Women, the HIV epidemic and human rights

JULIE HAMBLIN *
ELIZABETH REID **

Introduction

Women require special and urgent consideration in the response to the HIV epidemic. The reason for this may not be immediately apparent since the virus can and will infect a person regardless of sex, race or social status. There are compelling reasons why the particular needs and concerns of women must be addressed in the response to the epidemic.

One of the common misconceptions of HIV policy is that the virus does not discriminate in its spread and impact. To the extent that everyone can potentially be infected, this is true, but an understanding of the real impact of the epidemic requires much more than a knowledge of medical science. Increasingly, the people who are bearing the brunt of the epidemic are those who are socially, sexually and economically vulnerable and who, by reason of this, are unable to implement the measures necessary to protect themselves against infection and to deal with the consequences of the epidemic within their community. With the HIV epidemic, we have witnessed a new way in which deeply-rooted inequalities of race, gender and wealth are manifested. The emerging pattern of the epidemic is both reflecting and reinforcing existing social, economic and cultural relationships between individuals and within communities.

" One of the common misconceptions of HIV policy is that the virus does not discriminate in its spread and impact. "

HIV has given expression to the disadvantaged position of women in many ways. Through social and economic dependency, women frequently lack the power to determine the basis upon which their sexual relationships take place whether within or outside marriage. In many cases, there are no means available to them to protect themselves against HIV infection. As mothers, women must deal with the implications of HIV infection for unborn children, and as carers, they bear the burden of looking after the sick and dying - often at devastating emotional and economic cost to themselves - and of attempting to hold the family unit together in the face of the AIDS epidemic. On all these counts, women are disproportionately affected by the epidemic.

An understanding of the factors that affect women is critical to contain the spread of HIV and to deal with its effects for both women and men. The vulnerability of women to HIV must be understood in the broader context of deeply embedded social and gender inequalities which lie at the heart of women's inability to deal effectively with the risks and needs created by the AIDS epidemic. Unless the interaction between HIV infection, cultural values and the rights and needs of women is recognised, the fundamental changes required to stem this epidemic will be unattainable.

The epidemiology of HIV infection and AIDS in women

In 1990, the World Health Organization (WHO) estimated that there were between 8 and 10 million people worldwide infected with HIV. Between 3 and 4 million of these people are women[1]. The rate of infection among women has been increasing significantly. The number of infected women rose sharply during the second half of the 1980's and, in some areas of Africa, Latin America and Caribbean, there was more than fourfold increase over a period of between two and four years[2,3]. It is estimated that during the next decade the prevalence of HIV infection among women will equal and, in some cases, overtake that of men.

The increasing rate of HIV infection among women reflects the fact that heterosexual transmission has come to

* Ms Hamblin, UNDP Consultant from Ebsworth & Ebsworth, Sydney, Australia. ** Ms Reid, Director, HIV and Development Programme, UNDP, 304 East 45th St, Room FF986, New York, NY 10017, USA. Adapted and reprinted with permission from UNDP Issues Paper No.8; 1993.

be by far the most common route by which infection occurs. Globally, it is estimated that 60% of all cases of infection to date have occurred through vaginal intercourse. In sub-Saharan Africa, the estimate is 80%. In many developed countries, where HIV infection was initially contained within certain groups such as male homosexuals and drug users, increasing heterosexual transmission means that women are becoming more vulnerable and infection rates among women can be expected to rise.

The WHO estimates that during the 1990's, the number of women and children dying of AIDS will rise to 3 million. In most central African cities and in some major cities in America and Western Europe, AIDS is already the leading cause of death for women between the ages of 20 and 40. In sub-Saharan Africa over the next few years, infant mortality is expected to increase by up to 30% as a result of perinatal transmission of HIV[1]. In this region, one in every twenty adult women is thought to be infected[4], and women represent more than 50% of the total number of AIDS cases[1].

The majority of infected women are of child bearing age, opening the way for large scale perinatal HIV transmission. UNDP has estimated that about 85% of the cases of pediatric infection in Africa have resulted from perinatal transmission. For the Caribbean the estimate is 97.5%[5]. Even where the children do not themselves have HIV infection, the number of children orphaned by AIDS is increasing rapidly. WHO has estimated that as many as 10 million children in sub-Saharan Africa will be orphaned by the epidemic by the end of the 1990's.

The primary HIV risk activity for women globally is sexual activity. Over 90% of women currently infected with HIV have been infected as a result of transmission through vaginal intercourse. Efficacy of transmission is increased where women have poor general health and suffer from genital lesions, inflammation, secretions and scarification. Young women, in particular are especially vulnerable because of genital immaturity which makes it easier for HIV to be transmitted during sexual intercourse. Women are also at increased risk because of the high incidence of blood transfusions and injections associated with pregnancy, childbirth and post-pregnancy haemorrhage or treatment for anaemia caused by repeated pregnancies[6].

The WHO has admitted that its estimates of the levels of infection among women and children should be viewed as very conservative[1]. It is likely that under-reporting of HIV infection and AIDS in parts of Africa, the Caribbean and Asia has helped to conceal the true levels of infection. However, even the estimates currently available leave no doubt as to the magnitude of the impact of the HIV epidemic on women.

The status of women and the HIV epidemic

An understanding of HIV infection in women requires more than just an appreciation of the statistics. The social and cultural determinants of HIV infection in women are very different from those for men because they relate to the role of women within relationships, families and communities which, in turn, determines the nature and patterns of women's sexual activity and other factors that place women at risk of HIV infection. An understanding of the epidemic must therefore include not only how women have been affected but also why they have been affected.

" The social and cultural determinants of HIV infection in women are very different from those for men because they relate to the role of women within relationships, families and communities ... "

HIV infection is preventable. Given access to information and appropriate preventive measures and the means of implementing these measures, there need be no new cases of infection. But poverty, ignorance, dependency and powerlessness strip a person of the ability to protect oneself against infection. It is therefore inevitable that, as the epidemic progresses, those people who have the power to protect themselves against infection will be in a position to do so while those people who do not will continue to be infected in ever-increasing numbers.

The link between powerlessness and the risk of exposure to HIV provides the key to understanding the source of women's vulnerability to HIV infection. In more developed countries, the full impact of these social and cultural dynamics was not apparent in the early years of the epidemic when the majority of infections were occurring among homosexual men. With increases in infection levels in women in both the developed and the developing world, however, there has been a shift in the global demographics of HIV infection. This shift has forced a reassessment of the role of socioeconomic factors in the spread of HIV in order to address the ways in which women are being affected by the epidemic.

The male orientation of the understanding of the epidemic to date is evident even in the way HIV-related illnesses and AIDS have been defined. The case definition of AIDS used worldwide focuses on the marker diseases that are characteristic of HIV-related illness in men and omits conditions that often signify the onset of HIV-related conditions and AIDS in women, including pelvic inflammatory disease, cervical cancer, vaginal candidiasis and con-

junctivitis. This has had serious consequences for women, leaving many women undiagnosed or wrongly diagnosed, delaying diagnosis and treatment and denying women access to disability and other benefits and services because they have not been diagnosed with AIDS[7]. It has also inhibited an appreciation of the extent to which women have been affected by the epidemic.

The patterns of social and economic dependency that render women vulnerable to HIV infection are manifested in many different ways. First and foremost, they lead to women being deprived of the power to determine the basis upon which their sexual relationships with men take place. For many women, sexual relationships are determined by cultural roles and expectations. Often, a woman's relationship to her husband and her role as mother are the main source of her social identity. Her sexual relationship with her husband is part of a web of social and economic roles and responsibilities that are resistant to change by individual women alone. Marriage can provide economic and social support to women, as well as the opportunity to fulfill their desire to have children, that would not be available to them if they were to remain single[2,8,9,10].

Similar social constructs may also mean that a married woman has little or no power to negotiate. A common pattern is that married women are expected to remain faithful to their husbands but are not necessarily accorded the right to compel fidelity in return. Multiple sexual relationships on the part of men are often socially condoned or at least tolerated. The tendency for men to have sexual relationships outside their marriage may be reinforced by male migration and mobility common in many developing countries where men leave the village to obtain work elsewhere[11].

In these circumstance, women often have little alternative but to accept the risk that sexual intercourse with their husband entails. Even if condoms are available to them at an affordable price, they cannot insist that their husband uses them and social inhibitions may prevent them from raising the question. Leaving a marriage even in cases where remaining married may lead to the wife's infection with HIV, is not an option for the many women who have no other means of support for themselves and their children.

The inability of women to control the factors that place them at risk of HIV infection is compounded by the fact that many societies place a high value on the role of women as child bearers and child rearers. Therefore HIV barrier preventive measures, such as condoms, that inhibit women's ability to have children are unsatisfactory. The experience with family planning programmes in the past has highlighted the extent to which the cultural value placed upon reproduction has been an obstacle to change and has demonstrated that women rarely have complete or independent control over the reproductive process.

Although it is almost invariably the husband who is the vector of HIV infection for wives, a married woman who is found to be infected with HIV will often be expelled from the family unit by the husband. The husband will then seek a new wife, often a younger woman who is believed to be uninfected. In some parts of Africa, there have been reports of increased rape of young girls, because they are believed to be free of HIV infection[10,12]. Prostitution is often the only means of support for deserted, separated, divorced or unmarried older women, highlighting once again the close link between economic need and exposure to HIV infection. Prostitution is the wide variety of ways in which women exchange sexual intercourse for cash or other forms of economic support, food, shelter or care.

There has been serious distortions of the understanding of HIV among women due to the targeting of female sex workers by HIV researchers and policymakers. Most women are not sex workers and, in fact, the largest group of women at high risk of infection are wives. Recent data from Mexico indicate that only 0.8% of all reported AIDS cases have been among sex workers and 9% among housewives.[13] Similar figures can be found in other developed and developing countries. In Senegal where the epidemic is still in its infancy (less that 2% of the adult population infected), modes of transmission to women in one infectious diseases ward were 20% acquired iatrogenically, 30% occupationally (sex workers) and 50% had no risk factor other than sex with their husband[14].

" Prostitution is often the only means of support for deserted, separated, divorced or unmarried older women, highlighting once again the close link between economic need and exposure to HIV infection. "

The targeting of female sex workers as the main group of women affected by the epidemic encourages blame, stigma and discrimination. It also allows those who infect sex workers and the wives to deny that they are at risk. It is another example of how the response to the epidemic to date has not been sufficiently sensitive to the nature and extent of the risks for women.

Women's access to the cash economy may be limited by land ownership or usage regulations, by their poor access to education, training, credit or employment, and through their culturally restricted mobility. In addition to forcing some women to resort to the sale of sex for economic support, the economic dependency of women increases

their HIV risk in other ways. Lack of access to affordable health care means women are more likely to become infected as a result of sexual intercourse with an infected partner. Low levels of literacy means that women are less likely to have access to information about HIV prevention. The social and geographic isolation of women further reduces their ability to protect themselves[9].

Women are also in a markedly disadvantaged position with respect to confidentiality. The majority of HIV-infected women discover their HIV status during pregnancy or when their children become sick with AIDS. At this point, any confidentiality protection for the woman disappears as public knowledge of the child's illness leads to open assumptions about the HIV status of the mother. The woman is frequently held responsible for having transmitted HIV to her children, even though it is usually the husband who introduced HIV to the family unit. The consequences of this lack of control over the disclosure of her HIV status can be blame, social alienation and repudiation by her husband[2,15].

As the primary carers, women bear the burden of caring for the sick, of holding the family unit together in the face of crisis and of coping with the emotional trauma of the dying. They must often forego productive activities or employment in order to fulfill their duties as care givers. The psychological burdens and responsibilities carried by women in these circumstances are great and will be exacerbated where women are infected with HIV and experiences anxiety about her own health and future care of her children[16].

" Knowing what has to be done in order to protect oneself from HIV is meaningless if one has no power to control the circumstances that give rise to the risk or in which prevention must occur. "

These scenarios paint a grim picture of a cycle of dependency. Unless the cycle can be broken, by addressing the underlying social and economic inequality of women, it seems inevitable that the epidemic will continue to spread, leading to the deaths of increasing numbers of women and men.

HIV prevention among women

The prevention of HIV transmission among women present very different challenges to that of preventing infection in men. It is necessary to consider not only whether preventive strategies are inherently effective in reducing transmission but also whether the cultural environment is such that women are in a position to implement the preventive strategies. Knowing what has to be done in order to protect oneself from HIV is meaningless if one has no power to control the circumstances that give rise to the risk or in which prevention must occur.

HIV prevention efforts to date have failed to offer women effective and achievable ways of reducing their exposure to transmission risks. The prevention efforts have focused on three issues - a reduction in the number of sexual partners, monogamy or fidelity within relationships, and safer sexual practices, in particular the use of condoms. These prevention measures are drawn from men's physique and lifestyle and should be directed at men. As means by which women can protect themselves from HIV, they are hopelessly inadequate.

Reducing the number of one's sexual partners is of no help to the many women who have sexual intercourse only with their husband or regular partner. Even where a woman does have multiple sexual partners, she will often be powerless to change this behaviour because her sexual relationships are too often born out of economic need and dependency. Unless these women are offered some other solution to the underlying problem, warnings about the risks involved in multiple sexual relationships will not in themselves lead to any actual reduction in the risk[8,9,15].

Similarly, HIV prevention messages that emphasise the importance of monogamy within relationships are not of any practical relevance to a majority of women. It is estimated that between 60% and 80% of HIV-infected women in Africa have had sexual intercourse with only their husband. [15] The problem is not that these women are not faithful to their husbands but that their role and status within the relationship may mean that they are unable to compel faithfulness in their husbands in return. Their lack of choice is exacerbated by economic dependency which provides a powerful disincentive for a woman to leave a sexually unsafe marital relationship.

The third prevention strategy which relates to safer sexual practices could provide some protection for women. However, it is evident that the inequality of women within relationships obstructs their ability to protect themselves against HIV. If women have no power to negotiate the basis upon which their sexual relationships take place, they will equally have no power to compel the use of condoms by their male partners nor to negotiate abstinence. Moreover, the use of barrier protection to reduce HIV transmission presents difficulties for many women because of the desire and the cultural imperative to bear children[9,15,17].

HIV prevention measures advocated to date have offered women little or no protection from infection. By focussing on prevention strategies that men can use and ignoring the needs and realities for women HIV policy has not only failed

to respect the rights of women but has also jeopardised the prospects of preventing the spread of infection among both men and women. This imbalance in the focus of HIV prevention efforts must be redressed as a matter of urgency.

Strategies for change

1. The policy dilemma

The HIV epidemic clearly provides an imperative for fundamental cultural and social change. It also requires that the change occur quickly[18,19]. This creates a potential tension between prevention strategies for women to lessen their subordination and those that women can use immediately. Addressing strategies that are achievable without also addressing the inequalities that have given rise to the risk of infection creates the possibility that the impetus for more fundamental cultural and social change will be defused[20]. Is it possible to overcome the tension between the urgent need for immediate, practical interventions to protect women from HIV infection and the need to address the systemic inequalities that render women vulnerable in the first place?

The experience in recent times with family planning provides a relevant analogy. The pattern has been that women have increasingly taken responsibility for the consequences of sexual relationships, either through the use of contraceptives or through being the primary carers for children. This has increased women's control over the consequences of sexual activity but may not reduce the sexual exploitation of women. The availability of contraceptives for women may merely assist the sexual exploitation of women since men need no longer be concerned that intercourse will lead to unwanted pregnancies and paternal obligations.

"... by encouraging women to be the initiators of HIV prevention measures within sexual relationships, there is a risk that we will further entrench the sexual exploitation of women by men."

Any effort to redress women's vulnerability to HIV must be recognised as being potentially a two-edged sword. On the one hand, there is an urgent need for HIV prevention measures that women can control. On the other hand, by encouraging women to be the initiators of HIV prevention measures within sexual relationships, there is a risk that we will further entrench the sexual exploitation of women by men. Similarly, other measures aimed at reducing HIV infection risks for women, such as treatment of STD, many only serve to obscure the fact that it is sexual subordination and not poor health that is the primary HIV risk factor for women. It must be clearly understood that the most effective prevention strategy for women is behaviour change in men.

It is critical that the need to reconcile this potential conflict between the long-term and the short-term goals for women to be recognised when formulating strategies to respond to HIV/AIDS. The two goals of improving the status of women and protecting women against HIV are entirely consistent, as long as HIV/AIDS policy is properly informed by an understanding of the social and cultural dynamics that place women at risk.

Strategies need to be developed to assist women collectively in taking greater control over sexual relationships, instead of interventions that require little active participation by women. Measures that address the legal and economic inequality of women can provide real and immediate prospects for reducing women's risk of infection because they give women autonomy and, therefore, an alternative to a dependent relationship. Initiatives that take account of these broader objectives are ultimately the ones that offer the best prospects for the effective containment of HIV both immediately and in the long term.

2. Research and national policy strategies

HIV infection risks for women necessitate a re-thinking of HIV research strategies, both biomedical and social. Research efforts directed towards developing barrier protection methods that do not rely upon the cooperation of men have the potential to offer women immediate and effective protection against HIV infection.

The primary barrier protection currently available, the male condom, clearly does not meet this need and it is notable how little medical research has been devoted to HIV prevention methods that women can use. Although there is a female condom, it still requires the tacit consent of the man. Little research has been carried out into the biological factors, such as genital immaturity, that may increase transmission risks in women or to investigate whether other devices, such as modified diaphragm, may offer protection against HIV. There is still no form of chemical barrier protection, such as a virucide, available to women. These are all matters that should be an urgent priority of research[17].

It is also important that research assist in accommodating the social and cultural factors that otherwise would prevent women from protecting themselves against HIV. For example, by working to develop a virucide that does not at the same time prevent conception. In this way practical measures could be put in place to ensure that the desire or social imperative for women to have children does not also expose them to an increased risk of HIV infection [8,17,20].

In addition to effective barrier protection, there are other interventions that can protect women against HIV infection. Foremost among these are measures to encourage better genital health and hygiene among women and an end to practices such as female circumcision. In relation to iatrogenically-acquired HIV, improved sterilisation procedures, blood screening, the use of blood substitutes and measures to decrease the likelihood that a woman will require a blood transfusion could also be effective in reducing risk factors[9].

The fact that these measures have not yet been given a high priority in HIV strategies indicates the extent to which those strategies have failed to place women at the centre of the analysis. Women are at the heart of this epidemic as bearers of its consequences in families and communities[21]. The experience of women can provide special insights into the emotional trauma and social and economic impact of the epidemic. It is therefore critical that their voices be heard, that their needs be recognised and that they be actively involved in all levels of HIV research and policy development.

"Statements have been issued dealing with prostitution and STD but these statements risk perpetuating the distortion of the way in which the impact of the epidemic on women has been perceived."

3. The international HIV policy framework

The international community failed to recognise the source of women's vulnerability to HIV and the measures necessary to overcome this vulnerability. Since 1987, the WHO has issued 18 consensus statements of specific issues surrounding the HIV epidemic. Only one of these statements has dealt specifically with issues affecting women. However, it limits its attention to women's roles as mothers and, focuses more on the ramifications for families and children of HIV infection in women than on the consequences for women themselves[22]. Statements have been issued dealing with prostitution and STD but these statements risk perpetuating the distortion of the way in which the impact of the epidemic on women has been perceived.

The Paris Declaration on Women, Children and AIDS issued on 30 November 1989 reinforces the view that women's issues in relation to HIV/AIDS are essentially those that also affect children[23]. It emphasises the importance of prevention and support programmes that are directed specifically at women but does not state why women require independent consideration and analysis in the context of HIV[24]. Similarly, the resolution on the Avoidance of Discrimination in relation to HIV-infected People and People with AIDS, fails to deal with the broader discrimination and human rights issues that are critical to a proper understanding of why the HIV risks faced by women are so grave[25].

It is only in the last three years that there has been an emerging recognition within some areas of the international community of the inter-relationship between the status of women and women's risk of exposure to HIV. In July 1989, an International Consultation on AIDS and Human Rights that special attention should be given to the human rights of women. It notes that there are *"certain factors relating to the reproductive role of women and their subordinate position in society which render them particularly vulnerable to infection"*[26]. Women's lack of equal access to education, health training, independent income, property and legal rights was acknowledged to affect both their access to knowledge about HIV and their ability to protect themselves from infection.

This theme was taken up by the Committee for the Elimination of Discrimination Against Women which recommended among other things, that national programmes to combat AIDS should give special attention to *"the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection"*[27].

The UNDP has prepared a set of policy principles to assist and guide UNDP policy formulation relating to programming and personnel policies. These include the principle that 'the power imbalances in interpersonal relationships and in society which create women's subordination must change if women are to be able to protect themselves from HIV/AIDS infection and its consequences'. Within the UNDP policy framework, priority has been given to 'measures to address women's needs for prevention, care, support and access to treatment, to reduce discrimination and trauma, to strengthen their ability to protect themselves from infection and to assist affected women to meet their child rearing, domestic and economic responsibilities'[27].

In November 1990, a WHO consultation on women was called to consider research priorities for women and HIV/AIDS. The meeting recognised the need to redress the neglect of gender specificity in existing research on HIV/AIDS and to focus on research that will contribute to the empowerment of women. Among the specific issues allocated research priority were the cultural factors that inhibit behaviour changes necessary to enable women to protect themselves against HIV, the impact of different contraceptive methods on HIV transmission to women, the diagnosis and treatment of STD in women and the impact of geographical mobility on changing sexual patterns and HIV transmission risks for women[29].

These initiatives are an important first step towards an international policy response to HIV/AIDS that will give proper weight to the rights and needs of women. However, the fact that it took nine years for the HIV research needs of women to be explicitly recognised by the international community means that there is lost time to be recouped. A sense of the urgency of the need for effective HIV research for women has to be communicated to policymakers at both the national and international levels.

4. Human rights and the HIV epidemic

Human rights do not merely provide the backdrop against which HIV/AIDS strategies should be planned, but rather are a powerful tool that can be actively used to enable women to protect themselves against HIV. The urgent and critical need to improve the social and economic status of women and thereby to overcome their vulnerability to HIV means that human rights considerations in this context must look beyond immediate concerns such as discrimination against people with HIV and access to health care to address the fundamentally unequal social and economic position of women.

"A sense of the urgency of the need for effective HIV research for women has to be communicated to policymakers at both the national and international levels."

The rights and needs of women have already been seriously compromised by the HIV epidemic. At the most fundamental level, women's right to life is threatened by the fact that so many women, by reason of their social, cultural and economic status, are powerless to protect themselves against the risk of HIV infection. Equally, women have been denied the right to health and often access to health care. Many have been denied the right of access to education, including information about HIV, and to economic independence, both of which impact critically upon their vulnerability to the effects of the epidemic.

Women infected with HIV suffer further through being deprived the right to bear children and of reproductive choice. Their right to privacy may be lost when their own HIV status becomes known because of the illness of their children, or when they are rejected by their husbands because they are infected with HIV.

The right to freedom from discrimination has a powerful meaning for women who are blamed by men for the consequences of HIV infection. Women who are powerless to avoid the risk of exposure to HIV are nonetheless blamed for having been a vector of HIV infection and suffer stigmatisation, rejection and expulsion from family and community structures. The failure to recognise the need of these women for protection against discrimination further compounds the socially vulnerable position of women generally which, in turn, increases their risk of exposure to HIV.

The right to knowledge has been transgressed in a number of ways in the course of the HIV epidemic. The denial of this right is linked directly to cultural assumptions about who best exercises rational deliberation and to women's lack of participation in decisions affecting their lives. The recognition of women's right to knowledge is essential to their informed choice and action. A woman who knows about patterns of infectivity in HIV infected people, for example, may be able to devise strategies to avoid sexual intercourse. Similarly, a woman who knows the facts about the risk of HIV transmission through breastfeeding can make an informed choice about breastfeeding.

The abuses of the rights of women must be addressed at a fundamental structural level if the international community is to fulfill its moral, ethical and legal obligations to women. The changes required are far-reaching. They include changes to cultural values and expectations that deny women the power to control their own sexual relationships, changes to the law and culture that deny women the same economic rights and opportunities as men, and changes to the role of women within their communities in order to give recognition to women's individual identity and consciousness. Thus, the urgent need to act to protect women against HIV demands that policymakers move human rights concerns, for both women and men, to the top of their political priority list.

5. The role of law

The inescapable link between human rights and effective HIV/AIDS prevention for women points to the role of law in bringing about the changes necessary to enable women to protect themselves against HIV. The law has always been one of the principal mechanisms by which human rights have been given direct recognition both through international law and through domestic human rights codes and charters. A rights-focused analysis of the factors that render women vulnerable to HIV immediately demonstrates how human rights instruments can be used directly in HIV/AIDS strategies for women. In addition, the law can and should be used to promote and protect human rights indirectly by redressing structural inequalities and injustices in a way that actively seeks to bring about social change.

The direct role of law: The international community has a responsibility to utilise fully the human rights protection afforded by existing international law. If used creatively and appropriately, international instruments offer wide scope to

promote and reinforce the rights and needs of women. Among the instruments that could be used in this context are the United Nations Charter of 1945, the Universal Declaration of Human Rights, the International Convenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights. There are also a number of regional treaties, such as the African Charter on Human and People's Rights and the European Convention on Human Rights. These instruments explicitly recognise rights such as the right to life, the right to privacy and the right to bear children, which go to the heart of the HIV epidemic as it affects women.

More must be done to give formal legal effect to these international instruments through the domestic law of each country. This has been one area of notable neglect in international law, and one where immediate and tangible recognition of human rights could be implemented. In countries where human rights codes and charters already exist as part of the domestic law, there is debate as to the extent to which these instruments are of practical effect in the context of the HIV epidemic. As with any legal remedy, issues of accessibility and cost may mean that legal protection that is available in theory is not available in practice. In developing countries, in particular, practical access to the legal system is likely to be non-existent for all but a very small number of people. Nonetheless, the symbolic effect of a recognition by the law of explicit and enforceable human rights should not be underestimated. It represents a public statement as to the value of those rights and the need for the rights to be respected in practice. In this way, these legal instruments can have an effect on conduct by individuals and on government policy. It may be wrong to believe that human rights codes by themselves can provide adequate protection of individual rights, but equally it would be wrong to dismiss them as being entirely ineffectual.

The indirect role of law: The notion of the law as an instrument of social and behavioural change has been the subject of a long and controversial jurisprudential debate. There are countless examples of how the law has been ineffectual in changing social behaviour either because it has been ignored or been selectively enforced. Nonetheless, the need for urgent action to meet the threat of the HIV epidemic demands that all possible strategies be explored. This includes considering whether a creative use of the law to assist in bringing about changes in social attitudes and practices that lead to increased risk of HIV infection.

There are a number of areas where the role of law could usefully be explored. First, there is the interaction between the law and economic dependency. In many developing countries, the law upholds the economic dependence of women through land ownership, marital property laws and credit regulations which deny women the right to independent ownership of property or through laws which prohibit women access to certain forms of paid employment or to financial credit[30]. The removal of these legal barriers to economic independence may be a first step towards enabling women to control some of the circumstances that give rise to the HIV transmission risks. This could facilitate better health care for women and greater access to education. Within the marital relationship, measures that reduce the economic dependence of the wife may also assist in increasing her power to negotiate over matters such as condom use and faithfulness on the part of her husband.

" Thus, the urgent need to act to protect women against HIV demands that policymakers move human rights concerns, for both women and men, to the top of their political priority list. "

Second, the law is one mechanism that can be used to assist in enhancing the status of women within marriage or other sexual relationships. In many countries, for example, the absence of any criminal sanctions attaching to rape within marriage reinforces attitudes about the sexual subordination of women. By enacting laws that recognise the rights of women to make their own decisions, the ability of women to protect themselves against the risks of HIV transmission within sexual relationships will also be increased. Similarly, cultural traditions embodied in law and which encourage or condone activities that may spread HIV can be the subject of legal reform.

Third, the law can be used to express an appropriate policy response to activities, such as unprotected sexual intercourse, prostitution and injection drug use. Depending upon the context, the appropriate response will vary. For women who have no access to information, prevention measures and support, laws that seek to criminalise or otherwise regulate the behaviour that places them at risk of HIV infection will only entrench the alienation they already experience. A legal regime that is coercive and unresponsive to the powerlessness of women will inevitably be ineffective.

Women's interests may be protected by laws that seek to change the behaviour of men. This has been shown to be possible in parts of southern Africa where the introduction of laws requiring men to pay maintenance for children they father has led to marked changes in men's sexual behaviour in that they have fathered fewer children. By attaching legal obligations to certain forms of behaviour, these patterns of behaviour have changed. For women whose risk of exposure to HIV results directly from patterns of sexual behaviour controlled by men, the law can be used constructively

to confront and change the cultural values and behaviours that place women at risk.

Finally, the law can be used to provide positive incentives for measures that assist in containing HIV. For women, this may mean affirmative action programmes that require the participation of minimum numbers of women in the process of policy formulation, either in relation to HIV/AIDS specifically or more general matters, such as economic assistance and health care. Economic incentives can be legislated in the form of tax concessions or training programmes to encourage a greater participation by women in the workforce. Such initiatives, by enhancing the economic and social status of women, would contribute directly to the ability of women to protect themselves against HIV.

Conclusion

The way in which the HIV epidemic has affected women in all parts of the world is a tragic manifestation of women's social, economic and cultural inequality. This inequality has stripped many women of the means of protecting themselves against the virus and, unless it is addressed, will lead to their deaths from AIDS in increasing numbers. The international response to the epidemic has failed to recognise adequately that the disadvantaged status of women is their main risk factor for HIV and to allow HIV strategies to be shaped to meet the rights and needs of women as well as those of men.

"Mechanisms must be established to promote and uphold human rights for women as a reality and to use to the full potential of the law to reinforce changes to the structural inequalities that leave women so vulnerable to HIV."

While millions of women are already infected with HIV, the lives of many more can be saved if immediate action is taken to address the violations of the rights of women that have been perpetrated by the HIV epidemic. Strategies that permit women to exercise control over factors that place them at risk of HIV infection are critical. Mechanisms must be established to promote and uphold human rights for women as a reality and to use to the full potential of the law to reinforce changes to the structural inequalities that leave women so vulnerable to HIV.

These changes require a fundamental reorientation of the values, beliefs and laws that shape the perception and role of women within relationships, families and societies. The challenge is great, but so too is the moral imperative that demands urgent action.

References

1. Chin J. Current and future dimensions of the HIV/AIDS pandemic in women and children. *Lancet*, 1990; 336:221-224.
2. Sabatier R. Women and AIDS: Strategies for the Future. *Proceedings of the meeting on Women and HIV/AIDS*. CIDA, Ottawa, Canada; 1990.
3. Diaz FG and Rodolfo NM. HIV/AIDS in Mexico. AIDS Action. *AHRTAC Newsletter*, Issue 10, April 1990.
4. WHO. *The Global AIDS Situation Update*. WHO, Geneva;1990.
5. Narain JC. Carribbean AIDS Action. *AHRTAC Newsletter*, Issue 10, April 1990.
6. United Nations Division for the Advancement of Women. Interrelationships Between the Status of Women and HIV-Epidemic: A Review of Published Literature. *Paper prepared for the Expert Group Meeting on Women and HIV/AIDS and the Role of National Machinery for the Advancement of Women*. Vienna, 24-28 September 1990.
7. Center for Women Policy Studies. *Memorandum on Federal Women and AIDS Legislation*. Washington DC, 6 March 1991.
8. Carovano K. More than mothers and whores: redefining the AIDS prevention needs of women. *International Journal of Health Services*, 1991, 21 131-142.
9. Panos Institute. *Triple Jeopardy: Women and AIDS*. Panos Publications Ltd, 1990.
10. Reid E. Young Women and the HIV Epidemic. *Development Journal of SID*, February 1990; 1.
11. Jochelson K,Mothibeli M and Leger J-P. Human Immunodeficiency Virus and migrant labor in South Africa. *International Journal of Health Services*, 1991, 21.157-173.
12. Akeroyd A. Sociocultural Aspects of AIDS in Africa: Topics, Methods and Some Lacunae. *Paper presented at the Conference on "AIDS in Africa and the Caribbean: The Documentation of an Epidemic"*. Columbia University, New York; 5 November 1990.
13. Uhlig M. *Prostitutes Join Mexico AIDS Fight*. New York Times, 10 April 1991.
14. Coll Seck AM. *Personal communication*, Dakar, Senegal.
15. Reid E. Placing women at the centre of the analyses: the case of HIV/AIDS. *Pacific Health Dialog*, 1995, 2(1): 69–72.
16. Hankins C. Psychological and Social Consequences of HIV infection in mothers and children. *Proceedings of the International Conference on the Implications of AIDS for Mothers and Children*. Paris, 27-30 November 1989.

17. Stein Z. HIV prevention: the need for methods women can use. *American Journal of Public Health*, 1990; 6: 460-462.

18. Lloyd G *The Man of Reason: 'Male' and 'Female' in Western Philosophy*. Methuen, London; 1984.

19. WHO estimates 4,000 new infections each day.

20 Hankings C. Women and AIDS: Strategies for the Future *Proceedings of the meeting on Women and HIV/AIDS*. CIDA, Ottawa Canada; 1990

21. Bailey M *Report of the Fifth International Conference on AIDS in Africa*. Save the Children Fund, United Kingdom; 1990

22. WHO Global Programme on AIDS *Statement on health of mothers and children in the context of HIV/AIDS*, Geneva; November 1989.

23. *Paris Declaration on Women, Children and AIDS*; 30 November 1989.

24. Reid E. UNDP Statement. *Proceedings of the International Conference on the Implications of AIDS for Mothers and Children*. Paris, 27-30 November 1989

25 *World Health Assembly Resolution on the Avoidance of Discrimination in Relation to HIV-infected People and People with AIDS*. Geneva, 13 May 1988.

26 Centre for Human Rights. *Report of an International Consultation on AIDS and Human Rights*. Geneva, 26-29 July 1989.

27. Committee for the Elimination of Discrimination Against Women. General Recommendation no. 15 on the Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS) *Report of the 9th Session*, 1990.

28. UNDP. *Policy Framework for UNDP's Response to the HIV/AIDS Epidemic*, May 1990.

29. WHO. Global Programme on AIDS *Report of the Meeting on Research Priorities Relating to Women and HIV/AIDS*. Geneva, 19-20 November 1990

30. Longwe S H and Clarke R. Proposed methodology for combating women's subordination as a means towards improved AIDS prevention and control. *Paper prepared for the Expert Group Meeting on Women and HIV/AIDS and the Role of National Machinery for the Advancement of Women*. Vienna, 24-28 September 1990. □

" ... the absence of any criminal sanctions attaching to rape within marriage reinforces attitudes about the sexual subordination of women. "

The history of epidemics shows that the instinct to blame and to isolate is a common response. Isolation of those isolated by past epidemics such as smallpox, plague and tuberculosis may be understandable - because these diseases are contagious through everyday contact - although quarantine has never been an unqualified success. But in the case of AIDS, which is <u>not</u> 'contagious', isolation is not only a gross human rights violation: it is pointless and even dangerous.

WHO. Geneva, 1994