



WOMEN, HIV/AIDS AND HUMAN RIGHTS:

An Annotated Syllabus

(Updated April 2008)

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An Introduction to the Annotated Syllabus

In 2006, the International Reproductive and Sexual Health Law Programme, along with several partner organizations,* hosted a Women, HIV/AIDS and Human Rights Skills Building Workshop Series at the University of Toronto Faculty of Law. The Skills Building Workshop Series, which took place during the XVI International AIDS Conference, was designed to enable participants to frame the neglect and marginalization of women's needs and circumstances in the context of HIV/AIDS as not simply poor health and social policy, but as violations of women's human rights. The Series further addressed collaborative legal and political approaches to hold state and non-state actors accountable for the violation of women's rights in the clinical, health systems and underlying socio-economic contexts.

The Women, HIV/AIDS and Human Rights Syllabus was originally distributed to participants of the Skills Building Workshop Series. It was re-structured and updated in December 2007, and again in April 2008 by Pei Li, a Pro Bono Students Canada volunteer working under the supervision of Fellow Simone Cusack, to reflect developments in reports, articles, and case law. As a project of this nature is always evolving, the Syllabus is not intended to be exhaustive.

Advocacy and educational organizations are encouraged to adopt and adapt these materials for their teaching and skills-building purposes.

* Partner organizations were:

Advancing Gender Equity and Human Rights in the global response to HIV/AIDS (ATHENA)
AIDS Law Project, South Africa
Canadian HIV/AIDS Legal Network, Canada
Center for Reproductive Rights, U.S.A.
Human Rights Watch - Women's Rights Division, U.S.A.
International Council of AIDS Service Organizations
Program on Reproductive and Sexual Health Law, University of the Free State, South Africa

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(1) Overview Articles

Cathi Albertyn, "Using Rights and the Law to Reduce Women's Vulnerability to HIV" (2000) 5(4) *Can. HIV/AIDS Policy Law Rev.* 72.

<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=372>

Cathi Albertyn's paper, an edited and updated version of her presentation at "Putting Third First," argues that both human rights and the law can play an important, if limited, role within a wider set of national and international strategies to reduce women's vulnerability to HIV. It analyzes the nature of women's vulnerability to HIV/AIDS, and highlights some of the issues and lessons in using rights and the law to advance gender equality and reduce women's vulnerability to HIV/AIDS.

Joanna Erdman & Lisa Kelly, "HIV/AIDS and the Women Left Behind" *The Toronto Star* (19 July 2006), p. A15.

http://www.stephenlewisfoundation.org/news_item.cfm?news=1216&year=2006

In this article Joanna Erdman and Lisa Kelly discuss the efforts of Stephen Lewis, the UN Special Envoy for HIV/AIDS in Africa, to create an independent multilateral agency dedicated exclusively to women's human rights. Erdman and Kelly outline some of the ways women are particularly vulnerable to HIV/AIDS and admonish the UN for its failure to thus far put in the necessary resources to protect women's rights and deal with the disproportionate effect of HIV/AIDS on women.

Sofia Gruskin, "Negotiating the Relationship of HIV/AIDS to Reproductive Health and Reproductive Rights" (1994) 44 *Am. U. L. Rev.* 1191.

This article outlines how the HIV/AIDS pandemic is affecting women's human rights and particularly focuses upon the denial of reproductive rights to HIV positive women. The author argues that there exists a gap in ensuring that non-discrimination principles are applied to HIV positive women in order to protect their reproductive rights. The article also reviews developments in international law concerning women's reproductive rights and considerations of human rights and HIV/AIDS. The final section of the article reviews relevant provisions from the Program of Action of the Cairo International Conference on Population and Development for the protection of women's rights.

Mildred Tambudzai Mushunje, "Challenges and Opportunities for Promoting the Girl Child's Rights in the Face of HIV/AIDS" (2006) 14(1) *Gender & Development* 115.

This article explores the gender dimensions of the AIDS pandemic, focusing on its impact on the girl child. It draws on the rights-based approach and argues that the protection and recognition of the rights of the girl child are essential in the face of the AIDS pandemic in Southern Africa. The article also gives insights into some innovative programmes that have been developed in Zimbabwe. Finally it gives recommendations for improving the conditions of, and paving the way for the empowerment of, the girl child.

Alice Welbourn with Joanna Hoare, *HIV and AIDS* (London: Oxfam GB, 2008)

This book takes a look at the key challenges of HIV and AIDS from a gender perspective, and describes positive responses in areas of the world as diverse as Cambodia, South Africa, the UK, and Papua New Guinea.

The impacts of HIV on women and men across the world are devastating and wide-ranging. Girls may have to drop out of school to look after sick relatives, boys to earn money. The death of working-age adults can mean that surviving family members struggle to get by, with grandparents shouldering the burden of looking after orphaned grandchildren, often in dire poverty. Young women may have to resort to sex work, and other risky survival strategies to support themselves and their families. Young men are growing up with ideas about masculinity that include violence and the sexual domination of women, contributing to the spread of HIV.

The contributors analyse these contexts, exploring the links between HIV, AIDS, gender inequality, and poverty. They present accounts of successful interventions, recording experience, describing good practice, and sharing information about resources.

See also:

Julie L. Andreff, "The Power Imbalance Between Men and Women and Its Effects on the Rampant Spread of HIV/AIDS among Women" (2001) 9 *Hum. Rts. Brief* 24.
<http://www.wcl.american.edu/hrbrief/09/1hiv.cfm>

This article examines some of the reasons why women are vulnerable to HIV/AIDS. These reasons include: violations of their economic rights, violations of their political rights, and cultural beliefs, such as the cultural value placed on virginity, fertility and the subservience of women to men in marriage. The article also discusses the role of the international community in protecting women's rights with special attention paid to the UN Commission on the Status of Women and the Convention on the Elimination of all Forms of Discrimination against Women. The article concludes with recommendations to the international community to help ensure the rights of women are protected.

Judith Bruce & Shelley Clark, *Including Married Adolescents in Adolescent Reproductive Health and HIV/AIDS Policy*. Prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents (Geneva: WHO, 2003).
<http://www.popcouncil.org/pdfs/CMImplications.pdf>

This article examines the fact that married adolescent girls are some of those most at risk for HIV infection in Africa, yet are rarely considered in HIV/AIDS policies and programmes. The article begins with a discussion on the traditional omission of married adolescents from policy. The second section outlines reasons why married adolescents are at risk of HIV infection. The third section identifies the policy gap in relation to HIV prevention and married adolescents. The fourth section offers analytical tools for determining the level of urgency in a country for programmes targeting married adolescents. The fifth section examines the vulnerability of married adolescent girls to HIV infection in four countries: Burkina Faso, Zambia, Dominican Republic, and India. The final section offers some policy recommendations for better protecting married adolescent girls from HIV infection.

Center for Reproductive Rights, *HIV/AIDS: Reproductive Rights on the Line* (New York: Center for Reproductive Rights, 2002).
http://www.crlp.org/pdf/bp_HIV_rroline.pdf

This article examines seven key areas where women's rights are at risk in relation to mother-to-child transmission (MTCT) of HIV. The first is that reduction of MTCT of HIV programmes overlook the mother in their attempts to protect the foetus. The second is that women's health

is missing from the debate between breastfeeding and formula feeding by HIV positive mothers. The third is the risk to the right to marry and found a family. The fourth is the right to abortion. The fifth is the danger of coerced abortions. The sixth is the issue of mandatory testing of pregnant women for HIV. The seventh is attack on women's sexuality. The article ends with a brief discussion on the efforts of the international community to protect these rights.

Rebecca J. Cook, "Human Rights, HIV Infection, and Women" in D.C. Jayasuriya, ed., *HIV Law, Ethics and Human Rights – Text and Materials* (New Delhi: UNDP Regional Project on HIV and Development, 1995), pp. 235-270.

Recent court decisions, for instance in South Africa and Latin America, have held states bound to respect and serve HIV/AIDS patients' human rights to indicated and available medical care. HIV/AIDS is estimated to affect over 36 million people worldwide, including 16.4 million women of reproductive age. In the last 20 years, nearly 58 million people have been infected. This article reviews national responses to mounting concern with the HIV/AIDS pandemic, particularly in China, India and Africa, medical professional responses, notably by the World Medical Association, and international guidelines on human rights responses. These pay special attention to patients' rights to be treated without discrimination. It addresses national and international approaches to advancing HIV prevention, treatment and research on which UNAIDS and the UN High Commissioner for Human Rights have collaborated. Special issues in clinical care concern abortion services for HIV-positive women, breastfeeding and patients' involvement in research.

Human Rights Watch, *A Dose of Reality: Women's Rights in the Fight against HIV/AIDS* (New York: Human Rights Watch: 2003).

http://hrw.org/english/docs/2005/03/21/africa10357_txt.htm

This article discusses how certain chronic abuses of women's human rights compound the problem of HIV/AIDS. The abuses discussed are domestic violence, violations of women's property and inheritance rights, bride price, widow inheritance, ritual sexual "cleansing", and the sexual abuse of girls. The article then considers how traditional HIV/AIDS prevention programmes are insensitive to women's human concerns. The article concludes with a call to governments and international organizations to put in place concrete protections of women and girls' rights to prevent the violations that fuel the spread of HIV and makes concrete recommendations to both groups.

Human Rights Watch, *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda* (New York: Human Rights Watch, 2003).

<http://www.hrw.org/reports/2003/uganda0803/>

This article details the connections between domestic violence and HIV/AIDS using Uganda as a case study. The article begins with a summary of the issue before moving on to recommendations to both the Ugandan Government and international organizations. The article then gives some background information on the issue including politics and law in Uganda, the history of HIV/AIDS in Uganda, and domestic violence and the position of women in Uganda. The main section of the article specifically outlines the connections between HIV/AIDS and domestic violence. Some of the topics in this section include: economic dependence, tradition, and polygamy. The last two sections of this article discuss what Uganda's response to HIV/AIDS and to domestic violence have been and what their obligations are under international law.

Jonathan Mann *et al.* "Health and Human Rights" (1994) 1 *Health Hum. Rights* 7.

Health and human rights are complementary approaches for defining and advancing human well-being. This article presents a three-part provisional framework for exploring potential collaboration in health and human rights. The first relationship involves the impact (positive and negative) of health policies, programs and practices on human rights; the goal is to negotiate an optimal balance between public health goals and human rights norms. The second relationship posits that violations of rights have important health effects, thus far generally unrecognized, that must be described and assessed. The third and most fundamental relationship proposes that promotion and protection of health are inextricably linked to promotion and protection of human rights and dignity. The interdependence of health and human rights has substantial conceptual and practical implications. Research, teaching, field experience and advocacy are required to explore this intersection. This work can help revitalize the health field, contribute to enriching human rights thinking and practice, and offer new avenues for understanding and advancing human well-being in the modern world.

Open Society Institute, "HIV/AIDS and Human Rights" in *Health and Human Rights: A Resource Guide for the Open Society Institute and Soros Foundations Network* (New York: Open Society Institute, 2007), pp. 2-i.

This chapter introduces key issues and resources in HIV/AIDS and human rights. It addresses six key questions: how is HIV/AIDS a human rights issue? What is Open Society Institute's work in the area? Which are the most relevant international and regional human rights standards related to HIV/AIDS? What are some examples of effective human rights programming in this area? And finally, what are the key terms related to HIV/AIDS and human rights? The chapter also addresses how a human rights approach can be used to address the link between HIV/AIDS and tuberculosis. A bibliography of additional resources on HIV/AIDS and human rights is included for further reference.

Wendy Patten & Andrew Ward, "Empowering Women to Stop AIDS in Côte d'Ivoire and Uganda" (1993) 6 *Harv. Hum. Rts. J.* 210.

In this article the authors discuss how violations of women's human rights in Uganda and Côte d'Ivoire make women more vulnerable to HIV infection and prevent them from adequately caring for themselves after they are infected. They examine how the dual system of law in these countries often works to the disadvantage of women because even if there is some protection of women's rights under the formal law, many women are only aware of customary law and thus do not know their rights. The authors outline a number of cultural practices that increase women's vulnerability to HIV including: polygamy, wife inheritance, female genital cutting, and the belief that having sex with a virgin will "cleanse" you of HIV. They also discuss how discriminatory laws such as those surrounding property, inheritance, and the availability of credit for women can cause women to be financially dependant on men and thus not able to negotiate for safe sex. Finally, the authors make suggestions for how women's vulnerability to HIV could be lessened such as: better enforcement of existing laws, more protection of women under formal laws, better respect for the social and economic rights of women, and grassroots legal education.

Dingie van Rensburg *et al.*, "Strengthening Local Government and Civic Responses to the HIV/AIDS Epidemic in South Africa" (Ford Foundation, Centre for Health Systems Research & Development, 2002).

The aim of this study is to inform the expansion of the *Sexual and Reproductive Health Programme* of the Ford Foundation in South Africa. The research generates new information and systematises existing knowledge on HIV/AIDS in South Africa. The focus remains on local government and civil society, serving as a source and resource for general use by those who are grappling with the complexities involved in dealing with the epidemic. Topics discussed include the social landscape of sexual and reproductive health, policies since the advent of the epidemic, public and private funding, the strengths and weaknesses of prevailing strategies and initiatives, case studies and key recommendations.

(2) Sex, Gender & Social Context in the HIV/AIDS Pandemic

(a) Stigma, Discrimination, and Violence

Asia Pacific Network of People Living with HIV/AIDS, *AIDS Discrimination in Asia* (APN+, 2004), pp. v, 1-4, 13-25.

<http://www.gnpplus.net/regions/files/AIDS-asia.pdf>

From July 2001 to November 2002, the Asia Pacific Network of People Living with HIV/AIDS (APN+) conducted the first regional documentation of AIDS-related discrimination in Asia. The project is an action-based, peer-led study that aimed to develop an understanding of the nature, pattern and extent of AIDS-related discrimination in several Asian countries. The project was designed and implemented by people living with HIV (positive people) and received ethical approval and funding from UNAIDS. Age and educational background do not influence the level of discrimination faced by positive people but sex, state of health, marital status and the level of choice one has in testing do. Women are significantly more likely than men to experience discrimination within the family and the community because of their HIV status, including ridicule, harassment and physical assault and being forced to change their place of residence.

Scott Burris, "Stigma and the Law" (2006) 367 *Lancet* 529.

There are three broad areas where law affects the operation of stigma in society. Law can be a means of preventing or remedying the enactment of stigma as violence, discrimination, or other harm; it can be a medium through which stigma is created, enforced, or disputed; and it can play a role in structuring individual resistance to stigma. For the individual with a stigmatised health condition, acceptance of society's views and self-stigmatisation may lead to concealment to avoid discrimination. But an anti-stigma activism is also possible. For many stigmatised diseases (epilepsy, for example), the consequences of concealment may often be more severe than those of resistance. In both cases the individual faces status loss and discrimination, but, depending on the nature and incidence of enacted stigma, people who adopt resistance strategies may actually face less stigma, experience less social harm, and be better able to cope with any discrimination. At the same time they avoid the life-long hidden distress and unhappiness experienced by people who conceal.

Theodore de Bruyn, "HIV-Related Stigma and Discrimination - The Epidemic Continues" (2002) 7(1) *Can. HIV/AIDS Policy Law Rev.* 8.

<http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter.htm>

This article is one of a series commissioned to mark the tenth anniversary of the Canadian HIV/AIDS Legal Network, discussing past developments and future directions in areas of policy and law related to HIV/AIDS. It looks at HIV-related stigma and discrimination. The article summarizes the present situation as described in reports from numerous countries throughout the world. It reviews the institutional, non-institutional, and structural dimensions of HIV-related discrimination. It also identifies some essential components of anti-discrimination efforts: legal protection; public, workplace, and health-care programs; community mobilization; and, strategizing on the determinants of health.

Viva C. Thorsen et al., "Potential Initiators of HIV-Related Stigmatization: Ethical and Programmatic Challenges for PMTCT Programs" (2008) 8(1) *Developing World Bioethics* 43.

HIV/AIDS continues to constitute a serious threat to the social and physical wellbeing of African mothers and their babies. In the hardest hit countries of sub-Saharan Africa, more than 60% of all new HIV infections are occurring in women, infants and young children. Mother-to-child transmission (MTCT) constitutes 90% of new HIV infections among infants and young children. Most of these infections can be prevented. However, the social stigma of HIV/AIDS insidiously continues to undermine the success of prevention programs. Ironically, some attributes or characteristics of prevention of mother-to-child transmission (PMTCT) programs may in fact serve as catalysts to the stigmatization process. This paper identifies and discusses six potential initiators: (1) Routine HIV testing, (2) Six months exclusive breastfeeding, (3) Incentives, (4) Home visits, (5) Location of PMTCT program, and (6) PMTCT terminology. In all these areas, there are practical strategies that may be applied to reduce the chances of being stigmatized. These strategies are introduced and discussed.

WHO, "HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes for Women" (Geneva: WHO, 2004).

http://www.who.int/gender/documents/en/VCTinformationsheet_%5b92%20KB%5d.pdf

Full report: <http://www.who.int/gender/documents/en/genderdimensions.pdf>

This information sheet summarizes some of the key findings of a new WHO document *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes*. It synthesizes current information available on HIV status disclosure to sexual partners in terms of rates, barriers, and outcomes among women. The full paper also addresses research gaps, and programmatic and policy strategies that have been adopted to overcome these barriers and support individuals through the disclosure process.

See also:

Virginia Bond et al., "Stigma, HIV/AIDS and Prevention of Mother-to-Child Transmission in Zambia" (2002) 25 *Evaluation and Program Planning* 347.

This report evaluates the extent of perceived and enacted HIV/AIDS-related stigma in a rural setting in Zambia. Stigmatisation is abundant, ranging from subtle actions to the most extreme degradation, rejection and abandonment. Women with HIV and pregnant women assumed to be HIV positive are repeatedly subjected to extensive forms of stigma, particularly once they become sick or if their child dies. Despite increasing access to prevention of mother to child

transmission initiatives, including anti-retroviral drugs, the perceived disincentives of HIV testing, particularly for women, largely outweigh the potential gains from available treatments. HIV/AIDS related stigma drives the epidemic underground and is one of the main reasons that people do not wish to know their HIV status. Unless efforts to reduce stigma are, as one peer educator put it, “written in large letters in any HIV/AIDS campaign rather than small”, stigma will remain a major barrier to curbing the HIV/AIDS pandemic.

Scott Burris, "Law as a Structural Factor in the Spread of Communicable Disease" (1999) 36 *Hous. L. Rev.* 1755.

For most of the past century, the prevalence of communicable disease was in decline throughout the developed world. In any event, citizens and policy makers are once again paying attention to infectious disease. Drawing on the epidemiological literature addressing the causes of illness in the social and physical environment, I will suggest that infectious diseases are themselves symptomatic of deeper maladies. On this view, infectious disease is merely another mechanism by which social and material inequalities take a disproportionate toll on the relatively poor within countries and across the world. This article discusses the implications of this “structural analysis” of infectious disease for public health law and identifies four questions for future research and action: what legal structures can be linked to infectious diseases in the population? Through what mechanisms do legal structures matter and how can we intervene? How may we effectively make the case for intervention in a culture unfamiliar with structural analyses? And finally, how do we measure the success of structural changes in complex social processes? Practical disease control efforts traditionally approached the problem of disease at multiple levels – from the microbe, through human behaviour, to environmental factors. With regard to prevention of infection, the rights of women and girls to the highest attainable standard of physical and mental health, to education, to freedom of expression, and to freely receive and impart information, should be applied to include equal access to HIV-related information, education, means of prevention, and health services.

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

<http://hrw.org/reports/2004/dr0704/>

This article examines the growing HIV/AIDS epidemic in the Dominican Republic. While the Dominican Republic’s government has taken steps to slow the spread of HIV/AIDS, it has not taken seriously the link between sex inequality and HIV infection. As a result of this failure the HIV/AIDS prevention policies in the Dominican Republic often fail to protect women and in some cases actually contribute to the violations of women’s human rights. This article focuses on discrimination against women in the workplace and discrimination in the administration of public health care. In the workplace women are often subject to mandatory HIV testing which violates their right to nondiscrimination in finding work. In the health care sector women’s sexual and reproductive health care needs are often grossly under funded, women’s HIV test results are not always confidential, decisions are made about women’s health without their consent, and women are abused and coerced by health care personnel. This article contains recommendations to the government of the Dominican Republic and to NGOs to better protect women’s human rights and thus help curb the spread of AIDS.

Miriam Maluwa *et al.*, "HIV and AIDS-Related Stigma, Discrimination, and Human Rights" (2002) 6 *Health Hum. Rights* 1.

Against the backdrop of the developing global epidemics of HIV and AIDS, demands have been made for a radical scaling up of the international response. Central among the steps that need to be urgently taken are efforts to combat stigma and discrimination. This article offers a conceptual overview of the relationship between the stigma associated with HIV and AIDS and discrimination and human rights, with the goal of demonstrating the interconnectedness of these concerns and describing elements of a future, and potentially more effective, programmatic response.

Physicians for Human Rights, "Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland – An Evidence-Based Report on the Effects of Gender Inequality, Stigma and Discrimination" (Cambridge, MA: Physicians for Human Rights, 2007).
<http://physiciansforhumanrights.org/library/documents/reports/botswana-swaziland-report.pdf>

This report describes the effects of gender inequality, stigma and discrimination on the HIV/AIDS pandemic in Botswana and Swaziland, the two countries with the highest HIV prevalence in the world. Despite their distinct demographic and policy profiles, the epidemic in Botswana and Swaziland exemplifies many of the key dimensions of the pandemic that is ravaging the southern African region: an infection primarily transmitted through sexual practices rooted in women's disempowerment and lack of human rights and facilitated by poverty and food insufficiency. Using population-based studies in each country, PHR found four key factors contributing to women's vulnerability to HIV: lack of control over sexual decision making, persistent HIV-related stigma and discrimination, gender-discriminatory beliefs held by the majority, and the failure of leadership to demonstrate the will and allocate the resources to prioritize and implement actions to promote the equality, autonomy and economic independence of women and people living with HIV/AIDS.

(b) Gender, Sexuality, and HIV/AIDS

Jonathan Berger, "Re-Sexualising the Epidemic: Desire, Risk and HIV Prevention" (2004) 5 *Development Update* 4.
<http://www.eldis.org/static/DOC18515.htm>

Even in the 'era of treatment' successful HIV prevention remains an enormous challenge. In this article Jonathan Berger argues that there is a need to pay more attention to sex and desire in the design of HIV prevention programmes and to move away from stereotyped explanations of vulnerability that ignore agency and desire in the decisions that people make about sex. The article also warns against the continued marginalisation of people who engage in 'dirty sex' from access to HIV prevention programmes and services.

Rhadhika Chandiramani, "Sexual Health and Rights in India" in Wendy Chavkin & Ellen Chesler, eds., *Where Human Rights Begin* (Piscataway NJ: Rutgers Univ. Press, 2005) 127, pp. 132-137.

This section of Chandiramani's article discusses how the taboos in Indian Culture that surround sex make young people particularly vulnerable to HIV infection. The section also examines AIDS in India in general including when the first cases appeared and how HIV/AIDS is perceived in India. It also briefly discusses HIV/AIDS case law in India with attention paid to the

court ruling that suspended the right of HIV positive people to marry, which was later overturned.

L.M. Kelly, "Polygyny & HIV/AIDS: A Health and Human Rights Approach" (2006) 31(1) *Journal of Juridical Science*, pp. 1-12, 32-33.

Concurrent sexual networks have been identified in empirical studies as significantly amplifying rates of HIV transmission in comparison to sequential monogamy or sporadic sexual encounters. This paper examines how states' legal condonation of discriminatory, high-risk concurrent sexual networks, including polygyny, violates women's human rights and undermines their sexual and reproductive health. Because of its gender asymmetry and aggravation of marital inequality, polygyny places women at a greater risk of HIV infection and restricts their ability to insist on partner fidelity, negotiate condom use and leave high-risk relationships. The continued legal recognition of polygyny at the point of marriage formation by the majority of southern African states violates women's equality, health, and dignity rights. This paper stresses states' international obligations to cease deferring to parallel legal systems that perpetuate inequality within marriage and family life. In moving to discourage polygyny, this paper posits an engagement approach that would continue to protect women's rights within existing unions while discouraging the practice at the point of marriage formation. Going forward, HIV prevention programmes can provide useful fora to advance social justice and equality within marriage and intimate relationships when they are evidence-based and respond to the diverse realities of women's lived sexual and marital experiences. Programmes that address social constructions of gender and sexuality will likely prove the most effective in discouraging polygyny and advancing transformative gender equality.

Alice M. Miller & Carol S. Vance, "Sexuality, Human Rights, and Health" (2004) 7(2) *Health Hum. Rights* 5.

This article examines the connections between health, sexuality and human rights and the problems that result from their intersection. The authors argue that without examining health and human rights with respect for sexual traditions and sexual rights, efforts to improve health could be ineffectual or even further infringe on women's rights. The authors identify three specific issues that are in need of more attention. These issues are sexual hierarchy, enthusiasm among advocates for regulation, and representation and innocence. The authors conclude by calling for increased examination of sexuality across all cultures and ages so that it can be better understood and incorporated into health and human rights struggles.

See also:

Marge Berer, "HIV/AIDS, Sexual and Reproductive Health: Intimately Related" (2003) 11(22) *Reproductive Health Matters* 6.

This article suggests some reasons why HIV/AIDS advocates and sexual and reproductive health advocates did not come together in their campaigns despite the links between HIV and reproductive rights. It then discusses a few examples of how they have come together in recent years despite the extremely limited attention and funding sexual and reproductive rights have received the last decade or so. There are, however, many sexual and reproductive rights issues that impact HIV/AIDS that are not receiving adequate attention. This article also discusses some of the stereotypes that surround sex and compound the problem of HIV/AIDS. These stereotypes are perpetrated by both traditional organizations and influences as well as feminist movements. Berer calls for greater understanding of sexual relationships so that effective

programs to limit transmission are possible and a greater focus is placed on the socio-economic factors that lead to HIV vulnerability.

Marge Berer, "Sexuality, Rights and Social Justice" (2004) 12(23) *Reproductive Health Matters* 6.

This article attempts to develop a better understanding of the term "sexual rights." Berer provides an overview of some of the ways sexual rights can and are violated around the world and concludes that sexual rights are in no way comprehensively protected for either men or women, though women are often more vulnerable to abuses. She points out the sexual rights violations of homosexual and transgendered people as well as those who choose to participate in sexual activities that are marginalized and often viewed as immoral, such as sadomasochism. This article also contains possible suggestions for improving sexual rights.

Sylvia Chirawu, "Till Death Do Us Part: Marriage, HIV/AIDS and the Law in Zimbabwe" (2006) 13 *Cardozo J.L. & Gender* 23.

This paper discusses the different laws governing marriage, adultery, condom use, lobola or bride price, virginity testing, pregnancy, menstruation and dry sex in the context of gender equity and protecting married women from HIV/AIDS infection. For women who are in an unregistered customary law union, courts have extended the recognition by allowing men in such unions to sue any man who has a relationship with their 'wife' for adultery. This policy places blame for adultery and consequently HIV/AIDS infection squarely at the door of the wife. Women who want to use condoms often keep silent rather than upset their sexual partner, who may be the only source of food and shelter for themselves and their children. This passivity in sexual matters is a major contributory factor to married women getting infected with HIV/AIDS within marriage.

Gary Dowsett, "Some Considerations on Sexuality and Gender in the Context of AIDS" (2003) 11 *Reproductive Health Matters* 21.

Gender has become a major conceptual tool for understanding the evolving HIV pandemic globally. As such, it has provided a powerful way to see the structure of relations between men and women as central to various epidemics, and added weight to our understanding of HIV infection as not simply an individual experience of disease. Yet, as a concept, gender has its blind spots. This paper argues that there are four issues central to our understanding of how the HIV pandemic moves and develops that are not necessarily best understood through an analysis that uses gender alone, namely: women's vulnerability, men's culpability, young people's sexual interests and marginalised sexual cultures. The paper proposes using sexuality as a framework for analysing these issues and seeks to utilise developments in critical sexuality research to add to gender as a way to increase the capacity to respond to the HIV/AIDS crisis.

T. Frasca, "Men and Women - Still Far Apart on HIV/AIDS" (2003) 11 *Reproductive Health Matters* 12.

What could be more logical than a gay-feminist alliance to respond to the AIDS epidemic in Latin America? However, drawing on published articles and the author's experience in HIV/AIDS work in Chile, this paper argues that such an alliance is more rhetorical than real. Instead, both groups tend to stick to their respective niches and view the epidemic through the prism of the particular needs and concerns of their target constituencies, rather than learn from and support each other. Feminist rhetoric sometimes suggests that AIDS is a problem only

because it affects women. The African paradigm of vulnerable women is inexactly applied, given the predominantly male and homosexual nature of the epidemic in most Latin American countries. Both women and homosexually active men are highly vulnerable to HIV infection, and little is gained by competing for the top slot on the "tragedy honour roll". Latin American gay men's groups, torn between AIDS and gay rights activism, often resist both protagonism by women and women's issues. Although the fight for access to antiretroviral treatment has obscured this conflict, it resurfaces in associations of HIV-positive people and may increase along with heterosexual transmission in the region. Discussion and exchanges should be encouraged to overcome these largely hidden divisions.

Nancy Goldstein, "Lesbians and the Medical Profession: HIV/AIDS and the Pursuit of Visibility" in Nancy Goldstein and Jennifer L. Manlowe, eds., *The Gender Politics of HIV/AIDS in Women* (New York: New York University Press, 1997), pp. 86-112.

In this chapter, Goldstein discusses standard AIDS medical discourse that traditionally represents both self-identified lesbians and women who have sex with women as no-risk or low-risk groups for HIV infection. She contends that the myth of lesbian immunity is disseminated in an information vacuum that has no substantial basis in medical research at its core and has been constituted by a tendency to confuse sexual identity and behaviour. Goldstein discusses the failures of the Centres for Disease Control and Prevention in compiling national surveillance data on persons infected with HIV, including female-to-female transmission as a risk-exposure category in their AIDS case-reporting protocol, and their inability to define 'lesbian' in a reasonable manner. Systemic issues involving health care access and treatment for lesbians are also discussed.

Geeta Rao Gupta, "Gender Sexuality and HIV/AIDS: The What, the Why, and the How" (2000) 5 *Can. HIV/AIDS Policy Law Rev.* 86.
<http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter.htm>

The focus of Geeta Rao Gupta's plenary presentation of 12 July 2000 at the XIII International AIDS Conference is on the what, why, and how of gender, sexuality, and HIV/AIDS. Dr Rao Gupta discusses the factors associated with women's vulnerability to HIV and the ways in which unequal power balance in gender relations increases not only women's, but also men's, vulnerability to HIV – despite, or rather because of, their greater power. She then addresses the question of how one is to overcome the seemingly insurmountable barriers of gender and sexual inequality. How can we change the cultural norms that create damaging, even fatal, gender disparities and roles? According to Dr Rao Gupta, an important first step is to recognize, understand, and publicly discuss the ways in which the power imbalance in gender and sexuality fuels the epidemic. She provides examples of sensitive, transformative, and empowering approaches to gender and sexuality and concludes that, in the final analysis, reducing the imbalance in power between women and men requires policies that are designed to empower women – policies that aim to decrease the gender gap in education, improve women's access to economic resources, increase women's political participation, and protect women from violence.

Alice Miller, "Sexual But Not Reproductive: Exploring the Junction and Disjunction of Sexual and Reproductive Rights (2000) 4(2) *Health Hum. Rights* 68.

Although the term "sexual rights" has gained widespread currency, its concrete scope and content have not yet been fully defined. The need for definition is critical not only for promoting governmental accountability but also for ensuring that sexual rights can be claimed by diverse

persons around the world. Ironically, the concept of “sexual and reproductive rights” poses a challenge to this effort; practices and people not traditionally addressed by reproductive rights work must be explicitly named and protected. This article considers how international norms have contributed to a gendered regulation of sexuality and of contemporary theories of “socially constructed sexuality,” and it proposes a focus on the conditions that contribute to the ability to choose and on the links between sexuality, conduct, identity, social structures, and reproduction. Given the probable politically charged responses, global coalition- building is needed.

Martina Morris & Mirjam Kretschmar, “Concurrent Partnerships and the Spread of HIV” (1997) 11 *AIDS* 641.

The purpose of this article is to examine how concurrent partnerships amplify the rate of HIV spread, using methods that can be supported by feasible data collection. Concurrent partnerships exponentially increase the number of infected individuals and the growth rate of the epidemic during its initial phase. The primary cause of this amplification is the growth in the number of people connected in the network at any point in time: the size of the largest ‘component’. Concurrency increases the size of this component, and the result is that the infectious agent is no longer trapped in a monogamous partnership after transmission occurs, but can spread immediately beyond this partnership to infect others. Concurrent partnerships may be as important as multiple partners or cofactor infections in amplifying the spread of HIV. The public health implications are that data must be collected properly to measure the levels of concurrency in a population, and that messages promoting ‘one partner at a time’ are as important as messages promoting fewer partners.

Jennifer Oriel, “Sexual Pleasure as a Human Right: Harmful or Helpful to Women in the Context of HIV/AIDS?” (2005) 28 *Women's Studies International Forum* 392.

Sexual rights advocates recommend that sexual pleasure should be recognised as a human right. However, the construction of sexuality as gender-neutral in sexual rights literature conceals how men's demand for sexual pleasure often reinforces the subordination of women. In the context of HIV/AIDS, men's belief that they have a right to use women for sexual pleasure is a recognised as a cross-cultural barrier to effective HIV prevention. Research on sexuality from the fields of feminism, political science, public health, and HIV/AIDS reveals that violence against women is fundamental to the construction of masculinity. This violence is manifested through rape, sexual coercion, sexual objectification, and prostitution. By challenging the forms of sexuality and sexual pleasure that reinforce masculinity, it may be possible to imagine sexual rights that are based on sexual equality. In this article, I suggest that a new model for sexual rights that simultaneously provides women with greater sexual pleasure and lessens the risk of HIV transmission is possible.

(c) Criminality and HIV/AIDS

Carol Beth Barnett, “The Forgotten and Neglected: Pregnant Women and Women of Childrearing Age in the Context of the AIDS epidemic” (1993) 21 *Golden Gate U. L. Rev.* 863, pp. 885-893.

This article discusses state control of HIV-positive women during pregnancy. The first part of the article is a general overview of demographics of women infected with HIV, the relation of HIV to substance abuse, and the number of children born with HIV. The second part compares the attack on pregnant women who abuse drugs with the attack on pregnant women who are HIV

positive and shows how the idea of protecting the fetus has led certain states to attempts to criminalize certain activities during pregnancy. The third part focuses on issues surrounding women's reproductive rights and HIV, specifically HIV screening and counselling, access to abortion, and coerced abortion or sterilization. The author concludes by calling on the state to expand women's reproductive choices, not to try to limit them by force, coercion or law.

Mary Anne Bobinski, "Women and HIV: A Gender-Based Analysis of a Disease and its Legal Regulation" (1994) 3 *Tex. J. Women & L.* pp. 7, 35-45.

This section of Bobinski's article examines the criminal regulation in the area of transmission of HIV from a gender sensitive perspective. In particular this section asks whether the indemnification of behavior for criminalization is tainted by gender bias, whether the use of criminalization is appropriate to prevent mother-to-child transmission of HIV, and whether criminalization can help protect women from infection. Bobinski discusses criminal regulations on transmission of HIV with reference to the fact that men are much more efficient transmitters of the virus than women are and finds that the criminal law punished activities equally that are vastly dissimilar in risk. She also concludes that criminal regulation of mother-to-child transmission is unlikely because of issues of intent, constitutionality, the legal status of the fetus and the social and medical objectives of preventing mother-to-child transmission. Finally, Bobinski discusses the defence of consent in transmission prosecutions in relation to the powerlessness and lack of choice many women have in sexual relationships. She concludes that the issue of consent raises more questions than answers.

See also:

Scott Burris *et al.*, "Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial" (2007) 39 *Arizona State Law Journal* 467.

All states have criminal laws that can be used to punish sexual behaviours that pose some risk of HIV transmission; half have HIV-specific laws criminalizing sexual contact by people with HIV unless they abstain from unsafe sex, or disclose their HIV status and obtain consent from their partners. Whether these laws influence behaviour is unknown. This study tests the null hypothesis that differences in law and beliefs about the law do not influence condom use in anal or vaginal sex. People at elevated risk were interviewed in both Chicago and New York. Results show that people who lived in a state with a criminal law explicitly regulating sexual behaviour of the HIV-infected were little different in their self-reported sexual behaviour from people in a state without such a law. Our data did not support the proposition that passing a law prohibiting unsafe sex or requiring disclosure of infection influences people's normative beliefs about risky sex. Criminal law is not a clearly useful intervention for promoting disclosure by HIV-positive people to their sex partner. Given concerns about possible negative effects of criminal law, such as stigmatization or reluctance to cooperate with health authorities, our findings suggest caution in deploying criminal law as a behaviour change intervention for seropositives.

Larry Gostin, *The AIDS Pandemic: Complacency, Injustice, and Unfulfilled Expectations* (Chapel Hill: University of North Carolina Press, 2004), pp. 195-7.

This section looks at using criminal law as a tool for preventing the spread of HIV/AIDS. Gostin begins by discussing circumstances in which the use of criminal sanctions related to the transmission of HIV/AIDS is justified, such as when a person intentionally exposes another person to HIV in order to harm them. Gostin argues that in the vast majority of cases criminal sanctions are unlikely to deter risk behaviour and, even if they could deter some risk behaviour,

they would probably be unnecessarily intrusive and discriminatory. When there is low risk behaviour and no intention to harm there seems little use for criminal law. Gostin even suggests that criminal prohibitions might deter people from getting tested and thus aid in the spread of the virus. Therefore, he concludes that generalized criminal sanctions are not helpful in the fight against HIV/AIDS.

Lawyers Collective, India (HIV/AIDS Unit), *The Criminalisation of Lives* (Newsletter #7, 2000).
http://www.lawyerscollective.org/lc_hivaids/publications/newsletters

This article examines some of the criminal laws in India that have a negative effect on the fight against HIV/AIDS. The first is the Intervenes Drug Use and the Narcotic Drugs and Psychotropic Substances Act which strictly prohibits the trafficking, use or possession of narcotic drugs. This law results in the violation of the rights of narcotic drug users while doing very little to stop the traffickers of these drugs. It has changed drug use patterns in India to more HIV-risky behaviour. The second law examined is the Sex Work and Immoral (Traffic) Prevention Act. This does not criminalize sex work itself but criminalizes activities that surround sex work. It has been abused to further oppress, marginalize and victimize sex workers, which makes them more vulnerable to HIV infection. The last law considered is the criminal prohibition on "sexual intercourse against the order of nature" which has been used to persecute homosexual intercourse. It has lead to unsafe homosexual sexual behaviour which puts gay men at further risk for HIV infection. The article also briefly examines a decision by the High Court of Guwahati calling for greater state measures to help prevent HIV infection and treat HIV/AIDS.

Richard Pearshouse, "Legislation Contagion: The Spread of Problematic New HIV Laws in Western Africa" (2007) 12 (2/3) *HIV/AIDS Policy & Law Review* 5.

Modern legislation can be a useful tool for fighting HIV/AIDS, but only if it is based on sound human rights principles. In 2004, AWARE-HIVAIDS prepared a model law on HIV for use in Western Africa. Several countries in the region have already drafted national laws based on the model law. In this article, Richard Pearshouse reviews some of the key provisions in the model law, identifying a number of human rights concerns that should be addressed before such legislation should be considered as a model to be implemented by national legislatures.

(d) Sex Trade Work

Khabir Ahmad, "Call for Decriminalization of Prostitution in Asia" (2001) 358 *Lancet* 643.

This article briefly discusses Gilles Pomerol, the WHO western pacific regional advisor on HIV/AIDS and sexually transmitted infections, and the call for decriminalization of prostitution in Asia to help prevent the spread of HIV as well as the WHO report entitled "Sex Work in Asia." The criminalization of prostitution makes it difficult to give out condoms and relay information on safe sex practices to prostitutes. There is evidence that despite criminalization sex work is a thriving industry in Asia and that HIV/AIDS is spreading quickly among sex workers and from them to the wider population.

Chris Beyrer, "Shan Women and Girls and the Sex Industry in Southeast Asia: Political Causes and Human Rights Implications" (2001) 53 *Social Science & Medicine* 543.

The human rights abuses which occur during civil conflicts pose special threats to the health and lives of women. These can include rape, sexual violence, increased vulnerability to trafficking into prostitution, and exposure to HIV infection. The long-standing civil conflict in the

Shan States of Burma is investigated as a contributing cause to the trafficking of ethnic Shan women and girls into the Southeast Asian sex industry, and to the subsequent high rates of HIV infection found among these women. The context of chronic human rights abuses in the Shan states is explored, as well as the effects of recent forced population transfers on the part of the Burmese Military Regime. Rights abuses specific to trafficked women may further increase their vulnerability to HIV and other STDs. The need for a political resolution to the crisis in Burma is discussed, as are approaches aimed at preventing trafficking, empowering women already in the sex industry, and reducing the risks of HIV and other STDs among these women and girls.

Joanna Busza, "Having the Rug Pulled from under your Feet: One Project's Experience of the US Policy Reversal on Sex Work" (2006) 21(4) *Health Policy and Planning* 329.

After the election of President George W Bush in 2000, US government policy toward sexual and reproductive health changed dramatically. In May 2003, the Global AIDS Act was passed. It prohibits allocation of US government funds to organizations that 'promote or advocate' legalization and practice of prostitution and sex trafficking. There are few documented examples of early impacts of this policy reversal on USAID-funded programmes already working with sex worker communities. This paper offers an anecdotal account of one programme in Cambodia that found itself caught in the ideological cross-fire of US politics, and describes consequent negative effects on the project's ability to offer appropriate and effective HIV prevention services to vulnerable migrant sex workers.

Central and Eastern Europe Harm Reduction Network, *Sex Work, HIV/AIDS, and Human Rights in Central and Eastern Europe and Central Asia* (Vilnius: Central and Eastern European Harm Reduction Network, 2005), pp. 31-41.

http://www.soros.org/initiatives/health/focus/sharp/articles_publications/publications/sexwork_20051018

In Central and Eastern Europe and Central Asia, sex workers remain among the most marginalized members of society. Policymakers and authorities view them as nuisances to be ignored or immoral lawbreakers rather than as individuals who can and should be protected from violence and receive social and economic assistance and support. At the same time, the surging HIV/AIDS epidemic in the region places sex workers at increasingly greater risk of infection not only from HIV, but also from other potentially debilitating conditions related to sex work and drug use. This report provides an overview of these and other issues that sex workers face in the region as well as the political, economic, and social factors that influence policies and attitudes toward sex workers. It focuses primarily on existing laws and policies and their consequences from the perspective of HIV prevention and treatment. The report also offers recommendations designed to uphold sex workers' human rights and remove barriers that reduce their ability or willingness to obtain access to consistent and equitable health care and other social services.

See also:

Canadian HIV/AIDS Legal Network, *Sex, Work, Rights: Reforming Canadian Criminal Laws on Prostitution* (Toronto: Canadian HIV/AIDS Legal Network, 2005).

<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=203>

This report examines the criminal law in Canada that surrounds prostitution. The report discusses in detail the legal regulation of prostitution in Canada, the connection between sex work and HIV/AIDS, the effect of criminalization of prostitution on sex workers health and safety,

including on their vulnerability to HIV/AIDS, international law and human rights in relation to sex work, and the Canadian Charter of Rights and Freedoms. The report examines proposals for reform, including Bill C-339, which proposed licensing places of prostitution and suspending the criminal prohibitions that surround prostitution. The Bill also proposed mandatory HIV testing for sex worker and their clients. The report concludes with a list of specific recommendations for legal reform in Canada.

Canadian HIV/AIDS Legal Network, *Vectors, Vessels and Victims: HIV/AIDS and Women's Human Rights in Canada* (Toronto: Canadian HIV/AIDS Legal Network, 2005), pp. 31-33.
<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=526>

This paper argues that although women in Canada do not suffer from the most extreme forms of subordination that other women face, inequality still contributes to women's vulnerability to HIV infection. Women in Canada represent an increasing number of the people newly infected with HIV every year. Despite this fact, programmes that deal specifically with women's vulnerability to HIV are scarce. While all women in Canada face some inequality in their lifetime, there are specific groups of women who are much more at risk for violations of their human rights. These groups include Aboriginal women, women in the sex trade, women who inject drugs, and women in prisons. This report examines the policies that exist in relation to HIV and women in Canada today and discusses their efficacy. It then discusses key issues surrounding women and HIV/AIDS, especially in relation to the high risk groups of women mentioned above. Following this it examines Canada's responsibilities under international and domestic law. Finally, this paper recommends a number of policies to create a more effective response to HIV/AIDS among Canadian women.

UNAIDS, "At Risk and Neglected: Sex Workers," *Report on the Global AIDS Epidemic* (Geneva: UNAIDS, 2006), pp. 105-110.
http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH05_en.pdf

This section focuses on sex workers and their under representation in HIV prevention and treatment initiatives. It briefly looks at HIV/AIDS and sex work internationally, providing some statistics and comments about specific countries. It also examines related issues such as drug use and young and uninformed sex workers. The environment sex work often takes place in and the typical clients of sex workers are also discussed. This section concludes with examples of positive policy initiatives for the protection of sex workers from HIV/AIDS.

WHO (Regional Office for the Western Pacific), *STI/HIV: Sex Work in Asia* (Geneva: WHO, 2001), pp. 1-10.
http://www.wpro.who.int/NR/rdonlyres/D01A4265-A142-4E19-99AE-6CC7E44F995C/0/Sex_Work_in_Asia_July2001.pdf

This report examines sex work in Asia. It begins with an introduction to the structure and demands of the sex market and Asia, along with a discussion on the idea of "choice" and HIV/AIDS among sex workers. The report then details the sex market in 17 Asian countries. These country reports give brief descriptions of the legal status of prostitution, its prevalence and the forms of sex work most common in each country.

(e) Women's Property and Inheritance Rights

Bhe and Others v. The Magistrate, Khayelitsha and Others; Shibi v. Sithole and Others; South African Human Rights Commission and Another v. President of the Republic of South Africa and Another 2005 (1) SA 580 (CC).

<http://www.constitutionalcourt.org.za/uhtbin/cqisirsi/focdEPrtDw/0/57/518/0/J-CCT49-03>

The Constitutional Court of South Africa rejected the application of the customary law of primogeniture, while remaining sensitive to the importance of custom.

Scott Drimie, "HIV/AIDs and Land: Case Studies from Kenya, Lesotho and South Africa" (2003) 20(5) *Development Southern Africa* 647.

Recent research conducted in Lesotho, Kenya and South Africa has revealed that HIV/AIDS will seriously impact on a range of land issues as a direct result of very high infection rates in these countries, including different forms of land use, the functioning of land administration systems, land rights of women and orphans as well as the poor generally, and inheritance practices and norms. The epidemic not only affects the productivity of the infected, but also diverts the labour of the household and extended family away from other productive and reproductive activities as they take care of the sick. Affected households fall below the social and economic threshold of vulnerability and 'survivability', leaving the survivors – mainly the young and elderly – with limited resources to quickly regain a sustainable livelihood. This indicates the importance of effective land administration systems and of land rights as HIV/AIDS impacts on the terms and conditions on which households and individuals hold, use and transact land. This has a particular resonance for women and children's rights, which, in the context of rural power relations that are themselves coming under increasing pressure from the epidemic, are especially vulnerable to being usurped. Thus, the impact of HIV/AIDS on land raises complex and sensitive issues for land policies and programmes, particularly if they are intended to underpin rural development and sustainable livelihoods.

See also:

Human Rights Watch, *Double Standards: Women's Property Rights Violations in Kenya* (New York: Human Rights Watch, 2003).

<http://www.hrw.org/reports/2003/kenya0303/>

This report examines the inequalities women in Kenya face in relation to property rights and the effect that has on them. Women in Kenya face a variety of property rights violations including exclusion from inheritance, eviction by in-laws and unequal property right during and after marriage. These violations put women at greater risk of HIV infection and stem from a variety of cultural, legal and social factors. Any laws that Kenya has in place to protect women's property rights defer to religious or customary property laws and so are largely ineffective. This report gives some background information on the issue including the historical status of women in Kenya, HIV/AIDS, customary laws and the traditional response to property rights violations by the government of Kenya and others. The report then details some of the most prevalent property rights abuses and their consequences. Following this is a discussion of some of the contributing factors to these violations and international standards and obligations. It also contains specific policy recommendations to the government of Kenya, NGOs and the international community.

Emma Ssali Namuli, "Women and HIV/AIDS in Uganda", in Johanna Bond ed., *Voices of African Women: Women's Rights in Ghana, Uganda, and Tanzania* (Durham: Carolina Academic Press, 2005), pp. 288-300.

This article discusses how women in Uganda are vulnerable to HIV/AIDS. It begins by describing some of the cultural practices that exist in Uganda and how they make women vulnerable to HIV, including brideprice, polygamy, female genital mutilation, and widow inheritance. The article then examines the laws in Uganda and how they contribute to the problem of HIV infection in women. In particular, laws on marriage and succession are part of the problem. The article ends with specific recommendations for legal reform and for policy changes that would help protect Ugandan women from HIV infection.

Richard S. Strickland, *To Have or To Hold: Women's Property and Inheritance Rights in the Context of HIV/AIDS in Sub-Saharan Africa* (International Center for Research on Women, 2004).

Summary: http://www.icrw.org/docs/2004_info_haveandhold.pdf

Full Report: http://www.icrw.org/docs/2004_paper_haveandhold.pdf

In 2004, UNAIDS launched the Global Coalition on Women and AIDS to call more global attention to HIV/AIDS related abuses of women's and girls' rights and to promote action to counter abuses. The Global Coalition focuses on preventing new HIV infections among women and girls, promoting equal access to HIV care and treatment, accelerating microbicide research, protecting women's property and inheritance rights, and reducing violence against women. For each issue, the Global Coalition worked through a convening agency to raise awareness and promote action. The International Center for Research on Women (ICRW) is the convening agency for the realization of women's and girls' property and inheritance rights. This bulletin is based on research, undertaken for ICRW by Dr. Richard Strickland, examining the linkages between women's property rights and HIV/AIDS in sub-Saharan Africa.

(f) Orphan & Vulnerable Children in Changing Family Structures

Christopher Olekea *et al.*, "When the Obvious Brother is not There': Political and Cultural Contexts of the Orphan Challenge in Northern Uganda" (2005) 61 *Social Science & Medicine* 2628.

It is estimated that two million of Uganda's children today are orphaned primarily due to AIDS. While recognising the immense impact of HIV/AIDS on the present orphan problem, this article calls for a broader historic and cultural contextualisation to reach an understanding of the vastness of the orphan challenge. The study on which the article is based was carried out among the Langi in Lira District, northern Uganda, with a prime focus on the situation of orphans within the extended family system. The findings reveal a transition over the past 30 years from a situation dominated by 'purposeful' voluntary exchange of non-orphaned children to one dominated by 'crisis fostering' of orphans. Sixty-three percent of the households caring for orphans were found to be no longer headed by resourceful paternal kin in a manner deemed culturally appropriate by the patrilineal Langi society, but rather by marginalised widows, grandmothers or other single women receiving little support from the paternal clan. This transition is partly linked to an abrupt discontinuation of the Langi 'widow inheritance' (*laku*) practice. It is argued that the consequential transformations in fostering practices in northern Uganda must be historically situated through a focus on the effects of armed conflicts and uprooting of the local pastoral and cotton-based economy, which have occurred since the late

1970s. These processes jointly produced dramatic economic marginalisation with highly disturbing consequences for orphans and their caretakers.

See also:

Candice Audemard & Kokou Vignikin sous la directions d'Annabel Desgrées au Loû, *Orphans and Vulnerable Children Due to HIV/AIDS in Sub-Saharan Africa* (Centre Population et Développement, 2006).

http://ceped.cirad.fr/cdrom/orphelins_sida_2006/en/index.html

This paper deals with children who have had at least one parent die of HIV/AIDS and attempts to define and measure the number of children affected by HIV/AIDS. The focus, for the most part, is on orphans in Africa, where the problem is worst. Support networks available for orphans are examined, including traditional support mechanisms and new institutional support programmes. The paper then examines how the HIV infection of a parent influences the life of the child both before and after the parents' death. The paper concludes with a list of recommendations for research priorities in order to better understand the problem.

L.M. DeMatteo *et al.*, "The Family Context of HIV: a Need for Comprehensive Health and Social Policies" (2002) 14 *AIDS Care* 261.

This paper reports on the findings from a multi-site psychosocial study of Canadian families with HIV-positive mothers. A total of 110 adults, representing 91 families across Canada participated in interviews. Qualitative analysis revealed a number of themes including: a complex web of personal, health and family concerns; the needs of children; family finances; disclosure dilemmas; and social experiences and challenges. These themes reflect an intricate and dynamic picture of parental and family life for adults and children living with HIV infection. Nowhere in the literature do we see HIV framed as a 'family infection'. Surveillance reporting reflects information on infected adults and children but not family groupings. Yet with HIV several family members and multiple generations as well as single or both parents may be infected, highlighting the importance of 'family HIV' as a framework for health policy and programme development. At issue is the problem that medical and other institutions view issues of surveillance, treatment and care through the lens of the infected individual, rather than being family focused. Often it is only in the context of identifying support, or barriers to support, for the medically diagnosed individual that biological or socially created families become a focus of concern. The failure to situate both chronic and life-threatening illnesses within the family setting has serious quality of life and planning consequences for parents and children living with HIV infection as well as other illnesses.

Erick Otieno Nyambedha *et al.*, "Changing Patterns of Orphan Care Due to the HIV Epidemic in Western Kenya" (2003) 57 *Social Science & Medicine* 301.

The HIV/AIDS epidemic has given rise to major demographic changes including an alarming number of orphans in sub-Saharan Africa. The study describes a rural community in western Kenya in which one out of three children below 18 years of age had lost at least one biological parent—and one out of nine had lost both. The main problems these children faced were lack of school fees, food and access to medical care. The high number of orphans has overwhelmed the traditional mechanisms for orphan care based on patrilineal kinship ties. Thus, 28% of the orphans were looked after by culturally "inappropriate" categories such as matrilineal kin or strangers. Furthermore, many of the caretakers were themselves not capable due to ill health or old age. Factors such as poverty, negative attitudes, and traditional funeral customs made the

orphans' situation even worse. The authors conclude that though community based interventions are urgently needed as the most appropriate way to address the issue, the complex, local reality in which cultural factors, kinship ties, and poverty are interwoven needs to be taken into consideration if sustainable solutions are to be found.

Constance Nyamukapa & Simon Gregson, "Extended Family's and Women's Roles in Safeguarding Orphans' Education in AIDS- Afflicted Rural Zimbabwe " (2005) 60(10) *Social Science & Medicine* 2155.

The extended family forms the basis for orphan care and education in sub-Saharan Africa. Initial absence followed by emergence of differentials in primary school enrolment between orphans and non-orphans have been attributed to the strength and subsequent HIV/AIDS-induced breakdown of extended family orphan care arrangements. Yet, few attempts have been made to describe how these arrangements are affected by HIV/AIDS or how they relate to observed patterns of childhood outcomes by sex and orphan status. We use a combination of quantitative and qualitative data to show that maternal orphans but not paternal or double orphans have lower primary school completion rates than non-orphans in rural Zimbabwe, and that these patterns reflect adaptations and gaps in extended family orphan care arrangements. Sustained high levels of primary school completion amongst paternal and double orphans—particularly for girls—result from increased residence in female-headed households and greater access to external resources. Low primary school completion amongst maternal orphans results from lack of support from fathers and stepmothers and ineligibility for welfare assistance due to residence in higher socio-economic status households. These effects are partially offset by increased assistance from maternal relatives. These findings indicate that programmes should assist maternal orphans and support women's efforts by reinforcing the roles of extended families and local communities, and by facilitating greater self- sufficiency.

(g) Neglected Population: Indigenous & Aboriginal Women

Canadian HIV/AIDS Legal Network, *Vectors, Vessels and Victims: HIV/AIDS and Women's Human Rights in Canada* (Toronto: Canadian HIV/AIDS Legal Network, 2005), pp. 28-30.
<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=526>

Is it right to assume that some of the same violations of the human rights of women that impede the struggle against HIV/AIDS in developing countries do not also undermine HIV/AIDS prevention, diagnosis, treatment, care and support for women in Canada and other developed countries? In this paper, we examine this question with reference to the experience of Canadian women living with HIV/AIDS or vulnerable to the disease. The focus is on the specific issues of human rights challenges faced in prevention, testing and treatment, and challenges faced by Aboriginal women, women drug users, women sex trade workers, incarcerated women, and women from HIV-endemic countries. The partitioning of this analysis into these subject areas risks giving the impression that these issues are discrete. On the contrary, one of the central conclusions of this paper is that women in Canada face numerous overlapping and inter-related sources of stigma, discrimination and abuse that impede their struggle against HIV/AIDS. Poverty exacerbates all of these. Youth also exacerbates most of the risks discussed here. But even in the absence of poverty and even for older women, the subordination that Canadian women face is most often a complex interaction of sexism and discrimination linked to other status (for example, recent immigrant, detainee, ethnic or racial minority, sex worker, drug user, lesser income earner, or worker in a caring profession not valued by the community) with direct consequences for their ability to protect themselves from HIV infection or to gain access to care, treatment and support services.

See also:

Physicians for Human Rights, "No Status: Migration, Trafficking & Exploitation of Women in Thailand (Health and HIV/AIDS Risks for Burmese and Hill Tribe Women and Girls) (Boston: Physicians for Human Rights, 2004).

<http://physiciansforhumanrights.org/library/report-nostatus-2004.html>

This study was designed to provide critical insight and remedial recommendations on the manner in which human rights violations committed against Burmese migrant and hill tribe women and girls in Thailand render them vulnerable to trafficking, unsafe migration, exploitative labor, and sexual exploitation and, consequently, through these additional violations, to HIV/AIDS. This report describes the policy failures of the government of Thailand, despite a program widely hailed as a model of HIV prevention for the region. Physicians for Human Rights (PHR) findings show that the Thai government's abdication of responsibility for uncorrupted and nondiscriminatory law enforcement and human rights protection has permitted ongoing violations of human rights, including those by authorities themselves, which have caused great harm to Burmese and hill tribe women and girls.

Tracey Prentice, *HIV/AIDS and Aboriginal Women, Children and Families* (Ottawa: The Canadian Aboriginal AIDS Network, 2004)

This paper deals with the growing HIV/AIDS epidemic among aboriginal women. It discusses some of the ways that aboriginal women are vulnerable to the virus, including a section on gender roles and violence against women. Drug use among aboriginal women and aboriginal women in prisons is also dealt with. Issues surrounding testing, treatment and disclosure are considered in the final sections of this paper. Recommendations are made to policy makers and HIV/AIDS programme facilitators to better include the needs of aboriginal women.

Michael R. Wright *et al.*, "Fulfilling Prophecy? Sexually Transmitted Infections and HIV in Indigenous People in Western Australia" (2005) 183(3) *Medical Journal of Australia* 124.

http://www.mja.com.au/public/issues/183_03_010805/wri10151_fm.pdf

The object of this article is to compare trends and rates of HIV and sexually transmitted infections in Indigenous and non-Indigenous people of Western Australia. It analyses Western Australian notification data for chlamydia, gonorrhoea, and primary and secondary syphilis in 2002, and for HIV infections from 1983 to 2002. The article concludes that Indigenous Western Australians are at greater risk of HIV transmission than non-Indigenous people. Strategies to prevent further HIV infection in Indigenous Australians should include control of sexually transmitted infections.

(3) Challenges in Access to Prevention, Treatment and Care

R. J. Cook & B. M. Dickens, "Human Rights and HIV-Positive Women" (2002) 77 *International Journal of Gynecology & Obstetrics* 55.

Recent court decisions, for instance in South Africa and Latin America, have held states bound to respect and serve HIV/AIDS patients' human rights to indicated and available medical care. HIV/AIDS is estimated to affect over 36 million people worldwide, including 16.4 million women of reproductive age. In the last 20 years, nearly 58 million people have been infected. This article reviews national responses to mounting concern with the HIV/AIDS pandemic,

particularly in China, India and Africa, medical professional responses, notably by the World Medical Association, and international guidelines on human rights responses. These pay special attention to patients' rights to be treated without discrimination. It addresses national and international approaches to advancing HIV prevention, treatment and research on which UNAIDS and the UN High Commissioner for Human Rights have collaborated. Special issues in clinical care concern abortion services for HIV-positive women, breastfeeding and patients' involvement in research.

R.J. Cook & C. Ngwena, "Women's Access to Health Care: The Legal Framework" (2006) 94 *International Journal of Gynecology and Obstetrics* 216.

The Millennium Development Goals set ambitious targets for women's health, including reductions in maternal and child mortality and combating the spread of HIV/AIDS. The law, which historically has often obstructed women's access to the health care they require, has a dynamic potential to ensure women's access that is being progressively realized. This paper identifies three legal principles that are key to advancing women's reproductive and sexual health. First, law should require that care be evidence-based, reflecting medical and social science rather than, for instance, religious ideology or morality. Second, legal guidance should be clear and transparent, so that service providers and patients know their responsibilities and entitlements without litigation to resolve uncertainties. Third, law should provide applicable measures to ensure fairness in women's access to services, both general services and those only women require. Legal developments are addressed that illustrate how law can advance women's equality, and social justice.

Leslie London *et al.*, "'Even If You're Positive, You Still Have Rights Because You Are a Person': Human Rights and the Reproductive Choice of HIV-Positive Persons" (2008) 8(1) *Developing World Bioethics* 11.

Global debates in approaches to HIV/AIDS control have recently moved away from a uniformly strong human rights-based focus. Public health utilitarianism has become increasingly important in shaping national and international policies. However, potentially contradictory imperatives may require reconciliation of individual reproductive and other human rights with public health objectives. Current reproductive guidelines remain largely nonprescriptive on the advisability of pregnancy among HIV-positive couples, mainly relying on effective counselling to enable autonomous decision-making by clients. Yet, health care provider values and attitudes may substantially impact on the effectiveness of nonprescriptive guidelines, particularly where social norms and stereotypes regarding childbearing are powerful, and where providers are subjected to dual loyalty pressures, with potentially adverse impacts on rights of service users. Data from a study of user experiences and perceptions of reproductive and HIV/AIDS services are used to illustrate a rights analysis of how reproductive health policy should integrate a rights perspective into the way services engage with HIV-positive persons and their reproductive choices. The analysis draws on recognized tools developed to evaluate health policies for their human rights impacts and on a model developed for health equity research in South Africa to argue for greater recognition of agency on the part of persons affected by HIV/AIDS in the development and context of policies on reproductive choices. We conclude by proposing strategies that are based upon a synergy between human rights and public health approaches to policy on reproductive health choices for persons with HIV/AIDS.

Allan Rosenfield & Emily Figdor, "Where is the M in MTCT? The Broader Issues in Mother-to-Child Transmission of HIV" (2001) 91(5) *American Journal of Public Health* 703.

In 1985, a report subtitled "Where is the M in MCH" pointed out that most, if not all, maternal and child health programs, both domestic and international, focused on health issues concerning infants and young children. Women were considered, if at all, only in relation to improving infant neonatal outcomes. A similar dynamic underlies efforts to decrease mother-to-child transmission (MTCT) of HIV. There is a paucity of research examining the health impact of short-course therapy on women. The following imperatives need to be considered in relation to MTCT: treatment of women, but not just to decrease MTCT; treatment of infants who are HIV positive; access to clean water and adequate amounts of formula milk; and, significant investment in the infrastructure needed to fulfil these goals.

WHO & UNAIDS, *Progress Report on Global Access to HIV Antiretroviral Therapy: A Report on '3 by 5' and Beyond* (Geneva, Switzerland: WHO, 2006), p. 22.
http://www.who.int/hiv/fullreport_en_highres.pdf

This report describes global progress in scaling up access to antiretroviral therapy and outlines the areas in which important progress has been made and lessons learned. It also outlines the remaining challenges and roadblocks to treatment access. The report will be complemented by the results of an independent evaluation of WHO's contribution to achieving the "3 by 5" target as well as a WHO report on country action on HIV/AIDS that will describe WHO's work in more detail and provide updates on progress made in the 49 "3 by 5" focus countries.

See also:

Jude Mary Antonyappan, "Preventing HIV/AIDS among Women and Children in India" (2003) 46 *Development: Globalization, Reproductive Health and Rights* 90.

Jude Mary Antonyappan looks at the prevention and treatment of HIV/AIDS among women and children in Tamil Nadu, India. The study examines the prevention, education and treatment of women and children with HIV/AIDS, working with women who were engaged in risky sexual behavior in the construction, hotel and coffee industries. She argues that there is an urgent need for understanding how cultural factors compounded by poverty and poor infrastructure for health delivery can be addressed in the war to combat HIV/AIDS in India.

R.J. Cook *et al.*, "Counselling and Caring for an HIV-Positive Woman," *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law* (Oxford: Oxford University Press, 2003), pp. 323-335.

Updates: <http://www.law.utoronto.ca/faculty/cook/ReproductiveHealth.html>

This chapter contains a fictional case study involving an HIV-positive pregnant woman who seeks advice from her doctor about the risks to herself and her child if she has the baby. The discussion is broken down into six sections: background of the case; medical aspects of the case, including WHO guidelines and how the virus can pass from mother to child; ethical aspects; legal aspects; human rights issues; and finally different approaches, including clinical duty, health care systems obligations, and social action for underlying conditions.

Johanna Daily *et al.*, “Women and HIV Infection: A Different Disease?” in Paul Farmer *et al.*, eds., *Women, Poverty, and AIDS: Sex, Drugs, and Structural Violence* (Monroe, Maine: Common Courage Press, 1996), pp. 125-144.

Human Rights Watch, *Hidden in the Mealie Meal: Gender-Based Abuses and Women’s HIV Treatment in Zambia* (New York: Human Rights Watch, 2007).
<http://hrw.org/reports/2007/zambia1207/>

Women in Zambia report that gender-based human rights abuses are real barriers to accessing and adhering to treatment. Women’s unequal status in Zambian society gravely undermines their ability to access and adhere to antiretroviral treatment (ARV), and the government is paying little if any attention to the gender dimension of treatment. Policies and programs still tend to ignore the connection between domestic violence or women’s insecure property rights and their ability to seek, access and adhere to HIV treatment. This report examines the background and context in which gender-based abuses occur, their impact on women’s HIV treatment. It also makes recommendations on how the government of Zambia might seek to address these abuses.

Edward Mills *et al.*, “Enrolling Women into HIV Preventive Vaccine Trials: An Ethical Imperative But a Logistical Challenge” (2006) 3 *PLoS Med* 94.

Mills examines the need to enroll more women in HIV vaccine trials. He outlines some of the fears that women have in regards to enrolling in vaccine trials including fear of infection, adverse effects, issues surrounding confidentiality, and the benefits of having more women participate in vaccine trials. It is imperative to have the most vulnerable people involved in these trials so that they might produce an effective and ethical vaccine. Mills argues that researchers should be advocates for the human rights of their trial participants and work with human rights organizations to make sure research participants are safe and protected.

Charles Ngwena, “Access to Antiretroviral Therapy to Prevent Mother-to-Child Transmission of HIV as a Socio-Economic Right: an Application of s. 27 of the Constitution” (2003) 18 *SAPR/PL* 83.

This article discusses the right to access medication to prevent mother-to-child transmission of HIV using *Treatment Action Campaign v. The Minister of Health* as a case study. Ngwena argues that while state policies should be given deference when determining the allocation of resources for public health care, there should be a constitutional requirement to fund drugs when the costs are low and the benefits far outweigh the risks. It contains an analysis of the content and legal function of socio-economic rights in general and in South Africa in particular. The construction of socio-economic rights by the Constitutional Court of South Africa in a number of cases leading up to *Treatment Action Campaign* as well as the judicial reasoning and remedies provided by the court are also examined.

WHO, *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).
<http://www.who.int/hiv/pub/mtct/en/arvdrugswomenguidelinesfinal.pdf>

This publication summarizes existing evidence on the use of antiretroviral drugs for preventing mother-to-child transmission of HIV and makes recommendations on the choice of regimens in

the context of expanding access to antiretroviral (ARV) treatment. Topics discussed include the safety of ARV drugs for pregnant women and infants, balancing the risks and benefits, ARV resistance, ARV efficacy during breastfeeding, and recommendations for ARV use in different clinical situations. The recommendations complement revised guidelines for antiretroviral treatment that have been issued in support of the 3 by 5 Initiative (target of treating 3 million people in developing countries by the end of 2005).

(a) Women and HIV Testing

Russell Armstrong, "Mandatory HIV Testing in Pregnancy: Is There Ever a Time?" (2008) 8(1) *Developing World Bioethics* 1.

Despite recent advances in ways to prevent transmission of HIV from a mother to her child during pregnancy, infants continue to be born and become infected with HIV, particularly in southern Africa where HIV prevalence is the highest in the world. In this region, emphasis has shifted from voluntary HIV counselling and testing to routine tests of women during pregnancy. There have also been proposals for mandatory testing. Could mandatory testing ever be an option, even in high-prevalence settings? Many previous examinations of mandatory testing have dealt with it in the context of low HIV prevalence and a well-resourced health care system. In this discussion, different assumptions are made. Within this context, where mandatory testing may be a strategy of last resort, the objections to it are reviewed. Special attention is paid in the discussion to the entrenched vulnerability of women in much of southern Africa and how this contributes to both HIV prevalence and ongoing challenges for preventing HIV transmission during pregnancy. While mandatory testing is ethically plausible, particularly when coupled with guaranteed access to treatment and care, the discussion argues that the moment to employ this strategy has not yet come. Many barriers remain for pregnant women in terms of access to testing, despite the presence of national and international human rights instruments aimed at empowering women and removing such barriers. While this situation persists, mandatory HIV testing during pregnancy cannot be justified.

Joanne Csete *et al.*, "'Opt-out' Testing for HIV in Africa: A Caution" (2004) 363 *Lancet* 493.

The call by Kevin De Cock and colleagues (Nov 29, p 1847) for more widespread HIV testing inspires respect for their dedication to seeking optimum use of public-health tools in the urgent fight against the HIV/AIDS epidemic. De Cock and colleagues argue that use of "opt-out" testing—whereby HIV testing is routine unless the person to be tested explicitly refuses the test—conforms to human rights principles such as the right to privacy and personal autonomy, and makes the unassailable assertion that universal voluntary knowledge of HIV serostatus is a vital HIV prevention goal. The challenge is to ensure that this goal is realised with fairness.

Joanne Csete & Richard Elliott, "Scaling up HIV Testing: Human Rights and Hidden Costs" (2006) 11 *Can. HIV/AIDS Policy and Law Review* 1.

<http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter.htm>

The calls for provider-initiated routine HIV testing are growing more intense. In this article, Joanne Csete and Richard Elliott discuss the human rights and ethical issues raised by the routine testing approach. Some points in this paper are inspired by an international expert meeting on HIV testing and human rights convened by the Center for Health and Gender Equity, Gay Men's Health Crisis and the Canadian HIV/AIDS Legal Network in Montreal in October 2005. The meeting was attended by academic experts, UN officials, activists and people living with HIV/AIDS from around the world.

Kevin De Cock *et al.*, "Shadow on the Continent: Public Health and HIV/AIDS in Africa in the 21st Century" (2002) 360 *Lancet* 67.

Increased efforts are required to arrange for couples to be tested together for HIV infection, so that HIV/AIDS can be approached as a disease of the family and of society. Unfortunately, premarital testing in industrialised countries has not had much effect, which has led it to being ignored in Africa's high prevalence heterosexual epidemic. For ethical and public health purposes, people should be strongly encouraged to learn the HIV status of prospective sex partners, undergo premarital testing, and notify partners of their status. The usefulness of partner notification as an intervention to prevent HIV or sexually transmitted infection is uncertain in the context of high rates of partner change, but might play a part in assuring the safety of long-term sexual partnerships in high prevalence areas. Couples who embark on long-term relationships or marry unaware of their differing HIV infection status are a source of further adult and paediatric infections, and HIV-negative people in such discordant relationships are one of the largest and most vulnerable groups in Africa. Most HIV-infected children are born to women unaware of their infection status. The most practical interventions for prevention of orphanhood, one of the epidemic's most devastating consequences, are to prevent infection in girls, to provide family planning choices to infected women, and to preserve the sero-negative status of partners in discordant relationships. Short-course antiretroviral treatment can reduce mother-to-child transmission of HIV even in breastfeeding populations. However, the delivery of interventions to prevent mother-to-child transmission has proven more difficult than expected, largely because of the requirements for pretest counselling, low uptake, and low return rate by women to obtain their test results. We are now in the paradoxical situation of achieving universal HIV testing in most industrialised countries, where prevalence is low, but not in Africa, where prevalence is high. Since the efficacy of all short-course antiretroviral regimens in breastfeeding populations is under 50%, if a substantial proportion of HIV-infected women go untested or untreated the intervention will have little effect at a population level. Provision of nevirapine to all mothers has been suggested and might be appropriate if HIV testing has not been possible, but it represents a less than ideal solution if applied as a means to avoid HIV testing.

Ebenezer Durojaye, "Addressing Human Rights Concerns Raised by Mandatory HIV Testing for Pregnant Women through the Protocol to the African Charter on the Rights of Women" (2008) 52(1) *Journal of African Law* 43

This article considers the importance of preventing mother to child transmission of HIV in Africa. It argues, however, that any approach to achieving this aim must be consistent with respect for human rights. In particular, it argues that testing pregnant women for HIV without informed and voluntary consent violates their rights to autonomy, health and reproductive care and non-discrimination all guaranteed in the Protocol to the African Charter on the Rights of Women (Women's Protocol) and other international and regional human rights instruments. It further examines the clamour for routine HIV testing for pregnant women to scale up treatment for prevention of mother to child transmission of HIV (PMTCT) and points out that, if implemented with proper attention to the human rights of pregnant women, this has a potential to act as a catalyst to improving HIV testing and preventing further infections in the region. The human rights concerns raised by mandatory testing for pregnant women far outweigh its benefits. Respect for women's human rights should form the fulcrum for any call for routine HIV testing for pregnant women in Africa.

Sofia Gruskin *et al.*, "Provider-Initiated HIV Testing and Counseling in Health Facilities – What Does This Mean for the Health and Human Rights of Pregnant Women?" (2008) 8(1) *Developing World Bioethics* 23.

Since the introduction of drugs to prevent vertical transmission of HIV, the purpose of and approach to HIV testing of pregnant women has increasingly become an area of major controversy. In recent years, many strategies to increase the uptake of HIV testing have focused on offering HIV tests to women in pregnancy-related services. New global guidance issued by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) specifically notes these services as an entry point for provider-initiated HIV testing and counselling (PITC). The guidance constitutes a useful first step towards a framework within which PITC sensitive to health, human rights and ethical concerns can be provided to pregnant women in health facilities. However, a number of issues will require further attention as implementation moves forward. It is incumbent on all those involved in the scale up of PITC to ensure that it promotes long-term connection with relevant health services and does not result simply in increased testing with no concrete benefits being accrued by the women being tested. Within health services, this will require significant attention to informed consent, pre- and post-test counselling, patient confidentiality, referrals and access to appropriate services, as well as reduction of stigma and discrimination. Beyond health services, efforts will be needed to address larger societal, legal, policy and contextual issues.

Fiona Scorgie, "Virginity Testing and the Politics of Sexual Responsibility: Implications for AIDS Intervention" (2002) 61(1) *African Studies* 55.

This article examines how participants in the virginity testing movement frame and understand their activity as a form of AIDS intervention in South Africa. Following a brief overview that traces the development of the revival and places it in a historical context, I then turn to a discussion of the more dominant meanings that participants in the movement attach to the notion of virginity and its importance in the broader context of sexuality. Finally, I consider how certain perceptions of sexual responsibility are embodied in the rhetoric and practice of the virginity testing movement, and what implications these might have for AIDS interventions in the region.

See also:

Isaac N. Luginaah *et al.*, "From Mandatory to Voluntary Testing: Balancing Human Rights, Religious and Cultural Values, and HIV/AIDS prevention in Ghana" (2005) 61 *Social Science & Medicine* 1689.

This paper examines efforts by some churches in Ghana to reduce the spread of HIV/AIDS. The analysis is based on focus group discussions with two groups of men and two groups of women, along with in-depth interviews with 13 pastors and marriage counsellors in the churches studied. In response to government and public criticisms about human rights violations, churches that previously imposed mandatory HIV testing on members planning to marry now have voluntary testing programmes. However, the results suggest that what the churches refer to as voluntary testing may not be truly voluntary. Cultural values and traditional practices, including traditional courtship and marriage rites (which are performed before church weddings), not only clash with considerations about pre-marital HIV testing but also complicate the contentious issue of confidentiality of information on HIV testing. Associated with these complexities and issues of confidentiality is a reluctance among participants, particularly those from northern Ghana, to test for HIV. The results reveal how broader social impacts of HIV testing for those planning to marry

may extend beyond individuals or couples in different cultural contexts. The findings also support the general view that there are no perfect or easy solutions to combating the HIV/AIDS pandemic. Practical solutions and programs for Ghana cannot be neutral to cultural values and need to be tailored for particular (ethnic) populations.

(b) Pregnant Women Living with HIV/AIDS

Cynthia Eyakuze *et al.*, "From PMTCT to a More Comprehensive AIDS Response for Women: A Much-Needed Shift" (2008) 8(1) *Developing World Bioethics* 33.

Half of the 33.2 million people living with HIV today are women. Yet, responses to the epidemic are not adequately meeting the needs of women. This article critically evaluates how prevention of mother-to-child transmission (PMTCT) programs, the principal framework under which women's health is currently addressed in the global response to AIDS, have tended to focus on the prevention of HIV transmission from HIV-positive women to their infants. This paper concludes that more than ten years after their inception, PMTCT programs still do not successfully ensure the adequate treatment, care and support of HIV-infected women. Of particular concern is the continued widespread use of single-dose nevirapine despite World Health Organization recommendations to employ more effective combination therapies that do not potentially jeopardize women's future treatment outcomes. In response, the article calls for a more comprehensive approach that places women's health needs at the centre of AIDS responses. This is critical in settings where the pandemic is generalized and there is a push to greatly expand PMTCT programs, as a more effective and equitable way of meeting the needs of women in the context of HIV. Without such a comprehensive approach, women will continue to be impacted disproportionately by the pandemic, and current strategies for prevention, including PMTCT, and treatment will not be as effective and responsive as they need to be.

Sofia Gruskin *et al.*, "Reproductive Health and HIV: Do International Human Rights Law and Policy Matter?" (2007) 3(1) *McGill International Journal of Sustainable Development Law and Policy* 69.

Protecting reproductive rights is understood to be a critical component of working to ensure reproductive health. Likewise, promotion and protection of human rights is considered key to an effective AIDS response. As HIV and reproductive health are increasingly joined in health and development strategies and initiatives, it is critical that human rights play a central role in these efforts. This paper focuses primarily on women as one way of exemplifying the unequal distribution of the burden of HIV and reproductive ill health across many sub-population groups. Likewise, a focus on the effects of gender on vulnerability to reproductive ill health and HIV infection, as well as access to care and treatment services if needed, can find welcome attention in international human rights law. The evolving legal and policy environment of reproductive health and HIV is discussed, including areas of persisting controversy (such as premarital testing and testing during delivery) and challenge. The author concludes that consequences of gendered expectations for women's reproductive health can potentially be mitigated through the clear, consistent and comprehensive application of reproductive rights, norms and standards.

Minister of Health and others v Treatment Action Campaign [2002] 5 S. Afr. L. R. 721 (S. Afr. Const. Ct).

<http://www.constitutionalcourt.org.za/Archimages/2378.PDF>

On 5 July 2002, South African treatment activists won a significant victory when the Constitutional Court ordered the South African government to make the antiretroviral drug nevirapine available in public hospitals and clinics for the purposes of preventing mother-to-child transmission of HIV. The Court also ruled the government has a constitutional obligation to implement a program to realize the right of pregnant women and their newborn children to access health services to prevent transmission.

In addition: see section (a) above: Women & HIV Testing

See also:

Center for Reproductive Rights, *Pregnant Women Living with HIV/AIDS: Protecting Human Rights in Programs to Prevent Mother-to-Child Transmission of HIV* (New York: Center for Reproductive Rights, 2005).

http://www.crlp.org/pdf/pub_bp_HIV.pdf

This publication discusses fundamental human rights that must be protected in the attempts to prevent mother-to-child transmission of HIV, including ideas of informed consent, confidentiality and non-discrimination. It gives background information on how HIV prevention programmes in general and mother-to-child transmission prevention programmes in particular have operated in the past. It outlines possible ways that prevention of mother-to-child transmission programmes can violate women's human rights. It also provides suggestions to states and health care organizations on policies and procedures to effectively safeguard women's rights.

(c) Gender-Based Violence against Women

Alessandra Guedes *et al.*, "Gender-Based Violence, Human Rights and the Health Sector: Lessons from Latin America" (2002) 6(1) *Health Hum. Rights* 177.

By labeling gender-based violence as gender-based, the UN highlighted the need to understand this violence within the context of women's and girls' subordinate status in society. In recent years, advocacy groups have raised awareness of gender-based violence (GBV) as a human rights violation, and a growing number of international agreements have addressed violence against women. Some countries have responded to these international agreements by strengthening legislation against GBV. However, GBV poses a challenge to classic human rights work because it occurs in what have traditionally been considered "private spheres" (e.g., the family and the home) rather than involving direct abuse by the state. Consequently, freedom from GBV cannot be ensured through government action alone but requires convincing the broader society that violence against women is a violation of human rights. Because GBV is both a public health problem and a human rights violation occurring in the "private" domain, international documents have increasingly called on governments to collaborate with health services. Affiliates of the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) have tried to overcome the ambivalence traditionally expressed by the health sector by addressing GBV in the context of providing sexual and reproductive health services. This article describes efforts to improve the health system response to survivors of violence and to raise awareness of GBV as a violation of human rights among health professional, clients, and the broader society.

Sapna Desai, "HIV and Domestic Violence: Intersections in the Lives of Married Women in India" (2005) 8 *Health Hum. Rights* 140.

Gender inequality is driving two distinct yet interlinked epidemics among women in India: HIV and AIDS and domestic violence. As domestic violence is increasingly recognized and HIV infection expands, policy and programs do not reflect the interlinked risks and consequences in married women's lives. This article seeks to establish the nexus between HIV and AIDS and domestic violence, and to identify potential areas for a state-led response. Using a health and human rights approach, it assesses women's vulnerability to each epidemic at the individual, societal, and program levels to analyze direct and underlying factors that determine women's risk. Three areas are identified as opportunities for an integrated response: strengthen HIV and domestic violence strategies and address their overlap; mainstream gender; and improve data and research.

N.M. Naylor, "Cry the Beloved Continent...Exploring the Impact of HIV/AIDS and Violence on Women's Reproductive and Sexual Rights in Southern Africa" (2005) 30(2) *Journal for Juridical Science* 52, pp. 52, 55-63.

The impact of violence on women's personal, sexual, social and reproductive lives reduces their autonomy and destroys their sense of personal safety and quality of life. In the context of HIV/AIDS, the issue of sexual violence takes on alarming proportions since violence against women fuels the epidemic and the epidemic exacerbates the impact of violence against women. This paper considers the extent to which violence against women and reproductive autonomy have become "actionable" for women in Southern Africa, and whether countries have adequately managed to protect women by contextualising violence against women as a reproductive rights issue and vice versa, or whether they have failed to protect women by silencing and masculinising women's realities. It will be argued that all jurisdictions have made progress toward a feminisation of the law but that significant lacunae and problems still remain, particularly in relation to a masculinist approach to violence against women and reproductive autonomy in the context of HIV/AIDS. State responses in the form of protective and coercive measures are examined with issues such as violence against women as a pre-disposing factor to HIV and violence upon disclosure of women's status being considered. In addition, coercive practices such as the criminalisation of HIV-related behaviour and forced sterilisation are considered.

Richard North & Karen Rothenberg, "Partner Notification and the Threat of Domestic Violence Against Women with HIV Infection" (1993) 329 *New England Journal of Medicine* 1194.

This article discusses partner notification principles in light of the pervasive problem of violence against women in the United States. Partner notification principles are in place for good reason; they protect those who are not infected from becoming so and they give those who may be infected the chance to get tested. However, due to the violence associated with HIV/AIDS in general, the links between HIV, drug use and violence, and the general problem of violence against women, partner notification can put women in real danger of injury. The authors of this article advocate a partner notification principle that requires doctors to seriously consider their ethical obligations to their patients and the possibility of violence before notifying the partner. The ethical duty to protect the patient must be weighed against the ethical duty to protect the partner.

See also:

R.J. Cook *et al.*, "Caring for Victims of Sexual Abuse" (2005) 91 *International Journal of Gynecology and Obstetrics* 194.

Recognizing sexual abuse to be universal, in stable as well as disordered societies and directed predominantly but not only against younger women, this article first considers legal definitions of sexual abuse and the forensic evidence health care providers may be expected to gather. It explores the impact on victims of historic definitions of rape, and legal reforms to dispense with proof of sexual penetration. The WHO 2003 guidelines for medico-legal care for victims of sexual violence are noted, which emphasize the need for physical and psychological care of victims. The guidelines show that goals of treating victims and retaining forensic evidence can create a clinical dilemma. Ethical issues concern management of this dilemma, probing whether patients' psychological disturbance may have roots in past sexual abuse, and the conduct of appropriate research. It concludes that much sexual abuse is symptomatic of women's sexual subordination and disregard of their human rights.

Sapna Desai, "HIV and Domestic Violence: Intersections in the Lives of Married Women in India" (2005) 8(2) *Health and Human Rights* 140.

Gender inequality is driving two distinct yet interlinked epidemics among women in India: HIV and AIDS and domestic violence. As domestic violence is increasingly recognized and HIV infection expands, policy and programs do not reflect the interlinked risks and consequences in married women's lives. This article seeks to establish the nexus between HIV and AIDS and domestic violence and identify potential areas for a state-led response. In a health and human rights approach, it assesses women's vulnerability to each epidemic at the individual, societal, and program levels to analyze direct and underlying factors that determine women's risk. Three areas are identified as opportunities for an integrated response: strengthen HIV and domestic violence strategies and address their overlap; mainstream gender; and improve data and research.

Alice Miller, "Sexuality, Violence Against Women, and Human Rights: Women Make Demands, and Ladies Get Protection" (2004) 7(2) *Health Hum. Rights* 17.

Although women's rights advocates came to human rights demanding accountability for all human rights, this demand has been stymied. Specific elements of violence against women (VAW) as a human rights issue, coupled with sexual harm's particular operation to make VAW visible, produced a paradox: the harms themselves are not yet effectively responded to, yet women's sexual vulnerability is now firmly on the global agenda. This piece explores the state-oriented focus of rights work on the suffering body, its reliance on criminal law, and its failure to develop a theory of economic justice. Health and human rights work must consider the complexities of portraying women as sexual agents, targets of abuse and citizens at the same time, if it seeks to fulfill its original promise.

Republic of South Africa, *Criminal Law (Sexual Offences and Related Matters) Amendment Bill (2006)*.

The Criminal Law (Sexual Offences) Amendment Bill, 2003, emanating from the South African Law Reform Commission's report on sexual offences, aims to widen the scope of the crime of

rape and to create numerous new offences related to sexual misconduct. It also addresses aspects of sentencing for sexual offenders and certain evidentiary matters.

Michelle Teti *et al.*, "Identifying the Links between Violence against Women and HIV/AIDS: Ecosocial and Human Rights Frameworks Offer Insight into US Prevention Policies" (2006) 9(2) *Health and Human Rights* 40.

While US government-sponsored HIV prevention initiatives have achieved notable successes, challenges remain to serving women effectively. Intimate partner violence hinders women's efforts to decrease their HIV risk behaviours. The global HIV/AIDS epidemic is often viewed as a human rights crisis. An analysis of US HIV prevention strategies based on ecosocial and health and human rights frameworks clarifies women's HIV risk practices and suggests opportunities for progress. These two frameworks help to 1) demonstrate how HIV/AIDS is a clinical manifestation of violence against women, 2) identify safety from violence as a human right necessary for well-being, and 3) suggest ways in which HIV prevention initiatives can more effectively improve women's health and fulfill their basic human rights.

United Nations, Economic and Social Council, "Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences, Yakin Ertürk" *E/CN.4/2005/72* (2005), See Section: "Intersections of Violence against Women & HIV/AIDS"
<http://daccessdds.un.org/doc/UNDOC/GEN/G05/102/11/PDF/G0510211.pdf?OpenElement>

This report deals with the connection between violence against women and HIV/AIDS. The first section deals with the general prevalence of HIV/AIDS among men and women. The second section looks at how different types of violence against women makes women especially susceptible to HIV/AIDS. The types of violence considered are: rape and sexual assault, domestic violence, violence related to harmful practices such as forced marriage, violence related to commercial sex work, and violence in armed conflict. The third section examines the violence and discrimination faced by women who are HIV positive. The final two sections deal with barriers to accesses to health care and barriers to access to justice.

(d) Access to Post-Exposure Prophylaxis

Julia C. Kim *et al.*, "Rape and HIV Post-Exposure Prophylaxis: Addressing the Dual Epidemics in South Africa" (2003) 11(22) *Reproductive Health Matters* 101.

In South Africa, a country notable for both a rapidly escalating AIDS epidemic and high levels of sexual violence, the issue of HIV post-exposure prophylaxis (PEP) following rape has recently come to the fore, and a policy supporting provision of PEP has been approved by the national government. This paper compares the conditions for providing PEP in Europe and North America with the conditions faced by two initiatives in South Africa, one serving a primarily rural base, and one urban. It is based on a review of the literature on sexual violence in South Africa and use of PEP following occupational and non-occupational exposure. It incorporates perspectives from in-depth interviews in 2000 with 18 key informants, including survivors of sexual violence, gender and HIV activists, domestic violence NGOs, rape crisis centres, physicians, lawyers, researchers and HIV/AIDS advisors in the Department of Health. The paper argues that given the scientific evidence for PEP, and the nature of the dual epidemics of HIV and sexual violence in South Africa, the public health and social justice rationale for implementing PEP equals and indeed exceeds that put forward in industrialised countries. However, delays in accessing PEP caused by the public justice system and lack of training for service providers constitute significant obstacles to effective implementation. In this respect,

provision of PEP presents an opportunity to reform and strengthen existing services for post-rape care and to link attention to the epidemic of sexual violence to HIV/AIDS prevention.

WHO, *Guidelines for Medico-Legal Care for Victims of Sexual Violence* (Geneva: WHO, 2003), pp. 68-70 (adults); 88-90 (children).

<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>

The aim of these guidelines is to improve professional health services for all individuals (women, men and children) who have been victims of sexual violence by providing: (1) health care workers with the knowledge and skills that are necessary for the management of victims of sexual violence; (2) standards for the provision of both health care and forensic services to victims of sexual violence; (3) guidance on the establishment of health and forensic services for victims of sexual violence. By making the guidelines available as a resource document to all levels of health workers, it is hoped that awareness of the problem of sexual violence will be raised and, in turn, the detection rate of such activities increased. Ultimately, increased knowledge and awareness are paramount to finding the road to prevention. These guidelines focus on the care of women and children. Although existing evidence points to comparable rates of sexual violence among males and females during childhood, in adulthood women are much more likely to suffer sexual violence than men. This finding, coupled with the fact that information about the specific health needs of male victims of sexual violence is very limited indeed, has determined the focus of the document. Nevertheless, these guidelines address a range of health care issues that apply to individuals of both sexes, and highlight several concerns that are specific to male victims.

See also:

Division of Reproductive Health, Ministry of Health, Government of Kenya, *National Guidelines on Medical Management of Rape and Sexual Violence* (2004).

Policy Guidelines for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault (South Africa).

<http://www.doh.gov.za/aids/docs/rape-protocol.html>

These guidelines are meant to be followed by health care workers after someone has come to a clinic or hospital claiming to be sexually assaulted. Individuals can call for counseling on HIV/AIDS and the offer of post-exposure prophylaxis (PEP) if the assault took place less than 72 hours before. Voluntary rapid HIV testing should be made available to all and must be given to those opting for PEP. The guidelines also outline doses and timelines for administering antiretroviral medications.

Human Rights Watch, "Deadly Delay: South Africa's Efforts to Prevent HIV in Survivors of Sexual Violence" (New York: Human Rights Watch, 2004).

<http://hrw.org/reports/2004/southafrica0304/southafrica0304.pdf>

This publication concerns South Africa's pledge to provide post-exposure prophylaxis (PEP) to survivors of sexual violence. Human Rights Watch argues that despite this pledge many victims of sexual violence still do not have access to PEP. This is due to the lack of information police and health care providers have about PEP and the resistance to providing PEP by those who do have the information. Children survivors of rape face even more obstacles since HIV tests are necessary to qualify for PEP and children under 14 cannot consent to these tests without permission from a parent or guardian. People in rural areas often do not have access to medical clinics and thus cannot obtain PEP. This publication examines some of the efforts that have

been made to extend the accessibility of PEP programmes, as well as what domestic and international legal obligations South Africa is bound by. It also contains recommendations for making PEP programmes more widely available in South Africa.

International Planned Parenthood Federation, "IPPF Guidelines on Protection Against HIV Infection, Including Post-Exposure Prophylaxis, in the Service Setting" (2005) 30(4) *International Planned Parenthood Medical Bulletin* 1.

http://www.ippf.org/NR/rdonlyres/DECF2625-346C-4E24-9453-8D9619735F7B/0/39_4_dec05.pdf

This article outlines IPPF guidelines on protection against HIV infection, including post-exposure prophylaxis, in the service setting. Developed with the assistance of IPPF's International Medical Advisory Panel and selected experts on HIV medicine, these guidelines offer a comprehensive approach to the occupational risk of HIV infection. Part 1 gives advice on prevention, by application of "universal precautions" in circumstances of exposure to potentially infectious materials, and Part 2 details steps that can be taken when a health worker sustains a needle-stick or other penetrative injury. The guidelines draw upon other published recommendations, especially those from the US Centers for Disease Control and the World Health Organization.

(e) Access to Microbicides & Other Female-Controlled Prevention

Anna Alexandrova, "Global Access to Treatment, Vaccines, and Microbicides" (2004) 9(2) *Can. HIV/AIDS Policy Law Rev.* 39.

The Canadian AIDS Society (CAS) recently completed a report entitled *Microbicides Development and Delivery in Canada: Legal, Ethical and Human Rights Issues*. The report builds on Canadian and international experience and was written in consultation with Canadian community and international experts. It is available on the CAS website (www.cdnaids.ca) and from the Canadian HIV/AIDS Information Centre (www.aidssida.cpha.ca) as of September 2004. In this article the report's author, Anna Alexandrova, argues that Canada needs to develop a microbicides development and delivery strategy that addresses research and development issues, outlines possible roles for meaningful community participation, and provides guidelines on funding, promotion, licensing, and distribution.

Amy Kaler, "'It's Some Kind of Women's Empowerment': the Ambiguity of the Female Condom as a Marker of Female Empowerment" (2001) 52 *Social Science and Medicine* 783.

The female condom is the latest in a series of sexual and reproductive technologies to be imported into the third world, following the contraceptive pill, the Depo-Provera injection, the latex male condom, and others. It is an example of "traveling technology", which accrues different meanings and connotations in the different settings into which it is introduced in its journey through the circuits of international technological diffusion, from the headquarters of international NGOs and bilateral aid programs, through the bureaucracies of national ministries of health to the communities in urban and rural settings where the condoms are distributed. The female condom almost always carries connotations of women's empowerment, and the possibility of greater sexual autonomy for women. This association is a result of the female condom being the first new "post-Cairo" technology, the diffusion of which was spurred by the consensus reached at the 1994 International Conference on Population and Development in Cairo, at which the need to promote women's empowerment was moved to the center of international family planning and population movements. However, I demonstrate that

“empowerment” is an ambiguous term, interpreted in different ways in different contexts. I illustrate this through interviews conducted in 1998 and 1999 with stakeholders in the female condom in Cape Town, Nairobi, and in rural western Kenya. These stakeholders range from directors of US-based development programs to heads of national AIDS-prevention efforts to community-based distributors and primary health care nurses at the village level. I argue that three different notions of empowerment are being articulated with respect to the female condom — two which correspond to Maxine Molyneux’s typology of strategic and practical gender interests, and a third in which women’s empowerment is conceived of as something which diminished the power of men. I argue further that the disjunctures between these three different notions of what “empowerment” means will pose a challenge for people at all levels which are seeking to make the female condom more widely accessible to women at risk of HIV/AIDS.

Joanne Mantell *et al.*, "The Promises and Limitations of Female-Initiated Methods of HIV/STI Protection" (2006) 63 *Social Science & Medicine* 1998.

New methods are now available, and others are being developed, that could enable women to take the initiative in preventing sexually transmitted infections. However, attempts to capitalize on “female-controlled” preventive methods thus far have met with limited success. Female-initiated methods were introduced to intervene in the state of gender relations and assist women who are disempowered vis-à-vis their male partners. Paradoxically, however, we underscore that it is the very structure of regional and local gender relations that shapes the acceptability (or lack of acceptability) of these methods. This paper specifically addresses how the structure of gender relations – for better and for worse – shapes the promises and limitations of widespread use and acceptance of female-initiated methods. We draw on examples from around the world to underscore how the regional specificities of gender (in)equality shape the acceptance, negotiation, and use of these methods. Simultaneously, we demonstrate how the introduction and sustained use of methods are shaped by gender relations and offer possibilities for reinforcing or challenging their current state. Based on our analyses, we offer key policy and programmatic recommendations to increase promotion and effective use of women-initiated HIV/STI protection methods for both men and women.

See also:

Katy Backes *et al.*, "One Choice Is No Choice: The Need for Female-Controlled HIV Prevention Tools for Women and Girls Worldwide" (2005) 6(1) *Harvard Health Policy Review* 19.

This article critiques the standard “ABC” model of HIV/AIDS prevention as being unrealistic for many women and not within a woman’s control. The article begins by examining a few of the biological, cultural and economic reasons why women are more susceptible to HIV infection. It then discusses how abstinence, monogamy and condom use are often not realistic choices for women and how the lack of a sole female controlled preventative measure is making prevention largely impossible for many women. The authors advocate increased availability and information on the female condom. They also discuss microbicides and diaphragms and call for greater research and development in these areas. This article also contains discussion on condom use patterns and the potential impacts of other forms of female controlled preventative measures.

Global Campaign for Microbicides – *Facts Sheets*

<http://www.global-campaign.org/download.htm>

#1: *Take Action for this New Hope for HIV Prevention* (2007).

#2: *Frequently Asked Questions About Microbicides* (2007).

#4: *Gender Equality in AIDS Prevention* (2007).

#5: *Clinical trials: Are they ethical?* (2007).

#13: "Trials Watch: Microbicides in Late Clinical Development" (2007).

The Global Campaign for Microbicides is a broad-based, international effort to build support among policymakers, opinion leaders, and the general public for increased investment into microbicides and other user-controlled prevention methods. The Campaign works to accelerate product development, facilitate widespread access and use, and protect the needs and interests of users, especially women.

M. Gottemoeller, "Empowering Women to Prevent HIV: The Microbicide Advocacy Agenda", (2000) 44 *Agenda* 6.

Research into the development of effective microbicides should be treated as a priority, as women need prevention strategies that are within their personal control.

E. McGrory & G. Rao Gupta, *Preparing for Microbicide Access and Use: A Report by the Access Working Group of the Microbicide Initiative* (Washington: Global Campaign for Microbicides, 2000).

http://www.global-campaign.org/clientfiles/rep6_preparing.pdf

This paper discusses the special initiatives that will need to be taken to ensure that microbicides, when and if they are fully developed, are accessible to the poorest and most vulnerable women in the world. This paper identifies and outlines five main dimensions of access: acceptability and appropriate use, creating a supportive environment, availability, affordability, and regulatory approval and licensing. Each of these sections is broken down into a goal statement, a number of specific objectives, background information, and proposed activities.

Phyllis Orner *et al.*, "Challenges to Microbicide Introduction in South Africa" (2006) 63 *Social Science & Medicine* 968.

Qualitative research was conducted in South Africa to determine perceptions about intra-vaginal microbicides in order to better understand the socioeconomic, cultural and structural contexts for the support of future introduction of this new HIV prevention method. Focus group discussions and in-depth interviews were conducted at community, health service, and policy levels of inquiry. The main study site was a black working class urban area close to Cape Town. Desperation in response to the HIV/AIDS epidemic, rape, sexual coercion and unplanned consensual sex emerged as major reasons to support microbicides, while concerns about the partial effectiveness of microbicide protection and its hypothetical nature elicited a more cautious approach. Other key findings included the likelihood that microbicides would be "mainstream", the possible impact on sexual practices and gender norms, issues of condom substitution/migration and potential avenues for education and distribution.

We found that microbicides have the potential to meet diverse needs beyond that suggested by prior research. This included a desire for products that could protect against HIV infection following rape, sexual coercion and unplanned sex, and the finding that a wider range of people than previously suggested would potentially use microbicides. The challenge for microbicide

introduction will be to develop products that can meet diverse needs not only in South Africa, but also in the broader global context.

(f) Access to Reproductive Health Services, including Abortion

New Jersey Division of Youth & Family Servs. v. L.V., 2005 WL 3527274 (N.J. Super. Ch. Aug. 3).

The superior Court, Chancery Division, Passaic Country, Rothstadt J.S.C., held that refusal by a mother who was HIV-positive to take recommended medication during pregnancy to reduce risk of transferring virus to unborn child was not an act of abuse or neglect.

Maria de Bruyn, "Safe Abortion for HIV-Positive Women with Unwanted Pregnancy: A Reproductive Right" (2003) 11(22) *Reproductive Health Matters* 152.

About 2.5 million women who become pregnant each year worldwide are HIV-positive. UNAIDS recommends that HIV-positive women should be able to control their fertility and prevent HIV transmission perinatally if they decide to have children. Yet a literature review on these matters found that termination of pregnancy for HIV-positive women receives very little attention. This paper describes the difficulties faced by HIV-positive women in obtaining safe legal, affordable abortion services. It shows that voluntary HIV counselling and testing for women seeking induced abortions and post-abortion care may not be provided. HIV-positive women wanting to avoid pregnancy for the same reasons as other women, but they also do not want to infect their partners through unprotected sex, worry about effects of pregnancy and childbirth on their own health, and about infecting a child and the child's future care. Little research has been done on whether HIV-positive women have a greater risk of morbidity following unsafe abortions than HIV-negative women, but evidence suggests they might. Studies in Zimbabwe and Thailand show that when information and access to legal pregnancy termination are lacking, HIV-positive women may be prevented from terminating a pregnancy. The paper concludes that it is essential for women living with HIV/AIDS to be able to exercise their right to decide whether and when to have children.

See also:

Maria de Bruyn, "Fulfilling Reproductive Rights for Women Affected by HIV/AIDS: A Tool for Monitoring Progress Toward Three Millennium Development Goals" (Chapel Hill, NC: Ipas, 2006).

http://www.ipas.org/publications/en/MDGHIV_E06_en.pdf

This publication discusses strategies for meeting the Millennium Development Goals (MDG) that deal with the sexual and reproductive rights of women as organized into five sections. The first section details the relevant MDG's and outlines areas where women's sexual and reproductive rights are more neglected. The second section gives benchmarks and sample questions for data collection on the progress of realizing each MDG. The third section deals with the potential uses for the collected data. The fourth section contains a list of organizations that support the use of this tool. The fifth and final section contains the text of the Barcelona Bill of Rights, which is an advocacy tool formulated at the 2002 International AIDS Conference.

Maria de Bruyn, "HIV/AIDS and Reproductive Health: Sensitive and Neglected Issues. A Review of the Literature. Recommendations for Action" (Chapel Hill, NC: Ipas, 2005).
http://www.ipas.org/publications/en/HIVLITREV_E05_en.pdf

This publication examines reproductive rights issues that surround HIV and concludes that there are many areas in which inadequate attention is paid to women's reproductive rights. It addresses issues of informed consent, access to other parenting options, safe abortion, contraceptives, and confidentiality. This article also looks at international law and guidance on these issues and concludes with recommendations for health care, policy and research.

Maria de Bruyn, "There's Nothing you Could do if your Rights Were Being Violated: Monitoring Millennium Development Goals in Relation to HIV-Positive Women's Rights." (Chapel Hill, NC: Ipas, 2006)

On 8 March 2004, 25 NGOs submitted a statement to the UN Commission on the Status of Women to draw attention to areas of reproductive health that are neglected with regard to HIV-positive women, such as fertility regulation and gynaecological care. The benchmarks in this monitoring tool emerged from that statement and were related to the MDGs, which had become a major framework for development work and assistance at the international and national levels. A gender scan of several national MDG reports by UNDP in 2005 found that most reports did not adequately include gender concerns across all the goals; moreover, "attempts to 'step out of the box' and place discussions on issues such as poverty and HIV/AIDS in the larger context of gender equality and women's rights and freedoms, were infrequent exceptions." There is no specific sexual and reproductive health goal or target in the MDGs, although UN Secretary General Kofi Annan stated that ensuring access to sexual and reproductive health services promotes development since it advances gender equity and empowers women. The World Bank has added that development assistance to improve health status and health care is only significantly effective when given in a context of good policies and institutions. In our view, such an environment includes policies and institutions that promote respect for, and fulfillment of, sexual and reproductive rights for all people, including those living with and affected by HIV/AIDS. Others, such as the European Union, NGOs and international reproductive-health experts, support that viewpoint.

Ruth R. Faden *et al.*, "HIV Infection and Childbearing: a Proposal for Public Policy and Clinical Practice," in Ruth R. Faden & Nancy E. Kass eds., *HIV, AIDS and Childbearing: Public Policy, Private Lives* (New York: Oxford University Press, 1996), pp. 447-461.

This chapter puts forward a policy proposal for whether and how others should attempt to influence, counsel or otherwise interfere with the reproductive choices of HIV-infected women based on the analyses, arguments and findings presented in earlier chapters. It focuses on recommendations for public policy and clinical practice. Specifically, a particular model for how persons who provide services to HIV-infected women should approach questions of childbearing with patients and clients is presented. This model is defended against alternative approaches to the provider-client relationship.

Charles Ngwena, "Access to Legal Abortion: Developments in Africa from a Reproductive and Sexual Health Rights Perspective" (2004) 19 *SAPR/PL* 328.

In this article Ngwena explores how abortion law has developed in Africa and how abortion laws in Africa fit in with ideas about sexual health and reproductive rights. He begins by looking at the

preamble to the South African Choice on Termination of Pregnancy Act, which explicitly discusses abortion in relation to human rights. Ngwena then examines abortion law in Africa through three phases: the indigenous phase, the colonial phase and the post-colonial phase and explores the idea of reforming abortion law using human rights, using South Africa as an example. Ngwena concludes that the language of human rights is particularly appropriate and efficacious in relation to abortion in Africa and should be used by all who seek improvements to women's human rights.

Landon Myer & Chelsea Morroni, "Supporting the Sexual and Reproductive Rights of HIV-Infected Individuals" (2005) 12(1) *South African Journal of Obstetrics and Gynaecology* 16, 18.

The past 10 years have seen major advances in health care policy and services that support sexual and reproductive rights in South Africa. Significant milestones include legalisation on termination of pregnancy and the provision of free public sector services for maternal and child health and contraception. At the same time the HIV epidemic has expanded rapidly during the last decade, and today an estimated 29% of women of reproductive age (15-49 years) in South Africa are HIV-infected. Despite these parallel developments, little attention has paid to the way in which advances in sexual and reproductive rights in South Africa are extended to HIV-infected individuals.

Adriana Ortega-Ortiz, "Women's Fundamental Rights and the Statutory Defense for Abortion Based on Health Risks in Mexico" (LL.M. Thesis, University of Toronto, Faculty of Law, 2005).

In this thesis, I analyse the statutory defence regime for abortion in Mexico in general and the statutory defence of health risks in particular. Relying on the constitutional and human rights frameworks, I argue that the legislative incorporation of every statutory defence is a consequence of the Mexican State's obligation to protect and respect women's fundamental rights. I analyze the statutory defence of health risks in a way that offers guidance to physicians performing risk assessments in a manner that respects and gives effect to the rights of women that are involved in this defence, particularly the constitutional right to health protection and the human right to health. I understand this approach as a strategy to overcome the unfairness resulting from the varying interpretation and operation of the exceptions to the criminal prohibition of abortion.

(g) Neglected Population: Adolescent Girls

Olivia Bayley, "Improvements of Sexual and Reproductive Health Requires Focusing on Adolescents" (2003) 362 *Lancet* 830.

In many developing countries a large proportion of young women become pregnant during adolescence. Pregnancy and childbirth at this age carry major risks and according to WHO constitute the main cause of death in 15-19 year old girls worldwide, with about 60 000 young women dying each year. Furthermore, early pregnancy inhibits young women's chances of obtaining an education and may diminish their social status. Consequently, most births to both married and unmarried adolescents are unwanted or mistimed. Indeed, a large proportion end in unsafe abortion, since even where abortion is legal, poor access and high cost affect adolescents disproportionately. In addition, sexually transmitted infections pose a serious threat to adolescents' health, as is powerfully illustrated in the case of HIV: more than 7000 young people become infected with HIV every day, accounting for at least half of all new infections. This fact represents serious and wide-ranging issues regarding adolescents and their behaviours.

Lawrence J. D'Angelo *et al.*, "HIV infection and AIDS in Adolescents: An Update of the Position of the Society of Adolescent Medicine" (2006) 38 *Journal of Adolescent Health* 88.
<http://www.genderhealth.org/pubs/SAMPositionPaperHIV.pdf>

The Society of Adolescent Medicine reaffirms its call for accurate and comprehensive monitoring of HIV infection in youth. The Society endorses efforts to expand knowledge of HIV infection to youth from all countries and recognizes that priorities in this regard need to be based on local needs, not externally developed policies. The Society supports research into HIV care and treatment initiatives that are focused on youth, expansion of testing and counseling efforts that utilize state-of-the-art techniques and an immediate linkage to comprehensive care for positive or concerned youth. It endorses community based HIV/AIDS prevention and education that recognizes the importance of abstinence but that is comprehensive and sensitive to the needs of all adolescents, including those who are gay, lesbian, bisexual, transgender or questioning. The Society supports continued research focusing on the antecedents of HIV infection and important preventive tools such as microbicides and vaccines.

June Larkin & Claudia Mitchell, "Gendering HIV/AIDS Prevention: Situating Canadian Youth in a Transitional World" (2004) 3(2) *Women's Health and Urban Life* 34.
https://tspace.library.utoronto.ca/bitstream/1807/3067/2/Larkin_Gendering_HIV-AIDS_Prevention.pdf

In this research note we bring the work of transnational feminist scholars to our study of gender, risk and HIV prevention and make the case for situating prevention work with Canadian youth in a larger global context. Drawing on HIV work in both Canada and South Africa and preliminary data from our focus groups with Canadian youth, we consider the value of a transnational analytic for furthering our understanding of the complexities of gendered risks both within and across two countries: South Africa with HIV infection rates around 20% and Canada where infections rates are low but with worrying signs about the potential for the spread of the disease. In an increasingly globalized world, we argue that the problem of first world/third world binaries, the transnational circulation of racist representations of AIDS, and the restructuring of gender systems are important considerations for HIV research and education with youth.

See also:

Kate Barnhart, "Adolescent Underrepresentation in Clinical AIDS Research" in Nancy Goldstein & Jennifer L. Manlowe, eds., *The Gender Politics of HIV/AIDS in Women* (New York; London: New York University Press, 1997), pp. 74-85.

This chapter focuses on one of the most invisible groups in the AIDS epidemic: HIV-infected adolescents. The author outlines some of the gaps in knowledge about HIV infections in adolescence. These gaps include information about the epidemiology of HIV in adolescents, the natural history of HIV in adolescents, and correct drug dosage during puberty. Some of the issues that contribute to the exclusion of adolescents from AIDS research are also addressed, particularly issues around capacity to consent, access to care, and stereotypes of adolescents as non-compliant. Finally, it is contested that the historic exclusion of women from AIDS research combines with the exclusion of adolescents to create formidable barriers to understanding HIV infection in young women.

B.M. Dickens & R.J. Cook, "Adolescents and Consent to Treatment" (2005) 89 *International Journal of Gynecology and Obstetrics* 179.

Adolescents, defined by WHO as 10 to 19 years old, can give independent consent for reproductive health services if their capacities for understanding have sufficiently evolved. The international Convention on the Rights of the Child, almost universally ratified, limits parental powers, and duties, by adolescents' "evolving capacities" for self-determination. Legal systems may recognize "mature minors" as enjoying adult rights of medical consent, even when consent to sexual relations does not absolve partners of criminal liability; their consent does not make the adolescents offenders. There is usually no chronological "age of consent" for medical care, but a condition of consent, meaning capacity for understanding. Like adults, mature minors enjoy confidentiality and the right to treatment according to their wishes rather than their best interests. Minors incapable of self-determination may grant or deny assent to treatment for which guardians provide consent. Emancipated minors' self-determination may also be recognized, for instance on marriage or default of adults' guardianship.

Anne Hellum & Anne Lene Staib Knudsen, "From Human Developments to Human Rights: A Southern African Perspective on Women's and Teenage Girls' Right to Reproductive Choice" (2006) 1 *Forum for Development Studies* 53.

The human rights based approach to development has in recent years made its mark on international and national development policies. This article explores how human development is considered in the evolving body of human rights law. Focusing on the practice of human rights treaty bodies, it addresses the interdependence between women's and girls' human development, their right to reproductive choice and the right to life, health, education, participation and work. The relationship between the right to reproductive choice and economic and religious constraints is given particular attention. To what extent can states be exempted, on the basis of resource constraints, from obligations embedded in human rights instruments? What are the human rights constraints of the policy of mainstreaming social, cultural and religious factors for advancing development goals? Are some rights more fundamental than others and, if so, which ones and on what basis?

IPPF, UNFPA, and Young Positives, *Change, Choice and Power: Young Women, Livelihoods and HIV Prevention – Literature Review and Case Study Analysis* (London, New York, Amsterdam: IPPF, UNFPA, Young Positives, 2007).
http://www.unfpa.org/upload/lib_pub_file/674_filename_change.pdf

If poor young women and adolescent girls have access to their own incomes, will they better be able to protect themselves against HIV infection? This paper focuses on Southern and Eastern Africa, where HIV prevalence rates are highest and concerted efforts are being made to address young women in terms of prevention. The roles of microfinance and vocational training are discussed. Some of these findings may be useful to illuminating issues relating to young women's empowerment in the context of HIV in the formal sector. In the end, innovative, far-reaching and rapid responses are needed to impact whole generations so that the Millennium Development Goal of reducing poverty can be within reach.

Deborah Robertson, "Sexual Health Related Decision-Making: Operationalizing Adolescents' Capacity to Consent" (Draft, 2006).

(h) Evidence-Based Practices and Policies

Charles Ngwena, "AIDS in Schools: A Human Rights Perspective on Parameters for Sexuality Education" (2003) 35 *Acta Academica* 102.

This article is set against the background of a sustained HIV/AIDS epidemic affecting the South African population, including the education sector. It explores the education sector's responses to the epidemic in the area of sexuality education for learners. It is submitted that lifeskills education – the main medium for imparting sexuality education – is an essential instrument in the armamentarium against HIV/AIDS. However, lifeskills education is not value-free. The values that underpin lifeskills education are libertarian in orientation. They cherish diversity, and do not sit easily with a sectarian view of life. The success of lifeskills education will depend, in part, on striking an acceptable balance between the duty of the school to impart the knowledge and skills essential for development and survival, the evolving capacity of the learner, and parental authority. In the final analysis, the impetus is towards a sexuality education in which the core values of human dignity, liberty and equality are protected and promoted in accordance with the imperatives of the Constitution.

John Santelli *et al.*, "Abstinence-Only Education Policies and Programs: A Position Paper of the Society of Adolescent Medicine" (2006) 38 *Journal of Adolescent Health* 83.

Abstinence from sexual intercourse represents a healthy choice for teenagers, as they face considerable risk to their reproductive health from unintended pregnancy and sexually transmitted infections (STIs) including infection with the human immunodeficiency virus (HIV). However, abstinence as a behavioral goal is not the same as abstinence-only education programs. Providing "abstinence only" or "abstinence until marriage" messages as a sole option for teenagers is flawed from scientific and medical ethics viewpoints. Abstinence-only education programs provide incomplete and/or misleading information about contraceptives, or none at all, and are often insensitive to sexually active teenagers. Federally funded abstinence-until-marriage programs discriminate against gay, lesbian, bisexual, transgender and questioning youth, as federal law limits the definition of marriage to heterosexual couples. Conversely, efforts to promote abstinence, when offered as part of comprehensive reproductive health promotion programs that provide information about contraceptive options and protection from STIs have successfully delayed initiation of sexual intercourse. "Abstinence only" as a basis for health policy and programs should be abandoned.

See also:

Hazel Glenn Beh & Milton Diamond, "The Failure of Abstinence-Only Education: Minors Have a Right to Honest Talk About Sex" (2006) 15 *Colum. J. of Gender & L.* 12.

This article criticizes abstinence only programs provided to American youth. The basis for this criticism is that they contain false and misleading information, they are not what the majority of the American public want as sex education, and that they do not fulfill the needs of the students. The authors are careful not to criticize the value of abstinence; they only criticize the decision to use misleading and incomplete information to promote the value of abstinence. The first part of this article discusses the sexual development of young people and the risks of unprotected sex. Part two examines the federal policy of funding abstinence only programs. Part three compares these abstinence only programs with more comprehensive sexual education programs. Part four argues that abstinence only programs are illegitimate in light of minors rights. The authors

conclude that abstinence only programs have no legitimate place in state funded schools because of their tendency to endanger the health of young people and because they violate the rights of young people.

Jonathan Cohen *et al.*, "Responding to the Global HIV/AIDS Pandemic: Perspectives from Human Rights and Public Health Ethics" in Chris Beyrer & H.F. Pizer, eds., *Public Health and Human Rights: Evidence-Based Approaches*. (Baltimore, MD: Johns Hopkins University Press, 2007).

This chapter discusses three public health interventions that aimed to reduce the spread or effect of HIV. Before examining the case studies the authors provide an overview of both human rights frameworks and public health ethics frameworks. The three case studies discussed are: condoms and safe sex campaigns, standardized HIV testing, and equitable provision of antiretrovirals. The authors use these interventions as examples to show that human rights tactics and principles should be used in all efforts to slow the spread of HIV or mitigate its effects. They argue that human rights and public health ethics are essential in the fight against HIV and in many areas they overlap, but they should be pursued separately to ensure programs and policies are both effective and ethical. The authors also advocate for prevention policies that take the human rights atmospheres of individual countries into account and do not try to make "one-size fits all" solutions. This article focuses on human rights and public health aspects of policy making as opposed to the provision of care.

Brigitte Holzner & Dede Oetome, "Youth, Sexuality and Sex Education Messages in Indonesia: Issues of Desire and Control" (2004) 12 *Reproductive Health Matters* 40.

Since the 1994 International Conference on Population and Development, the need for sexuality education for youth has been articulated, and numerous activities in Indonesia, especially Java, have been directed at young people. However, many parents, teachers and religious leaders have considered it essential that such education should suppress youth sexuality. This article reflects upon current discourses on youth sexuality in Java as against the actual sexual behaviour of young people. Using examples from popular magazines and educational publications, and focus group discussions with young men and women in Rurabaya, East Java, we argue that the dominant prohibitive discourse in Java denounces youth sexuality as unhealthy, reinforced through intimidation about the dangers of sex. In contrast, a discourse of competence and citizenship would more adequately reflect the actual sexual behaviour of youth, and raises new challenges for sexuality education. Information should be available to youth concerning different sexualities, respecting the spectrum of diversity. Popular youth media have an especially important role to play in this. The means to stay healthy and be responsible – contraceptives and condoms – should be available at sites where youth feel comfortable about accessing them. Meanwhile, young Indonesians are engaging in different forms of sexual relationships and finding their own sources of information, independent of government, religion and international organisations.

Zita Lazzarini & Robert Klitzman, "HIV and the Law: Integrating Law, Policy, and Social Epidemiology" (2002) 30 *J.L. Med. & Ethics* 533.

In the foundational piece in this issue of the journal, "Integrating Law and Social Epidemiology," Burris, Kawachi, and Sarat present a model for understanding the relationship between law and health. This article uses the case of a specific health condition, the human immunodeficiency virus (HIV) infection, as an opportunity to flesh out this schema and to test how the model "fits" the world of the HIV pandemic. This article will consider first how laws in the United States could

plausibly act as pathways, or mechanisms, by which deeper social determinants affect health, specifically HIV risk and resilience. Next, it will address the role of law in shaping those determinants themselves. For each example, we will ask the following questions: (1) how do law and policy link with risk; (2) what evidence supports this link; (3) what conclusions can we draw from the relationship between law/policy and risk; and (4) based on these conclusions, what policy options or research questions can we identify that will enhance the use of law/policy as a structural intervention.

(i) Community and Family Based Care

Jessica Ogden et al., "Expanding the Care Continuum for HIV/AIDS: Bringing Carers into Focus" *Horizons Report* (Washington: Population Council and International Center for Research on Women, 2004).

<http://www.popcouncil.org/pdfs/horizons/xpndngcrctnm.pdf>

Although the role that men and boys are playing as providers of care in the context of the HIV/AIDS epidemic has been poorly documented and inadequately understood, it is generally recognized that women and girls are the principal caregivers in the vast majority of homes and bear the greatest degree of responsibility for the psychosocial and physical care of family and community members – a responsibility with substantially greater weight in homes affected by HIV and AIDS. This review explores the specific issues that cluster around the provision of care in the context of the global HIV/AIDS pandemic. The care economy provides an important lens through which to view the HIV/AIDS pandemic, as it illuminates the increased labor, time and other demands placed upon households and shows that the assumptions on which norms and expectations of care provision are based are increasingly being challenged. Many indigenous social safety nets that, in the pre-AIDS era, underpinned the care economy and in times of crisis enabled many households to remain viable are being eroded in highly affected communities. Various development interventions that have helped many families to manage, such as microfinance, micro-credit and income generation projects, are likewise not necessarily appropriate as currently designed and implemented for those affected by AIDS. A strategy of simply downloading responsibility for care onto women, families, and communities can no longer be a viable, appropriate or sustainable response.

See also:

Rebecca L. Upton, "'Women Have No Tribe': Connecting Carework, Gender, and Migration in an Era of HIV/AIDS" (2003) 17(2) *Gender & Society* 314.

The country of Botswana currently has one of the highest HIV infection rates in the world. Government and international aid agencies have undertaken initiatives to address the rapidly growing epidemic, but few measures address the current crisis of care as a key element in that process. In this article, the author uses case study data to highlight how women in Northern Botswana are affected by the increasing burden of caregiving to children who are orphaned as a result of the HIV/AIDS epidemic. In particular, she describes how the role of women as caregivers in communities has been transformed as a result of the HIV/AIDS crisis. She suggests that the intersecting cultural patterns of migration and reproduction are central to understanding the spread of the disease in the current emerging crisis of care.

(j) Gender Dimensions of Health Rationing

Minister of Health and others v Treatment Action Campaign [2002] 5 S. Afr. L. R. 721 (S. Afr. Const. Ct).

<http://www.constitutionalcourt.org.za/Archimages/2378.PDF>

On 5 July 2002, South African treatment activists won a significant victory when the Constitutional Court ordered the South African government to make the antiretroviral drug nevirapine available in public hospitals and clinics for the purposes of preventing mother-to-child transmission of HIV. The Court also ruled the government has a constitutional obligation to implement a program to realize the right of pregnant women and their newborn children to access health services to prevent transmission.

Sara Bennett & Catherine Chanfreau, "Approaches to Rationing Antiretroviral Treatment: Ethical and Equity Implications" (2005) 83(7) *WHO Bulletin* 541.

<http://www.who.int/bulletin/volumes/83/7/541arabic.pdf>

Despite the growing global commitment to the provision of antiretroviral therapy (ART), its availability is still likely to be less than the need. This imbalance raises ethical dilemmas about who should be granted access to publicly-subsidized ART programmes. This paper reviews the eligibility and targeting criteria used in four case-study countries at different points in the scale-up of ART, with the aim of drawing lessons regarding ethical approaches to rationing. Mexico, Senegal, Thailand and Uganda have each made an explicit policy commitment to provide antiretrovirals to all those in need, but are achieving this goal in steps – beginning with explicit rationing of access to care. Drawing upon the case-studies and experience elsewhere, categories of explicit rationing criteria have been identified. These include biomedical factors, adherence to treatment, prevention-driven factors, social and economic benefits, financial factors and factors driven by ethical arguments. The initial criteria for determining eligibility are typically clinical criteria and assessment of adherence prospects, followed by a number of other factors. Rationing mechanisms reflect several underlying ethical theories and the ethical underpinnings of explicit rationing criteria should reflect societal values. In order to ensure this alignment, widespread consultation with a variety of stakeholders, and not only policy-makers or physicians, is critical. Without such explicit debate, more rationing will occur implicitly and this may be more inequitable. The effects of rationing mechanisms upon equity are critically dependent upon the implementation processes. As antiretroviral programmes are implemented it is crucial to monitor who gains access to these programmes.

Norman Daniels, "Fair Process in Patient Selection for Antiretroviral Treatment in WHO's Goal of 3 by 5" (2005) 366 *Lancet* 169.

This article addresses the question of who should be selected for treatment in reference to the WHO's goal to treat 3 million people with antiretroviral drugs by 2005. The author points out that other than guidance from some international human rights documents given in relation to fair processes, such as principles of non-discrimination, there is no agreement on which 3 million out of 6 million infected people should receive treatment. The article is separated into four competing considerations in the 3 by 5 plan. The first is cost-recovery. Many advocates argue for completely free treatment because many people affected by HIV/AIDS would not be able to afford even subsidized treatment, while others argue that this would endanger the plan's sustainability. The second consideration is medical eligibility. Some people think that preference for treatment should be given to those who would receive the best outcomes from treatment.

The third consideration is sitting. It is easy and cost effective to take advantage of existing medical facilities in cities and if the area of the treatment centre has a higher population than you can treat more people with less resources. However, people in rural settings also need treatment and many think it is not morally permissible to neglect them due to cost issues. The fourth and final consideration is whether to give priority to health care workers or other groups. The principle that people should not be treated differently according to social worth conflicts with the idea that certain groups, most notably health care workers, should receive preferential treatment because of society's dependence on them. The author does not attempt to answer the question of who should be chosen for treatment but instead offers these considerations as factors relevant to fair process decision-making.

See also:

Lesley Doyal, "Gender Equity in Health: Debates and Dilemmas" (2000) 51(6) *Social Science & Medicine* 931.

Gender equity is increasingly cited as a goal of health policy but there is considerable confusion about what this could mean either in theory or in practice. If policies for the promotion of gender equity are to be realisable their goal must be the equitable distribution of health related resources. This requires careful identification of the similarities and differences in the health needs of men and women. It also necessitates an analysis of the gendered obstacles that currently prevent men and women from realising their potential for health. This article explores the impact of gender divisions on the health and the health care of both women and men and draws out some of the policy implications of this analysis. It outlines a three point agenda for change. This includes policies to ensure universal access to reproductive health care, to reduce gender inequalities in access to resources and to relax the constraints of rigidly defined gender roles. The article concludes with a brief overview of the practical and political dilemmas that the implementation of such policies would impose.

Hillary Standing, "Gender and Equity in Health Sector Reform Programmes: A Review" (1997) 12(1) *Health Policy Plan* 1.

This paper reviews current literature and debates about Health Sector Reform (HSR) in developing countries in the context of its possible implications for women's health and for gender equity. It points out that gender is a significant marker of social and economic vulnerability which is manifest in inequalities of access to health care and in women's and men's different positioning as users and producers of health care. Any analysis of equity must therefore include a consideration of gender issues. Two main approaches to thinking about gender issues in health care are distinguished - a 'women's health' approach, and a 'gender inequality' approach. The framework developed by Cassels (1995), highlighting six main components of HSR, is used to try to pinpoint the implications of HSR in relation to both of these approaches. This review makes no claim to sociological or geographical comprehensiveness. It attempts instead to provide an analysis of the gender and women's health issues most likely to be associated with each of the major elements of HSR and to outline the actual impact of HSR from a gender point of view and in relation to substantive forms of vulnerability (e.g. particular categories of women, specific age groups). The use of generic categories, such as 'the poor' or 'very poor' leads to insufficient disaggregation of the impact of changes in the terms on which health care is provided. This suggests the need for more carefully focused data collection and empirical research.

(4) Accountability, Advocacy & Documentation

Catherine Albertyn, "Contesting Democracy: HIV/AIDS and the Achievement of Gender Equality in South Africa" (2003) 29 *Feminist Studies* 595.

This article will interrogate progress toward gender equality in South Africa through the lens of HIV/AIDS. An analysis of the relationship between HIV/AIDS and gender reveals how gender inequalities have fueled the epidemic in South Africa. It also reiterates the complex nature of gender inequality by highlighting the multiple and intersecting levels of sexual, cultural, and economic inequality that structure the impact of HIV/AIDS on different groups of women in South Africa. The HIV/AIDS epidemic reemphasizes the role of the private in subordinating women and compels us to confront the power that men have over women, and how this is differentially constructed, reinforced, and reinvented through cultural norms about gender and sexuality. In confronting this power, we also need to uncover the multiple ways that women have opposed, resisted, and subverted it. These are perhaps necessary prerequisites to finding new voices and strategies for achieving gender equality in the public and private spheres.

Luisa Cabal & Pardiss Kebriaei, "Using Litigation to Address Gender Violations in the HIV/AIDS Context" (2006) 13 *U.C. Davis Journal of International Law & Policy* 9.

Using litigation to address gender violations is a more recent strategy in the realm of economic and social rights, such as the right to health, and issues particular to certain groups, such as women or people living with HIV/AIDS. Victories in these areas attest to the potential of using litigation to address human rights violations in the context of access to health care and, for the purposes of this article in particular, the sex and gender dimensions of such violations. Violations against women and girls living with HIV/AIDS in the health-care context have been documented in countries around the world. Judicial successes in this context indicate the potential of using litigation to hold governments accountable for gender-related violations in health-care systems, including those experienced by women and girls living with HIV. Instances of forced or coerced sterilization of HIV-positive women have been documented in countries in Latin America, Asia, Africa and Eastern Europe. The experiences of the Center for Reproductive Rights and collaborating organizations in litigating reproductive rights cases demonstrate the potential of using litigation to address the sex and gender dimensions of health and human rights violations, such as those that occur in the HIV/AIDS context. Increasingly, sex and gender based violations in the HIV/AIDS context are being documented and recognized by both activists on the ground and international human rights bodies.

Ebenezer Durojaiye, "Advancing Gender Equality in Access to HIV Treatment Through the Protocol on the Rights of Women in Africa" (2006) 6 *African Human Rights Law Journal* 188, pp.10-23.

This article examines the challenges women face in accessing HIV/AIDS treatment in Africa and the need to ensure equality in access to treatment. It further argues that, in accordance with the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, there is a need for states to adopt affirmative action in order to improve access to HIV treatment for women in Africa. The focus of this article is measures to ensure equity in access to anti-retroviral drugs for women. Although the article briefly discusses access to Nevirapine to prevent mother-to-child-transmission of HIV/AIDS, the focus is on women's needs and not the needs of the child. Factors limiting women's rights to access to HIV treatment, such as discrimination, poverty and inadequate spending on the health care, are considered. The article

discusses the role state parties to the Protocol can play in ensuring equity in access to treatment for women in their territories.

Caren Grown *et al.*, "Taking Action to Improve Women's Health Through Gender Equality and Women's Empowerment" (2005) 365 *The Lancet* 541.

This article outlines how the persistent disadvantages experienced by women act as barriers to improved health status. The authors argue that long-term and sustained improvements in women's health can only be achieved by eliminating the inequalities and disadvantages that women and girls face in education and economic opportunity. Research shows how secondary education for women is associated with high age at marriage, low fertility and mortality, good maternal care and reduced vulnerability to HIV and AIDS. It also shows how improved infrastructure and economic independence is linked to improved health. The authors outline necessary changes to address these inequities. Improvements in education include making school more affordable and building secondary schools close to where girls live. Key changes also include improving content, quality and relevance through curriculum reform and teacher training and other activities aimed at transforming attitudes, beliefs, and gender-based social norms. Governments also need to guarantee effective and independent property and inheritance rights to land and housing for women. Gender inequality is deeply rooted in attitudes, institutions and market forces. Consequently, political commitment at national and international levels is needed to enact these policies and allocate the necessary resources for gender equality and women's empowerment to improve female health.

Helen Watchirs, "A Human Rights Approach to HIV/AIDS: Transforming International Obligations into National Laws" (2002) 22 *Aust. Y.B.I.L.* 77, pp. 77-84, 86-87, 95-97, 108-112.

This article explores the intersection between international human rights obligations and their observance at national and other levels in the context of HIV/AIDS. It argues that increased compliance with human rights norms may be gained by auditing legal implementation of the specific benchmarks in the *International Guidelines on HIV/AIDS and Human Rights*. The article describes a new methodology for charting progress or deterioration in the legal protection of human rights, on the assumption that "what gets measured gets done." Specificity is an important safeguard against states parties using 'weasel' words to avoid implementing international obligations. Such a mechanism should be especially useful in dualist states where international instruments are not self-executing (as in monist states), and require domestic legislation to make them operative. The audit attempts to answer the call by the late Jonathan Mann, the founder of the health and human rights movement to "move from concepts to action in health and human rights."

See also:

Luisa Cabal *et al.*, "What Role Can International Litigation Play in the Promotion and Advancement of Reproductive Rights in Latin America?" (2003) 7(1) *Health Hum. Rights* 50.

During the past decades, legal advocacy has played a critical role in changing the realities of women's reproductive lives in countries worldwide. The courts may be an excellent venue for bringing about change, especially where there is a disconnect between international, constitutional, or legislative norms and the reality of women's lives. The Center for Reproductive Rights' International Legal Program and its partner organizations in Latin America have pioneered the use of international litigation as a strategy to ensure that legislation and policies better reflect the international community's recognition of reproductive rights. This article aims to

share the Center's experiences; explore the use of high-impact litigation to further reproductive rights; evaluate whether the time is right for litigation; examine the process of identifying issues and cases; and understand the potential pitfalls and opportunities of such litigation.

Center for Reproductive Rights, *Reproductive Rights in the European Court of Human Rights* (New York: Center for Reproductive Rights, 2004).

http://www.crlp.org/pdf/pub_bp_RREuropeanCourt.pdf

This briefing paper provides a short background on the European human rights system, including an explanation of the European Convention on Human Rights and its enforcement mechanisms, including the European Court of Human Rights and the European Commission of Human Rights (Commission). It then examines the most important Court and Commission judgments related to reproductive rights divided by issue; the judgments under each issue are followed by analysis and application of the decisions and how they can be used to address or advance related reproductive rights issues. There are two appendixes; one provides information on how to bring a claim before the European Court of Human Rights and the other contains relevant provisions of the European Convention on Human Rights.

Center for Reproductive Rights, *Reproductive Rights in the Inter-American System for the Promotion and Protection of Human Rights* (New York: Center for Reproductive Rights, 2002).

http://www.crlp.org/pdf/pub_bp_rr_interamerican.pdf

This briefing paper examines the inter-American system's work on reproductive rights since its inception. This paper also discusses the cases and reports brought before the inter-American system by the Center for Reproductive Rights and partner organizations.

Center for Reproductive Rights, *Bringing Rights to Bear: An Advocate's Guide to the Work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights* (New York: Center for Reproductive Rights, 2002).

http://www.crlp.org/pdf/pub_bp_brb.pdf

This paper is a practical guide for advocates for using the UN treaty monitoring bodies to gain advances in women's reproductive and sexual health rights. It begins by giving a basic description of international treaties and the UN bodies that monitor them. It then systematically examines each of the main treaty monitoring bodies that are relevant to women's reproductive rights issues. These monitoring bodies are: the committee against torture, the committee on the elimination of discrimination against women, the committee on economic, social and cultural rights, the committee on the elimination of racial discrimination, the committee on the rights of the child, and the human rights committee. For each of these committees this paper outlines its mandate, the reproductive rights related provisions of the treaty, basic information about the body, state parties, and the standing of NGOs.

NB: An update to *Bringing Rights to Bear* was published in 2008. The update consists of a series of independent briefing papers, and reflects the growing recognition among UN bodies that reproductive rights are firmly grounded in international human rights treaties. The first four updated briefing papers focus on the subjects of sex education, HIV/AIDS, violence against women, and contraception and family planning. Check back for briefing papers on the issues of maternal mortality, female genital mutilation, abortion, and marriage and private life, scheduled for release later this year.

See:

- Family Planning is a Human Right: http://www.reproductiverights.org/pdf/BRB_Contra.pdf

- Human Rights in the Context of HIV/AIDS and Other Sexually Transmissible Infections:
http://www.reproductiverights.org/pdf/BRB_HIV.pdf
- The Human Right to Information on Sexual and Reproductive Health:
http://www.reproductiverights.org/pdf/BRB_SexEd.pdf
- Freedom from Violence is a Human Right:
http://www.reproductiverights.org/pdf/BRB_VAW.pdf

Canadian HIV/AIDS Legal Network and the Joint UN Programme on HIV/AIDS, *Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV* (Geneva: Canadian HIV/AIDS Legal Network and UNAIDS, 2006).

<http://www.aidslaw.ca/Maincontent/issues/discrimination/Courtingrights-ENG.pdf>

This is a collection of case studies involving HIV/AIDS litigation in developing countries. The cases are separated into three different sections: HIV-related discrimination, access to HIV-related treatment, and HIV prevention and care in prisons. Each section contains approximately ten cases from a variety of jurisdictions. Each case study contains the court and the date of the decision, the parties, the remedy sought, the outcome, the background and material facts, the legal arguments and issues addressed, and commentary on the case.

Larry Gostin & Jonathan Mann, "Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies" (1994) 1(1) *Health Hum. Rights* 58.

<http://www.hsph.harvard.edu/xfbcenter/V1N1gostin.htm>

All governmental policies in general, and health policies in particular, have the potential to burden human rights to a greater or lesser degree, whether by restricting freedoms, discriminating against individuals or population groups, or other mechanisms. While the protection of public health may in some cases outweigh concerns relating to human rights burdens, there are many instances where human rights are needlessly infringed. This article proposes a Human Rights Impact Assessment Tool that allows policy makers and human rights advocates to identify potential human rights burdens posed by public health policies and suggests strategies for ameliorating those burdens.

International Guidelines on HIV/AIDS and Human Rights, U.N.C.H.R. Res. 1997/33, U.N. Doc. E/CN.4/1997/150 (1997)

<http://www1.umn.edu/humanrts/instree/t4igha.html>

This document summarizes guidelines made as a result of the report of the Secretary-General on the Second International Consultation on HIV/AIDS and Human Rights. The report itself presents the outcome of the Consultation, including guidelines recommended by expert participants for States on the promotion and protection of fundamental rights and freedoms in the context of HIV/AIDS, and strategies for their dissemination and implementation. General guidelines include the establishment of an effective national framework for AIDS policy, political and financial support, review of public health laws, anti-discrimination measures, legal support, and public and private sector coordination.

D.C. Jayasuriya, "AIDS-Related Legislative Strategies Relating to Women and Infants" (1993) 7 *Int'l Journal of Law and the Family* 1, pp. 12-13.

Several million women and infants are currently infected with the human immunodeficiency virus (HIV), and within a matter of a few years, many of them will die of the acquired immunodeficiency syndrome (AIDS). The international community is increasingly concerned with the implications of HIV and AIDS in women and infants, on family life in particular and on society in general. Among the many strategies deployed to deal with the problem of HIV/AIDS in women and infants, and to minimize HIV transmission, are legal interventions. However, not all such interventions are capable of satisfactorily responding to the problems of particular relevance to women and infants. This article looks at AIDS-related legal approaches relating to women and infants in the contexts of screening; occupational hygiene and licensing; breastfeeding, adoption and infant care; and abortion. There is a need for the HIV/AIDS problem, in women and infants, to be studied from a broad social perspective, before appropriate legislative strategies are devised. The failure to do so might result in the formulation of ill-conceived strategies which focus on narrow and low-priority issues.

Jayanth Krishnan, "The Rights of the New Untouchables: A Constitutional Analysis of HIV Jurisprudence in India" (2003) 25 *Human Rights Quarterly* 791, pp. 792-794; 807-819 (*Mr. X v. Hosp. Z*, 1999).

It is believed that India will soon have the highest number of HIV/AIDS cases of any country. Some reports project that 37 million people will be infected within the next two decades. Sadly, few studies have examined the legal claims of those who suffer with this disease in this, the world's largest democracy. In this article, I systematically examine how the courts in India have responded to rights-based claims brought by people who have HIV. The conventional wisdom is that the Indian judiciary frequently protects the rights of the poor, the under-represented, and the ill. But my findings reveal that, at least for people with HIV, the courts have not extended to this group full constitutional protection. The implications of this conclusion force us to revisit whether the courts in India best safeguard the rights of others who are disadvantaged.

Ministry of Law and Justice, India, *The HIV/AIDS Bill 2006 (pending legislative approval by Government of India)*.
<http://www.lawyerscollective.org/content/draft-law-hiv>

The Lawyers Collective HIV/AIDS Unit (LCHAU) was asked to prepare draft legislation on HIV/AIDS to present to the Indian Parliament. The goal was to create a comprehensive law that protects the rights of persons living with HIV/AIDS. Substantive provisions of the legislation address issues of discrimination, disclosure of HIV status, safe working environments, social security payments, informed consent, access to treatment, risk reduction, information education and communication, and state obligations. The draft legislation is currently under consideration by the Government of India.

Eileen O'Keefe & Alex Scott-Samuel, "Human Rights and Wrongs: Could Health Impact Assessment Help?" (2002) 30(4) *Journal of Law, Medicine & Ethics* 734.

While the importance of civil and political rights to health advocates is widely acknowledged, economic and social rights are not yet securely on advocates' agenda. Health impact assessment is an approach that can promote an appreciation of their importance. This paper introduces health impact assessment, gives examples of how it is being used, links its development to a focus on inequalities in health status, indicates the insufficiency of civil and

political rights to protect health, and shows that the use of health impact assessment draws attention to economic and social rights. While civil and political rights are an astonishing social achievement, they are not in themselves sufficient to promote health.