

Advancing gender equity in access to HIV treatment through the Protocol on the Rights of Women in Africa

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Summary

This article examines the challenges women face in accessing HIV/AIDS treatment in Africa and the need to ensure equality in access to treatment. It argues that, in accordance with the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women's Protocol), there is a need for states to adopt affirmative action in order to improve access to HIV treatment for women in Africa. Although the article briefly discusses access to Nevirapine to prevent mother-to-child-transmission of HIV/AIDS, the focus is on women's needs and not the needs of the child. Factors limiting women's rights to access HIV treatment, such as discrimination, poverty and inadequate spending on the health care, are considered. The article discusses the role state parties to the Women's Protocol can play in ensuring equity in access to treatment for women in their territories.

1 Introduction

The HIV/AIDS pandemic, now in its second decade, has continued to claim lives all over the world. However, the devastating effect of the pandemic is felt most in sub-Saharan Africa. While it is estimated that about 40 million people are living with HIV/AIDS worldwide at the end of 2005, the largest share of this figure is borne by Africa, accounting for about 70% of the total number.¹ Yet, sub-Saharan Africa is home to

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¹ UNAIDS/WHO *AIDS epidemic update* (2005) 17.

just 10% of the world's population. Approximately 25 million people are living with the epidemic in Africa.² Of this figure, women constitute about 13,5 million, that is, about 57% of the total number of people infected with HIV in this region.³ This is a rise of about 400 000 from the prevalence rate in 2003. In 2005 alone, not less than 3 million people worldwide (of which 2 million are from Africa) lost their lives to HIV/AIDS-related complications.⁴

In countries such as Kenya, Uganda and Zimbabwe there were reports of a lower prevalence rate, while others, such as South Africa, Swaziland, Tanzania and Zambia recorded a high prevalence rate. The situation in Swaziland is of particular interest as recent figures of pregnant women attending antenatal programmes show that close to 43% of them are infected with HIV/AIDS.⁵ In the same vein, about 3,2 million people were newly infected on the continent at the end of 2005. Several years of gains in the area of economic and social development are being reversed. A report has shown a correlation between poor development and HIV/AIDS, in many very poor countries.⁶ In many African countries, life expectancies have fallen considerably, mainly due to HIV/AIDS. For instance, it is estimated that the life expectancy in Botswana will fall from 70 years to 40 years by 2010.⁷

Although there exists no cure for HIV/AIDS, anti-retroviral drugs have been developed. These are useful in prolonging the lives of infected persons, thereby transforming HIV/AIDS from a death sentence into a manageable chronic disease. However, the hope of accessing treatment for persons infected by HIV in Africa is slim. Many people in dire need of treatment for HIV/AIDS are not getting it. Of the six million people in the world in need of anti-retroviral drugs, only about 440 000 have access.⁸ The situation is worse in Africa than in any other region. It is estimated that just 3% of people in need of treatment currently have access.⁹ For countries such as South Africa, it is estimated that at least 85% of those requiring anti-retroviral drugs were not receiving them by mid-2005.¹⁰ In countries such as Ethiopia, Ghana and Nigeria, the figure of those without treatment is about 90%.¹¹

Worst affected by this predicament are the women in the region. In 2003, it was estimated that testing and treatment of HIV/AIDS was available only to 1% of pregnant women in the countries where the

² As above.

³ As above.

⁴ As above.

⁵ As above.

⁶ UNDP *Human development report* (2003) 2.

⁷ US Bureau of Census *World population report* (2000).

⁸ UNAIDS/WHO *AIDS epidemic update* (2004).

⁹ As above.

¹⁰ UNAIDS/WHO (n 1 above) 30.

¹¹ As above.

pandemic had struck the hardest.¹² As will be demonstrated below, a lack of access to treatment amounts to a violation of recognised rights in international and regional human rights instruments.

This article examines the challenges women face in accessing treatment in Africa for HIV/AIDS and the need to ensure equality in access to treatment. It further argues that, in accordance with the Protocol to African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women's Protocol),¹³ there is a need for states to adopt affirmative action in order to improve access to HIV treatment for women in Africa. The focus of this article is on ensuring equity in access to anti-retroviral drugs for women. Although the article briefly discusses access to Nevirapine to prevent mother-to-child-transmission of HIV, this discussion will be general, as the focus is on women's needs and not the needs of the child. Factors limiting women's rights to access to HIV treatment, such as discrimination, poverty and inadequate spending in the health care sector, will be considered. The article discusses the role state parties to the Women's Protocol can play in ensuring equity in access to treatment for women.

2 Philosophical basis of equity and access to treatment

Before examining the human rights implications of ensuring gender equity in access to HIV treatment, it is important to understand the philosophical discussion on equity and access to treatment. Such discussion will enable us to appreciate better the reasons why equity must be achieved by states in providing treatment to their citizens.

Ensuring access to treatment for people living with HIV/AIDS (PLWHA) remains an important way of mitigating the impact of HIV on the lives of persons who are infected or affected. However, for many people, especially vulnerable and marginalised groups in society, the notion of access to treatment may be unrealisable unless equity is obtained in providing treatment. The concept of equity entails achieving justice and equality in society. It does not have one single meaning, rather it depends on the ideological leaning of the interpreter.¹⁴ Equity

¹² UNIFEM *Facts and figures on HIV/AIDS* http://www.unifem.org/gender_issues/hiv_aids/facts_figures.php (accessed 10 April 2006).

¹³ The Protocol of African Charter on Human and Peoples' Rights on the Rights of Women in Africa approved by African Union governments in Maputo, 2003; entered into force on 25 November 2005 after Togo became the 15th country to ratify the Protocol.

¹⁴ C Ngwenya 'The historical development of the modern South African health-care system: From privilege to egalitarianism' (2004) 37 *De Jure* 290.

entails the just distribution of resources in a society or fairness in provision of health care services. There are two main schools of thought on the concept of equity — libertarianism and egalitarianism.¹⁵ Ngwena has observed that, while these schools of thought agree on the need to achieve justice and a coherent view of life, they differ sharply in their conception of justice and the parameters of state *vis-à-vis* private sector provision of health.

The libertarian school of thought holds the view that equal access to health care implies treating people equally without discriminating arbitrarily on the basis of 'irrelevant' grounds such as race, gender or sexual orientation.¹⁶ Under this 'neutral' notion of justice, equity does not aim at guaranteeing access to health on the basis of need or requiring the state to take positive steps in the provision of health care for all. A shortcoming of this school is that it may be blind or insensitive to the position of vulnerable or marginalised groups in society. For instance, a strict adherence to this concept in relation to access to HIV treatment in Africa may suggest that as long as PLWHA are getting treatment, regardless of the ratio of men to women, all is well and that the state has done its bit. However, a critical examination of the ratio between the two groups may reveal a great disparity and thus, injustice.

The egalitarian notion of equity in health care goes beyond merely achieving minimal justice in the provision of health care. It aims at more than just avoiding unfair discrimination or allowing for choice in health care.¹⁷ At the very minimum, the state must develop a health care system which meets the needs of everyone and is not dependent on the ability to pay.¹⁸ This requires extensive intervention by the state in the provision of health care services. The egalitarians reason that access to health should be viewed as a communal or social good, which should be determined by need rather than life's arbitrary lottery of birth, natural endowment, socio-economic status or historical circumstances.¹⁹

It is important to note here that the underlining principle of equity is not to remove differences, since differences are bound to occur in every society. Rather, it is to ensure that everyone has a fair opportunity to access one of the determinants of health as part of the enjoyment of equality, freedom and human dignity in a democratic and caring

¹⁵ As above.

¹⁶ D Feldman *Civil liberties and human rights in England and Wales* (1993) 901-902; HT Engelhardt 'Rights to health care: A critical appraisal' (1979) 4 *Journal of Medicine and Philosophy* 113, cited in Ngwena (n 14 above).

¹⁷ Ngwena (n 14 above) 292.

¹⁸ HCJ van Rensburg *et al Health care in South Africa: Structure and dynamics* (1992) 364-370.

¹⁹ Ngwena (n 14 above) 292.

society. As Landman correctly argues, without access to health care one cannot effectively make autonomous choices, including realising one's potential in a free society.²⁰

Beauchamp and Childress²¹ have identified three forms of justice – compensatory justice, distributive justice and liberal justice. Compensatory justice shows the reasons why certain people have to be compensated for wrongs they suffered in the past. It often requires proof of past discrimination. However, it has been observed that compensatory justice is not suitable for health care services 'since mandating fair treatment for those who have suffered historical wrongs will not be compensation for them, but only the fair enforcement of nondiscriminatory health policies to which they are properly entitled'.²² Distributive justice aims at ensuring equitable availability of health resources to subgroups at abnormally high levels of risk. This may involve the adoption of the utilitarian approach which seeks to improve the welfare and capacities of the female half of society in order to increase overall social satisfaction and productivity. This rationale might justify programmes to promote equality in availability of services to ensure that women's distinctive health needs are satisfied, such as maternity care. The liberal theory of justice accords women the autonomy, as rational beings, to make decisions with regard to their clinical care and to remove barriers such as the need for their husbands' consent before medical treatment. This theory is faulted on the ground that it places emphasis on the abstract notion of autonomy without recognising women's peculiar situation in society and the determinants of health, such as the impact of society's structure on women's reproductive roles which tend to hinder their access to health care services.²³

3 Access to treatment as a fundamental right

Access to treatment constitutes an integral part of the right to health and a denial of the right to treatment to PLWHA amounts to a violation of their fundamental human rights.²⁴ The UN General Assembly in its Declaration of Commitment on HIV/AIDS observed that '[a]ccess to medication is a fundamental element for achieving progressively the right of everyone to the highest attainable standard of physical and

²⁰ W Landman 'Appropriate health care as a human right' in A van Niekerk (ed) *Health care as human right* (1993) 37-40.

²¹ TL Beauchamp & FJ Childress *Principles of biomedical ethics* (2001).

²² RJ Cook 'Exploring fairness in health care reform' (2004) 29 *Journal of Juridical Science* 1.

²³ As above.

²⁴ E Durojaye & O Ayankogbe 'A rights-based approach to access to HIV treatment in Nigeria' (2005) 5 *African Human Rights Law Journal* 287-307.

mental wellbeing'.²⁵ The right to health is guaranteed in numerous international and regional human rights instruments.

However, the most authoritative provision on this is article 12 of the International Covenant on Economic, Social and Cultural Rights (CESCR).²⁶ It provides that state parties to the Covenant shall 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. It further stipulates the determinants essential for the enjoyment of the right to health. The Committee responsible for the implementation of the Covenant in its General Comment No 14 has noted that the right to health is connected to other rights such as the right to life, non-discrimination, dignity, equality and liberty.²⁷ It further observes that health care services should be guaranteed for all on a non-discriminatory basis, taking into account the situation of vulnerable and marginalised members of society, such as women and people living with HIV/AIDS.²⁸ According to the Committee, good quality health care services should be made available, accessible and acceptable to all. It states further:²⁹

The right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health.

The Committee has emphasised the need for equity in the provision of health care services. It notes that poor households should not be unduly burdened with payment for health care services.³⁰

Apart from the provision in CESCR, article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)³¹ guarantees the right to access to health care for women on an equal basis with men. The Convention additionally guarantees women's right to 'appropriate services in connection with pregnancy'.³² The CEDAW Committee in its General Recommendation No 24 on Women and Health³³ noted that states are under an obligation to ensure that policies and laws facilitate equal access to health care for

²⁵ UN General Assembly Special Session on HIV/AIDS Resolution A/S-26/L2 June 2001 para 15.

²⁶ International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976).

²⁷ The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment No 14, UN Doc E/C/12/2000/4 para 3.

²⁸ n 27 above, para 12.

²⁹ n 27 above, para 9.

³⁰ As above.

³¹ Convention on the Elimination of All Forms of Discrimination Against Women GA Res 54/180 UN GAOR 34th Session Supp 46 UN Doc A/34/46 1980.

³² As above.

³³ General Recommendation No 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1.

women in a non-discriminatory manner. According to the Committee, health care services must be gender sensitive and take into account the peculiar needs of women.

Similarly, the revised Guideline 6 to the International Guidelines on HIV/AIDS and Human Rights enjoins states to take necessary measures in ensuring equity in the availability and accessibility of quality goods, services and HIV/AIDS prevention and treatment, including access to anti-retroviral drugs for all persons.³⁴

At the regional level, the right to health is guaranteed under article 16 of the African Charter on Human and Peoples' Rights (African Charter).³⁵ Article 16 states that everyone has the right to enjoy the best attainable state of physical and mental health. The African Commission on Human and Peoples' Rights (African Commission) in *Social and Economic Rights Action Centre (SERAC) and Another v Nigeria*³⁶ held that a violation of the right to health may lead to a violation of other rights such as life, human dignity and to a clean and healthy environment. The Women's Protocol in article 14 contains important provisions relevant in advancing the sexual and reproductive health of women. Under article 14, states are required to 'ensure that the right to health of women, including the sexual and reproductive health of women, is respected and promoted'. In addition, states should respect and promote:

- (a) the right to control their fertility;
- (b) the right to decide whether to have children, the number of children and the spacing of children;
- (c) the right to choose any method of contraception;
- (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
- (e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
- (f) the right to have family planning education.

³⁴ Adopted at the third International Consultation on HIV/AIDS and Human Rights (Geneva 25 July 2002), organised by the Human Rights Office of the United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS.

³⁵ African Charter on Human and Peoples' Rights OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.

³⁶ (2001) AHRLR 60 (ACHPR 2001).

Similarly, state parties are expected to take appropriate measures to:

- (a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas;
- (b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.

By including these elaborate provisions on the right to health and sexual and reproductive health, the Women's Protocol is the first international instrument to expressly articulate women's reproductive rights as human rights, and to expressly guarantee a woman's right to control her fertility.³⁷ The Women's Protocol clearly articulates women's rights to reproductive choice and autonomy and clarifies African states' duties in relation to women's sexual and reproductive health.³⁸ The Women's Protocol is the only human rights instrument that specifically protects women's rights in relation to the HIV/AIDS pandemic and to identify protection from HIV/AIDS as a key component of women's sexual and reproductive rights. Added to these, the Women's Protocol guarantees women's rights to adequate affordable and accessible health services. International and regional human rights treaties previously lacked specific provisions on HIV/AIDS. Rather, provisions on the right to health, life, human dignity and others were invoked indirectly to apply to rights in the context of HIV/AIDS.³⁹ The approach followed in the Women's Protocol is commendable and radical in nature. The drafters of the Women's Protocol seem to recognise the grave impact of the pandemic on the people in the region, particularly women.

Significantly, however, despite these copious provisions on the right to health in international and regional human rights instruments, the right to health has been described as being vague and because it intersects with other rights, its enforceability is difficult.⁴⁰ Furthermore, the right to health, being a socio-economic right, is subject to the debate of non-justiciability. Evans observes as follows:⁴¹

Liberal arguments against accepting a right to health as a human right rest upon the presumption that civil and political rights are qualitatively and significantly different from socio-economic rights.

Such distinction is rooted in the classification of civil and political rights as negative rights and social and economic rights as positive rights.

³⁷ See art 14 of the Women's Protocol.

³⁸ Center for Reproductive Rights *Briefing paper: The Protocol on the Rights of Women in Africa: An instrument for advancing reproductive and sexual rights* (2005).

³⁹ Eg, in *D v United Kingdom* (1997) 24 EHRR 423, the European Court on Human rights held a violation of the right to human dignity a purported deportation of an HIV-positive immigrant to his country of origin where treatment could not be guaranteed.

⁴⁰ DP Fidler *International law and infectious diseases* (1999).

⁴¹ T Evans 'A human right to health?' (2002) 23 *Third World Quarterly* 200.

Simply put, the protection of negative rights demands not more than forbearance, while the protection of positive rights demands a redistribution of resources.⁴²

4 Factors affecting women's access to HIV treatment

Many factors have been attributed to the inability of women to enjoy equal access to HIV treatment in Africa. These include discrimination, poverty, the denial of property rights, poor transportation system and the unwillingness on the part of governments to make money available. This article only considers the following problems: discrimination, poverty and inadequate funding of the health sector. The implications of these factors for equal access for HIV treatment for women are discussed below.

4.1 Discrimination

The essence of discrimination is to treat a person differently in an unfair way. In many African societies, women encounter discriminatory attitudes, often perpetuated by patriarchal tradition. Discriminatory attitudes against women often serve as barriers to the enjoyment of equal access to HIV treatment. Experience has shown that in many households in Africa where resources are limited, families prefer to pay for medication for men rather than for women.⁴³

Furthermore, many women today still require the authorisation of the husbands before seeking medical treatment, including HIV/AIDS treatment.⁴⁴ The implication of this is that, even in situations where treatment is free, fewer women than men may be accessing treatment. For example, a study in Zambia has shown that, despite the drastic reduction in the cost of ARV from about US \$64 to about US \$8 per month, an insignificant number of women were receiving treatment.⁴⁵ In a town of about 40 people receiving treatment, only three are women.⁴⁶ It is to be noted that, of the about 900 000 Zambians living with HIV/AIDS, about 70% are women. In other cases, young women face great difficulty in seeking treatment because of the fear that their sexual and reproductive health will not be respected.

⁴² As above.

⁴³ Centre for Health and Gender Equity *Gender, AIDS, and ARV therapies: Ensuring that women gain equitable access to drugs within US funded treatment initiatives* (2004).

⁴⁴ As above.

⁴⁵ UNAIDS, UNFPA, UNIFEM *Women and HIV/AIDS: Confronting the crisis* (2004).

⁴⁶ n 45 above, 24.

Discrimination is a violation of recognised human rights under international human rights law. Under article 1, CEDAW enjoins states to take steps and measures to eliminate discrimination against women within their territories.

Reaffirming the language of CEDAW, the Women's Protocol requires states to eliminate practices that discriminate against women and urges state parties to take all appropriate steps to eliminate social and cultural patterns and practices that are discriminatory to women.⁴⁷ Shalev argues that equality implies non-discrimination, and that therefore discrimination will amount to a violation of the right to equality.⁴⁸ A wide range of gender inequalities entrenched in social, economic, political and cultural structures often renders the situation threatening to women. When women are deprived of educational opportunities, their ability to care for their health and that of their children is greatly impaired.

During the International Conference on Population and Development (ICPD)⁴⁹ and the Fourth World Conference on Women, it was agreed that the human rights of women include rights to have control over their sexuality, including their sexual and reproductive health, free from discrimination, coercion and violence.⁵⁰ One of the important goals of the UN Millennium Declaration and the Millennium Development Goals (MDGs) is to promote gender equality and empower women.⁵¹ With regard to access to health care, the CEDAW Committee notes that states are required to take appropriate steps and measures, including legislative, judicial, administrative and budgetary, to ensure access to health care for women on an equal basis with men.⁵² While it is admitted that not all discrimination amounts to a violation of rights, it is not in contention that adverse discrimination which promotes women's subordination to men will result in a violation of human rights. Cook⁵³ rightly observes as follows:

If health care facilities, personnel and resources are to be accessible, governments must do more than simply provide them as bulk services. Accessibility requires that the delivery and administration of health care is organised in a fair, non-discriminatory manner, with special attention to the most vulnerable and marginalised.

⁴⁷ See art 12 of the Women's Protocol, which drew its inspiration from art 2 of CEDAW.

⁴⁸ C Shalev 'Rights to sexual and reproductive health: The ICPD and the Convention on the Elimination of All Forms of Discrimination Against Women' (2000) 4 *Health and Human Rights* 39.

⁴⁹ International Conference on Population and Development (ICPD) UN A/CONF.171 (13) 18 October 1994.

⁵⁰ Fourth World Conference on Women, Beijing held on 15 September 1995 A/CONF.177/20.

⁵¹ UN Millennium Declaration and Millennium Development Goals launched in 2000.

⁵² General Recommendation No 24 (n 33 above).

⁵³ Cook (n 22 above).

The Canadian Supreme Court in *Eldridge v British Columbia (Attorney-General)*⁵⁴ has held that failure to make money available for sign language interpretation that would equip hearing-impaired patients to communicate with health services providers in the same way as unimpaired patients can constitute discrimination in violation of the Canadian Charter on Rights and Freedoms. This decision of the Court is relevant in ensuring equality for all and in particular for people with disabilities in accessing treatment. The reasoning of the Court in this case can also be relied upon to demand equity in access to HIV treatment for women in Africa. The decision also confirms the fact that courts have an important role to play in holding governments accountable for failing to ensure equity in the provision of medical care.

It should be observed that stigma and discrimination associated with HIV/AIDS tend to further exacerbate the condition of women in most African countries. The popular belief that HIV infection is linked to promiscuity creates more barriers for women than for men with respect to seeking treatment. In most cases, women are the ones who first find out their status during antenatal care. Experience has shown that in such situations, treatment may not be available for these women, nor are they referred to places where they can get treatment. Many of the existing family planning clinics and reproductive health centres do not integrate HIV/AIDS treatment into their services. Worse still, in the few hospitals or centres where treatment is provided, the focus often is on the unborn baby and not on the mother. The treatment programme for pregnant women known as prevention of mother-to-child-transmission (PMTCT) summarises the exclusion of women from benefiting from HIV/AIDS treatment. This arguably results in discrimination against women.

At the Beijing Conference, governments of the world agreed to 'increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services'.⁵⁵ Similarly, the Action for the Further Implementation of the ICPD observes as follows:⁵⁶

Governments should ensure that prevention and services for STDs and HIV/AIDS are an integral component of reproductive and sexual health programmes at the primary health-care level. Gender, age-based and other differences in vulnerability to HIV infection should be addressed in prevention and education programmes and services.

⁵⁴ (1977) 151 DLR (4th) 577.

⁵⁵ Fourth World Conference on Women Programme of Action Strategic Objective C1 (n 50 above).

⁵⁶ UN follow-up meeting of the ICPD held in New York between March and June 1999, para 68.

There is no doubt that African governments are legally bound to promote equality in access to HIV treatment by removing obstacles to the treatment of women.

4.2 Poverty

The inability of women to pay for treatment is one of the reasons many are not receiving treatment. More women than men are unable to afford to pay for their monthly medication. While sub-Saharan Africa is regarded as a poor region, women remain the poorest of the poor. Many women are economically dependent on their husbands, thus making it difficult to get treatment, especially if husbands disapprove or refuse to support such treatment. Added to this is the fact that many women in Africa are denied inheritance rights, cannot own property and even lack access to financial resources. For instance, according to the customary law of the Igbo people of Eastern Nigeria, a female child is not regarded as a member of the family and so is unable to inherit any property from her father.⁵⁷ While denial of inheritance rights is a problem for all women, it is more debilitating for women living with HIV/AIDS. For such women, feeding, caring for their children or paying for their treatment could pose serious problems. A study carried out in Uganda among HIV-positive widows showed that about 90% of widows interviewed encounter difficulties with their in-laws over property and about 88% of those in rural areas were unable to meet their household needs or may have to lose everything that belongs to them.⁵⁸

In some communities in Africa, women are allowed the right of inheritance only if they agree to the cultural practice of 'widow cleansing'. This often involves a widow having sexual relations with an appointed village cleanser or with a relative of her late husband. Many women refuse to partake in this act. The fact remains that some of these women do not have an alternative source of income. This has become a big problem for many women and in particular HIV-infected women, leading to most of them 'ending up homeless or living in slums, begging for food and water and unable to afford health care or school fees for their children'.⁵⁹ Harmful cultural practices such as

⁵⁷ This customary practice was held as discriminatory and a violation of women's rights contrary to CEDAW by the Court of Appeal in *Mojekwu & Others v Ejikeme & Others* (2000) 5 NWLR 402. See also *Mojekwu v Mojekwu* (1997) 7 NWLR 283 on the same issue.

⁵⁸ Global Coalition on Women and AIDS *Media backgrounder: AIDS and female property inheritance rights* (2004).

⁵⁹ Human Rights Watch 'Fact sheet: HIV/AIDS and women's property rights in Africa' <http://www.hrw.org/campaigns/women/property/aidsfactsheet.htm> (accessed 1 March 2006).

widow cleansing not only constitute a threat to women's rights, but may also amount to violence against women. The Women's Protocol in article 1 defines violence against women to include 'physical, sexual, psychological and economic harm' to women. It recognises that such practices may impact negatively on women's rights to health, life and human dignity. Thus, it urges state parties to take adequate steps and measures to eliminate such harmful cultural or traditional practices.

Women's poverty may be described as a two-edged sword, in the sense that poverty not only renders women vulnerable to HIV infection, but also makes it almost impossible for them to get treatment. Furthermore, when women are poor, even in cases where treatment is provided free of charge, compliance with treatment may still be difficult due to the fact that money to buy food may not be available. Because women more often than not engage in menial jobs, they are paid poorly and are therefore unable to afford even vitamins, fruits or antibiotics. The above scenarios may be even more precarious for women in rural areas who might need to travel some distance to get treatment. For such women, access to treatment remains a pipe-dream. A UNIFEM regional adviser for HIV/AIDS in Brazil comments as follows on this situation:⁶⁰

There are a few clinics in the rural areas, but it is hard for women to leave their families to travel by bus to a place with a clinic. In rural areas, women do not have the same mobility as men. In some states, 90% of pregnant women do not go for prenatal care because it is far off. So you are not bringing women into prenatal care and therefore, you are not testing them and introducing them into HIV programmes.

The comments above represent the challenges to the Brazilian HIV treatment programmes, but it also captures the problems of many African countries. Realising the challenge poverty may pose to women's health, it was agreed at the Beijing Conference that it was necessary to 'promote women's economic rights and independence, including access to employment, appropriate working conditions and control over economic resources'.⁶¹ In addition, the UN Millennium Declaration emphasises the importance of promoting gender equality and women's empowerment as an effective pathway to combat poverty, hunger and disease and to stimulate truly sustainable development.⁶² It has been observed that the powerlessness of women — political and economic — renders them vulnerable to human rights violations.⁶³

⁶⁰ An interview with Bant Astrid, UNIFEM regional adviser for HIV/AIDS in Brazil held on 3 February 2004 cited in UNAIDS, UNFPA, UNIFEM *Women and HIV/AIDS; Confronting the crisis* A Joint Report (2004).

⁶¹ Fourth World Conference on Women Strategic Objective F1 (n 50 above).

⁶² UN Millennium Declaration and Millennium Goals (n 51 above).

⁶³ R Cook *et al* *Reproductive health and human rights: Integrating medicines, ethics and law* (2003).

The ESCR Committee has explained that accessibility to health care involves both physical accessibility and economic affordability. In other words, any barrier (such as setting up a health care institution far away from people) which makes it difficult for people to physically get health care services, amounts to a violation of the right to health. In the same manner, high medical fees or the high cost of drugs that are beyond the reach of vulnerable and marginalised groups in the society may lead to a violation of their rights to health and life. As noted earlier, the ESCR Committee warns that indigent members of the society should not be unfairly burdened with the high cost of medical services.⁶⁴ The CEDAW Committee in its General Recommendation No 24 has reaffirmed this position.⁶⁵

4.3 Inadequate funding of health services

The health care sector remains a very important aspect of society. The amount of money spent on this sector may determine the quality of health of the citizens. It is being estimated that about US \$2 985 billion or almost 8% of the world's gross domestic product was expended on this sector in 1997.⁶⁶ It is no longer doubted that many African countries spend far less on health care services for their citizens than is expected. For instance, while it is estimated that in 1990, developed economies accounted for about 86% of all health spending, sub-Saharan Africa merely accounted for 1% of such spending.⁶⁷ In the era of the HIV pandemic, this inadequate spending has further implications for the health sector as essential infrastructures are lacking in most hospitals or health clinics. Economic restructuring programmes in the 1980s and the huge debt of African governments have translated to a shrinking health sector.

The area most affected by this development is reproductive health services. Aside from these problems, many governments in Africa are reluctant to provide health care services for all as a matter of state duty. Rather, governments often cite a lack of resources as an excuse for an inability to guarantee health care for the populace. This unwillingness on the part of most African governments is founded on the arguments of some legal philosophers. Notably among these philosophers is Fuller,⁶⁸ who argues that social and economic rights, including the right to health, are generally polycentric in nature. According to him,

⁶⁴ General Comment No 14 (n 27 above).

⁶⁵ General Recommendation No 24 (n 33 above).

⁶⁶ World Health Report (2000); International Federation of Gynaecology and Obstetrics (FIGO), FIGO Resolution on Women's Rights Related to Reproductive and Sexual Health (London FIGO 2000).

⁶⁷ WHO Evaluation, cited in Cook *et al* (n 63 above).

⁶⁸ L Fuller 'The forms and limits of adjudication' (1978) 92 *Harvard Law Review* 353-409.

this polycentrism renders social and economic rights not easily amenable to adjudication before a court of law.⁶⁹

Governments can be held accountable for their refusal or unwillingness to provide a special kind of health care service for targeted members of society. In such a situation, governments will not be allowed to 'toll the bell of a lack of resources'.⁷⁰ The ESCR Committee in its General Comment No 3 notes that a lack of resources should not always be cited by governments as an excuse for not meeting their obligations under the Covenant.⁷¹ It admitted that resource constraints is a crucial issue, but for a state to rely on this to excuse its inability to meet its obligation under the Covenant, such a state 'must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations'.⁷²

The Venezuela Supreme Court, in rejecting the government's claim of a lack of resources, held that the country's Ministry of Health is legally bound to provide anti-retroviral drugs for people living with HIV/AIDS at no cost as the failure to do so may impair the right to life of those affected and infected with HIV/AIDS in the country.⁷³

Similarly, the South African Constitutional Court in *Minister of Health v Treatment Action Campaign and Others*⁷⁴ held that failure on the part of the South African government to make available Nevirapine, an anti-retroviral essential in preventing mother-to-child-transmission of HIV, amounts to a breach of the section 27 obligation under the Constitution. In this case, the South African government argued that providing Nevirapine in public hospitals to prevent transmission of HIV from pregnant women to their children was too expensive and that there was no medical proof guaranteeing the safety and efficacy of the drug. In its judgment, the Court found that the refusal on the part of the South African government to make the drugs available at public health institutions contravened the right to health guaranteed under section 27 of the Constitution. The Court further noted that the inability of children to access Nevirapine due to the government's refusal to make it available in the public health care sector compromises the rights of children guaranteed in section 28 of the Constitution. It rejected as untenable the government's excuse of a lack of resources. Instead, the Court ordered the government to roll out plans on how Nevirapine would

⁶⁹ As above.

⁷⁰ This phrase was adopted in the English case of *R v Cambridge Health Authority (ex p B)* (QBD) 25 BMLR 5 17 *per* Laws J.

⁷¹ The Nature of States Parties' Obligations UN Comm on Economic, Social and Cultural Rights General Comment No 3, 5th session UN doc E/1991/23, Annex III.

⁷² n 71 above, para 10.

⁷³ *Cruz Bermudez et al v Ministerio de Sanidad y Asistencia Social* (MSAS) No 15789 1999.

⁷⁴ 2002 10 BCLR 1033 (CC).

be made available in public hospitals. It described the existing policy that excluded 90% of pregnant women with HIV/AIDS from Nevirapine as being unreasonable and incapable of meeting the needs of those who deserve urgent attention.

It is instructive to note that the decision in the *Treatment Action Campaign* case drew its inspiration from an earlier decision of the Constitutional Court in the *Grootboom* case.⁷⁵ In that case, the Court adopted the reasonableness test in finding the government's policy and programmes on housing unreasonable and not meeting the needs of those most urgently in need.

This decision is no doubt a model for holding African governments accountable for their failure or unwillingness to provide comprehensive treatment programmes for HIV/AIDS. Ngwena described it as a bold decision in that it 'countermanded government policy and effectively prescribed what it deemed to be equitable health policy'.⁷⁶ However, a major shortcoming of this decision was the fact that the Court failed to address the gender issues raised by this case. Rather, its focus was on the rights of children. Commentators have criticised this gender-neutral approach by the Court. Cook,⁷⁷ for instance, argues that the Court failed to consider whether neglecting the need of pregnant women who are HIV positive constitutes discrimination on the enumerated grounds of sex, race or disability under the equality clause in section 9 of the Constitution. She explains further:

Had the Court taken a more contextual approach to constitutional interpretation, it could have built upon its article 9 jurisprudence on substantive equality, and in so doing applied the norms of the Women's Convention, which South Africa has ratified.

The Constitutional Court in the *Treatment Action Campaign* case should have been bold enough to call a spade a spade by telling government officials that the policy of non-provision of Nevirapine in public hospitals constituted a clear manifestation of discrimination against women. It has been argued that, if only the Court had addressed its mind to⁷⁸

the barriers that women face in accessing health care in the way they addressed the 'most urgent' needs of children in accessing Nevirapine, they could have signalled that governments have obligations to accommodate women's particular needs.

⁷⁵ *Government of the Republic of South Africa v Grootboom* 2000 3 BCLR 227 (CC).

⁷⁶ C Ngwena 'Access to anti-retroviral therapy to prevent mother-to-child transmission of HIV as a socio-economic right: An application of section 27 of the Constitution' (2003) 18 *South African Public Law* 83.

⁷⁷ Cook (n 22 above) 18.

⁷⁸ Cook (n 22 above) 19.

Notwithstanding this, the *Treatment Action Campaign* case remains a landmark decision in advancing the right to health and access to treatment worldwide.

5 Relevance of affirmative action in ensuring equity in access to HIV treatment

The principle of substantive equality, of which affirmative action is a by-product, determines that people must be treated equally, paying attention to their social and economic disparities. Unlike formal equality where all persons are treated in the same manner regardless of the differences that exist among them, substantive equality aims at correcting injustice in society. It seeks to provide justice for vulnerable and marginalised groups in society who have been historically disadvantaged.

For instance, if pupils with mental disabilities undergo the same training with healthy children, they may end up disadvantaged since the training may not meet their peculiar needs. In order to realise the right to equality of mentally disabled pupils, they may have to be treated differently from others, bearing in mind their differences. This analogy is applicable to the position of women in society. Aside from the biological differences between the two sexes, women are regarded as vulnerable members of society who deserve special treatment and care with a view to uplifting their social status and upholding their human dignity. The South African Constitutional Court in *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice*⁷⁹ observed that the rationale behind substantive equality is the respect for human dignity. It is generally accepted that in certain situations, measures may be taken with a view to correcting past injustices meted out to some groups in society. Such measures may include the adoption of affirmative action. This is often seen as a remedial measure, which does not violate the human right to non-discrimination. It is necessary to adopt affirmative measures with regard to HIV treatment in order to advance fairness and substantive equality in health care reform. The notion of affirmative action is based on adopting temporary positive measures intended to increase opportunities for the advancement of the health of historically and systemically disadvantaged groups.⁸⁰ It is a policy or a programme that seeks to redress past discrimination through active measures to ensure equal opportunity, such as in education, employment and health care.

⁷⁹ 1999 1 SA 6 (CC).

⁸⁰ As above.

Article 2 of the Women's Protocol captures the notion of affirmative action. It provides as follows:

State Parties shall combat all forms of discrimination against women through appropriate legislative, institutional and other measures. In this regard they shall:

- (a) include in their national constitution and other legislative instruments, if not already done, the principle of equality between women and men and ensure its effective application;
- (c) integrate a gender perspective in their policy decisions, legislation, development plans, programmes and activities and all other spheres of life;
- (d) take corrective and positive action in those areas where discrimination against women in law and in fact continues to exist.

There is no doubt that this provision imposes an obligation on African countries to ensure equity in providing access to HIV treatment in their countries. This will involve paying particular attention to the needs of women in providing health care services.

A similar provision exists in article 4 of CEDAW. The CEDAW Committee in its General Recommendation No 25 notes that article 4(1) of CEDAW distinguishes between permissible temporary measures, aimed at achieving *de facto* or substantive equality, from otherwise discriminatory measures.⁸¹ The Committee reasons that these temporary corrective measures will not amount to discrimination if:⁸²

- (i) they accelerate equality as a matter of fact;
- (ii) they are devoid of maintenance of unequal or separate standards;
- (iii) they cease to exist the moment the objectives of equality of opportunity and treatment have been achieved.

An example of such temporary measures may include programmes that facilitate the access of high-risk groups to necessary health services until such time as those groups are at no more than the ordinary risk in the general population. It was noted that the more targeted and robust the measures are, the more controversial they become.⁸³ Article 12 of CEDAW requires courts to consider that temporary measures are required when such measures are the most pertinent in eliminating discrimination against women in the field of health care.

It must be pointed out, however, that it may prove difficult when determining the success of affirmative action in health care services, since the issue is not only 'treating equal eligibility equally, but also of reacting appropriately to biological and physiological differences

⁸¹ Committee on CEDAW General Recommendation No 25, on art 4(1) of CEDAW, on temporary special measures, CEDAW/C/2004/I/WP 1/Rev 1, 30 January 2004, CEDAW, para 18.

⁸² n 81 above, paras 18-24.

⁸³ Cook (n 22 above) 23.

between the sexes and the underlying social conditions that affect the sexes differently'.⁸⁴ The adoption of such measures must aim at ensuring general equality in access to specific therapeutic drugs and services such as HIV treatment for women. The existing lopsidedness in access to HIV treatment between men and women in Africa calls for the implementation of corrective temporary measures to eliminate discrimination against women.

In order for affirmative action to be adopted successfully with regard to HIV treatment, there is a need for a formidable and proactive court. Courts play an important role in holding governments accountable for their failure to adopt measures that will guarantee equal access to HIV treatment for women. The court of law is often referred to as the last hope of common men and women when there have been human rights violations. Because of the controversial nature of affirmative action, courts must be willing and ready to apply this measure to correct the inequities that exist in governments' ARV treatment programmes. Courts may invoke the principle of non-discrimination contained in several international and regional human rights instruments to justify the necessity for affirmative action with regard to ensuring equal access to HIV treatment for women.

Aside from the role of courts, the creation of a favourable political environment, strong institutions and open participatory processes are also essential for the realisation of human rights, including the adoption of affirmative action.⁸⁵ Institutions such as the national human rights commission can similarly ensure that a government addresses inequity in the provision of health care services within its territory. The South African Human Rights Commission, for example, is constitutionally empowered under section 184(3) of the Constitution⁸⁶ to request information from relevant organs of state on the steps that they have taken to respect, protect, promote and fulfil socio-economic rights in South Africa. This provides a crucial avenue for the monitoring and implementation of these rights in the country.

At the regional level, the African Commission, charged with the implementation of the Women's Protocol, can play a similar role. This can be done through the decisions of the Commission or its powers to examine state reports. The Commission may raise questions based on reports submitted as to why women are not given special attention with regard to access to HIV treatment in a particular country.

⁸⁴ As above.

⁸⁵ See S Liebenberg 'Socio-economic rights and the Constitution', paper delivered at a workshop on Monitoring Socio-Economic Rights in South Africa: The Role of the SA Human Rights Commission held on 30 June to 1 July 1997 in Johannesburg.

⁸⁶ Constitution of Republic of South Africa Act 108 of 1996.

6 Conclusion

African countries need to do more to improve access to treatment for women within their territories. African governments need to take urgent steps to address discrimination against women, which have often impeded access to HIV treatment in many countries. Moreover, it is imperative that the position of women is improved in society. Unless women's economic status is improved, their ability to access HIV treatment may remain a challenge. The time is now for African countries to live up to their commitment at international and regional meetings and conferences to elevate the position of women in their countries. Also, African governments need to exhibit the political will to ensure that resources are made available in the health care sector, particularly for reproductive health services.

At the Abuja Summit on HIV/AIDS,⁸⁷ African leaders agreed to commit at least 15% of their annual budgetary expenses to the health sector. Five years after this commitment, many African states are failing to meet this target. In order to correct the existing inequality in access to HIV treatment in the region, governments must do more than merely providing treatment for all, they must give special attention to the needs of women. This is not a matter of choice, but rather an obligation now imposed by the Women's Protocol.

⁸⁷ Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases by African leaders, April 2001 OAU/SPS/ABUJA/3.