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Women's Health at a Crossroad: Global Responses to HIV/AIDS

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Article

WOMEN'S HEALTH AT A CROSSROAD: GLOBAL RESPONSES TO HIV/AIDS

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I. INTRODUCTION

IN THE LAST SEVERAL YEARS the issue of women's health has begun to emerge as a powerful global political concern. Although the global impact of the human immunodeficiency virus ("HIV")/acquired immune deficiency syndrome ("AIDS") is only a fragment of the story, it has been the most vivid part of the history of the recent unfolding of interest in women's health. Worldwide, the incidence of the disease among women is spiraling.[1]

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1. AIDS IN THE WORLD 29-30 (Jonathan M. Mann et al. eds., 1992). According to the Global AIDS Policy Coalition, "the number of HIV-infected men increased about 90-fold from 1980 to 1991; and the number of HIV-infected women increased more than 225-fold during this period." *Id.* at 30; *see also* RONALD BAYER, PRIVATE ACTS, SOCIAL CONSEQUENCES: AIDS AND THE POLITICS OF PUBLIC HEALTH 1-2 (1989). Since the identification of AIDS in 1981 and the causative HIV virus in 1984, BAYER, *supra*, the course of the fatal pandemic has been increasingly characterized by inequality of vulnerability and exposure. *See also Forty-fifth World Health Assembly, Geneva, 4-14 May 1992, Resolutions and Decisions, Annexes*, at WHA Res. 45.35, WHO Doc. WHA45/1992/REC/1 (1992) [hereinafter WHA Resolution 45.35]; *Global Strategy for the Prevention and Control of AIDS*, WHO Executive Bd., 89th Sess., Provisional Agenda Item 12, WHO Doc. EB89/29 (Nov. 18, 1991) [hereinafter *Global Strategy*]; *Global Strategy for the Prevention and Control of AIDS: 1992 Update*, World Health Assembly, 45th Sess., Provisional Agenda Item 33, at 6, WHO Doc. A45/29 (Feb. 28, 1992) [hereinafter *1992 Update*]. WHO predicts that 90% of the projected HIV infections and AIDS cases in this decade will be in developing states. *1992 Update, supra.*

The global response to the HIV/AIDS pandemic exposed the long-standing circumstance that women's health has not been a priority area for attention or investment by international organizations. Despite the ubiquitous global impact of HIV infection on women, the World Health Organization ("WHO"), the international organization charged with coordinating multilateral efforts against AIDS,[2] did not until recently appreciate the threat of the pandemic to women's health.[3] The inadequate global efforts to address the toll of HIV/AIDS on women has underscored the fact that international organizations have neglected to promote and protect women's international right to health. A history of discrimination is apparent in the way that international organizations have conventionally defined women's health and developed services for them.

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2. G.A. Res. 42/8, U.N. GAOR, 42d Sess., Supp. No. 49, at 19-20, U.N. Doc. A/42/49 (1987). In 1987, the General Assembly confirmed WHO's established leadership in AIDS prevention and control and confirmed that WHO should direct and coordinate the United Nations activities against AIDS. *Id.* at 20; *but see U.S. and 37 Others Press U.N. to Unify Battle Against AIDS*, N.Y. TIMES, May 12, 1993, at A10 [hereinafter *U.S. and 37 Others*]. However, WHO's Global Programme against AIDS has been subject to mounting criticism in international political circles. Frequent reports of infighting, duplication of efforts among agencies and bureaucratic delays prompted the U.S. and 37 other nations to circulate a petition at the 1993 meeting of the World Health Assembly calling for a United Nations AIDS program to take over coordinating global AIDS efforts. *U.S. and 37 Others, supra.* The resultant resolution called on the Director-General of WHO to report on the feasibility of such a new unified program in January 1994. *Id.*; *AIDS Plan Under Fire as Shift is Demanded*, N.Y. TIMES, May 15, 1993, at A2 ("The World Health Organization agreed . . . to review its global strategy on AIDS after major donors pressed for United Nations agencies to be given a greater role."); WHO to Study Joint UN Role in Combatting AIDS, Agence France Presse, May 14, 1993, *available in* LEXIS, News library, AFP file.

In response to such frequent criticism, in January 1994 the Executive Board of WHO recommended the establishment of a co-sponsored United Nations program on HIV/AIDS to be administered by WHO. This program, scheduled to begin in 1996 will merge the AIDS programs of WHO, the U.N. Development Program, the U.N. Population Funds UNICEF, the World Bank and UNESCO. *See, e.g., WHO New United Nations Program Administered*, AIDS WKLY., February 7, 1994; Paul Lewis, *UN Undertaking New AIDS Assault: Efforts of Several Agencies Combined*, HOUSTON CHRON., Jan. 23, 1994, at 17.

3. *See* E.S.C. Res. 1987/75, U.N. ESCOR, 2d Sess., at 22-23, U.N. Doc. E/1987/INF/7 (1987). WHO's AIDS strategy provides the global policy framework for HIV/AIDS prevention and control activities. The Economic and Social Council ("ECOSOC") unanimously endorsed WHO's Global Strategy for the prevention and control of AIDS in 1987 and urged all organizations of the United Nations system to support the worldwide struggle against AIDS in close collaboration with WHO. *Id.* ECOSOC has also consistently reaffirmed WHO's global leadership on AIDS prevention and control. In Res. 1990/86, ECOSOC called upon the UN System, governments and non-governmental organizations to coordinate their efforts with WHO in implementing the global strategy for the prevention and control of AIDS. E.S.C. Res. 1990/86, U.N. ESCOR, 2d Sess., at 60-61, U.N. Doc. E/1990/INF/8 (1990). *But see supra* note 2.

Multilateral organizations have traditionally defined women's health as synonymous with maternal health. WHO, for example, historically has paid limited attention to the specific treatment of women with respect to illnesses which are common to both men and women and has allocated inadequate resources for women's unique health concerns other than reproductive health.

From a wider perspective, the inadequacy of international efforts to protect and promote women's right to health reflects and reinforces the extensive neglect of women's health by nations worldwide. For example, it has only recently been widely realized that biomedical research in the U.S., much of which is nationally funded and directed, defined women's health principally in terms of their reproductive functions. Media attention to HIV/AIDS has, however, contributed to an increasing awareness that women's health concerns have been understudied and underfunded. Globally, the pandemic has served to deepen gender-based critiques of traditional approaches to biomedical research and contributed to a growing understanding of the inadequacies of national efforts to develop and provide diagnostic measures and therapeutic interventions to protect women's health.

The resultant public scrutiny of the responses to HIV/AIDS has contributed to a radical transformation of interest in women's health issues in the last few years. At the international level, WHO has begun to broaden its concern with women's health to include the full dimensions of women's physiological health beyond reproductive issues and, consequently, to redirect resources and attention to limiting the impact of the pandemic on women. However, despite the extraordinary resurgence of concern with women's health, international policymakers have yet to address the fundamental social and cultural determinants of health that worldwide render women uniquely vulnerable to illness and disease, including HIV/AIDS.

The HIV/AIDS pandemic has dramatized the fact that women's health depends not merely upon the course of scientific and medical interventions, but also on social and cultural circumstances. There is a consensus within the public health community that women's unique vulnerability to HIV infection extends beyond physiological susceptibility or even conventional scientific neglect. Rather, the determinants of the relative increase in the incidence of the disease in women globally are the

outcome of the pervasive conditions of gender discrimination worldwide. Women have a special, social vulnerability to HIV infection and other illness because of their subordinated social status. National laws and policies continue to reinforce traditional values that violate women's fundamental human rights and enhance their vulnerability to illness, including HIV infection, despite the overwhelming evidence that women's health status is inextricably linked to their social status. International policymakers, however, have yet to address effectively the circumstances of social and legal discrimination which augment women's susceptibility to HIV/AIDS in particular, and illness and disease in general.

This article explores the role that international organizations have played and should play in limiting the global impact of the HIV/AIDS pandemic on women. Part II discusses the incidence of HIV infection among women worldwide. Part III analyzes the slowness of the global response to the rapid spread of HIV/AIDS to illustrate that international organizations conventionally have had a narrow concern with women's health status. It also describes how HIV/AIDS has contributed to a metamorphosis of public concern with the physiological, scientific basis of women's health among international organizations by publicly unveiling the universal neglect of women's health issues. Part IV describes how future international efforts to protect and promote women's health must further broaden concern with women's health status to take into account the pervasive circumstances of gender discrimination which make women uniquely vulnerable to illness and disease, including HIV/AIDS. It shows that recent efforts to correct the disparities in scientific research and medical treatment of women, although important, cannot alter the severe social inequities which render women vulnerable to HIV infection. Part V discusses the limited, but important, contribution that international law and organizations can have on future efforts to improve women's social status and to limit the spread of HIV/AIDS. Overall, this article will show that the HIV/AIDS pandemic has recently contributed to heightening international concern with the physiological basis of women's health status. It also shows how the pandemic has critically illustrated that future global efforts to promote and protect women's health must address the opportunities for and limitations of international interventions to promote the social status of women.

II. THE INCIDENCE OF HIV INFECTION AMONG WOMEN

The documented incidence of HIV infection in women is increasing at a staggering rate. In 1990, twenty-five percent of HIV-positive adults were female.[4] By the end of 1992 that figure had climbed to approximately forty percent.[5] WHO estimates that worldwide at least 4.8 million women have been infected with HIV,[6] and this number is expected to soar rapidly in the next few years.[7] By the year 2000, WHO predicts that approximately thirty to forty million adults and children will be HIV-positive[8] and that the annual rate of HIV infection for men and women will be the same.[9]

Worldwide, heterosexual sex is the dominant mode of HIV transmission.[10] The incidence of HIV has been evenly distributed between the sexes in areas of traditionally high heterosexual spread such as Africa[11] and Asia,[12] and now the relative impact of HIV/AIDS in women in industrialized states is rising.[13] In the U.S., for example, women make up the fastest

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4. Marsha F. Goldsmith, *'Critical Moment' at Hand in HIV/AIDS Pandemic, New Global Strategy to Arrest its Spread Proposed*, 268 JAMA 445, 445 (1992).

5. *Id.*

6. WORLD HEALTH ORGANIZATION, WOMEN'S HEALTH: ACROSS AGE AND FRONTIER 80 (1992) [hereinafter WOMEN'S HEALTH].

7. *Id.* at 79.

8. *1992 Update*, *supra* note 1, at 3.

9. WOMEN'S HEALTH, *supra* note 6, at 79 (figure citing WHO, GLOBAL PROGRAMME ON AIDS DATABASE (1991)); *1992 Update*, *supra* note 1, at 6.

10. *1992 Update*, *supra* note 1, at 6. Accordingly to WHO, two-thirds or more of all HIV infections have been the result of heterosexual transmission, and this percentage will increase to 75 or 80% by the year 2000. *Implementation of the Global AIDS Strategy: Report by the Director General*, WHO Executive Bd., 93d Sess., Provisional Agenda Item 9, at 3, WHO Doc. EB93/26 (Dec. 6, 1993).

11. *1992 Update*, *supra* note 1, at 6. WHO estimates that 90% of the projected HIV infections this decade will occur in the developing countries. *Id.* In sub-Saharan Africa, over six million adults are already infected and as result 10 to 15 million children will be orphaned by the year 2000. *Id.*

12. *Id.* at 6. HIV is rapidly becoming as much a scourge in Asia as in Africa. WHO forecasts that by the mid to late 1990s, more Asians than Africans will be infected each year. *Id. See also* Leah Makabenta, *Asia: AIDS Burden Heaviest on Women*, INTER PRESS SERV, Apr. 23, 1993; David Schaefer, *AIDS Ravaging Asia, McDermott Says: Spread Called Worse Than in Africa*, SEATTLE TIMES, June 8, 1991, at A14. *Cf.* James Brooke, *AIDS Squeezing the Life out of Latin America: Epidemic May Surpass Infection Rate in U.S.*, HOUSTON CHRON., January 25, 1993, at A1 (noting that the situation in Latin America is also becoming worse).

13. Helena Brett-Smith & Gerald H. Friedland, *Transmission and Treatment*, *in* AIDS LAW TODAY: A NEW GUIDE FOR THE PUBLIC 20 (Scott Burris et al. eds., 1993); *1992 Update*, *supra* note 1, at 6. According to WHO, developing countries already hold as

growing population of HIV infection.[14] HIV/AIDS has become the leading cause of death of women between the ages of twenty and forty in major American cities and one of the top five causes of death among women in this age group nationally.[15] The actual incidence of HIV infection among women may be much higher due to inaccurate reporting of HIV/AIDS in general and under-diagnosis of HIV/AIDS in women in particular.

III. THE GLOBAL RESPONSE

A. Traditional Conceptions of Women's Health

Despite the documented incidence of HIV infection in women, international policymakers did not, until recently, recognize HIV/AIDS as a profound threat to women's health. The slowness of the multilateral response to the peril HIV/AIDS poses to women's health underscores the low priority which international organizations have traditionally accorded to the protection and promotion of women's international right to health. From a wider perspective, the inadequacy of the international response to HIV infection in women reflects and reinforces the extensive neglect of women's health by policymakers worldwide.

The international community did not specifically identify HIV/AIDS as a health crisis for women until 1989. In that year, the global implications of HIV/AIDS for women's health

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many newly infected women as men, and developed countries are approaching equal incidence in men and women. *1992 Update*, *supra* note 1, at 6.

14. AIDS IN THE WORLD, *supra* note 1, at 3. *See also* SPECIAL INITIATIVE ON AIDS, AM. PUBLIC HEALTH ASS'N, WOMEN AND HIV DISEASE (1991) (providing a general discussion of the impact of HIV on women in the U.S.) [hereinafter WOMEN AND HIV]. Half of the 15,000 cases of AIDS among women reported in the U.S. by 1991 have been reported since 1989. *Id.* at 1. For the past several years, intravenous drug has been the most prevalent mode of HIV contraction in the U.S. *Id.* In 1992, for the first time, heterosexual sex became the number one cause of HIV infection. *Id.* For 60% of these women, their sexual partners were intravenous drug users. *Id.*; Lawrence K. Altman, *Sex is Leading Cause of AIDS in Women*, N.Y. TIMES, July 23, 1993, at A12. In the U.S., the number of AIDS cases among women increased by 9.8% compared to 2.5% for men. Altman, *supra*.

15. Suzanne C. Smeltzer, *Women and AIDS: Sociopolitical Issues*, 40 NURSING OUTLOOK, July-Aug. 1992, at 152. In particular, more adolescent females than males are infected with HIV. *Id.* *See* WOMEN AND HIV, *supra* note 14, at 1, 5. In the U.S., the numerical brunt of HIV infection has been borne by poor women, particularly by African-American and Hispanic women in urban centers. *Id.* at 5.

was recognized by the United Nations General Assembly.[16] WHO did not begin to address the significance of the HIV pandemic to women's health until the beginning of this decade.[17] In 1990, WHO finally held its first consultation on research priorities relating to women and HIV.[18]

From a wider perspective, the failure of international organizations to more promptly identify and respond to the global impact of HIV/AIDS on women reflects the low priority that the international community has conventionally accorded to the protection and the promotion of women's international right to health. The principal legal basis for the international right to health is found in the Covenant on Economic, Social and Cultural Rights.[19] It provides that each nation, to the maximum extent of its available resources, must undertake steps to guarantee the right to the highest attainable standard of physical and mental health of each individual, without discrimination.[20] Promoting the right to health is also an explicit part of the WHO's constitutional mandate.[21] The preamble of WHO's constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity."[22]

Despite the international affirmation of the fundamental concept of equality in the promotion of each person's health status, discrimination is apparent in the way that women's health problems have been conventionally defined and services that have been developed for women by international organizations. Multilateral efforts have traditionally defined or equated women's health as maternal health. Numerous international conventions and declarations have identified motherhood as be-

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16. G.A. Res. 44/233, U.N. GAOR, 44th Sess., Supp. No. 49, at 158, U.N. Doc. A/44/49 (1989).

17. *See generally Forty-Third World Health Assembly, Resolutions and Decisions*, at WHA Res. 43.10, WHO Doc. WHA43/1990/REC/1 (1990). In WHA Resolution 43.10, the World Health Assembly called upon WHO and member nations to strengthen AIDS prevention and control in respect of women and children.

18. *See Forty-Fifth World Health Assembly, Geneva, February 1992, Resolutions and Decisions*, WHO Doc. WHA45/30 (1992) [hereinafter *Implementation of the Global Strategy*].

19. The International Covenant on Economic, Social and Cultural Rights, Dec. 19, 1966, 999 U.N.T.S. 3.

20. *Id.* at arts. 2(1), 2(2), 12(1).

21. WORLD HEALTH ORGANIZATION CONST. pmbl., *reprinted in* WORLD HEALTH ORGANIZATION. BASIC DOCUMENTS 1 (38th ed. 1990) [hereinafter WHO CONST.].

22. *Id.*

ing entitled to special protection,[23] and maternal health has almost been the principal focus of international women's health initiatives.[24]

Maternal health is a critical international health concern that contributes to catastrophic levels of infant and child mortality worldwide.[25] However, the slowness of the global response to the impact of HIV on women illustrates that the crucial defect of this special concern for maternal health has been the failure of the international community to limit its application and pay sufficient attention to the promotion and protection of women's health beyond maternal health.[26]

From a broader perspective, the limited attention that international organizations have traditionally accorded to women's health other than reproductive health merely reflects and reinforces the extensive neglect of women's health by

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23. *See, e.g.*, G.A. Res. 180, U.N. GAOR, 34th Sess., Supp. No. 46, at 196, U.N. Doc. A/34/46 (1979) [hereinafter CEDAW]; *Universal Declaration of Human Rights*, G.A. Res. 217A (III), U.N. GAOR, 3d Sess., U.N. Doc. A/810 (1948). The Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW"), while recognizing the inequality in women's health care, also called for particular attention to maternal health. CEDAW at 193-98. Article 12(2) specifically provides that "States Parties shall ensure to women appropriate services in connexion [sic] with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation." *Id.* at 196; *see also* G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 196, U.N. Doc. A/34/46 (1979). Article 12.2 of the Covenant on Economic, Social and Cultural Rights states that "[s]pecial protection should be accorded to mothers during a reasonable period before and after childbirth." G.A. Res. 34/180, *supra*; *see also* G.A. Res. 217A(III), U.N. GAOR, 3d Sess., 67th plen. mtg., at 1, U.N. Doc. A/811 (1948). Article 25(2) of the Universal Declaration of Human Rights declares the priority of similar protections; it states that "Motherhood and childhood are entitled to special care and assistance." G.A. Res. 217A(III), *supra*.

24. WORLD HEALTH ORGANIZATION, WOMEN, HEALTH AND DEVELOPMENT A REPORT BY THE DIRECTOR-GENERAL 5 (1985) [hereinafter WOMEN, HEALTH AND DEVELOPMENT]. In 1985, for example, WHO stated that "women's special health needs are primarily related to their reproductive role." *Id. See also id.* at 14-24 (describing international efforts to protect maternal health).

25. WORLD HEALTH ORGANIZATION, GLOBAL HEALTH SITUATION AND PROJECTIONS: ESTIMATES, at 27-28, WHO Doc. WHO/HST/92.1 (1992). 500,000 women, 99% of them in developing countries, die each year due to complications during pregnancy and delivery. *Id.* at 28. In 1990, an estimated 13 million children under the age of five died in developing countries. *Id.* at 27.

26. *See, e.g.*, SUSAN SHERWIN, NO LONGER PATIENT: FEMINIST ETHICS AND HEALTH CARE 167, 193-94 (1992). The medical/scientific community has tended to conceptualize and respond to women's health as reproductive health, and have conventionally accorded only limited attention to women's other unique health concerns. *Id.* at 167. The notion that medicine has reduced female bodies to their constituent sexual and reproductive functions is widely recognized. *See id.* Accordingly, science has tended to uniquely treat women only as it relates to reproductive functions. *See id.*

policymakers worldwide. The following section will explore how the global impact of HIV/AIDS has expanded public awareness of the widespread neglect of women's health concerns by national policymakers globally. As a result, the pandemic has contributed to the recent transformation of concern with women's health status by domestic as well as international authorities.

B. New Directions in Women's Health

In the last several years the domain of women's health has undergone a radical transformation. Although the impact of HIV/AIDS on women may not have been the sole cause of the resurgence of interest in women's health,[27] the recent media attention to the global threat of HIV/AIDS to women[28] has focused attention on the fact that women's health has not been a priority issue for attention or investment worldwide. Thus, the global impact of HIV/AIDS has contributed to encouraging industrialized nations as well as WHO to expand their traditionally restricted concern with women's maternal health to broader and more comprehensive views of women's health.

Recent media attention on the impact of the HIV/AIDS on women has highlighted not only the inadequacy of international efforts to promote and protect women's health, but national efforts as well. For example, the absence of reference to women's unique concerns in scientific and clinical discussions of HIV/AIDS, until recently, contributed to exposing the low priority that domestic authorities have conventionally accorded to women's health concerns. HIV/AIDS has, therefore, reinforced recent gender-based critiques of traditional approaches to biomedical research and exposed the neglect of longstanding concerns in women's health. HIV/AIDS thus has brought the scientific community and national authorities under public

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27. *See* THE SOCIAL IMPACT OF AIDS IN THE UNITED STATES 106 (Albert R. Jonsen & Jeff Stryker eds., 1993) [hereinafter SOCIAL IMPACT].

28. *See* Alan L. Otten, *The Influence of the Mass Media on Health Policy*, 11 J. HEALTH AFFAIRS 111, 117-18 (Supp. 1992). One commentator has noted, however, that in the United States, at least, the media has been slow to give attention to the unique concerns HIV has posed for women and consequently contributed to the neglect of the disease in women by national policy makers. *See id.*

scrutiny, as much of the scientific research on HIV/AIDS is nationally administered and funded, particularly by the U.S.[29]

The nature of the scientific investigation of HIV/AIDS served to deepen recent gender-based critiques of biomedical research by exposing the issue of the traditional exclusion of women from clinical trials for a wide range of illnesses. The prevailing norm for clinical studies has been to exclude women.[30] Research studies have conventionally used men as models for the prototypical study population, with results applied to women as though such diseases or conditions would have the same natural history or response in both men and women.

The prevailing view in science, that there are few differences in the incidence and manifestations of illness and disease between men and women, was extended to research on HIV/AIDS incidence and treatment.[31] As a result, women have largely been excluded from the multi-billion dollar global research agenda on HIV/AIDS.[32] Despite the extraordinary

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29. AIDS IN THE WORLD, *supra* note 1, at 260-63. Of the $5.45 billion governments spent on HIV research between 1982 and 1991, approximately 97% was expended in the industrialized States. *Id.* at 261. The U.S. has by far spent the most money on HIV research. *Id.* It spent $4.78 billion in the same period and accounted for eighty-three percent of the public funding. *Id.* at 262. *Cf.* Goldsmith, *supra* note 4, at 446 (discussing the discrepancies in AIDS research funding between industrialized and developing countries).

30. *See, e.g.*, Paul Cotton, *Is There Still Too Much Extrapolation from Data on Middle-aged White Men?*, 263 JAMA 1049, 1049-50 (1990) [hereinafter *Too Much Extrapolation*]; Paul Cotton, *Examples Abound of Gaps in Medical Knowledge Because of Groups Excluded from Scientific Study*, 263 JAMA 1051, 1055 (1990); Rebecca Dresser, *Wanted: Single, White Male for Medical Research*, HASTINGS CENTER REP, Jan.-Feb. 1992, at 24-29 (rebutting justifications for the exclusion of women). Women are not alone in this scientific neglect as minorities also are regularly excluded from clinical studies. *Too Much Extrapolation*, *supra*; Dresser, *supra*; Vivian W. Pinn, *Women's Health Research: Prescribing Change and Addressing the Issues*, 268 JAMA 1921 (1992); H. Rodriguez-Trias, *Women's Health, Women's Lives, Women's Rights*, 82 AM J PUB HEALTH 663, 664 (1992).

31. Smeltzer, *supra* note 15, at 152. The U.S. has been the major financier for HIV/AIDS treatment and initially the disease was seen as confined to gay man. *Id.* Other reasons include society's lack of attention to the health and social problems women face and society's view of women's role in society. *Id.* at 153-54.

32. *Effects of the Acquired Immunodeficiency Syndrome (AIDS) on the Advancement of Women*, Commission on the Status of Women, 33d. Sess., Provisional Item 5(b), at 10, U.N. ESCOR Doc. E/CN.6/1989/6/Add.1 (Feb. 17, 1989) [hereinafter *AIDS on the Advancement of Women*]; *see also* NATIONAL COMM'N ON ACQUIRED IMMUNE DEFICIENCY SYNDROME, AMERICA LIVING WITH AIDS: TRANSFORMING ANGER, FEAR AND INDIFFERENCE INTO ACTION 95, 101 (1991) [hereinafter NATIONAL COMM'N ON AIDS]. In 1991, the National Commission on AIDS recommended that NIH should increase its efforts to expand the recruitment of women and other underrepresented groups in clinical trials. NATIONAL COMM'N ON AIDS, *supra*, at 101. At the end of 1991 fewer than seven

numbers of women infected with the virus, comparatively little is known about the vectors and the course of the disease on women, whether it is marked by the same progression as men and to what extent it is characterized by same opportunistic infections.[33]

Recent reports indicate that there may in fact be significant differences in the manifestations of HIV infection and the trajectory of the disease between men and women.[34] HIV/AIDS has publicly evidenced that an ostensibly "gender neutral" illness may be expressed differently in women and in men.[35] Media scrutiny of the pervasive gender biases in research on HIV/AIDS has contributed to shattering the historical tenet that the incidence and impact of illness and disease are the same in women as in men.[36]

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percent of the participants in the AIDS Clinical Trials Group were women. SOCIAL IMPACT, *supra* note 27, at 106.

33. *See* WOMEN AND HIV, *supra* note 14, at 1, 3, 4. *See also* 1992 Update, *supra* note 1, at 14. ("There are accordingly large gaps in knowledge about women and AIDS"); Catherine A. Hankins & Margaret A. Handley, *HIV Disease and AIDS in Women: Current Knowledge and a Research Agenda*, 5 J. AIDS 957, 957-67 (1992).

34. *See* WOMEN AND HIV, *supra* note 14, at 3. It is well known, for example, that women are physiologically more susceptible to HIV. Ray P. Brettle & Clifford L.S. Leen, *The Natural History of HIV and AIDS in Women*, 5 J. AIDS 1283, 1286 (1991). The largest published epidemiological study to date indicates that women are more than twice as likely as men to become infected with HIV during heterosexual sex. *AIDS Risk Held Twice as High for Women*, N.Y. TIMES, Nov. 1, 1994, at C5. The clinical manifestations of HIV/AIDS also appear to be different in men than women including the association of HIV/AIDS in women with esophageal candidiasis, and with a host of gynecological abnormalities. Brettle & Leen, *supra*, at 1286; Hankins & Handley, *supra* note 33, at 959-71. Reports also suggest that the progression of the disease may be faster in women than in men, although it is unclear whether the different survival rates may be due to women's relative lack of access to early treatment and diagnosis. Hankins & Handley, *supra* note 33, at 966; *see also* Brettle & Leen, *supra*, at 1284-85 (discussing studies which suggest that pregnancy accelerates the progression of HIV to AIDS). It is unclear, however, whether the association of HIV/AIDS with gynecological abnormalities indicates that HIV/AIDS in women gives rise to gynecological disorders or whether the risk factors for HIV/AIDS are the same risk factors for such diseases. WOMEN AND HIV, *supra* note 14, at 4; *see also infra* note 49.

35. Dresser, *supra* note 30, at 24.

36. Joann E. Manson et al., *A Prospective Study of Obesity and Risk of Coronary Heart Disease in Women*, 322 NEW ENG. J. MED. 882 (1990). "In June 1990 . . . . the General Accounting Office revealed that despite a 1986 federal policy to the contrary, women continued to be seriously underrepresented in biomedical research study populations." Dresser, *supra* note 30, at 24. "This practice 'has resulted in significant gaps in [our] knowledge' of disease that affect both men and women." *Id.* (quoting statement of Mark Nadel of the U.S. General Accounting Office). Recent studies have also revealed significant differences among men and women with respect to stroke, cancer, heart disease and many other health problems. *See, e.g.*, Lawrence J. Appel & Trudy Bush, *Preventing*

From a wider perspective, the conventional practice of excluding women from clinical trials on HIV/AIDS[37] serves as a reflection of the deep-rooted preoccupation with women's reproductive functions and the concomitant disregard of women's other unique health concerns.[38] The traditional neglect of women's health issues other than reproductive health is evident in the earliest clinical studies of HIV/AIDS infection in women, which concentrated on analyzing or conceptualizing women as vectors of transmission to their sexual partners or to their children.[39]

HIV/AIDS also revealed the narrow attention that national authorities have conventionally given to developing diagnostic and therapeutic interventions to protect women's health. For example, health authorities have devoted limited resources to developing protective programs for women. Despite women's peculiar susceptibility to HIV infection, global research efforts have largely bypassed development of prevention methods that could be used by women.[40] An effective female condom, for example, which could be utilized by women to prevent transmission of HIV without the knowledge or consent of their sexual partners, is still not generally available.[41]

Measures to control the opportunistic infections and diseases that uniquely affect women with HIV/AIDS require investigation and have further contributed to revealing the long-

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Heart Disease in Women: Another Role for Aspirin?, 266 JAMA 565, 565-66 (1991); Manson et al., *supra*, at 882.

37. SHERWIN, *supra* note 26, at 167. As Susan Sherwin notes, "[m]ost of the medical research on specifically female health issues that is pursued [in the U.S.] has been concentrated on matters of reproduction." *Id.*

38. Dresser, *supra* note 30, at 25. Rebecca Dresser has noted that "NIH officials and biomedical researchers have, consciously or unconsciously, defined the white male as the normal representative human being. From this perspective, the goal of advancing human health can be achieved by studying the white male human model." *Id.* at 28.

39. Hankins & Handley, *supra* note 33, at 957.

40. *But see infra* text accompanying note 61 (describing a new WHO initiative to develop a vaginal microbicide).

41. *Global Strategy*, *supra* note 1, at 5 (noting WHO's aims to prevent "HIV transmission to and from women" through such methods as the female condom). *See also* AIDS IN THE WORLD, *supra* note 1, at 700-07 (providing a general discussion about the "Reality" Condom); Lawrence K. Altman, *New Strategy Backed for Fighting AIDS*, N Y TIMES, Nov. 2, 1993, at C1; *Firm Gets OK for Female Condom*, SACRAMENTO BEE, May 11, 1993, at A8. The female condom is expensive and scientists are uncertain about its ability to prevent the transmission of HIV. Altman, *supra*. *See infra* note 60 and accompanying text (discussing recent initiatives to develop effective barrier methods that can be used by women).

standing neglect of women's health concerns by national authorities.[42] For example, sexually transmitted diseases ("STDs") are a co-factor in the transmission of HIV that greatly increase women's vulnerability to infection.[43] Persons with STDs are five to ten times more likely to contract HIV.[44] STDs, however, represent a longstanding issue in women's health care which were, until recently, conferred inadequate research dollars and scientific attention.[45] These diseases affect a disproportionate number of women, are much more difficult to detect in women and have much graver medical consequences for women.[46] Despite the ubiquitous global impact of STDs, gender differences in transmissions, symptoms and treatment are still not well understood or appreciated by health authorities.[47] National policymakers have been slow in responding to these problems, and facilities for the treatment and detection of these diseases in women are lacking.[48]

The nexus between HIV/AIDS and cervical cancer, a disease closely associated with STDs, also highlights the conven-

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42. *AIDS on the Advancement of Women*, *supra* note 32, at 9-10. Women are also at increased risk of HIV transmission through contaminated blood supplies. In a number of developing countries, donated blood is not screened for HIV/AIDS. Women are at increased risk of infection because of the frequency of blood transfusion for women relative to men as a result of post-partum hemorrhage, ectopic pregnancies, crudely induced abortions and as a treatment for anemia caused by repeated pregnancies. *Id.*; *National, Regional and International Machinery for the Effective Integration of Women in the Development Process, Including Non-Governmental Organizations*, U.N. ESCOR Commission on the Status of Women, 35th Sess., Provisional Agenda Item 5(b), at 2, U.N. Doc. E/CN.6/1991/CRP.2 (Feb. 6, 1991).

43. AIDS IN THE WORLD, *supra* note 1, at 165. *See also Global Health Situations and Projections*, at 44, WHO Doc. WHO/HST/92.1 (1992) (outlining the estimated yearly incidence of STDs). Although reliable data for the worldwide incidence of STDs are not available, WHO estimates that the minimal yearly incidence of four major bacterial STDs, gonorrhea, genital chlamydia infections, infectious syphilis and chancroid, exceeds 75 million. *Id.*

44. *Report of the Twenty-Eighth Session Held at the Headquarters of the World Health Organization, Geneva, 28-30 January 1991*, UNICEF/ WHO Joint Committee on Health Policy, at 25, ESCOR Doc. E/ICEF/1991/L.15 (1991).

45. *See* PAN AM. HEALTH ORG., HEALTH OF WOMEN IN THE AMERICAS 143 (1985).

46. U.N. DEP'T OF INT'L ECONOMICS & SOCIAL AFFAIRS, THE WORLD'S WOMEN, 1970-1990 TRENDS AND STATISTICS at 62, U.N. Doc. ST/ESA/STAT/SER.K/8, U.N. Sales No. E.90.XVII.3 (1991). "Sexually transmitted diseases (STDs) render millions of women subfertile or infertile and give them recurrent infections. Often much harder to detect in women than in men, many STDs reach more advanced stages in women, so the mortality and morbidity rates associated with these diseases are higher in women." *Id.*

47. WOMEN'S HEALTH, *supra* note 6, at 75.

48. *1992 Update*, *supra* note 1, at 3.

tional neglect of diseases that uniquely affect women.[49] Cervical cancer is a major disease associated with HIV/AIDS that likely can be controlled or prevented to prolong the lives of infected women.[50] Yet the U.S. Centers for Disease Control and Prevention's widely used definition of AIDS[51] did not include invasive cervical cancer until the end of 1992.[52] In addition, facilities for the treatment and detection of cervical cancer are lacking in most developing nations. Despite the fact that cervical cancer is a relatively preventable form of cancer, it is the most prevalent form of cancer in women in Africa and Asia, and the second leading type in Latin America.[53] Worldwide, cervical cancer accounts for fifty-one percent of all forms of female cancer incidence in developing countries.[54]

HIV/AIDS has contributed to raising the political profile of women's health. The pandemic has publicly highlighted the global neglect of women's health with respect to conditions that are shared by men and women and the absence of appropriate treatment of diseases that affect women exclusively. As such, the pandemic has contributed to the recent transformation of interest in women's health, at least among industrialized states and international organizations. Although HIV/AIDS is only one facet in the recent resurgence of interest in women's health status, the public scrutiny of national and international re-

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49. WOMEN AND HIV, *supra* note 14, at 3. Studies have found an 8 to 11 times greater risk of cervical dysplasia, the cellular abnormalities that characterize the precancerous state, in HIV-infected women than non-infected women from the same community. The exact relationship between the association of HIV and cervical cancer is not well understood; however, it is unclear whether cervical cancer and other cervical disorders rampant in women infected with HIV are opportunistic infections associated with the virus since many of the risk factors for cervical cancer are the same as those for HIV. *Id.* at 4. *See also supra* note 34.

50. Brettle & Leen, *supra* note 34, at 1286-87.

51. Verla S. Neslund et al., *The Role of CDC in the Development of AIDS Recommendations and Guidelines*, 15 LAW MED. & HEALTH CARE 73 (1987); *see also* Smeltzer, *supra* note 15, at 153 ("The CDC's definition [of AIDS] is used by others, including federal and state agencies, to determine eligibility for services.").

52. *See* James W. Buehler et al., *The Surveillance Definition For AIDS in the United States*, 7 J. AIDS 585 (1993). "Inclusion of cervical cancer [in the definition of AIDS] emphasizes the importance of gynecologic care for HIV-infected women." *Id.* at 586.

53. WOMEN'S HEALTH, *supra* note 6, at 86.

54. *Id.* at 87; *see also* WOMAN, HEALTH AND DEVELOPMENT, *supra* note 24, at 9.

sponses to the impact of the pandemic on women has clearly served to heighten concern with women's health status.[55]

Policies and priorities with respect to women's health and specific women's issues raised by the HIV/AIDS pandemic are transforming at the international level. WHO, for instance, has begun to broaden its conventional concept of women's health and alter its programmatic activities to take into account a fuller spectrum of women's physiological concerns beyond reproductive health. In 1992, for example, the World Health Assembly, the legislative organ of WHO, stressed the importance of new interventions for women's health, including STDS, and directed WHO to establish the first Global Commission on Women's Health before the end of the year.[56] Acknowledging that international efforts have failed to take into account the scope of women's health issues beyond maternal health, the resultant resolution recognized that "women's health means their health throughout their entire life span, and not only their reproductive health."[57]

In the context of controlling the spread of HIV/AIDS, WHO also recently emphasized the development of new initiatives to specifically address the physiological vulnerability of

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55. *See, e.g.*, Dresser, *supra* note 30, at 27. During the last several years, women's health issues have emerged as a pressing political concern. Bernadine Healy, *Women's Health, Public Welfare*, 266 JAMA 566, 566 (1991). In 1991, the former Director of National Institutes of Health ("NIH") noted that "women's health in general in terms of research, services and access to care—has come of age and become a priority, medically, socially, and politically." *Id.* NIH directives now require the participation of women in federally funded research. *Id.*; Dresser, *supra* note 30, at 24. Under the NIH directives, NIH has taken the position that no application will be funded in which women and minorities are not to be included in the planned clinical research program unless compelling scientific justification is given. Healy, *supra*. In 1990, NIH established the Office of Research on Women's Health to address the inequities in the research of women's health concerns and to ensure that women are included in clinical trials. Pinn, *supra* note 30, at 1921. *See also* Andrew A. Skolnick, *Women's Health Specialty, Other Issues on Agenda of 'Reframing' Conference*, 268 JAMA 1813 (1992). In the U.S., experts have begun to explore the possibility of creating a women's health specialty. *Id.*; *see also* SOCIAL IMPACT, *supra* note 27, at 106. In addition, in 1991, NIH announced a new ten year, $500 million initiative, the largest single research project that NIH has ever launched, to redress the neglect of women's health on post-menopausal women. "HLN" (Hilde L. Nelson), HASTINGS CENTER REP., Jan.-Feb. 1992, at 27.

56. *Forty-Fifth World Health Assembly, Geneva, 4-14 May 1992, Resolutions and Decisions, Annexes*, at WHA Res. 45.25, WHO Doc. WHA45/1992/REC/1 (1992) [hereinafter WHA Resolution 45.25]; *see also Report of the 1992 Technical Discussions: Women, Health and Development*, World Health Assembly, 45th Sess., WHO Doc. A45/Technical Discussions/2 Rev.1 (Jun. 10, 1992) [hereinafter *Technical Discussions*].

57. WHA Resolution 45.25, *supra* note 56, at pmbl.

women to HIV infection.[58] Protecting women from HIV infection is now a priority theme of WHO's Global Programme on AIDS. In addition, recognizing that STDs are an important cofactor in the transmission of AIDS, WHO reorganized its structure in 1991, transferring its organizational unit for sexually transmitted diseases to the Global Programme on AIDS.[59] WHO is also turning to a new strategy to contain the spread of HIV to women by focusing on the development of more effective "barrier" methods that could be used by women without the knowledge or consent of their sexual partners.[60] In 1993, WHO launched the new venture to develop a safe and effective vaginal microbicide, a substance in the form of a foam, gel or sponge, that could be used by women to prevent HIV infection.[61]

Thus, the international community appears to be expanding its traditionally restricted concern with women's physical health to embrace a wide variety of physiological issues and concerns beyond maternal health. HIV/AIDS has highlighted the longstanding neglect of women's health issues and thus has served to hasten the recent elevation of interest in women's health. Resources and attention are being redirected to address longstanding issues in women's health, including the development of preventative measures and therapeutic interventions for HIV/AIDS. Despite the slowness of the initial global response to the impact of HIV/AIDS on women, WHO has begun to adjust policies and priorities to address women's health issues, including women's physiological vulnerability to HIV/AIDS infection.

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58. *1992 Update*, *supra* note 1, at 14; WHA Resolution 45.35, *supra* note 1. In WHA Resolution 45.35, the World Health Assembly called upon the Director-General of the organization to "strengthen the development and evaluation of intervention to improve strategies for gender-specific prevention as well as strategies for care in national AIDS programmes."

59. *Implementation of the Global Strategy*, *supra* note 18, at 5.

60. *See supra* note 41 and accompanying text. The difficulty that women have in persuading their partners to use condoms highlights the urgency of developing safe and effective barrier methods that can be used by women without the knowledge of their partners. *Id.*

61. *See* Altman, *supra* note 41.

IV. EXPANDING THE DEFINITION OF WOMEN'S HEALTH: THE SOCIAL AND CULTURAL DIMENSIONS OF HEALTH STATUS

Although the expansion of international health policy to include the full dimensions of women's physiological health is promising, global policymakers have yet to seriously identify and address the social and cultural determinants of women's health status. The impact of HIV/AIDS on women demonstrates that women's health status is not merely the outcome of scientific analysis or medical intervention. Rather, the disease highlights the social and cultural determinants of women's health status. Future multilateral efforts to protect women's health in general and to control the spread of HIV/AIDS in particular must further expand the scope of policy concern with women's health to include consideration of the social and cultural circumstances of gender discrimination that affect women's health status.

There is a consensus within the public health community that the root causes of the relative increase in the incidence of HIV/AIDS in women go beyond the virus itself and are the outcome of the pervasive conditions of social and economic discrimination against women worldwide.[62] Indeed, the inequities in scientific research on HIV/AIDS and medical treatment of women only reflect the widespread disparities in social life that render women uniquely vulnerable to HIV infection. Despite overwhelming confirmation that women's health status is specifically threatened by social and cultural discrimination, women continue to be disadvantaged by the legal and social policies of many nations.

Although the lower status of women within family and society varies from culture to culture, rough generalizations are possible. Worldwide, the consequences of women's inferior so-

62. *See, e.g., 1992 Update, supra* note 1, at 7-9; *Discrimination Against HIV-Infected People or People with AIDS: Progress Report by Mr. Valela Quiros, Special Rapporteur*, U.N. ESCOR Sub-Commission on Prevention of Discrimination and Protection of Minorities, 43rd Sess., Provisional Agenda Item 4, at 7-8, U.N. Doc. E/CN.4/Sub.2/1991/10 (Jul. 24, 1991) [hereinafter *Progress Report on Discrimination*]; *Technical Discussions, supra* note 56; *see also* SHERWIN, *supra* note 26, at 219-22. From a wider perspective, bioethicists agree that health is generally a reflection of social status and that a person's health needs vary inversely with their power or position in society. SHERWIN, *supra* note 26, at 222.

cial status are similar, resulting in a special vulnerability to HIV infection. Economic inequalities and traditional attitudes and values limit the ability of women to protect themselves from infection. Efforts to combat the pandemic must, therefore, go beyond the technical medical aspects of HIV/AIDS. To effectively prevent the further spread of the pandemic, the underlying, deep-rooted social and cultural contexts that dramatically restrict women's choices must be addressed.

Globally, cultural norms reflect and contribute to the biases in prevailing practices regarding the extent, type and quality of education, feeding and health care available to women.[63] This lack of equal access to education and health care restricts women's access to knowledge about HIV/AIDS and the means to prevent infection. Gender inequality in sexual relations and economic status also increases the risk of infection in women. Women's economic and social dependency on men restricts the ability of women and girls in all societies to refuse unprotected sex. The economic inequality of women is a global phenomenon; worldwide, women constitute a majority of the poor.[64] Education and literacy programs are pivotal factors in empowering women and limiting the spread of the pandemic because misconceptions about modes of transmission and risk behaviors reduces the effectiveness of public health messages. Nonetheless, in many societies even women who are informed about ways to control HIV infection are powerless to control their sexual vulnerability to HIV within or outside the context of marriage.

Cultural values and patterns regarding appropriate male and female behavior tend to encourage male promiscuity[65] and lock women into dependency, exacerbating their danger of exposure to HIV and perpetuating the spread of the pandemic.

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63. AM. PUBLIC HEALTH ASS'N 1 (1991). For example, in the U.S., the American Public Health Association has emphasized the enormous barriers to care for HIV-infected women. HIV-infected women are "often misdiagnosed during the early state of their disease. They lack access to drug treatment, abortion services, AZT and early intervention services and clinical trials . . . . The eligibility of HIV-infected women for disability and health benefits is complicated by criteria which may not reflect the nature of the disease in women." *Id. See generally Technical Discussions, supra* note 56, at 3.

64. *Technical Discussions, supra* note 56, at 2.

65. *See, e.g.,* Barbara O. de Zalduondo et al., *AIDS in Africa: Diversity in the Global Pandemic,* 118 DAEDALUS 165, 183 (1989) (describing how within many polygamous cultures little or no shame or stigma attaches to mens extramarital sexual encounters).

Studies from regions of high heterosexual transmission of HIV, for example, indicate that the major risk factor for married women is the pre-marital and extra-marital activities of their husbands.[66] Worldwide, women have little power in influencing their partner's sexual life; have difficulty in demanding that their partners use condoms;[67] and in discussing sexual behavior.[68] Traditional practices, such as the early marriage of girls, means that women are also becoming infected at a significantly younger age than men—five to ten years earlier than men on average and often in their early childbearing years.[69]

Traditional beliefs about marriage, spirituality, sexuality, reproduction and disease causation prevalent in many societies provide a fertile breeding ground for the virus. Cultural conventions in many societies entitle a man to his wife's sexual services.[70] Because of these traditions, the wife is at risk because she may not refuse her husband's request for sexual relations even after he has been diagnosed with HIV/AIDS. In addition, although women who test positive for HIV/AIDS are encouraged to avoid childbearing, that choice may be unavailable or unrealistic in certain cultural contexts. In some African societies, for instance, the status of a woman is critically linked

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66. *Discrimination Against HIV-Infected People or People with AIDS: Final Report submitted by Mr. Varela Quiros, Special Rapporteur*, U.N. ESCOR Sub-Commission on Prevention of Discrimination and Protection of Minorities, 44th Sess., Provisional Agenda Item 4, at 10, U.N. Doc. E/CN.4/Sub.2/1992/10 (Jul. 28, 1992) [hereinafter *Final Report on Discrimination*].

67. Lori L. Heise, *Reproductive Freedom and Violence Against Women: Where are the Intersections?* 21 J.L. MED. & ETHICS 206, 208 (1993) (providing an excellent discussion of rape internationally and its impact on the AIDS pandemic). In some nations, legal provisions require that women receive spousal permission before birth control can be dispensed. *Id.* Studies conducted in the U.S. indicate that women are at increased risk of violence if they ask their sexual partners to use condoms. *See, e.g.*, Dooly Worth, *Sexual Decision-Making and AIDS: Why Condom Promotion Among Vulnerable Women is Likely to Fail*, 20 STUDIES IN FAMILY PLANNING 297 (1989).

68. *Technical Discussions*, *supra* note 56, at 3; Ntiense B. Edemikpong, *Women and AIDS*, in WOMEN'S MENTAL HEALTH IN AFRICA 25, 31 (Esther D. Rothblum & Ellen Cole eds., 1990). Traditional marital practices such as polygamy also increase women's vulnerability to exposure to HIV. Some traditional African religions and Islam endorse polygamy. Edemikpong, *supra*. *See also* Zalduondo, *supra* note 65, at 181-86, 188 (providing an excellent discussion of how several social and cultural conventions of people of the Kagera district in Tanzania and other parts of Africa fuel the spread of the pandemic).

69. Jane Mutambirwa, *Aspects of Sexual Behavior in Local Cultures and the Transmission and Prevention of HIV/AIDS*, *in* TRADITION AND TRANSITION: NGOs RESPOND TO AIDS IN AFRICA 7, 19 (Mary Anne Mercer & Sally J. Scott eds., 1991).

70. *Id.* at 10; *see also* Heise, *supra* note 67, at 206-09 (providing an international perspective on marital rape).

to her ability to bear children and her reproductive role is regarded as the property of her husband's family.[71] As a consequence, a positive HIV test result may, at times, accelerate a woman's plans to conceive.[72]

The global phenomenon of sexual violence against women further limits the ability of women to protect themselves from infection.[73] Sexual violence in the form of rape most directly eliminates a women's control over the means to protect herself against sexual infection with the virus. In addition, sexual victimization, the threat of rape and other forms of physical violence, may also limit the ability of women to protect themselves against infection by "help[ing] to create an atmosphere of female deference to male decision-making regarding sexual behavior."[74]

Stereotypes in many societies place the blame on women for the spread of the disease. HIV/AIDS is, therefore, experienced differently by men and women and has vastly different social and economic consequences. In many societies, infected men expect and receive care, while infected women are frequently stigmatized, rejected and expelled by their communities and families.[75] Although AIDS-related stigmatization is not unique to women, men's property and other rights may be protected by the law, while women's lack of legal status in many nations may leave them homeless and destitute after abandonment by their families.[76] The ascription of HIV/AIDS to women thus further entrenches their social subordination.

Prostitutes are particularly vulnerable victims of AIDS-related stigmatization and discrimination. Poverty forces women and girls into prostitution, placing them at greater risk of ac-

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71. *See* Mutambirwa, *supra* note 69, at 9.

72. *Id.* at 8.

73. *See, e.g.*, Heise, *supra* note 67, at 206-07. In the final conference document of the 1993 World Conference on Human Rights, nations gave unprecedented recognition to the global circumstance of sexual violence against women. Vienna Declaration and Programme of Action, UN Doc. A/CONF.157/23 (1993), *reprinted in* 32 INT'L LEGAL MATERIALS 1661 (1991). See also the discussion in Donna Sullivan, *Women's Human Rights and the 1993 World Conference on Human Rights*, 88 AM. J. INT'L L. 152, 155-57 (1994).

74. *Id.* at 206.

75. *Final Report on Discrimination*, *supra* note 66, at 9-10; *see also* Technical Discussions, *supra* note 56, at 3 (noting that while "men expect and receive care, . . . women are often shunned by their families and communities.").

76. *See Technical Discussions*, *supra* note 56, at 3; *supra* text accompanying note 56.

quiring HIV/AIDS.[77] In addition, in Asia and Africa, thousands of women and girls are sold into prostitution every year.[78] In some countries, evidence of the high prevalence of HIV/AIDS infection among prostitutes[79] has contributed to their being stigmatized for the spread of the disease, without any blame placed on their clients or those who traffic in women.

The outcome of these pervasive conditions of gender discrimination is reflected in the poor health status of women worldwide, of which HIV infection is but one manifestation. Inequitable nutritional practices and lack of basic education put girls at greater risk of malnutrition and disease, including HIV/AIDS.[80] Social customs and sexual violence force girls into the reproductive cycle before they are physically mature, setting the stage for repeated pregnancies, dangerous abortions and sexually transmitted diseases, including HIV/AIDS.[81]

The spread of HIV/AIDS is a poignant illustration of the fact that women's health status is directly influenced by conditions of gender discrimination. Yet, despite the overwhelming recognition that social and economic discrimination fuels the spread of the pandemic and negatively impacts women's health generally, national laws in many countries often confirm or

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77. *See* B. N'Galy et al., *Obstacles to the Optimal Management of HIV Infection/AIDS in Africa*, 3 J. AIDS 430, 432 (1990).

78. *See, e.g.*, Ramon Isberto, *Asia: Fear of AIDS Boosts Child Sex Trade*, Inter Press Service, Apr. 27, 1993. The demand for uninfected girls in Thailand has encouraged traffickers to smuggle in children from Burma, China, Laos and Vietnam. *Id.*; *see also* Molly Moore, *'Even if I Run Away, Where Would I Go?'; Third World Prostitutes: Entrapped by Fate in a Sordid Trade*, WASH. POST, Feb. 16, 1993, at A25. Prostitutes throughout the world are also unable to demand that their clients use condoms. *See, e.g.*, Gayle Reaves, *AIDS Time Bomb; Asian Epidemic, Fueled by Sex Trade and Drugs, May Soon be World's Worst*, DALLAS MORNING NEWS, Apr. 30, 1993, at A1 (reporting "Indian men routinely refuse to use condoms, and workers promoting their use have been slain"); Isberto, *supra* (noting that "child sex workers are less likely than older prostitutes to insist that customers use condoms").

79. Barbara O. de Zalduondo, *Prostitution Viewed Cross-Culturally: Toward Recontextualizing Sex Work in AIDS Intervention Research*, 28 J SEX RESEARCH 223 (1991); *see also* Moni Nag, Sexual Behavior and AIDS in India: State of the Art 17-24, 31-35 (1993) (unpublished paper presented to the workshop on "Sexual Aspects of AIDS/STD Prevention in India," Tata Inst. of Soc. Sciences, copy on file with author) (providing excellent discussion of dynamics of sex trade in India).

80. UNITED NATIONS, WOMEN: CHALLENGES TO THE YEAR 2000 23-24 (1991).

81. *Technical Discussions*, *supra* note 56. Research also suggests that traditional practices such as female genital mutilation further increases women's vulnerability to HIV infection. Edemikpong, *supra* note 68, at 28-31. *See also* WOMEN, HEALTH AND DEVELOPMENT, *supra* note 24, at 7.

compound the violation of women's human rights. Worldwide, legislative discrimination is evident in the context of marital rights, social security benefits, retirement benefits, inheritance laws, property ownership and employment.[82] Such laws increase women's vulnerability to illness and disease, including HIV/AIDS, by narrowing their economic and social capacity to avoid situations which put them at risk. Such discriminatory laws also reflect and contribute to cultural biases which render women uniquely vulnerable to HIV infection.[83] From a wider perspective, entrenched legislative discrimination evidences the failure of many nations to promote and protect women's international right to health.

Future multilateral efforts to combat the spread of HIV/AIDS must therefore look beyond the medical and scientific basis for the disease and identify and address the social contexts which render women vulnerable to illness in general and HIV/AIDS in particular. Indeed, global efforts to combat the spread of HIV/AIDS must further broaden the conceptualization of women's health to recognize the fundamental social and cultural circumstances that render women vulnerable to illness. Policymakers should embrace the concept of health provided in the preamble to WHO's constitution which defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease of infirmity."[84] This paradigm of health must be introduced by policymakers to guide efforts to develop concrete interventions to improve women's health in general and to control the rampant spread of HIV/AIDS in particular.

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82. *Progress Report on Discrimination, supra* note 62, at 7.

83. *See* WORLD HEALTH ORGANIZATION, TABULAR INFORMATION ON LEGAL INSTRUMENTS DEALING WITH HIV INFECTION AND AIDS 20, 96, 133 WHO Doc. WHO/GPA/HLE/92.1 (1992). Female prostitutes have been subject to particularly coercive state imposed sanctions in a number of nations. In some countries, including Bolivia, Panama, and the Russian Federation, legislation has been enacted allowing forcible testing and official registration of prostitutes. *Id.* at 20, 96, 133; Susan Blaustein, *Asia's Bosnia: Ethnic Cleansing—in Burma*, NEW REPUBLIC, Apr. 12, 1993, at 18, 20 (noting that the United Nations Commission on Human Rights has reported that HIV-positive prostitutes deported by Thai authorities back to their native country of Burma have been killed by government authorities).

84. WHO CONST., *supra* note 21, at 1. *See* SHERWIN, *supra* note 26, at 193. One commentator notes that most feminist theorists support a holistic view of health which includes the social determinants of health status. *Id.*

Other observers have noted, however, that international HIV/AIDS interventions have continued to focus primarily on the purely medical aspects of the disease without addressing the underlying social contexts which both foster unsafe behavior and restrict the ability of women to protect themselves against the disease.[85] Indeed, conventional international health strategies, which build on and reinforce the stereotypical role of women as caregivers, compound the impact of HIV/AIDS on women by placing the increased responsibility on them to care for those who are ill.

International organizations have begun to at least identify the complex social and cultural links between women's personal vulnerability to HIV infection and their social status. In 1990, the United Nations Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW") recommended that discrimination against women be avoided in national AIDS programs.[86] In addition, the United Nations Commission on the Status of Women declared that their priority theme for 1993-97 was the effect of AIDS on the advancement of women.[87] In 1992, the World Health Assembly also stressed the importance of new organizational interventions to reduce women's vulnerability to HIV by focusing on the improvement of women's health, education, legal status and economic prospects.[88] Although international organizations have now given at least rhetorical recognition to the fundamental social circumstances which bear on women's health, the question that remains is what meaningful impact international law and institutions can have on the cultural and social mechanisms which fuel the pandemic.

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85. AIDS IN THE WORLD, *supra* note 1, at 659-61. International prevention strategies have conventionally focused on the reduction of the number of sexual partners, fidelity within relationships, safe sexual practices and the treatment of STDs. *Id.* at 659. These measures have had little relevance to the realities of most women's lives because many women cannot control the behavior or circumstances which put them at risk. *Id.* at 659-61.

86. CEDAW, *supra* note 23, at art. 12. The recommendation was based on Article 12 of CEDAW which states that "Parties shall eliminate discrimination against women in the field of health in order to ensure, on a basis of equality of men and women." *Id. See also* Sofia Gruskin, *AIDS and International Human Rights*, 1 ACLU INTERNATIONAL CIVIL LIBERTIES REPORT 11, at 13 (June 1993).

87. Gruskin, *supra* note 86, at 13.

88. *See supra* note 56 and accompanying text.

V. FUTURE INTERNATIONAL EFFORTS TO CONTROL THE SPREAD OF HIV

The cultural data clearly demonstrates that to respond effectively to the spread of HIV/AIDS, international programs must explore and address the interrelationship between HIV/AIDS and women's status. It is important, however, not to overestimate the impact that international organizations and the development of international law addressing the conditions which render women vulnerable to HIV/AIDS can have on the underlying and entrenched social conditions that impact the exposure of women to HIV.

International efforts can have only a limited impact on the entrenched cultural structures which render women vulnerable to illness and disease. An international discourse on rights has little meaning in the daily realities of women's lives. International law is unlikely to affect the status of women at the family and community level where discrimination is strongest.[89] International legislation is therefore unlikely to alter the underlying social structures that define women's roles and limits their choices.

States, moreover, are also likely to oppose international efforts directed towards altering the status of women. Many nations have been highly resistant to complying with their international obligations to promote the human rights of women. The history of a number of international efforts addressed at transforming the status of women, including CEDAW, demonstrates this resistance.[90] CEDAW confirms that states have a dual obligation to ensure that the rights of women are adequately protected by law and that women are empowered to enjoy their right to education, employment, health care and other resources on an equal footing with men. Of all the human rights treaties, however, CEDAW has attracted the greatest number of reservations with the potential to modify or exclude the central provisions of the treaty's terms.[91]

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89. Elizabeth A. Preble, *Women, Children, and AIDS in Africa: An Impending Disaster*, 23 N.Y.U. J. INT'L. L. & POL. 959, 968 (1991) (arguing that international law is unlikely to have a significant impact at the local and family level).

90. CEDAW, *supra* note 23.

91. Belinda Clark, *The Vienna Convention Reservations Regime and the Convention on Discrimination Against Women*, 85 AM. J. INT'L. L. 281, 282-83 (1991). As of December 31, 1989, one hundred states were a party to the convention. In addition, forty-one of

In the United Nations debates surrounding the adoption of the convention, states did not defend their reservations on the grounds that they were of limited effect, but rather that they were dictated by cultural and religious norms.[92] For example, reservations have concerned the incompatibility of gender equality with Islamic law or national customs which restrict women's inheritance and property rights and limit women's employment opportunities.[93] Despite the international rhetorical commitment to CEDAW, the pattern of reservations to the convention, as well as the entrenched legislative discrimination against women prevalent in many nations, indicates that many states are not prepared to alter societal structures that discriminate against women and contribute to the spread of the pandemic.

Efforts to advance the status of women in the context of HIV/AIDS prevention and control are likely, therefore, to be countered by allegations of cultural insensitivity and interference with the domestic affairs of states. International health law has traditionally been primarily functionalist in nature, restricted to activities on which there was international consensus. To effectively address the impact of the pandemic on women, international health law must now take into account a complex set of the social and cultural conditions. The advancement of women's legal and social rights is central to controlling the spread of HIV. Thus, international health law is led into a political quagmire.

The rapid global spread of HIV/AIDS has clearly illustrated that the proper domain of international health law should be expanded to take into account the complex social and cultural circumstances that affect health status. HIV/AIDS has vividly demonstrated that women's social status is not purely a matter of domestic concern. Rather, it is a threat to international health which requires collaborative multilateral action. Although HIV/AIDS has evidenced the interdependence of world health and the inseparable relationship between health and social status, international law is unlikely to affect the status of women in the absence of national commitment.

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the one hundred member states expressed substantive reservations with regards to the Convention. *Id.*

92. *Id.* at 299-300.

93. *Id.*

The final decision on the development of international law and its incorporation into rules of domestic law and, perhaps, behavior depends upon the priorities and the resolve of nations.

This does not mean, of course, that there is no role for international law and organizations in limiting women's vulnerability to HIV infection. The international human rights machinery can contribute to the efforts by examining and exposing national laws and policies which directly or indirectly affect HIV prevention and control on the basis of gender.[94]

International supervision and publication of national compliance with international human rights obligations related to women is a powerful mechanism to ensure that nations give appropriate and adequate attention to their international commitments to protect and promote women's health. The experience with surveillance systems in the United Nations as well as regional organizations indicates that disclosure and discussion of substandard national efforts in an international arena can provide powerful pressure on governments to escalate their efforts to comply with international legal obligations. Initially, such surveillance mechanisms were mainly created and effective in the field of the international protection of human rights. The international surveillance model has been also been adopted and applied in other realms of international law. For example, new international mechanisms for the surveillance of the implementation of environmental treaties are more and more numerous.[95] Supervision and publication of national compliance with international human rights obligations related to women may not only further national compliance with global norms, but also contribute to transforming contemporary no-

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94. The 1993 World Conference for Human Rights called for systemwide integration of women's human rights into the activities of the United Nations human rights bodies. Among other things, the Conference called upon the treaty-monitoring bodies of the United Nations to incorporate gender-specific information into their deliberations and findings. See the discussion in Sullivan, *supra* note 73, at 159.

95. For example, the 1989 Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal requires that state parties inform each other through the United Nations Environmental Programme of the transboundary movement of such waste and on measures adopted by them in the implementation of the Convention. 28 I.L.M. 649 (1989) (4 U.N. Doc. UNEP/IG.80/3). The experience with periodic national reporting systems in the United Nations indicates that state reports can serve a valuable role in promoting compliance with international obligations if the reports are subject to critical evaluation by the relevant international agencies. Philip Alston, *The United Nations Specialized Agencies and the Implementation of the Covenant on Economic, Social and Cultural Rights*, 18 COLUM. J. TRANSNAT'L L. 79, 96-101 (1979).

tions about states' responsibilities to guarantee women's fundamental human rights.

International efforts are also urgently needed to encourage all states to develop and implement specific, binding commitments to increase national health care financing and to equitably distribute existing resources to women. The medical aspects of HIV/AIDS have been particularly difficult to confront in most developing nations because of the pre-existing weaknesses of national health systems.[96] Prevention and control of HIV is critically linked to the existence of adequate primary health care services, including basic health care education.[97] In addition, despite the recent elevation of concern with women's health in some countries, throughout most of the world women's physiological health remains neglected by national policymakers. Therefore, the development of international legislation addressing the allocation, quality and accessibility of existing health care services to women in all nations is an area of critical concern.

Although international organizations have not yet addressed all these areas of critical concern, progress is evident. In its resolution calling for the new Global Commission on Women's Health, the World Health Assembly instructed the Commission to address this issue of health resource allocation.[98] Among other tasks, the Commission is charged to set standards and criteria necessary for regular monitoring of women's health status and countries' progress in implementing past Assembly resolutions bearing on women's health.[99] While these activities do not have the obligatory character of international law, they can, if effectively implemented, constitute an important first step in the advancement of women's right to health and may persuade some states to reconsider and revise national policies on women's health.

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96. *See* Allyn L. Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM J.L. & MED. 301, 304-09 (1992); *see id.* at 325-38 (providing a general discussion of WHO's efforts at securing national health care financing).

97. *1992 Update*, *supra* note 1, at 7-8.

98. WHA Resolution 45.25, *supra* note 56, at Sec. 3(1).

99. *Id.* at Sec. 3(3).

V. CONCLUSION

The global HIV/AIDS crisis has contributed to ushering in a new era of concern with women's health. The disease highlighted the long-standing neglect of women's health by national and international policymakers and intensified the recent metamorphosis of international concern with the physiological basis of women's health status. The disease has also underscored the sociocultural determinants of women's health status.

Protecting and promoting women's right to health is an extraordinary public health challenge. International organizations can have only a limited impact on the social and cultural circumstances which render women vulnerable to illness and disease, including HIV/AIDS. WHO and other international organizations can, however, through the use of international legislation and effective supervisory institutions, make an important, albeit limited, contribution to efforts to protect women's health status. International legislative efforts can encourage nations to rethink and revise domestic laws and policies which discriminate against women on the basis of gender, including the equitable reallocation of domestic health resources to protect and promote women's health.