

Swazi Women's right to health during the time of COVID-19

Recommendations to ensure
enjoyment of the highest attainable
standard of physical and mental
health



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1. INTRODUCTION

Eswatini is a monarchy.¹ Under its Constitution, customary law, except insofar as it is inconsistent with the former, is recognized as part of Eswatini's legal system in addition to common law and statutory law.² Eswatini is party to several binding international,³ including regional, human rights treaties guaranteeing the right to health, including sexual and reproductive health, for everyone, including women and girls.⁴ These international conventions require Eswatini to respect, protect and fulfil human rights without discrimination on any grounds prohibited by international human rights law, such as age, sex, sex characteristics, gender, sexual orientation, gender identity, gender expression, race, colour, national or social origin, ethnicity, migration status, property, birth or inheritance, language, religion or belief, political or other opinion, health status – including HIV status and drug use – disability, economic, minority, indigenous or other status.

However, according to Eswatini's Constitution, "unless it is self-executing, an international agreement becomes law in Swaziland only when enacted into law by Parliament".⁵ In addition, while various treaties binding on Eswatini guarantee the right to health, the country's Constitution does not enshrine it as an enforceable right, but lists the right to health as a "directive principle of state policy" committing Eswatini to "take all practical measures to ensure the provision of basic health care services to the population".⁶ More generally, economic, social and cultural rights (ESCR) are omitted from the Swazi Constitution. This complicates the full recognition and enforcement of ESCR by courts. Furthermore, while the Constitution provides for specific protection for the welfare of women, the provision is couched in weak language that also complicates enforcement efforts.⁷

Irrespective of the protections afforded in Eswatini's domestic legal system, as a matter of international human rights law, Eswatini is bound to fulfil its obligations to realize the right to health, including sexual and reproductive health. This is because, in accordance with Vienna Convention on the Law of Treaties, a State may not invoke its domestic law as justification for its failure to perform its international legal obligations.⁸ In context of ESCR, in particular, Eswatini is required to ensure that "at a minimum" judges are empowered to "interpret domestic law consistently with the States obligations under the ICESCR", for example;⁹ and while the COVID-19 pandemic has placed significant pressure on its health system, Eswatini remains obliged to ensure the right to health, including full enjoyment of the right to sexual and reproductive health.

In addition to being a party to the above-mentioned human rights treaties, Eswatini has adopted certain domestic policies with a view to aligning its domestic framework with additional instruments, such as the Maputo Plan of Action and the AU Continental Policy Framework on Sexual

¹ The Government of The Kingdom of Eswatini, Governance, available at <http://www.gov.sz/index.php/about-us-sp-15933109/governance>

² The Constitution of the Kingdom of Swaziland, Act 2005, Section 252(2)

³ Under international law, a State that ratifies or accedes to a treaty indicates its consent to be bound by its provisions. Vienna Convention on the Law of Treaties 1969, Articles 10, 18, 2(1)(b) and 16.

⁴ See Addendum B below.

⁵ The Constitution of the Kingdom of Swaziland, Act 2005, section 238(4)

⁶ Id, Chapter V, section 60(8)

⁷ Id, Section 28

⁸ Vienna Convention on the Law of Treaties 1969, Article 27 and Article 46 which reads in full: "INTERNAL LAW AND OBSERVANCE OF TREATIES A party may not invoke the provisions of its internal law as justification for its failure to perform a treaty. This rule is without prejudice to article 46." Article 46 reads: "Article 46. PROVISIONS OF INTERNAL LAW REGARDING COMPETENCE TO CONCLUDE TREATIES

1. A State may not invoke the fact that its consent to be bound by a treaty has been expressed in violation of a provision of its internal law regarding competence to conclude treaties as invalidating its consent unless that violation was manifest and concerned a rule of its internal law of fundamental importance. 2. A violation is manifest if it would be objectively evident to any State conducting itself in the matter in accordance with normal practice and in good faith."

⁹ ICJ, Practitioners Guide on Adjudicating Economic, Social and Cultural Rights at National Level, No.8" (2014), p. 28 available at: <https://www.icj.org/wp-content/uploads/2015/07/Universal-ESCR-PG-no8-Publications-Practitioners-guide-2014-eng.pdf>,

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Reproductive Health and Rights.¹⁰ Eswatini has enacted legal and policy frameworks aiming to protect women's human rights, such as the Sexual Offences and Domestic Violence Act (SODV Act),¹¹ which advances already existing protections against gender-based violence. However, there is still scope for Eswatini to adopt additional, much needed measures to improve the protection of women and girls' human rights by, for example, repealing discriminatory laws and enacting laws that afford enhanced protection to women's human rights. Moreover, in practice, Eswatini also records alarmingly high levels of gender-based violence,¹² which, in turn, significantly undermines women's ability to exercise a wide range of human rights, including their right to the highest attainable standard of health, including sexual and reproductive health.

Indeed, in reality, several challenges continue to jeopardize Swazi women's access to, equal enjoyment and exercise of their right to health.¹³ For one, the continued existence of discriminatory laws, such as legal provisions prohibiting abortion (see below) and colonial era sodomy laws,¹⁴ increases stigma against women and violates their sexual and reproductive rights. Albeit Eswatini courts have sometimes struck down laws in violation of the prohibition on non-discrimination based on sex, progress remains slow and legal protection limited.¹⁵

In this context, Swazi women face challenges in accessing key sexual and reproductive healthcare, goods and services, such as safe and legal abortion and access to contraceptives.¹⁶ The

¹⁰ The Kingdom of Swaziland- Ministry of Health, National Policy on Sexual and Reproductive Health (2013) p15, available at: <https://abortion-policies.srhr.org/documents/countries/02-Swaziland-National-Policy-on-Sexual-and-Reproductive-Health-2013.pdf>

¹¹ The Sexual Offences and Domestic Violence Act No 15 of 2018, available at: <https://www.ilo.org/dyn/natlex/docs/SERIAL/108709/134536/F1384531235/SWZ108709%20Eng.pdf>

¹² "In Eswatini, rates of GBV, violence against children and child sexual assault are alarmingly high...In Eswatini, it is expected that one in three Swazi girls will experience some form of sexual violence by the time they are 18 years old, while almost half of Swazi women will experience some form of sexual violence over their lifetime." SWAAGA, Gender Based Violence, available at: <http://www.swagaa.org.sz/gender-based-violence/> In its 2017 Concluding Observation on Swaziland, the Human Rights Committee expressed concern "at reports of widespread violence against women and children, in particular sexual violence, including rape, and that relevant officials lack specific training on gender based violence." UN Human Rights Committee, Concluding Observations on Swaziland in the absence of a report, 23 August 2017, available at:

<https://www.ohchr.org/en/countries/africaregion/pages/szindex.aspx> The CEDAW Committee has also expressed concern that the prevalence of violence against women and girls is high as is the rate of abduction of young girls, often by persons known to the victims." CEDAW Committee, Concluding observations on the combined initial and second periodic reports of Swaziland, 24 July 2014, available at: <https://www.ohchr.org/en/countries/africaregion/pages/szindex.aspx>; See also ICJ, Access to Justice Challenges Faced by Victims and Survivors of Sexual and Gender-Based Violence in Eswatini, March 2020, available at: <https://www.icj.org/wp-content/uploads/2020/09/Eswatini-SGBV-Report-Advocacy-Analysis-brief-2020-ENG.pdf>

¹³ References to woman or women throughout this document should be understood to include girl/s unless otherwise specified

¹⁴ Desktop research does not reveal primary source materials indicating the legal status of same-sex sexual conduct. However, secondary sources indicate that sodomy is a common law crime in Eswatini. The Swazi Penal Code contains the crime of Sodomy. However, no penalty is specified. Furthermore, the law does not prohibit discrimination based on sexual orientation. The Human Rights Committee expressed concern that "discrimination on the basis of sexual orientation and gender identity is not clearly prohibited under the Constitution, or in the State party's domestic law. It is also concerned at reports that reveal that lesbian, gay, bisexual, transgender and intersex persons frequently face discrimination, particularly in accessing adequate housing and employment. It is further concerned about reports of violence against lesbian, gay, bisexual, transgender and intersex persons, including the murder of two individuals directly linked to their sexual orientation and the rape of a gay man in detention. While noting the State party's position that the common law criminalization of same sex relations between men (sodomy) is not enforced in practice, the Committee is concerned at the State party's current intention to retain the law, and at the law's continued discriminatory effect on lesbian, gay, bisexual, transgender and intersex persons." The Committee further recommended that Eswatini repeal the common law crime of sodomy and criminalize the rape of men, forthwith. UN Human Rights Committee, Concluding observations on Swaziland in the absence of a report, CCPR/c/swz/co/1 (23 August 2017) para 18 and para 19(e), available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR/C/SWZ/CO/1&Lang=En; See also The Kingdom of Eswatini State report (2018), available at: https://www.state.gov/wp-content/uploads/2019/03/Eswatini-2018.pdf_pg18; See also Human Dignity Trust, Eswatini Country Profile, available at: <https://www.humandignitytrust.org/country-profile/eswatini/>

¹⁵ For example, *Sacolo and Women & Law Southern Africa-Swaziland v Sacolo, Ministry of Justice and Constitutional Affairs and Attorney General* (1403/16) [2019] SZHC (166) where the court abolished the common law doctrine of marital power on the ground that it discriminates against women and offends their constitutional right to dignity and equality. See also *Sihlongonyane v Sihlongonyane*, 2013 SZHC 207 which held that marital power unfairly discriminates based on sex and adversely affects women; See also *Attorney General v Doo Aphane*, 2010 SZSC 32 where the court declared unconstitutional a provision which prohibited women married in community of property from registering immovable property in their own name. See also *R v Shabangu* [2007] SZHC 47 where the court declared the 'cautionary rule' in rape cases, arbitrary and discriminatory towards women.

¹⁶ Abortion is unlawful in Eswatini except in circumstances specified by The Constitution of the Kingdom of Swaziland, Act 2005, section 15(5). Eswatini is yet to enact legislation implementing article 15 of the Constitution. The UN Human Rights Committee has expressed "Concern about the lack of clarity regarding the circumstances in which voluntary termination of pregnancy is legally available, and that the State party has not yet adopted the legislation as provided under article 15 of the Constitution." UN Human Rights Committee, Concluding Observations on Swaziland in the absence of a report, CCPR/C/SWZ/CO/1, (23 August 2017) para 28, available at: <https://www.ohchr.org/en/countries/africaregion/pages/szindex.aspx> See also, The Kingdom of Swaziland –

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Constitution of Swaziland prohibits abortion except in circumstances where a doctor certifies that exceptional circumstances exist that warrant permitting it.¹⁷ The Constitution does, however, more broadly permit abortion "on such other ground as Parliament may prescribe", thereby empowering Eswatini's Parliament to enact legal measures to protect women's sexual and reproductive health rights by permitting abortion in larger range of instances. To this date, however, no such legislation on abortion has been enacted.¹⁸

In addition, the HIV/AIDS epidemic has had a disproportionately detrimental impact on women, who, for example, face particular challenges in accessing HIV treatment.¹⁹ Finally, as in many parts of the world, generally speaking, the COVID-19 pandemic has exacerbated the human rights violations to which women are subjected, including with respect to their exercise of their right to sexual and reproductive health.

The purpose of this document is to assess whether Eswatini has met its human rights obligations under international human rights law with respect to women and girls' right to health, including sexual and reproductive health. It concludes with recommendations to the Eswatini authorities on how they may improve the ability of women and girls to fully and equally benefit from and enjoy these and other human rights without discrimination.

Ministry of Health, National Policy on Sexual and Reproductive Health (2013): "Abortion is only permitted in the country based only on medical or therapeutic grounds including where the pregnancy resulted from rape, incest or unlawful sexual intercourse with a mentally challenged female and on such other grounds as per Constitution of Swaziland (2005)." See also The New Humanitarian, Illegal abortions endangering lives (14 November 2012), available at:

<https://www.thenewhumanitarian.org/news/2012/11/14/illegal-abortion-endangering-lives>

¹⁷ The Constitution of the Kingdom of Swaziland, Act 2005, section 15(5) provides:

"Abortion is unlawful but may be allowed –

- (a) on medical or therapeutic grounds including where a doctor certifies that
 - (i) continued pregnancy will endanger the life or constitute a serious threat to the physical health of the woman;
 - (ii) continued pregnancy will constitute a serious threat to the mental health of the woman;
 - (iii) there is serious risk that the child will suffer from physical or mental defect of such a nature that the child will be irreparably seriously handicapped;
- (b) where pregnancy resulted from rape, incest or unlawful sexual intercourse with a mentally retarded female; or
- (c) on such other ground as Parliament may prescribe.

¹⁸ The UN Human Rights Committee expressed concern about "the lack of clarity regarding the circumstances in which voluntary termination of pregnancy is legally available, and that the state party has not yet adopted the legislation as provided under article 15 of the Constitution" Human Rights Committee, Concluding Observations on Swaziland in the absence of a report, para 28, 23 August 2017, available at: <https://www.ohchr.org/en/countries/africaregion/pages/szindex.aspx>; Swazi Media Commentary, Swaziland High Court judge calls for debate on legalising abortion, 30 September 2020, available at: <https://swazimedia.blogspot.com/2020/09/swaziland-high-court-judge-calls-for.html> See also Genderindex.org, Kingdom of Eswatini, 2019, available at: <https://www.genderindex.org/wp-content/uploads/files/datasheets/2019/SZ.pdf>

¹⁹ Of the 210,000 people living with HIV in 2018, 120,000 were women. Within the entire population, 35% of all women are living with HIV, compared to 19.3% men UNAIDS, Eswatini, Data, 2019 available at :

<https://www.unaids.org/en/regionscountries/countries/swaziland> See also Avert, Global information and education HIV and AIDS, HIV and AIDS in Eswatini, 2019, available at: https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/swaziland#footnote8_wv19tpq

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2. **WOMEN'S RIGHT TO HEALTH UNDER INTERNATIONAL AND REGIONAL LAW**

Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) guarantees the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health".²⁰ Albeit the right to health enshrined in Article 12 of ICESCR does not secure an entitlement to "be healthy", the right to health guaranteed by this provision is a human right to a functioning "system of health protection" and "to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health".²¹ In addition to Article 12 of ICESCR, the right to health is also protected under a range of other binding international, including regional human rights treaties.²² A full list of the treaties ratified or acceded to by Eswatini protecting the right to health are available in ADDENDUM B.

In its General Comment No. 14: "The Right to the Highest Attainable Standard of Health (Art. 12)", the Committee on Economic, Social and Cultural Rights has clarified that it "interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health".²³ In turn, international human rights law, including ICESCR, enshrines and guarantees many such determinants of health as distinct human rights in their own terms, such as the rights to:

- access to safe and potable water;
- adequate sanitation;
- adequate food and nutrition;
- adequate housing;
- safe and healthy working conditions and environment,
- health related education and information; and

²⁰ International Covenant on Economic, Social and Cultural Rights (16 December 1966), United Nations, Treaty Series, vol. 993, p. 3, available at: <https://www.refworld.org/docid/3ae6b36c0.html>

²¹ The CESCR Committee has issued General Comment 14 on "The Right to the Highest Attainable Standard of Health" (General Comment 14), which gives more detailed content to States' obligations in terms of the right to health and the content of the right itself. See UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) E/C.12/2000/4 (11 August 2000), paras 8-9, available at: <https://www.refworld.org/docid/4538838d0.html> .

²² **The International Covenant on Civil and Political Rights** (16 December 1966) Article 6 (" 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"), p. 171, available at: <https://www.refworld.org/docid/3ae6b3aa0.html> , as interpreted by the Human Rights Committee in: UN Human Rights Committee, General comment no. 36, Article 6 (Right to Life), 3 September 2019, CCPR/C/GC/35, para 8, 25, 26, available at: <https://www.refworld.org/docid/5e5e75e04.html> . **The Convention on the Rights of the Child** (20 November 1989), Article 49, Article 24 (" States Parties recognize 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.") as interpreted by the CRC Committee in: UN Committee on the Rights of the Child (CRC), General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, CRC/C/GC/15, available at: <https://www.refworld.org/docid/51ef9e134.html> **The Convention on the Elimination of All Forms of Discrimination Against Women** (18 December 1979), Article 12 ("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") as interpreted by the CEDAW Committee in: UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), 1999, A/54/38/Rev.1, chap. Available at: <https://www.refworld.org/docid/453882a73.html> . **The Convention on the Rights of Persons with Disabilities**, A/RES/61/106, (24 January 2007) Article 25, available at: <https://www.refworld.org/docid/45f973632.html> ("States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability"). **African Charter on Human and Peoples' Rights ("Banjul Charter")** (27 June 1981) CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), Article 16 ("Every individual shall have the right to enjoy the best attainable state of physical and mental health") available at: <https://www.refworld.org/docid/3ae6b3630.html> . **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)** (11 July 2003), available at: https://au.int/sites/default/files/treaties/37077-treaty-charter_on_rights_of_women_in_africa.pdf

²³ UN Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (Art 12), para 11, 11 August 2000, available at: <https://www.refworld.org/pdfid/4538838d0.pdf>. See also para. 3 where CESCR has affirmed that "The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health."

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- effective protection from all forms of violence, torture and discrimination and other human rights violations that have a negative impact on the right health, including sexual and reproductive health.²⁴

Despite the fact that, "the right to sexual and reproductive health is an integral part of the right to health", women and girls are often denied access to, enjoyment and exercise of the right to sexual and reproductive health on an equal basis with men and boys.²⁵ The right to sexual and reproductive health includes, among other things:

"the right to make free and responsible decisions and choices; and the right to be free from violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health."²⁶

The right includes an entitlement to unhindered access to a range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual health²⁷ and reproductive health.²⁸

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa ("Maputo Protocol") explicitly provides for women's sexual and reproductive health rights,²⁹ and emphasizes that these rights include: "the right to exercise control over one's fertility, to decide one's maternity, the number of children and the spacing of births, and to choose a contraception method," and that such rights are "inextricably linked, interdependent and indivisible."³⁰ In addition, women have the right to "make personal decisions without interference from the State or non-state actors."³¹ In this regard, a woman's right to make such personal decisions "involves taking into account or not the beliefs, traditions, values and cultural or religious practices, and the right to question or ignore them."³²

The UN Office of the High Commissioner for Human Rights (OHCHR) and the World Health Organization (WHO) have emphasized that:

"the prevalence of poverty and economic dependence among women, their experience of violence, gender bias in the health system and society at large, discrimination on the grounds of race or other factors, limited power many women have over their sexual and reproductive lives and their lack of influence in decision-making are social realities which have an adverse impact on their health."³³

Such considerations have a particular resonance in the context of Eswatini, which ranks among the world's poorest nations.³⁴ Furthermore, the distribution of power based on sex and gender and

²⁴ UN Committee on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) (2 May 2016), para 7:

²⁵ UN Committee on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) (2 May 2016) E/C.12/GC/22, para 1: <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmIBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQeiF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxiHySkUoHMavD%2Fpyfcp3YlZq>

²⁶ Id, para 5

²⁷ Id, para 6 Sexual Health means "a state of physical, emotional, mental and social well-being in relation to sexuality"

²⁸ Id, para 6 Reproductive health means the capability to reproduce and the freedom to make informed, free and responsible decisions. It includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behavior.

²⁹ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) (11 July 2003), Articles 14.1.a), b) and c)

³⁰ African Commission on Human and Peoples' Rights, General Comment No.2 on Article 14.1 a), b), c) and f) and Article 14.2 a) and c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 23

³¹ Id, para 24

³² Id, para 24

³³ UN OHCHR and WHO, The Right to Health. Fact Sheet 31. p12, available at: <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

³⁴ The World Bank, Poverty headcount ratio at national poverty lines (% of population) – Eswatini, available at: <https://data.worldbank.org/indicator/SI.POV.NAHC?locations=SZ>

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systemic discrimination against girls and women are also important social determinants of health in Eswatini. Societal discrimination, which is often enshrined in laws and policies, produces negative impacts on sexual and reproductive health rights by limiting women and girls' ability to exercise autonomy with respect to their sexual and reproductive health.³⁵

Article 5 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) requires States parties to CEDAW, to take measures to:

"modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women".³⁶

In addition, State party to the Maputo Protocol, are required to "remove impediments to the health services reserved for women, including ideology or belief-based barriers."³⁷

A. Normative content of women's right to health under international human rights law

What are kind of legal obligations flow from the ICESCR?

ICESCR General Comment No.3 explains the nature of States Parties' Obligation under the Covenant:

In explaining the nature of the legal obligations undertaken by states parties when ratifying the ICESCR, the CESCR highlights that there are obligations of conduct and obligations of result under the Covenant. "In particular, while the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes various obligations which are of immediate effect."

The CESCR has clarified that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights incumbent upon every State party.

See ADDENDUM A below for examples of core obligations.

The CEDAW Committee explains that States parties have an obligation to take all necessary measures to respect, protect and fulfil women's right to healthcare. Failure to do so amounts to a violation of a State's legal obligations under CEDAW.³⁸ Similarly, the Maputo Protocol creates an obligations on States to respect, protect, fulfil and promote sexual and reproductive health rights under article 14.³⁹ The ICESCR also requires States to **respect, protect** and **fulfil** the right to health.

³⁵ Id, para 8:

³⁶ The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (3 September 1981), Article 5(a).

³⁷ African Commission on Human and Peoples' Rights, General Comment No.2 on Article 14.1 a), b), c) and f) and Article 14.2 a) and c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 25

³⁸ Id, para 13

³⁹ African Commission on Human and Peoples' Rights, General Comment No.2 on Article 14.1 a), b), c) and f) and Article 14.2 a) and c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 41

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"1) The obligation to **respect**, requiring States to refrain from measures or conduct that hinder or prevent the enjoyment of rights;
2) The obligation to **protect**, which requires States to act to prevent third parties, such as businesses or armed groups, from interfering with or impairing the enjoyment of these rights; and
3) the obligation to **fulfil** rights by taking positive measures towards their realization."

Though some right to health obligations are "progressively realizable" within the maximum of States resources, others are "immediate obligations". These include the obligations to:

- **Take Steps:** Take steps towards realizing the right to health in full;
- **Non-retrogression:** Avoid any retrogressive steps decreasing existing access to health;
- **Non-discrimination:** Ensure that health services, facilities and goods are available to all without discrimination;
- **Minimum Core Obligations:** Ensure access to at very least the "minimum essential level" of health services, facilities and goods.

These four obligations must be met immediately and are not "progressively realizable" irrespective of the resources available to a state. The "availability of resources", although an important qualifier to the obligation to take steps, "does not alter the immediacy of the obligation, nor can resource constraints alone justify inaction".⁴⁰ Even when resources are "demonstrably inadequate", it must still "ensure the widest possible enjoyment" of ESCR.⁴¹

The **obligation to take steps** includes any necessary measures to ensure that a larger number and wider range of people may access healthcare services over time. Such steps may include legislative, judicial, administrative, financial, educational and social measures.⁴²

The obligation of **non-retrogression** creates a strong presumption that any retrogressive measures, decreasing existing access to health facilities, goods and services are not permissible. States are required to show that such measures are taken as a last resort and after careful consideration of all alternatives.⁴³

The obligation of **non-discrimination** prohibits discrimination of any kind, including on the basis of health status, sexual orientation and gender identity, sex and marital status.⁴⁴ Existing and widespread "stigmatization of persons on the basis of their health status" exists globally and amounts to prohibited discrimination.⁴⁵ States must repeal laws and policies that are discriminatory in their effect and prevent women and girls from fully enjoying their rights to sexual and reproductive health. Accordingly, as an example, laws that criminalize abortion or restrictive abortion laws must be repealed.⁴⁶ This obligation will be discussed in more detail below under the section entitled *Non-discrimination*.

⁴⁰ UN Committee on Economic Social and Cultural rights, An Evaluation of the Obligation to Take Steps to the "Maximum of Available Resources" under an Optional Protocol to the Covenant, Committee on Economic, Social and Cultural Rights, E/C.12/2007/1, 2007, para 9.

⁴¹ Id.

⁴² Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (1997) para 6, available at: http://hrlibrary.umn.edu/instreet/Maastrichtguidelines_.html; Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights (2011) para 24., available at: <https://www.icj.org/wp-content/uploads/2012/12/Maastricht-ETO-PrinciplesENG-booklet.pdf>

⁴³ UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), (11 August 2000) para 32.

⁴⁴ Id, para 18-19.

⁴⁵ UN Committee on Economic, Social and Cultural Rights (CESCR), General comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 2 July 2009, para 33 .

⁴⁶ UN Committee on Covenant on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International) (2 May 2016), para 34

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A list of States' **minimum core obligations** in terms of the right to health is provided in **Addendum A**. States have a core obligation to "at the very least, ensure minimum essential levels of satisfaction of sexual and reproductive health",⁴⁷ and to take at least the following steps:

- **Law and Policy Review:** Repealing laws and policies which criminalize, obstruct or undermine access to sexual and reproductive health facilities, services, goods and information. The Maputo Protocol also emphasizes that States "should provide a legal and social environment that is conducive to the exercise by women of their sexual and reproductive rights", which includes "revisiting restrictive laws, policies and administrative procedures relating to family planning/contraception and safe abortion".⁴⁸
- **Non-discriminatory Access:** Guaranteeing all people access to affordable, acceptable and quality sexual and reproductive health services, goods, information and facilities.
- **Medicines and Equipment:** Ensuring provision of medicines, equipment and technologies essential to sexual and reproductive health.
- **National Strategy:** Adopting and implementing a national strategy and action plan with an adequate budget to realize the right to reproductive health.
- **Preventing unsafe abortions** and making provision for post-abortion care and counselling.
- **Gender-Based Violence:** Prohibiting by law gender based violence and other harmful practices (including, female genital mutilation, child and forced marriage, domestic and sexual violence, and marital rape).
- **Education and Information:** Ensuring comprehensive education and information on sexual and reproductive health that is "non-discriminatory, non-biased, evidence-based". The African Commission has also stressed the importance of information and education on family planning and contraception and safe abortion for women, "especially adolescent girls and young women."⁴⁹ In addition, States must sensitize and educate "communities, religious leaders, traditional chiefs and political leaders on women's sexual and reproductive rights".⁵⁰
- **Remedies:** Providing effective and transparent remedies and redress, including through courts, for violations of the right to sexual and reproductive health.

Beyond these immediate obligations CESCR's general comments on the right to health (General Comment 14) and the right reproductive health (General Comment 22) respectively give further content to State's **obligations to respect, protect and fulfil** the right "individually and through international assistance and co-operation, especially economic and technical" and to the "maximum of its available resources".⁵¹ The African Commission has also issued General Comments pertaining to health and reproductive rights.⁵²

Measures taken by States, even for progressively realizable obligations in terms of the right to health, must be taken immediately or within a reasonably short period of time. Such steps should be "deliberate, concrete and targeted, using all appropriate means, particularly including, but not limited to, the adoption of legislative and budgetary measures."⁵³ States that are genuinely unable

⁴⁷ Id, para 49

⁴⁸ African Commission on Human and Peoples' Rights, General Comment No.2 on Article 14.1 a), b), c) and f) and Article 14.2 a) and c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 46

⁴⁹ Id, para 51

⁵⁰ Id, para 44

⁵¹ UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, available at: <https://www.refworld.org/docid/3ae6b36c0.html> [accessed 15 June 2020], Article 2(1). A more detailed description of these obligations is available in other International Commission of Jurists publications. SEE, ICJ, Living Like People Who Die Slowly, The need for Right to Health Compliant Covid-19 Responses, (September 2020), available at: <https://www.icj.org/wp-content/uploads/2020/09/Universal-Global-Health-COVID-19-Publications-Reports-Thematic-Reports-2020-ENG.pdf> and ICJ, "Practitioners Guide on Adjudicating Economic, Social and Cultural Rights at National Level, No.8" (2014), available at: <https://www.icj.org/wp-content/uploads/2015/07/Universal-ESCR-PG-no8-Publications-Practitioners-guide-2014-eng.pdf>

⁵² General Comment No. 1 on Article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa and General Comment No.2 on Article 14(1(a), (b), (c) and (f) and Article 14.2(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

⁵³ UN Committee on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) (2 May 2016), para 33:

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"to comply with their obligations and that cannot realize the right to sexual and reproductive health due to lack of resources must", in addition to fully detailing the reasons for the absence of resources, "seek international cooperation and assistance" in efforts to maximize and expand available resources.⁵⁴

For healthcare facilities, services and goods to meet States' right to health obligations under ICESCR, they must be available in sufficient quantity and range; accessible economically and physically; acceptable; and of good quality.⁵⁵ Furthermore, "health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination of any of the prohibited grounds", which include "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health."⁵⁶

I. Non-discrimination

ICESCR proscribes discrimination based on "race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".⁵⁷ Other status has been determined to include, among other grounds, sexual orientation or gender identity; age; gender; citizenship; nationality or migration status; health status; disability and socio-economic status.⁵⁸ According to the African Commission, there are multiple forms of discrimination that include: "race, sex, sexuality, sexual orientation, age, pregnancy, marital status, HIV status, social and economic status, disability, harmful customary practices and/or religion."⁵⁹ These and other forms of discrimination prevent women from being able to protect themselves from diseases like HIV/AIDS and to be protected.⁶⁰

State's obligation of non-discrimination "is an immediate and cross-cutting obligation".⁶¹ Equality for women and girls should also encompass substantive equality and not merely formal equality.⁶² Based on this understanding of equality, CESCR has affirmed that: "non-discrimination and equality are fundamental components of international human rights law and essential to the exercise and enjoyment of economic, social and cultural rights",⁶³ including, therefore, the right to the highest attainable standard of physical and mental health.

The rights to equality before the law and to equal protection of the law for all without discrimination (both of which encompass the principle of non-discrimination) are central to international human rights law.⁶⁴ There is a baseline of universal standards in respect of equality and non-discrimination

⁵⁴ Id, para 50-53:

⁵⁵ The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (3 September 1981), Article 5(a) para 12.

⁵⁶ CESCR General Comment No.14: The Right to the Highest Attainable Standard of Health (Art.12), 11 August 2000, paras 12(b), 18 and 19

⁵⁷ International Covenant on Economic, Social and Cultural Rights, Article 2.

⁵⁸ ICJ, A Guide for the Legal Enforcement and Adjudication of Economic, Social and Cultural Rights in South Africa, (August 2019), p196 available at: <https://www.icj.org/wp-content/uploads/2019/08/South-Africa-Guide-ESCR-Publications-Thematic-Report-2019-ENG.pdf>,

⁵⁹ General Comment No. 1 on Article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 4, available at: <https://www.achpr.org/legalinstruments/detail?id=14>

⁶⁰ Id

⁶¹ UN Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (Art 12), para 20.

⁶² Id, para 8.

⁶³ Id.

⁶⁴ This is reflective of article 7 of the Universal Declaration of Human Rights, which was also reinforced in the 1993 Vienna Declaration and Programme of Action agreed to by all States. See World Conference on Human Rights in Vienna, Vienna Declaration and Programme of Action (25 June 1993), para 5. African Commission on Human Peoples' Rights has affirmed that: "[t]ogether with equality before the law and equal protection of the law, the principle of non-discrimination provided under Article 2 of the Charter provides the foundation for the enjoyment of all human rights". See African Commission on Human and Peoples' Rights, Decision of 15 May 2006, Zimbabwe NGO Human Rights Forum v. Zimbabwe, Communication No. 245/2002, para. 169. See also Article 3, Human Rights Committee, CCPR General Comment No. 28, UN Doc. CCPR/C/21/Rev.1/A, (2000) and Human Rights Committee, CCPR General Comment No. 18, UN Doc. HRI/GEN/1/Rev.1

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that are not particular to ESCR but stem from and are part of general international law and rule of law principles. In international human rights law, a succinct expression of the right to equality before the law and equal protection of the law for all without discrimination is enshrined in article 26 of the ICCPR, which provides that:⁶⁵

"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, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

All health facilities, goods, information and services in Eswatini must therefore be "accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds".⁶⁶ Discrimination on any prohibited grounds listed above with the "intention or effect" of "nullifying or impairing the equal enjoyment or exercise of the right to health" is unlawful.⁶⁷ As an immediate obligation, CESCR has stressed that non-discrimination in access to health must be ensured "even in times of severe resource constraints".⁶⁸

The CEDAW Committee has affirmed that "accessing health care, including reproductive health is a basic right under the CEDAW Convention".⁶⁹ The CEDAW Committee has proclaimed that States have an obligation to:

"eliminate discrimination against women in their access to health-care services throughout their life cycle, particularly in the areas of family planning, pregnancy and confinement and during post-natal period."⁷⁰

The CEDAW Committee recommends that special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as, for example, the girl child and older women, and women with disabilities.⁷¹ Poor women, adolescents, lesbian, bisexual, transgender and intersex women, and women living with HIV/AIDS are also among individuals and groups who may be disproportionately affected by intersectional and multiple discrimination in the context of sexual and reproductive health.⁷² Importantly, the Committee highlights that: "it is discriminatory for a state party to refuse to provide legally for the performance of certain reproductive health services for women."⁷³ In protecting women's rights to sexual and reproductive health, States have an obligation to pay particular attention also to women in "situations of conflict" and ensure they are protected from third party interference in their enjoyment of sexual and reproductive health rights.⁷⁴

Non-discrimination, in the context of the right to sexual and reproductive health, also explicitly "encompasses the right of all persons, including lesbian, gay, bisexual, transgender and intersex persons, to be fully respected for the sexual orientation, gender identity and intersex status".⁷⁵ In this regard:

⁶⁵ UN General Assembly, International Covenant on Civil and Political Rights (16 December 1966), Art 26.

⁶⁶ UN Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (Art 12), para 12(b).

⁶⁷ Id, para 18.

⁶⁸ Id.

⁶⁹ UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), chap. I, para 1, available at: <https://www.refworld.org/docid/453882a73.html>

⁷⁰ Id para 2

⁷¹ Id para 6

⁷² Id para 30

⁷³ Id para 11

⁷⁴ Id, para 43

⁷⁵ Id para 23

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"criminalization of sex between consenting adults of the same gender or the expression of one's gender identity is a clear violation of human rights."⁷⁶

The right to access and benefit from sexual and reproductive healthcare, part and parcel of one's right to health, is therefore also directly linked, as a matter of States' international human rights law obligations, to gender equality and non-discrimination.⁷⁷

According to the African Commission, States must remove all:

"administrative laws, policies, procedures and practices, as well as socio-cultural attitudes and standards that impede access to contraception/family planning violate the woman's right to life, non-discrimination and health, in that they deprive her of her decision making power and force her to undergo early pregnancy, unsafe or unwanted pregnancy, with as consequence, the temptation to seek unsafe at the risk of her health and her life."⁷⁸

The African Commission therefore emphasized that the absence of such protections obliges women to resort to "unsafe, illegal abortions" with a risk of maternal mortality resulting.⁷⁹

With respect to the right to sexual and reproductive health, in particular, the Maputo Protocol also places an obligation on States to "refrain from hindering directly or indirectly, women's rights and to ensure that women are duly informed on family planning/contraception and safe abortion services, which should be available, accessible, acceptable and of good quality."⁸⁰ The African Commission on Human and Peoples' Rights has emphasized that "it is crucial to ensure availability, accessibility and acceptability and good quality reproductive health care, including family planning/contraception and safe abortion for women."⁸¹

II. Availability

Eswatini must ensure the existence and operation of a functioning public health system, healthcare facilities, goods and services of a sufficient quantity and quality to ensure that every person can fully enjoy the right to health. These goods, facilities and services also encompass a number of underlying determinants of health, such as sanitation, water, electricity and food at all health facilities.⁸²

With respect to sexual and reproductive health, States are required to ensure an adequate number of healthcare facilities, services and goods and programs "with the fullest possible range of sexual and reproductive healthcare".⁸³ For this requirement to be met, sufficient and skilled medical personnel trained to perform a full range of sexual and reproductive health services is necessary.⁸⁴

⁷⁶ Id

⁷⁷ Id, paras 25 to 27

⁷⁸ African Commission on Human and Peoples' Rights, General Comment No.2 on Article 14.1 a), b), c) and f) and Article 14.2 a) and c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 27

⁷⁹ Id, para 39 "39. The Protocol guarantees the right to terminate a pregnancy when the woman's life is threatened. Yet women's lives are in danger when they have no access to legal security procedures, which obliges them to resort to unsafe, illegal abortions. Maternal mortality from abortions performed in unhealthy conditions is a high risk, particularly for adolescent girls who seek to terminate pregnancies through unqualified or unspecialized service providers, or through abortions that are induced using dangerous procedures, products and objects."

⁸⁰ African Commission on Human and Peoples' Rights, General Comment No.2 on Article 14.1 a), b), c) and f) and Article 14.2 a) and c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 42

⁸¹ African Commission on Human and Peoples' Rights, General Comment No.2 on Article 14.1 a), b), c) and f) and Article 14.2 a) and c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 53

⁸² These include safe portable drinking water, adequate sanitation facilities, hospitals, clinics and other health related buildings, trained medical and professional personnel receiving domestically competitive salaries and essential drugs. See UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) (11 August 2000) para 12(a) E/C.12/2000/4, available at: <https://www.refworld.org/docid/4538838d0.html>

⁸³ UN Committee on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) (2 May 2016), Para 12

⁸⁴ Id, para 13

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Moreover, all health facilities should be equipped with all essential medicines necessary including: "a wide range of contraceptive methods, such as condoms and emergency contraception"; "medicines for abortions and for post abortion care";⁸⁵ and "for the prevention and treatment of sexually transmitted infections and HIV".⁸⁶

Importantly, the unavailability of goods and services "due to ideologically based policies or practices such as refusal to provide services based on conscience, must not be a barrier to accessing services".⁸⁷

III. Accessibility

Accessibility requires that all healthcare facilities, goods and services be available, physically and economically, without discrimination of any kind.⁸⁸

(a) *Physical accessibility*

All health services, goods, information and facilities "must be available within safe physical and geographical reach for all, so that persons in need can receive timely services and information".⁸⁹ Importantly "persons living in rural and remote areas" must be able to access all health services, goods, information and facilities including sexual and reproductive health services, goods, information and facilities.⁹⁰ Administrative laws, policies and procedures of health systems and structures cannot restrict access to family planning/contraception on the basis of religious belief.⁹¹

(b) *Economic accessibility*

Everyone must be able to afford all healthcare services.⁹² Whether reproductive health services are publicly (at government facilities) or privately provided (at private health facilities), they must be "affordable for all".⁹³ Essential reproductive healthcare, goods and services must therefore be "provided at no cost" or at a level that ensures "that individuals and families are not disproportionately burdened with health expenses".⁹⁴

(c) *Information accessibility*

To comply with its obligations under the right to health, States must ensure "information accessibility" to all without discrimination of any kind. States must take measures to ensure access to health-related education and information since the right to health, in turn, entitles all people to seek, receive and share information and ideas concerning health issues.⁹⁵ States are prohibited from "censoring, withholding or intentionally misrepresenting" health-related information or "preventing people's participation in health-related matters."⁹⁶

As mentioned above, States are under a core, immediate obligation to provide: "comprehensive education and information on sexual and reproductive health, that is non-discriminatory, non-

⁸⁵ Id

⁸⁶ Id

⁸⁷ Id, para 14

⁸⁸ Id, para 15

⁸⁹ UN Committee on Economic, Social and Cultural Rights, General Comment No. 20 Non-discrimination in economic, social and cultural rights (art.2, para.2, of the International Covenant on Economic, Social and Cultural Rights), para 16.

⁹⁰ UN Committee on Economic, Social and Cultural Rights, General Comment No. 20 Non-discrimination in economic, social and cultural rights (art.2, para.2, of the International Covenant on Economic, Social and Cultural Rights), para 16.

⁹¹ African Commission on Human and Peoples' Rights, General Comment No.2 on Article 14.1 a), b), c) and f) and Article 14.2 a) and c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 25

⁹² Id, para 12(b)

⁹³ UN Committee on Economic, Social and Cultural Rights, General Comment No. 20 Non-discrimination in economic, social and cultural rights (art.2, para.2, of the International Covenant on Economic, Social and Cultural Rights),para 17.

⁹⁴ UN Committee on Economic, Social and Cultural Rights, General Comment No. 20 Non-discrimination in economic, social and cultural rights (art.2, para.2, of the International Covenant on Economic, Social and Cultural Rights),para 17.

⁹⁵ UN Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (Art 12), para. 12(b).

⁹⁶ Id.

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biased, evidence-based".⁹⁷ Information must be provided on, among other things, family planning and contraceptives, maternal health, the prevention and treatment of sexually transmitted infections (STIs), including HIV/AIDS, safe abortion and post abortion care, infertility and fertility options, and reproductive cancers.⁹⁸

States themselves are prohibited from actively providing misinformation about sexual and reproductive health and therefore must "prohibit and prevent private actors", including businesses, religious institutions and non-governmental organizations from disseminating misinformation about sexual and reproductive health.⁹⁹

CEDAW requires States to "create an enabling, supportive, legal and social environment that empowers women to be in a position to fully and freely realise their right to self-protection and to be protected."¹⁰⁰ This right to self-protection includes women's right to access information and education, as well as sexual and reproductive health services.¹⁰¹ Women have the right to know about their health status, including HIV status without discrimination.¹⁰² The African Commission has emphasized the importance of information on HIV prevention for women, especially adolescents and youth by indicating that States "must guarantee information and education on sex, sexuality, HIV, sexual and reproductive rights."¹⁰³

IV. Acceptability

For health services, goods, information and facilities to be acceptable they must be respectful of medical ethics and culturally appropriate.¹⁰⁴ For example, for health-related information to meet the acceptability requirement under the right to health, such information must be sensitive to gender, age, disability, sexual diversity and life cycles requirements; moreover, for health-related information to fulfil the acceptability requirement, such information must be provided in a manner that respects confidentiality and aims to improve the health status of those concerned.¹⁰⁵

V. Quality

The quality of health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires sufficiently trained health workers and other personnel and the use of "scientifically approved" and unexpired drugs, hospital equipment, safe and potable water, and adequate sanitation at health facilities.¹⁰⁶ In the specific context of sexual and reproductive health services, this requires the incorporation of technological advancements and innovations, including regarding "medication for abortion", and "advancements in the treatment of HIV and AIDS".¹⁰⁷

In its General Comment 25 on "Science and Economic, Social and Cultural Rights, published in 2020, CESCR reaffirmed the need for States to ensure "access to up-to-date scientific technologies necessary for women" in relation to the right to reproductive health services, which includes ensuring "access to modern and safe forms of contraception, including emergency contraception, medication for abortion, assisted reproductive technologies, and other sexual and reproductive

⁹⁷UN Committee on Economic, Social and Cultural Rights, General Comment No. 20 Non-discrimination in economic, social and cultural rights (art.2, para.2, of the International Covenant on Economic, Social and Cultural Rights), para 49(f).

⁹⁸ Id, paras 18, 44.

⁹⁹ Id, paras 41, 43.

¹⁰⁰ Id, para 10

¹⁰¹ Id, para 11

¹⁰² Id, para 15

¹⁰³ Id, para 26

¹⁰⁴ Id, para 12(c)

¹⁰⁵ UN Committee on Economic, Social and Cultural Rights, General Comment No. 20 Non-discrimination in economic, social and cultural rights (art.2, para.2, of the International Covenant on Economic, Social and Cultural Rights), para 20.

¹⁰⁶ Id, para 12(d)

¹⁰⁷ Id, para 21.

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goods and services".¹⁰⁸ In the same General Comment, CESCR affirms that is an immediate, core obligation for States to "ensure that health professionals are properly trained in using and applying modern technologies and medicines resulting from scientific progress".¹⁰⁹

3. STATES' RESPONSES TO COVID-19 AND THE RIGHT TO HEALTH

Globally, the COVID-19 pandemic has itself had a disproportionately negative impact on women and girls.¹¹⁰ In addition, some of the measures put in place by states with the intention to respond to the pandemic have also had a disproportionately negative impact on women and girls.¹¹¹ Many States have declared either national disasters or emergencies with the stated intention to take adequate measures to protect public health. CESCR is clear that, though such restrictive measures may be taken, they must be: "necessary to combat the public health crisis posed by COVID-19", "reasonable and proportionate", "should not be abused", and "should be lifted as soon as they are no longer necessary for protecting public health".¹¹²

The CESCR has stated that measures limiting Covenant rights "must be necessary to combat the public health crisis posed by COVID-19, and be reasonable and proportionate."¹¹³ Furthermore, "emergency measures and powers adopted by states parties to deal with the pandemic should not be abused, and should be lifted as soon as they are no longer necessary for protecting public health."¹¹⁴ Such declarations should comply strictly with the procedural and substantive standards set out in international human rights law, which the Human Rights Committee has explicitly recently reaffirmed as applicable to the context of COVID-19.¹¹⁵

The Siracusa Principles,¹¹⁶ which may be taken as an authoritative interpretation of the permissible scope of limitations and derogations of rights even in public emergencies and disasters, sets out the following standards and restrictions for any limitation or derogation of rights in such circumstances.¹¹⁷ Such measures must be:

1. Provided for and carried out in accordance with the law;
2. Based on scientific evidence;
3. Directed toward a legitimate objective;
4. Strictly necessary in a democratic society;
5. The least intrusive and restrictive means available;
6. Neither arbitrary nor discriminatory in application;
7. Of limited duration; and
8. Subject to review.

Importantly in the context of the right to health, the Siracusa Principles explicitly indicate that any limitations or derogations of rights in the name of a "public health" emergency must be "specifically

¹⁰⁸ UN General Comment on Economic, Social and Cultural Rights No.25 (2020) on science and economic, social and cultural rights (article 15(1)(b),(2),(3) and (4) of the International Covenant on Economic, Social and Cultural Rights, para 33.

¹⁰⁹ Id, para 52.

¹¹⁰ CESCR COVID-19 Statement, para 2, 5 and 8. See also ICJ, Living Like People Who Die Slowly: The need for right to health compliant COVID-19 Responses, (September 2020), pg 56

¹¹¹ Committee on Elimination of Discrimination Against women, CEDAW – Guidance Note on CEDAW and COVID-19 (14 May 2020, para 2 <http://www.corteidh.or.cr/tablas/centro-covid/docs/Covid-19/CEDAW-Guidance-note-COVID-19.pdf>

¹¹² CESCR Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights, 6 April 2020, available at https://www.ohchr.org/Documents/HRBodies/CESCR/STM_COVID19.docx

¹¹³ CESCR Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights, 6 April 2020, para 11 available at https://www.ohchr.org/Documents/HRBodies/CESCR/STM_COVID19.docx

¹¹⁴ Id

¹¹⁵ Id, para 2(a).

¹¹⁶ For a detailed treatment of different aspects of the application of Siracusa Principles in the context of COVID-19, see B Sander & J Rudall (eds), COVID-19 and International Law Opinio Juris Symposium (March-April 2020), available at: <http://opiniojuris.org/wp-content/uploads/B.-Sander-J.-Rudall-eds-COVID-19-and-International-Law-Opinio-Juris-Symposium-copy-1.pdf>.

¹¹⁷ UN Commission on Human Rights, The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, E/CN.4/1985/4 (28 September 1984), available at: <https://www.refworld.org/docid/4672bc122.html>.

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aimed at preventing disease or injury or providing care for the sick and injured".¹¹⁸ Given the human rights obligations pertaining to the right to health outlined above, it is reasonable to insist that the "public health" objectives in pursuit of which emergency measures and restrictions are purportedly undertaken must, in turn, be specifically aimed at *both* improving public health *and* realizing the right to health.

Finally, even in the narrow circumstances in which some human rights may be limited or derogated from in order to address a public health emergency, such as COVID-19, the minimum core obligations of the right to health described above may not be subject to any such limitations or restrictions. As the CESCR Committee indicates unambiguously in General Comment 14:

"a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable."¹¹⁹

These core obligations therefore continue to bind States, even in the context of a public health emergency, such as COVID-19, *immediately*, and are not subject to the principle of progressive realization.

Consistently with this, in its statement on COVID-19 CESCR has indicated that "minimum core obligations imposed by the Covenant should be prioritized" in States responses to the epidemic.¹²⁰

The ICJ's report entitled "Living Like People Who Die Slowly: The Need for Right to Health Compliant COVID-19 Responses" ("ICJ Global Health Report") highlights some of the severe impacts that COVID-19 has had on women and girls.¹²¹ One such negative impact is the reduction, interruption or deprivation of access to sexual and reproductive healthcare services, such as family planning services, abortion services and HIV related services, to women in violation of States' core obligations. Such decrease of sexual and reproductive healthcare services is a retrogressive measure in direct violation of the obligation of non-retrogression in the realization of ESCR. Another detrimental impact of lockdowns imposed by States has been the increase of violence against women.¹²²

¹¹⁸ Id, para 25-26 which read in full:

"Public health may be invoked as a ground for limiting certain rights in order to allow a State to take measures dealing with a serious threat to the health of the population or individual members of the population. These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured. Due regard shall be had to the International Health Regulations of the World Health Organization."

¹¹⁹43. In general comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations: (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone; (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; (e) To ensure equitable distribution of all health facilities, goods and services; (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups." UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) /C.12/2000/4E (11 August 2000) para 47, available at: <https://www.refworld.org/docid/4538838d0.html> .

¹²⁰ UN Committee on Economic, Social and Cultural Rights, Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights, E/C.12/2020/1 (17 April 2020), para 12, available:

https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolNo=E%2fC.12%2f2020%2f1&Lang=en

¹²¹ ICJ, Living Like People Who Die Slowly: The need for right to health compliant COVID-19 Responses, (September 2020), p56

¹²² Id, p60

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States have an obligation to ensure that access to reproductive health services and other essential healthcare services needed by women remain available and unrestricted during this pandemic. In particular, comprehensive sexual and reproductive health must be provided as essential services during the COVID-19 pandemic. Women's mental and physical health must be protected and adequate healthcare access and sufficient social assistance for women living in poverty must be ensured. Pre- and post-natal healthcare services must remain available for women, in a manner that does not risk COVID-19 transmission. Survivors of gender-based violence must also have access to comprehensive health services.

4. EFFECTIVE REMEDIES AND REPARATIONS

It is a general principle of international human rights law that there are no violations of human rights without remedies, and that those subjected individually or collectively to human rights violations have the right to an effective remedy for such violations. Indeed, all States clearly endorsed these general principles and many elements of what the right to an effective remedy entails, for example, when they adopted by consensus at the UN General Assembly the UN Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law.¹²³ The right to remedy under international human rights law is explored in greater detail in the ICJ's Guide on "The Right to a Remedy and Reparation for Gross Human Rights Violations".¹²⁴

For present purposes, it is sufficient to recall that States are required to take all necessary measures to:¹²⁵

- **Prevent violations** of the right to health;
- **Effectively, promptly, thoroughly and impartially investigate violations** of the right to health;
- **Take action against those responsible for violations** of the right to health;
- **Provide effective access to justice for victims** of violations of the right to health; and
- **Provide effective remedies, including reparations, to victims** of violations of the right to health.

Indeed, these international human rights obligations are no different in the context of the right to health. In particular the CESCR Committee has urged States to incorporate the right to health in domestic law and enable "courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant".¹²⁶ Ensuring effective remedies for the violation of the right to sexual and reproductive health is a core, immediate obligation.¹²⁷ Similarly, the CEDAW Committee has explained that failure to put in place systems that ensure effective judicial remedies for CEDAW violations, including those relating to sexual and reproductive health, amount to violations of state's obligations.¹²⁸

¹²³ UN General Assembly, Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law : resolution / adopted by the General Assembly, A/RES/60/147, (21 March 2006) available at: <https://www.refworld.org/docid/4721cb942.html>

¹²⁴ ICJ, The Right to a Remedy and Reparation for Gross Human Rights Violations, A Practitioners' Guide (2018), available at: <https://www.icj.org/wp-content/uploads/2018/11/Universal-Right-to-a-Remedy-Publications-Reports-Practitioners-Guides-2018-ENG.pdf>.

¹²⁵ UN General Assembly, Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law : resolution / adopted by the General Assembly, A/RES/60/147, (21 March 2006), Principle 3.

¹²⁶ UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) /C.12/2000/4E (11 August 2000), paras 59-62.

¹²⁷ UN Committee on Economic, Social and Cultural Rights (CESCR), General comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 2 July 2009, para 49(h).

¹²⁸ Id, para 13

5. WOMEN'S RIGHT TO HEALTH IN ESWATINI

Eswatini has enacted legislation and various policy measures in order to give effect to women's right to health. A prominent example is the Sexual Offences and Domestic Violence Act,¹²⁹ which aims to provide a framework to curb domestic violence and sexual offences. The government also developed a National Health Policy,¹³⁰ which aims to guide the government in developing strategies to address health-related challenges in Eswatini in compliance with the Constitution and international standards.

The government has also introduced policies geared at ensuring that Swazi women enjoy their right to sexual and reproductive health. These include the National Policy on Sexual and Reproductive Health (NPSRH),¹³¹ which was developed by the Ministry of Health and aims "to ensure proper coordination, integration and harmonious delivery of comprehensive SRH [i.e., sexual and reproductive health] information and services".¹³²

The NPSRH aims to ensure that sexual and reproductive health services be provided without discrimination to Swazi women. It emphasizes that:

"every citizen is entitled to fundamental human rights and freedoms, including the right to health which incorporates the right to sexual and reproductive health, irrespective of sex, gender, culture, religion, age, race, disability, HIV and economic status."¹³³

The NPSRH recognizes that in Eswatini "gender based violence is often sexual in nature and leads to the violation of sexual and reproductive health and rights of girls and women..."¹³⁴

In addition, the National Multisectoral HIV and AIDS Strategic Framework, a five year policy and planning document aiming to guide focused resource allocation, programming and implementation of the HIV response in Eswatini, acknowledges the challenges posed by the HIV epidemic to the enjoyment of Swazi women's right to health.¹³⁵

Over and above the legislative and policy framework in Eswatini, the Eswatini Constitution includes a "directive principle of state policy" committing Eswatini to "take all practical measures to ensure the provision of basic health care services to the population".¹³⁶ It also includes a prohibition on discrimination including on the grounds of "gender", and empowers Parliament to enact "laws that are necessary for implementing policies and programmes aimed at redressing social, economic or educational or other imbalances in society".¹³⁷

In addition, the Constitution includes a specific provision on the "rights and freedoms of women", which reads as follows:

"Rights and freedoms of women

28. (1) Women have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities.

(2) Subject to the availability of resources, the Government ***shall provide facilities and opportunities necessary to enhance the welfare of women to enable them to realize their full potential and advancement.*** [our emphasis]

¹²⁹The Sexual Offences and Domestic Violence Act, No.15 of 2018

¹³⁰ Swaziland Ministry of Health and Social Welfare, National Health Policy, available at:

https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_174726.pdf

¹³¹ The Kingdom of Swaziland Ministry of Health, National Policy on Sexual and Reproductive Health, (2013). Available at:

<http://www.integrainitiative.org/blog/wp-content/uploads/2013/10/NATIONAL-POLICY-ON-SEXUAL-AND-.pdf>

¹³² Id, para 1.1

¹³³ Id, p15

¹³⁴ Id, p22

¹³⁵ The Government of the Kingdom of Eswatini, The National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018-2023 (2018) available at: https://hivpreventioncoalition.unaids.org/wp-content/uploads/2019/06/Eswatini_NSF-2018-2023_final.pdf

¹³⁶ The Constitution of the Kingdom of Swaziland, 2005, Chapter V, section 60(8)

¹³⁷ Id, section 20.

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(3) A woman shall not be compelled to undergo or uphold any custom to which she is in conscience opposed.”

Despite this constitutional guarantee of women's rights and freedoms, simultaneously, the Constitution explicitly prohibits abortion except in exceptional circumstances, and does not include a specific right to health, let alone a right to sexual and reproductive health.¹³⁸ However, under international human rights law, Eswatini is bound to fulfil its international law obligations to realize the right to reproductive health. As recalled earlier in the INTRODUCTION section of this document, in accordance with Vienna Convention on the Law of Treaties, a State may not invoke its domestic law as justification for its failure to perform its international legal obligations.¹³⁹ In this context, and with respect to ESCRs in particular, Eswatini is required to ensure that, “at a minimum”, judges be empowered to “interpret domestic law consistently with the States obligations under the ICESCR”.¹⁴⁰

In this connection, Swazi courts have provided guidance on purposive interpretation and interpretation in light of international human rights law and standards in some case relating to the rights of women.

In the case of *Ndzimandze v Ndzimandze*,¹⁴¹ the court held that a law that provided that, where spouses were married “in community of property”, a surviving spouse would be entitled to a child's share of the deceased estate, was unconstitutional and grossly discriminatory against women. In this case the court cited article 18(3) of the *African Charter on Human and Peoples' Rights*, which requires States to ensure the elimination of every discrimination against women.¹⁴² In answering the question of how far the court should go in attempting to find a meaning consistent with the constitution against the express language used in the statute itself, the court held:

“Section 2(1) of the Constitution of Swaziland must be read together with Section 35 of the Constitution wherein it is provided that the High Court may “make such order, issue such writs and make such directions as it may consider appropriate for the purpose of enforcing or securing the enforcement of any of the provisions of this chapter.””¹⁴³

In the case of *Doo Aphane*,¹⁴⁴ where the court declared unconstitutional a provision preventing women married “in community of property” from registering immovable property in their own name, the court cited the following when referring to the essential features of a court's order granting constitutional relief:

“Ideally speaking, a court's order must not only afford effective relief to a successful litigant, but also to all similarly situated people. This is the second factor that must be considered. As the Constitutional Court has stated, in constitutional cases there is ‘a wider public dimension. The bell tolls for everyone’...This requires a consideration of the interests

¹³⁸ Id, section 15(5)

¹³⁹ The Vienna Convention on the Law of Treaties (27 January 1980), Article 27 reads in full: “INTERNAL LAW AND OBSERVANCE OF TREATIES A party may not invoke the provisions of its internal law as justification for its failure to perform a treaty. This rule is without prejudice to article 46.” Article 46 reads: “Article 46. PROVISIONS OF INTERNAL LAW REGARDING COMPETENCE TO CONCLUDE TREATIES

1. A State may not invoke the fact that its consent to be bound by a treaty has been expressed in violation of a provision of its internal law regarding competence to conclude treaties as invalidating its consent unless that violation was manifest and concerned a rule of its internal law of fundamental importance. 2. A violation is manifest if it would be objectively evident to any State conducting itself in the matter in accordance with normal practice and in good faith.”

¹⁴⁰ ICJ, Practitioners Guide on Adjudicating Economic, Social and Cultural Rights at National Level, No.8” (2014), p. 28, available at: <https://www.icj.org/wp-content/uploads/2015/07/Universal-ESCR-PG-no8-Publications-Practitioners-guide-2014-eng.pdf>

¹⁴¹ *Wezzy Ndzimandze and 16 Others vs Titselo Dzadze Ndzimandze and 13 others* (981/2014) [2014] (23rd September 2014), available at: <https://swazilii.org/sz/judgment/high-court/2014/234/WENZY%20NDZIMANDZE%20AND%2016%20OTHERS%20VS%20TITSELO%20DZADZE%20NDZIMANDZE%20Hos1%20%281%29.docx%203.pdf>

¹⁴² Id, para 10

¹⁴³ Id, para 49

¹⁴⁴ *The Attorney General Civil Appeal v Mary-Joyce Doo Aphane* [2010] SZSC 32, available at:

https://swazilii.org/sz/judgment/supreme-court/2010/32/in_the_supreme_court_of_swaziland_9_pdf_20462_0.pdf

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of all those who might be affected by the order, and not merely the interests of the parties to the litigation"¹⁴⁵

As regards the court's duty regarding common law, the court held that:

"the common law is its law [and the] courts are protectors and expounders of the common law [and] have always had an inherent duty to refashion and develop [it]...in order to reflect changing social, moral and economic make-up of society."¹⁴⁶

In arriving at its decision, the court referred to the Human Rights Committee's General Comment 28 on Equality of Rights between men and women (2000),¹⁴⁷ which provides that an equality provision:

"implies that all human beings should enjoy the rights provided...on an equal basis and in their totality. The full effect of this provision is impaired whenever any person is denied the full and equal enjoyment of each such right. The Committee also notes that inequality in the enjoyment of rights by women throughout the world is deeply embedded in traditional, history and culture, including religious attitudes. The subordinate role of women in some countries is still illustrated by the high incident of pre-natal sex selection and abortion of female foetuses. States parties should ensure that traditional historical religious and cultural attitudes are not used to justify violations of women's rights to equality before the law and to equal enjoyment of all covenant rights."¹⁴⁸

The court held that Eswatini must fulfil its international human rights obligations:

"to fulfil their obligations states must ensure that the matrimonial regime contains equal rights and obligations for both spouses"¹⁴⁹... "[Eswatini] is a member of the United Nations and is signatory to the relevant convention or covenant. In enacting section 20 and 28 of the Constitution, the country was fully appreciative or mindful of its own obligations to its people on this front and also of its international obligations under these international instruments."¹⁵⁰

The above decisions show that indeed Swazi courts have upheld the principle of purposive interpretation of laws to give effect to constitutional rights and to women's human rights as enshrined in international human rights law and standards. Swazi courts have also highlighted the government's duty to fulfil its obligations as prescribed by international human rights law, including the African Charter on Human and Peoples' Rights. Accordingly, international human rights law must be followed by Eswatini and, if the authorities fail to do so, it must be enforced by the courts. As is evident from the cases cited above, Swazi courts have defended women's human rights where domestic legal provisions did not conform to human rights standards, and in so doing have cited international and regional sources of law. Such reliance on international human rights standards by courts in enforcing rights has the potential to further contribute to social change in Eswatini for the benefit of Swazi women.

¹⁴⁵Id, para 62

¹⁴⁶ *Sihlongonyane v Sihlongonyane* (470/2013) [2013] SZHC 144 (18 July 2013), para 19 <https://swazilii.org/sz/judgment/high-court/2013/144/>

¹⁴⁷ CCPR General Comment No.28: Article 3 (The Equality of Rights Between Men and women), CCPR/c/21/Rev.1/Add.10 (29 March 2000) available at: <https://www.refworld.org/pdfid/45139c9b4.pdf>

¹⁴⁸ *Sihlongonyane v Sihlongonyane* (470/2013) [2013] SZHC 144 (18 July 2013), para 2 para 27, available at <https://swazilii.org/sz/judgment/high-court/2013/144/>,

¹⁴⁹ Id, para 28

¹⁵⁰ Id, Para 29

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A. Key human rights concerns in the exercise of women's right to health in Eswatini

This section briefly highlights some of the key concerns to women and girls' access to, enjoyment and exercise of their right to health in Eswatini.

I. Sexual and Reproductive Healthcare

As discussed above, the right to sexual and reproductive health entails certain freedoms and entitlements, including the freedom to make autonomous decisions concerning one's body and sexual and reproductive health free of coercion, discrimination and violence, as well as the entitlement to have access to health services in order to enjoy the right to sexual and reproductive health.¹⁵¹ The term 'reproductive health' may be summarized as:

"Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth."¹⁵²

The World Health Organisation's working definitions of sexual health and sexuality are as follows:

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. Sexuality is a central aspect of being human throughout life; it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.

See Sexual Health, Human Rights and the Law, WHO, June 2015, pp. 49, Box 1: Working definitions, p. 5, http://www.who.int/reproductivehealth/publications/sexual_health/sexual-health-human-rights-law/en/

Some aspects of women's enjoyment of their right to sexual and reproductive health in Eswatini have given rise to concern. For example, in 2017, in its Concluding observations following its examination of Eswatini's compliance with the International Covenant on Civil and Political Rights, the Human Rights Committee expressed concern about "the significant increase in the maternal

¹⁵¹ UN Committee on Economic, Social and Cultural Rights, General Comment No.22 (2016) on the right to sexual and reproductive health (article 12 of the ICESCR) para 5, available at: <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmIBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQeiF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxiHySkUoHMavD%2Fpyfcp3YIzq>

¹⁵² See also Article 14 Maputo Protocol; Maputo Plan of Action 201-2030 for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights, available at: https://au.int/sites/default/files/documents/30358-doc-mpoa_7-revised_au_stc_inputs_may_se-rob-director_002.pdf

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mortality rate and the high rate of maternal mortality resulting from unsafe abortions".¹⁵³ In Eswatini the maternal mortality rate is high and is more than twice the global average.¹⁵⁴ While there is limited reliable data on unsafe abortions in Eswatini, "it is estimated that unsafe abortions account for about 10 percent of maternal deaths."¹⁵⁵ In addition, maternal mortality has been attributed, in part, to a lack of medical and commodities supply at health facilities.¹⁵⁶

While the Swazi Constitution provides for abortion in very limited circumstances, as mentioned above, there is however no legislation giving effect to the relevant constitutional provision.¹⁵⁷ There have been calls for the Swazi government to legalize abortion in Eswatini in order to prevent such deaths.¹⁵⁸ The law on abortion in Eswatini remains unclear as the government is yet to enact domestic laws on abortion. The Human Rights Committee has also expressed concern:

*"about the lack of clarity regarding circumstances in which voluntary termination of pregnancy is legally available, and that the State party has not yet adopted the legislation as provided under article 15 of the Constitution."*¹⁵⁹

And:

*"about reports that cumbersome procedural requirements, including requirements of court orders, and refusal to perform abortions on grounds of conscientious objection have obstructed access to women or girls seeking lawful abortions."*¹⁶⁰

Women's access to adequate family planning services in Eswatini has also been identified as an area of concern. The government of Eswatini is the main provider of family planning services through hospitals and clinics.¹⁶¹ The government's Family Planning Programme is implemented as part of the National Sexual and Reproductive Health Policy, which, according to the Ministry of Health "prioritizes family planning as a core element of the sexual reproductive health package."¹⁶² There are, however, other main providers, such as the Family Life Association of Swaziland (FLAS), who play a significant role in the provision of these services.¹⁶³ According to the Swazi government, family planning service availability was found in 75% of government health service sites in Eswatini; however, "whilst most of the facilities were ready to provide [family planning] fewer reported having the appropriate trainings, guidelines and a complete set of items for family

¹⁵³ UN Human Rights Committee, Concluding observations on Swaziland in the absence of a report, CCPR/C/SWZ/CO/1, para 28, available at <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=60kG1d%2FPPrICAqhKb7yhsguV2ca8YRoL5RMKMpLAWTcLB%2Fi6wNmMX6TyELJKY4VCxJXfNLfQik0dJzaMoubvEeHTEvJUJVM6OulSvZfCrQPZ1edvvSAVgzqbXKVkmUyQ>

¹⁵⁴ UNFPA, Kingdom of Eswatini Facts and Prospects. Sexual and Reproductive Health Rights (2019) https://eswatini.unfpa.org/sites/default/files/pub-pdf/UNFPA_MIC_Country_Policy_Brief_ESWATINI.pdf See also, WHO, Maternal mortality in 2000-2017 Internationally comparable MMR estimates by the Maternal Mortality Estimation Inter-Agency Group (MMEIG) WHO, Unicef, UNFPA, World Bank Group and the United Nations Population Division, Eswatini, https://www.who.int/gho/maternal_health/countries/swz.pdf?ua=1

¹⁵⁵ Id

¹⁵⁶ UNFPA, Kingdom of Eswatini Facts and Prospects. Sexual and Reproductive Health Rights (2019) https://eswatini.unfpa.org/sites/default/files/pub-pdf/UNFPA_MIC_Country_Policy_Brief_ESWATINI.pdf

¹⁵⁷ Section 15(5) Abortion is unlawful but may be allowed: (a) on medical or therapeutic grounds including where a doctor certifies that (i) continued pregnancy will endanger the life or constitute a serious threat to the physical health of the woman; (ii) continued pregnancy will constitute a serious threat to the mental health of a woman; (iii) there is serious risk that the child will suffer from physical or mental defect of such a nature that the child will be irreparably seriously handicapped; (b) where the pregnancy results from rape, incest or unlawful sexual intercourse with a mentally retarded female; or (c) on such grounds as parliament may prescribe."

¹⁵⁸ See, for example, Call by ICJ Commissioner Judge Qinisile Mabuza: Andile Nsibandwe Eswatini Observer, Legalise Abortion – Judge Qinisile, 29 September 2020 available at: <http://new.observer.org.sz/details.php?id=13879>

¹⁵⁹ UN Human Rights Commission, Concluding observations on Swaziland in the absence of a report, CCPR/C/SWZ/CO/1, para 28, available at:

https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2fSWZ%2fCO%2f1&Lang=en

¹⁶⁰ Id

¹⁶¹ The Kingdom of Eswatini, Sexual and Reproductive Health Unit. <http://www.gov.sz/index.php/component/content/article/73-health/health/473-sexual-reproductive-health?Itemid=799> . See also Gugulethu Gule, Socio-Cultural Constraints to family planning in Swaziland, Canadian Studies in Population, Vol. 21(1), 1994, pp 35-49, available at: <https://journals.library.ualberta.ca/csp/index.php/csp/article/view/15792/12597>

¹⁶² Swaziland Ministry of Health, Quantification of Family Planning Commodities for January 2014 to December 2018, (January 2014), available at <http://siapsprogram.org/wp-content/uploads/2014/05/14-140-Swaziland-FP-final-format.pdf> , p 2

¹⁶³ www.flas.org.sz

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planning services availability.¹⁶⁴ This shows that, in instances where the government has been able to ensure the availability of family planning services, personnel charged with administering such services may not always be trained on how to do so.

The most frequently used contraception relied upon by women in Eswatini are male condoms, injectables and pills.¹⁶⁵ Studies in Eswatini indicate that contraception use varies depending on where women live: contraception use is more prevalent in urban areas than in rural areas.¹⁶⁶ Use of contraception by Swazi women has also been closely associated with level of education, with women with lower education having a lower contraception prevalence.¹⁶⁷

Furthermore, data from the Eswatini Ministry of Health indicates that there is a high unmet need for family planning, especially among HIV positive women.¹⁶⁸ In addition, this data indicates that there is a high percentage of Swazi women who have had unplanned births.¹⁶⁹ Unmet need for contraception refers to "women who are not using any method of contraception, but who wish to postpone the next birth or who wish to stop childbearing."¹⁷⁰ The estimated unmet need for contraception was highest among the poorest women, and was prevalent in rural areas compared to urban areas.¹⁷¹ There is also high (30%) unmet need for family planning among young people in Eswatini.¹⁷² This is because a limited number of healthcare facilities in the country provide any youth-friendly services, which contributes to young people being deterred from accessing sexual and reproductive health services.¹⁷³ Indeed, the National Policy on Sexual and Reproductive Health acknowledges the inadequate amount of youth friendly services in Eswatini as a gap.¹⁷⁴

In Eswatini, teen pregnancy accounts for 41 percent of drop-out from lower secondary school and 52 percent from senior secondary school.¹⁷⁵ Adolescents and youth in Eswatini "do not have adequate information and accessibility to services which will enable them to make informed decisions on their sexuality and reproductive health."¹⁷⁶ This lack of knowledge contributes to young people engaging in sexual activity at an early age being ill-equipped to seek appropriate health information and access to appropriate health commodities, and to their having little knowledge on how to negotiate safer sex.¹⁷⁷

¹⁶⁴ Deputy Prime Minister's Office, The Kingdom of Eswatini's Country Progress Report on the Implementation of the Beijing Declaration and Platform for Action, May 2019, p41. Available at: https://www.uneca.org/sites/default/files/uploaded-documents/Beijing25/eswatini-beijing25_report.pdf

¹⁶⁵ Government of Swaziland, Swaziland; Monitoring the situation of children, women and men, Multiple indicator Cluster Survey 2010 (December 2011) p119, available at:

https://reliefweb.int/sites/reliefweb.int/files/resources/MICS4_Swaziland_FinalReport_2010_Eng.pdf See also Philile shongwe et al, Assessing the Acceptability of Vasectomy as a Family Planning Option: A qualitative Study with Men in the Kingdom of Eswatini, (17 December 2019), available at: <https://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC6950132&blobtype=pdf>

¹⁶⁶ Government of Swaziland, Swaziland; Monitoring the situation of children, women and men, Multiple indicator Cluster Survey 2010 (December 2011) available at:

https://reliefweb.int/sites/reliefweb.int/files/resources/MICS4_Swaziland_FinalReport_2010_Eng.pdf

¹⁶⁷ Id

¹⁶⁸ Swaziland Ministry of Health, Quantification of Family Planning Commodities for January 2014 to December 2018, (January 2014), p2 Available at: <http://siapsprogram.org/wp-content/uploads/2014/05/14-140-Swaziland-FP-final-format.pdf>,

¹⁶⁹ Id

¹⁷⁰ Government of Swaziland, Swaziland; Monitoring the situation of children, women and men, Multiple indicator Cluster Survey 2010 (December 2011) available at:

https://reliefweb.int/sites/reliefweb.int/files/resources/MICS4_Swaziland_FinalReport_2010_Eng.pdf

¹⁷¹ Id, p113

¹⁷² Deputy Prime Minister's Office, The Kingdom of Eswatini's Country Progress Report on the Implementation of the Beijing Declaration and Platform for Action, May 2019, p43. Available at: https://www.uneca.org/sites/default/files/uploaded-documents/Beijing25/eswatini-beijing25_report.pdf UNFPA Eswatini, Eswatini Annual Report, 2019. Available at:

https://eswatini.unfpa.org/sites/default/files/pub-pdf/unfpa_eswatini_annual_report_2019.pdf

¹⁷³ Id

¹⁷⁴ The Kingdom of Swaziland – Ministry of Health, National Policy on Sexual and Reproductive Health, (2013) , p12 available at: <https://abortion-policies.srhr.org/documents/countries/02-Swaziland-National-Policy-on-Sexual-and-Reproductive-Health-2013.pdf>

¹⁷⁵ UNICEF, Country Office Annual Report Eswatini (former Swaziland) (2018) available at:

[https://www.unicef.org/about/annualreport/files/Eswatini_\(Swaziland\)_2018_COAR.pdf](https://www.unicef.org/about/annualreport/files/Eswatini_(Swaziland)_2018_COAR.pdf)

¹⁷⁶ Ministry of Sports, Culture, and Youth Affairs, Swaziland State of The Youth Report, 2015, p33 Available at:

<https://eswatini.unfpa.org/sites/default/files/pub-pdf/Youth%20Report%202015%20with%20covers.pdf>

¹⁷⁷ Ministry of Sports, Culture, and Youth Affairs, Swaziland State of The Youth Report, 2015. Available at:

<https://eswatini.unfpa.org/sites/default/files/pub-pdf/Youth%20Report%202015%20with%20covers.pdf>

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This reality is also acknowledged in the National Policy on Sexual and Reproductive Health.¹⁷⁸ Swazi adolescents face significant challenges in accessing reproductive health information and services.¹⁷⁹

The CEDAW Committee in its Concluding observations following its examination of Eswatini's compliance with the CEDAW Convention expressed concern regarding the lack of age-appropriate sexual and reproductive health and rights education in schools in Eswatini owing to cultural resistance because sex education is considered taboo.¹⁸⁰ The CEDAW Committee recommended that the State integrate age appropriate sexual and reproductive health and rights education in schools.¹⁸¹ The Human Rights Committee has also recommended that Eswatini takes steps to:

*"ensure access for men, women, boys and girls to comprehensive reproductive health education and services throughout the country, particularly in rural areas, including access to affordable contraceptives, and increase awareness raising programmes on the importance of using contraceptives and on sexual and reproductive rights and choices".*¹⁸²

Article 5 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) requires States parties to CEDAW, to take measures to:

*"modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women".*¹⁸³

In addition, State party to the Maputo Protocol, are required to "remove impediments to the health services reserved for women, including ideology or belief-based barriers."¹⁸⁴ These general obligation are of particular relevance to the protection of women's sexual and reproductive health rights in Eswatini because access to, enjoyment and exercise of the right to sexual and reproductive healthcare, goods and services are negatively impacted by prejudicial religious and customary beliefs and practices in Eswatini. For example, in Eswatini "even mere talk about the subject of abortion is taboo" as the country is a both deeply religious and traditional country; and this has been cited as one of the main reasons why there has not been a comprehensive debate in parliament on the issue of abortion and consequently no laws drafted.¹⁸⁵

There are many other contextual factors, such as poverty, lack of education and high rates of unemployment that increase the risk of young Swazis engaging in behaviours that put them at high risk of contracting STIs, including HIV.¹⁸⁶ This highlights the importance of the interrelated nature of ESCR, and draws attention to the need for Eswatini to fully realize the right to an adequate standard of living and all other ESCR of women and girls both as independent binding commitments, but also in order to ensuring the full realization of their right to health.

¹⁷⁸ National Policy on Sexual and Reproductive Health, p18

¹⁷⁹ UNICEF, Country Office Annual Report Eswatini (former Swaziland) (2018) available at: [https://www.unicef.org/about/annualreport/files/Eswatini_\(Swaziland\)_2018_COAR.pdf](https://www.unicef.org/about/annualreport/files/Eswatini_(Swaziland)_2018_COAR.pdf)

¹⁸⁰ UN Committee on Elimination of Discrimination of all Forms of Discrimination Against Women, Concluding observations on the combined initial and second periodic report of Swaziland, CEDAW/C/SWZ/CO/1-2, para 30(c). Available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=En&CountryID=167&ctl00_PlaceHolderMain_radResultsGridChangePage=2

¹⁸¹ Id para 31(e)

¹⁸² UN Human Rights Committee, Concluding Observations on Swaziland in the absence of a report, CCPR/c/SWZ/CO/1 <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsquV2ca8YRoL5RMKMpLAWTCLB%2Fi6wnmMX6TyELJKY4VCxJXfNLfQik0djzaMoubvEeHTEvJUJVM6OulSvZfCrOPZ1edvvSAVgzbXKVkmUyQ>

¹⁸³ The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (3 September 1981), Article 5(a).

¹⁸⁴ African Commission on Human and Peoples' Rights, General Comment No.2 on Article 14.1 a), b), c) and f) and Article 14.2 a) and c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 25

¹⁸⁵ Cebelihle Mbuyisa, Eswatini needs to talk about illegal abortions, 27 October 2020, available at: <https://www.newframe.com/eswatini-needs-to-talk-about-illegal-abortions/>

¹⁸⁶ Ministry of Sports, Culture, and Youth Affairs, Swaziland State of The Youth Report, 2015, p32 Available at: <https://eswatini.unfpa.org/sites/default/files/pub-pdf/Youth%20Report%202015%20with%20covers.pdf>

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II. HIV/AIDS

Eswatini is one of the most severely HIV affected countries in the world with a high prevalence of HIV.¹⁸⁷ In 2019, in Eswatini 95% of people living with HIV knew their HIV status, 95% were on treatment and 92% were virally suppressed.¹⁸⁸ Though 95% of pregnant women living with HIV accessed antiretroviral medicine to prevent mother-to-child transmission of the virus in the process of giving birth.¹⁸⁹

Women in Eswatini remain disproportionately affected by HIV with 63.16% of those living with HIV being women.¹⁹⁰ In addition, in 2018 "new HIV infections among young women aged 15-24 years were more than quadruple those among young men."¹⁹¹ HIV and AIDS is more prevalent among young adults in Eswatini with young women having the highest rates of infection.¹⁹² Young women in Eswatini are also vulnerable to risky sexual interactions partly due to gender norms that make it difficult for them to negotiate safe sex.¹⁹³

The Swazi government has admitted that "adolescents and young people have relatively poor coverage of HIV services in the HIV treatment cascade and Sexual and Reproductive Health services, which threatens the achievement of goals set by the country and, more importantly, their health." In 2019, data from the ministry of health indicated that only 66.1% of persons living with HIV under the age of 15 were aware of their HIV status and only 31% of adolescent girls and women between 15-24 indicated using a condom as a contraceptive, and the rate of pregnancy among adolescents was high.¹⁹⁴

As detailed above under section entitled *Normative content of women's right to health under international human rights law*, states, including Eswatini have an obligation to protect women's right to health, including their right to sexual and reproductive healthcare. The Maputo Protocol, to which Eswatini is party, "is the first international legally binding human rights instrument that recognises the intersection between women's human rights and HIV."¹⁹⁵

III. Sexual and Gender-Based Violence Related Healthcare Services

The SODV Act was enacted in 2018 and creates a framework that aims to protect Swazis from sexual offences, gender-based and domestic violence.¹⁹⁶ Among other things, the SODV Act includes the following provisions that are of relevance to the present analysis:

¹⁸⁷ UNAIDS, Country, Eswatini (2019) available at: <https://www.unaids.org/en/regionscountries/countries/swaziland> ; See also WHO, Swaziland (December 2005) available at: https://www.who.int/hiv/HIVCP_SWZ.pdf and UNFPA Eswatini, Eswatini Annual Report, 2019. Available at: https://eswatini.unfpa.org/sites/default/files/pub-pdf/unfpa_eswatini_annual_report_2019.pdf see also UNICEF, Country Office Annual Report Eswatini (former Swaziland) (2018) available at: [https://www.unicef.org/about/annualreport/files/Eswatini_\(Swaziland\)_2018_COAR.pdf](https://www.unicef.org/about/annualreport/files/Eswatini_(Swaziland)_2018_COAR.pdf) and The Kingdom of Eswatini and UNICEF, Impact of the Teen Club Programme for Adolescents living with HIV in Eswatini, (December 2018), available at: [Impact_Evaluation_of_Teen_Club_Programme_for_Adolescents_living_with_HIV_in_Eswatini.pdf](https://www.unicef.org/about/annualreport/files/Eswatini_(Swaziland)_2018_COAR.pdf)

¹⁸⁸ UNAIDS, Country, Eswatini, (2019), available at: <https://www.unaids.org/en/regionscountries/countries/swaziland>

¹⁸⁹ id

¹⁹⁰ id

¹⁹¹ id

¹⁹² UNICEF, Country Office Annual Report Eswatini (former Swaziland) (2018) available at: [https://www.unicef.org/about/annualreport/files/Eswatini_\(Swaziland\)_2018_COAR.pdf](https://www.unicef.org/about/annualreport/files/Eswatini_(Swaziland)_2018_COAR.pdf)

¹⁹³ id

¹⁹⁴ Kingdom of Eswatini, Multisectoral Guidelines to Facilitate Adolescents' Access to Services Related to HIV and Sexual Reproductive Health, (2019) P3 Available at: <https://www.unicef.org/eswatini/media/1176/file/Multi-sectoral%20guidelines%20to%20facilitate%20adolescents%E2%80%99%20access%20to%20se%20to%20services%20related%20to%20HIV%20and%20SRH-2020.pdf.pdf>

¹⁹⁵ African Commission on Human and Peoples' Rights, General Comment No. 1 on Article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, available at: <https://www.achpr.org/legalinstruments/detail?id=14>

¹⁹⁶ For a summary of the Act see: Southern African Litigation Centre, Eswatini's Sexual Offences and Domestic Violence Act, A Summary. <https://www.southernafricalitigationcentre.org/wp-content/uploads/2019/10/SALC-New-Sexual-Offences-Legislation-SD-FINAL-WEB-version.pdf>

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- **Marital Rape:** Section 151 provides that a marital relationship is not a valid defence for the crime of rape and therefore outlaws "marital rape".¹⁹⁷
- **Counselling:** Section 72 requires that victims of sexual offenses must be informed of the availability of counselling services and support services, such as post exposure prophylactics.¹⁹⁸
- **Medical Treatment:** Sections 73, 74 and 75 provide that victims of sexual offences must be treated in accordance with the prescribed guidelines – pending the creation of such guidelines, the Guidelines of the WHO on medico-legal care for victims of sexual violence shall be followed; and such victims must be examined by a nurse or medical practitioner although no time limit is set by which such an examination should take place.¹⁹⁹
- **Secondary Victimization:** Section 76 requires that victims of sexual offences be treated in a manner that minimizes secondary trauma, and provides that a failure to do so on the part of a health practitioner may result in disciplinary measures implemented for such misconduct as contemplated by the Medical and Dental Practitioners Act and Nurses and Midwives Act.²⁰⁰
- **Domestic Violence:** Section 77 prohibits domestic violence, broadly defined to include physical, sexual, emotional, economical abuse, including controlling and abusive behaviour and intimidation, harassment and stalking, damage to property and entry into property without consent.²⁰¹ It prescribes up to 15 years' imprisonment for a person found guilty of this offence or "a fine not exceeding seventy-five thousand Emalangeni".²⁰²

Despite these provisions, gender-based violence continues to be a calamity in Eswatini. The prevalence of gender based violence is high in Eswatini with 26% of people between 15-49 years experiencing such violence.²⁰³ Many women in Eswatini experience sexual violence at home or in the homes of friends or neighbours before the age of 35.²⁰⁴ Many women also experience physical violence perpetrated by boyfriends, husbands or male relatives.²⁰⁵ There are high levels of gender-based violence in Eswatini with one in three women having experienced some form of sexual violence by the time they are 18 years old.²⁰⁶

The Ministry of Sports, Culture and Youth Affairs in Eswatini has expressed concern about "attitudes towards gender based violence in general [which] continue to be worryingly accepting, with 33.4% of women and 16.3% of men believing that a husband is justified in hitting his wife...which shows the magnitude of the acceptability of gender-based violence within the youth population."²⁰⁷ In its publication entitled "Achieving Justice for Gross Human Rights Violations in Swaziland" the ICJ previously reported similar concerns:

"Surveys on attitudes towards domestic violence have been conducted, the results of which demonstrate strong support for traditional gender roles, high levels of rape-supportive attitudes and tolerant attitudes for violence. For example, only 51 percent of men have been surveyed as believing that a woman may refuse to have sexual intercourse with her

¹⁹⁷ SODV Act, Section 151

¹⁹⁸ SODV Act, Section 72

¹⁹⁹ SODV Act, Sections 73 and 74

²⁰⁰ SODV Act, Section 76

²⁰¹ Includes physical, sexual, emotional, economical abuse including controlling and abusive behavior; and intimidation, harassment and stalking, damage to property and entry into property without consent. See SODV Act, Section 77(1)

²⁰² SODV Act, Section, 77

²⁰³ Ibid

²⁰⁴ Ministry of Sports, Culture, and Youth Affairs, Swaziland State of The Youth Report, 2015, p38 Available at: <https://eswatini.unfpa.org/sites/default/files/pub-pdf/Youth%20Report%202015%20with%20covers.pdf> See also UNICEF, A national study on violence against children and young women in Swaziland, 2007. Available at: https://www.togetherforgirls.org/wp-content/uploads/2017/09/2007_Swaziland_Findings-from-a-Violence-Against-Children-Survey.pdf

²⁰⁵ Ministry of Sports, Culture, and Youth Affairs, Swaziland State of The Youth Report, 2015, p38 Available at: <https://eswatini.unfpa.org/sites/default/files/pub-pdf/Youth%20Report%202015%20with%20covers.pdf>

²⁰⁶ SWAGAA, Gender Based Violence, <http://www.swagaa.org.sz/gender-based-violence/> See also UNFPA Eswatini, Eswatini Annual Report, 2019. Available at: https://eswatini.unfpa.org/sites/default/files/pub-pdf/unfpa_eswatini_annual_report_2019.pdf

²⁰⁷ Ministry of Sports, Culture, and Youth Affairs, Swaziland State of The Youth Report, 2015, p38-39 Available at: <https://eswatini.unfpa.org/sites/default/files/pub-pdf/Youth%20Report%202015%20with%20covers.pdf>

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husband, while 88 percent believe a woman should obey her husband and 45 percent believe a husband has a right to punish his wife if she does something he deems is wrong."²⁰⁸

In its 2018 report, UNICEF highlighted that violence against children and adolescents was a challenge in Eswatini and "is prevalent in all forms: physical, sexual and emotional abuse."²⁰⁹ Such violence "compromises women's and girls' ability to make autonomous decisions in matters affecting their lives. Violence exposes girls to the risk of early pregnancy, HIV and other sexually transmitted infections, stigmatization and abandonment of education."²¹⁰ Similarly, the Human Rights Committee has expressed concern about:

"reports of widespread violence against women and children, in particular pervasive sexual violence, including rape and marital rape and that relevant officials lack specific training on gender based violence."²¹¹

Several States expressed concern regarding the high incidence of gender-based violence in Eswatini during the country's most recent Universal Periodic Review.²¹² In its recent publication entitled "Access to Justice Challenges for Victims and Survivors of Sexual and Gender-Based Violence in Eswatini", the ICJ highlights some of the recommendations that States made in the course of the Universal Periodic Review process.²¹³ Some of the key challenges relating Swazi women's access to justice for sexual and gender-based violence are discussed in more detail in the ICJ's recent publication on this issue.²¹⁴

Gender-based violence affects women's right to health detrimentally in many ways. For example, as recognized by Eswatini's National Multisectoral HIV and Aids Strategic Framework:

"GBV affects women's health, particularly their sexual and reproductive health, and rights by compromising their ability to negotiate for safer sex through condom use and to timely test for HIV".²¹⁵

The main challenges relating to inadequacy of services for victims of sexual and gender-based violence include:

- **Limited access to health professionals:** such violence can increase vulnerability to a range of physical and mental health problems that need to be addressed as soon as possible. Exposure to sexual violence is linked to "depression, suicidal thoughts, unwanted pregnancy, complications of miscarriages, sexually transmitted diseases, difficulty in sleeping, and alcohol consumption."²¹⁶ Access to health professionals or social workers who can provide professional counselling is however limited in Eswatini.

²⁰⁸ ICJ, Achieving Justice for Gross Human Rights Violations in Swaziland, Key Challenges, May 2018, p 14 para 2.5. available at: <https://www.icj.org/wp-content/uploads/2018/05/Swaziland-GRABaselineStudy-Publications-Reports-Thematic-reports-2018-ENG.pdf>

²⁰⁹ UNICEF, Country Office Annual Report Eswatini (former Swaziland) (2018) available at: [https://www.unicef.org/about/annualreport/files/Eswatini_\(Swaziland\)_2018_COAR.pdf](https://www.unicef.org/about/annualreport/files/Eswatini_(Swaziland)_2018_COAR.pdf)

²¹⁰ Id

²¹¹ UN Human Rights Committee, Concluding observations on Swaziland in the absence of a report, UN Doc. CCPR/C/SWZ/CO/1 (2017), para. 26. Similar concerns have been expressed by the CEDAW Committee UN Committee on the Elimination of Discrimination against Women (CEDAW Committee), Concluding observations on the combined initial and second periodic reports of Swaziland, UN Doc. CEDAW/C/SWZ/CO/1-2 (24 July 2014), para. 20

²¹² United Nations Human Rights Council, Universal Periodic Review – Eswatini <https://www.ohchr.org/EN/HRBodies/UPR/Pages/SZIndex.aspx>

²¹³ International Commission of Jurists, Access to Justice Challenges Faced by Victims and Survivors of Sexual and Gender-Based Violence in Eswatini, March 2020, p3. Available at: <https://www.icj.org/wp-content/uploads/2020/09/Eswatini-SGBV-Report-Advocacy-Analysis-brief-2020-ENG.pdf>

²¹⁴ International Commission of Jurists, Access to Justice Challenges Faced by Victims and Survivors of Sexual and Gender-Based Violence in Eswatini, March 2020, p5-8. Available at: <https://www.icj.org/wp-content/uploads/2020/09/Eswatini-SGBV-Report-Advocacy-Analysis-brief-2020-ENG.pdf>

²¹⁵ The Government of Eswatini, The National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018-2023, June 2018, p 40 Available at: https://hivpreventioncoalition.unaids.org/wp-content/uploads/2019/06/Eswatini_NSF-2018-2023_final.pdf

²¹⁶ Id para 44

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- **Lack of medical kits:** there have been reports of shortages of rape kits and swabs to assist victims of rape and sexual violence.²¹⁷
- **Shortage of safe houses:** there is a shortage of safe houses and hostels for women and children who may require shelter from sexual and gender-based violence.²¹⁸ (see section 4. below)
- **Lack of access to legal aid:** since there is no provision for legal aid services for victims of sexual and gender-based violence in Eswatini, many victims and survivors face challenges in accessing justice through courts.

IV. *Access to Shelters and housing*

The Human Rights Committee has urged Eswatini to ensure that victims of GBV have access to "effective remedies and means of protection", including by ensuring "accommodation or shelters, are available in all parts of the country".²¹⁹ In 2018 Swazi civil society organizations reported that "there is still need for comprehensive response structures to be put in place for the protection of survivors of sexual and gender based violence including safe houses".²²⁰ The CEDAW Committee has also expressed concern that "shelters remain inadequate for and inaccessible for women and girls in other regions". The Committee had therefore recommended that the government "decentralize one-stop centres and shelters to the four regions of the state party in order to ensure that women and girls who are victims of violence can gain access to them."²²¹

In general, in Eswatini women have faced significant difficulties in accessing adequate housing with security of tenure because of customary law rules and social norms. The land is allocated to Swazi people through local chiefs and is based on a patronage system.²²² Many women are still forbidden to approach the chiefs for the allocation of land, unless they are accompanied by male relatives; it is common for chiefs to allocate communal land to women only through their husbands, male relatives or male children.²²³ While the Swazi Constitution provides for equal access to land for men and women,²²⁴ women are discriminated against when it comes to ownership of land. Such discrimination leaves widows, unmarried women and women without sons vulnerable when it comes to land ownership and access.

In addition, forced evictions, which are common place in Eswatini, also impact women disproportionately.²²⁵ Reports suggest that many evicted women face challenges when seeking to be allocated land by chiefs in the aftermath of being evicted, especially because they cannot afford the traditional fees associated with such allocation.²²⁶ There have been reports of homesteads of

²¹⁷ Id para 55

²¹⁸ Id para 45

²¹⁹ UN International Covenant on Civil and Political Rights, Concluding Observations on Swaziland in the absence of a report, 23 August 20217, CCPR/c/swz/co/1, para 27(e) Available at:

https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2fSWZ%2fCO%2f1&Lang=en

²²⁰ Kingdom of Eswatini, CSO Assessment of the implementation of follow-up recommendations, 4 October, 2018, Available at:

https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/SWZ/INT_CCPR_NGS_SWZ_33000_E.pdf

²²¹ UN Committee on the Elimination of Discrimination against Women, Concluding observations on the combined initial and second periodic report of Swaziland, CEDAW/c/swz/co/1-2, 24 July 2014, para 21(d) Available at:

[file:///Users/khanyofarise/Downloads/N1448196%20\(2\).pdf](file:///Users/khanyofarise/Downloads/N1448196%20(2).pdf)

²²² International Commission of Jurists, Achieving Justice for Gross Human Rights Violations in Swaziland: Key Challenges, May 2018, p24. Available at: <https://www.icj.org/wp-content/uploads/2018/05/Swaziland-GRABaselineStudy-Publications-Reports-Thematic-reports-2018-ENG.pdf> See also, Amnesty International, They don't see us as people, Security of Tenure and Forced Evictions in Eswatini. 2018. Available at: <https://www.amnesty.org/download/Documents/AFR5587852018ENGLISH.PDF> See also, SALC, Alignment of Eswatini's Domestic Laws with Recommendations of United Nations Human Rights Mechanisms, p32, Available at: <https://www.southernafricalitigationcentre.org/wp-content/uploads/2018/09/SALC-Eswatini-Human-Rights-Research-Report.pdf>

²²³ See Absalom M Manyatsi et al, Land Governance in Eswatini, September 2019, p 35. Available at:

<http://landsymposium.nust.na/sites/default/files/2019-08/Land%20Governance%20in%20eSwatini%203-4%20September%202019.pdf>

²²⁴ Section 211 (2) "Save as may be required by the exigencies of any particular situation, a citizen of Swaziland, without regard to gender, shall have equal access to land for normal domestic purposes"

²²⁵ Amnesty International, They don't see us as people, Security of Tenure and Forced Evictions in Eswatini. 2018. Available at:

<https://www.amnesty.org/download/Documents/AFR5587852018ENGLISH.PDF>

²²⁶ There are reports of women waiting for more than 3 years to be allocated land after they were evicted. See Amnesty

International, They don't see us as people. Security of Tenure and forced evictions in Eswatini, 2018

<https://www.amnesty.org/download/Documents/AFR5587852018ENGLISH.PDF>

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the families, many of which consisted of single mothers being destroyed and evictions done without any prior formal notice of the evictions.²²⁷

Furthermore, the UN Human Rights Committee has expressed concern that sexual minorities, including lesbian, bisexual and intersex and transgender women "frequently face discrimination, particularly in accessing adequate housing and employment."²²⁸

The above indicates that women in Eswatini generally have limited access to land ownership and are at risk of evictions, leaving them at risk of being homeless. As the Special Rapporteur on violence against women, its causes and consequences highlighted in her report in 2000 "housing policy is directly related to issues of violence against women", and "inadequate housing provides living conditions that are conducive to violence."²²⁹ In addition to the health related harm which can be caused by unhygienic environments and lack of access to safe drinking water as a result of homelessness, women also face health risks brought about by overcrowding in such inadequate housing conditions as well as high stress levels associated with living in such conditions.²³⁰

Furthermore, such inadequate housing exacerbates the risk of women experiencing violence, including rape and sexual violence.²³¹ In particular, the risk of eviction leave women at risk of being "exposed to violence and intense emotional stress before, during and after an eviction because of their close ties to the home and their role as caregivers for the entire family."²³² It is not uncommon for women to experience violence even during the process of eviction where "verbal abuse, beatings and rape may take place." After women have been evicted, they may be at an even greater risk of being abused, especially if they have been forced to move to inadequate housing, often in informal settlements where the lack of shelter and privacy can lead to increased exposure to sexual and other forms of violence.²³³

Inadequate housing can directly contribute to women remaining in abusive environments. Many women who have fled domestic violence have been reported to return to their homes and thus to violence, due to lack of shelter.²³⁴

B. Impact of COVID-19 on women's right to health in Eswatini

While Eswatini has made progress in the provision of healthcare services for women, the COVID-19 health crisis threatens to reverse such gains and impede further progress. As the CESCR has correctly highlighted, "the pandemic has deep negative impacts on the enjoyment of economic,

P26 and 27

²²⁷ For example, between October 2014 and April 2018, 19 homesteads consisting of at least 180 people were forcibly evicted to give way to the Royal Science and Technology Park. See Amnesty International, They don't see us as people. Security of Tenure and forced evictions in Eswatini, 2018 <https://www.amnesty.org/download/Documents/AFR5587852018ENGLISH.PDF> p18

²²⁸ UN International Covenant on Civil and Political Rights, Concluding Observations on Swaziland in the absence of a report, 23 August 2017, CCPR/c/swz/co/1, para 18 Available at:

https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2fSWZ%2fCO%2f1&Lang=en

²²⁹ Commission on Human Rights, Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women, Report of the Special Rapporteur on violence against women, its causes and consequences, E/CN.4/2000/68/Add.5, 24 February 2000, para 68-69. Available at: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G00/112/65/PDF/G0011265.pdf?OpenElement>

²³⁰ Id, para 69

²³¹ Human Rights Council, Report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living on the right to non-discrimination in this context, 30 December 2015, A/HRC/31/54. Available at:

https://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/31/54

²³² See also, Office of the High Commissioner for Human Rights, The right to Adequate Housing, Fact Sheet No.21. p18 Available at: https://www.ohchr.org/documents/publications/fs21_rev_1_housing_en.pdf

²³³ See also, Office of the High Commissioner for Human Rights, The right to Adequate Housing, Fact Sheet No.21. p18 Available at: https://www.ohchr.org/documents/publications/fs21_rev_1_housing_en.pdf

²³⁴ Commission on Human Rights, Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women, Report of the Special Rapporteur on violence against women, its causes and consequences, E/CN.4/2000/68/Add.5, 24 February 2000, para 70. Available at: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G00/112/65/PDF/G0011265.pdf?OpenElement>

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social and cultural rights, especially the right to health of the most vulnerable groups".²³⁵ The Special Rapporteur on the rights of women in Africa has also observed that many African women face significant challenges in accessing sexual and reproductive healthcare services due to measures put in place by states to curb the spread of COVID-19.²³⁶

The Swazi government is among those that have introduced measures to curb the spread of the coronavirus, including through restriction on travel and movement.²³⁷ However, being a country with a high HIV prevalence, coupled with the country facing a tuberculosis epidemic, Eswatini's health system has reportedly been placed under significant pressure by the COVID-19 outbreak.²³⁸ According to the United Nations Population Fund, there has been a significant drop in family planning services uptake by women due to the COVID-19 in Eswatini; the uptake dropped by 47% compared to the same period the previous year.²³⁹ There have also been reports, especially from health facilities based in rural areas, that since the lockdowns started, there have been more cases of women delivering babies at their homes in Eswatini or on the way to health facilities.²⁴⁰

COVID-19 restrictions have had an impact on the accessibility of health services for women through the decline of distribution of condoms, and restriction on access to places where contraceptives were previously distributed.²⁴¹ In addition, restriction of movement regulations have meant that people cannot visit family planning services; even shops selling contraceptives have run dry.²⁴² Travel restrictions have also hindered essential services such as gender-based violence services because of limited transport and lack of travel permits.²⁴³ According to UNFPA "Covid19 has severely disrupted access to life-saving sexual, reproductive healthcare".²⁴⁴

6. RECOMMENDATIONS FOR IMPROVING WOMEN'S ENJOYMENT OF THE RIGHT TO HEALTH IN ESWATINI

In order to realize the right to health of women and girls in Eswatini, the ICJ recommends that the Eswatini authorities take the following measures.

A. Sexual and Reproductive health

- Ensure **access to family planning health services** for all women and LGBT persons;
- **Parliament must enact domestic legislation**, in accordance with section 5(5)(c) of the Constitution, detailing the circumstances in which abortion is allowed. In particular, the legislation should clarify the circumstances under which abortion is legally available to women. Abortion must be allowed in line with international human rights law and standards, including in circumstances when it constitutes an informed, autonomous choice of the pregnant person to terminate a pregnancy. The legislation must ensure the de jure

²³⁵ Committee on Economic, Social and Cultural Rights, Statement on the coronavirus disease (COVID19 pandemic on economic, social and cultural rights, E/C.12/2020/1 6 April 2020 Available at: <https://www.gi-escr.org/latest-news/new-statement-by-the-committee-on-economic-social-and-cultural-rights-on-covid-19-and-esc-rights>

²³⁶ African Commission on Human and Peoples' Rights, Press Release of the Special Rapporteur on the Rights of Women in Africa on violation of women's rights during the COVID19 pandemic, 6 May 2020. Available at: <https://www.achpr.org/pressrelease/detail?id=495Press>

²³⁷ Eswatini Government Gazette Extraordinary, Coronavirus (COVID19) Regulations, 2020, 27 March 2020. Available at: <http://www.gov.sz/images/CORONA/The-Coronavirus-COVID-19-Regulations-2020.pdf>

²³⁸ Bernhard Kerschberger, eSwatini - Responding to Covid19 in A country Already Fighting A duel HIV/TB Epidemic, All Africa, 8 May 2020. Available at: <https://allafrica.com/stories/202005080300.html> Accessed 10 June 2020

²³⁹ UNFPA, UNFPA brings family planning SMS innovation against a looming post COVID-19 births spike, 16 June 2020. Available at: <https://eswatini.unfpa.org/en/news/unfpa-brings-family-planning-sms-innovation-against-looming-post-covid-19-births-spike>

²⁴⁰ UNFPA, UNFPA brings family planning SMS innovation against a looming post COVID-19 births spike, 16 June 2020. Available at: <https://eswatini.unfpa.org/en/news/unfpa-brings-family-planning-sms-innovation-against-looming-post-covid-19-births-spike>; see also United Nations Population Fund, Eswatini SMS Service helps women access family planning, food amid pandemic, (30 July 2020) available at: <https://www.unfpa.org/news/eswatini-sms-service-helps-women-access-family-planning-food-amid-pandemic>

²⁴¹ Sifiso Nhlabatsi, Access to SRHR Services Impacted by COVID19 Pandemic, GenderLinks for Equality and Justice, 24 April 2020. Available at: <https://genderlinks.org.za/news/absence-of-srhr-services-may-trigger-health-crisis-for-women/>

²⁴² Ibid

²⁴³ UNFPA, UNFPA's plan for Tackling Gender Based Violence in Communities During COVID19, 22 May 2020. Available at: <https://eswatini.unfpa.org/en/news/unfpas-plan-tackling-gender-based-violence-communities-during-covid-19>

²⁴⁴ Id

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and de facto exercise of the right to obtain a safe and legal abortion on broad socio economic grounds for anyone, not just rape survivors or in cases where the pregnancy "will endanger the life or constitute a serious threat to the physical health of the woman" or where "the child will suffer from physical or mental defect";

- **Ensure the existence and operation of a functioning public health system**, healthcare facilities, goods and services of a sufficient quantity and quality to ensure that every person can fully enjoy the right to health. These include underlying determinants of health such as sanitation, water, electricity and food at all health facilities;
- **Ensure all health facilities, throughout the country, are equipped with all essential medicines** including a wide range of contraceptive methods, such as condoms and emergency contraception and medicines for abortions and for post abortion care, as well as HIV related medicines;
- **Guarantee access to information and education** on sex, sexuality, HIV, sexual and reproductive rights especially for adolescents and youth; and
- **Modify the social and cultural patterns of conduct** of men and women, with a view to achieving the elimination of harmful gender stereotypes and bias, including those rooted in customary and all other practices based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;
- **Prioritise the provision of pre- and post-natal healthcare services** in a manner that does not risk COVID-19 transmission;
- **Refrain from deprioritising sexual and reproductive healthcare services** and, instead, ensure the provision of comprehensive sexual and reproductive health services availability during this pandemic;
- **Take proactive measures to remove barriers** preventing people from accessing sexual and reproductive health services, including by ensuring sufficient quantities of such goods and services remain available;
- **Ensure adequate healthcare access and sufficient social assistance** for women living in poverty, including those without health insurance and/income during COVID-19
- **Repeal discriminatory laws, policies and practices** in the area of sexual and reproductive health, including restrictive abortion laws and laws and policies that discriminate against LGBT persons.²⁴⁵

B. Sexual and Gender-Based violence

- **Increase access to healthcare services for victims and survivors of gender-based violence**, including medical and psychosocial support and ensure adequate rape kits in all health centres;
- **Adopt legislation providing for legal aid** to enable victims of gender-based violence to be better able to access justice and effective remedies for SGBV, including through courts; and
- **Provide training to public officials**, including police, health practitioners and prosecutors and judicial officers on SODV Act on Sexual and Reproductive health rights of victims and survivors of sexual and gender-based violence.
- **Ensure comprehensive services for survivors of sexual and gender-based violence** are available during the pandemic

C. Shelter and access to adequate housing

- **Increase access to shelters and alternative accommodation** for victims of gender based and domestic violence in Eswatini, including accommodation or shelters that should be made available in all parts of the country; and
- **Ensure compliance by customary leaders** with the Constitution providing for women's right to land ownership and amend laws to provide for security of tenure and prevent unlawful evictions.

²⁴⁵ Id, para 28. See also para Id, 7 and 9

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ADDENDUM A

Right and article in ICESCR	Core content and General Comment of the UNCESCR
<p>Right to Health (Article 12)</p> <p>In addition to these core obligations the CESCR notes that obligations of "comparable priority" include:</p> <ul style="list-style-type: none"> - Ensuring reproductive, maternal (prenatal as well as postnatal) and child healthcare; - Providing immunisation against the major infectious diseases - Taking measures to prevent, treat and control epidemic diseases; - Providing education and access to information concerning the main health problems including methods of preventing and controlling them; - Providing appropriate training for health personnel including education on health and human rights 	<p>General Comment 14</p> <ul style="list-style-type: none"> - Non-discrimination: "Access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups" and "to ensure equitable distribution of all health facilities, goods and services." - Access to food: "To ensure access to the minimum essential food, which is nutritionally adequate and safe, to ensure freedom from hunger to everyone." - Access to basic services: "To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water." - Provision of Essential Drugs: "To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs." - Strategy: "To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population" which "must be devised, and periodically reviewed, on the basis of a participatory and transparent process" and give "particular attention to all vulnerable or marginalised groups."

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ADDENDUM B

Right To health obligations of Eswatini		
Treaty	Ratification/Accession	Domestication
International Covenant on Economic Social and Cultural Rights ²⁴⁶	Ratification/Accession 2004	<p>No specific provision on the right to health in Swazi Constitution.</p> <p>Constitution, Section 15(5) Abortion is unlawful but may be allowed: (a) on medical or therapeutic grounds including where a doctor certifies that (i) continued pregnancy will endanger the life or constitute a serious threat to the physical health of the woman; (ii) continued pregnancy will constitute a serious threat to the mental health of a woman; (iii) there is serious risk that the child will suffer from physical or mental defect of such a nature that the child will be irreparably seriously handicapped; (b) where the pregnancy results from rape, incest or unlawful sexual intercourse with a mentally retarded female; or (c) on such grounds as parliament may prescribe."</p> <p>Constitution, Section 28(2) "Subject to the availability of resources, the Government shall provide facilities and opportunities</p>
International Covenant on Civil and Political Rights ²⁵²	Ratification/Accession 2004	
Convention on the Right of The Child ²⁵³	Ratified 07/09/1995	
Convention on the Elimination of All Forms of Discrimination Against Women ²⁵⁴	Accession 26/03/2004	
Convention on the Rights of Persons with Disabilities ²⁵⁵	Ratification/Accession 2012	
African Charter on the Rights and Welfare of the Child	Ratification/Accession 05/10/2012	
Africa Charter on Human and Peoples' Rights ²⁵⁶	Ratification/Accession 15/09/1995	

²⁴⁶ UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, available at: <https://www.refworld.org/docid/3ae6b36c0.html> Article 12: "(1) The State Parties to the present Convention recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2) The Steps to be taken by States Parties to the present Convention to achieve the full realization 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."

²⁵² UN General Assembly, International Covenant on Civil and Political Rights, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171, available at: <https://www.refworld.org/docid/3ae6b3aa0.html> [accessed 18 May 2020], Article 6 (" 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") as interpreted by the Human Rights Committee in: UN Human Rights Committee (HRC), General comment no. 36, Article 6 (Right to Life), 3 September 2019, CCPR/C/GC/35, available at: <https://www.refworld.org/docid/5e5e75e04.html> [accessed 18 May 2020], para 8, 25, 26.

²⁵³ The Convention on the Rights of the Child was adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989. It entered into force on 2 September 1990, in accordance with article 49, Article 24 ("States Parties recognize 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.") as interpreted by the CRC Committee in: UN Committee on the Rights of the Child (CRC), General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, CRC/C/GC/15, available at: <https://www.refworld.org/docid/51ef9e134.html> [accessed 18 May 2020].

²⁵⁴ UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13, available at: <https://www.refworld.org/docid/3ae6b3970.html> [accessed 18 May 2020], Article 12 ("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") as interpreted by the CEDAW Committee in: UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), 1999, A/54/38/Rev.1, chap. I, available at: <https://www.refworld.org/docid/453882a73.html> [accessed 18 May 2020].

²⁵⁵ UN General Assembly, Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly, 24 January 2007, A/RES/61/106, available at: <https://www.refworld.org/docid/45f973632.html> [accessed 18 May 2020], Article 25 ("States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability").

²⁵⁶ Article 16: (1)"Every individual shall have the right to enjoy the best attainable state of physical and mental health. (2) State Parties to the present charter shall take the necessary measures to protect the health of their people and to ensure they receive medical attention when they are sick

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<p>Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa²⁵⁷</p>	<p>Ratification/Accession 05/10/2012</p>	<p>necessary to enhance the welfare of women to enable them to realize their full potential and advancement.”</p> <p>Constitution, Section 32(4) “Parliament shall enact laws to: (a) provide for the right of persons to work under satisfactory, safe and healthy conditions.”</p> <p>Constitution, Chapter V Directive Principles of State Policy and Duties of the Citizen, Section 60(8) “without compromising quality the state shall promote free compulsory basic education for all and shall take all practical measures to ensure the provision of basic health care services to the population”</p> <p>The Sexual Offences and Domestic Violence Act No.15 of 2018 (SODV Act)²⁴⁷</p> <p>National Policy on Sexual and Reproductive Health²⁴⁸ The National Policy on Reproductive health recognises that “every citizen is entitled to fundamental human rights and freedoms, including the right to health which incorporates the right to sexual and reproductive health, irrespective of sex, gender, culture, religion, age, race, disability, HIV and economic status.”²⁴⁹</p> <p>National Health Policy.²⁵⁰</p> <p>National Multisectoral HIV and AIDS Strategic Framework²⁵¹</p>
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²⁵⁷ Article 14
²⁴⁷ Available at: <https://www.ilo.org/dyn/natlex/docs/SERIAL/108709/134536/F1384531235/SWZ108709%20Eng.pdf>
²⁴⁸ The Kingdom of Swaziland Ministry of Health, National Policy on Sexual and Reproductive Health, 2013. Available at: <http://www.integrainitiative.org/blog/wp-content/uploads/2013/10/NATIONAL-POLICY-ON-SEXUAL-AND-.pdf>
²⁴⁹ National Policy on Sexual and Reproductive Health, p15
²⁵⁰ Swaziland Ministry of Health and Social Welfare, National Health Policy, https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_174726.pdf
²⁵¹ The Government of the Kingdom of Eswatini, The National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018-2023, 2018 https://hivpreventioncoalition.unaids.org/wp-content/uploads/2019/06/Eswatini_NSF-2018-2023_final.pdf

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