Reproductive Health and HIV: Do International Human Rights Law and Policy Matter?

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Protecting reproductive rights is understood to be a critical component of working to ensure reproductive health. Likewise, promotion and protection of human rights is considered key to an effective AIDS response. As HIV and reproductive health are increasingly joined in health and development strategies and initiatives, it is critical that human rights play a central role in these efforts. Still to be achieved is the translation of gender equality, and other forms of equality, into the lived experience of people's lives. While international human rights law to counteract vulnerability in the context of HIV and reproductive health has evolved slowly, the time is right to translate rhetoric into reality. With due attention to its shortcomings, the corpus of international law and policy to promote and protect reproductive rights in the context of HIV can provide effective tools. Better use of what exists is needed, as is documentation of successful interventions to support replication where possible.

Il est admis que tout effort d'assurer la santé génésique doive inévitablement passer par la protection des droits génésiques, tout comme la promotion et la protection des droits humains jouent un rôle clé dans toute réponse efficace au sida. Alors que les initiatives et les stratégies visant le développement et la santé joignent de plus en plus les questions du VIH et de la santé génésique, il est d'autant plus impératif que ces efforts s'articulent autour des droits humains. Pour plusieurs, l'expérience de la vie quotidienne serait transformée par une plus grande égalité entre les sexes : la transposition dans la réalité de cette notion—ainsi que d'autres formes d'égalité—est à parfaire. Une lente évolution est à noter dans l'impact qu'a le droit international des droits humains sur la vulnérabilité dans le contexte du VIH et de la santé génésique, mais il est désormais temps de passer de la rhétorique à l'action, car ce régime et les politiques de promotion et de protection des droits génésique qui s'y allient peuvent s'avérer de puissants instruments. Un usage plus judicieux des outils existants, et une attention particulière à leurs limites intrinsèques, s'imposent, et une meilleure documentation des interventions réussies dans le but d'en répliquer l'approche ne constitue qu'une des avenues possibles.

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HIV[1] is the greatest development challenge and health crisis of the 20th and 21st centuries. The world's attention and resources are focused exclusively on biomedical aspects of the HIV virus: developing vaccines, microbicides, prophylaxes (pre- and post-exposure) and better long-term treatment regimens. Yet the underlying human rights concerns and social and political conditions that have fuelled the epidemic have not gone away, as inequalities have transformed HIV into an epidemic primarily affecting certain sub-populations.

Women, constituting one half of the world's population, are one 'group' that is becoming increasingly affected, with many in the field of HIV referring to the 'feminization' of the epidemic. While global HIV prevalence remained unchanged at 1% between 2003 and 2005, the number of women above the age of 14 infected with HIV rose from 16.5 million to 17.7 million.[2] This disproportionate burden of disease borne by women is even more marked among 15 to 24 year olds: worldwide women in this age group are 1.6 times as likely as men to be infected.[3]

While HIV is not simply a virus that is transmitted sexually, heterosexual transmission of the virus is the principle pathway of infection for the world's women and, in large parts

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1 As per UNAIDS guidelines, 'HIV' is used throughout this paper in place of HIV/AIDS, except when specifically referring to AIDS. UNAIDS, *Terminology Guidelines*, (March 2007) at 5, online: <http://data.unaids.org/pub/Manual/2007/20070328_unaids_terminology_guide_en.pdf>.

2 UNAIDS, *2006 Report on the Global AIDS Epidemic*, (May 2006) UNAIDS/06.13E at Annex 2, online: <http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp>.

3 UNFPA, "State of the World's Population: Youth and HIV/AIDS Fact Sheet" (2005), online at: <http://www.unfpa.org/swp/2005/presskit/factsheets/facts_youth.htm>.

of the world, remains the primary pathway for all HIV transmission.[4] Until the mid-1990s, affirmative efforts toward HIV prevention and education remained predominantly targeted at reducing the risk of infection generally, but inadvertently this focus was primarily on men. Yet, the evolution of the HIV epidemic has underscored how gender differences, along with the unequal distribution of power that it represents (acting in combination with a whole range of other social categories of difference), has been a major conduit for HIV infection.

People with, or at risk of, HIV differ by a range of factors including age, sex, race, ethnic and cultural identity, language, socioeconomic status, sexual orientation, educational background, relative level of power in their relationships, nature and extent of family responsibilities, work histories and employment opportunities. The distribution of the burden of reproductive ill health is affected by many of the same factors and this burden also falls disproportionately on women.

This paper focuses primarily on women, but this can be understood as one way of exemplifying the unequal distribution of the burden of HIV and reproductive ill health across many sub-population groups. Likewise, a focus on the effects of gender on vulnerability to reproductive ill health and HIV infection, as well as access to care and treatment services if needed, can find welcome attention in international human rights law. While today understood as crucial, the intersections of gender with other factors such as race, sexual orientation, and other social/lifestyle factors, have received disproportionately little attention to date.

Women's disproportionate vulnerability to HIV infection and reproductive ill health stems from social, cultural, economic, and political realities at the international, national, and community level, not simply from their immune systems or biology.[5] The understanding of the vulnerability of women to HIV and reproductive ill health has been further enriched by an increased recognition of the connection between women's health and the exercise of their rights.[6] Building on insights into the ways in which gender norms have disempowered women and impeded their ability to enjoy rights, the international human rights system[7] has become more responsive to women in the context of both HIV and reproductive health. One of the most notable developments in international human rights law and policy has been a marked increase in the range of norms, standards, and guidance around HIV and women's health,

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4 U.S., National Institute of Allergy and Infectious Diseases (NIAID), *HIV Infection in Women* (May 2006) online: <http://www.niaid.nih.gov/factsheets/womenhiv.htm>.

5 See Elizabeth Reid, "Gender, Knowledge, and Responsibility" in Jonathan M. Mann, Daniel J.M. Tarantola & Thomas W. Netter, eds., *AIDS in the World* (Cambridge, Mass.: Harvard University Press, 1992) 657; Jonathan M. Mann & Daniel J.M. Tarantola, eds., *AIDS in the World II: Global dimensions, Social Roots, and Responses* (Oxford: Oxford University Press, 1996) [*AIDS in the World*]; Judith Mariasy and Laura Thomas, *Triple Jeopardy: Women and AIDS* (London: Panos Institute, 1990) at v, online: <http://www.panos.org.uk/images/books/triple%20jeopardy%20women%20&%20AIDS.pdf >.

6 See Sofia Gruskin "The Conceptual and Practical Implications of Reproductive and Sexual Rights: How Far Have We Come?" (2000) 4 Health & Hum. Rts 1.

7 The international human rights system is generally understood to be comprised of the institutions of the United Nations, the regional human rights bodies and non-governmental organizations that work to ensure the respect, protection and fulfilment of human rights worldwide. The focal point is the United Nations Office of the High Commissioner of Human Rights.

designed to empower women to exercise their rights,[8] including their reproductive rights.[9] This development is also reflected in recent global policy initiatives: in the 2004 World AIDS Campaign theme "Women, Girls, HIV and AIDS,"[10] for example, or in the UNAIDS launch of the Global Coalition on Women and AIDS.[11]

Women, in general, are disadvantaged in relation to men because of gendered expectations and face discrimination linked to perceptions about their roles and functions within society. Just as discrimination against women has made them vulnerable to a range of illnesses and injuries, it increases their vulnerability to HIV infection and, if infected, to inadequate access to care and treatment. HIV-related discrimination, it should be noted, exists against both women and men. A man's property and other rights, however, may be protected by law, while a woman's unequal legal status may lead not only to violations of her rights based on HIV status, but also to her being denied equal protection under the law.[12] Due to pervasive gender-based discrimination, women may lack equal access to education, health, training, independent income, property, and legal standing. In addition, women who are, or are perceived to be, living with HIV are confronted with additional layers of stigmatization and discrimination.[13]

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8 See Françoise Girard, "Human Rights and Women's Health: The Light at the End of the Speculum" (Presentation at *Health, Law and Human Rights: Exploring the Connections*, Harvard School of Public Health, September 29 – October 1 2001), online: <http://www.iwhc.org/resources/fg100101.cfm?language=1>.

9 Reproductive rights have been defined and elaborated through the *Report of the International Conference on Population and Development: Programme of Action*, Annex, UN ICPD, 1994, UN Doc. A/Conf.171/13, at paras. 7.1-7.48, online: United Nations Population Information Network <http://www.un.org/popin/icpd/conference/offeng/poa.html> [*ICPD Programme of Action*]; the elements of sexual rights are found in the *Report on the Fourth World Conference on Women*, 1995, UN Doc. A/Conf.177/20, online: <http://www.un.org/documents/ga/conf177/aconf177-20en.htm>. Recently the World Health Organization (WHO) stated that "sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services…" WHO Department of Reproductive Health and Research (RHR), "Gender and Reproductive Rights", online: <http://www.who.int/reproductive-health/gender/sexual_health.html>. The trend in scholarship and activism is to refer to the ensemble as "sexual and reproductive rights," and in the context of HIV/AIDS we believe it to be entirely appropriate. See also Alice M. Miller "Sexual But Not Reproductive: Exploring the Junction and Disjunction of Sexual and Reproductive Rights" (2000) 4 Health & Hum. Rts. 69.

10 UNAIDS, *World AIDS Campaign 2004: Women, Girls, AIDS and HIV*, at 7, online: < http://data.unaids.org/WAC/wac-2004_strategynote_en.pdf?preview=true >, stating that "because of their lack of social and economic power, many women and girls are unable to negotiate relationships based on abstinence, faithfulness and use of condoms."

11 The Global Coalition on Women and AIDS is "an informal grouping of partners and organizations working to mitigate the impact of AIDS on women and girls worldwide", *ibid.* at 11.

12 Human Rights Watch, "Policy Paralysis: A Call for Action on HIV/AIDS-Related Human Rights Abuses Against Women and Girls in Africa" (December 2003) at 40: Online: Human Rights Watch <http://www.hrw.org/reports/2003/africa1203/africa1203.pdf> [*Policy Paralysis*].

13 See Sheila M. Bunting, "Sources of Stigma Associated with Women with HIV" (1996) 19 Advances in Nursing Science 64; See also Margarete Sandelowski, Camille Lambe & Julie Barroso, "Stigma in HIV-Positive Women" (2004) 36 Journal of Nursing Scholarship 122.

These issues are of concern in human rights terms, but they also reflect the degree to which the reproductive health of women, and of men, is directly affected by HIV.

There is an ever-expanding collection of references to women, reproductive health and HIV in human rights, political consensus documents and other international normative instruments. This provides a solid basis for the analysis we present here, even as an enormous gap still exists between the rhetoric and the reality of policy and program implementation.[14] Legislation in many countries of Latin America and the Caribbean, for example, incorporates relevant commitments set out in ratified international treaties that protect women's rights, but such positive changes in the law, in many cases, have not translated into corresponding changes in policy or implementation.

Regarding human rights, the focus of this paper is on the international legal and policy environment. Human rights are legally used to hold governments accountable for their promotion or violation in the context of HIV and reproductive health, as well as to encourage legal reform in order to bring national laws and policies in line with international human rights standards. By recognizing the applicability of international law to HIV and reproductive health, attention is drawn to the ultimate responsibility and accountability of the state under international law for issues relating to HIV and reproductive health and well-being. Attention to the legal and policy environment can identify laws and policies that might facilitate or impede programmatic interventions or service provision for HIV or reproductive health. If necessary, these can then be addressed.

International human rights law, and the international political consensus documents that flesh out political commitments and interpretation of human rights obligations relating to reproductive health, are the principle sources of interpretation for international reproductive rights frameworks.[15] These documents can be understood as contracts between governments: when governments sign and ratify them, they become 'binding', that is, they require governments to uphold and implement the rights contained in the treaties. Governments are required to report to UN treaty-monitoring bodies every few years on the progress made, and obstacles encountered, in fulfilling their obligations. Treaty-monitoring bodies review government reports on their progress in implementing the treaties, and issue concluding observations to them. In addition, by issuing General Comments and/or General Recommendations to clarify the nature and scope of obligations in relation to certain topics or rights, they help governments better understand their obligations under the treaties.

While these international documents are far from adequate, they are important sources not just for government action, but also for different actors in working to redress gender imbalances, in promoting reproductive rights, both generally and in the context of HIV specifi-

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[14] For further information on the gap between international human rights norms and their implementation, see Rebecca J. Cook, "International Human Rights and Women's Reproductive Health" (1993) 24 Studies in Family Planning 73.

[15] See Mindy J. Roseman, Sofia Gruskin and Sumita Banerjee, *HIV/AIDS and Human Rights in a Nutshell* (Harvard, Mass.: The Program on International Health and Human Rights, François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health and the International Council of AIDS Service Organizations, 2004) online: <http://www.hsph.harvard.edu/pihhr/files/ENGLISH.pdf>.

cally, as well as in intervening to decrease vulnerability to HIV.[16] Holding governments legally accountable for their human rights commitments is only one of the ways in which human rights are used to respond to HIV and reproductive health issues: over time, human rights norms and standards have come to be used in a variety of ways to facilitate the achievement of HIV and reproductive health-related public policy goals.[17] In addition to the use of national and international legal accountability mechanisms, this work also includes advocacy efforts, and rights-based programming. Advocacy efforts generally involve using human rights as a framework for pressuring governments into fulfilling their obligations to respect, protect, and fulfil rights in relevant areas. Rights-based programming refers to the conscious integration of human rights principles and concepts into all aspects of programming, including the design, implementation, monitoring, and evaluation stages.

There is an abundance of literature on what is needed to create an effective response to HIV, a fraction of which has also considered conceptual, policy and programmatic linkages with reproductive health. While acknowledging that attention to the legal and policy environment constitutes only one element of an effective response to HIV or to reproductive health, few academic or policy papers in the legal or policy arena have engaged with these linkages. Thus, this paper examines HIV and reproductive health and rights, particularly drawing on the formal international legal and policy frameworks that have emerged, with attention to how they have been translated into national-level policies and programs. Part 2 briefly reviews the magnitude of the global burdens of reproductive ill health and HIV. Part 3 then turns to the evolution of the international legal and policy environment, first in relation to reproductive health, then in relation to HIV, and finally in relation to how these two areas have come together. Part 4 critically examines two areas of persisting controversy in the fields of reproductive health, HIV and human rights, focusing on some of the shortcomings of the existing legal and policy frameworks both on paper and in their implementation. Part 5 then examines some of the current challenges to human rights in the contexts of reproductive health and HIV, including broader social factors, such as social constructions of gender and their relation to women's vulnerability to HIV, and other forms of reproductive ill health. This article concludes by arguing that the ability to exercise informed choice regarding reproductive health issues is critical, and that a more robust embracing of the human rights framework in reproductive health and HIV efforts is necessary to address these issues effectively and to retard, if not halt, the HIV epidemic.

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16 While it is beyond the scope of this article to discuss the relative hierarchy between the various sources of international human rights norms, UN treaties, along with the Universal Declaration of Human Rights, are considered to be the principle sources of human rights law and norms. The provisions of the treaties are binding on the States, who become parties to them by signing and ratifying them. UN conferences, and the documents issued from them, are political in nature. The outcome declarations, programs of action and consensus do not bind States in the same way, but they are important evidence of international commitment. See Sofia Gruskin, "The Highest Priority: Making Use of UN Conference Documents to Remind Governments of Their Commitments to HIV/AIDS" (1998) 3 Health & Hum. Rts. 107.

17 For further information see Sofia Gruskin & Daniel Tarantola, "Human Rights and HIV/AIDS" (HIV inSite, April 2002), online: < http://hivinsite.ucsf.edu/InSite?page=kb-08-01-07#S4X>.

2. THE MAGNITUDE OF THE PROBLEMS

Although unevenly distributed, the burden of disease attributable to reproductive ill health and HIV is substantial, especially among certain groups. In order to gain an understanding of the immediacy with which these issues must be addressed, this section provides an introduction to the scale of reproductive ill health and HIV at a global level, and demonstrates that a multitude of factors shape where these burdens of ill health fall, all of which must be addressed.

2.1 Reproductive Health: The Numbers

There are a few basic indicators that can be used to demonstrate, at least to some degree, the severity of reproductive ill health as a global issue. Perhaps the most commonly used are the prevalence of sexually transmitted infections and maternal mortality indicators. Complications arise, however, in quantifying morbidity and mortality relating to reproductive health more generally, to some degree due to the inclusion of health and well-being in its accepted definition.[18]

It is estimated that every year more than 340 million new cases of the common bacterial and protozoal sexually transmitted infections, i.e. syphilis, gonorrhoea, chlamydial genital infections and trichomoniasis, occur throughout the world in women and men aged 15 to 49 years.[19] In addition, millions of sexually transmitted viral infections occur every year, including herpes simplex, human papilloma virus and Hepatitis B (as well as HIV, which is discussed separately in the next section below). These measures do not include the potential sequelae of these sexually transmitted infections, such as pelvic inflammatory disease, cervical cancer and infertility, all of which need mention as they primarily affect women. Due to the asymptomatic nature of many sexually transmitted infections, it is also worth noting that these figures are likely to be underestimates. This is particularly relevant for resource-poor settings and for marginalized populations in both resource-rich and resource-poor settings, in that lack of information on these diseases can lead to lack of attention at a programmatic level.

Globally, sexually transmitted infections constitute a huge health and economic burden, especially for developing countries where, even by conservative estimates, they account for 17% of economic losses caused by ill health.[20]

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18 "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. 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. It also includes sexual health, the purpose of which is the enhancement of life and personal relations." WHO, *Reproductive Health Indicators: Guidelines for their Generation, Interpretation and Analysis for Global Monitoring* (2006) at 5, online: <http://www.who.int/reproductive-health/publications/rh_indicators/guidelines.pdf>.

19 WHO Secretariat, *Prevention and Control of Sexually Transmitted Infections: Draft Global Strategy* 59th World Health Assembly, Provisional Agenda Item 11.6, Doc. A59/11 (May 18, 2006) at 1, online: <http://www.who.int/gb/ebwha/pdf_files/WHA59/A59_11-en.pdf>.

20 P. Mayaud & D. Mabey, "Approaches to the Control of Sexually Transmitted Infections in Developing Countries: Old Problems and Modern Challenges" (2004) 80 Sexually Transmitted Infections 174 at 174.

Regarding maternal mortality, debate persists surrounding the accuracy of the measurement techniques in use, but the most widely accepted figure is that global maternal mortality stood at approximately 529,000 in 2000.[21] More than 99% of these deaths were in developing countries.[22] Thus, although this is a health issue affecting only women, it is clear that not all women are equal, with women in certain developing countries at much higher risk of death related to pregnancy and childbirth. And even within those countries, some populations are at much higher risk than others. While enormous, these figures nonetheless fail to capture morbidity associated with pregnancy and child birth, which are well known to constitute a heavy burden of disease disproportionately borne by the poor and disadvantaged.

Using the measure of disability-adjusted life years,[23] sexual and reproductive ill-health accounts for 22% of the global burden of disease among women of reproductive age, and 40% of this burden in Africa; for men of reproductive age, sexual and reproductive ill-health accounts for 3% of the global disease burden, and 9% in Africa.[24]

The reproductive health indicators that are available tend to capture national level data that is disaggregated by sex in the case of sexually transmitted infections. As noted earlier, the availability of population-level data disaggregated with attention to any other potential factors, such as age, race, or socioeconomic status, is extremely limited.

2.2 HIV: The Numbers

Now well into its third decade, the increase in numbers of people vulnerable, infected and affected by HIV continues unabated in many parts of the world: the nations of Southern Africa are particularly affected, with China and India potentially risking epidemics of similar proportion. More than 28 million people have lost their lives and 38.6 million people are currently living with HIV.[25] 11,000 new infections and 8,000 deaths occur every day.[26] There were 4.1 million new infections in 2005 and approximately 2.8 million people died from AIDS in the same period.[27]

In many countries, newly infected women now outnumber newly infected men, and in some parts of the world the number of women infected with HIV has already surpassed the number of infected men. There are 24.5 million people in sub-Saharan Africa living with HIV, aged 15 to 49; 13.2 million, or 59%, are women. In sub-Saharan Africa, 74% of young people

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21 WHO, *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF* (Geneva: WHO, 2004) at 10, online: <www.who.int/reproductive-health/publications/maternal_mortality_2000/mme.pdf>.

22 *Ibid.*

23 While recognising that this measure is problematic in terms of measuring the burden of sexual and reproductive ill health, it remains the most appropriate metric to use at the current time.

24 C. AbouZahr & J.P. Vaughan, "Assessing the Burden of Sexual and Reproductive Ill-Health: Questions Regarding the Use of Disability-Adjusted Life Years" 78 Bulletin of the World Health Organisation 655, Online: <http://whqlibdoc.who.int/bulletin/2000/Number%205/78(5)655-666.pdf>.

25 *Supra* note 2 at 8.

26 *Ibid.* at 6.

27 *Ibid.* at 8.

aged 15 to 24 living with HIV are female.[28] In Asia, 29% of adults living with HIV are women; in the Caribbean this proportion is 51%. In Trinidad and Tobago, girls aged 15 to 19 are six times as likely as boys of the same age group to be infected with HIV.[29]

It is obviously simplistic to assert that all women are a homogeneous vulnerable group with respect to HIV: as mentioned above, even as the data still fail to capture these differences, some women are far more vulnerable than others. It is when a variety of factors associated with increased vulnerability to HIV infection are compounded that vulnerability is highly exacerbated. Although some population-level studies are now collecting data on HIV prevalence, this is a relatively new phenomenon and there remains a dearth of internationally comparable data conducive to analysis of HIV prevalence among different sub-populations, or access to care by sub-populations. Little research has focused on disparities that exist in terms of ongoing access to HIV services or treatment outcomes. If such data were available, they could be useful in helping to identify where laws and policies might help ensure more equitable access to HIV-related services.

These numbers are extreme, but they do not even begin to capture the reality of daily life for each person, and especially for each woman, who is living with, or affected by, HIV. The increasingly disproportionate disease burden is particularly worrisome: beyond the physical and psychological impact of the disease for women, this trend must be understood as illustrative of pervasive social imbalances between men and women throughout the world.

2.3 Contextualizing the Numbers

Although the correlation is not perfect, there is a high degree of overlap between the population groups affected by HIV and the groups affected by reproductive ill health. Moving beyond biology, it therefore becomes critical to analyze the environment in which such health disparities persist, so as to identify where changes are necessary for improving health status and health equity. This environment comprises a wide range of social, cultural, economic, legal, political and other factors, all of which affect the creation and persistence of health disparities, as well as access to needed services. As highlighted above, many of these underlying factors affect vulnerability to both HIV infection and reproductive ill health. This paper focuses specifically on the legal and policy environment relevant to reproductive health and HIV, and its particular influence on health disparities in these areas of health.

3. THE EVOLVING LEGAL AND POLICY ENVIRONMENT OF REPRODUCTIVE HEALTH AND HIV

Ensuring the existence of a supportive legal and policy environment in which responses to reproductive ill health and HIV can be carried out, although insufficient on its own, is a critical component of ensuring effective responses to these issues. Once laws and policies are in place, ongoing monitoring of their content and the degree to which they are implemented is

[28] The Global Coalition on Women and AIDS, "Facts and Figures" (May 2006), online: <http://womenandaids.unaids.org/publications_facts.html>.

[29] J.A. Inciardi, J.L. Syvertsen & H.L. Surratt, "HIV/AIDS in the Caribbean Basin" (2005) 17:Supp.1 AIDS Care 9 at 16.

also crucial. And all of this work must, obviously, be carried out alongside other interventions to address the factors that influence the distribution of health within each society.

3.1 Reproductive Health

As early as 1968, the right of individuals and couples to control their reproductive lives was internationally acknowledged.[30] Since then, a myriad of international declarations and resolutions have expressed political commitment to ensuring reproductive rights and health; early international policy pronouncements provided increasingly strong language useful for promoting women's empowerment and reproductive health.[31] In 1974, in the U.N. World Population Conference's outcome document, recognition was given to the need of "ensuring that all couples are able to achieve their desired number and spacing of children," as well as of "preparing the social and economic conditions to achieve that desire."[32] However, the same document, although it promotes impacting fertility levels through the promotion of development, education, and health strategies, also asserts that if countries consider their birth rate detrimental to their national purposes, they are "invited to consider setting quantitative goals and implementing policies that may lead to attainment of such goals." Thus, at the time, recognition of the role of autonomous decision-making and human rights protection for the ability of individuals to make fertility decisions was limited at best.

In 1979, the equal rights of women and men to "decide freely and responsibly on the number and spacing of ... children" was officially accepted in the *Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW) as part of international human rights law.[33] This right must be understood, however, in light of the word "responsibly", which opens the door to potential government interference, and the almost universally held social expectation for people, especially women, to become parents.

The International Conference on Population and Development (ICPD), held in Cairo in 1994, was the first occasion where international commitments were made that gave full recognition to women's economic and reproductive roles. The twenty-year ICPD Programme of Action that emerged from the conference was one of the first international documents also to accord importance to male involvement in reproductive health. Defined in 1994, and accepted

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30 See Jason L. Finkle, Barbara B. Crane, "The World Health Organization and the Population Issue: Organizational Values in the United Nations," (1976) 2 Population and Development Rev. 367 at 375ff.

31 *World Population Plan of Action*, UN DESA, August 1974, online: UN Population Information Network (POPIN) <http://www.un.org/popin/icpd/conference/bkg/wppa.html>.

32 *Ibid* at para. 28.

33 *Convention on the Elimination of All Forms of Discrimination Against Women*, GA Res. 34/180, UN GAOR, 34th Sess., Supp. No. 44, UN Doc. A/34/46 (1980) 193 at art. 16(e) (entered into force 3 September 1981) [*CEDAW*]. In addition, art. 14(b) imposes an obligation on State Parties to ensure that rural women have "access to adequate health care facilities, including information, counselling and services in family planning." The right to family planning, education and services is also recognized in the *Convention on the Rights of the Child*, GA Res. 44/25 UN GAOR, 44th Sess., Supp. No. 49, UN Doc. A/44/49 (1989) 167 at art. 24(2)(f) (entered into force 2 September 1990) [*CRC*].

by the governments of 179 countries,[34] the enjoyment of reproductive health was predicated on the enjoyment of certain human rights deemed to be "reproductive rights":

> 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. …Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly on the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence.[35]

The human rights that have, therefore, come to be accepted by governments as reproductive rights secure claims around access to quality reproductive health services and, most importantly, the capacity to act autonomously.[36] These reproductive rights are generally understood to include: the right to the highest attainable standard of health; the right to liberty and security of the person; the right to life; the rights to non-discrimination and equality; the right to privacy; the right to decide, freely and responsibly, on the number, spacing, and timing of children; the right to marry and found a family; the right to seek, receive, and impart information; the right to be free from inhuman or degrading treatment; and the right to enjoy the benefits of scientific progress.[37] Over time, there has been an expansion of the legal obligations associated with many civil and political rights, moving them outside their traditional sphere to also include positive obligations more traditionally associated with economic, social, and cultural rights. The right to life, for example, while traditionally understood to relate to freedom from arbitrary deprivation of life, is now also understood to encompass the requirement for the state to prevent avoidable loss of life, such as deaths due to childbirth related causes. This means, for example, that there be sufficient emergency obstetrical services such that a woman in need can access them, and that there be sufficient services and protections in place so that the labouring woman has the ability to decide to get these services, and not be obstructed by her husband, mother-in-law, community, health care provider, or other entities.[38] Similarly, the right to seek, receive, and impart information was traditionally concerned only with the

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34 Seventeen countries lodged reservations, including the Holy See and Iran. The United States endorsed the ICPD Programme of Action without reservation. See *ICPD Programme of Action, supra* note 9. The reservations and statements regarding the ICPD Programme of Action can be conveniently found collectively on the UN Population Fund website under ICPD Programme of Action, "Part 2 - Statements and Reservations on the Programme of Action", online: UN FPA <http://www.unfpa.org/icpd/icpd_poa.htm#pt2ch>.

35 *ICPD Programme of Action, supra* note 9 at 7.2-7.3.

36 *Ibid.* at 7.6 and 8.25.

37 See generally Rebecca J. Cook, Bernard M. Dickens & Mahmoud F. Fathalla, *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law* (Oxford: Clarendon Press, 2003).

38 For a discussion of human rights and reproductive rights, see Rebecca J. Cook *et al.*, *Advancing Safe Motherhood through Human Rights*, (Geneva: WHO, 2001) online: <http://www.who.int/reproductive-health/publications/RHR_01_5_advancing_safe_motherhood/RHR_01_05_table_of_contents_en.html>.

media and a free press, but is now understood to include making information relating to family planning and other sexual and reproductive health matters available and accessible. This means that governments should not interfere in the circulation of scientifically accurate information, nor should they obstruct adolescents in obtaining such information (although this final point remains a source of debate).[39]

The right to non-discrimination encompasses the idea of substantive equality, which acknowledges that some distinctions are necessary to promote rights for people who are differently situated, but that all differences must be based on objective and reasonable criteria.[40] Placing special emphasis on ensuring that girls, rather than simply naming all young people, have access to reproductive health information must therefore be based on an understanding of existing gender differentials that make girls particularly vulnerable to reproductive ill health and, consequently, in disproportionate need of this information. The right to the highest attainable standard of health is perhaps the broadest recognized right in the corpus of reproductive rights, encompassing access, including availability, acceptability, and quality concerns, to the range of defined reproductive health services, as well as the underlying conditions necessary to utilize these services, including access to, and availability of, information.[41]

3.2 HIV

As the scale and significance of HIV became better appreciated, the WHO Global AIDS Strategy was put into place and became the guiding document to the response to HIV in the late 1980s.[42] First articulated in 1986-87, the strategy focused on a comprehensive range of issues necessary for an effective response to HIV, but was revolutionary in promoting non-discrimination towards people living with HIV, and recognizing the promotion and protection of human rights as a key element of the global response to HIV. The implications of the first global public health strategy to do so were far-reaching. The fact that it was put forward in these terms by an inter-governmental organization paved the way for the response to become firmly anchored in international law, thereby making governments and intergovernmental organizations publicly accountable for their actions, or inaction, in this area.[43]

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[39] See e.g. Committee on the Rights of the Child, *General Comment No.4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, UN CRC, 33d Sess., UN Doc. CRC/GC/2003/4 (2003) online: <http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CRC.GC.2003.4.En?OpenDocument>.

[40] See Jane Cottingham *et al.*, *Transforming Health Systems: Gender and Rights in Reproductive Health* (Geneva: WHO, 2001), online: <http://www.who.int/reproductive-health/publications/transforming_healthsystems_gender/index.html>.

[41] See e.g. Committee on Economic, Social and Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN ESC, 22nd Sess., UN Doc. E/C.12/2000/4 (2000), online: <http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En>.

[42] Jonathan Mann & Daniel Tarantola, "Responding to HIV/AIDS: A Historical Perspective" (1998) 2:4 Health & Hum. Rts. 5 at 5-6.

[43] See Sofia Gruskin & Daniel Tarantola, "Health and Human Rights" in Sofia Gruskin *et al.*, eds., *Perspectives on Health and Human Rights* (New York: Routledge, 2005) at 3.

In 2001, the United Nations held a General Assembly Special Session on HIV/AIDS, which led to a landmark outcome document, the Declaration of Commitment on HIV/AIDS, with specific targets for governments addressing HIV. Among other things, there are specific targets for young people, including having the information and means to protect themselves from HIV infection. In the context of adolescents, however, for whom frank sexual education has been shown to be most beneficial in reducing vulnerability to HIV infection, the Declaration of Commitment emphasizes that any youth-specific education program, created with the full participation of families, has to be consonant with "cultural, religious and ethical factors."[44] Such a condition, tacked on at the end, certainly was intended by conservative governments to vitiate the purpose of comprehensive sexual education, particularly using cultural and other values to dictate that adolescent girls remain virtually ignorant of such matters.

It is only recently that heightened attention is being paid to young people infected with HIV. Thought for a long time to be a relatively little-affected group, or most likely too politically loaded to be dealt with straightforwardly, only the prevention of infection in babies in the context of mother-to-child transmission received attention until very recently. With the majority of new infections occurring in those under 24 years of age, however, there is increased interest in HIV prevention among adolescents, especially adolescent girls. This was acknowledged in the 2003 Convention on the Rights of the Child, General Comment 3 on HIV/AIDS and the Rights of the Child: "Of particular concern is gender-based discrimination combined with taboos or negative or judgmental attitudes to sexual activity of girls often limiting their access to preventive measures and other services."[45] The Concluding Observations of both the Committee on the Rights of the Child and the Committee on the Elimination of Discrimination Against Women, it should be noted, frequently include concerns regarding the rates of HIV infection among adolescents, especially among girls, and what actions the state is taking, or failing to take, to address them. The committees urge states to address this weakness through access to education, including information on the prevention of HIV.[46]

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[44] *Declaration of Commitment on HIV/AIDS*, GA Res. S-26/2, UN GAOR, 26th Special Sess., UN Doc A/RES/S-26/2 (2001), online: <http://www.un.org/ga/aids/docs/aress262.pdf> [*Declaration of Commitment*], stating at para. 63: "By 2003, develop and/or strengthen strategies, policies and programmes which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors…"

[45] Committee on the Rights of the Child, General Comment No.3: *HIV/AIDS and the Rights of the Child*, UN CRC, 32nd Sess., UN Doc. CRC/GC/2003/1 (2003) at para. 6, online: UN HCHR <www.unhchr.ch/html/menu2/6/crc/doc/comment/hiv.pdf>.

[46] See e.g. Committee on the Elimination of Discrimination against Women, *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Dominican Republic*, UN OHCHR, UN Doc. A/53/38 (1998) at para. 312, online: OHCHR <http://www.unhchr.ch/tbs/doc.nsf/0/9c51f441e19ae4c880256664004f09a9?OpenDocument>. See also Committee on the Elimination of Discrimination against Women, *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Belize*, UN OHCHR, UN Doc. A/54/38 (1999) at para. 31, online: OHCHR < http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/A.54.38,paras.31-69.En?Opendocument>. See also Committee on Economic, Social and Cultural Rights, *General Comment No.16: Substantive Issues Arising in the Implementation of the Convention on Economic Social and Cultural Rights*, UN CESCR, 34th Sess., UN Doc. E/C.12/2005/4 (2005).

Ever since the promulgation of the original WHO strategy on HIV, human rights have been part of the rhetoric, and part of the practice, of the AIDS response. In fact, since that time, the work of human rights treaty bodies, as well as documents emanating from international conferences, have included references to HIV and human rights, even if not necessarily in relation to reproductive health. The section below examines how some of these documents have addressed these issues, and the extent to which this has been linked to reproductive health more broadly.

3.3 Convergence of Law and Policy Relating to Reproductive Health and HIV Over Time

Analysis of international legal and policy frameworks from the perspective of both HIV and reproductive health led to the identification of shortfalls in existing frameworks, as well as opportunities for reinterpreting or modifying these to incorporate concerns surrounding HIV. This section examines some of the main international legal and policy frameworks for addressing reproductive health from the perspective of HIV, drawing out how some of these have been, and can be, adapted to ensure their continued relevance in the context of HIV.

First, it is important to consider what reproductive rights mean when HIV is a factor. In essence, they are exactly the same as reproductive rights when HIV is not a factor, but given the discrimination surrounding HIV and the potential vulnerabilities arising from HIV infection, protection of reproductive rights in this context is particularly imperative. The international legal and policy environment has slowly evolved in an effort to address this need.

CEDAW affirms that women have a right to decide "freely and responsibly on the number and spacing of their children," and to have the information and means necessary to exercise that right.[47] It would logically follow that women have the right to determine whether, when, and how many children they will have. Even using recognized approaches for a state's restriction of most individual rights and freedoms, the evidence does not exist to justify curtailing any individual's desire to have children, or not to have children, on the basis of HIV infection.[48] A coerced termination of pregnancy cannot be seen as a legitimate restriction on such a right.[49] Instead, the growing corpus of international human rights norms recognizes the absolute impermissibility of discrimination against women, whether HIV infected or not, in the enjoyment of this and other reproductive rights. CEDAW's General Recommendation

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[47] *CEDAW, supra* note 33 at art. 16(e).

[48] UN Commission on Human Rights, *Status of the International Covenants on Human Rights: The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN ESC, 41st Sess., UN Doc. E/CN.4/1985/4 (1984) [*Siracusa Principles*] online: at <http://hei.unige.ch/~clapham/hrdoc/docs/siracusa.html>. See also Paul Sieghart, *AIDS & Human Rights: A UK Perspective* (London: British Medical Association Foundation for AIDS, 1989).

[49] *Siracusa Principles*, *ibid*. Examining these in the context of the above-mentioned right to decide on the number and spacing of children, it can be seen that justifying this limitation to the international community would be an impossibly onerous task. The last three conditions listed above prove particularly problematic in this context. See also Maria de Bruyn, "Safe abortion for HIV-positive women with unwanted pregnancy: a reproductive right" (2003) 11:22 Reproductive Health Matters 152.

No. 19 on Violence Against Women,[50] for example, states that "compulsory sterilization or abortion adversely affects women's physical and mental health, and infringes the rights of women to choose the number and spacing of their children."[51] In addition, State parties are specifically recommended to "ensure that measures are taken to prevent coercion in regard to fertility and reproduction."[52] There is no explicit mention of the HIV status of women, but the clear reading of the text, as well as the accepted understanding that impermissible discrimination on the basis of "other status" includes HIV infection, would logically include HIV-infected women.[53] Furthermore, CEDAW's General Recommendation No. 15 on Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of AIDS also recommends that "programmes to combat AIDS should give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection."[54]

As noted earlier, the ICPD document affirms the right of women and men to be informed of, and to have access to, safe, effective, and affordable methods of family planning of their choice.[55] The document further affirms that the definition of reproductive rights "rests on the recognition of the basic rights of *all couples and individuals* to decide freely, and responsibly, the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health."[56] It also "includes the right to make decisions concerning reproduction *free of discrimination, coercion and violence*, as expressed in the human rights documents."[57]

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50 Committee on the Elimination of Discrimination Against Women, *General Recommendation No. 19: Violence Against Women*, UN CEDAWOR, 11th Sess., UN Doc. A/47/38 (1992), online: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom19>.

51 *Ibid.* at para. 22.

52 *Ibid.* at para. 24(m).

53 See *The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)*, CHR Res. 2003/47, UN CHROR, 2003, UN Doc. E/CN.4/RES/2003/47, online: <http://www.unhchr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.RES.2003.47.En?Opendocument>; See also Committee on the Elimination of Discrimination Against Women, *General Recommendation 24: Women and Health*, UN CEDAWOR, 20th Sess., UN Doc. A/54/38 (part 1) (1999), online: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24>.

54 Committee on the Elimination of Discrimination Against Women, *General Recommendation No. 15: Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, UN CEDAWOR, 9th Sess., UN Doc. A/45/38 (1990), online: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom15> [*General Recommendation 15*].

55 The manner in which the ICPD addressed HIV/AIDS was, and is, woefully inconsistent with its approach to the exercise of human rights. That is, the language in the ICPD underscores the inconsistency that exists between the internationally recognized reproductive rights of women who are not HIV-infected and the failure to give equal recognition of these rights to those who are.

56 *ICPD Programme of Action*, *supra* note 9 at 7.3 (emphasis added).

57 *Ibid.* (emphasis added).

This language can be understood to imply that decisions concerning pregnancy, whether or not one of the parents is HIV-infected, should be made by couples and individuals, that population policies must allow individuals to decide freely and responsibly whether they want children, and that the ability to do so should be free from government interference. But when read against the sections of the ICPD document concerning HIV, it is made clear that when this section of the document was drafted, the right was not actually recognized to extend unfettered to all. The HIV language focuses on prevention and control. In addition to the usual rhetoric about vulnerability and the avoidance of discrimination in the context of HIV, the ICPD Programme of Action states as an objective that "sexual and reproductive health programs [must] address HIV infection and AIDS,"[58] but be limited to promoting "responsible sexual behaviour, including voluntary [sexual] abstinence" for the prevention of HIV infection.[59] Thus, for example, Ethiopia's 2001 policy that "prevention of pregnancy shall be encouraged among HIV-positive individuals"[60], although arguably discriminatory, would not be explicitly condemned by the language of the ICPD Programme of Action. There is a great deal in the ICPD Programme of Action that refers to reproductive and sexual health, as well as to reproductive rights. There is even a great deal about HIV. There is nothing, however, that even comes close to referring to reproductive health and rights in the context of HIV.

The Fourth World Conference on Women, held in Beijing in 1995, constituted, however, the beginning for establishing these connections. Using much of the same language as the ICPD Programme of Action, the Beijing Platform for Action reaffirmed the centrality of reproductive rights in advancing the status of women, and recognized women's social subordination and unequal power relations to men as key determinants of their vulnerability to HIV. In addition, the Beijing Platform for Action states that:

> The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.
>
> Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.[61]

The implicit recognition of sexual rights in this paragraph constitutes a positive development, useful both for setting normative frameworks and for designing programmatic activities. Despite the progressive nature of this language, however, its actual application has been hampered by a variety of factors.

The Beijing Platform for Action most strongly states the UN General Assembly's commitment to gender equality, gender equity and the empowerment of women. Although not specifically in the context of HIV, the Beijing Platform for Action recommends taking action

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58 *Ibid.* at 8.29(b).

59 *Ibid.* at 8.31.

60 *Women of the World: Anglophone Africa Progress Report 2001 – Ethiopia*, (The Centre for Reproductive Rights, 2001) at 23, online: <http://www.reproductiverights.org/pdf/wowaapr-ethiopia.pdf>.

61 *Report of the Fourth World Conference on Women: Beijing Platform for Action*, Annex 2, UN A/Conf.177/20/ Rev. 1, (17 October 1995) at para. 96, online: <http://www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en> [*Beijing Platform for Action*].

"to ensure the conditions necessary for women to exercise their reproductive rights and eliminate coercive laws and practices."[62] Such coercion could be understood to include, for example, forced abortion for seropositive pregnant women. These efforts helped to ensure that the promotion of reproductive rights remained firmly on the international agenda, but did not include mention of HIV status specifically in relation to reproductive rights.

The five-year review of the ICPD, 'ICPD plus 5,' presented the UN General Assembly with a chance to re-examine the challenges governments faced in improving reproductive health and rights, including in the context of HIV.[63] The progression of the HIV epidemic in the intervening five years highlighted how HIV had complicated the realization of reproductive health and rights. As a result, the language in the document addressed HIV more comprehensively, and governments agreed to specific targets for young people, aged 15 to 24, including having the information and means to protect themselves from HIV infection, a cornerstone of a human rights based approach to reproductive health.[64]

By 2001, the toll HIV was taking on women was recognized as evident. The Declaration of Commitment emanating from the UN General Assembly Special Session on HIV/AIDS therefore contains forceful references to women's human rights and empowerment, positioning them as fundamental to decreasing women's and girls' vulnerability to HIV, and thus to stopping the epidemic:

> Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS [and] Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic.[65]

The Declaration of Commitment reaffirms in its preambular language the commitments made in Cairo and Beijing, and at their five-year reviews, to promote women's empowerment with regard to sexual and reproductive health, especially in relation to HIV. References to women's sexual autonomy, manifest in the Beijing Platform of Action, were retooled, however, for the Declaration and subordinated to HIV protection: "[Women should be empowered] to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection."[66] Governments could support sexual autonomy, it would appear, only for the purposes of saying "no" to sexual activity, or perhaps demanding fidelity and/or the use of condoms.

2004 marked the ten-year anniversary of the ICPD Programme of Action. Building on the five year review, a number of UN economic commissions held regional review meetings: the Asian, Pacific and Latin American regions all strongly reaffirmed their commitment to the

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62 *Ibid.* at para. 107(d).

63 See *Report of the Ad Hoc Committee of the Whole of the Twenty-first Special Session of the General Assembly, Addendum: Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*, UN GAOR, 21st Special Sess., UN Doc A/S-21/5/Add.1 (1999), online at <http://www.un.org/popin/unpopcom/32ndsess/gass/215a1e.pdf>.

64 *Ibid.*

65 *Declaration of Commitment*, supra note 44 at paras. 14 and 15.

66 *Ibid.* at para. 59.

ICPD Programme of Action,[67] despite objections from the United States. There was also a host of non-governmental activity that assessed progress made in achieving reproductive and sexual health for all, which included reports drawing on the linkages between HIV and reproductive health.[68] But despite these positive actions, and in large part reflecting a lack of global support for the initial ICPD Programme of Action, as well as fear on the part of many governments to reopen discussions at a global level around these issues in the evolving conservative climate, it was determined that a global review would not take place.

In 2006, a High-Level Meeting on HIV was held at the UN General Assembly where, five years after the original Declaration of Commitment was agreed upon, a new political declaration was drafted. Although strikingly deficient in many areas relating to sexual and reproductive health, the 2006 Political Declaration on HIV/AIDS[69] is more explicit in its support for sexual autonomy for women, in the context of HIV, than the original Declaration of Commitment. The 2006 Political Declaration includes a pledge to:

> ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence.[70]

While the original Declaration of Commitment unabashedly declares that the "realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS,"[71] the document dodges a key but controversial issue: the reproductive rights of those living with HIV. Again, it is important to note progress made for women in this regard in the 2006 Political Declaration, which includes commitments to:

> … ensuring that pregnant women have access to antenatal care, information, counselling and other HIV services and to increasing the availability of and access to effec-

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67 Europe convened a meeting that focused less on reproductive health and the *ICPD Program of Action*, and more on the issue of aging. The Economic and Social Commission for Asia and the Pacific (ESCAP) hosted the Fifth Asia and Pacific Population Conference (APPC) in December 2002, on the theme of "Population and Poverty." The Conference adopted a Plan of Action at the conclusion of the meeting. The Economic Commission for Latin America and the Caribbean (ECLAC) held a meeting of the Caribbean Development and Cooperation Committee (CDCC) on November 11-12, 2003, in Port-of-Spain, to review progress in the implementation of the ICPD Program of Action in the Caribbean region. The twenty Caribbean countries and territories that attended reaffirmed their commitment to the ICPD and adopted a declaration. The Africa region held a meeting at which nations reaffirmed their commitment to the ICPD goals, highlighted the importance in achieving the MDGs, and underscored key areas for increased attention. The Arab region meeting focused on themes such as population, poverty and development, youth issues from a multi-faceted perspective, and analyzing and addressing prevailing challenges, and the impact of post-demographic transition. Nations also reaffirmed their intention to fulfil the ICPD goals.

68 See generally Countdown 2015: Sexual and Reproductive Health and Rights for All, online: <http://www.countdown2015.org/home.aspx>.

69 *Political Declaration on HIV/AIDS*, GA Res. 60/262, UN GAOR, 60th Sess., UN Doc. A/RES/60/262, (2006), online: <http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf> [*2006 Political Declaration*].

70 *Ibid.* at para. 30.

71 *Declaration of Commitment*, *supra* note 44 at 9.

> tive treatment to women living with HIV and infants in order to reduce mother-to-child transmission of HIV, as well as to ensuring effective interventions for women living with HIV, including voluntary and confidential counselling and testing, with informed consent, access to treatment, especially life-long antiretroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care.[72]

Nonetheless, even in the 2006 Political Declaration, an understanding or affirmation of reproductive rights in the context of HIV remains glaringly absent.

The global strategy most shaping the response to HIV at the present time is UNAIDS' and WHO's Universal Access initiative. Its aim is to come "as close as possible to the goal of universal access to treatment by 2010 for all those who need it."[73] Universal Access includes attention to prevention and care activities, which suggests room for concurrently addressing some of the reproductive health and rights issues that are most closely related to HIV. Numerical targets drive the strategy, however, with insufficient consideration of the role of human rights in achieving success.

The global agenda, which is now laudably focusing on poverty reduction, has the potential to countermand the promotion of reproductive rights even as the HIV epidemic makes their protection ever more urgent. The Millennium Development Goals (MDGs) constitute targets in various fields that will help to achieve the overall goal of reducing poverty; one target does focus world attention on stopping the progression of HIV, but does so without any reference to promoting and protecting reproductive health and rights.[74] Indeed, reproductive health was not explicitly mentioned in any of the original MDGs or indicators. Instead, there were two partial but inadequate goals: to reduce by two-thirds, between 1990 and 2015, under-five mortality and to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio. The most relevant indicator included under the promotion of gender equality was the ratio of male to female children enrolled in school; women's control over their fertility received no mention. As discussed in the preceding section, gender discrimination, particularly around issues of reproduction, has made women vulnerable to HIV infection; redressing the imbalance by strengthening reproductive rights would be most effective. Yet, this omission from the MDGs, now the most widely accepted global development indicators, was striking and could undermine the feasibility of achieving the stated goal of halting and reversing the spread of HIV by 2015. In recognition of this, and in response to long-term sustained pressure exerted by reproductive health advocates and others, the General Assembly adopted, in October 2006, an additional indicator under the maternal mortality goal: to achieve universal access to repro-

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72 *Supra* note 69 at para. 27.

73 *2005 World Summit Outcome*, GA Res. 60/1, UN GAOR, 60th Sess., UN Doc. A/RES/60/1 (2005) at para. 57(d), online: <http://daccessdds.un.org/doc/UNDOC/GEN/N05/487/60/PDF/N0548760.pdf>.

74 *United Nations Millennium Declaration*, A/Res//55/2, UNGAOR, 55th Sess., UN Doc. A/55/L.2 (2000). The MDGs do contain goals relating to gender equality, women's empowerment, maternal mortality and halting and beginning to reverse the spread of HIV/AIDS.

ductive health by 2015.[75] It has taken some time, once again, for the international policy environment to recognize an important issue but, now that this has been incorporated into the overriding development framework that is currently in use, this opportunity to have an impact on what work is carried out and how it is carried out can be taken.

Finally, the prevailing political wind blowing from the United States in its foreign assistance policies, as well as from some of its allies, has seriously hampered the protection of reproductive health and rights in the context of HIV. Upon entering office, US President George W. Bush reinstated the Mexico City Policy, or "global gag rule", which had initially been put in place under the Reagan administration but was repealed when President Clinton was in office. This policy restricts foreign NGOs receiving US funds from promoting or providing information about abortion services.[76] Such restrictions have severely and negatively impacted on the provision of reproductive health services in a number of countries.[77] If organizations wish to continue receiving US government funds they must comply with this regulation. If they choose not to comply, they may be left without sufficient funding to survive. Bearing in mind that many of the organizations promoting or providing abortion services also provide other health services, in particular reproductive health services and HIV services, access to these is being curtailed.[78] Human rights and reproductive health organizations document the closing of family planning clinics around the world, as well as the lack of condoms.[79] As noted by an NGO in Kenya, "because of the global gag rule, reproductive rights are being violated as women are not getting access to family planning."[80] They also are not getting access to proven means of HIV prevention.

Furthermore, the Bush administration has increased the focus on promotion of abstinence-only programs, and has increasingly channelled funds for prevention through religious organizations with little interest in proven HIV-prevention strategies. There is clear evidence that limiting access to condoms and to reproductive health services in the face of the AIDS epidemic, through political motivation, is detrimental to wider efforts to address it.[81] Moreover, the 'ABC' approach to HIV prevention (abstinence, being faithful, condoms) should include a particular focus on the 'C,' rather than the 'A' as currently emphasized. In Uganda, where ABC has been adopted and highly praised, married women, who are unable to practice absti-

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75 International Planned Parenthood Federation, "United Nations General Assembly Adopts Universal Access Target for Reproductive Health" (5 October 2006), online: <http://www.ippf.org/en/News/Press-releases/UN+General+Assembly+adopts+target.htm>.

76 USAID, "Mexico City Policy Contract Information Bulletin" (CIB) 01-08. 2001. Online: <http://www.usaid.gov/business/business_opportunities/cib/pdf/cib0108r.pdf>.

77 See generally Dina Bogecho & Melissa Upreti, "The Global Gag Rule—An Antithesis to the Rights-Based Approach to Health" (2006) 9:1 Health & Hum. Rts. 17.

78 See Center for Reproductive Rights, "The Bush Global Gag Rule: Endangering Women's Health, Free Speech and Democracy" (July 2003), online: <http://www.crlp.org/pub_fac_ggrbush.html>.

79 See Center for Reproductive Rights, "Breaking the Silence: The Global Gag Rule's Impact on Unsafe Abortion" (2003) at 17, online: <http://www.crlp.org/pdf/bo_ggr.pdf>. "Many [health service providers] are frustrated that the global gag rule forces them to subordinate the needs of the community they serve to USAID restrictions on abortion-related activity."

80 *Ibid.* at 20.

81 Population Action International, "How Access to Sexual and Reproductive Health Services is Key to the MDGs" (2005) at 3, online: < http://66.39.133.128/resources/factsheets/index.htm>.

nence, are still suffering from high rates of HIV infection.[82] As mentioned earlier, culture frequently dictates that, in marriage, a woman often is not expected to give consent to sexual relations. It is estimated that up to 80% of women throughout the world who were infected with HIV while in a long-term, stable relationship, were infected through their partners who had themselves become infected through sex outside their relationship or through drug use.[83] This persistent subordination of women is not being tackled in the context of HIV, even in the countries held up as examples for the rest of the world.

Although the international legal and policy environment relating to reproductive health and HIV has evolved considerably over the last few decades, room for improvement still remains. Alongside continuing efforts in this regard, existing laws and policies can effectively be used as the framework for progress in the areas of reproductive health and HIV.

4. WORK WITHIN THE INTERNATIONAL LEGAL AND POLICY ENVIRONMENT: AREAS OF PERSISTING CONTROVERSY

All reproductive rights take on an added dimension when considered in light of HIV. While international legal and policy documents offer some degree of attention to the need to ensure the protection of reproductive rights for all, irrespective of HIV status, governments and other actors experience many difficulties in operationalizing these principles and commitments. It is incumbent on national governments in all settings to ensure that conceptual attention to reproductive rights is translated into conducive national environments for programming and service delivery. Framed around some persistently controversial issues, this section provides a brief overview of how work relating to reproductive health and HIV is being implemented with attention to the above-described international legal and policy commitments.

4.1 HIV Testing

4.1.1 Premarital HIV Testing

It is not unheard of for states to require individuals to submit to a premarital HIV test before being allowed to marry.[84] Such requirements affect both women and men and raise many of the human rights concerns relevant to other forms of mandatory testing: voluntariness, privacy and confidentiality, appropriate counselling, referral and access to treatment, and so on. In India, for example, a Supreme Court ruling suspended the right to marry for all HIV

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82 For a clear illustration of the link between domestic violence and HIV/AIDS in Uganda, where many of the men interviewed preferred to beat their wives rather than to talk about HIV, or to let their wives seek counselling and testing, see *Policy Paralysis*, *supra* note 12, at 30.

83 National Council of Women's Organization, Online: <http://www.womensorganizations.org/pages.cfm?ID=63>.

84 For information on US marriage laws see "Marriage Laws of the Fifty States, District of Columbia and Puerto Rico," (Cornell Law School Legal Information Institute), online: <http://www.law.cornell.edu/topics/Table_Marriage.htm>.

infected individuals,[85] a ruling that was only recently overturned.[86] While the right to marry has been restored, the rights to privacy and confidentiality in disclosing HIV infection status to a partner are still unsettled.

Some women's rights groups both in India and beyond have been supportive of these and similar marriage restrictions, believing that preventing HIV-infected men from marrying women would redress inherent gender imbalances in society and help prevent women from being infected. Yet, there is a body of evidence that demonstrates that voluntary counselling and testing is always more effective than any coerced approach to HIV testing.[87] All UNAIDS/WHO testing policies to date have emphasized informed consent, confidentiality and counselling as critical to the success of all HIV testing.[88]

4.1.2 HIV Testing During Delivery and Prevention of Mother to Child Transmission

With the widespread availability of drugs to prevent mother to child transmission of HIV, antenatal care services have become an important location for the provision of HIV voluntary counselling and testing. For women who are first seen at a medical facility at the time of delivery, however, testing is often offered or imposed during delivery itself. Consider, for example, the situation of a pregnant woman unaware of her HIV status who is tested for HIV while in the throes of labour, ostensibly as part of a government's efforts to prevent mother to child transmission. Even if coercion is not explicit, asking a woman who is overcome by uterine contractions to "consent" to such a test raises a host of questions, including whether there was pre-test counselling and how consent was obtained. Should it be determined she is infected with HIV, a number of countries would give the mother and her newborn nevirapine, a single dose anti-retroviral drug that can stop transmission of HIV to infants in perhaps 70% of all cases.[89] This may be well and good, but it does not clarify when she would be informed of her own HIV status, what sort of post-test counselling she would receive, and whether she herself would have sustained access to antiretroviral therapy if needed.

In addition, questions must be asked as to who would be given the information regarding her status and in what ways. The right to privacy states that obtaining private information about health status must be done pursuant to the informed consent of the individual, whereas

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85 Mr. X v. Hospital Z – Supreme Court of India (1998) 8 SCC 296 C.A. No. 4641/ 1998: See The Lawyers Collective for case and information, online: <www.lawyerscollective.com>.

86 See Parthsarthy A. S. Pati, "A Critique on the Right to Marry of HIV/AIDS Patient (The Decaying Citadel of Justice" (sic), online: Legal Service India <http://www.legalserviceindia.com/articles/aids.htm>.

87 See Sofia Gruskin & Daniel Tarantola, "Health and Human Rights" in Roger Detels *et al.*, eds., *The Oxford Textbook of Public Health*, 4th ed. (Oxford: Oxford University Press, 2002) 311.

88 See e.g. *UNAIDS/WHO Policy Statement on HIV Testing* (Geneva: WHO, June 2004), online: <http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf> [*Policy Statement on HIV Testing*].

89 Without any intervention and with six months breastfeeding, there is a 30% risk of mother-to-child-transmission (MTCT). Claims of reducing that risk of transmission to 11% with nevirapine and modified feeding practices have been advanced. See UNAIDS, "Rates of Mother to Child Transmission and the Impact of Different PMTCT Regimens", (2005) at 2, online: <http://www.epidem.org/Publications/PMTCT%20report.pdf>.

the circumstances of active childbirth could easily be seen as duress. Moreover, CEDAW's General Recommendation No. 15, referred to in Part 3, calls for special attention to be given to women and adolescent girls in the context of HIV in terms of information, prevention of discrimination and rights.[90] Forcible HIV testing of pregnant women would seem to directly contradict these human rights norms.

In this instance, the international standards would seem to suggest that this type of action is unacceptable yet the practice not only persists but appears to be on the rise, underscoring the importance of attention not just to the mere existence of international, and even national, laws and policies, but also to their level of implementation.

4.1.3 HIV Testing in Health Facilities

The current shift towards "opt-out testing," whereby patients are given an HIV test by their health service provider in the context of "routine" health care services, with the proviso that they can opt out if they so choose,[91] is potentially of concern in that it represents a troublesome shift in approach away from the emphasis on voluntariness, counselling, and confidentiality that have, to date, been considered fundamental cornerstones of all testing strategies. Imagine, for example, a poor and illiterate female patient living in a society where she has limited access to health information. Is it realistic to assume that she is able to go against the "suggestion" of her male doctor that she take this test? And, if counselling is limited, what is the likelihood that she will understand the implications of her test result, whether negative or positive, and remain connected to the health services in such a way as to either maintain her HIV negative status or to access care and treatment and prevent further transmission of HIV if she is positive? The need to scale up HIV testing is evident. The emerging policy guidance for achieving this, however, even though stating on paper that informed consent, confidentiality and counselling are critical to the response, presents significant challenges for ensuring that the human rights commitments governments have made in a number of fora are protected in this endeavour.

The UNAIDS/WHO Policy Statement on HIV Testing issued in 2004 highlighted the need to ground any testing strategy in the "respect, protection, and fulfilment of human rights norms and standards."[92] Furthermore, it lists the following as key factors necessary for the success of HIV testing strategies: voluntariness, an ethical process for conducting the testing, addressing the implications of a positive test result, reducing HIV-related stigma and discrimination at all levels, ensuring a supportive legal and policy framework, and ensuring that the healthcare infrastructure is adequate. This policy statement is currently under review, and it remains to be seen how it will be altered, specifically whether the attention to human rights concerns, which have been the cornerstone of effective HIV policies and programs, will remain sufficiently emphasized.

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[90] See *General Recommendation 15*, *supra* note 54.

[91] See WHO & UNAIDS, "Secretariat Statement on HIV Testing and Counselling" (14 August 2006), online: <http://www.who.int/hiv/toronto2006/WHO-UNAIDSstatement_TC_081406_dh.pdf>.

[92] *Policy Statement on HIV Testing*, *supra* note 88 at 3.

4.2 Reproductive Health and Rights of People Living with HIV

Despite the clarity of international legal and policy commitments regarding the unacceptability of discrimination on the basis of HIV status, nation states in all parts of the world have been known to severely restrict reproductive rights in the context of HIV: in Poland, HIV infection of the mother is one of the few permissible grounds to terminate a pregnancy;[93] and a recent study in the Asian region found that 17% of HIV positive women in the study population were coerced into an abortion after their HIV diagnosis.[94] In both of these cases, the underlying assumption is that the reproductive lives of HIV-infected women and men may be treated exceptionally. Infringing rights without careful consideration of the public health consequences not only ignores well-settled methods for balancing rights and health concerns, but can also produce the very adverse health outcomes sought to be avoided.

It is only very recently that the reproductive rights of people living with HIV have begun to get serious attention from the international community. Yet, as highlighted in the examples above, reproductive rights are frequently not respected in the context of HIV. How might infringements of reproductive rights affect the enjoyment of reproductive health in this context?

Following on from the debate on pre-marital HIV testing introduced above, preventing HIV-infected individuals from enjoying the right to found a family, in light of less restrictive means of reducing HIV infections, is simply unjustifiable on human rights grounds. Rather than penalizing those HIV infected individuals who wish to found a family, a government should ensure that those individuals could do so safely while preserving their own health.

International guidance is also clear that decisions regarding if and when to have children are the responsibility of all couples and individuals. Yet, evidence suggests that this right has been curtailed in many places for people living with HIV. The Ethiopian policy noted earlier of encouraging the prevention of pregnancy among women living with HIV, although not overtly condemned in the language of the ICPD, is explicitly unacceptable in international human rights terms, thanks to CEDAW's General Comment No. 19, as outlined above.

Despite some progress, the lack of clear and comprehensive international legal or political commitments surrounding the reproductive rights of those living with HIV presents a continual challenge. Some of the difficulty in articulating a robust notion of reproductive rights in the context of HIV may be the underlying belief in some circles that prevention of HIV can be a legitimate ground for restricting sexual and reproductive behaviour. But such restrictions, if anything, are redolent of the eugenic marriage laws in the US and other countries, forbidding certain individuals from marrying and passing on their "defective" health to their offspring.[95] Nevertheless, different international human rights norms surrounding reproductive

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93 See The Center for Reproductive Rights (Formerly The Center for Reproductive Law and Policy), ed., *Women of the World: Laws and Policies Affecting their Reproductive Lives: East Central Europe* (New York: The Center for Reproductive Law and Policy, 2000). Online: <http://www.reproductiverights.org/pub_bo_wowece.html#PDF>.

94 S. Paxton *et al.*, "AIDS-related Discrimination in Asia" (2005) 17:4 AIDS Care 413 at 418.

95 Edward W. Spencer, "Some Phases of Marriage Law and Legislation from a Sanitary and Eugenic Standpoint" (1915) 25 Yale L. J. 58 at 64.

rights, found in the various international human rights treaties and relevant interpretations, are directly applicable to the situations of people living with HIV.[96]

In sum, the international human rights legal, political, and interpretative texts as they exist today do not offer sufficient protection or guidance concerning the reproductive rights of people living with HIV. There are some emerging norms that, if consistently applied in the context of HIV, would give the reproductive rights framework more utility. In order for this to make much difference, however, significant attention would be needed to address, in its entirety, persistent gender-based discrimination. The next section explores some of the ongoing barriers to further elaborating reproductive health and rights in the context of HIV.

5. PERSISTENT CHALLENGES TO ENSURING REPRODUCTIVE HEALTH AND RIGHTS IN THE CONTEXT OF HIV

Despite the positive evolution in the legal and policy environment noted in Part 3 above, challenges persist that make it difficult to move forward with work designed to ensure reproductive health and rights in the context of HIV. Some of these challenges are outlined below. Unlike the preceding section, these are not areas of controversy, they are simply ongoing challenges that need to be overcome as we strive to achieve reproductive health and rights for all. Moving this discussion squarely beyond the health sector, these are structural issues that require sustained attention in law, policy and practice at national and international levels.

5.1 Poverty and HIV

First of all, attention must be given to addressing poverty as it impacts on ill health and well-being. People with the least access to financial resources often have equally poor access to health services and information, which leaves them at increased risk not only of becoming HIV infected, but also of receiving less care and treatment once infected. Poverty creates its own desperation. The increasing feminization of poverty,[97] among other things, has been found to increase the likelihood that women and girls will trade and sell sex as a means to sustain themselves and their families economically. For women who have families to support, sex work, despite its inherent risks, often seems like the most viable alternative for supporting dependents.[98] And where poverty is deeply entrenched, many find it impossible to see beyond

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96 Different international human rights norms surrounding women's reproductive rights are directly applicable to the situation of a pregnant HIV-infected woman. An important source of such norms come from the international human rights treaty bodies – the committees that oversee how governments uphold the rights contained in the treaties that they have ratified. While governments are obliged to report to each treaty-monitoring committee on a periodic basis about the progress made and obstacles encountered in applying the rights contained in the treaty to their own nation, the treaty committees issue General Comments or Recommendations to help explain what the various rights actually mean to the governments.

97 See Martha Chess *et al.*, *Progress of the World's Women 2005: Women, Work & Poverty*, (New York, UNIFEM, 2005) at 37, online: <http://www.un-ngls.org/women-2005.pdf>.

98 See *Policy Paralysis*, *supra* note 12 at 58 for a health care worker's interview with Emily Joy Sikazwe, from Lusaka, Zambia: "A girl [orphan] told me 'HIV is not a monster… what I see [of it] is hunger. I'm fourteen – my siblings are crying for food, so I sell my body. I use condoms sometimes; otherwise it's raw sex. Yes I know I'll die. But my brothers and sisters are crying.'"

immediate needs: not using a condom and contracting HIV may result in death, but death that will fall years into the future. By contrast, having nothing with which to buy food means a more certain and imminent death.

5.2 Education and HIV

The association between educational attainment and improved health is widely accepted.[99] Since early in the HIV epidemic, links have been drawn between educational attainment and vulnerability to HIV infection. Although it initially appeared that in developing countries the increased mobility associated with higher education led to an increased risk of acquiring HIV,[100] it soon became apparent that more education is in fact protective against HIV infection.[101] Even if educated mobile populations are less vulnerable to HIV infection, vulnerability to HIV is elevated among people of low educational status, especially migrant workers and other particularly vulnerable groups.[102]

According to UNICEF and many of its partners, "education in itself offers a measure of protection against HIV/AIDS, particularly for girls. Education can reduce risk and vulnerability to HIV/AIDS by providing information and skills, by increasing young people's connectedness and security, by providing access to trusted adults, and by increasing literacy."[103] Tackling the low levels of school attendance in many countries must, therefore, continue to constitute a key component of HIV and reproductive health-related interventions.

5.3 Constructions of Gender

As already mentioned, the textual support for reproductive rights in the context of HIV is hampered by notions that HIV infection poses a threat that may allow for restrictions of human rights, in particular those that touch on sexuality and reproduction, because the primary means of infection for women is through heterosexual sex. Gendered expectations of women, when it comes to issues of sexuality, are almost universal in assigning agency to men. It is still true that fathers, husbands, brothers and the State generally have the authority, albeit social, not always legal, to define women's sexuality and reproductive choices.

Gendered expectations in many cultures impose upon women an obligation of sexual innocence, purity and virginity before marriage. Men, in contrast, are expected to be sexually

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99 See generally John R. Reynolds & Catherine E. Ross, "Social Stratification and Health: Education's Benefit beyond Economic Status and Social Origins" (1998) 45:2 Social Problems 221.

100 See Jan Vandemoortele & Enrique Delamonica, "The 'Education Vaccine' Against HIV" (2000) 3:1 Current Issues in Comparative Education 6, online: <http://www.tc.columbia.edu/cice/Archives/3.1/31vandemoortele_delamonica.pdf>.

101 See Damien de Walque *et al.*, "Changing Association between Schooling Levels and HIV-I Infection over 11 Years in a Rural Population Cohort in South-West Uganda" (2005) 10 Trop Med Int Health 993 at 993. See also Charles Michelo, Ingvild F. Sandøy & Knut Fylkesnes, "HIV Prevalence Declines in Higher Educated Young People: Evidence from Population-Based Surveys (1995-2003) in Zambia" (2006) 20 AIDS 1031 at 1034.

102 Yorghos Apostolopoulos *et al.*, "STI/HIV Risks for Mexican Migrant Laborers: Exploratory Ethnographies" (2006) 8:3 J Immigr Minor Health 291 at 293.

103 *HIV/AIDS and Education: A Strategic Approach* (Paris: International Institute for Education Planning, 2003) at 24, online: <http://unesdoc.unesco.org/images/0012/001286/128657e.pdf>.

experienced, resulting in pressure on men to prove their virility, often through multiple sexual partners. A recent study found that the percentage of males aged 15-49 in Lesotho who report having more than one regular sex partner or spouse is 55%.[104] The lack of legal, policy, and programmatic attention to reproductive rights which has, as a consequence, failed to transform gendered expectations, can be seen in the very real way women and men are made vulnerable to HIV infection and reproductive ill health.

Although the international legal and policy environment has been explicit for many years that discrimination on the basis of sex is unacceptable, social constructions of gender perpetuate gross inequalities that are tacitly accepted at individual, family, community, and national levels. The repercussions in terms of reproductive health and HIV are widespread and enduring.

5.4 Gender-Based Violence and HIV

Building on the notion of social constructions of gender, one potential repercussion of this is gender-based violence, which is a disturbingly pervasive phenomenon. In the context of HIV, gender-based violence has an even stronger impact: women who are victims of gender-based violence may be more likely to contract HIV, and women living with HIV may be more likely to be living in abusive relationships.[105]

Masculine sexual license is connected to the prevailing norm of machismo culture in many societies, which has been found to fuel the gender based and sexual violence that is connected to the HIV epidemic. Haiti has the highest HIV-prevalence rate in adults in the Caribbean, and the Ministry of Social Affairs and Labour of Haiti estimates that 90% of Haitian women are victims of violence.[106]

Recognition of this, as well as of the broader international legal framework, such as CEDAW's General Recommendation No. 19, has prompted some countries to amend national legislation surrounding violence against women, but there are doubts as to whether this alone is sufficient.[107] The administration of criminal justice does not often serve the interests of

[104] Daniel T Halperin and Helena Epstein, "Concurrent Sexual Partnerships Help to Explain Africa's High HIV Prevalence: Implications for Prevention" (2004) 364:9428 The Lancet 4 at 4-6.

[105] Sofia Gruskin *et al.*, "Using the Nexus of Sexuality, Health and Human Rights: Linking Efforts to Prevent Gender-based Violence and HIV in China, India, Thailand and Vietnam" (Oral Abstract Session: AIDS XVI International Conference, 2006) Abstract No. THPEO672, online: <http://www.iasociety.org/Default.aspx?pageId=11&abstractId=2198193>.

[106] Ms. Radhika Coomaraswamy, *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 - Report on the Mission to Haiti*, UN ESCOR, 56th Sess., UN Doc. E/CN.4/2000/68/Add.3, at 5. Online: <http://www.unhchr.ch/huridocda/huridoca.nsf/AllSymbols/1961657F6BC303F9802568BA004B4B3B/$File/G0010410.pdf?OpenElement>.

[107] In Mexico, recent reforms to the Penal Code and the Civil Code included the introduction of cohabitational and marital rape as an offense, and recognition of domestic violence as grounds for divorce. In some countries such as Brazil, although abortion remains illegal, there are exceptional circumstances, including pregnancy arising from rape, under which exceptions are permissible. It is important to note, however, that such legal reform constitutes the exception rather than the rule, and that even where legislation has been changed, it is often not implemented.

women; officials, who are rarely trained to handle cases of sexual violence in a sensitive and effective manner, provide a strong disincentive to report such crimes, especially for young girls. In South Africa, for example, there has been a reported increase in rapes of young girls, including female babies as young as nine months. This is attributed to a supposed belief that sex with a virgin is a cure for AIDS.[108] In response, the government ordered an official review of sexual offences legislation, but a targeted public education effort, which might be presumed to have more of an effect, has yet to be launched.[109] Governments often neglect to provide for a range of needed services, including emergency contraception, voluntary counselling and testing for HIV and for post-exposure prophylactic anti-retroviral treatment, even in countries that have ratified international treaties on women's rights and that have national legislation in place against sexual violence.[110]

Fear of violence contributes to the underlying imbalance of power between men and women, and limits the ability of women to protect themselves from HIV infection. For example, studies from India, Papua New Guinea, Guatemala, Brazil, and South Africa have indicated that even when women who are educated about HIV become aware that their partner is having sex with others, they are afraid to ask that he change his sexual behaviour or to insist on the use of a condom.[111] The link between violence and women's vulnerability to HIV infection is shown clearly in many of the testimonies contained in a recent human rights report.[112]

Women's inability to negotiate safe, consensual sex in such a climate of fear constitutes a grave danger and requires a much more robust understanding and implementation of repro-

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108 See Graeme J Pitcher and Douglas M Bowley, "Infant Rape in South Africa" (2002) 359:9303 The Lancet at 274.

109 See Government of South Africa, "Report of the Parliamentary Task Group on the Sexual Abuse of Children" (June 2002), online: <http://www.polity.org.za>.

110 See WHO, *International Review of Criminal Laws and Procedures Related to Sexual Violence*, (Geneva: WHO, forthcoming).

111 See National Sex and Reproductive Research Team & C. Jenkins, "National Study of Sexual and Reproductive Knowledge and Behavior in Papua New Guinea" (Goroka: Papua New Guinea Institute of Medical Research, 1994); Beatrice Bezmalinovic et al., "Guatemala City Women: Empowering a Vulenrable Group to Prevent HIV Transmission",in *Women & AIDS Program Research Rep. Series* (Int'l Center for Research on Women, 1995) at 2, online: <http://www.icrw.org/docs/archive/1994_rib_guatemala.pdf>; A. George & S. Jaswal, "Understanding Sexuality: Ethnographic Study of Poor Women in Bombay", in *Women & AIDS Program Research Rep. Series*, at 5, online: <http://www.icrw.org/docs/archive/1994_rib_bombay.pdf>; D. Goldstein, "Culture, Class, and Gender Politics of a Modern Disease: Women and AIDS in Brazil", in *Women & AIDS Program Research Rep. Series*, at 28, online: <http://www.icrw.org/docs/archive/1995_report_brazil.pdf>; Geeta Rao Gupta, Ellen Weiss & Daniel Whelan, "Women and AIDS: Building a New HIV Prevention Strategy," in *AIDS in the World*, supra note 5 at 215, citing Karim et al, "Determinants of a Woman's Ability to Adopt HIV Protective Behavior" in Natal/Kwazulu, South Africa: A Community Based Approach, in *Women & AIDS Program Research Rep. Series* online: <http://www.icrw.org/docs/archive/1994_rib_southafrica.pdf>.

112 See e.g. *Policy Paralysis*, *supra* note 12 at 30. An interview with Sara K. exemplifies the acceptance of unsafe sex as a marital duty: "My husband would beat me often… He used to beat me when I refused to sleep with him… He wouldn't use a condom. He said 'When we are man and woman married, how can we use a condom?' […] It's a wife's duty to have sex with her husband because that is the main reason you come together. But there should be love… When I knew about his girlfriends, I feared that I would get infected with HIV. But he didn't listen to me. I tried to insist on using a condom but he refused. So I gave in because I really feared [him]."

ductive rights. Here again, the international legal and policy environment has proved itself to be necessary but insufficient for ensuring reproductive health and rights in the context of HIV.

5.5 Lack of Female Controlled Methods for HIV Prevention

Another shortcoming in respecting, protecting, and fulfilling the reproductive rights of women can be seen in the lack of female controlled technologies that could help to prevent HIV transmission. Given that the most effective way to control the spread of HIV infection during sexual intercourse is through the use of a condom, women remain dependent on men to 'protect' them by using condoms; the male condom is therefore not in and of itself a solution. The female condom shows some promise, but it is still not a complete solution for a variety of reasons, including messiness and particularly the ability of a partner to perceive its use.

The female condom is the only currently available female-controlled method to prevent HIV infection, even though its availability and acceptability may be affected by such factors as cost and limited geographic distribution. Providing women only with HIV prevention methods that preclude their realization of most societies' accepted fertility norms is to provide them with no real options for HIV prevention.[113] Researchers and advocates stress that the development of a microbicide that would allow conception but prevent infection is necessary.[114] Women would not only be more in control, but decisions about pregnancy would be separated from the prevention of infection. Realistically, however, it will still be at least a few years until an effective microbicide is available (recent estimates indicate that if sufficient investment is provided, the earliest date by which a microbicide could be available would be 2012). Such an investment is critical not only to enable women to make reproductive choices, but also, in the bigger picture, to help reduce the spread of HIV.[115]

Does the slow development of female-controlled HIV prevention methods also signal a failure on the part of the world's governments to progressively realize women's reproductive rights? It was only in the 2006 Political Declaration that, for the first time in international policy, microbicides were mentioned and indeed the need for supporting their development promoted. As in previous examples, the international framework has proved slow to respond to the reproductive health needs of women, but now that this recognition exists, the challenge remains to translate this into effective international and national laws, policies and programs.

5.6 The Importance of Disaggregation of Data

Just as HIV and reproductive ill health are more likely to affect specific sub-populations, including women and ethnic minorities, so too are the barriers addressed in this section likely to affect these sub-populations disproportionately. As with reproductive health and HIV, the majority of population-level data available on economic disparities and access to education,

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113 See generally Kathryn Carovano, "More than Mothers and Whores: Redefining the AIDS Prevention Needs of Women" (1991) 21:1 Intl J Health Services 131.

114 Zena A Stein, "HIV Prevention: The Need for Methods Women Can Use" (1990) 80:4 Am. J. Pub. Health 460 at 461.

115 See The Rockefeller Foundation, "Mobilization for Microbicides: The Decisive Decade" (2002), online: < http://www.microbicide.org/microbicideinfo/rockefeller/mobilzation.for.microbicides.english.pdf>.

for example, relates to differences by sex. Yet, although these populations may require specific attention in policies and programs, further breakdown of these data so as to identify them and channel resources to them is rare.

Throughout the Declaration of Commitment, reference is made to 'vulnerable groups,' yet there is no definition of which groups are included. Nowhere in the document is there explicit mention of sex workers, intravenous drug users, men who have sex with men, prisoners or other groups that might fall into the definition of 'vulnerable'. The same lack of definition is evident also in the 2006 Political Declaration. But, significantly, there is substantial language in the 2006 Political Declaration about ensuring the full enjoyment of all human rights by people living with HIV and members of "vulnerable groups".[116] This marks a critical development in the political framework within which work in HIV can be assessed, in part with attention to the extent to which human rights are promoted or violated in the policy and programmatic actions that are carried out.

The Universal Access initiative, like its predecessor, is driven by numerical targets. Indeed, WHO's "3 by 5" initiative sought to provide three million people living with HIV in low- and middle-income countries with life-prolonging antiretroviral treatment by the end of 2005. While these targets are essential for promoting accountability, it is critical that attention be paid to how the numbers break down. In other words, which population groups have sustained access to treatment and which do not?

Guidance is summarily lacking in terms of who might be considered vulnerable and therefore how best to provide these groups with the programs and services that they most require. Without disaggregation, accurate and appropriate programming is difficult; thus, this seemingly technical issue has large-scale implications for how programs are designed and shaped, and ultimately who has access to the services they need.

6. CONCLUSION

The consequences of gendered expectations for women's reproductive health in the context of HIV, as just reviewed, could potentially be mitigated through the clear, consistent, and comprehensive application of reproductive rights, norms, and standards. The same could be said for other social factors that increase vulnerability to reproductive ill health and HIV, including race, colour, language, religion, political, or other opinion, national or social origin, property, birth, or other status.

There exists, despite its shortcomings, a corpus of international law and policy that affirms the necessity to promote and protect the reproductive rights of people living with and affected by HIV. There is a long way to go, however. Recent human rights investigations in Africa reveal abuses against women and girls, many of which are within the context of HIV.[117] Reports suggest that not enough is being done to implement the safeguards being designed specifically to protect the reproductive rights of women. The Concluding Observations of the Committee on the Elimination of Discrimination Against Women show a troublesome pattern of reports of violations of women's reproductive rights, with little to no improvement regarding such vio-

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[116] *Supra* note 69 at para. 29.

[117] See *Policy Paralysis*, *supra* note 12.

lations. In many countries in Latin America and the Caribbean, such as Guyana, Jamaica, and Peru (to focus on one, but representative, region of the world), the primary issue of concern remains the pervasive subordination of women in all spheres of life, due to widespread acceptance of ingrained social roles, thus contributing to vulnerability to infection. Beyond the legal framework and structural issues noted above, other common issues of concern include access to affordable and comprehensive reproductive health care services, availability of contraceptives, and lack of sex education for the prevention of HIV.[118]

The question, then, is what to do. What to do when the effects of social inequalities on people's reproductive health and lives is deadly, when global economic and political developments are turning a deaf ear to people's suffering, and international and national human rights protections are inadequate? There is unfortunately insufficient evidence that people, and in particular women, are more empowered and better protected today than they were ten years ago. Yet, the support available from the reproductive rights frameworks exists. What is needed is better promotion and protection of what exists, and efforts to document those instances where rights have been adequately promoted and protected to ensure replication where possible. With the plethora of fumbled occasions for the international community to affirm the reproductive rights of all, and especially those living with HIV, there are also new opportunities. Clear statements from individuals, NGOs, governments and inter-governmental agencies insisting that HIV cannot be grounds for restricting reproductive rights, and conversely demanding access to comprehensive reproductive health care, information, and treatment, can make a vital difference. The UN and regional human rights systems, as well as NGO activism, can support the claim that HIV infection status should never be the basis for restricting the exercise of any human rights. Insisting on the equality, dignity, rights, and worth of women and men, regardless of their HIV status, can offer progress towards reducing HIV vulnerabilities, and is a logical evolution of the human rights framework that exists to date. Protecting reproductive rights is a critical component of working to ensure reproductive health; this becomes even more imperative when taking into account its potential impact in relation to HIV.

A growing literature exists on the synergy between reproductive health and rights in the context of HIV, but there is little practical guidance on how best to apply this synergy in practice in order to achieve positive results, and little evidence to show that positive changes have moved beyond high-level rhetoric to adequately benefit the populations for which they were designed.[119] Even the discussions around the integration of reproductive health services and HIV services that have emerged in recent years have, to a large extent, been more conceptual than practical in nature. Models of service integration are beginning to emerge, but operational guidance is still lacking. And in all of this, there is nothing to suggest that the recent

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[118] See for example *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Panama*, UN CESCR, 2001, UN Doc. E/C.12/1/Add.64 at para. 37, online: <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1.Add.64.En?Opendocument>; See also *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Bolivia*, UN CESCR, 2001, UN Doc. E/C.12/1/Add.60 at para. 43, online: <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1.Add.60.En?Opendocument>; See also *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Honduras*, UN CESCR, 2001, UN Doc.E/C.12/1/Add.64 at para. 48, online: <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1.Add.57.En?Opendocument>.

[119] See generally (2003) 11:22 Reproductive Health Matters.

discussions in this area have taken as their starting point the international legal and policy frameworks that already exist. Although it has been demonstrated that these frameworks alone are insufficient, they provide the foundation on which to build national and local policies and programs designed to promote and protect reproductive rights in the context of HIV.

HIV is far greater than a challenge to public health: it has a major impact on all activities relating to development in its broadest sense. As HIV is incorporated into reproductive health and broader development strategies and initiatives, it is critical that human rights play a central role in these efforts.

What remains to be achieved is the translation of gender equality, and other forms of equality, into the fabric of lived experience of people's lives. While human rights promotion and protection can counteract vulnerability in the context of HIV and reproductive health, this cannot be accomplished without concrete efforts to translate rhetoric into reality.