MORTAL COMBAT: A RIGHT TO HEALTH PERSPECTIVE OF STATE OBLIGATIONS TO WOMEN IN THE CONTEXT OF HIV AND AIDS*

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> This is not simply a matter of social justice. Gender inequality is fatal…There is a direct correlation between women's low status, the violation of their human rights and HIV transmission. The reason that AIDS has escalated into a pandemic is because inequality between women and men continues to be pervasive and persistent. It is time for the AIDS community to join hands with the international women's community to hold governments accountable.[2]

I.INTRODUCTION

Women generally suffer poor health. Women's health is also intertwined with several factors that can be described as 'a patchwork quilt of patriarchies'.[3] The phrase was used by Bozzoli to describe the different positions of South African women. These patriarchies are expressed in class, race, gender, geographic location and ideological position. [4] Moreover, sexual and reproductive ill health gives rise to nearly 20 per cent of the global burden of ill health for women and 14 per cent for men.[5] For example, in 2005, there were an estimated 536 000 maternal deaths worldwide.[6] 99 per cent of these deaths occur in developing countries. Further, about 80 million women annually experience unintended pregnancies, some 19 million of whom undergo unsafe abortions, resulting in 68,000 deaths of all pregnancy-related deaths.[7] More pertinently within the context of this paper, women in Sub Saharan Africa represent about 67 per cent of young people living with HIV and AIDS.[8]

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[2] Former UNIFEM Executive Director Noeleen Heyzer while making a call for action to make women central to every strategy in the fight against HIV AND AIDS. June 2001.

[3] B Bozzoli 'Marxism, Feminism and South African Studies' (1983) 9 *Journal of South African Studies* 139.155.

[4] *Id*.

[5] *See*, P Hunt and De Mesquita 2007 'The rights to Sexual and Reproductive Health' Human Rights Centre, University of Essex. Hunt and de Mesquita write that for various reasons, sexual and reproductive ill health is severely underestimated and so statistics fail to capture the full burden of such ill health.

[6] World Health Organization [WHO], United Nations Children's Fund [UNICEF], United Nations Population Fund [UNFPA] and World Bank, 2007. 8.

[7] *Supr*a note 5.

[8] UNAIDS/WHO *AIDS epidemic update* 2008.

Despite this poignant state of women's health, issues relating to women's sexual and reproductive health remain on the peripheries of most states' agenda. This is despite the fact that sexual and reproductive health rights are integral elements of the right to health.[9] It is not surprising that the World Health Organisation said: [10]

> Women's health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination. Today, the status and well-being of countless millions of women worldwide remain tragically low.

The International Conference on Population and Development (ICPD)[11] and the Fourth World Conference on Women[12] recognised that sexual and reproductive health is fundamental to individuals and ultimately, to communities. Furthermore, the Millennium Development Goals deriving from the Millennium Declaration, although they do not expressly refer to sexual and reproductive health, embody three relevant goals on maternal health, child health and HIV and AIDS.[13] These three goals are interrelated in light of the recent trend on HIV and AIDS-related maternal motality. There have been reviews and reports on these processes all of which point to the fact that more needs to be done to realise women's health in the context of HIV and Aids among others. Legally, save for the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women Protocol),[14] there is no international binding treaty specifically mentioning HIV and AIDS in its provisions. Prior to this, the *International Guidelines on HIV/AID and human rights* (Guidelines)[15] and its Revision[16] provided the only human rights standards on HIV and AIDS.[17] Subsequently however, a body of rights and entitlements have emerged from existing legal instruments and their interpretations placing obligations on the state to provide for women's health in the context of HIV and AIDS. These will be explored in this paper.

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[9] General Comment 14, 'The Right to the Highest Attainable Standard of Health' (Article 12 of the Covenant) UN Committee on Economic, Social and cultural Rights. Twenty-Second session. 2000. Para 8; *See*, generally, A Miller 'Sexual but not Reproductive: Exploring the Junction of Sexual and Reproductive Rights' *(*2000) 4 *Health and Human Rights: An International Journal* 69 -109; RJ Cook, et al, (2003) *Reproductive Rights and Human Rights: Integrating Medicine, Ethics, and Law*. Clarendon Press.

[10] The World Health Report. World Health Organization, Geneva, 1998.

[11] UN International Conference on Population and Development, held in Cairo, 5- 13, September 1994.

[12] Fourth World Conference on Women, Beijing, China, 4-15 September 1995.

[13] UN Millennium Development Goals, available at www.un.org/milleniumgoals (accessed 15 October 2009).

[14] Adopted in Maputo in July 2003 and entered into force 25 November 2005.

[15] UNAIDS & OHCHR *International Guidelines on HIV/ AIDS and human rights*, 1997.

[16] UNAIDS & OHCHR *International guidelines on HIV/ AIDS: Revised Guideline 6*, 2002.

[17] The Guidelines were set by the office of the UN High Commission for Human Rights (OHCHR) and The Joint United Nations Programme on HIV/ AIDS (UNAIDS).

Against this background, this paper argues for a right to health approach to women's health in the context of HIV and AIDS. This is on the foundation that a human rights-based approach to HIV and AIDS relies on the availability of justiciable guarantees, secured through constitutions and legislation rather than on discretionary ad hoc policies.[18] The paper underscores the general and specific obligations of states to women in this context highlighting the key areas of concern, that is, in access to health services, access to adequate housing, inheritance rights in family relations and freedom from gender-based violence. The paper concludes that despite there being no express mention of HIV and AIDS in any international legal treaty, there has developed a body of rights over the years establishing legal and normative standards on realising women's right to health within this context. But what makes women more vulnerable to HIV and AIDS? A discussion of some of the factors causing this vulnerability follows.

II.WOMEN, HIV AND AIDS AND INEQUALITY

A plethora of literature exists on the vulnerability of women to HIV and AIDS.[19] This is especially argued within the context of biological and socio-economic factors. The underlying determinants are all related to gender inequities and inequalities.[20] Although it is difficult to quantify clinically, there is strong evidence that women and girls are physiologically more vulnerable than men and boys to HIV infection through heterosexual sex.[21] Vulnerability to HIV transmission is heightened for girls and

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[18] *See*, eg, L Gostin and JM Mann, 'Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies' (1994) 1 *Health and Human Rights* 58; C Kissoon et al, 'Whose Right? *AIDS Review 2002*. (Pretoria: Centre for the Study of AIDS, University of Pretoria, 2002) 13-19. See also, F Viljoen (2007) *International Human Rights Law in Africa*. Oxford University Press 586-607.

[19] *See*, generally, Human Rights Watch, 2003. Policy Paralysis: A Call for Action on HIV/AIDS-Related Human Rights Abuses against Women and Girls in Africa. Available at http://www.hrw.org/reports/2003/africa1203/africa1203.pdf. See also, C Albertyn 'Using Rights and Law to reduce Women's vulnerability to HIV AND AIDS' (2001) 5 *Law, Democracy and Development* 179-194; NM Naylor 'Cry the beloved Continent…'Exploring the impact of AIDS and Violence on Women's Sexual and Reproductive Rights in Southern Africa' (2005) 30 *Journal of Juridical Science* 52-79.

[20] Human Rights Watch, 2003. Policy Paralysis: A Call for Action on HIV/AIDS- Related Human Rights Abuses against Women and Girls in Africa. Available at http://www.hrw.org/reports/2003/africa1203/africa1203.pdf.

[21] A number of determinants of this higher risk have been cited, including the large surface area of the vagina and cervix, the high concentration of HIV in the semen of an infected man, and the fact that many of the other sexually transmitted diseases (STDs) that increase HIV risk are asymptomatic in women, which may lead to their being untreated for longer periods. Girls and women may also face discriminatory barriers to treatment of STDs, such as needing permission of a husband or male relative for certain services. See, e.g., Global Campaign for Microbicides, "About Microbicides: Women and HIV Risk," at http://www.global-campaign.org/womenHIV.htm (Accessed 15 October 2009); UNAIDS, "AIDS: Five years since ICPD—Emerging issues and challenges for women, young people and infants," Geneva, 1998, p.11, also at http://www.unaids.org/publications/documents/human/ gender/newsletter. PDF (Accessed 15 October 2009); and Population Information Program, Center for Communications Programs, The Johns Hopkins University Bloomberg School of Public Health, "Population Reports: Youth and HIV AND AIDS," vol. XXIX, no. 3, (Baltimore, MD, Fall 2001), p. 7.

young women because the vaginal lining is less well developed and the cervix more vulnerable to injury and erosion.[22] Furthermore, for women, successive pregnancies repress the immune system.[23] This is further exacerbated by culturally-sanctioned practices like dry sex, physiological factors like menstruation, co-efficiency with other Sexually Transmitted Diseases and Infections (STD/Is) which thrive more in women, and cross-generational sex.[24]

The above biological factors led to the medicalisation of HIV and AIDS.[25] One of the consequences of medicalising the problem is that it resulted in poor understanding of the socio-cultural characteristics of HIV transmission and its life-threatening implications for those affected, gender being one of them.[26] The increased physiological risk borne by women and girls in Africa is thus compounded by the HIV risk they bear from subordination, discrimination, and inequality under law and policy. This is especially experienced in barriers to access to health care services (including the underlying determinants of access to adequate housing, access to adequate nutrition, access to clean and safe drinking water) and gender-based violence.[27] This paper advocates for a move beyond epidemiology to address state obligation relating to access to health care services, access to adequate housing, right to inheritance and freedom from gender-based violence. A discussion of these in these areas follows.

A. Access to of heath services

Women continue to face discrimination in health services. This is linked to inequities in access to health services mainly caused by poverty (lack of training of health care providers).[28] What is more, within the debate of access to health services is the central discussion on access to Anti Retroviral therapy (ART) which includes anti-retroviral drugs (ARVs). Although there is no known cure for HIV and AIDS, anti-

[22] J Fleishman, 2003. *Fatal Vulnerabilities: Reducing the Acute Risk of HIV/ AIDS Among Women and Girls.* Available at http://csis.org/publication/fatal-vulnerabilities-reducing-acute-risk-hivaids-among-women-and-girls. Accessed 15 October 2009; Human Rights Watch, 2003. Policy Paralysis: A Call for Action on HIV/AIDS- Related Human Rights Abuses against Women and Girls in Africa. Available at http://www.hrw.org/reports/2003/africa1203/africa1203.pdf.

[23] S Page, Promoting the Survival of Rural Mothers with HIV/AIDS: A Development Strategy for Southern Africa (2001) 44 *Development* 40-46.

[24] J Simmons, et al, 'A Global Perspective' in P Farmer et al, (1996) (eds) *Women, Poverty and AIDS: sex, drugs and structural violence* 39.

[25] For a discussion on the reservation of the epidemic to biomedical aspects, *See*, generally, J Mann 'Health and Human Rights: If Not Now, When, Human Rights and the New Public Health' (1997) 2 *Health and Human Rights* 118.

[26] P McFadden 'Sex, Sexuality and the Problems of AIDS in Africa' in R A Meena (1992) (ed.) *Gender in Southern Africa: Conceptual and Theoretical Issues.* Harare: SAPES Books. 157-195.

[27] *Supra* note 22.

[28] *See* ME Greene & T Merrick, 2005. 'Poverty reduction: Does reproductive health matter? HNP discussion paper, *World Bank*, Washington DC.

retroviral drugs have been developed to prolong the lives of infected person. This means HIV and AIDS is manageable. However, many women do not have access to ARVs.[29] It was estimated in 2003 that testing and treatment of HIV and AIDS was available to only 1 per cent of pregnant women in the countries where the pandemic had struck the hardest.[30] The UNAIDS has however reported recent increase in access due to a decline in prices of the most commonly used antiretroviral drugs.[31] It will however be shown in this paper that many factors are attributed to women's inability to enjoy equal access to HIV treatment in Africa including discrimination, poverty, denial of property rights, poor transportation system and government reluctance to avail money and other resources.[32] This is worse for rural women. For example, the South African Human Rights Commission in its review of aspects of health services in the provinces, particularly noted that poor road conditions, long distances, infrequent transport and its high costs (relative to income) hinder patient's access to these services at the hospital level. [33] The report concluded that "poorest and most vulnerable members of society are frequently excluded from accessing higher levels of care…" for these reasons. These barriers to access were found to be worse for HIV and AIDS patients where only a small number of health care facilities have been accredited to provide ART in rural areas.[34] A study of the South African province of the Eastern Cape highlighted the serious transport barrier for some HIV patients who lived up to 200 kilometres from the nearest accredited treatment centre.[35]

Discriminatory attitudes towards women, as perpetuated by patriarchal tendencies further impede access to treatment. Research reveals that many families in Africa will prefer to pay for medication for men rather than women.[36] What is more, many

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[29] E Durojaye 'Advancing gender equity in access to HIV treatment through the Protocol on the Rights of Women in Africa' (2006)6 *African Human Rights Law Journal* 187.

[30] UNIFEM *Facts and figures on HIV/ AIDS*. Accessed 14 October 2009.

[31] The UNAIDS reports that of the estimated 9.5 million people in need of treatment in 2008 in low- and middle-income countries, 42% had access, up from 33% in 2007. The greatest progress was seen in sub-Saharan Africa, where two-thirds of all HIV infections occur. For details, go to http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090930_access_treatment_4millions.asp.

[32] *See* generally, Amnesty International 'I am at the lowest end of all: Rural women living with HIV face human rights abuses in South Africa', March 2008. The report is available at http://www.amnesty.org/en/library/info/AFR53/001/2008/en. (Accessed 16 October 2009).

[33] South African Human Rights Commission (2007), Provincial Findings in Preparation for the South African Human Rights Commission Public Enquiry into the Right to Have Access to Health Care Services. Synthesis Report, prepared by Antoinette Ntuli. Available at *www.sahrc.org.za/sahrc.../Provincial%20Synthesis%20Report.doc.*

[34] *Id.*

[35] *Id.*For more on how transport constrains women's access to health care services, see, C Venter, et al 'Engendering mobility: Towards improved gender analysis in the transport sector' in K van Merle (2006)(ed) *Sex, Gender, Becoming: Post apartheid reflections*. Pretoria University Law Press 117.

[36] Centre for Health and Gender Equity *Gender, AIDS, and ARV therapies: Ensuring that women gain equitable access to drugs within US funded treatment initiatives* (2004).

women still require the authorisation of husbands and partners before seeking medical treatment, including HIV and AIDS treatment.[37] They also face the fear of disclosure of status to family members. For example, a study in South Africa shows that most women feared to be abandoned or rejected.[38] They also feared violence, upsetting family members and facing accusation of infidelity.[39]

Also, women continue to face stigma from healthcare providers. This makes the health care ethos of respect, dignity, privacy and confidentiality elusive. These rights are crucial to the clinical management of women and HIV and AIDS. Health care centres are supposed to provide a congenial environment in which women are supported in decision-making regarding treatment thereby improving the quality of care. Generally therefore, women living with HIV and AIDS face problems in accessing appropriate services which meet their specific health needs, which are rarely understood or addressed by health service providers. A study in Zambia showed that young women faced difficulty in seeking treatment because of the fear that their sexual and reproductive health will not be respected.[40]

B. Access to housing (including water and sanitation)

Access to housing is closely linked with the right to health as a determinant of health.[41] Moreover there is increasing research showing that poorly housed and homeless women are more prone to HIV and AIDS.[42] The UN Special Rapporteur on Adequate Housing has reported that women living in situations of domestic violence inherently lived in inadequate housing.[43] The Special Rapporteur pointed out that there were different groups of women who were particularly vulnerable to discrimination and, due to a combination of factors, faced additional obstacles in

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[37] UNAIDS, UNFPA, UNIFEM Women and HIV/AIDS: Confronting the crisis (2004); *Supra* note 33.

[38] *Supra* note 32.

[39] *Id*. 64.

[40] *Supra* note 37.

[41] *See* paras 3, 8 and 11 of General Comment 14 of the CESCR.

[42] COHRE, 2008. Sources 5 'Women and housing rights-2nd edition. Centre on Housing Rights and Evictions. Available at http://www.cohre.org/sources5. Accessed 13 October 2009; H Swaminathan, et al (2008) Women's property rights, HIV and AIDS and domestic violence: Research findings from two districts in South Africa and Uganda. HSRC Press; See, generally, H Combrinck, 2009 'Living in security, peace and dignity: The right to have access to housing of women who are victims of gender-based violence'. University of the Western Cape: Community Law centre.

[43] Special Rapporteur on Housing. 2005. *Women and adequate housing*. UN Doc. E/CN.4/2005/43. Para 41.

accessing adequate housing.[44] In this category, he mentioned women who, *inter alia*, become widows as a result of HIV and AIDS.[45] He noted:[46]

> Highlighting the violations of the right to adequate housing experienced by different groups of women in vulnerable situations brings to the fore front the impact of multiple discrimination women face in relation to adequate housing, due to their gender, race, caste, ethnicity, age and other factors, but in many cases, also due to their relative impoverishment and lack of access to social and economic resources.

Access to affordable, accessible and reliable water and sanitation is crucial for people living with HIV and AIDS, and for providing home based care. Research shows that women bear the most burden of making water available in most homes in sub-Saharan Africa.[47] This is within the context of the burden of care largely borne by women.[48] This involves fetching water, bathing patients, washing laundry, digging pits for solid waste disposal, cleaning households and yards, assisting with access to social, health and other services, and providing counselling, information and support. Women and children walk long distances to find water in both rural and urban areas of sub Saharan Africa. Research showed that women and girls in Africa walk an average 6 km per day to collect water which translates into 150 million working days/year or a cost of then, in 2004, $208 million.[49] Studies in Zambia[50] and Malawi[51] indicate that water access in rural areas is on average 400 meters away from the home, but facilities are poorly maintained.

Research shows that water reform policy may increase social and gender differentiation, inequality and ill health. [52] Water is needed for taking anti-retroviral (ARV) medication, bathing patients, washing soiled clothing and linen; and for

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[44] Special Rapporteur on Housing. 2006. *Women and adequate housing*. UN Doc. E/CN.4/2006/118. Para 30; Combrinck, *supra* note 42.

[45] *Id.*

[46] *Id.*

[47] Water Supply and Sanitation Collaborative Council; Water, Engineering and Development centre. 2004. *For Her It's the Big Issue: Putting Women at the Centre of Water Supply, Sanitation and Hygiene Report*. Geneva. 7

[48] C Desmond et al 'The hidden battle: HIV/AIDS in the household and community' (2000) 7 *South African Journal of International Affairs*; *Supra* note 23; Henry Kaiser Family Foundation (2002) *Hitting Home*, How Households Cope with the Impact of the HIV/AIDS Epidemic. A Survey of Households Affected by HIV/AIDS in South Africa.

[49] *Supra* note 47.

[50] M Kangamba et al (2006). Catholic Relief Services – Water and Sanitation Assessment of Home-based Care Clients in Zambia. Baltimore, MD:Catholic Relief Services. Available at http://pdf.usaid.gov/pdf_docs/PNADJ423.pdf. (Accessed 17 October 2009).

[51] K Lockwood, et al (2006). Water & sanitation assessment of home-based care clients in Malawi. Baltimore, MD, USA, Catholic Relief Services (CRS). Available at http://pdf.usaid.gov/pdf_docs/PNADJ422.pdf. (Accessed 17 October 2009).

[52] A Ferguson (2003). *Water Reform, Gender, and HIV/AIDS: Perspectives from Malawi.* Paper delivered at the Society for Applied Anthropology Meetings, Portland.

essential hygiene, which reduces exposure to infections. Toilets are also need to be accessible for weak patients.[53] Hence, according to Potter et al, controlled water supply, as is the case in most urban and peri-urban areas, makes it difficult for home-based caregivers to carry out their activities, and compromises the impact of health and hygiene education and promotion carried out by community health workers. [54] The WHO[55] recognises the gender dimensions of home-care and that it is a strategy increasingly relied on by many countries adversely affected by HIV and AIDS, particularly those with weak health systems and infrastructures that are increasingly overwhelmed by the volume of patients requiring long-term care and management. The WHO adds that water, sanitation and hygiene are essential underpinnings to home care strategies, particularly in relation to HIV and AIDS, but that this is poorly recognised by either the health sector or the water and sanitation sector. [56] It is obvious that access to water and sanitation therefore defines the context of care women have to work in. Hence, according to Kofi Annan:[57]

> We shall not finally defeat AIDS, tuberculosis, malaria, or any other infectious diseases that plague the developing world until we have won the battle for safe drinking water, sanitation and basic health care

C.The culture of gender-based violence

A UN Secretary-General's study noted the patterns and consequences of violence against women (VAW) as a global phenomenon which is both a violation of women's human rights and prevents women from enjoying other human rights and fundamental freedoms, including the right to the highest attainable standard of health.[58]

[53] A Potter & V Molose, Mvula Trust. The report formed part of an integrated health and hygiene education project funded by the Water Research Commission; A Potter and Clacherty A (2007). Water services and HIV/AIDS. Water, sanitation and health and hygiene education in the context of HIV AND AIDS : a guide for local government councillors and officials responsible for water, sanitation and municipal health services. Pretoria, South Africa, Water Research Commission.

[54] *Id.*

[55] WHO, 2005 'Adequacy of Water, Sanitation and Hygiene in relation to Home-based Care Strategies for People Living with HIV/AIDS'. Available at http://www.who.int/water_sanitation_health/hygiene/wshhiv110705.pdf. (Accessed 13 October 2009).

[56] *Id.*

[57] Former United Nations Secretary General.

[58] UN Secretary-General (2006). UN Secretary – general's study on violence against women, background documentation for 61st session of the General Assembly Item 60(a) on advancement of women, UN Document A/61/122/Add.1 para 156; M Marmot (2007) [on behalf of the Commission on Social Determinants of Health] Achieving Health Equity: from root causes to fair outcomes (2007) 370 *Lancet* 1153-63.

According to Radhika Coomaraswamy: [59]

> Many forms of violence against women result in violations of women's reproductive rights because such violence affects their reproductive capacity or prevents them from exercising reproductive capacity or prevents them from exercising reproductive and sexual choices. Many reproductive rights violations similarly constitute violence against women

Domestic violence, particularly intimate partner violence may involve physical and sexual violence as well as threats of violence and emotional abuse. The WHO recognises this as a serious health problem internationally affecting up to 60 per cent of women across different countries. [60] The phenomenon is defined by unequal gender relations and has an impact on women's ability to protect themselves from HIV infection.[61] It reduces the autonomy of women and destroys their sense of personal safety and quality of life.[62] Naylor emphasises the point that for millions of girls and women in Africa, violence, HIV and AIDS and human rights abuses are experienced as strands of the same traumatic reality.[63]

It is therefore clear that several forms of inequality as explained above interact to put women in multiple and nested jeopardies. It is therefore imperative upon the state, to combat these inequalities and inequities in it law and policy. A discussion of the legal and normative framework on the right to health follows.

III.LEGAL AND NORMATIVE STANDARDS ON THE RIGHT TO HEALTH, HIV AND AIDS

At the international level, the right to health is provided for in most international treaties. The Universal Declaration of Human Rights proclaims the right to health.[64] However this declaration is not binding. The International Covenant on Economic Social Cultural Rights (ICESCR) also provides for the right to health. [65] The CESCR

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[59] Commission on Human Rights, Report by Special Rapporteur on Violence Against Women; Policies and Procedures that impact women's reproductive rights and contribute to, cause or constitute violence against women, Ms. Radhika Coomaraswamy E/CN 4./1999/68/Add.4, 21 January 1999; C Garcia-Moreno (1999) 'Violence Against Women' *Global Health Equity Initiative Working Paper no 15*, Harvard Centre for Population and Development Studies.

[60] World Health Organisation 2002 '*World report on violence and health.* Geneva: WHO. See also C Garcia-Moreno et al 'The Prevalence of violence against women: finding from the WHO multi-country study on women's health and domestic violence' (2006) 368 *Lancet* 1260-9; Amnesty International, 2004. *Women, HIV/ AIDS and human rights*. London.

[61] *Supra* note 32. P25.

[62] NM 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 *Journal for Juridical Science* 52 - 79; T Manuh 1998. *Women in Africa's Development: Overcoming Obstacles, Pushing for Progress.* http://www.un.org/ecosocdev/geninfo/afrec/bpaper/maineng.htm.

[63] *Id.*

[64] Adopted and proclaimed by the UN General Assembly in resolution 217 A (III) of 10 December 1948 at Paris. *See* article 25 thereof.

[65] Article 12 of the ICESCR.

provision on health deserves particular mention as the most important provision for the realisation of the right to health.[66] It provides for the right to the highest attainable standard of physical and mental health.[67] It adds that states must protect this right by ensuring that everyone within their jurisdiction has access to the underlying determinants of health, such as clean water, sanitation, food, nutrition and housing, and through a comprehensive system of healthcare, which is available to everyone without discrimination, and economically accessible to all.[68] The ICESCR further requires parties to take specific steps to improve the health of their citizens, including preventing, controlling and treating epidemic diseases, and creating conditions to ensure equal and timely access to medical services for all. [69] An interpretation of this provision, by the Committee on Economic, Social and Cultural Rights (CESCR), the monitoring body of the ICESCR, will be explored later in this paper.[70]

Further, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW/Women's Convention) also provides for the right to health.[71] CEDAW provides that states parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services.[72] This is a key provision within the context of women and HIV and AIDS. Interpretations of the provision by the Committee on the Elimination of Discrimination against Women (CEDAW Committee), the monitoring body of treaty in question, are elaborated later in this paper.

Also, the Convention on the Rights of the Child (CRC) provides a comprehensive provision on health.[73]The CRC enjoins states parties to strive to ensure that no child is deprived of his or her right of access to such health care services. [74] It emphasises that state parties should pursue full implementation of the right and to take measures to at *inter alia*, diminish infant and child mortality;[75] ensure the provision of necessary medical assistance and health care to all children with emphasis on the

[66] AR Chapman 'Core obligations related to the right to health and their relevance for South Africa' in D Brand & S Russell (eds) (2002) *Exploring the content of socio-economic rights: South African and international perspectives*. Pretoria: Protea Book House 40.

[67] Article 12.

[68] Article 12(1).

[69] Article 12(2)(c).

[71] Article12. The Convention on the Elimination of All Forms of Discrimination Against Women. *New York, NY: United Nations; 1979. UN document A/34/36.*

[72] Article 12 (1).

[73] The CRC was adopted by the UN General Assembly on 20 November 1989. It entered into force on 2 September 1990. *See* article 24 thereof.

[74] Article 24(1).

[75] Article 24(2)(a).

development of primary health care;[76] combating disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water;[77] ensure appropriate pre-natal and post-natal health care for mothers,[78] and to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. This provision is critical as it covers girl children who are also deemed to be women. Some interpretations under this provision by the Committee on the Rights of the Child (CRC Committee), the monitoring body of this treaty will be explored later in this paper.

More specifically on HIV and AIDS, the office of the UN High Commission for Human Rights (OHCHR) and The Joint United Nations Programme on HIV/AIDS (UNAIDS) formulated the *International Guidelines on HIV AND AIDS and human rights* (Guidelines).[79] The guidelines built on expert advice to integrate the principles and standards of international human rights law into the HIV and AIDS response. They are non-binding but have been argued to form a 'soft law' bridge between 'hard law' international obligations and the practice of countries. [80] The guidelines provide, *inter alia*, that states should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and AIDS.[81] It also provides that collaborations with and through the community should promote a supportive enabling environment for women, *inter alia*.[82] The Guidelines have also drawn attention of governments to the need to address "systematic discrimination based on gender [which'…impairs women's ability to deal with the consequences of their own infection…in social, economic and personal terms".[83]

Following the 2001 developments resulting from the United Nations Declaration of Commitment on HIV/ AIDS and the Doha Declaration, in 2002, the OHCHR and the UNAIDS updated the Guidelines. The revision was also meant to take into account the obligation of countries to provide ARVs as part of the right to health as interpreted by the CESCR.[84] This resulted in the *Revised Guideline 6* (Revision) which specifically refers to HIV and AIDS treatment and recommends that enactment

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[76] Article 24(2)(b).

[77] Article 24(2)(c).

[78] Article 24(3).

[79] *Supra* note 15.

[80] H Watchirs 'A human rights approach to HIV/ AIDS: Transforming International obligations into national laws' (2002) 22 *Australian Yearbook of International Law* 77 79-80.

[81] Para 5.

[82] Para 8.

[83] UNAIDS and Office of the UN High Commissioner for Human Rights (2006). *International Guidelines on HIV AND AIDS and Human Rights*. Consolidated Version. Geneva. p85, para 110.

[84] *Supra* note 9.

of legislation by countries to provide for HIV-related goods, safe, services and information so as to ensure, among other things, safe and effective medication.[85] The Revision requires countries to ensure access to essential medications at affordable prices, and on a non-discriminatory, sustainable basis.[86] It further requires countries to take measures to ensure for all persons, on a sustained and equal basis, the availability and accessibility of HIV-related goods, including anti-retroviral and other safe effective medicines. It calls upon countries to pay a particular attention to vulnerable individuals and populations.[87] The Revision further recommends that countries increase their budgetary allocation in order to provide sustainable access to ARVs and other HIV and AIDS related goods.[88] Despite the framing of the Guidelines which recognises that the right to health must be achieved progressively over time, it states that countries have an immediate obligation to take steps as quickly as possible to ensure, among other things, access to treatment.[89]

The Millennium Development Goal (MDG) 6 aims to halt and begin reversing 'the spread of HIV and AIDS by 2015.[90] Although the MDGs are not contained in a binding treaty format, it is argued that at least some of them – including goal 6 have attained the status of customary international law.[91] However, as it is formulated in terse terms, goal 6 does not provide much guidance to states intent on adopting a human rights-based approach. In 2001, the UN General Assembly Special Session (UNGASS) went further by adopting the Declaration of Commitment on HIV/AIDS, which provides for time-bound targets. Quantifiable targets such as the following have been set: 'By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and AIDS and members of vulnerable groups.'[92] Within the context of women and HIV and AIDS, The Declaration also affirms that:[93]

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[85] *Supra* note 10.

[86] *Id.*

[87] *Id.*

[88] *Id.* Para (c).

[89] *Supra* note 10. Preface.

[90] *Supra* note 13.

[91] P Alston, 2004. A Human Rights Perspective on the Millennium Development Goals, Paper prepared as a contribution to the work of the Millennium Project Task Force on Poverty and Economic Development; S Dairiam, 2005. The Relevance of the Links Between Human Rights, The Beijing Platform for Action and The Millennium Development Goals, paper prepared for the Expert Group Meeting on the achievements, gaps and challenges in linking the implementation of the Beijing Platform for Action and the Millennium Declaration and Millennium Development Goals, Baku, Azerbaijan; P Alston, 'Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen Through the Lens of the Millennium Development Goals' (2005) 6 *Human Rights Quarterly* 755.

[92] Para 58 of the Declaration of Commitment on HIV/AIDS, UNGA Res S-62/2,27 June 2001.

[93] I*d*.Para 4.

> Noting with grave concern that all people, rich and poor, without distinction of age, gender or race are affected by the HIV/AIDS epidemic, further noting that people in developing countries are the most affected and that women, young adults and children, in particular girls, are the most vulnerable

Closer to home, the African Charter on Human and Peoples' Rights (African Charter) provides for the right to health.[94] There is however no jurisprudence on women and HIV and AIDS from the African Commission.[95] In the absence of any jurisprudence on the subject, there is no point of reference in terms of interpretation by the African Commission on state obligation to women in this context. The African Commission however did find that states have an obligation to ensure that health care facilities and commodities including drugs are made available to citizens.[96]

More recently, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women Protocol) became the first document to provide for binding obligations on the right to health with specific mention of HIV and AIDS.[97] The African Women's Protocol requires, *inter alia*, that state parties take all appropriate measures to provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas.[98] This obligation is particularly crucial in light of the fact that women form the larger population of people affected with HIV and AIDS.

Still on the African continent, the African Union (AU), and its predecessor, the Organisation of African Union (OAU) adopted a number of declarations pertaining to HIV and AIDS. One of the most significant of these is the 2001 Abuja Declaration on

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[94] *See* article 16 of the African Charter. The African Charter, also known as the 'Banjul Charter', was adopted by the African Union in Nairobi, Kenya, in June 1981 and entered into force in October 1986.

[95] *See*, generally, S Gumedze, ' HIV/ AIDS and Human Rights: The Role of the African Commission on Human and Peoples' Rights' (2004) 4 *African Human Rights Law Journal* 181; *Supra* note 18. 588.

[96] *See* the case of *Purohit and Moore V The Gambia* Communication 241/2001 (2003) AHRLR 96 (ACHPR 2003). Decided at the 33rd ordinary session of the African Commission (15-29 May 2003).

[97] Adopted in Maputo in July 2003 and entered into force 25 November 2005, available at http://www.africa-union.org (accessed 17 October 2009). See article 14(1)(d),(e) thereof.

[98] Article 14(2) (a). SA Kaniye-Ebeku 'A New Hope for African Women: Overview of Africa's Protocol on Women's Rights (2004) 13 *Nordic Journal of African Studies* 264, *available at http://www.njas.helsinki.fi/pdf-files/vol13num3/ ebeku.pdf*. (Accessed 17 October 2009). See also, R Karugonjo-Segawa 'The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' (2005) Research Partnership, Danish Research Institute for Human Rights; E Durojaye ' Advancing gender equity in access to HIV treatment through the Protocol on the Rights of Women in Africa' (2006) 6 *African Human Rights Law Journal* 188-207; F Banda, 'Blazing a trail: The African Women's Protocol comes into force' (2006) 50 *Journal of African Law* 72; R Amollo 'A Critical Reflection on the African Women's Protocol as A means to Combat HIV/AIDS among Women in Africa' Unpublished masters thesis, University of Pretoria. Available at https://www.up.ac.za/dspace/items-by *author?author=Amollo%2C+Rebecca - 10k* -; R Amollo, The Protocol on Women's Rights in Africa: What does it say about Gender-based violence and HIV/ AIDS? (2007) 2 *Iminyango Quarterly Newsletter.* Available at www.gbvhiv.org.za/iminyango-newsletters/iminyango-vol2-no-1.pdf. (Accessed 16 October 2009).

HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (Abuja Declaration).[99] Also notable among the efforts on the African continent is the Solemn Declaration on Gender Equality in Africa (SDGEA). The SDGEA calls for an accelerated implementation of gender specific legal measures to combat HIV and AIDS.[100] Within the context of the skewed incidence and prevalence of HIV and AIDS amongst women, this Declaration represents the need to pay attention to women's position in the face of the epidemic.

Much as only one regional document (The African Women Protocol) expressly provides for women's right to sexual and reproductive health within the context of HIV and AIDS, the above discussion shows that there exists a normative basis to hold state accountable on what they have done to enable women live in the midst of the epidemic. The next section of this work looks at the general and specific obligations arising.

IV.STATE OBLIGATIONS RELATING TO WOMEN'S HEALTH AND HIV AND AIDS

The evolving body of rights critical to the realisation of women's health in the context of HIV AND AIDS can be summed up in the freedoms and entitlements within sexual and reproductive rights.[101] Freedoms in this context would include freedom violence including rape and all forms of sexual violence, forced pregnancy, non-consensual contraceptive methods (for example forced sterilisation and forced abortions).[102] Entitlements would include health care and the underlying determinants of health, which provide equality of opportunity for women to enjoy the highest standard of health.[103] For example, women should have equal access in law and in fact, to information on sexual and reproductive health issues. Sexual and reproductive rights

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[99] Adopted at the 24-27 April 2001 summit in Abuja, Nigeria.

[100] At the Third Ordinary Session of the African Union (AU) Assembly of Heads of State and Government in Addis Ababa, Ethiopia in July 2004, the Heads of State and Government adopted the Solemn Declaration on Gender Equality in Africa (SDGEA) See Para 1 of the SDGEA. It is Also arguable that the position of the African Union can be seen through its resolutions in sessions of the AU and through its other organizations like NEPAD. NEPAD has however been criticized for not embodying issues related to gender and HIV/AIDS. The NEPAD Document is available at http://www.nepad.org/AA0010101.pdf (accessed 16 October 2009). The NEPAD website http://www.nepad.org also contains other NEPAD texts such as the communiqués, legal instruments and reports. For a critique on human rights in NEPAD, see generally, E Baimu 'Human rights in NEPAD and its implications for the African human rights system' (2002) 2 *African Human Rights Law Journa*l 301; S Hlupekile-Longwe, Assessment of Gender Orientation of NEPAD. Available at http://dawn.thot.net/nepad1.html. (Accessed 15 October 2009).

[101] *Supra* note 5. P. 7; General Comment 14, para 34.

[102] For example, research shows that there is a practice among health care providers to force women living with HIV and AIDS to have abortions or be sterilized. This is discussed in chapter five of this work.

[103] E/C.4/2003/58,para 23; Commission on Human Rights Resolution 2003/28, preamble and para 6.

are therefore integral elements of the broader right to health.[104] This then gives rise on the part of the state to fulfil the right to health. A discussion of the obligations follows.

A. General obligations

The conceptual issues surrounding the core obligations relating to the right to health are not unique to the other socio-economic rights. All debate around the implementation of socio economic rights grapple with the conceptual issues of minimum core content, available resources, progressive realisation and what amounts to a violation.[105] This in turn implies that all discussion in terms of the obligations of states towards women affected by HIV and AIDS will spin around the same conceptual paradigm.

B.Minimum core

The core content of a right, also called the 'minimum core' or minimum threshold or 'essential content' entails a definition of the absolute minimum needed without which the right would be unrecognisable, meaningless and lose its *raison d'être*.[106] It is aimed at protecting vulnerable groups in which women fall. It therefore represents the 'floor' of immediately enforceable rights.[107] Here, a state pleading resource constraints to meet a minimum core, must demonstrate that every effort was made to use all resources that are at their disposal in an effort to satisfy , as a matter of priority, those obligations.[108] Within the context of health, this is elaborated in the CESCR General Comment 14 as will be discussed later in this paper.

C.Progressive realisation and available resources

Progressive realisation within available resource places duty upon the state to take steps individually and through international assistance and co-operation (especially

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[104] *Supra* note 5; note 9; *See* also, Commission on Human Rights Resolution 2003/28, preamble and para 6.

[105] *See* A Chapman, 'Monitoring Socio-Economic Rights: A Violations Approach', *(*1998) 1 *ESR Review* 1.

[106] General Comment 3 on the nature of States parties obligations, 1990, paras 9 and 10. See also Guideline 6 of the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (reprinted in (1998) 20 *Human Rights Quarterly* 691. For more on the minimum core on health, *see*, *Supra* note 66. 35,37; P de Vos 'The Economic and Social Rights of Children and South Africa's Transitional Constitution' (1995) 10 *SA Public Law* 233, 251; S Leckie 'Another Step Towards Indivisibility: Identifying the Key Features of Violations of Economic, Social and Cultural Rights (1998) 20 *Human Rights Quarterly* 81,101-02;D Bilchitz 'Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economics Rights Jurisprudence' (2003) 19 *South African Journal on Human Rights 1*; M Pieterse 'Resuscitating socio-economic rights: Constitutional entitlements to health care services' (2006) 22 *South African Journal on Human Rights* 473; D Bilchitz, The Right to health care services and the minimum core: Disentangling the principled and pragmatic strands, (2006) 7 *ESR Review* 2.

[107] *Id*.

[108] General Comment 3, para 10.

economic and technical) by all appropriate means including particularly the adoption of legislative measures to the maximum of their available resources.[109] Generally, states are required to 'take steps' with a view of achieving the full realisation of the right to health. The duty to 'take steps' is therefore an immediate one.[110] States are also required to 'undertake to guarantee' and to exercise rights 'without discrimination'.[111] The steps must be taken 'expeditiously' and 'effectively'.[112] The steps must also be 'appropriate' under the circumstances. [113] Also, any 'deliberate retrogressive measures' have to be fully justified in the context of full use of the 'maximum available resources'.[114] The principle is said to reflect the recognition by the drafters of the CESCR that most state parties would not be able to realise full all economic, social and cultural rights immediately upon ratification or even in a short period of time.[115]

D.Specific obligations to 'respect', 'protect' and 'fulfil'

The precise obligations of states vary from treaty to treaty but in general, states parties can be regarded as obliged to 'respect', 'protect' and 'fulfil' the rights contained within the treaty.[116] These tripartite obligations are the levels of state obligations that every right, including health must have. This interpretation of state obligations has been reflected by the CESCR and in the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights.[117] The duties to respect focus on preventing the state from unduly intervening in the enjoyment of a particular freedom or entitlement.[118] The duty to protect enjoins the state to prevent third parties from unduly interfering in the right-holders enjoyment of a particular freedom or entitlement. It therefore places emphasis on state action necessary to prevent, stop or obtain redress or punishment for third party interference.[119] The duty to fulfil imposes obligations to facilitate, provide and promote access to rights. Here, the

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[109] *Supra* note 106.

[110] *Id*.

[111] General Comment 3, para 1.

[112] General Comment 3, para 9.

[113] General Comment 3, para 4.

[114] General Comment 3.

[115] A Chapman and S Russell (eds) (2002). *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*. Intersentia Antwerp – Oxford – New York. 4.

[116] *See* paras 34, 35 and 36 of CESCR General Comment No 14.

[117] *Supra* note 106.

[118] *Id*.

[119] *Id*.

sate is expected to be a proactive agent, capable of bringing about an increase in access to a range of Economic, Social and Cultural (ESC) rights. [120]

What remains to be asked is what these concepts mean within the breadth of this study. In determining the precise obligations of the state are within the context of women and HIV AND AIDS, the normative framework of article 12 of the ICESCR as interpreted CESCR in General Comment 14 on the right to the highest attainable standard of health is instructive. The provision has been lauded as the most important treaty provision on health.[121] According to Chapman, General Comment No 14 is an important contribution to interpreting the right to health.[122] The General Comment treats the other underlying aspects of health such as access to adequate nutrition, housing and water as central to health thereby implying that the specific duties imposed apply to access to these determinants as components of the right to health.[123] Further, the general comment updates the covenant by emphasising the need for a gender perspective and a comprehensive national strategy for eliminating discrimination against women.[124] It remains the most comprehensive interpretation of the right to health and has emphasised the place of sexual and reproductive rights, non-discrimination and equality, all of which are key in the analysis of women's health in the context of HIV and AIDS.[125] The General Comment optimistically lays out the normative content, followed by obligations and possible violations. General Comment 14 is a wide- ranging embodiment of all the socio-economic rights aspects of the right to health. Within the context of women and HIV and AIDS, other important interpretations include the CESCR General Comments on the right to adequate housing,[126] the right to adequate housing: forced evictions, [127] the equal right of men and women to the enjoyment of all economic, social and cultural rights, [128] and Non-discrimination in Economic, Social and Cultural Rights.[129] Also, the CEDAW's General Recommendations on violence[130] and women and health,[131] will

[120] *Id.*

[121] *Supra* note 115.194.

[122] *Id.*

[123] *See* paras 3,4, 11.

[124] *See* paras 20-21.

[125] *See* paras 3, 8, 18.

[126] General Comment 4 on the right to adequate housing, 1991.

[127] General Comments 7 the right to adequate housing: forced evictions, 1997.

[128] General Comment 16 on the equal right of men and women to the enjoyment of all economic, social and cultural rights.

[129] General Comment 20 on non-discrimination in Economic, Social and Cultural Rights, 2009.

[130] CEDAW's General Recommendation 19 on violence Against Women. UN Doc.CEDAW/C/1992/L/1/Add.15(1992).

[131] General Recommendation 24 on women and health, 1999.

be taken into account. These will be taken into account alongside General Comment 14. An analysis of what the actual and specific state obligations are in the context of women and HIV and AIDS follows. This will be discussed through the themes of access to health services, access to adequate housing, rights relating to inheritance and freedom from gender-based violence. Some of these obligations overlap especially within the context of non-discrimination. Thus, equality and non-discrimination will be an over riding theme in discussing all these obligations.

1. Equality and non-discrimination

In light of the fact that it is the social, economic and cultural inequities and inequalities that underlie women's vulnerabilities in the context of HIV and AIDS, equality and non- discrimination is central in regard to women's health. The definition of discrimination against women in the Women's Convention encompasses a broad range of issues. It provides:[132]

> The term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field

The Women's Convention obligates states "to pursue by all appropriate means and without delay a policy of eliminating discrimination against women." [133] The Women's Convention also reconceptualises and extends the scope of the right to health to cover women's reproductive needs, thereby eliminating a fundamental source of discrimination in the definition and scope of the right. CEDAW further mandates states parties "to eliminate discrimination against women in the field of health care in order to ensure ... access to health care services."[134]

In its General Recommendation on women and health, the CEDAW Committee emphasises that states should eliminate discrimination against women in their access to health services.[135] The Committee added that women' health is an issue that is recognised as a central concern in promoting the health and wellbeing of women.[136] The Committee tasks states to report on what they have done to address the magnitude of women's ill health, in particular when it arises in conditions like HIV/AIDS.[137]

Under the ICESCR, states have an immediate obligation to ensure non discrimination. Thus, it calls on state parties "to guarantee that the rights enunciated in the ... Covenant will be exercised without discrimination of any kind as to race,

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[132] Article 1.

[133] Article 2.

[134] 12(11).

[135] General Recommendation 24. Articles, 2 and 8.

[136] Article 2.

[137] Article 17.

colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[138] Within the context of HIV and AIDS, the CESCR clarified that at the time of drafting the Convention, diseases like HIV ands AIDS that were formerly unknown now have to be taken into account.[139] In terms of discrimination in access to health services therefore, the CESCR further clarified that the ground of "health status" now includes HIV and AIDS.[140] The CESCR has classified the obligation to provide health without discrimination as an immediate obligation.[141] It has categorised it as a core obligation and therefore non-derogable.[142]

In its General Comment 16 [143] the CESCR reiterates the equal right of men and women to the enjoyment of rights in the Convention, the right to the highest attainable standard of health inclusive. The Committee emphasised that elimination of discrimination is fundamental to the enjoyment of economic, social and cultural rights on the basis of equality.[144] The Committee adds that women by virtue of their lesser status ascribed by tradition and custom are often denied equal enjoyment.[145] The Committee further refers to *de facto* (substantive) and *de jure* (formal) equality.[146] The Committee then refers to the need for temporary measures as a way of realising substantive equality for women.[147]

Recently, the CESCR expanded the definition of sex in its General Comment 20 [148] emphasising that the prohibited ground of 'sex' has evolved to encompass the social construction of gender stereotypes, prejudices and expected roles that can and do create barriers to equality in economic, social and cultural spheres.[149] The CESCR also refers to discrimination within the context of health and HIV.[150] This General Comment has therefore been a milestone in elaborating non-discrimination in relation to sexual and reproductive health rights of women.

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[138] Article 2(2).

[139] Para 10.

[140] Para 18.

[141] General Comment 14, para 30

[142] General Comment 14, para 43.

[143] On the equal right of men and women to the enjoyment of all economic, social and cultural rights, 2005.

[144] Para 3.

[145] Para 5.

[146] Para 7.

[147] Para 15.

[148] *Supra* note 129.

[149] I*d.*Para 20.

[150] *Id.* Para 33.

It can therefore be concluded that equality and non-discrimination should be the underlying principle in all state actions in law, policy and practice regarding the status of women within the context of health and HIV and AIDS. A discussion of actual and specific obligations on access to health services in the context of health services follows.

2. Obligations on access to health services

Having identified that access to health services is one of the key areas on which state obligation to women in the context of HIV and AIDS should focus, it is imperative to note that the conditions prevailing in a state should bear the essential elements of availability, accessibility, acceptability and quality. These four aspects overlap to ensure that state policies and programmes on HIV and AIDS, related to women should be capable of these criteria. A policy or programme devoid of these elements is considered not to meet the standards capable of ensuring women's health. All obligations should therefore be interpreted in this light.

The state has the obligation to refrain from, *inter alia*, limiting access to curative and palliative health services to women especially if discriminatorily done. For example, as was addressed by the court in the case of *Minister of Health and Others v Treatment Action Campaign (TAC).*[151] Here, the court found government policy on the provision of mother-to-child transmission unreasonable and unconstitutional because it excluded a significant segment of society.[152] The programme had failed to address the needs of mothers.[153] Hence, impeding access to other essential health services like sexual and reproductive services, which are key to women's health in the context of HIV and AIDS, would amount to a violation.[154] This includes the obligation not to withhold or misrepresent health-related information,[155] and to act transparently. [156]

The state is obliged to provide HIV and AIDS treatment without relinquishing duty to the private sector.[157] Within the context of health, privatisation can lead to the 'commoditisation of health' making the essentials of availability, accessibility, acceptability and quality elusive. In this regard, prices of treatments like ARVs have to be provided by the state not only as a core obligation,[158] but as an imperative to control marketing of medicines which are critical to the treatment and prevention of

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[151] 2002 (10) BCLR 1033(CC).

[152] *Id*. Para 68

[153] *Id*. Para 67

[154] *Supra* note 9. Paras 34; 35.

[155] *Id*.Para 34.

[156] *Supra* note 151.

[157] *Supra* note 131. Article17.

[158] Para 43.

HIV and AIDS among vulnerable groups like women. Here, the state should for example exercise control over pharmaceutical companies through its patent regime. In light of the flexibilities under the Trade Related Aspects of Intellectual Property (TRIPS) Agreement,[159] the state can make ARV drugs more available and accessible by issuing compulsory licenses or importing from other markets where it is cheaper.[160]

The state is further charged with the obligation to adopt legislative measures on HIV and AIDS and to adopt relevant health policies and plans targeted towards realising women's health in this context. A plan must appropriate and well – directed, and reasonable in conception and implementation. It should also be "balanced and flexible."[161] Here, for example, national plans on HIV and AIDS surveillance have to be well designed paying attention to gender differences, for example, it should have angles paying attention to ages 15-24 which are considered to be the most affected age group among women. Thus, for example, a programme on prevention of mother to child treatment should be implemented in such a manner that if an appraisal of it were to be done, it would be found to be well designed, with gender disaggregated data and with all its plans leading to the fulfillment of a safe programme for women as a marginalised group, and one that presents with specific biological and physiological attributes.

The state has the obligation to ensure that public health and health care facilities, goods and services, as well as programmes are in sufficient quantity.[162] Within the circumstances of women and HIV and AIDS, the state should include the availability of sexual and reproductive information on HIV and AIDS like testing and counseling services, prevention of mother to child programmes, antiretroviral drug administration services and all other related services. Additionally, the state should ensure the availability of other relevant determinants of health like water and food. Hence, obligation is upon the state to avail accessible and safe water. This is especially so in rural setting where most women live. Included in this, is the obligation to provide adequate sanitation services.[163]

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[159] The TRIPS Agreement is Annex 1C of the Marrakesh Agreement Establishing the World Trade Organization, signed in Marrakesh, Morocco on 15 April 1994.

[160] For more on the duty to procure ARVs under the TRIPS Agreement, see, generally, F Forman, (2006) 'Trading health for profit: bilateral and regional free trade agreements affecting domestic property rules on intellectual property rules on pharmaceuticals', in JC Cohen et al (eds) *The Power of Pills: Social, Ethical, and Legal Issues in Drug Development, Marketing, and Pricing*. London: Pluto Press; *Supra* note 29; L Forman , 'Trade rules, intellectual property and the right to health' (2007) 21 *Ethics and International Affairs* 337; D Mushayavanhu 'The Realisation of access to HIV and AIDS-related medicines in Southern African countries: Possibilities and actual realisation of international law obligations' in F Viljoen & S Precious (eds) (2007) *Human Rights Under Threat: Four perspectives on HIV, AIDS and the law in Southern Africa* Pretoria: PULP 127; R Amollo 'Revisiting the Trips Regime: Rwanda-Canadian ARV Drug Deal 'Tests' the WTO General Council Decision' (2009) 17 *African Journal of International and Comparative Law* 240-269.

[161] *TAC*, para 43; P de Vos 'So much to do, so little done? The right of access to anti-retroviral drugs post-*Grootboom* (2003) 7 *Law, Democracy and Development* 94.

[162] *Supra* note 9. Para 12(a) of General Comment 14; *Supra* note 97.

[163] *Supra* note 9. Para 12(a).

Management of women living with HIV and AIDS entails training in several skills, including patient clinical management, adherence to gender differences and to ethos of privacy, dignity and confidentiality.[164] This should, for example include training on some of the challenges women face in health care facilities like lack of respect from health care providers. In this regard, the state should ensure training of medical and professional personnel. The CESCR has elucidated this obligation.[165] Thus, Cook observed:[166]

> If health care facilities, personnel and resources are to be accessible, government must do more than simply provide them as bulk services. Accessibility requires that the delivery and administration of health care is organised in a fair non-discriminatory manner, with special attention to the most vulnerable and marginalised.

The state also has the obligation to provide access to essential drugs within the context of HIV and AIDS. The WHO Model List includes, for example, nevirapine as an essential medicine. [167] The administration of nevirapine is a certified method of reducing mother to child transmission. It therefore has the potential to reduce the burden on women that may come with mortality and morbidity of the child. This in turn reduces care burden which is still largely borne by women. In this context, nevirapine is an essential medicine that is also considered a core minimum obligation forming the floor below which the state should not sink.[168] The state is therefore obliged to provide essential drugs in a non-discriminatory manner, taking into account vulnerable or marginalized groups, here, women.[169] In this regard, several authors have argued that the provision of ARVs is a core minimum obligation upon the state.[170] In this regard, de Vos argues that due to the ability of HAART to suppress the replication of the virus within an HIV positive individual, the state is

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[164] *Supra* note 131. Article 12(d).

[165] Para 12 (2).

[166] RJ Cook 'Exploring fairness in health care reform' (2004) 29 *Journal of Juridical Science* 1.

[167] WHO Model List of Essential Medicines– March 2007. This list has gone though several modification in 1977,1983, 1999 and 2007. This is the 15th list.

[168] S Khoza 'Reducing Mother to Child Transmission of HIV: The Nevirapine Case' (2002) 3(2) *ESR Review* 2; D Chirwa 'Minister of Health and Others v Treatment Action Campaign and Others: Its Implications for the Combat Against HIV and AIDS and the Protection of Economic, Social and Cultural Rights in Africa' (2003) *East African Journal of Peace and Human Rights* 174 ; D Chirwa 'The Right to Health in international Law: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine' (2003) 19 *South African Journal on Human Rights* 547.

[169] Article 12 (c) of the ICESCR; *Supra* note 9. Para 43(d).

[170] *Supra* note 168; *Supra* note 161.83; L Foreman,'The Imperative to Treat: The South African State's Constitutional Obligations to Provide Antiretroviral Medicines' (2003) 12 *Health Law Review 9;* D Chirwa 'Minister of Health and Others v Treatment Action Campaign and Others: Its Implications for the Combat Against HIV and AIDS and the Protection of Economic, Social and Cultural Rights in Africa' (2003) *East African Journal of Peace and Human Rights* 174 ; D Chirwa 'The Right to Health in international Law;: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine' (2003) 19 *South African Journal on Human Rights* 547; *Supra* note 106.

obliged to provide it as a minimum core obligation and because it is a matter of life and death.[171]

The state is also under obligation to make accessible the relevant health facilities. This includes accessibility to goods and services like sexual and reproductive information on HIV and AIDS equipped with testing and counseling services, prevention of mother to child programmes, antiretroviral drug administration services and all other related services. Accessibility has been defined to have the dimensions of non-discrimination, physical accessibility, and affordability and information accessibility.[172] Within the context of HIV and AIDS, in light of the discrimination faced by women in health facilities, the state must take steps to ensure that women, especially those living in rural areas can access the relevant medical services.

Pertinently, the state should ensure that women can afford the medications, services and other forms of scientific progress made in medicine. This includes for example, providing free basic HIV and AIDS care, treatment, prevention and management services. In this regard, it is strongly argued that socially disadvantaged groups like women should not bear the burden of health expenses compared to richer households.[173] Women's economic status in most of sub Saharan Africa can not be more emphasised. This is especially so in light of the ethical health consideration of equity. In this regard, services should be affordable, whether publicly or privately provided. I argue that this means, for example, that the state should have a health system that is equitable, for example, through a health care system that includes greater access to women. This could include a national health system through a national health insurance or a social health insurance.[174] This would work well for women affected by HIV and AIDS in terms of reducing the burden of disease.

Also, the state has obligations in relation to women of all ages, including adolescents. Most adolescents represent the age group of 15-59 which is the most affected among women.[175] In this regard, accessibility to health services must pay attention to girl children who suffer judgmental attitudes when they visit health facilities.[176] This obligation extends to cover aspects of privacy and confidentiality of

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[171] *Supra* note 161.103.

[172] Article 12(b).

[173] *Supra* note 9. Para 12 (b).

[174] R Amollo 'In pursuit of health equity in South Africa: A critique of the proposed national health insurance' (2009)10 *ESR Review* 14; *Supra* note 161.105-106;

[175] UNICEF, 2003, *Africa's Orphaned Generation*, New York, UNICEF,2; UNAIDS, 2006 *AIDS Epidemic Update*, Geneva, UNAIDS. J Sloth-Nielsen & B Mezmur 'HIV and AIDS and Children's Rights in Law and Policy in Africa: Confronting Hydra Head On' in J Sloth-Nielsen (ed) (2008) *Children's Rights in Africa: A Legal Perspective* Ashgate Publishing Limited 280.

[176] CRC General Comment 3 on HIV/AIDS and the Rights of the Child. Para 9; *Supra* note 98.49; J Sloth-Nielsen & B Mezmur 'HIV and AIDS and Children's Rights in Law and Policy in Africa: Confronting Hydra Head On' in J Sloth-Nielsen (ed) (2008) *Children's Rights in Africa: A Legal Perspective* Ashgate Publishing Limited 283.

medical information and the need to have access to adequate information essential for adolescent health.[177]

The state is further under obligation to provide HIV and AIDS related services in a manner respectful of women's cultures and to be attentive to gender and life cycle requirements. Given women are already marginalised within the context of HIV and AIDS as vectors of disease for reasons elaborated earlier in this work, it is imperative that clinical management of health facilities is in a manner respective of this position.[178] Similarly, HIV and AIDS related services to women should be of quality taking into account scientific and medical appropriateness, for example, a contraindicated medication against an HIV infected pregnant woman can not be used. [179] Further, this enjoins the state to ensure that women are fully informed, by property trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available resources.[180] For example, recently microbicides were found to reduce risk of infection among women. The state should inform women of this development while highlighting all the angles involved.

The state should integrate a gender perspective into their HIV and AIDS and health-related policies, planning, programmes and research that recognises the important role of both biological and socio-cultural factors in influencing the health of women and men. [181] Within the context of HIV and AIDS, this means, for example that pharmacological research should pay attention to biological details of women and how it may interact with other conditions like menstruation, pregnancy and use of contraception.

3. Obligations on access to adequate housing

The right to adequate housing is closely linked with the right to women's health within the context of HIV and AIDS.[182] The right to adequate housing is protected under the ICESCR.[183] It has also been pointed out that all aspects of women's housing rights touches upon the themes of a woman's rights to non-discrimination and equality.[184] It is important to note that aspects of eviction are now interpreted within this right.[185] Broadly, the state is under obligation to refrain from forced

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177 CRC General Comment 4 on Adolescent Health and Development.

178 Para 12(c).

179 Para 12(d).

180 *Supra* note 131.Article 20.

181 Para 21. Supra note 131. Article 12 (a).

182 *Supra* note 42.

183 Article 11 of the ICESCR.

184 *Supra* note 42.

185 S*upra* note 127. Para 8.

evictions and must ensure that the law is enforced against its agents or third parties who carry out forced evictions. Hence, state parties must ensure that legislative and other measures are adequate to prevent and, if appropriate, punish forced evictions carried out without appropriate safeguards by private persons or bodies.[186]

The CESCR also obliges the state to ensure that evictions should not result in individuals being rendered homeless or vulnerable to the violation of other human rights.[187] It is therefore safe to say that this places an obligation on the state to ensure that women, as a vulnerable group, are protected from being exposed to a situation of homelessness which may result in their right to health within the context of HIV and AIDS being violated. The CESCR therefore recognises the lopsided impact of forced evictions on women:[188]

> Women…are especially vulnerable given the extent of statutory and other forms of discrimination which often apply in relation to property rights (including home ownership) or rights of access to property or accommodation and their particular vulnerability to acts of violence and sexual abuse when they are rendered homeless.

Thus, Farha argues that General Comment 7 should be interpreted so that women's material conditions and experiences are included in the definition of forced eviction and reflected in the conditions imposed on state actors to guarantee the right to freedom from forced evictions.[189] It is also argued that domestic violence is a form of forced eviction thereby imposing the duty on the state to guarantee the right to housing of victims.[190] Duties arising within the right to freedom from domestic violence within the context of HIV and AIDS are dealt with later in this paper.

4. Obligations on right to inheritance (in family relations)

Related to the right to housing, is the right to inheritance. The link has already been made between HIV and AIDS and women's right to inheritance in family relations.[191] This is also related to marriage and divorce laws. Lack of equal rights for women and property excludes women from accessing resources that would help reduce their availability to HIV and improve their ability to cope with the consequences of the epidemic. In many parts of sub-Saharan Africa, when a woman's husband dies from AIDS, she might lose her home and land, inheritance and livelihood. This can leave her in a situation where she is forced to enter into relationships and behaviours that

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[186] *Id*.

[187] *Id* Para 9.

[188] *Id*. Para 10.

[189] L Farha 'Is there a woman in the house? Re/conceiving the human right to housing?' (2002) 141 *Canadian Journal of Women and the Law* 118.

[190] G Paglione, 'Domestic violence and housing rights: A reinterpretation of the right to housing.' (2006) 28 *Human Rights Quarterly* 120.

[191] *See* UNAIDS Meeting on women's inheritance, land and housing rights in the context of HIV and AIDS. The meeting took place at the 53rd session of the Commission on the Status on women on 12 March 2009, New York. Available at ww.unaids.org; UNAIDS, Land tenure, property and HIV and AIDS: Approaches for reducing infection and enhancing economic security – Available at www.unaids.org.

render her more vulnerable to the virus. A meeting of the UN argued that when women have enhanced access to ownership and control of land and property rights, they have a greater range of choices, are far more able to exercise autonomy and, ultimately, are better able to protect themselves. [192]

As a general duty, the state is obliged to undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in articles 6 though 15 of the ICESCR.[193] Moreover, equality is a mandatory and immediate obligation. [194] Hence, within the particular context of women's right to inheritance, the state is obliged to refrain from discriminatory actions that result in denial of women's right to enjoy property on an equal basis.[195] More specifically, the state is enjoined to take steps aimed directly towards the elimination of prejudices, customary and all other practices that perpetuate the notion of inferiority or superiority of either of the sexes, and stereotyped roles of men and women.[196] Given most of the injustices on inheritance occur within marriage and custom, the state, within the context of health, is obliged to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional practices, for example, the practice of male primogeniture. [197]

The Women Convention enjoins the state to take appropriate means to eliminate discrimination against women in all matters relating to marriage and family relations and in particular to ensure on a basis of equality of men and women, the same right for spouses in respect of ownership, acquisition, management, administration, enjoyment and disposition of property.[198] Within the context of health, this would have the ultimate impact of empowering women and reducing their vulnerability in economic terms.

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[192] *Id.*

[193] *Supra* note 128. Para17.

[194] *Id.*Para 16; *Supra* 106.

[195] *Supra* note 128. Paras 1 and 18; *See* also, articles, 1,2,3 and 16 (1)(h) of CEDAW.

[196] *Supra* note 128. Para 19.

[197] *Supra* note 9. Para 21.

[198] Article 16 (1) (h) of CEDAW. See also, CEDAW General Comment 21 on Equality in marriage and family relations of 1994 paras 30 and 34.

5. Obligations on freedom from gender-based violence

The link between women's health, HIV and AIDS and domestic violence is abundantly catalogued.[199] The CESCR has pointed out that gender-based violence is a form of discrimination that inhibits the ability to enjoy rights and freedoms, including economic, social and cultural right on the basis of equality. [200] The CESCR obliges the state to provide victims of domestic violence, who are primarily women, with access to safe housing, remedies and redress for physical, mental and emotional damage.[201] The CEDAW Committee has elucidated state obligation on violence.[202] Thus, the state is obliged to use effective measures,[203] preventive measures[204] and protective measures such as refuges, counselling, rehabilitation and support services for women who are the victims of violence or who are at risk of violence.[205] Furthermore, the state is obliged to prevent violations or to investigate and punish acts of violence by providing compensation,[206] in light of the principle of due diligence.[207] The principle is now regarded as a tool for the elimination of violence against women and is argued to have attained status of international customary law.[208] Thus, under the due diligence principle, the Special Rapporteur on Adequate Housing sets that the duty to protect enjoins the state to provide services to women, such as legal assistance, shelters and financial aid to victims of

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[199] Amnesty International, 2004. *Women, HIV AND AIDS and human rights*. London; Commission on Human Rights, Report by Special Rapporteur on Violence Against Women; Policies and Procedures that impact women's reproductive rights and contribute to, cause or constitute violence against women, Ms. Radhika Coomaraswamy E/CN 4./1999/68/Add.4, 21 January 1999; C Garcia-Moreno (1999) 'Violence Against Women' *Global Health Equity Initiative Working Paper no 15*, Harvard Centre for Population and Development Studies; World Health Organisation 2002 '*World report on violence and health.* Geneva: WHO. See also C Garcia-Moreno et al 'The Prevalence of violence against women: finding from the WHO multi-country study on women's health and domestic violence' (2006) 368 *Lancet* 1260-9;

[200] *Supra* note 128. Para 27; *Supra* 130. Article 7.

[201] *Supra* note 128. Para 27.

[202] *Supra* note 130.

[203] Article 24(t)(i).

[204] Article 24(t)(ii).

[205] Article 24(t)(iii).

[206] Article 9.

[207] For more on due diligence, *see Supra* note 42. 45.

[208] Special Rapporteur on Violence against Women, 2006. *The due diligence standard as a tool for the elimination of violence against women*. UN Doc.E/CN/2006/61; Inter-American Court of Human Rights, *Velásquez-Rodriguez v. Honduras*, Series C: Decisions and Judgment No. 4, July 29, 1988 at para 70; See also the Declaration on the Elimination of Violence Against Women, 1993 (Article 4(c); the Beijing Platform for Action, 1995 (para 124(b)) and the Inter-American Conventions on the Prevention, Punishment and Eradication of Violence Against Women, 1994 (Article 7 (b)). See also article 15 of the CEDAW General Recommendation 24.

violence.[209] The Special Rapporteur adds that the duty to protect requires states to ensure that women and girls who were victims or at risk of violence had access to justice as well as to health care and support services that responded to their immediate needs, protected against further harm and addressed the ongoing consequences of violence for individual women.[210] This should, for example, include access to Post Exposure Prophylaxis (PEP).[211] The duty is also upon the state to provide immediate material assistance in terms of shelter, clothing, child maintenance, employment and education, to women who were survivors of violence.[212] It is important to note that reports of Special procedures are not binding.

V. VIOLATIONS

Violations of the obligation to respect would therefore include deliberately withholding or intentionally misrepresenting information vital to health protection or treatment, adopting and maintaining laws and policies that interfere with reproductive rights, imposing discriminatory measures as a state policy, maintaining discriminatory practices related to women's health status and needs. [213] Violations of core obligations to protect would include failure to implement gender responsive laws and policies within the context of HIV and AIDS in to health care provision, national health policies and plans, insufficient expenditure and disproportionate investment of public resources in ways which leave out women's concerns, failure to focus government initiatives on rectifying existing imbalances in the provision of health services and failure to undertake sufficient public health measures to protect against and combat HIV and AIDS. The analysis of what amounts to a violation is referenced on the bases of inability and unwillingness,[214] burden of justification,[215] retrogressive measures,[216] acts of commission [217] and acts of omission. [218]

[209] Special Rapporteur on Violence against Women, 2006, para 47.

[210] *Id*. Para 82.

[211] PEP is a treatment taken soon after a person has been exposed to an infective source in order to prevent an infection from occurring. For instance if someone is exposed to the HI virus, either by having unprotected sex with someone who is HIV-positive or through certain types of contact with infected blood, then an immediate course of antiretroviral (ARV) drugs can be taken to prevent HIV disease from developing. This treatment must be taken for four weeks and will only be effective if it is started within 72 hours (three days) of the exposure. PEP, if taken correctly, appears to be at least 80% effective at preventing an infection from developing.

[212] Special Rapporteur on Violence against Women, 2006. Para 83.

[213] On the violations approach, see generally, AR Chapman, 'A 'Violations Approach' for monitoring the International Covenant on Economic, Social, and Cultural Rights' (1996)18 *Human Rights Law Quarterly* 23.

[214] Para 47.

[215] Para 47.

[216] Para 48 ; *Supra* note 106.

[217] Para 48.

[218] Para 49.

VI.CONCLUSION

It is clear from the above discussion that much as HIV and AIDS is only mentioned expressly in the African Women Protocol, there has developed a body of rights over the years establishing legal and normative standards on realising women's right to health within the context of HIV and AIDS. It is obvious that non-discrimination is the fulcrum of most of the freedoms and entitlements discussed. It is therefore certain that the fulfilment of sexual and reproductive rights is central to women's health in the context of HIV and AIDS, gender inequality and inequity.

This paper has mapped out the key state obligations arising in the area of women's health and HIV and AIDS under international and regional documents, through a critical analysis of general and specific obligations arising under the discussed treaty provisions, General Comments, Recommendations, Declarations, Agreements, UN reports, regional and national court cases, consensus documents and processes. State obligations were set under the tripartite duties to protect, respect and fulfil from a right to health perspective. The paper thus concludes that there exist legal and normative standards on realising women's health in the context of HIV and AIDS in the areas of unequal access to health services and resources, right to adequate housing as a determinant of health, rights to inheritance in family relations and gender-based violence. Within this paradigm, the paper has come up with a normative calculus for not only appraising states' laws and policies within the context of HIV and AIDS, but also for holding governments accountable in its actions towards fulfilling the health of women as a marginalised group in society.