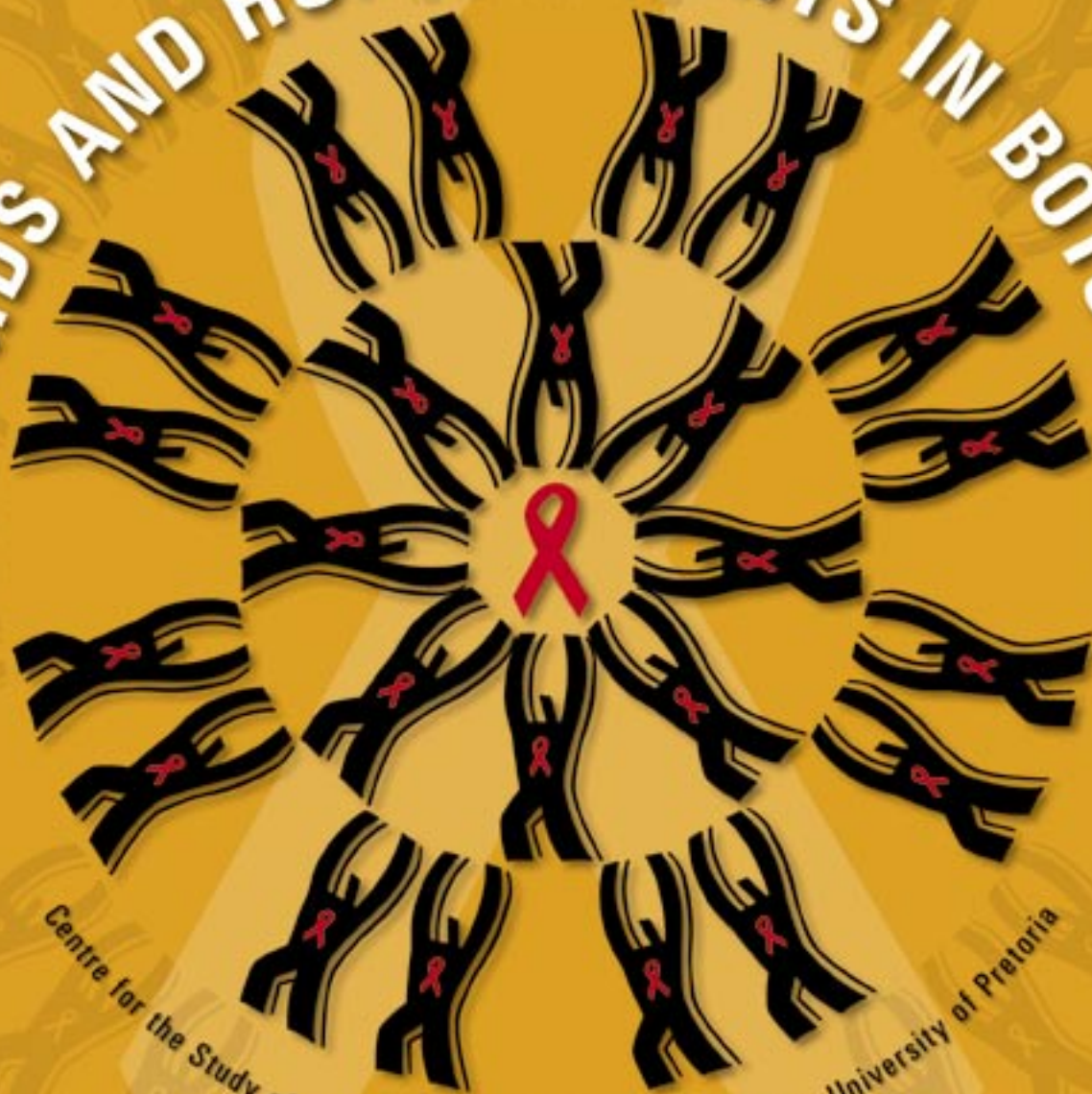


HIV/AIDS AND HUMAN RIGHTS IN BOTSWANA



Centre for the Study of AIDS and the Centre for Human Rights, University of Pretoria



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1. INTRODUCTION

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

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

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

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

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

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

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

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

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

³ Edward K Quansahe, Associate Professor in the Faculty of Law at the University of Botswana, and Janette Bezuidenhout, Office Secretary to UNAIDS in Botswana.

2. BACKGROUND

Botswana is a landlocked country in Southern Africa which shares its borders with Namibia, South Africa, Zambia and Zimbabwe. Botswana gained independence from Britain in 1966 and has since enjoyed one of the strongest economies on the continent, with diamond mining as its main industry. Botswana has an estimated population of 1 591 232 people.⁴ It is reported that 38,8% of adults in Botswana are HIV positive; this is an indication that the adult HIV-prevalence rate has almost tripled since 1992 when it was estimated at 10%.⁵ This places Botswana amongst the countries in the world with the highest HIV prevalence rate.

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

2.1 Geographical size and population

The following two tables illustrate the size and population of the SADC countries in this study:⁶

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

4 According to the *World Fact Book 2002*. Available at <http://www.cia.gov/cia/publications/factbook/geos/bc.html>. It is stated that estimates for this country "explicitly take into account the effects of excess mortality due to AIDS, this can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the distribution of population by age and sex than would otherwise be expected."

5 UNAIDS *Fact Sheets – HIV/AIDS in Africa*. Available at http://www.unaids.org/fact_sheets/files/Africa_Eng.html.

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

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

2.2 First reported instances of HIV infection⁷

Country	First reporting year	Number of cases
Botswana⁸	1985	3
Malawi	1985	17
Mozambique	1986	1
Namibia ⁹	1986	1
South Africa	1982	2
Swaziland	1987	1
Zambia ¹⁰	1984	1
Zimbabwe	1987	119

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

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

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

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

2.3 HIV prevalence rates

The following figures are provided by the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, which works in close collaboration with national AIDS programmes.¹¹ Statistics are also obtained from the *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 Update*, issued by UNAIDS, UNICEF and the WHO.¹²

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

¹¹ The estimates are from the *Table of Country-specific HIV/AIDS Estimates and Data, End 2001*, available at www.unaids.org/barcelona/presskit/barcelona%20reports/table.html. The estimates produced by UNAIDS/WHO draw on advice from the UNAIDS Reference Group on HIV/AIDS Estimates, Modelling and Projections. A measure of uncertainty applies to all estimates, depending on the reliability of the data available. Most of the data are from routine sentinel surveillance. For a detailed description of the general methodology used to produce the country-specific estimates, see Annexure 1 at <http://www.unaids.org/barcelona/presskit/barcelona%20report/annex1.html>.

¹² Available at: http://www.unaids.org/hivaidinfo/statistics/fact_sheets/all_countries_en.html#N. The methodology used in updating and compiling these country-specific estimates is summarised in the publication as follows: "In 2001 and during the first quarter of 2002, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates of people living with HIV/AIDS. These calculations are based on the previously published estimates for 1997 and 1999 and recent trends

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

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

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

¹³ Southern African Development Community *Health Annual Progress Report 2000-2001*.

¹⁴ *National HIV/AIDS/STD/TB Policy* published in October 2001 by the Ministry of Health of the Republic of Zambia. See par 1.2.3.

¹⁵ *Ibid*, par 1.2.4.

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

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

2.4 AIDS deaths in adults and children in 2001

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

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

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

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

This section examines the international, regional and SADC framework for the protection of human rights, as it relates to HIV/AIDS, to form the backdrop against which the national framework of Botswana should be considered. The international and regional human rights treaties examined do not include any HIV/AIDS-specific provisions. Nevertheless, a number of articles can be highlighted in the various treaties as they indirectly impact on people living with HIV/AIDS or their families. For instance, the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* affirms that state parties to the *Covenant* should recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.¹⁶ The *Covenant* then continues that state parties, in order to achieve this right, should prevent, treat and control epidemic, endemic, occupational and other diseases.¹⁷ These provisions would clearly apply to HIV/AIDS.

This section also briefly summarises the state reports submitted by Botswana in terms of its obligations under the various treaties that it has ratified, with a specific focus on HIV/AIDS reporting and recommendations made by the treaty monitoring bodies in relation to HIV/AIDS.¹⁸

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

¹⁶ Article 12(1) of the *ICESCR*.

¹⁷ Article 12(2)(c).

¹⁸ State reporting is a useful tool to monitor a state party's progress in implementing the various provisions of a treaty. Usually, states submit a report shortly after ratifying a treaty (initial report) and thereafter the state must report to the monitoring body every two

3.1 Applicable international legal norms

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

The status of these treaties is as follows (all dates denote ratification or accession, except when marked with 's,' in which case the treaty has only been signed by the state party):¹⁹

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

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

¹⁹ Status of ratification of international human rights treaties as of 02 November 2003 provided by the Office of the United Nations High Commissioner for Human Rights. Available at www.unhcr.ch/pdf/report.pdf. Date accessed: 24 November 2003.

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

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

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

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

International Covenant on Civil and Political Rights (ICCPR)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Convention on the Rights of the Child (CRC)

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

pressed opinions, or beliefs of the child's parents, legal guardians or family members.

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

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

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

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

3.2 State reporting

Under all treaties, states must report periodically to the Committee established under the treaty.

In May 2001, Botswana submitted its initial report to the Committee on the Rights of the Child. The government's report makes reference to the *National Policy on HIV/AIDS 1993* and the *Botswana HIV/AIDS Second Medium Term Plan*.²⁰ It specifically lists the strategies which relate to children. These include:

- enforcing the rights of girls to alleviate gender inequalities;
- enabling women and girls to negotiate safe sex;
- making provision for orphans; and
- making provision for children of parents infected with HIV and ill with AIDS.

The Report also deals with orphan care,²¹ prevention of mother-to-child transmission,²² and adolescent sexual and reproductive health.²³ The Committee, in turn, made no recommendations to the Botswana government in relation to HIV/AIDS in its Concluding Observations.

3.3 Applicable regional legal norms

The *African Charter on Human and Peoples' Rights (ACHPR)* was adopted in 1981 but makes no specific reference to HIV/AIDS. The *African Charter on the Rights and Welfare of the Child (ACRWC)* was adopted nearly ten years later, in 1990, but still does not include any reference to HIV/AIDS. It is only within the *Guidelines on State Reporting to the African Committee on the Rights and Welfare of the Child* that mention is made of HIV/AIDS. The *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, which has been adopted but is not yet in force, mentions HIV/AIDS in a cursory manner.²⁴ This is very unfortunate, given the impact of HIV/AIDS on African women.

The status of these treaties in respect of the states under discussion is as follows (all dates denote ratification or accession, except when marked with 's,' in which case the treaty has only been signed by the state party):²⁵

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

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

African Charter on Human and Peoples' Rights (ACHPR)

- *Article 2:* Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status.
- *Article 4:* Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.
- *Article 5:* Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status ...
- *Article 6:* Every person shall have the right to liberty and to the security of his person ...

²⁰ See pages 50–51 of the Report.

²¹ Page 52 of the Report.

²² Page 52 of the Report.

²³ Page 53 of the Report.

²⁴ Article 14(1) states that: "States Parties shall ensure that the right to health of women, including sexual and reproductive health, is

respected and promoted. This includes:... (d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS ...".

²⁵ Status of ratification and signature of the ACHPR and ACRWC compiled by the University of Minnesota, Human Rights Library as of 1 January 2000. Available at www1.umn.edu/humanrts/instree/afchildratifications.html and www1.umn.edu/humanrts/instree/ratzlafchr.htm. Accessed: 13 September 2002

- *Article 9:*
 - (1) Every individual shall have the right to receive information.
 - (2) Every individual shall have the right to express and disseminate his opinions within the law.
- *Article 10:* (1) Every individual shall have the right to free association, provided that he abides by the law.
- *Article 11:* Every individual shall have the right to assemble freely with others. The exercise of this right shall be subject only to necessary restrictions provided for by law, in particular those enacted in the interest of national security, the safety, health, ethics, and rights and freedoms of others.
- *Article 12:* (1) Every individual shall have the right to freedom of movement and residence within the borders of a State provided he abides by the law.
- *Article 15:* Every individual shall have the right to work under equitable and satisfactory conditions, and shall receive equal pay for equal work.
- *Article 16:*
 - (1) Every individual shall have the right to enjoy the best attainable state of physical and mental health.
 - (2) States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.
- *Article 17:*
 - (1) Every individual shall have the right to education.
 - (2) Every individual may freely take part in the cultural life of his community.
 - (3) The promotion and protection of morals and traditional values recognised by the community shall be the duty of the State.
- *Article 18:*
 - (1) The family shall be the natural unit and basis of society. It shall be protected by the State which shall take care of its physical health and morals.
 - (2) The State shall have the duty to assist the family which is the custodian of morals and traditional values recognised by the community.
 - (3) The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.
 - (4) The aged and the disabled shall also have the right to special measures of protection in

keeping with their physical or moral needs.

- *Article 19:* All peoples shall be equal; they shall enjoy the same respect and shall have the same rights. Nothing shall justify the domination of a people by another.
- *Article 24:* All peoples shall have the right to a general satisfactory environment favourable to their development.

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

- *Article 3:* Every child shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in this Charter irrespective of the child's or his/her parents' or legal guardians' race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status.
- *Article 4:* (1) In all actions concerning the child undertaken by any person or authority the best interests of the child shall be the primary consideration.
- *Article 5:* (1) Every child has an inherent right to life. This right shall be protected by law.
- *Article 8:* Every child shall have the right to free association and freedom of peaceful assembly in conformity with the law.
- *Article 10:* No child shall be subject to arbitrary or unlawful interference with his privacy, family home or correspondence, or to the attacks upon his honour or reputation, provided that parents or legal guardians shall have the right to exercise reasonable supervision over the conduct of their children. The child has the right to the protection of the law against such interference or attacks.
- *Article 11:*
 - (1) Every child shall have the right to an education.
 - (2) The education of the child shall be directed to: ... (h) the promotion of the child's understanding of primary health care.
 - (3) States Parties to the present Charter shall take all appropriate measures with a view to achieving the full realisation of this right and shall in particular: ... (e) take special measures in respect of female, gifted and disadvantaged children, to ensure equal access to education for all sections of the community.
- *Article 14:*
 - (1) Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.

(2) State Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures: (a) to reduce infant and child mortality rate; (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) to ensure the provision of adequate nutrition and safe drinking water; (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology; (e) to ensure appropriate health care for expectant and nursing mothers; (f) to develop preventative health care and family life education and provision of service; (g) to integrate basic health service programmes in national development plans ...

- *Article 21:* (1) States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices prejudicial to the health or life of the child; and (b) those customs and practices discriminatory to the child on the grounds of sex or other status.
- *Article 24:* State Parties which recognise the system of adoption shall ensure that the best interest of the child shall be the paramount consideration ...
- *Article 25:* (2) State Parties to the present Charter: (a) shall ensure that a child who is parentless, or who is temporarily or permanently deprived of his or her family environment, or who in his or her best interest cannot be brought up or allowed to remain in that environment shall be provided with alternative family care, which could include among others, foster placement, or placement in suitable institutions for the care of children;
- *Article 27:* States Parties to the present Charter shall undertake to protect the child from all forms of sexual exploitation and sexual abuse and shall in particular take measures to prevent:
 - (a) the inducement, coercion or encouragement of a child to engage in any sexual activity;
 - (b) the use of children in prostitution or other sexual practices;
 - (c) the use of children in pornographic activities, performances and materials.
- *Article 28:* States Parties to the present Charter shall take all appropriate measures to protect the child from the use of narcotics and illicit use of psychotropic substances ...

According to Article 43(1) of the *ACRWC*, state parties must undertake to submit to the African Committee of Experts of the Rights and Welfare of the Child, through the Chairperson of the Commission of the African Union, reports on the measures that have been adopted to give effect to the provisions of the *ACRWC*, and the progress made in the enjoyment of the rights guaranteed in the Charter. The *Guidelines* for reporting specify that the state parties should indicate what measures are in place for children in need of special protection, specifically in reference to AIDS orphans, in terms of Article 26 of the *Charter*.²⁶ States are also encouraged to provide specific statistical information and indicators relevant to children in need of special protection.²⁷ The first report under *ACRWC* is due within two years of the state's ratification of the *Charter*, and thereafter reports are due every third year. Unfortunately, not one of the eight countries in this study has submitted reports to date.

3.4 SADC framework for addressing HIV/AIDS

In September 1997, the SADC Council of Ministers adopted the first relevant document addressing HIV/AIDS-related issues, the *Code of HIV/AIDS and Employment in SADC*, as developed by the Employment and Labour Sector. The main objectives of the *Code* are to sensitise employers to the issue of employee rights and HIV/AIDS, and to provide a framework for states to consolidate national employment codes on HIV/AIDS-related issues. It addresses public sector employers, legislators, employees and trade unions.

In August 1999, the 14 member states adopted the *SADC Health Protocol*.²⁸ Article 10 specifically deals with HIV/AIDS and sexually transmitted diseases (STDs). The article urges states parties to harmonise policies and approaches for the prevention and management of HIV/AIDS and STDs, and to develop regional policies and plans that work towards an inter-sectoral approach to the epidemic.

In December 1999, the SADC HIV/AIDS Task Force adopted the vision document *A SADC Society with Reduced HIV/AIDS*. It was adopted to guide the work of the SADC in the development

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

27 Par 22.

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

and implementation of a multi-sectoral *HIV/AIDS Framework for 2000-2004* (hereinafter referred to as the *Strategic Framework*). The *Strategic Framework* is in principle guided by Article 10 of the *SADC Health Protocol*; all SADC sectors agree to use their comparative advantages to address the needs of those sectors and the communities they serve, whether transport, mining, tourism, etc. One of the principles that has been acknowledged as important in the development of the *Strategic Framework* is the respect for the rights of individuals.²⁹

The only sector in the *Strategic Framework* that specifically mentions stigmatisation and discrimination is the Human Resources Development. This sector aims to provide information to reduce stigma and to change attitudes by, amongst other initiatives, integrating HIV/AIDS education and life skills into school curricula across the region.³⁰

In September 2000, the SADC Council of Ministers approved the *Health Sector Policy Framework Document*, as developed by the SADC Health Ministers.³¹ A significant part of the programme focuses on HIV/AIDS and sexually transmitted diseases. One of the policy objectives in the programme, geared towards HIV/AIDS control, is to protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV/AIDS.

A month prior to the adoption of the *Health Sector Policy Framework*, the SADC Health Ministers adopted *Principles to Guide Negotiations with Pharmaceutical Companies on Provision of Drugs for Treatment of HIV/AIDS-Related Conditions in SADC Countries*.³² These principles focus on enabling SADC countries to make informed decisions in their negotiations with pharmaceutical companies and to consider factors such as sustainability, affordability, accessibility, appropriateness, acceptability and equity before accepting offers for free drugs or reduced prices on HIV/AIDS-related drugs.

In July 2003, the SADC Heads of Government signed the *SADC Declaration on HIV/AIDS*.³³ The *Declaration* affirms the commitment to address the pandemic and the issues relating to HIV/

AIDS in the SADC region through multi-sectoral intervention. A new *SADC HIV/AIDS Strategic Framework and Programme of Action 2003-2007* was also issued.

3.5 Relevant OAU/AU resolutions on HIV/AIDS

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

In June 1994, the *Tunis Declaration on AIDS and the Child in Africa* was adopted by the OAU at the Assembly of Heads of State and Government in Tunis, Tunisia.³⁴ The *Declaration* declares a commitment to: "Elaborate a national policy framework to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues."³⁵

In July 1996, at the Thirty-Second Ordinary Session of the Heads of State and Government of the OAU, a *Resolution on Regular Reporting of the Implementation Status of OAU Declarations on HIV/AIDS in Africa* was adopted by the Assembly.³⁶ The *Resolution* urged African leaders to implement those declarations and resolutions that had been adopted in the past, specifically referring to the *Tunis Declaration*.

On 27 April 2001, the Heads of State and Government gathered for a special summit devoted specifically to address the exceptional challenges of HIV/AIDS, tuberculosis and other related infectious diseases. This resulted in the *Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases*, and the *Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, aimed at implementation of the principles set forth in the *Abuja Declaration*.³⁷

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

30 *Ibid*, at p 28.

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

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

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

34 AHG/Decl I (XXX) 1994.

35 Par 2(I).

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

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

In the *Abuja Declaration*, the Heads of State acknowledged that “stigma, silence, denial and discrimination against people living with HIV/AIDS increases the impact of the epidemic and constitutes a major barrier to an effective response to it.”³⁸ The *Abuja Framework* conceptualises the commitments made in the *Abuja Declaration* into strategies followed by subsequent activities to be implemented by member states in collaboration with all stakeholders. The protection of human rights is recognised as one of the priority areas, and the following strategies are identified:

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

3.6 International guidelines on HIV/AIDS and human rights

In 1996 UNAIDS, in collaboration with the Office of the United Nations High Commissioner for Human Rights, adopted *HIV/AIDS and Human Rights – International Guidelines*. The *Guidelines* focus on three crucial areas: “(1) improvement of governmental capacity for acknowledging the government’s responsibility for multi-sectoral co-ordination and accountability; (2) widespread reform of laws and legal support services, with a focus on anti-discrimination, protection of public health, and improvement of the status of women, children and marginalised groups; and (3) support for increased private sector and community participation in the response to HIV/AIDS, including building the capacity and responsibility of civil society to respond ethically and effectively.”³⁹

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

- *Guideline 1*: Encourage states to adopt a multi-sectoral approach through an effective national framework.

- *Guideline 2*: Enable community organisations to carry out activities in the field of ethics, human rights and law. Consult widely with such organisations in drafting all HIV policies.
- *Guideline 3*: Review and reform public health laws to adequately address HIV/AIDS.
- *Guideline 4*: Review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and address HIV/AIDS without targeting vulnerable groups.
- *Guideline 5*: Enact or strengthen anti-discrimination laws to protect vulnerable groups. Ensure privacy, confidentiality and ethics in research involving human subjects.
- *Revised Guideline 6*: Enact legislation to provide for the regulation of HIV-related goods, services and information in order to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price. Ensure that all persons on a sustained and equal basis have access to quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including anti-retroviral and other safe and effective medicines, diagnostics and related technologies for the treatment of HIV/AIDS and related opportunistic infections.⁴⁰
- *Guideline 7*: Implement and support legal support services to educate people affected by HIV/AIDS about their rights, develop expertise on HIV-related legal issues and use means other than courts such as human rights commissions to protect the rights of people affected by HIV/AIDS.
- *Guideline 8*: States, together with communities, should promote an enabling and prejudice-free environment for women, children and other vulnerable groups.
- *Guideline 9*: Promote the distribution of creative education, training and media programmes designed to change attitudes of discrimination and stigmatisation around HIV/AIDS.
- *Guideline 10*: Translate human rights principles into codes of conduct with accompanying mechanisms to implement and enforce these codes.
- *Guideline 11*: States should ensure monitoring and enforcement mechanisms to guarantee and protect HIV-related human rights.
- *Guideline 12*: States should share experiences concerning HIV-related human rights issues at an international level and through UN agencies such as UNAIDS.

³⁸ Par 12.

³⁹ See Foreword in the *Guidelines*.

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

4.1 National legal system: General background

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

In understanding the legal context within which to analyse Botswana's legislation, case law and policies on HIV/AIDS, it is necessary to briefly outline the composition of the constitutional dispensation and the legal traditions underlying it. Botswana is a republican liberal constitutional democracy with an executive President who is both head of state and head of government. The *Constitution* provides for a unicameral legislature comprising the President and the National Assembly, which is elected every five years by universal adult suffrage. There is an independent judiciary, which has the power of judicial review of executive actions and legislation. The *Constitution* enshrines a justiciable Bill of Rights fashioned on the *Universal Declaration of Human Rights* and the *European Convention of Human Rights*. The *Constitution* entrenches fundamental rights and freedoms and is the supreme law of the land.

The domestic legal system is based on the English Common Law and Roman-Dutch Law traditions. There is also customary law, which operates side by side with received law. The hierarchy of courts consists of the Customary Courts, Magistrates' Courts, the High Court and the Court of Appeal. The domestic legal system was inherited from Britain, which governed Botswana during its protectorate years.

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

In 1989, the government of Botswana drafted its first national strategic policy response to the HIV/AIDS epidemic. The *Medium Term Plan for the Prevention and Control of HIV/AIDS in*

Botswana, 1989-1993 (MTP) outlined the role of the health sector and Ministry of Health with the support and assistance of other sectors and non-governmental organisations (NGOs). This was followed by the *National Medium Term Plan II, 1997-2002 for HIV/AIDS (MTP II)*. This revised strategic plan shifted the focus from a health-based approach to HIV/AIDS to a multi-sectoral response. The *MTP II* not only outlined the roles of each governmental sector but also addressed the position of the private sector and that of NGOs. The *MTP II* further outlined the international human rights context for addressing issues of stigma and discrimination against people living with HIV/AIDS.

MTP II makes specific reference to the protection of human rights in the following sections:

- *Section 8.1* states that the first goal of the Policy is to "reduce HIV infection transmission". In striving towards this goal, it states that gender inequalities should be eliminated. More specifically, it provides for the development of policies to incorporate the rights and protection of the girl child in all relevant policies and acts, to enforce the Children's Act to protect the girl child, and to review all laws and policies that disadvantage women.⁴¹ It further states that children's rights should be incorporated in school counselling procedures in an effort to address child sexual abuse.
- The second goal is to reduce the impact of HIV/AIDS at the macro-economic, social, community, household and personal levels. In striving towards this goal, it states that HIV-friendly and non-discriminatory workplace policies should be developed in line with the national AIDS policy; anti-discrimination legislation should be developed to protect people living with HIV/AIDS; and, a review should be undertaken of all existing legislation to ensure equal treatment of people infected with HIV and people living with AIDS.⁴²

⁴⁰ Guideline 6 was revised in 2002 and is available at: <http://www.unhcr.ch/hiv/g6.pdf>.

Following the *MTP II*, a new *National Strategic Plan for HIV/AIDS 2003-2009* was introduced on 26 September 2002. This *Strategic Plan* maps out the country's overall multi-sectoral response to the epidemic for the period 2003-2009. The main objectives of the *Strategic Plan* are:

- 1) to achieve at least 80% implementation of planned HIV/AIDS interventions by strengthening institutional, financial and information management systems;
- 2) to have 50% or more people in Botswana aged 15-49 years adopt safer sex practices;
- 3) to increase access to care, treatment and support services by 50%;
- 4) to increase the utilisation of care, support and treatment services by 25%;
- 5) to minimise the impact of the epidemic on the functioning of the economy, basic social services and affected households; and
- 6) to strengthen the legal and ethical environment to protect the rights of all people in Botswana in relation to HIV/AIDS.

The *Strategic Plan* articulates 24 priority strategies aimed at achieving these six objectives. The priority strategies encompass a number of key themes such as addressing the obstacles presented by limited human resources and capacities; developing strategic partnerships to expand prevention and care programmes; strengthening financial and information management systems; addressing socio-cultural issues and behaviour change; addressing the impact of HIV/AIDS at the macro and micro levels; and protecting individual rights through legislation.⁴³

The *Strategic Plan* specifically states that whilst some progress has been made over a number of years, important gaps remain in the national response in five critical areas. These areas form the foundation of the 2003-2009 response. Of specific interest is the fifth area identified in the *Strategic Plan* as the Legal and Ethical Environment. The objective of the area is: "to strengthen the legal and ethical environment to protect the rights of all people in Botswana in relation to HIV/AIDS." Three priority strategies are set forth to achieve this objective:

- advocate for and review existing legislation, guidelines and policies regarding prisons, homosexuality, orphans and vulnerable children, and people living with HIV/AIDS;

- strengthen the legal and regulatory framework regarding alcohol distribution and consumption; and
- support legal reform and enforcement of laws addressing the issues of rape and sexual violence in Botswana and educate vulnerable groups (men and women) on relevant behavioural change.

The *Strategic Plan* further mentions some key areas of consideration based on identified vulnerable groups such as people living with HIV/AIDS (PLWHAs). With regard to PLWHAs, considerations include human and legal rights, and stigma and discrimination.

The table below is a short summary of the responsibilities and activities of the various ministries as they relate to human rights.⁴⁴ The Ministry of Health and the Ministry of Local Government are the key ministries for implementing the *National HIV/AIDS Strategic Plan*.

Ministry	Strategic medium-term actions
Ministry of Local Government	Revise the criteria for eligibility for destitute support to enable families caring for people with HIV/AIDS and orphaned children to gain access to such support in line with the National Destitute Policy.
Ministry of Labour and Home Affairs	With partners such as BONELA ⁴⁵ and the Attorney General's (AG) Chambers, protect the employment rights of PLWHAs. Mainstream HIV/AIDS into the National Industrial Relations Code of Practice. Review and revise legislation regarding immigration and discriminatory practices, e.g. mandatory HIV/AIDS testing of foreigners seeking employment and/or residency in Botswana. Advocate for a national forum to discuss decongestion and condoms in prisons, and access to VCT by the prison community as national priorities.
Ministry of Education	In collaboration with the AG's Chambers, BONELA and other relevant organisations, expand education with respect

⁴¹ See page 43 of the Botswana *MTP II*.

⁴² See page 62 of the Botswana *MTP II*.

⁴³ See page 7 of the *Strategic Plan*.

⁴⁴ These responsibilities and activities relate directly to Intervention Area Number Five, "the legal and ethical environment".

⁴⁵ Botswana Network on Law Ethics and HIV/AIDS.

	to human rights issues, especially as they relate to PLWHAs, in both formal and non-formal settings. Facilitate development of policy concerning access to condoms for youth.
Ministry of Finance and Development Planning	Work with BONELA and the insurance industry to address the issue of restrictions on HIV-infected persons applying for life insurance.
Attorney General's Chambers	Integrate HIV/AIDS issues into the drafting of relevant laws, agreements and conventions. Provide appropriate support to organisations established to provide Legal Aid services to PLWHAs and their families. In collaboration with appropriate sector ministries, undertake a review of relevant legislation, e.g. employment law and the <i>Public Health Act</i> , to ensure that they are HIV/AIDS compliant. Provide technical support to public education campaigns regarding HIV/AIDS-related legal issues, e.g. discrimination, property rights, inheritance, human rights. Mainstream legal aspects of HIV/AIDS in the quarterly legal education programmes with the ministries.
Botswana Defence Force (BDF)	Review the BDF's HIV/AIDS policy.

For the purposes of monitoring and evaluation of the implementation of the *National Strategic Plan*, the following national indicators are listed in relation to the legal and ethical environment:

- The country has a policy or strategy to expand access, including by vulnerable groups, to essential preventative commodities.
- The country has a policy or strategy to reduce MTCT.
- The country has laws and regulations that protect people living with HIV/AIDS against discrimination.
- The country has laws and regulations that protect groups of people identified as especially

vulnerable to HIV/AIDS against discrimination.

- The country has HIV/AIDS policies to ensure equal access between men and women to prevention and care, with emphasis on vulnerable populations.
- The country has a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee.

According to the *Strategic Plan*, these indicators meet Botswana's obligations under international agreements.⁴⁶

In addition to the *Strategic Plan*, Botswana developed its first *National AIDS Policy* in 1993. This *Policy* set out the role of various sectors in all aspects of the national response with a specific focus on the Ministry of Health. The *Policy* has been revised twice since then, once in 1998 and again in 2002, to incorporate national and international developments in the understanding and management of the epidemic. The 2002 *Policy* states that it is based, amongst other factors, on the principles of public health, an ethical and legal rationale for respecting human rights, and privacy and self-determination of persons living with HIV/AIDS, in line with the country's *Constitution*. It further states that it takes cognisance of the responsibility of persons with HIV/AIDS to protect others from infection, as well as the right of society to protection from HIV infection.

The 2002 *Policy* provides for a multi-sectoral national response; in this sense it closely mirrors the *Strategic Plan*. The following is a summary of the strategies in the 2002 *Policy* relating to human rights within different ministries:

- The Ministry of Education will focus on the integration of AIDS and STD education into all levels and institutions of education.
- The Ministry of Labour and Home Affairs must develop legislation regarding the rights of HIV-infected individuals to employment, social welfare and compensation where relevant. The Labour Department must ensure that the rights of workers with HIV/AIDS are not infringed in any labour-related legislation that may be developed, as stipulated in the *Policy*.⁴⁷

⁴⁶ See page 52 of the *Strategic Plan*.

⁴⁷ See page 14 of the 2002 *Policy*.

Section 6 of the 2002 *Policy* is devoted to legal and ethical issues.⁴⁸ Section 6.1 states that since Botswana has no specific legislation dealing with HIV/AIDS, the guidelines in the *Policy* are derived from the principles expressed in national documents such as the *Constitution* and the *Public Health Act*. It affirms that persons with HIV/AIDS have the same rights as healthy persons, including the right to non-discrimination, security of person and protection of law, privacy, education and information about infections, and access to health and social services. The *Policy* then states that: “the rights of non-infected persons should not be sacrificed in trying to protect the rights of those infected.”⁴⁹ Section 6.2 contains guidelines on HIV testing; 6.3 deals with confidentiality; 6.4 contains guidelines on HIV/AIDS and employment, and 6.5 lists guidelines in relation to specific population groups.⁵⁰ A representative of Law Ethics and Human Rights serves as a member of the National AIDS Council established under the *Policy*.

In summary, the Government of Botswana has mainstreamed some human rights issues into both its *National Strategic Plan* and *National AIDS Policy*. However, there is a need to review how these human rights can be realised and how implementation will be measured. In addition, those areas where rights are not currently protected or provided for must be included.

4.1.3 Domestication of international and regional human rights treaties

The status of international and human rights treaties is not specifically addressed by the *Constitution* of Botswana. A dualist approach is adopted in the relationship between international law and domestic law in Botswana. International treaties and conventions form part of domestic law only if incorporated through national legislation. The Court confirmed this approach in *Attorney-General v Dow* [1992].⁵¹ Thus, until domesticated, international human rights treaties are used only as an interpretative tool by the Courts. Thus, in the cases of *Attorney-General v Dow* [1992]⁵² and *Petrus v The State* [1984],⁵³ the Court referred to the *African Charter on Human and People’s Rights*.

48 The revision of this section was drawn largely from Dingake, O.K. 2002. *AIDS and Human Rights in Botswana*.

49 See page 19 of the 2002 *Policy*.

50 The five groups are women, children, homosexuals, alcohol and drug users, and travellers.

51 B.L.R. 119 (CA) at pp. 153–154.

52 B.L.R. 119 (CA) at p. 154.

53 B.L.R. 14 (CA) at p. 37.

54 Criminal Appeal No. 49/2000.

There are no specific arrangements for the implementation of human rights treaties in Botswana. The Attorney General’s Chambers are responsible for initiating and drafting the necessary implementing legislation relating to the treaties Botswana has ratified. This has been done only in a very few cases.

4.2 HIV/AIDS-specific regulations

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

Few cases of direct relevance to HIV/AIDS have reached the Botswana Court of Appeal. Those cases that have been heard dealt primarily with intent under the criminal penal code. In the case of *Qam Nqubi v The State*,⁵⁴ the Court held that in the absence of proof that the offender was HIV positive at the time the rape was committed, the precondition for the imposition of the minimum of 15 years imprisonment in terms of Section 142(4)(a) of *Penal Code* (as amended) was not met.⁵⁵ The Court was not obliged to impose the 15-year minimum sentence for lack of proof, and HIV status was therefore not regarded as an aggravating factor. The Court of Appeal relied on the decision made in the same Court in the matter of *Dijaje Makuto v The State*.⁵⁶ In this case it was stated that: “As it was not shown that the appellant had the HIV syndrome at the time the offence of rape was committed, the precondition for the imposition of the minimum of 15 years imprisonment by section 142(4)(a) as amended has not been established.” This position was reconfirmed in *Lefang Gare v The State*⁵⁷ and in *Shima Matlapeng v The State*.⁵⁸

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

- *Penal Code (Amendment) Act, No. 5 of 1998*
- *Criminal Procedure and Evidence (Amendment) Act, 1997*

55 Section 142(4)(a) provides: “Any person who is convicted under subsection (1) or subsection (2) and whose test for the Human Immuno-deficiency Virus under subsection (3) is positive, shall be sentenced to a minimum term of 15 years’ imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that such person was unaware of being Human Immuno-deficiency Virus positive.”

56 Criminal Appeal No. 31 of 1999.

57 Court of Appeal Criminal Appeal No. 48/2000.

58 Criminal Appeal No. 45 of 2000.

4.2.3 HIV/AIDS policies, guidelines and programmes

HIV/AIDS policies and programmes are primarily under the umbrella of the Minister of Health. The AIDS/STD Unit and the National AIDS Coordinating Agency (NACA) are specifically tasked within the Ministry to drive programmes and lead in policy formulation. Some of the relevant policies, guidelines and other documents are as follows:

- *Botswana HIV/AIDS Second Medium Term Plan 1997-2002, NACP38*
- *National Strategic Plan for HIV/AIDS 2003-2009 (Zero Draft – 26th September 2002)*
- *Botswana Guidelines on Anti-retroviral Treatment (2002 Version) – Ministry of Health*
- *Short Term Plan of Action on Care of Orphans in Botswana 1999-2001 – Ministry of Local Government Lands and Housing/Social Welfare Division*
- *Botswana National Policy on HIV/AIDS (Revised Version), September 1998*
- *HIV/AIDS Resource Guide, June 2002*
- Ministry of Education Policy
- National Defence Force Policy
- National Teachers' Union (NANTU) Policy on HIV/AIDS, Windhoek
- *Botswana HIV/AIDS and Human Rights Charter, revised 2002 by the Botswana Centre for Human Rights*
- *Public Service Code of Conduct on HIV/AIDS in the Workplace, Directorate of Public Service Management, July 2001*
- *Botswana 2002 Second Generation HIV/AIDS Surveillance [A Technical Report, November 2002].*

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

Despite the barriers to the formal incorporation of international treaties, the International Guidelines have been recognised. Information from NACA indicates that the International Guidelines are followed in policy formulation and implementation by the various agencies involved in the fight against AIDS.

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

The Ministry of Local Government's strategic medium-term actions for the period 2003-2009 state that the Ministry should "revise the criteria for eligibility for destitute support to enable families caring for people with AIDS and orphaned children to gain access to such support in line with the *National Destitute Policy*."⁵⁹

According to the multi-sectoral national response as set out in the National Policy on HIV/AIDS, the Ministry of Labour and Home Affairs must develop legislation regarding the rights of HIV-infected individuals to employment, social welfare and compensation where relevant.⁶⁰ Section 6(4) of the Botswana *National Policy on HIV/AIDS* declares that: "HIV-infected employees should have access to and receive standard social security and occupationally related benefits."⁶¹

The *Short Term Plan of Action on Care of Orphans in Botswana* published by the Social Welfare Division of the Ministry of Local Government Lands and Housing for the period 1999-2001 dealt specifically with the delivery of social welfare and other essential orphan support services. Realising the difficulties faced by orphans, the Ministry issued a directive to all districts to assess, register and support orphans under the policy.⁶² In collaboration with the Ministry of Health, a "food basket" was established for orphans and other children in need of special nutritional care.

4.3 Health sector

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

The national response to the HIV/AIDS epidemic was initially led by the health sector. The initial response took the form of a National AIDS Programme and the *Short Term Plan* between 1987-1989, followed by *MTP I* and *MTP II*. Since 2000, however, the co-ordination of the national response has been re-organised with the establishment of the National AIDS Coordinating Agency (NACA). The Ministry of Health now focuses primarily on the co-ordination

59 See page 27 of the *National Strategic Plan for HIV/AIDS 2003-2009*.

60 See page 14 of the *National Policy*.

61 See page 21 of the *2002 Policy*.

62 Savingram LG 1/27/49 (21) dated 21 September 1998.

of the health sector response. NACA has the key responsibility of managing and coordinating the implementation of the national *HIV/AIDS Policy* and *Strategic Plan*. In discharging this responsibility, NACA is enjoined to ensure the concerted multi-sectoral action of all ministries, sectors, districts and civil society organisations, including non-governmental, community and faith-based organisations, associations of people living with HIV/AIDS and the private sector. The draft *Health Sector Plan for April 2003 – March 2005* identifies the following three areas as priorities for the health sector: prevention; care and support; and co-ordination, research, surveillance, monitoring and evaluation.

The African Comprehensive HIV/AIDS Partnership (ACHAP) is a joint initiative between the government of Botswana, the Bill and Melinda Gates Foundation, and Merck & Co. Inc./The Merck Foundation, to prevent and treat HIV/AIDS in Botswana. ACHAP's focus is to support the goals of the government of Botswana to prevent HIV infection and significantly increase the rates of diagnosis and treatment of HIV/AIDS, by rapidly advancing HIV/AIDS prevention programmes, health-care access, patient management and treatment of HIV.⁶³

Within the Ministry of Health, a number of programmes have been launched, addressing areas such as IPT (Isoniazid preventive therapy), ART (anti-retroviral therapy), PMTCT (prevention of mother-to-child transmission), VCT (voluntary counselling and testing centres) and measures ensuring safe blood transfusion. The AIDS/STD Unit in the Ministry of Health co-ordinates the AIDS Control Programme.

The right to health, like many other socio-economic rights, is given limited protection in the *Constitution* of Botswana. This, combined with the fact that Botswana has not signed or ratified the *International Covenant on Economic, Social and Cultural Rights*, creates a situation whereby people living with or affected by HIV/AIDS have almost no legal grounds to guarantee their right to access to health care.

4.3.2 HIV testing, notification and confidentiality

It is unclear whether or not HIV is a notifiable disease in Botswana.⁶⁴ Nevertheless, coded test result reporting is collated at the STD/AIDS Unit of the Ministry of Health. Thus, when patients are tested at government clinics or if during routine medical examination they are found to be HIV positive, this is reported to the National AIDS Coordinating Agency. Statistical profiles are compiled from these reports in order to ascertain the state of infection and spread of HIV.

There are nationwide confidential voluntary testing centres jointly sponsored by the governments of Botswana and the United States of America (BOTUSA). Trained personnel at these centres offer pre- and post-test counselling. Confidentiality is maintained at the testing centres and this can only be breached with the consent of the person identified as HIV positive. The *Botswana National Policy on HIV/AIDS, 2002 (Revised Version)*, sets forth certain principles that should be observed with regard to all HIV testing.⁶⁵ These principles include:

1. With the exception of the screening of donated blood and patients presenting with HIV suggestive symptoms, routine testing for HIV/AIDS should not be carried out.
2. HIV testing should not be carried out against the will of an individual and consent must be obtained.
3. Pre- and post-test counselling should accompany all testing in which the individual will receive the results.
4. Pre-employment testing as part of assessment of fitness to work is unnecessary and should not be carried out.
5. HIV testing should not be carried out as part of periodic medical examinations of employees.
6. Voluntary counselling and testing should be encouraged and provided.⁶⁶

The *Botswana National Policy on HIV/AIDS* also contains some measures on confidentiality, including:⁶⁷

63 The Bill and Melinda Gates Foundation and the Merck Company Foundation will each dedicate \$50 million over five years towards the project. Merck is also donating anti-retroviral medicines for the appropriate treatment programmes developed by the government of Botswana in accordance with nationally approved guidelines for the duration of the programme.

64 See Dingake, O.K. *AIDS and Human Rights in Botswana*, page 12.

65 Detailed guidelines on HIV testing are contained in the Ministry of Health's *Policy on HIV/AIDS (NACP 5)*.

66 See page 20 of the 2002 *Policy*.

67 See pages 20–21 of the 2002 *Policy*. The *Policy* states that detailed guidelines are in the Ministry of Health *Policy on HIV/AIDS*.

1. Consent to disseminate information about the HIV status of individuals should be obtained from the person concerned (i.e. the patient, employee, etc.) before divulging it to others.
2. The principle of “shared confidentiality” should be followed. According to this principle, “those who need to know” in order to provide appropriate health and social welfare should be told.⁶⁸ Families should be encouraged to be involved from the pre-test phase.
3. There should be no obligation to inform an employer about an employee’s HIV status. However, where the employee feels that sharing such information with a supervisor or employer would be helpful, health and social service providers should assist the employee.

The *Policy* also states that persons with HIV/AIDS should be made fully aware of their responsibility to prevent onward transmission to others. The *Public Health Act* provides for the prosecution of those who deliberately spread infections in general. This type of clause makes any protection of privacy clause vulnerable to violation in the absence of appropriate safeguards.

4.3.3 Patients’ rights

Patients living with HIV/AIDS have the same rights as any other citizen of Botswana attending health facilities. The existing ethical guidelines regulating behaviour of doctors and health workers relates to patients in general. There are currently no ethical guidelines to specifically regulate the behaviour of doctors or health workers towards HIV-positive patients. Information from the Botswana Network on Ethics Law and HIV/AIDS (BONELA) indicates that a policy will be formulated once a council is set up under the Botswana *Health Profession Act* of 2001.

4.3.4 Access to essential HIV/AIDS drugs

The Botswana *Guidelines on Anti-retroviral Treatment* (February 2002 version) were introduced by the Ministry of Health and set out the policy dealing with access to ARV drugs. It undertakes to provide highly active anti-retroviral therapy (HAART) to patients in Botswana who meet certain clinical and laboratory criteria. Anti-retroviral drugs are provided to those whose viral load is below 200 or on special recommendation from a doctor. This policy is designed to prevent

overloading of the existing health structure. Botswana is the first country in sub-Saharan Africa to undertake to provide this treatment countrywide. However, the *Constitution* does not provide a right to health and consequently if a patient is found to have met the criteria for access to ARV drugs and such a patient is refused the treatment, it is probable that there will be no legal basis to challenge the refusal.

Treatment for opportunistic infections has been available in Botswana since the early 1990s owing to available drugs and treatment guidelines. These guidelines were reviewed in 1998 and are currently under review once again to incorporate new developments. The draft *Health Sector Plan April 2003-March 2005* states that: “The major constraint in the management of opportunistic infections is the lack of trained manpower to diagnose and treat opportunistic infections. This situation has been complicated by high turnover of health personnel in the health sector, particularly the public sector.”⁶⁹

Despite having identified some of the barriers to treatment, the government has not taken a specific stand on the use of generic substitutes or compulsory licensing and parallel importation.

4.3.5 Medical trials on human subjects

The government of Botswana is guided by international law such as UNAIDS/WHO guidelines in its approach to medical trials. The *Constitution* of Botswana does not expressly mention the right to bodily and psychological integrity but it does guarantee the right to life, liberty and security of the person in Article 3(a). This has been interpreted to include the freedom to bodily integrity and freedom of choice.⁷⁰ There are as yet no procedures in place to protect the rights of volunteers in medical trials.

4.3.6 Condoms

Condom promotion forms part of the implementation of health-sector-based interventions by the Ministry of Health to prevent the transmission of HIV and STDs.⁷¹ In striving to reach the goal of 50% or more of the population between the ages of 15-49 adopting safer sex practices

68 During the Durban AIDS Conference, 5 July 2000, a paper was presented by Anneke Zuyderduin and Ingrid Melville entitled ‘Shared confidentiality – An ethical dilemma in Botswana’. This paper criticised the introduction of shared confidentiality into Botswana law through the *Botswana Medical Council (Professional Conduct) (Amendment) Regulations No 77 of 1999*. It stated that: “What the legalised concept of shared confidentiality might achieve in reality is to create the avenue for unlimited forced disclosure of the HIV status of a

person and thus pave the way for grave human rights abuses.”

69 See page 15 of the *Draft Plan*.

70 Dingake, O.K. *AIDS and Human Rights in Botswana*, page 11.

by 2008, the Ministry aims to increase male and female condom use through an increase in supply channels, improved access and sustained education for both sexes.⁷²

Condoms are already quite easily accessible. They are on sale at pharmacies at reasonable prices and condoms are also distributed free at various locations such as public places of convenience and in the workplace. The University of Botswana provides free condoms, placed in prominently displayed receptacles all around the campus.

4.3.7 HIV/AIDS and the mentally ill

According to the 2001 Census Report, approximately 59 000 people are living with disabilities, including about 12 000 with mental disabilities. According to the *Health Sector Plan for April 2003 – March 2005*, the Rehabilitation Services Division of the Ministry of Health has been mandated to ensure the overall well-being of people with disabilities. This includes developing policy and programmes, training, supervision, specialised services, referral services, etc. Currently, none of the existing rehabilitation services focuses on HIV prevention and care for people with disabilities. The proposed programme of the Rehabilitation Services Division seeks to develop comprehensive and specialised strategies and programmes to meet the needs of people living with disabilities through:

- developing the knowledge and skills of different service providers and people with disabilities on HIV/AIDS;
- promoting active participation of people with disabilities; and
- ensuring that people with disabilities have access to HIV/AIDS information and services.
- developing and disseminating information, education and communication materials addressing specific needs of people with disabilities; and
- recruiting and training specialised counsellors for various groups of people with disabilities.⁷³

The Botswana Association for Psychosocial Rehabilitation in Lobatse has received a one-year US\$74 000 grant from Secure the Future. The grant is intended for research on effective HIV/

AIDS prevention education for mentally challenged people in an area of Botswana that has high numbers of mentally challenged and ill patients. The research also aims to assess how the community can be taught to care for infected mentally ill patients and to compile a profile of the more prevalent mental illnesses that are triggered by HIV/AIDS.⁷⁴

4.4 Equality and non-discrimination

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

The right to equality and non-discrimination is guaranteed in Section 15 of the *Constitution*. The *Constitution* does not specifically prohibit discrimination in terms of HIV status, neither does it prohibit discrimination on grounds of gender or a medical condition. There is no specific provision at present for the protection of the right to equality of people living with HIV/AIDS and this has not yet been challenged in court. However, it is likely that HIV status would fall within the realm of Section 15 and be supported by case law, where it has been stated that “discrimination that is irrational and unfair discrimination would not be accepted.”⁷⁵

4.4.2 Specialised legislation on equality and non-discrimination

There is no special legislation in place in Botswana that guarantees the right to equality and non-discrimination.

In 1995, Ditshwanelo, the Botswana Centre for Human Rights, in collaboration with the Botswana Red Cross Society, released the *Botswana HIV/AIDS and Human Rights Charter*. This *Charter* was revised in 2002 and was launched on 10 December 2002 (Human Rights Day). The *Charter* is not a legal document, but rather is a statement of the aspirations of PLWHAs in Botswana. According to the *Charter*, people living with HIV/AIDS have, amongst others, the right:

- to a family, to marry and to have children;
- to have a full life, respect and dignity without being segregated, condemned or shunned;

71 See page 13 of the Botswana *National Policy on HIV/AIDS 2002*.

72 Page 17 of the *National Strategic Plan*.

73 Pages 11–12 of the *Draft Health Sector Plan April 2003–March 2005*.

74 See <http://www.securethefuture.com/program/data/032101.html>. Accessed: 11 February 2003.

75 *Unity Dow v The Attorney-General* Civil Appeal No 4 of 1991. See also OK Dingake AIDS and Human Rights in Botswana, page 9.

- to be tested only with their consent;
- to appropriate education on HIV/AIDS and prevention methods;
- to equal access to all public facilities, e.g. schools, health care, and social welfare; and
- to equal employment benefits and rights such as education and training and promotion.

The *Draft Health Sector Plan April 2003 – March 2005*, stipulates: “Stigma can also compromise quality of care by perpetuating negative practices among health workers, such as neglect and poor treatment of PLWHAs. Stigma reduction is therefore both a human rights and public health issue.”⁷⁶ The Ministry of Health’s proposed strategies to address stigma will be integrated into the existing programmes dealing with PMTCT, ARVs and TB. Furthermore, strategies will focus on the inclusion of capacity building and strengthening the greater involvement of PLWHA to fight stigma at all levels in the continuum of care.

In achieving the objective of “developing specific programmes to address stigma and discrimination”, the *Health Sector Plan* lists the following interventions:⁷⁷

- Conduct a study on stigma in the health sector.
- Conduct a workshop to disseminate the results of the study.
- Design and develop intervention programmes on stigma and discrimination.
- Organise a stigma week.

Despite the inclusion of stigma as a facet of discrimination within the proposed strategies, the right to equality and non-discrimination remains vulnerable. These rights are especially susceptible to abuse and need formal protection.

4.5 Labour rights

4.5.1 HIV/AIDS in the workplace

The *Employment Act*, as well as the *Trade Dispute Act: Cap 48:02*, are silent on the issue of HIV/AIDS. Thus, there is a dependence on the provisions of the common law and the *Constitution*.⁷⁸ No general policy exists to address the issue of pre-employment HIV testing and this is even more problematic because labour law in Botswana does not cover job seekers or job applicants.

The *Trade Dispute Act* (amended by Parliament) established an Industrial Court, which has exclusive jurisdiction over a wide range of labour matters. The Industrial Court is the most likely avenue for redress for an employee with HIV/AIDS who is discriminated against. The only case of discrimination/unfair dismissal that was brought by an employee with HIV to the Industrial Court was not decided because, unfortunately, the employee died.⁷⁹

The Ministry of Labour and Home Affairs’ strategic medium-term actions include the following strategies:

- to protect the employment rights of PLWHA in association with its partners such as BONE-LA and the Attorney General’s Chambers;
- to mainstream HIV/AIDS into the National Industrial Relations Code of Practice; and
- in association with BONELA and AG’s Chambers, to review and revise legislation regarding immigration and discriminatory practices, e.g. mandatory HIV/AIDS testing of foreigners seeking employment and/or residence in Botswana.⁸⁰

In July 2001, the Directorate of Public Service Management (DPSM) published the *Public Service Code of Conduct on HIV/AIDS in the Workplace*. The *Code* stipulates the rights, responsibilities and obligations of both public sector employers and employees in accordance with the Botswana *National AIDS Policy*, with respect to the public officer’s performance, public service productivity and the protection of individuals from the impact of HIV/AIDS. In terms of the

⁷⁶ Section 2.18 of the *Draft Plan*, page 13.

⁷⁷ See page 36 of the *Draft Plan*.

⁷⁸ Specifically Section 3 (dealing with fundamental rights and freedoms of the individual), Section 15 (dealing with grounds for non-discrimination) and Section 13 (on the protection of freedom of assembly and association).

⁷⁹ The President of the Industrial Court, J De Villiers, indicated at a seminar held in October 2002 that since that abandoned case, no other case has come before the Court.

⁸⁰ *National Strategic Plan for HIV/AIDS 2003–2009*.

Code, all ministries and departments are required to integrate the management of HIV/AIDS in the workplace into ongoing activities. Management is given the responsibility to create an environment in the workplace that is non-discriminatory for HIV/AIDS-infected employees. With regard to an officer's HIV status, the *Code* stipulates that it shall not be a factor in job status, promotion or transfer.

According to Section 6.4 of the *Botswana National Policy on HIV/AIDS (2002 Version)*, the DPSM should facilitate the adoption of the *Code* and monitor its implementation. The 2002 *Policy* further lists some basic principles that should apply to HIV/AIDS and employment:⁸¹

1. Being infected with HIV should not be a reason to dismiss an employee or to declare an individual unfit for employment. All workers should be treated equally.
2. Workers who are HIV positive should be treated the same as all other employees and should be retained in employment as long as they are medically fit to work.
3. HIV-infected employees should have access to and receive standard social security and occupationally related benefits.
4. Persons with HIV/AIDS should be protected against stigmatisation and discrimination in the workplace by colleagues, employers, unions and/or clients. Organisations should include aspects of this protection in workplace AIDS education and information programmes.
5. Employees should have access in the workplace to information and educational programmes on HIV/AIDS and STDs, as well as referrals for appropriate counselling and medical care.

4.5.2 HIV/AIDS and medical schemes

The government does not regulate medical aid schemes in Botswana. Most employers offer their employees the option of joining any of the available private medical aid schemes. The treatment of employees living with HIV/AIDS is dependent on the rules of the individual schemes. Botswana Medical Aid (BOMAID), for instance, has a provision called "dreaded disease scheme" under which a patient who has been certified by his/her doctor may obtain drugs directly from the dispensary at BOMAID up to a designated maximum amount.

⁸¹ See page 21 Section 6.4 of the 2002 *Policy*.

⁸² Interview held in December 2002 with Mavis Rakhudu, Assistant General Manager of Operations, Botswana Life Insurance Limited.

⁸³ *National Strategic Plan on HIV/AIDS 2003–2009*, page 31.

4.5.3 Insurance and HIV/AIDS

There is no law regulating the granting of life insurance to people who test HIV positive in Botswana. The *Insurance Industry Act Cap 46:01* does not make any provision for HIV/AIDS. It appears that insurance companies require an HIV test for those wanting coverage. If the results of the test reveal that the applicant is HIV positive, the application for life insurance is either rejected or a higher premium is imposed. Botswana Life Insurance Limited⁸² states that their practice in relation to PLHAs is as follows:

- There is no compulsory test for HIV. Where clients opt for the HIV test, pre- and post-test counselling is provided at the expense of the company, irrespective of the test result.
- One underwriter receives all medical reports and all reports are kept confidential.
- The personal doctor of the client or a preferred doctor of the client relates the results.
- For those clients who test HIV positive, Botswana Life has alternative policies that clients can opt for instead of a life cover policy. Alternatively, clients may obtain life cover on more expensive terms on a full underwriting basis.
- Life cover could still be obtained without undergoing an HIV test but the premiums for this policy are much higher.

The Ministry of Finance and Development Planning is supposed to be working together with BONELA and the insurance industry to address the issue of restrictions on PLHAs applying for life insurance.⁸³

4.6 Gender rights

4.6.1 Legal status of women and the role of cultural practices

Section 15 of the Botswana *Constitution* deals with non-discrimination. However, it does not mention gender or sex specifically.⁸⁴ The *Constitution* guarantees women equal rights with men. The landmark decision of the Court of Appeal in *Attorney General v. Dow (supra)* in 1992 has

⁸⁴ This, according to Dingake, does not necessarily mean discrimination on these grounds will be permitted because discrimination that is irrational and unfair has been deemed unacceptable by the Courts.

affirmed this position. The interpretation of Section 3 of the Botswana *Constitution* in the *Dow* case has the effect of indirectly adding “equality” and “equal protection” to the wording of Section 3.⁸⁵

There are customary laws and traditions in the country that place women in an unequal and vulnerable position and therefore increase their risk of HIV infection. For example, the practice of *bojale* (female circumcision), which is on the decrease, places woman at risk. Under the civil law system, there are vestiges of laws that discriminate against women, especially in the realm of marriage. For example, a woman married in community of property lacks legal capacity to act on her own as her husband is regarded as her legal guardian. Under customary law, women are discriminated against in terms of inheritance, property rights and access to land. The potential polygamous nature of customary marriage often inflicts economic hardship on women. A wife has little or no influence on her husband’s decision to marry another woman. Even where a husband does not marry another wife, his infidelity is generally tolerated, whereas a wife’s infidelity constitutes grounds for divorce. The institution of *bogadi* (bridewealth/*lobola*) by which the husband/his family gives the family of the wife some gift, usually in the form of cattle, as part of the marriage ceremony, confers on the husband further control. For example, the payment of *bogadi* transfers the woman’s reproductive powers to the husband’s family and limits the rights of the wife over their children when the marriage ends in divorce or by death. These have not been challenged in Court and there have been no concerted efforts to change them.

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

The Botswana *National Policy on HIV/AIDS* states that the prevention of sexual transmission of HIV is a key component of strategies for control and specifically mentions in this regard: “the promotion of gender equality in all spheres of national and community life, to enhance women’s social and economic status and empower them for more effective participation in decision making about safer sex.”⁸⁶ Section 6.5 of the 2002 *Policy* states the following: “A com-

prehensive review of the impact of current laws on women will be done to define appropriate formulation and enforcement of laws that effectively empower women to negotiate safer sexual practices.”

The *National Strategic Plan for HIV/AIDS 2003-2009* identifies the following goal as necessary to achieve the objective of strengthening the legal and ethical environment in order to protect the rights of all people in Botswana in relation to HIV/AIDS: “To support legal reform and enforcement of laws addressing the issues of rape and sexual violence in Botswana and educate vulnerable groups (men and women) on relevant behavioural change.”⁸⁷ The *National Strategic Plan* thus limits priority action to specific issues of rape and sexual violence without addressing gender vulnerability to infection and HIV/AIDS.

The *Penal Code (Amendment) Act of 1998* makes provision for a minimum sentence for convicted rapists of 10 years’ imprisonment and a maximum sentence of life imprisonment. It also provides that where the rape is committed with violence resulting in injury to the victim, the convicted rapist shall be sentenced to a minimum term of 15 years’ imprisonment or a maximum term of life imprisonment. Furthermore, all convicted rapists must undergo an HIV test before they are sentenced. Where the result is positive, and it is shown that the convicted rapist was unaware of being HIV positive at the time of the rape, the rapist is sentenced to a minimum term of 15 years’ imprisonment or a maximum term of life imprisonment with corporal punishment. Where it is shown on a balance of probabilities that such a person was aware of being HIV positive, the sentence is a minimum term of 20 years’ imprisonment and a maximum term of life imprisonment with corporal punishment. The admissibility of test results has been criticised by the courts. The Court of Appeal has had occasion to criticise the manner in which the result of the HIV test is admissible in the trial in the following cases: *Qam Nqubi v. The State* Crim. App. No. 49/2000 (31 January 2001); *Shima Matlapeng v. The State* Crim. App. No. 45/2000 (31 January 2001); and *Lefang Gare v. The State* Crim. App. No. 48/2000 (31 January 2001).

⁸⁵ See the discussion on the status of women in Botswana public law in the *Report on a Review of all Laws Affecting the Status of Women in Botswana* by the Department of Women’s Affairs in the Ministry of Labour and Home Affairs, September 1998, page 3.

⁸⁶ See page 9 of the *National Policy*.

⁸⁷ See page 18 of the *Strategic Plan*.

4.6.3 Administering ARVs to rape survivors

The *ARV Guidelines 2002* specify that a person who has been sexually assaulted and comes forward within 48 hours, should be offered post-exposure prophylaxis (PEP) and should be counselled to undergo an HIV test. If the result is positive, the PEP should be discontinued and appropriate counselling provided. If the test is negative, PEP should be continued for one month with follow up.

4.6.4 Commercial sex workers

Sex work is considered an offence against morality under the *Penal Code (Amendment) Act of 1998*. There is no movement in Botswana towards the decriminalisation of sex work.⁸⁸ Prostitutes cannot freely access HIV/AIDS education, condoms, counselling or testing facilities.

4.6.5 Homosexuality and HIV/AIDS

The *Penal Code* criminalises same sex relationships.⁸⁹ Section 164 provides as follows: “Any person who – (a) has carnal knowledge of any person against the order of nature; ... (c) permits a male person to have carnal knowledge of him or her against the order of nature; is guilty of an offence and is liable to imprisonment for a term not exceeding seven years.” In a recent High Court judgment,⁹⁰ Sections 164 and 167 dealing with unnatural offences and indecent practices between males were upheld.

Section 6.5 of the *Botswana National Policy on HIV/AIDS* states: “Homosexuality remains a criminal offence in Botswana’s criminal code. While this denies homosexuals of some of their constitutional rights it also robs public health managers and policy-makers of the opportunity to reach out to them with proven means of HIV prevention like condoms. Laws that pay attention to the rights of homosexuals should be passed to enable access to effective HIV/AIDS intervention.”⁹¹

Thus, the National Policy on HIV/AIDS calls for legislative reform and the decriminalisation of homosexuality in the light of the HIV/AIDS epidemic, whereas the judiciary has reinforced the constitutionality of criminal legislation outlawing homosexuality.

4.7 Children’s rights

4.7.1 Health care, orphans and HIV/AIDS

The *Constitution* of Botswana does not mention children specifically. It does, however, state in Section 3 that: “every person in Botswana is entitled to the fundamental rights and freedoms of the individual.” Apart from the rights guaranteed in the *Constitution*, the *Children’s Act: Cap 28:04* deals specifically with the rights and interests of children. The Government’s *AIDS Policy* provides that children living with AIDS have access to health-care facilities.

The Botswana government conceptualised a prevention of-mother-to-child transmission (PMTCT) programme in 1998, which was launched in April 1999 in the cities of Gaborone and Francistown. Expansion to other areas of the country started in July 1999 and was completed in November 2000. Services include counselling, blood testing, educating women on PMTCT, tracing partners, monitoring to 34 weeks, and referrals to hospital.

Children have access to anti-retroviral drug therapy at the government’s expense. ARVs are available through the PMTCT programme and through the anti-retroviral drug therapy programme. In March 1999, the Social Welfare Division of the Ministry of Local Government Lands and Housing published the *Short Term Plan of Action On Care Of Orphans in Botswana 1999-2001*. The *Plan*, which is still being implemented, is aimed at meeting the immediate needs of orphans, defined as the basic survival needs such as food,⁹² clothing and shelter, as well as psychosocial support, care, protection, access to health services and education. The *Plan* specifically mentions the violation of human rights of orphans by society and caregivers as an issue.

The *Plan* also identifies six priority areas of intervention for orphan care and support:

- policy development – creating an enabling environment;
- institutional capacity building and strengthening;
- delivery of social welfare and other essential orphan support services;

⁸⁸ The following Sections deal with prostitution: 149, 155, 156, 157, 158.

⁸⁹ Sections 164, 165, and 167.

⁹⁰ *Kanani v. State*, Criminal Trial No. F94/1995, Judgment delivered on 22 March 2002.

⁹¹ See page 22 of the 2002 *Policy*.

⁹² Registered AIDS orphans are provided with monthly food baskets under the guidance provided in the *Short Term Plan of Action*.

- support to community based initiatives;
- co-ordination and management; and
- monitoring and evaluation.

Further, the 2002 National Policy on HIV/AIDS requires the Ministry of Local Government:

- to revise criteria for eligibility for destitute support to enable families caring for people with AIDS and orphaned children access to bring such support in line with the *National Destitute Policy*; and
- to develop programmes and mechanisms for the provision of welfare support to ensure that the basic needs of orphans and vulnerable children are met.⁹³

4.7.2 HIV/AIDS and the educational system

In Botswana, the right to education is not constitutionally enshrined. The *Education Act: Cap 88:01* sets the commencement age for schooling at seven years, but does not make school attendance compulsory. Provision for children with HIV/AIDS is made in a number of policy documents, such as the *Policy on HIV/AIDS Education*, the *National Strategic Plan for HIV/AIDS 2003-2009* and the *2002 National Policy on HIV/AIDS*.

In September 1998, the Botswana Ministry of Education released its *Policy on HIV/AIDS Education*. According to the *Policy*: “The ministry has a major responsibility to reduce the spread of HIV infection by addressing HIV/AIDS in its education programmes. This is done through infusion and integration of HIV/AIDS issues in the school curriculum and related training of the teaching force. This will result in the reinforcement of concepts on HIV/AIDS across all subject areas.”⁹⁴

According to the *Policy*, HIV/AIDS education must be integrated into the curriculum and should be made compulsory at all levels of education from primary schools to teacher training institutions. The guidelines further stipulate counselling for AIDS prevention and that AIDS-related social problems should be a component of the training programme for guidance and

counselling teachers. In reference to non-discrimination, the *Policy* states the following: “Students, trainees, staff and all Ministry of Education employees with HIV/AIDS or from families with infected members should not be discriminated against and should remain in school/college/employment for as long as their health permits, and should be referred for support and care to appropriate institutions as the need arises.”

As part of the Ministry of Education’s strategic medium term actions as contained in the *National Strategic Plan for HIV/AIDS for 2003-2009*, the following goals are set:

- to expand education around human rights issues, especially as they relate to PLWHA in both formal and non-formal settings;
- to facilitate development of policy concerning access to condoms for youth;⁹⁵ and
- to oversee the implementation of sex education within the educational system.

In terms of the 2002 *National Policy on HIV/AIDS*, the Ministry of Education is also required to focus on the following: (a) the integration of AIDS and STD education into all levels and institutions of education, starting at primary school level, and extending to tertiary, teacher training and non-formal institutions; (b) involvement of parents, through parent-teacher associations and other appropriate mechanisms, in discussions of school-based HIV/AIDS education; and (c) ensuring that other services related to HIV and STD control and care are accessible to students in need. In addition to the responsibilities of the Ministry of Education, the Ministry of Local Government Lands and Housing is responsible for ensuring access to education for orphans in terms of the *Short Term Plan of Action on Care of Orphans in Botswana 1999-2001*.⁹⁶ The *Short Term Plan of Action* mentions that HIV/AIDS orphans are continually stigmatised, marginalised and sometimes isolated and rejected, not only by other students but also by teachers. The *Short Term Plan of Action* sets out activities to relieve the burden on AIDS orphans. These activities include the use of the *Education Act* to waive school fees and costs for needy orphans.

There is an increasing awareness of the need to take the special needs of HIV-positive children into account within the educational system. Teacher training colleges are taking steps to make

⁹³ See Section 4.12 of the *National Policy*, page 13.

⁹⁴ Foreword to the *Policy on HIV/AIDS Education*.

⁹⁵ *National Strategic Plan for HIV/AIDS 2003-2009*, page 30.

⁹⁶ The *Short Term Plan of Action* mentions that orphans continue to be sent home because of the lack of appropriate school uniforms, shoes and other miscellaneous school costs.

trainee teachers aware of these special needs. The Nursing Department provides a course entitled HIV/AIDS Education, Prevention and Control. The course is designed to sensitise students to the needs of HIV- positive children. These type of interventions need to be made in all departments.

To date, no case has come into the public domain in which a child has been denied access to education on the basis of his/her HIV status. However, some organisations that sponsor students for higher education do have policies requiring an HIV test before a sponsorship is granted. If the applicant tests positive, he/she does not qualify for the scholarship. The government does not deny applicants scholarships on the basis of HIV status; students are however encouraged to seek voluntary counselling and testing.

4.8 Criminal law and HIV/AIDS

Section 11 of the *Public Health Act 1971* deals with deliberate attempts to infect others with any communicable disease. The provision is limited to the spreading of the communicable disease in any street, public place, shop or public convenience. There is no similar provision in the Penal Code.

The *Penal Code (Amendment) Act No. 5 of 1998* amended the definition of the crime of rape (Section 141), and introduced minimum and maximum sentencing for rape, and the requirement for compulsory HIV testing for all convicted rapists before sentencing (Section 142).⁹⁷ Section 147 of the amended *Act* makes provision for harsher sentencing of any person who unlawfully and carnally knows any person under the age of 16 years and tests HIV positive before being sentenced.

⁹⁷ Section 142(3) reads as follows: "Any person convicted of the offence of rape shall be required to undergo a HIV test before he or she is sentenced by the court." Section 142(4)(a) continues by stating that: "Any person who is convicted under subsection (1) or subsection (2) and whose test for the Human Immuno-deficiency Virus under subsection (3) if positive shall be sentenced: (a) to a maximum term of 15 years' imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that such person was unaware of being HIV positive; or (b) to a minimum term of 20 years' imprisonment or to a maximum term of

4.9 HIV/AIDS and prisons

The Ministry of Labour and Home Affairs' activities include: "advocating for a national forum to discuss decongestion, condoms in prison and access to VCT by the prison community as national priorities."⁹⁸

HIV/AIDS awareness and education campaigns are conducted amongst prisoners with particular emphasis on risk behaviour, use of bleach for infection control, and the establishment of health committees whose members are prison officers and inmates. There are a number of policies on addressing HIV/AIDS in prisons such as the *National Policy on HIV Testing and Education in Prisons*, the *Health Care Delivery Policy*, a *Policy on HIV/AIDS/STDs for Inmates* and a *HIV/AIDS Policy and Procedure Manual for Prison Staff and their Families*. HIV testing of prisoners is not mandatory and there are, therefore, no reliable statistics on the number of prisoners that are HIV positive. The HIV status of prisoners is kept confidential and no attempt is made to keep them separate from other prisoners. Prisoners have the same access to anti-retroviral drugs as the general population.⁹⁹

life imprisonment with corporal punishment, where it is proved that on a balance of probabilities such person was aware of being HIV positive."

⁹⁸ *National Strategic Plan for HIV/AIDS 2003–2009*, page 29.

⁹⁹ Information gathered during an interview held with HR Kau, the Commissioner of Prisons and Rehabilitation, Gaborone, Botswana 12 December 2002.

5. CONCLUSIONS AND RECOMMENDATIONS

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

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

Three general trends should be highlighted:

- Firstly, the HIV/AIDS responses in the various countries from the reporting of the first case in the mid-1980s has followed a very similar approach. Initially, in each country the Ministry of Health co-ordinated the response through a short-term plan, which focused mainly on issues of blood screening. This was followed by one or more medium-term plans in the mid-to late 1990s, ultimately heralding the multi-sectoral approach adopted by all the countries by the end of the 1990s. Thus, all eight countries adopted national strategic frameworks on HIV/AIDS and all except South Africa, Namibia and Mozambique adopted further national policies on HIV/AIDS to give effect to the goals in the strategic frameworks. To varying degrees, this development from short-term plans to multi-sectoral strategic frameworks was also accompanied by a gradual inclusion of human rights provisions in the HIV/AIDS discourse. This coincided with an overall trend in the SADC countries to adopt new constitutions with a bill of rights. For example, new constitutions were adopted by Namibia in 1990, and by both South Africa and Malawi in 1994.
- Secondly, the legislative frameworks analysed indicate overwhelmingly that in addressing the HIV/AIDS epidemic, and affording protection to the rights of those affected or infected, states elect to respond by introducing policies, codes or guidelines, rather than legislation. This means that government interventions are not legally binding and generally cannot be enforced in the courts. Thus, people living with or affected by HIV/AIDS have few specific enforceable rights. Obligations with respect to human rights are further minimalised by states' reluctance to transform ratified human rights treaties into domestic legislation.
- Thirdly, where legislation does address HIV/AIDS issues, it tends to be limited to the areas of criminal law and labour law. Countries are inclined to promulgate criminal laws that try to "contain" the disease based on a model of "control" over the spread of the disease. Botswana, Namibia, South Africa and Zimbabwe have amended their criminal laws to provide for harsher sentencing of HIV-positive sexual offenders, whilst Zimbabwe has also criminalised the deliberate transmission of HIV. Swaziland and Zambia have declared that they will follow suit in the near future. With the exception of South Africa (in relation to homosexuality), governments have targeted homosexuals and commercial sex workers, groups that are already stigmatised in society, by criminalising their behaviour. In terms of labour legislation, governments have attempted to secure economic stability by focusing on the "economic active," people between the ages of 19 and 45 years, which is the age group that is hardest hit by the epidemic. Mozambique, Namibia, South Africa and Zimbabwe have adopted workplace legislation that outlaws discrimination on the basis of HIV status, prohibits pre-employment testing and secures medical benefits for HIV-positive employees. These efforts with respect

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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