

NEGOTIATING THE RELATIONSHIP OF HIV/AIDS TO REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

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I. INTRODUCTION

The HIV/AIDS pandemic, now in its second decade, continues to grow at an extraordinary rate. Meanwhile, the issues involved grow increasingly complex. Discussion of reproductive health and reproductive rights matters at the international level has generally failed to take into account the breadth of related HIV/AIDS concerns. In particular, consideration for the reproductive health and reproductive rights of women effectively disappears in the context of HIV/AIDS.

II. THE HIV/AIDS PANDEMIC

The following figures are presented prior to any substantive discussion of the issues in order to make clear the enormity of the problem, as well as to emphasize the sheer number of individuals affected. The Global AIDS Policy Coalition has estimated that as of January 1, 1994, 22.2 million people worldwide had been infected with HIV since the beginning of the pandemic.¹ Of these, 11.3 million were men, 8.7 million were women, and 2.2 million were children.² To date, nearly 6 million people have died from AIDS.³ The global total of cumulative HIV infections in adults has more than

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1. Epidemiological estimations presented in this section are excerpted from THE GLOBAL AIDS POLICY COALITION, HARVARD SCHOOL OF PUBLIC HEALTH, AIDS IN THE WORLD 2 (Jonathan Mann & Daniel Tavantola eds., 1994) [hereinafter AIDS IN THE WORLD].

2. *Id.*

3. *Id.* at 3.

doubled in four years, from nearly 10 million in 1990 to 20 million in 1994.⁴ Worldwide, an estimated 16.2 million people were living with HIV or AIDS on January 1, 1994.⁵

During 1993, more than 3.7 million new infections occurred worldwide in adults and children—over 10,000 a day.⁶ Globally, during 1993, 1.4 million women were newly infected, representing forty percent of all new adult infections in that year.⁷ The rates of infection among women continue to grow. By the mid-1990s, it is estimated that, in the parts of the world hardest hit by the pandemic, the number of women infected with HIV will equal or surpass the number of infected men.⁸ In sub-Saharan Africa, there is increasing evidence that there are already more women than men being newly infected; the estimated ratio in 1993 was 1.1 infected women for every one infected man.⁹

III. WOMEN AND HIV/AIDS

Given the overwhelming number of women who are affected, there continues to be a surprising lack of data concerning women and HIV/AIDS. At the Sixth International AIDS Conference in 1989, the first time since the beginning of the epidemic that women were placed squarely on the HIV/AIDS agenda, the then-existing neglect of women in AIDS prevention and control programs was demonstrated through a global survey of government national AIDS programs (GNAPs). A review of the GNAPs led to two principal conclusions: first, that “in most countries, AIDS prevention program[s] for women [did] not exist”; and second, “where program[s] for women [did] exist, they [were] often designed exclusively to reach female [commercial] sex workers.”¹⁰ In some regions, there was “a complete absence of program[s] targeting women *not* engaged in prostitution.”¹¹ Even more distressing was the blatantly discriminatory attitude in both research and education, where HIV transmission *from*

4. *Id.* at 2.

5. *Id.*

6. *Id.*

7. *Id.* at 3.

8. *Id.*

9. *Id.*

10. KATARINA TOMAŠEVSKI, *WOMEN AND HUMAN RIGHTS* 67 (1993).

11. Katarina Tomaševski, *Gender Discrimination in AIDS Prevention and Control* (1991) (unpublished paper) (*citing* WOMEN, CHILDREN AND AIDS IN LATIN AMERICA: LESSONS FOR THE FUTURE (Sixth Int'l Conference on AIDS, Abstract D.691, Montreal 1989)); *see also* K. CAROVANO ET AL., *WOMEN ARE MORE THAN MOTHERS: DEVELOPING EFFECTIVE AIDS PREVENTION STRATEGIES FOR WOMEN AND CHILDREN* (Int'l Conf. on Implications of AIDS for Mothers and Children, Paris 1989) Abstract 1.3.

women was given prominence at the expense of HIV transmission to women. This attitude completely disregarded the fact that a woman's risk of infection through intercourse is generally thought to be several-fold higher than the risk for a man engaged in the same act.¹²

Although the situation has changed since 1989, that change has come slowly. While the existing evidence makes clear that women are severely affected by HIV/AIDS in all parts of the world, with few exceptions at the GNP level, positive efforts toward prevention and education remain predominantly targeted at men. In many places, the dominant view was—and still is—that the AIDS pandemic affects women both later and less than men.

Women with, or at risk of, HIV differ by age, race, ethnic and cultural identity, language, socioeconomic status, sexual orientation, educational background, relative level of power vis-a-vis men in their lives, nature and extent of family responsibilities, work histories, employment opportunities, and other lifestyle factors.¹³ Yet it has been recognized that women as a group are more vulnerable to HIV infection because of social, cultural, economic, and political realities at the international, national, and community level, not simply because of their immune systems or biology.¹⁴

Many of the societal forces that impact on the probability of increased HIV infection in women are closely tied to women's reproductive health and reproductive rights. This is principally because, in many cultures, an essential dimension of the expectations for a woman's sense of personal satisfaction or self-esteem is the value placed on pregnancy.¹⁵ A woman's fertility or potential fertility can also influence her status in the community and in her own family, as well as be key to her economic survival.¹⁶ Research results have indicated that when women are asked if a positive HIV status would impact on their decision to bear children, they have made it clear that

12. See J. Mantell et al., *Women and AIDS Prevention*, 9 J. PRIMARY PREVENTION; see also PANOS INSTITUTE, *TRIPLE JEOPARDY: WOMEN AND AIDS* (1990).

13. See SEARCHING FOR WOMEN, A LITERATURE REVIEW ON WOMEN AND HIV IN THE UNITED STATES (College of Public and Community Service, University of Massachusetts ed., 1991) (work in progress).

14. See E. Reid, *Gender Knowledge and Responsibility*, in AIDS IN THE WORLD, *supra* note 1, at 657-67; see also PANOS INSTITUTE, *supra* note 12.

15. See Deborah Maine et al., *Risk, Reproduction, and Rights: The Uses of Reproductive Health Data*, in POPULATION AND DEVELOPMENT: OLD DEBATES, NEW CONCLUSIONS 203-04 (1994); E. Esu-Williams, Needs for a Female Controlled Method for the Prevention of HIV Transmission: A Woman's Perspective, *Speech at the Society for Women and AIDS in Africa* 13 (Nov. 1993).

16. See Maine et al., *supra* note 15, at 204; Esu-Williams, *supra* note 15, at 4.

it would not.¹⁷ For example, a study of HIV-positive women in Kigali showed that their primary concern upon learning their serostatus was whether their HIV status would alter their ability to bear more children.¹⁸ Nonetheless, the majority of interventions continue to assume that HIV-infected women will either avoid pregnancy, or that they should.

The AIDS pandemic has added another dimension to the examination of sexual practices both inside and outside of heterosexual marriage. Given that the most effective way to control the spread of HIV infection in intercourse is through the use of a condom,¹⁹ women remain dependent on men to "protect" them by using condoms. It is obvious that the male condom is of limited use to women in that its use depends on the agreement of the male partner. But the female condom—even if greatly improved and readily available—is also problematic. A Nigerian study sums up the difficulty best: Any method "detectable before or during use" is still dependent on the willingness of the man for its use.²⁰

The underlying imbalance of power between men and women also limits the ability of women to protect themselves from HIV infection in other ways. For example, studies from India, Papua New Guinea, Guatemala, Brazil, and South Africa have indicated that even when women who are educated about HIV/AIDS become aware that their partner is having sex with others, they are afraid to try to change their partner's sexual behavior or to insist on the use of a condom. Reasons given include fear of disrupting the relationship, as well as fear of jeopardizing their own physical safety.²¹

Women will continue to engage in unsafe sex and to take chances with their health, even if they are fully aware of the dangers of infection, simply because the social, economic, and cultural costs of

17. See TOMAŠEVSKI, *supra* note 10, at 67.

18. P. Keogg, An Evaluation of the Social Service Needs of HIV: Positive Women Enrolled in a Cohort Study in Kigali, Rwanda (Project San Francisco ed., 1988) (mimeograph).

19. See Maine et al., *supra* note 15, at 219.

20. See Esu-Williams, *supra* note 15, at 6.

21. See NATIONAL SEX AND REPRODUCTIVE RESEARCH TEAM & C. JENKINS, NATIONAL STUDY OF SEXUAL AND REPRODUCTIVE KNOWLEDGE AND BEHAVIOR IN PAPUA NEW GUINEA, at monograph 10 (Papua New Guinea Institute of Research ed., 1994); Bezmalinovic et al., *Guatemala City Women: Empowering a Hidden Risk Group to Prevent HIV Transmission*, in WOMEN & AIDS PROGRAM RESEARCH REP. SERIES (Int'l Center for Research on Women, 1994); A. George & S. Jaswal, *Understanding Sexuality: Ethnographic Study of Poor Women in Bombay*, in WOMEN & AIDS PROGRAM RESEARCH REP. SERIES, *supra*; D. Goldstein, *Culture, Class, and Gender Politics of a Modern Disease: Women and AIDS in Brazil*, in WOMEN & AIDS PROGRAM RESEARCH REP. SERIES, *supra*; Gupta et al., *Women and AIDS: Building a New HIV Prevention Strategy*, in AIDS IN THE WORLD, *supra* note 1, at 55 (citing Karim et al., *Determinants of a Woman's Ability to Adopt HIV Protective Behavior in Natal/Kwazulu, South Africa: A Community Based Approach*, in WOMEN & AIDS PROGRAM RESEARCH REP. SERIES, *infra*).

avoiding these risks may be too high.²² As Carovano has stated, "[T]o provide women exclusively with HIV prevention methods that contradict the fertility norms of most societies is to provide women with no options at all."²³

Researchers and advocates have made it clear that, given societal realities, the development of a microbicide that would allow conception but prevent infection²⁴ is necessary. Because it would not only be controlled by women, but also it would allow decisions about pregnancy to be separated from the prevention of infection. This is critical not only to enable women's ability to make reproductive choices, but also, in the bigger picture, to help reduce the spread of HIV. There is increasing recognition that prevention programs will have only limited success if they continue to encourage abstinence and the avoidance of pregnancy, and fail to recognize the tremendous societal pressures placed on women to conceive.

The HIV/AIDS pandemic affects women in other ways as well. Women are at increased risk of infection because, as has been demonstrated in a variety of cultures, they often place their own health needs below those of their partners, children, or other family members.²⁵ In addition, women are often the principal sources of care and support in formal and informal health care systems, including caring for their children and partners.²⁶ The increasing feminization of poverty²⁷ has also caused more women to be affected by the economic aspects of the AIDS pandemic. Initially, this may concern such things as the loss of employment by the family member who is responsible for bringing up children and providing for food. It also includes, however, such things as inability to secure adequate education and information about AIDS, as well as lack of access to health services, including family planning.²⁸

22. See Maine et al., *supra* note 15, at 204.

23. K. Carovano, *More than Mothers and Whores: Redefining the AIDS Prevention Needs of Women*, 21 INT'L J. HEALTH SERVICES 138 (1992).

24. See, e.g., C. ELIAS & L. HEISE, THE DEVELOPMENT OF MICROBICIDES: A NEW METHOD OF HIV PREVENTION FOR WOMEN (Population Council Working Paper No. 6, 1993); Esu-Williams, *supra* note 15, at 9-11; Zena A. Stein, *HIV Prevention: The Need For Methods Women Can Use*, 80 AM. J. PUB. HEALTH 460, 460-62 (1990).

25. See generally J. WASSERHEIT, THE CULTURE OF SILENCE: REPRODUCTIVE TRACT INFECTIONS AMONG WOMEN IN THE THIRD WORLD (1990).

26. R.J. Guidotti & J. Mann, *AIDS in Mothers and Children in Developing Countries*, in HEALTH CARE OF WOMEN AND CHILDREN IN DEVELOPING COUNTRIES 68 (H.M. Wallace & K. Giri eds., 1990).

27. See UNITED NATIONS, THE WORLD'S WOMEN 1970-1990: TRENDS AND STATISTICS 4, U.N. Doc. ST/ESA/Stat/ser.K/8 (1991).

28. See Reid, *supra* note 14, at 657-67.

IV. AIDS & HUMAN RIGHTS

The AIDS pandemic also affects the advancement of women in part because formal equality in rights has not yet been attained by women in many parts of the world. Although the subordination of women may vary in degree in various societies, its nature remains essentially the same. Women lack equal access to education, health, training, independent income, property, and legal rights. In the context of HIV/AIDS, this translates into difficulties for women both with respect to access to knowledge about HIV/AIDS and methods of prevention, as well as the ability to actually put these methods into practice once educated.²⁹

A woman with AIDS may be denied medical assistance, rejected by her family and friends, and forced to leave her job and her home. She may be physically abused by her partner and thrown out onto the streets. AIDS-related discrimination exists against both sexes. A man's property and other rights, however, may be protected by law, while a woman's unequal legal status may lead not only to violations of her rights based on HIV status, but also to her being denied equal protection under the law.³⁰

International human rights law recognizes public health as a legitimate ground for restricting most individual rights and freedoms. Nonetheless, such restrictions are permissible only if they are provided for and carried out in accordance with the law; in the interest of a legitimate objective of general interest; strictly necessary in a democratic society to achieve such a goal; imposed without a less intrusive means being available to reach the same goal; and not imposed arbitrarily.³¹ In other words, human rights principles and norms should set the limits for any compulsory, coercive, or restrictive measures justified on public health grounds. In the context of HIV/AIDS, good laws and policies arise out of a good understanding of the relevant scientific data, close attention to the nature of the virus in question and its established modes of transmission, attention to the risks and incidence of transmission, and a basic understanding of human rights norms.

29. See *Women and Education, Eradication of Illiteracy, Employment, Health and Social Services, Including Population Issues and Child Care: The Need for Social Support Measures, Effects of AIDS on the Advancement of Women*, U.N. ESCOR, Comm'n on the Status of Women, 33d Sess., Item 5(6), at 8-9, U.N. Doc. E/CN.6/6/Add.1 (1989).

30. *Id.* at 3.

31. See PAUL SIEGHART, AIDS & HUMAN RIGHTS—A U.K. PERSPECTIVE 12 (British Medical Association Foundation for AIDS ed., 1989).

The Global Programme on AIDS (GPA) at the World Health Organization (WHO) recognized that, from a public health point of view, avoidance of discrimination and protection of human rights of affected populations are critical to stop the spread of the disease. In fact, since 1988, the GPA has posited only three crucial, but necessary steps to stop the spread of HIV. They are: (1) information and education programs as a basis for influencing behavior; (2) health and social services to support and strengthen behavior change; and (3) a supportive social environment with public support.³² Unfortunately, these recommendations have not been reflected in the policies and practices of most countries around the world. The history of HIV/AIDS is replete with governmental violations of human rights based on ignorance, misunderstanding, irrational fear, homophobia, sexism, and racism.

Not surprisingly, the evidence suggests that women are more often the victims of HIV-related violations than their male counterparts.³³ In this way, HIV/AIDS compounds the types of violations that result from systematic gender discrimination. For example, it is reported that the governments of several countries are unwilling to provide safeguards against the practice of marrying off young girls to older men, a practice apparently motivated by the belief that younger girls (as young as eight) are not infected with the HIV/AIDS virus. Not surprisingly, this practice has been shown to result in early HIV infection of young girls.³⁴

The most troublesome governmental intrusion into the reproductive rights of women in the context of HIV/AIDS arises from the compulsory HIV testing of pregnant women. This practice exists in many countries, and in quite a few has either been introduced by law or made part of national AIDS programs. A 1993 survey of GNAP managers on both laws and practices in the context of HIV/AIDS demonstrates the extent to which this is done throughout the world. Nineteen of the 115 GNAP managers who responded to the survey stated that routine testing of pregnant women exists in their country, but only six responded that a law exists that authorizes them to carry

32. See J. Mann, *The Global Picture of AIDS* (presented at 4th Int'l Conf. on AIDS, Stockholm, Swed., June 12, 1988).

33. See generally NATIONAL AIDS PROJECT, AMERICAN CIVIL LIBERTIES UNION, *PATTERNS OF DISCRIMINATION* (1990).

34. See AMNESTY INTERNATIONAL, *HUMAN RIGHTS ABUSES IN THE CONTEXT OF HIV/AIDS RELEVANT TO THE MANDATE* (1994) (surveying nongovernmental organizations on AIDS policies of various governments).

out such tests.³⁵ If these answers accurately reflect reality in the countries surveyed—and it seems likely that practices that are problematic in human rights terms would be underreported by government officials rather than overreported—policies which interfere with human rights are being carried out without legal justification. Beyond whatever specific violations are occurring, this practice alone is clearly violative of human rights law in that, as stated earlier, governmental interferences with human rights must be provided for and carried out in accordance with the law.

The forced testing of pregnant women is increasingly of concern. A recent study suggests that HIV-infected women who are given AZT during pregnancy can reduce—by two-thirds—the risk of infecting their children.³⁶ Specifically, the transmission rate from pregnant women to newborns was only 8.3% for those taking AZT, as compared to 25.5% in the women and children not given the drug.³⁷ The competing interests of the mother and the child in testing have been raised in this debate. Although this study is of limited importance for the developing world, it is worth noting because, once again, the focus is on preventing infection in children, with little attention paid to the possible health risks to the mother.³⁸

Beyond raising clear human rights concerns, the compulsory testing of pregnant women can also seriously impact a woman's reproductive health in that women will avoid seeking medical care if they fear being tested. For example, in Berlin, compulsory HIV testing of pregnant women resulted in fewer women attending an antenatal clinic.³⁹ In another study, when 1500 pregnant women in London were asked if they would take an HIV test, only nine agreed to do so.⁴⁰ It is unclear how many of the remaining 1491 women would have continued to seek medical attention if HIV testing had been mandatory.

In addition to the forced testing of pregnant women, there is also an increase in the incidence of "coercive counselling," in which pregnant women who are seropositive are strongly encouraged, if not

35. Sofia Gruskin et al., *Worldwide Trends in Laws and Practices in the Context of HIV/AIDS: A Survey of Government National AIDS Program Managers* (presented at 10th Int'l AIDS Conf., Yokohama, Japan, Aug. 1994).

36. See K.A. Fackelmann, *AZT Lowers Maternal HIV Transmission Rate*, 145 SCI. NEWS 134 (1994).

37. *Id.*

38. See *id.*; see also Peter Aldhous, *Blazing an Ethical Trail*, NATURE, Sept. 5, 1991; Geoffrey Cowley, *Locking HIV Out of the Womb*, NEWSWEEK, Mar. 7, 1994, at 53.

39. See L. SCHERR ET AL., *PSYCHOLOGICAL COST OF HIV SCREENING IN ANTE-NATAL CLINICS* (Int'l Conf. on Implications of AIDS from Mothers and Children, Paris 1989) Abstract D.16.

40. *Id.*

required, to obtain an abortion.⁴¹ Further, there has been increasing pressure on seropositive women to avoid pregnancy entirely, and in some countries require seropositive women to be sterilized. At the same time, many clinics refuse to serve seropositive women, or will only serve them at an increased charge.⁴²

The following briefly sets out some of the human rights provisions that are directly applicable to the violations of the human rights of these women, but is by no means intended to be an exhaustive list.⁴³ First, one can look to Article 12 of the Covenant on Economic, Social and Cultural Rights,⁴⁴ which "recognize[s] the right of everyone to the highest attainable standard of physical and mental health."⁴⁵ What does it do to a woman's mental health (let alone her physical health) when she is forcibly tested, finds out she is infected with HIV, and then is forced to abort or is denied access to reproductive health services? Second, look at this same scenario under Article 16(e) of the Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention),⁴⁶ which recognizes that women have a right to decide "freely and responsibly on the number and spacing of their children" and to have the information and means necessary to exercise that right. This a right, as Professor Cook points out, which must not be limited by the government.⁴⁷

Finally, consider evaluating this scenario under the relevant provisions of the U.N. Committee on the Elimination of Discrimination Against Women's (CEDAW) General Recommendation No.19 on Violence Against Women.⁴⁸ General Recommendation No.19 recognizes that forms of coercion regarding fertility and reproduction place women's health and lives at risk, and specifically states that "compulsory sterilization or abortion adversely affects women's physical and mental health, and infringes the rights of women to choose the number and spacing of their children."⁴⁹ In addition, States Parties are specifically recommended to "ensure that measures

41. See generally AMNESTY INTERNATIONAL, *supra* note 34.

42. See, e.g., Elizabeth Rosenthal, *Abortion Records Subpoenaed: New York City Human Rights Commission Wants Records of Abortion Clinics That Have Refused Abortions to Women with the AIDS Virus*, N.Y. TIMES, Nov. 6, 1990, at B2.

43. For example, the right to found a family is not discussed because it does not offer much protection.

44. Economic Covenant, *infra doc. biblio.*, art. 12.

45. Economic Covenant, *infra doc. biblio.*, art. 12.

46. Women's Convention, *infra doc. biblio.*, art. 16(e).

47. REBECCA J. COOK, WOMEN'S HEALTH AND HUMAN RIGHTS 31 (1994).

48. *General Recommendation No. 19: Violence Against Women*, in *Report of the Committee on the Elimination of Discrimination Against Women*, 11th Sess., Item 7, U.N. Doc. CEDAW/C/L.1/Add.15 (1992).

49. *Id.* ¶¶ 26-27.

are taken to prevent coercion in regard to fertility and reproduction."⁵⁰ The actions just discussed would seem to run directly contrary to these provisions.

V. THE INTERNATIONAL RESPONSE

As mentioned earlier, AIDS prevention measures directed toward women continue to focus on preventing the infection of their future children or the men with whom they have sex. The rights of the women concerned, particularly around their reproductive health and rights, are secondary at best. NGOs concerned with AIDS issues, reproductive health/rights issues, and women's rights issues⁵¹ have, to varying degrees, all been attentive to this point. Although recognition of the fundamental dignity and worth of the individual, without discrimination, is key to human rights principles and central to discussion of HIV/AIDS and human rights issues, it is my contention that concern for the reproductive health and reproductive rights of women evaporates at the intergovernmental level in the context of HIV/AIDS.

An examination of international action, including statements and declarations, since the start of the pandemic illustrates this point all too well. Attention to women in the context of AIDS and human rights is limited to consideration of women's increased vulnerability to HIV infection and to the avoidance of discrimination in the context of HIV/AIDS. Although the references to nondiscrimination would seem to offer some protection to HIV-infected women, it is clear that the reproductive rights of these women have not yet been considered in this context. There is no international policy that adequately addresses the reproductive health and rights of women in the context of HIV/AIDS.

The Women's Convention is the only human rights document to explicitly recognize a right to "decide freely and responsibly on the number and spacing of . . . children."⁵² Consequently, specific references to reproductive rights and health existing in international declarations and resolutions are of particular importance to any claim

50. *Id.* ¶ 27.

51. This includes the Global AIDS Policy Coalition, the AIDS & Reproductive Health Network, and the International Center for Research on Women.

52. Women's Convention, *infra doc. biblio.*, art. 16(e). In addition Article 14(b) imposes an obligation on States Parties to be sure that rural women have "access to adequate health care facilities, including information, counselling and services in family planning." *Id.* art. 14(2)(b). The right to family planning education and services is also recognized in Article 24(2)(f) of the Convention on the Rights of the Child. Convention on the Rights of the Child, *infra doc. biblio.*, art. 24(2)(f).

that reproductive rights must be expanded to include HIV/AIDS-related issues. A myriad of international declarations and resolutions have expressed political commitment to ensuring reproductive rights and health. In 1968, the Tehran International Conference on Human Rights first termed reproductive choice a basic right.⁵³ This right has been further elaborated and reaffirmed in a host of international documents including the World Population Plan of Action of 1974,⁵⁴ the 1984 Recommendations of the International Conference on Population⁵⁵ held in Mexico, the Amsterdam Declaration of 1989,⁵⁶ and at the recent Conference on Population and Development in Cairo.⁵⁷

The international community first recognized the human rights dimension of HIV/AIDS as a global problem, requiring a coordinated global response, in 1987.⁵⁸ As part of the global AIDS strategy, the WHO called on human rights NGOs to join in the worldwide struggle against AIDS by monitoring and combatting discrimination against those with AIDS or infected by the HIV virus. This response was then endorsed by the U.N. General Assembly.⁵⁹

In 1990, the U.N. Commission on Human Rights (UNCHR) authorized a Special Rapporteur to the Subcommittee on discrimination and AIDS-related human right violations.⁶⁰ Although the Special Rapporteur's reports summarize the majority of the work done at the international level on AIDS and human rights, they are quite general and do not address specific violations. The 1990 preliminary report extensively discusses AIDS control measures that affect the enjoyment and exercise of human rights, including personal liberty

53. Statement by U.N. Family Planning Association, 3d Sess. of Preparatory Comm. for World Conf. on Hum. Rts., Geneva, Sept. 14-18, 1992. The right to family planning, however, was first affirmed by the World Health Assembly in 1965 and by the United Nations General Assembly in 1967.

54. *World Population Plan of Action of 1974*, G.A. Res. 3344(XXIX), U.N. GAOR, 29th Sess., U.N. Doc. A/RES/3344(XXIX) (1974).

55. *International Conference on Population, 1984*, G.A. Res. 39/228, U.N. GAOR, 39th Sess., Agenda Item 12, U.N. Doc. A/RES/39/228 (1984).

56. *Future Needs in the Field of Population, Including the Development of Resource Requirements for International Population Assistance*, G.A. Res. 44/210, U.N. GAOR, 44th Sess., Agenda Item 86, U.N. Doc. A/RES/44/210 (1990).

57. ICPD Programme of Action, *infra doc. biblio.*

58. See World Health Assembly, Res. 40.26 (May 15, 1987).

59. *Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, G.A. Res. 43/15, U.N. GAOR, 43d Sess., Agenda Item 12, U.N. Doc. A/RES/43/15 (1989); *International Decade for Natural Disaster Reduction Annex: International Framework of Action for the International Decade for Natural Disaster Reduction*, G.A. Res. 44/236, U.N. GAOR, 44th Sess., Agenda Item 12, U.N. Doc. A/RES/44/236 (1990).

60. *Discrimination Against HIV-Infected People or People with AIDS*, U.N. ESCOR, Comm'n on Hum. Rts., 46th Sess., Item 27, at 23, U.N. Doc. E/CN.4/L.11/Add.4 (1990).

and freedom of movement.⁶¹ The 1991 progress report analyzes discrimination associated with AIDS, and raises some of the conceptual and legal issues that relate to discrimination.⁶² The 1992 final report highlights the need to tackle the underlying causes of discrimination leading to poverty and social discrimination in the context of HIV/AIDS.⁶³ The 1993 Conclusions and Recommendations urges States to take all necessary steps to eliminate AIDS related discrimination, particularly as it concerns women and children.⁶⁴ Much of the 1992 report focuses on women's increased vulnerability to infection and the impact of discrimination on the rights of women in the context of HIV/AIDS, but there is no mention of the implications of HIV/AIDS for reproductive health and rights.

In addition to various resolutions referring to HIV/AIDS passed by the Commission in the last several years, in January 1994, the Commission asked the U.N. Secretary General to prepare a report on international and domestic measures taken to protect human rights and prevent discrimination in the context of HIV/AIDS.⁶⁵ The resolution also urged working groups, special rapporteurs, treaty monitoring bodies, and others to consider AIDS-related human rights issues in their work. The importance of this resolution will be determined by the degree to which it prompts reporting and monitoring of AIDS specific human rights violations (including those concerning reproductive rights issues) at the nongovernmental and intergovernmental level.

A range of other organizations within the United Nations, including the International Labour Organization, UNHCR, U.N. International Children's Education Fund, and the U.N. Population Fund have adopted explicit nondiscrimination policies with respect to HIV/AIDS in their work. The Committee on Economic, Social and Cultural

61. See *Discrimination Against HIV-Infected People or People with AIDS: Preliminary Report*, U.N. ESCOR, Comm'n on Hum. Rts., Subcomm'n on Prevention of Discrimination and Protection of Minorities, 42d Sess., Item 4, U.N. Doc. E/CN.4/Sub.2/9 (1990).

62. See *Discrimination Against HIV-Infected People or People with AIDS: Progress Report*, U.N. ESCOR, Comm'n on Hum. Rts., Subcomm'n on Prevention of Discrimination and Protection of Minorities, 43d Sess., Item 4, U.N. Doc. E/CN.4/Sub.2/10 (1991).

63. See *Discrimination Against HIV-Infected People or People with AIDS: Final Report*, U.N. ESCOR, Comm'n on Hum. Rts., Subcomm'n on Prevention of Discrimination and Protection of Minorities, 44th Sess., Item 4, U.N. Doc. E/CN.4/Sub.2/10 (1992).

64. See generally *Discrimination Against HIV-Infected People or People with AIDS: Conclusions and Recommendations*, U.N. ESCOR, Comm'n on Hum. Rts., Subcomm'n on Prevention of Discrimination and Protection of Minorities, 45th Sess., Item 4, U.N. Doc. E/CN.4/Sub.2/9 (1993).

65. See *The Protection of Human Rights in the Context of Human Immuno-Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)*, U.N. ESCOR, Comm'n on Hum. Rts., 50th Sess., Item 11, at 5, ¶ 11, U.N. Doc. E/CN.4/L.60 (1994).

Rights has included HIV/AIDS related human rights issues in its consideration of States' reports, but issues of reproductive health and reproductive rights in the context of HIV/AIDS have never been raised.

Even those efforts within the U.N. system to address HIV-related concerns specific to women have not addressed the reproductive health and rights of HIV-infected women. In 1990, CEDAW adopted a recommendation concerning the avoidance of discrimination against women in national AIDS strategies. Most relevant is the provision that "program[s] to combat AIDS should give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which makes them especially vulnerable to HIV infection."⁶⁶ Again, the only attention to women's reproductive health and rights concerns how HIV/AIDS makes women more vulnerable to HIV infection, not how it impacts on women's ability to make reproductive choices.

Also in 1990, the World Health Assembly passed a resolution calling on Member States to include a representative of a women's organization in National AIDS Committees, and to enhance women's social, economic, and legal status through income-generating activities, in order to allow them fuller participation in AIDS control programs at all levels.⁶⁷ No mention was made of reproductive rights issues.

The Commission on the Status of Women (CSW) declared the effects of AIDS on the advancement of women a priority theme for 1993-1997,⁶⁸ but has done little beyond including the standard HIV/AIDS related language in its meetings and requests for related reports.⁶⁹ To date, the preparatory documents prepared by the CSW for the Beijing Conference are also very limited in their mention of HIV/AIDS. Concern seems to be confined to giving "[s]pecial attention . . . to prevent[ing] the AIDS pandemic among women" and

66. *General Recommendation No. 15: Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, in *Report of the Committee on the Elimination of Discrimination Against Women*, 9th Sess., U.N. Doc. A/45/38 (1990).

67. 43rd World Health Assembly, Res. 43/10 (1990).

68. U.N. COMM. ON THE STATUS OF WOMEN, RESOLUTION OF THE COMMISSION ON THE STATUS OF WOMEN, U.N. Doc. A/RES/44/233 (1990).

69. *Development: Women in Urban Areas: Population, Nutrition and Health Factors for Women in Development, Including Migration, Drug Consumption and Acquired Immune Deficiency Syndrome*, Report of the Secretary General, U.N. ESCOR, Comm'n on the Status of Women, 38th Sess., Item 5(b), at 5, ¶ 14, U.N. Doc. E/CN.6/3 (1994).

"increasing women's access to information about and treatment of AIDS."⁷⁰

VI. CAIRO AND BEYOND

Finally, I would like to draw attention to the twenty-year Programme of Action, which came out of the Cairo International Conference on Population and Development (ICPD).⁷¹ This document is the first major international effort to give attention to both reproductive rights issues and HIV/AIDS. In endorsing a new strategy for population issues, which sees the empowerment of women as key, the ICPD document perfectly demonstrates the inconsistency that exists between the internationally recognized reproductive rights of women who are not HIV-infected, and the failure to give equal recognition of these rights to those who are.

The ICPD document affirms the right of men and women to be informed and to have access to safe, effective, affordable methods of family planning of their choice. The document further affirms that the definition of reproductive rights "rest[s] on the recognition of the basic right[s] of *all* couples and individuals to decide freely, and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health."⁷² It also "includes the[] right to make decisions concerning reproduction *free of discrimination, coercion and violence*, as expressed in the human rights documents."⁷³

This language would seem to imply that decisions concerning childbirth—whether or not one of the parents is HIV-infected—should be made by individuals, that population policies must allow individuals to decide freely and responsibly whether they want children, and that the ability to do so should be free from government interference. The sections of the document concerning HIV/AIDS, however, make clear that this right is not actually recognized to extend to people in the context of HIV/AIDS. The AIDS language focuses on prevention and control. In addition to the usual rhetoric about vulnerability and the avoidance of discrimination

70. *Preparations for the Fourth World Conference on Women: Action for Equality, Development and Peace, Report of the Inter-Sessional Working Group of the Commission on the Status of Women*, U.N. ESCOR, Comm'n on the Status of Women, 38th Sess., Item 6, at 19, ¶ 64, U.N. Doc. E/CN.6/12 (1994).

71. See ICPD Programme of Action, *infra doc. biblio.*

72. ICPD Programme of Action, *infra doc. biblio.*, ¶ 7.3 (emphasis added).

73. ICPD Programme of Action, *infra doc. biblio.*, ¶ 7.3 (emphasis added).

in the context of HIV/AIDS, the Programme of Action states as an objective that "sexual and reproductive health program[s] [must] address HIV infection and AIDS,"⁷⁴ but be limited to promoting "responsible sexual behaviour, including *voluntary [sexual] abstinence*" for the prevention of HIV infection.⁷⁵

There is a great deal in the document that refers to reproductive health and reproductive rights. There is even a great deal in the document about HIV/AIDS. There is nothing, however, that even comes close to referring to reproductive health and rights in the context of HIV/AIDS.

The Cairo document makes it clear that we must go a step further in Beijing. We have to push for the affirmation that women do not give up some of their rights because they are, or could be, HIV-infected. True realization of reproductive rights necessitates that all women be recognized as human beings capable of understanding and making decisions about their own lives. A woman's own perception of what she needs for her health and well-being must take priority. In addition to the social, economic, and cultural pressures put on women to conceive, the contradictory pressure put on HIV-infected women to avoid or terminate pregnancy must be recognized. Reproductive rights must be protected in the context of HIV/AIDS so that women can negotiate these conflicting pressures for themselves. Application of the nondiscrimination principle must be broadened to include the same reproductive rights and choices for women who are HIV-infected as for those who are not. The principle of nondiscrimination must no longer be discriminatory in its application, and must be applied to the reproductive rights of all women.

74. ICPD Programme of Action, *infra doc. biblio.*, ¶ 8.29.

75. ICPD Programme of Action, *infra doc. biblio.*, ¶ 8.31 (emphasis added).

