We need tools that will allow women to protect themselves. This is true whether the woman is a faithful married mother of small children — or a sex worker trying to scrape out a living in a slum. No matter where she lives, who she is, or what she does — a woman should never need her partner’s permission to save her own life.1

Drawing on the theme of the XVI International AIDS Conference in Toronto, Bill and Melinda Gates asserted that it is “time to deliver” female-controlled prevention methods, including effective microbicides and oral prevention drugs. Throughout the conference, delegates’ voices echoed their call.2

While these prevention methods are undoubtedly important, if not essential, they alone will not stem the tide of HIV infection for at-risk populations of women and girls.3 This is because an exclusively medicalized approach to the HIV/AIDS pandemic fails to address the underlying social conditions that fuel HIV transmission. The discovery and distribution of medical tools will not enable women to protect themselves from infection if structures of inequality remain unchanged.

Policies and programmes must account for the varied social realities of women’s lives if available resources for testing, treatment, and prevention are to be accessible to the populations for which they are intended. It is an unfortunate truth that where she lives, who she is, and what she does impacts a woman’s safe and effective access to HIV testing, prevention and treatment.

The devastation of the HIV/AIDS pandemic in the developing world renders manifest and unavoidable the harms of sex and gender inequality. To the extent that women’s subordinated status fuels the pandemic, sex and gender inequality contributes not only to ill health and death, but to depressed national economies, political instability and eroded public service delivery and social integration. It is also true, however, that to understand women’s equality solely or primarily as a means to reduce disease spread and maximize sustainable development continues a historical trend of instrumentalizing women and their bodies, particularly in the area of sexuality and reproduction.4 To move beyond this paternalistic paradigm, we must shift our social consciousness to respect women as moral agents deserving of equality, dignity and respect.

3 As of 2005, 17.5 million women were living with HIV, out of a total of 36 million adult sufferers. In southern Africa, 57 per cent of people with AIDS are women.
In order to “realize fully women’s rights as human rights” within the context of HIV/AIDS and beyond, we must identify, develop and share the skills necessary to transform legal, social, economic and cultural institutions that discriminate against women. We will not “put the power to prevent HIV in the hands of women” unless we are committed to the transformation of social, economic and cultural institutions.

In contribution to this commitment, the University of Toronto International Programme on Reproductive and Sexual Health Law, with partner organizations, convened a skills-building workshop series, entitled “Women, HIV/AIDS and Human Rights” for the XVI International AIDS Conference in August, 2006.

The four-day workshop series was designed to enable participants to frame the neglect and marginalization of women’s needs and circumstances in the context of HIV/AIDS as not simply poor health and social policy, but as violations of women’s human rights. The series addressed collaborative legal and political approaches to hold state and non-state actors accountable for the violation of women’s rights in the clinical, health systems and underlying socio-economic contexts. In conjunction with the series, a syllabus featuring academic literature, reports and jurisprudence in key areas relating to women, HIV/AIDS and human rights was developed.

Rebecca Cook and Joanna Erdman, co-directors of the International Programme on Reproductive and Sexual Health Law, chaired daily panels on which academics, public interest lawyers, social scientists and medical providers addressed issues of sex, gender, and human rights in HIV/AIDS prevention and treatment. Each panel addressed a distinct theme. Speakers included those working on HIV/AIDS issues in academic scholarship and lawyers pursuing human rights documentation and litigation. Others shared insights from clinical, medical anthropology, and pharmaceutical backgrounds as to how quality health care services can be delivered to women and girls in rights-respecting ways. Audience participants represented a myriad of geographic, cultural, and academic and advocacy backgrounds, including people living with and affected by HIV/AIDS.

In this report, the co-organizers of the series reflect on emergent themes, skills and lessons learned from the workshop series and related official sessions at the Toronto AIDS Conference. It is the authors’ goal to illuminate some key areas that warrant further legal research and skills development. The three primary skills and lessons learned that this report will focus on are:

(i) addressing context in HIV/AIDS programming, policies, and legislation;

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7 Partner organizations included Advancing Gender Equity and Human Rights in the global response to HIV/AIDS (ATHENA); the AIDS Law Project, South Africa; the Canadian HIV/AIDS Legal Network, Canada; the Center for Reproductive Rights, U.S.A.; Human Rights Watch – Women’s Rights Division, U.S.A.; the International Council of AIDS Service Organizations; the Program on Reproductive and Sexual Health Law, University of the Free State, South Africa.
8 The full syllabus and abstracted materials are available online: <http://www.law-lib.utoronto.ca/diana/women_hiv_aids/contents.htm>.
(ii) identifying and challenging laws, policies, and practices that privilege male sexuality and restrict women’s autonomy and sexual decision-making; and

(iii) using inter-disciplinary analyses to engage state accountability for women’s access to and provision of treatment and care.

(1) Addressing Context

It is essential that AIDS programming, policies, and related legislation address context in order to identify and respond to intersecting forms of discrimination that make individuals and groups more vulnerable to HIV-infection. Human rights scholars and advocates working in the area of women and HIV/AIDS face the challenge of drawing generalized conclusions and analogies without becoming overly simplistic. In this section of the report, we discuss the essential skill of engaging with context. Not only is a clear understanding and sensitivity to context essential for identifying the nature and harms of particular forms of discrimination, it is also fundamental to holding states accountable for their obligation to challenge harmful stereotypes and discriminatory practices.

(i) Vulnerability and Sexuality in Context

In elaborating on this skill of contextualizing one’s analysis, we will draw on workshop discussions related to women’s vulnerability to HIV. As Jonathan Berger (AIDS Law Project, South Africa) and Jonathan Cohen (Law & Health Initiative, Open Society Institute) stressed, the notion of vulnerability is too often advanced as a general concept with little reference to the legal and social contexts in which women and girls are situated. To advance the rights and needs of “vulnerable populations”, it is essential to critically examine the contextual factors and intersecting forms of discrimination that influence their vulnerability.

In his presentation, “Re-sexualising the epidemic: desire, risk and HIV prevention”, Berger stressed the importance of acknowledging women’s and girls’ particular vulnerability to HIV infection in the southern African context. However, he also emphasized the importance of not losing sight of men’s shared vulnerability, particularly men who have sex with men, prisoners, and injection drug users. He argued for a more complicated narrative that would go beyond the characterization of women as “desexualized beings trapped in men’s power and promiscuity … waiting to be infected.” An overly simplistic vulnerability framework that portrays all women as vulnerable, and by inference all men as invulnerable, risks marginalizing other at-risk groups.

In his commentary, Jonathan Cohen also reflected on the importance of moving beyond the paradigm of the passive woman waiting to be infected by her partner or husband. Critiques of abstinence-until-marriage programs, for example, have often emphasized the fact that many women who abstain until marriage are subsequently infected by their husband. Cohen complicated this vulnerability narrative by asking

10 Berger, “Re-sexualising the epidemic”, August 14, 2006 presentation, Ibid.
“what if this woman did not abstain until marriage – would she be as ‘deserving’ of the protection afforded to others?”11 As Cohen emphasized, how we conceive of women’s vulnerability should include reference to sexuality and sexual practices per se.

Engaging with context is also crucial where certain familial forms and institutions, including marriage, are encouraged as ways to “protect” oneself from infection. As Cohen, Kass and Beyrer note:

…an attention to context is an essential part of evaluating the human rights and ethical dimensions of a public health intervention. While it is hard to imagine a context in which it is appropriate to present marriage as broadly protective against HIV, the message is particularly false and misleading in sub-Saharan Africa and in South and Southeast Asia, where marriage has been shown in a number of studies to be a primary risk factor for incident and prevalent HIV infection in women.12

Recognizing women’s vulnerability within marriage and family life where social and legal norms undermine their sexual autonomy within marriage will lead to more effective legal and social advocacy strategies.

(ii) Historical and Political Context

In addition to addressing the complexities of women’s lived sexuality, it is essential to understand the historical and political contexts in which women are situated. In her commentary on the “Human Rights and Accountability” panel, Lisa Forman (post-doctoral studies, University of Toronto, Faculty of Law) emphasized the political and historical factors that have contributed to a heightened vulnerability among marginalized and racialized communities in South Africa. Factors such as race, class, and economic opportunity also impact people’s ability to claim and access their rights. A lesson learned from Forman’s presentation about the South African context is the dynamism of human rights cultures and the historical factors that shape its development. Developing curricula in schools to ensure politicians, judges, and advocates are aware of and sensitive to rights can go some way toward fostering a human rights culture that can challenge states to address these intersecting grounds of discrimination.

(iii) Stigma and Discrimination in Context

A final component of engaging with context that was emphasized at the skills-building workshop concerned the ways in which discrimination and stigma based on one’s HIV-positive status make many women and girls vulnerable to other rights violations. As Maria de Bruyn (ipas) noted, women living with HIV/AIDS are especially vulnerable to rights violations in the sexual and reproductive health care context.13

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These include forced or coerced sterilization or abortions and lack of access to sexual and reproductive health services, including prenatal care. Here, the dominant contextual factor is one’s health status and how society perceives and stigmatizes that status. As Rebecca Cook noted, it is essential that law school curricula address stigma as a form of discrimination, particularly where it intersects with health status.

(iv) Ethical Obligations in Responding to Contextual Vulnerabilities

As one identifies and fleshes out contextual vulnerabilities, this should also inform our understanding of the roles of human rights policymakers, activists, and scholars in such conditions. Rather than being passive observers, international organizations, donors, and human rights activists and scholars must ensure that they do not unintentionally undermine or exploit already vulnerable groups. In her discussion of microbicide trials and informed consent, Anna Forbes (Global Campaign for Microbicides) emphasized the “desperation” that often underscores participation in clinical trials and the need to address the particular vulnerabilities of women as research subjects. This reasoning applies equally in the context of HIV testing where women may be subject to coercion or a lack of negotiation in testing, and are vulnerable to post-testing discrimination. In his presentation on access to treatment and care for women living with HIV/AIDS in India, Anand Grover (Lawyers’ Collective – HIV/AIDS Unit, India) noted the essential role of counseling in ensuring adherence to antiretroviral (ARV) treatment. Where women are prevented from adhering to ARV treatment because they are concealing their HIV-status from their partner for fear of stigma, violence and/or abandonment, they can only remain on first-line drugs for a limited time.

Similarly in the human rights documentation context, Janet Walsh (Human Rights Watch, Women’s Division) stressed the ethical obligations of those who “document vulnerabilities” of women. Often there may be an expectation among affected women that human rights reporters will be able to provide tangible assistance to them, whether in the form of legal representation or otherwise. It is essential that human rights reporters make clear the limits of their work at the outset of any interview or observation process. Human rights documentation can serve as one tool to illuminate the context of human rights violations that make women vulnerable to HIV infection. In her presentation on human rights documentation in Kenya, Janet Walsh discussed the role of human rights reporting in publicizing local human rights contexts. For example,

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discrimination against women in land inheritance matters has contributed to women’s vulnerability to HIV infection in the Kenyan context.\textsuperscript{18}

(2) Identifying and challenging laws that privilege male sexuality and restrict women’s autonomy and sexual decision-making

As Sofia Gruskin (Program on International Health and Human Rights, Harvard School of Public Health) emphasized during her workshop presentation, a human rights approach will operate at different levels including advocacy, accountability, program design, implementation and evaluation.\textsuperscript{19} It is important to be aware of the differences between these elements and utilize clear language.

How one conceptualizes vulnerability will, in turn, dictate the nature of the legal and policy interventions one advocates in HIV prevention and treatment programming. As Jonathan Berger argues, a vulnerability analysis that fails to address women’s varied experiences risks reifying the very norms of male sexual privilege and female passivity that one is trying to challenge. One may premise prevention programmes and policies on the notion that these gendered dynamics of power are unchangeable (“women should be able to protect themselves from men”), instead of adopting more transformative approaches that would recognize and encourage women’s agency. To ensure sustainable prevention, the long-term goal should be transformed sexual relations and notions of gender. Geeta Rao Gupta has emphasized the importance of “transformative prevention programs”\textsuperscript{20} rather than simply equipping women with methods to protect themselves from men, though this will obviously be essential in the interim.

Identifying and challenging laws, policies and practices that privilege male sexuality and restrict women’s autonomy and sexual decision-making is essential for such transformative change. One of the recurrent themes at the Toronto AIDS Conference and its satellite sessions was the dysfunctional role that the criminal law plays in relation to HIV/AIDS transmission, particularly in the area of sex work. Despite the fact that the criminalization of sex work continues to translate into riskier sexual practices between sex workers and their clients,\textsuperscript{21} there is little consensus, even among those in the health and human rights fields, around its de-criminalization. Debates continue to centre on whether sex work is inherently exploitive or whether women should be able to freely pursue it. These debates often lack a critical examination of the role that the criminal law plays in this area. Even if one asserts that sex work privileges male sexuality and perpetuates discrimination against women through its commodification of predominantly women’s sexuality, it does not follow that the criminal law is the appropriate means by which to respond. In fact, there is significant evidence that the

stigma associated with the criminalization of sex work places women at greater risk by restricting their sexual decision-making, and in turn privileging male sexuality.\(^{22}\)

Discriminatory family or personal laws also have a deleterious impact on women’s health and decision-making. In her presentation on polygyny and HIV/AIDS, Lisa Kelly (Fellow, International Programme on Reproductive and Sexual Health Law) discussed how multiple partnering and inequality in polygynous marriages contributes to HIV transmission.\(^{23}\) Laws that allow for polygynous marriages privilege male sexuality by perpetuating harmful stereotypes of masculine hypersexuality and feminine passivity. By condoning high-risk concurrent sexual networks, such laws violate women’s health, dignity, and equality rights. In her discussion of the HIV/AIDS pandemic in Uganda, Annette Biryetega (National Community of Women Living with HIV/AIDS in Uganda (NACWOLA) emphasized how polygyny restricts women’s sexual autonomy in marriage by reinforcing other social norms that privilege male sexual and family decision-making.\(^{24}\) Women typically have no control over whether their husband takes additional wives. Polygyny also means that meager family resources have to be shared among multiple wives and their children, which places further strain on women’s ability to assert their rights.

One issue that was raised during one of the workshop question periods concerned the possibly “protective” role that polygyny may play in decreasing the risk of unsafe, extramarital sexual contact. In her response, Lisa Kelly noted that there is mixed evidence about this hypothetical protective role. In a Nigerian study, polygynous husbands reported less extramarital sexual contact at certain stages during marriage (for example, during a wife’s postpartum stage), but still had greater extra-marital contact when measured across their life span than their monogamous counterparts.\(^{25}\) However, the eventual empirical answer to this question remains unimportant when one considers polygyny as a violation of women’s equality, health and dignity rights.\(^{26}\) Debates about the possibly “protective” role of polygyny are misplaced. These instrumentalist debates do not treat women’s right to equality within marriage and family life as an end in itself and thus risk diluting and undermining a women’s rights framework in condoning discriminatory sexual hierarchies.

Once one has identified laws that reinforce gender and sexual hierarchies, it is necessary to challenge such laws. In her presentation on reproductive rights litigation, Elisa Slattery (Center for Reproductive Rights, New York) quoted the oft-cited


passage from *Fertilizer Corp. Kamgar Union v. India* that “a right without a remedy is a legal conundrum of a most grotesque kind.” Developing effective litigation strategies that build on human rights documentation and advocacy is an essential skill to ensure rights are realized. As Slattery outlined, the Center for Reproductive Rights works with local and international partners to advance reproductive and sexual health rights. This work includes law reform efforts, capacity-building and pursuing accountability. One of the advantages of international-local partnerships is that it ensures a sound awareness of the socio-cultural context and women’s needs in that context. Lawyers working on issues of health and human rights are essential to ensure that states are held accountable for their national and international obligations. Cases in this area may focus on inadequate laws or laws that are satisfactory, but are not being implemented adequately.

Another important legal advocacy strategy that Alana Klein (Canadian HIV/AIDS Legal Network) presented is model legislation. The objective of model legislation is to inform lawmakers and strengthen civil society advocates. As Klein argued, human rights abuses drive the pandemic and increase its impact, particularly in the case of women. Model legislation thus provides another avenue, beyond litigation, to advocate for legal changes where laws or their implementation undermine women’s rights. Discriminatory family or personal laws, ineffective or discriminatory sexual assault laws, and inadequate national HIV/AIDS legislation are all areas where model and comparative legislation can be utilized. The Canadian HIV/AIDS Legal Network project is particularly useful because it can be adapted and varied according to the socio-legal and political context in which it is to be applied. The public health and human rights protection objectives of the project are non-negotiable core elements.

(3) Using inter-disciplinary analyses to engage state accountability for women’s and girls’ access to and provision of treatment and care:

The third important lesson that was imparted at the workshop series was the need for inter-disciplinary engagement if one hopes to achieve the type of transformative change that the Convention on the Elimination of All Forms of Discrimination against Women was intended to achieve. The intersection of poverty and multi-faceted forms of discrimination is the primary cause of HIV disease spread in developing and transitional country contexts. If we are to respond to the rights violations and critical development crisis associated with the pandemic, we must adopt inter-disciplinary approaches that address the economic, social, and legal forces that shape women’s lives. In this section, we will focus on the important skills that our presenters drew upon in re-framing women’s and girls’ limited access to HIV treatment and care and the lack of compensation for the care they often provide to those living with HIV/AIDS.

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29 General Recommendation 25, Article 4, paragraph 1, of the Convention (temporary special measures), UN CEDAWOR, 30th Sess., UN Doc. HRI/GEN/1/Rev. 7 (2004) at 282, at para. 4.
In her presentation on “Sexual Health Related Decision-Making: Operationalizing Adolescents’ Capacity to Consent”, Deborah Robertson (Fellow, University of Toronto, Obstetrics and Gynecology) established a framework for evaluating adolescent consent in the reproductive health context. Robertson outlined how the notion of the “evolving capacity of the child” in the Convention on the Rights of the Child can be operationalized through medical concepts of emotional, physical, and mental development to ensure that adolescent girls are able to access treatment and care in the HIV/AIDS context. Globally, nearly a quarter of people living with HIV/AIDS are under 25 years of age and young people make up half of all new infections. However, adolescents continue to face significant barriers in accessing treatment and care, linked closely to consent and confidentiality concerns. Robertson’s framework is significant because it draws upon psychological, social and medical criteria for development that move beyond the arbitrary chronological measures that many providers still rely on. The human rights issue here is discriminatory and unfair access to health services on the basis of age. Operationalizing the “evolving capacity” standard in the clinical context is essential for the fulfillment of adolescents’ rights.

Commenting on the “Access to Treatment and Care” panel, Dorothy Shaw (University of British Columbia; President-Elect FIGO) discussed how physicians in particular are usually very unclear on the law regarding consent and adolescents and health care. With respect to sexual and reproductive healthcare, Shaw advocated that health care providers should treat those who come for services because they have reached a certain level of maturity to access care. Essentially, the concern for Shaw and others is that frameworks for evaluating emotional, physical, and mental development may still be used by some providers as a way of avoiding treating adolescents or involving their parents/guardians.

In their presentation, “Community Health Workers – Expanding Treatment and Care Capacity, Compensating Labour”, Brook Baker (Northeastern University, Faculty of Law; Health GAP) and Kiaran Honderich (Williams College, Center for Popular Economics) argued that there is an urgent need to re-conceptualize how we think about home care labour, particularly in the HIV/AIDS context. With resources finally beginning to be mobilized to reach communities affected by the pandemic, we are faced with two possibilities: one, we may be able to transform these relationships in a way that respects women’s human rights and promotes development or two, the

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resources may be allocated in a way that further ossifies existing power structures and vulnerabilities. The way that economies are currently constructed, much of the work that women perform is not considered work in the formal sense of being paid or supported. This not only deprives women and girls of access to public markets, it also places them at a higher risk of engaging in transactional sex to secure economic and material survival.

Bridging their economic analysis with a human rights approach that would challenge discriminatory legal and social frameworks allows one to develop a fuller analysis of the transformative measures needed to address this facet of women’s vulnerability to HIV/AIDS. Women are often deprived of full access to public employment (i.e. lack of legal recourse for women whose employment is terminated upon pregnancy; sex and gender discriminatory employment laws in general) and by reinforcing feminine dependence within the domestic sphere (i.e. discriminatory inheritance laws).

(3) Building Networks Across Disciplines and Across Advocacy Movements

With the language of women, HIV/AIDS and Human Rights under increasing assault, it is imperative that advocates and academics in varying disciplines develop shared research agendas and litigation goals. In her presentation “Building Bridges to Make a Movement”, Tyler Crone (ATHENA) emphasized that networks across disciplines, shared language and building relationships will be key. The Barcelona Bill of Rights developed at the XIV International AIDS Conference in Barcelona is an example of a rights-strategy developed by diverse stakeholders interested in pushing the rights agenda further. A pilot project involving the Center for Reproductive Rights, ICASO, and ATHENA to document forced abortions and sterilizations of women with HIV in South Africa aims to lead toward greater legal services, engage the healthcare profession and work as an empowerment and advocacy tool.