
2. Dignity in Daily Life: A Conceptual Framework

'All human beings are born free and equal in dignity and rights.'

– Article 1, Universal Declaration of Human Rights (UDHR), 1948

'(We)...commit ourselves to intensifying efforts to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and developing strategies to combat stigma and social exclusion connected with the epidemic.'

– Para 29, 'Political Declaration on HIV/AIDS', UN General Assembly, 2006

Introduction

The central tenet of this study is that dignity is an inalienable human right. Dignity is understood here as a key concept for understanding equality. A seminal 1999 decision by the Canadian Supreme Court¹ provides us with a definition of dignity in which the purpose of equality is 'to prevent the violation of essential human dignity and freedom from the imposition of disadvantage, stereotyping, or political or social prejudice, and to promote a society in which all persons enjoy equal recognition at law as human beings ... equally capable and equally deserving of concern, respect and consideration'.

In the recent past, the rights-based and capability approach to development policy has become part of the mainstream discourse. The pressing development challenges of our times such as poverty, hunger, illiteracy, malnutrition, infant and maternal mortality, discrimination and violence are increasingly being studied through a gender-responsive, human rights-based lens. Although States and international agencies have instituted policies and programmes that draw on a gender-responsive, human rights-based approach, human dignity has not yet received the attention it deserves. Even in the expanded framework of human rights, inclusion of dignity as an instrument for achieving other fundamental rights has not been systematically explored. This study asserts the centrality of human

dignity as a tool of analysis and applies it in the context of unpaid work in the HIV and AIDS care economy.

There have been very few studies that have dealt with the issue of unpaid work in HIV care at both a conceptual and programmatic level. While almost every report on HIV and AIDS highlights the role of gender, stigma and discrimination, the analysis is mostly from the standpoint of comparing the conditions of women and men living with HIV and AIDS. Although the discourse of human rights has been used extensively in prevention and treatment aspects of HIV policy, there has been very little use of the same tools in the case of care and support of HIV-positive individuals.

One common theme that emerges is that ‘women bear a disproportionate burden of HIV since they are caregivers and in many cases have to deal with their HIV-positive condition themselves’ (Commission on AIDS in Asia 2008). However, the role of the carer is not only limited to women; gay and transgender men and women also care for their partners, often under very difficult societal pressures and discrimination by the wider community.² It is also recognised that there are other outcomes on families as a result of HIV-positive status – such as lack of access to basic necessities, girls being pulled out of school to help in care work, and denial of health services as a consequence of entrenched discrimination against persons living with HIV. These and other direct and indirect impacts, ‘externalities’ in economics, cannot be easily valued in monetary terms and have been missing from the whole analysis until now.

The purpose of this conceptual framework is to place the unpaid care work performed by women and other carers at the centre of the discourse in order to privilege the dignity and rights of carers in HIV prevention and treatment strategies. It is also intended to provide an alternative to traditional economic methods of value judgement (economically understood) that are prevalent at the programmatic level. In situating unpaid HIV care within the context of human rights and social justice, and by emphasising State obligation and responsibility via international human rights instruments, the study intends to hold governments accountable for the conditions of servitude under which carers often live their lives.

Discourses and interventions in prevention and treatment

Policy approaches in both developing and developed countries have emphasised the role of prevention in containing the spread of HIV.

In the early years of the epidemic, certain groups that were thought to be 'responsible' – such as homosexual men in the United States and female sex workers in parts of Asia – were identified. The containment strategy ranged from aiding and abetting discrimination against such groups to outright incarceration on the pretext of safeguarding public health. From a public policy perspective, the solution in both cases was deemed to be cost efficient – it appeared to prevent the spread of the virus at least cost to the exchequer. However, as the epidemic has demonstrated, this was neither efficient nor effective.

A similar strategy was followed in the case of treatment; with the inordinately high ART prices until 2000 (WHO 2010), donor governments rationalised that the high costs of publicly funding this did not justify the social benefits. Such a line of argument can still be heard in certain quarters, although the use of generic ARTs has substantially reduced the cost of providing treatment to a large number of persons living with HIV.

Given the above, what actually changed the landscape of HIV interventions? The spread of and response to HIV in the context of violations of the fundamental rights of individuals led to a sustained campaign by activists, lawyers, academics, people living with HIV, international organisations and many others. Epidemiological evidence also resulted in the organisation of groups that are often marginalised – sex workers, sexual minorities, drug users – so that governments today cannot use the veil of HIV prevention to violate their basic rights and freedoms. At the same time, public action has led in some contexts to legal redress for these groups and brought long-standing issues of identity, sexuality and discrimination to the forefront of the public debate.³

This comes at a time when the combination of the public debt crisis and improved epidemiological data/profiling is showing that groups often deemed marginal – gay and bisexual men, sex workers and drug users in particular – are experiencing concentrated epidemics everywhere in the world. Evidence is also showing that political and social inequality undermines prevention efforts with women, given that power in sexual decision-making is deeply compromised in these situations. Epidemiological evidence has further demonstrated that for many of the communities hardest hit by HIV, human rights violations – or the absence of human rights protections – compromise prevention work as well as access to treatment, care and support for those living with HIV. Therefore the pivotal role of the placement of rights at the centre of prevention and treatment and care strategies becomes obvious; this has now led to access to justice and the removal

of punitive laws as core components of the 'prevention revolution' being called for in many quarters.

Economic analysis of the HIV care economy

At a conceptual level there is a tension between the economic analyses of HIV care and the rights-based approach to development. It is undeniable that there has been a massive mobilisation of resources worldwide for the fight against HIV. The total resource envelope for HIV stood at nearly US\$13.7 billion per year in 2008, but estimates put the annual requirement at nearly US\$25 billion in 2010 (UNAIDS 2010a). The bulk of funding for 'treatment, care and support' is spent to support treatment, with minimal expenditure on care and support – especially in the home. To give one example pertinent for women, programmes to tackle violence against women constitute only 1 per cent of the estimated total needed, although a detailed breakdown of the care component is not available (it is collapsed with treatment in the UNAIDS report). In a world where gender inequality and expectations of gender roles lead to women being expected to and assuming the burden of care when someone in the household is sick – whether their husband/partner or children or both – it should stand as no surprise that the global HIV response fails to take into account the burden of care borne by women, children and partners of people with AIDS-related illnesses. Gender analyses consistently document this oversight in policy and programmes where 'women' and, more generally, 'carers' go missing (Ogden, Esim and Grown 2004).

It is to be noted here that a plethora of government agencies, international development organisations and private foundations make up most of the HIV funding going into the developing world. Most governments in Africa, Asia and the Caribbean spend a small proportion of their own resources for HIV prevention, treatment and care in the face of small health budgets compared to the scale of the epidemic. This has two significant implications: first, the strategy for combating HIV and AIDS is decided by a global compact including various United Nations agencies, the Global Fund for AIDS, TB and Malaria (GFATM), the World Bank and bilateral development agencies of large donor countries such as the United States Agency for International Development (USAID), UK Department for International Development (DFID) and others, and large private donor agencies and international NGOs such as the Bill & Melinda

Gates Foundation, World Vision, the Clinton Foundation and others. Second, the prevailing consensus is that the effectiveness and efficiency of the resources spent on the programmes are evaluated on the basis of a target-oriented results framework. An evaluation criterion that incorporates human rights and social justice has largely remained outside the scope of donor frameworks, although change seems to be on the horizon with such initiatives as PEPFAR and the Ford Foundation's HIV programmes among others.

To illustrate, in the MDG framework a set of policies is effective if conditions improve in line with the indicators as defined in the goals and targets – in the case of HIV and AIDS, halting and reversing the epidemic along with providing universal access to treatment (Goal 6, targets 1 and 3). Three of the 8 MDG goals and 7 of the 18 targets set by the international community relate to health, and the Millennium Declaration admits that one major cause of low health status in developing countries in general, and among women in particular, is the discrimination that females face even before they are born (Jones et al. 2010).⁴ The MDG targets are quantifiable measures to track the progress of countries over time. They do not, however, address the underlying process of removal of discrimination against women through protection and enjoyment of basic human rights as an instrument of achieving the goals.

In terms of the efficiency argument, the standard framework applied in the health economics literature involves the evaluation of alternative policies vis-à-vis their impact on disability-adjusted life years (DALY) or quality-adjusted life years (QALY) gained per dollar of expenditure. For example, if there are two treatment regimens, one is more efficient than the other if the same amount of DALYs or QALYs is enhanced for a lower unit cost. In this scenario, universal access to first-line ART is more efficient than limited access to second-line ART due to the higher unit costs in the latter. As resistance to first line drugs deepens, the policy priority should be to ensure that cost-effective and efficient second and third line treatment is available in developing countries, perhaps through generics. However, the public debt crisis is leading to cutbacks in enrolment in ART programmes because the cost per patient has come to be seen as a burden on the donor country and so an inefficient use of development aid monies, referred to in a famous US paper on the subject as 'treatment mortgage' (Jack 2010). In contrast, and in anticipation of the increasing influence of the efficiency argument in development policy and spending, the UK All Parliamentary Group on AIDS argued in *The Treatment Time Bomb* (2009) that it is a global responsibility to not deliberately sacrifice human lives in the name of economic efficiencies. As the debates

on universal access have shown, the efficiency argument completely negates the right to life of people living with HIV and AIDS and is therefore untenable from the human rights standpoint.

As a logical extension to this approach, most macroeconomic studies on the economic cost of HIV in both developed and developing countries have estimated the impact of the epidemic on gross domestic product (GDP) or labour productivity. In countries of Southern Africa where the prevalence rate has touched 20 per cent or more of the adult population, the mathematical models predicted a sharp decline in the rates of GDP growth and an absolute decline in per capita GDP if the epidemic spread further. Similar conjectures were also made for countries such as Brazil, China and India, the underlying assumption being that an unchecked HIV epidemic would reduce the productivity of labour, increase the cost of health care and hence reduce productive investments elsewhere in the economy, with adverse consequences for long-term economic growth (Haacker 2004; Bloom and Godwin 1997).

The reality, however, is completely different from what the models predicted. Economic growth has been robust in most of the high-prevalence countries in Africa and Asia and no country has experienced an absolute decline in GDP. With a strong upsurge in international funding for HIV programmes, most affected countries have upgraded their health systems and appointed medical staff. On the flip side, this has increased aid dependence and a consequent diminution in the role of the governments in formulating health policy tailored to their own needs.

The incapability of the macroeconomic analysis to explain the impact of HIV and AIDS on economies has spawned a large body of work looking at the micro and household level evidence. Here, the impact of the epidemic comes out clearly in qualitative studies. These highlight the role of social and economic exclusion stemming from the presence of an HIV-positive individual(s) in the household and the adverse impact such exclusion has on children (especially young girls) who are often the silent victims (Pradhan et al. 2006). More recently, there have been attempts to quantify the psychological cost of HIV and its impact on individual welfare. This shows that in terms of mental well-being, the costs far exceed the expenditure on HIV and AIDS programmes - and that these can be substantially reduced by ensuring basic dignity to people sick with AIDS-related illnesses and their carers (Das et al. 2008). In other words, we have the foundation for merging the economic costs associated with HIV and AIDS with the concept of dignity and non-discrimination without recourse to the efficiency argument used until now.

Dignity, social justice and human rights: a framework for evaluating unpaid HIV care work

Given all of the above, there is an obvious need to develop an appropriate framework using the concept of human rights to ensure the enjoyment of freedoms and expansion of the capabilities of individuals involved in HIV care (Sen 1999). The ‘capability approach’ departs from other frameworks by providing direct support for a broad characterisation of fundamental freedoms and human rights that takes account of poverty, hunger and starvation, dignity and conditions of servitude. Individual substantive freedoms in the form of the capabilities and functionings that people can and do achieve can be included among the constituent elements of human freedom and incorporated into a framework of rights.

Capability freedoms focus on the set of valuable things that a person is able to do and be. For example, if a person has reasons to value a life without hunger and would choose such a life, then the capability of this person to achieve adequate nutrition is directly relevant to her/his real opportunity to promote her/his objectives and expand her/his freedom. Conversely, deprivation in the capability to achieve adequate nutrition restricts the person’s real opportunity to promote her/his objectives and is admissible as a ‘freedom-restricting’ condition. The classical case is that of servitude, which directly restricts the person’s choice to do and be. Similarly, discrimination on the basis of creed, religion or state of health (as in the case of people living with HIV) also prevents a person from achieving a life that s/he values and prevents her/him from ‘taking part in the life of the community’, which Sen regards as a basic functioning of human beings.

The central idea of ‘capability freedom’ is then associated in Sen’s conceptual framework with a set of ‘capability rights’ and obligations that protect and promote valuable states of being and doing. The ‘capability approach’ provides direct support for the characterisation of poverty, hunger and starvation, discrimination and servitude as ‘freedom-restricting’ conditions. In this way: ‘Minimal demands of well-being (in the form of basic functionings, e.g. not to be hungry), and of well-being freedom (in the form of minimal capabilities, e.g. having the means of avoiding hunger)’ can be conceptualised as rights that ‘command attention and call for support’ (Sen 1999). The ‘attention’ is the catalyst for public action, including action on the part of the international community, and the ‘support’ is from human rights instruments such as the Universal Declaration of

Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) – which have been ratified by most countries – along with international jurisprudence and case laws.

In the context of HIV and AIDS, it is important to associate the indignity of living with the disease with the idea of ‘freedom restricting’ conditions in the capability approach explained above. There is enough empirical evidence in this volume to suggest that the feeling of living without dignity is part of the reality for both people struggling with AIDS-related illnesses and their carers. The sense of living a life where they feel stigmatised and discriminated against flows directly from societal norms that disregard the ethical values of dignity and rights. Social justice demands that both people living with HIV and their carers be treated with equal respect and dignity to that afforded to each member of society (Jaising 2010). Unfortunately, most policies and programmes that seek to ‘halt and reverse’ the HIV epidemic in line with the MDG goal exacerbate rather than ameliorate the condition of HIV-positive persons and their carers. In our framework, therefore, States have to take responsibility for violations of the norms of social justice when a community or an institution discriminates against those living with HIV and/or experiencing symptoms of AIDS and their carers.

Until now, the critique of the efficiency argument has not been used to analyse women’s unpaid work in HIV care. The extension is straightforward. First, by definition, the effort of women caregivers is not valued in economic terms since it falls outside the ‘boundary of production’ defined by the UN System of National Accounts (SNA) (Waring 1988). In this case, evaluation of DALY or QALY is not possible since there is no monetary value attached to the ‘work’. The fallacy, however, is that having ‘no unpaid work’ would reduce the efficiency of the system from an economic perspective.

In the area of HIV care the ‘work’ is nearly always performed by women, especially if the situation relates to unpaid care-giving for family and friends in household settings. The definition of ‘household’ in this case might be different than the usual conjugal marital definition prevalent in mainstream discourse. It might refer to a community of sex workers or transgendered women. It might also refer to single mothers and same-sex couples who are involved in the care economy. In the case of same-sex couples, social sanction and stigma often force them to separate, pushing them into the ambit of the more familiar

definition of the family where he or she is looked after by a female member of the household. Therefore, we can focus on the analysis of women's unpaid work in HIV care without loss of generality and applicability of our framework from a policy perspective.⁵

Second, there have been efforts to value the 'time cost' of unpaid work in household production, especially in the context of recent developments in gender budgeting. However, in the specific case of unpaid care the concept of 'choice' usually does not exist – the caregivers do not optimise between less time spent on market as opposed to non-market transactions. Any time that is left after the basic subsistence needs have been met is spent on providing care; the choice between 'work' and 'leisure' becomes non-existent. The efficiency argument therefore breaks down completely (becomes untenable) and cannot be used as a tool to evaluate unpaid work in HIV and AIDS care.

The economics of capability and human rights

Governments and the international donor community often argue that fulfilment of rights requires resources that far exceed what is available at present. Sen has argued that where there are resource constraints, the positive obligations associated with 'capability-freedoms' and 'capability-rights' may not relate directly to valuable states of being and doing that may be currently unachievable but to policies and programmes that promote the achievement of rights and freedoms as an immediate or cumulative outcome. The violation of obligations of this type involves the absence and inadequacy of policies and programmes rather than the non-fulfilment of obligations per se (Sen 1982; 2000).⁶ This approach is reflective of a critical element in the establishment and development of international legal obligations in the field of poverty alleviation and human rights. For example, articles 26–29 of the Bill of Rights attached to the South African Constitution (1996) entrench a cluster of socio-economic rights essential for an adequate standard of living including the human rights to housing, health care, sufficient food and water, social security and education.

In this conceptual construct, a set of policies would enhance 'capability-rights' if it protected and fulfilled the basic human rights of women in care-giving situations. The gender dimension can be addressed by taking into account the implications of care-giving for

girls – whether their enjoyment of basic freedoms are circumscribed by the exigencies of taking care of persons sick from AIDS-related illnesses in the household. The framework can be extended to include children since international covenants and conventions specifically deal with the rights of the child. Apart from the notions of poverty and starvation that are linked to HIV-positive status, violation of specific provisions of the ICESCR (articles 11–14 related to food, shelter, physical and mental health and free primary education) constitute the basis for the violation of ‘capability rights’.

This study demonstrates that capability rights are violated for not only the person dying from AIDS but also the caregiver. The case studies based on the voices of unpaid carers that form the conceptual basis of our argument bear this out. In addition, the carer does not have the freedom to choose those functionings that are valuable to her/him – for example, rest from work and participating in the life of the society. This condition can be termed as ‘capability servitude’, where the carer’s dignity and freedom is circumscribed by her/his inability to break away from the situation of constant work and no leisure. The violation of capability rights comes from the fact that, in most countries, policies and programmes do not exist that unshackle caregivers from the situation of ‘capability servitude’.

Capability servitude

Given the conceptual framework in the context of unpaid HIV care, we need to determine whether the condition of the unpaid carers in AIDS affected households can be termed ‘capability servitude’, where their dignity and freedom are circumscribed by an inability to break away from the situation of constant work and no leisure. Do we recognise to what extent the burden of unpaid care work undermines women’s capacity to take an equal part in civil and political life? Do we think that the children who work long hours in unpaid care work might be losing out on access and opportunities – to the right to education, leisure and enjoyment of life as enshrined in the UDHR?

In terms of a rights-based approach applied to those in the unpaid workforce, we need to ask the following questions: To what extent does the discrimination and different treatment of girls and women in unpaid, long-term care in AIDS-affected households compromise or inhibit their capacity to participate effectively in political or community life, to attain the highest possible standard of physical and mental health, to exercise their right to opportunities of lifelong education or to enjoy safe and healthy working conditions?

Did the carers freely choose to deny themselves these opportunities or are there systematic violations of their fundamental rights and freedoms? Does this condition prevail in unpaid AIDS-care situations in different geographic, political and economic contexts? If so, can we outline a methodology for understanding the universal notion of capability servitude?

The capability model is not about what people are or what they do but what they can or cannot be, and what they can or cannot do, given the opportunities or the freedoms. Unpaid care of the sick is a critical part of the health-care system that compromises the well-being of the carer – who is then further penalised by the system in terms of loss of earnings, or time to do subsistence and other care work, or with no recognition at all.

The narratives in this volume help us understand the myriad ways in which the rights of women and other caregivers are systematically violated in the framework of capability and rights explained above. Our examples are taken from different geographical and cultural contexts, demonstrating the universal nature of the violations, and the analysis of dignity in the care-giving context is situated in terms of the obligations set out in international human rights instruments. Applying the conceptual framework proposed above to real-life situations also helps us identify a set of policies consistent with international human rights standards that would ensure dignity and justice to women involved in HIV and AIDS care.

A number of international human rights instruments, resolutions and statements in recognition of and for securing of women's human rights have been issued by the UN system since 1995.⁷ Ironically the increased endorsement of human rights has taken place at a time when neo-liberal policies adopted worldwide advocate a far lesser responsibility for the State in resource distribution and service delivery, with such mechanisms left to the market and the private sector.

While States may have signed and ratified human rights conventions as a commitment to achieving gender equality, by placing reservations on key elements and clauses they effectively negate the intent and purpose of that ratification. A case in point is CEDAW, the most 'reserved' of all treaties. Adherence to a treaty involves more than just recognising the framework it provides and making provisions through certain juridical and legislative devices. At a fundamental level, it involves a clear understanding of the responsibility in knowing what is the standard expected for achieving women's rights and how to get from that standard or norm to realising basic rights within national domains. It has been asserted that it is imperative for States and other stakeholders to recognise that commitment through treaty ratification

means more than ownership of the ‘unreserved’ articles and clauses; it is binding on all aspects of governance (see Bleie et al. 2001).

In the chapters that follow, as the narratives traverse such diverse settings as public hospitals, prisons and homes across various Commonwealth regions, we listen to the voices of carers and grapple with the erosion of their rights. In situating the policy and programme solutions, our primary aim is to privilege the dignity and rights of all those who are most affected by HIV as their households are the hardest hit by the epidemic.

Human rights instruments, work and the United Nations System of National Accounts (SNA)

As an illustration of how the conceptual framework and, more specifically, particular articles of human rights instruments are applied to the narratives/voices, we provide a snapshot here.

Article 8 of the ICCPR states:

- ‘2. No one shall be held in servitude.
- 3. (a) No one shall be required to perform forced or compulsory labour; (c) For the purpose of this paragraph the term “forced or compulsory labour” shall not include:
 - (iii) Any service exacted in cases of emergency or calamity threatening the life or well-being of the community;
 - (iv) Any work or service which forms part of normal civil obligations.’

What is the status of the unpaid carer in terms of the human rights available to workers? Four institutional units provide care:

- The private sector (private health providers),
- Government units (hospitals, prisons, health clinics, schools),
- Non-profit institutions (churches, NGOs, community groups), and
- Households

In the context of care-giving of HIV and AIDS patients, regardless of the unit providing care, these services are consumed as they are produced. However, only those working – paid or unpaid – in the first three listed, are deemed to be ‘workers’. The definition of what does and does not count as ‘work’ excludes household work.⁸

Women and men working unpaid for charitable organisations engaged in assisting households with people living with HIV and AIDS are at ‘work’ and have all the human rights of workers available to them.⁹ Staff in educational facilities or prisons, as well as hospitals and health centres, are ‘working’ when taking care of those with HIV and AIDS, but only for a period of time per day deemed to fulfil ‘safe and healthy working

conditions'. None of them is on duty 24 hours a day, 7 days a week. Neighbours assisting a local household with care are 'at work'. These are all 'economically active persons', engaged in productive activities as defined in the SNA (United Nations 1993, para. 1.22). The result is that unpaid community and voluntary care-giving counts as 'work', caring for your neighbour counts as work, but caring for a member of your household does not. 'Domestic and personal services produced and consumed by members of the same household are omitted' from the boundary of production and from the definition of work. It is the single major exception to the measurement of 'value added by all residential institutional units' (ibid., para. 1.75).

The work that does not count is specified in the SNA:

- The cleaning, decoration and maintenance of the dwelling occupied by the household, including small repairs of a kind usually carried out by tenants as well as owners;
- The cleaning, servicing and repair of household durables or other goods, including vehicles used for household purposes;
- The preparation and serving of meals;
- The care, training and instruction of children;
- The care of sick, infirm or old people; and
- The transportation of members of the household or their goods. (Ibid, para. 1.75)

Overwhelmingly it is women who perform this work and thus are excluded from the definition of 'work'. This is itself a breach of the intention of the key equality articles of ICCPR, namely articles 2(1), 3 and 26.

Just what is the context in which women (and men and girls and boys) who are carers of people living with HIV and AIDS in their households can be seen as having no human rights because their situation in the current policies constitutes a justified limitation on the right to be free from discrimination? How can this be if article 4 explicitly denies a right to derogation from the right to be free from servitude?

Examining ‘servitude’ and human rights

There has been no test of the meaning of servitude in UN human rights jurisprudence. However, it is possible to distinguish servitude from slavery. In the Oxford English Dictionary (Vol. 15, 2nd edition) ‘servitude’ is defined as ‘the condition of being a slave or serf or of being the property of another person, absence of personal freedom’. In the first definition it notes that the word usually carries the additional notion of subjection to the necessity of excessive labour. The second major definition is ‘the condition of being a servant, service, specially domestic service’. We are informed that its use in this context is now rare or obsolete.

Whenever the International Court of Justice seeks the origin of a specific challenge in international human rights law – for example, where/how the issue first arose, what a word might mean, what the intention of the Drafting Committee was – they trace back through documents and deliberations that led to the final text of recommendations, resolutions or covenant articles, including the sources of the original debate and the notes of the rapporteur.

Andrew Clapham (1993) has reported that in the debates on the drafting of the ICCPR ‘it was pointed out that “slavery”, which implied the destruction of the judicial personality, was a relatively limited and technical notion, whereas “servitude” was a more general idea ... While slavery was the best known and the worst form of bondage, other forms existed in modern society which tended to reduce the dignity of man. A suggestion to substitute the words “peonage” and “serfdom” for servitude was rejected as those words were too limited in scope and have no precise meaning... A proposal was also made to insert the word “involuntary” before servitude in order to make it clear that the clause dealt with compulsory servitude and did not apply to contractual obligations between persons competent to enter into such obligations. The proposal was opposed on the ground that servitude in any form, whether involuntary or not, should be prohibited. It should not be made possible for any person to contract himself into bondage’ (p. 97).

Richard Lillich (1984) believes that there is no doubt that customary international law now prohibits slavery and servitude, and that prohibition against those practices now constitutes *jus cogens* (‘compelling law’ that may not be violated). In respect of ‘normal civil obligations’ in article 8 (3)(c) of the ICCPR, he comments: ‘what is meant here is primarily the obligation of citizens to undertake joint efforts in the common interest on a local level, such as taking part in fire brigades or similar measures against other calamities. It cannot be translated into a general subjection to direction of labour for economic purposes’ (ibid., 125–126).

The linkage of women and article 8 are rare in UN reports. In 1982 a report on slavery to the Commission on Human Rights indicated that women were ‘among the victims’ of institutions such as slavery (United Nations 1982, para. 31). A special rapporteur noted ‘new forms of servitude and gross exploitation’ (para. 72) and recommended that ‘at a proper time the UN might find it convenient to consider a consolidated convention aimed at eradicating all forms of servile status’ (para. 33). The revision of this report contained a whole section on ‘Slavery-like practices involving women’.

Some may attempt to argue that the responses to HIV and AIDS constitute a state of emergency. But the ICCPR (article 4, para. 2) explicitly prescribes that no derogation from articles 6 (right to life), 7 (prohibition of torture or cruel, inhuman or degrading punishment), or 8 (prohibition of slavery, slave-trade and servitude) is available (HRC 2001, para. 7).

Notes

1. *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497, quoted in Brown 2005.
2. Please refer to the case studies of Jamaica and New Zealand in this volume.
3. See, for example, Misra 2009 on India.
4. For an exhaustive list of titles on this issue, see: www.chronicpoverty.org/uploads/publication_files/RefAnnIndex.pdf
5. For an exception, please see the Jamaica narrative below.
6. See Vizard (2005) for an extensive discussion of Sen’s capability approach and the human rights framework.
7. International human rights instruments specific to women’s rights that have been issued in the 1990s and beyond include General Assembly Resolution 52/86 on Crime Prevention and Criminal Justice Measures to Eliminate Violence Against Women, 1997; Statute of the International Criminal Court (Rome Statute), 1998; Optional Protocol to CEDAW, 1999; General Comment 28 on Equality of Rights Between Men and Women (Article 3, International Covenant on Civil and Political Rights), 2000; UN Security Council Resolution 1325 on Women, Peace and Security, 2000; The Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children that supplements the UN Convention on Transnational Organized Crime, 2000, in addition to the Protocol against the Smuggling of Migrants by Land, Air and Sea, supplementary to the UN Convention against Transnational Organized Crime which entered into force on 28 January 2004. Other Conventions with specific reference to women include the International Convention on Home Workers, passed at the International Labour Conference in 1996, and the Convention on the Protection of Migrant Workers and their Families.

8. 'The SNA is ... designed to meet wide a range of analytical and policy needs. A balance has to be struck between the desire for the accounts to be as comprehensive as possible and the need to prevent flows used for the analysis of market behaviour and disequilibria from being swamped by non-monetary values. The System therefore ... excludes all production of services for own final consumption within households ... [that] are consumed as they are produced' (United Nations 1993, para 1.22).
9. 'Many goods or services are not actually sold but are nevertheless supplied to other units: for example, they may be bartered for other goods or services or provided free as transfers in kind. Such goods and services must be included in the accounts even though their values have to be estimated. The goods or services involved are produced by activities that are no different from those used to produce goods or services for sale. Moreover, the transactions in which the goods and services are supplied to other units are also proper transactions even though the producers do not receive money in exchange' (ibid., para. 1.72).