

HIV/AIDS:

Reproductive Rights on the Line

HIV Disproportionately Impacts Women

Women and young people, especially adolescent girls, are particularly vulnerable to HIV infection due to an increased biological susceptibility and lower socioeconomic and political status.

- In several southern African countries, more than 30% of pregnant women are HIV-positive.¹
- In sub-Saharan Africa, women comprise 55% of those living with HIV/AIDS.²
- In some Caribbean countries, girls aged 15-to-19 are up to five times more likely than boys in their age group to be HIV-positive.³
- There are three times as many HIV-positive, heterosexual women as men in South Africa.⁴
- In the United States, adolescent girls constitute 61% of HIV-positive 13-to-19 year olds.⁵

In the two decades since the clinical identification of HIV/AIDS, the reproductive and sexual rights of women and girls continue to be ignored. The Center for Reproductive Rights has identified seven key areas of concern for HIV positive women and girls.

MOTHER-TO-CHILD TRANSMISSION OVERLOOKS MOTHER

While decreasing the mother-to-child transmission (MTCT) of HIV is an important goal—an estimated 540,000 infants were infected by their mothers during pregnancy, childbirth or through breastfeeding in 2000⁶—most MTCT prevention efforts have focused on the potential danger of HIV infection to the fetus, not the mother. "HIV-infected pregnant women have received a great

deal of attention," reads a report from the AIDS Office of the U.S. National Institutes of Health, "but this has mostly been focused on their role in preventing transmission to their offspring. Less attention has been given to these women as women."⁷

The June 2002 announcement by U.S. President George Bush of a funding initiative for Africa that provides anti-retroviral drugs (ARV) to pregnant women, is a clear example of a policy that unduly limits concern over a woman's health to her role as a mother. Such policies diminish the inherent importance of women's health, particularly when so little is known about the effects of pregnancy or ARVs taken only during pregnancy, on the health of HIV-positive women.⁸

Furthermore, policies aimed at curbing MTCT may also hold women solely accountable for their child's HIV infection, completely disregarding the role that men must play to prevent the transmission of HIV to children. Singling out mothers and ignoring fathers poses the added risk of alienating women who, to avoid blame and stigma, may forgo treatment that could improve their health and reduce the risk of transmission.

FORMULA VS. BREASTMILK: IMPACT ON HIV-POSITIVE WOMEN LOST IN THE DEBATE

The international health community is still debating whether the threat of HIV transmission to an infant through breastfeeding outweighs the risks of contracting pneumonia, diarrhea or other illnesses from ingesting formula that is defective or mixed with contaminated water. Current international guidelines recommend that HIV-positive women "be empowered to make fully informed decisions about infant feeding [through counseling about the risks and advantages of breastfeeding] and that they be suitably supported in carrying them out."⁹

National Policies Discriminate against HIV-Positive Mothers

Some countries have enacted national policies meant to curb MTCT that not only rely on inconclusive evidence, they curtail women's rights:

- In Bolivia, it is a crime for a mother to infect her child with HIV through breastfeeding.¹⁴
- Ghana has severely limited access to breastmilk substitutes for HIV-positive women by banning the sale, advertising or promotion of infant formula in public health facilities.¹⁵
- In Kenya, HIV-positive women are advised against breastfeeding, but are not ensured access to breast milk substitutes, nor given specific counseling on the merits and risks of substitute feeding.¹⁶

Yet, lack of decisive data on the relative risks and benefits of breastfeeding to infants and HIV-positive mothers continues to plague the debate on formula versus breastmilk.

One 2001 study conducted in four clinics in Nairobi, Kenya found no differences in the incidence of diarrhea, pneumonia, or other illnesses between breast and formula fed infants. Researchers concluded that formula-feeding to prevent HIV transmission can be a "safe and viable option even in resource poor settings" contingent on the availability of "maternal education, clean water, a supply of formula, and

access to health care."¹⁰ Other studies suggest that manipulating the type, duration and amount of breastfeeding has protective benefits for newborns that outweighs the risk of HIV transmission.¹¹

Research is still needed to assess the impact of breastfeeding and pregnancy in general on the health of HIV-positive mothers. The United Nations Inter-Agency Task Force on MTCT has called for analysis on whether breastfeeding impacts the disease progression and mortality of HIV-infected women.¹² Though little discussed, the high-energy demands and sleep deprivation associated with infant care, including breastfeeding, have been cited as factors that undermine the already weakened immune systems of HIV-positive women. In Kenya, for example, researchers found that the maternal mortality rate of HIV positive women who breastfeed is three times higher than that of women who formula feed.¹³

RIGHT TO PREGNANCY AND EVEN MARRIAGE AT RISK

Once a woman becomes HIV-positive, some national policies restrict her right to become pregnant, carry her pregnancy to term, or even marry:

- In Ethiopia, where abortion is severely limited and only 13% of women use contraceptives, the country's HIV/AIDS and Human Rights Policy states that "prevention of pregnancy shall be encouraged among HIV-positive individuals" without specifying how this policy will be implemented in an appropriate and non-coercive way.²³
- A 1999 Indian Supreme Court decision held that it is the duty of HIV-positive individuals not to marry, implying that HIV-positive people should not conceive.²⁴
- In January 2001, lawmakers made it a crime to marry anyone living with HIV/AIDS, in Chendgu, the capital of China's Sichuan province. The provincial regulations also suggest that pregnant HIV-positive women should be persuaded to have an abortion.²⁵
- In sub-Saharan Africa common findings suggest a general "emergence of doubts about continuing reproduction after HIV infection is confirmed."²⁶

LIMITED RIGHT TO ABORTION

In countries with restrictive abortion laws—where nearly 39% of the world's population resides—a woman's HIV status has not gained widespread recognition as grounds for obtaining a legal abortion under existing exceptions for risks to a woman's life, physical or mental health, or fetal impairment. Though the Center for Reproductive Rights urges all countries to liberalize their abortion laws, countries with restrictive laws must at a minimum regard HIV status as grounds for a legal abortion. Governments could either interpret existing exemptions for abortion to include HIV-positive status or list HIV status as a new exemption to abortion bans.

Only a few countries have abortion laws that allow HIV-positive women to terminate their pregnancies:

- Guyana's 1995 Medical Termination of Pregnancy Act permits abortion in cases "where the pregnant woman is known to be HIV-positive."²⁷

Nevirapine: A Safe and Accessible Alternative for HIV-Positive Mothers?

Nevirapine, combined with safe infant feeding methods has been shown to decrease the risk of MTCT by as much as 50%.¹⁷ But questions remain about its impact on women's health.

In April 2002, the World Health Organization (WHO) issued treatment guidelines for HIV/AIDS in resource-poor countries, which included anti-retroviral drugs (ARV) in its "essential medicines list."¹⁸ WHO defines "essential drugs" as those needed to "satisfy the health care needs of the majority of the population; they should therefore be available at all times . . . and at a price that individuals and the community can afford."¹⁹

According to WHO, nevirapine treatment costs only U.S. \$4 per pregnancy.²⁰ But in South Africa, activists had to petition the country's highest court to defeat government claims that the drug was too expensive for distribution in public hospitals.²¹ The next challenge facing all countries is to extend ARVs to all HIV infected people.

Meanwhile, studies must be conducted on viral resistance to ARVs and their impact on pregnancy and delivery, especially for HIV-positive women who have had multiple pregnancies.²² The dearth of such studies suggests that women are only obtaining ARVs when and because they are pregnant.

- In Poland, though not specified by law, HIV status has been interpreted as legitimate grounds for an abortion to protect the health of the woman. The policy has not been consistently applied.²⁸
- In Thailand, where abortion is only permitted to preserve the life and health of the pregnant woman, the Medical Council has recommended that a woman's HIV-positive status be recognized as a specific ground for obtaining an abortion.²⁹

In countries with liberal abortion laws, it remains unclear whether pregnant HIV-positive women receive complete and unbiased counseling about abortion and the risks of pregnancy and delivery to the health of both the woman and the fetus. In South Africa, for instance, providers are not required to discuss abortion with HIV-positive pregnant women even though 1999 statistics indicate that 23% of women attending antenatal clinics in urban areas carry the virus.³⁰

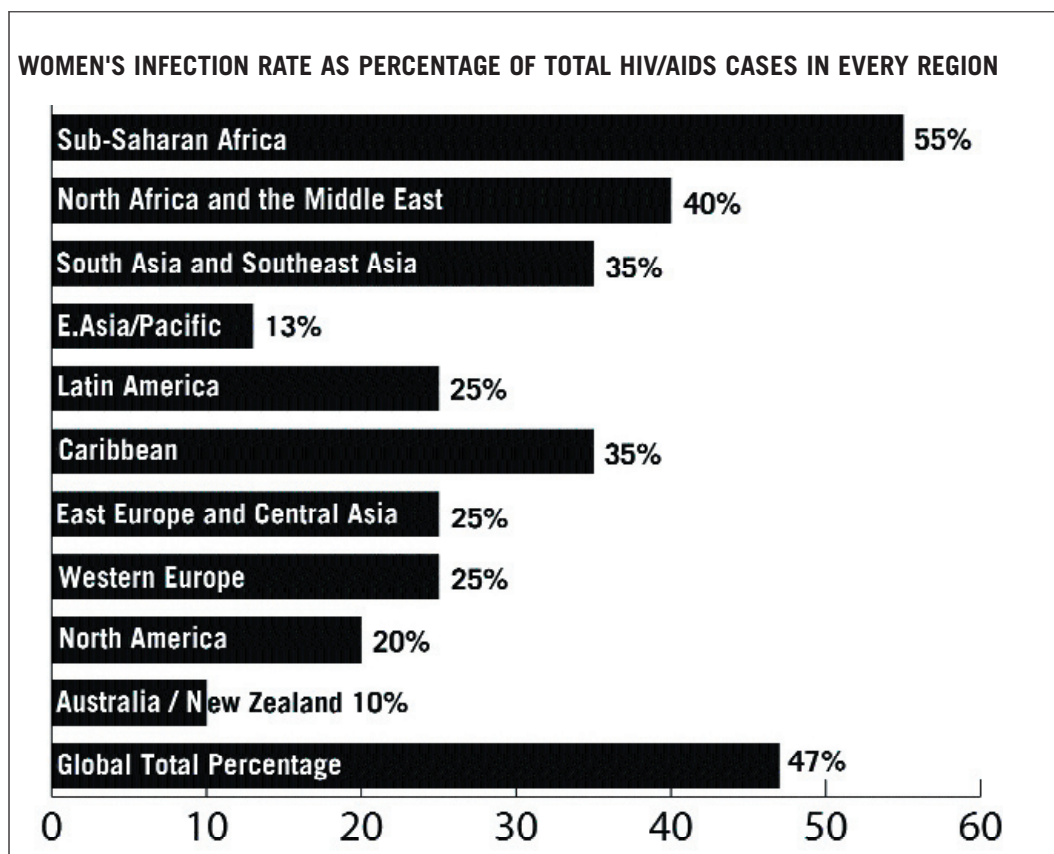
DANGER OF COERCED ABORTIONS

In India, there is an increasing tendency for women living with HIV/AIDS to opt for abortions.³¹ Many of these women say that medical providers advised them to undergo the procedure without full and accurate information on MTCT, which introduces an element of pressure.³² According to the Office of the High Commissioner for Human Rights (OHCHR) and the Joint United Nations Program on HIV/AIDS (UNAIDS), India is not alone in using this tactic; programs targeting pregnant women "often emphasize coercive measures directed towards the risk of transmitting HIV to the fetus, such as mandatory . . . testing followed by coerced abortion or sterilization."³³

The International Guidelines on HIV/AIDS issued by UNAIDS and the OHCHR mandate that "[w]omen should be provided with accurate information about the risk of perinatal transmission to support them in making voluntary, informed choices about reproduction."³⁴

UNAIDS has outlined a three-prong strategy to reduce MTCT that includes the prevention of "unwanted pregnancies in HIV-positive women and women at risk for HIV infection through [v]oluntary [c]ounseling and [t]esting of women and their partners in the context of family planning services."³⁵ The World Health Organization (WHO) has stated that when pregnant women test positive for the virus they should be counseled, among other things, on the option of continuing the pregnancy and must be referred to an appropriate clinic. WHO further specifies that women should have access to safe abortion, where legal, and be given "the information to make an informed decision without undue influence from health care workers and counselors."³⁶

Abortion policies pertaining to HIV-positive women should also account for unintended pregnancies that result from violence or unavailable or failed contraceptives. Specific counseling should be devised for women who discover their HIV status once they are already pregnant and seeking antenatal care.



Source: UNAIDS & WHO, AIDS epidemic update (2001)

MANDATORY TESTING PROMOTES STIGMAS

Requiring pregnant women to be tested for HIV discourages them from seeking prenatal care. Mandatory testing requirements may also put women at risk of physical abuse, abandonment, neglect or even ostracism by their husbands, partners or community. Studies from Kenya report that 20% of HIV-positive women suffer violence after revealing their status to their partners.³⁷ A study conducted in Tanzania found that more than half of the 242 women who were tested for HIV did not tell their partners about the test, regardless of their HIV status, because of "fear of their partner's reaction, principally fear of abuse or abandonment."³⁸

Despite such harmful consequences, some countries maintain policies for mandatory HIV testing and status notification, which disproportionately affect women. The Romanian Ministry of Health adopted a policy of targeting pregnant women for mandatory testing in 1998.³⁹ In Zimbabwe, the HIV/AIDS policy advocates enacting legal provisions that enable health professionals to disclose a patient's HIV status to "those who have critical reasons to know," even if the patient refuses.⁴⁰

Mandatory testing and reporting is also practiced in the U.S. states of New York and Connecticut. New York's law requires the reporting of persons with HIV, HIV-related illness and/or AIDS. The law permits health providers to notify sexual or needle-sharing partners of the HIV-

positive individual of their exposure and requires that pregnant women who take a confidential HIV-test and test positive are reported to the health department.⁴¹ In New York and Connecticut, all newborns are subject to mandatory testing for HIV, which effectively exposes the HIV status of their mothers.⁴²

WOMEN'S SEXUALITY UNDER ATTACK

Despite evidence that men's sexual practices play a far greater role in the high prevalence of HIV, government and traditional leaders around the world have demonized and stigmatized women's sexuality, identifying it as the key to both prevention and containment:⁴³

- A Zimbabwean chief has launched an annual event "honoring" local women with "virginity certificates."⁴⁴
- In South Africa, a few HIV-positive men have raped girls as young as 9 months old because of a myth that sexual intercourse with a female virgin will cure HIV.⁴⁵
- The Swazi king has announced a five-year ban on sex for young women.⁴⁶

Efforts to control women's sexuality rely on discriminatory social and cultural stereotypes and fail to address men's role in driving the pandemic. They constitute violations of the sexual and reproductive rights of women and girls.

Conservative forces in many countries have seized on the pandemic to promote abstinence-only sexuality education, which often targets young girls and women. When resources are allocated for abstinence-only education, it is at the expense of more comprehensive sexuality education programs that present a "balanced, medically correct program including both abstinence and protection against disease and unintended pregnancy."⁴⁷ Sexual health programs likewise suffer as a result of such skewed budgetary priorities. Apart from denying adolescents critical and often life-saving information, abstinence-only programs have not succeeded in curbing the sexual behavior of adolescents.⁴⁸ A 2001 study by the U.S. Surgeon General, found "no scientific support" for concerns that sexual education in the classroom results in earlier sexual activity among teens. The study also revealed that students receiving comprehensive sexual education are more likely to use condoms or contraceptives if they become sexually active.⁴⁹

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RESPONSE FROM THE INTERNATIONAL COMMUNITY

In June 2001, the United Nations (UN) held a landmark Special Session of the General Assembly on AIDS. 189 governments adopted a Declaration of Commitment that outlined tangible steps governments must take to combat the global HIV/AIDS crisis. Among its time-bound targets, the Declaration also called for governments to "ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS that . . . fully promote all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health" by 2003.⁵⁰ A Global AIDS Fund, with a fundraising goal of seven to ten billion dollars a year, was also established for HIV/AIDS prevention, care and treatment programs.⁵¹

The Declaration also recognized the strong link between gender equality and rates of HIV infection.⁵² While the Declaration did not explicitly highlight reproductive rights, it did acknowledge that gender discrimination and barriers to young people's access to sexuality information, education, and communication have been key to the spread of HIV/AIDS. It also reaffirmed the commitments made at the 1994 International Conference on Population and Development in Cairo, the 1995 Fourth World Conference on Women in Beijing, and their five year reviews, to promote women's empowerment in matters related to sexual and reproductive health, particularly HIV/AIDS.⁵³

The Center for Reproductive Rights urges governments to accept their international legal obligations to protect the sexual and reproductive rights of HIV-positive women and girls.

Endnotes

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- 14 See CENTER FOR REPRODUCTIVE LAW AND POLICY, WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES—LATIN AMERICA AND THE CARIBBEAN 42 (1997).
- 15 See CENTER FOR REPRODUCTIVE RIGHTS, WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES—ANGLOPHONE AFRICA PROGRESS REPORT 40 (2001), ANGLOPHONE AFRICA PROGRESS REPORT].
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- 17 See WORLD HEALTH ORGANIZATION (WHO), FACT SHEET 10: WOMEN AND HIV AND MOTHER TO CHILD TRANSMISSION 2000, available at www.who.int/health-services-delivery/hiv_aids/English/factsheet-10/index.html [hereinafter WHO, FACT SHEET 10].
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