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A human rights response to cervical cancer in Africa

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This article examines the prevalence and impacts of human papilomavirus (HPV) transmission among women in Africa. It then examines the relevance of a rights-based approach to health-related challenges such as cervical cancer. In particular, the article argues that ensuring access to comprehensive programmes for the prevalence and impact of cervical cancer in Africa is a human rights issue which demands the urgent attention of African governments. The article then discusses two broad barriers (socio-cultural factors and failure of the health care systems in Africa) to the prevention and treatment of cervical cancer. Thereafter, the article suggests the human rights framework that African governments can adopt to ensure access to the prevention and treatment of cervical cancer. It concludes that African governments would need to do more than what presently exists in the region with regard to improving HPV treatment.

Keywords: human rights; cervical cancer; sexual and reproductive rights; Africa

I Introduction

Cervical cancer death rates have started to decline in the developed nations, thanks largely to a wide spread of affordable and accessible screening programmes that detect cancers at early treatable stages. Conversely, however, the early detection tools and treatment technology that have helped control cancer in wealthier lands are often not readily available in many other countries. Rising life expectancy in these nations along with the adoption of modern lifestyles will unfortunately leave many more people vulnerable to cancer. As a result cervical cancer has been on the rise in developing countries.[1] Currently, the most acceptable way to prevent cervical cancer is through regular gynaecological screening and treatment of precancerous human papilomavirus (HPV) lesions. In developing countries, however, this method has had only a limited impact due to cultural beliefs, lack of access to health services and screening, which are either non-existent or reach few of the women who need it. This is due to cost and complexity of screening and treating women and ignorance with regard to the disease.[2] Although the disease represents a major health inequity, it has been neglected as a public health priority and control efforts continue to fail.[3]

In African countries the impact of cervical cancer is often thought to pale in contrast with other illnesses such as common infectious diseases like tuberculosis (TB), human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS). Cervical cancer is however a common disease in sub-Saharan Africa and it is associated with a high mortality

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rate.[4] Cervical cancer is estimated to account for up to 80 per cent of all gynecological cancer-related admissions in several African countries.[5] Indeed, a report has it that every two minutes a woman dies as a result of cervical cancer somewhere around the world.[6] In Zambia for instance, cervical cancer strikes 63 women in 100,000, almost ten times more when compared to the rate of seven per 100,000 women in Australia.[7] This calls for urgent action on the part of governments, particularly in worst affected areas such as Africa.

Sexual and reproductive ill-health mostly affects women and adolescents. Cervical immaturity, due to factors such as metaplastic changes during puberty, may increase the susceptibility of adolescents to HPV infection.[8] It is a well known fact that the unacceptably high maternal mortality rates in many African countries and the burden of disease unfairly carried by women as a result of their gender are mostly preventable. Sexual and reproductive health services are either absent or of poor quality and underused in many African countries because discussion of issues such as sexual intercourse and sexuality are regarded as taboo and are avoided by the majority of the people. This often accounts for high incidence of sexually transmitted infections (STIs) in the region. As a sexually transmitted infection that causes cervical cancer, HPV has significant implications for a woman's reproductive health.[9]

A variety of socio-economic factors have also served as obstacles to implementing cervical screening programmes in most of these countries. Among the barriers are lack of resources, poor infrastructure in the health care system, financial constraints, lack of technical expertise, and in many cases, cultural, religious and educational barriers have stopped women from taking advantage of screening programmes even when they do exist.[10] Deaths and loss of health in women due to HPV are preventable. Therefore, failure on the part of African governments to address this health challenge constitutes a gross violation of women's rights to health and life guaranteed in international and regional human rights instruments. Dorothy Shaw[11] quoted Mahmoud Fathalla, saying, 'Women are not dying because of diseases we cannot treat . . . they are dying because societies have yet to make the decision that their lives are worth saving.'[12] Experience has shown that in Africa cervical cancer is a disease that occurs with greatest frequency in women who live within a social context where their human rights are severely restricted, employment is non-existent, malnutrition is rampant, clean water is a rare commodity and sewer systems and electricity are not commonplace.[13] Therefore, the prevalence of cervical cancer among women in the region represents one of the greatest public health failures of our times.

Against this backdrop, this article examines the prevalence and impacts of HPV transmission among women in Africa. It then examines the relevance of a rights-based approach to health-related challenges such as cervical cancer. In particular, the article argues that ensuring access to comprehensive programmes for the prevention and treatment of cervical cancer in Africa is a human rights issue which demands the urgent attention of African governments. The article then discusses two broad barriers (socio-cultural factors and failure of the health care systems in Africa) to the prevention and treatment of cervical cancer. Thereafter, the article suggests the human rights framework that African governments can adopt to ensure access to the prevention and treatment of cervical cancer. It concludes that African governments would need to do more than what presently exists in the region with regard to improving HPV treatment.

II Prevalence of the human papilomavirus and cervical cancer

Cervical cancer is the most common malignant tumor of the female reproductive tract and the leading cause of death from cancers among women in the developing world.[14] In 2005,

there were – according to the World Health Organization (WHO) projections – over 500,000 new cases of cervical cancer, of which over 90 per cent were in developing countries and almost 260,000 women died of the disease, nearly 95 per cent of them in developing countries.[15] Cervical cancer affects approximately 1.4 million women worldwide,[16] making it one of the gravest threats to women's lives. This threat is more pronounced in Africa than in other regions.[17]

Africa as a region has the highest incidence rates in the world, and five of the seven countries with the highest rates are in eastern or southern Africa.[18] The International Agency for Research on Cancer designed a multi-centre study of HPV infection among the general female population in different global regions. Each study region aimed to enrol a population-based and age-stratified random sample of at least 1000 women. Of the 13,926 women included, 1,193 (8.6 per cent) tested HPV positive. However, HPV prevalence was highest in Nigeria (24.8 per cent) and lowest in Spain (1.3 per cent).[19] Many of those who die are relatively young women, as the peak incidence occurs among women in their forties. Mortality is highest in countries that are least equipped to deal with the problem. Many patients in Africa go for examination when the infection is far advanced and untreatable, radiation is rarely available, and even palliative care is often of poor quality. Current data demonstrate that adolescents represent a significant and growing segment of the population infected with the HPV virus.[20] Of the 6.2 million people infected with the HPV virus in this decade, 4.6 million are adolescents and young adults within the ages of 15 to 24 years.[21] The peak incidence of HPV infection occurs in adolescents and young women, while cervical cancer typically follows 20–30 years later.

HPV has been identified as the cause of 99 per cent of all cervical cancers in half a million women each year, [22] and two HR-HPV genotypes, 16 and 18, account for about 70 per cent of all cervical cancers worldwide.[23] It causes the cells in the cervix to grow out of control and become cancerous.[24] Cervical cancer not only affects women's health but also threatens their lives. Sexual and reproductive health are about enabling people of all ages, including adolescents and those older than the reproductive years, to have safe and satisfying sexual relationships by dealing with obstacles such as STIs, gender discrimination, inequalities in access to health services, and restrictive laws.[25] Although the mortality rates due to cervical cancer in Africa cannot be compared to that of HIV/AIDS or even maternal deaths, the mere fact that they are increasing and can be prevented makes it imperative for African governments to pay more attention to this health challenge.

III Relevance of a rights-based approach to cervical cancer

A rights-based approach to an issue such as access to preventive treatment for cervical cancer, not only offers a compelling argument for a state's accountability to ensure access to health care facilities, but may also help to ameliorate conditions that 'create, exacerbate, perpetuate poverty, deprivation, marginalization and discrimination'.[26] Potts has noted that accountability in the context of the right to health refers to the process which provides individuals and communities with an opportunity to understand how a government has discharged its right to health obligations.[27] It also provides a government an opportunity to explain what it has done and why. Moreover, it requires a government to provide redress where mistakes have been made. In other words, it is a process that identifies what law, policy or programme has worked so that it can be repeated and what is not working so that necessary amendments can be made.[28] Gruskin has noted that though the term 'right-based' approach has been subject to different interpretations, nonetheless, it has precipitated a robust discussion to the rights-based discourse and has kept this field alive

and well.[29] The World Health Organization[30] has explained that a rights-based approach to a health programme entails the following:

(a) Using human rights as a framework for health development;
(b) Assessing and addressing the human rights implications of any health policy, programme or legislation; and
(c) Making human rights an integral dimension of the design, implementation, monitoring and evaluation of the health-related policies, programmes in all spheres, including political, social and economic.

An important element of a rights-based approach is the fact that it focuses on those population groups considered to be marginalised or vulnerable in society.[31] These may include migrant workers, women, people living with HIV, adolescents, children and prisoners. Moreover, rights-based approach helps in framing individuals' needs such as access to the prevention and treatment of cervical cancer as an entitlement and not merely a privilege. In other words, applying human rights principles to health- related issues helps in bringing to the fore the hidden injustices occasioned by a disease such as cervical cancer. Indeed, human rights can be invoked by individuals to legitimately demand the attention and respect of governmental institutions and policy makers, and bridge the gap between law and its application.[32] Human rights are contained in international, regional and national documents and provide easy means for people to assert their interests. In this regard, governmental institutions can invoke human rights to advance the cause of the people, particularly women. And at the same time, individuals and vulnerable groups (such as women) in society can employ human rights to compel governmental institutions and agencies to observe the standards of conduct to which they have committed.[33]

It should be noted that despite the importance of a rights-based approach to health-related issues, some commentators have doubted its viability to addressing women's health needs.[34] Fears have been expressed as to the practicality of using human rights to advance the course of vulnerable groups in society. Indeed, it has been contended that the language of rights does not provide women with any protection against violations of their rights.[35] However, despite these concerns, human rights remain important tools of addressing social injustice in society. Through the use of human rights governments are obligated to take adequate measures with a view to addressing some of the barriers to preventative health care services (such as services for cervical cancer) needed by women. And as Cook *et al.* rightly pointed out, what will be necessary is to find a way of creating a better future through the application of human rights principles so that all women can live in dignity and good health.[36] In particular, it will be necessary for African governments to ensure that women do not die needlessly as a result of preventable diseases such as cervical cancer.

The right to health and access to treatment

It is now widely agreed that access to treatment constitutes an integral part of the right to health and a denial of the right to treatment to an individual constitutes a violation of his/her fundamental human rights.[37] Most often access to treatment is broadly used to encompass both therapeutic and preventative medicines and care. 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 mental wellbeing'.[38] Hunt and Khosla have noted

that 'Medical care in the event of sickness as well as the prevention, treatment and control of diseases are central features of the right to highest attainable standards of health.'[39] This supports the fact that African governments must take adequate steps to prevent cervical cancer among women in the region by ensuring access to HPV vaccines.

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).[40] It provides that states 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. This elaborate provision derives its inspiration from the preamble to the Constitution of the World Health Organization where health is explained as:

> (a) state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of all human beings without distinction as to race, colour, and religion.[41]

Reaffirming the WHO's definition of health, the International Conference on Population and Development (ICPD) Programme of Action broadly defines reproductive health to include 'total well-being in all matter relating to the reproductive system and its functions and processes'.[42] This includes access to preventive sexual and reproductive heath care services.

The Committee responsible for the implementation of the Covenant in its General Comment No. 14 clarifying the contents of the right to health has noted that the right to health should not be interpreted as the right to be healthy. Rather, the right to health contains both freedoms and entitlements.[43] The Committee further notes that the right to health intersects with other rights such as the right to life, non-discrimination, dignity, equality and liberty.[44] This interrelatedness of the right to health with other human rights is a re-affirmation of one of the conclusions reached at the Vienna Programme of Action where it was agreed that all human rights are universal, interdependent interrelated and indivisible.[45] Such a broad approach to the enjoyment of human rights has also received the support of commentators.[46] Implicit in this argument is that loss of women's lives due to lack of access to preventative treatment for cervical cancer not only violates their right to health but also impugns their right to life.[47] This approach imposes positive obligations on states to avoid unnecessary loss of lives. It coincides with the decisions of international tribunals such as the European Commission on Human Rights. In *Tavares* v. *France*,[48] for example, the Commission has held that the right to life guaranteed under the European Convention, extends beyond a state's duty to abstain from intentional killing, but also includes taking necessary steps to protect unintentional loss of life.

Also, the Committee on ESCR has observed 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.[49] According to the Committee, good quality health care services should be made available, accessible and acceptable to all. It states further:[50]

> 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.[51] Furthermore, the Committee has observed that essential components of the right to health include prevention, treatment and control of epidemic, endemic, occupational and other diseases.[52] This requires prevention and education programmes to address issues such as reproductive tract infections and other STIs. It also includes ensuring access to vaccines that could prevent transmission of HPV among women. Moreover, the Committee identifies the essential elements of the right to health to include availability, accessibility, acceptability and quality. These elements are examined in detail in another section of this article.

In addition to the above provisions on the right to health contained in the CESCR, article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[53] similarly guarantees the right to access to health care for women on an equal basis with men. The CEDAW Committee in its General Recommendation No. 24 on Women and Health[54] has noted that states are under an obligation to ensure that policies and laws facilitate equal access to health care for 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. As earlier mentioned, the prevalence of HPV is common among women, particularly young women. Therefore, this calls for a gender-sensitive approach to addressing this health challenge.

The CEDAW Committee has noted that measures taken to eliminate discrimination against women with regard to the right to health will be deemed to be inadequate if such measures fail to prevent, detect and treat illnesses which specifically affect women.[55] Obviously, this statement applies to health challenges rampant among women such as HPV. Cook and Howard have argued that gross apathy often displayed by governments with regard to issues affecting women's health (which usually results in loss of lives), amounts to an act of social injustice.[56] They argue further that such an act of apathy constitutes a gross violation of women's rights. This can be true of the little attention that is being given by African governments to the threat of cervical cancer to the health and lives of women in the region.

At the regional level, the right to health is guaranteed under article 16 of the African Charter on Human and Peoples' Rights (African Charter).[57] 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 *Purohit case* [58] has held that the 'Enjoyment of the human right to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realization of all the other fundamental human rights and freedoms.' It states further that the right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind.

The Protocol to the African Charter on the Rights of Women (African Women's Protocol)[59] 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; and
(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; and
(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 African Women's Protocol has become 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.[60] The African 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.[61] Banda has noted that by these explicit provisions on sexual and reproductive rights of women, the African Women's Protocol has become a trail blazer in the advancement of women's rights.[62] The African Women's Protocol is the only human rights instrument that specifically protects women's rights in relation to STIs including 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 African Women's Protocol guarantees women's rights to adequate affordable and accessible health services.

Therefore, it can be argued that the African Women's Protocol provides a good framework for holding African governments accountable for failing to address the deleterious impact of cervical cancer on women's health in the region. Moreover, one can rely on the African Women's Protocol to demand that African governments pay more attention to the health needs of women in general and their sexual and reproductive health in particular. More importantly, the language of the Protocol clearly requires African governments to take adequate steps or measures to address health-related issues such as cervical cancer threatening the health and lives of women in the region.

It should be noted that despite these numerous provisions on the right to health in international and regional human rights instruments, the right to health has been described as vague and that it intersects with other rights, thus, making its enforceability difficult.[63] However, this comment can be said to be somewhat exaggerated given the recent attention to the right to health internationally and nationally. In recent times, constitutions of many countries have included provisions on the right to health either as a legally enforceable right or merely as directive principles of governments' policy without imposing any obligation on a government.[64] In countries such as South Africa, India and Colombia national courts are beginning to give recognition to the enjoyment of the right to health.[65] Moreover, the mechanism for realising the right to health at the international level has been strengthened through the activities of treaty monitoring bodies such as the Committee on ESCR, the CEDAW Committee and the Convention on the Rights of the Child (CRC). These bodies, through issuance of general comments or recommendations and concluding observations to states parties' reports, are beginning to give clarifications to the content of the right to health and the nature of obligations expected of states.

IV Barriers to the prevention and treatment of cervical cancer in Africa

Sexual behaviour is not only linked to reproduction and expression of pleasure and love but it may also transmit disease.[66] The assessment of factors that influence utilisation of services for the prevention and treatment of STIs, including HPV, is a major area of scientific and practical relevance for the prevention and control of STIs.[67] In resource poor settings around the world, STIs are extremely common and the consequence for the health and social well-being of the women and their children are frequent and potentially devastating.[68] The status of one's reproductive health is partly the outcome of processes (both behavioural and biological) that involve a series of individual decisions and actions taking place within a social and cultural context. For many this context is a major determinant of vulnerability to preventable diseases, disability, and premature death, although other political, geographical or economic determinants also come into play.[69] Broadly speaking, barriers to the prevention and treatments of cervical cancer in Africa may be classified under two headings; namely socio-cultural factors and barriers with regard to the health system.

Socio-cultural factors

The HPV vaccine has the potential to significantly decrease the incidence of diseases caused by HPV, specifically cervical cancer.[70] Approved by the US Food and Drug Administration since late June 2006, this vaccine is currently being marketed for clinical use in girls and women aged nine to 26 years.[71] Because HPV is a STI, the goal of a primary immunisation strategy is to administer the vaccine before viral exposure at the onset of sexual activity. For this reason, childhood and early adolescence is a prime time to target this type of intervention. Moreover, the best antibody response to this vaccine occurs by 14 years of age.[72] Early administration, before or at the beginning of puberty, may be used by parents and clinicians optimally to help initiate dialogue about prevention of cancer, unwanted physical/sexual contact, and other difficult topics with parents of children and early adolescents.

Religion plays an important role in African societies. It is most likely that some African societies and local religious conservatives would react negatively to vaccinating young women against a sexually transmitted virus. One can draw this conclusion from the way most African societies have expressed strong opposition to use of contraceptives by adolescents. This is not peculiar to African societies. In the US, also, religious groups oppose HPV vaccination, preferring instead to advocate abstinence for prevention of STIs.[73] STIs highlight some of the most significant socio-cultural norms and practices that contribute to women's reproductive ill-health, particularly those related to unequal power between men and women.[74] Most women have been brought up to suffer quietly and not complain of their discomfort or pain.[75] Although this culture of silence is somewhat more relaxed in urban areas, it remains strong even in this setting.

The world's population contains more young people than ever, with almost half under the age of 25 years.[76] Millions every year enter their 'reproductive age'. Many do this in a safe and controlled way, and manage to balance life goals, education and sexual maturity as essential positive elements of human life. However, in developing countries, many young people are exposed to the increasing risks of unprotected sexual practice.[77] Most adults, especially parents, worry about their child's potential sexual behaviour. Early onset of sexual activity among adolescents is high in many countries, and parents worry because teenage sexuality has an implicit moral aspect, because they are afraid that the child will

suffer from abuse, and because they think there may be adverse outcomes such as unwanted pregnancy or infection with an STI.

Furthermore, gender is a critical issue in STI prevention and care. Gender-based inequalities put girls and young women at increased risk of acquiring STIs and damage their physical and mental health across the globe.[78] Gender-based inequalities also impede access to prevention and care services to them. In addressing these inequalities, it is important to consider the different needs and constraints of young women, and to design interventions accordingly.[79] Social, educational, religious and economic inequalities underlie the reasons why girls and young women often do not use health services. They do not know about them, are not allowed by their families to use them, or do not have money to pay for them.[80] Understanding the social position of girls and young women within societies and population subgroups is crucial to identifying strategies for the effective prevention, diagnosis, and treatment of STIs. In societies where a belief in male supremacy co-exists with restrictive social structures that limit women's economic, social and legal independence, men often maintain strong control over female sexuality.[81]

Girls and young women in many cultures have less access to medical care than boys and men, especially in situations where they cannot leave home without permission, or where their health is less valued (by themselves and others) than that of male family members.[82] Male dominance over female sexuality is a serious impediment to achieving social change in people's attitudes to sexuality and sexual behaviour.[83] Inadequate sex education and public information campaigns in many settings prevent candid and open discussion of STIs. This can have serious implications for immunization of girls against HPV.

The lack of communication about sexuality is aggravated in some societies like Nigeria by the use of poignant language that stigmatises women as disease vectors.[84] Although premarital sex is frowned upon, a study carried out among the Igbo of Awka and Agulu in Anambra State of Nigeria[85] identified circumstances that the community approves of women having children out of wedlock. About 63.4 per cent of the survey respondents indicated that where a couple does not have a male child, there could be a tendency to coerce one of their daughters to remain unmarried and have male children for the family in order to perpetuate the lineage.[86] The practice of having multiple sexual partners in order to have children and of couples coercing their unmarried daughters to bear children for their natal families exposes women and girls to the risk of contracting STIs including HPV. However, 81.5 per cent of the survey respondents held the view that only promiscuous women and commercial sex workers are vulnerable to STIs and only 14.2 per cent indicated that any woman who has unprotected sex is at risk of contracting STIs.[87] About 28.6 per cent of the men and 16.7 per cent of women perceived women as disease vectors and the majority of them said that it is the responsibility of women to ensure that married couples do not contract STIs.[88] Also in Kenya, like in the Nigerian community, sexuality matters are seen as taboo for adolescents. Sex is seen as sacred and often a topic for the married.[89] Beliefs as these can hinder steps and measures taken towards the prevention of cervical cancer.

It should be noted that under article 5 of CEDAW and article 2 of the African Women's Protocol states are enjoined to take measures including education programmes with a view to addressing socio-cultural factors that contribute to gender inequality and violation of women's rights. Therefore, African governments will be expected to embark on awareness programmes and campaigns among the population, particularly those in rural areas, with a view to promoting and protecting women's rights in general and their sexual and reproductive rights in particular.

Barriers associated with the health care system

In many African countries the health care sector is grossly underfunded and largely unprepared to handle emerging diseases such as cervical cancer. Access to health care services for the majority of women, particularly those in rural areas, is generally difficult. This accounts for the high incidence of cervical cancer in this region. Cervical cancer can be detected early enough (for the possibility of treatment) through screening programmes such as the Pap smear and destroying or removing precancerous cell tissue, but many health care services in Africa lack facilities for these procedures. Pap smear screening, if well organised on a regular basis for women, can reduce significantly incidence of cervical cancer. For instance a study of a national programme for cervical cancer screening in Ireland has shown about 80 per cent reduction in cervical cancer deaths over a 20-year period. By contrast, only about five per cent of women in developing countries have had access to Pap smear screening in the last five years.[90] More often than not, supplies, equipment and trained medical personnel required to conduct this screening are lacking. The essential requirements for a successful Pap smear screening programme include the following:

- Well-trained providers, including nurses, midwives, and physicians' assistants;
- Examination rooms and laboratories stocked with the necessary supplies and equipment;
- Linkages, including transportation, to reliable laboratories with appropriately trained technicians;
- Strategies for ensuring the quality of Pap smear samples and the accuracy of interpreting them;
- Proven systems for timely communication of Pap smear results to screened women; and
- Effective referral and follow-up systems for diagnosis and treatment of abnormalities.[91]

Sadly enough, many African countries lack the wherewithal to meet these requirements.

Even in rare cases where the Pap smear screening and other preventive procedures regarding cervical cancer are available they are usually too far away from many women in the rural areas.[92] In some situations preventive treatment for cervical cancers may require follow-up. This sometimes places strain on the pockets of poor households and may lead them to abandon continuation of treatment. For instance, a study has shown that the reason why some women could not go for HPV screening was because they did not have transport fares.[93]

In many African countries health services are met through out of pocket expenses. Therefore, many of the people, especially women, are unable to afford the cost of health care services. With regard to HPV screening the cost can be particularly prohibitive and may be unaffordable to many women who need it. Currently, the two available vaccines (Gardasil by Merck and Cervarix by GSK) that have been approved are very expensive and beyond the reach of many African women.[94] Moreover, there are generally shortages of health care personnel to provide health care services in general and services in relation to cervical cancer in particular. According to WHO, the global workforce shortage in the health care sector is about 4.2 million.[95] Africa is worst affected by this development. While sub-Saharan Africa is home to about 11 per cent of the world's population and accounts for 24 per cent of global health burden, it has only three per cent of the world's health workers.[96]

Often poor funding of the health care in many developing countries is due to lack of priority and corruption on the part of the leaders.[97] For instance, a country like Nigeria, which is well endowed with natural resources and about the seventh oil producing nation in the world, still has one of the highest maternal mortality rates in the world. Indeed,

Nigeria's health care system due to poor funding is in shambles as preventable health issues such as cervical cancer and high incidence of early and unwanted pregnancies continue to pose threats to lives of young women. On the other hand, a country like Lesotho despite being regarded as a least developed country and lacking in major natural resources, has a relatively better maternal mortality rate than Nigeria.[98] This supports the point that attending to the health needs of Africans is not so much dependent on the wealth of a nation but rather on its willingness to prioritise. The Committee on ESCR in one of its concluding observations has noted that failure on the part of a state to ensure access to essential medications so as to address an epidemic may constitute a breach of a state's obligation under the Covenant.[99]

A recent report has shown that the per capita expenditure on the health sector by some African countries ranges from 65 US dollars in Kenya, 51 US dollars in Nigeria, 29 US dollars in Tanzania to 45 US dollars in Mozambique.[100] The only exception is South Africa whose per capital expenditure on health is about 700 US dollars. This scenario contrasts sharply with spending in some developed countries, where for instance spending ranges from 5,274 US dollars in the United States, 3,446 US dollars in Switzerland to 3,409 US dollars in Norway.[101] It is indeed ironic that Africa which bears the burden of sexual and reproductive ill health spends so little an amount of money on the health care needs of its people, particularly women. Therefore, in line with the obligations imposed on African governments by the African Women's Protocol, more efforts are required to ensure comprehensive access to health care services in general and sexual and reproductive health care services in particular.

V The obligations of African governments to ensure access to the prevention and treatment of cervical cancer

These problems stated above compromise women's health and lives with regard to cervical cancer. It is generally agreed that international human rights law imposes obligations on states to respect, protect and fulfil the rights of their people. Such obligations extend to the right to health. Human rights instruments often provide an additional force to existing states' obligations under domestic constitutions. But as stated earlier, the right to health is regarded as a socio-economic right; hence the discussion about its juscticability cannot be ignored.[102] Indeed, article 2 of the CESCR enjoins states to progressively realise the rights contained under the covenant *subject to availability of resources* (emphasis supplied). This provision has become a veritable route of escape for states to avoid the obligations imposed under this Covenant. However, as Alston and Quinn correctly pointed out, this provision should not be viewed as 'an escape hatch for states whose performance failed to match their abilities or as a lessening of state obligations'. But rather, it should be viewed and defended simply as 'a necessary accommodation to the vagaries of economic circumstances'.[103]

Oftentimes, some states – particularly the poor ones mainly found in Africa – have cited lack of resources as a barrier to realising the right to health of their citizens. In most cases failure to guarantee the right to health is often hinged on the argument of some scholars that socio-economic rights – including the right to health – are not amenable to judicial interpretation. Besides, some have argued that socio-economic rights (including the right to health) are positive rights, thus making them too expensive for governments to guarantee. Fuller[104] for instance, has noted that adjudication on social and economic rights by the court is likely to pose polycentric problems. He describes polycentric problems as 'situation[s] of interacting points of influence "which, when possibly relevant to

adjudication, normally, although not invariably", involve many affected parties and a somewhat fluid state of affairs'.[105] To support this assertion, he therefore argues that the court should know its limit when such situations occur and thus desists from adjudicating on such issues *supporting* this assertion. Lester and O'Cinneide[106] have argued that judges lack the constitutional authority as well as expertise to make political decisions about raising and spending of public funds or execution of public programmes, since this will amount to arrogating to themselves roles of the legislature or executive branch in contradiction to the doctrine of separation of powers.

But these arguments have been debunked by other scholars who assert that enforcement of civil and political rights is no less expensive as socio-economic rights, citing as examples the right to fair trial and exercise of franchise. The realisation of the former right would require a functioning judicial system which will include building of more courtrooms, employment of skilled workers, provision of adequate facilities and so on. While the realisation of the latter rights will require setting up an electoral body, printing ballot boxes and establishing voting venues for voters to exercise this right.[107] All these could make civil and political rights financially demanding if not more than socio-economic rights. Moreover, An-Na'im' has contended that to leave the matter of public policy alone to the 'unfettered discretion of governments, however democratic without the possibility of judicial guidance and supervision', defeats the whole purpose of recognising social and economic rights as international human rights.[108]

Therefore, the argument of resource constraint or deference to the executive as important as it may seem is not a tenable excuse for non-implementation of socio-economic rights.[109] Moreover, African governments can embark on cost-effective means of preventing cervical cancer in the region. One of such means is the use of visual inspection method of detection for cervical cancer. This approach is simple, cheap and effective. It involves the application of the acetic acid programme, which screens the cervix and identifies acetowhite areas that possibly indicate a precursor lesion is present.[110] This method is very useful in resource-poor settings where follow-up and transportation are a barrier to women's access to Pap smear testing. A country like Kenya has begun to adopt this method of detecting cervical cancer. It is estimated that about 20 to 30 women a day in Kenya are now tested for cervical cancer through this method at no cost.[111] This is a significant increase in the number of women who are being tested compared to the period when Pap smear was being adopted. The important lesson to be drawn from this is that if there is political will, African governments can reduce drastically the incidence of cervical cancer and deaths associated with the disease through cost-effective means.

Indeed, courts are beginning to reject this excuse in some jurisdictions. For, instance the South African Constitutional Court in *Minister for Health* v. *Treatment Action Campaign and others*[112] rejected government's argument that making antiretroviral therapy available for prevention of mother-to-child transmission of HIV in public health institutions will be too financially burdensome for the government. The court had held that the South African government was legally obligated under section 27 of the South African Constitution to guarantee the right to health of its citizens, which encompasses ensuring access to life saving medications for those in need, particularly children.

Furthermore, while it is generally agreed that a lack of resources can pose challenges to realising the right to health, this should not become a magic wand that would automatically relieve a state from its obligations under the Covenant. One needs to point out that Africa is a richly endowed region made up of poor countries. Many of the least developed countries are found in Africa.[113] However, the Committee on ESCR in its General Comment 3 has observed that the crucial point to note in interpreting article 2 is to determine whether a

state is *unwilling* or *unable* (emphasis supplied) to fulfil its obligations with regard to socio-economic rights including the right to health under the Covenant.[114] In other words, even in a state of poverty a state party will still be expected to demonstrate that 'every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations'.[115] Explaining this further in its General Comment 14, the Committee notes as follows:[116]

> If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above.

Moreover, certain obligations are not subject to the excuse of lack of resources. For example, the obligation to ensure non-discrimination in provision of health care services and the obligations to make available essential drugs to the citizens are core content of the right to health which must be fulfilled regardless of the financial position of a state. The Committee has noted that provision of essential medications for the citizens constitutes a state party's 'core obligation to ensure the satisfaction of, at the very least minimum essential levels of each of the rights enunciated in the Covenant'.[117] Since lack of access to medicines (an integral part of the right to health) may implicate the right to life, it can be argued that a state's obligation with regard to ensuring access to preventive and curative medicines for its citizens is an immediate and not progressive obligation.[118] The urgency involved is born out of the threat to lives which may result if the needed medicines are not made available.

Thus, obligations of African governments to ensure access to preventive and palliative treatment with regard to cervical cancer for their citizens arguably constitute a core content of the right to health of women, thereby demanding urgent measures and steps from African governments to ensure access to comprehensive cervical cancer treatment. Although all the three forms of obligations (respect, protect and fulfil) mentioned above are important in the context of preventing cervical cancer in Africa, however, the most relevant as regards ensuring access to preventive and palliative HPV treatment is the obligation to fulfil. This obligation is discussed below.

The obligation to fulfil

This obligation requires states to take appropriate measures and steps including legislative, budgetary, administrative, economic, judicial and other necessary measures to ensure the realisation of the right to health. It involves enacting laws that will facilitate access to health care services for women. It similarly involves allocation of adequate and appropriate resources to the health care sector that will meet the needs of women. Equally, it requires states to ensure access to the justice system for women and to other means of seeking redress when they experience violations of their rights in the health care sector.

While spending on the health sector in Africa is generally poor, spending on sexual and reproductive health care is worse in many African countries. Preventable deaths and disabilities continue to plague women in the region due to scant attention to their health needs. For example, African women continue to face challenges in getting access to contraception which can easily prevent STIs and unwanted pregnancy, two major causes of mortality and morbidity in women in the region. Sedge *et al.* estimate that about 27 per cent of married women and about 25 per cent of unmarried women in Africa have an unmet need for contraception.[119] This merely demonstrates the little value placed by African

leaders on the lives of their citizens. It has been noted that in order to determine the priority of a state, one needs to measure where its money goes.[120]

Certainly, African governments are not spending their money to improve the health of their citizens, particularly women. It should be noted that spending to provide preventative health care services costs relatively little and can save lives and improve the health conditions of Africans, especially women. Re-affirming this point, it was agreed at the International Conference on Population and Development (ICPD) that states should invest more in the health needs of women throughout their life cycle so as to improve their condition.[121] Fathalla *et al.* have warned that if developing countries, and in particular African countries are to meet the targets of universal access to sexual and reproductive health for all by 2015, then it would be imperative for them to scale up cost-effective means of intervention, show more political will and allocate more resources with regard to the health needs of their citizens, particularly women.[122]

Unfortunately, many African countries, contrary to article 10(3) of the African Women's Protocol, prefer to spend their money on other less urgent or life-threatening areas such as the military, to the detriment of more urgent areas such as health. A report has shown that spending on the military by African governments has increased by about 51 per cent in the past ten years.[123] Ironically, millions of lives – within the same period – have been lost to diseases such as HIV/AIDS, tuberculosis, malaria and pregnancy-related complications. At the Abuja Declaration,[124] African governments resolved to allocate at least 15 per cent of their annual budgets to the health sector to address challenges posed by the HIV/AIDS pandemic and other diseases. However, many of these countries have failed to keep to this promise.

Recently, African ministers of health at the Maputo Plan of Action for Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa have called on African governments to strengthen the health care sector through increased allocation of financial resources so as to meet the targets of the Millennium Development Goals (MDGs).[125] They further note that Africa may miss the MDGs targets if African governments do not re-commit themselves to the promises they made during the Abuja Declaration in 2001.[126] This Plan of Action, which aims at universal sexual and reproductive health care services for Africans by 2015, lays emphasis on prevention and management of STIs, including HIV/AIDS, family planning services and adolescents' sexual and reproductive health.[127]

More importantly, as part of a state's obligation to fulfil the right to health of women, particularly, with regard to the prevention of HPV, it will be necessary for governments to draw out comprehensive plans and policies that are achievable, highlighting how the challenges posed by HPV will be addressed. Such plans and policies must be feasible, and realistic. They must also aim at ensuring availability of cost-effective means of preventing cervical cancer. Moreover, making plans and policies are not enough; they must in addition be reasonable and target the vulnerable and marginalised groups in society. Clarifying a government's role in this respect, the South African Constitutional Court in the *Grootboom*[128] case, while commenting on government's policy with respect to housing, has held that it is not enough for government to draw out plans and policies, but that such plans and policies must be reasonable and meet the needs of those in urgent need. Therefore, in relation to HPV, for a government's plans to be reasonable it must seek to provide access to treatment for those already affected and equally access to preventive services for those at risk of HPV, particularly young women in the rural areas.

Also, governments may be required in accordance with article 4 of CEDAW and 2 of the African Women's Protocol to take other measures such as affirmative action to guarantee access to preventive and curative treatment related to HPV for women and adolescents in the region. Thus, governments will be expected to commit more resources than they

presently spend to address health challenges such as cervical cancer facing women in Africa. This will not be seen as a discriminatory measure but rather as a corrective measure aimed at advancing equal access to treatment for women in the region and preserving lives. In *X* v. *United Kingdom* the European Commission on Human Rights hinted that had the United Kingdom not taken appropriate measures to prevent death from vaccination, the government would have been found to be in violation of the obligation to safeguard life under article 2 of the European Convention on Human Rights.[129] This decision supports the view that governments need to take adequate steps and measures to ensure access to preventative treatment to women so as to avoid unnecessary loss of lives and sexual ill health. The fact that cervical cancer poses a great threat to the lives and health of women in Africa requires African governments to redouble their efforts in addressing this health challenge.

Furthermore, bearing in mind that STIs are the major causes of HPV, African governments will be required to 'ensure, without prejudice and discrimination, access to sexual health information, education and services for all women and girls'.[130] This will go a long way in preventing further risks of death due to HPV in the region. In one of its concluding observations to Angola, the Committee on CEDAW has expressed grave concern over lack of adequate infrastructure and information on sexual and reproductive health for girls and women in the country, which have resulted in their lack of access to health care services and low health status. The Committee therefore urges the government of Angola to improve infrastructure in the health care sector and adopt a gender-sensitive approach to its health care reforms.[131] Similarly, the Committee has urged the government of Guinea to focus its policies and resources towards improving women's health needs, particularly with regard to sexual and reproductive health care, in order to ensure that they do not die from preventable health conditions.[132]

In order for African governments to be able to effectively fulfil the right to the health of women in the context of preventing cervical cancer, the framework provided by the Committee on ESCR in its General Comment 14[133] will be useful as a guide. The Committee notes that the right to health must satisfy the elements of availability, accessibility, acceptability and quality. These elements are equally essential for realising access to preventive and curative treatment with regard cervical cancer for women in the region. These elements are discussed below.

Availability

This implies that sexual and reproductive health care services including services related to HPV vaccines and other means of preventing cervical cancer must be made available in sufficient quantity to all women within the jurisdiction of a state. In particular, sexual and reproductive health care services must be available to vulnerable groups and marginalised groups such as women and girls including people in rural areas. Governments must ensure the establishment of functioning public health care services that provide sexual and reproductive health care services including services related to the prevention of cervical cancer to all. More importantly, availability of sexual and reproductive health care services will entail underlying determinants of health such as access to safe and drinkable water, adequate sanitation facilities and trained health care personnel.[134] Also, governments will be required to ensure availability of health care providers to meet the special needs (for instance services related to the prevention of cervical cancer) of vulnerable groups such as women, children and adolescents.[135]

Experience has shown that women and adolescent girls are often reluctant to seek sexual and reproductive health services if they know that they would be attended to by a

male health care provider. This is particularly true in the case of treatment of STIs including HPV. The outcome can be debilitating for women generally and young women in particular as their health and life may be in jeopardy. This further perpetuates discrimination against women and girls in accessing health care services, particularly sexual and reproductive health care services.[136] Therefore, it might be necessary for governments to ensure that health care services, including services related to the prevention of cervical cancer, are provided by female health care providers.[137] This will ensure appropriate access to confidential sexual and reproductive health care services to women and girls.

Accessibility

This requires states to ensure that sexual and reproductive health care services and facilities are made easily accessible to all without discrimination. Accessibility in turn has four components namely:

Non discrimination
Physical accessibility
Economic accessibility; and
Information accessibility.[138]

Non-discrimination means that governments must ensure that services related to the treatment of STIs including HPV vaccines are made accessible to all regardless of their age, sex, gender, ethnic group or religion. This is particularly important since young woman are among those worst affected by incidence of cervical cancer in Africa. It also requires that governments must ensure delivery of HPV vaccines in a fair and non-discriminatory manner paying attention to the needs of disadvantaged groups in society.[139]

Physical accessibility implies that governments must ensure that access to HPV vaccines is within the reach of all sections of society. More importantly, the interests of vulnerable and marginalised groups such as women and adolescents are prioritised above other members of society.[140] For instance, services related to prevention of cervical cancer must be within the reach of women and adolescents in rural areas. In particular, testing services to diagnose cervical cancer will need to be assured to women in general and rural women in particular.

Economic accessibility refers to the fact that the cost of HPV vaccines must not be too expensive for the women and adolescents who need it. Under no circumstances should treatment and prevention of cervical cancer be made burdensome to women, and adolescents and other socially disadvantaged members of the public. Due to their low status in many African societies, women and girls often lack economic power to afford health care services including services related to the prevention of cervical cancer. Therefore, government must strive to remove this obstacle by subsidising services related to the treatment and prevention of cervical cancer for women and girls. More importantly, governments will need to address the high cost of the HPV vaccine by subsidising it or making it free to women, especially young women in the region. The relative success in some countries such as Botswana with regard to providing antiretroviral drugs for the treatment of HIV provides hope that this can be repeated with HPV vaccines.

Moreover, article 2 of the CESCR enjoins states to seek international cooperation in realising the right under the Covenant. This makes it imperative on poor countries to seek international support from developed countries with regard to the prevention and treatment of cervical cancer. Goal no. 8 of the MDGs supports this position. This goal enjoins developed

countries to seek partnership with poor countries with a view to achieving the MDGs. Such international assistance and cooperation can lead to affordable access to HPV vaccines and other means of preventing cervical cancer. Indeed, one of the important MDG targets is to provide in 'cooperation with pharmaceutical companies access to affordable essential drugs in developing countries'.[141] This enjoins African governments to ensure that they work together with pharmaceutical companies to reduce prices of essential medicines for the people in the region. Where necessary, African governments may need to invoke the flexibilities contained in the Trade Related Aspects of Intellectual Property (TRIPS) Agreement,[142] in order to ensure affordable access to HPV vaccines for their citizens. For instance, compulsory licensing can be invoked to facilitate access to cheaper medicines including HPV vaccines.

Information accessibility means that African governments must ensure that socio-cultural hindrances to access to information related to the treatment and prevention of cervical cancer for women and girls are removed. In this regard, comprehensive access to sexual and reproductive health care information and services must be made accessible to all members of society, particularly vulnerable groups such as women and girls, living in the rural areas.[143] It will also require governments not to interfere with the right of women and girls to seek information related to the treatment and prevention of cervical cancer. For instance, young women and unmarried adolescents should not be unduly denied access to such services. Therefore, governments will need to introduce sexuality education in schools. More importantly, information related to screening for cervical cancer should be made available to women in general and rural women in particular. This requires governments to engage in dialogue constantly with religious and traditional leaders on issues relating to the sexual health needs of the people.

It would be recalled that during the International Conference on Population and Development and the Fourth World Conference on Women in Beijing, the international community agreed to remove socio-cultural, political and economic barriers to women's access to health care services. It was further resolved that governments should strive to 'increase women's access throughout their life cycle to appropriate, affordable and quality health care, information and related services'.[144]

Acceptability

This means that African governments must take steps to ensure that services related to the treatment and prevention of cervical cancer are culturally acceptable to women and girls. The Committee on ESCR notes that governments must ensure that health care services are respectful of the rights of women, children, adolescents and disadvantaged groups in society and sensitive to 'gender and life cycle requirements'.[145] More importantly, informed consent of women and girls must be sought before treatments are provided and their confidentiality must be respected. With regard to sexual and reproductive health care services (such as services related to the treatment and prevention of cervical cancer) peculiar to the need of women and girls the Committee on CEDAW has noted as follows:[146]

> Acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilisation, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women's rights to informed consent and dignity.

Quality

This implies that African governments must ensure that services related to the treatment and prevention of cervical cancer are not only sufficient but also of good quality. It will be necessary for governments to ensure that qualified and well trained personnel attend to women and girls seeking medical attention with regard to cervical cancer. Moreover, governments must ensure the availability of essential facilities for the prevention and treatment of cervical cancer in all health institutions, including those in rural areas. At present health care institutions in many African countries are failing to meet the needs of the people due to poor infrastructure. Thus, African governments are required to redouble their efforts in ensuring comprehensive quality health care services in relation to preventing cervical cancer among women.

VI Conclusion

Already fears are being expressed that many African countries may miss the targets set by the MDGs to attain universal sexual and reproductive health care for all by 2015. This is a serious cause for concern. Therefore, it has become crucially imperative that African governments should take more decisive steps and measures with a view to realising access to health care services to their citizens, particularly women. For so long Africa has been besieged by challenging situations such as poverty, needless conflicts and life-threatening diseases such as HIV/AIDS, tuberculosis, malaria and of late cervical cancer. As a result millions of lives have been lost and millions more – particularly those of women – are threatened by these circumstances. The situation looks daunting but not hopeless. Most of these diseases that continue to pose threats to the health and lives of Africans are either preventable or treatable.

The challenge now is for African governments to either continue to 'blame their stars' for these misfortunes or become the architects of their own fate by taking decisive measures to address the situation. But surely, African governments must have themselves to blame for their inability to take action when needed. The time is now for African governments to wake up from their slumbers and take the bull by the horn to save the lives of millions – especially women – still threatened by preventable diseases or infections. Hunt and Khosla have noted that if a government must meet its obligation with regard to access to medicines under international law, it must guarantee good supply mechanisms, good quality, reliable and sustainable sources of funding of medicines.[147] The first step will be for African governments to re-direct their priorities by allocating more resources to improve the health needs of their citizens. Such an approach must be gender-sensitive and focus on the needs of vulnerable and marginalised groups in society including women and those in the rural areas. Also, it will be necessary to adopt cost-effective methods to prevent cervical cancer among women in the region.

From all indications African governments have not yet recognised cervical cancer as a major threat to health and lives of women in the region. In line with the Oxford Declaration on Prevention of Cervical Cancer in Africa, the time has come for African governments to declare cervical cancer a major health challenge.[148] Furthermore, comprehensive access to information and services on sexual and reproductive health care services must be guaranteed to all, particularly women and adolescents in the rural areas. This will advance the health needs of women and female adolescents in the region. But in doing this, it must be borne in mind that 'advancing the health status of women necessarily involves human rights, not simply because women are child bearers and child rearers, but also because

women are the equal of men'.[149] Therefore, any steps taken by African governments to address the various health challenges facing the region must be grounded in the promotion and protection of fundamental rights of the people, particularly women.

Notes

1. C.M. Wilson *et al.*, 'The Exploding Worldwide Cancer Burden: The Impact of Cancer on Women', *International Journal of Gynaecology Cancer* 14, no.1 (2004): 1–11, at 1.
2. I.F. Adewole *et al.*, 'Evolving a Strategic Approach to Cervical Cancer Control in Africa', *Gynecologic Oncology* 99, no. 3 (2005): 209–12.
3. A. Bishop *et al.*, 'Cervical Cancer: Evolving Strategies for Developing Countries', *Reproductive Health Matters* 3, no. 6 (1995): 60.
4. H. Trottier and E.L. Franco, 'The Epidemiology of Genital Human Papillomavirus Infection', *Vaccine* 24, no.1 (2006): 1–15.
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6. See GlaxoSmithKline, 'A New Era in Cervical Cancer Prevention', http://us.gsk.com/html/spotlight/cervicalcancer.html (accessed 14 October 2009).
7. Ibid.
8. L. Wong and I. Sam, 'Current Issues Facing the Introduction of Human Papillomavirus Vaccine in Malaysia', *Malaysian Family Physician* 2, no.2 (2007): 47–63, at 48.
9. A.E. Pollack *et al.* on behalf of the WHO/UNFPA Working Group on Sexual and Reproductive Health and HPV Vaccines, *Ensuring Access to HPV Vaccines Through Integrated Services: A Reproductive Health Perspective*, http://www.who.int/reproductive-health/cancers/hpvvaccines_bulletinarticle.pdf (accessed 28 May 2009).
10. Wilson, 'The Exploding Worldwide Cancer Burden', 5.
11. D. Shaw, 'Sexual and Reproductive Rights in Action Obligations and Opportunities', *International Journal of Gynecology and Obstetrics* 84, no. 3 (2004): 197–9.
12. Ibid.
13. See V Sahasrabuddhe, 'Cervical Cancer Screening and Treatment in Africa and other Developing Areas', http://www.uptodate.com/patients/content/topic.do?topicKey (accessed 11 October 2009).
14. Adewole *et al.*, 'Evolving Strategic Approach to Cervical Cancer', 210.
15. L. Gissimann, 'Linking Human Papillomaviruses to Cervical Cancer: A Long Winding Road', in *Papillomavirus Research from Natural History to Vaccine and Beyond*, ed. M.S. Campo (Norwich, UK: Caister Academic Press, 2006), 3–11, at 3–6.
16. WHO, *Report on the Consultation on Human Papillomavirus Vaccine April 2005*, http://www.who.int/vaccine_research/documents/816%20%20HPV%20meeting.pdf (accessed 1 October 2008).
17. Adewole *et al.*, 'Evolving Strategic Approach to Cervical Cancer', 212.
18. G. Walraven, 'Prevention of Cervical Cancer in Africa: A Daunting Task', *African Journal of Reproductive Health* 7, no. 2 (2003): 7–12, at 8.
19. Monsonego, 'HPV Infections and Cervical Cancer Prevention', 837.
20. R.M. Farrell and E.S. Rome, 'Adolescents' Access and Consent to the Human Papillomavirus Vaccine: A Critical Aspect for Immunisation Success', *Journal of the American Academy of Pediatrics* 120, no. 2 (2007): 434–7
21. H. Amaro and I. Gornemann, 'Health Care Utilization for Sexually Transmitted Diseases: Influence of Patients and Provider Characteristics', in *Research Issues in Human Behaviour and Sexually Transmitted Diseases in the AIDS Era*, ed. J.N. Wasserheit *et al.* (Washington, DC: American Society of Microbiology, 1991), 140–60.
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23. The Future II Study Group, 'Effect of Prophylactic Human Papillomavirus L1 Virus-Like-Particle Vaccine on Risk of Cervical Intraepithelial Neoplasia Grade 2, Grade 3, and Adenocarcinoma In Situ: A Combined Analysis of Four Randomised Clinical Trials', *Lancet* 369, no. 9576 (2007): 1861–8.

24. The cervix is part of the female reproductive system. It is about one inch around and connects the vagina to the uterus (womb). Sperm travels through the cervix to fertilize a woman's egg during conception.
25. A. Glasier *et al.*, 'Sexual and Reproductive Health: A Matter of Life and Death', *Lancet* 368, no. 9547 (2006): 1595–1607, 1596.
26. S. Gruskin 'Rights-based Approaches to Health: Something for Everyone', *Health and Human Rights* 9, no. 2 (2006): 5–9.
27. H. Potts, *Accountability and the Right to the Highest Attainable Standard of Health* (Colchester, UK: University of Essex/Open Society Institute, 2008), 7.
28. See Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (P. Hunt) [99-101] UN Doc.A/HRC/7/11, 31 January 2008.
29. Gruskin, 'Rights-based Approach to Health', 6.
30. World Health Organization (WHO), *25 Questions and Answers on Health and Human Rights* (Geneva: World Health Organization, 2002), 18.
31. Ibid.
32. R.J. Cook *et al.*, *Advancing Safe Motherhood Through Human Rights* (Geneva: World Health Organization, 2001), 7.
33. Ibid.
34. See for instance, M. Tushnet, 'An Essay on Rights', *Texas Law Review* 62 (1984): 1371–2 where Tushnet argues that recourse to the use of the language of human rights may add a rhetorical flourish to an argument, but provides merely an ephemeral polemic advantage often obscuring the need to explore political and social change.
35. R. West, 'Feminism, Critical Social Theory and Law', *University of Chicago Legal Feminism* 59 (1989): 84–9.
36. Cook *et al.*, *Advancing Safe Motherhood through Human Rights*.
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38. UN General Assembly Special Session on HIV/AIDS Resolution A/S-26/L2 June 2001, para. 15.
39. See P. Hunt and R. Khosla, 'The Human Right to Medicines', *Sur International Journal of Human Right*s 5, no. 8 (2008): 99–115, 99–100; B.C.A. Toebes, *The Right to Health as a Human Right in International Law* (Antwerp: Intersentia-Hart, 1999), 284.
40. International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976).
41. The Constitution of the WHO was adopted by the International Health Conference, New York, 19–22 June 1945; opened for signature on 22 July 1946 by the representatives of 61 states; 14 UNTS 185.
42. *Report of the International Conference on Population and Development*, 7, UN Doc A/CONF.171/13 (1994), para. 7.4.
43. The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment No. 14, UN Doc E/C/12/2000/ para. 8. Freedom refers to the right of an individual to be free from coercive medical treatment while entitlements refers to a health system which guarantees equal access to the enjoyment of the best attainable standard of health.
44. Ibid., para. 3.
45. Vienna Programme of Action UN Doc A/CONF 157/24, Part 1, ch. III.
46. See for instance, A.E. Yamin, 'Not Just a Tragedy: Access to Medication as a Right under International Law', *Boston University International Law Journal* 21, no. 178 (2003): 325–71, 334; see also V. Leary, 'The Right to Health in International Human Rights Law', *Health and Human Rights* 1, no. 1 (1994): 24–42, 27.
47. See General Comment 6 of the Human Rights Committee where it was stated that the right to life should not be construed narrowly but should be seen to intersect with other rights such as rights to housing, food and medical care.
48. *Tavares* v. *France* App. No. 16593/90 Euro. Comm. HR.
49. General Comment 14, 'The Right to Health', para. 12.
50. Ibid., para. 9.
51. Ibid.

52. Ibid.
53. Convention on the Elimination of All Forms of Discrimination against Women, GA Res 54/180 UN GAOR 34th Session Supp 46 UN Doc A/34/46 1980.
54. General Recommendation 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1.
55. Ibid., para. 11.
56. R.J. Cook and S. Howard, 'Accommodating Women's Difference under the Women Anti-discrimination Convention', *Emory Law Journal* 56, no. 4 (2007): 1039–90.
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