

SWAZILAND LEGAL ENVIRONMENT ASSESSMENT FOR HIV and AIDS

An Assessment of The national legal, regulatory
and policy framework for HIV and AIDS
in Swaziland

June 2015



*Empowered lives.
Resilient nations.*

FOREWORD

ACKNOWLEDGEMENTS

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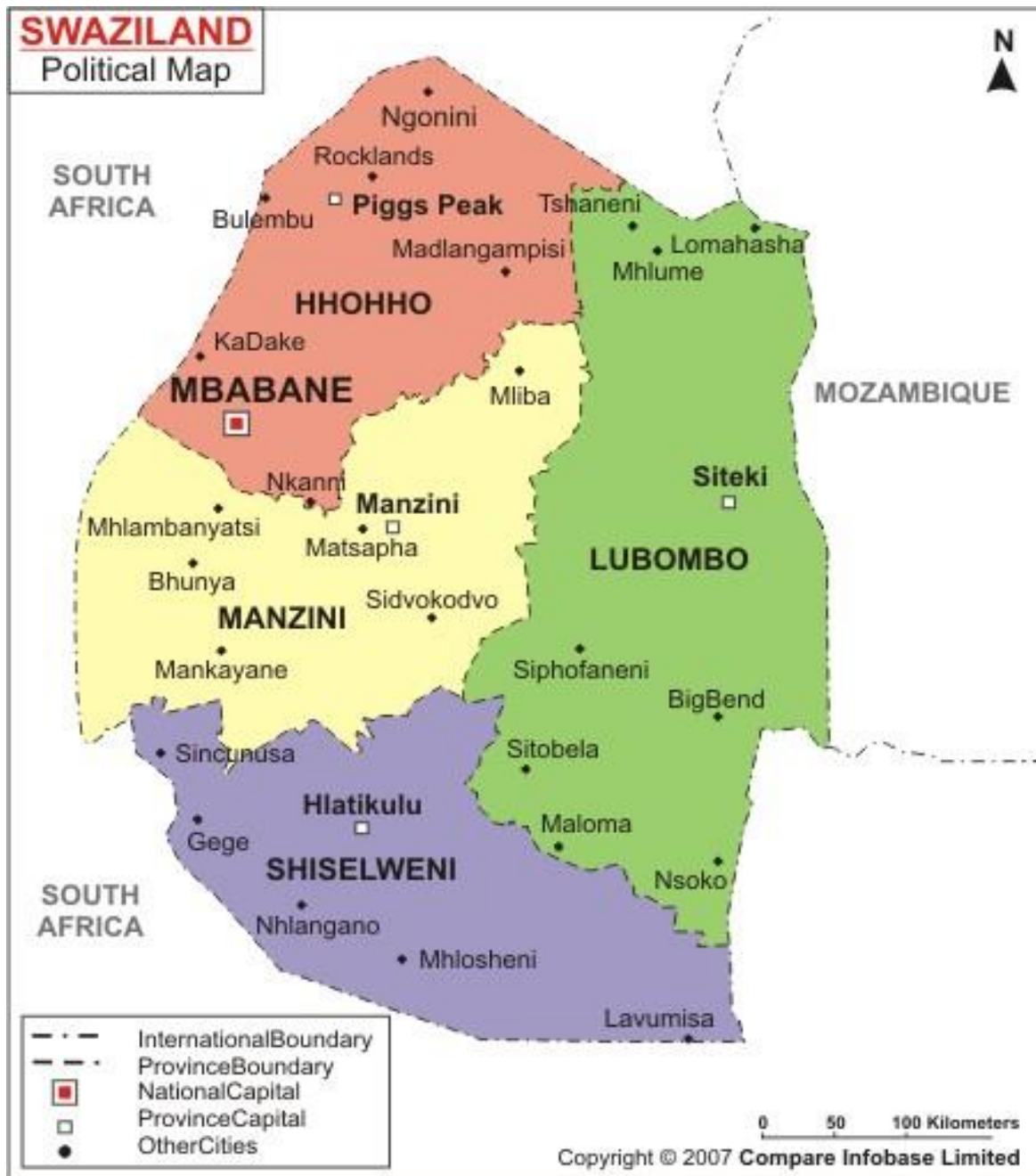
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Political Map of Swaziland



ACRONYMS AND ABBREVIATIONS

ACHPR	African Charter on Human and Peoples' Rights
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy/treatment
BSS	Behavioural Sentinel Surveillance
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Central Statistics Office
eNSF	extended National Strategic Framework
FGD	Focus Group Discussion
FY	Financial Year
GCHL	Global Commission on HIV and the Law
GDP	Gross Domestic Product
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
KII	Key Informant Interview
LEA	Legal Environment Assessment
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MoH	Ministry of Health
MSM	Men who have sex with men
NERCHA	National Emergency Response Council on HIV and AIDS
NGO	Non-governmental organisation
NSF	National Multi-Sectoral Strategic Framework
NSP	National Strategic Plan
PLHIV	People living with HIV
SACU	Southern Africa Customs Union
SADC	Southern Africa Development Community
SADC PF	Southern African Development Community Parliamentary Forum
SDHS	Swaziland Demographic and Health Survey
SHIMS	Swaziland HIV Incidence Measurement Survey
SHIES	Swaziland Household Income and Expenditure Survey
SNAP	Swaziland National AIDS Programme
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nation Office on Drugs and Crime
WHO	World Health Organisation

EXECUTIVE SUMMARY

Swaziland is one of the countries in the Southern African Development Community (SADC) with the highest HIV prevalence, with 27.4% of adults aged 15 to 49 years living with HIV, according to the most recent reports by the Joint United Nations Programme on HIV and AIDS (UNAIDS).¹

Bad laws and policies and HIV-related stigma and discrimination are recognised to be a driver of the spread and impact of the HIV epidemic in countries. HIV-related stigma and discrimination not only constitutes a violation of human rights, it also seriously undermines HIV prevention efforts. Eliminating stigma and discrimination against all affected populations, through protective laws and policies and strengthened access to justice and law enforcement will ensure that all people enjoy full equality and inclusion in the political, economic, social, and cultural life and are able to access health care services to protect and promote their health and well-being.

This comprehensive Legal Environment Assessment (LEA), commissioned by Government and National Emergency Response Council on HIV and AIDS (NERCHA) supported by the United Nations Development Programme (UNDP) in Swaziland, aimed to review HIV-related laws, policies and practices in Swaziland. It analysed international, regional and national human rights obligations, represented by those conventions, treaties, regional frameworks and the national Constitution to which Swaziland has committed to, against national HIV-related laws, policies and practices as implemented by the country's legislative framework and programmatic response to HIV and to populations affected by HIV. It furthermore investigated Swaziland's commitment to protecting the rights of and creating an environment that reduces vulnerability for people living with HIV (PLHIV) and for key populations at higher risk of HIV exposure.

The LEA was undertaken by experts in law and human rights as well as a public health consultant to supervise and direct the assessment. It included an identification and review of relevant literature on HIV-related legal and public health issues in Swaziland as well as commitments under national, regional as well as international human rights law. It looked specifically at a range of laws, regulations, policies, strategic frameworks and programmes on HIV and vulnerable and key populations as well as related reports.

Based on key issues arising, the LEA also included interviews with key informants from government departments and ministries, non-governmental organisations (NGOs) and civil society organisations (CSOs) as well as focus group discussions in the four regions of the country with different individuals, communities and organisations affected by and working with HIV, PLHIV and key populations. These consultations sought to clarify issues, to evaluate the impact of the legal and regulatory environment on the national HIV response and on the daily lives of affected people in terms of issues such as access to treatment, care and support and the realization of basic human rights.

¹ <http://www.unaids.org/en/regionscountries/countries/swaziland/>. Accessed 19 March 2015.

The LEA found that Swaziland has committed to protecting and promoting human rights broadly, in its signing and ratifying of various United Nations (UN) conventions, regional protocols and declarations and in the enactment of the National Constitution, 2005 which protects the rights of all people to equality and non-discrimination and promotes the health and welfare of people. Swaziland has also furthermore shown specific commitments to a rights-based response to managing the HIV epidemic. For instance, this is seen through the development and implementation of a multi-sectoral national HIV strategy based on human rights and gender equality, various rights-based HIV policies and the development of various programmes of prevention, treatment, care and support for a range of populations.

However, the LEA shows that there are several challenges in the Swaziland legal and regulatory framework which create barriers to universal access to HIV prevention, treatment, care and support. Firstly, the legislative and policy framework is not sufficiently protective. Even where protective laws exist, they are not adequately implemented and enforced, allowing stigma, discrimination and gender inequality to continue. In addition, discriminatory and punitive laws, policies and practices, such as those that condone gender inequality, those that exclude PLHIV and those that criminalise key populations, continue to create barriers for vulnerable and key populations.

As a result, stigma and discrimination against PLHIV and key populations continues unabated and is particularly serious for marginalised and criminalised populations such as men who have sex with men and sex workers. For instance, the criminalisation of same-sex practices and the stigma and discrimination against men who have sex with men perpetuates fear and reinforces the ‘invisibility’ of the population in society, creating barriers to their ability to access HIV-related health care services without discrimination. Swazi culture furthermore entrenches patriarchal beliefs, norms and practices as well as denies alternative gender identities, such as transgender and sexual orientations such as homosexuality.

The following is a summary of the specific recommendations that are set out in more detailed throughout the report and in the concluding section:

- a) Law reform should be considered a priority in order to
 - Increase protection from discrimination in law for HIV and AIDS, gender, sexual orientation and gender identity in various new Bills (e.g. Public Health Bill, Gender Equality Bill; Disability Bill) and in the possible development of a new Equality / Anti-Discrimination Act.
 - Enact the various new health bills currently in development, to improve the regulation of access to health care services and affordable medicines and to protect patient rights to non-discrimination, confidentiality, disclosure and voluntary HIV testing
 - Review criminal laws and the Public Health Bill to remove punitive and coercive provisions such as the criminalisation of HIV transmission, the criminalisation of sex work and sex between men
 - Enact clear protection from discrimination and pre-employment HIV testing in law in the Employment Act

- Enact the Sexual Offences and Domestic Violence Bill and update the Women and Girls Protection Act to increase protection for women from gender-based violence
 - Enact the Marriages Bill 2007 and Married Persons Equality Bill 2009 to protect women’s equality rights within marriage and to protect young girls from early marriage.
 - Review prisons law and policy to protect prisoners from mandatory HIV testing and to provide for access to voluntary HIV testing and counselling as well as the provision of condoms within prisons
 - Enact the Disability Bill and disability and HIV policy to provide for the protection of the rights of people with disabilities in the context of HIV and AIDS
- b) Increase access to justice and strengthen law enforcement in response to HIV and AIDS by:
- Developing stigma and discrimination reduction campaigns for the broader community as well as within specific sectors such as health care and the workplace
 - Conduct awareness, training and education for affected populations as well as service providers (health care workers, social workers) and law enforcement officials on
 - the rights of people living with HIV, women and girls’ rights to gender inequality and protection from harmful gender norms and gender-based violence
 - the rights of all vulnerable populations (e.g. people with disabilities) and key populations (e.g. sex workers, men who have sex with men and people who inject drugs, prisoners, mobile populations)
 - Strengthen the provision of legal support for people living with HIV and members of vulnerable and key populations
 - Strengthen the capacity of complaints mechanisms such as the Commission on Human Rights and Public Administration in order to strengthen the monitoring and enforcement of human rights in the context of HIV and AIDS.
- c) Increase programmatic responses to meet human rights and public health obligations with respect to key populations, including lesbian, gay, bisexual, transgender and intersex (LGBTI) populations, within their specific political, cultural and religious context.
- d) Support the meaningful participation of PLHIV and key populations at higher risk of HIV exposure in the national HIV response.
- e) Increase sustainable funding for effective responses to HIV and AIDS.

OPERATIONAL DEFINITIONS

TERMINOLOGY	DEFINITION
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Human Rights	Universal and inalienable rights accorded to all people by virtue of being human
Key Populations at higher risk of HIV exposure	Refers to those populations most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response, i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients and seronegative partners in sero-discordant couples are at higher risk of HIV exposure to HIV than other people. There is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.
Men who have sex with men	Describes males who have sex with other males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it includes men who self-identify as heterosexual but have sex with other men.
People who inject drugs	Refers to all persons who inject narcotic drugs for non-medical purposes. Drugs may be injected through subcutaneous, intramuscular and intravenous routes.
Sex work	Refers to the provision of sexual services between consenting adults over the age of 18, either regularly or occasionally, formally or informally, in exchange for money.
Sex worker	Any person involved in the sex industry as a seller, buyer or staff. The term sex worker is intended to be non-judgemental and focuses on the working conditions under which sexual services are sold. Sex workers include consenting female, male and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally.
Universal access	Refers to a situation where every person can access health services. Access is understood as a broad concept that measures three dimensions of key health sector interventions: availability, coverage, and outcome and impact. Availability is defined in terms of the reachability (physical access), affordability (economic access) and acceptability (sociocultural access) of services that meet a minimum standard of quality. Making services

	<p>available, affordable and acceptable is an essential precondition for achieving universal access.</p> <p>Coverage is defined as the proportion of people needing an intervention who receive it. Coverage is influenced by the supply or provision of services, and by the demand from those who need services and their health-seeking behaviour.</p> <p>Outcome and impact are defined in terms of medium-term effects, such as behavioural change or higher survival rates, and long-term effects, such as lower infection rates. Outcome and impact are the result of coverage, and depend on the efficiency and effectiveness of interventions.</p>
Transgender	<p>A transgender person is a person whose gender expression or gender identity is different from his or her biological sex or gender assigned at birth. Transgender people may be male to female or female to male. Transgender persons may also prefer not to conform to any gender binary, but use gender neutral references.</p>
Vulnerable population	<p>The UNAIDS (2011) <i>Terminology Guidelines</i> describe vulnerability as “unequal opportunities, social exclusion, unemployment, or precarious employment and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk and may be outside the control of individuals.</p>

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1. Introduction

The report presents the findings of the Legal Environment Assessment (LEA) conducted in Swaziland from 2013 to 2014. The LEA aims to document laws, regulations, policies, practices, HIV-related stigma, discrimination and human rights violations faced by people living with HIV (PLHIV), vulnerable and key populations at higher risk of HIV exposure. It furthermore aims to identify the extent to which the current legal and regulatory framework in Swaziland either protects rights or perpetuates human rights abuses in efforts to promote effective responses to HIV and AIDS.

The assessment emanates from the follow up to the Global Commission on HIV and the Law (2012) *Risks, Rights & Health* report which shows that human rights and the response to them through appropriate laws and law enforcement are key to the HIV response. According to the Global Commission on HIV and the Law (GCHL), evidence shows that in addition to HIV prevention and treatment interventions, "...the legal environment can play a powerful role in the well-being of people living with HIV and those vulnerable to it. Good laws, fully resourced and rigorously enforced, can widen access to prevention and health care services, improve the quality of treatment, enhance social support for people affected by the epidemic, protect human rights that are vital to survival and save public money" (GCHL, 2012:11).

Though the HIV epidemic has been described as generalised in the country, there is evidence of a concentrated epidemic among certain key populations such as sex workers and prisoners. These concentrated epidemics play an important role in the spread of the epidemic and its effective control. International and local evidence shows that men who have sex with men, transgender people, sex workers, people who inject drugs, prisoners, certain migrant populations, and people with disabilities are disproportionately affected by HIV and in many circumstances are marginalised by society. In Swaziland evidence shows that vulnerable and key populations bear a greater burden of HIV incidence and prevalence, perpetuated and exacerbated partly by violations of their human rights, stigma and discrimination, all of which directly impact on not only on their basic human rights but also on access to health services (c.f. Council of Swaziland Churches, 2010; Physicians for Human Rights, 2007).

The exclusion of populations who are vulnerable to or at higher risk of exposure to HIV or who are on the margins of society, undermines the ability of any response to be effective, while contravening human rights and public health principles of equality, freedom from discrimination and access to health services. Key populations and vulnerable groups can only reach their maximum potential if the social and legal environment is supportive of their health needs and if services are accessible, acceptable and provided in a non-discriminatory manner. Through the provision of tailored services aimed at the reduction of HIV incidence amongst key populations, a reduction in population incidence can be achieved.

It is clear that the HIV epidemic cannot be fully addressed without taking into consideration the needs of all affected populations, including vulnerable and key populations in Swaziland; hence vulnerable and key populations are a primary focus of this report. The findings of the

LEA will inform the mainstreaming of human rights protection in Swaziland's legal and policy development and programming for the national HIV and AIDS response, in order to create an enabling environment for universal access to comprehensive HIV services for all vulnerable and key population groups.

1.2. Country Background

Swaziland is a small country nestled between Mozambique in the east and South Africa in the west, north and south. The total population according to the 2007 population census is 1,018,449 with females comprising 52.7%. Swaziland has a youthful population, with 52% of the population below the age of 20 years and almost 40% younger than 15 years (Central Statistics Office Census Report, 2007). Though the country is ranked as a lower middle income country, poverty levels remain high; 63% of the population live below the poverty line, a slight improvement from 69% in 2000/1 and women are disproportionately poor compared to men (MEPD Swaziland Household Income and Expenditure Survey (MEPD.SHIES, 2010). The majority of the wealth (54.6%) is estimated to be held by 20% of the population and only 4.3% is held by the poorest 20% of the population. The high poverty level is directly linked to high unemployment, an education system that emphasises academic attainment rather than vocational skills and business entrepreneurship and the lack of opportunities in the private sector. Additionally, the poverty levels are exacerbated by high HIV prevalence, the aftershock of the global financial crisis experienced in 2010, external commodity price shocks especially with regards to food and fuel, a deteriorating fiscal situation and the lack of direct foreign investment (Blank, 2012).

1.3. Economic Profile

The World Bank classifies Swaziland as a lower middle income country with gross domestic product (GDP) of US\$ 25 900 and a per capita income of US\$ 2,280 (World Bank, 2012). Swaziland's economy is very closely linked to that of the Republic of South Africa with the local currency - Lilangeni sharing a currency parity with the South African Rand dating back to 1910 (Dlamini, 2011). The economy of the country is primarily agrarian, even though the manufacturing sector has grown over the years. Although the country has an open market economy characterized by a high ratio of exports and imports to the GDP, it is heavily dependent on South Africa from which it receives more than 90% of its imports and to which it sends 60% of its exports. The government is heavily dependent on customs duties from the Southern African Customs Union (SACU). The major export markets are SACU, the Common Market for Eastern and Southern Africa, SADC, the European Union and the United States of America. Exports include, amongst others, sugar cane processing, soft drink concentrate, canned fruits, beef and clothing.

While the country experienced high economic growth levels at 9% on average in the late 1980's, in recent years the economic growth has slowed down, reaching an average of a negative 0.2% in the period 2011 to 2012 as a result of the global recession as well as the closure of one of the biggest manufacturing industries, the Usuthu Pulp Company. The negative economic growth has had a direct effect on poverty levels in the country. The United Nations' Human Development Report (UNDP, 2011) ranked Swaziland very low in terms of the well-being of

its citizens, at 140 out of 187 countries. Moreover, the country's human development index (HDI) score has deteriorated from 0.641 in 1995 to 0.522 in 2011. The HDI rate for Swaziland is now approximately equal to the average for all of sub-Saharan Africa. This decline can largely be attributed to the decline in life expectancy, which stood at 59 years in the early 1990s but dropped to 48.9 years in 2010. On a positive note, Swaziland's HDI value for 2012 increased slightly to 0.536, placing the country in the medium human development category. A trend analysis shows that between 1990 and 2012, Swaziland's HDI value increased from 0.533 to 0.536, an increase of 1 percent or average increase of about 0.03 percent annually (Human Development Report (UNDP HDR, 2013). Additionally, Swaziland's score on the Education Index, a component of the HDI, continues to improve, with more children accessing education than in previous years, attributed to the free education policy (Blank, 2012).

1.4. Political and Administrative Structure

Swaziland is a patriarchal and traditional society with embedded cultural norms and practices. Like most African states of the Commonwealth, there are also dual systems of political governance and legal justice, with a traditional system existing alongside the modern system. This, it is argued, is a relic of the colonial masters. The government of Swaziland entails three branches: the executive, the legislative and the administrative branches.

The executive branch of government has its base at Mbabane, the capital city. It consists of the King, the Prime Minister who is appointed by the King, and the Cabinet, who all exercise total executive authority. The legislative branch consists of two houses of Parliament: the House of Assembly and the Senate, both of which are located at Lobamba, the cultural capital of the country. The House of Assembly contains 65 members, 55 of which are elected by the nation through popular vote directly to Parliament and the rest of whom are appointed by the King. The Senate consist of thirty members; twenty appointed by the King and the other ten of whom are elected by the House of Assembly through popular vote. Members of the Senate and the House of Assembly both have a five year term. The Parliament passes laws created by the various government ministries with the assistance of the Attorney General's office. However, the King confers the final assent to all legislation passed by both houses.

The judicial branch of government is based on a dual system. One part consists of courts based on the western model and laws from the Roman Dutch law tradition, while the second part consists of Swaziland laws and customs and National Swazi Courts. The King appoints the judiciary at the recommendation of the Judicial Service Commission and the Presiding Officers of the Swazi National Courts. Whereas the modern legal system derives much of its structures from the country's Constitution and the various written statutes and regulations, the traditional laws and customs have been documented but not codified. A process to document Swazi Law and Custom was initiated almost nine years ago and the report was tabled to his Majesty in 2013.

Administratively the country is divided into four regions, namely Hhohho, Manzini, Lubombo and Shiselweni. For political and development purposes, the country is further divided into 55 constituencies (*or Tinkhundla*) made of 360 chiefdoms. The country has two official languages: SiSwati and English.

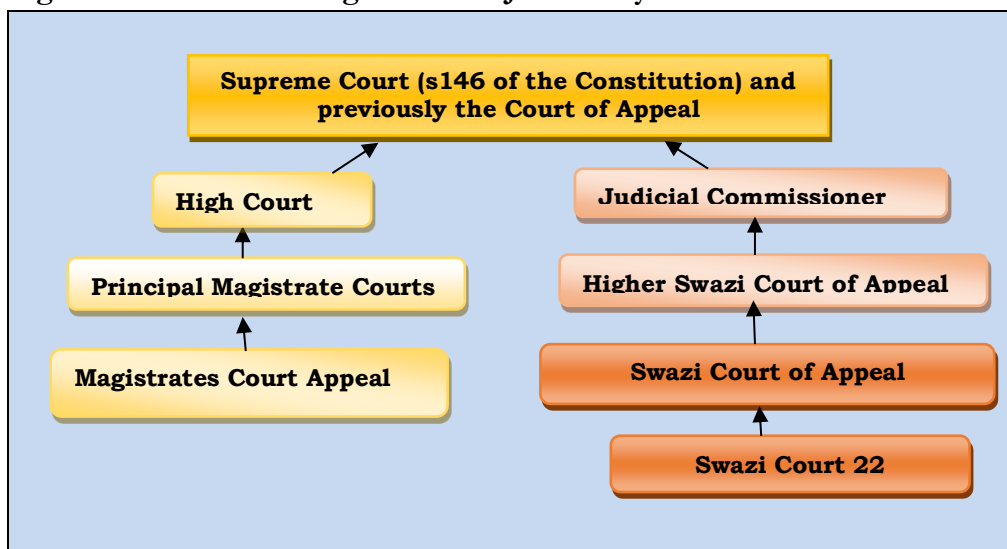
1.5. The Legal System

Like most African countries that were former colonies, Swaziland operates a dual legal system. In terms of this arrangement, statutory and Roman-Dutch common law co-exist beside Swazi law and custom. The country's legal system therefore is characterised by an interaction between the traditional law and customs and a western model of governance.

The country does not have a single code containing all laws. Instead, the legislative framework includes the Constitution, which is the supreme law of the country, statutes (Acts of Parliament) and other written subordinate legislation (e.g. Orders-in-Council and Regulations), the common law and customary law. These are also informed by authoritative texts and judicial precedent.

To adjudicate on statutory and common law, there are various courts including the Supreme Court, the High Court and magistrate's courts. The Supreme Court enjoys appellate jurisdiction, is the final appeal court and has supervisory and review jurisdiction over all the courts of Swaziland. The High Court on the other hand enjoys unlimited original jurisdiction in civil and criminal matters. It also has the jurisdiction to hear and determine on matters of a constitutional nature, and to enforce the fundamental human rights and freedoms guaranteed by the Constitution. Similar to the Supreme Court, the High Court has supervisory and review jurisdiction over all the magistrate's courts in the country. Matters relating to industrial and labour matters are dealt with through the Industrial Court and the Industrial Court of Appeal, which are specialist courts. Under Swazi law and custom there are Swazi Traditional Courts, the Swazi Court of Appeal, and the Higher Swazi Court of Appeal (as illustrated in the diagram below).

Figure 1: Illustration Diagram of the Judicial System in Swaziland



Section 252 of the Constitution of Swaziland provides for the dual legal system in Swaziland. It provides that the principles and rules of the common law as well as Swazi customary law both apply, provided they are not inconsistent with the Constitution.

- 1) Subject to the provisions of this Constitution or any other written law, the principles and rules that formed, immediately before the 6th September, 1968 (Independence Day), the principles and rules of the Roman Dutch Common Law as applicable to Swaziland since 22nd February 1907 are confirmed and shall be applied and enforced as the common law of Swaziland except where and to the extent that those principles or rules are inconsistent with this Constitution or a statute.
- 2) Subject to the provisions of this Constitution, the principles of Swazi customary law (Swazi law and custom) are hereby recognized and adopted and shall be applied and enforced as part of the law of Swaziland.
- 3) The provisions of subsection (2) do not apply in respect of any custom that is, and to the extent that it is, inconsistent with a provision of this Constitution or a statute, or repugnant to natural justice or morality or general principles of humanity.

Swaziland Constitution Section 252

There is no systematic and comprehensive assessment of the critical aspects of the legal and regulatory framework in relation to the HIV response as a whole in Swaziland. There are existing reports on selected HIV law and human rights challenges - such as the prevalence of stigma and discrimination of people based on their HIV status and sexual orientation, as well as the abuse of human rights including poor access to HIV related social and health services (SWANNEPHA, 2011). As a result, the government of the Kingdom of Swaziland, in collaboration with UNDP and other UN agencies supported this LEA in order to provide evidence for a strengthened legal and regulatory response to HIV underpinned by the protection and promotion of the rights of PLHIV and other vulnerable and key populations. Targeted actions to create enabling environments will contribute to achieving and maintaining Universal Access targets, the Millennium Development Goals and to reaching the goal of “zero new HIV infections, zero HIV-related stigma and zero HIV-related deaths” (UNAIDS, 2011) in the Kingdom of Swaziland.

2.1 Scope

The LEA focuses on the legal and environmental framework for PLHIV and vulnerable and key populations in the context of the HIV response in Swaziland. The main purpose of the LEA is to determine the availability or lack of laws and policies that protect the rights of PLHIV and other vulnerable and key populations; their application (or lack thereof), the extent to which rights are upheld or violated and by whom, and access to justice where rights have been violated. Vulnerable and key populations in the context of the report refer to women, children and young people, people living with HIV (PLHIV), persons with disabilities, sex workers, and lesbians, gay, bisexual and transgender people (LGBTI), factory workers, prisoners and public transport workers.

2.2 Objectives

2.2.1 Broad Objectives

The broad objectives of the national LEA was to review laws, regulations and policy guidelines and practices, access to justice systems and human rights knowledge in the context of HIV and AIDS with the view to identifying:

- The nature and extent of stigma, discrimination, gender inequality, harmful gender norms and gender-based violence and human rights abuses affecting vulnerable and key populations at higher risk of HIV exposure.
- The impact of the legal and regulatory framework in protecting rights and promoting universal access to HIV and AIDS services, especially for vulnerable and key populations at higher risk of exposure.
- The extent to which existing protective laws are accessed and enforced by the justice system in protecting vulnerable and key populations at higher risk of HIV exposure.

2.2.2 Specific Objectives

Specific objectives included the following:

- To conduct a desk review and analyse international, regional and national human rights obligations relating to HIV and AIDS to which Swaziland as a state has committed
- To review relevant national laws, regulations and policies and recent and on-going reform initiatives, including laws that impact on vulnerable and key populations
- To review findings from research studies relating to law, human rights, stigma, discrimination and HIV and affected populations in Swaziland society
- To examine the nature, extent, efficacy and impact of the national legal and regulatory framework to protect against discrimination and human rights abuses and promote universal access to HIV-related health care services for vulnerable and key populations
- To analyse the extent to which affected populations know their rights and are able to access health services and mechanisms for legal recourse
- To establish the extent to which service providers, lawmakers and law enforcers are sensitized to HIV-related law and human rights issues to enable effective implementation of services, support access to justice and enforcement of HIV-related laws and rights
- To identify mechanisms for strengthening the implementation and enforcement of laws, regulations and policies related to access to justice and creating an enabling legislative environment for the HIV and AIDS response.
- To make detailed and appropriate recommendations for reviewing, reforming and/or developing new laws, regulations and policies that align with the national Constitution, regional and international human rights commitments.

2.3 Structure of the Report

The Report is made up of 7 sections. Section 1 and this section 2 sets out the introduction and background to the LEA in Swaziland. Section 3 describes the HIV epidemic in Swaziland, including the impact of HIV on vulnerable and key populations. Section 4 describes the international, regional and national framework for the HIV response in Swaziland. Section 5 describes access to justice and law enforcement for people living with HIV, vulnerable and key populations. Section 6 presents a summary of the LEA's overall findings and recommendations and Section 7 sets out the LEA recommendations for law review and reform, access to justice and law enforcement.

2.4 Methodology

2.4.1 Design

The LEA aimed to not only review available laws as presented in literature but also to get the emic perspective and experiences of vulnerable and key populations on human rights in the context of HIV as well as the etic perspective from key informants. A predominately qualitative approach in the analysis of information obtained from key informant interviews and focus group discussions was adopted.

2.4.2 Setting

Data was collected from a desk review of all available international and regional human rights documents and HIV and human rights guidance; national laws, regulations and policies relating to HIV, health and areas of law and policy that impact on PLHIV and other vulnerable and key populations (such as, amongst others, labour law and policy, criminal law and policy) as well as a review of available and relevant literature on HIV-related law and human rights in Swaziland. For the key informant interviews (KIIs) and focus group discussions (FGDs), data was collected from Swaziland, covering all the four geographic regions in both rural and urban communities and included all populations that are a focus of this report, save for children.

2.4.3 Sampling and Sample size for the KII and FGD

A representative sample size (quantity) was not the major goal of the LEA; rather the quality of submissions was considered paramount in order to use the feedback and findings from KIIs and FGDs to inform the analysis of the Swazi legal and regulatory framework. However, care was taken to ensure that all sectors of society were given an opportunity to voice their experiences and / or views. Therefore all stakeholders and peoples affected were invited to make their submissions either through FGDs or in-depth interviews. Those who turned down requests for interviews or were unable to attend at various opportunities were not able to be included.

2.4.4 Data Collection Tools

The KII and FGD tools were adapted from those used for the same exercise in other countries in the region, such as Malawi and Seychelles. In addition to the semi-structured interview guide, a *vignette* was developed for the FGDs. The *vignette* was translated to siSwati and was used to open up discussions with participants. An information sheet with the procedure to be followed during data collection was also developed and used to explain the assessment to participants prior to data collection. Informed consent was sought and granted by all participants verbally.

2.4.5 Data Collection

A triangulation of techniques was used for collecting data. Two sets of data was collected, primary and secondary data. Primary data was collected through a nation-wide qualitative design composed of FGDs and in-depth interviews with key informants. In total, 121 people took part in 14 FGDs. In addition 17 in-depth interviews were done with key informants consisting mainly of directors from government ministries or departments, programme managers from NGOs, representatives of religious organisations and churches and experts in traditional norms and customary law.

Secondary data on the other hand was collected through an extensive desk review of international and regional human rights and HIV instruments; national laws, regulations, policies as well as research studies conducted on law, human rights, stigma and discrimination and HIV in the country. Where studies were not available locally, regional and international data was used to inform recommendations.

The data sets (primary and secondary data) were collected simultaneously, to correlate and validate findings as and when necessary, to produce a deep understanding and grasp of the issues under study.

2.4.6 Data Handling and Analysis

The aim of the LEA is to document findings on the legal and regulatory framework for HIV; stigma, discrimination and human rights violations and access to justice and enforcement of laws and regulations that protect the human rights of vulnerable and key populations at higher risk for HIV in Swaziland. HIV-related laws, regulations and policies were analysed in terms of the extent to which they comply with international, regional and national human rights norms and standards and guidance on rights-based responses to HIV. They were furthermore analysed in terms of the extent to which they protected, or are able to protect, populations from human rights violations as described in the KII and FGD and to promote access to services. Qualitative analysis methods were used to analyse the data obtained from KII and FGD and to give a picture of these violations and experiential data is, to the extent possible, presented verbatim.

2.4.6 Ethical Considerations and Technical Approach to LEA

The assessment was guided by a human-rights based approach to health, HIV and AIDS using national, regional and international human rights conventions and protocols ratified by Swaziland as the starting point for framing the enquiry, designing the tools for data collection, analysing the findings and developing the recommendations. In the context of HIV, the human rights based approach aims to promote the right to health, equality and other related rights. It examines the legal, socio-economic and cultural contexts which underlie the HIV epidemic in Swaziland, with the broader aim of recognising and responding to the underlying inequalities, prejudices and power relationships that impact upon HIV transmission and access to HIV-related health care services by vulnerable and key populations at higher risk in the country.

The human rights-based approach used as guiding principles for the assessment included equality and non-discrimination; participation and inclusion of rights-holders. The assessment recognised the inter-relationship between all human rights, including health rights and equality rights, and sought to balance public health and human rights goals in developing the rights of all people, and particularly the rights of vulnerable and key populations.

The research protocol ensured strict observance of the right to confidentiality and to participation only on the basis of informed consent for all participants in key informant interviews and focus group discussions. It was reviewed and approved by an ethics review committee in Swaziland.

2.5 Dissemination

The final Assessment Report will be disseminated in a launch of the project, as well as circulated to stakeholders in a national meeting and through the UNDP and government websites. Findings will also be published through peer reviewed journals.

CHAPTER 3: HIV AND AIDS AND AFFECTED POPULATIONS IN SWAZILAND

3.1. Introduction

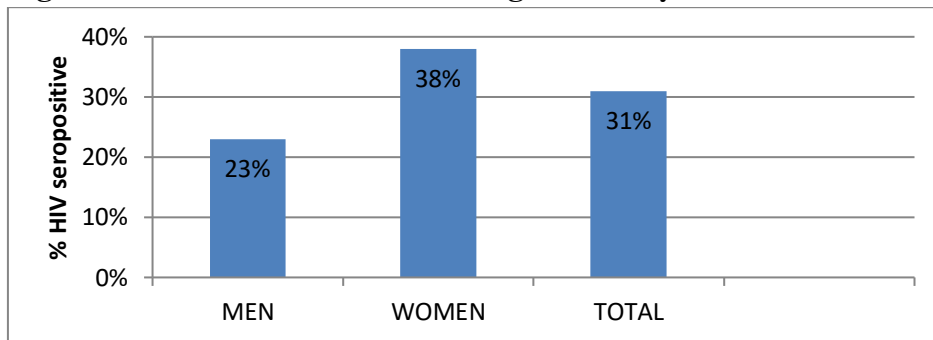
This section of the report presents a review of available literature and feedback from the KIIs and FGDs on the HIV epidemic in Swaziland. It also includes incidence, prevalence and the drivers of the HIV epidemic amongst the broader population as well as the specific impact of HIV on vulnerable and key populations at higher risk of HIV exposure. It furthermore highlights the achievements of the national HIV response to date.

3.2. HIV Incidence and Prevalence in Swaziland

Swaziland has a high HIV incidence and the highest prevalence of HIV in the world. Since the first case of HIV and AIDS was diagnosed in the country in 1986 and 1987 respectively, the country has experienced exponential growth in HIV prevalence from a mere 3.9% in 1992 to 41.1% in 2010 (12th ANC Sentinel Surveillance, 2010). The first Swaziland Demographic and Health Survey (SDHS) in 2007 found the HIV prevalence to be 19% in the general population, 26% in adults aged 15-49 years and 31-32% in the age group 18-49 years (CSO SDHS, 2007, Bicego, et al., 2013). The SDHS reports gender disparity in terms of HIV prevalence, with females more likely to be HIV positive and susceptible to HIV infection at younger ages than their male counterparts (CSO and Macro International, 2008).

Similarly, the HIV Incidence Measurement Survey (SHIMS) conducted in 2012 found that prevalence had remained essentially unchanged at 32% among adults aged 18 to 49 years (Bicego et al. 2013, MEPD SHIMS, 2012). Gender differentials were again noted with 38% HIV prevalence amongst women and 23% amongst men, with a peak prevalence of 54% among females aged 30-34 and 47% among males aged 35-39 years (MEPD SHIMS, 2012).

Figure 2: HIV Prevalence in Adults aged 18-49 by sex, 2011

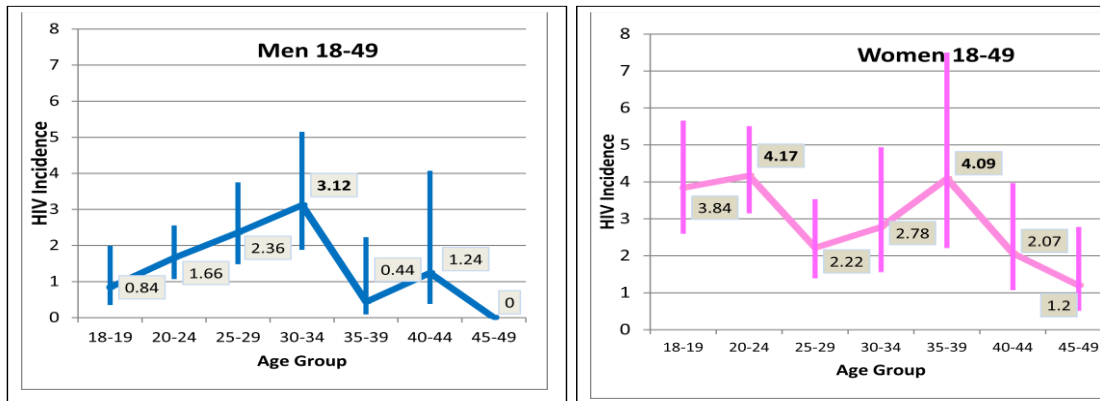


Source: SHIMS, 2012

The stabilization of the epidemic over the five year period between the two surveys can be attributed to the scale up of HIV prevention, treatment, care and support services, with decreases in the number of new HIV infections, particularly amongst young people, as well as increased access to anti-retroviral therapy (ART) (Bicego, et al., 2013; MoH, 2012).

HIV incidence refers to the proportion of people newly infected with HIV over a specified period of time, usually 12 months or one year. The National Multi-sectoral Strategic Framework (NSF) 2009-2014 reported that the HIV incidence rate was 3.2% in 2007, with a plan to reduce it to 1.4% in 2015 and maintain it at that level through 2018 (eNSF, 2014-2018). SHIMS (2012) shows evidence of a decrease in the incidence with a rate of 2.4% among the 18-49 year age group (1.7% in men and at 3.1% in women. However, incidence rates for women remain high, including amongst young women (4.2%), single women (4.1%) and pregnant women (4.4%) and even higher (9.6%) amongst women who had two or more sexual partners. The incidence among men was higher in those reporting inconsistent condom use at 2.7% and those with two or more partners, at 3.2%, (ibid). This gender variation in incidence may signify lack of power to negotiate safer sex such as condom use by women, and inconsistent or incorrect condom use during sexual intercourse.

Figure 3 HIV Incidence in Adult Men and Women aged 18-49, 2012



Source: MPED SHIMS, 2012

This is confirmed by Mngadi et al. (2009), who argue that the drivers of HIV in Swaziland include multiple concurrent partnerships in an environment of low or inconsistent and incorrect condom use; intergenerational sex with decision-making power differentials; gender inequality; harmful cultural norms and practices; gender-based violence and poverty. In addition, natural disasters in the form of persistent drought, food insecurity and high unemployment are seen as contributors. Finally, punitive laws and practices including those relating to criminalisation of same-sex sexual practices have been reported as contributors to HIV incidence (GCHL, 2012). The HIV incidence and prevalence amongst vulnerable and key populations in Swaziland, and specific ‘drivers’ or factors that increase the risk of HIV infection for these populations, is set out below.

3.3. HIV in Vulnerable and Key Populations

In the context of the LEA vulnerable populations include women, children, and people living with disabilities. Key populations include men who have sex with men, transgender persons, sex workers and people who inject drugs.

Globally, the prevalence of HIV amongst key population such as men who have sex with men, transgender people, sex workers and people who inject drugs, is reportedly higher compared to the general population. For example, UNAIDS (2012) has reported the HIV prevalence to be 22 times higher among people who inject drugs. Studies conducted in low and middle-income countries have found that men who have sex with men and female sex workers (compared to all women of reproductive age) are 19 and 13.5 times more likely to have HIV, respectively, than the background population (Baral et al., 2007; Baral et al. 2012). Another study that reviewed evidence from 15 countries found that over 19 percent of transgender women were living with HIV (Baral et al., 2012). Key populations and their sex partners account for as much as 51% of new infections in Nigeria, 33% in Kenya, 27.5% in Mozambique, and 80% in Morocco (Morocco, 2013).

Similar trends of high HIV prevalence are observed among vulnerable and key populations in Swaziland. In a study conducted in the country’s correctional facilities the prevalence was found to be higher than in the general population, at 34.8% (Dlamini, P et al., 2010). Additionally, the 2011 national behavioural surveillance survey found a prevalence of 70% among sex workers,

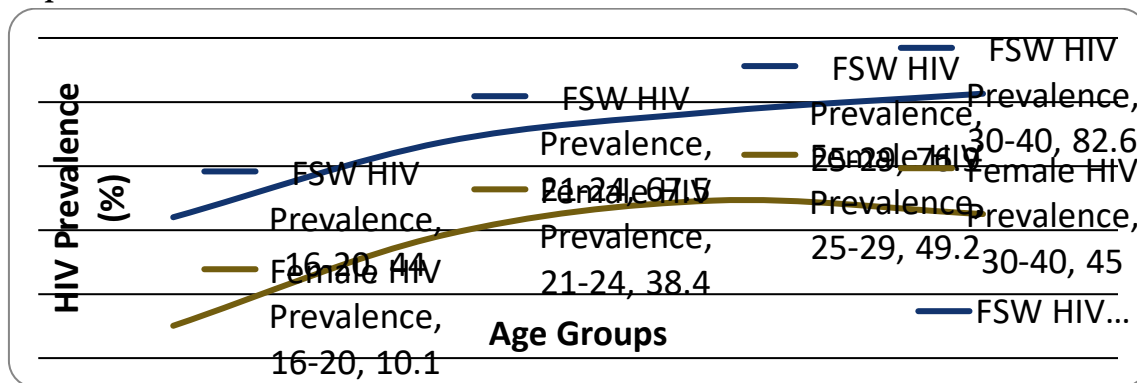
almost four times that of the general population (MoH, 2011). However the prevalence was found to be slightly lower than then general population in men who have sex with men at 17.6% (Baral et al., 2013).

In addition to high HIV prevalence rates, key populations also have specific health needs requiring access to specific services. For example men who have sex with men and sex workers require lubricants and people who inject drugs require access to clean syringes. Key populations are also marginalised members of society, exposing them to high levels of stigma and discrimination. These various factors combined increase their risk of exposure to HIV.

3.2.1. Sex Workers

According the Behavioural and Biological Surveillance Survey (BSS), the HIV prevalence amongst female sex workers was 69.7% in 2011 (MoH BSS, 2011), an insignificant decline from 70.3% in 2007 (CSO and Macro International, 2008). Figure 3 below shows HIV prevalence in female sex workers compared to that of women of the same age groups.

Figure 4: HIV Prevalence in FSW compared to Women of Reproductive Age in General Population



Source: CSO and Macro International, 2008 (cited MoH, 2011)

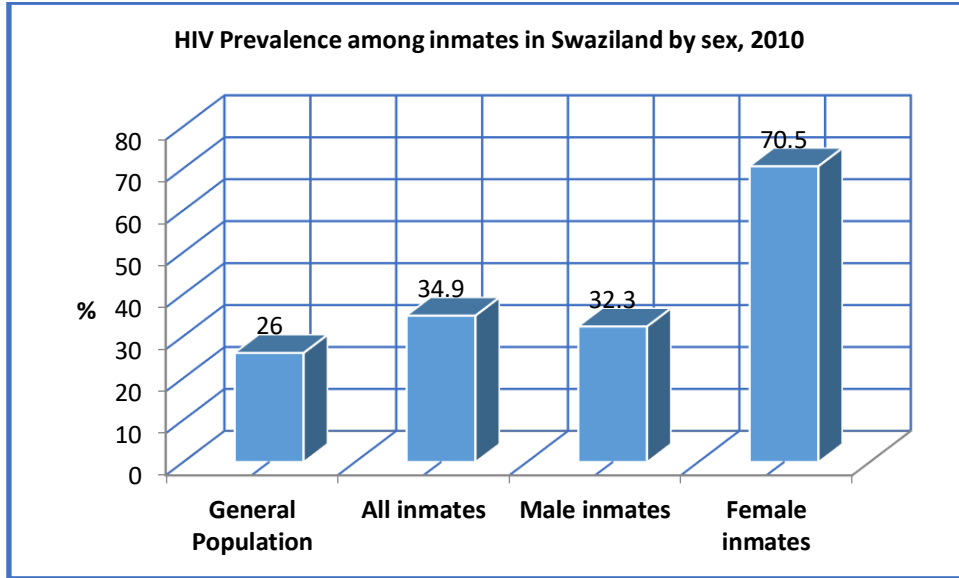
Amongst other factors, human rights violations against sex workers place them at risk of HIV exposure. They are exposed to high levels of stigma, abuse and violence, reducing their ability to access health services without fear of discrimination and to negotiate safer sex. Human rights violations include rape (39.2%), blackmail (34.8%) and torture (53.2%) (MoH, 2011) as well as poor or limited access to targeted HIV services (WHO, 2008; Baral et.al, 2009; Smith et.al, 2009). Amongst female sex workers who reported having been raped, 7.4% were raped at least six times or more by clients and 38.7% experienced physical abuse, beaten up for selling sex, often by police and members of the armed forces. Furthermore, 44% reported being afraid to seek health care because of fear of stigma while 49.4% indicated that were refused police protection when they sought it (MoH, 2011).

3.2.2. Prisoners

Prisoners also face a high HIV prevalence in the country, as elsewhere in the region. According to a situational assessment on TB, HIV, syphilis Hepatitis C and B Infections and Associated Risk Behaviour in correctional centres conducted by the United Nations Office on Drugs and

Crime (UNODC) in 2010, HIV prevalence amongst prisoners was 34.8%, with higher HIV prevalence amongst female prisoners (45%) than their male counterparts (25%).

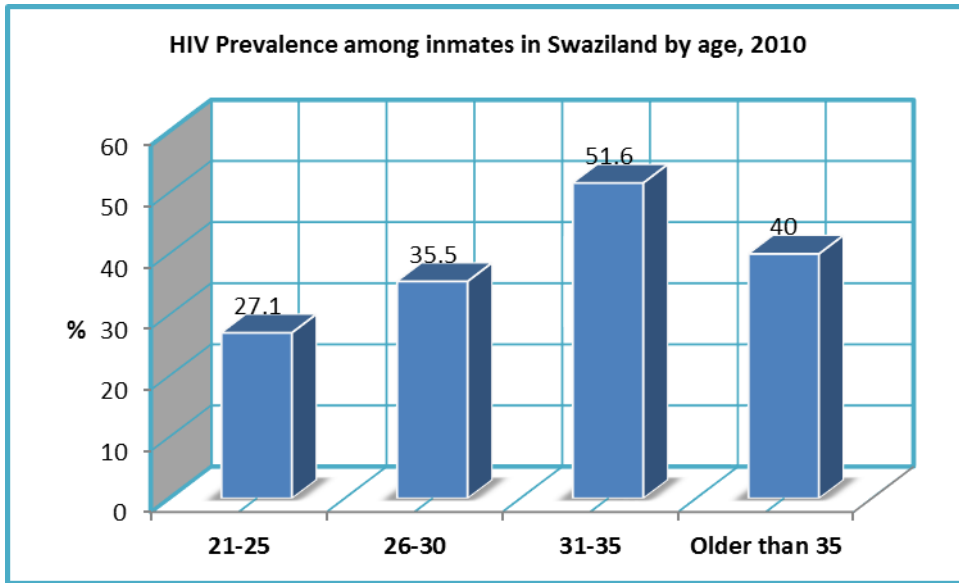
Figure 5: HIV Prevalence in Prisoners by Sex compared to General Adult Population 15-49 years



Source: UNODC Report, 2010

The drivers of high HIV prevalence amongst prisoners included sexually transmitted infections, unprotected transactional sex and tattooing. Though data from other countries reports high rate of needle sharing for injecting drug use amongst prisoners as one of the major contributing factors to HIV transmission, the UNODC report (2010) did not mention this behaviour locally. The figure below shows HIV prevalence by age in prisoners. The trends are similar to those of the general population with the prevalence amongst men higher in the age group 31-39 years, as a higher proportion of prisoners in the country are young to middle age men. Despite the observed high prevalence of HIV in prison setting, the HIV policy does not make any provision for condoms availability and distribution in prisons, placing prisoners at continued risk of HIV exposure.

Figure 6: HIV Prevalence among Prisoners by Age, 2010

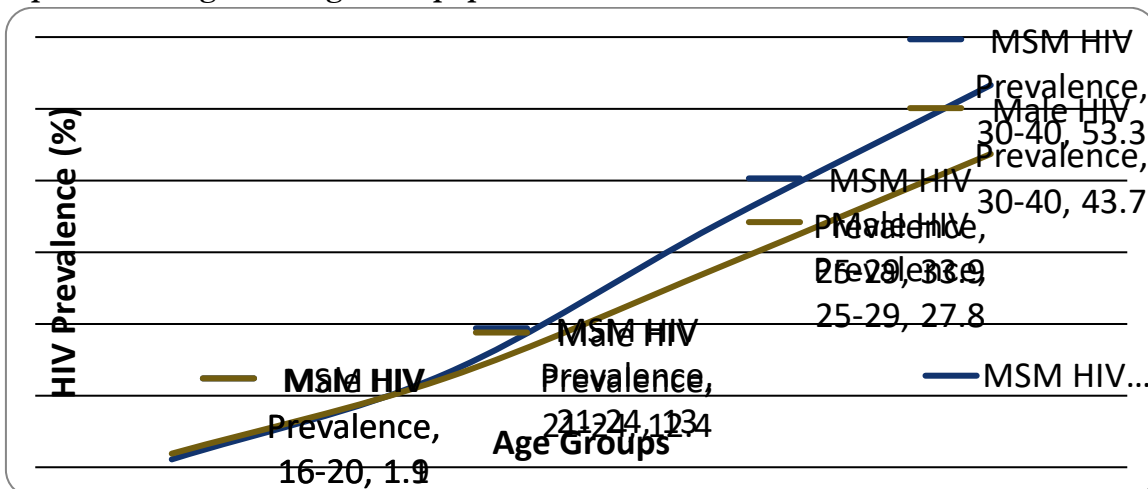


Source: UNODC, 2010

3.2.3. Men who have sex with men

There is limited information on men who have sex with men in Swaziland. However, the behavioural surveillance survey carried out in 2011 found a prevalence of 17.6% amongst men who have sex with men (Baral et al, 2013; MoH. BSS, 2011). The survey found age variations in prevalence, from 4% prevalence in the age group 16-20 years to as high as 53% in the 30-40 year age group (MOH. BSS, 2011). The figure below shows HIV prevalence amongst men who have sex with men in Swaziland.

Figure 7: HIV Prevalence in men who have sex with men compared with men of reproductive age in the general population

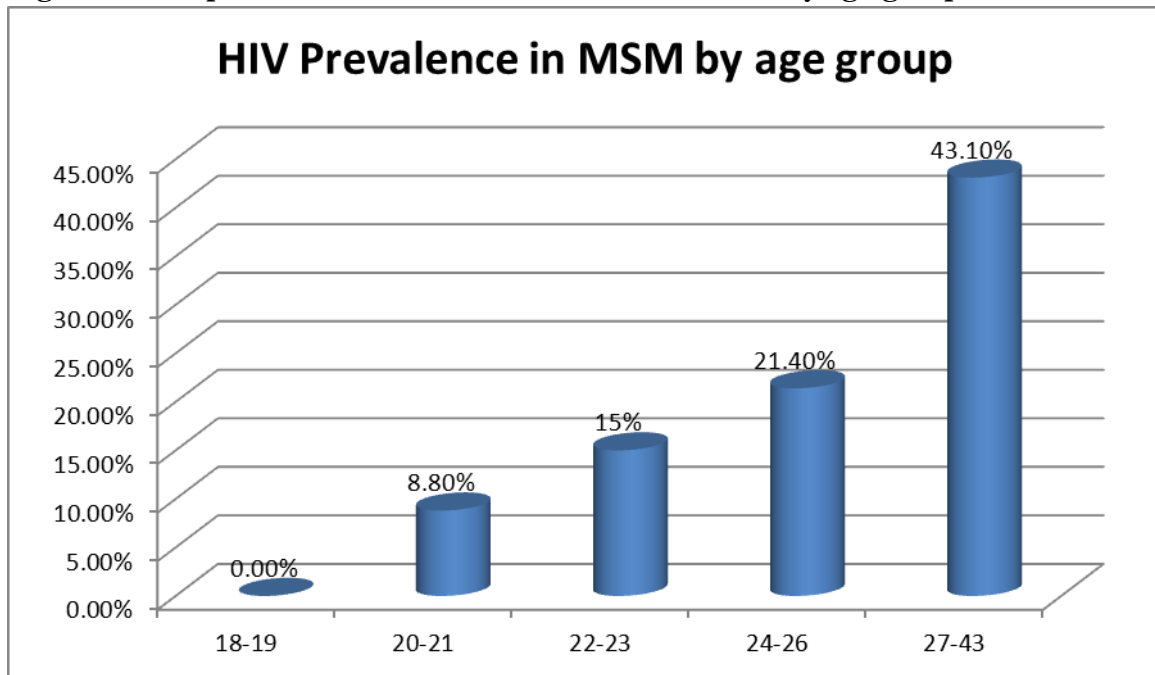


Source: CSO, 2008 (cited in MoH, 2011)

In a very recent study conducted by Baral et al (2013) involving 324 men who have sex with men, 93.4% were below the age of 30; 42.5% and 23% had completed secondary/high school and tertiary education respectively; 95.8% were single (never married) and 87.8% had no children. The study found that the HIV prevalence was increasing with age ranging from 0% in

younger aged 18-19, to 8.8% among participants aged 20-21; 15% among participants aged 22-23; 21.4% among participants aged 24-26, and 43.1% among participants aged 27-43.

Figure 8: HIV prevalence in men who have sex with men by age group, 2013



Source: computed with data from Baral et al. (2013)

The study further found that most participants (57.9%) had multiple male sexual partners, few (11.2%) used condoms and lubricants consistently and about half reported worrying about HIV during sexual acts. Thus men who have sex with men are at higher risk of HIV exposure, possibly due to lack of access to information or specific health services targeted to their needs.

The researchers also explored any human rights violations including denial of health care, police-mediated violence and physical or verbal harassment experienced by men who have sex with men. They found that about half of the participants reported having been violated, although perceived rights violations related to sexual orientation, fear of seeking healthcare and acceptance by the community were more common, with 79.6% reporting this.

The findings of the study resonate with those from other countries in the region. Behavioural studies of men who have sex with men in Africa consistently report the drivers of HIV in this group as unprotected anal sex, limited knowledge about and access to appropriate risk prevention measures and stigma, discrimination and human rights abuses (Cáceres et al., 2008, Smith et al., 2009; GCHL, 2012). The GCHL (2012) report shows how the marginalisation, stigma and discrimination against men who have sex with men, through the criminalisation of same-sex practices, perpetuates fear and reinforces the ‘invisibility’ of men who have sex with men in society, creating barriers to their ability to access HIV-related health care services and increasing the risk of HIV transmission. These risk factors have also been reported in similar studies conducted in Swaziland, and emphasize the HIV high risk exposure amongst men who have sex with men.

3.2.4. Mobile Populations

Mobility of populations has been argued to indirectly contribute to high HIV incidence in Swaziland. (Crush et. al., 2010). Swaziland defines its mobile population as those people who often spend more than two nights away from their homes. These include factory workers, seasonal workers such as cane cutters, transport operators, construction workers, long-distance truck drivers and uniformed forces (CSO and Macro International, 2008; eNSF, 2014-2018). For the purposes of this report, the mobile populations should be understood to be limited to factory workers and public transport operators. The prevalence among these mobile populations is reportedly high as well.

The Behavioural and Biological Surveillance Survey reported a prevalence of 30.4% among mobile populations increasing to 50.3% amongst factory workers. Multiple concurrent sexual partnerships and inconsistent condom use were cited as the major contributing factors to the high prevalence while poor remuneration, poor working conditions and poverty have been cited as the key structural drivers of the epidemic among factory workers (MOH, BSS, 2011). Data and information on public transport workers is not known, but the prevalence is believed to be higher than that of the general public as they have similar risks to that of factory workers. Other factors include spending long times away from home often with no time off, dangerous working conditions leading to more preoccupation with risks such as accidents and injuries than HIV and finally, lack of access to health services, as they spend most of their time at work (IOM, 2012).

3.2.5. Transgender People

Data and information on transgender people in Swaziland is limited, this is similar with many other countries across the continent. However, the few existing epidemiological studies amongst transgender people globally have shown disproportionately high HIV prevalence ranging from 8% to 68% and HIV incidence from 3.4 to 7.8 per 100 person years (Baral, et al 2013; WHO, 2011). High rates of high-risk sex coupled with stigma and discrimination, leading to low-self-esteem and disempowerment, increase the risk of HIV among transgender people (GCHL, 2012). According to UNAIDS (2012), due to social marginalization and a lack of employment opportunities, a high proportion of transgender people (up to 44%) are engaged in sex work, placing them at high risk of HIV exposure.

3.2.6. Other Key Population Groups

Data on other key populations such as male sex workers, bisexual, and intersex persons is not available for the country. However regional trends show that these populations are disproportionately infected and affected by HIV and face similar barriers as a result of stigma, discrimination and human rights violations.

3.2.6.1. Women

Women still remain disproportionately affected by HIV in Swaziland. According to SHIMS (2012), the adult (18-49yrs) HIV prevalence was 38% and the incidence 3.1%, while men had HIV prevalence and incidence rates of 23% and 1.7% respectively. Younger women are more likely to be infected with HIV than their male counterparts.

Women and girl's increased vulnerability to HIV may partly be explained by the physiological differences between females and males. Additionally, gender inequality and gender-based violence are considered to be major factors driving the HIV epidemic amongst women and girls in Swaziland. Culturally, Swaziland is founded on a patriarchal system and kinship is defined along patriarchal lines. Male dominance is deeply entrenched in the country's way of life with men having a large degree of control over women, constraining their autonomy. Women and girls are marginalised from decision-making at personal, family and societal levels, limiting their opportunities to improve their lives. This furthermore impacts on women's ability to control their sexual relationships i.e. negotiate condom use with their partners, including within inter-generational sexual relationships.

Gender discriminatory beliefs furthermore facilitate tacit acceptance of gender-based violence, including sexual violence, thus increasing women's and girls' risk for HIV infection. Research has established a clear association between intimate partner violence and HIV: women who experience intimate partner violence have more than 50% increased risk of acquiring HIV (UNAIDS, 2014). For example a study carried out in South Africa, intimate partner violence was found to be directly responsible for 12% of new HIV infections among young women, (Jewkes et al., 2010). The same findings were reported in a study conducted in Uganda among women aged 15-49 years, that intimate partner violence increased the odds of being HIV positive by 55% (Kouyoumdjian et al., 2013). Gender-based violence impacts on women's physical and mental well-being, lowering their self-esteem and self-worth, which in turn negatively affects their assertiveness and agency.

Women are 55% more likely to be HIV positive if they have experienced intimate partner violence (UNAIDS, 2014).

Gender-based violence is pervasive in Swaziland. A National study on violence against children and young women in Swaziland (UNICEF, 2007) study found that 48% of women and girls reported experiencing some form of sexual violence in their lifetime with 21% reporting that they had experienced some form of sexual violence in the preceding 12 months of the study. The Multiple Indicator Cluster Survey (CSO, MICS 2011) found that 1 in 5 women aged 15-49 is physically abused (beaten) by husband or male partner. Equally the Royal Swaziland Police performance report for the first quarter of 2014 reported a 40% increase in the number of women killed through intimate partner violence and rape increased by 10% between April and June compared to the same period in 2013 (Masinga, 2014). The MICS (2014) on assessment of attitudes towards domestic violence 19.9% of women aged 15-49 and 17% men stated that husbands were justified in heating or beating their wives when one of the following happened: she goes out without telling him, she neglects the children, she argues with him, refuses to have sex with him, and when she burns the food. This indicate significant levels disempowerment and low self-esteem amongst women who are continuously trapped in the cycle of violence.

However, there is limited research available that has explored the factors and manifestation of gender-based violence and its relationship HIV in Swaziland.

3.2.6.2. Children and Young People

The Child Protection and Welfare Act, 2012 defines a child as any person below the age of 18 years. Swaziland is a youthful country with almost 40% of its population below the age of 19 years. Though the incidence of HIV in children is not known, prevalence rates range from 5% among children aged 2-4 years rising to 10% among those in the 15-19 year age bracket (CSO and Macro International, 2008) and 16.2% in those out of school. Girls and young women have a higher prevalence than their male counterparts.

Epidemiological studies (MoH. BSS, 2011; CSO and Macro International, 2008; MoH, 2010) carried out in the country show that although HIV awareness is high among young people, this has not translated to appropriate change in preventive behavioural practices. The high HIV incidence among youth is attributed to inadequate knowledge of prevention, increased non-regular sexual partnerships, low and inconsistent condom use, intergenerational and transactional sexual relationships, gender disparities and high levels of gender-based violence, and inadequate access to HIV health services such as HIV testing and treatment of sexually transmitted infections, (Shabalala, 2012). However recent trends show a remarkable decline in new infections of up to 80% among young people (Von Vissel, 2012), yet increasing mortality rates of 50% (UNICEF, 2013) in the same population group.

Children are also affected by HIV; there are those children who have lost either one or both parents (orphans) or those whose parents are unable to provide for them (vulnerable children). According to the population projections preliminary report, 23% of children below the age of 18 are orphaned while 12% of children of the same age range are considered vulnerable. UNAIDS, (2010) Spectrum estimates projects that the country had an approximate of 101,000 orphans at the end of 2008 and that this expected to rise to 103,000 by 2015, with approximately 60-70% of these children being AIDS orphans.

Orphaned and vulnerable children experience a range of rights violations. They may experience property grabbing by surviving relatives, may be forced to drop out of school due to financial difficulties or find employment to sustain themselves and their siblings. Their vulnerability exposes them to exploitation of all kinds, including sexual exploitation which increases their risk for HIV. Swaziland has prioritised education for orphaned and vulnerable children through the Free Education for All initiative. This covers school fees for all orphaned and vulnerable children at primary level and provides for other basic needs, such as food, with the support of development partners and NGOs.

3.2.6.3. People with disabilities

In 2006, the UN estimated that approximately 10% of the world's population is living with some form of disability, and persons with disabilities form the world's largest minority. According to the National Census Report (CSO, 2007), approximately 170,000 people were living with disability in Swaziland.

Although there is limited information on HIV incidence and prevalence amongst people with disabilities, research indicates they are a vulnerable population who are often ignored in national HIV responses. “People with disabilities have generally poor health, lower education attainment, fewer economic opportunities, and high rates of poverty than people with no disabilities” (WHO, 2011). Assumptions about their sexuality and their perceived low risk of exposure to HIV, as well as a limited understanding of the inaccessibility of existing health services for people with disabilities has led to exclusion from many national intervention aimed at responding to the HIV epidemic (Grant et al., 2009, UNAIDS, 2009).

Specific disabilities may also decrease or block access to general AIDS education and outreach efforts (Groce et al., 2006). According to the UNAIDS (2009) policy brief on HIV and Disability people with disabilities are at risk for HIV exposure for various reasons including having unprotected sex and injecting drug use, sexual violence (particularly for women and girls with disabilities) and lack of / inadequate access to appropriate or accessible HIV education, information and prevention services. This is confirmed by a study carried out by Groce et al., (2006) who found that people with disabilities lacked knowledge and were misinformed about modes of transmission. In addition women with disabilities experienced higher rates of sexual exploitation and abuse by non-disabled men because of a belief that they were free of HIV. The researchers also found that the experiences of people with disabilities in health facilities are not always positive. The structural design and construction of most public facilities including health facilities in the country discriminates against people with disabilities, particularly those who rely on the use of wheel chairs, increasing their dependence on others. The available health information and educational materials are also not appropriate for those with hearing and visual impairments. As a result, people with disabilities report avoiding health facilities because of physical, social and communication barriers, thus limiting their access to HIV prevention, testing, treatment and care.

In summary, key population groups have a higher burden of HIV compared to the general population in the country, ranging from 17% to as high as 70%. In addition to social exclusion by families, friends and communities based on their “culturally and morally unacceptable” behaviour, structural factors such as discriminatory laws and policies, high levels of poverty due to lack of employment opportunities and stigma increases their vulnerability to HIV as these prevent their access to information and health services. Similarly vulnerable groups are disproportionately infected and affected by the epidemic with women, children and people with disabilities experiencing either higher rates of HIV prevalence and / or poor access to HIV services as a result of structural and systems factors and being subjected to discriminatory practices, all of which violate their right to non-discriminatory treatment, right to access quality health services, ultimately right to a quality life.

3.4. The National Response to the HIV Epidemic

The national HIV response has been underpinned by “a high level of political commitment” to fighting the spread of HIV since the start of the epidemic (WHO, 2005). In 1986 the Government established the Swaziland National HIV AND AIDS Programme (SNAP) under the Ministry of Health (MoH). Under the leadership of SNAP and the National Emergency

Response Council on HIV and AIDS (NERCHA), five consecutive plans driving the national response were developed: an initial Short Term Plan 1987-1988; two Medium Term Plans (MTP I 1990-1992 and MTP II 1993-1996), and two National Multi-sectoral HIV and AIDS Strategic Plans (NSP I 2003-2005) and NSP II 2006-2008). It is in the NSP II 2006- 2008 that respect for human rights, compliance with international and national laws, and gender equality and equity were first put forth as guiding principles in the HIV response.

In 1999 the King declared HIV and AIDS a national disaster that needed a multi-sectoral and multipronged response, resulting in the Crisis Management and Technical Committee being set up to lead the national response. In 2001, this was replaced by NERCHA, responsible for coordination and mobilizing an expanded response to the epidemic. In 2006 the National Multi-sectoral HIV and AIDS Policy was adopted and the HIV and AIDS decentralized coordinating structures were established in line with the National Decentralization Policy of 2005.

Building upon the aforementioned NSPs, in 2009, a five year National Multi-Sectoral Strategic Framework was developed and recently extended to 2018 (eNSF). The eNSF has mainstreamed gender and human rights in the HIV response. It also calls for the review of laws that are discriminatory and gender insensitive, to ensure a human rights based response to HIV that is underpinned by universal access for all people regardless of their sexual orientation and/ or social identity. However, the framework still falls short on strategic interventions targeted at key populations. Services tend to be provided on an *ad hoc* basis with support from development partners, such as the provision of lubricants for men who have sex with men and sex workers.

Swaziland has made commendable and significant progress in responding to the HIV epidemic, leading to a reduction in HIV incidence and deaths from AIDS. Notable successes include:

- A decline in HIV incidence from 3.2% in 2007 to 2.4% in 2012.
- An approximately 80% decline in new infections among young people.
- The prevention of mother to child transmission programme (PMTCT), initiated in 2003, has reduced mother-to-child transmission to less than 2% of exposed infants testing positive to HIV at 6-8 weeks in 2012.
- HIV Testing and Counselling has been integrated as part of standard of care, meaning every person who comes to contact with the health system at every level is counselled and tested for HIV unless the person opts out of the test. This approach has led to a 35% increase in the number of tests between 2011 and 2012.
- The early diagnosis of infants has contributed to the early initiation of ART in infants. It is yet to be known whether this will lead to reduction in HIV-related infant mortality.
- The proportion of people who have tested for HIV and received results has increased remarkably: 47.3% (31% in 2007) of women and 32.2% (9% in 2007) of men have been tested and know their HIV status as at the end of 2012 (CSO MICS, 2010).
- As at the end of 2012, 90% of the population that required ART² were receiving it, resulting in an improvement in the life expectancy from 32.4 years in 2007 to 44 years with more PLHIV surviving longer. The country is currently planning to initiate ART roll out to

² The ART eligibility criteria is CD4 cell count of <350cells/mm³ or WHO stage 3 and 4.

patients that have a CD4 count of <500cells/mm³ as part of the Early Access to ART for All project.

Worth noting is the role the MoH has played in contributing to the needs of vulnerable and key populations in the HIV response. Within the MoH structures, an LGBTI Coordination Unit has been established under SNAP to enhance coordination of key population's initiatives. To date a functional technical working group has been established to lead on advocacy, policy and research and an LGBTI draft strategy and technical guidelines have been developed aimed at improving service delivery specific to key populations.

CHAPTER 4: HIV, LAW AND HUMAN RIGHTS IN SWAZILAND

Human rights are a set of universal entitlements that individuals enjoy irrespective of their sex, nationality, religion, culture or other status, that are inherent to human beings and that are proclaimed and protected by international law. Developed in the context of global revulsion at the horrors of the Second World War and the establishment of the UN in 1945, today a growing body of international treaties and customary international law details the obligation of states to respect, protect, promote and fulfil human rights.

Human rights have major relevance for shaping appropriate responses to the HIV epidemic and other global health challenges, including offering system-wide public health responses and identifying deficiencies in the provision of public health services. Due to the scale of the epidemic, and the threats it posed to international security, peace and development and to humans suffering, the WHO identified the international law of human rights as a comprehensive framework to which public health practitioners could anchor responsibility for addressing the underlying causes of HIV and AIDS and other threats to health (Patterson and London, 2002). A human rights approach, according to the authors, “support sound public health practice by providing additional tools to motivate governments to act to achieve public health goals... can help facilitate the setting and monitoring of public health targets and provide a complementary language to identify failures, or incipient failures, of public health programmes...and can also provide links with other social movements that use the same language—for example, the women’s movement, the struggles of indigenous peoples and the movement of people working to protect the environment (Patterson and London, 2002:965).

Human rights and public health share the common goal of promoting and protecting the well-being of all individuals. The promotion and protection of human rights are necessary to empower individuals and communities to respond to HIV and AIDS, to reduce vulnerability to HIV infection and to lessen the adverse impact of HIV and AIDS on those affected. The incidence and spread of HIV is disproportionately high among populations who already suffer from a lack of human rights protection and experience discrimination. This includes populations that have been marginalized legally (through punitive laws), socially, culturally and economically; for example PLHIV, children orphaned by AIDS, sex workers, men who have sex with men, prisoners, people with disabilities and minority groups. In addition, once affected people suffer HIV-related discrimination and violations of their right, which further exacerbates the impact of HIV on their lives and creates barriers to their access to services.

The Global Commission on HIV and the Law, in its July 2012 report *Risks, Rights & Health* recognises that although the law alone cannot stop HIV and AIDS or be blamed when HIV responses are inadequate, legal environments can play a powerful role in the well-being of people living with HIV and those vulnerable to HIV. Good laws, fully resourced and rigorously enforced, can widen access to prevention and health care services, improve the quality of treatment, enhance social support for people affected by the epidemic, and protect human rights that are vital to survival and save public resources. The report also demonstrates that the law, if well enforced, has the ability to reduce the number of new infections by 1 million, (GCHL, 2012).

In this section we consider and critically analyse:

- The international, regional and national human rights principles that apply to and govern the national HIV response in Swaziland,
- The existing evidence on specific HIV-related human rights issues facing key populations in Swaziland and
- Current laws, regulations and policies applying in Swaziland in the context of HIV and AIDS.

Data for this section was derived from a desk review of international, regional and local legal documents, HIV policies and guidelines as well as research studies conducted and supplemented by the perspectives of key informants and participants in FGDs.

4.1 International, Regional and National Human Rights Framework

Swaziland is a signatory to a number of international and regional human rights treaties that set out internationally agreed upon principles of human rights. These are used to guide and form the basis for the interpretation of national human rights principles and obligations.

Swaziland is governed by the National Constitution, 2005 which enshrines a Bill of Rights aimed at the protection and promotion of the fundamental rights and freedoms of Swazi citizens. Swaziland does not have HIV-specific legislation. However, the constitutional right, where relevant, apply equally to the context of HIV and AIDS.

In this section we examine the international, regional and national human rights framework that oversees and governs the national response to HIV and AIDS in Swaziland. The Analysis considers:

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

It is this understanding of each right and how it is interpreted to apply in the context of HIV and AIDS which guides the analysis of HIV law and policy in Swaziland and the extent to which it protects, or poses a barrier to protection of the rights of people in the context of HIV and AIDS.

4.1.1 International and Regional Human Rights Treaties

International and regional human rights law provides an overarching framework for an analysis of HIV, law and human rights issues in Swaziland. International and regional human rights law is set out in the various charters, treaties and conventions signed and ratified by member states.

Once a state has signed and ratified a treaty or convention, it agrees to be legally bound by that convention and to ensure that the principles and provisions of that instrument are met and implemented at a national level (domesticated). Swaziland adopts a dualist approach for treaty domestication, which means that international and regional human rights treaties are not immediately binding; they require to be transformed into local legislation, in order for them to become enforceable by the courts. In the High Court case of *R v Mngomezulu* 1977/78 SLR the court held that unless an international treaty is incorporated into local law it confers no rights to a citizen of Swaziland. Section 238 of the Swaziland Constitution (2005) states the following in relation to international agreements:

- (1) The Government may execute or cause to be executed an international agreement in the name of the Crown.
- (2) An international agreement executed by or under the authority of the Government shall be subject to ratification and become binding on the Government by —
 - (a) an Act of Parliament; or
 - (b) A resolution of at least two-thirds of the members at a joint sitting of the two Chambers of Parliament.
- (3) The provisions of subsection (2) do not apply where the agreement is of a technical, administrative or executive nature or is an agreement which does not require ratification or accession.
- (4) Unless it is self-executing, an international agreement becomes law in Swaziland only when enacted into law by Parliament.
- (5) Accession to an international agreement shall be done in the same manner as ratification under subsection (2).
- (6) For the purposes of this section, —international agreement| includes a treaty, convention, protocol, international agreement

Source: Section 238 of the Swaziland Constitution (2005)

Currently, there is significant alignment of the local law to international law principles in areas such as, children’s law. For example Article 2 of the Convention on the Rights of the Child (CRC) provides that State parties shall take all measures to ensure that children are protected against all form of discrimination. The Children’s Protection and Welfare Act of 2012 provides, “*A child shall not be discriminated against on the grounds of gender, race, age, religion, disability, health status, custom, ethnic origin, rural or urban background, birth, socio-economic status, refugee status or other status*” (Part 3, article 4).

However, Swaziland has not yet adequately implemented all of its human rights commitments into domestic legislation,³ and there is no clearly defined policy with regard to the signature, ratification and incorporation of the provisions of international treaties or conventions. Importantly, though, even in dualist countries, international and regional law can still impose obligations on countries that have ratified particular treaties. The African Commission on Human and Peoples’ Rights, which is responsible for monitoring compliance with regional human rights treaties, has noted that “*international treaties which are not part of domestic law and which*

³ E.g. The Convention on the Rights of the Child expressly prohibits any corporal punishment and yet the national Constitution, 2005 in section 29(2) permits corporal punishment of children in the name of ‘lawful and moderate chastisement’

may not be directly enforceable in the national courts, nonetheless impose obligations on State Parties.” In addition, even where states have not signed or ratified conventions or treaties, these can still be binding if their principles form part of what is known as customary international law.

Swaziland is signatory to a number of international and regional human rights instruments that prescribe norms on human rights, the rule of law and the administration of justice, all of which are relevant for HIV and AIDS:

Significant International & Regional Human Rights Instruments

- The Universal Declaration of Human Rights (UDHR) 1948
- The Convention on the Rights of the Child (CRC) 1989
- The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) 1979
- The International Covenant on Civil and Political Rights (ICCPR) 1966
- The International Covenant on the Economic, Social and Cultural Rights (ICESCR) 1966
- The African Charter on Human and People’s Rights (ACHPR) 1981, and
- The African Charter on the Rights and Welfare of the Child.⁴

Many of these international instruments came into force before the emergence of HIV, but they all contain provisions that can, and have been applied to HIV and AIDS. For example, neither the ICCPR nor the ICESCR specifically list HIV status as a prohibited ground of discrimination in the non-discrimination clause. However, the Committee on Economic, Social and Cultural Rights (CESCR) explicitly state that the inclusion of “other status” in the ICESCR is a clear indication that the list is not exhaustive, and that unspecified grounds, such as HIV status or AIDS, may be included in the prohibition against discrimination.

“A flexible approach to the ground of ‘other status’ is thus needed in order to capture other forms of differential treatment that cannot be reasonably and objectively justified and are of a comparable nature to the expressly recognized grounds in article 2, paragraph 2 [of the ICESCR].”

Committee on Economic, Social and Cultural Rights (2001).

The ACHPR similarly provides for the right to be free from discrimination on a number of stated grounds, including “or any status”.

“Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social

⁴ The country has however, not ratified the Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict; The Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, and The International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families, amongst others. At regional level, Swaziland has not ratified the Protocol to the African Charter on the Rights of Women in Africa amongst others.

origin, fortune, birth or any status.”- **Article 2 of the African Charter on Human and Peoples’ Rights**

A further example of the interpretation of international human rights principles to include state obligations towards HIV and people living with HIV is found in the interpretation of Article 12(1) of the ICESCR. It provides that member states should recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Committee on Economic, Social and Cultural Rights (CESCR) has expanded on the meaning of this right in terms of General Comment 14 on the ICESCR’s right to health, including the obligation it places upon states to provide services for HIV and AIDS (CESCR, 2000).

Finally, there are also several international and regional declarations, commitments and guidelines which deal *specifically* with HIV, human rights and gender equality. While not strictly legally binding, they are nevertheless reflections of the application and interpretation of international and regional human rights principles to the HIV epidemic. There are also a range of international and regional strategies and plans that include guidance on law and policy responses to HIV and AIDS. In this respect, they are important guidance for Swaziland in its interpretation of its own human rights standards in the context of HIV and, in the case of declarations by states, they are furthermore reflective of government’s commitment to rights-based protections.

Regional HIV and AIDS related commitments

- 1997 SADC *Code of Good Practice on HIV AND AIDS and Employment* in SADC to provide for rights-based responses to HIV in the working environment.
- 1999 SADC *Health Protocol*
- 2000 UN Millennium Development Goals
- 2001 UNGASS *Declaration of Commitment on HIV/AIDS*
- 2001 *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases* which requires member States to develop a multi-sectoral national programme to address the HIV epidemic, especially vulnerable groups, as well as enact relevant legislation to protect the rights of people infected and affected by HIV, to promote human rights and gender equality.
- 2003 *Maseru Declaration on the Fight Against HIV/AIDS in the SADC Region* recognizes the importance of addressing discrimination against people living with HIV and provides that “the upholding of human rights and fundamental freedoms for all including prevention of stigma and discrimination of People Living with HIV and AIDS is a necessary element in our regional response to the HIV and AIDS pandemic...”
- 2006 UNGASS *Political Declaration on HIV/AIDS - Universal Access*
- 2006 *Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa in 2010*
- 2011 *Windhoek Declaration: Women, Girls, Gender Equality and HIV: Progress towards Universal Access*

- 2011 UNGASS *Political Declaration on HIV/AIDS*: Intensifying our Efforts to Eliminate HIV/AIDS which commits states to confront stigma and discrimination as a prerequisite for effective prevention and care, and reaffirms that discrimination on the grounds of one's HIV status is a violation of human rights.
- 2012 African Union *Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa* which also provides guidance to the county's implementation strategies and policies in the fight against HIV and AIDS.

The most useful of these HIV-specific guidance documents, for the purposes of this assessment are the UNAIDS (2006) *International Guidelines on HIV and Human Rights* and the Southern African Development Community Parliamentary Forum (SADC PF) *Model Law on HIV & AIDS in Southern Africa, 2008*, both of which provide specific guidance on legal and regulatory responses to HIV.

The *International Guidelines* are a direct interpretation of State human rights obligations in the context of HIV, based on the rights contained in international treaties such as the ICESCR, the ICCPR, the CRC and CEDAW. They are based on the premise that discrimination creates and sustains conditions leading to societal vulnerability to HIV infection, by failing amongst other things to create an environment that promotes behaviour change and enables people to cope with HIV. The *Guidelines* contain 12 Guidelines that provide direct recommendations to States on how to develop rights-based responses to HIV in law, policy and programmes. In addition, the SADC PF *Model Law on HIV & AIDS in Southern Africa 2008*, based on the protection of rights of people in the context of HIV, gives very specific model provision, in law, for HIV and AIDS.

Section 17 of the SADC Model Law on HIV & AIDS for Southern Africa (2008) states that:

- (1) People living with or affected by HIV shall enjoy all human rights under the law and in international human rights instruments.
- (2) Any direct or indirect discrimination against people living with or affected by HIV based on their or another person's actual or perceived HIV status is prohibited.

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

Human rights principles relevant to HIV/AIDS

- The right to non-discrimination, equal protection and equality before the law
- The right to life
- The right to the highest attainable standard of physical and mental health
- The right to liberty and security of person
- The right to freedom of movement
- The right to seek and enjoy asylum
- The right to privacy

- The right to freedom of opinion and expression and the right to freely receive and impart information
- The right to freedom of association
- The right to work
- The right to marry and to found a family
- The right to equal access to education
- The right to an adequate standard of living
- The right to social security, assistance and welfare
- The right to share in scientific advancement and its benefits
- The right to participate in public and cultural life
- The right to be free from torture and cruel, inhuman or degrading treatment or punishment.

UNDP (2013) *Legal protections against HIV-related human rights violations: Experiences and lessons learned from national HIV laws in Asia and the Pacific.* Bangkok: UNDP.

4.1.2. National Human Rights Framework

a) The National Constitution, 2005

Part III of the Swaziland National Constitution, 2005 provides protection for all citizens and residents of the country through the Bill of Rights. The Constitution includes a number of human rights principles important for all people in the context of HIV and AIDS, including those set out below:

- The right to equality before the law and equal protection of the law
- Protection from discrimination, inequality and inequity
- Protection from inhuman and degrading treatment, slavery and forced labour
- The right to life
- The right to health
- Protection of the right to personal liberty
- The right to a fair hearing
- Respect for the rights of the family, women, children, workers and persons with disabilities.
- Protection of the privacy of the home and other property rights of the individual
- Protection from deprivation of property
- Protection of freedom of expression
- Protection of freedom of assembly and association
- Protection of freedom of movement
- Rights and freedoms of women

4.2 National Laws, Regulations and Policies

This section examines the national laws, regulations, policies and guidelines that affect HIV and AIDS including laws that impact on people living with HIV, vulnerable populations as well as key populations at higher risk of HIV exposure. Where HIV-specific laws, regulations and policies are absent, the report refers to general human rights principles as well as general principles contained in law (such as health law) that apply equally to the context of HIV and AIDS. The report examines the following areas of law and policy:

- Equality and Anti-Discrimination
- Health
- Gender Equality and Gender-Based Violence
- Criminal Laws Affecting People living with HIV and Key Populations
 - Men who have sex with men
 - Sex Workers
 - People who use Drugs
 - Prisoners
 - Criminalisation of HIV Transmission
- Employment
- Children
- People with Disabilities

These existing laws, regulations and policies are analysed in terms of Swaziland's human rights commitments, in order to ensure that the country has an appropriate, effective and rights-based framework for promoting universal access to HIV prevention, treatment, care and support.

The *National Multi-Sectoral HIV and AIDS Policy*, 2006 provides that “[e]xisting laws will be reviewed to ensure that they adequately address the public health and human rights issues related to HIV and AIDS. Where necessary, appropriate laws will be passed and regulations made that will facilitate and enforce the implementation of HIV and AIDS-related policies... [T]he legal framework facilitating the implementation of this policy shall be in compliance with the Constitution of Swaziland of (2005) and international conventions and declarations signed and ratified by the country.”

Swaziland National Multi-Sectoral HIV and AIDS Policy, 2006

4.2.1 Equality and Anti-Discrimination Law, Regulation and Policy in Swaziland

"HIV and AIDS-related stigma is a real or perceived negative response to a person or persons by individuals, communities or society. It is characterized by rejection, denial, discrediting, disregarding, underrating, and social distance. It frequently leads to discrimination, and violation of human rights." **Smith R. (2004) for UNESCO, Module 1.4: HIV/AIDS related stigma and discrimination**

HIV-related stigma and discrimination is an issue of major concern in Swaziland. Research indicates that stigma and discrimination is encountered at work, school, family environment,

healthcare facilities and communities. A Stigma Index Report conducted by SWANNEPHA (2011) and Shabalala (2010) found that stigma and discrimination is endemic in the country: 85% of the participants who were living with HIV had experienced stigma and discrimination, 22% were verbally assaulted, harassed or threatened while 20.1% were gossiped about. During the LEA consultations, stigma and discrimination was the single most reported human right violation experienced by all groups, including PLHIV as well as vulnerable and key populations at higher risk of HIV exposure. The MICS (2014) reported continued existence of stigma and discrimination. A total of 37.4% women and 36.2% men between ages 15-49yrs reported having discriminatory attitudes towards people living with HIV. This being expressed as people who would not buy vegetables from a shopkeeper or vendor who is HIV positive and also believe that children living with HIV should not be able to attend school with children who are HIV Negative (MICS, 2014)

“...People living with HIV/AIDS are discriminated in their families, you find that the family members refuse to share their plates with an infected person. ...”MSM, FGD.

“... as a married woman you would be in deep trouble if you informed your mother in law that you are HIV positive, because when chopping a cabbage she would say ‘careful my child.’ Then she would start avoiding your food because of fear that you may cut yourself and your blood might get spilled into the food and infect her with HIV...” Member of Lutsango Regiment, FGD.

Stigma associated with HIV is believed to be underpinned by many factors including misconceptions about HIV transmission and lack of understanding and knowledge, lack of access to treatment, the incurability of AIDS, irresponsible media reporting on the epidemic, prejudice and fears relating to a number of socially sensitive issues including sexuality, disease and death and drug use (SWANNEPHA, 2011; WHO, 2011; UNAIDS, 2005).

Several studies indicate that stigma and discrimination turn to drive the spread of HIV, especially among key and vulnerable population groups. The impact of stigma and discrimination may lead to delays in seeking testing, treatment and care services (SWANNEPHA, 2011). Zamberia reports that stigma creates barriers to the uptake of HIV services, access to social support and continuity of care, as people fear rejection and ridicule (Zamberia, 2011). Similarly, Dlamini, et al (2009) found that stigma is a strong predictor of poor access to HIV services. Furthermore, the fear of being stigmatised and discriminated prevents people living with HIV from disclosing their HIV infection, to family members and sexual partners, increasing secrecy and denial around the epidemic. Key informants during this LEA reiterated that stigma and discrimination was a major barrier to access to HIV services and the main reason for non-disclosure of their HIV status to family members, at work and to their immediate social networks. Those affected, such as spouses, children and caregivers, also suffer stigma and discrimination and this may impact on access to home-based care and support for people living with HIV.

In addition to the general stigma faced by PLHIV, key populations groups living with HIV face double stigma based on their behaviours and sexual orientations as well and their HIV status. LGBTI populations experience stigma and discrimination due to the demonising of alternative

sexual orientations. Heteronormativity is often oppressive, stigmatizing and marginalizing perceived deviant forms of sexuality and gender. Heteronormative culture "privileges heterosexuality as normal and natural" and fosters a climate where LGBT are discriminated against in almost all spheres of social life (Weiss, 2001). The LEA found that LGBTI, or persons with "unconventional" sexual identities or who engage in "unconventional" sexual practices also suffered stigma and discrimination from the community, including the religious community.

"Another group of people that is stigmatised or discriminated are homosexuals and transgendered. It will take some time for them to be acceptable by society in Swaziland. We still have a long way to go in our communities and churches..... One of the major causes is our culture and religion. Swazi culture does not allow people of the same gender to have an intimate relationship and furthermore, Christianity also frowns upon such practice. Once a person discloses publicly that he/she is transgendered, people will remind her/him of Sodom and Gomorra and it's associated with demons. When it comes to culture I think they can even hang you if they can hear that you are homosexual. In South Africa there is a very little difference where homosexuality is acceptable and constitutional right, but in Swaziland and other African countries there is still a lot of advocacy to be done....." LGBTI female respondent, FGD.

Shabalala (2010) cites double discrimination for key populations as a major barrier to accessing services due to the fear of the negative attitudes of, and moralistic judgement by health and other service providers. This is exacerbated by the fact that most LGBTI persons have little recourse against discrimination. They are marginalised by families, peers and the community, placing them at increased risk to HIV exposure and further limiting access treatment, care and support (BSS, 2011; Baral et al., 2013).

HIV-related stigma is multi-layered, tending to build upon and reinforce negative connotations through the association of HIV and AIDS with already-marginalized behaviours, such as sex work, drug use, and homosexual and transgender sexual practice. It also reinforces fears of outsiders and otherwise vulnerable groups, such as prisoners and migrants.

UNAIDS, (2005): HIV related Stigma and Discrimination and Human Rights Violations

In order to deal with HIV-related discrimination, Guideline 5 of the UNAIDS *International Guidelines on HIV and Human Rights*, 2006 suggests that states should "enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors." The *Guidelines* recommend that this be achieved through various means, including strengthening the following areas of law:

- Anti-discrimination law to prohibit discrimination on the basis of HIV and AIDS in various areas including health care, social security, welfare benefits, employment, education and access to services
- Traditional and customary laws that affect the status and treatment of vulnerable populations, such as women and children.
- Workplace laws, regulations and collective agreements to guarantee workplace rights.

- Laws to reduce human rights violations against vulnerable and key populations at higher risk of HIV exposure such as women, children, people with disabilities, migrants, men who have sex with men, prisoners, sex workers and people who inject drugs, amongst others.

4.2.2. HIV-Related Anti-Discrimination Law and Policy

Currently, Swaziland does not have anti-discrimination legislation or HIV-specific legislation dealing with the equality rights of people living with HIV or key populations at higher risk of HIV exposure. However, as mentioned above, the Constitution protects the equality rights of all people. Section 20(1) of the Swaziland Constitution provides that all persons are equal before the law and shall enjoy equal protection in all spheres of political, economic, social and cultural life and equal protection of the law. The right to equality before the law is closely linked to the right to freedom from discrimination in section 20(2) which provides that a person shall also not be discriminated against on the grounds of gender, race, colour, ethnic origin, socio-economic standing, age or disability.

In international law, Article 2 of the ICCPR, Article 2(2) of the ICESCR and Article 2&3 of the ACHPR further support the recognition and promotion of the right to equality and non-discrimination. The African Commission on Human and Peoples' Rights, in *Good v Republic of Botswana Rapporteur*, 2005 described the principle of non-discrimination as a "fundamental principle in international human rights law and guarantees that those in the same circumstances are dealt with equally in law and practice". At the international level, the CESCR urges states to ensure that "*a person's actual or perceived health status is not a barrier to realising the rights under the Covenant*" and the Commission on Human Rights has confirmed that a person's health status, including HIV status falls within the protection from discrimination on the grounds of any "other status" (CESCR, 2000).

Since neither HIV status nor AIDS is specifically listed as a ground for non-discrimination in the Swaziland Constitution, a person complaining to a court of HIV-related stigma and discrimination would need to rely on the broad constitutional rights to equality and non-discrimination in the Swaziland Constitution, for protection. Importantly, other courts in SADC have found HIV status to be a protected ground for non-discrimination in broad equality clauses. For example, in the South African case of *Hoffman v South African Airways* the court found that even though HIV status was not specifically mentioned as a ground for non-discrimination in the constitution's equality clause, the refusal by an airline company to employ an HIV-positive individual as a cabin attendant violated the right to equality and freedom from discrimination. These South African court decisions are persuasive to the courts of Swaziland and can be used by the local courts in the formulation of their decision (Dube and Magagula, 2007). This means that it can be argued that people living with HIV will be protected by the equality clause from being discriminated against on the basis of their real or perceived HIV status. However, specific legislative protection from discrimination on the basis of HIV or AIDS would clarify and strengthen equality rights in the context of HIV.

At the policy and planning level, there is far more explicit protection for people living with HIV and for selected vulnerable and key populations in Swaziland.

Prohibition of HIV-Related Discrimination in Policy and Codes of Good Practice

The National Multi-Sectoral HIV and AIDS Policy, 2006: A guiding principle of the policy is that the national HIV response shall be guided by protection, non-discrimination, non-stigmatization of people living with HIV and AIDS and other vulnerable populations.

The Code of Good Practice: HIV/AIDS in Employment: Part 1.6 of the code provides for eliminating discrimination in the workplace based on HIV status and also promoting a non – discriminatory workplace in which people living with HIV or AIDS are able to be open about their status without fear of stigma or rejection.

The Swaziland National Gender Policy 2010: One of its programme objectives seeks to promote equitable access to treatment and care for HIV and AIDS by women, men, boys and girls.

The National Multi-sectoral HIV/AIDS Framework (2014-2018) includes strategies for creating broad public awareness on issues related to stigma and discrimination and customised interventions for key populations and vulnerable groups.

The Correctional Services HIV/AIDS Policy of 2008 prohibits discrimination and stigmatization of HIV and AIDS among inmates.

4.2.3. Protection from Discrimination on the basis of Sexual Orientation and Gender Identity in Law and Policy

LGBTI populations experience stigma and discrimination in Swaziland (Office of the High Commissioner for Human Rights (OHCHR), 2011), as well as censorship and criticism from traditional and church leadership in Swaziland (Lusweti Institute for Health Development Communication, 2011), creating obstacles to access to health services. It is furthermore exacerbated by laws that criminalise same-sex sexual behaviour, discussed in further detail in the criminal law section, below. This means that the rights and needs of LGBTI are largely ignored and not prioritised for government targeted HIV and AIDS interventions.

Similar to people living with HIV, LGBTI populations are also protected from discrimination by the section 20 equality provision in the National Constitution, 2005 which provides that all persons are equal before the law and shall not be discriminated against on the grounds of gender, race, colour, ethnic origin, tribe, birth, creed or religion, or social or economic standing, political opinion, age or disability. However, there is no specific protection in the Swaziland Constitution against discrimination on the basis of a person's sexual orientation or gender identity. In addition, the courts in Swaziland have not yet adjudicated on a matter concerning LGBTI populations. International and regional guidance suggest that key populations require specific protection, due to their marginalised status.

4.3. Health Law in Swaziland

In Swaziland, there are various reports of stigma, discrimination and rights violations against people living with HIV, vulnerable and key populations in the health sector; these include inadequate access to HIV-related health care services, discriminatory denial of access to appropriate services, ill-treatment and abuse and breaches of confidentiality relating to HIV and health status. Participants in the LEA reported increasing discrimination in health care and emphasized the need to be treated with respect and dignity, the need to be informed and involved in their care as well as the need for enactment or enforcement of legislation to address violation of human rights.

Section 16(6)(c) of the Swaziland Constitution (2005) provides for the right to health care; it provides that “[a] person shall be allowed reasonable access to medical treatment including, at the request and at the cost of that person, access to private medical treatment”. Although Swaziland has not adopted an HIV-specific law that sets out the rights of people to access to health care in the context of HIV and AIDS, there are various existing national laws as well as policies that regulate access to health care and medicines in Swaziland, as well as a new Public Health Bill of 2013. This section examines health law and policy in Swaziland in the context of international and regional guidance on HIV, AIDS and vulnerable and key populations, to determine the extent to which law and policy provides for non-discriminatory universal access to HIV-related health care services.

In international law, Article 27(1) of the UDHR states that “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including... medical care”. Article 12 of the ICESCR furthermore recognises “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and places an obligation on states to take steps to “achieve the full realization of this right”. The right to the highest attainable standard of physical and mental health comprises, *inter alia*, “the prevention, treatment and control of epidemic... diseases” and “the creation of conditions which would assure to all medical service and medical attention in the event of sickness”.

The CESCR’s General Comment No. 14: The Right to the Highest Attainable Standard of Health (U.N. Doc E/C.12/2000/4) provides detailed guidance on the scope of Article 12(1) and the rights and duties it imposes on the state. It recognises the importance of making a range of quality health services and information *available, accessible and acceptable* to allow individuals to engage in meaningful decision making regarding their health. This includes ensuring, *inter alia*, the following:

- Access to essential medicines as defined by the WHO Action Programme on Essential Drugs
- Health education and information, including sexual and reproductive health information should be available to all and should not be censored, withheld or intentionally misrepresented
- Provision for self-determination, including reproductive self-determination, through the protection of the right to freely consent to medical treatment
- Respect for medical ethics, including the confidentiality of medical information

- Provision for a system of health protection which provides equality of opportunity for people to enjoy the highest attainable standard of health, in terms of which “health facilities, goods and services have to be accessible to everyone without discrimination...especially the most vulnerable or marginalized sections of the population” including “persons with HIV/AIDS”.

General Comment 14 furthermore recognises that the duties of States includes the duty, *inter alia*, “to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; [and] to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services”

Article 16 of the ACHPR states that parties are expected to provide its citizens the right to enjoy the best attainable state of physical and mental health. The Women’s Protocol to the ACHPR makes specific mention of HIV and AIDS and the obligation to provide for women’s health needs in the context of HIV.

In order to meet these obligations in the context of HIV, the UNAIDS *International Guidelines* recommend that States should ensure the provision of a range of services without discrimination and with a particular focus on vulnerable populations, including, *inter alia*, HIV-related information, education and support, including access to services for sexually transmitted diseases, the means of prevention (such as condoms and clean injection equipment), voluntary and confidential HIV testing with pre-and post-test counselling as well as to treatment, care and support for those affected by HIV and AIDS. The revision of Guideline 6 in 2002 reflected the acceptance of access to treatment as a fundamental human right.

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

- States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.
- States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.
- States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

States are furthermore under an obligation to adopt measures to make medicines more affordable, and thus accessible. The *International Guidelines* recognise that this requires reviewing bilateral, regional and international agreements (such as those dealing with intellectual property) and national laws to promote access to affordable medicines. Similarly, the recent GCHL report (2012) recognises the need for states to develop effective intellectual property regimes for pharmaceutical products that are consistent with international human rights law and public health needs, while safeguarding the justifiable rights of inventors. Part of the strategy to make

medicines affordable must include, amongst other things, a patent framework that is flexible to incorporate public health needs.

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

4.3.1. Laws regulating access to health care services

Swaziland has prioritised universal access to health services. However, the regulation of all health goods and services, including HIV-related services in Swaziland, will be greatly improved when various new pieces of legislation are enacted and implemented.

Existing health law in Swaziland does not deal extensively with HIV and AIDS or individual health rights and access to services. The existing Public Health Act 5 of 1969 is more focussed on imposing standards for the sanitation, vaccines, monitoring and prevention of infectious diseases rather than providing for access to public health services as a whole. It even includes coercive provisions relating to HIV and AIDS, contrary to international and regional guidance: AIDS was made a notifiable disease by means of Legal Notice 25 of 1987 in terms of s3 (1)(b) of the Act. This means that provisions in the Act that place an obligation upon various persons, including occupiers of urban buildings and medical practitioners to report any such disease and allow the Minister to regulate the control of any such disease through coercive measures (e.g. through prohibition on entry into the country and compulsory medical examinations), if necessary, may be applied to AIDS. However, coercive provisions have not been applied to HIV or AIDS in Swaziland and the Act will be replaced by the Public Health Bill, 2013, when enacted.

Currently, the Pharmacy Act 38 of 1969 provides for chemists and the sale, supply and possession of pharmaceuticals in Swaziland. The Pharmacy Bill 2012 establishes a Pharmacy Council for regulating the pharmacy profession, registration of pharmacists and registration of manufacturers, which will further support the regulation of HIV-related medication in Swaziland.

The Medicines and Related Substances Control Bill provides for the establishment of a Medicines Regulatory Authority and provides for the registration of all medicines as well as the approval of clinical trials, which will promote the availability of quality medicines in the country. Part IV of the Bill, which deals with Labelling, Advertising, Sale and Special Permits is also significant in that the proposed s36 prohibits false advertising regarding medicines, protecting people living with HIV from false claims of AIDS cures. Section 54 of the Bill encourages those dispensing medicines to provide information regarding affordable generic medication, which will furthermore promote access to affordable medicines in Swaziland.

The Public Health Bill 2013 provides for the regulation of health care services in Swaziland, including for the manufacture, procurement, monitoring and control of all medicines. Part 6 of the Bill provides specifically for health responses to sexually transmitted infections and

requires health practitioners to treat all sexually transmitted infections, which would include HIV and AIDS.

Section 59(2), “Every health practitioner shall attend, examine, diagnose treat, inform, advise or refer the client/patient in respect of any sexually transmitted infection or disease in order to control the spread of the disease to others”

The Public Health Bill (2013)

There is more specific provision for access to HIV-related health care services for a range of affected populations in national strategic plans, policy guidelines and strategies.

The eNSF and related health policies provide for a range of health services for the prevention, treatment, care and support of people affected by HIV and AIDS. For example, the National Multi-Sectoral HIV and AIDS Policy (2006) aims to strengthen the multisectoral institutional framework for the co-ordination and implementation of HIV and AIDS interventions in the country. It provides for access to prevention, treatment, care and support to all those affected by HIV, including education and information, condoms, prevention of mother to child transmission of HIV, blood safety, HIV counselling and testing, post-exposure prophylaxis and universal precautions, ART, management of opportunistic infections, home-based care and palliative care and nutrition, amongst others.

In addition, vulnerable and key populations are included and prioritised in the response, although in many policy documents the focus is on vulnerable populations (such as people living with HIV, women, girls and children) rather than key populations such as LGBTI populations. The e-NSF, however, specifically aims to strengthen an enabling social, policy and legal environment where all people, including vulnerable groups and key populations at higher risk of HIV infection, have their basic human rights protected, respected and fulfilled. A key objective is promoting innovative strategies aimed at preventing new HIV infections among key populations, and in ensuring their access to and utilisation of targeted HIV prevention, treatment care and support services. Women and young people are particularly prioritised in the e-NSF as well as other health policies and guidelines. For instance, the Ministry of Health and Social Welfare’s *National Guidelines for Antiretroviral Treatment and Post-Exposure Prophylaxis* include a strong focus on the provision of ART to adolescents; they also provide for post-exposure prophylaxis (PEP) for survivors of sexual assault. The Swaziland *National Youth Policy* of 2008 recognises HIV as a key issue for young people and seeks to increase access to sexual and reproductive health care services for young people.

In terms of access to medicines, the Ministry of Health and Social Welfare developed detailed *National Guidelines for Antiretroviral Treatment and Post-Exposure Prophylaxis* in 2006, detailing the provision of ART for adults and adolescents in Swaziland. However, there has been limited use of intellectual property law and the TRIPS flexibilities to increase access to cheaper medicines in Swaziland. The Patents, Designs and Trade Marks Act, 1936 is not in alignment with the Trade-Related Aspects of Intellectual Property (TRIPS) Agreement. There is currently a new Patents Bill, 2013 which aims to update the 1936 Act which succeeds in bringing the law in Swaziland in alignment with the TRIPS Agreement and which contains many progressive

provisions particularly with regard to public participation in the patent approval process for medications. When enacted, this will allow for access to cheaper medicines in Swaziland.

Despite the various provisions in law and more so in policy, it appears that affected populations are still not able to access HIV-related health services effectively. In some cases this is argued to be as a result of lack of awareness of their rights and the availability of services amongst affected populations.

“...the violation of human rights that happens at health facility level is because of lack of information..... ordinary citizens do not know their health rights and what to expect when they go to hospital....we must be informed of our rights and the services expected to be delivered at a health facility. Knowledge is very important, there are always new things about HIV that we must know about...” PLHIV male respondent, FGD

Some key informants and FGD participants argued that access to health services was limited by the inadequate information provided to them by medical staff.

“...I developed lumps on my neck after I started ART...I went to the hospital and the doctor told me that I must be operated so that the lumps are removed. When I returned for the operation I was also informed by another doctor that I would die if I agreed to the operation because of my HIV positive status as I could lose a lot of blood and bleed to death. The doctors provided me with conflicting messages and I didn't know what to do...” PLHIV, FGD.

“From my experience after attending a number of clinics and hospitals I can conclude that some of the nurses are not well trained about the HIV/AIDS pandemic, stigma and discrimination because health workers are the main reason people do not go to the hospitals when they are sick.” Rural Health Motivator, FGD.

In other respects, this may be as a result of a broader failure to adequately programme for and implement policies at health facility level. Key populations, for instance, argue that their specific health needs are not met in current programmes. Key populations report that HIV testing and counselling services don't meet their particular needs. Lubricants for men who have sex with men are not easily available and affordable in public facilities and are expensive to buy from chemists or private facilities. Services that provide free disposable needles and syringes are not available in the country nor are other harm reduction services available to assist people who use drugs.

For people with disabilities, the infrastructure in most health facilities is not accessible for those who require, for example, wheelchair access and health workers are not trained to communicate with persons with hearing or visual impairments. Clinic hours are said not to be conducive for working women and young people who are in school.

Poverty furthermore impacts on access to health care services, with participants complaining of lack of resources to travel to health care facilities or food insecurity which impacts on nutritional requirements, wellness and adherence to ART for those affected by HIV and AIDS. This limits access to services that would otherwise improve the longevity and quality of life of patients.

“...My main worry is that many of the people who take the tablets are vulnerable and live in poverty so it is my plea that something be done to supply food to them...” male carer, FGD

“...How are we going to take the tablets because you don't even give us a meagre maize meal to eat?” RHM, FGD.

“...My suggestion is that the people who take ARVs must at least be given E50 bus fare depending on their vulnerability...Another point is that government should try to bring the tablets closer to the people so that there will be no need to board buses when we want to collect the tablets...” RHM, FGD.

“ I think it is better that the tablets are supplied in a clinic not the Gogo Centre, or if they are supplied at the centre it should not be ARVs only but there must be all types of medicines so that all people attend and in that way the positive people will disguise...” RHM, FGD.

“...Poverty is the most common and serious issue and the parcels of food they give are small and get finished. What I am asking is if they can assist us with anything so that we can plough and grow food which will be enough to sustain life...” female Carer, FGD

In a study on food sufficiency and high sexual risk behaviour in women in Botswana and Swaziland, Weiss et al (2007) found that lack of food has dire consequences that expose people especially women to transactional sex with underlying risk factors for HIV including inconsistent condom use, intergenerational sex and lack of control in the sexual relationship. The authors noted that targeted food assistance and income generating projects in conjunction with efforts to enhance women's legal and social rights may play an important role in decreasing HIV transmission risk for women.

4.3.2. Equality and Non-Discrimination in Access to Health Care

Stigma and discrimination in access to health care has been identified as a major concern for people living with HIV, vulnerable and key populations. The LEA found that violations of human rights in the health sector were perceived to be on the increase and mentioned by most of the participants in the FDGs. Stigma and discrimination in the health sector includes violations of the right to dignity and being denied access to services on the basis of their HIV status.

The principles of equality and non-discrimination in the response to HIV and AIDS is entrenched in various policies and plans relating to HIV and AIDS in Swaziland. Human rights principles were set out in the NSF 2009-2014 and again in the more recent e-NSF 2014 – 2018 as well as the National Multi-Sectoral HIV and AIDS Policy, 2006. These plans and policies all emphasise a non-discriminatory, human rights-based approach to health, including sexual and reproductive health, HIV and AIDS. The Policy, while more focussed on vulnerable populations rather than key populations, specifically provides for law review and reform to ensure laws and policies adequately address the public health and human rights issues relating to HIV and AIDS.

Commitments to rights-based responses to HIV and to vulnerable and key populations in Swaziland policy:

The National Multi-sectoral HIV and AIDS Policy, 2006 provides broad guidance to HIV response and recognizes the importance of promoting the rights to equality, non-discrimination and involvement of people living with HIV and vulnerable populations, including women, children, orphans, sex workers, prisoners and persons with disabilities.

NSF 2009-2014 and the e-NSF 2013-2018 (extended national strategic framework) guide the multi-sectoral HIV response in Swaziland and include a strong focus on mainstreaming human rights and gender equality into HIV programming. The e-NSF includes protection for the rights of all people with a particular focus on those vulnerable groups and populations at higher risk of HIV infection.

The National Health Policy, 2007 provides that fundamental human rights as set out in the Swaziland Constitution will be respected in the course of provision of all health services; health services shall be equitable, affordable and accessible to all.

The National Children's Policy provides for the right of every child to "the best attainable state of physical, mental and spiritual health without discrimination on the basis of gender, race, colour, ethnic origin, tribe, birth, creed or religion or social or economic standing, political opinion, age, health status or disability".

The National Gender Policy 2010 The Swaziland National Gender Policy 2010, in one of its objectives to take measures that will promote, improve, and protect the sexual and reproductive health rights as well as the health status of men, women, boys and girls throughout their life cycle. These will include strategies Empower women and men through education to care and protect themselves against HIV and AIDS and STIs. The policy also provides for strategies that promote equitable access to treatment and care for HIV and AIDS by women, men, boys and girls.

National Disability Policy 2013 The Swaziland national policy on disability provides for the rights of people with disabilities. It promotes strengthening sexual and reproductive health rights to persons with disabilities, including the provision of comprehensive information and management of STI's, HIV and AIDS.

Correctional Service HIV and IDS Policy His Majesties Government Correctional Service HIV/AIDS Policy 2008 provides guidelines for the reduction of transmission of HIV and AIDS and provision of appropriate care and support to personnel, their dependents and inmates infected and affected by HIV. It further commits to reduction of incidents of HIV and AIDS and mitigate its impact on personnel, their dependents and inmates.

The above shows that the country has taken the necessary efforts to make provisions for the promotion and protection of the rights of all populations in the context of HIV specifically the Swaziland's HIV and health policy frameworks. However, stigma and discrimination remains a

priority concern, as has been set out above, impacting on access to health care services for all people. Key populations, in particular, report the barriers created by the stigmatising attitudes and behaviour of health care providers.

The Medical and Dental Practitioners Act, 1970 and the Nurses and Midwives Act, 1965 regulate the conduct of medical practitioners and other health care workers and should also work to protect patients from discriminatory treatment. However, it appears that patients are afraid or unable to complain about discriminatory treatment in the health care sector. Participants reported that complaining to internal management structures, such as senior nursing staff, was not helpful. This is dealt with in further detail in Section 5 (Access to Justice), below.

“I feel very hurt when you talk about this because even if you submit your complaint to the matron nothing happens to the nurse. In 2004 I fell very sick and I was in a critical condition unable to walk for three months and I was admitted at hospital B in Hhobho region. The two nurses came to my bed, I was not able to walk or do anything and the tablet they had given me was still in my hand because I was not able to drink it. They shouted at me that they were tired of me because I did not die and I didn’t recover. I was horrified and I cried hysterically but it could not help me because I was not able even to walk. When the matron arrived, I reported the incidents to her but because they were her colleagues there was no action taken against them...” PLHIV female, FGD.

4.3.3. The Right to HIV Testing and Treatment with Voluntary and Informed Consent

The right to HIV testing and treatment only with voluntary and informed consent may be argued to be based on the right to liberty, amongst other rights such as the right to security of the person and privacy.

Section 16(1) of the Swaziland Constitution provides that a person shall not be deprived of personal liberty except where it is authorized by law.

In international law, article 9 of the ICCPR provides that *“Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law”*.

The Special Rapporteur on the Right to Health has stated that *“Guaranteeing informed consent is a fundamental feature of respecting an individual’s autonomy, self-determination and human dignity in an appropriate continuum of voluntary health care services . . . Informed consent invokes several elements of human rights that are indivisible, interdependent and interrelated. In addition to the right to health, these include the right to self-determination, freedom from discrimination, freedom from non-consensual experimentation, security and dignity of the human person, recognition before the law, freedom of thought and expression and reproductive self-determination.”* Guideline 3 of the *International Guidelines* requires states to ensure that public health legislation is consistent with human rights. Commentary on the guideline refers specifically to HIV testing and recommends that HIV testing should only be conducted with the ‘specific informed’ consent of the individual tested. The *International Guidelines* note that *“compulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of a*

person” and that “respect for the right to physical integrity requires that testing be voluntary and that no testing be carried out without informed consent”. They furthermore note that coercive or compulsory HIV testing is often applied to populations least able to protect themselves because they are within the ambit of government institutions (e.g. soldiers) or the criminal law (e.g. prisoners, sex workers, people who use drugs and men who have sex with men).

The SADC PF *Model Law on HIV & AIDS in Southern Africa, 2008* similarly recommends HIV testing should be voluntary, anonymous and confidential.

At a policy level, the Ministry of Health and Social Welfare’s *HIV Testing and Counselling National Guidelines* of 2006 provide for HIV testing and counselling (HTC) in Swaziland. Chapter 7 of the Guidelines recognise the right of all patients to information, education, privacy, non-discrimination and equality, the right to marry and the right to the highest attainable standard of health. HIV testing must be voluntary with clients and patients making an informed decision about accepting an HIV test and being given the right to refuse testing. A child of 12 years or above is considered able to give full informed consent to an HIV test and the consent of a parent or guardian is required for children below the age of 12 years. Mandatory HIV testing is prohibited, although the Guidelines provide that it “can be considered in special circumstances e.g. for blood donation and rape perpetrators.”

Section 2, Sub-Section 4.3.1 of the Ministry of Health and Social Welfare’s *National Guidelines for Antiretroviral Treatment and Post-Exposure Prophylaxis* provides for post-exposure prophylaxis in the event of sexual abuse. It provides that a parent or guardian of a child below 18 years of age should provide consent to an HIV test. This provision is in conflict with the testing guidelines and the Children’s Protection and Welfare Act of 2012 which allows a child of 12 years to consent to HIV testing.

While the constitutional right to liberty is protective and the Ministry of Health *Guidelines* are clear, the Public Health Bill 2013 does not clearly provide for a patient’s right to testing and treatment only with voluntary and informed consent. Section 59(2) of Swaziland’s Public Health Bill of 2013 does require that medical practitioners “inform and advise” a client or patient under treatment. However, it would be preferable to have a clear right to voluntary, informed consent set out in law.

Mandatory HIV Testing: While the Constitution protects the right to liberty, section 16(1) (g) of the Swaziland National Constitution provides that a person’s liberty can be deprived in the case where the objective of the law is to prevent the spread of an infectious or contagious disease. As a result, there are examples of punitive and coercive provisions in Swaziland’s law and proposed law relating to mandatory HIV testing, limiting a patient’s liberty, contrary to the recommendations of international guidance.

For example, there is provision for mandatory HIV testing of an alleged sex offender in the Sexual Offences and Domestic Violence Bill. Section 195(1) of the newly enacted Sexual Offences and Domestic Violence Bill (2009) provides that the Minister may make regulations regarding compulsory HIV testing, upon application, in the event of a sexual offence:

Section 195(1) of the Sexual Offences and Domestic Violence Bill, 2009

The Bill allows the Minister to make regulations for the following:

- (c) Designation of public health establishments for purposes of providing Post Exposure Prophylaxis (PEP) and carrying out compulsory HIV testing;
- (d) Application for compulsory HIV testing of alleged sex offender by victim;
- (e) Application by victim or interested person for HIV testing of alleged sex offender;
- (g) Application for compulsory HIV testing of alleged sex offender by police official;
- (h) Application by police official for HIV testing of alleged sex offender;
- (i) Execution of orders for compulsory HIV testing and results of HIV tests;
- (m) Confidentiality of HIV test results obtained;

The purpose of the proposed Regulations to be made by the Minister, the purpose of the compulsory HIV testing of a sexual offender and the conditions to be considered by a court in such an Application are unclear in the Bill. Possible reasons for HIV testing which may be posited include (i) providing information to a complainant to allow them to make a determination regarding post-exposure prophylaxis (PEP), (ii) allowing for aggravated sentencing of a rapist who was HIV-positive at the time of the offence and (iii) allowing for prosecutions of transmission of HIV.

With respect to the provision of PEP, the Ministry of Health and Social Welfare's *National Guidelines for Antiretroviral Treatment and Post-Exposure Prophylaxis* 2006 provide, in Section 2, subsection 4, for PEP to those who have been sexually abused and suggest that a "perpetrator should be traced and tested". The Ministry of Health and Social Welfare's *HIV Testing and Counselling National Guidelines* state that "mandatory testing and counselling for the rape perpetrator can only be performed with a court order and the results disclosed to the magistrate or judge handling the case. However, it is important to note that HIV testing for purposes of supporting a complainant to make decisions regarding PEP would only be useful if it was undertaken immediately after the offence.

In terms of evidence for imposing aggravated sentencing or prosecuting transmission, the limitation of compulsory HIV testing of a person charged with a sexual offence is that it can only provide evidence of a person's HIV status at the time of testing, whenever that may be. It cannot provide evidence of HIV status at the time of the offence, nor of a person's knowledge of their HIV status or whether HIV was transmitted from one person to another.

The concern with mandatory HIV testing provisions such as these is that they may result in the punishment of a person convicted of a sexual offence, simply for being HIV-positive at the time of HIV testing. This may be argued to be unreasonable and unjustifiably discriminatory against people living with HIV, in conflict with section 20(4) of the Swaziland Constitution which provides: "*Subject to the provisions of subsection (5) Parliament shall not be competent to enact a law that is discriminatory either of itself or in its effect.*"

UNAIDS (2013) emphasises the importance of prosecutorial guidance in the case of criminal laws relating to HIV, given the various complexities inherent in applying criminal law to harmful HIV-related behaviour. This is discussed in further detail, below in the section on criminal laws and HIV.

4.3.4. The Right to Medical Confidentiality

The right to medical confidentiality, including confidentiality with regard to HIV status, is founded upon the right to privacy. In Swaziland, breaches of confidentiality were reported as an issue of concern by respondents, occurring as a result of actions of health care workers or as a result of the manner in which facilities are set up and services are provided.

“The nurses embarrass patients because they talk to them publicly in the queue rather than a private consultation room...” Rural Health Motivator, FGD.

“...there is no confidentiality in most VCTs or any place where sick people go to get medication and that makes most people to be scared to go there because they fear to be embarrassed. Another point is the way the hospitals are built. The VCTs are separated from the other centres and the infected people are easily recognised because they form their own line to the VCT centre. This does not affect only HIV positive people but all people. The way that the hospital is set up; that those who are mentally disturbed go to their own separate department, those who have tuberculosis also go to their own department within the same health facility really affects the patients...” Health Care Worker, FGD.

The Swaziland Constitution has no explicit provision for the right to privacy. However, the right to privacy is guaranteed at the international level through various human rights treaties, which include Article 12 of the UDHR, Article 37 of the CRC and Article 17(1) of the ICCPR. The latter states that “no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence or to unlawful attacks on his honour and reputation”.

The UNAIDS *International Guidelines* state that the right to privacy encompasses obligations to respect physical privacy, including the obligation to seek informed consent to HIV testing, as well as privacy of information, including the need to respect confidentiality of all information relating to a person’s HIV status. The *International Guidelines* furthermore argue that limiting the right to privacy, through mandatory HIV testing and disclosures of a person’s HIV status, is an unjustifiable and discriminatory limitation of human rights. They recommend against limiting privacy rights; disclosures of a person’s HIV status should only take place under exceptional circumstances, where there is a clear risk to a third person (e.g. a sexual partner) and only after various steps have been taken to encourage voluntary disclosure. The SADC PF *Model Law on HIV & AIDS for Southern Africa*, 2008 recommend similarly, providing detailed guidance on steps to be considered prior to disclosure to a sexual partner at risk of HIV infection.

UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights* Commentary to Guideline 3:

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

- (i) The HIV-positive person in question has been thoroughly counselled;
- (ii) Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;

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

In protecting privacy rights, the State has an obligation to ensure that HIV testing occurs only with informed consent and that confidentiality is protected, particularly in health and social welfare settings, and that information on HIV status is not disclosed to third parties without the consent of the individual. In this context, States must also ensure that HIV-related personal information is protected in the reporting and compilation of epidemiological data and individuals are protected from arbitrary interference with their privacy in the context of media investigation and reporting. Confidentiality of medical information, including HIV status, is vital to promoting confidence in public health systems.

The current Public Health Act 5 of 1965 does not provide for individual health rights such as the right to confidentiality. However, the Ministry of Health and Social Welfare’s *HIV Testing and Counselling National Guidelines* provide for the right to confidentiality of all people testing for HIV. Chapter 7 provides that “those testing must be assured of the confidentiality of their records, the record keeping system and their test results” and that HIV test results should be disclosed only to the client in person or to others with the client’s consent. In the case of children, the test results may be disclosed to the child, if he or she is considered to have sufficient maturity, or to a parent or guardian. The *Guidelines* suggest that a counsellor should offer ongoing counselling to encourage a client to inform his or her HIV status to a sexual partner and may inform a sexual partner of the client in the presence of the client, at the client’s request.

The provisions of the newly enacted Sexual Offences and Domestic Violence Bill, 2009, however, contain potential for limitations of the right of medical confidentiality. The Minister is provided with the authority to make regulations concerning the confidentiality of HIV test results obtained during court proceedings in the event of a sexual offence; however no guidance is provided to the Minister with respect to limiting the right to confidentiality. Participants alluded to the lack of privacy at health facility level. They cited that there is no confidentiality maintained between health workers and patient, most health workers disclose their problems publicly.

There is a need to clarify the right to confidentiality in Swaziland health law and the lawful limitations on this right, such as in the case of disclosure to a sexual partner at risk of HIV infection.

4.4. Women, Girls and the Law in Swaziland

4.4.1. Inequality

Gender inequality has been cited as one of the drivers of HIV transmission, morbidity and AIDS mortality in Swaziland (Mngadi, et al. 2009; Whiteside, 2003). Gender inequality refers to the domination of one gender over the other and occurs in many forms from family level, to community and national level; and from private lives to political, social and economic spheres of life (Dugger, 1996).

Women and girls in particular are subjected to gender based physical, sexual and economical abuse and violence by their male counterparts. The majority of women and girls continue to experience insubordination and gender based violence in the hands of men as well as deny them the right to freely choose whether, when and where to seek health care, including HIV services. Participants reported that some women who dared sought HIV services, have been physically abused or thrown out of their marital homes by their husbands or family members. They felt that gender equality should be part of the school curriculum at lower grades so that as boys grow up they know and appreciate that all humans are equal and deserve to be treated as such.

Daly (2001) states that barriers to gender equality emanate from various sources including traditional societal, cultural, political, legal and economic values inherent in a particular country or society. However, gender inequality is a widely observed phenomenon in all the spheres of life in the country; from family, to community to national level and from private lives to political, social and economic spheres of life, gender equality remains elusive. According to Daly (2001), change and control or shift towards a gender responsive society or gender equality is progressing slowly in Swaziland. In his study on gender equality rights and traditional practices in Swaziland, Daly (2001) found that property rights, majority status and contractual transactions for women still require the support and approval of their male guardian. Women also have limited control over marriage, with customs placing parental and community interests above individual interests. Married men continue to have far greater latitude in their sexual relationships and when seeking divorce than do their spouses. Additionally, he found that women are disproportionately compensated for their knowledge, skills, abilities or talents including in the working environment, in both the public and private sectors. Females are expected to be caring, to nurture and to submit to males especially when married. Hence women are less likely to hold positions of authority such as leading church congregation or policymaking, as is evident in the country's previous and current parliamentary, judiciary and cabinet composition all of which are dominated by men despite that females account for 53% of the population. Women continue to lack a voice and participation in development public policy making processes and decision-making bodies of the country (Daly, 2001). This suggests that women are powerless and without opportunities to improve their lives and those of their dependants, resulting in a cycle of poverty and compounded by a cycle of abuse. Decision making in relationships and on reproductive health matters remains compromised.

“...In our culture a wife is not supposed to go to the hospital/clinic to test for HIV/AIDS without first getting permission from her husband....because testing without permission from

your husband is the same as going to a traditional healer without your husband's consent which is against Swazi culture. I think we should fight this but I don't know how. I think it is good in other things but in the health sector it is a setback..." Lutsango Member female respondent, FGD

Gender inequality has implications in the HIV response; most HIV prevention campaigns focus on individual behaviour change such as convincing individuals to stay faithful to one uninfected sexual partner, to consistently use condoms and to limit the number of their sexual partners to lessen exposure to HIV (Aral, 1993). By their nature these messages assume that women are able to control their sexual partnerships (i.e. choosing when to have sex and with whom), and that women are able to "negotiate" condom use with their partners.

Section 28 of the Swaziland Constitution outlines the specific human rights provisions aimed at protecting women.

Section 28

- (1) Women have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities.
- (2) Subject to the availability of resources, the Government shall provide facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement.
- (3) A woman shall not be compelled to undergo or uphold any custom to which she is in conscience opposed.

Swaziland National Constitution (2005)

The International Guidelines on HIV and Human Rights recognise women as a vulnerable population in the context of HIV and AIDS. Guideline 5 provides for strengthened protection from discrimination for all vulnerable populations, as set out above. Guideline 8 further says that "states should, in collaboration with and through the community, 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."

Sections 26 to 28 of the SADC PF *Model Law on HIV in Southern Africa* provide extensive guidance on the protection of women and girls in law and policy, including protection of equality and non-discrimination rights, protection against violence and access to health related information and education.

CHAPTER III: PROTECTION OF WOMEN AND GIRLS

26. Information and education

- (1) Notwithstanding the provisions of Part II of this Model Law, women and girls, regardless of their marital status, shall have equal access to adequate and gender sensitive HIV-related information and education programmes, means of prevention and health services including women-specific and youth-friendly sexual and reproductive health services for all women of

reproductive age and women living with HIV.

(2) Information and education programmes provided under subsection (1) shall ensure the sensitisation of men on HIV prevention, gender-based violence, gender inequality and challenge dominant / traditional conceptions of masculinity.

27. Protection against violence

(1) The State shall ensure that women and girls are protected against all forms of violence, including sexual violence, rape and other forms of coerced sex, as well as against traditional practices that may negatively affect their health.

(2) No marriage or other relationship shall constitute a defence to a charge of rape.

(3) Women have the right to refuse sexual acts, including those that put them at risk of infection with HIV or any other sexually transmitted infection. No marriage or other relationship shall deprive them of that right.

28. Equality and non-discrimination

(1) Women shall have equal legal rights in all areas including in matters such as marriage, divorce, inheritance, child custody, property and employment, and shall not be discriminated against on the ground of their sex, or their actual or perceived HIV status.

(2) The [Ministries responsible for health, gender and/or women affairs] in collaboration with and key national and local stakeholders, must develop and implement strategies, policies and programmes that respect, protect and fulfil the human rights of women and girls in the context of HIV. With the aim of promoting gender equality and the full enjoyment by women and girls of their human rights, these strategies, policies and programmes shall address issues such as:

- (a) equality of women and men, and girls and boys in all aspects of public and private life;
- (b) the sexual and reproductive rights and responsibilities of women and men, including women's right to refuse sex and the right and ability to negotiate safer sex and the right to access health and reproductive services independently;
- (c) men's responsibilities to take equal responsibility for sexual and reproductive health and outcomes and to avoid rape, sexual assault and domestic violence, inside and outside marriage;
- (d) strategies for increasing educational, economic, employment and leadership opportunities for women;
- (e) sensitising service providers and improving health care and social support services for women; and
- (f) strategies for reducing inequalities entrenched in formal, customary and religious laws and customs with respect to marriage, divorce, property, custody of children, inheritance and others.

SADC PF Model Law on HIV & AIDS in Southern Africa

Notwithstanding the progressive clause in the Constitution under section 28 (3) culture continues to perpetuate gender inequality which entrenches patriarchal beliefs, norms and practices. It also persists regardless of the signed and ratified international and regional conventions /declarations that protect the rights of women and promote gender equality such as CEDAW and the SADC *Gender Protocol*, amongst others. Some participants recognised the existence of the regional and international conventions established for the protection of women and girls, however felt that culture tends to take precedence and deny women those rights or women are simply not able to claim these rights.

“...there are such protocols from SADC, UN and the country signed CEDAW and even the Constitution says all people are equal no one is more equal than other people. But the problem is when we are supposed to put them into practice.Maybe our country sometimes has a problem that, they ratify these international and regional instruments without much commitment, I think. There are women who push, so that women’s rights are recognised but the problem is that women on their own are divided and have different views and understanding. I think we need to be educated.....” Leader of Lutsango Regiment, KII

“...I don’t know what we can do with this culture. This starts at school where young boys abuse our children. If you report him to his relatives they will tell you it is ‘acceptable’ for a male to have multiple partners and dump them when he feels like it. Females are often belittled and looked down upon and considered not to have feelings. This means that females are abused from tender age at school and if males do something wrong it is allowed and there is no problem but females do not have the chance...” member of Lutsango Regiment, FGD.

Other customary laws exist that constrain women’s access to their basic rights to own land, inherit property, find employment, conduct business and make decision on their reproductive health rights. The situation is perpetuated by the dualistic legal system and the fact that despite the enactment of the Constitution, old laws that discriminate on the basis of gender have remained on the statute books. Some of the laws that require alignment include the following:

Laws Relating to the Status of Women

The Marriage Act, 1964: perpetuates gender inequality. It sets the marriageable age for men at 18 years, and women at 16 years. According to the Act, unless a couple explicitly marry outside of ‘community of property’, upon marriage women assume a legal status comparable to that of a minor child.

Property, Maintenance and Inheritance Rights: Whereas the Constitution guarantees economic freedom as a right for women, there are still various laws that limit a women’s right to own and inherit property or to maintenance on the dissolution of marriage.

The 1970 Maintenance Act obliges both parents to provide for children. However, the right to maintenance is not automatic, and women are vulnerable to losing custody of their children particularly as children always assume the surname of the father at birth.

The 1902 Administration of Estates Act requires that the estate of those who have entered into marriage through Swazi law and custom be distributed according to the same. Swazi Law and Custom prohibits women from inheriting property.

Although unmarried women can independently and individually acquire title deed land, this is not true in the case of Swazi Nation Land tenure system where a male figure is invariably required for purposes of acquiring land rights through the custom of “kukhonta”.

For married women, the Deeds Registry Act 37 of 1969 required that all property be registered in the husband’s name, unless the couple is married out of community of property. A couple will automatically be married in community of property unless they specifically choose not to. However, this status quo was challenged with success in 2010 between *Mary-Joyce Doo Aphane’ and Registrar of Deeds, Minister of Justice and Constitutional Affairs and Attorney General*.⁵ The applicant had sought the invalidation of section 16 (3) of the Deeds Act 37/1969 and its declaration as null and void on the basis that these impugned laws were inconsistent with sections 20 and 28 of the Constitution. The outcome was an amendment of the Deeds Registry Act by Parliament to remove the discrimination inconsistency in the law. The Deeds Registry Amendment Act of 2012 replaces s16 of the previous Act and now provides for the equality of natural persons to own property and deeds. Section 16(3) provides that were spouses are married in community, neither spouse can deal with property alone, unless he or she has the consent of the other spouse.

4.4.2. Gender Based Violence:

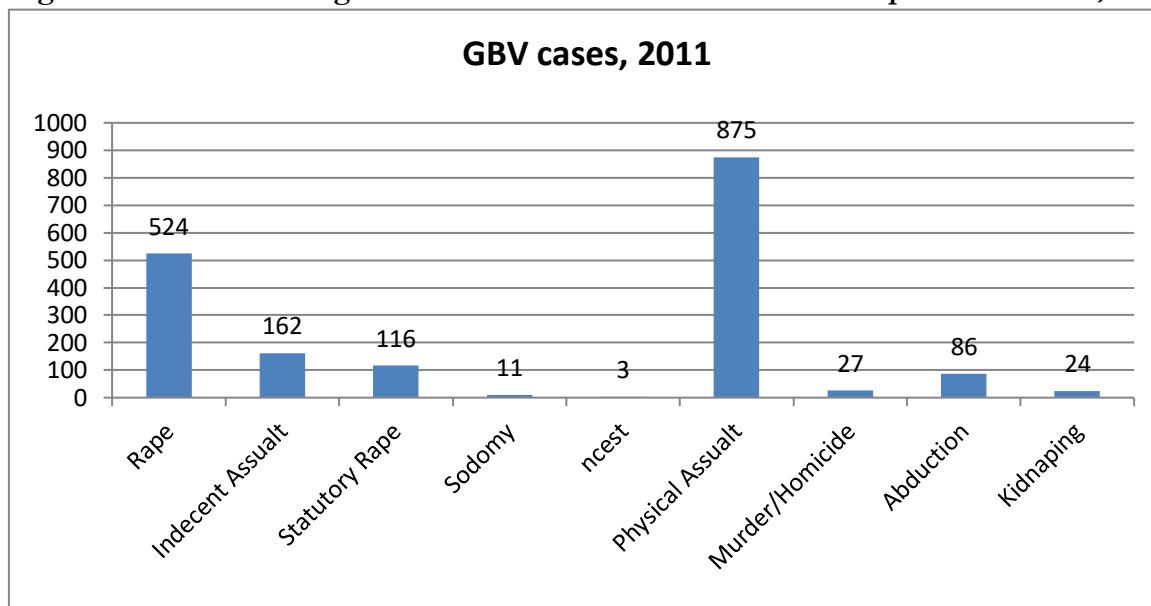
Gender based violence is an outcome of gender inequality and thrives in an environment and culture of power imbalances between men and women. Many cultural norms, practices and values on gender relations continue to give men a large degree of control over women facilitating tacit acceptance of sexual violence and gender-based violence.

Gender-based violence, including sexual violence is widespread. In a regional study conducted in eight countries in Southern Africa by Anderson and colleagues, they reported that 18% of women aged 16 to 60 years had experienced intimate partner violence in the past 12 months (Anderson et al, 2002). A study by Azih (2007) conducted in Hlathikhulu which found that 40.4% of the 326 participants in the study experienced physical abuse in the preceding 12 months of the study, with the prevalence as high as 65.2% in women with no education. A national study on violence against children and young women (UNICEF, 2007) found that, among 18-24 year old females in Swaziland, nearly 2 in 3 had experienced sexual violence, with boyfriends and husbands being the most frequent perpetrators of sexual violence. The study also showed that over half of all incidents of sexual violence were not reported to anyone, and less than 1 in 7 incidents resulted in a female seeking help from available services. The 2011

⁵ Civil Case No. 383/2009

Royal Swaziland Police report that sexual assault offences are second to physical assault, altogether comprising 654 convicted cases (rape, statutory rape, sodomy and incest). It's worth noting that the statistic captures convicted cases only, many more remains uncaptured because they were either dismissed, awaiting trial or not reported to the police.

Figure 9: Number of gender-based violence related cases reported to RSP, 2011



Source: Computed with data from Annual Police Performance Report, 2011

Gender-based violence has various impacts on health and health-seeking behaviour, critical to the HIV context. It results in physical, emotional and psychiatric health issues (Koss, 1990, in Azih, 2007) and has been shown to impact on the productivity and community participation of those affected - perpetuating poverty amongst women and furthering dependency on men, resulting in a circle of abuse. In particular, sexual violence places people at direct risk of HIV exposure. Additionally, fear of further abuse prevents people from seeking services, such as HIV-related health care services (Anderson, Cockroft and Shea, 2008). Evidence shows that there is a direct link between gender-based violence and vulnerability to HIV infection, particularly among young girls.⁶ Additionally, UNAIDS states that there is a clear association between intimate partner violence and HIV, with women experiencing such violence facing a 50 per cent increased risk of acquiring the virus. (UNAIDS, 2014).

There are various national laws that provide some protection for women and girls from sexual violence. The Girls and Women’s Protection Act 39 of 1920 provides some protection for women and girls from sexual offences. Section 3(1) of the Act states that “...*every male person who has unlawful carnal connection with the girl under the age of sixteen years or who commits with a girl under that age immoral or indecent acts or who solicits or entices a girl under such age to the commission of such acts shall be guilty of an offence...*”

Section 13 of the Prevention of Peoples’ Trafficking and People Smuggling (Prohibition) Act, 2009 criminalizes both smuggling and trafficking of persons. The Act prescribes up to 18 years

⁶ UN, CCA Final Report, 2009

imprisonment for both offences and up to 25 years' imprisonment for the trafficking of children.

In children's law, Part IV, section 23(1) (a) of the Child Protection and Welfare Act of 2012 defines a child who has been abused as a child in need of care and protection. The Act requires any member of the community to report suspected abuse of a child in section 36(1). Part X of the Act also prohibits the sale, harbouring or abduction of children.

The government of Swaziland, supported by UNICEF, has further shown its effort to increase efficiency and quick response to GBV matters by installing GBV software in 8 Magistrate Courts in the 4 regions of the country. This initiative also targets to further strengthen the GBV research capacity in the local courts. In 2013 a "one stop shop" service was established in the country's courts for survivors of GBV particularly sexual violence. The eNSF 2014 - 2018 also recognise gender based violence as one of the key drivers for HIV in the country and emphasises the need to develop appropriate interventions for prevention of GBV. Guidelines for health sector response to gender-based violence was developed in 2012.

Protection in law for women against gender-based violence will be greatly strengthened by the adoption of the Sexual Offences and Domestic Violence Bill of 2009, which is still awaiting the king's assent to fully become law. The bill aims to strengthen and consolidate common law and statutory provisions so as to adequately protect women from intimate partner violence (which protection was lacking in terms of the common law) and sexual violence. For example, the crime of rape is defined narrowly and marital rape is not criminalized in either statute or common law. The Girls and Women's Protection Act of 1920 specifically excludes marital rape from its range of offences (Amnesty International, 2010). The Sexual Offences and Domestic Violence Bill also addresses practices such as abduction and stalking which are considered a common practice in the Swazi way of courtship. However, abduction is specific to children and does not protect women. The Bill also criminalises sexual exploitation of a person including a child.

13(1) A person who engages in commercial sexual exploitation commits an offence and shall be liable on conviction to a term of imprisonment not exceeding twenty years or a fine of E50,000 but, where the victim is a child, the sentence of imprisonment shall not exceed twenty -five years or a fine of E100,000 **The Sexual Offences and Domestic Violence Bill (2009)**

4.5. Criminal Laws Affecting People living with HIV and Key Populations

This section provides an analysis of criminal laws that impact on PLHIV and key populations such as men who have sex with men and sex workers.

4.5.1. Criminalisation of HIV Transmission

The Crimes Act of 1889 and the Criminal Procedure and Evidence Act of 1938 do not deal with the criminalisation of HIV transmission. However, the Public Health Bill of 2013 purports to make the criminalisation of HIV transmission an offence. This is contrary to international guidance, which recommends against the specific criminalisation of HIV transmission for various reasons. Part 6 of the proposed Public Health Bill, 2013 deals with sexually transmitted infections and includes provision for a public health offence criminalizing the transmission of a sexually transmission infection.

Section 60 (1) “Any person who wilfully, negligently or recklessly transmits a sexually transmitted infection or disease(STI) commits an offence and is liable, on conviction, to a fine not exceeding five thousand emalangenani (E5,000) or to imprisonment for a period not exceeding five(5) years or to both.

The Public Health Bill 2013

Guideline 3 of the *International Guidelines on HIV/AIDS and Human Rights* provides that states “...review and reform public health legislation to ensure that they adequately address the public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligation.” The *Guidelines* furthermore provide that deprivations of liberty (e.g. through quarantine, isolation or detention) on the basis of a person’s HIV status are not justified by public health concerns. They state that restrictions on the right to liberty and security of the person may be warranted in exceptional cases concerning deliberate or dangerous behaviour; these cases should be handled under the ordinary provisions of public health, or criminal laws, with appropriate due process protection. Public health provisions, such as those to address harmful HIV-related behaviour, must strive towards creating a balance between public health and human rights (ARASA, 2009).

Recently, a number of countries across the world and in Africa have enacted HIV-specific laws that criminalize HIV transmission and exposure in an attempt to stop the spread of HIV and to protect women exposed through sexual violence or by partners who do not reveal their HIV diagnoses to them. While these are critical issues, experience has shown that criminalization of HIV exposure or transmission is unlikely to prevent new infections or reduce women’s vulnerability to HIV. In fact, it is more likely to harm women rather than assist them, and negatively impact both public health and human rights for various reasons, some of which are set out below:

- Applying criminal law to HIV transmission can have the effect of discouraging people from testing for HIV since lack of knowledge of one’s status could be the best defence in a criminal lawsuit.
- It creates a sense of false security by placing legal responsibility exclusively on people living with HIV for preventing the transmission of the virus. It reinforces the stereotype that people living with HIV are immoral and dangerous and exacerbates HIV-related stigma and discrimination.

- Prosecutions for HIV transmission or exposure also spread myths and misinformation about how HIV is (and is not) transmitted especially where convictions are upheld for acts that don't pose a risk of HIV transmission (such as spitting or biting).
- Applying criminal law to HIV transmission also does nothing to address the epidemic of gender-based violence or the deep economic, social, and political inequality that are at the root of women's and girls' disproportionate vulnerability to HIV. On the contrary, these laws are likely to be used to prosecute women more often than men since women are often more likely to know their HIV status and may be afraid to disclose or insist on condom use for fear of intimate partner violence. Laws that criminalise HIV exposure and transmission can also be used to prosecute women who transmit HIV to a child during pregnancy or breastfeeding. - This effectively makes pregnancy, wanted or not, a criminal offense.
- Proving that an accused person was HIV-positive at the time of an alleged offense, as well as proving who infected whom and when, is a serious challenge. Such technical evidence and its limitations are not well understood by police, prosecutors, defence lawyers, courts, the media, or people living with HIV or HIV organizations. This means there is considerable potential for a conviction without sufficient evidence.

For these reasons the enactment of HIV-specific laws that criminalise HIV transmission and exposure are counter-productive. The GCHL (2012) recommends that “countries must not enact laws that explicitly criminalise HIV transmission, HIV exposure or failure to disclose HIV status”. UNAIDS (2013) recommends that criminal laws be reviewed to limit criminal prosecution to cases that involve intentional HIV transmission, and must be:

- informed by the best available scientific and medical evidence relating to HIV and modes of transmission
- uphold the principles of legal and judicial fairness (including key criminal law principles of legality, foreseeability, intent, causality, proportionality and proof), and
- protect the human rights of those involved.

“Laws and prosecutions do not stop the spread of HIV. There is no correlation between the existence of these laws and the drop in HIV infection”

UNAIDS Executive Director – Michel Sedibe

4.5.2. Sex Workers

All people in Swaziland have the right to equality, non-discrimination and other human rights, including sex workers. Human rights that are of particular importance to sex workers, given their experiences, include the rights to equality and to non-discrimination; security of person and privacy; recognition and equality before the law; due process of law and the highest attainable standard of health; employment, and just and favourable conditions of employment; peaceful assembly and association; freedom from arbitrary arrest and detention, and from cruel and inhumane treatment; and protection from violence.

However, sex work is criminalised in Swaziland under the Crimes Act No 61 of 1889 in a very broad provision that fails to define “immoral acts”. Sections 32 to 40 of the Act also make it a criminal offence to keep a brothel. Section 13 of the proposed Sexual offences and Domestic Violence Bill of 2009 furthermore criminalises “commercial sexual exploitation.”

Part 5, Section 47:

Any person who —

- (a) entices or solicits immoral acts by words, signs, cards or in any other way whatsoever, or who knowingly aids or facilitates the commission of immoral acts; or
- (b) is a person of notoriously immoral character and exhibits himself in indecent dress or manner at any door or window or within the view of any public street or place or any place to which the public have access; shall be guilty of an offence and on conviction liable to a fine of six hundred emalangenzi or imprisonment for two years.

Crimes Act No 61 of 1889

Sex workers are highly stigmatised in Swaziland. During the LEA, they reported being physically, sexually, verbally, emotionally and economically abused by law enforcement agents, clients and family members. They are unable to access legal protection, due to the criminal laws and are at high risk of HIV exposure and have limited access to HIV-related health care.

“Abuse from police is a very common thing to us. They lock us up without charges; have forced sex with us without our consent or pay, and they verbally abuse us, calling us all sorts of names. Even if you report, no one takes you seriously. The police at Station X are the worst.....One day we were waiting at our usual spot at night. It was around 2am. A police patrol van came and stopped next to us. Two policemen alighted and asked why we were waiting there at night. Without waiting for a response they bungled us onto the back of the van and drove around their patrol area with us for almost four hours after which they went back to their duty station and locked us up without any charges. We were only released late in the afternoon...” female SW, FGD

The GCHL (2012) Report notes that criminalisation and stigmatisation of sex work makes sex workers’ lives more unstable, less safe and far riskier in terms of HIV. There is no legal protection from discrimination and abuse where sex work is criminalised, police harass and violate sex worker’s rights and sex workers tend to work ‘underground’ where it is harder to negotiate safe sex with clients and harder to access HIV-related health care.

The Report recommends that states reform their approaches to sex work: rather than punishing consenting adults involved in sex work, countries must repeal laws that prohibit consenting adults from buying or selling sex, ensure safe working conditions and offer sex workers and their clients, access to effective HIV and health services. In addition, the Report recommends that countries take all measures to stop police harassment and violence against sex workers and to prohibit the mandatory HIV and STI testing of sex workers.

Swaziland criminal laws regarding sex work require review, in order to protect the rights of sex workers and to promote their access to HIV-related prevention, treatment, care and support services.

4.5.3. Men who have sex with men

LGBTI populations are not specifically protected from discrimination on the basis of sexual orientation and gender identity in Swaziland, as has been set out above. In addition, Swaziland common law criminalises sodomy and men who have sex with men experience high levels of stigma, discrimination and human rights violations in the country. This impacts on their ability to access HIV-related prevention, treatment, care and support. MSM. During the consultations MSM reported reluctance to use health facilities when they were not well.

“...Most MSM do not want to go for treatment for HIV because confidentiality is broken so often by doctors, nurses and hospital staff. Health care professionals will disclose openly who the MSM is and who is HIV-positive. So most MSM will just keep things to themselves until they are too weak and sick to go on without health care...” MSM, FGD.

In the *Toonen v. Australia* case of 1994 (Communication No. 488/1992, U.N. Doc CCPR/C/50/D/488/1992), the Human Rights Committee held that the criminalisation of private homosexual act is a violation of the right to privacy and also impedes on HIV education and prevention interventions. A UN Office of the High Commissioners for Human Rights (OHCHR) Universal Periodic Review in Swaziland found that LGBTI populations were discriminated against and condemned openly in Swaziland and set out various recommendations (OHCHR, 2011):

Recommendation 139: Take concrete measures to decriminalize same-sex relations and prevent discrimination based on marital status and sexual orientation

Recommendation 140: Adopt the necessary political and legislative measures to establish a specific framework to protect against discrimination on the grounds of sexual orientation and repeal all laws which criminalize homosexual practice, and implement public awareness-raising campaign on this matter

Recommendation 141: Bring its legislation into conformity with its international human rights obligations by repealing provisions which may be used to criminalise same-sex activity between consenting adults

Recommendation 142: Take all necessary measures to ensure enjoyment of the right to the highest attainable standard of health, without discrimination on the basis of sexual orientation or gender identity

Swaziland Recommendations (UPR, Session 25)

4.5.4. People who inject drugs

There is very limited data on people who inject drugs in Swaziland and injecting drug use has been considered not to be an important factor in the HIV epidemic in Swaziland (NERCHA, 2009). The new eNSF identifies various target populations (Annex 2) for interventions, which include “key populations and vulnerable groups” such as people who inject drugs. However, it

is unclear to what extent HIV-related health service programming in fact takes place for people who inject drugs.

In terms of the law, the outdated Opium and Habit Forming Drugs Act of 1922 regulates habit forming drugs in Swaziland. Section 7 of the Act prohibits drug taking, including the use of drug equipment for taking drugs, as well as the keeping of premises for drug taking. It is unclear to what extent these provisions will act as barriers to harm reduction services for people who inject drugs (such as needle exchange programmes) in Swaziland. The Act does, however, recognise and provide for the use of habit-forming drugs for medical purposes. It will be important to ensure that research is conducted to determine more information on people who inject drugs and HIV in Swaziland and that harm reduction services are encouraged in policy, despite the existence of laws creating drug offences.

4.6. Workplace Law in Swaziland

The right to work and to fair conditions of work is a well-recognised basic human right. In Swaziland, section 32(4) (d) of the National Constitution (2005) provides that Parliament shall enact laws to protect employees in their work:

Parliament shall enact laws to —

- (a) provide for the right of persons to work under satisfactory, safe and healthy conditions;
- (b) ensure equal payment for equal work without discrimination;
- (c) ensure that every worker is accorded rest and reasonable working hours and periods of holidays with pay as well as remuneration for public holidays; and
- (d) Protect employees from victimisation and unfair dismissal or treatment.

In international law, the UDHR states that “[e]veryone has the right to work... [and] to just and favourable conditions of work”. Article 6 of the ICESCR furthermore recognises the right to work, which includes “*the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts*”.

At an international level, the concept of non-discrimination on the basis of HIV status in the working environment is well established. Article 6 of the ICESCR read with the principle of non-discrimination in the Covenant has been recognized by the CESCR as requiring States to guarantee that the right to work is exercised without discrimination on the basis of health status, including HIV or AIDS: “Under its article 2, paragraph 2, and article 3, the Covenant prohibits any discrimination in access to and maintenance of employment on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, or civil, political, social or other status, which has the intention or effect of impairing or nullifying exercise of the right to work on a basis of equality.

Guideline 5 of the UNAIDS *International Guidelines* recommend the enactment of workplace laws, policies and codes of good practice to strengthen workplace rights in the context of HIV and AIDS. The commentary to the guideline notes that anti-discrimination legislation should also prohibit mandatory HIV testing of vulnerable groups such as those working in the military.

The International Labour Organisation (ILO) has also set out detailed guidance on HIV-related workplace rights. In its most recent *Recommendation concerning HIV & AIDS and the World of Work* 200 of 2010, it commits member states “to tap into the immense contribution that the world of work can make to ensuring universal access to prevention, treatment, care and support” for HIV and AIDS. With respect to workers’ rights, the ILO Recommendation calls for, amongst other things:

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

At a regional level, the SADC PF *Model Law on HIV & AIDS in Southern Africa, 2008* provides that “any form of discrimination in the workplace against a person, his or her partner(s) or close relatives on the sole account of his or her actual or perceived HIV status, shall be prohibited” and includes various protections for employees, including the protection of confidentiality, the prohibition of HIV testing of a job seeker or an employee for the purpose of recruitment, promotion or any other reason and the prohibition of unfair dismissals simply on the basis of a person’s HIV status.

Courts in Southern Africa have upheld the rights of employees with HIV to non-discrimination and to be protected from pre-employment HIV testing in a number of instances. For instance, in the South African case of *Hoffman v South African Airways* (2000) ZACC 17 the court found that the applicant had been unfairly discriminated against by being refused employment on the basis of HIV status, and ordered that the respondent, SAA, should employ him with effect from the date of the judgment of the Constitutional Court. In the Botswana Industrial Court case of *Lemo v Northern Air Maintenance (Pty) LTD* [2004] 2 BLR 317 the court held that an employee who is unable to perform his or her duties as a result of HIV should not be discriminated against and should be treated the same as any other employee with a life-threatening illness.

Notwithstanding all the above guidelines HIV-related stigma and discrimination has been reported to be high at workplace in Swaziland especially around the Industrial factories and it takes various forms including:

- Stigma and discrimination from employers and colleagues
- Refusing to reasonably accommodate / provide HIV positive employees with sick leave; maternity leave or time off to access health care services
- Demanding disclosure of health status in the case of employees who request leave to access health services
- Unfair dismissals on the basis of an employee’s HIV status or on the basis of longer sick leave periods

- Pre- employment HIV testing carried out by many companies as part of a medical assessment of an employee for a position. Job candidates may run the risk of being discriminated against / not recruited for a particular job based on the results, even without their knowledge. Reports in Swaziland suggest that pre-employment HIV testing is particularly problematic in the military, where members are excluded from protective employment laws.

Participants reported that "...in some factories you are made to sign that you are never going to be sick again... The employer's wants to know the type of sickness that will require that you go to hospital time and again. Recently someone was made to sign a note promising that she will not be sick again. There is no law that compels the employer to release you if the doctor has advised you to go back to hospital..." Female factory worker, FGD

4.6.1. Non-Discrimination in the Working Environment on the basis of HIV status

In Swaziland, national employment legislation provides for non-discrimination in the working environment. However, the Employment Act does not contain HIV-specific anti-discrimination provisions and thus is limited in its scope and reach to protect persons from HIV-related workplace discrimination.

Section 29 of the Employment Act (1980) says that employers may not discriminate in any employment contract. HIV is not specifically referred to a specific ground for non-discrimination [but may arguably fall under protection on the grounds of "social status"]. Swaziland also has included protection from workplace HIV-related discrimination in codes, policies and plans: The Industrial Relations Act (2000), in keeping with the National Constitution as well as regional and international guidance, has published a *Code of Good Practice for HIV and AIDS and Employment* in terms of s109. The Code recognizes that HIV and AIDS are serious public health problems which have socio-economic, employment and human rights implications. The code's main objective is to eliminate discrimination in the workplace based on a person's HIV status, promoting a non-discriminatory workplace in which people living with HIV and AIDS are able to be open about their status without fear of stigma or rejection. It furthermore deals with a range of pertinent HIV-related human rights issues in the work place such as HIV testing, confidentiality and disclosure. The specific provisions are as follows:

Part 1.6—"Eliminating discrimination in the workplace based on HIV/AIDS status; promoting a non – discriminatory workplace in which people living with HIV/AIDS are able to be open about their status without fear of stigma or rejection.."

Part 2—"The Code's primary objective is to set out guidelines for employers, employees, trade unions and staff association to implement so as to ensure that individuals with HIV/AIDS are not discriminated against in the workplace. This includes provisions regarding; creating a non – discriminatory work environment; dealing with HIV/AIDS testing, confidentiality and disclosure"

Code of Good Practice: HIV/AIDS in Employment (Industrial Relations Act, 2000)

Swaziland's HIV policy also provides for a non-discriminatory approach to HIV in the working environment. The Swaziland Policy Document on HIV/AIDS and STD Prevention and Control deals with HIV testing, human rights and non-discrimination, as well as HIV/AIDS in the workplace. Section 4.7 states: "HIV testing will not be part of pre-employment medical examination of the would-be employee. Employees will be encouraged to provide HIV/AIDS/STD education to their employees at their workplace. In addition, the Swaziland NSF recommends the following with respect to HIV and AIDS in the workplace:

- Providing care and support to infected and affected employees
- Encouraging employers to develop non-discriminatory HIV and AIDS policies
- Advocating for inclusion of HIV and AIDS issues in labour legislation; and
- Ensuring confidentiality in voluntary counselling and testing.

Participants experienced stigma and discrimination in the workplace, not only from employers but also from colleagues. During an FGD it was reported that an employee in the public transport industry fell sick with TB, took sick leave to recuperate but when he recovered and returned to work he was informed that he no-longer had a job. Breaches of confidentiality and stigma in the workplace from colleagues was also reported:

"...as we wake up very early to rush to our workplace, we have no time to take the pills so we take them at the rank. Once they see you taking the pills same time every day, they conclude that you are taking ARV's and start calling you names-batsi nyakhuma-some try to remind you to take your pills very loud for that matter and every one eventually gets to know that you are on ARV's. Some stopped taking the pills because of the bad treatment here from colleagues and have since died..." Male Public Transport Worker, FGD

Key informants concurred with the participants on the prevalence of stigma at the workplace. A key informant running a workplace wellness programme told of their change of focus from HIV to wellness programmes because of a poor response to activities when they focused solely on HIV. He shared success stories from the programme.

"Stigma is still very much prevalent and I don't think there will be a time that we would say we have defeated it. It is the one major driver of the epidemic: people are afraid to be associated with HIV... We in the world of work had to be strategic and change our overall focus on the disease to the whole person-wellness. It was only after we did that that we had a good response. Now the programme is not only limited to the public service, but has

been embraced by the private sector as well...people do not want to be associated with HIV...” Wellness Programme Director, KII

4.6.2. Pre-Employment HIV Testing

The Swaziland Code of Good Practice as well as related policies and plans recognises that non-discrimination in the working environment includes a prohibition on pre-employment HIV testing for purposes of excluding candidates with HIV. However, despite this, anecdotal evidence over the years suggests that pre-employment HIV testing takes place in Swaziland in a number of working environments. The armed forces, such as the military and correctional services, are said to justify their policies and/or practices of conducting pre-employment HIV testing and excluding HIV-positive candidates from employment on the basis that they fall outside of the ambit of labour legislation.

The *Correctional Services HIV/AIDS Policy*, 2008 specifically requires candidates to undergo medical examinations including HIV testing and only those that test negative are accepted into the service. However, it appears that in terms of the policy, existing staff members’ rights to non-discrimination, confidentiality, HIV testing only with voluntary and informed consent as well as support for those who are HIV-positive, are recognised.

Chapter 4 “As an entry requirement all candidate recruits shall undergo medical examination including blood tests for any chronic diseases. HIV in this regard will be no exception but will be conducted at the knowledge and consent of the candidate. Only negative candidates will be allowed to join the Majesties Correctional Services”.
Correctional Services HIV and AIDS Policy 2008

Regulation 130 of the 2011 Civil Aviation Regulations promulgated by the Minister of Public Works and Transport in terms of the Civil Aviation Authority Act 10 of 2009,⁷ require commercial, private and student pilots, aircraft engineers as well as cabin crew to present authorised medical certificates in order to apply for their licenses, and to renew these certificates in periods between 6-24 months depending on the age of the applicant and the class of certificate required for the relevant license. Regulation 170 explicitly excludes the granting of a medical certificate to a person with HIV or AIDS in the following circumstances:

Regulation 170
(1) An applicant for a medical certificate with acquired immunodeficiency syndrome (AIDS) shall be assessed as unfit
(2) An applicant for a medical certificate who is sero-positive for human immunodeficiency virus (HIV) shall be assessed as unfit unless a full investigation provides no evidence of clinical disease.
Civil Aviation Regulations 2011

⁷ Civil Aviation Authority Act 10 of 2009, Available at: <http://www.swacaa.co.sz/documents/CIVIL-AVIATION-AUTHORITY-ACT-2009.pdf>, accessed 25 Marc 2015.

In effect, the Regulations therefore exclude all persons from being licensed in the relevant categories if they have AIDS or even detectable levels of HIV and indirectly subject applicants to mandatory disclosure or testing on an ongoing basis.

4.6.3. Occupational Health and Safety

Swaziland's employment law does not specifically provide for health and safety in the context of HIV. However, it contains important general principles relating to the obligations of both employers and employees to promote health and safety at work.

The Occupational Health and Safety Act of 2001 provides for the safety and health of all persons at work and in the working environment. It applies to all workplaces, in terms of section 3(1). Section 8(1) of the Act provides that "no person, including an employer or employee or any other person, shall do anything that endangers or is likely to endanger the safety, health or welfare of that person or any other person".

Section 9 places duties upon an employer to "ensure the safety and health of all employees during employment by securing safe and healthy working conditions in that employer's or occupier's workplace" and requires, in terms of s9 (4) that an employer provide "free of charge adequate and appropriate personal protective appliances, equipment and clothing to an employee" and well as that an employee receive adequate training to perform his or her work safely. Section 13 also requires employers to provide written policies relating to safety at work.

In the context of HIV and AIDS, this obligation has been interpreted as requiring employers to provide access to as well as training on universal infection control procedures to manage any risk of HIV transmission as a result of exposure to blood or bodily fluids in the working environment.

Similarly, the Workmen's Compensation Act, 1983 and accompanying regulations makes no specific mention of HIV. However, they provide broadly for compensation for occupational injuries and diseases, including medical examinations and treatment where required. However, there is more specific provision for workplace safety in the context of HIV in the Code of Good Practice.

As a result, it appears that while the protection provided to employees in the Code of Good Practice as well as policies and plans is a positive step towards the achievement of human rights in the workplace for PLHIV, it is insufficient to stop ongoing workplace discrimination and pre-employment HIV testing in certain sectors. Strengthened protection in law may be required to entrench the principle of non-discrimination against employees on the basis of HIV status, as well as to ensure that all working environments, including the aviation sector and the armed forces are required to adopt non-discriminatory approaches to HIV that also exclude pre-employment HIV testing. Research participants in KIIs and FGDs noted the lack of HIV-specific anti-discrimination laws as a concern in the working environment.

4.7. Children's Law

Children and young people are affected by HIV and AIDS in various ways. They experience HIV-related stigma and discrimination and are at risk of HIV exposure for various reasons including consensual sexual activity, sexual abuse as well as poor access to health information and services. The *Swaziland National Youth Policy* recognises that young people have poor access to sexual and reproductive health services, they are ignorant of their sexual and reproductive health rights, they are confronted by negative attitudes of health care providers and their parents are unwilling to talk about sexuality issues with them. This section examines the provisions in Swaziland law to protect children in the context of HIV and to increase their access to HIV-related prevention, treatment, care and support services.

The Swaziland National Constitution (2005) recognises children as a vulnerable population and provides for child rights in section 29.

Section 29

- (1) A child has the right to be protected from engaging in work that constitutes a threat to the health, education or development of that child.
- (2) A child shall not be subjected to abuse or torture or other cruel inhuman and degrading treatment or punishment subject to lawful and moderate chastisement for purposes of correction.
- (3) The child has the right to be properly cared for and brought up by parents or other lawful authority in place of parents.
- (4) Children whether born in or out of wedlock shall enjoy the same protection and rights.
- (5)
- (6) Every Swazi child shall within three years of the commencement of this Constitution have the right to free education in public schools at least up to the end of primary school, beginning with the first grade.

Swaziland National Constitution (2005)

The Government of the Kingdom of Swaziland ratified the CRC on 26 August 1995, and made a declaration that Swaziland would strive for full compliance as soon as possible. The rights of a child enunciated in the CRC relevant to HIV prevention and care include the right equality and non-discrimination, the right to be free from trafficking, sexual exploitation and sexual abuse, the right to health care, the right to education and the right to family care, amongst others. Similar rights are set out in the African Charter on the Rights and Welfare of the Child, which Swaziland has signed (in 2005), but not yet ratified. Significantly, the African Charter on the Rights and Welfare of the Child specifically places an obligation upon States to discourage harmful cultural practices.

The African Charter on the Rights and Welfare of the Child provides that State parties are obliged to discourage any custom, tradition, cultural or religious practice that is inconsistent with the provisions of the treaty (Article 1(3)).

It further provides that State parties are to take measures to eliminate harmful social and cultural practices, in particular those customs and practices which are prejudicial to the health or life of the child and those which are discriminatory to the child on the grounds of sex or other status (Article 21)

The African Charter on the Rights and Welfare of the Child

In terms of HIV-specific guidance, Guideline 5 of the UNAIDS *International Guidelines* suggests that states should “enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors.”

At a sub-regional level, the SADC PF *Model Law on HIV & AIDS in Southern Africa* sets out specific rights that it suggests be entrenched in law, to protect children in the context of HIV and AIDS, In particular, it provides for a child to enjoy all the rights under the CRC and African Charter on the Rights and Welfare of the Child and that children orphaned by AIDS are provided with appropriate care.

24. Protection of rights

(1) Children living with or affected by HIV, including orphans, shall enjoy all the rights under the law and in international instruments pertaining to children, in particular the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child.

25. Care of children orphaned by AIDS

(1) The State shall ensure that any surviving children of persons deceased due to AIDS related illnesses are given appropriate alternative care, including through foster care or adoption. If these are not available, children shall be cared for in public or private institutions registered with and regulated by the State.

SADC PF Model Law on HIV & AIDS in Southern Africa

4.7.1. Non-Discrimination

Stigma and discrimination extends to family members of PLHIV and children are often the most affected:

“...Children at school discriminate each other mostly at the primary level. Whilst they are busy playing one child will tell her friends, it is time for her to go and take tablets and because she is sick with HIV that she got from her mother. Then you will find that the other children will refuse to play with the infected child next time...the discrimination amongst children is perpetrated by the parents at home.....” PLHIV, FGD.

The Child Protection and Welfare Act of 2012 aims to extend the provisions of s29 of the Constitution relating to child rights, as well as the principles set out in international instruments, standards and rules relating to children.

Part III sets out the rights of the child and includes the right to non-discrimination (section 4) on the basis of a range of grounds, including “health status”. This provision should extend protection to children from discrimination on the basis of HIV status.

Other important rights which children affected by HIV are entitled to, without discrimination, include amongst others the right to the care of a family environment (section 8), the right to education, health services and medical attention (section 9).

4.7.2. Access to HIV-related prevention, treatment, care and support services

Children’s rights to access health services including HIV-related prevention, treatment, care and support services is set out in various national policies and programmes. The eNSF prioritises young people for HIV-related prevention, treatment, care and support services. The Guiding Principles of the e-NSF include a focus on young women and girls and almost all interventions specifically mention the need to target vulnerable populations and key populations. For instance, the section on HIV Testing and Counselling notes the need to review health guidelines to ensure they address the needs of special populations such as children. In addition, orphaned and vulnerable children are prioritised for care and support services to strengthen families.

The *Child Survival and Development Programme* aims to strengthen and scale up health and nutrition interventions, PMTCT and paediatric AIDS care as well as improve home and community care practices and increase access to safe water and sanitation. The Swaziland *National Children’s Policy* 2008 provides detailed strategies to deal with HIV and AIDS including to:

- Ensure the full and effective implementation of a comprehensive policy to prevent and treat HIV and AIDS
- Strengthen and expand mother-to-child transmission prevention programmes (PMTCT) and promote their effective uptake
- Ensure access to comprehensive services for prevention, care and treatment including voluntary HIV counselling and testing and positive treatments for children
- Ensure early infant diagnosis for HIV exposed infants and access to treatment, care and support
- Strengthen and scale- up programmes and interventions to combat HIV and AIDS through awareness-raising campaigns particularly dealing with issues around discrimination against children infected with and affected by HIV and AIDS
- Support HIV positive parents to prolong their productive lives through encouragement of testing, provision of counselling, nutritional-support, and access to appropriate treatments including anti-retroviral treatment
- Develop and implement an adolescent health policy and programmes with a particular focus on the prevention of early pregnancies and sexually transmitted infections (STIs), especially through reproductive health education
- Provide access to family planning services for adolescents in and out of school

The National Multi-Sectoral HIV and AIDS Policy of 2006 recognises young people as a priority. In addition, Swaziland National Youth Policy recognises HIV as key issue affecting young people and that poor access to HIV-related information and the inability of parents to discuss children's sexuality is a concern for young people. It furthermore notes the impact of HIV on orphaned and vulnerable children. The National Youth Policy identifies various strategies to improve access to HIV-related health care for young people in Section 5 relating to improving the health, education and quality of life of young people. Strategies include, amongst others, improving information on and access to HIV and sexual and reproductive health care services, strengthening prevention, strengthening access to treatment and improving care and support for people living with HIV and orphaned and vulnerable children. The government has embarked on school programs to provide information about HIV and AIDS and youth-targeted services such as condom distribution, educational materials and HIV testing and counselling facilities.

The Education Sector Policy of 2011 integrated HIV and AIDS within schools under the Centres of Care and Support Programme (*Inqaba*). A formal guidance and counselling syllabus was developed, focussing on age-sensitive health promotion at schools as well as reviving the traditional practice of '*liguma*' and '*lisango*' (gender specific huts) where girls and boys would be provided with age-specific sexuality education from generation to generation. The Policy calls for strategies to ensure equitable access to treatment, care and support services and reduce the impact of HIV and AIDS on education through the mainstreaming of a comprehensive response strategy at every level of education. It includes, amongst other things:

- Strengthening guidance, counselling and psycho-social support for learners, teachers and other employees, including those infected and affected by HIV and AIDS
- Integration of life skills, HIV and AIDS and STIs into the school curriculum as a compulsory component of the curriculum, and
- Protecting every learner, teacher, manager or official, including those with special educational needs and those with disabilities from all forms of sexual abuse, including harassment, sexual molestation, sexual exploitation and rape.

The Child Protection and Welfare Act 2012 specifically provides for a child's right to consent independently to HIV testing at 12 years of age, to confidentiality regarding his or her HIV status (sections 239 to 243, see further discussion below) and to access to reproductive health information (section 244). This will further strengthen access to HIV prevention, treatment, care and support for children.

Finally, Part IV of the Child Protection and Welfare Act of 2012 also provides for the care and support of children in need of care and protection. Section 23(1) defines a child in need of care and protection and includes in terms of s23(1)(a) children who are abused (including sexually abused) and in terms of s23(1)(l) children infected with or affected by HIV, as children considered to be in need of care and protection. The Act provides for measures to protect children including providing for children to be taken into care and also providing for the adoption and care of children without appropriate parental care.

4.7.3. Consent to HIV Testing and Confidentiality

The Child Protection and Welfare Act 2012 in Part XXVI [Protective Measures Relating to the Health of Children] contains specific provisions protecting a child's right to HIV testing only with voluntary and informed consent and with pre- and post-test counselling as well as providing for children of 12 years to consent independently to an HIV test. It furthermore provides for confidentiality of a child's HIV status.

1. Consent to medical treatment or surgical operation

A child may not be subjected to medical treatment without their consent. They should be at least 12 years (if under 12 years must be assisted by a guardian) old or of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment or operation, to give consent.

2. HIV Testing

No child may be tested for HIV except when this is in the best interests of the child and consent has been given.

3. HIV testing for adoption and placement purposes

If HIV testing of a child is done for adoption or placement purposes, the Crown shall bear the cost of such test.

4. Counseling before and after HIV testing.

A child may be tested for HIV only after proper counseling of –

(a) the child, if the child is of sufficient maturity to understand the benefits, risks and social implications of such a test; and

(b) the child's parent or guardian has an understanding of the implications of the test.

5. Confidentiality of information on HIV/AIDS status of children

No person may disclose the fact that a child is HIV-positive without consent given by the child, parent or guardian, a social worker arranging the placement of the child and children's court

The provision for HIV testing is only where it is in the "best interests of the child." In the case of *Ex parte Eric Mvana Dlamini* 1977-78 SLR 73 the court considered the concept of the best interests of the child; the court held that the authorities do not support the notion of "best", they merely refer to general interest, which is defined as "no reason to believe that the interest of the minor will be detrimentally affected". This undermines the interests of a child in decisions affecting them, including that of HIV testing.

The enactment of the Child Protection and Welfare Act 2012 has significantly improved access to health care services for children in the context of HIV, by providing for independent access to voluntary HIV testing and the right to confidentiality, encouraging young people to access health services. Children also have the right to education, including the right to receive information about HIV, such as information on how to avoid infection and to cope with their status, if infected. The only visible shortfall of this Act is that it does not define the age of a minor, as unified with other various pieces of legislation or even policies.

4.7.4. Protection from harm, including harmful cultural practices

Gender-based and sexual violence is still a major problem in Swaziland primarily affecting women and young girls. Children are protected from sexual abuse in various ways, as has been set out above. However, there is a need to further protect young people from harmful cultural practices, such as early marriages, that place them at higher risk of HIV exposure. In Swaziland, eradicating harmful practices is complex since some are endorsed by Swazi law and custom. In order to protect young people the *Swaziland National Youth Policy* encourages the need to protect young girls from gender based violence, domestic violence and sexual violence and to protect them from harmful traditional practices. It recommends the enactment of the Sexual Offences Bill, the prohibition on marriages without consent and the provision of support to pregnant adolescents, amongst other things. Therefore there is need for the development of a clear and explicit regulation, dealing with harmful traditional practices, through a non-discrimination provisions or law.

4.8. People with Disabilities

The National Constitution, 2005 Section 30 prohibits discrimination on the grounds of disability and provides for appropriate measures, including legislation to allow people with disabilities to achieve their full mental and physical potential:

Section 30

- (1) Persons with disabilities have a right to respect and human dignity and the Government and society shall take appropriate measures to ensure that those persons realize their full mental and physical potential.
- (2) Parliament shall enact laws for the protection of persons with disabilities so as to enable those persons to enjoy productive and fulfilling lives.

National Constitution, 2005

LEA participants confirmed that stigma and discrimination against people with disabilities it is still very high in the country and they experience all forms of discrimination.

“...Another group of people which is stigmatised are people living with disabilities. There is a lady in the community who is a Christian and a university graduate who is engaged to a man on a wheel chair, he only uses his upper body. The family members did not attend the engagement party of their daughter and only her mother came but looked very unhappy. People with disability continue to be discriminated and marginalised in communities and not acceptable. Some members of the community were also heard saying that they would have not allowed their child to marry a disabled person. Some people still believe that disability is associated with bad luck...” Member of Lutsango Regiment, FGD.

The Convention on the Rights of Persons with Disabilities (CRPD) was adopted by the UN General Assembly in December 2006. It aims to promote, protect and ensure the full and equal enjoyment of all human rights of persons with disabilities. Article 5 of the CRPD provides for the protection of the rights of all persons to equality and prohibits discrimination based on disability. The CRPD deals with a number of other key issues such as accessibility, personal

mobility, health, education, employment, rehabilitation and participation in political life. The Convention marks a shift in thinking about disability from primarily a welfare concern to a human rights issue.

While the CRPD does not specifically mention HIV or AIDS, the equality and health rights of people with disabilities require addressing HIV and AIDS for people with disabilities as a vulnerable population. The UNAIDS *Disability and HIV Policy Brief* 2009 recommends that states take various actions to protect the rights of people with disabilities in the context of HIV including:

- Ratifying and incorporating into national law instruments that protect and promote the human rights of persons with disabilities, including the CRPD
- Incorporating the human rights and needs of persons with disabilities into national HIV strategic plans and policies
- Prohibiting all forms of discrimination against persons with disabilities which may hinder access to services
- Establishing age-, gender-, culture- and language-appropriate HIV prevention programmes and providing HIV information in tailored formats for people with disabilities
- Developing appropriate programmes and mechanisms to prevent sexual assault or abuse of persons with disabilities focusing on those settings which place persons with disabilities at greatest risk
- Providing comprehensive HIV testing, treatment, care and support services for people with disabilities
- Providing persons with disabilities with the same range and quality of affordable HIV, sexual and reproductive health services as the rest of the population
- Ensuring the national AIDS monitoring and evaluation system has the necessary resources to evaluate the response to the HIV epidemic within the context of disability, and the HIV needs and rights of persons with disabilities.
- Involving persons with disabilities in the planning, implementation and evaluation of HIV programmes.
- Including training on the rights of persons with disabilities for professionals working in the area of HIV, by persons with disabilities, including those that are HIV positive.
- Integrating HIV education into training for rehabilitation professionals.
- Ensuring that persons with disabilities are appropriately supported to train and engage in HIV counselling and care provision.
- Providing adequate training and support for personal assistants or people who support persons with disabilities in households affected by HIV.

At a regional level, the ACHPR, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 2003 and the African Charter on the Rights and Welfare of the Child, 1990, all contain provisions on the rights of people with disabilities.

In Swaziland, there is no specific disability law. However, there is a Persons with Disabilities Bill, 2014 which provides for the rights of people with disabilities to equality, non-discrimination and to the enjoyment of health, amongst other things. Section 33 of the proposed Bill provides that essential health services should be provided to people with disabilities. The

bill makes no specific mention of HIV. Furthermore, there is protection for people with disabilities in Swaziland's children's law as well as in the National Disability Policy. In addition, there is mention of the needs of people with disabilities in HIV policies and action plans.

The Child Protection and Welfare Act 2012 provides for non-discrimination for children with disabilities and furthermore provides for the health care needs of children with disabilities, which should include in the context of HIV and AIDS.

Non-discrimination.

s4. A child shall not be discriminated against on the grounds of gender, race, age, religion, disability, health status, custom, ethnic origin, rural or urban background, birth, socio-economic status, refugee status or other status.

Rights of children with disabilities.

11. A child with disability has a right to special care, medical treatment, rehabilitation, family and personal integrity, sports and recreation, education, and training to help him enjoy a full and decent life in dignity and achieve the greatest degree of self-actualisation, self-reliance and social integration possible

Child Protection and Welfare Act 2012

The National Disability Policy 2013 also seeks to provide people with disabilities with equal opportunities. Section 3.3 of the Policy has the objective of ensuring all people with disabilities have equal access and opportunities to education and health services at all levels. The Policy furthermore recognizes the particular vulnerabilities of children with disabilities and women with disabilities. It aims to strengthen sexual and reproductive health and rights services for persons with disabilities (through for example comprehensive information, integrated sexual and reproductive health services and management of HIV, AIDS and STIs for all including children and adolescents) and prevents coercive treatment of people with disabilities.

There is additional, albeit limited, provision for the HIV-related health rights of people with disabilities in HIV policy:

- The National Multi-sectoral HIV and AIDS Policy (2006) recognises people with disabilities as a vulnerable population and provides for their protection in order to minimise the impact of HIV on people with disabilities.
- The e-NSF 2004-2018 identifies people with disabilities as a target population, noting that “people with disabilities are more vulnerable to HIV infection and some forms of disabilities make it difficult for them to access success equally. Some people with disabilities are also more vulnerable to HIV physical and sexual abuse.

So, while it appears that there is constitutional protection of the human rights of people with disabilities in Swaziland and provision for strengthening their rights in law, there is limited specific legislation that expands upon the health rights of people with disabilities broadly and in the context of HIV and AIDS. Disability and health policies certainly note the need to strengthen access to sexual and reproductive health services for people with disabilities, there is limited specific provision for what this may entail.

4.9. Prisoners

Prisoners in Swaziland are recognised as a population at high risk of HIV exposure. The e-NSF notes that key populations and vulnerable groups include inmates, due to behaviours and practices that put them at risk. It furthermore notes in Annex 2 that “key populations are also most likely to be stigmatised, marginalised and more than often have no access to correct and comprehensive HIV and AIDS related information.

The Swaziland National Constitution does not specifically provide for the rights of prisoners but rather for detainees awaiting trial. Though the human rights enshrined in the Bill of Rights Chapter apply to all human beings, there are limitations of their application to prisoners by virtue of the environment and circumstances under which they are kept.

In international law, the ICCPR provides that even persons denied their liberty have the right to be treated with dignity and respect. The Convention requires that the state should take all the necessary measures including the duty to protect the rights to life and to health of all persons in custody. According to the UNAIDS *International Guidelines on HIV/AIDS and Human Rights*, this presupposes, in the context of HIV, that they need to ensure access by prisoners to HIV-related information, education and means of prevention (e.g. condoms), voluntary testing and counselling, confidentiality and HIV treatment. The *International Guidelines on HIV/AIDS* furthermore provide for prisoners with AIDS to be considered for early release. The GCHL (2012) recommends that states take steps to ensure that “necessary health care is available, including HIV prevention and care services, regardless of laws criminalising same-sex acts or harm reduction. Such care includes provision of condoms, comprehensive harm reduction services, voluntary and evidence-based treatment for drug dependence and ART.

At a regional level, the SADC PF *Model Law on HIV & AIDS in Southern Africa* provides for various rights of prisoners in the context of HIV and encourages SADC member states to provide similarly:

Chapter 4 of the SADC PF *Model Law on HIV & AIDS in Southern Africa* provides as follows:

- Prison authorities shall ensure access to information and education about the causes, modes of transmission, means of prevention and management of HIV and AIDS messages on HIV and AIDS
- The distribution and possession of condoms and other safer sex materials in prisons in accordance with this Model Law shall not constitute a criminal nor administrative offence.
- No prisoner may be subjected to compulsory HIV testing and the rules related to informed consent, pre-test information and post-test counselling in this Model Law apply equally to prisoners.
- All health care procedures shall be designed to preserve the confidentiality of prisoners.

Courts in Southern Africa have upheld prisoners' rights to life and health, including adequate access to HIV prevention, treatment, care and support as well as protection from coercive or forced HIV testing.

The Swaziland Prisons Act, 1964 does not specifically provide for HIV and AIDS in prisons. However, it does contain general provisions that will apply to HIV, such as provision for the health of all prisoners. It also provides that a medical officer may conduct a medical examination of a prisoner and may take requisite action for treating prisoners, with or without a prisoner's consent. Worryingly, this provision suggests that a medical officer may test or treat a prisoner for HIV without his or her consent.

Medical officers.

27.

- (1) There shall be a medical officer for a prison.
- (2) The Chief Medical Officer may designate a medical officer as medical officer for a prison, and if a medical officer has not been so designated, the senior medical officer in the region in which the prison is situated or, in his absence, the next senior medical officer in that region shall be deemed to have been so designated.
- (3) The prison medical officer shall be responsible for the health of all prisoners in the prison, and shall cause all the prisoners to be medically examined at the prescribed times.
- (4) Whether or not the prisoner consents, a medical officer may take or direct to be taken such action, including the feeding, inoculation, vaccination, and other treatment of the prisoner as he considers necessary to safeguard or restore the health of a prisoner, or prevent the spread of disease.
- (5) No action at law shall lie against a medical officer, prison officer or other person in respect of anything done in good faith under, or pursuant to directions given under, subsection 4

Prisoners Act 1964

The Correctional Services HIV and AIDS Policy, 2008 provides further and more specific guidance on prisoners and HIV and aims to ensure inmates and personnel are healthy, through providing comprehensive prevention, care and support (Chapter 2). Section 3.1 of the Policy provides that it is based on principles of human rights, patient rights and international guidance relating to HIV in prisons. Guiding Principles set out in s3.5 include confidentiality, equity and gender equality, non-discrimination and shared responsibility for HIV and AIDS. The Policy provides for education, awareness, and prevention for all inmates (and personnel) in Chapter 5, although s5.1.6 notes that condoms will be provided to personnel (no mention is made of condom provision for inmates). It also provides for treatment, care and support in section 5.3 stipulating that all inmates will receive comprehensive health care services, including access to ART. Although the policy encourages voluntary HIV testing and counselling for all prisoners, confidentiality with encouraging disclosure of HIV status on admission, s5.2.8 also provides that all new inmates are required to test for HIV.

So, while prisoners' rights in the context of HIV are clear in terms of the Correctional Services policy, there is limited specific protection in law for prisoners with HIV. There is also provision for HIV testing on admission to prisons as well as no mention of condom availability for prisoners to prevent HIV transmission through sexual activity.

CHAPTER 5: ACCESS TO JUSTICE AND LAW ENFORCEMENT

Swaziland's National Constitution, 2005 includes rights relating to access to justice such as the right to a fair hearing and right to legal representation. This section examines the laws, regulations, policies and practices relating to access to justice and law enforcement in Swaziland and particularly in relation to HIV and to vulnerable and key populations. It furthermore includes information provided by key informants and participants in focus group discussions

regarding their ability to access justice for stigma, discrimination and other human rights violations.

Section 33 of the Constitution provides for the right to administrative justice as follows:

- (1) A person appearing before any administrative authority has a right to be heard and to be treated justly and fairly in accordance with the requirements imposed by law including the requirements of fundamental justice or fairness and has a right to apply to a court of law in respect of any decision taken against that person with which that person is aggrieved.
- (2) A person appearing before any administrative authority has a right to be given reasons in writing for the decision of that authority.

Section 21 provides for the right to a fair hearing.

21. (1) In the determination of civil rights and obligations or any criminal charge a person shall be given a fair and speedy public hearing within a reasonable time by an independent and impartial court or adjudicating authority established by law.

5.1 Access to Courts, Tribunals and other Statutory Institutions

5.1.1. The Court System in Swaziland

The administration of justice in Swaziland is done by the judicial branch of government and is expected to be independent and subject only to the provisions of the Constitution itself. The judiciary consists of the following structures

- The Supreme Court is the final Court of Appeal. Accordingly, the Supreme Court has appellate jurisdiction and such other jurisdiction as may be conferred on it by this Constitution or any other law.
- The High court has unlimited original jurisdiction in civil and criminal matters. It also possess further appellate and revisional jurisdiction. The High Court is granted jurisdiction to enforce the fundamental human rights and freedoms guaranteed by the Constitution.
- Magistrate Courts are not courts of record. They are established by provisions of the Magistrates Courts Act No 66 of 1938 and are presided over by judicial officers employed as civil servants (magistrates). Their decisions are not binding on other courts.

Apart from the High Court and Supreme Court, which are ordinary courts, Swaziland also has specialist courts set up to deal with particular matters. These are creatures of statute, with limited jurisdiction as set out in the legislation establishing them. The Industrial Court and Swazi National Courts are examples of specialist courts in Swaziland. Swaziland does not, however have small claims courts. This has the effect of denying the indigent aggrieved person the opportunity to access justice, especially since Swaziland does not have a legal aid system. The

Industrial Court was established by the Industrial Relations Act of 2000. It has jurisdiction over matters that touch on industrial relations, the employer-employee relationship. The Swazi National Courts (Swazi Courts) were established by the Swazi Courts Act 80 of 1950. They have jurisdiction on matters falling under customary law, and can only handle matters involving members of the Swazi nation. There is a new 'child-friendly' court that makes it easier for under aged plaintiffs in rape and abuse cases to deal with previously frightening legal proceedings.

5.1.2 Other Statutory Institutions

There is also a Commission on Human Rights and Public Administration tasked with investigating complaints concerning alleged violations of fundamental rights and freedoms under the Swaziland Constitution. Additionally, it has to investigate complaints of injustice, corruption, abuse of power in office and unfair treatment of any person by a public officer in the exercise of official duties;

5.1.3. Access to Mechanisms and Recommendations

Despite the courts and other statutory institutions, participants complained that they are unable to access justice for HIV-related human rights violations. In some cases this was because they were unclear of the mechanisms for recourse and how to go about using them. For example, when participants were asked about the role and function of the Commission for Human Rights and Public Administration (CHRPA), almost all participants reported to have never heard of the Commission however some were conversant with its function.

“... Oh I read about it in one of the papers. Am not sure what it does but I think it is responsible for investigating corruption... So how does it help with human rights, I am not clear...” MSM, FGD

From responses received, it also seems that the decision to use legal redress was influenced by who the perpetrator was and the circumstances under which violations took place. Fear was a major barrier to accessing justice. Most of the public transport workers shared that if the perpetrator was the employer, they did nothing about it because of fear of losing their jobs. Similarly, in the health sector, fear blocked access to justice. Participants feared the consequences of being ill-treated by health professionals if they reported to their seniors or authorities. Some participants reported changing health facilities and travelling longer distances to access services, further impacting on access to services.

“...we don't do anything, what can we do, nothing. What is important is to keep your job and that means you keep your HIV a secret or else you will be fired on the spot. These people are all about money, so when you are sick you do not bring in money...” Male Public Transport Worker, FGD

In many FDGs, participants recommended the establishment of an independent office to deal with human rights violations by employees of the public service, including health care workers.

“My suggestion is that the Ministry of Health should set up a separate department where the patient can report any case of harassment or ill-treatment. This department should be responsible for monitoring and investigating human rights violations and assess the nurse-patient relationship. I am saying this because if you report your

complaint to the hospital authorities your case will not be dealt with. I will make an example of South Africa where the government set up a private commission where anyone reports any form of harassment or ill-treatment by the police officers. It is called the Independent Police Commission. They did this because they felt it was important because it is difficult to report a police officer to his/her colleagues...” PLHIV female respondent FGD.

“... The Court will be helpful if there was an independent body where the harassed person will be open and be free to put her case without fear and she would have the hope and courage she got the help she dearly needed. After hearing the complaint the body would open a case at the court...” Member of Lutsango Regiment, FGD.

“It is true that we need an independent office where we can report such cases. There are thousands of such cases and we cannot finish counting them. Based on my experience, I want to propose that the office where patients can report their complaints must be independent and not be under any government Ministry. I think it must be under a non-governmental organisation. This is because even government sometimes protects her employees because if you sue the employee you are suing government...” PLHIV female Participants, FGD.

5.2 Access to Legal Support Services

5.2.1 Legal Aid

Swaziland does not have a legal aid system, save for *pro deo* counsel offered by the state in capital cases. This makes it difficult for the indigent to afford the legal fees and impacts on them accessing justice. There are also limited legal support services for people living with HIV and vulnerable and key populations; participants in the LEA noted the need for free or subsidised legal representation to assist patients and clients whose rights have been violated to get legal redress.

Section 21(2)(c) of the Constitution provides that a person charged with a criminal offence shall be entitled to legal representation at the expense of government in the case of any offence which carries a sentence of death or life imprisonment. The Legal Aid Bill of 2014 provides for a policy of non-discrimination and gender equality in access to legal aid.

Section 35

(1)The Board shall provide legal aid to all qualifying persons regardless of age, race, colour, gender, language, religion or belief, political or other opinion, national or social origin, citizenship or domicile, birth, education or social status or other status.

(2)The Board shall incorporate a gender perspective into all policies, processes, procedures, programmes and practices relating to legal aid, in order to ensure gender equality and equal and fair access to justice for all.

Swaziland Legal Aid Bill, 2014

5.3 Awareness and Education of HIV-Related Law & Human Rights

“...What is lacking are the laws; the knowledge and understanding of the laws more especially the females...”
Member of Lutsango Regiment, FGD

“What perpetrates stigmatisation against HIV positive people is lack of education; many people still don’t understand the virus and also the lack of legislation. There is still no legislation which we can use to sue anyone who tells people about one’s HIV status without their voluntary consent...” MSM, FGD

Limited awareness and education of HIV-related law and human rights and the human rights issues pertinent to people living with HIV, vulnerable and key populations is a major barrier to access to justice in Swaziland. The few who were aware of human rights were not informed of the procedures to follow for legal redress when violated.

To ascertain whether participants were aware of the Bill of Rights in the Constitution, relevant laws that protect and promote their access justice should their rights be violated, a vignette was used to assess the level of knowledge and understanding of Human Rights in the context of HIV.

Findings from this assessment show that a majority of key populations are not aware of laws that protect them from human rights violations, including the Bill of Rights enshrined in the Constitution. Additionally, they lack knowledge on the national policies, regulations and guidelines developed that relate to HIV and AIDS. This observation applied both to rural and urban participants and across all population groups. The participants were not aware of the contents of the Constitution’s Bill of rights or the existence of the Commission on Human Rights and Public Administration (CHRPA) which has the mandate to investigate human rights, promote and protect citizens from Human rights violations in the country.

This finding is akin to that of the Council of Churches study on human rights for all (2011) which found that only 29% of participants had an idea on the contents of the national constitution (Council of Churches/UNDP, 2011).

Participants expressed concern regarding their lack of knowledge of protective laws in the country and the need for human rights awareness and education.

“There must be serious education because there is a big gap... what is lacking is creation of awareness and fit in the legal aspect to polish the environment in which they work. The United Nations is talking, SADC is talking, the African Union is talking and many countries are talking but we don’t know if it reaches the grassroots level...” Member of Lutsango Regiment, FGD

Access to information is a constitutional right guaranteed in the Constitution of Swaziland which all citizens should have. Information and knowledge on HIV, Human rights and the law forms the basis for making informed decisions and choices when it comes to HIV prevention, access to justice and protection from human rights violations. The NSF 2014-2018 has prioritised information, education and communication (IEC) on HIV and human rights as an integral aspect of the HIV and AIDS national response. Additionally, the Constitution has provided a platform for civic education on matters that affect citizens.

5.4 Law Enforcement

Law enforcement is carried out by the police and prisons service. The Royal Swaziland Police Service derives its mandate from the National Constitution of the Kingdom of Swaziland Act 1 of 2005 and the Police Act 29 of 1957. It is divided into 6 Police Regions which are under the Command of Senior Officers holding the rank of Senior Superintendent and which report to the respective Executive Portfolio Commanders based at Police Headquarters. The Swaziland Prisons Service is constituted by Act No 40 of 1964, under the Ministry of Justice and Constitutional Affairs. Its main function is to undertake the secure containment and safe custody of prisoners committed to its custody as humanely as possible. It also provides skills and training to equip prisoners for life's challenges. Prisoners' issues in relation to HIV and AIDS have been dealt with in Section 4, above.

People living with HIV, vulnerable and particularly key populations reported acts of stigma, discrimination and human rights violations from law enforcement officials as well as fear of, or limited support for reporting of violations. For example, sex workers reported that they are physically, sexually, verbally, emotionally and economically abused by law enforcement agents, amongst others. Sex workers and people who inject drugs faced double violations in that if they reported the violation to law enforcers, they ended being the ones incarcerated on the basis of their behaviours (sex work or drug abuse).

"...In yesterday's newspaper I read about a man who had gone to the VCT centre and was abused by a doctor at VCT and when he reported it to the law enforcers [police] he did not get the help, this means the laws are there but they are not active..." PLHIV, FGD

CHAPTER 6: SUMMARY OF FINDINGS & CONCLUSIONS

The legal environment assessment of Swaziland's laws, regulations and policies in relation to HIV and AIDS, people living with HIV, vulnerable and key populations found the following:

Stigma, Discrimination and Human Rights Violations: Stigma, discrimination and human rights violations against people living with HIV, vulnerable and key populations remain an issue of major concern in Swaziland. HIV-related stigma and discrimination takes place in families and communities as well as in various sectors of society such as the health care sector and the workplace. They impact on access to health care as well as access to employment, hereby increasing the impact of HIV on the lives of those affected. The LEA further found that **gender inequality** and **gender-based violence** were major issues of concern for women and girls as well as for LGBTI populations, impacting on their access to a broad range of rights, their risk of HIV exposure and their universal access to health care services. Women living with HIV

appear to be particularly vulnerable to sexual, physical and psychological violence and also report violations of their sexual and reproductive rights, including coerced abortion and forced sterilization. LGBTI populations and sex workers reported being subjected to physical and emotional abuse in the hands of law enforcement agents, health providers and family members as a result of discrimination. People living with HIV and other vulnerable and key populations reported that as a consequence of issues such as stigma and discrimination, marginalisation and poverty, they had inadequate access to health care services.

Human Rights Based Protection in Law and Policy: As a country, Swaziland has committed to protecting the basic human rights of all people, both within its national Constitution as well as in signing and ratifying various regional and international human rights instruments. While there is **no specific anti-discrimination law, or HIV law** in Swaziland, the Constitution should, in theory, protect the rights of all people including people living with HIV and other vulnerable and key populations on the basis of, for example, HIV status, AIDS, gender, sex, sexual orientation or gender identity, amongst other things.

While **health law** also fails to provide specifically for a range of important issues relating to HIV, such as non-discrimination, the right to HIV testing only with voluntary and informed consent and the right to confidentiality, draft new legislation will greatly improve the regulation of access to health care services and affordable medicines in Swaziland. In addition, **health and HIV-related plans, policies and strategies** clearly provide for non-discrimination, protection of human rights and the prioritisation of people living with HIV, vulnerable and key populations.

Similarly, **employment law** fails to provide unequivocal protection against discrimination on the basis of HIV status, but workplace codes, policies and plans provide detailed protection for HIV in the working environment.

Strengthened protection for **women and girls** from sexual violence is a positive development, with various laws recently enacted or in the process of enactment to address sexual violence as well as other forms of gender-based violence.

Inadequate protection, implementation and enforcement: However, existing protections in law appear to be inadequately known or enforced to protect rights in the context of HIV and AIDS. Ongoing issues include limited access to appropriate health care services for HIV prevention, treatment, care and support; discrimination against people living with HIV and key populations by health care workers and breaches of confidentiality of HIV status. Vulnerable populations such as people with disabilities and key populations like men who have sex with men, while prioritised in policy, remain unable to access appropriate services in practice. In the workplace, HIV-related stigma and discrimination as well as pre-employment HIV testing remains an issue of concern, particularly within the aviation sector and the armed forces. For women and girls, gender inequality persists in practice as does gender-based violence. Clear prohibitions against all harmful gender norms that perpetuate inequality and violence against women or place them at higher risk of HIV exposure require eradication.

Punitive and coercive provisions in law: In addition to the inadequate protection for people living with HIV, vulnerable and key populations in law there are also instances of punitive, coercive and discriminatory provisions, or proposed provisions in some laws. For instance, the Sexual Offences and Domestic Violence Bill, 2009 provides for mandatory HIV testing of a sexual offender and the Public Health Bill, 2013 provides for the criminalisation of HIV transmission. These provisions, if not carefully applied, may lead to discrimination against persons simply on the basis of their being HIV-positive and require prosecutorial guidance in their application. Sex work is criminalised in terms of the Crimes Act of 1889, drug use in terms of the Opium and Habit Forming Drugs Act of 1922 and sex between men in terms of the common law, impacting on access to health care for key populations, including on the ability of the prisons service to provide condoms to men in prisons. Prisons policy provides for mandatory HIV testing as well as fails to provide provision of condoms for HIV prevention, placing prisoners at increased risk of HIV exposure.

Access to Justice and Law Enforcement: This is a further issue of concern. Despite the existence of various structures and institutions, as well as legal aid for certain cases, people living with HIV, vulnerable and key populations are unable to access justice. They do not know their rights, or how to use the various mechanisms. They are not able to afford legal representation or access legal support services. They are afraid of seeking legal redress for fear of the impact on the services they receive or believe that it will not be helpful. And in some cases, (such as for sex workers) law enforcement officials are not only unhelpful but are in fact the very perpetrators of human rights violations, creating barriers to access to justice.

CHAPTER 7: RECOMMENDATIONS

Based on the findings and conclusions of the LEA, the following recommendations are made to strengthen laws, regulations, policies and practices in the context of HIV and AIDS in Swaziland to increase protection for people living with HIV, vulnerable and key populations and to promote universal access to HIV-related prevention, treatment, care and support:

7.1. Law Review and Reform:

7.1.1. Equality and Non-Discrimination

Increase protection from discrimination in law for HIV and AIDS, gender, sexual orientation and gender identity by, for example:

- a) Including a non-discrimination clause in the Public Health Bill 2013 providing for non-discrimination on the basis of HIV status, gender, sexual orientation and gender identity, amongst others as well as the prioritisation of the health needs of vulnerable and marginalised populations
- b) Including a non-discrimination clause in the Gender Equality Bill to providing for non-discrimination for women on the basis of HIV status and to provide for non-discrimination on the basis of gender identity or sexual orientation
- c) Including a non-discrimination clause in the Disability Bill to provide for non-discrimination for people with disabilities on the basis of HIV status
- d) Consider the development of an Equality / Anti-Discrimination Act that includes protection from discrimination on the basis of HIV status or AIDS as well as gender, gender identity and sexual orientation, amongst others.

7.1.2. Health Law

- e) Enact the various new health bills (e.g. the Public Health Bill; the Pharmacy Bill, the Medicines and Related Substances Control Bill) to improve the regulation of access to health care services, including access to affordable medicines, in Swaziland.
- f) Include specific reference to health rights, and in particular HIV-related health rights, such as the right to HIV testing only with voluntary and informed consent and the right to confidentiality with regard to HIV status, including children's rights and with clarifications regarding justifiable limitations of these rights (that is, disclosure to a sexual partner at risk under specified circumstances, as set out in the SADC PF Model Law), in the Public Health Bill 2013
- g) Develop a code of ethics for the management of patients with HIV, for health care providers, to protect the rights to equality, non-discrimination, testing with voluntary and informed consent and the right to confidentiality.

7.1.3 Criminalisation of HIV Transmission

- h) Review the provision in the Sexual Offences and Domestic Violence Bill 2009 for mandatory HIV testing of a sexual offender as well as the Public Health Bill 2013 for criminalisation of intentional transmission of HIV, in line with UNAIDS guidance. Develop prosecutorial guidance on the appropriate and reasonable application of these provisions for harmful HIV-related behaviour.
- i) **Criminalisation of sex work**
Review the criminalisation of sex work in terms of the Crimes Act of 1889 with a view to decriminalising sex work in Swaziland
- j) **Criminalisation of sex between men**
Review the criminalisation of sex between men in terms of the common law with a view to decriminalising sex between men in Swaziland.

7.1.4 Workplace Law

- k) Enact clear protection from discrimination and pre-employment HIV testing in law (e.g. the Employment Act), to protect all employees and prospective employees from HIV-related discrimination in the working environment, including in the armed forces and aviation

7.1.5 Women and Girls

- l) Enact the Sexual Offences and Domestic Violence Bill, 2009 and update the Women and Girls Protection Act to increase protection for women from gender-based violence, including harmful gender norms that place women and girls at risk of HIV exposure.
- m) Enact the Marriages Bill 2007 and Married Persons Equality Bill 2009 to protect women's equality rights within marriage and to protect young girls from early marriage.

7.1.6 Prisoners

- n) Review prisons law and policy to protect prisoners from mandatory HIV testing and to provide for access to voluntary HIV testing and counselling as well as the provision of condoms within prisons

7.1.7 People with Disabilities

- o) Enact the Disability Bill and disability and HIV policy to provide for the protection of people with disabilities to non-discrimination on the basis of HIV and AIDS, the recognition of the vulnerability of people with disabilities to HIV and the specific provision for access to sexual and reproductive health and rights in the context of HIV and disability.

7.2 Access to Justice and Law Enforcement

The following recommendations are made to increase access to justice and strengthen law enforcement in response to HIV and AIDS:

7.2.1. Awareness and Education

a) Develop stigma and discrimination reduction campaigns. Conduct awareness and education for all people, including the broader community as well as within specific sectors (e.g. health care, workplace, schools) to ensure understanding of basic human rights as well as protective laws, regulations and policies:

- Awareness and understanding of the rights of people living with HIV to equality and non-discrimination
- Awareness and understanding of the rights of women and girls to gender inequality and protection from harmful gender norms and gender-based violence
- Awareness and understanding of the rights of all vulnerable populations (e.g. people with disabilities) and key populations (e.g. sex workers, men who have sex with men and people who inject drugs, prisoners, mobile populations)

b) Conduct education, training and sensitisation of key service providers on non-discrimination, informed consent, confidentiality and protection from violence:

- Training for health care workers on the health rights of people living with HIV, vulnerable and key populations, including within pre-service curricula.
- Training for social workers on the social assistance rights of people living with HIV, vulnerable and key populations.
- Training for law enforcement officials on the rights of all people in the context of HIV and AIDS, including the rights of criminalised populations such as sex workers and men who have sex with men.

7.2.2. Legal Support Services

c) Steps should be taken to strengthen the provision of legal support for people living with HIV and members of vulnerable and key populations including through the provision of legal aid, legal support services from civil society organisations, strategic litigation and community dispute resolution including working with traditional leaders.

7.2.3. Strengthening Complaints Mechanisms

d) Conduct capacity building for the Commission on Human Rights and Public Administration in order to strengthen the monitoring and enforcement of human rights in the context of HIV and AIDS.

7.3. Other Programmatic Responses

In addition to efforts to strengthen laws, regulations and policies, access to justice and law enforcement, the LEA also recommends the following to provide for improved access to services in the context of HIV:

- e) Provide for improved programming, implementation, monitoring and evaluation of existing health laws, regulations, plans and policies especially those targeting vulnerable and key populations such as people with disabilities, sex workers and men who have sex with men, amongst others.
- f) Provide for steps to encourage the development and implementation of workplace HIV-related policies and programmes by, for example, encouraging employers to affiliate to the Swaziland Business Coalition on HIV, promoting awareness and education in the workplace and requiring human resource officers to become accredited with Swaziland Standards Authority's wellness standards.
- g) Strengthen implementation and enforcement of gender equality laws and policies protecting women and girls.
- h) Provide social assistance (e.g. food security, income generation) to people in the context of HIV and AIDS to address the impact of poverty on access to health care services.

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APPENDIX A: LIST OF KEY INFORMANT ORGANISATIONS

1. NERCHA
2. Rock of Hope
3. Ministry of Education
4. Ministry of Health
5. International Labour Organisation
6. SWANNEPHA
7. PSHACC

8. Defence Force
9. Correctional Services
10. Royal Swaziland Police
11. SNYC

List of Focus Group Discussions

Focus Group Discussions		
1.	People Living with HIV	2 FGDs
2.	LGBT (2)	2 FGDs
3.	Sex Workers	2 FGDs
4.	Factory Workers (2)	2 FGDs
5.	Lutsango Women's Cultural Organisation	1 FGD
6.	Public Transport Workers	2 FGDs
7.	Police	1 FGD
8.	Army	1 FGD