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BRIEFING PAPER

UNGASS on HIV/AIDS: Women's Empowerment Embraced, Reproductive Rights Slighted

From June 25-27, 2001, the United Nations (UN) held the first ever General Assembly Special Session (UNGASS) to address the HIV/AIDS pandemic. The Special Session addressed the pandemic not only as a global public health issue, but also as a looming development and security crisis requiring a multi-sector, multi-front strategy.[1] Delegates from the highest levels of their national governments, including 12 heads of state and 14 heads of government, participated in the UNGASS.[2] In addition, more than 900 members of civil society, including 450 non-governmental organizations (NGOs) and numerous people living with HIV/AIDS (PLWHAs), attended the Special Session.[3] Although allotted a small formal role within the UNGASS, these individuals brought a crucial perspective and momentum to the process.

After limited pre-sessional negotiations, government delegates struggled to reach consensus on the Declaration of Commitment on HIV/AIDS (the Declaration),[4] and to mobilize the political will and economic resources needed to combat the epidemic. In addition to the plenary debate, the UNGASS also featured four round table discussions (the Round Tables), composed of national delegates and civil society representatives, to examine specific aspects of the epidemic, namely: 1) Prevention and Care; 2) HIV/AIDS and Human Rights; 3) Social and Economic Impact and the Strengthening of National Capacities; and 4) International Funding and Cooperation.[5] These Round Tables were a unique attempt within a UN conference to facilitate dialogue between Member States, UN agencies and civil society actors with expertise in the focus area.[6]

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I. Introduction

Several areas proved controversial during the negotiations on the Declaration, in particular the debt burden of low-income nations most affected by HIV/AIDS,[18] the creation of a Global AIDS Fund, and the constraints placed on NGO and youth participation during the UNGASS. However, it was the unwillingness of many conservative governments to identify specifically vulnerable groups within the Declaration – such as men having sex with men, sex workers and their clients, and injecting drug users – that proved most contentious during the negotiations.[19] Overall, however, even with weakened language regarding at-risk groups, the resultant Declaration calls for bold actions to address HIV/AIDS at the community, national, and international level.

In the two decades that have passed since its initial identification,[7] HIV/AIDS has grown into a pandemic that has devastated families and communities worldwide. Over the past 20 years, AIDS-related illnesses have taken the lives of more than 19 million people[8] and have left more than 13 million children orphaned.[9] Currently, an estimated 40 million adults and children carry the virus.[10] Its effect has been greatest in sub-Saharan Africa, where several nations report prevalence rates exceeding one out of every five adults.[11] In other regions, although prevalence rates have remained lower by comparison, the sheer number of infected persons threatens to overwhelm public health care infrastructure. In South and Southeast Asia, the number of HIV-positive people now stands at 6.1 million.[12]

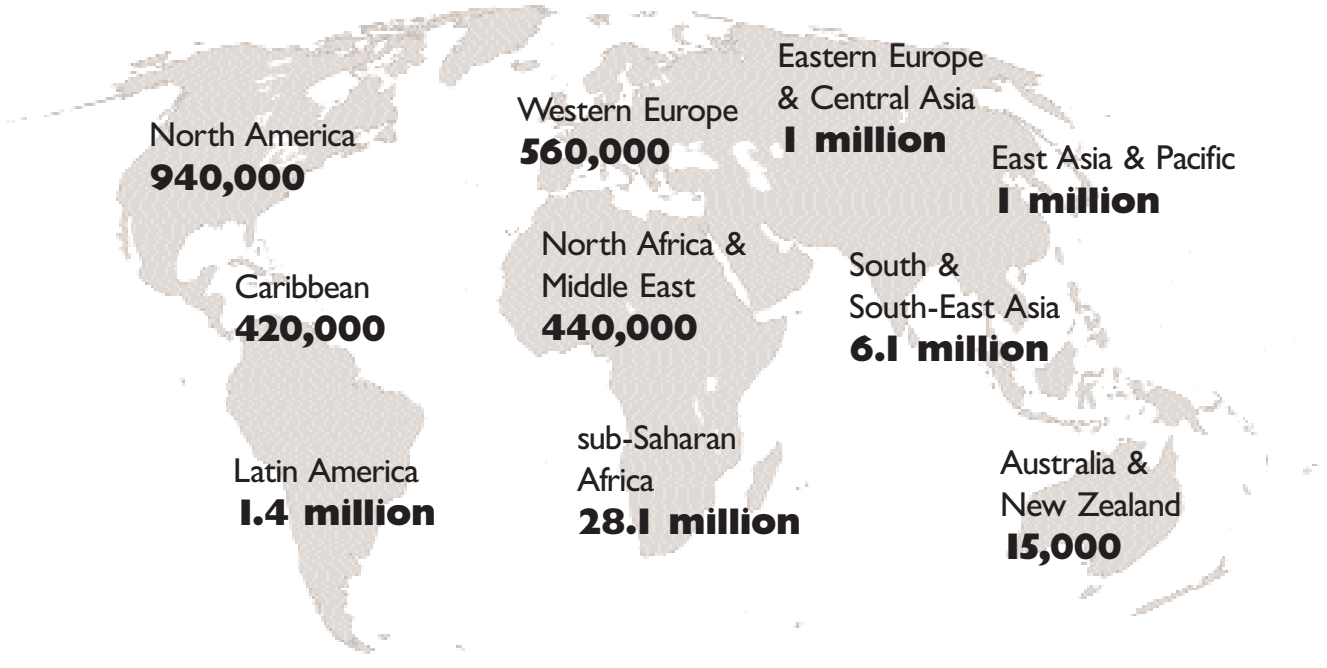
Although different modes of transmission have fueled the spread of the virus,13 women and young people, particularly adolescent girls, are most at risk for HIV infection. Biological susceptibility, combined with lower economic, social and political status contribute to women and adolescents' increased vulnerability to infection.[14] Women now represent over half the total number of all cases in the worst affected African countries,[15] and face increasing vulnerability to HIV infection in every region of the world. Adolescents currently account for half of all new infections.[16] In the United States, adolescent girls constitute 64% of HIV-positive 13-19 year olds.[17]

Many aspects of the Declaration stand out as important gains, in particular its focus on concrete, time-bound actions, unusually specific provisions for funding and resource allocation, and the protection of the rights of people infected and affected by HIV/AIDS. Also unusual in international instruments, the Declaration charges governments with contributing significant financial resources – between U.S.$7 and $10 billion annually – to HIV/AIDS prevention, care, and treatment programs in the most affected countries.[20] In addition, the Declaration calls for strengthened partnerships between governments, political leaders, and civil society, particularly PLWHAs, women, youth, and other vulnerable groups.[21]

One critical achievement of the UNGASS was the inclusion of some language within the Declaration promoting the health and rights of women and girls in the context of HIV/AIDS. Although the Declaration fails to explicitly address the broader concept of reproductive rights or the need for governments to provide comprehensive reproductive health care services, the Declaration makes clear the inextricable link between gender

equality, equity and empowerment and the ability of women and girls to protect themselves from HIV infection.[22] It likewise acknowledges that gender discrimination and barriers to young people's access to sexuality information, education, and communication (IEC) have been formidable factors in fueling the spread of HIV/AIDS.[23] Though taking a more limited approach, the Declaration reaffirms the commitments made at the landmark 1994 International Conference on Population and Development (ICPD),[24] the 1995 Fourth World Conference on Women (Beijing),[25] and their five-year reviews[26] to promote women's empowerment in matters related to sexual and reproductive health, particularly HIV/AIDS.

This paper will analyze issues that affected civil society participation and inter-governmental negotiations during this historic Special Session. It will then examine the strategies outlined in the Declaration of Commitment to protect and promote the reproductive health and human rights of women and girls infected and affected by HIV/AIDS.



II. The UN General Assembly Special Session

A. BACKGROUND TO THE PROCESS

In July 2000, the first major international AIDS conference to be held in the South took place in Durban, South Africa. It spotlighted the realities that sub-Saharan African and other low-income nations face in combating HIV/AIDS. From its opening, this conference emphasized the link between poverty and a lack of public-health infrastructure, and the rampant spread of HIV/AIDS.[27] Within the same month, the UN

Security Council passed a resolution recognizing the considerable threat that HIV/AIDS poses to international and regional stability and security. The resolution called for additional actions "among relevant United Nations bodies, Member States, industry, and other relevant organizations" to discuss issues on HIV/AIDS prevention and care.[28] This call to action was reiterated during the September 2000 Millennium Summit when the General Assembly voted to hold an emergency special session to address the problem of HIV/AIDS.[29]

Following the September General Assembly resolution, the secretariat of the Joint United Nations Programme on HIV/AIDS (UNAIDS) embarked upon the unprecedented challenge of organizing an international conference – to be attended by heads of state and high-level officials – with only nine months preparation time. Unlike other UN conferences or special sessions – which generally result from at least two years of planning and negotiations – the UNGASS on HIV/AIDS was organized with only two series of informal consultations among Member States, held in New York City from February 26 - March 2 and from May 21 - May 25, 2001.[30]

B. ROLE AND DYNAMICS OF GOVERNMENT BLOCS

Throughout the pre-session and main plenary negotiations on the Declaration, four groups emerged as unified negotiating blocs on most issues: the European Union (EU), represented by Sweden; the Rio Group, led by Chile; a group of Islamic states, led by Egypt; and the Southern African Development Community (SADC), led by Zambia. The EU maintained the progressive stance it has taken in other recent UN inter-governmental negotiations in advocating for strong language on sexual and reproductive health rights and the rights of individuals to a full range of sexual and reproductive health information and services.[31] The Rio Group, comprised of several Latin American countries that had taken a similarly progressive position at the five-year review of the Beijing Conference (Beijing+5),[32] stood firmly in support of the rights of women and girls in matters relating to sexual and reproductive health and HIV/AIDS prevention. These delegations also provided a strong voice in discussions on AIDS treatment medications and the need for affordable drugs and the development of domestic pharmaceutical industries in low- and middle-income countries.[33]

The Zambia-led SADC bloc likewise stood its ground amidst pressure from conservative governments and pushed for language supporting women's and girls' human rights in matters related to reproductive health, sexuality, and HIV/AIDS prevention, treatment, and care. In many instances, countries such as Australia, Canada, Lichenstein, New Zealand, and Senegal joined forces with SADC, the EU, and the Rio group in support of women's and girls' full enjoyment of human rights, adolescent- and youth-specific concerns, and the rights of vulnerable and at-risk populations.[34] A group of Islamic states[35] objected vociferously in debates surrounding these issues and maintained strong opposition throughout the negotiations to any language referring explicitly to gay/bisexual men's vulnerability to HIV infection.[36]

Notably, during the UNGASS, the Vatican and the United States altered their recent positions and negotiating strategies vis-à-vis reproductive and sexual health issues. The Vatican, which usually speaks out strongly against the inclusion of language on reproductive rights, adolescent sexuality, and individuals' access to contraceptive information and services, remained remarkably quiet in this forum. While the Vatican entered its usual reservations to UN consensus documents to the Declaration,[37] its participation throughout the UNGASS indicated a willingness to ensure progress on negotiations.[38] In disappointing contrast, the U.S. delegation stood for the first time in recent years as a fairly conservative voice in UN negotiations. Although many if its interventions related to drug pricing and manufacturing and to manufacturers' compliance with intellectual property rights,[39] the U.S. delegation also lobbied extensively for language on HIV/AIDS prevention that emphasized abstinence, at times at the expense of references to broader HIV/AIDS prevention and sexuality education components and to reproductive rights explicitly.[40]

C. CIVIL SOCIETY PARTICIPATION

Like in many UN fora, the pre-session and plenary negotiations of the UNGASS demonstrated the tensions that exist between calls for civil society participation at the United Nations and the actual mechanisms for NGOs to openly and fruitfully participate in UN conferences. Statements made by UNAIDS, acting as the secretariat throughout the preparatory process, acknowledged the central role that civil society actors have played in the fight against HIV/AIDS,[41] particularly in communities where government commitment to address HIV/AIDS and sexuality issues remains disturbingly weak. Furthermore, the General Assembly resolution establishing the process for this UNGASS encouraged Member States and Observers to include in their national delegations "civil society actors, people living with HIV/AIDS or representatives of their associations, … young people's organizations," and representatives from the private sector.[42] Participation of NGOs and PLWHAs was similarly encouraged for the Round Tables, in which government delegates and selected civil society actors with expertise in matters related to HIV/AIDS and medical, social, and economic issues were ideally to speak on equal footing.[43]

In reality, however, civil society representatives faced many obstacles to their effective participation in the UNGASS process. Despite recommendations to include them in national delegations, relatively few countries did so, and even fewer specifically incorporated youth, gender, and PLWHA perspectives.[44] Overall, 41 Member States out of 189 included civil society actors on their national delegations.[45] Many NGOs, particularly youth and PLWHA organizations, interpreted this marginalization as a lack of commitment by their governments to directly address HIV/AIDS and its intersection with poverty, gender, sexuality, and life style issues.[46]

The General Assembly resolution establishing the process for the UNGASS encouraged Member States and Observers to include in their national delegations "civil society actors, people living with HIV/AIDS or representatives of their associations, … young people's organizations," and representatives from the private sector. In reality, however, only 41 Member States out of 189 included civil society actors on their national delegations.

Likewise, because the informal consultations took place in New York City, many overseas groups were effectively excluded from providing input, due to prohibitive travel costs.[47] The groups that did attend the informal consultations in May found that only one civil society intervention was allocated, for which four civil society representatives were elected to present brief statements and respond to delegates' questions.[48] However, because the official intervention was scheduled for the evening of the first day, following an intense and lengthy series of meetings, only about 20 delegates remained in the hall for the statements.[49] A second dialogue opportunity was eventually added, but was scheduled for lunchtime of the third day and was conducted without any translation services. The inconvenience of the time slot again led to extremely limited attendance by delegates, while the absence of translation forced the diverse participants to struggle with English.[50]

Another serious threat to NGO participation and to the inclusion of diverse perspectives in the negotiations was the unsuccessful attempt by a group of Islamic states to void the appointment of a gay-and-lesbian-human-rights activist to the Round Table on HIV/AIDS and Human Rights. This attempt to silence the participation of gay, bisexual, and transgendered persons in this forum seriously undermined the call for substantive cooperation between governments and NGOs.[51] In the end, many NGOs voiced their frustration over the conflicting signals from the UN and from Member States, who called for civil society participation in the Special Session process but made their actual input very difficult.

III. Assessing the Declaration of Commitment on HIV/AIDS

A. OVERALL GAINS

Prior to analyzing the substantive sections of the Declaration, this section will highlight three overall gains – the focus on women's rights, the emphasis on the right to health, and the pledge of tangible resources to combat HIV/AIDS.

1. *Women's Rights get Center Stage*

Women's empowerment constitutes one of the Declaration's most pervasive themes.[52] The preamble recognizes that "gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS."[53] The section on HIV/AIDS and Human Rights, discussed in section B below, contains several provisions that elaborate on this commitment to women by linking the realization of women's human rights with containing and overcoming the pandemic.

Recognizing the importance of involving women in decision-making, the Declaration also commits to include women and young people – as members of vulnerable and at-risk groups – and PLWHAs in the development and implementation of national strategies and financing schemes to combat the pandemic.[54]

The Declaration further recognizes that many of the same obstacles that hamper the realization of women's rights also undermine HIV/AIDS prevention, care, support, and treatment efforts.[55] For example, while the preamble emphasizes "the important role of cultural, family, ethical and religious factors" in fighting the pandemic,[56] it notes "with concern that some negative economic, social, cultural, political, financial and legal factors are hampering awareness, education, prevention, care, treatment and support efforts."[57] Unfortunately, however, this provision of the Declaration stops short of explicitly stating that certain religious and familial influences also present obstacles to such efforts. Instead, it calls on countries to "develop and/or strengthen strategies, policies and programmes, which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors ...."[58]

Despite repeated reference to the importance of (potentially conservative) familial and religious influences in the battle against the pandemic,[59] the Declaration emphasizes "that in different cultural, social and political systems various forms of the family exist."[60] This language, however, while encompassing cohabiting couples, single-parent families and same-sex couples, could also be interpreted to include polygamous unions, which are associated with the lingering subordination of women in society.

Moreover, the important focus on women's rights represents a compromise gain. While women feature prominently in the Declaration, the political tradeoff was to eliminate specific mention of groups vulnerable to infection. The original draft provision that named the vulnerable groups, including "men who have sex with men, sex workers and their clients, injecting drug users and their sexual partners," was diluted and replaced with the vague reference to "sexual practices, drug using behaviour, [and] livelihood."[61]

2. Emphasis on the Right to Health as a Basic Human Right

The Declaration made groundbreaking advances toward bridging the artificial separation between civil and political rights, and economic and social rights. Traditionally, the right to health has been included in international instruments encompassing only social and economic rights, such as the International Covenant on Economic, Social and Cultural Rights.[62] Cold War politics[63] led many Western governments to champion civil and political rights, as represented by the International Covenant on Civil and Political Rights,[64] as "core" or "first generation rights," whereas they regarded the right to health, along with other economic and social rights, as a "lesser" right.[65]

Previous UN documents have also treated health as a "development" issue, and have failed to recognize the actual linkages between health and mainstream civil and political

human rights.[66] In this Declaration, however, the right to health is inextricably bound to a host of interrelated, fundamental human rights.[67] Numerous provisions emphasize the importance of the promotion of human rights and fundamental freedoms in curtailing a development crisis sparked by this epidemic.[68]

Moreover, the Declaration goes beyond merely singling out the human right to health and linking it to civil and political rights. It actually requires that states put financial resources into realizing the right to health, and monitor and enforce human rights protection by target dates. The Declaration provides that by 2003, governments must "ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that … fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health."[69] At the same time, it also sets up a global fund and sets target annual expenditures to be allocated to fighting the epidemic.[70]

The Declaration signals an emerging trend toward international consensus on the indivisibility and interdependence of the two sets of rights, at least in the context of the AIDS pandemic. Nevertheless, some governments, in particular the United States, shied away from recognizing such indivisibility and successfully advocated for dilution of some of the human rights language.[71]

3. Resources and Follow-up Pledged to Facilitate Achievement of Goals

One of the most groundbreaking features of the HIV/AIDS Declaration is the resource allocation and follow-up mechanisms associated with it. Unlike virtually any other international instrument dealing with human rights and development issues,[72] the

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Declaration calls for the commitment of annual expenditures, set at U.S.$7-10 billion, and outlines rough measures for collecting resources and ensuring allocation.[73] One of the most innovative mechanisms is the establishment of a global HIV/AIDS and Health Fund to ensure an integrated approach to battling the pandemic.[74] Contributions to the Fund will be mobilized from the public and private sectors, including pharmaceutical companies and private philanthropists.[75]

In addition, the Declaration urges "developed" countries to meet agreed-upon targets of 0.7% of Gross National Product (GNP) for development assistance;[76] welcomes the pledge of African countries to allocate 15% of their national budgets for health sector improvement;[77] and calls for a worldwide multi-sector fund-raising campaign to commence in 2002.[78] The Declaration reinforces the Millennium Declaration's call to cancel the bilateral and multilateral debts of Heavily Indebted Poor Countries (HIPC), and to address debt problems plaguing low- and middle-income countries, in particular those most affected by HIV/AIDS.[79]

Finally, unlike all other major UN consensus documents, which lack built-in review mechanisms or which rely on a 5- or 10-year review process, the Declaration mandates an annual review by the General Assembly. The General Assembly will devote "at least one full day" of its annual sessions to review progress in implementing the Declaration and to identify constraints and recommend additional action.[80]

B. HIV/AIDS AND HUMAN RIGHTS

The Declaration unequivocally states that the "full realization of human rights is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment."[81] It further recognizes that ensuring human rights is strongly associated with reducing vulnerability to HIV/AIDS and preventing "stigma and related discrimination against people living with or at risk of HIV/AIDS."[82] Overall, however, agreed language on HIV/AIDS and human rights was weakened and diluted by controversy.[83] For example, proponents of strong links between human rights and HIV/AIDS lost the battle for the inclusion of references to the UN International Guidelines on Human Rights and HIV/AIDS, affirmed by the UN Commission on Human Rights, which offer concrete measures to protect human rights and health in the context HIV/AIDS.[84] In addition, the phrase "rights-based approach" disappeared from the Declaration and was replaced with "[r]ecognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic."[85]

Nonetheless, a major achievement of the Declaration is its link between upholding human rights and curtailing the spread of HIV/AIDS. The following four provisions reflect this link, and the latter three do so with key time-bound goals:

- The preamble lists the "active promotion and protection of human rights" as a cornerstone in national progress in containing the HIV/AIDS epidemic.[86]
- Paragraph 37 requires that by 2003, governments "ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that … fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health." Such plans must also "confront stigma, silence and denial … [and] eliminate discrimination and marginalization."
- Linking human rights to legal measures, paragraph 58 states that "by 2003, [governments shall] enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to, inter alia education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic."

- The Declaration aims to ensure national follow-up mechanisms, providing that "by 2003, [states are to] establish or strengthen effective monitoring systems, where appropriate, for the promotion and protection of human rights of people living with HIV/AIDS."[87]
- The Declaration also clearly links human rights and HIV/AIDS with improving the status of women.[88] Recognizing that "globally women and girls are disproportionately affected by HIV/AIDS," it calls on states to "by 2005 … develop and accelerate the implementation of national strategies that: promote the advancement of women and women's full enjoyment of all human rights."[89] It also strengthens a provision first agreed to at Beijing+5,[90] that curtailment of girls' and women's vulnerability to HIV/AIDS will be ineffective without the "elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls."[91]

C. REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

1. Reproductive Rights Slighted

While the Declaration generally recognizes the important links between human rights and health, especially in the context of HIV/AIDS, it fails to include the term "reproductive rights," or to otherwise reaffirm a comprehensive approach to addressing the right to sexual and reproductive health and self-determination, as was advocated in previous international instruments.[92] Even as the Declaration moves toward emphasizing the interdependence of civil freedoms and health, these rights remain bifurcated in the context of reproductive health and rights.[93]

While the initial draft Declaration referred to reproductive rights, subsequent negotiations narrowed those references to "reproductive health," and only in relation to HIV/AIDS.[94] Moreover, though Beijing and ICPD receive explicit mention in the Declaration's preamble, the two specific references to reproductive health in the Declaration were diluted to pertain solely to HIV/AIDS, rather than to reinforce a holistic approach to human rights and the provision of comprehensive reproductive health services. These previous conferences, in contrast, recognized that reproductive rights consist of interrelated human rights that will be undermined if provided separately or in isolation of each other.

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For example, whereas Beijing and its five-year review upheld the right of decision-making over one's "sexuality, including sexual and reproductive health, free of coercion, discrimination and violence,"[95] the Declaration retained only a single reference to these rights.

Paragraph 59 states that women should be empowered "to have control over and decide freely and responsibly on matters related to sexuality *to increase their ability to protect themselves from HIV infection*" (emphasis added).[96] However, although this paragraph addresses only the reduction of HIV transmission, it does add a strong provision stating that national strategies to this end be implemented by 2005, a target not found in Beijing+5's more comprehensive language.[97]

2. Reproductive Health Services Debated

Controversy in the Preparatory Committee (PrepCom) negotiations for the 10-year Review of the World Summit for Children, which were in process during the last stage of negotiations on the HIV/AIDS Declaration, resulted in the phrase "reproductive health services" being replaced with a narrower reference to the "provision of health care and health services, including sexual and reproductive health" in the context of "measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection."[98] Conservative governments successfully argued that "reproductive health care" should replace "reproductive health services," as the latter could be construed to include abortion, although only where legal.[99] Such an approach is detrimental to the rights of women living with HIV/AIDS, who should be able to access legal abortion services where local law permits.

3. Previous Commitments Affirmed

The Declaration "recall[s] and reaffirm[s] … previous commitments on HIV/AIDS" included in the ICPD+5 Key Actions document, the Beijing+5 review document, the World Summit for Social Development 2000 review, the UN Millenium Declaration, and the seven regional declarations on HIV/AIDS.[100] This general affirmation is significant because by definition, it encompasses the reproductive rights and health commitments agreed to at these conferences.[101] However, as discussed above, the Declaration fails to directly and fully address reproductive rights or reproductive health. Nonetheless, the Declaration contains strong time-bound targets for realizing certain reproductive and overall health goals and pledges of financial resources.

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D. PREVENTING AND REDUCING PREVALENCE OF HIV/AIDS

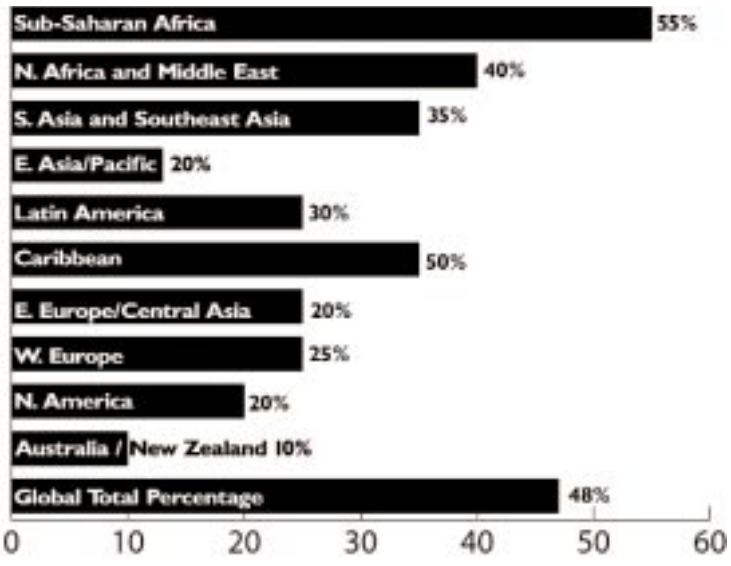
Although prevention constitutes the "mainstay" focus of the Declaration,[102] the document treats prevention as limited only to transmission of HIV. It therefore fails to incorporate the comprehensive approach set out in Beijing+5 and ICPD+5, which calls for broad reproductive health services and information aimed at preventing all sexually transmissible infections (STIs), including HIV/AIDS. The absence of this broader approach to prevention within the Declaration is dangerous, especially in light of the high correlation between the incidence of HIV and other STIs.

Paragraph 47 reaffirms ICPD+5's STI prevention goal (though limited to HIV/AIDS) in calling on governments to "[b]y 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010."[103] The same paragraph also emphasizes the critical need "to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys."[104] However, the Declaration maintains that prevention programs must account for "local circumstances, ethics and cultural values."[105]

Under conservative pressure and in exchange for including abstinence and fidelity as prevention strategies,[106] the Declaration concurrently calls for "expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counseling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections."[107]

An earlier draft's reference to "widespread and effective prevention" was tempered by conservative government blocs, including an alliance of some Islamic states, the Vatican and the United States, which successfully lobbied for the inclusion of language on "responsible sexual behaviors, including abstinence and fidelity."[108] While this emphasis should be one aspect of prevention programs, reproductive rights advocates cautioned against the unrealistic focus on an "abstinence only" approach and against furthering the damaging stigma that individuals are infected because of their "irresponsible" sexual behaviors.

Women's Infection Rate as Percentage of Total HIV/AIDS Cases in Every Region



1. Sexuality Education and Information

In relation to prevention strategies, the Declaration acknowledges the critical role of education and information about sexuality and reproductive health. As the preamble stipulates, "all countries must continue to emphasize widespread and effective prevention, including awareness-raising campaigns through education, nutrition, information and health-care services."[109]

Paragraph 53 repeats verbatim from ICPD+5 the only internationally agreed-upon prevention goal for young people, that governments "[b]y 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers."[110] Any education on prevention must also "promote[] gender equality within a culturally and gender sensitive framework."[111] While the Declaration mandates the provision of information, it fails to specify through which channels. Absent explicit requirements on the methods for disseminating such information, governments retain broad discretion, which often translates into inaction. The Declaration lacks emphasis on the need for governments to develop and implement sexuality education and information programs in school curricula, clinics and community outreach programs.

2. Availability of and Access to Commodities, Diagnostics and Treatment

The Declaration emphasizes that prevention programs are not to be limited to informational and educational efforts alone, but that practical commodities and services be made available and accessible. To that end, the Declaration "[recognizes] that effective prevention, care and treatment strategies will require behavioural changes and increased availability of and non-discriminatory access to, inter alia, vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drugs including anti-retroviral therapy, diagnostics and related technologies as well as increased research and development."[112]

The Declaration also calls on governments and the international community to "improve prevention and therapeutic approaches" and expedite access to technologies needed to prevent and treat HIV/AIDS and associated STIs and opportunistic infections.[113] Such technologies are enumerated to include female-controlled methods and microbicides, as well as "appropriate, safe and affordable HIV vaccines."[114]

3. Mother-to-Child Transmission

The Declaration attempts to balance the competing concerns surrounding MTCT issues by reflecting some, but not all, of the language on MTCT agreed to at ICPD+5.[117] According to paragraph 54 of the Declaration, the goal is to "reduce the proportion of infants infected with HIV by 20 per cent [by 2005], and by 50 per cent by 2010, by: ensuring that 80 per cent of pregnant women accessing antenatal care have information, counseling and other HIV prevention services available to them, increasing the availability of and by providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV … especially anti-retroviral therapy and, where appropriate, breast milk substitutes and the provision of a continuum of care."[118]

Unlike ICPD+5,[119] the Declaration fails to address MTCT prevention as "part of [women's] ongoing treatment." This narrow approach is problematic. Advocates caution that no consistent research exists about the potential long-term adverse

health impact of pregnancy-limited antiretroviral interventions on either the health of the woman or that of the fetus.[120] They also point out that outside of pregnancy, women would not be eligible for antiretroviral therapy, and that such a public health policy emphasis reinforces the discriminatory notion that women's health should be protected primarily because of their childbearing capacity.

E. CARE, SUPPORT AND TREATMENT

Advocates succeeded in having the phrase "prevention, care, treatment and support" included in the Declaration. However, the Declaration's main focus remains on prevention. One example of this emphasis is the lack of specific resource allocation for treatment initiatives focusing on the particular needs of women patients. While the Declaration states the need for additional research for therapies, treatment, and prevention, including research on MTCT, it fails to emphasize the important need to address gender bias in medical and social research. The Declaration, unlike Beijing+5, does not call for research on the long-term impact of drug treatments on women or children, or for the critical need for "gender-specific information about dosages, side-effects and effectiveness of drugs."[121]

Vertical transmission of HIV from infected mother to child (MTCT), which can occur during pregnancy, labor and delivery, or breastfeeding,115 has been the subject of ongoing debate.116 Governments in many low- and middle-income countries fear that the overall health risks for infants not receiving breast milk are greater than the risk of HIV transmission via breastfeeding. Moreover, countries that lack the resources or infrastructure to provide for the reduction of MTCT, either via antiretroviral therapies during pregnancy and delivery, or through breast milk substitutes, are concerned about the viability of any costly MTCT strategies. Past experience with defective milk formulas and lack of access to clean drinking water further complicate the debate on breastfeeding versus milk substitutes for HIV-positive women who are nursing. Some advocates also relate that fear of stigma and the possibility of banishment from their homes leads even HIV-positive women who have access to safe breast milk substitutes to choose to breastfeed in order not to attract suspicion about their serostatus.

Nevertheless, the Declaration obliges governments to "[b]y 2003, integrate HIV/AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans."[122] Specifically in terms of treatment and care, the Declaration recognizes that "access to medication … is one of the fundamental elements" needed for the enjoyment of the right to health.[123]

The Declaration acknowledges women as the primary caretakers of sick partners, children and families. This recognition signifies a growing understanding among governments that women's care for the sick subsidizes governments' lack of services and fills the vacuum left by inadequate and unaffordable health care services. For example, in one of the measures designed to "alleviat[e] social and economic impact," governments

agreed to develop and implement multisectoral strategies that "review the social and economic impact of HIV/AIDS at all levels of society e*specially on women* and the elderly, *particularly in their role as caregivers and in families affected by HIV/AIDS and address their special needs*" (emphasis added).[124] It is hoped that such review will lead to official economic and social recognition and support for women caretakers.

Finally, while the Declaration recognizes and protects the employment rights of PLWHAs in the formal economy,[125] it fails to extend such guarantees to PLWHAs engaged in the informal sector, which in many countries is comprised predominantly of women.[126]

F. ADOLESCENT REPRODUCTIVE RIGHTS

According to UNAIDS, young people account for half of all new HIV infections, and currently make up a third of the 40 million people living with HIV/AIDS worldwide.[127] The Declaration recognizes that "young adults and children, in particular girls, are the most vulnerable."[128] As discussed above, the prevention goals agreed to in the Declaration center around reducing the rate of infection among adolescents, as previously agreed to in ICPD+5.[129] That is, governments are prompted with greater urgency than before to facilitate a 25% reduction in prevalence rates among adolescents in the most affected areas by 2005, and globally by 2010.[130]

Likewise, the Declaration reaffirms the time-bound targets of ICPD+5,[131] with governments pledging to provide access to "information, education, and services to at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24."[132] However, only one out of the Declaration's 103 paragraphs specifically and explicitly outlines the types of services, information and education needed. Paragraph 63 stipulates that effective efforts to reduce vulnerability will include "ensuring safe and secure environments, especially for young girls; expanding good quality youth-friendly information and sexual health education and counselling services; [and] strengthening reproductive and sexual health programmes."[133] However, while adolescents are assured access to services, the provision encompasses only those deemed "necessary to develop the life skills required to reduce their vulnerability to HIV infection."[134] The Declaration does not outline specific channels of implementation, which may result in less effective implementation on the part of governments.

One specific tension within the Declaration is its dual acknowledgment of the importance of involving young people in the "design, planning, implementation and evaluation of programs,"[135] and its numerous references to religious and cultural sensibilities. Paragraphs that call for youth-specific education programs are balanced by deference to "cultural, religious and ethical factors."[136] Moreover, the emphasis on programs created in "full partnership with famil[ies]"[137] fails to account for the cultural and social factors that discourage or forbid young people from accessing health services and information contingent on their families' knowledge and approval.

Adolescents are prevented from receiving life-saving information about their reproductive and sexual health due to a number of factors. These include, but are not limited

to, lack of privacy and confidentiality, abusive or non-supportive environments, judgmental providers, or domestic laws that condition access to services on parental consent or accompaniment or on marital status.[138] As UNAIDS cautions, early onset of sexual activity among young people is common and requires early intervention with objective and complete information about sexuality.[139] Unfortunately, the Declaration falls short of reflecting this reality and succumbs to conservative forces whose religious or cultural mores are counter-productive to effective prevention and care strategies.

As discussed above, the exclusion of specific language listing the populations most at risk,[140] and the services that must be made available, accessible and affordable to adolescents,[141] exposes adolescents to double marginalization. Given this omission, governments may avoid targeting or allocating resources to the many adolescents who fall within these vulnerable groups, including refugees and imprisoned populations, thus exacerbating their vulnerability and further alienating and stigmatizing them.

IV. Conclusion

The Declaration on HIV/AIDS marks an important milestone in the struggle for women's human rights worldwide. It recognizes that the empowerment of women is essential to curtailing and managing the pandemic. However, it disappointingly falls short of calling for the full realization of women's reproductive rights. The Declaration limits its assurances for reproductive health to the context of battling the pandemic. In

One specific tension within the Declaration is its dual acknowledgment of the importance of involving young people in the "design, planning, implementation and evaluation of programs," and its numerous references to religious and cultural sensibilities.

isolating HIV/AIDS from interrelated reproductive health concerns, the Declaration departs from previous international acknowledgments that a comprehensive approach to sexual and reproductive health and rights is the most effective strategy. Nevertheless, if fully implemented by governments, the Declaration can potentially address the underlying discrimination, inequality and inequity that fuel women's vulnerability to all STIs, including HIV/AIDS.

Endnotes

1. *See, e.g.,* U.N. S.C. Res. 1308, U.N. Doc. S/Res/1308 (2000); *See* UNAIDS & World Health Organization (WHO), Report on the Global HIV/AIDS Epidemic 2000 9 (2000).
2. *See* Press Release, United Nations, With Unanimous Adoption of "Battle Plan" for Fight Against HIV/AIDS, Assembly Concludes Historic 3-day Special Session (June 27, 2001), U.N. Doc. GA/9888, *available at* http://www.un.org/News/Press/docs/2001/ga9888.doc.htm [hereinafter UN Press Release, Adoption].
3. Telephone Interview with staff person from UNAIDS - New York (Aug. 28, 2001).
4. *Declaration of Commitment on HIV/AIDS*, U.N. G.A. 26th Special Sess., U.N. Doc. A/Res/S-26/2 (2001), New York, U.S.A, June 25-27, 2001 [hereinafter *Declaration of Commitment*]. The Declaration also relies on the pledges made at regional conferences held in the months leading up to the Special Session, including the Abuja Declaration and Framework for Action adopted by African governments; the ESCAP Regional Call for Action to Fight HIV/AIDS in Asia and the Pacific of April 2001; the Caribbean Partnership Against HIV/AIDS of February 2001; the European Union Programme for Action: Accelerated Action on HIV/ AIDS, Malaria and Tuberculosis in the Context of Poverty Reduction of 14 May 2001; and the Central Asian Declaration on HIV/AIDS of 18 May 2001. *Id.* ¶¶ 6, 40.
5. *See* G.A. Res. 55/242, 55th Sess., at 4-6, U.N. Doc. A/Res/55/242 (2001).
6. In reality, however, the Round Tables provided only limited opportunity for meaningful exchanges between delegates and civil society.
7. *See* Center for Disease Control (CDC), *Pneumocycstis Pneumonia – Los Angeles,* June 5, 1981, *available at* http://www.cdc.gov/hiv/pubs/mmwr/mmwr05jun81.pdf. In their report issued June 5, 1981, the United States Center for Disease Control first reported the appearance in five male patients of a rare lung infection accompanied by extreme depression of cellular immune functions.
8. UNAIDS and WHO, *supra* note 1, at 10.
9. *See id.* at 8.
10. *See* UNAIDS and WHO, AIDS Epidemic Update (2001), *available at* http://www.unaids.org/epidemic_update/report_dec01/index.html
11. *See* UNAIDS and WHO, *supra* note 1, at 11.
12. *See supra* note 10, at 3.
13. Modes include intravenous drug use, blood transfusions, homosexual contact, and heterosexual contact.
14. UNIFEM, *Gender and HIV/AIDS: Critical Issues* (prepared for UNGASS on HIV/AIDS), *available at* http://www.unifem.undp.org/hiv_aids/ungass (last visited Sept. 26, 2001).
15. *See, e.g.,* UNAIDS and WHO, *supra* note 1, at 13.
16. UNAIDS, Fact Sheet: Preventing HIV/AIDS Among Young People (2001) (prepared for UNGASS on HIV/AIDS), *available at* http://www.unaids.org/fact%5Fsheets/ungass/html/fsyouth%5Fen.htm (last visited Sept. 24, 2001) [hereinafter UNAIDS, Fact Sheet: Young People].
17. *See* Center for Disease Control, *HIV Infection and Youth in the US*, *available at* http://www.cdc.gov/hiv/pubs/facts/youth.htm (last visited Sept. 24, 2001).
18. Debate also centered around the implementation of the World Bank and International Monetary Fund's Heavily Indebted Poor Countries (HIPC) initiative and its likelihood of freeing up public sector money for HIV/AIDS prevention, treatment, and care.
19. *See, e.g.,* UN News Service, News Wrap-up, Posting to Break-the-Silence@hdnet.org (June 26, 2001) (copy on file with CRLP).
20. *Declaration of Commitment,* ¶ 80. This provision, lobbied for at the highest levels by the UN Secretary General, represented a rare commitment of resources by governments and the UN within a Special Session negotiation. *See, e.g.,* Press Release, United Nations, Global AIDS, Health Fund Operational by Year End (June 5, 2001), U.N. Doc. AIDS/17, SAG/92, *available at* http://www.unaids.org/UNGASS/index.html.
21. *Declaration of Commitment,* ¶¶ 27, 33.
22. *Id.* ¶¶ 14, 47, 59.
23. *Id.* ¶¶ 23, 62.
24. *Programme of Action of the International Conference on Population and Development,* ¶¶ 7.27-7.33, 8/31,U.N. Doc. A/CONF.171/13/Rev.1 (1995), Cairo, Egypt, Sept. 5-13, 1994 [hereinafter *ICPD Programme of Action*].
25. *Beijing Declaration and the Platform for Action, Fourth World Conference on Women,* ¶¶ 89, 94, 98, U.N. Doc. DPI/1766/Wom (1996), Beijing, China, Sept. 4-15, 1995 [hereinafter *Beijing Declaration and Platform for Action*].
26. *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*, U.N. G.A., 21st Special Sess., ¶¶ 68-70, U.N. Doc. A/S-21/5/Add.1 (1999), New York, U.S.A, June 30-July 2, 1999 [hereinafter *ICPD+5 Key Actions Document*]; *Further Actions and Initiatives to Implement the Beijing Declaration and the Platform for Action*, U.N. G.A., 23rd Special Sess., ¶ 72, U.N. Doc. A/Res/S-23 (2000), New York, U.S.A., June 5-9, 2000 [hereinafter *Beijing+5 Review Document*].
27. *See, e.g.,* President Thabo Mbeki, Speech at the Opening Session of the 13th International AIDS Conference, Durban, South Africa (July 9, 2000), *available at* http://www.aids2000.org (last visited Sept. 24, 2001).

28. U.N. S.C. Res. 1308, U.N. Doc. S/Res/1308 (2000).
29. G.A. Res. 54/283, 54th Sess., U.N. Doc. A/RES/54/283 (2000).
30. *See* G.A. Res. 55/242, 55th Sess., at 6, U.N. Doc. A/Res/55/242 (2001).
31. *See, e.g.,* Brigitte Zypries, Statement by Germany, President of the European Union at the Special Session on the Review and Appraisal of the Implementation of the Programme of Action of the International Conference on Population and Development (June 30, 1999), *available at* http://www.germany-info.org/UN/eu_state_05_31_99.htm; Osmo Soininvaara, Statement by Finland at the 23rd Special Session of the General Assembly (June 8, 2000), *available at* http://www.un.int/finland/speech/Soininvaara8.6.html.
32. *See* The Center for Reproductive Law and Policy (CRLP), Beijing+5: Assessing Reproductive Rights 2 (2000). During the UNGASS on HIV/AIDS, the delegations comprising the Rio Group included Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Mexico, Panama, Paraguay, Peru, Uruguay, and Venezuela.
33. *See, e.g.,* Rio Group, Statement on Proposals for the Draft Declaration of Commitment on HIV/AIDS, *available at* http://www.un.int/chile/GRIO/sidagrioengl.
34. Ambassador Penelope Wensley, Address at the Women's Foreign Policy Group Meeting on the Outcomes of the UN General Assembly Special Session on HIV/AIDS (July 14, 2001) [hereinafter Wensley, Address].
35. Countries that negotiated in this bloc included Bahrain, Djibouti, Egypt, Qatar, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Malaysia, Pakistan, Saudi Arabia, Sudan, Syria, and United Arab Emirates. *See, e.g.,* Dyan M. Neary, Conference News Daily, *Human Rights Activist Banned from UNAIDS Meeting* (June 23, 2001), *available at* http://www.confnews.com/jun/hivaidshuman-rightsjun23_01.htm; Micheal Kwon, Conference News Daily, *Bleak Morning for Kaplan Countered by Reappointment to Human Rights Panel* (June 26, 2001), *available at* http://www.confnews.com/jun/hivaids-bleakmorningjun26_01.htm.
36. Wensley, Address, *supra* note 34. *See also id.* Just days before the start of the Special Session, a group of Islamic states lodged a complaint against the appointment of a gay and lesbian rights advocate to the Round Table discussion on Human Rights and HIV/AIDS, based on their cultural objection to homosexuality. On the opening day of the plenary negotiations, this conflict remained unresolved and threatened to derail the entire process. After hours of debate, the General Assembly finally voted, with many of the Islamic States vocally disassociating themselves from the voting procedure, to allow the participation of this NGO member.
37. *See* UN Press Release, Adoption, *supra* note 2.
38. *See* H.E. Archbishop Javier Lozano Barragan, Head of Holy See Delegation, Statement at the Close of the UNGASS on HIV/AIDS (June 27, 2001), *available at* http://www.holyseemission.org/html/27jun2001.html. Many people, however, viewed the Vatican's passive behavior as a desire to avoid political censure on issues that spell life and death in the context of HIV/AIDS, rather than as indicative of shifting dogma.
39. *See; e.g.,* Scott Evertz, Head of the U.S. Delegation for May 21-25 Prepcom, Statement before the General Assembly (May 21, 2001).
40. *See, e.g.,* Statement by U.S. Delegation on 3/30/01 Draft Declaration of Commitment on HIV/AIDS (Apr. 20, 2001) [hereinafter U.S Statement on Draft Declaration]; Wensley, Address, *supra* note 34.
41. *See, e.g.,* UNAIDS, Together We Can: Leadership in a World of AIDS 6 (2001), a*vailable at* http://www.unaids.org/UNGASS/index.html.
42. G.A. Res. 55/242, 55th Sess., at 1-2, U.N. Doc. A/Res/55/242 (2001).
43. *Id.* at 6.
44. *See, e.g.,* FUNDAMIND, Review of the Second UNGASS Informal Consultation Meeting and Parallel
Civil Society Sessions, May 21- 26, Posting to Break-the-Silence@hdnet.org (June 7, 2001) (copy on file with CRLP).
45. *See* E-mail from Vangie Parker, Partnerships Unit, UNAIDS, to the Center for Reproductive Law and Policy (CRLP) (Aug. 31, 2001) (on file with CRLP). Notably, 16 of the NGOs on national delegations were supported by UN funds, including those from Angola, Belize, Chad, Comores, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Lesotho, Liberia, Mozambique, Poland, Rwanda, Swaziland, Thailand, and Vietnam.
The U.S. delegation, unique among Member States, included a private business representative, Pfizer's Chairperson and Chief Executive Officer. *See* United States Dep't of State, *United States Delegation to the Special Session of the United Nations General Assembly on HIV/AIDS, available at* http://www.state.gov/documents/organization/3831.pdf (last visited Sept. 24, 2001).
46 *See, e.g.,* Press Release, Aisha Satterwhite, Africa Action, Youth Caucus Demands a Response from the UN General Assembly (June 27, 2001) (on file with CRLP); FUNDAMIND, *supra* note 44.
47 This exclusion was hardest felt by civil society actors from highly affected, low-income nations, due to high travel costs and to the U.S. government's denial of travel visas to many HIV-positive individuals. *See, e.g.,* ICASO Letter to General

Assembly President re: NGO Concerns with UNGASS, Posting to Break-the-Silence@hdnet.org (June 25, 2001) (copy on file with CRLP).
48 *See* A Participant's Diary 1: Second UNGASS Informal Consultation Meeting – May 21-25, Posting to Break-the-Silence@hdnet.org (May 31, 2001) (copy on file with CRLP). The intervention was originally scheduled for May 23rd but was moved to May 21st with only 2 days notice given before the start of the consultations.
49 *See* A Participant's Diary 2, Posting to Break-the-Silence@hdnet.org (June 1,2001) (copy on file with CRLP).
50 *See* A Participant's Diary 4, Posting to Break-the-Silence@hdnet.org (June 1,2001) (copy on file with CRLP).
51 *See, e.g.,* Neary, *supra* note 35; Kwon, *supra* note 35.
52 *See* UN Secretary-General Kofi Annan, Remarks at Press Conference Following Close of Special Session on HIV/AIDS (June 27, 2001), U.N. Doc. SG/SM/7865 (2001), *available at* http://www.un.org/News/Press/docs/2001/sgsm7865.doc.htm. In his remarks following the Special Session, UN Secretary General Kofi Annan, reinforced that "if there is one idea that stands out clearly from the declaration, is that women are the forefront of this battle. It can only be won if women are fully educated and enjoy their full rights, including a full say in devising society's collective response. It has been said that 'girl power is Africa's own vaccine against HIV,' and that should be true for the whole world."
53 *Declaration of Commitment,* ¶ 14.
54 *Id.* ¶ 37.
55 *See infra* notes 81-91 and accompanying text.
56 *Declaration of Commitment,* ¶ 20.
57 *Id.* ¶ 21.
58 *Id.* ¶ 63.
59 *Id.* ¶¶ 53. 63. See also paragraph 21, which fails to mention religious or familial attitudes amongst those factors that are "hampering awareness, education, prevention, care, treatment and support efforts."
60 *Id.* ¶ 31.
61 *Id.* ¶ 64.
62 International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GOAR, Supp. No. 16, U.N. Doc A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976) [hereinafter Economic and Social Rights Covenant].
63 The 1948 Universal Declaration of Human Rights, which includes civil and political rights (articles 3-16, 18-21) and socio-economic rights (articles 17, 22-28,) was designed as an indivisible document. Certain Western Member States successfully lobbied for the bifurcation of these rights into two separate covenants. *See* Louis Henkin et al., Human Rights 321 (1999). Reflecting the emerging Cold War divisions, the United States led advocacy for civil and political rights, and the Soviet Union championed economic, social and cultural rights. *See* Sofia Gruskin & Daniel Tarantola, *Health and Human Rights*, *in* The Oxford Textbook of Public Health 6 (Roger Detels et al. Eds., forthcoming 2001).
64 International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GOAR, 21st Sess., Supp. No. 16, U.N. Doc A/6316 (1966), 999 U.N.T.S. 171 *(entered into force* Mar. 23, 1976) [hereinafter Civil and Political Rights Covenant].
65 Hilary Charlesworh et al., *Feminist Approaches to International Law,* 85 Am. J. Int'l L. 613, 635 (1991). Notably however, most Member States have signed and ratified both covenants: 147 states signed and ratified the Civil and Political Rights Covenant, and 145 states signed and ratified the Economic and Social Rights Covenant. *See* UN Office of the High Commissioner for Human Rights, *Treaty Body Database, Status by Treaty*, *available at* http://www.unhchr.ch/tbs/doc.nsf/Statusfrset?OpenFrameSet (last visited Sept. 24, 2001).
Until recently, major human rights organizations nearly exclusively publicized and promoted civil and political rights. *See, e.g., Special Report: Human Rights-Righting Wrongs,* The Economist, Aug. 18, 2001, at 18.
66 Health as a development issue is articulated in the *Declaration on the Right to Development,* G.A. Res. 41/128, U.N. GAOR, 41st Sess., Supp. No. 53, at 186, art. 8(1), U.N. Doc. A/41/53 (1986). Not until the mid-1990s with the ICPD and Beijing outcome documents did international consensus documents begin to draw "concrete linkages of health and human rights." *See* Gruskin & Tarantola, *supra* note 63**,** at 2, 5-6.
67 The right to health is strongly associated and often dependant on a host of rights including the right to bodily integrity; rights to free speech, to exchange of information, and to political participation; and the right to be free from discrimination. *See, e.g.,* Human Rights Watch, *Economic, Social and Cultural Rights*, *available at* http://www.hrw.org/esc/ (last visited Sept. 24, 2001). The Constitution of the World Health Organization states that: "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." *See* World Health Organization (WHO), *Health as a Human Right, available at* http://www.who.int/archives/who50/en/human.htm, *citing* Constitution of the World Health Organization.
The Committee on Economic, Social and Cultural Rights interprets "the right to health …as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupation-

al and environmental conditions, and access to health-related education and information, including on sexual and reproductive health." *Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health*, U.N. GAOR, Comm. on Econ., Soc., Cultural Rts., ¶ 11, U.N. Doc. E/C.12/2000/4 (2000), *available at* http://www1.umn.edu/humanrts/gencomm/escgencom14.htm.
68 *Declaration of Commitment,* ¶¶ 16, 58-61.
69 *Id.* ¶ 37.
70 *Id.* ¶ 80.
71 *See infra* note 79. For example, those delegations succeeded in removing language from the section on HIV/AIDS and Human Rights that explicitly called for a "rights-based approach." *Compare Declaration of Commitment with* Draft Declaration of Commitment on HIV/AIDS (HIV/AIDS/CRP.4 (Rev.1), *available at* http://www.un.org/ga/aids/conference.html [hereinafter Draft Declaration Rev. 1]. In commenting on the draft Declaration, the U.S. delegation reaffirmed its resistance to placing social and economic rights on par with civil and political rights and rejected any inclusion of the phrase "rights-based approach" to HIV/AIDS. *See* U.S. Statement on Draft Declaration, *supra* note 40.
72 While the ICPD Programme of Action includes monetary goals, it has no real mechanism for allocation or disbursement. *ICPD Programme of Action, supra* note 24, ¶¶ 14.8, 14.11.
73 *Declaration of Commitment,* ¶¶ 80, 83-84, 87- 88, 91.
74 *Id.* ¶ 90.
75 *Id.* Nations have agreed that any contribution to the fund will not come at the expense of other development aid. Many governments agreed that allocations from the Fund will be to the most affected regions and will carry no conditions. Although not formally addressed in the Declaration, the UN Fund for Women (UNIFEM) has called for a gender-sensitive global fund that involves women in its creation and responds through its allocation to the disproportionate impact of AIDS on girls and women. *See* Noeleen Heyzer, Exec. Director, UNIFEM, Women at the Epicentre of the AIDS Epidemic: The Challenges Ahead, Panel Presentation at the UNGASS on HIV/AIDS (June 27, 2001), *available at* http://www.unifem.undp.org/speaks/hiv_aidsungass.html. Youth advocates have similarly requested that a General Assembly-backed Youth Advisory Board be able to monitor funds and programs of the Global Fund. *See* Youth Caucus of the UNGASS on HIV/AIDS, Youth Position Paper on the UNGASS on HIV/AIDS, Posting to Break-the-Silence@hdnet.org (June 28, 2001) (copy on file with CRLP).
76 *Declaration of Commitment,* ¶ 83. The target for least developed countries (LDCs) is 0.15-.20% of GNP.
77 *Id.* ¶ 9,
78 *Id.* ¶ 91.
79 *Id.* ¶¶ 87, 88; *Millenium Declaration,* G.A. Res. 55/2, U.N. GAOR , 55th Sess., ¶ 15, U.N. Doc. A/Res/55/2 (2000).
80 *Declaration of Commitment,* ¶ 100.
81 *Id.* ¶ 16.
82 *Id.*
83 Some delegates, led by the United States, took the stance that a "rights-based approach" to fighting HIV/AIDS was unacceptably vague and beyond their position on enforceable "basic" human rights. *See, e.g.,* U.S Statement on Draft Declaration, *supra* note 40.
84 Office of the High Commissioner on Human Rights (OHCHR) & UNAIDS, HIV/AIDS and Human Rights: International Guidelines (1998).
85 *Declaration of Commitment,* ¶ 16.
86 *Id.* ¶ 27.
87 *Id.* ¶ 96.
88 Of the four paragraphs in the section entitled "Human Rights and HIV/AIDS" (paras. 58-61), all but paragraph 58 deal directly and explicitly with empowering women.
89 *Id.* ¶ 59. See also paragraph 61, which calls for women's empowerment and reduction in their vulnerability to HIV/AIDS by "eliminating all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls."
90 *Beijing+5 Review Document, supra* note 26, ¶ 98(d). "Encourage, through the media and other means, a high awareness of the harmful effects of certain traditional or customary practices affecting the health of women, some of which increase their vulnerability to HIV/AIDS and other sexually transmitted infections, and intensify efforts to eliminate such practices."
91 *Declaration of Commitment,* ¶ 61.
92 Notably, the ICPD+5 Key Actions document contains an entire section labeled "Reproductive rights and reproductive health" and Beijing+5 refers to the concept numerous times. *ICPD+5 Key Actions Document, supra* note 26, ¶¶ 52-75; *Beijing+5 Review Document, supra* note 26, ¶¶ 11, 27, 72(j).
93 Reproductive rights, rooted in the most basic human rights standards, encompass two principles: the right to reproductive health care and the right to reproductive self-determination, which includes the right to autonomous and informed decision-making in matters related to sexuality and reproduction. *See* The Center for Reproductive Law and Policy (CRLP), Reproductive Rights 2000: Moving Forward 8-9 (2000).
94 The word "reproductive" appears only twice as part of the phrase "reproductive health." *Declaration of Commitment,* ¶¶ 60, 63.
95 *Beijing Declaration and Platform for Action, supra* note 25, ¶ 96; *Beijing+5 Review Document*, *supra* note 26, ¶ 72(k).
96 *Declaration of Commitment,* ¶ 59. The delegate

from Iran requested that references to women's sexuality be restricted only to the circumstances of HIV/AIDS. *See* Disputed Areas of the Declaration, Posting to Break-the-Silence@hdnet.org (June 21, 2001) (copy on file with CRLP) [hereinafter *Disputed Areas*].
97 *Declaration of Commitment,* ¶ 59.
98 *Id.* ¶ 60.
99 This new controversy over semantics threatens to undermine the consensus language from ICPD and Beijing asserting that the commitment to women's health must include safe abortion services, where they are not against the law. *ICPD Programme of Action, supra* note 24, ¶¶ 7.6, 8.25; *Beijing Declaration and Platform for Action, supra* note 25, ¶ 106(k),(j); *ICPD+5 Key Actions Document, supra* note 26, ¶ 63(i); *Beijing+5 Review Document, supra* note 26, ¶ 72(o).
100 *Declaration of Commitment,* ¶ 6.
101 *See, e.g., ICPD+5 Key Actions Document, supra* note 26, ¶ 70; *Beijing+5 Review Document, supra* note 26, ¶ 55.
102 *Declaration of Commitment,* ¶¶ 17-18.
103 *Compare with ICPD+5 Key Actions Document, supra* note 26, ¶ 70.
104 *Declaration of Commitment,* ¶ 47.
105 *Id.* ¶ 52.
106 Compare the initial draft Declaration with revision 1 to the Declaration. Draft Declaration Rev. 1, *supra* note 71.
107 *Declaration of Commitment,* ¶ 52.
108 *Id.* The U.S. delegation wanted to replace the phrase "vulnerable individuals" with people who engage in "risky sexual behavior." *See Disputed Areas, supra* note 96. In the Declaration, only paragraph 62 uses this language, in urging prevention programs to address activities "which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour."
109 *Declaration of Commitment*, ¶ 18.
110 Compare paragraph 53 with *ICPD+5 Key Actions Document, supra* note 26, ¶ 70.
111 *Declaration of Commitment,* ¶ 60.
112 *Id.* ¶ 23.
113 *Id.* ¶ 70.
114 *Id.*
115 *See* UNAIDS, Fact Sheet: Mother to Child Transmission (2001) (prepared for UNGASS on HIV/AIDS), *available at* http://www.unaids.org/fact%5Fsheets/ungass/html/fsmotherchild%5Fen.htm (last visited Sept. 24, 2001).
116 This has been the case in many of the most affected countries in sub-Saharan Africa. *See, e.g.*, The Center for Reproductive Law and Policy (CRLP), Women of the World: Laws and Policies Affecting their Reproductive Lives: Anglophone Africa – Progress Report 2001 165 (2001) [hereinafter CRLP, Anglophone Africa Progress Report 2001].
117 *ICPD+5 Key Actions Document, supra* note 26, ¶ 64.
118 *Declaration of Commitment,* ¶ 54. See also paragraph 70, which calls for the provision of "diagnostics, tests, methods to prevent mother-to-child transmission…."
119 *ICPD+5 Key Actions Document, supra* note 26, ¶ 69.
120 *See, e.g.,* Journal of the American Medical Association (JAMA), *Treatment Guidelines: Considerations for Antiretroviral Therapy in the HIV-Infected Pregnant Woman, available at* http://www.ama-assn.org/special/hiv/treatmnt/guide/nih/pregnant.htm (last visited Sept. 24, 2001).
121 *Beijing+5 Review Document, supra* note 26, ¶ 98(d).
122 *Declaration of Commitment,* ¶ 38.
123 *Id.* ¶ 15.
124 *Id.* ¶ 68.
125 *Id.* ¶ 69. Note however that paragraph 49 calls on governments to "establish[] and implement[] prevention and care programmes in public, private and *informal* work sectors…" (emphasis added).
126 In Zimbabwe, for example, women make up 70% of seasonal workers, and in Ghana and Tanzania, women constitute 52% and 54% of farm workers, respectively. Unfortunately, labor protections and benefits, in countries where they exist, do no extend to workers in the informal and agricultural sectors. *See* CRLP, Anglophone Africa Progress Report 2001, *supra* note 116, at 169.
127 UNAIDS, Fact Sheet: Young People, *supra* note 16; UNAIDS and WHO, *supra* note 10, at 2.
128 *Declaration of Commitment,* ¶ 4. The Declaration repeatedly affirms the particularly alarming vulnerability of girls. *Id.* ¶¶ 14, 59. Paragraph 47 also strives to "encourag[e] the active involvement of men and boys."
129 *ICPD+5 Key Actions Document, supra* note 26, ¶ 70.
130 *Declaration of Commitment,* ¶ 47.
131 *ICPD+5 Key Actions Document, supra* note 26, ¶ 70.
132 *Declaration of Commitment,* ¶ 53.
133 *Id.* ¶ 63.
134 *Id.* ¶ 53.
135 *Id.* ¶¶ 33, 37.
136 *Id.* ¶ 63. See also paragraphs 20, 52 and 60.
137 *Id.* ¶ 53.
138 *See, e.g.,* UNAIDS, Fact Sheet: Young People, *supra* note 16.
139 *Id.*
140 The compromise language that deleted mention to men having sex with men and injecting drug users, imprisoned populations, and refugees and internally displaced people.
141 For example, the Declaration fails to specify the need to provide adolescents with barrier contraceptives and clean needles as part of harm reduction strategies.