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PROTECTING THE RIGHTS OF KEY HIV-AFFECTED WOMEN AND GIRLS IN HEALTH CARE SETTINGS: A LEGAL SCAN

REGIONAL REPORT

**BANGLADESH, INDIA,
PAKISTAN, NEPAL**



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Protecting the rights of key HIV-affected women and girls in health care settings: A legal scan

Regional report

Bangladesh, India, Pakistan, Nepal



SAARC LAW
South Asian Association for Regional
Co-operation in Law

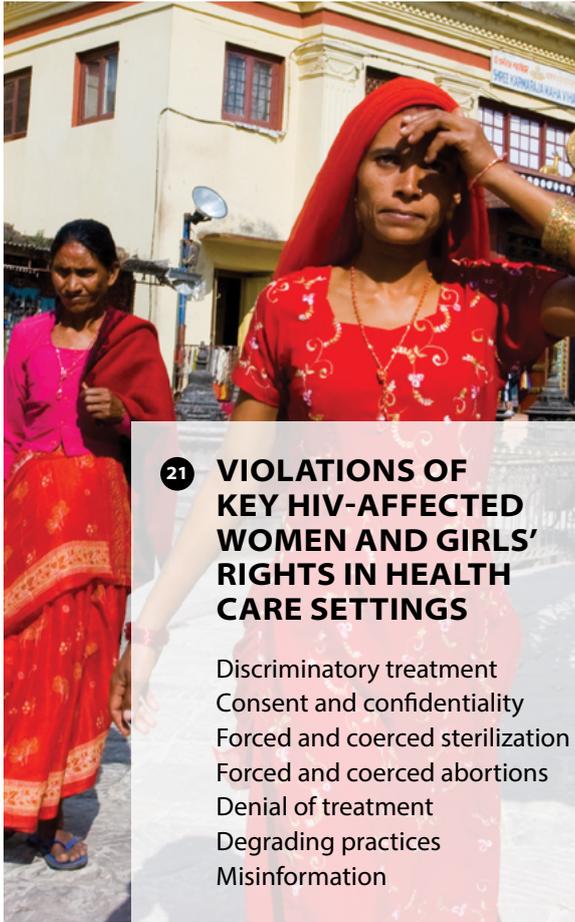


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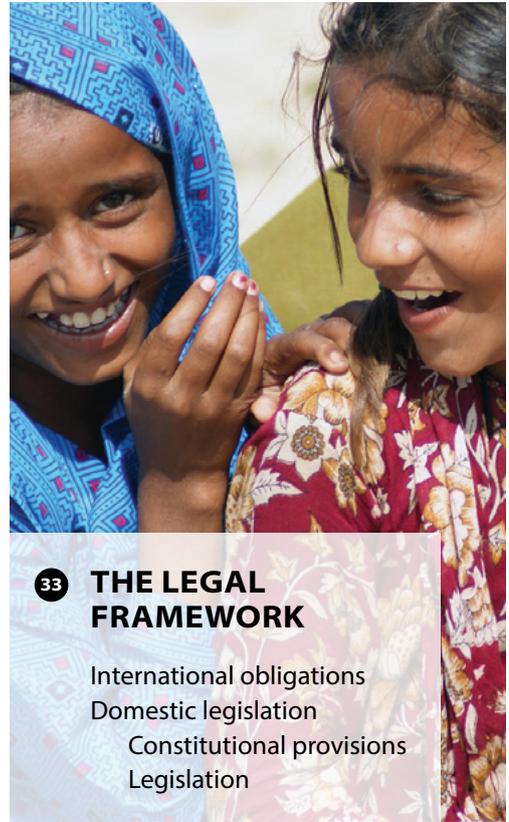


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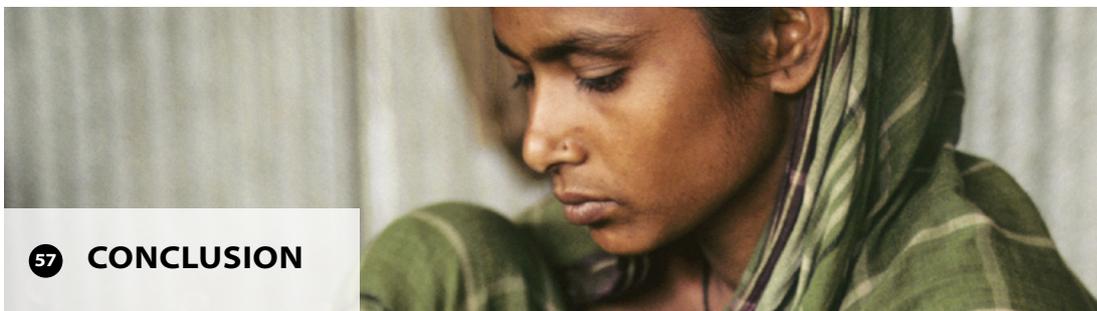
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FOREWORD

It is indeed a great achievement that gender equality is a fundamental element of the constitutions of all countries in South Asia, yet women and girls continue to be discriminated against within their homes, in schools, in the work place, in institutional settings, and even by law. More specifically, discrimination is especially strong among women and girls who are affected by HIV.

Evidence has emerged over the past few years that the fundamental rights of key HIV-affected women and girls¹ are often violated at health care settings. These violations can be in the form of discriminatory, humiliating, or degrading treatment; breaches of consent and confidentiality; forced or coerced sterilization and abortions; denial of services and care; and misinformation on standards of care.

This report looks into existing constitutional provisions, laws, and legal mechanisms in Bangladesh, India, Nepal, and Pakistan, and identifies provisions that provide protection or redress for violations of rights at health care settings. While the report focuses specifically on key HIV-affected women, the legal provisions identified also apply to the general population (including marginalized groups, such as disabled and very poor women) whose rights might be violated in health care settings.

The report demonstrates that there are serious gaps in laws to provide protection and redress for violation of rights at health care settings in the four countries under discussion. While the constitutions in all four countries guarantee equality under the law and prohibit discrimination based on sex, there are only a few laws or legal mechanisms that women can use to access justice if these rights have been violated in health care settings. Those that do exist, such as Pakistan's Reproductive Healthcare and Rights Act, lack effective implementation measures such as penalties for redress in the case of non-adherence to the provisions. Codes of conduct for physicians in these countries, such as the Bangladesh Medical and Dental Council Act (2010), also afford some level of protection, but they remain ineffectual given the limited resources allocated for their implementation and monitoring. This effectively means that large numbers of women whose rights have been violated at health care settings do not have any recourse to justice.

Despite the dearth of specific laws, the judicial system has sporadically stepped in to protect patients' rights, especially in India and Nepal, promoting changes in laws or stipulating additional protective guidelines on the basis of constitutional rights as well as those based on international instruments that the countries have signed or ratified, such as the Universal Declaration of Human Rights, International Convention on Civil and Political Rights, and Convention on the Elimination of Discrimination against Women. This report has reviewed these instances and notes that while these may apply to women and girls affected by HIV, they have not yet been used to provide justice for women who have been forced or coerced into having an abortion or being sterilized because they are HIV positive.

This is not to imply that countries are not aware of the issue and are not working towards solutions. For instance, Nepal, India, and Pakistan have drafted national HIV bills that provide such protection, although none of these bills have been passed and put into force. We call on countries to pass pending legislation that provides for rights-based provisions that ensure the protection of all people – including people living with HIV and HIV-affected women and girls – in the event that their rights are violated in health care and other institutional settings.

1 Key HIV-affected women and girls include: i) women and girls living with HIV; ii) female sex workers; iii) female spouses of male clients of sex workers; iv) women who use drugs; v) female spouses of men who inject drugs; vi) female spouses of men who have sex with men; and vii) women and girls from households affected by HIV/AIDS.

Intersectoral partnerships within countries and across South Asia are needed to address these and broader gender issues in the region. It is our hope that this report is a step in that direction, representing an important partnership between the Asia Pacific Network of People Living with HIV (APN+), South Asian Association for Regional Co-operation in Law (SAARCLAW) and the United Nations. Together, we remain committed to strengthening the rule of law in the region and addressing gender inequality and, specifically, the needs of HIV affected women and girls in the region.

A handwritten signature in black ink, appearing to read 'Clifton Cortez', with a stylized flourish at the end.

Clifton Cortez

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This report was authored by Ayesha Mago with support from Sheeza Ahmed for the section on Pakistan, Mohamed Zeeshan Mohsen for the section on Bangladesh, and Naomi Burke Shyne for the section on Nepal. The initiative was conceptualized by Nashida Sattar, HIV Health and Development Programme Specialist, UNDP Asia-Pacific Regional Center, and Brianna Harrison, Human Rights and Law Advisor, UNAIDS Asia Pacific Regional Support Team.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BLAST	Bangladesh Legal Aid Services Trust
BMDC	Bangladesh Medical and Dental Council
BNWLA	Bangladesh National Woman Lawyers Association
CAT	Convention against Torture and Cruel, Inhuman, and Degrading Punishment
CEDAW	Convention on the Elimination of Discrimination against Women
CEHAT	Centre for Enquiry into Health and Allied Themes
CESCR	Committee on Economic, Social and Cultural Rights
FIR	First Information Report
HIV	Human Immunodeficiency Virus
HRC	Human Rights Committee (of the United Nations)
HRW	Human Rights Watch
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Convention on Economic, Social and Cultural Rights
ICHRL	India Centre for Human Rights and Law
ICPD	International Conference on Population and Development
KAWG	Key HIV-affected women and girls
KPHR	Key Populations at Higher Risk
NHRC	National Human Rights Commission
PHC	Primary health care centres
PLHIV	People living with HIV
PPC	Pakistan Penal Code
PWUD	People who use drugs
SAARC	South Asian Association for Regional Co-operation
SAARCLAW	South Asian Association for Regional Co-operation in Law
STD	Sexually transmitted disease
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme



EXECUTIVE SUMMARY

There is emerging recognition that there are instances where health care institutions are sites of discrimination, violence, and abuse towards individuals who come seeking health care services, with health care providers withholding care or performing treatment that intentionally or negligently inflicts pain and suffering. Rights violations that key HIV-affected women and girls² (KAWG) face in health care settings may include forced and coerced sterilization, forced and coerced abortions, denial of access to sexual and reproductive health services, and being subjected to discrimination and degrading treatment.

In a report submitted to the twenty-second session of the Human Rights Council (February 2013), the Special Rapporteur on Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment, Juan Mendez, noted that some of these practices not only involve violations of human rights such as the right to health, the right to non-discrimination on prohibited grounds, and the right to found a family, but they may constitute torture and inhuman or degrading treatment. Specifically, the Special Rapporteur's report found evidence of significant levels of rights violations among KAWG in health care settings in each country. Despite the many interventions by non-governmental organizations (NGOs) and government institutions regarding the practices of health care workers, stigma and discrimination continue in many hospitals and health care centres across South Asia.

Key findings

Violations of rights of KAWG at health care settings

Given the varying nature of the health services sought by women, men, and transgender people, discrimination at health care settings has a gendered aspect. KAWG across the region face a range of specific violations in health care settings.

Discriminatory treatment: Discrimination towards women living with HIV, both within the household and family and within society at large, is mirrored in health care settings. Evidence suggests that HIV-related discrimination may be exacerbated for HIV-positive women who are sex workers, transgender, or who use drugs. A Nepalese study among 425 sex workers has shown that lack of confidentiality, discrimination, and negative attitudes by health care providers, as well as fear of being identified to the public or to law

² See footnote 1.

enforcement officials as a sex worker, were the major barriers to their seeking sexual health services.³ One fifth of the 425 respondents had never visited a health facility, as many female sex workers limit themselves to using private clinics, non-governmental clinics, and pharmacies to avoid the discrimination and poor treatment meted out to them on the basis of their work.⁴

Consent and confidentiality: A 2007 study in India found that of 884 health care workers interviewed half felt that the need for a patient's consent prior to testing for HIV was exaggerated, and just 39 percent agreed that a patient's blood should never be tested without prior consent. In addition, 86 percent of respondents were supportive of mandatory testing of all patients before surgery, and 79 percent said all pregnant women should be mandatorily tested.⁵ The Stigma Index report for Bangladesh found that approximately half of the 86 women surveyed who had been tested for HIV had consented to the test.⁶ The Stigma Index report for Nepal found that 7 percent of women respondents reported forceful testing of their HIV status during medical examination.⁷

Forced and coerced sterilization: Of 228 women surveyed in a six-country study in Asia, more than 70 percent said they had been asked or encouraged to have a sterilization procedure.⁸ More than 35 percent of the Indian women surveyed said they had been asked to consider sterilization. The same study showed that 15 percent of the Bangladeshi women surveyed were asked to have a sterilization, of whom only 40 percent felt they could decline. Fifteen percent of the 40 women surveyed in Nepal were asked to undergo sterilization, and only one felt she could decline. The Stigma Index report for Nepal showed that 2 percent of the 394 female respondents (women living with HIV) surveyed said that they had been coerced into sterilization.⁹ The Stigma Index report for Pakistan showed that 4.5 percent of the 228 women surveyed said that they had been coerced into sterilization.

Forced and coerced abortions: Studies showed a wide variation in the prevalence of abortion among HIV-positive women (including those that are forced or coerced), with 0.1 percent for India and Bangladesh but 25 percent for Nepal.¹⁰ Another study showed that 1.6 percent of HIV-positive women respondents in Nepal reported being coerced into an abortion by health personnel.¹¹ The Stigma Index report for India reveals that 4 percent of the 593 women interviewed reported being coerced into an abortion. Additionally, 7 percent of the 98 female sex workers interviewed reported being coerced into an abortion.¹² The PLHIV Stigma Index report for Pakistan shows that 37.3 percent of the 228 female respondents stated that they had been coerced by a health care professional into an abortion.¹³

Denial of treatment: The Stigma Index results from Pakistan showed that 33 percent of the 883 respondents (male and female) said they had been denied access to health care, including dental care, due to their HIV status.¹⁴ A 2012 report of the Nepal Health Research Council found six respondents stating that a health

3 Laxmi Ghimire and Edwin van Teijlingen, "Barriers to Utilisation of Sexual Health Services by Female Sex Workers in Nepal," *Global Journal of Health Science*, vol. 1, no. 1 (2009).

4 Ibid.

5 V. Mahendra et al., "Understanding and measuring AIDS-related stigma in health care settings: A developing country perspective," *Journal of Social Aspects of HIV/AIDS*, vol. 4, no. 2 (2007), pp. 616–625.

6 People Living with HIV Stigma Index, "Piecing It Together for Women and Girls: The Gender Dimensions of HIV-Related Stigma" (2011).

7 People Living with HIV Stigma Index Nepal (2011).

8 Asia Pacific Network of People living with HIV, *Positive and Pregnant: How Dare You? A study on access to reproductive and maternal health care for women living with HIV in Asia*. (Bangkok, APN+, 2012), hereafter referred to as Positive and pregnant.

9 Family Planning Association of Nepal, *PLHIV Stigma Index Report, Nepal* (2011), p. 66.

10 Ibid., p. 24.

11 Family Planning Association of Nepal, *PLHIV Stigma Index Report, Nepal* (2011), pp. 65–67.

12 Family Planning Association of India, *PLHIV Stigma Index Report, India* (2012), at www.aidsdatahub.org/en/reference-librarycols2/stigma-and-discrimination.

13 The Association of People Living with HIV and AIDS, Pakistan, "An Index to Measure the Stigma and Discrimination Experienced by People Living with HIV in Pakistan, 2009–2010" (2012), at www.aidsdatahub.org/en/reference-librarycols2/stigma-and-discrimination/item/24444.

14 UNAIDS, "People Living with HIV Stigma Index: Asia Pacific Regional Analysis," (2011).

institution had refused them treatment on the basis of their HIV status, including a government hospital, medical college, and private clinics. There have also been cases of pregnant HIV-positive women being turned away from hospitals in India at the time of delivery. For instance, in Uttar Pradesh a woman in labour was denied access to the hospital and had to be rushed to another at the last minute to deliver her baby.¹⁵

Degrading treatment during delivery: Many HIV-positive women continue to have negative experiences while giving birth. Women have recounted stories of being neglected by staff before, during, and after their delivery; of being abused by staff for getting pregnant while under the extreme stress of labour; and of staff refusing to touch them or their newborn baby. A Nepalese woman described how during her delivery the doctor wanted to put on two sets of gloves and tried to push the baby back in so that he could put the other set on.¹⁶ Most women said they were not given the option of having a vaginal delivery if their HIV status was known, and that the cost of a caesarean delivery is prohibitive. Women with HIV also reported severe delays in being attended to as well as being asked to leave the hospital earlier than other patients who had undergone the same procedure.¹⁷

Legal frameworks

Fundamental rights guarantees

All four countries have ratified, signed, or acceded to the core human rights conventions, including the Universal Declaration of Human Rights (UDHR); International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (ICESCR); Convention on the Elimination of All forms of Discrimination Against Women (CEDAW); and United Nations Convention on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

These conventions impose upon each state the legal obligation to ensure fundamental rights relevant to the rights violations experienced by KAWG in health care settings, including the right to life; the right to liberty; the right to the highest attainable standard of health; the right to non-discrimination and equality before the law; the right to found a family; and the right to privacy. Provisions in these conventions also prohibit torture and cruel, inhuman, or degrading treatment or punishment.

The constitutions of each of the studied countries also contain fundamental provisions guaranteeing rights to equality, health, life, privacy, and constitutional remedy.

Domestic legislation

This report also found that there is a significant dearth of domestic legislation dealing with discrimination and violations that take place in health care settings, with the notable exception of Pakistan's 2013 Reproductive Healthcare and Rights Act, and the Sindh HIV Control, Treatment, and Protection Act, which have recently been passed into law, and the national HIV bills in Nepal, India, and Pakistan – all of which are currently pending. However, countries currently have legislation that could be interpreted and expanded to include protection for KAWG in health care settings, or at least act as a model for different legislation to be framed around the issue. These laws include:

- Laws relating to discrimination
- Laws relating to reproductive rights
- Laws relating to codes of conduct for physicians

¹⁵ See articles.timesofindia.indiatimes.com/2011-07-20/india/29793628_1_hiv-positive-kaithal-rohtak.

¹⁶ *Positive and Pregnant*, p. 27.

¹⁷ *Ibid.*

- Laws relating to assault
- HIV-specific legislation

The report found that many laws contain provisions that can be used by KAWG who face violations in health care settings. Some examples include:

- Reproductive rights laws, such as Pakistan's Reproductive Health care and Rights Act (2013), are particularly relevant as they contain provisions specifically prohibiting forced abortion or sterilization and emphasize the importance of informed consent.
- Codes of conduct for physicians in all four countries emphasize ensuring informed consent and guaranteeing confidentiality towards patients. They also forbid physicians to deny treatment arbitrarily, as in the Indian Medical Council Regulations. These codes of conduct all contain complaints mechanisms, which in principle can be utilized by a person whose rights have been violated to initiate an enquiry into a specific physician's actions.
- Anti-discrimination Legislation, such as laws dealing with equal rights for persons with disabilities or prohibiting discrimination based on caste, as in the Caste Based Discrimination Act in Nepal, could be expanded to include PLHIV.
- Some assault laws contain provisions that apply to degrading treatment or humiliating remarks towards KAWG, for instance, the Indian Criminal Law Amendment Ordinance (2013). Nepal's country code also specifically addresses "decency" in health care settings, but only in the context of prohibiting sexual intercourse with a patient.
- Some HIV-specific legislation, such as Pakistan's Sindh HIV Act, contains specific provisions such as the mandated training of all health care workers on HIV, discrimination, confidentiality, and consent. This could have a very significant impact on reducing the stigma and discrimination feared and experienced by KAWG in health care settings. The act also provides specific penalties for defined offences by health care providers.

Of course, there are many gaps in the laws, not least the fact that none of the four countries has a comprehensive anti-discrimination law that would be applicable nationally in public and private health care settings and that would protect women and girls living with or affected by HIV and AIDS. Laws that do exist need to be properly enforced and bolstered by effective implementation and complaint mechanisms that are easy to access and that make people working within health care accountable for their actions. This includes ensuring the provision of information about complaints mechanisms to patients, and access to legal services for those who need it.

Key recommendations

General

Our research has identified several general recommendations for strengthening protection and ensuring rights for KAWG in health care settings:

1. Meaningful participation of key HIV-affected women and girls must be ensured in order for policy makers to understand and respond to the nature of their experiences in health care settings. Consultations ensuring participation of all stakeholders should be planned and should focus on joint development of recommendations for laws, policies, and programmes to prevent future rights violations in health care settings.

2. All pending HIV bills should be passed with the specific stipulation of implementing structures to ensure that provisions are effectively enforced and executed.
3. Enact non-discrimination legislation based on constitutional guarantees and applicable to both public and private actors in health care settings. Ensure that the legislation is aligned with international conventions such as ICESCR and CEDAW. The legislation should contain specific provisions that recognize the gendered experiences of women in health care situations by stipulating additional safeguards related to informed consent in cases concerning the reproductive rights of women, including KAWG. Countries should repeal laws that explicitly discriminate against women.
4. National or state-level interventions, including those carried out by state bodies, should deal with structural issues such as non-accessibility of legal services and the gendered nature of judicial systems to ensure that, where laws exist to protect women, they have access to justice. This would involve training of the judiciary on issues related to KAWG. Other necessary measures include:
 - Training and supporting NGOs, including HIV-positive women's networks and women's rights advocates, to implement programmes promoting increased awareness of laws and mechanisms for redress, effective documentation of rights violations, and assistance in approaching available legal-aid bodies.
 - Ensuring information on rights related to HIV and sexual and reproductive health (SRH) as well as on complaints and redressal mechanisms (where available) to women in community health centres, district hospitals, and local legal-aid centres.
5. Decriminalize sex work in order to reduce stigma and discrimination towards sex workers seeking health care and HIV-related testing and treatment.
 - Develop and implement a national policy to address HIV-related stigma and discrimination in health care settings, including through stigma and discrimination reduction programmes for health care workers. In accordance with Joint United Nations Program on HIV/AIDS (UNAIDS) guidance on stigma reduction,¹⁸ training in health care settings should be conducted with health care workers, administrators, and health care regulators with the objectives of ensuring that stigmatizing attitudes in health care settings are reduced and health care providers are given the skills and tools necessary to ensure patients' rights to informed decision-making, informed consent, confidentiality, treatment, and non-discrimination.

Recommendations for South Asian Association for Regional Co-operation in Law (SAARCLAW) chapters

1. Use regular SAARCLAW meetings as forums to disseminate information on the latest findings on violations of women's rights in health care settings. Raise awareness among SAARCLAW members on specific legal needs of women and encourage legal aid related involvement from constituent members.
2. Disseminate information on legal judgments to all lawyers, judges, and academics who are members of SAARCLAW. This could include: the Supreme Court's decision on the two-finger test in sexual assault cases in India; the UN Special Rapporteur report on re-classifying violations in health care settings as torture; and progress on new laws in each country on discrimination, HIV/AIDS, and violence against women.

18 See UNAIDS Guidance Note, "Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses" (2012).

3. Encourage national chapters to engage more actively with issues related to women's rights and to implement workshops to address the lack of awareness of legal rights and general knowledge on health-related rights.
4. Support national chapters to formulate and implement training programmes and to carry out workshops on discrimination against women at health care settings, for example, with District Bar Councils.
5. Encourage national chapters to engage affiliated lawyers to provide pro bono legal aid, or lead public interest litigation related to violations of women's rights in the health care sector.
6. Establish a legal knowledge online archive of the SAARC region with regard to the judgments, case law, and legislation pertaining to women – including KAWG, disabled women, and other marginalized women. This should be updated on a regular basis and be accessible to researchers and practitioners.



BACKGROUND

There is emerging recognition that some health care institutions are sites of discrimination, violence, and abuse towards individuals who come seeking services, with health care providers withholding care or performing treatment that intentionally or negligently inflicts pain and suffering. Rights violations that key HIV affected women and girls face in health care settings include forced and coerced sterilization, forced and coerced abortions, denial of access to sexual and reproductive health services, and being subjected to discrimination – such as advice against reproduction despite lack of medical indications of risk to mother or baby.

In a report submitted to the twenty-second session of the Human Rights Council (February 2013), the Special Rapporteur on Torture, and other Cruel, Inhuman, or Degrading treatment or Punishment, Juan Méndez, noted that some of these practices not only involve violations of human rights such as the right to health, the right to non-discrimination on prohibited grounds, and the right to found a family, but they may constitute torture and inhuman or degrading treatment. He also stated that “Medical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman, or degrading treatment or punishment; and if there is State involvement and specific intent, it is torture.”¹⁹ The Special Rapporteur’s report specifically focused on violations against marginalized groups, including people living with HIV, sex workers, and people of diverse sexual orientation and gender identity. It also examined reproductive rights violations, such as forced sterilisations and abortions.

Many KAWG find that their right to the highest attainable standard of health, the right to found a family, and the right to be free from discrimination on the grounds of sex or HIV status are regularly violated.²⁰ The legal environment – laws, law enforcement, and access to justice – play a critical role in protecting these rights or, conversely, in contributing to the discrimination and disempowerment of women and/or key affected populations. Yet, even where protective laws exist, few women have recourse to justice when their rights are violated. Structural weaknesses such as illiteracy, lack of awareness, lack of economic/bargaining power, and gender bias obstruct women’s access to justice. In this context, while recognizing that law reform is important, this report acknowledges that law enforcement practices, systems for documenting and addressing human rights violations and delivery of legal aid, access to justice, and community legal education are all equally so.

¹⁹ Juan E. Méndez, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (2013) at www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf.

²⁰ For instance, *Positive and Pregnant* and UNAIDS, *People Living with HIV Stigma Index: Asia Pacific Regional Analysis* (2011).

This report, then, may be looked at as a first step, identifying protective laws with the aim of supporting policy development related to protecting the sexual and reproductive health and rights of KAWG in health care settings.

Methodology

This report was commissioned by the United Nations Development Program (UNDP), in partnership with Asia Pacific Network of People Living with HIV (APN+), South Asian Association for Regional Co-operation in Law (SAARCLAW) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) to conduct a scan on legal protections of the rights of KAWG in health care settings.

This report aims to review the legal environment with regard to this issue in four countries in South Asia: Bangladesh, India, Nepal, and Pakistan. It also aims to assess the legislation with a view to recommending a way forward to improve and strengthen protection of rights of KAWG in health care settings in the four countries.

Research was conducted with the assistance of the National SAARCLAW chapters in the four countries, which identified and worked with the national consultants. This regional report is based partially on the findings of the national studies as well as on shared reports provided by partner UN agencies.

The majority of research was conducted online. Online databases that were utilised included:

- www.aidsdatahub.org
- PubMed at www.ncbi.nlm.nih.gov/pubmed
- www.ohchr.org/EN/HRBodies/Pages/TreatyBodies.aspx
- WomenWatch: Directory of UN Resources on Gender Equality and Empowerment of Women
- Databases of UNAIDS, United Nations Women, and UNDP were also used.

Key search words, in various different combinations and with and without specific country names, included but were not limited to: women, HIV, gender, inequality, South Asia, rights violations, human rights, forced sterilization, forced abortion, discrimination, health care, guidelines, stigma, denial of treatment, violence, sex workers, and prevalence. Additional search items were also related to the names of various laws in specific countries.

Objectives of the report

- To identify existing protective laws (including constitutional provisions) and legal mechanisms for seeking protection or redress for violations of rights of KAWG in health care settings;
- To document rights violations experienced by KAWG in health care settings;
- To document one or two selected court rulings on violations of rights of KAWG in health care settings;
- To document cases where KAWG have been able to access justice for violations of rights in health care settings through legal mechanisms;

- To identify gaps in laws and legal mechanisms that protect KAWG from such violations;
 - To develop recommendations for governments, the legal sector, health care institutions, and SAARCLAW for actions to be taken to improve the legal environment in order to protect the rights of KAWG in health care settings.
-



GENDER INEQUALITY AND HEALTH IN SOUTH ASIA

It is estimated that nearly 40 percent of the total number of people living in poverty in the world reside in South Asia.²¹ The latest *Human Development Report* (2013) focuses on the tremendous economic growth of countries such as India as well as on smaller economies such as Bangladesh, but key statistical indicators for human development remain low with the four studied countries occupying low positions on the human development index²² and the gender equality index.²³

Prevailing gender inequality, common to all four of the countries in this study, is inextricably linked to women's health. Evidence suggests that gender discrimination from a young age constitutes "a central risk factor for poor reproductive health outcomes in South Asia because it translates into a lifetime of social and health vulnerability."²⁴ A World Bank study explains that specific factors enhance these risks for women in South Asia. In addition, power dynamics within families tend to influence decisions on access to health facilities and skilled health care providers, with South Asian women getting lower priority in household resource allocations, and decisions about contact with outsiders often being made by husbands or mothers-in-law.²⁵ Studies show that a majority of women are still not able to take critical health care decisions,²⁶ in large part due to the fact that at the household level the health of women is a lower priority than that of male household members, and health care for women is thus sought much less frequently than for men.²⁷

Additionally, violence-against-women in South Asia is pervasive both within and outside the home regardless of social background, education, caste, region, or religion. The violence women face is sometimes culture specific and includes "domestic violence, rape, sexual harassment, incest, trafficking, honour killings, acid

21 Oxfam Briefing Paper 66, "Towards Ending Violence against Women in South Asia", 2004

22 The positions on the human development index ranked amongst 187 nations are : India 136, Pakistan and Bangladesh at 146, and Nepal at 157.

23 The 2010 Human Development Report introduced the Gender Inequality Index, which is a composite measure reflecting inequality in achievements between women and men in three dimensions: reproductive health, empowerment, and the labour market.

24 World Bank, *Sparing Lives, Better Reproductive Health for Women in South Asia* (2008), p. 5.

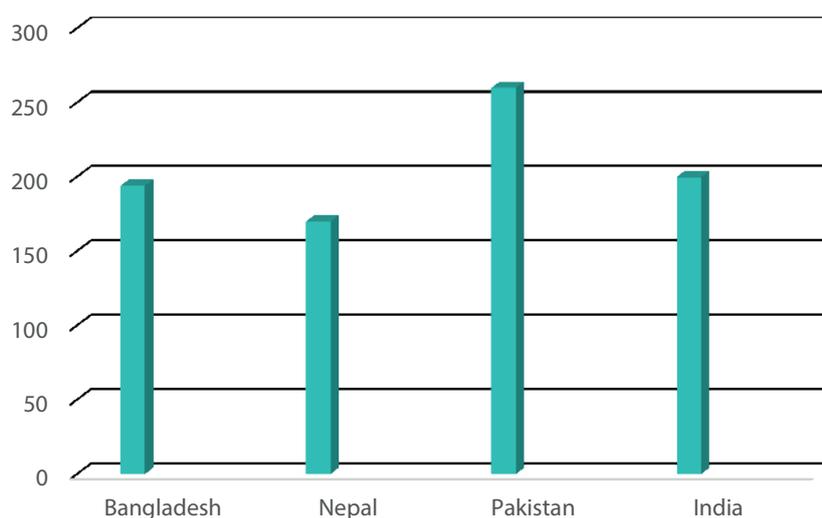
25 Ibid.

26 See news.priyo.com/health/2011/03/08/bangladesh-no-healthcare-say-w-21442.html.

27 J. Nidhi Khosla, 'HIV/AIDS Interventions in Bangladesh: What Can Application of a Social Exclusion Framework Tell Us', in *Journal of Health Population and Nutrition* August 2009; vol. 27, no. 4, pp. 587–597; and Dr. Subha Sri, Sarojini N, and Renu Khanna, *Maternal Deaths and Denial of Maternal Care in Barwani District, Madhya Pradesh: Issues and Concerns* (Jan Swastha Abhiyan, CommonHealth, and Sama - Resource Group for Women and Health, 2011).

attacks, public mutilation, stove-burnings, and forced temple prostitution.”²⁸ These multiple forms of violence have the effect of limiting women’s choices and seriously affecting their health, wealth, and mobility.²⁹

Figure 1: Maternal mortality rates (per 100,000)



Women living with and affected by HIV: Vulnerability and discrimination

“Gender inequality, manifested in women and girls’ restricted access to education; health; assets, resources, and economic opportunities; their diminished participation in decision making processes; their lack of control over their own sexual and reproductive choices; their disproportionate care responsibilities; influence women’s and girls’ experience of the HIV epidemic, and its response.”³⁰

It is widely acknowledged that women face greater HIV risks as well as disproportionate impacts of the HIV epidemic. This is true not only in terms of their vulnerability to infection and constrained access to services but also the higher burden of household responsibility and care that they face.³¹ Research in Asia shows that women living with or affected by HIV face significant burdens, including:³²

- i. Differences in asset accumulation, with women being denied a share in property or assets after the death of her husband.
- ii. Across the region, girls in HIV-affected households were the least likely to be attending school and the most likely to have dropped-out and/or be employed.

28 Oxfam Briefing Paper 66.

29 Ibid., p. 2.

30 Neelanjana Mukherjee, *Linkages between violence against women and HIV in Asia and the Pacific Region*, (UNDP Asia-Pacific Regional Centre, 2013), p. 16. For more information, see *UNAIDS Agenda for Accelerated Country Action* (UNAIDS and UNDP, 2009); *Essential Actions on Gender and AIDS* (UNIFEM, 2009); and *Transforming the National AIDS Response Mainstreaming Gender and Women’s Human Rights into the “Three Ones”* (UN Women, 2006)

31 *The Socio-Economic Impact of HIV at the Household Level in Asia: A Regional Analysis of the Impact on Women and Girls* (UNDP 2011).

32 Ibid.

- iii. Greater levels of discrimination within the family and within the health care system.
- iv. Less likely to seek health care, with financial constraints being the most commonly cited reason.
- v. Female-headed households are more likely to have had to migrate.

Several Indian studies have found that where both husband and wife are diagnosed with HIV, it is invariably the woman who is denied shelter, access to household property, and access to the children. She is usually blamed for the husband's HIV status, the rationale being that even if he did visit sex workers, it was because she could not keep him 'under control'.³³ A recent study among 68 women living with HIV in two villages in India found that over 80 percent of the women were told not to share food or utensils and not to touch or care for children, and 75 percent were forced to leave their homes by family members.³⁴ Researchers note that a recurrent theme in the discrimination against HIV-positive women in the household is the unwillingness of the family to expend money towards the daughter-in-law's treatment. Mothers with HIV face additional challenges related to inheritance, access to education for their children, and custody issues.³⁵



Women living with HIV in Asia

- Thirty-five percent of all HIV-positive people in the Asia-Pacific region are women.³⁶
- In India, 39 percent of adults living with HIV are estimated to be women.³⁷
- In Nepal, women aged 15–49 broadly account for 28 percent of HIV infections.³⁸
- In Bangladesh, women account for fewer than 1,000 of the total number of PLHIV.
- Pakistan is estimated to have approximately 28,000 women living with HIV.

Women come from diverse backgrounds and face "multiple and intersecting discriminations on the basis of their class, caste, race, ethnicity, age, sexual orientation, gender identity, and other factors."³⁹ To put it simply, some women are more vulnerable, marginalized, and discriminated against than others. In the context of HIV, this includes women who face multiple discriminations, often sanctioned by the state, on the basis of their work (sex workers), drug use, gender identity (transgender women), and HIV status (women living with HIV).

These women are also at a heightened risk of violence. As mentioned, violence against women is pervasive across South Asia, and it does not exist in isolation. It is connected to attitudes, social mores, and discriminatory beliefs and practices, both within and outside the family, in all the institutions that people interact with, including health care settings. The links between violence and HIV are widely acknowledged, with research showing that "violence or the fear of violence can restrict the ability of women and girls to seek HIV-prevention services and their ability to refuse sex or negotiate safe sex. It can also inhibit the ability of

33 Adeline Nyamathi et al., "Correlates of Stigma among Rural Indian Women Living with HIV/AIDS," *AIDS and Behavior* (January 2013).

34 Ibid.

35 Nyamathi, A., Thomas, B., Greengold, B., and Swaminathan, S., "Perceptions and Health Care Needs of HIV-Positive Mothers in India," *Progress in Community Health Partnerships*, (Summer 2009), vol. 3, no 2 pp. 99–108.

36 See www.unwomen.org/en/what-we-do/hiv-and-aids/facts-and-figures.

37 National Aids Control Organisation at <http://naco.gov.in/NACO/>

38 National Centre for AIDS and STD Control at <http://www.ncasc.gov.np/>

39 Mukherjee, *Linkages*.

women and girls to disclose their status and to access voluntary counselling and treatment services as well as care and support services."⁴⁰

While a thorough analysis of this issue is beyond the scope of this paper, it should be considered as an overarching influence when examining what is happening to women in health care institutions.⁴¹

40 Program on International Health and Human Rights, Harvard School of Public Health, *Gender Based Violence and HIV* (2011), cited in Mukherjee, *Linkages*, p. 16.

41 For a detailed analysis of the links between HIV and violence against women, see Mukherjee, *Linkages*.



VIOLATIONS OF KEY HIV-AFFECTED WOMEN AND GIRLS' RIGHTS IN HEALTH CARE SETTINGS

Despite the many interventions by NGOs and government institutions have carried out regarding the practices of health care workers, stigma and discrimination continue to be prevalent in many hospitals and health care centres throughout South Asia. Indeed, PLHIV regardless of gender experience discrimination in the context of health care settings. In Bangladesh, a 2010 study on the attitudes of health care workers revealed that almost 48 percent of health care professionals who were questioned – including nurses, medical technicians, and qualified support staff – said people with HIV and AIDS should not be allowed to mix freely with other people. Health care workers who had a sound understanding of HIV were likely to display the least discriminatory attitudes.⁴² Another study found that 68 percent of 884 hospital staff across three large hospitals in Delhi, India, agreed to the statement that “HIV spreads due to immoral behaviour” and that *across* staff levels (doctors, nurses, and ward staff) attitudes towards HIV-positive patients were unfavourable.⁴³

Given the varying nature of services sought by women, men, and transgender people, discrimination in health care settings has a gendered aspect. KAWG across the region face a range of specific violations in health care settings, including:

- Discriminatory and humiliating treatment
- Breaches of consent and confidentiality
- Forced/coerced sterilization
- Forced/coerced abortions
- Denial of services

42 Mohammad Bellal Hossain and Kippax Susan, “HIV-Related Discriminatory Attitudes of Healthcare Workers in Bangladesh,” *Journal of Health, Population and Nutrition*, April 2010; vol. 28, no. 2, pp. 199–207; available at www.ncbi.nlm.nih.gov/pmc/articles/PMC2980883/.

43 V. Mahendra et al., “Understanding and measuring AIDS-related Stigma in Health Care Settings,” *Journal of Social Aspects of HIV AIDS, Research Alliance (SAHARA)* August 2007, 4(2):pp. 616–625.

- Misinformation
- Degrading practices, including:
 - neglect and abuse during delivery
 - evidence tests in cases of sexual assault

Discriminatory treatment

Discrimination towards women living with HIV, within the household and family and within society at large, is mirrored in health care settings. The abovementioned Indian study on rural women living with HIV noted that 70 percent of the respondents reported that health care workers were afraid to touch them.⁴⁴ At least two-thirds reported that they had been denied medical/hospital care and had been mistreated by hospital workers.⁴⁵ Respondents also reported fear of disclosing status, even in health care settings, due to insensitive questions asked about their “morality.”⁴⁶ Another study noted insensitive treatment by health care professionals in maternity wards.⁴⁷

A 2012 study from the Nepal Health Research Council found that a majority of respondents reported stigmatizing behaviour by government hospital staff, explaining that “they do not give priority to us, and look in a different way when we go there.”⁴⁸

Evidence suggests that HIV-related discrimination may be exacerbated for HIV-positive women who are sex workers, transgender, or who use drugs. For instance, transgender women report various forms of humiliation and verbal harassment by hospital staff, including deliberate use of male pronouns in addressing *hijras*⁴⁹ as well as registering them as “males,” admitting them in male wards, and forcing them to stand in the male queue.⁵⁰ Similar accounts were given by transgender women during a 2011 regional consultation⁵¹ on legal barriers to accessing HIV prevention, treatment, and care services in India. One woman described approaching a hospital with a serious infection that was causing her extreme pain, only to have several doctors gather around her and ask humiliating questions about how she had sex rather than treating her for her condition.⁵²

A Nepalese study among 425 sex workers has shown that lack of confidentiality, discrimination, and negative attitudes by health care providers, as well as fear of being identified to the public or to law enforcement officials as a sex worker, were the major barriers to sex workers seeking sexual health services.⁵³ As one respondent explained, “health workers judge and recognize us as a sex worker. They might tell this to my friends and neighbours; it will be bad for me and my future life.”⁵⁴

44 Adeline Nyamathi et al., “Correlates of Stigma among Rural Indian Women Living with HIV/AIDS,” *Aids and Behaviour*, January 2013.

45 Ibid.

46 Ibid.

47 Nyamathi, A., Thomas, B., Greengold, B., and Swaminathan, S., “Perceptions and health care needs of HIV-positive mothers in India,” *Progress in Community Health Partnerships*, vol. 3, no. 2 (Summer 2009), pp.99-108.

48 Neupane, D., Khanal, V., Sharma, S., and Aro, A. R., “Perceived Discrimination among People Living with HIV in Nepal,” *Journal of the Nepal Health Resource Council*, May 2012; vol. 10, no. 21, pp. 136–140.

49 A culturally-specific transgender community found in India, Pakistan, and Bangladesh, many of whom identify as being neither male nor female, but as *hijra*.

50 UNDP, Transgender Issue Brief (2010), at www.undp.org.in/sites/default/files/reports_publication/TG-issue-brief.pdf.

51 Regional consultations were part of a joint UNDP, SAARCLAW, and TSF South Asia project on “Legal Barriers to Accessing HIV Prevention Care and Treatment Services.”

52 Ayesha Mago, Draft Report, *Scan of Laws that Impede Effective HIV Responses in India (UNDP, SAARCLAW, and TSF South Asia, 2012)*.

53 Laxmi Ghimire and Edwin van Teijlingen, “Barriers to Utilisation of Sexual Health Services by Female Sex Workers in Nepal,” *Global Journal of Health Science*, vol. 1, no. 1 (2009).

54 Ibid.

i Sex work and HIV in South Asia

- Sex workers comprise of 0.5 percent of India's adult female population and they account for 7 percent of HIV-positive females.⁵⁵
- There are an estimated 100,000 sex workers in Bangladesh. HIV prevalence among sex workers in Bangladesh is estimated at less than 1 percent.⁵⁶
- HIV prevalence among Pakistan's female sex workers is estimated at 0.6 percent.⁵⁷
- In Nepal, female sex workers, injecting drug users, and transgender women are particularly vulnerable to HIV, with female sex workers (aged 15 years and above) accounting for approximately 1 percent of all HIV infections.⁵⁸

Some respondents explained that health service providers in private clinics as well as doctors in the government hospitals tend to ask personal questions, often loudly and not in a private space, particularly about their work and sexual history. One respondent described being sexually harassed by a male doctor when he realized she was a sex worker. One fifth of the 425 respondent sex workers had never visited a health facility, and many female sex workers limited themselves to using private clinics, non-governmental clinics, and pharmacies to avoid the discrimination and poor treatment meted out to them on the basis of their work.⁵⁹

According to another study, sex workers in India are "treated callously in hospitals and clinics, made to wait longer periods to be seen...and are refused treatment until they agree to undergo HIV testing."⁶⁰ Being forced into having HIV tests and knowing that the results will not be kept private are another serious deterrent to seeking services. This atmosphere of discrimination and moral censure has, understandably, made many sex workers reluctant to approach health care services. Legal activists have pointed out that state health controls, "through measures purportedly serving a public health purpose, are a frequent source of violations of sex workers' rights: mandatory testing for STIs and HIV; routine infringements of confidentiality regarding HIV test results, and other medical information."⁶¹

Sex work is criminalized in all of the four countries in which this study was conducted, although in Nepal it is the client and not the sex worker who is liable for prosecution. Criminalization affects the efficacy of outreach services and HIV-prevention programmes, making sex workers harder to reach and deterring them from approaching health services in fear of legal consequences. A detailed discussion of this topic is beyond the scope of this paper, but multiple studies have linked criminalization to the lowering of access to services.⁶² Another important aspect of this has been highlighted in research carried out as part of the work of the

55 National Aids Control Organisation, Department of AIDS Control (Ministry of Health & Family Welfare), *Annual Report 2009-2010*.

56 UNICEF, "HIV/AIDS in Bangladesh" (updated March 2009); see www.unicef.org/bangladesh/HIV_AIS%281%29.pdf.

57 National Aids Control Programme, Pakistan, *Country Progress Report (2012)*.

58 National Centre for HIV and STD Control, Nepal.

59 Ibid.

60 WHO, *Violence Against Women and HIV/AIDS: Critical Intersections*, "Violence Against Sex Workers and HIV Prevention," Information Bulletin Series, no. 3 (2005), p 2.

61 K. Bhardwaj and V. Divan, *Sexual Health and Human Rights - A Legal and Jurisprudential Review of Select Countries in the SEARO Region: Bangladesh, India, Indonesia, Nepal, Sri Lanka, and Thailand* (International Council on Human Rights Policy, 2011).

62 John Godwin, *Sex Work and the Law in Asia and the Pacific - Laws, HIV and human rights in the context of sex work* (UNAIDS, UNFPA, and UNDP, 2012); Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law, *Issues Brief: Laws and Practices Relating to Criminalization of People Living with HIV and Populations Vulnerable to HIV*, (2011); Human Rights Watch, *Epidemic of Abuse: Police Harassment of HIV/AIDS Outreach Workers in India*, (July 2002); *Laws and policies affecting young people's access to sexual and reproductive health and HIV services in Asia and the Pacific* (UNESCO, UNFPA, UNICEF, UNAIDS, and UNDP, 2013).

Global Commission on HIV and the Law, showing that the conflation of the discourse on trafficking with that of sex work has led to increased criminalization of sex work.⁶³

Indeed, all four of the studied countries have enacted anti-trafficking laws⁶⁴ that include provisions criminalising various aspects of sex work.⁶⁵ Additionally, being predicated on the assumption that all sex workers are sexually exploited, these laws promote attempts to suppress all sex work – including ‘raid and rescue’ interventions, which can result in sex workers being forcibly removed from their workplaces, detained, and mandatorily tested for HIV. The unfortunate consequence of these laws is the reduction of the “options of people selling sexual services to either being ‘rescued’ from their livelihood, or to going ‘underground,’ that is, to becoming even less traceable by official entities, including governmental agencies, such as ministries of health, and non-governmental organizations that provide health and HIV-prevention services.”⁶⁶



Criminalization/ trafficking and health: The Nepalese case⁶⁷

In Nepal, the Anti-trafficking Act – more formally the Human Trafficking and Transportation (Control) Act (2007) – has enacted provisions that criminalize the client but not the sex worker. However, this has only increased the vulnerability of the sex worker from various perspectives. Due to enforcement of this law, the police have made many arrests of clients and brothel owners, but then forced female sex workers (FSWs) to file cases against these people. In Kathmandu, more than 70 cases are pending at the district court, and the sex workers and their families have been subjected to threats. Almost all those concerned have left Kathmandu and gone into hiding. This has meant that HIV-service providers have lost their networks of sex workers while HIV-related vulnerability still remains high. The law has also made it much harder for street-based sex workers to negotiate condom use with clients.

Consent and confidentiality

Testing for HIV without the informed consent of the individual and breaches of confidentiality are contraventions of the rights to dignity, privacy, and physical integrity. The International Guidelines on Human Rights and HIV stipulate that the duty of states to protect the right to privacy “includes the obligation to guarantee that adequate safeguards are in place to ensure that no testing occurs without informed consent, that confidentiality is protected, particularly in health and social welfare settings, and that information on HIV status is not disclosed to third parties without the consent of the individual.”⁶⁸

Paragraph 35 of the International Guidelines states that there is no public health rationale for mandatory testing and that respect for the right to physical integrity requires that “testing be voluntary and that no

63 S. Shah, *Trafficking and the Conflation with Sex Work: Implications for HIV Prevention and Control*, Working Paper for the Third Meeting of the Technical Advisory Group of the Global Commission on HIV and the Law, 7–9 July 2011.

64 Bangladesh - The Human Trafficking Deterrence and Suppression Act (2012); Nepal - Trafficking In Persons and Transportation Control Act (2007); India- Immoral Trafficking (Prevention) Act; Pakistan - Prevention and Control of Human Trafficking Ordinance (2002).

65 For instance, in India the 1986 Immoral Traffic (Prevention) Act penalizes acts such as keeping a brothel (section 3), soliciting in a public place (section 8), living off the earnings of prostitution and living with or habitually being in the company of a prostitute (section 4).

66 Shah, *op. cit.*, p. 5.

67 See also the Public Offences and Punishment Act (1970), Nepal.

68 Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006), para. 121.

testing be carried out without informed consent.”⁶⁹ Yet, all over South Asia women report these rights being consistently breached by HIV testing without informed consent.

In India, reports from 2004 indicated that “pregnant women are routinely tested for HIV without their knowledge, much less informed consent to the procedure.... Spouses of all HIV-positive men are advised, and sometimes forced, to undergo HIV testing whether seeking medical care or not (and)... HIV testing is also administered as a rule to all patients prior to surgery and in cases where a suspicion of HIV arises based on their physical appearance or belonging to a high-risk group, such as sex workers. Generally, such testing is mandatory, no consent is provided, and there is no pre- or post-test counselling.”⁷⁰ A more recent study conducted in 2007 found that of 884 health care workers interviewed, half felt that the need for consent prior to testing was exaggerated and just 39 percent agreed that patients’ blood should never be tested for HIV without their consent. In addition, 86 percent of respondents were supportive of mandatory testing of all patients before surgery and 79 percent said all pregnant women should be mandatorily tested.⁷¹

The stigma index report for Bangladesh found that approximately half of the 86 women surveyed who had been tested for HIV had consented to the test.⁷² The stigma index report for Nepal⁷³ also found that 7 percent of women respondents reported forceful testing of their HIV status during medical examination.

In a multi-country study on access to reproductive and maternal health care for women living with HIV in Asia,⁷⁴ many women identified lack of pre-test counselling as a crucial issue. According to them, where counselling existed it was mostly to persuade them to take the test rather than providing the necessary information.⁷⁵ Several women also said that they did not understand what the test was for or what HIV was even when they had been ‘counselled’.

“ Personal testimony

“I don’t think consent matters that much. Theoretically, it is nice to talk about consent, but practically it is not possible. Many people do not know how to read or sign. In that case, consent does not really matter.”⁷⁶

– Doctor in a Delhi hospital, India

“At the time of the first HIV test I was not counselled, only informed that the routine tests would include HIV. I picked up the blood report from the laboratory myself.... I did not understand what [HIV] was and was not sure what the test result meant.... I decided to take my mother-in-law to my next appointment and the gynaecologist told her I had HIV but she misinformed her by telling her that if anybody shared food with me or touched me they would also get HIV. After that it became very difficult for me....”⁷⁷

– HIV-positive woman, India

Many women interviewed for the above-mentioned study stated that their test results were disclosed to their in-laws and husband rather than to them, leading to serious problems within the family and leaving women

69 Ibid., para. 135.

70 Gillian MacNaughton, *Women’s Human Rights related to Health-Care Services in the Context of HIV/AIDS*, (INTERIGHTS, 2004), p. 8.

71 V. Mahendra et al., “Understanding and Measuring AIDS-related Stigma in Health Care Settings,” pp. 616–625

72 People Living with HIV Stigma Index, *Piecing it Together for Women and Girls: The Gender Dimensions of HIV Related Stigma (2011)*.

73 People Living with HIV Stigma Index, Nepal (2011).

74 *Positive and Pregnant*, p. 15.

75 Ibid.

76 Mahendra et al., “Understanding and measuring AIDS-related stigma in health care settings,” p. 620.

77 *Positive and Pregnant*, p. 15

vulnerable to violence, abandonment, and destitution. Nurses interviewed for the Indian study in three Delhi hospitals stated that “everybody (doctors, nurses, sweepers, and ward boys) who works with patients knows the status of the patient” and “if the result is positive, then the doctor tells the patient as well as...relatives.”⁷⁸

Legal activists have pointed out that “the maintenance of confidentiality of an individual’s health status is one of the cornerstones of a rights-based legal and public health response to HIV/AIDS.”⁷⁹ However, these studies demonstrate that protocols on confidentiality are repeatedly ignored. In addition to being a serious violation of rights, lax enforcement of confidentiality protocols also means that the fear of the negative ramifications of involuntary disclosure will continue to lead women to avoid seeking testing and treatment for HIV as well as for other conditions.

Forced and coerced sterilization

“Forced sterilization is an act of violence, a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment.”

Forced or coerced sterilization has been well established within the international human rights regime as a violation of women’s human rights. The Committee on the Elimination of Discrimination against Women has considered forced sterilization a violation of a woman’s right to informed consent, infringing on her right to human dignity and physical and mental integrity.⁸⁰ The United Nations Special Rapporteur on violence against women has asserted that “forced sterilization is a method of medical control... Essentially involving the battery of a woman – violating her physical integrity and security – forced sterilization constitutes violence against women.”⁸¹

Human rights instruments, including CEDAW and the International Conference on Population and Development (ICPD), support the right of all women to choose the number and spacing of their children and to have access to health care that will support them to do this. This includes HIV-positive women, who must also have access to information and services that enable them to minimize the chances of HIV transmission to the foetus. However, all too often women living with HIV express being treated as “vectors of HIV and unfit to have babies, rather than as women with health-care issues in our own right.”⁸²

There have been widespread reports globally about HIV-positive women being ‘persuaded’ or ‘forced’ into having sterilizations.⁸³ Coerced sterilization can be said to occur when a woman is offered financial or other incentives or when tactics of intimidation are used to compel someone to agree to undergo a procedure. Failure to obtain free and informed consent can also be seen in situations where a woman is asked to sign a consent form when she is already in labour or when she signs after being given misinformation about HIV risks and transmission. Forced sterilization occurs when a person is not given the opportunity to provide her consent at all.⁸⁴

Of 228 women surveyed in a six-country study in Asia, more than 70 percent said they had been asked or encouraged to have a sterilization procedure. More than 35 per cent of the Indian women surveyed said they had been asked to consider sterilization. The same study showed that 15 percent of the Bangladeshi women

78 Mahendra et al., op. cit.

79 See www.hivaidsonline.in/index.php/HIV-Human-Rights/legal-issues-that-arise-in-the-hiv-context.html.

80 Committee on the Elimination of Discrimination against Women (CEDAW Committee), General recommendation no. 24, article 12, of the Convention (women and health), chapter 1, para. 22 (1999).

81 Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, in accordance with Commission on Human Rights resolution 1997/44, *Integration of the Human Rights of Women and the Gender Perspective: Violence against Women* (1999).

82 UNAIDS, *Women Out Loud: How Women Living with HIV will Help the World End AIDS* (2012).

83 For instance, Open Society Foundation, *Against Her Will: Forced and Coerced Sterilization of Women Worldwide* (2011).

84 Ibid.

surveyed were asked to undergo sterilization, of whom 40 percent felt they could decline if they wanted to. Fifteen percent of the 40 women surveyed in Nepal were asked to undergo sterilization, and only one felt like she could decline. The Stigma Index report for Nepal showed that 2 percent of the 394 female respondents (women living with HIV) surveyed said that they had been coerced into sterilization.⁸⁵ The Stigma Index report for Pakistan showed that 4.5 percent of the 228 women surveyed said that they had been coerced into sterilization.

Some women interviewed for this study said that they did not understand what sterilization was when they agreed to it, thinking it meant a more sterile mode of delivery. In cases where the choice to be sterilized during delivery was available women did not feel they could consent to it without agreement from husband and in laws and even if they did the hospital required spousal consent. In other cases, incentives such as free formula were offered.⁸⁶

Other marginalized and vulnerable groups, such as disabled women and very poor rural women, are also at risk of having these critical decisions taken out of their hands. The World Health Organization (WHO) suggests that women with disabilities have poorer health outcomes, lower education achievements, less economic participation, and higher rates of poverty than women without disabilities. Similarly, poor women may have lower rates of literacy, less access to health care services, and may be pushed into higher-risk behaviours in order to survive. These marginalized groups face layers of stigma that make them more vulnerable to HIV, but also more likely to face violations in health care settings – including denial of SRH services and coercion into procedures such as sterilization and abortion.

A study of 35 women with disabilities in Nepal found that more than 50 percent suffered health problems relating to their disability. Only 20 percent had access to a hospital for medical check-ups, the primary obstacles being financial constraints and a lack of support persons to accompany them to hospital. It also revealed that 40 percent of the women (both married and unmarried) did not have information about contraception. Further, the study found that women with disabilities have inadequate knowledge about sexual and reproductive health and in extreme cases are sterilized.⁸⁷ Evidence from India suggests that 6 percent of women with disabilities in India have been forcibly sterilized.⁸⁸

Government-run population-control programmes are also responsible for coerced sterilizations. In a study of 10 reproductive and child health camps (so-called “sterilization camps”) in Uttar Pradesh, India’s most populous state, researchers witnessed “unconcealed disregard for standards of informed consent. . . . Poor, illiterate women were rushed through the consent process. They were asked to put their thumb-print on the consent form without being read its content or having the procedure fully explained. Women were informed only about sterilization and no other possible long-term methods of family planning.”⁸⁹ In addition to lack of adherence to standards of informed consent, the study found that the standards of medical practice, such as using separate gloves, clean tables, and sterilized instruments were not upheld either.

Government programmes such as the above may unwittingly create serious incentives for health care workers to coerce sterilization. Although the Indian Government stopped setting centralized targets two years after the International Conference on Population and Development, a Human Rights Watch (HRW) paper suggests that, in practice, state-level authorities and district health officials assign targets for health workers for every contraceptive method, including female sterilization. These do not specify particular groups to be targeted, looking instead at the numbers of children women have. On the basis of interviews with dozens of health workers, HRW concludes that “in much of the country, authorities aggressively pursue

85 Family Planning Association of Nepal, PLHIV Stigma Index Report (Nepal, 2011), p. 66.

86 *Positive and Pregnant*, supra note 16.

87 Neeti Aryal Khanal, *A Study on Status of Social Inclusion, Livelihood, and Violence against Disabled Women of Nepal* (Nepal Disabled Women Association, Action Aid Nepal, 2007).

88 United Nations Enable, “Factsheet on Persons with Disabilities” (2011), at www.un.org/disabilities.

89 Open Society Foundation, *Against her Will* p. 4; and A. Das, R. Rai, and D. Singhe, “Medical Negligence and Rights Violation,” *Economic and Political Weekly* (August 2004).

targets, especially for female sterilization, by threatening health workers with salary cuts or dismissals. As a result, some health workers pressure women to undergo sterilization without providing sufficient information, either about possible complications, its irreversibility, or safer sex practices after the procedure.⁹⁰ This includes information about sexually transmitted diseases (STDs) and HIV, with many health workers saying that they were not aware of any HIV-related information they needed to provide to women before or after sterilization.

“ Personal testimony⁹¹

“Each of us has to bring five women for operation [sterilization] in one year, the CDPO [Child Development Project Officer] told us in the meeting. This announcement they make every year... It has been like this almost since the time I was appointed [in the late 1980s]. If we don't do this, they say they will deduct our salary or that our salary will be stopped. They shout at those who have not fulfilled their targets during meetings. It's humiliating. They say, 'If others can achieve the target, why can't you? You must know some women? You must have relatives or some contacts after working in the villages? Use them and get women operated [sterilized].”

– Health worker, Gujarat

Forced and coerced abortions

“ Personal testimony

“One doctor asked me why I wanted to have the baby when I'm HIV-positive. He said the baby will also be infected and advised that I should not have the baby. Then he discussed it with my husband and asked him if he wanted the baby and he decided against it.”

– Mina, Nepal⁹²

“I was pregnant and went for a check-up at a small Dhaka hospital. The doctor was nice to me before I was diagnosed with HIV. During one of my follow-ups, the doctor told me to abort the baby. I have not gone to a doctor since, even though I have been pregnant for four months now.”

– 25-year-old housewife, Bangladesh⁹³

The Asia Pacific Regional Analysis of data from the People Living with HIV Stigma Index showed that 35 percent of PLHIV surveyed in Bangladesh and 33 percent of those surveyed in Pakistan had been advised by health care professionals not to have children after being diagnosed with HIV. The Nepal Stigma Index report revealed that 32 percent of PLHIV were similarly advised.

90 Human Rights Watch, *India: Target Driven Sterilisation Harming Women* (2012), at www.hrw.org/news/2012/07/12/india-target-driven-sterilization-harming-women.

91 Ibid.

92 *Positive and Pregnant*, p. 25.

93 Interviews conducted by Padakhep Manobik Unnayan Kratipakha, an NGO in Dhaka.

HIV-positive women have reported being discouraged from becoming pregnant and being treated judgmentally when they do become pregnant, told how irresponsible they are, and encouraged to give up the pregnancy.⁹⁴ Doctors provide a range of reasons for this, including the fact that a baby may be born HIV-positive, the baby may be orphaned, the woman's health may be weakened, or the woman is poor.⁹⁵ Husbands or in-laws may also influence women's decisions. In one study, 16.7 percent of respondents from India and 2.5 percent from Nepal stated that their mother or mother-in-law was involved in pregnancy-related decisions. While many women made decisions relating to abortion on their own, the study also documented testimony of women who felt that family members had coerced them to abort.⁹⁶

This study also showed a wide variation in the prevalence of abortion among HIV-positive women (including those that are forced or coerced), with just 0.1 percent for India and Bangladesh but 25 percent for Nepal.⁹⁷ Another study showed that 1.6 percent of HIV-positive respondents in Nepal reported being coerced into an abortion by health personnel.⁹⁸ The PLHIV Stigma Index report for India reveals that 4 percent of the 593 women interviewed reported being coerced into an abortion. Additionally 7 percent of the 98 female sex workers interviewed reported being coerced into an abortion.⁹⁹ The PLHIV Stigma Index report for Pakistan shows that 37.3 percent of the 228 female respondents stated that they had been coerced by a health care professional into an abortion.¹⁰⁰

There have also been cases reported in India where this situation has been reversed, wherein an HIV-positive woman seeking an abortion has been turned away and denied treatment because staff have not wanted to operate upon an HIV-positive patient.¹⁰¹

Denial of treatment

i Case study: Delayed treatment

"When Selvi went to the government hospital in Erode, in the state of Tamil Nadu in India, for treatment for a fibroid in her uterus, she was turned away. Hospital staff told her it was nothing major, and that she did not require surgery. But at the private hospital where she was first diagnosed, doctors had told her to get rid of the fibroid. Selvi, who lives with HIV/AIDS, was later diagnosed with a tumour that had spread to her ovaries. She had to undergo a surgery at a private hospital, which set her back by INR 40,000. "I did not have enough money and could barely afford the treatment."¹⁰² She suffered from excessive bleeding for 18 months before finally getting the surgery she needed.

Selvi's is not an isolated case. The same study from Tamil Nadu in India showed that many HIV-positive women faced distressing situations when they attempted to seek treatment at state-run hospitals. Several

94 *Positive and Pregnant*, p. 21; *Stigma Index Report, Pakistan*, p. 50.

95 *Ibid.*, p. 21.

96 *Ibid.*, p. 25.

97 *Ibid.*, p. 24.

98 Family Planning Association of Nepal, *PLHIV Stigma Index Report, Nepal* (2011), pp. 65–67.

99 Family Planning Association of India, *PLHIV Stigma Index Report, India* (2012), at www.aidsdatahub.org/en/reference-librarycols2/stigma-and-discrimination.

100 The Association of People Living with HIV and AIDS, Pakistan, *An Index to Measure the Stigma and Discrimination Experienced by People Living with HIV in Pakistan, 2009-2010* (2012), at www.aidsdatahub.org/en/reference-librarycols2/stigma-and-discrimination/item/24444.

101 See articles.timesofindia.indiatimes.com/2010-03-18/chennai/28127784_1_senior-doctor-medical-termination-kmc-hospital.

102 See www.thehindu.com/news/cities/chennai/women-with-hiv-aids-face-hostile-hospitals/article4469782.ece?textsize=small&test=2.

women who were undergoing screening for cervical cancer at their local hospital were sent for further testing to a district hospital much further away when it was discovered that they were living with HIV, despite the fact that the local hospital had the facilities for the necessary tests. Women living with HIV bear a higher risk for cervical cancer and must have access to screening services. However, the hostility these women faced from hospital staff as well as the inconvenience and cost of having to go further afield to seek treatment deters them from seeking the care, testing, and/or treatment that they critically needed. For all women, but especially those living with HIV, such denial of treatment can have serious health consequences.¹⁰³

“ Testimony

“I was detected with HIV before my delivery. The doctor who was treating me refused to continue, and I was asked to leave the hospital. I did not complain, because, I did not want to bring attention to myself. After all, I have to live here. I don't want this to become public knowledge.”

– A 28-year-old housewife from Dhaka¹⁰⁴

A 2012 report of the Nepal Health Research Council showed similar trends in Nepal, with six respondents stating that a health institution had refused them treatment on the basis of their HIV status, including a government hospital, medical college, and private clinics. The Stigma Index results from Pakistan showed that 33 percent of the 883 respondents (male and female) said they had been denied access to health care, including dental care, due to their HIV status.¹⁰⁵

There have also been cases of pregnant HIV-positive women being turned away from hospitals in India at the time of delivery. For instance, in Uttar Pradesh a woman in labour was denied access to the hospital and had to be rushed to another at the last minute to deliver her baby.¹⁰⁶ In a 2009 case, a pregnant HIV-positive woman was denied care at a government hospital in Haryana at an advanced stage of labour. She ended up giving birth to a baby boy outside the hospital gates.¹⁰⁷

Degrading practices

Delivery: Many HIV-positive women continue to have negative experiences while giving birth. Women have recounted stories of being neglected by staff before, during, and after their delivery; of being abused by staff for getting pregnant while under the extreme stress of labour; and of staff refusing to touch them or their new born baby. One Nepalese woman described how during her delivery the doctor wanted to put on two sets of gloves and tried to push the baby back in so that he could put the other set on.¹⁰⁸

Most women said they were not given the option of having a vaginal delivery if their HIV status was known, and that the cost of a caesarean delivery was prohibitive. Women with HIV also report severe delays in being attended to and being asked to leave the hospital earlier than other patients who have had the same procedure.¹⁰⁹

¹⁰³ Ibid.

¹⁰⁴ Interviews with NGO.

¹⁰⁵ UNAIDS, “People Living with HIV Stigma Index: Asia Pacific Regional Analysis” (2011).

¹⁰⁶ See articles.timesofindia.indiatimes.com/2011-07-20/india/29793628_1_hiv-positive-kaithal-rohtak.

¹⁰⁷ See www.indianexpress.com/news/govt-hospital-closes-door-to-hivpositive-pregnant-woman/484017.

¹⁰⁸ *Positive and Pregnant*, p. 27.

¹⁰⁹ Ibid.

“ Testimony: Bangladesh

“Everything for the caesarean had to be paid for, even though it was a government hospital. Before my caesarean my doctor was asking other nurses to assist, but they all had excuses like, ‘I have a cut finger’. Eventually, the doctor got staff to help. When I had the caesarean the bed was covered with hard disposable plastic. Afterwards, I was very cold due to the air conditioning and I asked for a cover, but nobody would give me a blanket. My status was disclosed. My bed was marked as HIV-positive and the clinic staff started to ask questions like, ‘How did you get infected?’ I was not given any bed sheets, and the day after the delivery I had to leave the hospital.”¹¹⁰

– Sharmin, Bangladesh

Sexual assault examinations: Although this specific subject is not directly linked to KAWG, sexual assault examinations (particularly the ‘two finger test’ described below) are key in terms of illustrating not only the general level of violence against women in society but also the discriminatory attitudes of health care workers when they are dealing with sexual violence. The stigmatizing attitude and lack of adherence to protocols that protect women’s rights are directly relevant for KAWG seeking care and treatment related to SRH, including pregnancy or STD and HIV testing. These practices are also a serious deterrent to KAWG seeking assistance in the case of sexual assault, especially female sex workers (including those who are transgender), who already expect that they will be humiliated and treated in a discriminatory way in formal health care settings and who will be particularly discriminated against by a test that is based on a concept of sexual ‘habituation’ to evaluate the assault experienced.

Studies have reported many practices that directly violate the rights of women who are seeking help in rape and sexual assault cases. These include the lack of uniform protocols for seeking consent, establishing history, conducting examinations, or collecting evidence¹¹¹ – resulting in a humiliating and degrading experience for many women who are survivors of sexual assault.

Of the problematic practices, one that activist groups have raised repeated concerns about is the ‘two-finger test’ – an archaic test involving “a doctor inserting fingers in a rape victim’s vagina to determine the presence or absence of the hymen and the so-called ‘laxity’ of the vagina.”¹¹² This test continues to be prevalent in India and Pakistan.

Apart from the fact that the test is outdated and unscientific, it is often very painful, often done without the survivor’s consent, and may be an echo of the assault she has experienced, leaving her feeling further violated and traumatized. In fact, rights activists point out that “carried out without informed consent, the test would constitute an assault, and is a form of inhuman and degrading treatment.”¹¹³

As one survivor explained: “The clerk told me a male doctor will conduct the test [forensic examination], and asked me whether that was ok, and I agreed. But other than that, I did not know what they were going to do. I was so scared and nervous and praying all the time: ‘God, let this be over and let me get out of here fast!’”¹¹⁴

Given that the presence of the hymen and the elasticity of the vagina can be affected by multiple activities other than sex, and that someone habituated to sex can still be the victim of a sexual assault, the test has been found to be scientifically baseless. In addition, the Indian Supreme Court has ruled that finger test

110 Ibid., p. 28.

111 Centre for Enquiry into Health and Allied Themes and Sama - Resource Group for Women and Health, *Responding to Sexual Assault: A Study of Practices of Health Professionals in a Public Hospital* (2011), p. 2 of summary and recommendations.

112 Human Rights Watch, *Dignity on Trial: India’s Need for Sound Standards for Conducting and Interpreting Forensic Examinations of Rape Survivors* (2010).

113 Ibid.

114 Ibid., p. 2 of summary and recommendations.

results cannot be used against a rape survivor, and that a survivor's "habituation to sexual intercourse" is immaterial to the issue of consent at trial.¹¹⁵ Yet, survivors of sexual violence continue to be subjected to this test in many hospitals around the country; and 'evidence' taken from these tests, based upon a purely subjective analysis by the doctor as to whether the person was 'habituated to sex', continues to be used in court to discredit the testimony of the survivor.

In Pakistan, for the majority of rape cases the primary health facility provider that a rape survivor has access to is the medico-legal officer. Unfortunately, these officers provide neither counselling and referral services nor screening for STIs or HIV. What they do focus on is the two-finger test, as described above. In Pakistan's social and cultural environment with the inescapable stigma attached to loss of virginity, the findings of the two-finger test invariably result in discrimination and stigmatization by the medical practitioners, law enforcement agencies, and society at large. Fear of such stigma contributes to the low reporting and prosecution rates for rape cases. In fact, statistics show that of 138 medical legal examinations that were conducted during the first six months of 2011, only 41 First Information Reports¹¹⁶ were registered.¹¹⁷ This means that despite the available medical evidence, women and girls were not willing or able to pursue criminal cases against their rapists.

Misinformation

Misinformation given by health care practitioners compounds the barriers faced by women in enjoying their right to the highest attainable standard of physical and mental health and other rights. Several women from a multi-country study in Asia reported this type of misinformation. For instance, one woman reported that she was informed that the risk of her baby getting HIV was 60 percent, another was told not to have unprotected sex as that might transmit HIV to the baby, another was warned of the virus "switching" between her and her husband, and yet another was prescribed Paracetamol (a widely used over-the-counter pain reliever) daily for a year. Callous and unprofessional prognoses also seems common, with one woman being told to prepare for death and another told not to save money as she would not have a long life.¹¹⁸ Several women reported the doctors behaving rudely and judgmentally and making unwarranted comments about their sexual behaviour.

As mentioned above, improperly trained staff who do not adhere to protocols on confidentiality and disclosure create barriers to women accessing critical HIV-related services. Similarly, misinformation given by staff seriously affects the way that women are treated after disclosure of their status. Health care providers who are advising HIV-positive women need comprehensive training in stigma reduction as well as technical training to enable them to provide holistic counselling, which includes the family, and to provide accurate information on HIV care, treatment, and modes of transmission.

115 See *Narayanamma v. State of Karnataka with State of Karnataka v. Muniyappa and others* (1994), 5 SCC 728, para. 4(iv). See also, *State of Punjab v. Ramdev Singh* (2004), 1 SCC 421, para. 5; and *State of Uttar Pradesh v. Pappu* (2005), 3 SCC 594, para. 3.

116 First Information Report (FIR) is a written document lodged with the police by the victim or by someone on his or her behalf in Bangladesh, India, and Pakistan when they receive information about the commission of a cognizable offence. It is only after the FIR is registered in the police station that the police take up investigation of the case

117 War Against Rape (WAR) "Sexual Violence Fact Sheet" (Jan–Jun 2011).

118 It is important to note that this data was collected in focus group discussions held in Bangladesh, Nepal, Cambodia, and Vietnam, and thus not all the above remarks may be from the studied countries. Cited in *Positive and Pregnant*, p. 14.



THE LEGAL FRAMEWORK

International obligations

The Universal Declaration of Human Rights (UDHR), 1948

The UDHR, a declaration that became the cornerstone of international human rights law, is considered binding on all countries as a matter of customary international law. Specific provisions that are reflected in later human rights conventions and relevant in the context of this report include article 1, which stipulates that “all humans are born free and equal in dignity and rights.” The UDHR also puts forward the principles of equality before the law without discrimination (article 7) and the right to life, liberty, and security (article 3) as well as the right to privacy (article 12). The UDHR also prohibits torture or cruel, inhuman, or degrading treatment or punishment (article 5).

The International Covenant on Civil and Political Rights (ICCPR), 1976

The ICCPR was ratified by India in 1979, Nepal in 1991, and only recently by Pakistan in 2010. Bangladesh acceded to the convention in 2000, but has not yet ratified it.¹¹⁹ The ICCPR obligates state parties to respect the civil and political rights of citizens.

At the core of the convention is the non-discrimination guarantee.

Non-discrimination (article 26): “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status

The UN General Assembly’s Human Rights Committee (HRC), which monitors and implements the ICCPR, clarified in General Comment 18 that discrimination should be understood as “any distinction, exclusion,

¹¹⁹ “Accession” is the act whereby a state that has not signed a treaty expresses its consent to become a party to that treaty by depositing an “instrument of accession.” Accession has the same legal effect as ratification.

restriction, or preference...which has the purpose or effect of nullifying or impairing the recognition, enjoyment, or exercise by all persons, on an equal footing, of all rights and freedoms."¹²⁰

Relevant also to the rights violation experienced by KAWG in health care settings are: the right to life (article 6); the right to liberty (articles 9 and 12); the right to found a family (article 23), and the right to privacy (article 17). Article 7, the prohibition on torture and cruel, inhuman, or degrading treatment or punishment, is also relevant, particularly in light of the fact that only one of the studied countries – Pakistan – has actually ratified the Convention against Torture.

Article 17 is relevant, since it has bearing in terms of the protection of confidentiality with regards to HIV status. The article states that "No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence"; and the HRC has stipulated that "Competent public authorities should only be able to call for such information relating to an individual's private life the knowledge of which is essential in the interests of society..."

The International Covenant on Economic, Social and Cultural Rights (ICESCR), 1976

The ICESCR was ratified by India in 1979, Nepal in 1991, Bangladesh in 1998, and Pakistan in 2008. This convention contains many rights that are pertinent in the context of HIV and AIDS, but in the context of this paper the most pertinent is the right to health.

The Right to Health (article 12): "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

This right has been interpreted as "an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health."¹²¹

The Committee on Economic, Social and Cultural Rights (CESCR) has stipulated that the right to health includes certain freedoms and entitlements some of which are immediately legally enforceable, such as the provision on non-discrimination. This and other issues that have been addressed by the committee are particularly relevant in the context of the violation of women's rights in health care settings.

- a. The right of access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalized groups. This is defined as a "core obligation" of states.¹²² The CESCR has stated that the Covenant "proscribes any discrimination in access to health care...on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation...which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health."¹²³
- b. The CESCR has observed that the obligation on states regarding treatment, prevention, and control of diseases¹²⁴ "requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health." This includes the provision of adequate information including on sexual and reproductive health, which would allow people to make informed decisions with regard to

120 Human Rights Committee, CCPR General Comment Number 18, at www.unhchr.ch/tbs/doc.nsf/0/3888b0541f8501c9c12563ed004b8d0e?Opendocument.

121 See www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx.

122 In General Comment No. 3, the Committee confirms that States Parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant.

123 Committee on Economic, Social and Cultural Rights, The Right to the Highest Attainable Standard of Health, (8 November 2000), para. 18, E/C.12/2000/4 (General Comments).

124 ICESCR, article 12.2 and interpretation in general comment at note 5, para. 16.

their sexual behaviour and to keeping themselves and their partners' safe. This is an important point for women and young girls, who may not always have access to the information they need.

- c. The right to be free from non-consensual medical treatment and the right to have personal medical data remain confidential is also deemed to be a part of the right to health.¹²⁵ As noted above, forced testing of women, specifically sex workers and pregnant women, and subsequent disclosure of their status is a serious deterrent to women who may need to access health services, and perpetuates stigma and discrimination.

The convention on the elimination of all forms of discrimination against women (cedaw), 1979

CEDAW was ratified by Bangladesh in 1984, Nepal in 1991, India in 1993, and Pakistan in 1996. Nepal has also ratified the optional protocol to CEDAW in 2001.

Non-discrimination, article 3: CEDAW prohibits all forms of discrimination and calls on states parties to take "all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men."¹²⁶

Right to Health, article 12: This article is particularly relevant in this context, establishing the obligation for States Parties to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."

Access to Justice, article 15: This article relates to access to justice, stating that all women must have "a legal capacity identical to that of men and the same opportunities to exercise that capacity."¹²⁷ The article refers to equality before the law, equal access to courts, non-discriminatory administration of justice, and equal protection of the law. To achieve substantive equality under the meaning of this article, legal literacy and legal aid must be accessible to women.

Equality within the Family, article 16: This article deals with equality and non-discrimination within marriage and family relations, and specifically mentions that men and women must have "the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."¹²⁸

Reservations are one way for countries to adhere to a treaty while not being legally bound to specific provisions to which it objects. India entered a reservation under CEDAW on articles 5 and 16, which deal with customary and personal laws. This means that they do not have to take action under articles that specifically deal with "the social and cultural patterns of conduct of men and women,"¹²⁹ with a view to modifying customary practices that are predicated upon unequal relations between the sexes. Additionally, this is also a refusal to modify laws that deal with "appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations."¹³⁰ Although Bangladesh initially had also entered a reservation under article 16, they have since withdrawn this. Pakistan has entered the declaration that their accession to the Convention is subject to the provisions of the Constitution of the Islamic Republic of Pakistan. Nepal has not entered any reservations to its adherence to CEDAW.

125 Supra note 5, paras. 8 and 12 (b).

126 CEDAW, article 3.

127 Ibid., article 15 (1) and (2).

128 Ibid., article 16 (1) (e).

129 Ibid., article 5 (a).

130 Ibid., article 16.

Although India's reservations may not seem directly relevant in the context of health care settings, social and cultural patterns of conduct are very relevant in terms of women having decision-making power in a household, including over her own sexual and reproductive health. In fact, the CEDAW Committee has issued general comments on women and health that also address HIV/AIDS, within which they note that women have inadequate access to information and services and insufficient power within their sexual relationships, citing marital rape as one example. They further suggest that "issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health."¹³¹

United Nations Convention on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), 1975

Pakistan ratified the Convention on Torture in 2010; India has been a signatory to the Convention since 1997. Nepal and Bangladesh acceded¹³² to the convention in 1991 and 1998, respectively. However, it is important to note that the prohibition of torture, first put forward in the UDHR, is recognized as an absolute and non-derogable norm of international law, binding on all countries regardless of whether they have ratified the CAT.

This convention defines torture (article 1), and commits parties to taking effective measures to prevent any act of torture in any territory under their jurisdiction (article 2), including ensuring that torture is a criminal offense (article 4).¹³³ In the context of this report, CAT is significant because of recent global developments recognising violations of rights in health care settings as torture.

As mentioned earlier, the report of the United Nations Special Rapporteur on torture has provided examples of several abuses that are tantamount to torture or ill-treatment, some of which are particularly relevant in the context of this report. The report recognizes that "abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering, inflicted on the basis of gender. Examples of such violations include abusive treatment and humiliation in institutional settings; involuntary sterilization; denial of legally available health services such as abortion and post abortion care; forced abortions and sterilizations...violations of medical secrecy and confidentiality in health care settings..."¹³⁴ The Special Rapporteur's report also addresses discrimination towards and mistreatment of people from marginalized communities in health care settings, including PLHIV, sex workers, and transgender people.

Based on an "evolving" definition of torture, the report concluded that torture or ill-treatment in any facility that is meant to provide health care or medical treatment – whether private or public – can be considered a violation of the Convention. The significance of reframing the debate around health care violations within the torture convention is related to the above-mentioned non-derogable nature of the prohibition of torture. The Special Rapporteur suggests that by reframing violence and abuses in health care settings as prohibited ill treatment, victims and advocates are afforded stronger legal protection and redress for violations of human rights,¹³⁵ and the "focus on the prohibition of torture strengthens the call for accountability."¹³⁶

131 Committee on the Elimination of Discrimination against Women, General Recommendation No. 24, Women and Health, article 12 (2 February 1999), at [www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/77bae3190a903f8d80256785005599ff?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/77bae3190a903f8d80256785005599ff?Opendocument).

132 Becoming a "signatory" to a treaty indicates that a state is obliged to refrain, in good faith, from acts that would defeat the object and purpose of the treaty. However, signature alone does not impose on the state obligations under the treaty. See www.wunrn.com/news/2009/05_09/05_25_09/052509_un.htm for further explanation.

133 See United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1987), articles 1–4, at www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx.

134 Méndez, op. cit., para. 46, at www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf.

135 See Convention on Torture, articles 13 (right to complaint mechanisms and speedy hearing) and article 14 (right to redress and compensation)

136 Ibid., para. 83.

Beijing Declaration and Platform for Action, 1995

All of the countries examined for this report are party to the Beijing Declaration and have also accepted the Platform for Action without reservation. These documents emphasize the right of women to the “enjoyment of the highest attainable standard of physical and mental health.” Particularly relevant is the Beijing Declaration’s recognition that “the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment....”¹³⁷

The Platform for Action acknowledges that inequality is a major barrier for women in terms of being able to achieve the highest standard of health. It also stipulates that reproductive rights are human rights that include the right “of all couples and individuals...to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.”¹³⁸

As part of the Platform of Action, Governments also committed to taking action in various spheres, including on HIV and AIDS. These action points included a commitment to:

Review and amend laws and combat practices, as appropriate, that may contribute to women’s susceptibility to HIV infection and other sexually transmitted diseases, including enacting legislation against those sociocultural practices that contribute to it, and implement legislation, policies, and practices to protect women, adolescents, and young girls from discrimination related to HIV/AIDS.

Encourage all sectors of society, including the public sector, as well as international organizations, to develop compassionate and supportive, non-discriminatory HIV/AIDS-related policies and practices that protect the rights of infected individuals.¹³⁹

Note on complaint mechanisms

The ICCPR, ICESCR, CEDAW, and CAT have each established a “treaty body” (committee) of experts to monitor implementation of the treaty provisions.¹⁴⁰ These treaty bodies may all consider individual complaints alleging violations of rights under their respective conventions. This is a potential avenue for redress for victims of rights violations in health care settings. However, in each case this is contingent upon States Parties also being party to the optional protocols related to the particular convention. In the case of CAT, the individual complaint mechanism is contingent upon states making a declaration under article 22. As noted above, Pakistan has ratified the CAT, but it has not made a declaration under article 22. Of the studied countries, only Bangladesh and Nepal have ratified the Optional Protocol to CEDAW, thereby accepting that individuals under their jurisdictions may approach the Committee on the Elimination of Discrimination against Women with individual complaints. None of the countries have ratified the optional protocol to ICESCR, and only Nepal has acceded to the First Optional Protocol for the ICCPR.¹⁴¹

Domestic legislation

As we have seen, all the countries studied for this report have ratified the major international human rights conventions. However, with dualist legal frameworks like those in most of South Asia, such international conventions related to rights are not automatically applicable in domestic law upon being ratified. This

137 Fourth World Conference on Women, Beijing Declaration (1995), para. 17.

138 Platform of Action, para. 95, at www.un.org/womenwatch/daw/beijing/platform/health.htm.

139 Ibid, Strategic Objective C3, ara. 108.

140 The Human Rights Committee for the ICCPR; the Committee on Elimination of Discrimination against Women for CEDAW; the Committee against Torture for CAT; and the Committee on Economic, Social and Cultural Rights for ICESCR.

141 See www.ohchr.org/EN/HRBodies/TBPetitions/Pages/HRTBPetitions.aspx.

means that these laws cannot be applied in the country unless appropriate domestic legislation relating to the treaty is enacted. This is the case in India, Bangladesh, and Pakistan. In contrast, in Nepal, Section 9 of the Nepal Treaty Act (1990) prescribes a monist approach. This means that once Nepal has ratified an international treaty through its Parliament, if there is a conflict between the treaty and current domestic law, then the latter shall be invalid.¹⁴²

Significantly, the Supreme Court in India and Nepal have called upon these international obligations while adjudicating cases, have declared the state to be bound to them, and have thereby affected law reform directly upon the basis of international conventions.¹⁴³ Some of the conventions also specifically obligate the States Parties to enact domestic legislation to give effect to the rights set forth in the treaty. For instance, article 2 of CEDAW states that States Parties must “adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women” and “establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination.”

Constitutional provisions

Equality provisions

Article 27 of the Constitution of the People’s Republic of Bangladesh (1972) declares that all citizens are equal before law and are entitled to equal protection. This is extended in article 28, which states that “the state shall not discriminate on grounds of religion, sex, caste, race or place of birth.” The same article states that women shall have equal rights with men in all spheres of the state and of public life. In addition, the possibility of affirmative action is allowed, with the proviso that “nothing in this article shall prevent the state from making special provision in favour of women or children or for the advancement of any backward section of citizens.”

Article 14 of the Constitution of India (1949) provides a guarantee of equality for all people “before the law or equal protection of the laws within the territory of India.” This principle is further extended in article 15, which prohibits discrimination on various grounds, including race, religion, sex, caste, or place of birth. These articles are within the fundamental rights chapter of the Indian Constitution.

Article 25 of the Constitution of The Islamic Republic of Pakistan (1973) states that all citizens are equal before the law and entitled to equal protection of the law. Further it states that there shall be no discrimination on the basis of sex, but allows the state to make special provisions for women and children.

Article 13 of the Interim Constitution of Nepal¹⁴⁴ provides for the right to equality, providing that no person shall be denied the equal protection of the law. Article 13 specifically provides that “no discrimination shall be made against any citizen in the application of general laws on grounds of ... race, sex, caste...” The article limits the parameters of discrimination, noting that “nothing shall be deemed to prevent the making of special provisions by law for the protection, empowerment, or advancement of the interests of women, *Dalit*, indigenous ethnic tribes...the disabled and those who are physically or mentally incapacitated.”

In addition, article 20 of the Interim Constitution is entitled “Rights of Women,” and states that “no one shall be discriminated in any form merely for being a woman” and goes on to provide that every woman shall have the right to reproductive health, and that no physical, mental, or any other form of violence shall be inflicted

142 K. Bhardwaj and V. Diwan, *Sexual Health And Human Rights; A legal and jurisprudential review of select countries in the SEARO region: Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand*, (WHO, 2011).

143 See Naz Foundation (India) Trust v Government of NCT of Delhi & others, WP(C) no. 7455/2001 [Delhi High Court], Date of Decision: 2 July, 2009, and *SUNIL Babu Pant v. Government of Nepal (2007)*, at njanepal.org.np/Anex_2.pdf.

144 It should be noted that in 2007 Nepal passed an Interim Constitution, intended to be enforceable only until a new Constitution was framed by the Constituent Assembly. At the time of this writing (August 2013), Nepal has no valid Constitution and is under an interim election government, agreed upon by political parties. While the expired Interim Constitution can no longer be relied upon as the basic law of Nepal, it remains the constituent document most recently in place, and may be a reflection of the provisions that Nepal envisages going forward. Accordingly, this study will consider the relevant provisions of the Interim Constitution.

on any woman. Together, these provisions establish the foundation of a legal framework to protect women's equality and right to non-discrimination (on the basis of gender and caste). The additional provisions related to reproductive health rights and domestic violence are not detailed provisions, but are significant inclusions.

Each country, in acknowledging that they retain the right to make special provisions for women under their non-discrimination guarantees, technically allow space for the adoption of supplementary provisions or new legislation to deal with women particularly vulnerable to discrimination – for instance, KAWG.

The right to health

The right to health is enshrined in the four constitutions in various forms. For instance, Nepal explicitly includes the right to health in its enumeration of fundamental rights. Article 16 sets out “the right to get basic health service free of cost from the State as provided for in the law.” Similarly, Bangladesh's Constitution recognizes, in article 15, that “it shall be a fundamental responsibility of the state to attain...a steady improvement in the material and cultural standards of living of the people...with a view to securing for its citizens the basic necessities of life including food, shelter, clothing, education and medical care.”

The Indian Constitution, on the other hand, does not contain a fundamental right to health, but article 21 recognizes every individual's right to life and liberty, which the Supreme Court has held includes the right to health.¹⁴⁵ In addition, there are the Directive Principles of State Policy that address issues related to health, such as article 47, which declares that “the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.”



Intervention by the courts: Denial of treatment, India

In a notable Delhi case, in January 2011 a poor, pregnant HIV-positive woman from Bihar was in urgent need of a blood transfusion before her caesarean delivery. She was admitted into the Lady Harding Hospital in Delhi. However, hospital staff refused to treat her and asked her husband to procure the blood and a universal precaution kit, despite his repeatedly informing them that he did not have the means to do so. Finally, he approached the Delhi High Court, which intervened and gave immediate directions to the hospital to provide blood and treatment for the woman.¹⁴⁶

The Supreme Court of India has ruled that failure to provide timely medical care to a patient in need is tantamount to a violation of the right to life.¹⁴⁷ In addition, in response to a public interest litigation case, filed in 1999, the Supreme Court in 2008 passed an order stipulating various conditions that must be upheld by antiretroviral centres as well as more general points for health care centres, including:¹⁴⁸

- ensuring the non-discrimination of people with HIV in health care settings;
- provision of free treatment for opportunistic infections;
- ensuring availability of universal precautions and post exposure prophylaxis for health care providers in public hospitals

145 In *CESC Ltd. v. Subash Chandra Bose* (1991), the Supreme Court relied on international instruments and concluded that the right to health is a fundamental right and that article 21 forms the basis of this right.

146 See hrln.org/hrln/hiv-aids/pils-a-cases/629-hiv-ve-pregnant-woman-denied-treatment.html.

147 *Paschim Bengal Khet Mazdoor Society v. State of West Bengal*, AIR (1996) SC 242.

148 *Sankalp Rehabilitation Trust v. Union of India*-Supreme Court of India. See details at www.lawyerscollective.org/hiv-and-law/current-cases.html.

In the case of Pakistan, the right to health can also be found in the constitutionally-mandated principles of policy, wherein article 38 of the Constitution declares that the state is responsible for providing the basic necessities of life, such as food, clothing, housing, education, and medical relief, for all such citizens – irrespective of sex, caste, creed, or race – as are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness, or unemployment.

These assurances are very relevant in the context of women living with HIV and other key affected women and girls who often have limited safety nets.

The right to privacy

Only Nepal specifically recognizes the right to privacy. article 28 of the Interim Constitution states that “except in circumstances provided by law, privacy in relation to the person and to their residence, property, documents, records, statistics and correspondence, and their reputation are inviolable.”



Intervention by the courts: Right to privacy, Nepal

In the case of *Sapana Pradhan Malla v. Government of Nepal and Others* (2006), the Court issued an order for a law providing for a certain level of privacy to be maintained in sensitive litigation, including where people living with HIV were involved.

In this case, it was contended that no legal provisions existed to protect the privacy of people living with HIV who were involved in litigation and that this is inconsistent with the guarantee of privacy at article 28 of the Interim Constitution. Ms. Malla further argued that this was inconsistent with Nepal’s commitments under a number of international human rights instruments. It was asserted that if the privacy of certain petitioners was not protected, then they would be unable to exercise their right of judicial remedy, due to the stigma surrounding HIV.

The Court issued a directive order requiring the Prime Minister, the Office of the Council of Ministers, and the Ministry of Law, Justice, and Parliamentary Management to draft a law providing for a certain level of privacy to be maintained in sensitive litigation where people living with HIV were involved. The directive order further stipulated the law should set out the rights and duties of the involved parties, noting that privacy had to be maintained from the time of registration of the case in the police office or law court until disposal of the case.

The Court also issued guidelines for the interim period (until the law is enacted), which are required to be followed in all proceedings. The guidelines require that in sensitive lawsuits, the “personal introductory information” of the person living with HIV is kept confidential throughout the litigation process.

Although this judgement does not specifically refer to health care settings, it is certainly relevant in terms of encouraging KAWG to access justice mechanisms with the knowledge that their identity will be protected.

Indian Courts have held that “the right to privacy is implicit in the right to life and liberty guaranteed to the citizens of this country by Article 21.”¹⁴⁹

149 In 1994, in *R. Rajagopal v. State of T.N.*, 6 SCC 632.

i Intervention by the courts: Right to privacy, India

It must be noted that the right to privacy, in the context of HIV, has not been upheld as an absolute right in the Indian courts. In *Mr. X v. Hospital Z*, Mr. X, a doctor, approached the Supreme Court over the breach of his right of privacy and confidentiality by Hospital Z in revealing his HIV status.¹⁵⁰ The Supreme Court examined the duty of doctors to respect confidentiality and weighed the right of Mr. X with that of the person with whom he was to be married before the result of his HIV test became known and led to his ostracism and eventual departure from his home state.

In relation to the disclosure of Mr. X's HIV status, the Court found that the right to privacy of Mr. X clashed with the right to life of his prospective bride. The Supreme Court held that her right to life "would positively include the right to be told that a person, with whom she was proposed to be married, was the victim of a deadly disease, which was sexually communicable." They further stated that "the Right [to privacy] is not absolute and may be lawfully restricted for the prevention of crime, disorder or protection of health or morals or protection of rights and freedom of others." Unfortunately, the Court did not use this opportunity to lay down specific protocols to be followed in the case of involuntary disclosure.

The International Guidelines on Human rights and HIV do stipulate specific criteria that should be met in this situation. These include ensuring that "the HIV-positive person in question has been thoroughly counselled; Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes; The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s); A real risk of HIV transmission to the partner(s) exists; The HIV-positive person is given reasonable advance notice; The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and Follow-up is provided to ensure support to those involved."¹⁵¹

In Pakistan, the right to privacy is linked to the idea of the dignity of man, with article 14 (1) stating the "the dignity of man and, subject to law, the privacy of home shall be inviolable." The right to privacy in the context of a person's home and communication is also mentioned in article 43 of Bangladesh's Constitution.

The right to privacy is relevant in protecting women against disclosure of private medical information, including HIV test results. As we have seen, the lack of confidentiality afforded by health care practitioners in South Asia is a violation of the right to privacy and also undermines the right to the highest attainable standard of health, since fear of disclosure acts as a major deterrent to women seeking HIV testing and care. Mandatory testing also violates the right to privacy.¹⁵²

Constitutional remedy against violation of fundamental rights

Clearly there are common threads in these constitutions in terms of guaranteeing fundamental rights to equality, non-discrimination, and, to some extent, the right to health and privacy.

Each of these constitutions also contains provisions allowing citizens the right to claim legal remedies against violation of their fundamental rights. Article 32 of the Interim Constitution of Nepal guarantees the right to

150 *Mr. X v Hospital Z* (1998) 8 SCC 296, cited in Bhardwaj and Divan, *Sexual Health and Human Rights*, p. 29.

151 Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights (2006)*, Guideline 20 (h).

152 Mandatory testing that is not based on informed consent is a violation of the right to privacy has had negative public health consequences and has proven to be detrimental to HIV-prevention efforts. Mandatory testing is not confined to employment contexts. There have been many reports of transgender people as well as sex workers and people who use drugs (PWUD) being routinely subjected to HIV tests without their consent in healthcare settings, communities, and in state custody.

claim for the enforcement of these rights under article 107,¹⁵³ which states that any citizen can file a petition in the Supreme Court to have a law voided on the grounds that it violates or imposes restrictions on the enjoyment of fundamental rights conferred by the Constitution. In this case, as conferred by the Interim Constitution, the Supreme Court has the extraordinary power to issue necessary and appropriate orders to enforce such rights or settle related disputes.¹⁵⁴

In Bangladesh, article 44 guarantees the right to move the High Court Division in accordance with Clause 102 for the enforcement of fundamental rights. This provision gives any aggrieved party the right to file a writ challenging the violation of a fundamental right and allowing them to approach the High Court, which as the designated court for constitutional cases, may recommend a quick remedy. Similarly, in India an aggrieved party may directly move the Supreme Court under article 32 or the High Court under article 226.

However, it is important to recognize that the fundamental rights enshrined in the various constitutions are enforceable against the state, not private actors. Therefore, government-run hospitals and health centres in each country would come under the purview of these rights, but discrimination in private health care settings remains largely unregulated as far as constitutional provisions are concerned.

In addition, although the directive principles of state policy are technically not enforceable in courts, Indian courts have held that “the Courts can use the Directive Principles so as to interpret [fundamental] rights as much in consonance with the Directive Principles as is possible”¹⁵⁵ and therefore should be considered a tool that can be used legally to some extent.

However, these provisions become meaningless in the face of barriers to access to justice for KAWG, including low literacy, lack of awareness of their rights, and the prohibitive cost of seeking legal help – including costs involved with employing lawyers, filing papers, and traveling to the nearest courts. The constitutions of the studied countries do recognize this and attempt to address these issues. For instance, Article 39 of the Indian Constitution declares that “the State shall secure that the operation of the legal system promotes justice, on a basis of equal opportunity, and shall, in particular, provide free legal aid, by suitable legislation or schemes or in any other way, to ensure that opportunities for securing justice are not denied to any citizen by reason of economic or other disabilities.”

Legislation

There is a significant dearth of domestic legislation dealing with violations that take place in health care settings, with the notable exception of the Reproductive Health care and Rights Act (2013) and Sindh HIV and AIDS Control Treatment and Protection Act (2013) of Pakistan, which have recently been passed into law, and the national HIV bills in Nepal, India, and Pakistan, all of which are currently pending. However, each country does have legislation that could be interpreted and expanded to include protection for KAWG in health care settings, or at least act as a model for different legislation to be framed around the issue. Below, this report examines those legal provisions that are potentially relevant in the case of health care violations.

153 Article 32 states that “the right to proceed in the manner set forth in article 107 for the enforcement of the rights conferred in this part is guaranteed.”

154 For these purposes, the Supreme Court may, with a view to imparting full justice and providing the appropriate remedy, issue appropriate orders and writs, including the writs of habeas corpus, mandamus, certiorari, prohibition, and quo warranto. However, except on the ground of absence of jurisdiction, the Supreme Court shall not interfere under this clause with the proceedings of the Legislature-Parliament concerning the violation of privileges and penalties imposed there to.

155 Adv. Mihir Desai and Adv. Kamayani Bali Mahabal, eds., *Health Care Case Law in India*, (Centre for Enquiry into Health and Allied Themes and India Centre for Human Rights & Law (2007), p. 18.

Laws relating to discrimination

There is a serious dearth of legislation that deals specifically with discrimination in health care settings in the countries examined. However, there are specific laws that could be used, expanded, or adapted to provide for non-discrimination in health care settings. These are discussed below.

India

The Persons with Disabilities (Equal Opportunities, Protection of Rights, and Full Participation) Act, 1995

This act attempts to give effect to article 14 of the Constitution in terms of equal opportunity. Globally, activists have been advocating for the inclusion of PLHIV within disability laws on the basis that the stigma and discrimination experienced by PLHIV is similar to that experienced by other people with disabilities. Many countries, including Germany, Norway, the United States, the United Kingdom, and Canada, have now extended their disability laws to include PLHIV.¹⁵⁶

Although this is not currently the case in India, one option for protecting the rights of PLHIV in India would be for the Person with Disabilities Act to be expanded to include PLHIV and to be applicable to the private sector. This act provides for special schemes in employment and public facilities, but does not include provisions on disabled women and health care settings. Useful additions would therefore relate specifically to including PLHIV within the purview of the act, prohibiting coerced abortions and sterilizations and emphasizing informed consent and confidentiality, all of which are relevant to disabled women as well as women living with HIV.

It is worth mentioning that India ratified the UN Convention on the Rights of Persons with Disabilities (Disability Convention) in October 2007. In response to this, a new bill, the Rights of Persons with Disabilities Bill,¹⁵⁷ was drafted by the Ministry of Disability Affairs after several multistakeholder consultations, with the aim of bringing the law in line with India's obligations under the convention. This bill contains several key provisions that would be useful in terms of protection of WLHIV in health care settings. One example is the stipulation that "No person with disability shall be subject to any medical procedure which leads to or could lead to infertility without their free and informed consent."¹⁵⁸ The bill also provides for equal access to family planning information; addresses the issue of health under a separate chapter; and provides for state authorities to implement programmes relating to sexual and reproductive health, especially for women with disabilities.¹⁵⁹

It also provides for access to justice for people with disabilities, stipulating that they have equal rights before the law and "have the right to move any court; tribunal; authority; commission; or any other body having judicial or quasi-judicial or investigative powers"¹⁶⁰ to ensure these rights. State authorities are instructed to make provisions ensuring that schemes, facilities, and services are accessible to facilitate access to justice. Specific penalties are laid out for a range of offences, including wrongful medical procedures that lead or are likely to lead to infertility and forceful termination of pregnancy.¹⁶¹

If PLHIV were to be included into the purview of an act like the one above, it would provide a considerable level of protection for WLHIV in health care settings.

155 For further explanation on this issue please see Interrights Written Submission on *Kiyutin v. Russia*, Application no. 2700/10. www.interrights.org

157 For full text, see Ministry of Social Justice and Empowerment, Department of Disability Affairs, *Draft Rights of Persons with Disabilities Bill (2012)*, at socialjustice.nic.in/pdf/draftpwd12.pdf.

158 *Ibid.*, article 17.

159 *Ibid.*, chapter 5, article 30

160 *Ibid.*, article 20 (1).

161 *Ibid.*, article 132 and 134 (imprisonment not exceeding seven years and ten years, respectively).

The Equal Remuneration Act (ERA), 1976

This act specifically addresses inequity and discrimination within the workplace, but only in terms of gender-based discrimination in wages. While this is not directly applicable to KAWG or health care, legal activists have pointed out that this law is useful in terms of “determining responsibility for discrimination by companies and corporations”¹⁶² and “confirms the commitment and intent of the State to right the wrongs of discrimination.”¹⁶³ By enacting legislation like this, the state brings private corporations under its purview with regard to constitutionally prohibited discrimination and unequal policies.

Similarly, anti-discrimination legislation focusing on health care settings could apply to hospitals at the state, district, and community level, including privately run hospitals and private clinics, and make specific provisions for marginalized groups – including KAWG.

Nepal

The Civil Rights Act

The Civil Rights Act (1955) states at Article 3(a) that “no citizen shall be denied equality before law and equal protection of law.”¹⁶⁴ The act also provides, at article 5, that the Government of Nepal has the power to make special provisions for women, children, and underprivileged class of citizens.

The Caste Based Discrimination Act

Caste Based Discrimination and Untouchability (Offence and Punishment) Act (2011) makes it an offence to discriminate against a person on the basis of caste. The act is strengthened by a provision that clarifies that if discrimination against caste occurs on the grounds of custom, tradition, religion, or culture (among others), this still constitutes discrimination under the act and is an offence.

The Caste Based Discrimination Act covers discrimination in public places and where goods and services are sold, but does not specifically note health clinics in the definition of public place. Subject to interpretation of the term “public place” and the particular case, this act may be useful to a *Dalit*¹⁶⁵ woman who has experienced discrimination at or outside a hospital or health clinic, but does not apply to other women.

Country Code (Muluki Ain)

Chapter 19, number 10A, of the Country Code sets out punishment for discrimination on the basis of caste, religion, colour, class, or work.¹⁶⁶ This provision may be useful to KAWG who come from a specific marginalised group (e.g., a *Dalit* woman) or work in a specific profession (e.g., a sex worker).

162 The Lawyers Collective, *Legislating an Epidemic: HIV/AIDS in India*, (New Delhi Universal Law Publishing, 2003), p. 13.

163 Ibid. The ERA outlines what a punishable offence is and prescribes punishments, including fines and prison terms, thereby providing an example of an anti-discrimination piece of legislation that has teeth.

164 Civil Rights Act, article 4, states: “No discrimination on the ground of religion, caste, tribe or gender: In the course of providing appointments, the Government of Nepal shall appoint only in the ground of merit and no citizen shall be discriminated on the ground of religion, colour, gender, caste, tribe or any of them in the appointment of government or any other Public Service.”

165 *Dalit*: In the traditional Indian caste system, a member of the lowest caste.

166 “If a person discriminates as an untouchable or excludes or prohibits any person on grounds of caste, religion, colour, class, or work, the person shall be liable to the punishment...”

Laws relating to reproductive rights

India

The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994

This is a piece of federal legislation enacted by Parliament to stop female foeticides and arrest the declining sex ratio in India. This act banned prenatal sex determination. In chapter 3 the act stipulates that no person, being a relative or the husband of the pregnant woman, shall seek or encourage the conduct of any prenatal diagnostic techniques on her except for the purpose specified in clause 2. The doctor involved must also ensure that:

- he has explained all known side- and after-effects of the ultrasound on the pregnant woman concerned;
- he has obtained in the prescribed form her written consent to undergo such procedures in the language that she understands; and
- a copy of her written consent obtained under clause (b) is given to the pregnant woman.

This act is relevant here in as much as it should have the effect of protecting women from being forced into an abortion by not allowing family members to get information on the sex of the foetus. It also lays out strict protocols in terms of consent of the woman to the procedure, and stipulates that she must understand what she is consenting to. This is a useful model to follow in terms of establishing protocols for KAWG seeking SRH-related procedures.

Indian Medical Council Regulations, 2002

The Indian Medical Council Regulations also specifically state that under no circumstance must a sex determination test be done with the intent of terminating a pregnancy unless the termination is in consonance with the Medical Termination of Pregnancy Act. "Any act of termination of pregnancy of normal female foetus amounting to female foeticide shall be regarded as professional misconduct on the part of the physician leading to penal erasure besides rendering him liable to criminal proceedings as per the provisions of this Act."¹⁶⁷

Also explicitly prohibited by the regulations are breaching confidentiality and failure to obtain written consent from both husbands and wives for operations that may cause sterility.¹⁶⁸

i Intervention by the courts: Guidelines for performing Sterilisation: India¹⁶⁹

In *Ramakant Rai v. Union of India* (2003) a Public Interest Litigation (PIL) petition cited data from the states of Uttar Pradesh, Bihar, and Maharashtra regarding female sterilization government practices that lacked counselling or informed consent, lacked pre- and post-operative care, and included unhygienic and un-anesthetized operating conditions, sterilization of minors, coercion, and cruelty. The PIL requested the Court to direct the state governments to comply with the Ministry of Health and Welfare's Guidelines on Standards of Female Sterilization, enacted in October 1999. They asserted that the current sterilization conditions violated not only the Guidelines but patients' reproductive rights,

¹⁶⁷ Para. 7.6.

¹⁶⁸ *Ibid.*, sect. 7.

¹⁶⁹ International Network for Economic, Social, and Cultural Rights-Case law database, at www.escr-net.org/node/365195.

women's rights, and health rights as articulated in international instruments ratified by India, including the Alma Alta Declaration, CEDAW, the ICPD Programme of Action, and the Beijing Platform for Action. They further contended that the current conditions violated patients' constitutional right to health, part of the right to life enshrined in articles 14, 15, 21, and 47 of the Indian Constitution.

In March 2005 the Court issued an interim order finding a lack of uniformity of procedures and norms to ensure that the Guidelines were followed, and leaving the case open. The Court ordered all states in India to outline "uniform standards to be followed by the State Governments," including norms of compensation. The court ruled that guidelines for sterilization should include:

- an approved panel of doctors to carry out sterilization procedures;
- a prepared and circulated checklist with information on the patient;
- circulated uniform copies of the pro forma consent form;
- the set up a Quality Assurance Committee;
- maintaining overall statistics;
- holding an inquiry into every case of breach of the Union of India guidelines [and] taking punitive action against them.

Ultimately issuing directives for the entire country and citing international standards, this case is especially relevant as the Court underscored the need for uniform guidelines in the performance of sterilization procedures, including requirements of informed consent, punitive action for violations, and compensation for victims.

Nepal

Country Code (Muluki Ain)

Chapter 10 of the Country Code deals with homicide, but also abortion and the abandonment of a baby. The Country Code provides that it is an offence to coerce, threaten, or offer abortion to a pregnant women, with specified exceptions.¹⁷⁰ Number 28B states: 'If an abortion is carried out by a qualified and registered health worker upon fulfilling the procedures as prescribed by the Government of Nepal, it shall not be deemed to be the offence of abortion, in the following circumstances:

- If the abortion of a foetus of up to twelve weeks is carried out with the consent of the pregnant woman.
- If the abortion of a foetus of up to eighteen weeks caused by rape or incest is carried out with the consent of the pregnant woman.
- If the abortion is carried out with the consent of the pregnant woman and on the advice of an expert pursuant to the prevailing law that if abortion is not carried out, the life of such a woman may be in danger or the physical or mental health may be deteriorated or a disabled child may be born."

¹⁷⁰ Number 28, chapter 10, Country Code: "Any person who commits abortion or causes abortion by doing any act with intention or knowingly or with sufficient reasons to believe that such an act is likely to cause an abortion shall be punished." Number 28A, chapter 10, Country Code: "No one shall cause abortion upon causing coercion, threat, lure or offer (*Pralovan*) to a pregnant woman. In cases where a person causes abortion in that manner, the person shall be liable to the following punishment...."

This provision makes it unlawful for anyone but a trained medical professional to carry out an abortion, and further emphasises the requirement of a woman's consent prior to carrying out a medical termination of a foetus. On the face of it, this provision forms the basis for a charge against any non-qualified person who carries out an abortion as well as a medical professional who carries out a termination without the consent of a woman. The Country Code further specifically provides that a person that discovers the gender of a foetus with the intention of abortion commits an offence.¹⁷¹ The prohibition on coercion, threat, or offering women an abortion could act as a protective provision for pregnant KAWG who are being pressured into an abortion.

Chapter 12 of the Country Code covers medical procedures. Chapter 12, number 2, sets out the requirements for surgery (in the best interest of the patient) and stipulates that the consent of the patient is required. Importantly, this provision emphasizes the requirement of consent for surgery. This provision would not be applicable for minor procedures or medical treatment that was not in the category of surgery. However, it should be applicable in the context of, for instance, forced sterilizations.

Pakistan

Reproductive Health Care and Rights Act, 2013¹⁷²

This act provides a framework for a rights-based national SRH programme, promoting non-discrimination in access to services and information on the basis of "race, colour sex, creed or any other criteria of discrimination." Most relevant in terms of the focus of this report is the provision stating that reproductive health care services shall ensure that "no person shall be subjected to forced pregnancy, sterilization, abortion or birth control."¹⁷³

Other key provisions include:

- Promotion of the right to gender-neutral information by ensuring access to "information related to reproductive rights and responsibilities within a gender perspective, which is free from stereotypes, discriminatory and obscurantist customs."¹⁷⁴
- Recognition that all couples have the right to information and to ensure reproductive life decisions are made with informed consent.

However, it should be noted that this act does not make provisions for legal redress in the event that people are mistreated or specific services are not provided. It simply states that the federal government must oversee the implementation of the act and make rules for this purpose.¹⁷⁵

This act is very new, but its focus is relevant to this report and it reflects the type of legislation that could fill some of the gaps in protecting women, including KAWG, in health care settings. The inclusion of "any other criteria" in the non-discrimination provision could form the basis for claims from KAWG in terms of denial of services or information. The provision also avoids imposing restrictions on the basis of marital status and age, and this is relevant for young girls and single women. Nevertheless, the inclusion of provisions dealing specifically with WLHIV, noting their specific vulnerability to violations and establishing protocols related to counselling, testing, confidentiality, and consent, would be very useful. In addition, provisions establishing complaint mechanisms and imposing sanctions for those violating rights need to be included.

171 Number 28C, chapter 10, Country Code: "No one shall commit or cause to be committed an act to identify (determine) the gender of the fetus for the purpose of committing the offence of abortion. A person who commits this offence shall be liable the punishment of imprisonment." Number 28D, chapter 10, Country Code: "A person who commits, or causes to be committed, abortion upon identifying the gender of the fetus as referred to in Number 28C, the person shall be liable to the punishment of imprisonment...."

172 For text, see: cappd.ca/wp-content/uploads/Pakistans-Reproductive-Healthcare-and-Rights-Act-2013.pdf.

173 Section 6 (h).

174 Section 4 (2).

175 Section 5.

Codes of conduct for physicians

Bangladesh

Medical and Dental Council Act, 1980 and 2010

The Bangladesh Medical and Dental Council (BMDC), established under the Medical and Dental Council Act (1980), is empowered to protect public interest by maintaining proper standards of services and education. The Act has been updated in 2010 but the changes largely relate to empowering the council to draw up new rules and regulations and the Act relies on the already established guidelines concerning conduct of physicians.

The Council is supposed to ensure adherence to the *Code of Medical Ethics* that specifically provides that: "In all dealings with patients the interest and advantage of their health should alone influence his conduct towards them. As their trust to their profession is great, so the obligation to be true to their interest is greater, and any single failure in this respect is wholly discreditable and inexcusable."¹⁷⁶

Guideline 4 specifically prohibits medical or dental practitioners from disclosing confidential information about a patient. Guideline 5 in referring to the disregard of personal responsibility to patient states: "Gross negligence in respect of his professional duties to his patient may be regarded as misconduct sufficient to justify the suspension or removal of the name of a medical/dental practitioner from the register." Guideline 6 stipulates that offences liable to disciplinary action by the council include "indecent behaviour or assault."

Women who were mistreated, denied treatment, or coerced into treatment that they did not want could conceivably use the above guidelines, to initiate proceedings against physicians. The Council has the authority to respond to complaints and to temporarily suspend or permanently remove the practitioner from the register for misconduct. However researchers have noted that due to "inadequate manpower support - both technical and administrative - inadequate resources, absence of any monitoring mechanism and follow-up action, lack of accountability, and lack of capacity in terms of enforcement of its own mandate,"¹⁷⁷ these are largely ineffective provisions.

India

Indian Medical Council Regulations, 2002

The Indian Medical Council (professional conduct, etiquette, and ethics) Regulations were established under the Indian Medical Council Act (1956). These rules specifically forbid physicians to deny treatment arbitrarily, and state that in an epidemic "the physician should not abandon his duty for fear of contracting the disease himself."¹⁷⁸

The rules also specify that any confidences that patients share must be respected except in very specific cases.¹⁷⁹ Physicians are also required to give an honest prognosis, and this could be relevant for cases of WLHIV who are discouraged from having children without adequate explanation of the medical options available to them. In a clause on human rights, the regulations state that "the physician shall not aid or abet torture nor shall he be a party to either infliction of mental or physical trauma or concealment of torture

176 Bangladesh Medical and Dental Council, Code of Medical Ethics, Jurisdiction Section, at http://www.bma.org.bd/pdf/code_of_medical_ethics.pdf

177 M. Huq, "Medical Ethics in Bangladesh," chapter in WHO, *Health Ethics in Six SEAR Countries, 1996*.

178 Indian Medical Council (Professional Conduct, Etiquette, and Ethics) Regulations (2002), paras. 2.1.1 and 5.2.

179 *Ibid.*, para 2.2: "Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the State."

inflicted by some other person or agency in clear violation of human rights.”¹⁸⁰ This provision may also be useful in this context, especially if the Medical Council were to take cognizance of and incorporate the Special Rapporteur’s view on what constitutes torture. The provision would be strengthened if it mentioned cruel, inhuman, or degrading treatment, which could incorporate less severe offences and which is a human rights violation recognized under the UDHR and the ICCPR.

The regulations state that specific acts of “commission or omission” on the part of a physician constitute professional misconduct, rendering him/her liable for disciplinary action. Complaints against physicians accused of violating the code of conduct can be brought to the council, and a disciplinary board has the power to strike the offending doctor off the register. Each case is supposed to be evaluated and decided within a period of six months.¹⁸¹ Research from 2006 to 2007 shows that the Medical Council did receive “732 complaints relating to ethical matters...of which 293 were referred to the relevant state councils/authorities for necessary action, 58 are awaiting clarification or further details from complainants and/or comments from the doctors in question, while 381 complaints have been resolved.”¹⁸²

An amendment in the *Consumer Protection Act, 1986*, also gives patients the right to sue or file a civil or criminal case against a physician, depending on the nature and severity of the issue.

Nepal

Medical Council Act, 1964

The Nepal Medical Council Act grants the Medical Council the power to remove a medical practitioner from the Medical Council Register in the event that the practitioner is convicted and sentenced to a criminal offence involving moral turpitude, or on the basis of misconduct related to the profession if decided by two thirds of the members of the Medical Council.¹⁸³

As in Bangladesh and India, a woman who experiences a rights violation by a medical practitioner can inform the Medical Council of the violation with a view to having the medical practitioner’s name removed from the register. A medical practitioner who is not registered with the Medical Council would face obstacles to practising as a doctor.

A similar provision exists in the Nepal Health Professional Council Act (1997) and the Nepal Nursing Council Act (1996) in relation to qualified nurses and allied health professionals.¹⁸⁴

Pakistan

The Pakistan Medical and Dental Council (PMDC) Code of Ethics, 2001 (revised)

The PMDC Code of Ethics, applicable to physicians in Pakistan, contains detailed provisions on consent, confidentiality, and non-discrimination.

In a comprehensive non-discrimination provision, the code states that the physician “will bear in mind the obligation of preserving life and will not discriminate on the basis of age, sex, gender, class, race, ethnicity, national origin, religion, sexual orientation, disability, health conditions, marital discord, domestic or parental status, criminal record, or any other applicable bias as proscribed by law, and ensure that personal beliefs do not prejudice patient care.” This is a significant provision, which clearly covers many of the grounds

180 Ibid., para. 6.6.

181 Ibid., paras. 8.2 and 8.4.

182 Rand Corporation, *International Comparison of Ten Medical Regulatory Systems* (UK Medical Council, 2009).

183 Note: After two years a medical practitioner can reapply for registration, but must show reasonable grounds for doing so.

184 For more information on the council composition, see www.nmc.org.np/contents/history-information.html.

upon which PLHIV and key HIV-affected women and girls typically experience discrimination in health care settings.¹⁸⁵

The Code of Ethics states that “the physician has a right to and should withhold disclosure of information received in a confidential context, whether this be from a patient, or as a result of being involved in the management of the patient...except in certain specific circumstances where s/he may carefully and selectively disclose information where health, safety and life of other individual/s may be involved.”¹⁸⁶

The Code of Ethics also states that all patients have a right to decide on their own treatment or to refuse treatment based upon all available information relevant to their decision. It also requires that “when taking consent the physician should consider issues of adequate disclosure, the patient’s capacity, and the degree of voluntariness.”¹⁸⁷

As with the Medical Council rules in the other countries, physicians found guilty of contravening these rules can be struck off the register. There is also a provision for taking a case to court, if required.¹⁸⁸ This would presumably occur in situations where the offence is serious enough to warrant a penalty that the Disciplinary Committee cannot enforce. Thus, it seems that a woman who experiences a rights violation by a medical practitioner can inform the Medical Council with a view to this being the first site of complaint, and may then enlist them to assist her in escalating the complaint to the courts. To initiate an inquiry, the complainant must provide an affidavit attested by a magistrate.

Research shows that these complaint provisions are being utilised to some extent. PMDC received complaints against some 2,500 doctors between 2004 and 2008, of whom approximately 500 have been ‘penalised’ and four have appealed the decision in the courts. However, critics suggest that there is too little transparency when a disciplinary proceeding begins, and that bribery and corruption play some role in the raising and the resolution of complaints.¹⁸⁹

Assault provisions in country codes

During the research phase for this report, a thorough examination of domestic violence and rape laws was undertaken. However, while there is extensive legislation in all the studied countries, and while the linkages between violence against women and HIV have been noted, a detailed analysis of these laws was deemed to be beyond the scope of this report since very few provisions in the legislation would be applicable to the rights of women in health care settings. This notwithstanding, a limited number of provisions in country penal codes on assault and harm use particular language that may be directly relevant to violations of KAWG rights in health care settings. These are described below.

India

Indian Penal Code, Sections 354 and 509

Section 354 penalises any person who assaults or uses criminal force towards any woman with the intention or knowledge that it will outrage her modesty. Section 509 penalises any person who uses language, gestures, or objects with the intention of insulting a woman’s modesty by such use. Although this law does not specifically mention health care settings, it applies to “any person,” and therefore there is no reason why a woman who has been humiliated or harassed in a health care setting should not be able to file a case under these provisions.

¹⁸⁵ Para. 11.2.2.

¹⁸⁶ Para. 12.

¹⁸⁷ Para. 18.

¹⁸⁸ Para. 27.1.5.

¹⁸⁹ Rand Corporation, *International Comparison*.

i Case law: Outraging modesty – India

In *Rupan Deol Bajaj and another v. KPS Gill and another* (a case involving sexual harassment at a party), the court concluded that “the ultimate test for ascertaining whether modesty has been outraged is the action of the offender such as could be perceived by one which is capable of shocking the sense of decency of a woman.” The respondent attempted to use the defence provided by Section 95 of the Penal Code, which provides that an act is not an offence if it causes harm so slight that it would be considered trivial by an ordinary person. The court cited precedent in determining that the ‘harm’ caused would include mental injury, and its triviality would depend on the nature of the injury, the position of the parties, and the intent or knowledge behind the action, but not merely on the measure of physical or other injury caused.

It is worth noting that the very recent Criminal Law (Amendment) Ordinance (2013) provides for amendment of the Indian Penal Code, Indian Evidence Act, and the Code of Criminal Procedure on laws related to sexual offences. Passed in the wake of the brutal gang rape and subsequent death of a student in Delhi, in December 2012, the law seeks to be a more rigorous mechanism for cases of sexual violence.

The law is significant in this context in as much as it now includes a recognition of graded sexual assault with offences such as “making of sexually coloured remarks by a man,” now punishable by one year in prison, and “Physical contact involving unwelcome and explicit sexual overtures,” punishable by three years.¹⁹⁰ The inclusion of these offences has widened the scope of the law and affords protection for certain types of violations in health care settings. For instance, verbally humiliating treatment such as inappropriate and degrading questions or remarks addressed to sex workers or transgender women would presumably be covered by this provision. Sexual harassment by physicians, which has also been reported by sex workers, whether verbal or non-verbal, would also be covered. Hospital staff are also explicitly mentioned in section 376 (c), in the context of assault by a person in a position of authority, but specifically relating to prohibiting and making punishable sexual intercourse with a patient.

Nepal

Country Code (Muluki Ain), Chapter 19

This deals specifically with decency and etiquette. Interestingly, chapter 19 of the Country Code provides protection for women against rape in the context of detention, health care, and guardianship relationships. At chapter 19, number 5, the Country Code makes the following punishable offences:

- “any government employee who commits sexual intercourse or arranges for sexual intercourse by other person with a woman who is imprisoned or detained;
- any medical practitioner or health worker who commits sexual intercourse with a woman who has come to avail medical service at time of rendering medical service or in the place of rendering such service;
- any guardian or caretaker who commits sexual intercourse with a women who is under his guardianship or care;

190 See the Criminal Law (AMENDMENT) Ordinance (2013), Section 354 (a), at mha.nic.in/pdfs/criminalLawAmndmt-040213.pdf.

- any official or employee, in any organization where a woman suffering from mental or physical illness is staying for the purpose of treatment or rehabilitation, who commits sexual intercourse with such a woman.”¹⁹¹

Clearly, this provision could be called upon in the event of the rape of a woman in a health care setting. It is limited in its ambit to “sexual intercourse,” however, meaning that it would not protect a woman in the event of sexual assault or other rights violations.

Muluki Ain, Chapter 14

This provision defines rape as any act of non-consensual sex with a woman whether married or unmarried. Highly significant is the recent amendment to the code, after the Supreme Court ruling¹⁹² that has specifically defined rape within marriage – regardless of the age of the wife – as rape, attracting the same penalties as rape of a non-spouse, 3–5 years imprisonment.¹⁹³ Nepal is the only country of the four to have a provision that recognises marital rape.

Although, as stated above, general laws on rape and violence are not being addressed by this report, we are briefly addressing marital rape as an exception, given the links between intimate partner violence and HIV.¹⁹⁴ Laws supporting consensual sexual activity are laws that protect women within the family and are linked to their ability to negotiate condom use and have access to family planning services. These structural changes could therefore have a significant impact on how women interact with the health care system at large.

HIV/AIDS bills

HIV and AIDS-related bills or draft legislation that addresses some of the primary gaps in the current law exists in Nepal, India, and Pakistan. Unfortunately, this legislation has not been passed into law in any of the countries under discussion, with the exception of an important provincial law in Sindh in Pakistan (where many of the responsibilities of the central government have recently been devolved to the provincial level). It is worth looking at the provisions of the pending bills as examples of the type of legislation that could make giant strides towards protecting the rights of people living with and affected by HIV and AIDS in South Asia, including improved specific protection of HIV-positive women’s rights in health care settings. The Indian HIV/AIDS Bill is a comprehensive piece of legislation, not only highlighting specific vulnerabilities but also providing penalties and mechanisms for redress. This bill could act as a model for other countries, so this will be examined in detail, and common provisions from the other bills will be highlighted as well.

India

HIV/AIDS Bill, 2007 (Pending)¹⁹⁵

In 2007 a unique joint initiative of the government and civil society saw the introduction of the HIV/AIDS Bill into Parliament. This bill seeks to provide for “the prevention and control of the HIV epidemic in India, the protection and promotion of human rights in relation to HIV/AIDS,” and for the establishment of relevant authorities “to promote such rights and promote prevention, awareness, care, support and treatment programmes to control the spread of HIV.”¹⁹⁶

191 A person in violation of this provision is liable to imprisonment for a term ranging from one to three years. “If such an act is an offence under [the Country Code] or any other prevailing law, the punishment imposed thereunder shall be added to such punishment.”

192 *Forum for Women, Law, and Development v. His Majesty's Government/Nepal*, Writ no. 55 of the year 2058 BS (2001–2002), Nepal Supreme Court (2002).

193 Chap. 14, para. 1.

194 Program on International Health and Human Rights, Gender-Based Violence and HIV (Harvard School of Public Health, 2011).

195 See www.lawyerscollective.org/files/Final%20HIV%20Bill%202007.pdf.

196 *Ibid.*, HIV Bill, Preamble, p. 3.

Key features of the bill include:

1. **Prohibition of discrimination:** Chapter II specifically prohibits discrimination related to HIV/AIDS in public and private spheres. Under the bill, no person may be discriminated against in employment, education, health care, travel, housing, insurance, etc. based on their HIV-related status.
2. **Informed consent for testing, treatment, and research:** In chapter III, the bill lays out the requirements for specific, free, and informed consent for HIV-related testing, treatment, and research. The bill leaves little room for ambiguity, here defining informed consent as “consent given, specific to a proposed intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation and obtained after disclosing to the person giving consent adequate information, including risks and benefits of, and alternatives to, the proposed intervention in a language and manner understood by such person.”¹⁹⁷
3. **Disclosure of information:** Chapter IV guarantees the confidentiality of HIV-related information (including the HIV status of a person) and outlines the few exceptions for disclosure. Importantly, while dealing with ‘partner notification’ and the ‘duty to prevent transmission’, the bill also recognizes the vulnerability of women, and specifies that the duty to notify partners is waived in the case of women who fear violence and loss of their homes in the event of notification.
4. **Right to access treatment:** Chapter V, within the context of the right to health, provides for access to comprehensive HIV-related “treatment, care and support facilities, goods, measures, services and information, including centres providing voluntary testing and counselling services...and free of cost treatment for HIV/AIDS for all persons.”¹⁹⁸
5. **Risk reduction:** Chapter VII specifically addresses harm reduction strategies, such as the provision of clean needles, promotion of safer sex practices, and provision of information and condoms to sex workers, protecting them from civil and criminal liability and law enforcement harassment.
6. **Information, education, and communication (IEC):** Chapter IX deals with IEC, recognizing that information is the key to any successful prevention programme, and places a duty on the state to promote positive and evidence-based messages that look at prevention as well as care, support, and rights. The information provided should be “age-appropriate, gender-sensitive, non-stigmatising, non-discriminatory”¹⁹⁹ and should promote gender equality. It also suggests that IEC should particularly be focused on the specific needs of women and young persons.
7. **Implementation and grievance redressal:** Chapters XI and XII address and create innovative implementation mechanisms, including institutional grievance redressal machinery. The HIV/AIDS Bill also specifies special court procedures, including quick trials and creative redressal. Thus, a case related to discrimination could see a court awarding damages and directing the offending person to undergo sensitization training and community service.
8. **Special provisions:** Chapter XIV is a comprehensive overview of special provisions taking into account nuanced needs that may exist for particular groups in particular circumstances. For instance, it specifically recognizes certain rights for women, children, and persons in the care and custody of the state who find themselves more vulnerable to HIV and are disproportionately affected by the epidemic.²⁰⁰

197 Chapter 1, art. 2 (q).

198 Chapter 5, art. 2.

199 HIV/AIDS Bill 2007, chapter IX, article 24 (1).

200 Ibid., chapter XIV, article 75.

This chapter also addresses some underlying causes of the vulnerability of women to HIV, providing for the registration of marriages, the provision of maintenance, and the right of residence for HIV-positive women.²⁰¹ The rights of pregnant women to proper counselling to enable them to decide treatment options as well as a prohibition on forced abortion or sterilization is also laid out.²⁰²

Critically, chapter XIV also addresses the link between sexual violence and HIV and directs the state to set up sexual assault crisis centres where survivors of sexual assault may access services such as counselling, treatment, referral, and management of STIs, including HIV and AIDS.²⁰³

Nepal

HIV and AIDS (Prevention, Control, Treatment, Re-integration, and Protection of Rights), 2012 (pending) (HIV Bill)²⁰⁴

The HIV Bill is currently being amended by the Ministry of Health and Population, after which it will be forwarded to the Ministry of Law and Justice and subsequently tabled before Parliament for endorsement and enactment.

1. **Prohibition of discrimination:** The HIV Bill states that “no person shall be subjected to any form of discrimination because of his/her being HIV infected or on a suspicion that he/she is HIV infected.” The bill further states that “no public or private enterprise shall discriminate against any person because of his/her being HIV infected or on a suspicion that he/she is HIV infected, in access or distribution of any facilities....”²⁰⁵ This discrimination provision may protect a woman living with HIV who faced discrimination in a hospital (notably, only after the HIV Bill is passed into law).
2. **Privacy and confidentiality:** The HIV Bill recognizes and reinforces the constitutional guarantee of the right to privacy by providing that “a person shall not be required to disclose his HIV status unless otherwise required by the provisions of the HIV Bill of any other law in force.”²⁰⁶

The bill also provides specifically for confidentiality within the health care system, stating: “All the health professionals, people working in the health sector and any doctor, nurse, or other staff or worker in the government or the private sector, who have the responsibility to maintain documents or any records, reports or reports of health-related testing to keep confidential any details related to HIV and AIDS status of any person that comes to his/her knowledge in the course of his/her work.”²⁰⁷ This confidentiality provision may protect a woman living with HIV whose HIV status was disclosed by a health care worker. The HIV Bill also prohibits mandatory testing but does not specify the way in which consent should be given, i.e free, after complete information has been provided and in writing.

201 Ibid., articles 70 and 71.

202 Ibid., article 73.

203 Ibid., article 74.

204 The above analysis is based on a draft of the HIV Bill dated 6 October, 2011, a version of which had been submitted to the Ministry of Health and Population (MoHP) in 2010.

205 Section 10 (1)

206 Section 9 (2)

207 Section 9 (3)

Pakistan

HIV Prevention Bill, 2007 (Pending)

The HIV Prevention Bill provides for the establishment of a National AIDS Commission and for Provincial AIDS Commissions for the prevention, control, care, support, and treatment of HIV/AIDS in the whole country and in each province, respectively.

1. **Non-discrimination:** The HIV Prevention Bill contains provisions prohibiting discrimination against a person on the basis of his/her HIV status and declares it unlawful to require or coerce a person to be screened for the following purposes: employment, promotion, training, or benefit, either in public or private sectors; membership in any organization; admission to any educational institution; admission to any public or private place of accommodation; marriage; immigration to, emigration from, or citizenship of Pakistan; or visiting another country for any purpose whatsoever, including but not limited to tourism, studies, or work. The bill also specifically prohibits discrimination in employment, housing, educational institutions, and health facilities, including denying or discontinuing medical treatment on the basis of HIV status.
2. **Harm reduction:** The providing of any product or any equipment to implement, enforce, plan, deliver, or monitor any of HIV/AIDS prevention harm reduction services shall not in any manner be prohibited, impeded, restricted or prevented and shall not constitute a criminal offence by the persons working in good faith towards HIV harm reduction services.
3. **Women and sexual violence:** An important provision in this bill is the stipulation that women who have been raped or have experienced sexual violence shall be provided with counselling and clinical services at public and private health care facilities, and services for rape survivors shall include post-exposure prophylaxis. Furthermore, every survivor of sexual assault, whether choosing to report the crime or not, shall have access at a public health care facility to the following services on a confidential basis: counselling; prevention and management of STIs, including testing and prophylactic treatment; prevention, treatment, and management of other medical conditions or injuries associated with the sexual assault; HIV/AIDS related counselling and treatment, if required; and follow up treatment and care.

In the case of Pakistan, due to the recent devolution of power in the country, it is necessary to look at subnational laws as well as those at the national level.

Sindh HIV and AIDS Control Treatment and Protection Act, 2013 (passed by the Sindh Provincial Assembly on September 21, 2013)

The Sindh HIV Law is the first legislation in Pakistan that protects PLHIV from discrimination and provides for strict confidentiality measures as well as legal penalties to health care workers who contravene the law. Key points of the law include:

1. **Prohibition of discrimination:** No person, whether in the field of health care services, education, employment, provision of general utility, or any other form of services; or in relation to accommodation whether in respect of lease, rent, to let, hire, or purchase, can discriminate against another person, on the basis of such other person's HIV status or presumed, suspected, or alleged HIV status.²⁰⁸
2. **Mandatory testing:** No person shall be required by any public or private health care facility to undergo HIV screening for routine testing or diagnostic testing purposes without their express consent. It is also unlawful to require or to coerce another person to be screened for HIV for any of the following purposes: employment, promotion, training, or benefit, either in public or private sectors; membership in

²⁰⁸ Section 8 (1).

any organization; admission to any educational institution; admission to any public or private place of accommodation; marriage; or immigration to, emigration from, or citizenship of Pakistan.²⁰⁹

3. Confidentiality: All health care facilities, whether public or private, are required to maintain the confidentiality of their patients' medical and personal records and information, including their HIV/ AIDS status.²¹⁰
4. Awareness and training: It is the duty of every health worker and every health care facility to make available information regarding the prevention, control, and treatment of HIV/AIDS to the public. Every health care facility is also required to enhance the knowledge and capacity of all its workers with regard to the dissemination of information about HIV/AIDS and the education of the general public about HIV/AIDS and on other HIV-related issues, such as discrimination, confidentiality, and informed consent.²¹¹
5. Penalties: A very significant aspect of this law is that it stipulates penalties for specific offences. For instance, it states that the penalty for publicizing the confidential health information of any individual or the health records of any person shall be imprisonment for a term not exceeding five years and not less than two years and a fine not exceeding PKR 200,000 (approximately US\$1,900).²¹²

Any contravention of section 8 of the act is punishable by imprisonment and/or a fine of up to PKR 300,000 (US\$2,800). In addition, if any contravention of section 8 of the act results in any delay or denial of the provision of health care services to any PLHIV by a health service provider, whether in a health care facility or otherwise, for any reason whatsoever, including but not restricted to the HIV status of the PLHIV, the health care provider shall pay a fine of between PKR 100,000 (US\$950) and not more than PKR 2,000,000 (US\$19,000). The act also links contravention of the provisions to the Penal Code, stating that in the event that delay or denial of health care services results in the premature acceleration or death of the PLHIV, the health service provider responsible for such acceleration shall be liable for the relevant punishment under the PPC.²¹³

The act also provides for specific functions to be carried out by two independent bodies—the working body and the governing body. All HIV and AIDS related projects including those pertaining to training, treatment provision, awareness raising etc. will be undertaken and implemented the Working Body, which shall report to the Governing Body, which meets every six months. This review of the act's implementation will be critical in determining how effectively provisions are enacted, especially with regard to activities (such as training) that are mentioned in the law. Adequate funding for these activities will need to be provided by the provincial government.

The fact that this law has been passed is a significant step forward in terms of HIV-related legislation in South Asia. Specific provisions such as the mandated training of all health care workers on HIV, discrimination, confidentiality, and consent could have a very significant impact on reducing the stigma and discrimination feared and experienced by KAWG in health care settings. Providing specific penalties for defined offences by health care providers is also critical to giving the act 'teeth' and making health care workers legally accountable. However, it should be noted that this is a provincial law, and therefore not applicable to other areas of Pakistan.

209 Section 8 (2) (5).

210 Section 8 (6).

211 Section 11 (3).

212 Section 23.

213 Section 9.



CONCLUSION

Women are vulnerable across South Asia, and certainly in all the countries examined in this study, to extreme inequalities within their households, communities, society, and all the institutions with which they interact. Key HIV-affected women and girls, including women living with HIV, female sex workers, and poor women from marginalized groups are particularly disadvantaged and often face discrimination and poor treatment in public institutions, including health care settings.

The health care system is one of the most critical public sites that women need to access in order to maintain health throughout their life cycle. Yet, as this report has documented, there is strong emerging evidence that some health care institutions are sites of discrimination, violence, and abuse towards individuals who come seeking services, with health care providers withholding care or performing treatment that intentionally or negligently inflicts pain and suffering. Rights violations that KAWG face in health care settings include forced and coerced sterilization, forced and coerced abortions, denial of access to sexual and reproductive health services, and subjection to humiliating and degrading treatment and discrimination.

Legislation against the sort of discrimination described in this report is urgently required to ensure that the health care systems in Bangladesh, India, Nepal, and Pakistan provide adequate and non-discriminatory treatment and care for KAWG. What is most needed is a comprehensive body of national and local legislations that:

- Provides a detailed definition of discrimination, specifies that this includes health settings, and specifies grounds upon which this is to be prohibited – including HIV status and work. Example of this is the pending HIV Bill in India, which prohibits discrimination.
- Sets out sanctions and processes for breaches of the law and appropriate penalties for health care practitioners who violate the law, as in the Sindh HIV Act in Pakistan.
- Identifies or establishes a mechanism for patients to lodge complaints against health care workers. For instance, the medical regulatory bodies in each country may be approached by individuals who feel they have a complaint against violations of the code of conduct by physicians.
- Is applicable to private actors including private hospitals and healthcare centres.
- Contains special provision for women and their needs, including ensuring that women receive adequate counselling and information on procedures such as HIV tests and treatment, sterilizations, and abortions. This is addressed in the pending HIV Bill in India in article 373.

- Specifically lays out protocols relating to confidentiality and consent regarding HIV testing, recognizing that women are often deterred from accessing services due to fear that their status may be disclosed to their families without their permission. Obligations to maintain a patient's confidentiality and ensure their informed consent for any procedure are specifically addressed in the codes of conduct for physicians in all the studied countries.
- Requires health care facilities to implement training of health care workers on issues including HIV basic facts, HIV-related stigma and discrimination, confidentiality, consent, and other patients' rights. For instance, the Sindh HIV Act in Pakistan has specifically addressed the issue of enhancing the knowledge and capacity of all health care workers on HIV-related issues.
- Protects the rights of health care workers by providing equipment and materials necessary for universal precautions and ensuring a safe working environment.

As noted, laws need to be properly enforced and bolstered by effective implementation and complaint mechanisms that are easy to access and that make people working within health care accountable for their actions. This includes ensuring the provision of information about complaints mechanisms to patients, and access to legal services for those who need it.

Even where laws do not exist, we have seen that courts in the countries studied have been able to play a critical role, using fundamental rights guaranteed by a country's constitution as well as international human rights instruments that the country is party to, to pass progressive judgments that cause eventual changes in the law. An example of this is the Indian Supreme Court's decision to lay down guidelines for sterilization based on the decision that current sterilization conditions violated patients' reproductive rights, women's rights, and health rights as articulated in the Indian Constitution and international instruments ratified by India, including the Alma Alta Declaration, CEDAW, the ICPD Programme of Action, and the Beijing Platform for Action.

With regard to HIV, legislation needs to include strict protocols on areas such as informed consent, confidentiality, testing, disclosure, and specific needs of key affected communities. The Sindh HIV Act passed in Pakistan is a significant piece of legislation in this regard, highlighting such critical areas as training of health care workers and providing specific penalties for offences by health care providers under the act. The current pending HIV/AIDS Bill in India is also a good example of such a piece of legislation, not only meeting many of the above requirements but also comprehensively addressing the underlying causes of vulnerability for KAWG and the specific issues faced by them. Needless to say, the passage of these bills should be a matter of priority since none of the studied countries currently has HIV-related legislation in place that is nationally applicable.

Meanwhile, it is worth considering the argument that HIV-focused protective provisions should be included under public health law, disability law, or anti-discrimination law. As we have seen, many different types of laws exist that could include specific provisions for people living with or affected by HIV. For instance, laws on assault could specifically address assault in health care settings by including "cruel, inhuman, or degrading treatment" in the definition, and thereby expanding the range of offences that would be covered, beyond sexual assault. Disability provisions, including those on non-discrimination, can be expanded to include PLHIV with specific provisions for WLHIV. Provisions regarding disabled women in health care settings, such as those in the new Disability Bill currently proposed in India, are particularly relevant to WLHIV, focusing as they do on informed consent and confidentiality and specifically prohibiting forced sterilizations.

Ultimately, proponents of this approach argue that distinguishing and separating HIV exacerbates stigma and that 'mainstreaming' the specific needs of PLHIV and specifically key affected women and girls is a more effective approach, utilizing existing laws to address new issues, reinforcing them where necessary, and perhaps ending up with stronger protective mechanisms for all people.



RECOMMENDATIONS

We should note that all four countries examined do have legislation that prohibits discrimination. Some of this legislation also relates specifically to healthcare settings. Strengthening provisions within existing laws as well as effective implementation and enforcement is critically needed. In addition, social determinants such as stigma, intolerance, apathy, and general dereliction of duty by both healthcare practitioners and administrators require renewed attention and focus within interventions by the legal, policymaking and healthcare sectors in each country.

General recommendations to governments

Participation of women in decisions that affect them

- a. Key HIV-affected women and girls need to be engaged in dialogue in a positive and meaningful way in order for policy makers to better understand the nature of their experiences in health care settings. This would involve including not only HIV-positive women's networks but also sex workers and young person's advocacy groups into consultations with policy makers and representatives from the legal and health sectors in each country. The consultations should focus on the joint development of recommendations for laws, policies, and programmes to prevent future rights violations in health care settings.
- b. Positive Women's Networks must be strengthened through financial support and capacity-building and training so that WLHIV may be involved in peer-based support services and counselling programmes for KAWG. WLHIV must be capacitated to advocate among peers, family, health care providers, and policy makers on their right to sexual and reproductive health and rights.

Legal sector

- a. All pending HIV bills should be passed with the specific stipulation of implementing structures to make sure that provisions are effectively enforced and executed.
- b. Non-discrimination legislation needs to be enacted based on constitutional guarantees and applicable to both public and private actors in health care settings. It is necessary to ensure that such legislation is aligned with international conventions, such as the ICESCR and CEDAW. The legislation should contain specific provisions that recognize the gendered experiences of women in health care situations by

stipulating additional safeguards related to informed consent in cases concerning the reproductive rights of women. Countries should repeal laws that explicitly discriminate against women

- c. Sex work must be decriminalized in order to reduce stigma and discrimination towards sex workers seeking health care and HIV-related testing and treatment.
- d. A review of enforcement and implementation of protective laws needs to be conducted, specifically with regard to how these can work to minimise rights violations in health care settings.
- e. Conduct a review of complaints and enforcement mechanisms relating to violations of rights in health care settings including the mechanisms available under national human rights institutions and medical council boards.
- f. In partnership with civil society organizations, governments need to provide interventions and training programmes for trial and appellate court judges on HIV/AIDS and the rights violations of KAWG in health care settings.
- g. Legal ministries in partnership with national human rights institutions should design programmes to create more awareness of constitutionally guaranteed rights, such as the right to the highest attainable standard of health – including the right to sexual and reproductive health – in the form of accurate information and accessible services related to HIV/AIDS, STDs, pregnancy, abortion and contraception amongst KAWG, disabled women, very poor women and other marginalized communities.
- h. National or state-level Interventions, including those carried out by state bodies, should deal with structural issues such as non-accessibility of legal services and the gendered nature of judicial systems to ensure that, where laws exist to protect women, they have access to justice. This would involve training of the judiciary on issues related to KAWG (see above). Other necessary measures would include:
 - Training and supporting NGOs, including HIV-positive women’s networks and women’s rights advocates, to implement programmes promoting increased awareness of laws and mechanisms for redress, effective documentation of rights violations, and assistance in approaching available legal aid bodies.
 - Ensuring information on rights related to HIV and SRH as well as on complaints and redressal mechanisms, where available, to women in community health centres, district hospitals, and local-level legal aid centres.

Health sector recommendations

- a. Develop and implement a national policy to address HIV-related stigma and discrimination in health care settings, including through stigma and discrimination reduction programmes for health care workers. In accordance with UNAIDS guidance on stigma reduction,²¹⁴ training in health care settings should be conducted with health care workers, administrators, and health care regulators with the objectives of ensuring that:
 - Health care providers know about their own human rights to health (HIV prevention and treatment, universal precautions, access to post-exposure prophylaxis, compensation for work-related infection) and to non-discrimination in the context of HIV.

214 See UNAIDS Guidance Note, “Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses” (2012).

- Stigmatizing attitudes in health care settings are reduced and health care providers are given the skills and tools necessary to ensure patients' rights to informed consent, confidentiality, treatment, and non-discrimination.

b. Create safeguards against violations of women's rights. Detailed protocols must be created and followed in all health care institutions, with accompanying penalties for non-observance.

On sterilizations, certain standards can be established, including:²¹⁵

- Allowing for sufficient time between the explanation of the sterilization procedure to the patient and the time when consent is sought;
- Not seeking consent while a woman is in labour;
- Mandating that informed consent be transmitted both verbally and in writing;
- Translating all forms into relevant languages;
- Stipulating that sterilization cannot be a condition of receiving other treatment or employment, and abolishing spousal consent requirements.

On HIV testing, in accordance with the *International Guidelines on HIV and Human Rights*, public health legislation must ensure:

- That HIV testing of individuals should only be performed with the specific informed consent of that individual and that pre- and post-test counselling be readily available.
- That information related to the HIV status of an individual be protected from unauthorized collection, use, or disclosure in the health-care and other settings.
- That the use of HIV-related information requires informed consent, and that disclosure to a person's partner can be made only according to specified criteria.²¹⁶
- Comprehensive counselling needs to be provided to women before they are tested for HIV. This must apply to all women, including pregnant women, transgender persons, sex workers, or wives of HIV-positive men. Counselling needs to be provided at many care points and available to women in a language that she can understand properly. It should also include family members.
- HIV-positive women should be trained and employed as peer counsellors at all government testing centres.

c. Create awareness programmes that include information on sexual and reproductive health and rights and legal literacy among the population, especially in rural areas, using government-sponsored mass-media advertising to reach the entire population.

215 Supra note 31, Open Society Foundation Report.

216 Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006). See Guideline 3, para. 20 (a-j).

Country-specific recommendations to governments: Legal

Bangladesh

1. Establish mechanisms to monitor rights violations with stipulated implementing measures. Violations of the right to health should be treated as violations of human rights and should be well-documented and subject to punitive action.
2. Draft and enact an HIV bill in keeping with the UN guidelines on HIV and human rights.
3. Ratify the Convention against Torture.
4. Enact legislation dealing with medical protocols relating to informed consent, confidentiality, standards of treatment, and negligence – including an effective complaints and enforcement mechanism.
5. Build strategic partnerships between Ministry of Law and religious organizations with a view to reaching people with informative and accurate messaging about HIV/AIDS and raising awareness among women of their rights in health care settings.

India

1. Remove reservations under CEDAW²¹⁷ and enact legislation that provides equal rights for all women, regardless of religion, with regard to family law. The relevance of this is to specifically enact legislation that addresses inequality within the household, which result in differential access to health care.
2. Ratify the Convention against Torture (CAT).
3. Strengthen para. 6.6 (torture) of the Indian Medical Council Regulations by including cruel, inhuman, or degrading treatment, thereby incorporating and dealing with less severe offences recognized as human rights violations under the UDHR and the ICCPR.
4. Establish and implement laws, programmes, and policies on zero tolerance towards violence against women. Have political and religious leaders publicly speak out and condemn all forms of violence against women and specifically address violations faced by women in health care settings.
5. Provide comprehensive training for lawyers and trial and appellate court judges on binding standards that make clear that finger test results and medical opinions about whether a survivor is “habituated to sexual intercourse” are unscientific, degrading, and legally irrelevant, and should not be presented in court proceedings related to sexual offences.²¹⁸

Nepal

1. Amend chapter 10 of the Country Code so that abortion is not dealt with under homicide. Enact a separate piece of legislation dealing with abortion with a focus on reproductive rights of all women, retaining paragraph 28 of the current law prohibiting coercion or threat, lure or offer, to a pregnant women, and retaining and strengthening the emphasis on consent.
2. Expand chapter 19, number 10A, of the Country Code, which sets out punishment for discrimination on the basis of caste, religion, colour, class, or work, to include sex, disability, and health status.

217 India entered a reservation under CEDAW on articles 5 and 16, which deal with customary and personal laws.

218 See Human Rights Watch report, *Dignity on Trial*, for detailed recommendations regarding this test.

3. Ratify the Convention against Torture.
4. Engage law and justice sector peers in partnership with civil society organizations in efforts to advocate for a national anti-discrimination law to support constitutional guarantees to equality.²¹⁹

Pakistan

1. The Provincial Government should promote the Sindh HIV and AIDS Control, Treatment and Protection Act (2013) as a model for similar laws to be promulgated in all other provinces, and ensure that adequate budget provisions are made for implementation of this law. The *governing body* should strictly follow the monitoring guidelines stipulated ensuring that the *working body* procedures on implementation and reporting every six months are being followed.
2. The Reproductive Rights and Health care Act should be strengthened by adding provisions establishing complaint mechanisms and imposing sanctions. Provisions dealing specifically with WLHIV, noting their specific vulnerability to violations, should be added.

Country-specific recommendations to governments: Health sector

Bangladesh

1. The Ministry of Law and Education along with major human rights institutions in the country (Bangladesh Legal Aid and Service Trust, Bangladesh National Woman Lawyers' Association and the National Human Rights Commission) should design programmes to create more awareness of the right to health care, including information and services related to HIV, sexually transmitted diseases, abortion, and contraception, among key HIV/AIDS-affected women and girls, disabled women, and other marginalized communities.
2. A medical ombudsman mechanism should be created, wherein complaints can be dealt with in a private environment and not through the court system.
3. NGOs or other public bodies associated with health should be given assistance and encouragement to conduct workshops in private and public medical facilities dealing with discrimination.

India

1. Undertake research on the cases that have been dealt with and are pending under medical regulatory boards, focusing on effective redressal of cases, obstacles to access, and duration until remedy is granted.
2. Create safeguards against violations of women's rights. In addition to protocols mentioned under general recommendations, India needs to implement protocols, with accompanying penalties on Sexual assault examinations.²²⁰ This includes:
 - The banning of the finger test and its variants from all forensic examinations of female survivors of rape and sexual assault.
 - Stipulation of penalties to be imposed on any health care institution that carries it out.

²¹⁹ *Shadow Report on the Fourth and Fifth Periodic Report of the Government of Nepal on CEDAW.*

²²⁰ *Supra* note 85.

- Instruction to doctors not to comment on whether they believe any girl or woman is “habituated to sexual intercourse.”
 - Instruction to senior police officials to ensure that they do not ask doctors to comment on whether a rape survivor is “habituated to sexual intercourse.”
 - Have one centre in at least one government hospital in every district of the country staffed with trained personnel who are equipped to provide integrated, comprehensive, gender-sensitive treatment, forensic examinations, counselling, and rehabilitation for survivors of sexual violence.
3. Ensure equal access to sexuality and rights education, including information on reproductive rights and health and HIV/AIDS prevention, treatment, and counselling services. Pre-marital counselling programmes focusing on providing information – in an accessible format and local languages – on issues related to sexual and reproductive health, including information on contraception, STDs, HIV, and marital rape, should be available at primary health care centres across the country.

Nepal

1. Train and sensitize health care professionals and health care workers on legal rights, HIV, disability, stigma, and discrimination.²²¹
2. Train health care professionals and health care workers on privacy and confidentiality.
3. Increase awareness of the rights to health, privacy, physical integrity, autonomy, privacy, and confidentiality among the population of Nepal through mass media campaigns and NGO interventions.
4. Ensure abortions are carried out only in accordance with strict standards of consent after counselling and the signing of an affidavit in a language the woman understands.
5. Ensure that women with disabilities and women living with HIV have access to a full range of reproductive and sexual health services.²²²

Pakistan

1. Conduct awareness workshops on HIV/AIDS among key affected groups in the identified HIV/AIDS hotspots. Given Pakistan’s sociocultural profile, HIV still remains a taboo topic and is not openly discussed.
2. Conduct a national study examining rights violations of KAWG in health care settings using community-based organizations as partners.
3. Conduct sensitization workshops for health care professionals not directly connected to the HIV/AIDS departments of hospitals. Additionally, the current process of providing treatment to PLHIV should be streamlined in order to ensure that there are no unnecessary difficulties and delays.
4. Introduce a non-invasive method for verifying sexual assault and discontinue the two-finger test. Establish strict protocols in this regard (see India recommendations, above).
5. Introduce optional HIV counselling and testing for all sexual assault cases. Provide medico-legal officers sensitization and HIV-awareness training in order to understand transmission risks.

²²¹ Stigma Index 2011.

²²² Stigma Index 2011.

Recommendations to SAARCLAW

1. Use regular SAARCLAW meetings as forums to disseminate information on the latest findings on violations of women's rights in health care settings. Raise awareness among SAARCLAW members on the specific legal needs of women and encourage legal aid-related involvement from constituent members.
2. Disseminate information on legal judgments to all lawyers, judges, and academics who are members of SAARCLAW. This could include: the Supreme Court's decision on the two-finger test in sexual assault cases in India; the UN Special Rapporteur report on re-classifying violations in health care settings as torture; and progress on new laws in each country on discrimination, HIV/AIDS, and violence against women.
3. SAARCLAW could advocate for the passing of specific legislation in its member countries. For instance, in India, Pakistan, and Nepal, SAARCLAW chapters could advocate for the passing of the pending HIV bills. In Bangladesh, it could assist in creating partnerships/networks and an advocacy platform to encourage the drafting of HIV-related legislation.
4. Continue involvement in international forums on social justice and rights issues with the aim of building capacity of all SAARCLAW chapters to act as advocates on these issues in their own countries.
5. Support national chapters to submit periodic reports on human rights issues under the universal periodic review process.
6. Encourage national chapters to engage more actively with issues related to women's rights and to implement workshops to address the lack of awareness of legal rights and general knowledge on health-related rights.
7. Support national chapters to formulate and implement training programmes and to carry out workshops on discrimination against women at health care settings, for example, with District Bar Councils.
8. Support national chapters to work closely with religious organizations, seek their assistance, and include them in the process of planning and generating options on issues related to health, including HIV and AIDS
9. Encourage national chapters to engage affiliated lawyers to provide pro bono legal aid, or lead public interest litigation related to violations of women's rights in the health care sector.
10. Establish an online legal knowledge archive of the SAARC region with regard to judgments, case law, and legislation pertaining to women, including KAWG, disabled women, and other marginalized women. This should be updated on a regular basis and be accessible to researchers and practitioners.

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