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Article

WOMEN’S HEALTH AT A CROSSROAD: GLOBAL RESPONSES TO HIV/AIDS

Allyn L. Taylor†

I. INTRODUCTION

IN THE LAST SEVERAL YEARS the issue of women's health has begun to emerge as a powerful global political concern. Although the global impact of the human immunodeficiency virus ("HIV")/acquired immune deficiency syndrome ("AIDS") is only a fragment of the story, it has been the most vivid part of the history of the recent unfolding of interest in women's health. Worldwide, the incidence of the disease among women is spiraling.1

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The global response to the HIV/AIDS pandemic exposed the long-standing circumstance that women's health has not been a priority area for attention or investment by international organizations. Despite the ubiquitous global impact of HIV infection on women, the World Health Organization ("WHO"), the international organization charged with coordinating multilateral efforts against AIDS,\(^2\) did not until recently appreciate the threat of the pandemic to women's health.\(^9\) The inadequate global efforts to address the toll of HIV/AIDS on women has underscored the fact that international organizations have neglected to promote and protect women's international right to health. A history of discrimination is apparent in the way that international organizations have conventionally defined women's health and developed services for them.

2. G.A. Res. 42/8, U.N. GAOR, 42d Sess., Supp. No. 49, at 19-20, U.N. Doc. A/42/49 (1987). In 1987, the General Assembly confirmed WHO's established leadership in AIDS prevention and control and confirmed that WHO should direct and coordinate the United Nations activities against AIDS. Id. at 20; but see U.S. and 37 Others Press U.N. to Unify Battle Against AIDS, N.Y. TIMES, May 12, 1993, at A10 [hereinafter U.S. and 37 Others]. However, WHO's Global Programme against AIDS has been subject to mounting criticism in international political circles. Frequent reports of infighting, duplication of efforts among agencies and bureaucratic delays prompted the U.S. and 37 other nations to circulate a petition at the 1993 meeting of the World Health Assembly calling for a United Nations AIDS program to take over coordinating global AIDS efforts. U.S. and 37 Others, supra.

In response to such frequent criticism, in January 1994 the Executive Board of WHO recommended the establishment of a co-sponsored United Nations program on HIV/AIDS to be administered by WHO. This program, scheduled to begin in 1996 will merge the AIDS programs of WHO, the U.N. Development Program, the U.N. Population Funds UNICEF, the World Bank and UNESCO. See, e.g., WHO New United Nations Program Administered, AIDS WKLY., February 7, 1994; Paul Lewis, UN Undertaking New AIDS Assault: Efforts of Several Agencies Combined, HOUSTON CHRON., Jan. 23, 1994, at 17.

Multilateral organizations have traditionally defined women’s health as synonymous with maternal health. WHO, for example, historically has paid limited attention to the specific treatment of women with respect to illnesses which are common to both men and women and has allocated inadequate resources for women’s unique health concerns other than reproductive health.

From a wider perspective, the inadequacy of international efforts to protect and promote women’s right to health reflects and reinforces the extensive neglect of women’s health by nations worldwide. For example, it has only recently been widely realized that biomedical research in the U.S., much of which is nationally funded and directed, defined women’s health principally in terms of their reproductive functions. Media attention to HIV/AIDS has, however, contributed to an increasing awareness that women’s health concerns have been understudied and underfunded. Globally, the pandemic has served to deepen gender-based critiques of traditional approaches to biomedical research and contributed to a growing understanding of the inadequacies of national efforts to develop and provide diagnostic measures and therapeutic interventions to protect women’s health.

The resultant public scrutiny of the responses to HIV/AIDS has contributed to a radical transformation of interest in women’s health issues in the last few years. At the international level, WHO has begun to broaden its concern with women’s health to include the full dimensions of women’s physiological health beyond reproductive issues and, consequently, to redirect resources and attention to limiting the impact of the pandemic on women. However, despite the extraordinary resurgence of concern with women’s health, international policymakers have yet to address the fundamental social and cultural determinants of health that worldwide render women uniquely vulnerable to illness and disease, including HIV/AIDS.

The HIV/AIDS pandemic has dramatized the fact that women’s health depends not merely upon the course of scientific and medical interventions, but also on social and cultural circumstances. There is a consensus within the public health community that women’s unique vulnerability to HIV infection extends beyond physiological susceptibility or even conventional scientific neglect. Rather, the determinants of the relative increase in the incidence of the disease in women globally are the
outcome of the pervasive conditions of gender discrimination worldwide. Women have a special, social vulnerability to HIV infection and other illness because of their subordinated social status. National laws and policies continue to reinforce traditional values that violate women's fundamental human rights and enhance their vulnerability to illness, including HIV infection, despite the overwhelming evidence that women's health status is inextricably linked to their social status. International policymakers, however, have yet to address effectively the circumstances of social and legal discrimination which augment women's susceptibility to HIV/AIDS in particular, and illness and disease in general.

This article explores the role that international organizations have played and should play in limiting the global impact of the HIV/AIDS pandemic on women. Part II discusses the incidence of HIV infection among women worldwide. Part III analyzes the slowness of the global response to the rapid spread of HIV/AIDS to illustrate that international organizations conventionally have had a narrow concern with women's health status. It also describes how HIV/AIDS has contributed to a metamorphosis of public concern with the physiological, scientific basis of women's health among international organizations by publicly unveiling the universal neglect of women's health issues. Part IV describes how future international efforts to protect and promote women's health must further broaden concern with women's health status to take into account the pervasive circumstances of gender discrimination which make women uniquely vulnerable to illness and disease, including HIV/AIDS. It shows that recent efforts to correct the disparities in scientific research and medical treatment of women, although important, cannot alter the severe social inequities which render women vulnerable to HIV infection. Part V discusses the limited, but important, contribution that international law and organizations can have on future efforts to improve women's social status and to limit the spread of HIV/AIDS. Overall, this article will show that the HIV/AIDS pandemic has recently contributed to heightening international concern with the physiological basis of women's health status. It also shows how the pandemic has critically illustrated that future global efforts to promote and protect women's health must address the opportunities for and limitations of international interventions to promote the social status of women.
II. THE INCIDENCE OF HIV INFECTION AMONG WOMEN

The documented incidence of HIV infection in women is increasing at a staggering rate. In 1990, twenty-five percent of HIV-positive adults were female. By the end of 1992 that figure had climbed to approximately forty percent. WHO estimates that worldwide at least 4.8 million women have been infected with HIV, and this number is expected to soar rapidly in the next few years. By the year 2000, WHO predicts that approximately thirty to forty million adults and children will be HIV-positive and that the annual rate of HIV infection for men and women will be the same.

Worldwide, heterosexual sex is the dominant mode of HIV transmission. The incidence of HIV has been evenly distributed between the sexes in areas of traditionally high heterosexual spread such as Africa and Asia, and now the relative impact of HIV/AIDS in women in industrialized states is rising. In the U.S., for example, women make up the fastest

5. Id.
6. WORLD HEALTH ORGANIZATION, WOMEN'S HEALTH: ACROSS AGE AND FRONTIER 80 (1992) [hereinafter WOMEN'S HEALTH].
7. Id. at 79.
8. 1992 Update, supra note 1, at 3.
10. 1992 Update, supra note 1, at 6. Accordingly to WHO, two-thirds or more of all HIV infections have been the result of heterosexual transmission, and this percentage will increase to 75 or 80% by the year 2000.
12. 1992 Update, supra note 1, at 6. WHO estimates that 90% of the projected HIV infections this decade will occur in the developing countries. Id. In sub-Saharan Africa, over six million adults are already infected and as result 10 to 15 million children will be orphaned by the year 2000.
13. Id. at 6. HIV is rapidly becoming as much a scourge in Asia as in Africa. WHO forecasts that by the mid to late 1990s, more Asians than Africans will be infected each year. Id. See also Leah Makabenta, Asia: AIDS Burden Heaviest on Women, INTER PRESS SERV, Apr. 23, 1993; David Schaefer, AIDS Ravaging Asia, McDermott Says: Spread Called Worse Than in Africa, SEATTLE TIMES, June 8, 1991, at A14. Cf. James Brooke, AIDS Squeezing the Life out of Latin America: Epidemic May Surpass Infection Rate in U.S., HOUSTON CHRON., January 25, 1993, at A1 (noting that the situation in Latin America is also becoming worse).
growing population of HIV infection.14 HIV/AIDS has become the leading cause of death of women between the ages of twenty and forty in major American cities and one of the top five causes of death among women in this age group nationally.15 The actual incidence of HIV infection among women may be much higher due to inaccurate reporting of HIV/AIDS in general and under-diagnosis of HIV/AIDS in women in particular.

III. THE GLOBAL RESPONSE

A. Traditional Conceptions of Women’s Health

Despite the documented incidence of HIV infection in women, international policymakers did not, until recently, recognize HIV/AIDS as a profound threat to women’s health. The slowness of the multilateral response to the peril HIV/AIDS poses to women’s health underscores the low priority which international organizations have traditionally accorded to the protection and promotion of women’s international right to health. From a wider perspective, the inadequacy of the international response to HIV infection in women reflects and reinforces the extensive neglect of women’s health by policymakers worldwide.

The international community did not specifically identify HIV/AIDS as a health crisis for women until 1989. In that year, the global implications of HIV/AIDS for women’s health...
was recognized by the United Nations General Assembly.\textsuperscript{18} WHO did not begin to address the significance of the HIV pandemic to women's health until the beginning of this decade.\textsuperscript{17} In 1990, WHO finally held its first consultation on research priorities relating to women and HIV.\textsuperscript{18} 

From a wider perspective, the failure of international organizations to more promptly identify and respond to the global impact of HIV/AIDS on women reflects the low priority that the international community has conventionally accorded to the protection and the promotion of women's international right to health. The principal legal basis for the international right to health is found in the Covenant on Economic, Social and Cultural Rights.\textsuperscript{19} It provides that each nation, to the maximum extent of its available resources, must undertake steps to guarantee the right to the highest attainable standard of physical and mental health of each individual, without discrimination.\textsuperscript{20} Promoting the right to health is also an explicit part of the WHO's constitutional mandate.\textsuperscript{21} The preamble of WHO's constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity."\textsuperscript{22}

Despite the international affirmation of the fundamental concept of equality in the promotion of each person's health status, discrimination is apparent in the way that women's health problems have been conventionally defined and services that have been developed for women by international organizations. Multilateral efforts have traditionally defined or equated women's health as maternal health. Numerous international conventions and declarations have identified motherhood as be-
ing entitled to special protection, and maternal health has almost been the principal focus of international women's health initiatives.

Maternal health is a critical international health concern that contributes to catastrophic levels of infant and child mortality worldwide. However, the slowness of the global response to the impact of HIV on women illustrates that the crucial defect of this special concern for maternal health has been the failure of the international community to limit its application and pay sufficient attention to the promotion and protection of women's health beyond maternal health.

From a broader perspective, the limited attention that international organizations have traditionally accorded to women's health other than reproductive health merely reflects and reinforces the extensive neglect of women's health by international law and policy.


24. WORLD HEALTH ORGANIZATION, WOMEN, HEALTH AND DEVELOPMENT A REPORT BY THE DIRECTOR-GENERAL 5 (1985) [hereinafter WOMEN, HEALTH AND DEVELOPMENT]. In 1985, for example, WHO stated that "women's special health needs are primarily related to their reproductive role." Id. See also id. at 14-24 (describing international efforts to protect maternal health).

25. WORLD HEALTH ORGANIZATION, GLOBAL HEALTH SITUATION AND PROJECTIONS: ESTIMATES, at 27-28, WHO Doc. WHO/HST/92.1 (1992). 500,000 women, 99% of them in developing countries, die each year due to complications during pregnancy and delivery. Id. at 28. In 1990, an estimated 13 million children under the age of five died in developing countries. Id. at 27.

26. See, e.g., SUSAN SHERWIN, NO LONGER PATIENT: FEMINIST ETHICS AND HEALTH CARE 167, 193-94 (1992). The medical/scientific community has tended to conceptualize and respond to women's health as reproductive health, and have conventionally accorded only limited attention to women's other unique health concerns. Id. at 167. The notion that medicine has reduced female bodies to their constituent sexual and reproductive functions is widely recognized. See id. Accordingly, science has tended to uniquely treat women only as it relates to reproductive functions. See id.
policymakers worldwide. The following section will explore how the global impact of HIV/AIDS has expanded public awareness of the widespread neglect of women’s health concerns by national policymakers globally. As a result, the pandemic has contributed to the recent transformation of concern with women’s health status by domestic as well as international authorities.

B. New Directions in Women’s Health

In the last several years the domain of women’s health has undergone a radical transformation. Although the impact of HIV/AIDS on women may not have been the sole cause of the resurgence of interest in women’s health, the recent media attention to the global threat of HIV/AIDS to women has focused attention on the fact that women’s health has not been a priority issue for attention or investment worldwide. Thus, the global impact of HIV/AIDS has contributed to encouraging industrialized nations as well as WHO to expand their traditionally restricted concern with women’s maternal health to broader and more comprehensive views of women’s health.

Recent media attention on the impact of the HIV/AIDS on women has highlighted not only the inadequacy of international efforts to promote and protect women’s health, but national efforts as well. For example, the absence of reference to women’s unique concerns in scientific and clinical discussions of HIV/AIDS, until recently, contributed to exposing the low priority that domestic authorities have conventionally accorded to women’s health concerns. HIV/AIDS has, therefore, reinforced recent gender-based critiques of traditional approaches to biomedical research and exposed the neglect of longstanding concerns in women’s health. HIV/AIDS thus has brought the scientific community and national authorities under public


28. See Alan L. Otten, The Influence of the Mass Media on Health Policy, 11 J. Health Affairs 111, 117-18 (Supp. 1992). One commentator has noted, however, that in the United States, at least, the media has been slow to give attention to the unique concerns HIV has posed for women and consequently contributed to the neglect of the disease in women by national policy makers. See id.
The nature of the scientific investigation of HIV/AIDS served to deepen recent gender-based critiques of biomedical research by exposing the issue of the traditional exclusion of women from clinical trials for a wide range of illnesses. The prevailing norm for clinical studies has been to exclude women. Research studies have conventionally used men as models for the prototypical study population, with results applied to women as though such diseases or conditions would have the same natural history or response in both men and women.

The prevailing view in science, that there are few differences in the incidence and manifestations of illness and disease between men and women, was extended to research on HIV/AIDS incidence and treatment. As a result, women have largely been excluded from the multi-billion dollar global research agenda on HIV/AIDS. Despite the extraordinary

29. AIDS IN THE WORLD, supra note 1, at 260-63. Of the $5.45 billion governments spent on HIV research between 1982 and 1991, approximately 97% was expended in the industrialized States. Id. at 261. The U.S. has by far spent the most money on HIV research. Id. It spent $4.78 billion in the same period and accounted for eighty-three percent of the public funding. Id. at 262. Cf. Goldsmith, supra note 4, at 446 (discussing the discrepancies in AIDS research funding between industrialized and developing countries).


31. Smeltzer, supra note 15, at 152. The U.S. has been the major financier for HIV/AIDS treatment and initially the disease was seen as confined to gay man. Id. Other reasons include society's lack of attention to the health and social problems women face and society's view of women's role in society. Id. at 153-54.

numbers of women infected with the virus, comparatively little is known about the vectors and the course of the disease on women, whether it is marked by the same progression as men and to what extent it is characterized by same opportunistic infections.\\(^{33}\)

Recent reports indicate that there may in fact be significant differences in the manifestations of HIV infection and the trajectory of the disease between men and women.\\(^{34}\) HIV/AIDS has publicly evidenced that an ostensibly "gender neutral" illness may be expressed differently in women and in men.\\(^{35}\) Media scrutiny of the pervasive gender biases in research on HIV/AIDS has contributed to shattering the historical tenet that the incidence and impact of illness and disease are the same in women as in men.\\(^{36}\)
From a wider perspective, the conventional practice of excluding women from clinical trials on HIV/AIDS serves as a reflection of the deep-rooted preoccupation with women's reproductive functions and the concomitant disregard of women's other unique health concerns. The traditional neglect of women's health issues other than reproductive health is evident in the earliest clinical studies of HIV/AIDS infection in women, which concentrated on analyzing or conceptualizing women as vectors of transmission to their sexual partners or to their children.

HIV/AIDS also revealed the narrow attention that national authorities have conventionally given to developing diagnostic and therapeutic interventions to protect women's health. For example, health authorities have devoted limited resources to developing protective programs for women. Despite women's peculiar susceptibility to HIV infection, global research efforts have largely bypassed development of prevention methods that could be used by women. An effective female condom, for example, which could be utilized by women to prevent transmission of HIV without the knowledge or consent of their sexual partners, is still not generally available.

Measures to control the opportunistic infections and diseases that uniquely affect women with HIV/AIDS require investigation and have further contributed to revealing the long-

Heart Disease in Women: Another Role for Aspirin?, 266 JAMA 565, 565-66 (1991); Manson et al., supra, at 882.

37. SHERWIN, supra note 26, at 167. As Susan Sherwin notes, “[m]ost of the medical research on specifically female health issues that is pursued [in the U.S.] has been concentrated on matters of reproduction.” Id.

38. Dresser, supra note 30, at 25. Rebecca Dresser has noted that “NIH officials and biomedical researchers have, consciously or unconsciously, defined the white male as the normal representative human being. From this perspective, the goal of advancing human health can be achieved by studying the white male human model.” Id. at 28.

39. Hankins & Handley, supra note 33, at 957.

40. But see infra text accompanying note 61 (describing a new WHO initiative to develop a vaginal microbicide).

41. Global Strategy, supra note 1, at 5 (noting WHO's aims to prevent "HIV transmission to and from women" through such methods as the female condom). See also AIDS IN THE WORLD, supra note 1, at 700-07 (providing a general discussion about the "Reality" Condom); Lawrence K. Altman, New Strategy Backed for Fighting AIDS, N Y TIMES, Nov. 2, 1993, at C1; Firm Gets OK for Female Condom, SACRAMENTO BEE, May 11, 1993, at A8. The female condom is expensive and scientists are uncertain about its ability to prevent the transmission of HIV. Altman, supra. See infra note 60 and accompanying text (discussing recent initiatives to develop effective barrier methods that can be used by women).
standing neglect of women's health concerns by national authorities. For example, sexually transmitted diseases ("STDs") are a co-factor in the transmission of HIV that greatly increase women's vulnerability to infection. Persons with STDs are five to ten times more likely to contract HIV. STDs, however, represent a longstanding issue in women's health care which were, until recently, conferred inadequate research dollars and scientific attention. These diseases affect a disproportionate number of women, are much more difficult to detect in women and have much graver medical consequences for women. Despite the ubiquitous global impact of STDs, gender differences in transmissions, symptoms and treatment are still not well understood or appreciated by health authorities. National policymakers have been slow in responding to these problems, and facilities for the treatment and detection of these diseases in women are lacking.

The nexus between HIV/AIDS and cervical cancer, a disease closely associated with STDs, also highlights the conven-

42. AIDS on the Advancement of Women, supra note 32, at 9-10. Women are also at increased risk of HIV transmission through contaminated blood supplies. In a number of developing countries, donated blood is not screened for HIV/AIDS. Women are at increased risk of infection because of the frequency of blood transfusion for women relative to men as a result of post-partum hemorrhage, ectopic pregnancies, crudely induced abortions and as a treatment for anemia caused by repeated pregnancies. Id.; National, Regional and International Machinery for the Effective Integration of Women in the Development Process, Including Non-Governmental Organizations, U.N. ESCOR Commission on the Status of Women, 35th Sess., Provisional Agenda Item 5(b), at 2, U.N. Doc. E/CN.6/1991/CRP.2 (Feb. 6, 1991).

43. AIDS IN THE WORLD, supra note 1, at 165. See also Global Health Situations and Projections, at 44, WHO Doc. WHO/HST/92.1 (1992) (outlining the estimated yearly incidence of STDs). Although reliable data for the worldwide incidence of STDs are not available, WHO estimates that the minimal yearly incidence of four major bacterial STDs, gonorrhea, genital chlamydia infections, infectious syphilis and chancroid, exceeds 75 million. Id.


45. See PAN AM. HEALTH ORG., HEALTH OF WOMEN IN THE AMERICAS 143 (1985).


47. WOMEN'S HEALTH, supra note 6, at 75.

48. 1992 Update, supra note 1, at 3.
tional neglect of diseases that uniquely affect women.\textsuperscript{49} Cervical cancer is a major disease associated with HIV/AIDS that likely can be controlled or prevented to prolong the lives of infected women.\textsuperscript{50} Yet the U.S. Centers for Disease Control and Prevention's widely used definition of AIDS\textsuperscript{51} did not include invasive cervical cancer until the end of 1992.\textsuperscript{52} In addition, facilities for the treatment and detection of cervical cancer are lacking in most developing nations. Despite the fact that cervical cancer is a relatively preventable form of cancer, it is the most prevalent form of cancer in women in Africa and Asia, and the second leading type in Latin America.\textsuperscript{53} Worldwide, cervical cancer accounts for fifty-one percent of all forms of female cancer incidence in developing countries.\textsuperscript{54}

HIV/AIDS has contributed to raising the political profile of women's health. The pandemic has publicly highlighted the global neglect of women's health with respect to conditions that are shared by men and women and the absence of appropriate treatment of diseases that affect women exclusively. As such, the pandemic has contributed to the recent transformation of interest in women's health, at least among industrialized states and international organizations. Although HIV/AIDS is only one facet in the recent resurgence of interest in women's health status, the public scrutiny of national and international re-

\footnotesize{\textsuperscript{49} Women and HIV, supra note 14, at 3. Studies have found an 8 to 11 times greater risk of cervical dysplasia, the cellular abnormalities that characterize the precancerous state, in HIV-infected women than non-infected women from the same community. The exact relationship between the association of HIV and cervical cancer is not well understood; however, it is unclear whether cervical cancer and other cervical disorders rampant in women infected with HIV are opportunistic infections associated with the virus since many of the risk factors for cervical cancer are the same as those for HIV. Id. at 4. See also supra note 34.}

\footnotesize{\textsuperscript{50} Brettle & Leen, supra note 34, at 1286-87.}

\footnotesize{\textsuperscript{51} Verla S. Neslund et al., The Role of CDC in the Development of AIDS Recommendations and Guidelines, 15 LAW MED. & HEALTH CARE 73 (1987); see also Smeltzer, supra note 15, at 153 ("The CDC's definition [of AIDS] is used by others, including federal and state agencies, to determine eligibility for services.").}

\footnotesize{\textsuperscript{52} See James W. Buehler et al., The Surveillance Definition For AIDS in the United States, 7 J. AIDS 585 (1993). "Inclusion of cervical cancer [in the definition of AIDS] emphasizes the importance of gynecologic care for HIV-infected women." Id. at 586.}

\footnotesize{\textsuperscript{53} Women's Health, supra note 6, at 86.}

\footnotesize{\textsuperscript{54} Id. at 87; see also Woman, Health and Development, supra note 24, at 9.}
sponses to the impact of the pandemic on women has clearly served to heighten concern with women's health status.55

Policies and priorities with respect to women's health and specific women's issues raised by the HIV/AIDS pandemic are transforming at the international level. WHO, for instance, has begun to broaden its conventional concept of women's health and alter its programmatic activities to take into account a fuller spectrum of women's physiological concerns beyond reproductive health. In 1992, for example, the World Health Assembly, the legislative organ of WHO, stressed the importance of new interventions for women's health, including STDS, and directed WHO to establish the first Global Commission on Women's Health before the end of the year.56 Acknowledging that international efforts have failed to take into account the scope of women's health issues beyond maternal health, the resultant resolution recognized that "women's health means their health throughout their entire life span, and not only their reproductive health."57

In the context of controlling the spread of HIV/AIDS, WHO also recently emphasized the development of new initiatives to specifically address the physiological vulnerability of

55. See, e.g., Dresser, supra note 30, at 27. During the last several years, women's health issues have emerged as a pressing political concern. Bernadine Healy, Women's Health, Public Welfare, 266 JAMA 566, 566 (1991). In 1991, the former Director of National Institutes of Health ("NIH") noted that "women's health in general in terms of research, services and access to care—has come of age and become a priority, medically, socially, and politically." Id. NIH directives now require the participation of women in federally funded research. Id.; Dresser, supra note 30, at 24. Under the NIH directives, NIH has taken the position that no application will be funded in which women and minorities are not to be included in the planned clinical research program unless compelling scientific justification is given. Healy, supra. In 1990, NIH established the Office of Research on Women's Health to address the inequities in the research of women's health concerns and to ensure that women are included in clinical trials. Pinn, supra note 30, at 1921. See also Andrew A. Skolnick, Women's Health Specialty, Other Issues on Agenda of 'Reframing' Conference, 268 JAMA 1813 (1992). In the U.S., experts have begun to explore the possibility of creating a women's health specialty. Id.; see also Social Impact, supra note 27, at 106. In addition, in 1991, NIH announced a new ten year, $500 million initiative, the largest single research project that NIH has ever launched, to redress the neglect of women's health on post-menopausal women. "HLN" (Hilde L. Nelson), Hastings Center Rep., Jan.-Feb. 1992, at 27.


57. WHA Resolution 45.25, supra note 56, at pmbl.
Protecting women from HIV infection is now a priority theme of WHO’s Global Programme on AIDS. In addition, recognizing that STDs are an important cofactor in the transmission of AIDS, WHO reorganized its structure in 1991, transferring its organizational unit for sexually transmitted diseases to the Global Programme on AIDS. WHO is also turning to a new strategy to contain the spread of HIV to women by focusing on the development of more effective “barrier” methods that could be used by women without the knowledge or consent of their sexual partners. In 1993, WHO launched the new venture to develop a safe and effective vaginal microbicide, a substance in the form of a foam, gel or sponge, that could be used by women to prevent HIV infection.

Thus, the international community appears to be expanding its traditionally restricted concern with women’s physical health to embrace a wide variety of physiological issues and concerns beyond maternal health. HIV/AIDS has highlighted the longstanding neglect of women’s health issues and thus has served to hasten the recent elevation of interest in women’s health. Resources and attention are being redirected to address longstanding issues in women’s health, including the development of preventative measures and therapeutic interventions for HIV/AIDS. Despite the slowness of the initial global response to the impact of HIV/AIDS on women, WHO has begun to adjust policies and priorities to address women’s health issues, including women’s physiological vulnerability to HIV/AIDS infection.

58. *1992 Update*, supra note 1, at 14; WHA Resolution 45.35, *supra* note 1. In WHA Resolution 45.35, the World Health Assembly called upon the Director-General of the organization to “strengthen the development and evaluation of intervention to improve strategies for gender-specific prevention as well as strategies for care in national AIDS programmes.”


60. *See supra* note 41 and accompanying text. The difficulty that women have in persuading their partners to use condoms highlights the urgency of developing safe and effective barrier methods that can be used by women without the knowledge of their partners. *Id.*

IV. EXPANDING THE DEFINITION OF WOMEN’S HEALTH: THE SOCIAL AND CULTURAL DIMENSIONS OF HEALTH STATUS

Although the expansion of international health policy to include the full dimensions of women’s physiological health is promising, global policymakers have yet to seriously identify and address the social and cultural determinants of women’s health status. The impact of HIV/AIDS on women demonstrates that women’s health status is not merely the outcome of scientific analysis or medical intervention. Rather, the disease highlights the social and cultural determinants of women’s health status. Future multilateral efforts to protect women’s health in general and to control the spread of HIV/AIDS in particular must further expand the scope of policy concern with women’s health to include consideration of the social and cultural circumstances of gender discrimination that affect women’s health status.

There is a consensus within the public health community that the root causes of the relative increase in the incidence of HIV/AIDS in women go beyond the virus itself and are the outcome of the pervasive conditions of social and economic discrimination against women worldwide.\(^6\) Indeed, the inequities in scientific research on HIV/AIDS and medical treatment of women only reflect the widespread disparities in social life that render women uniquely vulnerable to HIV infection. Despite overwhelming confirmation that women’s health status is specifically threatened by social and cultural discrimination, women continue to be disadvantaged by the legal and social policies of many nations.

Although the lower status of women within family and society varies from culture to culture, rough generalizations are possible. Worldwide, the consequences of women’s inferior so-

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cial status are similar, resulting in a special vulnerability to HIV infection. Economic inequalities and traditional attitudes and values limit the ability of women to protect themselves from infection. Efforts to combat the pandemic must, therefore, go beyond the technical medical aspects of HIV/AIDS. To effectively prevent the further spread of the pandemic, the underlying, deep-rooted social and cultural contexts that dramatically restrict women's choices must be addressed.

Globally, cultural norms reflect and contribute to the biases in prevailing practices regarding the extent, type and quality of education, feeding and health care available to women.63 This lack of equal access to education and health care restricts women's access to knowledge about HIV/AIDS and the means to prevent infection. Gender inequality in sexual relations and economic status also increases the risk of infection in women. Women's economic and social dependency on men restricts the ability of women and girls in all societies to refuse unprotected sex. The economic inequality of women is a global phenomenon; worldwide, women constitute a majority of the poor.64 Education and literacy programs are pivotal factors in empowering women and limiting the spread of the pandemic because misconceptions about modes of transmission and risk behaviors reduces the effectiveness of public health messages. Nonetheless, in many societies even women who are informed about ways to control HIV infection are powerless to control their sexual vulnerability to HIV within or outside the context of marriage.

Cultural values and patterns regarding appropriate male and female behavior tend to encourage male promiscuity65 and lock women into dependency, exacerbating their danger of exposure to HIV and perpetuating the spread of the pandemic.

63. AM. PUBLIC HEALTH ASS'N 1 (1991). For example, in the U.S., the American Public Health Association has emphasized the enormous barriers to care for HIV-infected women. HIV-infected women are “often misdiagnosed during the early state of their disease. They lack access to drug treatment, abortion services, AZT and early intervention services and clinical trials . . . . The eligibility of HIV-infected women for disability and health benefits is complicated by criteria which may not reflect the nature of the disease in women.” Id. See generally Technical Discussions, supra note 56, at 3.

64. Technical Discussions, supra note 56, at 2.

65. See, e.g., Barbara O. de Zalduondo et al., AIDS in Africa: Diversity in the Global Pandemic, 118 DAEDALUS 165, 183 (1989) (describing how within many polygamous cultures little or no shame or stigma attaches to mens extramarital sexual encounters).
Studies from regions of high heterosexual transmission of HIV, for example, indicate that the major risk factor for married women is the pre-marital and extra-marital activities of their husbands. Worldwide, women have little power in influencing their partner’s sexual life; have difficulty in demanding that their partners use condoms; and in discussing sexual behavior. Traditional practices, such as the early marriage of girls, means that women are also becoming infected at a significantly younger age than men—five to ten years earlier than men on average and often in their early childbearing years.

Traditional beliefs about marriage, spirituality, sexuality, reproduction and disease causation prevalent in many societies provide a fertile breeding ground for the virus. Cultural conventions in many societies entitle a man to his wife’s sexual services. Because of these traditions, the wife is at risk because she may not refuse her husband’s request for sexual relations even after he has been diagnosed with HIV/AIDS. In addition, although women who test positive for HIV/AIDS are encouraged to avoid childbearing, that choice may be unavailable or unrealistic in certain cultural contexts. In some African societies, for instance, the status of a woman is critically linked


67. Lori L. Heise, Reproductive Freedom and Violence Against Women: Where are the Intersections? 21 J.L. MED. & ETHICS 206, 208 (1993) (providing an excellent discussion of rape internationally and its impact on the AIDS pandemic). In some nations, legal provisions require that women receive spousal permission before birth control can be dispensed. Id. Studies conducted in the U.S. indicate that women are at increased risk of violence if they ask their sexual partners to use condoms. See, e.g., Dooly Worth, Sexual Decision-Making and AIDS: Why Condom Promotion Among Vulnerable Women is Likely to Fail, 20 STUDIES IN FAMILY PLANNING 297 (1989).

68. Technical Discussions, supra note 56, at 3; Ntiense B. Edemikpong, Women and AIDS, in WOMEN’S MENTAL HEALTH IN AFRICA 25, 31 (Esther D. Rothblum & Ellen Cole eds., 1990). Traditional marital practices such as polygamy also increase women’s vulnerability to exposure to HIV. Some traditional African religions and Islam endorse polygamy. Edemikpong, supra. See also Zalduondo, supra note 65, at 181-86, 188 (providing an excellent discussion of how several social and cultural conventions of people of the Kagera district in Tanzania and other parts of Africa fuel the spread of the pandemic).


70. Id. at 10; see also Heise, supra note 67, at 206-09 (providing an international perspective on marital rape).
to her ability to bear children and her reproductive role is regarded as the property of her husband's family. As a consequence, a positive HIV test result may, at times, accelerate a woman's plans to conceive.

The global phenomenon of sexual violence against women further limits the ability of women to protect themselves from infection. Sexual violence in the form of rape most directly eliminates a woman's control over the means to protect herself against sexual infection with the virus. In addition, sexual victimization, the threat of rape and other forms of physical violence, may also limit the ability of women to protect themselves against infection by "help[ing] to create an atmosphere of female deference to male decision-making regarding sexual behavior."

Stereotypes in many societies place the blame on women for the spread of the disease. HIV/AIDS is, therefore, experienced differently by men and women and has vastly different social and economic consequences. In many societies, infected men expect and receive care, while infected women are frequently stigmatized, rejected and expelled by their communities and families. Although AIDS-related stigmatization is not unique to women, men's property and other rights may be protected by the law, while women's lack of legal status in many nations may leave them homeless and destitute after abandonment by their families. The ascription of HIV/AIDS to women thus further entrenches their social subordination.

Prostitutes are particularly vulnerable victims of AIDS-related stigmatization and discrimination. Poverty forces women and girls into prostitution, placing them at greater risk of ac-

71. See Mutambirwa, supra note 69, at 9.
72. Id. at 8.
74. Id. at 206.
75. Final Report on Discrimination, supra note 66, at 9-10; see also Technical Discussions, supra note 56, at 3 (noting that while "men expect and receive care, . . . women are often shunned by their families and communities.").
76. See Technical Discussions, supra note 56, at 3; supra text accompanying note 56.
quiring HIV/AIDS.\textsuperscript{77} In addition, in Asia and Africa, thousands of women and girls are sold into prostitution every year.\textsuperscript{78} In some countries, evidence of the high prevalence of HIV/AIDS infection among prostitutes\textsuperscript{79} has contributed to their being stigmatized for the spread of the disease, without any blame placed on their clients or those who traffic in women.

The outcome of these pervasive conditions of gender discrimination is reflected in the poor health status of women worldwide, of which HIV infection is but one manifestation. Inequitable nutritional practices and lack of basic education put girls at greater risk of malnutrition and disease, including HIV/AIDS.\textsuperscript{80} Social customs and sexual violence force girls into the reproductive cycle before they are physically mature, setting the stage for repeated pregnancies, dangerous abortions and sexually transmitted diseases, including HIV/AIDS.\textsuperscript{81}

The spread of HIV/AIDS is a poignant illustration of the fact that women's health status is directly influenced by conditions of gender discrimination. Yet, despite the overwhelming recognition that social and economic discrimination fuels the spread of the pandemic and negatively impacts women's health generally, national laws in many countries often confirm or


\textsuperscript{78} See, e.g., Ramon Isberto, Asia: Fear of AIDS Boosts Child Sex Trade, Inter Press Service, Apr. 27, 1993. The demand for uninfected girls in Thailand has encouraged traffickers to smuggle in children from Burma, China, Laos and Vietnam. \textit{Id.}; see also Molly Moore, \textit{'Even if I Run Away, Where Would I Go?'}; Third World Prostitutes: Entrapped by Fate in a Sordid Trade, WASH. POST, Feb. 16, 1993, at A25. Prostitutes throughout the world are also unable to demand that their clients use condoms. See, e.g., Gayle Reaves, \textit{AIDS Time Bomb; Asian Epidemic, Fueled by Sex Trade and Drugs, May Soon be World's Worst}, DALLAS MORNING NEWS, Apr. 30, 1993, at A1 (reporting "Indian men routinely refuse to use condoms, and workers promoting their use have been slain"); Isberto, supra (noting that "child sex workers are less likely than older prostitutes to insist that customers use condoms").


\textsuperscript{81} Technical Discussions, supra note 56. Research also suggests that traditional practices such as female genital mutilation further increases women's vulnerability to HIV infection. Edemikpong, supra note 68, at 28-31. \textit{See also} WOMEN, HEALTH AND DEVELOPMENT, supra note 24, at 7.
compound the violation of women’s human rights. Worldwide, legislative discrimination is evident in the context of marital rights, social security benefits, retirement benefits, inheritance laws, property ownership and employment. Such laws increase women’s vulnerability to illness and disease, including HIV/AIDS, by narrowing their economic and social capacity to avoid situations which put them at risk. Such discriminatory laws also reflect and contribute to cultural biases which render women uniquely vulnerable to HIV infection. From a wider perspective, entrenched legislative discrimination evidences the failure of many nations to promote and protect women’s international right to health.

Future multilateral efforts to combat the spread of HIV/AIDS must therefore look beyond the medical and scientific basis for the disease and identify and address the social contexts which render women vulnerable to illness in general and HIV/AIDS in particular. Indeed, global efforts to combat the spread of HIV/AIDS must further broaden the conceptualization of women’s health to recognize the fundamental social and cultural circumstances that render women vulnerable to illness. Policymakers should embrace the concept of health provided in the preamble to WHO’s constitution which defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease of infirmity.” This paradigm of health must be introduced by policymakers to guide efforts to develop concrete interventions to improve women’s health in general and to control the rampant spread of HIV/AIDS in particular.


83. See World Health Organization, Tabular Information on Legal Instruments Dealing with HIV Infection and AIDS 20, 96, 133 WHO Doc. WHO/GPA/HLE/92.I (1992). Female prostitutes have been subject to particularly coercive state imposed sanctions in a number of nations. In some countries, including Bolivia, Panama, and the Russian Federation, legislation has been enacted allowing forcible testing and official registration of prostitutes. Id. at 20, 96, 133; Susan Blaustein, Asia’s Bosnia: Ethnic Cleansing—in Burma, New Republic, Apr. 12, 1993, at 18, 20 (noting that the United Nations Commission on Human Rights has reported that HIV-positive prostitutes deported by Thai authorities back to their native country of Burma have been killed by government authorities).

84. WHO Const., supra note 21, at 1. See Sherwin, supra note 26, at 193. One commentator notes that most feminist theorists support a holistic view of health which includes the social determinants of health status. Id.
Other observers have noted, however, that international HIV/AIDS interventions have continued to focus primarily on the purely medical aspects of the disease without addressing the underlying social contexts which both foster unsafe behavior and restrict the ability of women to protect themselves against the disease. Indeed, conventional international health strategies, which build on and reinforce the stereotypical role of women as caregivers, compound the impact of HIV/AIDS on women by placing the increased responsibility on them to care for those who are ill.

International organizations have begun to at least identify the complex social and cultural links between women's personal vulnerability to HIV infection and their social status. In 1990, the United Nations Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW") recommended that discrimination against women be avoided in national AIDS programs. In addition, the United Nations Commission on the Status of Women declared that their priority theme for 1993-97 was the effect of AIDS on the advancement of women. In 1992, the World Health Assembly also stressed the importance of new organizational interventions to reduce women's vulnerability to HIV by focusing on the improvement of women's health, education, legal status and economic prospects. Although international organizations have now given at least rhetorical recognition to the fundamental social circumstances which bear on women's health, the question that remains is what meaningful impact international law and institutions can have on the cultural and social mechanisms which fuel the pandemic.

85. AIDS IN THE WORLD, supra note 1, at 659-61. International prevention strategies have conventionally focused on the reduction of the number of sexual partners, fidelity within relationships, safe sexual practices and the treatment of STDs. Id. at 659. These measures have had little relevance to the realities of most women's lives because many women cannot control the behavior or circumstances which put them at risk. Id. at 659-61.

86. CEDAW, supra note 23, at art. 12. The recommendation was based on Article 12 of CEDAW which states that "Parties shall eliminate discrimination against women in the field of health in order to ensure, on a basis of equality of men and women." Id. See also Sofia Gruskin, AIDS and International Human Rights, 1 ACLU INTERNATIONAL CIVIL LIBERTIES REPORT 11, at 13 (June 1993).

88. See supra note 56 and accompanying text.
V. FUTURE INTERNATIONAL EFFORTS TO CONTROL THE SPREAD OF HIV

The cultural data clearly demonstrates that to respond effectively to the spread of HIV/AIDS, international programs must explore and address the interrelationship between HIV/AIDS and women's status. It is important, however, not to overestimate the impact that international organizations and the development of international law addressing the conditions which render women vulnerable to HIV/AIDS can have on the underlying and entrenched social conditions that impact the exposure of women to HIV.

International efforts can have only a limited impact on the entrenched cultural structures which render women vulnerable to illness and disease. An international discourse on rights has little meaning in the daily realities of women's lives. International law is unlikely to affect the status of women at the family and community level where discrimination is strongest.\(^9\) International legislation is therefore unlikely to alter the underlying social structures that define women's roles and limit their choices.

States, moreover, are also likely to oppose international efforts directed towards altering the status of women. Many nations have been highly resistant to complying with their international obligations to promote the human rights of women. The history of a number of international efforts addressed at transforming the status of women, including CEDAW, demonstrates this resistance.\(^9\) CEDAW confirms that states have a dual obligation to ensure that the rights of women are adequately protected by law and that women are empowered to enjoy their right to education, employment, health care and other resources on an equal footing with men. Of all the human rights treaties, however, CEDAW has attracted the greatest number of reservations with the potential to modify or exclude the central provisions of the treaty’s terms.\(^9\)

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89. Elizabeth A. Preble, Women, Children, and AIDS in Africa: An Impending Disaster, 23 N.Y.U. J. Int'l. L. & Pol. 959, 968 (1991) (arguing that international law is unlikely to have a significant impact at the local and family level).
90. CEDAW, supra note 23.
91. Belinda Clark, The Vienna Convention Reservations Regime and the Convention on Discrimination Against Women, 85 Am. J. Int'l. L. 281, 282-83 (1991). As of December 31, 1989, one hundred states were a party to the convention. In addition, forty-one of
In the United Nations debates surrounding the adoption of the convention, states did not defend their reservations on the grounds that they were of limited effect, but rather that they were dictated by cultural and religious norms. For example, reservations have concerned the incompatibility of gender equality with Islamic law or national customs which restrict women’s inheritance and property rights and limit women’s employment opportunities. Despite the international rhetorical commitment to CEDAW, the pattern of reservations to the convention, as well as the entrenched legislative discrimination against women prevalent in many nations, indicates that many states are not prepared to alter societal structures that discriminate against women and contribute to the spread of the pandemic.

Efforts to advance the status of women in the context of HIV/AIDS prevention and control are likely, therefore, to be countered by allegations of cultural insensitivity and interference with the domestic affairs of states. International health law has traditionally been primarily functionalist in nature, restricted to activities on which there was international consensus. To effectively address the impact of the pandemic on women, international health law must now take into account a complex set of the social and cultural conditions. The advancement of women’s legal and social rights is central to controlling the spread of HIV. Thus, international health law is led into a political quagmire.

The rapid global spread of HIV/AIDS has clearly illustrated that the proper domain of international health law should be expanded to take into account the complex social and cultural circumstances that affect health status. HIV/AIDS has vividly demonstrated that women’s social status is not purely a matter of domestic concern. Rather, it is a threat to international health which requires collaborative multilateral action. Although HIV/AIDS has evidenced the interdependence of world health and the inseparable relationship between health and social status, international law is unlikely to affect the status of women in the absence of national commitment.

the one hundred member states expressed substantive reservations with regards to the Convention. Id.
92. Id. at 299-300.
93. Id.
The final decision on the development of international law and its incorporation into rules of domestic law and, perhaps, behavior depends upon the priorities and the resolve of nations.

This does not mean, of course, that there is no role for international law and organizations in limiting women's vulnerability to HIV infection. The international human rights machinery can contribute to the efforts by examining and exposing national laws and policies which directly or indirectly affect HIV prevention and control on the basis of gender.94

International supervision and publication of national compliance with international human rights obligations related to women is a powerful mechanism to ensure that nations give appropriate and adequate attention to their international commitments to protect and promote women's health. The experience with surveillance systems in the United Nations as well as regional organizations indicates that disclosure and discussion of substandard national efforts in an international arena can provide powerful pressure on governments to escalate their efforts to comply with international legal obligations. Initially, such surveillance mechanisms were mainly created and effective in the field of the international protection of human rights. The international surveillance model has been also been adopted and applied in other realms of international law. For example, new international mechanisms for the surveillance of the implementation of environmental treaties are more and more numerous.95 Supervision and publication of national compliance with international human rights obligations related to women may not only further national compliance with global norms, but also contribute to transforming contemporary no-

94. The 1993 World Conference for Human Rights called for systemwide integration of women's human rights into the activities of the United Nations human rights bodies. Among other things, the Conference called upon the treaty-monitoring bodies of the United Nations to incorporate gender-specific information into their deliberations and findings. See the discussion in Sullivan, supra note 73, at 159.

95. For example, the 1989 Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal requires that state parties inform each other through the United Nations Environmental Programme of the transboundary movement of such waste and on measures adopted by them in the implementation of the Convention. 28 I.L.M. 649 (1989) (4 U.N. Doc. UNEP/IG.80/3). The experience with periodic national reporting systems in the United Nations indicates that state reports can serve a valuable role in promoting compliance with international obligations if the reports are subject to critical evaluation by the relevant international agencies. Philip Alston, The United Nations Specialized Agencies and the Implementation of the Covenant on Economic, Social and Cultural Rights, 18 COLUM. J. TRANSNAT'L L. 79, 96-101 (1979).
tions about states’ responsibilities to guarantee women’s fundamental human rights.

International efforts are also urgently needed to encourage all states to develop and implement specific, binding commitments to increase national health care financing and to equitably distribute existing resources to women. The medical aspects of HIV/AIDS have been particularly difficult to confront in most developing nations because of the pre-existing weaknesses of national health systems.\(^{96}\) Prevention and control of HIV is critically linked to the existence of adequate primary health care services, including basic health care education.\(^{97}\) In addition, despite the recent elevation of concern with women’s health in some countries, throughout most of the world women’s physiological health remains neglected by national policymakers. Therefore, the development of international legislation addressing the allocation, quality and accessibility of existing health care services to women in all nations is an area of critical concern.

Although international organizations have not yet addressed all these areas of critical concern, progress is evident. In its resolution calling for the new Global Commission on Women’s Health, the World Health Assembly instructed the Commission to address this issue of health resource allocation.\(^{98}\) Among other tasks, the Commission is charged to set standards and criteria necessary for regular monitoring of women’s health status and countries’ progress in implementing past Assembly resolutions bearing on women’s health.\(^{99}\) While these activities do not have the obligatory character of international law, they can, if effectively implemented, constitute an important first step in the advancement of women’s right to health and may persuade some states to reconsider and revise national policies on women’s health.

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98. WHA Resolution 45.25, *supra* note 56, at Sec. 3(1).
99. *Id.* at Sec. 3(3).
V. CONCLUSION

The global HIV/AIDS crisis has contributed to ushering in a new era of concern with women’s health. The disease highlighted the long-standing neglect of women’s health by national and international policymakers and intensified the recent metamorphosis of international concern with the physiological basis of women’s health status. The disease has also underscored the sociocultural determinants of women’s health status.

Protecting and promoting women’s right to health is an extraordinary public health challenge. International organizations can have only a limited impact on the social and cultural circumstances which render women vulnerable to illness and disease, including HIV/AIDS. WHO and other international organizations can, however, through the use of international legislation and effective supervisory institutions, make an important, albeit limited, contribution to efforts to protect women’s health status. International legislative efforts can encourage nations to rethink and revise domestic laws and policies which discriminate against women on the basis of gender, including the equitable reallocation of domestic health resources to protect and promote women’s health.