



Women, HIV/AIDS and human rights

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<i>The scale of the pandemic and its impact on women</i>	4
<i>Women's gender-specific susceptibility to the virus</i>	4
Gender-based violence.....	5
Rape	6
Violence in the family and community	6
Intimate partner violence	6
Harmful traditional practices	7
Early marriage	7
Wife inheritance	8
Female genital mutilation or cutting (FGM or FGC)	8
Violence against women in conflict.....	9
Lack of economic independence.....	10
Sex work.....	11
Injecting drug use	12
Intersecting discriminations – ethnicity, sexual orientation and age.....	13
Bisexual women and lesbians	13
The girl child.....	14
<i>Prevention and treatment</i>	15
Education on sex, health and HIV	15
Condoms.....	16
Female condom	17
The ABC approach.....	17
Testing and treatment	18
Antiretroviral medication	18
Discrimination and stigma	20
Preventing mother to child transmission (MTCT).....	21
Post-exposure prophylaxis (PEP).....	22
Microbicides	23
<i>Women as home-based care-givers</i>	23
<i>A rights-based approach to HIV/AIDS and the protection/empowerment of women and girls</i>	23
<i>Human rights standards and HIV</i>	24
Standards on women's rights to health.....	24
Standards on women's sexual and reproductive health rights	25
Standards on violence against women	25
Standards on discrimination against women.....	26
Standards on the rights of the child.....	27
Standards on HIV international cooperation.....	27
Human rights statements, declarations and guidelines relating to HIV/AIDS.....	27
<i>Recommendations</i>	29

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<i>Address violence against women in the home, in the community</i>	29
<i>Address violence against women during armed conflict</i>	30
<i>Fight stigma and discrimination</i>	30
<i>Prevention, treatment and care</i>	31
<i>International assistance and cooperation</i>	32
<i>The international community</i>	32
Web-links	32



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“Women must not be regarded as victims. They are, in many places, leading the way forward. In communities scattered around the globe, women and men are taking action to increase knowledge about the disease, expand access to sexual and reproductive health and educational services, increase women's ability to negotiate safer sexual relations, combat gender discrimination and violence and increase access to female-controlled prevention methods such as the female condom.”
Women and HIV/AIDS: Confronting the Crisis.¹

Women are fighting both a virus and systemic discrimination in trying to overcome the threat of HIV/AIDS. Across the world, they face a number of circumstances which increase their risk of HIV infection in gender-specific ways. Many women are exposed to sexual violence and coerced sex inside and outside marriage, including through harmful traditional practices such as genital mutilation, early marriage, and wife inheritance. They frequently lack information on and access to HIV prevention measures and to health care as well as to support and medication after infection. They are denied property and inheritance rights, employment and access to finance – denials which make them dependent on men – and are frequently excluded from participation in policy-making and implementation, including on issues which primarily affect them.

¹ UNAIDS, UNFPA, UNIFEM, *Women and HIV/AIDS: Confronting the Crisis*, New York, 2004. Available at: <http://www.unfpa.org/hiv/women/>

However women are increasingly campaigning effectively for their rights. Grassroots activism by women, including in particular women living with HIV/AIDS, has grown for years with some striking successes – and in the face of a multitude of impediments.

The HIV pandemic is increasingly viewed as a strongly gendered health, development and human rights issue.² It is a preventable disease yet some 40 million people live with the virus and the proportion of women affected is increasing. This paper offers a human rights analysis of the gender-specific factors which put women at risk of contracting HIV/AIDS and of the consequences of contracting HIV/AIDS which women face. The evidence below makes clear that:

- Violence against women and other forms of gender-based discrimination increase women's likelihood of contracting HIV;
- Gender-based discrimination also hinders women's access to prevention methods and to treatment;
- A comprehensive rights-based approach is needed to effectively tackle the pandemic, its causes and consequences;
- Agendas for an effective response to HIV/AIDS agreed by the international

² See for example, UNIFEM. *Turning the Tide: CEDAW and the Gender Dimensions of the HIV/AIDS Pandemic*. New York, 2001. Available at: http://www.unifem.org/index.php?f_page_pid=33; UNFPA. *State of the World Population 2004*. New York, 2004; available at: <http://www.unfpa.org/swp/swpmain.htm>

community – including UNAIDS human rights guidelines, the Cairo Programme of Action, the Beijing Declaration and Platform for Action, the Millennium Development Goals and others – have yet to be implemented effectively;

- International cooperation is needed to tackle the global inequities surrounding HIV prevalence and lack of access to treatment.

The report underlines in its conclusion the need for government action in a rights-based approach to the gender-related aspects of HIV/AIDS prevention, treatment and support.

The scale of the pandemic and its impact on women

The number of people living with HIV/AIDS in 2003 was estimated by UNAIDS to be 35.7 million adults (of whom 17 million were women) and 2.1 million children.³ More than 4 million adults and 630,000 children were newly infected in 2003 and 2.9 million people died of AIDS-related illnesses, bringing to 20 million the number of AIDS-related deaths since the start of the epidemic in 1981. Twelve million children have been orphaned by AIDS in Sub-Saharan Africa to the end of 2003.

In Sub-Saharan Africa 57% of adults living with the virus are women, and two thirds of young HIV-positive people are women and girls.⁴ The worldwide proportion of women living with HIV/AIDS is almost 50 percent.⁵ Globally, young women are 1.6 times more likely to be living with HIV/AIDS than young men.⁶ A review of HIV-infection levels among

³ UNAIDS. *2004 Report on the Global AIDS Epidemic*, Geneva, 2004. Available at:

<http://www.unaids.org/bangkok2004/report.html>. Adults, for the purposes of the UNAIDS report, means people between the ages of 15 and 49 – the major period of human sexual and reproductive activity. Children are defined by UNAIDS as those under 15 years. The highest rates of HIV prevalence are in southern Africa: Botswana (37.3%), Swaziland (38.8%), Lesotho (28.9%), Zimbabwe (24.6%), South Africa (21.5%), Namibia (21.3%), and Zambia (16.5%). Prevalence rates can fall where preventive measures are taken as shown by the case of Uganda where national prevalence dropped from 12% in the early 1990s to 4.1% in 2003.

⁴ *Ibid.*

⁵ UNAIDS. *Report on the Global HIV/AIDS Epidemic 2002*. Geneva, 2002, p.6. Available at: <http://www.who.int/hiv/pub/epidemiology/pubepidemic2002/en/>

⁶ UNAIDS, UNFPA, UNIFEM. *Confronting the Crisis*. 2004, p.1.

15–24-year-olds which compared the ratio of young women to young men living with HIV found that in South Africa twice as many women as men had the virus while in Kenya and Mali the ratio of HIV-positive young women to young men was 4.5 to 1.⁷

Around five to six million people in low and middle income countries do not have access to necessary life-saving antiretroviral drugs (ARVs).⁸

HIV affects not only those living with the virus but others who depend on, or are related to, them. It affects:

- Women living with the virus who face stigma, discrimination, violence, and unequal access to medication
- Women at particular risk – through gender-based violence, unsafe sex, injecting drug use or living with people who are injecting drug users, as sex workers⁹, and through discriminatory traditional practices.
- Women caring for affected family members or others.
- Women in their roles as campaigners, NGO activists, human rights defenders and service providers.

These different aspects will be discussed below.

Women's gender-specific susceptibility to the virus

Women face gender-specific risks from HIV in a number of ways. The growing proportion of women affected by HIV arises from a mix of physiological, social and human rights factors. Women and girls appear to have a higher inherent risk of being infected via heterosexual activity (compared to men) because semen contains higher levels of HIV than vaginal fluids. Moreover the vagina offers a larger area of mucosal tissue subject to micro-injuries through which the virus can enter the bloodstream.

⁷ UNAIDS. *2004 Report on the global AIDS epidemic*, Geneva, 2004, p.31.

⁸ UNAIDS. *Ibid.*, p.103.

⁹ In this report, a person selling sexual services is described as a “sex worker”. Terms such as “prostitute” or “woman [or man] working in prostitution” are widely used in the media and elsewhere. “Sex worker” is regarded by those working to combat HIV/AIDS as less stigmatising than other more morally loaded terms.

Women are thus more likely than men to contract HIV through a single heterosexual encounter.¹⁰

However the differential levels of infection seen in southern Africa and elsewhere, where four to five times more young women than young men in the same age group are infected each year, do not reflect solely or even mainly biological differences between males and females but rather social and human rights factors. For many women the most common risk factor they face is living with an HIV-positive husband or partner (whether he is aware of his status or not). Other risk factors include the level of violence to which women are subjected, harmful traditional practices which put women at higher risk, and socio-economic factors which limit women's capacity to protect themselves.

Although physiology affects women's greater risk of HIV transmission, it is women and girl's relative lack of power over their bodies and their sexual lives, supported and reinforced by their social and economic inequality, that make them such a vulnerable group in contracting, and living with, HIV/AIDS. ... The stereotypical gender roles that underpin sexual inequality and sexual violence are confirmed and reproduced by social, cultural and religious norms. This lends an aura of 'naturalness' and inevitability to these roles and can make them particularly difficult to contest and change.¹¹

Gender-based violence

Women face an epidemic of violence every day. Violence against women includes, but is not limited to:

- Violence in the family. This includes battering by intimate partners, sexual abuse of female children in the household, dowry-related violence, marital rape and female genital mutilation and other traditional practices harmful to women. Abuse of domestic workers – including involuntary confinement, physical brutality, slavery-like

conditions and sexual assault – can also be considered in this category.

- Violence against women in the community. This includes rape, sexual abuse, sexual harassment and assault at work, in educational institutions and elsewhere. Trafficking, forced prostitution and forced labour fall into this category, which also covers rape and other abuses by armed groups.
- Gender-based violence perpetrated or condoned by the state, or by “state actors” – police, prison guards, soldiers, border guards, immigration officials and so on. This includes, for example, rape by government forces during armed conflict, forced sterilization, torture in custody and violence by officials against refugee women.¹²

Violence is a key factor in increasing women's risk of contracting the virus. Studies suggest that the first sexual experience of a girl will often be forced.¹³ Women are two to four times more likely to contract HIV during unprotected vaginal intercourse than men¹⁴ both because their sexual physiology places them at higher risk of injury (especially in the case of young women) and because they are more likely to be at the receiving end of violent or coerced sexual intercourse.¹⁵

Other factors also come into play. Yakin Ertürk, the Special Rapporteur on Violence against Women, has stated that “multiple factors associated with women's subordinate position increase the risk of HIV infection. Among them are: illiteracy and poverty, conflict situations, lack of sexual autonomy, rape by intimate partners or strangers, multiple sexual partners, trafficking for sexual exploitation, genital

¹⁰ Unprotected anal sex, whether heterosexual or homosexual, carries a significantly higher risk of HIV infection for the receptive partner.

¹¹ Albertyn C. Prevention, Treatment and Care in the Context of Human Rights. Paper submitted to the UN Expert Group Meeting on “The HIV/AIDS Pandemic and its Gender Implications” (Windhoek, Namibia), UN Doc. EGM/HIV-AIDS/2000/WP 1, 2000. <http://www.un.org/womenwatch/daw/csw/hivaids/albertyn.html>.

¹² Amnesty International. *It's in our Hands*. London, 2003. p.3. Available at:

<http://web.amnesty.org/library/Index/ENGACT770012004>. See also: Amnesty International. *Making Rights a Reality: The Duty of States to Address Violence Against Women*. AI Index: ACT 77/049/2004, 2004. Available at:

<http://web.amnesty.org/library/Index/ENGACT770492004>

¹³ Garcia Moreno C. Sexual violence. *IPPF Medical Bulletin*, December 2003. Available at: http://www.ippf.org/medical/bulletin/pdf/37_no6_Dec2003_EN.pdf

¹⁴ UNAIDS. *Gender and AIDS Almanac*. Geneva, 2001, p.11

¹⁵ UNAIDS *ibid.* pp.2-3.

mutilation and other harmful practices, prostitution and child marriage.”¹⁶

Rape

One of the most pervasive and damaging forms of gender-based violence is rape. The psychological and physical trauma inflicted by rape is well-documented.¹⁷ However, increasingly, the transmission of HIV is an additional consequence of rape. Because it is by definition non-consensual, rape has a higher risk of leading to HIV infection by virtue of physical injury to the woman’s genitalia or anus. Even in the absence of apparent physical injury, rape can cause micro-lesions in the vagina which can be a route of infection for the virus.

Protecting women (and men) from rape, and thus from the potential exposure to HIV caused by rape, requires a number of measures. Amnesty International has documented rape in police custody, in prisons, in the community and in areas of conflict or war. While each situation requires some particular reform, what is common to all is that there needs to be political will to make clear that rape is an unacceptable crime and will be punished; that there must be public education to encourage greater gender-awareness; that police and medical professionals should be provided with more training on sensitive investigation and documentation of rape; that medico-legal and trauma services be strengthened and that laws on rape and other sexual offences be reformed to adequately address the nature and seriousness of rape. The gravity of rape has been recognised at the highest international level. The International Criminal Court, under article 7 (1) (g) of the Rome Statute of the ICC, considers rape (and similarly grave forms of sexual abuse) as crimes against humanity when committed as part of a widespread or systematic attack against any civilian population. When committed in the context of an

¹⁶ *Integration of the human rights of women and the gender perspective: violence against women. Towards an effective implementation of international norms to end violence against women. Report of the Special Rapporteur on violence against women, its causes and consequences, Yakin Ertürk.* UN document: E/CN.4/2004/66, 26 December 2003.

<http://www.unhchr.ch/Huridocda/Huridoca.nsf/TestFrame/b0ec728d91b871d8c1256e610040591e>.

¹⁷ Peel M (ed.) *Rape as a Method of Torture*. London: Medical Foundation for the Care of Victims of Torture, 2004.

international or non-international armed conflict, these offences also constitute war crimes.¹⁸

Addressing the crime of rape requires support and protection for witnesses before, during and after the trial. The obstacles posed to effective justice in rape cases are considerable and supporting complainants effectively is essential if justice is to be done and to be seen to be done.

In Swaziland, women and girls suffer high levels of domestic and sexual violence, and experience pervasive economic, social and legal discrimination. The HIV/AIDS pandemic has had a devastating impact on women and girls. The level of HIV infection amongst pregnant women attending ante-natal clinics in 2002 was 38.6 per cent. The United Nations Development Program concluded in the same year that "most cultural expectations and practices [in Swaziland]...contribute to women's vulnerability to HIV/AIDS".

Amnesty International, 2004 ¹⁹

Violence in the family and community

Intimate partner violence

Domestic violence or intimate partner violence places a significant health burden on women and on society. Intimate partner violence occurs in all countries and within all social, economic, religious or cultural groups. The overwhelming burden of partner violence is borne by women at the hands of men, although men can also be victims of violence at the hands of female partners, violence can be inter-generational, and same-sex relationships can also be characterized by violence. Intimate partner violence

¹⁸ The definition of what constitutes rape varies in different national jurisdictions. The International Criminal Tribunal on Rwanda, noting the lack of an agreed legal definition, itself defined rape as “physical invasion of a sexual nature, committed on a person under circumstances which are coercive. Sexual violence is not limited to physical invasion of the human body and may include acts which do not involve penetration or even physical contact”. (International Criminal Tribunal on Rwanda. Trial Chamber 1. The Prosecutor Versus Jean-Paul Akayesu, Case No. ICTR-96-4-T, 2 September 1998. Available at:

<http://www.icttr.org/ENGLISH/cases/Akayesu/judgement/akay001.htm>)

¹⁹ Amnesty International. *Stop violence against women: violence fuels the HIV/AIDS pandemic in Swaziland*. AFR 55/003/2004 April 2004. Available at:

<http://web.amnesty.org/library/Index/ENGAFR550032004>.

comprises verbal/psychological, physical and sexual violence and affects millions of women worldwide.²⁰

Women who live with violent partners face not only psychological trauma and physical injury but also experience difficulties time protecting themselves from unwanted pregnancy or disease, including sexually transmitted infections. Physical or sexual violence by a man living with HIV can contribute directly to the transmission of the virus to a partner – and the longer the violence continues the higher will be the risk of this happening. A woman is also at risk when she is in a sexual relationship with an HIV-positive man who is unwilling to take preventive measures such as using a condom (whether he is aware of being HIV-positive or not). However women are also at risk more indirectly by:

- being unable to negotiate the use of contraceptives including condoms;
- being unable to undertake other forms of safer sexual behaviour with a partner; or
- commencing to abuse alcohol or illegal drugs which can lead to undertaking higher risk sexual or drug-injecting behaviour.²¹

Intimate partner violence, child sexual assault, forced first intercourse and adult sexual assault by non-partners were generally associated with increased HIV risk behaviours, as were mid or high scores on the Sexual Relationship Power Scale (SRPS) which measured women's power in her relationship. Overall, 21.1% of participants reported transactional sex, which we defined as sex with a non-primary male partner in exchange for material goods or money. Women who reported intimate partner violence, problematic substance use, urban residence, ever [having worked], or living in substandard housing were more likely to report transactional sex, while women who delayed first coitus, were married, or had a post-secondary education were less likely to do so. Transactional sex was associated with increased risk of HIV...

*South Africa, 2003*²²

²⁰ World Health Organization. *World Report on Violence and Health*. Geneva: WHO, 2002, Chapter 4. Available at: http://www.who.int/violence_injury_prevention/violence/world_report/en/

²¹ *Ibid.*

²² Dunkle K, Jewkes R, Brown H, McIntyre J, Gray G, Harlow S. *Gender-Based Violence and HIV Infection among Pregnant Women in Soweto*. Pretoria: Medical Research Council of South Africa, 2003. Available at: <http://www.mrc.ac.za/gender/women.pdf>

Harmful traditional practices

A number of practices increasing a woman's risk of HIV infection are often justified in the name of cultural values and traditions. Some of these are discussed later in this paper under themes of sexual rights and economic independence. The three practices discussed here are: early marriage, wife inheritance and genital mutilation.

Early marriage

The Convention on the Rights of the Child does not set a fixed minimum legal age of marriage. However, other treaties do specify a minimum legal age for marriage. The African Charter on the Rights and Welfare of the Child (1990) states that “[c]hild marriage and the betrothal of girls and boys shall be prohibited” and sets the minimum age for marriage at 18.²³ The Committee monitoring the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW Committee) has also recommended that the minimum age for marriage of both men and women should be 18, commenting that, “[w]hen men and women marry, they assume important responsibilities. Consequently, marriage should not be permitted before they have attained full maturity and capacity to act.”²⁴ International agencies such as the United Nations Population Fund (UNFPA) make clear the risks of marriage below the age of 18.²⁵

Although data is incomplete it appears that, in practice around the world, girls marry earlier than boys.²⁶ Child marriage involves a number of factors

²³ African Charter on the Rights and Welfare of the Child, Article 21(2). Available at:

<http://www1.umn.edu/humanrts/africa/afchild.htm>

²⁴ CEDAW. General Recommendation 21, para. 36 [commenting on CEDAW article 16(2)]. Available at:

<http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom21>

²⁵ See for example the UNFPA press release ‘Married Adolescents Ignored in Global Agenda, Says UNFPA’, noting that “Most nations have declared 18 as the legal minimum age for marriage” adding that “Child marriage violates the human rights of millions of girls by threatening their health, restricting their education and limiting their social, economic and political growth.” Available at:

<http://www.unfpa.org/news/news.cfm?ID=456>

²⁶ For example, in Democratic Republic of Congo 74% of young women 15-19 are married compared to 5% of young men of the same age. In Uganda the equivalent figures are 50% and 11%; in Nepal 42% and 14%; and Honduras, 30% and 7%. (UN Population Division, Department for Economic

which increase a young woman's risk of HIV infection. The following factors increase potential exposure to the virus: lack of awareness of measures required for self-protection; lack of power within the marital relationship; family pressure to obey a husband; and pressure to start a family which militates against the use of condoms. Some studies have found a higher prevalence of HIV in young married women compared to unmarried women in the same age group, particularly where the husband is significantly older than the wife. Researchers have suggested that the increased risk is linked to older men's increased sexual experience and exposure to HIV, young wives' inability to make demands on older husbands, and less use of means of protection.²⁷

Child marriage impedes a girl's access to education with all that implies for managing her relationships, gaining employment and negotiating sexual behaviour. In Ethiopia, for example, some 80% of married young women have had no education and are unable to read.²⁸

From a policy viewpoint there is a risk that married adolescents fall outside the scope of programs intended to advance and protect adolescent sexual and reproductive health.²⁹

Wife inheritance

Wife inheritance is the practice of the transfer of the widow of a deceased man to that man's brother – she is "inherited", sometimes into a polygamous family. Subsequent sexual activity is often coerced and unsafe. The possibility that either the wife or the new

and Social Affairs, World Marriage Patterns, 2000.) It should also be noted that law is often lacking on minimum ages of marriage.

²⁷ Bankole A, Singh S, Woog V, Wulf D. *Risk and Protection: Youth and HIV/AIDS In Sub-Saharan Africa*. New York; Allen Guttmacher Institute, 2004. See: <http://www.guttmacher.org/pubs/riskandprotection.pdf>; see also UNAIDS, UNFPA, UNIFEM. *Confronting the Crisis*, Geneva, 2004, p.16.

²⁸ Population Council. Child marriage briefing: Ethiopia. July 2004. Available at: <http://www.popcouncil.org/pdfs/briefingsheets/ETHIOPIA.pdf>

²⁹ See Bruce J, Clark S. "The implications of early marriage for HIV/AIDS policy." Brief based on background paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents. New York: Population Council. Available at: <http://www.popcouncil.org/pdfs/CM.pdf>

husband will already be living with HIV increases the risk of transmission and thus facilitates the spread of the virus. In some traditions the woman must consent to the new marriage but if she refuses she will not receive any of the property associated with her previous married life and will lose her home. Either decision is likely to have an unwelcome outcome for the woman.³⁰

Female genital mutilation or cutting (FGM or FGC)

Cutting of the female genitalia as a cultural practice is widespread in parts of Africa and the Middle East.³¹ Female genital mutilation can involve excision of the clitoral hood, with or without excision of part or all of the clitoris; excision of the clitoris with partial or total excision of the labia minora; or removal of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation) allowing only a small hole to allow the exit of urine and menstrual blood. The practice places girls and women at increased risk to HIV infection through several routes. Firstly, the use of unsterilized razors or knives to carry out the procedure among a number of girls risks passing the virus from one girl to the next should one of them be HIV-positive. Secondly, FGM renders the genitals more likely to tear during intercourse. In cases of infibulation or sewing up of the vaginal entrance, penetration is bound to lead to bleeding, which in turn makes sexual transmission of the virus from an HIV-positive partner much more likely. Thirdly, difficulties with intercourse may make a woman less likely to welcome the partner's advances and lead him to a more violent approach to sex; or to engage in sexual practices with his wife (such as unprotected anal intercourse) which might place her at increased risk of HIV infection³².

In the Darfur region of western Sudan, where conflict is presently occurring and thousands of women have been raped, the majority of women have been subjected to excision of the labia minora and clitoris and many have been infibulated. This

³⁰ A summary of property rights violations against women in sub-Saharan Africa is available at the Human Rights Watch web-site:

<http://www.hrw.org/campaigns/women/property/qna.htm#13>

³¹ Amnesty International. Female genital mutilation. Available at: <http://www.amnesty.org/ailib/intcam/femgen/fgm1.htm>

³² Brady M. Female genital mutilation: complications and risk of HIV transmission. *AIDS Patient Care and STDs* 1999; 13: 709-716.

increases the risk of injuries both during consensual sex and, in particular, during rape, and consequently increases the risk of contracting HIV or other sexually transmitted infections. At present there are no adequate medical facilities to provide comprehensive medical care for those with HIV/AIDS-associated infections amongst the refugee population in Chad or in camps for internally displaced people in Darfur, as a consequence of the fact that humanitarian organizations are overwhelmed by the nutritional emergency and difficulties in access, logistics and capacity.³³

Violence against women in conflict

In many other parts of the world, rape and other sexual violence arising in the context of conflict are helping to drive the HIV pandemic. Rape and sexual violence have been used as a weapon of war through history and have been an all-too-common feature of contemporary conflicts.

In the Democratic Republic of Congo (DRC) both civilian women and girls and women forced to fight as combatants are at risk of sexual violence and exposure to HIV. Local and international NGOs have attempted to intervene with the armed groups in the DRC to secure the release of child soldiers. Following an intervention in early 2004 that led to the release of 36 girl soldiers, mostly aged around 14 or 15, one Congolese activist reported that 17 of the girls were found to be HIV positive.³⁴

The violence and destruction arising in the context of conflict has other ramifications for the health system. No more than eight percent of blood used in transfusions is tested for HIV, because either the infrastructure has been destroyed or the resources are not available.³⁵ According to the DRC National AIDS Programme, 80 per cent of health centres in the DRC do not test blood prior to using it for

transfusions, seriously endangering those who receive blood transfusions.³⁶

Reports emerged in mid-2004 that members of the United Nations Mission in the Democratic Republic of Congo³⁷ were having sexual contact with young girls living near the UN compound in a centre for internally displaced people in Bunia, DRC. Comments made by the girls made clear that they saw the sex as “transactional” – that is, they agreed to sex in order to receive food and other basic goods.³⁸

The responsibility of women for gathering food and water can render them liable to sexual violence in conflict zones. In the Central African Republic, hundreds of women and girls were raped in late 2002 and early 2003 during internal conflict. AI reported on a number of individual cases including that of a woman, known in the report as ‘BEY’, aged 24, who was raped by three combatants in December 2002 while on her way to fetch water. She was wounded by the men and was subsequently treated with traditional medicines. She was later found to be HIV-positive though how she contracted the virus is uncertain. It is common for women who have been raped to believe that they contracted the infection through rape and it is certain that for many this is the case.³⁹

HIV infection can compound the social as well as the health consequences for women who have been raped during conflict. One woman who was repeatedly raped during the genocide period in Rwanda told AI:

“I learned I had HIV when I got tested before the birth of my youngest, in 1999.

³³ Amnesty International. *Sudan: Darfur: Rape as a weapon of war: sexual violence and its consequences*. AI Index: AFR 54/076/2004. Available at:

<http://web.amnesty.org/library/Index/ENGAFR540762004>.

³⁴ Amnesty International. *Democratic Republic of Congo: Mass rape - time for remedies*. AI Index: AFR 62/018/2004. Available at: <http://web.amnesty.org/library/Index/ENGAFR620182004>.

³⁵ Ibid, citing: *Progress on the World's Women 2002*, volume 1, “Women War Peace”, The Independent Experts’ Assessment on the Impact of Armed Conflict on Women and Women’s role in Peace-building, Elisabeth Rehn and Ellen Johnson Sirleaf, 2002, p.36.

³⁶ Cited in Amnesty International, *ibid*.

³⁷ The Mission is known by its French acronym, MONUC. See: <http://www.monuc.org/>

³⁸ See BBC online, 3 June 2004, <http://news.bbc.co.uk/2/hi/africa/3769469.stm>

³⁹ Amnesty International. *Central African Republic: Five months of war against women*, AFR 19/001/2004. Available at: <http://web.amnesty.org/library/Index/ENGAFR190012004>.

Seeking medical care or reporting rape was difficult for most women. However there were considerable obstacles in seeking medical care for some women in particular. According to AI’s information a large number of rape survivors were members of the Muslim community, but very few of them presented themselves for medical examination or treatment. A medical charity that provided emergency care to rape survivors stated that only around 3% of survivors that they saw were Muslim. All were accompanied to the clinic by their husbands whose presence is believed to have restricted how fully they could describe their experiences and the extent of the physical and psychological trauma to which they had been subjected.

Since I learned I was infected, my husband said he couldn't live with me. He divorced me and left me with three children, so now I don't know how to pay for food, rent, school and so on. I have no family left... My six-year-old has many health problems, and she must have HIV. She looks three-years-old, coughs, and X-rays show that her left lung is destroyed, but she is allergic to antibiotics. She should be on ARVs [antiretroviral drugs], but there isn't the money, and it's hard to get children onto ARVs in Rwanda...⁴⁰

In both Rwanda and Burundi there remains a stigma against both survivors of rape and those living with HIV. AI has reported that some women in Burundi refrain from seeking medical treatment following rape because of the risk that they will subsequently be identified as rape victims within their community. The epidemic of rape and women's inability or unwillingness to find treatment following sexual assaults is contributing to the HIV crisis in Burundi.⁴¹ The same picture is replicated in other areas of conflict in Africa.

*Security Council Resolution 1325 (2000) "addresses protection of women during armed conflict, and calls for an end to impunity for gender-based abuses during and after conflict, the integration of a gender perspective in peace-making and peace-keeping, and the participation of women in all levels of decision-making and issues related to prevention management and resolution of conflict. It calls for action from a wide range of stakeholders, including governments, the UN Security Council, UN Secretary-General and all parties to armed conflict."*⁴²

In Colombia, women targeted for gender-based violence are among the casualties of the continuing

⁴⁰ Amnesty International. "Marked for Death", rape survivors living with HIV/AIDS in Rwanda, AI Index: AFR 47/007/2004, April 2004. Available at:

<http://web.amnesty.org/library/Index/ENGAFR470072004>

⁴¹ Amnesty International. *Burundi: rape – the hidden human rights abuse*. AI Index: AFR 16/006/2004, 2004. Available at:

<http://web.amnesty.org/library/Index/ENGAFR160062004>.

⁴² Amnesty International. Fourth anniversary of Security Council Resolution 1325. AI Index: IOR 52/004/2004, October 2004. Available at:

<http://news.amnesty.org/index/ENGEUR01520420042004>.

Resolution 1325 is available at:

http://www.un.org/events/res_1325e.pdf

internal conflict. A significant component of the strategy of armed groups for exercising control over the population is the imposition of rigid gender norms and rules of conduct that apply even within the family unit. This type of control is often preceded or accompanied by what the paramilitary groups call "social cleansing" – the killing of petty criminals, prostitutes, and others perceived as "socially undesirable". Gender-based violence is used to impose a moral code based on rigidly differentiated roles for men and women. Amnesty International has received testimonies which point to the persecution, disappearance and killing of women who depart from these social codes as well as persons from other stigmatized groups, including sex workers, people targeted on account of their sexual orientation and alleged carriers of sexually transmitted infections (STIs), such as HIV/AIDS.⁴³

The sexual and other violence directed at women which is seen in conflicts in different continents not only traumatises women and girls, but puts them at risk of STIs including HIV.

Lack of economic independence

For many women, financial, material or socially-determined dependence on men means that they cannot control when, with whom and in what circumstances they have sex. Nor can they make demands on men to minimise risky behaviour.

Women who have been infected with HIV find it difficult to share this important information with their partner because of fear of aggression. According to a survey conducted by the Kenyan Population Council in 2001, more than half of the women surveyed who knew they had acquired HIV said they had not disclosed their HIV status to their partners because they feared it would expose them to violence or abandonment.

Kenya, 2002⁴⁴

Absolute or relative poverty can pressure women to exchange sex for food or other material favours in order to ensure daily survival for the woman and her

⁴³ Amnesty International. *Colombia: "Scarred bodies, hidden crimes": Sexual Violence against women in the armed conflict*. AMR 23/040/2004, October 2004. Available at:

<http://web.amnesty.org/library/Index/ENGAMR230402004>.

⁴⁴ Amnesty International. *Kenya. Rape: the invisible crime*. AI Index: AFR 32/001/2002, 2002. Available at:

<http://web.amnesty.org/library/Index/ENGAFR320012002>.

family. The UN Secretary-General's Task Force on HIV/AIDS in Southern Africa put this very clearly:

Poverty and HIV infection are deeply intertwined. As the burden of caring for the sick, the dying and the orphaned forces millions of African women deeper into poverty and batters their energy and self-esteem, so it increases the pressure to resort to high risk "transactional" sex – sex in exchange for money or goods – or sex with older "sugar daddies" who offer the illusion of material security. And as more and more women and girls take to the streets as their only means of survival, the need to confront gender inequality becomes inescapable.⁴⁵

In some specific areas of women's lives, gender intersects with sexuality, race, ethnicity, age, occupation and social status to increase the risks women face from HIV. These areas include sex work and injecting drug use.

Employment and economic aspects of the impact of HIV on women

Women face particular problems, including:

- *Discrimination, unequal property and inheritance laws, and the lack of education opportunities limit women's income-earning possibilities and help perpetuate inequality between men and women.*
- *Women who have lost partners to AIDS or who have been abandoned because they are HIV-positive are often deprived of financial security and economic opportunities.*
- *The impact of poverty forces women to resort to sex for survival or to continue in relationships with men who refuse to practise safe sex.*
- *The power imbalance in the workplace exposes women to the threat of sexual harassment.*
- *Women's double burden is intensified when the family is affected by HIV because they have to provide care in addition to maintaining or boosting household income.*
- *Certain types of work situation may increase the risk of HIV infection.*
- *Women who travel for their work or who migrate to find work, and the spouses of migrant or mobile*

⁴⁵ *Facing the future together. Report of the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa*, p.6. Available at <http://womenandaids.unaids.org/regional/default.html>.

workers.

- *Women who are in a small minority at the workplace.*
- *Female domestic workers, especially those who live at their place of work.*
- *Women in sex work.*

ILO, 2004 ⁴⁶

Sex work

The Sonagachi experience cited below – which has led to a significant lowering of HIV prevalence among sex workers – offers important lessons. However, it is an exception. More typically, sex workers are exposed to relatively high risk of contracting HIV. They work in an informal and often illegal sector of society in which they occupy a low status and marginalised position. They frequently have little control over their working conditions and, in particular, are exposed to a primary mode of transmission of HIV – sexual intercourse. Their capacity to negotiate condom use or to look after their health in other ways is limited. They are subject to violence by those who control or manage them as well as violence by clients.

Women's health and HIV: experiences from a sex workers' project in Calcutta

The current rate of HIV/AIDS infection in India is very high. For most Indian women it is almost impossible to contemplate assertiveness in a sexual relationship with a man and negotiate safer sex. However there is a movement of sex workers in Sonagachi who are successfully negotiating safer sex relationships with clients as well as better treatment from society (including the police). In 1992 the STD/HIV Intervention Project (SHIP) set up a Sexually Transmitted Diseases (STD) clinic for sex workers to promote disease control and condom distribution. However their focus soon broadened to address structural issues of gender, class and sexuality. The sex workers themselves decide the programme's strategies. 25 per cent of managerial positions are reserved for sex workers and they hold many key positions. From early on the sex workers were invited to act as peer educators, clinic assistants and clinic attendants in the project STD clinics. SHIP aims to build sex workers' capacity to question the cultural stereotypes of their

⁴⁶ International Labour Organization. *Women, HIV/AIDS and the world of work*. Geneva, 2004. Available at: <http://www.ilo.org/public/english/protection/trav/aids/wd04en.pdf>

society, and build awareness of power.

India, 2000 ⁴⁷

Their rights are frequently ignored. ⁴⁸ A study by Human Rights Watch (HRW) reported Philippine sex workers as saying that they had been given HIV tests in government clinics without their informed consent—a practice that has been shown to be a disincentive for people to access health and prevention services and to increase their risk of infection. Sex workers also told HRW that police routinely used possession of condoms as evidence to arrest and prosecute women for prostitution. One 19-year-old sex worker said, “I like to have plenty of condoms in my bag, but if I see the police, I throw my bag away.”⁴⁹

Factors that appear to heighten sex workers' vulnerability to, and risk of, HIV infection include:

- *stigmatization and marginalization*
- *limited economic options, in particular for women*
- *limited access to health, social and legal services*
- *limited access to information and prevention means*
- *gender-related differences and inequalities*
- *sexual exploitation and trafficking*
- *harmful, or a lack of protective, legislation and policies*
- *exposure to risks associated with lifestyle (e.g. violence, substance use, mobility)* ⁵⁰

Where women are working as sex workers as a result of being trafficked they may face even more difficulties in protecting themselves. A 21-year-old

⁴⁷ Bala Nath M. Women's Health and HIV: Experiences from a Sex Workers' Project in Calcutta. *Gender and Development*, Vol 8 No 1. Summary available at:

<http://www.eldis.org/gender/dossiers/Indiasexworkers.htm>

⁴⁸ See Bindman J. *Redefining Prostitution as Sex Work on the International Agenda*. Anti-Slavery International, with the participation of Jo Doezema, Network of Sex Work Projects, 1997. Available at:

<http://www.walnet.org/csis/papers/redefining.html>

⁴⁹ Human Rights Watch. *The Philippines. Unprotected: Sex, Condoms and The Human Right To Health*. New York, 2004. Available at:

<http://www.hrw.org/reports/2004/philippines0504/>

⁵⁰ UNAIDS. *Sex work and HIV/AIDS: Technical Update*. Geneva: UNAIDS, 2002. (UNAIDS Best Practice collection. Technical Update)

http://www.dec.org/pdf_docs/PNACP800.pdf

single mother from Moldova, working in a Kosovo bar, told Amnesty International:

Eventually I arrived in a bar in Kosovo, [and was] locked inside and forced into prostitution. In the bar I was never paid, I could not go out by myself, the owner became more and more violent as the weeks went by; he was beating me and raping me and the other girls. We were his ‘property’, he said. By buying us, he had bought the right to beat us, rape us, starve us, [and] force us to have sex with clients.⁵¹

The health of women who have been trafficked for the purposes of sexual exploitation in sex work is at particular risk. A number of studies have documented the risks to health and well-being of women posed by trafficking.⁵² The sexual health of these women and their capacity to protect themselves from HIV is seriously compromised by the coercive environment in which they work.

Injecting drug use

Women [and men] who inject drugs such as heroin or cocaine are at high risk where access to clean needles is not possible or is difficult. Sharing of needles is a very efficient way of transmitting HIV (and other blood-borne viruses such as hepatitis B and C). Drug user populations tend to have a higher rate of infection than the base-line community HIV prevalence rate. In Canada, for example, HIV prevalence among people in Montreal who injected drugs increased almost fourfold from 1988 to reach 19.5 percent of drug users in 1997.⁵³ Research in Vancouver found that HIV incidence rates among female injection drug users were about 40% higher

⁵¹ Amnesty International. *"So does it mean that we have the rights?" Protecting the human rights of women and girls trafficked for forced prostitution in Kosovo*. AI Index: EUR 70/010/2004, May 2004. Available at:

<http://web.amnesty.org/library/Index/ENGEUR700102004>

⁵² Zimmerman C, Yun K, Shvab I, Watts C et al. *The health risks and consequences of trafficking in women and adolescents. Findings from a European study*. London: London School of Hygiene & Tropical Medicine (LSHTM), 2003. Available at:

<http://www.lshtm.ac.uk/hpu/docs/traffickingfinal.pdf>

⁵³ Jurgens R. Facing up to an epidemic: drug policy in Canada. Montreal: HIV/AIDS Legal Network, October 2004. Available at:

<http://www.aidslaw.ca/Maincontent/issues/druglaws.htm>

than those of male injecting drug users. The authors of the study suggested that a better understanding of the processes and factors that cause drug-related harm among women was needed and that sex-specific prevention initiatives were urgently required.⁵⁴

Because of the cost of a drug habit, both women and men who have drug needs may engage in transactional sex or regular unprotected paid sex. Condom use with regular or casual partners can be low⁵⁵ and, as in other circumstances, women anxious to earn money to purchase drugs may not feel in a strong bargaining position to insist on a man using a condom. Moreover, the man may offer higher amounts of money for sex without a condom which women may accept out of perceived economic necessity.

Women are also at risk where they are sexual partners of male injecting drug users, even if they themselves do not inject.

Intersecting discriminations – ethnicity, sexual orientation and age

Ethnic minorities

Women from ethnic, religious or cultural minorities can be at a higher risk of exposure to HIV infection, particularly in countries in conflict or where there are patterns of violence against disadvantaged groups. But they are also at risk where educational materials are not available in their own language, where women have no avenues to seek help for domestic violence, or where the health system is inaccessible to them.

In 2001, the then Special Rapporteur on violence against women, Radhika Coomaraswamy, noted that “Gender discrimination frequently interacts with other forms of discrimination, including racial discrimination, to deny racialized women their right to health. A variety of factors, including racial discrimination, neo-colonialism and poverty, prevent

⁵⁴ Spittal PM, Craib KJP, Wood E et al. Risk factors for elevated HIV incidence rates among female injection drug users in Vancouver. *Canadian Medical Association Journal* 2002; 166(7):894-9. Available at: <http://www.cmaj.ca/cgi/content/abstract/166/7/894>.

⁵⁵ See, for example, Houlding C, Davidson R. Beliefs as predictors of condom use by injecting drug users in treatment. *Health Education Research* 2003; 18:145-155; Pisani E, Dadun, Suahya PK, Kamil O, Jazan S. Sexual behavior among injection drug users in 3 Indonesian cities carries a high potential for HIV spread to noninjectors. *J Acquir Immune Defic Syndr*. 2003;34(4):403-6.

women of disadvantaged racial groups from having access to adequate health care.⁵⁶ She also noted that in the report on her mission to South Africa in 1996, she had “pointed out that HIV positive indicators [in that country] are 5.55 per cent for black women and .052 per cent for white women”.⁵⁷ Ms Coomaraswamy cited the example of HIV-positive Haitian refugees who were “detained at the United States naval base in Guantanamo Bay, Cuba in 1993, where doctors administered Depo Provera to female detainees and (mis)informed them that the birth control drug would help cure their AIDS”.⁵⁸

Bisexual women and lesbians

Women who have same-sex relationships, whether identifying themselves as lesbians or not, are a relatively neglected population with respect to health care generally and sexual health in particular.⁵⁹ Lesbian and bisexual women often face a double layer of discrimination based both on their gender and their sexual orientation. Severe discrimination often makes it even more difficult for these women to have access to health care information and materials. While it has been thought that women who are sexually active with other women are at lower risk of contracting HIV, there is evidence that sexual transmission of STIs does occur between women⁶⁰ and other risks faced by women – such as transmission through sharing needles – represent a common risk.⁶¹

Furthermore, because the expression of women’s sexuality is so severely restricted in many cultures, lesbian and bisexual women are not allowed to freely

⁵⁶ Radhika Coomaraswamy. Special Rapporteur on Violence against Women. Report to the Preparatory Committee of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, UN Document A/CONF.189/PC.3/5, 27 July 2001, Para 152. Available at: [http://www.unhcr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.CONF.189.PC.3.5.En](http://www.unhcr.ch/huridocda/huridoca.nsf/(Symbol)/A.CONF.189.PC.3.5.En).

⁵⁷ Ibid. para. 155.

⁵⁸ Ibid. para 162.

⁵⁹ Hughes C, Evans A. Health needs of women who have sex with women. *BMJ* 2003; 327:939-940. Available at: <http://bmj.bmjournals.com/cgi/content/full/327/7421/939>

⁶⁰ Bailey JV, Farquhar C, Owen C, Mangtani P. Sexually transmitted infections in women who have sex with women. *Sexually Transmitted Infections* 2004;80:244-246. Available at: <http://sti.bmjournals.com/cgi/content/abstract/80/3/244>.

⁶¹ Centers for Disease Control. HIV/AIDS & US Women Who Have Sex With Women (WSW). Fact Sheet, July 2003. Available at: <http://www.cdc.gov/hiv/pubs/facts/sws.htm>.

express their sexual orientation and are often forced into marriages and sexual relationships with men. Women who refuse to marry are often marginalized in their community, and without the “protection” of marriage to a man, may become targets for violence and rape, which increases the likelihood of HIV infection.

The girl child

In some countries, even when child- and adolescent-friendly HIV-related services are available, they are not sufficiently accessible to children with disabilities, indigenous children, children belonging to minorities, children living in rural areas, children living in extreme poverty or children who are otherwise marginalized within the society. In others, where the health system's overall capacity is already strained, children with HIV have been routinely denied access to basic health care. States parties must ensure that services are provided to the maximum extent possible to all children living within their borders, without discrimination, and that they sufficiently take into account differences in gender, age and the social, economic, cultural and political context in which children live.⁶²

Girls are at risk of exposure to HIV at several levels. They are exposed to sexual violence in the family, in the community and during conflict. They are frequently not given the same access as boys to educational opportunities, information, health care and nutrition, and in many countries are inculcated with gender norms which prescribe a subservient role for the woman. Girls can be caught between a conservative stratum of society which wishes to control their behaviour – through, for example, encouraging “virginity testing” and pledges of chastity⁶³ – and exploitation by older males who seek sexual relations with younger girls.

There is ... a reported pattern of abuse by men who target minors for sex in the belief that they are less likely to be infected with the HIV/AIDS virus. Men infected with HIV/AIDS have reportedly raped young girls under the illusion that they will be "cleansed" by having sex with a virgin.

*Kenya, 2002*⁶⁴

⁶² Committee on the Rights of the Child. General Comment 3: HIV/AIDS and the rights of the child, paras.20-21.

⁶³ See, for example, the web-site of the “Silver Ring Thing” movement: <http://www.silverringthing.com/about.html>

⁶⁴ Amnesty International. *Kenya. Rape: the invisible crime*. AI Index: AFR 32/001/2002, 2002.

In parts of Africa, marriage of the young girl represents an increase in the risk she faces since she is likely to marry an older man with a higher likelihood of being HIV-positive than would obtain among boys of the same age as the married girl. Evidence suggests that delayed marriage, delayed sexual relations and formal education correlate with lower rates of HIV among adolescent girls. According to UNAIDS “young people in several countries are becoming sexually active at an earlier age and ... premarital sex is increasing”⁶⁵ and women are increasingly becoming infected at an earlier age.⁶⁶

Children living with HIV-positive parents or living with the virus themselves can face a number of forms of discrimination which puts their physical and mental integrity at risk and exposes them to health risks.

A Human Rights Watch report on HIV and children in India documented how many doctors refused to treat or even touch HIV-positive children.⁶⁷ Some schools expel or segregate children because they or their parents are HIV-positive and many orphanages and other residential institutions reject HIV-positive children or deny that they house them. Children from families affected by AIDS may be denied education, ejected onto the street, forced into child labour, or otherwise exploited, all of which puts them at greater risk of contracting HIV.

Reviewing India's compliance with the Convention on the Rights of the Child in 2004, the Committee on the Rights of the Child expressed deep concern “at the persistence of discriminatory social attitudes and harmful traditional practices towards girls, including low school enrolment and high drop-out rates, early and forced marriages, and religion-based personal status laws which perpetuate gender inequality in such areas as marriage, divorce, custody and guardianship of infants, and inheritance.” It has also expressed concern about gender-based discrimination and HIV/AIDS and noted that states’

⁶⁵ UNAIDS and WHO, *AIDS Epidemic Update December 2002*, p.15
http://www.unaids.org/worldaidsday/2002/press/update/epiupdate2002_en.doc

⁶⁶ UNAIDS. *Gender and AIDS Almanac*. Geneva, 2001, p.10.
http://www.unaids.org/html/pub/topics/gender/genderandaidsalmanac_en.pdf.pdf

⁶⁷ *Future Forsaken: Abuses Against Children Affected by HIV/AIDS in India*. New York: HRW July 2004,
<http://hrw.org/reports/2004/india0704/>

HIV/AIDS strategies must take into account the fact that discrimination against people living with HIV/AIDS “often impacts girls more severely than boys”.⁶⁸

Children who lose their parent to AIDS are also at risk of deprivation and destitution. Basic rights are at risk. Stephen Lewis, the UN Special Envoy for HIV/AIDS in Africa, told a press conference at the XV International Conference on HIV/AIDS in Bangkok in July 2004: “[L]et me remind you, with special emphasis on girls, that one of the things which plagues the lives of children orphaned by AIDS most profoundly, is the inability to attend school. And the inability to attend school is often compromised because children cannot afford the school fees or the uniforms or the text-books or the registration costs. One wonders when, if ever, there will be a mass mobilization, on the continent, to have school fees abolished everywhere. The maintenance of fees is an explicit violation of the Convention on the Rights of the Child.”⁶⁹

Prevention and treatment

Prevention of HIV/AIDS requires a multi-pronged approach which combines basic education, health education, social empowerment, provision of protective measures such as condoms, implementation of a program of antiretroviral provision, prevention of violence against women and promotion and protection of human rights generally. The United Nations Secretary-General’s Task Force on Women, Girls and HIV/AIDS in Southern Africa⁷⁰ identified three key factors that contribute to the greater vulnerability of the sub-region’s women and girls to HIV infection: the culture of silence surrounding sexuality; exploitative transactional and intergenerational sex; and violence within relationships with boys and men. This suggests that preventing HIV in southern Africa (and undoubtedly

⁶⁸ Cited in *Future Forsaken*, ibid.

⁶⁹ Statement by Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa, delivered at a press conference at the XV International AIDS Conference in Bangkok, July 14, 2004, available at:

http://www.planetwire.org/files.fcgi/4929_Stephen_LewisBangkokStatement.doc

⁷⁰ *Facing the future together: the final report of the Task Force on Women, Girls and HIV/AIDS in Southern Africa*. July 2004. Available at:

<http://womenandaids.unaids.org/regional/docs/Report%20of%20SG%27s%20Task%20Force.pdf>

elsewhere) requires educational measures, the economic and social empowerment of women and girls and measures to address the different forms of gender-based violence.⁷¹

Education on sex, health and HIV

*Governments must take steps to encourage good health practice and to overcome public prejudice, misinformation and discrimination. There remains much ignorance about HIV/AIDS, requiring a huge effort to promote public awareness. One survey in Central Asia showed that a third of young women had not even heard of AIDS -- yet globally the infection rate for women is rising inexorably.*⁷²

Fundamental to protecting the rights of girls and women and to the prevention of HIV infection is to ensure that they receive education, particularly regarding their sexual and reproductive health and rights. The benefits of education show in their greater awareness of sex, health and HIV/AIDS. They benefit also from “training in negotiation and life skills and from their increased ability to think critically and analyse situations before acting”.⁷³ In summary, they are empowered to act more effectively in their own best interests.⁷⁴

In her 2004 report, the UN Special Rapporteur on the right to education summarized states’ obligations to provide sex education:

An explicit provision on sex education is contained in the Convention on the Elimination of All Forms of Discrimination against Women, which obliges States parties, in article 10 (h), to ensure for girls and

⁷¹ See also Amnesty International. *Swaziland: Human rights at risk in a climate of political and legal uncertainty*, AI Index: AFR 55/004/2004, p.13. Available at:

<http://web.amnesty.org/library/Index/ENGAFR550042004>.

⁷² Amnesty International. *World AIDS Day: human rights central to battle against AIDS*. AI Index: POL 30/008/2002, December 2002. Available at:

<http://web.amnesty.org/library/Index/ENGPOL300082002>.

⁷³ *Women and HIV/AIDS: Confronting the crisis*, p.39 (See footnote 1, page 2).

⁷⁴ Evidence suggests that among young women (15-24 years) the level of awareness of misconceptions about HIV and of HIV prevention methods is low, even in high prevalence countries. The median value in the countries surveyed in Eastern Europe and Central Asia was as low as five percent. In Africa, Asia and Latin America the equivalent figures ranged from 18 to 30%. UNAIDS. *2004 Report on the global AIDS epidemic*. Geneva: UNAIDS 2004, p.96.

women “access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning”. The Committee monitoring the Convention on the Elimination of Discrimination against Women (CEDAW Committee) has defined family planning to include sex education in its general recommendation No. 21. The Committee on the Rights of the Child in its general comment No. 3 on HIV/AIDS and the rights of the child, has interpreted the Convention on the Rights of the Child as affirming the right to sex education for children (para. 6) in order to enable “them to deal positively and responsibly with their sexuality”; it continues [at para 16]:

“The Committee wishes to emphasize that effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and that ... States parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality.”⁷⁵

In a similar spirit, the Cairo Program of Action recommends that “countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse.” It recognizes “the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capacities of the adolescent, appropriate direction and guidance in sexual and reproductive matters” but concludes that “countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents.”⁷⁶

⁷⁵ Economic and Social Council. The right to education. Report submitted by the Special Rapporteur, Katarina Tomasevski. UN Document E/CN.4/2004/45, 15 January 2004, para.36, p.16. Available at: [http://www.unhchr.ch/Huridocda/Huridoca.nsf/\(Symbol\)/E.CN.4.2004.45.En](http://www.unhchr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.2004.45.En)

⁷⁶ International Conference on Population and Development. Cairo Programme of Action, 1994, para.7.45.

It is also essential that knowledge is transformed into behaviour change. One recent study in South Africa, for example, found that knowledge levels about the causes and spread of STIs were high. Study participants were also well-informed about issues relating to protection against STIs and seeking treatment. However, there was significant contradiction between this knowledge and reported behaviours which continued to place young people at risk. The authors called for a reorientation of sexuality education to address gender discrepancies and promote communication skills.⁷⁷

Condoms

Condoms are one of the simplest measures to protect sexual partners from infection with HIV⁷⁸ (other than avoiding penetrative sex). However reliance on condoms alone as a prevention strategy is not without drawbacks; there continues to be a shortage of supplies of condoms in developing countries. Moreover there remain questions about whether the impact of condoms may be limited by inconsistent use and low use among those at highest risk, and negative interactions with other strategies.⁷⁹ In addition, opponents of condoms have suggested that, contrary to all available scientific data, condoms allow the virus to pass and therefore put users at risk. This view has been firmly rejected by authoritative bodies such as UNAIDS and WHO.⁸⁰

⁷⁷ James S, Reddy SP, Taylor M, Jinabhai CC. Young people, HIV/AIDS/STIs and sexuality in South Africa: the gap between awareness and behaviour. *Acta Paediatrica* 2004;93(2):264-9. Abstract available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15046286

⁷⁸ National Institute of Allergy and Infectious Diseases. *Scientific evidence on condom effectiveness for sexually transmitted disease (STD) prevention*. Summary of a workshop sponsored by the National Institute of Allergy and Infectious Diseases in Herndon, Virginia, June 2000. Available at: <http://www.niaid.nih.gov/dmid/stds/condomreport.pdf>. Condoms are not 100% efficacious but are highly effective if used with care.

⁷⁹ Hearst N, Chen S. Condom promotion for AIDS prevention in the developing world: is it working? *Studies in Family Planning* 2004; 35(1):39-47. Abstract available at: <http://www.popcouncil.org/publications/sfp/sfpabs/sfpabs351.html>

⁸⁰ For a short review on condom efficacy and problems see: Foss AM, Watts CH, Vickerman P, Heise L. *Condoms and prevention of HIV*. *BMJ* 2004; 329: 185-186. See: <http://bmj.bmjournals.com/cgi/content/full/329/7459/185>

Apart from problems associated with availability, the following factors continue to need addressing:

- A major obstacle for the effectiveness of condoms in HIV prevention is the difficulty faced by women in persuading male partners to use them. Many men do not like condoms and do not like a female partner suggesting that a condom be used.
- Sex workers are known to be put under pressure by men who offer to pay higher rates for sex without condoms. There is also a problem of inconsistent use, with women using condoms with paying clients but not with their own male partners.
- Injecting drug users are reported to use condoms in a sporadic and ineffective way.
- Women who are subjected to sexual violence will have no control over the use of condoms and these are unlikely to be used.
- Condoms also represent a barrier to conception and many couples want to have children.

Nevertheless UN and other agencies working in the field of HIV/AIDS have emphasized that condoms remain an essential component of current prevention strategies.⁸¹

Female condom

The female condom is a polyurethane sheath with rings at each end which can be inserted into the vagina up to eight hours before sexual intercourse. It provides protection against both pregnancy and sexually transmitted infections. The female condom has no known side-effects or risks – though care has to be taken in fitting it and in its use – and it has been found to be acceptable to large numbers of women. The female condom has been available in Europe since 1992 and was approved by the US Food and Drug Administration in 1993. Studies among various groups of women, including young married women and sex workers in some African countries and in Thailand have suggested that women found the biggest advantage of the female condom to be the control it gave them over their own sexual health since they could initiate its use, and could insert the condom well before sexual intercourse. There

⁸¹Joint United Nations Programme on HIV/AIDS, World Health Organization. Effectiveness of condoms in preventing sexually transmitted infections including HIV. Press statement. Geneva, 16 August 2001.

remains a problem of expense to overcome (they are currently around 20 times more expensive per unit than the male condom) and they have been distributed in relatively limited numbers.⁸²

The ABC approach

*HIV/AIDS prevention programmes must be practical and realistic. Lecturing young people and women does not protect them; the people who really need to hear the message about abstinence and fidelity are older, for the most part married, men. But I haven't yet heard that the government is funding such programmes.*⁸³

One approach to the prevention of HIV infection is the “ABC” method – Abstinence (from sexual intercourse), Be faithful (to one sexual partner) and use Condoms. While each of these measures has the potential to contribute to protection from exposure to HIV (and the approach appears to have had some success in some countries) ABC has important limitations, particularly if promoted as the only means for protection. Abstinence has little meaning to girls and women who are coerced into sexual activity or subjected to sexual violence. Similarly, faithfulness to one partner offers little protection to women whose husbands have other partners or were infected before they were married. (In several African countries young married women have higher rates of HIV than their unmarried counterparts and adolescent marriage is an indicator of increased susceptibility to infection.) The use of condoms requires the cooperation of men (or their tolerance in the case of female condoms). Men frequently do not want to use condoms or regard a wish by a woman to use a condom as a statement of distrust or unfaithfulness.

The ABC approach will present viable options for girls and women only if it is implemented as part of a multi-faceted package of interventions that take into consideration the specific problems of girls and women. These interventions should aim to empower girls and women through assertiveness and self-esteem building and inter-personal communication and leadership

⁸² The Global Coalition on Women and AIDS. Basic Facts on the Female Condom. Undated. Available at: http://www.unaids.org/html/pub/una-docs/gcwa_femalecondom_en.pdf.pdf

⁸³ ‘Women, Poverty, and HIV in Asia: Dynamics of Emergent Epidemics’. Statement by Nafis Sadik, MD, Special Envoy of the UN Secretary-General for HIV/AIDS in Asia and the Pacific, University of California Women’s Global Health Imperative 4th Annual International Women’s Day HIV Briefing, 8 March 2004. Available at: <http://www.unaids.org>

*skills development. They must be accompanied by changes in laws and efforts to transform social expectations that would allow women to live independent lives both socially and economically.*⁸⁴

Testing and treatment

Voluntary testing for the presence of HIV, in the context of a program of pre-test and post-test counselling and peer support (known as voluntary counselling and testing, VCT), is critical in diagnosis, in enabling early intervention as a management strategy for the disease and in minimising transmission of HIV. The WHO's 3 by 5 initiative⁸⁵ – 3 million people to receive antiretroviral medication by 2005 – depends on rapid expansion of VCT capacity. However, testing is also open to abuse and denial of human rights. Abuses include introduction of mandatory screening and compulsory testing, failure to obtain consent to testing, failure to provide adequate pre- and post-test counselling; failure to respect confidentiality, failure to inform the tested person of the outcome of the test and testing people on discriminatory grounds.⁸⁶

The purposes of testing are diverse. The UNAIDS Global Reference Group on HIV/AIDS and Human Rights identified at least nine possible purposes for testing for HIV including as a precondition to accessing AIDS-related care, to reduce mother to child transmission (MTCT) of HIV, to donate blood and as part of health screening.⁸⁷

⁸⁴ UNIFEM. *Confronting the Crisis*, p.17.

⁸⁵ WHO. *Treating 3 million by 2005. Making it happen: The WHO Strategy*. Geneva, 2003. Available at: <http://www.who.int/3by5/publications/documents/isbn9241591129/en/>

⁸⁶ See, for example, the recommendation of the World Health Assembly (WHA) in 1992. The WHA resolution on global strategy for the prevention and control of AIDS stated: "The Forty-Fifth World Health Assembly [recognizes] that there is no public health rationale for any measures that limit the rights of the individual, notably measures establishing mandatory screening". Resolution WHA 45.35.

⁸⁷ UNAIDS Global Reference Group on HIV/AIDS and Human Rights. Second Meeting, Geneva, 25-27 August 2003. Issue paper: Review of Human Rights Implications of HIV Testing in Identified Purposes and Settings. Available at: http://www.unaids.org/html/pub/topics/human-rights/hr_refgroup2_02_en.pdf.pdf. The other purposes for testing identified were: Where people voluntarily want to know their HIV status; because of societal attitudes and prejudices towards certain individuals and population groups; to determine eligibility of individuals for activities, services, and

While most of these purposes have legitimate goals, the application of testing can be discriminatory. UNAIDS recognises the importance of tackling stigma and discrimination and stresses that testing should be confidential, be accompanied by counselling and only be conducted with informed consent, meaning that it is both informed and voluntary. The minimum information that patients require to be able to provide informed consent is the following:

- the clinical benefit and the prevention benefits of testing
- explanation of the right to refuse
- the follow-up services that will be offered and
- in the event of a positive test result, the importance of anticipating the need to inform anyone at ongoing risk who would otherwise not suspect they were being exposed to HIV infection.⁸⁸

The first [area most immediately in need of reform] is discrimination against women in the workplace, in particular through involuntary HIV tests administered to workers and jobseekers. Our research showed that women who apply for positions in the tourism industry or the free trade zones—the two main employers of women—are often tested for HIV as a condition of work, in violation of their right to non-discrimination in access to work and in the workplace. None of the governmental mechanisms designed to enforce work-related rights protections have addressed these abuses adequately, allowing private employers to continue the abuse with impunity.

*Dominican Republic, 2004*⁸⁹

Antiretroviral medication

While there is currently no cure for HIV infection, the long-term use of antiretroviral medication is the only measure which will prevent the negative and life-

goods; to collect and analyze information needed for epidemiological surveillance; and for research purposes.

⁸⁸ UNAIDS/WHO Policy Statement on HIV Testing. Geneva, June 2004. Available at:

<http://www.unaids.org/en/default.asp>

⁸⁹ *Human Rights Watch*. A Test of Inequality: Discrimination against Women Living with HIV in the Dominican Republic. New York: HRW, 2004. Available at:

<http://www.hrw.org/reports/2004/dr0704/index.htm>

threatening consequences of the infection in those living with the virus.

Anti retroviral drugs work by different mechanisms⁹⁰ but each has the effect of blocking the reproduction of the virus which kills cells forming part of the human immune system. By taking such drugs on a regular basis for life, the long term harmful effects of HIV can be prevented. However, antiretroviral drugs have been very expensive and, even though the price is falling significantly, it still remains out of the reach of millions of people in need.

Of course, the state of health of a person living with HIV/AIDS depends on far more than access to medication: proper nutrition, psychological well-being, decent housing and personal and financial security can all have a dramatic impact on the physical health of such an individual. Average per capita annual GDP is \$US252, and, according to Rwandese government documents, 60% of Rwandese are estimated to live below the poverty line. More than half of the population lacks access to clean water, and 40% of Rwandese are undernourished. Only an estimated 28% of Rwandese households affected by HIV/AIDS are able to afford even basic health care; many families borrow money, sell assets, including land, or decide to forego healthcare. Under these conditions, it is clear that a holistic approach is needed if ARV treatment is to be effective, including improving living conditions of [people living with HIV/AIDS] and reducing the burden on their families or those caring for them.

Rwanda, 2004⁹¹

The WHO 3 by 5 initiative is intended to scale up access to ARVs⁹² though the challenge of respecting human rights and ethics while doing this has been underlined by commentators – including with regard to voluntary counselling and testing and

⁹⁰ The three main drug types are nucleoside analogues (which interfere with the virus's ability to make a key enzyme called "reverse transcriptase"); non-nucleoside analogues (which attach to reverse transcriptase and inhibit it), and protease inhibitors (which prevent HIV-infected cells from producing new copies of the virus).

⁹¹ "Marked for Death": Rape survivors living with HIV/AIDS in Rwanda. AI Index: AFR 47/007/2004, April 2004, pp.3-4.

Available at:

<http://web.amnesty.org/library/Index/ENGAFR470072004>.

⁹² WHO. *Treating 3 million by 2005. Making it happen: The WHO Strategy*. Geneva, 2003. Available at:

<http://www.who.int/3by5/publications/documents/isbn9241591129/en/>.

maintenance of confidentiality.⁹³ In South Africa, roll-out of antiretrovirals is happening slowly and "the standard of care is constantly changing and differs from province to province, and within provinces from district to district."⁹⁴ In other countries there is virtually no systematic provision of ARVs.

There remains important research to be undertaken on antiretrovirals, including with regard to the effective delivery of antiretroviral therapy for women. While ARVs protect the lives of women and men living with HIV, there has been inadequate research on gender differences in dosage and reaction to ARVs, or on the effect of hormone level changes, the effects of pregnancy, and levels and implication of ARVs in breast milk. There is more research needed on women and ARVs though there is clear evidence that women benefit from treatment with such medication.

Children also have special needs. A number of organizations have drawn attention to the limited number and expense of paediatric formulations.⁹⁵

*In Zambia ... the Government was able to dramatically reduce the monthly cost of [antiretroviral therapy] from \$64 to \$8 per month after receiving support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Given that well over half—some reports put it as high as 70 per cent—of the 870,000 Zambians living with HIV/AIDS are women, officials expected to see a majority of women receiving ART. Instead, men began showing up in much greater numbers. In one rural town, of the 40 people on ART, only three were women.*⁹⁶

⁹³ See for example Heywood M. Human rights and HIV/AIDS in the context of 3 by 5: time for new directions? *Canadian HIV/AIDS Policy and Law Review* 2004 August, 9: 1,7-12. Available at:

[http://www.aidslaw.ca/Maincontent/issues/cts/3by5_MHeywood\(9\)2.pdf](http://www.aidslaw.ca/Maincontent/issues/cts/3by5_MHeywood(9)2.pdf). See also: *Consultation on Ethics and Equitable Access to Treatment and Care for HIV/AIDS, 26-27 January 2004, Geneva: Summary of Issues and Discussion*. Geneva: World Health Organization and Joint United Nations Programme on HIV/AIDS. Available at: http://www.who.int/entity/ethics/en/equity_art_meeting_report_e.pdf

⁹⁴ Singh JA. Standards of care in the antiretroviral rollout world. *Lancet* 2004; 364:920-2.

⁹⁵ See, for example, Médecins sans Frontières, Children and AIDS: Neglected patients, 15 July 2004, available at: <http://www.msf.org/>

⁹⁶ *Women and HIV/AIDS: Confronting the Crisis*, p.23

Although antiretroviral drugs were first developed in the early 1990s, they were difficult to access due to limited production and, more significantly, the cost of treatment which made them unobtainable by the vast majority of people living with HIV/AIDS. In recent years members of the international community – and particularly NGOs – have been increasing pressure for the relaxation of patent protections to allow for the production of cheaper generic drugs. In response, ministers to the World Trade Organization (WTO) signed the Declaration on the TRIPS Agreement and Public Health in Doha, Qatar, promising to ease patent restrictions in order to promote access to antiretrovirals throughout the world.⁹⁷ Over the past three years there has been increasing, if grossly inadequate, access to antiretrovirals, though cost and capacity issues and the large numbers of people who do not know their HIV status mean a minority of people are receiving the medication they need.

Discrimination and stigma

Stigma associated with HIV/AIDS builds upon and reinforces prejudices related to gender, poverty, sexuality, race and other factors. Fears related to illness and death; the association of HIV with sex workers, men having sex with men and injecting drug use; and beliefs that attribute moral fault to people living with HIV/AIDS all contribute to the impact of stigma and often give rise to intolerance and discrimination. Stigma and discrimination against people living with HIV/AIDS affects the spread and impact of the disease in several crucial ways. For example, fear of being identified with HIV/AIDS stops people from seeking voluntary counselling and testing, which are vital to prevention, care and treatment efforts.⁹⁸

The origins of stigma are easy to understand but harder to deal with. Stigma often leads to active discrimination which further stigmatises people with, or thought to have, HIV or AIDS. This negative

⁹⁷ TRIPS is 'Trade-Related Aspects of Intellectual Property Rights'. The text of the declaration, signed 14 November 2001, is available at: http://www.wto.org/english/thewto_e/minist_e/min01_e/m indecl_trips_e.htm

⁹⁸ UN Special Rapporteur on the right of everyone to the highest attainable standard of health, Report to the UN Commission on Human Rights, UN Doc. E/CN.4/2003/58, 13 February 2003, para. 68. Available at: [http://193.194.138.190/Huridocda/Huridoca.nsf/0/9854302 295c2c86fc1256cec005a18d7/\\$FILE/G0310979.pdf](http://193.194.138.190/Huridocda/Huridoca.nsf/0/9854302 295c2c86fc1256cec005a18d7/$FILE/G0310979.pdf)

synergy acts as a barrier to open and effective addressing of HIV/AIDS. The reality of stigma and discrimination make the principle of informed consent and confidentiality of medical records and information even more important than usual. However maintaining confidentiality is difficult especially for the poor who may not have ready one-to-one access with a health worker to learn of test results. If confidentiality is maintained at diagnosis, it may prove difficult to maintain if and when the person starts taking medication since it is often visible to others in their family or community.

A study in three African countries found that both men and women are stigmatized for breaking sexual norms, but gender-based power dynamics result in women being blamed more easily. The authors found that the consequences of HIV infection, disclosure, stigma and the burden of care were higher for women than for men.⁹⁹

Differential discrimination against women

A study carried out by the Asia Pacific Network of People Living with HIV (APN+) identified the following HIV-related issues in which women faced significantly higher levels of discrimination than men:

- Being ridiculed, insulted or harassed
- Being physically assaulted
- Being refused entry to, removed from or asked to leave a public establishment
- Being forced to change place of residence
- Being excluded from social functions
- Suffering exclusion by family members
- Losing financial support from family members
- Being advised not to have a child after being diagnosed as HIV-positive¹⁰⁰

Stigma and discrimination also remain significant considerations in areas of conflict. In the Darfur region of Sudan thousands of women are believed to have been raped. However, as elsewhere, the stigma

⁹⁹ Nyblade L et al. *Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia*. International Center for Research on Women (ICRW), USA, 2003. Available at: <http://www.icrw.org/docs/stigmareport093003.pdf>

¹⁰⁰ Cited in Paxton S, with Welbourn A, Kousalya P, Yuvaraj A, Pradhan Malla S, Seko M. "Ob this one is infected!": *Women, HIV and Human Rights in the Asia-Pacific Region*. International Community of Women Living with HIV/AIDS, March 2004. Available at: http://www.icw.org/tiki-read_article.php?articleId=83

associated with rape means that women are reluctant to report it to the few medical workers present in refugee camps, which can lead to further medical complications of injuries they may have sustained during the rape.¹⁰¹ Women who have become pregnant as a result of rape often suffer complications before, during and after giving birth, because of the physical injuries resulting from assault. The trauma of rape gives rise to a potential for transmission of HIV. Even if women raped have not sustained serious physical injuries, the apparent lack of access to hygiene facilities and unavailability of sanitary products in the context of material relief shortages in Darfur (and also in neighbouring Chad) contribute to the risk of infections.

Preventing mother to child transmission (MTCT)

In the absence of any intervention, children born to women living with HIV have a 15-30% risk of acquiring the virus during pregnancy and delivery and of being born HIV positive. There is a 10-20 % risk of transmission of the virus through breast milk.¹⁰²

Prevention of mother to child transmission of HIV therefore requires addressing these routes of infection. Three broad recommendations have been made: delivery of the baby by caesarean section; implementation of antiretroviral treatment for the mother and baby; and substitution of artificial baby milk for breast feeding. However, in resource-limited settings, elective caesarean delivery is seldom available or safe, and refraining from breastfeeding is often not acceptable or feasible for the woman, or safe for the infant.

The World Health Organization has recommended that HIV-positive pregnant women who need ARV treatment for their own health should receive it in accordance with the WHO guidelines on ARV treatment. The use of such treatment, when indicated, during pregnancy will benefit the health of the woman and decrease the risk of HIV transmission to the infant. Where HIV-positive pregnant women do not have indications for ARV treatment, or do not

have access to treatment, they should be offered ARV prophylaxis to prevent MTCT using, for example, zidovudine from 28 weeks of pregnancy plus a single-dose of nevirapine during labour and a single-dose of nevirapine and a one-week course of zidovudine for the newborn infant. Alternative regimens based on zidovudine alone, or single-dose nevirapine alone, are also recommended.¹⁰³

A number of human rights issues arise in the context of addressing mother to child transmission (MTCT). These include

- Provision of pre-test counselling and information to assist in informed decision-making by the woman.
- Informed consent to testing during and after pregnancy, to the treatment itself and to decision-making with regard to management of the pregnancy
- Protection of confidentiality
- Access to post-pregnancy contraception
- Potential adverse effects of taking antiretrovirals (ARVs) especially in repeat pregnancies of an HIV infected woman.
- Women's access to care and treatment apart from the MTCT intervention
- Non-discrimination in provision of antiretrovirals to pregnant woman

In the case brought by the Treatment Action Campaign and others, the Constitutional Court in South Africa examined the government's duties with regard to provision of Nevirapine to prevent MTCT. In its judgement in 2002, the Court stated that:

We do not underestimate the nature and extent of the problem facing government in its fight to combat HIV/AIDS and, in particular, to reduce the transmission of HIV from mother to child. We also understand the need to exercise caution when dealing with a potent and a relatively unknown drug. But the nature of the problem is such that it demands urgent attention. Nevirapine is a

¹⁰¹ Amnesty International. *Sudan: Darfur: Rape as a weapon of war: sexual violence and its consequences*. AI Index: AFR 54/076/2004. Available at:

<http://web.amnesty.org/library/Index/ENGAFR540762004>.

¹⁰² EngenderHealth. HIV and AIDS. Module 3: Transmission and risk: MTCT. Available at:

<http://www.engenderhealth.org/res/onc/hiv/transmission/hiv3p4.html>

¹⁰³ World Health Organization. *Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Guidelines on Care, Treatment and Support for Women Living with HIV/AIDS and their Children in Resource-Constrained Settings*. Geneva: WHO, 2004. Available at:

<http://www.who.int/reproductive-health/rtis/docs/arvdrugsguidelines.pdf>

potentially lifesaving drug. Its safety and efficacy have been established. There is a need to assess operational challenges for the best possible use of nevirapine on a comprehensive scale to reduce the risk of mother-to-child transmission of HIV. There is an additional need to monitor issues relevant to the safety and efficacy of and resistance to the use of nevirapine for this purpose. There is, however, also a pressing need to ensure that where possible loss of life is prevented in the meantime.¹⁰⁴

The Court went on to declare that the South African Constitution “require[d] the government to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV”.¹⁰⁵

Post-exposure prophylaxis (PEP)

Post-exposure prophylaxis (PEP) is an emergency response to possible exposure to HIV.¹⁰⁶ PEP consists of medication, diagnostic laboratory tests and counselling. PEP should be initiated no later than 72 hours after possible exposure to HIV, and should continue for around four weeks. If a woman believes she has been exposed to the virus she would need to discuss this with a doctor within the possible treatment window period. The doctor and the woman would assess the risk and discuss whether PEP was needed. The possibly-exposed woman would need to consent to testing and treatment. Testing for HIV is

¹⁰⁴ Constitutional Court of South Africa. Minister of Health & Others, Appellants, versus Treatment Action Campaign & Others, Respondents (Case CCT 8/02), Para. 27, pages 57-58. Available at: <http://www.concourt.gov.za/files/tac/tac.pdf>.

¹⁰⁵ *Ibid*, para. 38, page 59. The success of the TAC in this case underlined the importance of NGO action in support of access to treatment. In December 2003 in a case brought by TAC and 11 other complainants a settlement was reached with pharmaceutical companies in which the companies said they would grant more licenses to generic firms to produce and import antiretroviral drugs at low cost. The settlement is available at:

<http://www.cptech.org/ip/health/sa/settlement12092003.pdf>

¹⁰⁶ Exposure to the virus is commonly divided into “occupational exposure”, usually caused by a needle-stick injury in clinical settings, or “non-occupational exposure” which can refer, among other infection routes, to exposure through consensual or non-consensual sexual activity.

necessary since if she is already positive the medication would not be effective. If she tested negative then she would be given the course of medication with advice about procedures. She should be tested at intervals over the following year to determine if the medication was effective.

Although PEP has not been conclusively proven to prevent the transmission of HIV infection¹⁰⁷, research studies suggest that if medication is initiated quickly after the possible exposure (no later than 72 hours) it may be effective. The efficacy of PEP is probably higher if treatment is started within the first few hours of exposure and is probably progressively reduced if started later. After 48-72 hours, the benefits are probably minimal or non-existent and the risk of side-effects associated with antiretroviral treatment will outweigh any potential preventive benefit.

Interventions by humanitarian organizations have enabled women in some areas to receive ...medical care, including free post-exposure prophylactic drugs to prevent HIV infection, in the immediate aftermath of the rape. However, in practice, these services are not available in many provinces, particularly to women who live far from health centres or in areas of conflict. Sometimes the medicines are just not available. Many people still do not know that such care or drugs exist. Additionally, the continuing stigma attached to sexual violence and fear of coming forward prevents some victims of sexual violence from accessing these services.

*Burundi, 2004*¹⁰⁸

Given the relatively low prevalence levels in some communities and the low rates of transmission via unprotected sex in certain contexts, some doctors have argued that routine PEP is not generally recommended though should be considered in particular cases.¹⁰⁹ In high prevalence countries, the

¹⁰⁷ Research is lacking on the effectiveness of PEP following sexual assault, but professional opinion increasingly suggests that implementing PEP is justified in the light of documented efficacy in the case of occupational exposure to HIV and in the absence of evidence that it carries unacceptable risks following sexual assault.

¹⁰⁸ Amnesty International. *Burundi. Rape – the hidden human rights abuse*. AI Index: AFR 16/006/2004.

¹⁰⁹ Mein JK, Palmer CM, Shand MC et al. Management of acute adult sexual assault. *Medical Journal of Australia* 2003; 178: 226-230. Available at: http://www.mja.com.au/public/issues/178_05_030303/mei10448_fm.html.

case for a routine offer of PEP becomes more compelling.¹¹⁰

Female-controlled preventive methodologies

The female condom is a potentially important female-controlled form of protection that already is available though at relatively high cost and with limited accessibility (see above p. 16). Increased development and promotion is needed to ensure that more women have access to this option. However one very important protective method which is currently under development could have a major impact on the protection of women within the next decade – microbicides.

Microbicides

A microbicide is any preparation with the capacity to prevent the sexual transmission of HIV and other sexually transmitted infections (STIs) when applied topically within the female genital tract. These new products could take a number of forms including gels, creams, suppositories, films, sponges or rings. The active ingredient(s) could function immediately on application or be released slowly from a carrier such as a sponge or vaginal ring so that it is active over an extended time. Dozens of candidate microbicides are being tested and five have entered the final stages of effectiveness testing. With sufficient public support for their development, the first microbicides may be available publicly by the end of the current decade.¹¹¹

Significance of microbicides. The key characteristic of a microbicide that makes it important for women is that it can be applied by a woman prior to sexual contact and would not require the consent of, or action by, a male partner. It is male control which makes other methods such as condom use so problematic for many women. Research into microbicides is continuing into two forms – a microbicide preparation which prevents the transmission of infections but permits conception, and one which prevents both infection and conception. Even if a microbicide is not 100% effective, it could still have the effect of preventing large numbers of women from contracting the virus.

¹¹⁰ See discussion in: Amnesty International. *Protecting the Human Rights of Women and Girls: A medico-legal Workshop on the Care, Treatment and Forensic Medical Examination of Rape Survivors in Southern and East Africa*. London, 2002

¹¹¹ See the web-site of the Global Campaign for Microbicides: <http://www.global-campaign.org>

Women as home-based care-givers

*Older women [in Botswana] were overwhelmed with the magnitude and multiplicity of tasks they had to perform. They were exhausted, often malnourished, depressed and neglectful of their own health. Although they had been taught to use universal precautions, very few complied with this regimen. When family members became too ill to care for themselves, they often returned to their mothers, bringing with them their own immediate family. Conversely, mothers might be called upon to care for their child at his/her home, leaving their own immediate family and means of psychosocial support behind.*¹¹²

In many countries, care of those with AIDS-associated illnesses falls to mother, grandmothers and daughters working within the home. It is unpaid and undervalued. It can threaten the health of the carer and widen the suffering caused by the infection by making it increasingly difficult for the carer to take part in income generation. The vast majority of women and girls who bear the burden of HIV/AIDS receive little material or moral support and no training.

Training and support programs need to address the circumstances of carers: elderly women who face depression and isolation; young female carers who will require support for continuing education and employment opportunities. Male carers also need support. Governments must address the three dimensions of orphaned families; loss of wages and other income due to care-giving duties, illness and death; and costs to families of medical care.¹¹³

A rights-based approach to HIV/AIDS and the protection/empowerment of women and girls

*A strategy driven by fear of infection cannot succeed. In the long term, success can only come through an approach based on values – the values of human rights and human dignity. Let us not forget that the Universal Declaration of Human Rights starts by placing dignity first.*¹¹⁴

¹¹² *Community home-based care: family caregiving. Caring for family members with HIV/AIDS and other chronic illnesses. The impact on older women and girls. A Botswana case-study.* WHO, 2000.

Available at:

http://www.who.int/chronic_conditions/en/community_home-based_care_family_caregiving.pdf

¹¹³ UNIFEM. *Women and HIV/AIDS: Confronting the Crisis*, chapter 4.

¹¹⁴ Irene Khan, Secretary General, Amnesty International. Speech to the 15th International Conference on HIV/AIDS, Bangkok, July 2004.

[A] “rights-based approach” to public health in general, and HIV/AIDS in particular, supports sound public health practice by providing additional tools to motivate governments to act to achieve public health goals. Rights considerations can help facilitate the setting and monitoring of public health targets and provide a complementary language to identify failures, or incipient failures, of public health programmes. The rights-based approach also provides links with other social movements that use the same language—for example, the women’s movement, the struggles of indigenous peoples and the movement of people working to protect the environment.¹¹⁵

Human rights are central to all aspects of an effective response to HIV and AIDS and have been emphasised in international and national programs since the creation of the World Health Organization’s Global Programme on AIDS in the 1980s.

A rights-based approach starts from the premise that respect for human rights forms a coherent basis for programs to address the pandemic and that abuses of human rights contribute to the spread of the virus and undermine attempts to contain it. As the Canadian HIV/AIDS Legal Network has put it, “[w]hen human rights are not promoted and protected, it is harder to prevent HIV transmission. When these rights are not promoted and protected, the impact of the epidemic on individuals and communities is worse.”¹¹⁶

The importance of human rights to protecting and promoting health has also been recognized within the UN system through the work of the treaty-monitoring bodies, the rights-based work of health-related UN agencies such as WHO, UNAIDS, UNIFEM and UNFPA, and the creation of the posts of UN Special Rapporteurs on the right to health and on violence against women.

Human rights standards and HIV

A number of international human rights standards – including those agreed to by, and binding on, governments – are relevant to protecting women’s

¹¹⁵ Patterson D, London L. International law, human rights and HIV/AIDS. *Bulletin of the World Health Organization* 2002;80:964-969. Available at: [http://www.who.int/docstore/bulletin/pdf/2002/bul-12-E-2002/80\(12\)964-969.pdf](http://www.who.int/docstore/bulletin/pdf/2002/bul-12-E-2002/80(12)964-969.pdf)

¹¹⁶ Canadian HIV/AIDS Legal Network. A human rights approach to HIV/AIDS. Montreal. Available at: http://www.aidslaw.ca/Maincontent/issues/discrimination/rights_approach_description.pdf

rights in the context of HIV/AIDS, both in terms of the prevention of HIV/AIDS and the response to it. International human rights law requires governments to take a range of measures to protect the right to the highest attainable standard of health (also known as the ‘right to health’), and the right to freedom from discrimination, among others. There are other rights which are also important to the consideration of HIV, including rights to information, to education, to work, to found a family, to enjoy the benefits of scientific knowledge and other rights. The relevance of human rights standards to HIV/AIDS prevention, treatment and support has been elaborated by international consultations on the subject, and independent experts within the UN human rights system have also commented on women’s human rights and HIV/AIDS.

Standards on women’s rights to health

The right to health for everyone was promulgated as a core value of the constitution of the World Health Organization at its establishment in 1946: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...” This right was later articulated in a number of international treaties.

The International Covenant on Economic, Social and Cultural Rights at article 12 requires states parties to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

Governments have also made important political commitments to secure the right to health of women, including in the Vienna Declaration and Programme of Action, as adopted by the World Conference on Human Rights on 25 June 1993 which recognizes the importance of women’s right to enjoy the “highest standard of physical and mental health throughout their lifespan”.¹¹⁷

The Convention on the Elimination of All Forms of Discrimination Against Women calls at article 12 for “States Parties [to] take all appropriate measures to eliminate discrimination against women

¹¹⁷ See Article 41, which reaffirmed “on the basis of equality between women and men, a woman’s right to accessible and adequate health care and the widest range of family planning services, as well as equal access to education at all levels.” The Declaration and Program are available at: [http://www.unhchr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.CONF.157.23.En](http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.CONF.157.23.En)

in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning”, adding that “States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period”.¹¹⁸

Standards on women’s sexual and reproductive health rights

A number of international agreements and standards address women’s sexual and reproductive health rights. The Cairo Programme of Action adopted at the International Conference on Population and Development (ICPD) in 1994, addressed sexually transmitted diseases and the prevention of HIV from the perspective of women’s vulnerability to the epidemic. It also set out key recommendations for addressing HIV through reproductive health services.¹¹⁹

Recommended measures included: increasing efforts in reproductive health programs to prevent, detect and treat STIs and other reproductive tract infections; providing specialized training to all health-care providers in the prevention and detection of, and counselling on, STIs, especially infections in women and youth; making information and counselling integral components of all reproductive and sexual health services; and promoting and distributing high-quality condoms as integral components of all reproductive health-care services.

*“...sexuality is a characteristic of all human beings. It is a fundamental aspect of an individual’s identity. It helps to define who a person is.... the Special Rapporteur has no doubt that the correct understanding of fundamental human rights principles, as well as existing human rights norms, leads ineluctably to the recognition of sexual rights as human rights”.*¹²⁰

¹¹⁸ CEDAW, article 12. Available at: <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>

¹¹⁹ Programme of Action of the ICPD, Chapter 7, section C, paras. 7.27-7.33. Available at: <http://www.iisd.ca/Cairo/program/p07000.html>

¹²⁰ Paul Hunt, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report to the 60th session of the Commission of Human Rights. E/CN.4/2004/49, 16 February 2004, para. 54. Available at: [http://www.unhcr.ch/Huridocda/Huridocda.nsf/\(Symbol\)/E.CN.4.2004.49.En](http://www.unhcr.ch/Huridocda/Huridocda.nsf/(Symbol)/E.CN.4.2004.49.En)

The Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women in 1995 stated that “[t]he social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases need to be seen from a gender perspective” and to “[u]ndertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues”.¹²¹

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; to seek, receive and impart information in relation to sexuality; to have access to sexuality education; and other related rights.¹²² For sexual rights, as with all rights, the responsible exercise of human rights requires that all persons respect the rights of others. In reality, women frequently are deprived of the realisation of many or most of these rights.

The Declaration of Commitment agreed at the 2001 UN General Assembly Special Session on HIV/AIDS took a small step forward by calling on governments to take action to “empower women 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.”¹²³

Standards on violence against women

The Declaration on the Elimination of Violence against Women (1993) calls, at article 4, for states to condemn violence against women and not invoke any custom, tradition or religious consideration to avoid

¹²¹ Beijing Declaration and Platform for Action, Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995), para. 99 and Strategic Objective C.3. (Note in particular the detailed recommendations of para 109); available at: <http://www1.umn.edu/humanrts/instree/e5dplv.htm>

¹²² World Health Organization. Draft working definition of sexual rights. WHO, Geneva, 2002, <http://www.who.int/reproductive-health/gender/glossary.html>

¹²³ United Nations, Declaration of Commitment on HIV/AIDS, Document A/S-26/L.2, New York, 2001, para.59. Available at: <http://www.un.org/ga/aids/coverage/FinalDeclarationHIV/AIDS.html>.

their obligations with respect to its elimination. States should pursue by all appropriate means and without delay a policy of eliminating violence against women.

The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), adopted in 1979, provides for the realization of equality between women and men through ensuring women's equal access to political and public life as well as to education, health and employment. CEDAW articles 2, 5, 11, 12 and 16 of the Convention require the States parties to take action to protect women against violence of any kind occurring within the family, at the work place or in any other area of social life. General Recommendation 19 of the committee which monitors the treaty (CEDAW Committee) noted that “[g]ender-based violence ... impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions” and was a form of discrimination.¹²⁴

Standards on discrimination against women

The principle of non-discrimination in international human rights law attaches to distinctions “of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”.¹²⁵ ‘Other status’ has been interpreted to include factors which “can affect individuals’ ability to exercise their rights” such as health status (HIV/AIDS)¹²⁶. The UN Human Rights Committee and the Committee on Economic, Social and Cultural Rights have stated that “sexual orientation” can be read into the Covenants’ non-discrimination provisions.¹²⁷

¹²⁴ CEDAW Committee. General Recommendation 19, 1992, para.7. Available at:

<http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom19>

¹²⁵ Universal Declaration of Human Rights, para. 2.

¹²⁶ Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2004/14, 11 August 2000. Available at:

[http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En). See resolutions by the UN Commission on Human Rights: 1994/49, 1995/44, 1996/43, 1999/49, 2001/51.

¹²⁷ For example, in *Toonen v. Australia*, the Human Rights Committee stated its view that the reference to sex in articles 2, paragraph 1, and 26 of the International Covenant on Civil and Political Rights is to be taken as including sexual orientation. CCPR/C/50/D/488/1992 (Australia), 4 April 1994, para.8.7. Available at:

The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) calls on States Parties “to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women; (Article 2(f)) and “to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women (Article 5(a)).¹²⁸

CEDAW requires at Article 5 the “elimination of prejudices and ... practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women”; at Article 10 to “take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education”; and at Article 12 to “eliminate discrimination against women in the field of health care”.

The Special Rapporteur on the Right to Health, Paul Hunt, has underlined the effect of discrimination on gender grounds when addressing women’s rights to sexual and reproductive health:

Discrimination based on gender hinders women’s ability to protect themselves from HIV infection and to respond to the consequences of HIV infection. The vulnerability of women and girls to HIV and AIDS is compounded by other human rights issues including inadequate access to information, education and services necessary to ensure sexual health; sexual violence; harmful traditional or customary practices affecting the health of women and children (such as early and forced marriage); and lack of legal capacity and equality in areas such as marriage and divorce.¹²⁹

<http://www.unhchr.ch/tbs/doc.nsf/0/d22a00bcd1320c9c80256724005e60d5>.

¹²⁸ Convention on the Elimination of all Forms of Discrimination against Women. Adopted in 1979 by the UN General Assembly, Available at:

<http://www.un.org/womenwatch/daw/cedaw/>

¹²⁹ UN Special Rapporteur on the right of everyone to the highest attainable standard of health, *Report to the UN Commission on Human Rights*, UN Doc. E/CN.4/2004/49, 16 February 2004, para. 34.

Standards on the rights of the child

The Convention on the Rights of the Child requires governments to: “recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health” (article 24).

The Committee on the Rights of the Child issued two General Comments in 2003. General Comment 3 on HIV/AIDS and the rights of the child sought to strengthen the identification and understanding of all the human rights of children in the context of HIV/AIDS; promote the realization of human rights of children in the context of HIV/AIDS; identify measures and good practices to increase the level of implementation by the States of rights related to the prevention of HIV/AIDS and the support, care and protection of children infected with or affected by this pandemic; contribute to the formulation and promotion of child oriented action and policy at national and international level.¹³⁰

The second General Comment – number 4, on adolescent health and development – urged States Parties, in a paragraph on HIV and adolescents, to:

- (a) develop effective prevention programmes, including measures to change cultural views about adolescents’ need for contraception and STI prevention, and to address cultural and other taboos surrounding adolescent sexuality; (b) adopt legislation to combat practices that either increase adolescents’ risk of infection or contribute to the marginalization of adolescents who are already infected with STIs or HIV; (c) take measures to remove all barriers hindering the access of adolescents to information, preventive measures such as condoms, and care.”¹³¹

The Committee also stated that discrimination against adolescents on the basis of sexual orientation or HIV status is not acceptable.¹³²

¹³⁰ United Nations, Committee on the Rights of the Child, General Comment No. 3 (2003) on HIV/AIDS and the Rights of the Child., para. 2. Available at: <http://www.unhchr.ch/html/menu2/6/crc/doc/comment/hiv.pdf>

¹³¹ United Nations, Committee on the Rights of the Child, General Comment No. 4 (2003) on Adolescent Health and Development, para. 23. Available at: [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/CRC.GC.2003.4.En](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CRC.GC.2003.4.En).

¹³² *Ibid*, para 6(a).

Standards on international cooperation

All UN member states are obliged to take joint and separate action for the purposes of achieving universal respect for and observance of human rights and fundamental freedoms for all without distinction.¹³³

The Universal Declaration of Human Rights states that “[e]veryone, as a member of society ... is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality”.¹³⁴ Article 2 of the International Covenant on Economic, Social and Cultural Rights calls for “[each] State Party to ... take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.”¹³⁵

The UNGASS Declaration of Commitment, the Millennium Declaration and Development Goals and the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria¹³⁶ all reflect a commitment to an international engagement on health, and particularly HIV/AIDS.

Human rights statements, declarations and guidelines relating to HIV/AIDS

A number of international agreements, statements and standards relate specifically to human rights in the context of HIV/AIDS.

¹³³ Articles 55 and 56 of the United Nations Charter.

¹³⁴ Universal Declaration of Human Rights, Article 22.

Available at: <http://www.unhchr.ch/udhr/lang/eng.htm>

¹³⁵ International Covenant on Economic, Social and Cultural Rights, Article 2(1).

¹³⁶ The Global Fund was created over the period 2000-2002: Leaders of G8 countries acknowledged the need for resources in their 2000 meeting, Japan. In 2001, UN Secretary General Kofi Annan called for the creation of a global fund to channel additional resources. UNGASS (2001) concluded with a commitment to create such a fund, endorsed the following month by the G8. A permanent Secretariat was established in January 2002 and starting making grants some months later. See:

<http://www.theglobalfund.org/en/about/road/history/default.asp>

UNAIDS and the Office of the United Nations High Commissioner for Human Rights (OHCHR) convened an International Consultation on HIV/AIDS and Human Rights in Geneva in 1996. This meeting adopted the *International Guidelines on HIV/AIDS and Human Rights*¹³⁷ which were endorsed by the UN Commission on Human Rights in 1997 (see box on p.25). In 2002, following a further consultation, a revised *Guideline 6: Access to prevention, treatment, care and support*¹³⁸ was adopted, providing up-to-date policy guidance based on current international law and best practice at country level.

The Millennium Declaration¹³⁹ and Millennium Development Goals¹⁴⁰ (2000), which represent a “road map towards the implementation of the United Nations Millennium Declaration”, elaborates eight goals with measurable targets for the international community to achieve by 2015 and calls on nations to (among other things) “promote gender equality and empower women” (Goal 3) and to “combat HIV/AIDS, malaria and other diseases” (Goal 6).¹⁴¹

The Declaration of Commitment adopted by the UN General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, referred to previous international and regional commitments made on HIV/AIDS. It stated at para. 14 “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 called, at para. 59, for the “empower[ment of] women 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”.¹⁴²

Expert comment and interpretation of standards is also important in the fight against HIV/AIDS. The Global Reference Group on HIV/AIDS and Human Rights provides expert commentary and recommendations to UNAIDS¹⁴³; many NGOs, including those bringing together women and men living with HIV/AIDS, regularly contribute expert refinement of human rights analysis;¹⁴⁴ the UN Special Rapporteurs on the right to health and violence against women have both made specific reference to the gender dimension of HIV/AIDS;¹⁴⁵ and other important sources of interpretation of UN standards make important points for the protection of the rights of women and girls in the context of HIV/AIDS.¹⁴⁶

The International Guidelines on HIV/AIDS and Human Rights form a sound basis to ensure that the full range of human rights, including those outlined above, are at the heart of an effective and accountable response to HIV/AIDS.

¹³⁷ Office of the High Commissioner for Human Rights (OHCHR), UNAIDS. *International Guidelines on HIV/AIDS and Human Rights*. Geneva, 1998. Available at: http://www.unaids.org/html/pub/publications/irc-pub02/jc520-humanrights_en_pdf.pdf

¹³⁸ *Revised Guideline 6: Access to prevention, treatment, care and support*. Geneva, 2002. Available at: http://www.unaids.org/html/pub/publications/irc-pub02/jc905-guideline6_en_pdf.pdf

¹³⁹ United Nations Millennium Declaration. Resolution to the General Assembly (55/2), 8 September 2000; see: <http://www.un.org/millennium/declaration/ares552e.htm>.

¹⁴⁰ The eight Millennium Development Goals – with targets to be achieved by 2015, as well as indicators – were set out in a report of the UN Secretary General in September 2001. See: <http://www.un.org/documents/ga/docs/56/a56326.pdf>

¹⁴¹ *Ibid.* Annex.

¹⁴² UNGASS. Declaration of Commitment on HIV/AIDS: Global Crisis, Global Action. 27 June 2001; available at: <http://www.icaso.org/ungass/dclonofcommnt.pdf>

¹⁴³ For details of the Global Reference Group see: http://www.unaids.org/en/in+focus/hiv_aids_human_rights/reference+group.asp

¹⁴⁴ See the list of organizations at the end of this report.

¹⁴⁵ See statements of these Special Rapporteurs at: <http://www.ohchr.org/english/issues/health/right/> and <http://www.unhchr.ch/html/menu2/7/b/women/index.htm> respectively.

¹⁴⁶ See, for example, the Committee on Economic, Social and Cultural Rights, General Comment 14. The right to the highest attainable standard of health, U.N. Doc. E/C.12/2000/4 (2000); the Committee on the Rights of the Child General Comment 3 on HIV/AIDS and the rights of the child. CRC/GC/2003/3, 17 March 2003; the Committee on the Rights of the Child General Comment 4 on Adolescent health and development in the context of the Convention on the Rights of the Child. CRC/GC/2003/4, 1 July 2003 (note particularly the call for states parties “to develop effective prevention programmes, including measures aimed at changing cultural views about adolescents’ need for contraception and STD prevention and addressing cultural and other taboos surrounding adolescent sexuality”); and the Committee on the Elimination of Discrimination against Women General Rec. No. 24, article 12 : Women and health. (paras.18 & 31(b), 1999)

International guidelines on HIV/AIDS and human rights¹⁴⁷

Governments should:

- *establish a national framework that is coordinated, participatory, transparent, and accountable across all branches of government;*
- *ensure consultation with communities and enable community organizations to carry out their activities;*
- *review and reform public health laws so that they address HIV/AIDS adequately, in a non-discriminatory way, and in accordance with international law;*
- *review and reform criminal laws and correctional systems so that they are not misused, are not targeted against vulnerable groups, and conform to international law;*
- *enact or strengthen anti-discrimination laws or other laws dealing with discrimination, privacy, confidentiality, and ethics in research;*
- *ensure by law that quality goods, services, and information are available and accessible for HIV/AIDS prevention, care, treatment, and support; [this guideline was subsequently expanded]¹⁴⁸*
- *provide legal support and services to educate people affected by HIV/AIDS about their rights, enforce those rights, and develop expertise in HIV-related legal issues;*
- *promote a supportive and enabling environment for women, children, and other vulnerable groups;*
- *change discriminatory and stigmatizing attitudes through education, training, and the media;*
- *develop, implement, and enforce professional and ethical codes of conduct in accordance with human rights principles;*
- *establish monitoring and enforcement mechanisms to guarantee that HIV-related human rights are protected;*
- *co-operate with the UN system to share knowledge and experience of HIV-related human rights issues and protection mechanisms at international level.*

¹⁴⁷ Available at:

http://www.unaids.org/html/pub/publications/irc-pub02/jc520-humanrights_en_pdf.pdf

¹⁴⁸ Available at:

http://www.unaids.org/html/pub/publications/irc-pub02/jc905-guideline6_en_pdf.pdf

Recommendations

The following recommendations flow from the content of this report. However they also re-state recommendations and observations contained in numerous international documents on HIV/AIDS and women's rights. The central themes of these documents and of this report are:

- End violence against women
- Address women's social and economic disempowerment
- Eliminate stigma and discrimination against people affected by HIV/AIDS
- Enable access to prevention, treatment and care for people affected by HIV/AIDS
- Increase international cooperation so as to meet the goals set by the international community and to enable all states to meet their international human rights obligations

Amnesty International urges governments to address the specific recommendations listed below.

In all aspects of the objectives listed which follow, governments should draw on the expertise and experience of women and men living with HIV/AIDS

- **Listen** to, and support, organizations of women living with HIV/AIDS and associated support networks. Respond to suggested HIV policies and recommendations on strategies, campaigns and laws addressing HIV/AIDS. Ensure that funding is made available to this end.
- **Support** actively the principle of greater involvement of people living with HIV in the development and implementation of anti-HIV programs including in education, outreach, prevention and service provision.

Address violence against women in the home, in the community

- **Promote a** culture of opposition to all forms of violence against women (VAW) and girls, using the media, and involving men in addressing gender stereotypes and discriminatory values and norms which increase the risks faced by both women and men.

- **Organize** public education campaigns on the rights of women and girls and encourage the public to bring cases of sexual violence to the police.
- **Provide** counselling services for girls and women who have experienced rape and other sexual violence to address their trauma, and mitigate long-term physical and mental consequences. Where it is needed, ensure the provision of free and accessible post-exposure prophylaxis (PEP) to survivors of rape within 72 hours of the assault.
- **Review** existing sexual offences laws to ensure that they meet international standards and offer adequate protection to women and girls.
- **Recruit** and train more women police officers and women members of the judiciary to increase the number of women able to exercise a professional role in cases of violence against women and girls.
- **Ensure** that all allegations of sexual abuse are treated seriously and properly investigated, including through the use of competent forensic programs.
- **Develop** mechanisms within the investigation and judicial processes to ensure the full protection of victims and witnesses from intimidation and reprisals.
- **Prosecute** men who rape or sexually abuse women or girls and punish those found guilty in line with the seriousness of the crime. Ensure that courts make it clear that sexual violence is always unacceptable
- **Ensure** that women who are at greater risk of violence, such as women known to be living in violent relationships and women who may face sexual violence in their work, such as sex workers, are adequately protected.

Address violence against women during armed conflict

Military forces

- **Ensure** that military forces are aware of relevant international standards governing the conduct of hostilities, such as the Geneva conventions, and that they are given

particular instruction on the prohibition against gender-based violence.

- **Undertake** gender-sensitive training of members of all armed forces, in all ranks, to ensure that they do not commit, condone or acquiesce in acts of sexual violence including rape.
- **Hold** military commanders accountable for full investigation of allegations of sexual abuse by their personnel, make public the outcome of investigations, and ensure that appropriate reparations are provided to survivors.
- **Prosecute** combatants alleged to be responsible for such abuses and bring to justice those found guilty in line with the gravity of the crime.

Stop supporting armed groups responsible for violence against women

- **Condemn** publicly all forms of violence against women committed by such armed groups.
- **End** the provision of any logistical, financial or military assistance to governments or armed groups responsible for violence against women and use their influence over armed groups to stop further abuses.

Prevent violence by UN peace-keeping forces

- Take all necessary measures to ensure that all allegations of sexual violence by civilian or military UN personnel are investigated and sanctioned, and that reparations are made to the victims.
- Ensure that UN personnel are trained and operate in compliance with the evolving UN standards and international human rights principles

Fight stigma and discrimination

Ratify and implement core human rights treaties to protect all citizens including those living with HIV

- **Ratify** the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and its Optional Protocol and other core instruments.
- **Ensure** that policies, programmes and laws are compatible with the UNAIDS guidelines

on HIV/AIDS and human rights. HIV should not be used as an excuse to restrict rights such as the right to marry and establish a family.

Address women's poverty and lack of economic independence and strengthen women's rights

- **Ensure** poverty reduction strategies address economic and social discrimination against women which undermines the achievement of the underlying determinants of health, impedes the implementation of an effective public health policy and which makes the fight against HIV more difficult.
- **Protect** and promote women's rights to property and to inheritance on the death of a father or male spouse. Undertake legislative and community reform of traditional customs which are harmful to women, such as wife inheritance.
- **Ensure** that measures are taken to end the practice of female genital mutilation. Such measures will include public education; discussion with affected communities; ensuring that adequate health care provision and education is available and legislative reform.
- **Review** marriage laws to ensure that they do not contribute to the violation of girls' rights and do not contribute to exposing them to a higher risk of HIV.

Strengthen education programs for girls and women

- **Promote** girls' education and women's literacy through economic measures to ensure girls stay at school
- **Make** equal access to primary and secondary education for girls a priority.
- **Ensure** that the education curriculum challenges gender stereotypes; support literacy education for adult women.
- **Implement** a program of health education for marginalised women who may not have access to mainstream information.

Prevention, treatment and care

Promote the use of condoms as a protection against HIV

- **Promote** awareness of, education about, and availability of male and female condoms for effective use by both men and women.
- **Increase** access to male and female condoms and the negotiation skills to use them effectively. Subsidise the costs of condoms.
- **Encourage** cheaper production of male and female condoms.

Take steps to improve the sexual and reproductive health of women and men

- **Take steps** to bring about an end to child marriages and coercive marriages or other forms of unequal sexual relationship between young girls and much older men through education, community dialogue and legislative means.
- **Enable** women and men to use condoms within sexual relationships by ensuring their availability and by encouraging men and women to discuss condom use.
- **Ensure** that adolescent girls and women have the knowledge and means to prevent HIV infection through active promotion of basic health information on HIV/AIDS and other STIs, tackling disempowering stereotypes of female behaviour, and increasing women's access to financial support and economic independence
- **Expand** sexual and reproductive health services. Increase training of health-care providers to provide HIV/AIDS treatment and prevention.
- **Involve** women and men living with HIV/AIDS in peer sexual and reproductive health education on HIV.

Ensure funding for a comprehensive approach to HIV/AIDS

- **Ensure** programs focusing on the prevention, treatment, community-based care, and health educational aspects of HIV/AIDS are funded and supported. Initiatives to prevent gender-based violence and to strengthen respect for women's human rights should also be encouraged.

Ensure that the gender dimension of HIV is built into all policies

- **Review** HIV/AIDS policies from a perspective of gender to ensure that all forms of gender discrimination are eliminated and women's human rights are protected and promoted.

Introduce measures to limit the harm done to injecting drug users

- **Increase** awareness of the risks associated with needle-sharing and ensure a harm reduction policy is put in place to protect women and men who use drugs. This could involve ensuring that drug users have access to clean needles and an environment where they can inject safely

Expand voluntary counselling and testing services and protect confidentiality

- **Ensure** universal access to voluntary and confidential counselling and testing for HIV in a form that protects confidentiality, minimises stigma and discrimination and avoids giving rise to gender-based violence.

Support home-based carers

- **Provide** training, counselling, and psychosocial support to home-based carers and volunteers. Protect caregivers who face a heavy burden of looking after family members who are sick or dying from AIDS-related illnesses or children orphaned by AIDS.

International assistance and cooperation

Global funding initiatives on HIV/AIDS

- **Support** the Global Fund to Fight AIDS, Tuberculosis and Malaria by ensuring government contributions match the need.
- **Include** HIV/AIDS projects within the scope of funding by national bilateral aid programs.
- **Bearing** in mind the links between poverty and ill-health, ensure that government commitments to the Millennium Development Goals relating to poverty are met.

The international community

In addition, the international community should:

- **Pressure** all parties to armed conflicts to ensure immediate cessation of sexual violence against women and girls.
- **Halt** all arms transfers and supplies of military, security and police equipment or training, as well as any logistical or financial assistance, to governments or armed groups responsible for violence against women and girls.
- **Provide** strong political and financial support to the Global Fund to Fight AIDS, Tuberculosis and Malaria.
- **Provide** funding and technical support for measures that contribute to the protection and fulfilment of the rights to health, food and education of people living with HIV/AIDS and their families.
- **Alleviate** the debt burden that siphons scarce resources from impoverished countries with transparent and accountable plans for addressing poverty and combating AIDS.
- **Support** the work of local independent media, human rights defenders and activists working to foster a climate in which human rights can flourish.

Web-links

- AIDSLaw Project: <http://www.alp.org.za/>
- Canadian HIV/AIDS legal network: <http://www.aidslaw.ca>
- Global Campaign for Microbicides: <http://www.global-campaign.org/>
- Global Coalition on Women and HIV/AIDS: <http://womenandaids.unaids.org/>
- GNP+: Global Network of People Living with HIV/AIDS: <http://www.gnpplus.net/>
- ICASO: International Council of AIDS Service Organizations: <http://www.icaso.org/>
- International Community of Women Living with HIV/AIDS: <http://www.icw.org/>
- International HIV/AIDS Alliance: <http://www.aidsalliance.org/>
- International Partnership for Microbicides: <http://www.ipm-microbicides.org/>

- Physicians for Human Rights Action on AIDS:
<http://www.phrusa.org/campaigns/aids/index.html>
- UNAIDS: <http://www.unaids.org>
- UNAIDS global reference group on HIV/AIDS and human rights
http://www.unaids.org/en/in+focus/hiv_aids_human_rights/reference+group.asp
- UNIFEM HIV/AIDS program:
<http://www.genderandaids.org/>
- UNFPA: Preventing HIV:
<http://www.unfpa.org/hiv/index.htm>
- WHO HIV/AIDS program:
<http://www.who.int/hiv/en/>

A tool for finding HIV/AIDS organizations internationally by region, country or activity is available at:

<http://www.aidsmap.org/en/orgs/ux/default.asp>