup>

The country is divided into 15 districts, each of which has their own local government structure, including District Committees, Village Development Committees and tribal entities.<sup>155</sup> Local entities are charged with implementing policies conceived by the national government.<sup>156</sup>

## Economy

Botswana has been hailed as an African success story<sup>157</sup> because it has transformed itself from one of the poorest countries in the world to an upper middle-income country since Independence.<sup>158</sup> This is largely due to the discovery of extensive diamond mines in 1967.<sup>159</sup> Diamond mining accounted for 79 percent of exports in 2006.<sup>160</sup> Other key sectors include agriculture and services, including government.<sup>161</sup> In 2006, Botswana's Gross Domestic Product (GDP) was approximately US\$18.72 billion.<sup>162</sup>

The workforce is divided among three major sectors, services, industry and agriculture.<sup>163</sup> Despite the country's national economic success, over 23 percent of the population lives below the poverty line of US\$1 per day,<sup>164</sup> and the country's official unemployment rate is 23.8 percent.<sup>165</sup> Over half of the population lives in rural areas and depends on subsistence farming.<sup>166</sup> Moreover, in an index of 124 countries ranked in ascending order of income inequality, Botswana was ranked 122nd, superceded only by Lesotho and Namibia.<sup>167</sup> Botswana women earn 36 percent their male counterparts' wages.<sup>168</sup>

## Health Care System

The Government of Botswana provides an estimated 90 percent of health services, with private clinics run by mines or sole practitioners making up the remaining providers.<sup>169</sup> The Ministries of Health and Local Government work in concert to deliver services to the population at hospitals, clinics and mobile units.<sup>170</sup> The Ministry of Health sets policy and provides secondary and tertiary care while the Ministry of Local Government delivers primary care services.<sup>171</sup> In 2002 Botswana had three national referral hospitals and one private referral hospital as well as 239 clinics and 810 mobile stops.<sup>172</sup>

Botswana ranks 168 out of 191 nations on an index of overall health attainment among WHO member states.<sup>173</sup> The Government devoted 5.6 percent of its gross domestic product (GDP) to health care in 2003.<sup>174</sup> The per capita expenditure that same year was US\$232.<sup>175</sup> Private health expenditure accounted for just over 41 percent of the nation's total health expenditure in 2003;<sup>176</sup> sources for private expenditure included both pre-paid plans and out-of-pocket expenditures.<sup>177</sup> Health worker staffing remains a problem in Botswana. In 2004, there were only 0.4 physicians for every 1,000 people;<sup>178</sup> Botswana has encouraged the immigration of physicians from Cuba and neighboring African countries to fill some of the gaps.<sup>179</sup> The WHO has reported

that Botswana is experiencing a brain drain of migrating experienced local medical staff due to opportunities overseas and the demands of the HIV/AIDS epidemic.<sup>180</sup> Between 1999 and 2005 Botswana lost approximately 17 percent of its health workers to AIDS.<sup>181</sup>

Over 85 percent of Botswana live within 15 kilometers of a health care facility.<sup>182</sup> While there is a standard US\$0.38 charge for outpatient medical services in government clinics, no one is refused care for inability to pay.<sup>183</sup> Moreover, most primary care services such as antenatal care, HIV/AIDS treatment, and child welfare services are exempt from any service fee.<sup>184</sup> By 2005, over half of people with HIV/AIDS in need of treatment were receiving ARVs.<sup>185</sup>

Prior to the HIV/AIDS epidemic, Botswana's success permeated its health system. In the 1980s, it posted some of the best health indicators in the region, including a drop in the crude birth rate and incidence of childhood immunizable diseases.<sup>186</sup> Since the HIV/AIDS epidemic, however, the country has experienced a rise in its crude death and infant mortality rates.<sup>187</sup> Life expectancy for women and men is 40 years,<sup>188</sup> down from 72.4 prior to the advent of AIDS.<sup>189</sup> In addition to the HIV/AIDS epidemic, Botswana's health system is battling rising tuberculosis prevalence and malaria transmission.<sup>190</sup>

## HIV/AIDS Epidemic

Since the first case of HIV infection was recorded in Gaborone in 1985,<sup>191</sup> Botswana has developed one of the highest prevalence levels of HIV/AIDS infection in Africa.<sup>192</sup> Until 2004, when Swaziland surpassed it, it had the highest HIV prevalence in the world.<sup>193</sup> The Government's most recent sentinel surveillance survey of pregnant women ages 15 to 49 making their first ante-natal clinic visit found 37.4 percent of women to be HIV-positive.<sup>194</sup>

The estimated prevalence of HIV in the country varied by age and residence location. The nation's highest prevalence, 73.7 percent, existed among unmarried women who lived with their partners in the Selebi Phikwe district.<sup>195</sup> HIV prevalence for all pregnant women in Selebi Phikwe was 52.2 percent.<sup>196</sup> Residents of the Bobirwa district between the ages of 25 to 29 had a 71.7 percent prevalence of HIV.<sup>197</sup> In that same district, 67.6 percent of pregnant women with regular jobs were HIV-positive.<sup>198</sup>

Recent government data from a systematic sample of Botswana households in 2004 revealed that nearly 10 percent of women and almost four percent of men ages 15 to 19 were HIV positive.<sup>199</sup> Approximately 44 percent of women and 36 percent of men ages 30 to 35 were

estimated to be HIV-positive.<sup>200</sup> Francistown led the urban infection category with an aggregate prevalence of 24.6 percent.<sup>201</sup>

It has been estimated that 18,000 adults and children died of AIDS in Botswana in 2005.<sup>202</sup> Approximately 120,000 children under the age of 17 have been orphaned as a result of AIDS.<sup>203</sup> The spread of HIV in Botswana has been attributed to a host of factors ranging from the subordination of women, to stigma and denial, to urbanization and migration.<sup>204</sup>

As elsewhere in the region, the epidemic in Botswana disproportionately affects women: there were three HIV-positive females to every HIV-positive male in the 15 to 19 year-old cohort.<sup>205</sup> The Botswana government has recognized that the reasons for this imbalance include power inequities, women's lack of sexual negotiating power, migration patterns<sup>206</sup> and the lack of economic empowerment of women.<sup>207</sup> More than a decade ago women's elevated vulnerability to HIV/AIDS in Botswana was attributed to their subordinate position in society and a mix of cultural, social and economic factors including men's culturally-sanctioned entitlement to sex "on demand," the "cultural imperative" of a woman to prove her fertility before marriage by bearing children, women's powerlessness to insist on condom use, the legitimization of violence against women, internal migration patterns and the commercial sex trade.<sup>208</sup>

## Botswana HIV/AIDS Policy

### Governmental and Organizational Response

Botswana reported that it spent US\$165 million on HIV/AIDS in 2005.<sup>209</sup> The primary body informing the Botswana government's response to the HIV/AIDS epidemic is the National AIDS Council (NAC), chaired by President Mogae.<sup>210</sup> The NAC's policy direction both informs and is informed by other national development strategies including those outlined in Vision 2016, Botswana's vision for 50 years following independence; National Development Plan 9 (NDP9) the socio-economic development plan for the country; and the 1997 National Population Policy.<sup>211</sup> The National AIDS Coordinating Agency (NACA), a directorate of the Office of the President, provides secretariat and technical support to the NAC and coordinates the national response to the epidemic.<sup>212</sup>

Vision 2016, developed in 1996 by a Presidential Task Group, is an inspirational guide for the development of Botswana.<sup>213</sup> The goals are based on the five principles of democracy, development, self reliance, unity and

*botho* (respect).<sup>214</sup> Vision 2016 incorporates the goal of halting the spread of HIV/AIDS.<sup>215</sup>

Botswana's National AIDS Policy was first developed in 1992, revised in 1998<sup>216</sup> and again in 2002.<sup>217</sup> The 12th version is reportedly being finalized by NACA and the Attorney General's Chambers for consideration by NAC and the Cabinet.<sup>218</sup> The current policy enumerates the role of each ministry in the government response to HIV/AIDS and is explicitly based on principles of health, human rights and privacy for PLWA.<sup>219</sup> Section 8.3 of the draft policy acknowledges and condemns the role discrimination against women plays in their risk of HIV.<sup>220</sup>

The National Strategic Framework (NSF) for HIV/AIDS 2003–2009 was developed over an eighteen-month period “to articulate, disseminate, and educate the public at large on agreed national priorities and strategies within the scope of Vision 2016” and “to provide clear guidance for Ministries, districts, NGOs, and the Private Sector to enable them to work in a collaborative manner in achieving the intended goal of the National Response to HIV/AIDS: to eliminate the incidence of HIV and reduce the impact of AIDS in Botswana.” In the development of the multi-sectoral NSF, consultations were held in communities in each district of the country, and with each ministry, civil society and the private sector.<sup>221</sup>

The five goals of the NSF are prevention; treatment, care and support; strengthening national response management; impact mitigation; and strengthening the legal and ethical environment.<sup>222</sup> For each goal, there are a limited number of specific and measurable objectives, followed by a series of strategies.<sup>223</sup> The NSF is undergoing a comprehensive Mid-Term Review with completion expected in June 2007.<sup>224</sup>

One of the six priority groups for the NSF is women.<sup>225</sup> As a priority group, women are subject to target interventions,<sup>226</sup> including their empowerment through PMTCT<sup>227</sup> and income generation programs.<sup>228</sup> The NSF charges the Women's Affairs Department with mainstreaming gender into HIV/AIDS programs.<sup>229</sup> This progressive rhetoric has to-date not been matched by implementation of gender-focused programming.

Commitment to addressing HIV/AIDS in Botswana's private sector lags behind that of the public sector. In 2003, the United Nations assisted NACA in establishing a private sector coordination unit.<sup>230</sup> Less than 20 percent of private companies surveyed in 2005 reported having HIV policies.<sup>231</sup> In 2005 the Botswana Business Coalition on HIV/AIDS began mobilizing the private sector around the epidemic.<sup>232</sup>

The international community has been a key player in augmenting Botswana's national response to the HIV/AIDS epidemic, both financially and in terms of research and the creation of health infrastructure. The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria awarded a grant of US\$18.6 million to Botswana's Ministry of Finance and Development Planning to fund health care personnel training, strengthen the treatment of PLWA, scale-up prevention, counseling and testing and create other initiatives over the course of two years, commencing July 1, 2004.<sup>233</sup> The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) supports the Botswana Government's treatment plan through financial support and technical assistance.<sup>234</sup> In fiscal year 2005, PEPFAR gave Botswana over US\$51.8 million for HIV/AIDS prevention, treatment and care.<sup>235</sup> The BOTUSA Project, a collaboration between the Government of Botswana and the U.S. Centers for Disease Control, employs over 12 international and 100 local staff to provide financial support, technical assistance, program support and HIV/AIDS research.<sup>236</sup>

The Botswana government has formed a number of partnerships to implement HIV/AIDS initiatives. The Botswana-Harvard School of Public Health AIDS Initiative for HIV Research and Education was launched in 1996 to assist with research and education projects on HIV/AIDS.<sup>237</sup> The African Comprehensive HIV/AIDS Partnerships, an initiative of the Government of Botswana, the Bill and Melinda Gates Foundation and Merck, has built and renovated clinics, scaled up laboratory facilities and trained healthcare workers.<sup>238</sup> UNAIDS Program Acceleration Funds amounted to \$0.5 million between 2002 and 2003 in the area of workplace education.<sup>239</sup> In addition, UNAIDS assisted the government in finalizing the NSF and providing guidance on routine testing policies.<sup>240</sup>

There are a number of local and national NGOs in Botswana working on HIV/AIDS and related issues. The Botswana Network of AIDS Service Organizations serves as an umbrella for such organizations.<sup>241</sup> It provides capacity building in the form of small grants and coordinates information sharing among groups.<sup>242</sup> The Botswana Network of People Living With HIV/AIDS (BONEPWA) was established in 2000 as a network of PLWA.<sup>243</sup> BONEPWA coordinates support groups, prevention activities and care for PLWA in Botswana.<sup>244</sup> It also sponsored the first “Mr. HIV Positive Living” pageant and campaign in April 2006.<sup>245</sup> The Centre for Youth of Hope (CEYOH) provides care and support to youth living with HIV/AIDS.<sup>246</sup> Its signature program is the

“Miss Stigma Free” pageant, which annually crowns an HIV-positive woman as a role model for destigmatization and ARV adherence.<sup>247</sup> The Botswana Network on Ethics, Law and AIDS (BONELA) advocates and lobbies at the national and international level for legislation that protects the rights of PLWA.<sup>248</sup> The Botswana Christian AIDS Intervention Programme (BOCAIP) has been providing pre- and post-test counseling to PLWA since 1997.<sup>249</sup> Bomme Isago Association is a growing network of support for HIV-positive women founded in 2005. The International Community of Women Living with HIV/AIDS also maintains a program officer in Botswana.

### Prevention/Education

HIV awareness is high in Botswana. Over 80 percent of people surveyed in the national AIDS household survey in 2004 correctly reported at least one method of preventing HIV transmission.<sup>250</sup> However, only 27 percent of females and 29 percent of males ages 15-24 were able to identify a method of HIV prevention.<sup>251</sup> As a PEP-FAR-funded country, Botswana’s prevention program has taken the “ABC” approach: abstinence before marriage (A); being faithful to one sexual partner (B); and, failing A and B, consistent condom use (C).<sup>252</sup>

### Testing

VCT has played an important role in HIV-related prevention and care in Botswana, particularly as an access point for other HIV/AIDS-related services. Since 2000, BOTUSA has supported the *Tebelopele* network of VCT centers, which provides HIV testing and counseling services for Botswana ages 18 to 49.<sup>253</sup> In 2004, *Tebelopele* established itself as an autonomous NGO offering VCT at 16 locations throughout the country.<sup>254</sup> In addition, prevention of mother-to-child transmission (PMTCT) programs provide testing, care and treatment for pregnant women.<sup>255</sup>

Despite the availability of testing, in the 2004 national survey just over a quarter of Botswana reported being tested for HIV.<sup>256</sup> Low testing rates in Botswana have been attributed in part to denial<sup>257</sup> and to the fear of potential stigma and discrimination associated with HIV/AIDS, causing Botswana to avoid seeking testing or attending treatment facilities.<sup>258</sup> The majority surveyed in 2004 reported stigma and discrimination against PLWA. For example, approximately 70 percent of the 2004 survey participants reported that they would prefer an HIV-positive teacher to stop teaching.<sup>259</sup> Over 92 percent of survey participants, however, indicated that they would be willing to care for a family member who had fallen ill from HIV/AIDS.<sup>260</sup>

Persistent low levels of testing in the general population, despite having launched a program of universal access to ARV treatment in 2002, prompted a shift in Botswana’s HIV testing policy in early 2004.<sup>261</sup> In January of that year, the Botswana government introduced a policy of “routine testing” under which nearly all patients would be tested as a part of routine medical visits.<sup>262</sup> The initial policy was unclear, however, as to whether patients would be tested unless they explicitly refused (“opt-out” testing) or whether they would only be tested if they gave their specific consent to an HIV test (“opt-in” or “routine offer”). Guidelines on the policy were only issued in February 2004 from the Ministry of Health to hospitals. A year later, training materials were still being developed.<sup>263</sup> In June 2004, WHO and UNAIDS issued a recommendation, in part based on the Botswana experience, that such testing should be “routine offer.”<sup>264</sup> The Government has subsequently stated that the policy is one of “opt-out” testing.<sup>265</sup> Since reporting has been incomplete, the nature, extent and uniformity of the implementation of the program in Botswana remain unclear.<sup>266</sup> At least one study has documented increased acceptance of testing in antenatal programs in Francistown in the first three months after the initiation of routine testing<sup>267</sup> and the Government reported an increase in testing rates since the introduction of the policy.<sup>268</sup>

### Treatment

In May 2002, Botswana became the first country in Africa to widely disseminate anti-retroviral therapy to HIV-positive people.<sup>269</sup> The program, named Masa (“new dawn”), is a collaboration of the Government of Botswana, the pharmaceutical company Merck and the Bill and Melinda Gates Foundation and is funded by the Gates and Merck Foundations at a cost of US \$50 million over five years.<sup>270</sup> As of 2003, the Ministry of Health was administering the program, operating in Gaborone, Francistown, Serowe and Maun.<sup>271</sup> The Botswana Guidelines on Anti-Retroviral Treatment were developed, aligned with international standards.<sup>272</sup> Under the 2002 Guidelines, ARV treatment is provided to patients with CD4 counts under 200 or with a physician’s recommendation.<sup>273</sup> The Guidelines also stipulate that sexual assault survivors should be provided with post-exposure prophylaxis within 48 hours of the attack and follow-up treatment if HIV test results are positive.<sup>274</sup>

By January 2004, only 17,500 patients were enrolled in Masa, out of an estimated 110,000 eligible individuals.<sup>275</sup> Low enrollment in the ARV treatment program was partly attributed to underutilization of HIV-testing;

by mid-2003, only 70,000 tests in total had been performed out of a population of 1.7 million.<sup>276</sup> From the advent of routine testing, the Government reported a significant increase in testing<sup>277</sup> and treatment<sup>278</sup> by mid-2005. UNAIDS/WHO estimated that, by the end of 2005, between 67,000 and 77,000 eligible Batswana were receiving ARV treatment, representing 85 percent coverage and surpassing the WHO '3x5' target of fifty percent of eligible PLWA.<sup>279</sup> In 2006 Masa reported that ARVs were being distributed to nearly 55,000 patients through 32 treatment sites,<sup>280</sup> comprising at least one dispensing site in each of the 24 health districts.<sup>281</sup> It has been observed, however, that the proportion of women accessing treatment is far greater than that of men, a disparity that cannot be explained by sex distribution in the population or HIV prevalence, but may have to do with the volume of referrals from antenatal clinics and women's leadership role in Botswana's HIV response.<sup>282</sup>

## Women's Status

Botswana has ratified or acceded to several international and regional human rights instruments that pertain to women's civil, political, economic, social and cultural status. Botswana ratified the African Charter in the Rights and Welfare of the Child,<sup>283</sup> African Charter on Human and Peoples' Rights<sup>284</sup> and the International Covenant on Civil and Political Rights.<sup>285</sup> It has acceded to the Convention on the Elimination of All Forms of Discrimination against Women<sup>286</sup> and the Convention on the Rights of the Child.<sup>287</sup>

## Legal Status

### *Civil Law*

Women's rights vary, depending on the application of common or customary law. Under Botswana's Constitution women and men are equally entitled to certain fundamental rights and freedoms irrespective of their sex.<sup>288</sup> The constitutional prohibition against discrimination in Section 15 of the Bill of Rights, however, does not refer to sex in its definition and is subject to a number of exceptions.<sup>289</sup> For example, Section 15 does not apply to laws "for the application in the case of members of a particular race, community or tribe of Customary Law."<sup>290</sup> In 1991, the Court of Appeals held that women and men are equally entitled to the fundamental rights and freedoms mentioned in Section 3 of the Bill of Rights.<sup>291</sup> However, subsequent court rulings have preserved the state's power to abridge rights on the basis of sex on "reasonable" grounds.<sup>292</sup> Further-

more, the bifurcation of the legal system means that customary laws that discriminate against women continue to be enforced, particularly in rural areas.<sup>293</sup>

In recent years reforms have been made to several discriminatory civil laws disempowering women; however, implementation has been weak. Most significantly, in December 2004 the Abolition of Marital Power Act was enacted to abolish the common law principle of marital power that men married in community of property enjoyed and it was replaced with equal joint powers to dispose of the assets of the joint estate.<sup>294</sup> Effectively, the marital power that existed between spouses married in community of property<sup>295</sup> (the majority of marriages) reduced women to minors, and granted husbands power and control over the joint estate. Most women are married customarily, however, so effectively, marital power still applies to those marriages. Moreover, several civil property-related laws circumscribe married women's rights. The Penal Code, for example, by inference suggests that only women can steal from jointly owned property<sup>296</sup> thus rendering such property under the husband's legal control. Women also face problems securing business loans or property because the Companies Act prohibits them from accepting company director positions without their husbands' consent.<sup>297</sup>

### *Customary Law*

Given that Botswana's legal system comprises both customary and Roman-Dutch traditions, Batswana theoretically have a choice of venue.<sup>298</sup> However, in light of the population's rural concentration, most civil disputes are heard by traditional tribunals.<sup>299</sup>

Under customary law, women are often subordinated to men, lack independent legal capacity and are subjected to the guardianship of their fathers, brothers, uncles or husbands.<sup>300</sup> There has been progress regarding women's representation at the tribal level, however. In 2003, Mosadi Seboko, a single mother and former bank manager, was appointed paramount chief of the Balete tribe.<sup>301</sup> Seboko assumed the throne after a protracted battle with her male relatives to claim the position left vacant by the deaths of her father and brother.<sup>302</sup> She and her female relatives relied on the Constitution's provision against discrimination to secure her ascension.<sup>303</sup> Seboko is joined by two other female chiefs in the national House of Chiefs,<sup>304</sup> of which she was appointed chairwoman.<sup>305</sup> The House of Chiefs advises the president on customary and tribal land issues.<sup>306</sup>

The Customary Courts Act codified the regime of customary courts throughout the country and provided that

such courts should apply “the customary law of that tribe or tribal community so far as it is not incompatible with the provisions of any written law or contrary to morality, humanity, or natural justice.”<sup>307</sup> Conflicts are resolved through the *kgotla*, the traditional court and meeting place, over which the chief presides. Traditionally although women could take part in these meetings, they generally only spoke up on behalf of a male minor<sup>308</sup> and could not initiate legal proceedings or claim damages.<sup>309</sup> The situation has changed, however, regarding women’s assertion of their rights. There is evidence that women take their cases to various customary courts to sue for adultery, damages and criminal offenses including assault.<sup>310</sup> While statutory law may yield judgments in favor of women’s status and property rights, many women avoid civil courts as a result of wanting to preserve family unity, due to lack of resources, or other restrictions resulting in their inability to travel to courts that are located in urban centers.<sup>311</sup>

A number of traditional laws restrict women’s property and inheritance rights.<sup>312</sup> For example, a woman married under traditional law is held to be a legal minor vis-à-vis her husband, requiring her husband’s consent to buy or sell property.<sup>313</sup> This severely impinges women’s access to credit, since they lack the collateral necessary to secure loans.<sup>314</sup> An unmarried woman under customary law will remain under the guardianship of the male head of her family, her rights being determined, and possibly restricted, through him.<sup>315</sup> Women are also traditionally barred from owning cattle, an important symbolic and financial asset, and a linchpin of the rural economy.<sup>316</sup> Under tribal tradition, a man must pay *bogadi* (cattle) to his potential bride’s father.<sup>317</sup> This practice reinforces the idea that wives become their husband’s property upon marriage and, as such, are to be controlled by them.<sup>318</sup> This fact is significant because, “[a] woman’s capacity to voluntarily enter into marriage, to dissolve a marriage, and to have equal rights within her marriage are essential to her ability to control her life and make voluntary, informed reproductive choices.”<sup>319</sup> Moreover, when women lack secure property rights they are not free to leave abusive marriages and relationships.<sup>320</sup>

The Administration of Estates Act stipulates that the property of all Batswana will be disposed of according to customary law.<sup>321</sup> Under customary law, women are not permitted to inherit property.<sup>322</sup> When a woman’s husband dies, his property is transferred to his eldest son, although the widow is allowed to remain in the home until her death or remarriage.<sup>323</sup> In the event that the eldest

son dies before his father, the father’s property passes to the second eldest son and his heirs.<sup>324</sup> It is only if a man dies with no sons that a daughter may inherit; even in that case, the property is maintained by her male guardian.<sup>325</sup> However, in the case of a deceased tribesman who accumulated property that cannot be equitably distributed under customary law, an executor will be appointed by a Master of the High Court to handle the affairs of the estate and divide the property in terms of common law.<sup>326</sup>

## Violence Against Women

While the dimensions of violence against Batswana women have been difficult to quantify due to fear, poor policing and scant data, social norms condone it and the Government has been slow to respond to this form of gender discrimination.<sup>327</sup> A report presented in May 2005 estimated that six out of ten women in Botswana are lifetime survivors of domestic violence.<sup>328</sup> Women of all classes and social strata are victims of violence.<sup>329</sup> Rape, incest and intimate partner violence are prevalent throughout the country.<sup>330</sup> Reasons for gender-based violence in Botswana include gender hierarchy, the equation of women with property, women’s dependence on men and the overall failure to grant women social, economic and legal rights.<sup>331</sup> In 2006, 1,544 rapes were reported nationally.<sup>332</sup>

The Penal Code stipulates a maximum life sentence accompanied by corporal punishment for rape, but such sentences are rarely pronounced.<sup>333</sup> Actual sentences have been found to fall between six months and nine years.<sup>334</sup> A Penal Code provision automatically denying bail to rape respondents was declared unconstitutional in 1998.<sup>335</sup> Botswana law takes into account the added risk of HIV when meting out sentences for rape. For example, while the minimum sentence is 10 years, it rises to 15 if the assailant is HIV-positive.<sup>336</sup> The term rises to 20 years if the assailant knew his or her HIV status.<sup>337</sup> Respondents in criminal rape cases are tested for HIV prior to sentencing;<sup>338</sup> however, the test cannot confirm whether the perpetrator was positive at the time of the attack, raising the issue of whether it is criminal intent that is being punished or HIV-positive status.<sup>339</sup>

Botswana’s criminal law makes no provision for marital rape.<sup>340</sup> Furthermore, rape is a moral offense rather than an offense against the person, which diminishes its status as a crime against women<sup>341</sup> and equates women’s value with family or community honor. The process for the prosecution of rape hinders reporting by requiring corroboration, allowing the admissibility of evidence of a prior relationship between the assailant and



the survivor and directing the conduct of rape trials in open court.<sup>342</sup> If survivors do report assaults, they are frequently faced with noncompliant and insensitive police.<sup>343</sup> In general, family violence is often considered a “domestic dispute” in which police officers are reluctant to intervene.<sup>344</sup> The nation has one shelter for battered women, the Kagisano Society Women’s Shelter Project.

Sexual harassment, especially at the workplace and in learning institutions, is prevalent in Botswana.<sup>345</sup> According to one report in 2000, 60 percent of secondary school students in Botswana have been sexually harassed by their teachers and girls’ declining school enrollment since 1997 is partly blamed for fear of sexual abuse.<sup>346</sup> In a survey of 560 secondary school students in 2002, 20 percent said that they had been asked by teachers to have sex with them and 42 percent of these reportedly accepted, “mainly because they feared lower grades if they refused.”<sup>347</sup>

### **Socio-Economic Status**

Economically, women in Botswana are significantly disadvantaged in comparison to men. In 2004, for example, the female GDP per capita was PPP (purchasing power parity) US\$5,322 while the male GDP per capita was PPP US\$14,748.<sup>348</sup>

Different factors account for gender-specific economic inequality, including the prevalent situation of households headed by women with little financial resources and the uneven distribution of family responsibilities between men and women.<sup>349</sup> During the last three decades, the number of female-headed households has increased greatly in Botswana. By 2001, 50 percent of all households in rural areas and 44 percent of those in urban areas were headed by women.<sup>350</sup> Women have nearly a 28 percent official unemployment rate as compared with less than 22 percent for men.<sup>351</sup> The gender disparity in income and employment has been attributed to a history of occupational segregation that has resulted in the exclusion of women from certain job sectors, such as construction.<sup>352</sup> Moreover, few income-generation opportunities for women exist outside of formal employment, particularly in rural areas.<sup>353</sup>

Historically, Botswana girls have enjoyed greater access to primary and junior secondary school than boys; since the late 1980s, however, girls and young women have tended to prematurely leave secondary school, partly due to family demands, including unwanted pregnancies.<sup>354</sup> Pregnancy is a leading reason girls terminate their schooling since discriminatory school regulations make it nearly impossible for girls to

resume their education after giving birth.<sup>355</sup> Also limiting their future opportunities, young women rarely pursue vocational and technical training, for similar reasons,<sup>356</sup> although in 2000, the Botswana Minister of Labour and Home Affairs reported to the UN a revision to the National Policy on Education to expand vocational and technical education to attract more women.<sup>357</sup>

### **Health Indicators and Access**

Urban women in Botswana give birth an average of 2.8 times and rural women average 3.7 births over their lifetimes.<sup>358</sup> Over 93 percent of women reported having attended an antenatal clinic during their last pregnancy.<sup>359</sup> Less than 1.5 percent of women experienced an unattended birth in 2002.<sup>360</sup> The adjusted maternal mortality ratio in 2000 was 100 maternal deaths per 100,000 live births.<sup>361</sup> Pregnancy can be legally terminated within the first 16 weeks for rape or incest, fetal impairment or risk to the mother’s life, mental or physical health.<sup>362</sup>

Botswana has made gains over the past decade in reducing the rates of adolescent pregnancy. The United Nations Population Fund has reported that, in 1996, six out of 10 teenage women had been pregnant at least once, whereas that ratio dropped to two in 10 in 2003.<sup>363</sup> While an encouraging downward trend, the problem remains serious, particularly for young girls.<sup>364</sup> A study by the Botswana Ministry of Health and Social Services in 2003 revealed that most adolescent pregnancies are the result of sexual relationships with older men.<sup>365</sup> Some of the reasons identified for this age disparity are young women’s fear of refusing older men sex and disempowerment vis-à-vis older, wealthier male partners.<sup>366</sup>

As discussed in the previous section on legal status, female subordination has been an integral part of traditional society.<sup>367</sup> Women’s customary roles were defined as “docile daughter, wife or caring mother.”<sup>368</sup> Women have had little control over their sexuality, including the right to decide when and how many children to bear or when and if to marry.<sup>369</sup> Women who refused sexual advances risked losing their partners<sup>370</sup> and women were not socially or culturally permitted to insist on condom use in male-dominated relationships.<sup>371</sup> Men’s continuing control of women’s sexuality and reproduction in Botswana directly translates into ill health for women and specifically into an elevated risk of contracting HIV and developing AIDS.

### **General Gender Policy**

In 1981, the government established a National Women’s Unit which was elevated in 1996 to a Department of

Women's Affairs (WAD) in the Ministry of Labor and Home Affairs.<sup>372</sup> WAD is staffed by 11 professionals<sup>373</sup> who work to integrate gender policies into various government initiatives.<sup>374</sup> United Nations Agencies including UNDP, UNAIDS, UNFPA and UNICEF support WAD objectives and initiatives to enhance women's status. Certain ministries have a designated Gender Focal Point.<sup>375</sup>

In 1996, in recognition of the vast gender inequalities in Botswana, the government instituted an ambitious National Policy of Women and Development with the aim of achieving "effective integration and empowerment of women in order to improve their socio-economic status, enhance participation in decision making and their role in the development process." Specifically, the policy aims to eliminate all economic, social and legal discrimination against women, to improve women's health, to promote education and skills training and to mainstream gender into development planning.<sup>376</sup> Vision 2016 called for strengthening and implementation of this policy, as well as a commitment of resources from the NDP to combat discrimination, and included six detailed areas of focus related to gender.<sup>377</sup>

Two years later, in 1998, the Government responded to the Fourth World Conference on Women in Beijing by creating the National Gender Programme Framework to transform policy principles into concrete strategies. The framework prioritized six areas of concern from the Beijing Declaration and Platform for Action, including poverty and economic empowerment; power and decision making; education and training; health; and girls.

In 1999, the Advocacy and Social Mobilisation Strategy and the Botswana National Council on Women (BNCW) were established.<sup>378</sup> The BNCW has the mandate to guide and support the Government, NGOs, and the private sector as well as monitoring and reviewing policies and programs for gender equality, awareness and progress; it is the highest advisory body to the government on women's issues.<sup>379</sup>

Several population health and gender equality indicators attest to improvements for women in Botswana in the last decade.<sup>380</sup> These impacts and the government policies that produced them represent real advances. Policies are limited, however, by being operational only at the national level<sup>381</sup> and in isolation from many Botswana women. As a result, political and social change addressing gender inequalities in Botswana has been indebted to the initiation and insistence of civil society, through the women's movement and women's NGOs such as Emang Basadi ("Stand Up

Women") and Women and Law in Southern Africa (WLSA) — Botswana.<sup>382</sup> Among other initiatives, WLSA has offered training on women's rights as human rights, provided legal advice and services, and lobbied and advocated for policy and legal reform. It has published several books documenting the status of women's rights in Botswana.<sup>383</sup>

Founded in 1986, Emang Basadi has conducted participatory research, mobilization and education to increase women's participation in national development, for example through the support of female politicians with its 1998 publication, *A Woman Candidate's Guide to Campaign Management*.<sup>384</sup> The organization has also secured major legislative victories for women's rights. Prior to 1995, the government denied women the ability to pass their Botswana citizenship to their children if they were born to foreign husbands.<sup>385</sup> Through researching state precedents and international standards, lobbying members of Parliament and publicizing the discriminatory nature of the practice, Emang Basadi was instrumental in securing the passage of the Citizenship Amendment Act in 1995 which granted Botswana women the right to pass their nationality onto their children born to foreign fathers.<sup>386</sup>

Other organizations focusing on gender include the Women's NGO coalition, Botswana Caucus for Women in Politics and the Botswana Council of Women. Ditshwanelo, the Botswana Centre for Human Rights, conducts human rights advocacy and education in a number of areas, including HIV/AIDS.<sup>387</sup> Women Against Rape trains women in income-generating skills and helps them gain credit to start their own small businesses.<sup>388</sup> The Kagisano Society Women's Shelter Project operates the only domestic violence refuge for women and children in Botswana, begun in 1998 and located in Gaborone.<sup>389</sup> The Parliamentarians for Women's Health Project is a three-year project in Botswana, Kenya, Namibia and Tanzania to educate and strengthen leadership in those countries with the goal of improving access to health services for women and girls, particularly related to HIV/AIDS.<sup>390</sup> In 1991 the University of Botswana established the Gender Policy and Programme Committee.

Women's representation in government has improved somewhat, largely as a result of NGO advocacy. The percentage of women elected to Parliament increased from 5 percent in 1990 to just over 11 percent in 2005.<sup>391</sup> Women's representation at the level of senior government officials was close to 31 percent in 2005.<sup>392</sup>

## Notes

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## IV. BOTSWANA PHR STUDY FINDINGS

This chapter presents the most significant results from the Botswana community survey and PLWA interviews. Key findings include:

1) *Participant Characteristics*: More women than men surveyed reported food insufficiency, lower incomes, greater likelihood of unemployment and having at least one dependent. Lack of food and women's economic dependence on men also affect many PLWA and are a particularly salient barrier to ARV treatment.

2) *Knowledge of HIV*: The majority of community survey participants correctly answered questions about HIV prevention and transmission. Common gaps in knowledge and misconceptions persist, however. PLWA described men's knowledge as inferior to women's.

3) *HIV Testing*: While the majority survey reported access to testing, 52 percent of women and 44 percent of men sampled had tested. Media messages were the most common facilitators to testing and fear of knowing one's status the most common barrier for both women and men. While the majority had voluntary and confidential tests and received pre- and post-counseling, 62 percent of women and 76 percent of men reported that they perceived that they could not refuse the test.

4) *Routine Testing*: Fifty-four percent of respondents had heard of Botswana's "routine testing" policy before the survey and 15 percent of those tested had tested under this opt-out program. After an explanation of the policy, the majority expressed positive views about its impacts, though 43 percent agreed that routine testing could cause people to avoid health care for fear of being tested. PLWA agreed that routine testing could facilitate increases in testing; they expressed the concern that counseling be assured so that recipients will be prepared to learn their HIV status.

5) *HIV-Related Stigma and Discrimination*: Fifty-four percent of women and 51 percent of men surveyed reported stigmatizing or discriminatory views toward PLWA. While the majority expressed acceptance of those living with HIV/AIDS and felt that discrimination had declined in Botswana since the advent of ARV treatment, projected fear of stigma should they themselves be HIV-positive was a common concern. For example, 50 percent of women and 57 percent of men reported

that they would be treated as social outcast by their community. PLWA interviewed believed that stigma and discrimination had lessened over time in Botswana and reported positive consequences of disclosure of their status. Nevertheless, those interviewed recounted poor treatment at home, in the workplace and in the community, particularly for women, which they associated with overall gender inequality in Botswana.

6) *Sexual Risk*: Women participating in the community survey lacked control over the decision of when to have sex (30 percent) or use a condom (22 percent) as compared with men (less than 2 percent and 7 percent, respectively). Fifty-three percent of women, and 13 percent of men, had unprotected sex at least once in the past year because their spouse or partner refused to use a condom. Eleven percent had unprotected sex with a non-primary partner. Twenty-five percent of women and 40 percent of men reported multiple sexual partners in the past year; 8 percent of women and less than 5 percent of men reported no partners. PLWA reported having fewer sexual partners and using condoms more consistently since discovering their HIV-positive status; women's lack of control mitigated against such changes for many women.

7) *Gender Discriminatory Beliefs*: 95 percent of women and 90 percent of men surveyed held at least one gender discriminatory belief and the majority reported 1 to 2. While participants endorsed women's subservience to men, 88 percent of women and 84 percent of men agreed that women should have the same legal rights as men in Botswana. Holding gender discriminatory beliefs predicted sexual risk. For example, community survey participants who held three or more such beliefs had 2.7 times the odds of those who held fewer beliefs of having had unprotected sex in the past year with a non-primary partner. PLWA testimony highlighted the association of women's dependency on male partners with their vulnerability to HIV and reported on the ongoing harm to female PLWA created by women's lesser social and economic status in Botswana.

8) *Leadership on HIV/AIDS*: Community survey participants identified gaps in the performance of leaders at all levels. PLWA gave mixed reviews, highlighting the

need for increased visibility and consistent effort, particularly at the local level.

Throughout this chapter, where sex differences are statistically significant ( $p < 0.05$ ), the sex stratified data are presented.

## Characteristics of Study Participants

### Community Survey

Descriptors of the participants in the community survey, disaggregated by sex, are presented in Table 1. For this study, 1,268 women and men from the five districts in Botswana with the highest number of HIV-infected peo-

ple were surveyed.<sup>393</sup> Fifty-two percent of participants were women. The mean age of those surveyed was 28.7 years; age differences between women and men were not statistically significant. The women surveyed experienced more food insufficiency and were poorer than the men. Twenty-eight percent of women, in contrast with 19 percent of men, reported problems obtaining food to eat in the past year. Fifty percent of women, as compared with 39 percent of men, had a monthly household income of less than or equal to 1,000 Botswana *pula* (approximately US\$220).<sup>394</sup> Women were also more likely to be unemployed: 34 percent of women and 27 percent of men reported that they were not working.

**TABLE 1: Characteristics of Participants in the Botswana Community Survey (N=1268)\***

Community Survey Participant Characteristics	Women (N=654) n(%) (except as noted)	Men (N=613) n(%) (except as noted)	p values**
Age (mean, years)	28.9	28.4	---
Marital Status			
Married	136(21)	105(17)	0.009
Unmarried/Living w/ Sexual Partner	191(29)	149(24)	
Unmarried/Not living w/Sexual Partner	326(50)	358(59)	
Dependents			
Having > or = 1 Dependent	440(73)	325(60)	0.000
Employment Status			
Employed	423(66)	443(73)	0.000
Unemployed	222(34)	165(27)	
Residence Type			
Urban	310(47)	247(40)	0.027
Urban village	187(29)	187(31)	
Rural	157(24)	179(29)	
Monthly Household Income			
< or = 1,000 Botswana pula (approximately US\$220)	326(50)	242(39)	0.000
> 1,000 Botswana pula	321(50)	371(61)	
Education			
< High School (Form 5) Education	301(46)	271(45)	0.572
> or = High School (Form 5)	349(54)	335(55)	
Food Insufficiency			
Problems getting enough to eat, past 12 months	184(28)	113(19)	0.000
Access to Good Quality*** Medical Services	495(77)	530(88)	0.000
Positive Screen for Depression****	190(31)	175(27)	0.096

\* Sex was missing for one individual; for sex-stratified data, N=1267.

\*\* P values refer to the statistical significance of the difference between women's and men's responses.

\*\*\* This term was not defined for survey participants.

\*\*\*\* Symptoms of depression were measured using the 15-item Hopkins Symptom Checklist for Depression (HSCL-D). People were considered to screen positive for depression if their score equaled or exceeded the cutoff threshold of 1.75.<sup>395</sup>

Fifty percent of women and 59 percent of men were unmarried and not living with a sexual partner. Seventy-three percent of women and 60 percent of men had one or more dependents. Close to 46 percent of those sampled had less than a Form 5 (high school) education. Forty-seven percent of women and 40 percent of men lived in an urban area, 24 percent of women and 29 percent of men were rural residents and 29 percent of women and 31 percent of men resided in urban villages (urbanized areas outside of main cities).<sup>396</sup>

The majority of participants in the survey had access to health services, primarily receiving care at public clinics. Ninety-one percent of women and men reported that they were usually treated with respect and dignity by health care professionals. Thirty-one percent of men self-assessed fair or poor health status, as compared with 27 percent of women; women reported a greater number of visits to a medical doctor in the past year.<sup>397</sup> Nearly a third of those surveyed screened positive for depression.

### **PLWA Interviews**

The 24 qualitative interview respondents were all HIV-positive members, leaders, volunteers or counselors with support groups for people infected or affected with HIV/AIDS from Gaborone, Serowe and the surrounding villages and rural areas. Twenty-one were women, in part reflecting the predominance of women in these groups. The mean age was 32 years. Two respondents were married, 3 co-habited with a sexual partner and 19 (including 2 out of the 3 men) were living alone and did not have a regular intimate partner. Only 4 participants had completed high school.<sup>398</sup> Nineteen were unemployed. Of those 5 individuals who were employed, all had jobs in HIV-related activities, as counselors, administrators, field workers or cleaning staff.

## **Access to ARV Treatment**

### **Community Survey**

Eighty-five percent of women and 90 percent of men projected that ARV treatment would be available to them should they develop AIDS.

### **PLWA Interviews**

Twenty-three of the 24 participants in the qualitative interviews were receiving ARV treatment. None reported difficulty in adhering to the regime. Interviewees described, however, that barriers to treatment still exist for many who need it. In particular, the lack of

food and gender inequality in relationships create obstacles for PLWA seeking to obtain ARVs.

### *Barrier to Treatment: Food Insufficiency*

Interviewees reported that for Botswana women and men, even before testing positive for HIV, lack of food was a problem. Food insufficiency is compounded by the demands of the disease and the treatment regimen. One 42 year-old housewife from Kopong, herself not receiving ARVs (due to lack of resources for transport), said, “[l]ack of food is a problem. ARVs increase the appetite. If there is not enough food, it is a problem.” Another woman, from the Gabane PLWA support group, noted that once people tested HIV-positive, if they met the criteria for ARV treatment they were eligible to receive a food basket once a month through the government’s home-based care program. Reportedly, “[s]ome people go for the test for the food basket. They don’t want any further ARV assistance.” A similar story was mentioned by a 37 year-old woman interviewed in Serowe:

*Seven men went to Tebelopele, one was negative. He wanted to test positive to get the home-based care ration. Most people are still starving.*

Even if the HIV-positive individual her/himself is given food assistance, she or he will often share it with relatives, as one 39 year-old man living with his HIV-positive 4 year-old son explained:

*Food is given at the hospice, there is also food from home-based care, but they do not give for my son. There is not enough food for my son.*

### *Barrier to Treatment: Gender Inequality*

A 32 year-old woman who works with the Botswana Network of People Living with HIV and AIDS (BONEPWA), the national network of HIV/AIDS support groups, noted the fear of abandonment by men that keeps some women from seeking ARVs:

*Women don’t take treatment. They are brave for the test, but not for treatment because men, their partner, will find out [that they are HIV-positive]. Women are afraid of losing their partner.*

In other instances, women may be denied treatment by their male partners. A 28 year-old man from Serowe who credits ARVs for saving his life reported:

*Last time I was at the clinic, I saw a woman who said that her boyfriend took the medicine and threw them away. ... I don’t know why he threw them away. ...It does happen.*

Control of access to life-saving treatment is a stark example of the control men exert over women's lives in Botswana in general, as discussed elsewhere in this report.

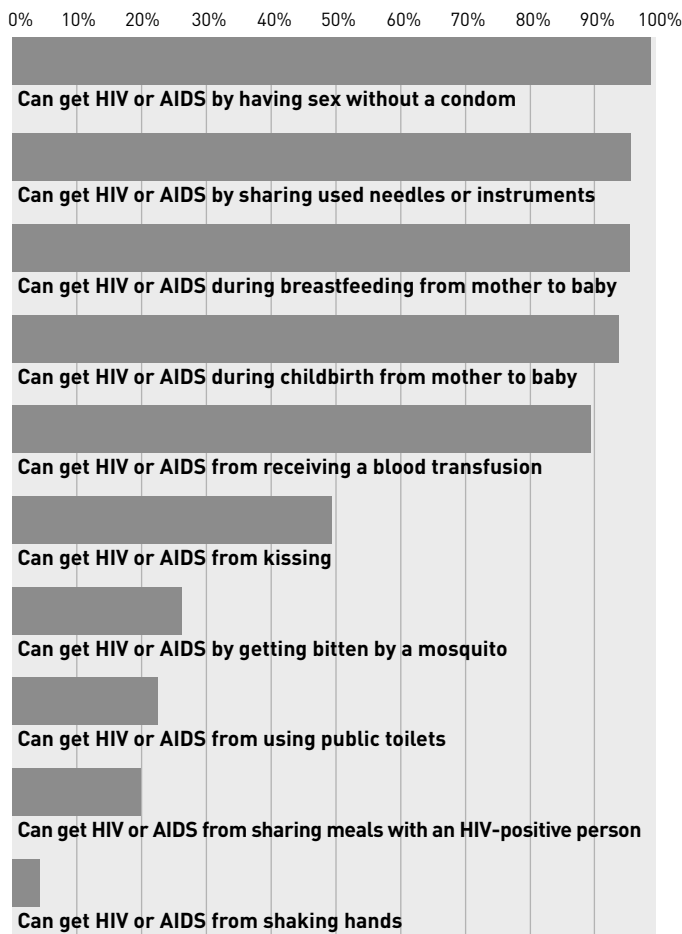
## HIV Knowledge

Participants in the community survey were questioned about their knowledge of HIV/AIDS transmission and prevention. Common gaps in knowledge and misconceptions about HIV/AIDS were also discussed in the interviews with PLWA. While the majority reported correct knowledge of HIV/AIDS, the results 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.

## Community Survey

The vast majority correctly answered questions concerning modes of HIV prevention and transmission,<sup>399</sup>

**GRAPH 1: Beliefs Regarding HIV Transmission, Botswana Community Survey**



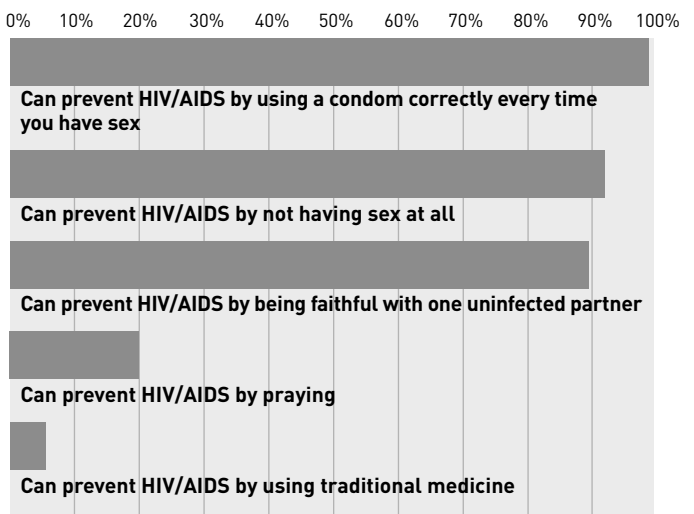
although lower proportions of women (82 percent) than men (89 percent) met this standard. This was found despite women's purported greater access to information through the efforts of community mobilization and the PMTCT program of antenatal care.

In terms of knowledge with regard to HIV transmission, among community survey respondents, 99 percent of women and men were aware that people can get HIV/AIDS from sexual intercourse without a condom. Ninety-six percent were aware that sharing used needles or instruments is risky. However, the survey also revealed misconceptions regarding HIV infection (see Graph 1). Twenty-nine percent of women and 22 percent of men thought that a person can get HIV through a mosquito bite; 29 percent of women and 17 percent of men believed that using public toilets can transmit HIV; and 19 percent of women and men believed that it could be transmitted by sharing meals with an HIV-positive person. In addition, in terms of HIV prevention knowledge, while 97 percent of women and men agreed that using a condom correctly every time can prevent HIV, 8 percent of those surveyed reported that using traditional medicine is a preventive measure and 10 percent agreed that praying is a strategy to prevent the HIV transmission (see Graph 2).

## PLWA Interviews

The interviews with PLWA revealed a misconception about HIV that many respondents saw as prevalent in their communities, particularly among men: there was limited public understanding that one can be both HIV-positive and asymptomatic. For example, as a 33 year-

**GRAPH 2: Beliefs Regarding HIV Prevention, Botswana Community Survey**



old woman who worked as a counselor with a PLWA youth organization reported:

*I've gone public with my status. Some people, when they meet me say I'm lying, the government pays me to say that I'm HIV-positive. They say how can I be HIV-positive if I'm looking so good? They say I want to 'eat government money.'*

This misconception reflects a failure in the Government's prevention initiatives to counter the stereotype that anyone HIV-positive would necessarily appear emaciated or ill. It also represents a missed opportunity in public messaging to link testing and treatment programs by targeting for testing those who do not look sick but may have the HIV virus. The latter is something the education component of the Masa program appears to have done successfully for enrollees. As one woman receiving ARVs and good nutrition who rated her health status highly commented, "I look just like anyone else who fears to go for a test."

There was also agreement among interviewees that men's knowledge of HIV prevention and transmission in general was inferior to that of women. One of the male PLWA group leaders interviewed, who worked as a Total Community Mobilization (TCM) field officer, attributed this to both men's lack of information and their denial of their vulnerability to HIV/AIDS:

*Men have a problem — they have to be really sick [to test]. There was a man who came for testing but did not go for his results. Now he needs viral loads and CD4 counts. I found him down — I need to persuade him and teach him. Men seem to be ignorant. ... Women have information, they are taught at home by TCM. But men are not at home.*

Both HIV-related knowledge and denial based on fear or unwillingness to confront one's own vulnerability to AIDS have direct implications for willingness to test for HIV and experiences with testing.

## HIV Testing

While over 80 percent of those surveyed reported access to testing, less than half had tested. When queried about what would assist them to test, treatment availability, couples testing and partner support were cited by the majority. Nineteen percent affirmed that having sufficient food would enable them to test. The majority of those who had tested did so voluntarily, found out the results of their test, reported no breaches of confidentiality or ill treatment and received pre- and

post-test counseling. However, the majority of those tested also felt they could not refuse the test.

For both women and men, television and radio messages were the most common facilitators for testing. Fear of knowing one's HIV-positive status was the most common barrier. Other barriers differed based on sex. PLWA interviews highlighted men's denial of HIV and women's fear of jeopardizing intimate relationships as barriers. When asked to project the consequences of their hypothetical HIV-positive status, the majority of community survey participants expressed fear of being stigmatized in their community, suggesting another significant barrier to testing, also discussed in PLWA interviews.

Half of survey participants had heard of Botswana's routine testing program, an opt-out policy introduced into public health facilities in January, 2004. Fifteen percent of those tested had tested under that program. While the majority favored the policy as explained to them, participants projected both positive and negative outcomes to routine testing. PLWA interviews had similar results, with most of the interviewees' concerns related to the potential for inadequate provision of counseling, necessary to ensure readiness to know one's status, under routine testing.

## Community Survey

### *Prevalence and Characteristic of Having Been Tested for HIV*

Eighty-four percent of community survey participants reported that they had access to HIV testing through a VCT or the *Tebelopele* program. Eighty-six percent of women and 78 percent of men agreed that it was possible for someone in their village to get a confidential HIV test.

Six hundred and five community survey participants reported that they had been tested for HIV, constituting 52 percent of the women surveyed and 44 percent of men. Factors associated with having been tested, in multivariate regression analyses adjusted for other respondent characteristics,<sup>400</sup> included a high school or more education, three or more visits to a medical doctor in the past year, perceived access to good quality medical services and to HIV testing, and inconsistent condom use.

### *Experiences with Testing*

In the community survey, among those tested, 47 percent of women and 63 percent of men were tested at VCT centers, 28 percent of women and 23 percent of men at public hospitals, 7 percent of women and 3 per-

cent of men at NGOs, 7 percent of women (and less than one-half percent of men) at antenatal clinics<sup>401</sup> and the rest in other clinics or private hospitals. Almost all respondents who had been tested reported that it was their decision to get tested (93 percent); however, 62 percent of women and 76 percent of men believed that they could not refuse the HIV test, whether or not they made the decision to test.<sup>402</sup> The perceived coercive experience of the majority of participants who have been tested raises potential human rights concerns about the voluntary nature of Botswana's testing services.<sup>403</sup>

At the same time, 98 percent of community survey participants tested reported no ill treatment related to testing and an equal proportion claimed that they did not regret getting tested. Indeed, 92 percent reported that their experience with testing led them to encourage others to be tested. Most participants found out the results of their tests (94 percent) and reported that confidentiality had been strictly maintained at the testing centers (95 percent). Of the participants who had informed their partner of their test (85 percent of those tested), nearly all (99 percent) denied that their partner had physically hurt or threatened them for being tested. Here, as elsewhere in the survey, the incidence of partner violence is likely to be under-reported.<sup>404</sup> Ninety-six percent reported receiving pre-test counseling and 93 percent of women and 87 percent of men reported post-testing counseling.

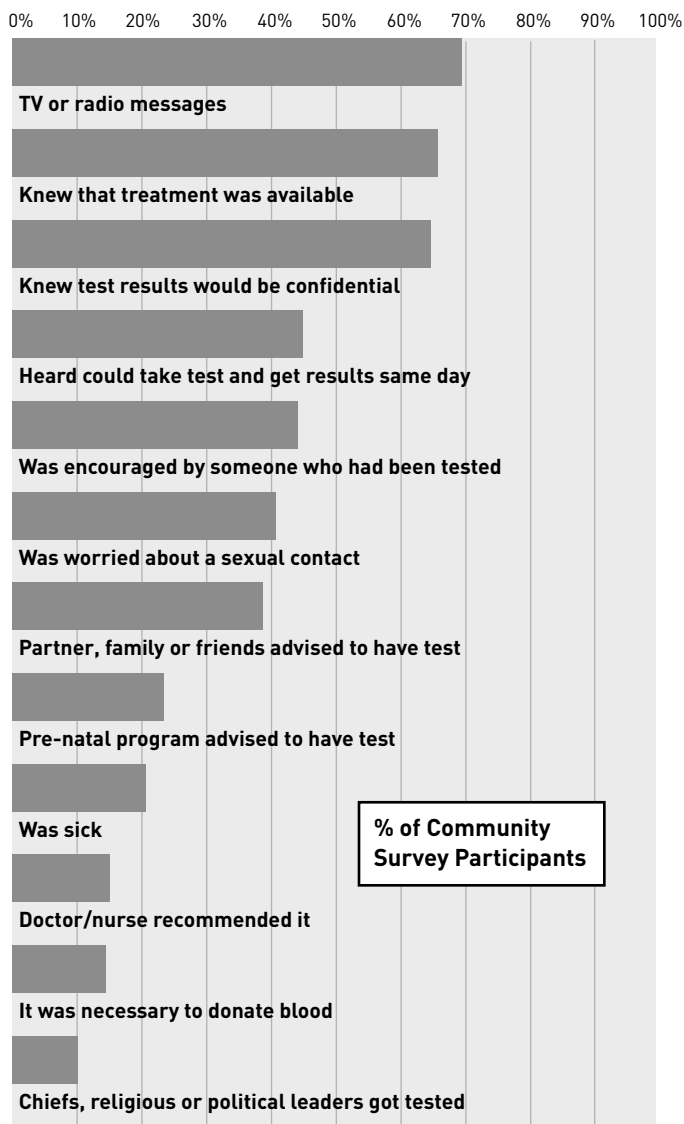
### Facilitators of Testing for HIV

The most common facilitating factors reported in the Botswana community survey, for more than three-fifths of those tested, were TV or radio messages, knowing that treatment was available and knowing that the test results would be confidential. Other reasons are listed in Graph 3. Women were significantly more likely to report encouragement from pre-natal programs (31 versus 13 percent) as a facilitator to testing. Men were significantly more likely than women to list treatment availability (74 versus 58 percent), advice from family or friends (44 versus 34 percent), messages from the media (77 versus 63 percent), encouragement or support from someone who had been tested (55 versus 33 percent) and confidentiality of testing (74 versus 56 percent) as factors that influenced them to get tested.

### Barriers to Testing for HIV

In the community survey, of the 658 respondents who had not been tested, 48 percent were women and 56 percent were men. In regression analyses, people who

**GRAPH 3: Principal Reasons Community Survey Respondents Who Had Been Tested Gave For Being Tested\* (n=602)**

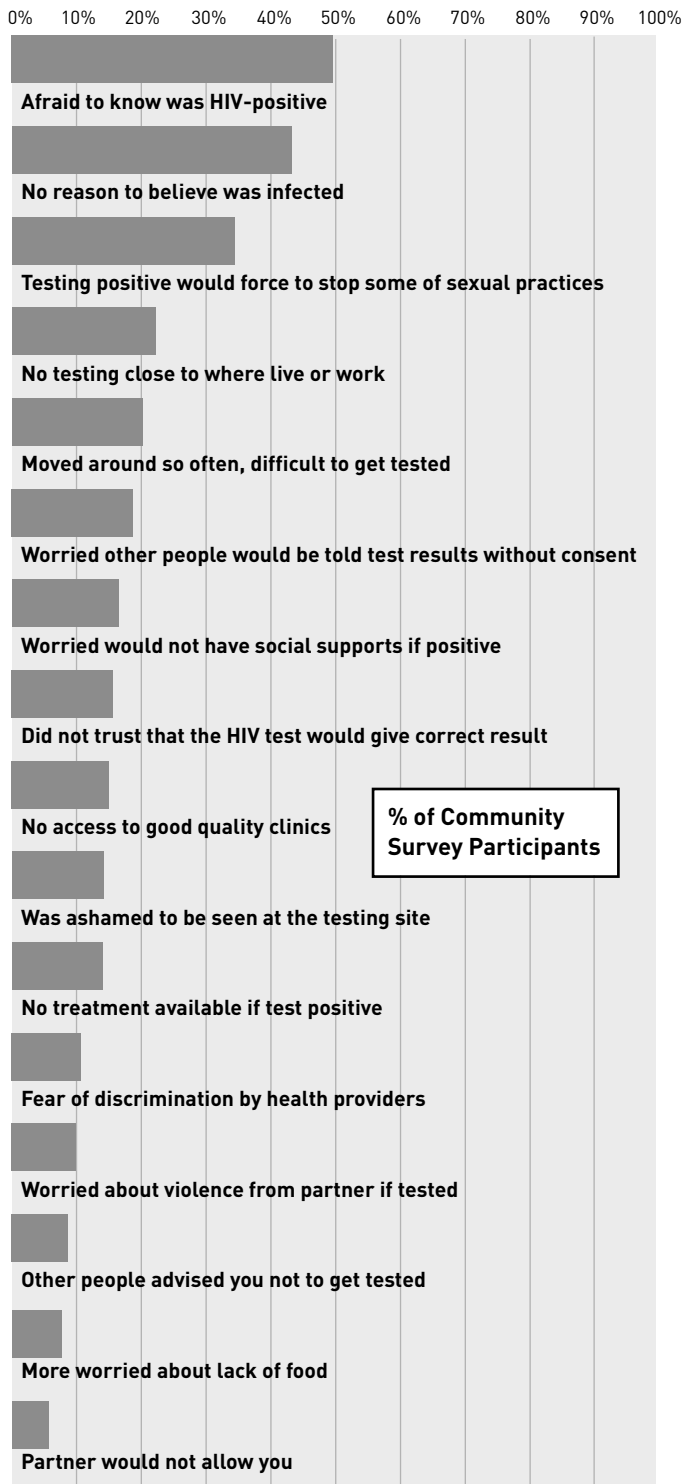


\*Respondents could agree with more than one reason.

self-assessed fair or poor health status, who did not know whether ARVs would be available to them if they tested positive or who reported stigmatizing attitudes towards people living with HIV/AIDS were less likely to have been tested for HIV. This suggests that, though only a minority may report being affected by a particular barrier, such as perceived access to treatment,<sup>405</sup> the impacts on testing behavior can be significant.

The most prevalent barrier to testing reported by those not tested was the fear of knowing one's HIV-positive status. Other reasons agreed to by participants as barriers to testing that they experienced are presented in Graph 4.

**GRAPH 4: Principal Reasons Community Survey Respondents Who Had Not Been Tested Gave for Not Being Tested\* (n=658)**



\*Respondents could agree with more than one reason.

All community survey participants were asked questions regarding potential consequences if they were (hypothetically) to test positive for HIV and disclose their status to others. Fear of losing one's partner if diagnosed with HIV was expressed by both female and male respondents as a serious concern: thirty percent of women and men, both tested and not tested, agreed with the statement that if they were to test positive for HIV and told others, this would result in the break-up of their marriage or intimate relationship.

Fear of being subjected to HIV-related stigma and discrimination may also present a significant barrier to testing. Were they to disclose an HIV-positive status, 28 percent of women and 34 percent of men expected that they would be treated badly at work or school, 40 percent of women and men expected to lose friends, and 50 percent of women and 57 percent of men believed that they would be treated like a social outcast in the community. For those not tested, fears of being stigmatized appear to translate directly into the avoidance of testing: 14 percent said that they were ashamed to be seen at the testing site and believed that going there would cause others to treat them badly.

There were several significant sex differences in the reported barriers to testing. Women were significantly more likely than men to report lack of permission from their spouse or partner (10 versus 3 percent). Men were more likely to cite frequent migration (25 versus 15 percent), not wanting to change sexual practices (39 versus 27 percent) and concerns about lack of social supports if they tested positive (20 versus 12 percent). This points to the need for specific interventions targeted to women and men around improving access to testing and encouraging individuals to test. It suggests that structural issues related to women's status, gender norms and sexual relationships need to be addressed for these interventions to succeed.

#### *Plans to Test in the Future*

Among those who had not been tested, 71 percent reported that they intended to be tested in the next six months. The most commonly cited factors that would enable testing included knowing that they could get treatment for HIV/AIDS (67 percent) and being tested with their spouse or primary sexual partner (64 percent). Other factors that participants agreed would convince them to test were if their spouse or partner would support their decision to test (61 percent) and if there was better counseling at testing sites (60 percent). Nineteen



percent of respondents affirmed that having enough food would remove a barrier to testing. These were no statistically significant differences in facilitating factors for female and male community survey participants.

In regression analyses, respondents who reported unprotected sex had more than twice the odds of planning to test. The only other participant characteristics associated with planning to test were urban residence and self-reported very good or good health. This suggests that, as with those who had been tested, some individuals may be motivated to test based upon a concern about a sexual contact, which may overcome the fear of knowing one's status or unwillingness to change sexual practices upon a positive test result. Respondents with stigmatizing attitudes had less than half the odds of planning to test than those without.

### *Knowledge of and Attitudes Toward Routine Testing*

In January 2004, the Botswana Government introduced HIV testing into health facilities as a part of routine medical care in an effort to increase enrollment in the ARV treatment program by overcoming some of the significant barriers causing individuals to delay testing or avoid it altogether. Survey questions on "routine testing" were based on the best available information at the time describing this opt-out policy.<sup>406</sup> Given that a minority of the survey sample had direct experience of this type of testing (91 out of 609 individuals reporting testing for HIV), 93 percent of participants were expressing their views of this policy in theory, based on the description provided by field researchers.

For the 15 percent of tested community survey respondents reported having been tested by "routine testing,"<sup>407</sup> their experiences, as compared with testing at a VCT site, differed in two respects: 6 percent of those tested by routine testing reported poor treatment (from any source) 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.

In regression analyses, the independent correlates of getting routine testing included being married and seeing a medical doctor more than three times in the past year. The former may imply, as with testing in general, that primary partners and other supportive family members can encourage care seeking, including HIV testing. People who held stigmatizing attitudes towards PLWA were significantly less likely to get routine testing, indicating that it may take more than health

worker-initiation and inclusion of an HIV test into routine medical care to overcome the persistent barrier that HIV stigma presents to testing.

Fifty-four percent of respondents had heard of "routine testing" before the survey. In regression analyses, after adjusting for other characteristics, having heard of routine testing was associated with high school or a higher level of education, household income greater than 1,000 *pula* per month, being married and having more frequent medical visits. Respondents who reported stigmatizing attitudes towards PLWA had lower odds of having heard of routine testing, as did respondents with more fears of being stigmatized if they tested positive, people living in rural areas, people who reported inconsistent condom use over the past year and those with self-reported poor health status. These associations indicate that even with opt-out testing, Botswana faces challenges in reaching the most marginalized populations and those most reluctant to test, including individuals engaging in risk-taking sexual practices.

After an explanation of the policy, a majority of respondents expressed positive views, as shown in Table 2. A majority also agreed with the proposition that this form of opt-out testing may result in less discrimination against HIV-positive people, lead to less violence against women and make it easier for people to get tested and to gain access to ARV treatment. By incorporating HIV testing into regular medical visits, individuals can be tested without requiring them to go to special testing centers which identify them as seeking an HIV test. More women than men expected positive outcomes in terms of decreasing HIV-related discrimination (65 percent of women versus 55 percent of men) and lessening gender-based violence (57 percent of women compared with 52 percent of men).

On the other hand, despite lacking any kind of experience with this testing intervention, survey participants projected some negative outcomes of opt-out testing. 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 of the community survey respondents thought that routine, opt-out testing could lead to more violence against women, given the greater number of women who would be tested and potentially have their HIV-positive status disclosed to a partner. Women's and men's views did not significantly differ statistically.

**TABLE 2: Attitudes Toward Routine Testing, Botswana Community Survey\***

	n (total N)	Percent
Have ever heard of routine testing	688(1,266)	54
Very much or extremely in favor of routine testing	1,014(1,251)	82
Somewhat in favor of routine testing	105(1,251)	8
Agree that routine testing helps people get access to ARV treatment	1,162(1,250)	93
Agree that routine testing makes it easier for people to get tested	1,120(1,263)	89
Agree that routine testing results in less discrimination (bad treatment) of HIV-positive people	761(1,259)	60
Agree that routine testing leads to <u>less</u> violence against women	685(1,256)	55
Agree that routine testing will cause people to avoid seeing doctor or nurse for fear of being tested	541(1,256)	43
Agree that routine testing leads to <u>more</u> violence against women	174(1,229)	14

\*The following explanation was given of the policy of routine testing: "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."

### PLWA Interviews

In interviews with PLWA, barriers to testing had a particular gender cast. ARVs were singled out as a significant facilitator to testing. Opt-out testing was viewed favorably, in large part due to its projected positive impact on overcoming the fears of knowing one's HIV status to be positive and of being stigmatized for testing.

#### Barriers to Testing

##### *Men's Denial of HIV*

Participants in the qualitative interviews described a cultural norm that sanctions multiple sexual partners for men and a climate of denial that fosters unsafe sexual behavior. A 32 year-old woman who tested positive together with her husband explained how men relied on myths and excuses to avoid taking responsibility for preventing HIV by seeking their status.

*For men, HIV/AIDS is not real. They would rather say they were bewitched. That, 'I am sick because that woman wants me to die to take my property.' Men want to stay strong, to be perceived as strong, and HIV/AIDS and strength do not go together.*

Interviewees, both men and women, noted that men were much less willing than women to acknowledge the existence of HIV/AIDS and its impacts. Thus they were less willing to engage in prevention and care ini-

tiatives, including testing, or to go for a test unless they were very sick — "Men think HIV/AIDS is not for them, only for women."

One man interviewed, now a support group counselor, learned of his status after he tested in 1999 when his girlfriend died of AIDS, but did not believe his results because he was asymptomatic. In 2002 he was sick and tested again and this time accepted his HIV-positive status.

*Most women go for testing, most men do not. Men have a block in their minds — I don't know what they think. Their minds are closed. In our support group women lead men. They are the ones that encourage men to test.*

Another man, a community educator agreed.

*Women — more come for testing. I refer four women for testing in a week, twenty in a month and two men in a month.*

One woman, who had herself been fearful to test until friends encouraged her to seek the cause of her illness, described the perspective from the other side of a partnership:

*Men fear finding out. They hear from their woman [her HIV-positive status] and then they know [their own status]. Then sometimes they go for a*

*test. I told my boyfriend. That made for a difficult relationship. We don't see each other very much any more. He has not had a test and he doesn't want to go for one.*

One of those interviewed, a youth educator, believed that the key was how the message to test was communicated:

*We go out to reach men ... to teach them about HIV/AIDS, OIs [opportunistic infections] and STDs. They open up when they talk to women. We go one month at a time, and for follow up. ... The DEB-SWANA [gold mine] men did get tested. They took our advice. ... CEYOHO [a youth HIV/AIDS support group] needs to target men, to go to the head boys of the cattle posts. ... I think it's only how you talk to them. That's when you can help them change their mind.*

Men's denial of their own potentially positive HIV status also translated into their abandonment of HIV-positive female partners, whether out of ongoing denial, rejection or blame of the woman for alleged infidelity, HIV-related stigma or fear of being stigmatized.

#### *Women's Fear of Jeopardizing Primary Relationships*

In terms of barriers to testing, interviewees suggested that many women feared that testing itself (regardless of the outcome of the test) would jeopardize their primary relationship. As one young woman living near Gaborone explained in an interview:

*[Women's] partners do not allow them to go for testing. Abuse by partners is a problem. Men run away from women sometimes just for testing, whether they are HIV-positive or HIV-negative.*

Another young woman voiced the same concerns: "At PMTCT women don't want to test because they are fearful of men leaving them behind."

Other qualitative interview respondents reported that, although women tested more frequently and earlier than men, the primary barrier prohibiting many women from testing was the fear of losing their partner upon disclosure, which would translate into a loss of financial support and imminent or worsening poverty and suffering. Men were perceived, and in most circumstances in fact were, the financial mainstay in domestic relationships. As one 22 year-old woman who believed she became infected with HIV from her boyfriend recounted:

*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.*

Men were also fearful of abandonment by partners, but their fears, as one 31 year-old woman expressed, were possibly centered on a loss of status or societal respect due to the stigma associated with HIV/AIDS:

*Men are also afraid to lose their partners. They are ashamed to be seen at the testing site. They think that people will discriminate against them. They think they will be valued less than people who are not HIV-positive.*

#### *Self-Stigma and Fear of HIV-Related Stigma*

As is clear from the testimony quoted above, interview participants mentioned stigma and discrimination as a barrier to testing. In the case of women, stigma could be two-fold, characterized both by prejudice against PLWA and belief in gender norms for women of virginity and monogamy. One 31 year-old single woman suggested:

*Women are ... afraid of stigma and discrimination. They are afraid that people will assume they had many sexual partners.*

Several individuals interviewed gave men's "shame," a combination of self-stigmatization and fear of stigma and rejection, as a reason for avoiding testing. For example, one 30 year-old woman who took eight months to come to terms with her diagnosis said: "Men are scared of knowing their status. They think people will laugh at them. They would be ashamed."

PLWA interview participants also spoke of how the nature of VCT may have contributed to fears of being stigmatized for visiting the special testing site. At some health clinics, caravans (mobile van facilities) were placed externally to the main building and used as HIV testing facilities. Interviewees noted that, because it stood alone, and was exclusively used for purposes related to HIV, this type of testing facility discouraged people from taking a test by contributing to the differential medical treatment of HIV/AIDS. As a woman who had sought out testing at a hospital on her own in 1994 after TB treatment failed, explained:

*Nurses say that a person should go the caravan [to be tested]. They don't go. They should get the test and counseling in the observation room [of the clinic]. The caravan is a barrier for women and men.*

### *Facilitators to Testing*

The qualitative interview respondents cited the availability of ARV therapy — and thus mitigation of the fear and/or the reality of imminent death — as a key facilitator for many, encouraging the taking of an HIV test. One 37 year-old man explained:

*The reason I had no problem accepting my status was because there were ARVs available. I had no issues with testing. I knew that to be HIV-positive was not a death threat.*

He had been tested after his pregnant, live-in partner tested positive for HIV and had suspected his own positive status “all along.”

Similarly, another person living with HIV/AIDS, speaking of herself and her husband, declared: “We were motivated [to test] by the fact that we could get therapy.”

One woman who had been tested in 1994, and did not initially go back for her results, spoke of the importance of the availability of same-day test results as a facilitator to testing: “There is much more testing now because you get your results in one day, and not in three months the way it used to be.”

### *Routine Testing*

The interviews with PLWA revealed strong support for the idea of routine, opt-out testing as it was defined by PHR researchers. The main reasons for support of the policy were that it would facilitate more people getting tested, because it would take away some of the shame of asking for a test or going to a free-standing center and, moreover, would result in decreased stigma by treating HIV/AIDS like any other illness. A 34 year-old woman tested without her consent when pregnant explained:

*I support the new policy. More people will get to know their status. Going from Gabane to Gaborone for an HIV test alone is a big deal. It is difficult. It's better that it be included in a group of issues for a health check. And there is less fear when the nurse asks you for a test, rather than you ask her.*

A 39 year-old man who tested at a VCT site when he became ill had heard about the new program of routine testing but did not understand it. After an explanation and further discussion he voiced his support:

*Originally nurses sent people to clinic caravans to be tested and they just went home. Routine testing is better. More people will get tested. If many people know their HIV status, then HIV will be taken as any other disease.*

Other interviewees mentioned a number of caveats to their support of opt-out testing. Most concerned the need to guarantee pre- and post-test counseling to help prepare people for receiving the results. One man from Serowe feared the consequences of not having counseling:

*I think counseling before and after the test is necessary. There would be problems if there was no counseling. Some people can kill themselves. I know that some people kill themselves when they learn the result.*

One woman, echoing those quoted above, described how previous government programs had tested people without this foundation:

*Opt-out testing is good but the government would need to implement more manpower. You need counseling along with routine testing. You've got to be ready to take an HIV test. The 'Show You Care Campaign' has some problems. People go for the t-shirt and the tickets [to a local sporting event] only, not for the HIV testing results. And then they have to deal with the test results after.*

This caveat seems especially salient for individuals like the participants in the community survey, for whom, among those not tested, the main reason for not testing was fear of knowing one's positive status. Moreover, those tested by opt-out testing in the community survey less frequently reported having received pre-test counseling than those tested under VCT.

## **HIV-Related Stigma and Discrimination**

Fear of knowing one's HIV-positive status was in part rooted in the fear of being stigmatized and discriminated against if that status is suspected or disclosed. Over half of community survey participants held stigmatizing or discriminatory views. At the same time, nearly all projected acceptance of an HIV-positive family member and support for HIV-positive (but asymptomatic) teachers and students. Fear of being stigmatized or mistreated was a concern of many community survey participants, as indicated by the finding that over half believed they would be treated as a social

outcast in their communities if they were known to be HIV-positive. Men had a higher level of projected fears of stigma than women. The majority of community survey participants reported that discrimination had lessened in Botswana with the advent of treatment. PLWA interviewed agreed that HIV-positive status was more accepted and easier to disclose than in the past and most had disclosed their status to some family members. Many, however, reported experiences of stigma and discrimination at home, work or in the community. Both female and male PLWA agreed that social stigma and poor treatment were worse for HIV-positive women than for men. They cited gender norms and discriminatory attitudes that blame and devalue women as reasons for this.

## Community Survey

### *Stigmatizing and Discriminatory Attitudes*

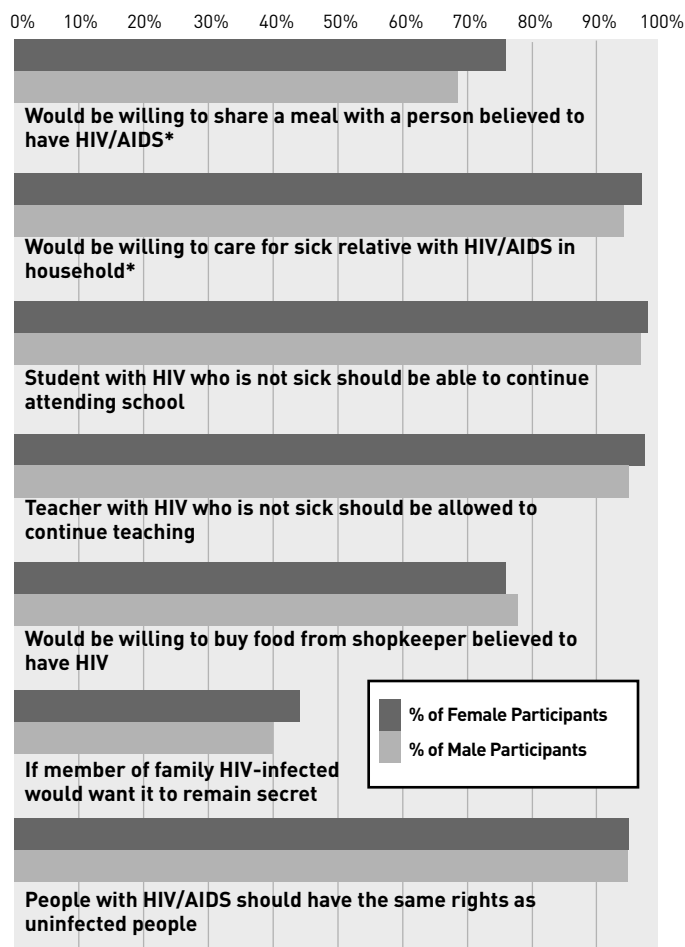
Fifty-four percent of women and 51 percent of men reported at least one stigmatizing or discriminatory attitude towards PLWA.<sup>408</sup> Stigmatizing or discriminatory attitudes are shown in Graph 5. Certain attitudes may reflect lack of knowledge regarding transmission of HIV. For example, 23 percent of women and 32 percent of men said they would be unwilling to share a meal with someone they believed to be living with HIV or AIDS and 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. Ninety-seven 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 thought that there was less discrimination in Botswana since the advent of ARV treatment.

While those surveyed affirmed nearly universally that they would accept a sick family member, the fear of being stigmatized by others was concurrently expressed by more than two-fifths of women and men. Specifically, 97 percent of women and 94 percent of men said they would be willing to care for a relative with HIV/AIDS in their household, but 42 percent of women and men would want it to remain a secret if a member of their family became ill.

Participants in the community survey were also asked to project how they would react to a spouse or

**GRAPH 5: Attitudes toward PLWA, Botswana Community Survey (n=1258)**



\* Statistically significant differences between responses of women and men.

partner testing positive for HIV.<sup>409</sup> Ninety-seven percent of women and men reported they would get a test immediately, 94 percent would be grateful that their spouse or partner had disclosed their HIV-positive status and 90 percent would always use condoms if they remained with him or her. However, 62 percent of women and men said that they would assume that their spouse or partner was having sex with someone else, 8 percent said they would kick the spouse or partner out of the home and 5 percent admitted that they might try to hit or hurt the spouse or partner. There were no statistically significant differences between the responses of women and men.

### *Fears of Stigma and Discrimination*

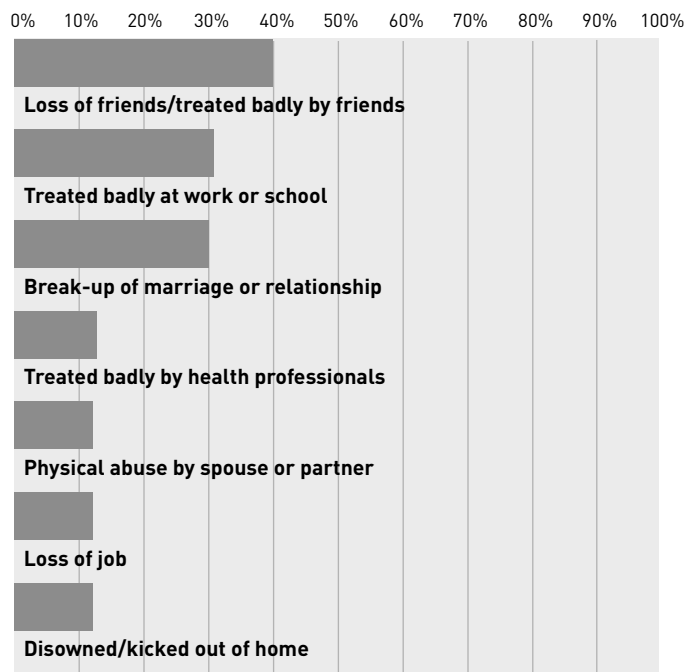
Despite their own reported support for the rights of PLWA, and projected acceptance of family members with HIV, the community survey results demonstrate the per-

sistence of the fear of being stigmatized and discriminated against associated with testing positive for HIV and disclosing one's status. These results are shown in Graph 6. Fifty percent of women and 57 percent of men believed that their community would treat them like a social outcast were they known to be HIV-positive. Forty percent of women and men feared a loss of friends. Thirty percent of women and men believed that disclosure of their HIV-positive status would lead to the break up of their marriage or relationship<sup>410</sup> and 12 percent of women and men feared resulting physical abuse by a spouse or partner. As many as a quarter to a third of those surveyed also expected discrimination as a consequence of HIV-positive status: 28 percent of women and 34 percent of men believed that testing positive and disclosure would lead to bad treatment at work or school; 10 percent of women and 14 percent of men feared a resultant loss of a job. Likewise, 10 percent of women and 14 percent of men expected poor treatment by health professionals. Overall, men exhibited a higher level of projected fears than women should they test positive.<sup>411</sup>

### PLWA Interviews

PLWA interviewed reported an improved climate for PLWA in Botswana. Nevertheless, many described experiences of HIV-related stigma and discrimination. Both women and men expressed the view that the situ-

**GRAPH 6: Projected Consequences of Disclosure of Hypothetical HIV-Positive Status in Botswana Community Survey (n=1244)**



ation was worse for HIV-positive women than for men, a phenomenon rooted in the lack of women's rights and women's low status in Botswana.

### Perceived Decreased Prevalence of Stigma and Discrimination

Interview participants believed that stigma and discrimination had lessened over time in Botswana. One man, who found out his status in 2003 and had very supportive parents who volunteered for the home-based care program and support groups, said:

*There is discrimination that comes from telling your status but not much. Not like in the past. Some are now living with people who have HIV/AIDS, which makes it easier.*

A 33 year-old woman who tried three times to go to Tebelopele before she managed to take a test, because she was afraid of what people would think, described how one of her sisters needed time to believe her and become supportive.

*It took a while for people to accept my status. My friends were becoming few. I had five and I was down to one. People who used to invite me out didn't anymore. Now every weekend, I'm out!*

The lessening of HIV-related prejudice and unequal treatment was particularly evident in interactions with health care workers. One woman described the situation at the time she found she had HIV, a decade ago.

*In 1994 there was discrimination from health workers. They said things like, 'Don't come near me. Don't touch me. You are HIV-positive.' Some people would go to a nurse at the clinic worrying about HIV. The nurse would say, 'Ah, who told you this is HIV/AIDS. Just go home.' Stigma and discrimination is less now. It's gone down, especially in health clinics.*

Another woman receiving treatment at the ARV treatment clinic at Sekgoma Memorial Hospital in Serowe explained:

*Nurses are also trained for counseling, they smile to patients, not like those from the olden days.*

The reportedly decreasing stigma and discrimination was credited to the availability of ARVs. One woman, who found out her HIV status when she became ill and had started ARV treatment a month before the interview, described how she and her family could more easily come to terms with her diagnosis.

*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.*

### *Positive Consequences of Disclosure*

Twenty out of 24 PLWA interviewed chose to share their HIV status with some family members. Moreover, interviewees spoke about their increased level of comfort with disclosure and their motivation to speak openly about living with HIV/AIDS to family, friends, members of the community and wider audiences.

*I talk to my family, 'Here is the situation. If you listen to me, you can live like me.' I want them to live positively.*

*Yes, I advise my neighbors, family and friends to get tested. I say, 'Do you remember how I was? Don't let this happen to you.'*

*When I tell people my status, there is change. I think my voice comes to their ears. If people treat me badly, I don't accept it. No one treats me badly now.*

PLWA interviewed reported that their communications frequently resulted in the behavior change of others, primarily evidenced through family members, friends and others taking an HIV test. As one woman, put it, "After I talk to people they go [for testing]. I really know how to convince someone. People understand now." Another reported, "All of my [3] sisters got tested because I took a test."

At the same time, respondents reported evidence of stigma and episodes of discrimination when their status was known in their families, the workplace and the community, and how persistent negative attributions to PLWA and HIV/AIDS contributed to their sense of shame and alienation in these contexts.

### *Negative Consequences for PLWA Within the Family*

In the home, interview participants noted that stigma was evident in how family members sought to segregate cooking and eating utensils. Often the relative with HIV or AIDS was forced to eat meals alone. One young woman, who got HIV from her partner of two years, described how she tried to keep her HIV-positive status hidden from her family to avoid poor treatment.

*There was a big problem within the family. They don't want to share meals with me or utensils with me. They think I am dying. They discovered my status because I was given a blanket by President Mogae. He was giving blankets to people who were HIV-positive and I was one of them. My family discovered it then and started treating me badly then.*

### *At the Workplace*

Both fear and the actual presence of discrimination in the workplace prevented people from disclosing their status, or even learning of it. One woman, who had not herself experienced much discrimination — which she ascribed to not being sick — commented:

*Stigma in the workplace is still a big issue. ...people think they will lose their job [if it is found out that they are HIV-positive]. You have many issues to handle and numerous visits to the clinic are necessary. This needs to be okay with the employer.*

### *In the Community*

Stigma in the community was reported as mainly expressed by gossiping and shaming behavior where individuals suspected of having HIV were singled out and publicly disparaged for their status. Or community members refused to have physical contact with them, for example, to sit together on the bus. A 26 year-old woman whose current boyfriend is also HIV-positive and very supportive, gave this example:

*Women go to the boys and say, 'that lady will infect you because she's HIV-positive'. That person [one of the boys] will come back and tell me.*

### *Fear of Stigma Discouraging Access to Treatment*

Taking treatment could "out" someone's status before they were ready to disclose it, which they might hesitate to do, fearing the rejection of others. One 37 year-old woman, though active in TCM, head of a support group, possessing a diploma in counseling and currently studying to be an HIV/AIDS educator, had not been able to discuss her illness with her family even though her niece and brother had died of AIDS and she herself had been gravely ill prior to treatment.

*They had a meeting under the tree and said, 'we should save money for her casket.' ...Even me, I didn't tell. But if it's time for my medicine my girl [daughter] will just bring my bag to me. But I didn't say anything. She just knows.*

One leader and educator similarly described the effects of stigmatizing attitudes on treatment.

*Lots of people come here [to the treatment center], take ARVs and hide them. When it's time to take them, they go into the toilet. They hide from their families and communities.*

### *Gender Dimensions of HIV-Related Stigma and Discrimination*

Both female and male interviewees noted that women with HIV or AIDS generally experienced more stigma and discrimination than men. HIV-related social consequences for women appeared to be inevitably entangled with expected norms of behavior, gender stereotypes, male power and discriminatory attitudes towards women. One 28 year-old man reported:

*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. Yet less than five percent of women are prostitutes or are having sex to get money.*

Given many women's dependence on men for legal status and economic security, the fear of HIV-related abandonment was understandably a great motivation toward non-disclosure. As a 33 year-old woman explained:

*I think there is more stigma against women than men. Men stigmatize women. When men find out that their partner is HIV-positive they say, 'No, I'm going to look for the people who are not HIV [-positive].' That's why women stay quiet when they come back home HIV-positive.*

One reason suggested by those interviewed for this greater stigmatization was the perception that more women disclose their status than men and were thus relatively more exposed to the consequences. One young woman, who described herself as very open with her status, explained:

*Most women open up with their status. Most men don't disclose and therefore women get the stigma.*

Several people noted — and the gender-breakdown of the membership of the support groups participating in the interviews themselves underline — that women participated more in PLWA support groups and other volunteer work. One man, himself very active, nonetheless was stymied by this, and ascribed it to fear of stigma:

*This is a thing which embarrasses me a lot. How can we pull men into support groups? ... They don't want to be seen talking about HIV/AIDS.*

Others placed women's disclosure and men's non-disclosure in the context of the traditional gender-based roles and community care responsibilities shouldered by women without recognition or compensation. As one female volunteer put it:

*Most [of those in a small village support group] are women, also some are men. Men always think that women like to volunteer; [men say], 'why should I go there if I am not paid?'*

In the context of social, economic and legal gender discrimination in Botswana, the situation of women's inequality was so endemic that several of the women interviewed were at a loss to put it this disparity into words, resigned to greater stigma and discrimination for female PLWA as just the way things were, women were inexplicably treated more poorly and viewed as inferior to men.

*Men discriminate against women who are HIV-positive. Women don't discriminate against men. I don't know why.*

*...women are valued less than men in society. I don't know why. It is not something that I can have the words to explain.*

One woman, infected by a partner who refused to use condoms because he said that they diminished sexual pleasure, saw direct links between household and national decision makers.

*Women are valued less in our society. Men are the only ones making the decisions. The leaders in our country are all men.*

In order to diminish HIV-related stigma and discrimination in Botswana, the lack of women's autonomy must be acknowledged and addressed. Discriminatory norms and realities are particularly salient in the context of heterosexual sexual relationships, the source of most HIV infection in Botswana.

## **Sexual Practices: Risk-Taking and Risky Circumstances**

The community survey results describe the commonality of sexual risk-taking among participants, who reported multiple sexual partnerships and engaging in unprotected sexual intercourse. Women's lack of control over the deci-



sion whether to have sex or use a condom was at the root of risk for many women. This lack of control is the result of socially-sanctioned, economically-driven and culturally embedded behaviors and circumstances. The line between choice and compulsion regarding sexual practices can be stark or subtle for many women, particularly for those, like many in the study population, who may have low incomes and lack access to resources such as food for themselves or their children. These findings were confirmed and amplified in interviews with PLWA.

### Community Survey

Eighty-nine percent of community survey participants had ever had sexual intercourse. There was no statistically significant difference between the responses of women and men in the survey sample.

### Multiple Sexual Partnerships

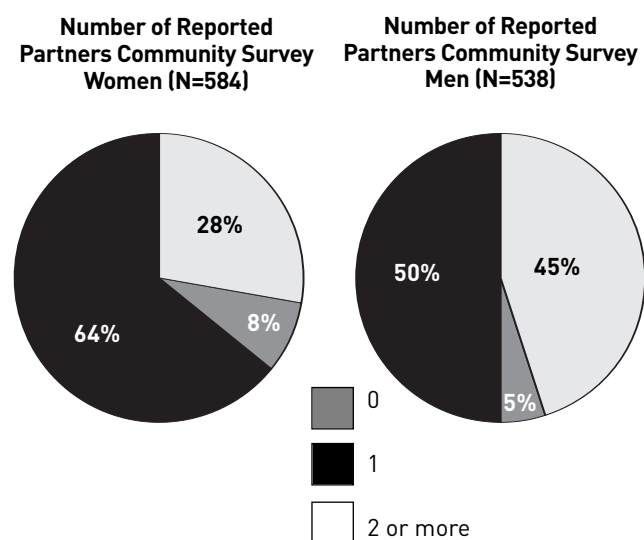
Multiple sexual partners were reported by 25 percent of women and 40 percent of men in the community survey. Results are depicted in Chart 1. Of those who had ever had sex, 8 percent of women and less than 5 percent of men reported not having a sexual partner in the past year. Of those who were sexually active,<sup>412</sup> 13 percent of women and 19 percent of men reported more than one partner in the past month. Of those who were not sexually active, 71 percent of women and 60 percent of men said that they practiced abstinence as a

way to prevent themselves or others from becoming infected with HIV.

### Condom Use

In terms of unprotected sex, 46 percent of sexually active community survey participants reported having had sexual intercourse without a condom over the past year — for a variety of reasons — and 11 percent had

**CHART 1: Number of Sexual Partners in Past 12 Months, Botswana Community Survey (n=1122)**



**TABLE 3: Reasons for Unprotected Sex in the Past 12 Months, Botswana Community Survey\***

Statement of Reason	Percent of participants who agreed				p-value
	Women		Men		
	N	n(%)	N	n(%)	
Your spouse/partner does not want to	251	134(53)	221	29(13)	0.000
It decreases sexual pleasure	252	116(46)	222	154(69)	0.000
You or your spouse/partner(s) are trying to get pregnant	252	76(32)	222	78(32)	0.248
You use other birth control methods	252	74(29)	223	80(36)	0.130
You have no control over whether your spouse/partner(s) uses a condom	250	55(22)	222	16(7)	0.000
Condoms are inconvenient to use	250	38(15)	223	65(29)	0.000
Condoms do not prevent HIV/AIDS	251	15(6)	221	11(5)	0.635
You cannot afford condoms	252	13(5)	223	9(4)	0.561
Condoms are not available in your area	251	12(5)	223	13(6)	0.610
You do not know how to use a condom	252	7(<3)	222	6(<3)	0.960

\*Respondents could agree with more than one statement.

unprotected sex with a non-primary partner during that same period.<sup>413</sup> There were no significant differences in condom use data between men and women.

Table 3 presents the reasons given by survey participants for not using a condom with each sexual encounter over the past year. Fifty-three percent of women, as compared with 13 percent of men, reported not having used a condom in the past year in at least one instance because their partner refused. Twenty-two percent of women, versus 7 percent of men, agreed that they had no control over whether their partner used a condom or not. This highlights that condom use is a decision that more typically rests with men in Botswana, as would be expected given patriarchal norms of sexuality and power dynamics in intimate partner relationships.

### *Women's Lack of Control Over Decision Making in Sexual Relationships*

The lack of control experienced by women with regard to condom usage was borne out in other responses to the community survey. Of those sexually active, thirty percent of women and less than 2 percent of men reported that their partner alone made the decision when to have sex. Five percent of women and 31 percent of men agreed that they alone made that decision.

In analyses adjusted for other participant characteristics, lacking control in sexual relationships was associated with risky sexual practices.<sup>414</sup> For example, women in the community survey who reported having little decision making power over engagement in sex had three times the odds of exchanging sex for money or other resources<sup>415</sup> and nearly two times the odds of having multiple partners<sup>416</sup> as others surveyed.

### **PLWA Interviews**

The interviews with PLWA provided some illumination as to potential reasons for engaging in sexual risk-taking practices, such as having multiple sexual partners and failing to use condoms consistently. Participants reported women's lack of control in sexual relationships and discussed changes to their own practices after learning of their HIV-positive status. While several interviewees, female and male, had reduced their number of partners and increased condom use, lack of autonomy in their primary relationships prevented some women from protecting themselves and others, despite knowing their status.

### *Multiple Sexual Partners*

The commonality of men having multiple sexual partners in a highly mobile society was described by one PLWA counselor:

*Some women say, 'My husband got those small houses over there [residences where the husband has relationships with other women]. Maybe he has five small houses — one in Jwaneng, Francistown, cattlepost and more.*

Another woman who also worked as a counselor described the reason for men having multiple sexual partners in terms of the formation of masculine identity.

*Because for a man to be a man, he has to be seen around with girls. There is a lot of peer pressure on guys. They have to prove they are men.*

### *Sex Without Condoms*

Qualitative interview respondents spoke of the realities of multiple sexual partnerships and the barriers to condom usage. Speaking from his own experience, one man explained:

*Men are closed. They are stuck in their ways and this puts them at risk. They don't want to change their sexual behavior and their habits. This is the problem. ... Before I became infected, I was one of those men. My mind was closed, I did not use condoms. I convinced women not to use condoms.*

Other interviewees also discussed the refusal of men to use condoms, and a willingness to believe the myths and misconceptions concerning their use. The same man described this as well:

*Condoms are a problem. There is a saying in Botswana that you can't eat seeds with plastic. This means that sex with condoms does not feel as good. Men also say that when they use condoms, they become sick.*

One of the young women interviewed agreed and described how men persuade women to have unprotected sex:

*Men have the wrong information about condoms also. They think it is not 100 percent safe. They tell you there are worms in condoms. They say it is safer to have sex without a condom. They say condoms have HIV in it. They also say condoms reduce sexual pleasure.*

She was infected by her partner after they stopped using condoms in order to get pregnant. She also commented, "I don't know a lot about condoms. Some say it is 100% safe, others say it is not. Now we use condoms."

### *Women's Lack of Control*

Women's lack of control over when to have sex and whether or not to use condoms was evident in the interviews. One woman described how she became infected from sexual intercourse with her husband.

*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.*

Her husband had accused her of having other partners and threw her out of the house after she tested positive for HIV, but reconciled with her four months later. He later tested positive for HIV.

Another woman described women's lack of control over childbearing:

*I have a friend, a woman who is HIV-positive and she had two kids [by] her husband because he says so. She says, 'I have to obey this man.'*

Another described her own economic dependence on her sexual partner:

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

One male support group counselor described the negative impacts of the social sanctioning of intergenerational relationships that leave young women, like the previous interviewee, vulnerable to more powerful, better-resourced partners.

*If I am a man and have cars and money, and I see schoolgirls, I would say to them, 'come have sexual intercourse and I will give you money.' This contributes to HIV. The man will then refuse to use a condom. These are the men who spread HIV.*

Behaviors and sexual practices that place women and men at risk of HIV arose out of gender roles and norms woven into the fabric of Botswana society. This construct of gender, maintained by laws, social practices and cultural values, persistently disenfranchised and endangered women.

### *Sexual Behavior Change Among PLWA and Barriers to Change for Women*

Sexual behavior change could result from an HIV diagnosis. Interviewees reported having fewer sexual partners and using condoms more consistently.

*Yes, my sexual behavior has changed. I now use condoms every time I have sex, and my husband has agreed.*

*Before, I was active. Now I cool it. I have a reduction in the number of partners and I use a condom.*

*Now I have only one partner. My dreams tell me that I am going to marry her. I have been only with her. Before, I had many partners, more than ten a month. I did not use condoms then. Now I have only one partner and I use condoms all the time.*

Those interviewed noted the emotional and psychological complexities of changing a fundamental aspect of one's life. One woman, who had decreased her partners to two, commented:

*I think two partners are OK. It is better to have two partners. If I have only one, I will put too much trust in him. Too much heart in one person is dangerous.*

Women who reported no change in their practices when they discovered their HIV status reported 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." She suspected that her partner had tested for HIV, but hadn't told her so.

## **Gender Norms and Beliefs and Perceived Vulnerability to HIV/AIDS**

Findings from the study demonstrated the prevalence of gender discriminatory beliefs among a significant minority of the study sample. For example, 17 percent agreed that a man may beat his partner if he believes she is having sex with other men. Ten percent affirmed that it is a wife's duty to have sex with her husband even if she does not want to.

This is of particular concern when the relationship of these beliefs to sexual practices is considered: regression analyses demonstrated that holding gender discriminatory attitudes is predictive of sexual risk-taking and risky sexual circumstances. In other words, participants who affirmed women's lesser legal and social status and subservience to men had greater odds than those who did not of engaging in multiple sexual partnerships or unprotected sex, or lacking control over decision making in sexual relationships — circumstances that increase the risk of transmission of HIV.

Factors identified as important to creating vulnerability to HIV for women and men by PLWA interviewed reflected the inequality and disadvantages faced by women and the control over decision making possessed by men. PLWA experiences elaborated on these views and confirmed that, whether gender discriminatory beliefs are held by women or men, the legal, social, economic and cultural norms that they reflected often had devastating consequences.

## Community Survey

### Prevalence of Gender Discriminatory Beliefs

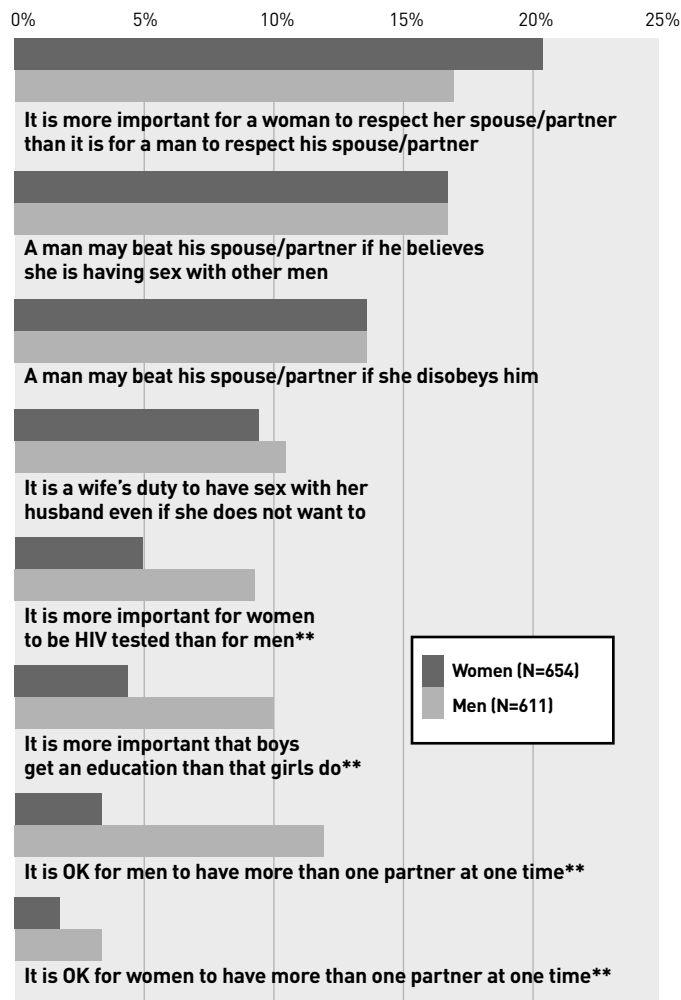
Overall, the large majority of those surveyed held at least one belief that could be described as gender discriminatory. In the community survey sample, women held slightly more gender discriminatory beliefs than men: 5 percent of women and 10 percent of men reported no discriminatory beliefs; 68 percent of women and 65 percent of men reported one to two; and 26 percent of women and 25 percent of men reported three or more.<sup>417</sup>

In terms of specific beliefs, each belief was held by a significant minority of those surveyed. Where there were differences between responses of women and men in the community sample they were quite small or statistically insignificant, as shown in Graph 7.

Study participants endorsed attitudes that women should be subservient in their relationships with men. Nineteen 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. Ten percent of all survey respondents agreed that it is a wife's duty to have sex with her husband even if she does not want to. Seventeen percent of all participants agreed that it is acceptable for a man to beat his partner if she is having sex with other men and 13 percent agreed that it was acceptable for him to beat her if she disobeys him.

In terms of expectations of sexual behavior, women's and men's attitudes as reported in the community survey diverged primarily and to the greatest degree over the approval of concurrent multiple sexual partnerships. Whereas 3 percent of women and 12 percent of men agreed that "it is OK for men to have more than one partner at a time," 3 percent of men affirmed this behavior for women (versus 2 percent of women surveyed), suggesting that, for male respondents, different standards of behavior apply based on sex. This may constitute under-reporting of this belief, indicating the social undesirability of sanctioning engagement in potential sexual

**GRAPH 7: Specific Gender-Discriminatory Beliefs, Botswana Community Survey**



\*This is a gender discriminatory belief because it assumes that women are more responsible for the transmission of HIV than men are, or that mother-to-child transmission is largely responsible for the AIDS epidemic.

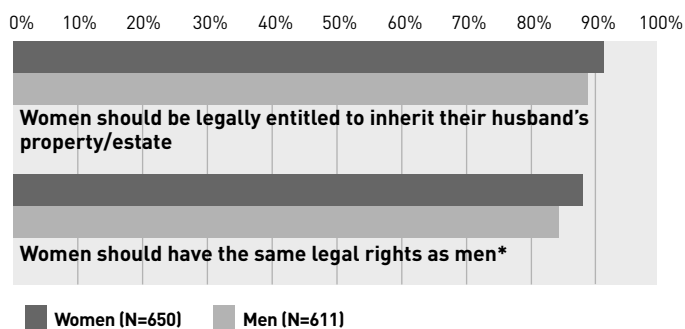
\*\*The difference between the proportions of men and women holding this belief is statistically significant.

risk-taking in the context of a high level of community knowledge of the transmission of HIV through unprotected sexual intercourse and public awareness of the elevated prevalence of HIV in the national population.

### Prevalence of Beliefs in Women's Rights

As shown in Graph 8, more than four-fifths of community survey participants reported believing in equal rights for women in the legal sphere. This points to a divergence between participants' attitudes and the legal system in Botswana, which does not grant the same rights to women as to men under either civil or

### GRAPH 8: Individual Beliefs in Women's Rights, Botswana Community Survey



\* The difference between the proportions of men and women holding this belief is statistically significant.

customary law, and suggests an opportunity for crucial legal reform with popular support.

#### Gender Discriminatory Beliefs Predict Sexual Risk

Community survey 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 discriminatory beliefs.<sup>418</sup> Men who held three or more of these beliefs had 3.6 times the odds of having had sex without a condom with a non-primary partner in the same period.<sup>419</sup> Other associations with specific beliefs are shown in Table 4.

#### PLWA Interviews

In interviews, PLWA highlighted women's dependency on male partners as the most significant reason mak-

ing them more vulnerable than men to HIV transmission. Testimony also revealed that women's lesser status in Botswana fostered ongoing harm to women even after they become infected, and moreover, increased the precariousness of their ability to meet basic needs. Participants also discussed the role of gender norms around fertility as encouraging risk-taking behavior for both women and men.

#### Women's Vulnerability to HIV

The 24 respondents spoke about gender inequality. Many expressed women's fear of losing the male family breadwinner and of the poverty and consequent life-threatening circumstances that were associated with this loss in a country where women faced many legal and social barriers to economic opportunities and self support. One woman assisting others to form support groups explained:

*In Shashe-Mooke, 5 kilometers from Francistown, there's a care center and active people in a support group there, and the epidemic there is big. Because of poverty. ... They are starving. Women are heading households, there are so many. ... Most are not working.*

This economic dependence translated into a lack of power in negotiating sexual relations, often resulting in sex without condoms, in order to keep a partner providing financial means, or to enable a women to independently obtain resources to support herself and her family. This "exchange" took place in both long and short-term relationships. A 21 year-old woman from Gaborone said, "My partner said he will give me every-

**TABLE 4: Selected Specific Gender Discriminatory Beliefs as Predictors of Unprotected Sex with a Non-Primary Partner in the Past Year in the Botswana Community Survey**

Statement of Belief*	N	AOR **	95% Confidence Interval
A man may beat his spouse/partner if he believes she is having sex with other men	599 (women only)	2.8	1.22-6.61
A man may beat his spouse/partner if she disobeys him	561 (men only)	3.4	1.05-11.36
It's a wife's duty to have sex with her husband even if she does not want to	561 (men only)	2.4	1.03-5.78

\*The model included 5 belief statements and was stratified by sex. The other two discriminatory statements in the model were 1) It is okay for men to have more than one partner at one time and 2) It is more important for a woman to respect her spouse/partner than for a man to respect his.

\*\*The odds ratio is a relative measure of risk, predicting the likelihood of the outcome at issue if a certain characteristic (here a particular belief) is present. The adjusted odds ratio (AOR) is the odds ratio adjusted for the possible confounding effects of the other variables included in the model. In these analyses, the variables are age, education level, monthly household income, food insufficiency, marital status, residency location, HIV knowledge, HIV-related stigma and fears of HIV-related stigma.

thing and will marry me, but I need to sleep with him without condoms." A 32 year-old woman from Serowe, now unemployed and living with her partner reported:

*I had sex with men so that I can be valued. ...I worked as a domestic worker. The wife of the house left and was staying in other places. The husband asked me to have sex and I felt that I had to for money. It was very difficult because I knew he was married and I did not want to do this, but I felt like I had to because he had money.*

Another woman said:

*Poverty forces women to have many partners, maybe five. She needs gas, food, rent, transport — one from each partner.*

Similarly, the support group founder, a single 37 year-old woman also living in Serowe and supporting two children by pooling the little money she earned with others in her household, explained:

*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.*

One PLWA activist and AIDS educator noted that, "young women in Botswana are not working" and explained that he invited them to support groups and sent them to trainings "to keep them busy, so they won't go to bars, to truck drivers, looking for something to eat or something for a living."

Outside of marriage, economic dependence was reflected in intergenerational sexual relations, where younger women had sexual relations with older men with financial means. The unequal power dynamics often mean that women have little ability to negotiate the circumstances of their engagement in sexual intercourse.<sup>420</sup> One 22 year-old woman described one of her past relationships:

*I was never forced to have sex. I was in a relationship with an older man, he was more than 10 years older than me. ... I was given things in exchange for sex. I had trouble saying no to sex because he was supporting me. This was difficult. After he gave me money, I felt that I had to have sex.*

There may also be stigma or blame, shame or loss of social status in losing a husband or partner as a result of insisting on behavior change, in addition to the economic ramifications or risk of violence in doing so. Moreover, women have been socialized to believe that

decision making within relationships and the family was the province of men. One married woman from Gaborone, who was infected with HIV through sex with her husband, described her own experience.

*Women think that men are the breadwinners, and therefore they don't introduce safe sex to him. Our culture doesn't allow women to initiate safe sex. Women are too scared to say to the husband, 'I don't want you to do this.'*

She further explained how girls were socialized to value men's opinions above their own and cede power to them.

*... Girls learn from how their mother is in relationship with their father. The mother doesn't want to lose the husband and so does everything for him. The girl then has sex with her boyfriend because she doesn't want to lose him. So, we have to start with the girls.*

As the testimony suggests, the desire to avoid abandonment by a partner was also a practical consideration given the limited economic opportunities permitting independence for women in Botswana.

A 21 year-old woman infected by a partner, with whom she was currently living, explained that he knew his status and failed to disclose it to her before she became pregnant and was tested for HIV. She stated, "Men are always regarded as the head of the family, they make the decisions alone."

### *Risk-Taking to Bear Children for Social Status and Economic Security*

With restricted opportunities and dependent on men to provide whatever economic security they did obtain, women might seek to establish or safeguard their ties to men through bearing children in the hopes of achieving greater prospects of security.<sup>421</sup> Traditional social norms of masculinity which value demonstrations of virility encouraged and facilitated this view with its attendant risk-taking, as did norms that equated women's worth with childbearing. Several of the women interviewed, when asked what put women at risk for HIV, answered that proving fertility was important for both women and men. One 26 year-old single mother responded, "women want to have babies." A 29 year-old woman seeking a relationship at the time of the interview commented, "[m]en are wanting to have children and so they don't use condoms." In the absence of available means to prevent HIV transmission while permitting conception, this desire or perceived need to reproduce mitigated against HIV prevention.

## Leadership on HIV/AIDS in Botswana

Community survey participants were asked about the overall performance of leaders in general in their approach to the HIV/AIDS epidemic in Botswana, interventions that would facilitate testing and their specific opinions about what could be done to encourage increased access to ARV treatment in the country. The results showed clear gaps in the performance of actors at all levels of governance and demonstrated the perceived need for stronger leadership, strengthening basic safeguards and education, innovative approaches and seizure of all opportunities to undo the stigma associated with HIV/AIDS. PLWA interviewed similarly highlighted the need for increased and more consistent leadership, particularly in the communities.

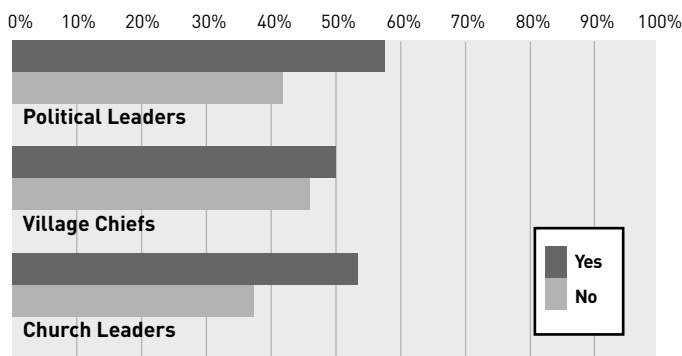
### Community Survey

When asked general questions about whether national and local leaders have done enough to address 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 participants reported that their own village chiefs had done not done enough. In addition, 37 percent of community survey respondents did not believe that their church leaders had done enough. Results are shown in Graph 9.

### Testing

It appears that community leaders (such as politicians, chiefs and church leaders), did not play a major role in terms of their personal testing practices in convincing people to undergo HIV testing in Botswana. In the community survey, among those who had been tested,

**GRAPH 9: Beliefs Regarding Whether Political, Village and Church Leaders Have Done Enough to Address HIV/AIDS in Botswana, Botswana Community Survey (n=1232)**



ten percent agreed that chiefs, religious or political leaders having been tested convinced them to do the same. For those who had not been tested, 39 percent of women and 48 percent of men stated that they would be convinced to test by a national HIV testing week where leaders in society such as politicians, clergy, chiefs, celebrities and sports stars would get tested.

### Treatment

Community survey respondents were asked what more could be done to help more people get ARV treatment in Botswana. Results are shown in Table 5. The majority agreed that encouraging more people to get tested and improving education about treatment would facilitate access. There was less agreement on the efficacy of additional HIV/AIDS support groups, access to higher quality medical care, increasing confidentiality at treatment centers, decreasing delays, improved treatment of HIV-positive persons by doctors and nurses or provision of food assistance to those seeking treatment.

### PLWA Interviews

Participants in the interviews gave mixed reports on leaders as role models in the context of HIV/AIDS. One HIV educator explained,

**TABLE 5: Opinions on Interventions to Improve Access to Treatment in Botswana, Botswana Community Survey\***

Statement of Intervention	Community Survey Participants N= 1267 n (%)
Encouraging more people to get tested	886(70)
Improving education about treatment	665(52)
If there were more HIV/AIDS support groups	253(20)
Increasing confidentiality at treatment centers	237(19)
If people had access to better clinics and hospitals	204(16)
Decreasing time delays at the treatment centers	180(14)
If doctors/nurses would treat people with HIV better	156(12)
Providing assistance with food	126(10)

\*Respondents could give more than one reason.

*I deal with many villages. 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.*

A 21 year-old woman noted the need for leadership from influential village elders.

*The community stakeholders should take part in the HIV pandemic. We are young, we do the visits, and men tell us to go away. It is better for the community leaders to go [to] the families to encourage testing. If older people did it, it would make a big difference.*

Another woman who works with the national network of PLWA in Gaborone praised innovative efforts by local authorities.

*Communities are trying to do their best. Village elders are now recommending testing at funerals. They suggest that people say, 'O tsogile jang? A o itse seemo sa gago?' (How are you? Have you been tested?)*

Some expressed concern that there were not enough community leaders willing to speak out about their own experiences as people living with HIV/AIDS. One youth counselor commented:

*Most community leaders are doing a good job; however, there are no leaders coming out and saying that they are HIV-positive. People in prominent positions do not speak out, most speak about HIV/AIDS from an HIV-negative status.*

An unemployed mother of one commented, that, on the other hand, some leaders only get involved in the issue if they have been personally touched by it.

*The dikgosi (chiefs) and baruti (church leaders) are only getting involved when they have personal experience, when some[one] in their own family has HIV for example.*

## **Conclusion**

Results from the community survey and PLWA interviews illustrate how the HIV/AIDS epidemic in Botswana is undergirded by: 1) persistent HIV-related stigma and discrimination and attendant fears; 2) women's lack of decision making on sexual matters;

and 3) prevalent gender discriminatory beliefs associated with sexual risk-taking. Participants identified the gaps in the national response that must be addressed in order to stem new infections and provide the care and treatment needed by those infected or affected by HIV/AIDS, particularly women. In particular, all aspects of women's lack of autonomy, including food insufficiency and economic dependence on men, must be addressed in order to lessen women's vulnerability to HIV infection and its negative health, social, economic and other devastating impacts.

While the findings suggested some areas of real achievement in Botswana, such as the overall positive nature of experiences with HIV testing, they also revealed gaps in HIV knowledge and high levels of fear of stigma should an individual test positive. The latter appeared to play an important role as a key reason for why less than half the community sample had tested, despite high levels of perceived access to testing and the existence of media messages, treatment and confidentiality that were identified as facilitators by those who had tested — fear of knowing one's positive status was the most prevalent barrier.

The prevalence of sexual risk-taking, whether chosen or compelled, was of primary concern, and clearly linked to the economic dependency and low social and legal status of women in Botswana. Female community survey participants were more food insufficient, poorer and more likely to be unemployed than their male counterparts. Participants' reports demonstrated that vulnerabilities created by economic need and lack of resources translated directly into the lack of control over decision making on sexual matters for women, including sexual partnerships with non-monogamous partners and unprotected sex. Moreover, regression analysis confirms that beliefs in gender discriminatory norms predicted sexual risk-taking for women and men.

Changing these beliefs and circumstances by promoting women's equality, reforming discriminatory laws and condemning discriminatory norms and practices should be a priority for the Government. In fact, leadership was judged to be lacking on every level. Respondents nearly universally agreed in the efficacy of encouraging testing through a range of interventions and improving education about both testing and treatment, implying that although Botswana has had some laudable success in these areas, more is left to be done. In particular, participants identified concerns that these include ensuring that the routine testing program incorporates safeguards to guarantee the provision of counseling and to prevent avoidance of



health care seeking and violence against women who test. The potential for negative impacts of the testing program is rooted in the existence of HIV-related stigma and discrimination, and the vulnerability of women in a country where some significant steps towards women's equal legal rights have been made, but the goal of gender equality is as yet unrealized.

## Notes

<sup>393</sup> This represents an 88.5 percent response rate.

<sup>394</sup> Currency conversion at the Interbank Rate for November 15, 2004 (1 US dollar = 4.54 Botswana *pula*). FXConverter. Available at: <http://www.oanda.com/convert/classic>. Accessed on February 13, 2007.

<sup>395</sup> Derogatis LR, Lipman RS, Rickels K, Uhlenhuth EH, Covi L. "The Hopkins Symptom Checklist (HSCL): A measure of primary symptom dimensions." *Modern Problems of Pharmacopsychiatry*. 1974;7(0):79-110. This screen has been validated previously in a number of international settings in Africa and elsewhere. Bolton P, Wilk CM, Ndogoni L. "Assessment of depression prevalence in rural Uganda using symptom and function criteria." *Soc Psychiatry Psychiatr Epidemiol*. Jun 2004;39(6):442-447.

<sup>396</sup> An urban village is a large village classified as urban under the Botswana census. See Buthalini D. "Methodological aspects, quality control measures and outcome: 2001 population and housing census in Botswana." Central Statistics Office. Available at: [http://www.cso.gov.bw/html/census/meth2\\_2.html](http://www.cso.gov.bw/html/census/meth2_2.html). Accessed August 28, 2006.

<sup>397</sup> Women reported as follows: 18 percent had zero visits, 44 percent had 1-2 visits and 38 had 3 or more visits. Men reported fewer visits: 27 percent had zero visits, 45 percent had 1-2 and 28 percent had 3 or more.

<sup>398</sup> Education data was missing for one interviewee.

<sup>399</sup> Participants were asked 15 questions about their knowledge of 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).

<sup>400</sup> The other characteristics were age, sex, monthly income, marital status, residency location, self-reported overall health status, perceived availability of ARV treatment, HIV knowledge, HIV-related stigma, fears of HIV-related stigma and a positive screen for depression.

<sup>401</sup> Through the PMTCT Plus program it is possible for male partners to get tested for HIV at antenatal clinics. Available at: [http://www.pathfind.org/site/DocServer/FP\\_HIV\\_Integration\\_web\\_copy.pdf?docID=3461](http://www.pathfind.org/site/DocServer/FP_HIV_Integration_web_copy.pdf?docID=3461). Accessed on April 5, 2006.

<sup>402</sup> All questions asked respondents about the most recent time they were tested.

<sup>403</sup> While those that tested because they were sick may have felt, in the broad sense, that they "had no choice" because their physician needed to determine the cause of their illness, that proportion of respondents (21 percent of women and men) does not account for the larger group that reported not being able to refuse the test. In this group, some may have felt a personal imperative to find out the cause of their illness and thus that they could not, in that sense, refuse the HIV test.

<sup>404</sup> [cross ref limitations sub-section in Methods]

<sup>405</sup> As stated earlier, 85 percent of women and 90 percent of men surveyed reported the belief that treatment would be available to them if they had AIDS.

<sup>406</sup> The following explanation was given of the policy of routine testing: "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."

<sup>407</sup> Sixty-two percent of those in the community survey who reported testing had tested after the introduction of routine testing.

<sup>408</sup> 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.

<sup>409</sup> These additional questions about projected stigma were asked in order to counter the influence that wanting to give the "correct" answer (social desirability bias) might have on participants' responses to the more general stigma questions.

<sup>410</sup> This projection contrasts with the 8 percent of women and men who reported that they would kick an HIV-positive spouse or partner out of the home.

<sup>411</sup> 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 2.07) and for women it was 1.67 (+/- 1.76), a statistically significant difference.

<sup>412</sup> "Sexually active" is defined as having had at least one sexual partner in the past 12 months.

<sup>413</sup> The latter is a traditional indicator or predictor of high-risk sexual practice (a practice likely to lead to HIV transmission), given that a non-regular sexual partner is also likely to be non-monogamous, the couple is less likely to be seeking pregnancy and HIV status is less likely to be disclosed between such partners.

<sup>414</sup> This association was also statistically significant for men reporting lack of control. In regression models "lack of control" was defined as your partner usually or always deciding when you have sex. 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.

<sup>415</sup> AOR: 3.04, 95% CI (1.31-7.04).

<sup>416</sup> AOR: 1.79, 95% CI (1.12-2.86).

<sup>417</sup> 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.

<sup>418</sup> 95% CI (1.01-7.1).

<sup>419</sup> 95% CI (1.08-11.99).

<sup>420</sup> Social norms and status differentials related to age and gender also contribute to this dynamic.

<sup>421</sup> In the community survey, 21 percent of women and 27 percent of men agreed that a woman must prove her fertility before she can marry and 20 percent of women and 27 percent of men affirmed that a man must do so.

# V. BOTSWANA RECOMMENDATIONS

## To the Government of Botswana:

### I. Comprehensively Advance Women's Human Rights and Address Violations, Including:

#### A. Legal and Policy Reform to Eliminate Gender Discrimination

- Systematically end discrimination in marriage, inheritance, property and employment laws and harmonize laws with international human rights instruments. For example, legislation should establish uniform criteria for determining the validity of marriage, presumption of spousal co-ownership, equal division of property upon termination of marriage or death and equal rights to own property and land irrespective of marital status; employment law should cover equity in wages, discriminatory dismissals and sexual harassment.
- Enact the pending Domestic Violence Bill to end impunity for gender-based violence and ensure women recourse and protection from violence in all its forms; strengthen the current bill so that it covers marital rape and includes the provision of shelter for survivors and training of police officers.

#### B. Dissemination of Information and Assistance Regarding Recourse for Rights Violations

- Implement, enforce and publicize reforms, including those that have already been made, such as the abolition of marital power, and educate the public and private sector and communities on their implications.
- Increase knowledge of and access to legal remedies and victims' services, including providing legal aid and sensitizing law enforcement agencies and the judiciary through training programs.
- Support short-term safety nets for women who are the victims of violence, abandonment, disinheritance or other acute abuses through the provision of post-exposure prophylaxis for HIV and shelter and other emergency services and care, in partnership with civil society organizations.

#### C. Popular and Civic Education to Change Gender Norms

- Incorporate comprehensive sexuality education, gender and human rights awareness into basic educational curricula with the goal of changing norms and expectations and promoting equality regarding male and female social roles, including in intimate relationships.
- Conduct outreach to radio, print and television media to:
  - Reinforce positive messages and marginalize stereotypes;
  - Challenge gender-discriminatory attitudes;
  - Broaden the public health discourse to include discussion of relationship power dynamics and healthy sexuality (i.e., targeting social norms that sanction men's behavior, challenging gender roles, increasing risk perceptions and presenting supportive male and empowered female role models).

#### D. Reform and Strengthening of the Women's Affairs Department (WAD)

- WAD should support the organization by civil society of the women's movement in Botswana and partner with civil society organizations, including in the drafting of the gender policy and the CEDAW report.
- WAD should support documentation of experiences of gender discriminatory practices to inform policy-making and implementation in the public and private sectors.

## II. Mitigate Poverty and Meet Basic Needs By:

#### In the Short-Term:

- 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:
- Food should meet the needs of HIV-positive persons;
- Programs should feed the whole family of a vulnerable person.

### *In the Medium- and Long-Terms:*

- Address the underlying causes of food insufficiency and failure to meet other basic needs, and recognizing that women and girls disproportionately experience poverty and the burdens of care-giving, by providing skills training and sustainable programs directed at creating economic opportunities particularly for women, PLWA and families affected by HIV/AIDS.
  - Ensure access to loans, credit and training (e.g., marketing, entrepreneurship, business skills) through microfinance projects;
  - Fund local employment and educational/training opportunities, particularly for and led by women, such as community-based income-generation projects;
  - Create legal protections for women in the informal economy.

### **III. Eradicate HIV/AIDS-Related Stigma and Discrimination Through:**

#### *A. Strengthening Leadership and Legal/Policy Reform for Support and Protection of Affected Persons*

- Parliament should adopt comprehensive legislation and policy addressing HIV/AIDS and employment, and strengthen enforcement of prohibitions, including: non-discrimination, job security, testing prohibitions, confidentiality, care and support of HIV-positive workers and workplace-based prevention programs.
- Church leaders should end complicity in stigmatization and play educational roles to support gender equality and end discriminatory customary practices in marriage and other areas.
- Traditional leaders should endorse programs that promote gender equality; ensure access by community to testing and treatment; and denounce, discourage and transform harmful customary practices.
- All sector ministries should set, fund, monitor and be held accountable for meeting gender equality objectives as part of the national HIV/AIDS strategy.

#### *B. Challenging Prejudices and Closing Information and Services Gaps*

##### *With Regard to Information/Education:*

- Work with PLWA groups and other civil society organizations to create or adapt and widely disseminate information on testing, prevention and treatment.

These should be accessible materials that address information gaps, such as:

- Men's denial, fear and/or lack of knowledge about HIV/AIDS;
  - HIV-positive women's needs;
  - Treatment literacy and preparedness, including information targeted at men both as patients and partners.
- Adapt a systematic and coordinated approach to public education, addressing key knowledge areas of prevention, support and rights, including messages that:
    - Address risk, vulnerability and fear of stigma directly and integrate gender concerns into prevention messages (i.e. forced sex, power in relationships);
    - Target people's misperceptions concerning HIV transmission, condom effectiveness and other topics.

##### *With Regard to Testing and Health Services:*

- Address the knowledge and resource gaps in the implementation of routine testing by training health workers, monitoring implementation, systematically evaluating programmatic impacts and incorporating participation and feedback by affected populations.
- Support those seeking testing with campaigns, resources to overcome barriers such as lack of food or transport, and protection from discrimination and partner violence through guidelines and training for health workers.
- Ensure the "three Cs" are safeguarded with respect to all forms of testing: confidentiality, counseling and informed consent.
- Identify and close other services gaps, including meeting men's and women's reproductive and sexual health needs, and implement human rights training for health workers.

### **To the US Government:**

#### **Expand and Reform PEPFAR to Increase Effectiveness and Promote Human Rights:**

- 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.

- Foster integration between PEPFAR and development programs focused on health, education, poverty reduction, and respect for women's rights.
- 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.
- Coordinate PEPFAR's programming with other bilateral and multilateral development programs promoting gender equality.
- Initiate and support programs that address the link between food insufficiency and women's vulnerability to HIV infection.
  - Support the expansion of existing programs to help PLWA and poor women obtain food, shelter, and potable water.
- Invest in locally produced television and radio public education messages that focus on the availability of voluntary and confidential HIV testing and treatment.
- Invest in the local development of programs that eliminate discriminatory attitudes toward women and promote gender equality.
- Foster participation of women in national AIDS policy making and implementation.
  - Fund women's and PLWA organizations and facilitate the establishment of networks to strengthen organizational capability and contribute to a corps of skilled women leaders, especially women living with HIV/AIDS.

## **To All Donors:**

### **Support the Government of Botswana to Meet These Goals and Build Complementary Capacity in Civil Society:**

#### *For Gender Reform:*

- Provide training, technical assistance and financial resources to women's organizations and other civil society actors to undertake advocacy, civic education and popular campaigns promoting women's legal rights and empowerment, including:
  - Advocacy for the Domestic Violence Bill and other legal reform measures;
  - Shelter, legal aid and other emergency services and care for women or PLWA who are victims of violence, abandonment, disinheritance or other acute abuses;

- Skills training and sustainable programs directed at creating economic opportunities for women, PLWA and families affected by HIV/AIDS;
- Training on women's rights, gender sensitivity and human rights, to decrease vulnerabilities and dispel myths regarding HIV/AIDS for various sectors, including media, employers, educational institutions and health care workers.
- 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.

#### *For Food Sufficiency:*

- Increase food aid and aid for other basic needs through, for example:
  - Support for farming cooperatives, extension schools, new agricultural initiatives such as community gardens and low-labor/high nutrition crops;
  - Meals provision at school, work, empowerment programs and ARV treatment centers and through community health worker and home-based care visits;
  - Support for legal aid projects to assist in securing productive property for widows, orphans and PLWA.

#### *For HIV/AIDS Programming that Respects, Protects and Promotes Human Rights:*

- Support the Government in designing, implementing and monitoring testing programs to ensure the "3 Cs" (confidentiality, counseling and informed consent).
- Support, encourage, and, if possible, mandate government and civil society partnerships and coordination in gender, reproductive/sexual health and HIV/AIDS policymaking and programs.
- Support PLWA organizations and networks to increase their visibility and services by funding the coordination and expansion of national networks, training officers for NGOs and support capacity building for community mobilization efforts.



# VI. SWAZILAND COUNTRY BACKGROUND

## Geography and Population

Swaziland, Africa's last absolute monarchy and the smallest country in the southern hemisphere,<sup>422</sup> is a land-locked kingdom located between Mozambique and the northeast edge of South Africa. It covers 17,364 square kilometers<sup>423</sup> and includes a variety of geographic and climactic features. Much of the country is a mountainous and well-watered plateau, with dry lowveld in the surrounding regions.<sup>424</sup> Annual temperatures range from 2.5 to 45 degrees Celsius, with the rainy season falling between September and March.<sup>425</sup>

The two major urban centers are Mbabane, the country's capital, and, to the southeast, Manzini, the principal commercial hub. About three-quarters of the population lives in rural areas.<sup>426</sup> In the recent past, Swaziland has experienced an annual population growth rate of 2 percent; the country's 2006 population was estimated to be 1.14 million, with nearly 56 percent falling between the ages of 15 and 64.<sup>427</sup>

The ethnic breakdown of the population is 97 percent African, with the remainder having European roots.<sup>428</sup> Forty percent of the population practices Zionism, a mix of Christian and traditional worship, while 20 percent are Roman Catholic, ten percent Muslim and 30 percent Anglican, Bahai, Methodist, Mormon, Jewish and other faiths.<sup>429</sup> SiSwati and English are the official languages.<sup>430</sup>

## History and Politics

The Nkosi Dlamini, a Nguni people, migrated south from Central Africa and settled what would later become Swaziland in the 18<sup>th</sup> century.<sup>431</sup> Swaziland became a protectorate of Great Britain after King Mswati II sought help in defending his country from raids by Zulu warriors and others from areas that later became part of South Africa.<sup>432</sup>

King Sobhuza II assumed the throne in 1921 and reigned for more than 60 years.<sup>433</sup> In 1964, elections for the first legislative council were held and the Imbokodvo National Movement (INM), which strongly identified with Swazi tradition, won all 24 elective seats and started lobbying for independence.<sup>434</sup>



Britain granted independence to a sovereign Swaziland as a constitutional monarchy and parliamentary democracy on September 6, 1968.<sup>435</sup> In 1973, a court ruling prompted King Sobhuza II to declare a state of emergency, abrogate the constitution, and assume the authority to rule by decree and appoint the government. King Sobhuza II died in August 1982 and, after some political maneuvering, was succeeded by his son, Prince Makhosetive, who was enthroned as King Mswati III in 1986.<sup>436</sup>

Swaziland has four administrative regions, Manzini, Hhohho, Lubombo and Shiselweni, which are subdivided into 55 political constituencies (*tinkhundla*).<sup>437</sup> Each *inkhundla* (constituency) is comprised of several chiefdoms and led by an *indvuna yeNkhundla*, (elected official), who works together with each chief's representative (*bucophol*); chiefs are determined by heredity and appointed by the King.<sup>438</sup> Officials manage day-to-day affairs of the chiefdom.<sup>439</sup>

Swaziland's parliament includes a House of Assembly, which can consist of up to 76 members, and a Sen-

ate of no more than 31 members.<sup>440</sup> Up to 60 members of the House can be elected by citizens via *tinkhundla* elections.<sup>441</sup> The King may nominate up to ten House members.<sup>442</sup> Under the new Constitution, four women are to be specially elected to represent each of the regions.<sup>443</sup> The Attorney General also serves as an *ex officio* member.<sup>444</sup> House members elect ten members of the Senate (half of which must be women)<sup>445</sup> and the King appoints 20 senators.<sup>446</sup> In addition, the King, who serves as head of state with legislative and judicial powers, keeps a circle of traditional advisors who constitute a "parallel executive government" which has raised serious concerns about the credibility of the Swazi government and justice systems.<sup>447</sup>

Swaziland has a dual-legal system, comprised of Swazi Law and Custom, often referred to as customary law, as well as General (Roman-Dutch) Law, known as civil law.<sup>448</sup> Customary law, while unwritten, is recognized and maintained by a network of traditional courts.<sup>449</sup> Swazi civil law is maintained by a formal court system including magistrate courts, a High Court and, until 2006, a Court of Appeal, whose judges came from South Africa.<sup>450</sup> Chiefs deal informally with community disputes in their chiefdoms.<sup>451</sup>

The efficacy of the courts was seriously undermined in November 2002. The Court of Appeals limited the King's power to rule by decree by overruling his removal of 200 subjects from their homes for protesting the royal appointment of a new chief.<sup>452</sup> The then Prime Minister, Sibusiso Dlamini, in turn announced that all royal decrees were absolute and that the Government would ignore the court.<sup>453</sup> All Appeals judges resigned and returned to South Africa. After two years of protest and behind-the-scenes negotiation, the judges returned to work in late 2004 after receiving assurances from the new Prime Minister, Themba Dlamini, that the government would abide by their decisions.

Although the Prime Minister has kept that promise, the Swaziland Law Society has pointed out that the law crisis persists since the King retains authority with regard to the appointment of the judiciary.<sup>454</sup> The failure of the Government to ensure an efficient judicial appointment process and a full bench of judges on the High Court has continued to have an impact on access to justice and legal remedies. The constitutionality of the Judicial Services Commission, which advises the King on judicial appointments, was challenged in October 2006; the hearing was postponed until 2007.<sup>455</sup> More positively, the Minister of Justice is in the process of establishing a new "Supreme Court" with appellate

jurisdiction, and with the intention of eventually replacing expatriate judges with local ones. Two new appointments were made in 2006.<sup>456</sup>

King Mswati III, who is polygamous, has faced some public criticism for this in the past decade. For example, his decision in 2004 to marry a teenage schoolgirl has provoked controversy,<sup>457</sup> as did an episode in 2002 when court proceedings were held to determine the legality of the King marrying an 18 year-old against her mother's formal objection.<sup>458</sup>

In 2002, moving forward with an ongoing constitutional process in response to escalating national and international pressure, King Mswati appointed a Constitution Drafting Commission headed by one of his brothers, Prince David, the current Minister of Justice and Constitutional Affairs. The King presented a draft to the nation in May 2003 and, in September 2004, the Government convened a week-long forum in the royal cattle kraal, sometimes referred to as the "People's Parliament," to allow citizens a chance to express their views.<sup>459</sup> While Prince David's management of the process has been praised, the public meeting has been criticized as ineffective and unrepresentative.<sup>460</sup> The document was passed by Parliament in June 2005, and assented to and signed by the King on July 26, 2005.<sup>461</sup> It went into effect in February 2006.<sup>462</sup>

Political parties have been prohibited by the Government in the past, and may continue to be so by omission from the final draft Constitution,<sup>463</sup> although some experts believe that the new freedoms of speech and assembly provide a basis for the legalization of parties.<sup>464</sup> There is confusion regarding whether the new Constitution's bill of rights superseded the 1973 decree by King Sobhuza banning political parties. Although King Mswati III claims that political parties are allowed under the new constitution,<sup>465</sup> the Prime Minister has stated that the Constitution nullified the decree.<sup>466</sup> The Swaziland Law Society brought a legal challenge on the matter in February 2006 which is pending before the Mbabane High Court.<sup>467</sup>

King Mswati III has stated publicly that the country is not economically prepared for multiparty democracy.<sup>468</sup> He has criticized foreign envoys for international scrutiny of Swaziland's one-party state.<sup>469</sup> Opposition in the form of political coalitions and labor unions does exist. The most notable example is the People's United Democratic Movement (PUDEMO), which named itself the official opposition in 1992,<sup>470</sup> and the Swaziland Federation of Trade Unions. In January 2003, the Swaziland Coalition of Concerned Civic Organizations was formed in response to the country's rule of law crisis and provides training and

civic education to Swazi civil society.<sup>471</sup> However, Swaziland's political climate remains hostile to opposition. In December 2005 and January 2006, 16 PUDEMO and Swaziland Youth Congress members were incarcerated on charges of treason for allegedly fire-bombing government structures.<sup>472</sup> In March 2006, the Acting Chief Justice of Swaziland ordered the release of the men on reduced bail and instructed the Government to create a commission of inquiry to investigate allegations that the accused were subjected to torture while in detention.<sup>473</sup>

## Economy

The GDP of Swaziland in 2006 was estimated at US\$5.91 billion, or US\$5,200 per capita, with most of that coming from industry and services.<sup>474</sup> While agriculture accounted for just 11.8 percent of the GDP, more than 80 percent of the population practices subsistence farming.<sup>475</sup> Due to poor weather conditions, HIV/AIDS and low crop production,<sup>476</sup> 177,050 people received food aid in Swaziland in 2004; over 97,000 of these recipients were women.<sup>477</sup> Sixty-nine percent of the population lives below the poverty line.<sup>478</sup> The Swaziland economy is also one of stark inequity. The top 10 percent of the population controls 40 percent of the country's wealth while the bottom 40 percent of the population controls only 14 percent of the national wealth.<sup>479</sup> In an index of countries based on the level of income equality, Swaziland ranks 119<sup>th</sup> out of 124 nations.<sup>480</sup> In the 2006 Transparency International Corruption Perception Index, Swaziland ranked 121 out of 163 countries, and on a scale of 0 (highly corrupt) to 10 (highly clean), it scored a 2.5.<sup>481</sup> The Prime Minister and the Minister of Justice and Constitutional Affairs are trying to address pervasive corruption systematically through the Anti-Corruption Act of July 2006, an August 2006 national Anti-Corruption Summit and commissions of inquiry into incidents of large-scale corruption, and with capacity-building and training assistance from the UNDP and South African investigators.<sup>482</sup>

Unemployment in Swaziland stood at 30 percent in 2005.<sup>483</sup> Including those who stopped looking for work, unemployment was 40 percent.<sup>484</sup> Swaziland ranks 97<sup>th</sup> out of 103 developing nations on a scale which measures human development, based on indicators such as access to education and health care, as well as the nation's standard of living.<sup>485</sup> Swaziland's gender-related development index, the human development index adjusted for gender equality, places it 146<sup>th</sup> out of 177 developing countries.<sup>486</sup> Women earn 29 percent of what men earn in Swaziland.<sup>487</sup>

South Africa has always played a significant role in Swaziland's economy. South Africa is Swaziland's largest trading partner.<sup>488</sup> Swaziland has suffered from changes in the value of the South African rand to which the Swazi *lilangeni* is pegged. The rand appreciated from R12 to the US dollar to half that amount between 2002 and 2005.<sup>489</sup> As a result, and compounded by increased competition and law changes affecting the international textile market,<sup>490</sup> and the end of preferential agreements to sell sugar to the European Union,<sup>491</sup> two of Swaziland's chief industries have suffered, costing the country thousands of jobs.<sup>492</sup> Many Swazis have also returned home from South Africa after cutbacks in the latter's mining industry.<sup>493</sup>

The structure of land tenure in Swaziland has also result in inequities, particularly with respect to gender. Tenured Swazi land is divided into three categories: communal property on Swazi Nation Land (SNL), freehold rights on private land known as Title Deed Land (TDL) and Crown Land.<sup>494</sup> The King owns the title to SNL, TDL and Crown Land.<sup>495</sup> The new Constitution affirms this, vesting all land except privately-held TDL in the King in trust for the nation.<sup>496</sup> With respect to Swazi Nation Land, the King may divide the land between individual chiefdoms for allocation to individuals for cultivation, residence and communal grazing, but not for ownership.<sup>497</sup> SNL is allocated through the *kukhonta* tradition whereby men pledge allegiance to chiefdoms in exchange for land rights.<sup>498</sup> Women are barred from performing *kukhonta*, though they have been allocated land by chiefs, for example through programs which grant land access for commercial use.<sup>499</sup> Some women have formed co-operatives to take advantage of such programs.<sup>500</sup> Individual ownership of TDL is permitted for residential, business and commercial agricultural use.<sup>501</sup> While women can own and register businesses in their own names, women married in community of property cannot own land or secure loans, making them reliant on their husband's signatures. This leaves women's enterprises vulnerable because men can sell or otherwise dispose of their wives' business lands or his family can claim them upon his death.<sup>502</sup> Crown Land can also be sold to individuals; some has been allocated on a "temporary" basis stretching into years but without formal rights.<sup>503</sup> Of particular note is that while the new Constitution permits women to own land, those rights extend only to land to be used for "normal domestic purposes."<sup>504</sup> Thus, it remains to be seen what the impact of the new provision will be on women's access to property.



## Health Care System

The most recent statistics available indicate that Swaziland's total health expenditure, both public and private, dropped from 6.4 percent of the GDP in 1999 to 5.8 percent in 2003.<sup>505</sup> The Government spends 10.9 percent of its annual budget on health care.<sup>506</sup>

The country's health care system is comprised of modern health centers and traditional healers, with much of the general populace relying on both for care.<sup>507</sup> The national system is decentralized into the four regions but overseen at the central level.<sup>508</sup> Private and public clinics operate throughout the country and Rural Health Motivators educate local communities about condom use, sanitation, breastfeeding and general disease prevention.<sup>509</sup> Eighty percent of the population lives within eight kilometers of a facility that provides at least antenatal care,<sup>510</sup> though problems exist regarding access for certain rural communities due to the lack of public transport and persistent poverty.<sup>511</sup> There are approximately 0.2 physicians available for every 1,000 people<sup>512</sup> and one nurse for every 356 people.<sup>513</sup> Swazi nurses rallied in 2002 and 2004 for pay raises, winning a 7.5 percent increase in 2002.<sup>514</sup> Despite this, between 100 and 150 nurses are estimated to leave the profession each year as a result of low pay, lack of HIV/AIDS training and personal assaults,<sup>515</sup> while the Mbabane and Manzini hospitals graduate approximately 100 new nurses each year.<sup>516</sup>

Traditional healers continue to play a significant role in providing health services, for HIV and other ailments, particularly in rural areas with little access to modern medicine.<sup>517</sup> Many Swazis consult both traditional healers and modern health centers when they fall ill.<sup>518</sup> WHO/AFRO statistics have reported one traditional healer per every 100 people.<sup>519</sup> Medicines derived from plants play a large role in traditional Swazi healing.<sup>520</sup>

After Swaziland gained independence, life expectancy rose to 65 years for women and 58 years for men.<sup>521</sup> In 2004, life expectancy for women and men was 31.3 years.<sup>522</sup> The infant mortality ratio stood at 108 deaths/1,000 live births in 2004.<sup>523</sup> That same year, the probability of a child dying under five years of age was 163/1,000 live births for boys and 150/1,000 for girls.<sup>524</sup>

## HIV/AIDS Epidemic

In March 2004, Swaziland officially became the country with the world's highest HIV prevalence.<sup>525</sup> That year, Botswana's HIV-positive adult population dropped from 38.8 percent of all adults to 37.5 percent while

Swaziland's remained at 38.6 percent of the total adult population.<sup>526</sup>

Since 1992 the Government has been conducting sentinel sero-surveillance surveys at antenatal clinics every other year, with the cooperation of WHO.<sup>527</sup> The most recent survey based on estimates derived from 2,467 blood samples taken from pregnant women visiting antenatal care health centers in August to October 2006, found a prevalence of 39.2 percent,<sup>528</sup> as compared with 42.6 percent in 2004.<sup>529</sup> A similar survey revealed an infection level of just 3.9 percent in 1992.<sup>530</sup> That was six years after the first case of HIV infection in the Kingdom was identified.<sup>531</sup>

According to the 2006 surveillance data, 41 percent of HIV-positive Swazi women are from urban areas as compared to 36.9 percent from rural regions.<sup>532</sup> The prevalence of infection fell for women ages 15-29, but rose for women in the 30-34 and 35-39 age groups.<sup>533</sup> Pregnant women ages 25-29 had the highest prevalence, 48 percent, a decline from 56.3 percent in 2004, and close to the 2002 prevalence, 47.7 percent.<sup>534</sup> Unmarried pregnant women previously married or living with their partners had the highest HIV prevalence, 51.2 percent.<sup>535</sup> Women with tertiary and higher education had the lowest levels of infection compared with women with lower levels of education or vocational training.<sup>536</sup>

Women are disproportionately affected by the HIV/AIDS epidemic in Swaziland. Of the 220,000 adults in Swaziland estimated to be HIV-positive at the end of 2005, 120,000 — 54.5 percent — were women.<sup>537</sup> UNDP reported that 52.8 percent of female hospital inpatients in Swaziland were HIV-positive at the end of 2003, compared with 45.6 percent of male patients.<sup>538</sup>

Unequal power relations between men and women and gender discrimination disadvantaging women are key factors underlying the higher prevalence of HIV in women in Swaziland.<sup>539</sup> Intergenerational sexual transmission has been cited as a major driving force behind Swaziland's HIV/AIDS epidemic and, in particular, for its gender disparity.<sup>540</sup> Moreover, while polygamy itself is not seen as a cause per se of HIV transmission, infidelity within polygamous marriage can increase infection rates among women<sup>541</sup> in a manner similar to the dynamics seen in other multiple concurrent (and serial) sexual partnerships.<sup>542</sup>

As is the case elsewhere in the region, gender inequality and poverty are driving the epidemic's disproportionate effect on women.<sup>543</sup> For example, rising food insecurity among an increasing number of female-headed households has been faulted for forcing women

into high-risk sexual behavior such as exchanging sexual intercourse for food, money or other resources.<sup>544</sup> As mentioned above, high mobility both within and out of Swaziland has also been cited as a factor in the country's HIV/AIDS epidemic.<sup>545</sup> Studies have shown that many men work away from home in urban Swaziland or the South African mines, increasing the rate of multiple partnerships, sexually transmitted diseases and thus risk of HIV infection.<sup>546</sup>

Traditional practices have also been identified as possible factors in the epidemic. In 2001 the King revived the customary practice of *umcwasho* by royal decree with the intention that it serve as a means by which to curb HIV infection.<sup>547</sup> *Umcwasho* are traditional woolen tassels young women wear to indicate their sexual abstinence.<sup>548</sup> The revival was received with mixed reviews within Swaziland<sup>549</sup> and was repealed in 2005, one year earlier than planned.<sup>550</sup> Months into the ban, the King himself paid the traditional fine of one cow to the father of a 17-year-old woman with whom he broke the chastity vow.<sup>551</sup> He chose his 13<sup>th</sup> fiancée in 2005 after he saw her at the annual reed dance in which virgins dance for the King and he can choose his next wife from among the dancers.<sup>552</sup> Moreover, while customary polygamy has come under fire from HIV/AIDS activists as facilitating the spread of the epidemic, King Mswati III has defended it by blaming individual infidelity rather than the practice itself for the epidemic.

Traditional health practices also increase the risk of contracting HIV. For instance, *kugata*, during which incisions are made in the skin to administer traditional medicines, is potentially dangerous, since *kugata* blades are customarily not cleaned between uses.<sup>553</sup> Some healers have claimed to be able to cure AIDS through a cleansing ritual of goat slaughter and herbal medicine injection which could lead to misplaced belief of being cured.<sup>554</sup>

Like many countries in southern Africa, Swaziland is feeling the economic effects of the HIV/AIDS epidemic and a shrinking workforce. UNAIDS has estimated that AIDS-related deaths would account for a 41 percent decrease in Swaziland's population between 2002 and 2015.<sup>555</sup> In 2005 alone an estimated 16,000 Swazis died of AIDS.<sup>556</sup> Those affected by the disease come disproportionately from society's working population.<sup>557</sup> The loss of its economically productive citizens is straining Swaziland's health care structure and raising the number of dependents who cannot generate income to sustain themselves.<sup>558</sup> It is estimated that Swaziland is currently home to 63,000 children orphaned by AIDS.<sup>559</sup> The Swazi government expects that the country will be

home to 120,000 orphans by 2010.<sup>560</sup> The United Nations Children's Fund (UNICEF) estimates that AIDS will be the cause of 82 percent of the orphaned population.<sup>561</sup>

## Swaziland HIV/AIDS Policy

### Governmental and Organizational Response

The first case of HIV was identified in Swaziland in 1986.<sup>562</sup> In response, the Government created the National AIDS Prevention and Control Programme (NAPCP) in the Ministry of Health and Social Welfare that same year.<sup>563</sup> Two years later, with the help of WHO, the program was expanded and renamed the Swaziland National AIDS/STI Programme (SNAP). SNAP's mandate is to reduce HIV and STI transmission through information, education and communication campaigns.<sup>564</sup> In 1999, King Mswati III declared HIV/AIDS a national disaster.<sup>565</sup> The Government created the National Emergency Response Committee on HIV/AIDS (NERCHA) in 2001 to oversee and coordinate a comprehensive and multisectoral approach to managing the epidemic,<sup>566</sup> operating under the National Strategic Plan for HIV and AIDS (2000-2005).<sup>567</sup>

A comprehensive review of the strategic response plan was commissioned and produced in 2005 to guide NERCHA and other stakeholders in developing a second strategic plan for the next three years.<sup>568</sup> The result was the Second Multisectoral HIV and AIDS Strategic Plan 2006-8<sup>569</sup> and the National Multisectoral HIV and AIDS Policy.<sup>570</sup> Whereas the first National Plan focused on risk reduction, response management and impact mitigation,<sup>571</sup> the current strategy incorporates prevention; care, support and treatment; and management of the national response as an "urgent priority," and emphasizes comprehension and scaling up. The Policy puts forth as three of its guiding principles respect for human rights, compliance with international and national laws, and gender equality and equity.<sup>572</sup> Moreover, women's sexual and reproductive rights and protection of women against gender-based violence and traditional practices negatively affecting their health are explicitly endorsed.<sup>573</sup>

The Swazi government reported that it spent US\$4.1 million on HIV/AIDS in 2005.<sup>574</sup>

The international community is also involved in Swaziland's fight against HIV/AIDS. For example, WHO and several UN agencies facilitate Swaziland's United Nations Theme Group on HIV/AIDS, a joint policy and strategy collective.<sup>575</sup> In 2004 the Theme Group, together with Support to International Partnership

Against AIDS in Africa, assisted PLWA support groups to conduct a rapid assessment of local organizations that work with PLWA.<sup>576</sup> Also in 2004, the Theme Group helped create the Swaziland Partnership Forum on HIV and AIDS to bolster “multisectoral cooperation and resource mobilization efforts for HIV and AIDS.”<sup>577</sup> The group also assisted in the establishment of a national PLWA network, the Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA), which advocates for PLWA.<sup>578</sup> In 2000, Swaziland’s chapter of the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL) formed in Manzini.<sup>579</sup> AMICAALL addresses the social, economic, cultural, and political impacts and drivers of the epidemic in Swaziland’s municipalities.<sup>580</sup> Since its inception, AMICAALL has established and strengthened 40 feeding centers to ease food insecurity as a result of HIV/AIDS.<sup>581</sup> The alliance has also promoted PMTCT services, trained home-based care volunteers and facilitated monitoring and evaluation projects.<sup>582</sup>

In 2005, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria contributed US\$4,318,890 to Swaziland for Mother to Child Transmission services, VCT, ARV treatment, blood bank safety measures and legal assistance to PLWA.<sup>583</sup> In 2004, the European Union gave US\$2.85 million and the World Bank gave US\$0.4 million for HIV/AIDS prevention and treatment.<sup>584</sup>

In 2005, the United States reported that it was providing US\$32 million to several HIV/AIDS-related initiatives in Swaziland through a variety of agencies, including the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria.<sup>585</sup> The United States Agency for International Development’s (USAID) Regional HIV/AIDS Program in South Africa supports a number of projects in Swaziland through faith-based, non-governmental and community-based organizations, including orphan care, palliative treatment and community preparation for ARVs.<sup>586</sup> The US Embassy’s International Visitor Exchange program trains Swazis in-country and sponsors study tours to the United States to share HIV/AIDS fighting strategies.<sup>587</sup> In 2005, the US Ambassador’s Girls Scholarship Program committed US\$210,000 to the provision of basic education for 1,000 Swazi girls who have been orphaned, abused or live with HIV/AIDS.<sup>588</sup> USAID, through MEASURE DHS, also supported a Demographic and Health Survey in Swaziland in the first four months of 2006.<sup>589</sup>

A number of Swazi non-governmental and community-based organizations have been created to address HIV/AIDS. These include The AIDS Information and Support Center (TASC), which in 1993 became the first

organization to offer free voluntary counseling and testing to PLWA.<sup>590</sup> TASC in turn created the first support group for PLWA, the Swaziland AIDS Support Organization (SASO) that same year.<sup>591</sup> Like other support groups, SASO also advocates at the national level for the rights of PLWA.<sup>592</sup> In 2001, Swazis for Positive Living (SWAPOL) was formed by several HIV-positive women<sup>593</sup> who approached Swaziland’s UNICEF representative for support.<sup>594</sup> With funds from its own agricultural projects in addition to UNICEF and other donor assistance, SWAPOL educates communities, trains caregivers, provides medical and home-based care to PLWA and assists abused women and children.<sup>595</sup> Rural Health Motivators, nurses, Swaziland Hospice at Home and the Family Life Association of Swaziland (FLAS), a youth sexual and reproductive health services NGO, also lead prevention activities at the homestead level.<sup>596</sup> SWAPOL, SASO and Women Together have organized counseling and testing initiatives and provide support to PLWA.<sup>597</sup> The Nhlengano AIDS Training and Information Counseling Center (NATICC) is an education and counseling organization formed in 2002 in the Shiselweni region.<sup>598</sup> The southern Africa regional office of the International Community of Women Living with HIV/AIDS opened in Mbabane in April 2004. In collaboration with the POLICY Project, this advocacy network focuses on gender equality, universal access to care and treatment and women’s participation in decision making at all levels.<sup>599</sup> Many of these organizations have worked together through CANGO, the Coordination Assembly of Non-Governmental Organizations, which in 2006 organized workshops with NGOs working on HIV/AIDS, NERCHA and the Ministry of Health to enhance collaboration among these agencies.<sup>600</sup>

The Swaziland Infant Nutrition Action Network (SINAN), a local NGO and Secure the Future, an initiative of Bristol Meyers Squibb, as well as the Ministry of Health and Social Welfare, oversee PMTCT programs which provide, without charge, hospital delivery, ARV prophylaxis for mother and child, treatment of opportunistic infections, male and female condoms, VCT services during pregnancy, food supplements for the mother and child and infant formula.<sup>601</sup> PMTCT also offers ARV treatment to women and families at certain sites.<sup>602</sup>

Various organizations and government ministries are struggling to care for Swaziland’s growing AIDS orphan population. The Government has asked chiefs to forego the practice of redistributing a deceased man’s land in favor of letting the deceased’s orphans remain on it.<sup>603</sup> The traditional practice of the “chief’s

field” has also proven useful. Custom provides for a plot of land to be reserved for growing communal village supplies, to be drawn upon in times of drought and other emergencies.<sup>604</sup> The Government asked the 366 chiefs to create such plots for orphans and, by September 2002, 190 had started designating some cropland for such use.<sup>605</sup> However, of the 190 fields that were planted in 2003, only 12 percent were able to produce enough food to feed the area’s orphans.<sup>606</sup>

Swazi media has been criticized for failing to comprehensively address the HIV/AIDS epidemic as a result of strict government regulation, cultural taboos and lack of capacity.<sup>607</sup> While many Swazis receive information via radio, HIV/AIDS is often relegated to unpopular health education programs.<sup>608</sup> The state owns much of the media in the country and keeps tight reins on its content, barring any reports that suggest critique of the Government.<sup>609</sup> In 2003, NERCHA established a communications office to assist media outlets to craft HIV/AIDS awareness programming.<sup>610</sup> Some activities resulting from this initiative include a weekly HIV/AIDS column in the *Times of Swaziland* as well as weekly HIV/AIDS briefings at NERCHA.<sup>611</sup> The Media Institute of Southern Africa has a Swaziland chapter focused on creating a legal framework for realization of the right to freedom of information, educating civil society on this right, monitoring violations and integrating a gender perspective, among other activities.<sup>612</sup>

### Prevention/Education

A review by the Swazi government in 2005 found that programs designed to communicate information and promote behavioral change were not coordinated at a national level, had not been adequately evaluated as to effectiveness and lacked an overarching communications strategy.<sup>613</sup> The Swazi Government reported to the 2006 UN General Assembly’s Special Session on HIV/AIDS (UNGASS) meeting that only 47 percent of 15 to 24-year olds were able to identify at least one way that HIV is prevented.<sup>614</sup> Swaziland also lacks national policies on the prevention of mother-to-child transmission and on addressing HIV and AIDS in the workplace.<sup>615</sup>

In April 2003, Chief Madelezi Masilela of Vusweni area, 40 kilometers southeast of Mbabane, became the first traditional leader to publicly admit his HIV-positive status.<sup>616</sup> He said he contracted the virus through the practice of widow inheritance, meaning that he “inherited” and married his sister-in-law after his brother died of AIDS.<sup>617</sup> Chief Masilela urged his subjects to get tested and practice safe sex.<sup>618</sup>

The Ministry of Health is also working with traditional healers to build upon healers’ access to patients and improve patient education and care.<sup>619</sup> Healers are encouraged to sterilize any invasive implements to conduct *kugata*.<sup>620</sup> Some healers also distribute condoms.<sup>621</sup>

A 2006 NERCHA prevention campaign was controversial and has been strongly criticized by PLWA and women’s groups. Called “Makhwapheni Uyabulala” (“a secret lover kills”), it included SMS text messages imitating lovers’ solicitations sent to thousands of mobile phones. The campaign was publicly denounced by organizations including SWANNEPHA, for being insulting to PLWA and suggesting that they irresponsibly have multiple sexual partners.<sup>622</sup> Women’s groups raised concerns of gender discrimination in the portrayal of women in the campaign, pointing out that *makhwapheni* is an insulting term in Swazi culture when referring to women, and fearing that women already stigmatized as transmitting HIV to their partners, and female PLWA in particular, would be further marginalized by the impression that they are seeking, and have been infected due to, risky, adulterous relationships.<sup>623</sup>

### Testing

Despite the prevalence of HIV in Swaziland, widespread testing has been a relatively recent practice. Insurance companies usually require HIV tests of life insurance applicants.<sup>624</sup> If applicants test positive they are often denied policies.<sup>625</sup> The national army, the *Umbutfo* Swaziland Defense Force, announced in February 2004 that it would begin mandatory, anonymous HIV testing for its 3,500 members.<sup>626</sup> Though staff would be able to receive their results and voluntary counseling and treatment upon request, the policy is aimed more at measuring the scope of infection rather than identifying infected individuals.<sup>627</sup>

The central element of the Government’s testing policy in the past few years has been the creation of 22 VCTs, with several in each of the country’s four districts, the majority located within other health facilities.<sup>628</sup> The centers offer pre- and post-test counseling and some rapid testing services.<sup>629</sup> The testing policy has faced implementation challenges. For example, in 2005 it was determined that the recruitment and training of additional counselors were not keeping up with the demand for testing services.<sup>630</sup> In addition, some centers were found to keep poor records, fail to protect confidentiality and lack strong links with community-based organizations that provide support services for people with HIV.<sup>631</sup>

Moreover, despite educational campaigns to promote HIV testing, many of those at risk are afraid of being tested.<sup>632</sup> Such fears could stem from the fact that Swaziland remains an inhospitable environment for people with HIV because of associated stigma and the difficulty of preventing or redressing HIV/AIDS-related discrimination.<sup>633</sup> For example, women have been driven from their homes after disclosing their HIV-positive status.<sup>634</sup>

## Treatment

Swaziland has recently begun to provide HIV/AIDS treatment. When the National Strategic Plan was drawn up in 2000, only a few private clinics offered access to ARVs.<sup>635</sup> In August 2002, the Government of Swaziland promised to make ARVs available to HIV-positive mothers and rape survivors “soon” at public health facilities, with an eye toward eventually expanding the service to all HIV-positive citizens, as well as increasing training and counseling services.<sup>636</sup> In January 2004, the Ministry of Health and Social Welfare launched an effort to make ARVs available without cost on a national level.<sup>637</sup> In September 2005, the most recent estimate, NERCHA reported that 14,500 patients had enrolled in ARV treatment.<sup>638</sup>

As of early 2005, treatment was free at six public hospitals around the country, but many patients who live in rural areas still found it difficult to access such treatment.<sup>639</sup> Additionally, because of the rising number of individuals seeking treatment, the inadequately staffed and supplied centers find themselves unable to cope with the demand.<sup>640</sup> In November 2005, for example, public hospitals in Mbabane, Siteki (in eastern Swaziland) and Hlatikhulu (in southern Shiselweni District) reported ARV shortages<sup>641</sup> due in part to a decision by the Global Fund to Fight AIDS, Tuberculosis and Malaria to suspend funding for drug distribution pending the meeting of certain requirements, including the implementation of management systems.<sup>642</sup>

The estimated cost of treating one patient with ARVs for one year in Swaziland was US\$380 in January 2004.<sup>643</sup> By spring 2005, the cost had fallen to between US\$150 and US\$170.<sup>644</sup> Swaziland participated in WHO’s “3 by 5 Campaign,” aimed at providing 3 million people in developing and “transitional” countries with ARVs by 2005.<sup>645</sup> WHO estimated the number of Swazis in need of ARVs to be 32,000 by 2005 and committed to providing treatment to half of them.<sup>646</sup> The major sources of funding for ARV treatment in Swaziland are the Global Fund, the Swazi government and the private sector.<sup>647</sup> For example, Royal Swaziland Sugar Corporation and South

African Paper and Pulp Industry *Usuthu* purchase their own ARVs for distribution to employees.<sup>648</sup>

Despite the influx of funds, lack of adequate infrastructure remains a roadblock in the delivery of HIV/AIDS treatment in Swaziland. The country’s lack of a national drug-testing facility prompted its exclusion from a fourteen-country, US-backed program promoting ARVs for pregnant women, which in turn prevented Swaziland from being included in PEPFAR.<sup>649</sup>

A 1990s survey indicated that the majority of Swazis consult traditional healers as their first mode of health care.<sup>650</sup> There were an estimated 3,000 healers working in Swaziland in 2003.<sup>651</sup> That same year, Swaziland’s Traditional Healers Association reported that 20 percent of workers diagnosed with HIV in the northern sugar belt had consulted healers after their diagnosis, with many claiming to have been bewitched.<sup>652</sup> In light of people’s reliance on traditional medicine for knowledge about HIV prevention and transmission, as well as treatment, the Ministry of Health and Social Welfare (MOHSW) has recruited *tinyango* (traditional medicine men and women) to assist in HIV treatment such as counseling.<sup>653</sup>

Home-based care for PLWA is provided by volunteer or nominally-paid caregivers who are overwhelmingly female. MOHSW provides approximately 5,500 caregivers, who are trained by UNAIDS, with US\$17 monthly stipends each, but this is not nearly enough to meet expenses.<sup>654</sup> Moreover, due to high demand, many caregivers receive no compensation for their services which include feeding, washing, dressing and advising HIV-positive patients.<sup>655</sup>

## Women’s Status

Swaziland’s prolonged status as an absolute monarchy has raised concerns about its human rights policies. Nonetheless, Swaziland has signed, ratified or acceded to several important international human rights documents. Swaziland has acceded to the Convention on the Elimination of All Forms of Discrimination against Women,<sup>656</sup> the International Covenant on Civil and Political Rights,<sup>657</sup> the International Covenant on Economic, Social and Cultural Rights,<sup>658</sup> and the International Convention Against Torture.<sup>659</sup> The obligations under these treaties were accepted without entering any reservations. It has ratified the Convention on the Rights of the Child<sup>660</sup> and the African Charter on Human and People’s Rights.<sup>661</sup> Swaziland has signed the African Charter on the Rights and Welfare of the Child<sup>662</sup> as well as the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women.<sup>663</sup>

## Legal Status

The legal rights of Swazi women are unclear given the country's dual legal system and pending implementation of the new Constitution. The new Constitution contains some victories for Swazi women, including equal access for Swazis to land "for normal domestic purposes"<sup>664</sup> and the right of women to be free from customs to which they are opposed.<sup>665</sup> Yet, at present, many Swazi people continue to adhere to customary law, particularly in rural areas.<sup>666</sup> While there have been consultations on the development of draft legislation to reform and consolidate customary and civil law relating to marriage, property and inheritance rights for women, the Attorney General's office has not yet completed work on the bill and the situation is unclear pending the passage of new laws implementing the constitutional provisions and their interpretation by the courts.<sup>667</sup> Women's lives remain highly constricted by traditional cultural rites and many aspects of customary law, which limit their rights and ability to own land, inherit property, find employment and conduct business.<sup>668</sup>

Much of Swazi women's economic and societal vulnerability stems from the fact that, upon marriage, they assume a legal status comparable to that of a minor child, unless a couple is explicitly married "out of community of property," in which case the husband does not have marital power.<sup>669</sup> Marital power prohibits women from securing bank loans, opening bank accounts, leaving the country,<sup>670</sup> making major decisions, registering property in their names or suing in court without their husbands' permission.<sup>671</sup> The practice of polygamy, while less prevalent than in the past, further entrenches discrimination against women. Although civil law does not recognize the practice, customary law allows men to take an unlimited number of wives.<sup>672</sup>

Further evidence of women's subordinate status in customary law is revealed in marriage rites. As in some other African countries, many Swazi marriages involve payment of a bride price, or *lobola*.<sup>673</sup> In *kwendiziswa*, a traditional method of marriage, a young woman's father negotiates her marriage as an economic transaction.<sup>674</sup> Typically, *lobola* is exchanged as cattle, although cash is increasingly being substituted.<sup>675</sup> In some traditional settings, a woman need only be smeared with ochre to signify that a marriage has taken place.<sup>676</sup> Custom dictates that the woman be informed of the ritual in advance, but there have been cases where she has been not been warned beforehand.<sup>677</sup>

Customary marriage rites and laws reinforce the concept that women's social and familial status is

derived from their reproductive role. For example, *lobola* can be recalled if a woman fails to fulfill her reproductive or labor capacities.<sup>678</sup> Moreover, if a woman is found to be infertile, her biological family may give her husband an aunt or sister as a surrogate mate or *inhlanti* ("substitute wife") rather than return the *lobola* to the husband's family.<sup>679</sup> The *inhlanti* does not keep her children, since her role was simply to provide offspring in lieu of the woman who did not. Likewise, if a man impregnates a woman or girl before she is married, he must pay a fine to the girl's father in compensation for the *lobola* the family will lose in trying to marry off a daughter who is no longer a virgin.<sup>680</sup>

Upon her husband's death, a woman's life is further ruled by custom. For example, *kuzila*, mourning rites, outline the protocol for a widow's behavior for months to years.<sup>681</sup> Widows are expected to wear black gowns for up to three years.<sup>682</sup> Because widows are believed to be omens of bad luck, they are generally prohibited from socializing with others, especially men.<sup>684</sup> These and other customs have created conflicts for women who work in environments where observing such behavior is difficult, further endangering their economic well-being by threatening their jobs. Furthermore, in-laws may seek to usurp ownership of land and property because the widow is not allowed inside a courtroom while in mourning. The widow herself is sometimes married, even without consent, to her late husband's brother, as in the practice of *kungenwa*.<sup>685</sup>

Swazi women also face struggles to fulfill their rights in the civil legal system. Maintenance, for instance, is a general term allowing for the provision of basic necessities of life. It can be claimed from a husband by a wife, parents from children and grandchildren from grandparents.<sup>686</sup> The 1970 Maintenance Act of the Swazi civil law system obligates both parents to provide for children.<sup>687</sup> However, if a child is born outside of marriage and the woman demands maintenance from her male partner, customary law gives him the right to "buy" his child from the maternal grandfather for the price of one cow for a boy and two cows for a girl.<sup>688</sup> The grandfather cannot refuse even if the mother objects.<sup>689</sup> The possibility of losing one's children prevents many women from making maintenance claims,<sup>690</sup> preferring to struggle to care for their children in exchange for being able to keep them.

There is no specific law criminalizing domestic violence in the Swazi civil law system. Therefore, domestic violence complaints must be brought under general assault or rape laws,<sup>691</sup> which exclude marital rape.<sup>692</sup>

Though the police, magistrates and a small number of NGOs, such as WLSA and the Swaziland Action Group Against Abuse (SWAGAA) provide some recourse for women experiencing abuse,<sup>693</sup> their effectiveness is often limited by women's low social and legal status and the limitations of civil law.

In 2005, Prime Minister Dlamini announced that he had instructed the Minister of Justice and Constitutional Affairs to draft a bill offering victims of domestic violence civil legal remedies.<sup>694</sup> Certain provisions of the draft bill on sexual offenses and domestic violence raised concerns about human rights, including those of PLWA. For example, the draft bill labeled the failure to disclose HIV status to one's sexual partner as fraud.<sup>695</sup> Given that women are more often aware of their HIV status than men, this provision put women at increased risk of violence as a result of the disclosure requirement.<sup>696</sup> The bill also prescribed the death penalty for cases in which HIV/AIDS is an aggravating factor. This could discourage men from learning their HIV status.<sup>697</sup> In the past, rapists had been able to avoid prosecution by marrying their victims.<sup>698</sup> In addition to legal hurdles, women's economic vulnerability often makes them reluctant to report abuse.<sup>699</sup> There is a new version of the bill which addresses some of these concerns, but the Minister of Justice has not acted on it to-date.<sup>700</sup>

### **Socio-Economic Status**

Swazi women are economically disadvantaged as compared to Swazi men. In 2004, Swazi women earned an estimated PPP (purchasing power parity) of US\$2,576 per year, 29 percent of men's income.<sup>701</sup> However, some Swazi women are assuming control over their economic destinies. A 2003 study by Swaziland's Ministry of Enterprise and Employment indicated that over 70 percent of small businesses are owned by women.<sup>702</sup> Due to restricted land laws, however, while businesses can be registered in women's names, the land upon which they operate can only be owned by men.<sup>703</sup> Women are typically relegated to the informal sector, such as produce markets, or to small enterprises, such as hair salons, tailors and restaurants.<sup>704</sup> A third of Swazi households are headed by females.<sup>705</sup>

Education levels are comparable between Swazi men and women, with men enjoying a slight advantage over women. Approximately 59 percent of men attend primary and secondary school and tertiary institution compared with 57 percent of women.<sup>706</sup> Literacy rates reflect a similar relationship, with just over 78 percent of women over the age of 15 being literate, compared to more than 80 percent of men in the same age group.<sup>707</sup>

### **Health Indicators and Access**

While women's health in Swaziland is neglected, their cultural status as caregivers compels them to tend to others even when they themselves are ailing.<sup>708</sup> Seventy percent of pregnant Swazi women give birth in the presence of skilled health personnel.<sup>709</sup> The adjusted maternal mortality ratio for Swaziland was 370 maternal deaths per 100,000 live births in 2000<sup>710</sup> and the total fertility rate, or the number of lifetime births per woman, was 3.7 in 2005.<sup>711</sup> In 2005, the teen pregnancy rate was 36 births per 1000 women ages 15 to 19 years old; this data only accounts for live births.<sup>712</sup> Swaziland has no statutory law on abortion.<sup>713</sup> The practice is generally governed by principles of Roman-Dutch law which preclude abortion except in cases where the woman's mental health or the life of the mother or child is in jeopardy.<sup>714</sup>

### **General Gender Policy**

Since the United Nations Fourth World Conference for Women held in Beijing in 1995, Swaziland has taken a number of steps to place women's issues on the national agenda, though to date Swaziland has not formally approved a national gender policy.<sup>715</sup> In 1996, the Government created a Gender Coordination Unit (GCU) in the Ministry of Home Affairs.<sup>716</sup> The GCU is charged with mainstreaming gender into all sectors of national development.<sup>717</sup> The government also appointed a "gender focal point" for each sector of the executive and established the Swaziland Committee on Gender and Women's Affairs, a group of government, non-governmental and private sector representatives who are responsible for drafting a gender program.<sup>718</sup> The United Nations agencies also contain gender focal points.<sup>719</sup> In 2001, UNDP, UNESCO, UNIFEM and the World Bank created "An Integrated Approach to Gender Equality in Swaziland," an initiative intended to assist the Swazi Government in "examining gender issues and formulating a national gender policy."<sup>720</sup> The Gender Consortium is a non-governmental organization that is charged with mainstreaming gender into various government and non-profit sectors.<sup>721</sup>

Women accounted for just under 17 percent of parliamentarians in 2006.<sup>722</sup> In 2003 the King appointed two women as House members and seven as senators.<sup>723</sup> Five women were popularly elected to the House.<sup>724</sup> A Parliamentary Women's Caucus has been created to build the capacity of women representatives so that they can better influence the policy-making process and plan for gender equality throughout the country.<sup>725</sup>

There are several Swazi NGOs that address women's issues. WLSA, a regional women's rights NGO, has a national office in Mbabane.<sup>726</sup> WLSA conducts research, advocacy and lobbying on women's issues.<sup>727</sup> It also provides gender-rights training and related educational materials.<sup>728</sup> Umtapo Wa Bomake, also known as the Women's Resource Centre, began in 1992<sup>729</sup> but has since closed. It provided enterprise skills training to

rural women and advocated for the repeal of discriminatory legislation and cultural practices.<sup>730</sup> FLAS was founded in 1979 as a sexual and reproductive health organization.<sup>731</sup> FLAS operates clinics targeting youth ages 10-24 in Manzini and Mbabane.<sup>732</sup> These clinics offer reproductive health services, information and education.<sup>733</sup> FLAS specifically targets gender-sensitive issues such as maternal mortality, unsafe abortion and

## Notes

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<sup>440</sup> The Constitution of the Kingdom of Swaziland Act, (2005), Ch. VII, Part 2, sec. 94(1) and 95(1).

<sup>441</sup> The Constitution of the Kingdom of Swaziland Act, (2005), Ch. VII, Part 2, sec. 95(1)(a).

<sup>442</sup> The Constitution of the Kingdom of Swaziland Act, (2005), Ch. VII, Part 2, sec. 95(1)(b).

<sup>443</sup> The Constitution of the Kingdom of Swaziland Act, (2005), Ch. VII, Part 2, sec. 95(1)(c).

<sup>444</sup> The Constitution of the Kingdom of Swaziland Act, (2005), Ch. VII, Part 2, sec. 95(1)(d).

<sup>445</sup> The Constitution of the Kingdom of Swaziland Act, (2005), Ch. VII, Part 2, sec. 94(2).

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## VII. SWAZILAND PHR STUDY FINDINGS

This chapter presents the most significant results from the Swaziland community survey and PLWA and key informant interviews. Key findings include:

1) *Participant Characteristics*: More women than men surveyed reported food insufficiency, lower incomes, lower education levels and having at least one dependent. Of the PLWA interviewed, the majority female, 48 out of 58 reported having experienced the lack of food or water at some point. Fifty-two were caring for 2 or more dependents and 40 had not completed high school. The poverty of female PLWA in Swaziland was also highlighted by key informants.

2) *Knowledge of HIV*: The majority of community survey participants correctly answered questions about HIV prevention and transmission, with no statistically significant sex differences. Gaps in knowledge, such as attributing HIV infection to mosquito bites (34 percent of participants), were also evident, however. PLWA cited condom use as particularly subject to myths and stigmatization. Key informants reported that blaming women for HIV/AIDS was prevalent in rural communities.

3) *HIV Testing*: 59 percent of those surveyed reported access to HIV testing in their community, but 78 percent had not yet tested. Being afraid or not ready to know their HIV status was the most common reason for not testing (43 percent), and wanting to know one's status the most prevalent reason for having tested (58 percent) for those who had done so. Forty-one percent did not feel they could refuse the test, though the majority had made the decision to test, had a confidential test and received pre- and post-test counseling. While more women had tested than men, the most common barriers and facilitators and testing experiences did not differ based on sex. PLWA reported both gender-related barriers to testing and financial and geographical barriers to access.

4) *HIV-Related Stigma and Discrimination*: 61 percent of women and men surveyed held at least one stigmatizing or discriminatory attitude toward PLWA. Many expressed the fear of being stigmatized should they test positive for HIV and have that status disclosed to their partners, families, work or communities. Women reported higher levels of fear of stigma than did men. While most PLWA had disclosed their status to others

and reported positive consequences of that disclosure, the majority also recounted experiences of stigma and discrimination. Twenty out of 58 PLWA confirmed that experiences of poor treatment were worse for women than for men living with HIV/AIDS in Swaziland and most key informants interviewed agreed.

5) *Sexual Risk*: Women surveyed lacked control over the decision of when to have sex (40 percent) or use a condom (18 percent) proportionally more than men (3 percent in each category). Thirty-four percent of women and 4 percent of men reported not using a condom at least once in the past year because their partner refused to do so. Eight percent of women and 39 percent of men reported having more than one sexual partner in that time period. A majority of PLWA reported a reduction in the number of partners and more routine use of condoms after discovering their status. However, 16 out of 45 women reported that they lacked control over the decision of when to have sex, as compared with none of the 13 men interviewed. Key informants discussed the underlying socialization to female subservience and the disempowerment of women that underlie risky sexual practices.

6) *Gender Discriminatory Beliefs*: 97 percent of those surveyed held at least one gender discriminatory belief and the majority reported 3 or more such beliefs. The majority also held beliefs in women's rights and equality. Holding either type of belief predicted sexual risk taking. For example, women and men who felt that men should control decisions in relationships with women had nearly twice the odds of unprotected sex with a non-primary partner than those who did not. Conversely, participants who agreed that women should be able to end relationships with men had 50 percent decreased odds of unprotected sex as compared with those who disagreed.

7) *Leadership on HIV/AIDS*: Participants in the community survey found all leaders wanting on every domain of inquiry, including spending on HIV prevention, setting a good example in personal behavior, meeting the basic needs of those infected and affected by HIV/AIDS, opposing poor treatment of PLWA and protecting women and children from abuse. Chiefs and national political leaders in particular were faulted. PLWA cited some accom-

plishments by leaders, but criticized their failure to go beyond rhetoric to action, as did key informants who noted the detrimental failure to move from draft policies to commitment and implementation.

Throughout this chapter, where sex differences are statistically significant ( $p < 0.05$ ), the sex stratified data are presented.

## Characteristics of Study Participants

Community survey participants were 788 adult men and women from all four regions of Swaziland.<sup>736</sup> Their characteristics are reported in Table 1. Fifty percent were women and the mean age for the total sample was 29 years. Women were more likely to affirm than men that they had problems getting enough food to eat in the past year: 38 percent of women versus 29 percent of men surveyed. Of these, 65 percent of women and

men reported that food or water shortages had affected their health care decisions; 82 percent of women and men said that these shortages had affected their ability to support dependents; and 85 percent of women and men reported that these shortages had made them economically dependent on someone else.

Thirty-nine percent of women and 28 percent of men were married and 25 percent of marriages were polygamous.<sup>737</sup> Forty-six percent of women and 42 percent of men lived with a sexual partner or spouse. Eighteen percent of women and 19 percent of men were unmarried and living with a sexual partner. Seventy-two percent of women and 62 percent of men had one or more dependents. Thirty-six percent of women, compared with 48 percent of men, had completed Form 5 (high school) or a higher level of education. Fifty-eight percent of female participants lived in an urban area and

**TABLE 1: Characteristics of Swaziland Community Survey Participants (N=788)\*\***

Participant Characteristics	Women (N=397) n(%)	Men (N=390) n(%)	p value**
Mean age	30	29	0.2578
Marital/Partner Status			
Married	157(39)	112(28)	0.003
Unmarried, living w/ sexual partner	73(18)	75(19)	
Ever Widowed	26(7)	18(5)	
Having > or = 1 Dependent	286 (72)	240(62)	0.048
Urban Residence	228(58)	196(50)	0.040
Rural Residence	168(42)	194(50)	
Monthly Household Income			
< 5,000 Emalangeni (approx. US\$821) <sup>735</sup>	357(90)	327(84)	0.014
> or = 5,000 Emalangeni	40(10)	62(16)	
Monthly Household Income			
< or = 1,000 Botswana pula (approximately US\$220)	326(50)	242(39)	0.000
> 1,000 Botswana pula	321(50)	371(61)	
Receiving assistance from government (money, food, supplies, etc.) to care for PLWA or orphans	50(13)	31(8)	0.032
< High School (Form 5) Education`	254 (64)	204 (52)	0.005
> or = High School (Form 5)	143 (36)	186 (48)	
Problems getting enough to eat, past 12 months	150(38)	111(29)	0.004
Seen by a medical doctor in the past 12 months	273(69)	191(49)	0.000

\*The sex of one individual is missing; for sex-stratified data, N=787.

\*\*P values refer to the statistical significance of the difference between women's and men's responses.

42 percent in rural areas; male participants lived almost equally in urban and rural areas.

In addition to being less educated than men, women had lower incomes and were more likely to be receiving assistance from the Government, such as money food or supplies, to care for PLWA or orphans. Women reported more frequent contact with medical care providers: 69 percent of women in contrast with 49 percent of men had been to a medical doctor in the past year.<sup>738</sup> This likely reflects women’s greater access to free or basic health services, particularly through the antenatal care program.

### PLWA Interviews

Fifty-eight women and men living with HIV/AIDS were interviewed. Their characteristics are reported in Table 2. These individuals were VCT patients, support group members or clients of HIV-related services. The majority were women and urban residents.<sup>739</sup> Their mean age was 34 years. Sixteen of those interviewed were married and 3 were in polygamous marriages. Twelve of the PLWA interviewed had ever been widowed and AIDS was most commonly the cause of a partner’s death. Fifty-three participants believed themselves to have been infected by unprotected sex.

Indicating the difficulty many PLWA had in meeting their basic needs and supporting family members, 48 out of 58 had been affected by the lack of food or water at some point. Thirty-six reported hunger as a consequence, 6 reported economic dependence, 5 individuals said that they couldn’t farm and 1 reported that access to health care was affected. Food insufficiency is a particularly salient issue for PLWA who are receiving ARV treatment, as adequate calories and nutrition affect both the ability to comply with the medication regimen and the effectiveness of the drugs. One man, age 45, described the typical situation:

*Without food, the treatment alone is too difficult. It demands that you eat. You get hungry quickly. You need to have a decent diet. They give you the ARVs without supplements, and there are people who cannot even afford half a loaf of bread.*

Forty-three out of the 58 individuals interviewed were getting some type of care or treatment for HIV/AIDS; 14 were receiving no care or treatment. The most common form was ARVs (33 people),<sup>741</sup> followed by nutritional foods or food supplements (17 interviewees) and medication for HIV/AIDS-related conditions (6 individuals). Two people said that they were receiving treatment from a traditional healer, but both were also on ARVs.

**TABLE 2: Characteristics of Swaziland PLWA Interview Participants (N=58)**

Participant Characteristics	n
Age, mean 34 years	
Women	45
Men	13
Marital/Partner Status	
Married	16
Unmarried	42
Living w/ Sexual Partner (married or unmarried)	16
Widowed	12
Dependents, mean 4.5	12
Urban Residence	40
Rural Residence	17
< High School (Form 5) Education	40
> or = High School (Form 5)	18
Reported Hunger	36
Positive Screen for Depression <sup>740</sup>	21

Women, with fewer economic opportunities than men and, in most cases, primarily responsible for the support of children, reported finding the associated costs of the free ARVs prohibitive. As one 43 year-old woman put it:

*If you don’t have sugar at home for the children, and you need 20 rands [approximately US\$3]<sup>742</sup> for transport to get ARVs, you will choose not to get ARVs.*

Fourteen individuals were receiving some type of aid related to food and 15 were receiving support or assistance related to HIV including social support groups, adherence support, hospice and other home visits. Additional barriers to self-sufficiency include that nearly all had dependents to care for in addition to themselves<sup>743</sup> and 40 had not completed high school. Of the 52 interviewees who completed a depression symptom checklist, 21 screened positive for depression.<sup>744</sup>

### Key Informant Interviews

Several key informants who work with PLWA commented specifically on the poverty of female PLWA in Swaziland. One women’s support group leader said:

*Most women living with HIV/AIDS are not working and most are single mothers without support from the father of the children. They are not working because there are not enough jobs, they*

*are brought up to be dependent on men and, if they are sick, they can't work.*<sup>745</sup>

## HIV Knowledge

The majority of community survey participants correctly identified modes of prevention and transmission of HIV. Responses did identify gaps in knowledge, however. For the most part, women's and men's responses did not differ. PLWA and key informants interviewed identified the persistence of denial, particularly by men, and of HIV-related stigma as perpetuating myths and other incorrect beliefs.

## Community Survey

Despite low levels of formal education, and the lack of comprehensive HIV/AIDS prevention and information campaigns to-date in Swaziland, 81 percent of participants scored as having correct knowledge based on their responses to survey questions, with no statistically significant differences overall between women's and men's responses.<sup>746</sup>

In terms of specific knowledge of HIV transmission, 98 percent of women and men surveyed knew that you can get HIV by having sex without a condom and sharing used needles or instruments; 83 percent agreed that a blood transfusion could transmit HIV; and 3 percent believed witchcraft was a means of transmission. Mosquito bites and sharing meals with an HIV-positive person were thought to transmit HIV by 34 and 17 percent of participants, respectively.

With regard to prevention, using a condom correctly every time you have sex (96 percent of women and 90 percent of men), being faithful to one uninfected partner (91 percent of women and men) and abstinence (93 percent of women and men) were identified by the majority in the community survey as successful methods of protection from HIV. A significant minority also agreed that praying (18 percent) or traditional medicine (7 percent) could prevent HIV transmission.

## PLWA Interviews

While they were not directly asked about HIV knowledge, the PLWA interviewed were aware of the need for correct information to be widely disseminated at the community level as a key component of a comprehensive approach to the HIV/AIDS epidemic in Swaziland. They also pointed out that individuals may have adequate knowledge of HIV but rely on myths about transmission or prevention of the virus to avoid taking responsibility for having exposed themselves or others to risk.

Condoms — and men's refusal to use them — were described as subject to misinformation about their role in causing AIDS, stigmatized as something non-Swazi or not masculine, and derided as decreasing enjoyment of sex.

*They [men] believe that it's not natural, that God didn't create condoms. The example they use is that you can't eat candy in the candy wrapper. And they say condoms cause HIV.*

*Some men say condoms are from white people, that they spread HIV and that white men want to spread HIV in Africa. When Mbeki [the President of South Africa] said that, it influenced people here.*

Perpetuation of some of these myths was mentioned by those interviewed as likely to stem as much from men's denial of their own suspected HIV-positive status or wish to rationalize not testing in order to delay taking responsibility for their own risk-taking behavior as from active belief. The role of persistent high levels of HIV-related stigma played a role as well. As was noted by one 30 year-old woman:

*They need to mobilize communities and tell them about HIV/AIDS. They need to teach them what does it mean to be HIV-positive and have AIDS — teach them the difference between the two. Teach that HIV-positive is like flu or a headache — it doesn't mean you are dead. Proper dissemination of information to the communities can help.*

## Key Informant Interviews

One government official has suggested that the urban/rural divide is a key gap in terms of HIV-related knowledge.

*Particularly in the rural areas, [the existence of] HIV/AIDS is not accepted; it's taken as a mystery. People are infected in towns and they go back to the rural areas where they will be cared for, where they will be terminally ill. We need campaigns in the rural areas; in the towns we have media and so much being said.*<sup>747</sup>

HIV-related stigma in the rural areas was described as particularly strong, fueled by traditional, conservative views on women's roles.

*In rural communities, men think women bring it, because they are doing prostitution within the community. [Men] forget that they are working in the mines, at industrial sites and are careless. Men don't disclose to wives.*<sup>748</sup>

Gaps in education, such as those seen in the community survey, and the persistence of stigmatizing beliefs about the transmission of HIV have direct implications for testing.

## HIV Testing

While the level of HIV-related knowledge among Swazis surveyed was high, testing levels were low for a country whose leader declared HIV/AIDS to be a national emergency eight years ago and where the impacts of the disease can be seen in every community. Physical access to testing was cited as a barrier for only a small proportion of those not tested in the community survey, whereas personal issues, such as readiness to test, illness and self-perceived risk were most frequently reported.<sup>749</sup> Likewise, wanting to know one’s HIV status was the most common facilitator to testing. While the majority who tested found out their results, received counseling and did not experience poor treatment as a result of testing, 41 percent felt that they could not refuse the HIV test. VCT was the favored method of personal testing among survey participants, both tested and not.

PLWA interviewed discussed a number of barriers to testing. They cited gender-related barriers, including the lack of women’s empowerment and men’s fear of stigma and not wanting to change their sexual behavior; financial and geographical barriers to access; and lack of food support. Key informants agreed that men were more reluctant than women to test, and that lack of resources and fear of stigma were barriers to testing. Routine testing was not seen by those interviewed as an appropriate intervention to increase testing, given the poor status of the health infrastructure and lack of a scaled-up treatment program in Swaziland.

## Community Survey

Twenty-five percent of women surveyed and 18 percent of men had tested for HIV. Fifty-nine percent of participants reported that they had access to HIV testing in their community. Sixty-six percent of respondents reported that it is possible for someone to get a confidential HIV test in their community.

### *Community Survey Participants Not Tested: Barriers to Testing*

The principal reasons for not yet testing are shown in Chart 1.

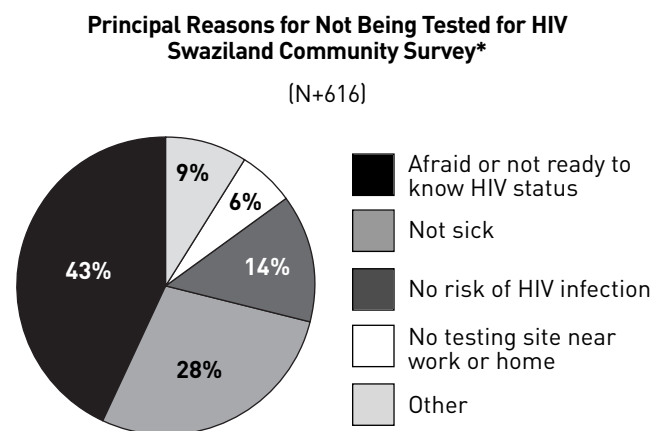
For those not tested (616 individuals), the most common reason for not testing, given in response to an open-ended question by 43 percent of participants, was

being afraid or not ready to know their status. Two percent or fewer volunteered any of the following reasons as being their most important in terms of not testing: shame to be seen at the testing site; fear of being hit or otherwise hurt by a spouse or partner; worry about disclosure of their test results without their permission; not having access to ARV treatment if they were to test positive; not wanting to change their sexual practices if HIV-positive; or being advised by others not to test. Only women reported fear of partner violence in retaliation for testing, not being allowed to test by a spouse or partner or being advised by others not to test as barriers. Only men reported not wanting to change their sexual behavior as a primary reason for not testing.

When asked a series of structured questions about specific barriers, 14 percent of participants agreed that they had not tested because they thought others would treat them badly if they were to test positive and disclose their status; 12 percent of respondents said that not having testing facilities close to home or work kept them from testing; 7 percent confirmed that knowing they would have to change their sexual practices if they tested positive had stopped them; 5 percent of women and 2 percent of men reported that a spouse or partner not allowing them had prevented their testing; 5 percent said not having ARVs available prevented them; and 2 percent agreed that a lack of food was the cause.<sup>750</sup>

Thus, even when asked directly whether their experience with testing had been influenced by any of these other factors, a far smaller proportion acknowledged

**CHART 1: Principal reasons community survey participants who had not been tested gave for not being tested (n=616)**



\*Respondents could agree with more than one reason. Sex differences were not statistically significant.

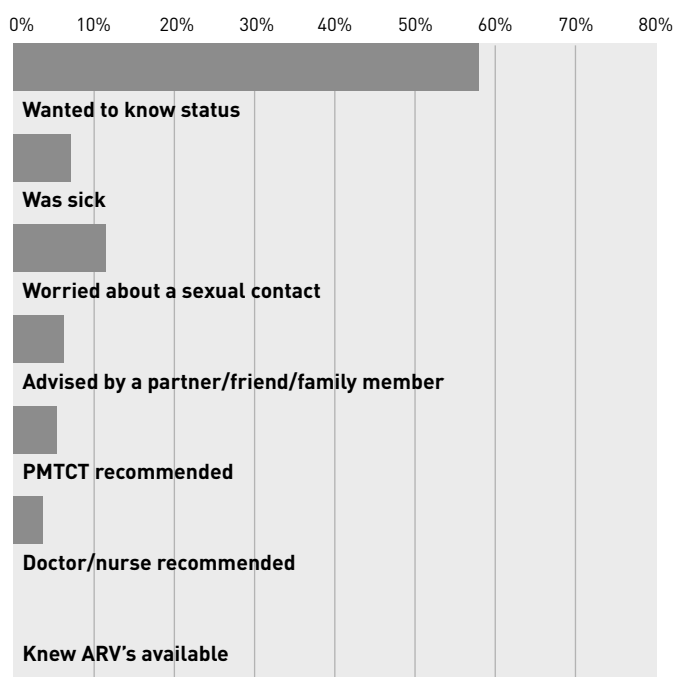
their importance than did those who cited not being ready or not being sick. This indicates the challenge presented to health care workers and policymakers to overcome psychological barriers and perhaps the persistently held belief that HIV is equated with physical illness (“being sick”) as a first step to encouraging Swazis to test for HIV. Both are likely rooted in the stigmatization of HIV/AIDS in Swaziland, in addition to the very real challenges, for a significant portion of those surveyed, of living with a life-threatening disease with few financial resources.

*Community Survey Participants Tested: Facilitators to Testing*

The most common facilitator for those who had been tested for HIV (170 individuals) was the personal motivation of wanting to know their status (58 percent of those tested). The other principal reasons are listed in Graph 1. Only women reported recommendation by the PMTCT program.<sup>751</sup>

As with the barriers, while there were a number of reported facilitators, none of the others were as common as wanting to know one’s HIV status. Three percent of those surveyed had been influenced by messages on television, radio or billboards to test and 2 percent were advised by their church or required by a

**GRAPH 1: Principal Reasons\* for Being Tested for HIV, Swaziland Community Survey (n=170)**



\*Respondents could agree with more than one reason.

job to test. No one reported that the knowledge that treatment was available had encouraged them to test. This may reflect the situation that in Swaziland there have not been media campaigns around testing, nor is there yet a scaled-up program of universal access to antiretroviral (ARV) treatment.

With regard to testing sites, nearly half of the women and men in the community survey tested at a public hospital. Reported testing sites are shown in Table 3.

Ninety-four percent of those surveyed found out their test results; 6 percent reported, however, that someone learned their results from the testing center or doctor without their permission. Thirteen percent said that they did not make the decision to get tested and 41 percent felt that they could not refuse the test. The latter report is particularly troubling from a human rights perspective, indicating that there may be some element of coercion involved in the testing process.<sup>752</sup>

Eighty-four percent received pre-test counseling and 75 percent received post-testing counseling. Nearly 100 percent reported that they received useful information, were treated with respect by counselors and had their questions (if any) answered. Some participants reported negative consequences to testing: 5 percent felt that they were treated badly by others in their community and 4 percent reported that they regretted getting testing. Seventy-three percent reported that their partner knew that they had tested; of these, 2 percent (one woman and one man) reported being hurt in any way or threatened on account of this disclosure. Eighty percent of those tested agreed that their experience with HIV testing had led them to encourage others to get tested. Women’s and men’s experiences did not differ in statistically significant ways.

**TABLE 3: Reported HIV Testing Sites, Swaziland Community Survey (n=170)**

Type of Site	Community Survey n (%)
Public hospital	83(49)
VCT center	32(19)
Private hospital	31(18)
Other location	10(6)
NGO	8(5)
Antenatal clinic	6(4)
TB clinic	---

**TABLE 4: Appropriate Forms of Testing for the Participant, Swaziland Community Survey**

Testing Method	N	n(%)
VCT [“confidential testing at HIV testing and counseling centers”]	781	737(94)
Couples Testing [“testing men and women partners together for HIV and giving them their results together”]	780	593(76)
Mobile Testing [“testing from a vehicle that moves around to different places, close to where people live or work, such as markets or community centers, and gives the test results on the same day”]	771	435(56)
Routine Testing [“testing everyone for HIV as part of a routine clinic or hospital visit, unless they say no [opt-out testing]”] <sup>753</sup>	777	369(47)

### Opinions on HIV Testing Programs

Several types of testing programs were described to all community survey participants — both those who had tested and those who had not — and they were asked whether each of these would be appropriate for them and which one would be best. Table 4 shows the number/percentage of those who agreed that the method in question was appropriate for them. Fifty-nine percent of those surveyed reported that VCT would be best for them, 27 percent favored couples testing and 8 and 6 percent, respectively, chose mobile or routine testing. There were no statistically significant differences between the responses of women and men.

### PLWA Interviews

Women and men interviewed who were living with HIV or AIDS expressed similar motivations to test as those in the community survey and were likewise generally positive about their testing experiences.

PLWA interviewed perceived themselves as self-motivated to test rather than influenced by information or advice that they received. For example, the two most common reasons for testing were being sick (29 individuals) and wanting to know their status (24 interviewees).<sup>754</sup> VCT centers (22 individuals) and public hospitals (19 individuals) were the most common testing sites.

### Gender-Related Barriers

Forty-three interviewees felt that barriers to testing were different for women and men. In particular, the interview participants emphasized that men are less

likely than women to want to know their HIV status. Women and men interviewed attributed this to factors including men’s misunderstanding of transmission of HIV and their refusal, often willful, to believe that it causes AIDS; men’s lower emotional capacity to face the diagnosis; their greater reluctance to undertake changes in sexual behavior if they were to test positive; and their higher levels of fear of stigma, all of which are interrelated to some degree. The statements of two young women were typical:

*For some men, they just don’t know that they can get HIV at all. That’s common among men; they believe they’re healthy.*

*Many men deny that there is HIV — and then they don’t see any reason why they should test. The men think they know everything.*

Several of respondents felt that men were more fearful and less responsible than women.

*Men fear the truth because the truth is painful. Women want to know their status. They have more courage.*

*Men are scared to get the HIV test; women think of the children and get tested.*

*Men prefer not to know. Once they know, their world is shattered.*

A 36 year-old man explained men not testing in terms of sexual norms for men’s behavior and not wanting to change that behavior.



*Women get tested when pregnant. Men want to engage with other ladies, we are encouraged to have many girlfriends. Men don't get tested because they don't want to change their practices like their number of partners or using condoms.*

One 20 year-old woman cited fear of stigma as a primary barrier to testing for men.

*For men, stigma stops them having a test. For women, it is fear of reprisal from [their] husband or partner.*

Women's empowerment — and control over sexual decision making — was also identified as an essential component to getting men to test. As one woman, age 20, put it:

*Wives and girlfriends need to encourage men to go for an HIV test. They need to say, 'No condoms, no sex.' They need to say, 'This is my body.' The one who controls your body is you. Women lack that control.*

A 29 year-old man agreed that lack of women's empowerment was 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.*

### *Physical and Financial Access*

Twenty-eight of 58 PLWA felt that physical access to testing was a problem in Swaziland. Twenty-five mentioned the long distance that rural residents had to travel to get to a VCT as a barrier to HIV testing. Distance was seen as a barrier both because rural people did not know where to go for testing as well as for the prohibitive costs of transport needed to get to the test sites from rural areas. The following two responses were typical:

*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.*

*In some areas there is only one VCT for many people, and the times of operation are not con-*

*venient. People travel long distances only to be turned back, and then they lose interest.*

Lack of food and income were also cited as barriers. One woman interviewed was often sought out by others for advice because she was formerly a teacher. Her husband, who drank excessively and had other sexual partners, died of AIDS and left her with 11 dependents; many family members had also died. She emphasized the importance of nutritional and monetary support to convince people to test, in an environment of persistent stigma fueling their fears of the consequences of having HIV:

*If financial and food support can be available, testing may increase. After testing, who will take care of my family? Why should someone be tested if they risk losing their job or facing discrimination?*

## **Key Informant Interviews**

### *Gender-Related Barriers to Testing*

Several key informants identified similar differences between women's and men's testing behaviors in Swaziland as the PLWA interviewees. They also suggested that men should be the focus of testing interventions.

A health services provider summed up some of the differences, also highlighting that women face barriers to disclosure after testing, stemming from their dependence on men, whereas testing at all is the challenge for male partners:

*We have to create some aggressive strategies to bring in males. Males don't like waiting and they don't like queues, but they should know their status. ...[I]t's difficult for women to report to their partners that they're positive, because then they are blamed and may be rejected, as if he himself is negative.<sup>755</sup>*

### *Concerns Regarding Routine Testing*

Several key informants suggested that Swaziland is not ready or in need of routine testing, primarily because they fear that proper counseling would be neglected due to lack of human resources, and/or that the health care delivery system, already overburdened by the existing ARV caseload, lacked the ability to expand in order to meet increased demand for treatment, at least in the short term.

For example, one PLWA educator stated:

*The problem with routine testing is that the health system is not ready for it. Three weeks ago I went*

to one community to mobilize them. The following day, lots of people came in for testing, but there were no testing kits. So the infrastructure isn't there. It requires pre-test and post-test counseling, and I don't think these structures are ready.<sup>756</sup>

One AIDS official described the current treatment situation in Swaziland as running at capacity.

*If you had routine testing, and a massive enrollment of ARVs, you would create a situation where 'can you really cope?' Now the enrollment rate is so consistently high, I would think that we should let it continue. If uptake is not what it should be, than promoting VCT more or introducing routine testing would make sense. ... I don't want to raise expectations and dash them. If you are going to tell people to test, but we [can't] treat them, what's the point?<sup>757</sup>*

### *Lack of Resources to Meet Basic Needs*

At least one Government official suggested that lack of support and assistance, in the form of economic resources and food assistance for example, was one factor discouraging people from testing, beyond the question of personal readiness and regardless of testing innovations.

*Some people prefer to remain not knowing their status because they will need tangible measures in place to address [being HIV-positive] — they'll need ARVs but there is the issue of nutrition, poverty. If there was a cure [this wouldn't be the case], but there isn't.<sup>758</sup>*

### *Stigma*

Others at international agencies explicitly suggested that fear of stigma, in part created and maintained by the segregation of testing and treatment services for HIV and AIDS, was the chief barrier to testing. When stigma was prevalent, or perceived as such, privacy concerns became even more fundamental and paramount. As one PLWA community activist stated:

*My point of view is that the main obstacle [to testing] is the lack of confidentiality. You go to the hospital, you get treated for an HIV-related ailment, and a lot of people know about it. I think it's that Swaziland is too small—if you tell one person, you've already told the whole world. People are still blaming HIV-positive people for everything.<sup>759</sup>*

## **HIV-Related Stigma and Discrimination**

The study results demonstrate that HIV-related stigma, fear of being stigmatized for suspected HIV-positive status and discriminatory attitudes toward PLWA are widespread in Swaziland and frequently resulted in poor treatment for those living with HIV or AIDS, notably for women. For a minority in the community survey, stigmatizing beliefs concerning PLWA translated into attitudes stripping those with the virus of their rights to marry, work or go to school, seek political office or own property on the same basis as uninfected individuals.

At the same time, in response to a generalized inquiry, women and men surveyed nearly universally believed that they had a duty to treat every person with dignity and respect. Nearly all the PLWA interviewed had disclosed their HIV status, and most reported positive consequences from doing so. Still, hurtful and inequitable treatment at home, in the community, at work and other public places was also prevalent and coexistent with experiences of acceptance and support.

### **Community Survey**

Sixty-one percent of the women and men surveyed in the community held at least one stigmatizing or discriminatory attitude towards people living with HIV/AIDS.<sup>760</sup>

Certain discriminatory attitudes may reflect incomplete knowledge about the transmission of HIV and the mistaken belief that HIV is transmitted through food or casual contact. For example, 30 percent of participants in the community survey would not share a meal with someone they suspected of having HIV or AIDS. Other discriminatory attitudes exhibited by participants revealed the underlying belief that fewer fundamental rights should be held by those with the virus or disease. For example, 19 percent of women and men did not believe that PLWA should be able to marry or have an equal opportunity to participate in Parliament. Other discriminatory attitudes are shown in Table 5.<sup>761</sup>

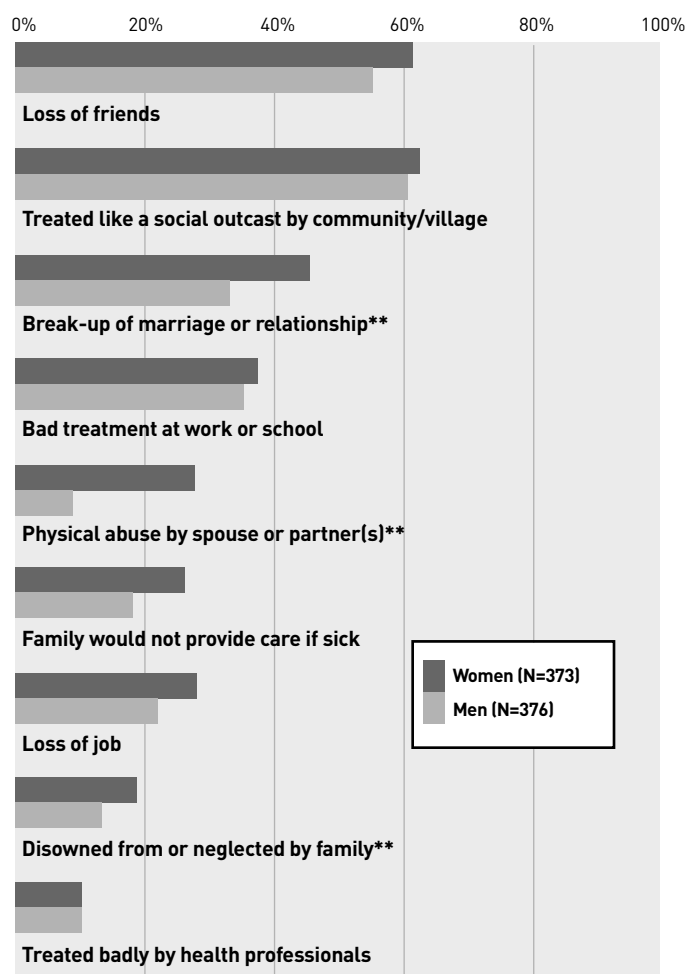
### *Fears of Stigma and Discrimination*

Women in the community survey exhibited a higher level of projected fears of being stigmatized and experiencing discrimination than men should they test positive for HIV.<sup>762</sup> Participants were asked to project their expectations of negative consequences of testing positive and disclosing their status to others. These are shown in Graph 2. The proportion of those surveyed

**TABLE 5: Stigmatizing or Discriminatory Attitudes Toward PLWA, Swaziland Community Survey**

Statement of Attitude	N	n(%)
Would not share a meal with person believed to have HIV or AIDS	770	230(30)
Would not buy food from shopkeeper or food seller believed to have HIV	756	205(27)
People with HIV/AIDS should not be able to marry	750	146(19)
People with HIV/AIDS should not have the same chance as others to be in Parliament	761	143(19)
People with HIV/AIDS should not have the same chance as others to have a job	771	78(10)
A teacher with HIV but not sick should not be allowed to continue teaching	777	62(8)
Not willing to care in household for a relative sick with HIV/AIDS	764	61(8)
People with HIV/AIDS should not be able to own property	772	60(8)
A student with HIV but not sick should not be allowed to continue attending school	776	48(6)

**GRAPH 2: Projection of Stigma and Discrimination, Swaziland Community\* Survey (n=749)**



\*Respondents could agree with more than one reason.

\*\*These sex differences are statistically significant.

predicting that they would be stigmatized by their friends, communities and sexual partners ranged from more than a third to nearly two-thirds of participants. Discrimination at work or school was expected by over one-third of those surveyed. Women had higher projections of stigma and discrimination by partners and other family members, for example, 27 percent of women versus 8 percent of men predicted intimate partner abuse from disclosure.

At the same time, the majority of those participating in the community survey (86 percent) projected that they would disclose their status to their sexual partner should they test positive for HIV. The difference between women's and men's responses was not statistically significant. One interpretation is that the need, whether physical, emotional or ethical, to discuss status may trump the fear of stigma or negative consequences in intimate relationships. Alternatively, the participants may have been responding by articulating ideally how they would act, or would like to be able to act, given that only less than a quarter of them had actually been tested and a significant percentage reported sexual risk-taking, feeling themselves at risk due to the behavior of their partners or lacking control over sexual decision making.

Nevertheless, the persistence of HIV-related stigma in Swaziland, or at least the ongoing fear of stigma and its consequences, is demonstrated by the finding that 48 percent of those participating in the community survey would want the status of an HIV-positive family member to remain a secret. Yet, perhaps reflecting the very visible crisis in Swaziland that has left few families

untouched by the devastating economic effects of the AIDS epidemic, 98 percent affirmed that the Government should provide PLWA with food or other basic assistance. Thus, though stigmatizing and discriminatory attitudes continued to be factors driving behavior, these appeared to be coexisting with knowledge and compassion for those infected and affected by HIV/AIDS, and perhaps with self-interest as well.

## PLWA Interviews

Stigmatizing and discriminatory attitudes continued to be significant factors in the everyday realities for PLWA. Despite increased public discourse in Swazi society on HIV/AIDS, and frequent disclosure of their HIV-positive status among those interviewed, both women and men reported that they faced significant stigma and discrimination in private and public spheres. Twenty of 58 Swazi PLWA interviewed expressed their opinions, based on their own lives, that experiences of poor or unequal treatment were worse for women than for men in Swaziland.

### *Voluntary and Involuntary Disclosure of HIV-Positive Status and Reported Consequences*

Fifty-five of those interviewed said that they had told someone of their status, whether a sexual partner, parent or some other relative or close friend. The identity of the recipient of the disclosure varied, as did whether or not spouses or sexual partners were told immediately, after a delay or not at all. Failure to disclose was most often due to fears of violence or abandonment. Nearly half of those interviewed reported that someone had revealed their HIV-positive status to others without their permission. One 30 year-old woman told how a nurse had disclosed her status to a village teacher:

*My daughter is friends with the daughter of the teacher. My daughter came to me one day and asked me about my status, she said her friend told her. She was very upset. I tried to calm my daughter down, she was crying. I told her I am living, like others with the disease, and that things would be okay.*

Others felt that their status was exposed even without their active disclosure. One 29 year-old man who had told his girlfriend that he was going to test but had heeded her request not to tell her the results, felt that she and others knew anyway. He had been sick with pneumonia and skin infections and attended a health clinic, as well as a support group near Manzini.

*By looking at me, people are able to tell I'm HIV-positive. They're running away from me. I haven't told my friends, but they know.*

This man reported that he and his partner had not had sex in over a year.

Most reported positive consequences from telling others their HIV status. Fifty of the 58 said that disclosure had provided them with a sense of emotional relief. One 29 year-old man said:

*I love sharing my status with others. I feel relieved when I tell people. Some ignorant people asked me why did I tell others, they thought I should keep it a secret. I tell them I have nothing to hide.*

A 52 year-old woman said:

*When I first told three members of my church about my status, they accepted and embraced me in a way that made me feel honored and blessed.*

The majority of those interviewed received support from their family as a positive consequence of disclosure, though this may have been achieved piecemeal or taken some time. One 27 year-old woman whose family members joined a PLWA support group for rural women and families described the difficulties she initially faced:

*It took some time to feel relaxed, but it was killing me to keep my status to myself. My mother was very hurt when I told her — she couldn't believe it. After a while, she supported me. My brothers didn't want to accept it. They didn't say anything, but I could read their expression.*

Others routinely disclosed their status as part of participation in community education programs and advocacy for their own needs and those of other PLWA. Forty-five out of 58 interviewees reported that by disclosing their status they had convinced others to get tested for HIV. These efforts were framed as actively countering stigma. One 30 year-old woman explained:

*I told my family and community. We used to visit homesteads with terminally ill people and tell them our own status: 'You can see that I am alive and okay. You can take medications.' People may gossip, but it doesn't matter.*

Nevertheless, there were negative consequences of disclosure for a significant minority of those interviewed. Sixteen individuals lost friends upon disclosure. Fifteen PLWA reported that they had experienced poor

or unequal treatment due to telling others their HIV status. Five individuals reported job loss. Violence or forced sex was experienced by two people. Discrimination took the form of being harassed on the job or even fired.

*My boss has been checking my work more vigorously, he said maybe I'm not really working enough. I told him because I just wanted to be clear with him and there might be days I was very sick and couldn't work. Sometimes I have to go to the hospital, and he says I don't have enough time to do my job.*

*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.*

### *Experiences of HIV-Related Stigma and Discrimination*

While many said they had told people without incident, 32 individuals reported that once their status became known, they had been stigmatized by family members, friends, neighbors, acquaintances, colleagues, or health care workers by being rejected, shunned, gossiped about or pointed out to others. One woman said this was particularly the situation in areas like the one she lived in, a rural part of the region of Hhohho. Another woman, 49 years old, described the general reception for PLWA, especially those experiencing physical illness:

*There is stigma both for men and women. When you are sick, people don't want to approach you or comfort you. They just look at you and don't give you any help.*

More than half felt there had been changes in their relationships with family, friends or colleagues because of their HIV status. One woman, age 41 at the time of the interview, initially experienced rejection from her in-laws who had tried to send her back to her parental home when she became a widow, assuming that she would die and should do so with her natal family. This woman had tested because she had tuberculosis; she was not surprised to be HIV-positive, as her husband had a child with another woman and drank alcohol and stayed away from home at night. She described the solace and support she received from other PLWA.

*After I tested, I just wanted HIV-positive friends. I get support from them. And from support groups. Information gives me strength. Knowledge is power. HIV-negative friends moved away from me.*

Others also told stories of family rejection, at least initially. Several women told of experiences similar to this 43 year-old's:

*A cousin of mine told me to stop cooking. He said don't touch the pots or anything in the kitchen. He said I could not even wash my dishes in the sink — this hurt me so much. That same cousin is now HIV-positive. I have forgiven him. He did not know better.*

In terms of experiences with providers for HIV-related care and the quality of medical care since they tested positive for HIV, individuals interviewed reported positive experiences overall. About the same number felt there was no change in their care before and after diagnosis (23 interviewees) or that they were now receiving better medical care (21 individuals); only 3 people reported that the care they were given was worse now than before.

Discriminatory treatment at work, school, hospitals or other public places was reported, nonetheless, by 14 of the 58 of PLWA interviewed. For example, some said they were treated unequally at medical clinics or other health care facilities because of the HIV status.

*I experienced bad treatment from a clerk at the hospital. She was rude and was discussing my status loudly in front of others.*

*Once the nurses discover you are HIV-positive you are treated badly and neglected. You also get verbal mistreatment.*

*Doctors [are] fine. Nurses have attitudes. [They] undermine people who are HIV-positive. Quarrel with them. They talk sometimes. [Nurses] build stress, but [PLWA] have to put up with it in order to get drugs.*

### *Stigmatization of Women and Sex Discrimination*

Twenty of the PLWA interviewed believed that there were differences in the experience of stigma and poor treatment for HIV-positive women and men in Swaziland. Stigmatization of women, and discrimination against them based on their HIV-status, was linked by those interviewed to normative assumptions around sexual practices and gender roles that ascribed HIV-positive status to "bad women" and blamed and condemned them for "spreading" the virus.

For example, women and men reported that many people assumed that women with HIV had had multiple sexual partners and treated them badly on that account, rather than ascribing their status to the far

more common unfaithful behavior of boyfriends and husbands. One 26 year-old man described this:

*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.*

As previously described, many women were blamed, for these or other reasons, by in-laws for introducing HIV into the family and subsequently rejected or otherwise mistreated by them. This is particularly consequential because many Swazi families, especially in rural areas, follow the traditional custom of a woman moving to her spouse's home and community upon marriage, thus giving power over her and her children's well being and control over her access to resources to her in-laws.<sup>763</sup>

*When a woman is HIV-positive she is called 'prostitute' by her in-laws. They say, 'You are the one who brought the disease into the home.' The woman comes from outside, and is not part of the family.*

## Key Informant Interviews

### *Stigma, Disclosure and Gender*

Key informants reported that, though the scope and dimensions of stigma may have changed over time, and acceptance of PLWA increased, stigmatizing attitudes and fears of stigma figure strongly for many in Swaziland. HIV-related discrimination persists as an unjust and demoralizing fact of life for PLWA, particularly for women.

Several experts from both government and the PLWA community believed that stigma was lessening in Swaziland, though they disagreed regarding the extent of this decrease:

*The more you focus on the issue of stigma, the more of a problem there will be. While I think stigma was an issue in the past, I think it is lessening. Now, when you go to communities, I see an outpouring of support for the sick, I have not seen stigma. I think we are beyond the point of people avoiding contact with others who are believed to be HIV-positive.<sup>764</sup>*

*Stigma is still a great problem. It takes a lot of shapes, but it's still there. Sometimes you know, because you live with people, but you have no proof. There's self-stigma, social stigma, family stigma, business stigma. The environment has changed since I first tested positive [in 1992] —*

*there is more support rather than rejection. But we need to look at family stigma. And in the workplace: it's very difficult to take treatment publicly, so you don't take it if you don't have the opportunity [for privacy at work].<sup>765</sup>*

A representative of the national network of PLWA suggested that cases of discrimination in the workplace were prevalent and as yet scarcely documented, especially for women, who are the majority of workers in several of the most abusive workplaces and industries, such as textile factories.<sup>766</sup>

*A lot of women have approached us with the fact that they are discriminated against. They test through a workplace program and are encouraged to disclose—but once the company retrenches, they're the first to go. I think we really have to have a place where you can report such cases.<sup>767</sup>*

The majority of key informants interviewed agreed that stigma and discrimination are worse for women than for men in Swaziland. As the PLWA network coordinator described it, echoing the PLWA interviews:

*Stigma is worse against women, especially because women are usually blamed for it, for giving HIV both to her partner and her child. She's blamed for the whole thing.<sup>768</sup>*

The injustice of the persistence of HIV-related stigma and discrimination, and particularly its gender bias, is underlined when taking into account the sexual risk-taking observed among Swazi men and the lack of control over decision making, in sexual and other matters, among Swazi women.

## Sexual Practices: Risk-Taking and Risky Circumstances

Differences in the experiences of women and men were pronounced in the community survey and PLWA interviews. The results paint a clear picture for women of lack of control over sexual decision making in the context of known HIV risk, inability to control male sexual partners and lack of economic, social and psychological empowerment. Men's situation is described by social values encouraging multiple sexual partners and the influence of myths and taboos, personal denial of the threat of HIV and a lack of strong prevention messages discouraging condom use.

Twice as many women (23 percent) as men (11 percent) surveyed perceived themselves to be at high or 100 per-

cent risk of becoming infected with HIV. Forty percent of women and 3 percent of men lacked control over the decision of when to have sex. Similar dynamics can be seen in decision making over condom use. While the majority of community survey participants expressed willingness to use abstinence at some point in the future to prevent the transmission of HIV, 20 percent of women and 17 percent of men reported having no sexual partners in the past month, and smaller proportions reported abstinence in the past year. Interviews with PLWA amplified the finding that women's lack of autonomy and control persists for many HIV-positive women, despite increased knowledge and motivation to change their sexual behavior. A third of those interviewed reported lacking control over when or whether to have sex; economic dependence and fear of violence were cited as the primary reasons.

## **Community Survey**

### *Women's Lack of Control Over Decision Making in Sexual Relationships*

Women's lack of control over whether and when to have sexual intercourse, and whether or not to have unprotected sex, comes through clearly in the survey results. Forty percent of sexually active<sup>769</sup> women, as compared with 3 percent of men, affirmed the statement that "my partner only decides when I have sex." Conversely, 47 percent of men, and 5 percent of women, agreed that "I alone decide when I have sex." In regression analyses, married people had more than twice the odds of lacking control when compared with their unmarried counterparts<sup>770</sup> and those with a high school or greater education had less than half the odds of lacking control.<sup>771</sup> This speaks to the increasingly acknowledged risk of married women and the benefits of education as a route of escape from discriminatory gender norms or economic dependence.

Eighteen percent of women, compared with 3 percent of men, reported that their partners had sole decision-making authority with respect to condom use. In contrast, while 19 percent of women reported that they alone made the decision to use a condom, 37 percent of men reported this level of control.

### *Exposure to HIV through Multiple Sexual Partnerships*

Eighty-eight percent of the participants in the community survey had ever had sexual intercourse. 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 sexually active in the past year, 1 percent of women and 21 percent of men reported having more than one partner (serial or concurrent) in the past month.<sup>772</sup> In regression analyses, those who were unmarried and living with a sexual partner had twice the odds of having multiple partners in the past year as those married or unmarried and not living with a partner.<sup>773</sup>

### *Condom Non-Use*

For sexually active participants, 78 percent of women and 67 percent of men reported not using a condom at some time over the past year for a variety of reasons, listed in Table 6. Two percent of women and 13 percent of men surveyed said that they had engaged in unprotected sex with a non-primary partner in the past year.<sup>774</sup>

While it may be expected that some portion of those married or living with partners did not use a condom because they were seeking to become pregnant, 3 percent gave that as a reason in the community survey. The reasons most commonly reported by women were trusting a partner and not being permitted to use condoms by a partner. This indicates that women's decisions, though in the majority reported as their own choices, still implicitly relied and were dependent on the behavior of partners. Men's reasons for not using condoms were most commonly their trust of their partner, followed by inconvenience and the belief that condoms decrease sexual pleasure. While men's trust may be more rightly placed than women's in their sexual partners, given the comparatively low percentages of women in the community survey reporting multiple partners, these answers also speak to the agency that men have over condom use.

### *Abstinence*

Abstinence was defined in the community survey as "not having sex at all, as a way to prevent yourself or others from becoming infected with HIV/AIDS." Forty-five percent of women surveyed and 40 percent of men reported that they were currently practicing abstinence in order to prevent HIV transmission. However, of those who had ever had sex (88 percent of participants), 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, in contrast to the actual experience of not being able to practice it, due to lack of control or other factors, may underlie this response. Assimilation of abstinence messages from churches or other sources, embarrassment to admit stigmatized sexual practices,

**TABLE 6: Reasons for Not Using Condoms in the Past Year, Swaziland Community Survey (n=424)**

Statement of Reason*	Women N=215 n(%)	Men N=209 n(%)	p value
I trust my partner	75(35)	88(42)	0.126
My spouse or partner(s) does (do) not want to use condoms			
Condoms are inconvenient	19(9)	38(18)	0.005
Condoms decrease sexual pleasure	17(8)	38(18)	0.002
I believe that I am in a monogamous relationship with an HIV-negative partner	13(6)	17(8)	0.402
I use other birth control methods	9(5)	10(5)	0.766
I/partner trying to get pregnant	10(5)	4(2)	0.115
Condoms are not available to me	7(3)	15(7)	0.069
Condoms do not prevent HIV/AIDS	3(1)	7(3)	0.185
I do not know how to use condoms	3(1)	6(3)	0.292
Condoms carry HIV	3(1)	6(3)	0.292
I cannot afford condoms	0(0)	2(1)	0.151

\*Participants were asked an open-ended question and could give more than one response.

or desire to please researchers with a “correct” response may also explain this discrepancy.

In this same context, 83 percent of women and 75 percent of men reported that they would consider using abstinence some time in the future to decrease their risk of HIV infection. Ninety-seven percent agreed that they have a duty to avoid putting others at risk for HIV/AIDS.

### PLWA Interviews

PLWA interviewed echoed the lack of control women have over sexual decision making in Swaziland, both anecdotally and in reporting their own experiences. They highlighted the role of economic dependence and food insufficiency in compelling women to have sex or multiple sexual partners. They discussed the social norms that encouraged multiple partnerships among men. At the same time, their testimony of experiences and sexual behavior change after discovering their HIV-status suggests that some HIV-positive individuals in Swaziland were able to make changes in their personal behavior that could reduce the transmission of HIV.

### Women’s Lack of Control and Vulnerability to HIV

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 accused of being unfaithful or prostituting themselves. As one 27 year-old explained:

*Sometimes you don’t feel like having sex. Sometimes you have to compromise; otherwise, the man will say, ‘If you are saying no to me now, you must be having sex with someone else.’*

Twenty-two out of 45 women reported that a sexual partner had hurt them or forced them to have sex when they did not want to in their lifetime, emblematic of their lack of control. One 30 year-old woman’s husband died in 2002 from AIDS, having hidden his HIV-positive status from her; she tested for HIV after his doctor told her the cause of his death.

*My husband forced me to have sex. He would also beat me for nothing. When he came from his other girlfriends he would beat me.*

Compulsion or coercion to have sex could be more indirect than pressure from a partner. As one 49 year-old woman explained:



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

The link between women’s lack of economic resources and sexual partnership choices came through clearly in the interviews. For example, one woman, age 38, explained:

*Lack of income is the major factor. You need money — the kids are expecting something from you. You are vulnerable. You decide you can have sex once or twice. You know there is risk, but you say to yourself, ‘I won’t die from HIV today.’*

Three men reported giving women money or resources in return for sex. One, a 36-year-old man, said:

*The lady that I stay with. She was in Mbabane to sell some brew. She lacked a place to sleep. She fell in love with me to get a place to sleep. During the day, I proposed love and offered her a place to stay. She had nowhere to sleep. That is how our relationship started.*

### Multiple Partnerships

As noted earlier, 53 of the 58 PLWA interviewed suspected they had become infected with HIV through sexual intercourse with an HIV-positive partner. Five women and 10 men reported having more than one sexual partner at the time that they believe they became infected. Thirty-seven out of 45 women reported ever knowing that a primary sexual partner had had more than one partner concurrently, as did 10 out of 13 men.

Interviews made it clear that the reasons for multiple sexual partnerships for women and men, given the socio-economic environments in which Swazis live. Thirty-eight reported that there was social pressure for men to have multiple partners. As one 45 year-old man put it succinctly:

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

Both women and men ascribed men’s sexual behavior towards women — multiple partnerships, in particular — to the pressure to adhere to gender norms that value women for fertility and childbearing and men for virility and sexual prowess. One man interviewed, 29 years old and a former bus conductor who found many sexual partners through that line of work and rarely used condoms, explained:

*You look like a failure if you only have one girlfriend. They say it is like only having one tooth. If you bite with one tooth and it breaks, it is dangerous.*

Four of those interviewed blamed the polygamous marriage of the current King, Mswati III, for setting a poor example, or being an excuse for men’s behavior. One young woman interviewed articulated this: “Swazi men have a feeling that if the King can have so many wives, so can they.”

### Persistent Vulnerability of Female PLWA Despite Sexual Behavior Changes

Two themes stand out in the interviews with PLWA, in terms of respondents’ sexual practices. One-third of women interviewed living with HIV/AIDS reported lacking of control over decision making in sexual relationships. At the same time the majority of those interviewed reported having made changes to reduce risk-taking in their sexual practices.

First, the persistent lack of autonomy experienced by women was clear from the discussion of current sexual practices among the PLWA interviewed. This was true for a sizeable proportion of the women interviewed despite their acute awareness of the relationship of women’s disempowerment to their vulnerability to coer-

**TABLE 7: Lack of Control in Sexual Decision Making by PLWA**

Statement Response	Women N=45		Men N=13	
	Yes	No	Yes	No
Lack control over the decision of when to have sex	16	26	0	11
Partner(s) only or mostly partner(s) decide whether or not to have sex	15	24	0	11
Lack control over the decision of whether or not to use a condom	12	29	1	10
Lack control over childbearing decisions	10	30	1	9

cion, and despite their own empowerment as revealed in the interview testimony on other topics, such as testing. Sixteen out of 45 female PLWA, and none of the males, reported that they did not have control over the decision of when to have sex. Other responses indicating lack of control are shown in Table 7.

Second, many women and men interviewed had been able to make changes in the number of their sexual partners and the nature of their intimate relationships. Fifty of those interviewed reported that learning of their HIV-positive status was a catalyst for a number of changes they deemed positive, including reducing the number of sexual partners and more routine use of condoms. Three women and 3 men reported having more than one partner at the time of the interview, compared with 12 women and 13 men interviewed who had ever had more than one sexual partner at the same time. However, women also 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.

One 39 year-old man described how his relationship with his girlfriend changed after she tested positive when seven months pregnant. At the time of the interview his child was a few weeks old (and HIV-negative) and the interviewee had just received his own positive test results.

*We trust each other more in our love. I've grown up. I'm living a healthy life now — no cheating. As a man, I used to cheat. She didn't know before this.*

Both men and women reported choosing abstinence based on a sense of moral responsibility to themselves and/or others.

*I feel like being celibate is best. You could re-infect yourself, or the condom can break and you can infect someone else. I haven't had sex since I got tested.*

*When I tested positive, I made it my duty not to infect others, so I chose abstinence.*

*While abstinence might be an ideal choice for some, however, it was not always an actual, practical one.*

*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. But I told my husband, if we don't use a condom, then no sex.*

*We are not allowed in our culture to say today I don't want to have sex...If I refused to have sex, my husband would beat me.*

The compulsion for sex exchange derived from economic dependence affected the women interviewed, even more so perhaps than before the HIV-positive diagnosis, given the restrictions their health and HIV-related illness could place on their ability to earn an income or receive support from their families. Whether or not she wants to remain abstinent, a 29 year-old man explained,

*A woman will be forced to sleep with men for food and a place to live.*

### Key Informant Interviews

According to most key informants, women's lack of control over sexual decision making is prevalent in Swaziland. This resulted in sexual practices that place women and men at risk for HIV infection. This lack of control, and men's refusal to use condoms, were socially sanctioned and rooted in the power imbalance between women and men.

*Women are vulnerable to contracting HIV because they don't have the power to control their own bodies. Men... think about themselves, and society applauds them. ... They say condoms have worms, or they have HIV. It's just an excuse so they don't have to use condoms.<sup>775</sup>*

Others agreed that failing to use condoms was less about misinformation than about gender and sexual relations, which were driving the HIV epidemic in ways very resistant to change.

*There's awareness and information of HIV/AIDS that doesn't translate to an improvement in the infection rate because attitudes are difficult to change. ... People hear the campaigns but do something different. Collecting condoms is one thing, but using them is a private affair, a grey area, a challenge.<sup>776</sup>*

Coupled with masculine ideologies precluding behavior change was the economic dependence of women unable to insist on safe, respectful and responsible behavior from men. Several key informants described the need for both women and men to migrate to find jobs in urban areas or "company towns" (industrial estates in peri-urban or rural areas) and the lack of affordable and available housing for workers who do so as a key factor

in creating an environment of temptation and exploitation. As a result, women and men who were strangers to each other share housing, and women (often with husbands at home) “paid in kind” for a place to live.<sup>777</sup>

*Many people in Mbabane moved here from rural areas. It’s a group that doesn’t have the means to survive city life. The women want accommodations, but it’s not easy to get accommodation if you’re not employed. They stay with the men and permit them to do what they want. ...She’s like a beggar.<sup>778</sup>*

The risks that people took through their sexual practices were derived from their socialization and economic circumstances and enforced by expectations and norms. The latter can only change when the social structures underlying attitudes and practices change.

## Gender Norms and Beliefs and Perceived Vulnerability to HIV/AIDS

Ninety-seven percent of community survey participants held at least one gender discriminatory belief. Proportionally more men than women held such beliefs. For example, 22 percent of women and 33 percent of men agreed that it is more important for a woman to respect her spouse or partner than it is for a man to do so. Regression analyses demonstrated the associations between attitudes accepting and reflecting women’s inferior legal, cultural and socio-economic status in Swaziland and the unsafe practices and circumstances that render both women and men vulnerable to HIV/AIDS. For example, participants who held the belief that it is a woman’s duty to have sex with her spouse or partner even if she does not want to had over 2 times the odds of unprotected sex in the past year with a non-pri-

mary partner as those who did not hold that belief. On the other hand, the majority of community survey participants, particularly women, endorsed statements of full and equal human rights for women. Decreased odds of sexual risk were associated with holding these beliefs. For example, women and men who agreed that women should be able to hold the same jobs at the same pay as men had half the odds of multiple sexual partnerships in the past year as those who disagreed with that statement. PLWA interviewed confirmed the prevalence of gender inequality and discrimination against women in families, communities and workplaces and its association with women’s, and men’s, vulnerability to HIV. Key informants similarly explained HIV/AIDS in Swaziland as an epidemic rooted in unequal relationships, social norms and legal structures disempowering women.

## Community Survey

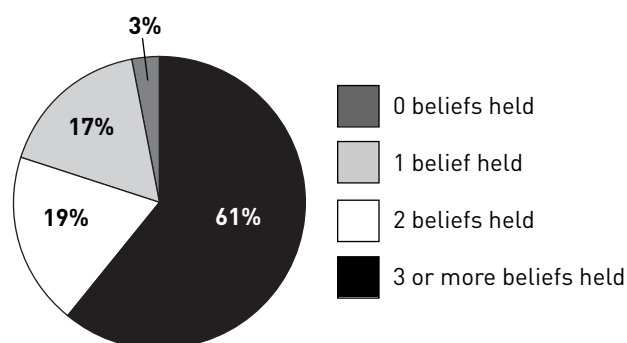
### Belief in Gender Discriminatory Norms

Swaziland community survey participants were asked to agree or disagree with statements expressing beliefs about men’s and women’s roles in society in order to assess the prevalence of gender discriminatory norms and support for women’s equal rights with men.<sup>779</sup> Persistent discriminatory beliefs<sup>780</sup> were held by a majority of those surveyed and more commonly by male participants.

Ninety-seven percent of community survey participants held at least one gender discriminatory belief. Sixty-one percent of women and 80 percent of men held three or more discriminatory beliefs. Charts 2 and 3 show the proportions of women and men in the community survey holding gender discriminatory beliefs. Twenty-four percent of women and 44 percent of men held 6 or more, indicating widespread entrenchment of such views.

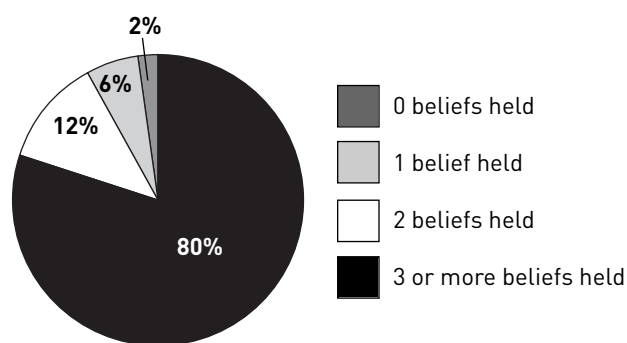
**CHART 2: Gender Discriminatory Beliefs Held by Women, Swaziland Community Survey (n=397)**

Prevalence of Women’s Gender Discriminatory Beliefs



**CHART 3: Gender Discriminatory Beliefs Held by Men, Swaziland Community Survey (n=390)**

Prevalence of Men’s Gender Discriminatory Beliefs



**TABLE 8: Selected Individual Gender-Discriminatory Beliefs, Swaziland Community Survey\***

Statement of Belief	Women		Men	
	N	n (% agree)	N	n (% agree)
A woman is expected to have children if a man pays <i>lobola</i> [bride price] to marry her	384	183(48)	385	228(59)
It is a woman's duty to care for the sick	394	138(35)	385	151(39)
Women should not insist on condoms if their partner refuses	381	104(27)	379	132(35)
It is more important for a woman to respect her spouse/partner than it is for a man to respect his spouse/partner	396	87(22)	388	130(33)
Men should control decisions in relationships with women (whether to marry, whether to have sex, how many children to have)	389	73(19)	386	129(33)
It is OK for a man to take another wife if his current wife does not bear children	380	63(17)	379	137(36)
It is a woman's duty to have sex with her spouse/partner even if she does not want to	391	49(13)	380	76(20)
A man may beat his spouse/partner if he believes she is having sex with other men	389	40(10)	385	67(17)
A man may beat his spouse/partner if she disobeys him	393	21(5)	388	47(12)
It is OK for men to have more than one sexual partner at one time	396	11(3)	388	45(12)

\*All responses in the table show statistically significant differences ( $p < 0.05$ ) between men and women.

In terms of specific beliefs, a picture emerges of men and women 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. Selected individual beliefs are listed in Table 8. Approximately one-third of the men in the community survey held the following beliefs: 1) that men should control significant decisions in relationships; 2) that it was more important for a woman to respect her spouse or partner than for a man to do so; 3) that women should not insist on condom use if their partner refused; and 4) that a man could marry a second wife if his current spouse does not bear children. Seventeen to 27 percent of women held these beliefs.

The influence of traditional cultural beliefs concerning women and women's social devaluation is evident in these attitudes, and demonstrated most clearly by the fact that more than half of surveyed men and almost half of women agreeing that a woman is expected to have children if the traditional practice of bride price (*lobola*) was part of the marriage.<sup>781</sup> The

potential consequences of these practices, in the context of women's poverty and lack of autonomy, were demonstrated by the strongly held belief among male participants that a man should marry another wife if he has paid *lobola* and there are no children. Likewise, about equal proportions of women (35 percent) and men (39 percent) affirmed that it is a woman's duty to care for the sick, a traditional division of labor that has become even more burdensome on women and girls in the era of HIV/AIDS.

At the same time, however, social change was clearly at hand, perhaps more rapidly and profoundly influencing the minds of women than those of men. Compared with the other discriminatory statements, for example, fewer women and men agreed that it is a woman's duty to have sex with her partner even if she does not want to, though more men (20 percent) than women (13 percent) held this view. Changes in attitudes, however, do not appear as yet to be widely reflected in the private and public sphere experiences of women, as discussed elsewhere in this chapter.

### Support for Women's Rights

Support for women's rights was articulated by the majority of those surveyed. Responses are listed in Table 9. In light of the prevalence of gender discriminatory beliefs among those surveyed, attitudes that demonstrate support for women's rights are possible indicators of the potential for acceptance of the socio-cultural change and legal reforms necessary to enable women to achieve equality with men in intimate relationships as well as the public sphere.

More women than men surveyed endorsed women's equality and empowerment. The majority of participants showed support for increasing women's control over their own lives through property ownership, inheritance rights and other measures to promote autonomy, eradicate inequality and address the inferior legal status of women in Swaziland. For example, women and men supported women's non-discriminatory access to employment and ownership. Seventy-five percent of women and 61 percent of men agreed that a woman should be able to end a relationship with a man, suggesting an endorsement of women's autonomy and decision making on equal footing with male partners. The minority who disagreed represents the persistence of discriminatory views, however.

Holding men responsible for children and recognizing the need to protect women and acknowledge their rights were also supported by community participants. Both women and men felt nearly universally that men should financially support the children they have from all relationships. Similarly, 91 percent of women and men felt that a woman's in-laws should protect her if her husband hurt or mistreat her. These beliefs stand in contrast to the status quo, where many women have experienced social and legal barriers to obtaining financial support from spouses, and disempowered outsider status and abuse from in-laws, particularly if they are HIV-positive or have AIDS.

### Associations of Gender Discriminatory Beliefs and Support for Women's Rights with Sexual Risk-Taking

There is a predictive relationship between holding gender discriminatory beliefs and sexually risky practices or circumstances. Those surveyed who held six or more discriminatory beliefs (34 percent of participants) had twice the odds of having multiple sexual partners as those who held fewer discriminatory beliefs.<sup>782</sup>

Holding certain specific discriminatory beliefs predicted having multiple partners or unprotected sex with a non-primary partner, increasing the odds of doing so anywhere from nearly 1.6 to 4 times. These associations are shown in Tables 10a and 10b. Those who endorsed men having multiple sexual partners had 4 times the odds of reporting this practice and 3.5 times the odds of unprotected sex with a non-primary partner as those who did not. Participants who felt that men should control decisions in relationships with women had more than 1.5 times the odds of having multiple sexual partnerships and nearly twice the odds of having unprotected sex with a non-primary partner. Conversely, beliefs in women's rights decreased the odds of sexual risk; these associations are shown in the shaded boxes in Tables 10a and 10b. Participants who thought that women should hold the same jobs at equal pay as men had 51 percent lower odds of having multiple sexual partners and 42 percent lower odds of sex without a condom with a non-primary partner as those who did not. Women and men 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.

### PLWA Interviews

In the interviews, women and men living with HIV/AIDS described the association of prevalent gender norms

**TABLE 9: Support for Individual Rights, Swaziland Community Survey\***

Statement of Belief	Women		Men	
	N	n (% agree)	N	n (% agree)
Women should be able to hold the same jobs at the same pay as men	390	331(85)	381	286(75)
Women should be able to own property in their own name	385	307(80)	381	240(63)
A woman should be able to end a relationship with a man	381	284(75)	384	236(61)
Women should have their own houses and land when they marry	387	282(73)	382	202(53)

\* All responses in the table show statistically significant differences ( $p < 0.05$ ) between men and women.

with women's and men's risk of HIV in Swaziland and their own experiences as PLWA with gender-based inequality and discrimination.

### *Discriminatory Institutions and Behaviors*

PLWA interviewed confirmed the strong influence in women's and men's lives of customary law and traditional practices. Swazi women's contemporary situation as dependent on others for resources and status is rooted in many of the traditional elements of southern African tribal culture, such as bride price and wife inheritance, according to those interviewed. For example, as discussed earlier, the payment of *lobola* to the

bride's family was viewed as granting the husband and his family absolute rights over a woman's sexual activity and childbearing.<sup>783</sup> Thus there is very little legal or social support for women to refuse to follow the wishes of her in-laws, as custom dictates. One HIV-positive woman interviewed described her own experience with wife inheritance:

*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.*

**TABLE 10A-B: Selected Specific Gender-Related Beliefs as Predictors of Sexual Risk-Taking in the Swaziland Community Survey, Total Sample by Outcome Variable**

#### **A) Associations of Beliefs and Multiple Sexual Partners in Past Year**

Statement of Belief*	N	AOR**	95% Confidence Interval
It is OK for a man to take another wife if his current wife does not bear children	741	2.57	1.71-3.87
A woman is expected to have children if a man paid <i>lobola</i> to marry her	751	1.84	1.25-2.73
Men should control decisions in relationships with women (whether to marry, whether to have sex, how many children to have)	756	1.56	1.04-2.32
Women should be able to hold the same jobs at the same pay as men	752	0.51	0.33-0.78

#### **B) Associations of Beliefs and Unprotected Sex with a Non-Primary Partner in Past Year**

Statement of Belief*	N	AOR**	95% Confidence Interval
It is OK for men to have more than one (sexual) partner at one time	751	3.50	1.61-7.61
It is a woman's duty to have sex with her spouse/ partner even if she does not want to	738	2.25	1.16-4.35
A woman is expected to have children if a man paid <i>lobola</i> to marry her	736	1.98	1.03-3.78
Men should control decisions in relationships with women (whether to marry, whether to have sex, how many children to have)	741	1.87	1.02-3.43
Women should not insist on condom use if their partner refuses	726	1.89	1.02-3.50
Women should be able to hold the same jobs at the same pay as men	737	0.42	0.24-0.83
A woman should be able to end a relationship with a man	731	0.50	0.28-0.90

\* A separate model was created for each belief.

\*\* The odds ratio is a relative measure of risk, predicting the likelihood of the outcome at issue if a certain characteristic (described by the independent variable) is present. The adjusted odds ratio is the odds ratio adjusted for the possible confounding effects of the other variables included in the models. 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.

Fortunately, her in-laws accepted her refusal and, because she owned the home in which she lives, could not legally evict her and her five children.

Others described how in-laws and other members of the husband's family would seek to take advantage of the dependent status of women who were widowed. They also reported women's difficulties in establishing rights to inherit their marital property under Swazi civil law, a time-consuming process of accessing the overburdened legal system. Most women had left their own family homesteads and had no property in their own names. Estate determinations pending, in-laws evicted women and children from their homes or insisted on their return to the wives' natal families.

While such situations might be overcome if women were able to earn incomes to support themselves financially, gender discrimination in the workforce was described as commonplace by the PLWA interviewed. Not only was it more difficult for women than men to find employment, salaries were low and women usually had families to support. Moreover, women living with HIV or AIDS would often be battling ill health and needing to satisfy increased nutritional and medical needs, in addition to the resource inequalities that all women endured. Employment discrimination often took the form of sexual harassment, including demands for sex in exchange for work, closing the circle of vulnerability.

*Before being employed, if you don't agree to have sex with managers, you will not get the job. When an advertisement is placed for a job, sleeping with the manager is a pre-requisite. It happened to me one time ... They told me I would have to have sex with the manager.*

One woman was blamed by her in-laws for bringing HIV into the family even though her husband had had an extra-marital relationship and child with another woman and both she and the child died of HIV. Later the husband reconciled with the interviewee and subsequently tested HIV-positive himself. In the interview, this woman pointed to the powerlessness of women in a patriarchal society. She commented on the difficulty of changing this entrenched dynamic, so embedded in social and political structures.

*Only the law can help. The law must be revised and amended. Even Parliament, it is run by Swazi men. They don't want to change the laws because the laws serve them, they benefit from the laws.*

The new Swaziland constitution contains a passage allowing women to refuse to follow customs to which they are opposed. It remains to be seen whether women will feel empowered to defy their families and tribal leaders and, moreover, how this provision — or any of the Constitution — will be implemented through law and public education and subsequently enforced.

### *Women's Vulnerability*

PLWA were nearly unanimous in their view that women's unequal position in the family and community resulted in women's vulnerability to harm, including the high risk of HIV transmission. One woman explained how men's control of women's lives translated into HIV infection:

*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.*

She was 30 years old at the time of the interview and had tested when she was pregnant with her second child, because her husband had had children with another woman.

For those interviewed, men's multiple sexual partnerships were clearly linked to women's vulnerability.

*Women are vulnerable because men can have as many wives as they want. And he dictates what to do. He can say no to condoms, and she can't refuse.*

Nearly all of those interviewed agreed that lack of income and inability to hold title to property placed women at risk by forcing them to depend on casual and long-term male partners as financial providers. One 28 year-old woman was a widow whose husband, like his previous wife, had died of AIDS, leaving her with five dependents. She summed up the intersection of women's responsibility and disempowerment in this way:

*Lack of income is the primary problem that puts women at risk for HIV. Men force their wives to sleep with them without protection. Unemployment, being poor, having to feed and take care of kids.*

Fifty-one of the 58 individuals interviewed identified violence against women as a problem in their community, reflecting women's low status and men's power and control which often led to coerced unprotected sex.

*There was a time when I had a boyfriend dragging me to his house when I did not want to have sex.*

*He would lock me up and force me to have sex...I would end up sleeping with him for fear that he would beat me up.*

### **Men's Vulnerability**

Those interviewed described men's risk of getting HIV as rooted in men's own behavior of sexual risk-taking, including having many sexual partners, excessive alcohol consumption and refusal to use condoms. It was recognized that this behavior was itself influenced, or even dictated, by social and cultural pressures, and the erosion of traditional limitations. As one 52 year-old woman put it, "A real man is expected to have many girlfriends and wives." Men's vulnerability was understood as the flipside of women's: men's control, coercion and exploitation of women's dependence, allowing men to insist on unprotected sex, likewise left men vulnerable to HIV transmission.

Social expectations put pressure on men to be patri-archs. One unmarried 30 year-old man living with a sexual partner and responsible for supporting five dependents, including his four children, said:

*Your family expects you will produce children. Your children will expect an income from you since women are not expected to work. If she works she doesn't belong to you, she belongs to someone else.*

### **Key Informant Interviews**

Key informants viewed HIV/AIDS as "a gender issue."<sup>784</sup> They understood women's vulnerability as rooted in inequalities of power between men and women: fostered by civil and customary legal institutions of marriage, property and inheritance and maintained at the individual level in domineering or coercive relationships. A gender expert with a local NGO summed up the situation:

*Men always dominate in our society... . Males and females don't share the same amount of power. Females are not respected by society. Our policies, our laws, are betraying women and favoring men. That is the problem. HIV will be there as long as women are subordinate to men.*<sup>785</sup>

The challenge presented by this structural and normative gender inequality was also recognized in the expert interviews, including obstacles presented by women themselves. Women, like men, were members of Swazi society socialized into its norms and constricted by its customs and laws in their beliefs and actions. As an AIDS services agency representative explained:

*Women don't want to be empowered, they want to subordinate. Always when something is launched, on the radio there will be a woman discussing empowerment strategies negatively, smearing them. For example, CEDAW [UN Convention on the Elimination of All Forms of Discrimination Against Women, acceded to by Swaziland in 2004] caused a lot of discord, there were men and women both for and against. It is very difficult to break the barriers and harness the situation.*<sup>786</sup>

Several key informants commented on the entrenchment of gender discrimination in the rural areas in particular:

*Seventy percent of the country is rural, and they are very traditional. Young boys are turning out like their fathers. There is not enough change.*<sup>787</sup>

At the same time that traditional practices which keep women subordinate persisted, the formerly protective elements of unwritten, customary law — such as the registry of marriages with chiefs who granted each wife and her children their own land<sup>788</sup> and the safe haven that could be found for the vulnerable in the house of the senior grandmother in the homestead<sup>789</sup> — disappeared.<sup>790</sup> As people migrated to urban areas in search of work and families were fractured, the extent to which the benefits of the old ways had been lost has become evident to progressives and conservatives alike. Yet these were not replaced by protective and empowering structures and politics to ameliorate the hardships of the modern society and economy. As explained by a researcher at WLSA, PHR's field partner for the Swaziland study:

*In the money economy...the elders are dependent on the young rather than the other way around ... and they don't have the power to enforce [beneficial and protective] norms and traditions. Culture is dynamic and it changes — but the problem for women is that culture is frozen, whereas men have changed. They can't accept that women can do the same, that things have changed and women also need to lead the modern life.*<sup>791</sup>

Interview testimony was clear that achieving meaningful equality at the individual and household levels required reform of the gender discriminatory norms and institutions, both locally and nationally in Swaziland.



## Leadership on HIV/AIDS in Swaziland

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 men in particular) 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. Forty to 89 percent of survey participants faulted national leaders, chiefs, church leaders and the King in every domain on which they were questioned, including not setting a good example in their personal behavior or sexual practices. For example, 73 percent agreed that national leaders had not spent enough money on HIV prevention and 72 percent felt that chiefs had not done enough to oppose bad treatment of PLWA. Aside from educational campaigns generally, no one strategy for closing the gaps in policy was endorsed by community survey participants when asked an open-ended question, suggesting the need for a range of strategies coupled with enhanced dissemination of information concerning them. PLWA and key informant interviews were also mainly critical of leaders, particularly for failing to take the initiative of concrete actions to speak out about HIV/AIDS, change their own behavior, educate their constituencies and implement policies to address the socio-economic conditions of Swazis that create barriers to access for testing and treatment.

### Community Survey

#### *Inadequacy of Leadership Addressing HIV/AIDS in Swaziland*

Study findings reflected the large gaps in national and local policy and programs addressing the HIV/AIDS

epidemic in Swaziland. Participants in the community survey were asked their opinions of the response of Swaziland's leaders to the HIV/AIDS crisis in five domains: spending on prevention; personal behavior and sexual practices; assistance to PLWA and those affected by HIV/AIDS; opposing HIV/AIDS-related stigma and discrimination; and domestic violence protection for women and children. Their responses are shown in Table 11.

Nearly half of participants voicing an opinion found fault with each category of leader in every domain, and 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 and chiefs for not spending enough on HIV prevention<sup>793</sup> and on all leaders for not setting a good example by their personal behavior.

In contrast to the poor marks given to leaders in terms of providing assistance to PLWA and others affected by HIV/AIDS, as mentioned previously, nearly all of those surveyed agreed that PLWA should receive food or other assistance from the Government (98 percent). They also 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<sup>794</sup> was an important contributor to the spread of HIV in Swaziland, more than half believed that chiefs, national leaders and the King had not done enough to protect women and children from abuse and two-fifths agreed that church leaders had not done so.

In addition, 31 percent of women and men participating in the community survey reported that the way gov-

**TABLE 11: Opinions on Leadership in Swaziland on HIV/AIDS, Swaziland Community Survey**<sup>792</sup>

Statement of Opinion	Chiefs		National Political Leaders		King		Church Leaders	
	N	n(%)	N	n(%)	N	n(%)	N	n(%)
Not spent enough money on HIV prevention	689	614(89)	688	504(73)	679	325(48)	704	444(63)
Not set a good example in their personal behavior/sexual practices	704	554(79)	677	542(80)	701	538(77)	720	342(48)
Not given survival basics (food, water, shelter, land) to people infected or affected by HIV/AIDS	698	447(64)	691	387(56)	700	294(42)	716	297(41)
Not done enough to oppose bad treatment of PLWA	686	496(72)	685	455(66)	670	359(54)	698	327(47)
Not protected women and children from abuse	708	473(67)	706	418(59)	691	397(57)	725	290(40)

ernment works in Swaziland prevented them from having a say in the way HIV/AIDS is addressed in the nation. The centralized decision making of the Swazi monarchy and the lack of opportunities for civic participation may underlie these views.

The heavy criticism of chiefs may reflect their perceived high level of influence on the daily lives and attitudes of their constituents and, therefore, their actual ability to affect the transmission of HIV and its impacts. National political leaders were also criticized by half or more of respondents in every domain. This assessment was likely for the same reasons as those reported for chiefs, given their responsibility for national policies and their visibility in Parliament and the ministries. In contrast, church leaders were assessed comparatively less harshly; their actions were judged wanting, though, by 40 percent or more of the sample in each category.<sup>795</sup>

Given the cultural significance of and high regard for the royal family in Swaziland, and the potential negative consequences of critiquing the King, during most of Swaziland's history rebuke of the King's actions or policies was rare, private or indirect. Whether a measure of increased openness, the confidential nature of the survey, the current level of dissatisfaction with his lack of leadership on HIV/AIDS, the magnitude of the AIDS crisis itself or some combination of these, community survey participants were critical of the King. Only with regard to spending for prevention measures was the King judged less negatively than the other leaders, yet 48 percent of participants still felt that he had not done enough in that arena. Funding is an area of Swazi policy where the King has great power, both as a political leader and in his role as a direct donor to social causes and to the needs of individuals such as AIDS orphans.

### *Strategies for Going Forward and Closing the Gaps*

When community survey participants were asked in an open-ended question for their opinion about what could be done in Swaziland to prevent further spread of HIV, the only answer given by more than 50 percent of participants, as shown in Table 12, was educational campaigns. This category was inclusive of campaigns on a wide range of HIV/AIDS-related subjects.

The value of information and public education on topics ranging from prevention to testing, treatment and stigma was recognized by 60 percent of women and men. When asked directly, 94 percent of participants said that they would support HIV education directed at men as a prevention strategy. Seventy-three percent of

**TABLE 12: Preventing the spread of HIV in Swaziland, Swaziland Community Survey (N=787)\***

Statement of Intervention	n(%)
Educational campaigns	471(60)
Increasing the availability of condoms	173(22)
Supporting people to get tested	86(11)
Providing resources	59(8)
If the King would set an example or speak out	54(7)
Making treatment, including ARVs, more available**	52(7)
Addressing domestic and sexual violence	44(6)
Increasing availability of testing	43(5)
If people had access to good or better quality medical care	39(5)
If there were more HIV/AIDS support groups	34(4)
Increasing confidentiality at testing sites	32(4)

\*Participants could give more than one answer.

\*\*The difference between women's (5 percent) and men's responses (8 percent) was statistically significant (p=0.000).

women and 63 percent of men agreed that promoting abstinence could contribute "extremely" or "quite a lot" to changing sexual behavior in Swaziland.<sup>796</sup> As discussed in the section on sexual practices, this opinion may reflect recognition of the efficacy of abstinence to prevent HIV without taking into account the barriers to its successful practice, such as women's lack of control over sexual decision making.

The second most common response, given by 22 percent of those surveyed, was to increase the availability of condoms. As mentioned previously, only 4 percent of those surveyed affirmed that unavailability or lack of affordability of condoms was the reason they did not consistently use them over the past year. This response may speak, therefore, to the need for increased distribution of condoms or better coverage in certain areas, given that they are already widely available.<sup>797</sup> It also highlights the importance of education around the preventive value of condoms. Finally, it suggests a perceived need for the imprimatur of endorsement by peers and community, church and national leaders in order to demythologize condoms and normalize their use.

Despite the small proportion of community survey participants who reported having tested for HIV, in open-

ended questions only 11 percent suggested that supporting people to get tested would assist in HIV prevention and 5 percent mentioned increasing availability of testing as a prevention strategy. In addition, 7 percent claimed that increasing the availability of ARVs was a key prevention measure. This may reflect the fact that, at this point in the HIV/AIDS epidemic, Swazis were more aware of the impact of education and condom availability on HIV prevention, and had not yet been made cognizant (through campaigns, for example) of the effects of expanded access to testing and treatment as prevention measures.

## PLWA Interviews

Women and men living with HIV/AIDS interviewed for the study were asked an open-ended question about whether and how leaders have addressed the HIV/AIDS problem in their communities. They were also asked what the King has done to address the epidemic in Swaziland and their recommendations for what he should do.

### *Praise and Criticism for Leadership*

Feelings about the actions of leaders among PLWA were mixed. Some reported that they had made an effort to disseminate information and establish and expand testing and treatment access.

*They've increased educational campaigns, established VCT centers and have concentrated on HIV in the workplace.*

Some recognized the important role PLWA needed to play to educate leaders in the first instance.

*We need to train community leaders, chiefs, key people: HIV doesn't mean that life is over. We need teaching by people in the community. We need to empower leaders first, and fix misconceptions in key people.*

Leaders were criticized for being merely rhetorical and not delivering concrete action in their approach to the epidemic, including changing their own behaviors. Twelve out of 58 individuals interviewed charged that the King in particular was a poor role model for other Swazi men because he was polygamous and has so many wives. They said that other men justified their own behavior by referring to the King, and that the King's behavior therefore undermined HIV education efforts aimed at reducing multiple sexual partnerships.

*They have not done anything. What they did is just lip service. They don't walk the talk. They use HIV programs for their campaigning only so that they*

*can win our support. But then they do nothing. And the King is a bad role model. If I am a young man, I want to imitate the King. I would also love to have many wives.*

On the other hand, 16 interviewees praised the King, in particular for declaring the epidemic a national disaster in 1999, speaking publicly about HIV, funding orphan care programs and appealing to foreign leaders for financial assistance, particularly for the distribution of ARVs in Swaziland.

*He has asked every Swazi to help in any way. He has said it's a disaster.*

*The King has asked donors from overseas to support Swaziland.*

### *Strategies to Increase Testing and Treatment*

One of the most direct recommendations for leadership stemmed from the identification of leaders as influential role models for other Swazis: the King and chiefs should get tested for HIV and announce their test results publicly. Those interviewed suggested that the King's actions in particular would have a significant effect on the willingness to test of the general Swazi population.<sup>798</sup>

*He [the King] should get tested. And all his wives. It would have a big impact. Maybe if he was positive, more people would test. He has to take a step in order for everybody to take it.*

Likewise, leadership was deemed wanting around treatment. In particular, interviewees urged leaders to provide accurate information about the nature and efficacy of the ARV regimen.

*There needs to be more teaching about ARVs. There are rumors that the medicines which have been donated are poor quality — that they want us to die. We need more information to empower people.*

Other barriers to treatment discussed by the PLWA interviewed suggested the need for a coordinated leadership effort at the national level. Barriers included costs of transport and non-ARV drugs, the lack of dispensaries outside of the 6 located in major towns, inconsistent supply of medications and an unmet demand for trained health workers.

*The problem is you have to wait in long lines. You can wait five hours. The whole work day is gone. Once I was too sick to come in. But you have to try to get here. Your life depends upon it.*

*The problem is the distance from clinics. People who are suffering cannot travel. There is a shortage of doctors, so people must wait for one doctor to prescribe to many people.*

The urgency of the situation was discussed by more than half of PLWA interviewed, speaking as they were from the center of a pandemic in a very small country in a region subject to the “triple threat” of AIDS, food insecurity and poverty,<sup>799</sup> for which dire predictions loomed.<sup>800</sup> As one 31 year-old man, whose girlfriend died in 1998 and who himself started exhibiting symptoms in 2002, lamented:

*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.*

### **Key Informant Interviews**

Several key informants criticized the political nature of the response to the HIV/AIDS crisis in Swaziland and felt that the disease itself had been politicized to the detriment of the national approach. Both Government officials and PLWA activists pointed out that national policies related to the crisis — the AIDS and gender policies — remained in draft form for long stretches of time, yet to be formally approved, let alone implemented.

*There is a slogan: 'it's everyone's problem.' But the King said that, too. What is the real meaning? It's just a political statement that everyone has to mention. When I see action, I will appreciate the Government talking about AIDS. We should be talking about amending policy, but in our case we [still] have to develop one, fast.<sup>801</sup>*

### **Inaction of Leadership**

Like the PLWA interviewed, many experts in Swaziland criticized leaders for failing to follow words with deeds in the area of HIV/AIDS, including as role models for behavior change. A few questioned the influence leaders could have on the general public, given the effects of poverty, food insufficiency and other socioeconomic factors constraining individuals' choices.

*There isn't much commitment, but there's a lot of lip services. ...Just talking and not doing. I don't think public figures will make people change. Their lives are different — they have everything you may not have, money to buy food and so forth.<sup>802</sup>*

One coordinator for an association working on AIDS and workplace issues suggested a prescription that summarized many key informants' critiques and recommendations for the national leadership:

*If the country leadership could change and be seen to do something: first, to talk openly about HIV; second, act what they talk; third, support policies and legal instruments ... especially those trying to amend laws to include HIV/AIDS and fourth, [to comply] with the [human rights] conventions Swaziland has signed, to include budget implementation provisions. This impacts how people behave, because they look at the budget priorities of the Government and then say, okay this is a problem.<sup>803</sup>*

In terms of individual leaders, many key informants from the spectrum of Swazi service organizations, government, international agencies and PLWA groups were highly critical of the King — though for the most part “off the record” — indicating, perhaps, the precarious status of the lessening of that particular taboo. They criticized his polygamy, his declaration and subsequent violation of the revival of *umcwasho* (signifying a ban on sex with girls under the age of 18), his enormous material wealth and spending, and his failure to raise the issue of gender in his speeches on HIV/AIDS. One NGO representative explained the reaction of communities when she goes to educate them:

*They will say, we don't understand why you say there is HIV/AIDS when 'someone' [the King] behaves as if there is no HIV/AIDS.<sup>804</sup>*

Chiefs, as a category of leadership, were faulted for shirking their traditional role:

*If the chiefs were living a true chiefly life, they are supposed to protect you [as a woman], there would be more protection in the Swazi way than in the civil law.<sup>805</sup>*

Church leaders were criticized for missing opportunities to influence their many parishioners through their Sunday sermons, and particularly for having come so late — or not at all — to accept and encourage condom use or acknowledge the HIV risks of married individuals.

*In the church, our priests and bishops are not taking HIV seriously enough ... they just talk about it in a passive way. They should be allocating more time to it because every Friday they're having mourning services and every Sunday they're burying people. They're all saying, abstain and be*

*faithful. But they also need to talk about condoms in churches. Even in churches, people are failing to abstain, and failing to be faithful.*<sup>806</sup>

Public health and medicine were additional areas of leadership singled out for criticism by key informants. Those responsible for failing to address the inadequate health infrastructure were cited as lagging in their response to HIV. Moreover, key informants interviewed repeatedly cited the burden on the public health system that treatment provision and the increasing numbers of people identified as living with AIDS was exacting in Swaziland. The perspective of the national director of Swaziland's AIDS coordinating agency was typical:

*Our system could not cope with a more aggressive program to get more people on treatment right now. Until the Ministry of Health increases the number of sites, and gets more doctors, we don't have the capacity to increase enrollment.*<sup>807</sup>

Health professionals were criticized by one key informant for not "taking the initiative" to learn about HIV/AIDS and for the fact that training and other programs failed to keep pace with increasing caseloads of HIV-infected and AIDS patients.

*Capacity is the challenge. The whole country is not ready. The slow pace of putting in a system. There's brain drain.... Another issue is ...HIV is like any other disease — you have the capacity as a nurse to learn. ... Doctors also — they don't read — there are guidelines ...*<sup>808</sup>

### *Need for Diverse, Grassroots Strategies*

As one donor agency AIDS coordinator noted, in terms of leadership, "[Swaziland] needs to use whatever resources they have: rural health motivators, traditional healers, chiefs."<sup>809</sup> Key informants recognized that participation from the ground up was essential to holding everyone, leaders and individuals alike, accountable to successful strategies for change.

*We need to ask people in their constituencies, regionally — how would you prevent HIV as an individual, as a group? Stop pointing fingers at someone else. ...How would you like to see women respected in life? If we can individualize the problem, I think we can bring about behavior change. It should come from the people themselves. If it comes from the top, they won't pay attention.*<sup>810</sup>

Education, both formal and popular, was identified as crucial to changing the beliefs and practices that maintained HIV-related stigma and discrimination at high levels, continued to entrench gender inequality and discrimination, and preserved the harmful mythology and silence around HIV/AIDS.

*At the end of the day it is attitudes. Take a multi-pronged approach. Get young ones at a tender age through the education system curriculum. Traditional authorities — whenever they have meetings with constituents they should talk about [HIV/AIDS], at every funeral occasion. We need more testimonies from PLWA — I'm not undermining the current situation, but in the rural areas, it's still a taboo.*<sup>811</sup>

PLWA advocates pointed out that interventions need to comport with the realities of people's lives in Swaziland. Food aid needs to recognize that PLWA had families who were likewise food insufficient and thus they would share their ration with their relatives and run out of food before the end of the month's allotment. Income generation programs needed to supplement credit given with food aid so the resources doled out would not be used for immediate needs. Moreover,

*...income generation should be meaningful, not worsen the situation of the women. An example is a project where there were 100 women to watch over 20 chickens. Women need access to resources, skills to do what women think would be meaningful livelihoods for them ...start up funds and advice on what to market.. and support at home.*<sup>812</sup>

## **Conclusion**

Findings from the Swaziland study highlighted several important themes concerning the HIV/AIDS epidemic in Swaziland: 1) the cross-cutting negative impacts of food insufficiency and economic dependence, particularly for women; 2) fear of knowing one's HIV status, high levels of HIV-related stigma and fear of being stigmatized should one test positive for HIV; 3) women's lack of control over sexual decision making; and 4) prevalent gender discriminatory beliefs associated with sexual risk-taking.

Female community survey participants were more food insufficient, less educated and had lower incomes than male participants. For women and men experiencing food or water shortages, the majority reported that they became economically dependent and that their

health care decisions were affected. The majority of PLWA had also been affected by the lack of food or water.

The majority of those surveyed correctly answered questions about HIV prevention and transmission despite the lack of a national educational campaign. Certain incorrect beliefs persisted, however. For example, that mosquito bites and sharing meals could transmit HIV, and praying and traditional medicine could prevent it. PLWA testimony suggested that men in particular might have correct knowledge, but relied on myths to avoid responsibility in preventing the transmission of the virus to themselves or others.

The lack of scaled-up HIV/AIDS-related infrastructure in Swaziland was reflected in the finding that 25 percent of women and 18 percent of men surveyed had tested for HIV. The chief barrier to finding out one's status was fear or lack of readiness to test. PLWA and key informants also discussed the existence of gender-related barriers to testing. More than half of Swazi community participants who had tested cited personal motivation to know their status; for PLWA that reason was second only to testing because they were sick. While overall experiences with testing were positive, the question of voluntariness was raised by the community survey results: 13 percent reportedly had not made the decision to test and 40 percent felt that they could not refuse the test.

Stigmatizing and discriminatory attitudes toward PLWA were reported by over 60 percent of Swazi community survey participants. The persistence of these attitudes, and the greater burden borne by HIV-positive women, was consistent with the reported experiences of the PLWA interviewed. Moreover, Swazi women reported more fears of being stigmatized should they test positive than did Swazi men. This appears to be in line with actual experiences, as reported by PLWA of poor treatment in the family, work and community as being more common among women. At the same time, PLWA interviewed report near universal levels of disclosure and its positive consequences.

Nearly 90 percent of those surveyed had ever had sex. Differences between women and men surveyed were stark. Forty percent of women and 3 percent of men lacked control over the decision to have sex. Eight percent of women and 39 percent of men reported having more than one sexual partner in the past year. The majority of sexually active participants reported not

using a condom at some point in the past year; 18 percent of women and 3 percent of men agreed that they had no control over the decision of whether or not to use a condom. Interviews with PLWA discussed women's lack of autonomy in relationships with partners in the context of their economic dependence on men, as rooted in social, cultural and legal inequalities. Many PLWA reported reducing their number of partners and increasing condom use after testing positive for HIV. However, one-third of female PLWA lacked control over sexual decision making despite knowledge of the risks of HIV transmission and re-infection.

Nearly all Swazis surveyed held at least one gender discriminatory belief and the majority held 3 or more. Twenty-four percent of women and 44 percent of men held 6 or more such beliefs. The content of specific beliefs held illustrated the strong influence of traditional culture and the norm that women should be subservient to men.<sup>813</sup> The majority of those surveyed, and more women than men, also supported women's rights. Gender discriminatory beliefs predicted sexual risk-taking (have multiple sexual partnerships or unprotected sex with a non-primary partner) for both women and men. Conversely, holding beliefs in women's rights had a protective effect, decreasing the odds of risky sexual practices or circumstances. Interviews with PLWA and key informants elaborated on the findings regarding the prevalence of gender inequality and discrimination in all facets of women's lives and its association with women's vulnerability to HIV/AIDS.

When asked extensive questions in terms of assessing the country's leadership around HIV/AIDS, community survey participants affirmed failures and gaps in the national response. Nearly half faulted both local and national leaders on every domain in the survey: spending on HIV/AIDS, role modeling, assisting those infected and affected by HIV, opposing HIV-related stigma and discrimination and taking action to protect women and children from domestic abuse. PLWA had a mixed assessment, noting the need to move beyond rhetoric and their own role in educating the leadership. Key informants condemned the passivity of leaders and cited the need to reform laws, prioritize spending, build capacity within the public health system and address widespread food insufficiency and poverty that affect individual sexual behavior.

## Notes

<sup>735</sup> Currency conversion at the Interbank Rate for May 4, 2005 (1 US dollar = 6.14 Swaziland *lilangeni*). FXConverter. Available at: <http://www.oanda.com/convert/classic>. Accessed on February 13, 2007.

<sup>736</sup> This represents a 92 percent response rate, taking into account subsequent exclusions from the sample of surveys with missing data on key predictors or outcomes.

<sup>737</sup> Participants who were currently married were asked whether there was more than one wife in their marriage.

<sup>738</sup> Thirteen percent of women and 19 percent of men reported having visited a traditional healer in the past year. The fact that participants in both the community survey and the PLWA interviews infrequently admitted to visiting traditional healers is likely a result of the prohibitions and shaming around such consultation from public health and medical sources early in the crisis.

<sup>739</sup> This is likely due to the urban locales of the recruitment for the investigation sample, in addition to the overrepresentation of women among the population of individuals being tested and treated for HIV in Swaziland and the higher prevalence of HIV in women.

<sup>740</sup> N=52. Symptoms of depression were measured using the 15-item Hopkins Symptom Checklist for Depression (HSCL-D). People were considered to screen positive for depression if their score was  $\geq 1.75$  on this scale. Derogatis LR, Lipman RS, Rickels K, Uhlenhuth EH, Covi L. "The Hopkins Symptom Checklist (HSCL). A measure of primary symptom dimensions." *Mod Probl Pharmacopsychiatry*. 1974;7(0):79-110; This screen has been validated previously in a number of international settings in Africa and elsewhere. Bolton P, Wilk CM, Ndogoni L. "Assessment of depression prevalence in rural Uganda using symptom and function criteria." *Soc Psychiatry Psychiatr Epidemiol*. Jun 2004;39(6):442-447.

<sup>741</sup> 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". Of the 6 others not receiving ARVs, 4 expressed concerns about the side effects or the efficacy of the treatment, and 2 of the 4 had made the decision to focus on a healthy diet or other behavior changes to maintain or improve their health. Two also expressed concerns about the difficulty in taking the medications as prescribed and feared getting worse if they forgot to take them on time.

<sup>742</sup> Currency conversion at the Interbank Rate for May 4, 2005 (1 South African rand = 0.164 US dollar). FXConverter. Available at: <http://www.oanda.com/convert/classic>. Accessed on February 13, 2007; The Swazi *lilangeni* is pegged to the value of the rand.

<sup>743</sup> Fifty-two interviewees had two or more dependents; 5 had over 10 people they were supporting.

<sup>744</sup> This is equivalent to 40 percent, similar to depression prevalence estimates in HIV-positive populations in the US, which is 36-37 percent. Bing EG, Burnam MA, Longshore D, et al. "Psychiatric disorders and drug use among human immunodeficiency virus-infected adults in the United States." *Arch Gen Psychiatry*. Aug 2001;58(8):721-728; Asch SM, Kilbourne AM, Gifford AL, et al. "Underdiagnosis of depression in HIV: who are we missing?" *J Gen Intern Med*. Jun 2003;18(6):450-460.

<sup>745</sup> Interview with Albertinah Nyathi, Women Together, March 14, 2005, Mbabane, Swaziland.

<sup>746</sup> Participants were asked 11 questions about their knowledge of 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 HIV knowledge if they correctly identified the two most common modes of HIV prevention in Swaziland (consistent condom use and abstinence).

<sup>747</sup> Interview with Gideon Gwebu, Ministry of Home Affairs, Gender Unit, May 16, 2005, Mbabane, Swaziland.

<sup>748</sup> Interview with Siphwe Hlophe, Swaziland for Positive Living (SWAPOL), September 23, 2004, Manzini, Swaziland.

<sup>749</sup> Though it should be noted that those who have not tested, may, by definition, not have attempted to test and therefore may be less aware of potential barriers to access, such as lack of infrastructure in rural areas.

<sup>750</sup> Participants could agree with more than one reason.

<sup>751</sup> PMTCT Plus is provided in Swaziland; HIV testing is available at the sites for male partners. See The Elizabeth Glaser Pediatric AIDS Foundation Annual Report. 2004. Available at: <http://www.rhap.org.za/resources/208.pdf>. Accessed May 24, 2006.

<sup>752</sup> While those that tested because they were sick may have felt, in the broad sense, that they "had no choice" because their physician needed to determine the cause of their illness, that proportion of respondents does not account for the larger group that reported not being able to refuse the test. In this group, some may have felt a personal imperative to find out the cause of their illness and thus that they could not, in that sense, refuse the HIV test.

<sup>753</sup> This definition was based on the routine testing policy in Botswana, and used in the companion study.

<sup>754</sup> Participants could give more than one answer.

<sup>755</sup> Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

<sup>756</sup> Interview with Thembi Nkambule, Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA), May 24, 2005, Mbabane, Swaziland.

<sup>757</sup> Interview with Derek von Wissell, National Emergency Response Council on HIV/AIDS (NERCHA), May 23, 2005, Mbabane, Swaziland.

<sup>758</sup> Interview with Gideon Gwebu, Ministry of Home Affairs, Gender Unit, May 16, 2005, Mbabane, Swaziland.

<sup>759</sup> Interview with Thembi Nkambule, Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA), May 24, 2005, Mbabane, Swaziland.

<sup>760</sup> 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.

<sup>761</sup> The sex differences, though statistically significant are not shown here, given that they were small, in most cases less than 1 percent, and overall in the range of less than 1 to 4 percent.

<sup>762</sup> 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.

<sup>763</sup> Even where families no longer live together or are separated, for example by urban migration, by law women married in community of property have minority legal status and cannot register property in their own names; in practice any property in a marriage is often retained by the husband’s family.

<sup>764</sup> Interview with Derek von Wissell, National Emergency Response Council on HIV/AIDS (NERCHA), May 23, 2005, Mbabane, Swaziland.

<sup>765</sup> Interview with Vusi Matsebula, March 12, 2005, Mbabane, Swaziland.

<sup>766</sup> Interview with Makhosazana Hlatshwayo, Business Coalition on HIV/AIDS, Federation of Swaziland Employers (BCHA), April 29, 2005, Mbabane, Swaziland.

<sup>767</sup> Interview with Thembi Nkambule, Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA), May 24, 2005, Mbabane, Swaziland.

<sup>768</sup> Id., Interview with Thembi Nkambule, May 24, 2005.

<sup>769</sup> Defined as having had at least one sexual partner in the past 12 months.

<sup>770</sup> Adjusted odds ratio (AOR): 2.07, 95% confidence interval (CI) (1.19-3.63). In regression models “lack of control” was defined as your partner usually or always deciding when you have sex. All logistic regression models reported included the variables of sex, age, education level, monthly household income, food insufficiency, marital status, residency location, gender discriminatory attitudes (aggregate or individual), HIV knowledge, HIV-related stigma and fears of HIV-related stigma. The associations described in the text have been adjusted for the possible confounding effects of these other variables.

<sup>771</sup> AOR: 0.45, 95% CI (0.25-0.81).

<sup>772</sup> The percentages for women may in part reflect underreporting by women due to the cultural taboo for women in having more than one sexual partner.

<sup>773</sup> AOR: 1.91, 95% CI (1.17-3.11).

<sup>774</sup> The latter is traditional indicator or predictor of high-risk sexual practice (a practice likely to lead to HIV transmission), given that a non-regular sexual partner is also likely to be non-monogamous and HIV status is less likely to be disclosed between such partners.

<sup>775</sup> Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

<sup>776</sup> Interview with Gideon Gwebu, Ministry of Home Affairs, Gender Unit, May 16, 2005, Mbabane, Swaziland.

<sup>777</sup> Interview with Makhosazana Hlatshwayo, Business Coalition on HIV/AIDS, Federation of Swaziland Employers (BCHA), April 29, 2005, Mbabane, Swaziland.

<sup>778</sup> Interview with Thulisile Dladla, SEBENTA National Institute, May 20, 2005, Mbabane, Swaziland.

<sup>779</sup> Interview with Makhosazana Hlatshwayo, Business Coalition on HIV/AIDS, Federation of Swaziland Employers (BCHA), April 29, 2005, Mbabane, Swaziland.

<sup>780</sup> 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 contradictory views concerning the roles of women and men.

<sup>781</sup> Additionally, more than three times as many men (22 percent) as women (6 percent) believed that women should prove their fertility before marriage ( $p=0.000$ ).

<sup>782</sup> AOR: 1.99, 95% CI (1.17-3.39) for the whole sample (N=768) and AOR: 2.40, 95% CI (1.29-4.47) for men only (N=386). In multivariate models odds ratios are 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.

<sup>783</sup> Additionally, more than three times as many men (22 percent) as women (6 percent) believed that women should prove their fertility before marriage ( $p=0.000$ ).

<sup>784</sup> Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

<sup>785</sup> Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

<sup>786</sup> Interview with Thandi Nhlengethwa, The AIDS Information and Support Centre, March 17, 2005, Manzini, Swaziland.

<sup>787</sup> Interview with Derek von Wissell, National Emergency Response Council on HIV/AIDS (NERCHA), May 23, 2005, Mbabane, Swaziland.

<sup>788</sup> Interview with Zakhe Hlanze, Women and Law in Southern Africa Research Trust — Swaziland (WLSA), March 14, 2005, Mbabane, Swaziland.

<sup>789</sup> Interview with Alan Brody, UNICEF, April 28, 2005, Mbabane, Swaziland.

<sup>790</sup> Interview with Zakhe Hlanze, Women and Law in Southern Africa Research Trust — Swaziland (WLSA), March 14, 2005, Mbabane, Swaziland.

<sup>791</sup> Interview with Zakhe Hlanze, Women and Law in Southern Africa Research Trust — Swaziland (WLSA), March 14, 2005, Mbabane, Swaziland.

<sup>792</sup> The only statistically significant difference between the opinions of women and men was regarding whether chiefs have set a good example; 82 percent of women answered no versus 75 percent of men.

<sup>793</sup> It has been pointed out, however, that chiefs do not have their own budgets for expenditures. Personal communication at meeting to review preliminary study data, November 2, 2005, Mbabane, Swaziland.

<sup>794</sup> This was defined for participants as threatening or hurting someone or forcing them to have sex when they do not want to.

<sup>795</sup> For some participants this may reflect the partial success of local social programs, the strong faith and confidence in the church felt by many Swazis or a judgment that the church is unwilling or unable to affect the AIDS crisis, having failed in many quarters to acknowledge it as something other than punitive until recently. See Rev. Vitillo RJ. “HIV and AIDS: The Challenge and the Context. Why Should Churches Respond to Issues of Stigma and Discrimination in Reaction to HIV and AIDS?” UNAIDS. A Report of A Theological Workshop Focusing on HIV and AIDS Related Stigma. December 8-11, 2003: 22-29. Available at: [www.e-alliance.ch/postercd/resource/UNAIDSConsultantReport\\_english.doc](http://www.e-alliance.ch/postercd/resource/UNAIDSConsultantReport_english.doc). Accessed June 27, 2006.



<sup>796</sup> As mentioned above, the endorsement of abstinence appears to stand in contrast to the actual practice of it. For example, of those surveyed who were sexually active, only 19 percent of women and 7 percent of men reported having no sexual partners in the past year.

<sup>797</sup> Avert.org. "Condoms: History, Testing, Effectiveness and Availability." May 10, 2006. Available at: <http://www.avert.org/condoms.htm>. Accessed May 25, 2006.

<sup>798</sup> According to the AIDS coordinator of one donor government's program in Swaziland, the King has been quoted in the press as saying that he tests every 6 months for HIV, but the results have not been made public. Interview with Julie Cory, US Embassy, March 9, 2005, Mbabane Swaziland.

<sup>799</sup> "Triple Threat in Southern Africa." [UNICEF website.] Available at: [http://www.unicef.org.uk/campaigns/campaign\\_pages.asp?page=25](http://www.unicef.org.uk/campaigns/campaign_pages.asp?page=25). Accessed May 8, 2006.

<sup>800</sup> For example, see de Waal A and Whiteside A. "New Variant Famine: AIDS and Food Crisis in Southern Africa." *Lancet*. 2003; 362:1234-1237; See also UNAIDS (2005). *AIDS in Africa: Three Scenarios to 2025*. Available at: [http://www.unaids.org/un aids\\_resources/images/AIDSScenarios/AIDS-scenarios-2025\\_report\\_en.pdf](http://www.unaids.org/un aids_resources/images/AIDSScenarios/AIDS-scenarios-2025_report_en.pdf). Accessed May 8, 2006.

<sup>801</sup> Interview with Vusi Matsebula, March 12, 2005, Mbabane, Swaziland.

<sup>802</sup> Interview with Thembisile Dlamini, UNAIDS, May 19, 2005, Mbabane, Swaziland.

<sup>803</sup> Interview with Makhosazana Hlatshwayo, Business Coalition on HIV/AIDS, Federation of Swaziland Employers (BCHA), April 29, 2005, Mbabane, Swaziland.

<sup>804</sup> Interview with Makhosazana Hlatshwayo, Business Coalition on HIV/AIDS, Federation of Swaziland Employers (BCHA), April 29, 2005, Mbabane, Swaziland.

<sup>805</sup> Interview with Zakhe Hlanze, Women and Law in Southern Africa Research Trust — Swaziland (WLSA), March 14, 2005, Mbabane, Swaziland.

<sup>806</sup> Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

<sup>807</sup> Interview with Derek von Wissell, National Emergency Response Council on HIV/AIDS (NERCHA), May 23, 2005, Mbabane, Swaziland.

<sup>808</sup> Interview with Thembisile Dlamini, UNAIDS, May 19, 2005, Mbabane, Swaziland.

<sup>809</sup> Interview with Julie Cory, US Embassy, March 9, 2005, Mbabane, Swaziland.

<sup>810</sup> Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

<sup>811</sup> Interview with Gideon Gwebu, Ministry of Home Affairs, Gender Unit, May 16, 2005, Mbabane, Swaziland.

<sup>812</sup> Interview with Gcebile Ndlovu, International Community of Women Living with HIV/AIDS, March 15, 2005, Mbabane, Swaziland.

<sup>813</sup> As the key informant interviews and the country background chapter point out, it is important to understand the complexity of culture which includes the erosion of traditionally protective norms that put women at risk. For example, traditional Swazi culture did not accept rape and intimate partner violence per se, as illustrated by the saying "indvuku ayiwakhi umuti" (violence does not insure family unity). Personal communication with WLSA, September 26, 2007.

# VIII. SWAZILAND RECOMMENDATIONS

## To the Government of Swaziland:

### I. Comprehensively Advance Women's Human Rights and Address Violations, including:

#### A. Legal and Policy Reform to Eliminate Gender Discrimination

- 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.
  - Work with civil society organizations to draft laws called for by the Constitution, such as legislation conferring inheritance rights on surviving spouses.
  - Build capacity in the Attorney General's office to fast track reforms and domestication.
- 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.

#### B. Dissemination of Information and Assistance Regarding Recourse for Rights Violations

- Collaborate with civil society organizations to facilitate community dialogues in each chiefdom to educate the populace on women's rights and equality under the Constitution.
- Increase knowledge of and access to legal remedies and victims' services, including providing legal aid and sensitizing law enforcement agencies and the judiciary through training programs.
- Support short-term safety nets for women who are the victims of violence, abandonment, disinheritance or other acute abuses through the provision of post-exposure prophylaxis for HIV, shelter and other emergency services and care, in partnership with civil society organizations.

#### C. Popular and Civic Education to Change Gender Norms

- Incorporate comprehensive sexuality education, gender and human rights awareness into basic educational curricula with the goal of changing norms and expectations and promoting equality regarding male and female social roles, including in intimate relationships.
- Conduct outreach to radio, print and television media to:
  - Reinforce positive messages and marginalize stereotypes;
  - Challenge gender-discriminatory attitudes;
  - Broaden the public health discourse to include discussion of relationship power dynamics and healthy sexuality (i.e., targeting social norms that sanction men's behavior, challenging gender roles, increasing risk perceptions, presenting supportive male and empowered female role models).

#### D. Building and Creating Institutional Capacity to Address Gender Issues

- Build capacity and resources in the Gender Desk at the Ministry of Home Affairs.
- Appoint gender-balanced representation to all commissions embedded in the Constitution of Swaziland, including those that will consider gaps related to gender, such as citizenship restrictions, and monitor implementation of provisions that promote and protect women's rights, such as the right not to comply with a customary practice to which a woman objects.

### II. Mitigate Poverty and Meeting Basic Needs By:

#### In the Short-Term:

- 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.
  - Food should meet the needs of HIV-positive persons.

- Programs should feed the whole family of a vulnerable person.
- Home-based care programs, schools, workplaces, treatment centers, PLWA support groups and other service sites and organizations should be assisted to provide food aid, including appropriate training and resources for staff.

#### *In the Medium- and Long-Terms:*

- Address the underlying causes of food insufficiency and failure to meet other basic needs, and recognize that women and girls disproportionately experience poverty and the burdens of care-giving, by providing skills training and sustainable programs directed at creating economic opportunities particularly for women, PLWA and families affected by HIV/AIDS.
  - Ensure access to loans, credit and training (e.g., marketing, entrepreneurship, business skills) through microfinance projects.
  - Create local employment and educational/training opportunities, particularly for and led by women, such as community-based income-generation projects.
  - 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.
  - Legislate and promote equity in wages for factory workers to decrease co-habitation; create legal protections for women in the informal economy.

### **III. Eradicating HIV/AIDS-Related Stigma and Discrimination Through:**

#### *A. Leadership and Legal/Policy Reform for Support and Protection of Affected Persons*

- The King, national politicians, chiefs, community leaders and church leaders should publicly test for HIV and encourage people to test at every opportunity.
- The King should propose, and Parliament enact, comprehensive legislation and policy addressing HIV/AIDS and discrimination, and strengthen enforcement of prohibitions, with particular attention paid to employment practices.
- All sector ministries should set, fund, monitor and be held accountable for meeting gender equality objectives as part of the national HIV/AIDS strategy.
- Church leaders should end complicity in stigmatization and play educational roles to support gender

equality and end discriminatory customary practices in marriage and other areas.

- Traditional leaders should endorse programs that promote gender equality; ensure access by community to testing and treatment; and denounce, discourage and call for transformation of harmful customary practices.

#### *B. Challenging Prejudices and Closing Information and Services Gaps*

##### *With Regard to Information/Education:*

- Incorporate anti-stigma education at the community and primary and secondary school levels and support linkages between grassroots peer educators.
- Create a coordinated media campaign, including television and radio messages on prevention and testing.
  - Disseminate real people's stories of living with HIV.
  - Address risk, vulnerability and fear of stigma directly and integrate gender concerns into prevention messages (i.e. forced sex, power in relationships).
  - Target people's misperceptions concerning HIV transmission, the equation of HIV with physical illness, condom effectiveness and other topics.
- Work with PLWA groups and other civil society organizations to create or adapt and widely disseminate information on testing, prevention and treatment.

##### *With Regard to Testing and Health Services:*

- Ensure the "three Cs" are implemented with respect to all forms of testing: confidentiality, counseling and informed consent.
- Identify and close other services gaps, including:
  - Meeting reproductive and sexual health needs for HIV-positive women.
  - Collaborating at the level of NERCHA, local governments and the Ministry of Health to create a "supermarket" of comprehensive health and social services around the provision of VCT.
  - Strengthening referral systems from testing to treatment.

## **To the US Government:**

### **I. Expand HIV/AIDS Aid Programming and Promote Women's Rights:**

- Require that a gender focus be incorporated into US-funded programs.
  - Foster integration between HIV/AIDS programs and development programs focused on health, education, poverty reduction and respect for women's rights.
  - Increase the US Government'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.
  - Coordinate US-funded programming with other bilateral and multilateral development programs promoting gender equality.
- Invest in locally produced television and radio public education messages that focus on the availability of voluntary and confidential HIV testing and treatment. Assure that all public education campaigns promote women's rights and empowerment.
- Invest in the local development of programs that eliminate discriminatory attitudes toward women and promote gender equality.
- Mandate that the Government of Swaziland ensure that the "3 Cs" (confidentiality, counseling and informed consent) are implemented and monitored in all HIV testing programs; provide technical assistance as necessary.
- Contribute to the formation of a national plan for identifying and establishing best practices for scaled-up HIV testing. This plan should be developed with substantial local input from PLWA and women who are particularly vulnerable, such as poor women or those experiencing food insufficiency.
- Foster participation of women in national AIDS policy making and implementation.
  - Fund women's and PLWA organizations and facilitate the establishment of networks to strengthen organizational capability and contribute to a corps of skilled women leaders, especially women living with HIV/AIDS.

### **II. Contribute to Food Sufficiency, Particularly for Women and PLWA:**

- Increase funding to the World Food Programme.
- Initiate and support programs that address the link between food insufficiency and women's vulnerability to HIV infection.
  - Support the expansion of existing programs to help PLWA and poor women obtain food, shelter, and potable water.
- Adopt policies and legislation oriented toward promoting the population's capacity for self-sufficiency in food production, including:
  - Encourage local purchase rather than shipping of foodstuffs; require minimum percentages of locally purchased food in US farm aid laws.

## **To All Donors:**

### **I. Build Gender Reform Capacity in the Government and Civil Society Organizations:**

- Provide training, technical assistance and financial resources to women's organizations and other civil society actors to create collaborations and undertake civic education, political advocacy and popular campaigns relating to women's rights.
  - Provide technical assistance to draft legislation, such as marriage and administration of estates bills, in compliance with international human rights instruments, to use for lobbying government to review these acts.
  - Mobilize resources and identify cases for test litigation, with the goals of judicial education and creation of dialogue around these issues as a lobby and advocacy tool.
  - Building capacity in the Attorney General's office to advocate for gender reform legislation and constitutional and human rights commissions.

### **II. Contribute to Food Sufficiency, Particularly for Women and PLWA:**

- Urge expansion of the World Food Programme criteria for food aid to include all PLWA and affected families; provide food at the point of treatment; provide school-based feeding for all children; and encourage private employers to provide food for workers on site.
- Increase food aid and aid for other basic needs, including the support of:

- Farming cooperatives, extension schools and other agricultural initiatives to foster local capacities.
- Meals provision at school, work, training programs and treatment centers and through home-based care.
- Legal aid projects to assist widows and orphans in securing productive land.
- Implementation of nutritional monitoring in the most vulnerable communities to promote care of malnourished women and children.
- incorporate participation by affected populations in design, evaluation and testing programs;
- focus on increasing readiness to test;
- facilitate access to treatment; and
- ensure the “3Cs:” confidentiality, counseling and informed consent.
- Address people’s persistent fears of being stigmatized including support for PLWA organizations and networks to increase their visibility and services by funding the expansion of national networks, training officers for NGOs and supporting capacity building for PLWA in their community mobilization and sensitization efforts.

### **III. Assist the Government to Close Services Gaps and Support the Assurance of PLWA Rights:**

- Assist the Government to expand and monitor current testing and treatment programs that should:

# 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 ...*<sup>814</sup>

Recognition of the human rights dimensions of the AIDS pandemic has evolved over time, from a matter of individual privacy rights<sup>815</sup> 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.<sup>816</sup> Despite this acknowledgement, however, human rights obligations are rarely reflected in national action plans or HIV/AIDS policies and programs.<sup>817</sup>

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,<sup>818</sup> signed<sup>819</sup> or ratified<sup>820</sup> 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) <sup>821</sup>	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) <sup>822</sup>		Acceded March 26, 2004
Convention on the Elimination of All Forms of Discrimination against Women (December 18, 1979, entered into force September 3, 1981) <sup>823</sup> (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) <sup>824</sup>	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) <sup>825</sup>	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) <sup>826</sup>	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) <sup>827</sup>		Signed December 7, 2004

regarding violations of the ICCPR.<sup>828</sup> Botswana submitted a report in 2006, five years overdue. Swaziland has yet to report regarding compliance.<sup>829</sup> Compliance with the ICESCR is monitored by the UN Committee on Economic, Social and Cultural Rights (ESC Rights Committee).<sup>830</sup> 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).<sup>831</sup> 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.<sup>832</sup> The Committee on the Rights of the Child (CRC) plays a similar oversight role for the Children's Convention.<sup>833</sup> Botswana and Swaziland have submitted reports to the CRC, in 2003 and 2005 respectively, each a number of years overdue.<sup>834</sup> The African Commission on Human and Peoples' Rights monitors the African Charter on Human and Peoples' Rights (ACHPR).<sup>835</sup> 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.<sup>836</sup>

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 con-

cern 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."<sup>837</sup>

### 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.<sup>838</sup> 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<sup>839</sup> 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,<sup>840</sup> they provide states with an incentive to comply with the norms contained therein.<sup>841</sup>

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

Programme)<sup>845</sup> and the Beijing Declaration and Platform of Action (Beijing Platform)<sup>846</sup> 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.<sup>847</sup>

## 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.<sup>863</sup>

Legal equality,<sup>864</sup> and legal capacity “identical to that of men and the same opportunities to exercise that capacity”<sup>865</sup> 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.<sup>866</sup> 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.<sup>867</sup> The ACHPR protects the property rights of all people.<sup>868</sup>

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<sup>869</sup> and the ICCPR<sup>870</sup> 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<sup>871</sup> and to access family planning.<sup>872</sup> It also directs states to ensure gender equality in access to health services.<sup>873</sup> 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.<sup>874</sup> 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.”<sup>875</sup> 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, <sup>848</sup> ICESCR <sup>849</sup>
Right to Health	ICESCR, <sup>850</sup> Women’s Convention, <sup>851</sup> Children’s Convention, <sup>852</sup> ACRWC, <sup>853</sup> ACHPR <sup>854</sup>
Right to Food	ICESCR <sup>855</sup>
Right to Life	ICCPR <sup>856</sup>
Right to Information	ICCPR, <sup>857</sup> ACHPR, <sup>858</sup> Children’s Convention <sup>859</sup>
Right to be Free from Violence	Women’s Convention, <sup>860</sup> ACRWC, <sup>861</sup> Children’s Convention <sup>862</sup>



practices which negatively affect the human rights of women and which are contrary to recognized international standards."<sup>876</sup>

The ACHPR also vests states with the duty to protect all people from discrimination.<sup>877</sup> The same charter extends the non-discrimination principle to women and children specifically:<sup>878</sup> "[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."<sup>879</sup>

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.<sup>880</sup>

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."<sup>881</sup> The former UN Commission on Human Rights (CHR) has explicitly confirmed that health status, including HIV/AIDS, is an included ground.<sup>882</sup> 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.<sup>883</sup>

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 Botswana, 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 Botswana 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 one 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*<sup>884</sup>

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."<sup>885</sup> 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."<sup>886</sup> 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.<sup>887</sup> 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.<sup>888</sup> Popular participation in all levels of decision making regarding health is an aspect of the right,<sup>889</sup> which encompasses availability, accessibility, acceptability and quality.<sup>890</sup> 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.<sup>891</sup>

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”<sup>892</sup> and situates the need for a comprehensive strategy to promote women’s health in the obligation to eliminate gender-based discrimination.<sup>893</sup> 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.”<sup>894</sup>

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.<sup>895</sup> 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.”<sup>896</sup> Food must be available from either land or adequate distribution<sup>897</sup> as well as economically and physically accessible.<sup>898</sup> 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.<sup>899</sup>

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."<sup>900</sup> 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."<sup>901</sup> 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."<sup>902</sup>

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.<sup>903</sup> In General Comment 10, the Human Rights Committee emphasizes the comprehensiveness of this right and that it applies to all media.<sup>904</sup> General Comment 12 highlights information concerning health matters as a dimension of accessibility.<sup>905</sup> 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."<sup>906</sup> Furthermore, that information should not only comprise HIV prevention and transmission and sexual and reproductive matters, but also include stigma, discrimination and equality<sup>907</sup> and explicit linkage to the right itself.<sup>908</sup>

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."<sup>909</sup> The Women's Convention specifically forbids traditional practices that may subject women to discriminatory violence<sup>910</sup> as well as the trafficking and prostitution of women.<sup>911</sup> The prohibition of gender-based violence is echoed in the non-discrimination provisions of the ACHPR<sup>912</sup> and the ICCPR<sup>913</sup> 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."<sup>914</sup> The Declaration also advises governments to draft national action plans to promote women's safety<sup>915</sup> and to create prevention programs.<sup>916</sup>

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.<sup>917</sup> 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.<sup>918</sup> 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.<sup>919</sup> 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.<sup>920</sup>

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.<sup>921</sup> 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 Botswana 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),<sup>922</sup> which has issued a Code of HIV/AIDS and Employment in SADC,<sup>923</sup> the SADC Health Protocol<sup>924</sup> and the SADC Declaration on HIV/AIDS.<sup>925</sup> SADC has also issued an HIV/AIDS Strategic Framework to guide member states in implementing policies and programs to curb the HIV/AIDS epidemic.<sup>926</sup> In 2003, several southern African NGOs drafted a code for SADC to promote gender equality and reduce women's risk of HIV transmission.<sup>927</sup> 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,<sup>928</sup> 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,<sup>929</sup> the Tunis Declaration on AIDS and the Child in Africa<sup>930</sup> and the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases.<sup>931</sup> 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.<sup>932</sup> 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.<sup>933</sup> 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...".<sup>934</sup>

## 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).<sup>935</sup>

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.<sup>936</sup>

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

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

<sup>815</sup> 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/hivaid/hivaid.pdf>. Accessed September 21, 2006.

<sup>816</sup> "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.

<sup>817</sup> Cross reference country backgrounds.

<sup>818</sup> "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.

<sup>819</sup> 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).

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

<sup>821</sup> Available at: <http://www.ohchr.org/english/law/ccpr.htm>. Accessed March 27, 2007.

<sup>822</sup> Available at: <http://www.ohchr.org/english/law/cescr.htm>. Accessed March 27, 2007.

<sup>823</sup> Available at: <http://www.ohchr.org/english/law/cedaw.htm>. Accessed March 27, 2007.

<sup>824</sup> Available at: <http://www.ohchr.org/english/law/crc.htm>. Accessed March 27, 2007.

<sup>825</sup> Available at: <http://www.hrcr.org/docs/Banjul/afhr.html>. Accessed March 27, 2007.

<sup>826</sup> Available at: <http://www1.umn.edu/humanrts/africa/afchild.htm>. Accessed March 27, 2007.

<sup>827</sup> Available at: [http://www.achpr.org/english/\\_info/women\\_en.html](http://www.achpr.org/english/_info/women_en.html). Accessed March 27, 2007.

<sup>828</sup> *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.

<sup>829</sup> See UN Treaty Body Database. Available at: <http://193.194.138.190/tbs/doc.nsf>. Accessed May 6, 2006.

<sup>830</sup> *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.

<sup>831</sup> *Convention on the Elimination of All Forms of Discrimination against Women*. Art. 18.

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

<sup>833</sup> *Convention on the Rights of the Child*, Art. 44.

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

<sup>835</sup> "African Commission on Human and Peoples' Rights Mandate." Available at: [http://www.achpr.org/english/\\_info/mandate\\_en.html](http://www.achpr.org/english/_info/mandate_en.html). Accessed April 4, 2006.

<sup>836</sup> See [http://www.achpr.org/english/\\_info/status\\_submission\\_en.html](http://www.achpr.org/english/_info/status_submission_en.html). Accessed January 22, 2007.

<sup>837</sup> Concluding Observations: Botswana. D. 50.

<sup>838</sup> Botswana became a UN member on October 17, 1966. Swaziland became a UN member on September 24, 1968.

<sup>839</sup> Brownlie I. "Principles of Public International Law." 4th ed; 1990:15.

<sup>840</sup> Adopted by the UN General Assembly on June 27, 2001.

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

<sup>842</sup> Adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948.

<sup>843</sup> Adopted by the World Conference on Human Rights on June 25, 1993.

<sup>844</sup> Adopted by the UN General Assembly on December 20, 1993.

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

<sup>846</sup> 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](http://www.uneca.org/sros/sa/publications/economic_report_2000/Woman.htm). Accessed September 29, 2006.

<sup>847</sup> Cairo Programme. Chapter IV(a) Empowerment and status of women: Actions.

<sup>848</sup> ICCPR, Article 26.

<sup>849</sup> ICESCR, Article 3.

<sup>850</sup> ICESCR, Article 12.

<sup>851</sup> Women's Convention, Article 11.1(f).

<sup>852</sup> Children's Convention, Article 24(1).

<sup>853</sup> ACRWC, Article 5.

<sup>854</sup> ACHPR, Article 16.

<sup>855</sup> ICESCR, Article 11.

<sup>856</sup> ICCPR, Article 6(1).

<sup>857</sup> ICCPR, Article 19(2).

<sup>858</sup> ACHPR, Article 9.

<sup>859</sup> Children's Convention, Article 17.

<sup>860</sup> 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).

<sup>861</sup> ACRWC, Article 16(1).

<sup>862</sup> Children's Convention, Article 19(1).

<sup>863</sup> Women's Convention, Article 3.

<sup>864</sup> Women's Convention, Article 15(1).

<sup>865</sup> Women's Convention, Article 15(2).

<sup>866</sup> Women's Convention, Article 15(2).

<sup>867</sup> Women's Convention, Article 16(1)(h).

<sup>868</sup> ACHPR, Article 14.

<sup>869</sup> Women's Convention, Article 16(1).

<sup>870</sup> ICCPR, Article 23(3). See also General Comment No. 19, paragraph 8.

<sup>871</sup> Women's Convention, Article 16(1)(e).

<sup>872</sup> Women's Convention, Article 14(2)(b).

<sup>873</sup> Women's Convention, Article 12(1).

<sup>874</sup> Women's Convention, Article 2(f).

<sup>875</sup> General Comment No. 28, paragraph 5.

<sup>876</sup> Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. Article 5.

<sup>877</sup> ACHPR, Article 3 and 19.

<sup>878</sup> ACHPR, Article 18(3).

<sup>879</sup> ACHPR, Article 18(3).

<sup>880</sup> 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.

<sup>881</sup> For example, see ICCPR, Article 2 (1), ICESCR, Article 2(2).

<sup>882</sup> See Commission on Human Rights Resolutions 1995/44 (3 March 1995) and 1196/43 (19 April 1996).

<sup>883</sup> 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](http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2005-84.doc). Accessed October 2, 2006.

<sup>884</sup> 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.

<sup>885</sup> ICESCR, Article 12(1).

<sup>886</sup> 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 of Health." UN Doc. E/C.12/2000/4. August 11, 2000.

<sup>887</sup> General Comment 14(3).

<sup>888</sup> ICESCR General Comment 14(4).

<sup>889</sup> ICESCR General Comment 14(11).

<sup>890</sup> ICESCR General Comment 14(12).



- <sup>891</sup> ICESCR General Comment 14(16).
- <sup>892</sup> ICESCR General Comment 14(20).
- <sup>893</sup> ICESCR General Comment 14(21).
- <sup>894</sup> ICESCR General Comment 14(21).
- <sup>895</sup> 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.
- <sup>896</sup> “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.
- <sup>897</sup> Id., Committee on Economic, Social and Cultural Rights, UN Doc. E/C.12/1999/5, December 5, 1999, para. 12.
- <sup>898</sup> Id., Committee on Economic, Social and Cultural Rights, UN Doc. E/C.12/1999/5, December 5, 1999, para. 13.
- <sup>899</sup> 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.
- <sup>900</sup> ICCPR, Article 6(1).
- <sup>901</sup> General Comment No. 6, paragraph 1.
- <sup>902</sup> General Comment No. 6, paragraph 5.
- <sup>903</sup> ICCPR, Article 19(2).
- <sup>904</sup> General Comment No. 10, paragraph 2 (19th Session, 1983). Available at: [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/2bb2f14bf558182ac12563ed0048df17?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/2bb2f14bf558182ac12563ed0048df17?Opendocument). Accessed October 2, 2006.
- <sup>905</sup> ICESCR, General Comment 12(12)(b).
- <sup>906</sup> 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.
- <sup>907</sup> Report of the Special Rapporteur, paragraph 44.
- <sup>908</sup> Report of the Special Rapporteur, paragraphs 51, 52.
- <sup>909</sup> General Recommendation No. 19. Section 6. 11th Session, 1992.
- <sup>910</sup> Women’s Convention, Article 5.
- <sup>911</sup> Women’s Convention, Article 6.
- <sup>912</sup> ACHPR, Article 18(3).
- <sup>913</sup> ICCPR, Article 2 and 3.
- <sup>914</sup> Declaration on the Elimination of Violence Against Women. Section 11(d).
- <sup>915</sup> Declaration on the Elimination of Violence Against Women. Section 11(e).
- <sup>916</sup> Declaration on the Elimination of Violence Against Women. Section 11(f).
- <sup>917</sup> For a list of guidelines and policy statements, see: <http://www.ohchr.org/english/issues/hiv/document.htm>
- <sup>918</sup> “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).
- <sup>919</sup> 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).
- <sup>920</sup> UNAIDS and OCHR. *HIV/AIDS and Human Rights International Guidelines*. 2002:Guideline 8.
- <sup>921</sup> 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](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.
- <sup>922</sup> SADC Treaty signed August 17, 1992.
- <sup>923</sup> Adopted by SADC Council of Ministers September 1997.
- <sup>924</sup> Adopted by SADC member states August 1999.
- <sup>925</sup> Signed by SADC Heads of State July 2003.
- <sup>926</sup> *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.
- <sup>927</sup> 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.
- <sup>928</sup> Constitutive Act of the African Union. July 11, 2000.
- <sup>929</sup> Adopted July 1996.
- <sup>930</sup> Adopted June 1994.
- <sup>931</sup> Adopted April 27, 2001.
- <sup>932</sup> Abuja Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases.
- <sup>933</sup> Id., Abuja Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Section XII.
- <sup>934</sup> Id., Abuja Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Section III.
- <sup>935</sup> ICESCR, Article 2(1).
- <sup>936</sup> General Comment No. 3, paragraphs 13-14.

# APPENDIX 1: BOTSWANA COMMUNITY SURVEY

Physicians for Human Rights  
Botswana Community Survey  
11.25.04



1. Survey # \_\_\_\_\_ (1-75) ID
- 2a. Date of interview \_\_\_\_ - \_\_\_\_ - 2004 DATE
- 2b. Interviewer code \_\_\_\_\_ (1, 2, 3,...) ICD
- 3a. District code \_\_\_\_\_ DC
- 3b Enumeration area code \_\_\_\_\_ EAC
- 3c. Locality code \_\_\_\_ LOC
4. Participation Outcome: [Circle ONE]  
Survey Complete \_\_\_\_\_ 1 OUTC  
Not Available (2 visits) \_\_\_\_ 2  
Refusal \_\_\_\_\_ 3a=Lack Time; 3b=Fear Reprisal; 3c=Opposed to Study; 3d=Other \_\_\_\_\_  
Unable to Complete \_\_\_\_ 4a=Interrupted; 4b=Emotional; 4c=Safety; 4d= Lack of Privacy; 4e=Other \_\_\_\_\_

## INTRODUCE YOURSELF

Was this household interviewed for BAIS II (Botswana AIDS Impact Survey)? **IF YES, GO TO NEXT HOUSE.**

*I am working with a non-governmental organization called Physicians for Human Rights (PHR) and the University of Botswana. PHR is an organization that promotes the health and human rights of all people. We are conducting a health survey of as many women and men as possible and would like to speak to one member of this household. The person we select to interview must be between 18 and 49 years-old, speak Setswana or English, and be a resident of Botswana. With your permission, I would like to know how many people like that live in this household; then using a statistics table I will randomly select one member of your household and interview them in private.*

## LIST HOUSEHOLD MEMBERS AND CHOOSE PARTICIPANT

### READ CONSENT FORM

5. Consent provided [Circle ONE]:  
No \_\_\_\_\_ 0 CNST  
Yes \_\_\_\_\_ 1

## PARTICIPANT CHARACTERISTICS

- 6a. Sex [Circle ONE]  
Male \_\_\_\_\_ 0 GEN  
Female \_\_\_\_\_ 1
- 6b. I will begin by asking you for some information about yourself. What month and year were you born? \_\_\_\_\_  
\_\_\_\_\_(month/year) AGEN

Appendix 1

6c. *Are you currently married or living with a man/woman with whom you have a sexual relationship?* [Circle ONE]

- Currently married, living with spouse \_\_\_\_\_ 1 MRST
- Currently married, living with other sexual partner \_\_\_\_\_ 2
- Currently married, not living with spouse or any other sexual partner \_\_\_\_\_ 3
- Not married, living with sexual partner \_\_\_\_\_ 4
- Not married, living with non-sexual partner \_\_\_\_\_ 5
- Not married, not living with sexual partner \_\_\_\_\_ 6
- NR \_\_\_\_\_ 99

7. *How many children or other people depend on you for support?* \_\_\_\_\_ (number) NDEP

8. *What is the highest year you completed in school?*

- Not finished primary \_\_\_\_\_ 1 SCHL
- Finished primary \_\_\_\_\_ 2
- Junior certificate \_\_\_\_\_ 3
- High school (form 5) \_\_\_\_\_ 4
- Post-secondary diploma \_\_\_\_\_ 5
- Tertiary \_\_\_\_\_ 6

9. *What is your main occupation?* [Circle ONE]

- Professional, non-health worker \_\_\_ 1 OCUP
- Professional, health worker \_\_\_\_\_ 2
- Clerical or office worker \_\_\_\_\_ 3
- Entrepreneur (public or private) \_\_\_ 4
- Military/Police/Prison \_\_\_\_\_ 5
- Security Guard \_\_\_\_\_ 6
- Mining \_\_\_\_\_ 7
- Farming for Employer \_\_\_\_\_ 8
- Housewife \_\_\_\_\_ 9
- Cleaning Staff (non-domestic) \_\_\_ 10
- Domestic Work \_\_\_\_\_ 11
- Construction \_\_\_\_\_ 12
- Street Vendor \_\_\_\_\_ 13
- Subsistence Farming for Self \_\_\_ 14
- Retired \_\_\_\_\_ 15
- Student \_\_\_\_\_ 16
- Unemployed \_\_\_\_\_ 17
- Other (Specify) \_\_\_\_\_ 18

10. *What is your average monthly household income (total wages/income earned by all living with you)?* (Show List) HINC

- <400 Pula \_\_\_\_\_ 1
- P400-P1,000 \_\_\_\_\_ 2
- >P1,000-P5,000 \_\_\_\_\_ 3
- >P5,000-P10,000 \_\_\_\_\_ 4
- >P10,000-P20,000 \_\_\_\_\_ 5
- >P20,000-P30,000 \_\_\_\_\_ 6
- >P30,000 \_\_\_\_\_ 7

11. *In the **PAST 12 MONTHS**, have you had problems getting enough food to eat?* [Circle ONE]

- No \_\_\_\_\_ 0 FOOD
- Yes \_\_\_\_\_ 1
- DK \_\_\_\_\_ 88
- NR \_\_\_\_\_ 99

12a. *During a typical week, how many days a week do you consume alcohol?* \_\_\_\_\_ (#days/week) ALDA

12b. *On the days that you drink alcohol, how many drinks do you usually have?* \_\_\_\_\_ (#drinks/drinking day) ALDR

Appendix 1

12c. During a typical week, how often do you feel drunk? \_\_\_\_\_ (#times/drunk/week) ALDK

13. How would you describe your overall health? [Circle ONE]

Very Good/Excellent \_\_\_\_\_ 1 HSTAT  
 Good \_\_\_\_\_ 2  
 Fair \_\_\_\_\_ 3  
 Poor \_\_\_\_\_ 4  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

**KNOWLEDGE REGARDING HIV/AIDS**

14. I will now ask you some questions about what you know about HIV and AIDS. Based on what **you** know about AIDS, do **you** think that a person can get HIV or AIDS from any of the following? [READ ALL: Circle YES or NO for 14a-14j] TRANS

Statement	Yes	No	DK	NR
a. Having sexual intercourse without a condom (For the purpose of this survey, sexual intercourse is defined as vaginal or anal sex)	1	0	88	99
b. Using public toilets	1	0	88	99
c. Receiving a blood transfusion	1	0	88	99
d. Sharing used needles or instruments	1	0	88	99
e. Sharing meals with an HIV-positive person	1	0	88	99
f. During childbirth from mother to baby	1	0	88	99
g. During breastfeeding from mother to baby	1	0	88	99
h. Getting bitten by a mosquito	1	0	88	99
i. Shaking hands	1	0	88	99
j. Kissing	1	0	88	99

15. Based on what you know of HIV and AIDS, which of the following do **you** think can help prevent someone from becoming infected with HIV/AIDS? [READ ALL: Circle YES or NO for 15a-15e] PREV

Statement	Yes	No	DK	NR
a. Using a condom correctly every time you have sex	1	0	88	99
b. Using traditional medicine	1	0	88	99
c. Being faithful with one uninfected partner	1	0	88	99
d. Praying	1	0	88	99
e. Not having sex at all	1	0	88	99

**TESTING AVAILABILITY**

16. Do **you** have access to HIV testing (VCT or 'Tebelopele')? [Circle ONE]

No \_\_\_\_\_ 0 ACCT  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

17. Is it possible in **your** village for someone to get a confidential test to find out if they are infected with HIV? By confidential, I mean that no one will know the test result, except you and your doctor, if you don't want them to know? [Circle ONE]

No \_\_\_\_\_ 0 CNFT  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

**TREATMENT AVAILABILITY**

18. Is treatment for AIDS, known as Antiretroviral (ARV) therapy, available in or near **your** village? [Circle ONE]

No \_\_\_\_\_ 0 AVAIL  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

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19. *If you had HIV or AIDS, would ARVs be available to you?* [Circle ONE]

No \_\_\_\_\_ 0 AVAILY  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

20. *Do you think there is less discrimination (bad treatment) of people with HIV/AIDS since ARVs became available in Botswana?* [Circle ONE]

No \_\_\_\_\_ 0 STIGT  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

**HIV TESTING**

21. *I will now ask you some questions about HIV testing. I will **not** ask you to tell me your HIV status. If you were HIV positive, would you tell your sexual partner(s) your status?* [Circle ONE]

No \_\_\_\_\_ 0 TELLP  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

22. *If you were to test positive for HIV and told others your status, do you think any of the following may happen to you?* [READ ALL: Circle YES or NO for 22a-22j] FEARS

Statement	Yes	No	DK	NR
a. Break-up of your marriage or relationship	1	0	88	99
b. Physical abuse by your spouse/partner(s)	1	0	88	99
c. You would lose your job	1	0	88	99
d. You would be treated badly at work or school	1	0	88	99
e. Loss of your friends	1	0	88	99
f. Disowned from or neglected by your family	1	0	88	99
g. Treated badly by health professionals	1	0	88	99
h. Your community(village) would treat you like a social outcast	1	0	88	99
i. Your family would not care for you if you became sick	1	0	88	99
j. Other (please specify)	1	0	88	99

23. *If your spouse or one of your partner(s) was HIV-positive, how would you react to their status? Please let me know whether you agree or disagree with each of the following statements.* [READ ALL: Circle AGREE or DISAGREE for 23a-23h] REACT

Statement	Agree	Disagree	DK	NR
a. You would get a test immediately	1	0	88	99
b. You would kick your spouse/partner out of the home	1	0	88	99
c. You would assume that your spouse/partner was having sex with other people	1	0	88	99
d. You would be grateful that he/she had told you	1	0	88	99
e. You may try to hit or hurt your spouse/partner	1	0	88	99
f. You would use condoms always if you continued to stay with him/her	1	0	88	99
g. You would not have sex anymore with your spouse/partner	1	0	88	99
h. Other (please specify)	1	0	88	99

Appendix 1

**ROUTINE TESTING**

24a. Have you ever heard of routine testing? 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. [Circle ONE]

No \_\_\_\_\_ 0 OPT  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

24b. Now that you know what routine testing means, how much are **you** in favor of routine testing? [Circle ONE]

Extremely \_\_\_\_\_ 1 OPT1  
 Very much \_\_\_\_\_ 2  
 Somewhat \_\_\_\_\_ 3  
 Not really \_\_\_\_\_ 4  
 Not at all \_\_\_\_\_ 5  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

25. We want to ask your opinion of routine testing. I will read you statements, let me know whether you agree or disagree. [READ ALL: Circle YES or NO for 25a-25f] OPTR

Statement	Yes	No	DK	NR
a. Routine testing results in less discrimination (bad treatment) of people who are HIV-positive	1	0	88	99
b. Routine testing makes it easier for people to get tested	1	0	88	99
c. Routine testing makes it harder for people to get tested	1	0	88	99
d. Routine testing leads to more violence against women	1	0	88	99
e. Routine testing leads to less violence against women	1	0	88	99
f. Routine testing helps people get access to ARV treatment	1	0	88	99
g. Routine testing will cause people to avoid seeing the doctor or nurse for fear of being tested	1	0	88	99

26. Have you ever been tested for HIV? [Circle ONE]

No \_\_\_\_\_ 0 [GO TO 27] TEST  
 Yes \_\_\_\_\_ 1 [GO TO 32]  
 DK \_\_\_\_\_ 88 [GO TO 27]  
 NR \_\_\_\_\_ 99 [GO TO 27]

**FOR PEOPLE NOT TESTED**

27. People have different beliefs about their risks for getting HIV. In your opinion, how would you rate your chances of becoming infected with HIV? [Circle ONE]

No risk \_\_\_\_\_ 1 RISK  
 Low risk \_\_\_\_\_ 2  
 Average risk \_\_\_\_\_ 3  
 High risk \_\_\_\_\_ 4  
 100% chance \_\_\_\_\_ 5  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

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28. Which of following prevented you from getting tested? I will read some statements, let me know if you agree or disagree. [READ ALL: Circle YES or NO for 28a-28q] **ROLE**

Statement	Yes	No	DK	NR
a. You were afraid to know if you are HIV- positive	1	0	88	99
b. You were ashamed to be seen at the testing site and believe that it will cause others to treat you badly (stigma)	1	0	88	99
c. Your spouse/partner(s) did not allow you	1	0	88	99
d. You were worried that your spouse/partner(s) would hit you or hurt you if he/she found out you were positive	1	0	88	99
e. You had no reason to believe that you were infected	1	0	88	99
f. You were worried that other people would be told your test results without your permission	1	0	88	99
g. There was no testing available close to where you live or work	1	0	88	99
h. You moved around so often, it was difficult to get tested	1	0	88	99
i. You knew that testing positive for HIV would force you to stop some of your sexual practices	1	0	88	99
j. Other people advised you not to get tested	1	0	88	99
k. Because health care providers would treat you badly if you were HIV-positive	1	0	88	99
l. You did not have access to good quality clinics	1	0	88	99
m. Because you did not trust that the HIV test would give the correct result	1	0	88	99
n. You thought that there is no treatment for HIV that would be available to you so there would be no point in having a test.	1	0	88	99
o. You were more worried about lack of food than about getting tested	1	0	88	99
p. You were worried that you would not have social supports	1	0	88	99
q. Other (please specify)	1	0	88	99

29. What was the most important reason that made you not get tested? \_\_\_\_\_ (# from 28a-28q; if OTHER, record response in English (specify) \_\_\_\_\_) **PREVI**

30. Do you intend to get tested for HIV within the **NEXT SIX MONTHS**? [Circle ONE]

No \_\_\_\_\_ 0 PLAN  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

31a. Which of the following would help convince **YOU** to get tested? [READ ALL: Circle YES or NO for 31a-31m] **CONV**

Statement	Yes	No	DK	NR
a. If you were tested together with your spouse or main partner	1	0	88	99
b. If you had more trust in your doctor	1	0	88	99
c. If you knew that no one would find out your test results without your permission	1	0	88	99
d. If there was better counseling at the testing sites	1	0	88	99
e. If your spouse/partner would support your decision to get tested	1	0	88	99
f. If you knew that you could get treatment for HIV/AIDS (ARVs)	1	0	88	99
g. If health care providers would treat you well if you were HIV-positive	1	0	88	99
h. If there were better health care facilities near you	1	0	88	99
i. If you could be tested and get the test results on the same day	1	0	88	99
j. If there were testing sites closer to your home or work	1	0	88	99
k. If there were a National HIV Testing week when leaders in society such as politicians, clergy, chiefs, celebrities and sports stars would get tested	1	0	88	99
l. If you had enough food to eat it would be easier for you to think about getting tested	1	0	88	99
m. Other (please specify)	1	0	88	99

31n. What is the most important thing that would convince you to get tested? \_\_\_\_\_ (# from 31a-31m; if OTHER, record response in English (specify) \_\_\_\_\_) **CONVM [NOW GO TO 36]**

Appendix 1

**FOR PEOPLE WHO HAVE BEEN TESTED**

32a. *Were you ever tested as part of routine testing?* [Circle ONE]

No \_\_\_\_\_ 0 PLAN  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

**For people who were tested more than once, responses for 32b-35 refer to the MOST RECENT time they were tested.**

32b. *The following questions on HIV testing refer only to the MOST RECENT time you were tested. When were you last tested for HIV?* \_\_\_\_\_ (month/year) LASTT

32c. *Where were you tested?* [Circle ONE]

Public Hospital \_\_\_\_\_ 1 WHERE  
 Private Hospital \_\_\_\_\_ 2  
 TB Clinic \_\_\_\_\_ 3  
 Pre-natal Clinic \_\_\_\_\_ 4  
 Other Clinic \_\_\_\_\_ 5  
 NGO \_\_\_\_\_ 6  
 Private Laboratory \_\_\_\_\_ 7  
 VCT Center \_\_\_\_\_ 8  
 Other (specify) \_\_\_\_\_ 9  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

32d. *Did you make the decision to get the HIV test?* [Circle ONE]

No \_\_\_\_\_ 0 WILL T  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

32e. *Did you feel you could say no to getting the HIV test?* [Circle ONE]

No \_\_\_\_\_ 0 REFUS  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

32f. *Did others treat you badly because you got tested?* [Circle ONE]

No \_\_\_\_\_ 0 DISCT  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

32g. *Do you regret getting tested?* [Circle ONE]

No \_\_\_\_\_ 0 REGR  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

32h. *Did you find out the results of your test?* [Circle ONE]

No \_\_\_\_\_ 0 REST  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99



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32i. Did anybody find out your HIV test results from the testing center or your doctor without your permission? [Circle ONE]

No \_\_\_\_\_ 0 PERMI  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

32j. Did your partner know you were tested?

No \_\_\_\_\_ 0 PKTS [GO TO 32l]  
Yes \_\_\_\_\_ 1 [GO TO 32k]  
No partner \_\_\_\_\_ 2 [GO TO 32l]  
DK \_\_\_\_\_ 88 [GO TO 32l]  
NR \_\_\_\_\_ 99 [GO TO 32l]

32k. Did your partner hit you, kick you, hurt you in anyway, or threaten you because you were tested? [Circle ONE]

No \_\_\_\_\_ 0 TESTV  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

32l. Did your experience with HIV testing lead you to encourage others to get tested? [Circle ONE]

No \_\_\_\_\_ 0 CONVT  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

**PRE TEST COUNSELING**

33a. Did you receive counseling **before** being tested for HIV? [Circle ONE]

No \_\_\_\_\_ 0 COUNB  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

**POST-TEST COUNSELING**

33b. Did you receive counseling **after** the HIV test? [Circle ONE]

No \_\_\_\_\_ 0 COUNA  
Yes \_\_\_\_\_ 1  
Did not go back for results \_\_\_\_\_ 2  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

Appendix 1

34. What made **you** decide to have an HIV test? (READ ALL: Circle YES or NO for 34a-34r) FACTT

Statement	Yes	No	DK	NR
a. You did not decide, the test was done without your consent [if YES, GO TO 36]	1	0	88	99
b. The doctor/nurse recommended it to you	1	0	88	99
c. You knew that treatment (ARVs) was available	1	0	88	99
d. You were sick	1	0	88	99
e. You knew that the test result would be confidential (that no one would find out the test result if you did not want them to know)	1	0	88	99
f. Your partner, family or friends advised you to have a test	1	0	88	99
g. TV or radio messages	1	0	88	99
h. People at church advised you to have a test	1	0	88	99
i. It was necessary for your job	1	0	88	99
j. It was necessary to donate blood	1	0	88	99
k. The prenatal (PMTCT) program advised you or your partner to have a test	1	0	88	99
l. It was required for military service	1	0	88	99
m. You were worried about a sexual contact	1	0	88	99
n. You heard that you can take the test and get the results in the same day	1	0	88	99
o. It was necessary to apply for health insurance or life insurance	1	0	88	99
p. You were encouraged and supported by someone who had been tested	1	0	88	99
q. Chiefs, religious leaders or political leaders got tested and this convinced you	1	0	88	99
r. Other (please specify)	1	0	88	99

35. What was the most important reason that you got tested? \_\_\_\_\_ (# from 34b-34r; if OTHER, record response in English (specify) \_\_\_\_\_) FACTT

**STIGMA AND ATTITUDES TOWARDS PLWA**

36a. I will now ask you some questions about people living with HIV or AIDS. Would you be willing to share a meal with a person you believed had HIV or AIDS? [Circle ONE]

No \_\_\_\_\_ 0 SHAR  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

36b. If a relative of yours became ill with HIV/ AIDS, would you be willing to care for him or her in your household? [Circle ONE]

No \_\_\_\_\_ 0 RELM  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

36c. If a student has HIV but is not sick, should he or she be allowed to continue attending school? [Circle ONE]

No \_\_\_\_\_ 0 SCHLS  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

36d. If a teacher has HIV but is not sick, should he or she be allowed to continue teaching in school? [Circle ONE]

No \_\_\_\_\_ 0 SCHLT  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

Appendix 1

36e. *If you believed a shopkeeper or food seller had the AIDS virus, would you buy food from him or her?* [Circle ONE]

No \_\_\_\_\_ 0 SHOP  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

36f. *If a member of your family became ill with HIV/AIDS, would you want it to remain secret?* [Circle ONE]

No \_\_\_\_\_ 0 FSEC  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

37. *Do you think that people with HIV/AIDS should have the same rights as people who do not have the disease?* [Circle ONE]

No \_\_\_\_\_ 0 RGHT  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

**HEALTH CARE EXPERIENCES**

38a. *I will now ask you about your use of health care services. Where do you get most of your health care?* [Circle ONE]

Public clinic \_\_\_\_\_ 1 HEALT  
 Private clinic \_\_\_\_\_ 2  
 Hospital \_\_\_\_\_ 3  
 Traditional healer \_\_\_\_\_ 4  
 Other (specify): \_\_\_\_\_ 5

38b. *How often in the PAST 12 MONTHS did you see a medical doctor?* [Circle ONE]

Never \_\_\_\_\_ 1 OFTEN  
 1-2 times \_\_\_\_\_ 2  
 3-4 times \_\_\_\_\_ 3  
 More than 4 times \_\_\_\_\_ 4

38c. *Do you have access to good quality medical services?* [Circle ONE]

No \_\_\_\_\_ 0 ACCS  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

39. *Have you experienced any of the following from a doctor or nurse over the PAST 12 MONTHS?* [READ ALL: Circle YES or NO for 39a-39e] HPABS

Statement	Yes	No	DK	NR
a. Denial of care or treatment	1	0	88	99
b. Denial of admission to a hospital	1	0	88	99
c. Verbal mistreatment or insults	1	0	88	99
d. Usually treated with respect and dignity	1	0	88	99
e. Other mistreatment (specify)	1	0	88	99

Appendix 1

**SEXUAL PRACTICES**

*As you may know, a person may get the AIDS virus through sexual activity. To help prevent the spread of HIV/AIDS, we need to know more about the different types of sexual practices people engage in. Some of these questions need to be rather detailed and personal. Since this survey is confidential, no one will know your answers. I would appreciate your cooperation and honesty in answering these questions.*

40. Have you **EVER** had sexual intercourse? For the purpose of this survey, sexual intercourse is defined as vaginal or anal sex with either a man or a woman. [Circle ONE]

No	_____	0	[GO TO 44, THEN TO 48] EVER
Yes	_____	1	[FOR ALL OTHER, GO TO 41]
DK	_____	88	
NR	_____	99	

41. In your lifetime, have you ever been forced to have sex when you did not want to? [Circle ONE]

No	_____	0	FFSX
Yes	_____	1	
DK	_____	88	
NR	_____	99	

42. The number of sexual partners people have had differs a lot from person to person. Some people report having had one sexual partner, some two partners, and others many partners. How many sexual partners have you had in the **PAST 12 MONTHS**? [Circle ONE]

None	_____	1	[GO TO 44, THEN TO 48] NUMB
One	_____	2	[FOR ALL OTHER, GO TO 43]
Two	_____	3	
Three	_____	4	
Other (specify)	_____	5	

43. How many sexual partners have you had in the **LAST MONTH**? [Circle ONE]

None	_____	1	[GO TO 44] NUMBLM
One	_____	2	[FOR ALL OTHER, GO TO 45a]
Two	_____	3	
Three	_____	4	
Other (specify)	_____	5	

44. Do you practice abstinence as a way to prevent yourself or others from becoming infected with HIV/AIDS? [Circle ONE]

No	_____	0	ABST
Yes	_____	1	
DK	_____	88	
NR	_____	99	

**FOR SEXUALLY ACTIVE PARTICIPANTS ONLY**

45a. Who generally decides when you have sex? [READ ALL: Circle ONE]

You	_____	1	DCES
You and your partner(s) equally	_____	2	
Your partner(s)	_____	3	
DK	_____	88	
NR	_____	99	

45b. Thinking about all the times you had sex in the **PAST 12 MONTHS**, how often did you drink alcohol before having sex? [READ ALL: Circle ONE]

Very infrequently or never	_____	1	ALCS
Less than half of the time	_____	2	
More than half of the time	_____	3	
Very frequently or always	_____	4	
DK	_____	88	
NR	_____	99	

Appendix 1

45c. *Have you had sex with a commercial sex worker during the PAST 12 MONTHS?* [Circle ONE] COMSX

No \_\_\_\_\_ 0  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

45d. *During the PAST 12 MONTHS, have you given another person money, food, or other resources in exchange for sex?* [Circle ONE]

No \_\_\_\_\_ 0 PAID  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

45e. *During the PAST 12 MONTHS, has another person given you money, food, or other resources in exchange for sex?* [Circle ONE]

No \_\_\_\_\_ 0 EXCH  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

45f. *Were you forced to have sex against your will over the PAST 12 MONTHS?* [Circle ONE]

No \_\_\_\_\_ 0  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

45g. *Did you have sex with others when they did not want to over the PAST 12 MONTHS?* [Circle ONE] FOSEX

No \_\_\_\_\_ 0  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

45h. *To the best of your knowledge, have your sexual partners had sex with anyone else besides you over the PAST 12 MONTHS?* [Circle ONE]

No \_\_\_\_\_ 0 PMONO  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

45i. *In the PAST 12 MONTHS, have you had a sexual relationship with someone 10 or more years older than you?* [Circle ONE]

No \_\_\_\_\_ 0 INTGN  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

45j. *In the PAST 12 MONTHS have you had a sexual relationship with someone 10 or more years younger than you?* [Circle ONE]

No \_\_\_\_\_ 0 INTGN1  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

45k. *We need to ask you about the sex of your sexual partner because some sexual practices can contribute to the spread of HIV. The sex of your sexual partners over the PAST 12 MONTHS includes:* [READ ALL: Circle ONE]

Men Only \_\_\_\_\_ 1 SEX  
 Women Only \_\_\_\_\_ 2  
 Usually Men \_\_\_\_\_ 3  
 Usually Women \_\_\_\_\_ 4  
 Both men and women \_\_\_\_\_ 5  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

Appendix 1

**REGARDING CONDOM USE**

46a. Now I will ask you about condom use. Have you and your spouse/primary partner discussed condom use? (For the purpose of this survey, primary partner means your partner in an exclusive sexual relationship or the person who is most often your sexual partner.) [Circle ONE]

No \_\_\_\_\_ 0 CONDD  
 Yes \_\_\_\_\_ 1  
 No Partner \_\_\_\_\_ 2  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

46b. Thinking about all of the times you had sex over the **PAST 12 MONTHS**, how often did you use a condom? [Circle ONE]

All sexual encounters \_\_\_\_\_ 1 CONDT  
 Most sexual encounters \_\_\_\_\_ 2  
 Half of sexual encounters \_\_\_\_\_ 3  
 A few sexual encounters \_\_\_\_\_ 4  
 Never \_\_\_\_\_ 5 [GO TO 46d]  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

46c. In your sexual encounters, who typically decides whether you use a condom? [Circle ONE]

You only \_\_\_\_\_ 1 DECI  
 Mostly you \_\_\_\_\_ 2  
 You and your partner(s) equally \_\_\_\_\_ 3  
 Mostly partner(s) \_\_\_\_\_ 4  
 Partner(s) only \_\_\_\_\_ 5  
 Other (please specify) \_\_\_\_\_ 6

46d. Have you or your sexual partner(s) used the female condom? [Circle ONE]

No \_\_\_\_\_ 0 FCND  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

46e. How many times did you have sex **without** a condom over the **PAST MONTH** with someone who is **not** your spouse or primary partner? \_\_\_\_\_ (WRITE IN number of times) UNPRO

46f. Was there anytime that you did **not** use a condom over the **PAST 12 MONTHS**? [Circle ONE]

No \_\_\_\_\_ 0 [GO TO 48] NCOND  
 Yes \_\_\_\_\_ 1 [GO TO 47]  
 DK \_\_\_\_\_ 88 [GO TO 48]  
 NR \_\_\_\_\_ 99 [GO TO 48]

47. Why do you **not** use a condom with each sexual encounter? [READ ALL: Circle YES or NO for 47a-47k] CONDW

Statement	Yes	No	DK	NR
a. Condoms are inconvenient to use	1	0	88	99
b. It decreases sexual pleasure	1	0	88	99
c. Your spouse/partner(s) does not want to	1	0	88	99
d. You have no control over whether your spouse/ partner(s) uses a condom	1	0	88	99
e. You or your spouse/partner(s) are trying to get pregnant	1	0	88	99
f. You cannot afford condoms	1	0	88	99
g. Condoms are not available in your area	1	0	88	99
h. You do not know how to use a condom	1	0	88	99
i. Condoms do not prevent HIV/AIDS	1	0	88	99
j. You use other birth control methods	1	0	88	99
k. Other (please specify)	1	0	88	99

Appendix 1

**FOR ALL PARTICIPANTS**

48a. If your partner wants to use a condom, do you think this means that they are having sex with other people? [Circle ONE]

No \_\_\_\_\_ 0 CONDS  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

48b. If your partner wants to use a condom, do you think this means that they don't trust you? [Circle ONE]

No \_\_\_\_\_ 0 COND T  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

**GENDER ROLES**

49. I will now read you some statements about your beliefs about the different roles of men and women in society. Please let me know whether you agree or disagree with each of the following. [READ ALL: Circle AGREE or DISAGREE for 49a-49o]

GEND

Statement	Agree	Disagree	DK	NR
a. It is OK for men to have more than one partner at one time	1	0	88	99
b. It is OK for women to have more than one partner at one time	1	0	88	99
c. A women must prove her fertility before she can marry	1	0	88	99
d. A woman should remain a virgin until she marries	1	0	88	99
e. A man should remain a virgin until he marries	1	0	88	99
f. A man must prove his fertility before he can marry	1	0	88	99
g. It is a wife's duty to have sex with her husband even if she does not want to	1	0	88	99
h. It is more important for a woman to respect her spouse/partner than it is for a man to respect his spouse/partner	1	0	88	99
i. A man may beat his spouse/partner if she disobeys him	1	0	88	99
j. A man may beat his spouse/partner if he believes she is having sex with other men	1	0	88	99
k. Women should be legally entitled to inherit their husband's property/estate	1	0	88	99
l. Women should have the same legal rights as men	1	0	88	99
m. You support the practice of men paying a bride price in order to marry a woman	1	0	88	99
n. It is more important that boys get an education than that girls do	1	0	88	99
o. It is more important for women to get HIV tested than for men to get tested	1	0	88	99

50. Women get HIV more often than men do in Botswana. Why do you think this is? I will read you a number of reasons and please let me know if you agree or disagree with each one. [READ ALL: Circle YES or NO for 50a-50o] VULNW

Statement	Agree	Disagree	DK	NR
a. Women cannot say no to sex	1	0	88	99
b. Men refuse to use a condom	1	0	88	99
c. Women do not have enough power within relationships with their partner	1	0	88	99
d. Women cannot insist on using condoms if their partner does not want to	1	0	88	99
e. Domestic violence/rape	1	0	88	99
f. Relationships between young women and older men are common	1	0	88	99
g. Women have multiple sexual partners	1	0	88	99
h. Men have multiple partners and put women at risk	1	0	88	99
i. Women exchange sex for food, money or other resources	1	0	88	99
j. Women do not have equal rights to men	1	0	88	99
k. Women are valued less than men in society	1	0	88	99
l. Women are dependent upon men economically	1	0	88	99
m. Men drink too much alcohol which makes them act irresponsibly	1	0	88	99
n. Women drink too much alcohol which makes them act irresponsibly	1	0	88	99
o. Other (specify)	1	0	88	99

Appendix 1

51. *What is the most important reason that women are at high risk for HIV?* \_\_\_\_\_ (# from 50a-50o; if OTHER, record response in English (specify) \_\_\_\_\_) VULWO

52. *What is the most important reason that men are at high risk for HIV?* \_\_\_\_\_ (# from 50a-50o; if OTHER, record response in English (specify) \_\_\_\_\_) VULMN

**HIV/AIDS IN BOTSWANA**

53. *Now I will ask you about what more can be done about HIV/AIDS in Botswana. In your opinion, what could be done to help more people get **treatment** (ARVs) for HIV/AIDS in Botswana?* [DO NOT READ: CIRCLE ALL THAT APPLY] MRTX

- Improving education about treatment \_\_\_\_\_ 1
- Encouraging more people to get tested \_\_\_\_\_ 2
- Increasing confidentiality at treatment centers \_\_\_\_\_ 3
- Decreasing time delays at the treatment centers \_\_\_\_\_ 4
- Providing assistance with food \_\_\_\_\_ 5
- If doctors/nurses would treat people with HIV better \_\_\_\_\_ 6
- If people had access to better clinics and hospitals \_\_\_\_\_ 7
- If there were more HIV/AIDS support groups \_\_\_\_\_ 8
- Other (specify) \_\_\_\_\_ 9

54. *Have political leaders done enough to address the problem of HIV/AIDS in Botswana?* [Circle ONE]

- No \_\_\_\_\_ 0 LEADP
- Yes \_\_\_\_\_ 1
- DK \_\_\_\_\_ 88
- NR \_\_\_\_\_ 99

55. *Has your village chief done enough to address the problem of HIV/AIDS?* [Circle ONE]

- No \_\_\_\_\_ 0 LEADC
- Yes \_\_\_\_\_ 1
- NA (no chief) \_\_\_\_\_ 2
- DK \_\_\_\_\_ 88
- NR \_\_\_\_\_ 99

56. *Have your church leaders done enough to address the problem of HIV/AIDS?* [Circle ONE]

- No \_\_\_\_\_ 0 LEADR
- Yes \_\_\_\_\_ 1
- NA (no church leaders) \_\_\_\_\_ 2
- DK \_\_\_\_\_ 88
- NR \_\_\_\_\_ 99



Appendix 1

**ASSESSMENT FOR MAJOR DEPRESSION: Hopkin’s Symptom Check-List for Depression**

57. The following are symptoms or problems that people sometimes have. Please let us know the extent to which each of the following symptoms has bothered you or distressed you in the **LAST WEEK**, including today. [READ ALL: Select ONE ANSWER from options 1 to 4 for questions 57a-57o] DEPR

Statement	Not at all	A little	Quite a bit	Extremely	NR
a. Feeling low in energy, slowed down	1	2	3	4	99
b. Blaming yourself for things	1	2	3	4	99
c. Crying easily	1	2	3	4	99
d. Loss of sexual interest or pleasure	1	2	3	4	99
e. Poor appetite	1	2	3	4	99
f. Difficulty falling asleep, staying asleep	1	2	3	4	99
g. Feeling hopeless about the future	1	2	3	4	99
h. Feeling down or blue	1	2	3	4	99
i. Feeling lonely	1	2	3	4	99
j. Thoughts of ending your life	1	2	3	4	99
k. Feelings of being trapped or caught	1	2	3	4	99
l. Worry too much about things	1	2	3	4	99
m. Feeling no interest in things	1	2	3	4	99
n. Feeling everything is an effort	1	2	3	4	99
o. Feeling worthless	1	2	3	4	99

**IF you circled 2-4 for 57j, GO TO 58; if not, GO TO 60.**

58. Based on your response, I am concerned about your safety. I would like you to speak with one of the doctors or nurses working on this study because they may be able to help you. While you are free to refuse, I want you to know that the doctor or nurse will not tell anyone else anything that you tell them without your permission. This health worker would like to help make sure that you are safe and that you know where to go to get help. Would you like to speak with a health worker?

- No \_\_\_\_\_ 0 [GO TO 59] SUICP
- Yes \_\_\_\_\_ 1 [GO TO 60]
- DK \_\_\_\_\_ 88 [GO TO 59]
- NR \_\_\_\_\_ 99 [GO TO 59]

59. I would like to provide you with some information on nearby hospitals or clinics that can help people who have thoughts about hurting themselves. Can I give you some information on where you can get help?

- No \_\_\_\_\_ 0 SUICI
- Yes \_\_\_\_\_ 1
- DK \_\_\_\_\_ 88
- NR \_\_\_\_\_ 99

60. If you would like any information on the availability of HIV testing in your community please let me know. Would you like some information?

- No \_\_\_\_\_ 0 INFO
- Yes, information provided \_\_\_\_\_ 1

61. If you would like information on how to prevent HIV transmission or on treatment for AIDS, I have a pamphlet with some information for you. Would you like a pamphlet?

- No \_\_\_\_\_ 0
- Yes, information provided \_\_\_\_\_ 1 INFOP

**FOR ALL PARTICIPANTS**

62. In Botswana, people sometimes don't feel safe at home because they experience domestic violence. Domestic violence means that their partners hurt them (hit or kick them), threaten them or force them to have sex when they don't want to. As part of our study, we would like to let you know who to contact if you or someone that you know does not feel safe at home. These organizations are here to protect people who are being hurt. We also want you to know that in Botswana every citizen has the right to report domestic violence to the police. Would you like information on how you can contact these organizations?

- No \_\_\_\_\_ 0 FORCI
- Yes, information provided \_\_\_\_\_ 1

# APPENDIX 2: BOTSWANA PLWA INTERVIEW

Physicians for Human Rights  
Botswana PLWA Interview  
10.02.2004

<b>1</b>	<b>DEMOGRAPHICS</b>
	a) Sex
	b) Age
	c) Marital Status
	d) Occupation
	e) Education
	f) Geography of residence [rural, urban, migration/mobility]
<b>2</b>	<b>How do you believe you became infected with HIV?</b>
	a) What were some of the factors that made it difficult for you to prevent your infection?
	a) What are your thoughts around: - condom use? - having sex with only one partner? - abstinence as a way to prevent HIV?
<b>3</b>	<b>What were your experiences around HIV testing?</b>
	a) How did you find out you were HIV-positive?
	b) Were you tested voluntarily (in other words, did you feel you had the option to refuse the test)?
	c) If so, what made you decide to get tested?
	d) Where were you tested?
	e) What were some of the barriers to testing before you decided to get tested? Was stigma a problem? Was mobility a problem?
	f) What were some of positive and negative consequences of testing?
	g) Did you get pre-test and/or post-test counseling at your testing site? If so, did that help you come to terms with your diagnosis of HIV?
	h) Did anyone tell you how to get access to AIDS treatment, or work out a plan for you to get treatment at the testing site?
	i) What was your reaction when you found out you were HIV positive?
	j) Is access to testing a big problem in Botswana? If so, elaborate?
	k) Has there been adequate community leadership surrounding HIV testing in your community? Please elaborate.
<b>4</b>	<b>In what ways do the barriers to testing differ for men and women?</b>
	a) What are some of the barriers to testing specific to women?
	b) What can be done in your community or elsewhere to encourage more women to get tested?
	c) What are some of the barriers to testing specific to men? What can be done in your community or elsewhere to help more men get tested?
<b>5</b>	<b>What do you think about the new policy of routine testing in Botswana?</b>
	d) What do you know about routine testing?

**Physicians for Human Rights  
Botswana PLWA Interview  
10.02.2004**

	<p>e) Do you think it is perceived as voluntary/coerced?</p> <p>f) Do you support this policy? Please explain.</p> <p>g) Does it increase or decrease barriers to testing?  - How so?  - Do you think it has increased or decreased the stigma around HIV/AIDS?  Please explain</p> <p>h) What are your recommendations on how to improve routine testing?  - Is lack of pre- and post-test counseling a problem?  - Was it a problem for you?</p>
<b>6</b>	<p><b>Tell me about your experiences related to disclosure of your HIV status to others.</b></p> <p>a) Who did you disclose to?  - Did you disclose to your sexual partner(s)?</p> <p>b) Did anyone else disclose your status to others without your permission?</p> <p>c) What were some of the positive or negative consequences of disclosure?  - Probe for violence, shamed in home/community, convinced others to get tested, emotional relief, support from family.</p>
<b>7</b>	<p><b>What have been your experiences of discrimination or stigma related to your HIV status?</b></p> <p>a) Have there been any changes in your relationships, work environment, or friendships because of your HIV status? If so, please elaborate.</p> <p>b) Have you experienced any poor treatment at work, home, hospitals/clinics, or in other public settings? If so, please explain.</p> <p>c) Do you think HIV-related stigma and discrimination differ for men and women? If so, how?</p> <p>d) What do you think can be done to decrease the stigma surrounding HIV in your community or elsewhere in Botswana?</p> <p>e) Do you have any social support to help you cope with the challenges of living with HIV and AIDS?</p> <p>f) How important is your network of social supports (family, friends, co-workers, etc.) in dealing with problems you may have experienced since you were HIV positive?  - Probe for effects of social supports on stigma, symptoms of depression, economic problems, access to treatment etc..</p>
<b>8</b>	<p><b>Tell me about your thoughts and experiences surrounding AIDS treatment (antiretroviral treatment)?</b></p> <p>a) Are you enrolled in BNTP?</p> <p>b) Are you on HAART treatment?</p> <p>c) If not, why not? What factors have prevented you from using HAART?  - Was mobility/moving around a barrier to treatment?  - Was stigma a problem?</p> <p>d) If yes, what have been your experiences with the treatment? What have been some of the challenges? What has been positive about being on treatment?</p>
<b>9</b>	<p><b>Do you think the barriers to treatment differ for men and women? If so, how?</b></p>

**Physicians for Human Rights  
Botswana PLWA Interview  
10.02.2004**

	<p>a) What are some of the barriers to treatment specific to women?</p> <p>b) What do you think would help more women get treated?</p> <p>c) What are some of the barriers to treatment specific to men?</p> <p>d) What do you think would help more men get treated?</p>
<b>10</b>	<p><b>Some of the factors that make people vulnerable to HIV differ between men and women. What do you think are some of the factors that make <u>women</u> particularly vulnerable to HIV in this country?</b></p> <p>a) Is violence against women (rape/physical abuse) a big problem in your community? Please elaborate.</p> <p>b) Do you think women are valued less than men in society? If so, in what ways?</p> <p>c) Do you think women have less power than men in Botswana? If so, in what ways?</p> <p>d) How do these unequal gender dynamics contribute to the spread of HIV?</p> <p>e) What can be done to help women protect themselves against becoming infected with HIV?</p> <p>f) For women informants: Do you think any of these factors played a role in you becoming infected with HIV?</p> <p><u>Other domains to probe:</u></p> <ul style="list-style-type: none"> <li>-negotiating power in sexual relationships</li> <li>-barriers or facilitators to ending or leaving abusive situations</li> <li>-need to prove fertility before marriage</li> <li>-intergenerational sex</li> <li>-exchanging sex for money or other resources</li> <li>-access to resources/dependence on someone else/family or partner to provide</li> <li>-any care/assistance/support receiving other than medical (home, legal, etc..)</li> </ul>
<b>11</b>	<p><b>What do you think are some of the factors that make <u>men</u> particularly vulnerable to HIV infection in this country?</b></p> <p>a) Tell me about what it means to be a “man” in Botswana? What are society’s expectations for men, particularly with respect to sexual behavior? Do these expectations make it difficult for men to take the necessary measures to prevent HIV transmission? If so, elaborate.</p> <p>b) Is alcohol use (and alcohol use associated with sex) common among men? How does alcohol use contribute to HIV transmission?</p> <p>c) What do you think are some of the barriers to using condoms for men?</p> <p>d) What can be done to encourage men to get involved in AIDS prevention efforts, and to take the steps necessary to prevent HIV infection?</p> <p>e) <u>For men:</u> Do you think expectations for you as a “man” played a role in you becoming infected? If so elaborate.</p>
<b>12</b>	<p><b>Has your HIV status changed your sexual behavior?</b></p> <p>a) Have there been changes in the number of your partners?</p>

**Physicians for Human Rights  
Botswana PLWA Interview  
10.02.2004**

	<p>b) Have you changed your patterns of condom use?</p> <p>c) Do feel that you can change your sexual behavior with your partner(s)? If not, what prevents you?</p>
<b>13</b>	<p><b>Has your HIV status led to other significant changes in your life or in your relationships with others?</b></p> <p>a) Have you talked to your peers or family about preventing HIV? About stigma and discrimination?</p> <p>b) Have you become involved in organizations or advocacy for PLWHA or around HIV/AIDS prevention? Have you become involved in issues of women's rights? Have you joined any support groups for men or women related to HIV/AIDS?</p> <p>c) Have you changed your behavior towards your partner(s) in other ways not related to sexual practices? Please elaborate.</p>
<b>14</b>	<p><b>What has been your experience with health care providers with respect to testing or treatment of HIV?</b></p> <p>a) Where do you get most of your care: modern doctors, traditional doctors or both?</p> <p>b) What do you think about the quality of care you have received in modern health facilities?</p> <p>c) What have been some of the positive aspects of your interactions with modern health providers? What have been some of the problems with your interactions with modern health providers? Have your modern providers treated you with respect and dignity? What role have modern providers played in terms of helping you treat and cope with HIV/AIDS?</p> <p>d) What have been some of the positive aspects of your interactions with traditional healers? What have been some of the problems with your interactions with traditional healers? Have traditional healers treated you with respect and dignity? What role have traditional healers played in terms of helping you treat and cope with HIV/AIDS?</p> <p>e) What do you think modern doctors can do to help encourage people to be tested or treated for HIV?</p> <p>f) What do you think traditional healers can do to help people get tested or treated for HIV? Other probes:          - What have you learned from modern doctors about what causes HIV/AIDS?          -What have you learned from them about how you can treat HIV/AIDS?          -What have you learned from traditional healers about what causes HIV/AIDS?          -What have you learned from them about how you can treat HIV/AIDS?</p>
<b>15</b>	<p><b>How well have community leaders addressed the HIV/AIDS problem in your community? Please explain.</b></p>

# APPENDIX 3: BOTSWANA KEY INFORMANT INTERVIEW

Physicians for Human Rights  
Botswana Key Informant Interview  
10/02/04

1	<b>OCCUPATION/POSITION</b>
2	<b>What do you think are the key obstacles towards controlling the HIV/AIDS epidemic in Botswana?</b>
3	<p><b>What do you think are the most significant barriers to HIV testing in Botswana?</b></p> <p>a) To what extent is HIV/AIDS stigma a barrier?</p> <p>b) In what ways do the barriers to testing differ for men and women?</p> <p>c) Which groups are hardest to reach with regard to testing? (e.g., related to age, gender, sexuality, region, socio-economic status, education, mental illness)</p> <p>d) Is access to testing still a problem in some regions in Botswana?</p> <p>e) Is gender violence related to testing a significant problem? Please elaborate.</p> <p>f) What are some of the community-based programs and policies that aim to mobilize people for testing?</p> <p>g) What are your recommendations for decreasing these barriers to testing for both men and women?</p>
4	<p><b>What are your thoughts about the new policy of routine testing in Botswana?</b></p> <p>a) Is the implementation of this policy widespread? Can you tell us more about how it is being implemented?</p> <p>b) Do most patients still receive pre- and post-test counseling when they are tested as part of routine testing?</p> <p>c) In your opinion, what have been some of the positive impacts of this policy? - Has it decreased barriers to testing for both men and women? - Has it led to a decrease in HIV/AIDS related stigma?</p> <p>d) Has this policy had any negative impacts? If so, please elaborate. - Is it perceived as coercive by some patients? Is it always truly voluntary? - Are the test results divulged to anyone other than the patient? - Is there an increase in violence against women related to testing?</p> <p>e) What are your recommendations on how to improve routine testing?</p>
5	<p><b>What type of stigma and discrimination do PLWAs experience at home, at work, at schools and elsewhere in their communities?</b></p> <p>a) What policies/laws are in place to protect the rights of PLWAs?</p> <p>b) Do you think HIV-related stigma and discrimination differ for men and women? If so, how? Is violence towards HIV-positive women a big problem?</p> <p>c) What programs are in place to address HIV/AIDS-related stigma and discrimination in Botswana at both the community and national levels?</p> <p>d) What else do you think could/should be done to decrease the stigma surrounding HIV in Botswana?</p>
6	<p><b>What are the key barriers to HAART utilization among HIV-positive men and women in Botswana?</b></p> <p>a) Do you think there are many HIV-positive people in Botswana who are eligible for treatment and are not receiving it? If so, what structural, social and cultural barriers do you think are preventing people from initiating HAART? Are</p>

**Physicians for Human Rights  
Botswana Key Informant Interview  
10/02/04**

	<p>treatment delays at the BNTP a big problem?</p> <p>b) Do barriers to ARV treatment differ for men and women? If so, how?</p> <p>c) What do you think could be done to minimize these barriers to initiating HAART?</p> <p>d) Once people have initiated HAART, are treatment discontinuation and/or treatment non-adherence significant problems? If so, please elaborate.</p>
<b>7</b>	<p><b>What do you think are some of the factors that make <u>women</u> particularly vulnerable to HIV in this country?</b></p> <p>a) What role does rape/physical abuse of women play in the Botswana AIDS epidemic?</p> <p>b) To what extent does women's unequal status to men under customary law contribute to the spread of HIV in Botswana?</p> <p>c) What type of programs are in place at the community and national level to address the factors that make women vulnerable to HIV, and to empower women?</p> <p>d) What are your recommendations for helping to decrease women's vulnerability to HIV?</p> <p style="padding-left: 40px;"><u>Other domains to probe:</u></p> <ul style="list-style-type: none"> <li>-negotiating power in sexual relationships</li> <li>-barriers or facilitators to ending or leaving abusive situations</li> <li>-need to prove fertility before marriage</li> <li>-intergenerational sex</li> <li>-exchanging sex for money or other resources</li> <li>-access to resources/dependence on someone else/family or partner to provide</li> </ul>
<b>8</b>	<p><b>What do you think are some of the factors that make <u>men</u> particularly vulnerable to HIV infection in this country?</b></p> <p>a) Do you think cultural expectations for men contribute to risky sexual behaviors and play a role in the transmission of HIV in Botswana?</p> <p>b) Is alcohol use (and alcohol use associated with sex) common among men? To what extent does alcohol use contribute to HIV transmission?</p> <p>c) What are some of the barriers to using condoms for men?</p> <p>d) Are there programs in place that target men specifically, and that mobilize men to get involved in AIDS prevention and screening efforts? If so, please describe.</p> <p>e) What are your recommendations for how we can encourage men to get involved in AIDS prevention efforts, and to take the steps necessary to prevent HIV infection?</p>
<b>9</b>	<p><b>In your opinion, to what extent do positive test results lead to changes in people's sexual behavior in terms of number of partners and condom use?</b></p> <p>a) Does this differ for men and women? Please elaborate.</p> <p>b) What type of HIV prevention education do HIV-positive individuals receive at testing sites, clinics and hospitals?</p>
<b>10</b>	<p><b>What role are traditional healers playing in the HIV/AIDS epidemic?</b></p>

**Physicians for Human Rights  
Botswana Key Informant Interview  
10/02/04**

	<p>a) Have they been enlisted significantly in programs to encourage HIV/AIDS prevention, testing and treatment?</p> <p>b) Do you think their role in addressing this epidemic has been mostly positive or negative? Please elaborate.</p> <p>c) What can be done to increase the involvement of traditional healers in HIV/AIDS prevention and education programs?</p>
<b>11</b>	<p><b>Please tell me more about other organizations that are working on advocacy for PLWAs or around HIV/AIDS Prevention.</b></p> <p>a) Do you think these groups are having significant impact on controlling the HIV/AIDS epidemic?</p> <p>b) What are your recommendations for strengthening community mobilization for PLWAs?</p>
<b>12</b>	<p><b>Are there other people who you suggest we contact for further information on these issues? Can we contact you with further questions?</b></p>





# APPENDIX 4: SWAZILAND COMMUNITY SURVEY

## Physicians for Human Rights Swaziland Community Survey 5.6.05



### INTRODUCE YOURSELF

I am working with Physicians for Human Rights (PHR) and Women and Law in Southern Africa Research Trust (WLSA). We are conducting a health survey of as many women and men as possible and would like to speak to one member of this household (homestead). The person we select to interview must be between 18 and 49 years-old, speak Siswati or English, and be a resident of Swaziland. With your permission, I would like to know how many people like that live in this household (homestead), then I will randomly select one member and interview them in private.

### USE TOOL TO LIST HOUSEHOLD MEMBERS AND CHOOSE PARTICIPANT

#### OBTAIN CONSENT:

##### Introduction and Purpose

- This is a study about HIV/AIDS prevention, testing and treatment and is being conducted by Physicians for Human Rights and Women and Law in Southern Africa Research Trust, two non-governmental organizations.
- We are conducting a survey to help understand more about HIV and AIDS among men and women in Swaziland.
- You have been selected randomly as part of a general population survey.
- Your participation in the research is entirely voluntary: you can decide not to take part at all.
- There is no payment for participating in the survey.

##### Study procedures

- The questions require only short answers and will take up to an hour to complete.
- I will not ask you to tell us your HIV status at any point.
- We will need some privacy for our conversation because some of the questions may be sensitive. If you do not understand a question, please ask me to explain it to you.
- You can refuse to answer any question, and are free to stop the interview at any point.

##### Confidentiality

- None of what you say will be shared with anyone else.
- I will not write down your name or any identifying information anywhere on the forms I fill out.

Do you have any questions for me?

Do you agree to take part in the study?

1. Consent provided [Circle ONE]: No \_\_\_\_\_ 0 CNST  
Yes \_\_\_\_\_ 1

2. Survey # \_\_\_\_\_ ID

3a. Interviewer code \_\_\_\_\_ (1, 2, 3, ...) ICD

3b. Date of interview \_\_\_\_ [day] - \_\_\_\_ [month] - 2005 DATE

4. Enumeration area code \_\_\_\_\_ EAC

5. Participation Outcome: [Circle ONE]

Survey Complete \_\_\_\_\_ 1 OUTC

Not Available (1 return visit) \_\_\_\_\_ 2

Refusal/would not consent \_\_\_\_\_ 3a=Lack Time; 3b=Fear Reprisal; 3c=Oppose Study; 3d=Other \_\_\_\_\_ OUTC3dO

Unable to Complete \_\_\_\_\_ 4a=Interrupted; 4b=Emotional; 4c=Safety; 4d=Lack of Privacy;

4e=Other \_\_\_\_\_ OUTC4eO

### PARTICIPANT CHARACTERISTICS

6a. Sex [Circle ONE]

Male \_\_\_\_\_ 0 FEMALE  
Female \_\_\_\_\_ 1

6b. I will begin by asking you for some information about yourself. How old are you now? \_\_\_\_\_ (years) AGEN

6c. Are you **currently** married? [Circle ONE]

No \_\_\_\_\_ 0 [GO TO 6e] MARR  
Yes \_\_\_\_\_ 1 [GO TO 6d]  
NR \_\_\_\_\_ 99 [GO TO 6e]

6d. Is there more than one wife in your marriage? [Circle ONE]

No [one husband, one wife] \_\_\_\_\_ 0 MARP  
Yes [one husband, more than one wife] \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

6e. Are you **currently** living with a sexual partner (or spouse)? [Circle ONE]

No \_\_\_\_\_ 0 SXPT  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

6f. Have you **ever** been widowed? [Circle ONE]

No \_\_\_\_\_ 0 WIDW  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

7a. How many children or other people depend on you for financial support, food or shelter? \_\_\_\_\_ (number) NDEP

7b. Do you get any assistance from the government (such as money, food or supplies) to help you care for individuals with HIV or AIDS or who have been orphaned?

No \_\_\_\_\_ 0 CDEP  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

8. What is the highest year you completed in school?

Not finished primary \_\_\_\_\_ 1 SCHL  
Finished primary \_\_\_\_\_ 2  
Junior certificate \_\_\_\_\_ 3  
High school (form 5) \_\_\_\_\_ 4  
Tertiary \_\_\_\_\_ 6

9. What is your average monthly household income (total wages/income earned by all living with you)? HINC

<5,000 Emalengeni \_\_\_\_\_ 1  
5,000 E – 10,000 E \_\_\_\_\_ 2  
>10,000 E – 50,000 E \_\_\_\_\_ 3  
>50,000 E \_\_\_\_\_ 4

10. How would you describe your overall health? [READ ALL: Circle ONE]

Very Good/Excellent \_\_\_\_\_ 1 HSTAT  
 Good \_\_\_\_\_ 2  
 Fair \_\_\_\_\_ 3  
 Poor \_\_\_\_\_ 4  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

11a. In the **PAST 12 MONTHS**, have you had problems getting enough food to eat? [Circle ONE]

No \_\_\_\_\_ 0 FOOD  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

11b. In the **PAST 12 MONTHS**, have food or water shortages affected your access to or decisions about health care? [Circle ONE]

No \_\_\_\_\_ 0 FODH  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

11c. In the **PAST 12 MONTHS**, have food or water shortages affected your ability to support dependents? [Circle ONE]

No \_\_\_\_\_ 0 FODC  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

11d. In the **PAST 12 MONTHS**, have food or water shortages made you economically dependent on someone else? [Circle ONE]

No \_\_\_\_\_ 0 FODE  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

12a. I will now ask you some questions about alcohol use. During a typical week, how many days a week do you consume alcohol? \_\_\_\_\_ (#days/week) ALDA

12b. On the days that you drink alcohol, how many drinks do you usually have? \_\_\_\_\_ (#drinks/drinking day) ALDR

12c. What is the maximum number of drinks you had on any given day in the past month? \_\_\_\_\_ (#drinks/past month) ALDX

**KNOWLEDGE REGARDING HIV/AIDS**

13. I will now ask you some questions about what you know about HIV and AIDS. Based on what **you** know about AIDS, do **you** think that a person can get HIV or AIDS from any of the following? [READ ALL: Circle YES or NO for 13a-13k] TRANS

Statement	Yes	No	DK	NR
a. Having sexual intercourse without a condom [for the purpose of this survey, sexual intercourse is defined as vaginal or anal sex]	1	0	88	99
c. Receiving a blood transfusion	1	0	88	99
d. Sharing used needles or instruments	1	0	88	99
e. Sharing meals with an HIV-positive person	1	0	88	99
h. Getting bitten by a mosquito	1	0	88	99
k. Witchcraft	1	0	88	99

14. Based on what you know of HIV and AIDS, which of the following do **you** think can prevent someone from becoming infected with HIV/AIDS? [READ ALL: Circle YES or NO for 14a-14e] PREV

Statement	Yes	No	DK	NR
a. Using a condom correctly every time you have sex	1	0	88	99
b. Using traditional medicine	1	0	88	99
c. Being faithful with one partner who you know to be HIV-negative	1	0	88	99
d. Praying	1	0	88	99
e. Not having sex at all	1	0	88	99

15. Some people believe that sex with a virgin can cure AIDS. Do **you** agree? [Circle ONE]

No \_\_\_\_\_ 0 CURE  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

### TESTING

16a. Do **you** have access to HIV testing in your community? [Circle ONE]

No \_\_\_\_\_ 0 ACCT  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

16b. Is it possible in **your** community for someone to get a confidential test to find out if they are infected with HIV? By confidential, I mean that no one will know the test result, except you and the health care worker who tests you, if you don't want them to know? [Circle ONE]

No \_\_\_\_\_ 0 CNFT  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

### HIV TESTING

17. I will now ask you some questions about HIV testing. I will **not** ask you to tell me your HIV status. If **you** were HIV positive, would you tell your sexual partner(s) your status? [Circle ONE]

No \_\_\_\_\_ 0 TELLP  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

18. If **you** were to test positive for HIV and told others your status, do you think any of the following could happen to **you**? [READ ALL: Circle YES or NO for 18a-18j] FEARS

Statement	Yes	No	DK	NR	
a. Break-up of your marriage or relationship	1	0	88	99	
b. Physical abuse by your spouse/partner(s)	1	0	88	99	
c. You would lose your job	1	0	88	99	
d. You would be treated badly at work or school	1	0	88	99	
e. Loss of your friends	1	0	88	99	
f. Disowned from or neglected by your family	1	0	88	99	
g. Treated badly by health professionals	1	0	88	99	
h. Your community (village) would treat you like a social outcast	1	0	88	99	
i. Your family would not care for you if you became sick	1	0	88	99	
j. Other (specify)	1	0	88	99	FEARSO

19. People have different beliefs about their risks for getting HIV. In your opinion, how would you rate your chances of becoming infected with HIV? [READ ALL: Circle ONE]

No risk \_\_\_\_\_ 1 RISK  
 Low risk \_\_\_\_\_ 2  
 Average risk \_\_\_\_\_ 3  
 High risk \_\_\_\_\_ 4  
 100% chance \_\_\_\_\_ 5  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

20. Have you ever been tested for HIV? I am not asking you to tell me your status, only whether you have been tested. [Circle ONE]

No \_\_\_\_\_ 0 [GO TO 21] TEST  
 Yes \_\_\_\_\_ 1 [GO TO 23]  
 DK \_\_\_\_\_ 88 [GO TO 21]  
 NR \_\_\_\_\_ 99 [GO TO 21]

**FOR PEOPLE NOT TESTED**

21. What were the most important reasons that prevented you from getting tested? [DO NOT READ: Check ALL THAT APPLY]

<input type="checkbox"/>	Afraid or not ready to know status	1 ROLE
<input type="checkbox"/>	Not sick	2
<input type="checkbox"/>	No risk of HIV infection	3
<input type="checkbox"/>	Ashamed to be seen at testing site (stigma)	4
<input type="checkbox"/>	Spouse/partner(s) did not allow	5
<input type="checkbox"/>	Fear spouse/partner(s) would hit or hurt (if tested)	6
<input type="checkbox"/>	Worried about disclosure of tests results without permission	7
<input type="checkbox"/>	No testing site near work/home	8
<input type="checkbox"/>	No access to treatment (ARVs) if HIV+	9
<input type="checkbox"/>	Do not want to have to change sexual behavior if HIV+	10
<input type="checkbox"/>	Others advised not to test	11
<input type="checkbox"/>	Other (specify)	12
<input type="checkbox"/>	DK	88
<input type="checkbox"/>	NR	99

22a. Did not having testing available close to where you live or work prevent you from getting tested? [Circle ONE]

No \_\_\_\_\_ 0 CLOSE  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

22b. Did your spouse/partner(s) not allowing you prevent you from getting tested? [Circle ONE]

No \_\_\_\_\_ 0 ALLOW  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

22c. Did not having enough food prevent you from getting tested? [Circle ONE]

No \_\_\_\_\_ 0 NOFOO  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

22d. Did knowing that if you tested positive for HIV you would need to change your sexual practices prevent you from getting tested? [Circle ONE]

No \_\_\_\_\_ 0 CHANG  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

22e. Did thinking there would not be treatment (ARVs) available to you for HIV prevent you from getting tested? [Circle ONE]

No \_\_\_\_\_ 0 NOARV  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

22f. Did thinking that others would treat you badly if you were HIV-positive (and they knew your status) prevent you from getting tested? [Circle ONE]

No \_\_\_\_\_ 0 BADTR  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

**[GO TO 37a]**

**FOR PEOPLE WHO HAVE BEEN TESTED**

23. The following questions on HIV testing refer only to the **MOST RECENT** time you were tested. What year were you last tested for HIV? \_\_\_\_\_ (year). What month in that year were you tested? \_\_\_\_\_ (month) LASTT

24. Where were you tested? [DO NOT READ: Circle ONE]

Public Hospital \_\_\_\_\_ 1 WHERE  
Private Hospital \_\_\_\_\_ 2  
TB Clinic \_\_\_\_\_ 3  
Antenatal Clinic \_\_\_\_\_ 4  
NGO \_\_\_\_\_ 6  
VCT Center \_\_\_\_\_ 8  
Other (specify) \_\_\_\_\_ 9 WHEREO  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

25. Did you feel you could refuse getting the HIV test? [Circle ONE]

No \_\_\_\_\_ 0 REFUS  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

26. Did others in your community treat you badly because you got tested? [Circle ONE]

No \_\_\_\_\_ 0 DISCT  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

27. Do you regret getting tested? [Circle ONE]

No \_\_\_\_\_ 0 REGR  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

28. I am **not** asking to know the result, but did you **find out** the result of your test? [Circle ONE]

No \_\_\_\_\_ 0 REST  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

29. Did anybody find out your HIV test results from the testing center or your doctor without your permission? [Circle ONE]

No \_\_\_\_\_ 0 PERM1  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

30. Did your partner know you were tested?

No \_\_\_\_\_ 0 [GO TO 32] PKTS  
 Yes \_\_\_\_\_ 1 [GO TO 31]  
 No partner \_\_\_\_\_ 2 [GO TO 32]  
 DK \_\_\_\_\_ 88 [GO TO 32]  
 NR \_\_\_\_\_ 99 [GO TO 32]

31. Did your partner hit you, kick you, hurt you in anyway, or threaten you because you were tested? [Circle ONE]

No \_\_\_\_\_ 0 TESTV  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

32. Did your experience with HIV testing lead you to encourage others to get tested? [Circle ONE]

No \_\_\_\_\_ 0 CONVT  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

**COUNSELING**

33a. Did you receive counseling **before** being tested for HIV? [Circle ONE]

No \_\_\_\_\_ 0 COUNB  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

33b. Did you receive counseling **after** the HIV test? [Circle ONE]

No \_\_\_\_\_ 0 COUNA  
 Yes \_\_\_\_\_ 1  
 Did not go back for results \_\_\_\_\_ 2  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

**[If NO on 33a AND NO or DID NOT GO BACK on 33 b, GO TO 35. ALL OTHERS, continue to 34]**

34. In **your** counseling experience, did the counselor: [READ ALL: Circle YES or NO for 34a-c] COUNS

Statement	Yes	No	Does Not Apply	DK	NR
a. give you information that you found useful	1	0	2 (no information given)	88	99
b. treat you with respect?	1	0	2	88	99
c. answer your questions?	1	0	2 (no questions asked)	88	99

35. Did **you** make the decision to get the HIV test? [Circle ONE]

No \_\_\_\_\_ 0 [GO TO 37] WILLT  
 Yes \_\_\_\_\_ 1 [GO TO 36]  
 DK \_\_\_\_\_ 88 [GO TO 36]  
 NR \_\_\_\_\_ 99 [GO TO 36]



36. What were the most important reasons that made **you** decide to have an HIV test? [DO NOT READ: Check ALL THAT APPLY]

<input type="checkbox"/>	Wanted to know status	1 FACT
<input type="checkbox"/>	Was sick	2
<input type="checkbox"/>	Doctor/nurse recommended	3
<input type="checkbox"/>	PMTCT recommended	4
<input type="checkbox"/>	Worried about a sexual contact	5
<input type="checkbox"/>	Knew treatment (ARVs) was available	6
<input type="checkbox"/>	Partner/friend/family advised	7
<input type="checkbox"/>	Church advised	8
<input type="checkbox"/>	TV/Radio/billboard messages	9
<input type="checkbox"/>	Job required	10
<input type="checkbox"/>	Other (specify)	11
<input type="checkbox"/>	DK	88
<input type="checkbox"/>	NR	99

### STIGMA AND ATTITUDES TOWARDS PLWA

37a. I will now ask you some questions about people living with HIV or AIDS. Would you be willing to share a meal with a person you believed had HIV or AIDS? [Circle ONE]

No \_\_\_\_\_ 0 SHAR  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

37b. If a relative of yours became ill with HIV/ AIDS, would you be willing to care for him or her in your household? [Circle ONE]

No \_\_\_\_\_ 0 RELM  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

37c. If a student has HIV but is not sick, should he or she be allowed to continue attending school? [Circle ONE]

No \_\_\_\_\_ 0 SCHLS  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

37d. If a teacher has HIV but is not sick, should he or she be allowed to continue teaching in school? [Circle ONE]

No \_\_\_\_\_ 0 SCHLT  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

37e. If you believed a shopkeeper or food seller had the AIDS virus, would you buy food from him or her? [Circle ONE]

No \_\_\_\_\_ 0 SHOP  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

37f. *If a member of your family became ill with HIV/AIDS, would you want it to remain secret?* [Circle ONE]

No \_\_\_\_\_ 0 FSEC  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

38a. *Do you think that people with HIV or AIDS should be able to marry?* [Circle ONE]

No \_\_\_\_\_ 0 RGHT1  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

38b. *Do you think that people with HIV or AIDS should be able to own property?* [Circle ONE]

No \_\_\_\_\_ 0 RGHT2  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

38c. *Do you think that people with HIV or AIDS should have the same chance as others to have a job?* [Circle ONE]

No \_\_\_\_\_ 0 RGHT3  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

38d. *Do you think that people with HIV or AIDS should have the same chance as others to be in Parliament?* [Circle ONE]

No \_\_\_\_\_ 0 RGHT4  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

38e. *Do you think that people with HIV or AIDS should receive food or other assistance from the government?* [Circle ONE]

No \_\_\_\_\_ 0 RGHT5  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

## HEALTH CARE EXPERIENCES

39a. *How often in the PAST 12 MONTHS did you seek medical care?* [Circle ONE]

Never \_\_\_\_\_ 1 OFTEN  
1-2 times \_\_\_\_\_ 2  
3-4 times \_\_\_\_\_ 3  
More than 4 times \_\_\_\_\_ 4

39b. *How often in the PAST 12 MONTHS did you see a traditional healer (inyanga)?* [Circle ONE]

Never \_\_\_\_\_ 1 OFTH  
1-2 times \_\_\_\_\_ 2  
3-4 times \_\_\_\_\_ 3  
More than 4 times \_\_\_\_\_ 4

40. Have you experienced any of the following from a doctor or nurse over the **PAST 12 MONTHS**? [READ ALL: Circle YES or NO for 40a-40d] HPABS

Statement	No	Yes	N/A	DK	NR
a. Denial of care or treatment	0	1	2	88	99
b. Denial of admission to a hospital	0	1	2	88	99
c. Verbal mistreatment or insults	0	1	2	88	99
d. Usually treated with respect and dignity	0	1	2	88	99

## SEXUAL PRACTICES

As you may know, a person may get the AIDS virus through sexual activity. To help prevent the spread of HIV/AIDS, we need to know more about the different types of sexual practices people engage in. Some of these questions need to be rather detailed and personal. Since this survey is confidential, no one will know your answers. I would appreciate your cooperation and honesty in answering these questions. Some of the questions are repetitive, but I need to ask all of them so I apologize if you have already answered what I ask.

41a. Do you currently practice abstinence, which means not having sex at all, as a way to prevent yourself or others from becoming infected with HIV/AIDS? [Circle ONE]

No \_\_\_\_\_ 0 ABST  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

41b. Would you consider using abstinence at any time in the future to decrease your risk of HIV/AIDS infection? [Circle ONE]

No \_\_\_\_\_ 0 ABST1  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

42. Have you **EVER** had sexual intercourse? For the purpose of this survey, sexual intercourse is defined as vaginal or anal sex with either a man or a woman. [Circle ONE]

No \_\_\_\_\_ 0 [GO TO 49] EVER  
 Yes \_\_\_\_\_ 1 [GO TO 43]  
 DK \_\_\_\_\_ 88 [GO TO 43]  
 NR \_\_\_\_\_ 99 [GO TO 43]

43a. In **YOUR LIFETIME**, have you ever been forced to have sex when you did not want to? [Circle ONE]

No \_\_\_\_\_ 0 FFSX  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

43b. In **YOUR LIFETIME**, have you ever had sex with someone when they did not want to? [Circle ONE]

No \_\_\_\_\_ 0 FFSXA  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

43c. In **YOUR LIFETIME**, have you ever had sex with a commercial sex worker? [Circle ONE]

No \_\_\_\_\_ 0 COMSXL  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

43d. In **YOUR LIFETIME**, have you ever given another person money, food, or other resources in exchange for sex? [Circle ONE]

No \_\_\_\_\_ 0 PAIDL  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

43e. In **YOUR LIFETIME**, has another person ever given you money, food, or other resources in exchange for sex? [Circle ONE]

No \_\_\_\_\_ 0 EXCHL  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

44. The number of sexual partners people have had differs a lot from person to person. Some people report having had one sexual partner, some two partners, and others many partners. How many sexual partners have you had in the **PAST 12 MONTHS**? [Circle ONE]

None \_\_\_\_\_ 1 [GO TO 49] NUMB  
One \_\_\_\_\_ 2 [GO TO 45]  
Two \_\_\_\_\_ 3 [GO TO 45]  
Three \_\_\_\_\_ 4 [GO TO 45]  
Other (specify) \_\_\_\_\_ 5 [GO TO 45] NUMBO

45. How many sexual partners have you had in the **LAST MONTH**? [Circle ONE]

None \_\_\_\_\_ 1 NUMBLM  
One \_\_\_\_\_ 2  
Two \_\_\_\_\_ 3  
Three \_\_\_\_\_ 4  
Other (specify) \_\_\_\_\_ 5 NUMBLMO

**FOR SEXUALLY ACTIVE PARTICIPANTS ONLY**

46a. Who generally decides when you have sex? [READ ALL: Circle ONE]

You \_\_\_\_\_ 1 DCES  
You and your partner(s) equally \_\_\_\_\_ 2  
Your partner(s) \_\_\_\_\_ 3  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

46b. Thinking about all the times you had sex in the **PAST 12 MONTHS**, how often did you drink alcohol before having sex? [READ ALL: Circle ONE]

Very infrequently or never \_\_\_\_\_ 1 ALCS  
Less than half of the time \_\_\_\_\_ 2  
More than half of the time \_\_\_\_\_ 3  
Very frequently or always \_\_\_\_\_ 4  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

46c. Have you had sex with a commercial sex worker during the **PAST 12 MONTHS**? [Circle ONE]

No \_\_\_\_\_ 0 COMSX  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

46d. During the **PAST 12 MONTHS**, have you given another person money, food, or other resources in exchange for sex? [Circle ONE]

No \_\_\_\_\_ 0 PAIDL  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

46e. During the **PAST 12 MONTHS**, has another person given you money, food, or other resources in exchange for sex? [Circle ONE]

No \_\_\_\_\_ 0 EXCH  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

46f. Were you forced to have sex against your will over the **PAST 12 MONTHS**? [Circle ONE]

No \_\_\_\_\_ 0 FORC  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

46g. Did you have sex with others when they did not want to over the **PAST 12 MONTHS**? [Circle ONE]

No \_\_\_\_\_ 0 FOSEX  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

46h. To the best of your knowledge, have your sexual partners had sex with anyone else besides you over the **PAST 12 MONTHS**? [Circle ONE]

No \_\_\_\_\_ 0 PMONO  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

46i. In the **PAST 12 MONTHS**, have you ever thought that your sexual partner(s) may have exposed you to HIV/AIDS by having sex with others?

No \_\_\_\_\_ 0 PEXPO  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

46j. In the **PAST 12 MONTHS**, have you had a sexual relationship with someone 10 or more years older than you? [Circle ONE]

No \_\_\_\_\_ 0 INTGN  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

46k. In the **PAST 12 MONTHS** have you had a sexual relationship with someone 10 or more years younger than you? [Circle ONE]

No \_\_\_\_\_ 0 INTGN1  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

#### REGARDING CONDOM USE

47a. Thinking about all of the times you had sex over the **PAST 12 MONTHS**, how often did you use a condom? [READ ALL: Circle ONE]

All sexual encounters \_\_\_\_\_ 1 CONDT  
Most sexual encounters \_\_\_\_\_ 2  
Half of sexual encounters \_\_\_\_\_ 3  
A few sexual encounters \_\_\_\_\_ 4  
Never \_\_\_\_\_ 5  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

47b. In your sexual encounters, who typically decides whether you use a condom? [READ ALL: Circle ONE]

- You only \_\_\_\_\_ 1 DECI  
 Mostly you \_\_\_\_\_ 2  
 You and your partner(s) equally \_\_\_\_\_ 3  
 Mostly partner(s) \_\_\_\_\_ 4  
 Partner(s) only \_\_\_\_\_ 5  
 DK \_\_\_\_\_ 6  
 NR \_\_\_\_\_ 7

47c. Where do you get condoms? [DO NOT READ: Check ALL THAT APPLY]

<input type="checkbox"/>	Never get condoms	0 CONDG
<input type="checkbox"/>	Free from clinic	1
<input type="checkbox"/>	Free from NGO	2
<input type="checkbox"/>	Buy in store or petrol station	3
<input type="checkbox"/>	Buy in restaurant or club	4
<input type="checkbox"/>	Partner(s)	5
<input type="checkbox"/>	Other (specify)	6
<input type="checkbox"/>	DK	88
<input type="checkbox"/>	NR	99

47d. How many times did you have sex **without** a condom over the **PAST MONTH with someone who is not a primary partner**?  
 \_\_\_\_\_ (number of times) UNPRO

47e. Was there anytime that you did **not** use a condom over the **PAST 12 MONTHS**? [Circle ONE]

- No \_\_\_\_\_ 0 [GO TO 49] NCOND  
 Yes \_\_\_\_\_ 1 [GO TO 48]  
 DK \_\_\_\_\_ 88 [GO TO 49]  
 NR \_\_\_\_\_ 99 [GO TO 49]

48. Why do you **not** use a condom with each sexual encounter? [DO NOT READ: Check ALL THAT APPLY]

<input type="checkbox"/>	Inconvenient /did not have at time	1 CONDW
<input type="checkbox"/>	Decrease sexual pleasure	2
<input type="checkbox"/>	Trust partner	3
<input type="checkbox"/>	Believe are in monogamous relationship w/ HIV- partner	4
<input type="checkbox"/>	Spouse/partner(s) does not want to	5
<input type="checkbox"/>	Trying to get pregnant (you or spouse/partner)	6
<input type="checkbox"/>	Cannot afford condoms	7
<input type="checkbox"/>	Not available (where live/shop)	8
<input type="checkbox"/>	Do not know how to use	9
<input type="checkbox"/>	Condoms don't prevent HIV/AIDS	10
<input type="checkbox"/>	Use other birth control methods	11
<input type="checkbox"/>	Condoms carry HIV	12
<input type="checkbox"/>	Other (specify)	13
<input type="checkbox"/>	DK	88
<input type="checkbox"/>	NR	99

**FOR ALL PARTICIPANTS**

49. *What is the most important reason that women are at high risk for HIV in Swaziland?* [DO NOT READ: Check ALL THAT APPLY]

<input type="checkbox"/>	Women cannot refuse sex	1 VULWO
<input type="checkbox"/>	Men refuse to use condoms	2
<input type="checkbox"/>	Physical or sexual violence	3
<input type="checkbox"/>	Intergenerational relationships	4
<input type="checkbox"/>	Women have multiple sexual partners	5
<input type="checkbox"/>	Men have multiple sexual partners/spouses	6
<input type="checkbox"/>	Transactional sex	7
<input type="checkbox"/>	Women's low status/lack of rights	8
<input type="checkbox"/>	Women are economically dependent on men	9
<input type="checkbox"/>	Women drink too much	10
<input type="checkbox"/>	Men drink too much	11
<input type="checkbox"/>	Traditional practices [wife inheritance, lobola, etc.]	12
<input type="checkbox"/>	Other (specify)	13
<input type="checkbox"/>	DK	88
<input type="checkbox"/>	NR	99

50. *What is the most important reason that men are at high risk for HIV in Swaziland?* [DO NOT READ: Check ALL THAT APPLY]

<input type="checkbox"/>	Men refuse to use condoms	1 VULMN
<input type="checkbox"/>	Men don't have enough knowledge about HIV prevention	2
<input type="checkbox"/>	Intergenerational relationships	3
<input type="checkbox"/>	Women have multiple sexual partners	4
<input type="checkbox"/>	Men have multiple sexual partners/spouses	5
<input type="checkbox"/>	Transactional sex (non-commercial)	6
<input type="checkbox"/>	Commercial sex	7
<input type="checkbox"/>	Women drink too much	8
<input type="checkbox"/>	Men drink too much	9
<input type="checkbox"/>	Traditional practices [wife inheritance, lobola, etc.]	10
<input type="checkbox"/>	Other (specify)	11
<input type="checkbox"/>	DK	88
<input type="checkbox"/>	NR	99

## GENDER ROLES

51. I will now read you some statements about your beliefs about the different roles of men and women in society. Please let me know whether you agree or disagree with each of the following. [READ ALL: Circle AGREE or DISAGREE for 51a-51u]

Statement	Agree	Disagree	DK	NR
a. It is OK for men to have more than one (sexual) partner at one time	1	0	88	99
b. It is OK for women to have more than one (sexual) partner at one time	1	0	88	99
c. A woman must prove her fertility before marriage	1	0	88	99
d. It is OK for a man to take another wife if his current wife does not bear children	1	0	88	99
e. A woman should remain a virgin until she marries	1	0	88	99
f. A man should remain a virgin until he marries	1	0	88	99
g. It is a woman's duty to have sex with her spouse/partner even if she does not want to	1	0	88	99
h. It is more important for a woman to respect her spouse/partner than it is for a man to respect his spouse/partner	1	0	88	99
i. A man may beat his spouse/partner if she disobeys him	1	0	88	99
j. A man may beat his spouse/partner if he believes she is having sex with other men	1	0	88	99
k. Women should be able to own property in their own name	1	0	88	99
l. Women should have their own houses and land when they marry	1	0	88	99
m. Men should financially support the children they have from all relationships	L	0	88	99
n. Women should be able to hold the same jobs at the same pay as men	1	0	88	99
o. A woman should be able to end a relationship with a man	1	0	88	99
p. A man should pay a bride price (lobola) in order to marry a woman	1	0	88	99
q. A woman is expected to have children if a man paid lobola to marry her	1	0	88	99
r. A woman's in-laws should protect her if her husband hurts or treats her badly	1	0	88	99
r. It is more important that boys get an education than that girls do	1	0	88	99
s. It is a woman's duty to care for the sick	1	0	88	99
t. Men should control decisions in relationships with women (whether to marry, whether to have sex, how many children to have)	1	0	88	99
u. Women should not insist on condom use if their partner refuses	1	0	88	99

## ADDRESSING HIV/AIDS IN SWAZILAND

52. Now I will ask you about what more can be done about HIV/AIDS in Swaziland. In your opinion, what could be done to prevent further spread of HIV in Swaziland? [DO NOT READ: Check ALL THAT APPLY]

<input type="checkbox"/>	Educational campaigns (on testing, prevention, treatment, stigma)	1 SWAZI
<input type="checkbox"/>	Supporting people to get tested	2
<input type="checkbox"/>	Increasing availability of testing (#centers, mobile testing, etc.)	3
<input type="checkbox"/>	Increasing confidentiality at testing sites	4
<input type="checkbox"/>	Providing resources (food, transport, etc.)	5
<input type="checkbox"/>	Making treatment (including ARVs) more available	6
<input type="checkbox"/>	If people had access to good/better quality care at clinics or hospitals	7
<input type="checkbox"/>	If there were more HIV/AIDS support groups	8
<input type="checkbox"/>	If the King would set an example/speak out	9
<input type="checkbox"/>	Addressing domestic/sexual violence (prevention, protection, etc.)	10
<input type="checkbox"/>	Increasing availability of condoms (distribution, cost, etc.)	11
<input type="checkbox"/>	Other (specify)	12
<input type="checkbox"/>	DK	88
<input type="checkbox"/>	NR	99



53a. In your opinion, which of the following forms of testing are appropriate for you? Voluntary counseling and testing, which is confidential testing at HIV testing and counseling centers? No \_\_\_\_\_ 0 VTEST

Yes \_\_\_\_\_ 1

DK \_\_\_\_\_ 88

NR \_\_\_\_\_ 99

53b. Routine testing, which is testing everyone for HIV as part of a routine clinic or hospital visit, unless they say no? [Circle ONE]

No \_\_\_\_\_ 0 RTTEST

Yes \_\_\_\_\_ 1

DK \_\_\_\_\_ 88

NR \_\_\_\_\_ 99

53c. Couples testing, which is testing men and women partners together for HIV and giving them their results together? [Circle ONE]

No \_\_\_\_\_ 0 CTTEST

Yes \_\_\_\_\_ 1

NA (no partner) \_\_\_\_\_ 2

DK \_\_\_\_\_ 88

NR \_\_\_\_\_ 99

53d. Mobile testing, which is testing from a vehicle that moves around to different places close to where people live or work, such as markets or community centers, and gives the test results on the same day? [Circle ONE]

No \_\_\_\_\_ 0 MTTEST

Yes \_\_\_\_\_ 1

DK \_\_\_\_\_ 88

NR \_\_\_\_\_ 99

53e. Which one of these forms of testing would be **best** for you? [READ ALL: Circle ONE]:

Voluntary \_\_\_\_\_ 1 BESTT

Routine \_\_\_\_\_ 2

Couples \_\_\_\_\_ 3

Mobile \_\_\_\_\_ 4

Other (specify) \_\_\_\_\_ 5 BESTTO

DK \_\_\_\_\_ 88

NR \_\_\_\_\_ 99

54. Would you support HIV/AIDS education directed at men as a way to prevent the further spread of HIV in Swaziland? [Circle ONE]

No \_\_\_\_\_ 0 SWAED

Yes \_\_\_\_\_ 1

DK \_\_\_\_\_ 88

NR \_\_\_\_\_ 99

55. Projects that help women make their own money could provide HIV-positive women with access to resources for daily living and treatment for HIV/AIDS. Would you support this type of project as a way to decrease the impact of HIV/AIDS in Swaziland? [Circle ONE]

No \_\_\_\_\_ 0 INCGEN

Yes \_\_\_\_\_ 1

DK \_\_\_\_\_ 88

NR \_\_\_\_\_ 99

56. Do you think violence (threatening or hurting someone, or forcing them to have sex when they don't want to) is an important contributor to the spread of HIV in Swaziland? [Circle ONE]

No \_\_\_\_\_ 0 SWASV

Yes \_\_\_\_\_ 1

DK \_\_\_\_\_ 88

NR \_\_\_\_\_ 99

57. Abstinence (not have any sexual intercourse) is one way to decrease the spread of HIV/AIDS. Do you think promoting abstinence will change sexual behavior in Swaziland? [READ ALL: Circle ONE]

Not at all \_\_\_\_\_ 0 ABST2  
 A little \_\_\_\_\_ 1  
 Quite a lot \_\_\_\_\_ 2  
 Extremely \_\_\_\_\_ 3  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

I am going to read you a list of individuals and groups. For each one, please tell me your opinion of their efforts to address HIV/AIDS in Swaziland. [READ ALL: Circle ONE ANSWER for EACH COLUMN 58-61(a-e)]

	a. Spent enough money on HIV prevention? A	b. Set a good example in their personal behavior and sexual practices? B	c. Given people infected or affected by HIV/AIDS the things they need to survive, such as food, water, shelter or land? C	d. Done enough to oppose bad treatment of people with HIV/AIDS? D	e. Protected women and children from abuse? E
58. Have national political leaders- POL	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99
59. Has the King- KING	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99
60. Have chiefs- CHIEFS	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99
61. Have church leaders- CHURCH	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99	No _____ 0 Yes _____ 1 DK _____ 88 NR _____ 99

62a. Do you believe that **you** have a duty to avoid putting others at risk for HIV/AIDS? [Circle ONE]

No \_\_\_\_\_ 0 DUTY1  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

62b. Do you believe that **you** have a duty to treat every person with dignity and respect? [Circle ONE]

No \_\_\_\_\_ 0 DUTY2  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

62c. Does the way that the government works in Swaziland prevent **you** from having a say in the way HIV/AIDS is addressed in Swaziland? [Circle ONE]

No \_\_\_\_\_ 0 BERE  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

### INFORMATION

63. If you would like any information on the availability of HIV testing in your community please let me know. Would you like some information?

No \_\_\_\_\_ 0 INFO  
Yes, information provided \_\_\_\_\_ 1

64. If you would like information on how to prevent HIV transmission or on treatment for AIDS, I have a pamphlet with some information for you. Would you like a pamphlet?

No \_\_\_\_\_ 0  
Yes, information provided \_\_\_\_\_ 1 INFOP

65. In Swaziland, people sometimes don't feel safe at home because they experience domestic violence. Domestic violence means that their partners or family members physically hurt them, threaten them or force them to have sex when they don't want to. As part of our study, we would like to let you know who to contact if you or someone that you know does not feel safe at home. These organizations are here to assist people who are being hurt. They can also help you to report domestic violence to the police. Would you like information on how you can contact these organizations?

No \_\_\_\_\_ 0 FORCI  
Yes, information provided \_\_\_\_\_ 1

# APPENDIX 5: SWAZILAND PLWA INTERVIEW

Physicians for Human Rights  
Swaziland PLWA Interview  
5.6.05

**INSTRUCTIONS:**

*READ if in italics*

DO NOT READ if in plain text

1. **Qualitative Interviewer code** \_\_\_\_\_ (1, 2, 3, ...) ICD2

**OBTAIN CONSENT:**

**Introduction and Purpose**

- *This is a study about HIV/AIDS prevention, testing and treatment and is being conducted by Physicians for Human Rights and Women and Law in Southern Africa Research Trust, two non-governmental organizations.*
- *We are conducting a survey to help understand more about HIV and AIDS among men and women in Swaziland.*
- *You have been selected because you belong to an HIV/AIDS support group/ peer education group/ are a patient at an ARV treatment center.*
- *Your participation in the research is entirely voluntary: you can decide not to take part at all.*
- *There is no payment for participating in the interview.*

**Study procedures**

- *The questions will take about an hour.*
- *We will need some privacy for our conversation because some of the questions may be sensitive. If you do not understand a question, please ask me to explain it to you.*
- *You can refuse to answer any question, and are free to stop the interview at any point.*

**Confidentiality**

- *None of what you say will be shared with anyone else.*
- *I will not write down your name or any identifying information anywhere in my notes.*

*Do you have any questions for me?*

*Do you agree to take part in the study?*

2. Consent provided: No \_\_\_\_\_ 0 CNST  
Yes \_\_\_\_\_ 1

**DEMOGRAPHICS**

3a. Sex

Male \_\_\_\_\_ 0 FEMALE  
Female \_\_\_\_\_ 1

3b. *Where do you live?* [Circle ALL THAT APPLY]

Urban \_\_\_\_\_ 1 LIVE  
Peri-Urban \_\_\_\_\_ 2  
Company Town \_\_\_\_\_ 3  
Rural \_\_\_\_\_ 4

3c. *How old are you now?* \_\_\_\_\_ (years) AGEN

3d. *Are you **currently** married?* No \_\_\_\_\_ 0 [GO TO 3f] MARR  
Yes \_\_\_\_\_ 1 [GO TO 3e]  
NR \_\_\_\_\_ 99 [GO TO 3f]

3e. *Is there more than one wife in your marriage?* No [one husband, one wife] \_\_\_\_\_ 0 MARR  
Yes [one husband, more than one wife] \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

3f. Are you **currently** living with a sexual partner? No \_\_\_\_\_ 0 SXPT  
 Yes \_\_\_\_\_ 1  
 NR \_\_\_\_\_ 99

3g. Have you **ever** been widowed? No \_\_\_\_\_ 0 WIDW  
 Yes \_\_\_\_\_ 1  
 NR \_\_\_\_\_ 99

3h. How many children or other people depend on you for support? \_\_\_\_\_ (number) NDEP

3i. What is the highest year you completed in school? Not finished primary \_\_\_\_\_ 1 SCH  
 Finished primary \_\_\_\_\_ 2  
 Junior certificate \_\_\_\_\_ 3  
 High school (form 5) \_\_\_\_\_ 4  
 Tertiary \_\_\_\_\_ 6

4. How do you believe you became infected with HIV? From caring for HIV+ person \_\_\_\_\_ 1 HOW  
 Unprotected sex \_\_\_\_\_ 2  
 Other \_\_\_\_\_ 3 (specify) \_\_\_\_\_

What factors, if any, made it difficult to prevent HIV infection? DIFFICULTIES\_PREVENT

Tell me about your experience finding out you were HIV positive. EXPERIENCES\_HIV+

5a. Where were you tested? Public Hospital \_\_\_\_\_ 1 WHERE  
 Private Hospital \_\_\_\_\_ 2  
 TB Clinic \_\_\_\_\_ 3  
 Antenatal Clinic \_\_\_\_\_ 4  
 NGO \_\_\_\_\_ 6  
 VCT \_\_\_\_\_ 8  
 Other \_\_\_\_\_ 9 (specify) \_\_\_\_\_  
 DK \_\_\_\_\_ 88

5b. Were you tested voluntarily (did you feel you had the option to refuse the test)? No \_\_\_\_\_ 0 REFUS  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88

5c. What were the most important reasons that made **you** decide to have an HIV test? Wanted to know status \_\_\_\_\_ 1 FACT  
 Was sick \_\_\_\_\_ 2  
 Doctor/nurse recommended \_\_\_\_\_ 3  
 PMTCT recommended \_\_\_\_\_ 4  
 Worried about a sexual contact \_\_\_\_\_ 5  
 Knew treatment (ARVs) was available \_\_\_\_\_ 6  
 Partner/friend/family advised \_\_\_\_\_ 7  
 Church advised \_\_\_\_\_ 8  
 TV/Radio/billboard messages \_\_\_\_\_ 9  
 Job required \_\_\_\_\_ 10  
 Other (specify) \_\_\_\_\_ 11  
 DK \_\_\_\_\_ 88

5d. Did you receive counseling **before** being tested for HIV? No \_\_\_\_\_ 0 COUNB

Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88

5e. Did you receive counseling **after** the HIV test? No \_\_\_\_\_ 0 COUNA  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88

Were your counseling experiences adequate (confidential, informative, respectful, etc.)? Please elaborate.  
 COUNSELING\_EXPERIENCES

5f. Did anyone tell you how to get access to AIDS treatment? No \_\_\_\_\_ 0 TRAC  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88

5g. Do you regret getting tested? No \_\_\_\_\_ 0 REGR  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88

Why or why not? REGRETS\_DETAIL

5h. Do you think barriers to testing differ for men and women? No \_\_\_\_\_ 0 BARR  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88

Can you tell me more? BARRIERS\_DETAIL

5i. Is access to testing a problem in Swaziland? No \_\_\_\_\_ 0 ACCES  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88

Why or why not? ACCESS\_DETAIL

Do you think the following would increase or decrease testing in Swaziland? TESTS

	Increase	Decrease	No Change
5j. Introducing routine testing which means testing everyone for HIV as part of routine clinic or hospital visit, unless they say no?	1	2	3
5k. Increasing mobile testing which means testing from a vehicle that moves around to different places close to where people live or work, such as markets or community centers, and gives the test results on the same day?	1	2	3
5l. Introducing couples testing which means testing men and women partners together for HIV and giving them their results together?	1	2	3

What can be done to encourage HIV testing in Swaziland? ENCOURAGE

6a. Have you told anyone your HIV status?

No \_\_\_\_\_ 0 DISCL  
 Yes \_\_\_\_\_ 1  
 NR \_\_\_\_\_ 99

Who? TOLDWHO

6b. Did anyone tell your status to other people without your permission?

No \_\_\_\_\_ 0 DISCL2  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88

Please tell me more. DISCLOSURE\_DETAIL

6c. What were the consequences of telling others your HIV status? [Circle ALL THAT APPLY] CONSEQ

<b>Were any of the following a consequence?</b>	<b>No</b>	<b>Yes</b>	<b>NR</b>
c. Violence (such as being hit, kicked or forced to have sex, or hurt in any way)	0	1	99
d. Shame	0	1	99
e. Poor treatment	0	1	99
f. Losing a job	0	1	99
g. Losing friend(s)	0	1	99
h. Convincing others to get tested	0	1	99
i. Getting support from your family	0	1	99
j. Emotional relief	0	1	99

Were there other consequences of telling others your HIV status?

Please tell me more. CONSEQ\_DETAIL

7. Have you experienced discrimination (unequal treatment) or stigma because of your HIV status?

No \_\_\_\_\_ 0 DISCR  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88

If so, please tell me more. DISCRIM\_DETAIL

7a. Have there been changes in your relationships, family, work environment, or friendships because of your HIV status?

No \_\_\_\_\_ 0 CHANG1  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88

If so, please tell me more. CHANGES\_RELATIONSHIPS

7b. Have you experienced poor treatment at work, school, hospitals or in other public places because of your HIV status?

No \_\_\_\_\_ 0 CHANG2  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88

If so, please tell me more. CHANGES\_POORTX

7c. Do you think that HIV-related stigma or poor treatment differs for HIV-positive women and men in Swaziland?

No \_\_\_\_\_ 0 STIGG  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88

If yes, how so? STIGMABYGENDER\_DETAIL

What do you think can be done to reduce stigma surrounding HIV in your community and in Swaziland? REDUCE\_STIGMA

**8a. Are you getting care or treatment for HIV/AIDS?**

No \_\_\_\_\_ 0 [GO TO 8c] TREAT  
Yes \_\_\_\_\_ 1 [GO TO 8b]

8b. What kind of care or treatment are you getting? [Circle ALL THAT APPLY]

Traditional healer \_\_\_\_\_ 1 TREATT  
Clinic/ hospital care \_\_\_\_\_ 2  
ARVs \_\_\_\_\_ 3 [SKIP to 8c]  
Meds for HIV/AIDS-related conditions \_\_\_\_\_ 4  
Nutritional foods/supplements \_\_\_\_\_ 5  
Home-based care \_\_\_\_\_ 6  
Other \_\_\_\_\_ 7 (specify) \_\_\_\_\_

8c. Why are you not receiving ARVs? [Circle ALL THAT APPLY]

Lack of information \_\_\_\_\_ 1 NOARV  
Lack of money for transport \_\_\_\_\_ 2  
Lack of time \_\_\_\_\_ 3  
Have not disclosed \_\_\_\_\_ 4  
Ashamed to be seen at treatment site \_\_\_\_\_ 5  
Treatment site too far away \_\_\_\_\_ 6  
Lack of food \_\_\_\_\_ 7  
Concern about quality/effects of ARVs \_\_\_\_\_ 8  
Other \_\_\_\_\_ 9 (specify) \_\_\_\_\_

If you are receiving ARVs, what have been your experiences with treatment? ARV\_EXPERIENCES

[Probes: process, treatment literacy (what understand), adherence (staying with the regimen)]



How do people get access to antiretroviral treatment (ARVs) in Swaziland? ARV\_ACCESS  
[Probes: process, availability, information, travel/costs/payment issues]

8d. Is access to care or treatment different for HIV-positive men and women?

No \_\_\_\_\_ 0 CAREG  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88

Why or why not? ACCESSBYGENDER\_DETAIL

9. What are some of the main things that put women at risk for HIV in Swaziland? MAINRISKSWOMEN  
[Probe cultural practices, such as polygamy, wife inheritance, other mourning customs, etc.]

9a. Is violence against women (forced sex, physical abuse) a big problem in your community?

No \_\_\_\_\_ 0 VIOLE  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88

If so, please tell me more. VIOLENCE\_DETAIL

9b. Do women not being able to have property in their names leave them without a secure place to live or farm and put them at risk for HIV?

No \_\_\_\_\_ 0 NOPRO  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88

9c. Does lack of income put women at risk of HIV?

No \_\_\_\_\_ 0 NOINC  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88

What are other reasons women are at risk for HIV? OTHERRISKSWOMEN

What can be done to help women protect themselves against becoming infected with HIV? HELPWOMENPROTECT

**FOR FEMALE PARTICIPANTS ONLY:**

*In order to understand more about how HIV is spread in Swaziland, we need to know more about your personal experiences. What you tell me will be completely confidential and may help make changes to policies and programs so other women will be safer and less at risk for HIV. I really appreciate your honesty and willingness to share your experiences.*

9d. Do you feel like you have control over the decision of when to have sex? No \_\_\_0 IFSEX  
Yes \_\_\_1  
DK \_\_\_88

9e. Who usually decides whether or not to have sex in your relationship(s)?  
You only \_\_\_\_\_1 DECI  
Mostly you \_\_\_\_\_2  
You and your partner(s) equally \_\_\_3  
Mostly partner(s) \_\_\_\_\_4  
Partner(s) only \_\_\_\_\_5  
Other (please specify) \_\_\_\_\_6

9f. Do you feel like you have control over the decision of whether to use a condom? No \_\_\_0 IFCN  
Yes \_\_\_1  
DK \_\_\_88

9g. Do you feel like you have control over decisions about childbearing? No \_\_\_0 IFCHLD  
Yes \_\_\_1  
DK \_\_\_88

How are these decisions made and carried out? HOWSEXDECISIONS\_DETAILW  
[Probe use of force or other forms of control]

9h. Do you have more than one sexual partner? No \_\_\_0 PART1  
Yes \_\_\_1  
NR \_\_\_99

9i. Have you had more than one sexual partner at the same time? No \_\_\_0 PART2  
Yes \_\_\_1  
NR \_\_\_99

9j. Have any of your primary partners had more than one partner at the same time as you?  
No \_\_\_0 PPART  
Yes \_\_\_1  
DK \_\_\_88  
NR \_\_\_99

9k. Did you have more than one partner at the time you became infected with HIV?  
No \_\_\_0 MPART  
Yes \_\_\_1  
DK \_\_\_88  
NR \_\_\_99

9l. Do you feel like alcohol use (by you or your partner) played a role in your becoming infected with HIV?  
No \_\_\_0 ALCU  
Yes \_\_\_1  
DK \_\_\_88  
NR \_\_\_99

*If so, please tell me more.* ALCOHOL\_ROLEW  
[If own use, probe frequency and level of use]

9m. *Have any of your sexual partners ever hurt you or forced you to have sex when you didn't want to?*

No \_\_\_\_\_ 0 ABUSE  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

*If so, in what ways?* ABUSE\_DETAIL

9n. *Have you ever had a sexual relationship with someone 10 or more years older or younger than you?*

No \_\_\_\_\_ 0 INTERG  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

*If so, please tell me more.* INTERGEN\_DETAILW  
[Probe frequency, length of relationship(s)]

9o. *Have you ever had sex with someone because he gave you food, gifts, money, or other things?*

No \_\_\_\_\_ 0 TRANSX1  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

*If so, please tell me more.* TRANSACT\_RECEIVEW  
[Probe frequency, length of relationship(s)]

9p. *Have you ever given someone food, gifts, money, or other things to have sex with you?*

No \_\_\_\_\_ 0 TRANSX2  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

*If so, please tell me more.* TRANSACT\_GIVEW  
[Probe frequency, length of relationship(s)]

*Who owns or rents the dwelling where you live?* WHOOWNS

9q. *Do you own livestock that you can dispose of as you wish?*

No \_\_\_\_\_ 0 LIVSTK  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

*Do you feel there are certain expectations for your behavior or living situation as a Swazi woman, such as when or whether you have sex or bear children, whether you earn an income, your roles in your family and community? Please tell me more.*

EXPECT\_ASWOMEN

*Do you feel there are certain expectations for your partner's behavior or living situation as a Swazi man, such as when or whether he has sex or fathers children, whether and how he earns an income, his roles in the family and community?*

*Please tell me more.* EXPECT\_ONMALEPARTNER

**FOR ALL PARTICIPANTS:**

**10. What are some of the main things that put men at risk for HIV in Swaziland? MAINRISKSMEN**

[Probe migration; cultural practices such as wife inheritance, polygamy]

10a. *Is there pressure for men to have many sexual partners?*

No \_\_\_\_\_ 0 MMPAR

Yes \_\_\_\_\_ 1

DK \_\_\_\_\_ 88

*If so, please tell me more.* MANYPARTNERS

10b. *Is alcohol use common among men?*

No \_\_\_\_\_ 0 MALC

Yes \_\_\_\_\_ 1

DK \_\_\_\_\_ 88

10c. *Does alcohol use put men at risk for HIV?*

No \_\_\_\_\_ 0 AURSK

Yes \_\_\_\_\_ 1

DK \_\_\_\_\_ 88

*If yes, how so?* ALCOHOLRISK\_MEN

*How common is condom use among men?* HOWCOMMON\_CONDOM

*What do you think are some reasons men do not use condoms?* WHYNOT\_CONDOM

*What can be done to encourage men to take the steps necessary to prevent HIV infection and to get involved in HIV prevention efforts?* HELPMEN\_PREVENT

**FOR MALE PARTICIPANTS ONLY:**

*In order to understand more about how HIV is spread in Swaziland, we need to know more about your personal experiences. What you tell me will be completely confidential and may help make changes to policies and programs so other men will be less at risk for HIV. I really appreciate your honesty and willingness to share your experiences.*

10d. *Do you feel like you have control over the decision of when to have sex?* No \_\_\_\_\_ 0 IFSEXM  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88

10e. *Who usually decides whether or not to have sex in your relationship(s)?*  
You \_\_\_\_\_ 1 DECIM  
Mostly you \_\_\_\_\_ 2  
You and your partner(s) equally \_\_\_\_\_ 3  
Mostly partner(s) \_\_\_\_\_ 4  
Partner(s) only \_\_\_\_\_ 5  
Other (please specify) \_\_\_\_\_ 6

10f. *Do you feel like you have control over the decision of whether to use a condom?* No \_\_\_\_\_ 0 IFCM  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88

10g. *Do you feel like you have control over decisions about childbearing?* No \_\_\_\_\_ 0 IFCHLDM  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88

*How are these decisions made and carried out? HOWSEXDECISIONS\_DETAILM*  
[Probe use of force or other forms of control]

10h. *Do you have more than one sexual partner?* No \_\_\_\_\_ 0 PARTM1  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

10i. *Have you had more than one sexual partner at the same time?* No \_\_\_\_\_ 0 PARTM2  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

10j. *Have any of your partners had other sexual partners during the time that you were together?*  
No \_\_\_\_\_ 0 PPARTM  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

10k. *Did you have more than one partner at the time you became infected with HIV?*  
No \_\_\_\_\_ 0 MPARTM  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

10l. *Do you feel like alcohol use (by you or your partner) played a role in your becoming infected with HIV?*  
No \_\_\_\_\_ 0 ALCUM  
Yes \_\_\_\_\_ 1  
DK \_\_\_\_\_ 88  
NR \_\_\_\_\_ 99

If so, please tell me more. ALCOHOL\_ROLEM  
[If own use, probe frequency and level of use]

10m. Have you ever had a sexual relationship with someone 10 or more years older or younger than you?

No \_\_\_\_\_ 0 INTERM  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

If so, please tell me more. INTERGEN\_DETAILM  
[Probe frequency, length of relationship(s)]

10m. Have you ever had sex with someone because that person gave you food, gifts, money, or other things?

No \_\_\_\_\_ 0 TSX1  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

If so, please tell me more. TRANSACT\_RECEIVEM  
[Probe frequency, length of relationship(s)]

10n. Have you ever given someone food, gifts, money, or other things to have sex with you?

No \_\_\_\_\_ 0 TSX2  
Yes \_\_\_\_\_ 1  
NR \_\_\_\_\_ 99

If so, please tell me more. TRANSACT\_GIVEM  
[Probe frequency, length of relationship(s)]

Do you feel there are certain expectations for your behavior or living situation as a Swazi man, such as when or whether you have sex or father children, whether and how you earn an income, your roles in your family and community? Please tell me more.  
EXPECT\_ASMAN

Do you feel there are certain expectations for your partner's behavior or living situation as a Swazi woman, such as when or whether she has sex or bears children, whether and how she earns an income, her roles in the family and community? Please tell me more. EXPECT\_ONFEMALEPARTNER

**FOR ALL PARTICIPANTS:**

**11. Are food shortages a significant problem in Swaziland? FOODSHORTAGES**

11a. *Have you been affected by lack of food or water?* Not affected \_\_\_\_\_ 0 NOFD  
 Hunger \_\_\_\_\_ 1  
 Access to health care \_\_\_\_\_ 2  
 Ec dependence \_\_\_\_\_ 3  
 Can't farm \_\_\_\_\_ 4  
 Other (specify) \_\_\_\_\_ 5  
 NR \_\_\_\_\_ 99

*If so, how so?* AFFECTED\_NOFOOD

11b. *Are you receiving any assistance or support related to food needs?* No \_\_\_\_\_ 0 FDSUP  
 Yes \_\_\_\_\_ 1  
 NR \_\_\_\_\_ 99

*If so, what type of assistance?* ASSIST\_FOOD

11c. *Are you receiving any assistance or support related to your HIV status?* No \_\_\_\_\_ 0 HASUP  
 Yes \_\_\_\_\_ 1  
 NR \_\_\_\_\_ 99

*If so, what type of assistance?* ASSIST\_HIV

**12. Has being HIV-positive changed your sexual behavior?** No \_\_\_\_\_ 0 CHSX  
 Yes \_\_\_\_\_ 1  
 DK \_\_\_\_\_ 88  
 NR \_\_\_\_\_ 99

How? [Probe number of partners, condom use, behavior towards partners] HOWSEX\_CHANGED

*If so, what helped you to change your behavior?/ If not, what prevents you from changing your behavior?*  
 HELPHINDERED\_CHANGE

**13. Has being HIV-positive led to other significant changes in your life or in your relationships with others?**

RELATIONSHIPS\_CHANGED

[Probe experiences as a person who is HIV+ and healthy, if applicable]

[Probe changes to drug/alcohol use, other risky behaviors]

**14. What has been your experience with health care providers with respect to HIV?** HEALTHPROVIDERS

14a. Has the quality of your medical care changed since you tested positive? [Circle ALL THAT APPLY]

- Better care \_\_\_\_\_ 1 QUAL
- No change \_\_\_\_\_ 2
- Worse care \_\_\_\_\_ 3
- Denial of care/treatment \_\_\_\_\_ 4
- Verbal mistreatment \_\_\_\_\_ 5
- DK \_\_\_\_\_ 88
- NR \_\_\_\_\_ 99

Please tell me more. HOWQUALITY\_CHANGED

**15. Have community and political leaders addressed the HIV/ AIDS problem in your community? What have they done?**

COMMUNITY\_POLITICIANS

[Chiefs, clergy, Members of Parliament, Ministers, etc.]

What has the king done to address HIV/ AIDS in Swaziland? KINGDONE

What should he do? KINGSHOULD

**ASSESSMENT FOR MAJOR DEPRESSION**

**16. The following are symptoms or problems that people sometimes have. Please let me know the extent to which each of the following symptoms has bothered you or distressed you in the LAST WEEK, including today.** DEPR

Statement	Not at all	A little	Quite a bit	Extremely	NR
a. Feeling low in energy, slowed down	1	2	3	4	99
b. Blaming yourself for things	1	2	3	4	99
c. Crying easily	1	2	3	4	99
d. Loss of sexual interest or pleasure	1	2	3	4	99
e. Poor appetite	1	2	3	4	99
f. Difficulty falling asleep, staying asleep	1	2	3	4	99
g. Feeling hopeless about the future	1	2	3	4	99
h. Feeling down or blue	1	2	3	4	99
i. Feeling lonely	1	2	3	4	99
j. Thoughts of ending your life	1	2	3	4	99
k. Feelings of being trapped or caught	1	2	3	4	99
l. Worry too much about things	1	2	3	4	99
m. Feeling no interest in things	1	2	3	4	99
n. Feeling everything is an effort	1	2	3	4	99
o. Feeling worthless	1	2	3	4	99

**FOR PARTICIPANTS WHO REPORT THOUGHTS OF ENDING THEIR LIVES [2-4 on 16]:**

Based on your response, I am concerned about your safety. I would like you to speak with one of the doctors or nurses working on this study because they may be able to help you. While you are free to refuse, I want you to know that the doctor or nurse will not tell anyone else anything that you tell them without your permission. This health worker would like to help make sure that you are safe and that you know where to go to get help. Would you like to speak with a health worker?

**IF NO:**

I would like to provide you with some information on counselors you can talk to about the feelings you've expressed. Can I give you some information on where you can get help?



## **INFORMATION HANDOUTS**

*I have some written information on living with HIV/AIDS and treatment, would you like these pamphlets?*

*In Swaziland, people sometimes don't feel safe at home because they experience domestic violence. Domestic violence means that their partners or family members physically hurt them, threaten them or force them to have sex when they don't want to. There are organizations to assist people who are being hurt. They can also help you to report domestic violence to the police. Would you like information on how you can contact these organizations?*

# APPENDIX 6: SWAZILAND KEY INFORMANT INTERVIEW

Physicians for Human Rights  
Swaziland Key Informant Interview  
4.20.05

<b>1</b>	<b>OCCUPATION/POSITION</b>
<b>2</b>	<b>What are the key obstacles towards controlling the HIV/AIDS epidemic in Swaziland?</b>
<b>3</b>	<p><b>What are the most significant barriers to HIV testing in Swaziland?</b></p> <p>a) Which groups are hardest to reach or have least access with regard to testing? - Probe: region, age, sex, sexuality, mobility, nationality, socio-economic status, education, etc.</p> <p>b) In what ways do the barriers to testing differ for men and women? Is gender violence related to testing a significant problem?</p> <p>c) To what extent is HIV/AIDS-related stigma a barrier to testing?</p> <p>d) What are some of the local and national programs and policies that aim to encourage testing? What else is needed at the national level?</p> <p>e) Do you have other recommendations for decreasing barriers to testing?</p>
<b>4</b>	<p><b>What are your thoughts about new policies related to testing, many of which have been introduced elsewhere in Africa? Are any of these feasible or appropriate for Swaziland? If so, how can they be implemented?</b></p> <p>a) Rapid testing, where results are given on the same day? What are your thoughts about the pilot program at the University of Swaziland?</p> <p>b) Mobile VCT programs? Mobile testing by volunteers (TCM, support groups)?</p> <p>c) Couples testing?</p> <p>d) Opt-out or routine testing as a part of regular medical exams and clinical visits?</p> <p>e) What are your recommendations on how to improve testing? What, if anything, distinguishes Swaziland from other countries in the region in terms of testing?</p>
<b>5</b>	<p><b>What are the key barriers to ARV treatment at both the individual and national levels?</b></p> <p>a) Do people have information about ARVs? [Probe: HIV+, general population] Do you think there are differences in knowledge between men and women?</p> <p>b) How do people get access to ARVs? Who has access to date? What are the key barriers to ARV rollout?</p> <p>c) Is non-adherence to treatment a significant problem?</p>
<b>6</b>	<p><b>What are some of the factors that make women at risk for HIV in Swaziland?</b></p> <p>Probe: -negotiating power in sexual relationships -alcohol use by women -need to prove fertility before and/or during marriage -intergenerational sex -access to resources/economic dependence -exchanging sex for money or other resources -caregiving responsibilities, especially for orphans or PLWA</p> <p>a) What role does sexual or physical abuse play in the epidemic? -Probe: barriers or facilitators to ending or leaving abusive situations</p> <p>b) Does women's status under customary law contribute to the spread of HIV in Swaziland? How about women's status under civil law? Please explain. -Probe: property, inheritance, child custody, other</p> <p>c) What cultural traditions or obligations play a role? How? -Probe: polygamy, lobola, forced marriage, chastity and mourning customs, other</p> <p>e) What types of programs are there at the community or national level to address the factors that make women vulnerable to HIV and/or to empower women?</p> <p>f) What are your recommendations on how to decrease women's vulnerability to HIV?</p>

**Physicians for Human Rights  
Swaziland Key Informant Interview  
4.20.05**

<b>7</b>	<p><b>What are some of the factors that make men particularly at risk for HIV in Swaziland?</b></p> <p>a) Do you think cultural expectations for men contribute? - Probe: multiple sexual partners/polygamy, proving fertility, controlling women's sexuality, other</p> <p>b) Is alcohol use (and alcohol use associated with sex) common among men? To what extent does it contribute to HIV transmission?</p> <p>c) What are some of the barriers to using condoms for men?</p> <p>d) Are there programs in place that target men specifically and/or that mobilize men to get involved in AIDS prevention and screening efforts?</p> <p>e) What are your recommendations for how we can encourage men to get involved in prevention efforts and to take the steps necessary to prevent HIV infection?</p>
<b>8</b>	<p><b>Has food insecurity and/or drought had an impact on the HIV/AIDS epidemic in Swaziland? If so, in what ways?</b></p> <p>- Probe: barrier to testing, care, treatment; factor increasing economic dependence/vulnerability, other</p>
<b>9</b>	<p><b>What type of stigma and discrimination do PLWA experience at home / work / school / elsewhere in their communities?</b></p> <p>a) Do you think HIV-related stigma and discrimination differ for men and women? If so, how? Is violence towards HIV-positive women a significant problem?</p> <p>b) What policies/laws are in place to protect the rights of PLWA?</p> <p>c) What programs address stigma and discrimination at the community and national levels?</p> <p>d) What else do you think could/should be done to decrease stigma?</p>
<b>10</b>	<p><b>What role do traditional healers play in health care generally? In the HIV/AIDS epidemic specifically?</b></p> <p>a) Have they been enlisted significantly in programs to encourage HIV/AIDS education, prevention, testing and treatment? Should they be? If so, how?</p> <p>b) Do you think their role in the epidemic has been mostly positive or negative?</p>
<b>11</b>	<p><b>What role are chiefs playing in the HIV/AIDS epidemic?</b></p> <p>a) Have they been enlisted significantly in programs to encourage HIV/AIDS education, prevention, testing and treatment? Should they be? If so, how?</p> <p>b) Do you think their role in addressing this epidemic has been mostly positive or negative?</p>
<b>12</b>	<p><b>Do religious leaders have a significant role? Is it positive or negative overall?</b></p>
<b>13</b>	<p><b>What role are political leaders playing in the HIV/AIDS epidemic?</b></p> <p>a) Have they adequately encouraged HIV/AIDS education, prevention, testing and treatment?</p> <p>b) What impact has the King had in addressing the epidemic?</p> <p>c) What should political leaders and the King do now?</p>
<b>14</b>	<p><b>Please tell me more about organizations that are working on advocacy for PLWA or HIV/AIDS education/prevention.</b></p> <p>a) Do you think these groups are having significant impact on controlling the HIV/AIDS epidemic?</p> <p>b) What are your recommendations for strengthening community mobilization or advocacy for PLWAs?</p>
<b>15</b>	<p><b>Can we contact you with additional questions? Are there other people who you suggest we contact for information on these issues? Is there any Swaziland-specific information you would suggest that we obtain?</b></p>