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**INTEGRATION OF THE HUMAN RIGHTS OF WOMEN AND THE
GENDER PERSPECTIVE: VIOLENCE AGAINST WOMEN**

INTERSECTIONS OF VIOLENCE AGAINST WOMEN AND HIV/AIDS

**Report of the Special Rapporteur on violence against women,
its causes and consequences, Yakin Ertürk**

Summary

This is my second report to the Commission in my capacity as the Special Rapporteur on violence against women. Chapter I of the report summarizes my activities in 2004 and Chapter II contains a study of the intersection of violence against women and HIV/AIDS.

HIV is on the rise in all parts of the world, spreading in particular among women and girls. The pandemic represents a medium where the complex manifestations of gender inequality as it impacts on women are observed. Discrimination against women, due to gender inequality, is multiple and compounded at the intersection of patriarchy and other sites of oppression, which subjugate women to a continuum of violence, making them susceptible to HIV/AIDS.

The report analyses the interconnections between violence against women and HIV/AIDS, considering violence both as a cause and a consequence of HIV. It examines how the various types of violence to which women are subject, from the domicile to the transnational arena, increase the risks of transmission of HIV; the ways in which stigma, discrimination, and gender-based violence are experienced by women living with HIV, as well as the obstacles to women's access to medical care and justice. Throughout the report, emphasis is placed on the intersectionality of violence against women and HIV as well as the multiplicity of types of discrimination experienced by women living with HIV, particularly by migrant, refugee, minority, and other marginalized groups of women.

Whereas HIV-related human rights are protected under international human rights law, and while the connections between violence against women and HIV/AIDS are indisputable, States have yet to create integrated and effective responses dealing with gender inequality as the root cause and consequence of the gender-specific manifestations of the disease. While some progress is being made separately on ending violence against women and stemming the spread of HIV/AIDS, national and international efforts would be vastly more effective if they addressed the interconnectedness between the two pandemics.

Today, HIV is acknowledged as a development, security and human rights issue with differential gender implications and impact. It is, therefore, increasingly recognized that the promotion and protection of human rights of women can reduce the spread of the disease and mitigate its consequences.

The report ends with recommendations for an effective and integrated strategy to fight the spread of the deadly disease in the context of the intersections between violence against women and HIV under five broad categories: (i) gender-based violence; (ii) the gender dimensions of HIV/AIDS; (iii) women's access to health care; (iv) empowerment of women; and (v) the global coalition against HIV/AIDS.

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Introduction

1. In its resolution 2004/46, the Commission on Human Rights welcomed the work of the Special Rapporteur, and took note of her report (E/CN.4/2004/66) in particular the elaboration of guidelines for developing strategies for the effective implementation of international standards to end violence against women at the national level. It encouraged the Special Rapporteur to respond effectively to reliable information that comes before her and requested all Governments to cooperate with and assist the Special Rapporteur in the performance of her mandated tasks and duties, to supply all information requested, including with regard to implementation of her recommendations, and to respond to the Special Rapporteur's visits and communications.

2. In accordance with Commission resolution 2004/46, I hereby submit my second report to the Commission. Chapter I of the report summarizes my activities in 2004 and Chapter II examines the intersection of violence against women and HIV/AIDS. I draw the attention of the Commission to the addenda to the present report. Addendum 1 contains summaries of general and individual allegations, as well as urgent appeals transmitted to Governments and their replies thereto. Addendum 2 reports on my visit to El Salvador, Addendum 3 on my visit to Guatemala, Addendum 4 on my visit to the Occupied Palestinian Territories, and Addendum 5 on the situation in the Darfur region of the Sudan.

I. ACTIVITIES IN 2004

Country visits

3. I visited El Salvador (2 to 7 February), Guatemala (8 to 14 February) and the Occupied Palestinian Territories (13 to 18 June), at the invitation of the Governments and Authority concerned. Visits to the Russian Federation and Afghanistan in June and July of 2004 were postponed due to security reasons; the former by the Government of the Russian Federation and the latter by the United Nations. The visit to the Russian Federation, including the North Caucasus, has been rescheduled for December 2004. I intend to visit the Islamic Republic of Iran in January 2005.

Consultations and participation in meetings

4. On 28 January, I had a fruitful dialogue with the Committee on the Elimination of Discrimination against Women on how to institutionalize procedures for sharing information of mutual concern, in particular the processing of cases under the communications procedure of the Special Rapporteur and the newly established protocol to the Convention on the Elimination of All Forms of Discrimination against Women which allows for the submission of individual complaints.

5. In April, I presented my reports to the Commission on Human Rights and participated in a number of parallel events. I returned to Geneva later that month to attend a conference and board meeting of the United Nations Research Institute for Social Development. From 14 to 17 May, I participated at the third session of the Permanent Forum on Indigenous Issues in New York. In June, I attended the annual Special Procedures meeting at the Office of the United Nations High Commissioner for Human Rights in Geneva.

6. From 27 to 28 July, I participated in the Asia Pacific Regional Consultation on violence against women, organized by the Asia Pacific Forum on Women, Law and Development in Jakarta. Women's rights advocates and experts from 15 countries in the region participated (Afghanistan, Australia, Bangladesh, India, Indonesia, Japan, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Republic of Korea, Sri Lanka and Thailand). The focus of the consultation was an exploration of critical issues in the Asia Pacific region surrounding sexuality, violence against women and access to justice.¹ Participants called for greater access to justice and State accountability for violence against women.² The Regional Consultation was followed by a national consultation with local organizations, organized by the National Commission on Violence against Women (Komnas Perempuan). The consultation reviewed the implementation of recommendations made by the former Special Rapporteur on violence against women following her mission to Indonesia in 1998 as well as current concerns. Issues discussed included lack of access to justice, gender discrimination in the criminal justice system, and the politicization of religion and tradition and poverty.

7. From 25 to 26 September, I participated in the first Africa Regional Consultation on violence against women with the Special Rapporteur of the African Commission on Human and People's Rights on women's rights in Africa, Angela Melo. The consultation was held in Khartoum and was organized by the Geneva Institute for Human Rights, African Women's Development and Communications Network (FEMNET) and the Babiker Badri Scientific Association for Women's Studies (BBSAWS). Women's rights advocates and experts from the following participated (Burundi, Democratic Republic of the Congo, Djibouti, Eritrea, Ethiopia, Mozambique, Rwanda, Somalia, Somaliland, South Africa, Sudan, Uganda and Zambia). Participants were informed about the regional and international mechanisms and shared their concerns and strategies for the promotion and protection of women's rights on a wide range of issues, from harmful traditional practices to violence against women in situations of armed conflict.³

8. The Regional Consultation was followed on 27 September by a national consultation with local organizations at Afad Women's University, organized by BBSAWS. Participants raised the following issues of concern: violence against women in zones of conflict in the Sudan, female genital mutilation, HIV/AIDS, and implications for women of the Public Order Act 1999, namely random virginity testing, restrictions on women's freedom of movement, imposition of dress code, and prosecution for selling of tea and alcohol. Reportedly, the majority of women in jail in Sudan are detained for these types of offences.

9. On the occasion of the launch of the Human Rights and Social Justice Research Centre on 12 October I delivered the keynote entitled "The Real War against Terror: Protecting Women against Violence" at the London Metropolitan University.

10. On 29 October, I had a dialogue with the Third Committee of the General Assembly. In my statement I expressed concern over the increased politicization of culture, especially its articulation in the form of religious fundamentalism(s). I noted that the current competition over global power poses a major challenge to the effective implementation of international human rights standards, as the use of violence in all spheres of life become widespread and legitimate.

I emphasized the importance of a dialogue among civilizations, based on the convergence of values embedded in the common heritage of human rights, as critical for resisting such extremist ideologies, and thus, preventing their transgression on women's human rights.

11. From 22 to 24 November, I participated in the Women Defending Peace Conference organized in Geneva by The Suzanne Mubarak Women's International Peace Movement and the Federal Councillor Head of the Federal Department of Foreign Affairs of Switzerland, at which I made a presentation entitled "Women in Armed Conflict". On 1 December, I participated in an event for International AIDS Day organized by the Turkish Family Planning Association and the National Commission for HIV/AIDS in Ankara. On 6 December, I delivered the keynote at a meeting on militarization and violence against women, organized in Stockholm by Amnesty International. Throughout the year I also participated in national events in Turkey.

Communications with Governments and press releases

12. The number of communications sent to Governments has increased this year. A comprehensive analysis of communications sent can be found in Addendum 1. I also issued several press releases during the period under review to voice my concern at country situations and also to commemorate significant days, including joint statements with the United Nations High Commissioner for Human Rights on 25 November (International Day for the Elimination of Violence Against Women) and 1 December (International AIDS Day).

II. INTERSECTIONS OF VIOLENCE AGAINST WOMEN AND HIV/AIDS

13. Over the last five years, there has been increased attention to the relationship between violence against women and HIV/AIDS. At its forty-fifth session in 2001 the Commission on the Status of Women addressed the thematic issue "Women, the girl child and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)" and urged Governments and all relevant actors to include a gender perspective in the development of HIV/AIDS programmes and policies (E/CN.6/2001/14). The same year, in resolution S-26/2 adopted by the General Assembly's twenty-sixth special session on HIV/AIDS, Governments committed themselves to implement, by 2005, national action programmes to empower women to freely decide on matters related to their sexuality and protect themselves from HIV infection. At its sixtieth session, the Commission on Human Rights in its resolution 2004/27 stressed that the advancement of women and girls is the key to reversing the HIV/AIDS pandemic. Moreover, in its resolution 2004/46, the Commission emphasized that violence against women and girls increases their vulnerability to HIV/AIDS, that HIV infection further increases women's vulnerability to violence, and that violence against women contributes to the conditions fostering the spread of HIV/AIDS.

14. In response to the concerns of the international community and resolution 2003/47, in which the Commission requested special rapporteurs to integrate the protection of HIV-related human rights within their respective mandates, I have dedicated my report this year to this theme. The report addresses the multiple kinds of gender-based violence which put women at risk of contracting HIV/AIDS; the particular kinds of stigma and discrimination experienced by women living with HIV; and the obstacles they face in access to medical care and justice. It further

establishes that entrenched sexual violence, compounded by lack of access to information, prevention, treatment and care, undermines women's fundamental rights to life, to the highest attainable standard of mental and physical health, equal access to education, work, privacy, and non-discrimination, amongst other human rights. The report ends with recommendations for action by Governments.⁴

15. This report is meant to complement the work of other special procedures, such as the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, who has stressed the importance of addressing gender inequalities in the context of HIV/AIDS and has emphasized, in particular, the rights to sexual and reproductive health as indispensable in the struggle against HIV/AIDS. Furthermore, it aims to contribute to the numerous international campaigns that have been launched this year, including the UNAIDS World AIDS Campaign and the 16 Days of Activism against Gender-Based Violence for the reduction of women's and girls' vulnerability to the disease.

16. A lack of respect for women's rights both fuels the epidemic and exacerbates its impact.⁵ The international human rights instruments, in particular the Convention on the Elimination of All Forms of Discrimination against Women, provide the normative legal framework and the tools to ensure the implementation of HIV-related rights in the face of gender-based violence and discrimination. The CEDAW Committee in its general recommendation No. 24 (1999), affirming women's access to health care as a basic human right, the Committee on the Elimination of Discrimination against Women recommended that States ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and, in particular, allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS. States have made commitments in the 2001 United Nations General Assembly Declaration of Commitment on HIV/AIDS as well as in each of the eight Millennium Development Goals. While achieving these goals will help reduce the risk of HIV/AIDS, addressing violence against women will also significantly help States in achieving them, including goal 6 to reduce HIV).

17. Information for the present report was obtained from relevant entities of the United Nations, Governments,⁶ NGOs, and research institutes from around the world as well as through a review of existing literature. An earlier draft of the report was circulated among a number of experts for their feedback. I would like to express my gratitude to all Governments, United Nations entities, NGOs and individual experts who contributed to the preparation of this report.

A. Global prevalence of HIV/AIDS among women and men

18. Approximately 39 million women and men around the world are living with HIV/AIDS.⁷ In all regions, the percentage of women living with HIV is significantly increasing. Women now account for almost half of all people living with HIV/AIDS worldwide. In sub-Saharan Africa, the epicentre of the epidemic, 23 million people are infected, 57 per cent of whom are women.⁸ It has been reported that 77 per cent of all women living with HIV live in sub-Saharan Africa.⁹ Throughout the world, male-female differences in HIV prevalence are shrinking. "Feminization" of the epidemic is occurring throughout Latin America and the Caribbean,

Asia and the Pacific, and Eastern Europe and Central Asia. Similar trends are evident amongst marginalized populations in developed countries. In the United States of America, for example, AIDS is the leading cause of death for young African-American women age 25-34¹⁰ while in Canada indigenous women are almost three times more likely to have AIDS than non-indigenous women.¹¹

19. Whereas HIV was initially perceived as a health issue, today it is increasingly recognized as a cross-cutting issue of development, security and human rights that impacts differentially on all segments of the population. As the Special Rapporteur had pointed out in her previous report, “women and girls are particularly vulnerable to HIV/AIDS owing not only to their biological conditions, but also to economic and social inequalities and culturally accepted gender roles which place them in a subordinate position vis-à-vis men regarding decisions related to sexual relations. Relations of dominations are multiple and they intersect, creating for women layers of inequalities and subjection to different forms of violence” (E/CN.4/2004/66, paras. 47 and 53). Owing to gender inequality, HIV-positive women are stigmatized, which trigger further discrimination and violence. Therefore, understanding of the interplay between gender inequality, violence and HIV can offer plausible areas of intervention to fight the pandemic effectively.

20. Research shows that women exposed to HIV are at least twice as likely to become infected with HIV as their male counterparts.¹² Women’s subordinate position in sexual relations as well as their biological condition makes heterosexual sex the most common way the disease is transmitted in many parts of the world. Women’s susceptibility to HIV is exacerbated by unequal power between women and men and the use of violence to sustain that imbalance, which limit women’s ability to negotiate safe sex. As a result, women may encounter sex in a violent manner, either in or out of their home. Young women are especially at risk owing to their physiology.¹³ Furthermore, sexually transmitted infections (STIs), which increase the likelihood of contracting HIV, are more often undetected and therefore untreated in women.

21. The connection between violence against women and HIV must be understood in the context of discrimination resulting from gender inequality, including women’s lack of adequate access to information, education, and health services. Worldwide, girls attend school in far fewer numbers than boys,¹⁴ and knowledge of HIV/AIDS prevention is almost always higher among men than among women.¹⁵ In communities afflicted by poverty and/or devastated by HIV, girls are the first to be taken out of school in order to generate income or help take care of the sick. Because women disproportionately bear the burden of care for sick relatives, HIV/AIDS also affects their ability to provide for themselves and their families and to engage in a remunerated employment. Poverty, illiteracy, and gender power imbalances within families and communities limit women’s access to preventive care, drugs and treatment. Such treatment is critical not only to easing the burden of the disease, but to shielding women from further abuse.

22. As patriarchy intersects with other sites of oppression such as class, race, ethnicity, displacement, etc., discrimination becomes compounded, “forcing the majority of the world’s women into situations of double or triple marginalization”, as stated by the former Special Rapporteur Radhika Coomaraswamy (A/CONF.189/PC.3/5, para. 2).

23. In some regions of the world, women are not allowed to own property or have access to their own financial resources. In areas of sub-Saharan Africa, for example, a woman's access to property hinges on her relationship to a man. When she separates from her husband or when her husband dies, she risks losing her home, land, household goods and other property. Failure to ensure equal property rights upon separation or divorce discourages women from leaving violent marriages, as women may be forced to choose between violence at home and poverty in the street.¹⁶ Because customary practices dictate that a man's property traditionally returns to his natal family upon his death, relatives may seize a widow's possessions with no regard to her health, well-being, or ability to support herself. Because of high HIV mortality rates in Africa, this scenario of "property grabbing" has become increasingly widespread.

24. Property grabbing is often the last in a chain of events common for African women dealing with HIV. As recounted by a member of a Kenyan NGO, "Too often in recent years, a tragic and ironic story has been repeated. A woman caring for a husband ill with AIDS finds herself impoverished when he dies because neither has been able to earn an income. His family takes her house, garden acreage or other property and possessions - sometimes down to the cooking pots - leaving her homeless and destitute, just as she herself becomes ill from the infection passed on to her by her husband."¹⁷ Women's susceptibility to violence, lack of education and increased care-giving roles intersect with their lack of property rights to keep their socio-economic status low, thereby subjecting them to more violence and discrimination.

25. A good practice with regard to combating women's economic vulnerability is the adoption a property regime in the new Turkish Civil Code (2002) that provides for the equal sharing of all property acquired during marriage in the event of a divorce, thus acknowledging women's unpaid contributions to the family's sustenance.

B. Violence against women and susceptibility to HIV

26. Violence against women by intimate partners in the home, or by strangers outside - whether through community-sanctioned traditional practices; in institutional settings such as hospitals, schools or detention facilities; in the transnational arena as refugees, migrants, or persons trafficked for sexual exploitation; in times of peace or armed conflict - increases the risk of HIV infection for women and of further violence. This section explores types of violence which women commonly experience and the ways this exposes them to the risk of HIV/AIDS.

1. Rape and sexual assault

27. Sexual assault and coercion "exists along a continuum, from forcible rape to non-physical forms of pressure that compel girls and women to engage in sex against their will. The touchstone of coercion is that a woman lacks choice and faces severe physical or social consequences if she resists sexual advances".¹⁸ Sexual assault and coercion can occur at all stages of a woman's life, whether in the context of marriage, between close family or extended family members, between acquaintances or total strangers. Cases of lesbian women being targeted for rape specifically because of their sexual orientation in order for the aggressor to "prove [the victim's] womanhood" have also been documented.¹⁹

28. Rape and sexual assault take away women's control over when, with whom, and how they have sex, significantly increasing risk of HIV. In cases of gang rape, multiple assailants and the violence associated with such an assault increase the chance of infection. Also, the use of condoms is unlikely in such situations.²⁰ Forced sexual relations are a component of many kinds of gender-based violence described in this report. Most often, the perpetrator of such violence is a member of the victim's family or somebody known to her.²¹

2. Domestic and intimate partner violence

29. In the domestic setting, physical violence is often accompanied by sexual abuse, making it difficult, if not impossible, to have safe sex. Consequently, even in marriage and long-term relationships safe sex may not be possible. Intercourse within marriage may not be consensual; whether protection is used and what kind, is often decided by the man. Marital rape occurs across cultures, and may not be considered a crime. The lack of legal prohibition of, or redress for, marital rape in many societies serves to perpetuate the idea that women have no choice but to submit to their husband's sexual desires, entirely on the man's terms.²² In Nicaragua, for example, domestic violence is so entrenched in the patriarchal culture it is referred to as "the cross women must carry".²³

30. Even when not physically forced, women who are expected by their social norms to provide sex as their marital duty may feel coerced into sex by their husbands. Practices such as the payment of a dowry or bride price to the woman's family reinforce the concept that a man is literally purchasing his wife and has the right to do whatever he wants with her. Violence is used as a means of controlling women's sexuality, and is often perceived as normal, even by women. According to information received from the Government of Turkey, "Men personalize battery and rape, and regard rape as a part of their male identity. The most visible incentives behind violent acts against women are the social norms and traditional understanding of chastity. Women challenging these norms are punished by violent means."

31. Women who engage in high-risk behaviour may often do so because they want to please their male partners or because they have difficulty in convincing them to wear condoms. For example, according to information provided by the Government of Guatemala, over 50 per cent of Guatemalan women need permission from their husbands to use any form of birth control. Many women do not feel comfortable talking about sex with their partners or may stop using protection when involved in a long-term relationship as a sign of trust and faithfulness. Sometimes even the suggestion of using protection will be seen as an accusation of the husband's infidelity, or an admission of adultery on the part of the woman herself. Such implications may provoke violence towards women and prevent them from speaking up. Research has shown that suspicions of female infidelity are a significant factor in murder by men of their female partners.²⁴

32. According to the Population Council, the "dramatic rise in the frequency of unprotected sex [amongst married couples] is driven not only by the implication of infidelity or distrust associated with certain forms of contraception such as condoms, but also by a strong desire to become pregnant ... On average, 80 per cent of unprotected sexual encounters among adolescent girls occurred within marriage".²⁵

33. Male infidelity within marriage is highlighted throughout the literature as a major risk factor for married women. Studies in Thailand show that 75 per cent of women living with HIV were likely to have been infected by their husbands,²⁶ while according to the Association de lutte contre le SIDA, research in Morocco shows that up to 55 per cent of women living with HIV have had no possible source of infection but their own spouse. Similarly, in societies where polygamy is acceptable, the social sanctioning of several wives makes it almost inevitable that if one partner is HIV-positive, other partners in the marriage will contract HIV as well. According to the South African NGO People Opposing Women Abuse, polygamy is enhanced through patriarchy, encouraging the dominance of the man in these polygamous relationships, thereby shifting the balance of power in favour of the man and not encouraging women to negotiate and exercise control over their sexual intimacies with their husband.

34. Women involved in long-term relations with a man living with HIV also face the danger of reinfection.²⁷ This occurs because the virus can mutate over time when exposed to medication. Regular unprotected intercourse with a HIV-infected man, even if the woman herself has already contracted HIV, exposes her to the possibility of reinfection by a mutated version of the virus. Reinfection makes treatment more difficult, or potentially ineffective, for both women and men. Female physiology, along with women's inability to access health care and treatment, make women more susceptible to reinfection than men.

3. Violence related to harmful practices

35. Forced marriage and marriage of children are forms of gender violence hindering girls' abilities to control their sexuality and entailing pregnancy and childbirth before their bodies are sufficiently mature. It may also be a precursor to domestic violence, forced labour and sexual slavery. Young women are fast becoming the new face of the HIV/AIDS epidemic. Worldwide, adolescents and young women are more than three times more likely to be living with HIV/AIDS than young men.²⁸

36. National AIDS policies are increasingly looking into age gaps between sexual partners as a factor for the spread of the disease, as unprotected sexual intercourse and the age differentials between spouses are the main determinants of HIV risk in married couples. According to a demographic and health survey of 26 countries, "the majority of sexually active girls, aged 15-19, in developing countries are married, and these married adolescents tend to have higher rates of HIV infection than their peers".²⁹

37. Girls may also be coerced into early and short-term sexual relations by men known in some societies as "sugar daddies" who are usually more than 10 years older than their partners. These men entice girls with necessities such as food, money or school fees, or luxuries such as expensive gifts, in exchange for sex. According to surveys in Kenya, Uganda and South Africa, "sugar daddies" prefer girls because they believe them to be "pure" (i.e. HIV-negative).³⁰ Because such men are unlikely to use protection, they put young girls at risk of contracting HIV.

38. In parts of Africa and Asia the rape of young girls has been linked to popular mythology that sexual intercourse with a young virgin will cleanse the body of HIV. This encourages men to seek younger and younger partners in the hope of an elusive cure. According to a survey in

Cambodian brothel districts, “79 per cent of foreign virginity seekers [are] well-organized, mostly Asian sex tourists, and many believed intercourse with a virgin would rejuvenate them or even cure AIDS”.³¹

39. Certain traditional practices aimed at controlling women’s sexuality may also make women more susceptible to HIV/AIDS. Female genital mutilation is a coming of age ritual in some societies. The practice hinders women’s sexual pleasure, causes pain and chronic infections and occasionally leads to death. Scars resulting from the procedure increase the incidence of tearing during intercourse and childbirth. The use of unsterilized instruments, unhealed or open wounds or other complications arising in the process facilitates entry of the HIV virus into the body. Another traditional practice found within certain African cultures is that of “dry sex”, which also increases the likelihood of abrasion and thereby of HIV infection.

40. Another tradition that subjects women to increased risk of HIV transmission is “wife inheritance”. The practice, although it may take different forms in different regions, entails the remarrying of a widow within the husband’s family or ethnic group. Widows may be forced to have unprotected sex with the brother of the deceased or another man in the community to “cleanse” her of his spirit. Research by Human Rights Watch in a region in Kenya where these practices are common found that this region also has the highest rate of HIV/AIDS.³²

4. Violence related to commercial sexual exploitation of women

41. Feminized poverty and women’s lower socio-economic status are directly connected to their work in the sex industry.³³ Women usually enter the sector because they lack assets and marketable skills, or because they are coerced or tricked into prostitution. So-called “transactional sex” describes a range of sexual interactions women may enter into in which sex is “bartered” in return for goods.

42. Women in the sex industry, with multiple sexual partners, have higher susceptibility to HIV and violence than most other population groups. According to the Indonesian National Commission on Violence against Women, most sex workers are exposed off and on to rough sex which will leave them highly vulnerable to infection.³⁴ They also lack the power to negotiate safe sex. Surveys in South Africa showed that sex workers working at truck stops faced violent reactions, loss of clients or as much as a 25 per cent cut in income for insisting on condom use.³⁵

43. In countries where prostitution is illegal, the clandestine nature of such activities makes HIV and STI prevention activities difficult to implement, while in countries with legal but regulated systems, registration and periodic health testing tend to drive sex workers at highest risk underground.³⁶ Furthermore, as a marginalized sector, they are more vulnerable to human rights violations.³⁷

44. Commercial sexual exploitation of women and girls has become a lucrative business for transnational criminal networks who traffic women across borders. According to the United Nations Population Fund, between 700,000 and 2 million women are trafficked across international borders annually.³⁸ Women who are trafficked across borders often find themselves in situations with a high probability of contracting HIV. According to data from the

Russian NGO Angel Coalition, approximately one third of women surviving criminal sexual exploitation abroad and returning to the Russian Federation are carriers of the HIV virus. Without treatment or counselling, which are widely unavailable, and with the high degree of ignorance about the disease among the general population, this sexually active population fuels the already raging epidemic in the country. Sixty per cent of HIV-infected Russians today are between 20 and 30 years old and most trafficking survivors are in this age group.

45. Perceptions of women in the sex industry, including of those trafficked, as spreading HIV to the general population makes this sector the crossroads where multiple types of stigma and discrimination converge. They also face abuse, compounded by racism, cultural and language barriers, lack of documentation and information on social and legal rights, fear of deportation and a general sense of isolation. Its transnational character also deprives women of protective State mechanisms that may be available in their home country, leaving them dependent on pimps and criminal networks. Women of minority groups may encounter similar problems in their own countries. For example, many minority hill tribe populations living in the northern highlands of Thailand are denied legal status, even though they were born in the country. Such minority groups “cannot register births or marriages, are denied opportunities for education and work, cannot access public health-care services through the universal health-care plan”.³⁹ As non-citizens, they have few opportunities for education and employment and become easy prey for sex traffickers.

46. A good practice in responding to trafficking is the integrated approach employed by the Government of Lithuania, whereby regional preventive and awareness-raising campaigns and educational programmes have been organized, involving police and other law enforcement officials, educational institutions, social workers, and the media. Furthermore, the Lithuanian Ministry of Social Security and Labour has organized social assistance projects directed towards reintegration of trafficking victims into Lithuanian society, particularly into the labour market.⁴⁰

47. The situation of women migrant workers, although of a different nature than the situation of those trafficked, also requires attention as many such women typically work in unregulated sectors. Because their work situations tend to involve greater levels of isolation and lower levels of social support, they may not have the knowledge or power to speak out against abuse and violence or to seek out testing and treatment if they are infected with HIV. They are also more likely to work without the protection of local labour standards or the rights to health care and treatment accorded to citizens.

48. In Portugal, the High Commissioner of Immigration and Ethnic Minorities, a post created to promote the integration of ethnic minorities into the society, has developed a health guide for immigrants and foreign citizens who live and/or work in Portugal to help them protect themselves against HIV, and also ensures that minority and migrant populations have access to health care regardless of their nationality or financial or legal situation.⁴¹

49. The Government of Austria has reported on several projects sponsored by Austria and the European Union addressing the particular vulnerabilities of women migrants to HIV/AIDS, which seems to be on the rise among this group. These include the “Park Project”, in which counsellors discuss issues of safe sex and gender-based violence with female migrants and provide them with information about health and HIV in a variety of foreign languages. The

European Project on HIV/AIDS and Mobility maintains, in cooperation with the AIDS Support Centre in Vienna, a network of organizations within the European Union, which provide HIV/AIDS prevention and care services to migrants, ethnic minorities and mobile populations in Europe, both male and female.

50. The mass migration of workers in the construction and oil exploration industries in Viet Nam is accompanied by the movement of women into urban centres to work in the sex trade, which is rapidly spreading the rate of HIV infection.⁴² Similarly, in situations and areas where there are large numbers of military or peacekeeping personnel, women may be targeted for sexual exploitation or rape, putting them at risk of HIV.

5. Violence in armed conflict

51. Armed conflict often involves an overall militarization of the population, resulting in generalized violence with women themselves becoming the “war zone”. It has been demonstrated that violence against women has been deliberately used as an integral part of military and war strategy, in particular sexual violence. Rape has been widespread in recent conflicts in such diverse places as Bosnia, Cambodia, Liberia, Peru, Somalia, Rwanda and Sierra Leone, and continues today in the Democratic Republic of the Congo and the Sudan, amongst other places. In Sierra Leone, for example, women were forced to become sexual slaves of the rebel forces, (so-called “bush wives”). Teenage girls were particularly vulnerable because they were sought after and targeted because they were virgins. In Rwanda, brutal forms of violence such as gang rape were perpetrated with impunity. It is estimated that half a million Rwandan women were raped during the genocide, and that 67 per cent of rape survivors are HIV-positive. In some cases, men who knew they were HIV-positive deliberately raped women in order to infect them. Because war-torn areas tend to lack medicine and adequate health-care services, being HIV-positive is virtually a death sentence.

52. Survivors of rape in armed conflict situations may not know their HIV status for certain, and may have little incentive to find out about it as the trauma of violent rape may leave women anxious about consulting a male doctor or health provider. With little access to medication and treatment, especially long-term treatment - because of the high cost of the drugs themselves and of the effort and associated expense of travelling to a distant hospital - an HIV-positive diagnosis may do little more than increase a rape survivor’s mental and emotional anguish. Even if treatment were available, many would not be able to take advantage of it. The abject poverty of these women means that some of them are not even getting a proper diet needed to allow drug treatments to work effectively.

53. War and conflict also increase displacement, a factor that places women at higher risk of sexual violence and HIV infection. Internally displaced (IDP) and refugee women escaping conflict become vulnerable when fleeing alone or with children, unprotected by community members or male relatives. Border guards, soldiers, and other security forces often assault these women. United Nations peacekeepers have also been involved in sexual exploitation. According to the UNDP, “In many countries rates of HIV infection are considerably higher among military personnel than among the population generally. The very real possibility of death in combat may serve to distance men from the more remotely perceived threat of HIV infection.”⁴³

54. In IDP and refugee camps, communal living and sleeping spaces, insecure and out of the way facilities and dark pathways put women at risk of violence and sexual assault. Displaced women accompanied by a man may be no better off than women on their own. Male refugees, stripped of their traditional patriarchal power and roles, sometimes become violent toward their partners. Women may be compelled to endure such situations in silence, particularly if food rations and other necessities are distributed on the male head of household model.⁴⁴

C. Violence, stigmatization and discrimination against women with HIV

55. Throughout the world, stigma suffered by people living with HIV/AIDS results in discrimination and other violations of human rights. Stigmatization is so prevalent it has been referred to as the inevitable “third epidemic”, occurring after the “silent” epidemic of HIV infection and the AIDS epidemic.⁴⁵ Across cultures, stereotypes remain that people living with HIV/AIDS contracted the disease through some sort of deviant activity. Stigmatization occurs because of misinformation about transmission, fears of infection and the incurability of the disease, and its nature and degree are determined by a variety of social, cultural, political and economic factors, including the stage of the disease and the sex of the infected person.⁴⁶

56. Stigmatization takes on different forms of treatment, including physical or social exclusion from the family and community, and withdrawal of care and support by the family, community and health system. Diverse studies show that women are stigmatized more directly and severely, which exacerbates existing gender, social, cultural and economic inequities. When men contract the disease through sexual intercourse, their proclivity for multiple partners is assumed to be the norm. However, women are almost always branded as loose, promiscuous and immoral. According to a study conducted in Africa, “the worst blame and other forms of stigma are reserved for those women thought to be responsible for HIV through ‘improper’ or immoral sexual behaviour. For instance, women who dress in ways considered immodest, particularly urban, young, and mobile women”.⁴⁷

57. According to the information received from the Government, Mexico has developed a notable three-pronged strategy to prevent STIs and HIV/AIDS while addressing stigma and discrimination amongst women in the sex industry. It includes reducing the cost and expanding the distribution of the female condom; conducting a media campaign directed at the clients; and working with civil society groups to empower women in the sex sector to better their socio-economic situation. Such a strategy may prevent the spread of the disease and help ensure that these vulnerable groups do not suffer further discrimination, exploitation and violence once they have contracted HIV.

58. The intersection of discrimination related to gender, HIV status and sexual orientation - often combined with race and class - create multiple forms of oppression and violence that keep women subordinated. Overall, women consistently face more and greater discrimination at home, in the community, in the workplace, or in the health-care setting. As a woman in Burkina Faso explained, “If [a woman] finds herself HIV-positive, she is signing three deaths: psychological death, social death, and later physical death.”⁴⁸

1. Differential treatment within the family and the community

59. While many persons living with HIV/AIDS receive love and support from their families, the burden of care may strain a family's financial and emotional resources, challenging their capacity to offer support. Consequences may include severed relationships, desertion, separation; denial of share of property or access to finance; blocked access to spouse, children, or other relatives; physical isolation (e.g. separate sleeping arrangements) or blocked entry to common areas or facilities.⁴⁹

60. Women are more highly stigmatized since they are seen as having compromised the family integrity, which is often measured by women's moral standing. They may even be held responsible for the indulgences of their HIV-positive husbands. The relationships that suffer most because of HIV status are those between parents-in-law and daughters-in-law, as well as between spouses. In India, for example, "Even when the parents knew that their son had visited sex workers, it was the wife who was blamed for not keeping her husband 'under control'. She had failed in her role as a wife, thereby justifying the family's rejection."⁵⁰ Rejection leaves a dependent widow, who may also be unwelcome in her own family, with few sources of support.

61. A study of "discordant couples" in Uganda showed that where one partner has HIV and the other does not, healthy women tended to stay and support their husbands or partners, while women with HIV often experienced violence or abandonment by their HIV-negative partners.⁵¹ A study in India similarly concluded, "in sero-discordant couples where the man is negative, the woman is more likely to experience rejection and isolation from the spouse and the marital family than if her husband is HIV-positive".⁵² Such findings have been echoed in multiple settings around the world.

62. In some cases, women are held responsible for HIV by the very person who infected them, often their long-term partner. HIV-infected men may knowingly infect their wives, believing they have the right to maintain the pleasure of unprotected sex, or feeling it unjust that only they should suffer from the disease. Furthermore, they may blame their wives, even if they themselves are the source of the infection. As a man in Zambia put it, "I might transmit the disease to my wife then tell my wife to go for an AIDS check-up. If she is found positive I blame it on her and tell the whole community that she has infected me."⁵³

63. Families that care for and support an infected individual may also be stigmatized, isolated and ostracized within the community. Community members may be worried about risks to their health from living with an HIV-infected person in their midst. In extreme instances, communities reject people living with HIV/AIDS altogether, forcing them and/or their families to move.⁵⁴ Rejection and social isolation create emotional stress, exacerbating the physical effects of the disease. "It is not sometimes the disease that kills these patients, it is the bad words and remarks from people. Gossip has harsher consequences for women who generally rely more heavily than men on social networks."⁵⁵ Stigma may cause families to conceal an HIV-positive diagnosis, causing considerable stress and depression within the family.⁵⁶

2. Involuntary testing and disclosure of HIV status

64. A human rights approach to testing insists on voluntary informed testing, with pre- and post-test counselling. Involuntary HIV testing and disclosure of results not only violate individual rights but also lead to discrimination and stigmatization. Involuntary testing in the workplace often takes place with the intent of denying or terminating employment if the individual is found to be HIV-positive. Such practices are found in the more feminized sectors such as the service, entertainment and tourism sectors as well as the lower-level, insecure jobs. Human Rights Watch found this to be particularly common in the Caribbean region. In the Dominican Republic, “Virtually all women living with HIV ... who had previously worked in the formal sector said they had stopped applying for jobs for fear of being tested, denied work, stigmatized in their communities, and eventually abandoned by their partners.”⁵⁷

65. The issue of sexual harassment and abuse of women in the workplace is an issue receiving increased attention from Governments. The Government of Ethiopia, for example, informed that it is conducting a multi-year assessment of existing practices in HIV/AIDS prevention, control, care and support services for women factory workers. The objective is to identify the ways in which sexual harassment, exploitation and seduction by superiors and/or male co-workers promote HIV infection in female employees.

66. Involuntary testing has similarly disastrous consequences in the health-care sector. Women seeking prenatal care in India, for example, have been subject to mandatory testing and the results were made known to their friends and families.⁵⁸ “In the case of pregnant women, confidentiality did not even appear to be an issue. Women were sometimes not told of their own HIV status. Their husbands, though, were often informed, based on the assumption that it was they who would decide the future course of action - that is, whether or not to continue with the pregnancy and whether or not to get tested for HIV themselves.”⁵⁹ Fear of confronting such treatment and association with HIV discourage many women from seeking regular medical care.

67. Because testing is a regular part of prenatal care, the HIV status of a woman is more likely to become disclosed at a hospital or clinic where the principle of confidentiality is often violated, especially when it comes to HIV. Moreover, although health-care providers theoretically have more accurate information than the general public on how HIV is transmitted, this does not necessarily translate into more sensitive care and treatment of HIV patients. The worst discrimination encountered by HIV-infected women relates to family planning, pregnancy and childcare. The choice of whether or not to have children and information on the means of avoiding transmitting the disease to an unborn child or a newborn infant make women the focus of intense scrutiny: pregnancy and childcare are areas around which multiple stigmas of family, community and health care converge.

3. Reproductive rights

68. Mother-to-child transmission (MTCT) may take place during pregnancy, childbirth, or while breastfeeding, in which case mothers with HIV are held to be solely responsible for infecting their child, thus constituting another source of gender discrimination for women living with the virus. In many countries, women may receive treatment for HIV only when pregnant in order to prevent MTCT.

69. HIV-infected pregnant women may be advised or pressured to terminate their pregnancy. In Ukraine, for example, where many obstetricians and gynaecologists have never received HIV/AIDS-related counselling, doctors may immediately recommend abortion to women living with HIV when they find out they are pregnant.⁶⁰ In Venezuela, where there are allegedly no gender-focused HIV/AIDS interventions, women have reported to have been subjected to forced sterilization.⁶¹ A Venezuelan NGO documented the case of a teenager infected with HIV who was sterilized without her knowledge or consent at a maternity ward after giving birth to her child.⁶² Forced sterilization is not only a fundamental violation of a woman's reproductive rights; it has few benefits in terms of HIV prevention. Furthermore, it may undermine women's negotiating power by removing the need for condoms as a form of birth control.⁶³

70. The stress of pregnancy for women living with HIV is further intensified by the denial of proper medical care. When care is denied, a woman may have to go through labour on her own or rely on traditional attendants. Delivery under such conditions can endanger the lives of the mother and the baby and put birth attendants at risk of HIV infection.

71. In most communities women living with HIV who decide to have children are criticized and blamed for infecting their children. "In India, motherhood is perceived as the ultimate validation of womanhood. With the increasing risk of married, monogamous women contracting HIV, it was reported to be common for women to be stigmatized and blamed for passing on the infection to her unborn child. Blame is accentuated if a male baby becomes infected, due to the high value already awarded to male children."⁶⁴ Indeed, women living with HIV may have their babies taken away from them. The Moroccan NGO Association de lutte contre le SIDA has documented numerous cases of women separated from their children and driven from their homes. Such women live in social centres, where their situation is known and they are treated with contempt, and even violence.

D. Constraints on access to health care

72. Gender-based discrimination constrains women's access to medical care in HIV prevention, testing and treatment. Condoms are the most effective means of protection against STIs, yet "less than half of all people at risk of HIV infection are able to obtain them, often simply because not enough are being produced".⁶⁵ Female condoms are even less readily available, despite the fact that they allow women more control over their sexual relations. A woman's main constraint in using male or female condoms is ultimately the agreement of her partner. When men refuse to comply, women's health is compromised.

73. A woman's decision to be tested is similarly negatively influenced by actual or threat of violence from her partner. According to a study conducted in Tanzania, the "primary barrier to HIV testing and serostatus disclosure that women described was fear of conflict with partners".⁶⁶ Women living with HIV overall are almost three times more likely than HIV-negative women to have experienced a violent episode by their partner. Young women with HIV were 10 times more likely to do so.⁶⁷ Violence against women is a prime reason why women face barriers to testing and fear disclosure. Studies in Africa and Latin America show that men used testing as a preventive health measure or to confirm their HIV-negative status and/or that of their partner before committing to a relationship. Furthermore, more men than women were likely to make a

decision to be tested on their own and to disclose the results to their partner freely. Women, on the other hand, decided to be tested, often with the permission of their partner, to confirm their HIV status, particularly after the death of their child or partner, or in the process of reproductive health check-ups.⁶⁸

74. Globally, only one fifth of those who need medical treatment for HIV are receiving it.⁶⁹ Men do not only have priority in treatment, but also have power over decisions regarding their wives' treatment. In Kenya, Botswana and Zambia, women have reported being forced by their husbands to return drugs given to them to fight HIV, based on unfounded fear that the drugs could harm the foetus.⁷⁰ Practices such as *purdah* in Islamic or Hindu societies limit women's access to treatment if a female health-care provider is not available.

75. Feminized poverty also poses a barrier to treatment given the high cost of antiretrovirals (ARV). Even when ARV drugs are given free of charge, taking time off from work to go to the clinic means additional wages lost for a woman working in a low-paying job, or they may be burdened by other fees applicable during the treatment. "Health-care providers, often working with very minimal resources, sometimes lack accurate information about who is exempt from fees, and sometimes charge fees informally as a way of supplementing clinic or personal income."⁷¹ Such fees, even if small, often affect the very poorest in society, usually women, who need to make trade-offs between paying for food, shelter, or other immediate necessities instead of medication.

76. Women, who are generally less mobile than men, may not be able to access health centres even when a universal health-care system is available. They may have difficulty paying the cost of transportation to and from a clinic, or for expenses such as a babysitter. Furthermore, women are often unable to make effective use of existing health care because the hours and patterns of operation of these services do not accommodate their work schedules and domestic responsibilities. The Government of Brazil runs one of the most successful HIV/AIDS programmes in the world, including free STD and HIV testing, free male and female condom distribution, as well as preventive services for women in the sex industry and intravenous drug users. The Government also provides education on subjects such as citizenship and human rights. Despite these far-reaching efforts, it is estimated that up to 90 per cent of rural Brazilian women do not go for prenatal care and/or take advantage of free services because they have no way of getting to clinics located in urban areas.⁷² South Africa has taken important steps to address violence against women and girls, including efforts to provide HIV post-exposure prophylaxis for rape survivors. In particular Western Cape and Gauteng provinces provide legal and health services for rape survivors, and the National Prosecuting Authority and the Durban magistrate's court have made important strides in setting up specialized courts to deal with sexual offences.⁷³

E. Access to justice

77. In the context of the HIV/AIDS pandemic, gender inequality has proven fatal. Gender-based violence, discrimination and stigma reinforce one another and subjugate women, leaving them more vulnerable to infection and less likely to access effective treatment and care. Despite the increased recognition of HIV as a fundamental and cross-cutting human rights issue,

the intersection of inequality, violence and HIV hinders women's access to justice. A survivor of gender-based violence seeking a judicial remedy may be asked to describe the events to a public and insensitive audience, and find her character and lifestyle being questioned during the process. Stigmas associated with rape and other forms of sexual violence compound stigmas associated with HIV, creating obstacles at every step of the judicial process to complicate women's access to justice. As pointed out by the previous Special Rapporteur on violence against women, "women members of particular racial or ethnic groups, because of their gender and/or their race or ethnicity may be disproportionately affected by illiteracy, lack of legal capacity, community pressure and other social barriers" (A/CONF.189/PC.3/5, para. 34). Redress for women who face discrimination due to HIV/AIDS, like redress for discrimination in other areas, cannot be achieved without eliminating gender biases in the laws and the judicial system.

78. International human rights law provides the legal framework for gender-sensitive responses to the epidemic. HIV and AIDS are inextricably linked to reproductive and sexual rights, which are regulated within the context of power inequalities between women and men in favour of the latter. Thus, the rights of women to make choices concerning their reproductive and sexual lives are often violated by men.

79. As evidenced in this report, differential responses to women with HIV/AIDS curtail a much broader range of their rights, including the rights to life, health, work and education, as well as the right to privacy, non-discrimination and equal protection under the law, amongst others. Because response to HIV/AIDS is affected by gender discrimination and its consequences affect the human rights of women and girls, the protection and promotion of human rights are essential in preventing the spread of HIV and to mitigate the social and economic impact of the pandemic.

III. CONCLUSION AND RECOMMENDATIONS

80. **Programmes aimed at the prevention and treatment of HIV/AIDS cannot succeed without challenging the structures of unequal power relations between women and men. As demonstrated in this report, the multiple ways in which violence against women and HIV intersect increase the risk of HIV infection among women, their differential treatment once they are infected and their stigmatization, which in turn triggers further violence. Recognizing the importance of gender inequality and its manifestations, particularly for young women, and women from minority, indigenous and other marginalized groups, is critical to stemming the spread of the disease. Multiple layers of subordination that increase women's exposure to violence, limit their sexual and reproductive rights, increase stigmatization and discrimination and constrain their access to medical care, as well as feminized poverty, are all causes and consequences of HIV.**

81. **In spite of the number of women contracting HIV/AIDS through violent means, States have yet to fully acknowledge and act upon the interconnection between these two mutually reinforcing pandemics. By and large, Governments fail to take into consideration gender discrimination in formulating HIV/AIDS policies. This is evidenced by the lack of data on HIV disaggregated by sex in most countries.**

82. Most intervention strategies tend to target specific groups such as migrants or women who are trafficked for purposes of sexual exploitation. Such programmes are important; however, an integrated approach is needed to tackle the impact of gender inequality, while at the same time to reach specific risk groups. National policies and action plans would be vastly more effective if they acknowledged and acted on the interconnectedness between the two pandemics of HIV and violence against women.

83. Enabling approaches must also allow women to control their sexual and reproductive lives as well as to exercise a broader range of political, economic, social and cultural rights. These range from “gender-sensitive” programmes that acknowledge that men and women may have different needs, to “empowerment interventions” that strive to enhance women’s capacity and ability to take initiative and control over matters related to their life, and to “transformative interventions” that seek to “change the underlying conditions that cause gender inequities”.⁷⁴

84. I recall the internationally agreed targets contained in a number of different United Nations documents and fully support the relevant recommendations to which Governments have committed themselves. In view of the findings of this report and the principles of equality and human rights of women, I would like to make the following recommendations for an integrated response to HIV/AIDS.

A. Eliminate violence against women

- Use due diligence to comply fully with the requirements of the Declaration on the Elimination of Violence against Women adopted by the General Assembly in resolution 48/104;
- Enact and enforce gender-sensitive laws and human rights norms to address the root causes of the problem, including adoption of domestic violence laws, criminalization of marital rape, raising the legal age of marriage and outlawing forced marriage practices, and enforcing laws on trafficking in persons and commercial sexual exploitation, with a view to protecting the victim and persecuting the perpetrators (i.e. users and abusers);
- Complement legislative reforms and empowerment programmes with “cultural negotiation” campaigns to raise awareness of the oppressive and discriminatory nature of certain practices pursued in the name of culture;
- Conduct gender-sensitivity campaigns to address violence against women as a product of larger power imbalances between the genders, and dispel male and female stereotypes that encourage violent behaviours;
- Adopt gender analysis in overall policy-making to identify the diverse and multiple types of violence emanating from the intersection of gender inequality and other sites of oppression, and monitor how and where gender inequalities are reproduced.

B. Address the gender dimensions of HIV/AIDS, discrimination and stigma

- **Enact or revise general anti-discrimination laws compatible with international human rights instruments, as well as the International Guidelines on HIV/AIDS and Human Rights (HR/PUB/98/1), in particular concerning all persons living with HIV/AIDS, protect against involuntary HIV testing, guarantee confidentiality of results in all sectors and ensure women's rights to sexual and reproductive health, including their reproductive choice;**
- **Invest in female-controlled methods of HIV/AIDS prevention that give women immediate power to protect themselves during sexual intercourse. The female condom is one reliable method of prevention currently on the market that reduces risk of STIs and HIV;**
- **Train work inspectors, health-care providers, judges, lawyers and other relevant officials to monitor and enforce non-discriminatory policies and procedures in responding to HIV-positive women;**
- **Document and investigate systemic HIV-related violations of human rights of patients and prosecute the perpetrators;**
- **Provide holistic sex education and life skills courses, including factual information about HIV/AIDS and how it is transmitted, to ensure protection and prevent stigma and discrimination. Efforts should be made to reach out to population groups with less access to mainstream programmes because of poverty, a language barrier or other constraints;**
- **Ensure gender-sensitive clinical research trials for HIV drugs and vaccines. More research is needed on the effects of ARV on young women's bodies, especially their impact on fertility. Greater participation of women and adolescents is needed in HIV vaccine clinical trials.**

C. Ensure equal access to health care for women

- **Ensure women's access to medical care and HIV testing and treatment through the provision of mobile health centres, reduced or waived fees and affordable ARV, childcare at health-care centres, among others. Where female modesty or inhibitions are a concern, ensure adequate privacy for women in health-care settings or hire sufficient numbers of female health-care providers. Women living with HIV themselves can be recruited as treatment advocates or distributors to ensure that care is gender-sensitive;**
- **Provide voluntary counselling and testing (VCT), consisting of both pre- and post-test counselling, to facilitate behaviour change and serve as an entry point for care and support for those who test positive. VCT also offers a chance to address HIV holistically, dealing with the social and psychological aspects of the disease in addition to the physical. VCT is especially important for pregnant women, who are making decisions about prenatal and post-natal care.**

VCT counsellors can also play a role in preventing gender-based violence when trained to observe confidentiality and ask questions about partner violence. Effective counselling of women living with HIV and of their families helps women face the physical and emotional challenges of the disease;

- **Ensure comprehensive care for survivors of sexual violence, including the use of ARV drugs known as post-exposure prophylaxis (PEP). PEP can protect against HIV infection if administered immediately after intercourse or sexual assault. In situations of conflict and emergency, PEP should be provided as part of reproductive health kits available to IDPs and refugees.**

D. Empower women for the full enjoyment of all human rights

- **Ratify international human rights treaties, in particular the Convention on the Elimination of All Forms of Discrimination against Women and its Optional Protocol;**
- **Provide women and girls equal access to literacy, education, skills training and employment opportunities;**
- **Strengthen women's economic independence, including through access to land, credit, agricultural extension, right to inheritance, and business and leadership skills training;**
- **Support women in their care-giving roles to alleviate the disproportionate burden of AIDS care that largely fall on them, through training, social protection mechanisms and financial support;**
- **Adopt gender budgeting in all budgetary plans and allocations.**

E. Promote and join a global coalition against HIV/AIDS, and as the community of States, collectively

- **Ensure that the poor worldwide have access to affordable drugs, support a generic drugs policy and call on pharmaceutical companies to reduce drug prices;**
- **Press for demilitarization and strongly condemn all forms of violence against women and girls in armed conflict and punish all guilty parties;**
- **Support research on an HIV vaccine, microbicides and other female-controlled prevention methods;**
- **Prioritize political and financial support for the Global Fund to Fight AIDS, Tuberculosis and Malaria.**

Notes

¹ The impact and implications of the construction of male sexuality on women, violence against women and women's sexual and bodily autonomy was discussed, noting that the construction of male sexuality makes women particularly vulnerable to violence. Sexuality and violence against women was examined in light of growing fundamentalisms, militarization and situations of armed conflict and the rise of neo-liberal globalization in the region.

² For further details, papers and recommendations see: *Sexuality and Violence against Women: Access to Justice*, Summary Report of study workshop and Asia Pacific Consultation with the Special Rapporteur on violence against women, Jakarta, Indonesia, 25-28 July 2004, APWLD, Forum Asia, Komnas Perempuan.

³ See the final report of the First African Regional Consultation on violence against women with the Special Rapporteur on violence against women and the Special Rapporteur of the African Commission on Human and Peoples Rights on Women's Rights, Khartoum, Sudan, 25-26 September 2004, prepared by the Geneva Institute for Human Rights.

⁴ I would like to acknowledge and thank Jennifer Dreizen for her desk-based research which greatly assisted in the preparation of this study.

⁵ See Human Rights Watch, *Policy paralysis: A call for action on HIV/AIDS-related human rights abuses against women and girls in Africa* (December 2003).

⁶ I requested information from Governments on action taken to address violence against women in the face of the HIV/AIDS pandemic, including progress made and remaining gaps as well as suggestions on how to remedy women's susceptibility to the disease. Governments reporting included Afghanistan, Armenia, Austria, Azerbaijan, Bolivia, Brazil, Costa Rica, Croatia, Czech Republic, Estonia, Ethiopia, Finland, Guatemala, Honduras, Kyrgyzstan, Lithuania, Luxembourg, Maldives, Mauritius, Mexico, Poland, Portugal, Slovakia, Spain, Switzerland, Syria Arab Republic, Trinidad and Tobago, Turkey and Ukraine.

⁷ UNAIDS, *Aids Epidemic Update* (December 2004). http://www.unaids.org/wad2004/report_pdf.html

⁸ UNAIDS/UNFPA/UNIFEM, *Women and HIV/AIDS: Confronting the Crisis*, 2004. http://www.unaids.org/Un aids/EN/In+focus/Topic+areas/Women_gender.asp

⁹ Ibid.

¹⁰ UNAIDS fact sheet, "Women and AIDS: A Growing Challenge". <http://www.unaids.org/bangkok2004/factsheets.html>

¹¹ Health Canada, *HIV/AIDS Among Aboriginal Persons in Canada: A Continuing Concern* (2003), p. 2. http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/epiu-aepi/hiv-vih/aborig_e.html

¹² WHO/UNAIDS press release. www.who.int/mediacentre/news/releases/2004/pr59/en/

¹³ Paxton, S. and the International Community of Women Living with HIV/AIDS (ICW), 2004. Oh! This one is infected!: Women, HIV and Human Rights in the Asia-Pacific Region. See also UNDP.HIV and Development Programme. Young Women: Silence, Susceptibility and the HIV Epidemic.

¹⁴ According to a OECD/UNESCO study, two-thirds of the 113 million children out of school are girls. http://www.oecd.org/document/48/0,2340,en_2649_37423_2969008_1_1_1_37423,00.html

¹⁵ An average of 75 per cent among men, as compared to 65 among women. However, in the least developed countries, these differences are much wider. World Bank, *Inequalities in Knowledge of HIV/AIDS Prevention: An Overview of Socio-Economic and Gender Differentials in Developing Countries*, 2001.

¹⁶ Human Rights Watch, *Double Standards: Women's Property Rights Violations in Kenya* (2003), p. 25.

¹⁷ Jane Kiragu, International Federation of Women Lawyers, Kenya (FIDA-K) on the Family Health International web site. (www.fhi.org).

¹⁸ Heise, L., Ellsberg, M. and Gottemoeller, M. 1999. "Ending Violence against Women". *Population Reports*, Series L, No. 11. Baltimore: Johns Hopkins University School of Public Health, Population Information Program: 9 <http://www.infoforhealthh.org/pr/111/violence.pdf>

¹⁹ Gender Project, Community Law Center, University of the Western Cape, *Strategic Interventions: Intersections between Gender Based Violence and HIV/AIDS* (2003), p. 7. See also Human Rights Watch, *Hated to Death: Homophobia, Violence and Jamaica's HIV/AIDS Epidemic* (2003).

²⁰ WHO, *Violence against Women and HIV/AIDS: Setting the Research Agenda* (2000), p. 6.

²¹ WHO, *World Report on Violence and Health* (2002), p. 89.

²² Human Rights Watch, *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda*, 2003, p. 25.

²³ OMCT, *Violence against Women in Nicaragua*, 2001, p. 12.

²⁴ Centre for the Study of Violence and Reconciliation, *Violence, Vengeance and Gender: A Preliminary Investigation into the Links between Violence against Women and HIV/AIDS in South Africa* (2001), p. 10.

²⁵ Population Council, *The Implications of Early Marriage for HIV/AIDS Policy*, 2004, p. 1. <http://www.popcouncil.org/pdfs/CM.pdf>

²⁶ UNAIDS (see note 10 above).

- ²⁷ Human Rights Watch, *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda*, 2003, p. 25.
- ²⁸ See note 8 above, *Confronting the Crisis*.
- ²⁹ See note 25 above.
- ³⁰ Kaisernetwork.org. 2004. "'Sugar Daddies' Contribute to Spread of HIV in Africa, Experts Say." http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=24805
- ³¹ Liam Cochrane, "Sex Tourists Seek Virgins", *The Cambodia Daily* (6 July 2004).
- ³² Human Rights Watch, *Double Standards: Women's Property Rights Violations in Kenya* (2003).
- ³³ On this subject, see UNAIDS, *Sex Work and HIV/AIDS: Technical Update* (2002), especially pp. 2 and 7.
- ³⁴ "Sexuality, Violence and HIV/AIDS in Indonesia", presentation by Nafsiah Mboi, Vice-Chair, Indonesian National Commission on Violence Against Women, during the meeting with the Special Rapporteur in Jakarta in June 2004.
- ³⁵ Abdool Karim, 1998, "Women and AIDS - the imperative for gendered prognosis and prevention policy". Agenda No. 39: 15-25.
- ³⁶ See World Bank, *AIDS in Latin American Countries: The Challenges Ahead* (2003), p. 7.
- ³⁷ See, for example, the following reports by Human Rights Watch: *Ravaging the Vulnerable: Abuses Against Persons at High Risk of HIV Infection in Bangladesh*, vol. 15, No. 6 (C), (August 2003); *Epidemic of Abuse: Police Harassment of HIV/AIDS Outreach Workers in India*, vol. 14, No. 5 (C), (July 2002); *Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation*, vol. 16, No. 5 (D), (April 2004).
- ³⁸ See www.unfpa.org/gender/trafficking.htm
- ³⁹ Physicians for Human Rights, *No Status: Migration, Trafficking and Exploitation of Women in Thailand - Health and HIV/AIDS Risks for Burmese and Hill Tribe Women and Girls* (2004), p. 8. <http://www.phrusa.org/campaigns/aids/pdf/nostatus.pdf>
- ⁴⁰ Information received from the Government of Lithuania.
- ⁴¹ Information received from the Government of Portugal.
- ⁴² Horizons and Population Council, *Expanding Workplace HIV/AIDS Prevention Activities for a Highly Mobile Population: Construction Workers in Ho Chi Minh City* (2003).

- ⁴³ UNDP, *Dying of Sadness: Gender, Sexual Violence and the HIV Epidemic*, SEPED Conference Paper Series No. 1, (2002), p. 4.
- ⁴⁴ United Nations High Commissioner for Refugees, *Sexual and Gender based Violence against Refugees, Returnees, and Internally Displaced Persons: Guidelines for Prevention and Response* (2003), p. 42.
- ⁴⁵ Bennett, Olivia 1990. Panos Dossier: *Triple Jeopardy: Women and AIDS*.
- ⁴⁶ Panos Institute and UNICEF, *Stigma, HIV/AIDS and prevention of mother-to-child transmission: A pilot study in Zambia, India, Ukraine and Burkina Faso* (2001), p. 3.
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- ⁴⁸ *Stigma, HIV/AIDS and prevention of mother-to-child transmission ...*, p. 33.
- ⁴⁹ UNAIDS, *India: HIV and AIDS-related Discrimination, Stigmatization and Denial* (2001), pp. 16-17.
- ⁵⁰ *Ibid.*, 42.
- ⁵¹ *Just Die Quietly ...*, pp. 30-31. These findings are echoed in *Stigma, HIV/AIDS and prevention of mother-to-child transmission ...*, and in *Understanding HIV and AIDS-related Stigma and Discrimination in Viet Nam*, p. 35.
- ⁵² *Stigma, HIV/AIDS and prevention of mother-to-child transmission ...*, p. 36.
- ⁵³ *Disentangling HIV and AIDS Stigma in Ethiopia, Tanzania and Zambia ...*, p. 35.
- ⁵⁴ *Stigma, HIV/AIDS and prevention of mother-to-child transmission ...*, p. 17.
- ⁵⁵ *Disentangling HIV and AIDS Stigma in Ethiopia, Tanzania and Zambia ...*, p. 38.
- ⁵⁶ *India: HIV and AIDS-related Discrimination*, p. 9.
- ⁵⁷ Human Rights Watch, *A Test of Inequality: Discrimination against Women living with AIDS in the Dominican Republic* (2004), p. 27. <http://hrw.org/reports/2004/dr0704/dr0704.pdf>
- ⁵⁸ *India: HIV and AIDS-related Discrimination*, pp. 22-24.
- ⁵⁹ *Ibid.*, p. 24.
- ⁶⁰ *Stigma, HIV/AIDS and prevention of mother-to-child transmission ...*, p. 30.
- ⁶¹ International Council of AIDS Service Organizations (ICASO), *In-country Monitoring of the Implementation of the Declaration of Commitment Adopted at the United Nations General Assembly Special Session on HIV and AIDS - A Four Country Pilot Study* (2004), p. 22.

⁶² LACCASO and UNAIDS, *Magdalena's Story: The Reproductive Rights of a Street Teenager in Caracas* (1999), p. 23.

⁶³ *A Test of Inequality: Discrimination against Women living with AIDS in the Dominican Republic*, p. 41.

⁶⁴ *Stigma, HIV/AIDS and prevention of mother-to-child transmission ...*, p. 31.

⁶⁵ UNAIDS/UNFPA/UNIFEM, *Confronting the Crisis ...*, p. 20.

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⁶⁸ *Ibid.*, 14.

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⁷⁰ Center for Health and Gender Equity, *Gender, AIDS and ARV Therapies: Ensuring that Women gain equitable access to drugs within US funded Treatment Initiatives* (2004), p. 3.

⁷¹ *Ibid.*, p. 5.

⁷² UNAIDS/UNFPA/UNIFEM, *Confronting the Crisis ...*, p. 25.

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⁷⁴ WHO, *Integrating Gender into HIV/AIDS Programme: a Review Paper* (2003), pp. 27-41, especially p. 33.
