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

Ebenezer Durojaye*
Attorney, Centre for the Right to Health, Lagos, Nigeria

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

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

* LLB (Lagos), LLM (Free State); ebenezer1170@yahoo.com. The author is grateful to Prof Charles Ngwena of the University of the Free State for his comments on the earlier drafts of this article.

just 10% of the world’s population. Approximately 25 million people are living with the epidemic in Africa.\(^2\) Of this figure, women constitute about 13.5 million, that is, about 57% of the total number of people infected with HIV in this region.\(^3\) This is a rise of about 400 000 from the prevalence rate in 2003. In 2005 alone, not less than 3 million people worldwide (of which 2 million are from Africa) lost their lives to HIV/AIDS-related complications.\(^4\)

In countries such as Kenya, Uganda and Zimbabwe there were reports of a lower prevalence rate, while others, such as South Africa, Swaziland, Tanzania and Zambia recorded a high prevalence rate. The situation in Swaziland is of particular interest as recent figures of pregnant women attending antenatal programmes show that close to 43% of them are infected with HIV/AIDS.\(^5\) In the same vein, about 3.2 million people were newly infected on the continent at the end of 2005. Several years of gains in the area of economic and social development are being reversed. A report has shown a correlation between poor development and HIV/AIDS, in many very poor countries.\(^6\) In many African countries, life expectancies have fallen considerably, mainly due to HIV/AIDS. For instance, it is estimated that the life expectancy in Botswana will fall from 70 years to 40 years by 2010.\(^7\)

Although there exists no cure for HIV/AIDS, anti-retroviral drugs have been developed. These are useful in prolonging the lives of infected persons, thereby transforming HIV/AIDS from a death sentence into a manageable chronic disease. However, the hope of accessing treatment for persons infected by HIV in Africa is slim. Many people in dire need of treatment for HIV/AIDS are not getting it. Of the six million people in the world in need of anti-retroviral drugs, only about 440 000 have access.\(^8\) The situation is worse in Africa than in any other region. It is estimated that just 3% of people in need of treatment currently have access.\(^9\) For countries such as South Africa, it is estimated that at least 85% of those requiring anti-retroviral drugs were not receiving them by mid-2005.\(^10\) In countries such as Ethiopia, Ghana and Nigeria, the figure of those without treatment is about 90%.\(^11\)

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

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\(^2\) As above.
\(^3\) As above.
\(^4\) As above.
\(^5\) As above.
\(^7\) US Bureau of Census World population report (2000).
\(^9\) As above.
\(^10\) UNAIDS/WHO (n 1 above) 30.
\(^11\) As above.
pandemic had struck the hardest. As will be demonstrated below, a lack of access to treatment amounts to a violation of recognised rights in international and regional human rights instruments.

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

2 Philosophical basis of equity and access to treatment

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

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

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

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

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

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

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15 As above.
17 Ngwena (n 14 above) 292.
19 Ngwena (n 14 above) 292.
society. As Landman correctly argues, without access to health care one cannot effectively make autonomous choices, including realising one’s potential in a free society.\textsuperscript{20}

Beauchamp and Childress\textsuperscript{21} have identified three forms of justice – compensatory justice, distributive justice and liberal justice. Compensatory justice shows the reasons why certain people have to be compensated for wrongs they suffered in the past. It often requires proof of past discrimination. However, it has been observed that compensatory justice is not suitable for health care services ‘since mandating fair treatment for those who have suffered historical wrongs will not be compensation for them, but only the fair enforcement of nondiscriminatory health policies to which they are properly entitled’.\textsuperscript{22} Distributive justice aims at ensuring equitable availability of health resources to subgroups at abnormally high levels of risk. This may involve the adoption of the utilitarian approach which seeks to improve the welfare and capacities of the female half of society in order to increase overall social satisfaction and productivity. This rationale might justify programmes to promote equality in availability of services to ensure that women’s distinctive health needs are satisfied, such as maternity care. The liberal theory of justice accords women the autonomy, as rational beings, to make decisions with regard to their clinical care and to remove barriers such as the need for their husbands’ consent before medical treatment. This theory is faulted on the ground that it places emphasis on the abstract notion of autonomy without recognising women’s peculiar situation in society and the determinants of health, such as the impact of society’s structure on women’s reproductive roles which tend to hinder their access to health care services.\textsuperscript{23}

3 Access to treatment as a fundamental right

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

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  \item \textsuperscript{20} W Landman ‘Appropriate health care as a human right’ in A van Niekerk (ed) Health care as human right (1993) 37-40.
  \item \textsuperscript{21} TL Beauchamp & FJ Childress Principles of biomedical ethics (2001).
  \item \textsuperscript{23} As above.
\end{itemize}
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mental wellbeing'. The right to health is guaranteed in numerous international and regional human rights instruments.

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

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

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

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

25 UN General Assembly Special Session on HIV/AIDS Resolution A/S-26/L2 June 2001 para 15.
27 The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment No 14, UN Doc E/C/12/2000/4 para 3.
28 As above.
29 As above.
30 As above.
32 As above.
women in a non-discriminatory manner. According to the Committee, health care services must be gender sensitive and take into account the peculiar needs of women.

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

At the regional level, the right to health is guaranteed under article 16 of the African Charter on Human and Peoples’ Rights (African Charter).35 Article 16 states that everyone has the right to enjoy the best attainable state of physical and mental health. The African Commission on Human and Peoples’ Rights (African Commission) in Social and Economic Rights Action Centre (SERAC) and Another v Nigeria36 held that a violation of the right to health may lead to a violation of other rights such as life, human dignity and to a clean and healthy environment. The Women’s Protocol in article 14 contains important provisions relevant in advancing the sexual and reproductive health of women. Under article 14, states are required to ‘ensure that the right to health of women, including the sexual and reproductive health of women, is respected and promoted’. In addition, states should respect and promote:

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

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

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

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

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

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

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

37 See art 14 of the Women’s Protocol.
39 Eg, in D v United Kingdom (1997) 24 EHRR 423, the European Court on Human rights held a violation of the right to human dignity a purported deportation of an HIV-positive immigrant to his country of origin where treatment could not be guaranteed.
Simply put, the protection of negative rights demands not more than forbearance, while the protection of positive rights demands a redistribution of resources.\textsuperscript{42}

4 Factors affecting women’s access to HIV treatment

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

4.1 Discrimination

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

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

\textsuperscript{42} As above.

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

\textsuperscript{44} As above.


\textsuperscript{46} n 45 above, 24.
Discrimination is a violation of recognised human rights under international human rights law. Under article 1, CEDAW enjoins states to take steps and measures to eliminate discrimination against women within their territories.

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

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

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

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47 See art 12 of the Women’s Protocol, which drew its inspiration from art 2 of CEDAW.
50 Fourth World Conference on Women, Beijing held on 15 September 1995 A/CONF.177/20.
51 UN Millennium Declaration and Millennium Development Goals launched in 2000.
52 General Recommendation No 24 (n 33 above).
53 Cook (n 22 above).
The Canadian Supreme Court in *Eldridge v British Columbia (Attorney-General)* has held that failure to make money available for sign language interpretation that would equip hearing-impaired patients to communicate with health services providers in the same way as unimpaired patients can constitute discrimination in violation of the Canadian Charter on Rights and Freedoms. This decision of the Court is relevant in ensuring equality for all and in particular for people with disabilities in accessing treatment. The reasoning of the Court in this case can also be relied upon to demand equity in access to HIV treatment for women in Africa. The decision also confirms the fact that courts have an important role to play in holding governments accountable for failing to ensure equity in the provision of medical care.

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

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

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

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54 (1977) 151 DLR (4th) 577.
55 Fourth World Conference on Women Programme of Action Strategic Objective C1 (n 50 above).
56 UN follow-up meeting of the ICPD held in New York between March and June 1999, para 68.