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J.M. Spectar

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THE HYDRA HATH BUT ONE HEAD: THE SOCIO-CULTURAL DIMENSIONS OF THE AIDS EPIDEMIC & WOMEN'S RIGHT TO HEALTH

J.M. SPECTAR*

Abstract: The AIDS pandemic is exacting a heavy toll on women and girls in developing countries. The collusion of myriad social and cultural forces at the epicenter of the pandemic, to the detriment of women's health, heightens the need for an international focus on women's human rights and HIV/AIDS. It appears there is an inextricable nexus between certain socio-cultural practices and women's vulnerability to HIV/AIDS. Further, there is mounting evidence that women's vulnerability to disease is exacerbated by governmental policies that condone or institutionalize the marginalization of women. Yet, despite its multifarious causes, catalysts and consequences, the AIDS pandemic, like the Hydra of ancient lore, can be vanquished. Humankind can, and must, marshal a Herculean effort to defeat this global threat to women's health and well being. In this article, the author argues that to be successful, the campaign against AIDS must adopt a holistic approach to women's health that reflects an awareness of the interlocking structural and contextual determinants affecting the actualization of the right to health.

INTRODUCTION

AIDS has morphed into a multidimensional global pandemic—imperiling the human rights of millions, particularly women in developing countries. This article examines the social dimensions of the pandemic and its impact on women's human rights, specifically the international human right to health. This article argues that the inextricable relationship between AIDS and certain social practices or conditions necessitates a holistic approach to safeguarding women's

* Ph.D. 1999, Claremont Graduate University; M.A.P. 1997, Claremont Graduate School; J.D. 1992, University of Maryland School of Law; M.A. 1992, George Washington University; M.B.A. 1989, Frostburg State University; B.A. 1989, University of La Verne; G.C.E. Advanced Level 1984, Cameroon College of Arts, Science & Technology; Associate Professor of Law and Assistant Dean of Students, La Verne College of Law, California.

health and human rights. In that regard, this article argues that attempts to curb the spread of the pandemic must focus on the structural and contextual determinants shaping the course of the pandemic, especially the social or traditional practices that violate women's human rights and leave them more vulnerable to HIV/AIDS. The article also makes several recommendations designed to empower women in developing countries and to reduce their vulnerability to AIDS.

In Part I, this article examines the social impact of the pandemic, focusing on the plight of women in developing countries. The article argues that certain traditional or cultural practices/values fuel the spread of AIDS and jeopardize women's right to health. In Part II, this article examines the right to health in the context of international law and argues in favor of a comprehensive definition of this right. In Part III, the article makes recommendations for enhancing and improving the lives of women caught in the throes of the pandemic. The recommendations adopt a holistic approach¹ to women's health, focusing in particular on social and cultural conditions that constitute key structural or contextual determinants of health. This focus conceives of national and international efforts to strengthen human rights protections and to reform certain social/cultural conditions, with the aim of reducing the vulnerability of women and young girls to HIV/AIDS.

I. SOCIAL & CULTURAL DETERMINANTS

The AIDS pandemic is exacting an increasingly heavy toll on women—especially in developing countries. Women are contracting the disease at a faster rate than men, and the total number of infected women is rapidly approaching that of men.² African women and girls

¹ As the recent Geneva session on the condition of women worldwide concluded, "The absence of a holistic approach to health and health care for women and girls based on women's right to the enjoyment of the highest attainable standard of physical and mental health throughout the life-cycle has constrained progress." *See Report of the Ad Hoc Committee of the Whole of the Twenty-Third Special Session of the General Assembly, Women 2000: Gender Equality, Development and Peace for the Twenty-First Century*, U.N. GAOR, 23d Sess., 10, U.N. Doc. A/S-23/10/Rev.1, <http://www.un.org/womenwatch/daw/followup/as2310rev1.pdf> (2000) [hereinafter *Women 2000*]. In addition, the Geneva conferees concluded that a significant obstacle to the realization of women's right to health has been the lack of a comprehensive approach to women's health that pays sufficient "attention to the role of social and economic determinants of health." *Id.*

² *See* BUREAU OF OCEANS & INT'L ENVTL. & SCIENTIFIC AFFAIRS, U.S. DEP'T OF ST., 1999 U.S. INTERNATIONAL RESPONSE TO HIV/AIDS, http://www.state.gov/www/global/oes/health/1999_hiv aids rpt/issues.html (Mar. 16, 1999) [hereinafter *INTERNATIONAL RESPONSE*]. Ninety percent of infected women became infected through heterosexual

are experiencing the full fury of this plague: the Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that African girls aged fifteen to nineteen are about five to six times more likely to be infected with HIV than are boys of the same age.³ With about twelve or thirteen infected African women for every ten infected African men, there are an estimated 12.2 million women and 10.1 million men aged fifteen to forty-nine living with AIDS in sub-Saharan Africa.⁴ The infection rates among teenage African girls and especially women under twenty-five “defy belief,” with several studies showing that more than 20% of women in their early twenties are infected.⁵ About 60% of women in their twenties in the South African town of Carletonville tested HIV-positive and a large proportion of these women will not live to see their thirtieth birthday.⁶

The AIDS pandemic poses severe challenges to the international human rights of women and young girls in developing countries. Many of these challenges arise out of social/cultural practices inimical to female autonomy, dignity and integrity. In fact, the situation in developing countries is becoming increasingly grave—to a degree that AIDS is effectively an “aggressor”⁷ or a global threat to women’s international human rights, particularly the right to health.

It is increasingly apparent that the social and cultural context of women’s lives affects their vulnerability to HIV/AIDS. Social and cultural conditions that impact human rights by restricting women’s autonomy, and leaving them vulnerable include:

intolerance of racial, religious or sexual minorities; discrimination against people with known or suspected HIV infec-

intercourse. *Id.* Transmission of the virus through sexual intercourse is four times more efficient from men to women than from women to men. *Id.* Women and girls are biologically more vulnerable than males to infection in part because the female reproductive tract is more susceptible to infection of HIV and other sexually transmitted diseases (STDs). *Id.* Additionally, susceptibility to infections is higher in girls since their genital tract is not fully mature. *Id.*

³ See JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, AIDS EPIDEMIC UPDATE 1999 at 35, <http://hivinsite.ucsf.edu/social/un/2098.44d3.html> (1999) [hereinafter AIDS EPI-DEMIC UPDATE 1999].

⁴ *Id.* at 15.

⁵ JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, REPORT ON THE GLOBAL AIDS EPIDEMIC at 11, http://www.unaids.org/epidemic_update/report/Epi_report.pdf (June 2000) [hereinafter UNAIDS REPORT JUNE 2000].

⁶ *Id.*

⁷ Vice President Al Gore, Remarks at U.N. Security Council Session on AIDS in Africa, http://www.un.int/usa/00_002.html (Jan. 10, 2000) [hereinafter Gore U.N. Remarks] (personifying AIDS as an “aggressor”).

tion; lower status of women; abuse of power by older or wealthier individuals; scarcity of HIV counseling and testing facilities and of condoms; lack of care and support for those infected or affected; poverty or trafficking that leads to prostitution; domestic violence and rape⁸

In some cases, cultural taboos prohibit discussion of sex and sexuality, thus increasing the vulnerability of all persons to HIV/AIDS.⁹

The collusion of myriad social and cultural forces in the vortex of the pandemic, to the detriment of women's health, heightens the need for an international focus on women's human rights and HIV/AIDS. In fact, vulnerability to AIDS is exacerbated by the lack of respect for women's human rights.¹⁰

[T]he root causes of the epidemic—can be best understood within the universal principles of human rights. Vulnerability to AIDS is often engendered by a lack of respect for the rights of women and children, the right to information and education, freedom of expression and association, the rights to liberty and security, freedom from inhuman or degrading treatment, and the right to privacy and confidentiality.¹¹

Their relative "low status" or "disempowerment" in many developing countries makes women especially susceptible to sexual abuse and coercion which, in turn, results in greater exposure to the HIV virus and to possible infection.¹² At the same time, the inferior social status of women in these countries often makes it impossible for HIV-infected women to fight the ensuing discrimination.¹³ As Professor

⁸ UNAIDS REPORT JUNE 2000, *supra* note 5, at 37. Other factors include military conflict and labour migration that split up families. *Id.*

⁹ *Id.* at 41 (noting that cultural taboos prohibit the open discussion of sex or sexuality in Egyptian society).

¹⁰ *Id.* at 37.

¹¹ *Id.*

¹² Audrey R. Chapman, *Conceptualizing the Right to Health: A Violations Approach*, 65 TENN. L. REV. 389, 407–08 (1998). The economic "disempowerment" of women in African countries is not only tragic, it is also very ironic, considering that these women labor all day long to feed their families. See Press Release GA/SHC/3367, United Nations, Improved Status of Women Necessary to Sustain Economic Growth, Third Committee Told, as Debate Continues on Women's Issues, <http://www.un.org> (Oct. 28, 1996) (using search terms "African women" and "economic empowerment"). For example, Miss Illo, representing Niger, notes that although African women in rural areas work an average of seventeen hours per day, there exists a "statistical invisibility which fail[s] to recognize the true value of women's work in these areas." *Id.*

¹³ Chapman, *supra* note 12, at 407–08.

Allyn Taylor correctly observes, "gender inequality in sexual relations and economic status" increases the risk of HIV infection in women.¹⁴ In particular, the "imbalance of power between men and women in most cultural settings limits women's ability to protect themselves."¹⁵ In these settings, many women and young girls are "forced to accept sexual partnerships that put them at high risk of contracting the virus and are unable to insist on condom use by their partners."¹⁶ For example, over 50% of the young women in a Malawi study reported coercion, and 20% of Nigerian women surveyed reported being compelled to succumb to sexual intercourse.¹⁷ Many of these rape victims are very young—one study shows that two-fifths of rape cases in Botswana involve girls under the age of sixteen.¹⁸ Furthermore, a study of HIV-positive children at a clinic in Harare, Zimbabwe, revealed that many children do, in fact, acquire the virus as a result of sexual violence or rape.¹⁹ Reasons for these rapes included, "outright violence," and/or "social pressure through coercion by older men in authority," as well as the prescription and practice of "sex with virgins" conceived as a "remedy for a range of illnesses."²⁰

Young girls are often the victims of potentially "lethal rapes" and other offensive practices as they are perceived to be uninfected with HIV/AIDS and are, therefore, "safe."²¹ In fact, adolescent women are often in greater peril as their "extreme biological vulnerability" is further exacerbated by their "psychological and cultural subordination"²² as well as their relative material deprivation. Young girls are "far more likely than boys to be coerced or raped or to be enticed into sex by someone older, stronger or richer."²³ Although the power held over girls is sometimes a function of "greater physical strength," girls are also coerced by "social pressure to acquiesce to elders."²⁴ Additionally, some older men "buy their favours with sugar-daddy gifts"²⁵ and/or

¹⁴ Allyn L. Taylor, *Women's Health at a Crossroad: Global Responses to HIV/AIDS*, 4 HEALTH MATRIX 297, 314 (1994).

¹⁵ INTERNATIONAL RESPONSE, *supra* note 2; see also UNAIDS REPORT JUNE 2000, *supra* note 5, at 47.

¹⁶ INTERNATIONAL RESPONSE, *supra* note 2.

¹⁷ *Id.*

¹⁸ See UNAIDS REPORT JUNE 2000, *supra* note 5, at 51.

¹⁹ *Id.* at 51–53.

²⁰ INTERNATIONAL RESPONSE, *supra* note 2.

²¹ *Id.*; see also UNAIDS REPORT JUNE 2000, *supra* note 5, at 47–48.

²² INTERNATIONAL RESPONSE, *supra* note 2.

²³ UNAIDS REPORT JUNE 2000, *supra* note 5, at 47.

²⁴ AIDS EPIDEMIC UPDATE 1999, *supra* note 3, at 15.

²⁵ *Id.*

money for school fees.²⁶ Consequently, "age-mixing between young women and older men who have had much more sexual experience and are much likely to be exposing the girls to HIV" is prevalent.²⁷ A study in rural Tanzania showed that about 17% of unmarried teenage girls had had sex with a man at least ten years older than themselves.²⁸ Similarly, a survey of four African cities revealed that among men identified as clients of prostitutes or sex workers, about one third had had casual sex with teenage girls.²⁹

Additionally, traditional practices, such as the early marriage of girls, result in higher infection rates for young women at the peak of their childbearing years.³⁰ Yet, even the practice of seeking "safe" young partners is itself fraught with a "double deadly irony" as some of these men may themselves be infected or their young partners may have received early exposure to the virus.³¹

Women and female children endure additional traumas inflicted by barbaric cultural practices, such as genital mutilation, that increase potential exposure to AIDS.³² Over two million girls from ages four to twelve are genitally mutilated each year, particularly in Egypt, Ethiopia, Kenya, Nigeria, Somalia and the Sudan.³³ These "surgeries" include: (1) subtotal clitoridectomy or circumcision, (2) excision, which consists of a clitoridectomy along with removal of part or all of the labia minora and (3) infibulation, the most extreme surgery, which involves the removal of the entire clitoris, the entire labia minora, and at least two-thirds of the labia majora.³⁴ Even if the young female victims of these practices are lucky enough not to contract AIDS, they often face the prospect of bleeding to death.³⁵

²⁶ *Id.*

²⁷ UNAIDS REPORT JUNE 2000, *supra* note 5, at 11.

²⁸ *Id.* at 48.

²⁹ *Id.*

³⁰ Taylor, *supra* note 14, at 315. On average, women become infected about five to ten years earlier than men. *See id.*

³¹ UNAIDS REPORT JUNE 2000, *supra* note 5, at 48-49.

³² *See* Kirsten M. Backstrom, Note, *The International Human Rights of the Child: Do They Protect the Female Child?* 30 GEO. WASH. J. INT'L L. & ECON. 541, 545 (1997) (citing Council on Scientific Affairs, Am. Med. Ass'n, *Female Genital Mutilation*, 274 JAMA 1714 (1995)). Another barbaric practice is the deliberate killing of female children. *See* Gerald Abraham, *Giannella Lecture: The Cry of the Children*, 41 VILL. L. REV. 1345, 1353-54 n.51 (1996) (noting that infanticide is a "gender-related health risk"); Backstrom, *supra*, at 543-45.

³³ *See* Abraham, *supra* note 32, at 1353 n.51.

³⁴ *See* Backstrom, *supra* note 32, at 545 n.32 (citing Isabella R. Gunning, *Arrogant Perception, World-Travelling and Multicultural Feminism: The Case of Female Genital Surgeries*, 23 COLUM. HUM. RTS. L. REV. 189, 189 (1992)).

³⁵ *Id.* at 546.

Domestic violence is another major socio-cultural condition that violates women's human right to health and increases their exposure to HIV/AIDS.³⁶ In settings where such violence is regarded as "a man's right," women are often unable to "negotiate condom use or refuse to have sex."³⁷ While alarming rates of physical violence have been recorded in some developing countries, domestic violence knows no borders. Studies indicate that in many countries and on all continents, between a third and a half of all married women have been beaten or physically assaulted by their partners.³⁸ Physical violence is often accompanied by sexual coercion—one study shows that 7% of men in the Indian State of Uttar Pradesh use physical force to coerce their wives to engage in sex.³⁹ Another survey shows that less than 25% of Zambian women believed that a married woman could refuse to engage in sexual relations with her spouse, even if he had been demonstrably unfaithful and was infected.⁴⁰ Only 11% of women in the survey believed that a woman could require her spouse to wear a condom in such circumstances.⁴¹

Due to the lack of governmental or institutional support, women in developing countries are often afraid or even embarrassed to report abuse and rape. Often, the legal systems act in collusion with the abusers—women that do make such reports "are sometimes made to suffer themselves and are seldom rewarded by the arrest of the person in question."⁴² Record keeping is often abysmal, prosecutions and convictions are infrequent; even where suspects are successfully prosecuted, prison sentences are often relatively light.⁴³ For example, UNAIDS reports that only about 20% of reported rape cases in Botswana ended in conviction, and three quarters of those convicted were given a sentence of four years or less.⁴⁴ Often times, the legal process itself heaps even more abuse on the traumatized victim. For

³⁶ UNAIDS REPORT JUNE 2000, *supra* note 5, at 49.

³⁷ *Id.* at 49–50.

³⁸ *Id.* at 50.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ UNAIDS REPORT JUNE 2000, *supra* note 5, at 50.

⁴² *Id.* at 51. Such official malfeasance is by no means limited to developing countries. The recent scandal in which the New York City police ignored the physical assaults, sexual batteries and other indignities heaped on women in Central Park by marauding gangs is just the latest, and perhaps most visible, example. See Associated Press, *Some Victims of Central Park Assaults Say Police Ignored Pleas for Help*, available at <http://www.cnn.com/2000/US/06/13/central.park.assaults> (June 14, 2000).

⁴³ UNAIDS REPORT JUNE 2000, *supra* note 5, at 51.

⁴⁴ *Id.*

example, in Tanzania, female rape victims who bring charges against their attackers are discriminated against to the extent that these women (but not their male attackers) are required to disclose their HIV-status.⁴⁵

In addition, some women with AIDS are not only denied access to health care, jobs, and housing, but are “even murdered.”⁴⁶ UNAIDS reports that “women who are often monogamous wives infected by their husbands are especially stigmatized.”⁴⁷ Women with HIV are often “blamed by their in-laws for the fate of their infected spouse, even in cases when they themselves are not infected.”⁴⁸ Sometimes, when a man dies of AIDS, his spouse “risks being thrown out of her home by her in-laws, often losing her children in the process.”⁴⁹ A recent study by the Food and Agriculture Organization (FAO) in Namibia found “gender bias” in the treatment of women with AIDS: households headed by HIV-infected women generally lose their livestock, “thus jeopardizing the food and security of surviving members.”⁵⁰ During an official trip to Africa, U.S. Ambassador Richard Holbrooke spoke poignantly of a visit with six HIV-infected pregnant women in Windhoek, Namibia, who had met with the U.S. delegation clandestinely because of the stigmatization and shame linked with the disease:

These women told us that if they even admitted their ailment, they would lose their husbands and families, their jobs, and are completely ostracized from society. Under such circumstances, these women are simply left to die. . . . In too many places, families (and many doctors) even refuse to recognize AIDS as a cause of death. Often, they’ll cover it up by attributing death to AIDS-related illnesses like pneumonia.⁵¹

⁴⁵ Chapman, *supra* note 12, at 408 (citing Nicole Grimm, *Combating Discrimination Against AIDS Patients in Tanzania*, 4 HUM. RTS. BRIEF 2, 21 (1997)).

⁴⁶ UNAIDS REPORT JUNE 2000, *supra* note 5, at 39.

⁴⁷ AIDS EPIDEMIC UPDATE 1999, *supra* note 3, at 12. For example, a study of the sex industry in Cambodia where the prevalence among sex workers had reached 40% showed that men who were frequent clients of these prostitutes were “passing the infection on to their wives.” UNAIDS REPORT JUNE 2000, *supra* note 5, at 46.

⁴⁸ AIDS EPIDEMIC UPDATE 1999, *supra* note 3, at 12.

⁴⁹ *Id.*

⁵⁰ UNAIDS REPORT JUNE 2000, *supra* note 5, at 33.

⁵¹ See *Statement for the Record Submitted to the House Comm. on Banking and Fin. Servs.*, http://www.state.gov/www/policy_remarks/2000/000308_holbrooke_hiv-aids.html (Mar. 8, 2000) (statement of Richard Holbrooke, U.S. Ambassador to the United Nations) [hereinafter Holbrooke Statement].

The stigmatization of AIDS further lessens the likelihood of its successful prevention or treatment because many at-risk persons might be "discouraged from obtaining the necessary information, goods and services for self-protection."⁵² If women with AIDS face rejection and other violations of their human rights, women who suspect they are HIV-infected may avoid getting tested and may be disinclined to take "precautionary measures with their partners, for fear of revealing their infection; they may even avoid seeking health care."⁵³ The silence surrounding AIDS creates "a pandemic time-bomb waiting to explode," especially in areas of the developing world where most infected persons do not even know they are infected.⁵⁴

UNAIDS reports that in countries such as India, "the association between HIV and promiscuous sexual behaviour has created a belief that people who are infected with HIV somehow deserve their fate."⁵⁵ The stigmatization of AIDS as a moral failing often fuels a syndrome of silence that, in turn, places many women and young girls in further jeopardy.

Although warnings about the HIV threat date back to the early 1980s, many people, including leaders of global organizations and heads of state, "failed to take them seriously."⁵⁶ In many cases the denial is deliberate—"people do not want to admit that a fatal disease spread by behaviour branded as immoral could be rampaging through their community or country."⁵⁷ As the then Deputy President Thabo Mbeki of South Africa lamented in 1998, "For too long we have closed our eyes as a nation, hoping the truth was not so real. For many years, we have allowed the HIV virus to spread . . . and now we face the danger that half of our youth will not reach adulthood."⁵⁸

While HIV-infected persons are often denied care within their family, or even in medical facilities, women are the most likely victims of such discrimination. In many societies, while HIV-infected men expect and receive care, infected women are "frequently stigmatized, rejected and expelled by their communities and families," often leav-

⁵² UNAIDS REPORT JUNE 2000, *supra* note 5, at 37.

⁵³ *Id.*

⁵⁴ Holbrooke Statement, *supra* note 51.

⁵⁵ AIDS EPIDEMIC UPDATE 1999, *supra* note 3, at 12.

⁵⁶ UNAIDS REPORT JUNE 2000, *supra* note 5, at 38.

⁵⁷ *Id.* Even children get caught up in the stigmatization of AIDS. When some Kenyan children whose parents had died of AIDS were asked about the cause of their parents' death, "the single most common response was witchcraft or a curse," and many of these children gave "detailed explanations of the nature of the curse." *Id.* at 40.

⁵⁸ *Id.* at 38–39.

ing them homeless, dispossessed and destitute.⁵⁹ In India, a majority of hospitals "turn away HIV-infected patients or serve their needs badly."⁶⁰ In addition, there is a common perception that treating HIV patients is "a waste of time and money because the patients would go on to die anyway," although similar views are not expressed about other chronic or fatal diseases that afflict adults.⁶¹ Meanwhile, some governments have risked the lives of women and other patients by "deliberately" withholding or misrepresenting data about the incidence of HIV infection "so as not to discourage tourism or to embarrass or to stigmatize their countries."⁶²

For the most part, women and young girls have much less access to health care facilities in comparison to men.⁶³ As Taylor concludes, "the inequities in scientific research on HIV/AIDS and medical treatment of women only reflect the widespread disparities in social life that render women uniquely vulnerable to HIV infection."⁶⁴ It is estimated that female children are three times more likely to suffer from malnutrition than are male children and that they are also less likely to receive adequate nutrition or continuing pediatric care after birth than are male children.⁶⁵

Women's access to health services is also imperiled because some governments "maintain pro-natalist policies and accordingly ban or severely restrict the availability of contraception, information about contraceptives, and other reproductive health services."⁶⁶ For example, despite women's "peculiar susceptibility to HIV infection," research efforts have generally failed to develop effective prevention methods for women.⁶⁷ An effective female condom that could be used

⁵⁹ Taylor, *supra* note 14, at 316.

⁶⁰ AIDS EPIDEMIC UPDATE 1999, *supra* note 3, at 12.

⁶¹ *Id.*

⁶² Chapman, *supra* note 12, at 402.

⁶³ See Backstrom, *supra* note 32, at 543 (citing Rebecca J. Cook, *Human Rights and Infant Survival: A Case for Priorities*, 18 COLUM. HUM. RTS. L. REV. 1, 22-23 (1986)).

⁶⁴ See Taylor, *supra* note 14, at 313. The American Public Health Association reports that HIV-infected women are:

often misdiagnosed during the early state of their disease. They lack access to drug treatment, abortion services, AZT and early intervention services and clinical trials. . . . The eligibility of HIV-infected women for disability and health benefits is complicated by criteria which may not reflect the nature of the disease in women.

Id. at 314 n.63.

⁶⁵ Backstrom, *supra* note 32, at 543-44.

⁶⁶ Chapman, *supra* note 12, at 402.

⁶⁷ Taylor, *supra* note 14, at 308.

to prevent transmission of HIV without the knowledge or consent of women's sexual partners is still not generally available.⁶⁸

The pandemic has "reinforced recent gender-based critiques of traditional approaches to biomedical research," and it has placed the scientific community and national authorities under considerable public scrutiny.⁶⁹ For example, treatment of women with sexually transmitted diseases (STDs) is perennially underfunded even though STDs "affect a disproportionate number of women, [and] are much more difficult to detect in women."⁷⁰ It follows that persons with STDs are five to ten times more likely to become HIV-positive.⁷¹ Similarly, although cervical cancer (a preventable form of cancer) is a major disease associated with HIV/AIDS, most developing countries lack the facilities for the treatment and detection of cervical cancer.⁷² Further, donated blood is not screened for HIV/AIDS in many countries although women are at a greater risk of HIV transmission through contaminated blood supplies because the greater percentage of blood transfusions are to women.⁷³

The related matter of discrimination in female access to education compounds the problem of women's access to health care in developing countries.⁷⁴ A report by the United Nations Educational Scientific and Cultural Organization found that, in addition to being minorities in education in many countries, "the proportion of in-

⁶⁸ *Id.*

⁶⁹ *Id.* at 305. Taylor notes that women have "largely been excluded from the multi-billion dollar global research agenda on HIV/AIDS." *Id.* at 306. Taylor further observes that traditional biomedical research often uses white males for medical research, "as though such diseases or conditions would have the same natural history or response in both men and women." *Id.* This practice has resulted in gaps in our knowledge of a disease that affects both sexes. *See id.*

⁷⁰ *Id.* at 309.

⁷¹ *See id.* The World Health Organization (WHO) estimates that the yearly incidence of gonorrhea, genital chlamydia infections, infectious syphilis and chancroid, exceeds seventy-five million. *Id.* at 309 n.43 (citing WORLD HEALTH ORG., GLOBAL HEALTH SITUATIONS AND PROJECTIONS at 44, WHO Doc. WHO/HST/92.1 (1992)).

⁷² Taylor, *supra* note 14, at 310.

⁷³ *Id.* at 309 n.42 (citing *Effects of the Acquired Immunodeficiency Syndrome (AIDS) on the Advancement of Women*, Commission on the Status of Women, 33d. Sess., Provisional Hearing 5(b) at 9-10, U.N. ESCOR Doc. E/CN.6/1989/6/Add.1 (1989)). Women tend to receive more blood transfusions than men because of post-partum hemorrhage, ectopic pregnancies, crudely induced abortions, and as a treatment for anemia caused by repeated pregnancies. *Id.*

⁷⁴ Backstrom, *supra* note 32, at 548.

affected girls and women tends to decrease progressively as the level of education rises."⁷⁵

Meanwhile, boys often have greater access to education and information in developing countries, including life-saving information about HIV/AIDS prevention.⁷⁶ Surveys reveal that in four countries where the adult HIV prevalence rate is greater than 10%, 20% or more of girls in their late teens know too little about the virus to protect themselves.⁷⁷ Many girls do not know about "their own biological vulnerability to infection if they start having sex very young."⁷⁸ Studies show that sexual activity during the early teens inexorably results in a higher prevalence of HIV among girls. In a study of teenage girls in Kisumu, Kenya, where over 25% of the group had engaged in sexual intercourse before the age of fifteen, one in twelve were HIV-positive.⁷⁹ The greater access to information enjoyed by males "may be one reason why they have lower HIV rates" in developing countries.⁸⁰ When women and girls are "denied the basic information, education and skills to deal with HIV—whether because of religious values, social mores or cultural preferences"—their vulnerability to AIDS increases.⁸¹

Finally, some women may be adversely impacted by "extreme formal state policies for discriminating against specific racial and ethnic groups," or state policies that disproportionately invest funds to benefit certain groups at the disadvantage of others.⁸² In sum, overwhelming evidence supports the view that the health of women worldwide is imperiled by social and cultural discrimination, as well as by the legal and social policies of many nations.⁸³

⁷⁵ *Id.* at 548 n.58 (citing *Education for All*, UNESCO COURIER, Jan. 1983, at 11). For example, in Zaire, female children spend just about 33% as much time in school as do male children. See *id.* (citing Steven Greenhouse, *State Department Finds Widespread Abuse of World's Women*, N.Y. TIMES, Feb. 3, 1994, at A1).

⁷⁶ UNAIDS REPORT JUNE 2000, *supra* note 5, at 42.

⁷⁷ *Id.*

⁷⁸ *Id.* at 47.

⁷⁹ *Id.* at 47–48.

⁸⁰ *Id.* at 42.

⁸¹ UNAIDS REPORT JUNE 2000, *supra* note 5, at 44.

⁸² Chapman, *supra* note 12, at 403. For example, in extreme cases, Apartheid South Africa "segregated public hospitals and allocated significantly more funds per capita to health care for whites than for blacks." *Id.* The Apartheid regime also limited black enrollment in medical schools, and black students were disadvantaged by an inferior educational system. *Id.*

⁸³ See Taylor, *supra* note 14, at 310.

II. WOMEN'S RIGHT TO HEALTH & INTERNATIONAL LAW

The phrase "right to health," often used interchangeably with "right to health care,"⁸⁴ is well-grounded in international legal instruments. Article 25 of the Universal Declaration of Human Rights (UDHR) states, "Everyone has the right to the standard of living adequate for the health and well-being of himself and his family."⁸⁵ This includes the right to "medical care and necessary social services," as well as "the right to security" in the event of sickness, or "other lack of livelihood in circumstances beyond [her] control."⁸⁶ This provision can be interpreted to "require that individuals be given full medical access to the medical benefits,"⁸⁷ as well as to the new therapies generated by scientific and technological developments.⁸⁸ Moreover, one can argue that the "right to life"⁸⁹ in the Universal Declaration includes a right to life-saving medicine for all persons. The WHO constitution also recognizes that all human beings have a fundamental right to health, and defines health as a "state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."⁹⁰

Additionally, the International Covenant on Economic, Social and Cultural Rights includes a provision granting everyone "the right to the highest attainable standard of physical and mental health."⁹¹ To realize this right, states must take steps necessary for the "prevention,

⁸⁴ See Aart Hendriks, *The Right to Health: Promotion and Protection of Women's Right to Sexual and Reproductive Health Under International Law: The Economic Covenant and Women's Convention*, 44 AM. U. L. REV. 1123, 1128 (1995).

⁸⁵ G.A. Res. 217 (III 1948), reprinted in BASIC DOCUMENTS SUPPLEMENT TO INTERNATIONAL LAW 143, 145 (Louis Henkin et al. eds., 1993) [hereinafter BASIC DOCUMENTS].

⁸⁶ *Id.*

⁸⁷ See Alastair T. Illes, *The Human Genome Project: A Challenge to the Human Rights Framework*, 9 HARV. HUM. RTS. J. 27, 36 (1996).

⁸⁸ See J.M. Spectar, *The Fruit of the Human Genome Tree, Cautionary Tales About Technology, Investment & the Heritage of Humankind*, 23:1 LOY. L.A. INT'L & COMP. L. REV. (forthcoming 2001) [hereinafter Spectar, *Fruit of the Human Genome Tree*].

⁸⁹ G.A. Res. 217, *supra* note 85, reprinted in BASIC DOCUMENTS, *supra* note 85, at 143. Similarly, Article 6 of the International Covenant on Civil and Political Rights posits that "[e]very human being has the inherent right to life." G.A. Res. 2200, 21 U.N. GAOR, Supp. 16, at 52, U.N. Doc. A/6316 (1967), reprinted in BASIC DOCUMENTS, *supra* note 85, at 151, 153.

⁹⁰ Hendriks, *supra* note 84, at 1129. To ensure the realization of this right, the WHO has launched an ambitious "health for all campaign." See generally David P. Fidler, *Neither Science Nor Shamans: Globalization of Markets and Health in the Developing World*, 7 IND. J. GLOBAL LEGAL STUD. 191, 194 (1999).

⁹¹ G.A. Res. 2200, *supra* note 89, reprinted in BASIC DOCUMENTS *supra* note 85, at 146, 149.

treatment and control of epidemic, endemic, occupational and other diseases."⁹² States must also create "conditions which would assure to all medical service and medical attention in the event of sickness."⁹³ Several regional human rights instruments have also included the right to health and other related provisions.⁹⁴

In addition to these general international human rights instruments, certain specific agreements and declarations have brought the matter of women's rights to health, life, and well being to the forefront. The Convention on the Elimination of All Forms of Discrimination Against Women contains several key provisions with regard to the protection of women's health and well being.⁹⁵ Women have an equal claim to "the right to protection of health" and state parties to the Convention must ensure that all women, including women in rural areas, have the right of "access to adequate health care facilities."⁹⁶

⁹² *Id.*

⁹³ *Id.* at 150.

⁹⁴ European Social Charter, done Oct. 18, 1961, Europ. T.S. No. 35, reprinted in BASIC DOCUMENTS, *supra* note 85, at 248, 253. The European Social Charter states that anyone without adequate resources has the right to social and medical assistance and everyone has the right to benefit from social welfare services. *Id.* at 248. With a view to ensuring the effective exercise of this right, the parties undertake: "to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition." *Id.* at 253. Meanwhile, Article 16 of the African Charter on Human and Peoples' Rights states that everyone shall have "the right to enjoy the best attainable state of physical and mental health" and the parties to the Charter "shall take all the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick." African Charter on Human and People's Rights, adopted June 27, 1981, 21 I.L.M. 58, reprinted in BASIC DOCUMENTS, *supra* note 85, at 311, 313. Similarly, the American Declaration of the Rights and Duties of Man states, "[e]very person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources." American Declaration of the Rights and Duties of Man, adopted May 2, 1948, reprinted in BASIC DOCUMENTS, *supra* note 85, at 287, 288.

⁹⁵ G.A. Res. 180, U.N. GAOR (1979), 19 I.L.M. 33 (1980), reprinted in BASIC DOCUMENTS, *supra* note 85, at 174-80. Unfortunately, of all the human rights treaties, the Convention has the most reservations, including some that have the potential of modifying or of excluding core provisions of the treaty. See Taylor, *supra* note 14, at 321 (citing Belinda Clark, *The Vienna Convention Reservations Regime and the Convention on Discrimination Against Women*, 85 AM. J. INT'L. L. 281, 282-83 (1991)). During the debates leading to the Convention, some states claimed their reservations were "dictated by cultural and religious norms" with some reservations relating to the purported "incompatibility of gender equality with Islamic law or national customs which restrict women's inheritance and property rights and limit women's employment opportunities." *Id.* at 321.

⁹⁶ See G.A. Res. 180, *supra* note 95, reprinted in BASIC DOCUMENTS, *supra* note 85, at 177-78.

The parties have pledged to take all appropriate measures to "eliminate discrimination against women in the field of healthcare in order to ensure a basis of equality of men and women, and access to health care services, including those related to family planning."⁹⁷ To eliminate discrimination against women in the field of education, states must provide equal "access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning."⁹⁸ The state parties to the Convention also commit themselves to taking measures to "suppress all forms of traffic in women and exploitation of prostitution of women."⁹⁹

While the "right to health" in international law is often defined as "the right to the highest attainable standard of health,"¹⁰⁰ there are varying views on the content of the right to health, and the minimal obligations it entails. Some opine that the concept of a "right to health" packs more rhetorical punch than it does policy or legal guidance for states or international organizations."¹⁰¹ Others simply write it off as another second generation human right, precatory and hortatory in nature, yet imposing no extra-territorial obligations on states.¹⁰² Meanwhile, some suggest that the right to health includes an obligation to implement this right through international assistance.¹⁰³ It is argued that this obligation encompasses a duty to support health services in poorer countries—particularly because it is virtually impossible to isolate the health concerns of one nation from other nations.¹⁰⁴

A woman's right to health, properly defined, should also encompass the right to reproductive health and choice. Reproductive health is "a state of complete physical, mental and social well-being . . . in all matters relating to the reproductive system and to its functions and processes."¹⁰⁵ Reproductive health includes "sexual health, the purpose of which is the enhancement of life and personal relations, and

⁹⁷ *Id.* at 177.

⁹⁸ *Id.* at 176.

⁹⁹ *Id.* at 175.

¹⁰⁰ Hendriks, *supra* note 84, at 1128 (citing Virginia Leary, *Implications of a Right to Health*, in *HUMAN RIGHTS IN THE TWENTY-FIRST CENTURY: A GLOBAL CHALLENGE* 481-93 (Kathleen E. Mahoney & Paul Mahoney eds., 1993)).

¹⁰¹ Fidler, *supra* note 90, at 193.

¹⁰² See generally *HUMAN RIGHTS IN THE WORLD COMMUNITY* 18-19 (Richard Pierre Claude & Burns Weston eds., 1989).

¹⁰³ See Allyn L. Taylor, *Globalization and Biotechnology: UNESCO and an International Strategy to Advance Human Rights and Public Health*, 25 *AM. J.L. & MED.* 479, 504 n.209 (1999).

¹⁰⁴ See *id.*

¹⁰⁵ See *Women 2000*, *supra* note 1, at 30.

not merely the counseling and care related to reproduction and sexually transmitted diseases."¹⁰⁶ The concept of reproductive health also embraces certain human rights that are already recognized in national and/or international law, including the right to family planning, as well as the right to make reproductive decisions free from discrimination, coercion and violence.¹⁰⁷

There have been several attempts to define and to clarify the scope of the right to health. For example, Fidler suggests that "at a minimum" the right to health should mean that "an individual's mental and physical health should be protected from governmental acts of torture and cruel, degrading, or other inhumane treatment."¹⁰⁸ Meanwhile, Gostin and Lazzarini propose a minimum content for the right to health in which "the state would have a responsibility, within the limits of its available resources, to intervene to prevent or reduce serious threats to the health of individuals or populations."¹⁰⁹

It is increasingly important to think about health and the right to health in a holistic or comprehensive approach that recognizes the underlying socio-cultural determinants that affect health, especially in the vortex of a pandemic such as AIDS. With regard to a holistic right to health, government obligations include providing health services, sanitation, clean air, clean water, housing, universal access to health, education, living wages, sustainable development, and securing other social and economic conditions of peace and progress, including respect for fundamental human rights.¹¹⁰ The right to health cannot be

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, and when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe effective, affordable and acceptable methods of family planning of their choice . . . and the right of access to appropriate health-care services

Id.

¹⁰⁸ David P. Fidler, *International Law and Global Public Health*, 48 U. KAN. L. REV. 1, 41 (1999).

¹⁰⁹ *Id.* at 43 (citing LAWRENCE O. GOSTIN & ZITA LAZZARINI, *HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC* 29 (1997)).

¹¹⁰ *See id.* (noting that government obligations under a right to health approach must include clean air, sanitation, housing and education).

meaningfully actualized when governments fail to eradicate oppressive social or cultural practices that jeopardize the health of women.¹¹¹

III. TOWARD A HOLISTIC FRAMEWORK FOR THE HEALTH OF WOMEN

A significant obstacle to the realization of women's right to health has been the lack of a comprehensive approach to women's health that pays sufficient "attention to the role of social and economic determinants of health."¹¹² As the recent Geneva session on the condition of women worldwide concluded: "the absence of a holistic approach to health and health care for women and girls based on women's right to the enjoyment of the highest attainable standard of physical and mental health throughout the life-cycle has constrained progress."¹¹³

To fully address the impact of AIDS on women, policy makers must adopt a holistic approach to women's health that reflects an awareness of the interlocking structural and contextual determinants affecting the actualization of the right to health.¹¹⁴ In that regard, there must be national and international efforts to strengthen and protect women's rights and to reform certain social/cultural conditions, with a special emphasis on empowering all women. Below, this article sets forth recommendations for actualizing the right to health, particularly in the context of the AIDS pandemic. The recommendations focus on the following areas: (1) demonstrated commitment to gender equity; (2) legal enactment and enforcement of laws protecting women from violence, rape and other forms of abuse, as well as zero-tolerance for derogations; (3) eradication of socio-cultural practices harmful to women's health; (4) comprehensive prevention strategies targeting the needs and experiences of women in develop-

¹¹¹ In addition, chronic poverty and persistent or recurring conflict constitute systematic impairments of health and well-being, as well as gross infringements upon the right to health. The right to health cannot be meaningfully realized when governments and, in certain cases, the international community, fail to eradicate poverty and fail to support comprehensive primary education for all. See, e.g., J.M. Spectar, *The Hybrid Horseman of the Apocalypse, the Global AIDS Pandemic & the North-South Fracas*, GA. J. INT'L & COMP. L. (forthcoming Spring 2001) [hereinafter Spectar, *Hybrid Horseman*] (discussing the implications of the apparent link between pestilence and acute underdevelopment).

¹¹² *Women 2000*, *supra* note 1, at 10.

¹¹³ *Id.*

¹¹⁴ Elsewhere, I have argued that in social and economic conditions characterized by abject poverty and perpetual civil strife or war—as is often the case in the vortex of the pandemic—the right to health is effectively devoid of meaning. See generally Spectar, *Hybrid Horseman*, *supra* note 111.

ing countries; (5) de-feminization of poverty; (6) education and literacy for participation in the digital economy; (7) data collection and research on the condition of women; (8) Non-Governmental Organizations' (NGOs) & grassroots' involvement; (9) inclusive political leadership that mobilizes resources and ends the silence about the suffering of women; and (10) raising the profile of women's health in international law and society.

A. Demonstrated Commitment to Gender Equity

Efforts to stem the disproportionate impact of the AIDS pandemic on women must begin with demonstrated national and global commitments to achieving real gender equity in social, political and economic contexts. As the Geneva Conference on Women states:

Achieving gender equality and empowerment of women requires redressing inequalities between women and men and girls and boys and ensuring their equal rights, responsibilities, opportunities and possibilities. Gender equality implies that women's as well as men's needs, interests, concerns, experiences and priorities are an integral dimension of the design, implementation, national monitoring, follow-up, and evaluation, including at the international level, of all actions in all areas.¹¹⁵

To be effective, risk-reduction programs must "increase the capacity and autonomy" of women and girls by addressing "gender imbalance and the inability to negotiate when, how and with whom they have sex."¹¹⁶ In addition, policy makers must address the problem of gender equity with respect to AIDS treatment within the overall context of the right to health.

B. Prosecutions & Penalties for Domestic Violence, Rape & Other Forms of Abuse

National leaders must enact and robustly enforce strict laws against domestic violence and rape. This is especially necessary in certain countries in which the legal systems have not provided adequate protection for women and children despite historical and cultural patterns of abuse. For example, Botswana, which formerly had lax

¹¹⁵ *Women 2000*, *supra* note 1, at 23.

¹¹⁶ UNAIDS REPORT JUNE 2000, *supra* note 5, at 111.

rape laws, recently increased the minimum sentence for rape from about four years to ten years; the sentence is further increased to fifteen years if an HIV-positive defendant commits the rape.¹¹⁷ Additionally, states must offer protections for women and children who take the difficult step of confronting their accusers. Meanwhile, Zimbabwe now has a "child-friendly court" in every province designed to improve the process of evidence collection and child counseling and to make the court hearings less intimidating.¹¹⁸

In addition, governments should develop comprehensive programs to deal with perpetrators of violence against women and girls. Multidisciplinary approaches in response to violence could involve the health and justice systems, as well as education, the media and work places.¹¹⁹ Additionally, governments must develop effective systems for collecting data on violence against women and establishing the nexus between such abuses and women's vulnerability to HIV/AIDS.

C. Eradicating Harmful Socio-Cultural Norms & Practices

In order for women to realize their right to health, the traditional social and cultural practices that encourage the spread of HIV/AIDS must be discontinued.¹²⁰ Governments must adopt and implement laws to sanction practitioners of traditional practices that violate human rights, such as female genital mutilation.¹²¹ Additionally, governments must develop effective programs to change discriminatory socio-cultural attitudes which make women and girls "vulnerable to many forms of violence, such as physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women."¹²²

¹¹⁷ *Id.* at 51.

¹¹⁸ *Id.* at 53.

¹¹⁹ See *Women 2000*, *supra* note 1, at 22-25.

¹²⁰ Press Release, Statement of Peter Kasanda, Security Council Holds Debate on Impact of AIDS on Peace and Security in Africa, at <http://www.un.org/News/Press.html> (Jan. 10, 2000) (Press Release SC/6781) [hereinafter Security Council Holds Debate].

¹²¹ See *Women 2000*, *supra* note 1, at 42.

¹²² *Id.* at 11.

D. Comprehensive Prevention Strategies

AIDS prevention strategies must increasingly focus on the social and cultural context of peoples' lives. Governments must provide adequate access to "affordable primary health care services of high quality including sexual and reproductive healthcare, sufficient attention to maternal and emergency obstetric care," as well as to adequate screening and treatment for gender-specific conditions such as cervical cancer.¹²³ Additionally, reproductive choice is an important human right that must be safeguarded, defended and vindicated at appropriate fora.

Given that many children in "marginalized communities" are having sex at the very early age of eleven or younger, national leaders should ensure that sex education is introduced as early as necessary, especially before the target populations become sexually active.¹²⁴ Additionally, governments should take a more active role in making condoms "widely and conveniently accessible,"¹²⁵ including providing the female condom to women at subsidized rates.¹²⁶ In partnerships with NGOs, the international community should mobilize resources and develop prevention strategies to protect women from HIV/AIDS and other STDs through the development of safe, effective and affordable contraceptives, including microbicides.¹²⁷

¹²³ *Id.* at 10.

¹²⁴ UNAIDS REPORT JUNE 2000, *supra* note 5, at 49.

¹²⁵ *Id.* at 64. A survey of men in South Africa revealed that while 50% of them were inclined to use a condom, only 16% actually did so because they did not always have a condom handy. *Id.*

¹²⁶ *Id.* at 63. Since the female condom is several times more expensive than the male condom, many women are unable to procure this vital, potentially life-saving device. *Id.* Nevertheless, since 1996, a special agreement between UNAIDS and the Female Health Company, the sole manufacturer of the female condom, has made the female condom available to several governments and to other public agencies. *Id.* The female condom is very important to the empowerment of women—such empowerment being a precondition for the realization of women's right to health. *Id.* The female condom reduces the need for negotiation (where the woman is often at a disadvantage) and, it is reported, "can be used even when a man has an incomplete erection," as may be the case with drunken and/or potentially violent "partners." *Id.* Surveys have shown that people who are drunk are less likely to use condoms, thus highlighting the importance of the female condom for protecting the woman from possible infection. *Id.* at 62.

¹²⁷ See INTERNATIONAL RESPONSE, *supra* note 2. Topical microbicides are chemical barriers that, if properly applied, can inhibit HIV infection. *Id.* While their effectiveness is limited, microbicides are needed due to the "high prevalence of nonconsensual sex, lack of condom use, and the need for reproductive choices." *Id.* Additionally, effective microbicides can facilitate conception while preventing infection of HIV and other STDs. *Id.*

National governments should also support intervention strategies designed to provide prevention counseling to women who are being treated for other STDs.¹²⁸ In addition, prevention strategies directed at men experiencing their first bout with an STD would encourage behavioral modifications that might, in turn, diminish the likelihood of their transmission of HIV to women.¹²⁹ Furthermore, governments in developing countries need to support the establishment of adequate testing and counseling facilities, especially in rural areas.¹³⁰ In particular, it is necessary to intensify efforts to prevent mother-to-child transmissions of the virus by, *inter alia*, providing antiretroviral drugs¹³¹ in late pregnancies, and counseling at risk mothers about breastfeeding.¹³²

Meanwhile, governments should encourage and assist companies with their HIV prevention programs, especially where there is resistance to such programs.¹³³ Efforts to encourage these prevention programs could include tax breaks,¹³⁴ subsidies and other preferential

¹²⁸ UNAIDS REPORT JUNE 2000, *supra* note 5, at 72.

¹²⁹ *Id.* at 73. Many of these approaches will not yield immediate results, and measurable impact may take four to five years to develop. *Id.* at 111. Yet, a key component of an effective national response is the adoption of a "long-term and sustained response" designed to build resistance to AIDS in demographic and age groups over time. *Id.* In addition, governments and international organizations must build on what has worked in the past, taking advantage of what UNAIDS refers to as the "best practice" from successful HIV interventions or projects. *See id.* at 112. The ability to learn from experience is thus a key component of any effective plan to combat the pandemic. *See id.*

¹³⁰ *Id.* at 79 (noting that HIV testing and counseling facilities in the developing world are far from adequate).

¹³¹ *Id.* at 81. A USAID-funded clinical trial conducted by the Centers for Disease Control (CDC) and Thailand Ministry of Health determined transmissions from mother to child could be reduced by 50% by giving the drug AZT to mothers during the last four weeks of pregnancy and during labor and delivery. *See* INTERNATIONAL RESPONSE, *supra* note 2.

¹³² UNAIDS REPORT JUNE 2000, *supra* note 5, at 81 (noting that these measures have reduced mother-to-child transmission of the virus). Australia has promised to fund a regional "optimal feeding practices" project to reduce mother-to-child transmissions in southern Africa. *See* Security Council Holds Debate, *supra* note 120.

¹³³ *See* UNAIDS REPORT JUNE 2000, *supra* note 5, at 35. For example, interviews conducted in engineering and construction companies in Gaborone, Botswana found resistance to prevention initiatives, albeit 39% of city workers were HIV-positive. *Id.* at 33. Initiatives led by businesses involving a mix of education, counseling and condom distribution are yielding some success at Volkswagen in Brazil, American International Insurance of Thailand, the Tata Iron and Steel Company of India, and the Botswana Business Coalition on AIDS. *Id.* at 34-35. Strong workplace prevention programs have also been shown to reduce HIV transmission and associated costs in factories in Zimbabwe. *Id.* at 35.

¹³⁴ *See id.* at 36 (suggesting that governments encourage companies in the private sector to invest in HIV prevention in the workforce).

treatment. Furthermore, governments in areas with high prevalence rates could also require AIDS prevention efforts in the workplace as a requirement for any large tender.¹³⁵

Over the long-term, the international community should develop a special fund for the development of a safe, effective and affordable AIDS vaccine.¹³⁶ More resources should also be allocated to providing affordable diagnosis and single-dose treatments, as well as to providing access to "adequate and affordable treatment" for HIV/AIDS and associated opportunistic infections such as tuberculosis.¹³⁷ Further, efforts should be undertaken at the international level to eliminate gender biases in bio-medical, clinical and social research, including conducting voluntary clinical trials involving women.¹³⁸

E. *De-feminization of Poverty*

Policy makers seeking to strengthen women's right to health must recognize the "gender dimensions of poverty," and further recognize that "gender equality is one of the factors of specific importance for eradicating poverty, particularly in relation to the feminization of poverty."¹³⁹ Governments should mainstream a gender perspective in the formulation and implementation of macro-economic and social development policies and national development programs.¹⁴⁰ Also, governments should adopt budgetary measures that address the gender-specific aspects of HIV/AIDS, such as providing subsidies to manufacturers of female condoms.

It is also necessary to develop comprehensive gender-sensitive programs to reduce the proportion of women (especially rural women) living in poverty.¹⁴¹ Policy makers must take steps to close the "gender wage gap" and to realize the goal of equal pay for women and men for equal work.¹⁴² True empowerment is unlikely unless governments undertake necessary reforms and promote social policies to

¹³⁵ *Id.* Botswana is considering such a measure. *See id.*

¹³⁶ *Id.* at 68. *See generally* Spectar, *Fruit of the Human Genome Tree*, *supra* note 88 (suggesting that a prospective Human Genome Fund should devote some resources to developing an AIDS therapy or an affordable vaccine).

¹³⁷ *Women 2000*, *supra* note 1, at 47.

¹³⁸ *Id.* at 40.

¹³⁹ *Id.* at 7.

¹⁴⁰ *See id.* at 10.

¹⁴¹ *See id.*

¹⁴² *See Women 2000*, *supra* note 1, at 14.

increase women's access to land, property, markets, information, technology and other resources.¹⁴³

With regard to mainstreaming AIDS into the national development agenda, it is essential to support strategies such as building schools, increasing funds for the education of young girls in rural areas, and boosting funding for life skills in curricula that include information on STDs.¹⁴⁴ Governments must also secure women's access to clean water, adequate nutrition, safe sanitation, gender-specific health research, and access to reproductive health information,¹⁴⁵ and must support women's right to choose their family planning options.

International lending institutions should make more efforts to introduce a "gender perspective" into their policies and to encourage the strengthening of emerging micro-credit institutions. The institutions should provide additional "micro-credit" to women (especially female-headed households) struggling to emerge from poverty.¹⁴⁶ Additionally, at the international level, policy makers should identify and implement solutions that integrate a gender perspective to external debt and debt-servicing problems of developing countries, through debt relief, including the option of debt cancellation, so that poor countries can finance development projects that are targeted, in part, to the health and welfare of women.¹⁴⁷ International organizations must also ensure that food and medicine are not used as tools for political pressure, and must take steps to lessen the impact of economic sanctions on women and children.¹⁴⁸

G. Education & Literacy in the Digital Economy

Education is "one of the most valuable means of achieving gender equality and the empowerment of women."¹⁴⁹ Efforts to promote education, especially for young girls in rural areas, should be an essential component of any sustainable development agenda designed to realize women's right to health.¹⁵⁰ Given the possible relationship

¹⁴³ See *id.*

¹⁴⁴ UNAIDS REPORT JUNE 2000, *supra* note 5, at 113.

¹⁴⁵ *Women 2000*, *supra* note 1, at 10.

¹⁴⁶ *Id.* at 7–8.

¹⁴⁷ *Id.* at 39.

¹⁴⁸ See *id.*

¹⁴⁹ *Id.* at 8.

¹⁵⁰ For example, the World Bank has made education for young girls a top priority going forward into the twenty-first century. This goal is especially important because about 125 million primary school age children are still not in school. See THE WORLD BANK GROUP, FACT SHEETS, EDUCATION FOR ALL, at <http://www.worldbank.org/html/extdr/pb>

between educational levels and AIDS prevalence rates, governments should work with international partners to provide comprehensive early childhood development programs to increase the adult literacy rate and to assure essential skills training for all girls.¹⁵¹

Governments should take proactive steps to remove the economic, social and cultural obstacles in the way of eradicating illiteracy in women and girls, including providing more resources to elevate women out of poverty. Efforts to promote literacy must be connected to the fight against discrimination of women, particularly the "traditional discriminatory practices [that] have contributed to lower enrollment and retention rates for girls."¹⁵² It is necessary to close the gender gap in primary and secondary education, to implement gender sensitive curricula, to develop plans to improve retention of

/pbeduc.html (last visited July 21, 2000). In the 1990s, about 8% of the Bank's new lending was devoted to education, with a significant portion directed at basic education initiatives. *Id.*

¹⁵¹ See UNAIDS Report June 2000, *supra* note 5, at 42 (noting that "in general people with more education lead healthier, more productive lives"). A UNAIDS analysis of the results of studies conducted among fifteen- to nineteen-year-olds in seventeen African and fourteen Latin American counties found that "better-educated girls tend to start having sex later." *Id.* at 43. The proportion of girls who were sexually active by the age of eighteen was 24% lower among girls with a secondary school education compared to girls with only a primary school education. *Id.* The emphasis on education should also include significant improvements in higher education in developing countries. The Task Force on Higher Education and Society, an autonomous group of experts convened by UNESCO found that:

[h]igher education in developing countries is inadequate and falling further behind [I]t is generally overcrowded, chronically under-funded, poorly managed, and beset with inadequate faculty and curricula Demand for higher education is rising rapidly, compounding the challenges for countries that hope to improve quality, reduce public cost, and increase access to all strata.

See Press Release, World Bank Group, Higher Education Key to Knowledge Economy, <http://www.wb1n0018.worldbank.org/news/pressrelease.nsf> (last visited July 12, 2000). The Task Force calls the situation a "crisis," and it emphasizes the need for a "holistic approach to education policy" that includes viewing higher education as a "vital part of their overall human development strategy." *Id.* The Task Force argues that higher education is a pre-condition for overcoming a wide range of problems, including persistent poverty and economic under-performance. *Id.* The Task Force suggests specific areas for emphasis by developing countries, including improving scientific and technological capacity and respecting principles of good governance. *Id.* In launching the Task Force's Report, James Wolfensohn, World Bank President, noted that institutions of higher learning that train "well-educated people" in the developing world are key to confronting "staggering problems [such] as the HIV/AIDS pandemic and the need to build up infrastructure and telecommunications." *Id.*

¹⁵² *Women 2000*, *supra* note 1, at 9.

women and girls and to address the problem of negative gender stereotyping.¹⁵³ International lending institutions should support programs designed to improve female literacy and skills training for women.¹⁵⁴

To ensure adequate representation of women in all sectors of the global knowledge economy, governments should actively support the education of girls in science, mathematics, technical subjects and the new information technologies.¹⁵⁵ International organizations should join governments in supporting equal access for women to information and communications technologies, and should assist in bridging the digital gap between men and women.¹⁵⁶ Governments must also take affirmative steps to increase the participation of women in all sectors of the labor market, as well as to encourage women, through career advising, to seek employment in high growth and high wage sectors.¹⁵⁷

H. Data Collection

In addition, the appropriate international institutions, working in concert, should collect data, disaggregated by sex, on the health of women, with the goal of compiling an authoritative study of the impact of HIV/AIDS on women throughout their life cycle.¹⁵⁸ In that regard, it is necessary to encourage the exchanging and reporting of

¹⁵³ *Id.* at 26.

¹⁵⁴ *Id.* at 41

¹⁵⁵ *Id.* at 36.

¹⁵⁶ See J.M. Spectar, *Bridging the Global Digital Divide, Frameworks for Access & the World Wireless Web*, 26:1 N.C. J. INT'L L. & COM. REG. 57, 59-65, 90-103 (2000). The "digital divide" is the differentiation between those with access to the essential tools of the information society/knowledge economy and those without, especially where the latter are deprived due to structural economic and social factors largely beyond their control. *Id.* It is a growing gulf between those who enjoy access to the infrastructure of the networked society/economy and those who are deprived of access. *Id.* There is a growing consensus that this divide is both reflective and symptomatic of extant economic and social barriers. *Id.* Discussion of the digital divide tends to focus on the differential technology penetration between middle/upper income groups versus lower income persons, racial minorities and rural communities. *Id.* Yet, some maintain that the digital divide is about more than just socio-economic barriers to participating in the new economy; they urge policy makers to consider and address other related "gaps" such as the gender gap in technology. *Id.*; see also U.S. NAT'L TELECOMMS. & INFO. ADMIN., FALLING THROUGH THE NET: DEFINING THE DIGITAL DIVIDE, at <http://www.ntia.doc.gov/ntiahome/digitaldivide/summit.html> (Dec. 9, 1999). Summit participant, Mr. Arthur Tighe, encouraged policy makers to examine related 'gaps' such as gender, geography, and generational differences. See *id.*

¹⁵⁷ See *Women 2000*, *supra* note 1, at 36.

¹⁵⁸ *Id.* at 39.

data on the root causes and trends in violence against women, including trafficking in women.¹⁵⁹ It is also important to support and develop national statistical services and/or women's research institutes for gathering and analyzing data on the impact of socio-cultural conditions on the health of women/girls in the course of the AIDS pandemic. The data generated should be made available to national policy makers, NGOs and international organizations. International lending institutions should support national efforts to use information technologies to conduct research and to disseminate information about women's health.¹⁶⁰

I. *NGOs & Local Community*

National strategies should also take advantage of the expertise of NGOs, women-oriented community based organizations, and the perspectives of women and girls living with AIDS in the development of an effective response to the human rights dimensions of the pandemic.¹⁶¹ Often, local communities have the relevant expertise as well as the credibility to intervene effectively.¹⁶² Community members must be effectively incorporated into the effort to mobilize national commitment against the violations of the right to health and other human rights. At the international level, the U.N. and/or other appropriate international organizations and participating NGOs should assist governments to build institutional capacity and develop national anti-AIDS plans or implement existing plans.¹⁶³

J. *Energetic & Inclusive Political Leadership*

Improving the social and cultural conditions of women as well as stemming the tide of AIDS should be, for the most part, a nationally-driven agenda.¹⁶⁴ Inclusive political leadership can be instrumental in securing women's right to health to the extent that it performs essen-

¹⁵⁹ *Id.* at 28.

¹⁶⁰ *See id.* at 33, 38.

¹⁶¹ UNAIDS REPORT JUNE 2000, *supra* note 5, at 110 (noting that "responses to AIDS are in the first instance local[,] and that they imply the involvement of people in their neighborhoods, workplaces, schools and religious centers).

¹⁶² *Id.* at 88, 110-11.

¹⁶³ *See Women 2000*, *supra* note 1, at 47.

¹⁶⁴ UNAIDS REPORT JUNE 2000, *supra* note 5, at 7. As Peter Piot, the executive director of UNAIDS states, "while international political, financial and technical support are important, lowering incidence and mitigating the epidemic's impacts must be a *nationally* driven agenda." *Id.*

tial tasks such as: mobilizing human and financial resources, making necessary policy changes, passing needed legislation, and working with change agents closest to the level of impact.¹⁶⁵ Vigorous political leadership against AIDS must also work tirelessly to end the silence about the disproportionate suffering that HIV/AIDS causes women and young girls.

A major task for political leadership in the course of the pandemic is to help break the silence about the disproportionate impact of AIDS and AIDS-related dislocations on women in developing countries. Political leaders and respected members of the community must help reduce the stigma, shame, and vulnerability suffered by women and girls around the world by speaking openly about the pandemic. As Vice President Gore stated at the Security Council meeting on AIDS:

We must talk about AIDS not in whispers, in private meetings, in tones of secrecy and shame. We must face the threat as we are facing it right here, in one of the great forums of the earth—openly and boldly, with urgency and compassion. Until we end the stigma of AIDS, we will never end the disease of AIDS.¹⁶⁶

Political leaders should use the mass media, outreach programs, schools and workplaces to openly discuss how HIV is spread, as well as initiatives for preventing or reducing the disease without stigmatizing the affected persons or behaviors associated with HIV transmission.¹⁶⁷ Openness about AIDS at the highest levels of government would help end the ignorance about the disease—a key step in reducing the extreme vulnerability of young girls in developing countries. In addition, political leaders must express open and strong support for preventive measures such as the use of condoms, especially the female condom. Where appropriate, governments should support the use of hotlines and/or information seminars in rural areas so that trained counselors could disseminate accurate information.¹⁶⁸

¹⁶⁵ See *id.* at 108 (identifying political will and leadership as key components of an effective national response to the pandemic).

¹⁶⁶ See Gore U.N. Remarks, *supra* note 7.

¹⁶⁷ UNAIDS REPORT JUNE 2000, *supra* note 5, at 108 (identifying societal openness and determination to fight against stigma as key components of an effective national response to the pandemic).

¹⁶⁸ *Id.* at 42. The extraordinary success of an AIDS hotline in Egypt has provided a safe forum to discuss issues rarely addressed in public. *Id.* This is reportedly the only such hotline run by a government service in the Middle East. *Id.*

National political leadership at the frontlines of the struggle against AIDS must include women in key decision and policy-making positions on an equal basis with men.¹⁶⁹ In addition, political leaders must encourage the nomination of more women candidates to legislative bodies and other policy-making structures.¹⁷⁰

National leadership at the highest level has made some difference in countries like Uganda where, through the use of strong prevention campaigns, the prevalence rate has been brought down to 8% from a peak of about 14% in the early 1990s.¹⁷¹ Uganda is reportedly one of the first governments on the African continent to recognize the threat of HIV/AIDS to national development and to take active steps to combat the pandemic tinderbox by forming cooperative partnerships between the government, community development organizations and religious leaders.¹⁷² The broad-based approach led by President Yoweri Museveni coupled with a large increase in condom use, contributed to a reduction in the infection rate among thirteen- to nineteen-year-old girls and young pregnant women living in towns and cities.¹⁷³ More recently, there are signs that the government of Zambia has adopted a similar, multi-pronged approach to fighting AIDS, involving the private-sector, education, agriculture, industry, and religious or church groups.¹⁷⁴ Other African heads of state who have recently launched high profile campaigns—"wars"—against AIDS include, Bakili Muluzi of Malawi, Thabo Mbeki of South Africa, Festus Mogae of Botswana, Arap Moi of Kenya, Benjamin Mkapa of Tanzania and Olusegun Obasanjo of Nigeria.¹⁷⁵

Valuable lessons can be learned from the experience of the United States where the Clinton Administration has addressed the question of gender equity in relation to AIDS at the highest levels of government. For example, the President's Interagency Council on Women addresses the problem of gender bias in HIV treatment (treatment equity) by coordinating "actions to increase women's access to appropriate, affordable, and quality healthcare, information,

¹⁶⁹ See *Women 2000*, *supra* note 1, at 35.

¹⁷⁰ See *id.* at 36–37.

¹⁷¹ UNAIDS REPORT JUNE 2000, *supra* note 5, at 9.

¹⁷² *Id.*

¹⁷³ *Id.* The prevalence rate among teenage boys remained more or less stable. *Id.* The infection rate among boys is generally lower than girls' infection rate because "boys are less likely than girls to have partners in the older, more heavily infected age groups . . ." *Id.*

¹⁷⁴ *Id.* at 10.

¹⁷⁵ *Id.* at 38. In fact, the mounting death toll caused Presidents Arap Moi and Yoweri Museveni to reverse their long-standing opposition to condoms. See generally *id.*

and related services.”¹⁷⁶ In addition, the Council undertakes “gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.”¹⁷⁷

K. *Raising the Profile of Women's Health in International Law & Society*

International law and its rich normative domain of international human rights can, and must, play a key role in the empowerment and liberation of women worldwide. The health of women must not only be at the forefront of the global agenda, but certain offenses against women's health and well-being should be treated as crimes against humanity, susceptible to universal jurisdiction and the severest international sanctions.

The world is slowly awakening to the need to link women's health concerns with international human rights. The impact of the AIDS pandemic on women is spurring a rethinking of the right to health, its scope and the obligations it entails. Yet progress has been slow because, until recently, women's health and human rights were perceived as “separate and *unrelated* issues.”¹⁷⁸

Professor Allyn Taylor correctly observed that the lack of reference to “women's unique concerns in scientific and clinical discussions of HIV/AIDS, until recently,” has helped expose “the low priority” conventionally accorded to “longstanding concerns in women's health.”¹⁷⁹ The WHO and most of its member states did not begin to address the threat of the HIV pandemic to women's health until the beginning of the 1990s.¹⁸⁰ The inadequacy of international responses to the impact of HIV/AIDS on women has “underscored the fact that international organizations have neglected to promote and protect women's international right to health.”¹⁸¹ Additionally, Taylor concludes that “a history of discrimination is apparent in the way that international organizations have conventionally defined women's health and developed services for them.”¹⁸² Conventional medicine

¹⁷⁶ See INTERNATIONAL RESPONSE, *supra* note 2 (discussing U.S. national interests). The Council, chaired by the Secretary of State, is charged with coordinating the implementation of the Platform for Action adopted at the U.N. Fourth Conference on Women. The Council also encourages both women and men “to take responsibility for their sexual and reproductive behavior.” *Id.*

¹⁷⁷ *See id.*

¹⁷⁸ *See* Hendriks, *supra* note 84, at 1124.

¹⁷⁹ Taylor, *supra* note 14, at 305.

¹⁸⁰ *Id.* at 303.

¹⁸¹ *Id.* at 298.

¹⁸² *Id.*

tended to reduce female bodies to their "constituent sexual and reproductive functions," and accordingly, science has "tended to uniquely treat women only as it relates to reproductive functions."¹⁸³ Thus, the medical/scientific community has often limited its focus on women's health issues to reproductive health and, consequently, has ignored women's other unique health concerns.¹⁸⁴ The inadequacy of the international response to the impact of HIV/AIDS on women shows that "the crucial defect of this special concern for maternal health has been the failure of the international community to limit its application and pay sufficient attention to the promotion and protection of women's health beyond maternal health."¹⁸⁵

By the 1980s, many women's health and women's human rights activists acknowledged the "intrinsic relationship" between women's health and human rights, and began to collaborate on a search for solutions.¹⁸⁶ The spiraling AIDS pandemic, and growing recognition of the "health damage" inflicted on women as a result of human rights violations, increased awareness of the linkages between women's health and human rights.¹⁸⁷ As a result of these efforts, there is currently "an undeniable, worldwide reappraisal" of the matter of women's health as a human rights issue.¹⁸⁸ In addition, activists in the public health area are increasingly recognizing that international law can play a very important role.¹⁸⁹

Internationalizing the protection of women against extreme "health damage" can be accelerated by use of peremptory norm *jus cogens*—from which no derogation is allowed¹⁹⁰—and the concept of

¹⁸³ *Id.* at 304 n.26 (citing SUSAN SHERWIN, NO LONGER PATIENT: FEMINIST ETHICS AND HEALTH CARE 167, 193–94 (1992)).

¹⁸⁴ Taylor, *supra* note 14, at 304.

¹⁸⁵ *Id.*

¹⁸⁶ Hendriks, *supra* note 84, at 1124.

¹⁸⁷ *Id.* at 1125.

¹⁸⁸ *Id.*

¹⁸⁹ Fidler, *supra* note 90, at 2 (noting that public health antipathy toward international law is changing, and that the "globalization of public health" gives rise to the need for more international cooperation between states).

¹⁹⁰ See HOFFMAN, DUTIES BEYOND BORDERS 97 (1981) (citing RONALD DWORKIN, TAKING RIGHTS SERIOUSLY 92 (1978)). Rights accorded the status of *jus cogens* cannot be defeated by appeals to the "routine goals of political administration." *Id.* It is not uncommon for writers to seek to increase the list of peremptory norms *jus cogens*. See, e.g., Diller & Levy, *Child Labor, Trade and Investment: Toward the Harmonization of International Law*, 91 AM. J. INT'L L. 663, 664 (1997) (arguing that certain "extreme forms of child labor can be said to come within the scope of *jus cogens*, customary law and common treaty obligations relevant, in particular, to slavery, labor, and human rights"). See generally J.M. Spectar, *Pay Me Fairly Kathie Lee! The WTO, the Right to a Living Wage & a Proposed Protocol*, 20 N.Y.L. SCH. J.

"crimes against humanity." International efforts to protect women must designate sexual slavery, enforced prostitution, forced pregnancy, and the use of rape as a weapon of war as peremptory norms *jus cogens*. This designation is particularly warranted when certain gross abuses against women, including rape as a weapon of war, disproportionately subject women to extreme mortal peril, systematic and extreme abuse of the dignity of the person, or life-threatening illness and death. In this regard, the international community should support the Rome Statute of the International Criminal Court, which affirms that rape, sexual slavery, forced pregnancy, enforced sterilization and other forms of sexual violence constitute war crimes, and in certain circumstances, crimes against humanity—especially when these crimes are used as weapons of war.¹⁹¹ All member states of the UN should also consider signing and ratifying the Rome Statute.¹⁹²

Gross or persistent violations of such a peremptory norm *jus cogens* should trigger the severest responses by the international community. It is anticipated that the *jus cogens* designation for certain offenses against women's rights to health will announce, in the strongest possible terms, the international community's willingness to take a collective moral stance against abuses that, in collusion with AIDS, systematically destroy millions of women worldwide.¹⁹³

With regard to the profile of the right to health, it can be argued that its designation or characterization as just another second generation human right does not provide a solid framework for concerted international action to stave off the AIDS pandemic. Second generation human rights, as opposed to first generation, occupy a diminished and often uncertain international legal and diplomatic status.

INT'L & COMP. L. 61 (2000) (suggesting that the human right to a living wage may someday be accorded the status of a peremptory norm *jus cogens*).

¹⁹¹ See *Women 2000*, *supra* note 1, at 42.

¹⁹² *Id.* at 26.

¹⁹³ To be sure, many legal positivists would express serious concern about another new-fangled *jus cogens* norm, seeing it as another instance of licentious norm creation. See, e.g., Prosper Weil, *Towards Relative Normativity in International Law*, 77 AM. J. INT'L L. 413, 421–22 (1983) (arguing that the libertine elevation of certain norms over others—through designations such as *jus cogens* or *obligations erga omnes*—leads to norm dilution and a diminution of respect for norms). *Id.* It is contended that these new norms are entirely bereft of "legal value," and they pertain instead "to the realm of politics and morality." See INTERNATIONAL LAW AND DEVELOPMENT 98 (Paul de Waart ed., 1988). The positivist view is echoed in the *Lotus* case: "the rules of law binding upon states . . . emanate from their own free will." Weil, *supra*, at 420 (quoting 1927 PCIJ, ser. A., No. 10, at 18). To be sure, wanton norm creation would indeed erode respect for norms. Yet, it can hardly be argued that the creation of a new norm *jus cogens* to save life on earth is unduly forward.

In fact, the perception that the right to health is a “second generation” human right and/or soft international law is likely to weaken the prospects of a robust international response in defense of this right. Taking women’s human rights seriously, within the context of the AIDS pandemic, necessitates stricter sanctions for systematic violations of women’s right to health—especially in light of the effect of HIV/AIDS on women.

Meanwhile, the international community should support policies and programs for women and girls in armed conflict, including the prohibition of their forced recruitment.¹⁹⁴ In this regard, states should sign the ban on conscription of children into armed conflict. Additionally, member states should intensify efforts toward a comprehensive program of international demilitarization in order that the resulting peace dividend could be used for, among other things, efforts to realize the right to health of women and girls.¹⁹⁵ In particular, a comprehensive international regime should be undertaken to reduce excessive military expenditures, the arms trade, and investment for arms production and acquisition, including global military expenditures.¹⁹⁶

The international community should strengthen the legal regimes aimed at the elimination of “all forms of violence against women and girls” and “consider launching an international ‘zero tolerance’ campaign on violence against women.”¹⁹⁷ Governments must strive to eliminate any discriminatory provisions in the legal system, and where applicable, ratify and sign international treaties or conventions that protect women from discrimination, abuse and violence.¹⁹⁸ Further, efforts at the international level must encourage, through the media, “high awareness of harmful effects of certain traditional or customary practices affecting the health of women, some of which

¹⁹⁴ See *Women 2000*, *supra* note 1, at 13.

¹⁹⁵ See *id.*

¹⁹⁶ *Id.* at 13.

¹⁹⁷ *Id.* at 27, 38.

¹⁹⁸ *Id.* at 12; see, e.g., G.A. Res. 180, *supra* note 95, reprinted in BASIC DOCUMENTS, *supra* note 85, at 177–78; see also *The Rome Statute of the International Criminal Court*, U.N. Diplomatic Conf. of the Plenipotentiaries on the Establishment of an ICC, U.N. Doc. A/CONF.183/9 (1998) (providing that rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization and other forms of sexual violence are “war crimes” when committed in the context of armed conflict and, also under certain circumstances, “crimes against humanity”). Meanwhile, international organizations should also encourage states to include a gender perspective in their reports to treaty bodies. *Women 2000*, *supra* note 1, at 13.

increase their vulnerability to HIV/AIDS" and other STDs, and "intensify their efforts to eliminate such practices."¹⁹⁹

CONCLUSION

To arrest the spread of AIDS, and to reduce its impact on women and girls in developing countries, policy makers must attack the social and cultural dimensions of the pandemic. Since extant social conditions and practices fuel the pandemic, and thereby impair and imperil women's health, attempts to curb the spread of the pandemic must focus on the structural and contextual determinants shaping the course of the pandemic. To this end, it is essential for policy makers to embrace a holistic approach to women's health—one that is focused on the social and cultural conditions that significantly affect prospects for realizing this all-important goal.

There must be national and international efforts to strengthen and protect women's rights and to eradicate certain oppressive social/cultural conditions, with special emphasis on empowering all women. Addressing the socio-cultural dimensions of the pandemic will require the persistent engagement of governments, international organizations, NGOs and people at the grassroots level.²⁰⁰ To foster a culture of prevention, care and non-discrimination, policy makers must de-stigmatize AIDS through policies of social openness. Comprehensive policies and programs to fight the epidemic must be designed to empower women, girls and other inordinately vulnerable populations.

Meanwhile, the legal community of humankind must not shirk its responsibilities in the vortex of the pandemic. The women of the world must not be left to die in agony and shame. International law and the vibrant domain of international human rights can, and must, play a key role in the empowerment and liberation of women worldwide. The health of women, particularly the forgotten billion or two

¹⁹⁹ *Women 2000*, *supra* note 1, at 42.

²⁰⁰ See generally J.M. Spectar, *Saving the Ice Princess: NGOs, Antarctica & International Law in the New Millennium*, 23 SUFFOLK TRANSNAT'L L. REV. 57, 96–99 (1999) (noting that as states recede in influence, NGOs and other non-state entities linked by the world wide web and other communications technologies are likely to be at the vanguard of global change in the new millennium). See also J.M. SPECTAR, *THE PROMISE OF GLOBAL SOCIETY, MULTI-LEVEL PARTNERSHIPS & THE POSSIBILITIES OF POST-INTERNATIONAL RELATIONS* (forthcoming 2001) (arguing that a pluralistic network or framework of partnerships between state and non-state inter-actors is needed to manage the critical challenges facing global society).

in developing countries, should be placed at the epicenter of the international legal agenda. The same international community that said "No!" to murderous tyrants in the last century must now help refashion the Grim Reaper's scythe into a healer's scalpel. The moral community of humankind that has on occasion expressed itself above the din of Babel by elevating certain norms to the status peremptory norms *jus cogens* must declare itself once again. This, too, will not stand!

Winning the fight against this multi-dimensional global pandemic is possible. Yet, success will require a multi-pronged strategy. AIDS, like the mythical Hydra of ancient lore, will not be easily vanquished. In fact, this time around, every Head of the fabled beast appears vested with Gorgonian prowess. In its wake, it leaves a body count rivaling the most the fearsome tyrants, Genghis Khan, Idi Amin, Pol Pot, Stalin and Hitler. And its work is not done. Yet, amidst the woe, the wails, the hue and the cry, there lies hope: Humankind, determined, will triumph in a head-to-head with this Hydra.