THE UPR PROJECT AT BCU

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About the UPR Project at BCU:

Birmingham City University's Centre for Human Rights was created in 2014 to promote human rights, ensure access to justice, and enhance the rule of law around the world. We seek to achieve this through leading research, education, and consultancy. We submit expert reports to international human rights regions, provide advisory services to governments and nongovernmental organisations, and draft legal opinions and file legal briefs in domestic courts and international human rights courts.

The Centre for Human Rights established the UPR Project in 2018 as part of our consultancy service. We engage with the Human Rights Council's review process in offering support to the UPR Pre-sessions, providing capacity building for UPR stakeholders and National Human Rights Institutions, and the filing of stakeholder reports in selected sessions. The UPR Project is designed to help meet the challenges facing the safeguarding of human rights around the world, and to help ensure that UPR recommendations are translated into domestic legal change in member state parliaments. We fully support the UPR ethos of encouraging the sharing of best practice globally to protect everyone's human rights. The UPR Project at BCU engages with the UPR regularly as a stakeholder, having submitted seven reports and been cited by the OHCHR. You can read more about the UPR Project here: www.bcu.ac.uk/law/research/centre-for-human-rights/projects-and-consultancy/upr-project-at-bcu

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INTRODUCTION

1. Eswatini has the highest rate of HIV across the world.[1] It is estimated that around 200,000 adults and children in Eswatini are living with HIV, which is approximately 17.4% of the country's total population.[2] Whilst the number of people currently living with HIV is still steadily increasing, the number of new infections is decreasing.[3] There are several reasons for this, including a rise in the general population, and an expansion of access to antiretrovirals (HIV medication) in Eswatini, meaning that more people infected with HIV are living longer lives. In fact, around 95% of those infected with HIV in Eswatini can now access antiretrovirals.[4] However, there is still much work to be done in Eswatini, particularly in terms of women and girls, as over 60% of those aged over 15 and living with HIV are women.[5] This is a particularly sensitive issue, as women in Eswatini are often considered to be "subordinate to men," with gender inequality being pervasive across the country.[6]

2. This Stakeholder Report focuses on two key issues for women and girls living with HIV in Eswatini: (1) the effect of HIV-related stigmatisation on women and girls, and (2) protecting female sex workers from HIV. We make recommendations to the Government of the Kingdom of Eswatini on these two key issues, implementation of which would also see Eswatini moving towards achieving Sustainable Development Goal 5 which aims for gender equality.

A. Eswatini and International Law

3. It is widely agreed that taking a human rights approach to tackling HIV is both progressive and effective.[7] Eswatini is a party to seven of the nine core international human rights treaties and a signatory to one,[8] for which the government should be commended. Particularly relevant for the regulation of the right to health, including in the context of HIV, is the International Covenant on Economic, Social and Cultural Rights ('ICESCR'), which Eswatini ratified in 2004. Article 12(1) ICESR states that:

> 1. The States Parties to the present Covenant 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 the States Parties to the present Covenant 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; …
>
> (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.

4. Also relevant to the right to health, and in particular ensuring access to antiretrovirals, is Article 27 of the Universal Declaration of Human Rights, which states, "[e]veryone has the right…to share in scientific advancement and its benefits,"[9] and Article 15(1)(b) ICESCR, which recognises the right of everyone "[t]o enjoy the benefits of scientific progress and its applications."[10]

5. Furthermore, Eswatini should abide by the International Guidelines on HIV/AIDS and Human Rights ('International Guidelines'), which were published by the OHCHR and UNAIDS to ensure that Member States were implementing international human rights standards on HIV in practice.[11] There are twelve guidelines in place, followed by recommendations for implementation and guidance on how to enact international human rights laws.[12]

B. Implementation of Recommendations from Cycle Two in 2016

6. Eswatini received 181 recommendations in the Second Cycle, of which 131 were accepted and 50 were noted.[13] This is a laudable response to the UPR recommendations, but it is also important that accepted recommendations are subsequently implemented by the government.[14]

7. Nine of the 181 recommendations focused specifically on HIV/AIDS and all were supported by the government. Whilst it is positive that all nine were accepted, this is a relatively low number of recommendations for such a serious issue, and Member States should ensure all key areas are being covered in Eswatini's third cycle of review in 2021.

8. **Haiti (para. 109.29)** recommended that Eswatini should "[t]ake new measures to put an end to cultural practices that discriminate against children with disabilities, women and all persons living with HIV/AIDS."[15] There has arguably been some positive action taken in respect to this recommendation, as the Sexual Offences and Domestic Violence Bill of 2015 was signed into law by the King in 2018.[16] However, in practice this has done little to improve the significant and culturally entrenched gender inequality that is rife across Eswatini. A suggestion for recommendations in the third cycle would be for countries with historically similar cultural views and practices regarding women to provide recommendations on how they have attempted to overcome gender inequality in relation to HIV, as a blueprint for Eswatini to implement.

9. **Angola (para. 107.66)** recommended that the government "[s]trengthen measures to prevent and reduce the prevalence of HIV/AIDS."[17] **Ukraine (para. 107.72)** suggested that the government "[f]urther intensify efforts in fighting HIV/AIDS."[18] Whilst, on its face, it seems that strengthening and intensifying efforts would likely assist in preventing HIV infections, this recommendation is far too broad to ensure any meaningful implementation. Recommendations from Member States would be more effective if they provided details of specific policies and programmes to be employed.[19] Specific

recommendations can easily be formulated through utilising information provided in the Compilation and Stakeholder Reports.

10. **Libya (para. 107.68)** recommended that the government "[c]ontinue efforts to combat HIV/AIDS through the National Parliament Strategy on HIV/AIDS for 2016-2021."[20] **Turkey (para. 107.69)** recommended that the government "[c]ontinue to implement the adopted HIV/AIDS response strategies, with a view to further reducing new infections."[21] **Uganda (para. 107.70)** made the suggestion to "[e]xpedite the implementation of the Extended National Strategic Framework on HIV/AIDS that was adopted in 2014."[22] Similarly, **Equatorial Guinea (para. 107.71)** asked Eswatini to "[p]rovide follow-up to the expanded strategic framework for national action against HIV/AIDS."[23] **Ghana (para. 107.67)** suggested that the government should "[r]edouble its efforts on HIV/AIDS response, particularly on prevention strategies, and take steps to address discrimination against persons living with HIV/AIDS."[24] The current strategic policy in place in Eswatini is the National Multisectoral HIV and AIDS Strategic Framework 2018 – 2023 (NSF), adopted in 2015.[25] The NSF is lengthy and covers many topics, under the headings: 'HIV Prevention', 'HIV Treatment, Care, and Support', 'Social Protection and Reduction of Structural Vulnerabilities', 'Management of HIV and AIDS Response', and 'Sustainable Financing of the HIV Response'. Under each of these headings comes numerous sub-headings. As such, the recommendations provided above are far too broad to have any reasonable chance of implementation when making recommendations on strategic frameworks. UN Member States' recommendations would be more impactful if they focused on just one of the specific issues in the NSF, as opposed to providing a broad recommendation on the entire Framework.

11. **Ethiopia (para. 107.73)** recommended that the government should "[g]ive emphasis on allocating adequate National Funding for the response of the HIV/AIDS problems to implement all required actions in the country."[26] Eswatini has noted that $790.13 million is needed to cover the cost of the NSF.[27] Whilst the NSF identifies some sources of funding, it also states that there is still a need for "additional resources to address the funding gap."[28] Funding and support is imperative for the NSF to succeed, and this must be addressed at the global level.

12. A key point noted is that no recommendation in the 2016 UPR directly referred to women and girls infected with HIV. UN Member States should particularly focus their efforts on making suggestions to improve the safeguarding of the rights of women and girls with HIV in Eswatini in the third cycle.

C. <u>Further Points for Eswatini to Consider</u>

Effect of HIV-related Stigmatisation on Women and Girls in Eswatini

13. The stigma faced by people with HIV in Eswatini is widespread,[29] despite the commentary on International Guideline 6 stating that, "States should also ensure that their laws, policies, programmes and practices do not exclude, stigmatize or discriminate against people living with HIV or their families."[30] Although eliminating HIV-related stigma is a core feature of the NSF,[31] stigmatisation continues to be rife in Eswatini, with a particularly damning effect upon women and girls

14. A specific concern surrounding stigmatisation is the fact that it can affect the number of women and girls seeking treatment. A study carried out in 2016-17 in the region of Shiselweni found that, in some cases, "asymptomatic people living with HIV were motivated to start ART in order to prevent them from developing symptoms that would visibly show them to be HIV-positive."[32] While, of course, the number of people seeking HIV testing is commendable, this study indicates that it is driven by a fear of stigmatisation. Furthermore, the study also found that in other cases, "engaging with treatment and care services was also seen as having the potential to expose someone as HIV-positive and thereby open to stigmatisation." In these cases, "[w]hen the risk of exposure through clinic attendance was deemed too great, people were found to disengage from care and take treatment intermittently."[33] Statistics also show that this stigmatisation particularly affects women and girls, as PEPFAR has found that women and girls aged 15-24 have a low rate of antiretroviral treatment coverage.[34] Equally important, Horter et al note that, even when antiretroviral treatment is being used effectively, this treatment "does not directly address the structural drivers of stigmatisation, such as poverty, gender inequality and racism."[35]

15. A practical way of tackling this stigmatisation experienced by women and girls with HIV, whether they are seeking antiretroviral treatment or not, is through education. It is widely agreed that the education provision in Eswatini regarding HIV and AIDS is poor.[36] Statistics from 2014 show that only "49% of young women (ages 15-24) and 51% of young men demonstrated adequate knowledge on this subject."[37]

16. Although formal education and training is necessary, it is not the only way of tackling stigmatisation. International Guideline 9 provides specific ways that the public can be educated on this issue, as "[p]ublic programming explicitly designed to reduce the existing stigma has been shown to help create a supportive environment which is more tolerant and understanding."[38] To some extent, Eswatini is already seeking to implement this, as "[t]he Ministry of Health's Health Promotion Programme…runs radio and television shows about HIV."[39] This is a great start towards educating the general public. Moreover, in relation to the Health Promotion Programme, "[a] 2016 survey found radio is a more effective medium for raising awareness, with 90% of respondents aware of HIV radio programmes but only 21% aware of television programmes, mainly due to a lack of access to television."[40] Taking the findings of this study into account, the Kingdom of Eswatini should look to extend its current Health Promotion Programme, using different types of accessible media, "including creative and dramatic presentations, compelling ongoing information campaigns for tolerance and inclusion and interactive educational workshops

and seminars,"[41] especially as this approach to educating people on HIV, as a way of reducing stigma, has been supported by scientific studies and academic literature.[42] The government should make use of these studies, looking to the successful implementation of these educative materials as a guide.

17. Another invaluable resource of education and support is civil society in Eswatini. Non-governmental organisations have put a great deal of effort towards engaging projects and strategies to tackle stigma and foster inclusivity, for example, Frontline AIDS works in Eswatini to end stigma and engage with marginalised communities.[43] However, whilst these NGOs carry out invaluable work, they often lack the requisite financial support,[44] which is something the international community must address.

18. It must be noted that Eswatini has particularly deep-rooted gender roles and cultural norms, which often lead to negative consequences for women and girls, including in the context of HIV.[45] Whilst this presents a bigger challenge, through careful work with the community the government can tackle the issue of stigma.

Protecting Female Sex Workers from HIV in Eswatini

19. Eswatini has the highest rate of HIV amongst sex workers in the world, as around 60.5% of sex workers in the country are infected with HIV.[46] Sex work is illegal in Eswatini,[47] leading to further problems for female sex workers, including "routine abuse, discrimination and violence from police, healthcare workers and others in authority as well as from clients and the general public."[48] This also makes accessing healthcare facilities, "including HIV prevention, testing and treatment services" much more difficult.[49]

20. In 2019, PEPFAR set out its HIV prevention strategy in Eswatini, and one of the key populations being targeted as part of this strategy is female sex workers.[50] In the 2018 financial year, $9,595,760 was spent on "key populations for prevention" which covers female sex workers and men who have sex with men.[51] It is not clear how this money has been spent specifically in the context of protecting female sex workers and preventing transmission in the female sex worker community. Particularly given that Eswatini is a developing nation with more limited resources, this is something that should be addressed in the third cycle.

21. PEPFAR has identified, via studies and focus groups, that "specifically tailored testing, messaging and service delivery approaches based on population type, age, geography, and other contextual factors" is needed for key populations in Eswatini, including female sex workers.[52] As such, PEPFAR is co-ordinating an "HIV self-testing" approach to identify people who are living with HIV from hard-to-reach communities, including the clients of female sex workers.[53] It is not immediately obvious whether female sex workers will also be offered HIV self-tests, but it is important that they are not marginalised from this testing, as this would exacerbate the gender divide in relation to HIV even further.

22. Pre-Exposure Prophylaxis (PrEP) "is a way for people who do not have HIV but who are at very high risk of getting HIV to prevent HIV infection by taking a pill every day."[54] PrEP has been rolled out across Eswatini to the general population, as opposed to targeting certain key populations, as a government initiative to avoid stigmatisation.[55] Bärnighausen et al conducted a study in 2019 of 24 Eswatini women who were using PrEP.[56] The study found that, "PrEP helps women in Eswatini envision longer, healthier and more fulfilled lives. PrEP enhances resilience through several pathways, including self-efficacy, choice, control over HIV infection and relief from the fear of HIV infection."[57] This is a very positive outcome of a small study, the findings of which could equally be applied to female sex workers, should they become a key population to be targeted for PrEP. There are examples of this working well elsewhere in sub-Saharan Africa. For instance, when South Africa became the first country in Africa to approve the use of PrEP in 2016, one of the first groups of people it targeted was sex workers.[58] Should Eswatini follow in South Africa's footsteps, caution must be taken. This was demonstrated by a study conducted by Eakle et al, on female sex workers and PrEP in South Africa, which found that it is "important to ensure accurate, relevant, and widespread messaging in communities to generate demand and support for PrEP."[59] As PEPFAR's focus is shifting to prevention of HIV in Eswatini, female sex workers must be a high priority for PrEP, with clear and targeted messaging being utilised to avoid further stigmastisation of this vulnerable community.

23. Whilst it is appreciated that sex work is a sensitive area of discussion in Eswatini in particular, this is an issue that must be addressed by the UN Member States in Eswatini's third cycle UPR.

D. Recommendations

The UPR Project at BCU recommends that the Government of the Kingdom of Eswatini should:

i. Ratify the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, to allow for individual communications to be made regarding any violations of the ICESCR.

ii. Develop education provisions for all people in Eswatini on how HIV is transmitted and the dangers of stigmatisation, particularly for women and girls. This should include, but is not limited to, formal education and training, and other, alternative sources of media.

iii. Establish opportunities to work with NGOs who are offering projects and strategies to tackle stigma and foster inclusivity for women and girls with HIV, providing financial support where possible.

iv. Identify how HIV-related funding is being spent specifically in the context of protecting female sex workers and preventing transmission in the female sex worker community. From the findings, assess whether a more effective strategy is needed.

v. Ensure that female sex workers will be part of PEPFAR's HIV self-testing, to avoid exacerbating the gender divide in relation to HIV even further.

vi. Ensure female sex workers in Eswatini are made a high priority for PrEP, using positive examples from other countries and studies conducted, with clear and targeted messaging being utilised to avoid further stigmastisation of this vulnerable community.

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[1] PEPFAR, 'Eswatini Country Operational Plan' (5 April 2019) <https://www.state.gov/wp-content/uploads/2019/09/Eswatini_COP19-Strategic-Directional-Summary_public.pdf> 1.
[2] UNAIDS 'Eswatini <www.unaids.org/en/regionscountries/countries/swaziland> accessed 10 March 2021.
[3] ibid.
[4] ibid.
[5] ibid.
[6] Avert, 'HIV and AIDS in Eswatini' <www.avert.org/professionals/hiv-around-world/sub-saharan-africa/swaziland> accessed 10 March 2021.
[7] Bell et al, 'Sexual and Reproductive Health Services and HIV Testing: Perspectives and Experiences of Women and Men with HIV and AIDS' (2007) 19(59) Reproductive Health Matters 113-135.
[8] International Convention on the Elimination of All Forms of Racial Discrimination, ratified in 1969; International Covenant on Civil and Political Rights, ratified in 2004; International Covenant on Economic, Social and Cultural Rights, ratified in 2004; Convention on the Elimination of All Forms of Discrimination Against Women, ratified in 2004; Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ratified in 2004; Convention on the Rights of the Child, ratified in 1995; Convention on the Rights of Persons with Disabilities, ratified in 2012; International Convention for the Protection of all Persons from Enforced Disappearances, signed in 2012 See, OHCHR, 'Status of Ratification Interactive Dashboard' <http://indicators.ohchr.org> accessed 10 March 2021.
[9] Universal Declaration of Human Rights (adopted 10 December) 1948 UNGA Res 217 A(III), Article 27.
[10] International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, Article 15(1)(b).
[11] OHCHR & UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights' (2006) <www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf>.
[12] ibid. The guidelines provide that: (1) There should be a national framework in place to prevent HIV; (2) There is community input in the creation of HIV policies; (3) Public health laws should take HIV into account; (4) Criminal laws should not be misused in the context of HIV; (5) Anti-discrimination laws should be in place to protect those with HIV; (6) All should have access to HIV-related goods, services, and information; (7) Legal support services should be provided; (8) A supportive environment should be created for women, children, and other vulnerable groups; (9) Educative materials should be provided to avoid stigmatisation; (10) Codes of practice for professional responsibility should be developed; (11) Monitoring and enforcement mechanisms should be created; and (12) States should cooperate with UN agencies on HIV.
[13] UNHRC, 'Report of the Working Group on the Universal Periodic Review – Eswatini Addendum 1' (21 September 2016) UN Doc A/HRC/33/14/Add1, para 2.
[14] Alice Storey, 'Challenges and Opportunities for the UN Universal Periodic Review: A Case Study on Capital Punishment in the USA' (2021) 90(1) UMKC Law Review (forthcoming Spring 2021).
[15] UNHRC, 'Report of the Working Group on the Universal Periodic Review – Eswatini' (13 July 2016) UN Doc A/HRC/33/14, para 109.29.
[16] Avert (n 6).
[17] UNHRC, 'Report of the Working Group' (n 15) para 107.66.
[18] ibid para 107.72.
[19] Storey (n 4).
[20] UNHRC, 'Report of the Working Group' (n 15) para 107.68.
[21] ibid para 107.69.
[22] ibid para 107.70.
[23] ibid para 107.71.
[24] ibid para 107.67.
[25] The Government of the Kingdom of Eswatini, 'The National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018 – 2023' (June 2018) <https://hivpreventioncoalition.unaids.org/wp-content/uploads/2019/06/Eswatini_NSF-2018-2023_final.pdf> accessed 10 March 2021.
[26] ibid para 107.73.
[27] NSF (n 25) 63.
[28] ibid 67.
[29] Horter et al, 'I Don't Want them to Know: How Stigma Creates Dilemmas for Engagement with Treat-all HIV Care for People Living with HIV in Eswatini' (2018) African Journal of AIDS Research, 18:1, 27-37; Kitchen et al, 'Expansion of HIV Testing in Eswatini: Stakeholder Perspectives on Reaching the First 90' (2020) African Journal of AIDS Research, 19:3, 186-197.

[30] OHCHR & UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights' (n 11) para 30.
[31] NSF (n 25) 2.
[32] Avert (n 6), citing Horter et al (n 29).
[33] ibid.
[34] PEPFAR (n 1) 39.
[35] Horter et al (n 29) 28.
[36] Avert (n 6).
[37] ibid.
[38] OHCHR & UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights' (n 11) para 63.
[39] Avert (n 6).
[40] ibid.
[41] ibid.
[42] Thomas J Coates, 'Behavioural Strategies to Reduce HIV Transmission: How to Make them Work Better' (2008) 372(9639) Lancet, 669–684.; Elizabeth Armstrong-Mensah et al, 'Perinatal HIV Transmission Prevention: Challenges Among Women with HIV in sub-Saharan Africa' (2020) 9(3) IJMA, 354–359.
[43] Frontline AIDS, 'Eswatini' <https://frontlineaids.org/we-have-an-impact-in/eastern-and-southern-africa/eswatini/> accessed 1 March 2021.
[44] NSF (n 25).
[45] PEPFAR (n 1).
[46] Frontline AIDS (n 43).
[47] Crimes Act 1889, Section 49.
[48] Avert (n 6).
[49] ibid.
[50] PEPFAR (n 1) 1.
[51] ibid 25.
[52] PEPFAR (n 1) 46.
[53] ibid.
[54] Centers for Disease Control and Prevention, 'Pre-Exposure Prophylaxis (13 May 2020) <www.cdc.gov/hiv/risk/prep/index.html> accessed 10 March 2021.
[55] Bärnighausen et al, 'This is mine, this is for me: Pre-exposure Prophylaxis as a Source of Resilience among Women in Eswatini' (2019) AIDS Volume 33 S45-S52.
[56] ibid.
[57] ibid.
[58] Pillay et al, 'Factors Influencing Uptake, Continuation, and Discontinuations of Oral PrEP among Clients at Sex Worker and MSM Facilities in South Africa' (30 April 2020) Plos One <https://doi.org/10.1371/journal.pone.0228620> accessed 10 March 2021.
[59] Eakle et al, '"I Am Still Negative": Female Sex Workers' Perspectives on Uptake and Use of Daily Pre-exposure Prophylaxis for HIV Prevention in South Africa' (9 April 2019) Plos One <https://doi.org/10.1371/journal.pone.0212271> accessed 10 March 2021.