USING LITIGATION TO ADDRESS GENDER VIOLATIONS IN THE HIV/AIDS CONTEXT

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I. INTRODUCTION

Litigation is becoming an increasingly attractive advocacy tool for human rights movements around the world. It has served as an effective strategy not only for reforming or enforcing laws that deny or protect basic human rights, but also for raising awareness of and mobilizing support for human rights issues. To be sure, there are critiques of using litigation in human rights advocacy,[1] and a favorable court ruling is not a panacea for the suffering of victims or systemic human rights violations in a given country. Nonetheless, as experiences in human rights litigation prove, courts and other judicial fora can fill a critical but often missing role within broader advocacy efforts by holding governments accountable for their human rights obligations under national and international laws.

Litigation has long been used to address certain civil and political rights issues within the more "mainstream" discourse on human rights. However, it is a more recent strategy in the realm of economic and social rights, such as the right to health, and issues particular to certain groups, such as women

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[1] Critiques include questioning whether the grievances of the plaintiff are actually heard and addressed by litigation and whether the lawyers involved are acting in the best interest of their client or of the case and the community it might impact. *See Litigating Human Rights: Promise v. Perils*, HUMAN RIGHTS DIALOGUE 2(2) (Spring 2000), *available at* http://www.cceia.org/resources/publications/dialogue/2_02/index.html.

or people living with HIV/AIDS. Despite the still nascent development of litigation in these areas, there have been important if not landmark successes, for example, in the areas of reproductive rights and HIV/AIDS. Victories in these areas attest to the potential of using litigation to address human rights violations in the context of access to health care and, for the purposes of this article in particular, the sex- and gender-dimensions of such violations.

This article focuses on a specific area within the realm of women's health and rights: the rights of HIV-positive women and girls. In particular, we address violations women experience vis-à-vis access to health care and aim to show the possibilities for litigation to help advance efforts to protect and promote human rights in this area. Violations against women and girls living with HIV/AIDS in the health-care context have been documented in countries around the world. However, litigation largely has not addressed these issues, despite increasing resort to the courts on broader issues relating to HIV/AIDS and the rights of positive individuals. Part II of this article provides an overview of HIV-related litigation to date and identifies an absence of gender analysis in the existing body of jurisprudence. Notwithstanding this gap, there is increasing international recognition of the gender-specific dimensions of human rights violations in the HIV context.[2] Part III discusses this growing awareness and outlines some of the documented violations against HIV-positive women and girls, with a particular focus on the health-care context. Part IV shares the experience of the Center for Reproductive Rights and collaborating organizations in litigating reproductive health and rights issues. Judicial successes in this context indicate the potential of using litigation to hold governments accountable for gender-related violations in health-care systems, including those experienced by women and girls living with HIV.

II. LITIGATION IN THE HIV/AIDS CONTEXT

To date, most HIV-related litigation has primarily (but not exclusively) focused on three thematic areas: access to treatment and health services, discrimination against positive individuals, and prevention and care in prisons.[3] Litigation in this field has yet to focus on gender issues, despite growing recognition that the disease not only disproportionately affects

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[2] Comm. on the Elimination of Discrimination against Women, *Gen. Recommendation No. 15, Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, 9th Sess., U.N. Doc. A/45/38 (1990); Comm. on the Elimination of Discrimination against Women, *Gen. Recommendation No. 24, Women and Health*, 20th Sess., U.N. Doc. A/45/38/Rev.1, ch. 1 (1999).

[3] UNAIDS, COURTING RIGHTS: CASE STUDIES IN LITIGATING THE HUMAN RIGHTS OF PEOPLE LIVING WITH HIV 8 (2006) [hereinafter COURTING RIGHTS].

women, but also affects them in different ways.[4] Yet, in a UNAIDS survey of HIV-related litigation, only one of thirty-two highlighted cases specifically involved the rights of HIV-positive women.[5]

Minister of Health v. Treatment Action Campaign involved a South African government policy restricting the availability of Nevirapine, an antiretroviral drug used to prevent or reduce HIV transmission from mother to child at birth, in public health facilities. More broadly, it challenged the South African government's failure to implement a comprehensive national program to prevent mother-to-child transmission of HIV that would include voluntary testing and counseling for pregnant women. The Treatment Action Campaign, a non-governmental organization that advocates for the rights of people with HIV, argued that the policy violated women's rights to access to health care, information, and nondiscrimination. The case ultimately made its way to the Constitutional Court of South Africa, which ordered the government to remove restrictions on the availability of Nevirapine in public facilities and take measures to expand voluntary testing and counseling for women.[6]

Most other cases involving access to treatment deal generally with state obligations to ensure access to HIV treatment or the obligations of pharmaceutical companies to make treatment more affordable, but fail to address the specific needs or experiences of positive women.[7] International policy documents recognize that women may be the last group to have

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[4] *See, e.g.,* Susan Paxton et al., *"Oh! This One is Infected!": Women, HIV & Human Rights in the Asia-Pacific Region,* Expert Meeting on HIV/AIDS and Human Rights in Asia-Pacific, Bangkok, Thailand, Mar. 23-24, 2004 [hereinafter Expert Meeting on HIV/AIDS]; *see* The Secretary-General, *Report of the Secretary-General on the Declaration of Commitment on HIV/AIDS: Five Years Later*, para. 12, U.N. Doc. A/60/736 (Mar. 24, 2006); *see also* Declaration of Commitment on HIV/AIDS, G.A. Res. S-26/2, para. 4, U.N. GAOR, 26th Special Sess., U.N. Doc. A/RES/S-26/2 (Aug. 2, 2001).

[5] *See* COURTING RIGHTS, *supra* note 3.

[6] *Minister of Health v. Treatment Action Campaign* 2002 (5) CC (S. Afr.), *available at* http://www.tac.org.za/Documents/MTCTCourtCase/ConCourtJudgmentOrderingMTCTP-5July2002.pdf.

[7] *See, e.g.,* Luis Guillermo Murillo Rodrigues et al. v. Caja Costarricense de Seguro Social, Constitutional Chamber of the Supreme Court of Justice (1997) (Costa Rica) (finding that Social Security must cover the cost of antiretroviral drugs for people living with HIV/AIDS); *see* Jorge Odir Miranda Cortez v. El Salvador, Case 12.249, Inter-Am C.H.R., Report No. 29/01 (2001) (holding that the State must provide antiretroviral treatment); *see also* AIDS Access Found. v. Bristol Myers-Squibb Co., Black Case No. Tor Por 34/2544, Red Case No. 92/2545 (2002) (Thailand) (successful challenge to a pharmaceutical company's patent on an antiretroviral drug); *see also* Edgar Mauricio Carpio Castro v. Programa Nacional del SIDA-VIH-ITS, Constitutional Tribunal (Third Chamber), Decision No. 0749-2003-RA (2004) (Ecuador) (ordering the government to ensure a continuous supply of antiretroviral drugs).

access to drugs under facially neutral laws and policies.[8]

Most litigation on HIV-related discrimination concerns the employment context, such as employers' refusal to employ, or dismissal of, people with HIV, or illegal military discharge on the basis of HIV status.[9] Discrimination cases have also included employee dismissals for refusing to submit to compulsory HIV testing. But, again, the disparate impact of such policies on women has received little attention.[10] Issues concerning HIV prevention and care in prisons have also been litigated in high-level courts around the world. These cases have dealt mainly with the provision of condoms to prisoners, access to HIV treatment for prisoners, and inadequate medical care in prisons.[11] While the achievements of litigation in all of these areas have also benefited women with HIV, there is increasing international recognition of the need to address the specific gender dimensions of human rights violations in the HIV/AIDS context, which have gone largely unaddressed in the courts.

III. INTERNATIONAL RECOGNITION OF GENDER-SPECIFIC VIOLATIONS IN THE HIV/AIDS CONTEXT

International human rights bodies have recognized that women and girls with HIV experience violations of their basic human rights in ways that, because of their gender, are unique to them.[12] Gender-based violations are

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[8] OFFICE OF THE UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS & THE JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS), HIV/AIDS AND HUMAN RIGHTS: INTERNATIONAL GUIDELINES: REVISED GUIDELINE 6, at 16, 2002 ("[C]hildren (particularly girls) and women may be the last to receive access even if treatment is otherwise available in their communities.").

[9] *See, e.g.,* MX v. ZY, AIR 1997 Bom 406 (High Court of Judicature, 1997) (India) (ruling against an employer's policy of refusing to hire HIV-positive persons); *see* JRB v. Ministry of Defence, Case No. 14000, Supreme Court of Justice (Political-Administrative Bench) (1998) (Venezuela) (upholding the Ministry of Defence's policy preventing HIV-positive personnel from continuing their active duty).

[10] *See, e.g.,* Diau v. Botswana Building Society (BBS), Case No IC 50/2003, Industrial Court (2003) (Botswana) (finding that an employee cannot be dismissed for refusing to submit to an HIV test).

[11] *See, e.g.,* R. v. Sec. State for the Home Department *ex parte* Glen Fielding [1999] EWHC Admin 641 (High Court of Justice, Queen's Bench Division) (upholding the Home Department's policy of making condoms available to prisoners only through a doctor's prescription); *see* Van Biljon v. Minister of Correctional Services (1997) 50 BMLR 206, High Court (Cape of Good Hope Provincial Division) (South Africa) (stating that where combination antiretroviral treatments had been prescribed medically to specific prisoners, those prisoners had the constitutional right to the provision of the drugs at state expense); *see also* Leatherwood et al. v Cambell, No. CV-02-BE-2812-W (N.D. Al. 2004) (finding that inadequate medical care for HIV-positive prisoners is a violation of rights).

[12] Comm. on the Elimination of Discrimination against Women, *Gen. Recommendation*

especially prominent in the health-care setting. A multitude of studies from around the world have documented coercive practices and violations of informed consent in testing women for HIV during pregnancy or delivery.[13] Many women in these situations have their rights violated again when doctor-patient confidentiality is breached and their HIV status is reported to others without their permission.[14] Societal and cultural notions of women as subordinate in relation to men and within the family structure contribute to the practice and acceptability of informing a woman's husband or father of her HIV status, before she herself is notified.[15]

Also prevalent is discrimination by health-care personnel. Women with HIV have been turned away from public health facilities,[16] directed to private hospitals specializing in HIV care,[17] subjected to delays in receiving essential treatment,[18] and forced to pay extra fees for services.[19] Pregnant women who arrive at health facilities in the middle of delivery are tested for HIV and directed to other facilities if the results are positive.[20] In cases where a woman with HIV requires a caesarian section, there are reports that

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No. 15, Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS), 9th Sess., U.N. Doc. A/45/38 (1990); Comm. on the Elimination of Discrimination against Women, *Gen. Recommendation No. 24, Women and Health*, 20th Sess., U.N. Doc. A/45/38/Rev.1, ch. 1 (1999).

[13] *See* HUMAN RIGHTS WATCH, A TEST OF INEQUALITY: DISCRIMINATION AGAINST WOMEN LIVING WITH HIV IN THE DOMINICAN REPUBLIC 29 (2004) (describing women tested when they sought health care services unrelated to HIV/AIDS despite domestic law prohibiting it) [hereinafter A TEST OF INEQUALITY]. In a survey of HIV-positive people in four Asian countries, one in eight reported being coerced into testing, usually in the context of pregnancy or employment, and women were more likely to be coerced into a test than men. Additionally, of the women tested during pregnancy, 35% of them were told the test was mandatory. ASIAN PACIFIC NETWORK OF PEOPLE LIVING WITH HIV/AIDS, AIDS DISCRIMINATION IN ASIA 17, 20 (2004) [hereinafter AIDS DISCRIMINATION IN ASIA].

[14] A TEST OF INEQUALITY, *supra* note 13, at 29, 35-39; AIDS DISCRIMINATION IN ASIA, *supra* note 13, at 17, 18 (one in three people surveyed said someone else had been informed of their HIV status without their consent, some before they themselves were told).

[15] UNAIDS, INDIA: HIV AND AIDS-RELATED DISCRIMINATION, STIGMATIZATION AND DENIAL 24, U.N. Doc. UNAIDS/01.46E (Aug. 2001) (*prepared by* Shalini Bharat).

[16] AIDS DISCRIMINATION IN ASIA, *supra* note 13, at 18 (finding that 15% of the respondents who had been discriminated against by a health-care worker were refused treatment).

[17] INDIA: HIV AND AIDS-RELATED DISCRIMINATION, STIGMATIZATION AND DENIAL, *supra* note 15, at 26.

[18] *Id.* (describing how some surgeries are delayed or cancelled upon discovery of the patient's HIV status on the basis that "it might not be of much use to the patient").

[19] AIDS DISCRIMINATION IN ASIA, *supra* note 13, at 18 (finding that 9% of the respondents who had been discriminated against by a health-care worker had to pay extra for services and treatment).

[20] AIDS DISCRIMINATION IN ASIA, *supra* note 13, at 19 ("When arriving at the hospital about to give birth, I was told, 'You're not fit to give birth here.'").

positive women must wait until all caesarian sections on non-positive women have been completed for the day before they may have the operation.[21] Hospitals and doctors also routinely require women with HIV to purchase AIDS kits containing gloves and aprons that other patients are not required to provide.[22] Furthermore, HIV-positive women have been denied medically-beneficial procedures or, alternately, forced to submit to medically unnecessary procedures. Some women have been encouraged to terminate their pregnancy after testing positive[23] and denied information on available methods to reduce perinatal transmission.[24] In other instances, women who learn of their HIV status after conceiving and wish to terminate their pregnancy face obstacles in obtaining safe abortions, even where the procedure is legal.[25] Also disturbing are reports that access to abortion for HIV-positive women has been contingent upon the woman's agreement to sterilization.[26] Instances of forced or coerced sterilization of HIV-positive women have been documented in countries in Latin America, Asia, Africa, and Eastern Europe.[27]

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[21] A TEST OF INEQUALITY, *supra* note 13, at 41-42.

[22] INDIA: HIV AND AIDS-RELATED DISCRIMINATION, STIGMATIZATION AND DENIAL, *supra* note 15, at 27.

[23] *Id.* at 43; AIDS DISCRIMINATION IN ASIA, *supra* note 13, at 21 (finding that 12% of all HIV-positive women surveyed had been coerced into having an abortion or being sterilized).

[24] AIDS DISCRIMINATION IN ASIA, *supra* note 13, at 20 (finding that almost one-third of the respondents—45% of women and 18% of men—were advised not to have children after being diagnosed with HIV, but only one in five was given information on preventing perinatal transmission of the virus); *see also Living in Hope*, THE HINDU, Apr. 1, 2001, *available at* http://www.hinduonnet.com/2001/04/01/stories/13010619.htm.

[25] IPAS, REPRODUCTIVE RIGHTS FOR WOMEN AFFECTED BY HIV/AIDS?: A PROJECT TO MONITOR MILLENNIUM DEVELOPMENT GOALS 5 AND 6, at 44 (2005); *see also* IPAS, HIV/AIDS AND REPRODUCTIVE HEALTH: SENSITIVE AND NEGLECTED ISSUES: A REVIEW OF THE LITERATURE AND RECOMMENDATIONS FOR ACTION 44-46 (2005).

[26] INTERNATIONAL COMMUNITY OF WOMEN LIVING WITH HIV/AIDS VISION PAPER 1: HIV POSITIVE YOUNG WOMEN 3 (2004) ("I did not want to have a child at this stage and requested the pregnancy be terminated. The doctors only agreed to the termination on condition that I consented to sterilisation. I had no option.") [hereinafter ICW VISION PAPER 1].

[27] INTERNATIONAL COUNCIL OF AIDS SERVICE ORGANIZATIONS [ICASO], COMMUNITY MONITORING AND EVALUATION: IMPLEMENTATION OF THE UNGASS DECLARATION OF COMMITMENT ON HIV/AIDS 19 (2006) (reporting that women in El Salvador have been forced to be sterilized because of their HIV status); ICW VISION PAPER 1, *supra* note 26, at 3; AIDS DISCRIMINATION IN ASIA, *supra* note 13, at 21; A TEST OF INEQUALITY, *supra* note 13, at 39-41 ("[D]octors sometimes imposed a 'decision' to sterilize women living with HIV, and ... women were given inadequate or misleading information about the benefits or drawbacks of sterilization procedures.").

IV. LITIGATION IN THE REPRODUCTIVE RIGHTS CONTEXT

The experiences of the Center for Reproductive Rights ("the Center") and collaborating organizations in litigating reproductive rights cases demonstrate the potential of using litigation to address the sex and gender dimensions of health and human rights violations, such as those that occur in the HIV/AIDS context. Such litigation has addressed violations that are often similarly at issue in the experiences of women and girls with HIV within health-care systems, and advanced rights and principles that have important applications in the latter context. These include principles of government accountability for protecting its citizens from harm and respecting women and girls' rights to physical integrity, autonomy, informed consent, and access to quality health services free from discrimination, coercion, and violence.

Nowhere are these rights and principles more at stake than in the case of forced and coerced sterilizations. Throughout history, societies have forcibly sterilized women who are mentally disabled, socially undesirable, members of racial or ethnic minorities, or simply impoverished.[28] The practice has been documented and addressed by activists worldwide, including the Center, which has worked with its partners in South Asia, Eastern Europe, and Latin America on the issue. In India, the Center supported a petition by the Human Rights Law Network to the Indian Supreme Court alleging human rights violations resulting from abusive practices, poor quality of care, and noncompliance with consent requirements in government-run sterilization camps. The Center submitted legal memoranda to the Court on the illegality of coercive sterilization under international law, and an analysis of possible remedial measures using comparative examples from other countries that have confronted such abuses. A final decision on the petition is pending, but the Court issued an interim order in 2005 requiring state governments to take immediate steps to regulate health-care providers who perform sterilization procedures. The interim order also required the state to compensate women who suffered complications due to sub-standard practices and the relatives of victims who died from botched operations.

The Center was also a co-petitioner in *Maria Mamerita Mestanza Chavez v. Peru*. Mestanza, a Peruvian woman with seven children, was coercively sterilized in 1996 after local health officials threatened criminal

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[28] *See generally* EZRA GOSNEY, STERILIZATION FOR HUMAN BETTERMENT: A SUMMARY OF RESULTS OF 6,000 OPERATIONS IN CALIFORNIA, 1909-1929 (1929); *see generally* JENNIFER NELSON, WOMEN OF COLOR AND THE REPRODUCTIVE RIGHTS MOVEMENT (2003); *see generally* HARRY BRUINIUS, BETTER FOR ALL THE WORLD: THE SECRET HISTORY OF FORCED STERILIZATION AND AMERICA'S QUEST FOR RACIAL PURITY (2006).

action and loss of food aid if she did not undergo the procedure.[29] She developed complications from the procedure and died a few days later. The Inter-American Commission on Human Rights (IACHR) settled the case in 2003. Under the final settlement, the Peruvian government acknowledged international legal responsibility and agreed to compensate Mestanza's husband and children. In addition, the government agreed to modify and implement recommendations made by Peru's Human Rights Ombudsman concerning patients' rights and sterilization procedures in government facilities.[30]

The Center and its partners have also used litigation strategies to hold governments responsible for violence against women in public health facilities. In *MM v. Peru*, a doctor drugged and raped a 19-year-old Peruvian woman when she came in for medical services. As required, the victim filed a criminal report with local authorities, but the doctor was acquitted after an openly discriminatory judicial process. The Center, in conjunction with Study for the Defense and the Rights of the Woman (DEMUS) and the Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), filed a petition with the IACHR alleging violations of her rights to, *inter alia*, life, physical integrity, health, and liberty. The parties eventually reached a friendly settlement in 2000 and the government agreed to pay compensation to the victim, professionally sanction the doctor, improve legal and administrative measures involving sexual violence claims, and, most importantly, admit responsibility under international law for the violation of MM's human rights.

Adolescents' rights, including access to medically necessary health and reproductive health care, have also been the subject of the Center's litigation efforts. In *KL v. Peru,* Peruvian health officials denied an abortion for a 17-year-old Peruvian woman carrying a fetus with a fatal anomaly (anencephaly), despite Peruvian law's exception allowing for pregnancy termination for health reasons. The young woman was compelled to carry the fetus to term and forced to feed the baby until its inevitable death several days later. The Center, DEMUS, and CLADEM filed a complaint with the UN Human Rights Committee charging government officials with a failure to protect the petitioner's rights under the Civil and Political Rights Covenant to be free from inhumane and degrading treatment, to privacy, and to special protection on account of her status as a minor. The Committee

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[29] Maria Mamerita Mestanza Chavez v. Peru, Case 12.191, Inter-Am. C.H.R., Report No. 66/00 OEA/Ser. L/V/II.111, doc. 20 (2000), *available at* http://www.cidh.org/annualrep/2000eng/ChapterIII/Admissible/Peru12.191.htm.

[30] Friendly Settlement, Maria Mamerita Mestanza Chavez v. Peru, Case 12.191, Inter-Am. C.H.R., Report No. 71/03, OEA/Ser. L/V/II.111, doc. 20 (2003), *available at* http://www.cidh.org/annualrep/2003eng/Peru.12191.htm.

issued its decision in 2005, establishing that denial of access to abortion services where legal violates women's basic human rights. This decision marked the first time that an international human rights body held a government accountable for failing to ensure access to legal abortion services.

V. CONCLUSION

HIV/AIDS-related litigation to date has made important gains in protecting and promoting the human rights of people living with HIV/AIDS. However, this litigation has largely omitted the specific needs and experiences of women and girls, who comprise an ever-increasing proportion of HIV-positive individuals. Increasingly, sex- and gender-based violations in the HIV/AIDS context are being documented and recognized both by activists on the ground and international human rights bodies. Litigation is but one strategy to begin addressing these violations, but a critical one nonetheless that can support and complement other advocacy efforts. As demonstrated in the reproductive rights context, litigation has proven effective in raising and remedying violations of women's human rights in the health-care context, and holding governments accountable for their human rights obligations under national and international laws. These successes point to the potential of using litigation in still further areas of women's health and rights, including efforts to advance the rights of women and girls with HIV.