High Income Countries Issue Brief:

RIGHTS OF WOMEN AND GIRLS

For the High Income Countries Dialogue of the Global Commission on HIV and the Law

17 September 2011
Oakland (CA), USA
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Oakland (CA), United States of America, 17 September 2011
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Abbreviations

AIDS Acquired Immune Deficiency Syndrome
AR Assisted Reproduction
ART Anti-Retroviral Treatment
CEDAW Convention on the Elimination of all forms of Discrimination against Women
CDC Centers for Disease Control and Prevention
EC Emergency Contraception
EU European Union
HIV Human Immunodeficiency Virus
OHCHR Office of the High Commissioner for Human Rights
PEP Post-exposure prophylaxis
STI Sexually Transmitted Infections
UN United Nations
UNAIDS Joint United Nations Programme on HIV and AIDS
UNFPA United Nations Population Fund
USA/ US United States of America
WHO World Health Organisation
VCT Voluntary Counselling and Testing

Countries included in the High-Income Countries Dialogue:

Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Iceland, Israel, Italy, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland, and United States of America (USA/ US).
1. Introduction

In the context of the Human Immunodeficiency Virus (HIV) epidemic, the social and economic inequality of women has been linked to poor health outcomes for women. As stated by the Joint United Nations Programme on HIV and AIDS (UNAIDS):¹

Deeply-rooted social, economic, legal and cultural factors underpin women's and girls' unequal status in societies and the related risk and vulnerability to HIV and violence. Unbalanced power relations, lack of access to services, economic and legal empowerment differentials between men and women, sexual coercion and violence, and entrenched gender roles limit women's and girls' ability to exercise their rights. HIV-related stigma and discrimination disproportionately affect women and girls, constraining women and girls' ability to access services. HIV positive women and girls are less likely to have access to services, disclose their status or negotiate safe sex for fear of being mistreated, rejected or experiencing violence.

In high-income countries, the proportion of new HIV diagnoses of women has steadily increased since the beginning of the HIV epidemic.² There is evidence that prevention activities in several high-income countries are not keeping pace with the changes occurring in the spread of HIV. In 2009, women accounted for about 26% of people living with HIV in North America, and 29% in Western and Central Europe.³

In North America, among young people, 28% of those living with HIV are female. According to the US Centers for Disease Control and Prevention (CDC), the proportion of Acquired Immune Deficiency Syndrome (AIDS) cases among adult and adolescent women in the United States has more than tripled since 1985. The epidemic has increased most dramatically among African American and Hispanic women. Together they represent less than one fourth of all women in the USA, yet they accounted for 80% of AIDS cases reported among women in 2000. Heterosexual contact is the greatest risk for women followed by injecting drug use. A significant proportion of women were infected through heterosexual sex with an injecting drug user.⁴

³ Ibid.
Inequality, subordination and violations of women’s human rights make women vulnerable to HIV, including women in high-income countries. Although most women in high-income countries do not suffer the same extent of social, economic and legal exclusion faced by women in many other parts of the world, and are arguably better protected by the policy and legal framework, gender-based discrimination and inequality exist in this region exacerbating women’s vulnerability to HIV and increasing the negative impact of HIV on women. Women who live in poverty or who inject drugs, Aboriginal women, women, sex workers, women who have sex with men and women, male to female transgendered women, immigrant/migrant women, women from HIV endemic countries, and racial and ethnic minority women may be particularly vulnerable to HIV and poor health, due to a range of issues.

HIV epidemics among women in high-income countries have not received as much research, policy-level or legislative attention as women in low- and middle-income countries have. Calls have been made for states to strengthen the enabling environment - through law and policy, under national AIDS plans, and through funding - so that women and girls are able to take a leadership role in advancing their human rights in the context of the HIV epidemic. An analysis of data included in the National Composite Policy Index (a reporting mechanism to monitor country progress under the 2001 Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS) found that countries without generalised epidemics lagged behind countries with generalised epidemics in responding to issues of particular importance to women:

In every region, more countries than before have integrated women-related issues into their policies and national AIDS strategic plans. Progress has been strongest in countries experiencing serious “generalised” HIV epidemics. In countries where most people affected by HIV are men, however, “gender equity” (meaning that women affected by HIV, although a minority, receive the services they need) seems not to be a strong priority in HIV responses.

More work is needed to bring attention to the human rights of women, especially marginalised women, in the context of the HIV epidemics in Canada and in the USA.

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Structure, Methodology and Limitations

The Issue Brief is based on a desk review of literature, United Nations (UN) and other international organisations’ policy briefs, reports and analytical papers, analyses of selected statutes, judicial precedents and law enforcement practices. It does not aim to provide a comprehensive overview of the legislation, policies and enforcement practices in all study countries. Rather, the aim of the Issue Brief is to provide examples of positive and negative legal regulations, policies and enforcement practices, which serve as illustrations of supportive or punitive legal environments, and point out challenges faced by the high income countries in relation to HIV, the law and human rights. A short explanation of why certain policies may be harmful for individual human rights and public health goals is provided, as well as links to international standards.

This brief will focus on four aspects that affect women’s’ vulnerability to HIV, and their health when living with HIV: the first part will provide an overview of legal protection for women in the form of anti-discrimination and constitutional equality protections. This part will also briefly explore vulnerabilities of women who face multiple layers of marginalisation and stigmatisation - women sex workers, migrants, and ethnic minority women. The second part will examine legal and policy framework protecting women and girls from violence. The third part will examine women’s sexual health and reproductive rights with respect to HIV and AIDS. In each section, good practices in legislation, policy guidance and practice will be identified.

2. Legislation to Prevent Discrimination Against Women and Promote Women’s Equality

Guideline 5 of *International Guidelines on HIV/AIDS and Human Rights* calls upon States to “enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV, and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasise education and conciliation, and provide for speedy and effective administrative and civil remedies”.

In general, high-income countries have explicit constitutional guarantees of equality of the sexes and of non-discrimination against women. They have also ratified and domesticated all international binding legal treaties guaranteeing gender equality, such as the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). In addition, countries may have legislation guaranteeing equality of opportunity of the sexes, or prohibiting discrimination on the basis of sex, in relation to goods, services, entitlements, and employment. Enforcement of the rights to equality and non-discrimination found in domestic legislation is achieved through administrative agencies, independent specialist tribunals or ombudspersons, domestic courts, and regional human rights adjudicative bodies.

In Canada women’s right to equality and non-discrimination is set out in the constitution and other types of legislation:

- The Canadian Charter of Rights and Freedoms guarantees every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on sex (section 15), and further provides that the rights and freedoms referred to in the Charter are guaranteed equally to male and female persons (section 28).

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The federal government and each province and territory have enacted anti-discrimination laws that together make it illegal to discriminate on the basis of sex in respect to contracts, goods, services, government services and programmes, accommodation, and employment. This type of legislation is considered “quasi-constitutional.” Each jurisdiction has a human rights commission, the functions of which may include education, accepting and investigating complaints, conducting investigations into issues of systematic discrimination, and mediation of complaints.

Tribunals have been created to consider cases involving infringements of anti-discrimination legislation. Moreover, courts have inherent jurisdiction to consider Charter claims, and many statutory tribunals have jurisdiction to consider the rights guaranteed in the Charter when adjudicating cases.

The overall objective of Sweden’s gender equality policy is that women and men should enjoy equal opportunities, rights and responsibilities in all significant areas of life. Specific legal protections and mechanisms to respect, and fulfill women’s rights include:

- The second chapter of the Instrument of Government (the Swedish Constitution), which prohibits legislation that discriminates on the basis of sex unless the legislation is one of the measures taken to achieve gender equality or applies to military service or similar compulsory service.

- The Equal Opportunities Act (1991:433) promotes the equal rights of women and men with regard to work, employment conditions as well as other working conditions and scope for professional development.

- The Office of the Equal Opportunities Ombudsman’s prime responsibility is to ensure compliance with the Equal Opportunities Act. The Office also promotes gender equality in schools, universities, labour market training and other forms of education in accordance with the Ordinance with Instructions for the Equal Opportunities Ombudsman (1991:1438). The Office of the Equal Opportunities Ombudsman is to monitor compliance with the Equal Treatment of Students at Universities Act (2001:1286).

Germany has enacted constitutional and legislative provisions guaranteeing equality and non-discrimination for women, which include:

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10 See also the Government of Sweden’s Human Rights website at www.humanrights.gov.se/extra/pod/?module_instance=2&action=pod_show&id=39.
• Article 3 of the German constitution, which enshrines the principle of equal treatment, including equal treatment on the basis of sex.

• General Equal Treatment Act, which came into force in August 18, 2006. It is the first comprehensive anti-discrimination law in Germany, and transposes into German law all four European Union (EU) Equality Directives (2000/43, 2000/78, 2002/73 and 2004/113). The Act applies to employment and occupation, and goods and services.

• The Federal Anti-Discrimination Agency was established in 2006, under the General Equal Treatment Act. Federal Anti-Discrimination Agency and the competent Federal Government Commissioner and Parliamentary Commissioner of the German Bundestag co-operate in cases of discrimination.

• The Industrial Relations Act regulates the relationship between employer and the employees, represented by the work council and their rights and duties. It applies to private companies with more than five employees. According to this Act, the employer and the work council are obliged to take care that all employees are treated equally irrespective of their descent, religion, nationality origin, political or trade union activities or opinions, gender or sexual orientation.

It has been argued that it is important to recognise the concept of “intersectionality” when examining discrimination as lived by people in the real world. Intersectional oppression arises out of the combination of various oppressions that, together, produce something unique and distinct from any one form of discrimination standing alone. An intersectional approach to anti-discrimination law takes into account the historical, social and political context and recognises the unique experience of the individual based on the intersection of all relevant grounds. The intersectional approach offers an important analytical framework when examining law in relation to women living with or at risk of HIV and has recently been identified as a “basic concept” in understanding the scope of state obligations when pursuing policies to eliminate all forms of discrimination against women.

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In high-income countries, the same laws that guarantee equality and outlaw discrimination on the basis of sex often protect people based on race, creed, national or ethnic origin, and disability among other grounds. This is important given that many women experience discrimination as a result of different facets of their identities, including being women of colour, women who use drugs, migrant women, racial minority women, Aboriginal women, women living with HIV, transgendered women, and women who have sex with women. The UN Committee on the Elimination of Discrimination against Women has recognised that the discrimination against women based on sex and gender is inextricably linked with other factors that affect women, including sexual orientation and gender identity.\(^{14}\) It has been recognised that male-to-female transgender women experience a host of psychosocial issues such as discrimination, stigmatisation and marginalisation.\(^{15}\) These challenges may limit their economic opportunities, may affect mental health, and may place transgendered women at increased risk for HIV infection.\(^{16}\) It has also been posited that, in the context of access to HIV-related health care and social services, women who have sex with women may suffer marginalisation as a result of being women and their identity as a lesbian, bi-sexual or other sexual identification.\(^{17}\)

**Protection from discrimination on the basis of gender identity/ sexual orientation**

Protection from discrimination on the above grounds is much rarer than protection on the ground of gender.

In Canada, the *Human Rights Act* of the Northwest Territories is the only human rights legislation that explicitly prohibits discrimination on the basis of gender identity.\(^{18}\) Canadian courts and in most cases, human rights agencies and tribunals, may have the authority decide questions of legislative interpretation. The Manitoba Human Rights

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\(^{14}\) Ibid.

\(^{15}\) DeSantis J (2009), *HIV Infection Risk Factors Among Male-to-Female Transgender Persons: A Review of the Literature*, Journal of the Association of Nurses in AIDS Care 20(5):362-72. The review identified in the literature a number of risk factors for HIV infection specific to the male-to-female population, including needle sharing and substance abuse, high-risk sexual behaviours, commercial sex work, health care access, lack of knowledge regarding HIV transmission, violence, stigma and discrimination, and mental health issues.

\(^{16}\) Ibid.

\(^{17}\) See also, Young RM (2005), *The trouble with "MSM" and "WSW": erasure of the sexual-minority person in public health*, American Journal of Public Health 95(7):1144-1149. 2005. An estimated 20-30 % of women drug users are lesbian, bisexual or other women who have sex with women (WSWs). Contrary to theories that WSW drug users' same-sex behavior is a function of sex work or incarceration, recent ethnographic work on WSW injectors suggests that a majority of WSW drug users can be considered "sexual minorities," which we define as women for whom same-sex orientation is an important aspect of their social lives. Sexual minority status appears to affect health, health-related behaviors, and the health and drug treatment service experiences of women drug users in important ways.

Commission interprets the Human Rights Code\(^{19}\) of Manitoba to prohibit discrimination on the basis of gender identity. Bills have been introduced in the Canadian Parliament to amend the Canadian Human Rights Act\(^{20}\) to include gender identity and expression as prohibited grounds of discrimination. There are also proposals at the Provincial level to include gender identity and expression as prohibited grounds of discrimination in provincial human rights legislation.\(^{21}\)

In the USA, neither sexual orientation nor gender identity is a protected class under Title VII of the \textit{Civil Rights Act} 1964, which prohibits discrimination in employment.\(^{22}\) The federal government has taken some steps to protect those groups – for instance, it will not discriminate against its own civilian employees on the basis of sexual orientation. Twenty states and the District of Columbia outlaw sexual orientation discrimination in employment, while twelve states also prohibit gender identity discrimination.

Discrimination based on “gender identity” is not explicitly covered in legal frameworks in a large majority of Council of Europe member states.\(^{23}\) Sweden prohibits discrimination on the ground of a person’s “transgender identity or expression” in the \textit{Discrimination Act} that entered into force on 1 January 2009.\(^{24}\) The EU Agency for Fundamental Rights reports that thirteen EU Member States treat discrimination on the ground of gender identity as a form of sex discrimination, two Member States consider it as sexual orientation discrimination and in eleven Member States, it is treated neither as sex discrimination nor as sexual orientation discrimination.\(^{25}\)

\section*{2.1. Law enforcement and public health impact}

Women who face multiple vulnerabilities, such as women who use drugs, incarcerated women or women former prisoners, ethnic minorities and migrant women, experience human rights violations on a larger scale and are more vulnerable to HIV and AIDS.

Women who use drugs face increased stigma and discrimination, and may have less access to harm reduction services and drug dependence treatment. Women are more likely than men to report needing assistance with injecting, which may place them at an

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\begin{itemize}
\item \(^{19}\) CCSM, c H175.
\item \(^{22}\) Ibid.
\item \(^{24}\) Ibid.
\item \(^{25}\) Ibid.
\end{itemize}
increased risk of an injection that misses the vein. In addition, the process of assistance itself may result in contamination of the injecting equipment. Gendered social roles and power dynamics within sexual relationships may also play a role, as these have been reported to have an impact on HIV-related risk behaviours. The EU’s drug strategy and action plan for 2009 to 2012 notes that further improvements are needed in accessibility, availability and coverage of harm reduction services across the region. It also highlighted shortcomings of current responses in addressing the needs of subpopulations such as women, young people, migrants and specific ethnic groups.

Within prison populations, women may be at higher risk of infection - in particular, the prevalence of HIV and HCV infection among women tends to be higher than among men. Although women constitute a very small proportion of the total prison population in Europe, 4–5% on average, the number of women in prison is increasing rapidly. There are about 100,000 women in prison in Europe on any given day. Most offences for which women are imprisoned are non-violent, property or drug related. Incarcerated women face a complex set of problems, and prison worsens these problems, and increases the vulnerability of most of these women. Incarcerated women are far more likely to have had traumatic experiences in early childhood than incarcerated men, such as early sexual, mental and physical abuse. Half will also have experienced domestic violence. At least 75% of women entering European prisons are estimated to have problems with drug and alcohol use. Further, women prisoners are more likely than male prisoners to inject drugs and thus are at higher risk of HIV. The prevalence of HIV and other infectious diseases is often higher among women prisoners. There are reports from the US, that incarcerated women who use drugs experience frequent human rights violations and abuse by prison guards. There is very little drug dependence treatment available in the US prisons.

Women are more likely to live in poverty and thus are more vulnerable to HIV and various human rights violations; this is particularly relevant to ethnic minorities, such as Aboriginal women. Furthermore, HIV may increase a woman’s chances of living in poverty. Human rights violations may vary from forced and coerced sterilisation (also described in the section on sexual and reproductive rights), to lack of adequate treatment of drug dependence and inadequate/lesser access to harm reduction services, police violence and discrimination in economic and social spheres.

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26 Global State of Harm Reduction (2010), Key Issues for Broadening the Response.
27 Ibid.
28 Ibid.
30 Ibid.
31 However, it is noted, that recently New York state made changes to its Juvenile Justice system, in order to reduce human rights violations and help people and young adults with dependence in prisons. Ryan L (2011), Juvenile Incarceration: The Need for Reform, http://blog.soros.org/2011/10/juvenile-incarceration-the-need-for-reform/, accessed on 6 October 2011.
3. Violence against Women and Girls

The UN Commission on the Status of Women has pointed to the increased vulnerability to HIV infection faced by women and girls living with disabilities resulting from factors including legal and economic inequalities, sexual and gender-based violence, discrimination, and violations of their rights. A number of factors that increase women’s vulnerability to HIV have also been identified regarding the intersections of violence against women and HIV/AIDS:

- rape and sexual assault;
- domestic and intimate partner violence;
- violence related to harmful practices such as forced marriage, female genital mutilation, wife inheritance;
- violence related to the commercial exploitation of women;
- violence in armed conflict.

The UN Commission on the Status of Women has pointed to the ways in which the HIV epidemic reinforces gender inequalities – women and girls are disproportionately affected by the pandemic; they are more easily infected, especially at an earlier age than men and boys; they bear the disproportionate burden of caring for and supporting people living with and affected by HIV and AIDS; and they become more vulnerable to poverty as a result of the pandemic. The Commission has stressed the need for women to be empowered to protect themselves against violence and further states that women have the right to have control and decide freely and responsibly on matters related to their sexuality, including their sexual and reproductive health, free of coercion.

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34 See also in relation to the link between violent armed conflict and HIV, United Nations Security Council Resolution 1983. S/RES/1983(2011), wherein the Security Council underlined the continuing need for urgent and coordinated global action to curb the impact of HIV and AIDS in conflict and post-conflict situations, while recognising the important role UN peacekeeping operations can play in responding to the epidemic.
discrimination and violence.\textsuperscript{36} Numerous actors have also pointed to the mutually reinforcing link between HIV and violence against women and girls.\textsuperscript{37}

Based on accounts of clients’ experiences and data from public health studies, the District of Columbia, USA, has articulated eight categories of HIV/AIDS-related domestic violence experienced by women:\textsuperscript{38}

- repercussions from partner notification;
- use of knowledge of a partner’s HIV status to exert control;
- interference with medical treatment;
- inability to negotiate condom use;
- sexual assault;
- infidelity;
- intentional infection with HIV;
- other ways survivors of domestic violence are at risk.

Canadian Aboriginal women and Native American women have been found to suffer high levels of violence (sexual abuse as minors, family violence, intimate partner violence), which has been associated with homelessness, injecting drug use, sex work, imprisonment, and the risk of acquiring HIV.\textsuperscript{39} “[T]he HIV epidemic among Aboriginal people in Canada is compounded by racism, both past and present: forced assimilation, residential schooling and loss of culture have contributed to poverty, unemployment,


\textsuperscript{38} Stoever J (2009), Stories Absent from the Courtroom: Responding to Domestic Violence in the Context of HIV and AIDS, North Carolina Law Review 87(4):1157-1229.

multigenerational violence and substance abuse, all of which make Aboriginal people – particularly Aboriginal women and two-spirited people – more vulnerable to HIV.”

3.1 Law, Law Enforcement and Public Health Impact

With the exception of criminal laws related to sex work and criminal HIV disclosure in certain circumstances (examined in section 4.3 of the companion brief, Laws regulating HIV non-disclosure, exposure and transmission, sexual orientation, sex work, and illicit drug use), little attention has been paid in high-income countries to the impact of specific laws and law enforcement on violence against women in the context of HIV/AIDS. However, an exploration of relevant good practice and law reform are noted below.

3.2 Good Practice and Law Reform

Under international human rights law, women have the right to be free from sexual and gender-based violence. This right is protected under the Convention on the Elimination of All Forms of Discrimination against Women (Articles 5(a), 6) and the Convention on the Rights of Persons with Disabilities (Article 16(1)).

Guideline 5 of the International Guidelines on HIV/AIDS and Human Rights calls on states to “enact or strengthen anti-discrimination and other protective laws ... and provide for speedy and effective administrative and civil remedies.” The commentary makes a similar statement, noting the state’s responsibility to enact laws to ensure the right to demand safer sex practices and the right to legal protection from sexual violence, outside and inside of marriage, including legal provisions for marital rape.

Guideline 8 calls on states to “promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.” The commentary furthers this, stating that “Violence against women, harmful traditional practices, sexual abuse, exploitation, early marriage and female genital mutilation, should be eliminated”, and calls for the implementation of the Cairo Programme of Action of the International Conference on

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42 Ibid.
Comprehensive models of legislation to address gender-based violence have been both published and promoted. In 2008, the UN published Good Practices in Legislation on Violence against Women, including a framework for legislation. In 2009, the Canadian HIV/AIDS Legal Network published model legislation on sexual and domestic violence to promote respect for women’s rights in the context of the HIV epidemic. As comprehensive models, they may be of limited applicability in high-income countries given the well-developed criminal laws and criminal procedure already in place. However, many of the specific elements may be relevant in high-income countries seeking legislative and policy solutions that promote the rights of women and women living with HIV by addressing gender-based violence. In 2010, UNAIDS and the World Health Organisation (WHO) published evidence for interventions to address the intersections of violence against women and HIV. Recommended legal reforms centre on women’s inheritance laws, laws against marital rape, national standards for post-rape care, and protecting sex workers from violence by police.

In the USA, Congress has enacted the Violence Against Women and Department of Justice Reauthorisation Act 2005 (VAWA). Among other things, VAWA reauthorised existing VAWA programmes and created new programmes. The Act encourages collaboration among law enforcement, judicial personnel, and public and private service actors who provide services to victims of domestic and sexual violence by: increasing public awareness of domestic violence; addressing the special needs of victims of domestic and sexual violence, including the elderly, disabled, children, youth, and individuals of ethnic and racial communities; authorises long-term and transitional housing for victims; makes some provisions gender-neutral; and requires studies and reports on the effectiveness of approaches used for certain grants in combating violence. Recently the Department of Justice proposed legislation to address violence

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43 Ibid.
44 Ibid.
48 P.L. 109-162. The original VAWA was enacted in 1994 as Title IV of the Violent Crime Control and Law Enforcement Act (P.L. 103-322). See also Laney GP (2010), Violence Against Women Act: History and Federal Funding, Federal Publications Paper 711, Washington, DC, Congressional Research Service. A broad-based coalition of civil society AIDS organisations have called for additional reforms to VAWA to respond to women’s needs: “The Violence Against Women Act (VAWA) should be updated to include provisions that encourage sexual and reproductive health and HIV/AIDS service providers to offer screening with relevant responses for intimate partner violence and sexual coercion, and provision of post-exposure prophylaxis (PEP) and emergency contraception.” See African Services Committee et al (2009), Critical Issues for Women and HIV, at 21.
against women in Native American tribal communities. The legislation would recognise certain tribes’ power to exercise concurrent criminal jurisdiction over domestic-violence cases, regardless of whether the defendant is Native or non-Native.

In the context of domestic violence proceedings in the court system in Washington, DC, USA, a number of legal system advancements have been proposed:

- courtroom options for reporting experiences of violence and protecting HIV-related information;
- substantive changes to the law;
- judicial remedies tailored to the experience of HIV-related domestic violence;
- client-centred lawyering;
- multi-disciplinary (i.e., medical, legal, victims’ and other social services) responses to better respond to the needs of survivors of domestic violence.

The above proposals seek to address the concerns expressed by people living with HIV including loss of privacy, social stigma, and discrimination. They also seek to minimise or avoid the “social costs of making public one’s HIV status” and include:

- scheduling cases throughout the day so that there are fewer people in the courtroom;
- moving to close the courtroom;
- holding hearings in chambers;
- sealing portions of the record to protect medical information;
- listing the petitioner as “Jane Doe”.

While some of these options may run contrary to the constitutional protection for open courts, some have argued that they can be justified based on the constitutional right to privacy regarding a medical condition, which interest can only be overcome by a strong countervailing interest.

France passed a new public health Act (Loi n° 2004-806 du 9 août 2004 relative à la politique de santé publique), which required the development of a national strategic plan to limit the health impact of violence, risk behaviour and addictive behaviour. The national strategic plan was to include a strategic plan for violence against women.

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50 Stoever J (2009), Stories Absent from the Courtroom.

51 Ibid.

Spain enacted the *Organic Act* 1/2004 of 28 December on Integrated Protection Measures Against Gender Violence. The scope of the Act is limited to intimate partner violence (i.e., violence exercised against women by their present or former spouses or by men with whom they maintain or have maintained analogous affective relations). The Act is intended to implement recommendations of international and regional bodies, such as the UN, WHO and European Parliament. It focuses on the rights of women who have been victims of gender-based violence. The guiding principles include:

- strengthening preventive awareness among citizens by providing public authorities with effective instruments to fulfill this goal in the educational, social services, health, advertising and media spheres;
- detection of domestic violence through health services;
- establishing Courts of Violence against Women to provide victims with the most immediate, complete and effective protection, and the means to avoid any recurrence of abuse;
- coordinating of services, at regional and municipal level so that victims of gender-based violence are given rapid, transparent and effective access to services;
- guaranteeing the economic rights of women subjected to gender-based violence in order to facilitate their social integration;
- guaranteeing employment conditions which reconcile contractual requirements with the particular circumstances faced by employees or civil servants subjected to gender-based violence.

4. Sexual and Reproductive Health Rights

The issues raised by sexual and reproductive health rights in the context of HIV have been described as follows:\textsuperscript{54}

Protection of reproductive and sexual health for persons living with HIV/AIDS and those at risk of contracting the virus is predicated on the recognition of individual reproductive and sexual rights and other human rights under the law. Pursuant to these rights, women must (1) be able to make reproductive health decisions without coercion; (2) receive necessary prenatal, delivery, and postpartum health care and treatment; and (3) have the means and information to prevent perinatal transmission. All persons should be given access to necessary sexual health information, including information about sexuality and HIV transmission, and tools to reduce transmission of HIV, such as male and female condoms.

The WHO has offered the following working definition of “sexual health”:\textsuperscript{55}

...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”

In the context of the HIV epidemic in high-income countries, legislation and literature women’s sexual and reproductive health has tended to focus on the reproductive health of women living with and vulnerable to HIV. As HIV-positive women live longer and healthier lives, many express fertility desires and choose to become pregnant, while others may face unintended pregnancies.\textsuperscript{56} The implementation framework for the WHO Global Health Strategy targets five core elements in reproductive health:\textsuperscript{57}

\textsuperscript{57} WHO Department of Reproductive Health and Research (2006), Accelerating progress towards the attainment of international reproductive health goals: a framework for implementing the WHO Global Reproductive Health Strategy.
1. improving antenatal, delivery, postpartum and newborn care;
2. providing high-quality services for family planning, including infertility services;
3. eliminating unsafe abortion;
4. combating sexually transmitted infections (STI), including HIV, reproductive tract infections, cervical cancer and other gynecological morbidities;
5. promoting sexual health.

Access to sexual health information and education, and reproductive health services, for girls are examined in sections 1 and 2, respectively, of the companion brief on access to health information and services for minors in the context of age of consent.

Women living with HIV, and women who are marginalised because of their race, ethnicity, immigration status, use of illicit drugs, work in the sex trade, or poverty may face barriers to realising their sexual and reproductive health rights. Of particular concern is the situation of migrant women. It has been reported that health policies towards asylum seekers differ significantly between EU countries, and that restrictive laws and policies may contribute to the fact that the health needs of asylum seekers are not always adequately met. Based on a review of available literature, reports have suggested that the sexual and reproductive health needs of asylum seekers and refugees in Europe are usually more pressing than those of the host country's population. The research findings also indicate that refugees in the EU have less access to SRH services. National regulations, laws and policies which regulate entitlements to health services for women refugees and asylum seekers in EU Member States have considerable variation in entitlement to sexual and reproductive services, as well as the scope and quality of those services.

Violations of sexual and reproductive rights of women are reported in high-income countries. There are reports that forced sterilisation of women living with HIV and other vulnerable populations still happen in the USA, where sterilisation of poor and vulnerable women have been practiced widely in the past. In 2009, an American woman receiving social assistance filed a lawsuit against a hospital after she was sterilised without her consent while undergoing a caesarean section. It is reported that

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60 Ibid.
62 In 2011, the state of North Carolina formed a task force to consider compensating the surviving victims of forced sterilisations, which had been carried on until the 1970s, in order to reduce welfare payments to poor people, many of whom were uneducated and black. See also Open Society Foundations (2011), *Against Her Will: Forced and coerced sterilisation of women worldwide*. 

many members of the community rallied in favor of the doctors, calling the victim a “state-check-collecting waste of space” who deserved to be sterilised.\(^{63}\)

Stigma related to poverty, and consequently risk of sterilisation and other human rights violations, is even deeper when women engage in criminalised behaviors. For example, Project Prevention is a U.S.-based nonprofit organisation that pays women who use illicit drugs to be sterilised or to accept long-term contraception. So far, more than 1,300 women have been sterilised. In 2010, the project expanded to the United Kingdom.\(^{64}\) National law in Spain and other countries allows for the sterilisation of minors who are found to have severe intellectual disabilities. In the United States, fifteen states have laws that fail to protect women with disabilities from involuntary sterilisation.\(^{65}\) Considering that women living with HIV are often poor, and in addition to HIV may be using drugs or have (other) disabilities, involuntary sterilisation continues to be a threat to women’s sexual and reproductive health.

### 4.1 Laws and Law Enforcement

**Emergency Contraception**

It has been suggested that emergency contraception (EC) fills a unique role in the range of modern contraceptive methods and is particularly valuable for victims of sexual violence, adolescents, and other marginalised groups who may have greater difficulty accessing alternative contraceptive methods.\(^{66}\) Barriers to accessing EC identified in the literature include: legislative or policy restrictions; the absence of a clear government policy on the provision of EC; requirements for a doctor’s prescription from a physician; parental consent and minimum age requirements; pharmacists’ unwillingness to provide women and adolescent girls with EC; and lack of awareness of EC.\(^{67}\) As EC is most effective when taken within 72 hours of unprotected intercourse, such barriers may limit women’s access to the drug.\(^{68}\)

Examples of varying approaches to provide EC, contraception and issues of concern include the following:

In the USA, four EC drugs have been licensed for use. Three of these products are approved for preventing pregnancy when taken within 72 hours after sexual intercourse, and may be purchased by adults (people 18 years of age or older) without a

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\(^{63}\) Ibid.
\(^{64}\) Ibid.
\(^{65}\) Ibid.
\(^{66}\) See also Center for Reproductive Rights (2010), *The Right to Contraceptive Information and Services for Women and Adolescents*, at 16.
\(^{67}\) Ibid.
\(^{68}\) Ibid.
prescription. Only one of these products can be purchased by young adults 17 years and over without a prescription. The fourth drug is effective up to five days after sexual intercourse; however it is only available with a prescription. State laws with respect to EC vary. The table below is based on a 2011 review of State laws and policies.⁶⁹

**Expanding Access**

- 17 states and the District of Columbia require hospital emergency rooms to provide emergency contraception-related services to sexual assault victims.
- 16 states and the District of Columbia require emergency rooms to provide information about emergency contraception.
- 12 states and the District of Columbia require emergency rooms to dispense the drug on request to assault victims.
- 9 states allow pharmacists to dispense emergency contraception without a physician’s prescription under certain conditions.
- 7 states allow pharmacists to distribute it when acting under a collaborative-practice agreement with a physician.
- 3 states, including 1 that also gives pharmacists the collaborative-practice option, allow pharmacists to distribute emergency contraception in accordance with a state-approved protocol.
- 4 states direct pharmacies to fill all valid prescriptions.
- 1 state directs pharmacists to fill all valid prescriptions.

**Restricting Access**

- 9 states have adopted restrictions on emergency contraception.
- 2 state legislatures, in directing the state to apply for federal approval (known as a waiver) to expand eligibility for Medicaid-covered family planning services, added language aimed at excluding emergency contraception from the services to be covered.
- 2 states exclude emergency contraception from their contraceptive coverage mandate.
- 5 states explicitly allow pharmacists to refuse to dispense contraceptives, including emergency contraception.
- One state explicitly allows pharmacies to refuse to dispense contraceptives, including emergency contraception.

Since April 2005, pharmacists across Canada have had the authority to dispense EC without a written prescription from a physician.⁷⁰ The National Drug Scheduling Advisory Committee has listed EC medications as a “Schedule II” drug – a product, available without a physician’s prescription, kept “behind the counter” in pharmacies, and only made available by request to the pharmacist.

Access to EC and the use of contraception commodities in general can become an issue of concern; in several cities in the USA (San Francisco, Washington DC, New York) it has been reported that police and prosecutors have used condoms as evidence in prostitution-related criminal proceedings.⁷¹

**HIV Testing of Pregnant Women**

In 2006, in the USA the CDC recommended opt-out testing for all pregnant women who presented for care.⁷² Specific recommendations included:

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⁷² CDC (2006), Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in
• All pregnant women in the United States should be screened for HIV infection;
• Screening should occur after a woman is notified that HIV screening is recommended for all pregnant patients, and that she will receive an HIV test as part of the routine panel of prenatal tests unless she declines (opt-out screening);
• HIV testing must be voluntary and free from coercion. No woman should be tested without her knowledge;
• Pregnant women should receive oral or written information that includes an explanation of HIV infection, a description of interventions that can reduce HIV transmission from mother to infant, the meanings of positive and negative test results, and they should be offered an opportunity to ask questions and to decline testing;
• No additional process or written documentation of informed consent beyond what is required for other routine prenatal tests should be required for HIV testing;
• If a patient declines an HIV test, this decision should be documented in the medical record;
• Any woman with undocumented HIV status at the time of labor should be screened with a rapid HIV test unless she declines (opt-out screening).

That being said, HIV testing laws in the USA varies from state to state. Some laws specifically address HIV testing of pregnant women while others do not. For example, the State of Alabama requires physicians to test pregnant women for HIV, without the requirement to obtain consent or advise women of their right to refuse testing; while North Carolina law requires providers to test all pregnant women who present for labor and delivery if the woman’s status is unknown. A number of states have enacted laws that either require or encourage physicians to test (or offer to test) pregnant women for HIV, unless the women opt out, meaning testing will be carried out unless explicitly refused.

In Canada, HIV testing law and policy is determined at the provincial/territorial level. There are two approaches to prenatal testing – opt-in and opt-out – as detailed in the table below that the Public Health Agency of Canada has compiled of each province and territory.

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74 Alabama Administrative Code, r. 420-4-1.14.
75 North Carolina Administrative Code, 41A.0202(14).
76 Public Health Agency of Canada (2010), HIV/AIDS Epi Update: July 2010, Her Majesty the Queen in Right of Canada
A survey of countries in the EU revealed that all eighteen of them have a national policy prescribing voluntary antenatal HIV screening. In almost all EU countries with antenatal HIV screening policies, screening conditions are defined. Sixteen countries opted for a system in which HIV testing is offered to all women attending antenatal services while only two opted for selective screening. The voluntary testing strategies are of two types - the opt-in versus opt-out approach.

In the UK, guidelines developed by professional associations include the following recommendations:

- All pregnant women should be recommended HIV testing at an early stage in pregnancy or as soon as possible if they present for antenatal care at a later stage.
- A woman who is at continuing risk of HIV infection during pregnancy should be recorded and repeat testing offered.
- Rapid or near-patient testing should be considered for women who arrive in labour without having received prior antenatal care.

In France, the public health code was amended in 1993 to require that pregnant women be counseled about the risk of HIV infection and offered an HIV test at their first prenatal healthcare visit.

Deblonde J et al (2007), Antenatal HIV screening in Europe: a review of policies, European Journal of Public Health 17(5): 414-418. The review was based on information obtained from all EU Member States with the exception of Cyprus and Luxembourg.


Loi no. 93-121 du 27 janvier 1993 portant diverses mesures d'ordre social, Art. 48. – I: L'article L. 154 du code de la santé publique est complété par un alinéa ainsi rédigé: "A l’occasion du premier examen prénatal, après information sur les risques de contamination, un test de dépistage de l’infection par le virus de l’immuno-déficience humaine est proposé à la femme enceinte."
Abortion

Laws in the USA regulating access to abortion regularly receive legislative and judicial attention, at both the federal and state level. In *Roe v. Wade*[^80], the Supreme Court held that bans on abortion are unconstitutional. Since that decision, some legislatures have passed laws that may restrict access to abortion.[^81] It has been reported that, as of May 2011, 34 states require counselling prior to an abortion (in seven states the counselling must include information on breast cancer, in ten states it must include fetal pain, in twenty states it must include the mental health impact of abortion, and in nine states it must include information on access to ultrasound services). Twenty-nine states have waiting periods to access abortion services, twenty-two of which require a 24-hour wait between receiving counselling and accessing the abortion procedure.[^82]

In general, as illustrated in the table below, there are very few legal impediments to access abortion in the European high-income countries considered in this brief, although government funding has been perceived to be absent in a number of countries.

<table>
<thead>
<tr>
<th>Country or area</th>
<th>To save a woman's life (1)</th>
<th>To preserve a woman's physical health (2)</th>
<th>To preserve a woman's mental health (3)</th>
<th>In case of rape or incest (4)</th>
<th>Because of fetal impairment (5)</th>
<th>For economic or social reasons (6)</th>
<th>On request (7)</th>
<th>Government support for family planning (12)</th>
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**Assisted Reproduction**

Giving birth and having children play a significant role in the social and personal identity of women and men in most if not all cultures.\(^{83}\) In addition to normal fertility issues, people living with HIV face additional challenges to healthful conception, including the lack of legislation and policies that clarify the reproductive rights of people living with HIV. As a result, even in high-income countries, access to assisted reproduction technologies (AR) is limited and costly.

The most commonly used AR technologies to prevent HIV transmission from male-to-female during conception include sperm preparation techniques, such as sperm washing, column purification, and intracytoplasmic sperm injection. Sperm washing has shown substantial success in pregnancy outcomes, with no HIV transmission to women.\(^{84}\)

In Canada, the regulation of the use of AR Technologies is complex, a result of its many facets falling under federal jurisdiction, and carried out in varying provincial/territorial contexts.\(^{85}\) The parliament, through the *Assisted Human Reproduction Act*\(^{86}\) and regulations made under authority of that Act, regulates many aspects of AR Technologies that also fall under other federal jurisdictions, including criminal law (e.g. via criminal prohibitions on cloning), and trade and commerce (e.g., via prohibitions on importing and exporting reproductive material to and from other countries).\(^{87}\) In practice, access to AR technologies is, in fact, limited by a number of factors, including, most prominently, screening procedures employed by the physician, and the high cost of treatment. The province of Ontario has chosen to insure AR services under their provincial health care insurance plan. A provincial court of appeal held that Nova Scotia’s policy of not insuring AR procedures amounted to discrimination on the basis of disability or on analogous grounds, but that the discrimination was justified given the province’s limited financial resources.\(^{88}\)

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\(^{86}\) SC 2004, c.2. The Act received Royal Assent on 29 March 2004. Sections of the Act and regulations giving effect to certain provisions of the Act have been, and will continue to be, introduced in stages by the Government of Canada.

\(^{87}\) Ibid.

\(^{88}\) *Cameron v Nova Scotia (Attorney General)*, (1999) 177 DLR (4th) 611 (NSCA); aff’g [1999] 172 NSR (2d) 227 (SC); leave to appeal dismissed (without reasons) [1999], SCCA No 531.
The situation within the USA regarding sperm washing has been described as follows.\textsuperscript{89} 

... there are state-by-state differences in the laws surrounding the use of HIV-positive semen with some classifying it as a felony (Delaware and Indiana) and others a misdemeanor (Illinois), further complicated by laws less specifically referring to exposure to infected bodily fluids as either a felony in seven states or misdemeanor in three states. In contrast to these concerns and the concern about civil lawsuits, should a partner or a child seroconvert, there is the paradoxical concern of successful prosecution under the \textit{American Disabilities Act} of 1990 with refusal to treat HIV-positive patients.

4.2 Public Health Impact

The vast majority of literature describing and evaluating laws, policies and practices related to the sexual and reproductive rights of women living with HIV examine the situation of women in high HIV prevalence settings in low- and middle-income countries. The literature from high-income countries is relatively underdeveloped. However, there is some literature which examines these issues, as discussed below.

\textit{HIV Testing of Pregnant Women}

Qualitative research on women’s experience of prenatal HIV testing in Canada has raised some concerns regarding the nature of pregnant women’s consent, some of which may be relevant in other high-income countries.\textsuperscript{90} These concerns include: ensuring principles of HIV counselling and testing, including the need for voluntary informed consent; ensuring women are provided with adequate information to assess the risks and benefits of HIV testing for themselves or for their unborn child; and in jurisdictions with opt-out testing, providing testing in a way that supports women’s decision-making.\textsuperscript{91}

\begin{thebibliography}{99}
\bibitem{nicopoullos2010} Nicopoullos JDM et al (2010), \textit{A decade of the United Kingdom sperm-washing program: untangling the transatlantic divide}, Fertility and Sterility 94(6):2458-2461, at 2459.
\bibitem{ibid} Ibid.
\end{thebibliography}
Examples of recent studies of routine (i.e., opt-out) HIV testing for pregnant women in high-income countries raise a number of issues including women’s need for full information about the rationale for HIV testing during pregnancy and their right to decline, and the need for a confidential and supportive health care environment. In Ireland, a study of routine testing in one hospital setting concluded that routine antenatal HIV screening is effective at detecting HIV among pregnant women and significantly benefits the health of mother and child.

**Assisted Reproduction**

Fertility screening in the UK has identified high incidence infertility among couples living with HIV, and Hepatitis B or C virus (HBV, HCV) infection. The same study documented limited access to specialist clinics and restricted funding to assist couples in obtaining risk-reducing ART treatment, which was concluded to have had potential long-term public health implications as individuals attempt to conceive through unprotected intercourse.

In Canada, a study of registered fertility clinics found that access to infertility investigations and treatments is limited and regionally dependent. The most commonly available treatment was intrauterine insemination for couples in which the female partner was HIV-positive (52%); sperm washing (26%) or in vitro fertilisation (17%), were less commonly offered. A study of HIV-discordant couples has reported that access to anti-retrovirals (ARTs) was difficult, as very few clinics offered ART for HIV-discordant couples; they were not nearby and few health care providers or those living with HIV were aware of available options. Furthermore, support varied amongst health care providers, family and friends, and also depended on whether couples disclosed their HIV status to others. Few health care providers asked directly about couples’ family planning desires and that if HIV status was not disclosed to family and friends, health care providers may be the only source of support they have throughout the process.

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The legal regulation of AR varies across European countries, in terms of what procedures are permitted, who is permitted to access such procedures, and whether state funded services are available. In addition, privacy and affordability are factors in patient decision-making. These factors contribute to individuals and couples seeking reproductive care in jurisdictions other than the jurisdiction in which they reside.

4.3 Good Practice and Law Reform

It has been argued that fulfillment of women’s sexual and reproductive health rights is fundamental to ensuring that women enjoy other human rights – it is critical for gender equality and to ensure that women can participate as full members of society. The commentary to Guideline 3 (review and reform of public health laws) of the International Guidelines on HIV/AIDS and Human Rights calls on states to ensure access to voluntary counselling and testing (VCT), STI and sexual and reproductive health services for men and women. The commentary to Guideline 5 (anti-discrimination and other protective laws) states:

Laws should also be enacted to ensure women’s reproductive and sexual rights, including the right of independent access to reproductive and STD health information and services and means of contraception, including safe and legal abortion and the freedom to choose among these, the right to determine number and spacing of children, the right to demand safer sex practices and the right to legal protection from sexual violence, outside and inside marriage, including legal provisions for marital rape.

The commentary to Guideline 6 (regulation of HIV-related goods, services and information) calls on states to establish legal and social support services to protect individuals from any abuses arising from HIV testing, and to ensure supervision of the quality of delivery of VCT services.

A new law introduced into the New York State legislature would prescribe that possession of a condom may not be received in evidence in any trial, hearing or proceeding as evidence of prostitution, patronising a prostitute, promoting prostitution,

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100 Center for Reproductive Rights (2010), The Right to Contraceptive Information and Services for Women and Adolescents; Center for Reproductive Rights (2009), Reproductive Rights are Human Rights.
102 Ibid.
103 Ibid.
permitting prostitution, maintaining a premises for prostitution, lewdness or assignation, or maintaining a bawdy house.\textsuperscript{104} In the State of California, up until 2008, the California Health and State Codes prohibited the transfer of sperm from HIV-positive men and thereby prohibited their treatment whereas treatment of HIV-positive women was allowed. In 2008, the law was amended to sperm washing of semen from an HIV-positive man for ART, with a designated partner after mutual informed consent.\textsuperscript{105}

Clinics in Italy, Spain, the United Kingdom, Switzerland, France, Belgium and Israel have established a network of clinics, termed CREATHE (Centres for Reproductive Assistance to HIV Couples in Europe), which is designed to ensure the optimisation of treatment and proper monitoring of outcomes.\textsuperscript{106}

According to the WHO, the use of anti-retroviral medications for post-exposure prophylaxis (HIV-PEP) to non-occupational situations has raised numerous areas of uncertainty for policy makers and healthcare providers caring for potentially exposed individuals.\textsuperscript{107} Key issues include the appropriate indications for HIV-PEP, ART choices, and management strategies to accompany use of PEP for HIV. A number of high-countries, and jurisdictions within those countries, have published guidance on the use of HIV-PEP after sexual exposures to HIV, which may include discussion of the use of HIV-PEP in cases of rape or sexual assault.\textsuperscript{108}

Greater research and practical efforts are required to address the HIV epidemic among women and girls in high-income countries and to fulfill concrete health needs of women and girls, as well as guarantees of gender equality. It is critical at this point in the global pandemic that efforts focus simultaneously on individual behaviour change, and on wider social, cultural and economic change. Realistic strategies must be found that address the triple challenge of poverty, gender inequality and HIV.

\textsuperscript{104} New York State Bill A1008-2011/S323-2011.
\textsuperscript{105} Barnhart N et al (2009), \textit{Assisted reproduction for couples affected by human immunodeficiency virus in California}, Fertility and Sterility 91(4):1540–1543.
\textsuperscript{106} Lentz V (2008), \textit{Asking the Inconceivable}?
“Every day, stigma and discrimination in all their forms bear down on women and men living with HIV, including sex workers, people who use drugs, men who have sex with men, and transgender people. Many individuals most at risk of HIV infection have been left in the shadows and marginalised, rather than being openly and usefully engaged... To halt and reverse the spread [of HIV], we need rational responses which shrug off the yoke of prejudice and stigma. We need responses which are built on the solid foundations of equality and dignity for all, and which protect and promote the rights of those who are living with HIV and those who are typically marginalised.”

- UNDP Administrator Helen Clark

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