Health and reproductive rights, HIV and the Protocol to the African Charter on the Rights of Women in Africa

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The overarching goal of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women's Protocol or Protocol) is to bring about gender equality in Africa, the converse of which is fuelling the spread of HIV on the continent. The Protocol includes corresponding and comprehensive measures to be taken by states in order to promote, protect, and fulfil women's human rights in Africa. It addresses many of the root causes of the disproportionate spread of HIV among young women in Africa, such as sexual violence and early marriage, as well as factors that exacerbate the effects of HIV infection on the enjoyment of human rights, such as the denial of inheritance rights (article 21).

Health and reproductive rights are provided for in article 14 of the Women's Protocol, including women's rights to, among others, control their fertility; choose any method of contraception; decide whether to have children, how many to have and their spacing; and to receive family planning education. It is the first binding international human rights treaty to guarantee the right to abortion under qualified circumstances, as well as the right to be protected from HIV infection (article 14(2)(c). The Women's Protocol offers greater protection for the reproductive rights of women than any other legally binding international human rights instrument. That provisions explicitly relating to HIV are grounded in the Protocol reiterates at least two important points: that HIV is a human rights issue and that HIV has a disproportionate impact on African women and girls. The inclusion of rights relating to HIV explicitly under health and reproductive rights confirms that challenges to women's reproductive health are compounded in the context of the HIV pandemic.

Along with the provisions in international human rights law that are specific to reproductive health rights, numerous other human rights principles, enshrined in the Women's Protocol and other defining international human rights instruments, are applicable to the promotion and protection of HIV-positive women's reproductive health rights. These include, but are not limited to: the right to equality and to be free from all forms of discrimination; rights relating to individual freedom, self-determination and autonomy; rights regarding survival, liberty, dignity and security; rights regarding family and private life; rights to information and education; and the right to the highest attainable standard of health. Violations of women's reproductive health rights are cross-cutting and inhibit the enjoyment of numerous other rights. While women living with HIV have the same rights concerning their reproductive health as other women, they also have needs and concerns that are unique and they may be confronted with violations of their rights on the basis of their HIV status. These are elaborated below.

The right to control fertility

Violations of reproductive autonomy negatively affect women's empowerment, of which being able to make informed decisions is an integral component. The right to control one's fertility exists regardless of HIV status. Many women desire children for a variety of personal reasons and cannot imagine a life where such a desire is left unfulfilled. Others do not want children at all or do not want to have more children beyond those they already have, yet they are unable to prevent unplanned pregnancies due to an inability to negotiate safe sex, or to a lack of access to adequate information provided by well-resourced family planning services. When confronted with an unplanned and unwanted pregnancy, many women are unable to safely terminate the pregnancy due to prohibitive abortion laws in their countries.

Studies show that more than 80% of all women living with HIV, and their partners, are in their reproductive years. An enabling environment for informed choice is required for women living with HIV to choose whether or not to have children, how many, and when. In the context of pregnancy, the right to control one's fertility creates a complicated intersection between HIV status and women's childbearing desires. Despite increased availability of state-provided treatment, HIV-positive women's health can be threatened during pregnancy and labour. There is also a risk of babies becoming infected with HIV via perinatal transmission. This scenario creates a conflict for women living with HIV and impacts on their reproductive decision-making, whether it relates to a desire to reproduce or to inhibit reproduction.

There are numerous impediments that inhibit African women's capacity to exercise their right to make coercion-free decisions concerning their fertility. Social norms and cultural values can place significant pressure on women to bear at least one child, although more are usually expected. Women's value to family and society can be determined by doing this. However, HIV-positive women face strong pressure from community members and health

care providers to give up the idea of having children, either because of the risk of mother-to-child transmission of HIV or out of concern for the welfare of children whose parents may die prematurely of AIDS-related illnesses. A considerable number of service providers are of the opinion that pregnancy ought to be prevented at all costs in HIV-infected women.

Some HIV-positive women still maintain their desire to have children. A study in South Africa found that personal desires and family and societal expectations frequently outweighed the influence of HIV status in determining whether or not to have children. Hope, happiness and a reason for living were cited as factors influencing the desire for children among HIV-positive men and women. However, concerns were also noted in the same study about childbearing, including the health of the infant, the risk of deteriorating health during pregnancy, fears of infecting an uninfected partner while trying to conceive and the possibility of dying and condemning a child to orphanhood.

Along with the importance assigned to childbearing in sub-Saharan Africa and the accompanying social pressure for women to produce offspring, as well as personal desires for motherhood, HIV-positive women are confronted with unique factors influencing their reproductive decisions.

Control over one's body and fertility is more easily exercised in situations where one is informed and empowered to make relevant decisions, particularly where one is HIV-positive. In Africa, however, many women are poor and disempowered. They are thus susceptible to directive counselling or outright coercion where the power relations are unequal between themselves and those they confront in the health-care system. Health-care workers, untrained in human rights, will act on their own judgement, which may be clouded by personal perceptions or their own notions of morality. A human rights-based approach to reproductive health and HIV, guided by the Women's Protocol, is necessary to protect the rights of HIV-positive women to control their fertility. This would require that legislation, policies and guidelines based on internationally accepted human rights norms are enacted and implemented.

Family planning and access to contraceptive services

The 2011 Millennium Development Goals Report indicates that in sub-Saharan Africa, one in four married women has an unmet need for family planning. The right to choose whether and when to have a child lies at the core of reproductive rights. The right to family planning is enshrined explicitly in the Women's Protocol. In order for HIV-positive women to make an informed decision regarding childbearing they must be informed and given access to safe, effective, affordable and acceptable methods of family planning of their choice, along with other reproductive health-care services and the means to make use of such facilities.

There is a direct relationship between a woman's fertility rights and contraceptive services available. The World Health Organisation (WHO) has confirmed the effectiveness and safety of the use of contraceptives by HIV-positive women. However, the reproductive rights of HIV-positive women are curtailed where access to safe and effective contraception is limited. A study conducted in Botswana (Weiser 2006), for example, indicates that women's desire to control their fertility is hampered by the limitations of available contraceptive options. The South African Litigation Centre (2009) documented that HIV-positive women in Zambia reported difficulty in asking for and accessing forms of contraceptives other than condoms. One woman reported having been told that requesting other forms of contraception is a confirmation of not using condoms, and therefore of exposing others to risk and exposing oneself to re-infection and more infections. Even where contraceptives are available, women often do not possess adequate information to make the appropriate choice. There is a need for explicit policies that recognise reproductive choice in HIV-infected individuals, including improved access to contraception and other reproductive health-care services.

Difficulties women have in negotiating condom use with men are widely recognised. To address this challenge and others, increasing access to and quality of family planning services must be undertaken together with ongoing initiatives, guided by prescribed actions in the Women's Protocol, toward gender equality, particularly through education, economic empowerment and eradication of violence against women. Where gender inequality prevails, women are unable to decide freely on whether or not to bear children regardless of the availability and quality of services in place.

Access to legal abortion

Restrictions on abortion have devastating effects on women's health and rights. In Africa, where 13% of maternal deaths are the result of unsafe abortion (White 2009), the risk of dying following unsafe abortions is the highest worldwide. Many African countries have restrictive abortion laws, which violate women's rights to reproductive autonomy and fail to take into account the reality of women's lives. Prohibitive abortion laws only affect women's health, not men's; therefore, denial of abortion services also violates the right to equality and non-discrimination enshrined in the Women's Protocol and other regional and international human rights instruments.

In light of unplanned pregnancies, impediments to reproductive choice must be considered. Many pregnancies, for example, are the result of sexual violence, including within marriage, which in many African countries can occur with impunity in the absence of legislation addressing marital rape. In many countries in sub-Saharan Africa, children are being forced into marriage and into bearing children. Other unintended pregnancies result from ignorance as a result of a lack of sex education. Many women cannot negotiate safe sex in their relationship and others cannot access contraceptives because, for example, they are only available in urban centres, which are often

beyond the reach of rural women. Unplanned pregnancies among HIV-positive women can have serious negative health consequences if they require but do not receive treatment, or if they are not in an optimum state of health pre-conception.

The Joint United Nations Programme on HIV/AIDS (UNAIDS 2008) recommends that women living with HIV should have a right to choose to terminate a pregnancy upon learning of their HIV status and should be supported to do so without judgement. Some legal experts believe that it is unnecessary to specifically mention HIV as one of the grounds to terminate a pregnancy because HIV status should entitle women to legal abortions, where abortion is permitted to protect a woman's health or life as provided for in the Women's Protocol. This move should, however, not be used to coerce or pressure HIV-positive women into having abortions in cases where they desire to have children.

Forced or coerced sterilisation

Research carried out by the International Community of Women Living with HIV (ICW 2009) documented 40 instances of coerced or forced sterilisation in Namibia, in which informed consent was not adequately obtained. According to the ICW, consent was either obtained under duress, or it was invalid as the women were not informed of the contents of the documents they signed, or medical personnel failed to provide full and accurate information regarding the sterilisation procedure. Women were also asked to provide signed consent for sterilisation in order to access other services, including abortion and caesareans and to receive assistance with childbirth. Similar cases have been documented in South Africa and Zambia. Three Namibian women are currently seeking redress in the High Court. If local mechanisms are exhausted without success, the cases should be brought before the African Commission on Human and Peoples' Rights or the United Nations Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) Committee.

Compulsory sterilisation or abortion adversely affects women's physical and mental health, and infringes upon the right of women to control their fertility and to decide on the number and spacing of their children. It violates other human rights, including the right to be free from cruel, inhuman and degrading treatment; the right to liberty and security of person; the right to bodily integrity; and the right to equality and to be free from discrimination. The International Federation of Gynecology and Obstetrics (FIGO 2006), in outlining ethical considerations in sterilisation, stated that no incentives should be given or coercion applied to promote or discourage any particular decision regarding sterilisation. Withholding other medical care by linking it to sterilisation is unacceptable. Because sterilisation is permanent, the decision made by the woman should be based on voluntary informed choice and should not be made under stress or duress.

Restrictions on women's reproductive choices are bound to fuel discrimination and stigma against HIV-positive women, subjecting them to double discrimination. Forced sterilisation, for example, will also lay additional favourable ground for further discrimination in societies that emphasise fertility and childbearing as a defining factor in women's successful contribution to the extended family and society as a whole.

Conclusion

Barriers to controlling their fertility, unmet family planning needs and lack of access to contraceptive services, restrictive abortion laws, and coerced or forced sterilisation, are all issues confronted by women living with HIV, which threaten their rights guaranteed under the Women's Rights Protocol. National legal frameworks must be strengthened to address the HIV-related discrimination that fuels violations of these enshrined rights. At the same time, other non-legal measures, such as awareness-raising and education campaigns, must be undertaken towards the same end.

To create an enabling environment for women to exercise their right to control their fertility, intersecting factors such as inequality and violence against women must be addressed through law and policy and accompanying implementation mechanisms with dedicated adequate financial resources. The 23 African states that have not yet ratified the Protocol should be encouraged to do so in order that they may also be held accountable to commitments to promote, protect, and fulfill the rights of women living with HIV, including their health and reproductive rights.

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The full report can be downloaded at **http://www.chr.up.ac.za/images/files/research/gender/publications/gender_realising_right_to_health_hiv_southern_africa.pdf.**

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