

WORKING PAPER

Violence Against Women, HIV/AIDS Vulnerability and the Law

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I INTRODUCTION

1.1 The "HIV Paradox"

The Human Immunodeficiency Virus (HIV) / Acquired Immunodeficiency Syndrome (AIDS) epidemic has exposed the deadly consequences of gender inequalities and violations of girls and women's human rights. Where HIV/AIDS is concerned, gender inequality has become fatal.¹ The link between violence against women (VAW) and HIV vulnerability exemplifies what the Hon. Michael Kirby has termed the "HIV paradox": in order to promote public health, we must protect the rights of those vulnerable to infection *and* of HIV-positive persons.² Yet, what if attending to these respective rights – say, those of an HIV-positive man, on the one hand, and of his wife, on the other – require what appear, at first glance, to be conflicting legal measures? Or if policies to prevent/reduce mother-to-child-transmission (MTCT) are more attentive to the health of the foetus than that of the mother? How do we evolve a legal framework that protects the various rights (to life, to privacy, to information and to equality) of all concerned: HIV-positive persons, groups vulnerable to infection (for the purpose of this paper: women experiencing violence) and the community at large? When health (individual and public), human rights and the law intersect, how best do we attend to the multiple discriminations generated by HIV/AIDS: the social stigma conferred by HIV-positive status and the subsequent – and, frequently, legally-sanctioned – discrimination against both women *and men*; the patriarchal discrimination against women specifically, that renders them especially vulnerable to infection and doubly discriminated against post-diagnosis; and the vulnerabilities created by class, caste, race and other inequalities that exacerbate the discrimination faced by HIV-positive members of these already marginalised groups?

This paper seeks to analyse the nexus between VAW, HIV vulnerability and legal regimes, based on the understanding that disease vulnerability is a complex amalgam of socio-medical factors:

"[A]ll people are not equally susceptible to HIV infection and... people who are more subject to socio-economic and political inequalities are more susceptible to becoming infected... [A] rights-based approach to addressing the HIV epidemic... considers individuals' vulnerabilities, not just in terms of risk [of] HIV infection but also in terms of their vulnerability to marginality and the impacts of marginality on their vulnerabilities."³

1 UNFPA, *Protecting the Health of Women and Girls* [<http://www.unfpa.org/hiv/women.htm>], as cited in *Gender-Based Violence and HIV*, Harvard School of Public Health (2009), available at http://www.hsph.harvard.edu/pihhr/files/homepage/program_resources/GBV_HIV_FINAL_DRAFT_REPORT_SEPT_2009.pdf

2 Kirby M (1996), *Human Rights and the HIV Paradox*, *The Lancet*, Volume 348, Issue 9036, pp. 1217 – 1218.

3 The Lawyers Collective (2007), *Legislating an Epidemic: HIV/AIDS in India*, Universal Publishing Pvt. Ltd, New Delhi, India.

Furthermore, these structural inequalities are “often produced by state action through law and authoritative policy. Thus, many key material factors affecting sexual health are often not inevitable or unchangeable, but rather represent discrete choices made by legislators, administrators, courts and executives.”⁴

1.2 Methodology

This paper seeks to analyse the links between VAW, their HIV vulnerability and laws that address these issues to productive or counter-productive effect. The paper regards disease vulnerability as a socio-medical phenomenon and understands VAW as both a violation of equality rights and a manifestation of the unequal status of women in society. Given the focus on HIV/AIDS, the paper does not examine *all* forms of VAW, but limits its purview to those forms of violence that have a specific impact on HIV vulnerability. The paper also does not attempt a country-by-country assessment of laws; rather, it presents a macro-analysis of issues arising in this context by examining relevant laws, jurisprudence evolved by courts and practice against prevailing international standards and constitutional guarantees. The analysis is derived from an intensive review of secondary literature; the authors have not conducted field research for this paper. Although every attempt has been made to have a wide geographic representation, the lack of data on the Middle East – a known lacuna in the HIV/AIDS literature – has meant its relative absence from this paper as well.

II Setting the Context

2.1 Violence against Women as a Form of Discrimination Requiring Substantive Equality Interventions

The fact that society is organised around – indeed, predicated on – the patriarchal subordination of women requires no elaboration. Moreover, it is now widely accepted that VAW is both a manifestation of gender-based inequality/discrimination and functions to reinforce it. According to the *Declaration on the Elimination of Violence against Women* (DEVAW):

“...[V]iolence against women is an obstacle to the achievement of equality, development and peace...[It] constitutes a violation of the rights and fundamental freedoms of women and impairs or nullifies their enjoyment of those rights and freedoms...[It] is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women...[It] is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men...”⁵

Credit for developing this analytic perspective – i.e., seeing VAW not as “the result of random, individual acts of misconduct, but [rather as] deeply rooted in structural relationships of inequality between women and men”⁶; understanding it as a violation of women’s human rights; bringing it to the attention of policymakers; and advocating for the adoption of international norms and standards, legal and policy instruments and monitoring and reporting mechanisms tailored to address it – goes to women’s movements worldwide.⁷

Just as we understand HIV vulnerability to be a dynamic product of socio-medical conditions, so too do we ground our discussion of VAW in the context of a structural patriarchy that produces (and requires) a continuum⁸ of normalised,

4 Bhardwaj K & Divan V (2011), *Sexual Health and Human Rights: A Legal and Jurisprudential Review of Select Countries in the SEARO Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/182/140_searo_divan_bhardwaj_2011.pdf

5 This paper follows the DEVAW categorisation of VAW in the family, in the community and perpetrated/condoned by the state. According to Articles 1 and 2 of DEVAW:

“...the term ‘violence against women’ means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. Violence against women shall be understood to encompass, but not be limited to, the following:

(a) 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, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.”

6 UN General Assembly (2006), *In-depth Study on All Forms of Violence against Women: Report of the Secretary General*, A/61/122/Add. 1, available at <http://www.unhcr.org/refworld/docid/484e58702.html>

7 For a succinct overview of the crucial importance of women’s activism in this regard, see *ibid*, which charts the process by which women’s activism introduced the issue of VAW into the UN Decade of Women Conferences (especially in Copenhagen in 1980 and Nairobi in 1985); prompted the CEDAW Committee to recognise VAW (hitherto conspicuously absent from the Convention) as a form of gender-based discrimination through its General Recommendations No. 12 (1989) and 19 (1992); resulted in the Vienna Declaration and Programme of Action (1993) that recognised women’s rights as human rights, which in turn added significant momentum to the General Assembly’s adoption of DEVAW later that year and led to the appointment of a Special Rapporteur on VAW by the Commission on Human Rights in 1994; and consolidated these gains in the Beijing Declaration and Platform for Action (1995), which shifted the focus to demanding State accountability to eliminate VAW.

8 See Annexure I for an illustration of the continuum of violence faced by women throughout their lives.

systemic, gendered violence (rather than the isolated acts of aberrant individuals), which is better addressed through the conceptual, legal and policy tools of substantive equality than those of formal equality.

Of the international women's movement's many accomplishments, one of the most significant is catalysing the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW): the sole international standard-setting treaty that contains within it the promise of substantive equality for women.

In contrast to formal equality – which is premised on the Aristotelian principle of treating likes alike – substantive equality understands that, in order to achieve equality, one must address the systemic, historical, cumulative disadvantage suffered by discriminated groups that adversely affects their ability to benefit from the identical treatment ensured by formal equality. In fact, as Amartya Sen has argued, *“Equal consideration for all may demand very unequal treatment in favour of the disadvantaged. The demands of substantive equality can be particularly exacting and complex when there is a good deal of antecedent inequality to counter.”*⁹ And, we might add, when the sometimes varying interests of two differently disadvantaged groups must be protected in their interaction with each other in order to ensure equality for both.

Another noteworthy feature of substantive equality is that, unlike formal equality – which is *“based on a negative conception of liberty, aiming to restrain the State from interfering with individual rights”*¹⁰ (say, by refraining from discriminating against women) – substantive equality places positive obligations on the State *“to protect, promote and fulfil [the] right to non-discrimination for women and to ensure the development and advancement of women in order to improve their position to one of de jure as well as de facto equality with men.”*¹¹

2.2 The Intersection of Violence against Women and HIV Vulnerability

Although women face specific risks of HIV infection due to their physiology,¹² it is essential to remember that physiology is not the sole or even prime determinant of their HIV vulnerability. If health is understood as a socio-medical condition, it follows that it is a *gendered* condition: wellbeing, vulnerability to disease, the nature of exposure to risk factors, access to healthcare and experience of social support or stigma are influenced by (among other determinants) one's gender (understood as a socio-political artefact rather than merely a function of biological sex):

*“The consequences of gender inequalities in terms of low socioeconomic and political status, unequal access to education, and fear of violence, add to the greater biological vulnerability of women and girls being infected with HIV. Too often they have little capacity to negotiate safer sex, access the services they need, and utilise opportunities for empowerment.”*¹³ [emphasis added]

*“Unequal power relations, whether on the basis of gender, class, caste, or sexuality, and the attendant discrimination in society are at the heart of disproportionate vulnerabilities in marginalised communities. In the context of HIV, a lack of power translates directly to vulnerability to infection because of a lack of the knowledge and skills to take the appropriate harm reduction measures. The barriers posed by inequality and unfair discrimination limit many people's access to the information and the tools to take back power in unequal circumstances.”*¹⁴ [emphasis added]

“Although physiology affects women's greater risk of HIV transmission, it is women and girl's relative lack of power over their bodies and their sexual lives, supported and reinforced by their social and economic inequality, that make them such a vulnerable group in contracting, and living with, HIV/AIDS...The stereotypical gender roles that underpin sexual inequality and sexual violence are confirmed and reproduced by social, cultural and religious norms. This lends

9 Sen A (1992), *Inequality Re-examined*, Oxford: Oxford University Press, UK.

10 Fredman S (2011), *Substantive Equality for Women* in Jaising I (Ed.), *Elusive Equality: Constitutional Guarantees and Legal Regimes in South Asia, Malaysia and China*, Women Unlimited, New Delhi, India.

11 CEDAW General Recommendation Number 25, Paragraph 4.

12 According to Amnesty International in *Women, HIV/AIDS and Human Rights* (2004), AI Index: ACT 77/084/2004, available at <http://www.amnesty.org/en/library/info/ACT77/084/2004/en>:

“Women and girls appear to have a higher inherent risk of being infected via heterosexual activity (compared to men) because semen contains higher levels of HIV than vaginal fluids. Moreover the vagina offers a larger area of mucosal tissue subject to micro-injuries through which the virus can enter the bloodstream. Women are thus more likely than men to contract HIV through a single heterosexual encounter...Violence is a key factor in increasing women's risk of contracting the virus. Studies suggest that the first sexual experience of a girl will often be forced. Women are two to four times more likely to contract HIV during unprotected vaginal intercourse than men both because their sexual physiology places them at higher risk of injury (especially in the case of young women) and because they are more likely to be at the receiving end of violent or coerced sexual intercourse.”

13 UNAIDS (2010), *Report on the Global AIDS Epidemic*, Geneva, Switzerland, available at http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf

14 Bhardwaj K & Divan V (2011), *Sexual Health and Human Rights: A Legal and Jurisprudential Review of Select Countries in the SEARO Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/182/140_searo_divan_bhardwaj_2011.pdf

Links between VAW and HIV/AIDS: an experience from Pakistan

Pakistan is a low incidence yet very high-risk country given the rampant nature of poverty, unemployment, gender inequity and illiteracy. The realization is only beginning to emerge that the HIV is now a predominately female disease and that its spread is being accelerated by the very high level of violence against women in countries such as Pakistan.

The individual stories are heart wrenching. In the displacement following the 2005 catastrophic earthquake in Pakistan, Shazia (28 years) was gang-raped by a group of looters. She reported the rape to her husband but he felt powerless to help her due to his own injuries and poverty. A few months after the rape, Shazia began to feel ill, and discovered first that she was pregnant and then that she was HIV-positive. Her husband abandoned her and her twin sons.

- Submission made by Friends for Progress, Pakistan, for the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law

an aura of 'naturalness' and inevitability to these roles and can make them particularly difficult to contest and change."¹⁵ [emphasis added]

It also follows, then, that VAW – a manifestation of gender-based inequality and discrimination – “increases their vulnerability to HIV/AIDS, that HIV infection further increases women’s vulnerability to violence, and that violence against women contributes to the conditions fostering the spread of HIV/AIDS.”¹⁶

The links between VAW and HIV vulnerability are the subject of numerous studies and reports¹⁷ (Annexure II summarises some of these links). Epidemiological statistics¹⁸ also bear witness to this link; for instance, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS) Global Report 2010:

“Slightly more than half of all people living with HIV are women and girls. In sub-Saharan Africa [which accounts for 68% of the total number of people living with HIV globally], more women than men are living with HIV, and young women aged

15 Albertyn C (2000), *Prevention, Treatment and Care in the Context of Human Rights*, paper submitted to the UN Expert Group Meeting on “The HIV/AIDS Pandemic and its Gender Implications” (UN Document: EGM/HIV/AIDS/2000/WP.1)

16 Office of the High Commissioner on Human Rights (2004), *Commission on Human Rights Resolution 2004/46: Elimination of Violence against Women*, E/CN.4/RES/2004/46, available at <http://www.unhcr.org/refworld/docid/43f313730.html>

17 See, for instance, UN Women’s summary of the issue, *Understand the Linkages between HIV/AIDS and Violence against Women and Girls*, available at <http://www.endvawnow.org/en/articles/677-understand-the-linkages-between-hiv-aids-and-violence-against-women-and-girls.html>, included in Annexure II to this paper. In 2005, the Special Rapporteur on Violence against Women prepared an important report on the issue, *Intersections of Violence against Women and HIV/AIDS*, E/CN.4/2005/72, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/102/11/PDF/G0510211.pdf?OpenElement>. The Harvard School of Public Health’s 2009 final draft report prepared for UNFPA, *Gender-Based Violence and HIV*, contains a comprehensive review of English-language, peer-reviewed literature in the social sciences, law, health policy, public health and medicine, published during 2000-2008 (see note 1); Annexure II includes an excerpt from this report summarising the links between gender-based violence and HIV. Also see Amnesty International in *Women, HIV/AIDS and Human Rights* (2004), AI Index: ACT 77/084/2004, available at <http://www.amnesty.org/en/library/info/ACT77/084/2004/en>. The WHO in partnership with the Global Coalition on Women and AIDS, has also produced a fact sheet providing a brief overview of the issue, available at <http://www.who.int/hac/techguidance/pht/InfosheetVaWandHIV.pdf>.

18 It is important to note, however, that there are significant lacunae in data linking gender-based violence (GBV)/VAW and HIV/AIDS. Some of the research gaps identified by the Harvard report, *Gender-Based Violence and HIV* (see note 2), in this regard include:

- There is a need for more work that examines the linkages between HIV seropositivity and the risk of experiencing GBV and the linkages between GBV and adherence to HIV treatment.
- Further attention is warranted to the risks and vulnerabilities that potentially impact the pathways between GBV and HIV, such as substance abuse and mental health.
- More attention is needed to psychological violence and structural violence, including economic violence, in the peer-reviewed literature.
- Studies are also needed that focus on perpetrators of violence beyond intimate partners, including the state, other family members and other adults.
- More attention is needed to the intersections within the context of HIV testing and disclosure, especially in resource-poor settings.
- More attention is needed to the intersections between GBV and HIV in conflict settings.
- Examination, and if, necessary, reformation of the legal and policy climate within countries is needed to ensure the best support to address the intersections of GBV and HIV.
- Peer-reviewed publications are needed which explain strengths and weaknesses of interventions that work to address GBV and HIV, especially in relation to integrated interventions. These are often called for in the English-language literature but are still rare.
- Policy-makers should be encouraged to support research and programming addressing the intersections among vulnerable populations, even when to do so might be considered to be ‘politically controversial!’
- Creative and committed efforts are needed to address the intersections at the policy and programme levels. Attention to existing calls for concrete actions to jointly address these two issues in the current literature is needed.
- More attention is needed to both the quantitative and the qualitative research which already exists in this area in order to ensure that policies or programmes are truly informed by evidence and supportive of vulnerable populations.

15-24 years are as much as eight times more likely than men to be HIV-positive. Protecting women and girls from HIV means protecting against gender-based violence and promoting economic independence from older men.¹⁹

2.3 International Human Rights Standards Regarding Violence against Women and HIV: The Rights-Based Approach

By international consensus, “poverty, gender inequality and stigma” are regarded as “key drivers of the [HIV/AIDS] epidemic”²⁰ and the rights-based approach as one best equipped to address these interwoven strands of HIV vulnerability: one that is premised on respect for human rights and which identifies promotion and protection of human rights as strategies for preventing HIV transmission.²¹

CEDAW obligates signatory States to respect, protect, promote and fulfill women’s human rights and to take measures to eliminate all forms of discrimination (direct and indirect) against women so as to achieve substantive equality. In order to take such measures, the State must examine each situation and take context-specific action to achieve results, i.e., the practical realisation of women’s right to equality. CEDAW is unique in that not only does it recognise both civil/political and socio/economic rights, but it also binds the State for actions taken by private parties that adversely impact women’s human rights. Hence, Article 5 of CEDAW urges States to take action “to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and practices that are based on the idea of inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.” On issues of VAW, General Recommendation Number 19 of the CEDAW Committee clarifies that States may be held responsible for private acts of persons, organisations or enterprises, if they fail to act with due diligence to prevent violations of rights or to investigate and punish acts of violence, and for providing compensation. The CEDAW Committee has also recognised the links between VAW and HIV vulnerabilities and violence and, in General Recommendation Number 15, urges State Parties to pay special attention to the rights and needs of women and their particular vulnerability to HIV and to take measures *inter alia* to address the needs of HIV-positive women and to prevent discrimination in response to AIDS.²²

CEDAW’s rights-based approach resonates with international consensus on adopting a rights-based approach to preventing HIV transmission. Essential to protecting the rights of persons living with HIV/AIDS and those vulnerable to infection is adherence to the fundamental principles of non-discrimination,²³ consent²⁴ and confidentiality²⁵ which form the foundation of the rights-based approach in the context of HIV/AIDS.

In addition to international norms and standards, regional human rights bodies have also adopted treaties which either directly address VAW or can be used to do so. The *Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women*, 1994 (Convention of Belém Do Pará) deserves special mention due to its emphasis on substantive equality and its comprehensive definition of VAW. According to Catharine Mackinnon, the Convention of Belém Do Pará and the *Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa*, 2003 (African Women’s Protocol) “are the only two pieces of modern international human rights law that view women’s equality in truly substantive terms and conceive of gender violence as a form of sex discrimination.”²⁶ A rich body of jurisprudence has emerged from adjudicatory regional mechanisms.

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- Peer-reviewed publications which explore the conceptual underpinnings of the intersections between GBV and HIV remain lacking.
 - Further attention is warranted to human rights as a framework for understanding how these epidemics are linked and how they can be jointly addressed.
 - More research needs to be published in the English-language literature from regions outside the United States. There is a particular lack of studies on GBV and HIV in the Arab region, Eastern Europe, and Central Asia.

19 UNAIDS (2010), *Report on the Global AIDS Epidemic*, Geneva, Switzerland, available at http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf

20 Harvard School of Public Health (2009), *Gender-Based Violence and HIV*, available at http://www.hsph.harvard.edu/pihhr/files/homepage/program_resources/GBV_HIV_FINAL_DRAFT_REPORT_SEPT_2009.pdf

21 Amnesty International (2004), *Women, HIV/AIDS and Human Rights*, AI Index: ACT 77/084/2004, available at <http://www.amnesty.org/en/library/info/ACT77/084/2004/en>

22 CEDAW General Recommendation Number 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of AIDS. Also see General Recommendation Number 24, which acknowledges the role of unequal gender power relations in making women and girls more vulnerable than males to contracting HIV and other sexually transmitted infections, and calls for specially designed programmes to meet their needs. Also relevant in this regard are the state obligations delineated in Strategic Objective C.3 of the Beijing Platform of Action on undertaking “gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.”

23 Guideline 5 of the International Guidelines on HIV/AIDS and Human Rights reads in part: “States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors...”

24 See Article 1 of the Rights and Humanity Declaration and Charter on HIV and AIDS, 1991 (International Association of Rights and Humanity). Guideline 3 of the International Guidelines on HIV/AIDS and Human Rights deals with aspects of informed consent to HIV testing.

25 See the UNGASS Declaration of Commitment on HIV/AIDS and the International Guidelines on HIV/AIDS and Human Rights.

26 As cited in Restrepo-Saldarriaga E (2011), *Advancing Sexual Health through Human Rights in Latin America and the Caribbean*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/183/140_Restrepo_LAC_2011.pdf

2.4 Constitutional and Statutory Provisions Regarding Violence against Women and HIV/AIDS

As is clear from the preceding discussion, inequality and discrimination have a strong impact on health, as they determine one's likelihood of encountering (or ability to avoid) specific health risks and one's access to preventive and treatment health care services. Recognising this impact, most countries have constitutions that guarantee equality rights and prohibit discrimination on certain protected grounds, which include sex and/or gender. Additionally, some countries have enacted either special laws on anti-discrimination or human rights or other gender-specific laws to give effect to constitutionally-guaranteed rights, for instance: laws on equal opportunities, laws establishing human rights commissions, laws on maternity benefits, employment provisions, etc. Some exceptions notwithstanding, constitutional guarantees are mostly applicable against state actors. The advantage of special legislation is that it often applies to both public and private actors.

Certain constitutions are noteworthy for their inclusion of provisions for substantive equality for women (in the form of affirmative action policies), in addition to those for formal equality: for instance, Argentina (Articles 37 and 75[23]); Colombia (Article 13); the Philippines' *Magna Carta of Women* (introduced in 2009); and Vietnam's *Law on Gender Equality* (introduced in 2006). South Africa's Constitution is unique on the continent for using both 'sex' and 'gender' as protected categories, in recognition of the former as a biological category and the latter as a social one, and in keeping with its "equality clause that envisages substantive equality rather than merely formal equality."²⁷

Although VAW is now understood to be a form of gender discrimination, only some countries have specific constitutional provisions addressing it. Nepal is one such country: Article 20 of its Interim Constitution of 2007 prohibits "physical, mental or any other form of violence" against women; recognises women's right to reproductive health and "other reproductive rights"; and, acknowledging the importance of women's economic rights, guarantees equal rights to ancestral property for sons and daughters. The *Law on Gender Equality* in Bosnia Herzegovina also has a specific provision on gender-based violence: Article 17 prohibits "[a]ll forms of violence in private and public life on the grounds of gender."

It is important to note that many countries (especially in Africa and South Asia) have plural legal systems – general laws, on the one hand, that are applicable to matters in the public domain, and codified customary/religious laws, on the other, applicable to the private domain and to do mainly with the regulation of the family – a complicated legacy of their colonial pasts that, due to political choices exercised by postcolonial governments, can serve to perpetuate gender inequality and discriminatory practices. Although most constitutions of the two regions provide that constitutional law will prevail in the event of a conflict, "customary...and religious laws enjoy the status of binding sources of law in the preponderance of countries in the African region."²⁸ For women, this means that, in addition to contending with the gender-discriminatory components of general laws, they must also deal with the gender-discriminatory aspects of customary/religious laws, which can have "negative implications for [their] sexual health."²⁹

CEDAW (in particular Articles 2[f] and 5[a]) obligates signatory States to "take all appropriate measures" to "modify or abolish" gender-discriminatory customary laws and practices; however, "many signatory states have not undertaken these obligations... Problematic areas [of customary law include] marriage, maintenance, inheritance, succession, ownership and control of property."³⁰ State policy can be reinforced by jurisprudence: for the most part, Indian courts have been reluctant to strike down gender-discriminatory provisions of personal laws in favour of constitutional imperatives, preferring instead to grant women their rights by reading down these provisions.³¹ Thus, "[d]iscriminatory practices have often been shielded from the test of the guarantee of equality on grounds of protecting the right to religion."³² In contrast, in some of Africa's newer constitutions (Section 39[2] of the South African Constitution of 1996; Article 66[2] of the Namibian Constitution; Section 10 of the Malawi Constitution of 1994; Article 9 of the Ethiopian Constitution of 1995), "the development of customary law to render it consonant with the constitutional values is expressly required by the constitution as a positive duty incumbent on the courts that are charged with interpreting and applying law."³³

27 Ngwena C (2011), *Sexual Health and Human Rights in the African Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/185/140_Ngwena_Africa_2011.pdf

28 *Ibid.*

29 *Ibid.*

30 Parmar S (2005), *Gender Equality in the Name of Religion in Men's Laws, Women's Lives: A Constitutional Perspective on Religion, Common Law and Culture in South Asia*, Women Unlimited, New Delhi.

31 Jaising I (2005), *Gender Justice: A Constitutional Perspective in Men's Laws, Women's Lives: A Constitutional Perspective on Religion, Common Law and Culture in South Asia*, Women Unlimited, New Delhi. Jaising's essay analyses court decisions in *State of Bombay v Narasuappamali* AIR 1952 Bom 84; *Mohd Ahmed Khan v Shah Bano Begum* AIR 1985 SC 945; *Mary Roy v State of Kerala and Others* 1986 (1) SCR 371; *Madhu Kishwar v State of Bihar* 1996 (5) SCC 125; *Githa Hariharan v Reserve Bank of India* (1999) 2 SCC 228

32 *Ibid.*

33 Ngwena C (2011), *Sexual Health and Human Rights in the African Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/185/140_Ngwena_Africa_2011.pdf

The constitutions of very few countries include health status and/ or specifically mention HIV-positive status as a protected ground against discrimination. In Africa, which continues to bear an inordinate share of the global HIV burden, only one constitution – that of Burundi – lists “*suffering from HIV/AIDS*” in its equality and non-discrimination clauses. Most other Africa countries have adopted special legislation that reads HIV status as a protected ground into their constitutions. South Africa has taken a lead in this regard: see *Hoffman v South African Airways*³⁴ and Section 6(1) of the *South African Employment Equity Act*. Moreover, although the *South African Promotion of Equality and Prevention of Unfair Discrimination Act (Equality Act)* “*does not list HIV status as a protected ground, it is clear that such status falls under the category of an analogous ground under the Act. Like the Constitution, protected grounds under the Equality Act are an open rather than closed category. Grounds that are analogous to listed grounds are protected.*”³⁵ In contrast, in *Festus Odaife and Others v Attorney General of the Federation and Others*³⁶ the High Court of Nigeria held that since the equality and non-discrimination grounds listed in Article 42 of the constitution did not cover discrimination on the grounds of health or disease status, the Article would not offer protection against HIV-related discrimination. The Tanzanian *HIV/AIDS (Prevention and Control) Act, 2008* is praiseworthy in prohibiting discrimination on the basis of association with a person living with HIV (Section 28).

In Europe, Belgium’s federal anti-discrimination law, the *Act of 10 May 2007 Aimed at Combating Certain Forms of Discrimination*, includes “*current and future state of health*” as a protected ground.

In Latin America,³⁷ jurisprudence has extended the constitutional prohibition of discrimination to HIV/AIDS status, as exemplified by Colombia where, since 1996,³⁸ the Constitutional Court has developed a doctrine of “*reinforced employment stability*” that “*strongly protect[s] the rights of HIV-positive citizens*”³⁹ as a “*vulnerable group*” deserving special protection from the State, as per Article 13 of the Constitution. The Court’s doctrine is not limited to labour discrimination; it has been extended, through case law, to education, the military and prisons.

However, the existence of legal norms is only half the battle; implementation is the other – and, in the case of both VAW and HIV legislation, countries have much to achieve in terms of the latter. According to the United Nations (UN) Secretary General’s report on VAW:

*“Progress in the development of international legal norms, standards and policies has not been accompanied by comparable progress in their implementation at the national level, which remains insufficient and inconsistent in all parts of the world...Lack of political will is reflected in inadequate resources devoted to tackling violence against women and a failure to create and maintain a political and social environment where violence against women is not tolerated.”*⁴⁰

The UNAIDS Global Report 2010 makes similar observations about the inadequate budgeting and enforcement of HIV/AIDS legislation, both generally and, specifically, for women:

“...although about 90% of country activity plans included stigma and discrimination reduction programmes, fewer than 50% of countries costed or budgeted such programmes... .”

Parallel to increased acknowledgement of laws that pose obstacles to HIV responses, more countries report the existence of laws and regulations that protect people living with or vulnerable to HIV from discrimination but data are insufficient to indicate whether they are adequately enforced... .In addition, only 56% of countries report having a mechanism to record, document, and address cases of discrimination experienced by people living with HIV or other people vulnerable to HIV... .”

*Governments in 80% of countries...reported that they include women as a specific component of a multisectoral HIV strategy...[but the] number of countries with a specific budget for HIV activities related to women is considerably lower: 46%...”*⁴¹

34 2001 (1) SA 1 (Constitutional Court of South Africa).

35 Ngwenya C (2011), *Sexual Health and Human Rights in the African Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/185/140_Ngwenya_Africa_2011.pdf The discussion in this paragraph is based on Ngwenya’s analysis.

36 AHRLR 205 (NgHC 2004).

37 This paragraph draws on the analysis of Restrepo-Saldarriaga E (2011), *Advancing Sexual Health through Human Rights in Latin America and the Caribbean*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/183/140_Restrepo_LAC_2011.pdf

38 Const. Ct. Col., Decision SU-256/96 (30 May 1996).

39 Restrepo-Saldarriaga E (2011), *Advancing Sexual Health through Human Rights in Latin America and the Caribbean*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/183/140_Restrepo_LAC_2011.pdf

40 UN General Assembly (2006), *In-depth Study on All Forms of Violence against Women: Report of the Secretary General, A/61/122/Add. 1*, available at <http://www.unhcr.org/refworld/docid/484e58702.html>

41 UNAIDS (2010), *Report on the Global AIDS Epidemic*, Geneva, Switzerland, available at http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf. Chapter 5 of the report, “Human Rights and Gender Equality”, surveys the status of HIV/AIDS legislation and multisectoral strategies globally. Three particularly relevant bar graphs from this chapter are reproduced in Annexure III of this paper; also recommended (although not reproduced here) are the chapter’s regional “Scorecards” on human rights and gender equality.

2.5 Laws Regarding Violence against Women and their Impact on Women's HIV Vulnerability

To address VAW, DEVAW urges States to exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of VAW, whether those acts are perpetrated by the State or by private persons. In the context of HIV/AIDS, in addition to realising gender equality, it is also recognised that effective prevention can be achieved by ensuring access to care, support and treatment and through the acceptance of voluntary and confidential counselling and testing.⁴² Sections III-V below examine laws regarding VAW in terms of their impact on women's HIV vulnerability and their role in either enhancing or impeding women's access to HIV/AIDS-related healthcare and support.

III Violence against Women in Intimate Situations

VAW is a function of inequality – legal, political, economic and social – and factors that lead to or reinforce this inequality – laws, policies, customary practices, etc. – exacerbate women's vulnerability to violence and, consequently, their vulnerability to HIV infection. This section examines a variety of situations in the domestic sphere where women experience violence because they are denied equality rights, lack awareness of existing rights or lack a facilitative environment that would empower them to exercise their rights effectively.

3.1 Violence against Women in the Context of Marriage⁴³ and Domestic Relationships⁴⁴

Although most countries have brought marriages under civil legal systems, some countries (particularly in Africa and South Asia, as mentioned earlier), also have customary/ religious/ personal laws that regulate marriages and that, in many instances, are explicitly discriminatory towards women.⁴⁵ However, it is important to recognise that a patriarchal ideology permeates such civil systems as well, which while perhaps not explicitly gender discriminatory, are nevertheless founded on patriarchal principles of social order, morality and justice, where women occupy a subordinate position to men and where control of women's sexuality is a male prerogative. This is demonstrated, for instance, in the fact that marital rape is not recognised in many common law countries. The notion of marriage as the sole arena for the legitimate exercise of female sexuality and the family as a naturally "*monogamous, exogamic and heterosexual*"⁴⁶ institution headed

42 Article 14, UNGASS Declaration of Commitment on HIV/AIDS.

43 The link between women's equality rights in marriage and their sexual health is well summarised below:

"In human rights, the focus on equal, free and full consent for all persons (female and male) to decide if, when, and whom to marry, and to dissolve marriage—as an aspect of their dignity and rights—has important consequences for sexual health... Equality of rights in marriage is an especially important aspect of rights for the sexual health of women, and it is important to note that equality between men and women in marriage may require affirmative action by the state. The equal right of men and women, therefore, underscores the importance of laws that promote: access to reproductive and sexual health information and services; men's and women's right to access and use family planning; and, ensure rights to legal and other remedies for any abuses that may occur within marriage and on its dissolution..."

Many legal regimes governing marriage operate in ways that mean that women are regularly denied bodily autonomy and also face conditions that undermine their sexual health: when they are coerced into marriage, cannot refuse sex within marriage, or are compelled by custom or law to remain widowed or to remarry, or conversely when law or custom allows them to be shunned or otherwise socially ostracized after divorce or widowhood... Of particular importance to sexual health are marriage regimes that treat married women as legal minors or dissolve their rights into the rights and privileges of the male spouse, particularly those regimes that: disallow women access to health care services (through requiring male or spousal consent); bar (in law or in practice) prosecution or other intervention against an abusive spouse; or, restrict widows or divorced women from equal powers over property, inheritance, or control or decisions over children, etc."

From Cusack S (2011), *Advancing Sexual Health and Human Rights in the Western Pacific*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/179/140_Simone_Cusack_Western_Pacific_2010.pdf

44 The term "domestic relationships" as used in this paper covers all relationships in a shared household.

45 For instance, levirate marriages (or 'widow inheritance') in Africa draw from customary law and, though violative of human rights enshrined in international and regional instruments and domestic law, are not specifically outlawed in African jurisdictions. Sri Lanka's *Kandyian Marriage & Divorce Act, 1952* sets unequal standards for divorce by requiring fewer grounds from the husband (who need only show adultery on his wife's part) than the wife (who must prove adultery coupled with incest or gross cruelty on her husband's part). Sri Lanka's *Muslim Marriage and Divorce Act, 1951* recognises the right of Muslim men to enter into polygamous marriages, as does Bangladesh's *Muslim Family Laws Ordinance, 1961*. Section 9 of India's *Hindu Marriage Act, 1955* allows the restitution of conjugal rights and, while its language is gender-neutral, in practice it is almost always used by husbands and rarely resorted to by wives. A laudable decision of the Andhra Pradesh High Court in *T. Sareetha v T. Venkata Subaiah* AIR 1983 AP 356, noted this uneven use and struck down section 9 as "*the grossest form of violation of [a woman's] right to privacy*" and violative of constitutional guarantees of equality. However, when this precedent was cited in *Harvinder Kaur v Harjinder Singh* AIR 1984 Del 66, the Delhi High Court strongly disagreed with the judgement, saying that the "*[i]ntroduction of constitutional law in home is most inappropriate. It is like introduction of a bull in a china shop. It will prove to be a ruthless destroyer of the marriage institution and all that it stands for. In the privacy of the home and the married life neither [the Constitutional guarantee of privacy nor of equality] has any place.*" In *Saroj Rani v Sudarshan Kumar Chadha* (1984) 4 SCC 90, the Supreme Court of India upheld the Delhi High Court judgement and overruled the Andhra Pradesh High Court. In contrast, courts in Bangladesh have, on occasion, held the restitution of conjugal rights (permitted under the *Muslim Family Laws Ordinance, 1961* to be incompatible with constitutional guarantees of equality. In *Nelly Zaman v Giasuddin Khan* 34 DLR (1982), the High Court commented: "*It is difficult to appreciate that the right of conjugal relationship with one's wife can be compared with the transfer of immovable property unless a woman is considered as immovable property... [This] proposition... must be held to be grossly erroneous and absurd on the faith of it.*" Section 15 of India's *Hindu Succession Act, 1956* provides two different schemes of succession based on the sex of the intestate; in *Sonabai Yeshwant Jadhav v Bala Govinda Yadav* AIR 1982 Bom 156, the court upheld these gender-discriminatory provisions. For further case law in this regard, see Pradhan Saxena, P (2011), *Constitutional Validity of Personal Laws in India* in Jaising I (Ed.), *Elusive Equality: Constitutional Guarantees and Legal Regimes in South Asia, Malaysia and China*, Women Unlimited, New Delhi, India.

46 Restrepo-Saldarriaga E (2011), *Advancing Sexual Health through Human Rights in Latin America and the Caribbean*, International Council on

by the *pater familiae* is the implicit, unquestioned basis of most legal regimes which, therefore, place great emphasis on the preservation of the 'normal' family as the cornerstone of society. In civil systems, the State often assumes the role of *pater familiae*, especially in its dealings with women, who are seen as in need of protection rather than empowerment.

VAW can occur at all stages of the marriage:

- At the time of entry when women are forced into marriages or are coerced into marriages without their free and informed consent.
- During the course of the marriage/ domestic relationship when there may be domestic and/ or sexual violence.
- At the end of marriage either through dissolution of marriage or on the death of the spouse when women are rendered vulnerable due to discriminatory alimony or inheritance laws.⁴⁷

3.1.1 Entering into Marriage

Full and Free Consent

*"The majority – often the vast majority – of sexually active girls aged 15-19 in developing countries are married."*⁴⁸

*"Forced marriage and marriage of children are forms of gender violence hindering girls' abilities to control their sexuality. . . It may also be a precursor to domestic violence, forced labour and sexual slavery. . . Worldwide, adolescents and young women are more than three times more likely to be living with HIV/AIDS than young men."*⁴⁹

Article 16 of CEDAW⁵⁰ and the *Convention on the Right to Marriage* (an oft-overlooked international instrument) both emphasise the integral link between women's full and free consent to marriage and their ability to negotiate safe sex within marriage.

Although marriage laws in most countries are premised on free and voluntary consent of both parties, the CEDAW Committee, in its General Recommendation 21, notes that, *"an examination of States parties' reports discloses that there are countries which, on the basis of custom, religious beliefs or the ethnic origins of particular groups of people,⁵¹ permit forced marriages or remarriages."*

The issue of consent in marriage is addressed by provisions that (i) make forced marriages void/voidable or criminalise them⁵² and (ii) that restrain child marriage.

Human Rights Policy, available at http://www.ichrp.org/files/papers/183/140_Restrepo_LAC_2011.pdf

47 Please note that this paper will not address inheritance and property laws, which is covered in a separate working paper. However, our discussion of harmful practices (section 3.2) includes mention of some cultural practices that are set in motion at the time of the death of a husband.

48 Bruce J (2007), *Child Marriage in the Context of the HIV Epidemic*, Population Council, available at http://www.popcouncil.org/pdfs/TABriefs/PGY_Brief11_ChildMarriageHIV.pdf

49 Special Rapporteur on Violence against Women (2005), *Intersections of Violence against Women and HIV/AIDS*, E/CN.4/2005/72, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/102/11/PDF/G0510211.pdf?OpenElement>

50 CEDAW's Article 16 reads, in part:

"1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

(a) The same right to enter into marriage;

(b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent;"

51 According to Ngwena (in *Sexual Health and Human Rights in the African Region*, note 28), in most jurisdictions in Africa, parties can choose whether to marry under civil, customary or religious law. Although, in theory, this choice is freely available to men and women, in practice, entrenched gender inequality in the region means that, usually, men make this decision. Geographic location and education also affect this choice: people living in rural areas and/or with little or no education, are more likely to choose customary or religious law marriages.

52 For example, Indonesia's *Law on Human Rights, 1999* provides that *"marriage shall be entered into only with the free and full consent of the intending spouses."* India's *Hindu Marriage Act, 1955* makes marriages voidable if there is no consent. Its *Special Marriages Act, 1954* makes those marriages voidable at the instance of either party where there is no valid consent or where the consent was obtained through fraud or coercion. However, the country's *Parsi Marriage and Divorce Act, 1936* neither provides specifically for consent, nor recognises the lack of consent as a ground for divorce or nullification. In contrast, in Bangladesh, in *Dr. Shipra Chaudhary and Another v Government of Bangladesh and Others* 29 BLD (HCD) 2009, the High Court considered a case of forced marriage and, while noting that *"the line between forced and arranged marriages is often not drawn in [Bangladeshi] culture with a deeply traditional respect for the family hierarchy"*, nevertheless held that forced marriages were not permissible in the country. Referring to CEDAW, DEVAW, the International Covenant on Civil and Political Rights and International Covenant on Economic, Social and Cultural Rights, among other international instruments, the court said:

"In this connection it is important to note that the parents, of course, have the right to advise their children but they must not treat their children as their slaves who must have their freedoms particularly when they are adults. The parents must remember that they are not living in old ages, but in the twenty first century where freedom of every human being irrespective of sex is universally recognized. The petitioner's liberty enshrined in the Constitution shall mean and include her right to make decision concerning her groom free of coercion, violence and discrimination."

Several European countries – including Belgium, the Czech Republic, Germany, Hungary, Portugal and the Russian Federation – deem forced marriages null and void. In 2003, Norway chose to directly penalise forced marriages through an amendment to the *Norwegian Criminal Code* (LAW-

Age of Consent

Consent to marriage is also a function of the age of the parties to the marriage. UN instruments recommend that the minimum age of marriage be 18 years,⁵³ but do not specify a numeral age, leaving this determination to the State's discretion. The statutory age of marriage varies from country to country, but is mostly within the 15-22 years range, with many countries recognising marriages below this age bracket through parental/guardian consent provisions or the recognition of customary/ religious/ personal laws.⁵⁴

A majority of countries prescribe differential ages for men and women, with women's ages being lower than that of men: a practice based on patriarchal notions of women's development and role in the family and one which further impedes women's ability to negotiate safe sex.⁵⁵

A few countries criminalise child marriages. In some countries – Malawi, for instance – provisions penalising those marrying off children are part of laws protecting children's rights.⁵⁶ In most countries, child marriages may be declared

1902-05-22-10, as amended). In 2007, the Swedish Migration Court granted asylum to a 15-year-old Tunisian girl on the grounds that she risked being subject to a forced marriage if she returned to Tunisia. The court considered forced marriage as a violation of human rights serious enough to be understood as persecution as per the terms of the Refugee Convention (case: UM 721-07). The United Kingdom does not have a law expressly prohibiting forced marriage; nor is it a specific criminal offence to force someone into a marriage. There is some concern that such legislation could drive forced marriages underground and prevent victims from seeking help. Instead, the UK has civil legislation on this issue: the *Forced Marriage (Civil Protection) Act 2007* gives British courts the power to issue Forced Marriage Protection Orders. These orders aim to protect both a person from being forced into marriage and to persons who already have been forced into marriage. The orders can contain "prohibitions, restrictions or requirements" or "other terms" that the court considers necessary in the individual case and can include, *inter alia*, orders to prevent a forced marriage from occurring, order to hand over passports, to stop intimidation and violence, and to stop a person from being taken abroad. The terms may relate to conduct both within the UK and outside the UK. They can relate both to the person about to be forcefully married and to anybody aiding, abetting, or encouraging the forced marriage. Force is to be understood not only when there are threats of violence to the victim, but also when threats are made of violence against other parties, such as against the victim's family, or self-violence, such as when the perpetrator threatens to commit suicide if the marriage does not occur. The courts can attach powers of arrest to the orders, so that a person who breaches the order can be arrested. It is not clear from the wording of the Act what effect a protection order will have if issued after a forced marriage already has taken place. For more information on this Act, see Westeson J (2011), *Sexual Health and Human Rights: European Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/177/140_Johanna_Westeson_Europe_2010.pdf. In Papua New Guinea, the *Marriage Act 1963* allows for a marriage to be declared void if consent was obtained through duress or fraud; however, customary law marriages are exempt from the conditions enumerated in the Act and cannot be voided in the usual way, regardless of fraud or coercion. The *Marriage Act* does empower the district court to forbid the customary marriage of a woman, but it is the woman's responsibility to access the court in a timely manner and demonstrate coercion to the court's satisfaction. It is also important to note that legal definitions of consent and coercion vary: in Fiji, for instance, coercion is defined narrowly to mean only physical coercion.

53 CEDAW General Recommendation 21, Paragraph 36; Convention on the Rights of the Child General Comment 4, Paragraph 20.

54 In Tanzania, for example, the *Marriage Act of 1971* prescribes the ages of consent as 18 years for males and 15 years for females. However, it must be read alongside the country's Penal Code [section 138(6)] which provides that a person of African or Asiatic descent may marry or permit the marriage of a girl under the age of 12 years, provided there is no intention to consummate the marriage before the girl is 12 years old. In Kenya, the *Marriage Act of 1962* prescribes 21 years as the age of consent and 16 years as the minimum age of marriage with parental/guardian consent, but this does not affect Kenyan customary law, which does not specify a minimum age of consent save the practice of certain ethnic communities of requiring the girl to have menstruated prior to marriage. In Uganda, although the constitution sets the age of marriage for both men and women at 18 years, its parliamentary legislation also recognises customary law marriages under the *Marriage of Africans Act* and the *Hindu Marriage and Divorce Act*, both of which allow lower ages of marriage. In Nigeria, the *Marriage Act* prescribes 21 years as the age of consent to marriage. Under Islamic Sharia (Maliki school of jurisprudence) followed in Northern Nigeria, the mutual consent of both parties is a prerequisite for entry into marriage. At the same time, however, the Maliki school recognises the right of the father/ legal guardian of the bride and groom to conclude a valid marriage on behalf of their charges – a provision that can be used for conducting child marriages/ coerced marriages. Interestingly, as discussed by Ngwena (in *Sexual Health and Human Rights in the African Region*, note 28), in *Karimatu Yakubu v Alhaji Paiko* [unreported suit, appeal number CA/K80s/85 (Sharia Court of Appeal)], the Sharia court held that the marriage concluded on behalf of a teenage girl by her father without her consent constituted a violation of the girl's rights to liberty and dignity under the Nigerian Constitution.

55 According to the Foundation for Women's Health Research and Development (FORWARD):

"Child brides may also suffer vulnerability to HIV/AIDS. Being young and female in Africa is a major risk factor for infection and young girls are being infected at a considerably disproportional rate to that of boys. Whilst early marriages are sometimes seen by parents as a mechanism for protecting their daughters from HIV/AIDS, future husbands may already be infected from previous sexual encounters; a risk which is particularly acute for girls with older husbands. The age disparity between a child bride and her husband, in addition to her low economic autonomy, further increases a girl's vulnerability to HIV/AIDS. It exacerbates the abilities of girls and women to make and negotiate sexual decisions, including whether or not to engage in sexual activity, issues relating to the use of contraception and condoms for protecting against HIV infection, and also their ability to demand fidelity from their husbands."

From *Child Marriage and Forced Marriage*, available at <http://www.forwarduk.org.uk/key-issues/child-marriage>.

Further, according to the Special Rapporteur on Violence against Women:

"National AIDS policies are increasingly looking into age gaps between sexual partners as a factor for the spread of the disease, as unprotected sexual intercourse and the age differentials between spouses are the main determinants of HIV risk in married couples. According to a demographic and health survey of 26 countries, 'the majority of sexually active girls, aged 15-19, in developing countries are married, and these married adolescents tend to have higher rates of HIV infection than their peers.'"

From Special Rapporteur on Violence against Women (2005), *Intersections of Violence against Women and HIV/AIDS*, E/CN.4/2005/72, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/102/11/PDF/G0510211.pdf?OpenElement>.

56 *Act 7 of 2010 on Child Care, Protection and Justice*. However, according to a submission made by the National Youth Council of Malawi, Malawi,, for the Africa Regional Dialogue of the Global Commission on HIV and the Law: *"[Malawi's current laws do] not conform with the United Nations Convention on the Rights of the Child that Malawi ratified in 1991. Due to absence of comprehensive laws and weak implementation of available instruments, it is not surprising that most children are forced to drop out of school and are increasing being exposed to contracting HIV as they marry to older men. Unfortunately in such marriages they can not even demand HIV Testing and*

void or voidable at the option of the parties. India's *Prohibition of Child Marriage Act, 2006*, sets the minimum age of marriage at 21 for males and 18 for females. The *Act* does not make child marriages void *ab initio*, even though it prohibits them from taking place. The marriage is voidable at the option of the person who was the child in the marriage or when there is an element of being forced or deceived.

Matters are also complicated by inconsistencies between the age of consent to marriage and the age of consent to sexual intercourse: for instance, as per the Tanzanian *Marriage Act* of 1971 (discussed in endnote 55), the female age of consent to marriage is 15 years. Tanzania's *Penal Code*, on the other hand, prescribes 18 years as the minimum age of consent to sexual intercourse, and then goes on to make an exception for married, unseparated women and for persons of African or Asiatic descent where the girl's age of consent to marriage is under 12 years and her age for consummation of the marriage is 12 years. This inconsistency seems to imply that marriage provides a guarantee of sexual health for young girls – a presumption contradicted by physiological fact and socio-political reality. In addition to the grave burden that pregnancy and childbirth place upon a young girl's still-developing body, the low levels of literacy, agency and autonomy associated with child marriage render young girls more vulnerable to violence and less able to protect their health, both general and sexual.⁵⁷

Pre-marital HIV Testing

As per the Special Rapporteur on VAW,⁵⁸ forced marriages increase women's vulnerability to sexual violence. A forced marriage is defined as one entered into without the free and full consent of both parties.⁵⁹ In the context of HIV, this raises the vexed issues of level of consent and pre-marital disclosure of HIV status. In order to prevent HIV transmissions in the context of an epidemic and, in some cases, with a view to protecting women who are forced into marriage, there has been a growing trend of countries adopting mandatory pre-marital testing policies.⁶⁰ However, in addition to being ineffective and expensive,⁶¹ this practice tends to infringe upon the human right of privacy, which includes free consent to HIV testing, pre- and post-test counselling and maintaining confidentiality of test results.⁶²

Counseling as a protective factor as they do not have a voice. [sic.]"

According to the submission, at least half of currently married women in Malawi were wed before the age of 18. The submission goes on to say: "It is reported that the risk of HIV infection among young people is highly correlated to early marriages. The prevalence of HIV among females in union is 2 times more than those not in union for those aged 15-24 years."

57 According to FORWARD:

"A lack of education also means that young brides often lack knowledge about sexual relations, their bodies and reproduction, exacerbated by the cultural silence surrounding these subjects. This denies the girl the ability to make informed decisions about sexual relations, planning a family, and her health, yet another example of their lives in which they have no control. The cyclical nature of early marriage results in a likely low level of education and life skills, increased vulnerability to abuse and poor health, and therefore acute poverty..."

Women who marry early are more likely to suffer abuse and violence, with inevitable psychological as well as physical consequences. Studies indicate that women who marry at young ages are more likely to believe that it is sometimes acceptable for a husband to beat his wife, and are therefore more likely to experience domestic violence themselves...Violent behaviour can take the form of physical harm, psychological attacks, threatening behaviour and forced sexual acts including rape."

From *Child Marriage and Forced Marriage*, available at <http://www.forwarduk.org.uk/key-issues/child-marriage>

58 Special Rapporteur on Violence against Women (2005), *Intersections of Violence against Women and HIV/AIDS*, E/CN.4/2005/72, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/102/11/PDF/G0510211.pdf?OpenElement>

59 UN Division for the Advancement of Women (2010), *Supplement to the Handbook for Legislation on Violence against Women: "Harmful Practices" against Women*, available at <http://www.un.org/womenwatch/daw/vaw/handbook/Supplement-to-Handbook-English.pdf>

60 According to the Open Society Institute:

"The countries of Bahrain, Guinea, United Arab Emirates, and Saudi Arabia have enacted national laws and policies mandating premarital testing. Local governments and legislatures in five Indian states, districts in the Yunnan province of China, Ethiopia, and the Democratic Republic of the Congo have introduced or passed similar laws or regulations. Uzbekistan requires a premarital consultation with a medical practitioner, who has the discretion to mandate an HIV test. In Cambodia, Senegal, and Zimbabwe, some women's and mothers' groups have called on the government to enact mandatory HIV testing policies in the hope that it will reduce the spread of HIV to young women who are often powerless in choosing a husband..."

From Open Society Institute (2010), *Mandatory Premarital HIV Testing: An Overview*, available at http://www.soros.org/initiatives/health/focus/law/articles_publications/publications/mandatory-hiv-testing-20100513/mandatory-premarital-hiv-testing-20100513.pdf

61 Even in a resource-rich country like the US, for instance, states that enacted laws in the 1980s mandating premarital HIV testing soon repealed them due to concerns over effectiveness and cost. See Miller A et al (2010), *Sexual Health and Human Rights: United States & Canada*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/178/140_Miller_Roseman_Friedman_uscan_2010.pdf

62 According to the Open Society Institute:

"Confidentiality of mandatory premarital HIV test results is extremely challenging to maintain. In some cases, medical professionals disclose premarital test results directly to church marriage committees or traditional leaders. In other cases, couples are themselves required to disclose their results to the religious or state authorities who perform the marriage ceremony or issue the marriage license. For instance, in Malaysia, Muslim couples submit a certificate disclosing their HIV status to state religious departments when applying for a marriage license."

Even when such disclosure is not required, confidentiality can be compromised, especially in cases where serodiscordant marriages – in which one partner tests HIV-positive and the other HIV-negative – are disallowed or discouraged. The cancellation of marriage plans can lead to suspicions that one of the prospective partners has tested positive."

The manner in which marriages are arranged in many communities – as a contract between large families – makes it difficult, if not impossible, for premarital HIV test results to remain confidential. When parents or other family members arrange marriages or are the primary decision makers in the selection of a marriage partner, they may be the first to find out a test result even before the person who has been tested."

From Open Society Institute (2010), *Mandatory Premarital HIV Testing: An Overview*, available at http://www.soros.org/initiatives/health/focus/law/articles_publications/publications/mandatory-hiv-testing-20100513/mandatory-premarital-hiv-testing-20100513.pdf

It has been argued that a better strategy – i.e., one that is more effective from the perspective of both individual human rights (to life and privacy, among others) and public health, more tailored to address entrenched gender inequality and more realistic in a resource-constrained context – is to ensure the provision of pre-marital counselling on all aspects of sexual and reproductive rights, with a view to encourage parties to the marriage to opt for voluntary testing and to empower women to claim equality rights in marriage.

In 2002, when the government of the Indian State of Andhra Pradesh considered mandatory premarital HIV testing, the Lawyers Collective, a leading HIV/AIDS non-governmental organisation in India, wrote to the State government pointing out the various inadequacies of such a policy. These include: the ‘window period’ of the HIV-antibody test; the fact that premarital testing confers no protection post-marriage; and the considerable financial strain imposed upon resource-constrained public health systems.⁶³ Rather than the State merely adopting a punitive (and, possibly, paternalistic) strategy, the Lawyers Collective pointed out the importance of empowering women to negotiate sexual relations:

“It is not our intention to suggest that a woman (or any prospective spouse) does not have the right to ask for an HIV test. The question is that should it be done by making it mandatory or by empowering women so that they can themselves decide... [Mandatory] pre-marital testing is an easy way out. However, such a policy will only give a false sense of security. It will not empower women to negotiate sexual relations, which is what is really required i.e. the empowerment of women to prevent infection.”⁶⁴

However, this still leaves the question of disclosure unresolved. According to the Lawyers Collective, “all persons have the right to have the necessary information to protect [the] right [to life].⁶⁵ Most rights advocates maintain that women have the right to information about their fiancé’s HIV status prior to entering into marriage – although most women themselves are unaware that they may have this right. And most rights advocates are acutely sensitive to the importance of consent and confidentiality as regards testing. How should states take steps to create an enabling environment to meet the demand of women seeking disclosure without compromising the rights of HIV-positive persons? One possible approach is that suggested above by the Lawyers Collective: investing in the provision of education, information and counselling about HIV/AIDS, testing protocols and legal rights so as to empower women to make informed choices about their sexual health and responsibly exercise their human rights. If, after receiving pre-test counselling, a woman – or a couple – decides to get tested, the State must provide these services in a manner that balances the rights to information and confidentiality of both parties involved.

3.1.2 Violence against Women during the Course of Marriage and Domestic Relationships

Domestic violence – in its myriad forms – has the effect of inducing fear and creating vulnerability.⁶⁶ As sexual encounters are a vector for HIV transmission, this paper focuses on sexual violence⁶⁷ within domestic relationships.

Domestic Violence and HIV: An Overview

“Unremedied domestic violence, which is itself a widespread and chronic abuse of women all over the world, plays a critical role in exposing women to HIV infection. Violence, or the fear of violence, prevents women from freely accessing

63 Excerpts from the Lawyers Collective letter, available at <http://health.groups.yahoo.com/group/AIDS-INDIA/message/2349>, are reproduced below:

“...The most common way of testing for HIV is through an antibody test. However, the peculiarity of an HIV antibody test is the ‘window period’... [whereby] a single antibody test for HIV does not serve the purpose of preventing the prospective spouse from getting infected... [There] is also a high rate of false positive results in the country and... in view of the stigma surrounding HIV, a person who is actually not HIV-positive could be marred for life on account of a false positive result and may not be able to marry at all... Mandatory testing for HIV prior to marriage would only give the state a false sense of security and a false belief that the infection is being effectively prevented from spreading. A pre-marital HIV mandatory test does not prevent persons from getting infected after marriage, and thereby putting the spouse at the risk of getting infected. A pre-marital HIV test would not really prevent the spread of infection to the unmarried sexual partners or the needle sharing partners of the person affected by HIV... Further, this would only have the consequence of people going outside the State to marry, where such tests are not required. Mandatory testing could also open a racket of issuance of false certificates prior to marriage, thereby having a negative impact on the entire public health system. Mandatory pre-marital testing for HIV could prove to be very costly public health strategy for the state, as repeated tests require to be undertaken for confirming the positive status of a person. This could drain out the funds substantially. In most personal laws marriages are not required to be registered. Thus, for example, a Hindu marriage can be solemnized only by performing ceremonies. No registration is required. Therefore, a policy for mandatory testing would be impossible to implement. Successful public health strategies are those that have optimally utilised the scarce resources, both infrastructural and financial resources, in empowering and encouraging women to prevent themselves from getting infected.”

64 *Ibid.*

65 “Preface” in The Lawyers Collective (2007), *Legislating an Epidemic: HIV/AIDS in India*, Universal Publishing Pvt. Ltd, New Delhi, India.

66 See Annexure IV for selected statistics on domestic violence.

67 Due to space constraints, this paper focuses on sexual violence as the more direct vector of HIV transmission, although the authors are aware of the “substantial overlap” between physical and sexual violence as reported in the World Health Organisation (2005), *Multi-Country Study on Women’s Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes and Women’s Responses*, available at http://www.who.int/gender/violence/who_multicountry_study/en/

*HIV/AIDS information, from negotiating condom use, and from resisting unprotected sex with an HIV-positive partner. Women may also face violence as a result of their own HIV-positive status.*⁶⁸

Due to their lack of economic independence and, in resource-scarce countries, the lack of adequate public support systems, women are compelled to stay in violent relationships. To address all forms of VAW, the UN Division for the Advancement of Women recommends the adoption of a comprehensive legal approach “encompassing not only the criminalization of all forms of violence against women and effective prosecution and punishment of perpetrators, but also the prevention of violence, and the empowerment, support and protection of survivors.”⁶⁹ The appropriate intervention, therefore, is not only to enact laws on VAW, but also to write effective implementation into such laws – hence, the emphasis on prevention, support and protection. This recommendation is particularly relevant in the context of domestic violence.

Several countries have enacted special laws on domestic violence; these are mostly criminal laws that also contain provisions for civil injunctions or protection orders.⁷⁰ However, enacting special laws on VAW is effective only if these laws are duly implemented which, in turn, requires certain financial and infrastructural investments, such as: adequate budgeting; procedures tailored to provide timely relief and justice; and mechanisms to monitor on-the-ground enforcement so as to hold the State accountable for realising women’s human rights to dignity and a life free of violence. Unfortunately, States often fall short in instituting such measures. A recent Human Rights Watch report points out that, despite strong protection laws in Turkey that set out requirements for protection orders and women’s shelters, gaps in the law and implementation failures by police, prosecutors, judges and other officials make the system “unpredictable at best, and at times downright dangerous.”⁷¹

Case law from the European Court of Human Rights and the Inter-American Court of Human Rights also demonstrates instances where the State has failed in its duty to protect victims of domestic violence and to take adequate and timely action against its perpetrators despite the presence of strong legal provisions requiring it to do so.⁷²

68 Human Rights Watch (n.d.), *Domestic Violence and HIV Infection in Uganda* available at <http://www.hrw.org/legacy/campaigns/women/aids/index.htm>

69 UN Division for the Advancement of Women (2009), *Handbook for Legislation on Violence against Women*, available at <http://www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>

70 *Ibid.* The handbook recommends that legislation on violence against women should be gender-sensitive to prevent manipulation by violent perpetrators and to reflect the specific experiences and needs of female victims of violence. However, a survey of 78 countries on the UN Secretary General’s database on violence against women indicates that only some countries have gender-specific laws on violence (Spain, Philippines, India, certain South American countries) or have laws that include a combination of gender-specific and gender-neutral clauses (Sweden, Austria). Further, the majority of countries (almost 50) use criminal provisions and provisions in special enactments to address violence against women. It is noteworthy that almost all criminal provisions and most special enactments are not gender-sensitive. However, a majority of countries (56) have specific national plans to combat violence against women and address issues of violence against women under broader policies on gender and women’s rights. Similarly, protocols issued and trainings provided to a range of law enforcement officials and other stakeholders are on violence against women and, hence, are gender-specific, with some countries acknowledging that although laws may be neutral, violence – particularly sexual and domestic violence – is primarily targeted towards women. A significant number of countries have made provisions for services to women victims of violence. Many countries in which citizens are entitled to certain social services – such as shelter, health, housing, and financial services – make provisions to ensure that such services are made available to women victims of violence on a priority basis. For further information, see Basu A (2011), *A Study of Measures Taken by State Parties to Address Violence against Women* (unpublished paper prepared for UN Women) available at <http://webapps01.un.org/vawdatabase/home.action>

71 Human Rights Watch (2011), *He Loves You, He Beats You: Family Violence in Turkey and Access to Protection*, available at <http://www.hrw.org/en/reports/2011/05/04/he-loves-you-he-beats-you>

72 In *Airey v Ireland* [Application No. 6289/73, decided on 9 October 1979], the Court ruled that the state’s failure to provide access to the remedy of judicial separation/divorce, thereby compelling the applicant to remain in an abusive relationship, constituted a violation of Articles 6 (right to a fair trial) and 8 (right to respect for private and family life) of the European Convention of Human Rights. In *Kontrova v Slovakia* [Application No. 7510/04, decided on 31 May 2007], the Court ruled that Article 2 (right to life) of the European Convention required not only that the state abstain from the unlawful taking of life, but also that it take appropriate steps to safeguard the lives of persons within its jurisdiction by putting in place a criminal law regime. This was the first case in the European Court that applied the concept of positive state obligations or ‘due diligence’ to cases of domestic violence. In *Bevacqua and S. v Bulgaria* [Application No. 71127/01, decided on 12 June 2008], this obligation was expanded to Article 8; the Court ruled that states have positive obligations to protect individuals from violence stemming from private parties and, noting the particular vulnerability of victims of domestic violence, reiterated that several international bodies have emphasised the active involvement of the state in their protection. In *Branko Tomasic and Others v Croatia* [Application No. 46598/06, decided on 15 January 2009], the Court ruled that the state’s obligations, under Articles 2 and 8, to intervene in order to protect persons from domestic violence extended to situations where the partners are not married to each other. In *Opuz v Turkey* [Application No. 33401/02, decided on 9 June 2009], the Court strengthened due diligence jurisprudence on intimate partner violence by ruling that the state’s failure to effectively counteract foreseeable domestic violence violated Articles 2 and 3 (prohibition of torture) of the Convention. This was also the first time that the Court recognised that the state’s failure to respond adequately to gender-based violence could amount to a violation of Article 14 (prohibition of discrimination) of the Convention. In reaching this decision, the Court referenced international instruments – such as CEDAW and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Pará) – where VAW has been placed in the context of discrimination against women. According to Westeson, “[t]hese cases make clear that domestic abuse no longer shall be seen as a ‘private matter’ within the family, but instead as one where the state has a real obligation to intervene.” For further case law in this regard, see Westeson J (2011), *Sexual Health and Human Rights: European Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/177/140_Johanna_Westeson_Europe_2010.pdf. In *Maria da Penha Maia Fernandes v Brazil* [Case 12.051, Report No. 54/01 (Merits), Inter-Am. C.H.R., OEA/Ser.LV/II.111 Doc. 20 rev. at 704 (2000) (16 April 2001)], the Inter-American Court of Human Rights noted that systemic procedural inefficiency and judicial delay in cases of domestic violence create an atmosphere of impunity:

Denial of the Right to Reside: an experience from Sri Lanka

The right to choose one's place of residence and the right to freedom of movement is a constitutionally guaranteed human right in Sri Lanka. Yet for Princey Mangalika this constitutional right meant nothing as residents of her village set fire to her home and forced her and her two young daughters to leave because of her HIV status.

In 2001, her husband who worked in Germany for many years, tested positive for HIV. Soon after that Princey also tested positive and since then Princey has battled to ensure her right to dignity and the rights of others living with HIV.

Violation of the right to choose her place of residence is among only one of the many violations that Princey experienced. After her husband tested positive, medical staff at a state run hospital where he underwent the test breached his right to privacy by sharing this information with other staff in the hospital who in turn shared it with the residents of the village in which Princey and her husband lived. The hostile reaction of the community forced Princey to leave the village in which they resided and return to 'her' village.

Her husband could not handle the marginalization, the shame and the stigma of his HIV status and committed suicide. Burial of her husband's body in his village was prevented by the residents and Princey was forced to bury her husband's body in Colombo. It was after her husband's death that her neighbours set fire to her house in which she resided with her two daughters and which caused Princey to flee yet again.

Princey's two daughters were also subjected to discrimination. Soon after she tested positive, parents had removed their children from the school in which her daughters were studying forcing Princey in turn, to take her children out of school. "At that time I took it as their fate that even my children would be subjected to discrimination because of my HIV status. My greatest regret is that I did not teach my children that this need not be so," says Princey. "I will not allow any other child to suffer the same fate as my children," she said. "No child, whether they are HIV-positive, or live with parents who are HIV-positive, should face the discrimination that my children did."

...According to Princey although the constitution contains a right to equality and non-discrimination there are several areas in which PLHIV experience discrimination and exclusion. The health sector was one of those areas. Several of those who have sought support from the Positive Women's Network have complained about the lack of confidentiality in the health sector; the marginalisation they experience when they seek treatment; the unwillingness of medical staff to provide adequate information; and blood tests which are done without the consent of the patient. "It is my body, yet I did not get the information I was entitled to. They treated me like I didn't own my own body," says Princey in relation to her own experience.

- Submission made by Positive Women Network, Sri Lanka, for the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law

Apart from implementation failures, other aspects may also impede a woman's access to justice under special legal measures taken for domestic violence. For instance, the United States (US), Canada and some countries in Europe follow policies of warrantless or mandatory arrest in cases of domestic violence or protective order violations and a policy of mandatory or no-drop prosecutions, which means that proceedings continue independent of the woman's consent. Such laws are controversial: while proponents argue that they protect victims and send a clear message of zero tolerance to the abuser, it has also been observed that such practices can discourage women – particularly undocumented immigrants and minority groups mistrustful of the police – from reporting violence. Further, since such laws are gender-neutral, there is a possibility of dual arrests – i.e., of the man and the woman – in cases where the police is unable to determine who the abuser is. In Canada, it has been observed that no-drop prosecution policies have discouraged women from testifying.

"The failure to prosecute and convict the perpetrator under these circumstances is an indication that the State condones the violence suffered by Maria da Penha, and this failure by the Brazilian courts to take action is exacerbating the direct consequences of the aggression by her ex-husband. ... Given the fact that the violence suffered by Maria da Penha is part of a general pattern of negligence and lack of effective action by the State in prosecuting and convicting aggressors, it is the view of the Commission that this case involves not only failure to fulfill the obligation with respect to prosecute and convict, but also the obligation to prevent these degrading practices. That general and discriminatory judicial ineffectiveness also creates a climate that is conducive to domestic violence, since society sees no evidence of willingness by the State, as the representative of the society, to take effective action to sanction such acts. ... [The combination of] ineffective judicial action, impunity, and the inability of victims to obtain compensation [demonstrates] the lack of commitment [of the Brazilian state] to take appropriate action to address domestic violence."

For further details on this case, see Restrepo-Saldarriaga E (2011), *Advancing Sexual Health through Human Rights in Latin America and the Caribbean*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/183/140_Restrepo_LAC_2011.pdf.

An important consideration that prevents women from leaving violent relationships is the inability to find appropriate accommodation - being driven out of their homes as a result of domestic violence is also alarmingly common. Housing and residence rights, therefore, assume added importance in the context of domestic violence. Laws on protection orders also provide for ouster orders (whereby the perpetrator is prevented from entering the shared residence) and residence orders to guard against unlawful eviction. In the US, the *Violence against Women and Department of Justice Reauthorization Act, 2005* introduced new provisions and programmes to provide survivors of violence further housing rights, and amended laws to guard against eviction of survivors or from them being denied public housing. While it may be argued that the US has the finances to undertake such measures, India's *Protection of Women from Domestic Violence Act, 2005* provides a good practice example that may be adopted in the context of unjust religious laws and scarce resources. The Indian law is a civil law that recognises a woman's right to reside in a shared household to prevent illegal evictions resulting from domestic violence. The reform of religious laws governing inheritance and marriage is a contested issue in India and state-sponsored public shelter services are far from adequate. By recognising a right to reside, as distinguished from the right to property, the law circumvents the tricky issue of reforming religious laws and ensures that survivors are sheltered in their own homes.⁷³ This right is given effect by empowering courts to grant residence orders to meet shelter requirements of survivors and monitoring reports indicate that the law has proven effective in safeguarding women's rights within the home: for instance, women widowed due to AIDS have been able to use these provisions counter coercion and forced eviction by their in-laws.⁷⁴

Another important aspect of laws on domestic violence is that, in most cases, the ambit of the law is limited to violence between legally married couples, leaving a range of cohabitative relationships out of the law's protective remit. For instance, in Japan, unmarried couples are not covered by the country's domestic violence prevention law, thus leaving an entire demographic of young women at increased risk of HIV infection through sexual violence.

Partner Notification in the Context of Domestic Violence

An issue that arises in the context of domestic violence and HIV is that of disclosure of HIV status to spouses/ sexual partners.⁷⁵ In many countries, while laws on HIV prevention and non-discrimination promote voluntary testing, they also obligate HIV-positive persons to disclose their serostatus to their spouse/ sexual partner at the earliest opportune time.⁷⁶ This duty is grounded in the obligation to do no harm and the concept of a partner's right to know about the risks they face. This form of partner notification is usually voluntary.⁷⁷ However, many countries authorise physicians or counsellors to conduct partner notification upon the failure or unwillingness, post-counselling, of the HIV-positive person to notify his/ her partner/s. This duty to disclose to partners who may be at risk of infection is based on the 'duty to warn'. Yet, extreme care must be exercised in the context of domestic violence and coercive partner notification policies should be discouraged in favour of the case-by-case exercise of discretion based on well-established protocols of partner notification that require an assessment of significant risk of transmission. Disclosure exacerbates domestic

73 This example should not be taken to imply that the reform of discriminatory religious or customary laws is unnecessary. It merely serves as an example of an effective, context-specific legislative response to a particular aspect of domestic violence in India.

74 Lawyers Collective Women's Rights Initiative (2007), *Staying Alive: First Monitoring & Evaluation Report 2007 on the Protection of Women from Domestic Violence Act 2005*, available at <http://lawyerscollective.org/files/Staying%20Alive%20First%20Monitoring%20and%20Evaluation%20Report%202007.pdf>, and Lawyers Collective Women's Rights Initiative (2008), *Staying Alive: Second Monitoring & Evaluation Report 2008 on the Protection of Women from Domestic Violence Act 2005*, available at <http://www.lawyerscollective.org/files/Staying%20Alive%20Second%20Monitoring%20and%20Evaluation%20report%202008.pdf>

75 For further information, see World Health Organisation (2004), *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes*, available at <http://www.who.int/gender/documents/en/genderdimensions.pdf>

76 Some states, for instance, require persons with HIV/AIDS to disclose their serostatus to sexual partners, and punish persons who fail to abide by that legal duty, regardless of circumstances (such as the threat of violence). See China: *Regulations on AIDS Prevention and Treatment of 2006* [Article 38(2)]; Papua New Guinea: *HIV/AIDS Management and Prevention Act 2003* [Section 24]; Philippines: *Philippine AIDS Prevention and Control Act of 1998* [Section 34]; Vietnam: *Law on HIV/AIDS Prevention and Control of 2006* [Article 4(2)(b)]; Moldova: Although the *Law on Prevention and Control of HIV/AIDS (2007)* is premised on a clear rights-based approach, HIV-positive individuals are required to disclose their serostatus to spouses/sexual partners.

77 An interesting contrast to the mandatory disclosure laws listed in *ibid* is the judgment of a New Zealand court in *Police v Dalley* (2005) 22 CRNZ 495, discussed by Cusack in *Advancing Sexual Health and Human Rights in the Western Pacific*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/179/140_Simone_Cusack_Western_Pacific_2010.pdf. New Zealand courts have held that while persons with HIV/AIDS must exercise reasonable care to avoid infecting sexual partners, such persons are under no legal obligation to disclose their HIV/AIDS status to sexual partners. In *Police v Dalley*, the Court dismissed charges of criminal nuisance against Justin Dalley, an HIV-positive man who had protected vaginal intercourse and unprotected oral sex with a woman to whom he had not disclosed his HIV status. In dismissing the charges against Dalley, the Court held that New Zealand law imposes a legal duty not to engage in conduct that could foreseeably expose a sexual partner to harm, including the risk of HIV infection. It also imposes a duty to take reasonable precautions against, and to use reasonable care to avoid, such harm. However, the Court held that the legal duty does not extend to disclosing one's HIV status:

"It seems ... that most people would want to be told that a potential sexual partner was HIV-positive. There may well be a moral duty to disclose that information. There is however a difference between a moral duty and a legal duty, the legal duty in this case being to take reasonable precautions against and use reasonable care to avoid transmitting the HIV virus. I note that the duty at common law is essentially the same - to take reasonable steps."

Therefore, Dalley was under no legal obligation to disclose his HIV status to his sexual partner. He was, however, required not to engage in conduct that could foreseeably expose her to the risk of infection:

"The duty... is to use 'reasonable' precautions and care. The duty is not to take failsafe precautions. Reasonableness is an objective standard. On the basis of this evidence, I find that in the circumstances Mr Dalley did take reasonable precautions and care."

Consequences of Partner Notification: an experience from Tanzania

I got married to Mr. X a holder of MBA in 1994. At that moment my husband was working with an International Organization. We had a middle class life and lived happily. After knowing that I was HIV-positive I had to disclose my HIV status to my husband. Surprisingly, he was very furious and started blaming me for our sons' illness. He exposed me to a lot of stigma and torture. My health deteriorated because of stigma and torture from my husband. I finally decided to come out in the open and get help instead of suffering in silence, so I joined a support group after disclosing my status. My husband accused me for being the cause of the death of his relatives who died of AIDS. I was also expelled from the matrimonial house that I built with my own money.

The whole situation was unbearable and I also got angry with him and filed a case for divorce in December, 1999. However, when we started the case he engaged a lawyer who put objection. The court had to start hearing the objection; in his objection he denied having married me. After the hearing it was ruled out that he had a case to answer. The case was transferred to the District Magistrate for hearing in 2004. However, the case was not heard until now. I wrote a letter to the Registrar and told him that I'm HIV-positive so my case should be treated with urgency because any delay of the case may cause denial of my rights. The Registrar wrote a letter to the District Magistrate court to start the proceed[ing]s but in vain. I wonder when justice will take place.

Though Tanzania has an HIV and AIDS Prevention and Control Act 2008 that started its operations in January 2009, the law does not protect those who disclose their status, because it is evident that 75% of the women who disclose their status do lose their marriages. As a woman living with HIV I thought this Law could help me and others live happily but it has proved a failure. Since justice could not prevail I lost my properties and decided to move out of STIGMA and find a better place for me to live, poorly but humbly.

It is a real challenge to the HIV and AIDS Prevention and Control Act 2008 in Tanzania, because there is no HIV and AIDS tribunal to deal quickly with ...appeals arising. If a knowledgeable person living in an urban area like me cannot obtain justice, how many women in the rural areas who cannot even afford to hire a lawyer or even fare to attend the court session can get justice? I feel that the law has not protected me because it is almost 11 years and the proceed[ing]s have not come to an end due to unknown reasons. I even hired a lawyer to assist me but he did not show any interest to continue with the case.

The Government of Tanzania is encouraging people to come out and disclose their HIV status but there is no mechanism to cope with the consequences after disclosure. I am a victim of sharing my HIV status with my partner.

- Anonymous submission from Tanzania for the Africa Regional Dialogue of the Global Commission on HIV and the Law

VAW and because pregnancy often triggers routine HIV testing, it is likely that women accessing prenatal care find out their serostatus before their partners do. An American Civil Liberties Union report on partner notification early on identified that:

"...45% of health care providers serving HIV-positive women reported that they had patients who feared partner notification because they were afraid of domestic violence. One quarter of the providers had patients who were in fact assaulted by their partners upon notification."⁷⁸

Healthcare policy in Canada and the New York State law on HIV prevention, therefore, obligates health professionals to assess the possibility of domestic violence and abandonment prior to notifying partners. The proposed Indian law on HIV carves out a specific exception to the duty of partner notification vis-à-vis health care providers:

"The healthcare provider shall not inform a partner, particularly in the case of women, where there is a reasonable apprehension that such information may result in violence, abandonment or actions which may have a severe negative effect on the physical or mental health and safety of the HIV-positive person, their children or someone who is close to them."⁷⁹

78 American Civil Liberties Union (1998), *HIV Partner Notification: Why Coercion Won't Work*, available at http://www.aclu.org/lgbt-rights_hiv-aids/hiv-partner-notification-why-coercion-wont-work

79 Article 13. See <http://www.lawyerscollective.org/files/Final%20HIV%20Bill%202007.pdf>

Sexual Violence within Marriage and HIV Vulnerability

"Because it is by definition non-consensual, rape has a higher risk of leading to HIV infection by virtue of physical injury to the woman's genitalia or anus. Even in the absence of apparent physical injury, rape can cause micro-lesions in the vagina which can be a route of infection for the virus."⁸⁰

Marital rape has been generally defined as unwanted intercourse or penetration obtained by the woman's husband through force, threat or when the wife is unable to consent.⁸¹ Although marital rape is an extremely prevalent form of sexual violence, historically, rape and sexual assault within marriages were not criminalised. This trend continues in countries where marital rape is an exception to the crime of rape (unless the couple is separated) – particularly South Asian and African countries which have not reformed their inherited colonial penal codes. Often, sex within marriages is regarded as a conjugal right, denial of which constitutes a marital offence.⁸² Marital rape is strongly linked with women's exposure to HIV, particularly since many women have little power within their marriage to abstain from sexual intercourse or negotiate safe sex.

In recent years, a number of countries have reformed criminal laws to criminalise marital rape and to recognise that married women have a right to refuse sex with their husbands: as one US court explained, the marital exception is *"based upon archaic notions about the consent and property rights incident to marriage,"* while gendered rape laws were grounded in long-standing stereotypical notions of the differences between the sexes and could not meet constitutional muster.⁸³

In a path-breaking judgment, Nepal's Supreme Court applied international norms to interpret marital rape as a crime and held that:

"If an act is an offence by its very nature, it is unreasonable to say that it is not the offence merely because of difference in person committing the act. It will yield discriminatory result, if we read that an act committed to any other woman is an offence and is not an offence, if the same act is committed to one's own wife. There is no justification in differentiating between the women who are wives and other women. Such discriminatory practice is against the provisions of the CEDAW and... the Constitution of Nepal..."⁸⁴

Although the criminalisation of marital rape and deletion of exceptions to marital rape constitute necessary steps⁸⁵ towards preventing sexual violence within marriages, law reform alone cannot comprehensively address this issue due to entrenched, patriarchal notions of marital obligations. In Ghana, for example, where the criminal law was amended to

80 Amnesty International (2004), *Women, HIV/AIDS and Human Rights*, AI Index: ACT 77/084/2004, available at <http://www.amnesty.org/en/library/info/ACT77/084/2004/en>

81 Kennedy Bergen R (1996), *Wife Rape: Understanding the Response of Survivors and Service Providers*, Sage.

82 International Association of Women Judges (2005), *The Gender and Legal Dimensions of HIV/AIDS: Women's Access to Justice and the Role of the Judiciary*.

83 *Pepe v Liberta*, 64 N.Y.2d 152 (1984), 1164-69485 N.Y.S. 2d 207 (N.Y. 1984). As per Westeson (in *Sexual Health and Human Rights: European Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/177/140_Johanna_Westeson_Europe_2010.pdf), in 1994, the UK amended its *Sexual Offences Act* to include marital rape within its definition of rape; according to the British Court of Appeals, *"a rapist remains a rapist subject to the criminal law, irrespective of his relationship with his victim."* In 1995, the European Court of Human Rights upheld this amendment, saying:

"What is more, the abandonment of the unacceptable idea of a husband being immune against prosecution for rape of his wife [is] in conformity not only with a civilised concept of marriage but also, and above all, with the fundamental objectives of the Convention, the very essence of which is respect for human dignity and human freedom." [Application Nos. 20166/92 and 20190/92, decided on November 22, 1995]

The Turkish Penal Code was reformed in 2004 and introduced major changes in its laws on sexual crimes including:

"...removal of patriarchal concepts, different classification and more progressive definitions of sexual crimes, and longer sentences for sexual crimes. For example, while sexual crimes were earlier classified as 'crimes against society/crimes against public morality and family', indicating familial and societal ownership over women's bodies and sexualities, they are now considered under the category 'crimes against sexual inviolability'. All references to concepts such as 'morality', 'chastity', 'decency', 'honor', 'shame', and 'public customs' have been eliminated. Earlier, crimes of rape and sexual abuse were defined as 'forced seizure of chastity and attack on honor'; the perpetrator of rape or abduction could avoid punishment by marrying the victim... All such references have been removed. The new code defines sexual assault as 'violat[ing] the physical integrity of another person, by means of sexual conduct', and is gender neutral... The marital rape exemption has been abolished."

84 *Forum for Women Law and Development v His Majesty's Government*, 2002 (Nepal).

85 However, not all countries have implemented the reforms necessary to comply with international standards in this regard: although the Zimbabwean *Criminal Law (Codification and Reform) Act of 2004* recognises non-consensual sex within marriage as rape, the removal of the marital exception is qualified by a restriction on the powers of law enforcement officers to bring a prosecution. Where a spouse is charged with 'rape', 'aggravated indecent assault', 'assault' or 'indecent assault', the Attorney General must authorise the prosecution. Lesotho criminalises marital rape with a substantive qualification: Section 3(3) of its *Sexual Offences Act* says that, *"Marriage or any other relationship shall not be a defence against a charge under this Act where it is shown that: (a) the complainant spouse or partner was sick;"* thus providing an exception in cases where the wife is not "sick". In addition to failing to define what constitutes "sick", the Act places on the wife the onus for proving both her sickness and her husband's knowledge of her sickness. For further analysis of marital rape laws in Africa, see Ngwena C (2011), *Sexual Health and Human Rights in the African Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/185/140_Ngwena_Africa_2011.pdf. Romania's *Criminal Code* exempts the rapist from criminal liability if he, before the ruling becomes final, marries his victim. In the Philippines, the *Anti-Rape Act of 1997* abolished the marital rape exception; however, marital rape is still permitted under section 2 of the Act insofar as subsequent forgiveness by the victim (i.e., the wife) removes criminal liability for the rape.

delete exceptions to marital rape, it has been observed that cultural practices which allow the treatment of women and girls as inferior in status to men still lead to some level of acceptance of marital rape.⁸⁶ Similarly, in Malawi, the secular penal code criminalises marital rape upon proof of lack of consent. However, customary law – wherein universal consent is implied upon marriage – applies in both the civil and criminal context, effectively exempting recognition of marital rape. Since marital rape is not recognised at the societal level, women subjected to marital rape are unable to access health services that, as per the Guidelines for the Management of Sexual Assault and Rape in Malawi (2005), should be offered to all victims of sexual assault: a full medical examination, emergency contraception, sexually transmitted infection (STI) treatment, Post-Exposure Prophylaxis (PEP) for HIV, treatment of injuries and psychosocial counselling. The lack of access to PEP for victims of marital rape also contributes to the high prevalence of HIV in Malawi.⁸⁷

And, as ever, implementation remains a challenge:

“The case law of the European Court of Human Rights shows that a number of countries may have sufficiently clear laws on paper but inadequate mechanisms for implementing these laws, or resistance within police and prosecutorial sectors to the application of more modern and rights-based approaches to sexual self-determination. Here should be reiterated that the lack of clarifying case law and reports from many countries, despite the existence of modern and inclusive laws, is a sign that sexual violence is still a significant and under-reported problem. This is even truer when it occurs within the home. The stigma attached to sexual violence in many countries and power relationships between perpetrator and victim make the law insufficient to bring the phenomenon to the surface and to effectively deal with it.”⁸⁸

3.2 Harmful Practices

The UN Secretary-General’s Report on VAW⁸⁹ records that women may be exposed to a wide range of “harmful practices” across their life cycle: pre-natal sex selection and female infanticide, child marriage, dowry related violence, female genital mutilation, so-called honour crimes, maltreatment of widows, inciting women to commit suicide, dedication of young girls to temples, restrictions on second daughter’s right to marry, dietary restrictions for pregnant women, forced feedings and nutritional taboos, marriage to the deceased husband’s brother and witch hunts. Harmful practices are emblematic of women’s inferior status in society and are shaped by culture, which makes these forms as varied as culture itself.⁹⁰ The UN Division for the Advancement of Women notes that migration, globalisation and/or conflict have resulted in the transfer of certain harmful practices to different locations as well as in changes and/or adaptations to the practices.⁹¹ Although there is little research to establish a firm causal link between harmful practices and HIV transmission,⁹² it is likely that any practice which involves gender-based violence, surgical or physical alteration procedures or coerced sexual interactions will have an impact on women’s vulnerability to HIV and their general health and well-being.

3.2.1 Widow Cleansing

Section 3.1.1 above discussed issues of consent/ coercion at the time of entry into marriage. The end of marriage generates its own set of consent/ coercion concerns. Widow cleansing, a ritual practiced by some communities in Africa, involves a widow having sexual relations with a designated village cleanser or with a relative of her deceased husband. This has traditionally been a way to break with the past and move forward, as well as an attempt to establish the family’s ownership of the husband’s property, including his wife.⁹³ Refusal to participate in such practices may lead to ostracism and social opprobrium. The risk of contracting HIV through this coercive practice is extremely high, leading some African countries to criminalise it: *“Political and tribal leaders are starting to speak out publicly against so-called sexual cleansing, condemning it as one reason HIV has spread to 25 million sub-Saharan Africans, killing 2.3 million last year alone.”⁹⁴* However,

86 Archampong E (2010), *Marital Rape: A Woman’s Equality Issue*, Equality Effect, available at <http://theequalityeffect.org/pdfs/maritalrapeequalityghana.pdf>

87 Submission made by Malawi Network of Religious Leaders Living With or Personally Affected by HIV and AIDS (MANERELA+), Malawi, for the Africa Regional Dialogue of the Global Commission on HIV and the Law.

88 Westeson J (2011), *Sexual Health and Human Rights: European Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/177/140_Johanna_Westeson_Europe_2010.pdf

89 UN General Assembly (2006), *In-depth Study on All Forms of Violence against Women: Report of the Secretary General*, A/61/122/Add. 1, available at <http://www.unhcr.org/refworld/docid/484e58702.html>

90 UN Division for the Advancement of Women (2010), *Supplement to the Handbook for Legislation on Violence against Women: “Harmful Practices” against Women*, available at <http://www.un.org/womenwatch/daw/vaw/handbook/Supplement-to-Handbook-English.pdf>

91 *Ibid.*

92 *KIT Exchange on HIV/AIDS, Sexuality and Gender* (2008).

93 UNAIDS, UNIFEM & UNFPA (2004), *Women and HIV/AIDS: Confronting the Crisis*, available at http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/women_ aids.pdf

94 La Franiere S, *AIDS Now Compels Africa to Challenge Widows’ Cleansing* in The New York Times, 11 May 2005, available at <http://www.nytimes.com/2005/05/11/international/africa/11malawi.html?hp&ex=1115870400&en=2082121aeb377902&ei=5094&partner=homepage>

the implementation of such laws – Zambia, for instance, amended its criminal code to make widow cleansing illegal – requires changes in traditional mindsets as well as actively collaborating with customary and traditional leaders.⁹⁵

3.2.2 Widow Inheritance/ Levirate Marriages

Levirate marriages (also described as ‘widow inheritance’), prevalent in some parts of Africa, are based on a (now declining) customary law practice whereby a widow, whether child or adult, is regarded as part of the estate of her deceased spouse and is thereby inherited by a relative (often the brother) of the deceased so that she can become his wife. Although customary law recognises the right of the widow to refuse the offer of a levirate marriage, in practice several factors may compel her to accept it. These include access to her deceased husband’s estate being conditional upon her consent to the marriage offer, fear of becoming destitute, and fear of being ostracised by the community. Levirate marriages have been identified as a significant fuel for the spread of HIV.⁹⁶

Levirate marriages violate international human rights instruments, regional human rights guarantees such as those provided by the *African Charter on Human and Peoples’ Rights* (African Charter) and the *African Women’s Protocol*⁹⁷ and the domestic law of African countries. However, only Nigeria specifically prohibits levirate marriage (and, there too, only for some States⁹⁸). Zimbabwe is the only jurisdiction that specifically recognises levirate marriages under its *Customary Marriage Act*, although it requires that such marriages be non-coercive.

The practices of widow cleansing and widow inheritance both manifest and exacerbate the vicious cycle of disempowerment and violence in which women all too often find themselves. Gender discriminatory property and inheritance rights leave widows with negligible negotiating power: her husband’s relatives can make access to matrimonial property conditional upon the widow’s adherence to traditional practices such as widow cleansing and/ or widow inheritance, which in turn can expose her to HIV. Inequality within marriage leaves women unable to negotiate safe sex; if they acquire HIV during their marriage, the fear of stigma and physical abuse discourages them from disclosing their serostatus to their husband or, in the case of widows, to their in-laws. Countries that criminalise HIV transmission – such as Kenya – compound the problem because women fear imprisonment should they disclose their serostatus.⁹⁹

3.2.3 Female Genital Mutilation or Cutting

Twenty-eight countries in Africa practice FGM,¹⁰⁰ which is also prevalent in some parts of the Middle East and Asia. Owing to migration, FGM has also spread to countries in Europe, North America, Australia and New Zealand.¹⁰¹

According to an Amnesty International report, FGM places girls and women at increased risk of HIV infection through several routes:

“Firstly, the use of unsterilized razors or knives to carry out the procedure among a number of girls risks passing the virus from one girl to the next should one of them be HIV-positive. Secondly, FGM renders the genitals more likely to tear during

95 Malungo JRS (2001), *Sexual Cleansing (Kusalazya) and Levirate Marriage (Kunjililamung’anda) in the Era of AIDS: Changes in Perceptions and Practices in Zambia* in *Social Science & Medicine*, Volume 53, Issue 3, pp 371–82, available at <http://users.aims.ac.za/~kgross/discussion/malungo2001.pdf>

96 Immigration and Refugee Board of Canada (2006), *Nigeria: Levirate Marriage Practices Among the Yoruba, Igbo and Hausa-Fulani; Consequences for a Man or Woman who Refuses to Participate in the Marriage; Availability of State Protection*, available at <http://www.unhcr.org/refworld/docid/45f1478811.html>. Also see UNDP (2004), *Human Development Report for Nigeria 2004, HIV and AIDS: A Challenge to Sustainable Human Development*, available at <http://hdr.undp.org/en/reports/nationalreports/africa/nigeria/name,3289,en.html>

97 Article 20 of the African Women’s Protocol states:
“States parties shall take appropriate legal measures to ensure that widows enjoy all human rights through implementation of the following provisions:
(a) that widows are not subjected to inhuman, humiliating or degrading treatment;
(b) that a widow shall automatically become the guardian and custodian of her children, after the death of her husband, unless this is contrary to the interests and welfare of the children;
(c) that widows shall have the right to remarry, and in that event to marry the person of her choice.”

98 *Prohibition of Infringement of a Widow’s and Widower’s Fundamental Rights Law of Enugu State, 2001; Widows’ Empowerment Law of 2002* (Edo State); *Malpractices against Widows and Widowers (Prohibition) Law of 2004* (Anambra State); *Inhuman Treatment of Widows (Prohibition) Law 2004* (Edo State).

99 See the submission made by Federation of Women Lawyers-Kenya (FIDA-Kenya), Kenya, for the Africa Regional Dialogue of the Global Commission on HIV and the Law. FIDA-Kenya undertook a study in collaboration with Georgetown University to evaluate the impact of the widely prevalent practices of widow cleansing and widow inheritance in the Nyanza region of Kenya and concluded that the region’s high incidence of HIV/AIDS could be attributed to these traditional practices.

100 FGM is practiced in three main forms:
“Type 1 which entails excision of the prepuce with or without excision of part or all of the clitoris; Type 2 which entails excision of the prepuce and clitoris together with partial or total excision of the labia minora, with or without excision of the labia majora; and Type 3 which entails narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia major, with or without excision of the clitoris (infibulation).”
From Ngwena C (2011), *Sexual Health and Human Rights in the African Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/185/140_Ngwena_Africa_2011.pdf

101 Ras-Work B (2009), *Legislation to Address the Issue of Female Genital Mutilation: Expert Paper on Harmful Practices against Women*, UNDAW, Addis Ababa, Ethiopia.

*intercourse. In cases of infibulation or sewing up of the vaginal entrance, penetration is bound to lead to bleeding, which in turn makes sexual transmission of the virus from an HIV-positive partner much more likely. Thirdly, difficulties with intercourse may make a woman less likely to welcome the partner's advances and lead him to a more violent approach to sex; or to engage in sexual practices with his wife (such as unprotected anal intercourse) which might place her at increased risk of HIV infection.*¹⁰²

FGM violates international human rights instruments and regional human rights guarantees, such as those provided by the *African Charter*, the *African Women's Protocol* and the *African Charter on the Rights and Welfare of the Child* (African Children's Charter). The *African Women's Protocol* is the first international treaty to prohibit FGM explicitly. In Article 5, this Protocol imposes a duty of legal proscription upon the State and, recognising that an exclusively legal intervention is insufficient, also places positive obligations on the State to create public awareness about harmful practices, provide support to victims and protect those at risk of being subject to such practices. Article 20 of the Gender and Development Protocol of the Southern African Development Community identifies FGM as a form of gender-based violence and requires State Parties to adopt legislation prohibiting all forms of gender based violence (GBV), including FGM, by 2015 and to ensure that perpetrators are brought before the courts.

FGM also violates some provisions of domestic law. Here its proscription may be through provisions in existing criminal codes or through special enactments that seek to penalise excisers (those conducting such procedures). However, the implementation of such measures remains a challenge, as is evidenced by the low levels of prosecution and conviction of excisers.¹⁰³ The lowest recorded rate of FGM in Africa is in Ghana (3.8% of girls and women in the 15-49 age group), which, in addition to constitutional provisions protecting women and girls from FGM and other harmful traditional practices, also has criminal provisions on FGM. The implementation of law is effective in Ghana for a number of reasons, including high levels of legal awareness in the community¹⁰⁴ and vigilante action by ex-excisers to book others engaged in the practice.

Laws in Europe and North America also prohibit FGM. In these countries, in addition to providers, parents coercing girls to undergo such procedures may be punished. Following a resolution of the European Parliament in 2001, a number of countries in Europe have assumed extra-territorial jurisdiction in matters of FGM. In the US, FGM has been recognised as a ground for persecution and hence a policy of non-refoulement is followed if there is a fear of FGM being committed.

3.2.4 Polygamy

Although secular marriage laws in most countries criminalise bigamy,¹⁰⁵ polygamy is sanctioned under customary or religious laws in many countries. Some countries that allow polygamous marriages under religious laws impose conditions for the entry into such marriages such as the consent of the existing wife/wives (Bangladesh's *Muslim Family Laws Ordinance, 1961*); the man's ability to provide living necessities and fair treatment to all his wives and children (Indonesia's *Marriage Law, 1974*); and notification to religious authorities (Sri Lanka's *Muslim Marriage and Divorce Act, 1951*).

In addition to inequality of status vis-à-vis men and women's lack of autonomy in polygamous marriages,¹⁰⁶ it has been observed that, in polygamous households, if one spouse (husband or wife) is HIV-positive, it is "almost inevitable" that other partners will also contract HIV.¹⁰⁷

102 Amnesty International (2004), *Women, HIV/AIDS and Human Rights*, AI Index: ACT 77/084/2004, available at <http://www.amnesty.org/en/library/info/ACT77/084/2004/en>

103 Ras-Work B (2009), *Legislation to Address the Issue of Female Genital Mutilation: Expert Paper on Harmful Practices against Women*, UNDAW, Addis Ababa, Ethiopia.

104 In his discussion of Eritrea's "crime and punishment" approach to FGM (an approach common to many African countries), Ngwena observes (in *Sexual Health and Human Rights in the African Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/185/140_Ngwena_Africa_2011.pdf):

"It is not accompanied by imposition of duties on the state to fulfil especially the implicated human rights through a holistic approach to the eradication of female genital mutilation. For example, the proscription does not come with duties to educate, raise awareness and involve democratic institutions, civil society in particular in the eradication of the practice."

105 In contrast, Nepal's secular law – the Chapter on Marriage of the Country Code – allows bigamy for men under certain conditions.

106 CEDAW Committee General Recommendation Number 21, which states:

"Polygamous marriage contravenes a woman's right to equality with men, and can have such serious emotional and financial consequences for her and her dependents and that such marriages out to be discouraged and prohibited."

107 Special Rapporteur on Violence against Women (2005), *Intersections of Violence against Women and HIV/AIDS*, E/CN.4/2005/72, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/130/90/PDF/G0513090.pdf?OpenElement>

3.2.5 Adultery

In many countries across the world, adultery continues to be a crime punishable by severe penalties, including, in the most extreme instance, stoning.¹⁰⁸ Such laws are discriminatorily drafted as they criminalise women far more than they do men. In some countries, women who are unable to prove rape (for which itself evidentiary requirements are heavily skewed against women) are charged with having committed adultery. A diagnosis of HIV-positivity can also result in a woman being accused of having acquired it through adultery and consequently being subject to violence. As we have seen elsewhere, here too criminalisation has an adverse impact on women's autonomy and health.

IV Violence against Women in the Community

While all forms of GBV are discriminatory and adversely affect women's well being, sexual violence in particular increases women's vulnerability to HIV. Sexual violence ranges from exhibitionism to penetration. In addition to sexual violence in intimate settings, women face sexual violence from strangers and acquaintances, teachers, employers and family members.¹⁰⁹ The authors recognise that sexual violence is not directed at women alone, yet it is an inherently gendered phenomenon. Systemic sexual violence has featured in all recent situations of conflict, making women disproportionately vulnerable to HIV. Laws in most countries protect women from sexual violence within the community by criminalising rape, sexual harassment and trafficking and prostitution. International law obligates States to protect human rights in the context of sexual violence by taking positive measures to prevent and prohibit sexual violence in all its forms and to fulfill the right to health by providing appropriate health care to survivors of sexual violence.

4.1 Rape

Historically, the recognition of sexual violence in law has been limited to rape, and definitions of rape have focused on proof of penetration and use of force. This formulation does not take into account the full range of sexual violations faced by women. Further, criminal laws, couched as they are in the language of morality, decency and public honour, regard rape as a crime against the family and society rather than as a violation of an individual's bodily integrity. There has been some progressive law reform in some countries with sexual violence being recognised as a crime against the individual and the adoption of graded definitions of sexual assault that addresses a range of types of sexual violence. Definitions have also evolved over time to shift the focus from requirements of force or violence to requirements of lack of consent.¹¹⁰ Although sexual harassment and non-penetrative forms of sexual violence constitute violations of women's equality rights and pose grave challenges to women's autonomy, this paper focuses on rape or forced penetrative sexual intercourse due to its direct link with HIV transmission.

As noted earlier, in situations of rape, in addition to the most obvious risk of contracting HIV through unprotected intercourse, the potential for HIV transmission increases due to injuries and micro-lesions caused during forced penetration.¹¹¹ Due to the stigma associated with rape,¹¹² assaulted women are less likely to be tested for HIV infection, less likely to accept treatment and less likely to adhere to treatment reducing the risk of transmission to infants.¹¹³

Rape laws can be ineffective for a variety of reasons: substantive definition limitations, procedural inadequacies, implementation shortfalls and obstacles in accessing timely justice and quality healthcare services, all underlain with a systemic patriarchal bias. In so far as substantive definitions are concerned, most countries limit the definition of rape to coerced penetrative sexual acts, often requiring proof of the victim's physical resistance. Even in countries that have definitions premised on lack of consent, practice shows that secondary victimisation takes place when the prosecution has to prove non-consent beyond reasonable doubt. In an attempt to address this issue, some countries have "developed

108 UN Division for the Advancement of Women (2010), *Supplement to the Handbook for Legislation on Violence against Women: "Harmful Practices" against Women*, available at <http://www.un.org/womenwatch/daw/vaw/handbook/Supplement-to-Handbook-English.pdf>

109 International Association of Women Judges (2005), *The Gender and Legal Dimensions of HIV/AIDS: Women's Access to Justice and the Role of the Judiciary*.

110 UN Division for the Advancement of Women (2009), *Handbook for Legislation on Violence against Women*, available at <http://www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>

111 Amnesty International (2004), *Women, HIV/AIDS and Human Rights*, AI Index: ACT 77/084/2004, available at <http://www.amnesty.org/en/library/info/ACT77/084/2004/en>

112 In its report on the AIDS epidemic in Africa, Human Rights Watch observes: "The stigma of rape keeps it underreported and its perpetrators safe from prosecution. When women or girls are courageous enough to file complaints, law enforcement officials are rarely trained for sensitive and effective handling of sexual and domestic violence cases." From Human Rights Watch (2009), *Policy Paralysis: A Call for Action on HIV/AIDS-Related Human Rights Abuses against Women and Girls in Africa*, available at <http://www.hrw.org/en/node/80717/section/1>

113 *Canadian Strategy on HIV/AIDS: HIV and Sexual Violence against Women* as quoted in The Lawyers Collective (2007), *Legislating an Epidemic: HIV/AIDS in India*, Universal Publishing Pvt. Ltd, New Delhi, India.

definitions of rape that rely on the existence of certain circumstances rather than demonstrating a lack of consent” – Namibia’s *Combating Rape Act*, for example, requires proof of “coercive circumstances” instead of lack of consent.¹¹⁴

A major procedural hurdle is the absence of ‘rape shield laws’ that limit a defendant’s ability to cross-examine the complainant about her sexual history and that prohibit the publication of her identity. In many countries, evidence relating to past sexual history is allowed in to contradict the complainant’s credibility (by casting aspersions on her character). Introduction of such evidence leads to the re-victimisation of women and deters them from seeking justice in cases of rape. In some countries, although such provisions have broadly been discarded, exceptions allow evidence of past sexual history to be admitted if it is relevant to the case at hand.¹¹⁵ Reports from the United Kingdom (UK) indicate that, despite limitations placed, sexual history evidence was introduced in more than three-quarters of trials.¹¹⁶

Another adverse evidentiary practice is that of seeking corroboration in rape cases. This practice is based on the belief that complainants lie about rape and that their evidence must be independently corroborated.¹¹⁷ This is a high evidentiary burden given that there are seldom any witnesses to acts of rape. Although several countries have allowed trials and convictions based on the sole testimony of the complainant, this requirement of corroboration continues to be followed in a number of countries, particularly those with common law¹¹⁸ and Sharia jurisdictions.

In cases of sexual violence, it is crucial that collection of medical and forensic evidence is done in an expeditious and diligent manner. Reliance on the sole testimony of the complainant often becomes essential because evidence in court proceedings may not be available for a number of reasons: the complainant’s lack of knowledge regarding the importance of evidence; fear of procedures for collecting medical evidence¹¹⁹; actions that may unintentionally compromise evidence, such as washing after being sexually assaulted, or time lapse in seeking services; and lack of available facilities or personnel trained in the collection of evidence in a manner sensitive to the complainant.¹²⁰

Delays in evidence collection may also result in a denial of justice. For example, in the US, rape kits are used for testing physical evidence in rape cases to identify an unknown rapist, to confirm the presence of a known suspect, to affirm

114 UN Division for the Advancement of Women (2009), *Handbook for Legislation on Violence against Women*, available at <http://www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>

115 In the US, criminal defendants may still present evidence of sexual behaviour to prove that someone else was the source of semen or other physical evidence, and both defendants and prosecutors may offer evidence of “specific instances of sexual behavior by the alleged victim with respect to the person accused” [Fed. R. of Ev. 412(a)]. If the evidence is offered by the defendant, it can be offered only to prove consent.

116 Johnston P, *Rules on Sexual History of Rape Victims Tightened* in The Telegraph (June 21, 2006), available at <http://www.telegraph.co.uk/news/uknews/1521849/Rules-on-sexual-history-of-rape-victims-tightened.html>

117 UN Division for the Advancement of Women (2009), *Handbook for Legislation on Violence against Women*, available at <http://www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>

118 In 2005, while deliberating the requirements for a conviction in a rape trial on the basis of the uncorroborated testimony of the victim (case 105/5005), the Spanish Supreme Court discussed the balance that had to be struck between the victim’s right to justice and the defendant’s right to due process and presumption of innocence:

“It determined that with regard to crimes that tend to occur in private, such as crimes against sexual liberty, courts have to closely examine three aspects of the accusation. These are, first, the absence of circumstances suggesting underlying motives on behalf of the victim, such as a desire for revenge, retaliation, confrontation, or similar interests; second, believability of the accusation, of a kind that meets the standard of proof required in civil cases; and, third, internal coherence of the accusation over time, without ambiguities and inconsistencies. These criteria were not to be seen as preconditions that had to be met for a conviction in a sexual crimes case, since, for example, the existence of sentiments of revenge on behalf of the victim will not necessarily mean that the crime has not occurred. However, close attention must be paid to these three aspects.”

From Westeson J (2011), *Sexual Health and Human Rights: European Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/177/140_Johanna_Westeson_Europe_2010.pdf

India’s Supreme Court has also allowed rape convictions on the basis of the sole testimony of the prosecutrix: In *Bharwada Bhoginbhai Hirjibhai v State of Gujarat* AIR 1983 SC 753, it was held that the “absence of corroboration notwithstanding... if the evidence of the victim does not suffer from any basic infirmity, and the ‘probabilities factor’ does not render it unworthy of credence, as a general rule, there is no reason to insist on corroboration.” Papua New Guinea’s criminal code provides that “a person may be found guilty on the uncorroborated testimony of one witness” [Criminal Code Act 1974, Section 352A; *Criminal Code (Sexual Offences and Crimes Against Children) Act 2002*]. As per its *Criminal Justice and Public Order Act 1994* (Sections 32 & 33), the UK (a common law country) abolished the mandatory ‘corroboration warning’ (whereby the judge instructs the jury in cases of sexual assault that they must be careful not to convict the defendant on the basis of the victim’s uncorroborated evidence); however, the new provisions do not prohibit the judge from issuing this warning in individual cases if he/she finds it appropriate. Ireland (another common law country) has also abolished the obligatory nature of the warning as per its *Irish Criminal Law (Rape) (Amendment) Act 1990* (Section 7); however, it clarifies even more strongly than the British law that judges might be required to issue warnings about a victim’s uncorroborated testimony. Also see UN Division for the Advancement of Women (2009), *Handbook for Legislation on Violence against Women*, available at <http://www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>

119 Human Rights Watch reports the ongoing use of ‘finger testing’ in India: *“This practice, described in outdated medical jurisprudence textbooks used by many doctors, lawyers, and judges, involves a doctor inserting fingers into a rape victim’s vagina to determine the presence or absence of the hymen and the so-called ‘laxity’ of the vagina. These findings perpetuate false and damaging stereotypes of rape survivors as ‘loose’ women. Defence attorneys use the findings to challenge the credibility, character, and the lack of consent of the survivors.”* From Human Rights Watch (2010), *Dignity on Trial: India’s Need for Sound Standards for Conducting and Interpreting Forensic Examinations of Rape Survivors*, available at <http://www.hrw.org/en/reports/2010/09/06/dignity-trial-0>

120 UN Division for the Advancement of Women (2009), *Handbook for Legislation on Violence against Women*, available at <http://www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>

the complainant's version of the events or even exonerate an innocent defendant. Human Rights Watch notes that prosecution and conviction rates in rape cases increase considerably in jurisdictions that test rape kits. However, it also notes that, all too often, rape kits remain untested.¹²¹

Even if rape cases are proved, legislation in a number of countries contains provisions which absolve or provide lesser sentences for perpetrators if they marry the victim. This practice is in utter disregard of women's rights.¹²²

Specific issues arise in the context of HIV and rape: for instance, in some countries, HIV transmission as a result of rape is a ground for enhanced sentences; in others, it may amount to aggravated assault. HIV status also raises the unique issue of consent/ disclosure in cases where the sex may have been consensual, but where the HIV-positive person failed to disclose his serostatus. In *R v Cuerrier*¹²³, a Canadian case where an HIV-positive man was charged with aggravated assault for having unprotected sex with two non-infected partners, the court held that the accused's failure to disclose his HIV-positive status was a type of fraud which may vitiate consent to sexual intercourse and that the extent of the duty to disclose increases with the risks attendant upon the act of intercourse. However, subsequent cases in Canada have been decided on the aspect of "significant risk" posed by non-disclosure. Hence, non-disclosure may not lead to a criminal charge if precautionary measures, like condom use, were taken.¹²⁴

Another issue that arises in the context of HIV and rape is of mandatory testing of offenders. A number of countries have formulated provisions specifically to allow such testing. In the Netherlands, this issue came up before the Supreme Court in a case where the complainant demanded that the offender undergo an HIV test, which the offender refused on the ground of his right to bodily integrity under the Dutch Constitution. The court held that the blood test was necessary, as it was the right of the woman that the consequence of rape be mitigated and that uncertainty concerning HIV transmission was one of those consequences. Thus, she had a substantial interest in eliminating this uncertainty, which justified a blood test against the will of the offender. The court also emphasised that the offender's request not to be informed about the result of the test had to be respected.¹²⁵ While the decision of the Dutch court upholds a woman's right to be informed and also balances the perpetrators right not to know, providing for mandatory testing of rape offenders in legislation has been discouraged as a practice. In Canada, the Minister of Justice countered pressures to introduce laws allowing mandatory HIV testing of persons accused of sexual assault by proffering the following reasons:

*"(1) Such testing does not provide timely or reliable information about the sexual assault survivor's risks of contracting HIV infection. (2) It is a misdirected and unrealistic approach to addressing the needs of a sexual assault survivor. (3) It perpetuates the dangerous misperception that information about an assailant's HIV status is critical to the sexual survivor's health. (4) It does not help the survivor's psychological recovery. (5) It sets a dangerous precedent for extending mandatory testing to others."*¹²⁶

While information on the offender's HIV status may be important to rape survivors, access to PEP is also crucial to prevent the possible transmission of HIV. Few countries recognise this as a right of a rape survivor. South Africa's *Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007* explicitly grants this right to rape survivors and provides that anti-retroviral medication will be available at designated health facilities. Interestingly, this provision also gives the survivor the right to obtain an order for the alleged offender to be tested for HIV at State expense after following prescribed procedure. It also criminalises persons who, with malicious intent or grossly negligent manner, lay a charge to ascertain the HIV status of any person or make a disclosure in contravention of this law.¹²⁷

121 According to its report:

"Every year, nearly 200,000 people report to the police that they have been raped. Almost all are asked to submit to the invasive and sometimes traumatic process of having DNA evidence collected from their bodies. They assume this will help catch their rapist. They are often wrong. Thousands of kits throughout the United States remain untested, and the arrest rate for rape is less than 25 percent of reported cases."

From Toft S (2009), *Rape Kits Just Set Aside: This is Not Your Television's CSI*, Human Rights Watch, available at <http://www.hrw.org/en/news/2009/12/04/rape-kits-just-set-aside>

122 UN Division for the Advancement of Women (2009), *Handbook for Legislation on Violence against Women*, available at <http://www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>. As mentioned in note 85 above, Romania's *Criminal Code* exempts the rapist from criminal liability if he, before the ruling becomes final, marries his victim. Article 599 of the Eritrean *Penal Code* also offers immunity from criminal prosecution to a rapist if the victim "freely contracts" a marriage with him.

123 [1998] 2 S.C.R. 371.

124 Also see *Police v Dalley* in note 78 above.

125 NJ 1994/347, Dutch Supreme Court decision of 18 June 1993, nr. 15015. As discussed by Akveld and Hessing in *Dutch Legal Responses to AIDS*, in Frankowski S & Gostin L (Eds.) (1998), *Legal Responses to AIDS in Comparative Perspective: Balancing Individual Rights and Societal Interests*, Springer.

126 Hubbard D (1997), *A Case against Mandatory HIV Testing of Rapists*, Gender Research Project, Legal Assistance Centre, Windhoek, Namibia available at <http://www.lac.org.na/news/inthenews/pdf/mandatoryhivtest.pdf>

127 As per section 28 (Services for Victims Relating to Post Exposure Prophylaxis and Compulsory HIV Testing of Alleged Sex Offenders):
"(1) If a victim has been exposed to the risk of being infected with HIV as the result of a sexual offence having been committed against him or her, he or she may –
(a) ... (i) receive PEP for HIV infection, at a public health establishment designated from time to time by the cabinet member responsible for health by notice in

4.2 Sexual Violence in Times of Conflict

VAW by both State and non-State actors is exacerbated in the context of the generalised violence of conflict, with “women themselves becoming ‘war zones’”, as noted by the Special Rapporteur on VAW.¹²⁸ The report adds that, “violence against women has been deliberately used as an integral part of military and war strategy, in particular sexual violence.”

According to the UN Secretary General’s report on VAW:

“[R]ape of women has been used to humiliate opponents, to drive communities and groups off land and to wilfully spread HIV. Women have been forced to perform sexual and domestic slave labour. Women have also been abducted and then forced to serve as “wives” to reward fighters.”¹²⁹

The World Health Organisation (WHO) adds:

- *In Rwanda, the HIV prevalence rate in rural areas jumped from 1% in 1994, before the civil war, to 11% in 1997. Surveys indicate that 67% of women who survived rape in Rwanda tested HIV-positive.*
- *A report by the UN (1996) Special Rapporteur on Rwanda estimated that at least 250,000 women were raped during the genocide.¹³⁰*

Widespread sexual VAW during conflict provides several routes for increased HIV transmissions and war time makes it difficult to access medication and treatment:¹³¹

- Direct transmission through rape, sometimes with the intent to infect.
- Being placed in situations where they may be forced to exchange sex for survival (‘survival sex’ or ‘transactional sex’).
- Experiencing increased levels of overall violence including intimate partner violence which, in turn, makes it difficult for them to negotiate safe sex in their relationships.
- Internally displaced and refugee women escaping conflict are vulnerable to sexual violence perpetrated by soldiers, border guards, security forces and even UN peacekeeping personnel: according to the Special Rapporteur on VAW, “[i]n many countries rates of HIV infection are considerably higher among military personnel than among the population generally. The very real possibility of death in combat may serve to distance men from the more remotely perceived threat of HIV infection.”
- Overburdened and inaccessible health care systems, coupled with crippling poverty, make it almost impossible for women to obtain timely treatment (PEP and/or long-term).

Following decisions of the International Criminal Tribunals in Rwanda and Yugoslavia, the discourse on sexual violence during situations of conflict has changed from rape being viewed as spoils of war to being understood as a violation of international humanitarian and criminal law.¹³²

the Gazette for that purpose under section 29, at State expense and in accordance with the State’s prevailing treatment norms and protocols;
(ii) be given free medical advice surrounding the administering of PEP prior to the administering thereof; and
(iii) be supplied with a prescribed list, containing the names, addresses and contact particulars of accessible public health establishments contemplated in section 29 (1)(a) ; and
(b) subject to section 30, apply to a magistrate for an order that the alleged offender be tested for HIV, at State expense.”

The procedure for applying for tests to be conducted on offenders is set out in section 30 of the Act, available at <http://www.justice.gov.za/legislation/acts/2007-032.pdf>

128 Special Rapporteur on Violence against Women (2005), *Intersections of Violence against Women and HIV/AIDS*, E/CN.4/2005/72, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/130/90/PDF/G0513090.pdf?OpenElement>

129 UN General Assembly (2006), *In-depth Study on All Forms of Violence against Women: Report of the Secretary General*, A/61/122/Add. 1, available at <http://www.unhcr.org/refworld/docid/484e58702.html>. In Sierra Leone, for example, women were forced to become sexual slaves of the rebel forces (so-called “bush wives”). Teenage girls were particularly vulnerable because they were sought after and targeted as virgins.

130 WHO (2004), *Violence against Women and HIV/AIDS: Critical Intersections: Sexual Violence in Conflict Settings and the Risk of HIV*, Information Bulletin Series, No. 2, available at <http://whqlibdoc.who.int/unaid/2004/a85593.pdf>

131 See Special Rapporteur on Violence against Women (2005), *Intersections of Violence against Women and HIV/AIDS*, E/CN.4/2005/72, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/130/90/PDF/G0513090.pdf?OpenElement>; UN General Assembly (2006), *In-depth Study on All Forms of Violence against Women: Report of the Secretary General*, A/61/122/Add. 1, available at <http://www.unhcr.org/refworld/docid/484e58702.html>; Amnesty International (2004), *Women, HIV/AIDS and Human Rights*, AI Index: ACT 77/084/2004, available at <http://www.amnesty.org/en/library/info/ACT77/084/2004/en>; WHO (2004), *Violence against Women and HIV/AIDS: Critical Intersections: Sexual Violence in Conflict Settings and the Risk of HIV*, Information Bulletin Series, No. 2, available at <http://whqlibdoc.who.int/unaid/2004/a85593.pdf>; Gordon P and Crehan K (2000), *Dying of Sadness: Gender, Sexual Violence and the HIV Epidemic*, United Nations Development Programme.

132 Ellis M (2007), *Breaking the Silence: Rape as an International Crime*, available at <http://www.case.edu/orgs/jil/vol.38.2/38-2%20-%20ELLIS.pdf>

As per its Resolution 1325 (2000), the UN Security Council:

"Calls on all parties to armed conflict to take special measures to protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse, and all other forms of violence in situations of armed conflict;

Emphasizes the responsibility of all States to put an end to impunity and to prosecute those responsible for...crimes... relating to sexual and other violence against women and girls..."

The *Rome Statute* of the International Criminal Court (ICC Statute), which entered into force in 2002, recognises as a crime against humanity "rape, sexual slavery, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity"¹³³ "when committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack."¹³⁴

Article 8 of the ICC Statute provides that the following acts constitute a grave breach of the Geneva Convention and can be prosecuted as war crimes when committed during international or internal armed conflict: "[c]ommitting rape, sexual slavery, enforced prostitution, forced pregnancy, as defined in article 7, paragraph 2 (f), enforced sterilisation, or any other form of sexual violence also constituting a grave breach of the Geneva Conventions."

The *ICC Statute* also recognises that VAW can be used as a means to commit genocide. This provision builds on the ruling of the International Criminal Tribunal for Rwanda's decision in the *Jean Paul Akayesu case*¹³⁵, where it was held that when rape is used as a method to destroy a protected group (based on national, ethnical, racial or religious identity) by causing serious physical or mental harm to the members of the group, it constitutes an act of genocide.

The essential elements of the definition of rape as provided in the ICC (irrespective of the context of the crime) are:

- i. The perpetrator invaded the body of a person by conduct resulting in penetration, however slight, of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body.
- ii. The invasion was committed by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, against such person or another person, or by taking advantage of a coercive environment or the invasion was committed against a person incapable of giving genuine consent.

Other than the expansive definition of rape, the *ICC Statute* marks a major development by moving away from an assumption of implied consent to the recognition that, under certain coercive circumstances, there is an assumption that sex was unwanted. This understanding and other aspects of sexual violence included in the *ICC Statute* have significant lessons for future law reform efforts on the issue of rape and sexual violence, particularly since sexual violence is a continuum of inequality, which is exacerbated during situations of conflict.

The development of international criminal law jurisprudence sets standards for progressive legal interpretations on issues of VAW, generally. For instance, in *The Prosecutor v Alex Tamba Brima and Others*, the Special Court on Sierra Leone recognised forced marriages during situations of conflict as a crime against humanity by holding that:

"[F]orced marriage describes a situation in which the perpetrator through his words or conduct, or those of someone for whose actions he is responsible compels a person by force, threat of force, or coercion to serve as a conjugal partner resulting in severe suffering, or physical mental or psychological injury to the victim."

Other than the violence perpetrated during the course of the conflict, violence may also be a result of widespread displacement and the breakdown of law and order as a consequence of conflict. As mentioned above, the humanitarian crisis brought on by armed conflicts – such as the loss of homes, incomes, families and social support – also puts women and girls in positions where they have to engage in 'survival sex' in order to secure their safety and access to basic needs.¹³⁶ Impediments that cause under-reporting during peace times assume greater magnitude during situations of conflict: particularly the fear of retribution, shame, powerlessness, lack of support, breakdown or unreliability of public services and the dispersion of families and communities. This makes it difficult to accurately assess the extent of the problem.¹³⁷ It is the duty of the government in whose jurisdiction the sexual attack has occurred to take action. However,

133 Rome Statute (2002) Article 7(1)(g).

134 Rome Statute (2002) Article 7(1).

135 *Jean Paul Akayesu case*, ICTR-96-4.

136 WHO (2004), *Violence against Women and HIV/AIDS: Critical Intersections: Sexual Violence in Conflict Settings and the Risk of HIV*, Information Bulletin Series, No. 2, available at <http://whqlibdoc.who.int/unaid/2004/a85593.pdf>

137 UNFPA (1999), *Reproductive Health in Refugee Situations: An Inter Agency Field Manual*, available at <http://www.unfpa.org/emergencies/manual/index.htm>

host states, especially ones that are financially constrained and lack adequate criminal justice infrastructure, might find it difficult to take positive steps in the face of mass exodus and inadequate international support.¹³⁸

4.3 Violence against Women in Sex Work¹³⁹

“Sex workers are especially vulnerable to HIV because stigmatization and discrimination may cause them to avoid health care and pursuing legal remedies against violence. There are seldom laws protecting sex workers, and when there are such laws, they often are not enforced. Limited information on health and risk of HIV infection, as well as limited power to negotiate safer sex places sex workers further at risk.”¹⁴⁰

Having multiple sex partners under conditions of unsafe sex increases the risk of sexually transmitted infections, yet prevention efforts directed at sex workers for STIs and HIV are often demeaning, discriminatory, substandard, and ineffective. Effective prevention programs are often stymied by police practices under criminalization regimes: for example, while condom promotion is essential to HIV prevention efforts, in many settings possession of condoms is used as evidence of criminal activity (engaging in prostitution).”¹⁴¹

Governments usually adopt one of three approaches to sex work: direct prohibition, which includes laws that prohibit prostitution or criminalise activities relating to prostitution; regulating sex work, which involves licensing sex workers, brothel owners and/or pimps, mandating including health and sanitation requirements; or an absence of any regulation regarding sex work. The Special Rapporteur on VAW, while noting that women in the sex industry have a higher susceptibility to HIV and violence than most other population groups, also mentions that *“in countries where prostitution is illegal, the clandestine nature of such activities makes HIV and STI prevention activities difficult to implement, while in countries with legal but regulated systems, registration and periodic health testing tend to drive sex workers at highest risk underground.”¹⁴²*

Legal and public health policy regarding sex work often subjects sex workers to multiple rights marginalisations: while their work places them at increased risk of violence (from clients and the State) and HIV infection, criminalisation – the most prevalent intervention¹⁴³ – compels them to avoid accessing health services or legal remedies in order not to risk arrest or conviction, although, in so doing, they increase their susceptibility to disempowerment and infection.

4.4 Trafficking

“Trafficking and sexual exploitation must be forcefully prevented and combated. In this process, whether trafficking has occurred for sexual exploitation or for any other reason, it is paramount that a human rights framework be employed. This is true with regard to preventative measures against trafficking – making sure that these do not restrict fundamental rights such as the right to movement, the right to seek asylum, or the right to make a living. It is further imperative that human rights standards be applied in the field where anti-trafficking measures meet immigration policies; a complicated intersection of international policies that has to be closely monitored.”¹⁴⁴

Trafficking can be for different purposes – sex trafficking, forced labour – and while some countries¹⁴⁵ criminalise all forms of human trafficking, others target trafficking for sexual exploitation.

In Europe and the US, trafficking legislation is linked to immigration concerns and, countries usually prioritise the prevention of trafficking over the rights of victims of trafficking. In some instances, assistance to victims is provided

138 A recent Human Rights Watch report illustrates this point. In Liberia (which has received 150,000 Ivorian refugees since the November 2010 violence in Cote d'Ivoire), Ivorian women refugees report high levels of sexual violence and engagement in survival sex. Although Liberian law criminalises prostitution (both the prostitute and her client), rape and other activities promoting rape, its weak and ill-equipped police force fails to investigate complaints adequately or follow up on prosecutions. The Liberian Refugee Commission's officials told Human Rights Watch that they were not surprised about women being engaged in survival sex due to reasons of overcrowding and little available food. See Human Rights Watch (April 2011), *Liberia: Protect Refugees Against Sexual Abuse*, available at <http://www.hrw.org/en/news/2011/04/20/liberia-protect-refugees-against-sexual-abuse>

139 As separate Working Papers on sex work and trafficking have been prepared for the Global Commission on HIV and the Law, this paper does not address these topics in detail, save to flag a few issues.

140 Gable L et al (2007), *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform*, The World Bank available at <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/LegalAspectsOfHIVAIDS.pdf>

141 See Miller A et al (2010), *Sexual Health and Human Rights: United States & Canada*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/178/140_Miller_Roseman_Friedman_uscan_2010.pdf

142 Special Rapporteur on Violence against Women (2005), *Intersections of Violence against Women and HIV/AIDS*, E/CN.4/2005/72, available <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/130/90/PDF/G0513090.pdf?OpenElement>

143 According to UNAIDS, more than 100 countries criminalise some aspect of sex work. See UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*.

144 Westeson J (2011), *Sexual Health and Human Rights: European Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/177/140_Johanna_Westeson_Europe_2010.pdf

145 Section 5, *Immoral Traffic (Prevention) Act 1986* (India).

on condition of support to book traffickers, but making provision of services conditional on cooperation with state agencies to book traffickers impedes reportage and access to services.¹⁴⁶

In 2004, the Council of the European Union adopted the *Council Directive 2004/81/EC on Residence Permit for Trafficking Victims*. The Directive defines the conditions for the granting of temporary residence permits to third-country nationals (entering the EU legally or illegally) who have been the victims of human trafficking and who are willing to cooperate with the authorities in fighting trafficking. While a temporary residence permit can be granted to victims whose cooperation is clearly beneficial to the law enforcement authorities (Article 8), the Directive provides no protection for persons who are not required to give testimony or who for some reason cannot cooperate with law enforcement officials.

Similarly, in the US, the *Trafficking Victim Protection Act* (TVPA) creates a private right for victims of sex trafficking to recover damages and reasonable attorney's fees. However, this is conditional on the victim's consent to cooperate with the authorities in their efforts to investigate and prosecute traffickers and, because cooperation is only sought when authorities feel that they will be pursuing the prosecution, this policy revictimises the trafficked person. The TVPA also includes special provisions penalising tactics commonly used by traffickers to pressurise their victims, such as threats to notify the authorities about the victim's irregular immigration status or engagement in sex work, resulting in her deportation.

The provisions mentioned above illustrate the manner in which victims of trafficking are put at a special disadvantage. Typically, women trafficked for the purpose of sexual exploitation are enslaved, subjected to violence and forced to have unsafe sex, increasing their vulnerability to HIV infection.¹⁴⁷ Their vulnerability is compounded by fears of prosecution (particularly in countries where prostitution is criminalised) and deportation (if they are in the country illegally). Language and cultural barriers, as well as a lack of information on their rights, makes them unlikely to access justice or services. While many countries have laws that prohibit trafficking, more often than not these laws penalise the victims of trafficking rather than traffickers. Treating victims of trafficking as offenders not only exacerbates their victimisation, but also complicates efforts to protect them from contracting HIV.¹⁴⁸ In order to avoid this double victimisation, it is important that laws on trafficking focus on protecting the rights of victims and enabling their access to legal, medical and housing services. Witness and victim protection programmes should also be put in place for those willing to testify against their traffickers.

V State Condoned Violence against Women and HIV/AIDS-related Stigmatisation

5.1 Overview

"[HIV related stigma and discrimination is] a process of devaluation of people either living with or associated with HIV and AIDS...Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Stigma and discrimination breach fundamental human rights and can occur at a number of different levels including: political, economic, social, psychological and institutional."¹⁴⁹

Stigma and discrimination are associated with lower uptake of HIV prevention services, reduced and delayed disclosure, postponement or rejection of treatment, care and support.¹⁵⁰ Women not only face added stigma and discrimination based on stereotypical notions of women's sexuality, but also violence as a consequence of stigma. Additionally, they face a range of human rights violations in accessing reproductive health care including: discrimination from health care workers,¹⁵¹ coercive practices and violations of informed consent and confidentiality, denial of reproductive rights and choice, denial of public services or inadequacy of services, etc.¹⁵²

Findings of an April 2011, three-country, UNAIDS-Programme Coordinating Board-Non-Governmental Organisation (NGO) delegation report demonstrate the impact of HIV-related stigma on women:¹⁵³

146 Basu A (2011), *A Study of Measures Taken by State Parties to Address Violence against Women* (unpublished paper prepared for UN Women) available at <http://webapps01.un.org/vawdatabase/home.action>. Moldova and The Netherlands are an exception in this regard as both provide assistance without conditions of collaboration with law enforcement agencies.

147 Advocates for Human Rights (2005), *Trafficking and HIV*, available at http://stopvaw.org/Trafficking_and_HIV_AIDS.html

148 Gable L et. Al (2007), *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform*, The World Bank available at <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/LegalAspectsOfHIVAIDS.pdf>

149 UNAIDS (2003), *Stigma and Discrimination*, available at http://data.unaids.org/publications/Fact-Sheets03/fs_stigma_discrimination_en.pdf

150 UNAIDS (2007), *Reducing HIV Stigma and Discrimination: A Critical Part of National AIDS programs*, available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2008/jc1521_stigmatisation_en.pdf

151 Paxton S et. Al (2004), *"Oh! This One is Infected": Women, HIV and Human Rights in the Asia Pacific Region*, available at http://www.aidslex.org/site_documents/W024E.pdf

152 Center for Reproductive Rights (2008), *At Risk: Rights Violations of Positive Women in Kenyan Health Facilities*.

153 International Planned Parenthood Federation (2011), *Piecing it Together for Women and Girls: The Gender Dimension of HIV Related Stigma*,

Violations Experienced by Women Living with HIV/AIDS: an experience from Ghana

Women living with HIV in Ghana... sometimes suffer from multiple human rights violations and encounter daunting barriers to quality healthcare... In many contexts, the social and cultural value surrounding female purity means that women and girls living with HIV/AIDS are subjected to greater discrimination than men. Cases where women are blamed for their infection has led to heightened levels of domestic abuse, abandonment by spouses or in-laws, or dismissal from paid employment...

Gifty Asamoah got a job at the Ghana Fire Service. She went through the recruitment process and was employed. Subsequently, she felt sick and was asked to go to a particular clinic for HIV test. The Doctor breached confidentiality, disclosed her status to the boss at Ghana Fire Service and she was sacked.

Linda Okyere was ejected from her rented apartment because she went on television to disclose her HIV status whilst she was advocating for funding to implement project for Orphans and Other Vulnerable Children. Her landlady heard of it and ejected her from the house. The landlady sent Linda's luggage outside her rented apartment. She stayed in the open for one week before a good Samaritan offered her assistance to rent a new apartment.

Monica Atokoba went to hospital for antenatal services and one of the nurses chastised her that as HIV-positive woman, she should not get pregnant. The Nurse engaged in a long argument with Monica trying to indicate that positive women cannot give birth to a negative child. That put Monica in a very sad mood for days. Monica broke the news to her husband and indicated her intention to abort the unborn baby. It took the intervention of the husband to resolve the issue.

- Submission made by Ghana Network of Persons Living with HIV/AIDS (NAP+ Ghana), Ghana, for the Africa Regional Dialogue of the Global Commission on HIV and the Law

- In Bangladesh, over half of women living with HIV have experienced stigma by a friend or neighbour; 87% have decided not to get married as a result of their HIV status; and nearly a fifth feel suicidal.
- In Ethiopia, only 45% of women living with HIV have disclosed their status to their partner or husband; over half have low self-esteem; and 44% have been advised by a health worker not to have a child due to being HIV-positive.
- In the Dominican Republic, a fifth of women living with HIV have been coerced into being sterilised; 60% fear being the subject of gossip; nearly a quarter did not, while pregnant, receive anti-retroviral drugs for prevention of mother-to-child-transmission; 75% of women give support to other people living with HIV.

Although countries have constitutional guarantees on equality and special laws prohibiting discrimination on grounds of HIV status, women's rights – particularly women's reproductive rights – continue to be ignored, and such laws remain largely unimplemented, thus entrenching the social, economic and other barriers that prevent women's access to treatment and services.¹⁵⁴ For instance, a Human Rights Watch Report on discrimination against women living with HIV showed that although Dominican domestic legislation specifically prohibits HIV testing as a condition for obtaining or remaining in a job and penalises companies adopting such practices, many women said that they were being subjected to HIV tests in tourism and export processing sectors with the clear intent of denying employment if they tested positive. This form of discrimination has many deleterious consequences, including permanent unemployment; abandonment by partners and being left as sole providers for children; and, of course, dire economic hardships.¹⁵⁵ The Special Rapporteur on VAW, while referring to this report, also mentions that such practices are found more often in feminised sectors, such as service, entertainment and tourism, as well as in lower-level insecure jobs.

available at <http://www.stigmaindex.org/317/press-releases/piecing-it-together-for-women-and-girls-the-gender-dimensions-of-hivrelated-stigma.html>

154 Studies show that since women are vested with greater domestic responsibilities, they are unable to travel to access treatment. See Paxton S et. Al (2004), "Oh! This One is Infected": Women, HIV and Human Rights in the Asia Pacific Region, available at http://www.aidslex.org/site_documents/W024E.pdf

155 Human Rights Watch (2004), *A Test of Inequality: Discrimination against Women in the Dominican Republic.*, available at <http://www.hrw.org/en/reports/2004/07/12/test-inequality-0>

Medical Practitioners Fail to Uphold Reproductive Rights of HIV-positive Women: an experience from the US

HIV specialist and general medical practitioners routinely fail to educate HIV-positive female patients about their fertility, conception and contraception options. The lack of information provided to women living with HIV about their reproductive options limits their full range of reproductive choice and violates their sexual and reproductive rights under both international and domestic law...

Despite the reproductive options available in the US, women living with HIV and AIDS frequently suffer from judgment, lack of, or mis-information, and discrimination when inquiring into their sexual and reproductive choices or attempting to exercise their sexual and reproductive rights. A 2007 Foundation for AIDS Research survey of Americans found that one-third of Americans would not support an HIV-positive woman's choice to become pregnant despite ART to prevent mother to child transmission and only 14% believed HIV-positive women should be able to have children.

The U.S. Positive Women's Network conducted a survey and issued a report, *Diagnosis, Sexuality, Choice*, on HIV-positive women's experiences with reproductive health choices, and found discouraging results. The survey indicated that many doctors are either uninformed about HIV-positive women's reproductive options, choosing to forego any conversation about reproductive options or care for HIV-positive women, or are entirely unsupportive of an HIV-positive woman's right to reproductive choice, which includes the right to have a child...

A study conducted in 2008, *Gynecologic Issues in the HIV-infected Woman*, of 181 HIV-positive women of reproductive age in urban health clinics, confirms some of the PWN's findings. Namely, only 31% of the women had discussed their reproductive options with health care providers. Of those 31%, 64% had initiated the conversation with the health care provider herself. Yet "between 25% and 45% of HIV-positive individuals of reproductive age report wanting to have a baby in the future compared with about 35% in the general population."

On top of provider attitudes, the costs of reproduction – sperm washing, artificial insemination – are high, and are often not covered by health insurance plans. This makes safe reproduction for some HIV-positive women altogether unattainable.

- Submission made by the US Positive Women's Network, for the High-Income Countries Dialogue of the Global Commission on HIV and the Law

In the context of employment, the situation of migrant workers requires special attention. Many countries impose conditions of HIV testing prior to entering a country or availing of a work permit.¹⁵⁶ For instance, under Papua New Guinea's *Migration Act 1978*, migration officials may require a person seeking entry into the country to undergo a medical examination to allow the officer to form an opinion as to whether or not s/he should be refused entry because s/he is suffering from a disease that could endanger the community.

A significant number of migrant workers are women and tend to be employed in unregulated sectors – such as in domestic work. A United Nations Development Programme report on the interlinks between women migrant labourers and HIV in six countries notes that, "female domestic workers are only recognised when it comes to pre-employment HIV testing, but are not protected by the basic labour rights of migrants as their jobs are not recognised by labour laws."¹⁵⁷ The isolated and individualised nature of household work within the private home, along with their unprotected status put women at a greater risk of verbal, physical and sexual abuse. However, workers fleeing such abusive situations are considered illegal under sponsorship programmes ('*kafala*' programmes in some Middle Eastern countries, where women's illegal/irregular status increases their vulnerability to sexual violence and exploitation). Further, testing HIV-positive results in deportation without any steps taken to ensure reintegration or prevent abuse and discrimination perpetrated by the family.¹⁵⁸

Other than these grave violations, migrant workers are also discriminated against in terms of access to health services since laws and policies in most countries make access to health services contingent upon citizenship. This presents often-insurmountable burdens for undocumented migrants. For instance, Japan's national health insurance system

156 For further information, see *The Global Database on HIV-Specific Travel and Residence Restrictions*, available at <http://www.hivrestrictions.org>

157 UNDP (2008), *HIV Vulnerabilities of Migrant Women from Asia to the Arab States: Shifting from Silence, Stigma and Shame to Safe Mobility with Dignity, Equity and Justice*, Colombo, Sri Lanka, available at http://hdru.aprc.undp.org/resource_centre/pub_pdfs/P1105.pdf

158 *Ibid.*

does not cover non-citizens without permanent resident status. Undocumented migrants are, therefore, unlikely to seek medical help for fear of legal repercussions. Similarly, in Europe,¹⁵⁹ migrants who either are undocumented or whose status is not yet official cannot claim health insurance and are apprehensive of availing health services for fear of being deported. There are, however, some exceptions: in the Netherlands, those uninsured and without resident permits are entitled to “*medically necessary*” care, which includes care in relation to HIV/AIDS. HIV results do not affect the grant of either asylum status or residence permits. The UK follows a slightly more restrictive practice by entitling citizens, asylum applicants and those living lawfully in the UK for 12 months or more free treatment under the National Health Service. Emergency medical treatment is available to all; however, while HIV testing and initial diagnosis is free, treatment fees may be levied on those whose asylum appeal has been refused and who are awaiting deportation. The broadest protection is provided in Moldova where citizens, foreign citizens and stateless persons who live or have temporarily lived in Moldova have the right to free and anonymous HIV tests. Moldova prohibits mandatory testing and provides universal access to anti-retroviral treatment (ART).

The issue of access to health services vis-à-vis women has a significant impact on their reproductive rights. The following section takes a look at the intersection of violence, reproductive rights and HIV.

5.2 Reproductive Rights and Prevention of Mother-to-Child Transmission

“[Reproductive rights] rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health... [and] to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.”¹⁶⁰

The protection of these rights assumes added importance in the context of HIV since most women are made to undergo HIV testing while accessing antenatal care. However, more often than not, medical personnel fail to provide women with the clear and complete information they need in order to make an informed decision regarding their health.

Another important issue is that of MTCT. An HIV-positive woman may transmit the virus to her foetus at the time of childbirth or while breastfeeding. In the absence of any intervention, the risk of MTCT and of the child being born HIV-positive is 15-30% during pregnancy and delivery. There is a 10-20% risk of transmission through breast milk.¹⁶¹ Before the effect of ART in reducing the risk of transmission was known, curtailing the spread of HIV to infants meant the termination of pregnancy by HIV-positive women. This frequently meant that HIV-positive pregnant women were made to undergo abortions or sterilisation without their consent. However, despite progresses made in technology, treatment is not made available to women or is inadequate¹⁶² and the practice of forced abortions and sterilisations continues, in derogation of internationally recognised reproductive and human rights of women. Even in countries that have MTCT prevention programmes, the programmes focus on the potential danger to the foetus rather than the health of the mother.¹⁶³

The human rights issues that arise in the context of MTCT are:¹⁶⁴

- Provision of pre-test counselling and information to assist in informed decision-making by the woman.
- Informed consent to testing during and after pregnancy, to the treatment itself and to decision-making with regard to management of the pregnancy.
- Protection of confidentiality.
- Access to post-pregnancy contraception.
- Potential adverse effects of taking anti-retrovirals especially in repeat pregnancies of the HIV-positive woman.

159 Westeson J (2011), *Sexual Health and Human Rights: European Region*, International Council on Human Rights Policy, available at http://www.ichrp.org/files/papers/177/140_Johanna_Westeson_Europe_2010.pdf

160 International Conference on Population and Development (1994).

161 Amnesty International (2004), *Women, HIV/AIDS and Human Rights*, AI Index: ACT 77/084/2004, available at <http://www.amnesty.org/en/library/info/ACT77/084/2004/en>

162 Center for Reproductive Rights (2005), *Pregnant Women Living with HIV/AIDS: Protecting Human Rights in Programs to Prevent Mother-to-Child Transmission of HIV*, available at <http://reproductiverights.org/en/document/pregnant-women-living-with-hiv-aids-protecting-human-rights-in-programs-to-prevent-mother-to>

163 Center for Reproductive Rights (2002), *HIV/AIDS: Reproductive Rights on the Line*, available at <http://reproductiverights.org/en/document/hiv-aids-reproductive-rights-on-the-line>. Also see UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*.

164 Amnesty International (2004), *Women, HIV/AIDS and Human Rights*, AI Index: ACT 77/084/2004, available at <http://www.amnesty.org/en/library/info/ACT77/084/2004/en>

- Women's access to care and treatment apart from MTCT intervention.
- Non-discrimination in provision of anti-retrovirals to the pregnant woman.

5.2.1 Informed Consent and Confidentiality

Informed consent to HIV testing and treatment is essential to women's right to physical integrity, as the CEDAW Committee clarifies:

*"Women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment... including likely benefits and potential adverse effects of proposed procedures and available alternatives."*¹⁶⁵

Crucial to arriving at an informed decision is the availability of information. In a 2007 briefing note on the prevention of MTCT, WHO estimated that, as a mode of transmission, MTCT accounts for more than 10% of all HIV infections globally.¹⁶⁶ HIV testing is required in order to prevent MTCT and administer appropriate treatment. Therefore, prevention of MTCT has provided most countries with a public health justification to impose mandatory testing for pregnant women in violation of their right to informed decision-making. Even where it has not been made mandatory, HIV testing is included as part of routine antenatal testing. It is recommended that HIV testing as part of antenatal care be provided on an 'opt-out' basis: i.e., individuals can opt out or decline an HIV test after receiving pre-test information.¹⁶⁷ However, studies have found that few women receive counselling and most undergo the test without knowing that they can opt out of it. A study conducted in Kenya showed that:

*"High coverage of HIV testing appears to be achieved at the cost of pregnant women not understanding that testing is optional. Good quality HIV pre-test information is central to ensure that pregnant women understand and accept the reasons for testing and will thus come back to collect their test results, an important prerequisite for completing PMTCT for those who test HIV-positive."*¹⁶⁸

*"Even where pre-test counselling takes place, women may feel coerced into being tested for fear that health workers may otherwise refuse to deliver the child or deny her access to treatment."*¹⁶⁹

Informed consent to being administered anti-retrovirals to prevent MTCT is also essential, particularly since prevention regimens are targeted towards preventing infection in the newborn and may affect the health of the pregnant woman as well her future HIV treatment.¹⁷⁰ The question that arises in this context is whether an HIV-positive woman can refuse treatment despite potential benefits to the foetus. Under common law, as per the doctrine of *parens patriae*, the State has the right to protect the rights of a child already born. However, such rights are not conferred on a foetus as rights accrue upon birth and a foetus does not have a legal persona. The Canadian Supreme Court has held that, *"the court does not have the power to override the rights of a pregnant woman for the purpose of preventing harm to the unborn child."*¹⁷¹ Given that women are primary caregivers to children, it is essential that efforts to protect both woman and child are pursued simultaneously.

In this form of provider-initiated testing, health providers have a duty to respect and ensure a patient's right to privacy and maintain confidentiality of their health information, particularly due to HIV-related stigma and consequential VAW.¹⁷²

165 CEDAW General Recommendation 24 (1999).

166 WHO (2007), *Prevention of Mother to Child Transmission: Briefing Note*, available at <http://www.who.int/hiv/pub/toolkits/PMTCT%20HIV%20Dept%20brief%20Oct%2007.pdf>

167 Branson B et al (2006), *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*, available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>. In France, Finland, Poland and Sweden, for instance, health care providers must offer HIV tests to pregnant women, who are, in turn, free to refuse the test.

168 Opondo Awiti Ujji et al (2011), *Is 'Opt-Out HIV Testing' A Real Option among Pregnant Women in Rural Districts in Kenya?*, BMC Public Health, available at <http://www.biomedcentral.com/1471-2458/11/151>. Also see Human Rights Watch (2004), *A Test of Inequality: Discrimination against Women in the Dominican Republic*, available at <http://www.hrw.org/en/reports/2004/07/12/test-inequality-0>, according to which, *"women receive grossly inadequate information about HIV from the public health system, preventing them from giving their informed consent to testing and treatment."*

169 Panos Institute Global AIDS Programme and UNICEF (2001), *Stigma, HIV/AIDS and Prevention of MTCT: A Pilot Study in Zambia, India, Ukraine and Burkina Faso*, available at http://www.unicef.org/spanish/evaldatabase/files/Global_2001_Stigma_index.pdf

170 Center for Reproductive Rights (2005), *Pregnant Women Living with HIV/AIDS: Protecting Human Rights in Programs to Prevent Mother-to-Child Transmission of HIV*, available at <http://reproductiverights.org/en/document/pregnant-women-living-with-hiv-aids-protecting-human-rights-in-programs-to-prevent-mother-to-child> mentions reports that state that even one dose of Nevirapine (a drug used to prevent MTCT) can cause resistance, thus undermining efforts to treat HIV-positive women with the drug after childbirth. See also UNAIDS (1999), *Prevention of HIV Transmission from Mother to Child: Strategic Options*, available at http://data.unaids.org/Publications/IRC-pub05/prevention_en.pdf, according to which:

"The fact that ARVs can serve two separate purposes – as [a] vaccine for infants against MTCT of HIV and as treatment of HIV infected persons – is of course very significant. But the issue of ARV treatment for infected people must be considered separately from the issue of ARV drugs used for the prevention of MTCT. It requires debate and policy decisions outside the scope of MTCT policy making."

171 Quoted in The Lawyers Collective (2007), *Legislating an Epidemic: HIV/AIDS in India*, Universal Publishing Pvt. Ltd, New Delhi, India.

172 Center for Reproductive Rights (2005), *Pregnant Women Living with HIV/AIDS: Protecting Human Rights in Programs to Prevent Mother-to-Child*

However, practice shows that health workers treat women's confidentiality in a cavalier manner. There are several reports of health workers having disclosed HIV status to the woman's family members without her consent – which, in some instances, has had drastic consequences such as abandonment and violence.¹⁷³ Other than being violative of rights, the failure of health systems to maintain confidentiality puts women's health at great risk and prevents them from accessing treatment.

5.2.2 The Abortion Paradox in the Context of HIV

Laws and practices in relation to abortion services give rise to an 'abortion paradox': while most countries allow abortions only on limited grounds that restrict a woman's access to safe abortions services, practice reveals that HIV-positive women are often coerced into undergoing abortions, despite the presence of drugs that may reduce the possibility of MTCT. A casualty in this paradox is women's right to reproductive choice and autonomy.

Conditions under which abortions are legally permitted vary from country to country and according to the stage of pregnancy. In some countries access is highly restricted; in others, termination of pregnancy is available upon request on broad medical and social grounds.¹⁷⁴ The most common ground for allowing abortions is to save the life of the pregnant woman; other grounds include grave injury to the woman's physical and, in some cases, mental health, when the pregnancy is a result of rape, when the woman is mentally infirm, and when there is a possibility of genetic malformations in the foetus. Costa Rica includes an exception to the penalty for abortions if the abortion is conducted to save the woman's honour. Some laws on medical termination explicitly recognise HIV-positive status to be a ground for abortion, for example, Guyana's *Medical Termination of Pregnancy Act of 1995* permits abortions in cases "where the pregnant woman is known to be HIV-positive."

Abortion laws are as complex as they are diverse. In countries where abortion services are liberalised under the law, women can obtain abortions upon request in the first 10-12 weeks, after which medical opinion is required prior to conducting abortions.¹⁷⁵ In other countries with liberal abortion laws, such services may be provided upon the fulfilment of certain conditions, such as provision of prior counselling with a view to ensuring the woman's safety, the provision of services only in approved institutions, requirement for medical opinion prior to performing the abortion, etc. In most countries, the least number of conditions are imposed on abortions within the 10-12 week period. However, even in countries with liberal abortion laws, it remains unclear whether pregnant HIV-positive women receive complete and unbiased counselling about abortions and the risk of pregnancy and delivery to the health of both the woman and the foetus.¹⁷⁶ Further, in countries where abortions are legally permitted, safe abortion services may not be easily accessible and legal grounds alone do not reflect the manner in which laws are applied.¹⁷⁷

The situation is worse in countries that criminalise abortions or place severe restrictions on access to such services. Studies have found that where legislation allows abortions on broad indications, there is a lower incidence of unsafe abortions and much lower mortality from unsafe abortions, as compared to where legislation greatly restricts abortions.¹⁷⁸

Although clinical research on the links between the provision of abortion care and HIV is inadequate, according to WHO/UNAIDS:

"Women living with HIV/AIDS are prone to septicaemia and may be particularly at risk of complications, so that preventing unintended pregnancies and unsafe abortion is essential for improving the health of these women... Ensuring that safe

Transmission of HIV, available at <http://reproductiverights.org/en/document/pregnant-women-living-with-hiv-aids-protecting-human-rights-in-programs-to-prevent-mother-to>

173 See, for instance, Human Rights Watch (2006), *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight against HIV/AIDS*, available at <http://www.hrw.org/en/node/11464/section/8>

174 WHO (2007), *Unsafe Abortion: Global and Regional Estimate of the Incidence of Unsafe Abortion and Associated Mortality in 2003*, available at http://whqlibdoc.who.int/publications/2007/9789241596121_eng.pdf

175 South Africa's *Choice on Termination of Pregnancy Act* recognises abortion on request in the first 12 weeks. In Slovenia, the right to reproductive choice is given constitutional recognition and medical laws allow abortions upon request in the first ten weeks of pregnancy. Several European countries (such as France, Russia, Albania, and Slovenia) also allow abortion on request in the 10-12 week period.

176 Health service providers in South Africa are not required to discuss abortion with HIV-positive pregnant women, even though a significant percentage of women attending antenatal clinics in urban areas carry the virus. (Center for Reproductive Rights (2002), *HIV/AIDS: Reproductive Rights on the Line*, available at <http://reproductiverights.org/en/document/hiv-aids-reproductive-rights-on-the-line>).

177 Berer M (2004), *National Laws and Unsafe Abortions: Parameters of Change*, *Reproductive Health Matters*, 12 (24 Supplement): 1-8.

178 According to the UN:

"Restrictive abortion laws do not prevent abortions but force women to seek illegal and usually unsafe abortions. In Latin America, the rate is 30-60 per 1,000. In the Netherlands, with Europe's most liberal abortion law, only five out of 1,000 women opt for abortion. The average of Western Europe is 14 per 1,000 women. Of the estimated 45 million abortions worldwide annually, only 25 million are legal. At least 70,000 women die each year as a consequence of unsafe abortions, and millions more suffer severe health problems."

From *What is the UN Stand on the Issue of Abortion?* UN Fact Sheet #6 (October 2000).

An HIV-positive Woman Faces the Pressure to Abort Her Foetus: an experience from Ukraine

In 2006, I learned that I was pregnant and was looking forward to giving birth, when will my daughter be born... When I was about 5 weeks pregnant I happily and promptly went to the prenatal clinic for registration. The gynecologist found out that I was HIV-positive and began, in a rude manner, to put pressure on me, threatened with the dire consequences of the HIV infection for the baby, and frankly stated that in my situation I can only have an abortion. My pregnancy was desired, I very much wanted to have a baby, and the words of the gynecologist terribly frightened me. If I do not have information that I have a good chance of having a healthy baby, I do not know how this visit would have ended.

The first problems started when I went to the regional AIDS center already with some visible signs of pregnancy. There I overheard a conversation about her two medical workers, who said that I was a criminal, since I was putting my husband at a deliberate risk of HIV infection. This was despite the fact that he was warned about my illness. I thought bitterly, that with discordant couples, because of our law, one partner is always a criminal. Practically, the law does not give me and my husband the chance to live together.

During my pregnancy I was insulted the staff of medical institutions many times. With pain I remember that when a woman-gynecologist, was making an ultrasound, she not only showed complete ignorance in the aspects of anti-retroviral therapy and PMTCT, by insisting that I should start taking Zidovir against while on a triple therapy (HAART), allegedly “for the benefit of the child”, but also insisted that by women like me, the fruit can not be without pathologies. For “humane” reasons she offered me an abortion, even at this late stage of pregnancy. Moreover, offered to make “a salty abortion” when saline solution is entered in the uterus and the fetus dies from dehydration. She wanted to use this barbaric way because she did not want to “soil” her tools with HIV infected blood.

At the end of pregnancy I was on conserving therapy in the hospital. When I first came into the dining room, the maid loudly stated that “...with your illness you should come with your own utensils...” All those who at that moment were in the dining room, learned that I was HIV-positive, and no one ever spoke to me since then. This attitude depressed me a lot, and I still fear, when unknown people learn about my status, that this will lead to discrimination and loathing.

Doctors, treating patients with HIV infection should not only have sufficient knowledge, but also tolerance and tact. During pregnancy I was very nervous, I needed help and support, but instead I received only rudeness and ignorance. I think it was one of the reasons why I had a threat of premature birth.

- Submission made by Victoria Lintsova, Ukraine, for the Eastern Europe and Central Asia Regional Dialogue of the Global Commission on HIV and the Law.

abortion is available and accessible to the full extent allowed by law to women living with HIV who do not want to carry a pregnancy to term is essential to preserving their reproductive health.”¹⁷⁹

On the other hand, there are numerous instances of women being coerced into abortions:

“We also know of examples where HIV-positive women have been forced or feel pressured by health-care workers to have abortions. HIV-positive women may ‘choose’ to have an abortion because they are misinformed about the possible impact of a pregnancy on their health and that of their child; they may be told that the risks of perinatal transmission are high. Such misperceptions can be heightened by health workers who promote a view that HIV-positive women should not have children. Indeed, a number of our members have felt that sometimes health-care workers present abortion as the only option once a positive woman becomes pregnant. Yet HIV-positive women have the right to have children and, given the right care, treatment and support, they generally can have healthy pregnancies and babies. Positive women should never be pressured by their partners, families or health workers to have abortions — that is also a violation of our human rights.”¹⁸⁰

UNAIDS also confirms that programmes targeting pregnant women often emphasise coercive measures directed towards the risk of transmitting HIV to the foetus, such as mandatory testing followed by coerced abortions or

179 As quoted in IPAS (2008), *HIV/AIDS, Unwanted Pregnancy and Abortion: The Situation Today and What Needs to be Done*, available at <http://www.hivlawandpolicy.org/resources/view/444>

180 International Community of Women Living with HIV/AIDS (2008), *Addressing the Needs of HIV Positive Women for Safe Abortion Care*, available at <http://www.icw.org/files/ICW%20abortion%20briefing%20paper%206-08.pdf>

sterilisations. Coerced abortions are not allowed in any countries, particularly those which criminalise service providers and accessors (pregnant women seeking services) alike for illegal abortions. However, Singaporean law on the medical termination of pregnancy specifically deals with the aspect of coerced abortions: women have unrestricted access to abortion services in the first 24-week period, and may avail of abortion services thereafter if there is a danger to their lives or to their mental or physical health. Abortions must be performed only with voluntary and informed consent of the woman, failing which persons compelling or inducing a woman to abort may be liable for penalty/ imprisonment.

5.2.3 Coerced Sterilisation

Pressure or coercion not to have children is a common global manifestation of discrimination against women living with HIV.¹⁸¹ Consequentially women are being forced into sterilisations. In most cases, sterilisation is conducted without obtaining consent or providing counselling, particularly in relation to the use of anti-retrovirals to prevent MTCT and, sometimes, as a pre-condition for providing abortion services. Studies show that forced sterilisation occurs at the time women, especially those who are poor, seek other services such as abortion, caesarean deliveries, prevention of MTCT or cervical cancer screening, all of which are then provided only on condition that the woman be sterilised.¹⁸²

Other than constituting a breach of women's human rights, forced sterilisations also discourage women from accessing much needed medical services. However, research on the complicity of the health system vis-à-vis forced sterilisation is inadequate. In a study conducted in Namibia and South Africa, it was found that informed consent was not taken due to the following reasons: consent was obtained under duress; medical personnel failed to provide full and accurate information regarding sterilisation procedure; consent was invalid as the women were not informed of the contents of the documents they signed; and women were told or given the impression that they had to consent to sterilisation in order to obtain another medical procedure such as an abortion or caesarean section.¹⁸³ This happened despite the fact that both South Africa and Namibia have laws regulating sterilisations that penalise persons conducting sterilisation without informed consent.¹⁸⁴ Similarly, Brazil's law on voluntary sterilisation¹⁸⁵ mandates that sterilisation can only be performed in institutions which offer all options and methods of reversible contraceptives. However, studies show that providers – rather than women themselves – play a significant role in determining whether HIV-positive women are sterilised after delivery.¹⁸⁶ In Indonesia, a number of women report to have undergone coerced sterilisation due to fears of being refused preventive MTCT regimens. While Indonesian law does not have specific provisions regulating sterilisation, according to government representatives there are also no regulations requiring doctors to advise HIV-positive women to be sterilised and the government guarantees that all programmes related to HIV/AIDS are accessible for free.¹⁸⁷ Thus, the non-existence of specific laws or the non-implementation of progressive ones leads to the violation of women's human rights.

Given the gravity of women's rights violations due to forced or coerced sterilisations – treaty monitoring bodies have interpreted coercive sterilisation to be a violation of the right to be free from cruel or inhuman treatment¹⁸⁸ – and the degree of discrimination manifested, it is essential that laws preventing such practices be immediately implemented. Pursuing litigation based on empirical evidence to enforce State accountability could be one of the methods in which this issue may be addressed. An initiative that bears mentioning in this regard is that of a Chilean HIV-positive woman who, with the support of the Center for Reproductive Rights and Vivo Positivo, filed a petition in the Inter-American Court of Human Rights in 2009, on grounds that the government had failed to protect her from being forcibly sterilised

181 Center for Reproductive Rights and Vivo Positivo (2010), *Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities*, available at http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/chilereport_FINAL_singlepages.pdf

182 Mazzotta M (2010), *Group Raises Awareness of Forced Sterilization among HIV Positive Women*, Science Speaks: HIV & TB News, available at <http://sciencespeaksblog.org/2010/11/19/group-raises-awareness-of-forced-sterilization-among-hiv-positive-women/>; Tapiwa Satande L (2010), *Sexual and Reproductive Health Rights Threatened through Forced Sterilization of Women Living with HIV/AIDS: Case Studies from Namibia and South Africa*, available at <http://www.tigweb.org/resources/toolkits/view.html?ToolkitID=2649>; Center for Reproductive Rights and Vivo Positivo (2010), *Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities*, available at http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/chilereport_FINAL_singlepages.pdf

183 Tapiwa Satande L (2010), *Sexual and Reproductive Health Rights Threatened through Forced Sterilization of Women Living with HIV/AIDS: Case Studies from Namibia and South Africa*, available at <http://www.tigweb.org/resources/toolkits/view.html?ToolkitID=2649>

184 South Africa's *Sterilization Act, 1998*, available at <http://www.doh.gov.za/docs/legislation/acts/1998/act44.pdf>; Namibia's *Abortion and Sterilization Act, 1975*, available at <http://www.hsph.harvard.edu/population/abortion/NAMIBIA.abo.htm>

185 Law 9.263 1997.

186 In studies conducted with HIV-positive women in Brazil, it was found that such women were faced with disapproval from health professionals if they wanted to have children. As cited in Paiva V et al (2003), *The Right to Love: The Desire for Parenthood among Men Living with HIV*, *Reproductive Health Matters*, 2003 Volume 11, Number 22, pp 91-100.

187 Proditia S (2010), *HIV-positive Women Resent Sterilization Advice*, *The Jakarta Post*, available at <http://www.thejakartapost.com/news/2010/11/10/hivpositive-women-resent-sterilization-advice.html>

188 According to the Beijing Platform of Action, forced sterilisation during times of conflict constitutes violence against women.

at a State hospital after she gave birth. The petition was filed pursuant to the research cited above, conducted by these two organisations on forced sterilisations on HIV-positive women in Chile.¹⁸⁹

5.2.4 Criminal Laws on HIV Transmission

In recent years, more than 30 countries in Africa, Asia, Latin America and the Caribbean have enacted new laws criminalising HIV transmission. In at least 25 other countries, including those in Europe and North America, existing criminal laws are being used to prosecute people for transmitting HIV or exposing others to HIV.¹⁹⁰

The GNP+ *Global Criminalization Scan Report 2010* finds that:

*"HIV related prosecutions are distributed unevenly. Although most countries have not initiated HIV-related prosecutions, 60 countries and judicial territories have recorded convictions. Nearly as many have recently enacted or are considering enacting HIV-specific laws that have not yet been applied."*¹⁹¹

Although most of these laws are not gender-specific, the use of criminal laws is being promoted as being, *inter alia*, a means to protect women. However, it has been observed that criminal laws on transmission place significant disadvantages on women, particularly since they are, in most instances, the first to learn about their HIV status during the course of receiving antenatal care, are more likely to be blamed for HIV transmission, and face violence upon disclosure.¹⁹² A study on the ramifications of Kenyan legislation criminalising intentional HIV transmission showed that the vague language of such laws poses a real risk of prosecution and imprisonment of women even if they are victims of culturally imposed practices such as widow cleansing and inheritance.¹⁹³ In Honduras, the *Special HIV and AIDS Law* (Articles 74 and 75) requires that anyone diagnosed with HIV must inform his/her partner. In order to avoid being indicted for exposing their partners to HIV, women who are HIV-positive are forced to either reveal their condition or refuse to have sexual relations or insist on the use of condoms. However, for many women these actions entail the risk of violence, dispossession, loss of custody of their children and severe abuse.¹⁹⁴

Although the focus of HIV-specific criminal law is on sexual transmissions, some countries have enacted laws that criminalise MTCT explicitly or implicitly due to overly broad drafting of the law.¹⁹⁵ Some laws even explicitly criminalise transmission through breast-feeding.¹⁹⁶ The Special Rapporteur on the right to the highest attainable standard of health notes:

*"Where the right to access to appropriate health services (such as comprehensive prevention of mother-to-child transmission services and safe breastfeeding alternatives) is not ensured, women are simply unable to take necessary precautions to prevent transmission, which could place them at risk of criminal liability."*¹⁹⁷

In 2008, UNAIDS estimated the worldwide coverage of prevention of MTCT interventions at 33%.¹⁹⁸

189 Center for Reproductive Rights and Vivo Positivo (2010), *Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities*, available at http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/chilereport_FINAL_singlepages.pdf

190 UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*; AIDS Legal Network et al (2009), *10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women*, available at <http://reproductiverights.org/en/document/10-reasons-why-criminalization-of-hiv-exposure-or-transmission-harms-women>. Please also note that this paper does not address criminalisation of transmission in detail as a separate paper on this issued has been prepared for the Global Commission on HIV and the Law.

191 Global Network of People Living with HIV (2010), *The Global Criminalization Scan Report 2010*, available at http://www.gnpplus.net/images/stories/Rights_and_stigma/2010_Global_Criminalisation_Scan.pdf

192 *Ibid.* See *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* (2010) available at <http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.20.pdf>, which notes that HIV-positive women are ten times more likely to experience violence and abuse than women who are HIV-negative.

193 See the submission of Federation of Women Lawyers-Kenya (FIDA-Kenya), Kenya,, for the Africa Regional Dialogue of the Global Commission on HIV and the Law.

194 See the submission of Fundacion Llanto, Valor y Esfuerzo-LLAVES, Honduras, for the Latin America Regional Dialogue of the Global Commission on HIV and the Law.

195 *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* (2010) available at <http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.20.pdf>

196 Center for Reproductive Rights: <http://reproductiverights.org/>

197 *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* (2010) available at <http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.20.pdf>

198 UNAIDS (2008), *Substantial Increases to HIV Prevention Efforts Producing Results, But Not Enough to Turn Back the Epidemic*, available at http://www.unaids.org/en/media/unaids/contentassets/restored/080725_gr08_pressrelease_en.pdf

The GNP+ Report mentions that,

"[P]rosecutions for vertical transmissions are rare. Charges are known to have been brought in Sweden, the USA and Canada against women who did not disclose their HIV status or take ARVs when instructed, and who consequently transmitted HIV to their child."¹⁹⁹

However, even if prosecutions have not been brought, there is a potential that such laws can be used against women and compound the stigma they face already, which could, in turn, discourage them from accessing prevention of MTCT programmes.²⁰⁰ On the other hand, there are some countries that have included explicit provisions exempting MTCT from the ambit of criminal laws on transmission. In Papua New Guinea, the *HIV/AIDS Management and Prevention Act 2003* clarifies that *"nothing in this Part [shall] apply to the transmission of HIV by a woman to her child, either before, during or after the birth of the child."* Another good practice that bears mention is in Sierra Leone, where, pursuant to advocacy efforts of international and local activists, the law on MTCT was repealed in mid-2010.²⁰¹

Cases reported from the US on criminal liability illustrate how different forms of bias are brought to the fore in litigation on this issue. For instance, in 2009, a Cameroon national was arrested in the US for falsifying immigration documents. Upon finding out that she was HIV-positive and pregnant, the court extended her sentence on the rationale that it was necessary for the protection of her unborn child as she would be provided MTCT treatment in custody, despite the fact that she had secured medical care outside the prison. The court reasoned that, though the transmission of HIV to an unborn child is not technically a crime under the law, *"it is as direct and as likely as an ongoing assault."* Although the woman was later granted bail due to advocacy efforts by an NGO, this case demonstrates the paternalistic attitude of judges who follow a policy of prioritising an unborn child's rights over a woman's rights.²⁰²

Predicating women's liability on their having failed to take reasonable measures, as emerging jurisprudence and laws tend to do, especially in the context of a lack of access to health services, is extremely problematic.²⁰³ Instead, it is more likely that the implementation of such laws will only serve to marginalise an already marginalised and stigmatised population: i.e. women living HIV.

VI Conclusions and Recommendations

Both gender discrimination (and the attendant VAW) and HIV/AIDS go to the core of patriarchal control over women's sexuality and the policing of 'aberrant' sexual behaviour. This disciplinary function operates on every register – in the public and private spheres, in religion and laws, in socialisation and statecraft – where a gamut of institutions – family, community and state – dovetail to generate a systemic inequality, even as they speak the language of equality and concern.

Challenging inequality requires (for the specific purposes of this paper) legal and policy interventions that recognise the pervasive and complex nature of both direct and indirect discrimination and which formulate measures to achieve substantive equality. Such measures are not simply punitive (seeking, say, to criminalise prostitution) or paternalistic (mandating disclosure of HIV serostatus, for instance); rather, they use human rights principles to empower women to claim their rights and to obligate States to provide the facilitative environment for women to do so.

Broadly speaking, this means that:

- Laws and policies to address VAW and HIV/AIDS must be based upon an understanding of the links between the two. For instance, a diagnosis of HIV-positivity can be a cause of VAW, so when devising interventions on HIV testing (involuntary testing policies at the time of pregnancy or seeking employment) or serostatus disclosure (mandatory pre-marital testing, partner notification) it is important to be aware of the possible violent repercussions of this intervention for women and to carry out impact assessments that monitor its intended and unintended effects.

199 Global Network of People Living with HIV (2010), *The Global Criminalization Scan Report 2010*, available at http://www.gnpplus.net/images/stories/Rights_and_stigma/2010_Global_Criminalisation_Scan.pdf

200 Csete J, Pearshouse R and Symington A (2009), *Vertical Transmission Should Be Excluded from Criminal Prosecution*, Reproductive Health Matters, available at http://www.aidslex.org/site_documents/CR-0106E.pdf

201 Global Network of People Living with HIV (2010), *The Global Criminalization Scan Report 2010*, available at http://www.gnpplus.net/images/stories/Rights_and_stigma/2010_Global_Criminalisation_Scan.pdf

202 Csete J, Pearshouse R and Symington A (2009), *Vertical Transmission Should Be Excluded from Criminal Prosecution*, Reproductive Health Matters, available at http://www.aidslex.org/site_documents/CR-0106E.pdf; Ahmed A (2011), *HIV and Women: Incongruent Policies, Criminal Consequences*, Yale Journal of International Affairs, available at <http://yalejournal.org/wp-content/uploads/2011/03/116107ahmed.pdf>

203 Csete J, Pearshouse R and Symington A (2009), *Vertical Transmission Should Be Excluded from Criminal Prosecution*, Reproductive Health Matters, available at http://www.aidslex.org/site_documents/CR-0106E.pdf

- Laws and policies to address VAW and HIV/AIDS must be cognisant of the need to tackle the politics of gender inequality. For instance, with regard to gender-discriminatory customary law practices, although CEDAW expressly obligates signatories to modify/abolish discriminatory customary practices, few do so. Revealingly, CEDAW is both one of the most widely signed instruments as well as one with the most reservations, frequently to do with customary practices. And yet, dealing with customary law is an important aspect of bringing equality into the family which, in turn, will allow women to control their sexuality and, thereby, their sexual health. Developing programmes at the community level that involve men should also be considered as an effective strategy to reduce intimate partner violence, which, in turn, may have a desirable effect on rates of HIV incidence.²⁰⁴
- In the context of VAW and HIV/AIDS, it is important to recognise and ensure women's sexual and reproductive rights:
 - i. Laws on rape and sexual violence should recognise the myriad forms of sexual violence, remove marital rape exceptions and move towards an understanding of rape as a violation of a woman's bodily integrity. While there has been some progressive law reform in some countries, with sexual violence being recognised as a crime against the individual and the adoption of graded definitions of sexual assault that addresses a range of types of sexual violence, in most countries the law remains unreformed.

204 Submissions made to the Regional Dialogues conducted by the Global Commission on HIV and the Law in 2011 outline interventions that merit consideration as best practices:

(i) A submission made by Sonke Gender Justice, South Africa, for the Africa Regional Dialogue of the Global Commission on HIV and the Law describes the importance of involving boys and men in programmes about gender equality:

"With the implementation of programs engaging men and boys, a body of effective evidence based programming has emerged. These programs have confirmed that men and boys are willing to participate in discussions related to gender equality, and are rethinking masculinities, and that targeted, well-designed interventions can be effective in changing traditional and rigid attitudes and behaviours that perpetuate gender inequalities."

The submission discusses the work of the Men as Partners Network (MAP) in South Africa. Studies indicate that MAP workshop participants have significantly more gender-sensitive outlooks than men in a control group vis-à-vis issues such as: women's rights, domestic violence and the rights of sex workers. The submission also references a study conducted by the Nicaraguan Men's Association Against Violence on nearly 150 Nicaraguan men who participated in workshops on masculinity and gender equity (reported in Welsh P (2001), *Men aren't from Mars: Unlearning Machismo in Nicaragua*, Catholic Institute for International Relations. The study:

"...revealed significant positive attitudinal and behavioural changes according to both partner reports and self evaluations in a wide range of indicators including: use of psychological and physical violence, sexual relations, shared decision making, paternal responsibility and domestic activities."

The submission concludes:

"For the most part, the existing [South African] legal and policy framework vests women and girls with adequate legal rights and policy entitlements save for the fact that the integration of work with men and boys to address gender inequality and its link with HIV and AIDS, is insufficient in policies even though an evidence base exists, which proves the importance and benefits of the inclusion of working with men and boys."

(ii) A submission made by Proyecto Construyendo Alianzas de VIH en el Mundo Rural de Centroamerica, Nicaragua, for the Latin America Regional Dialogue of the Global Commission on HIV and the Law, discusses the importance of involving women in HIV/AIDS interventions among rural, indigenous communities. Discussing changes at the community level as a result of the organisation's interventions, the submission says:

"It is possible to enumerate a number of changes, but the most important change was that women, after being assisted for a number of years at a center that offered comprehensive care and provided them with medicines, at no point had taken action to defend their rights as women, as indigenous and as people with HIV. However, as a result of the project's different efforts, a change occurred in the perspective and formation of the partnerships (from organizations that worked with HIV, community organizations, people with HIV and other key actors.) The most important achievements included the following:

1. Many women broke the cycle of violence. Before, they had feared attending half-day appointments but now were able to delegate the care of the children and the home to the men, allowing them to go out and speak to other communities. The work has been done based on the methodology of self-support groups, in which personal situations are identified that are projected onto others. This makes it possible to highlight a reality, one which had not been spoken of before and seeks alternatives to diminish the situations presented on a personal as well as social level.

2. In the case of community stigma, women have developed the skills to push and advocate with actors in the protection sectors (police, judge, mayor, etc.) to act immediately on behalf of people with HIV.

3. Women in the past were scared of speaking out in public (as a person with HIV but also because they feared speaking "differently.") Now they attend public protests in which they demand recognition of their cultural identity and the respect of their rights."

(iii) A submission made by Rakai Health Sciences Program, Uganda, for the Africa Regional Dialogue of the Global Commission on HIV and the Law, describes the organisation's four-year project, SHARE (Safe Homes and Respect for Everyone): an initiative to reduce intimate partner violence (and, thus, reduce HIV incidence) in Uganda's Rakai district through the formulation of a set of "community bye-laws" that promote human rights. Some of the community-initiated and endorsed by-laws include:

"...any person in an act or caught in an act of violating someone's human rights...will be fined up to 50000/= Uganda Shillings and...the money shall be paid to the treasurer of the local village council.

• Proceeds from the above act shall be used to purchase items such as plates, cups which can be used by community members within that area when need arises, especially in community support groups e.g. Muno Mukabi.

• Should a person get caught in an act of violating someone's right and he/she fails to pay the above amount of money the victim shall be given a punishment to clear the bush alongside the roads in their locality. The size of the piece to be cleared by the victim is determined by the community.

SHARE's achievements include:

• Initiation and having all community members assenting to the set byelaws helped in minimizing or prevention of [intimate partner violence] as people fear to be seen paying money or clearing the bush.

• Low earners fear to be involved in [intimate partner violence] as they may not be able to raise that money

• SHARE partners had various trainings/sensitizations on issues related to Domestic Relations Bills and strongly advocated for it to be passed as a law in Uganda.

• Increased awareness that violation of human rights is a crime especially in areas where the project was being implemented.

• Selected community volunteers do counsel those experiencing [intimate partner violence], refer cases to the local leaders and some are referred to the police for further management."

- ii. In cases of sexual violence, women must have access to justice and measures must be taken to prevent the revictimisation of women seeking legal redress (for instance, by reforming laws that allow consideration of the woman's sexual history or mitigate criminal liability upon marriage, and by making provisions for witness/victim protection).
 - iii. With regard to women's reproductive rights, a human rights approach emphasises autonomy in reproductive decision making: measures to ensure informed consent and to guard against coercion at the time of making reproductive decisions; prohibition of forced abortion or coerced sterilisation of women who are HIV-positive; MTCT programmes must be attentive not just to the health of the foetus, as is currently the case, but also that of the mother.
 - iv. In order to empower women to make their own reproductive and sexual health decisions, women must be able to access information about both their legal rights and the potential health risks that they could encounter. Laws and policies must provide for awareness creation because this is crucial as a prevention strategy.
- In the context of VAW and HIV/AIDS, it is also important to recognise women's health rights and ensure their access to health care services for HIV testing, prevention and treatment:
 - i. It is amply documented that the threat of violence impedes women's usage of HIV health care services, so it is essential to maintain patient confidentiality and ensuring access to healthcare.
 - i. Removal of discrimination in treating women who are HIV-positive: a rights-based approach in delivering healthcare is cognisant of and designed to address women's realities and experiences (such as the unaffordability of ART, lack of mobility and access to health centres). Additionally, it provides access to PEP for survivors of sexual violence on a priority basis. Further, it regards voluntary testing as an entry point for providing care and support to HIV-positive women.
 - i. Regarding access to health (and HIV) services for victims of trafficking, it is important to orient trafficking legislation around victim-protection rather than apprehending offenders and, thus, not making the provision of health services conditional on testifying (or, in the case of migrants, on citizenship status).
 - i. The criminalisation of prostitution places significant burdens on women accessing health and justice and so should be decriminalised.
 - With regard to VAW specifically, the emphasis has traditionally been on criminalisation, but rights advocates recommend the adoption of a comprehensive legal approach *"encompassing not only the criminalization of all forms of violence against women and effective prosecution and punishment of perpetrators, but also the prevention of violence, and the empowerment, support and protection of survivors."*²⁰⁵ The appropriate intervention, therefore, is not only to enact laws on VAW, but also to write effective implementation into such laws: hence, the inclusion of and emphasis on provisions for prevention, support and protection within the law.
 - In addition to empowering women to make decisions about their sexual and reproductive health, it is also essential to create public awareness about women's human rights as a strategy for preventing VAW and challenging gender stereotypes.
 - Another key aspect of effective implementation is the adequate costing and budgeting of VAW and gender-specific HIV/AIDS interventions, which, as discussed in section 2.4 above, is an area of significant weakness. According to the UNAIDS Global Report 2010, *"prevention strategies... often do not adequately address patterns of HIV transmission"* which, in the context of evolving heterosexual epidemics, include increasing numbers of serodiscordant couples and rising rates of HIV transmission within long-term relationships.²⁰⁶ Designing and budgeting for interventions that target women (by ensuring equality rights in marriage, for example) is clearly crucial. Yet, not only are the majority of gender-specific interventions not budgeted, but most States do not even invest in generating the sex-disaggregated data that will enable them to tailor effective strategies.

"Programmes aimed at the prevention and treatment of HIV/AIDS cannot succeed without challenging the structures of unequal power relations between women and men... [T]he multiple ways in which violence against women and HIV intersect increase the risk of HIV infection among women, their differential treatment once they are infected and their stigmatization, which in turn triggers further violence. Recognizing the importance of gender inequality and its manifestations, particularly for young women, and women from minority, indigenous and other marginalized groups, is

205 UN Division for the Advancement of Women (2009), *Handbook for Legislation on Violence against Women*, available at <http://www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>.

206 UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*.

*critical to stemming the spread of the disease. Multiple layers of subordination that increase women's exposure to violence, limit their sexual and reproductive rights, increase stigmatization and discrimination and constrain their access to medical care, as well as feminized poverty, are all causes and consequences of HIV.*²⁰⁷

Finally, as we seek to challenge the gender inequality that creates the vicious nexus between VAW and their HIV vulnerability, we must urgently remedy that manifestation of inequality whereby women are, more often than not, excluded from participation in policy-making, even on issues which primarily affect them.

207 Special Rapporteur on Violence against Women (2005), *Intersections of Violence against Women and HIV/AIDS*, E/CN.4/2005/72, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/130/90/PDF/G0513090.pdf?OpenElement>

Annexure I

Continuum of Violence against Women throughout the Life Cycle

Reproduced from: *Violence against Women: A Priority Health Issue*. World Health Organisation (1997) WHO/FRH/WHD/97.8

Phase	Type of violence
Pre-birth	Sex-selective abortion; effects of battering during pregnancy on birth outcomes.
Infancy	Female infanticide; physical, sexual and psychological abuse.
Girlhood	Child marriage; female genital mutilation; physical, sexual and psychological abuse; incest; child prostitution and pornography.
Adolescence and Adulthood	Dating and courtship violence (e.g. acid throwing and date rape); economically coerced sex (e.g. school girls having sex with "sugar daddies" in return for school fees); incest; sexual abuse in the workplace; rape; sexual harassment; forced prostitution and pornography; trafficking in women; partner violence; marital rape; dowry abuse and murders; partner homicide; psychological abuse; abuse of women with disabilities; forced pregnancy.
Elderly	Forced 'suicide' or homicide of widows for economic reasons; sexual, physical and psychological abuse.

Annexure IIa

The Linkages between HIV/AIDS and Violence against Women and Girls

Reproduced from: UN Women's Virtual Knowledge Centre to End Violence against Women and Girls [<http://www.endvawnow.org/en/articles/677-understand-the-linkages-between-hiv-aids-and-violence-against-women-and-girls-.html>]

Since HIV and AIDS emerged over 25 years ago, the percentage of HIV-positive people who are girls and women has increased globally. The 'feminisation' of the HIV epidemic has resulted in more women than men living with HIV. In sub-Saharan Africa, young women aged 15-24 are as much as eight times more likely than men to be HIV-positive. In Asia overall, women account for a growing proportion of HIV infections: from 21% in 1990 to 35% in 2009 (UNAIDS, 2010).

Studies are consistently showing a statistical association between experiences with violence and HIV infection:

- In India, women who had experienced both physical and sexual violence from intimate partners were over three times more likely to be HIV-positive than those who had experienced no violence (Silverman, 2008).
- In Rwanda, women who had been sexually coerced by male partners were 89% more likely to be HIV-positive (van der Straten A. et al. 1995 and 1998).
- In South Africa, women seeking routine antenatal care who had experienced physical or sexual violence were 53% more likely to test HIV-positive and those experiencing high levels of gender power inequality in relationships were 56% more likely to test HIV-positive (Dunkle, 2004).
- In the United Republic of Tanzania, women seeking voluntary counselling and testing who had experienced violence were also more likely to be HIV-positive; among women under 30 years, those who had experienced violence were about ten times more likely to be HIV-positive (Maman, 2009).

Although there has been increased attention in recent years to understanding linkages between HIV and AIDS and VAW, the evidence base still remains weak due to gaps in information (Harvard School of Public Health, 2009). This is at least partly due to the nature of the fundamental issues involved with these dual pandemics: sex and violence (CWGL, 2006). In many contexts around the world sex and violence are viewed to be private concerns and not community or governmental issues. The silence that typically accompanies these dual pandemics makes it difficult for women to access information and services for treatment, care and prevention of *both* HIV and violence. This in turn makes accurate data collection about the intersection of violence and HIV difficult (CWGL, 2006).

Nevertheless, the growing body of data suggests that **VAW and girls is linked to an increase in HIV risk**. Broadly, the evidence shows:

- Significant overlap in prevalence.
- Intimate partner violence as a risk factor for HIV infection among women and men.
- Past and current violent victimisation increasing HIV risk behaviours.
- Violence or fear of violence from an intimate as an impediment or as a consequence of HIV testing.
- Fear of partner violence as a barrier to accessing and uptaking PMTCT services.
- Partner violence as a risk factor for STIs, which increases the rate of HIV infection.
- Women who have violent partners are less likely to negotiate condom use and more likely to be abused when they do.
- Economic violence may increase the risk of acquiring HIV by deepening gender inequalities and increasing vulnerability.
- Various adverse health effects related to intimate partner violence compromise women's immune systems in a way that increases their risk of HIV.
- Abusive men are more likely to have other sexual partners unknown to their wives.
- Women who have experienced childhood sexual abuse are more likely to engage in HIV risk behaviours as an adolescent/adult.

[Sources: excerpted from Kimberly A. Scott, *Rapporteur*, Planning Committee for a Workshop on Violence Prevention in Low- and Middle-Income Countries. 2008. Institute of Medicine; Harvard School of Public Health, 2009. Final Draft Report; Devries et al., 2010; Maman, personal communication, 2010; and WHO/UNAIDS, 2010]

Specific Forms of Violence and Risk of HIV	
Type of Violence	HIV Risk
Sexual Assault	Sexual assault increases the vulnerability of HIV infection amongst women and girls in both direct and indirect ways. Directly, sexual assault can result in trauma and tissue tearing that facilitates HIV infection. This is pronounced amongst young women and girls whose reproductive tracts are not yet mature (CWGL, 2006). Indirectly, the threat of sexual assault makes it difficult for women and girls to negotiate condom use and/or try to refuse sex all together (Black, 2001 cited in Ward et al., 2005; USAID and UNICEF, 2005). Experiencing sexual assault can also increase the likelihood of future risk taking behaviours such as: unprotected sex, multiple partners, substance use, and sex work (Ward, 2008). Additionally, in many contexts, the stigma attached to being sexually assaulted can prevent women and girls from seeking medical treatment, including PEP (CWGL, 2006).
Coerced Sex	Girls who have experienced coercive first sex may be more likely to be HIV-positive (Harvard School of Public Health, 2009). Across the world between 7 and 48% of young women and girls report that their first sexual experience was coerced (Krug et al. eds., 2002; Reza et al./CDC and UNICEF, 2008; and WHO/UNAIDS, 2010). As with sexual assault, sexual coercion often involves unequal power relations, which limit the extent to which a woman or girl can exercise control over condom use or take other measures to protect herself from HIV infection. In some parts of the world, 'Sugar daddies'—older men who seduce girls into sexual relationships in exchange for food, money, and/or gifts, often prefer to exploit those who they believe are virgins and therefore HIV-negative (Ward, 2008). To the extent that these men fail to use protection, they put girls at risk of contracting HIV. Adolescent girls who have experienced sexual coercion may also be more likely to be non-users of contraception and to have unintended pregnancies.
Intimate Partner Violence	In cases of intimate partner violence, inequality of power within the sexual relationship is linked to the risk of HIV transmission (Jewkes et al., 2010). For example, when intimate partner violence is present fear of violence and abuse can prevent women and girls from negotiating safe sex, even when they fear a partner may be HIV-positive. This is especially dangerous given that abusive men are more likely than non-abusive men to have multiple sex partners, be adulterous, and to have STI symptoms (Dunkle et al., 2005 & Martin et al., N.d. cited in Makunda, 2009). A study using data from 96 countries demonstrated that women who had experienced intimate partner violence were more than two times as likely to contract HIV (Watts cited in Hale and Vasquez/Development Connections, International Community of Women Living with HIV/AIDS and Un Women, 2011).
Child Marriage	Because of biological factors, young wives are more physically vulnerable than mature women to contract STIs, including HIV, from an infected partner—a danger which only increases given the fact that young girls are even less likely to be able to negotiate safe sex with their partners than older women (Ward, 2008). A study conducted in Rwanda found that 25% of girls who became pregnant at age 17 years or younger were infected with HIV, even though many reported having sex only with their husbands. According to the study, the younger the age at sexual intercourse and first pregnancy, the higher the incidence of HIV infection (Excerpted from USAID and UNICEF, 2005, pg. 9 citing UNICEF 1994 in Black, 2001 cited by Ward et al., 2005). Additionally, a study conducted in Uganda found that girls aged 13 to 19 years who were HIV-positive were twice as likely to be married as girls who were HIV-negative (Otoo-Oyortey and Pobi, 2003 cited by Ward et al., 2005).
Trafficking	Epidemics of STIs, including HIV, have increased the demand for sex with children, who are believed to be less likely to be infected than adults. While overall data is not available on the risk of HIV transmission related to trafficking, sexual exploitation is a high-risk factor for HIV (Ward, 2008).
Female Genital Mutilation/Cutting	FGM/C may also contribute to the risk of HIV infection among women and girls. This is because of the unsterilised instruments sometimes used to perform such procedures, and also because the scarred or dry vulva of a woman who has undergone FGM is more likely to be torn during intercourse, which can facilitate transmission from an infected partner (Centre for Reproductive Rights, 2005 cited in Ward, 2008). More three million girls are at risk of FGM/C every year (WHO, 2008a). For country statistics on FGM/C, see: the Multiple Indicator Cluster Survey (UNICEF), the Demographic and Health Surveys (MEASURE) and Female Genital Mutilation/Cutting: Data and Trends (Population Reference Bureau, 2010). For more information and tools for medical professionals to address FGM/C, see the World Health Organisation website page on Female Genital Mutilation and Other Harmful Practices.

Other Harmful Traditions	<p>Traditional practices across the world that both support and intensify VAW and girls can contribute to HIV transmission. These include:</p> <p>Polygamy is when a person has more than one spouse. In most parts of the world, the most common practice of polygamy is polygyny, where a husband has multiple wives. Unprotected sex with multiple concurrent partners is a proven risk factor for HIV transmission and in cases of polygyny the husband may not use condoms with his wives.</p> <p>Wife inheritance is when a widow is given to a male family member of the deceased husband. Cases of wife inheritance usually involve unequal power relations where a woman or girl may be forced into the practice. This lack of power may increase the chances of sexual assault or coerced sex. These unequal power relations can also limit the extent to which a woman or girl can exercise control over condom use or take other measures to protect herself from HIV infection.</p> <p>Widow Cleansing is when new widows are forced to have sex with a member of their late husband's family or with a member of the community as a cleansing rite after the death. With this practice emphasis is placed on the sex being unprotected. This practice increases HIV risk factors through: a) the unequal power relations where a woman or girl may be forced into the practice and b) the lack of condom use.</p>
Discrimination in Property and Inheritance Laws	<p>In some parts of the world property ownership is traditionally passed patrilineally. Because of these traditions even women who do inherit property may be at risk of eviction or 'property grabbing' by extended family (Ward, 2008). The impacts of HIV/AIDS, for example the premature death of a husband, may serve to accelerate disinheritance and/or property grabbing. For widows and their children, this practice is particularly harmful given that the related economic vulnerability can force them into situations of transmission risk. For example, HIV-orphaned girls who become heads of households may be forced into sex work in order to survive and support their siblings (Fleishman, 2002).</p>
Discrimination in Education	<p>Lack of education appears to have an effect on female vulnerability to HIV: According to one study, "women with at least a primary education are three times more likely than uneducated women to know that HIV can be transmitted from mother to child" and "completion of secondary education was related to lower HIV risk, more condom use and fewer sexual partners, compared to completion of primary education." (World Bank, 2002, and Boler and Hargreaves, 2006, in Action Aid, 2007 cited in Ward, 2008).</p>

Just as VAW and girls can increase their risk of HIV transmission, **HIV infection can also increase the risk of VAW** and girls and worsen the effects of other forms of gender discrimination. A study conducted in four countries in Asia Pacific found that HIV-positive women are significantly more likely than men to experience discrimination, violence and be forcefully removed from their homes (Amnesty International, 2004, cited in CWGL, 2006). Across the world many women have reported experiencing different forms of violence following the disclosure of their HIV status, or even after disclosing that they have gone for HIV testing (Harvard School of Public Health, 2006). Fear of these repercussions can prevent women from being tested, revealing their status and/or seeking treatment care and support.

HIV-positive women face various forms of violence, because of their HIV status - physical, psychological and economic abuse, in addition to: being shunned or rejected by family and the community; eviction from home and loss of assets; denied access to their children; ill-treatment by service providers; loss of livelihoods and denied work opportunities; and abuse by police, including extortion (Hale and Vasquez, 2010).

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Annexure IIb

Linkages between Gender-Based Violence and HIV*

Reproduced from: *Gender-Based Violence and HIV*. Harvard School of Public Health (2009) [http://www.hsph.harvard.edu/pihhr/files/homepage/program_resources/GBV_HIV_FINAL_DRAFT_REPORT_SEPT_2009.pdf]

GBV and the Risk of Acquiring HIV

- Physical and sexual GBV have been associated with HIV transmission.
- Economic violence may increase the risk of acquiring HIV by deepening gender inequalities and increasing vulnerability.
- GBV or the threat of violence may prevent women from being able to practice safer sex.
- Experiencing GBV may be associated with engaging in “HIV risk behaviours,” such as unprotected sex and transactional sex.
- Male perpetrators of violence may engage in “HIV risk behaviours,” such as not using condoms with multiple casual sexual partners.

Child Sexual Abuse and the Risk of Acquiring HIV

- Child sexual abuse is an important facet of GBV with implications for HIV risk and vulnerability.
- Individuals who have been sexually assaulted in childhood may later exhibit a pattern of sexual risk taking.
- Individuals who experience coerced sex in their childhood may have an increased risk of acquiring HIV or other STIs later in life.

HIV Seropositivity and the Risk of Experiencing GBV; GBV and Adherence

- HIV seropositivity may be associated with the risk of experiencing violence.
- GBV or fear of GBV may potentially delay a woman’s decision to disclose her HIV status.
- GBV may negatively influence adherence because, for example, it may hinder women from accessing health services.

GBV and HIV in Conflict/Emergency Situations

- Conflict and emergency situations may affect the intersections of GBV and HIV.
- In conflict situations, rape and sexual violence are often reported to be high and interventions to address GBV, HIV or their intersections are often sorely lacking.

*GBV is a broad category (addressing women, men, men who have sex with men, male and female sex workers, girls and boys and transsexual or transgender individuals), of which violence against women is a component. Although this table provides linkages between GBV and HIV, the authors of the Harvard report clarify that, “the bulk of the report focuses on the links between GBV against women and HIV”.

Annexure III

HIV/AIDS Legislation and Multisectoral Strategies

Reproduced from: *Global Report: UNAIDS Report on the Global AIDS Epidemic 2010* [http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf]

Figure 5.1

Countries with laws or regulations that create obstacles

Percentage of countries in which nongovernmental sources report laws or regulations that create obstacles to effective HIV prevention, treatment, care, and support for population groups at higher risk and other vulnerable population groups.

Source: *Country Progress Reports 2006, 2008, 2010.*

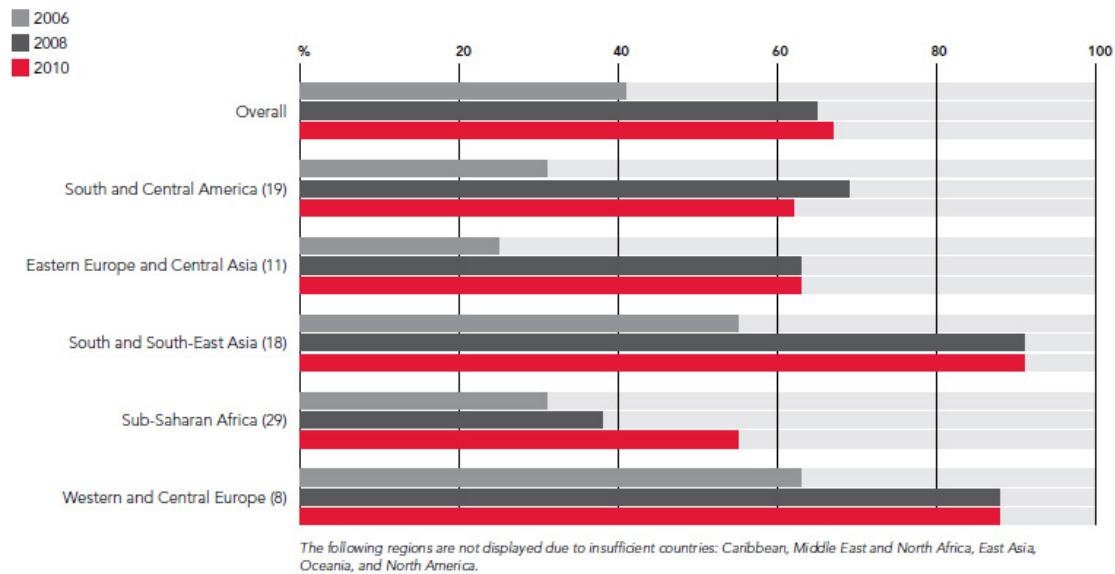


Figure 5.3

Legal protections against discrimination for people living with HIV

Percentage of countries with legal protections against discrimination for people living with HIV and mechanisms for redress, as reported by nongovernmental sources.

Source: *Country Progress Reports 2010.*

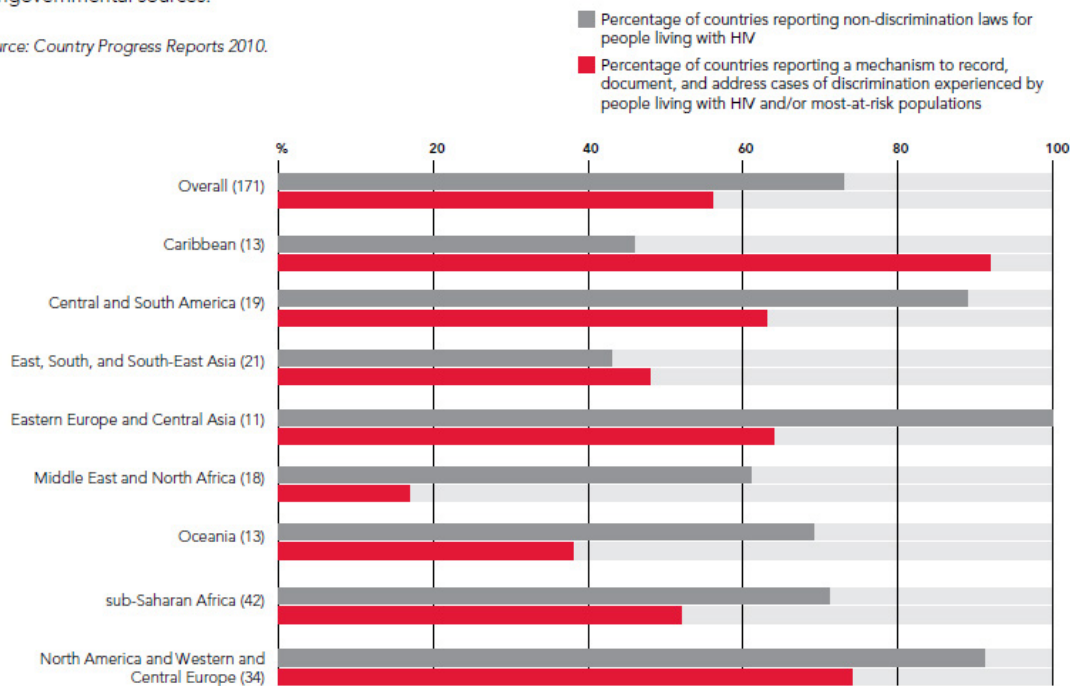


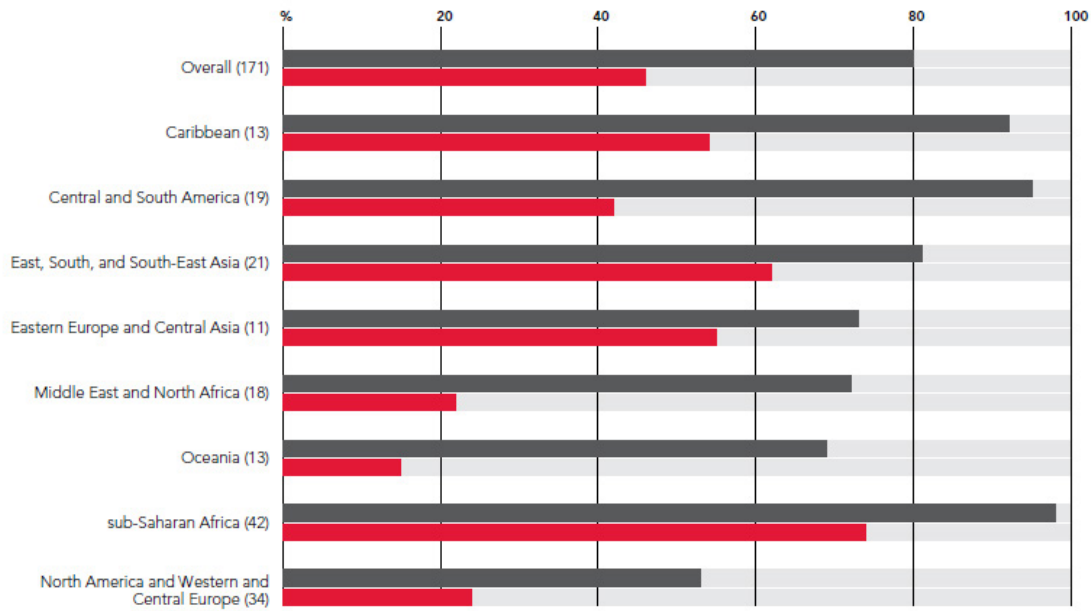
Figure 5.8

Multisectoral HIV strategies specifically including and budgeting for women

Percentage of countries in which governments report that multisectoral HIV strategies specifically include and budget for women.

■ Women included
■ Budget included

Source: Country Progress Reports 2010.



Annexure IV

Prevalence of Domestic Violence against Women

Source: WHO Multi-Country Study on Women's Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses. World Health Organisation (2005) [http://www.who.int/gender/violence/who_multicountry_study/en/]

- Between 19% and 76% of all women had experienced physical or sexual violence, or both, by partners or non-partners, since the age of 15 years. In almost all settings, the majority of VAW had been perpetrated by their intimate partner.
- The range of lifetime prevalence of sexual violence by an intimate partner was between 6% and 59%, with most sites falling between 10% and 50%.
- ...[A]cross a broad range of settings, men who are violent towards their partners are also more likely to have multiple sexual partners. In many ways this association between partner violence and partner infidelity is not surprising, as the same notions of masculinity that condone male infidelity also tend to support male violence or control. This association may result in women being at increased risk of HIV or STI. Because violent men are more likely to be unfaithful, they may have a greater chance of becoming infected with HIV and other STIs, potentially putting women in violent relationships at increased risk of infection. This conclusion is supported by a study in South Africa, which found that abusive men are more likely than non-abusive men to be HIV-infected. A similar study in India found that abusive men were significantly more likely to have engaged in extramarital sex and to have STI symptoms than non-abusive men.

Table 4.2 Percentage of ever-partnered women who have experienced different acts of sexual violence by their intimate partners, by site

Site	Physically forced to have sexual intercourse		Had sex because afraid of what partner might do		Forced to do something degrading/humiliating		Experienced any of the 3 forms of sexual violence listed		Total no. of ever-partnered women
	Ever (%)	Current ^a (%)	Ever (%)	Current ^a (%)	Ever (%)	Current ^a (%)	Ever (%)	Current ^a (%)	
Bangladesh city	34.4	16.1	21.4	14.0	3.1	2.0	37.4	20.2	1373
Bangladesh province	45.7	18.4	31.7	18.3	3.8	1.7	49.7	24.2	1329
Brazil city	8.3	2.0	7.0	1.9	3.3	1.0	10.1	2.8	940
Brazil province	10.3	3.8	9.7	3.8	5.3	1.6	14.3	5.6	1188
Ethiopia province	46.0	32.6	57.6	42.5	0.4	0.3	58.6	44.4	2261
Japan city	4.9	1.2	3.1	0.7	1.3	0.2	6.2	1.3	1275
Namibia city	12.9	7.4	9.8	5.7	5.9	3.0	16.5	9.0	1367
Peru city	16.4	4.6	15.8	5.0	8.1	1.9	22.5	7.1	1087
Peru province	37.7	18.1	37.4	17.7	11.3	5.4	46.7	23.0	1534
Samoa	17.7	10.3	11.4	6.6	3.3	2.0	19.5	11.4	1204
Serbia and Montenegro city	3.5	0.2	4.0	0.9	1.5	0.1	6.3	1.1	1191
Thailand city	7.9	3.6	26.7	15.5	4.9	2.2	29.9	17.0	1048
Thailand province	7.5	3.5	26.1	14.0	4.1	2.0	28.9	15.6	1024
United Republic of Tanzania city	19.3	10.5	11.8	6.7	1.9	1.0	23.0	12.7	1442
United Republic of Tanzania province	27.1	16.2	17.5	10.0	2.0	1.4	30.7	18.3	1256

^a At least one act of sexual violence during the 12 months prior to the interview.